Southern DHB Board Meeting

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

08/12/2020 09:30 AM - 12:30 PM

APOLOGIES

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

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Board
Date of Meeting:	8 December 2020

Summary:

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

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

Changes to Interests Registers over the last month:

- Jean O'Callaghan – resigned from Geneva Health, effective August 2020
- Tuari Potiki – resigned from District Licensing Committee, DCC, November 2020.

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 25/11/2020

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~~, Member, Spokes Dunedin (cycling advocacy group)		Updated 22.10.2020
	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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
	03.04.2020	Client, Royal District Nursing Service NZ Ltd		
Jean O'Callaghan	~~13.05.2019~~	~~Employee of Geneva Health~~	~~Provides care in the community; supports one long term client but has no financial or management input.~~	Resigned, effective August 2020
	13.05.2019	St John Volunteer, Lakes District Hospital	No involvement in any decision making.	~~Taking six months' leave.~~ Recommencing 22.08.2020.
Tuari Potiki	09.12.2019	Employee, Otago University		
	09.12.2019	Chair, NZ Drug Foundation		
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd* (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)~~		Resigned 06.11.2020
	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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Andrew Connolly (Crown Monitor)	21.01.2020	Employee, Counties Manukau DHB		
	21.01.2020	Deputy Commissioner, Waikato DHB		
	21.01.2020	Southern Partnership Group		
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
	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	
	20.11.2020	Chair, South Island CIOs	
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

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
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
	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 Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	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~~

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	Daughter, medical student at Auckland University.	
	23.07.2020	Wife, Chief Data Architect, Inde Technology	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
	23.10.2018	Shareholder and Director, Barr Burgess & Stewart Limited	Accounting services
	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, 3 November 2020, 9.30 am
Board Room, Southland Hospital Campus, Invercargill

Present:	Dr David Perez	Deputy Chair
	Ms Ilka Beekhuis	
	Dr John Chambers	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly	
	Mr Terry King	
	Mrs Jean O'Callaghan	
	Mr Tuari Potiki	
	Miss Lesley Soper	*(until 2.45 pm)*
	Dr Moana Theodore	
In Attendance:	Mr Roger Jarrold	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Ms Kaye Cheetham	Chief Allied Health, Scientific and Technical Officer *(by Zoom until 11.00 am)*
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Julie Rickman	Executive Director Finance, Procurement and Facilities *(by Zoom)*
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Deputy Chair welcomed everyone, and the meeting was opened with a karakia by the Chief Māori Health Strategy and Improvement Officer.

2.0 PUBLIC FORUM

Dialysis South

Mrs Sally Tily presented the Board with a submission requesting "two satellite haemodialysis units with associated equipment and staff support, as part of the Dunedin based unit, in Invercargill" (tabled), which included an overview of the impact of current arrangements on families and the health and wellbeing of patients.

In speaking in support of the submission, Mr Mike Blair, dialysis patient, outlined the mental, emotional, physical, and financial challenges he and his whānau experienced from having to travel to Dunedin for treatment.

Mrs Sharon Blair informed the Board that the dialysis facility was also required to enable people from out of town to dialyse when visiting Invercargill.

The Deputy Chair thanked Mrs Tily and Mr Blair for their presentation and sharing their experiences.

In response, the Chief Executive Officer (CEO) advised that a business case was being developed to site two dialysis units in the Community Services Building on the Southland Hospital campus. He advised that it would not solve all the problems, as people who were acutely unwell could not receive treatment in Invercargill, but it would provide base support. He anticipated that the business case would be submitted to the Board in December or early in the new year.

3.0 APOLOGIES

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

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

The Board:

- Requested that the 2013 proposal for a gastroenterology unit and the Disability Strategy implementation timeline be circulated to members;
- Requested that advice on performance monitoring reporting to the statutory advisory committees be brought back in due course;
- Noted that the recommendation for seven-day hospital service provision had been discussed by the Hospital Advisory Committee (HAC) the previous day and it was desirable that be implemented prior to the new hospital coming on stream. This would be considered as part of the strategic planning exercise;
- Noted that the use of MRI for breast screening in Southland had been discussed by HAC and would be considered as part of a broader view of radiology services across the district.

New Dunedin Hospital Multi-Faith Centre

The CEO informed the Board that there had been a request to re-open consultation on the new Dunedin Hospital multi-faith centre, as there had been a suggestion that the correspondence received by the Programme Office had not been shared with the Board. The correspondence had been included in the agenda papers, so at this stage it was not intended to re-open the previous discussion and debate. The design of the multi-faith centre, and how it would operate, would be the subject of a hui led by Iwi.

It was resolved:

"That the minutes of the Board meeting held on 6 October 2020 be approved and adopted as a true and correct record."

D Perez/ I Beekhuis

6.0 ACTION SHEET

The Board reviewed the Action Sheet (tab 5).

Performance Dashboard

The CEO reported that:

- A quantitative dashboard was being mocked up and would be discussed with Jean O'Callaghan and Roger Jarrold, prior to being presented to the Board;
- The definition of short notice postponements had been changed to postponement within 24 hours of surgery.

Urology

The Board requested that an expected completion date be added for moving components of Urology to a district wide service.

Theatre Utilisation

The CEO informed the Board that the theatre utilisation measure had been corrected, so it now captured planned elective surgery and not acute theatre work.

Strategic Plan Refresh

The CEO reported that the request for proposal (RfP) for the Strategic Plan refresh would close on 12 November 2020 and it was proposed that a small RfP evaluation panel be formed comprising the Board Deputy Chair, Chair of CPHAC, the Executive Director Strategy, Primary and Community (EDSP&C), CEO, and Principal Advisor to the CEO.

7.0 ADVISORY COMMITTEE REPORTS

Finance, Audit and Risk Committee

Mrs O'Callaghan, Deputy Chair of the Finance, Audit and Risk (FAR) Committee, gave a verbal report on the FAR Committee meeting held on 22 October 2020, during which she highlighted the following items.

- The Committee requested further information for its next meeting on unexpected deaths, planned leave guidelines and HR metrics.
- The external auditor attended the meeting and advised that a similar audit opinion would be issued this year in relation to holiday pay; the impact of COVID-19 on performance reporting was being looked at, along with the treatment of the remaining useful life of property, plant and equipment that may be impacted by the new Dunedin Hospital.
- The year-end timetable and the cut-off dates for events after the close off of the balance sheet were discussed.
- The Protected Disclosures Whistleblowing Policy and procedures were considered, and it was expected they would be submitted to the next Board meeting.
- The monthly Health, Safety and Welfare report was presented and the Committee was advised that all actions required of the DHB by WorkSafe were on track to be delivered. The Committee requested further information on the hazards register.

- IT projects were reported on and the Committee was assured of progress and risk management.
- The Quality and Clinical Risk Report covered a wide range of areas. Analysis of pressure injuries and pressure on nursing staff was covered and further reporting would be received on those.
- The Strategic Risk Report was reviewed, and it was still intended that a high-level risk report would be considered at Board level.
- The consolidated financial report was presented. This showed a net deficit for the period ended 30 September 2020 of $1.1 million unfavourable to budget. The FAR Committee Chair requested that the impact of that be made clear in future reporting.
- The annual leave liability continued to trend upward.

The CEO informed the Board that the FAR Committee Chair had indicated that she wished to end her term in December 2020. The Deputy Chair advised that the Board had agreed in principle that her replacement would be an external person with financial expertise.

It was resolved:

"That the Board receive and note the verbal report on the FAR Committee meeting held on 22 October 2020."

J O'Callaghan/L Kelly

Community and Public Health and Disability Support Advisory Committees

The unconfirmed minutes of the joint meeting of the Community and Public Health and Disability Support Advisory Committees held on 5 October 2020 were circulated with the agenda (tab 6) and taken as read.

It was resolved:

"That the Board receive and note the unconfirmed minutes of the CPHAC/DSAC meeting held on 5 October 2020."

M Theodore/T Potiki

Hospital Advisory Committee

The Board received a verbal report from Dr Perez on the business considered at the Hospital Advisory Committee (HAC) meeting held on 2 November 2020, during which he reported on the following key discussion items.

- *Equity Reporting* – The Executive Director Specialist Services (EDSS) presented First Specialist Appointment (FSA) data rates by ethnicity. As the figures were crude, the Committee suggested that some common conditions requiring hospital referral be looked at to get more meaningful referral rates.
- *ESPI2 and ESPI5 Performance* – Recovery funding would be used to apply the prioritisation tool more widely to achieve ESPI2 compliance. There was a process under way to review patients on the ESPI5 list for more than 24 months and fast track them as appropriate.
- *Faster Cancer Treatment* – Work had started on developing and streamlining pathways in the Oncology Department.
- *Gastroenterology* – An update was received on the gastroenterology project.

- *Next Meeting* – It was decided to hold an additional meeting of HAC prior to Christmas, at which updates on Valuing Patient Time (VPT), hospital escalation planning, and a presentation on radiology would be received.

It was resolved:

"That the Board receive and note the verbal report of the Hospital Advisory Committee meeting held on 2 November 2020."

D Perez/J O'Callaghan

8.0 CHIEF EXECUTIVE OFFICER'S REPORT

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

- *Organisational Performance* – Volumes, occupancy, caseweights, ED attendances, and bed days were down but the workload was not, which was puzzling. The team were working to understand this challenge.
- *South Island Alliance* – A process was currently under way to realign the priorities of the South Island Alliance.
- *Annual Plan 2020/21* – The Annual Plan had been approved and was available on the Southern DHB website.
- *Service Planning* – A high level timetable for the development of service plans was included in the CEO's report.
- *Recovery Funding* – Due to the work of the Executive Director Specialist Services (EDSS) and his team, Southern DHB had received more COVID-19 recovery funding than expected. The capital requested was still subject to the approval of a business case.
- *Gastroenterology* – The EDSS gave a verbal update on the gastroenterology project key achievements to date.
- *Enhanced Generalism* – The business case for enhanced generalism and a Medical Assessment Unit (MAU) were expected to be submitted to the December 2020 Board meeting.

  It was suggested that, to relieve the current pressure, some of the functionality of an MAU be implemented ahead of building the MAU facility. The Deputy Chair asked that this item be added to the Hospital Advisory Committee agenda.
- *Aged Residential Care: Psychogeriatric Bed Occupancy* – The CEO advised that more investigation was required to understand the models of care in the South Island, as the data showed that DHBs in the south had more psychogeriatric beds than the rest of New Zealand.
- *Kaumatua Retirement*: Southland – A farewell function was being held at the Murihiku Marae on 20 November 2020 for Mohi Timoko, who was retiring from his role as Kaumatua for the Southern DHB in Southland, which Board members were welcome to attend.
- *Prioritisation of Equity Funding* – The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) reported that iwi representatives were holding a wānaka to consider the prioritisation of equity funding approved by the Board.

Management then responded to questions on the South Island Alliance Programme Office (SIAPO), the enhanced generalism business case and the timeframe for building an MAU, cancer waiting times and communication with patients, and the increase in demand for mental health services for young people in rural areas.

During discussion the Board:

- Requested that it be informed of any gaps identified during service planning, other than haemodialysis, that may need to be addressed;
- Noted the benefits of co-locating the acute stroke and rehabilitation stroke units;
- Received advice from the EDSP&C that temperature control for Ward 9B was on the capex list and would be implemented by Building and Property.

It was resolved:

"That the CEO's report be noted."

9.0 PRIMARY MATERNITY FACILITIES – CENTRAL OTAGO/WANAKA

Mary Cleary-Lyons, General Manager, Primary Care and Population Health, and Heather La Dell, Midwifery Director, joined the meeting for this item.

A paper on the location of primary maternity facilities in Central Otago/Wanaka was circulated with the agenda (tab 11) and Mrs Cleary-Lyons presented an overview of the consultation and process followed to arrive at the recommendation to the Board (tab 13).

The CEO informed the Board that the option recommended would cost more than the status quo but offered an improved service.

Mrs Cleary-Lyons and Ms La Dell then responded to questions from members on the options and the proposed model.

In thanking Mrs Cleary-Lyons and Ms La Dell, the Deputy Chair noted that the duration of the consultation process had allowed very wide input.

It was resolved:

"That the Board:

1. **Note the contents of the Decision Paper: Where should we locate Primary Maternity Facilities in Central Otago/ Wanaka?**
2. **Endorse the recommendation of the Central Lakes Locality Network (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 two unit model can only be financially sustainable if the DHB can work with local LMC midwives and other local providers 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."**

I Beekhuis/L Kelly

10.0 FINANCE AND PERFORMANCE

The finance, volumes and performance reports to 30 September 2020 (tab 8) were taken as read and management took questions.

It was resolved:

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

D Perez/T Potiki

11.0 DIGITAL PROGRAMME BUSINESS CASE

The CEO presented an update on the status of the Digital Programme (tab 10), then responded to members' questions.

It was resolved:

"That the Board:

- **Note the status of the Digital Programme;**
- **Note the outcomes from the business case review clinic held with Treasury on 21 October 2020."**

D Perez/L Soper

12.0 PERFORMANCE REPORTING

The Executive Director Strategy, Primary and Community presented an update on performance reporting and a revised draft reporting format (tab 9).

It was resolved:

"That the report be noted."

D Perez/L Soper

PUBLIC EXCLUDED SESSION

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

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

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

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

L Soper/I Beekhuis

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

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

The meeting closed at 3.20 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board
BOARD MEETING ACTION SHEET

As at 27 November 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020 Updated Nov 2020	**Quantitative Performance Dashboard** (Minute item 6.0)	Draft quantitative dashboard to be presented to the Board.	CEO	Work in progress, structure agreed and being worked up by the team.	
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	MoH PBFF review is on hold pending further work to be completed by Health and Disability System Review Transition Unit.	~~December 2020~~ June 2021
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	Options paper included in agenda.	December 2020
Oct 2020	**Home and Community Support Services** (Minute item 2.0)	Report to be provided on how the contract is monitored.	EDSP&C	Attached.	December 2020
Oct 2020 Nov 2020	**Performance Monitoring** (Minute item 5.0) (Minute item 5.0)	Information clarifying reporting responsibilities to the statutory advisory committees to be circulated to the Board. To be brought back to Board in due course.	CEO CEO	Completed.	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Oct 2020 Nov 2020	**Urology** (Minute item 6.0) (Minute item 5.0)	Consideration to be given to moving components of Urology to a district wide service. Expected completion date to be added.	EDSS 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 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. This is complete. There will be challenges from time to time with staff, but there is one clinical leader across both sites. The next component to implement is introducing the same clinical priority scoring tool across both sites. Expected implementation end June 2021.	Complete
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		Completed
Oct 2020	**Southland MRI** (Minute item 10.0)	Further information to be provided on the use of MRI for breast screening in Southland.	EDSS	Will be considered by HAC as part of a broader view of radiology services across the district.	Will be part of HAC agenda
Nov 2020	**Colonoscopy** (Minute item 5.0)	2012 proposal for a gastroenterology unit to be circulated to members.	Deputy Chair/BS	2012 Gastrointestinal Disease Centre Proposal uploaded to Diligent Resource Centre.	Completed
Nov 2020	**Disability Strategy** (Minute item 5.0)	Implementation timeline to be circulated to members.	BS	Emailed 9 November 2020.	Completed

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Nov 2020	**Service Planning** (Minute item 8.0)	Board to be informed of any gaps that may need to be addressed.	EDSP&C		

Home & Community Support Services Monitoring

At the October Board meeting, a report was requested on how the HCSS contract is monitored.

1 Quality Monitoring

1.1 Certification to NZS 8158:2012

The providers are required to be certified to NZS 8158:2012, which includes a full certification audit every three years, with a surveillance audit every 18 months. Audits are conducted nationally by Designated Audit Agencies, with not all branches audited at every audit.

All three agencies were audited in 2019, and are due for their next audits either over the next twelve months. None had any high risk findings, and all findings had Corrective Actions followed up by their Designated Audit Agencies.

1.2 DHB Audit to Contract

All three providers are scheduled for a routine contractual audit during the 2020/2021 year.

1.3 Provider Specific Quality Reporting

Providers are required to submit comprehensive Quality Reporting 6 monthly as shown in Appendix One. These are reviewed at our Alliance Service Development Group meetings.

1.4 Alliance Management Group and Service Development Group

Our HCSS Alliance is focussed on working collaboratively for the best outcomes for the clients and the best outcomes for the system. The relationship is more than a traditional funder/contracted provider relationship. The Alliance meets monthly at an operational level as a Service Development Group to address operational issues, areas of concern, and quality monitoring and initiatives. Additionally, The Alliance meets monthly at a strategic level as an Alliance Management Group to monitor the activity in the service, financial sustainability, and review and decide on any recommendations from the Service Development Group.

Our Service Development Group has identified and implemented the following Quality Initiatives across the system with great success:

- Identifying those at Risk of Suicidal Ideation
- Process to review health and safety concerns that may lead to service withdrawal
- Carer Stress Screening Tool
- STOP and WATCH
- Supporting the HOME Team initiative, including quick response supports when required
- Onboarding to Health Connect South/Health One Patient Information Systems

We are currently developing processes and pilots in the following areas, based on the 2019 *Medication Guidelines for the Home & Community Support Services Sector:*

- Fentanyl Patches
- Insulin administration

1.5 Agreement Expiry and Request for Proposal

This current HCSS Agreement expires 30 June 2022. As the lead time for a new agreement and new providers is significant, a Request for Proposal (RFP) will be issued later in the 2021 year. This RFP

will be based on national work in the HCSS area, eg National Framework for Home and Community Support Services, the updated National Service Specification for Home and Community Support Services, and in line with our Primary and Community Strategy.

Appendix One

Six-monthly HCSS Report
HOME AND COMMUNITY SUPPORT SERVICES
For Services Delivered to
Health of Older People (HOP) clients

Provider			
Provider/Vendor ID No			
Contract ID No (HOP)			
Name of person filling out this report			
Contact email for that person			
Contact phone number for that person			
Reporting period			

PART A: DATA ON HEALTH OF OLDER PEOPLE (HOP) CLIENTS

Total Number of Current Health of Older People (HOP) Clients at the close of reporting period (31 March 2015):			
Care Plans:	**Number**	**Number**	**Number**
Total number of current Health of Older People (HOP) clients at the close of the reporting period			
Total number of current clients with care plans in place			
Number of plans with evidence of client involvement in the development of the Individual Care Plan			
Number of plans completed within three weeks from date of referral			
Number of care plans with clear contingency plan documented			
Number of clients with clearly identified goals in the Care Plan			
Total Number of Clients serviced during reporting period			
Explanation if numbers with Care Plans, Goals, etc. Not similar to Total Number of HOP Clients:			

Client Goals and Outcomes for the reporting period:			
Total number of Health of Older People (HOP) clients serviced during the reporting period			

Percentage of Health of Older People (HOP) clients surveyed for satisfaction during the reporting period			
Percentage of surveys returned			
Within the standardized satisfaction survey responses:			
Percentage of clients who reported that the way their goals were planned met their needs			
Percentage of clients who reported making progress toward their goals			
Percentage of clients who reported there was flexibility in the way their care was delivered			
Percentage of clients who reported their support worker did not turn up as expected			
Percentage of clients who reported overall satisfaction with the quality of care they received			
Explanation of deviations from survey expectations:			

Complaint Management			
Total number of complaints received from Health of Older People (HOP) clients during this reporting period			
Total Number of Health of Older People (HOP) clients who made complaints during this reporting period			
Describe briefly improvements that have been made as a result of complaint monitoring and resolution			
Describe briefly the top three themes coming out in complaints (for example support worker communication or attitude, allegations of abuse, or community integration).			
HCSS Complaints Reporting Template  HCSS Complaints Categorisation Repor			

Compliments			
Total number of compliments received from Health of Older People (HOP) clients			
Describe briefly the top three themes coming out of compliments			

PART B: SERVICES AND TRENDS

This part of the report is expected to be a narrative report. It needs to describe any service issues, trends, and innovation.

B1 Service delivery issues

	Please describe these issues briefly	Please describe briefly what you have done, or are doing, to address these issues	Please describe these issues briefly	Please describe briefly what you have done, or are doing, to address these issues	Please describe these issues briefly	Please describe briefly what you have done, or are doing, to address these issues
a. Staff turnover, recruitment, retention						
b. Staff training (including the percentage of support workers who are trained to Level 2 and Level 3 in the National Certificate in Community Support Services and/ or have completed recognition of current competence process)						
c. Paid Family Carers						
d. Undelivered services						
e. Workforce reliability						

f. Quality						
g. Other						

B2 Emerging trends or innovative approaches relating to your services

(a) Emerging trends			
(b) Innovative approaches			
c) Other Service Delivery Issues			

**FINANCE, AUDIT AND RISK COMMITTEE MEETING,
19 November 2020**

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

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITEE MEETING
7 December 2020

- Verbal report from Tuari Potiki, Chair, Community and Public Health Advisory Committee

DISABILITY SUPPORT ADVISORY COMMITEE MEETING
7 December 2020

- Verbal report from Moana Theodore, Chair, Disability Support Advisory Committee

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 2 November 2020, commencing at 1.30 pm in the Board Room, Community Services Building, Southland Hospital Campus

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

1.0 WELCOME

The Chair welcomed everyone to the meeting.

2.0 APOLOGIES

An apology for lateness was received from Ms Justine Camp.

3.0 DECLARATION OF INTERESTS

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

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

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 7 September 2020 be approved and adopted as a true and correct record."

D Perez/L Soper

5.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 4).

Nitrous Oxide Usage

The Chair advised that the Nitrous Oxide issue is work in progress and a request was made for the matter to be formally transferred to the Finance Audit and Risk Committee meeting.

Seven-day Hospital Services Initiative

Further work is to be undertaken on developing the seven-day Hospital Services Initiative with a view to registering it in the Strategic Plan. In discussion, the Committee were advised that:

- The outcome of a meeting with the New Build Team to discuss what they see as the need for seven days versus current needs will form the basis for what is fed in to the Strategic Plan.
- If the Generalism business case is approved in December 2020 it will be the catalyst for further discussion.
- The culture change required to move from a five day to a seven-day service.
- A seven-day service should result in enhanced patient safety.
- Phased steps should be implememnted prior to the opening of the NDH.

6.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director of Specialist Services Report

The Executive Director Specialist Services (EDSS) monthly report (tab 5.1) was taken as read and the EDSS, Mr Patrick Ng, drew the Committee's attention to the following items:

Ethnicity

An update was provided on the work undertaken in an effort to develop ethnicity reporting across Southern, with the first of the Power BI reports developed. The initial report identified a significant gap for Pasifika FSA rates and further work will be undertaken to explore and understand the results. The work done in the area of bowel screening to ensure rates representative of the population could be replicated. Concern was raised around the inference drawn from the results and the EDSS acknowledged the work to date is a starting point only and further work will be done to take prevalence into account. In addition to the First Specialist Appointment, ethnicity is to be looked at from a number of angles, including the proportion that move on to definitive treatment, impact where GPs have stopped referring, etc. A couple of large disease groups are to be chosen to follow prevalence and hospital service delivery. The EDSS is to work with the Chief Māori Health Strategy and Improvement Officer (CMHS&IO) and members of the Strategy, Primary and Community team to advance the work.

Surgical Performance – Case Weights and Discharges

Management has worked with the Ministry of Health (MoH) to lock down Southern DHB's Annual Elective Surgery Production Plan. Southern is materially on plan for September year-to-date. Elective surgery has been impacted during the August/September 2020 period and will need to be managed carefully to stay on plan for the remainder of the year. Surgery recovery was undertaken prior to the MoH confirming what they would fund from a recovery perspective and Southern has done $1M more surgery than the normal plan year-to-date. There is a daily process in place to monitor elective cancellations. More accurate forecasting is now in place and Theatre cancellations are down from 400 per month to 70 per month across the two sites. Management responded to queries around the impact on

surgical flow from move of the Assessment Unit on the sixth floor of Dunedin Hospital to Wakari and the decision to return it to Dunedin Hospital.

Fifth Theatre in Southland

The MoH has confirmed new initiative funding to fund a fifth Theatre in Southland and the business case will be submitted on 6 November 2020. Southern DHB will be required to pay the capital charge. The Committee congratulated the EDSS and his team on their success in gaining the initiative funding for the capital requests.

Outpatient Performance ESPI 2

Progress made in recovering outpatient performance post COVID-19 and the on-going expectation of improvement in performance with the assistance of the pending recovery funding. Development of the prioritisation tool in a wider range of services and linkage to determining unmet need using Obstetrics and Gynaecology in Southland as an example.

Inpatient Performance ESPI 5

The challenges with resolving the inpatient wait list, with recovery in this area more dependent on recovery funding. The initial focus is on patients who have been on a waiting list for over two years and these are being looked at on a case by case basis. The reason for the long waits and potential patient harm will be documented.

Committee member, Ms Justine Camp, joined the meeting at 2.05pm.

Transfer of care is in line with policy but requires engagement with General Practice and fast tracking through the outpatient process when they meet the criteria for surgery. The Committee noted that the requirement to quit smoking or lose weight prior to treatment could adversely impact equity, with Māori over-represented in these areas. The Chief Nursing and Midwifery Officer, Mrs Jane Wilson, suggested that the Clinical Council look at the risk register and include this on the agenda for the next meeting with a view to a report being done on a number of factors including demographics and reasons for delay in treatment. The Committee asked for an assurance that where patients are referred back to General Practice there are programmes available for them to access ongoing assessment and there is a means of tracking them through the system. Management agreed to provide a report for the next meeting outlining the ESPI 5 status, including volumes added and taken off the waiting list, managing the backlog and the potential impact of recovery money and initiative funding. The Chief Medical Officer, Dr Nigel Millar, provided an update on managing the waiting list and the reasons for and impact on supply and demand. The recovery funding has been backdated to July 2020 and is available for three years at $5.2M per annum. Crown Monitor, Mr Andrew Connolly advised that no patient should be on a waiting list for two years unless their priority has been re-assessed. Whilst waiting list fluctuation is normal, CME and annual leave should be factored into production planning and the Surgeons need to manage the situation. With the exception of Vascular and Cardiothoracic, there are very few specialties where a patient who smokes would be denied surgery. The CEO advised that the work being undertaken within Specialist Services is on track and the EDSS confirmed the goal is to systematically reduce the waiting list.

Medical imaging diagnostics

CT Performance – progress made in CT performance, with an increase of 25 additional scans per week and an ability to further increase this in the coming months. Concerns were raised in relation to inpatients waiting in hospital beds on availability of CT scans and management advised that acute procedures are prioritised and the goal is to treat acute cases more quickly and provide more capacity for elective patients. The addition of CT scan capacity with contrast would be useful and options to use the CT facilities across the district are available for those able to travel. A request was made for the reporting on CT Performance to

be broken down specifically for Dunedin and Southland and for the longest waiting times to be recorded. A request was also made for the differential for acute scans to be reported separately due to the requirement for acute CT scans to be completed within one week. A request was made for clarification on who is being offered remote CT scans under the agreement with Oamaru and what the uptake rate is.

MRI Performance – improvement to MRI performance as a result of one-off recovery money funding additional activity. Two extended outages in September will impact the MRI performance reflected in the October 2020 results. The Chair requested that an options paper be provided on MRI and Ultrasound to identify what the wait limiting steps are for each and what the options are around those. Following discussion on delays in waiting times for biopsies and fine needle aspirations, Dr Nigel Millar and Dr Lyndell Kelly are to discuss this further and report back to the Committee on the waiting times and any other issues identified. Advice was received on the outsourcing of MRI for breast screening and challenges with recruiting Radiologists with breast MRI expertise within Southern DHB due to a nationwide shortage. In response to concerns raised, a request was made for a presentation on Radiology to be made to the next HAC meeting, with a focus on staff shortages and needs now and over the next five years, workforce planning and other challenges for the service including access by primary care to diagnostic tools.

Emergency Department (ED) – ED performance across the district and work being done by the Chief Medical Officer (CMO) and the General Manager Operations on the implementation of an escalation plan with a view to getting specialist assessments happening faster on the Dunedin site. An update was provided on the key initiative for the implementation of a generalist admitting model and the development of a Medical Assessment Unit (MAU) to be built next to the ED. Following discussions with relevant stakeholders the case will be put to the Board for consideration, but completion of the unit would be 18-24 months away. An options paper will be provided for a decision on whether the new CT should go in to the MAU, the ED or in to the community. There is pressure on the ED in Southland. Crown Monitor, Mr Andrew Connolly stressed the importance of the six-hour target in ED. It is a whole of Hospital issue with timeliness of discharge, effectiveness of communication on the Wards to clear the beds etc. critical. The CMO spoke on the importance of the Valuing Patients Time (VPT) Plan and advised that the additional Physicians to serve generalism are already in place. An update on VPT is to be provided for the next HAC meeting. The CEO advised on the conflict between what the data is showing and the acuity and workload pressures being experienced by Charge Nurse Managers on the ground. Admittance rates to Hospital were also higher than in the past.

Faster Cancer Treatment – the Committee raised concerns that some people have been waiting seven weeks for treatment when the indicative time is four weeks. The CEO advised that DHBs are required to be transparent around their waiting times. The radiation oncology wait list has stabilised and the EDSS is to investigate and report back. A meeting has been arranged to discuss the longer term challenges for the Medical Oncology service. There is a challenge when Pharmac expand the scope of a drug as the resourcing implications are not taken into account in their budget. Concern was raised around the tone and content of a letter sent to an older patient by the Southern Cancer and Blood Service. In discussion, the CEO confirmed that pro-forma letters being forwarded to the community were to be considered by the Community Health Council. The wording of the letter is to be modified and needs to be empathetic, but honest and transparent. Management will review the process and provide feedback. Information was requested on the effectiveness of the whole of Cancer services, including performance against the 31-day and 62-day target and a comparison of those against other DHBs is to be included.

Gastroenterology – Ms Emma Bell has been appointed as Project Manager to run the improvement programme and support has been provided to Mr Andrew Connolly

to develop the Terms of Reference (ToR) for the Endoscopy Oversight Committee, with the first meeting held on 23 October 2020. A draft ToR has been developed for the Referral User Group which is scheduled to get underway over the next two weeks. An update was provided on referral practice and process. A workshop is to be held this week to enhance the electronic internal referral used for referrals into Gastroenterology. A key focus will be around data definitions and reconciliation of that so there is confidence in what is being reported to the MoH on a monthly basis. Mr Connolly acknowledged the work done by the EDSS and advised on the six recommendations in the Bissett report and progress against those. Issues have been raised in a report to the Board that require resolution, including the inability for a Clinician to seek an increase in priority for their case without changing categories. A recommendation has been made that an audit be undertaken of acute presentations, noting that an observational study was done on all cancers of any sort presenting acutely to the DHB over a three-month period in 2016. The Southland Surgeons advise they are getting a case a week of this type. The paper in the HAC agenda refers to encouraging greater referrals from primary care. Concern was noted around Southern DHB's colonoscopy decline rate of 15% compared to around 3% in most other DHBs and decision making should be based on need. The information on Intervention Rates by DHB is a quarterly report and will be included for members' information as it becomes available.

Caseweights - a request was made for the acute and elective volumes for Medical, Surgical, etc. to be added to the 'caseweight and discharge volumes graph'.

Financial Report

The EDSS presented the Financial Report (tab 5.2) then took questions, with the following highlighted:

- The adverse result of $1,027K for the month and $2,712K year-to-date was largely due to workforce costs ($745K year-to-date) driven by:
  - SMO costs – some prior year costs were not accrued for.
  - Timing issues with budgeted leave taken versus actual leave taken.
  - SMO CME leave balance being written off over five years instead of three with a $200K impact for the quarter.
  - Allied leave taken less than the 100% per annum budget assumption.
  - Allied leave expenses related to continued vacancies.
- Expenditure is unfavourable by $3,661K year-to-date. Work is being done to investigate the underlying causes of the key drivers for expenditure due to:
  - Higher rates of interventional cardiology than budgeted for in the first quarter. Feedback from Cardiology indicates this is due to Post COVID catch-up.
  - On-going over-expenditure in blood products and Haemophilia.
  - One off costs associated with the MRI machines in September 2020.
  - High Pharmacy costs for Gastroenterology and Rheumatology in September 2020 of approximately $200K.
  - Cleaning costs with the additional higher costs incurred during COVID continuing.
- The off-set of $1.6M in revenue is due to:
  - The outsourcing of $1M more surgery than planned.
  - $200K of radiology revenue from the MoH, which was spent on the outsourced clinical services line.

- The remainder relates to Haemophilia.

The CEO advised on the growth in FTE. The Chief Nursing and Midwifery Officer and the Chief Allied Health Scientific and Technical Officer are taking a lead on work to understand the growth in FTE related to their respective areas.

The Recovery Plan work being led by the EDSS will be reported through the Finance, Audit and Risk Committee (FARC) with a high level summary provided for the HAC.

***It was resolved**:*

"That the reports to the Hospital Advisory Committee be noted.

7.0 GENERAL BUSINESS

The Chair tabled a one-page summary outlining Specialist Services Performance Measures in the 2020/2021 Annual Plan (AP) and highlighted the following:

- Of the 19 bullet points identified, only five are currently reported on through the HAC. Some of the others are reported through to the Board.
- Under the HAC ToR, the Committee should have oversight of all 19 Performance Measures.
- The report in the Southern DHB Board Agenda written by the Executive Director of Strategy, Primary and Community, Ms Lisa Gestro, providing a reporting matrix which goes to the MoH and the need for HAC to receive a copy of that report.
- HAC has responsibility to monitor the performance measures relating to Specialist Services in the AP and the focus should be to eliminate any areas showing as red, change amber to green and maintain green indicators.
- Discussion was deferred to the Board meeting to be held on 3 November 2020.

CONFIDENTIAL SESSION

At 4.00pm it was resolved that the Hospital Advisory Committee move into committee to consider the agenda items listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
2. Dunedin Hospital Redevelopment	To allow commercial activities and negotiations (including commercial and industrial negotiations) to be carried out without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.

Confirmed as a true and correct record:

Chair: _____

Date: _____

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	8 December 2020

Summary:

Considered in this paper are:

- General information and emerging issues

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

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

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

Prepared by: Chris Fleming Chief Executive Officer **Date:** 30 November 2020	**Presented by:** Chris Fleming Chief Executive Officer

RECOMMENDATIONS:

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

CHIEF EXECUTIVE OFFICER'S REPORT

1. PURPOSE

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

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

2. ORGANISATIONAL PERFORMANCE

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

- Finance report
- High Level Volumes
- Performance Dashboard.

Financial performance for the month of September is a deficit of $0.439 million compared to a planned deficit of $0.293 million, and hence $0.146 million unfavourable to plan. Year to date (YTD) financial performance is a $4.597 million deficit against a planned deficit of $3.350 million, resulting in a year to date deficit against plan of $1.247 million. Breaking the result down however the net COVID related costs are actually positive for both the month and year to date due to the accounting treatment of ventilator and other related equipment the Ministry procured to support COVID, which was then donated to the DHBs. The receipt of the conation has to be treated as income and the expenditure sits on the balance sheet as Fixed Assets. The total amount of this donation was $1.823 million and COVID overall is favourable by $813k after offsetting unbudgeted COVID related costs year to date. The underlying core deficit excluding COVID is therefore $5.410 million deficit compared to a budgeted deficit of $3.350 million representing a true adverse result to plan of $2.060 million. The forecast for year-end has been discussed at the Finance, Audit and Risk Committee (FARC) Meetings and submitted to the Ministry of Health at a deficit of $15.7 million compared to the planned deficit of $10.9 million. This forecast excludes:

- Any financial impact attributable to COVID-19 in this year
- Any impact of accounting treatment for the New Dunedin Hospital
- Any further unbudgeted impact for the Holidays Act.

From a volumes perspective, case weighted discharges were up 3.0% for the month of October compared to the previous year, and Emergency Departments (EDs) across the district have picked up with them being 1.6% up for the month. Mental Health bed days remain down 7.2% compared to last October. On a year to date basis, case weights are now very close to last year but with a significant reduction in Medical being offset by an increase in Surgery (largely acute). Other indicators remain down with ED being 2.1% down and Mental Health bed days being 6.7% down.

3. STRATEGIC REFRESH

The request for proposal (RFP) process for supporting the refresh of the Southern District Health Board has now closed with five proposals being received. The evaluation of these proposals will be undertaken by David Perez, Tuari Potiki, Lisa Gestro, Greer Harper and myself on 2 December. Assuming that one of the proposals are accepted, we will do the necessary work required to enable the review to get underway formally in the new year.

As a precursor to the Strategic Refresh, a workshop is being held on Friday 18 December to which the Board members, Iwi Governance Committee (IGC) and Executive Leadership Team (ELT) members are all invited. This workshop will be facilitated by Pat Snedden, who is the Chair of Auckland DHB. Pat has served as Chair of Auckland District Health Board on two separate occasions and has also been the Chair of Counties Manukau DHB. Pat brings a strong commitment to Te Tiriti O Waitangi and has a real drive to ensure actions are taken that empower Māori and address the principles of equity that have plagued the health system over many years.

The purpose of the workshop is really as a thought provoking piece, so that we start to think differently about the future moving into the Strategic Refresh in the new year.

4. BALANCED REPORTING

We are progressively working towards developing four core reports for the Board and relevant Committees to get a balanced picture across performance. The four reports are:

- Financials – existing financial statements reported
- Quality Performance Scorecard – this is the report which has been developed over the last 18 months and is included regularly in the Board reporting
- Quantitative Performance Scorecard – historically we have produced a report which presents case weights, mental health bed days and ED attendances. A subset of the FAR Committee met with key Executives mid-month and we agreed a series of information which should be added to this report to provide an overall picture. This month we have added raw discharges and we will progressively add further indicators over the coming months as they are captured. Of note with the addition of raw discharges it indicates:
    - The average case weight (cwd) of medical discharges has risen marginally with last year being 0.64 cwd per discharge, rising to 0.67 this year. With surgery the average case weight has dropped from 1.51 last year to 1.45 this year. Theoretically this means the acuity has potentially risen in medicine by circa 4.5%, while it has dropped in surgery by 3.9%.
- HR Dashboard – in development to provide a picture from a workforce perspective.

We expect that then Executive, Committee Members and the Board will be able to review performance in a more balanced way to understand the impact and inter relationships across the various areas.

5. COVID 19 – PREPAREDNESS OVER SUMMER HOLIDAY PERIOD

More substantive reporting on the status of COVID activity within Southern has been presented at the Community and Public Health Advisory Committee (CPHAC)

meeting, however the Board should be aware that there has been a requirement to be prepared over the holiday season in terms of being able to respond in the event that there is any resurgence events. Clearly, within the Southern region the Queenstown Lakes / Central Otago region in particular attracts a lot of holiday makers to the region. During this time we need to be prepared to be able to respond to any demands placed on our services, as well as being able to support other regions in the event of significant demand on public health tracing needs in particular, however we also want to ensure we are allowing as many of our staff to take well earned breaks during this period. It is a very fine balancing act. The Ministry's expectations on us are to ensure that:

- We have plans in place to activate, if required, an Emergency Operations Centre (EOC) using a Coordinated Incident Management System (CIMS) structure.
- We have an on-call duty roster to respond to any resurgence or other emergency within a 2/4/6 hour period over the period 14 December 2020 to 9 February 2021.
- Our public health unit (PHU) has two-thirds of its target level of case investigation and contact tracing capacity in place and available to manage outbreaks over this period. This has an expectation that this capacity will also contribute to a national outbreak response team that will be available to provide additional support to a region where a significant outbreak occurs.
- Our DHB/PHU has established surge capability to support community testing, swabbing stations and laboratory capacity within respective communities.
- Our DHB/PHU has coverage for a Medical Officer of Health over the holiday period and an understanding of the potential risks/limitations that may be associated with this coverage.

We are presently working through these expectations to ensure that we are able to respond adequately. Further progress on where we are with this will be available if needed at the Board meeting.

6. PRIMARY MATERNITY FACILITIES CONSULTATION

The project team and the Central Lakes Locality Network reached consensus on a preferred option and presented this to the Executive Leadership Team for agreement on 15 October. Subsequently, the recommendation has been agreed by the Board at their November meeting. Work is underway to develop implementation plans.

7. EQUITY ANALYSIS – SPECIALIST SERVICES

Further analysis by Specialist Services into ethnicity which identified that Pasifika patients appear to get almost one-third less referrals accepted at triage relative to their share of the population, Specialist Services have organised a meeting with the Chief Māori Health Strategy & Improvement Officer to see how they can work with his team on starting to address this issue. The manner in which this may be addressed includes considering how to target this population group from a health literacy perspective. A further breakdown for the disease groups to further assess where the under representation is would also be a logical next step. Specialist Services will also engage on where we should focus our next round of equity analysis in order to take a holistic view of where the most pressing equity gaps are to help us to best target an approach for improving equity overall.

8. SURGICAL PERFORMANCE – CASE WEIGHT DISCHARGES

Elective surgery has been under ongoing pressure throughout October and into November in Dunedin. We scaled up the model from our previous analysis which compared three weeks of August to the comparable weeks last year to cover all of August and September (as more data became available), and the same themes persisted over this period, i.e. high length of stay in the surgical wards, the impact of the bariatric patient consuming four surgical beds (up until 20 September), the impact of the assessment unit being offsite. However, we have not yet analysed October and November.

The assessment unit is due to come back this week which will help, but we continue to see significant pressure on the wards, and frequent bed block related cancellations. Our occupied acute beds appear high in a number of days during November (to date), when compared to the equivalent day for the last three years, and we are now working on formulating a view of month to date November medical case weights, acute case weights and elective case weights (using the planning and funding data set) so that we can ascertain the extent to which either higher medical or acute pressure has caused a displacement of elective case weights.

As well as having a negative impact on patients and service managers (patients because they are sometimes being cancelled multiple times, and have sometimes travelled fairly significant distances to get here and then be cancelled, service managers, because they are having to advise the patients of their cancellation), the high rate of cancellations is having a negative impact on our delivery against our elective production plan. Whilst we are technically ahead on the elective production plan (by circa 63 case weight discharges, year to date, on circa 6,500 case weight target year to date), included in our year to date picture was circa $650k of additional outsourced surgery we did pre-emptively to recover case weights lost due to COVID (prior to the Ministry providing guidance about the recovery funding). We had accrued the revenue for this and have essentially now had to unwind it, which has deteriorated our year to date result.

Getting a clear picture of how demand compares to normal, what is driving our ongoing access block and working out how to address these pressures remains a key priority.

Elective surgery is also under pressure in Southland who are facing similar bed block/access block issues. Their problem is also compounded by a shortage of anaesthetic technicians whom they are struggling either to replace or to find locum to cover.

For both Dunedin and Southland, we hope to provide more comprehensive analysis in the December HAC report to explain what is driving the bed access issues (e.g. the extent to which these are a continuation of some of the themes from the earlier analysis, the extent to which they are a function of additional demand for non-elective surgery, the extent to which this is being driven by additional factors). We are also hoping to undertake a scientific analysis of what is driving up average length of stay in the Dunedin surgical wards. If we can develop a representative control group in the surgical wards (e.g. a meaningful sample with a number of conditions and the story and themes behind length of stay), we can then develop a comparable sample group for the current year for the same disease conditions. We can then look at the reasons for higher length of stay, theme them and have a clearer picture about what conditions were consistent from one year to the next and what conditions changed. This would help to quantify anecdotal stories we hear to explain results such as 'the residential care beds in the community are full' and

allow us to quantify the extent to which reasons given such as this one have contributed to the overall increase in length of stay.

9. OUTPATIENT PERFORMANCE ESPI 2

We are continuing to monitor our work programme which is focused on reducing the number of ESPI 2 breaches (patients who have had to wait > 120 days for an outpatient appointment). We achieve good performance in the period immediately after COVID, dropping from circa 2,600 breaches to circa 1,100 breaches from June-July to October. We achieved this with minimal investment of trajectory funding, so we are hoping that the trajectory funding for the first quarter of the year (July to September) will be able to be applied to reducing our year to date deficit. However, we will need to invest in the initiatives we identified in our recovery plans for the coming quarters, and as the Ministry has yet to pay us for the first quarter we have been reluctant to commit to any initiatives yet as this would essentially see us incurring the cost of the initiatives with uncertainty remaining about when the funding will flow. Once we have received our first quarter revenue, we will start to move the initiatives forward and take on more risk associated with completing the initiatives first and then being paid retrospectively for them on the basis of the funding following confirmed performance against the trajectories. We also confirmed funding for the further implementation of the prioritisation tool and once we receive this, we will employ more resources to assist with the implementation of this.

10. INPATIENT PERFORMANCE ESPI 5

Work is continuing with the long waiting ESPI 5s, and we are now down to a handful of patients across all specialities who have been waiting > 24 months, have been given certainty and have not been deferred for genuine reasons such as patient availability. A proof of concept is underway for the roll out of 'transfer of care' guidelines which are to be used where for valid reasons patients will not move forward on the wait list without further work occurring elsewhere. Once proven to be working effectively this will be systematically rolled out.

11. GASTROENTEROLOGY

We will produce a more detailed report for gastroenterology. We have made good progress in a number of key areas, as follows:

a) We have formed the Endoscopy Oversight Group, developed their Terms of Reference and supported the running of the group for the Chair (Andrew Connolly).

b) We have developed a Terms of Reference for the Referral Group, identified membership and this group will meet this week. The group's core focus will be on providing assurance for the second review process, but its remit will expand over time.

c) We have implemented a new code in IPM which now allows us to separate colonoscopy referrals from other referral types. This will enhance our ability to report on our waiting lists and therefore waiting times and so on.

d) We are developing new Power BI reports which will enable us to run the report the General Manager used to provide for the Chief Executive (which he effectively had to stitch five reports together for) at the push of a button. This report gives waiting times and volumes as at the date it is run. We have also developed draft volumes reporting, which will allow us to report on the volume

of colonoscopies received and completed on a weekly / monthly basis. We are developing an initial manual report which will allow us to report on session utilisation, but we are also requesting Provation data from the Ministry which would allow us to prepare push button reporting which breaks down the time components of the scoping, the room used and therefore the utilisation of the session in that room. This will be a future enhancement.

e) And we are in the process of developing an enhanced digital internal referral which will collect the information on it most relevant for triaging. This will be rolled out to the surgical specialties to replace what is in some cases letters sent to the Gastroenterology service in the mail as quasi referrals.

Overall, the establishment of the project manager role and the engagement from our IS colleagues has enabled us to make good progress on the referral based improvements identified in the Bissett report. We anticipate that the larger, directional changes (such as increasing the intervention rate / scoping more) will come from the direction set by the Endoscopy Oversight Group as we progress forward.

The current waiting list as at 1 November 2020 is set out below.

	Dunedin					Southland				
	Bowel Screening	A	B	Planned and Staged	Surveillance (overdue)	Bowel Screening	A	B	Planned and staged	Surveillance (overdue)
Number of patients	23	3	102	69	315	11	2	47	28	386
Average wait	15	10.33	24	36	102	13	4	21	38	150
Longest wait	59	13	97	138	274	30	5	58	94	360

12. STAFF WELLBEING

There is growing concern regarding the atmosphere around the organisation with the perception that our workforce is unusually fatigued and under considerable pressure. It is unclear whether this is due to increases in actual workload or whether this is related to the wider issues and challenges that have been faced by the hospital and community during 2020, however it is being consistently reported that our staff currently have very low resilience. This presents a risk both in terms of patient safety, but also performance which is difficult to quantify, however the results of the staff survey may give a better and more objective guide to this.

Work is underway to be able to determine whether the issues are due to increased actual workload, or not, what is becoming evident is that the pressure will be a mixture of both changes in workload. Looking into one particular area, it is clear that patient numbers are clearly down, but length of stay and average case weights were up. This could reflect an increase in acuity, but it also could reflect delays in service delivery which increases length of stay and by default the case weight. Reality will more than likely be a mix of both. The other issue that we are seeing in some areas is physical capacity constraints. This is particularly evident in Southland in the Medical and Surgical wards where the physical occupancy over the past year at 7:00am has been consistently over 90%. This means that bed blockages associated with freeing up capacity to allow both ED patients and elective admissions to flow into the beds are challenged resulting in backlog in ED as well as elective cancellations. We need to review how we are utilising space potentially available on this site to optimise capacity and as a part of that we will need to consider what the options for funding the resources can be.

13. PRIORITISATION OF EQUITY FUNDING

An equity funding meeting was held on 11 November with IGC representatives and the three Māori board members. The increase in funding was approved by the Board for the 2020/21 financial year. The meeting was facilitated by Mike Collins and started with a short discussion with Dunedin Hospital clinical staff looking at Māori oncology and long terms conditions. Mike facilitated a session around the principles for approving this funding and then the discussion around prioritisation based on the IGC District Annual Plan (DAP) priorities previously identified as part of the DAP planning process:

- Mental Health & Addictions
- Cancer
- Long Term Conditions – Respiratory Child and Youth; Diabetes; Cardiovascular Disease (Cardiac and Stroke)
- Access to diagnostic testing
- Oral Health (reduction of caries).

There was general agreement that additional investment for Māori providers was appropriate, that cancer innovation was seen as a priority inclusive of cervical screening. There was consensus that hospital based services should have an opportunity to bid for funding that will increase equity outcomes and the minutes from this meeting are currently being prepared.

14. ONCOLOGY

As discussed in our recent Hospital Advisory Committee (HAC) meeting, Oncology is something we would like to expand our reporting on. As well as the 31 day target and associated charts that we currently report against in our HAC report, we are now expanding the HAC report to cover the 62 day target. We will incorporate a robust definition of what is counted under Faster Cancer Treatment reporting and we will analyse and report on our performance against the various cancer streams. Reporting appears to vary from one DHB to another. For example, we are reporting higher numbers of cancer in some cases than DHBs with a much larger population, which suggests that the manner in which we are reporting is different to other DHBs. Nevertheless, our cancer performance for some tumour streams as currently reported does not compare well to our DHB peers and we need to analyse this further to determine what action we can take to improve performance in some areas.

During COVID we managed to get the Radiation First Specialist Appointment (FSA) wait list close to our desired forward load (a wait list of circa 50 per week). However, since June we have been challenged to systematically maintain the wait list at this level and it has grown to a current wait list of circa 120. As the wait list exceeds 100 our ability to see patients within clinically indicated timeframes starts to become impacted.

A brief review of the referrals accepted compared to the referrals seen in outpatient clinics suggests that our average over the period of July 2020 to early November 2020 is in the region of 25 referrals accepted versus 22 referrals actually seen, which translates into us slowly adding to our wait list by about three referrals per week. A look at the last month indicates that we have only been able to see an average of 18 referrals per week in outpatient clinics. Further discussion with the Service Manager has identified that this has been caused by higher sick leave and annual leave occurring in the last month.

Initial analysis by the service manager suggests that our current senior medical officer (SMO) capacity allows us to see an average of 19 referrals per week (after accounting for anticipated leave). This suggests that our underlying capacity is currently six less than required. We have five SMO (noting that they are sized at 55 hours) and we are recruiting a sixth SMO and have plans for a second RMO to start in April. The sixth SMO is coming from Zambia, but is not anticipated until mid-next year. On the basis of this, the sixth SMO (assuming that they were able to work unsupervised from day one) would contribute 20% of additional capacity and we need 32% of additional capacity. So, we are likely to be short on required capacity even when the sixth Radiation Oncologist starts. There will be some offset with the additional resident medical officer (RMO) and this needs to be quantified. We also committed to re-job sizing once the sixth SMO starts. So, we believe we have a longer term problem we will need to address.

However, we have further problems that need to be addressed in the shorter term, too:

a) We currently have SMO sickness and are projecting this will continue.

b) We have an SMO resignation. Although this won't take effect until the end of next year, we know that recruiting may be difficult, particularly for the sub-specialisation. (We are underway with recruitment currently).

Short-term solutions being worked on to increase capacity:

a) We have a small number of SMO led clinics occurring on weekends to bolster our capacity. This will continue until the end of the calendar year but we are unsure at present whether we can continue these in the New Year.

b) We are working up the opportunity to use a nurse specialist to improve our capacity. **

** The service manager is currently working on a proposal for this. We would use a nurse specialist to re-direct follow up workload from SMO/s which could be directly translated into additional FSA clinic capacity and would assist with our immediate need to increase capacity. Once we have had this quantified, we will advise what the positive impact will be on our ability to manage the workload on a weekly basis. Theoretically the specialist nurses' cost would be offset by the sixth Radiation Oncologist role. However, due to a budget error the sixth Radiation Oncologist wasn't included in the 2020/21 budget (and needs to be corrected in the 2021/22 budget). However, we have few options, and this will be a cost effective way to increase capacity so we will be recommending proceeding with this role once the positive impact on the wait list has been quantified.

15. RURAL HEALTH PROJECTS

The Chief Executives of the Rural Trust Hospital Trusts in the Southern region are meeting with key Southern DHB leaders from Strategy, Primary and Community Directorate to agree a programme of work that will enhance opportunities for the populations we serve.

The aim of this partnership group

Within available resources to:

- Deliver a cohesive, seamless health system which maximises efficiencies and quality of care provided to the rural communities each organisation serves
- Maximise services delivered as close to home that is safe and efficient to do so
- Provide a coherent rural hospital voice.

Key projects under discussion are:

- Develop a joint Southern Rural Health Strategy including the location and future role of rural hospitals, noting this needs to be within the scope of the Southern District Health Boards Strategic Refresh
- Medical staffing to ensure a sustainable supply of medical staff
- Clinical leadership across rural southern hospitals
- Radiology review – underway
- Allied Health review
- Patient Transfer Service.

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

The Steering Group has been established and had its first meeting. Dr Clive Bensemann has been appointed as the Chair. The first task for the steering group will be to evaluate the proposals to undertake this review and identify a supplier. This meeting was held on 12 November and we are now finalising arrangements with the successful vendor.

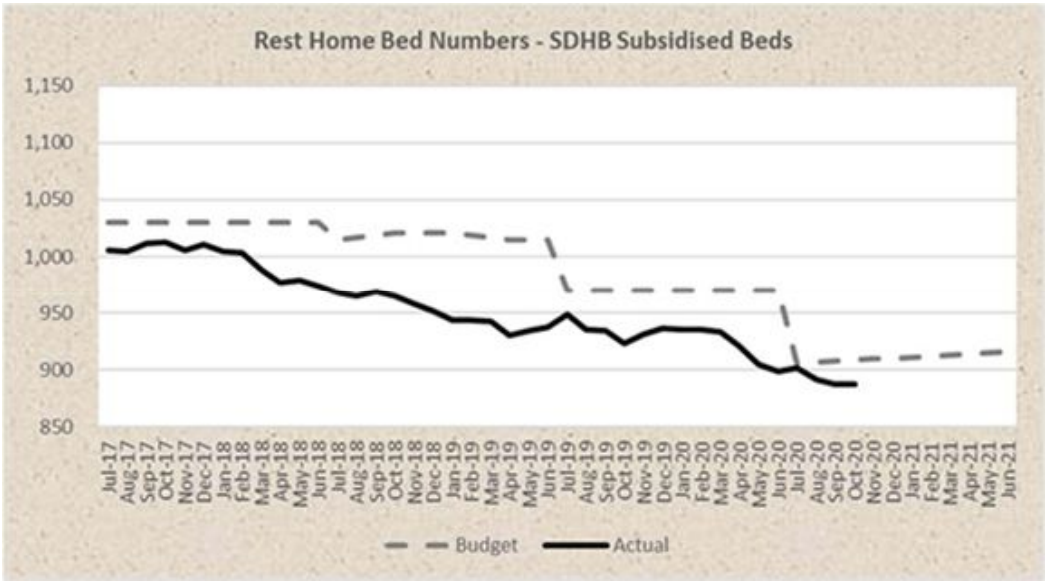
17. AGED RESIDENTIAL CARE OCCUPANCY/VOLUME ANALYSIS

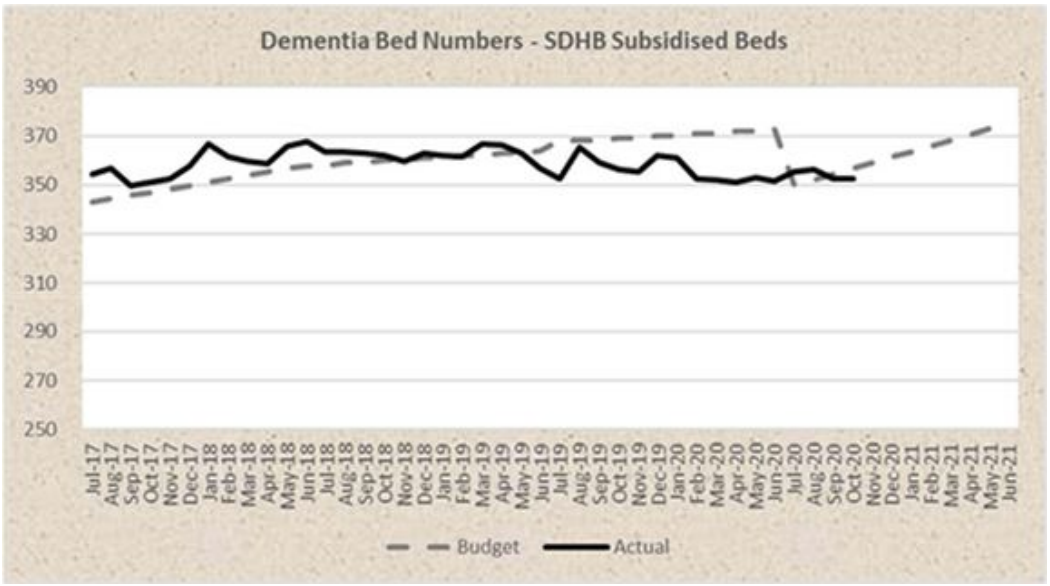
The DHB continues to experience elevated levels of occupancy in Aged Related Residential Care (ARRC), primarily at Hospital and Psychogeriatric levels of care, noting there has been an improvement in the unfavourable deficit to budget in October. The team continues to investigate multiple avenues but to date has not reached any conclusions:

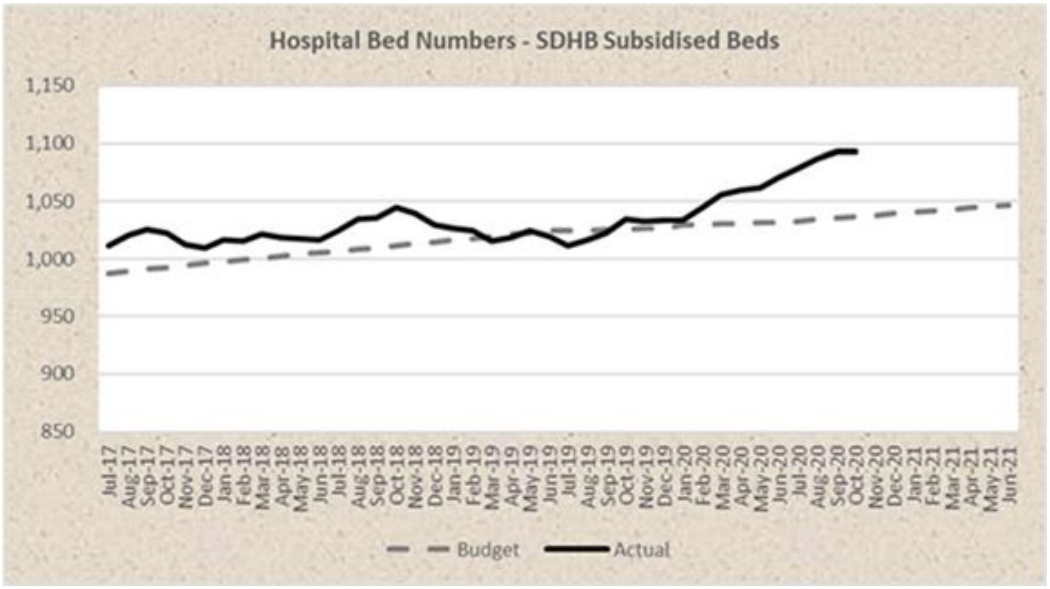
We continue to consider:

- Have there been fewer deaths?
- Is there a backlog from the COVID lockdown that is starting to come through? Are patients enjoying better health due to lack of illness or worse health due to lack of socialisation and activity?
- Has the time patients receive Home Support increased so that by the time they enter care, they go in at Hospital Level rather than Rest Home Level?
- Are there more patients being discharged from Hospital into ARRC?
- As a result of the lockdown (isolation and decreased activities) have there been increased changes in level of care from rest home to hospital level care?
- What is the impact of supply induced demand?

In addition, we continue to interrogate national datasets and the ARRC demand planner to establish how SDHB’s position compares to other DHBs.


Rest Home Bed Numbers - SDHB Subsidised Beds
1,150
1,100
1,050
1,000
950
900
850
Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21
Budget
Actual


Dementia Bed Numbers - SDHB Subsidised Beds
390
370
350
330
310
290
270
250
Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21
Budget
Actual



Over the last three years Southern has focussed on reducing Aged Residential Care utilisation, and with the exception of the spike in the last few months this has been successful, however high level analysis suggests that while it may have been successful our relative utilisation of aged care beds has relatively static compared to the rest of the country. It is therefore important that we continue to investigate further opportunities to see how we can more successfully manage our older population in their own homes as it appears that Southern continues to have a higher proportion of its older population in residential care than the rest of New Zealand. A fresh approach to managing this situation may be required

18. KAUMATĀU RETIREMENT – SOUTHLAND

Mohi Timoko's retirement was celebrated at the Murihiku Marae in Invercargill on 20 November.

Mohi has been employed for 19 years in the Mental Health Kaumatua role, working actively with our Māori Mental Health team and with patients both in the community and in the inpatient wards. The replacement of this position will an agenda item for the December IGC meeting. This position is funded through the mental health ring fence and the decision to replace will need to include consultation with the MHAID directorate. In addition, the directorate has a designated forensic 0.5 FTE kaumātua position which should also be considered at this time.

19. WHĀNAU FLAT 3 – WAKARI HOSPITAL SITE

Whānau Flat 3 is still decommissioned up on the Wakari site and we await the decision to refurbish the kitchen and bathroom areas. Although this facility is looked after by the Māori Health Team it is utilised by all ethnicities and is not a dedicated Māori resource. A discussion has been had with the General Manager Health Safety and Welfare Officer on looking at the risks associated with accommodating family/whānau across our facilities. Other DHBs have similar facilities so the General Manager is looking at how other DHBs manage the risks associated with these types of facilities. The ability to accommodate family/whānau is critical for our patients with such a large geographical district. Family/whānau transport and/or accommodation is not covered under the National Travel Assistance Scheme. There

are several restrictions to this fund including travel needing to be over 350kms, more than 22 specialist appointments in two months and needing to have a community services card, etc. Therefore, the ability to support family/whānau in certain circumstances should be a core service that the DHB should provide.

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

We are participating in a South Island Māori PHO network and met for the first time face to face in Christchurch on 6 November. The meeting included the Māori managers from WellSouth, Pegasus, Rural Canterbury, South Canterbury and Nelson Bays Primary Health. We have developed a terms of reference and have been sharing strategic documents as a first step in understanding each of our organisations work programmes. This forum has the ability to start to consider some of the strategic issues associated with primary care across the South Island and advocate for greater responsiveness from general practice aligned to WAI 2575 stage one.

21. MĀORI HEALTH WORK PLAN

The Māori Health Leadership Team are working on a revised Māori Health Work Plan that supports joined up activity across tertiary, secondary, primary and community. The plan is a requirement of the 2020/21 DAP and we have been awaiting the recently released Whakamaua: Maori Health Action Plan 2020-2025 that provides a template for activities. The meeting with IGC on the funding priority provides further direction for this plan.

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

The Southern DHB is progressing contracts for the COVID-19 Māori Communities Outreach and Support fund. The closed RFP went out to contracted DHB Māori providers who will 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 whānau and communities (especially kuia and koroua) healthy and independent during a 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.

23. MĀORI SUICIDE POST-VENTION

A meeting was held with our Māori suicide postvention networks on 18 November at WellSouth. The meeting will look at the needs and possible coordination of a district wide postvention conference in the New Year. 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 postvention 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 and led by Māori expertise and community champions. It is proposed that we look to establish a Southern Māori postvention group which is informed by strong leaders in suicide prevention/ postvention and

aligned to the Southern District Suicide Prevention Action Plan 2019-2023. We plan shortly to pull those Māori members from the postvention groups together to identify the needs and aspirations from those involved in supporting whānau directly impacted by suicide.

24. SOUTHERN EXCELLENCE AWARDS AND STAFF SERVICE MILESTONES

On 26 November 2020 we held a combined Southern Staff Excellence Awards and Staff Service Milestones Celebration. The event was held concurrently in Dunedin and Southland with a video link. Attendance in both venues were high and it was a great night enjoyed by all.

The staff service milestones were impressive with six staff members being recognised for 40 years of continuous service, and large numbers in the 10, 20, and 30 years. The fact that the organisation recognises this is greatly appreciated, however there were a number of people that noted in fact they had worked collective years far longer than being recognised. That is due to them working for us then leaving and then returning in later years. The most common reason is of course years where the staff member took time out of the workforce (beyond maternity leave) to raise families before returning once the children were more independent, however equally some had spent years overseas and returned. We are going to review our processes to see whether there are simple solutions to recognise this broken service in the milestones. It will be important that this is not confused with long service leave entitlements in employment agreements as this is clearly linked to continuous service.

It was great to see the calibre of the nominations for the Southern Excellence Awards. The winners of the awards were:

- Behind the Scenes (Unsung Hero) Award – Chris Crane, Planning and Performance Manager, Strategy Primary & Community, Dunedin.

  Chris is passionate and effective in her drive for excellence and improvement across the DHB, and her work supports many of the organisational key activities and innovations. She quietly and efficiently connects people and teams, captures the big picture, informs this with data, and equips and challenges clinical teams – all with the highest personal integrity and work ethic.

  Despite not having one-on-one patient interactions, improving the system for individual patients and the teams providing care is always at the centre of her work. She engages clinical teams in a way that demonstrates value and generates buy in, using robust change methodology and data insights to inform service planning and quality improvement.

- Breaking Boundaries Award – joint winners being Jo Mitchell, Specialist Rheumatology, in Dunedin and Konrad Richter, Clinical Associate Professor General Surgery Southland.

  Jo Mitchell has worked tirelessly to develop a model of care for Rheumatology that is built on true partnership with Primary Care, leading the way in our District on the development of new models of care in line with the aspirations of the Primary and Community Strategy. She has become an inspiration to the whole sector in terms of clinically led service redesign and patient centred care.

  Konrad Richter has shown outstanding leadership and dedication in the development of the Southland Hospital Campus as a campus of Otago University. He works tirelessly to foster clinical, academic and research partnerships between Southland Hospital and the University of Otago and is the epitome of breaking boundaries by working and sharing resources with the

university. He also fosters and mentors talent, innovation and the sharing of knowledge with the Southland public through his series of free public lectures.

- Team of the Year – Public Health COVID-19 Response Team

  This team came together from various services and background and were quickly part of our unprecedented and rapid public health response to COVID-19. This was a true multi-disciplinary team with everyone playing a key role from data analysis, administration, contact tracing, providing public health staff at our borders and public health advice for the District.

  This was an amazing team effort and everyone had at the front of their mind how important the work was in stopping the spread of COVID-19 in our district.

  The scale and pace of this response was unprecedented. Most of the 216 cases and their contacts were contacted within a two week period. Systems had to be put in place extremely quickly and were constantly revised. The team showed amazing resilience and professionalism.

- Graham Crombie Outstanding Leadership Award – Dr Susan Jack, Medical Officer of Health, Dunedin

  Paying homage to the late Deputy Commissioner Graham Crombie – an exceptional individual and leader who made a phenomenal contribution to the DHB – this award recognises an individual, team or volunteer who demonstrate outstanding leadership, including mentoring, supporting and enabling the development of people and services – inspiring and motivating others to be the best they can be.

  Susan is an outstanding Public Health Physician and has worked tirelessly over the last 12 months to provide Public Health leadership over what has been a challenging time. Her leadership has been instrumental in ensuring that significant outbreaks in the Southern district, including Measles in 2019 and COVID-19 in 2020, have be able to be contained and not escalated to a point of widespread, uncontrolled community outbreaks.

  She takes an evidence based approach and continues to provide clear direction and guidance. Her leadership has driven and inspired the team to work to a high standard during a rapidly evolving situation. She is a role model to the team and works with them in a way that supports staff to grow in their knowledge and practice.

- Māori Health Development Award – Mautai Dunlop, Māori Health Worker, Māori Mental Health Unit, Dunedin

  Mautai provides strong leadership, mentorship, cultural advice and support to the Māori Mental Health teams, particularly Te Oranga Tonu Tanga, within his work with the Mental Health Addictions and Intellectual Disability directorate services and a positive influence with the wider mental health sector. He is recognised as an influential leader in Te Ao Māori and tikanga and practices within the SDHB values and behaviours of manaakitanga, pono, whaiwhakaaro and whanaungatanga, a clear understanding of the spiritual, physical, mental and whanau health and wellbeing needs of Māori. He provides a whanau-centred approach in decision making and when progressing change to improve inequities and health outcomes.

- Outstanding Care and Contribution Award – Kim Snoep Clinical Nurse Specialist – Colorectal, Southland

  Kim is a colorectal nurse specialist and works tirelessly to look after her patients as they negotiate the difficult pathway of colon cancer. She is always cheerful, kind, compassionate and goes above and beyond for every patient she cares

for. She makes the time to meet with the patients when a surgeon is 'breaking the news' of their cancer diagnosis, providing them with support immediately after the consultation. An innovator, she has set up a 'colorectal whiteboard' that has revolutionised the tracking of patients through the department, ensuring they get timely tests and treatment.

- Rising Star – Claudia Hutton, HR Consultant, Dunedin

  Claudia joined the organisation as a new graduate in the Human Resources Team in May 2019. Her professional and personal growth in the last 18 months has been outstanding, while her intelligence, communication skills and confidence that are exceptional for a new graduate in a complex health environment. Highly committed, she is always at her desk at 7:30am and learns as much as she can from every situation. She listens, learns, takes advice, reflects, and then provides meaningful suggestions. A deserving winner, she has a great career ahead of her.

- Southern Future Values Champion – Sharon Adler, Portfolio Manager Community Services, Dunedin

  Sharon is a tireless advocate for the health and well-being of the older people in our community. She is always seeking the best outcomes through excellence and quality improvement. Every interaction she has, whether they are staff, providers, consumers or their family, is about putting the person first. She treats people with kindness and respect at all times, she communicates extremely well and actively listens.

  Our winner has worked tirelessly over the years to foster relationships amongst the DHB and aged residential care providers. A prime example of this positive culture she has fostered is how she engaged and activated the Aged Residential Care (ARC) sector during COVID. The relationships and respect she has developed over the years were valuable in bringing all the ARC providers together and establishing an ARC Leaders Forum. This forum succeeded because of the values and behaviours she has consistently demonstrated over a number of years.

- Southern Innovation Challenge Award – Dr Hong Shen Chiong, Registrar Ophthalmology, Dunedin

  Hong Sheng is a pioneer in the field of teleophthalmology - revolutionising the way patients can be treated from the comfort of their own home. He co-founded oDocs in 2014 – a social enterprise start-up helping optometrists identify eye damage and restore eyesight to the blind with smartphones. Now, he's using this innovation to empower his patients and their families. The goal of teleophthalmology is to bring equity to eye care in addition to saving time and reduce the need to travel – reducing stress and prioritising patient wellbeing.

25. SOUTHERN NURSING WORKFORCE STRATEGIC DIRECTION

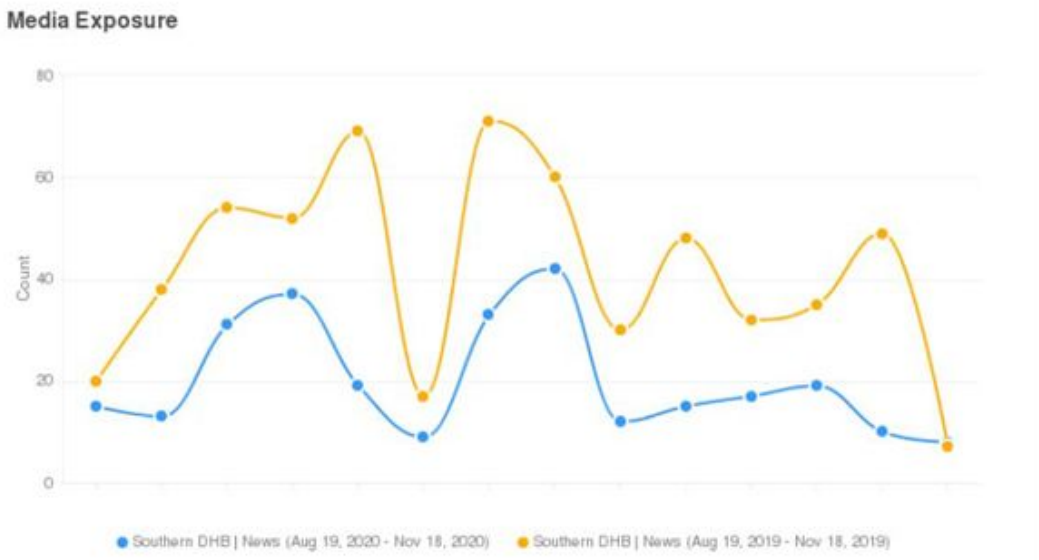
Building on the Southern Health System Workforce Strategy and Action Plan as a base document and aligned to other relevant strategic documents, work is underway to consider our strategic direction for the nursing workforce over the next 5-10 years. The Directors of Nursing and Chief Nursing and Midwifery Officer have had an initial workshop to identify a process for this piece of work that was commenced quite some time ago and to consider how we might best engage with partners across the system. A follow up meeting with some assistance from Chris Crane is planned for 9 and 23 November to assist with framing up this work, similar to the transformational engagement process but on a smaller scale.

26. RESIGNATION JULIE RICKMAN – EXECUTIVE DIRECTOR FINANCE, PROCUREMENT AND FACILITIES

During the month Julie Rickman tendered her resignation from her role. Julie has given us plenty of notice with her resignation being effective from 30 April 2021. We have commenced the process of recruiting for Julie's replacement, however given the Christmas / New Year period the process is unlikely to make progress until the new year. Depending on where the new appointment is coming from there remains a risk of a gap despite the advance notice.

27. COMMUNICATIONS

Volumes of daily media mentions are somewhat reduced when compared with the same period last year. Areas of interest over the past month have included alcohol-related presentations to the emergency department, testing of shipping crew for COVID-19, the board's decision regarding the location of primary maternity facilities in the Central Otago/ Wanaka area, demand for mental health services. Reporting on progress towards the new Dunedin Hospital includes demotion plans, the multi-faith centre, the DHB's digital strategy, and an exhibition from local school children capturing their visions for a new hospital.



This month the communications team has also supported national initiatives including CyberSmart Week, MedSafety week, Occupational Therapy Week, Aotearoa Patient Safety Day, Stop Pressure Injury Day and World Antimicrobial Awareness Week. Facebook posts with the greatest engagement and reach included a call for those aged 15-30 to be immunised for measles, learning the signs of stroke, the Books for Babies programme, and the retirement of revered kaumatua Mohi Timoko.

Chris Fleming
Chief Executive Officer

30 November 2020

Southern DHB Financial Report

Financial Report for: 31 October 2020
Report Prepared by: Finance
Date: 12 November 2020

Report to Board

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

The net deficit for the period ending 31 October 2020 was $0.4m, being $0.1m unfavourable to budget.

During October 2020, Revenue was $3.2m favourable to budget, including COVID-19 donated assets of $1.8m from Ministry of Health, $0.4m for Pharmacy funding, and $0.3m for Inter District Flows. The Expenses were $3.4m unfavourable comprising Outsourced Clinical Services $0.3m unfavourable to budget and Clinical Supplies were $0.9m unfavourable to budget, reflecting further Recovery Plan activity for the month. Provider Payments were $2.0m unfavourable with Community Pharmaceutical spend $0.7m unfavourable, and a further $0.6m in COVID-19 Surveillance and Testing expenses.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 31 October 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						
97,792	96,372	1,420	F	Government & Crown Agency	394,770	385,513	9,257	F	1,089,019	1,155,951
2,663	877	1,786	F	Non-Government & Crown Agency	4,975	3,509	1,466	F	11,047	10,528
100,455	97,250	3,206	F	*Total Revenue*	399,745	389,022	10,723	F	1,100,066	1,166,479
				EXPENSES						
37,699	37,375	(324)	U	Workforce Costs	152,364	151,872	(492)	U	450,139	462,125
4,006	3,760	(246)	U	Outsourced Services	16,563	15,047	(1,517)	U	41,837	43,556
9,285	8,338	(947)	U	Clinical Supplies	37,492	33,758	(3,734)	U	99,345	96,871
4,910	5,039	129	F	Infrastructure & Non-Clinical Supplies	20,109	20,390	281	F	63,258	60,354
41,806	39,801	(2,005)	U	Provider Payments	165,266	158,663	(6,604)	U	466,737	474,021
3,188	3,230	42	F	Non-Operating Expenses	12,548	12,642	95	F	34,951	40,469
100,894	97,543	(3,351)	U	*Total Expenses*	404,342	392,372	(11,970)	U	1,156,267	1,177,396
(439)	(293)	(146)	U	**NET SURPLUS / (DEFICIT)**	(4,597)	(3,350)	(1,247)	U	(56,201)	(10,917)

Revenue (Year To Date)

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

Other Income includes $1.8m for the COVID-19 clinical equipment assets donated by MoH. These assets contribute to Southern DHB's capacity and readiness for COVID-19 resurgence.

Overall, Revenue is $10.7m favourable to budget Year To Date.

Expenditure (Year To Date)

Total Expenses year to date were $404.3m which is $12.0m unfavourable to budget.

Outsourced Clinical Services are $1.6m unfavourable year to date reflecting additional costs incurred for delivery of the Recovery Plans.

Clinical Supplies are $3.7m unfavourable year to date as hospital clinical activity has lifted to deliver the Recovery Plan. This included Treatment Disposables, Instruments & Equipment, Implants & Prostheses and Pharmaceuticals.

Provider Payments are $6.6m unfavourable year to date for payments to NGOs supporting COVID-19 activity, including $3.7m COVID-19 testing in the community and $0.7m for Community Pharmaceuticals.

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 31 October 2020

	YTD COVID-19 $000	YTD Holidays Act $000	YTD NDPH $000	YTD BAU $000	YTD Total $000
REVENUE					
Government & Crown Agency	4,108	-	-	390,662	394,770
Non-Government & Crown Agency	1,823	-	-	3,152	4,975
Total Revenue	5,931	-	-	393,814	399,745
EXPENSES					
Workforce Costs	455	-	-	151,909	152,364
Outsourced Services	(3)	-	-	16,566	16,563
Clinical Supplies	6	-	-	37,486	37,492
Infrastructure & Non-Clinical Supplies	64	-	-	20,045	20,109
Provider Payments	4,596	-	-	160,670	165,266
Non-Operating Expenses	-	-	-	12,548	12,548
Total Expenses	5,118	-	-	399,224	404,342
NET SURPLUS / (DEFICIT)	813	-	-	(5,410)	(4,597)

Financial Position Summary

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

Actual 30 Jun 2020 $000		Actual 31 Oct 2020 $000	Budget 31 Oct 2020 $000	Actual 30 Sep 2020 $000	Budget 30 Jun 2021 $000
	CURRENT ASSETS				
31,011	Cash & Cash Equivalents	22,450	4,658	16,016	7
49,819	Trade & Other Receivables	55,831	55,499	63,882	48,830
6,095	Inventories	6,379	5,658	6,547	5,235
86,925	*Total Current Assets*	84,660	65,815	86,445	54,072
	NON-CURRENT ASSETS				
326,463	Property, Plant & Equipment	329,981	339,483	326,569	355,122
3,307	Intangible Assets	3,907	13,966	3,907	20,149
329,770	*Total Non-Current Assets*	333,888	353,449	330,476	375,271
416,695	**TOTAL ASSETS**	418,548	419,264	416,921	429,343
	CURRENT LIABILITIES				
-	Cash & Cash Equivalents	-	-	-	16,259
64,666	Payables & Deferred Revenue	69,772	66,621	71,296	64,494
962	Short Term Borrowings	819	1,085	817	955
129,920	Employee Entitlements *	89,533	126,625	86,745	85,533
195,548	*Total Current Liabilities*	160,124	194,331	158,858	167,241
	NON-CURRENT LIABILITIES				
1,091	Term Borrowings	926	1,076	1,000	1,018
-	Holidays Act 2003*	41,113	-	41,166	-
19,810	Employee Entitlements	19,810	19,810	19,810	19,810
20,901	*Total Non-Current Liabilities*	61,849	20,886	61,976	20,828
216,449	**TOTAL LIABILITIES**	221,973	215,217	220,834	188,069
200,246	**NET ASSETS**	196,575	204,047	196,087	241,274
	EQUITY				
485,956	Contributed Capital	486,882	486,956	485,956	531,750
108,500	Property Revaluation Reserves	108,500	108,502	108,500	108,502
(394,210)	Accumulated Surplus/(Deficit)	(398,807)	(391,411)	(398,369)	(398,978)
200,246	*Total Equity*	196,575	204,047	196,087	241,274
	Statement of Changes in Equity				
172,410	Opening Balance	200,246	206,397	198,296	206,398
(56,201)	Operating Surplus/(Deficit)	(4,597)	(3,350)	(2,209)	(10,917)
84,744	Crown Capital Contributions	926	1,000	-	46,500
(707)	Return of Capital	-	-	-	(707)
200,246	Closing Balance	196,575	204,047	196,087	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 31 October 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	394,831	385,363	9,468	1,156,983	359,909
Non-Government & Crown Agency Revenue	3,057	3,432	(375)	10,296	3,324
Interest Received	93	77	16	232	134
Cash was applied to:					
Payments to Suppliers	(247,459)	(237,559)	(9,900)	(675,364)	(227,634)
Payments to Employees	(148,769)	(149,334)	565	(499,568)	(141,851)
Capital Charge	-	-	-	(12,605)	-
Goods & Services Tax (net)	(64)	148	(212)	(486)	641
Net Cash Inflow / (Outflow) from Operations	1,689	2,127	(438)	(20,512)	(5,477)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	3	-	3	-	1
Cash was applied to:					
Capital Expenditure	(10,868)	(29,059)	18,191	(72,294)	(13,689)
Net Cash Inflow / (Outflow) from Investing Activity	(10,865)	(29,059)	18,194	(72,294)	(13,688)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	928	1,000	(72)	45,763	
Cash was applied to:					
Repayment of Borrowings	(312)	(422)	110	(220)	1,098
Repayment of Capital	-		-		
Net Cash Inflow / (Outflow) from Financing Activity	616	578	38	45,543	1,098
Total Increase / (Decrease) in Cash	(8,560)	(26,354)	17,794	(47,263)	(18,067)
Net Opening Cash & Cash Equivalents	31,011	31,012	(1)	31,011	(9,888)
Net Closing Cash & Cash Equivalents	22,451	4,658	17,793	(16,252)	(27,955)

Cash flow from Operating Activities is unfavourable to budget by $0.4 million. The higher payments to suppliers not completely offset by higher revenue received.

Cash flow from Investing Activities is favourable to budget by $18.2m. The capital projects in progress continue to plan and new projects are underway now following approval of the 2021 Annual Plan. The Capital Expenditure cash spend is $2.8m less than same time last year largely reflecting the timing of approval.

Cash flow from Financing Activities is favourable to budget by $38k.

Overall, Cash flow remains favourable to budget.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD

Capital Expenditure - Cash Flow

For the period ending 31 October 2020

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	LY YTD Actual $000
Land, Buildings & Plant	2,580	7,639	5,058	U	7,085
Clinical Equipment	5,164	5,581	417	U	4,527
Other Equipment	204	461	256	U	220
Information Technology	1,427	5,692	4,266	U	1,016
Motor Vehicles	-	-	-	-	-
Software	1,493	9,687	8,194	U	841
Total Expenditure	10,868	29,059	18,191	U	13,689

At 31 October 2020, our Financial Position on page 3 shows Non-Current Assets comprising Property, Plant & Equipment and Intangible Assets totalling $333.9m, which is $19.5m less than the budget of $353.4m.

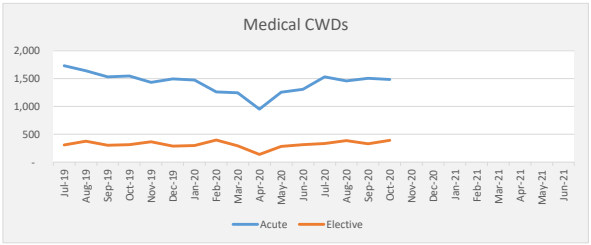
Information Technology and Software combined at $12.4m contributes to the variance, including Radiology RIS, Vocera Hands Free Clinical Communications, Regional Service Provider Index and South Island Patient Information Care System (SIPICS) projects.

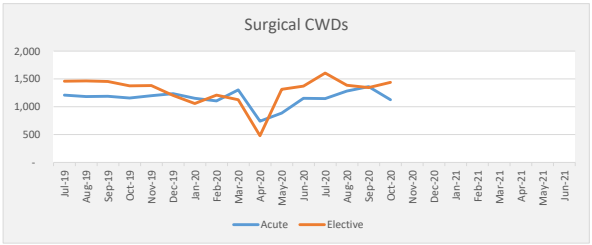
Until the approval of the 2021 Annual Plan by the Minister of Health, only those projects that were urgently required to progress had commenced.

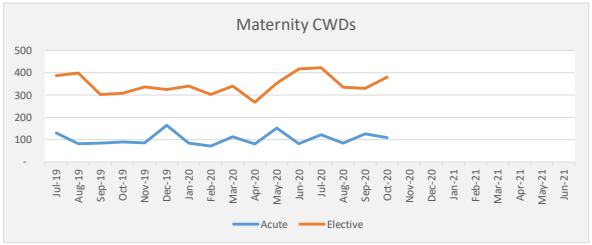
CASEWEIGHTED DISCHARGES

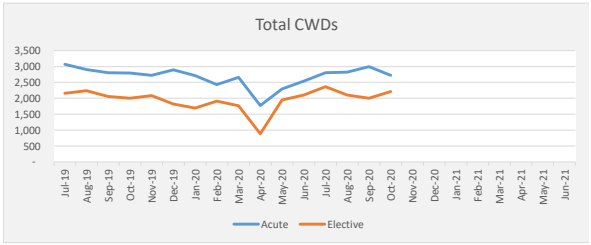
Oct-20				Oct-19	YEAR ON YEAR		YTD 2020/2021				YTD Oct-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,484	1,473	11	1%	1,547	(62)	Acute	5,982	6,048	(67)	-1%	6,448	(466)
394	285	109	38%	315	78	Elective	1,445	1,216	230	19%	1,304	141
1,878	**1,758**	**119**	**7%**	**1,863**	**16**	**Total Medical Caseweights**	**7,427**	**7,264**	**163**	**2%**	**7,752**	**(324)**
						Surgical Caseweights						
1,129	1,202	(74)	-6%	1,155	(27)	Acute	4,916	4,954	(38)	-1%	4,735	181
1,439	1,375	64	5%	1,375	64	Elective	5,772	5,740	31	1%	5,751	20
2,567	**2,577**	**(9)**	**-0%**	**2,531**	**37**	**Total Surgical Caseweights**	**10,688**	**10,694**	**(6)**	**-0%**	**10,486**	**202**
						Maternity Caseweights						
110	90	19	21%	89	21	Acute	442	377	66	17%	393	49
381	364	17	5%	308	72	Elective	1,470	1,489	(19)	-1%	1,429	40
490	**454**	**36**	**8%**	**397**	**93**	**Total Maternity Caseweights**	**1,913**	**1,866**	**47**	**3%**	**1,822**	**91**
						TOTALS						
2,722	**2,766**	**(44)**	-2%	**2,792**	**(70)**	**Acute**	**11,340**	**11,379**	**(39)**	-0%	**11,576**	**(236)**
2,213	**2,023**	**190**	9%	**1,999**	**216**	**Elective**	**8,687**	**8,445**	**242**	3%	**8,484**	**204**
4,936	**4,789**	**146**	**3%**	**4,790**	**146**	**Total Caseweights**	**20,027**	**19,824**	**204**	**1%**	**20,061**	**(32)**

						TOTALS excl. Maternity						
2,613	**2,676**	**(63)**	-2%	**2,703**	**(89)**	**Acute**	**10,898**	**11,002**	**(104)**	-1%	**11,183**	**(284)**
1,833	**1,659**	**173**	10%	**1,691**	**143**	**Elective**	**7,217**	**6,956**	**261**	4%	**7,055**	**162**
4,445	**4,335**	**110**	**3%**	**4,393**	**53**	**Total Caseweights excl. Maternity**	**18,115**	**17,958**	**157**	**1%**	**18,239**	**(123)**





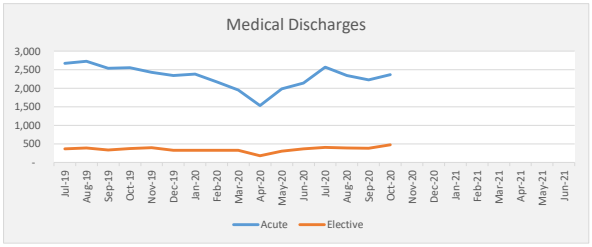


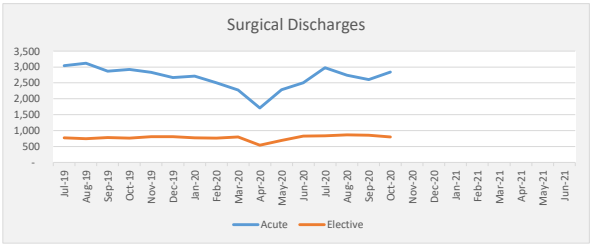


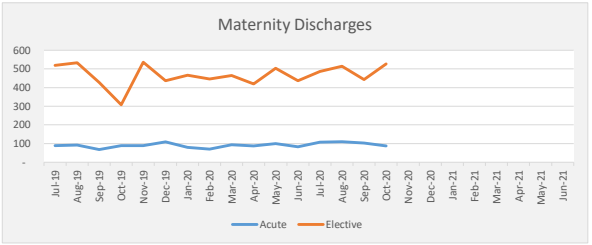
RAW DISCHARGES

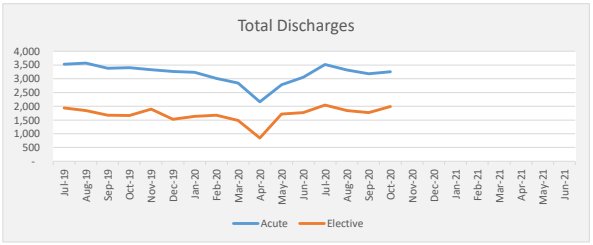
Oct-20				Oct-19	YEAR ON YEAR		YTD				YTD	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Discharges						
2,367	2,367	(0)	-0%	2,551	(183)	Acute	9,507	9,688	(181)	-2%	10,485	(977)
475	330	145	44%	372	103	Elective	1,655	1,405	250	18%	1,471	184
2,842	**2,697**	**145**	**5%**	**2,923**	**(80)**	**Total Medical Discharges**	**11,162**	**11,092**	**70**	**1%**	**11,956**	**(793)**
						Surgical Discharges						
798	779	19	2%	762	36	Acute	3,354	3,213	141	4%	3,066	288
988	964	24	2%	988	0	Elective	4,023	4,024	(1)	-0%	3,863	160
1,786	**1,744**	**42**	**2%**	**1,750**	**36**	**Total Surgical Discharges**	**7,377**	**7,237**	**140**	**2%**	**6,929**	**448**
						Maternity Discharges						
87	81	6	8%	89	(2)	Acute	407	336	71	21%	331	76
527	488	39	8%	308	218	Elective	1,971	1,992	(21)	-1%	1,983	(13)
614	**569**	**45**	**8%**	**397**	**217**	**Total Maternity Discharges**	**2,378**	**2,328**	**50**	**2%**	**2,314**	**64**
						TOTALS						
3,252	**3,227**	**25**	1%	**3,402**	**(150)**	**Acute**	**13,268**	**13,237**	**31**	0%	**13,882**	**(614)**
1,990	**1,783**	**207**	12%	**1,668**	**323**	**Elective**	**7,649**	**7,420**	**229**	3%	**7,317**	**333**
5,242	**5,010**	**232**	**5%**	**5,070**	**173**	**Total Discharges**	**20,917**	**20,657**	**260**	**1%**	**21,199**	**(281)**

						TOTALS excl. Maternity						
3,165	**3,146**	**19**	1%	**3,313**	**(147)**	**Acute**	**12,861**	**12,901**	**(40)**	-0%	**13,551**	**(689)**
1,463	**1,294**	**169**	13%	**1,360**	**104**	**Elective**	**5,678**	**5,428**	**250**	5%	**5,334**	**345**
4,628	**4,441**	**187**	**4%**	**4,673**	**(44)**	**Total Caseweights excl. Maternity**	**18,539**	**18,329**	**210**	**1%**	**18,885**	**(345)**



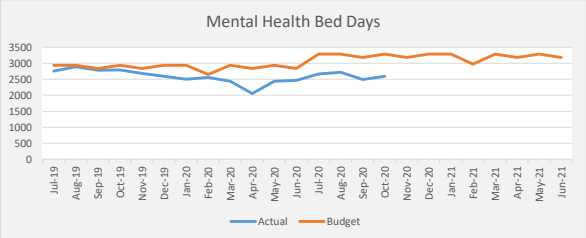




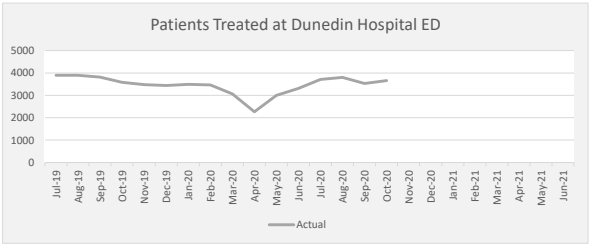


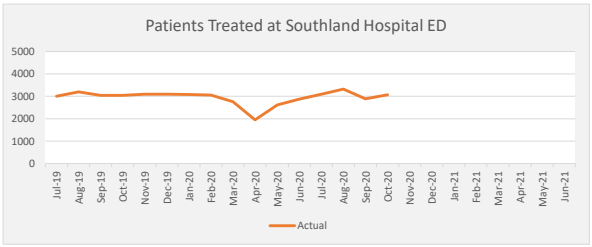
OTHER ACTIVITY

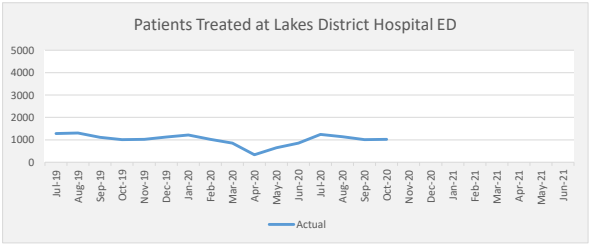
Oct-20				Oct-19	YEAR ON YEAR		YTD 2020/2021				YTD Oct-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,590	3,286	(696)	-21%	2,790	(200)	Mental Health bed days	10,459	13,038	(2,579)	-20%	11,215	(756)

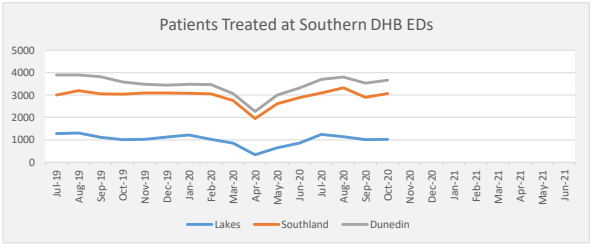


Oct-20	Oct-19	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2020/2021	YTD Oct-19	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,659	3,579	80	Dunedin	14,702	15,181	(479)
1,024	1,003	21	Lakes	4,416	4,701	(285)
3,070	3,045	25	Southland	12,373	12,295	78
7,753	7,627	126	**Total ED presentations**	31,491	32,177	(686)









SOUTHERN DISTRICT HEALTH BOARD

Title:	**PERFORMANCE DASHBOARD**
Report to:	Board
Date of Meeting:	8 December 2020

Summary:

Of note on this month's dashboard:

The Performance Dashboard is now fully transitioned to the PowerBI platform. As a part of this transition some measures are being aligned with other PowerBI reporting. The measures in Board, the previous reporting source, had been in place for some time and required updating which has occurred as part of this process. However for some measures this process is ongoing as some issues have arisen that need to be ironed out. These measures include caseweights (currently excluded) and readmissions within 7 days. Theatre utilisation now only reports elective surgeries and late notice postponements are only for operations cancelled within 24 hours.

8.3

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 early next year
Equity:	
Other:	n/a

Document previously submitted to:	**Executive Leadership Team**	**Date: 3/12/2020**
Approved by Chief Executive Officer:	Pending	**Date:** 3 December 2020

Prepared by: Patrick O'Connor, Quality and Performance Improvement Manager on behalf of Gail Thomson Executive Director Quality and Clinical Governance 24 November 2020	**Presented by:** Chris Fleming Chief Executive Officer 8 December 2020

RECOMMENDATION:

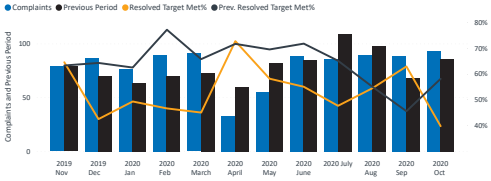
That the Board notes the Performance Dashboard.

Executive Dashboard - Patient Experience

(Southern)

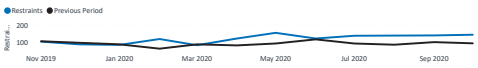
Southern - Complaints, Previous Period, Resolved Target Met%, Prev. Resolved Target Met%

BY YEAR, MONTH



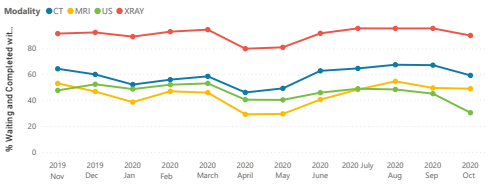
Southern - Restraints, Previous Period

BY YEAR, MONTH



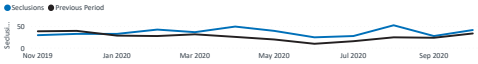
Southern - % Waiting and Completed within 42 days

BY YEAR, MONTH AND MODALITY



Southern - Seclusions, Previous Period

BY YEAR, MONTH

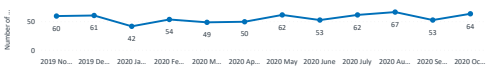


Executive Dashboard - Effectiveness

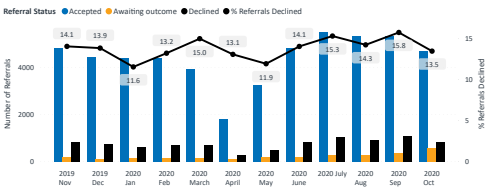
(Southern)

Southern - Mortality

NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH

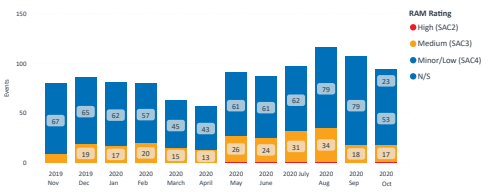


Southern - Referrals Accepted / Awaiting Outcome and Declined



Southern - Staff Events

BY RAM RATING, YEAR, MONTH

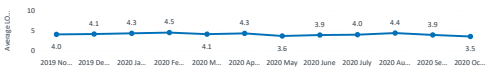


Executive Dashboard - Efficiency

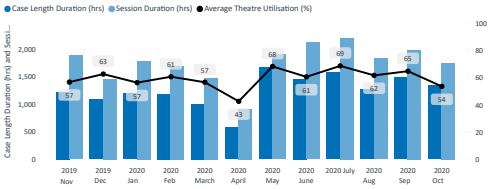
(Southern)

Southern - Average LOS

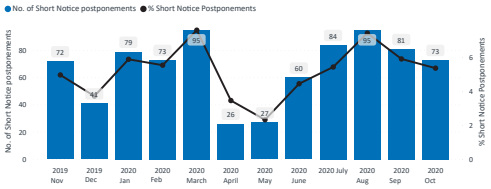
BY DAYS



Southern - Average Theatre Utilisation (%)



Southern - Short Notice Postponements



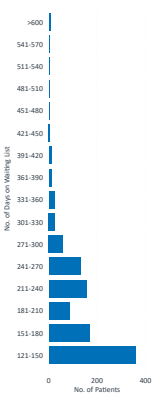
Executive Dashboard - Timely

(Southern)

Southern - Number of Patients with LOS > 7 days

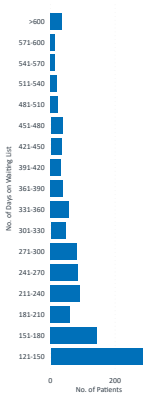
Southern - ESPI 2 Breaches

FOR THE LAST COMPLETED MONTH

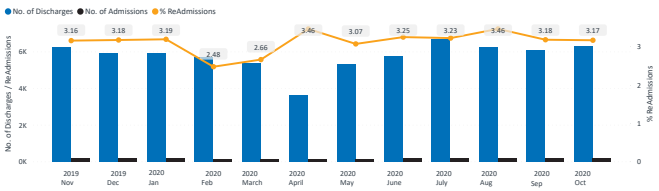


Southern - ESPI 5 Breaches

FOR THE LAST COMPLETED MONTH



Southern - Unplanned Hospital ReAdmissions within 7 days



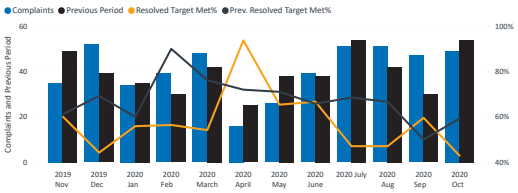
Add Cumulative Variance Caseweight - Service Provider

Executive Dashboard - Patient Experience

(Dunedin)

Dunedin - Complaints and Previous Period

BY YEAR AND MONTH

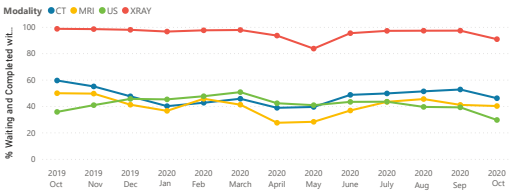


Dunedin - Restraints and Previous Period

BY YEAR AND MONTH

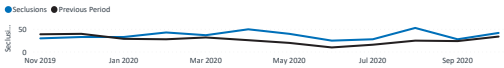
Dunedin - % Waiting and Completed within 42 days

BY YEAR, MONTH AND MODALITY



Dunedin - Seclusions and Previous Period

BY YEAR AND MONTH

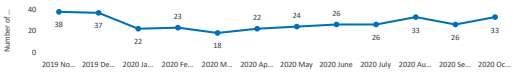


Executive Dashboard - Effectiveness

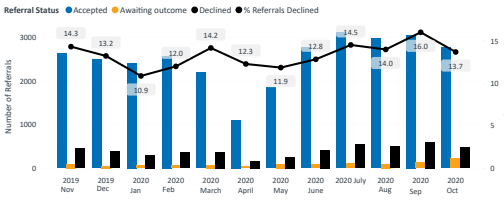
(Dunedin)

Dunedin - Mortality

NUMBER OF PATIENTS DECEASED BY DISCHARGE MONTH

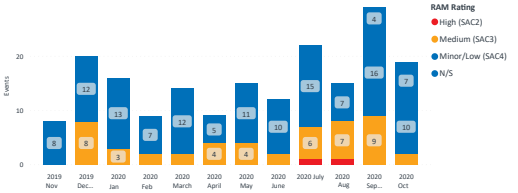


Dunedin - Referrals Accepted / Awaiting Outcome and Declined



Dunedin - Staff Events

BY RAM RATING, YEAR, MONTH

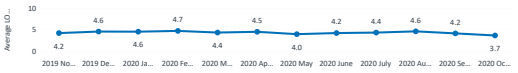


Executive Dashboard - Efficiency

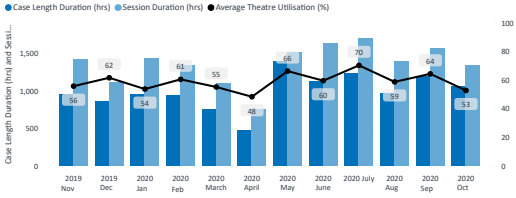
(Dunedin)

Dunedin - Average LOS

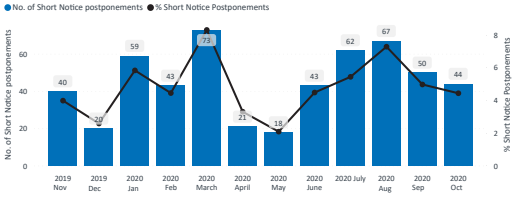
BY DAYS



Dunedin - Average Theatre Utilisation (%)



Dunedin - Short Notice Postponements

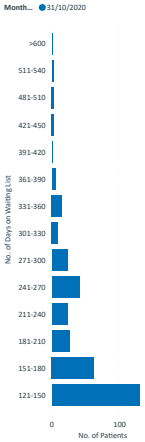


Executive Dashboard - Timely

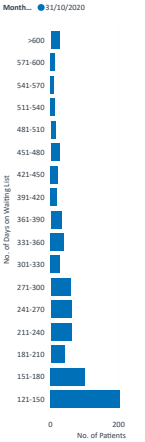
(Dunedin)

Dunedin - Number of Patients with LOS > 7 days

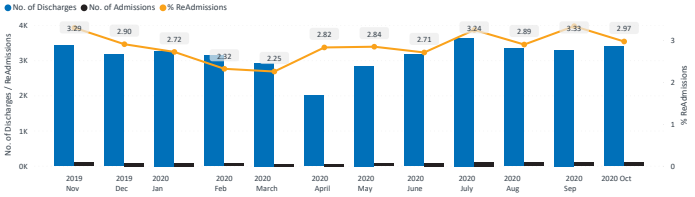
Dunedin - ESPI 2 Breaches f...



Dunedin - ESPI 5 Breaches f...



Dunedin - Unplanned Hospital ReAdmissions within 7 days

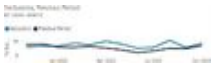


Performance Dashboard Tile Definitions

Safety 1st data.
Complaints
The number of internal complaints (from website, phone, email, letter, health and disability, comment form, etc) per month.
Resolutions
The percentage of complaints that were resolved within 35 working days.

Restraints
Safety 1st data. The number of restraint events per month. Please note that Southern includes all Hospitals including* Waikari

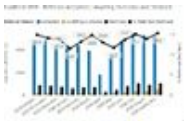
Seclusions
iPM and HCS data. The number of seclusion events per month.



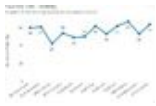
Percent Waiting and Completed
Percentage of patients completed or waiting for their reports within 42 days as at end of the month

Staff Events
The monthly number of reported staff adverse events categorised by severity assessment codes 1-4 and by 'N/S' (Not Specified).

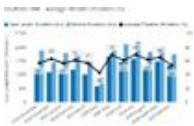
Referrals accepted (authorised), awaiting outcome or declined by month.
% referrals declined



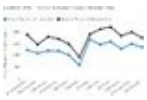
Mortality
Number of patients deceased by discharge month.



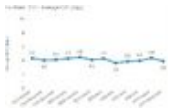
Theatre Utilisation is calculated as a percentage
(CaseLength Time) / (Session Time Scheduled) * 100
CaseLength Time = Anaesthetic Time + Procedure Time
Anaesthetic Time = Time duration between "Anaesthetic Start Time" and "Patient Ready for Procedure Time"
Procedure Time = Time duration between "Procedure Start Time" and "Procedure Complete Time" i.e. the Cut to Close Time. Report only shows elective theatre sessions. The report does not exclude any theatres



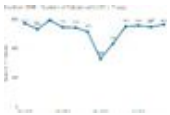
Short Notice Postponements
Theatre postponements within 24 hours of the scheduled procedure



Average Length of stay
Average Length of stay by specialty of all patients present in the hospital at any point of time

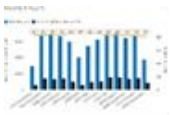


Number of Patients with LOS > 7 Days
Number of patients in hospital at any point of time when they have exceeded 7 days since admission

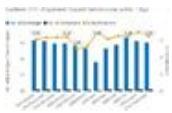


ESPI 2 and ESPI 5
ESPI 2 and ESPI 5 waitlists organised into the given time buckets

Monthly 6 Hour %
Short Stay in ED (SSED) time given by the percentage of patients discharged from ED within 6 hours of their Triage at ED. This excludes the time spent in ED observation



Unplanned Hospital Readmissions within 7 Days
Acute / Unplanned readmissions within 7 days of the initial discharge from hospital organised on the basis of the month of discharge



SOUTHERN DISTRICT HEALTH BOARD

Title:	**Quarter One 20/21 Performance Summary (Annual Plan non-financial measures)**
Report to:	Southern DHB Board
Meeting Date:	8 December 2020

Summary:

The appended shows 20/21 Q1 performance against the Annual Plan Statement of Performance Expectations non-financial performance measures.

The purpose of this summary is to ensure a consolidated version of the Annual Plan targets are monitored throughout the year.

Summaries will be provided in Q2 and Q3, while Q4 will be incorporated in to our Annual Report.

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

Financial:	Nil
Workforce:	Nil
Other:	Nil

Document previously submitted to:	ELT	**Date:** 19 Nov 2020
Approved by Chief Executive Officer:	n/a	**Date:** n/a

Prepared by: Strategy & Planning Date: 23 November 2020	**Presented by:** Lisa Gestro – Executive Director Strategy Primary and Community

RECOMMENDATION:

1. The Board note the performance levels.

EXECUTIVE SUMMARY: Statement of Service Performance Expectations

Quarterly performance overview:

Performance area	Performance met or exceeded target	Performance was within 5% of target	Performance was 5-10% of target	Performance was >10% below target	Measures unreported (including not applicable for Quarter)	Total number of measures
Prevention Services	**4 of 19**	**3 of 19**	**2 of 19**	**6 of 19**	**4 of 19**	**19**
Early Detection and Management	**2 of 14**	**-**	**-**	**5 of 14**	**7 of 14**	**14**
Intensive Assessment and Treatment	**6 of 20**	**2 of 20**	**2 of 20**	**3 of 20**	**7 of 20**	**20**
Rehabilitation and Support	**2 of 6**	**2 of 6**	**-**	**1 of 6**	**1 of 6**	**6**

Output Class: Prevention Services

Output Class: Prevention Services					
Measure		**2019/20**		**2020/21**	
		Target	**Q4**	**Target**	**Q1**
Percentage of children fully immunised at age 8 months	Total	>95%	**95%**	>95%	**93%**
	Māori	>95%	**90%**	>95%	**71%**
Percentage of children fully immunised at age 2 years	Total	>95%	**95%**	>95%	**93%**
	Māori	>95%	**96%**	>95%	**88%**
Percentage of eligible girls and boys fully immunised with HPV vaccine	Total	>75%	**64%**	>75%	**Q4 only**
	Māori	>75%	**63%**	>75%	**Q4 only**
Percentage of people (≥ 65 years) having received a flu vaccination	Total	>75%	**Q1 only (54%)**	>75%	**62%**
	Māori	>75%	**Q1 only (44%)**	>75%	**56%**
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking	Total	>90%	**73%**	>90%	**70%**
	Māori	>90%	**74%**	>90%	**72%**
Infants exclusively or fully breastfeeding at 3 months	Total	>60%	**64%**	>60%	**63%**
	Māori	>60%	**57%**	>60%	**56%**
Percentage of 4 year old children receiving a B4 School Check	Total	>90%	**78%**	>90%	**100%**
	Quintile 5	>90%	**74%**	>90%	**98%**
Percentage of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	>95%	**92%**	>95%	**95%**
Percentage of eligible women (50-69 years) having a breast cancer screen in the last 2 years	Total	>70%	**66%**	>70%	**Pending (ex)**
	Māori	>70%	**63%**	>70%	**Pending (ex)**
Percentage of eligible women (25-69 years) having a cervical cancer screen in the last 3 years	Total	>80%	**71%**	>80%	**72%**
	Māori	>80%	**63%**	>80%	**64%**

Select breaches	Service Commentary for Improvement
8 month immunisation rates – Māori	WS has employed a Project Manager who will work on behalf of Alliance South on the first 1000 days project with an initial focus on immunisation: • MMR vaccinations for 15-29 year olds • Flu vaccinations (from March 2021) • Childhood Immunisations For 8-month immunisations the project manager will take advantage of the work already being done by the Maori Health Team in improving health literacy amongst tangata whenua in their work with contracted providers and runaka, and by the outreach team to increase referrals from general practice. Crucial to improving performance against this target is increasing enrolments of new-born babies in general practice as early as possible. WellSouth will be implementing the National Hauora Coalition's Generation 2040 programme in 2020. Generation 2040 incentivises general practice teams to collect information to assist pregnant Maori women in accessing the services they need, provides screening questions to identify at-risk women and families. (the incentives are available for Maori patients, but the tool is available for all patients).
Flu vaccinations	The Alliance South Immunisations Project Manager will also ensure that activity towards the Flu Vaccination target is a priority from March 2021. Anecdotally we believe that practices are committed to this target and see flu vaccinations as an important part of their care of older patients. This is not being borne out in the data, so clearly work needs to be done to validate this activity and ensure it is being captured. To achieve this we will be regularly auditing data collected in general practice and comparing it to that captured in the NIR as a first step to ensuring data integrity. Where necessary there will be education sessions provided to ensure that practice staff are capturing data correctly. The Project Manager will work with the practice relationship team to ensure any supply chain issues are resolved as early as possible. Working with the IPD team at SDHB and Health Logistics any issues can be identified and worked through.
Smoking cessation advice	WS last achieved the smoking target in the April-June 2018 quarter. This was achieved using a combination of improved communication with practices, including better data analysis and reporting, the incentive programme and a smoking call centre. This approach will be replicated, with a different approach to incentivising practices. The WellSouth Call Centre will commence making calls to smokers on behalf of general practice in November 2020. Additional staff will be employed to increase our capacity, and all staff will receive appropriate training. The Practice Relationship team will be back to full strength from November, and a key message in their communications with general practices will be performance against the targets. We will work with each practice to agree a Practice Development Plan that sets out agreed activity towards a set of targets. WS will set some targets, and practices will propose some of their own. We will progressively phase out the existing incentive programme and replace it with the Practice Development Plan. Financial incentives will be based on agreeing and implementing the Practice Development Plan. All practices have access to Thalamus for their own patients. WS will be able to provide daily updates of performance to stakeholders, using the tools that had previously been developed.

Legend:
Target met
Performance within 5% of target
Performance within 5-10% of target
Performance >10% below target

Technical notes on quarterly reporting results

Data for those metrics reported as "pending ex" are externally sourced – in this case provided to DHBs by the Ministry of Health. This data wasn't available at the time of submission.

Output Class: Early Detection and Management

Output Class: Early Detection and Management					
Measure		**2019/20**		**2020/21**	
		Target	**Q4**	**Target**	**Q1**
Percentage of eligible preschoolers enrolled in community oral health services	Total	>95%	**84% (Q3)**	>95%	**Q3 only**
	Māori	>95%	**63% (Q3)**	>95%	**Q3 only**
Percentage of children caries-free at five years of age	Total	>70%	**69% (Q3)**	>70%	**Q3 only**
	Māori	>70%	**56% (Q3)**	>70%	**Q3 only**
Avoidable Hospital Admissions (ASH) rates for children (0-4 years)	Total	<5,370	**5,496**	<5,370	**4,505**
	Māori	<5,370	**6,685**	<5,370	**5,312**
Number of people receiving a brief intervention from the primary mental health service	Total	>6,000	**7,025**	>7,000 (>1,750 YTD)	**Q2 & Q4 only**
Percentage of the eligible population who have had a CVD Risk Assessment in the last 5 years	Total	>90%	**76%**	>90%	**75%**
	Māori	>90%	**77%**	>90%	**76%**
Percentage of the population identified with diabetes having good or acceptable glycaemic control	Total	>60%	**54%**	>60%	**Q2 & Q4 only**
	Māori	>60%	**46%**	>60%	**Q2 & Q4 only**
Percentage of accepted referrals for Computed Tomography (CT) scans receiving procedure within 42 days	Total	>85%	**50%**	>85%	**65%**
Percentage of accepted referrals for Magnetic Resonance Imaging (MRI) scans receiving procedure within 42 days	Total	>67%	**31%**	>67%	**51%**
Percentage of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	Total	>90%	**65%**	>90%	**73%**

Legend:
Target met
Performance within 5% of target
Performance within 5-10% of target
Performance >10% below target

Technical notes on quarterly reporting results

Nil

Select breaches	**Service Commentary for Improvement**
CVD	In 2020 WS undertook a significant review of its Long-Term Conditions programme, CLIC. CLIC remains our LTC management programme but with changes to help practices make decisions about which clients will benefit the most from the programme. A project manager to assist with implementing the changes to CLIC has been appointed. WellSouth will work with colleagues in Secondary Mental Health services with regards to engaging and managing patients who are found to have higher-than-average CVD risk. CLIC already incorporates a significant mental health, addictions and social isolation component and offers general practice a process to engage with these patients in a more targeted and individualised manner. We are also keen to improve how our own teams work together to improve performance against this measure: • The WellSouth Outreach Team works with general practice to identify and engage hard-to-reach patients amongst our priority groups, particularly Maori and Pacific Island patients. • The Health Promotion team will develop a health promotion plan of work to be implemented in general practice that will be integrated with health promotion activities elsewhere in Southern district, for example with Green Prescription, with the Heart Foundation and with other harm reduction strategies (smoking, diet, mental health) WS has aligned the CVD RA programme to the national guidelines and expanded the pool of patients that are eligible for funded CVD risk assessments which will increase uptake at general practice. We will review this data monthly to ensure that the work done at practices is valued and rewarded.
CT	Southern DHB has two initiatives underway to address the issues principally being experienced at Dunedin: 1) Additional CT sessions – weekday evenings Mon-Thu. These have commenced, as has training staff in the use of the NM SPECT/CT. A proposal for change to finalise these sessions is currently being undertaken and is expected to be completed mid October 2020. 2) Invest in second diagnostic CT for Dunedin – on approved Capital list for 2020/21 year. A draft business case has been prepared for discussion.
MRI	The improvement in MRI performance in Q1 can also be attributed in part to MoH funding for additional activity in June and July. Improvement was not as high at Dunedin as would have been hoped for owing to a two-week equipment outage experienced in the latter half of August. However this was offset by a concerted effort at Southland Hospital to reduce their waitlist prior to the scanner being decommissioned on 14 August. The replacement scanner was commissioned on 30 September 2020 by which time the waitlist had grown less than predicted (c.270 vs predicted 300). Some deterioration is expected in Q2 as Southland works to catch up on work deferred by the replacement project. The variance in MRI from the required target is explained primarily by – • Demand for both acute and elective MRI exceeds capacity at Dunedin. Southern DHB intends to address the issues principally being experienced at Dunedin through: • Outsourcing of long waiting Cardiac MRI examinations to a private provider • Border change to direct some rural patients to Southland Hospital for MRI

Output Class: Intensive Assessment and Treatment

Output Class: Intensive Assessment and Treatment					
Measure		**2019/20**		**2020/21**	
		Target	**Q4**	**Target**	**Q1**
Percentage of young people (0-19 years) accessing specialist mental health services	Total	>3.75%	**5.29%**	>3.75%	**Q2 & Q4 only**
	Māori	>3.75%	**6.02%**	>3.75%	**Q2 & Q4 only**
Percentage of adults (20-64 years) accessing specialist mental health services	Total	>3.75%	**4.33%**	>3.75%	**Q2 & Q4 only**
	Māori	>5.22%	**8.96%**	>5.22%	**Q2 & Q4 only**
Percentage of people who have a transition (discharge) plan	Total	>95%	**54%**	>95%	**58%**
Percentage of people (0-19 years) referred for non-urgent mental health or addiction DHB Provider services who access services in a timely manner	< 3 weeks	>80%	**70%**	>80%	**72%**
	< 8 weeks	>95%	**88%**	>95%	**89%**
People are assessed, treated or discharged from ED in under 6 hours	Total	>95%	**85%**	>95%	**80%**
Number of people presenting at ED	Total	<88,000	**77,331**	<85,000 (21,250 YTD)	**20,727**
Number of elective surgical service discharges	Total	>12,588	**11,179**	>12,518 (3,189 YTD)	**3,273**
Percentage of elective and arranged surgery undertaken on a day case basis	Total	>60%	**57%**	>60%	**60%**
Percentage of people receiving their elective and arranged surgery on day of admission	Total	>95%	**88%**	>95%	**90%**
Number of elective surgical services (CWDs) delivered (elective initiative)	Total	>18,134	**17,292**	>18,680 (4,781 YTD)	**4,912**
Number of maternity deliveries in Southern DHB facilities	Total	3,400	**3,439**	3,400	**Q2 only**
	Maori	560	**543**	560	**Q2 only**
Percentage of pregnant women registered with a Lead Maternity Carer in the first trimester	Total	>80%	**79%**	>80%	**Q2 only**
Average length of stay (days) for inpatient AT&R services	< 65 years	<21.8	**28.2 (Q3)**	<21.8	**27.3**
	≥ 65 years	<18.5	**16.4 (Q3)**	<18.5	**16.6**
Patients have improved physical functionality on discharge	< 65 years	>26.1	**29.4 (Q3)**	>26.1	**25.7**
	≥ 65 years	>18.3	**21.4 (Q3)**	>19.7	**20.3**

Legend:
Target met
Performance within 5% of target
Performance within 5-10% of target
Performance >10% below target

Select breaches	Service Commentary for Improvement
Discharge Plans (Mental Health)	Our goal of moving to one district-wide 'Wellness Transition Plan' continues as we progressively shift from the various discharge, wellness, recovery, and relapse prevention plans that we have in place towards a more aligned 'Wellness Transition Plan'. A critical success factor we have achieved along this path is having the transition plan is now on Health Connect South and this will aid with the sharing of information. 58% of the patients accessing community-based services who were discharged in Quarter One of 2020-2021 had a plan in place. 84% of the people who are accessing specialist mental health and addiction services for more than a year have a plan in place. All patients discharged from inpatient have a plan. MHAID continues to focus on lifting compliance with a Recovery Plan in place. Our current focus is ensuring patients who have been in the service for three months or more have a plan in place. Likewise we are now moving to auditing the quality of plans. A small audit was completed of 10 Invercargill Community Mental Health Team patients, 8 of which had a transition plan and all 8 were of a high standard was a pleasing start to this work which will expand over the coming year.
ED Target	• Fit 2 to Sit 8 chairs expansion of ambulatory area to be completed by Dec • Older Person's Assessment Liaison process continuing. • Board rounding done by EDSOMs several times a day. • Continue to embrace use of telehealth to enable care to be delivered to anywhere within SDHB. • Additional resource to fully implement generalist acute admitting model of care by December20/21 •Southland ED – prioritised work to address demands on the physical space.
AT&R Length of Stay	The AT&R service is progressing to a two-tier model of delivery where services are differentiated based on level of need of patients rather than by age of patients. This is anticipated to improve outcomes by grouping patients by need and ensuring specialist care delivery is based on this need. Because the underlying data to these metrics is based on facility locations (Wakari and Dunedin Hospital) with <65s going to Wakari and >65s going to Dunedin, the reporting measure will become insufficient as we evolve the model of care. We accordingly anticipate replacing this metric in 2021/22.

Technical notes on quarterly reporting results

Note that the performance stated for ED excludes Lakes Hospital performance. DHB performance when Lakes is included = 82%

The stated targets for Elective Discharges and Caseweights (CWD) are the targets agreed with the Ministry of Health (12,518 and 18,680 respectively). These exceed the targets stated in our Statement of Performance Expectations (12,237 and 18,464 respectively) as the SPE was submitted prior to final agreement of the Planned Care targets. In this summary, we are reporting against the Planned Care target, but our Annual Report is required to report performance against the lesser figure in the Annual Plan/SPE (to comply with Audit Standards).

Output Class: Rehabilitation and Support

Output Class: Rehabilitation and Support					
Measure		**2019/20**		**2020/21**	
		Target	**Q4**	**Target**	**Q1**
Percentage of aged care residents who have had an InterRAI assessment within 6 months admisison	Total	>95%	**75%**	>95%	**94%**
Percentage of people ≥ 65 years receiving long-term home support who have a Comprehensive Clinical Assessment and an Individual Care Plan	Total	>95%	**99%**	>95%	**99%**
Total number of eligible people aged over 65 years supported by home and community support services	Total	>4,400	**4,474**	>4,800	**4,650**
Percentage of HCSS support workers who have completed at least Level 2 in the National Certificate in Community Support Services (or equivalent)	Total	>80%	**86%**	>80%	**Q2 & Q4 only**
Number of people assessed by the GP (primary care procedure) for fracture risk using the portal	Total	>1,050	**1,865**	>2,000 (500 YTD)	**330**
Number of Rest Home Bed Days per capita of the population aged over 65 years	Total	<6.8	**5.8**	<6.1	**5.7**

Select breaches	Service Commentary for Improvement
Fracture risk assessments	Performance is below target, however for context, this is a measure that was implemented in late 16/17 with an initial target of 170 assessments. In 2-3 years performance grew to 10-12 times this (with a reduction last financial year due to COVID). It may be that lesser performance this quarter is due to saturation against target or due to latent effects of COVID. We will continue to monitor performance and support assessments.

Legend:
Target met
Performance within 5% of target
Performance within 5-10% of target
Performance >10% below target

Technical notes on quarterly reporting results

Nil

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Strategic Change Reports**
Report to:	Board
Date of Meeting:	8th December 2020

Summary:

Strategic Change reports have been prepared by the Executive Leadership Team summarising progress towards achieving actions as highlighted in the Strategic Intentions section of the Annual Plan 2020/21.

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

Financial:	Recovery due to missed targets may have financial implications.
Workforce:	Recovery due to missed targets may have workforce implications.
Equity:	Gaps in equity are highlighted in some reports. Gaps need to be addressed to ensure that there is equitable service delivery in the Southern district to improve outcomes for Māori and other vulnerable populations.

Document previously submitted to:	n/a	**Date:** N/A
Approved by Chief Executive Officer:	Yes	**Date:**

Prepared by: Lisa Gestro, Executive Director Strategy, Primary and Community **Date:** 25/11/2020	**Presented by:** Lisa Gestro, Executive Director Strategy, Primary and Community

RECOMMENDATIONS:

That the Board note these updates.

Specialist Services monthly report for Nov 2020

Lead Executive: Patrick Ng

EXECUTIVE SUMMARY

- Our key challenge for the month has been access issues for inpatient beds for elective surgery. Despite volumes being slightly down year on year we appear to have higher lengths of stay and higher occupancy overall. Organisationally we are working through this to better understand the drivers of this.

Performance area	Previous month	Current month	Commentary
Case weights surgery	→	→	Case weight surgery is circa 60 case weights ahead of the year to date production plan but we have had to count extra outsourcing completed for recovery in our baseline. There have been ongoing challenges gaining access to beds for surgery as outlined in monthly reporting.
Discharges	→	→	Elective surgical discharges have followed the same pattern as case weight discharges – we have been able to achieve less elective surgery than planned.
ED six-hour target	↓	↓	Generalism + medical assessment (Dunedin) and a medical assessment approach (Southland) are being worked on and are key to long term performance.
Cancer target <31 days	↑	↑	Performance against this measure is on target. However, our performance against the 62 target is not on target and we will provide overall reporting to HAC going forward.
FSA (ESPI 2)	↑	↑	Recovery performance remains good. However, this will tail off if we don't start spending recovery funding soon to further improve performance against this target.
Elective treatment< 4 months	→	→	Elective surgery backlogs remain challenging to progress without additional surgical delivery from outsourcing or other means. We continue to focus on patients waiting > 24 months to ensure these are booked or cleared.
Medical imaging CT	→	→	An options and recommendations paper has been drafted for the proposed location of the new CT machine. We aim to present the completed paper to the Board in Dec.
Medical imaging MRI	↓	→	MRI capacity in Dunedin is a challenge. Per HAC action, we will develop an overall paper concerning medical imaging diagnostic capacity early in the New Year.
Colonoscopy 14 days	↑	↑	Remains on target.
Colonoscopy 42 days	↑	↑	Remains on target.
Colonoscopy 84 days	↓	↓	Further capacity required to acheive target. Will be worked through with the Endoscoopy Oversight Group.

Current Issues	Update/Achievements	Upcoming key deliverables
Elective surgical delivery	On plan year to date but this has been achieved with more outsourcing than planned for.	Outputs of organisational analysis required to explain ongoing bed access block challenges.
Financial performance	Recovery plan programme manager appointed.	Regular reporting, development of controls.
ICU air handling issues (for stage 2) slow to be addressed	Timeline for completion of most complex system now clear (late February). Design for remaining systems complete pre-Christmas.	Overall project timeline early in the New Year once contractor confirms timeframe for remedial work.

Planned Care Recovery

- Elective surgery was under pressure in DN throughout Oct and into Nov in DN. We are formulating a view of Nov. medical case weights, acute case weights and elective case weights to determine cause of pressure on elective case weights. High rate of bed related cancellations is impacting negatively on our delivery against elective production plan. Our key priority is working out how to address pressures, e.g. ongoing access block
- Elective surgery also under pressure in Southland who are facing similar bed block/access block issues and a shortage of anaesthetic technicians.
- We hope to provide a more comprehensive analysis in the Dec HAC report to explain what is driving the bed access issues. We will also look at what is driving up average. LOS in Dunedin surgical wards.
- ESPI 2- We are continuing to monitor our work programme which is focused on reducing the number of ESPI 2 breaches (patients waiting more than 120 days for an outpatient appointment. Once we have received our first quarter revenue we will start to implement initiatives in anticipation of retrospective payment. We also confirmed funding for the further implementation of the prioritisation tool and will employ more resources to assist with the its implementation once we receive funding.
- ESPI 5 – Work is continuing with the long waiting ESPI 5's and we are now down to a handful of patients across all specialty areas who have been waiting more than 24 months, have been given certainty and have not been deferred for genuine reasons such as patient availability. A proof of concept is underway for the roll out of 'transfer of care' guidelines which are to be used where, for valid reasons, patients will not move forward on the wait list without further work occurring elsewhere. Once proven to be working effectively this will be systematically rolled out.

Gastroenterology

- The Endoscopy Oversight Group has had its second meeting and received good feedback.
- We have drafted TOR for the Referral Users Group. The group will meet this week. It's core focus will be on providing assurance for the second review process, but its remit will expand over time
- We have implemented a new code in IPM which now allows us to separate colonoscopy referrals from other referral types –this will enhance our ability to report on waiting lists and waiting times.
- We are developing new Power BI reports which enable reporting waiting times and volumes
- We are enhancing the electronic internal referral to ensure it covers the triage information requirements. This will then be rolled out to replace the existing electronic referral and to replace paper based referrals.

Valuing Patient Time – Acute Patient Flow report for Nov 2020

Lead Executive: Jane Wilson

EXECUTIVE SUMMARY

SAFER is a Patient Flow bundle and practical tool out of 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. One of the key initiatives is Clinical Criteria for Discharge (CCD). The use of discharge criteria to support patient discharge from hospital is documented and the criteria can also be used alongside existing care pathways to expedite discharge within agreed parameters. CCD incorporates the term 'nurse-led' discharge and has been around for a very long time as a concept. Unfortunately efforts to embed CCD in Southern DHB has been patchy with limited success in effectively rolling it out despite the best efforts of a few and the request from many staff to implement CCD. By making full implementation of the SAFER bundle an 'expectation' of all inpatient adult services through service level accountability (now endorsed by the Board, ELT and Clinical Council) significant gains should be made if followed through. CCD and Rapid Rounds are the priority components to be focused on over the next few months and this will require strong and visible leadership and coaching support to teams.

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.

SAFER bundle service level accountability baseline assessment tool has been modified and ready for use. It is now ready to be taken out to every inpatient service engaging with the respective CNM and CD/s. This will commence end of November. A refreshed VPT Patient Flow Action plan focusing on the SAFER bundle has been completed

Elements (Safer Bundle)	Previous month	Current month	Commentary
S - Senor Review	→	→	• SAFER assessment templates developed for completion at ward level as part of Service Level Accountability (SLA). To be included in SLA roll out.
A - All patient have expected date of discharge (EDD & CCD)	→	→	• Rapid Round Audit tool customised to Southern DHB completed. Audits commencing in Nov.
F - Improved flow from ED to inpatient wards	→	→	• SAFER bundle metrics developed – revised reporting to be ready next month - Dec
E - Early Discharge			• Dunedin Hospital Escalation plan drafted and presented to Clinical Council
R - Review (multi-disciplinary team review of stranded patients)	→ →	→ →	• Meeting held with IT to discuss and address functionality issues with 'Red to Green' on electronic whiteboard. System issues not resolved as yet but issues now understood. • Detailed implementation steps to be fleshed out under the Action Plan high level objectives

Current Issues	Update/Achievements	Upcoming key deliverables
Cultural engagement	• Refreshed VPT presentation and refreshed actin plan completed to be used in engagement forums Nov/Dec • SAFER bundle presentation to Clinical Council	• VPT Sponsors to attend Clinical Directors meeting and engage on SAFER with a focus on CCD • Stakeholder Analysis to be completed • SAFER engagement to commence more widely • 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	• Sponsors meeting held with Chiefs, EDQCG and QI Mgr and Principal Advisor to the CEO on 11 Nov to discuss plan and support going forward.
Dedicated VPT QIF role ending in Nov	• Extension of VPT QI support role to June 2021 to support SAFER roll out	• Completed

• 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 reporting through EDSPC

• Emergency Department

- Refer EDSS reporting regarding ED performance, and work on Southland ED and Discharge Lounge concept.
- Dunedin Hospital 'FiT to Sit' development in Dunedin Hospital official opening on Monday 16 November with a Mihi and Karakia. Unit to be named the Emergency Department Ambulatory Care Unit

• Medicine

- Refer to EDSS report regarding Enhanced Generalism Dunedin Hospital Business Case.
- Draft to be presented to the Bipartite Action Group (BAG) on 17 November 2020

SP&C Services monthly report for Nov 2020

Lead Executive: Lisa Gestro

EXECUTIVE SUMMARY

Positioning Public Health services for the future	Previous month	Current month	Commentary
COVID-19 Response	↑	↑	Public Health continues work on an escalation plan to ensure that we have an appropriate number of teams to respond quickly to a second wave of cases A testing strategy is currently being developed for ELT sign off. It is imperative that the ongoing requirement to maintain sufficient surveillance in our community, as well as undertake the required level of port and border testing, alongside the need to deliver regular pop ups in high tourism areas, such as Queenstown, means that we need to transition Covid testing into more of a business as usual approach. It is also imperative that staff who were previously being diverted from their core service delivery to swabbing activities need to focus on the recovery of volumes that may have been lost during our Covid response.
Psychosocial Response planning	↑	↑	The Central Lakes Mental Wellbeing recovery group met face to face in October with a focus on supplying information sharing and advocacy for mental health well-being plans. There is a need to target wellbeing resources to sectors of our community. To support this aspect of the workplan a Mental Wellbeing Navigator role has been proposed and funding sought to support this role.
Immunisation	→	→	Demands on this service have been exceptionally high during Covid-19 and are expected to continue for the foreseeable future with addition of new measles campaign, general increase in vaccine demand, pressure on Immunisation Co-ordinator and National immunisation register (NIR) for advice and support.
Maternity	↑	↑	Four options were developed after considering stakeholder and public feedback. The project team and the Central Lakes Locality Network reached consensus on a preferred option and presented this to ELT for agreement on the 15th of October, followed by endorsement by the Board at their November meeting. Work is underway to develop implementation plans.

Current Issues	Update/Achievements	Upcoming key deliverables
Waitaki District Health Services – clinical safety	Southern DHB executive working with WDHSL Board and new Chief Executive to monitor financial performance	Local solutions are investigated to develop an SMO employed workforce, rather than relying on locums.
Public Health Communicable Disease Nurse Capacity	Currently we have two Communicable Disease Nurses. We are currently working to develop a plan for when additional surge capacity is required in responses.	Development of plan for surge capacity
Population Health Service – Covid-19 resurgence and preparedness for new cases	Turn on of services while maintaining capacity to respond to resurgence of Covid cases.	Monitor; continue new ways of working, e.g. telehealth
Population Health – Immunisation team demands	Development of business case	Implementation of immunisation response plan Move to use of Medtech for immunisation

Service Planning

- A small team from Finance and Planning has been working together to facilitate a more joined up process of budgeting, annual planning and service planning. The aim is for a single, coherent and achievable process for consultation and prioritisation decisions. A key focus is to ensure that service planning is patient outcome driven, rather than cost savings driven, with clinical outcomes linked to financial planning. Planning processes will be coordinated with planning for the new Dunedin Hospital.

Health Care Home Reconfiguration

- Health Care Home (HCH) has operated since July 2018, with 14 practices at a mix of one or two years in the programme. Practices are currently invited to express an interest in participating in a shorter (two years, not three, per practice), simpler and more flexible in implementation, using processes and activities proven in the programme to date
- Practices have until mid-October to express interest and those with high needs populations will be prioritised for a new phase of implementation starting in November 2020

SP&C Services monthly report for Nov 2020

Lead Executive: Lisa Gestro

EXECUTIVE SUMMARY

• Mental health and addiction system transformation

- Independent review of the Southern Mental Health and Addiction System Continuum of Care – The Steering Group has been established and had its first meeting. The first task for the steering group will be to evaluate the proposals to undertake this review and identify a supplier
- Child and Adolescent services continue to have referrals with high acuity, this is challenging within Southland with the lack of SMO coverage and the pressure this puts on services. Services in Otago are also experiencing high demand and Central Lakes remains a particular area of concern with a number of vacancies. A plan is in place to support local service provision while recruitment occurs.
- 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 developing the newly funded Mental Health Educator role based in the ED departments. Advertising has occurred, interviews have been held and an appointment to the position is expected very shortly.
- Primary Brief Intervention services are experiencing increased rates of referrals. A particular area of concern is the Central Lakes area which experienced a 40% increase in referrals over the same time last year with a three to seven week wait time which is similar to last year. The appointment of Health Improvement Practitioners and Health Coaches is expected to make a significant difference.
- Integrated Mental Health and Addiction Primary Mental Health and Addiction System - This agreement between Southern DHB and WellSouth provides for 25.3 FTE, being a mix of Health Improvement Practitioners (HIPS), Health Coaches and Community 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. In essence, the programme provides same day access for supporting mental health and wellbeing in primary care.
- Health Quality Safety Commission (HQSC) Mental Health and Addiction Quality Improvement Programme: The zero seclusion programme continues to focus on the three areas that are used to measure progress with these being the number of individual people secluded, the overall number of seclusion evens and the time seclusion is used. The service continues to see a reduction in the length of events but not so with the other two categories

• Rural health

- The Chief Executives (CEs) of the Rural Trust Hospital Trusts in the Southern region are meeting with key Southern DHB leaders from Strategy, Primary and Community Directorate to agree a programme of work that will enhance opportunities for the populations we serve. The Aim of this partnership group is, within available resources, to:
    - deliver a cohesive, seamless health system which maximises efficiencies and quality of care provided to the rural communities each organisation serves;
    - maximise services delivered as close to home that is safe and efficient to do so;
    - provide a coherent rural hospital voice
- Dependence on locum cover for Rural Trust Hospitals in Gore, Balclutha and Oamaru persists. An initiative to explore a shared Full Time Equivalent (FTE) between Central Otago Health Services Ltd and Waitaki District Health Services Ltd is being explored. In addition a DHB team are considering if a registrar level medical cover should be included in the Lakes roster and the information from this is being shared with the other Rural Hospitals.

• Stroke unit

- Planning has commenced on establishing a Comprehensive Stroke Unit on the 6th floor. Agreement in principle was reached between Internal Medicine, Operation, and OPH on progressing this work. This means bring the acute stroke unit (8th floor) and rehabilitation stroke unit (6th floor and Wakari) services together.
- Planning work shows a combined single stroke unit in itself is entirely feasible and desirable with real potential benefits for improved patient flow, journey, experience, and outcomes. However, this would require significant reconfiguration of other services. It is the impact on the other services that does not allow for the establishment of a single stroke unit at this time.
- Currently there are limited options to bring other patients to Wakari as they need to be medically stable. The number of occupied beds would reduce at Wakari, creating some efficiency and viability issues. It would be difficult to effectively and safely staff less than 10 beds. This continues to be worked through and there is commitment from all services to try and achieve this.

Systems for success monthly report for October 2020 *Lead Executive: Gail Thomson*

Executive Summary

The Quality Improvement Facilitators have responded in a timely manner to some requests for help from Specialist Services. The aim to have 30% capacity in order to be more responsive appears to be paying off as staff then work with teams that are already engaged in improvement. This has resulted in successes for teams.

Quality Improvement Activities	
Safe	The impact of the EWS and deteriorating patient roll out in 2019/2020 was presented to Clinical Council on 12 November. The absolute measure of success of less cardiac arrests is not yet available, however, there was general consensus that interventions were happening earlier to avert cardiac arrest and death.
Effective	Audit tool under development to assess impact of 'Not for CPR' practice changes.
Patient Centred	Improvements to the Southland Fracture clinic service has been audited and shows 'referral to appointment made' has moved from ≥ 7 days to < 2 days.
Equitable	Patient stories from people with lived disability are being gathered now for use in the New Year.
Efficient	Improvement to management of patients with abscesses requiring surgical intervention has seen a move from overnight stay to DOSA.
Timely	The Community health Council have provided input into a few key primary/community initiatives recently such as primary birthing location.

Service Updates	Previous month	Current month	Commentary
Emergency Management	↑	↑	COVID-19 debrief complete, for presentation to ELT 19 November.
Infection Prevention & Control	→	→	Nurses are being onboarded to support ARC facilities in Infection Prevention & Control and COVID preparedness.

Current Issues	Update/Achievements	Upcoming key deliverables
Change proposal	Progressing well with EOIs, managing staff transition and severance processes.	24 November change over day.

Health Pathways

- A number of pathway opportunities have been identified through the access to ultrasound in the community improvement initiative. Topics being explored are:
- Abnormal Uterine Bleeding' UTI' Scrotal Mass, Abnormal LFTs, Gallbladder Polyps, Angiomyolipomas

Clinical Governance

- Timing of communications to the organisation on key governance committees is being very well received to date.
- **Clinical Council** membership complete except for a community IWI representative.

Risk Management Programme

- Work underway on a combined risk register that will support the identification of the top 10 strategic and other risks
- ELT members to review and comment on risks assigned to them prior to presenting the final draft to ELT as a whole.

People and data & digital monthly report for Nov 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)	↑		MyLab to be established and phase one operational by Dec 2020. Terms of Reference agreed.
Digital programme of work			
New Dunedin Hospital (Digital)	→		Programme Business case developed and approved by Nov
Digital Strategy Update	↑		SI PIC's approval of SIPICS business case by National Capital Investment Committee
New Dunedin Hospital (Workforce)	→		Continued recruitment of key roles to the Early Works team
South Island PICS	→		SI PIC's approval of SIPICS business case by National Capital Investment Committee
BAU			
Telecommunications	↑		
Iaas (Bureau & Outsourcing	↓		
Consulting Services	↑		
E-subscriptions	↓		
Software Licensing	↑		
Crown Storage/mgt of 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 formalised

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 Māori Health Providers – Good progress
- Cyber security role appointment made as per Audit NZ request and activity underway
- E-pharmacy go live complete
- SI PIC's approval of SIPICS business case by National Capital Investment Committee
- Wireless improvements on track progressing well. On track to complete Q2 20.21
- EDIS upgrade delayed pending resource availability. Project expected to complete Q2 20.21
- 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. On track to complete Q2. 20.21
- Scanning Solution to digitize records business case to Exec in Nov 2020
- MS office 365 – Complete PIC's Data sharing agreement with WellSouth finalised
- Recruitment Upgrade go Live Feb 2020
- RIS Replacement on track to complete Q2 FY20/21
- Exec review of Human Capital System Upgrade
- NDH early works team establishment progress report to SPG programme business case end of Oct and preapproval to Exec/Board ahead of SPG

People and data & digital monthly report for Nov 2020

Lead Executive: Mike Collins

EXECUTIVE SUMMARY

Roll out of digital strategy	Previous month	Current month	
Change Proposals (no.)	→		Colour cells green, orange or red to indicate status (refer page 8). Use arrows to indicate expected change in status.
Employment related matters e.g. PG's	→		
Collective agreements	↑		
Workforce Planning	→		
Total Vacancies	→		
Staff turnover	↓		
Annual Leave			
Sick Leave			
Proactive Support Heatmap			
Volume of job evaluations			
Registered worksafe incidents	↑		
Locum Costs	↓		

Current Issues	Update/Achievements	Upcoming key deliverables
Management of BAU within HR	Staff Engagement Survey launched November 2020	
	Southern Excellence Award Finalists decided and processes underway to host the event in DN and INV simultaneously. Event linking in service milestone awards.	
	New recruitment system progressing well launch in Feb 2021	People Forum first engagement

- **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** Assisting with review of 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)

Māori Health monthly report for Nov 2020

Lead Executive: Gilbert Taurua

EXECUTIVE SUMMARY

Implementation of the Māori Health Action Plan	Previous month	Current month	Commentary
Engagement and obligations as a Treaty Partner	↑	↑	The Southern DHB Board is committed to holding a board meeting each year on a local marae. It is planned that a board meeting will be held on marae in Q2 and training will be delivered at this meeting
Accelerate the Spread of Kaupapa Māori Services	↑	↑	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
Reducing Health Inequities	↑	↑	Refer to Long term conditions, cancer, ASH respiratory children age 0-4 years. A monthly community oral health outreach clinic for Māori will be established in conjunction with the Community Oral Health Service, with planning to commence Q2.
Shifting Cultural and Social Norms	↑	↑	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. Work is underway to enhance the Southern DHB website using cultural imaging and the use of Te Reo Māori.
Strengthening System Settings	↑	↑	The Southern Māori DHB directorate are participating on regional alliance groups including the Cardiac Alliance, South Island Public Health Partnership Alliance and Te Herenga Hauora o Te Waipounamu (Regional Māori DHB Alliance).

Current Issues	Update/Achievements	Upcoming key deliverables
Prioritisation of equity funding	Meeting with Iwi Governance Committee occurred discuss and prioritise equity funding.	Key outcomes were decided: 1. Investment to build capacity & capability for Kaupapa Māori Health Providers 2. Explore feasibility of a cervical screening project – HPV self testing for Māori woman 20-69 years

- **Prioritisation of equity funding**
- Discussion of principles for approving funding and prioritisation
- Agreement that additional investment for Māori providers is appropriate
- Cancer innovation see as a priority, including cervical screening
- Consensus that hospital based services should have opportunity to bid for funding – this will increase equity outcomes

- **Explore use of navigators across the continuum of care**
- 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.
- Respiratory admissions in children - Contract for service in placed with Awarua Whanau Service with a whānau ora navigator in place.

Long Term Conditions

- Hauora Wellness Checks for Māori aged 50 years and older by are underway utilising the WellSouth Primary Health Network call centre. Māori patients have been identified GP practice by practice based on priority numbers of high risk patients. An electronic portal is being developed to capture this data collection and analysis. This data is currently being captured manually.
- At the end of Q1, 47.83% of all Māori registered under CLIC have had a CHA completed. The CLIC programme has recently been evaluated and redesigned.

Māori Health monthly report for Nov 2020

Lead Executive: Gilbert Taurua

- **ASH Respiratory - children age 0-4 years**
- The WellSouth PHN and Southern DHB Māori Health Directorate has established a new service targeting respiratory admissions for Māori children age 0-4 years in Dunedin (EOA)
- Contract for service in placed with Awarua Whanau Service with a whānau ora navigator in place Q1.
- 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.
- 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.

- **Cancer**
- Māori 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 Māori 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 Māori health workers is a work in progress.
- Service Plans have a strong focus on Māori health.

- **Mental Health and addictions**
- Mohi Timoko is retiring after employment of 19 years in the Mental Health Kaumatua role in Southland and working actively with Māori Mental Health Team and inpatients/community
- IGC will discuss replacement of this position - this position is funded through the mental health ring-fence. In addition, the MHAID directorate has a designated forensic 0.5FTE Kaumatua position which will be considered.
- Meeting being held with Māori suicide postvention networks on 18 November. Southern DHB has 8 postvention community groups across the district but there is little active Māori contribution and participation in these groups.
- It is proposed that we look to establish a Southern Māori postvention group which is informed by strong leaders in suicide prevention/postvention and aligned to the Southern District Suicide Prevention Action Plan 2019-2023.

- **COVID-19**
- The Māori Leadership Group have re-developed our COVID-19 Māori escalation plan based on IGC feedback. This includes an escalation plan that will be developed in consultation with our Māori health providers, Runaka and Māori community. This document will sit alongside hospital and community resurgence plans.
- Southern DHB is progressing contracts for the COVID-19 Māori Communities Outreach and Support fund. The closed RFP went out to contract DHB Māori providers who will assist Māori communities in the southern district affected by COVID-19.

- **Family/Whanau accommodation**
- Family/whanau transport and/or accommodation is not covered under the National Travel Assistance Scheme. The ability to accommodate family/whanau is critical for our patients because of our large geographic size.
- Whanau Flat 3 (Wakari Site) is under renovation and there has been considerable wait for this to be completed. The Whanau Flat 3 has been available to facilitate accommodation for whanau for several years.

Finance monthly report for Nov 2020 (Report as at 31 Oct)

Lead Executive: Julie Rickman

EXECUTIVE SUMMARY

The net deficit for the period ending 31 October 2020 was $0.4m, being $0.1m unfavourable to budget.

During October 2020, Revenue was $3.2m favourable to budget, whereas Expenses were $3.4m unfavourable to budget. The Revenue included the donation from MoH of the COVID-19 capital equipment at circa $1.8m. The overrun in Expenses was primarily attributable to Outsourced Clinical Services $0.3m and Clinical Supplies $0.3m which reflects further Recovery Plan activity. In addition, Provider Payments were unfavourable as the impact on dispensing fees through Community Pharmaceutical caused by the Pharmac instruction to dispense monthly rather than three-monthly flowed through the system and COVID-19 Surveillance and Testing expenses of $0.7m.

Key Projects	Previous month	Current month	Commentary
Financial sustainability	↓	↓	The delivery of savings is fundamental to achievement of the budgeted deficit. A specific plan has been developed for EDSS to investigate the expenditure and identify where further controls can be implemented to enable improved transparency of activity and associated expenditure.
Holidays Act 2003	→	→	The Holidays Act project is currently in the 'Review phase.' The collective of DHBs are working through the issues identified during the "Review Phase" with a particular focus on casual workers and RMO workforce.
FPIM: Finance Procurement & Information Systems	→	↑	The FPIM underway and now the challenge is the Product Catalogue project which has commenced and achieving alignment of the two projects within a compact timeframe.
New Dunedin Hospital Business Case	→	→	The Detailed Business Case for the New Dunedin Hospital is being revised for resubmission to the Ministry of Health and the Ministers. There is an increasing importance to ensure that Detailed Business Cases are connected and share common assumptions. In particular, the Digital Detailed Business Case must integrate with the New Dunedin Hospital Detailed Business Case.

Current Issues	Update/Achievements	Upcoming key deliverables
Savings plans	The delivery continues to be "at risk".	Assess impact of NZHPL targets on Southern DHB procurement activity.
FPIM go live date	Date set at 1 June 2021	Assess impact on Project Plan of Product Catalogue project which has now commenced.
Holidays Act 2003	Discussions with stakeholders progressing well.	Assessment of recognised liability and potential for further accrual.

Systems for Success

- The review of the Procurement and Purchasing Policy to align with revised All of Government and MBIE guidelines to be completed prior to Christmas 2020.
- An ongoing focus is Clinical Supplies expenses especially blood products, cardiac implants and pacemakers.

Delivery of System Improvements

- The management of Workforce and Annual Leave remains critical given the impact of COVID-19 on the capacity of the workforce to take leave and the needs for the workforce to have rest and recreation. Over recent months the focus has been on compiling a report and dashboard to provide information about leave entitlements. From 31 October 2020 the leave report has been pushed out to managers to assist them in understanding the leave entitlements of their teams. During November 2020 training on the reports and leave guidelines is being delivered to assist managers to understand and then manage future leave.

Facilities

- The year to date operating budget excluded expenditure relating to the New Dunedin Hospital of $993k and accelerated depreciation on the existing Dunedin Hospital. The timing of recognition and quantum of impact is being assessed in accordance with accounting standards and Ministry of Health guidance. It is expected that November 2020 financial performance will incorporate the year to date impact of the approval "in principle" of the New Dunedin Hospital Detailed Business Case by Cabinet in September 2020.

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
FINANCE	GREEN	Tracking to budget 5% (or $100k).
	AMBER	Moderate variance to approved budget 10% (or $100-$500k)
	RED	Significant variance to approved budget 25% (or $50k+)
RESOURCES	GREEN	Adequately resourced
	AMBER	Constrained resources which will impact delivery
	RED	Resource shortfall, preventing tasks from being completed
FORECAST		Status expected to improve
		No change expected in status
		Status expected to decline

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Recommendation paper – placement of additional diagnostic Computed Tomography (CT) scanner**
Report to:	Board
Date of Meeting:	08 December 2020

Summary:

- This paper considers 3 options for the location of the new CT scanner and provides an overall recommendation.
- The 3 options considered were:
  1. Locate the CT in a primary and community setting.
  2. Locate the CT in the Radiology Department.
  3. Locate the CT in the Emergency Department.
- The proposed option is option 2 (locating the machine in the Radiology Department).

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

Financial:	The relative cost of the 3 options was considered as one of a number of pros and cons for each option. The preferred option is also the least cost option.
Workforce:	The preferred option maximises the use of the medical imaging technologist workforce across two CT machines and minimises the need to hire duplicate staff.
Equity:	Any equity issues are covered in the body of the report.
Other:	The preferred option mitigates an existing clinical risk, and this was seen as a key differentiator for this option by the working group.

Document previously submitted to:		**Date:**
Approved by:		**Date:**

Prepared by: Stephen Jenkins, Service Manager Patrick Ng, Executive Director **Date:** 04/11/2020	**Presented by:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:

That the Board approve our proposal to locate the new CT machine in the existing Radiology Department (option 2).

Background

Earlier this year the Board gave their approval to invest in operational resources to increase the number of CT scans performed at Dunedin hospital. Access to CT has previously been significantly constrained at Dunedin hospital. For example, whilst Southland and the rest of the South Island have an access rate of circa 880 scans per 10,000 population, Dunedin hospital has had a comparable access rate of circa 580.

As well as approving the operational investment required to complete additional evening scanning and some scanning on the Spec CT machine (which was upgraded to facilitate this), the Board also asked that an additional CT machine at Dunedin hospital be included in the 2020/21 capital plan and this was added to the approved capital list. Subsequently, we were asked by the Ministry of Health to 'bid' for new capital that has been allocated as part of COVID recovery, and we have been successful in securing capital from this source for our additional CT machine.

One of the key questions associated with the commissioning of an additional CT machine is where it should be located. Stakeholders have advocated for a community placement, a placement within the Radiology Department and a placement within the Emergency Department. We were tasked with exploring the options and providing an overall recommendation for the placement of the new CT machine, which is the subject of this paper.

Approach

In order to ensure the alignment of our stakeholders and to be confident that our recommendation is one of a united Southern District Health Board, we undertook a brief workshop with key stakeholders who represent the interests of the 3 options noted earlier.

These representatives included:

- Primary and Community: The Executive Director was invited but delegated attendance to the Primary and Community Medical Director.
- Primary and Community: We also invited the Chief Executive for the primary health organisation (WellSouth).
- Emergency Department: We invited the Clinical Leader and the Charge Nurse to attend.
- Radiology Department: We invited the Clinical Leader, the Service Manager and the two charge Medical Imaging Technologists.
- Also, in attendance: Also, in attendance (to facilitate the meeting) were the Executive Director of Specialist Services and the General Manager for Surgery and Radiology.

The workshop / stakeholders unanimously concluded that the preferred option was option 2 (locating the CT machine within the Radiology Department). An options assessment and strengths, weaknesses, opportunities and threats (SWOT) analysis in support of this option are provided in the body of this paper.

Options Assessment

Option 1: Locating the new CT in the Community

Discussion:

Greater access to CT scanning by primary care was initially suggested as a possible strategic opportunity that may increase the number of patients that were able to be managed in the community. Having a community scanner in a more accessible location was also seen as a potential benefit for patients who otherwise have to find parking at the main hospital in order to receive their scan.

In our discussion with stakeholders, it was agreed that the above benefits were desirable. However, it was also concluded that this option would create a number of dis-benefits which outweighed the benefits and overall this option was the least preferred by the group.

Dis-Benefits included:

a. The advantages of having the CT located in the hospital outweighed the benefits described above, particularly those related to patient safety. The advantages of having the CT machine located at the hospital are described in the other two options.

b. Greater access to CT scanning by primary care is desirable but can also be achieved by providing greater access to CT scanning at the main hospital.

c. Whilst having the new CT machine in the community would improve the separation of acute and elective flow, a reasonable proportion of elective scans would still need to be done in the hospital, which would effectively require them to be done on the acute scanner that was retained in the radiology service.

d. The separation of the two machines would require duplicate staffing and would thus be a less efficient / more expensive option that the hospital based options.

Option 2: Locating the new CT in the Radiology Department

Discussion:

The benefits of this option are believed to outweigh the disadvantages. The key disadvantages are that there would not be a clear separation between acute and elective flow, and the ED would not have a dedicated CT scanner which was felt to be desirable by the reference group if sufficient capacity existed in the Radiology Department (the ED will get their own scanner when new Dunedin hospital is built).

In our discussion with stakeholders, it was felt that the benefits of this option outweighed the dis-benefits.

Benefits included:

- The ability to complete an urgent scan if the other machine was already in use for an urgent case. With the current constraints associated with having only one scanner, it is not infrequent that an urgent case has to wait because another urgent case is

already using the scanner. Having two CT scanners would reduce the instances when urgent patients have to wait longer than they should and the whole reference group felt that this was a compelling reason to locate the new CT scanner in the Radiology Department.

- It has been identified that the required space (100 square meters) can be made available in the radiology department and this space can be appropriately developed to meet Australasian guidelines.

- A lower specification machine would be able to be purchased (as it would sit alongside a higher specification machine) and this option could be optimally staffed with medical imaging technologist and support staff shared across both machines.

Option 3: Locating the new CT in the Emergency Department

Dicussion:

The main benefit associated with this option is the ease of access to CT that would be possible for the Emergency Department and the two senior ED staff on our reference group did note that if there was sufficient CT capacity in the Radiology Department then they would be very keen to have a CT machine located within or proximate to the ED, which will be the case when the new Dunedin hospital is built. However, they did also acknowledge that the insufficient CT capacity that exists in the Radiology Department and the risk of having urgent patients who need the Radiology service waiting because there was already a patient on the only available machine was a risk that outweighed the advantage of having a CT machine within located within or proximate to the ED.

The dis-benefits associated with this option were noted as:

- The main Radiology risk which is improved upon if the new CT machine is located in the Radiology Department would remain unaddressed.

- Although it would be possible to locate the CT scanner within the footprint for the new medical assessment unit the size would have to be restricted (we would not be able to make a full 100 square meters available) and this would consequentially reduce the functional space and therefore functionality of what could be offered. The timeframe for construction and implementation would also be likely to be longer than if the available space in the Radiology Department were used.

- There would be staffing inefficiency when compared to the option of locating the CT machine in the Radiology Department.

'SWOT' Analysis of the Options

The team have completed a strengths, weaknesses, opportunities and threats (SWOT) analysis which is attached as appendix A to support the conclusions note above.

Appendix A

SWOT analysis for Community placement of a CT

Strengths	Weaknesses
• Separates outpatient and inpatient activity. • Provides additional elective capacity. • Requires less space (e.g. no bed bay requirements). • No disruption to main Department during build.	• Cannot be used for any acute imaging (ED or inpatients). • Difficulty in staffing across 2 sites (most likely require additional staffing and some duplication across sites). • Not able to utilise as a backup to current scanner. • Lack of flexibility of use e.g. unable to be used for any Interventional procedures especially those that would require post care. • Does not reduce current risk issues that exist when lengthy procedures are underway and urgent (e.g. ASPRO) patients require scans. • Potentially no medical support in the event of an anaphylactic reaction to contrast. • Creates inefficiencies in staffing and throughput. • Does not eliminate current risk issues that exist when the current scanner is unavailable due to breakdown or servicing and the service has to use the Oncology scanner. • Time taken in sending staff from one site to another in the case of sickness/IT issues/radiation safety testing. • Increased volumes require increased medical staffing and/or increased outsourcing. • Complex imaging would still need to be undertaken at Hospital (e.g. Cardiac, gated studies, neuroperfusion, some angiography etc). • No (or very limited) back up for this scanner if breaks down.
Opportunities	**Threats**
• Increased GP access to CT (currently only access for CT KUB pathway) • Ease of access for patients (parking etc.) – dependant on setting • Site able to be utilised beyond the new hospital build by the DHB or sold to another provider. • Can be low specification – therefore lower cost - as complex imaging would still need to be undertaken at Hospital (not really a strength from a Radiology perspective).	• Supply chain for consumables, no existing infrastructure. • Availability and timeliness of a ready site of operation; will add months to planning phase. • Potential increase in demand from GP. • Cost to buy a site, build an outpatient unit, fit out and then staff it. • Likely to have wasted capacity, at least initially. • Effectively no Radiology buy in for this option. • Potentially confusing for out of Dunedin patients (we see this daily with DUDAC and Pacific Radiology).

SWOT analysis for Option 2: Additional CT in Radiology

Strengths	Weaknesses
• Location already identified, faster installation • Qualified staff available to operate scanner • Access to medical staff in case of anaphylaxis to contrast • Able to use existing supply chain for consumables • Able to use existing patient holding areas • Versatility/flexibility as the scanner could be used for inpatients, outpatients and procedures • Can be utilised by all referral pathways • Maximum efficiency in staffing - less staffing duplication, higher patient throughput • Ability to be responsive and flex staffing and patient appointments between scanners during staff sickness or high demand periods with SMOs, RMOs, RNs and MITs all nearby • Can be lesser specification scanner (than the current Somatom Dual Flash) • Can be utilised as a backup for the current scanner thereby reducing risk during replacements, servicing or breakdown • Reduced clinical risk of performing urgent scans in a timely manner especially when one scanner has a procedure taking place • Provides surge capacity when acutes spike (for inpatients and ED patients)	• Distance between ED and Radiology • Requires relocation of main reporting room (e.g. to current Health Informatics Team Office) • Requires relocation of Health Informatics Team • Increased volumes require increased medical staffing and/or increased outsourcing
Opportunities	**Threats**
• Ease of access for specialists to attend outpatient scanning clinics e.g. Cardiology • Less expensive to fit out and staff • Can bring CT Colonography in house (currently c. 200 pa. outsourced)	• Clinical service building age and historical issues with asbestos and leaks • Inadequate car parking for elective patients near Dunedin Hospital, especially during business hours.

SWOT analysis for Option 3: Emergency Department / MAU CT

Strengths	Weaknesses
• ED acute patients have less distance to travel for imaging • No disruption to Radiology Department to build/fit out • As the scanner is for ED patients only (unless inpatients and elective patients can be examined here) allows for ED surge without disrupting other examinations (but not inpatient referral surge). • Ground floor CT scanner not necessarily for ED patients only. When MAU built can serve ED and MAU where a significant load of acute scans originate from. Has potential to be used for other in-patient urgent scans, e.g. ICU, especially after hours • Brings ED access and adjacency to CT up to international and Australasian College for Emergency Medicine standards for a tertiary ED and major trauma centre. • Establishes model of care with ED then subsequently MAU prior to new build • Reduction in length of time ED nursing and medical staff spend outside of ED escorting patients to CT.	• Would require a new build in or near the ED; Radiology is unclear of timeframes or available space – in order to examine all patient types, footprint of CT and associated rooms is c.100m^2 as per Australasian healthcare facility guidelines • Not able to be fully utilised as a backup to current scanner. • Cannot be used for any Interventional procedures. • Reduction of efficiency in staffing and throughput compared to in Radiology option (will require additional staffing) • Less ability to flex staffing or between scanners in response to demand. • Scanner would have to be of the highest specification (As ED examinations currently make full use of existing scanner's functionality). • Increased volumes require increased medical staffing and/or increased outsourcing. • Having a CT scanner situated near an ED is likely to increase referrals for CT imaging through that scanner due to proximity and perceived ease of getting high tech imaging. • Will need provision of holding bays and change facilities for OPs if this is to be a backup for the radiology department CT scanner.
Opportunities	**Threats**
• Establishes a similar Radiology service in ED as planned for the new build • Provide ED access to CT scanning in-line with international best practice	• Timeliness of prepared site as no known location/space available currently • Cost to build, fit out and staff • More expensive scanner and maintenance costs than other options. • Disruption to ED of build/fit out • Likely capacity waste if not utilised by inpatient and elective referrals

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Enhanced Generalism, Dunedin, Business Case**		
Report to:	Board		
Date of Meeting:	08 December 2020		
Summary: Considered in these papers are: ▪ Generalism Cover Paper ▪ Generalism Business Case			
Specific implications for consideration (financial/workforce/risk/legal etc):			
Financial:	The preferred option: $2.4m operating costs per annum, $5.4m capital build costs. Financial benefits as outlined in the business case.		
Workforce:	The Preferred option requires Senior Medical Officer (3.7), Nursing (9.7) and Allied Health (5.8) recruitment.		
Equity:	The preferred option proposes a medical assessment unit which must operate according to equity and cultural principles as outlined in the case.		
Other:	No		
Document previously submitted to:	Executive Leadership Team Unions Clinical Council	Date: 15/10/2020 17/11/2020 20/11/2020	
Approved by:		**Date:**	
Prepared by: Patrick Ng (Generalism Cover Paper) Emma Bell, Project Manager (Business Case) with key input from the working group). **Date:** 24/11/2020		**Presented by:** Patrick Ng Executive Director of Specialist Services	
RECOMMENDATION: **That the Board approves the preferred option (option 2) and agrees to the necessary operating and capital investment to implement an enhanced generalism model combined with a medical assessment unit at Dunedin hospital.**			

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Generalism Cover Paper

The generalism business case is lengthy (it runs to 70+ pages) and covers a number of concepts. This (brief) cover paper is intended to synthesise the key concepts from the business case to assist the reader to understand the key principles outlined in the case and to provide clarity on the preferred option and how it would be implemented.

Brief Background

The concept of implementing a General Acute Medical Admitting model (now referred to as 'enhanced generalism') has been discussed at Dunedin hospital since at least 2011. Currently the proportion of internal medicine patients who are admitted by a generalist team (as opposed to sub-speciality admission) is 60%, which compares poorly to peer hospitals that admit 85-90% of patients under generalist admitting principles.

As well as enhanced generalism, the preferred option in this business case proposes the construction of a medical assessment unit to be located next to the Emergency Department with the intention that the generalist team would staff the medical assessment unit and would 'pull' suitable Emergency Department patients through into the unit.

The implementation of a generalism approach and a medical assessment unit would allow patients to be admitted into the medical assessment unit more quickly than if they were admitted into a ward in the hospital, assessed more quickly in the medical assessment unit with more rapid senior medical and allied health input and in many cases discharged home within 36 hours.

What Problem/s are we trying to Solve?

There are a number of challenges that the Enhanced Generalism Business case is seeking to address simultaneously. These include:

- The > 75 year old population comprises 60% of the internal medicine intake and is projected to grow by 5% cumulatively over the decade prior to the opening of the full new Dunedin Hospital. A 'do nothing' approach to this problem will not allow the DHB to pro-actively prepare for and cope with this high level of growth.

- The current approach of admitting patients into sub-speciality care often slows the admission and discharge processes and can result in speciality 'ping-pong', where multiple services are involved in the care of a patient, but it is unclear who needs to take overall responsibility for the patient. The DHB is seeking to address this with a generalist admitting team taking responsibility for patients in up to 85-90% of cases.

- A combination of factors including insufficient allied health input, outlier patients (who take, on average 1.6 days longer to discharge) and senior medical officer input being limited to '9 to 5' rostered hours all contribute to Southern DHB having a higher average length of stay for internal medicine patients than its peer hospitals. The proposal seeks to reduce average length of stay by tackling each of these issues.

- The Dunedin Emergency Department is unable to cope during demand peaks, for example during winter. By proposing a medical assessment unit built alongside the

ED and staffed with the generalist admitting team/s, the proposal is to 'pull' patients from the ED into this unit and assess and discharge them quickly. This will increase the flow out of the ED and reduce the ward admissions required (which by default involves a longer length of stay in the hospital for patients). As well as improving the flow out of the ED the DHB is seeking to serendipitously improve performance against the ED six-hour target (which is 95%).

What do we mean by 'Generalism'?

As outlined in the business case, generalism can have a number of meanings. This case proposes a generalist approach whereby two generalist teams led by six SMOs each takes responsibility for up to 85-90% of all internal medicine admissions (up from the 60% who are currently admitted by the existing internal medicine teams). The DHB will extend the hours of cover to allow greater senior medical officer input to assist more rapid decision making.

The preferred option then combines this with a medical assessment unit located next to the ED, which will be staffed seven days per week with both nursing and allied health staff. The intention with the medical assessment unit is to 'pull' suitable patients in from the ED, assess them more quickly and in most cases discharge them home within 36 hours, rather than have them admitted into an internal medicine ward for a length of stay that would typically be greater than 36 hours.

What are the options we have considered?

A number of alternatives were considered, which were narrowed down to three options:

1. Implement 'just generalism'. This option would require expansion of the Emergency Department to cope with current and future ED pressures.
2. Implement generalism, combined with a medical assessment unit.
3. Maintain the 'Current state.' This scenario would also require expansion of the ED, for the reasons outlined above.

What is our preferred option and why?

The preferred option is the implementation of generalism combined with a medical assessment unit. Why?

a. The team believes that the addition of the medical assessment unit is required to achieve the upper bound of possible length of stay reduction (targeting 29%).
b. The medical assessment unit will improve flow and aid the objective of reducing length of stay, rather than simply adding capacity as would occur under the ED expansion scenario.
c. The preferred option also increases the amount of allied health input to seven days per week. The DHB's studies have shown that allied health input is key to achieving an early discharge for patients.
d. The financial modelling demonstrates that this option provides the best financial return. In addition to the quantifiable financial return, it is believed that this option produces a number of additional benefits related to flow which, whilst not immediately measurable in financial terms, nevertheless will ultimately reduce the amount of time patients spend in hospital and the costs associated with longer length of stay.

What are the financial implications?

As you will see in the business case, the detailed financial modelling suggests that the preferred option produces the best financial result, as summarised by the following table:

Option	Cashflow over 10 years	P&L Impact over 10 years	Capital	NPV
Generalism + MAU (Aspirational)	(25,651,894)	(25,651,894)	(5,435,000)	(20,455,459)
Generalism + ED Expansion	(30,565,561)	(30,565,561)	(5,435,000)	(23,645,865)
Do Nothing	(32,924,672)	(32,924,672)	(5,435,000)	(25,304,512)

The preferred option (highlighted in dark grey) requires an additional investment of $20.5m over the remaining ten years until the new Dunedin hospital opens. This compares with $25.3m under the 'do nothing' option, effectively creating a financial benefit (the difference in investment required) of $4.8m when calculated on a net present value (NPV) basis.

How will we implement the preferred option?

Implementing generalism and the medical assessment unit (the preferred option) will be complex. A dedicated change manager (provided for in the financial section) will be employed and a steering group comprising of senior managers and clinicians will provide oversight for the implementation, with support also required from the Clinical Council. Considerations that will need to be managed carefully will include:

a. Implementing new protocols for admission (i.e. under what circumstances general medicine will be responsible for admission and under what circumstances sub-specialities will be responsible) and ensuring adherence to these protocols;

b. Ensuring that the senior medical officer and allied health speciality input is provided, and corresponding decisions are made quickly;

c. Ensuring that the medical assessment unit is built as quickly as possible and bypasses avoidable bureaucracy;

d. Ensuring that deliberate decisions are made concerning the realisation of benefits associated with reduced length of stay and the DHB's subsequent ability to close beds.

Most of the Executive Directors have a role to play in making this programme successful and the Management Case section of this business case outlines how responsibilities will need to be shared out.

What support are we seeking from the Board?

A budget allocation was made in 2020/21 which would enable the DHB to initiate generalism. The business case is seeking endorsement by the Board to:

a. Incur the budgeted expenditure to initiate generalism immediately;

b. Commitment to fund the ongoing operating costs associated with generalism, which translate into a steady state commitment of $2.4m per annum excluding depreciation and capital charge, (noting that additional costs are offset by bed day savings. but we will need to make robust decisions about how these benefits will be realised), and by

avoiding growth in cost that will otherwise require more investment over the next ten years;

c. Commit to fund the capital cost associated with developing a medical assessment unit next to the Emergency Department and relocating the physiotherapy gym and rheumatology outpatient services that currently occupy this space.

In Summary:

The opportunity to implement an 'enhanced generalism' approach to caring for internal medicine patients, combined with a medical assessment unit next to the ED (assuming that the preferred option is endorsed) will lead to unclogging of our ED, a more rapid assessment and discharge for patients, reduced length of stay in the hospital, a better patient experience and a number of related and exciting benefits. The enhanced generalism approach is also assumed as one of the initiatives that will reduce demand when the new hospital opens in ten years' time and this, together with other change initiatives, is crucial if the DHB is to 'bend the growth curve' sufficiently to fit into the new hospital, once it opens.

Southern DHB business case for enhanced generalism in Dunedin Hospital

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Prepared for:	
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1.1		
1.2		Exec summary
1.3		Addition to management case
1.4		Further addition to management
1.5		Assignment process
1.6	30.06.20	Amendment to options in economic case
1.7	02.07.20	Amendment to options in economic case
1.8	03.07.20	Economic case, exec summary
1.8.1	03.07.20	Update to exec summary
1.9	03.07.20	Updates from meeting 03.07.20
1.10	07.07.20	Updates to economic & management cases
1.11	10.07.20	Updates from meeting 10.07.20
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2.0	08.09.20	Changes post-ELT review & meeting 27.08.20
2.1	10.09.20	Changes post-benefits workshop, meeting 10.09.20
2.2	11.09.20	Updates from DA; refer to 'enhanced generalism'; change to risk table, w addition of risk matrix
2.3	23.09.20	Changes post meeting 18.09.20: amendment to reduction in bed night volumes, addition of discussion around RMO, updates to risk register; addition of graphic representation of push vs pull model
2.4	24.09.20	Edit to move RMO content from exec summary to economic case
2.5	24.09.20	Updated financial modelling
2.6	25.09.20	Updates post meeting 24.09.20
2.7	28.09.20	Replace '20 bed MAU' with '10+8'; changes post-mtg PN EB 28.09.20
2.8	30.09.20	Changes post-mtg PN EB 30.09.20, inclusion of change in availability for sub-spec RMOs
2.9	13.10.20	Formatting, minor edits; updates post meeting with CE 06.10.20
2.10	14.10.20	Updated financials
2.11	19.11.20	Updated benefits realisation table; updates post-ELT feedback October
2.12	20.11.20	Removed reference to SAFER bundle of care – not agreed within the service
2.13	23.11.20	Reinstated reference to SAFER bundle of care; incorporating feedback from PSA re AH; confirmation of commitment from Clinical Council; update to

		commitment re RMO; updated equity section; relocation cost for MAU; updated financials
2.14	25.11.20	Correction to equity data; updated financials; caveat added re appendix 9
2.15	26.11.20	Final edits
2.16	26.11.20	Addition of appendix 15 and summary to financial case
2.17	26.11.20	Removal of appendix 15, update to commercial case

Document Review

Role	Name	Review Status
Project Manager		

Document Sign-off

Role	Name	Sign-off Date
Project Manager		
Senior Responsible Owner/ Project Executive		

Contents

Executive Summary

This business case seeks formal approval to invest up to $2.4m per annum to staff an enhanced generalism approach that includes the development of a medical assessment unit. This case also seeks formal approval to invest approximately $4.7m in the capital development of a medical assessment unit.

Dunedin Hospital is coming under increasing pressure each winter and these increased pressures are predicted to continue as the cohort of elderly people in the Southern region (those aged 75 plus - the cohort of our population most likely to have an inpatient medical admission) continues to grow every year. While Statistics NZ is projecting Otago's overall population growth to be modest (an increase of 7% by 2028 and 12% by 2038, respectively), the growth in the elderly cohort is anticipated to be 51% and 112% during the same period.

Elderly people currently comprise around 60% of all existing generalist admissions and it is therefore anticipated that generalist admissions (6,170 per annum) will increase by 1,888 per annum by 2028 and by 4,146 per annum by 2038, when compared to current generalist admission levels. At the same time, Dunedin has a lower proportion of internal medicine (IM) admissions that are generalist rather than sub-specialist (around 59%) than comparable DHBs (around 85%).

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Benefits to applying a generalist approach to admitting patients are well documented. In broad terms they relate to the timeliness of decision making, more efficient flow and improved patient safety. There are compelling benefits associated with reduced length of stay, which would translate both into dark green dollars being saved (which would be seen as a reduction in the relevant budget/s) and notional savings (the avoidance of additional costs to address the growing demands on the hospital). This business case considers generalism under two construction scenarios. The first scenario does not involve a medical assessment unit and will require an ED expansion to be built (as we are currently unable to cope with ED volume during our regular peaks in demand in the ED). The second scenario involves the construction of a medical assessment unit next to the ED. The medical assessment unit enhances the bed day saving opportunities that generalism provides, increasing the length of stay saving opportunities from 15% under the first scenario to 28% under a scenario which includes a medical assessment unit.

In order to achieve these benefits, investment is required. The preferred option in this case has been constructed on the basis of relocating the MAU to be next to the Emergency Department (ED), so that it can act as a hub for the staff who would care for those patients admitted into the MAU under an enhanced generalism model. As well as the capital cost associated with building the MAU, further operational costs would be incurred to operate the enhanced generalism

model. Savings have also been identified however, both in terms of avoided future costs and bed day savings related to achieving a reduced length of stay across all medical patients admitted into the hospital.

The working group has identified three options for progressing with enhanced generalism, based on the historic work that has been completed on generalism and from the recent Francis Health engagement with the teams that was undertaken as part of the *'Valuing Patient Time'* initiative.

- Option one considers implementing enhanced generalism independently of a new MAU and commencing a formal roll out as soon as possible. Project management and change management resources would be required. The activities required for roll out would include the establishment of protocols (the rules that would determine whether a patient was admitted under generalist or sub-specialist care), monitoring adherence to these protocols, recruitment of the additional medical staffing required for the six-team approach, implementing changes to terms and conditions to extend the hours of operation for medical staff, and recruitment of the necessary allied health staff. This option also assumes that a capital build will be required to expand the ED due to inability to cope with peak ED demand.

- Option two (our recommended option) considers the implementation of enhanced generalism immediately followed by the construction of a new 10 bed plus 8 chair MAU on the ground floor. As well as the changes required under option one, this option would require a change management plan that aligns the recruitment of non-medical staff and a reconfiguration of wards and specialty resources to align with the new MAU. This option would require investment in an MAU build, ward configuration changes and additional allied health recruitment (when compared to option one).,.

Option three proposes maintaining the pre-COVID status quo. This option would initially be cost neutral but would then result in incurring costs as the DHB managed the impact of increasing demand. Initial costs relate to outstanding job sizing claims, but additional costs would be incurred over the years between now and the new hospital build to cope with forecast demand. This option would also force the DHB into expanding the ED (as per option one) at a similar cost to the construction of an MAU. A brief summary of the financial impacts of each of the options is as follows:

Option	Cashflow over 10 years	P&L Impact over 10 years	Capital	NPV
Generalism + MAU (Aspirational)	(25,651,894)	(25,651,894)	(5,435,000)	(20,455,459)
Generalism + ED Expansion	(30,565,561)	(30,565,561)	(5,435,000)	(23,645,865)
Do Nothing	(32,924,672)	(32,924,672)	(5,435,000)	(25,304,512)

Each of these options leads to the DHB facing rising costs (to cope with increasing demand) over the next ten years, but the preferred option (enhanced generalism plus an MAU) has the least cost growth and therefore the most positive financial impact.

- The proposed option (option two, enhanced generalism plus an MAU) would allow the benefits from a generalist admitting approach (which translate into reduced patient length of stay) to be enhanced to a potential length of stay reduction of up to 29%. In addition to the savings achieved by 'just generalism', enhanced generalism combined with a medical assessment unit would allow appropriate patients to be 'pulled' from the ED into the MAU. This option also provides resourcing of allied health staff seven days per week; allied health inputs have been shown to be crucial to enabling rapid assessment and discharge. This option will also benefit the ED as it will enable patients to flow from the ED faster than if they had to be admitted into the wards. The modelling estimates a 3-4% improvement on the overall six-hour ED target if this approach is implemented.

In short, the move to enhanced generalism provides an opportunity to develop a more responsive model of care and to deliver a better, more patient-focused acute service for the DHB's largest patient cohort. Combined with a medical assessment unit, the achievement of considerable length of stay reductions and an improvement in the ED six-hour performance are also made possible.

Strategic Case

Strategic context

The number of people with multiple long-term health conditions in New Zealand is increasing, as it is globally. The combination of an ageing population, rising obesity rates and social inequities suggests the number of people living with multi-morbidity will rise further (Davey, 2004) Under a specialist model a patient with multi-morbidity will see many different specialists while there is no single physician that oversees the patient as a whole (Levi, 2017).

Countries across the world are calling for a change in how healthcare is delivered to meet this rising challenge, with an increasing uptake of generalism. A generalist takes a holistic interest in all parts of the body and mind and, where required, can act as the first point of medical contact for the patient, to deal with both acute and chronic health problems and, critically, to manage illness that presents in an undifferentiated way at an early stage of development. The 2011 report 'Guiding patients through complexity: modern medical generalism' recommended "management of the first presentation of illness and discussion with the patient of any treatment plan is the clear responsibility of a generalist health care professional" (Guiding patients through complexity: modern medical generalism, 2011). As far back as 2005 the Internal Medicine Society of Australia and New Zealand, supported by the Royal College of Australian Physicians, published a position paper aiming to advance the practice of general medicine in both countries. It advocated the establishment of acute medical wards (or assessment/planning/management units) staffed by general physicians (Internal Medicine Society of Australia and New Zealand, 2005).

With the increase in younger patients with multi-morbidities, it has been suggested that generalists in the UK should be able to provide a variety of services such as pre-assessment clinics for complex patients, perioperative ward reviews and provision of advice on early rehabilitation (Khan, 2017).

The US and Canada have seen an increase over recent years in the number of hospital-based general physicians, known as hospitalists. Their presence in US hospitals has grown from just a few hundred to 30,000 in just 15 years, and they are now found in around 70% of US hospitals (Kirthi, 2012). Major managed care programmes in the US such as Kaiser, Humana and CIGNA use hospitalist programmes in their plans (Lee, 2008). Hospitalists are responsible for patients throughout their stay in hospital. They deliver care to their patients irrespective of where their patients are in the hospital, often following them into the intensive care unit and co-managing surgical patients. This reduces the number of different people involved in a patient's care, offering greater continuity of care for patients, and also reduces the number of patients for whom sub-specialty teams have ongoing care (Kirthi, 2012). IMSANZ noted that optimal patient outcomes can be achieved across a variety of clinical scenarios if general physicians assume primary responsibility for co-ordinating and directing their patients' care, while consulting other subspecialty physician colleagues when appropriate (Internal Medicine Society of Australia and New Zealand, 2005). In Singapore hospitalists specialise in the co-ordination and integration of care within the hospital and with community-based health providers. They spend the majority of their time managing inpatients, with some time spent with outpatients to maintain their skills and integrate care with the community (Lee, 2008).

New Zealand's rural population may be served by rural medical generalists, whose scope of practice encompasses primary care, secondary care, emergency care, advanced skill sets and a population-based approach to their health needs. Over 25 hospitals in New Zealand meet the Medical Council of New Zealand's definition of a rural hospital and are staffed by a predominantly generalist medical workforce. Targeted postgraduate training is offered to doctors interested in rural medical generalism (Nixon, 2017). It has been identified that approximately one third of all patients admitted with a heart attack in the Southern DHB region are managed at least initially by a rural generalist doctor, and it has beens suggested that the same figures would apply for admissions for a range of other conditions (Nixon, 2018).

It has been shown that admission under a general care unit rather than a specialty service can improve outcomes for patients, including a reduction in time to surgery, length of stay[1] and average cost of stay, without significant compromise in mortality or readmission rates (Guiding patients thrugh complexity: modern medical generalism, 2011) (Horwood, 2018) (Phy, 2005; 165(7)) A ten-year transition from a secondary specialist to a rural generalist medical model of care in Ashburton Hospital similarly saw a decreased length of stay in acute medical inpatients, possibly due to the integrated specialist model with no specialist silos and greater contuinuty of patient care from admission to discharge (Withington, 2020). IMSANZ also suggested that prudent and efficient use of limited healthcare resources may be better achieved in many settings through a consultant physician trained in general medicine (Internal Medicine Society of Australia and New Zealand; Royal Australian College of Physicians, 2005).

The Australasian College of Physicians (Internal Medicine Society of Australia and New Zealand; Royal Australian College of Physicians, 2005) and the Australian Medical Association (Australian Medical Association, 2019) have both signalled the need for more general medicine expertise. Specific to the New Zealand health context, the Council of Medical Colleges has supported the statement "New Zealand requires its senior specialist medical workforce to have a high degree of general specialist training and to work across the spectrum of their speciality" (Council of Medical Colleges, 2012). Atmore (2015) recommended more generalism in the specialties to offer holistic care for multi-morbid patients, with generalists working in teams with sub-specialists, nurses, allied health professionals, patients and their whānau.

Southern DHB is no exception having had several discussions over the past decade at Dunedin hospital on the need to move to enhanced generalism, and an assumption of the new Dunedin Hospital is that the DHB will operating under an enhanced generalist model when the move takes place. The current acute medical model of care is based on higher levels of sub-specialisation compared with more generalist models at similar sized DHBs around the country. This variation is rooted in a history and challenge of being the smallest tertiary centre in New Zealand, the co-location of the medical school, co-appointment of positions and challenging inter-speciality relationships, which have resulted in a slower evolution towards a generalist approach.

The table below depicts the variation of the Dunedin Hospital acute generalist take compared with other similar sized hospitals for which data was available to Southern DHB, demonstrating that Dunedin Hospital is an outlier.

DHB	Medical admissions	General Medicine admissions	% General Medicine
Southern DHB – Southland (FY 18/19)	3,946 (10.8 daily)	3,925 (10.9 daily)	99%

[1] [1] Dunedin Hospital has a longer average length of stay than its peer group hospitals, as shown in appendix 1

MidCentral DHB – Palmerston North (FY 17/18)	6,106 (16.7 daily)	5,521 (15.1 daily)	90%
Bay of Plenty – Tauranga (CY 2017)	8,452 (23.2 daily)	7,026 (19.2 daily)	83%
Southern DHB – Dunedin (FY 18/19)	**6,170 (16.9 daily)**	**3,647 (10.0 daily)**	**59%**

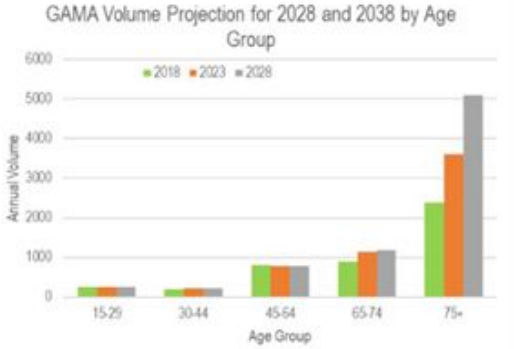
Table 1 – comparison of acute generalist take between Dunedin Hospital and other centres

The case for change

If the DHB continues to provide service focused on organ-specific care and sub-specialisation to a growing population with multiple and complex health issues costs are likely to increase, care will become increasingly fragmented and the workforce will be unable to meet the needs of the community. This will ultimately lead to poorer experiences and clinical outcomes for patients. While Statistics New Zealand projects modest population growth for the Otago population of 7% and 12% by 2028 and 2038 respectively, the growth within certain age cohorts is more significant, with the number of people aged over 75 projected to increase by 51% and 112% by 2028 and 2038 respectively.

Elderly patients account for approximately 60% of the generalist admissions. Assuming a similar age distribution in future years this would result in a 32% and 65% growth in admission volumes by 2028 and 2038. The tables below show the projected population growth and the anticipated growth in generalist medical admissions. It is noted that while numbers are increasing quickly, the number of people requiring significant complex treatment is lower; however, the complexity of that care is greater. Please refer to appendix 2 for further details.

Overall Otago population growth by age group



Generalist admission projections based on population growth by age group

Figure 1 – growth in population and generalist admissions, by age

What is a generalist model of care?

There is no universally agreed definition of what constitutes a generalist model of care and as such the approach varies significantly based on size, rurality and access to sub-speciality services, ability to recruit and expertise within generalist services.

A Commission on Generalism in the UK noted that where specialism was about depth, generalism was about breadth. It identified medical generalism as an approach to the delivery of health care that deals with undifferentiated illness and works across inter-professional boundaries, recognising the interdependency of professionals' skills (Guiding patients through complexity: modern medical generalism, 2011). Generalism has been described as patient and family-centred care; and as expertise in whole-person medicine. Generalism is not settings-bound and exists in both the hospital and community. A doctor can practice generalism within their specialty, such as

a general physician or general surgeon, or as a generalist with a broad set of skills and expertise who provides care across specialty boundaries.

The scope of a generalist hospital model ranges between:

1. Rule based: rigorous clinical criteria that aim to establish the types of patients and which patients are appropriate for each sub-specialty. Tension can occur where patients with multiple conditions cross more than one speciality.
2. Complex medical: most medical patients are admitted via a general take with sub-speciality consultation or a post-take distribution. This applies particularly to patients with complex comorbidities and / or frailty.
3. Any complexity - all patients (medical or surgical) with complex comorbidities and / or frailty are managed by a generalist team with medical and surgical sub-specialty collaboration. This excludes "hyper-complex" patients such as major trauma and ICU patients or younger patients with specific mono-organ conditions.

How could an enhanced generalist model look in Dunedin?

Given the current state at Dunedin and the need to strike a balance between ambition and pragmatism, the complex medical model described above is an appropriate starting point. Irrespective of the approach, the following characteristics and principles are key to a successful generalist model:

- Strong inter-specialty collaboration and collegiality to care for patients with multiple conditions requiring input from multiple disciplines
- Early senior decision making to identify the appropriate and necessary diagnostics, and establish a definitive case management plan identifying the clinical criteria for discharge, expected dates of discharge, and input from other professions to progress the patient's journey in a timely manner
- Clinical expertise and comfort managing complex patients that other specialties find difficult to manage
- Strong collaboration with the ED to identify and pull patients into the generalist service as early in their presentation as possible to expedite care, avoid deconditioning and enable the ED to manage other patients in the waiting room
- A functional assessment and planning unit with sufficient capacity and rapid access to laboratory and diagnostic investigations that supports pulling the patient from ED
- Rostering of senior resourcing to align with the arrival pattern of patients to the hospital
- Models of care that actively manage the different patient streams (ambulatory and short stay, ward and frail elderly patients)
- Expertise in managing older patients with frailty or who are at risk of hospital-acquired functional decline using an inter-disciplinary team-based approach. International evidence indicates that patients who are admitted from ED benefit from having a comprehensive geriatric assessment (Australian and New Zealand Society for Geriatric Medicine, 2019) (Mudge & Hubbard, 2019). Having acute geriatricians available on the MAU would facilitate this.
- Admitted patients are based in home-based wards to enable IDT teams and relationships to form to the betterment of patient care
- Timely access to social and community services to support safe discharging.

The enhanced generalism model would be implemented alongside the SAFER care bundle, one of the Valuing Patient Time strategic priorities that the Hospital Advisory Committee has endorsed on behalf of the Board for use in both Dunedin and Southland Hospitals. The SAFER patient flow

bundle is a model of care that combines five elements of best practice (senior review; all patients having an expected discharge date and clinical criteria for discharge; flow of patients from assessment unit to wards as early as possible; early discharge; and review for stranded patients) in a practical tool to reduce delays for patients in adult inpatient wards.

The graphic below demonstrates how an enhanced generalism model could support the Institute for Health Improvement's six domains of quality improvement in healthcare. More detail around how the preferred option would benefit patients, staff and the organisation across the six domains can be found in Table 7. It is important to note that a move to enhanced generalism is not an issue for IM to solve alone, rather an organisation-wide change that requires specialities and leaders to agree on and transition to a new model, working collaboratively to support complex patient care in a new context.

Another enabler for increased patient safety is digitally-enabled medicines dispensing, which forms part of the Medicine Management Strategy for the New Dunedin Hospital. A recommendation has been to pilot the use of automated dispensing cabinets before use in the new hospital, and the MAU has been suggested as a suitable pilot site. While the MAU may provide an opportunity for early adoption of automated dispensing, the cost of approximately $125,000 has not been factored into financial modelling for this business case and a separate business case will be required to evaluate this..

Internal medicine at Dunedin Hospital (current state)

Dunedin Hospital is struggling to meet the needs of the current population, with those admitted under IM spending an average of eight hours in the ED and a growing proportion of people leaving ED without being seen. The national six-hour Shorter Stays in Emergency Departments (SSED) target is an international metric used to assess hospital flow and is an indicator of patient safety. The national target is for 95% of patients presenting to an ED to be attended to within six

hours (either discharged from the ED or admitted to an inpatient ward). The current performance in Dunedin is approximately 80%, with patients admitted to IM achieving 54% against the target.

The generalist service is currently based on a four-team model comprising of two SMOs, one registrar and one house surgeon per team. Within each team the SMOs rotate using a block model approach, whereby one SMO is on the ward managing the current inpatient caseload while the other is off the ward, on a four-weekly cycle. The IM take in Dunedin represents less than 60% of all acute medical admissions, whereas in other similar-sized hospitals it accounts for over 80%. The service is largely a SMO-led service, operating from Monday to Friday, 8:00-16:30, with RMOs providing evening and overnight resourcing. A SMO from one team provides an after-hours on-call service, which is a combination of telephone oversight and onsite delivery as needed.

Many patients are referred by the ED and there is a sense that referrals are often made to a sub-speciality first, with IM becoming the default destination if the sub-specialty declines to accept the patient. This approach can lead to delays for patients while specialties resolve disagreements on ownership, and it has led to IM SMOs describing that their service feels like a “dumping ground” for unwanted patients rather than the “heart” or “engine” of the hospital medical service. This is symptomatic of the fragmented and siloed medical culture that exists within the organisation and a fundamental issue to be addressed as one of the key success factors previously identified. The fragmented service and delays have a significant negative impact on the DHB’s patients.

Patients' voices

"I arrived in Dunedin Hospital Emergency Department before lunchtime on a Friday with acute cellulitis and I was there into the evening when I was sent to the MAU – it was a long time waiting. I felt so sick but what I can remember is having to explain to different health professionals what was wrong due to staff coming and going off shifts as I was there so long. I was only supposed to be in the MAU overnight but ended up there over the weekend and was discharged on Monday at lunchtime. The ward was very busy and loud. I was in a mixed ward with three men, one was very elderly and sick and the other two were young. The staff were run off their feet and over the weekend I wasn't reviewed by a doctor. I can recall hearing the one doctor telling one of the nurses he couldn't see all the patients due to such a high workload. He was very stressed and I felt sorry for him."

"I was recently discharged from the Medical Service but had to come back to the hospital because of the exacerbation of my chronic condition. This time I had to wait for more than 6 hours in Emergency Department before being transferred up to the 8th floor medical ward. It wasn't a very comfortable experience. I am pleased with the care I received here. But when my doctor says I am ready to go home and should come back if I start feeling sick again, I feel very anxious and scared - I never want to go through the same process all over again."

Under a generalist model and MAU model these patients would have been seen first in MAU or transferred earlier to MAU, with the first patient having a review and subsequent discharge from the MAU over the weekend. The MAU is also expected to be used for post-discharge follow-up of high-risk patients with chronic conditions (e.g. heart failure) in order to prevent readmissions. The second patient would have been assessed and treated in MAU with a timely post-discharge follow-up plan before their condition exacerbated to require readmission to the ward.

In addition to the fragmentation, the size and sub-specialisation of Dunedin Hospital leaves the sub-specialties vulnerable to changes in capacity, particularly when a SMO leaves a service. Given their generalist skills, IM often fills capacity gaps in medical services. For example, IM began accepting acute rheumatology patients in September 2019 after the departure of a specialist rheumatologist. IM's resilience is starting to stretch under the four-team model but increasing to six teams (as outlined in the options in this business case) will increase the institutional resilience of the medicine service, strengthening the capacity of Dunedin Hospital. A distribution model that was developed and introduced in 2019 has helped; however, staff are feeling fatigued with a high census and take of patients per team, onerous weekends and high frequency of call. Junior doctors often cite IM as the busiest run in the hospital. Further, the Royal Australasian College of Physicians has indicated changes for general medicine training (Internal Medicine Society of Australia and New Zealand; Royal Australian College of Physicians, 2005) which, under the current four team model, would be a challenge to implement.

Climate for change - what's different now?

While current performance is a result of complex and interdependent variables, moving to a generalist model as described above will support significant improvements and promote patient safety. Recent changes in the teams, in addition to previous efforts to support a move to enhanced generalism (as summarised in appendix 3Appendix 3: A short history of the evolution of generalism and its enabling factors at Dunedin Hospital), will support a more successful transition. These include:

- Executive support in 2017 to fund a MAU on the seventh floor, which has helped improve buy-in to the principles of ambulatory emergency care within the IM team

- The expansion of the MAU to include acute patients from all medical specialties, which has increased buy-in from the specialties outside IM
- Support and drive from management that a move towards enhanced generalism is an important aspect of maintaining high quality and viable services.

The IM team has established a working group devoted to developing a General Acute Medical Admitting (GAMA) model of care and an expanded MAU under the Valuing Patients' Time programme. This group has achieved broad consensus within the department on the need to move towards a more generalist approach and has initiated consultation with their subspecialty and junior doctor colleagues. A draft paper presented to the Executive Leadership Team gained endorsement for the GAMA model. Beyond the IM department, the sub-specialties have expressed an openness to a more generalist approach; however, the scope and extent of this requires further discussion.

More details around enhanced generalism and its enabling factors at Dunedin hospital can be found in appendix 3.

Objectives for this case

The team working on the generalist approach believes that a reasonable aspiration for the new model is to deliver up to a 29% reduction in the hospital beds occupied by IM patients. Achieving this quantum of change will require further improvements across a range of areas, including discharge timeframes, admission and ward processes and inter-specialty collaboration, in addition to the generalist admitting model described in further detail below. This is modelled further in the case as a 15 bed reduction across the hospital. It is also important to note that the financial benefits achieved by enhanced generalism will be a combination of 'hard green dollars' (identifiable savings that can be removed from budgets), and 'light green dollars' (notional savings). The key 'light green dollar' savings represent avoiding the growth in demand that would otherwise translate into further hospital pressures requiring additional funding in the future.

A key enabler of a generalist approach includes the introduction of an appropriately sized medical assessment unit that would enable flow out of the ED and expedite patient turnaround and admission planning. The modelling undertaken to date (shown in appendix 4) suggests a 35-57% improvement on the SSED performance for patients admitted under a generalist model, which translates to a 3 to 6% improvement in the overall SSED performance. A generalist admitting model would therefore be a key enabler both for helping to manage pressures in the ED (e.g. winter demand) and meeting the SSED target of 95% of patients treated and discharged or admitted within six hours.

Additionally (not modelled) the released capacity would enable ED to see and refer patients to other specialties earlier in the day (within business hours), with increased resourcing available to make treatment decisions and reduce avoidable delays. It's important to note that the MAU in and of itself will not achieve these benefits without other dependencies contributing to the improvements, i.e. the GAMA model of care, prompt access to diagnostics, and community and allied health (AH) support.

It is also anticipated that decreasing the acute patient load of the medicine sub-specialties will afford specialists a greater capacity to focus on their non-acute and outpatient commitments, enabling them to provide a faster, more responsive service than is currently possible (demonstrated in appendix 5).

Proposed scope

The preferred option is based on operationalising the GAMA model aligned with the complex medical approach described earlier, immediately followed by construction of the MAU on the ground floor. The following are therefore in scope:

- Appropriate resourcing of the medical wards with nursing, AH, RMO and SMO staff is recognised as an important enabler. The costs associated with the change in resources that is required are outlined in the financial case.

- Learning from previous attempts at generalism has highlighted the importance of a process to address and support inter-specialty culture. The management case outlines a process directed through the Clinical Council for establishing and managing principles to support a generalist approach and to ensure ongoing adhesion to the new way of working. A robust change management approach will be required to establish the change, transition from current processes to new ways of working, and then maintain these new practices. This is also outlined in the management case.

- A functional MAU with sufficient capacity and rapid access to laboratory and diagnostic investigations that supports pulling patients from the ED has been cited as a critical success factor in any generalist approach. The current MAU is limited in size and has inadequate allocated AH and SMO capacity to maximise same day and next day discharging. Its location on the seventh floor also poses a challenge in promoting "pull" of patients from ED. The economic case outlines options for increasing the size of the MAU and co-locating it with ED to meet both current and future demand. The management case outlines how the admitting model will change to be SMO-led with more focus on same day and next day discharging.

The **introduction of a generalist approach to the surgical wards is out of scope** for this case, with the focus of this case being on medical sub-specialities and the ED.

Generalism and Equity

It is well documented that Māori and Pacifica people in New Zealand face multiple barriers in accessing primary care (Ludeke, 2012; Ministry of Health, 2018), and are therefore more likely to present acutely to secondary care services. Data for discharges from Dunedin Hospital for cardiology, respiratory, gastro, neurology, rheumatology, endocrine, renal and haematology services between 01.07.2019 and 30.06.2020 shows that Pacifica and Māori patients were more likely than patients identifying as Other to present acutely. For people of all ages, 58% of discharges for Pacifica people were acute, versus 43% for Māori and 38% for Other. The figure for Pacifica patients aged 50 and over was also 58%, and the figure for Māori had increased to 52%, compared for 41% for Other.

Based on Ministry of Health population data for the Southern region as a whole, Pacifica people account for 2% of discharges for the specialties listed above (and 3% of acute discharges), while they make up only 2% of the population. For patients aged over 50, discharges for Pacifica people of all ages was in line with population. The same data shows that Māori of all ages make up 11% of the population and 7% of discharges (8% of acutes); those aged 50 and over make up 6% of the population and 5% of all discharges (6% of acutes). Please see appendix 6 for a more detailed breakdown of data.

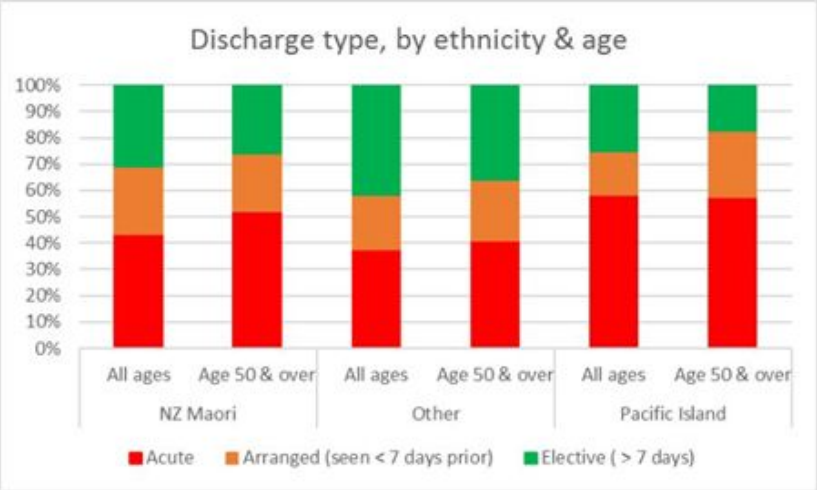


Figure 2 - discharge types from Dunedin Hospital by ethnicity and age

The fact that a large proportion of Māori and Pacifica patients present acutely to a number of the specialties that will be covered by enhanced generalism means that it is imperative that the generalist model of care is implemented in a culturally safe way that will ensure equity of outcome for all patients. It presents an opportunity for the DHB to follow the guidance of He Korowai Oranga (Ministy of Health, 2014), Whakamaua (Ministry of Health, 2020) and 'Ola Manuia (Ministry of Health, 2020) and provide high quality, sustainable, responsive and effective services for Māori and Pacifica patients by organising services around the needs of patients and their whānau rather than the needs of the providers, removing barriers that may act as obstacles to seamless delivery of care and increasing the number of healthcare professionals meeting standards of cultural competence and safety.

Responsiveness to families and whānau should be demonstrated through the delivery of family-inclusive services and support for the provision of direct services to meet the needs of families and whānau, including the components of whānau ora. The Mental Health Commission (2005) recognises that the family unit has always been, and will continue to be, the foundation of support, strength, security and identity to build and maintain wellbeing across society. The

success of enhanced generalism across the Southern DHB will hinge on the responsiveness to not only the patient but the family/whānau and/or those significant in the patient's life. This will be evident in family/whanau-inclusive practice and the ability of the team to engage respectfully with Māori, having an understanding of interpersonal and cross- cultural communication and dialogue. An understanding in cultural humility, the use of te reo Māori in health and knowledge of the Treaty of Waitangi and its application to health will also support this respectful engagement.

The Royal Australasian College of Physicians' Indigenous Strategic Framework (RACP, 2018) has a number of strategic priorities and associated actions to support the College's commitment of equitable health outcomes, including contributing to addressing indigenous health equity differences; growing the indigenous physician workforce; equipping and educating the broader physician workforce to improve indigenous health; and fostering a culturally safe and competent College.

Having reviewed Rautaki Manaaki Mana (Australasian College for Emergency Medicine, 2019), immediate actions that the team believes can be taken are shown below; work will continue on reviewing other actions that could be implemented

- Ensuring that the MAU is seen as a friendly environment to patients of Māori and Pacifica descent;
- Ensuring that whānau are involved in decision making;
- Ensuring that Māori and Pacifica SMOs attend relevant hui and conferences, and being aware of grant, award and scholarship opportunities and the use of CME funding;
- Supporting best practice patient tikanga.

The Health Equity Assessment Tool (HEAT) is a planning tool that improves the ability of mainstream health services to promote equity in health care. It consists of a set of questions that assess health initiatives for their impact on health equity. The HEAT was applied to the proposal for the generalist model of care to ensure that the change would contribute to reducing health inequities; the questions and responses are shown below:

Application of the HEAT tool to the proposed generalist model

What inequalities exist in relation to the health issue under consideration?

- Higher proportion of acute admissions for Māori and Pacifica
- Service integration with primary and community from secondary or tertiary should improve and reduce acute hospital admissions

Who is most advantaged and how?

- People identifying as other more likely to have planned admissions

How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?

- More acute presentations among Māori and Pacifica can be linked to barriers to accessing primary care

Where/how will you intervene to tackle this issue?

- Expanding the service by changing the model of care. Currently Medicine takes all acute patients and expanding the service will improve outcomes for more patients. IM is assisting an already struggling demographic of patient.
- Greater inclusion of family/whānau in the treatment pathway

How will you improve Māori health outcomes and reduce health inequalities experienced by Māori?

- Currently Medicine takes all acute patients and expanding the service will improve outcomes for more patients
- Recognition that disparity and bias impact more profoundly on Māori and Pacific patients
    - Where there is evidence of inadequate access by Māori, Pacifica and other disadvantaged groups, the biases will be addressed and removed

How could this intervention affect health inequalities?

- Reduce length of stay
- Lower rates of deconditioning
- Minimise patient delays
- Enhanced reintegration back to primary and community-based support and services

Who will benefit most?

- Stranded patients
- People who already have extended LOS will have improved LOS
- Māori and Pacific patients who are linked back into primary and community-based support and services

What might the unintended consequences be?

- Unwillingness of surgeons to admit surgical patients because there is the expectation that the cohort of IM physicians will admit all comers

What will you do to make sure the intervention does reduce inequalities?

- Monitor key hospital inpatients indicators, including equity in access and outcome across ethnicity

How will you know if inequalities have been reduced?

- Monitor reporting to ensure equitable reduction in ALOS across all ethnicities
- Review domicile of origin on a regular basis.

In summary Māori and Pacifica patients are the most likely to be admittedly acutely under IM; the changed model of care will improve outcomes for these patients in terms of reduced length of stay in hospital and decreased deconditioning.

Economic Case

The economic case considers the options available to the DHB for the implementation of enhanced generalism in Dunedin Hospital. The purpose of the economic case is to consider options and the benefits that derive from those options, holistically. This means that wider benefits (in this case to patients, staff and flow) are considered independently of the financial impact associated with those benefits.

Many options and permutations are possible. The three options included in this case build on the generalism work that has been ongoing in the hospital for several years. The same basic parameters have been used for each option, outlined in the table below.

Each option has a specific set of associated change management considerations. The costs and benefits associated with the preferred (recommended) option are outlined in the financial case and the change management implications of the preferred option are outlined in the management case.

	Current State	Future State
Resourcing	• 8 x SMOs • 4 x Registrars • 4 x House Officers	• 12 x SMOs • 6 x Registrars • 6 x House Officers
Teams	4 x SMO-led teams comprised of: • 2 x SMOs • 1 x Registrar • 1 x House Officer	6 x SMO-led teams comprised of: • 2 x SMOs • 1 x Registrar • 1 x House Officer
Acute Medical Admitting Inpatient Specialties[2]	• Internal Medicine • Cardiology • Respiratory • Gastroenterology • Neurology • Rheumatology	• General Medicine • Cardiology • Respiratory
Delivery Model	• Acute physician of the day overseeing 2 x MAU H/Officers • Post-take process where majority of patients are seen by a senior decision maker the next day after their admission • Normal working hours (i.e. 0800-1630) • Distributive model where patients are decanted across teams to even-out patient load • Block roster model whereby one SMO is on the ward managing the current inpatient caseload while the other is off the ward in a four-week cycle	• SMO-led team based in MAU with clear expectations set • Intake process where majority of patients are seen by a senior decision maker the same day of their admission • Extended working hours (i.e. 1000-1800 or 1200-2000) • Distributive model where patients are decanted across teams to even outpatient load • Block roster model whereby one SMO is on the ward managing the current inpatient caseload while the other is off the ward in a six-week cycle
SMO Job size	46 hour working week + afterhours	43 hour working week with afterhours redistributed
Supporting Policies	Unenforced Hunter Rules from 2011	Set of supporting structures and policies developed and enforced via Clinical Council: • Service Level Agreements • Referral Guidelines for ED • Agreed Standards and Expectations on Acute Patient and Flow Management (i.e. ED response times, inpatient consult response times) • Clinical Management Structures to enforce above policies, i.e. wider attendance at patient handover meetings, feedback loops, escalation steps

Table 2 – internal medicine model of care – current and future states

[2] Other acute medical specialities remain unchanged i.e. Renal, Oncology, Haematology

Critical success factors

In addition to the investment objectives, the following assessment criteria will be used for screening the options

Key critical success factors	Broad description
Strategic fit and business needs	How well the option: • meets the agreed investment objectives, related business needs and requirements, and • fits with other strategies, programmes and projects
Potential value for money	How well the option: • optimises value for money (i.e. the optimal mix of potential benefits, costs and risks)
Potential affordability	How well the option: • can be met from likely available funding, and • matches other funding constraints

Table 3 – critical success factors for short-listed options

Short-listed options

Option 1: Implement enhanced generalism

The current model of care in IM is problematic as there is a high census (take per team), weekends are onerous, there is a high frequency of call and it does not meet registrar training requirements. Enhanced generalism provides an opportunity to better manage complex/comorbid patients with speciality support as well as reducing ED length of stay and delays associated with transfer of care/speciality ping-pong.

This option is based on operationalising the GAMA model independent of a new MAU as soon as possible. It would require an upfront investment in staff recruitment but with little change management and investment associated with ward configuration, as the model would rely on utilising the current MAU on the seventh floor. Implementation timeframes would be circa six months (depending on recruitment of new staff and transition of existing staff).

Benefits	Disadvantages
Better safer management of complex health needs, particularly in elderly	Inferior outcomes for some acute admissions
Provides critical mass of general specialists to perform acute assessments in ED	Appropriate referrals to sub-specialists may not always occur
Improves patient flow	Potential loss of some specialised nursing expertise
Reduces need for after-hours cover for sub-specialities	
Shorter lengths of stay	
Reduces readmissions	
Enhances discharge planning	

Table 4 – benefits and disadvantages of option one

As well as these benefits, a well implemented enhanced generalism model would achieve a number of direct and indirect financial benefits, which are modelled and outlined in the financial case. Direct benefits are achieved by reducing the average length of stay of patients who are admitted into hospital under IM, and indirect benefits are achieved by better managing future

inpatient growth and therefore reducing the extent to which future financial budgeting would need to allow for bed growth.

Option 2: Enhanced generalism and a new MAU

This option is based on operationalising the GAMA model immediately, followed by construction of the MAU on the ground floor. It would require a change management plan that aligns the recruitment of non-medical staff, reconfiguration of wards and specialty resources with the anticipated completion of the MAU.

This option would require investment in the MAU build, ward configuration and staff recruitment upfront but the majority of investment in non-medical staffing would be timed to coincide with the opening of the MAU. The benefits realisation of the MAU would be delayed over a longer timeframe i.e. 18-24 months (3-6 months after the MAU build is complete), though GAMA benefits would begin to materialise earlier.

This option brings the benefits outlined for option one, and it has the further advantage of affording multiple additional benefits in terms of patient safety and quality of service provision. This model is the fundamental solution to overcrowding in ED, bed block and patient flow, ultimately leading to improved patient safety and quality of care. These in turn will lead to additional financial benefits, but not all of these have been able to be quantified. Construction of the MAU offers a greater opportunity to improve outcomes for a greater number of patients, with a reduced length of stay and lower rates of deconditioning.

Benefits and disadvantages of this option, and how they support the six dimensions of quality in healthcare, can be found in Table 7.

Option 3: Maintain the pre-COVID status quo

This option would be cost neutral in the short term. Any increased costs will be detrimental if the DHB progresses a job size without the benefits associated with the other two. There would be no improvement to acute patient flow in Dunedin Hospital and there is the potential increasing cost burden of a higher than peer average length of stay.

Increasing demand on Dunedin Hospital's acute services has seen a significant decline in performance against the Shorter Stays in ED (SSED) target and an increase in acute occupancy, and action is required to tackle these challenges. The move to a generalist approach to support the SSED target has been noted as a key objective in the Southern DHB 2018/19 Annual Plan in delivering the objectives of the New Zealand Health Strategy of *Value* and *High Performance.* Inpatient beds are increasingly a barrier to flow with the average IM ED length of stay increasing. Although throughput through the eight bed MAU has increased with expanded admissions criteria, the MAU average length of stay is increasing, and the unit risks being used as another ward. The location and the processes for the current MAU are sub-optimal and relocating the MAU adjacent to the ED will improve access to diagnostics, patient flow and patient experience.[3]

The move to the GAMA model provides an opportunity to develop a more responsive service and deliver better, more sustainable acute care for our biggest patient cohort.

[3] Senior clinical staff in ED have expressed support for the relocation of the MAU

Benefits	Disadvantages
Cost neutral in short term	No improvement in patient flow
	No improvement in discharges
	No improvement in lengths of stay
	Reduction in ED performance
	Recruitment of new SMOs into a sub-optimal environment
	Excessive workload for RMOs attached to IM
	Costs related to overnight call and required rest time would increase
	Current issues around level of staffing would be exacerbated, with increased fatigue and decreased morale among clinical staff causing retention issues and affecting sustainability of service
	Potential increasing cost burden of a higher than peer average of average length of stay.

Table 5 - benefits and disadvantages of option three

The table below offers a summary of the benefits and disadvantages of all three options.

Comparison of options		
Timeframes	**Implement**	**Benefits**
Option 1	6 months (Recruit, test, implement GAMA)	From 6 months
Option 2	Stage 1: 6 months (Test, implement GAMA) Stage 2: 12-24 months (MAU build, ward configuration, recruit)	From 6 months
Option 3	Immediate	Immediate

Benefits	**Options**			**Disadvantages**	**Options**		
	1	2	3		1	2	3
Benefits start to be realised sooner				Benefits will not be realised to the same level due to physical capacity of MAU			
Better safer management of complex health needs, particularly in elderly				Increased frustration for both existing and new staff and reduced buy in to model due to limited size and location of MAU			
Provides critical mass of general specialists to perform acute assessments in ED				Benefits will not be realised to the same level due to physical capacity of MAU			
Improves patient flow				Significant upfront financial investment			
Reduces need for after-hours cover for sub-specialities				Increase resourcing to align with demand and expanded capacity, 10 bends plus 8 chairs on ground floor			
Shorter lengths of stay				Full benefits not realised until MAU constructed			
Reduces readmissions				High patient loads / occupancy over winter 2020 increases pressure on Inpatient and ED staff			
Enhances discharge planning				Significant challenge to align the build and people aspects of the model			
Reduces overcrowding in ED				No improvement in patient flow			
Reduces clinical risk - patient receives timely care in the most appropriate setting - ED, MAU or co-managed by both services				No improvement in discharges			

Benefits	Options			Disadvantages	Options		
	1	2	3		1	2	3
Improves access to diagnostics				No improvement in lengths of stay			
Reduces outliers on medical wards				Reduction in ED performance			
Improves process measures including time between consult request, attend, bed request and departure				Recruitment of new SMOs into a sub-optimal environment			
Reduces need for after-hours cover for sub-specialities				Excessive workload for RMOs attached to IM			
Reduce ED to specialty ping pong				Costs related to overnight call and required rest time would increase			
Reduce inpatient handovers				Current issues around level of staffing would be exacerbated, with increased fatigue and decreased morale among clinical staff causing retention issues and affecting sustainability of service			
Improve implementation of case management plan				Potential increasing cost burden of a higher than peer average of average length of stay			
Early senior decision making with improved inter-specialty collaboration							
All roles working at top of scope							
A generalist approach to managing comorbid patients with specialty support							
SMO to GP liaison & co-management							
More efficiently manage inpatient beds in larger wards							
Free up sub-specialist time from inpatient care to inpatient consults							
Early streaming of patients (short stay, long stay)							
Increase learning opportunities in broad based medicine for RMOs & students							
Reduces clinical risk – patient receives timely care in the most appropriate setting - ED, MAU or co-managed by both services							
Cost neutral in short term							

Table 6 – benefits and disadvantages of all three options

The preferred option

The following matrix outlines how each option was assessed by the working group against the critical success factors. A RAG rating and score was assigned to each box with Red / 0 indicating 'no delivery on factor', orange / 1 indicating 'some delivery on factor', amber / 2 indicating 'delivers on factor' and Green 3 indicating 'strongly delivers on factor'.

	Option 1	Option 2	Option 3
Strategic fit / Meets SDHB need	1	3	0
Value for money	1	2	0
Capability / Capacity to deliver	1	3	0
Affordability	1	1	2
Achievability	2	2	3
Overall Score	6	11	5

The preferred option is option two - investment in both the enhanced generalism approach and the relocation of the MAU and to then commence the roll out, recruitment and ramp up of enhanced generalism in parallel to the construction of the new MAU (which is estimated to require 18 months). The cost for relocation of the physiotherapy gym and rheumatology has been estimated at $700,000; this is included in the financial modelling.

This option delivers more benefits than either of the other options. It provides sufficient time to recruit into the roles and develop the change approach (including the development of protocols and guidelines, delivery of training to those required to use the protocols, and development of control processes to monitor and report on adherence to the new protocols). These activities would require dedicated project management and change management resources to formulate a project and change management plan and ensure adhesion to the tasks outlined in the plan. The project management costs have been allowed for in the financial case.

Option one was assessed as sub-optimal as it would incur many of the costs of option two (including capital build costs), while being able to offer significantly fewer benefits in the form of reduced average length of stay (15% compared to up to 29% for option two). The development of a suitably sized MAU proximate to the ED was seen as crucial for achievement of the most important benefits afforded by a generalist approach. Option two provides for the generalist teams to be established ahead of the MAU being built and for the organisation to be in a state of readiness to proceed with the new model once the MAU is built.

As previously noted, implementation of a GAMA model and a new MAU could support the Institute for Healthcare Improvement (IHI's) six domains of quality improvement in health care; the table below demonstrates how such benefits could be realised for patients, staff and the organisation as a whole.

Benefits	Safety	Effectiveness	Pt Centred	Timeliness	Efficiency	Equity	Disadvantages
Better safer management of complex health needs, particularly in elderly							Inferior outcomes for some acute admissions
Provides critical mass of general specialists to perform acute assessments in ED							Appropriate referrals to sub-specialists may not always occur
Improves patient flow							Potential loss of some specialised nursing expertise
Shorter lengths of stay							
Reduces readmissions							
Enhances discharge planning							
Reduce ED to specialty ping pong							
Reduce inpatient handovers							
Improve implementation of case management plan							
Early senior decision making with improved inter-specialty collaboration							
Enhance discharge planning from admission							
All roles working at top of scope							
A generalist approach to managing comorbid patients with specialty support							
SMO to GP liaison & co-management							
Improved access to diagnostics							
More efficiently manage inpatient beds in larger wards							
Reduce the need for after-hours cover for sub-specialties							
Free up sub-specialist time from inpatient care to inpatient consults							
Early streaming of patients (short stay, long stay)							
Increase learning opportunities in broad based medicine for RMOs & students							
Reduces overcrowding in ED							
Reduces clinical risk – patient receives timely care in the most appropriate setting - ED, MAU or co-managed by both services							
Reduces outliers on medical wards							
Improves process measures including time between consult request, attend, bed request and departure							
Better safer management of complex health needs, particularly in elderly							

Table 7 – benefits and disadvantages of the preferred option, option two, relating to the domains of quality improvement in health ca

Resourcing the Preferred Option

SMO resourcing

Currently the IM SMOs average a 46-hour working week which, across eight physicians, equates to 9.2 FTE. Additional services provided under IM including stroke, infectious disease and the Director of Physician Education (DPE) and the Associate and Clinical Director roles take the service up to 11.1 FTE.

Moving to a six-team model with two SMOs per team and a reduced job-size of 43 hours per week requires an additional 3.7 FTE. With an increase in SMOs and RMOs under general medicine, subsequent increases in the DPE and Clinical Director roles are also required, taking the future generalist service to 15.1 FTE; a difference of 4.0 FTE. However, 0.3 FTE has been identified within two subspecialties to transition to General Medicine leaving 3.7 FTE required, as per the table below.

	General Medicine SMO FTE		
	Current (8 @ 46 hours)	Future (12 @ 43 hours)	Difference
General Medicine SMOs	9.2	12.9	**3.7**
Infectious Disease SMO	1.0	1.0	0.0
Stroke Service	0.5	0.5	0.0
Clinical Director	0.2	0.3	0.1
Associate Clinical Director	0.1	0.1	0.0
Director of Physician Education	0.1	0.3	0.2
FTE Required	**11.1**	**15.1**	**4.0**
FTE Identified			
From specialties (Rheum & Neuro)			0.3
Remaining FTE Required			**3.7**
Clinical requirement			3.4
Department requirement			0.3

Table 8 – general medicine SMO FTE, current and future state

A benchmarking exercise was undertaken to ascertain the number of SMOs and RMOs in IM in Wellington Hospital, which operates a similar model to that proposed for Dunedin; the findings are shown below:

	Dunedin			Wellington	
SMO	6 teams of 2 SMO	12		9 teams of 2 SMO	18
RMO	6 teams of 2 RMO	12		9 teams of 2 RMO	18
Population served		200,000			300,000
SMO ratio per capita		1:16,667			1:16,667
RMO ratio per capita		1:16,667			1:16,667

Notes

- Table reflects physical numbers in Wellington Hospital, not FTE (SMO FTE in Wellington is 12.6)
- Services in Dunedin: as Wellington plus stroke
- Wellington Hospital does not include clinics
- Dunedin has a greater volume of geriatric admissions than Wellington
- Different age mix – Dunedin has a larger cohort of elderly people
- Different deprivation levels – Dunedin has a larger cohort of high dep elderly people
- Dunedin has limited private treatment options compared to Wellington

- Although the SMO and RMO teams proposed under the enhanced generalism model for Dunedin are similar in size to those in Wellington, a greater workload would be expected in Dunedin for the reasons outlined above.

RMO resourcing

The proposed generalist model and increase in volumes require a transition from a four-team to a six-team service. Teams will be made up of one SMO, one registrar and one house officer.

General Medicine will need four additional RMOs. In order to expedite implementation of enhanced generalism and the MAU it is anticipated that one RMO will come to General Medicine from neurology and the other from gastroenterology, with agreements for access to the RMO between the specialty teams and the Generalist team. The RMO unit and medical directors will review the other house officer runs in Dunedin hospital over the following 12 months, with a view to re-deploying the house officers in a more equitable manner and a reduction of at least two house officer positions from other specialties over that time to enable the deployment of two to general medicine. These positions will be converted to registrar runs for general medicine by the end of 2021. This business case incorporates an extra two RMO FTE for the first year only to allow time for this to occur, while keeping the model cost neutral for RMO FTE in the long run. The Executive Director of Specialist Services, General Manager Operations, Chief Medical Officer and clinical leads will need to collaborate to agree on a plan to restructure RMO resources to facilitate this.

Nursing resourcing

The nursing team has worked up the required staffing based on the assumption that the current MAU resource will be reallocated into the 10 bed plus 8 chair ground floor MAU. In addition to this a further 9.87 FTE of resource will be required, allowing dedicated senior leadership for ten hours per day and sufficient resource for the safe management of 18 patients.

Allied health resourcing

Allied health resourcing across the current IM service has been described as 'stretched', with AH assessments identified as a key constraint to timely discharge on 8 Med by the Red2Green process. These assessments contributed to 406 'red' days from March to mid-July 2019. Furthermore, the AH staff on the 8-Med wards are less experienced, with several new graduates in post relative to staff on the 6-ATR ward.

Experienced AH staff with the relevant expertise have the potential to add considerable value in an urgent assessment on initial presentation/admission but have not traditionally been used in this way.

Although the introduction of the HOME team has helped to encourage same day and next day discharging, the team lacks the critical mass to support a robust ambulatory emergency care service in the MAU whilst supporting the ED and the rapid response function in the community. Assessments in the MAU would be an additional workload in an additional location, and reprioritising staff from other areas would be counter-intuitive, risking compromising timely assessment, treatment and discharge for other patients.

Current staffing levels and locations are shown in the table below.

Location	Discipline	FTE
8th floor	Physiotherapy	3.0
	OT	3.0
	Social work	1.5
7th floor	Cardio-respiratory physiotherapy	4.6*
	OT	0.63
	Social work	1.0
	* For 7th floor, ICU & Children's Unit	

Table 9 – current allied health staffing levels and locations

Ideally there would be dedicated AH staff in the MAU across extended hours, seven days a week; indeed, a standard for MAUs identified by the Internal Medicine Society of Australia and New Zealand is an AH team with a sufficient number of experienced non-rotational staff dedicated to the unit, providing seven-day cover and extended hours to match the patient demand profile (Internal Medicine Society of Australia and New Zealand, 2016). This team would ideally comprise of physiotherapy, occupational therapy, social work, pharmacy, speech and language and dietetics, all practising inter-professionally through models of combined assessments and structured skill-sharing. The team would be supported by robust and responsive community services and operate over extended hours, i.e. 08:00-22:00, seven days per week.

The importance of having seven-day cover and the impact this has on the average length of stay of patients in an assessment unit has been demonstrated at Dunedin hospital through the Older Person's Assessment and Liaison (OPAL) unit. Throughout their pilot in July 2019, the average length of stay for all patients who were assessed in the OPAL unit, some of whom were then admitted to the Rehabilitation ward, was 7.6 days. This increased to 9 days throughout August and September when AH resourcing reduced to a six-day service and in October further increased to 10 days when AH resourcing returned to a five-day service (see appendix 7).

Currently, the only AH service offering extended hours and seven-day service is the Home Team, with other inpatient AH staff employed Monday to Friday. Details of how to move to a seven-day AH team have not yet been clarified but adopting this model would require the DHB to work with the PSA to establish it within the terms of the MECA. Therefore, while the future direction of AH services is likely to include seven-day working, it would be unsustainable to transition this small contingent of the existing workforce to service the MAU. The ability to staff this service sustainably and flexibly and grow inter-professional capability would be compromised without a significant increase in resourcing. The DHB would be keen to engage with the PSA to work out how to address this challenge. In the current context, the following factors could contribute to an early and responsive AH service that included mobility, functional and social assessment; acute respiratory intervention; deconditioning avoidance; medicines review and management; and discharge planning and facilitation:

- An increase in Home Team AH resourcing to achieve consistent AH presence within ED and MAU. This would provide the benefit of smoother, earlier discharge to the community for those able to be supported home from MAU;
- An increase in the resourcing of the acute medical AH teams to facilitate early assessment, planning and intervention within MAU, and improved continuity of care with reduced duplication and a focus on deconditioning avoidance for patients admitted to the inpatient ward.

Given the range of AH professions noted above and the potential diversity of patient needs, running the ideal model of AH cover for the MAU would be challenging. In reality it would be a mix of rostered time of dedicated staff such as physiotherapy and occupational therapy, and request/referral system for other professions such as dietitians, speech language therapy, social work and pharmacists.

Assuming all patients admitted under the proposed generalist model over the age of 75 require AH input, the number of new admissions per day would range from seven to ten patients (on average and at the 85th centile respectively, see figure 5). The following table demonstrates the average AH hours required per patient admitted, suggesting that on average 5.8 FTE would be required to see seven patients a day under a seven-day, 08:00-16:30 service or 8.3 FTE at the 85th centile of ten admissions a day.

	PT	OT	SW	Pharm	Diet	SLT
Estimated average initial assessment and planning hours per admission	1.5	1.5	0.5	0.5	0.5	0.25

	Per Admission			
	1	5	7	10
Total AH Hours	4.8	23.8	33.3	47.5
FTE 5-days	0.6	3.0	4.2	5.9
FTE 7-days	0.8	4.2	5.8	8.3

Table 10 – average AH hours required per patient admitted

This FTE would include a range of AH disciplines (as stated above), the mix of which would be determined by model of care planning with existing teams. Acknowledging that not every patient will require every profession's input, and that inter-professional practice will generate some efficiencies, an initial investment of 5.8 FTE is recommended, noting that increases in demand (such as during winter) may require resourcing to flex to 8.3 FTE. An estimate of 5.8 FTE has been used in the initial financial model.

Commercial Case

The case for the MAU has been signed off and architects Oakley Gray have been engaged. The current concept plan and quote are shown in appendix 8. In the normal course of events a lengthy process is involved to complete a new build of this nature, including tendering for full concept design work, tendering for detailed design work, tendering for construction and lodgement and confirmation of building consent. The need to de-compress the Emergency Department is urgent and all possible options to minimise the timeframe from business case approval to the completion of the construction of the proposed medical assessment unit will be explored.

Financial Case

- Option 1 (enhanced generalism and necessitating a future ED expansion) gives a $2m net benefit when compared to 'do nothing.'
- Option 2 (enhanced generalism and a new MAU) gives a $3m net benefit when compared to 'do nothing.'
- Option 3 ('do nothing', i.e. maintaining the pre-COVID status quo) requires further operational and capital investment over the next decade which amounts to $22m over ten years.

The preferred option (option two) produces a Net Present Value of +$4m over the ten-year investment horizon. Option one produces a Net Present Value of +$3m over the same investment horizon and maintaining status quo ('do nothing') would incur costs over the same horizon of circa $22m. The benefits for options one and two have been calculated on the basis of what would be saved (by avoiding bed day growth and other cost growth), when compared to 'do nothing.' It is important to note that options one and two avoid some of the additional costs associated with doing nothing (which is how their net benefit has been calculated), but do not avoid all of the costs that will be incurred under the 'do nothing' scenario. This has been explained further in the following analysis.

Option 1: Implement enhanced generalism (with ED expansion)

Under this option the medical workforce would be configured to enable the generalist admitting model but the medical assessment unit would not be implemented. However, within three years and per the 'do nothing' approach, expansion of the ED and appropriate resourcing would be required in order to cope with peak demand. In order to create a valid comparison to the 'do nothing' and option two approaches, the cost of the Emergency Department development and subsequent staffing has been included to ensure an 'apples for apples' comparison.

This option would not see the allied health staffing costs found in option two, and would not see the 29% average length of stay reductions found in the full generalism plus medical assessment unit model. Instead, implementing the enhanced generalism model well would bring a 20% reduction in average length of stay by (as demonstrated in appendix 9).

This option requires an investment in two house officer / registered medical officer roles in the first year whilst an overall restructure of the house officer / registered medical officer roles and how they are distributed across specialities occurs. After one year the Internal Medicine team has committed to operate without these two roles if the restructure of role allocations does not create the two roles they require. However, this is sub-optimal and the reconfiguration needs to occur (the approach will be articulated later in this case). In order to implement enhanced generalism well, investment in a change management role is required for the first year, which will ensure that protocols are developed and used, and that the new way of working is adopted.

Under this scenario some of the growth in demand is managed because the model translates into an overall average length of stay reduction of 20%. This is reflected in both bed days saved and future bed day growth being partially avoided and is captured as benefits in the overall model when compared to the 'do nothing' approach. This scenario avoids the cost of building a medical assessment unit, but then requires the cost of an Emergency Department expansion within three years. Once developed, operational costs to staff the Emergency Department are then incurred on an ongoing basis.

Annual Bed / Day to Dollars Saved			Loaded Resource Costs (annually)		FTE Required	Totals	Capital Cost (Depreciated Over 7 Years)			Values
Bed Days	3,261		SMO Cost (p.a.):	290,000	3.7	1,073,000	Required Capital:	5,435,000		5,435,000
LOS Reduction	15%									
Cost per Bed / Night	362		Nursing Cost (p.a.):	90,000	9.7	873,000	Capital Charge:	5.0%	At 50%	135,875
Occupancy	85%		Allied Cost (p.a.):	85,000	0.6	51,000	Depreciation (in years):	7	Depn	7
Bed Days Benefit p.a.	**1,003,533**		**Annual Resource Costs:**		**14**	**1,997,000**	**Annual Operating Impact:**			**776,429**

Benefits Phasing	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Costs Phasing	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Net Annual Benefit and Net Present Value over Depreciation Life

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
1 Savings: Bed Days:	501,766	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533
	501,766	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533
2 Growth +75 pop (Bed Days):	0	212,691	436,017	670,508	916,725	1,175,252	1,446,706	1,731,732	2,031,009	2,292,685
3 Growth <75 pop (Bed Days):	0	17,724	35,626	53,706	71,968	90,411	109,040	127,854	146,857	162,840
4 FTE Cost:	536,500	1,073,000	1,073,000	1,997,000	1,997,000	1,997,000	1,997,000	1,997,000	1,997,000	1,997,000
5 Year 1 RMO Cost (2 X $110,000):	110,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000
6 Year 1 Clinical Change Manager:	60,000	60,000	0	0	0	0	0	0	0	0
7 Lease costs of Clinical Space	0	0	0	0	0	0	0	0	0	0
8 Less: SMO Allowance Reduction:	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)
9 Net SMO Cost Growth:	0	94,372	192,833	295,581	402,825	514,784	631,685	753,770	881,292	1,014,515
	634,661	1,605,948	1,885,636	3,164,957	3,536,679	3,925,608	4,332,592	4,758,518	5,204,320	5,615,201
10 Capital MAU Build:	0	0	4,735,000	0	0	0	0	0	0	0
11 Existing MAU space decant	0	0	700,000	0	0	0	0	0	0	0
12 Less: Capital Avoid ED Expansion:	0	0	0	0	0	0	0	0	0	0
	0	0	5,435,000	0	0	0	0	0	0	0
Net Benefit:	(132,895)	(602,415)	(6,317,103)	(2,161,424)	(2,533,146)	(2,922,076)	(3,329,059)	(3,754,985)	(4,200,787)	(4,611,669)
Cost of Capital:	5.0%									
NPV at 0.05:	**($23,645,865)**									

Bed Day Saving Calculation:

Linen:	20
Meals X 3:	51
Morning Shift Nurse:	1.68
(covers 4 beds with leave cover).	
Rate @ $90k p.a. incl loading:	346
Beds covered (circa):	4
	145
Afternoon Shift Nurse:	1.68
(covers 4 beds with leave cover).	
Rate @ $90k p.a. incl loading:	346
Beds covered (circa):	4
	145
Evening Shift Nurse:	Nil
Total Dollars Saved:	362

Impact on Profit & Loss

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
1 Savings: Bed Days:	501,766	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533
2 Avoided Growth +75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
3 Avoided Growth <75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
	501,766	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533	1,003,533
2 Growth +75 pop (Bed Days):	0	212,691	436,017	670,508	916,725	1,175,252	1,446,706	1,731,732	2,031,009	2,292,685
3 Growth <75 pop (Bed Days):	0	17,724	35,626	53,706	71,968	90,411	109,040	127,854	146,857	162,840
4 FTE Cost:	536,500	1,073,000	1,073,000	1,997,000	1,997,000	1,997,000	1,997,000	1,997,000	1,997,000	1,997,000
5 Year 1 RMO Cost (2 X $110,000):	110,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000
6 Year 1 Clinical Change Manager:	60,000	60,000	0	0	0	0	0	0	0	0
7 Lease costs of Clinical Space	0	0	0	0	0	0	0	0	0	0
7 Less: SMO Allowance Reduction:	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)
8 Net SMO Cost Growth:	0	94,372	192,833	295,581	402,825	514,784	631,685	753,770	881,292	1,014,515
	634,661	1,605,948	1,885,636	3,164,957	3,536,679	3,925,608	4,332,592	4,758,518	5,204,320	5,615,201
Depreciation	0	0	0	776,429	776,429	776,429	776,429	776,429	776,429	776,429
Impact on P&L	(132,895)	(602,415)	(882,103)	(2,937,853)	(3,309,575)	(3,698,504)	(4,105,488)	(4,531,414)	(4,977,216)	(5,388,097)

Capital

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
9 Capital ED Build			4,735,000							
10 Existing MAU space decant			700,000							
11 Less: Capital Avoid MAU										
			5,435,000							
Cumulative Capital	0	0	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000

Avoided Cost Growth Model +75 Cohort

Projected Growth +75 age Cohort	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Current State (do nothing) scenario:	**Baseline**									
% Growth (+75 age cohort):	0%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Cumulative Growth	0%	5%	10%	15%	20%	25%	30%	35%	40%	45%
Medicine speciality beds	22,970	24,119	25,324	26,591	27,920	29,316	30,782	32,321	33,937	35,634
Growth in bed nights:	0	1,149	1,206	1,266	1,330	1,396	1,466	1,539	1,616	1,697
Cumulative growth in bed nights:		1,149	2,354	3,621	4,950	6,346	7,812	9,351	10,967	12,664
Proportion of beds for > 75	60%	689	724	760	798	838	879	923	970	1,018
Cost growth at bed night rate	0	249,454	261,927	275,023	288,774	303,213	318,374	334,292	351,007	368,557
Reduction in LOS - Generalism:	15%	36,763	38,601	40,531	42,558	44,686	46,920	49,266	51,730	106,882
Cumulative Reduction:	15%	36,763	75,365	115,896	158,454	203,140	250,060	299,326	351,056	457,938
Cumulative SMO required at 1 per 3,611 beds:		0.27	0.56	0.85	1.17	1.50	1.84	2.21	2.59	2.99
% Saving in Beds due to Generalism	15%									
Cost @ Rate per SMO:	290,000	78,643	161,218	247,922	338,961	434,552	534,922	640,312	750,970	867,162

Avoided Cost Growth Model <75 Cohort

Projected Growth +75 age Cohort	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Current State (do nothing) scenario:	**Baseline**									
% Growth (V 75 age cohort):	0%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Cumulative Growth	0%	1%	2%	3%	4%	5%	6%	7%	8%	9%
Medicine speciality beds	22,970	23,200	23,432	23,666	23,903	24,142	24,383	24,627	24,873	25,122
Growth in bed nights:	0	230	232	234	237	239	241	244	246	249
Cumulative growth in bed nights:		230	462	696	933	1,172	1,413	1,657	1,903	2,152
Proportion of beds for < 75	25%	57	58	59	59	60	60	61	62	62
Cost growth at bed night rate	0	20,788	20,996	21,206	21,418	21,632	21,848	22,067	22,287	22,510
Reduction in LOS - Generalism:	15%	3,064	3,094	3,125	3,156	3,188	3,220	3,252	3,285	6,528
Cumulative Reduction:	15%	3,064	6,158	9,283	12,439	15,627	18,847	22,099	25,384	31,912
Cumulative SMO required at 1 per 3,611 beds:		0.05	0.11	0.16	0.22	0.28	0.33	0.39	0.45	0.51
% Saving in Beds due to Generalism	15%									
Cost @ Rate per SMO:	290,000	15,729	31,614	47,659	63,864	80,232	96,763	113,459	130,322	147,354

Table 11 – financial modelling for option one

Option 2: Enhanced generalism and a new MAU

The enhanced generalism plus a medical assessment unit option is the preferred option. This scenario is similar to the 'just generalism' scenario but a medical assessment unit would be built in the first year (offset by avoiding the need to expand the Emergency Department by the third year). Staffing the medical assessment unit would be a requirement from the outset and more allied health resources are required to assist in the achievement of the overall 'enhanced generalism plus medical assessment unit' reduction in average length of stay, achieving the full 29% reduction found in the Francis Group workings.

This financial analysis is focused on capturing only those benefit and cost elements that can be quantified financially. It is the preferred option, but per the economic case there are a number of significant benefits associated with patient flow, rapid assessment and discharge which, if they could be easily translated into additional financial benefits, would create a further point of differentiation between this option and option one.

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Annual Bed / Day to Dollars Saved			Loaded Resource Costs (annually)		FTE Required	Totals	Capital Cost (Depreciated Over 8 Years)			Values
Bed Days	6,280		SMO Cost (p.a.):	290,000	3.7	1,073,000	Required Capital:	5,435,000		5,435,000
LOS Reduction	28%									
Cost per Bed / Night	362		Nursing Cost (p.a.):	90,000	9.7	873,000	Capital Charge:	5.0%	At 50%	135,875
Occupancy	85%		Allied Cost (p.a.):	85,000	5.8	493,000	Depreciation (in years):	8	Depn	8
Bed Days Benefit p.a.	**1,932,505**		**Annual Resource Costs:**		**19.2**	**2,439,000**	**Annual Operating Impact:**			**1,041,708**

Benefits Phasing	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Costs Phasing	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Net Annual Benefit and Net Present Value over Depreciation Life

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
1 Savings: Bed Days:	966,253	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505
2 Avoided Growth +75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
3 Avoided Growth <75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
	966,253	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505
2 Growth +75 pop (Bed Days):	0	178,659	366,251	563,223	770,043	987,205	1,215,224	1,454,645	1,706,036	1,967,712
3 Growth <75 pop (Bed Days):	0	14,888	29,925	45,113	60,452	75,945	91,593	107,397	123,359	139,342
4 FTE Cost:	1,219,500	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000
5 Year 1 RMO Cost (2 X $110,000):	110,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000
6 Year 1 Clinical Change Manager:	60,000	60,000	0	0	0	0	0	0	0	0
7 Lease costs of Clinical Space	0	0	0	0	0	0	0	0	0	0
8 Less: SMO Allowance Reduction:	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)
9 Net SMO Cost Growth:	0	79,272	161,978	248,286	338,371	432,415	530,612	633,163	740,280	852,187
	1,317,661	2,919,980	3,145,316	3,443,784	3,756,028	4,082,727	4,424,590	4,782,366	5,156,837	5,546,402
10 Capital MAU Build:	0	4,735,000	0	0	0	0	0	0	0	0
11 Existing MAU space decant	0	700,000	0	0	0	0	0	0	0	0
12 Less: Capital Avoid ED Expansion:	0	0	0	0	0	0	0	0	0	0
Net Benefit:	(351,409)	(6,422,475)	(1,212,811)	(1,511,279)	(1,823,523)	(2,150,222)	(2,492,085)	(2,849,861)	(3,224,332)	(3,613,897)

Cost of Capital: 5.0%

NPV at 0.05: ($20,455,459)

Bed Day Saving Calculation:

Linen:	20
Meals X 3:	51
Radiology:	
Laboratory:	
Morning Shift Nurse:	1.68
(covers 4 beds with leave cover).	
Rate @ $90k p.a. incl loading:	346
Beds covered (circa):	4
	145
Afternoon Shift Nurse:	1.68
(covers 4 beds with leave cover).	
Rate @ $90k p.a. incl loading:	346
Beds covered (circa):	4
	145
Evening Shift Nurse:	Nil
Total Dollars Saved:	362

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Impact on Profit & Loss

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
1 Savings: Bed Days:	966,253	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505
2 Avoided Growth +75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
3 Avoided Growth <75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
	966,253	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505	1,932,505
2 Growth +75 pop (Bed Days):	0	178,659	366,251	563,223	770,043	987,205	1,215,224	1,454,645	1,706,036	1,967,712
3 Growth <75 pop (Bed Days):	0	14,888	29,925	45,113	60,452	75,945	91,593	107,397	123,359	139,342
4 FTE Cost:	1,219,500	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000	2,439,000
5 Year 1 RMO Cost (2 X $110,000):	110,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000	220,000
6 Year 1 Clinical Change Manager:	60,000	60,000	0	0	0	0	0	0	0	0
6 Lease costs of Clinical Space	0	0	0	0	0	0	0	0	0	0
7 Less: SMO Allowance Reduction:	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)	(71,839)
8 Net SMO Cost Growth:	0	79,272	161,978	248,286	338,371	432,415	530,612	633,163	740,280	852,187
	1,317,661	2,919,980	3,145,316	3,443,784	3,756,028	4,082,727	4,424,590	4,782,366	5,156,837	5,546,402
Depreciation			679,375	679,375	679,375	679,375	679,375	679,375	679,375	679,375
Impact on P&L	(351,409)	(987,475)	(1,892,186)	(2,190,654)	(2,502,898)	(2,829,597)	(3,171,460)	(3,529,236)	(3,903,707)	(4,293,272)

Capital

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
9 Capital MAU Build:		4,735,000								
10 Existing MAU space decant		700,000								
11 Less: Capital Avoid ED Expansion:										
	0	5,435,000	0	0	0	0	0	0	0	0
Cumulative Capital	0	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000

Avoided Cost Growth Model +75 Cohort

Projected Growth +75 age Cohort	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Current State (do nothing) scenario:	Baseline									
% Growth (+75 age cohort):	0%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Cumulative Growth	0%	5%	10%	15%	20%	25%	30%	35%	40%	45%
Medicine speciality beds	22,970	24,119	25,324	26,591	27,920	29,316	30,782	32,321	33,937	35,634
Growth in bed nights:	0	1,149	1,206	1,266	1,330	1,396	1,466	1,539	1,616	1,697
Cumulative growth in bed nights:		1,149	2,354	3,621	4,950	6,346	7,812	9,351	10,967	12,664
Proportion of beds for > 75	60%	689	724	760	798	838	879	923	970	1,018
Cost growth at bed night rate	0	249,454	261,927	275,023	288,774	303,213	318,374	334,292	351,007	368,557
Reduction in LOS - Generalism:	28%	70,795	74,335	78,051	81,954	86,052	90,354	94,872	99,616	106,882
Cumulative Reduction:		70,795	145,130	223,181	305,135	391,187	481,541	576,413	676,029	782,911
Cumulative SMO required at 1 per 3,611 beds:		0.23	0.47	0.72	0.98	1.26	1.55	1.85	2.18	2.51
% Saving in Beds due to Generalism	28%									
Cost @ Rate per SMO:	290,000	66,060	135,422	208,253	284,725	365,021	449,332	537,858	630,811	728,411

Avoided Cost Growth Model <75 Cohort

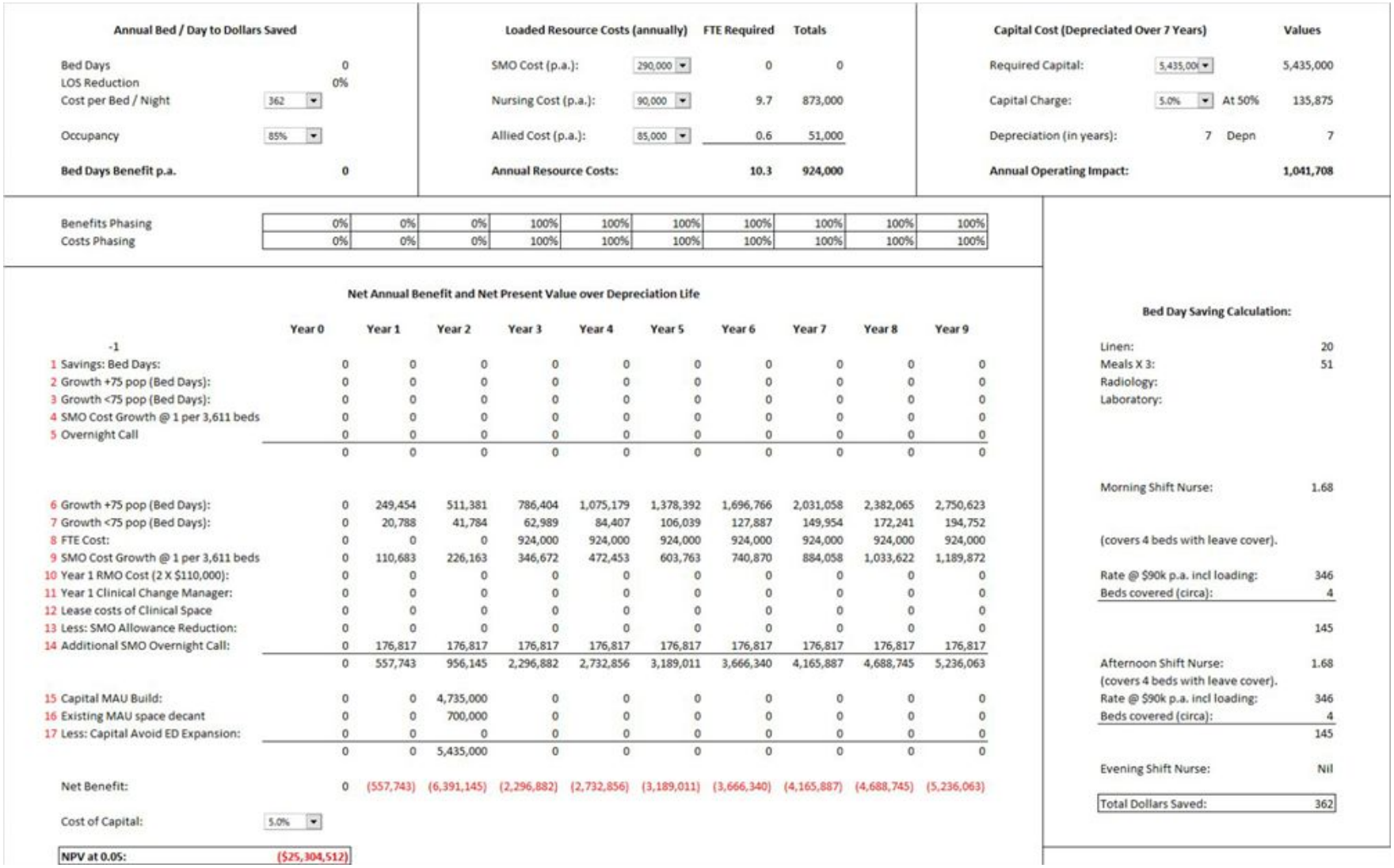
Projected Growth +75 age Cohort	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Current State (do nothing) scenario:	Baseline									
% Growth (V 75 age cohort):	0%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Cumulative Growth	0%	1%	2%	3%	4%	5%	6%	7%	8%	9%
Medicine speciality beds	22,970	23,200	23,432	23,666	23,903	24,142	24,383	24,627	24,873	25,122
Growth in bed nights:	0	230	232	234	237	239	241	244	246	249
Cumulative growth in bed nights:		230	462	696	933	1,172	1,413	1,657	1,903	2,152
Proportion of beds for < 75	25%	57	58	59	59	60	60	61	62	62
Cost growth at bed night rate	0	20,788	20,996	21,206	21,418	21,632	21,848	22,067	22,287	22,510
Reduction in LOS - Generalism:	28%	5,900	5,959	6,018	6,078	6,139	6,201	6,263	6,325	6,528
Cumulative Reduction:	28%	5,900	11,858	17,876	23,955	30,094	36,294	42,557	48,882	55,410
Cumulative SMO required at 1 per 3,611 beds:		0.05	0.09	0.14	0.18	0.23	0.28	0.33	0.38	0.43
% Saving in Beds due to Generalism	28%									
Cost @ Rate per SMO:	290,000	13,212	26,556	40,033	53,646	67,394	81,280	95,305	109,470	123,776

Table 12 – financial modelling for option two

Option 3: Maintain the pre-COVID status quo ('do nothing')

Doing nothing will cause the DHB to face cost pressures between now and the opening of the new hospital. Immediate cost pressures will arise due to the need to better cover SMO overnight call. In the longer term, per Statistics NZ projections, the cohort of elderly patients (75 years plus) who consume 60% of inpatient beds is projected to grow at 5% per annum cumulatively. The Emergency Department cannot cope with the peak volumes of presentations over winter and doing nothing today will necessitate the expansion of the Emergency Department within the next three years. The capital cost associated with doing this has been assumed to be a similar cost to building a medical assessment unit. Once built, operational resources would need to be increased to manage the additional Emergency Department capacity. This has been assumed to be at a similar nurse resourcing rate as the medical assessment unit.

A net present value analysis has been run over the investment that would be required (the NPV translates future costs back to a present value by discounting them at the cost of capital, which is 6%). This is demonstrated in the following table.



Annual Bed / Day to Dollars Saved

Bed Days		0
LOS Reduction		0%
Cost per Bed / Night	362	
Occupancy	85%	
Bed Days Benefit p.a.		**0**

Loaded Resource Costs (annually)

		FTE Required	Totals
SMO Cost (p.a.):	290,000	0	0
Nursing Cost (p.a.):	90,000	9.7	873,000
Allied Cost (p.a.):	85,000	0.6	51,000
Annual Resource Costs:		**10.3**	**924,000**

Capital Cost (Depreciated Over 7 Years)

			Values
Required Capital:	5,435,000		5,435,000
Capital Charge:	5.0%	At 50%	135,875
Depreciation (in years):	7	Depn	7
Annual Operating Impact:			**1,041,708**

Benefits Phasing	0%	0%	0%	100%	100%	100%	100%	100%	100%	100%
Costs Phasing	0%	0%	0%	100%	100%	100%	100%	100%	100%	100%

Net Annual Benefit and Net Present Value over Depreciation Life

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
-1										
1 Savings: Bed Days:	0	0	0	0	0	0	0	0	0	0
2 Growth +75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
3 Growth <75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
4 SMO Cost Growth @ 1 per 3,611 beds	0	0	0	0	0	0	0	0	0	0
5 Overnight Call	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0
6 Growth +75 pop (Bed Days):	0	249,454	511,381	786,404	1,075,179	1,378,392	1,696,766	2,031,058	2,382,065	2,750,623
7 Growth <75 pop (Bed Days):	0	20,788	41,784	62,989	84,407	106,039	127,887	149,954	172,241	194,752
8 FTE Cost:	0	0	0	924,000	924,000	924,000	924,000	924,000	924,000	924,000
9 SMO Cost Growth @ 1 per 3,611 beds	0	110,683	226,163	346,672	472,453	603,763	740,870	884,058	1,033,622	1,189,872
10 Year 1 RMO Cost (2 X $110,000):	0	0	0	0	0	0	0	0	0	0
11 Year 1 Clinical Change Manager:	0	0	0	0	0	0	0	0	0	0
12 Lease costs of Clinical Space	0	0	0	0	0	0	0	0	0	0
13 Less: SMO Allowance Reduction:	0	0	0	0	0	0	0	0	0	0
14 Additional SMO Overnight Call:	0	176,817	176,817	176,817	176,817	176,817	176,817	176,817	176,817	176,817
	0	557,743	956,145	2,296,882	2,732,856	3,189,011	3,666,340	4,165,887	4,688,745	5,236,063
15 Capital MAU Build:	0	0	4,735,000	0	0	0	0	0	0	0
16 Existing MAU space decant	0	0	700,000	0	0	0	0	0	0	0
17 Less: Capital Avoid ED Expansion:	0	0	0	0	0	0	0	0	0	0
	0	0	5,435,000	0	0	0	0	0	0	0
Net Benefit:	0	(557,743)	(6,391,145)	(2,296,882)	(2,732,856)	(3,189,011)	(3,666,340)	(4,165,887)	(4,688,745)	(5,236,063)

Cost of Capital: 5.0%

NPV at 0.05: ($25,304,512)

Bed Day Saving Calculation:

Linen:	20
Meals X 3:	51
Radiology:	
Laboratory:	
Morning Shift Nurse:	1.68
(covers 4 beds with leave cover).	
Rate @ $90k p.a. incl loading:	346
Beds covered (circa):	4
	145
Afternoon Shift Nurse:	1.68
(covers 4 beds with leave cover).	
Rate @ $90k p.a. incl loading:	346
Beds covered (circa):	4
	145
Evening Shift Nurse:	Nil
Total Dollars Saved:	362

Impact on Profit & Loss

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
1 Savings: Bed Days:	0	0	0	0	0	0	0	0	0	0
2 Growth +75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
3 Growth <75 pop (Bed Days):	0	0	0	0	0	0	0	0	0	0
4 Growth in SMO (1 per 3,611 beds)	0	0	0	0	0	0	0	0	0	0
5 Overnight Call	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0
6 Growth +75 pop (Bed Days):	0	249,454	511,381	786,404	1,075,179	1,378,392	1,696,766	2,031,058	2,382,065	2,750,623
7 Growth <75 pop (Bed Days):	0	20,788	41,784	62,989	84,407	106,039	127,887	149,954	172,241	194,752
8 FTE Cost:	0	0	0	924,000	924,000	924,000	924,000	924,000	924,000	924,000
9 SMO Cost Growth @ 1 per 3,611 beds	0	110,683	226,163	346,672	472,453	603,763	740,870	884,058	1,033,622	1,189,872
10 Year 1 RMO Cost (2 X $110,000):	0	0	0	0	0	0	0	0	0	0
11 Year 1 Clinical Change Manager:	0	0	0	0	0	0	0	0	0	0
12 Lease costs of Clinical Space	0	0	0	0	0	0	0	0	0	0
13 Less: SMO Allowance Reduction:	0	0	0	0	0	0	0	0	0	0
14 Additional SMO Overnight Call:	0	176,817	176,817	176,817	176,817	176,817	176,817	176,817	176,817	176,817
	0	557,743	956,145	2,296,882	2,732,856	3,189,011	3,666,340	4,165,887	4,688,745	5,236,063
Depreciation		0	0	776,429	776,429	776,429	776,429	776,429	776,429	776,429
Impact on P&L	0	(557,743)	(956,145)	(3,073,311)	(3,509,284)	(3,965,439)	(4,442,769)	(4,942,316)	(5,465,174)	(6,012,492)

Capital

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
9 Capital MAU Build:			4,735,000							
10 Existing MAU space decant			700,000							
11 Less: Capital Avoid ED Expansion:										
			5,435,000							
Cumulative Capital	0	0	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000	5,435,000

Avoided Cost Growth Model +75 Cohort

Projected Growth +75 age Cohort	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Current State (do nothing) scenario:	**Baseline**									
% Growth (+75 age cohort):	0%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Cumulative Growth	0%	5%	10%	15%	20%	25%	30%	35%	40%	45%
Medicine speciality beds	22,970	24,119	25,324	26,591	27,920	29,316	30,782	32,321	33,937	35,634
Growth in bed nights:	0	1,149	1,206	1,266	1,330	1,396	1,466	1,539	1,616	1,697
Cumulative growth in bed nights:		1,149	2,354	3,621	4,950	6,346	7,812	9,351	10,967	12,664
Proportion of beds for > 75	60%	689	724	760	798	838	879	923	970	1,018
Cost growth at bed night rate	0	249,454	261,927	275,023	288,774	303,213	318,374	334,292	351,007	368,557
Cumulative Increase:		249,454	511,381	786,404	1,075,179	1,378,392	1,696,766	2,031,058	2,382,065	2,750,623
Cumulative SMO required at 1 per 3,611 beds:		0.32	0.65	1.00	1.37	1.76	2.16	2.59	3.04	3.51
Cost @ Rate per SMO:	290,000	92,236	189,084	290,775	397,550	509,663	627,383	750,988	880,774	1,017,049

Avoided Cost Growth Model <75 Cohort

Projected Growth <75 age Cohort	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Current State (do nothing) scenario:	**Baseline**									
% Growth (V 75 age cohort):	0%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Cumulative Growth	0%	1%	2%	3%	4%	5%	6%	7%	8%	9%
Medicine speciality beds	22,970	23,200	23,432	23,666	23,903	24,142	24,383	24,627	24,873	25,122
Growth in bed nights:	0	230	232	234	237	239	241	244	246	249
Cumulative growth in bed nights:		230	462	696	933	1,172	1,413	1,657	1,903	2,152
Proportion of beds for < 75	25%	57	58	59	59	60	60	61	62	62
Cost growth at bed night rate	0	20,788	20,996	21,206	21,418	21,632	21,848	22,067	22,287	22,510
Cumulative Increase:		20,788	41,784	62,989	84,407	106,039	127,887	149,954	172,241	194,752
Cumulative SMO required at 1 per 3,611 beds:		0.06	0.13	0.19	0.26	0.32	0.39	0.46	0.53	0.60
Cost @ Rate per SMO:	290,000	18,447	37,079	55,897	74,903	94,099	113,488	133,070	152,848	172,824

Table 13 – financial modelling for option 3

Further notes on the composition of the financial model

- Bed day savings have been calculated on a reduction in length of stay that has been modelled as being achievable when moving to a generalist admmitting model and cohorting outliers into an internal medicine home ward. The savings per bed day have been calculated in conjunction with the operations team at $362 per day, which accounts for morning and afternoon shift nurses and costs for meals and linen per 24-hour stay. They are based on improved patient lengths of stay and reducing 70% of outlier patients, achieved through the improved flow offered by the introduction of enhanced generalism including less sub-specialty involvement.
- Avoided growth in the over 75 cohort has been calculated on the basis that this cohort comprises 60% of the DHB's inpatient bed stays and is projected to grow at 5% per annum over the next ten years which is based on Statistics new .
- For simplicity, avoided growth in the under 75 age cohort has been assumed at general population growth of 1%.
- FTE costs are anticipated salary costs with loading.
- The DHB's service manager and business analyst have identified $193k of allowances that are currently paid to sub-specialists and could be removed with the implementation of enhanced generalism (this will need to be implemented via a change management process).
- The team has also identified that the new MECA requires cover for situations when an SMO is called out overnight. This has been quantified and added as a cost that would be avoided under an enhanced generalism scenario.
- In addition to improving the appropriateness and quality of care, enhanced generalism will also create a very positive effect on bed blocking and the resulting cancellation of elective surgery. Whilst this business case hasn't sought to quantify the additional elective surgery that could be achieved through reduced bed block, when quantified at the opportunity cost of $5,545 per outsourced case weight further financial benefits will be achieved due to less bed block and the ability to complete more elective surgery. The provision of additional beds for this purpose would however lead to financial savings through bed closures being reduced and a deliberate decision concerning the offsetting of these impacts will need to be made.

Summary of financials and sensitivities

Financially the modelling shows that while the aspirational model proposed is the best option financially when the growth of internal medicine volumes for the age group over 75s is 5%, if this growth is reduced to 3% then the Do Nothing model becomes the preferred option financially. These sensitivities are outlined in the following table:

Option	Cashflow over 10 years	P&L Impact over 10 years	Capital	NPV
Generalism + MAU (Aspirational)	(25,651,894)	(25,651,894)	(5,435,000)	(20,455,459)
Generalism + ED Expansion	(30,565,561)	(30,565,561)	(5,435,000)	(23,645,865)
Do Nothing @ 5% growth for > 75s	(32,924,672)	(32,924,672)	(5,435,000)	(25,304,512)
Do Nothing @ 4% growth for > 75s	(29,017,200)	(29,017,200)	(5,435,000)	(22,448,893)
Do Nothing @ 3% growth for > 75s	(25,311,719)	(25,311,719)	(5,435,000)	(19,734,794)
Do Nothing @ 2% growth for > 75s	(21,798,060)	(21,798,060)	(5,435,000)	(17,155,270)

Key financial risks

There are a number of risks associated with achieving the financial benefits outlined in the analysis. These will need to be addressed as part of the benefit realisation framework that will be required to implement enhanced generalism.

1. The financial model and specifically the P&L impact includes between $1m - $2m of bed day savings, which require the removal of up to 15 beds under the aspirational model. There will be pressure to use these beds for other demands instead of removing them. Unless there is additional revenue or reduced costs from these (which haven't been identified as part of this business case) there is a risk that this will create soft savings not actual hard savings to the bottom line.
2. The increase in bed days projected under the "do nothing" scenario would require additional beds to be resourced at the DHB. Currently there is no allowance for this.
3. The costs of decanting Rheumatology and Physiology is currently an estimate provided by the General Manager Building and Property and could be subject to change either up or down. All options include this however, so comparatively it wouldn't impact the decision taken between models.
4. The financials currently phase in all costs and savings after year one. This assumes therefore that that the reduction in length of stay proposed under the aspirational model can be achieved in the same timeframe that it takes to achieve a lesser reduction in LOS under the ED expansion proposal. This is a further risk that could result in a deterioration of the savings under the aspirational model.

Management Case

As outlined in appendix 3 Appendix 3: A short history of the evolution of generalism and its enabling factors at Dunedin Hospitalthe concept of enhanced generalism has been discussed within the DHB for a number of years and agreement to implement this model of care needs to be accompanied by strong clinical and management commitment to this approach as the new way of working.

The project team has confirmed with both the Executive Leadership Team and with the Chair of the Clinical Council that the organisation will adopt enhanced generalism as its new way of working once this business case has received Board approval.

The Chair of the Clinical Council has confirmed support for this approach and reiterated the Council's commitment to the changes that are required. The business case identifies that call back and time involved in ward care will be reduced for some sub-specialities once enhanced generalism is implemented. The case identifies that reduced call back allowances can be used to partially offset the additional costs required to implement the model and that sub-specialist effort saved from no longer doing ward rounds and ward based-care will be deliberately applied to improve performance in outpatients by providing more capacity there (both for first specialist assessments and for follow ups), noting that the overall time saved is modest.

The Chair of the Clinical Council has confirmed that the Council will provide key leadership to support the Chief Medical Officer and Executive Director to ensure that these benefits are realised. It will also provide leadership in identifying where workforce realignment is required in the future and in the implementation of this, as expansion of the enhanced generalism approach leads to further streamline sub-specialist care in favour of generalist care.

Project management planning

Five key areas will need to be project managed to support a successful transition to a generalist model of care at Dunedin Hospital; these will be supported by a change management process.

1. Ward configuration: reconfiguring the wards to accommodate the change in the model of care
2. MAU build: co-locating and growing the MAU to the ground floor to meet demand
3. Recruitment and transition of staff: recruiting new and transitioning existing staff to support the change in the model of care
4. Inter-specialty and ED culture: agreeing principles and setting expectations that value patients' time and address the fragmented, siloed medical culture
5. New in-take / admissions process: moving from a post-take process to an in-take process where the majority of patients are seen on the day on which they are admitted

Given the ordered nature of the first three changes that need to take place, they will be managed via the traditional waterfall approach, i.e. a series of sequential stages with each key milestone building on the completion of the previous. The fourth and fifth areas are more complex system changes that require an experiential approach and will therefore be managed via a rapid cycle test of change methodology. In recognition of the changes required to the intake/admissions process and the manner in which specialities will need to collaborate under the proposed new model, a change management resource is proposed for the first year of implementation, to facilitate the necessary changes and manage the realisation of the benefits.

High-level milestones and timeframes for each of these areas are outlined below; a more detailed transition plan is shown in appendix 10.

Plan	Sponsor	Milestones	Timeframe
Inter-specialty and ED culture	CMO, Nigel Millar	• First test of rules and expectations including feedback loop during COVID 6-team trial	Sep– Oct 20
		• Test and refine	
		• Second test and refine	
New in-take / admissions process	Clinical Director IM, Dion Astwood	• First test of rules and expectations including feedback loop during COVID 6 team trial	Sep – Oct 20
		• Test and refine	
		• Second test and refine	
Recruitment, transition and induction of staff	GM Medicine, Women's and Children's Health, Simon Donlevy; GM Human Resources, Tanya Basel; ED People, Culture & Technology Mike Collins; GM Community Services, Glenn Symon	• Consult on the feasibility of transitioning staff	Dec 20 – Mar 21
		• Plan the transition and recruitment of staff	
		• Design the new rosters	
		• Recruit / transition staff	
		• Induct / onboard staff	
		• Implement change management plan (with change manager)	
Ward configuration	GM Ops, Megan Boivin	• Consult on the feasibility of configuration options	Dec 20 – Jun 21
		• Outline the timeline and plan for chosen configuration option	
		• Design the configuration	
		• Implement the configuration	
		• Monitor and review the configuration	
MAU build	GM Facilities and Property, Paul Pugh	• Consult on the feasibility of the size and location options of the MAU	Dec 20 – Jun 21
		• Outline the timeline and plan for chosen MAU option	
		• Design the new MAU	
		• Build the new MAU	
		• Install the new MAU	
Change management process	Change manager (to be appointed)	• Develop change management plan • Co-ordinate the delivery of all abovementioned plans • Record realisation of benefits	Dec 20 – Dec 21

Table 14 – project milestones

A Steering Group will be established, including Medical Director, Clinical Directors of Internal Medicine and Emergency, relevant management representatives and others TBC.

The Steering Group will be formed upon approval of the business case and will meet fortnightly initially, in order to guide implementation of the model of care.

Dedicated project management and change management resources will be funded by the project and will report to the Steering Group.

Change management planning

Several change management plans will need to be developed in order to implement option two. These plans are outlined below, with detailed change plans to be worked up and implemented by their respective owners, supported by the change manager, once the business case is approved.

Ward configuration

The current capacity of the IM ward is 46 beds, including a six-bed stroke unit. Demand frequently exceeds this capacity, for example an average of 52 beds occupied at midnight from July-September 2019 and 617 outlier bed nights in July 2019, an average of 20 per night. Assuming current practice, there would be an average of 62 patients under IM every night under the proposed GAMA model and 73 at the 85th centile. While an outlier model could accommodate these additional volumes on wards other than 8 Med, it would not be ideal for patients and would adversely impact on their length of stay, with current outlier patients staying an additional 1.6 days compared to those who stay only on the IM wards (please see appendix 11).

With the estimated 29% bed day reduction over 18 months, the IM patient load each night would reduce to 45 patients, or 60 patients at the 85th centile. The proposal is therefore to grow the current IM inpatient footprint to 66 beds to reduce outliers and accommodate the additional volumes during the first 18 months as the service transitions and bed day savings are realised.

Ward	Existing	Proposed
MAU New	0	10 (+8)*
8MED	40	40
8 MED Stroke Unit	6	6
MAU Existing	8	0
IM sub-total	**54**	**56 (+8)***
6th Floor OPAL	10	10
7a	24	16
Non-IM sub-total	**34**	**26**
Total	**88**	**82**

* waiting chairs

Table 15 – IM bed numbers, current and future state

Medical assessment unit construction

A concept design has been completed by Oakley Grey Architects. Upon approval of this business case an immediate assessment will be made to determine whether the DHB can consolidate the next stages of design and tendering for construction to minimise the timeframes required for the overall development and commissioning of the MAU.

Recruitment and transition of staff

Further detail on recruitment and transition timeframes are to be scoped with SMOs, RMOs, nursing and AH. Initial discussions are underway in respect of transition.

SMO and AH numbers are confirmed; RMOs are to be reallocated; nursing allocation to be determined.

Inter-specialty and ED culture

The fragmented and siloed medical culture that exists within the DHB results in delays to care that significantly impact on patients and has led to IM SMOs describing their service as a "dumping ground" for unwanted patients rather than the "heart" or "engine" of the hospital medical service. While the IM service will continue to consult with sub-specialties to work up age-based and clinical criteria for patients admitted under the proposed generalist model, the Clinical Council has been tasked with signing off these criteria as well as implementing inter-specialty standards and expectations to reduce specialty ping-pong and align with valuing patients' time.

Specialist services have shown increasing support for enhanced generalism over the last few years. This support was increased during COVID-19, with IM working more closely with various specialists to upskill in case of a surge of patients presenting to the hospitals. The ability for generalists to attend multimorbidity in a predominantly elderly population who require inpatient management was appreciated by specialists, whose generalist training has diminished somewhat over their time providing specialist services. They note the benefit in providing specialist input for patients who carry multi-morbidity with holistic oversight of the patient.

In order to affect such changes, it is envisaged that standard operating procedures (SOPs) will include simple rules such as one-way flow from ED to subspecialties or all requests for transfers of care between inpatient specialties being enacted within 24 hours. Draft Internal Medicine / specialty referral guidelines are attached as appendix 12. These documents are drawn up with input from both departments and are to be followed by both departments. Processes to support these standards will also need to be tested; these could include all subspecialties attending the IM handover, rounding on new patients in MAU to promote an in-take process, or delegating one specialty the right of assignment to act as a "circuit breaker" when a consensus on the specialty under which the patient would best be admitted under cannot be reached in a timely manner. Should such a situation arise, it would be vital for IM to be able to determine the service under which the patient should be admitted to allow the best possible outcomes; for the enhanced generalism model to succeed, this right of assignment needs to be clearly set out in the SOP and observed by all subspecialty services involved.

Historical patterns and the new criteria being introduced will also require the Clinical Council to implement escalation steps and feedback loops for occasions when there are disagreements between specialties or further information suggests that a specialty assignment was not correct. Course correction can be addressed by increasing awareness of policy documents and reporting and identifying policy violations with an associated feedback mechanism. This could include appointing a 'senior clinician on call' to adjudicate, address behaviour that does not align with valuing patients' time and collect key themes from disagreements to feedback to the DHB. These steps and loops should be viewed as opportunities for increased collaboration and learning and may become less necessary as the model evolves and inter-specialty collegiality improves.

New in-take / admissions process

The SMOs will work closely with the admitting RMOs, providing them with timely decision making support for adequate assessment and treatment. The on-call SMO will also consolidate a further inpatient management (or discharge) plan with the RMOs. The SMO will be available to advise GPs when necessary and collaborate with ED staff to ensure a seamless transition of care when receiving patients from them. The current 'push' model of patients from ED to Internal Medicine and the MAU and the 'pull' model that would operate under enhanced generalism and the new MAU are demonstrated in appendix 13.

The SMO will actively be involved in the admission of patients, facilitating and controlling the flow of patients between the ED, the MAU and the inpatient wards. This will involve decanting and distributing patients to ward-based teams to ensure that review of patients occurs within 24 hours of their admission.

Clinical focus will be on the short-stay patients, active support for the RMOs to maximise same day and next day discharging, utilisation of the rapid access clinic, timely diagnostics and relationships with community teams including GPs.

The changes required under these three components will require a full change management plan, using a model such as ADKAR[4], to support affected members of staff to make the transition between the previous and new models of care. Support for personal change will be available through the 'Cycle of Change' programme being developed by Human Resources. An organisation development response can help to strengthen capacity and capability, ensuring that team members are clear about their role and their fit in the team.

Pathways for primary care

The adoption of an enhanced generalism model combined with the new MAU could offer additional pathways for patients presenting via primary care; currently all patients present to ED and are admitted via IM. General practitioners would need to be aware of these changes to be able to refer their patients via the most efficient and appropriate pathway. The diagram below demonstrates pathways to and from the MAU, from primary care and within the hospital.

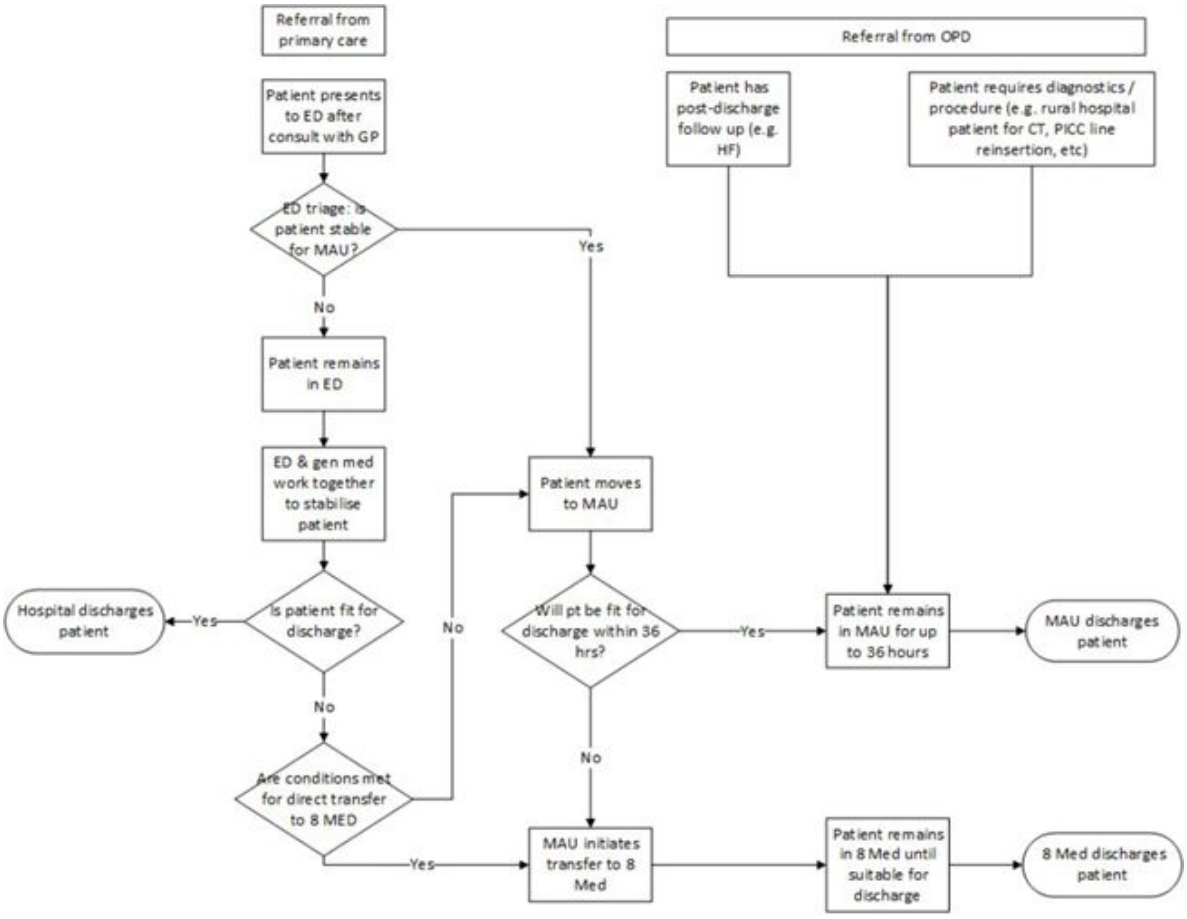


Figure 3 – possible pathways to and from the MAU

[4] ADKAR is an internationally-recognised individual and organisational change management model. The acronym represents the five outcomes that people need to achieve for lasting change: Awareness of the need for change; Desire to support the change; Knowledge of how to change; Ability to demonstrate skills & behaviours; Reinforcement to make the changes stick

The following table outlines responsibilities for each of the six key areas of change:

Plan	Responsible	Accountable	Consulted	Informed
Ward configuration	Ops directorate	GM Operations Management, Megan Boivin	Affected wards: • 8 Med • 6ATR • 6C • MAU	
MAU build	Property and facilities team	GM Facilities and Property, Paul Pugh	• IM service • ED service • Fracture clinic • Physiotherapy service	
Recruitment and transition of staff	*SMOs*: Sarah Kalmakoff *RMOs*: Rhonda Skilling *Nursing*: Therese Duncan *Allied Health*: Kaye Cheetham	GM Human Resources, Tanya Basel	Affected: • SMOs • RMOs • Specialty services • Nurses • Allied Health	• Unions
Inter-specialty and ED culture	Clinical Council	CMO, Nigel Millar		
New in-take / admissions process	IM SMOs, MAU ACN, IM RMOs	Clinical Director IM, Dion Astwood		
Pathways for primary care	Health Pathways	Exec Director Quality & Risk, Gail Thomson		

Table 16 – responsibilities for the key areas of change management

Benefit management planning

Benefits	Safety	Effectiveness	Pt Centred	Timeliness	Efficiency	Equity	How	Measure	Target
Pre-admission									
Reduced delay of ED referrals to medicine for complex patients							• 'Pull' model approach to MAU from ED • Clear pathways for accessing MAU	• Time from referral to medical review • Time from referral to leaving dept (MAU)	4% improvement of achievement against SSED target within 12 months post implementation
Reduced admission rate							• Review patients earlier in day (prevent overnight stay) • Quicker access to diagnostics	Admission rate (% patients discharged at 0 days)	5% reduction on baseline within 12 months (baseline TBC)
Admission									
Reduced length of stay in ED for all patients							• Co-located ED & MAU • Pull model to MAU from ED • Earlier senior decision making for medical patients in ED • Reduced number of patients in the ED will improve efficiency and prevent overload	• 95% SSED target improvement • Mean wait time in ED for medical patients and all patients	• 4% improvement of achievement against SSED target within 12 months post implementation • 95% achievement against SSED target within 4 years
Reduced length of stay for medicine patients							• Reduction in LOS through holistic care co-ordinated by single service rather than multiple services providing isolated care • Parallel rather than serial decision making • Access to decision making • SAFER Patient Flow Bundle[5]* • 7-day hospital model* (* assumptions of new hospital)	ALOS for all medicine (time of day LOS, based on admission or discharge under IM)	• Reduction from 5 to 3.5 days

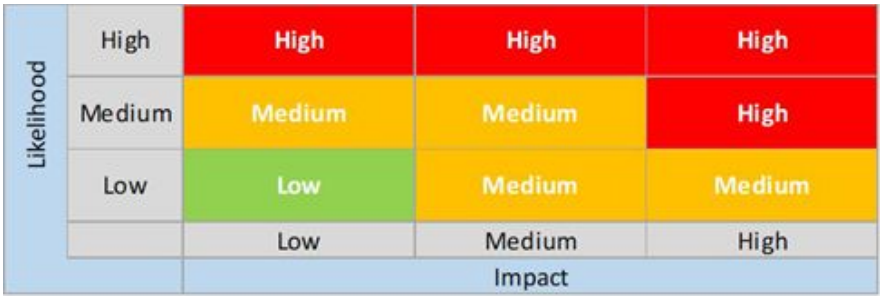
Benefits	Safety	Effectiveness	Pt Centred	Timeliness	Efficiency	Equity	How	Measure	Target
Reduction in outliers (defined as patients not on their home ward)							Increase number of co-located medical beds / reconfiguration of beds; reduction in bed day numbers	Outlying rate	27.5% reduction in bed nights from 4,494 to 3,259
Reduced number of occupied beds (gives greater flexibility around peak admission seasons or not stopping surgery)							• Increased level of discharge from MAU preventing 'full' admissions • Patients admitted to ward with established plan of care • Earlier senior decision making • Consequence of reduced LOS	Hospital occupancy rate	TBD
Reduced avoidable investigations							Only investigations required to assess patient are undertaken in a generalist model rather than fully working up patients for speciality services	Imaging rates per medical hospital admission. Baseline pre and post	TBD
Clinicians working at the top of their scope							• Patients to be seen by appropriate specialty • Increased use of appropriate referral pathways • Possibly decreased referrals in some situations	Survey Monitor inpatient referrals	
Reduced number of stranded and super-stranded patients							Through adoption of enhanced generalism model	% admissions day stay > 7 days and > 21 days	[target to be determined from baseline; baseline TBC)
Reduced number of patients staying longer than 2 days							• Quicker access to diagnostics • Quicker specialty review	% patients staying 3+ days	[target to be determined from baseline; baseline TBC)
Faster specialist review							• Agreed referral process • Same day review for referral before midday • Referrals only made to specialist services where there is a specific identified need rather than on the basis of condition, they present with	• Time from referral to specialist review • Responsiveness of the specialist teams	95% of general medicine patients reviewed within 24 hours

Benefits	Safety	Effectiveness	Pt Centred	Timeliness	Efficiency	Equity	How	Measure	Target
Reduced hospital-acquired deconditioning and harm							• LOS in hospital • Reduction in complication rate for patients in hospital (available through HRT data) • Reduction in LOS through holistic care co-ordinated by single service rather than multiple services providing isolated care	Harms (e.g. pressure sores, falls)	10% reduction on baseline within 1 year (baseline 560 2019-20, for GM, neurology, respiratory, gastroenterology & cardiology)
Discharge									
Reduced readmissions							• MAU post-discharge review of high risk patients • Holistic approach	Number of readmissions	[target to be determined from baseline; baseline TBC)
Staff culture									
Fair & adequate leave cover							• Block roster design • Fewer ad hoc arrangements		[no target]
Improved SMO collegiality							Through adoption of enhanced generalism model	Satisfaction surveys	10% improvement on baseline within 1 year
Increased GP satisfaction with referrals							Through adoption of enhanced generalism model	Satisfaction surveys	10% improvement on baseline within 1 year

Table 17 – benefit management planning

Risk Management Planning

Each workstream has identified risks and mitigation actions:



Description	Sponsor	Risk level	Prevention/mitigation strategies
Relocation of existing services needs to be determined prior to possible relocation of MAU	GM Community Services, Glenn Symon; GM Facilities and Property, Paul Pugh; Manager Medicine and Emergency, Sarah Kalmakoff		Once business case is signed off and determination of space for the MAU has been made, consultation with affected services will need to occur to ensure that an appropriate space is provided
7 day a week model of care not aligned to current allied health model of care	Director of Scientific & Technical, Tracy Hogarty; GM Community Services, Glenn Symon		Current Allied Health model for inpatient beds is primarily a 5 day a week service with reduced service over the weekend. A 5 day a week service will reduce effectiveness of the MAU
Recruitment of necessary SMO	Manager Medicine & Emergency, Sarah Kalmakoff; Clinical Director IM, Dion Astwood; SMO IM Yuki Aoyagi		Recruitment will be required in order for the full SMO model to be able to be enacted. Current SMO will be asked to work additional paid shifts to fill any roster gaps whilst recruitment of some known candidates is ongoing. Mitigation will allow for enhanced generalism model to commence without the need for initial recruitment

Table 18 – risk register

Next Steps

This business case seeks formal approval from the Board to progress the implementation of the preferred option, option two. Once this business case is agreed to, the next steps will include recruitment of the additional Senior Medical Officers and the change manager. A detailed project and change plan will then be developed and a steering group will provide oversight and ensure benefit realisation as the changes are implemented.

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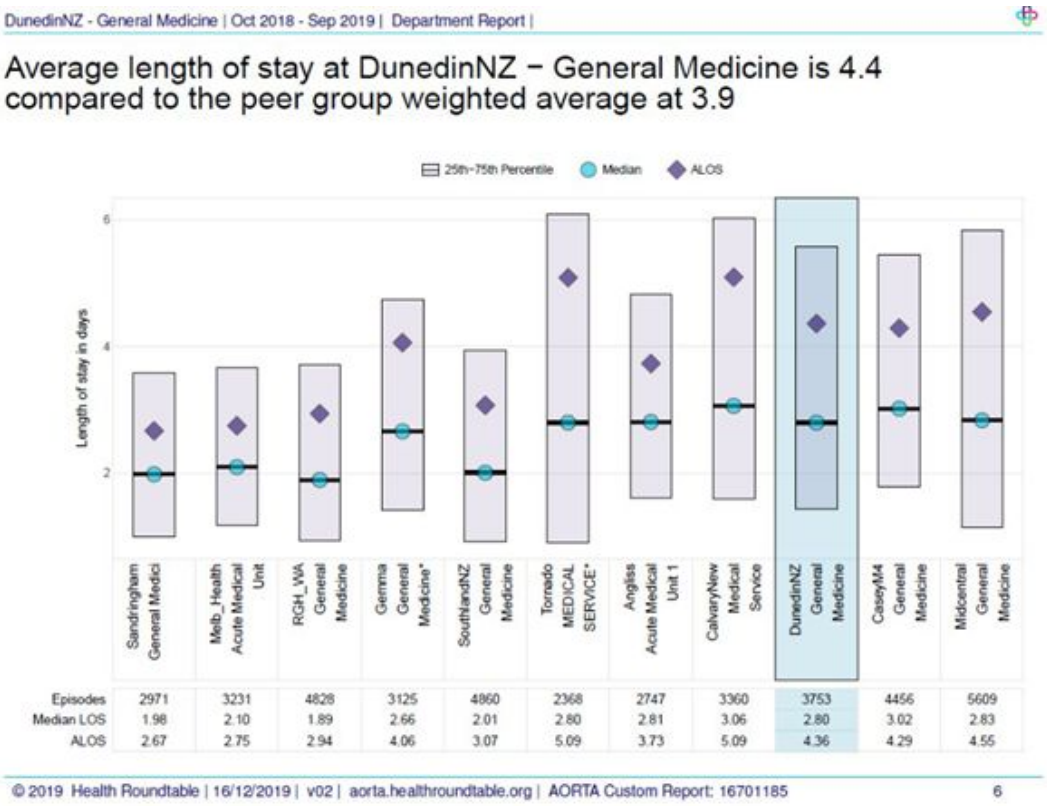
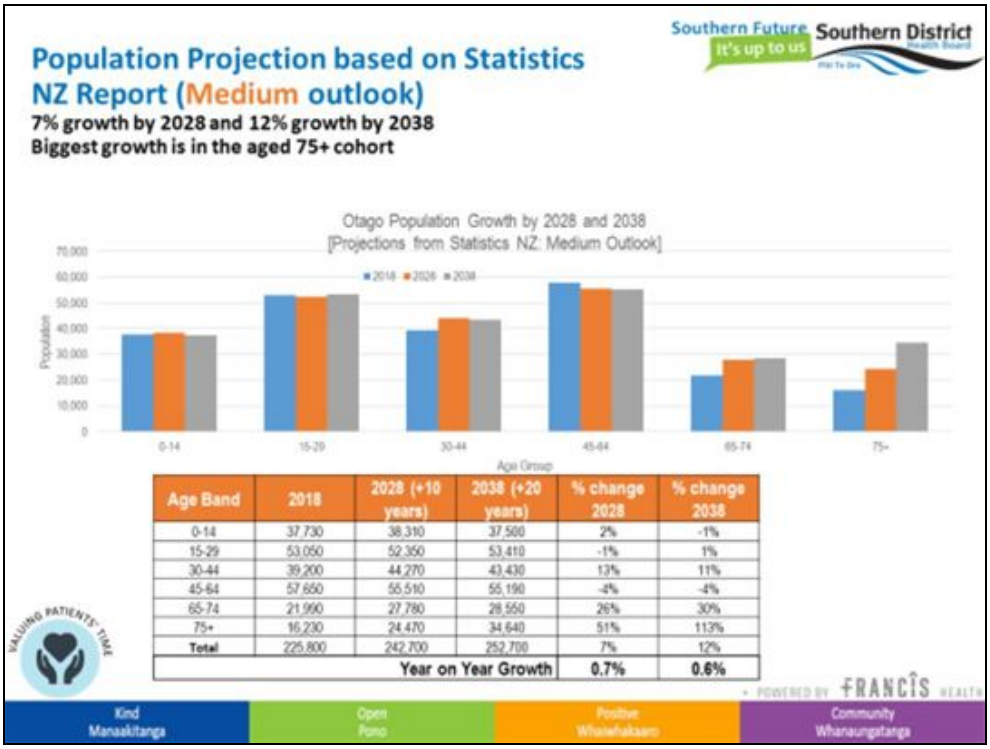
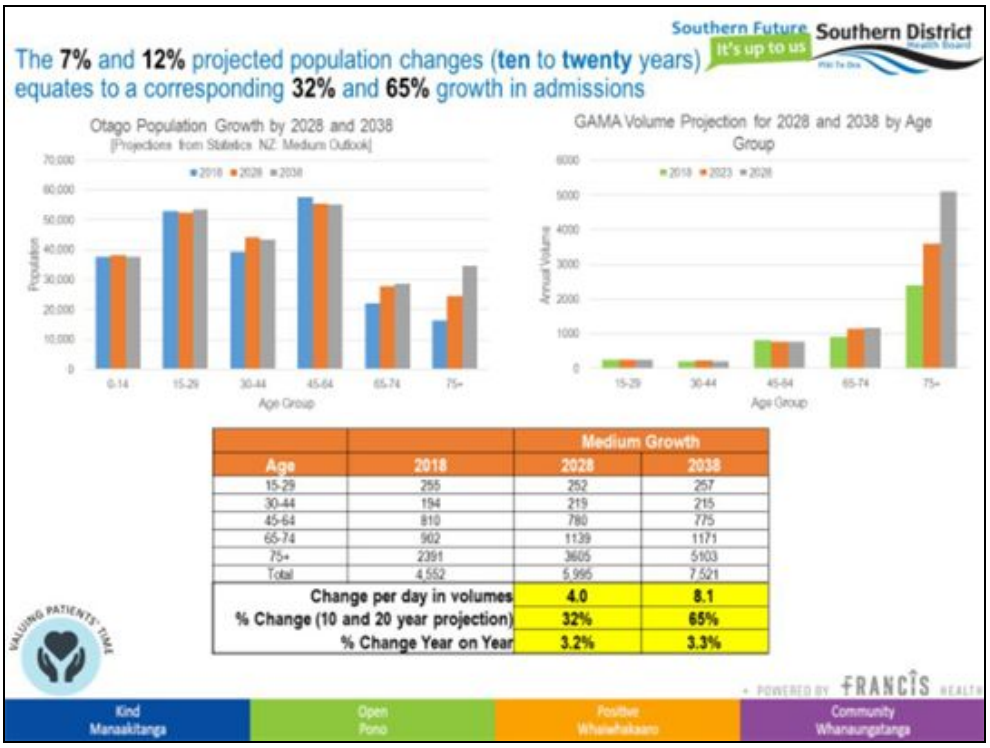
Appendix 1: LOS comparisons for peer hospitals



Appendix 2: Population projections and growth in admissions



Age Band	2018	2028 (+10 years)	2038 (+20 years)	% change 2028	% change 2038
0-14	37,730	38,310	37,500	2%	-1%
15-29	53,050	52,350	53,410	-1%	1%
30-44	39,200	44,270	43,430	13%	11%
45-64	57,650	55,510	55,190	-4%	-4%
65-74	21,990	27,780	28,550	26%	30%
75+	16,230	24,470	34,640	51%	113%
Total	225,800	242,700	252,700	7%	12%
			Year on Year Growth	0.7%	0.6%

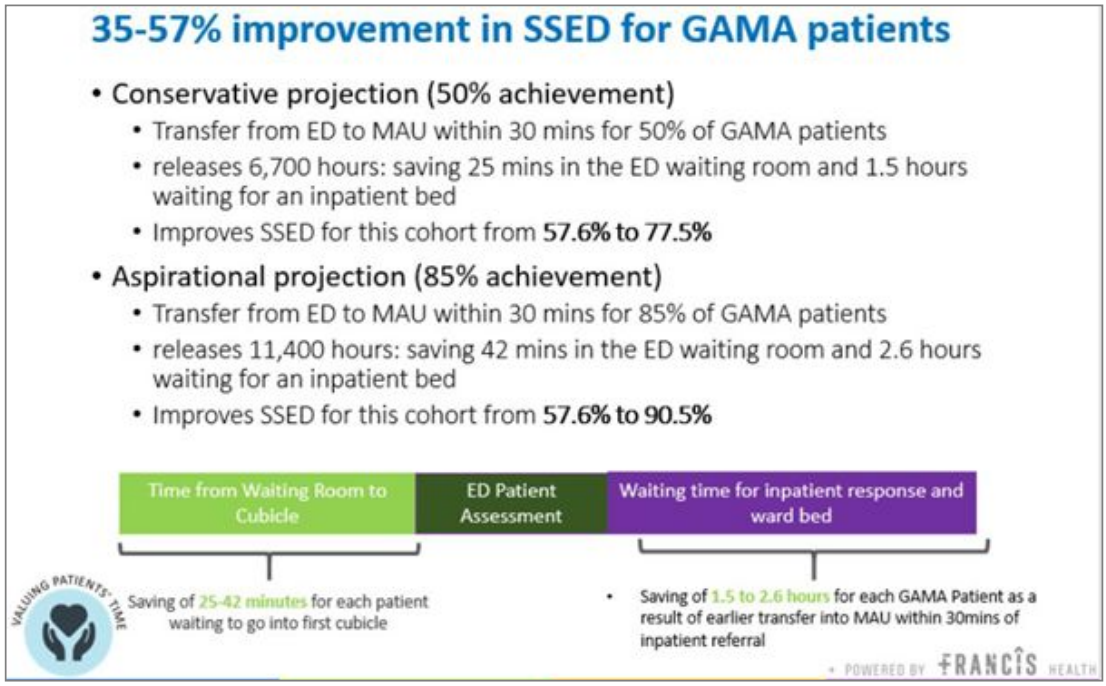


		Medium Growth	
Age	2018	2028	2038
15-29	255	252	257
30-44	194	219	215
45-64	810	780	775
65-74	902	1139	1171
75+	2391	3605	5103
Total	4,552	5,995	7,521
Change per day in volumes		4.0	8.1
% Change (10 and 20 year projection)		32%	65%
% Change Year on Year		3.2%	3.3%

Appendix 3: A short history of the evolution of generalism and its enabling factors at Dunedin Hospital

Timeline	Milestone
Sept 2011	• Principles (Hunter Rules) developed and agreed by CDs setting expectations of how services in Dunedin hospital will function regarding the assessment, admission and discharge of patients who present acutely to ED or are referred by their GP/other community provider. • Although endorsed, the Hunter Rules were not well managed with little or no consequence applied when the principles were not followed, resulting in a lack of adherence.
Feb 2015	• Business case submitted for a 20-bed and 3-clinic room Medical Assessment & Planning Unit (MAPU) co-located with ED, Radiology and Fracture Clinic on the ground floor of Dunedin hospital. • Business case was not supported.
Aug 2015	• Acute Admission Criteria was developed for each medical sub-specialty including a service level agreement between IM and Orthopaedic Surgery.
May 2017	• The Clinical Leadership Group (CLG) developed a discussion paper on Medical Generalism and Specialism with three key recommendations: o The development and implementation in practice of clear guidelines on which patients would be most appropriately managed by medical generalists or medical sub-specialists. o Generalist and specialist admission criteria be developed for separate categories of patients requiring admission. o SMO after-hours availability should be reviewed, and determinations be based on common objective criteria, including the frequency of after-hours call-back. • In tandem with the discussion paper, a business case for an 8-bed medical assessment unit (MAU) with additional House Officer resource and HOME team support was developed and approved under new Executive management. The decision was taken to limit the unit to an Internal Medicine Assessment Unit (IMAU) due to the growth in admissions and complexity of patients impacting junior doctor staff load at the time. • Despite the constraints of the model including its location on the seventh floor, the investment along with recruitment of dual-trained SMOs to IM diluted previous resistance experienced during the MAPU business case and supported further buy-in to the principles of same day discharging / acute ambulatory care. • Although discussed at CLG, the generalism concept was not progressed at the time as sub-speciality buy-in was limited.
2018	• IM took acute call for the endocrinology and diabetes service.
2019	• IM established a working group devoted to developing a General Acute Medical Admitting (GAMA) model of care and an expanded MAU under the Valuing Patients' Time programme. • Expanded admission criteria of the former IMAU to a MAU admitting acute sub-specialty patients as supported by sub-specialities. • IM started taking acute geriatric patients and rheumatology patients due to decreases in these services' capacity. • CMO tasked with engaging with ED & Inpatient services to establish principles to support inter-specialty professional standards (i.e. Timely response to referral)

Appendix 4: Modelled improvement to SSED



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Appendix 5: Change in sub-specialty SMO clinical availability

	Current state						Future state					
Sub-specialty	Effort			SMOs			Effort			SMOs		
	Pts / wk	Effort / pt	Weekly	Non-clinical	Clinical	Inpt	Pts / wk	Effort / pt	Weekly	Non-clinical	Clinical	Inpt
Neurology	4	1 hr	4 hr (10% SMO)	30%	60%	10%	4	0.25 hr	1 hr (2.5% SMO)	30%	65%	5%
Rheumatology	1	1hr	1hr (2.5% SMO)	30%	67.5%	2.5%	1	0.25 hr	0.25 hr (0.6% SMO)	30%	70%	-
Gastroenterology	4	1hr	4hr (10% SMO)	30%	60%	10%	4	0.25 hr	1 hr (2.5% SMO)	30%	65%	5%
Respiratory	5	1hr	5hr (12.5% SMO)	30%	57.5%	12.5%	1	0.25 hr	0.25 hr (0.6% SMO)	30%	70%	-
Cardiology	7?	1hr	7hr (17.5% SMO)	30%	52.5%	17.5%	1	0.25 hr	0.25hr (0.6% SMO)	30%	70%	-

Notes:

Cardio and Respiratory won't pick up consults on balance
Figures are based on a 40-hour week

Appendix 6: Matters of equity

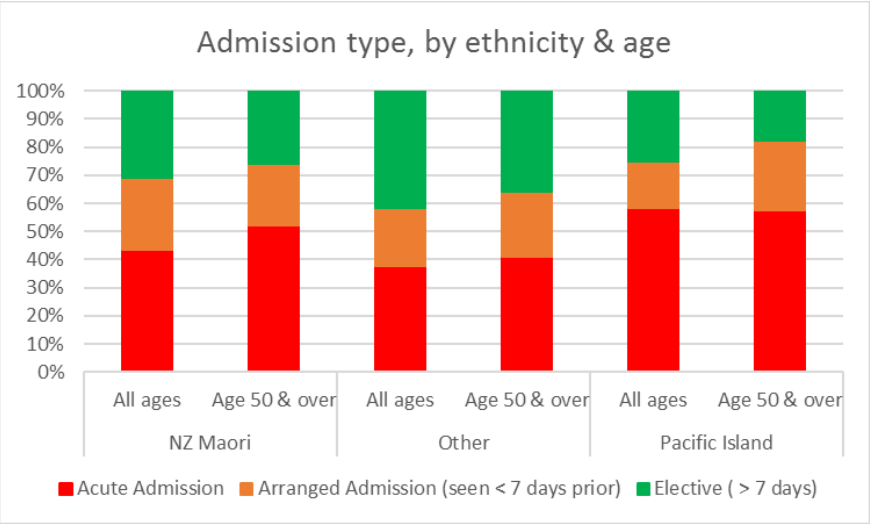
Admission patterns by ethnicity

Facility Dunedin Hospital, discharges 01/07/2019 and 30/06/2020

Discharge specialties cardiology, respiratory, gastro, neurology, rheumatology, endocrine, renal, haematology

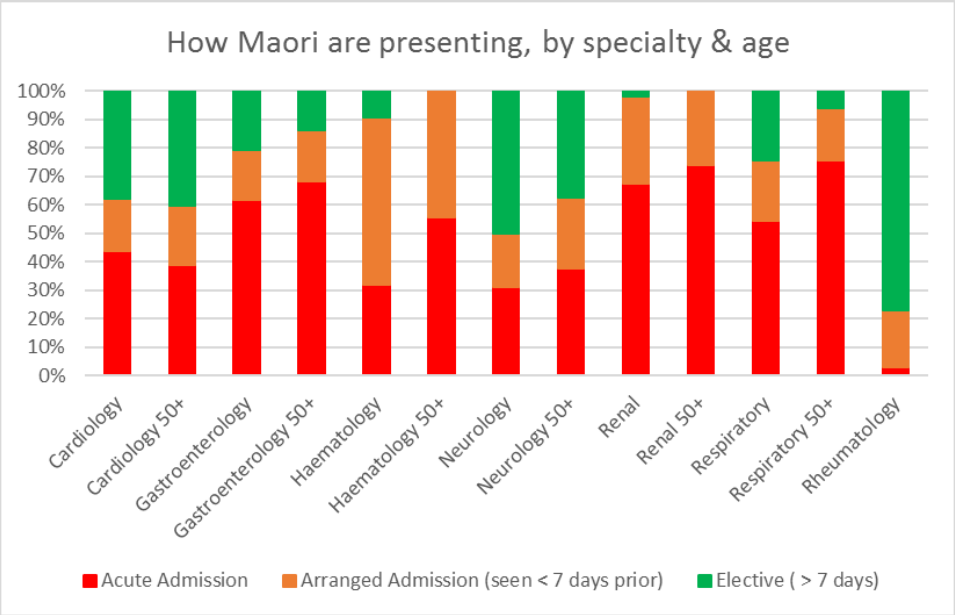
91% of all discharges for all specialties (and 89% of acutes) were patients identifying as Other, with Māori 7% (8% of acutes) and Pacifica 2% (3% of acutes). Looking at patients of all ages, 58% of Pacifica present acutely, vs 43% of Māori and 38% of other (all specialties). A greater percentage of Māori of all ages are discharged from the following specialties: cardiology (44%), respiratory (54%), gastro (62%) and renal (67%)

94% of discharges of patients aged 50 or over from all specialties (and 92% of acutes) were patients identifying as other, with Māori 5% (6% of acutes) and Pacifica 1% (1% of acutes).



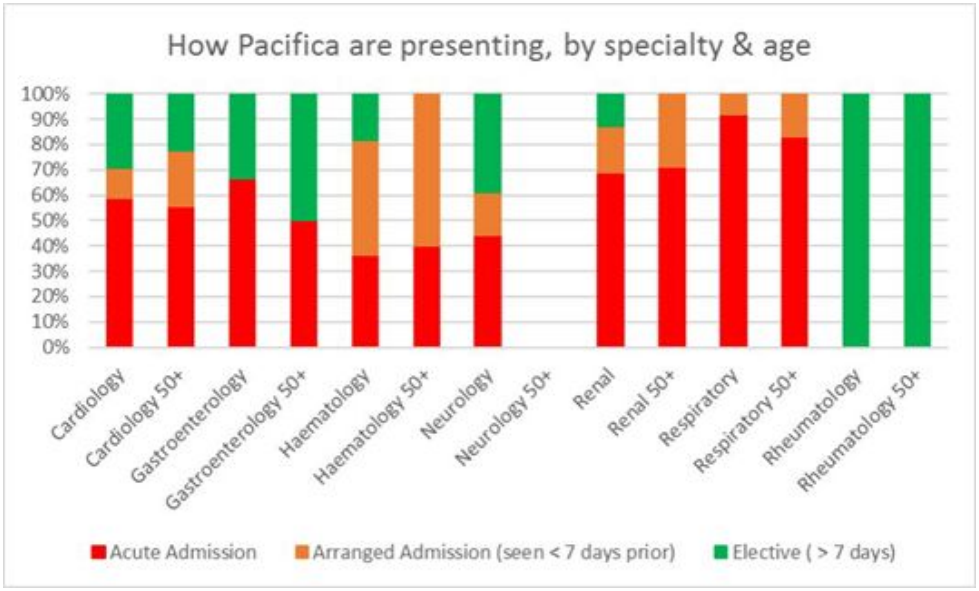
Māori were more likely to have an acute admission for gastroenterology than arranged or elective (62% vs 38), renal (67% vs 33%) and respiratory (54% vs 46%). Acute admissions were more likely than elective for Māori patients with haematological conditions (32% vs 9%), with the majority of admissions being arranged. Just under half of Māori patients presenting to cardiology were acute (44%).

52% of presentations for Māori aged 50 & over were acute. The figure was higher for the following specialties: haematology (56%), gastroenterology (68%), renal (74%) and respiratory (76%).



Pacifica patients of all ages were more likely to have acute admissions for cardiology, gastroenterology, haematology, neurology, renal and respiratory, but patient numbers were small (56 across all six specialties). 58% of presentations for Pacifica people aged 50 and over were acute.

Pacifica patients aged 50 and over were more likely to have acute admissions for cardiology, renal and respiratory (n = 20).

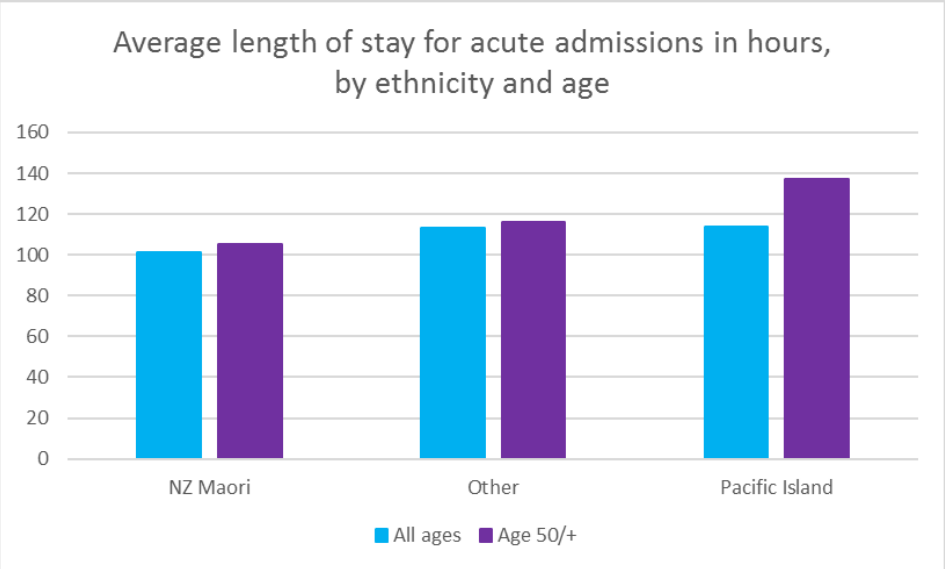


Just over half of patients identifying as Other presenting to renal and respiratory were acute (54% and 59% respectively), with the majority of admissions for other specialties being elective or arranged.

Just over half of patients identifying as Other presenting to renal and respiratory were acute (56% and 59% respectively), with the majority of admissions for the other specialties being elective or arranged.

41% for of presentations for people identifying as Other aged 50 and over were acute.

There were also differences by ethnicity in the average length of stay for patents of all ages and those aged 50 and over. Māori patients had the shortest stays, and Pacifica patients the longest. Monitoring will be required to ensure that there is an equitable reduction in length of stay for patients of all ethnicities.



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Appendix 7: Allied health resourcing

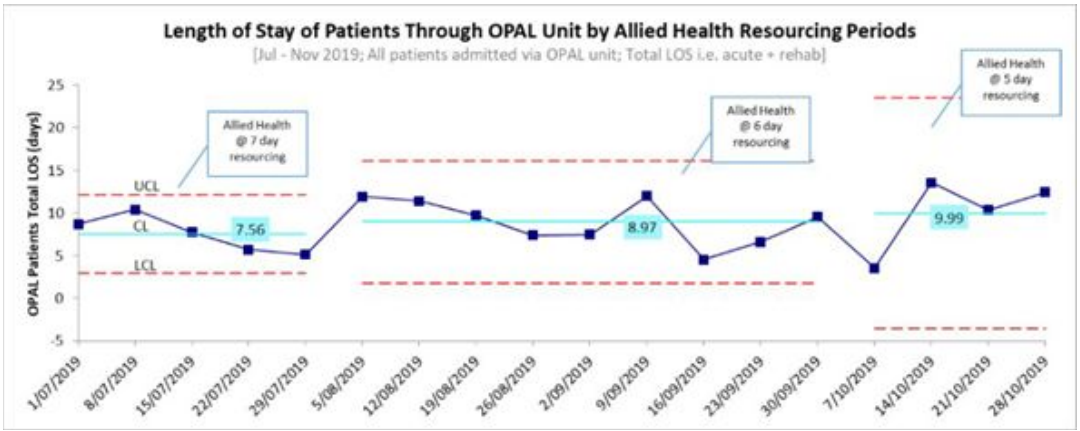


Figure 4 Increased average length of stay and variability as allied health resourcing transitioned from a 7-day service to a 6-day and 5-day service

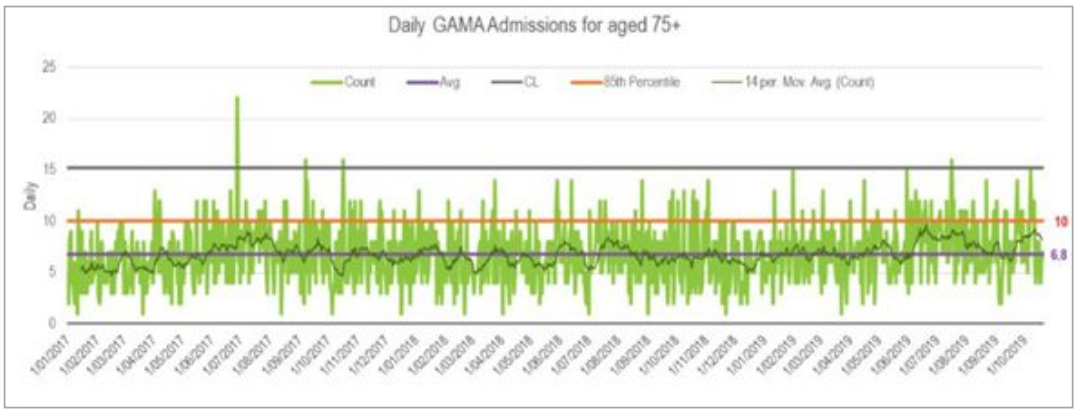
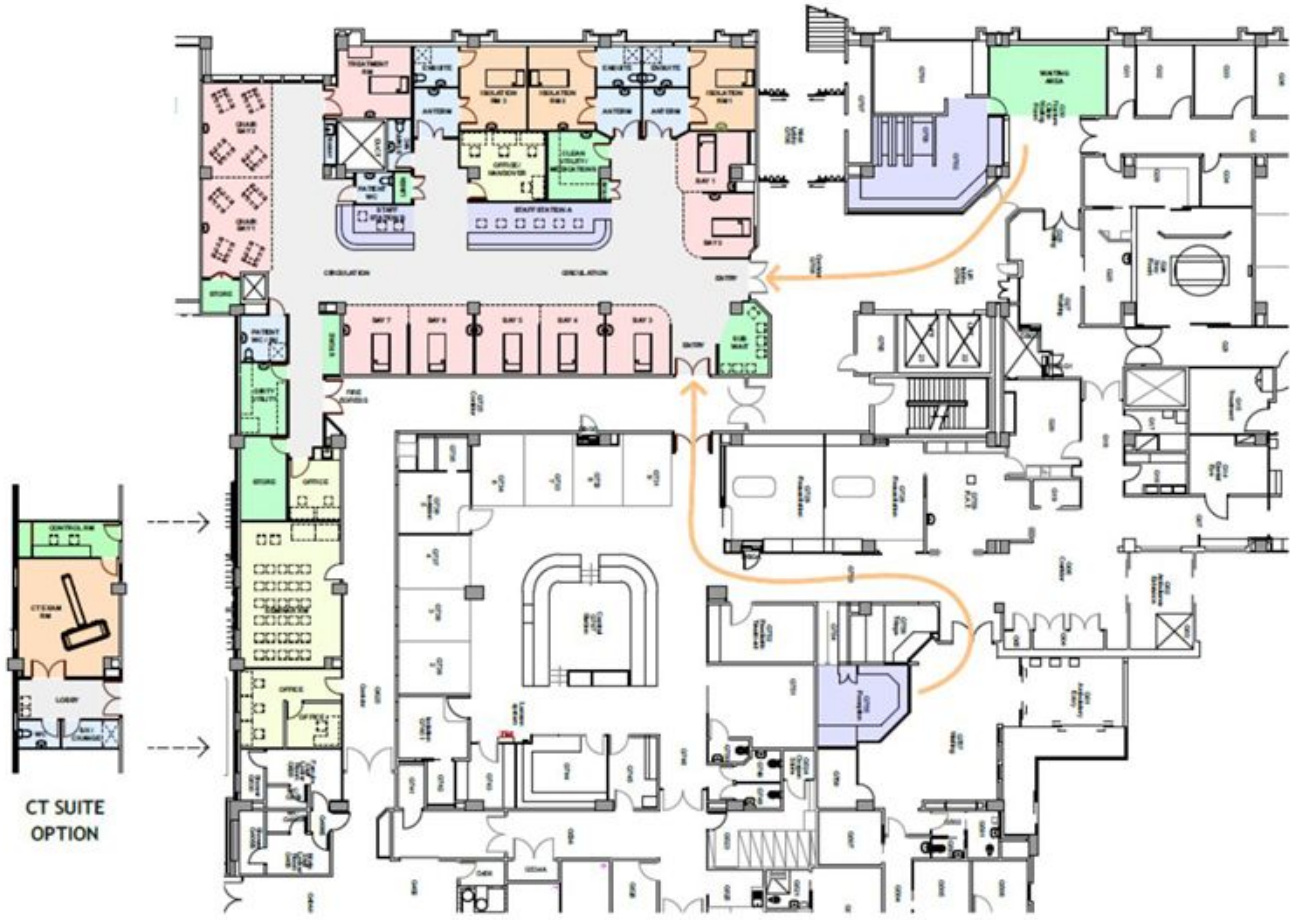


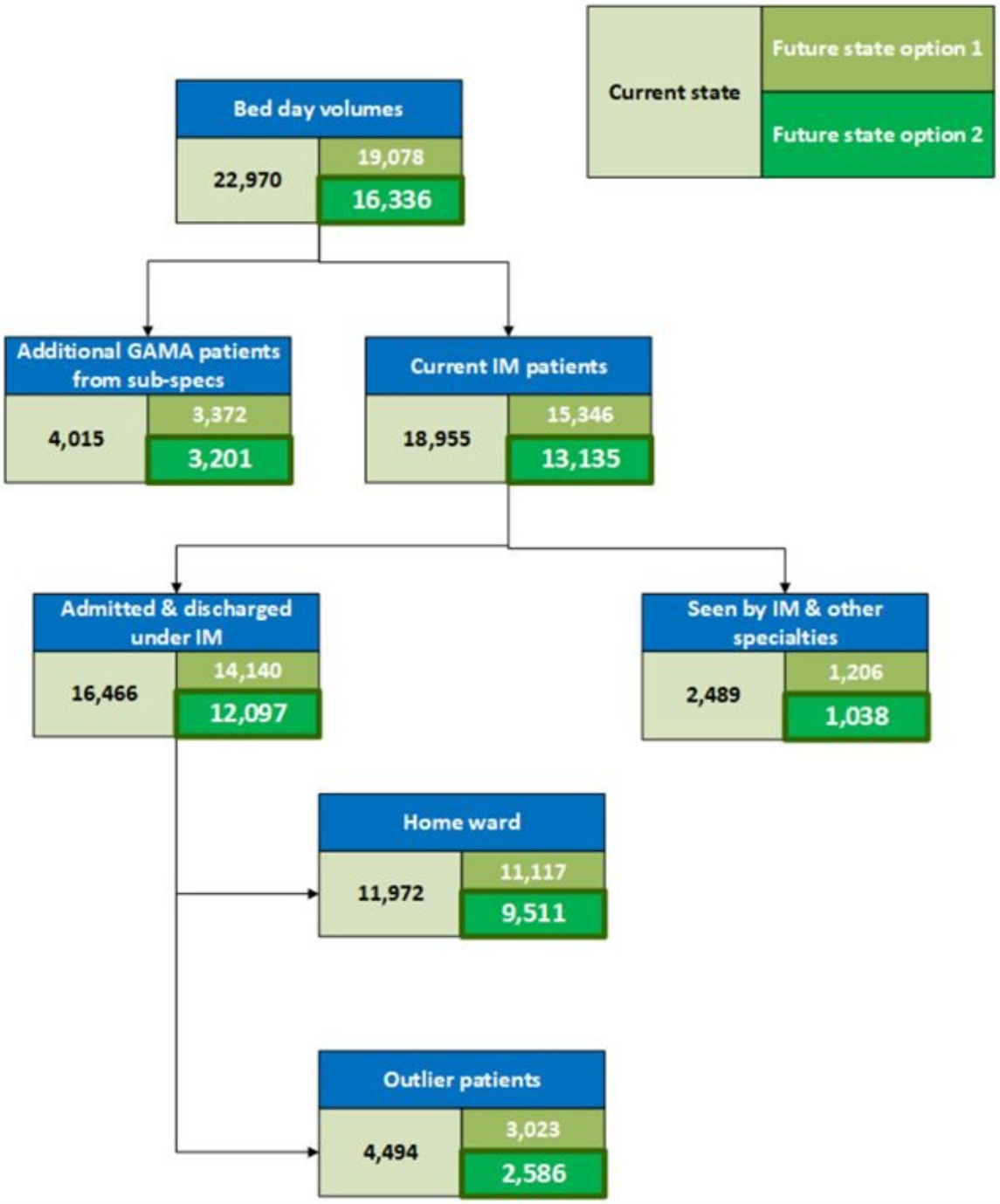
Figure 5 Daily acute admissions under new GAMA model for patients aged over 75

Appendix 8: MAU concept plan and quote



Appendix 9: Forecast reduction in bed day volumes

Enhanced generalism (option 1) vs enhanced generalism plus MAU (option 2)



Note: This diagram illustrates the initial workings from Francis Health to determine bed day savings, but the financial case has subsequently been updated with further assumptions and analysis. This data should be considered as illustrative only

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Internal Medicine Home-Ward Patients: Reducing Length of Stay

	Current State				Change	Future state option 1			Change	Future state option 2		
Midnights	Volume	ALOS	Bed Days	% Volume	Target	Volume	ALOS	Bed Days	Target	Volume	ALOS	Bed Days
0	72	0	0	3%	5%	143	0	0	20%	571	0	0
1	668	1	668	23%	23%	656	1	656	20%	571	1	571
2	576	2	1,152	20%	25%	714	2	1,427	20%	571	2	1,142
3-6 Days	1,010	4.1	4,147	35%	30%	856	4.1	3,516	25%	714	4.1	2,930
7+ Days	528	11.4	6,005	19%	17%	485	11.4	5,518	15%	428	11.4	4,869
Total	**2854**	**4.2**	**11,972**	**100%**	100%	**2,854**	**3.9**	**11,117**	100%	**2854**	**3.3**	**9,511**

Additional GAMA patients from Sub Specialties: Reducing Length of Stay

	Current State				Change	Future state option 1			Change	Future state option 2		
Midnights	Volume	ALOS	Bed Days	% Volume	Target	Volume	ALOS	Bed Days	Target	Volume	ALOS	Bed Days
0	62	-	-	7%	5%	45	-	-	20%	178	-	-
1	190	1	190	21%	23%	205	1	205	20%	178	1	178
2	169	2	338	19%	25%	223	2	445	20%	178	2	356
3-6 Days	296	4	1,196	33%	30%	267	4	1,079	25%	223	4	899
7+ Days	173	13	2,291	19%	17%	151	13	2,004	15%	134	13	1,768
Total	**890**	**5**	**4,015**	**100%**	100%	**891**	**4**	**3,732**	100%	**890**	**4**	**3,201**

Outlier Patients: Reducing LOS for patients who would have previously been in outlying wards

	Current State				Change	Future state option 1			Change	Future state option 2		
	Volume	ALOS	Bed Days	% Volume	Target	Volume	ALOS	Bed Days	Target	Volume	ALOS	Bed Days
Current Outliers	*776*	*6*	*4,494*									
% shift to 'Home wards'	776	6	4,494		100%	776	4	3,023	100%	776	3	2,586
Remaining Outliers	-	-	-		0	-	6	-	0	-	6	-
Total	**776**		**4,494**			**776**		**3,023**		**776**		**2,586**

Seen by IM and other specialties: Reducing Length of Stay

	Current State				Change	Future state option 1			Change	Future state option 2		
	Volume	ALOS	Bed Days	% Volume	Target	Volume	ALOS	Bed Days	Target	Volume	ALOS	Bed Days
0	8	-	-	3%	5%	12	-	-	20%	49	-	-
1	20	1	20	8%	23%	57	1	57	20%	49	1	49
2	26	2	52	11%	25%	62	2	124	20%	49	2	99
3-6	70	4	279	28%	30%	74	4	295	25%	62	4	246
7+	123	17	2,138	50%	17%	42	17	730	15%	37	17	644
Total	**247**	**10**	**2,489**	**100%**	100%	**247**	**5**	**1,206**	100%	**247**	**4**	**1,038**

Table 19 – Francis Health data showing forecast reduction in bed day volumes

Notes:

- This table illustrates the initial workings from Francis Health to determine bed day savings, but the financial case has subsequently been updated with further assumptions and analysis. This data should be considered as illustrative only
- Acute patients only
- Current state October 2018-September 2019
- Outliers identified as having been to a non-IM home-based ward (home wards being MAU, MED8 and Acute Stroke Unit)

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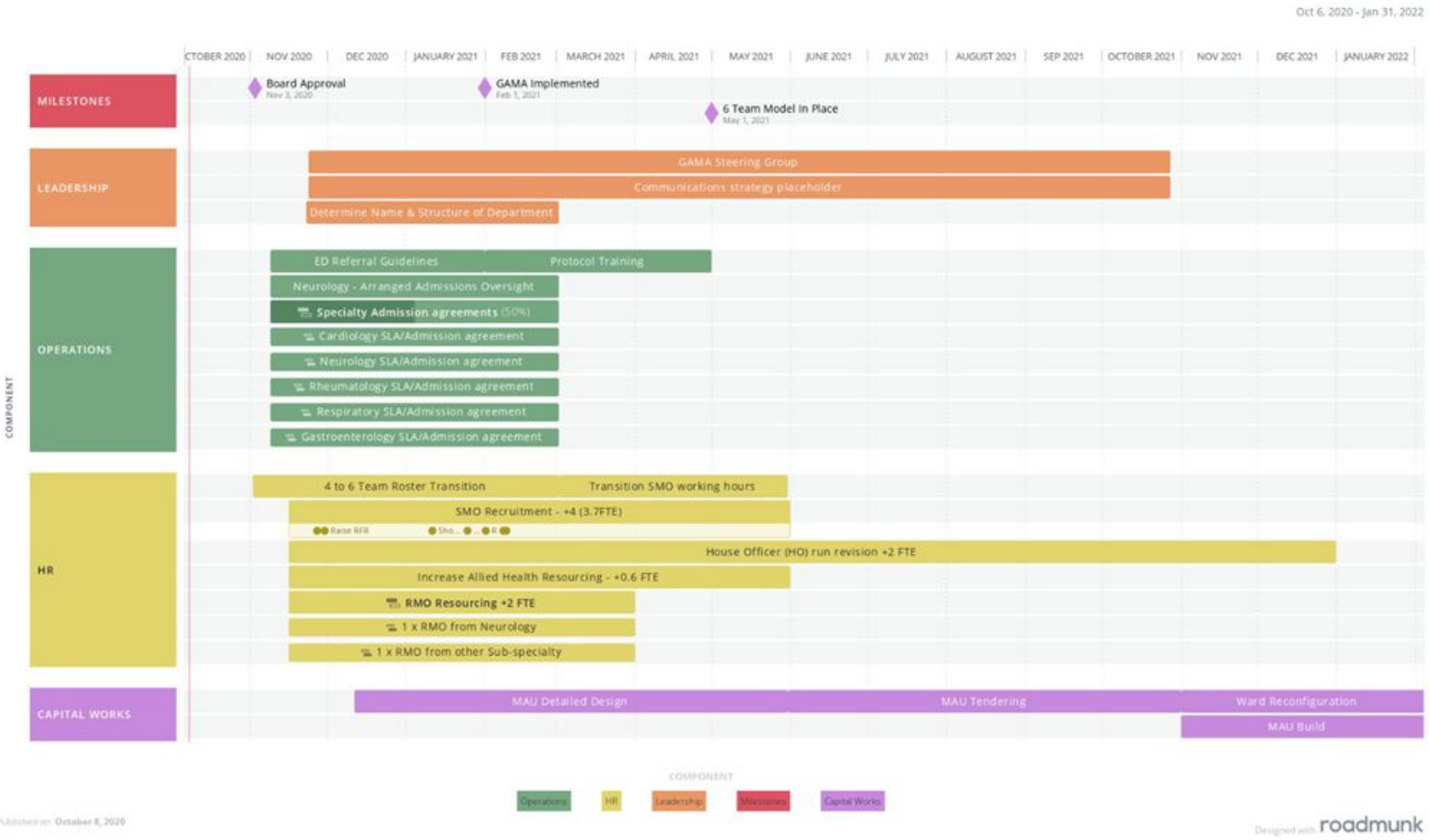
Item	Description	Total ($)
1	**Construction Cost** • Demolition • Construction • Mechanical and Electrical Services • Data and audio-visual • Plumbing and drainage	$3,118,813
2	**Preliminary and General Costs** • Contractor's site facilities and management • Allowance for some out of hours work	$467,822
3	**Margin** • Contractor's profit	$358,663
4	**Contingencies** • Project contingency	$789702
5	**Estimate Total:**	**$4,735,000.00**
6	**Options** • CT Suite	$352,000

Table 20 – supplied costings for construction of MAU

Appendix 10: Internal Medicine to GAMA transition plan



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Appendix 11: Outlier analysis

Analysis from October 2018 to September 2019 has demonstrated that outlying patients, that is patients who have been admitted and stayed under IM for the duration of their hospital visit but were based on a ward other than 8 Med or the MAU, stayed on average 1.6 days longer than if they had stayed solely on the IM 'home wards'. By reconfiguring and growing the IM 'home ward' base to accommodate a generalist model, there is an opportunity to reduce outlying patients. Although it is anticipated some outliers will remain, a generalist approach with appropriate ward configuration that eliminates outliers has the potential to save 1,235 bed days per year.

Current State				Change	Future State		
IM Home-Ward Pts	Outlier Pts						
ALOS	**Volume**	**ALOS**	**Bed Days**	**Target**	**Volume**	**ALOS**	**Bed Days**
4.2	776	5.8	4494	100% reduction in outliers (i.e. LOS ↓ 4.2)	776	4.2	3259
						Bed Days Saved	**1235**

Appendix 12: General medicine and specialty referral guidelines

1.0 Guidelines Overview

1.1 These guidelines represent an agreement between General Medicine and <*Specialty*> on the acute admission criteria to each service at Dunedin hospital.

2.0 Aim of Guidelines

2.1 The purpose of these guidelines is to ensure that the agreed requirements and commitments are in place to provide consistent admission, treatment and discharge of acute patients under General Medicine and <*Specialty*>.

2.2 The goal of these guidelines is to obtain mutual agreement for service provision between Emergency Medicine, General Medicine and <*Specialty*>.

2.3 The key principles of these guidelines are trying to deliver care better for our patients including

- 2.3.1 Care of patient under the appropriate <*Specialty*>
- 2.3.2 Optimise flow for patient by minimising unnecessary time patients spend in ED

3.0 Periodic Review

3.1 These guidelines will come into effect from <*Generalism start date*> and will be reviewed and updated as the collaboration between <*Specialty*> and General Medicine evolves.

3.2 After hours the medical registrar makes the decision as to which <*Specialty*> a patient is to be admitted under and both Clinical Directors will discuss the decision the next working day.

3.3 The Clinical Directors will meet weekly to review patient admissions and update the guidelines accordingly for the first month of implementation, then monthly thereafter (subject to change in accordance with feedback at the time).

4.0 Guidelines

4.1 Scope

- 4.1.1 The scope of this agreement is for acute <*Specialty*> and General Medicine patients admitted to Dunedin Hospital.

4.2 Patient Admission Criteria

- 4.2.1 Specialties
  - 4.2.1.1 Cardiology
  - 4.2.1.2 Respiratory

4.2.1.3 Gastroenterology

4.2.1.4 Neurology

4.2.1.5 Rheumatology

4.2.2 Example criteria

4.2.3 **Atrial fibrillation**

4.2.3.1 New onset atrial fibrillation not secondary to acute illness

4.2.3.2 Cardiology: age < 65

4.2.3.3 General Medicine: age >= 65

4.2.4 **Pneumonia**

4.2.4.1 Respiratory infection with lung consolidation on chest x-ray

4.2.4.2 Respiratory: <criteria for ref. to respiratory>

4.2.4.3 General medicine:

4.3 Availability

4.3.1 The <*Specialty*> On-Call SMO will come to the 08:00 General Medicine handover every morning. The General Medicine team will prioritise discussion of specialty patients first, including <*Specialty*>.

4.3.2 If after review the <*Specialty*> or General Medicine team determine the patient is better suited under the other's service, the team will contact the on-call team of the day to discuss transfer (the SMOs retain final responsibility for the transfer).

4.3.3 Consistent with referral policies of this DHB that all inpatient referrals are seen within 24 hours.

4.3.3.1 The <*Specialty*> team will be available to provide advice to General Medicine patients within 24 hours of request; same day when feasible

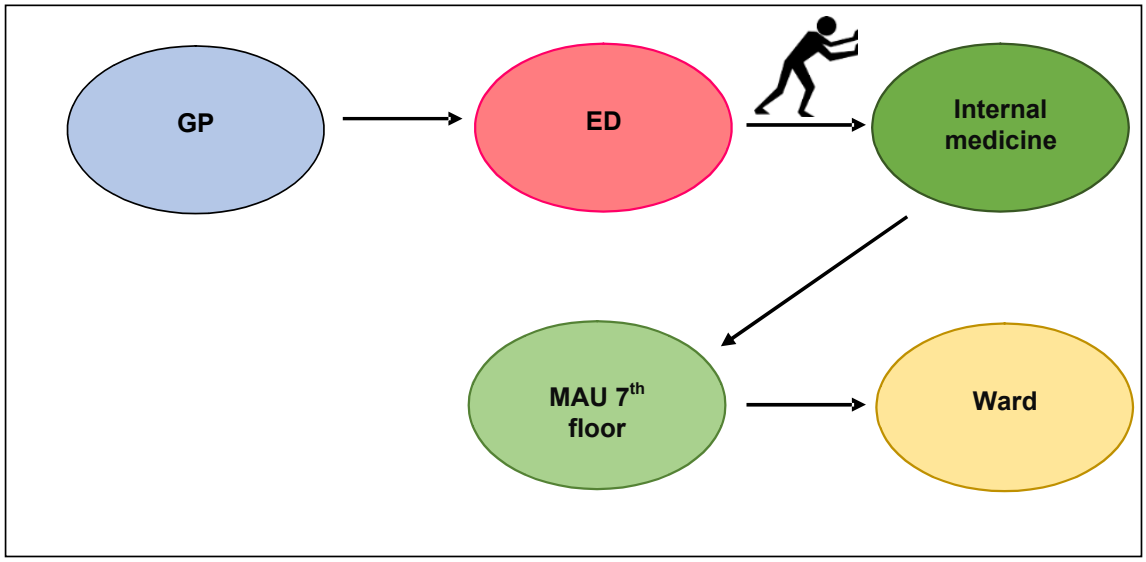
4.3.3.2 The General Medicine team will be available to provide advice to <*Specialty*> patients within 24 hours of request; same day when feasible

4.3.3.3 It's the expectation that patients referred before 1200 will have a review which includes a consultant opinion on the same day

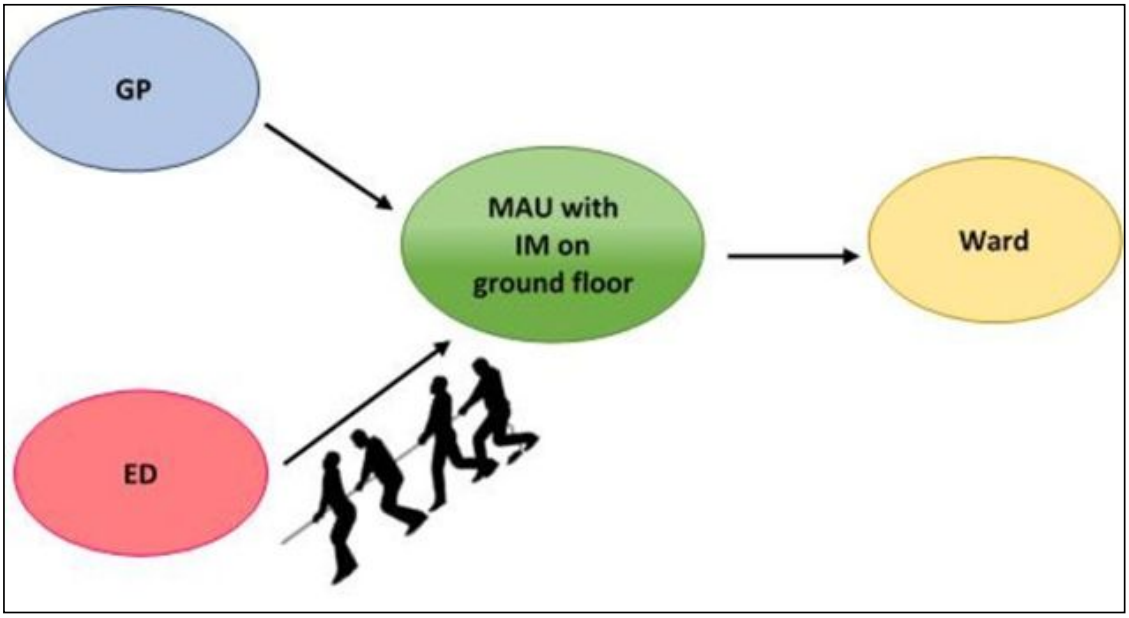
4.4 Assumptions

4.4.1 Changes to the admission, treatment and discharge of patients in the scope of these guidelines will be communicated and documented to all stakeholders.

Appendix 13: Patient flow from ED to MAU – current versus future state



Current state: patients are pushed from ED to IM/MAU



Future state: MAU pulls patients from ED

Appendix 14: Abbreviations

ACN	Associate Charge Nurse
AH	Allied health
ALOS	Average length of stay
ATR	Assessment, treatment and rehabilitation
CMO	Chief Medical Officer
CY	Calendar year
DPE	Director of Physician Education
ED	Emergency department
FY	Financial year
GAMA	General Acute Medical Admitting
GM	General Manager
ICU	Intensive care unit
IDT	Inter-disciplinary team
IM	Internal medicine
ISIS	Wakari Rehabilitation Centre
LOS	Length of stay
MAU	Medical assessment unit
MECA	Multi Employer Collective Agreement
OPAL	Older Person's Assessment and Liaison
OT	Occupational therapy
PSA	Public Service Association
RAG	Red, amber, green rating for assignment of risk level
RMO	Resident medical officer
SMO	Senior medical officer

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Clinical Council**
Report to:	Board
Date of Meeting:	8 December 2020

Summary:

- Update of activities of Clinical Council since reconfiguration of membership

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

Financial:	
Workforce:	
Equity:	
Other:	

Document previously submitted to:	(Eg ELT, Board or management committee, etc)	**Date:** dd/mm/yy
Approved by Chief Executive Officer:	Pending	**Date:** dd/mm/yy

Prepared by:	**Presented by:**
Tim Mackay Chair, Clinical Council **Date:** 27/11/2020	Tim Mackay Chair, Clinical Council

As the year comes to an end, I am pleased to inform the board of the activities the refreshed Clinical Council (CC) has been undertaking over the last few months.

We have been working with the comms team to help raise the profile of the CC and the subcommitees that report to the Clinical Council, the recent profiles that have been completed to date for the Mortality Committee and Clinical Practice Committees are attached for your information. The Clinical Council is also continuing to develop its web presence. https://www.southernhealth.nz/about-us/about-southern-dhb/clinical-council

The recent changes to the membership, format and structure of the meetings has a positive benefit for the Clinical Council, with the change of day and also length of the meetings ensuring excellent attendance and adequate time to discuss agenda, and ensure outcomes and actions are identified.

The support from Gail Thompson's Team Executive Director Quality & Clinical Governance Solutions has been very helpful especially as support is needed for the work in the Older Peoples workstream; and this will be crucial as further discrete "projects" are identified and supported by the CC.

I am currently meeting with the Chairs of subcommittees and discussing expectations that they have of the CC and also that of the CC for them; also their terms of reference.

The current workplan is attached, it is assumed that this will continue to evolve as new opportunities and issues are raised to the CC.

As 2021 approaches the Clinical Council needs to ensure that it is able to push and drive clinical quality changes in the system, and subsequently communicate to the organisation and also wider audiences the positive outcomes and improvements that these changes have been able to achieve.

RECOMMENDATION:

1. Board accepts report.

Clinical Council Charter

This Charter outlines our commitments and the key principles or "rules of engagement" we will follow as members of the South District Health Board Clinical Council.

This Charter sets out key principles that govern the conduct of members, both individually and collectively.

PURPOSE OF CLINCIAL COUNCIL

The *Clinical Council* is a Committee of the Southern District Health Board (SDHB). It is the principal interprofessional clinical governance and leadership advisory group for the DHB. It puts patient safety and quality of care at the centre of all decision making on every level of Southern DHB Services. Clinical Council ToR

PRINCIPLES

The foundation of our Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system'. As a clinical governance group, we will conduct ourselves and undertake our leadership role in a manner consistent with the following principles.

- We will conduct ourselves with honesty and integrity, and develop a high degree of trust;
- We will promote an environment of high quality, performance, accountability, and low bureaucracy;
- We will adopt a patient/whanau-centred, whole-of-system approach and make decisions on a Best for System basis;
- We will adopt and foster an open and transparent approach to sharing information;
- We will actively monitor and report on our achievements, including staff and public reporting.
- We will uphold and 'live' the Southern DHB values

COMMITMENT

We will work closely and collaboratively with our fellow members, in an innovative and open manner, to produce outstanding results. To achieve this we make the following commitments:

- **Shared responsibility:** We will be diligent in preparing for and attending Council meeting and actively address all tasks and duties of our role as members of the Council to undertake the work of the Council, and to commit the time required to carry out these responsibilities. We will be as informed and as knowledgeable as possible about the responsibilities of the Southern Health system and the issues they are confronted with in order to arrive at the best advice possible.

The Charter has been developed based on the South Island Alliance Charter and the Community Health Council Code of Conduct

- **Shared decision making:** We agree that our decisions will be supported by the best available evidence. We will use our best endeavours to facilitate unanimous decisions, and will not prevent a consensus being reached for trivial or frivolous reasons. Members may clearly express their individual views at Council meetings, and endeavour to achieve a particular decision and course of action. However, members accept that once the Council has formally reached a decision, this decision becomes the policy of the Council. Individual members will not attempt to re-litigate previous decisions at subsequent meetings of the Council, unless the majority of members agree to re-open the debate.

- **Shared accountability:** We agree that we will have a robust airing of views, but that once the Council has reached a decision or position we will all abide by that decision and support it publicly. (This includes keeping confidential the views of particular individuals expressed during the discussion, but does not prevent us sharing the issues that were balanced in reaching that decision.)

- **Good faith:** We agree to openly discuss all matters that affect our ability to effectively advise ELT or the Board or make decisions, including any conflicts of interest and any limits on our mandate (where we carry these from participant organisations), so that all members of our team are fully aware of any restrictions, caveats or further authority that may be required. It is inappropriate for a member to undermine a decision of the Council once made or to engage in any action or public debate that might frustrate its implementation.

- **Treaty of Waitangi:** We agree that the Treaty of Waitangi establishes the unique and special relationship between Iwi, Māori and the Crown. Parties with Treaty obligations will honour these when participating in Clinical Council activities.

- **Confidentiality:** To encourage the open and transparent sharing of information we agree to keep confidential matters shared on a confidential basis, to enable improved decision-making.

- **Active engagement:** We agree our members' continuous involvement in and attendance at our Council meetings is critical, and will make every effort to attend as set out in the ToR and participate fully.

If a member of the Council does not act in accordance with our principles and commitments, the Chair will discuss the situation with the member involved. If no resolution can be found, that member may be removed in consultation with the CEO or the Board.

COMMITMENT TO SERVE

On the basis of the above, I agree to serve as a member of the Clinical Council for the Southern District health Board

Signed: _____

Name: _____

Date: _____

The Charter has been developed based on the South Island Alliance Charter and the Community Health Council Code of Conduct

	2020			2021											
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Quality Improvement & Patient Safety															
Improving Care for Older People- Sally, Hywel, Patrick		Update													
Valuing Patient Time- Jane Wilson, Hywel															
Deteriorating Patient- Kim Caffell and Tina Gilbertson															
Early Warning System & Deteriorating Patient – what's working and not - ISBAR Kim Caffell and Tina Gilbertson															
Delirium – Michelle Muir															
Falls Governance group- Sharon Adler															
Healthcare- acquired pressure injury - Sally O'Connor															
Abuse or Deliberate Harm - Violence Intervention – Kaye Cheetham															
Self-Harm..?															
Clinical Practice Committee- Jo Krysa															
Clinical Effectiveness															
Maternity Quality & Safety- decision-making- Jane Wilson, Mary Cleary Lyons		Decision for noting													
Infection Prevention and Control- Healthcare Acquired Infection															
Mortality Review Committee – John Edmonds															
Delays in Care ESPI 2&5 -Patrick/ Janine															
Medicines management Committee – Craig McKenzie															
Medicine, Women's & Children Directorate															
Operations Directorate															
Surgical Services and Radiology Directorate															
Mental Health, Addictions & Intellectual Disability															
Strategy, Primary, Community Directorate															
Clincial Risk Register - Wayne/ Gail					Deep dive into Clincial Risks through 2021										
Clinical Audit -Vascular Access Management (VAM)															
Engaged Effective Workforce															
Staff Wellbeing – Tanya Basel															
Diverse Workforce – Tanya Basel															
Credentialing- Interprofessional credentialing			Report				Report				Report				
Consumer Engagement															
CHC Engagement Framework & Roadmap - Karen Browne															
Patient Experience surveys – Tina Gilbertson															

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Consumer Feedback Report- Tina Gilbertson															
HQSC Quality Safety Marker-Charlotte/Karen															
Patient Stories															
	2020			2021											
Clincial Council reporting to Board															
DHB Certification															

other aspects to consider

- Equity
- Children and youth

CLINICAL COUNCIL

Clinical Council Summary Notes

Thursday 10 September 2020

The Clinical Council is a committee of the Southern DHB. It is the principal interprofessional clinical governance and leadership advisory group for the DHB. It puts patient safety and quality of care at the centre of all decision-making at every level of Southern DHB Services.

- A Charter has been developed for all Clinical Council members to sign-up to as members which outlines their commitments and rules of engagement as members of this Council.
- The Clinical Council will be seeking expressions of interests for two new members 'Rising Stars' to be members of the Council. This will be advertised in the coming week.
- The Council is finalising their workplan for 20/21, which will be put up on the website once it is completed
- The Chair of the COVID-19 Technical Advisory Group (TAG), Dr Nigel Miller provided an update to the Clinical Council on how this group operated since being formed in February 2020. This committee will continue to have a linkage with the Clinical Council.
- A draft Service Level Accountability Pack was reviewed by members and will be coming out to services to have input on in 2021.
- Clinical Council members reviewed data on harm occurring to Older People when they are in the care of Southern DHB. Council members believe this should be apriority area to focus on going forward and more information around actions to address this will come out in the coming months.
- The Community Health Council (CHC) provided an overview of who and what this Council is. A key focus of engaging community, whānau and patients in projects that are occurring across the Southern health system has grown significantly. The Council is keen to review feedback from both staff and CHC advisors engaged with this work to ensure that the organisation is genuinely listening and working in partnership and not simply ticking a box. The CHC has been working with the Health Quality and Safety Commission on a new Quality Safety Marker focussed in consumer engagement. The DHB will report on this in the coming year.

Tim MacKay, Chair Clinical Council
Date of next meeting – Thursday 8 October 2020

For more information about the Clinical Council click on link
https://www.southernhealth.nz/about-us/about-southern-dhb/clinical-council

or email clinicalcouncil@southerndhb.govt.nz

CLINICAL COUNCIL

Clinical Council Summary Notes

Thursday 8 October 2020

The Clinical Council is a committee of the Southern DHB. It is the principal interprofessional clinical governance and leadership advisory group for the DHB. It puts patient safety and quality of care at the centre of all decision-making at every level of Southern DHB Services.

- Two new members were appointed through the Expressions of Interest process for rotational members - Samantha Graham, Physiotherapist and Jessica Dixon, Nurse Educator

- A Risk Workshop was facilitated by Wayne Alcock, Risk Management Advisor at Southern DHB. A key aspect of work for the Clinical Council will be monitoring and reviewing the risk register and ensuring that risks are mitigated appropriately.

- The Council endorsed the draft Hospital Escalation Plan – which maps out a clear direction of how the system will respond when the Emergency Department is struggling with the volume of patients attending.
  Council members were supportive of a whole of system approach, which outlines specific tasks and duties for staff when the ED reaches defined limits. In order for the system to work effectively, it will need a change in culture with how staff undertake their normal duties.
  Council members suggested having a practice run, such as is done with disaster preparation.
  The Hospital Escalation Plan will now go to the Executive Leadership Team (ELT) for endorsement and when implemented will have a focus on Dunedin Hospital initially, before rolling out to Southland Hospital.

- Clinical Council members support and endorse the work around Improving Care for Older People. Executive Director of Quality and Clinical Governance will sponsor this initiative which has been identified by Clinical Council. Some Clinical Council members will present to the Community Health Council and the ELT.

- John Edmonds, Chair of the Mortality Review Committee joined the meeting to discuss the work that has been undertaken to date by this Committee. Members were informed that some departments are undertaking regular Mortality and Morbidity Review meetings, and the committee has undertaken a stocktake which identifies where gaps are. The Committee drafted up the Southern Mortality Review Model which is a living document on Midas. This document is aimed to support services in doing MMR meetings.

Tim MacKay, Chair Clinical Council
Date of next meeting – Thursday 12 November 2020

For more information about the Clinical Council click on link
https://www.southernhealth.nz/about-us/about-southern-dhb/clinical-council

or email clinicalcouncil@southerndhb.govt.nz

Mortality Review Committee news

More than eighteen months since a Southern DHB Mortality Review Committee was formed, we spent five minutes with the Committee Chair, Dr John Edmond, Consultant Cardiologist to find out more about the committee and its role.

Why was the committee set up?
Mortality and Morbidity committees (M&M) are run within departments to review the care of their patients, and in particular review issues when there has been a death or a specific problem. Our committee was formed to provide advice to, and oversight of, the individual department groups to ensure information is shared between departments. We want to ensure potential changes and quality improvements aren't lost because they are only discussed amongst a small group of practitioners. Additionally, our group will explore the range of safety data available to the DHB, to try and identify potential problems and review/remediate as soon as possible.

What does it do?
Our main role so far has been putting together a support pack (Southern Mortality Review Model) for department M&M groups. We're also learning how to explore the various safety and outcome data sets available to us. There is an enormous, almost overwhelming, amount of data available!

What are the procedures in place to help staff review mortality at SDHB?
Currently most departments do undertake mortality review, but all have evolved their own processes over the years. Our aim to try and unify these processes as much as possible, so we can share outcomes and good practice. It is important to note however that most of these departments do a good job in their reviews, so we must be alert to the fact that we don't want to make things harder or lower quality by interfering

Do you report to another Committee?
Yes - we report to the Clinical Council.

Why is a Mortality Committee so important?
I firmly believe we provide an excellent quality of care in Southern, but currently I think we would struggle to evidence that view. Mortality review is an important part of quality improvement in any organisation like this, and I would like us to be able to show that we do it well and learn from any issues in Southern.

How often do you meet?
Monthly.

How has the first eighteen months been?
Challenging! Of course there has been COVID- 19 to contend with, but also we have had to learn more about the regulatory framework within which we work. However, we have an excellent and diverse group of people on the committee, all of whom have contributed and we are slowly making our way forward!

What is the Southern Mortality Review Model?
The Southern Mortality Review Model provides a format for the systematic review of deaths that occur under the care of Southern District Health Board teams. This is to ensure that all deaths are reviewed and any suggestions for local or system wide improvements can be shared and implemented.

Where can staff find the model?
The Southern Mortality Review Model is on MIDAS: **102430** (this includes a reporting tool within the document).

The Southern Mortality Reporting Tool (standalone document) is on MIDAS: **102493**

The Model is a working document and feedback is welcome – if you have feedback relating to the document please email the Mortality Review Committee mortalityreviewcommittee@southerndhb.govt.nz

Meet the Committee

Members:

John Edmond	Cardiac SMO (Committee Chair)
Gail Thomson	Executive Director Quality & Clinical Governance
Tim Mackay	Deputy Chief Medical Officer
Nancy Todd	Associate Maori Health Officer
Kylie Butcherine	Consultant Medicines, Women's & Children's
James Goodwin	Service Manager General Surgery
Michelle Derrett	Social Worker Professional leader
Mike Hammond	Senior staff nurse Public Health
Rosie Hoyt	Oncology/Haematology Nurse
Sharon Ayto	Child Youth Mortality Review Co-ordinator
Sierra Beck	Emergency Medicine SMO
Fiona Thomas	ICU/Trauma Nurse
Hansjoerg Waibel	Intensivist
Duncan Watts	Anaesthetic
Heather Casey	Mental Health DON
Kath Paterson	Quality & Performance Improvement Facilitator

Feedback and expressions of interest
The committee would welcome feedback, and if you are a member of staff interested in being a part of the committee please email: mortalityreviewcommittee@southerndhb.govt.nz

Clinical Practice Committee News

With the formation of a Clinical Practice Committee and Mortality Review Committee, and a revamped Clinical Council, clinicians, managers and other staff now have more pathways to work together to help improve the provision of safe patient care and our patients' experience and outcomes.

Find out about the Clinical Practice Committee from the Chair, and read the inspiring story of how a successful application is making a difference to the lives of cardiac patients in our district.

Five minutes with Jo Krysa

A year and a half on since a Southern DHB Clinical Practice Committee was formed we spent five minutes with the Committee Chair, Dr Jo Krysa, General Surgery Specialist to find out more about the committee and its role.

Why was the committee set up?

The Committee was set up as part of the DHB's quality framework to improve the provision of safe patient care and our patients' experience and outcomes.

What does it do?

Its main function is to support SDHB staff by providing a pathway to consider new procedures, techniques and technologies. We ensure the implications of a 'new way of doing things' have been evaluated. A second potential function of the committee is to develop a tool to prioritise 'new ways of doing things.'

Do you report to another Committee?

Yes – we report to the Clinical Council. Some applications need the Clinical Council to discuss them and make recommendations.

Why is a Clinical Practice Committee so important?

The Committee offers governance to oversee applications for the whole hospital. It allows transparency of process and clinical oversight. We are able to consider applications and give feedback with clear rationale as to why we approve them with 'no bias' decision making. Ultimately we look at what is best for our patients and for the DHB.

How often do you meet?

We meet monthly

How has the first year and a half been?

The committee has been on a journey to find out how to best support people and streamline processes for the benefit of the DHB and our patients. It's been a privilege to look at systems and processes outside of what I normally do.

Can you tell us about some of the proposals you've endorsed?

The committee has endorsed a number of proposals. One of the proposals was to administer azacitadine, a chemotherapy drug at home. Patients now have the convenience of treatment at home, especially if they live out of town.

We have also received a request for a drug bin in theatres. When the request came into the committee we felt a SDHB solution should be considered as it was such a good idea, not just in theatres, but also on the wards and in clinics. Since then a working group has been set up to consider options and identify best solutions for the DHB. It's great when someone comes up with a good idea for one department that can be utilised across the whole system.

If a member of staff has a proposal how do they apply?

All the information you need to can be found on MIDAS:

Policy
MIDAS 101751

Procedure for submitting a proposal
MIDAS 101752

Flowchart
MIDAS 101753

Application Form
MIDAS 101754

Meet the Committee

The Committee has a diverse membership with representation from procurement to infection prevention and control.

Committee members

Jo Krysa	Vascular Senior Medical Officer/ Clinical Lead
Gail Thomson	Executive Director Quality & Clinical Governance
Julie Rickman	Executive Director Finance, Procurement & Facilities
Gilbert Taurua	Chief of Mauri Health Strategy & Improvement
Ian Caird	Procurement Manager
Miranda Buhler	Physiotherapist
Nancy Sweeney	Theatre Charge Nurse Manager
Jared Vautier	Registered Medical Officer
Gary Hulm	Cardiology Charge Nurse Manager
Jo Stodart	Infection Prevention & Control Charge Nurse Manager
Trudy Sullivan	Health Economist
Mel Green	Charge Nurse Manager Psych General Services South Team
Katelyn Costello	Senior House Officer

Feedback and expressions of interest

The committee would welcome feedback, and if you're a member of staff interested in being a part of shaping our clinical practice please email:
ClinicalPracticeCommittee@southerndhb.govt.nz

Less travel for cardiac patients

A successful application to the Clinical Practice Committee means that Southern DHB cardiac patients can now have an Implantable Cardioverter/Defibrillator (ICDs) fitted in Dunedin rather than having to travel to Christchurch for the procedure.

An ICD is a type of pacemaker that helps keep the heart beating at a steady rate and can reduce the risk of a person dying from dangerous heart rhythms.

“ICDs are implanted in patients for a number of clinical reasons,” says Dr James Pemberton, Consultant Cardiologist who made the application to the committee.

“These are usually when there's a high risk that the patient’s heart could stop beating – a cardiac arrest. This may be because they've already had a cardiac arrest, or because their heart condition means they’re at high risk of having one.”

Pictured: Derek McKinnel during his recovery at Wakari Hospital with his wife Helen

A recent patient who benefited from having this procedure in Dunedin is Derek McKinnel. Derek’s heart stopped while he was driving, fortunately his wife was with him and CPR was started promptly. After spending three weeks in Southland Hospital with complications he was transferred to Dunedin Hospital and fitted with an ICD. He completed his recovery in the ISIS rehabilitation ward at Wakari Hospital.

Mr McKinnel’s wife Helen says having the procedure in Dunedin made a huge difference. “It was brilliant news that the procedure could be done in Dunedin and we didn’t have to go to Christchurch. It was really stressful with Derek being so unwell and I really don’t think I could have coped with driving that far – it would have been too traumatic.

"Being in Dunedin also gave me the opportunity to ask questions and discuss the procedure and implications fully with Dr Pemberton. It was another bonus that I knew the Doctor who was caring for Derek."

Consultant Cardiologist Dr John Edmond who performed the procedure says thanks to the successful application to the Clinical Practice Committee the SDHB cardiology department can now provide a full range of pacemaker implant procedures.

"This provides a better service for patients, it's more cost effective, staff have been able to upskill, and having the ability to fit ICDs is a positive factor for the future recruitment of new staff members to the team."

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Southern Health – Key Alliances**
Report to:	Board
Meeting Date:	8 December 2020

Summary:

As requested by the Community and Public Health Advisory Commtitee, attached is a slide explaining the Southern Health alliances.

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

Financial:	Nil
Workforce:	Nil
Other:	Nil

Document previously submitted to:	n/a	**Date:** n/a
Approved by Chief Executive Officer:	n/a	**Date:** n/a

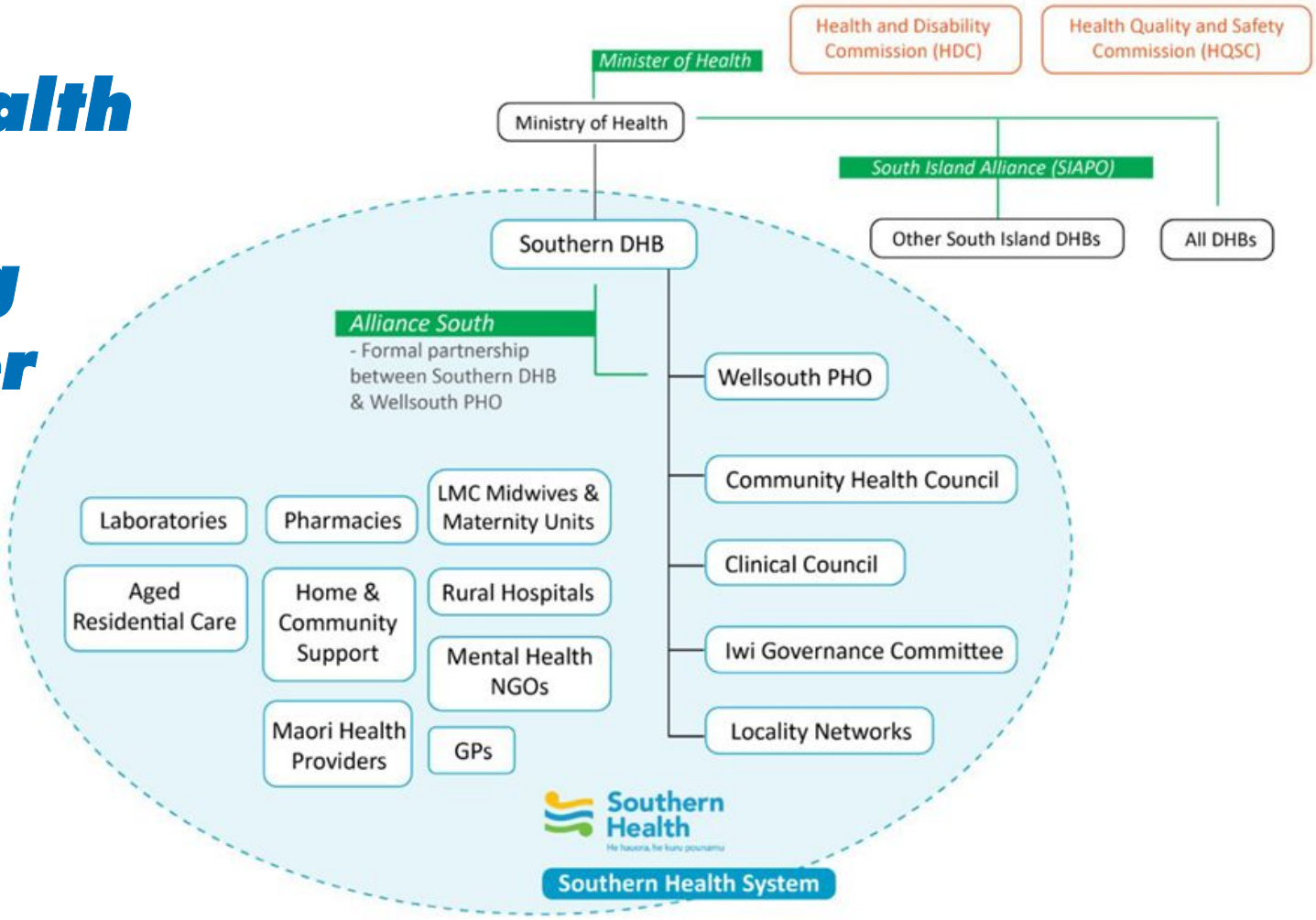
Prepared by: Strategy & Planning Date: 25/11/2020	**Presented by:** Lisa Gestro Executive Director Strategy Primary and Community

RECOMMENDATION:

1. That the information be received.

11.2

One health system, working together



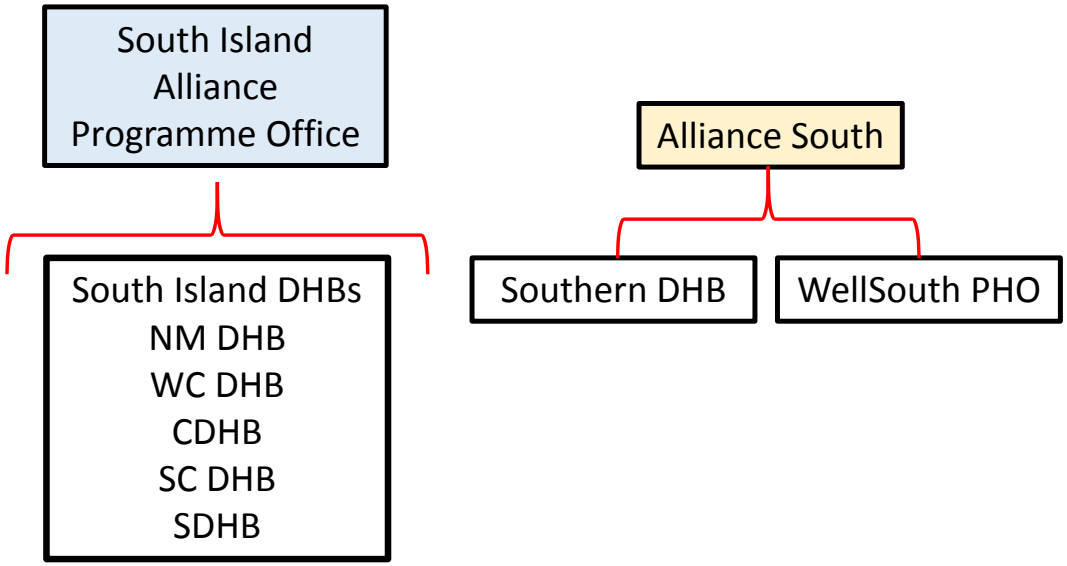
South Island Alliance Programme Office:

The South Island Alliance enables the South Island region's five District Health Boards (DHBs) to work collaboratively to develop more innovative and efficient health services than could be achieved independently.

Some of the successes of the Alliance so far have been the development of a South Island wide early-intervention eating disorder service; savings of $15 million through regional procurement; a regional workforce hub to support the workforce strategy and development of the health workforce for the South Island, particularly rural health professionals, and several integrated information service programmes that will improve regional patient administration.

Major projects that are underway include the regional rollout of information systems that enable electronic prescribing, electronic referrals and a single patient administration system across the South Island. Work is progressing on the Faster Cancer Treatment Plan to ensure patients journey from diagnosis to treatment is as streamlined and quick as possible (1).

Key alliances in the South Island as they relate to Southern DHB



Alliance South:

Healthcare alliances were established in all health districts across the country in 2013 to help DHBs and primary health organisations (PHOs) better work together and promote a 'one health system' view for the delivery of health care services.

In the Southern district, Alliance South is the partnership between Southern DHB and WellSouth primary health network, overseeing the implementation of the Primary and Community Care Strategy. Its aim is to promote better integration of health services to improve the health and well-being of people and communities across the Southern district (2).

11.2

References:

(1) https://www.sialliance.health.nz/about/

(2) https://www.southernhealth.nz/about-us/about-southern-health/alliance-south-leadership-team

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 ▪ 19 November 2020 Minutes b) Hospital Advisory Committee ▪ 2 November 2020 Minutes c) Iwi Governance Committee ▪ 7 December 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 ▪ New Dunedin Hospital ▪ Invercargill After Hours ▪ Pay Equity ▪ Oncology ▪ ICU Stage 2 Development ▪ ICU and Nursing Pressures ▪ Covid Vaccination Implementation Steering Group ▪ Ward 10A ▪ Coroner's Hearing	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.
Collective Insurance Risk Sharing Agreement	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Capex Requests ▪ Stereotactic Service – Additional Funding for LINACs ▪ Digital Programme	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.
Contract/Lease Approvals ▪ Strategy, Primary and Community ▪ Polaris IaaS Contract	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.

*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.