Southern DHB Board Meeting

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

04/02/2020 09:30 AM - 12:30 PM

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PUBLIC FORUM

At the time of going to print, no applications had been received to speak at the public forum.

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APOLOGIES

An apology has been received from Dr Nigel Millar, Chief Medical Officer.
Dr Tim McKay, Deputy Chief Medical Officer, will be in attendance.

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SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Board
Date of Meeting:	4 February 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:

- New Board Members and Crown Monitors added.

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 24/01/2020

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 works for Southern DHB		
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		
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 Universtiy School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	09.12.2019	No conflicts of interest with Southern DHB.		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
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 Company*		
	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		
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		
	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, Christrchurch		

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.
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	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
	12.12.2019	Daughter employed by Harrison-Grierson	A NZ construction and civil engineering consultancy - may be involved in tenders for DHB or new Dunedin Hospital rebuild work
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	17.11.2017	Wife works for key technology supplier CCL	Nil
	18.12.2017	Daughter, medical student at Auckland University 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

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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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Southern District Health Board

COMMISSIONER'S/BOARD MEETING ACTION SHEET

As at 24 January 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
July 2019 Oct 2019	**Fleet Vehicle Management** (Minute item 10.0) (Minute item 4.0)	Information to be provided on the intentions for fleet management and future initiatives. Further information to be provided on what is being done to ensure efficient management of vehicles, incl. how efficient use is incentivised and measured, and how the optimum number of vehicles is determined.	EDFP&F EDFP&F	Report attached.	
Sept 2019 Oct 2019	**Valuing Patient's Time (VPT) - ED** (Minute item 9.0) (Minute item 4.0)	Update to be provided on the development of an ED escalation pathway. Timeframe to be provided.	EDQCGS EDQCGS	Raised at Clinical Council.	
Nov 2019	**Not Able to Attend Policy and Guidelines** (Minute item 7.0)	Draft policy to be amended with feedback provided by Commissioner Team.	EDQCGS		Completed

Southern DHB Vehicles – Fleet Management

Introduction

- Southern owns 17 vehicles and leases 283 vehicles.
- Vehicles are based in 17 locations across the district, with the main fleets based in Dunedin and Invercargill (list at end of document).
- Current vehicle fleet supplier is Customfleet which has supplied vehicles to the DHB for 12 years, providing proactive account management, timely reporting and high quality service and support.
- The DHB sources the vehicles through the All of Government (AoG) pricing. This means the cost price of each vehicle is negotiated centrally by Government which removes the base price of the lease from the control of fleet management company. (The lease base cost is determined by the AoG price of the vehicle).
- Vehicle make and model choices for the Southern fleet are selected from the AoG list
- Vehicles leased range in type from light commercial (District Nursing vehicles) to AWD passenger vehicles (for winter driving and rural road conditions).
- Most vehicles are leased on a 45 month contract, however some specialist vehicles (e.g. District Nurse) are classified as light commercial and leased for 60 months (spreading the lease cost).
- Vehicles are selected on a range of criteria and where applicable, staff are consulted to ensure a fit for purpose vehicle that meets the service delivery needs. (e.g. rural or town driving, long/short distance, winter driving, transporting patients, transporting equipment).
- All leased vehicles are 5 star ANCAP rated
- All vehicles are petrol or hybrids. By using one fuel type the risk of incorrect fuelling is mitigated e.g. filling a petrol vehicle with diesel fuel and vice versa.
- Demand for vehicles has increased with the uplift in delivery of healthcare services throughout the community as the Primary and Community Strategy is progressively implemented.
- All vehicles are pooled where possible and all are booked with the in house electronic booking system.
- To assist fleet management, all drivers complete a running sheet for every journey. The run sheet records destination, time out and in and driver details.
- Running sheets are collated monthly by the Transport Manger, based in Dunedin.
- Running sheets inform the Transport Manager of vehicle kilometres used and ensures regular servicing and review of utilisation.

Fleet Management and Future Initiatives

Sustainability

- Government has signalled an expectation that DHBs should move to sustainable vehicles, ideally Electric Vehicles (EVs).
- A major obstacle for Southern has been the limited travel distance of EVs (approximately 200 kms only) and access to infrastructure for charging.
- The AoG price of EVs results in the lease cost being approximately twice the cost of a petrol fuelled vehicle. This, combined with the cost of infrastructure (charging stations), currently EVs are significantly more expensive to operate.
- The DHB has taken an interim step by leasing hybrid vehicles where practicable. There are currently 30 hybrids in the fleet and these typically have 30% lower carbon emissions than combustion engines.
- Over time the vehicle options available to further mitigate carbon emissions is expected to widen, thus assisting in the transition to an alternate fleet composition.

Fleet Management Software

The ability to understand the whereabouts of a vehicle in real time is fundamental to a fleet of this size.

- A range of products have been reviewed. To date, the products reviewed do not provide reporting functionality that is significantly more advantageous than the existing electronic system.
- Products are constantly reviewed for ability to provide simple GPS tracking and a reporting functionality to support management of vehicle utilisation.

Utilisation Process

- Utilisation studies are undertaken to ensure maximum use of vehicles and to assist with redistributing vehicles to satisfy service demand.
- The utilisation process is based on three sources of information:
- Electronic booking data
- Running Sheet data and
- Fuel use data
- Vehicle use is analysed via the electronic booking system. This is sense checked against the running sheets (often running sheet data varies from electronic booking data) and further validated with a final check against the fuel use for the vehicle for the month.
- Results are provided to Managers of pool vehicles and used to negotiate redistribution of vehicles. The redistribution of vehicles is the preferred option to adding more vehicles to the fleet.

List of locations of Fleet

Our fleet are very spread out across the district to match demand needs:

Dunedin
Invercargill
Gore
Winton
Lumsden
Te Anau
Frankton
Clyde
Palmerston
Oamaru
Riverton
Tokanui
Wyndham
Stewart Island
Arrowtown
Clyde
Balclutha

Community & Public Health and Disability Support Advisory Committees

- Verbal report of 3 February 2020 meeting

SOUTHERN DISTRICT HEALTH BOARD

FINANCE, AUDIT AND RISK COMMITTEE

23 January 2020

RECOMMENDATIONS TO BOARD:

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

Dunedin Hospital Interim Works Drawdown

> "That the Board approve the request for a further drawdown of capital funding for Dunedin Hospital Interim Works Projects."

Delegation of Authority Policy *(attached)*

> "That the Board approve the updated Delegation of Authority Policy."

Note: Amendments to the Delegations of Authority Policy do not come into force until approved by the Minister (s39, Sch 3, NZ Public Health and Disability Act 2000).

7.2

Southern DHB

Policy Statement

Delegation of Authority (District)

Date: November 2019

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1. Introduction

This policy sets the delegation of authority limits and all employees and board members of Southern District Health Board ('the DHB'), must comply with this policy.

Under the New Zealand Public Health and Disability Act 2000 ('the NZPHD Act') and the Crown Entities Act 2004 ('the CE Act') the DHB and the Board of the DHB have a number of functions, duties and powers. The NZPHD Act:

(a) Expressly authorises the Board of the DHB to delegate any of the functions, duties or powers of the Board or of the DHB (clause 39(5) of Schedule 3);

(b) Requires the Board of the DHB to make certain delegations to the DHB's chief executive (section 26(3)); and

(c) Requires the Board of the DHB to formulate, keep under review and amend or replace (as it considers appropriate) a policy for the exercise of its powers of delegation (clause 39(1) of Schedule 3).

This policy has been formulated by the Board as its policy for the exercise of its powers of delegation under the act and replaces any previous delegation policies of the Board.

Every exercise by the Board of a power of delegation must comply with this policy (clause 39 (3) of Schedule 3 of the NZPHD Act).

1A Definitions

In this policy:

Finance Audit & Risk Committee (FARC) means the sub-committee appointed by the Board to review matters pertaining to financial performance, audit and risk management.

Board means the members of the DHB board.

Employees includes temporary employees and contractors to the DHB.

Minister means the Minister of Health.

Conflict of interest has the meaning given to that expression in section 6 of the NZPHD Act.

The DHB refers to Southern DHB.

2. Governance

2.1 Functions, duties and powers of the DHB and the Board

The NZPHD Act and the CE Act set out the objectives, functions, duties and powers of the DHB and the Board, and restrictions on those functions, duties and powers. Those restrictions include, but are not limited to, the following:

- The DHB must pursue its objectives in accordance with its district strategic plan, its annual plan, its statement of intent, and any directions or requirements given to it by the Minister under section 33 of the NZPHD Act or sections 103 or 107 of the CE Act (section 22(2) of the NZPHD Act). The DHB's objectives are set out in section 22(1) of the NZPHD Act.
- Acts of the DHB may be invalid if they are contrary to, or outside the authority of, an Act or are done otherwise than for the purpose of performing the DHB's functions (section 19 of the CE Act). The DHB's functions are set out in section 23 of the NZPHD Act and section 14 of the CE Act.
- The Board must ensure that the DHB acts in a manner consistent with the DHB's objectives, functions and current statement of intent (section 49 of the CE Act).
- The Board must ensure that the DHB performs its functions efficiently and effectively and in a manner consistent with the spirit of service to the public (section 50 of the CE Act).
- The Board must ensure that the DHB operates in a financially responsible manner, in a way that prudently manages the DHB's assets and liabilities and in a way that endeavours to ensure the DHB's long-term financial viability and that the DHB acts as a successful going concern (section 51 of the CE Act).
- The Regional Health Services Plan or its equivalent, including any significant amendments, requires the consent of the minister.
- The Annual Plan must be agreed upon with the minister.
- This policy and any amendments to it require the consent of the minister (clause 39(2) of Schedule 3 of the NZPHD Act).
- The Board is required to put in place the following advisory committees:
  - Hospital Advisory Committee (HAC)
  - Community and Public Health Advisory Committee (CPHAC)
  - Disability Support Advisory Committee (sections 34-36 of the NZPHD Act) (DSAC)
- The terms and conditions of employment of the chief executive officer ('the CEO'), while determined by the Board, require the consent of the state services commissioner (clause 44 of Schedule 3 of the NZPHD Act).
- The Board (and its members and committees of the Board) must not interfere in respect of matters relating to decisions on individual employees (for example, relating to the appointment, promotion, demotion, transfer, personal grievances, disciplining, or cessation of employment, of an employee). These are the independent responsibility of the CEO (clause 44(4) of Schedule 3 of the NZPHD Act).
- The DHB may not borrow, amend the terms of any borrowing, give a guarantee or indemnity or acquire shares except in accordance with sections 160 – 162 of the CE Act and section 45 of the NZPHD Act.

2.2 The Board's power to delegate

Clause 39 of Schedule 3 of the NZPHD Act authorises the Board to delegate any of the functions, duties or powers of the Board or of the DHB to -

(a) A committee of the Board
(b) A member of the Board
(c) An employee of the DHB
(d) A person or class of persons approved by the Minister for the purpose

Every delegation of the Board of any of the functions, duties, or powers of the Board, or of the DHB, must

- Be in writing (clause 39 (4) and (5) of Schedule 3 of the NZPHD Act).
- Be revocable at will and does not prevent the Board or the DHB from performing the function or duty, or exercising the power (clause 39 (6) of Schedule 3 of the NZPHD Act).
- Be made to any named person or to any member of a specified class of persons; and, if made to a specified class of persons is, unless it provides otherwise, to each member of the class for the time being, even though the membership of the class has changed since the delegation was made (clause 39 (7) of Schedule 3 of the NZPHD Act).

2.3 The Powers Reserved for the Board

The Board reserves all its functions, duties, or powers with the exception of any of those specifically delegated.

3. Principles Governing All Delegations

3.1 General

Any delegated function, duty or power performed or exercised by a delegate must be performed or exercised:

- In pursuit of the DHB's objectives, as set out in section 22(1) of the NZPHD Act, in accordance with the Regional Health Services Plan, Annual Plan, Statement of Intent, and any directions or requirements given to it by the Minister under section 33 of the NZPHD Act or section 103 or section 107 of the CE Act (section 22(2) of the NZPHD Act).
- For the purpose of performing the DHB's functions as set out in section 23 of the NZPHD Act and section 14 of the CE Act (section 19(1)(b) of the CE Act);
- In a way that is not contrary to or outside the authority of an Act (section 19(1)(a) of the CE Act).
- In a manner consistent with the DHB's objectives, functions and current Statement of Intent (section 49 of the CE Act).
- Efficiently and effectively and in a manner consistent with the spirit of service to the public (section 50 of the CE Act).
- In a financially responsible manner, in a way that prudently manages the DHB's assets and liabilities and in a way that endeavours to ensure the DHB's long-term financial viability and that the DHB acts as a successful going concern (section 51 of the CE Act).
- In line with statutory requirements (in particular the requirements of the NZPHD Act).
- With due regard for the need to obtain best value from the available health resources.
- In a manner which would withstand full public scrutiny of process and outcome.

3.2 Key Principles of all Delegations

Board approval is required for any action exceeding the limits delegated to the CEO.

All new ventures and changes of policy or practice, outside those signalled in the Board approved District Annual Plan that are likely to significantly affect outputs or change access to a service, require Board approval.

Notification to the Board when appropriate is required for any management proposal or action that might attract significant adverse publicity, or can with reasonable foresight be predicted to result in legal action against the DHB.

3.3 General Principles of all Delegations

A delegate may not assign any functions, duties or powers they have been delegated, unless expressly permitted by the delegation concerned or with the written consent of the Board (clause 40(1)(b) of Schedule 3 of the NZPHD Act).

No employee shall approve timesheets, leave, expenditure, benefit, etc. which relates to themselves or for the purpose of personal gain. In all such instances, the individual's manager must give approval. CEO expenses shall require the approval of the Chair of the Board. Chair expenses require the approval of the chair of the Finance Audit & Risk Committee.

At least two people must be involved in each transaction or as specified in the delegation schedules outlined in this policy, for example, the same person should not perform all of the following functions:

- Raise a manual purchase order
- Receive the goods
- Authorise the invoice for payment

Monetary delegations refer to GST exclusive amounts in NZD.

3.4 Substitution (limited as set out below)

Substitution of approved operating expenditure can only be authorised by the CEO.

Substitution of approved capital items can only be authorised by the CEO (or delegated to joint authorisation of the Acting CEO and Executive Director Finance, Procurement & Facilities if the CEO is absent and approval is urgent)

4. Delegate Responsibilities

4.1 Conflict of Interest

Delegates must comply with clauses 39(8) and (9) and 40(2) and (3) of Schedule 3 of the NZPHD Act regarding conflicts of interest. Section 6 of the NZPHD Act defines a conflict of interest as follows:

> **Conflict of interest**, in relation to a person and a DHB, includes:
> (a) The person's interest in a transaction (within the meaning of subsection (2)) of the DHB; and
> (b) The person's interest that would, if the person were a member of the board of the DHB or a member of a committee of that board or a delegate of that board, be an interest in a transaction (within the meaning of subsection (2)) of the DHB; and
> (c) To avoid any doubt, the employment or engagement of the person, or of the person's spouse or partner, as an employee or contractor of the DHB.

Section 6(2) of the NZPHD Act provides:

> For the purposes of this act, a person who is a member of a board of a DHB or a member of a committee of such board or a delegate of such board is interested in a transaction of a DHB if, and only if, the board member or member of the committee or the delegate—
>
> (a) Is a party to, or will derive a financial benefit from, the transaction; or
> (b) Has a financial interest in another party to the transaction; or
> (c) Is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is:
> (i) The Crown; or
> (ii) A publicly-owned health and disability organisation; or
> (iii) A body that is wholly owned by 1 or more publicly-owned health and disability organisations; or
> (d) Is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
> (e) Is otherwise directly or indirectly interested in the transaction.

Under clause 39(8) and (9) of Schedule 3 of the NZPHD Act, a delegate who on any day is to perform a function or duty or exercise a power:

(a) Must, before doing so, consider whether or not he or she has (or, as the case requires, will have) on that day any conflicts of interest with the DHB; and

(b) If the delegate has (or will have) any such conflicts of interest, must give the Board a statement completed by him or her in good faith that discloses those conflicts of interest, together with any such conflicts of interest the delegate believes are likely to arise in the future. The delegate must inform the Board of any relevant change in their circumstances affecting a matter disclosed in that statement, as soon as practicable after the change occurs.

(c) If the delegate who has (or will have) no such conflicts of interest, must inform the Board of any relevant change in the delegate's circumstances affecting that fact, as soon as practicable after the change occurs.

Clause 40(2) and (3) of Schedule 3 of the NZPHD Act provides that a delegate who is interested in a transaction of the DHB may not perform a function or duty, or exercise a power, under the delegation if the function, duty, or power related to the transaction. The only exception is if the

Board has given its prior written consent to the delegate performing the function or duty, or exercising the power, even though the function, duty, or power relates to the transaction.

4.2 Restrictions on the Boards right to Delegate

The Board will not delegate:

- To any person the authority to raise capital or to specifically borrow money or enter into lease agreements for a term of more than 5 years by any means whatsoever;
- The power to sell, exchange, mortgage, or charge land. Ministerial consent is required for the Board to enter into such agreements as outlined in clause 43 of Schedule 3 of the NZPHD Act.

The Board may exercise the power to delegate:

- In the case of appropriate risk management tools such as interest risk derivatives or forward exchange contracts within limits specified under this policy.
- In the case of interest rate derivatives, joint ministers' approval must be obtained first as outlined in the CE Act. Where such instruments are entered into, appropriate reporting to the Board or the Finance Audit & Risk Committee is expected.

A delegate may, unless the delegation concerned provides otherwise, perform the functions or duties, and exercise the powers, they have been delegated in the same manner, subject to the same restrictions, and with the same effect, as if they were the Board or the DHB (including in accordance with all relevant policies and procedures set by the Board from time to time) (clause 40(1)(a) of Schedule 3 of the NZPHD Act). All delegates must familiarise themselves with the relevant provisions of the NZPHD Act, CE Act, Operational Policy Framework and Crown Funding Agreement before performing delegated functions or duties, or exercising delegated powers.

4.3 Financial Delegations

Financial delegations will apply on a 'per transaction' basis provided that the item is within the annual budget; otherwise delegation limits for items outside of budget apply.
In determining if an item is within budget or not, it is assessed against each level 4 (chart of accounts) account code line, e.g. 5260 Staff Accommodation & Meals. Items may not be netted off across a range of account codes or against a cost centre total expenditure line unless it is a planned and approved service change, for example where a salary is used in replacement of an outsourced contract. It is recognised that when ordering supplies in a clinical environment that this identification at the point of order may not be practical and retrospective approval or notification may be required.

Where a contract for goods or services is in place the delegated authority level applicable for transactions under that contract is limited to the maximum per annum contract value. This applies where transactions are paid either singularly or by instalment so that the annual contract value cannot be exceeded. The person holding delegation is responsible for ensuring transactions authorised adhere to this maximum.

4.4 Avoidance

Any attempt to bring something within delegated authority which would otherwise not be including splitting items requiring approval into smaller components and so avoiding the need to obtain approval from a person with higher authorisation limits, or any action or inaction which has

this effect, is considered to be a failure to comply with delegated authority and may result in disciplinary action.

4.5 Monitoring and Enforcement

Delegators must inform the Finance Department in writing of any new delegations they make or any additions, changes or deletions to existing delegations they have made. Refer to Appendix 2 of this policy.

Electronic workflow is enabled via the Oracle Financial System and Payroll systems and a master list is held in Finance of those personnel holding delegated authority for each cost centre area. These electronic workflows therefore monitor ordering authority on purchase orders, invoice approvals and payroll / timesheet approvals. Changes to staff holding delegated authority must be notified to Finance to enable these electronic hierarchy systems to be updated.

5. Delegations to Board Committees

5.1 Board Committees and their Roles

The NZPHD Act requires the establishment of a Community and Public Health Advisory Committee, a Disability Support Advisory Committee and Hospital Advisory Committee (sections 34-36 of the NZPHD Act). The NZPHD Act gives the Board the power, after first obtaining the minister’s approval, to establish or dissolve 1 or more other committees of the Board for a particular purpose or purposes (clause 38 of Schedule 3 of the NZPHD Act). The Board has established a Finance Audit & Risk Committee and an Iwi Governance Committee.

The Board may delegate to a committee of the Board any of the functions, duties or powers of the Board (clause 39(4) of Schedule 3 to the NZPHD Act).

5.1.1 Community and Public Health Advisory Committee (“CPHAC”)

The functions of CPHAC are to give the Board advice on the needs, and any factors that the committee believes may adversely affect the health status, of the DHB's resident population and priorities for use of the health funding provided. The aim of the CPHAC's advice must be to ensure that all service interventions the DHB has provided or funded or could provide or fund for that population and all policies the DHB has adopted or could adopt for that population maximise the overall health gain for the population the committee serves. The CPHAC's advice may not be inconsistent with the New Zealand Health Strategy (clause 2 of Schedule 4 of the NZPHD Act).

The CPHAC will oversee and monitor the DHB funder financial and operational performance, specifically this advisory committee will ensure that recommendations on allocation of funds are based on health and disability needs to advance the health and independence of people in the community. Responsibility and decision making remains with the Board.

5.1.2 Disability Support Advisory Committee (“DSAC”)

The functions of the DSAC are to give the Board advice on the disability support needs of the DHB's resident population and priorities for use of the disability support funding provided. The aim of the DSAC's advice must be to ensure that the kinds of disability support services the DHB has provided or funded or could provide or fund for those people and all policies the DHB has adopted or could adopt for those people promote the inclusion and participation in society, and maximise the independence of the people with disabilities within the DHB's resident population. The DSAC's advice may not be inconsistent with the New Zealand Disability Strategy (clause 3 of Schedule 4 of the NZPHD Act).

This advisory committee will ensure that recommendations on allocation of funds are based on health and disability needs to advance the health and independence of people in the community. Responsibility and decision making remains with the Board.

5.1.3 Hospital Advisory Committee ("HAC")

The functions of the HAC are to monitor the financial and operational performance of the hospitals (and related services) of the DHB, to assess strategic issues relating to the provision of hospital services by or through the DHB and give the Board advice and recommendations on that monitoring and that assessment (clause 4 of Schedule 4 of the NZPHD Act).

Responsibility and decision making remains with the Board.

5.1.4 Finance Audit & Risk Committee

The Finance Audit & Risk Committee has been established for the purpose of providing advice and recommendations to assist the Board in the proper auditing and scrutiny of its financial control environment and risk management issues. By approving this policy the Board delegates to the Finance Audit & Risk Committee the establishment purposes including administration and oversight of the internal audit function, liaison with external auditor, the annual report, insurance contracts and risk management issues.

Responsibility and decision making remains with the Board.

5.1.5 Iwi Governance Committee

This Committee has been established for the purpose of reducing health inequalities and improving health outcomes for Māori in accordance with government's health strategies and policies, and in particular section 4 of the NZPHD Act (Treaty of Waitangi).

5.1.8 Short-term or Specific Issue Committees

After first obtaining the minister's approval, the Board may, from time to time, establish one or more committees for particular purposes, and appoint to such committees members of the Board and/or other persons (s38, Schedule 3, NZPHDA).

5.2 Authorities of the Board and its Committees

5.2.1 Appointment of Members

The chair and membership of the advisory committees will be determined by the Board, with membership for a term up to three years.

The membership and operation of each advisory committee is determined by its Terms of Reference which have been approved by the Board.

Provisions applying to CPHAC, DSAC, and HAC are attached as Appendix 3. Provisions applying to other committees of the Board are attached as Appendix 4.

5.2.2 Levels of Authority

The Board has delegated to each committee the power to make recommendations to the Board on matters of service provision, service funding and service changes, and the power to advise the Board on issues and recommend actions.

The chairs of each committee may request management to provide information, assistance and prepare reports to their committee, to enable their committee to fulfil its particular purpose or purposes.

Each committee is accountable to the Board.

6. Delegations to the CEO

6.1 Delegation to CEO of Power to Make Decisions on Management Matters

Section 26(3) of the NZPHD Act requires the Board to delegate to the DHB's CEO the power to make decisions on management matters relating to the DHB, and any such delegation may be made on such terms and conditions as the Board thinks fit.

In accordance with section 26(3) of the NZPHD Act and by approving this Policy the Board has delegated to the CEO the power to make decisions on management matters relating to the DHB. That delegation includes, without limitation, the power to make decisions on the following management matters of the DHB:

- Human resources
- Revenue and funding contracts up to the financial limitation delegated
- Capital expenditure up to the financial limitation delegated
- Expenditure for major maintenance up to the financial limitation delegated
- Financial delegations up to the financial limitation delegated
- Property matters subject to any conditions in respect of approval
- Legal matters subject to any conditions specified
- Administration matters subject to any conditions and relevant policies
- Supplies and services subject to any conditions and up to the financial limitation delegated
- Research matters subject to any conditions in respect of approval.

6.2 Delegation of other Functions, Powers and Duties to the CEO

The Board further delegates to the CEO its functions, powers and duties under any statutory enactment which authorises delegation to the CEO. The Board may delegate the implementation of any decision it has made to the CEO.

6.3 Terms and Conditions of Delegations

Delegations made to the CEO are made on the following terms and conditions:

(a) The Board consents, in accordance with clause 40(1)(b) of Schedule 3 of the NZPHD Act, to the CEO assigning:

- Any non-financial powers, duties or functions set out in this Policy and
- The financial powers, duties or functions in accordance with Appendix 1.

(b) Delegations made do not include:

- Delegation of any function, duty or power of the Board or of the DHB which the Board currently retains or exercises; and
- Any delegation to a committee of the Board.

And otherwise on the terms and conditions set out in this policy.

6.4 CEO to Maintain Delegations Register

The CEO will maintain a register of delegation authorities (Oracle hierarchy system) in accordance with this policy. The delegations register will show what delegations are in force, and where they are not open-ended, the dates at which attention should be given to renewal. The register will also record the statutory power that has been delegated, the office held by the delegate, any conditions on the delegation, and whether consent is given to sub-delegation.

7. Delegations to Persons Outside DHB / Board

If the Board desires to delegate any functions, duties, or powers to persons who are neither members of the Board nor employees of the DHB, the prior approval of the minister is required.

8. Powers, Functions and Duties Reserved for Minister

In addition to those matters detailed in clause 4.2, the NZPHD Act, the Public Finance Act 1989 and government policy require approval by the minister of the following transactions:

- Sale of land and buildings
- Borrowing or financing transactions not conducted by The Treasury
- Cooperative arrangements
- Purchasing and holding of shares or securities
- Creating or settling trusts.

9. Related Matters

9.1 Governance

By approving this policy, the Board has made the delegations in relation to governance matters to the persons listed in Appendix 1.

9.2 Process for Delegating Responsibilities

This clause applies where employees holding delegations wish to sub delegate any delegated authority they have. For delegating powers, duties or functions of the DHB or the Board, the delegator will:

- Define the powers, duties or functions to be delegated specifically outlining the limits of the powers, duties or functions being delegated;
- Determine to whom it is proposed the powers, duties or functions are to be delegated ("the potential delegate"), particularly ensuring that the person is not 'interested' in the transaction;
- Define the criteria to be used in assessing whether to delegate the power;
- Assess the competence of the potential delegate to perform the powers, duties or functions being delegated;
- Determine and then approve the fitness of the potential delegate for delegation;
- Formally delegate in writing the powers, duties or functions as defined;
- Consider the question of sub-delegation of that power and any conditions attached to that sub-delegation.

9.3 Temporary Assignment

Whenever a manager of a DHB who has been delegated functions, duties or powers, and who has the power to assign all or part of his or her delegations takes leave or is going to be absent for a significant period, he or she should decide whether any of those functions, duties or powers ought to be temporarily assigned to another employee to ensure continuation of the service. For the purpose of this policy 'assign' includes 'sub-delegate'. Delegations may be assigned in part.

Temporary assignments are made using the financial system's AP approval workflow routing rules. This will notify the assignee and specifies the length of time the temporary assignment is to be in effect. It is mandatory to have this temporary assignment approved by the manager of the person temporarily delegating their authority at the time the absence is approved and such approval may be evidenced by email communication or through the leave approval process.

Permanent assignment using the forms in Appendix 2 (part B) requires 'one-up' approval.

9.4 Policy Review

This policy shall be reviewed annually. The DHB's Finance Audit & Risk Committee shall review and make recommendations to the Board. Any policy amendments require the further approval of the Minister.

9.5 Related Policies

- DHB Code of Conduct Policy
- Procurement and Tendering Policy
- Sensitive Expenditure Policy
- Conflict of Interest Policy
- Treasury Policy

Delegates must also consider and reference where appropriate the following guidelines:

- State Sector Standards of Integrity & Conducts
- Controller & Auditor General Controlling Sensitive Expenditure Guidelines

Appendices:

1. Delegation Schedule
2. Assignment of Delegated Authority
3. Provisions Applying to CPHAC, DSAC and HAC
4. Provisions Applying to Other Board Committees
5. Delegations under Other Enactments

Appendix 1 – Delegation Schedule

Level 1	Chief Executive Officer
Level 2	All Executive members
Level 3	Tier 3 & Tier 3A
Level 4	Tier 4
Level 5	Cost centre budget holders, Financial Controller (FC)
Level 6	Zero delegation unless “sub delegation” form completed

Note: All amounts are GST exclusive in New Zealand dollars.

Delegation of Authority	Ability To Sub-Delegate	Board	Level 1	Level 2	Level 3	Level 4	Level 5	Policy Statement and Comments
1.01 Annual Business Plan								
Approve Annual Plan	No	✓						Annual Plan, Regional Health Services Plan and Annual Report and associated financial statements require Board approval.
1.02 Expenditure outside of Business Plan								
>=$250,000	No	✓						
<$250,000	No		✓					
<$100,000	No			✓				
Approve capital programme	No	✓						
Approve operating budget	No	✓						
1.03 Capital Expenditure (including leased assets)								
>=$500,000	No	✓						Delegations must be aligned with the itemised approved capital plan and exercised relative to the complete item (i.e. not broken down into components).
<$500,000	No		✓					
<$100,000	No			✓				
Contingencies >$250,000	Yes	✓						
=<$250,000	No		*✓	✓				* In the absence of the CEO joint approval of Executive Director Finance, Procurement & Facilities and Executive Director Specialist Services required and only if urgent.
Substitution	Yes		*✓					* In the absence of the CEO joint approval of Executive Director Finance, Procurement & Facilities and Executive Director Specialist Services required and only if urgent.

Delegation of Authority	Ability To Sub-Delegate	Board	Level 1	Level 2	Level 3	Level 4	Level 5	Policy Statement and Comments
1.04 Capital Asset Disposal (excluding land & buildings)								
Net market value >=$250,000	No	✓						Asset disposals must comply with asset disposal policies and in all cases the best net realisable value must be sought. Sales of land or buildings require minister's approval.
Net market value <$250,000	No		✓					
Book or market value <$50,000	No			✓				
Book or market value <$10,000	No				✓			
Book or market value <$1,000	No					✓		
1.05 Operating Expenditure within Approved Budget other than gifts, sponsorship and staff travel, hospitality, entertainment & recruitment								
>=$500,000	Yes		✓					All expenditure is expected to be generated in accordance with the purchasing policy & procedures.
<$500,000	Yes			✓				
<$250,000	Yes				✓			
<$50,000	Yes					✓		
<$5,000	Yes						✓	
ACC, PAYE / GST / FBT / Capital charge & interest payments	Yes		Executive Director Finance, Procurement & Facilities or Financial Controller					
1.06 Human Resources / Dismissals								
Dismissal of any staff	Yes		✓					Can be delegated on a specific case by case basis. If a regulated health professional, then involve the relevant Level 2 manager.
1.07 Human Resources / Payroll								
Disciplinary for L3 & above	Yes		✓					In line with HR policies.
Disciplinary for L4 & below	Yes			✓				In line with HR policies.
Suspension of staff	No			✓				All cases to be reported to the chief executive.
Signing of MECA documentation	No		✓					
New, replacement & temporary (excl SMO/RMO Locum) appointments and increases in FTE within budget								All staff appointments have an automated workflow that requires recommendation from L5 thru to L4 and approval by L3.
- Salary >$150,000	No			✓				
- Salary < $150,000	No				✓	✓	✓	
Unbudgeted appointments (permanent or temporary)	No		✓					
								Within agreed organisational parameters established and maintained by HR .
SMO / RMO locum expenditure	No				✓			

Delegation of Authority	Ability To Sub-Delegate	Board	Level 1	Level 2	Level 3	Level 4	Level 5	Policy Statement and Comments
Salary progression outside of contractual arrangements or budget parameters	No		✓					Salary progressions / appointments require 1 level further up counter approval.
Relocation expenses > HR policy	No		✓	✓				
Recruitment costs >= $40,000	No		✓					
Recruitment costs < $40,000	No			✓				
1.08 Human Resources Personal Grievance / Severances								
>=$50,000	No	✓						The limits referred to in this section exclude any contractual entitlement.
<$50,000	No		✓					Must be disclosed to Chief Executive and Finance, Audit & Risk Committee
<$20,000	No			✓				
1.09 Write-Offs (Bad Debt and Stock)								
>=$50,000	No	✓						Finance Audit & Risk Committee recommends to the Board.
<$50,000	No		✓					
<$25,000	No			EDFPF				
<$2,000	No				FC			
1.10 Receiving Gifts, Hospitality, Entertainment & Donations								
Non-financial gifts >=$1,000	No		✓					Gifts, hospitality, entertainment and the 3rd party provision of education/attendance at conferences and accompanying goods by 3rd parties with a value > $1000 must be cleared on a two up basis with the exception of the CEO which is one up (the Board). Any individual gift, donation or sponsorship offered over the value of $150, or cumulatively over $500 in any twelve month period from the same source, must be entered and approved into the electronic gift register that is available on the Intranet. A hierarchy will create automated workflow for approvals. If a conflict of interest exists the gift will be declined or donated towards a worthwhile cause as nominated by staff member with sign-off approval.
Non-financial gifts >=$500 & <$1,000	No			✓				
Non-financial gifts >=$200 & <$500					✓			
Non-financial gifts < $200 & >$100						✓		
Financial gratuities	No							Cash gifts are not to be accepted under any circumstances as set out in the Gifts and Sponsorship Policy.

Delegation of Authority	Ability To Sub-Delegate	Board	Level 1	Level 2	Level 3	Level 4	Level 5	Policy Statement and Comments
1.11 Giving of Gifts / Koha								
Koha / Gifts >$100	No		✓					The giving of gifts is generally not supported from public funds, however culturally there are circumstances by which a Koha will be given, these circumstances are covered in the related Koha policy, and any Koha given under this delegation must be in line with the policy. Gifts are also given for recognition of long service in accordance with the organisational approach determined over time by the Executive Leadership Team / Board. Generally gifts should not be cash or items transferrable to cash, and valid receipts must be produced.
Koha / Gifts >$50<=$100	No			✓				
Koha / Gifts <=$50					✓			
1.12 Staff Travel / Expenses and Hospitality (non CME)								
>=$10,000	No		✓					All staff travel approvals and expense reimbursements must be approved on a one-up basis and therefore must not be authorised by: • Themselves, • Their peers *or* • Their subordinates Claims for hospitality must be by the most senior employee present at the event. Approved hospitality and entertainment expenditure shall be limited to a maximum of $50 per person at any event. All staff expenses reimbursements must be authorised in accordance with the Sensitive Expenditure and Staff Travel Policies. All international travel (excluding the east coast of Australia) is to be signed off by a L3 or above within the above limits. All approval of travel is on a one-up basis. CEO reimbursements and travel are approved by the Board Chair. Note the limits are related to the entire event i.e. travel, registration, accommodation etc
<$10,000	No			✓				
<$5,000	No				✓			
<$1,000	No					✓		
<$500	No						✓	
Note: If > 6 people are attending the same conference, L1 signoff is required. If > 3 and <=6 people are attending the same conference L2 signoff is required.								

7.2

Delegation of Authority	Ability To Sub-Delegate	Board	Level 1	Level 2	Level 3	Level 4	Level 5	Policy Statement and Comments
1.13 Staff Travel / Expenses and Hospitality (CME)								
>=$25,000	No		✓					Note the limits are related to the entire event i.e. travel, registration, accommodation etc
<$25,000	No			✓				
<$15,000	No				✓			
1.14 DHB Contracts and Multi-Year Contracts for Revenue or Expenditure								
Contracts with a term > five years regardless of value unless it is a national procurement agreement	No	✓						• Contracts to follow Contract Approval Workflow / Policy agreed at the DHB. • Terms and conditions are specified in the DHB contractual documentation and are reviewed by legal and approved by management. • National procurement contracts still require approval under the specified annual value limits. • Any contract that has a right of renewal (whether automatic or not) shall be considered to have a term equal to the sum of its component terms (e.g. a 3 year contract with a 3 year right of renewal would be considered to be a 6 year contract for the purposes of this document and therefore need Board approval) . Revenue contracts are only to be approved if the cost of delivering the contract can be met within the contracted revenue (including overheads). • Any extension of term must consider the total contract value, not just the variation amount
>=$1,000,000 (annualised)	No	✓						
<$1,000,000 (annualised)	No		✓					
<$500,000 (annualised)	No			✓				
<$100,000 (annualised)	No				✓	Portfolio/ Service Manager for Funder Arm		
1.15 Trust, Bequest & Research Funds								
Use of trust, bequest or research funds must be in accordance with the stated purpose and by the nominated signatory to the funds. If signatories or purpose are not specified then the following applies.								
>=250,000		✓						
<$250,000	No		✓					
<$50,000	No			✓				
<$5,000	No				✓			Requires two approvals, one of which must be the Executive Director Finance, Procurement & Facilities.
<$2,000	No					✓		Requires two Level 3 approvals, one being relevant senior manager.
								Requires one approval.

Delegation of Authority	Ability To Sub-Delegate	Board	Level 1	Level 2	Level 3	Level 4	Level 5	Policy Statement and Comments
1.16 Treasury and Finance								
Set and amend treasury investment, forex, debt and trading policies	No	✓						The Treasury Policy sets out guidelines and requirements. National Banking Collective Arrangement will apply.
Approve investment in treasury bills, government stock, bank deposits and other securities	Yes	✓		EDFPF	FC			
Approve finance leases	No			EDFPF	FC			
Approve foreign exchange cover	No			EDFPF	FC			
Approve interest rate hedging	No	✓						
Approve main banking relationship	No	✓		EDFPF				Set under national procurement National Banking Collective Arrangement will apply
Approve all permanent bank facilities and overdraft arrangements	No	✓						
Approve drawdown of debt within arranged facilities	Yes			EDFPF				
Approve cheque signatories	No	✓	CEO	EDFPF	FC			
Approve other bank accounts	No	✓						
Approve short-term investments per Treasury Policy	Yes			EDFPF	FC			

Appendix 2 – Assignment of Delegated Authority

Part A - Temporary Assignment of Delegated Authority

Temporary assignments are made using the financial system's AP approval workflow routing rules per the instructions below. The assignee will need to have access to Oracle Financials (see Appendix 2 part C)

1. You need to log on to oracle Financials.
2. Next you need to navigate through the following oracle menus
   - Select from the menu AP Approval
   - Select from the menu Work List
3. Next you need to click the option of Routing Rules, it is located on the bottom left side of the screen

4. Next you need to click the option of Create Rule, it is located on the right side of your screen. *Please note that you can have one person approving purchase orders (requisitions) and another person approving invoices.*

   Next you need to select the relevant option you require from the drop down list

   You may have several options the following are relevant to Delegating Authorities

   a. Requisitions, will only delegate the Requisition for approve onto the delegate

   b. SA AP Invoice, will only delegate Invoices for approve onto the delegate

   or

   c. All, will do both purchase orders and invoice approvals

   d. After you have selected your type press Next

5. Rule Response - you need to enter the following fields

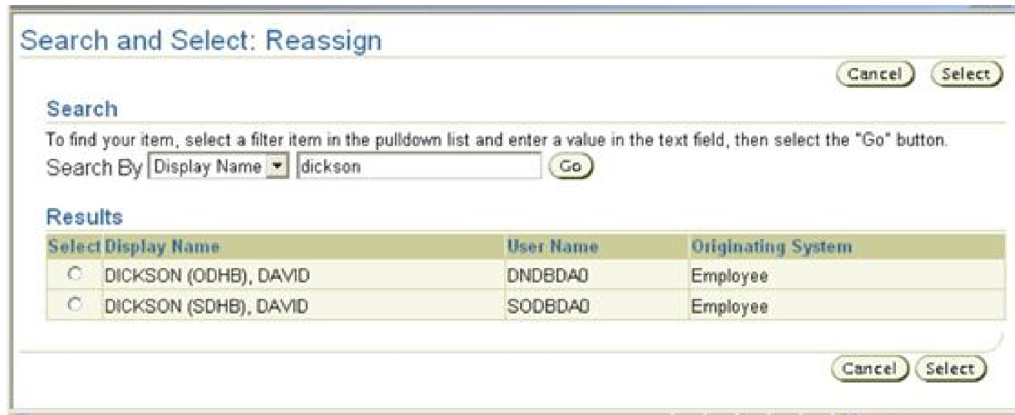
Rule Response
Complete the form below to set up the proper response for the rule.
Item Type All
Notification All
* Start Date 10-Dec-2008
(example: dd-MMM-yyyy)
End Date 11-Dec-2008
(example: dd-MMM-yyyy)
Message Annual Leave 10th of December
Comments will display with each routed notification
Reassign COOKE (ODHB), DEREK
Delegate your response
Transfer notification ownership

Start Date – the **first date of your absence**, this can be a future start date set-up in advance

a. End date – this is the **date of your first day back at work**, therefore the delegation will be effective up and until that day.

b. Message regarding why this delegation is needed
i.e. for your two week annual leave period or for one week while you are at conference

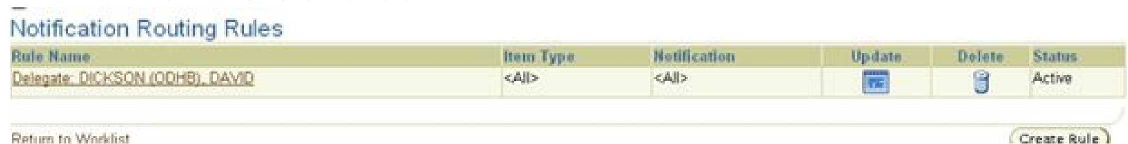
c. Reassign - you then need to **select who you are delegating to by clicking on the torch – if someone is listed twice choose the correct ledger (20) or (21)**. The torch brings up the search and select box where you need to enter the Surname of the person you are delegating to (make sure whoever you are delegating to has oracle access with AP approval menu).



d. Select Delegate your response

e. Press Submit to complete the delegation of your authority

6. How to review, edit and delete your rules
   a. Complete steps 1,2 and 3 – this will show you the list of current rules in place
   b. If you need to edit a rule you can just click on the Update option on that rule and complete step 5
   c. If you need to delete a rule you just click on the Delete option on that rule and that will remove that rule.



Part B –

Assignment of Delegated Authority

Why	For assignment of delegated authority to enable new / existing personnel to authorise requisitions or invoices over and above existing delegated responsibility.
Considerations	1. That the person you are delegating to is appropriate under the delegations policy, and familiar with the delegations policy. 2. What type of authority and amount you wish to delegate That the person who you are delegating to has the correct oracle access. If they don't have the correct access please ensure that this is requested (allow two working days).
What needs done?	As part of delegating your authority you need to:- 1. Complete all sections of this form. 2. List all cost centres this delegation is to apply to. 3. You need to decide the type and what $ value you intend to delegate (note this value can be different for catalogue requisitions, non-catalogue requisitions, and Invoice approvals). 4. This form must be authorised by the delegating manager and also the appropriate manager's supervisor for the cost centres which the authority applies.

Assignment of Delegated Authority

I ……………………………………………………… Position ………………………………………….

Employee number: ……………………………..…

Delegates name ……………………………………. Position…………..……………………………….

Employee number ……………….…………………

This delegation is effective from ____/____/______

Cost centre/s (*please state all applicable Cost Centres including those currently held*)
………

………

………

Sub-delegation is: (*Tick where appropriate)*

☐ Purchasing: Catalogue orders $……..................

☐ Non catalogue orders $ …………………….……

☐ Invoice approval $ ………………………………

Other / Special Conditions (if any, i.e. partial sub-delegation on specific duties).

……

……

……

______________________________________	______________________________________
Signed by delegator	Approved and signed by delegator's supervisor
______________________________________	______________________________________
Print name	Print name
Date:_________________	Date:_________________

Send to: Hierarchy administrator, Finance Department
E-mail to: Hierarchy administrator

PART C – Request / Access to Financial System

Access to Oracle Financials

Why	For new and existing personnel requiring access to oracle financials.
Considerations	As part of this access you need to consider 1. The person you are giving access to is appropriate under the Delegations Policy. 2. Do you have the appropriate authority to delegate this position 3. Is the person able to complete their tasks under the current delegation level. 4. Does this affect an existing delegation. 5. Access is not immediate. (Allow two working days.)
What needs done?	As part of allowing access to Oracle you need to: 1. Confirm person is appropriate under Delegation Policy 2. This form must be authorised by the authorised manager (level 1-5) for the cost centres being allocated. 3. Select the appropriate level with your position - any additional delegation you will need to complete an Assignment of Delegated Authority Form 4. Complete all sections of the form and return to: Hierarchy administrator, Finance Department, Email: Hierarchy administrator 5. Access will be given once Oracle training is completed

Levels of Delegation

Level	Description
Level 1	Chief Executive Officer
Level 2	All Executive members
Level 3	Tier 3
Level 4	Tier 4
Level 5	Cost centre budget holders, Financial Controller (FC)
Level 6	Zero delegation unless “sub delegation” form completed

Oracle Financials Set-up

Requirements for gaining Oracle access

- This form must be authorised by a suitable manager for the cost centres listed below and returned to hierarchies administrator, Finance Department.
- All staff must attend a training session before being given their access to the Oracle system.
- You will be contacted to make a suitable time for training in Oracle financials and internet procurement.
- Sub delegation other than below must have a sub delegation form completed .

Is this a new user Yes / No

Change to an existing Oracle user Yes / No

Start date: ……………………………………

Employee number …………………………..

Surname ……………………………………………………………………………………..

First name …………………………………………………………………………………….

Hospital e-mail ……………………………………………………………………………….

Phone extension ………………………………………Network user ID ……………………………

Job position /Title …………………………………………………………………………………...

Please specify ALL cost centres ……………………………………………………………………….

…….

Please circle level of delegation as per delegations policy: 6. 5. 4. 3. 2. 1.

Levels of Delegation as per Delegations Policy

Level	Description
Level 1	Chief Executive Officer
Level 2	All Executive members
Level 3	Tier 3
Level 4	Tier 4
Level 5	Cost centre budget holders, Financial Accountant (FA)
Level 6	Zero delegation unless “sub delegation” form completed

Does this delegation replace an existing staff member Yes / No

(Note this will remove existing staff member’s delegation permanently as at end date)

Employee name ……………………………………Employee number …………………

End date: ……………………………………………

Is this holiday cover Yes / No

_______________________________________ Date _____/_____/________

Signed by manager

____

Print name

Appendix 3 – Provisions Applying to CPHAC, DSAC and HAC

Extract from New Zealand Public Health and Disability Act 2000/Schedule 4. Provisions applying to community and public health advisory committees, disability support advisory committees, and hospital advisory committees:

6 **Members**

(1) Members of the committee:

(a) Must each be appointed by the board by notice in writing to the member for a term, not exceeding 3 years, stated in the notice together with the date on which the member comes into office:

(b) Are eligible for reappointment.

(2) A person who is a member of a board of a publicly-owned health and disability organisation may not be appointed as a member of a committee that regularly advises, or is likely regularly to advise, on matters relating to transactions of a kind in which the person is interested.

(3) Before the board of a DHB appoints a person who is not a member of that board to a committee, the person must give the board a statement completed by the person in good faith that—

(a) Discloses any conflicts of interest that the person has with the DHB as at the date on which the statement is completed, or states that the person has no such conflicts of interest as at that date; and

(b) Discloses any such conflicts of interest that the person believes are likely to arise in future, or states that the person does not believe that any such conflicts are likely to arise in future.

7 **Terms or conditions of office, and remuneration**

Members of the committee:

(a) Have the terms or conditions of office, consistent with this Act, that the board determines; and

(b) Are remunerated [in accordance with section 47 of the Crown Entities Act 2004 and are entitled to be reimbursed for expenses in accordance with section 48 of that Act as if the members of the committee were members of the DHB.

8 **Resignation**

A member of the committee may resign from that office by notice in writing to the committee and board stating the date on which the resignation takes effect.

9 **Vacation of office**

(1) A member of the committee ceases to hold that office if:

(a) the period of his or her appointment expires; or

(b) he or she dies; or

(c) the DHB to which the board relates is disestablished by an Order in Council made under section 19(2).

(2) For the purposes of subclause (1)(c), a DHB is not disestablished just because it—

(a) is renamed; or

(b) is involved in a reorganisation of districts (as described in clause 18 of Schedule 2); or

(c) has its district altered (as described in clause 19 of Schedule 2).

(3) Subclause (1) overrides any deed or agreement.

10 Removal from office

(1) A member of the committee may be removed from that office by the board by notice in writing to the member and committee stating the board's reasons for the removal and the date on which the removal takes effect.

(2) A board may exercise the power under subclause (1) only if it has first consulted the member, and committee, about the removal.

(3) Subclauses (1) and (2) override any deed or agreement.

11 Chairperson and deputy chairperson

(1) A board:
  - (a) must appoint a member of the committee as chairperson of the committee; and
  - (b) may appoint another member of the committee as deputy chairperson of the committee.

(2) The appointment must be by notice in writing to the member and committee that—
  - (a) may be the same notice as the notice under clause 6(1)(a) appointing the member; and
  - (b) must state the period (starting at or after the time the member comes into that office, and ending at or before the time he or she must cease to be a member) for which the member is appointed chairperson or deputy chairperson and the date on which he or she comes into that office.

(3) A member appointed chairperson or deputy chairperson and whose appointment as such has expired—
  - (a) continues in that office until his or her successor is appointed; and
  - (b) is eligible for reappointment to that office so long as he or she continues to be a member of the committee.

12 Resignation

A chairperson or deputy chairperson of the committee:
  - (a) may resign from that office by notice in writing to the committee and board stating the date on which the resignation takes effect; but
  - (b) if he or she does so, continues to be a member of the committee unless he or she also resigns from that office, under clause 8.

13 Vacation of office

(1) A chairperson or deputy chairperson of the committee ceases to hold that office if he or she ceases to be a member of the committee.

(2) A deputy chairperson of the committee ceases to hold that office if he or she is appointed chairperson of the committee.

(3) Subclauses (1) and (2) override any deed or agreement.

14 Removal from office

(1) A chairperson or deputy chairperson of the committee may be removed from that office by the board by notice in writing to the chairperson or, as the case requires, deputy chairperson, and committee stating the board's reasons for the removal and the date on which the removal takes effect.

(2) A board may exercise the power under subclause (1) only if it has first consulted the chairperson or, as the case requires, deputy chairperson, and committee, about the removal.

(3) Subclauses (1) and (2) override any deed or agreement.

(4) A chairperson or deputy chairperson removed from that office continues to be a member of the committee unless also removed from that office, under clause 10(1).

15 Board to notify minister of appointments, etc.

(1) The board must give the Minister notice of any appointment, resignation, vacation of office, or removal from office, of any chairperson, deputy chairperson, or member of a committee, under any of clauses 6, or 8 to 14.

(2) The notice must be in writing and given as soon as practicable, and no later than 10 working days, after the board becomes aware of the appointment, resignation, vacation of office, or removal from office.

Appendix 4 – Provisions Applying to Other Board Committees

Extract from New Zealand Public Health and Disability Act 2000/Schedule 3. Provisions applying to DHBs and their boards:

38 Committees

(1) A board of a DHB may:
- (a) After first obtaining the minister's approval establish 1 or more committees of the board for a particular purpose or purposes:
- (b) Appoint, as members of a committee of the board, or as the chairperson or deputy chairperson of any such committee, either members of the board, or other persons, or both:
- (c) Dismiss any member, or chairperson, or deputy chairperson, of a committee of the board:
- (d) Dissolve any committee of the board.

(2) In making appointments to a committee of a board, the board must endeavour, where appropriate, to ensure representation of Māori on the committee.

(3) If a board of a DHB dismisses any member, or chairperson, or deputy chairperson, of a committee of the board, under sub clause (1)(c), the board must, on or as soon as reasonably practicable after the dismissal, give that person a written statement of the board's reasons for the dismissal.

(4) A board may regulate the procedure of each committee of the board in any manner not inconsistent with this act the board thinks fit.

(5) If meetings of a committee of a board involve making decisions or resolutions on behalf of the board, clauses 16 to 24, 28, and 31 to 35 apply to those meetings as if the committee were the board.

(6) Before a board of a DHB appoints a person who is not a member of the board to a committee of the board, the person must give the board a statement completed by the person in good faith that:
- (a) Discloses any conflicts of interest that the person has with the DHB as at the date on which the statement is completed, or states that the person has no such conflicts of interest as at that date; and
- (b) Discloses any such conflicts of interest that the person believes are likely to arise in future, or states that the person does not believe that any such conflicts are likely to arise in future.

Appendix 5 – Delegations under Other Enactments

Pursuant to section 26 and clause 39 of Schedule 3 of the act, the Board delegates to the CEO any function or duty required to be performed, or any power that may be exercised, by the DHB.

8

SOUTHERN DISTRICT HEALTH BOARD

Title:	**2019/20 ANNUAL PLAN**
Report to:	Board
Date of Meeting:	4 February 2020

Summary:

Considered in this paper are:

- Public release of the 2019/20 annual plan.

The annual plan is a core accountability document for each District Health Board. The development of the annual plan is undertaken annually and is a confidential document until the Minister of Health formally signs it off.

Ideally the annual plan would be signed before the financial year starts on 1 July, however given the timing of the governments budget announcements, which are late May, achievement of this has not been possible over the past few years. The 2019/20 annual plan was endorsed by the Commissioner Team and the formal approval was received on the 19th December.

The document is therefore now the key accountability document in terms of performance expectations. The Minister's approval letter is attached.

The final annual plan is not replicated in this Board pack as the Board members already have access to it in the resource centre in Diligent Board Books. Members of the public and the media can access the document at www.southernhealth.nz

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

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

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

Prepared:	**Presented by:**
Chris Fleming Chief Executive Officer **Date:** 4 February 2020	Chris Fleming Chief Executive Officer

RECOMMENDATION:

That the Board:

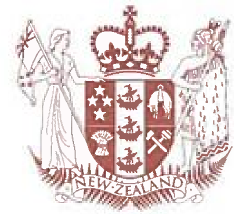
- **Note** the approved 2019/20 annual plan.

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance



19 DEC 2019

Mr David Cull
Chair
Southern District Health Board
davecculI@gmail.com

Dear David

Southern District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed Southern District Health Board's (DHB's) 2019/20 Annual Plan for one year together with the Minister of Finance, as submitted by the previous DHB governance.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan on the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

The Annual Plan indicates an improving out-years position. However, I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that as Chair, along with your Board, you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

I am aware you are planning a number of service reviews in the 2019/20 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute

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approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

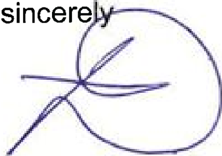
I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your annual plan.

8

I would like to thank you, your staff, and your Board for your commitment to delivering quality health care to your population and wish you every success with the implementation of your 2019/20 Annual Plan. I look forward to seeing your achievements.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely



Hon Dr David Clark
Minister of Health

Hon Grant Robertson
Minister of Finance

cc Mr Chris Fleming
Chief Executive
Southern District Health Board
chris.fleming@southerndhb.govt.nz

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	4 February 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 report.
Workforce:	As set out in report.
Other:	As set out in report.

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

Prepared:	**Presented by:**
Chris Fleming Chief Executive Officer **Date:** 27 January 2020	Chris Fleming Chief Executive Officer

RECOMMENDATION:

That the Board:

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

CHIEF EXECUTIVE OFFICER'S REPORT

1. PURPOSE

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

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

2. ORGANISATIONAL PERFORMANCE

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

- Finance report
- High Level Volumes
- Performance Dashboard.

These reports are deliberately at a high level for Board reporting purposes. More detailed reports will be in sub-committees with finance being discussed in the Finance, Audit and Risk Committee (FARC) Meeting, Disability Support Advisory Committee/Community and Public Health Advisory Committee (DSAC/CPHAC) Meeting, and Hospital Advisory Committee (HAC) Meeting. Volumes will be in HAC, and Quality in FARC.

Overall, the financial position is extremely challenging with us being $5.4 million adverse to plan. Some of this adverse position is as a result of events during the year we were not expecting, such as the issues in Neurosurgery, the handling of the Measles outbreak, and implications of industrial action. Some of the adverse result is as a consequence of higher than expected demand increases associated with pharmaceuticals more specifically cancer pharmaceuticals, some is associated with higher costs of locums and overtime expenditure in areas hard to recruit, particularly in senior medical officers (SMOs) and in some Allied Health areas, and some is associated with general demand pressures across our system. Unfortunately, we continue to be plagued by some budgeting inaccuracies, which while reduced from previous years, still exist. A focus on optimising the achievements against the five savings plans is ongoing, however there are challenges in translating the performance improvements demonstrated in valuing patients' time into tangible savings, and the medical workforce right sizing is taking considerably longer than was expected.

It is worth noting that the actual deficit of $22.507 million on a year to date basis is an improved financial performance on the same time period last year, which was sitting at $25.925m. Unfortunately, the latest information released publicly is indicating that in the two months to the end of August 2018 the sector had a deficit of $83.3 million and this has increased to $102.8 million. Six DHBs' financial positions had improved on a year to date basis while 14 had deteriorated. Southern's had improved, however it was still the fifth highest deficit amongst the DHBs.

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. In essence, on a year to date basis, inpatient activity, as measured in caseweights, is 2.5% up on plan and 3.1% up compared to the same year to date period last year. The mix of inpatient activity is quite different with medical caseweights up 6.2% on the same period last year, surgical up 0.6% and maternity up 5%. Acute surgical activity has dropped on the same time period last year by 0.5%. Mental health (measured in bed days) has also reduced by 0.6%. Looking at the emergency department (ED), overall volumes have grown by 2%, however it has reduced in Dunedin by 1%, increased in Southland by 1% and increased in Lakes by 13%. 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 is also alarming as there has clearly been a large step which makes the medium term planning even more important.

The performance dashboard is a new report out of Board which shows key quality and performance initiatives covering patient experience, effectiveness, efficiency, and timeliness. The majority of the indicators are very much hospital orientated and as such should be further developed over time. Key take away messages from this report highlights significant issues with over promising and under delivering with Elective Service Performance Indicators (ESPIs) with 694 patients breaching ESPI 2 (waiting for outpatient assessment) and 837 patients breaching ESPI 5 (waiting for surgery). Care should be taken to not confuse the ESPIs and unmet need. ESPI results simply highlight whether we have kept our commitment to patients and treated them if we say we would. We, like all other DHBs, are falling short on this. The other key indicators indicating significant issues are the number of patients with a length of stay of >7 days and the radiology turnaround which is exceptionally poor (see the separate paper on computed tomography (CT)).

We are presenting the information as a package of three components to ensure that when we are reviewing and monitoring overall DHB performance we ensure we balance our assessment of the situation. There is no single silver bullet indicator that one can keep an eye on to know everything is well, but rather a suite of indicators.

Of interest, if we look at expenditure, excluding external provider payments, on a year to date basis to the previous year our expenditure has risen by $19.4 million or 6.1%, however if we look at total caseweights they have increased by 3.1%. This means our costs have risen by 3% over the cost structures in the previous year compared to workload with caseweights as a proxy. Using caseweights as a proxy is not an exact science as there is a significant amount of work undertaken in the hospital including ED activity, outpatient activity, mental health etc which are not measured in caseweights, but it is a high level check. In terms of reality, cost pressure of 3% year on year given the industrial settlements is not necessarily unexpected, however the challenge is that we did not anticipate the volume growth to the extent it is.

3. CORONAVIRUS UPDATE

A novel coronavirus first diagnosed in Wuhan, in the Hubei province of China, has now been reported in other cities in China and other countries including Japan, Thailand, Korea, the USA and Australia.

Person-to-person transmission has been confirmed. To date there have been no cases identified in NZ.

Signage for Chinese and other travellers arriving at international points of entry, along with health advice cards, have been developed and distributed for use. The Ministry of Health have scheduled regular updates to the health sector.

Southern DHB's risk is primarily Queenstown Airport, but risk of internal movements will also be present if cases are identified in NZ.

Preparatory actions underway:

Southern DHB has an Emerging Infectious Disease Coordinating Committee (EIDCC) which will meet as a matter of urgency this week. The Committee has started the formalising coordination of activity as it becomes required.

Beneath the EIDCC there is an Emerging Infectious Diseases Technical Advisory Group that operationalises plans and escalates issues up for decisions/information.

The EIDCC will meet as often as required and communicate immediately as follows:

- Briefings to the Chief Executive and Board
- Communications – briefings to the organisation, district, WellSouth, rurals etc
- For now we intend to communicate daily as public awareness increases.

The Ministry of Health, based on the Public Health Emergency of International Concern (PHEIC) declaration from the World Health Organisation (WHO), will issue a White Alert to the health sector setting out the process for border screening if it is required.

4. PLANNING 2020/21 – MINISTRY OF HEALTH EXPECTATIONS – PLANNING 2020 AND BEYOND

Historically, the DHB annual planning process has followed a pathway of:

- In early December draft annual planning guidance is issued to DHBs for use in their planning cycle for the year beginning 1 July
- Immediately prior to Christmas, the Ministry of Health would release draft 'funding envelopes' which would indicate the funding the DHB would be receiving in the next financial year
- Draft Annual Plans were then submitted to the Ministry in late March/early April
- Feedback would then be received in late April, with resubmission in early May and approval of the plan being received in June through September.

A couple of years ago the Government indicated that advance notice of funding envelopes would not be received anymore, and since then we have had to wait until Government's budget night in late May for formal advice of funding. The planning process has been in a reasonable degree of chaos since then and annual plans largely end up being supported in the last quarter of the calendar year, i.e. the annual plan for the year starting on 1 July 2019 was not approved until December.

The other issue has been that both the DHB and the Ministry have placed a lot of emphasis on year 1, but limited emphasis on year 2 and 3 other than broader macro assumptions and bottom lines.

Immediately prior to Christmas, the Ministry of Health set out expectations that all DHBs would be required to submit detailed financial templates phased by month for three years by 28 January 2020 and the draft annual plan submitted by 3 March 2020. These requirements were new expectations of DHBs and included in the annual planning guidance, but without any dialogue or communication with DHBs. For Southern, along with most other DHBs, these change of expectations were not noticed until early this year.

Southern has placed a lot of focus on trying to ensure that the Annual Plan is aligned with more detailed Service Planning. The criticism in the past has been that the Annual Plan is very template driven and is at times remote from the more substantive service planning. This has created tension and to a large degree distrust. To try to get a balance of both pace and buy in we are going to submit a draft annual plan in accordance with the 3 March expectation. This plan will align with the template required by the Ministry of Health, but will have considerable holes in it. We will then submit a more substantive document in early April. This will give us time to allow input from:

- Community Health Council
- Clinical Council
- Southern Alliance
- WellSouth Primary Health Network
- Iwi Governance Committee.

It will mean that the Board endorsement of the draft Annual Plan will be sought at the April Board meeting, however there may be a need to consider a special meeting to review in March. If this is the case, the suggestion will be to attach it to the date of the Finance, Audit and Risk Committee meeting. The Annual Plan is not a document considered in open Board meetings as there is a requirement that the document is confidential until approved by the Ministers of Health and Finance.

The formal timetable the Ministry of Health published is:

Activity	Date (2020)
DHB strategic conversations	From February
DHBs submit draft Annual Plans, Statement of Performance Expectations (SPE), financial templates, Regional Service Plans to the Ministry.	*2 March*
Feedback to DHBs on first draft Plans and release of guidance for any additional confirmed Government priorities	9 April
Final Plans due to the Ministry	*Tbc*
DHB Board signed SPE to be published on DHB websites	Before end of June
Ministry approval of SLM plan	31 July
Any outstanding 2020/21 SPEs tabled with 2019/20 Annual Reports	December

5. BUDGET 2020/21

The development of the budget for 2020/21 is underway. The challenge in the development of the budget for 2020/21 is the balance between business as usual, which is a large part of the health system, ensuring we are supporting change to

occur, and addressing critical system constraints. Some examples of the conflicting challenges include:

- Demand pressure in the hospital
- Enhancing access to diagnostics
- Implementing a Generalist Model of Care for Medicine
- Oncology resourcing constraints (both radiation and medical)
- Investing in Planned Care and expanding access to elective activity
- Investing in the next steps of the Primary and Community Strategy
- Investing in enhancing the digital footprint of the health system
- Enhancing Primary Mental Health
- Enhancing services in the Central Otago area where population growth is a factor
- Investing in developing and changing the workforce to ensure it meets future needs.

These areas are not exclusive, the list will be extensive, however in a DHB with relatively stable population projections and little growth, the ability to invest is heavily influenced by the extent of change and its ability to release resources. Overall funding growth does not track ahead of inflationary and modest demand pressures.

The annual planning guidelines require the DHB to identify a subset of five initiatives from savings plans that are expected to have most significant impact in 2020/21. It is clear that the Ministry of Health's and Minister of Health's expectations are that the financial performance of Southern, and infact all DHBs, improves in 2020/21. We will need savings initiatives to both contribute to this as well as make space for investment in priorities supported by the Board.

The tough challenge is always looking to see what we may be doing which we potentially should either do differently or not at all to free up resources to enable the needed investments in priority areas. Unfortunately, the low hanging fruit have already been extracted.

In terms of the planning timetable, we have fallen behind in the timeline for a multitude of reasons. Key (relative to budget) Executive team members met on 22 January to discuss and have committed to reviewing where things are and to be able to present a plan for the steps moving forward to the Chief Executive. A verbal update will be provided to the Board at the Board meeting. It is expected that we will have a budget workshop on 2 March 2020 before the Hospital Advisory Committee Meeting to consider the draft budget prior to submission to the Ministry of Health that week.

6. HEALTH SELECT COMMITTEE ANNUAL REVIEW

Every year the Health Select Committee sends a list of questions out to each DHB to respond to. The list of questions generally come in around November and the Select Committee holds hearings and asks a small number of DHBs to attend. DHBs who are living within their means generally tend to be called every few years while those in intensive monitoring are normally called each year. The list of questions are extensive and this year there are 365 questions. Our responses are due to be submitted by 7 February.

The hearing is supposed to be looking back at the year that has been, i.e. 2018/19 for the February review, however given the political nature of the proceedings there are normally as many questions asked about moving forward as there have been on looking backwards. Topics covered are rarely about the subjects traversed in the questions, but are more topical subject to key issues at the time. For Southern they have indicated they want to cover primary maternity, and I am sure they will traverse the rebuild of Dunedin Hospital, our financial performance and some of the clinical risks that we have been open about over the past year.

The hearing is on 12 February. The people who would normally attend are the Chief Executive and Chair along with the Chief Medical Officer and the Executive Director Strategy, Primary & Community. In this instance, the Committee has requested that the former Commissioner also attends.

7. RESOURCING IMPLICATIONS OF PHARMAC DECISIONS

The issue of resourcing implications of PHARMAC decisions has once again raised its head. The PHARMAC model is well established within New Zealand. In essence, PHARMAC manage a national pharmaceutical budget, they negotiate with the pharmaceutical companies and they make decisions about which drugs to fund based on evaluation and evidence understanding the cost and the benefits. They have a track record of doing really well with management at a national level, however DHB by DHB the budget management is more variable as the actual results are very much driven by individual prescriber behaviour and clinical needs.

One of the frustrations however, is that PHARMAC are not responsible for addressing any resourcing implications from their decisions. While I understand that they do look into the downstream resourcing requirements, their budget process only addresses the cost of the drug. So take a simple example, if PHARMAC add a drug to a schedule, which say costs half of the previous drug that would have been utilised, but requires more clinical input for each patient, PHARMAC take the savings from the old drug to the new one and uses those savings to invest in further pharmaceuticals. The DHB then is left paying for the drug, the new pharmaceuticals that PHARMAC invest in, and the additional clinical input required. A real example is PHARMAC's recent decision to fund Palbociclib, which will be given to approximately 70% of women with incurable breast cancer. In the trial, the drug prolonged control of the cancer by a median ten months and survival by a median six months. This is clearly excellent news for women and their families/whanau, however for each person prescribed the drug there is a need for two to four weekly blood testing, four to six weekly clinic appointments, monthly nurse phone assessments, and three monthly CT scans. Based on the number of women expected to be prescribed the drug in Southern this will add:

- 390 extra follow up clinic appointments
- 468 nurse phone consultations
- 156 extra CT scans

This is only one of many new drugs that are/have been added to the schedule and it is placing considerable pressure on already stretched resources. We are advocating that the total cost of supporting new drugs should be included in the evaluation/decision making and that when making such investment decisions all the required resources should be included in that decision making.

I have raised these issues with the Director General of Health and encouraged consideration of a wider conversation to find sustainable solutions to move forward.

8. PRIMARY AND COMMUNITY STRATEGY

Good progress is being made with regards the implementation of the Primary and Community Strategy. The two key planks in the current year is the progress on the implementation of Healthcare Homes, the establishment of the first locality network being Queenstown Lakes/Central Otago, and the conceptual development of the Community Health Hubs. Each of these priorities have different drivers.

Locality Network

The locality network has been prioritised on Queenstown Lakes/Central Otago as this is the area of the most rapid growth in population and has the least developed health infrastructure. Rather than allowing adhoc and piecemeal development we are wanting to take a locality approach focussing on planned development over time, which fits the needs of this locality whilst also at the same time integrates into the wider Southern Health System. A key deliverable for this locality network is advice on how to further develop primary maternity services across this locality. This is expected to be provided by June 2020 which will then enable key decision making moving forward.

Community Health Hubs

The Community Health Hub activity is largely centred around Dunedin, being driven by the key assumption in the New Dunedin Hospital development, which assumes that medical demand will be 30% less than the counterfactual (that is current practice continuing and growing solely on change in population and demographics), centred around contemporary models of care and the expansion of activity which could and should be occurring in the community. On this front, meetings of interested primary care teams and key clinical personnel from specialist services commenced in December, with a plan for them to now be held monthly, with an open invitation to all who are interested. The idea is that the group will work together to identify better ways of working together to develop improved outcomes for patients, and to inform what services might be appropriate to deliver from a community health hub, once these are established. There was a clear commitment shown from both WellSouth and DHB management to eliminating the barriers that prevent teams from working together effectively and efficiently.

In the initial meeting the wide ranging conversation included:

- The importance of health pathways, and the opportunity to super-charge this framework in future
- Artificial, contractual and system barriers to integration exist but are not insurmountable and need to support new models of care
- The bricks and mortar conversations can wait until the models of care are agreed
- The opportunities for workforce development go hand in hand with the integration approach
- There is a need to find space for services outside the new hospital rebuild, but co-location without integration will be a missed opportunity
- There are services that are absolutely keen to develop an integrated model right now. These are where general practice teams and hospital teams agree there is opportunity for new ways to work
- While funding will follow the patient, there needs to be a funding model that recognises collaboration time and outcomes, rather than 'bums on seats'
- There are solutions to problems with information sharing that will be implemented to enable integration.

The group will meet again on the evening of 27 January with a focus on the following areas, who have been identified as early adopters for the new model, in addition to the previously identified areas of Health of Older People, Mental Health and Child Health:

- Diabetes
- Wound care
- Rheumatology
- Respiratory

In addition, conversations are underway as to how we enhance our pathways strategy to facilitate the development of integrated models of care across these services.

There is some natural tension as the statement "bricks and mortar conversations can wait until the models of care are agreed" is a noble statement, however this needs to be tempered with ensuring pace and scale can be achieved. A critical part of the Community Hub development is integration, without integration all we would be doing is developing alternative facilities away from the hospital. It is important that progress is made as we need these services evolving and developing in the community well ahead of the New Dunedin Hospital development. Seeing progress will influence directly the needs within the hospital.

9. ELECTIVE SURGERY PATIENT FLOW INDICATOR (ESPI) RECOVERY

The government policy on elective services is that we should only accept the volume of referrals for specialist outpatient assessments to the extent we have the resources to see, and that we see all of these patients in clinical priority order, but within a maximum of four months. This is measured as ESPI 2. Once seen in clinic, if the patient needs surgery once again, it is to be prioritised and we are required to provide patients with 'certainty' once again when we have the resources to treat them. This indicator is called ESPI 5. There are certain exceptions to this rule and this includes cardiothoracic surgery where New Zealand operates an entitlement system, meaning if you meet the criteria then there is an expectation the surgery be provided, and cancer related surgery where we never decline referrals on the basis of resources available.

Unfortunately, over a very extended period of time, Southern has traditionally accepted more referrals than we have the resources to see and then treat, and as such we are non-compliant with the government's expectations. Recovery plans have been developed for ESPI 2 and we are still in the process of developing recovery plans for ESPI 5.

We now have the processes in place so that the Southland general surgery service can use the prioritisation tool as the basis for determining which referrals can be accepted into the service (ESPI 2). The service is almost in balance (referrals accepted are close to what the service has the capacity to see) and we envisage that the tool will allow us to fine tune what is accepted and consistently manage to keep the service in balance.

There is willingness on the part of the general surgeons in Dunedin to also use the tool. However, we have been slowed down by a lack of nurse triaging capacity. We are working on solving this as quickly as we can and envisage starting use of the tool in February.

Our next priority, in terms of using the tool, is obstetrics and gynaecology on both the Dunedin and Southland sites. We have asked for a meeting with each of the clinical teams in late January/early February. The services believe they are triaging carefully and accepting only patients who meet health pathways criteria. However, the reality is we are still consistently accepting more referrals than they can see, and a relatively large proportion of referrals are for routine issues. We will work though the logic of utilising the prioritisation tool with these services on the same basis as we have with urology and orthopaedics in Dunedin.

Our ESPI 2 performance has deteriorated slightly in the last six weeks and we are very keen to ensure there is continued momentum in this programme and that it keeps moving. We will be making this a key focus in the first quarter of 2020.

As well as the prioritisation tool, we want to systematically implement the acuity booking tool. This tool ensures that patients are booked in priority order on the basis of both how urgent their condition is and how long they have been waiting. The tool is live with ENT and urology, and will go live with obstetrics and gynaecology in December. We will also look at systematically implementing the tool in other services, too.

The electives services manager has implemented monthly wait list checks. The principle of these checks is that patients >120 days are systematically reviewed and either booked if they have become sufficiently urgent, or corrected if they are a data quality issue (e.g. have already had their surgery).

We believe the above initiatives form the basis of our 'formula' for recovery, i.e. only accept what we have the capacity to see, ensure we see patients in an appropriate order, book patients if they have become more urgent and regularly cleanse our data.

We have also been working on an ESPI 5 recovery plan, and we are now showing ESPI 2 and ESPI 5 side by side on the dashboard at our weekly ESPI meetings as we develop an understanding of the supply and demand balance for surgery, too.

Our ESPI 5 recovery plan will focus on the three services which comprise circa 80% of our current breaches. These are general surgery, orthopaedics and urology (all in Dunedin). An outline for our plan (under construction) is as follows:

- General Surgery Dunedin – we have re-directed capacity from neurosurgery (we can no longer complete three neurosurgery lists per week as we do not have surgeons to resource the lists, so we are sending patients to Christchurch when our available surgeon is not rostered on). This has enabled us to give general surgery two additional half day theatre lists, which we have been able to resource from within existing capacity. We estimate recovery by August/ September with this additional capacity.
- Urology Dunedin – likewise, we have provided the urology service with an additional six hour list per week, which was a neurosurgery list. This will allow the service to recover their breaches, but will require a longer timeframe (of 12-15 months). Once again, we will be able to utilise existing surgical capacity.
- Orthopaedics Dunedin – we have not finalised quantifying the plan for orthopaedics yet. However, we have reduced referrals accepted (from about 85% of referrals received being accepted to about 55%), and although the conversion rate of referrals to surgery will increase, the total number of referrals accepted for surgery should reduce overall. We will quantify this as part of finalising the plan.

We have advised the Ministry that we won't be submitting our formal ESPI 5 recovery plan to them until we have gained approval from the Executive Leadership

Team and the Board. However, we have stepped them through what will be included in the plan at a high level.

10. ELECTIVE DELIVERY

We are still ahead of plan on a year to date basis. However, the strikes and acute pressures impacted us in October, as did less outsourcing (we deliberately slowed this down to bring back year to date outsourcing to match budget). This was further exacerbated by intensive care unit (ICU) blockages for circa two weeks in November, where bed block let to a number of cancellations, particularly cardiothoracic. As of the end of December we were circa 53 caseweights ahead of plan on a year to date basis, so we are still ahead of plan, but our safety margin has dwindled.

We have undertaken a deliberate programme of identifying arranged admissions that have been coded acutely. An initial look at the data has found that a sample of 50 discharges generated 22 caseweights. The total sample available to us is 400 discharges, and whilst the same rate of conversion may not be possible across the full dataset, we will seek to maximise caseweight revenue that can be achieved from this. We are also progressing with a report which identifies non-cardiothoracic cases which were on our elective wait list and have subsequently received their surgery acutely, on the advice of the CEO who has previously gained agreement with the Ministry that these could be re-coded as electives. The report parameters are proving complex, but we are persevering as once completed there may be a number of opportunities to rebook what was acute work load as elective workload.

A significant amount of work has also gone into ensuring that January lists are as filled as possible, so that January is run as a normal month.

11. ANAESTHETIC PROCEDURE ROOM

Our business case for conversion of our anaesthetic procedure room into an operating theatre was approved by the Commissioners in November 2019. The capital expenditure request has been raised, but it has proven to be a slow journey getting approvals in place. We envisage getting approvals in place in the next week so that the project can be planned and initiated.

12. STERILE SERVICES

The capital expenditure for the new theatre sterile supply unit has been successfully raised and planning work is now underway. With the ongoing high rate of conformities in our non-fit for purpose current facility it is imperative that we get this project moving and landing as quickly as possible. Detailed design work planning is now underway. In the meantime, an educator role is desperately needed in the service to try to work around the constraints that exist and to minimise staff related non-conformities. We are working out how to offset the financial impact of needing this additional role.

13. GENERAL SURGERY – CANCER CASES

A high number of cases has been identified as needing to be completed between now and into January. Altogether, 13 lists worth of activity was identified. The data we are collecting suggests a steady increase in cancer cases requiring surgery. A

high proportion of these are colorectal and the increase correlates with additional screening per the bowel screening programme. However, there also appear to be increases in a number of other cancer types, as well.

The team is reporting that they have made good progress in getting through this cancer workload. In some cases they have had to reallocate capacity from lower priority lists both in general surgery but also in other specialities, too.

14. INTENSIVE CARE UNIT (ICU)

An independent review has now been completed to understand what will be required to get the air handling to the standard required by council (10 air changes per hour) and clinically (circa 12 air changes per hour in some areas). We will review the recommendations in early December and work with building and property to formulate an overall plan.

15. GENERALISM

Work is continuing on the Generalism case, as outlined earlier. We are developing a financial model in early December which will quantify the net financial benefit once the additional SMO teams and the saved bed days from earlier assessments (both real bed days saved and notional, bed days growth avoided) are taken into account. We still need robust input from building and property with a pre-concept design for the medical admitting unit in order to get our case to completed first draft status. We have found a design from Hawkes Bay which meets most of the requirements and have forwarded this to building and property as a starting point for what the design will look like. The team have also looked at reconfiguring the general medicine wards to reduce outliers, which will assist with the overall benefits that could be achieved. Apart from the commercial case (which requires at least a high level concept design and associated cost estimate), the overall case will be completed in first draft by the end of December. Consultation and socialisation will then occur in late January so that the case can be iteratively improved prior to a final case coming to ELT and Board proposing investment.

16. EMERGENCY DEPARTMENT

A workshop has been run recently to decide what tactical actions can be taken ahead of next winter to manage the acute pressures placed on both the Emergency Department and the hospital during winter. We are looking forward to the outputs, which will enable some proactive planning to occur (given that the medical assessment unit won't be built next winter in Dunedin, and there is unlikely to be any build work completed at Southland, either). A good understanding is required in terms of the underlying capacity required at Southland given the high presentations there relative to the rest of the country. However, placeholder items have been requested on the capital list for both the medical assessment unit in Dunedin and capacity in Southland, so that if a robust case is made, there isn't a missed opportunity by virtue of not having an item on the capital list (which will then be considered further in early 2020).

17. RADIATION ONCOLOGY

A proposal has been developed seeking circa $1m of capital from the Ministry of Health to invest in our linear accelerator project. As the Ministry has indicated that a high level request is all that is required a full business case has not been produced, rather we have produced a high level request for funding instead.

18. ANTENATAL TELEMEDICINE CLINIC TRIAL

The Wanaka antenatal telemedicine clinic trial led by Dunedin based Obstetrics and Gynaecology (O&G) consultants late in 2018 has been successful. An ongoing clinic has continued in 2019 with positive feedback. Request received for extension of this service to other areas in Central Otago. Plans are underway to commence a second telemedicine clinic located in Dunstan in 2020.

Excellent work has been undertaken by the Urogynae nursing and medical team in the development of a joint led Urogynae clinic for these women. The clinic encompasses both the initial gynaecology FSA and the Urodynamics testing in the same visit to determine surgical plan on the day if required.

19. ROYAL AUSTRALIAN AND NZ COLLEGE OF OBSTETRICS AND GYNAECOLOGY (RANZCOG) REACCREDITATION OF SOUTHLAND HOSPITAL

The reaccreditation visit was undertaken early December 2019 and the outcome being full accreditation for a period of four years ending 31 December 2023 which is a credit to Clinical Leader Dr Jim Faherty and the team.

20. NURSING ENTRY TO PRACTICE (NETP) AND NURSING ENTRY TO SPECIALTY PRACTICE (NESP) (MENTAL HEALTH)

NETP/NESP 2020 recruitment assessment centres were held in early October in Southland and Otago. The numbers of applicants were consistent with previous years with 137 applicants.

All offers have been made though the advanced choice of employment (ACE) programme and new graduates have been appointed to 12 month fixed term positions in line with approved budgeted FTE.

There are two cohorts, one commencing end of January and the other group at the beginning of April with phased FTE correctly budgeted this year to cover the six week supernumerary period.

Efforts have been more successful this year to increase the Māori workforce to better reflect the local population mix with 12.5% Māori, 3.7% Pacific Island and 6.25% Asian. Our DHB Preceptorship Training Programme continues to be delivered six times a year across the district, with strong demand for places and increasing involvement from the Otago Polytechnic School of Nursing.

21. ACE NURSING PROCESS FOR ENROLLED NURSES

Additional funding will be received by DHBs to support a new graduate enrolled nurse programme. The national Director of Nursing group wants to have a national talent pool process which remains open throughout the year and allows for three intakes. At a local level, DHBs and NETP Coordinators will be responsible for working

with local tertiary training providers to ensure that students and providers understand the process. The group raised concerns about the lack of clarity around this funding and the Ministry of Health will forward more information clarifying the costs and how to access the funding. The DHB Directors of Nursing will lead the Enrolled Nurses Framework that is being developed.

22. AUSTRALIAN NURSE EDUCATORS CONFERENCE (ANEC)

A very successful conference was held in Dunedin organised by Otago Polytechnic in collaboration with Southern DHB and Mercy Hospital. Approximately 350 delegates from across Australasia attended with excellent presentations given by a number of nurses from across the Southern Health system. This was another opportunity to strengthen relationships with our tertiary partners.

23. 2020 YEAR OF THE NURSE AND MIDWIFE/NURSING NOW

2020 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. The Directors of Nursing and Midwifery will be working with nursing leaders across the system to promote nursing and midwifery through various campaign activities and communications throughout 2020.

24. NURSE PRACTITIONER TRAINING PROGRAMME

The Ministry has developed an open tender process for an expanded nurse practitioner training programme (NPTP). The request for proposal (RFP) is now on the Government Electronic Tender Site (GETS) website.

The Ministry is seeking collaborative responses between educators, employers, and other parties and we are liaising with Auckland and Otago Universities.

Part One: Nurse Practitioner Training Programme (NPTP)

The aim is to expand the current training programme (NPTP) with a focus on those who will work in a substantive mental health and/or addictions role in primary mental health, and to increase the numbers and support for Māori nurse practitioner and Pacific nurse practitioner candidates.

Part Two: Supported placements for nurse practitioners and enrolled nurses in primary mental health settings

The aim of the supported placement of nurse practitioners and enrolled nurses (with wrap around support) is to showcase nurse practitioners and enrolled nurses in primary mental health care settings and to increase access to mental health and addictions support for people in high needs populations.

25. NURSE PRACTITIONER COTINUING MEDICAL EDUCATION (CME)

The Minister requested all DHBs have a CME policy in place by June 2020 as a requirement in this year’s annual plan. The Directors of Nursing are working together to achieve consistency. Some DHBs already have such policies in place (mostly an annual $6k ring-fenced entitlement). This will need to be prepared in advance of budget decisions of 2020/21.

26. CNM/ACNM LEADERSHIP DEVELOPMENT

A successful leadership forum was held on the Southland site for all charge nurse managers (CNMs) and associate CNMs, previously held on the Dunedin site earlier in the year. The programme focussed on leadership expectations with emphasis on charge nurse accountabilities, quality of care and nursing standards. Further forums will follow with a dedicated one to be scheduled as soon as possible on effective nursing workforce management including effective rostering practices.

27. DIRECTOR OF MIDWIFERY ROLE

The Director of Midwifery role is a critical one for our DHB and the wider Southern Health System and we are now advertising this position following a thorough review of the role purpose and functions.

Extensive feedback was received from a widely distributed survey and this feedback has either been used to inform the structure going forward, been reflected in the position description or will be used to inform decision making in the appointment process. Southern DHB is strengthening midwifery leadership and this has resulted in us committing to introduce additional operational leadership reporting to the Director of Midwifery once the position has been appointed to. The Director of Midwifery role is now positioned to focus more on championing professional leadership and strategy for improving the quality of care for women and their babies across all maternity settings. We will be looking for someone who will 'lead with influence' across the wider system strengthening the midwifery voice at all levels as well as championing new models of care, workforce planning and development. We will follow a robust recruitment process involving our professional and union partners including the NZ College of Midwives, the Midwifery Employee Representation and Advisory Service (MERAS) and the Ministry of Health, as well as consumer input. We will be advertising until the end of January (five weeks) to ensure no one misses the opportunity to apply due to leave over the festive season. It was important that we did not delay the process any further balanced with taking time to get it right. In the interim period Heather LaDell will continue the Director of Midwifery role in an acting capacity until a suitable appointment is made.

28. MEASLES EPIDEMIC EMERGENCY RESPONSE SAMOA

Four registered nurses and one paediatrician went to Samoa on secondments for a week each to assist with the measles epidemic emergency response. This was a valuable learning experience for all staff.

29. WHAKAARI/WHITE ISLAND ERUPTION

ICU was able to assist with the White Island tragedy by taking a patient from Christchurch ICU to free up some capacity in Christchurch Burns Unit. A number of ICU nurses on leave over the Christmas period assisted with staffing the Counties Manukau National Burns Unit over the holiday period as part of a national request for assistance. At this stage only nurses on leave are being deployed, however if more response is needed there may need to be reduction in elective activity to achieve this. This request would come via the CEO and Chief Nursing and Midwifery Officer.

30. CARE CAPACITY DEMAND MANAGEMENT (CCDM)

Safe Staffing Accord National Update

The Ministry, NZ Nurses' Organisaiton (NZNO) and the DHBs are progressing the commitments of the Accord:

Part A - Employment of all nursing and midwifery graduates

- An Interim process for distribution of increased volumes and distribution of funding is decided for 2020.
- Contracts, service specifications and accountability mechanisms are being developed.
- Funding of full employment of graduates who apply via ACE will commence with the mid-year 2020 intake.
- The Accord Operations Group is working with Central Technical Advisory Services (TAS) to strengthen data analysis to measure success of employment within six months and placement settings of new graduate nurses.
- The subgroup for implementing the enrolled nurse support into practice programme (ENSIPP) is working on service specifications and a framework for the programme, as well as deciding the allocation and matching process.

Part B – Additional safe staffing and CCDM implementation by 2021

- The Ministry continues to review and refine its accountability levers for implementation of CCDM.
- Further discussion with Accord signatories is needed to agree the level and nature of oversight required and the continued role the Group will play
- The first reporting on the National Reporting Framework has occurred and has been shared with the Minister.

Part C - Develop a strategy for workforce retention

- A 'bundles of intervention' approach has been agreed, with multiple actions to address contributing factors and to enable relevance to the varied employment settings.
- A subgroup has been formed to refine actions, with Central TAS and General Manager Human Resources completing a stocktake of current retention and recruitment activities across DHBs.
- Links to a campaign for 2020 International Year of the Nurse and Midwife are under development.
- A budget bid for 2020 for re-entry to nursing is being prepared.

Safe Staffing Healthy Workplaces Unit Governance Visit

We are awaiting a confirmed date for the visit likely to be late February or March.

Highlights

The CCDM Council has supported the recommended 0.7 FTE increase following completion of the FTE calculation process and this has now been approved. Inter-rater reliability (IRR) testing at 100%. Undertaking minimum staffing workshop with the Mental Health Addiction and Intellectual Disability (MHAID) Directorate.

Acuity and Workforce Management (AWFM) Steering Group

December/January CCDM/TrendCare information poster release to staff. IRR testing 100% completed by 10 wards. Significant improvement for wards commencing IRR

testing and those completing compared to 2018. Communication from Safe Staffing Healthy Workplace Unit in relation to delaying the submission time for the Quarter 2 National Milestone Report, now 20 February 2020.

Mental Health, Addiction and Intellectual Disability Service Improvement Plan

Ward 9C held their second Local Data Council (LDC) meeting, was not a quorum however education conducted. Planning underway for rollout of LDC for remaining MHAID wards, ward 6C and Inpatient Mental Health Unit (IMHU) Southland next with rest by mid-2020. Close support for ward 10A senior leadership and staff continues. Daily operations meeting commenced and currently in development to best meet MHAID needs. IRR testing for all MHAID should be complete by end December 2019. Senior leadership to continue to encourage e-learning participation.

Safe Staffing - Local Data Councils (LDC)

Neo-Natal Intensive Care (NICU) commenced. Queen Mary commenced. Next: Neo-Natal Unit (NNU) to join Children's Ward (CW) beginning 2020. Critical Care Unit (CCU) meeting held to initially discuss LDC formation, further discussions to occur 2020. Wakari/Dunedin MHAID ward to roll out LDCs, ward 9C commenced in October, plan in place for ward 6C and IMHU, then the rest to follow early 2020. Southland Maternity and Te Puna Wai Ora will be early to mid-2020.

Maternity Improvement Plan

First LDC held on 4 December. VRM planning advancing well. Health Informatics Team Leader undertook an assessment of Maternity computer hardware and updated information technology programmes to enable staff to utilise TrendCare effectively and efficiently. IRR testing delayed and Queen Mary requiring close support from Maternity TrendCare Coordinator to aid 100% completion.

31. CONSUMER PARTICIPATION IN IMPROVING COMPLAINT LETTERS

A patient contacted the DHB to provide feedback on how we could improve our management of complaints. His main concern related to the language used in letters, and what felt like the absence of caring due to how some letters were constructed. Positive meetings have been held with the patient and a plan formed to utilise the feedback in staff education and training. The timeline for this is Quarter 3 2019/2020.

32. ADVERSE EVENT TRAINING

Fifty staff from Dunedin and Southland attended a two day Adverse Event Review workshop in Dunedin in December. The training was facilitated by the Health Quality and Safety Commission, and targeted at key people from all clinical disciplines who regularly undertake reviews. Attendee feedback has been very positive.

33. CERTIFICATION

Full engagement with the responsible leads for the Certification Corrective Actions. Collation of the progress update almost complete. This will be prepared for submission to the Executive Leadership Team in January 2020 in preparation for uploading on the Ministry of Health website on 27 January 2020.

34. EMERGENCY MANAGEMENT

A Spark network outage activated the emergency operations centre (EOC) at Dunedin Hospital in response to the communications issues. An email based debrief has been employed to gather staff feedback and thoughts. Actions from this outage have included a staff wide updating of personal details on Employee Connect to ensure home addresses and emergency contacts are up to date (with an offline repository of this information to be updated monthly), investigation into dual SIM phones, and identification of mass call back processes of staff through broadcast radio. Lessons learnt from the outage are being shared in future training programs and via the intranet. A business case for emergency radios is under development.

35. DISABILITY AWARENESS TRAINING

Disability awareness training is now on offer to all staff within Southern DHB. To date 346 staff have completed it (~7%) voluntarily, however from early 2020 it will be included in the mandatory training.

36. COMMUNITY HEALTH COUNCIL (CHC)

An Iwi representative has been confirmed by the Iwi Governance Committee for the CHC. The Chair and CHC Facilitator will meet with this new member ahead of their first CHC meeting.

Chris Fleming
Chief Executive Officer

27 January 2020

Southern DHB Financial Report

Financial Report for: 31 December 2019
Report Prepared by: Finance
Date: 16 January 2020

Report to Board

This report provides a commentary on Southern DHB's financial performance for the period ending 31 December 2019 and the financial position as at that date.

The net deficit for the month of December was $5.7m, being $1.9m unfavourable to budget. The key contributors to the unfavourable variance for the month were Workforce costs, Outsources Clinical Services, and Clinical Supplies.

10.1

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 31 December 2019

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								
89,511	89,085	426	F	Government & Crown Agency	537,653	535,206	2,447	F	505,871	1,020,148		1,070,140
1,078	983	95	F	Non-Government & Crown Agency	5,522	5,220	302	F	4,882	11,892		11,252
90,589	90,068	521	F	*Total Revenue*	543,175	540,426	2,748	F	510,753	1,032,040		1,081,392
				EXPENSES								
38,248	37,351	(897)	U	Workforce Costs	215,481	214,254	(1,227)	U	205,494	451,823	*	437,490
3,298	2,933	(365)	U	Outsourced Services	22,081	20,281	(1,800)	U	19,101	39,624		38,754
8,356	7,499	(857)	U	Clinical Supplies	51,173	47,283	(3,890)	U	48,075	96,479		93,657
4,676	4,657	(19)	U	Infrastructure & Non-Clinical Supplies	29,564	28,452	(1,112)	U	26,602	60,062	**	56,777
38,764	38,207	(557)	U	Provider Payments	229,956	228,582	(1,374)	U	220,295	438,921		454,704
2,924	3,161	237	F	Non-Operating Expenses	17,427	18,705	1,278	F	17,115	34,476		38,522
96,266	93,808	(2,458)	U	*Total Expenses*	565,682	557,556	(8,126)	U	536,682	1,121,385		1,119,904
(5,677)	(3,740)	(1,937)	U	**NET SURPLUS / (DEFICIT)**	(22,507)	(17,129)	(5,378)	U	(25,929)	(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 (YTD)

Government and Crown Agency revenue includes additional funding to offset Pay Equity. This and other additional revenue mostly offset expenditure on Provider Payments.

On a year to date basis we are 27 caseweights behind with the Planned Care volume delivery to our population. However, Canterbury DHB currently has 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 Canterbury DHB and our revenue has been recognised on that basis.

Expenditure (YTD)

Total Expenses year to date were $565.7m and includes unbudgeted one-off costs for the Measles Outbreak $0.3m and Neurosurgery $0.8m. Neurosurgery medical workforce is currently insufficiently resourced to maintain a safe roster and therefore Canterbury District Health Board (CDHB) is assisting in providing this service.

Workforce Costs are $1.2m unfavourable 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 $3.9m unfavourable year to date. Air Ambulance, Blood Products and Implants & Prostheses being contributors to the unfavourable variance. 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 uplift for 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 the Microsoft Software licencing which has impacted across All of Government following the negotiation of a national contract during 2018. To the greatest degree practicable we have managed other expenditure to offset the overrun on the Microsoft contract. Our Telecommunications costs are regularly reviewed in conjunction with our supplier to mitigate any ineffective spend.

Provider Payments are $1.4m 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 $1.3m 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 31 December 2019

10.1

As at 30 Jun 2019 $000		Actual 31 Dec 2019 $000	Budget 31 Dec 2019 $000	Budget 30 Jun 2020 $000	As at 31 Dec 2018 $000
	CURRENT ASSETS				
7	Cash & Cash Equivalents	7	7	7	8
47,353	Trade & Other Receivables	49,029	43,051	45,213	45,251
5,762	Inventories	5,670	5,516	5,235	5,453
53,122	*Total Current Assets*	54,706	48,574	50,455	50,712
	NON-CURRENT ASSETS				
323,050	Property, Plant & Equipment	330,385	345,645	346,288	321,741
4,505	Intangible Assets	3,066	7,502	10,393	4,620
327,555	*Total Non-Current Assets*	333,451	353,147	356,681	326,361
380,677	**TOTAL ASSETS**	388,157	401,721	407,136	377,073
	CURRENT LIABILITIES				
9,895	Cash & Cash Equivalents	36,090	36,609	44,587	36,013
63,925	Payables & Deferred Revenue	73,096	73,620	62,804	69,655
922	Short Term Borrowings	689	994	784	1,189
112,595	Employee Entitlements	106,208	111,294	91,680	72,801
187,337	*Total Current Liabilities*	216,083	222,517	199,855	179,658
	NON-CURRENT LIABILITIES				
1,568	Term Borrowings	1,260	983	783	1,895
19,362	Employee Entitlements	19,362	18,150	18,756	18,149
20,930	*Total Non-Curremt Liabilities*	20,622	19,133	19,539	20,044
208,267	**TOTAL LIABILITIES**	236,705	241,650	219,394	199,702
172,410	**NET ASSETS**	151,452	160,071	187,742	177,371
	EQUITY				
300,969	Contributed Capital	302,518	305,761	354,813	343,461
108,502	Property Revaluation Reserves	108,500	108,500	108,502	108,500
(237,061)	Accumulated Surplus/(Deficit)	(259,566)	(254,190)	(275,573)	(274,590)
172,410	*Total Equity*	151,452	160,071	187,742	177,371

Statement of Changes in Equity

192,584	Opening Balance	172,410	172,410	172,410	192,590
(89,345)	Operating Surplus/(Deficit)	(22,505)	(17,127)	(38,512)	(25,931)
69,878	Crown Capital Contributions	1,547	4,789	54,551	10,712
(707)	Return of Capital	-	-	(707)	-
-	Movements in Reserves	-	-	-	-
172,410	Closing Balance	151,452	160,072	187,742	177,371

Cash and Cash Equivalents are on budget, with the continued underspend on capital expenditure and favourable Pharmac rebate timing offsetting operational overspends and shortfall in the Crown Capital Contributions.

Trade and Other Receivables were higher than budget due to accruals for Government and Crown Agency funding primarily related to In Between Travel (IBT) and Disability Support Services (DSS).

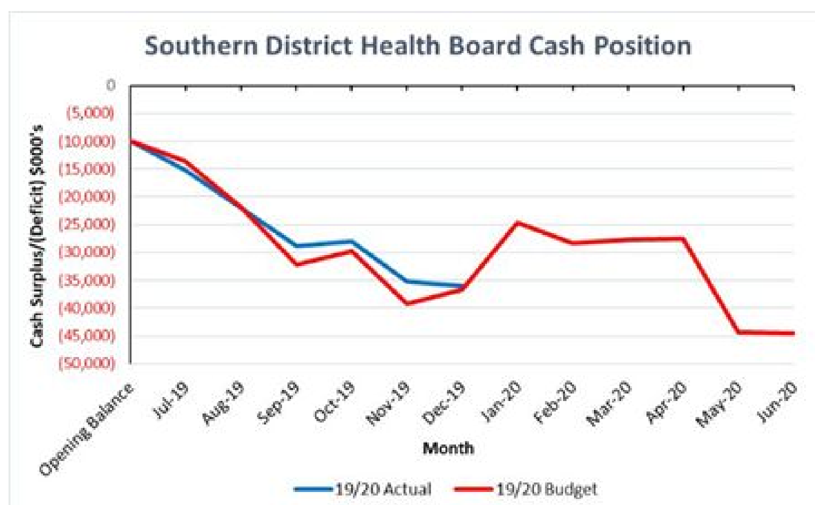
The IDF outflow expense accrual of $1m a significant additional accrual for Canterbury District Health Board (CDHB), due to delays in CDHB submission of National Minimum Dataset (NMDS). A portion of this accrual will be related to Neurosurgery and unfortunately it is not possible given the lack of data to quantify this cost.

Property, Plant and Equipment spend is lower than budget, reflecting the timing of capital expenditure on a number of projects, Dunedin Hospital ICU, Southland MRI, TOPS and Deferred Maintenance.

Cash Flow Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 31 December 2019

	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	539,775	543,891	(4,116)	1,071,528	507,735
Non-Government & Crown Agency Revenue	5,344	5,126	218	11,065	4,901
Interest Received	175	93	82	187	-
Cash was applied to:			-		
Payments to Suppliers	(338,026)	(329,495)	(8,531)	(649,567)	(316,916)
Payments to Employees	(216,333)	(212,465)	(3,868)	(453,068)	(202,076)
Interest Paid	-	-	-	-	-
Capital Charge	(5,138)	(5,194)	56	(10,500)	-
Goods & Services Tax (net)	5,244	6,213	(969)	7	5,541
Net Cash Inflow / (Outflow) from Operations	(8,959)	8,169	(17,128)	(30,348)	(815)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	2	-	2	-	1
Cash was applied to:					
Capital Expenditure	(18,058)	(39,098)	21,040	(57,139)	(14,225)
Net Cash Inflow / (Outflow) from Investing Activity	(18,056)	(39,098)	21,042	(57,139)	(14,224)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	1,547	4,789	(3,242)	54,550	10,025
Cash was applied to:					
Repayment of Borrowings	(726)	(575)	(151)	(1,755)	(615)
Net Cash Inflow / (Outflow) from Financing Activity	821	4,214	(3,393)	52,795	9,410
Total Increase / (Decrease) in Cash	(26,194)	(26,715)	521	(34,692)	(5,629)
Opening Cash & Cash Equivalents	(9,888)	(9,888)	-	(9,888)	(30,377)
Closing Cash & Cash Equivalents	(36,082)	(36,603)	521	(44,580)	(36,006)



10.1

The cash position at 31 December 2019 continues the trend with Accounts Receivable reflecting Government and Crown Agency revenue received being less than budget, while payments to suppliers and employees are higher than budget, aligning with operational activity to give a net unfavourable outflow from Operations of $17.1m.

Capital expenditure outflow is favourable to budget by $21.1m, reflecting the lower than budget spend on capital expenditure across Property, Plant and Equipment.

Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD
Capital Expenditure Movement
For the period ending 31 December 2019

Description	Cost As at 30 Jun 2019 $000	YTD Cost Movement $000	Cost As at 31 Dec 2019 $000	Acc Depr 30 Jun 2019 $000	YTD Depr Movement $000	Acc Depr 31 Dec 2019 $000	Net Value As at 31 Dec 2019 $000
Land, Buildings & Plant	268,799	1,552	270,351	(10,152)	(5,319)	(15,471)	254,880
Clinical Equipment	134,025	5,280	139,305	(94,699)	(3,721)	(98,420)	40,885
Other Equipment	14,935	270	15,205	(12,740)	(214)	(12,954)	2,251
Information Technology	28,348	1,718	30,066	(21,568)	(1,217)	(22,785)	7,281
Motor Vehicles	2,354	2	2,356	(2,144)	(59)	(2,203)	153
Software	24,160	594	24,754	(20,382)	(712)	(21,094)	3,660
WIP	16,621	7,720	24,341	-	-	-	24,341
Grand Total	489,242	17,136	506,378	(161,685)	(11,242)	(172,927)	333,451

Property, Plant and Equipment and Intangible Assets are a combined $333.5m, being $19.7m less than the budget of $353.1m.

Land, Buildings and Plant is $14.7m less than budget in projects including Lakes Hospital Redevelopment, Dunedin Hospital ICU, Southland MRI, TOPS and Deferred Maintenance.

Clinical Equipment is $1.9m less than budget with project timing for various items of equipment, for example the Linac machine and the Cardiac Catheter Laboratory.

Software is $2.9m underspent, the FPIM (Oracle upgrade) and SI PICS (Patient Management) system projects being two of the major contributors.

Dec-19				Dec-18	YEAR ON YEAR		YTD 2019/20				YTD Dec-18	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,509	1,314	195	15%	1,239	270	Acute	9,382	8,738	644	7%	8,783	599
288	298	(9)	-3%	300	(11)	Elective	1,923	1,814	109	6%	1,867	56
1,798	**1,612**	**186**	**12%**	**1,539**	**259**	**Total Medical Caseweights**	**11,305**	**10,552**	**752**	**7%**	**10,649**	**656**
						Surgical Caseweights						
1,122	1,156	(34)	-3%	1,102	20	Acute	7,160	7,351	(190)	-3%	7,195	(35)
1,264	1,228	36	3%	1,279	(16)	Elective	8,283	8,181	101	1%	8,156	126
2,385	**2,383**	**2**	**0%**	**2,381**	**4**	**Total Surgical Caseweights**	**15,443**	**15,532**	**(89)**	**-1%**	**15,351**	**91**
						Maternity Caseweights						
163	83	80	97%	103	60	Acute	642	544	96	18%	491	151
326	321	5	2%	350	(25)	Elective	2,093	2,145	(52)	-2%	2,112	(19)
489	**403**	**85**	**21%**	**454**	**35**	**Total Maternity Caseweights**	**2,735**	**2,690**	**44**	**2%**	**2,603**	**132**
						TOTALS						
2,794	**2,552**	**242**	9%	**2,444**	**350**	**Acute**	**17,184**	**16,633**	**550**	3%	**16,468**	**715**
1,877	**1,846**	**32**	2%	**1,929**	**(53)**	**Elective**	**12,299**	**12,140**	**158**	1%	**12,135**	**164**
4,671	**4,398**	**273**	**6%**	**4,373**	**297**	**Total Caseweights**	**29,483**	**28,774**	**709**	**2%**	**28,603**	**879**
						TOTALS excl. Maternity						
2,631	**2,470**	**161**	7%	**2,341**	**290**	**Acute**	**16,542**	**16,089**	**453**	3%	**15,978**	**564**
1,552	**1,525**	**27**	2%	**1,578**	**(28)**	**Elective**	**10,206**	**9,995**	**210**	2%	**10,023**	**183**
4,183	**3,995**	**188**	**5%**	**3,919**	**262**	**Total Caseweights excl. Maternity**	**26,748**	**26,084**	**664**	**3%**	**26,001**	**747**

Dec-19				Dec-18	YEAR ON YEAR		YTD 2019/20				YTD Dec-18	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,585	2,944	(359)	-12%	2,503	82	**Mental Health bed days**	16,478	17,472	(994)	-6%	16,572	(94)

Dec-19	Dec-18	YEAR ON YEAR		YTD 2019/20	YTD Dec-18	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
3,456	3,592	(136)	Dunedin	22,138	22,266	(128)
1,119	1,141	(22)	Lakes	6,823	6,084	739
3,085	3,163	(78)	Southland	18,406	18,492	(86)
7,660	7,896	(236)	**Total ED presentations**	47,367	46,842	525

10.2

Performance Dashboard Southern

10.3

SOUTHERN DISTRICT HEALTH BOARD

Title:	Computed Tomography (CT) Briefing paper
Report to:	Board
Date of Meeting:	23 January 2020

Summary

This paper provides the Board with a briefing on the current CT capacity and performance across the Southern District Health Board. The paper has been prepared quickly and as such, some of the questions posed by the data presented have not been able to be quantitatively answered. Where this is the case, empirical information has been collected from our medical imaging technologist leaders to assist in explaining year on year changes in performance.

The information contained in the paper demonstrates that Dunedin hospital CT performance is relatively low compared to Southland, with higher waiting times that do not achieve Ministry targets. Southland, on the other hand, achieves close to the Ministry target for CT reporting. Because most of our performance issue is in Dunedin the paper has focused on Dunedin performance and offers a number of short and longer term options for improving performance.

The longer term option proposed for improving Dunedin CT performance is to develop a business case (using the Treasury short-business case format) to make the case for a second CT scanner at Dunedin and to identify (from a range of options) the preferred option for implementing a second scanner.

Depending on the guidance provided from the Board to Management, the short term and longer term options proposed will subsequently be worked up and a proposals will be put forward for further consideration.

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

Financial:	n/a
Workforce:	n/a
Other:	Briefing only.

Document previously submitted to:		**Date:**

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<table>
<tr><td>Approved by:</td><td></td><td>Date:</td></tr>
<tr><td colspan="2">Prepared by:
Stephen Jenkins, Service Manager, Surgical Services and Radiology
and
Patrick Ng
Executive Director Specialist Services

Date: 21/01/2020</td><td>Presented by:
Patrick Ng
Executive Director Specialist Services</td></tr>
<tr><td colspan="3">RECOMMENDATION:

That this briefing paper is used as the basis for a conversation about current CT performance and that guidance is provided by the Board to management about whether the proposed next steps (or alternative actions) should be taken.</td></tr>
</table>

Southern DHB Computed Tomography (CT) Briefing Paper

11

Stephen Jenkins, Service Manager, Surgical Services and Radiology
Patrick Ng, Executive Director of Specialist Services
January 2020

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Purpose 2

Background 2

Current CT Performance 4

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Increasing demand for elective CT scans 9

Conclusion (most of our wait time problem is in Dunedin) 11

Options for improving Dunedin CT performance 11

Proposed Next Steps 13

Purpose

The primary purpose of this paper is to provide a briefing about the current CT demand, capacity and performance across the Southern District Health Board (SDHB). This paper also discusses options for expanding capacity, with a focus on Dunedin hospital where capacity constraints are currently impacting the most on CT performance.

Various options exist to expand CT capacity. In each case, additional investment is required, ranging from small cost increases to cover extra shifts (e.g. completing elective CT during evening shifts), to a relatively significant investment in the region of $1m of capital and circa $900k p.a. of annual operating costs to install and operate a second CT machine at Dunedin hospital. Future investment in CT would need to be considered during the 2020/21 budget process. These costs have previously been worked up by the finance and radiology teams at a high level and include the capital costs associated with an additional CT machine and building works, and the annual machine maintenance and staffing costs required to operate an additional CT machine.

This briefing paper has been put together relatively quickly and does not have complete quantitative analysis for the questions that the included data poses in some cases. Where this is the case, empirical information has been collected by discussing observed changes with the medical imaging technologist (MIT) leaders.

This paper concludes that the most significant wait times for CT scanning are at Dunedin hospital and proposes several options for how wait times could be improved in the short and longer term. It is important to note that none of the financial implications of implementing either the short or long term solutions are currently in either the budget or the forecast. A discussion is sought about whether, and which of, these options should be worked up further.

Background

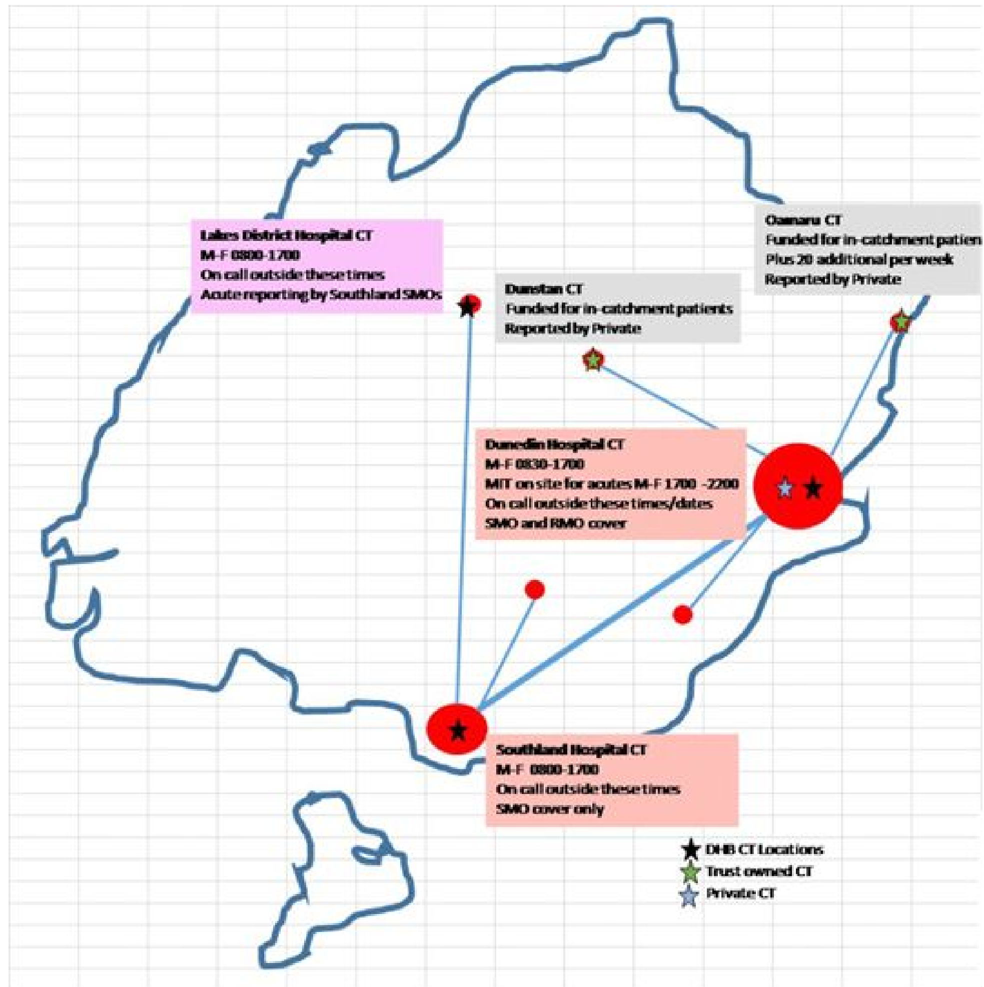
CT Capacity across the District

A total of six CT scanners exist in the public system across SDHB.

Three are owned and operated by the DHB at Southland Hospital, Dunedin Hospital and Lakes District Hospital. Two additional scanners at Dunstan and Oamaru Hospitals are owned and operated by Trusts and are funded to scan patients living within their catchment area. In Dunstan's case this includes both locally and DHB referred patients. At Oamaru local patients are fully funded and DHB referred patients are funded at an agreed volume. A sixth scanner is located in Oncology at Dunedin Hospital and is utilised between 09:00 and 17:00 on weekdays for Radiation Oncology planning studies.

Southern DHB CT is divided into two catchment areas, Otago and Southland. Otago catchment cases are those where the patient is referred for a CT at Dunedin Hospital and Southland cases are referred for a CT to Southland Hospital. Referrals are triaged by Radiologists at the relevant DHB site and the examination is prioritized on the basis of clinical acuity. The Ministry of Health has an expectation that 95% of elective CT scans are completed and the report distributed within six weeks (42 days) of the referral being accepted.

SDHB CT Capacity and Use Across the District



Should a patient referred to either Dunedin or Invercargill live within another catchment area (per the above map), referrals are sent to those sites for the patient to be scheduled and scanned. In addition, an agreement is in place for additional patients to be scanned at Oamaru (20 per week), which is their limit for additional scans. Lakes has also indicated they can take on some Southland cases; but only 2 per week, as their staffing capacity is limited. It may be possible to increase this number with additional administration staff. These additional scans from outside the catchment are selected on the basis of priority, willingness to travel and proximity to the outlying site. Outsourcing scans to private practice does not occur routinely, with the exception of CT Colonography, as the equipment

required to undertake these types of scans is not available at Dunedin Hospital. The private sector has previously indicated an ability to take on more volumes if there was a reasonable commitment in terms of both volumes and timeframes (as they would have to increase staffing and to complete additional work).

Currently, centralised booking and scheduling of CT examinations is not technically possible as there are two versions of the Radiology Information System (RIS) being used across the District. As a consequence of this separate (local) waitlists are maintained and disparities of access have developed over time. A project is underway to install a District wide RIS which will create the opportunity to centralise referrals, triaging and scheduling. A centralized wait list will be explored further once the new system has been implemented.

Dunedin has had vacancies in their Radiologist medical workforce for a number of years and these vacancies have proven very difficult to recruit into. This has resulted in radiology clinical work being completed in non-clinical hours. Southland has had sufficient number of Radiologists until last year, when a resignation and a maternity leave caused a shortage in Radiologists. This has necessitated the use of additional outsourcing to complete the reporting of scans in Southland.

Current CT Performance

Acute demand takes precedence over elective demand for CT. As a result access to elective CT is becoming increasingly problematic for our Dunedin referred patients. While there are two CT scanners on site one is fully utilised in Radiation Oncology during business hours meaning there is only one CT scanner to complete normal radiology work.

The following table shows the average waiting time in days for Dunedin patients compared to Southland patients:

Site:	Waiting:	Waiting and Un-booked:	Average time waiting (days):
Southland:	239	54	27.54
Dunedin:	784	612	76.07

A further breakdown of the Dunedin wait list is as follows:

Triage Category (Target wait):	Waiting:	Waiting and Un-booked:	Average time waiting (days):
Urgent (2w):	317	274	63
Semi Urgent (4w):	168	117	104
Non Urgent (6w):	120	84	80
Outpatient Clinics:	136	102	69

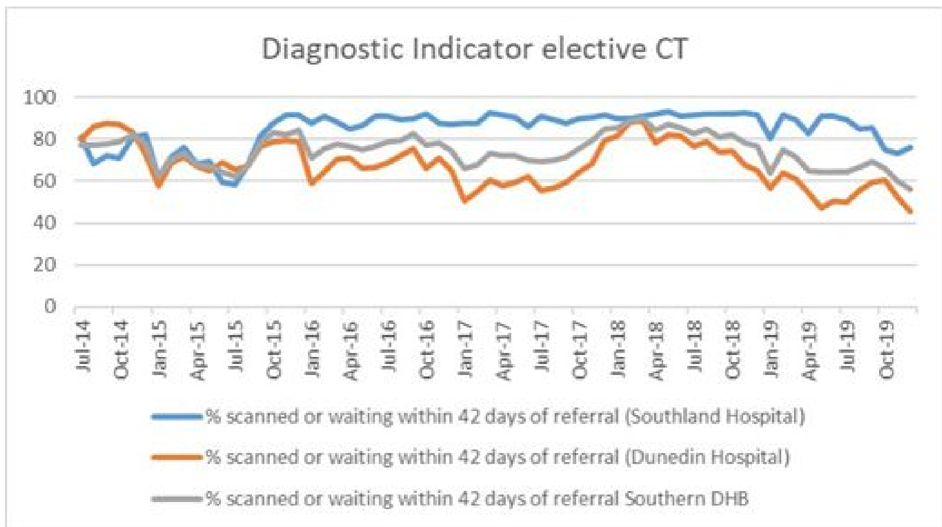
The 2w, 4w and 6w target for waiting times refers to the timeframes in which the triaging Radiologist believes the patients should be seen (w = weeks). The average waiting time is outside of the indicated timeframe for each category.

It should be noted that the reason the semi-urgent category has a higher average waiting time than the non-urgent and outpatient categories is that the recent trial (completing elective scans in the evening) could only be done on for routine cases not requiring contrast and for this reason higher numbers of these cases were completed relative to the other categories.

The Ministry target for CT performance is that 95% of CT scans are completed and reported within 42 days of receipt of the referral. Most, if not all District Health Boards (DHBs) are currently failing to meet this target. However, Dunedin's performance is likely to be low compared to most other hospitals.

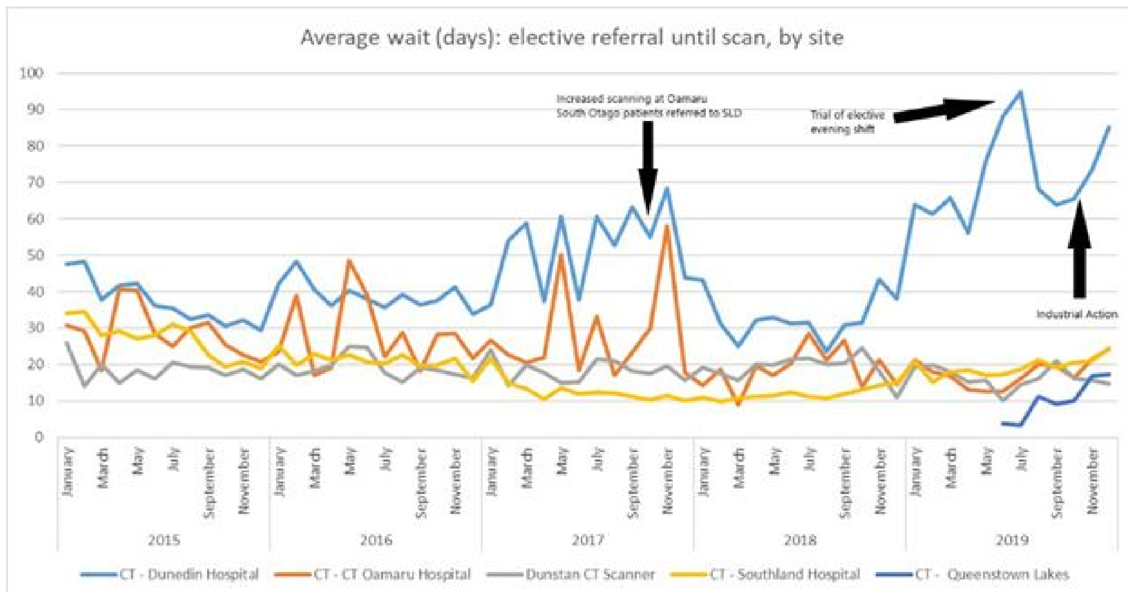
Performance against this target (per the graph below) further demonstrates the issue of high average waiting times in Dunedin. Southland's performance has been close to the Ministry target for a number of years.

CT Performance against Ministry Target (Dunedin versus Southland)



Waiting times at Dunedin hospital are also higher than waiting times in the other catchment areas, as demonstrated by the following graph.

Average Wait Time for CT Scan by Site



Dunedin has clearly had longer waits than other sites since 2015. However, this worsened markedly in 2017, improved throughout 2018 and then wait times rose steeply since the beginning of 2019. The 2018 improvement is due to an increase in funded capacity at Oamaru, from 2 to 12 exams per week, as well as the redirecting of South Otago patients to Southland Hospital for scanning. The deterioration in performance between November 2018 and July 2019 is hard to explain and the first clarification sought was that the initiatives implemented in 2018 to do more scans in the other catchments in support of Dunedin had continued. This was confirmed to be the case. The next question asked was whether CT volumes rose significantly from 2018 to 2019. However, whilst there was a modest increase in volumes (as indicated in the following tables), this was not significant. A discussion with the Medical Imaging Technology Leaders and the Service Manager has indicated that empirically what they have observed is that the cases completed have become longer and more complex. CT guided procedures vary from 1 -3 hours in duration, can be curative, frequently involve inpatients and are resource intensive. The requirement for Nursing, MITs, Radiologists (and sometimes Anesthesia) to be present at a procedure means these are undertaken during business hours unless very acutely required. In 2019, around 280 hours of Dunedin's capacity were taken up with CT guided procedures (93% during business hours), the equivalent to 780 – 840 standard outpatient appointments.

CT whole body trauma investigations are another example of a complex examination which is increasing in volumes requested, year on year. These exams take between 45 and 60 minutes and are one example of a number of complex exams which we are seeing more of, at the expense of more routine elective examinations. Volumes have more than doubled in the past five years. In 2019, 48 of these (or the equivalent of between 108 and 144 elective appointments) took place during core business hours.

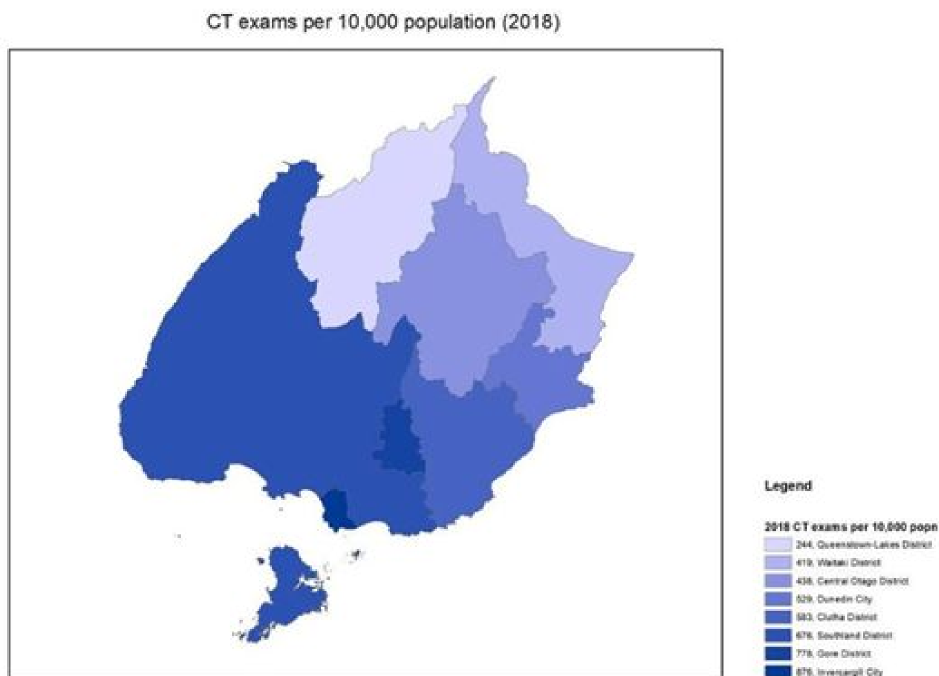
The comment was also made that as available CT capacity was limited this acted as a natural constraint. In the short-term, it is believed that the additional capacity that was created by doing more Dunedin scanning in the other catchment areas allowed the wait list to be worked through more quickly. Then, as unmet need filled the void the positive impact of this diminished. This does not appear to completely align to the modest volume growth (indicated in the tables below), and further

investigation is required to really understand the overall deterioration in wait time performance at Dunedin from 2018 to 2019.

A period of improvement can be seen between July 2019 and September 2019 and this corresponds to a trial of non-contrast patient scanning in weekday evenings. This ended as staffing numbers no longer enabled additional staff to be rostered into CT in the evenings. This was a recruitment challenge rather than being a budget challenge. However, the team believe they have been able to recruit some of the resources they need to continue with this initiative. During the trial they were able to complete an additional 5 scans per week. They believe they have been able to recruit the resources they need to maintain 3 additional scans per week going forward.

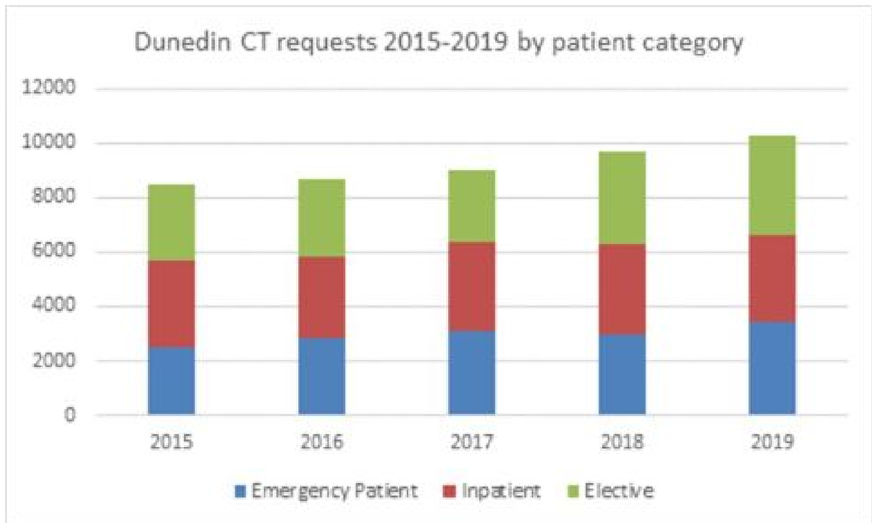
From September 2019 onwards there were several rounds of industrial action (and the service is still recovering from this). This created a deterioration in results from September onwards.

The difference in CT capacity between Dunedin and Invercargill hospitals has resulted in a clear disparity of access to CT for the population domiciled in Dunedin, as shown below:



Increased waiting times at Dunedin explained further

The following table shows that requests for CT in Dunedin have progressively increased year on year since 2015 from circa 8,200 in 2015 to circa 10,100 by 2019 (an overall increase of 23% over the 5 year period).



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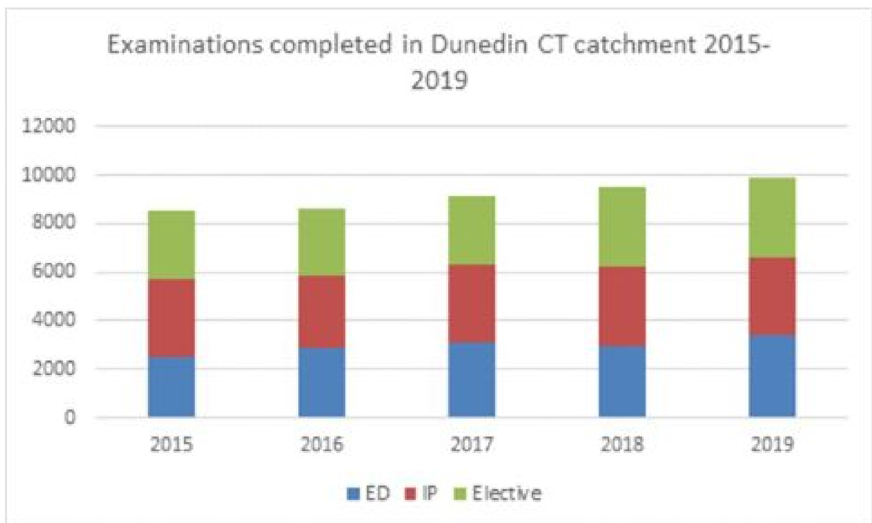
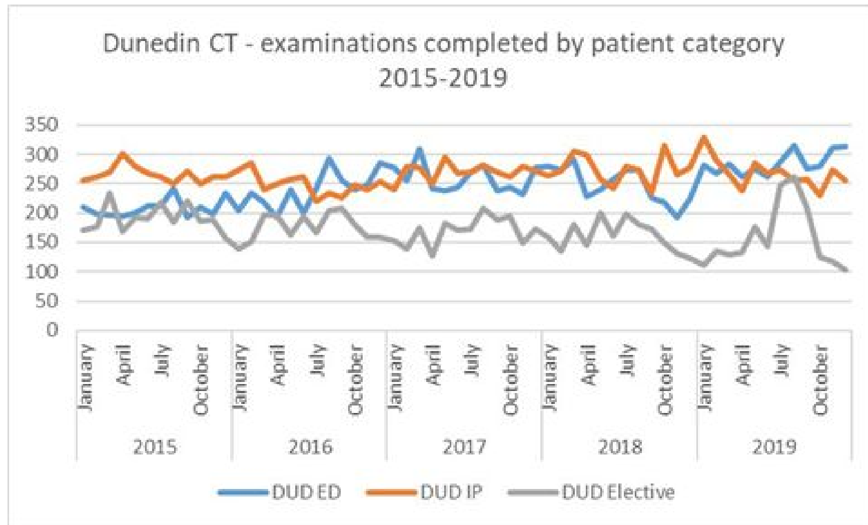
The number of CT scans completed is similar to the number requested (per the chart below), and has therefore been growing at a similar rate.



The trend over time across the CT categories completed (ED, inpatient and elective) suggests that higher ED volumes are being completed, inpatient volumes completed are fairly static and elective volumes completed are decreasing, as outlined on a month by month basis in the following time series chart.

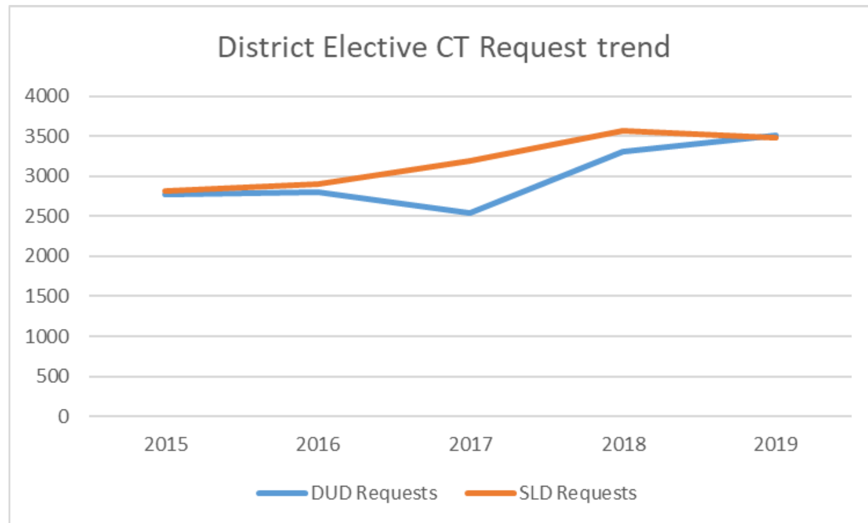
Dunedin CT Examinations Completed by Type



Emergency Department (ED) cases are more time consuming and resource intensive. ED patients are often acutely unwell, often with strong pain relief and require more staff time to transfer to the scanner bed and position (this also applies to intensive care unit (ICU) patient exams). Whole body trauma scans are also one of the longer examinations in CT. When occurring during normal business hours they disrupt elective scanning and during extended periods of high ED and inpatient (IP) demand this leads to postponements. The volumes of elective exams undertaken at Dunedin have consistently decreased as seen above. The increase in acute demand (ED) in 2019 over 2018 appears to directionally support the empirical observations noted earlier indicating that part of the problem of increasing wait times can be attributed to a rise in the number of more complex acute cases being completed than previously.

Increasing demand for elective CT scans

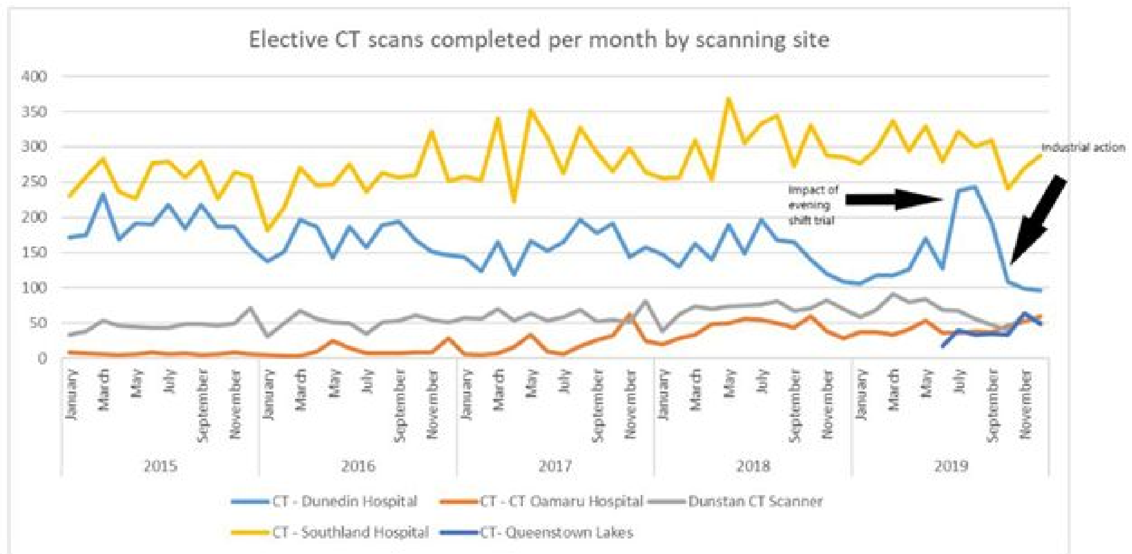
Both Dunedin and Southland are experiencing more elective requests. The year on year average increase for the District since 2015 has been 6.53% per annum. This has been more pronounced in Otago with an 8% average annual increase.



11

A logical question from this data is 'why are the volumes similar for Dunedin and Southland when Dunedin serves a population that is roughly twice the size of Southland?' In other words we would expect to see twice the elective and total CT volumes in Dunedin that we see in Southland. The reason we don't is likely to be a combination of how much CT capacity is supplied at each hospital and how much private CT capacity is available. Each hospital has one CT scanner available to them (if we ignore the oncology scanner in Dunedin which is only used for a specific purpose). If both CT scanners are used at capacity it stands to reason that a similar number of scans would be produced on each machine. Southland does not have a private CT in the district, so some of the higher volume can probably be explained in this way (Dunedin does have private CT in the district), however, a large proportion of the answer is likely to be that Southland is better serving the needs of their population (as indicated by the higher intervention rate in the previous chart), whilst Dunedin could arguably be underserving the needs of their population, particularly relative to Southland.

As shown below, the number of elective scans completed at Southland have increased to meet rising demand. Oamaru scans are also shown to increase to match increases in funding. Dunedin electives however have been trending down owing to the pressure on the available resource coming in acutely. The evening trial at Dunedin mentioned earlier accounts for the increase in volumes scanned in late 2019. This was followed by industrial action effecting all four DHB scanners, which offset much of the gains made during the trial.



Conclusion (most of our wait time problem is in Dunedin)

Although CT demand has increased across the district over the last 5 years, it is the Dunedin site which has struggled the most to manage increasing demand. This is evidenced by the number of Dunedin elective scans that are being completed decreasing, and the wait times for Dunedin patients to receive their scan increasing, relative to the other catchment areas.

Options for improving Dunedin CT performance

An analysis of weekly demand and production data from June to December 2019 suggests that an average of 15 more exams are needed at Dunedin each week to match demand to supply. In addition to this, the current wait list is 794, so an additional 22 exams would need to be undertaken each week if the existing wait list was to be cleared within 6 months.

There are several short and longer term options for how we could improve CT capacity at Dunedin.

Short Term Options to improve Dunedin CT performance include the following.

Option 1: Further utilise scanners from elsewhere in the District:

- Southern DHB has recently increased the numbers of patients to be sent to Oamaru from 12 to 20.
- Dunstan has indicated they would consider scanning Dunedin patients if additional funding was available.
- Note: Ad hoc capacity is typically not available but additional scanning may be able to be completed in private if a longer term arrangement was entered into.

Limitations:

- Rural scanners have limitations with regard to their capability to undertake complex examinations.
- Patients may be unwilling to travel.
- Outsourcing on a per case basis is relatively costly.

Option 2: Further utilisation of existing Dunedin scanners:

- Rostered shifts in evenings/weekends staffed at safe levels for elective scanning. This would require another MIT between 17:00 and 22:00 weeknights, two medical imaging technologists (MITs) between 08:30 and 17:00 weekends, potentially a registered nurse (RN) and a registered medical officer (RMO) at a minimum (medical supervision is required for contrast scans and more complex scanning) with outsourced reporting for electives or more senior medical officer (SMO) resource. This could be worked up as a proposal with options but would be unbudgeted expenditure.
- The July trial showed that an additional MIT rostered on between 17:00 and 22:00 on weeknights enabled 20-25 additional elective patients to be scanned per week. These had to be 'non-contrast patients' as no medical supervision was present (medical supervision is required when contrast is used for imaging). The number of suitable patients is limited and consequently a permanent elective capable shift would need medical cover on site and ideally an RN. Similar results could be achieved at the weekend. Additional benefits of full seven day shift cover is that acute demand would likely be better spread throughout the working week rather than peaking on Mondays and Fridays in response to weekends on call. Continuation of the trial (for non-contrast patients) could achieve a relatively high proportion of the additional volumes to achieve on a weekly basis with a much lower investment in staffing.
- Further utilisation of the Oncology scanner. While mostly in use for its core function of Radiation Oncology Planning, this scanner is largely idle outside of working hours. It has been suggested that Radiology could use this scanner to run an elective evening clinic. Although not currently configured with ideal wait and changing areas we are advised that these could be relatively easily configured. This option is likely to be more difficult to staff than the option of further utilizing the radiology scanner.

Limitations:

- Additional staffing would be required to run an evening or weekend shift in CT which has the capability to scan elective patients. Because of MECA rostering requirements, to run two day shifts at the weekend would require an additional 4-5 MITs. Additional RN, RMO and SMO resource would be needed. All these groups can be problematic to recruit. An evening shift would require fewer additional resources compared to weekend shifts. Capacity gains would be uncertain as these time periods are already reasonably busy with acute work, although the initial trial to get more elective work done in the evenings was quite successful.
- Radiology staff are of the view that resourcing an evening session in Radiology CT would require fewer resources and be more efficient than doing so for the Oncology scanner. Radiology do not favour the Oncology option because it is located away from the main department.
- Lead time to implement. Increasing MIT and Radiologist staffing has a long lead in time. Severe difficulties exist in SMO recruitment at the current time.

A Longer-Term Option to increase Dunedin CT capacity is the installation of an additional CT scanner.

Options 3: An Additional Scanner at Dunedin Hospital:

- The Ministry of health (MoH) review for New Hospital planning has suggested that 2 CT scanners have been required at Dunedin Hospital since 2014. Radiology have requested funding for a second diagnostic CT as part of the 2020/21 CAPEX process. This would enable

a separation of acute and elective workflows and provide a considerable boost to elective capacity of up to 6,000 standard elective appointments per annum. If demand continues to grow at 8% per annum, the additional capacity would be consumed within the next 7-8 years (i.e. prior to the commissioning of the new hospital). Running evening and weekend shifts on the new machine would further increase the available capacity in the future. It should also be noted that unmet need (because of the natural constraint posed by having only one CT scanner at Dunedin hospital currently, if the Oncology scanner is excluded) may cause the additional capacity of a second machine to be consumed more quickly.

- A business case for a second scanner would need to consider a number of options and make a considered recommendation. Options for consideration would include whether elective and acute flows should be separated or whether both scanners would be applied to the total workload, whether the second scanner would need to be located adjacent to the existing scanner so that it can act as a back-up if urgent scans needs to occur simultaneously, or whether it should be located in the community.

  This additional capacity would be likely to result in a number of operational benefits. For example, a faster turn-around of inpatient cases would result in bed day savings. Radiology has identified the main reporting room would be a viable location for a second scanner. Vendors have indicated this would be of sufficient size. The room is immediately adjacent to the existing scanner and therefore could utilise the same waiting/preparation and administration infrastructure.

Limitations:

- Surplus capacity would exist initially.
- Staffing issues per the other options would need to be resolved.
- There would be a lead in time to implement this initiative, likely to be 18-24 months.

Proposed Next Steps

Subject to feedback on this discussion paper the logical next steps would be the development of a proposal for the provision of additional short-term capacity at Dunedin (with options and a recommendation) for rapid consideration, and then the development of a business case for a second Dunedin CT for further consideration.

The business case would be developed utilsing the approach we have recently used for cases, which is based on Treasury guidance – a strategic case to outline the reason for the proposed investment, an economic case to outline the options analysis, a brief commercial case to outline the procurement and property requirements, a financial case to outline the capital and operating cost implications and a change case to outline how the change would be implemented (for example, the location of the second CT, the creation of separate acute and elective flows and so on).

12.1

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Maia Financial New Zealand Limited** **Operating Lease for Two CT scanners**
Report to:	Board
Date of Meeting:	4 February 2020

Summary:

The issues considered in this paper are:

- The SDHB operates two CT scanners at Dunedin Hospital, in the Radiation Oncology Service and Radiology Service respectively. The original operating leases had a term of five years, which has expired.
- This contract is a variation to the master agreement:
  - updating the rental period for 24 months, commencing 1 January 2020, expiring 31 December 2021.

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

Financial:	The value of the contract is $530,200 (excl GST), with quarterly instalments of $66,725 (excl GST) paid quarterly in advance. The contract commences 1 January 2020, and is for a term of 24 months. Maintenance and service charges are not included, these costs are budgeted and are covered under separate contracts.
Workforce:	Business as usual
Other:	None

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

Prepared by:	**Presented by:**
Michael Turner Business Analyst Date: 16/01/2020	Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:

That the Board

- **Approve** the signing of this contract by Southern DHB Management (under delegation) for Operating Lease of two CT Scanners with Maia Financial New Zealand Limited, contract commencing 1 January 2020 for a 24 month term.

Contract Number: _MAI-2019 _ _ _ _ _ _ _

NB: Signatories to this form must declare any conflict of interests as per the COI Policy: MIDAS 27894

Southern DHB Contract Approval Form (District)

Provider Arm

Name of Contracted Party:	Maia Financial New Zealand Limited
Contract Description:	Operating Lease for CT Scanner equipment.
Service Provided:	
Contract Category:	[ ] New – no prior contractual arrangement [ ] Variation of existing contractual arrangement [Yes] Replacement – supersedes prior contractual agreement
Contract Type:	Revenue/Expense/Service/Licence /Supply/MoU (delete as appropriate) Vulnerable Children Act requirements covered? Yes / No
Contract Cancellable:	Y / N (please circle)
Contract Total Value:	$ 530,200.32 — Yr1$_265,100.16 Yr2 $_265,100.16_ Yr3 $______
Budget Total Value	$ ~~530,200~~ ∅ — 2019/20 ~~$132,550~~ 2020/21 ~~$265,100~~ 2021/22 ~~$132,550~~
Contract Start Date:	01 /01 /2020 — Budgeted Cost Code: Radiology / Radiation Oncology
Expiry Date:	31 /12 /2021 — Service Area:

Handwritten note: Currently no budget. To be approved via contingency.

Dept Manager Initiating: (approval & no conflict of interest)	Stephen Jenkins / Matthew Paris	Signed: [signature] [signature]	Date: 25/11/2019 25/11/2019
General Manager: (approval & no conflict of interest)	Janine Cochrane / Karin Drummond	Signed: [signature] [signature]	Date: 17/12/2019 19/12/19
Procurement (if required): (approval & no conflict of interest)	Graham Carter [signature]	Signed: [signature] Procurement Mgr	Date: 27/11/19
Reviewed by Business Analyst: (approval & no conflict of interest)	Michael Turner / Mark Voice	Signed: [signature] [signature]	Date: 16/12/19

Handwritten note: Dept not budgeted – acc'ty treatment to be finalised. See attached info paper

Legal Input Received: (Yes) / [ ] (please circle) Required for contracts > $100,000 or lower if deemed appropriate.

Comment: Corporate Solicitor – ~~Melanie Naulls~~ Karen Billinghurst

Signed: (Legal Adviser) (approval & no conflict of interest) [signature] Date: 15/12/19.

Additional Finance Approval [Yes] [ ] (please circle) Required for Contracts > $100,000

Comment: NEEDS TO BE APPROVED VIA CAPEX CONTINGENCY – CONTRACT O.K.

Signed: GMFF/ Business Analyst / (approval & no conflict of interest) Grant Paris [signature] Date: 20/12/19

Approval per Delegated Authority (approval & no conflict of interest)

Name: ~~Patrick Ng~~ Chris Fleming

Signature:

Date: __/__/____

Copies to: ________________ Entered: [ ] ✓

Documentation Flow: Dept/Group Manager ► Finance - Contract Database Administrator (for input onto database / scan draft) ► Business Analyst ► Legal ► Finance ► Approval L3/L2/L1 ► Finance - Contract Database Administrator (scan final signed copy / complete input onto database / filing & distribution, (Original held in Central Storage Room))

Southern DHB 45387 V8 Released 26/04/2018

Contract Approval Form (District)
Southern DHB 45387 V7 Released 12/09/2017

Contract Key Points

Summary of procurement process e.g. rfx method, project exec(s) team members by DHB, number of responses received.	Secondary selection process off an NZHP panel for the lease of two CT scanners for Dunedin. Three Suppliers approached Siemens, Philips, and GE. After evaluation it was determined that the preferred option would be to extend the lease for the existing Siemens machines.
• *Supplier*	Maia Financial New Zealand Limited
• *Brief Product/ Service Description*	Extension of lease of two CT scanners from Siemens for radiology and Oncology departments in Dunedin.
• *Term*	24 months
• *Planned start*	1/01/2020
• *Previously under contract?*	Yes (contract previously held by Maia Financial New Zealand Limited)
• *Annual $*	$ 265,100.16
• *Source of annual spend (e.g. Regional BA)*	
• *Price fixed for*	24 months
• *.0Departure(s) from standard contract template at Schedule? Cl?*	
• *Savings*	$192,004.88 (against previous annual cost of lease for two scanners)

12.1

CT Asset compared to Lease Contract and Impact on 2019/20

Asset Register 30 November 2019

Asset Number	Description	Date Placed in Service	Life Yr.Mo	Approved Value	Cost	Accumulated Depreciation	Net Book Value	Major	Minor	Tag Number	Serial Number	Parent Number	Parent Description	Cost Centre	Accum Deprn to Dec-19	NBV @ Dec 19	Months Remaining
111645	CT Scanner Radiology	01-Jan-15	8	1,731,581.00	1,956,309.64	3,202,315.39	753,994.25	CLINLE	DIAGN					5081	$ 1,222.694	$ 733,616	36
111628	Oncology CT Scanner (Leased)	31-Oct-14	7	560,000.00	668,100.00	493,121.37	174,978.63	CLINLE	DIAGN					3675	$ 501.075	$ 167,025	21

Lif in Month	Monthly Depreciation	Months to Nov-19	Ann Depr
96	$ 20,378	59.00	$ 244,538.71
84	$ 7,954	62.00	$ 95,342.86

NEW CONTRACT PROPOSED		CT Bige Bore Rad Onc	CT Radiology	TOTAL
Start Date	01/01/2020			
End Date	31/12/2021			
Quarterly Payments		$ 14,155	$ 52,120	$ 66,275
Per Annum		$ 56,620	$ 208,480	$ 265,100
Life of Contract		$ 113,240	$ 416,960	$ 530,200
Expenditure				
Depreciation		$ 95,443	$ 244,539	$ 339,982
Depreciaton of "new" Capital - extending life		$ 56,620	$ 208,480	$ 265,100
Total Cost p.a				
Budget				
Current Asset Depreciation p.a		$ 95,443	$ 244,539	$ 339,982

	CT Bige Bore Rad Onc Depre	CT Radiology Depr	Total	Budget	Variance	Annual
Jul-19	$ 7,954	$ 20,378	$ 28,332	$ 28,332	$0	$0
Aug-19	$ 7,954	$ 20,378	$ 28,332	$ 28,332	$0	$0
Sep-19	$ 7,954	$ 20,378	$ 28,332	$ 28,332	$0	$0
Oct-19	$ 7,954	$ 20,378	$ 28,332	$ 28,332	$0	$0
Nov-19	$ 7,954	$ 20,378	$ 28,332	$ 28,332	$0	$0
Dec-19	$ 7,954	$ 20,378	$ 28,332	$ 28,332	$0	$0
Jan-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($31,287)
Feb-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($62,573)
Mar-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($93,860)
Apr-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($125,146)
May-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($156,433)
Jun-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($187,720)
Jul-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($31,287)
Aug-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($62,573)
Sep-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($93,860)
Oct-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($125,146)
Nov-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($156,433)
Dec-20	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($187,720)
Jan-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($219,006)
Feb-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($250,293)
Mar-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($281,579)
Apr-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($312,866)
May-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($344,153)
Jun-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($375,439)
Jul-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($31,287)
Aug-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($62,573)
Sep-21	$ 11,678	$ 47,941	$ 59,618	$ 28,332	($31,287)	($93,860)
Oct-21	$ 11,678	$ 47,941	$ 59,618	$ 20,378	($39,240)	($133,100)
Nov-21	$ 11,678	$ 47,941	$ 59,618	$ 20,378	($39,240)	($172,340)
Dec-21	$ 11,678	$ 47,941	$ 59,618	$ 20,378	($39,240)	($211,580)
Jan-22			$ -	$ 20,378	$20,378	($191,202)
Feb-22			$ -	$ 20,378	$20,378	($170,824)
Mar-22			$ -	$ 20,378	$20,378	($150,446)
Apr-22			$ -	$ 20,378	$20,378	($130,067)
May-22			$ -	$ 20,378	$20,378	($109,689)
Jun-22			$ -	$ 20,378	$20,378	($89,311)
Jul-22			$ -	$ 20,378	$20,378	$20,378
Aug-22			$ -	$ 20,378	$20,378	$40,756
Sep-22			$ -	$ 20,378	$20,378	$61,135
Oct-22			$ -	$ 20,378	$20,378	$81,513
Nov-22			$ -	$ 20,378	$20,378	$101,891
Dec-22			$ -	$ 20,378	$20,378	$122,269
	$327,986	$1,272,846	$1,600,832	$1,070,632	($530,200)	

	Rad Onc	Radiology
Asset Value 1/1/20	$ 167,025	$ 733,616
24 mth Lease extension	$ 113,240	$ 416,960
Total Asset Value to be depreciated over the remaining life of the lease	$ 280,265	$ 1,150,576
Monthly Depr Matchs lease period	$ 11,678	$ 47,941

Either coded to Depn
430.8000.4355

or

OPEX leases under
400.3675.4365 Radiation Oncology
400.5081.4365 Radiology CT

SOUTHERN DISTRICT HEALTH BOARD

BOARD MEETING AND REPORTING

INDICATIVE WORK PLAN 2020

Indicative Work Schedule	*To be submitted to:*		
	HAC	**DSAC/ CPHAC**	**Board**
February			
March			
Annual Plan 2019/20 Progress Report (Q2)			•
Approve first draft of the Annual Plan 2020/21 and Statement of Performance Expectations (due to MoH on 2 March).			•
April			
Dunedin Hospital DBC Risks, Assumptions, Issues and Dependencies (RAID) Register			•
May			
June			
Approve Annual Plan 2020/21		•	
Approve South Island Health Services Plan 2020/21		•	
Annual Plan 2019/20 Progress Report (Q3)		•	
Capital Expenditure Budget 2020/21 Approval			•
Approve CEO objectives for 2020/21			•
July			
August			
September			
Annual Plan 2019/20 Progress Report (Q4)			•
Draft Annual Report Approval			•
October			
November			
December			
Annual Plan 2021/22 Planning Package (with policy priorities)			•
Annual Plan 2020/21 Progress Report (Q1)		•	

13

Closed Session:

RESOLUTION:
That the Board move into committee to consider the agenda items listed below.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 32, Schedule 3 of the NZ Public Health and Disability Act (NZPHDA) 2000* for the passing of this resolution are as follows.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Commissioner's Public Excluded Meeting		Section 31(2)(a) of the New Zealand Public Health and Disability Act 2000
Southern DHB Performance Report	Information provided in confidence.	Section 9(2)(f)(iv) of the Official Information Act.
Public Excluded Advisory Committee Reports a) Finance, Audit & Risk Committee, 23 January 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.
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.