Southern DHB Board Meeting

By Zoom

07/04/2020 09:30 AM - 11:30 AM

APOLOGIES

An apology for lateness has been received from Mr Andrew Connolly, Crown Monitor.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Board Meeting
Date of Meeting:	7 April 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.

Interests 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:

- Lesley Soper's entry updated.

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 27/03/2020

RECOMMENDATION:

1. That the Interests Registers be received and noted.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Dave Cull (Board Chair)	09.12.2019	Daughter-in-law employed as a nurse by Southern DHB		
	25.02.2020	Board Member, Cosy Homes Trust		
	25.02.2020	President, Local Government New Zealand (until July 2020)		
	25.02.2020	Trustee, Weller Trust (Property investment)		
	25.02.2020	Director, Popaway Ltd (Property investment)		
David Perez (Deputy Chair)	13.05.2019	Director, Mercy Hospital, Dunedin	SDHB holds contracts with Mercy Hospital.	Step aside from decision making.
	13.05.2019	Fellow, Royal Australasian College of Physicians		
	13.05.2019	Trustee for several private trusts		
Ilka Beekhuis	09.12.2019	Patient Advisor, Primary Birthing FiT Group for Dunedin Hospital Rebuild		
	09.12.2019	Member, Otago Property Investors Association		
	09.12.2019	Secretary, Spokes Dunedin (cycling advocacy group)		
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
John Chambers	09.12.2019	Employed as an Emergency Medicine Specialist, Dunedin Hospital		
	09.12.2019	Employed as Honorary Senior Clinical Lecturer, Dunedin School of Medicine	Possible conflicts between SDHB and University interests.	
	09.12.2019	Elected Vice President, Otago Branch, Association of Salaried Medical Specialists	Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals.	
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	09.12.2019	Employee, Findex NZ		
	14.01.2020	Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust		
	14.01.2020	Member, National Council of Women, Southland Branch		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Lyndell Kelly	09.12.2019	Employed as Specialist, Radiation Oncology, Southern DHB	Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB.	
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
Jean O'Callaghan	13.05.2019	Employee of Geneva Health	Provides care in the community; supports one long term client but has no financial or management input.	
	13.05.2019	St John Volunteer, Lakes District Hospital	Nil	Taking six months' leave.
Tuari Potiki	09.12.2019	Employee, Otago University		
	09.12.2019	Chair, NZ Drug Foundation		
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd*		
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.12.2019	*Shareholder in Te Kaika		
Lesley Soper	09.12.2019	Elected Member, Invercargill City Council		
	09.12.2019	Board Member, Southland Warm Homes Trust		
	09.12.2019	Employee, Southland ACC Advocacy Trust		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	Sister-in-law, Employee of SDHB (Clinical Nurse Specialist Acute Mental Health)		
	15.01.2019	Shareholder, RST Ventures Limited		
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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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		
Roger Jarrold (Crown Monitor)	16.01.2020	CFO, Fletcher Construction Company Limited		
	16.01.2020	Member, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Management of staff conflicts of interest is covered by SDHB's Conflict of Interest Policy and Guidelines.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Kaye CHEETHAM	08.07.2019	Ministry of Health Appointed Member of the Occupational Therapy Board	
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
	01.07.2019	Capable NZ Assessor	Asked from time to time to assess students, bachelor and masters students final presentation for Capable NZ.
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.

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
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	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
Lisa GESTRO	06.06.2018	Lead GM National Travel and Accommodation Programme	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	NASO Governance Group Member	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	Lead GM Perinatal Pathology	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.

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
	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~~	~~Clinical Lead for HQSC Atlas of Healthcare variation~~	~~HQSC conclusions or content in the Atlas may adversely affect the SDHB.~~
	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
	~~07.08.2019~~	~~Father, Mayoral candidate for Waitaki District~~	~~Removed 27.11.2019~~
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	17.11.2017	Wife works for key technology supplier CCL	Nil
	18.12.2017	Daughter, medical student at Auckland University and undertaking Otago research project over summer 2017/18.	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
	23.10.2018	Shareholder and Director, Barr Burgess & Stewart Limited	Accounting services
		Specified contractor for JER Limited in respect of:	

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
	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

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Minutes of the Southern District Health Board Meeting

Tuesday, 3 March 2020, 9.30 am
Board Room, Southland Hospital Campus, Invercargill

Present:	Mr Dave Cull	Chair
	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	
	Dr Moana Theodore	
In Attendance:	Mr Andrew Connolly	Crown Monitor
	Mr Roger Jarrold	Crown Monitor
	Mr Chris Fleming	Chief Executive Officer
	Ms Kaye Cheetham	Chief Allied Health and Technical Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nigel Millar	Chief Medical Officer *(from 10.10 am)*
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Julie Rickman	Executive Director Finance, Procurement and Facilities
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary *(by videoconference)*

Unconfirmed

1.0 WELCOME

The Chair welcomed everyone to the meeting.

2.0 PUBLIC FORUM

Mrs Chris Henderson presented a submission on the DHB funding model and cited the closure of Lumsden Maternity Hospital as an example of poor decision-making resulting from the current funding model.

Mrs Henderson advocated that government, "forgive DHB debt forthwith and institute a funding model based on population plus need, require thorough and meaningful consultation with communities, as well as medical and managerial sectors" and that a second fund be created for buildings, so DHBs could focus on health outcomes, as well as staff recruitment, training and retention. In the meantime, Mrs Henderson requested that reinstatement of the Lumsden Maternity Centre and improvement of maternity services in Otago be made a priority.

3.0 OPENING KARAKIA

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

4.0 APOLOGIES

There were no apologies.

5.0 DECLARATION OF INTERESTS

The Interests Registers were circulated with the agenda (tab 4).

It was resolved:

"That the Interests Registers be received and noted."

D Cull/L Soper

6.0 PREVIOUS MINUTES

It was resolved:

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

L Kelly/L Soper

7.0 ACTION SHEET

The Board reviewed the Action Sheet (tab 7).

Valuing Patients' Time - ED Escalation Pathway

It was resolved:

"That the Board request:

- **A timeline and precise of the plan to develop an ED/hospital escalation pathway, to be submitted to the next meeting, and;**
- **That discharging patients earlier in the day be made a priority."**

D Perez/L Soper

8.0 ADVISORY COMMITTEE REPORTS

Community & Public Health and Disability Support Advisory Committees

The unconfirmed minutes of the joint meeting of the Community & Public Health and Disability Support Advisory Committees (CPHAC/DSAC) held on 3 February 2020 were circulated with the agenda (tab 8.1).

Mr Potiki, CPHAC Chair, highlighted the Committees' endorsement of the draft Southern DHB Disability Strategy and Action Plan for consultation and the approach for selecting primary birthing unit/s in Central Otago as part of the implementation of the Primary Maternity Strategy. He also reported that:

Unconfirmed

- The Committees had reviewed their terms of reference and, because of the connection between CPHAC and DSAC, it had been decided the two Chairs would work together and co-chair meetings;
- The Iwi Governance Committee had been invited to appoint representatives to the Board's advisory committees;
- The Committees had requested regular reporting on Māori Health.

During discussion, it was agreed that:

- Equity and cultural considerations would be added to the business case template;
- An orientation session on equity would be held after the next Board meeting.

It was resolved:

"That the unconfirmed minutes of the Community & Public Health and Disability Support Advisory Committee meeting held on 3 February 2020 be received."

T Potiki/M Theodore

Hospital Advisory Committee

Dr Perez, Chair of the Hospital Advisory Committee (HAC), gave a verbal report on the HAC meeting held on 2 March 2020, during which he highlighted the following items.

- The Committee's terms of reference included monitoring performance against the Annual Plan, so a decision needed to be made whether reporting against that should be split out to the advisory committees.
- HAC was also required to think strategically, so a standing item would be added to the Committee's agenda for suggestions to be referred to the Executive Leadership Team for consideration.
- The Committee received a report from the Executive Director Specialist Services covering elective service delivery, ED, outpatients, and cancer services. Because the meeting was held in Southland, some of the clinical management staff there were invited to contribute to the discussion.
- The Committee endorsed the proposal to develop a business case for a fifth theatre in Southland.
- The Committee was keen to see telemedicine developed for outpatient delivery.
- A briefing was received on COVID-19 and the impact of that on the hospital service. This highlighted that capacity to deal with severe cases was limited and there may need to be appropriate communication to manage public expectations.
- The Committee received a Health Roundtable report and wished to see a structured approach in response to that dataset.

Finance, Audit and Risk Committee

Mrs O'Callaghan, Deputy Chair of the Finance, Audit and Risk (FAR) Committee, gave a verbal report on the FAR Committee meeting held on 20 February 2020, during which she advised that:

- The Committee's terms of reference required further work and would be submitted to the next meeting.

Unconfirmed

- The financial report for January 2020 was considered and the Committee was pleased to receive improved reporting on expenditure management plans.
- A request was made for rolling productivity metrics.
- A report on Health and Safety was received and the current focus on completing critical risk profiles and compliance checks noted.
- A Quality and Clinical Governance Report was presented and provided an update on a range of metrics.
- The Committee again expressed concern about the lack of progress in medical staff credentialing and requested further follow-up.
- The Committee was pleased to note the Mortality Review Committee's progress and looked forward to receiving further quarterly reports from the Committee.
- The Strategy and Planning Manager gave an update on inter-district flows (IDFs).
- The Strategic Risk Register was considered by the Committee and would be submitted to the Board quarterly.
- The Clinical Risk Register was not available but the Committee expected to receive it at their next meeting.
- Good progress was being made on the Digital Strategy Action Plan.

9.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 9) was taken as read and the following items highlighted during discussion.

The Chief Medical Officer joined the meeting at 10.10 am.

Population Projections

Population projections, based on 2018 Census information, and the population based funding formula (PBFF) were discussed.

The Board requested that an explanation of funding and PBFF be included in its training/orientation programme.

Linear Accelerator (LINAC) Replacement Programme

The CEO informed the Board that a report had been received about LINAC capacity across the region. The South Island view was that additional LINACs in Nelson and Christchurch were a priority and projections showed a fourth LINAC would be required in Southern DHB. He advised that consideration needed to be given to where that should be placed within the district.

Management provided the following advice in response to members' questions.

Valuing Patients' Time (VPT)

The CEO clarified that the key focus of VPT was to improve patient care, eg by reducing stranded patients and blockages in patient flow through the hospital; making savings as a result was secondary to that.

Unconfirmed

Implementation of the Primary and Community Strategy

The Executive Director Strategy, Primary and Community (EDSP&C) advised that there was a matrix of activity to implement the Primary and Community Strategy, some of which was predicated on Health Pathways. She cited wound management as an example of how a network of care could operate, with senior secondary clinical staff supporting primary care.

Dunedin Physiotherapy Pool

The CEO reported that Southern DHB was in negotiations with the Physiotherapy Pool Trust to lease the pool to them until the current Dunedin Hospital closed. When it did, the energy source that heated the pool would no longer be available, and the future use of the land it was on was yet to be determined. The Physiotherapy Pool Trust was responsible for the maintenance of the pool.

Staff Engagement Activities

The CEO informed the Board that another staff engagement survey would be undertaken later in the year.

It was resolved:

"That the Board note the CEO's report."

D Cull/J O'Callaghan

10.0 FINANCE AND PERFORMANCE REPORTS

Financial Report

The Financial Report for the period to 31 January 2020 (tab 10.1) was taken as read and the Executive Director Finance, Planning and Funding (EDFP&F) took questions.

Cash Flow

The EDFP&F reported that the $25m advance on revenue had been received from the Ministry of Health.

Volumes

A summary of volume throughput to 31 January 2020 (tab 10.2) was taken as read.

Performance Dashboard

The Board considered the performance dashboard to 31 January 2020 (tab 10.3), and additions and improvements to it were discussed.

It was resolved:

"That the reports be noted."

D Cull/I Beekhuis

Unconfirmed

11.0 CHANGE MANAGEMENT AND BENEFITS REALISATION PLAN

The CEO presented a paper outlining the proposed Change Management Programme, which would be underpinned by a Benefits Realisation Plan, to prepare and realise system-wide benefits afforded by investment in the new Dunedin Hospital (tab 11). He advised that the plan was still 'work in progress' and would be reported on quarterly.

During its deliberation, the Board suggested that clinical input into the plan be made explicit, equity be embedded from the start, and requested that a key be added to the plan timeline chart.

It was resolved:

"That the Board:

- **Note the background to, and overview of, Southern DHB's Change Management Programme and the accompanying indicative Benefits Realisation Plan;**
- **Endorse the Change Management Programme as described and note that additional work is underway to develop the accompanying draft Benefits Realisation Plan (Appendix 4); and**
- **Note that quarterly updates on progress will be provided to the Southern DHB's Board, via a dashboard approach".**

I Beekhuis/J O'Callaghan

12.0 ANNUAL PLAN 2019/20 PROGRESS REPORT

The Board considered a progress report on performance against the 2019/20 Southern DHB Annual Plan (tab 12) and requested:

- Further information on what was being done to meet diabetes targets;
- That management investigate and report back on stroke services and the accuracy of the statement that, "patients with acute strokes not being managed in the Dunedin Acute Stroke Unit … are typically post-operative patients";
- That PHO performance indicators be submitted to the Community and Public Health Advisory Committee;
- Progress reporting be provided for all high risk areas.

It was resolved:

"That the Board:

- **Note the progress in Quarter Two in delivering the Southern DHB Annual Plan 2019/20 and the intended actions where activity is incomplete;**
- **Note Southern DHB Performance Reporting to the Ministry of Health for Quarter Two 2019/20.**

L Soper/D Perez

Unconfirmed

PUBLIC EXCLUDED SESSION

***At 11.40 am, 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 Reports a) Finance, Audit & Risk Committee, 20 February 2020 b) Hospital Advisory Committee, 2 March 2020	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 a) Waitaki District Health Services b) Industrial Negotiations/Issues	Commercial sensitivity and to allow activities and negotiations (incl commercial and industrial negotiations) to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Contract Approvals a) 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.
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.

***At 12.35 pm, it* was *resolved*:**

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

The meeting closed at 12.35 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Unconfirmed

Southern District Health Board

BOARD MEETING ACTION SHEET

As at 31 March 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020	**Fleet Vehicle Management** (Minute item 5.0)	Quarterly progress reports to be provided.	EDFPF		June 2020
Sept 2019 Oct 2019 Mar 2020	**Valuing Patients' Time (VPT) - ED Escalation Pathway** (Minute item 9.0) (Minute item 4.0) (Minute item 7.0)	Update to be provided on the development of an ED escalation pathway. Timeframe to be provided. ▪ A timeline and precise of the plan to develop an escalation pathway to be submitted to the next meeting. ▪ Discharging patients earlier in the day to be made a priority.	EDQCGS CEO/ EDSS	Raised at Clinical Council, plan being developed. Due to COVID-19, a response to this action has been delayed.	 September 2020
Feb 2020	**Clinical Council** (Minute item 5.0)	Quarterly reports to be submitted to Board.	CEO/ EDQCGS	Will be submitted to DSAC/CPHAC meeting.	
Feb 2020	**Trust and Bequest Funds** (Minute item 6.0)	Breakdown of donated funds held by SDHB to be provided.	EDFPF	Data collated and being reviewed. The schedules are being tied back to source documentation.	~~April 2020~~ May 2020
Feb 2020	**Risk** (Minute item 6.0)	Top five major risks to be reported to the Board quarterly.	CEO	Will be reporting at Board meeting closest to end of each quarter.	April 2020
Feb 2020	**Resourcing Implication of PHARMAC Decisions**	Further information to be provided, including explanatory	EDSPC	A report will be provided.	April 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
	(Minute item 8.0)	detail on the growth areas, eg the number of patients receiving high cost drugs over time and the clinical areas involved.			
Feb 2020	**Performance Dashboard** (Minute item 9.0)	▪ Caseweights per FTE to be added as a productivity indicator; ▪ Graph axes to be reviewed; ▪ Guidance to be provided on each graph.	EDQCGS	In development. Report not available this month, due to staff being diverted to COVID-19 response.	~~April 2020~~ May 2020
Feb 2020	**CT Capacity** (Minute item 9.0)	▪ All options (including resourcing) and recommendations for addressing short and medium term CT capacity to be developed. ▪ A business case (including the clinical case) for a second Dunedin CT to be developed in consultation with Southern Alliance.	EDSS	A report will be provided when available. This has been impacted by the Corona Virus situation A report will be provided when available. This has been impacted by the Corona Virus situation	TBC TBC
Mar 2020	**Business Cases** (Minute item 8.0)	Equity and cultural considerations to be added to the business case template.	CEO	Noted and being implemented.	
Mar 2020	**Funding and PBFF** (Minute item 9.0)	To be a Board training/orientation topic.	CEO		TBC
Mar 2020	**Change Management and Benefits Realisation Plan** (Minute item 11.0)	Clinical input into the plan to be made explicit, equity embedded from the start, and a key added to the plan timeline chart.	CEO	Will be woven into the plan when it is updated, iteratively, in coming months.	
Mar 2020	**Annual Plan 2019/20 Progress Report** (Minute item 12.0)	▪ Further information to be provided on diabetes services. ▪ Management to investigate and report back on stroke	EDSP&C		TBC

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		services and the accuracy of the statement that, "patients with acute strokes not being managed in the Dunedin Acute Stroke Unit … are typically post-operative patients". ▪ Progress reporting to be provided for all high risk areas. ▪ PHO performance indicators to be submitted to the Community & Public Health Advisory Committee.			

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 2 March 2020, commencing at 1.30 pm in the Board Room, Southland Hospital Campus, Invercargill

Present:	Dr David Perez	Chair
	Mrs Jean O'Callaghan	Deputy Chair
	Dr John Chambers	Committee Member
	Mr Dave Cull	Committee Member
	Dr Lyndell Kelly	Committee Member
	Miss Lesley Soper	Committee Member *(until 2.55 pm)*
	Dr Moana Theodore	Committee Member
In Attendance:	Ms Ilka Beekhuis	Board Member
	Mrs Kaye Crowther	Board Member
	Mr Terry King	Board Member
	Mr Tuari Potiki	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mr Patrick Ng	Executive Director Specialist Services
	Dr Tim McKay	Deputy Chief Medical Officer *(from 2.55 pm)*
	Dr Nigel Millar	Chief Medical Officer *(from 3.15 pm)*
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chair welcomed everyone to the meeting.

2.0 APOLOGIES

Apologies were received from Mr Andrew Connolly and Mr Roger Jarrold, Crown Monitors, and the Chief Nursing and Midwifery Officer. An apology for lateness was received from Dr Nigel Millar, Chief Medical Officer, and Miss Soper tendered an apology for an early departure.

3.0 DECLARATION OF INTERESTS

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

The Chair asked for any changes to the registers to be sent to the Board 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."

Unconfirmed

4.0 PREVIOUS MINUTES

The Executive Director Specialist Services (EDSS) was asked to confirm the accuracy of the minute on Radiation Oncology and if appropriate correct it.

***It was resolved**:*

"That, subject to clarification of item 6.0, Radiation Oncology, the minutes of the meeting held on 27 November 2019 be approved and adopted as a true and correct record."

5.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 4).

Radiology - Virtual Ward

It was agreed that this item would be kept open, pending clarification of the reason for the low utilisation of the virtual ward.

Nitrous Oxide Usage

The Committee requested a report back on the outcome of the investigation into the high use of nitrous oxide on the Dunedin site.

Winter Planning

The Committee requested an update on winter planning prior to May 2020. It was agreed that this would be submitted to the April 2020 Board meeting.

Terms of Reference

The Chair summarised the responsibilities of the Hospital Advisory Committee, as set out in its terms of reference, and advised that he and the EDSS were giving consideration to how these could be built into future agendas. "Future Strategies" would be added as a standing item, to enable the Committee to collect suggestions and schedule them for consideration at future meetings.

Dialysis Unit at Southland Hospital

The Committee received advice that the Southland Board members had been approached by a group who wished to present to the May meeting regarding a dialysis unit at Southland Hospital. It was agreed that the request be submitted to the Chair in writing.

6.0 PROVIDER ARM MONITORING AND PERFORMANCE REPORTS

The EDSS introduced Simon Donlevy, General Manager, Medicine, Women's and Children's Health, Jo McLeod, Southland Director of Nursing, and Megan Boivin, General Manager Operations, and they were invited to join the meeting.

Executive Director Specialist Services' Report (tab 5)

The Executive Director Specialist Services (EDSS)' monthly report was taken as read and the following items highlighted during discussion.

Unconfirmed

Planned Care Surgery Performance (Elective Surgery)

The EDSS explained the elective surgery target, the processes in place to meet that target, and initiatives to increase capacity. He reported that planned surgery was about 50 caseweights ahead of plan for the year to date.

The Committee expressed support for a fifth operating theatre at Southland Hospital and improvements in the patient discharge process in order to increase capacity.

Correction: The EDSS advised that the last sentence of the penultimate paragraph on page 3 of his report should read, "*acute* surgery is bulk funded as part of our base funding."

Outpatient Performance - First Specialist Appointments

The EDSS reported that there was a programme of work focused on improving performance against Elective Service Performance Indicator (ESPI) targets, which included:

1. Implementing the Ministry of Health prioritisation tool
2. Booking outpatient appointments on an 'acuity basis', and
3. Reviewing the full waitlist on a regular basis to eliminate data quality errors.

Measurement of Need

The Committee discussed the measurement of need for service planning purposes. The EDSS advised that he would obtain comparative standardised intervention rates per hospital for the Committee's consideration.

Telemedicine

The Committee requested reporting, including targets, for telemedicine outpatient clinics.

Dunedin Emergency Department Performance and Generalism

Dr Chambers' interest, and potential conflict, in this item was noted.

The EDSS explained the "Generalist" approach for admitting medical patients and the process for developing a business case to implement this.

The Committee requested:

- Background information on Generalism;
- Equity ramifications be included in the Generalism business case.

Southland Emergency Department (ED) Performance

Management commented on the high presentation rate at Southland ED, the factors contributing to this, and the impact on staff.

At 2.55 pm Miss Soper left and the Deputy Chief Medical Officer joined the meeting.

Radiation Oncology

Consideration of Interest: It was noted that this item did not have a direct impact on Dr Kelly.

The EDSS gave an update on the current status of radiation oncology capacity, during which he reported that the current waitlist for First Specialist Appointments (FSAs) was close to 100, when ideally it should be 50, which meant that less urgent cases were waiting 6-8 weeks on average, instead of 4 weeks. The EDSS then outlined the initiatives in place to enable more FSAs to be seen. Other means of

Unconfirmed

easing the pressure, eg employing additional Registrars and supporting their Fellowship, were suggested

Health Targets

The Committee reviewed performance against Health Targets and:

- Noted that a report on Radiology would be available in April 2020;
- Requested Radiology reporting be expanded to include other modalities, eg ultrasonography.

Financial Performance Summary

The January 2020 financial results for Specialist Services (tab 5) were taken as read and the EDSS advised that:

- Clinical Supplies and Outsourced Clinical Services were presenting some challenges;
- Nursing workforce costs were favourable due to the amount of leave taken in January 2020.

***It was resolved**:*

"That the reports be noted."

CONFIDENTIAL SESSION

At 3.15 pm 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. Building Projects	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the OIA.
3. Budget	Annual Plan - Subject to Ministerial approval.	Section 9(2)(f)
4. Health Roundtable Briefing	Information provided in confidence.	Section 9(2)(ba)

Confirmed as a true and correct record:

Chair: _____

Date: _____

Unconfirmed

SOUTHERN DISTRICT HEALTH BOARD
FINANCE, AUDIT AND RISK COMMITTEE
19 March 2020

RECOMMENDATIONS TO BOARD:

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

Finance, Audit and Risk Committee Terms of Reference

"That the Board approve the proposed amendments to the Finance, Audit and Risk Committee's Terms of Reference."

Bribery and Corruption Policy

"That the Board approve the Bribery and Corruption Policy."

Health, Safety and Welfare Charter

"That the Board approve the Health, Safety and Welfare Charter."

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Finance, Audit + Risk Committee Terms of Reference (District)

These terms of reference (TOR) set out the scope, responsibility, accountability and membership of the Finance Audit and Risk Committee (FAR Committee) to enable the FAR Committee to give advice and recommendations to the board members of Southern District Health Board (Southern DHB) on audit, financial and risk management matters.

Finance, Audit and Risk Committee

Purpose

To assist the board members of Southern DHB board in fulfilling their responsibilities relating across all financial and risk based operational areas namely Governance, Funder and Provider-arm.

These responsibilities include but are not limited to those set out in sections 39 and 41-42 New Zealand Public Health and Disability Act 2000 (NZPHD Act) and section 51 and part 4 Crown Entities Act 2004 (CE Act) and related regulations.

~~**Note: F**or the purpose of this TOR, reference to the board or chair includes the commissioner and deputy commissioners.~~

Scope

To give advice and recommendations to the board members of Southern DHB on audit, financial and risk management matters ~~including~~ through review and consideration of:

- ~~Assurance that c~~Control mechanisms ~~are~~ in place to ensure compliance with legislation, regulations, and Ministry of Health strategies relating to the services provided or funded by Southern DHB.
- ~~Assurance that the Southern DHB has appropriate service agreements, m~~Monitoring and audit~~ing~~ processes in place to optimise financial and operational outcomes.
- ~~Assurance that f~~Financial matters including funding, operating expenditure, capital expenditure, financial, and strategic planning are appropriately managed.
- ~~Assurance that appropriate i~~Internal and external audit~~s are carried out to ensure internal control systems are robust.~~ designed to test the robustness of internal controls.
- ~~Assurance that i~~Internal and external systems ~~are~~ in place to identify and manage financial, clinical and other operational risks. ~~through robust contingency planning~~.
- ~~Assurance that the appropriate s~~Systems are in place to meet obligations arising from health and safety ~~legislation~~obligations.

Responsibilities

Audit

- Overseeing the audit function ~~-~~and recommending to the board an appropriate internal audit work plan. ~~that is prioritised by the DHB's key risk areas.~~
- ~~Assist the external auditor to identify risks and issues relevant to the external audit planning process.~~
- ~~Liaise with the internal auditor, review the internal audit scope, planning and resourcing.~~
- Oversee the annual external audit process.
- Recommend to the board the appointment of the internal auditor and periodically review the performance and effectiveness of the internal auditor.
- Receive the reports of the internal and external auditors and review their findings and management's responses.
- Meet with both the internal and external auditors at least once per annum with management excluded.
- Monitor the progress made by management in implementing recommendations arising from internal and external audit.

Financial ~~Planning and~~ Reporting

- ~~Review the development of the board's financial and operational strategies both long and short term~~.
- Develop a work plan identifying the key time frames for accountability documents and other legislative requirements relevant to the committee.
- Review the annual budget assumptions and budget plan.
- ~~Review~~ Monitor capital ~~expenditure financial parameters,~~expenditure and asset management. ~~planning and their relationship with service planning.~~
- ~~Review~~Review ~~all~~ significant or statutory accounting policy changes and recommend acceptance by the board.
- Review district annual plans, statements of intent and district strategic plans for their financial impact.
- Review CFIS and the annual report ~~with the chief executive officer, chief financial officer, executive director planning and funding and the external auditors~~ and recommend acceptance by the board.
- ~~Review and advise the board regarding finance related policies and procedures requiring board approval, including an annual review of its delegation policy.~~

- Monitor the financial performance and position of Southern DHB against budget and forecast. ~~in addition to the normal monthly board financial reporting.~~
- ~~Develop a work plan identifying the key time frames for accountability documents and other legislative requirements relevant to the committee.~~
- Monitor capital expenditure against budget and large capital projects.

Risk and Financial Management Oversight

- Monitor~~ing~~ systems in place to ensure that Southern DHB complies with its obligations under key legislation and keeps other legislative compliance arrangements under review.
- Review the risk management ~~strategy~~ policy for Southern DHB and monitor its implementation and regular risk reporting processes.
- Review and monitor options for annual insurance cover within the DHB national collective approach to insurance. ~~Any shortfall or risk identified by the committee shall be reported to the board.~~
- Receive and monitor reports of alleged fraud and Fraud Hotline use in line with the Fraud Policy (District) (25546).
- Review ~~organisation wide~~ risk assessments and management processes and monitor appropriate, timely action and contingency planning to manage risks.
- Review the approach to maintaining an effective internal control framework, including external parties such as contractors, is sound and effective.
- Consider and oversee the fraud prevention strategy, policies and procedures for the board. ~~board and recommending to the board an appropriate Fraud Policy (District) (25546) and Fraud Prevention Framework.~~
- ~~Receive~~Receive and investigate disclosures under Southern DHB's Protected Disclosures / Whistle-blowing Policy (District) (19708) ~~where it is not appropriate for these to be received and investigated by the chief executive~~.
- Oversee the development and~~,~~ maintenance ~~and compliance with~~of a robust framework of governance policies ~~and procedures~~ designed to provide an appropriate system of internal controls.

Accountability / Reports to	The FAR Committee is constituted by the board under clause 38 of schedule 3 to the NZPHD Act 2000 and must operate in accordance with directions from the board. Any recommendations made by the FAR Committee must be ratified by the board prior to any release of recommendations or decisions to other parties. Any decisions that are sub-delegated and made by the FAR Committee must be ratified by the board. The internal auditor is responsible to the board through the chair of the FAR Committee. The internal auditor reports to the committee against an agreed programme as determined by the FAR Committee.
Membership	The FAR Committee comprises of at least three members and any external advisor with the appropriate skills and experience if required. The chairperson will be appointed by the ~~committee~~board. Committee members shall be appointed for the term of the board.~~.~~ In the absence of the appointed chairperson, the deputy chairperson will act as chairperson. If both the appointed chairperson and deputy chairperson are absent, the committee shall elect a member to act as chairperson for the purposes of any properly constituted meeting. The following individuals, while not members of the FAR Committee, will ~~be invited to~~ be in attendance ~~by the committee when appropriate~~: ▪ Chief Executive Officer ▪ ~~Chief financial officer~~Executive Director, Finance, Procurement and Facilities ▪ Executive Director, Quality and Clinical Governance Solutions The following individuals will be invited to be in attendance by the committee when appropriate: ~~▪~~ ▪ Executive management staff ▪ ~~Risk and quality manager~~ General Manager, Health, Safety and Welfare ▪ Internal auditor and external auditor ~~Committee members shall be appointed for the term of the board.~~
Conflict of Interest	Conflicts of interest are to be declared by members and staff when a potential conflict exists with an agenda item. A register of interests shall form part of each committee meeting's agenda.

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7.2

Meetings	Committee meetings are to be held regularly, with no less than four and up to twelve meetings per annum.
Quorum	A quorum shall consist of a majority of all committee members or half if the membership is an even number.
Review	These terms of reference shall be reviewed annually by the board.
Access and Reporting	The FAR Committee has confidential access to the internal and external auditors (and vice versa) as required to ~~fulfill~~fulfil its objectives, roles and responsibilities. It also has access to the Southern DHB's chief executive officer and ~~chief financial officer~~executive director finance, procurement and funding and to any other staff through the chief executive officer. The FAR Committee is authorised by the board to obtain outside legal or other independent professional advice if necessary to ~~fulfill~~fulfil its role. The FAR Committee shall report its activities via its minutes to the board.
Information	The following information will be supplied to the FAR Committee: **Audit** ▪ Draft and final internal and external audit plans and strategies. ▪ External audit engagement, arrangements and representation letters. ▪ Internal and external audit reports/letters (draft and final). ▪ Schedules of action points and reporting of management's progress with implementation. **Financial Reporting and Monitoring** ▪ Draft and final financial statements of Southern DHB. ▪ Proposals to change accounting policies and their impact. ▪ Draft and final annual plans, strategic plans and annual report. ▪ Finance related policies and procedures of Southern DHB and details of any planned amendments. ▪ Monthly management accounts and financial reports~~, as supplied to the board and other board committees~~. ▪ Asset management and capital expenditure plans. ▪

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Risk Management Oversight

- Risk management policies, procedures and regular risk register reports.
- A schedule of governance policies with current and review dates.
- Governance policies and procedures.

Associated Documents:

- Fraud Policy (District) (25546)
- Protected Disclosures / Whistle-blowing Policy (District) (19708)
- Treasury Policy (District) (47832)
- Internal Audit + NGO Auditing Policy (District) (44704)

References:

Legislation:

- Public Records Act 2005

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Bribery and Corruption Policy

Introduction:

Southern District Health Board is committed to maintaining the highest ethical standards in business conduct and to complying with all applicable anti-bribery and corruption laws. This commitment is embodied in our Code of Conduct, which requires us all to act with integrity, honesty and transparency and comply with the law.

Bribery and corruption is criminal in both the public and private sectors in New Zealand. Offences apply to transactions that happen domestically and those that occur overseas. A New Zealander or New Zealand organisation may also be prosecuted under overseas legislation. This Policy extends beyond our individual responsibility to comply with bribery and corruption law globally, to ensuring that any third parties we engage to act on our behalf do the same.

This Policy should be read in conjunction with the Code of Conduct and Integrity Policy, Fraud Policy, Sensitive Expenditure Policy, Koha Policy, Protected Disclosures/Whistleblower Policy, Disclosure of Interests Policy, Managing Gifts and Sponsorship Policy and the Procurement and Purchasing Policy.

SCOPE PURPOSE & DEFINITIONS

Policy Applies to	This is policy applies to employees, joint appointments, contractors, Board members, volunteers, students and other representatives of Southern District Health Board.
Policy Purpose	The purpose of this Policy is to provide guidance and education about what is considered Bribery and Corruption and to set out Southern District Health Board's expectations.
Definitions	**DHB:** Southern DHB, hereafter, will be referred to as the DHB. **Bribe:** The offer, promise or giving of anything of value in order to improperly influence a person's actions or decisions to gain or retain a business benefit. Bribery and corruption can take many forms including, the provision or acceptance of cash payments, facilitation payments, kickbacks, political contributions, charitable contributions, social benefits, favours, preferential treatment, gifts, travel, hospitality and rebates or reimbursements. **Corruption:** The misuse of entrusted power or office, whether in the public or private sector, for private gain. **Due Diligence:** An investigation of a business or person prior to signing a contract, or a standard of care taken before entering into an agreement or a transaction with another party.

Facilitation Payments: Facilitation payments are typically small, unofficial payments made to secure or expedite a routine government action by a government official. These constitute Bribes under the law, regardless of whether they are a "way of doing business" or "local way of working" in a particular country.

Public Official: Those in government departments, including employees of government-owned commercial enterprises, international organisations, political parties and political candidates.

Kickback: Payment for awarding business given to a person in a position of power or influence for having assisted the supplier in relation to awarding of the business.

PRINCIPLES

Southern DHB has a zero tolerance approach to bribery and corruption.

Local ways of working do not override this policy

Due diligence is expected in all dealings with third parties.

Training will be provided to all employees about bribery and corruption

All instances of attempted or actual bribery and corruption must be reported Executive Director Finance, Procurement & Facilities

Following internal investigation, matters of suspected bribery and corruption will be referred to the New Zealand Police.

POLICY

Facilitation Payments

Facilitation payments or "kickbacks" of any kind must not be made or accepted.

Individuals who are asked to make a payment on behalf of Southern DHB must be mindful of what the payment is for, and whether the amount is proportionate to the goods and services being provided.

Third Parties

Southern DHB could be liable for the actions of third parties (e.g. agent, contractor, supplier, joint venture partner) acting on its behalf. Individuals engaging third parties must complete sufficient due diligence to confirm that bribery is unlikely, before any agreement or contract is signed or renewed, and before any work is undertaken under that relationship.

Situations where there may be a significant bribery risk or "red flags" which may raise concerns are outlined in **Appendix 1** of this Policy.

Results of due diligence must be documented and be available on request to management and Internal Audit.

All procurement shall be through a process that is open, fair and transparent and in compliance with the Procurement and Purchasing Policy, the Disclosure of Interests Policy and the Managing Gifts and Sponsorship Policy.

Public Officials

The provision of money or gifts to any Public Official for the purpose of influencing them in their official capacity is prohibited.

Record Keeping and Internal Controls

An effective system of internal control and monitoring of transactions shall be maintained at all times.

Individuals must maintain accurate and complete records (e.g. receipts and invoices) of payments made to third parties that evidence the business reason for transactions.

Training

All employees will be provided training on the Code of Conduct and how to recognise, avoid and respond to bribery and corruption during the induction process and thereafter annually.

Roles and Responsibilities

All Individuals are responsible for:

- Reading, understanding and complying with this Policy at all times;
- Being vigilant to "red flag" issues or significant bribery risks, which necessitate further due diligence;
- Raising with the Executive Director Finance, Procurement & Facilities any concerns about the possibility of a facilitation payment or any other kind of bribery or corruption prior to entering into any agreements or arrangements.
- Reporting any incidents of facilitation payments or kickbacks, or any other actual or potential breaches of this Policy or concerns to Corporate Legal Services and Executive Director Finance, Procurement & Facilities.

Management are responsible for ensuring that all those reporting to them:

- understand and comply with this Policy
- receive adequate and regular training on the Policy.

Executive Director Finance, Procurement & Facilities is responsible for providing guidance and direction when any individual brings concerns about potential bribery or corruption matters and escalating these where appropriate to the Board and/or Finance, Audit & Risk Committee.

As defined in the Fraud Policy, the threshold for reporting to the Board and Finance, Audit and Risk Committee (FARC), a significant event will usually involve a value of more than $1,000 or potentially impact on the reputation of the DHB.

Executive Director Finance, Procurement & Facilities is responsible for anti-bribery and anti-corruption training and awareness for individuals to support them in complying with their obligations under this Policy.

Compliance

Breach of this Policy may lead to disciplinary action, up to and including dismissal (or termination of existing contractual arrangements for contractors or other agents) in accordance with Southern DHB's Disciplinary Policy. In some circumstances, a breach of this Policy may result in civil or criminal liability.

The only valid exception to this Policy is where there is an imminent threat of physical harm. Should this occur, the incident must be reported immediately to Executive Director Finance, Procurement & Facilities.

SPEAK UP

Any known violations of this Policy may be notified to a Speak Up supporter, HR Business Partner, Executive Director Finance, Procurement and Facilities or confidentially through the fraudhotline@moh.govt.nz.

Retaliation against an individual for raising concerns or reporting improper, inappropriate or unethical behaviour in good faith under the provisions of this Policy, or participating in the investigation of a complaint, is prohibited.

If it is not appropriate to report the suspected violations through the above channels, then the alternates are:

- the chief executive officer; or
- the board chairperson; or
- the chair of the Finance, Audit & Risk Committee
- the National Fraud Hotline

The contact details for reporting suspected fraud to the chair of the Finance, Audit & Risk Committee are:

E-mail: CoA&R@shandthomson.co.nz

Phone: 03 4180020 ext 702

The DHB's Protected Disclosures Whistle-blowing Policy (District) (19708) and the Protected Disclosure Act 2000 cover staff reporting suspected bribery and corruption.

Associated Documents:

- Code of Conduct and Integrity Policy (District) (18679)
- Disciplinary Policy (District) (55569)
- Procurement and Purchasing Policy (District) (11400)
- Protected Disclosures / Whistle-blower Policy (District) (19708)
- Fraud Policy (25546)
- Disclosure of Interests Policy (27894)
- Managing Gifts and Sponsorship Policy (81063)
- Koha Policy (24622)
- Sensitive Expenditure Policy (48567)

References:

Legislation

- Crimes Act 1961 and Secret Commissions Act 1910
- Audit NZ Bribery and Corruption Fact Sheet http://www.oag.govt.nz/2014/auditing-standards

General Notes

Scope of Practice: Ensure you are fully qualified to perform the role specified in any document.
Deviations: If you need to deviate from any procedure, policy, or guideline, make notes and follow up.

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Document Data for XXXXXX V1

APPENDIX I – POTENTIAL BRIBERY / CORRUPTION RISK SCENARIOS: "RED FLAGS"

There are a number of issues i.e. "red flags" that may raise concerns and require further investigation/due diligence into whether a particular transaction presents a potential bribery issue. Potential issues that may call for further investigation include (this list is not intended to be exhaustive):

- A third party:
  - engages in, or has been accused of engaging in, improper business practices;
  - has a reputation for paying bribes, or requiring that bribes are paid to them, or has a reputation for having a "special relationship" with foreign government officials;
  - insists on receiving a commission or fee payment before committing to sign up to a contract, or carrying out a government function or process for the DHB;
  - requests payment in cash and/or refuses to sign a formal commission or fee agreement, or to provide an invoice or receipt for a payment made;
  - requests that payment is made to a country or geographic location different from where the third party resides or conducts business;
  - requests an unexpected additional fee or commission to "facilitate" a service, or a fee that is not published;
  - demands lavish entertainment or gifts before commencing or continuing contractual negotiations or provision of services;
  - requests that a payment is made to "overlook" potential legal violations;
  - insists on the use of side letters or refuses to put terms agreed in writing;
  - requests or requires the use of an agent, intermediary, consultant, distributor or supplier that is not typically used by or known to Southern DHB;
  - sends an invoice that appears to be non-standard or customised;
- An individual is offered an unusually generous gift;
- We have been invoiced for a commission or fee payment that appears large given the service stated to have been provided;
- Payments of unusually high fees or commissions;
- Requests for cash payments;
- Request for payments to different companies or to different countries;
- Undefined or unreported payments to third parties made on Southern DHB's behalf;
- Absence of written agreements;
- Unusually close relationships with Government officials;
- A refusal to certify compliance with this Policy.

Individuals who encounter any of these red flags or have other concerns must report them promptly to the Executive Director Finance, Procurement & Facilities.

Health, Safety and Welfare Charter

We, the Board and Chief Executive (CE) of Southern District Health Board (Southern DHB), acknowledge our duties and responsibilities under the Health and Safety at Work Act 2015 and our own Health, Safety and Welfare Policy.

We want to provide a safe and healthy workplace for our workers, patients and visitors. This Charter sets out how we will jointly lead health, safety and welfare at Southern DHB.

Commitment

We personally commit to exhibiting and promoting safe and healthy behaviours that are in line with our values. We are jointly committed to enabling and maintaining the right systems, structures, processes and resources to plan, deliver, monitor and improve health, safety and welfare practice and performance. We will:

Set the direction (plan):

- Maintain a Health, Safety and Welfare Policy, and ensure it is supported by a Strategy and Action Plan;
- Set measurable health, safety and welfare objectives for Southern DHB;
- Include health, safety and welfare outcomes as a specific, measurable, part of the annual CE performance review and ensure that a similar process is applied to management roles;
- Consider any impacts on health, safety or welfare when making decisions.

Engage and enable (deliver):

- Make available all necessary resources, so far as is reasonably practicable;
- Promote and cultivate a strong focus on risk management and injury prevention;
- Consult with workers and/or their representatives or unions on matters affecting health, safety or welfare;
- Encourage the Executive Leadership Team to lead health, safety and welfare.

Know what's going on (monitor):

- Acquire and maintain our knowledge of current work health and safety matters and good practice;
- Take interest in, and gain understanding of the work of Southern DHB and the risks involved in the work;
- Verify the provision and use of systems, structures, processes and resources we have enabled;
- Monitor health, safety and welfare key performance indicators, with emphasis on lead indicators;
- Require both internal and external auditing of practice and performance.

Drive improvement (review):

- Closely review health, safety and welfare reports and audit findings;
- Enable and/or support interventions or initiatives required to facilitate ongoing improvement;
- Review this Charter and its effectiveness, via the Finance, Audit and Risk Committee.

Dave Cull	Chris Fleming
Board	Chief Executive
Chairman	
_____	_____
Date ……	Date ……..

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	7 April 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:** 31 March 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. COVID-19

This month has seen dramatic developments with regards to COVID-19 (a type of coronavirus). From a Chief Executive perspective, life has changed dramatically. Many of the areas we saw as critical last month have paled into less significance and the entire team's oversight of COVID-19 has become all consuming. It continues to be a challenge in terms of recognising that we need to still pursue some 'business as usual' activiites as this process is going to take many months.

As an executive team, we have split ourselves into blue and gold teams and have put a process in place where the blue and gold team members only interact with each other electronically (one week blue team members are able to be at work in Dunedin, the second week they will need to work from home or be the executive presence in Southland and Queenstown). We are trying to replicate this through many teams to ensure there is a resilience in our workforce, but it is quite complex in terms of the different streams of patients (red and green), as well as the various shifts across the day.

Our approach to managing the situation is presented in the attached presentation (appendix 1) and we will talk through this at the Board meeting.

A complexity with regards to structures is such that in any other event, such as a flood, earthquake, snowstorm etc, Health is not the lead agency. In this event, Health is the lead agency and are required to establish an Emergency Coordination Centre (ECC) to coordinate across the entire event. On top of this, we have specific Emergency Operations Centres (EOCs). The delineation and function of the ECC v the EOCs has created some challenge and tension in the process. Equally, generally EOC functions cut across normal operational management responsibilities. In shortlived events, such as floods and snow storms, this is generally okay as they last for a limited number of days. In this event, the Pandemic is going to last for months and having separate responsibilities under the ECC/EOC and operational management does not make as much sense. We are therefore refining the structures to align EOC responsibilities to operational responsibilities and winding the ECC structure back to be a higher level oversight with the formalised linkages to Civil Defence, the National Health Coordination Centre and other external stakeholders.

Activity has been extensive and includes:

- Supporting the Public Health team in their efforts around active contact tracing.

- Southern Community Laboratories (SCL) stood up the third laboratory processing site in New Zealand in Dunedin.
- Supporting WellSouth Primary Health Network to establish the three Community Based Assessment Centres (CBACs) and the Designated Practices in the other parts of our region.
- Creating red, orange and green streams within our services – red for COVID-19 positive patients, orange for suspect COVID-19 patients, and green for patients who do not have COVID-19.
- Red and green streaming within the Emergency Departments (EDs) were the first area to be stood up, followed progressively by other areas.
- Ensuring we have the capability to have COVID-19 positive or suspected patients in the operating theatre environment. Clearly, this will only be done for life preserving activity, as otherwise it is safer to wait for recovery from the virus before operating.
- Looking at capacity options in terms of escalation plans. This has included committing to unbudgeted capital expenditure to maximise our ability to provide intensive care services to COVID-19 positive or suspected patients. Initially, Dunedin Hospital only had the capacity to manage two patients with either positive or suspected statuses. We now have three step-up levels available, with trigger points being when there are more than two cases requiring intensive care.
- Supporting the establishment of blue and gold teams wherever possible. This concept is separating our staff in teams to ensure that in the event staff do contract the virus (either from work or community setting) we do not lose entire functions. This is easier for Monday to Friday and non-frontline services, but when we move into the frontline services we have the complexity of working with red, orange and green stream patients as well as 24/7 rosters. Wherever possible, however we are supporting this approach.
- Encouraging those who can work from home to do so and providing them with the appropriate technology to do so.
- Developing and reviewing personal protective equipment (PPE) guidelines. This is one of the more critical areas as we must balance the utilisation of PPE with ensuring that the people who really need it have access to it. Our Technical Advisory Group (TAG) have provided some guidelines in the absence of national guidelines being finalised, and we will refresh our guidelines as and when national guidelines materialise. We need to ensure that the guidelines are balanced across the entire health and disability sector.
- Centralising logistics and workforce into single teams to ensure coordination across the district.
- Regular forums with the region's mayors to ensure that there is a balanced awareness of issues outstanding.
- Maintained a strong relationship with Civil Defence Emergency Management (CDEM), which includes linkages with Iwi, emergency services, Police etc.
- Strengthening our communications processes to ensure regular updates for both internal and external stakeholders.

How our staff, contractors, contracted providers and volunteers have stepped up to contribute to our response has been really impressive. There are clear examples of where things have been stood up in extremely short order when in normal times it would takes days if not weeks. A couple of examples of this include standing up the assessment centre for the Logan Park High School close contacts. Within five hours of identifying that we needed to test all the contacts we had a venue, infrastructure,

staffing, and coordination of getting 150 people to be tested established and the first test done. A second example was when we realised that we needed a larger Community Based Assessment Centre in Dunedin, we identified the facility on Cumberland Street that the Ministry of Health has acquired as a part of the New Dunedin Hospital development, the Ministry, WellSouth, and the Southern DHB Building & Property team swung into action and the building works, electrical, information techology, and clinical infrastructure was all actioned within 48 hours ready for the centre to open.

Another key thing we are seeing is significant changes in how people are accessing services. There has been a huge uplift in the use of virtual clinics in primary care, and there has been a tremendous reduction in presentations in emergency departments right across our district. Dunedin Hospital at the time of writing this report is only about 50% occupied in terms of beds. Whilst not all of this is sustainable, we need to look at the changes and identify those changes that have occurred which we should try and hold on to post the pandemic. Why would we not keep primary care optimising telemedicine. There will be funding issues that will need to be addressed to ensure that changes are sustainable for all parties, but there is a real opportunity to make significant inroads to improvements moving forward.

3. ORGANISATIONAL PERFORMANCE

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

- Finance report
- High Level Volumes
- Performance Dashboard.

The month of February was unfavourable to budget by $724k bringing the year to date result to a deficit of $24.287 million, which is $6.0 million adverse to plan. The issues remain largely the same as previous months. The obvious challenge now however with the COVID-19 pandemic is that we will now be facing significant cost pressures as we take all steps possible to mitigate the spread and reduce harm for any patients who do contract the virus. We will also now be facing a loss of revenue associated with cancelling deferrable activity. When we move to the recovery phase, it is likely we will need to utilise the private sector to catch up activity, but this will come at an unanticipated cost.

In terms of volumes, we are only reporting high level information at the Board level, it is expected that the Hospital Advisory Committee will be interested in a greater level of detail. Inpatient activity in February was almost identical to the same month last year, and on a year to date basis is 2.2% up on plan or 1.9% up on last year. The mix of inpatient activity is quite different with medical caseweights up 7.2% on the same year to date period last year, surgical is now down 1.3% and maternity almost identical. Acute surgical activity has dropped on the same time period last year by 3.0%. Mental health (measured in bed days) has also reduced by 0.6%. Looking at the emergency department (ED), overall volumes have grown by 1.2%, however it has reduced at Dunedin Hospital by 1.2%, increased at Southland Hospital by 3.9% and increased at Lakes District Hospital by 6.8%. While the ED volumes in Dunedin have reduced, the number of patients admitted has increased which has placed greater pressure on the ED and the wider hospital. There is considerable concern over the volumes in Southland as they are very disproportionate to the Dunedin ED despite their catchment population being so much smaller. This is an area of focus which needs some tangible actions, which will be both within the hospital and in primary care. The growth in Lakes District

Hospital is also alarming as there has clearly been a large step, which makes the medium term planning even more important.

The performance dashboard continues to require further work. It is now presented as three tables, the first being consolidated for the organisation and the second and third one being for Dunedin and Southland.

4. ANNUAL PLAN AND BUDGET 2020/21

The development of the annual plan and budget for 2020/21 continues to be very challenging. Presently there has been no feedback from the Ministry on either the draft annual plan or the draft budget. The challenge is that there are now so many unknowns including how long the Covid challenge will last and then what the recovery will look like. Since the last board meeting there has been very little focus on the plan or the budget. When we move into a more stable phase we will be able to return our attention to this.

5. LAKES DISTRICT HOSPITAL

Increased turnover of nursing staff at Lakes District Hospital is impacting on roster coverage. Delays in recruiting to a fixed term senior medical officer (SMO) position, the inability to fill the registrar position for the second half of 2020 and the short term implementation of four hour evening shifts to safely cover the emergency department over summer have resulted in significant roster gaps for SMOs in the latter part of this financial year. These staffing issues coupled with the potential impact on staff if COVID-19 spreads creates a risk to business as usual.

6. MUMPS OUTBREAK

We are continuing to manage an outbreak of mumps in Queenstown, with 30 confirmed cases since 23 December 2019 (as at the end of February). We are taking a pragmatic approach to vaccinating close contacts of mumps cases. To date, all the cases are living in Queenstown (although one case is under investigation in Cromwell) and in the 20-45 years age group. Many cases are from overseas, working in bars/hospitality etc and often living in houses with 5-7 others of similar age. Close contacts with uncertain or undocumented measles, mumps and rubella (MMR) vaccination status are being encouraged to immediately have an MMR vaccination which is free for them. There is evidence that the mumps component of the MMR vaccine wanes after 7-10 years and there is evidence that giving a third MMR for those who are fully vaccinated can help in containing a mumps outbreak. As most people cannot produce documented evidence of their vaccination status, we are erring on the side of caution and encouraging contacts to get an MMR vaccination as soon as possible.

7. BARIATRIC PATIENTS NEEDING RESIDENTIAL CARE

Over the past month, we have had three instances of bariatric patients in hospital who require ongoing residential care, and facilities are refusing to accept them. Issues include extra items (from hoists to linens to fit the bariatric beds) to size of rooms, to staffing requirements. While the age-related residential care (ARRC) funding model review addresses this issue, those solutions may or may not be implemented nationally, and if there are, not quickly. Additional resources have been deployed to assure that patients are moved to the right environment as soon as feasible.

8. SOUTHLAND FLOODING

On 4 February, we were altered to rising rivers levels and a Southland-wide declaration of emergency. Civil Defence requested an evacuation of Resthaven Care Home in Gore (60 beds at Rest Home, Secure Dementia and Hospital levels), which was facilitated by the Southern DHB health liaison at Civil Defence.

On 5 February, Southern DHB set up an Emergency Operations Centre in Dunedin and was notified that Wyndham Home (23 Rest Home level beds) was threatened with flooding and was cut off. While some residents from both facilities were able to return to family, 52 Resthaven residents and 14 Wyndham residents were shifted to 12 other facilities for up to three nights. Due to the declaration of emergency, decision-making was with Civil Defence.

The Southland Care Coordination Centre played a crucial role in assuring residents received the care required. Numerous DHB and facility staff went 'above and beyond' with excellent outcomes for all. All residents returned to their home facility on 7 February. Learnings have been noted and shared among the facilities, as we realise these events are bound to occur with increased frequency.

9. IMPLEMENTATION OF THE PRIMARY AND COMMUNITY STRATEGY

The System Integration Group (SIG) met in February to begin to map the strategic priorities for the 2020/21 year in terms of progressing the strategy.

There has been some dedicated reflection on understanding what we achieved in the previous nine months, and agreement that despite there being significant progress on Healthcare Homes, other priorities have not been progressed as quickly or as comprehensively as would have been liked. There are several reasons for this, which will continue to be explored, with a view to ensuring we make better inroads on critical pieces of activity in the next year.

One key principle will be to do less, but to do it better, as the view across both teams (DHB and WellSouth) is that we are taking too much on, and spreading our efforts too thinly. To this end, the agreed list of priorities for the 2020/21 year are:

- Redefined pathways leading to models of care for Health of Older People, Mental Health and Child Health
- Progress on Access to Diagnostics (in conjunction with specialist services, but focusing on community/non-acute pathways as a priority
- Development of a schematic that clearly paints a map of where integrated care spaces will be configured, including what services will be placed where.

Work on detailed work programmes, including any resourcing implications, is currently delayed due to COVID-19 work.

10. PRIMARY MATERNITY PROJECT

On 10 February a media release was issued signalling the beginning of the process to agree the future configuration of primary maternity facilities in Central Otago. Given the high level of interest in this objective, and in the strategy in general, determining the best configuration of primary birthing facilities in the Central Otago area will be a key priority, which will be managed in conjunction with the Central Lakes Locality Network (CLLN).

As at early March, over 250 responses have been received from the public, health professionals and others via the online webform. In addition, face-to-face meetings have been held during February with key stakeholders such as local Lead Maternity Carers (LMCs), General Practitioners (GPs) and the Maternity, Quality and Safety group.

Key considerations that have emerged from consultation to date are:

- 24/7 midwifery availability at birthing facilities preferred by LMCs
- Rapid access to urgent transport, especially helicopter, is essential
- Equity of travel times and access to primary birthing facilities for all parts of the district
- Co-location with other health services especially medical support is highly valued by public and professionals
- Need to take account of pace and locations of population growth and develop a future proofed proposal.

Work began in March, in conjunction with the Central Lakes Locality Network group, to develop the short list of options for detailed consideration. Delays are now expected due to the effects of COVID-19.

A project manager has been recruited for a one year fixed term to support the rollout of the Primary Maternity Strategy. She started in this position on 2 March.

11. HOME AND COMMUNITY SUPPORT SERVICES

The Home and Community Support Services (HCSS) contract with the existing three providers – Access, RDNS and Health Care NZ, is due to expire on 30 June 2020. A steering group was formed to look at options from 1 July 2020. This group used the Auckland UniServices Report (2012) and the Primary and Community Strategy as a basis to review the effectiveness of HCSS in the Southern Health system.

HCSS are an important part of the system around older people, and to optimise the effectiveness of HCSS we have to look at the wider model of care for older people, especially how the collective providers/services support them in the community.

We have made some meaningful changes to the model of care for older people over the past year where patients come to hospital (ED or inpatient). We now need to turn our attention to older people in the community where services are often fragmented and multiple providers can independently be working with patients. Examples include general practice, HCSS, district nursing, rehabilitation, hospice, and care coordination/needs assessment.

This is going to require changes to the way we work as a system with a more integrated network of providers working together around patients in their locality, especially our most vulnerable. We need to dovetail the development of our Integrated Community Teams for hospital avoidance and supported discharge with our HCSS in a way that:

- Avoids duplication of services
- Provides the most effective service for the client
- Provides effective transitions of care for those needing long term supports.

To do this, we need to:

- Work with our Southern DHB provided services and rurally-proved services and WellSouth to develop those Integrated Community Teams
- Work with our HCSS Providers to align those services to dovetail with the Integrated Community Teams.

We want to go to market for HCSS that are well integrated into our Primary and Community Strategy informed Community Teams. Progress has occurred nationally developing a National HCSS Framework, with a national Service Specification and Core Casemix system being developed (currently due to be released March/April 2020).

While we had hoped that all of the work referenced above would have settled by now, much remains dynamic. While the direction in the framework is well known, details on what may be mandatory and funding/pricing mechanisms are still being robustly debated. This lack of clarity creates some risks.

We are aware that the months preceding a national election is not the appropriate time to make significant changes.

We are recommending extending our current contracting arrangement with our HCSS providers for a further 24 months. The extended contract will allow for a co-design period where:

- Some HCSS services to be streamlined, e.g. short-term and those with rehabilitation potential, as our Community Integrated Teams develop. This will require engagement and flexibility across multiple localities
- By mutual agreement, HCSS adheres to the national service specification and core casemix methodology as it is finalised
- HCSS is incentivised to use technology to its potential.

12. LOCAL DIABETES TEAM (LDT) MINISTRY OF HEALTH VISIT

Following the Ministry and national clinical lead visit to Southern in 2018, which resulted in significant criticism being made of the DHB in respect to progress on delivering against the national Diabetes Standards, the national clinical lead and relevant Ministry officials visited Southern on 17 of February to check in on progress. The meeting was attended by the clinical leads and their teams, relevant managers from the hospital and primary and community and members of the Executive Team.

The Ministry lead discussed our progress against the standards, highlighting many areas where significant improvement is still required. In particular, there was a focus on gaps in the provision of adequate SMO cover in Southland Hospital and data reporting from primary care that suggests that while we have identified our type 2 diabetics in the community, we are not meeting the standards for monitoring and ongoing support of these patients.

We are now completing a self-assessment and work is underway to check and validate the data that has been submitted to the Ministry as there are concerns that we are not capturing activity properly. However, the Board should note that the final assessment is likely to highlight that we are still falling short of the level of care we would aspire to in many areas and significant work and focus is required to achieve the standards.

13. PHARMACY

Community Pharmacies that have the capability to deliver flu vaccine will have the scope of their contract extended to include all patients under 65 years of age who are immuno-compromised or have chronic conditions. The commencement date of the campaign is 16 March, rather than 1 April 2020.

14. SYSTEM LEVEL MEASURES

The responsible owners of each of the areas of the System Level Measures plan will be contacted to outline their actions and contributory measures for inclusion in this year's plan. A draft of the 2020/21 plan is currently due to the Ministry by 30 April.

15. INTEGRATING COMMUNITY BASED SERVICES FOR OLDER PEOPLE

The team have been working with Information Systems for many, many months with a goal to allow our three Home and Community Support Agencies (Access, HCNZ and RDNS) and our 65 aged residential care facilities, access to information on their clients/residents in our information system, Health Connect South (HCS), via Health One (used primarily by GP practices). This has overwhelming support, but is contingent on access via Health One, via Pegasus. We are making significant progress, with Access fully onboarded, HCNZ partially onboarded, and progress with onboarding RDNS. Additionally, the team have identified three aged care facilities to pilot. The result will be that all providers will have access to the same information about the older people they are supporting and caring for.

16. ELECTIVE SURGERY PATIENT FLOW INDICATOR (ESPI) RECOVERY

As noted in the HAC update recently, although we implemented the prioritisation tool with minimal resourcing, it has proven to be a key tool in the recovery of services and we have now implemented it into General Surgery in Dunedin and are in the process of bedding it in.

Several issues have been raised during the latest implementation. The first of which was that the triaging nurses could not see both the referral and HCS at the same time (they need to use HCS for any investigation work). This was easily solved by our Information Systems colleagues. The next issue was that further information is required from GPs to utilise the prioritisation tool as five additional questions now need to be answered. A meeting with the Ministry was set up to help guide the team in dealing with this and other issues, and the conclusion was that the team need to contact Southland GPs, clarifying the need for additional information. A letter has been drafted by the service in conjunction with the Medical Director for Primary Care, and the service planned to move forward with this in March.

At the same time, a 'snippet' is under development. The snippet will allow us to request the information from the GP in the electronic screen they see when they complete the electronic referral. The team also met with Carolyn Gullery (Executive Director Planning and Strategy at Canterbury DHB), together with the Ministry, and got agreement to make permanent changes to the Southern DHB electronic referrals to clearly request this information as part of the referral process. As well as making things easier for the nurses who triage the general surgery referrals in Southland, these changes will make further rollout of the tool more straight forward and will set us up well for when the Ministry starts to formally expect that the tool will be utilised in the coming years.

We are now also in the initial planning phases with General Surgery in Dunedin to utilise the tool there as well. Work has also occurred to collaborate with the gastroenterology service to provide much needed rectal bleeding clinics in Dunedin. This will assist us to get through what may be quite urgent cases faster and will assist with us staying on top of overall ESPI 2 performance.

17. ELECTIVE DELIVERY

Note: Subsequent to writing the below report being submitted we have now had to cancel all deferrable surgery and outpatient activity. This will significantly impact on our projections for the year. Once the limitations are lifted, plans will need to be in place to address catch up and as such the team are continuing to work on the initiatives detailed below as much as they are able.

As at the end of February, elective surgery continued to be impacted by cancellations caused either to complete more acute case load, or due to access block. Most cancellations in Dunedin in February were due to acute pressures. Additional acute weekend lists were put together, but sometimes unsuccessfully. The regular cancellation of elective cases to manage acute demands has been frustrating the teams and a meeting was held with the quality team in Clinical Governance to request to to document an improved set of processes that would allow any decisions to cancel elective patients to complete more acute work to be as robust as possible.

At the same time, an additional 'rolling' acute list was agreed to. This will be achieved by systematically converting one all day elective list into an acute list each week, rolling from Tuesday to Friday. This means that from a speciality point of view, specialities will only lose one list every 25 weeks or so, and the capacity gained will provide more assurance that we can manage overall acute volumes with less cancellation and associated disruption. Controls are being implemented alongside this change to ensure that the additional acute list is utilised productively. And the Executive Director Specialist Services is developing a brief model to determine whether a regular acute Saturday list can be implemented at zero or favourable net cost. To ensure sufficient utilisation the list would draw from both the accumulated acute hours at the end of the week and patients who have been placed on the acute home pathway for orthopaedics. General surgical patients will also need to be considered on a similar basis.

It is the belief of the team that this will create a net positive benefit when the additional Saturday lists that are being run as overtime when they are needed are taken into account and when the lost case weight activity is taken into account. Assuming that this can be demonstrated to be neutral or better a change control will then be raised seeking to increase staffing budgets slightly and to correspondingly reduce the outsourcing budget.

In Southland our main challenge is access block and the month of February saw a number of cancellations due to the inability to supply a bed. Whilst work will soon get underway in the ED initiative to improve patient flow, the available beds in Southland falls into the broader challenge that has been described as general capacity issues.

To try to progress the sterile services solution more quickly in Dunedin we met with representatives of the Dunedin Dental School, toured the children's pavilion and identified an initial space where we could de-cant the people who are currently in the space where the sterile services unit will be constructed into. At their request, we are now writing to them to ask for the minimum spaces that we need to be freed up prior to the current lease expiry date of December 2020. We believe that we may be able to develop a win-win solution, whereby the Dental School frees up the space

we need by July/August, and we can accommodate them if they need more time beyond December for the remaining space once their lease expires. We have now written to them and will continue the dialogue in the hope of speeding this much need project up.

We have tasked one of our team to do the ground work for the fifth theatre business case for Southland and this work is slowly getting underway. Key points which will need to be worked through in this case include demonstration that with all costs included there is a strong financial payback, a clear identification, articulation and costing for the supply and resourcing of the beds required by a fifth theatre (noting that Southland is regularly access blocked in terms of the current theatres, so a case for an additional theatre clearly needs the beds), and a robust discussion of the counterfactual of building a fifth theatre, i.e. outsourcing or outplacing more caseload with Southern Cross hospital. Although we will deliberately time the completion of this case to follow the Generalism case, we are getting the groundwork underway now.

Despite the challenges, we ended February with the production plan circa 60 case weights ahead of the year to date plan. However, deterioration in the opening weeks of March has us back to being circa on target on a year to date basis and we continue to need to manage very carefully.

In late February we followed through with a commitment to the Ministry to send them a pro-forma projection of ESPI 5 and eventual recovery. ESPI 5 is the target of completing surgery within 120 days after having given the patient certainty. Three services account for approximately 75% of our total breaches. These are the Dunedin General Surgical Service, Dunedin Urology Service and Dunedin Orthopaedics Service.

The General Surgical service now has an additional full day list per week which has been allocated from the Neurosurgery lists which can no longer be used. The threshold of what is accepted for surgery has also been tweaked slightly (in partnership with our SMO colleagues) from the start of March. At the time it was thought that with these adjustments to supply and demand we could recover the surgical backlog in this service by approximately December 2020. This will now need to be revised due to delays caused by COVID-19.

Similarly, Urology has been given an additional list (six hour list on a Friday), and access criteria is being reviewed as we believe this could be appropriately and safely tightened. With these changes it was believed that the service could be recovered in a similar timeframe.

Unfortunately, we are unable to provide more theatre time to Orthopaedics, who also have the largest backlog, and there appears to be limited ability to reduce acceptance rates (although the reduction in acceptance rates for ESPI 2 – outpatient appointments – should begin to flow into ESPI 5, noting that a higher conversion rate is also probable).

The Ministry is offering additional funding to complete more ESPI 5 cases and the team completed a submission that involved seeking further funding to complete more surgery as outsourced surgery and would have enabled us to reduce backlogs without impacting elsewhere within our services. Unfortunatley, due to COVID-19 we have had to withdraw this submission.

The other initiative that the team have been looking into is to enhance booking processes so that patients are pulled from the back of the wait list where appropriate to do so (utilising an acuity basis to achieve this).

18. ACCESS TO DIAGNOSTICS

Work was started, and continues where possible, within the Specialist Surgery and Radiology Directorate to compile the short term options paper for CT access in Dunedin. Unfortunately, options are limited for catching up performance in a timely way (e.g. achieving the Ministry target by December 2020), and a combination of purchasing more CT capacity in the district and running evening shifts in Dunedin, which can do contrast scanning, will be required to achieve these sorts of timeframes. The paper will be written objectively, but is likely to settle on a recommendation to use a hybrid of these two solutions.

The team was also in the process, prior the the effects of COVID-19, of organising a workshop including with WellSouth so that the team can work through a full set of options for the CT business case in terms of where the CT should be located and the pros and cons associated with the options that are available. When the workshop is held, the team will ensure that there is good representation from across the Southern Health System as appropriate.

19. INTENSIVE CARE UNIT (ICU) STAGE TWO

Over February and March, the Dunedin ICU team became increasingly concerned about the possibility/probability of having to manage COVID-19 cases in the ICU and how quickly the ICU could get overwhelmed.

The team identified a pro-forma plan which would be utilised in the event that infectious patients had to be cared for. The plan involves moving non-infectious patients across to stage 2 (noting that stage 2 has inadequate air quality and is not fit for general use currently), on the basis of a 'needs must' continuity plan. This would allow infectious patients to be treated in the isolation areas in stage 1.

Enacting this plan would have consequences, as it would slow our ability to complete and move into stage 2 permanently, however, we are in a bit of a quandary as not having a plan and needing to execute one would be harmful to patients and staff, whereas executing the plan and not needing it would slow down stage 2 completion.

20. SOUTHERN BLOOD AND CANCER SERVICE

We believe we have now successfully recruited to the Service Manager vacancy, with a variable acceptance of an offer from what we believe to be a very good candidate for the role. The candidate has previously worked as a service manager in Auckland and ran the cardiology service there. He came highly recommended from one of our colleague SMOs and he interviewed very well. He is initially on a fixed term 12 month contract and will start in the coming months.

As at the beginning of March, the service had maintained the forward list of FSA appointments at circa 100. Urgent patients are being seen within clinically indicated timeframes, however, less urgent cases are being seen in 7-8 weeks rather than the clinically indicated 4 weeks. The back to back sabbaticals are now almost complete, with the exception of the clinical leader who will be away later in March. As we get the capacity of the SMOs back into the service we will start to see improvement. The SMOs were also running regular weekend follow up clinics, allowing us to do more FSAs during the week, and we have approved an initiative for implementation which would allow GPs to see follow ups under supervision, allowing the radiation oncologists more capacity for follow ups.

Interviews for a sixth radiation oncologist have concluded and there appear to be two good candidates. The team is now working on how to attract one of the candidates (for example, one of the candidates is married to a plastic surgeon, but we do not currently have vacancies in plastic surgery, so the team is working through whether they can attract the other candidate). This is a bit of an ongoing process, but once a sixth radiation oncologist is confirmed we will start to see sustainable capacity in the service, enabling SMOs to appropriately spread their time over clinical commitments, non-clinical work and quality.

21. EMERGENCY DEPARTMENT SOUTHLAND

The CEO, Executive Director Specialist Services (EDSS) and the senior nursing team met with the charge nurses in Southland recently to discuss their concerns with the intense pressure acute demands are currently placing on them, despite the fact that winter has not yet arrived. We discussed the inability to recruit nursing staff and discussed possible ways to improve upon this, the impact to the nursing teams of slow clinician decision making / discharge, and the requirement for more space.

I have provided a clear message to the two Executive Directors sponsoring the ED initiative (Strategy, Planning & Community and Māori Health) and to the EDSS that three initiatives need to be worked up in parallel in Southland – reducing presentations from primary care / ensuring that these are appropriate, improved patient flow from timely clinician decision making and discharge, and consideration of additional space / requirements – which may be a combination of medical assessment beds and inpatient beds, or other forms of additional capacity. Working up an improvement programme across all three initiatives in parallel will give us a good opportunity to make timely decisions for Southland as quickly as possible.

The EDSS has asked for a full data set which includes all presentations, wait times, admission percentages and triage categories for Southland going back over the last three years. Collectively, we believe that the acute volumes presenting at Southland have worsened year on year and it will be useful to analyse the changes in patterns in these metrics over time.

22. INTERNATIONAL YEAR OF THE NURSE AND MIDWIFE

The International Year of the Nurse and International Year of the Midwife, 2020 is a year for a double celebration. We have created a page on the Southern Health website to tell the stories of some of our dedicated nurses and midwives working in the Southern district. Each month we will be highlighting a different aspect of nursing and midwifery and asking these health professionals to tell their stories in their own words. There are plans in place for a number of initiatives working with partners across the system. The Year of the Nurse and Midwife coincides with the 200th anniversary of the birth of one of the founders of modern nursing, Florence Nightingale, and the completion of the Global Nursing Now campaign. Nursing Now is a three-year global campaign (2018-2020) which aims to improve health by raising the profile and status of nursing worldwide.

23. MEDICATION ADMINISTRATION PROJECT

In response to a serious drug error in 2018, Southern DHB has been working hard on reducing medication administration errors. We are now working closely with the Accident Compensation Corporation (ACC) as part of a funded project to introduce robust adverse event reviews, and the resulting improved processes or practices that can help to reduce the risk of preventable treatment injuries. ACC is partnering

with five healthcare facilities including Southern DHB to complete current and future state mapping of their adverse event review processes, to help the facilities to understand their existing processes and to identify opportunities for improvement. Southern DHB has chosen to focus on medication adverse events. The delivery of this work includes:

- Capturing the adverse event review process as it is currently run ('Current State Process Mapping') completed
- Analysing the adverse event review process, and capturing a future ideal state for the process ('Future State Process Mapping') completed
- Outlining suggested ways to implement the future state process in an implementation plan; with the aim to provide the facilities with the best chance of success in implementing change.

Nursing leaders, pharmacists and front line staff are working with the Quality Team, Health Quality and Safety Commission (HQSC) and ACC on this project and finding this extremely valuable piece of work with the ultimate aim to reduce medication related harm and improve patient safety.

24. OLDER PERSONS' HEALTH ROTATIONAL PROGRAMME

Placements continue to be working well for Presbyterian Support Otago who are very positive about the programme. Evaluation of the programme will start mid-year. Decision made to move the programme start date to February next year to align with Nursing Entry to Practice (NeTP) completion. The changed date will also align better with the academic year. The team are working with current rotational nurses to extend contracts by four months. Considering plans for Southland starting in February 2021.

25. CARE CAPACITY DEMAND MANAGEMENT (CCDM)

CCDM Quarterly Milestone Reporting

The National Milestone Report for Quarter 2 for CCDM Implementation was submitted on 20 February. There was a notable increase in percentage of Local Data Councils (LDCs) in each ward and variance response management (VRM) implemented driving the overall percentage increase of 8%. Of the five larger DHBs, Southern DHB is still leading progress on CCDM implementation. Information Systems are working hard on getting all 23 core data set measures running so that this will meet all criteria in that category.

Mental Health, Addiction and Intellectual Disability (MHAID) Service Improvement Plan

Inaccuracy of the service's allocate staff screen and timely input of resource staff is an issue and support has been requested from Service Managers to address this. Support requested from Director of Nursing by TrendCare MHAID Service Coordinator and CCDM Programme Manager. Work continues on determining the minimum staffing levels as the first service and DHB to undertake this work.

Maternity Improvement Plan

Some improvements noted, and a positive meeting held with senior staff to discuss ways to support and further improve data integrity such as for Inter-rater Reliability (IRR) testing, actualisations and categorisations, use of TrendCare at handover, and ways to support Queen Mary with regular Local Data Council meetings. This will help staff to 'own' data and understand why accurate data capture is important.

Ward level Local Data Councils (LDCs)

Ward 6C started in February and CCU Southland is about to start. Ward 11 and the Mental Health Inpatient Unit are next (scheduled for March). This will leave five areas to introduce LDCs – Wards 9A, 9B, 10A, the Cottage and Dunedin ICU.

Patient Types

Patient types outside of benchmark are trending down, including Ward 8MED.

Bi-monthly core data set summary

Across Wakari, Dunedin and Southland we areseeing negative variances across most am shifts. This has had a significant impact on teams having to pull on senior leaders to participate in direct care to ensure adequate available hours. Southern DHB has Southland specialling hours increased compared with previous months, Dunedin and Southland Required HPPD increased when compared to January 2019.

FTE calculations

A number underway but some on hold; ATR Southland discussing model of care vs TrendCare.

Variance Response Management (VRM)

NICU is due to start in March. The indicator has been approved and an education day is to be held. Queen Mary is nearly complete awaiting an action plan, NICU Southland have been loaded into CaaG. Mental Health areas have been delayed to the next quarter.

Chris Fleming
Chief Executive Officer

31 March 2020

COVID-19

Strategy and overview plan

Introduction

- Mission
- Stopping COVID
- Responding to COVID
- Preserving essential care
- Data driven
- Workforce
- Mobilising the community
- Preserving our health system

Mission

1. Minimise the number infected with COVID-19
2. Limit the harm to people with COVID-19 - RED
3. Maintain an effective acute and urgent care health system - GREEN
4. Look after our health community
5. Support planning and provision of wider community support
6. Maintain a viable health system for the long term

Suppress COVID-19

- Follow national direction regarding status for the region
  - Level 4 – Eliminate
  - Level 3 – Restrict
  - Level 2 – Reduce
  - Level 1 – Prepare
- All possible resources applied to Public Health Action
  - Case isolation
  - Contact tracing
  - Testing plan
- Staff risk management plan

National Hospital Response Framework

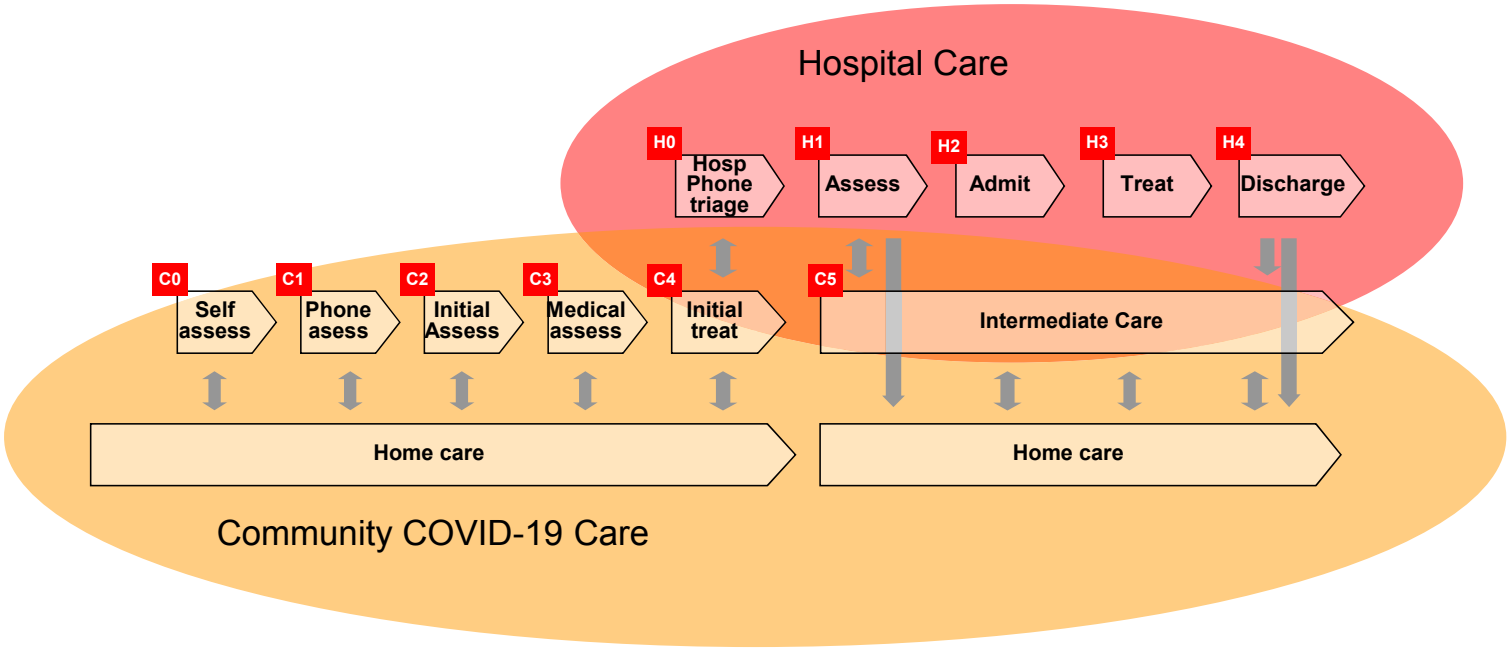
1
- Normal service – training and readiness

2
- Community and hospital cases
- Capacity manageable

3
- Many community cases
- Capacity Compromised

4
- Capacity exceeded

RED stream model

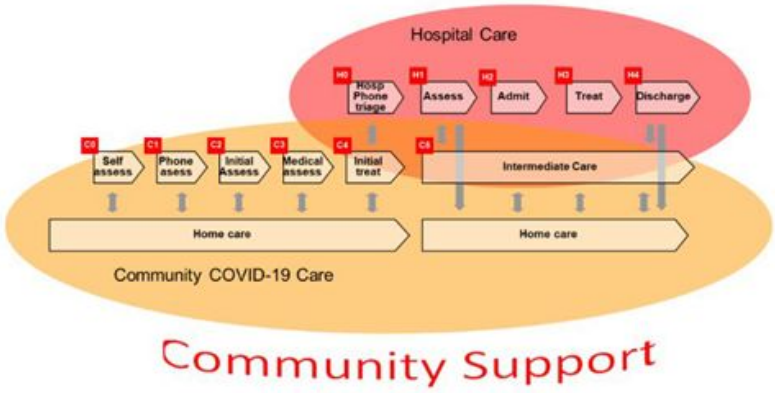


Community Support

Kind Manaakitanga | Open Pono | Positive Whaiwhakaaro | Community Whanaungatanga

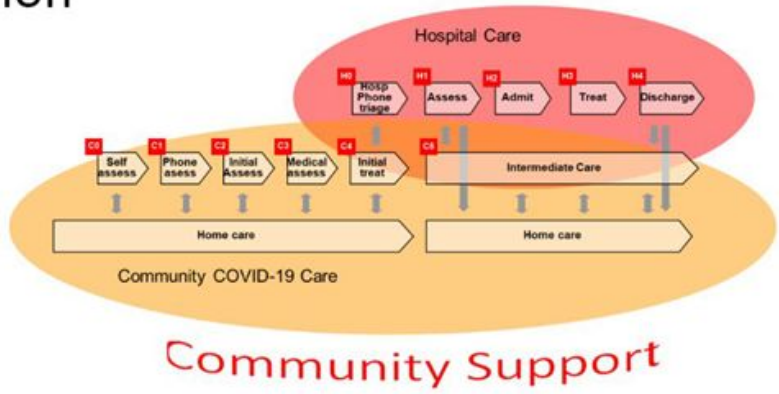
RED stream primary care

- Self Assessment at home – web based – national and/or local
- Phone support at home – Healthline and/or Local
- Community Based Assessment Centre or Designated Practice
    1. Testing
    2. Nurse Assessment and treatment
    3. Medical Assessment – complex cases
    4. Treatment capacity – Pharmacy onsite
    5. Welfare onsite
    6. Close relationship with Hospital – triage
    7. Palliative Care



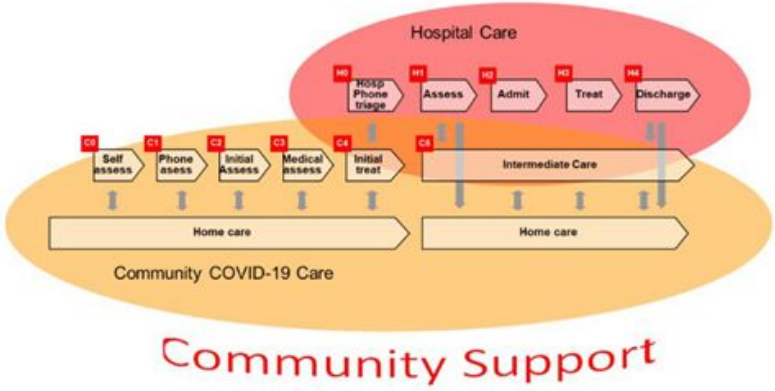
RED stream hospital

- Emergency direct entry only – ambulance at triage level
- Triaged entry from CBAC
- Separated stream – physical and staff
- Continuous capacity monitoring and prediction
- Progressive areas of care
  - Low level oxygen
  - High flow oxygen and non-invasive ventilation
  - ICU
  - Recovery and rehab
- Discharge pathway



RED stream intermediate care

- Alternative to hospital admission
  - People who cannot be at home
  - Nursing care
  - Possibly Oxygen – seek sources
  - Palliative care
- Senior Nurse Leadership
  - Volunteers
  - Nursing Students
  - Support staff



GREEN stream principles

- Discrete (physical and staff) **GREEN** streams for:
  - ED
  - Maternity
  - Med/Surg
  - Child Health
  - Mental Health
  - Primary care
  - Some community services
- Out Patients and GP visits
  - Face to face – essential only
  - Rationalise follow up and FSA
  - Use virtual

Intelligence

- Data – multiple streams from all sources
  - Primary care activity including CBAC
  - Public Health – EpiServ
  - Hospital activity
- Information
  - Visualisations to support
    - Planning
    - Service provision
- Knowledge management – use librarians
  - External knowledge
  - Created Knowledge

Planning

- Long term principles
- Commission planning for medium long term
- Support local planning
- Coordinate consistency of plans

Workforce

- Coordinate through one point
  - Volunteers
  - New health professionals
  - Staff seconded from Council
  - New commercial staff
- Rapid response
  - Minimum essential paperwork
  - Smooth fast approvals
- Monitoring programme to pick up problems

Logistics

- Single service point
- Rapid turnaround
- Creative solutions
- Good data
- Supporting the mission - critical

Communications

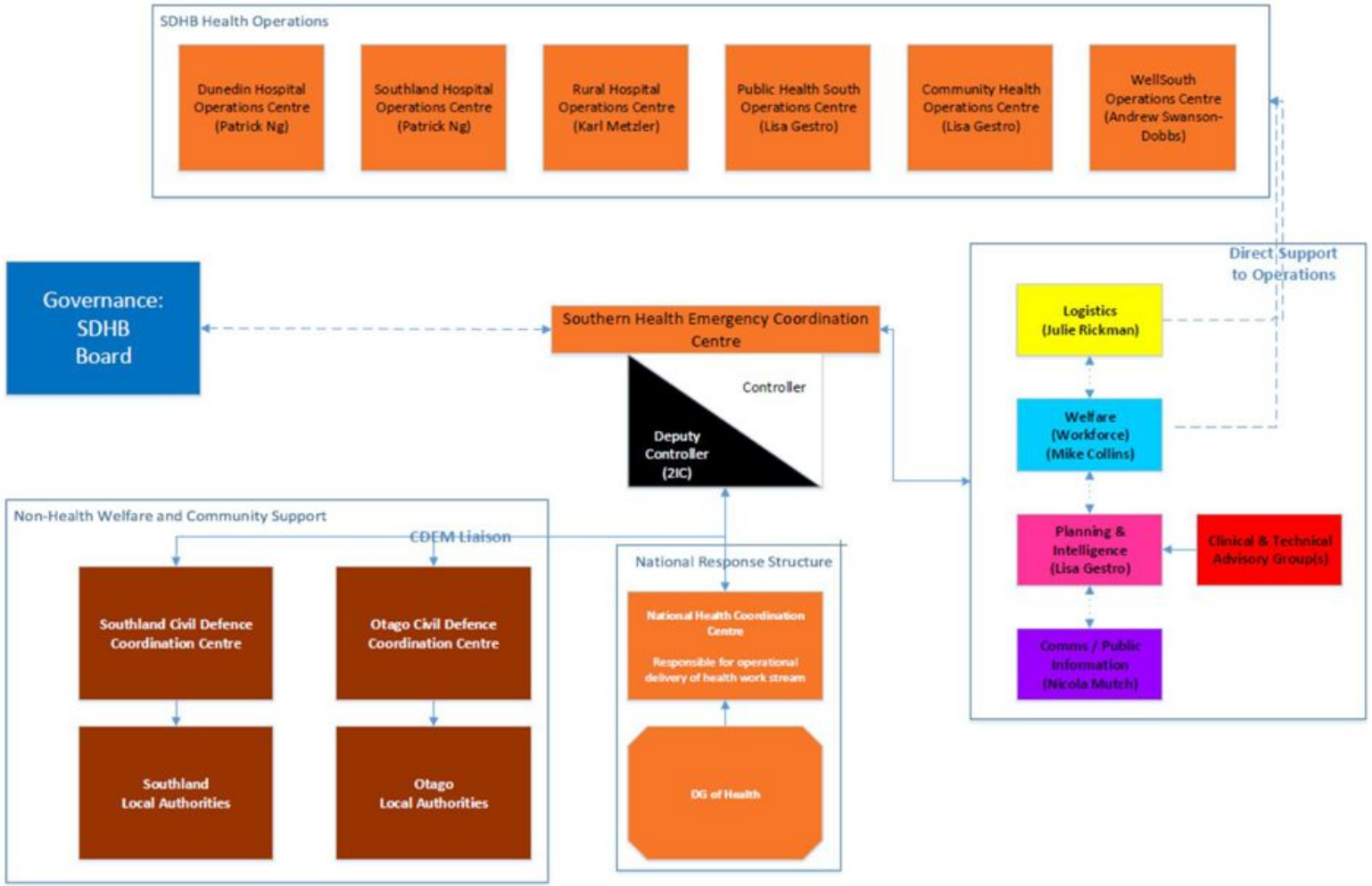
- Ensure key messages are distributed:
  - across health system providers
  - across agencies
  - to our communities

Understanding the situation in the district
How we are preparing and working together
What this means for services
What we need from the community

Mobilise the community

- Connect with
  - Local Territorial Authorities
  - Local businesses
  - Voluntary organisations
- Encourage and support their innovations
  - To support the community
  - To support health response
- Emphasise the value of supporting the community

COVID-19 RESPONSE
TRANSITIONAL STRUCTURE: CIMS to BAUU



Summary

- A clear mission is essential
- Suppress COVID
- Respond – Community, Primary Care and Hospital – **RED** stream
- Preserve – Acute and Urgent care – **GREEN** stream
- Data driven Intelligence and Planning
- Care for our workforce
- Mobilise the community
- Preserve our health system

Further slides for reference

- See next slides

National Hospital Response Framework

Trigger Status: No COVID-19 positive patients in your hospital; no cases in your community; managing service delivery as usual with only staffing and facility impact being for training & readiness purposes

1

- Screen for COVID-19 symptoms & travel history for any new Emergency Department attendances, pre-op sessions, planned admission, or clinic attendance
- Plan for triage physically outside the Emergency Department (or outside the hospital building)
- Plan to have a separated stream for COVID-19 suspected cases and non COVID-19 cases in Emergency Department
- Undertake training and practice runs for management of a COVID-19 suspected case in the Emergency Department, Wards, Theatres, ICU/HDU
- Practice PPE use for COVID-19 care in the Emergency Department, wards, theatres, ICU/HDU, outpatients, other relevant settings
- Plan for isolation of a single case & multiple case/ cohorting
- Plan for Early Supported Discharge, aggressive discharge and step down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- Plan for separate streams for staffing, cleaning, supplies management and catering
- Plan for management of referrals, and increased workload on booking and Call Centre teams
- Plan to have a COVID-19 capable theatre for acute surgery for a known or suspected positive patient
- Plan and prepare a dedicated COVID-19 ward
- Engage with alternative providers (such as private) to confirm arrangements for their assistance during higher escalation levels, and to fast-track urgent, lower complexity care procedures such as cataracts, endoscopy etc.
- Arrange for outpatient activity to move to telehealth and phone screening for virtual assessment, and MDTs to videoconference wherever possible
- Planned Care surgery, acute surgery, urgent elective and non-deferrable surgery to operate as usual
- Review patients on waiting list (surgery, day case, other interventions) and group patients by urgency

National Hospital Response Framework

Trigger Status: One or more COVID-19 positive patients in your hospital; cases quarantined in your community; isolation capacity and ICU capacity manageable; some staff absence and some staff redeployment to support response and manage key gaps

2

- Continue screening for COVID-19 symptoms and travel history as per Green Alert
- Activate plans as described in Hospital Green Alert, as appropriate
- Activate Emergency Department triaging in a physically separate setting
- Activate streaming of suspected COVID-19 or COVID -19 positive and non-positive patients as planned across Emergency Department, Wards, Theatres, ICU/HDU, and have dedicated COVID-19 capable theatre available
- Activate Early Supported Discharge, aggressive discharge and step down arrangements, including with other partners as appropriate (e.g. private, aged residential care, community providers)
- DHBs to ensure appropriately discharged out of area patients back to domicile hospital or other setting (to be considered in conjunction with current Hospital Alert Level at other DHBs)
- Acute surgery, urgent elective, and non-deferrable surgery to operate as usual, with consideration given to repatriation processes if patient is non-domicile
- Start to move pre-op assessments and outpatient appointments to be undertaken virtually, or in an off-site setting as necessary
- Defer non-urgent pre-assessments and non-urgent clinic patients unless can continue to be managed
- Activate any outsourcing arrangements reached, and engage on options for supporting 'cold trauma' cases and less-complex urgent cancer surgery
- Planned Care surgery and other interventions to be prioritised based on urgency, and where ICU/HDU is not required, delivery should continue as much as possible
- Redeployment of staff as needed/ available to ensure perioperative workforces are in place to run theatre including anaesthesia, anaesthetic technicians, nursing. Scale deliverable of non-urgent planned care as needed

National Hospital Response Framework

Trigger Status: One or more COVID-19 positive patients in your hospital; community transmission/multiple clusters in your community; isolation capacity and ICU capacity impacted; significant staff absence, extensive staff redeployment, gaps not being covered

3

- Continue screening for COVID-19 symptoms and travel history as per Green Alert
- Activate plans as described in Hospital Green and Yellow Alert levels
- Divert end of life patients to alternative providers
- Provide Emergency Department services with prioritisation on high acuity medical and trauma care. Provide advice in non-contact settings where possible
- Fully activate any agreements reached with private (or other) providers
- Acute surgery to operate as usual, with priority on trauma cases, as staffing and facilities allow
- Prioritise urgent non-deferrable Planned Care cases not requiring ICU/HDU care
- Postpone all non-urgent high risk Planned Care surgery requiring HDU/ICU, adjusting the prioritisation threshold for surgery with Senior Clinician for non-deferrable cases
- Increase ICU/HDU capacity as needed, retaining cohorting of suspected COVID-19 and COVID-19 positive and non-positive patients, including moving non-COVID-19 ICU/HDU to theatre complex or other location that is manageable
- Postpone all outpatient activity and pre-op assessments, and implement acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows
- Only accept urgent outpatient referrals

National Hospital Response Framework

Trigger Status: One or more COVID-19 positive patients in your hospital; community transmission/widespread outbreaks in your community; isolation capacity, ICU capacity at capacity; all available staff redeployed to critical care

4

- Emergency Department services limited to high acuity medical and trauma care
- Activate plans as described in Hospital Green, Yellow and Orange Alert levels
- Continue to divert end of life patients to alternative providers
- Continue acute surgery as staffing and capacity allows, prioritising non-deferrable, life-saving surgery
- Cancel all non-acute surgery
- Activate additional streaming, including non-COVID-19 ICU/HDU to theatre complex, or private provider if agreement reached
- As a last resort, move ventilated COVID-19 patients to repurposed ICU/HDU theatre complex or other location that is manageable for overflow; aim is to not impact on ability to meet non-deferrable, life-saving acute surgery
- Continue with acute ambulatory assessments or virtual/telehealth assessments for urgent, non-deferrable cases only, as staffing allows
- Only accept urgent outpatient referrals

Southern DHB Financial Report

Financial Report for: 29 February 2020
Report Prepared by: Finance
Date: 12 March 2020

Report to Board

This report provides a commentary on Southern DHB's financial performance for the month and year to date ending 29 February 2020 and the financial position as at that date.

The net surplus for the month of February was $0.7m, being $0.7m unfavourable to budget. The net deficit for the period ending 29 February 2020 was $24.3m, being $6.0m unfavourable to budget.

During February 2020, Revenue was on budget overall. Workforce costs were $0.9 million unfavourable to budget across all workforce categories. Clinical Supplies were $0.9 million unfavourable to budget being a continuation of the clinical supplies impact from the mix of services delivered to reduce waitlists. The focus continues to on reviewing processes to achieve optimal outcomes from the available resources.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 29 February 2020

Month Actual $000	Month Budget $000	Variance $000			YTD Actual $000	YTD Budget $000	Variance $000		LY YTD Actual $000	LY Full Year Actual $000	Full Year Budget $000
				REVENUE							
89,504	89,339	165	F	Government & Crown Agency	716,501	713,391	3,110	F	677,583	1,020,148	1,070,140
946	1,116	(170)	U	Non-Government & Crown Agency	7,478	7,419	59	F	7,112	11,892	11,252
90,450	90,455	(5)	U	*Total Revenue*	723,979	720,809	3,170	F	684,695	1,032,040	1,081,392
				EXPENSES							
35,076	34,102	(974)	U	Workforce Costs	286,596	285,588	(1,008)	U	269,864	451,823	437,490
2,888	3,255	367	F	Outsourced Services	27,758	25,971	(1,787)	U	25,305	39,624	38,754
8,335	7,479	(856)	U	Clinical Supplies	67,981	61,860	(6,121)	U	63,356	96,479	93,657
4,694	4,472	(222)	U	Infrastructure & Non-Clinical Supplies	38,723	37,549	(1,174)	U	35,164	60,062	56,777
35,785	36,484	699	F	Provider Payments	304,007	303,038	(969)	U	290,861	438,921	454,704
2,934	3,201	267	F	Non-Operating Expenses	23,201	25,093	1,892	F	22,793	34,476	38,522
89,712	88,993	(719)	U	*Total Expenses*	748,266	739,099	(9,167)	U	707,343	1,121,385	1,119,904
738	1,462	(724)	U	**NET SURPLUS / (DEFICIT)**	(24,287)	(18,290)	(5,997)	U	(22,648)	(89,345)	(38,512)

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

Revenue (Year To Date)

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

On a year to date basis we are 68 caseweights behind our Planned Care volume delivery to our population. However, Canterbury District Health Board (CDHB) continue to have a timing delay in the coding of Inter District Flow (IDF) activity. We anticipate our shortfall in delivery within our own district will be offset by delivery of services from CDHB and our Planned Care revenue has been fully recognised on that basis.

Expenditure (Year To Date)

Total Expenses year to date were $748.3m and includes unbudgeted one-off costs for the Measles Outbreak $0.3m and Neurosurgery $1.3m (excluding IDF Outflows and additional hospital transfer team). Neurosurgery medical workforce is currently insufficiently resourced to maintain a safe roster and therefore CDHB is providing cover for this service.

Workforce Costs are $1.0m unfavourable to budget year to date. This does not include the financial risk of an estimated $0.4m each month ($4.8m annualised) for the Holidays Act 2003.

Outsourced Services are $1.8m unfavourable year to date. This reflects the continued cover for SMO vacancies in Surgical and Medical Imaging areas and service provision to reduce wait backlogs.

Clinical Supplies are $6.1m unfavourable year to date. Air Ambulance, Blood Products and Implants & Prostheses are contributors to the unfavourable variance. Air Ambulance activity has increased significantly with Neurosurgery patients being transported from/to Dunedin. The increase in Air Ambulance usage has led to a review of the patient assessment process for determining transport resource, whether that be fixed wing, helicopter or road ambulance. The increase in Implants and Prostheses reflects an uplift in orthopaedic activity particularly in Southland.

Infrastructure and Non-Clinical Supplies are $1.1m unfavourable year to date. The overspend primarily arising from Cleaning & Orderly Services, Software Maintenance and Telecommunications. The Cleaning and Orderly Services include the SECA settlement which increases the ongoing cost for these services. While we continue to review the levels of cleaning and orderly input required, we have new areas such as the Intensive Care Unit for which there is additional cleaning and older areas, which require careful cleaning to maintain infection prevention standards. The Software Maintenance costs include licencing fees for Microsoft Software which is a national contract negotiated by MBIE for All of Government during 2018. As far as practicable, we manage other expenditure to offset the additional expenditure on the Microsoft contract. Our Telecommunications costs continue to be regularly reviewed in conjunction with our supplier to mitigate any ineffective spend.

Provider Payments are $1.0m unfavourable year to date. This is driven largely by the additional costs incurred in Home Support and other Disability Support Services and are offset by additional revenue from Government and Crown Agency.

Non-Operating Expenses are $1.8m favourable year to date. The Depreciation charge is lower than budget, reflecting the timing and category of capital expenditure.

Financial Position Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Position
As at 29 February 2020

As at 30 Jun 2019 $000		Actual 29 Feb 2020 $000	Budget 29 Feb 2020 $000	Budget 30 Jun 2020 $000	As at 29 Feb 2019 $000
	CURRENT ASSETS				
7	Cash & Cash Equivalents	7	7	7	8
47,353	Trade & Other Receivables	53,196	49,348	45,213	54,116
5,762	Inventories	5,336	5,122	5,235	5,173
53,122	*Total Current Assets*	58,539	54,477	50,455	59,297
	NON-CURRENT ASSETS				
323,050	Property, Plant & Equipment	331,750	347,761	346,288	324,378
4,505	Intangible Assets	2,847	7,239	10,393	4,282
327,555	*Total Non-Current Assets*	334,597	355,000	356,681	328,660
380,677	**TOTAL ASSETS**	393,136	409,477	407,136	387,957
	CURRENT LIABILITIES				
9,895	Cash & Cash Equivalents	15,460	28,335	44,587	17,673
63,925	Payables & Deferred Revenue	94,828	66,567	62,804	57,600
922	Short Term Borrowings	955	964	784	1,055
112,595	Employee Entitlements	108,795	109,741	91,680	70,797
187,337	*Total Current Liabilities*	220,038	205,607	199,855	147,125
	NON-CURRENT LIABILITIES				
1,568	Term Borrowings	1,307	811	783	1,734
19,362	Employee Entitlements	19,362	18,149	18,756	18,149
20,930	*Total Non-Current Liabilities*	20,669	18,960	19,539	19,883
208,267	**TOTAL LIABILITIES**	240,707	224,567	219,394	167,008
172,410	**NET ASSETS**	152,429	184,910	187,742	220,949
	EQUITY				
300,969	Contributed Capital	305,277	331,760	354,813	282,813
108,502	Property Revaluation Reserves	108,500	108,500	108,502	108,502
(237,061)	Accumulated Surplus/(Deficit)	(261,348)	(255,350)	(275,573)	(170,366)
172,410	*Total Equity*	152,429	184,910	187,742	220,949

Cash Flow Summary

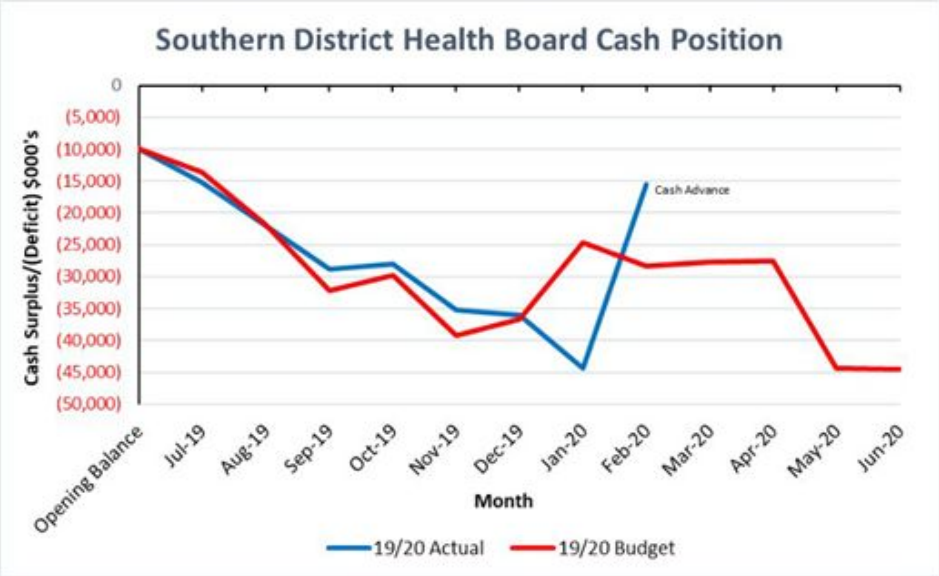
SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 29 February 2020

	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	738,119	715,946	22,173	1,071,528	671,098
Non-Government & Crown Agency Revenue	7,272	7,293	(21)	11,065	7,047
Interest Received	201	125	76	187	65
Cash was applied to:					
Payments to Suppliers	(445,784)	(435,746)	(10,038)	(649,567)	(419,241)
Payments to Employees	(285,441)	(286,061)	620	(453,068)	(269,243)
Interest Paid	-	-	-	-	-
Capital Charge	(5,138)	(5,194)	56	(10,500)	(5,735)
Goods & Services Tax (net)	4,798	775	4,023	7	(264)
Net Cash Inflow / (Outflow) from Operations	14,027	(2,862)	16,889	(30,348)	(16,273)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	4	-	4	-	1
Cash was applied to:					
Capital Expenditure	(23,394)	(45,569)	22,175	(57,139)	(20,444)
Net Cash Inflow / (Outflow) from Investing Activity	(23,390)	(45,569)	22,179	(57,139)	(20,443)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	4,306	30,790	(26,484)	54,550	50,342
Cash was applied to:					
Repayment of Borrowings	(508)	(799)	291	(1,755)	(914)
Net Cash Inflow / (Outflow) from Financing Activity	3,798	29,991	(26,193)	52,795	49,428
Total Increase / (Decrease) in Cash	(5,565)	(18,440)	12,875	(34,692)	12,712
Net Opening Cash & Cash Equivalents	(9,888)	(9,888)	0	(9,888)	(30,377)
Net Closing Cash & Cash Equivalents	(15,453)	(28,328)	12,875	(44,580)	(17,665)

The improved cash position at 29 February 2020 results from the revenue advance of received from the Ministry of Health on 27 February 2020. The overall additional expenditure including Clinical Supplies causes Payments to Suppliers to be higher than budget and overall contributes to Operating cash flowing being favourable to budget by $16.9m.

Investing Activity outflows are favourable to budget by $22.2m, reflecting the timing of spend on Capital Expenditure.

Cash from Financing is unfavourable to budget by $26.2m as the Ministerial approval of Deficit Support Funding has been delayed.



Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD

Capital Expenditure - Cash Flow

For the period ending 29 February 2020

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	FY19 YTD Actual $000	FY19 Full Year Actual $000
Land, Buildings & Plant	9,388	26,219	16,831	U	9,864	15,327
Clinical Equipment	8,830	10,646	1,816	U	7,525	12,574
Other Equipment	322	175	(147)	O	340	406
Information Technology	2,417	3,747	1,330	U	2,714	4,158
Motor Vehicles	3	-	(3)	O	-	44
Software	2,434	4,782	2,348	U	1	121
Total Expenditure	23,394	45,569	22,175	U	20,444	32,630

Property, Plant and Equipment and Intangible Assets are a combined $334.6m, being $20.4m less than the budget of $355.0m.

Land, Buildings and Plant is $16.8m underspent in projects including Queenstown Lakes Hospital Redevelopment, Dunedin Hospital ICU, Southland MRI and Deferred Maintenance.

The Queenstown Lakes Hospital redevelopment has been completed although further work is scheduled for mid-year to complete the sub-project work in particular on birthing areas.

Clinical Equipment is $1.8m underspent with project timing for various items of equipment. The Cardiac Catheter Laboratory and Lamson Tube projects were both completed under budget.

The Dunedin Hospital ICU development has been delayed due to unresolved issues with the ventilation systems.

Software is $2.3m underspent, the timing of investment on FPIM (Oracle upgrade) and SI PICS (Patient Management) projects being two of the major contributors.

Feb-20				Feb-19	YEAR ON YEAR		YTD 2019/2020				YTD Feb-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,261	1,315	(54)	-4%	1,216	45	Acute	12,133	11,397	735	6%	11,390	742
393	264	129	49%	253	140	Elective	2,620	2,307	313	14%	2,373	247
1,654	**1,579**	**76**	**5%**	**1,469**	**185**	**Total Medical Caseweights**	**14,752**	**13,704**	**1,048**	**8%**	**13,763**	**990**
						Surgical Caseweights						
1,095	1,148	(53)	-5%	1,231	(136)	Acute	9,416	9,640	(224)	-2%	9,711	(295)
1,199	1,192	7	1%	1,211	(11)	Elective	10,582	10,622	(40)	-0%	10,550	32
2,295	**2,340**	**(46)**	**-2%**	**2,442**	**(147)**	**Total Surgical Caseweights**	**19,998**	**20,261**	**(264)**	**-1%**	**20,261**	**(263)**
						Maternity Caseweights						
74	81	(7)	-9%	99	(25)	Acute	799	708	91	13%	696	103
300	322	(22)	-7%	305	(5)	Elective	2,735	2,798	(63)	-2%	2,836	(101)
375	**403**	**(29)**	**-7%**	**404**	**(29)**	**Total Maternity Caseweights**	**3,534**	**3,506**	**28**	**1%**	**3,531**	**3**
						TOTALS						
2,431	**2,544**	**(113)**	-4%	**2,546**	**(115)**	**Acute**	**22,348**	**21,745**	**603**	3%	**21,797**	**551**
1,893	**1,778**	**115**	6%	**1,769**	**124**	**Elective**	**15,936**	**15,727**	**210**	1%	**15,758**	**178**
4,324	**4,322**	**1**	**0%**	**4,315**	**9**	**Total Caseweights**	**38,284**	**37,472**	**812**	**2%**	**37,555**	**729**

						TOTALS excl. Maternity						
2,356	**2,463**	**(106)**	-4%	**2,447**	**(91)**	**Acute**	**21,549**	**21,037**	**512**	2%	**21,102**	**447**
1,593	**1,457**	**136**	9%	**1,464**	**129**	**Elective**	**13,202**	**12,929**	**273**	2%	**12,922**	**279**
3,949	**3,919**	**30**	**1%**	**3,911**	**38**	**Total Caseweights excl. Maternity**	**34,750**	**33,966**	**784**	**2%**	**34,024**	**726**

Feb-20				Feb-19	YEAR ON YEAR		YTD 2019/2020				YTD Feb-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,541	2,648	(107)	-4%	2,357	184	**Mental Health bed days**	21,527	22,984	(1,457)	-6%	21,653	(126)

Feb-20	Feb-19	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2019/2020	YTD Feb-19	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,469	3,709	(240)	Dunedin	29,060	29,423	(363)
1,020	1,053	(33)	Lakes	9,073	8,497	576
3,055	3,197	(142)	Southland	24,612	25,603	(991)
7,544	7,959	(415)	**Total ED presentations**	62,745	63,523	(778)

PERFOMANCE DASHBBOARD SOUTHERN DHB

9.3

PERFORMANCE DASHBOARD DUNEDIN HOSPITAL

9.3

PERFORMANCE DASHBOARD SOUTHLAND HOSPITAL

9.3

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

David Cull
Chair
Southern District Health Board
daveccull@gmail.com

Tēnā koe David

Letter of Expectations for district health boards and subsidiary entities for 2020/21

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2020/21.

DHBs make positive differences in the lives of New Zealanders and I look forward to working with you and your new Board to deliver the wider changes we need to improve outcomes. Strong and sustained leadership provides a foundation for high-performing DHBs and is critical to overall sector performance.

The Government intends to deliver long term, sustainable change to support improved wellbeing for New Zealanders. In the coming months we will receive the final report from the New Zealand Health and Disability System Review. Many of you have contributed to the review, and I thank you for that. The interim report aligned strongly with our Government's priorities and the changes we have underway to deliver better outcomes for Māori and improving equity and wellbeing. I expect you to be prepared and ready to implement Government decisions resulting from the review.

Wellbeing and equity underpin my priorities. Appendix one details expectations for the five system priorities:

- improving child wellbeing
- improving mental wellbeing
- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

This letter will outline my expectations for a range of matters that contribute to performance across these priority outcomes.

Governance

The DHB Board sets the direction for the DHB and rigorously monitors the DHB's financial and non-financial performance and delivery on the Government's priorities.

I expect you to hold your Chief Executive (CE) and senior leadership team to account for their financial performance and on the delivery of equitable health outcomes for your population.

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As Chair, you will need to provide leadership and direction to the Board, providing guidance and support to members to ensure they effectively govern the DHB. Please ensure that you have a process in place to review the performance of the Board on a regular basis.

Sustainability

Every DHB must clearly demonstrate how strategic and service planning will support improved system sustainability, including models of care and the scope of practice of the workforce. You should address how your DHB will work with sector partners to deliver the Government's priorities and outcomes for the health and disability system while reducing cost increases and deficit levels.

Please ensure that your 2020/21 planning documents clearly identify your DHB's approach to financial and clinical sustainability at both a strategic level and operationally across each of my priority areas.

Service performance

I expect you to challenge and support your CE and senior leadership team to identify ways to respond to the challenges the DHB faces, including timely, high quality delivery of planned care, reducing the length of emergency department stays and increasing immunisation coverage. You will oversee progress on the plans they develop to address these issues.

You need to ensure that workforce and delivery plans support innovative models of care and don't merely add FTE to maintain existing approaches. I expect this to be supplemented with other activities, such as managing annual leave liabilities and maximising productivity in theatres and wards.

Achieving equity

Achieving equity in health outcomes and ensuring fairness in access to and experience of care is essential. I will always expect you to consider equity as you develop plans across priority areas and to prioritise resources to achieve equity across population groups. This will include improving health outcomes for Maori and Pasifika, and an explicit focus on addressing racism and discrimination in all of its forms across all aspects of your operations.

Embedding Te Tiriti o Waitangi and achieving pae ora (healthy futures) for Māori

Māori-Crown relations are a priority for this Government, and I expect your DHB to meet your Te Tiriti o Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I expect you to develop your plans in partnership with your iwi/Māori partnership boards and include a statement from the Chair of the partnership board in your annual plan alongside statements from yourself and your CE.

Achieving pae ora (healthy futures) for Māori is an important goal for the entire health and disability system. While this includes achieving equity in health outcomes for Māori, responding to our obligations under the Treaty of Waitangi goes beyond that. A critical aspect is enabling iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing. I expect your plan to specify how you will work with iwi and Māori communities in your district to achieve this goal.

Financial performance and responsibility

The 2018/19 and 2019/20 budgets have provided the largest increases in funding that DHBs have ever had. To improve service and financial performance, you must focus on good

decision-making within your sphere of control and influence. Most of the issues driving costs are within the control of the DHB, including the number and mix of full-time equivalent staff.

A central challenge in the public health system is to deliver a wide range of quality health services to New Zealanders while remaining within budget. You will be aware of your DHB's financial position and my expectation is that you and your Board will deliver improved financial management and performance; this is especially true for those DHBs that have struggled in recent years.

The In-Between Travel (IBT) appropriation will be devolved from 1 July 2020. I expect you to work with the Ministry of Health (the Ministry) to ensure a seamless transition of responsibilities. The Ministry has an ongoing stewardship responsibility to ensure that all IBT obligations are met.

Capital investment

Timely delivery of the business cases prioritised for investment from the Budget appropriation should be a strong focus. You must comply with financial performance expectations for capital investments requiring Crown equity. You will also be expected to deliver a business case within the budget parameters set, and ensure all investments are procured in a timely manner.

Business cases for high priority projects should continue to be developed irrespective of their immediate investment status and I will seek your assurance that this work is progressing.

I expect all DHBs to follow the guidelines for construction procurement developed by the Ministry of Business, Innovation and Employment. I also expect DHBs to support the initiatives being developed under the Construction Accord. Information on these initiatives will be provided as the work develops.

The Government is supporting a range of capital infrastructure initiatives. The wider public good from our capital projects must be realised, which requires adherence to certain principles. An example is the NZ Green Building Council (NZGBC) Green Star rating for new building developments. Capital builds ought to meet a 5-star standard in the absence of any other mature standard, and this aim should be written into design thinking from the outset. This should result in longer term efficiencies, both financial and environmental. During 2020/21, you will need to engage with the Ministry and other partners as we continue to evolve approaches to sustainable facility design.

National Asset Management Plan

I would like to thank your DHB for supporting the first iteration of the National Asset Management Plan (NAMP) and ask that you continue to engage with the NAMP work as we develop and implement the next phases. Please continue to strengthen your DHB's asset management approach, including focusing on critical service assets, embedding asset management practices and ensuring you appropriately govern service improvement and asset performance.

Service user councils

Service user/consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality and Safety Commission (the Commission) has provided guidance to support an effective approach – 'Engaging with consumers: A guide for district health boards' and 'Progressing consumer engagement in primary care'. I am aware that many DHBs already

have strong service user councils and I want to strengthen this across all districts and regions.

The Commission, in partnership with the sector, has developed quality and safety markers for service user engagement and I encourage your DHB to participate in this.

My priority areas

I have clearly communicated my priorities for the health system. I expect your annual plans to address these priorities to meet the needs of all population groups, especially those groups that experience the most significant inequities. The actions you commit to in your plan must contribute to lasting equity and outcome improvements for Māori and for your Pacific population, including a strong focus on prevention. Appendix one details expectations for the five system priorities, which will be further described in the planning guidance your DHB receives from the Ministry.

I look forward to engaging with you on your planning intentions, receiving your planning documents for 2020/21 and working with you as your DHB delivers on your commitments. I appreciate you are receiving this letter at a time when our system is facing emerging pressures from COVID-19. I am pleased to see the way the sector has worked together during the early response phase and I know DHBs will continue to support our collective system response.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Appendix one: Ministerial planning priority areas

Improving child wellbeing

The Child and Youth Wellbeing Strategy and Programme of Action (the Strategy) launched in August 2019 provides a clear pathway to ensuring New Zealand is the best place in the world for children and young people to live. I expect your annual plans to reflect how you are working to improve the health and wellbeing of infants, children, young people and their whanau. Your plans should focus on improving equity of outcomes (especially for Māori); on children and young people of interest to Oranga Tamariki; and children with greater need, including children and young people with disabilities.

I expect DHBs to increase childhood immunisation rates, especially for Māori. The recent measles outbreaks remind us of the impact of communicable diseases on our communities and the health sector and the importance of achieving full immunisation. I expect DHBs to work closely with their primary care providers to prioritise immunisation, including a renewed focus on robust pre-call and recall processes and immunisation outreach services.

I expect DHBs to focus on family and sexual violence screening, early intervention and prevention to ensure victims and families receive effective and timely health care and perpetrators are supported to break the cycle of family and sexual violence.

High quality maternity care is fundamental to ensure children get the best possible start in life. As part of their commitment to the Midwifery Accord signed in April 2019, I expect DHBs to implement a plan to improve recruitment and retention of midwives. You should use Care Capacity Demand Management (CCDM) work to ensure optimal staffing in maternity facilities.

Working with a full range of stakeholders, the Ministry has developed a comprehensive Maternity Action Plan to support a flexible, innovative and sustainable maternity system. I expect DHBs to work with all elements of the maternity system to ensure responsiveness to Māori and equitable access to quality maternity care, including maternal and infant mental health services.

Improving mental wellbeing

He Ara Oranga: Report on the Government Inquiry into Mental Health and Addiction and the Government's response, has set a clear direction for mental wellbeing in New Zealand. Supported by the investments announced in the 2019 Wellbeing Budget, we have a unique opportunity to improve the mental health and wellbeing of New Zealanders. Your leadership will drive system transformation in the mental health and addiction sector.

Collective action is needed to achieve equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes, including Pacific peoples, youth and Rainbow communities. You will work with the Ministry, the Initial Mental Health and Wellbeing Commission and the Suicide Prevention Office to support system transformation and the rollout of the Government's priority initiatives.

The mental health and addiction system must respond to people at different life stages and levels of need. I expect DHBs to work individually and collectively on mental health and addiction promotion, prevention and early intervention at the primary and community level. At the specialist end of the continuum you should ensure those with the most need have access to sustainable quality mental health and addiction services.

Improving New Zealanders' mental wellbeing will require collaboration with communities and non-government organisations (NGOs). I consider that DHBs have a social responsibility to

support the sustainability of NGOs and to empower communities to engage in the transformation of New Zealand's approach to mental health and addiction. This includes offering your expertise at no charge to NGOs and community organisations to support participation in new service delivery, particularly for communities who experience disproportionately poorer outcomes.

I expect you to contribute to the development of a sustainable and skilled workforce. You must invest to diversify, train and expand both the existing and new workforces. You should focus on training workforces to support the Government's primary mental health and addiction initiatives and communicate proactively with the Ministry about opportunities to expand coverage to reach underserved populations.

Improving wellbeing through prevention

Environmental sustainability

Ensure that you continue to contribute to our Government's priority of environmental sustainability, including green and sustainable facility design as noted above in the section on Capital Investment. I expect your annual plan to reflect your work to progress actions to mitigate and adapt to the impacts of climate change and enhance the co-benefits to health from these actions.

Antimicrobial resistance

I am concerned about the increasing threat of antimicrobial resistance (AMR) to our health security. DHBs have a key role in minimising this threat. The issues are systemic and require long-term planning and sustained actions.

I expect your annual plan to reflect actions that align with the objectives of the New Zealand Antimicrobial Resistance Action Plan and demonstrate you are working towards a sustainable approach to containing AMR.

Smokefree 2025

Smoking remains a major preventable cause of premature death, morbidity and health inequities. My expectation is that you work towards achieving Smokefree 2025. I expect to see effective community-based wrap-around interventions to support people who want to stop smoking, with a focus on Māori, Pacific people, pregnant women and those on a low income. The interventions should reflect your regional and programme provider collaborative efforts.

Bowel Screening

The National Bowel Screening Programme remains a priority for this Government. DHBs are expected to achieve national bowel screening targets (where applicable) and consistently meet diagnostic colonoscopy wait times. It is crucial that symptomatic patients are not negatively impacted by screening demand. DHBs must work individually and collectively to develop a sustainable endoscopy workforce, including support of training positions for nursing and medical trainees to meet growing demand in this area.

Better population health outcomes supported by a strong and equitable public health and disability system

National Cancer Action Plan

On 1 September 2019 the Prime Minister, Rt Hon Jacinda Ardern and I launched the National Cancer Action Plan and its four key outcomes. DHBs have an important responsibility to drive the necessary changes and deliver of these outcomes.

I have established a National Cancer Control Agency, which will report to me on the implementation of the Cancer Action Plan. You will work with and take direction from the Agency to reach national standards of care and improve quality.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the general population. Your DHB should look for opportunities to increase its employment of disabled people to improve the competency and awareness of your workforce in matters regarding disabled people and to advance social inclusion more generally.

Accessibility means that your DHB provides a barrier-free environment, including information and communications for the independence, convenience and safety of a diverse range of people. This includes people who may have access needs, including disabled people, older people, parents and carers of young children and travellers.

Enabling disabled people to access health services includes ensuring that all key public health information and alerts are translated into New Zealand Sign Language. It means consulting disabled patients (including people with sensory, intellectual or physical impairments) on their preferred means of communication for appointment notifications and the like.

As with previous years, your DHB must make progress towards, or fully implement, the United Nations Convention on the Rights of Persons with Disabilities. DHBs also need to implement policies and procedures to collect information about disabled people within your patient population. DHBs should also ensure contracts with providers reflect the requirement to either ensure accessibility or put in place plans to transition to a more accessible service.

Healthy ageing

If our ageing population continues to grow as current trends suggest, the number of people with dementia, and the associated financial and social consequences, will grow commensurately. This Government is determined to make a positive difference in the lives of people with dementia, their families, whānau, friends and communities. I expect your DHB to work with your region to implement the regional dementia priorities.

Please ensure the DHB develops models of care to identify frail and vulnerable older people in community settings, in particular Māori and Pacific peoples, and provides supports to restore function and prevent the need for acute care.

Workforce

I expect DHBs to develop bargaining strategies that progress the Government Expectations on Employment Relations in the State Sector.

I expect bargaining strategies to progress consistent employment arrangements and support agile, innovative workforces to deliver services. Employment arrangements should encourage people to grow, develop and thrive in a work environment that supports transdisciplinary teams and innovative models of care. I expect commitments made in bargaining to be met, including working party commitments, Accords or programmes, such as the CCDM programme.

DHBs have an essential role in training our future workforce and providing learning and development opportunities for current workforces. I expect you to continue to utilise current workforces to support innovative and transdisciplinary practice across models of care and enable people to work to their full scope of practice.

DHBs must create environments in which all health and disability workforces thrive. DHBs should facilitate healthy and culturally reinforcing working environments that support health equity outcomes for all.

Workplace violence

I am concerned about what appears to be increased levels of violence in the health workplace. In accordance with the Health and Safety Act 2016, DHBs are responsible for the health and safety of their staff, patients and visitors. I expect DHBs to keep staff, patients and visitors safe by implementing appropriate policies, procedures and training to maintain public trust and confidence in the health and disability sector.

Health Research Strategy implementation

Research and innovation, analytics and technology are all crucial to achieving an equitable, sustainable health system and better patient outcomes.

The New Zealand Health Research Strategy (2017-2027) is the key platform for us all and it is important to implement the strategic priorities. In the next year, we should focus on developing a flourishing research and innovation culture in our DHBs in both primary and secondary care.

I have asked the Ministry to work with you and other stakeholders to build up DHB people and resources to support and enhance research, innovation and analytics so the system can make better use of the evidence and innovation and contribute to the Health Research Strategy objectives. Please work with the Ministry to design and invest in the programme of work with a focus on creating regional research and analytics networks that support staff engaged with research and innovation.

National Health Information Platform (nHIP/Hira)

Digital health services are important to me and to all New Zealanders and I expect DHBs to ensure the digital services you use are safe, secure, integrated, reliable and provide appropriate access to data and information.

I also expect you to support the Ministry in developing and designing nHIP/Hira services and to prioritise nHIP/Hira implementation activities in your annual plan.

Planned care

The refreshed approach to deliver elective and arranged services, under a broader planned care programme, will build on the development of the three-year plan you started in 2019/20. Timely access to planned care remains a priority. I urge you to take advantage of the increased flexibility in where and how you deliver these services; to ensure improved equity

of access and sustainability of service delivery; and to provide services that meet your population's health care needs, support timely care and make the best use or your workforce and resources.

I am particularly concerned, across many DHBs, about the number of people waiting beyond expectations for first specialist assessments, planned care interventions, ophthalmology follow-ups and diagnostic radiology services. Please ensure you have appropriate plans in place to support timely care.

Measuring Health System Performance

The System Level Measures (SLM) programme provides a framework for continuous quality improvement and integration across the health system. I intend to build upon the SLM framework by publicising local progress in responding to my national priorities from quarter one 2020/21. I expect DHBs to work with all health system partners to agree local actions and the contributory measures needed to make a tangible impact on health system performance. This will require broadening of alliances to include partners beyond the primary health organisations (PHOs). Equity gaps are evident in all SLMs and in nearly all districts. Where equity gaps exist, I expect local actions and contributory measures to focus on addressing these gaps.

Care Capacity Demand Management

I continue to expect significant progress on implementing all components of the CCDM programme this year, including detailed plans for full implementation in all units in nursing and midwifery by June 2021. Full implementation includes annual FTE calculations and agreed budgeted FTE in place. I expect timely reporting, including your assessment on progress towards meeting the June 2021 deadline for full implementation of CCDM. It is vital that nurses and midwives see the impact of CCDM FTE increases and effective variance response management on safe staffing levels and that the core data set drives quality improvement. It remains my expectation that CE performance expectations include delivering CCDM expectations within agreed timelines.

Better population health outcomes supported by primary health care

Primary care

Primary care makes a significant contribution to improving health outcomes and reducing demand on hospital services. Continuing to improve primary health care remains a priority for this Government.

DHBs must work with their primary care partners and lead their alliance(s) to develop and implement models of care that improve equity for Māori and other high needs populations through services that target the needs of these populations. I expect these new models of care to use broader multi-disciplinary teams, strengthened inter-professional collaboration and improved integration between secondary, primary and community care. I expect high-quality information and data to be shared through formal agreements and used to support decision-making, particularly in improving outcomes for Māori.

Long-term conditions

As I have previously advised, I expect DHBs to explicitly require improvements in performance and reporting on long-term conditions in their contracts with PHOs. DHBs should incentivise PHOs to improve equity, reduce the burden of long-term conditions, demonstrate improvements in primary care settings and increase accountability for effectively managing long-term conditions, especially diabetes.

Pharmacy

Progress has been made on the strategic vision of the Pharmacy Action Plan 2016. I expect this progress to accelerate as you work with the pharmacy sector to develop funding models and models of care that are equity focused and centred on service users. Please ensure your DHB enables pharmacist vaccinators to deliver a broader range of vaccinations to improve access.

Rural workforce

DHBs with rural communities should build on 2019/20 and improve access to services for rural people. I expect you and your rural alliance partners, including rural hospitals, to explore the opportunities to use the Ministry's rural workforce initiatives to strengthen your rural workforce and improve the sustainability of rural services.

Supporting delivery of the Māori health action plan

The sector has recently engaged in the development of a Māori Health Action Plan to further implement He Korowai Oranga: the Māori Health Strategy and improve Māori health outcomes. I expect all DHBs to demonstrate delivery and implementation of this plan in 2020/21 planning documents.

Improving wellbeing through public health service delivery

Public Health Units (PHUs) are key to protecting and improving health and you should ensure that your DHB has strong and sustainable public health capability and capacity. I expect to see PHU plans integrated with DHB Annual Plans where appropriate in 2020/21.

Over the next year, a programme is underway to develop criteria and to confirm the accountability arrangements for public health service delivery. I encourage your PHU and DHB to get involved in this process and support the programme.

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Dave Cull
Chair
Southern DHB

daveccull@gmail.com

17 MAR 2020

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Dear Mr Cull

The Government has implemented a range of measures in response to the COVID-19 global pandemic. It is essential that the health system response remains coordinated, agile and rapid.

To support this, I have decided to issue a Ministerial direction to all district health boards under section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act 2004 (a copy of the Ministerial direction is enclosed).

The purpose of the direction is to ensure that there is a nationally consistent and well-coordinated response to COVID-19 that is aligned to:

- national policy decisions on COVID-19 taken by the Government
- national response frameworks published by the Ministry of Health.

In practical terms, the direction means that district health board Chief Executives are not required to seek approval from Boards to enact significant policy decisions within the Government's COVID-19 response – for example expenditure outside normal financial delegations. This is to ensure key actions required as part of the response are enacted quickly and efficiently in a rapidly-evolving environment.

However, I will still be relying on you to play a key leadership role in the health system and in delivering positive health outcomes for New Zealanders. I expect that your Chief Executive will continue to keep you well informed about such decisions throughout the COVID-19 response.

I appreciate that you will be conscious of your responsibilities as Chair as your district health board supports New Zealand's response to COVID-19. To recognise this, the Government has established a dedicated appropriation to fund your COVID-19-related activities. The accountabilities set out in your Letter of Expectation, including financial accountabilities, remain unchanged.

I want to thank you for your support for New Zealand's collective response to COVID-19. It has never been more important to ensure a cooperative and collective national response; and I know that staff, leadership and boards at all district health boards are working incredibly hard to keep New Zealanders safe.

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Thank you for your ongoing efforts.

Yours sincerely

Hon Dr David Clark
Minister of Health

COVID-19 Response Direction 2020

Pursuant to section 32 of the New Zealand Public Health and Disability Act 2000 and section 103 of the Crown Entities Act 2004, the Minister of Health gives the following direction to every District Health Board.

Part A: Information about this direction

A1 Title

This is the COVID - 19 Response Direction 2020.

A2 Commencement

This direction comes into force on the day after the date of its publication in the Gazette.

A3 Application of this direction

This direction applies to circumstances as they arise.

A4 Direction does not have retrospective effect

This direction does not have retrospective effect.

A5 Purpose of this direction

The purpose of this direction is to ensure a nationally coordinated and consistent approach to responding to the outbreak of COVID -19 across District Health Boards.

A6 Term

This direction remains in force until notice is given to District Health Boards and it a notice revoking the Direction is published in the *Gazette*.

Part B: District Health Boards to give effect to national policy in relation to COVID-19

B1 Direction to act consistently with national plans

In accordance with District Health Boards' responsibilities under section 23 of the New Zealand Public Health and Disability Act 2000 to plan and co-ordinate at local, regional, and national levels for the most effective and efficient delivery of health services, all District Health Boards must act consistently with the following national-level plans and policies :

a. The Government Response to the COVID-19 pandemic, informed by the New Zealand Influenza Pandemic Plan, a framework for action (Ministry of Health 2017); and
b. the National Health Emergency Plan (Ministry of Health 2015).

Direction ~~dated this~~ 17th day of March 2020

Hon Dr David Clark
Minister of Health

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Acquisition of Land for Road – Mutton Town Road, Clyde**
Report to:	SDHB Board meeting
Date of Meeting:	7 April 2020

Summary:

Attached is a request from Central Otago District Council to:

- Legalise part of an existing road (Mutton Town Road) under the Public Works Act 1981 to correct the historic formation of the existing road on private property, by:
  - Council acquiring ~3008 square metres of SDHB land (on Dunstan Hospital grounds), subject to survey and valuation
  - Stopping an area of unformed road and disposing of it to the adjoining owner, Dunstan Village Limited
- The first action stated above (Council acquiring land) requires SDHB Board approval.

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

Financial:	
Workforce:	
Equity:	
Other:	**Minister of Health**: Ministerial consent is required to sell, exchange, mortgage or charge land (Section 43, Schedule 3, of the NZ Public Health and Disability Act 2000). **Central Otago District Council**: The Council's position is that this is a standard process, undertaken in accordance with the Public Works Act 1981, where effectively nothing changes on the ground: it is a redefining of the legal boundaries. Currently SDHB owns land on the outside of the fence, but does not use or occupy it. That land would become legal road. Road realignment to avoid SDHB selling the land is not an option as it would take the intersection of Hospital and Mutton Town Roads **closer** to the intersection of Hospital and Sunderland Streets. Furthermore, it is a high use sealed carriageway – if it were gravel, with minimal use, it may have been an option, but not in this instance due to the multiple intersections.

Document previously submitted to:	n/a	**Date:** n/a

Prepared by:	**Presented by:**
Karen Billinghurst Corporate Solicitor **Date:** 27 March 2020	Julie Rickman Executive Director Finance, Procurement and Facilities

RECOMMENDATIONS:

That the Board:

1. **Supports the legalisation (acquisition of SDHB land for road); and**
2. **Authorises consent being sought from the Minister of Health to dispose of the land in question.**

ID: 384548

02 July 2019

CENTRAL OTAGO DISTRICT COUNCIL

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Facilities & Property Manager
Southern District Health Board
Private Bag 1921
Dunedin 9054

Attention: **Paul Pugh**
By email: ***paul.pugh@southerndhb.govt.nz***

Dear Paul

Re: **Proposed Road Stopping (& Taking) – Mutton Town Road**

I refer to you to a letter dated 08 March 2019 as received from Paterson Pitts Group, on behalf of their client, Dunstan Village Limited. The letter advises Council that a part of Mutton Town Road has been formed over privately owned land, outside of the legal road corridor, and includes an application to stop a portion of the adjacent unformed road.

The privately owned land has been identified as part of the Clyde Hospital grounds, being part Section 3 Block LV Town of Clyde, and belonging to Southern District Health Board. As shown on the **attached** map, part of Section 3 is 'fenced out' of the Hospital grounds, reflective of the historical construction error, and has the road formed over it.

Legalisation of the road is now proposed under the Public Works Act 1981. Legalisation in this instance would require two actions, being:

1. Council acquiring an area of approximately 3008 square metres of Health Board land for road, (subject to survey and valuation), from the Southern District Health Board for road, then;
2. Stopping an area of unformed road and disposing of it to the adjoining owner, Dunstan Village Limited.

If the Southern District Health Board supports the legalisation (acquisition of Health Board land for road), could you please confirm your support in principle.

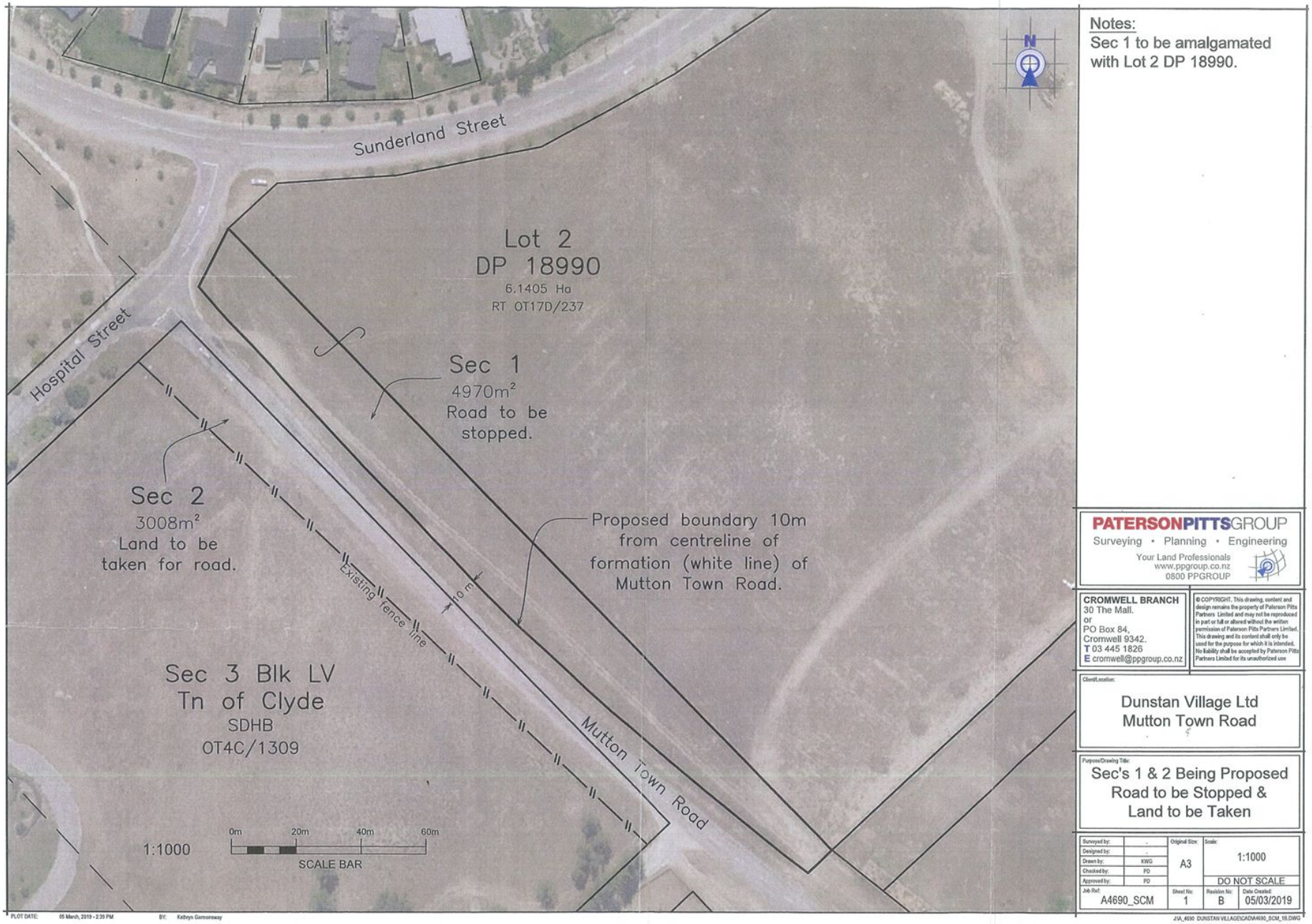
Upon receipt of your confirmation, I would commence with the process of acquisition in accordance with the Public Works Act 1981.

If you have any queries, please do not hesitate to contact me to discuss the matter.

Yours faithfully

Linda Stronach
STATUTORY PROPERTY OFFICER

Cell: 022 0144 095
Email: linda.stronach@codc.govt.nz


Sunderland Street
Hospital Street
Lot 2
DP 18990
6.1405 Ha
RT OT17D/237
Sec 1
4970m²
Road to be
stopped.
Sec 2
3008m²
Land to be
taken for road.
Existing fence line
10 m
Proposed boundary 10m
from centreline of
formation (white line) of
Mutton Town Road.
Sec 3 Blk LV
Tn of Clyde
SDHB
OT4C/1309
Mutton Town Road
1:1000
0m 20m 40m 60m
SCALE BAR
N
Notes:
Sec 1 to be amalgamated
with Lot 2 DP 18990.
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Client/Location:
Dunstan Village Ltd
Mutton Town Road
Purpose/Drawing Title:
Sec's 1 & 2 Being Proposed
Road to be Stopped &
Land to be Taken
Surveyed by: -
Designed by: -
Drawn by: KWG
Checked by: PD
Approved by: PD
Original Size: A3
Scale: 1:1000
DO NOT SCALE
Job Ref: A4690_SCM
Sheet No: 1
Revision No: B
Date Created: 05/03/2019
PLOT DATE: 05 March, 2019 - 2:39 PM
BY: Kathryn Gormonway
J:\A_4690 DUNSTAN VILLAGE\CAD\A4690_SCM_1B.DWG

11

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 Minutes a) Hospital Advisory Committee, 2 March 2020 b) Finance, Audit & Risk Committee, 20 February and 19 March 2020	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 a) Funding b) Provider Issues	Commercial sensitivity and to allow activities and negotiations (incl commercial and industrial negotiations) to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Lake District Hospital Review	To allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Contract Approvals a) Primary and Community Contract Rollover b) Refugee Services	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
South Island Patient Information Care System	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.
Primary Care Funding for COVID-19	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.
Future Home Based Support Contracting Model	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:*
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.

*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.