Southern DHB Board Meeting

Board Room, Level 2, Main Block,
Wakari Hospital Campus, 371 Taieri Road, Dunedin
(Maximum 12 attendees for physical distancing)

and Zoom

03/06/2020 09:30 AM - 11:30 AM

APOLOGIES

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

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Board Meeting
Date of Meeting:	3 June 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:

- Nil

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 25/05/2020

RECOMMENDATION:

1. That the Interests Registers be received and noted.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

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

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
	03.04.2020	Client, Royal District Nursing Service NZ Ltd		
Jean O'Callaghan	13.05.2019	Employee of Geneva Health	Provides care in the community; supports one long term client but has no financial or management input.	
	13.05.2019	St John Volunteer, Lakes District Hospital	Nil	Taking six months' leave.
Tuari Potiki	09.12.2019	Employee, Otago University		
	09.12.2019	Chair, NZ Drug Foundation		
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd*		
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.12.2019	*Shareholder in Te Kaika		
Lesley Soper	09.12.2019	Elected Member, Invercargill City Council		
	09.12.2019	Board Member, Southland Warm Homes Trust		
	09.12.2019	Employee, Southland ACC Advocacy Trust		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	Sister-in-law, Employee of SDHB (Clinical Nurse Specialist Acute Mental Health)		
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
Roger Jarrold (Crown Monitor)	16.01.2020	CFO, Fletcher Construction Company Limited		
	16.01.2020	Member, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

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

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Kaye CHEETHAM	08.07.2019	Ministry of Health Appointed Member of the Occupational Therapy Board	
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
	01.07.2019	Capable NZ Assessor	Asked from time to time to assess students, bachelor and masters students final presentation for Capable NZ.
Matapura ELLISON	12.02.2018	Director, Otākou Health Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki (Note: Kāti Huirapa Rūnaka ki Puketeraki Inc owns Pūketeraki Ltd - 100% share).	Nil
	12.02.2018	Trustee, Araiteuru Kokiri Trust	Nil
	12.02.2018	National Māori Equity Group (National Screening Unit)	
	12.02.2018	SDHB Child and Youth Health Service Level Alliance Team	
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	

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
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	
	25.09.2016	Deputy Chair, InterRAI NZ	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
Lisa GESTRO	06.06.2018	Lead GM National Travel and Accommodation Programme	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	NASO Governance Group Member	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	Lead GM Perinatal Pathology	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	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.

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	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:	
	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

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
	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

Population Based Funding Formula (PBFF) & Projections and characteristics of SDHB's population

SDHB Board June 2020

What is the PBFF?

- The PBFF has been used to allocate funding to District Health Boards (DHBs) since 2003/04.
- Determines DHB's **share** of funding, not the **amount** of funding
- Reviewed every five years by MoH (last review 2015).
- Comprises two parts: the core model that determines relative health need and three adjusters that modify funding allocations between DHBs.

What is the PBFF?

Includes	Does not include
Primary Care	<65 Disability Support Services
Hospital and Community Care services	Public Health
Health of older People	Lead Maternity Carers
Mental Health	Tertiary Adjuster (sits in IDF)

The PBFF Model

- The Core Model
  - Cost weight model using the national average expenditure per head per year for a person in a particular demographic group.
  - Uses DHB level estimated resident population projections produced by Statistics New Zealand (based on MoH provided assumptions).
  - Adjusted for age, socioeconomic status, ethnicity and sex.
  - cost weights are applied to each DHB population grouping, which gives the estimated PBFF share the DHB needs to provide for the range of health care services to its population.

The PBFF Model

The following Adjusters sit within PBFF.

1. Unmet need adjuster (~ $165m)
   - targets funding at population groups with access issues to health services. The current target groups are Māori, Pacific and those living in areas of high deprivation.
2. Overseas eligible and refugees adjuster (~ $30m)
   - unavoidable costs of providing services to eligible overseas visitors, includes an allowance to meet the high health costs of new refugees to New Zealand.
   - It includes cover for New Zealand citizens domiciled overseas who return to New Zealand for treatment, those patients for whom there is a reciprocal arrangement.

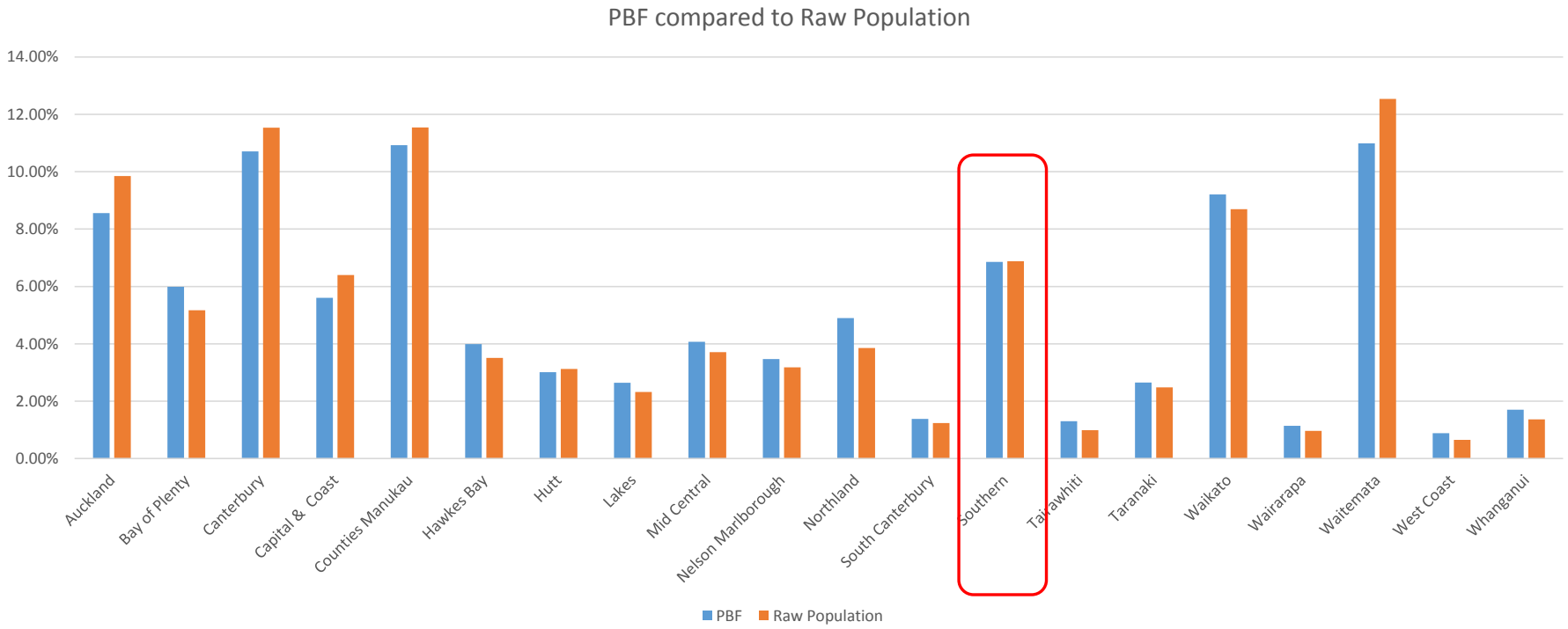
The PBFF Model

The Adjusters cont'd

3. Rural adjuster (~$170m)

- This compensates DHBs for having to provide services in more rural areas.
- Based on a Weighted rural population index, which uses *weighted rural population*, *weighted travel time* and *weighted travel to tertiary* as key inputs.
- Historically SDHB has had the largest share of Rural Adjuster (18% of total pool in 13/14).

Compare PBF to Raw Population graph and table



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Snapshot of our funding

Revenue Stream (000's)	Budget 20/21	Examples of funding
Devolved Funding	1,027,690	Funding Envelope
Non Devolved MOH Funding	20,207	Care Plus, U 14's, Very Low Cost Access
Crown Funding Agreement subcontracts	42,923	Planned Care, Refugee
Public Health Side Contracts	7,192	Public Health Core contract, School based services
Personal Health Side Contracts	3,720	Bowel Screening
Disability Support Side Contracts	4,087	
HWNZ Training	7,673	
MOH Funding Total	**1,113,492**	
Inter- District Flows	23,385	
Other Government	17,679	ACC
Patient Related	3,963	
Other Income	7,712	
Total Budgeted Income	**1,166,231**	

Perceived shortcomings to PBF (from a SDHB perspective)

- Is PBFF the best funding allocation for Pharmaceuticals?
  - International Literature states link between distance from the equator and prevalence of Autoimmune disease.
  - Many new, highly effective (and expensive) treatments for Autoimmune diseases are pharmaceutical based.
- Does the rural adjuster adequately deal with running multiple secondary hospitals for a small population?
  - It is much cheaper to run a single secondary hospital to serve a population of 340,000 people than it is to run one for 200,000 people and one for 100,000 people.
- ACC
  - Public Health Acute Service (PHAS) levy is allocated to DHB's as part of PBF. Is SDHB disadvantaged from a higher burden of ACC events for non eligible overseas patients?

Projections and characteristics of SDHB's population

Southern DHB at a glance

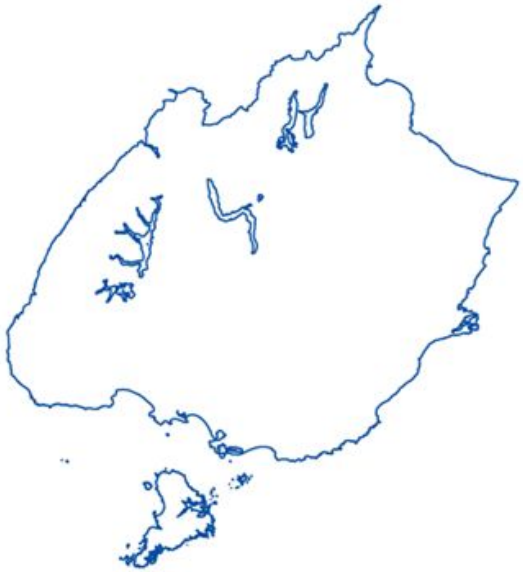
- Southern DHB is NZ's largest DHB by area: We span 65,608 km^2
- Bigger than Sri Lanka, Latvia, Denmark, Belgium or Taiwan…
- 6th largest DHB by population
- 30.7% of Southern's population live >60 min from secondary facilities.

Different Data Sources

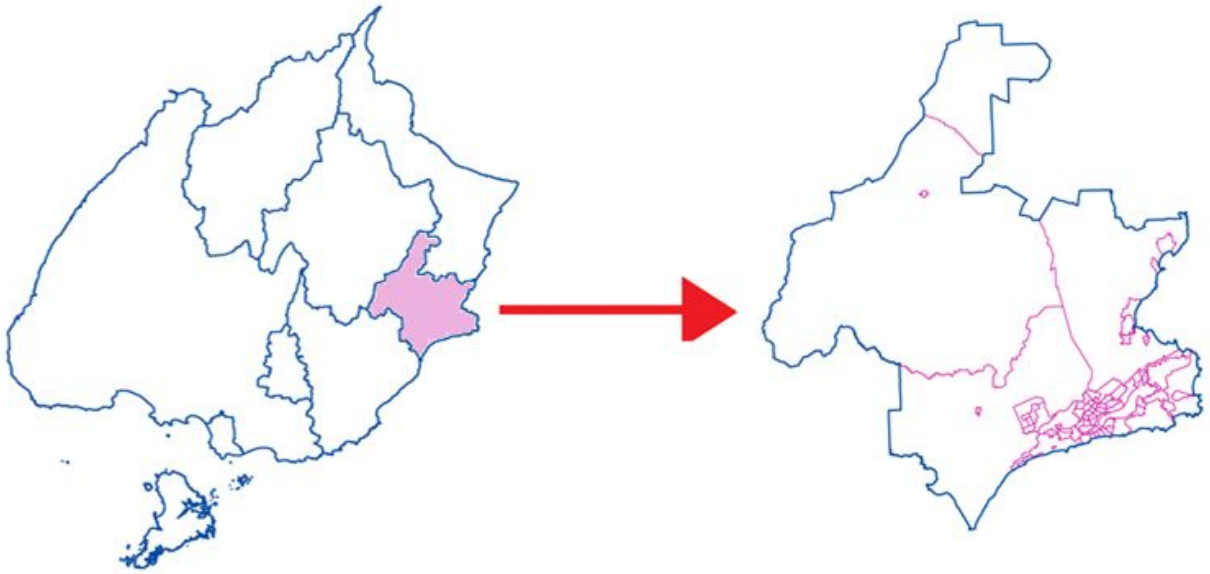
- Stating the population size is more complex than first appearances
- There are four key data sources available:
  1. Census (Stats NZ)
  2. Population projections and estimates (Stats NZ)
  3. Ministry of Health population estimates (used for PBFF)
  4. PHO enrolment data
- Each have strengths and weaknesses

Geographical area explanation

Ministry level



Stats NZ level



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Comparing the Data Sources

Data source	Benefits	Short-comings
#1 Census data	-	5 yearly Snapshot Not adjusted
#2 Stats NZ estimates ✓	Adjusted TLA and CAU/SA2 Forecasts	Differs at times to MoH projections
#3 Ministry estimates ✓	Level used for funding Forecasts	Not available at TLA or CAU/SA2
#4 PHO enrolment	Actual enrolment	Not everyone is enrolled No forecast

Data Source	2013	2018	2020	2023	2028	2033	2038
MoH Projection	306,430	334,370	343,360	349,830	356,560	361,480	-
Stats NZ High	-	333,860	-	352,620	367,900	382,260	395,070
Difference	-	**510**	-	**-2,790**	**-11,340**	**-20,780**	-

Population analysis: Main trends

- Main trends and projections
  - Growth projections
  - Aging
  - Ethnic composition and age structures
  - Central Otago
  - Distance from hospitals

Growth projections (1 of 2): Southern total

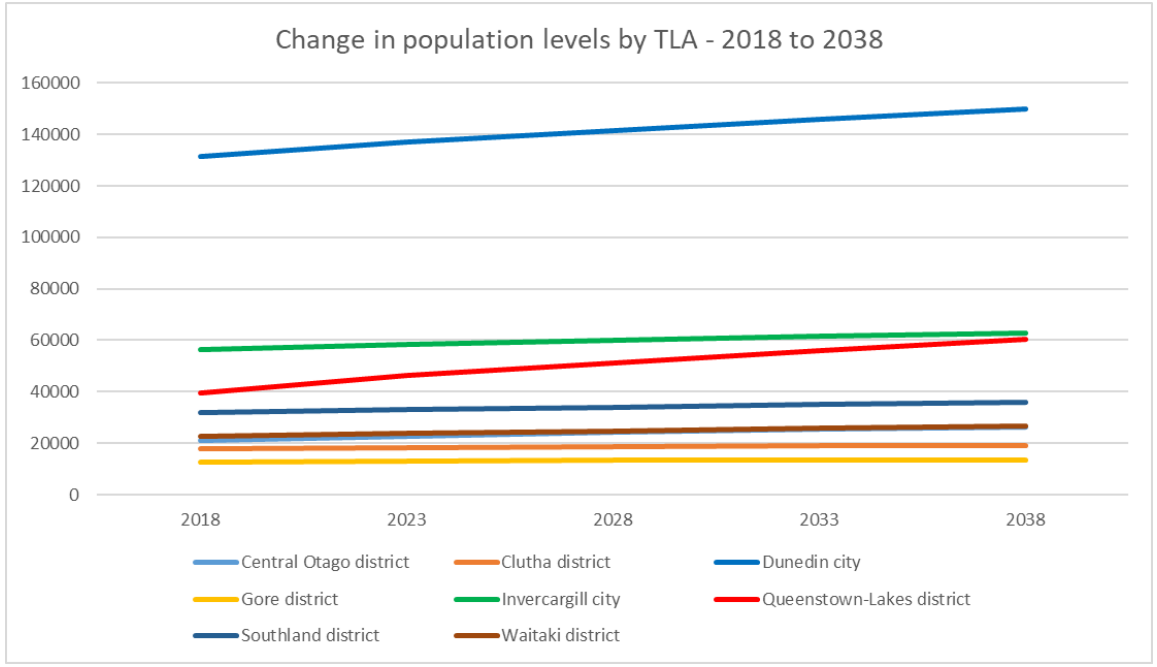
- Overall, between 6.6% and 10.2% growth from 2018 to 2028

Data Source	2013	2018	2020	2023	2028	2033	2038
MoH Projection	306,430	334,370	343,360	349,830	356,560	361,480	-
Stats NZ High	-	333,860	-	352,620	367,900	382,260	395,070
Difference	-	**510**	-	**-2,790**	**-11,340**	**-20,780**	-

2018 population	2018 to 2023		2018 to 2028	
Population	Population Increase	% increase	Population Increase	% increase
334,370	+15,460	4.6%	+22,190	6.6%
333,860	+18,760	5.6%	+34,040	10.2%

Growth projections (2 of 2): By TLA

- The greatest change is in Queenstown Lakes – from 40,000 to 60,000 in 20 years (50% increase)
- Central Otago also has a large increase from 20,000 to 25,000 (25% increase)
- Note that these are "high" projections and pre-COVID19

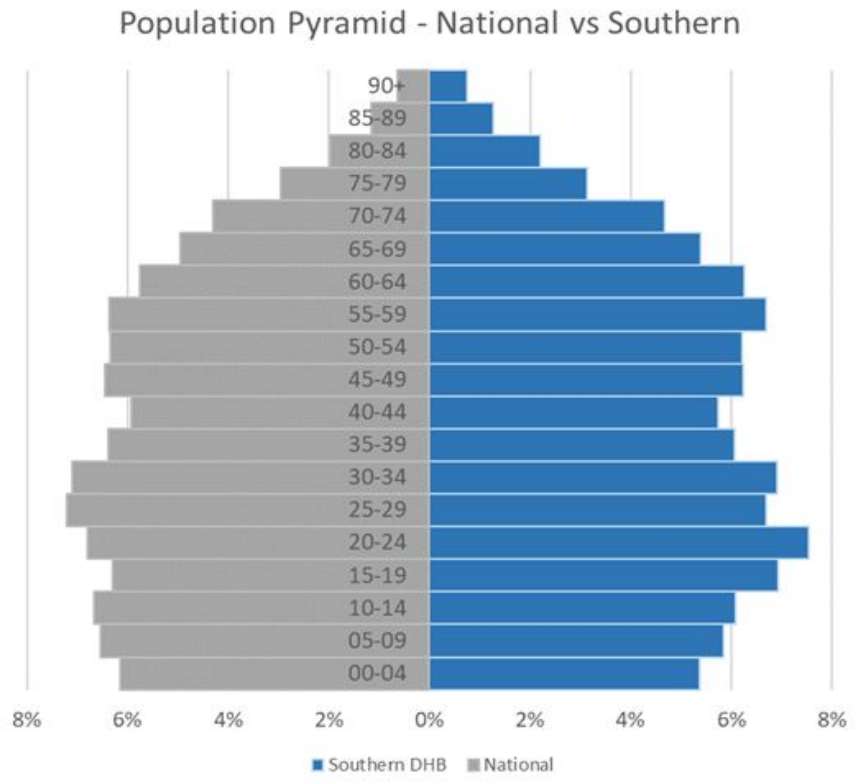


Source: Stats NZ (#2): Subnational ethnic population projections, by age and sex, 2013(base)-2038 update

Aging (1 of 3): Profile compared to national

- Southern has a lower percentage of children, but higher levels of other age groups compared to national.
- The most significant is the >65 at 1.4% more than national
- 15-39 and 40-64 aren't significantly different (+0.3% and 0.2% respectively)

Age Band	National	Southern	*South Island*
0-14	19.4%	17.3% ↓	*17.7%*
15-39	33.8%	34.1%	*32.6%*
40-64	30.9%	31.1%	*32.0%*
65+	16.0%	17.4% ↑	*17.7%*



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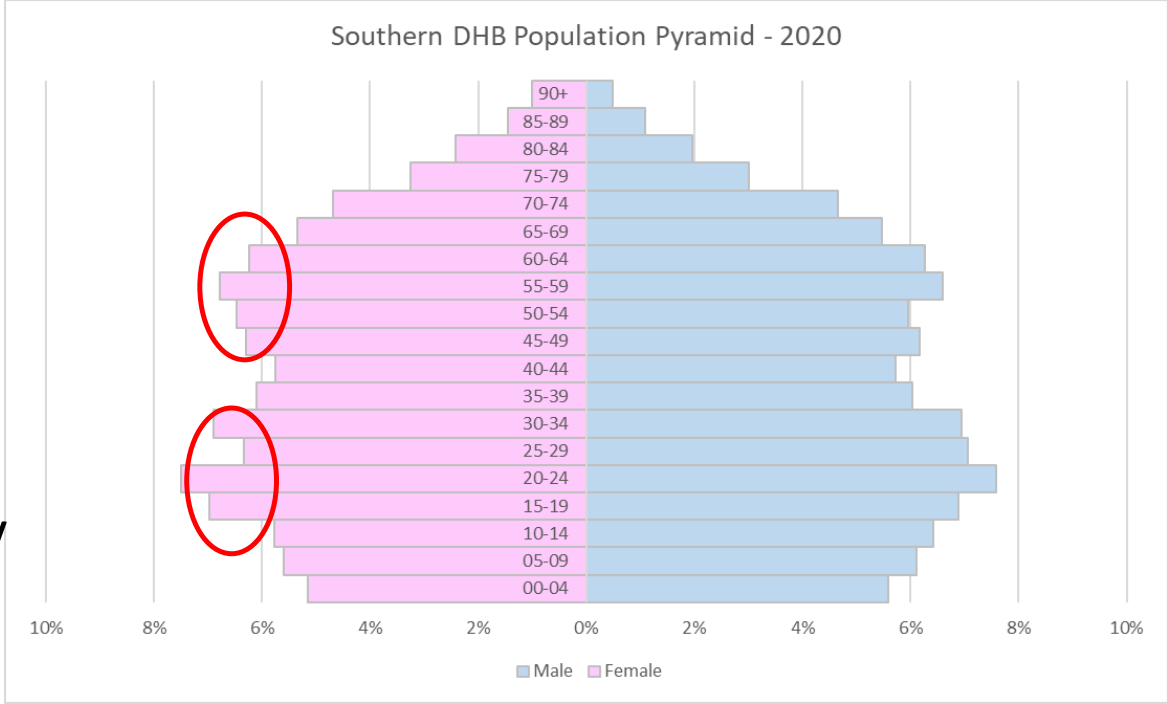
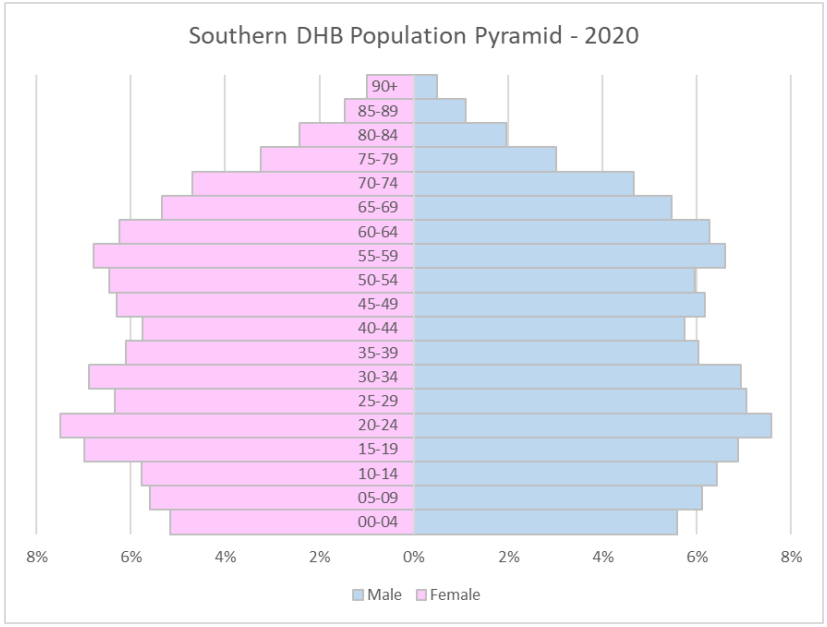
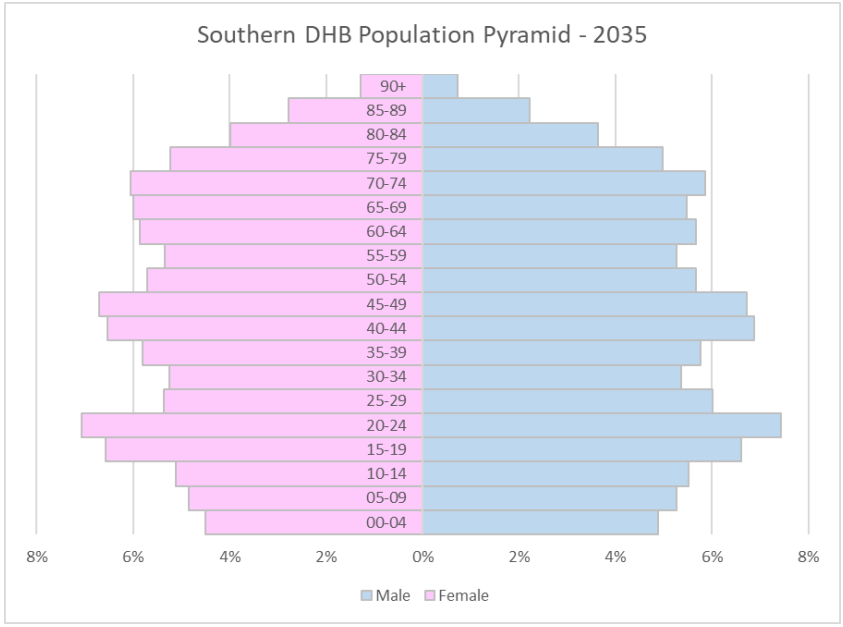
Aging (2 of 3): Age distribution by sex

- Can see that the student population has an impact
- Proportionality less 35-49
- 50-64 is a large cohort that will require increased services in the coming years
- Female population is slightly older on average



Aging (3 of 3): Projections of aging

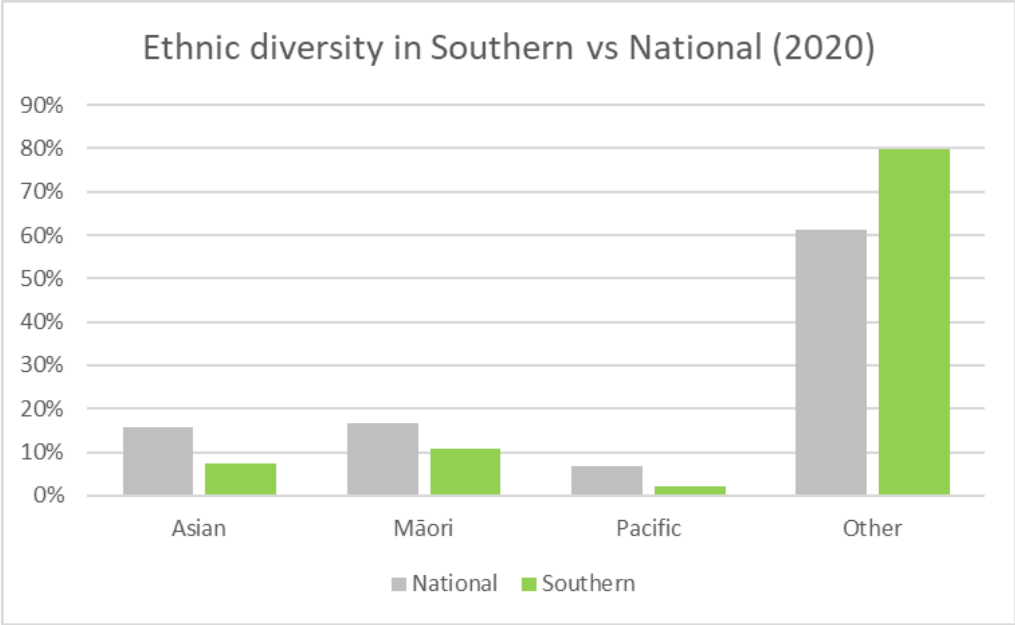




- Can the impact of the 55-64 cohort aging as the pyramid shape shifts between 2020 and 2035 to become "top heavy"

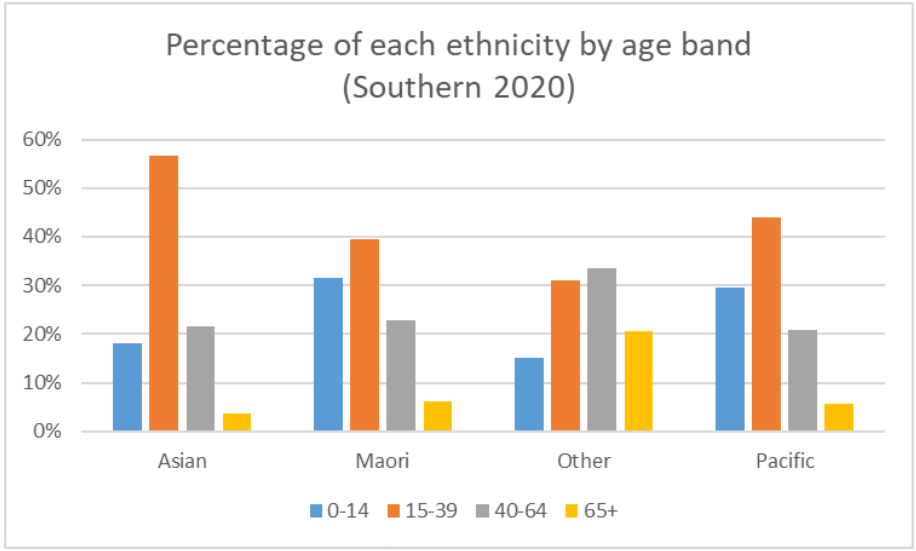
Ethnic composition (1 of 2)

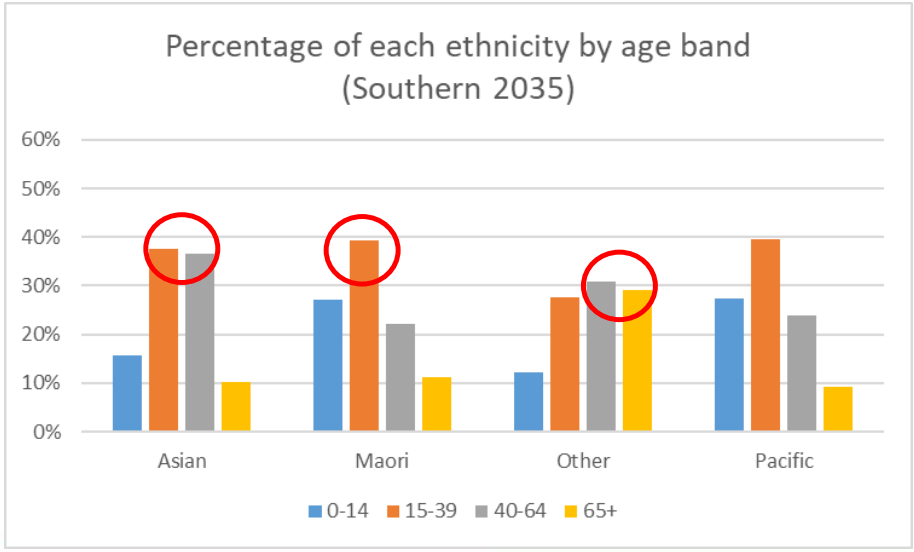
- Southern is predominantly NZ European / “Other”
- We have smaller Asian, Māori and Pacific populations than in other areas of the country



Ethnic composition (2 of 2)

- Different age structures of ethnic groups – can see Māori 0-14 is >30%; vs <15% for Other
- Can observe shifts in the demographics





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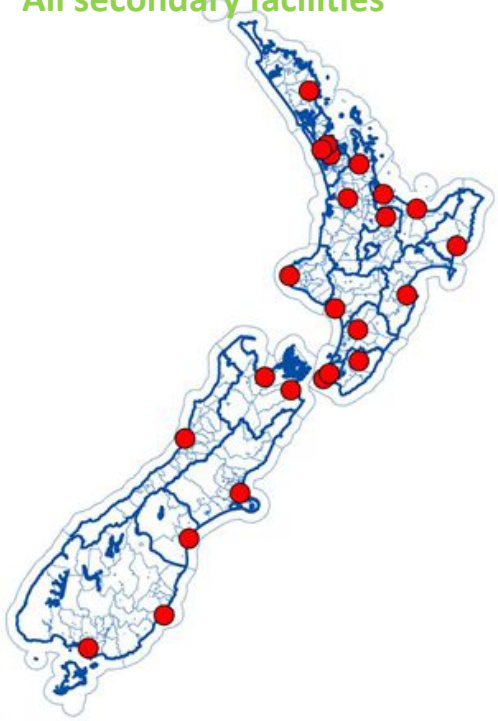
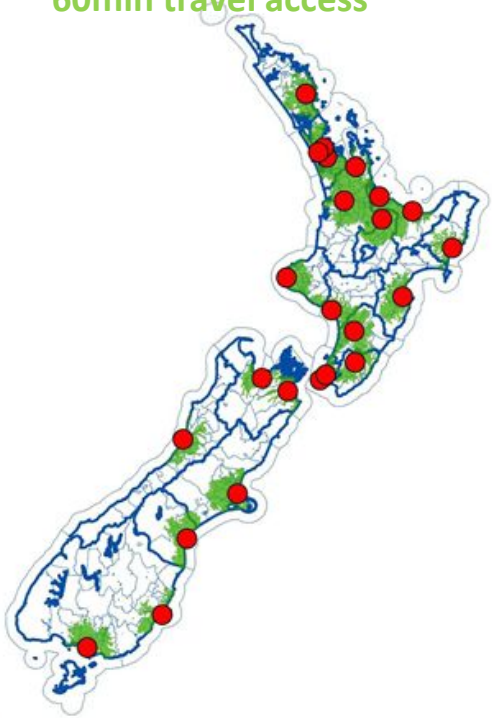
Access to secondary services (1 of 2)

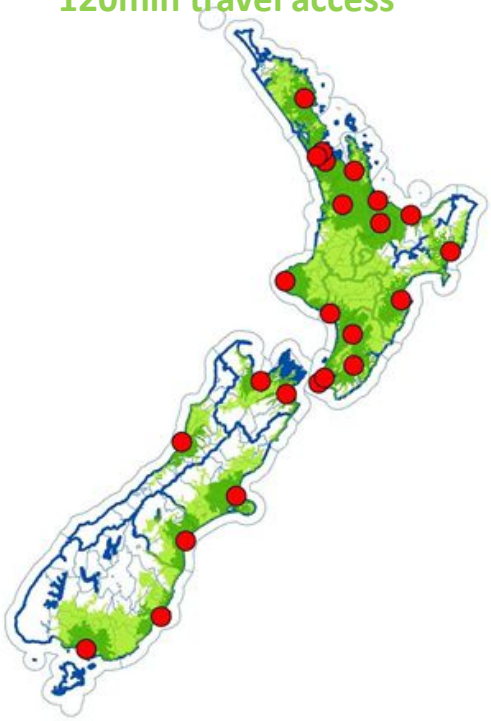
All secondary facilities



60min travel access



120min travel access



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Access to secondary services (2 of 2)

Results

Population within 120min to a base hospital (2018 pop est.)			
	Southern	NZ Total	NZ minus Southern
Within 120min	267,980	4,778,750	4,510,770
Outside 120min	64,080	85,740	21,660
Total	332,060	4,864,490	4,532,430
% pop within 120min	80.7%	98.2%	99.5%

Note that the 2018 population figure is slightly lower than elsewhere in the powerpoint because of differences in datasets necessary for the application

Central Otago / Queenstown Lakes

If Central Otago / Queenstown Lakes was a DHB in its own right, it would:

- Be the 6th largest by area (15 DHBs smaller)
- Be the 6th smallest by population (2023, 5 smaller)
- Have the highest predicted % change in population (growth) sustained for the period 2018-2037 of all DHBs

Non-resident populations

- Non-resident populations are comprised of tourists, transient workers, short-term visa holders, etc.
- Capturing levels is difficult with different surveys focusing on different groups with subsequent limitations (Census, MBIE, Regional Tourism Organisations, private data companies etc)
- Pre-COVID, tourism was a major contributor to Southern's non-resident count, especially in Central Otago/Queenstown
- For example, 2019 saw 3.1 million visitors to Queenstown with peak season growing from the base 40,000 to up to 130,000 a night.
- Similar stresses in Central Otago and Wanaka areas. Lesser in Dunedin/Invercargill

Summary - PBFF

- A funding formulae is a means to provide fair distribution of resources (the CORE model) without reinforcing the health inequities of those who systematically under-utilise the health services relative to their health needs (the ADJUSTERS)
- Note that the factors in the CORE model identify factors that correlate with demand (age, ethnicity, socioeconomic group, geography) and by implication reflect health need
- MOH directly fund some national services (Public Health etc) as well as Tertiary Adjuster

Summary – Southern population

- Balance fair distribution with health need
- Proxy for health need includes:
  - Population growth
  - Age structure
  - Ethnic composition
  - Distance from rural and metropolitan hospitals
  - Demographics – particularly since COVID-19, socioeconomic and non-resident

5

Minutes of the Southern District Health Board Meeting

Tuesday, 5 May 2020, 9.30 am
By Zoom

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

1.0 KARAKIA AND WELCOME

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

On behalf of the Board, the Chairman acknowledged and thanked staff and primary care providers for their efforts over the past 5-6 weeks, in particular those in the Public Health Unit who had done a sterling job in contact tracing. The Chairman noted that, despite having one of the two bigger clusters of COVID-19 in the country, the Southern district was now free of new cases.

2.0 APOLOGIES

Miss Soper tendered an apology for a departure from the meeting between 10 and 10.30 am.

An apology for lateness was received from the Chief Medical Officer.

3.0 DECLARATION OF INTERESTS

The Interests Registers were circulated with the agenda (tab 3) and the following additions were notified.

- Andrew Connolly - member of the Ministry of Health's Planned Care Advisory Group, whose responsibilities include monitoring recovery programmes;
- Moana Theodore - nephew is a causal Mental Health Assistant, Southern DHB.

It was resolved:

"That the Interests Registers be received and noted."

D Cull/L Soper

4.0 PREVIOUS MINUTES

It was noted that the Board had requested that asset management be added to the Finance, Audit and Risk Committee's Terms of Reference but this did not appear to be referenced in the minutes.[1]

It was resolved:

"That, with the above addition, the minutes of the meeting held on 7 April 2020 be approved and adopted as a true and correct record."

D Perez/T Potiki

5.0 MATTERS ARISING

There were no matters arising from the previous minutes that were not covered by the agenda or action sheet (tab 6.1).

6.0 ACTION SHEET

The Board reviewed the Action Sheet (tab 6) and noted that a number of actions were deferred or on hold due to the COVID-19 pandemic response.

Clinical Council

Members expressed concern about the Clinical Council's ability, in its current form, to usefully contribute to addressing the various clinical issues being reported to Board.

Mr Terry King joined the meeting at 9.50 am.

The Board requested that management submit a comprehensive paper to the next meeting on the Clinical Council's work plan, how they envisaged the Clinical Council could be rejuvenated, and how it would interact with the Board. The report is to include a copy of the Council's terms of reference.

[1] Following the meeting, it was confirmed that this was recorded in the Board's resolution, page 4 of the 7 April 2020 minutes, and had been actioned.

Trust and Bequest Funds

A summary of the custodial funds held by Southern DHB was appended to the action sheet (tab 6.2) and taken as read.

It was resolved:

"That the action sheet be noted"

I Beekhuis/L Kelly

7.0 ADVISORY COMMITTEE REPORTS

Finance, Audit and Risk Committee

Mrs O'Callaghan, Deputy Chair of the Finance, Audit and Risk (FAR) Committee, gave a verbal report on the FAR Committee meeting held on 29 April 2020 by Zoom, during which she advised that:

- The Committee received a report from the CEO on COVID-19 revenue and the cost of recovery.
- The Finance and Payroll Teams had been working from home, which had made it difficult to produce reports for the Committee and much of the Executive Director Finance, Procurement and Facilities' time had been taken up with the Procurement Team on Personal Protective Equipment (PPE).
- A lot of programmed capital expenditure activity had reduced, as preparations for COVID-19 patients were focused on.
- The Committee requested more detailed reporting on the management of annual leave and casual workforce costs.
- The Committee considered a further capital drawdown for Dunedin Hospital's Intensive Care Unit (ICU) and deferred maintenance, and an initial drawdown for critical infrastructure works, and recommended that this be approved by Board (tab 7.1).
- The Committee discussed the annual statement timeline and Holidays Act compliance and reviewed the Health and Safety report.
- The quality and clinical governance reports were discussed, noting that it was important not to lose sight of the safety of non-COVID patients at this time. The clinical dashboard continued to be developed and helped to highlight areas that needed to be focused on.
- The CEO gave a comprehensive briefing on COVID-19 planning and status.
- A number of assurance and IT reports were received. The Committee commended the work of IT in enabling staff to work from home in a very short timeframe.

The FAR Committee Deputy Chair and CEO answered questions on expenditure management plans.

It was resolved:

"That the Board:

- **Receive and note the verbal report on the FAR Committee meeting held on 29 April 2020;**

- **Approve the request for a further drawdown of capital funding for Dunedin Hospital interim and critical infrastructure work projects."**

D Cull/T Potiki

8.0 CHIEF EXECUTIVE OFFICER'S REPORT

The Chief Executive Officer's monthly report (tab 8) was taken as read and the CEO highlighted the following items.

- Financial performance was at risk due to the COVID-19 pandemic. Currently an assumption was being made that planned revenue would be replaced and there would be no further contribution to the extra costs incurred for COVID-19.

- Volumes were down during March, and would continue to be down during April 2020. 418 surgeries had been cancelled due to the COVID-19 pandemic and it was estimated that a total of 900 would have been delivered if there had not been a lockdown.

- Work was continuing on the Annual Plan for 2020/21, which would have to be reframed and reshaped to include recovery plans.

- Pharmac funding decisions were increasingly impacting DHB services, as additional staffing, clinics, imaging and labs were required when new drugs were funded. The CEO was advocating that these resource implications be taken into account when decisions are made.

Planned Care Recovery

During discussion on recovery planning, the Board was informed that:

- The planned surgery recovery model was still in the process of being finalised, however based on available external and internal capacity, the Executive Director Specialist Services (EDSS) thought that volumes could be recovered within 4-6 months provided there was funding for that. Funding would be the limiting factor.

- In addition to surgery, there were first specialist assessments (FSAs) and follow-ups (FUs) that needed to be caught up. Negotiations were taking place with the PHO to include primary care in the recovery plan.

- Clinicians had been delivering many services virtually and that needed to continue where appropriate. Extra capacity could be freed up by allowing General Practitioners to order tests where the clinical scenario fitted the pathway.

- There had been some positive engagement on re-orienting models of care to maximise the opportunities revealed over the past eight weeks.

- Equity, in terms of digital access, needed to be taken into consideration when expanding telemedicine.

Influenza Vaccinations

The Executive Director Strategy, Primary and Community (EDSP&C) reported that contradictory information was being received about the availability of influenza vaccines, so it was difficult to determine whether there was a supply issue, however there had been gaps where providers had to wait 3-5 days for vaccines to arrive.

The CEO reported that statistics were indicating that there was a significantly higher uptake of influenza vaccinations than in previous years.

It was resolved:

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

D Cull/I Beekhuis

9.0 FINANCE AND PERFORMANCE REPORTS

Financial Report

The Executive Director Finance, Procurement and Facilities (EDFP&F) presented the Financial Report for the period to 31 March 2020 (tab 9.1), then took questions.

Mr Roger Jarrold, Crown Monitor, joined the meeting.

Volumes

A summary of volume throughput to 31 March 2020 (tab 9.2) was taken as read. The impact of the COVID-19 response on caseweight volumes and ED presentations was noted.

Performance Dashboard

The performance dashboard (tab 9.3) was taken as read. The CEO observed that other radiology modalities needed to be added to it and the mortality graph had not been updated.

It was noted that:

- Unplanned readmissions had not changed but the average length of stay (ALOS) had increased;
- The CT turnaround graph did not appear to be correct.

The EDSP&C undertook to report back on the likely impact on inter-district flows (IDFs) of moving to COVID-19 alert level 2.

It was resolved:

"That the reports be noted."

D Cull/K Crowther

The Chief Medical Officer joined the meeting.

10.0 ANNUAL PLAN/BUDGET 2020-21 UPDATE

The Executive Director Strategy, Primary and Community (EDSP&C) gave an update on the revised process for completing the Annual Plan for 2020/21, during which she informed the Board that guidance from the Ministry of Health was still outstanding, however the executive team were taking the opportunity to refresh and re-orient the draft Annual Plan. This included receiving a series of presentations from specialist and community services on recovery planning and reflections on the COVID-19 response. As a result, teams had been asked to give thought to how the gains made over the past eight weeks could be locked in.

The revised timeline for completing the draft Annual Plan was mid-June 2020.

Mr Jarrold, Crown Monitor, noted that the Annual Plan was a three-way contract between management, the Ministry and the Board, and it was the Board's commitment to the community on the health services that would be delivered. As such, he advised it was important the Board understood the implications of what it was signing up to for the year.

11.0 COVID-19 UPDATE

The CEO presented a comprehensive report on the COVID-19 pandemic and Southern DHB's response to it (tab 11).

The CEO reported that since the report was written there had been no new cases of COVID-19 in the Southern district and there were 11 remaining active patients.

The Chief Medical Officer (CMO) observed that the Southern district had the most cases of COVID-19 per head of population in the country and commended the extraordinary contribution made by the Public Health Team and the whole of system health response, which included the setting up of community based assessment centres (CBACs) by WellSouth. The CMO expressed concern about the impact of the pandemic on primary care, noting it was a critical part of the health system.

The Executive Leadership and Public Health Teams were complimented on their mobilisation and courage which, along with the effort of other staff, had averted the scenarios seen elsewhere in the world.

Ms Ilka Beekhuis left the meeting.

12.0 E-BIKES

The EDFP&F presented a report on assisting employees to purchase electric bikes (tab 12).

It was resolved:

"That the Board:

- **Note and approve the Procurement Team process to source suppliers of discounted E-bikes for employees of Southern DHB;**
- **Acknowledge that legislation prohibits the Southern DHB providing any loan/advance to an employee for the purchase of an E-bike and therefore any such arrangement is not adopted."**

J O'Callaghan/L Soper

PUBLIC EXCLUDED SESSION

***At 11.37 am it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Minutes a) Finance, Audit & Risk Committee, 29 April 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.
Health Roundtable Executive Briefings	Information provided in confidence.	Section 9(2)(ba) of the Official Information Act.
Elective Services Outsourcing	To allow negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Short Term CT Proposal	Commercial sensitivity and to allow negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Contract Approvals a) Strategy, Primary & Community b) Holidays Act 2003 Remediation	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
New Dunedin Hospital	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Annual Plan 2020/21	Plan is subject to Ministerial approval	Section 9(2)(f) of the Official Information Act.

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

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

The meeting closed at 1.55 pm.

Confirmed as a true and correct record:

Chairman: _____

Date: _____

Southern District Health Board

BOARD MEETING ACTION SHEET

As at 25 May 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020	**Fleet Vehicle Management** (Minute item 5.0)	Quarterly progress reports to be provided.	EDFPF		June 2020
Sept 2019	**Valuing Patients' Time (VPT) - ED Escalation Pathway** (Minute item 9.0)	Update to be provided on the development of an ED escalation pathway.	EDQCGS	This has been raised on many times with the Clinical Council, as well as Clinical Leadership with very little traction.	
Oct 2019	(Minute item 4.0)	Timeframe to be provided.		The ED escalation is on the Clinical Council work plan. Dr Nigel Millar (CMO) is the clinical lead for this work with the Medical and Clinical Directors groups and will provide updates at future Clinical Council meetings.	
Mar 2020	(Minute item 7.0)	▪ A timeline and précis of the plan to develop an escalation pathway to be submitted to the next meeting. ▪ Discharging patients earlier in the day to be made a priority.	CEO/ EDSS		July 2020
Apr 2020	(Minute item 6.0)	Progress report to be submitted to Board in July.	EDSS		
May 2020	**Clinical Council** (Minute item 6.0)	Management to submit a comprehensive paper to the June Board meeting on the Council's work plan, how they envisage the Council can be rejuvenated and how it will interact with the Board. Report to include a copy of the Council's terms to reference.	Deputy CMO/ EDQCGS/ CMO/ CN&MO	A presentation will be made at the meeting.	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Feb 2020	**Resourcing Implication of PHARMAC Decisions** (Minute item 8.0)	Further information to be provided, including explanatory detail on the growth areas, eg the number of patients receiving high cost drugs over time and the clinical areas involved.	EDSPC	This has now shifted to a regional piece of work, with support from the SIAPO office and CEO sponsorship. A combined South Island DHB's paper is currently being developed, which will be available for the next meeting of the Board.	July 2020
Feb 2020 Apr 2020 May 2020	**Performance Dashboard** (Minute item 9.0) (Minute item 9.0) (Minute item 9.0)	Caseweights per FTE to be added as a productivity indicator. Legibility of graphs to be improved by increasing the resolution and/or reducing them to six per page. Radiology by modality to be added to the dashboard.	EDQCGS EDQCGS EDQCGS/ EDSS	In development. Improvement made with more to come. MRI and CT on graph Ultrasound and Plan X Ray to be added	~~April 2020~~ ~~May 2020~~
Feb 2020	**CT Capacity** (Minute item 9.0)	A business case (including the clinical case) for a second Dunedin CT to be developed in consultation with Southern Alliance.	EDSS	Business case for additional CT Scanner will be a part of the refreshing of the Annual Plan.	
Mar 2020	**Funding and PBFF** (Minute item 9.0)	To be a Board training/ orientation topic.	CEO	On agenda	Completed
Mar 2020	**Change Management and Benefits Realisation Plan** (Minute item 11.0)	Clinical input into the plan to be made explicit, equity embedded from the start, and a key added to the plan timeline chart.	CEO	Will be woven into the plan when it is updated, iteratively, in coming months.	
Mar 2020	**Annual Plan 2019/20 Progress Report** (Minute item 12.0)	▪ Further information to be provided on diabetes services.	EDSP&C	A more detailed report on what is being done to help meet national targets is currently being developed.	June 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		▪ Progress reporting to be provided for all high risk areas. ▪ PHO performance indicators to be submitted to the Community & Public Health Advisory Committee.		New quarterly reporting formatting, with targeted high risk focus will be developed as a result of the new Annual Plan being finalised, and will be available from Quarter 1, 2020/21. A draft of what these could look like has been included in the pack.	October 2020 Complete
May 2020	**Inter-District Flows** (Minute item 9.0)	Board to be advised of the likely impact on IDFs of moving to COVID-19 alert level 2.	EDSP&C	Detail of this is included in the Finance/CEO reports	Complete

FINANCE, AUDIT AND RISK COMMITTEE MEETING, 21 MAY 2020

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

SOUTHERN DISTRICT HEALTH BOARD
FINANCE, AUDIT AND RISK COMMITTEE
21 May 2020

RECOMMENDATIONS TO BOARD:

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

Insurance - Fire Loss Limit

"That the maximum fire loss limit for 2019-2020 be set at 100% of the likely loss in a level II event, noting that this will result in increasing cover by $1,929,905 to a total of $156,089,345."

JOINT MEETING OF THE COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEES, 2 JUNE 2020

- Verbal Report from Tuari Potiki, Chair of the Community and Public Health Advisory Committee, and Moana Theodore, Chair of the Disability Support Advisory Committee

SOUTHERN DISTRICT HEALTH BOARD

Title:	**COVID-19 Māori Response Action Plan**
Report to:	Board
Date of Meeting:	3 June 2020

Summary:

Attached for the Board's consideration is the Southern DHB and WellSouth PHN COVID-19 Māori Response Action Plan. Meetings have been held with a sub-committee of the Iwi Governance Committee to assist with development of the Action Plan and the Southern DHB Executive Leadership Team (ELT) has endorsed the document. The Iwi Governance Committee (IGC) and Community and Public Health Advisory Committee (CPHAC) will be considering the Action Plan on 2 June 2020, and it will also be submitted to the WellSouth PHN Board meeting in June 2020 for approval.

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

Financial:	We are currently in negotiations with the NMDHB on a contract for Māori targeted COVID-19 recovery funding released from the MoH. This funding will assist with communications, strengthening Māori provider COVID-19 response and influenza vaccination. This is one off funding.
Workforce:	The plan is based on utilising Māori DHB capacity, WellSouth and Māori provider workforce capacity.
Equity:	Equity is the key focus for this plan based on Māori COVID-19 recovery.
Other:	As set out in the report.

Document previously submitted to:	Iwi Governance Committee DSAC/CPHAC	**Date:** 2 June 2020

Prepared by: Gilbert Taurua Chief Māori Strategy and Improvement Officer **Date:** 21 May 2020	**Presented by:** Gilbert Taurua Chief Māori Strategy and Improvement Officer

RECOMMENDATIONS:

That the Board approve the COVID-19 Māori Response Action Plan included with the agenda.

COVID-19 MĀORI RESPONSE ACTION PLAN

Southern District Health Board

WellSouth Primary Health Network

Progress	Dashboard
	On Target
	Caution
	Critical
	Complete
	Not Started

Reporting	
Quarter 1	July-Sept
Quarter 2	Oct-Dec
Quarter 3	Jan - March
Quarter 4	April - June

COVID-19 Māori Response Action Plan

Final 21 May 2020

Introduction

The severe impact of the 1918/19 pandemic on Māori and the increased susceptibility of Māori to the 2009 H1N1 Influenza A pandemic (H1N1 pandemic) provide rationale strengthening the Māori-specific response to COVID-19. It is evident from previous pandemic responses that the business-as-usual model previously used preferentially benefited non-Māori and failed to protect whānau, hapū, iwi and Māori communities from the worst outcomes. Consideration to the specific needs of Māori, particularly equity and active protection, should be integral to the Southern DHB's response to COVID-19. The Māori population of the Southern district sits at 36,740 with 6,860 of this population assessed as those living in the highest deprivation.

Indigenous health inequities in New Zealand

Indigenous ethnic inequities in infectious diseases are marked. Māori experience higher rates of infectious diseases than other New Zealanders. One example that highlights the ethnic difference within close contact infectious diseases was the higher rates of hospitalisations reported for Māori and Pacific peoples, compared with other New Zealanders, during the H1N1 pandemic. (Māori RR=3.0, 95% CI: 2.9–3.2, Pacific peoples RR=6.7, 95% CI: 6.2–7.1).

Historically, individuals at risk of close contact infectious diseases are generally children, pregnant women, older people, individuals with underlying chronic medical conditions and individuals with immunosuppressed disorders. For COVID-19, older people and individuals with underlying conditions are at increased risk of severe infection. Māori generally have higher rates of chronic conditions and co-morbidities and following international trends are likely to have an increased risk of infection should a community outbreak occur.

Socioeconomic and co-morbidity factors increase risk for Māori

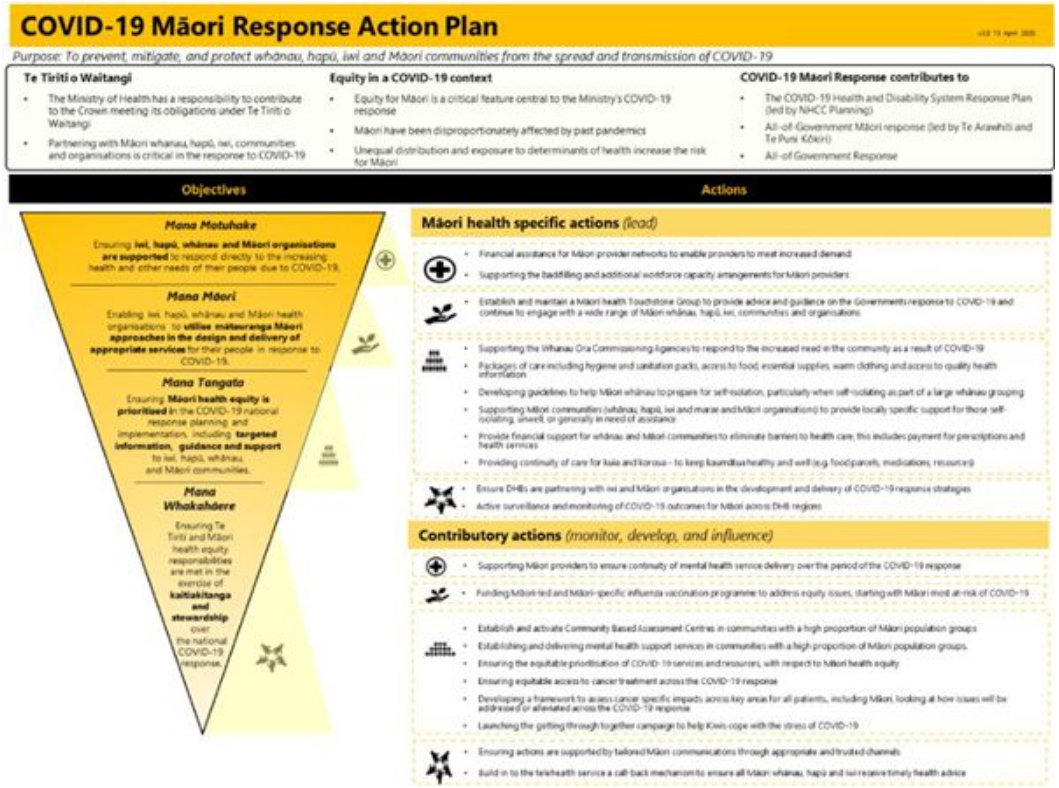
Health differences between ethnic groups are complex. The overarching drivers such as the historical and contemporary manifestations of colonisation, racism and discrimination are reflected in more proximal contributing factors including socioeconomic factors and deprivation, access to and outcomes of healthcare services, and the constellation of risk factors for co-morbidities and adverse health outcomes. An increase in the incidence of close-contact infection is also associated with crowded living conditions and lower socioeconomic status. The incidence of close-contact infectious diseases is higher among individuals who live in the most deprived areas. Māori and Pacific peoples are more likely than other New Zealanders to live in higher deprivation areas, and are also more likely to be living in 'over-crowded' households or in higher-density housing conditions. The psychosocial impacts for Māori arising from public health measures such as self-isolation, physical distancing, and general societal anxiety are likely to exacerbate existing mental health conditions and place increased pressure on the wider whānau units.

Equity for Māori is a critical feature central to the Ministry's pandemic response**.** Measures must be taken in a way that actively protects the health and wellbeing of whānau, hapū, iwi and Māori communities. Critically, this means that *equity* will be at the centre of each level of the alert system. There will be a requirement nationally and within DHBs, as well as across other sectors, to ensure whānau, hapū, iwi and Māori communities have the resources to undertake and respond to public health measures to prevent and manage the spread of the virus.

Draft Māori COVID-19 Response Action Plan

National COVID-19 Māori Response Action Plan

The National COVID-19 Māori Response Action Plan sits under one of twelve Ministry of Health COVID-19 operational work streams. This Plan acknowledges that Māori are a priority population group for the COVID-19 response and that actions specific to supporting whānau, hapū, iwi and Māori communities will sit across all the COVID-19 operational work streams. The Plan consists of actions designed to expand the reach and coverage of COVID-19 activities to better support whānau, hapū, iwi and Māori communities. This also includes support to Māori providers and organisations. Delivery of these actions is led by the Māori health work stream and primarily co-ordinated by the Māori Health Directorate within the Ministry of Health.



Southern Health Services

Differences in living conditions for Māori compared with non-Māori means that Māori are more likely to be exposed to COVID-19 community transmission. Evidence shows that transmission of infectious diseases is greater within areas of social deprivation, including housing standards and crowding. Information to date informs us that the seriousness of illness and risk from dying from COVID-19 increases for those living with long term conditions (King, Cormack, McLeod, Harris and Gurney, April 2020). This plan attempts to co-ordinate activities that aim to reduce the harm from COVID-19 for the Southern health system in collaboration with the Iwi Governance Committee, Pandemic Sub-committee based on the agreed mission statement as developed by Dr Nigel Millar, Chief Medical Officer Southern DHB. This is developed with the understanding that we are guided by the Government's COVID-19 national alert system, the COVID-19 National Hospital Campus and Facilities Management Framework (27 March 2020) and the National Hospital Visitors' Guidance.

Mission

The COVID-19 Southern DHB and WellSouth Primary Health Network has developed this mission which is broken down into six key areas and provides a template for WellSouth and the Southern DHB COVID-19 Māori Response Action Plan:

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

Primary, Intermediate and Hospital

The WellSouth and Southern DHB approved pathway describes the interface between primary, intermediate and hospital streams of flow as we move forward in our planning in managing our COVID-19 response as a whole of southern health system.

Draft Māori COVID-19 Response Action Plan

Each of these streams have agreed green and red pathways based on agreed triggers and are based on the national direction regarding status for the region:

- Level 4 – Eliminate
- Level 3 – Restrict
- Level 2 – Reduce
- Level 1 – Prepare

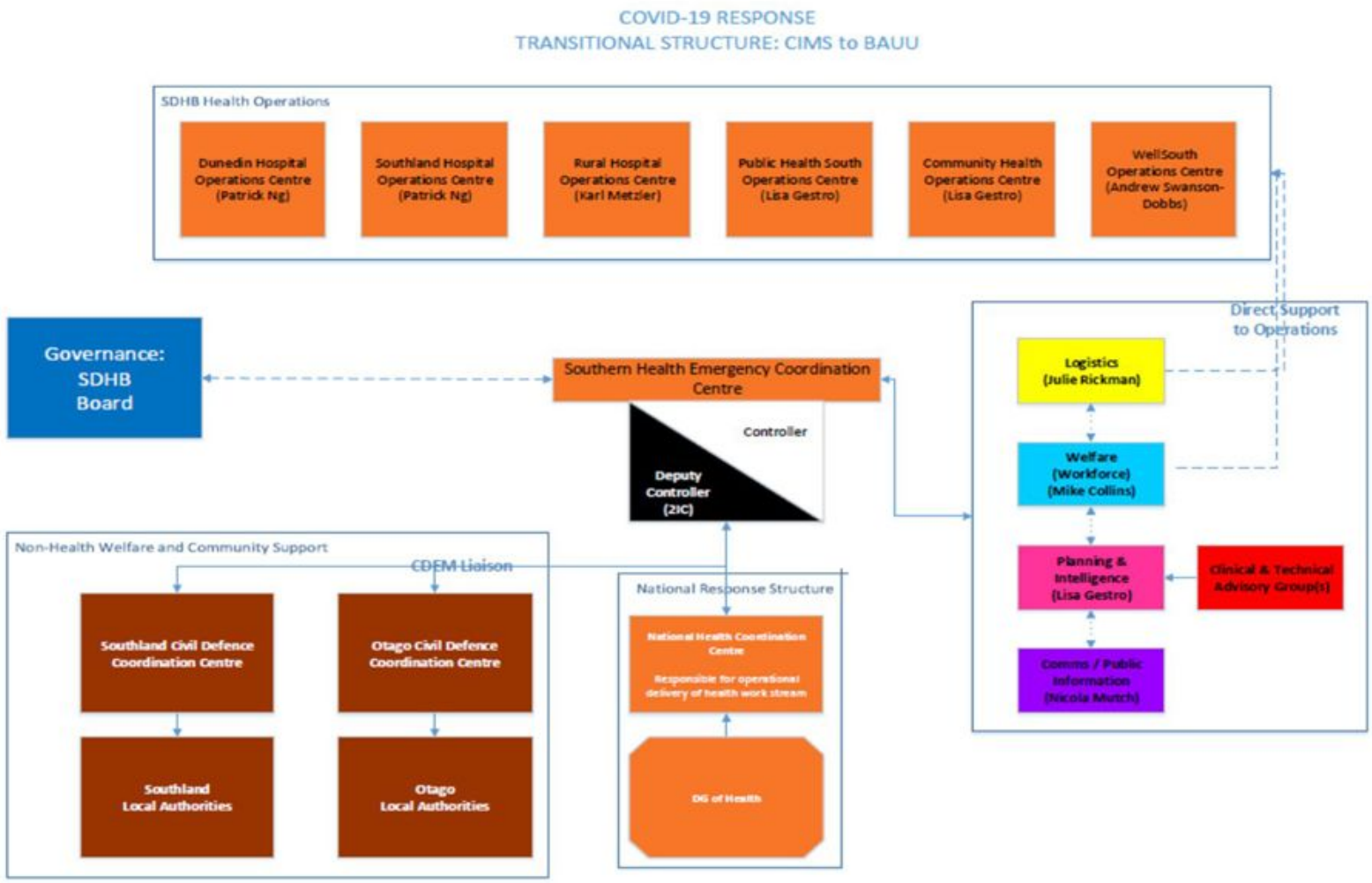
Where possible resources applied to Public Health Action includes:

- Case isolation
- Contact tracing
- Testing plan

Co-ordinate Incident Management System

This diagram provides an overview of the current Southern Health System incident management structure including the six EOCs coving our hopistals, community based services, community and public health and WellSouth primary care. The ECC structure links back to a controller with logistics, welfare, planning and intelligence and communicatiions reporting back to ELT, the Board and the National Response Structure. This Māori Response Action Plan requires approval from ELT inclusive of the WellSouth CEO and will then be socilaised with this structure in collaboration with the Iwi Goverance Committee and the Māori health providers and communities.

Draft Māori COVID-19 Response Action Plan



Draft Māori COVID-19 Response Action Plan

Māori Response Action Plan

Section 1: Minimise the number infected with COVID-19			
This section consists of actions specific to supporting our communities, in our collective efforts to minimise the number infected with COVID-19 in the Southern DHBs.			
Action	**Responsibility**	**Progress**	**Measure/Narrative**
Communications – Collaborate with national targeted COVID-19 Māori communication and media providing targeted information, guidance and support. Support tailored messages across the district to Māori.			
1. Support the communication messaging from Te Rōpū Whakakaupapa Urutā (National Māori Pandemic Group Māori), Te Putahitanga o Te Waipounamu (#Manaaki20), National Telehealth Service, Te Arawhiti (Office Māori Crown Relations), Te Rūnanga o Ngāi Tahu, National Iwi Chairs Forum (Pandemic Response Group), #Protect our Whakapapa and the MoH Māori Expert Advisory Group.	Māori Leadership Team - Communications	●	
2. Southern DHB and WellSouth PHO to develop specific messaging internally and externally i.e: local tangihanga policies, adverting CBACs, infectious control, practical tips and advice.	Māori Leadership Team	●	
3. Provide weekly correspondence updates to Iwi Governance Committee, Māori DHB Board members and the Māori Health Directorate.	Māori Leadership Team	●	

Draft Māori COVID-19 Response Action Plan

<table>
<tr><td>4. Regular correspondence updates to Papatipu Rūnanga, Kaupapa Māori Health Providers and WellSouth General Practices.</td><td>Māori Leadership Team</td><td>●</td><td></td></tr>
<tr><td colspan="2">Designated Practices, CBACs and Outreach Services - Working with Māori Health Providers to support wide COVID-19 testing across the district.</td><td></td><td></td></tr>
<tr><td>5. Look to establish Māori CBAC practices and outreach mobile services through CBACs and/or designated primary care practices in collaboration with kaupapa Māori Health Providers, WellSouth Primary Health Network and the Southern DHB.</td><td>Māori Leadership Team - WellSouth - Māori Health Providers</td><td>●

●</td><td>Covid-19 Māori Mobile Outreach Clinics:
<table>
<tr><th>Date</th><th>Locality</th><th>No. Received Testing</th></tr>
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</table>
Covid-19 Designated Practices:
Quarter 4: April – June 2020
<table>
<tr><th>Locality</th><th>No. Tested</th><th>No. Māori</th><th>No. non-Māori</th></tr>
<tr><td>Te Kaika</td><td></td><td></td><td></td></tr>
<tr><td>He Puna Waiora</td><td></td><td></td><td></td></tr>
</table>
Quarter 1: July - Sept 2020
<table>
<tr><th>Locality</th><th>No. Tested</th><th>No. Māori</th><th>No. non-Māori</th></tr>
<tr><td>Te Kaika</td><td></td><td></td><td></td></tr>
<tr><td>He Puna Waiora</td><td></td><td></td><td></td></tr>
</table>
Quarter 2: Oct - Dec 2020
<table>
<tr><th>Locality</th><th>No. Tested</th><th>No. Māori</th><th>No. non-Māori</th></tr>
<tr><td>Te Kaika</td><td></td><td></td><td></td></tr>
<tr><td>He Puna Waiora</td><td></td><td></td><td></td></tr>
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Quarter 3: Jan - March 2021
<table>
<tr><th>Locality</th><th>No. Tested</th><th>No. Māori</th><th>No. non-Māori</th></tr>
<tr><td>Te Kaika</td><td></td><td></td><td></td></tr>
<tr><td>He Puna Waiora</td><td></td><td></td><td></td></tr>
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Draft Māori COVID-19 Response Action Plan

<table>
<tr><td colspan="2">Hygiene Packs - Reduce community transmission of COVID-19 to vulnerable populations.</td><td></td><td></td></tr>
<tr><td>6. Supporting the Whānau Ora Commissioning Agency Te Putahitanga o Te Waipounamu and the Ministry of Health in the distribution of whānau hygiene packs to at risk communities based on the vulnerable.</td><td>Te Putahitanga o Te Waipounamu</td><td>●</td><td></td></tr>
<tr><td colspan="2">Māori Community Influenza Vaccines - Reduce pressure on our hospital presentations and admissions</td><td></td><td></td></tr>
<tr><td>7. Monitor influenza stocks and distribution.

8. Establish Māori community free vaccination clinics and outreach mobile vaccination services to vulnerable patients available for kaumātua aged 65 and older, pregnant women, and other people with serious health conditions like severe asthma, diabetes, heart, lung and kidney problems or cancer. Young children with a history of severe respiratory illness are also eligible for free vaccination.</td><td>Ministry of Health Māori Leadership Team - Population Health</td><td>●

●</td><td>Māori Influenza Vaccination Outreach Clinics:<table><tr><th>Dates</th><th>Locality</th><th>No. Vaccinated</th><th>Age Ranges</th></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td colspan="2">Māori District 0800 Number - Increase advice and support for whānau on COVID-19</td><td></td><td></td></tr>
<tr><td>9. Scope the range of helpline call centres across the district and their ability to activate and/or co-ordinate support for Māori and their whānau.</td><td>Māori Leadership Team</td><td></td><td></td></tr>
</table>

Draft Māori COVID-19 Response Action Plan

10. Explore options for establishing a district wide 0800 number that provides support and advice in collaboration with the Ministry of Social Welfare. 11. Development, Te Putahitanga o Te Waipounamu, WellSouth Primary Health Network, Southern DHB contracted Kaupapa Māori Health and Social Service Providers and the Southern Health Services. Co-ordination of services and distribution of welfare support.			
Data Integrity – establish and maintain data measures that provide COVID-19 intelligence for the purposes of planning and highlighting equity gaps.			
12. Identify a series of data sets that provide measures that monitor the impact of COVID-19 on Māori. 13. Work with the University of Otago to analyse this data and where possible include cross governmental data and systems to measure the impact of COVID-19 on Māori.	Māori Leadership Team	●	

Draft Māori COVID-19 Response Action Plan

Section 2: Limit the harm to people with COVID-19			
This section consists of actions specific to minimising the harm to people with COVID-19			
Action	**Responsibility**	**Progress**	**Measure/Narrative**
Hospital Visiting Policies – Reduce exposure to COVID-19 for those visiting our Hospitals, including Rural Hospitals.			
14. Develop consistent messaging to Māori presenting or visiting our hospitals based on the national hospital visiting guidance produced by the Ministry of Health.	Māori Leadership Team, Communications	●	
15. Maintain dedicated Kaiawhina FTE resource in Southland and Dunedin Hospitals that support whānau, Duty Charge Nurse Managers and Security. 16. Support to include direct interaction with whānau and providing different strategies in interacting with whānau impacted by this policy for DHB staff. 17. Signage developed to be culturally responsive with use of Te Reo Māori.	Kaiawhina and Māori Leadership Team	● ● ●	Fulltime Kaiawhina are working in Dunedin Public Hospital and Southland Hospital. - Kaiawhina Dunedin – on-site Kaiawhina moving through green zones supporting Māori admissions. Daily digital karakia occurs. - Kaiawhina Invercargill – on-call Kaiawhina located at Southland Hospital moving through green zones supporting Māori admissions. Daily digital karakia occurs. *Ongoing review occurs*

Draft Māori COVID-19 Response Action Plan

Tangihanga - Working with Māori whānau to understand the impact on this policy			
18. Co-ordinate messaging internal and external on the national tangihanga guidance, providing practical support to our hospitals and community on change of tikaka protocols.	Māori Leadership Team	●	
Māori Communications – Supporting Māori communication and media providing targeted information, guidance and support that limits the harm from COVID-19.			
19. Alongside Section 1.1 targeted communication, information and advice on strategies that reduce the harm from COVID-19.	Māori Leadership Team and Population Health	●	
Hospital Alert Level Systems – Design detailed COVID-19 level alert systems for Māori response.			
20. Development of an alert level system based on the national hospital alert specific to a Māori Action Plan.	Māori Leadership Team	●	
ICU Triage Tool – Support an equity lens for the national ICU triage tool			
21. Development of equity criteria for the National ICU triage tool with support from Te Tumu Whakarae.	Māori Leadership Team	●	

Draft Māori COVID-19 Response Action Plan

Māori Cancer Patient Pathway – Māori cancer patient support and communication.			
22. Support communications to Māori cancer treatment patients impacted by COVID-19 per guidance provided by Te Rōpū Whakakaupapa Urutā (National Māori Pandemic Group Māori): https://www.uruta.maori.nz/cancerpatients	Māori Leadership Team	●	
Population Health and Public Health – Provide active support for preventative and protection strategies that reduces the burden of COVID-19 on Māori.			
23. Support strategies that promote prevention and protective initiatives that reduce the burden of COVID-19 on Māori. This will include support for contact tracing, vaccinations and other strategies that are evidenced to reduce the harm to Māori.	Māori Leadership Team	●	

Draft Māori COVID-19 Response Action Plan

Section 3: Maintain an effective acute and urgent care health system			
This section consists of actions specific to maintaining acute and urgent heath care systems in response to COVID-19.			
Action	**Responsibility**	**Progress**	**Measure/Narrative**
Co-ordination of Mortuary Services - Working with partners to develop a pathway for mortuary services in collaboration with the Police, Funeral Directors, WellSouth and CDEM.			
24. Co-ordinate regional mortuary services planning and response. Promote national tangihanga and MoH guidance on funerals to the community.	Māori Leadership Team		
Tangihanga Tikanga Support – Tikanga support for temporary mortuaries if required.			
25. Provide co-ordinated Māori tikanga support teams for locations with temporary mortuaries if established. The aim of this service would include small Māori teams that would support the transportation of Māori who have died from COVID-19 that ensures tikanga and kawa for Māori deceased are in place.	Māori Leadership Team		
Transport COVID-19 Māori Patients – Transportation options for positive or suspected COVID-19 patients.			
26. Establish district wide protocols on the transportation of positive and suspected COVID-19 patients by Māori Health Providers and/or Civil Defence Emergency Management (CDEM) services.	Māori Leadership Team – CDEM	●	

Draft Māori COVID-19 Response Action Plan

27. Ensure Māori Health Providers have appropriate safe guards and a policy in place for transportation of positive or suspected COVID-19 patients.		●	
Community Access to PPE – Monitor Māori community PPE needs and support.			
28. Monitor PPE requests and distribution to Māori community services where required. 29. Complete stocktake on Māori Health Providers use of PPE, review their policies and procedures.	Māori Leadership Team	● ●	

Draft Māori COVID-19 Response Action Plan

Section 4: Look after our health community			
This section consists of actions specific to looking after our health workforce both external and/or internal. This is inclusive of NGO Kaupapa Māori Health Providers, DHB and WellSouth Primary Health Network employees, volunteers and kaumātua.			
Action	**Responsibility**	**Progress**	**Measure/Narrative**
Kaupapa Māori Health Provider Relationships – Maintain relationships with Māori Health Providers that supports community need, intelligence, planning, collective action and innovation.			
30. Maintain weekly contact with contracted Māori Health Providers that enables opportunities for identifying Māori community need, intelligence and opportunities for innovation or collective action.	Māori Leadership Team, Communications	●	
31. Maintain weekly contact with Te Putahitanga o Te Waipounamu and Te Rūnanga o Ngāi Tahu on developments or opportunities to collaborate based on discussions with our funded DHB Māori Health Providers.	Māori Leadership Team,		
Māori Health Directorate Staff - For Southern DHB employees.			
32. All DHB Māori Health Directorate staff will receive weekly contact either by their direct line manager or by their directorate leads as a means of providing support professionally or personally. Direct contact with the Chief and/or Associate Secondary/Tertiary Officers.	Māori Leadership Team	●	Staff receives weekly contact by the Associate Māori Health Secondary/Tertiary. Discussions include workplace environment, psychological support, challenges of Covid-19. *Ongoing review will continue.*

Draft Māori COVID-19 Response Action Plan

<table>
<tr><td>33. Complete skills matrix for our Māori Health Directorate staff and look to redeployment options if and when required. Registered Nurses with appropriate skills and qualifications are redeployed to CBACs or other services based on negotiation with the Associate Secondary/Tertiary Officer.</td><td>Māori Leadership Team</td><td>●</td><td>Southern DHB skills matrix completed with Māori Health Directorate staff redeployed across primary/community and secondary care. Staff redeployed to CBAC Clinics; 0800 Call Centre; Kaiawhina in Dunedin and Southland Hospitals; Community Liaison roles within Rūnaka.

Ongoing review will continue.</td></tr>
<tr><td>34. Southern DHB to support approved overtime coded to COVID-19 for essential Kaimahi.</td><td>Māori Health Directorate</td><td>●</td><td>All redeployed staff working overtime is coded to Covid-19.</td></tr>
<tr><td>35. Any Māori staff that fit the criteria as ‘vulnerable staff’ to complete the staff survey and submit to their direct line manager for consideration, redeployment and/or work from home options.</td><td>Māori Health Directorate</td><td>●</td><td>Staff who identify as “vulnerable” are aware to complete staff survey. Weekly discussion occurs with all staff.

Ongoing review will continue.</td></tr>
<tr><td colspan="2">ASK HR - For DHBs</td><td></td><td></td></tr>
<tr><td>36. Communicate to the Māori Health Directorate the availability of the ASK HR email address designed to give timely accurate clarification to staff requiring HR advice or support.</td><td>Māori Leadership Team - DHB HR</td><td>●</td><td>All staff have received an email and weekly discussions from the Associate MH Secondary/Tertiary Officer on access and use of HR advice and support. Staff aware of Psychological Support through Southern DHB and 1737.
Ongoing review will continue.</td></tr>
<tr><td colspan="2">Front Line Māori Health Workers Influenza Vaccines - To reduce the burden of influenza on our front line workforce we have prioritised this year’s vaccines for Māori staff</td><td></td><td></td></tr>
<tr><td>37. Prioritise free influenza vaccinations to all Māori staff working in either Southern DHB, WellSouth Primary Health Network and/or kaupapa Māori Health Providers.</td><td>Māori Leadership Team - Population Health</td><td>●</td><td>Covid-19 Front Line Māori Health Workers – Influenza Vaccination
<table>
<tr><th>Date</th><th>Locality</th><th>No. Vaccinated</th></tr>
<tr><td></td><td>Southern DHB</td><td></td></tr>
<tr><td></td><td>WellSouth PHN</td><td></td></tr>
<tr><td></td><td>Māori Health Providers</td><td></td></tr>
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Draft Māori COVID-19 Response Action Plan

Section 5: Supporting planning and provision of wider community support			
This section consists of actions that maintain planning for the provision of community support in managing our response to COVID-19 both nationally and across our southern district.			
Action	**Responsibility**	**Progress**	**Measure/Narrative**
Te Herenga Hauora o te Waka a Maui – Maintain relationships with the South Island Regional Māori DHD GMs in supporting regional activities and the possibility of joined up funding initiatives.			
38. Maintain regular contact with Te Herenga Hauora o te Waka a Maui. Supporting regional funding allocations and shared innovation in reducing the harm from COVID-19.	Māori Leadership Team,	●	
Te Tumu Whakarae – Maintain relationships with the National Māori DHB GMs in supporting SitRep Reports to MoH, COVID-19 best practice and innovation. Direct advocacy mechanism to MoH and allocation.			
39. Participate in national SitReps from a Māori DHB perspective, provide insights and intelligence to MoH and advocate for service responsiveness and community need.	Māori Leadership Team	●	
Te Putahitanga o Te Waipounamu – Maintain relationships with the Southern Whānau Ora Commissioning Agency.			
40. Collaborate with the Southern Whānau Ora Commissioning Agency funded by central Government to respond to localised whānau need	Māori Leadership Team	●	

Draft Māori COVID-19 Response Action Plan

for COVID-19. Support joined up activity and service co-ordination.			
Southern DHB Planning and Intelligence – Participate in planning and intelligence forums across the DHB and WellSouth including ELT and SMT meetings.			
41. Participate in major decision making forums and networks that contribute to planned decision-making across the southern health system.	Māori Leadership Team	●	
Iwi Governance Pandemic Sub-committee – Participate in planning and intelligence.			
42. Continue to meet weekly with the IGC pandemic sub-committee that provides intelligence, support and advice to the Māori Leadership Team, WellSouth and the Southern DHB.	Māori Leadership Team	●	

Section 6: Maintain a viable health system for the long term			
This section consists of actions that look to maintain a viable health system as we move into recovery and plan for the longer term future and the possibility of continuing to live with COVID-19.			
Action	**Responsibility**	**Progress**	**Measure/Narrative**
Integrated Psychosocial Recovery – Build relationships across sectors that support psychosocial.			
43. Help build an interagency psychosocial recovery plan and model as we move into recovery. Work with the community in partnership with key Government agencies to support integrated community care and recovery as a district.	All of Government collaboration		
Mental Health and Addiction – Provide opportunities to meet the holistic needs of service users, tangata whaiora and their whānau as we counter the impact of COVID-19 on our wellbeing.			
44. Provide opportunities to support service users, tangata whaiora and their whānau with tools and supports to aid recovery that promotes wellbeing and integrated Māori models of wellness.	Māori Leadership Team		
Future Pandemic Planning – Learn from our COVID-19 experiences and plan for the future.			
45. Learn from the COVID-19 experience and intelligence by both formal and informal evaluation	Māori Leadership Team		

Draft Māori COVID-19 Response Action Plan

that provides insights, tools and resources for future pandemic planning. 46. Translate these lessons into practice by providing education and training, developing an online portal for future planning with tools and resources suitable for application into the future.			
Māori health – Maintain an appropriate level of health intervention for Māori patients and their whānau.			
47. Maintain essential health services that supports the reduction of Māori illness and disease. Continue to advocate for essential health services that provides preventative and timely responses to systemic health disease and sickness for Māori. Enhance opportunities for health literacy and personal responsibility.	All of systems response.		

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CHIEF EXECUTIVE OFFICER'S REPORT**
Report to:	Board
Date of Meeting:	3 June 2020

Summary:

Considered in this paper are:

- General information and emerging issues

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

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

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

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

RECOMMENDATIONS:

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

9

CHIEF EXECUTIVE OFFICER'S REPORT

1. PURPOSE

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

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

2. ORGANISATIONAL PERFORMANCE

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

- Finance report
- High Level Volumes
- Performance Dashboard.

Financial performance for the month of April is unfavourable to plan by $707k increasing the year to date unfavourable result to $6.125 million adverse to plan. The result is somewhat distorted by two unknowns:

- The impact of the under performance on planned care as a consequence of reducing activity to respond to COVID-19. On a year to date (YTD) basis we are now 1,187 caseweights behind plan. We are still awaiting clarification as to what we should assume about revenue (given a significant proportion of costs are fixed), so we have assumed that the Ministry of Health (MoH) will wash up the under performance, but replace it with a new funding line to recognise our costs are largely fixed. There is a risk of $5.9 million if the Ministry does not recognise this revenue.
- Additional costs attributable to the COVID-19 response to the end of April net at $4 million. These costs are predominately:
  - Annual leave not taken $1.4 million
  - Special leave due to staff not able to work (70 years and over and/or immuno compromised) $1.3 million
  - Casual workers payment as per State Service Commission position $258k
  - Southern DHB response, additional staff, higher cost of supplies, additional cleaning etc $1.1 million

Presently, apart from the adjustment for electives, we have not assumed any additional revenue. The Ministry will be looking for variable cost savings attributable to the clinical activity we did not carry out. From a clinical supplies and outsourced clinical services perspective, the savings are reflected in the results, however they are showing up as lower overspending. Clinical supplies to the end of February have averaged an overspend of $765k per month. For the months of March and April clinical supplies have been favourable by $852k for the two months, which is $2.4 million favourable compared to the counter factual assuming Febuary YTD was a good yard stick. Outsourced clinical services has previously been overspent at the

rate of $180k per month on average YTD to February while it has been favourable to budget across March and April by $496k. Outsourced clinical supplies are more difficult to determine the counter factual as they were very overspent for the first part of the year and we have taken deliberate steps to manage these back towards budget.

The other major impact for the April results has been the booking of an increased Holidays Act provision of $1.2 million. Based on the information we have to date, this will be a similar result for May and June to align year end provisions to the extent we have available information. This $3.5 million ($1.2 million per month for three months) was not included in the budget and explicitly noted to be excluded in our annual plan.

Forecast for year end is difficult to determine largely due to some uncertainties:

- Ongoing potential impact of COVID-19 – this is reducing but will have an ongoing impact as practices are changed, and the loss of non-resident income.
- The stance the MoH will take regarding replacing planned care revenue lost – we are assuming they will wash up the under delivered planned care volumes, and replace this funding stream with a specific COVID-19 appropriation. That will allow the MoH to then return the planned care revenue when we catch the volumes up.
- The stance the MoH will take with regards to the costs incurred in recovery, particularly outsourced surgery – we are assuming that this should be covered through recovering the revenue washed up during COVID-19, but there is a risk the MoH may attempt to offset this with the bullet point above.
- Timing for the accelerated depreciation for the write off of the existing Dunedin Hospital – we are assuming that given the Detailed Business Case (DBC) will not be approved until post the end of the financial year accelerated depreciation will commence in 2020/21, however there is a risk that Audit New Zealand may expect this to commence in the current year.
- Holidays Act accrual – by the time audit is concluding we are likely to be at the end of the first stage in the Holidays Act remediation work. This will allow us to materially evaluate our provisions for adequacy.
- Actuarial calculations – with the continued reduction in interest rates there is a risk that the actuarial calculations which are being reworked on the leave liabilities at the end of April may increase. We should have provisional information by the time we get to May month end.

At this stage we are assuming our forecast will remain as per previously advised with the exception of the addition of $3.6 million provision for the Holidays Act. This moves the forecast to $49.413 million which is $10.9 million adverse to plan (1% of revenue).

From a volumes perspective, activity is well down. Emergency Department (ED) activity is down 43.6% on the same month last year, with Dunedin down 40.1%, Lakes 64.0% and Southland 42.0%. Medical caseweights are down 33.4% on the same month last year, surgical caseweights are down 52.2% (acute down 42.0% and electives down 63.4%). Maternity was also down 12.3%. Mental Health bed days were down 20.2%.

While much of this was to be expected, it is intriguing that acute activity reduced dramatically and we need to monitor for workload pressure if the activity returns with a vengeance. The extent of the acute surgery reduction is interesting, we expected reductions as people were in lockdown and as such having less trauma

events, however it also is likely to reflect the arbitrariness of the delineation between acute and elective activity.

A concerning point, however, is that despite a 43.6% reduction in ED attendances across the district we still only achieved a 87% performance against the ED 6 Hour target. This is disappointing as the EDs were all well staffed and the hospitals had plenty of bed capacity, it therefore reinforces that there is a culture of accepting long unnecessary delays. I have reinforced an expectation that the Clinical Council focus on ensuring that we address this blockage. It has been on their work programme for many months now.

On a performance dashboard perspective as to be expected there has been a dramatic reduction in referrals received during the COVID-19 lockdown.

3. FUNDING FOR 2020/21

The funding envelope for 2020/21 was received from the Ministry of Health on Friday 22 May. The increase is significantly higher than anticipated in the earlier draft budget submitted pre COVID-19, however until there is clear guidance as to expectations understanding the implications of the funding envelope is very difficult.

There is a paragraph which states:

> "Now, more than ever, with increasing financial constraints in New Zealand, we must recognise the significance of this investment, and match it with high levels of responsibility and commitment to improved access, equity and outcomes. To that end, it is important that this additional funding has a corresponding impact on our overall sector financial position, and we must achieve meaningful gains in our health service performance in 2020/21.
>
> We expect to work with DHBs to ensure this expectation is reflected in your Annual Plans for the year, with all DHBs delivering a break-even, or for a small number of DHBs, a significantly reduced deficit plan."

While funding has increased by $79 million for 2020/21, our plan had already anticipated a $43 million funding increase. It is clear that the underlying cost pressure funding amount of $18.5 million will be expected to reduce off the deficit, and the challenge is working through the rest of the funding envelope and to align our Annual Plan in terms of investments and change required. This remains a work in progress.

4. ANNUAL PLAN 2020/21

The draft 2021 Annual Plan and Budget was submitted to the Ministry of Health on 6 March 2020. Initially, further work continued in March 2020 until the Government announced Alert Level 4, at which time work was paused as the focus across the organisation was on preparations for COVID-19 activity.

At that time, the Ministry of Health advised that they were adjusting the 2020/21 annual planning processes and timelines in consideration of COVID-19. During the Alert Level 4 lock down, Central Government Agencies have been exploring a range of options, including potentially modifying legislative requirements to assist entities to manage legislative planning and reporting requirements and they expect to be in a position to provide updates later in April. In the absence of definitive advice, the Ministry have provided DHBs with the following revised planning timeframes:

1. Feedback on first draft plans and advice on updated planning guidance that includes any new guidance/COVID-19 impacts to be issued mid-May.
2. No revised sections/full drafts of 2020/21 annual plans or regional services plans or second draft financial templates will be expected at this stage until at least mid-June. Dates will be confirmed dependant on any legislative modifications that may occur.
3. The Ministry's financial monitoring team will continue to stay in contact during April regarding the financial templates provided to date.

The below timeline for review of the 2021/21 plans received on 14 April 2020 confirmed the advice above.

Timeline for Review of the 2020/21 Plans		
Activity	**Date: 2020**	**Revised Timeline**
DHB strategic conversations	From February	From February
DHBs submit draft Annual Plans, Statement of Performance Expectations (SPE), financial templates, Regional Service Plans to the Ministry.	*2 March*	*2 March*
Feedback to DHBs on first draft Plans and release of guidance for any additional confirmed Government priorities	9 April	Mid-May
No revised sections/full drafts of 2020/21 annual plans or regional services plans or second draft financial templates will be expected at this stage until at least mid-June. Dates will be confirmed dependant on any legislative modifications that may occur.		Mid-June
Final Plans due to the Ministry	*TBC*	*TBC*
DHB Board signed SPE to be published on DHB websites	Before end of June	TBC
Ministry approval of SLM plan	31 July	31 July
Any outstanding 2020/21 SPEs tabled with 2019/20 Annual Reports	December	TBC

Assumptions

- No legislative changes (we still need to publish SPE by end of June)
- The second draft of the DAP does not need to go to an actual Board meeting, but the SPE does.

Therefore, in the absence of formal guidance, we are arbitrarily working towards 19 June, because we need to give our teams a date to work to. To achieve this, we need:

- All final Executive Leadereship Team (ELT) approved content by 12 June.
- A final draft for ELT on 4 June.
- Content from services/ELT received by 28 May (to allow for compilation to ELT).

The below broadly outlines the components of the DAP, who is the accountable ELT member and accompanying notes.

Accountable Owners for DAP Sections			
Section Name	**Accountable Owner(s)**	**Content**	**Notes**
Overview of Strategic Priorities	Lisa Gestro	Input required from multiple ELT members (Nicola, Gilbert, Lisa)	Full rewrite required
Delivering on Priorities	Relevant ELT member of Service completing the template	All templates allocated to individual services	1. Teams need to review everything that has been submitted to SPC. 2. Expectation that MOH will update some guidance 3. Teams need to react to updated guidance
Service Configuration	Lisa Gestro		Needs Reviewed to reflect COVID related change
Stewardship	Lisa Gestro	Input required from multiple ELT members (Mike and Julie)	Needs Reviewed to reflect COVID related change
Performance Measures	Lisa Gestro	Note, this is only the MOH non-financial reporting framework	Waiting on any MOH change
Statement of Performance Expectations	Lisa Gestro & Julie Rickman	Includes Output Class measures and Financial tables, Financial notes	1. No significant change to Output Class measures is on the horizon (to maintain continuity across years). 2. Budget content can be "dumped in" at last minute, but needs to align to financial templates submitted by Finance team"

Next Steps

The focus for the next 2-3 weeks is on finalisation of our recovery plans, initially focussing on acute/specialist services and planned care, and then extending into public health, population health and primary care. It is imperative that the individual plans are coordinated to deliver a cohesive healthcare system response. These recovery plans will then be reviewed against previously developed service plans, and used to inform specific investment decisions. Collectively, these will form an adjunct to the final District Annual Plan (DAP) 2020/21 and this process, as well as the joining together of key messages will be managed by ELT.

1. District annual planning was originally prepared on the basis that 100% of resources could be applied to delivery of services. However, for 2020/21 and perhaps beyond, the impact of COVID-19 reduces capacity by an estimated 20%. Although the Ministry has not (yet) provided the revised guidance on the DAP, it will be necessary to review the draft DAP 2020/21 based on our learnings to date of the impact of COVID-19 and our recovery planning.

2. The development of expenditure management plans that support the models of care to take us into the future are a key component of the revised annual planning and budget.
3. The proposed approach above, together with the recent guidance from the MOH on planned care, will guide changes to Southern DAP 2020/21 where the current draft does not meet the Southern population's health needs and priorities.
4. The Statement of Performance Expectations (SPE) to be prepared and published on the Southern DHB website by 30 June 2020 in accordance with existing legislation.
5. The Southern DAP 2020/21 to be revised for submission to the Board by mid-June 2020. Given the Board meeting is scheduled for the first week in June 2020, there is likely to be a need to circulate the Southern DAP 2020/21 for feedback from the Board after the scheduled Board meeting.

5. SERVICE PLANNING 2020/21 AND 2021/22

Development of service plans for 2020/21 has been delayed due to COVID-19. Services will be contacted during May 2020 to assist with recommencing service planning for 2020/21. It is expected that learnings and changes to models of care made as a result of responding to COVID-19 are reflected in the service plans, and that the service plans are consistent and supportive of each other. The response to COVID-19 over the past few weeks has demonstrated that Southern DHB can respond as a system; service planning is an excellent framework to support on-going relationships across services and providers.

6. COVID-19

The focus for the majority of our services continues to be on either the management of representation, or recovery from COVID-19. As of Wednesday 20 May Southern DHB now has no active Covid-19 cases within the district. In total, the Southern district had 216 cases of COVID-19. This comprised of 186 laboratory confirmed cases and 30 probable cases. The number of people who have recovered is 207 and 2 people have died. No new cases have occurred in the district since 17 April.

Number of Cases by TA

TerritorialAuthority	Confirmed	Probable	Total	Recovered	Dead
Central Otago District	13	6	19	19	
Clutha District	5	0	5	5	
Dunedin City	46	4	50	50	
Gore District	2	0	2	2	
Invercargill City	40	2	42	40	2
Queenstown-Lakes District	70	17	87	87	
Southland District	10	1	11	11	
Waitaki District	0	0	0	0	
Total	**186**	**30**	**216**	**214**	**2**

Number of Cases by Ethnicity

Ethnicity	Confirmed	Probable	Total	Recovered	Dead
Asian	5	0	5	5	
European	160	30	190	188	2
Maori	12	0	12	12	
Other	6	0	6	6	
Pacific Peoples	2	0	2	2	
Unknown	1	0	1	1	
Total	**186**	**30**	**216**	**214**	**2**

Number of Cases by Age Band

AgeBand	Confirmed	Probable	Total	Recovered	Dead
<1	0	2	2	2	
1 to 4	0	1	1	1	
5 to 14	4	3	7	7	
15 to 24	38	8	46	46	
25 to 44	62	5	67	67	
45 to 64	70	11	81	80	1
65+	12	0	12	11	1
Unknown	0	0	0	0	
Total	**186**	**30**	**216**	**214**	**2**

Public Health

Staff from other services who were assisting with the COVID-19 response have mostly returned to their substantive duties. Public Health, who have led the response have been able to return staff back to working Monday to Friday with some additional on call capacity over the weekend should any further cases occur. We would like to acknowledge that the success of our COVID-19 response could not have been achieved without the support from other services making staff available. This is especially true of the Public Health nursing staff and moving forward we need to look how we can continue to use the skills of the staff who assisted when case numbers increase again.

A survey was sent to everyone involved in all aspects of our public health response to get feedback to support system improvements. We had a very good response with 99 of 145 people responding. On the whole the feedback was very positive about what had been achieved. People acknowledged that the situation was challenging and many were working outside their normal roles which was stressful. Many comments acknowledged that systems were put in place quickly and changed frequently. Areas for improvements included more in-depth training, improving communications, and improving our systems and processes. This feedback is being used to inform improvements to the processes that are now occurring. These include amending our current procedures for case management and contact tracing, and finalising frequently asked questions.

We are working with the Ministry of Health to utilise a national contact tracing solution as a means of managing case and contact information for any future cases. This system was used briefly during the peak of our cases but it had limitations as it was very early in development and did not meet our needs at that point. Further improvements to the functionality are being made to address our needs. We have identified two super-users who are being trained in using the system and are participating in user testing to inform the next upgrade that will introduce the functionality of the daily follow up of cases and contacts. Further training will occur with wider staff who will be using the system once this upgrade goes live. The benefits of this system are that all the information about contacts and cases are in one place, it is web based and provides a dashboard so that we can see at a glance what has occurred for our cases in Southern. If we choose to refer contacts to the national service to follow up, we retain complete visibility over what actions have been completed and when. We believe this will provide a number of efficiencies for any cases in the future.

Southern was selected as one of three Public Health units to have their contact tracing system audited. We were selected as we have a large geographic area with rural populations and we had also managed clusters of cases. The audit investigated how we undertook contact tracing, what worked well, and what the challenges and barriers were. It included reviewing our data, and understanding how we have allocated the additional funding allocated to Southern for the public health COVID-19 response. A draft report has been produced, but we have not yet been provided with the final report.

One of the challenges moving forward is to develop escalation and de-escalation plans to rapidly scale up and down our response capacity as required. We are currently developing a capacity model and capacity forecasting algorithm that can be applied. This is currently being developed with input from staff and will inform planning for our resourcing requirements when further cases occur.

To inform the government cabinet decision making for moving from Alert Level 4 to 3 and from Alert Level 3 to 2, testing of asymptomatic people in our district occurred. The first involved over 300 people (staff and shoppers) at the Pak'n'Save supermarket in Queenstown. More recently a programme of sampling has occurred

for health care workers in services where COVID-19 cases had been, Community Based Assessment Centre (CBAC) workers, General Practices designated to do swabbing, two alliance freezing works, four Marae, Pacific people, and people staying in backpackers accommodation in Queenstown. We expect around 1,800 swabs of asymptomatic people to have been taken across our district. All results received as of 7 May are negative.

A second project has emerged and is currently being developed from this around temporary accommodation, like backpackers. This is currently being developed and will look at the preparedness of accommodation providers with communal facilities for preventing / managing an outbreak of disease and aim to improve capacity and capability of these settings to protect residents in a pandemic situation.

Public Health have been working with the Community Directorate to inform guidance for aged residential care (ARC) facilities and there is an ongoing piece of work to support the prevention and control of COVID-19 outbreaks and being extended to influenza-like illness outbreaks in ARC facilities.

As the alert levels reduce and with the work associated with our cases decreasing, the service is now considering what our business as usual needs to look like. The Ministry of Health continues to advise that responding to COVID-19 and disease outbreaks remains our top priority. However, issues are emerging in Southern communities as a result of the lockdown and closure of the borders. Staff are currently reviewing work with a COVID-19 lens to identify what is still current and needs to continue, what should be paused, and what new priorities are emerging.

Primary Care and Community Services

Both the Primary care and Community Services Emergency Operations Centres (EOCs) have ceased to formally operate, although significant work continues across both parts of the business to ensure we are not caught short if COVID-19 was to reappear in our district. For primary care, the focus is to work closely with general practice around operating a different model of care. Moving forward it is expected that up to 50% of all primary care consultations will be delivered virtually. The uptake of this type of clinical consultation has been widely acknowledged as the future of primary care in Southern DHB.

Close to $70 million has been distributed to District Health Boards, Primary Health Organisations, general practices and pharmacies to support the primary care COVID-19 response, with $15m distributed directly to support general practice on 31 March 2020 and $7.8m distributed to general practices on a per COVID-19 test basis. This is an initial payment intended to contribute to primary care's response (including virtual consultations) to minimise community spread.

CBACs continue to operate in Dunedin and Invercargill, with the Queenstown CBAC closed in the first week of May given the significantly reduced demand. General Practice in all areas continue providing COVID-19 responses across the district in the form of designated practices. WellSouth Primary Health Network has worked tirelessly to ensure that the CBACs and Designated Practices have been well supported, and they have also been working actively with General Practice to understand the significant changes in the way in which primary care is operating. There has been a significant shift in practice through the uptake of telephone/video consultations as opposed to face to face. The challenge is how to make some of these changes sustainable over the longer term.

Latest data from CBAC and General Practice COVID-19 activity:

Level of activity at CBAC and GP

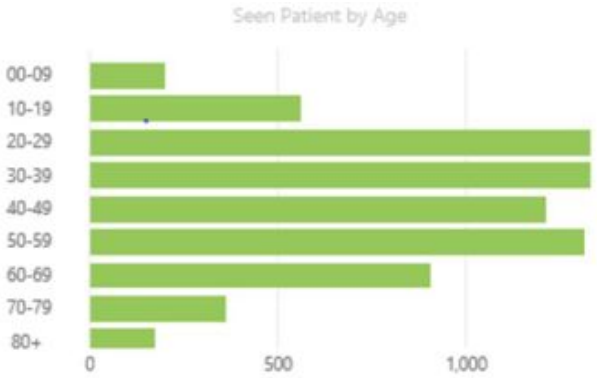
Facility Type	Seen	% Swabs Taken	% Symptomatic	% Fit Clinical Measure
General Practice	6,336	86.1%	91.7%	88.3%
Community Based Assessment Clinic	5,386	98.6%	75.0%	74.8%
Total	**11,722**	**91.9%**	**84.0%**	**82.1%**

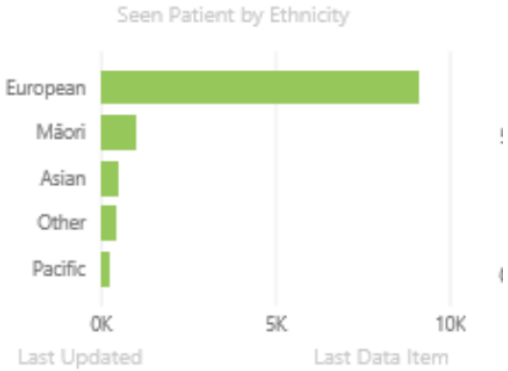
COVID-19 Activity by Territorial Local Authority (TLA)

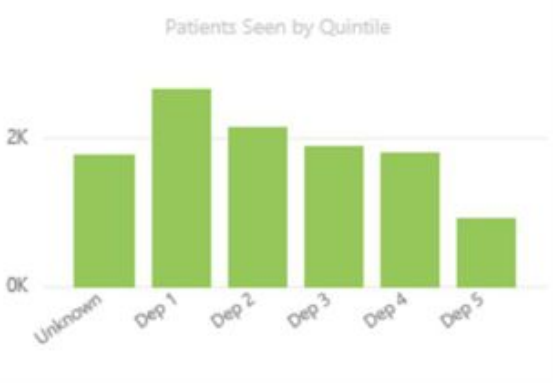
Facility Location TLA

Territorial Authority	Seen	Swab Rate Per 1000
Dunedin City	4,229	33.7
Queenstown-Lakes District	2,503	57.4
Invercargill City	2,488	38.1
Central Otago District	710	28.9
Waitaki District	609	22.4
Southland District	391	18.8
Gore District	390	20.3
Clutha District	380	23.2
Total	**11,722**	**92.7**

The demographic distribution of COVID-19 testing can been seen in the graphs below:







Rural Hospitals

The rural hospitals have worked closely together during the month of April, contributing to the Rural Emergency Operations Centre. There have been no further COVID-19 positive patients admitted to any of the Rural Hospitals (one was admitted to Dunstan Hospital in March prior to transfer to Dunedin Hospital). Gore has had a positive patient present to the ED, where they were treated and discharged. No staff exposure occurred at that time. Some of the rural hospitals have felt the impact of 'vulnerable staff' having to stand down during Alert Level 4, which has created some staffing challenges.

For our rural hospitals, April was a challenging month with the Level 4 lockdown and the constant threat of COVID-19 presenting to any one of the rural hospitals. Lakes District Hospital in particular, during April was still preparing for an onslaught of COVID-19 positive patients needing hospital treatment. A second positive patient was admitted in early April. The patient was in hospital for six days, and then followed up by Public Health. Since then we have had no positive patients admitted to any of the rural hospitals. There have been 36 patients swabbed in April, who all presented with symptoms of COVID-19. Fortunately, all were negative.

The lockdown has severely impacted on the number of presentations to the ED at Lakes District Hospital and to the number of inpatients during the month. People were staying home and staying safe, so there were fewer accidents and fewer alcohol related presentations. Unfortunately, there is now an increasing number of people presenting with mental health issues. We are focussing training for staff on these areas, and also building the connections between the hospital, Mental Health services and primary care.

Maternity services in Queenstown were also impacted, and the primary unit spent the month of April working out of the Dental Health building across the road from the hospital. There have been six births during their time there. The decision to relocate services was made to ensure expectant mothers and their new-borns were not potentially exposed to COVID-19. This seemed to be a significant risk at the time. The main issue that was challenging for women was the lack of an internal shower. However, the proximity to emergency medical support, St John ambulance and the rescue helicopter, plus the short term nature of the relocation was thought to mitigate the inconvenience of the lack of showering within the building. As we moved to Alert Level 3 and became increasingly confident the curve has flattened, the risk of exposure to COVID-19 at the hospital is greatly reduced. Plans are underway to relocate the service back to the hospital. There are also plans to make improvements to the facility that will greatly benefit women in the future.

It has been humbling, the support we have received from the community. There have been donations of meals, sanitiser, cleaning wipes and even Easter eggs and coffee pods. It makes the essential workers aware that we are all in this together.

Non-Government Organisations (NGOs)

For our NGO partners, particularly those providing residential care services for either aged or mental health clients, April has been extremely stressful as they have watched COVID-19 spread in facilities in other parts of New Zealand. There has been a significant burden on facilities to keep residents safe, which has meant keeping up with regularly updated advice and guidance from Ministry of Health on personal protective equipment (PPE), case definitions for testing, and admission requirements, sourcing PPE and other supplies (e.g. thermometer probe covers) as usual supply chains are unable to deliver, managing rosters with the need for separate teams/streams/bubbles whilst also staff not working due to age, pre-existing conditions, sickness as well as managing conflicting expectations of residents, families, staff, the DHB, owners, and the Aged Care Association.

Facilities have been supported by their locality groups, with the locality leaders meeting regularly (initially daily, now twice weekly) with the Health of Older People Portfolio Manager, allowing information to be shared regularly, and issues to be elevated and resolved. Most importantly, facilities have been heard and included.

An age related residential care (ARRC) group had been established to support the Community EOC and this was used to undertake the COVID-19 preparedness assessments, which were a requirement of the Ministry of Health for all aged care, mental health and Ministry funded disability homes. This was a significant task, issued at very short notice to DHBs and our team responded admirably, bringing in additional nurse practitioners and clinical nurse specialists from Mental Health of Older People, Hospice, Rural Hospitals, Infection Prevention and Control, and Specialist Services, plus administration support.

This process has been very useful in understanding the risks not only at an individual facility level but also vulnerabilities across the system and localities. The ARRC group are continuing to develop contingency plans for a range of scenarios.

The DHB has worked with the ARRC sector, and Dunedin and Southland District Nursing teams to agree on pathways to support ARRC residents with sub cut fluids and catheters in their own facilities, keeping residents out of hospital EDs. Rural hospitals and Trusts are working to accomplish the same.

For mental Health, a whole of system approach has been taken with DHB and NGO services both having well developed plans and preparing to support the approximately 6,300 people who access services for moderate to severe mental illness at any one time. There was little change in service delivery across the mental health and addiction system as New Zealand moved from Level 4 to Level 3 restrictions.

We have been working particularly closely with the mental health and addictions NGO sector over this pandemic period. Initial activity saw the quick assessment of the overall readiness of all providers under contract to us to test what level of plans they had available to implement in relation to COVID-19. All providers had current plans and were ready to implement them. As we moved quickly from Alert Level 2 to Alert Level 4 the sector rapidly reoriented itself to either curtail services that could not be safely delivered or devised new methods of service delivery so that services could be continued in some shape or form.

We undertook to capture this change by surveying each mental health and addiction provider to determine what level of service was being delivered. This survey was extended to include Mental Health, Addictions and Intellectual Disability Directorate services and the resulting document was shared with the wider sector. We will periodically update the document.

An audit to assess the COVID-19 preparedness of mental health and addiction residential providers has been completed. This used the national audit tool provided based on critical factors and guidance suited to adult mental health residential facilities. This process was enhanced by frequent NGO meetings and a question and answer session with the DHB Infection Prevention and Control (IPC) Nurse. Audits were peer reviewed which included IPC and the Māori Health Directorate.

Southern DHB had been requested to undertake similar audits of disability providers in the Southern area. These 127 providers do not have a contractual relationship with Southern DHB. The Ministry selected 20 facilities for audit which will be undertaken during May.

The 'one system' approach was maintained during April with a clear communication cascade, high level plans supported by detailed plans, daily briefing reports, weekly newsletter, twice a week NGO forums. Planning for Alert Level 2 restrictions involved the review and status of DHB and NGO provided services to ensure everyone knows the status of all services within the Southern mental health and addiction sector.

Surgery Recovery

A surgery recovery plan has been completed in draft for Dunedin and is about to be consulted upon. A similar plan is being developed for Southland. At a high level, the Dunedin plan has been developed using the following principles:

a) The priority for recovery is the deterioration to the inpatient wait list (by speciality) from pre the COVID-19 emergency to post the COVID-19 emergency. We have used 23 March and 9 May respectively to determine the deterioration.

b) The remainder of the surgery to be caught up should focus on the long waiting patients (ESPI 5), again by specialty.

We have calculated that circa 850 caseweights would need to be made up for Dunedin if we were to catch up on their share of the deterioration against the surgical target that occurred during the COVID-19 emergency. However, the deterioration to the inpatient wait list is a smaller number than this. The deterioration is circa 188 patients which has been calculated out at circa 270 caseweights across the specialities.

The reason for the difference in these two numbers is that there was a significant reduction to the outpatient appointments attended during COVID-19, and these are the key determinant in terms of putting patients onto the inpatient wait list, i.e. in the normal course of events a patient would have a first specialist assessment and as a result of this assessment would have been placed on the inpatient wait list for surgery. However, during the COVID-19 lockdown, general practitioners referred patients at circa 50% of the level they would normally refer, and specialists appear to have accepted only circa 60% of what was referred for a first specialist assessment. As a consequence, first specialist assessments were down circa 70% during the period and despite all deferrable elective surgery being cancelled, the overall deterioration to the wait list was modest as a consequence. What we have also seen is that because specialties like general surgery continued to complete non-deferrable (urgent) elective surgery, they managed to clear higher volumes of these cases faster than they normally would.

The difference between the surgeries that need to be caught up and the deterioration to the inpatient wait list represents a unique opportunity to catch up 'ESPI 5', those patients who have waited more than the Ministry target of 120 days for their surgery. Unfortunately, we had more patients waiting >120 days during the lockdown, but overall we should be able to use the recovery to improve our

ESPI 5 breeches. We calculate that we can address circa 33% of all ESPI 5 breaches in Dunedin during recovery.

We have calculated that we need circa 44 all day surgical lists in order for the specialities to recover the deterioration to their inpatient wait lists, which leaves a further 100 lists that can be used to improve ESPI 5 performance. Again, this is calculated on the Dunedin share of the target. To recover in 15 weeks we would need to run circa 10 lists per week. To recover in 25 weeks we would need to run circa 6 lists per week. We will now 'shop out' the lists to the specialities to see what can be achieved and this will determine the length of time required to catch up.

Recovery options available to us include outsourcing, some further outplacement and weekend lists. We have been cautioned by our teams that it will be very challenging to both return to normal volumes and recover using internal capacity, and there are also likely to be hidden costs with internal capacity that will need to be added, such as being able to agree a fee for service basis for funding additional surgery and anaesthesia work, overtime payments for the other specialities and needing to resource additional beds for post-operative recovery. This will be against a backdrop of ongoing social distancing and possibly reductions in staffing if all initial signs of sickness need to be taken more seriously. And we have been asked to partner more with our private hospital providers. All of this suggests that if we are to be case weight funded for recovery, the smoothest route to recovering quickly will be to outsource cases on private lists where possible, and only use the other tactics to top this up. We will continue to work through this.

Surgery has recovered well in the past few weeks. In Dunedin, surgery for the week ending Friday 15 May was back at circa 95% of target. However, some additional capacity at Mercy Hospital was used to get to this point and we have also had low acute numbers whilst still at Alert Level 3. Surgery in Southland for the same period was at 60% of target. However, they from next week the COVID-19 theatres are being returned to normal use and with some successful weekend bookings they have booked at circa 115% of normal capacity for next week.

Bed management forecasting tool

Some good work has occurred in collaboration with the information systems and quality teams to develop a bed forecasting tool in Power BI, which was demonstrated to the teams recently. The tool utilises the same day over the last three years as the basis for a forecast of acute demand and overlays the actual elective bookings to give a forecast picture of bed demands day by day over the course of a week. More work is now required to forecast beds that will be available to show us whether and how much of a bed shortfall will occur during a week, but this looks like a very promising piece of work and once completed with significantly enhance our understanding of whether we are likely to face a bed block issue during the course of the week. This in turn will allow better decisions to be made in terms of elective bookings versus clearing of acute volumes and landing on the right acute capacity to meet our needs at the right times.

Renewing our focus on the sterile services and tenth operating theatre implementations in Dunedin

As we start to return to normal we must now renew our focus on getting the sterile services solution built and implemented, and on developing the much needed additional operating theatre capacity (operating theatre 10). Unfortunately, our building and property service colleagues initially understood that they could get a procurement exemption and engage consultants on the detailed design. They have recently been advised that this is no longer the case and a tender process is required to select the detailed design team. Whilst it is important that appropriate procurement processes are followed it now becomes imperative that the tender

process is run quickly so as not to delay the build, and we will work closely with both services to try to get this completed as quickly as possible.

Renewing our focus on the fifth theatre proposal for Southland

At our Hospital Advisory Committee meeting in Southland earlier this year we undertook to develop a business case for a fifth theatre in Southland (and the requisite beds) utilising the standard Treasury Light 5 Business Case approach that we use for all significant specialist services business cases. We now need to resume this and will commence a short series of stakeholder workshops to get the necessary input to construct this case.

Recovering Outpatient Activity

Although we have put a lot of focus on developing our plan to recover surgery, we have deliberately slowed the planning for outpatient recovery. This is due to a number of factors. To start with, there is a push nationally, regionally and locally, to work more collaboratively with primary care and to try to use the big changes that came with COVID-19 to permanently shift outpatient activity where appropriate from primary to secondary care. Secondly, unlike surgery, it is unclear what needs to be recovered. The deterioration of the outpatient wait lists were modest as the amount of outpatient activity (e.g. first specialist assessments and follow ups) that were accepted and then went on to the wait lists was significantly reduced. We can't recover what we would normally have done because the activity that creates the wait lists did not occur at the same levels as it normally would. And finally, as urgent activity such as cancers and cancer treatment occurred at similar levels as normal during COVID-19 so many of our risky areas appear to be relatively under control.

Whilst spending time to formulate a better primary-secondary approach to outpatient recovery is reasonable, what is not reasonable is letting any risks that have occurred during the period perpetuate. We have asked our analysts to try to quantify for us possible areas of risk and we will be promoting more rapid recovery plans for risk areas. One area that has obvious risks is gastroenterology. However, they appear to have devised a means of recovering lost activity and returning to normal (including the goodwill of senior medical officers who are running free weekend clinics to make up for the period of low activity) by August.

Māori Health Directorate

The Māori Health Directorate has developed a draft COVID-19 plan in collaboration with our Iwi Governance Group COVID-19 sub-committee established under the Chair. The team been meeting weekly with representatives of Te Rūnanga o Ngāi Tahu (TRoNT) and have been actively participating with our South Island Māori DHB colleagues Te Herenga Hauora o te Waka-ā-Māui. The Chief Māori Health Strategy and Improvement Officer (CMHSIO) has been meeting two to three times weekly with Te Tumu Whakarae and the Ministry of Health providing input into the national Māori SITREP report. We have maintained contact with our kaupapa Māori Health Providers across our district and some of the Papatipu Rūnaka over the lock down period.Some of our Māori DHB staff have supported Te Pūtahitanga o Te Waipounamu with the distribution of hygiene packs and have been supporting the #manaaki20 campaign.

It's good to acknowledge that our mainstream colleagues have recognised that Māori and Pacific are at higher risk of COVID-19 community transmission. To address likely inequities between Māori and non-Māori, consideration needs to be given to reducing any further inequities that might arise should there be a shortage of facilities with limited access to hospital beds or respirators. To that end and to address Māori inequities, our team has supported the development of a national Intensive Care Unit (ICU) Equity Tool that aims to prioritise Māori access to respirators and access to ICU beds.

We have been working with the WellSouth COVID-19 telephone call centre on targeting calls to our over 50-year-old Māori patients. This model has had some success in the northern region and the plan is to target communities in higher deprivation areas such as Eastern Southland. The purpose of the calls will be a welfare check and personal health inquiry with a view to patching potential patients back to their general practice and/or linkages to our Māori Health Providers.

We are working with the University of Otago to develop a series of Māori data sets that can measure the impact of COVID-19 on our region. The plan is to review Māori health indicator data and other external social and economic indicators, such as the Integrated Data Infrastructure (IDI) under Statistics NZ. This project was identified as part of our COVID-19 Māori plan and has involved Justine Camp in her role with the University of Otago.

Regional Māori COVID-19 Testing and Influenza Vaccination Clinics

Southern DHB and WellSouth have been working with our Māori Health Providers and local Papatipu Rūnaka to run a series of asymptomatic COVID-19 testing and influenza vaccination pop-up clinics over the last couple of weeks. These marae have included:

- Kati Huirapa Rūnaka ki Puketeraki Marae, Karitane
- Awarua Rūnanga Te Rau Aroha Marae, Bluff
- Te Rūnanga o Waihōpai, Murihiku Marae, Invercargill
- Te Rūnanga o Ōtākou, Ōtākou Marae, Dunedin.

The team are currently in negotiations with other Rūnaka to support similar clinics based on approval from the Medical Officer of Health and the WellSouth clinical lead. These includes Te Rūnanga o Moeraki, Hokonui Rūnanga and Mataura Marae. In addition to the Marae activities we have supported an influenza clinic held in Brockville on 18/19 May 2020 with Te Kāika Medical Centre Caversham.

COVID-19 Community Outreach and Support Funding

The CMHSIO has been in negotiation with the NMDHB who is acting as fund holder and South Island regional lead for Ministry of Health COVID-19 Māori Community Outreach and Support Funding which has been designed to provide flexible services and resources as needed to keep Māori whānau and communities safe, healthy and independent during the COVID-19 outbreak. Services include outreach and wrap around support, taking a holistic model of care in line with the following kaupapa Māori principles:

1. Hapori Māori
2. Māori Provider Booster
3. Māori Communications
4. Manaaki/Welfare
5. COVID-19 Innovation.

It is expected that Māori health and disability providers use this combined funding to provide the most benefit to Māori communities and without duplication. Delivery of services will be targeted towards COVID-19 priority groups including:

- Pakeke, kuia and koroua, as they often will have other health conditions that make them more vulnerable to COVID-19.
- Whānau members with underlying medical conditions such as respiratory issues, heart conditions, high blood pressure, diabetes and other long term conditions.

- Whānau members undergoing treatment for cancer and blood conditions, as treatments impact their immune systems, making them more vulnerable to COVID19.
- Whānau members caring for tamariki and rangatahi Māori during the COVID-19 outbreak.
- Hapū māmā; whilst it is uncertain how COVID-19 impacts pregnant women, during pregnancy women experience changes in their bodies that may increase their risk from some infections.
- Whānau without easy access to healthcare, including mental health and addiction services, primary care and disability support services.

A distribution of funding project plan is being developed in consultation with procurement in our attempts to release this funding as soon as practical.

Regional Māori COVID-19 Communications Project

Southern DHB has been in negotiation with Nelson Marlborough DHB to act as the regional lead for funding released from the Ministry of Health for the purposes of regional COVID-19 Māori communications support. The funding aims to deliver communications activities throughout all the remaining phases of the pandemic response. The regional lead will work with the other Māori DHB managers to determine which communication activities are best suited for their region. These activities may include:

- Strengthening existing communications work
- Social media campaigns
- Regular print and digital pānui to whānau within their respective regions
- Regular TV and radio opportunities with iwi radio and/or regional news
- Digital and print collateral like posters, cards
- Text messaging campaign
- Other activities that are agreed between the DHB and the Ministry as being appropriate for the regional communications approach.

COVID-19 Screening App

The Clinical Leader for Quality Improvement has turned the COVID-19 screening algorithm into an app to improve consistency of application of the screening tool and gather data to allow future tuning and manipulation of the algorithm.

The app was programmed in Microsoft Power Apps (part of the Southern DHB Office 365 package). The app was initially tested in the Emergency Department and then deployed in the Hospital Foyer on 1 May. The next steps will be to:

- produce training and installation video guides
- discuss deployment with General Managers
- set up Information Systems (IS) support and operational management support workflows, and
- link the data via Power BI to the COVID-19 dashboard.

This has been achieved without any additional IS cost to date. There is interest in disseminating this nationally.

Health Pathways

COVID-19 specific pathways went live in April which include information and management for aged residential care and palliative care.

Impact on clinical care and local services is being updated regularly and are key to communicating service delivery changes.

Statistics for the period 10 February to 5 May 2020 highlight 3,956 COVID-19 specific page views from a total page views of 56,895 representing 8.04% of the total page views.

7. DEVELOPING OUR RECOVERY APPROACH

Incorporating 'Recovery' into our Planning

As part of revised planning information, the Ministry has begun developing a COVID-19 recovery planning framework for DHBs to complete leading into the 2020/21 financial year, alongside the broader annual planning processes.

A synopsis of the key areas identified by the Ministry include:

- The significant risk that, without appropriate balance, focusing on COVID-19 alone compromises the short and longer-term care and outcomes of New Zealanders
- A proactive approach to shaping the 'new' normal for health in New Zealand is expected, rather than being reactive during these times of uncertainty and disruption
- Innovative changes made during Alert Level 4 need to be tracked and monitored, and shared with other DHBs
- DHBs to consider in their planning the following aspects: quality and safety, access, workforce, and financial

(Ministry of Health, presentation to DHB Chairs, 17 April 2020)

The Ministry has also signalled that DHBs are to:

- Deliver more planned care activity as practicable
- Ensure that services are delivered according clinical priority
- Improve health equity a priority, and actively monitor this
- Partner with private facilities when planning for capacity

Arrowsmith, M. Chair, COVID-19 National Hospital Response Group, Increasing and improving Planned Care in accordance with the National Hospital Response Framework, 21 April 2020

In addition, there has been new advice from the Ministry on "getting to the new normal", and increasing planned care. Accordingly, new planned care guidance has been issued to DHBs, which promotes the idea that a whole of system response is required if we are to recover our planned care activity as well as other critical system metrics. The key priorities are highlighted below:

- Pathway development – joint Health Pathways across primary, secondary and tertiary care

- COVID-19 prevalence – plan on available bed capacity taking into account COVID-19 inpatient and ICU beds available for surges
- Waiting list review – active review of waitlists to identify any patients where priority or treatment advice/options may have changed since the patient was accepted by secondary care
- Facilities – review physical facilities throughout the entire pathway of care, including clinical and non-clinical support services, to ensure distancing can be maintained
- Virtual options – all patients for FSA and follow-up should be considered for a virtual consultation
- Screening of patients (and any support person) for physical meetings – accurate risk stratification if a physical meeting with a patient is required
- New referrals vs follow-ups – all scheduling must be based on assessment of clinical urgency
- Prioritising out-patient consultations – for physical or virtual review, priority must be based on an assessment of clinical need
- Prioritisation of Surgical and Interventional Waiting Lists
- It is essential that clinical urgency is the over-riding principle guiding scheduling
- Use of private sector capacity and facilities
- Human resources – management of staff leave and sickness.

Ministry of Health, Increasing and improving Planned Care in accordance with the National Hospital Response Framework, Advice from the Planned Care Sector Advisory Group 21 April 2020

Drawing from both the national guidance, and the local service recovery activity that is underway as we plan to transition to a revised business as usual, the following approach is proposed for discussion and endorsement:

- Acknowledge there should be "A new normal", and there may be opportunities to address issues and develop new pathways
- Take a systems approach which encapsulates the patient flow through from primary, secondary, tertiary and return to primary, with the focus on mitigating demand for secondary and tertiary. Risk management frameworks will be essential
- Maintain the integrity of health care services by:
  - Prevention and early intervention to reduce impact on health systems
  - Integrate services with other agencies to deliver a "rounded" care model to our population
  - Continue to respond to everyday health situations – episodic and chronic care
  - Access to acute and complex care across the healthcare system.
- Anticipate health inequalities and be proactive, especially for those vulnerable to poor health (children, older people, Māori, Pasifika, young workers, low income families, refugees and people with chronic conditions)
- Recognise that this is a Public Health crisis with momentous economic and financial impact on our population for many years

- Enable environments to support behaviour change, in particular:
  - Build social capital in communities - partnerships
  - Contribute factual guidance to workplaces, schools, community organisations to enable them to operate safely and effectively. A multidisciplinary effort is essential to strengthen the health system, promote linkages and optimise the resources across our District.

Locally, a group have begun to engage other health organisations, community support agencies, Tangata whenua organisations and the wider community to deliver psychosocial support and interventions. The psychosocial support activities need to be ongoing and be proactive rather than reacting to an adverse event when it happens.

Within the psychosocial support plan, it is important to understand the social aspects of risk including what makes people vulnerable during adverse events. The psychosocial impacts of COVID-19 will be like ripples in a pond, with consequences reaching out well beyond the initial outbreak.

The plan can be used to guide individuals, families/whanau and communities to heal and rebuild the social structure of the community after the initial outbreak of COVID-19. Psychosocial support needs to come from the grassroots level by members of the community rather than from tertiary level Mental Health services.

8. DEVELOPING OUR APPROACH TO PLANNED CARE

On 13 May 2020, general practitioners (GPs) and hospital specialists met to share their ideas on working together to change our paradigms of care. Several themes emerged from that meeting including access to services, access to specialist advice, joint clinics (GP and specialist), clinical care of patients with chronic conditions, and alternate settings for minor surgery. An overarching theme was 'communication'.

It was agreed as a result of this meeting that a 'Planned Care' forum would be established. The forum would consist of WellSouth and Southern DHB representatives, reporting to the Alliance Leadership Team (ALT). The role of the forum will be to provide clinical leadership across the Southern Health System as needed to change the paradigms of care. The function of the forum will be to identify, and then prioritise, planned care initiatives for the Southern Health System. As clinical leaders it is expected that each clinician will actively seek ideas and discussion on working together across the system with their professional colleagues and their department/ unit/ business work colleagues. It is anticipated that the forum will meet monthly, and will report up to the next ALT meeting.

The timing of the 13 May meeting was coincidentally at the same time as the Acute and Planned Care Working Group (hereafter, 'the Working Group') prepared a draft paper and recommendations for the National Primary Health Organisation (PHO) Services Agreement Amendment Protocol Group (PSAAP) for 'Increasing the capacity for Primary Care to provide Planned Care services in the community' (authors: Carol Limber, Canterbury DHB/Ministry of Health, and David McCartney, Technical Advisory Services (TAS), draft 12 May 2020).

The Working Group suggest that there is a need for urgency to progress this area of work, not just because of unmet need and necessary changes to health care delivery, but also to take advantage of the sense of momentum and drive in the system to do things differently.

Included in the draft paper are some overarching principles for Planned Care in the community. These are high level and appear to be consistent with Southern DHB Strategic approach and Primary and Community Health Care Strategy. One high level principle however deserves special mention (page 3):

> *"the purpose of this shift is to develop services within the community….The prime purpose is not around delivering cost-savings".*

It is this mind-set that will allow the courageous discussions to take place across the Southern Health System, facilitate the strategic changes, and allow the time for trust to develop in order to work on the details. To focus on costs at the outset will lead to failure because barriers will be put up to preserve what is already there.

The Working Group do provide some detail about costs to patients and a "fair funding approach". This is guidance, and acknowledges the different models adopted by different DHBs. It will be up to Southern DHB to work with its partners to establish a fair and transparent methodology for attributing costs. Such discussions will not be easy, and successful navigation will depend on sound relationships, mutual trust, and adherence to agreed principles. The Working Group do offer ideas on a pricing structure for "packages of care", which is a useful checklist, and should be referred to.

Intrinsic to clinical governance, the Working Group advocates Health Pathways as the underpinning structure. The influence of Health Pathways should not be under-estimated, and this is one area that Southern DHB and the Southern Health system will need to reinforce.

As with any change project, it is important to monitor if the changes have made a difference, and if the benefits are forthcoming. The Working Group have provided a draft provisional list of measures, although specific measures will need to be developed. Many of the benefits mentioned in the paper are familiar to Southern (travel time and costs, waiting time for treatment). It is likely that new measures will need to be adopted in the new working environment, for example, measures for rapid access to care.

Equity is specifically mentioned by the Working Group. The Southern Health system will need to be vigilant that existing inequities are not inadvertently made worse, and that there are processes in place to resolve unintended and unwanted consequences.

The Working Group suggest that training and upskilling of the workforce may be needed. For example allowing electronic referrals to indicate the place of treatment, and establishing services provided by clinicians (medical, nursing, allied) with special interests. It is anticipated that ideas such as these will come forward to the Planned Care forum.

Events over the first four months of 2020 has provided ample evidence that the Southern Health System can work differently and provide good care to our patients. The challenge now is to keep the gains that have been made and continue to build the trust and transparency necessary for a primary/specialist partnership of care and maintaining the momentum of change. The establishment of the "Planned Care" forum is an important first step to promote and support a joined-up Southern approach. Early wins will require agreement of high level principles and measures, establishment of prioritisation criteria, clear process, effective and regular communications, and visible leadership across the whole of system.

9. RENEWING THE FOCUS ON GENERALISM

Some progress was made implementing a more generalist approach during the COVID-19 crisis. However, work still needs to occur to complete a business case for generalism and we are anticipating some challenging debates about how cost gets added in, cost gets extracted and net benefits are demonstrated. Pre-COVID-19 we completed the first two of the five cases needed for a Treasury Light business case in draft. We now need to resume the work on the business case, picking up where we left off. This remains a relatively complex case to complete, but is well worthwhile in terms of the transformational change that will be possible when combined with a medical assessment unit proximate to the Emergency Department and we will commence workshops to start working through the remaining cases, soon.

10. RENEWING THE FOCUS ON INTENSIVE CARE UNIT STAGE 2

With it now looking less likely that the stage two space for the ICU will need to be made available for COVID-19 response, we now need to work with our building and property colleagues to get the air handling issues comprehensively solved so that the second stage of the ICU development can be finalised. Consultants have been engaged to design a system that will provide the required air changes per hour. Whilst complex to achieve with our ageing plant and a lack of 'as built' drawings and plans, we need to see a design that will meet requirements and can be systematically implemented and fin-tuned until it does. This also needs to become a priority post-COVID-19.

11. IMPLEMENTATION OF COMPUTED TOMOGRAPHY (CT) PROPOSAL

With the recent approval of the CT proposal for Dunedin we have instituted a regular weekly meeting with the relevant General Manager and Service Manager so that we can track progress in terms of ordering of equipment, recruitment of the necessary medical imaging technologists, registered medical officer and nursing, and the commencement of implementation. This will be a key initiative to buy us some time until a case is made for the longer term solution of an additional CT in Dunedin.

The case for the CT machine needs to connect with broader thinking occurring in primary care and whilst it is important not to tie up the case in larger and intractable issues, we will start engaging with our colleagues both in primary care and in the other directorates to address questions such as where a second CT would be located (hospital or community) before we start developing the Treasury Light business case.

12. RADIATION ONCOLOGY

Radiation oncology first specialist assessment referrals dropped during COVID lockdown but only modestly whilst conversely, we were able to see more referrals in clinic as we had all of our radiation oncologists available (a planned sabbatical was unable to go ahead). As a consequence, our radiation oncology first specialist appointment (FSA) performance actually improved markedly and is now down from 100 FSAs on our wait list, to close to the 50 referrals on the wait list we have had when the service has been performing optimally.

13. PRIMARY MATERNITY PROJECT

Primary Maternity Facilities Consultation

Work to determine the best configuration of primary maternity facilities in Central Otago/Wanaka has been disrupted over the last few months by the need to prioritise our efforts on addressing COVID-19.With the DHB workforce returning to focus on business as usual, now is an appropriate time to revisit the consultation timeline and update it. In early 2020, Southern DHB and the Central Lakes Locality Network worked with stakeholders to develop some potential options through workshops. We had initially aimed to propose options for feedback by April 2020 and reach approval of a preferred option in July 2020.

An adjusted high level timeline is proposed as follows:

Adjusted High Level Timeline		
Milestone	**Due Date**	**Progress**
Open online engagement form	*Complete*	
Initial engagement sessions with stakeholders	*Complete*	
Revised timeline communicated	22 May 2020	
Deliver written options paper	30 June 2020	
Completed consultation with stakeholders	15 August 2020	
Agreement on preferred option with stakeholders	31 August 2020	
Operational approval of preferred option	30 September 2020	

A paper outlining the discussed options and indicating a preferred option will now be submitted to the Board in September.

The updated timeline and next steps will be communicated to stakeholders through updating the consultation website engage.southernhealth.nz, emailing those who have made submissions as well as other identified stakeholders, and issuing a media statement.

It is proposed that the options would be communicated to key stakeholders at a workshop for health providers, followed by a public meeting, in July. These would be advertised across print and social media channels, and through our stakeholder network. Please note the format of and ability to hold these workshops may be dependent on any restrictions upon gatherings we are required to adhere to at that time.

Wanaka Hub - Gordon Road Fit Out

While decisions about a birthing unit are pending, work has continued on a short term solution for housing the Wanaka Maternal and Child Hub. Southern DHB currently funds the rental of space for the Hub at Wanaka Lakes Health Centre. This is a single room and is not fit for purpose.

Southern DHB also holds a lease for a property in Gordon Road Wanaka with the intent of renovating this space into a fit for purpose Hub for midwives and the community.

Work has been undertaken by the DHB Building and Property Services team to design and draft the changes required to renovate Gordon Road. We are awaiting some final engineering information before plans can be finalised and submitted to council. Delivering this information has been impacted by COVID-19.

Once the final plans are ready for council submission the aim is to get the works out to tender on the procurement system (GETS) at the same time.

Pre COVID-19 estimates for this work have exceeded available budget by $100,000. The required inclusion of an accessible bathroom has contributed to the costs being greater than expected.

We expect that there could be additional impacts to the project going forward as a result of COVID-19, for example the actual estimates received through the tendering process could be markedly different and there could be a shortage of available trades to complete the work.

COVID-19 has also had an impact on local businesses and commercial property. We have been recently approached by another medical centre with a potentially fit purpose space now available.

For now, we will continue with the Gordon Road renovation project and proceed as soon as possible to the tender process to enable an accurate and full cost work up. This will progress alongside the Primary Facilities Consultation. A decision will need to be taken by ELT in a few months about proceeding with the renovation. We will also continue to explore the commercial property market and other fit for purpose options that may arise as suitable alternatives.

14. MYLAB

Work has commenced on the development of MyLab. MyLab is an interactive innovation centre aimed at showcasing, researching and developing future and current health technology solutions which may be leveraged across the Southern Heath System. MyLab is designed to support the change management process for the New Dunedin Hospital, new models of care and health pathways. This is a facility that engages with staff, patients and the wider community seeking feedback on solution and showcasing new possibilities.

The point of difference from other similar centres within NZ and internationally being the tertiary partnerships within MyLab and the links to research opportunities, understanding the change in behaviours as a result of the new healthcare solutions.

Pre-COVID-19 the Executive Leadership Team endorsed the development of a implementation proposal for MyLab. An initial meeting with establishment partners (Dunedin City Council, Otago Polytechnic, Otago University, Callaghan Innovation, WellSouth, Treasury, the Ministry of Business, Innovation and Employment (MBIE), and the Ministry of Health) as well as digital partners to focus on endorsement of the vision, purpose and approach to implementation. It is still early days for MyLab, but we are currently working on sourcing a physical space, budget requirements and developing the detailed implementation plan. A presentation to the Board will be provided at the meeting in July.

We are excited to be launching MyLab to staff and the wider community later this year.

15. CARE CAPACITY DEMAND MANAGEMENT (CCDM)

COVID-19 has impacted on CCDM programme deliverable timeframes and data accuracy in March and April. The CCDM Programme team leads were deployed to assist in COVID-19 response work; however they are now back to the day job and recommencing implementation activity. During the first few weeks of April in Alert Level 4, inpatient numbers were at their lowest with a ready and prepared workforce in a position to be able to respond to a potential influx of positive patients with COVID-19 based on the alarming projections and international picture. Staff were also not inclined to take up annual leave at short notice due to NZ being at Alert Level 4. Planning and response work such as reorganising inpatients wards, moving 6AT&R ward up to Wakari Hospital, refining red and green streams, PPE and infection control training, mask fit testing and other training and simulation was at full steam. Staff were also familiarising themselves with different processes being introduced such as COVID-19 screening and caring for suspected or confirmed patients with COVID-19 in the red stream areas. Despite expectations that TrendCare available hours be amended to reflect all non-clinical time, it is very likely that available hours are inflated with care hours diverted to other activities described above and are not accurately recorded. Compliance with TrendCare actualisation and categorisation accuracy was clearly not top of mind in most areas in the first few weeks of April and therefore we cannot rely on April data for this reason.

Priorities to mitigate impact on CCDM progress

- Resume CCDM implementation activities in May as COVID Alert Level reduced from level 4 to level 3 on 28 April.
- Chief Nursing and Midwifery Officer, Acting General Manager Operations and NZ Nurses' Organisation (NZNO) supported the move to modified Local Data Council (LDC) meetings with virtual Zoom options included.
- Communication to all Charge Nurse and Midwife Managers to encourage staff to actively utilise the Variance Response Management (VRM) tool.
- Operational Steering Group meetings to resume in May.
- CCDM Council meetings to resume in May.
- Review wards that can undergo FTE Calculations and prioritise a programme of work for these areas for completion.
- FTE calculations for 2021 will require a planned process with Health Union partners and SSHWU to managing appropriate data solutions for the data period affected by COVID. Begin the process toward the end of 2020, Quarter 2.
- Alter draft 2020/2021 CCDM Annual Plan to reflect planning process for FTE calculations in the 2021 year.
- The 2020 CCDM Standard Assessment will reflect the mitigation requirements for Southern.
- Recommence ATR Southland FTE Calculation and book a workshop when Alert Level 2 allows travel, aim for beginning June.
- Liaise with Inpatient Mental Health Unit (IMHU) and Critical Care Unit (CCU) to hold inaugural LDC meetings – 25 May.
- Liaise with remaining Mental Health, Addictions and Intellectual Disability (MHAID) Directorate wards; 9A, 9B, 10A and the Cottage to set dates and organise LDC membership for inaugural meetings.

- Plan meeting with the Associate Director of Nursing Surgical and Charge Nurse Manager of Te Puna Wai Ora as to when they will commence LDC.
- Roll out VRM to remaining areas Queen Mary/CCU/MHAID wards/Medical Assessment Unit/Maternity. Send Charge Nurse/Midwife Manager VRM implementation tools, meet with them and begin planning.

16. PRACTICE DEVELOPMENT UNIT – OTAGO CLINICAL SKILLS LAB (OSCL)

In the last few weeks the COVID-19 lockdown resulted in reduced inpatient numbers and no curriculum delivery through the OCSL. After discussion the OCSL took the opportunity to run in-situ simulation to assist COVID-19 planning.

In total they held fix simulations:

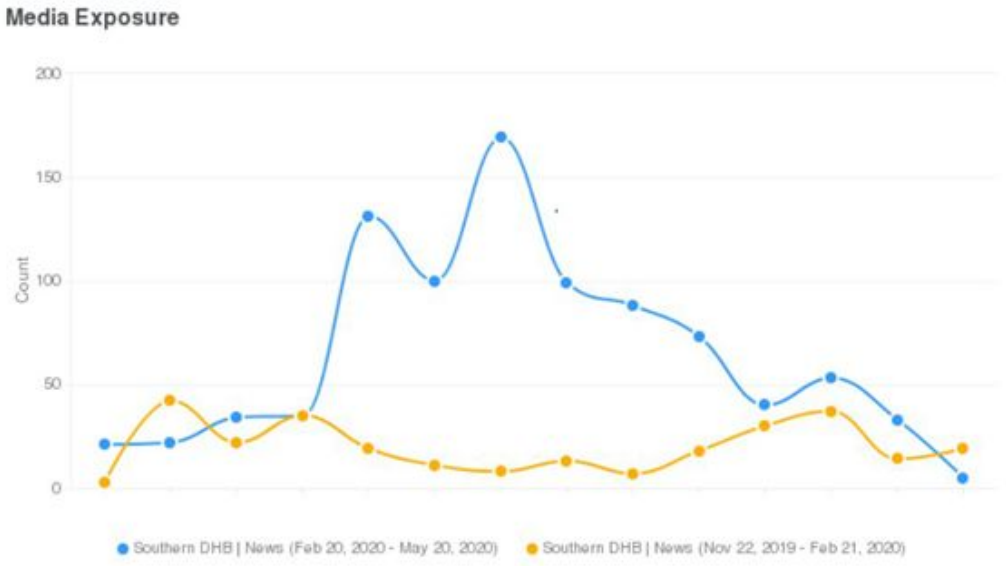
1. ED COVID Patient Flow
2. COVID Intubation
3. COVID respiratory compromise
4. COVID VF arrest
5. COVID Trauma.

Each of these simulations were process driven, designed to test pathways and clinical environments deemed to be Covid treatment areas. The simulations were complex in that they were inter-professional, inter-departmental and inter-service. At times the simulation were mobile moving from one clinical area to another. After each simulation the OCSL provided a report to the appropriate clinical area's management. The simulations were high yield and identified various latent risks that needed to be addressed. OCSL appreciated the opportunity to contribute to the wider COVID-19 response effort but it was a good opportunity to demonstrate the possible service OCSL could provide given the appropriate resources.

17. COMMUNICATIONS

Communications has continued to be largely focused on COVID-19 over the past month.

This has involved producing daily communications for Southern DHB staff, health care partners and community stakeholders, and media. Daily media mentions can be seen returning to more normal volumes following an intense peak through March and early April, comparing the past three months of 2020 with the same period in 2019.



With no new cases in the Southern district for over a month, media queries have moved from tracking the status of the disease in the Southern district to an increased interest in the impact of wider services and steps to recover the lost activity over the lockdown period.

Looking ahead, communications need to continue to prepare for scenarios such as ongoing surveillance; episode management; health demands arising from the broader social changes; and ultimately, hopefully, the rollout of a vaccination programme.

We also have an opportunity to use our recent experiences as impetus to engage with our communities and reshape aspects of the health system.

All of these requirements place a stronger emphasis on stakeholder engagement, and working with our communities alongside our partner agencies will need to remain a strategic focus over the next 6-12 months.

Chris Fleming
Chief Executive Officer

27 May 2020

Southern DHB Financial Report

Financial Report for: 30 April 2020
Report Prepared by: Finance
Date: 13 May 2020

Report to Board

This report provides a commentary on Southern DHB's financial performance for the month and year to date ending 30 April 2020 and the financial position as at that date.

The net deficit for the month of April was $5.1m, being $0.7m unfavourable to budget. The net deficit for the period ending 30 April 2020 was $33.2m, being $6.1m unfavourable to budget.

During April 2020, Revenue was $3.3m favourable to budget while Workforce costs were $3.5m unfavourable to budget across all workforce categories. Clinical Supplies were $1.1m favourable to budget, reflecting the significantly reduced hospital activity due to COVID-19. The reverse is true for Provider Payments, $2.7m unfavourable due to NGO 'pass-through' payments reflecting the response of Primary healthcare services to COVID-19.

Financial Performance Summary

SOUTHERN DISTRICT HEALTH BOARD
Statement of Financial Performance
For the period ending 30 April 2020

Month Actual $000	Month Budget $000	Variance $000			YTD Actual $000	YTD Budget $000	Variance $000		LY YTD Actual $000	LY Full Year Actual $000	Full Year Budget $000
				REVENUE							
92,955	89,171	3,784	F	Government & Crown Agency	899,451	891,693	7,758	F	848,980	1,020,148	1,070,140
606	1,118	(512)	U	Non-Government & Crown Agency	9,255	9,653	(398)	U	9,323	11,892	11,252
93,561	90,289	3,272	F	*Total Revenue*	908,706	901,346	7,360	F	858,303	1,032,040	1,081,392
				EXPENSES							
41,528	37,995	(3,533)	U	Workforce Costs	365,921	361,165	(4,756)	U	337,312	451,823	437,490
2,729	3,278	549	F	Outsourced Services	33,999	32,624	(1,375)	U	32,710	39,624	38,754
6,505	7,614	1,109	F	Clinical Supplies	82,869	77,600	(5,269)	U	78,746	96,479	93,657
4,635	4,755	120	F	Infrastructure & Non-Clinical Supplies	48,534	47,088	(1,446)	U	44,263	60,062	56,777
40,357	37,636	(2,721)	U	Provider Payments	381,592	378,200	(3,392)	U	364,461	438,921	454,704
2,878	3,375	497	F	Non-Operating Expenses	29,005	31,758	2,753	F	28,480	34,476	38,522
98,632	94,653	(3,979)	U	*Total Expenses*	941,920	928,434	(13,485)	U	885,972	1,121,385	1,119,904
(5,071)	(4,364)	(707)	U	**NET SURPLUS / (DEFICIT)**	(33,214)	(27,089)	(6,125)	U	(27,669)	(89,345)	(38,512)

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

Revenue (Year To Date)

Government and Crown Agency revenue includes additional funding for Pay Equity, In Between Travel (IBT) and COVID-19 revenue offsets the increased expenditure in Provider Payments.

The Non-Government & Crown Agency revenue unfavourable position for the month reflects the loss of revenue from Ineligible Patients as tourism ceased during Alert Level 4 and ACC activity was limited.

On a year to date basis we are 1,187 caseweights behind our Planned Care volume delivery to our population. We have adjusted Planned Care revenue by $6m for the shortfall of 1,187 caseweights, including the IDF Outflow component.

Before activity commenced on the COVID-19 response, we were delivering Planned Care close to agreed targets. Therefore, in anticipation of COVID-19 support from the Ministry of Health we have recognised an equivalent amount of funding ($5.9m) to offset the shortfall in Planned Care revenue excluding the IDF component.

Expenditure (Year To Date)

Total Expenses year to date were $941.9m and includes unbudgeted one-off costs for the Measles Outbreak $0.3m and Neurosurgery $1.4m (excluding IDF Outflows and additional hospital transfer team). Neurosurgery medical workforce is currently insufficiently resourced to maintain a safe roster and therefore Canterbury DHB is providing cover for this service.

Workforce Costs are $4.7m unfavourable to budget year to date. Including $4.0m for COVID-19 and $1.1m for an additional estimate for the Holidays Act 2003 remediation.

Outsourced Services are $1.4m unfavourable year to date. This reflects the continued cover for SMO vacancies in Surgical and Medical Imaging areas and service provision to reduce waitlist backlogs.

Clinical Supplies are $5.3m unfavourable year to date. The clinical activity was pulled back in anticipation of COVID-19 patients, resulting in favourable variances for the month in Treatment Disposables, Implants & Prostheses and Other Clinical Costs. All of these areas are favourable for the month however remain unfavourable year to date.

Other Clinical Costs includes Air Ambulance activity, which has increased significantly with Neurosurgery patients being transported from/to Dunedin. The increase in Air Ambulance usage has led to a review of the patient assessment process for determining transport resource, whether that be fixed wing, helicopter or road ambulance. The increase in Implants and Prostheses reflects an uplift in orthopaedic activity particularly in Southland.

Infrastructure and Non-Clinical Supplies are $1.4m unfavourable year to date, the overspend primarily arising from Cleaning & Orderly Services, Software Maintenance and Telecommunications. The Cleaning and Orderly Services include the SECA settlement which increases the ongoing cost for these services. There has been a significant increase in cleaning demand and therefore cost as we have responded to COVID-19 across all our facilities. Both now and into the future, careful cleaning to maintain infection prevention standards is a fundamental part of the response to COVID-19. The Software Maintenance costs include licencing fees for Microsoft Software which is a national contract negotiated by the Ministry of Business, Innovation & Employment (MBIE) for All of Government during 2018. As far as practicable, we manage other expenditure to offset the additional expenditure on the Microsoft contract. Our Telecommunications costs continue to be regularly reviewed in conjunction with our suppliers to mitigate any ineffective spend.

Provider Payments are $3.4m unfavourable year to date. This includes $4.6m payments to Providers for COVID-19 activity, this is offset by additional revenue received from Government and Crown Agency. Residential care is $1.0m favourable year to date, continuing to reflect lower volumes across all levels of care.

Non-Operating Expenses are $2.8m favourable year to date. The Depreciation charge is lower than budget, reflecting the timing and category of capital expenditure.

Financial Position Summary

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

As at 30 Jun 2019 $000		Actual 30 Apr 2020 $000	Budget 30 Apr 2020 $000	Budget 30 Jun 2020 $000	As at 30 Apr 2019 $000
	CURRENT ASSETS				
7	Cash & Cash Equivalents	53,419	7	7	8
47,353	Trade & Other Receivables	63,388	46,938	45,213	51,493
5,762	Inventories	5,605	5,150	5,235	5,199
53,122	*Total Current Assets*	122,412	52,095	50,455	56,699
	NON-CURRENT ASSETS				
323,050	Property, Plant & Equipment	329,010	345,496	346,288	326,679
4,505	Intangible Assets	5,909	10,831	10,393	3,294
327,555	*Total Non-Current Assets*	334,919	356,327	356,681	329,973
380,677	**TOTAL ASSETS**	457,331	408,422	407,136	386,672
	CURRENT LIABILITIES				
9,895	Cash & Cash Equivalents	-	27,463	44,587	7,419
63,925	Payables & Deferred Revenue	98,756	73,401	62,804	62,339
922	Short Term Borrowings	957	934	784	950
112,595	Employee Entitlements	113,521	104,147	91,680	78,476
187,337	*Total Current Liabilities*	213,234	205,945	199,855	149,184
	NON-CURRENT LIABILITIES				
1,568	Term Borrowings	1,237	797	783	1,726
19,362	Employee Entitlements	19,362	18,149	18,756	18,149
20,930	*Total Non-Current Liabilities*	20,599	18,946	19,539	19,875
208,267	**TOTAL LIABILITIES**	233,833	224,891	219,394	169,059
172,410	**NET ASSETS**	223,498	183,531	187,742	217,614
	EQUITY				
300,969	Contributed Capital	385,274	339,181	354,813	282,780
108,502	Property Revaluation Reserves	108,500	108,500	108,502	108,502
(237,061)	Accumulated Surplus/(Deficit)	(270,276)	(264,150)	(275,573)	(173,668)
172,410	*Total Equity*	223,498	183,531	187,742	217,614

Statement of Changes in Equity

192,584	Opening Balance	172,410	172,410	172,410	192,585
(89,345)	Operating Surplus/(Deficit)	(33,215)	(27,089)	(38,512)	(27,666)
69,878	Crown Capital Contributions	84,303	38,210	54,551	52,695
(707)	Return of Capital	-		(707)	
172,410	Closing Balance	223,498	183,531	187,742	217,614

Cash Flow Summary

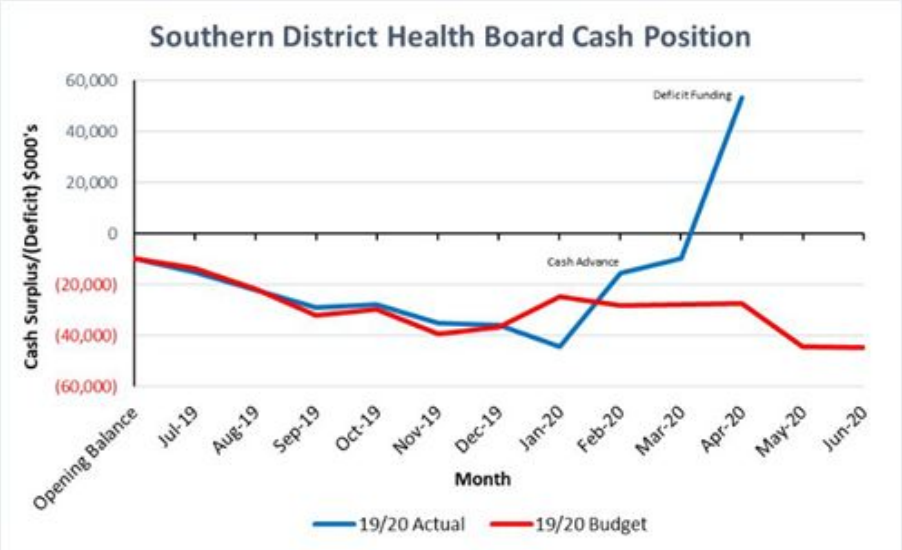
SOUTHERN DISTRICT HEALTH BOARD
Statement of Cashflows
For the period ending 30 April 2020

	YTD Actual $000	YTD Budget $000	Variance $000	Full Year Budget $000	LY YTD Actual $000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash was provided from Operating Activities:					
Government & Crown Agency Revenue	918,448	894,611	23,837	1,071,528	843,891
Non-Government & Crown Agency Revenue	9,013	9,498	(485)	11,065	9,168
Interest Received	238	156	82	187	132
Cash was applied to:					
Payments to Suppliers	(564,990)	(541,821)	(23,169)	(649,567)	(522,680)
Payments to Employees	(358,485)	(366,060)	7,575	(453,068)	(332,614)
Capital Charge	(5,138)	(5,194)	56	(10,500)	(5,735)
Goods & Services Tax (net)	8,515	5,687	2,828	7	5,475
Net Cash Inflow / (Outflow) from Operations	7,601	(3,123)	10,724	(30,348)	(2,363)
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from Investing Activities:					
Sale of Fixed Assets	4	-	4	-	24
Cash was applied to:					
Capital Expenditure	(28,004)	(51,791)	23,788	(57,139)	(25,685)
Net Cash Inflow / (Outflow) from Investing Activity	(28,000)	(51,791)	23,792	(57,139)	(25,661)
CASH FLOW FROM FINANCING ACTIVITIES					
Cash was provided from Financing Activities:					
Crown Capital Contributions	84,306	38,210	46,096	54,550	52,025
Cash was applied to:					
Repayment of Borrowings	(601)	(863)	262	(1,755)	(1,035)
Net Cash Inflow / (Outflow) from Financing Activity	83,705	37,347	46,358	52,795	50,990
Total Increase / (Decrease) in Cash	63,307	(17,567)	80,874	(34,692)	22,966
Net Opening Cash & Cash Equivalents	(9,888)	(9,888)	0	(9,888)	(30,377)
Net Closing Cash & Cash Equivalents	53,419	(27,455)	80,874	(44,580)	(7,411)

The cash position at 30 April 2020 reflects revenue received from the Ministry of Health in both late February 2020 (advance) and late March 2020 (COVID-19) (both noted previously), as well as the $80m Equity Support received in late April 2020. The overall additional expenditure including Clinical Supplies and Outsourcing impacts on the Payments to Suppliers being higher than budget, however the Operating cash flows are still favourable to budget by $10.7m. Payments to Employees were $7.6m lower than budget due to the end of month pay period timing.

Investing Activity outflows are favourable to budget by $23.8m, reflecting the timing of spend on Capital Expenditure with unbudgeted COVID-19 clinical equipment only partially offsetting delays in other projects. Expenditure YTD however remains currently higher than the same time last year.

Cash from Financing is now favourable to budget by $46.4m, due to the receipt of the $80m Equity Support Funding received in April 2020. The Equity Support Funding is not revenue.



Capital Expenditure Summary

SOUTHERN DISTRICT HEALTH BOARD

Capital Expenditure - Cash Flow

For the period ending 30 April 2020

Description	YTD Actual $000	YTD Budget $000	Variance $000	Over Under Spend	FY19 YTD Actual $000	FY19 Full Year Actual $000
Land, Buildings & Plant	10,852	28,420	17,568	U	12,334	15,327
Clinical Equipment	10,867	12,324	1,457	U	9,708	12,574
Other Equipment	372	215	(157)	O	349	406
Information Technology	2,837	4,662	1,825	U	3,149	4,158
Motor Vehicles	3	-	(3)	O	-	44
Software	3,073	6,169	3,096	U	145	121
Total Expenditure	28,004	51,790	23,786	U	25,685	32,630

Property, Plant & Equipment and Intangible Assets are a combined $334.9m, being $21.4m less than the budget of $356.3m.

Land, Buildings and Plant $17.5m underspent in projects including Queenstown Lakes Hospital Redevelopment, Dunedin Hospital ICU, Southland MRI and Deferred Maintenance.

The Queenstown Lakes Hospital redevelopment has been completed. Additional work was scheduled for mid-year on the maternity ward and birthing areas, however COVID-19 has delayed progress.

Clinical Equipment is $1.5m underspent with project timing later than expected for various items of equipment. The Cardiac Catheter Laboratory and Lamson Tube projects were both completed under budget.

The Dunedin Hospital ICU development was delayed due to unresolved issues with the ventilation systems and is likely to remain so while the COVID-19 response takes priority.

Software is $3.1m underspent, the timing of investment on FPIM (Oracle upgrade) and SI PICS (Patient Management) projects being two of the major contributors.

Apr-20				Apr-19	YEAR ON YEAR		YTD 2019/2020				YTD Apr-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
954	1,315	(361)	-27%	1,380	(426)	Acute	14,232	14,219	13	0%	14,176	57
145	253	(108)	-43%	268	(123)	Elective	3,083	2,887	196	7%	2,969	114
1,098	**1,568**	**(470)**	**-30%**	**1,648**	**(550)**	**Total Medical Caseweights**	**17,315**	**17,106**	**210**	**1%**	**17,145**	**171**
						Surgical Caseweights						
769	1,169	(400)	-34%	1,326	(557)	Acute	11,468	12,105	(637)	-5%	12,438	(971)
442	1,260	(818)	-65%	1,206	(765)	Elective	12,106	13,259	(1,153)	-9%	13,254	(1,148)
1,210	**2,428**	**(1,218)**	**-50%**	**2,532**	**(1,321)**	**Total Surgical Caseweights**	**23,574**	**25,364**	**(1,790)**	**-7%**	**25,692**	**(2,118)**
						Maternity Caseweights						
80	80	(0)	-0%	53	27	Acute	989	883	106	12%	863	126
283	322	(39)	-12%	361	(78)	Elective	3,353	3,489	(136)	-4%	3,526	(173)
363	**402**	**(40)**	**-10%**	**414**	**(51)**	**Total Maternity Caseweights**	**4,341**	**4,371**	**(31)**	**-1%**	**4,389**	**(48)**
						TOTALS						
1,803	**2,564**	**(761)**	-30%	**2,759**	**(956)**	**Acute**	**26,688**	**27,206**	**(519)**	-2%	**27,477**	**(788)**
869	**1,835**	**(966)**	-53%	**1,835**	**(967)**	**Elective**	**18,542**	**19,635**	**(1,093)**	-6%	**19,749**	**(1,207)**
2,672	**4,399**	**(1,727)**	**-39%**	**4,594**	**(1,923)**	**Total Caseweights**	**45,231**	**46,841**	**(1,612)**	**-3%**	**47,225**	**(1,995)**

						TOTALS excl. Maternity						
1,723	**2,484**	**(761)**	-31%	**2,706**	**(983)**	**Acute**	**25,700**	**26,324**	**(624)**	-2%	**26,614**	**(914)**
586	**1,513**	**(926)**	-61%	**1,474**	**(888)**	**Elective**	**15,190**	**16,146**	**(957)**	-6%	**16,223**	**(1,033)**
2,309	**3,996**	**(1,688)**	**-42%**	**4,180**	**(1,872)**	**Total Caseweights excl. Maternity**	**40,889**	**42,470**	**(1,581)**	**-4%**	**42,837**	**(1,947)**

Apr-20				Apr-19	YEAR ON YEAR		YTD 2019/2020				YTD Apr-19	YEAR ON YEAR
Actual	Budget	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
2,053	2,838	(785)	-28%	2,572	(519)	**Mental Health bed days**	26,033	28,754	(2,721)	-9%	26,821	(788)

Apr-20	Apr-19	YEAR ON YEAR	Treated Patients (excludes DNW and left before seen)	YTD 2019/2020	YTD Apr-19	YEAR ON YEAR
Actual	Actual	Monthly Variance		Actual	Actual	YTD Variance
			Emergency department presentations			
2,266	3,782	(1,516)	Dunedin	34,389	37,364	(2,975)
333	926	(593)	Lakes	10,252	10,504	(252)
1,949	3,362	(1,413)	Southland	29,313	32,425	(3,112)
4,548	8,070	(3,522)	**Total ED presentations**	73,954	80,293	(6,339)

Note: Restraints data has been deliberately removed as it is under repair

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SOUTHERN DISTRICT HEALTH BOARD

Title:	**SDHB's Change Management Programme and Benefits Realisation Plan: May 2020 Update**
Report to:	Board
Date of Meeting:	3 June 2020

Summary:

The issues considered in this paper are:

- Quarterly updates of activity in the Change Management Programme are provided to the Southern Partnership Group and the SDHB's Board.
- COVID-19 planning priorities have meant that progress in delivering the plan was delayed in some workstreams but presented opportunities for change in the way we work and deliver care in others. A workstream-specific update of key activity since February is presented in Appendix 1.
- Future reporting will be aligned to the District Annual Planning (DAP) process.
- The benefits proposed for the DBC were assigned Executive leads. Work to update these was postponed due to COVID-19 planning but will shortly restart.

11

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

Financial:	None at this time, but will need to be reflected in future benefit profiles
Workforce:	N/A
Equity:	Work to follow to align with the cultural responsiveness/equity/Treaty sections in the DAP to ensure cohesion.
Other:	N/A

Document previously submitted to:	ELT and SDHB's Board	**Date:** Feb and March 2020
Approved by Chief Executive Officer:		**Date:** 25/05/2020

Prepared by: Hamish Brown, Lisa Gestro (and team) and Simon Crack **Date:** May 2020	**Presented by:** Hamish Brown and Lisa Gestro

RECOMMENDATIONS:

That the Board:

1. **Note** the background to, and overview of, SDHB's Change Management Programme and the accompanying indicative Benefits Realisation Plan as presented in Appendix 2; and
2. **Note** the narrative commentary of Change Management Programme progress, as presented in Appendix 1 to this paper, with further detailed updates to follow in August 2020 aligned to the SDHB's District Annual Planning process.

To: SDHB's Board *(for noting at SPG on 26 May 2020*)

From: Chris Fleming, Hamish Brown, Lisa Gestro and Patrick Ng

Date: May 2020

CC: New Dunedin Hospital Programme Management Office (PMO)

SDHB's Change Management Programme and Benefits Realisation Plan: May 2020 Update

Issue

1. SDHB's Executive Leadership Team and Board endorsed the high-level description of SDHB's Change Management Programme and Benefits Realisation Plan in February and March 2020 respectively. For completeness and ease of review, this material is provided in Appendix 2. Specific comments by the Board were subsequently integrated into the programme.

2. SDHB committed to providing quarterly updates of activity in the Change Management Programme. COVID-19 planning priorities have meant that progress in delivering the plan was delayed in some workstreams but presented opportunities for change in the way we work and deliver care in others. A workstream-specific update of key activity since February is presented in Appendix 1. A one-page dashboard report will follow from the August 2020 update onwards.

Background to the Change Management Programme and draft Benefits Realisation Plan

3. We define change management in two ways. Firstly, as the long-term process of realignment of behaviours and culture required by the Southern health system to meet changing demands in our region; and secondly as the need to shift the health delivery environment away from a hospital-centric position.

4. We acknowledge that the depth and breadth of requisite change across the Southern health system – for which the New Dunedin Hospital is a key enabler – is vast.

5. Our response to these challenges is outlined in the SDHB's Change Management Programme and accompanying draft Benefits Realisation Plan, as presented in Appendix 2. Each workstream will be underpinned by planned improvements to processes, technologies and models of care to improve patient care. The work is iterative and will be reported quarterly.

Work to align District Annual Planning and Change Management Programme activity will be prioritised

6. Due to COVID-19 priorities (see para 12), Change Management Programme updates that are presented in Appendix 1 were extracted from recovery plans presented to the ELT. These recovery plans are designed to help leverage the SDHB's response to the challenges posed by the pandemic.

7. SDHB's Change Management Programme will, alongside the District Annual Planning (DAP) process, need to demonstrate and reflect the changes made in direct response to COVID-19 and in maintaining the health system. This activity includes both the enhanced professional

relationships fostered across the system and those changes to processes and models of care that have proven successful in managing care appropriately outside of the hospital setting.

8. Work to embed the Change Management Programme into the DAP refresh process is underway and will continue at pace, either explicitly as a subsection under the DAP's local priorities section (with milestones and measures for benefit realisation actions) and/or woven throughout the document. It is vital that the Change Management Programme and Annual Plan are not seen as separate parallel processes. Instead, the Annual Plan remains our key accountability document that describes what activity we will deliver in the coming year. The themes and messages from the Change Management Programme will, in turn, help to provide a lens through which the Annual Plan is reviewed and approved for appropriateness.

9. In practical terms, then, the DAP and Change Management Programme will be reviewed and updated to include:

    - learnings from the last two months of activity during the COVID-19 response;
    - assessment as to the on-going relevance of the annual planning targets, given that new models of care may mean some targets are less valid than they were pre- COVID-19; and
    - specific changes to services/enablers and outcomes.

10. SDHB's Executive and their direct reports assume accountable and responsible roles for each element of the DAP process. PMO will work with leads over the coming reporting period to ensure alignment and consistency of reporting, which will be reflected in the next Change Management Programme dashboard report (August 2020).

COVID-19 has changed the landscape of health service provision

11. As alluded to above and shortly after the Change Management Programme's structure and direction was endorsed, the Southern health system required urgent mobilisation to prepare for the COVID-19 pandemic. Now, more than ever, success of SDHB's Change Management approach will be dependent on strong, coherent leadership from the SDHB's Executive Leadership Team (ELT) and Board. Both ELT and the Board will need clear support from senior management and clinical teams to deliver the changes outlined in the workstreams.

12. COVID-19 presents a real and present opportunity to change behaviours, systems and cultures across the Southern health system. It will also affect our planning for the New Dunedin Hospital. Our desire is to ensure we maximise both our flexibility of usage and ability to respond to future pandemics in terms of core capacity. These issues will be worked through the design phases.

Immediate next steps being led by our Executive Leadership Team to realise recent benefits

13. SDHB's ELT have identified a number of immediate actions to take, as detailed below:

    - a lessons learnt process to ask what we did, how we did it, who was involved, what worked and what we could have done differently. While some of our actions taken during COVID-19 cannot be maintained (for example the significant reduction in demand for inpatient services due to cancelling all planned care) there will still be positive lessons that can be picked up;

- championing health pathways wherever possible and appropriate. A collective drive on this will be led by the Executive Directors of Strategy, Primary and Community and Quality and Clinical Governance Solutions and the Chief Allied Health, Scientific and Technical Officer. Historically, Health Pathways have been viewed as the electronic tool which codifies the pathway for care in specific services. The real value of Health Pathways is, however, how it can help facilitate meaningful conversations between primary and secondary clinicians. We need to further encourage the re-envisioning of how each relevant service *could* be and then codify the new normal into the technical tool; and
- refresh the Telehealth Steering Group – that will include clinicians and a representative from the Clinical Leadership Group – to build on recent gains to rapidly investigate the further roll-out of this functionality across the Southern health system.

14. Key learnings will also help to inform our overarching strategy, which will be refreshed over the latter half of the 2020 calendar year to deliver a cohesive and clear Strategic Plan. This plan will outline SDHB's vision and provide a clear "true North" for change across the system to which all of our activity and investment will align. In so doing, we will reposition various strategic documents as action plans that have clear alignment to the Strategic Plan, stop any activity that does not align, and plan proactively for any required activity. We will do this to help to reduce duplication of effort and prioritise resources towards areas of need.

Next steps to further develop the Change Management Programme and Benefits Realisation Plan

15. Now that we have moved into Level 2 in the COVID-19 response, work has restarted to further develop SDHB's Change Management Programme and the accompanying Benefits Realisation Plan. In particular, the following steps will be undertaken in collaboration with the Executive:

    - The reporting dashboard will be populated and presented in August 2020, aligned to DAP activity.
    - There is an acknowledged gap in change management plans, as presented, relating to hospital-specific activity. Much of what is described is short-term and tactical. A longer-term view will need to be provided and will require a collective view from ELT based on a refresh of strategic priorities (see para 14), refresh of the DAP, and other recovery plans.
    - Additional work will be undertaken to increase the visibility of SDHB's equity agenda in the Change Management Programme. In time, we will align these documents with the cultural responsiveness/equity/Treaty sections in the Annual Plan to ensure cohesion.
    - Updates will be provided to, and comments received from, the Clinical Leadership Group to help inform the ongoing development of the Change Management Programme and Benefits Realisation Plan. Shared metrics for system integration and improvement will also be prioritised to ensure alignment and to not duplicate effort.
    - The benefits proposed for the DBC were assigned Executive leads. Work to update these was postponed due to COVID-19 planning but will shortly restart. We will work together to better define the benefits management plans, supporting metrics, and to ensure alignment with existing strategies and action plans. Ongoing monitoring can then commence.

Requested actions and next steps

16. SDHB's Board is asked to:

    note the background to, and overview of, SDHB's Change Management Programme and the accompanying indicative Benefits Realisation Plan as presented in Appendix 2; and

    note the narrative commentary of Change Management Programme progress, as presented in Appendix 1 to this paper, with further detailed updates to follow in August 2020 aligned to the SDHB's District Annual Planning process

Appendix 1 – Synopsis of SDHB's Change Management Programme update: May 2020 (based on recovery plans) – *see reporting key on p12*

Workstream	Owner(s) +	Workstream Overview	Key milestones planned (as at Feb 2020)	Overview of Progress/Issues to report in Q1 2020 (as at May 2020)	RAG rating (May 2020) ++	Related Key Benefits
Development/ Update of Southern Strategic Health Plan: 2020	LG (ELT)	Building on work to date, SDHB will refresh our overarching strategy to develop a cohesive and clear Strategic Plan.	• Scoping of work undertaken	• No progress to report due to COVID-19 planning priorities.		• All
Cross Sector Work Programme/ Health in all policies	LG	"Health in All Policies" describes our activity to deliver public policies across sectors and with communities. It systematically takes into account the health implications of our decisions, seeks synergies, and avoids harmful health impacts – in order to improve our population's health and strive towards equity in outcomes.	• Cross Sectoral Collaboration (2019—21, and beyond) • Primary Health Care Integration (2020/21) • Improving Child Wellbeing Programme (2020/21) • Improving Mental Wellbeing (2019/20 activity in Annual Plan) **Supportive Delivery Mechanisms/enablers including** • Health Pathways (ongoing) • Disability Action Plan development (2020/21)	• Flexibility in delivery of population health initiatives in recognition of COVID-19 effects on BAU (e.g. cervical screening programme, sexual health, newborn hearing screening, vision hearing screening, public health nursing) • Public Health maintaining a focus on health literacy, immunisations, outbreak readiness, healthy populations COVID-19 responses have confirmed that: • The system was able to mobilise quickly, transfer skills within and across functions • Clinical partnerships are invaluable • Health Care Homes' providers had to use patient portals, skill mix and telemedicine to safely provide care (and stay in business) • Fast tracking Health Needs		• One Health Team • Better Patient Outcomes • Improve Patient Safety • Improved Patient and Staff Experience

Workstream	Owner(s) +	Workstream Overview	Key milestones planned (as at Feb 2020)	Overview of Progress/Issues to report in Q1 2020 (as at May 2020)	RAG rating (May 2020) ++	Related Key Benefits
				Assessment critical to future planning • Mental Health and Addiction Services delivering closer collaboration with WellSouth and delivery care via different models (e.g. online or phone contact, where appropriate)		
Public Health Equity	LG, GT	Reducing health inequalities for those in the Southern health system is an explicit goal of the SDHB and a priority for action. Increased collaboration and integration across the Southern health system is crucial to help ensure a more organised, co-ordinated and seamless service delivery model; to help reduce any gaps, overlap or duplication in service delivery; and to help strengthen efforts to more effectively address determinants of health and Government priorities to achieve health equity and wellbeing.	• Māori Health Directorate programme/delivery plans (2020/21 and beyond) • SLMs Improvement Plans (ongoing)	• Strong Public Health response during COVID-19 • Rapid scaling-up of outreach immunisation to include flu and childhood vaccines (and other increased outreach) to Māori and Pacific high priority whānau • Puketai continues to cover services remotely but scaled back and nurse redeployed to youth initiatives • Recognised need to now build on strong foundations intersectoral relationships • Recovery planning to commence for how to best manage our most vulnerable patients and their whānau		• One Health Team • Better Patient Outcomes • Improve Patient Safety • Improved Patient and Staff Experience
Provide a broader range of services in the community	PN, GTh	Building on the roadmap described in the Primary and Community Care Strategy and Action Plan, SDHB has identified a range of services that could	• Primary and Community Care Action Plan roll-out (HCH, Hubs and Locality Networks)	• COVID-19 has presented a range of issues and opportunities. These are still being worked through. Learnings from the community include:		• One Health Team • Better Patient Outcomes

Workstream	Owner(s) +	Workstream Overview	Key milestones planned (as at Feb 2020)	Overview of Progress/Issues to report in Q1 2020 (as at May 2020)	RAG rating (May 2020) ++	Related Key Benefits
		appropriately be repositioned in the community. To support this evolving discussion, a closer examination of current patient pathways through the inpatient journey continues. We do this to ensure that as an organisation we truly are valuing patient time, but also to ensure that we are committed to delivering as much activity to the community to be in a primary/secondary partnership model as is clinically appropriate. In turn, opportunities to execute a more generalist medical workforce within the hospital and initiatives such as the Calderdale Framework for Allied Health, are also being explored.	• Build the primary and community care workforce • Planning for enhanced delivery of "community based" services	- Additional school based service/youth health work underway - Reviewing community services' delivery systems and processes for delivery during L4 and L3 lockdown (e.g. virtual delivery, home visits etc across a range of services such as speech language, dietetics, district nursing, community allied, physio OP etc) - Desire being heard from across the sector to embed change now - Desire to increase non face-to-face contacts (phone especially), with further work to understand what is safe and effective clinical care - Roles are changing (e.g. GPs doing CHAs; nurses doing LTCs) - Maintaining networks & relationships across primary and community critical - Need to (re) consider required facilities and technology (to be informed by the ICT Digital Blueprint 2.0)		• Improve Patient Safety • Improved Patient and Staff Experience • Increased Productivity • Living Within our Means`

Workstream	Owner(s) +	Workstream Overview	Key milestones planned (as at Feb 2020)	Overview of Progress/Issues to report in Q1 2020 (as at May 2020)	RAG rating (May 2020) ++	Related Key Benefits
Patient Flow/Quality Improvement *Note: ELT leads for individual Valuing Patient Time initiatives will develop their own work plans, which will be reflected in this workstream in future updates*	PN, GTh	Valuing Patients Time (VPT) is about focusing on patient flow through Southern's hospital system to remove steps that add time with no value to our patients. Improved access and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it. Alongside the VPT programme is work to improve the depth and breadth of quality improvement in service delivery, systems and processes. In sum, these will improve patient safety, reduce the number of events causing injury or harm and improve health outcomes.	• Valuing Patients' Time programme (quality framework; ED activity; Internal Medicine MoC change; Red2Green action plan, older people with frailty activity): 2019—21 • Generalism: development of action plan (2020) • Development of Quality Dashboard/Quality Performance Indicators (2020)	Recovery plans post COVID-19 are being developed. Broadly, these will include: • Recovering surgical capacity – to be seen in the context of having less capacity in the short term. Responses will likely include working staff up to do additional (e g weekend) theatre work and increased theatre hours • Investigating additional capacity over the week (e.g. reviewing list lengths; run Saturday initiative lists for priority areas) • Working staff up to enable red and green areas and additional outpatient activity to be covered • Identification and operation of additional outpatient spaces (particularly in Southland) • Review of outpatient clinic delivery – e.g. nurse-led clinics, workforce reconfiguration to work at top of scope • Common business intelligence reporting initiated • Holding daily clinical meetings • Non-contact phone consults via telehealth • Repurposing of wards and other areas to offer flexibility in response		• Better Patient Outcomes • Improve Patient Safety • Improved Patient and Staff Experience • Increased Productivity

Workstream	Owner(s) +	Workstream Overview	Key milestones planned (as at Feb 2020)	Overview of Progress/Issues to report in Q1 2020 (as at May 2020)	RAG rating (May 2020) ++	Related Key Benefits
Digital	MC	Digital transformation is an important enabler of, and contributor to, the establishment of the new Dunedin Hospital and digital transformation of the entire Southern health system. It is beyond digitalisation of existing processes and needs greater focus on initiatives that allow us to rethink work and how care is delivered.	• Launch of MyLab to community and staff (by Dec 2020) • Electronic Request Management System (ERMS) (2020) • e-Pharmacy (2020/21) • South Island PICS – Business Case (2020) • Paper-lite programme (2019—24) • EMR replacement (2019—21) • SDHB-led Programme to Deliver ICT Blueprint (2020—24)	• Early Works Team recruited. • Work underway since Feb 2020 includes: - Work has commenced, with establishment partners (DCC, Otago Polytechnic, Otago University, Callaghan Innovation, WellSouth and the Ministry of Health) on the development of MyLab. MyLab is an interactive innovation centre aimed at showcasing, researching and developing future health technology solutions which may be leveraged across the Southern Region. - Digital Blueprint V2.0 (delivery expected by August 2020) - Digital Programme Plan (delivery expected by August 2020) to outline the streams of work necessary to implement the Digital Blueprint - Digital Programme Business Case (expected late 2020) to support the implementation of the Digital Blueprint and execution of the Digital Programme Plan.		• One Health Team • Better Patient Outcomes • Improved Patient and Staff Experience • Increased Productivity • Living within our means

Workstream	Owner(s) +	Workstream Overview	Key milestones planned (as at Feb 2020)	Overview of Progress/Issues to report in Q1 2020 (as at May 2020)	RAG rating (May 2020) ++	Related Key Benefits
Workforce	MC, NM, JW, KC	SDHB's vision is to develop an integrated generalist, interprofessional workforce where all staff work at the top of their scope; are responsive to the needs of the community (via service planning); connected to the strategic direction of the SDHB; and aligned with regional, national directions, and well supported by data (people dashboard).	• Strategic direction of SDHB Workforce Plan agreed (2020) • Scenario planning – Options Analysis (2020) • Workforce modelling completed (2020) • Identifying gaps and risks (2020) • Identifying specific gap closing actions and roll-out strategy (2020/21) • Monitoring progress (2020—24)	• Additional PM resource recruited into PMO (April 20), with the key deliverable to help determine the workforce required for the successful transition into – and ongoing operation of – the Ambulatory Services Centre (in the first instance). • Refined workforce configuration would help inform Implementation Business Case (Financial and Management Cases)		• One Health Team • Better Patient Outcomes • Improved Patient and Staff Experience • Increased Productivity • Living within our means
Business Intelligence and Production Planning Capabilities	MC, JR, GTh	Health and business intelligence at SDHB plays a vital role in supporting our evidence-based planning, funding and care delivery. This includes supporting the rapid evaluation of initiatives – such as geospatial tools and production planning roll-out – and provision of measurable feedback for performance and quality improvement, which when taken together will help to inform decision-making.	• Development and refinement of BI and Production Planning Functions (2020—23) • Production Planning Function: Delivery and Roll-Out (2019—23) • Geospatial Analysis: Development Roll-Out (2020/21) • Asset Management Strategy and Action	• Combined approach to business intelligence, including public health business intelligence, delivered to help inform decision-making during COVID-19 preparation • Performance Dashboard for SDHB developed and delivered to ELT (April 2020) • COVID-19 response has reinforced that Fast tracking Health Needs Assessment critical to future planning (i.e. how to understand change in population need in real time)		• One Health Team • Better Patient and Staff Experience • Increased productivity • Living within our means

Workstream	Owner(s) +	Workstream Overview	Key milestones planned (as at Feb 2020)	Overview of Progress/Issues to report in Q1 2020 (as at May 2020)	RAG rating (May 2020) ++	Related Key Benefits
			Plan Development (2020/21) • Health Needs Analysis: Online Tool Development Roll-Out (2020) • Primary and Community Strategy: Health and BI Action Plan (2020—23)			
Eradicate waste and reduce emissions	MC	As a large, complex organisation, SDHB procures large quantities of medical supplies, is energy intensive, produces significant amounts of waste and medical gas emissions, utilises large quantities of transport fuels, uses toxic chemicals, and has multiple other environmental impacts. We need to develop sustainable practices to ensure our decisions today do not result in negative outcomes in the future.	SDHB Sustainability Action Plan: Key Actions (2020—24) FPIM implementation (2020—21)	• No specific progress to report in Q1.		• Living within our means • Better patient outcomes

+ SDHB Executive Leads are as follows:

LG = Lisa Gestro, Executive Director Strategy, Primary and Community
GT = Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer
PN = Executive Director, Specialist Services
GTh = Gail Thompson, Executive Director Quality and Clinical Governance Solutions)
JR = Julie Rickman, Executive Director Finance, Procurement and Facilities
MC = Mike Collins, Executive Director People, Culture and Technology
NM = Nigel Millar, Chief Medical Officer
JW = Jane Wilson, Chief Nursing and Midwifery Officer
KC = Kaye Cheetham, Chief Allied Health, Scientific and Technology Officer
HB = Hamish Brown, Programme Director, New Dunedin Hospital and Infrastructure Support

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++ Red/Amber/Green (RAG) ratings:

Green – Progress tracking to programme, with no significant risks to delivery.

Amber – Progress being made, with some risk to delivery that will require management attention.

Red – Progress has stalled. Immediate management attention required.

To: SDHB's Board *(for noting at SPG on 25 February 2020*)

From: Chris Fleming, Hamish Brown, Lisa Gestro and Patrick Ng

Date: February 2020

CC: New Dunedin Hospital Programme Management Office (PMO)

Endorsing SDHB's Change Management Programme and Benefits Realisation Plan

Issue

1. To present the high-level description of SDHB's Change Management Programme and Benefits Realisation Plan to SDHB's Board and ask for endorsement of the programme. This change management programme – and the Benefits Realisation Plan that, when completed, will underpin it – describes how the SDHB is preparing itself to realise the system-wide benefits afforded by the investment in the new Dunedin Hospital. An overview of the programme will also be included in the Detailed Business Case's (DBC) Management Case.

2. This paper, with enclosed draft documents, is structured as follows:

   - Appendix 1 – SDHB's Change Management Programme Preparation Document
   - Appendix 2 – Synopsis of SDHB's Change Management Programme: February 2020
   - Appendix 3 – SDHB's Change Management Programme Plan: February 2020
   - Appendix 4 – Indicative benefit profiles for Change Management Programme: February 2020

Background to this programme and accompanying draft Benefits Realisation Plan

3. We define change management in two ways. Firstly, as the long-term process of realignment of behaviours and culture required by the Southern health system to meet changing demands in our region; and secondly as the need to shift the health delivery environment away from a hospital-centric position. Our response to these challenges is outlined in the SDHB's Change Management Programme (Appendices 1, 2 and 3) and accompanying draft Benefits Realisation Plan (Appendix 4). Each will be underpinned by planned improvements to processes, technologies and models of care to improve patient care.

4. The SDHB's Programme Management Office (PMO) has developed the high-level overview of the SDHB's Change Management programme, with input from SDHB's Executive leads and their teams. PMO's role in this programme is facilitative. The initiatives themselves are owned by Directorates. SDHB's Board will assume the overall governance role.

5. The Annual Plan remains SDHB's key accountability document. Further refinements to the Change Management Programme, which are underway, will continue to be aligned with both reporting against progress in 2019/20 Annual Plan – and subsequent years' – delivery and service planning for 2020/21, which is currently underway (see para 16).

6. We acknowledge that the depth and breadth of requisite change across the Southern health system – for which the New Dunedin Hospital is a key enabler – is vast. Treasury, at the

November 2019 SPG meeting, identified a need and desire to support change across the SDHB. Further details about the practicalities of this support are currently being sought.

We used an Intervention Logic Map (ILM) approach to structure our programme

7. We have used an Intervention Logic Map (ILM) approach to help provide a framework for structuring the Change Management Programme and associated Benefits Realisation Plan. The ILM framework – see p3 – provides a mechanism for relevant stakeholders to come together for a robust discussion to identify problems; the solutions to address these problems; the enablers to operationalise these solutions; the benefits that will be realised; and the key metrics for measuring these benefits.

8. Initiatives included within the programme include changes to both business processes and supporting ICT and technology; greater integration between primary, secondary and tertiary care; and changes to models of care.

9. Three ILM workshops were held (July, October and December 2019) with SDHB's Executive Leadership Team (ELT) to review and update an earlier version of SDHB's ILM. Follow-up discussions with Executive Directors and their teams have helped to identify an initial picture of contributory benefits, key indicators and to begin to interrogate the workplans that will fall under each. Further work is required and continues.

Current approach

10. Our change management programme is divided into workstreams necessary to meet the problems outlined in the ILM. Each workstream has Executive Director lead(s). Further details are outlined in Appendix 2, which includes a high-level description of workstreams, their owners, key contributing projects and indicative measures we could use to measure benefits arising from our investment. An illustration of the programme itself is provided in the Gantt Chart, presented in Appendix 3.

11. SDHB's Board should note that this plan is iterative. Further refinements will continue to be made to initiatives undertaken – and investments made – over time.

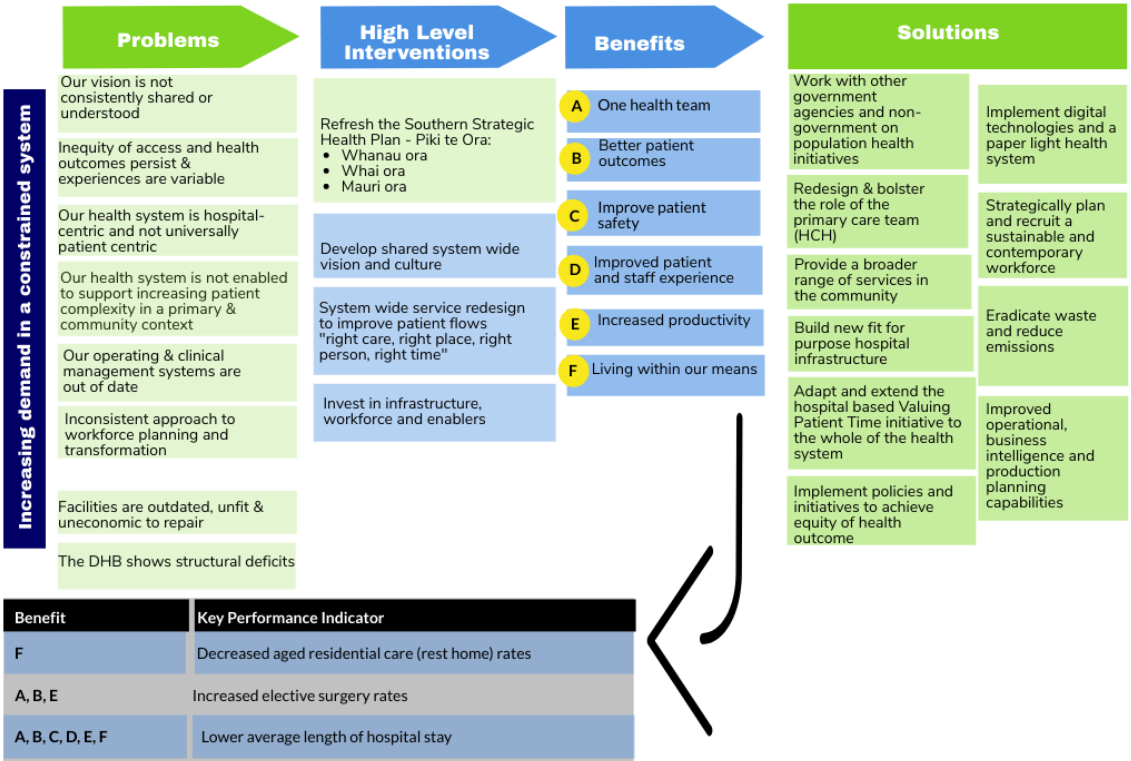
SDHB's Executive Leadership Team (ELT) will play a key role in driving the change forward

12. Success of SDHB's Change Management approach will be dependent on strong, coherent leadership from the ELT. ELT will, in turn, need clear support from senior management and clinical teams to deliver the changes outlined in the ILM's workstreams.

13. We will shortly refresh our overarching strategy, to incorporate and integrate the principles and strategic directions of the existing strategies and plans into a cohesive and clear Strategic Plan. This plan will outline SDHB's vision and provide a clear "true North" for change across the system to which all of our activity and investment will align. In so doing, we will reposition various strategic documents as action plans that have clear alignment to the Strategic Plan, stop any activity that does not align, and plan proactively for any required activity. We will do this to help to reduce duplication of effort and prioritise resources towards areas of business need.

14. SDHB's ELT will play a crucial change management decision-making and monitoring role, supported by SDHB Board oversight. Clear, measurable reports of progress against each workstream will be developed. PMO will help monitor progress to ensure cohesion and integration of the workstreams and alignment with the SDHB's strategic objectives. Responsibility for the delivery of activity within the workstreams themselves will remain with the respective leads.

15. A consolidated view of progress across SDHB's change programme – and, in time, identifying areas that require management attention – will be presented to the SDHB's ELT and Board via a dashboard. The Southern Partnership Group (SPG) will receive bi-monthly updates of progress.



Benefit	Key Performance Indicator
F	Decreased aged residential care (rest home) rates
A, B, E	Increased elective surgery rates
A, B, C, D, E, F	Lower average length of hospital stay
A, B, D, E	Decreased wait times (for community, primary and secondary care and diagnosis
A, B, C, D, E, F	Decreased acute medical discharge rate
A, B, C, D, F	Decreased hospital readmission rate
D	Reduce staff vacancies
F	Reduced deficit

Note these KPIs are in addition to, or are contributory measures, for the System Level Performance Measures of:

- Ambulatory sensitive hospitalisation rates for 0 - 4 year olds
- Acute hospital bed day utilisation per capita
- Patient experience of care
- Amenable mortality
- Youth measure (sexual and reproductive health)
- Proportion of babies that live in a smoke-free house at six weeks

Next steps to further develop the Change Management Programme and Benefits Realisation Plan

16. Work is required to further develop the SDHB's Change Management Programme and the accompanying Benefits Realisation Plan. In particular, the following steps need to be undertaken in collaboration with the Executive:

- There is an acknowledged gap in change management plans, as presented, relating to hospital-specific activity. Much of what is described is short-term and tactical. In response, the ongoing roll-out of the "Valuing Patient Time" (VPT) programme – Emergency Department; General Medicine; Older People's Heath and Red2Green initiatives – will need to be more explicitly woven into this change management programme. Further detail about specific initiatives within each VPT workstream will follow.
- Additional work is required to increase the visibility of SDHB's equity agenda in the Change Management Programme. In time, we will align these documents with the cultural responsiveness/equity/Treaty sections in the Annual Plan to ensure cohesion.
- SDHB's Service Planning (2020/21) templates will report back in late February 2020 on planned activity for the coming year. At that time, proposed service-specific activity will be mapped back against the change programme to ensure alignment.
- The Gantt Chart, as presented in Appendix 3, does not yet offer a view about priorities and critical dependencies between initiatives. Led by the ELT, we will need to take some hard decisions about which are the higher priority items that we should do collectively; those that we will (de)prioritise directly; how delivery will take place alongside business as usual; and how new initiatives will be resourced.
- The Benefit Profiles outlined in Appendix 4 are draft and indicative. They will require further refinement and, ultimately, SDHB's ELT approval. Some benefit indicators are proposed by PMO and/or in development, subject to further interrogation and approval by Executive leads. Once the benefit indicators and key metrics/indicators are agreed, further work to identify potential cost savings associated with each benefit will be required. These benefits will then be tracked and reported over the life of the programme.

Requested actions and next steps

17. SDHB's Board is asked to:

    note the background to, and overview of, SDHB's Change Management Programme and the accompanying indicative Benefits Realisation Plan;

    endorse the Change Management Programme as described and **note** that additional work is underway to develop the accompanying draft Benefits Realisation Plan (see Appendix 4); and

    note that quarterly updates on progress will be provided to the SDHB's Board, via a dashboard approach

Appendix 1: SDHB's CHANGE MANAGEMENT PROGRAMME PREPARATION DOCUMENT

Drafted by:	**Accepted by:**
New Dunedin Hospital PMO	SDHB's Executive Leadership Team (20 February 2020)
Date: February 2020	**Final Version:**
Version: 1.0	

PROJECT ORGANISATION

Change Management Programme Sponsor	Chris Fleming, Chief Executive Officer
Steering Committee	SDHB's Executive Leadership Team *(SDHB's Board will also have a governance role in this programme, the details of which will need to be agreed)*
Senior Responsible Owners for the Change Programme	Lisa Gestro (Executive Director Strategy, Primary and Community), Hamish Brown, (Programme Director) and Patrick Ng (Executive Director, Specialist Services) (*note: Executive Leads are the SROs for their individual project/programmes*)
Project Manager	Simon Crack (Interim)
Team Members (including peer reviewers/assurance/ challenge members) (not FTE resourced via programme)	• SDHB's PMO • Strategy and Planning Team • Dr John Adams, Chair of CLG, and Deputy CLG Chairs • Clinical Leadership Group • HR, ICT and Communications teams, including Early Works Team • Executive Leadership Team members

PROJECT CONTEXT

Area of Focus	Description
Change Programme: Description and Overview	Success of SDHB's Change Management approach will be dependent on a number of factors and strong, coherent leadership both from the management- and service-specific perspectives. An important element of this change will be the integration between primary and secondary services, as indicated in the Primary and Community Care Strategy and Action Plan. In general terms, change management is the process of realignment required by the Southern health system to meet the changing demands of its business and a need to shift the health delivery environment away from a hospital-centric position. It will be underpinned by improvements to processes, technologies and patient and population health outcomes. The DBC's Change Programme (included in the Management Case) provides SDHB with the opportunity to articulate how we will prepare ourselves to realise the system-wide benefits afforded by the new Dunedin Hospital project. Initiatives included within the programme include changes to business processes; integration between primary, secondary and tertiary care; underpinning ICT and

Area of Focus	Description
	technology; and changes to organisational structures to best prepare for the new operating models and ways of working. SDHB's Executive Leadership Team will play a crucial oversight, decision-making and monitoring role for the project. Clear, measurable reports of progress against each workstream will be developed and PMO will play an active monitoring role to ensure cohesion and integration of the workstreams and alignment with the SDHB's strategic objectives. Responsibility for the delivery of activity within the workstreams themselves will remain with the respective leads. Ongoing reporting will provide updates to the Southern Partnership Group and SDHB's Board, via the Chief Executive of the SDHB.
Change Programme Vision	For the SDHB to play a key stewardship role in delivering a modern, efficient, responsive and effective Southern health system – underpinned by research, teaching and education – that is best placed to serve patients and their whānau both now and into the future.
Change Programme Scope	An outline of the work required to prepare the SDHB for the successful delivery of the preferred option outlined in the DBC.
Link to SDHB's Southern Strategic Health Plan	This project aligns with the six priorities in the Southern Strategic Health Plan: • Priority 1: Develop a coherent Southern system of care (by ensuring the strategic model of care is aligned across the region ahead of the New Dunedin Hospital being commissioned) • Priority 2: Build the Southern health system on a foundation of population health, and primary and community care (aligning with primary and community care to help meet current and projected future need) • Priority 3: Secure sustainable access to specialised services (separating ambulatory services from inpatient/acute care, where appropriate) • Priority 4: Strengthen clinical leadership, engagement and quality improvement (working with the University of Otago and other health providers to encourage inter-professional practice, research and education) • Priority 5: Optimise system capability and capacity (provide patient health services in a community setting to support patients staying healthier at home) • Priority 6: Live within our means (focus on improving efficiency and enhanced patient flow to support patients staying healthier at home) SDHB will shortly refresh its overarching strategy, to incorporate and integrate the principles and strategic directions of the existing strategies and plans into a cohesive and clear Strategic Plan. In so doing, SDHB will reposition the various documents as action plans that have clear alignment to the Strategic Plan, stop any activity that does not align and plan proactively for any required activity.
Current Assessment of SDHB's	SDHB has been on the path of change for several years starting with the merger of the Southland and Otago DHBs in 2010. Over the ensuing years, the DHB has embarked on a significant programme of work to align the clinical, management and support

Area of Focus	Description
readiness to Change	functions of the two former DHBs into one DHB, and to refresh and modernise models of care and hospital organisation. The Southern Strategic Health Plan Piki te Ora, 2014, laid the framework for realigning the DHBs' work programmes. Since 2014 there have been several strategies (e.g. Primary and Community Health Strategy, Raise Hope – Hapai te Tumanako & Next Steps, Workforce Strategy) model of care frameworks/statements (e.g. Clinical leaders Group Model of Care 2018) and plans (e.g. Southern Health Workforce Plan 2014—2018) that span the Southern health system. SDHB is building strong, collaborative relationships with local government, social agencies and iwi to address the wider determinants of health that are beyond the health sectors control. An **All in Health Policies** approach recognises that social, economic and environmental factors have an impact on the health of individuals, whanau and wider communities. In 2018, SDHB released its **Primary and Community Care Strategy and Action Plan** that sets out a very clear articulation of the future strategic directions and programmes of work that are required to transform the way in which services are delivered across the health system. SDHB recognises the Strategy and Action Plan as one of two important "planks" to create system wide service redesign. The second key plank – **Valuing Patients Time**, is a programme of patient flow and redesign, to ensure that patient flows through the hospital are efficient and effective. To implement these programmes that SDHB is committed to developing a "**whole-of-system culture** based on shared values, collaboration and innovation", investing in **business and IT systems** and implementing its **workforce** and **digital** strategies (Southern DHB, 2019). SDHB have developed an **environmental sustainability strategy** "Green Healthcare: creating an environment for health" (2019). The DHB have recently completed a carbon footprint for the Southern DHB to gauge the impact that it is having on the environment related to energy use, transport, waste and procurement.
Change Management Programme: approach	• The programme will be directed via a portfolio management approach, with regular reviews of the portfolio against strategic objectives undertaken. We will do this to help to reduce duplication of effort, to identify any gaps, and prioritise resources towards areas of business need. • Our change management programme is divided into workstreams necessary to meet the problems outlined in the ILM. Each workstream will have Executive Director lead(s). • A Benefits Realisation Plan, which is tied back to the ILM presented earlier in this paper, provides more granular detail about benefits to be realised as a consequence of the initiatives outlined in the change management programme. Quarterly updates will be provided to the ELT about progress and areas that require management attention and action.

Area of Focus	Description
	• Wherever possible and appropriate, change activity will be underpinned by Southern Future and other people-centred strategies, to ensure buy-in and resonance with staff and patients. • A quarterly change management dashboard will be prepared for ELT's review, with corresponding updates provided to the SDHB's Board. The Southern Partnership Group (SPG) will also receive updates on progress.
Workstreams of SDHB's Change Management Programme	**SDHB Change Management Programme Workstreams** **Agreed workstreams, as presented in the Intervention Logic Map (ILM), are:** • **Cross Sector Work Programme/Health in all policies –** Lisa Gestro (Executive Director Strategy, Primary and Community) • **Redesign and bolster the role of Primary and Community team** – Lisa Gestro, (Executive Director Strategy, Primary and Community) • **Provide a broader range of services in the community** – Patrick Ng (Executive Director, Specialist Services) and Lisa Gestro (Executive Director Strategy, Primary and Community) • **Patient Flow/Quality Improvement** – Patrick Ng (Executive Director, Specialist Services) and Gail Thomson (Executive Director Quality and Clinical Governance Solutions) – *Note: ELT leads for individual Valuing Patient Time initiatives will develop their own work plans, which will be reflected in this workstream* • **Public Health Equity** – Lisa Gestro, Executive Director Strategy, Primary and Community and Gilbert Taurua (Chief Māori Health Strategy and Improvement Officer) • **Digital** – Mike Collins (Executive Director People, Culture and Technology) • **Workforce** – Mike Collins (Executive Director People, Culture and Technology) and Nigel Millar (CMO), Jane Wilson (Chief Nursing and Midwifery Officer) and Kaye Cheetham (Chief Allied Health, Scientific and Technology Officer) • **Business intelligence and production planning capabilities** – Mike Collins (Executive Director, People, Culture and Technology), Julie Rickman (Executive Director Finance, Procurement and Facilities) and Gail Thomson (Executive Director Quality and Clinical Governance Solutions) • **Eradicate waste and reduce emissions –** Mike Collins (Executive Director, People, Culture and Technology
Outputs	• Draft of Change Management Programme approach delivered (February 2020) ✓ • Draft programme plan submitted to ELT for endorsement (February 2020) ✓ • Update for SPG prepared (February 2020) ✓ • Quarterly reporting of Change Management Programme initiated, using a dashboard approach and portfolio report of progress against projects and programmes, including a view of risk and benefits (April 2020)
Assumptions	Key assumptions made in the development of this change programme include: • Detailed planning for up to two years will be presented, with a more aspirational view about delivery beyond that time period. • Individual change initiatives will be delivered via business as usual governance channels, with PMO prepared a consolidated view of change for ELT to consider via

Area of Focus	Description
	the quarterly dashboard. • Additional resource to help manage the change programme will be needed, acknowledged to be dependent on securing additional funding. • SDHB's Board will be provided with ongoing updates about progress of the programme, with ELT directing changes as required.
Risks	• The significant scale of SDHB change processes underway represents a risk to completing key dependencies in time for inclusion in the DBC and for realising the benefits of the NDH investment. • Primary care and/or Secondary Care will not organise itself to respond to future demand challenges, which will lead to potential inefficiencies, duplication of effort and sub-optimal models of care. • Lack of cohesion of outputs/lack of relationships between projects.
Constraints	• Timeframes for the DBC and the need to establish a change management programme for the Management Case. • Lack of dedicated resources/resource shortage to deliver the work programme, on top of BAU activity. • Lack of specifics about plans in some workstreams requires additional action to develop more granular plans. • Need for standardisation of reporting, which doesn't currently exist for this purpose, and/or dedicated resource to ensure momentum across the programme is maintained at the macro-level. • Lag-time between initiatives and realising benefits – in some cases, many years (e.g. education/training pipeline if a new workforce strategy is sought). • Issues with attribution of benefits and a potential misalignment between a project (and budget) associated with a new hospital with benefits that are system-wide. • Uncertainty needs to be considered as part of change management planning. • Number of initiatives that require initiation simultaneously.
Benefits Framework	An accompanying Benefits Realisation Plan is being prepared for quarterly review, via a dashboard reporting approach. The current working draft is presented in Appendix 4. Further work to identify potential cost savings associated with each benefit will be required as part of their development.

Appendix 2 – Synopsis of SDHB's Change Management Programme: February 2020

Workstream	Owner(s) +	Workstream Overview	Key Projects/Programmes/ Milestones	Related Key Benefits	Key Benefit Indicators *(Indicative only)*
Cross Sector Work Programme/Health in all policies	LG	"Health in All Policies" describes our activity to deliver public policies across sectors and with communities. It systematically takes into account the health implications of our decisions, seeks synergies, and avoids harmful health impacts – in order to improve our population's health and strive towards equity in outcomes.	• Cross Sectoral Collaboration (2019—21, and beyond) • Primary Health Care Integration (2020/21) • Improving Child Wellbeing Programme (2020/21) • Improving Mental Wellbeing (2019/20 activity in Annual Plan) **Supportive Delivery Mechanisms/Enablers including** • Health Pathways (ongoing) • Disability Action Plan (2020/21)	• One Health Team • Better Patient Outcomes • Improve Patient Safety • Improved Patient and Staff Experience	• Primary Health Care Services' Performance • Avoidable hospital admissions • Fewer avoidable hospital admissions • Improved Consumer Engagement and satisfaction
Public Health Equity	LG, GT	Reducing health inequalities for those in the Southern health system is an explicit goal of the SDHB and a priority for action. Increased collaboration and integration across the Southern health system is crucial to help ensure a more organised, co-ordinated and seamless service delivery model; to help reduce any gaps, overlap or duplication in service delivery; and to help strengthen efforts to more effectively address determinants of health and Government priorities to achieve health equity and wellbeing.	• Māori Health Directorate programme/delivery plans (2020/21 and beyond) • SLMs Improvement Plans (ongoing)	• One Health Team • Better Patient Outcomes • Improve Patient Safety • Improved Patient and Staff Experience	• Health Promotion and Education Services • Mortality rates
Provide a broader range of services in the community	PN, GTh	Building on the roadmap described in the Primary and Community Care Strategy and Action Plan, SDHB has identified a range of services that could appropriately be repositioned in the community. To support this evolving discussion, a closer	• Primary and Community Care Action Plan roll-out (HCH, Hubs and Locality Networks) • Build the primary and community care workforce	• One Health Team • Better Patient Outcomes • Improve Patient Safety	• Increased % of non-Dunedin based patients accessing services via telehealth

Workstream	Owner(s) +	Workstream Overview	Key Projects/Programmes/ Milestones	Related Key Benefits	Key Benefit Indicators *(Indicative only)*
		examination of current patient pathways through the inpatient journey continues. We do this to ensure that as an organisation we truly are valuing patient time, but also to ensure that we are committed to delivering as much activity to the community to be in a primary/secondary partnership model as is clinically appropriate. In turn, opportunities to execute a more generalist medical workforce within the hospital and initiatives such as the Calderdale Framework for Allied Health, are also being explored.	• Planning for enhanced delivery of "community based" services	• Improved Patient and Staff Experience • Increased Productivity • Living Within our Means`	• Community Referred Testing and Diagnosis • Care Closer to Home (reduction in FSA referrals)
Patient Flow/Quality Improvement *Note: ELT leads for individual Valuing Patient Time initiatives will develop their own work plans, which will be reflected in this workstream*	PN, GTh	Valuing Patients Time (VPT) is about focusing on patient flow through Southern's hospital system to remove steps that add time with no value to our patients. Improved access and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it. Alongside the VPT programme is work to improve the depth and breadth of quality improvement in service delivery, systems and processes. In sum, these will improve patient safety, reduce the number of events causing injury or harm and improve health outcomes.	• Valuing Patients' Time programme (quality framework; ED activity; Internal Medicine MoC change; Red2Green action plan, older people with frailty activity): 2019—21 • Generalism: development of action plan (2020) • Development of Quality Dashboard/Quality Performance Indicators (2020)	• Better Patient Outcomes • Improve Patient Safety • Improved Patient and Staff Experience • Increased Productivity	• Waits for Urgent Care • Acute readmissions • Falls prevention • Adverse events reduction
Digital	MC	Digital transformation is an important enabler of, and contributor to, the establishment of the new Dunedin Hospital and digital transformation of the entire Southern health system. It is beyond digitalisation of existing processes and needs	• Electronic Request Management System (ERMS) (2020) • e-Pharmacy (2020/21) • South Island PICS – Business Case (2020)	• One Health Team • Better Patient Outcomes • Improved Patient and Staff	• Improved Patient access • Improved Consumer Engagement and

Workstream	Owner(s) +	Workstream Overview	Key Projects/Programmes/ Milestones	Related Key Benefits	Key Benefit Indicators *(Indicative only)*
		greater focus on initiatives that allow us to rethink work and how care is delivered.	• Paper-lite programme (2019—24) • EMR replacement (2019—21) • SDHB-led Programme to Deliver ICT Blueprint (2020—24)	Experience • Increased Productivity • Living within our means	satisfaction • Improved technological support District wide • Digitalisation of Health Records
Workforce	MC, NM, JW, KC	SDHB's vision is to develop an integrated generalist, interprofessional workforce where all staff work at the top of their scope; are responsive to the needs of the community (via service planning); connected to the strategic direction of the SDHB; and aligned with regional, national directions, and well supported by data (people dashboard).	• Strategic direction of SDHB Workforce Plan agreed (2020) • Scenario planning – Options Analysis (2020) • Workforce modelling completed (2020) • Identifying gaps and risks (2020) • Identifying specific gap closing actions and roll-out strategy (2020/21) • Monitoring progress (2020—24)	• One Health Team • Better Patient Outcomes • Improved Patient and Staff Experience • Increased Productivity • Living within our means	• % of SMOs as a generalist workforce • % of qualified nursing staff • % of qualified AH staff • Implementation of Calderdale Framework for Allied Health professionals
Business Intelligence and Production Planning Capabilities	MC, JR, GTh	Health and business intelligence at SDHB plays a vital role in supporting our evidence-based planning, funding and care delivery. This includes supporting the rapid evaluation of initiatives – such as geospatial tools and production planning roll-out – and provision of measurable feedback for performance and quality improvement, which when taken together will help to inform decision-making.	• Development and refinement of BI and Production Planning Functions (2020—23) • Production Planning Function: Delivery and Roll-Out (2019—23) • Geospatial Analysis: Development Roll-Out (2020/21) • Asset Management Strategy and Action Plan Development (2020/21) • Health Needs Analysis: Online	• One Health Team • Better Patient and Staff Experience • Increased productivity • Living within our means	• Increased elective surgery rates • Maintain elective procedures

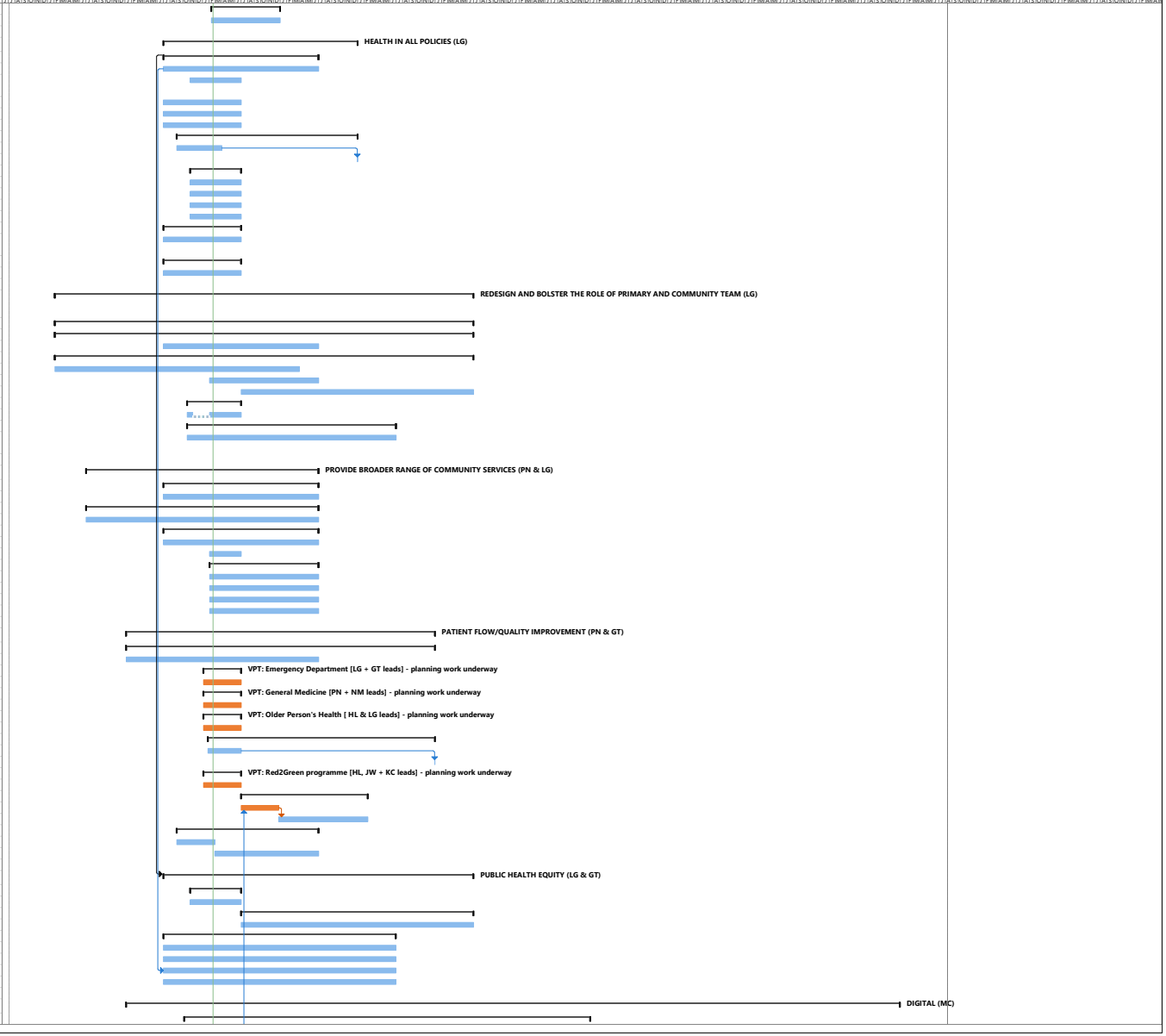
Workstream	Owner(s) +	Workstream Overview	Key Projects/Programmes/ Milestones	Related Key Benefits	Key Benefit Indicators *(Indicative only)*
			Tool Development Roll-Out (2020) • Primary and Community Strategy: Health and BI Action Plan (2020—23)		
Eradicate waste and reduce emissions	MC	As a large, complex organisation, SDHB procures large quantities of medical supplies, is energy intensive, produces significant amounts of waste and medical gas emissions, utilises large quantities of transport fuels, uses toxic chemicals, and has multiple other environmental impacts. We need to develop sustainable practices to ensure our decisions today do not result in negative outcomes in the future.	SDHB Sustainability Action Plan: Key Actions (2020—24) FPIM implementation (2020—21)	• Living within our means • Better patient outcomes	Coal use tonnes per annum Absolute electricity use measured in kWh per annum Total waste sent to landfill annually % reduction in patient NTA (National Travel Assistance) claims by 2030

+ SDHB Executive Leads are as follows:
LG = Lisa Gestro, Executive Director Strategy, Primary and Community
GT = Gilbert Taurua, Chief Māori Health Strategy and Improvement Officer
PN = Executive Director, Specialist Services
GTh = Gail Thompson, Executive Director Quality and Clinical Governance Solutions
JR = Julie Rickman, Executive Director Finance, Procurement and Facilities
MC = Mike Collins, Executive Director People, Culture and Technology
NM = Nigel Millar, Chief Medical Officer
JW = Jane Wilson, Chief Nursing and Midwifery Officer
KC = Kaye Cheetham, Chief Allied Health, Scientific and Technology Officer
HB = Hamish Brown, Programme Director, New Dunedin Hospital and Infrastructure Support

Appendix 2 -

SDHB's Change Management Programme Overview: February 2020

ID	Task Name	Start
1	**Development/Update of Southern Strategic Health Plan: 2020**	**Wed 12/02/20**
2	Plan Developed and Agreed	Wed 12/02/20
3		
4	**HEALTH IN ALL POLICIES (LG)**	**Mon 01/07/19**
5	**Inter-sectorial Collaboration**	**Mon 01/07/19**
6	Health in all policy (HiAP) action plan to support intersectorial action	Mon 01/07/19
7	Develop framework to incorporate climate change and sustainability objectives in to 20/21 service plans	Mon 04/11/19
8	Healthy Food and Drink Strategy/Approach Roll-Out	Mon 01/07/19
9	Smokefree 2025 Action Plan delivery	Mon 01/07/19
10	Breast and Cervical Screening: Cross-Agency/Sector work programme	Mon 01/07/19
11	**Disability Action Plan**	**Mon 02/09/19**
12	Develop Disability Action Plan	Mon 02/09/19
13	Disability Steering Group in place	Fri 31/12/21
14	**Primary Health Care Integration**	**Mon 04/11/19**
15	Maintain and Support ALT Structure and Work Programme	Mon 04/11/19
16	Improve access to primary care services, particularly for high needs patients	Mon 04/11/19
17	Diabetes and Other Long-Term Conditions: Action Plan Roll-Out	Mon 04/11/19
18	Pharmacy Action Plan Roll-Out	Mon 04/11/19
19	**Improving Child Wellbeing Programme**	**Mon 01/07/19**
20	Immunisation; School Based Health Services; Midwifery; First 1,000 days; Family and Sexual Violence; and SUDI prevention activity	Mon 01/07/19
21	**Improving Mental wellbeing**	**Mon 01/07/19**
22	Population Mental Health; Mental Health and Addictions Improvement activity	Mon 01/07/19
23		
24	**REDESIGN AND BOLSTER THE ROLE OF PRIMARY AND COMMUNITY TEAM (LG)**	**Mon 05/02/18**
25	**Primary and Community Care Strategy and Action Plan Roll-Out**	**Mon 05/02/18**
26	**Area 1. Care Models**	**Mon 05/02/18**
27	Support self-care; Create Locality Networks	Mon 01/07/19
28	**Develop HCH**	**Mon 05/02/18**
29	Tranche 1	Mon 05/02/18
30	Tranche 2	Mon 03/02/20
31	Tranche 3	Wed 01/07/20
32	**Develop Community Health Hubs**	**Mon 21/10/19**
33	Functional Brief (Draft) delivered	Mon 21/10/19
34	**Area 2. Supporting infrastructure**	**Mon 21/10/19**
35	Governance and leadership; Workforce capability and culture; Health & Business intelligence; Information and Care Technologies; Funding and contracting	Mon 21/10/19
36		
37	**PROVIDE BROADER RANGE OF COMMUNITY SERVICES (PN & LG)**	**Mon 02/07/18**
38	**Access to Planned Care initiatives**	**Mon 01/07/19**
39	Delivery of Action Plan	Mon 01/07/19
40	**Build the primary and community care workforce**	**Mon 02/07/18**
41	Calderdale Framework delivery	Mon 02/07/18
42	**Planning for enhanced delivery of "Community Based" services**	**Mon 01/07/19**
43	Out of [NDH] Scope Services: Process for Future Planning	Mon 01/07/19
44	Stocktake of out of scope service planning prepared	Mon 03/02/20
45	**Health Pathways Development**	**Tue 04/02/20**
46	Development of Service-Specific Pathways	Tue 04/02/20
47	Implementation of HealthInfo in Southern District	Tue 04/02/20
48	Potential implementation of Hospital HealthPathways	Tue 04/02/20
49	Implementation of an Audit Framework for HealthPathways	Tue 04/02/20
50		
51	**PATIENT FLOW/QUALITY IMPROVEMENT (PN & GT)**	**Mon 07/01/19**
52	**Valuing Patients' Time**	**Mon 07/01/19**
53	Quality Framework delivery	Mon 07/01/19
54	**VPT: Emergency Department [LG + GT leads] - planning work underway**	**Mon 06/01/20**
55	Programme Defined (plans to follow)	Mon 06/01/20
56	**VPT: General Medicine [PN + NM leads] - planning work underway**	**Mon 06/01/20**
57	Programme Defined (plans to follow)	Mon 06/01/20
58	**VPT: Older Person's Health [HL & LG leads] - planning work underway**	**Mon 06/01/20**
59	Programme Defined (plans to follow)	Mon 06/01/20
60	**Generalism [PN lead]**	**Mon 27/01/20**
61	Generalism Business Case created and agreed	Mon 27/01/20
62	Roll-out of preferred option	Fri 30/12/22
63	**VPT: Red2Green programme [HL, JW + KC leads] - planning work underway**	**Mon 06/01/20**
64	Programme Defined (plans to follow)	Mon 06/01/20
65	**7-day Hospital**	**Wed 01/07/20**
66	Programme Defined (plans to follow)	Wed 01/07/20
67	Work Programme Underway (details, TBC)	Fri 25/12/20
68	**Development of Quality Dashboard/Performance Indicators**	**Mon 02/09/19**
69	Recruitment of GM Quality to lead work programme	Mon 02/09/19
70	Inclusion of Quality Performance Indicators in Board Reporting	Fri 28/02/20
71		
72	**PUBLIC HEALTH EQUITY (LG & GT)**	**Mon 01/07/19**
73	**Engagement and Obligations as a Treaty Partner**	**Mon 04/11/19**
74	Strategy Roll-Out	Mon 04/11/19
75	**Public Health Programme and Related Plans**	**Wed 01/07/20**
76	Health Promotion, Prevention and Awareness activities	Wed 01/07/20
77	**Māori Health Directorate Leadership Activity**	**Mon 01/07/19**
78	Service Level Measures Improvement Plan (Māori Health Focus)	Mon 01/07/19
79	Māori Workforce and Professional Development	Mon 01/07/19
80	Māori Community Relationships: Strategy	Mon 01/07/19
81	Whānau Ora	Mon 01/07/19
82		
83	**DIGITAL (MC)**	**Mon 07/01/19**
84	**ICT Early Works Team/Digital Hospital Programme**	**Mon 07/10/19**



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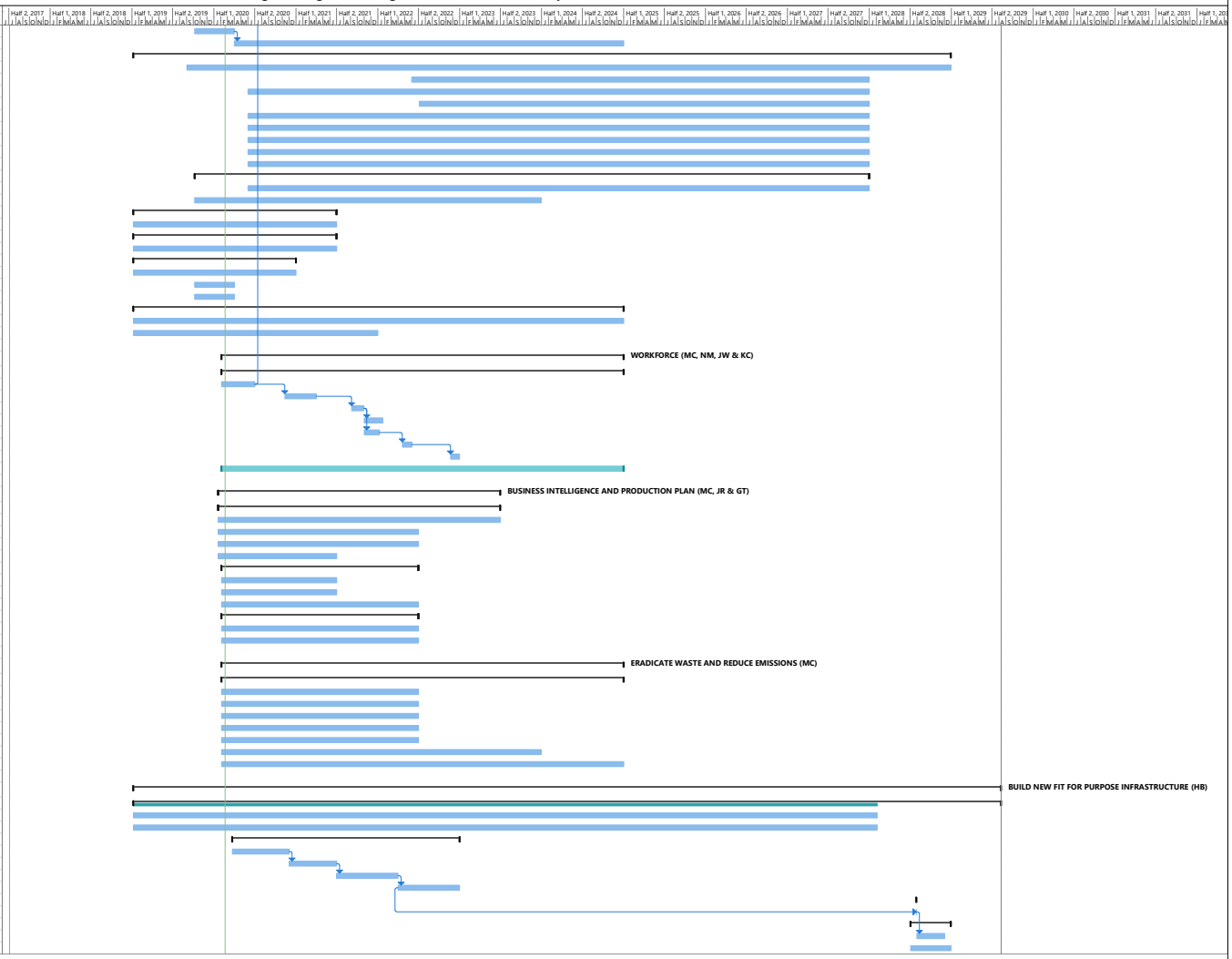
Appendix 2 -

SDHB's Change Management Programme Overview: February 2020

ID	Task Name	Start
85	Confirm Programme Business Case and Roles and Responsibilities	Mon 07/10/19
86	Establish ICT programme and commence ICT design	Wed 01/04/20
87	**ICT Programme of Work**	**Mon 07/01/19**
88	Management and Design	Mon 02/09/19
89	Facility	Wed 01/06/22
90	Network	Mon 01/06/20
91	Server and Storage	Mon 04/07/22
92	Unified Communications	Mon 01/06/20
93	End User Computing	Mon 01/06/20
94	Directory and Identity Services	Mon 01/06/20
95	Integration	Mon 01/06/20
96	Audio Visual	Mon 01/06/20
97	**Systems Development**	**Mon 07/10/19**
104	DA, BI & Reporting	Mon 01/06/20
105	Data	Mon 07/10/19
106	**Corporate**	**Mon 07/01/19**
107	Reduce administration time with a system refresh	Mon 07/01/19
108	**Biomedical**	**Mon 07/01/19**
109	Implement supporting connectivity for critical biomedical systems	Mon 07/01/19
110	**National or Regional Projects**	**Mon 07/01/19**
111	Electronic Request Management System (ERMS)	Mon 07/01/19
112	e-Pharmacy	Mon 07/10/19
113	South Island PICS – Business Case	Mon 07/10/19
114	**SDHB Projects**	**Mon 07/01/19**
115	Paper-lite programme	Mon 07/01/19
116	EMR replacement	Mon 07/01/19
117		
118	**WORKFORCE (MC, NM, JW & KC)**	**Tue 04/02/20**
119	**Delivery of Southern Workforce Action Plan**	**Tue 04/02/20**
120	Strategic direction of SDHB Workforce Plan agreed	Tue 04/02/20
121	Scenario planning – Options Analysis	Thu 12/11/20
122	Workforce modelling completed	Mon 06/09/21
123	Workforce supply analysis	Mon 01/11/21
124	Workforce demand analysis	Mon 01/11/21
125	Identifying gaps and risks	Wed 20/04/22
126	Identifying specific gap closing actions and roll-out strategy	Mon 21/11/22
127	Monitoring progress	Tue 04/02/20
128		
129	**BUSINESS INTELLIGENCE AND PRODUCTION PLAN (MC, JR & GT)**	**Mon 20/01/20**
130	**Development and refinement of BI and Production Planning Functions**	**Mon 20/01/20**
131	Production Planning Function: Delivery and Roll-Out	Mon 20/01/20
132	Geospatial Analysis: Development Roll-Out	Mon 20/01/20
133	Asset Management Strategy and Action Plan Development	Mon 20/01/20
134	Health Needs Analysis: Online Tool Development and Roll-Out	Mon 20/01/20
135	**Primary and Community Strategy: Health and BI Action Plan**	**Tue 04/02/20**
136	Establish a shared health intelligence function	Tue 04/02/20
137	Establish a care coordination approach	Tue 04/02/20
138	Prioritise and introduce new technologies	Tue 04/02/20
139	**Delivery of Digital Strategy and Action Plan**	**Tue 04/02/20**
140	Digital strategy goal 1: digital environment	Tue 04/02/20
141	Digital strategy goal 2: digital solutions	Tue 04/02/20
142		
143	**ERADICATE WASTE AND REDUCE EMISSIONS (MC)**	**Tue 04/02/20**
144	**SDHB Sustainability Action Plan: Key Actions**	**Tue 04/02/20**
145	Waste Disposal strategy development (food and recycling)	Tue 04/02/20
146	Measure, monitor and report the carbon footprint of SDHB	Tue 04/02/20
147	Energy Supply and Efficiency	Tue 04/02/20
148	Travel Strategy	Tue 04/02/20
149	Procurement Strategy	Tue 04/02/20
150	Built Environment Actions/Culture Changes	Tue 04/02/20
151	Engagement of Staff and Sustainability Culture Change	Tue 04/02/20
152		
153	**BUILD NEW FIT FOR PURPOSE INFRASTRUCTURE (HB)**	**Mon 07/01/19**
154	**Dunedin Hospital Transition Programme**	Mon 07/01/19
155	Essential Maintenance on Critical Infrastructure undertaken	Mon 07/01/19
156	Model of Care Changes/Change Management programme delivered	Mon 07/01/19
157	**Design Phases (Timing is Indicative Only)**	**Mon 23/03/20**
158	Concept Design	Mon 23/03/20
159	Preliminary Design	Tue 01/12/20
160	Developed Design	Thu 01/07/21
161	Detailed Design	Fri 01/04/22
162	**Fit Out Phase (Timing is Indicative Only)**	**Fri 28/07/28**
163	Buying and Fit-Out of FF&E	Fri 28/07/28
164	**Handover/Migration Phase (Timing is Indicative Only)**	**Mon 03/07/28**
165	Planning for, and Migration to, New Hospital	Mon 31/07/28
166	Commissioning	Mon 03/07/28



Appendix 4 – Indicative Benefit Profiles for Benefits Realisation Plan: February 2020

Issue

1. To present the working draft of SDHB's Benefits Realisation Plan for the SDHB Board to note (*presented to SPG on 25 February)*.

Background

2. SDHB's Change Management Programme, as described earlier, is the key vehicle for realising the system-wide change associated with the New Dunedin Hospital Project. Benefits outlined in this document are dependent on the delivery of the solutions/workstreams presented in the Intervention Logic Map (ILM) on page 3 of the cover paper.

3. Key benefits likely to form part of future reporting to Treasury are outlined in the ILM, and include:
   - Decreased aged residential care (rest home) rates
   - Increased elective surgery rates
   - Lower average length of hospital stay
   - Decreased wait times (for community, primary and secondary care and diagnosis
   - Decreased acute medical discharge rate
   - Decreased hospital readmission rate
   - Reduce staff vacancies
   - Reduced Deficit

Development of Benefit Indicators

4. Additional benefit indicators were developed in collaboration with Executive leads and by desktop review. These proposed benefit indicators will be useful for workstream leads to help monitor their delivery progress. The New Dunedin Hospital PMO is working with Executive Leads to ensure that the benefits that are being described are correct, aligned with current and planned reporting, and appropriate.

5. Given difficulty in attribution, choosing appropriate benefit indicators was not a precise science. Priority was given to those metrics already being reported on across SDHB in order to reduce administrative burden. We acknowledge that a further review and refinement of benefit indicators is required in order to agree those indicators that will reported to Treasury – for the next decade – as part of our ongoing monitoring.

6. Benefits, and benefit indicators, are described in the following pages as follows:
   - Related workstream(s) from the ILM necessary to deliver this benefit. Most benefits will be dependent on activity across a number of workstreams presented in the ILM.
   - Benefit Owner(s). SDHB's Executive Lead, responsible for the realisation of the benefit. SDHB's Clinical Chiefs will play a key, contributory role across most of the benefit categories.
   - Benefit Description and characteristics. Overview of what success – in other words, benefit realisation – will look like.
   - Linked project and post-implementation programmes and associated milestones. Projects that will help contribute to the realisation of the benefit. In several cases there is significant

overlap. Some rationale for why these projects are included is provided in these sections (in italics). Note that direct attribution to a project is difficult.

- Possible benefit indicator. The initial, "long list" of benefit indicators subject to further refinement and approval.
- Baseline and Target. Included where information exists from key documentation (e.g. SDHB's Statement of Intent).
- Measurement. How progress against indicators will be tracked.
- Data source and frequency. Description of which data source(s) information will be extracted and their likely reporting frequency.

Some caveats about the plan exist and should be noted

7. The Benefit Profiles outlined in this document are draft and require further refinement and, ultimately, SDHB's Executive approval.

8. Some benefit indicators are proposed by PMO and and/or in development, subject to further interrogation and approval by Executive leads. For ease of review, these benefits are highlighted in light grey.

9. Other caveats about the plan to note include:

    - At present, no costing of savings arising from the realisation of benefits has been attempted. This work will need to follow, although clear attribution will be difficult and the risk of double-counting a benefit saving is high. An approach will need to be described and agreed.
    - The New Dunedin Hospital Detailed Business Case (DBC) is for capital investment towards a new hospital, whereas we have developed benefits related to wider system change. While the DBC does outline a Cost Benefit Analysis of those quantifiable benefits associated with the infrastructure element of this project, the alignment back to wider-system change will need to be explored.
    - In some instances, proposed benefit measures are not currently reported on/do not exist. Work to develop reporting mechanisms for these benefits will be required.

Next steps

10. This Benefit Realisation Plan is presented to update SDHB's Board about our progress and to describe next steps.

11. SDHB's PMO, in collaboration with Executive Leads, will continue to refine the plan ahead of a further update being to the SDHB Board in Quarter Two.

Southern Health
He hauora, he kuru pounamu

Southern District Health Board
Piki Te Ora

One Health Team – Benefits Profile		
Related workstream(s) from the ILM necessary to deliver this benefit: • Health in All Policies • Redesign and bolster the role of the PCT • Provide a broader range of care in the community • Public Health Equity	**Date:** February 2020	**Benefit No:** **1**
Benefit Owner: Lisa Gestro, Executive Director Strategy, Community and Primary		
Benefit description and characteristics: We recognise the need to take a more cohesive team approach across the Southern health system. We will work towards shared goals and supersede traditional organisational, sectoral and clinical boundaries to proactively help our people and populations in need and to ensure continuity. We will do this by operating as a seamless, interprofessional team that reflects the community that we serve and that operates in a high-trust, participative and community-facing system. Using health pathways, our focus will be to work together with the person and their family and whānau at the centre of care.		
Linked project and post-implementation programmes and associated milestones: • Primary and Community Care Strategy and Action Plan milestones (Health Care Home Roll-Out; Locality Network initiation/implementation; Community Health Hub planning and implementation) – *rationale: roles that span primary and community* • ICT Digital Hospital/Early Works programme deliverables (January 2020—December 2024) – *rationale: ICT as key enabler* • Valuing Patient Time – Emergency Department workstream milestones (2019—2021) – *rationale: care closer to home, reducing ED attendance rates*		

Possible Benefit Indicator	Baseline	Target	Measurement	Data source	Frequency
Low acuity ED presentation			ED presentations by triage category as % of total ED presentations, and rates/1,000		
GP and practice nurse/Rural nurse specialist usage			GP and nurse consultations per 1,000 patients		
Community Health Hub implementation	N/A	TBC	Number of services provided out of a Community Health Hub	TBC	Annually
Health Promotion and Education Services	88% 87%	>90% >90%	Number of smokers seen in primary care offered support to stop smoking Infants fully/partially breastfed at 3mths		

One Health Team – Benefits Profile					
Primary Health Care Services' Performance	5,869 (18/19) 5,913 (18/19)	<5,370 >6,000	ASH admission rates (per 100k) for 0—4 yo children Number receiving a brief intervention from the primary mental health service	NDMS and Population Estimates	Annually
Community Referred Testing and Diagnosis	79 % (18/19) 74% (18/19) 67% (18/19)	>90% >85% >70%	First Cancer Treatment within 62 days CT referrals within 42 days Accepted MRI scans within 42 days	Internal Performance Measurement	Annually
Patient Experience of One Health Team	N/A	TBC	% of patients who record a positive experience of the "One Health Team" told via patient journey questionnaires	Patient Journey questionnaire (to be developed)	Annually
Health Pathways		50% increase in 12mths	Increase in Health Pathways utilisation	Google Analytics	Annually
Workforce Change	2020/21 workforce	TBC	Number of staff employed in roles that span primary and secondary	SDHB internal workforce data	Annually
Linked risks: • Linked data/information systems across the system are not available within time scale required; • Changes in behaviours and culture across the system – and within clinical workforces – are not realised in time; • Lack of a recognised, shared vision across the system; • Lack of a system-wide workforce strategy to articulate the pathway to one-health team • Traditional funding pathways that do not support modern ways of working with NGO's/Primary care					
Linked assumptions: • SDHB will, during 2020, refresh its overarching strategy to incorporate and integrate the principles and strategic directions of existing strategies and plans into a cohesive and clear Strategic Plan with supporting action plans • New Dunedin Hospital's Digital Hospital programme will provide background solution and information architecture; • A system-wide workforce strategy will be implemented to ensure the future system workforce is reflective of changes to models of care;					

One Health Team – Benefits Profile
Linked dependencies: • ICT Digital Hospital Programme (Early Works Programme) • Delivery of a southern health system workforce strategy and action plan • New Dunedin Hospital project planning milestones (Functional Design and Design Phases, including Out of Scope Services) • Further development, and refinement, of "Health in All Policies" workstream

Better Patient Outcomes – Benefits Profile		
Related workstream(s) from the ILM necessary to deliver this benefit: • Redesign and bolster the role of the PCT • Provide a broader range of care in the community • Business Intelligence and Production Planning • Valuing Patients' Time/Quality Improvement • Public Health Equity • Health in All Policies	**Date:** February 2020	**Benefit No:** **2**
Key Benefit Owners: Gail Thompson, Executive Director Quality and Clinical Governance Solutions and Patrick Ng (Executive Director, Specialist Services)		
Benefit description and characteristics: Effective, safe, efficient, equitable and timely patient-centre care for all patients and their whānau across the Southern health system is the focus of all our work. We have adopted the Fourfold Aim – a set of four balanced goals chosen as the focus of all our work, which comprise population health, patient experience of care, cost per capita and teaching and learning – to demonstrate our commitment to achieving better patient outcomes in all that we do.		

Better Patient Outcomes – Benefits Profile					
Linked project and post-implementation programmes and associated milestones: • Cross-Sector Collaboration (2019—2021, and beyond) – *rationale: wrap-around, patient centred approach* • Health Pathways Development (2019 and beyond, with plans tied to service-specific and business need) – *rationale: localisation of Health Pathways and HealthInfo* • Primary and Community Care Strategy and Action Plan (Health Care Home Roll-Out, Community Health Hub initiation, Locality Network development, and establish a shared health intelligence function) – *rationale: care closer to home, right place/right time* • Valuing Patients' Time programme activity (ongoing activity, linked into service planning) – *patient-centric approach to healthcare* • Development of Quality Dashboard (*rationale: better, more timely performance information for decision-makers)* • Māori Health Directorate SLMs improvement plan (2020/21 activity) – *rationale: improving equity of access* • Digital Hospital/ICT Early Works Programme Activity (from January 2020, building on ICT Blueprint) – *rationale: key enabler to system change*					
Possible Benefit Indicator	**Baseline**	**Target**	**Measurement**	**Data source**	**Frequency**
Avoidable hospital admissions	2,957 (18/19)	<2,844 (18/19)	Avoidable hospital admission rates per 100,000 for the population aged 45-64 Lower average length of hospital stayacutr	NDMS	Annually
Waits for Urgent Care	87% (18/19)	95% (18/19)	Percentage of people presenting at ED who are admitted, discharged or transferred within 6 hours	MoH Quarterly Reporting	Quarterly
Age-Related Residential Care	6.1 (18/19) 93 (18/19)	<7.0 >95	Decreased aged residential care (rest home) rates Number of Rest Home Bed Days per capita of the population aged over 65 years Percentage of aged care residents who have had an InterRAI assessment within 6 months of admission	MoH Quarterly Reporting	Quarterly
Acute readmissions	11.8% (18/19)		Rate of acute readmissions to hospital within 28 days of discharge	MoH Quarterly Reporting	Quarterly

Better Patient Outcomes – Benefits Profile					
Community Referred Testing and Diagnosis	79 % (18/19) 74% (18/19) 67% (18/19)	>90% >85% >70%	First Cancer Treatment within 62 days CT referrals within 42 days Accepted MRI scans within 42 days	Internal Performance Measurement	Annually
Care Closer to Home			Reduction in FSA referrals Increase in number of procedures in community – care closer to home	Internal Performance Measurement	Quarterly
FSA DNAs		Year-on year reduction	% of FSA DNAs	Internal Performance Measurement	Quarterly
Increased elective surgery rates			Average Length of Stay (run charts) Caseweight Target vs Forecast Percentage of day-case to non day-case surgery	Internal Performance Measurement	Quarterly
Maintain elective procedures			Meet procedures vs plan discharge and CWD to plan	Internal Performance Measurement	Quarterly

Better Patient Outcomes – Benefits Profile					
Health Care Home	2019 data (as at Oct 19)	Year-on-year increase	Percentage of patients activated on a portal in HCH practices vs percentage of patients registered on a portal in Non-HCH practices Total number of patients who had their issue resolved over the phone % of patients who have had an MDT in HCH practices vs Non-HCH practices	WellSouth internal reporting data	Monthly
Linked risks: • Linked data/information systems across the system are not available within time scale required; • Changes in behaviours and culture across the system – and within clinical workforces – are not realised in time; • Lack of a recognised, shared vision across the system; • Lack of a system-wide workforce strategy to articulate the pathway to one-health team • Traditional funding pathways that do not support modern ways of working with NGO's/Primary care					
Linked assumptions: • SDHB will, during 2020, refresh its overarching strategy to incorporate and integrate the principles and strategic directions of existing strategies and plans into a cohesive and clear Strategic Plan with supporting action plans • New Dunedin Hospital's Digital Hospital programme will provide background solution and information architecture; • A system-wide workforce strategy will be implemented to ensure the future system workforce is reflective of changes to models of care;					
Linked dependencies: • ICT Digital Hospital Programme (Early Works Programme) • Delivery of a southern health system workforce strategy and action plan • New Dunedin Hospital project planning milestones (Functional Design and sequential design phases, including Out of Scope Services)					

Improve Patient Safety – Benefits Profile		
Related workstream(s) from the ILM necessary to deliver this benefit: • Public Health Equity • Health in All Policies • Quality Improvement and Patient Flow	**Date:** February 2020	**Benefit No:** **3**
Benefit Owner: Gail Thompson, Executive Director Quality and Clinical Governance Solutions and Patrick Ng (Executive Director, Specialist Services)		
Benefit description and characteristics: All who work in the Southern health system are committed to improve health and disability support services we offer for patients and their whānau. Our end goal is to improve medication safety; infection prevention and control; reduce adverse events; reduce harm from falls; facilitate consumer engagement and participation; and reduce perioperative harm.		
Linked project and post-implementation programmes and associated milestones: • Cross-sectoral collaboration work programme (2019—2021) – *rationale: patient safety across the broad spectrum of health and wellbeing* • Health Pathways: further development and service-specific work programme (ongoing) -- *rationale: localisation of Health Pathways and HealthInfo* • Quality dashboard/performance reporting (2020) *rationale: better, more timely performance information for decision-makers)* • Public Health Equity workstream/work programme (ongoing) – *rationale: improving equity of access and outcome* • Business Intelligence and Production planning activity (ongoing) – *rationale: key enabler, improved flow and improved data*		

Possible Benefit Indicator	Baseline	Target	Measurement	Data source	Frequency
Mortality rates	112 (2016 data)	-	Rate of all-cause mortality for people aged under 65 (age standardised per 100,000)	MoH reporting	Annual
Fewer avoidable hospital admissions	TBC	2,865 (19/20)	Rate of ambulatory sensitive hospital admission for adults (45-64)	MoH reporting	Annual
Falls prevention	5.6% (18/19)	5%	Percentage of population (75 years and over) admitted to hospital as a result of a fall Rate of falls in hospital	NDMS	Quarterly

Improve Patient Safety – Benefits Profile					
Adverse events	0.09% (18/19)	0.05% (18/19)	Rate of SAC Level 1 and 2 falls in hospital (per 1,000 inpatient bed-days)	Internal quality system data reporting	Quarterly
Acute readmissions	11.8% (18/19)		Rate of acute readmissions to hospital within 28 days of discharge	MoH Quarterly Reporting	Quarterly
Linked risks: • Linked data/information systems across the system are not available within time scale required; • Changes in behaviours and culture across the system – and within clinical workforces – are not realised in time; • Lack of a recognised, shared vision across the system; • Lack of a system-wide workforce strategy to articulate the pathway to one-health team • Traditional funding pathways that do not support modern ways of working with NGO's/Primary care					
Linked assumptions: • SDHB will, during 2020, refresh its overarching strategy to incorporate and integrate the principles and strategic directions of existing strategies and plans into a cohesive and clear Strategic Plan with supporting action plans • New Dunedin Hospital's Digital Hospital programme will provide background solution and information architecture; • A system-wide workforce strategy will be implemented to ensure the future system workforce is reflective of changes to models of care;					
Linked dependencies: • ICT Digital Hospital Programme (Early Works Programme) • Delivery of a southern health system workforce strategy and action plan • New Dunedin Hospital project planning milestones (Functional Design and Design Phases, including Out of Scope Services)					

Improve Patient and Staff Experience – Benefits Profile		
Related workstream(s) from the ILM necessary to deliver this benefit: • Workforce • Digital • Environmental Sustainability • Production Planning and Business Intelligence • Health in All Policies	**Date:** Jan 2020	**Benefit No:** **4**
Benefit Owner: Mike Collins, Executive Director People, Culture and Technology		
Benefit description and characteristics: Patients' interactions with the Southern health system are shaped by our culture. We strive to develop strong partnerships and authentic community, patient and whānau-centred care. To do this, we will work with patients and whānau to co-design care and develop facilities and strategies to improve patients' experience and facilitate positive outcomes, while retaining a focus on the patient and their holistic physical and emotional needs. How staff feel when they are at work is key to the successful delivery of high quality patient care and staff wellness. Evidence shows us that having engaged, healthy staff leads to increased productivity and an overall happier workforce. We are committed to demonstrating SDHB's values to empower our staff to work as one health team. Our staff will be engaged, motivated, supported by technology and provided with development opportunities to further improve their professional practice.		
Linked project and post-implementation programmes and associated milestones: • Primary and Community Care Strategy and Action Plan milestones (Health Care Home Roll-Out; Locality Network initiation/implementation; Community Health Hub planning and implementation) – *rationale: care closer to home, right place, right time* • ICT Digital Hospital/Early Works programme deliverables – *rationale: systems and processes geared around patient and clinician (not the building)* • Valuing Patient Time – Emergency Department workstream milestones – *rationale: reduced ED attendances, where appropriate* • Development and Refinement of business intelligence and production planning capabilities (ongoing) – *rationale: systems that support patient care in a timely, accessible and reliable fashion* • Speak Up/staff engagement activity (ongoing) – *rationale: focus on staff improvement and wellbeing* • ICT Programme/Digital Hospital development (2019—24) – *rationale: key enabler for system change*		

Improve Patient and Staff Experience – Benefits Profile					
Possible Benefit Indicator	**Baseline**	**Target**	**Measurement**	**Data source**	**Frequency**
Staff Satisfaction	TBC TBC TBC TBC	TBC TBC TBC TBC	% of staff who rate SDHB as good, or very good, place to work Average number of sick leave days by FTE Turnover rate of staff (% of employee resignations) Reduced staff vacancies	Staff survey Internal reporting Internal reporting	Annually Quarterly Annually
Patient Satisfaction	TBC	TBC	% of patients who are satisfied with their care	Patient satisfaction survey	Biannually
Patient access	-	Year on year increase	Year-on year % of patients accessing portal	Internal reporting	Annually
Improved Consumer Engagement and satisfaction			% of overall home based support services clients with Patient experience data	HQSC	Annually
Improved technological support District wide			Shorter waiting times for patients reduced NTA reduced travel distance % of clinical appts delivered via TH Increased % of non-Dunedin based patients accessing services via telehealth	Internal performance reporting	Biannually

Improve Patient and Staff Experience – Benefits Profile					
Digitalisation of Health Records			Delivery of Electronic Health Records (EHRs) against plan Paper-lite roll-out plans	Internal performance reporting	Biannually
Linked risks: • Linked data/information systems across the system are not available within time scale required; • Changes in behaviours and culture across the system – and within clinical workforces – are not realised in time; • Lack of a recognised, shared vision across the system; • Lack of a system-wide workforce strategy to articulate the pathway to one-health team • Traditional funding pathways that do not support modern ways of working with NGO's/Primary care					
Linked assumptions: • SDHB will, during 2020, refresh its overarching strategy to incorporate and integrate the principles and strategic directions of existing strategies and plans into a cohesive and clear Strategic Plan with supporting action plans • New Dunedin Hospital's Digital Hospital programme will provide background solution and information architecture; • A system-wide workforce strategy will be implemented to ensure the future system workforce is reflective of changes to models of care;					
Linked dependencies: • ICT Digital Hospital Programme (Early Works Programme) • Delivery of a southern health system workforce strategy and action plan • New Dunedin Hospital project planning milestones (Functional Design and Design Phases, including Out of Scope Services)					

Increased Productivity – Benefits Profile		
Related workstream(s) from the ILM necessary to deliver this benefit: • Business Intelligence and Production Planning • Build new fit for purpose hospital infrastructure • Valuing Patients Time/Production Planning • Workforce	**Date:** February 2020	**Benefit No:** **5**
Benefit Owner: Patrick Ng, Executive Director Specialist Services		
Benefit description and characteristics: Productivity isn't about doing more with less, but instead about working smarter, doing the right things and doing them in the right way, ensuring we have the right tools and right equipment to do our jobs and prioritisation of where we focus our time effort and investment to realise the best patient outcomes. We are constantly seeking the right outcome for our investment, in collaboration with our patients and their whānau.		
Linked project and post-implementation programmes and associated milestones: • Delivery of Southern Workforce Action Plan (*rationale – staff at top of scope)* • Primary and Community Care Strategy and Action Plan milestones (Health Care Home Roll-Out; Locality Network initiation/implementation; Community Health Hub planning and implementation) – (*rationale – ensuring right care at the right place at the right time)* • Valuing Patient Time – Emergency Department workstream milestones (*rationale – reducing ED attendance for low acuity)* • Development and Refinement of business intelligence and production planning capabilities (ongoing) – *rationale: business intelligence to help ensure efficacy and effectiveness of investment)* • ICT Programme/Digital Hospital development (2019—24) – *rationale: technology that supports the user and clinician*		

Possible Benefit Indicator	Baseline	Target	Measurement	Data source	Frequency
Workforce	TBC	Increasing % (year on year)	% of SMOs as a generalist workforce	Internal workforce data	Annual
	TBC N/A	Increasing % (year on year) Annual plans completed	% of qualified nursing staff % of qualified AH staff Implementation of Calderdale Framework for Allied Health professionals	Internal workforce data Internal reporting	Annual Annual

Increased Productivity – Benefits Profile					
Acute Patient Flow	TBC	TBC	Acute Midnight Occupancy (run charts) Decreased acute medical discharge rate Discharges with LOS>2.3 days (target by MoH from memory) Stranded patients with LOS>7 days	MoH Quarterly Reporting	Quarterly
Staff activity	TBC	TBC	Nurse (FTE) to case weighted discharge ratio Doctor (FTE) to case weighted discharge ratio	MoH Quarterly Reporting	Quarterly
Linked risks: • Linked data/information systems across the system are not available within time scale required; • Changes in behaviours and culture across the system – and within clinical workforces – are not realised in time; • Lack of a system-wide workforce strategy to articulate the pathway to one-health team • Traditional funding pathways that do not support modern ways of working with NGO's/Primary care					
Linked assumptions: • New Dunedin Hospital's Digital Hospital programme will provide background solution and information architecture; • A system-wide workforce strategy will be implemented to ensure the future system workforce is reflective of changes to models of care;					
Linked dependencies: • ICT Digital Hospital Programme (Early Works Programme) • Delivery of a southern health system workforce strategy and action plan • New Dunedin Hospital project planning milestones (Functional Design and Design Phases, including Out of Scope Services)					

Living Within Our Means – Benefits Profile		
Related workstream(s) from the ILM necessary to deliver this benefit: • Improved Business Intelligence and Production Planning Capabilities • Digital • Workforce • Environmental Sustainability	**Date:** Jan 2020	**Benefit No:** **6**
Benefit Owner: Julie Rickman, Executive Director Finance, People and Technology		
Benefit description and characteristics: As one of the Southern Strategic Priorities, we aim to work together across the Southern health system in smarter, more clinically, financially and environmentally sustainable ways. We will do this to move towards living within our means and continue to deliver the best possible care for patients, their whānau and the wider communities that we serve.		
Linked project and post-implementation programmes and associated milestones: • Primary and Community Care Strategy and Action Plan milestones (Health Care Home Roll-Out; Locality Network initiation/implementation; Community Health Hub planning and implementation) – *rationale: right care at the right place and right time* • ICT Digital Hospital/Early Works programme deliverables – *rationale: enhanced use of technology to reduce cost and waste* • Valuing Patient Time – various workstream milestones – *rationale: efficiency and effective flow through secondary services*		

Possible Benefit Indicator	Baseline	Target	Measurement	Data source	Frequency
Deficit reduction	2019/20 actuals	Year on year reduction (aligned to annual plans)	Reduction in deficit (year-on-year actuals) Agreed fiscal sustainability plan with MoH (TBC)	Internal reporting	Monthly

Living Within Our Means – Benefits Profile					
Environmental Sustainability: Energy Supply and Efficiency		Zero coal use at SDHB by 2030 10% reduction in electricity consumption by 2030	Coal use tonnes per annum Absolute electricity use measured in kWh per annum	Internal reporting	Biannually
Environmental Sustainability: Waste		50% reduction in waste to landfill by 2030	Total waste sent to landfill annually	Internal reporting	Biannually
Environmental Sustainability: Travel		50% increase by 2030 10% reduction by 2030	Number of EVs in fleet by 2030 % reduction in patient NTA (National Travel Assistance) claims by 2030	Internal reporting	Biannually
Business Intelligence and Reporting		FPIM implementation by 2021	FPIM implementation go live scheduled for February 2021	Internal reporting	Annually

Living Within Our Means – Benefits Profile
Linked risks: • Linked data/information systems across the system are not available within time scale required; • Changes in behaviours and culture across the system – and within clinical workforces – are not realised in time; • Lack of a recognised, shared vision across the system; • Lack of a system-wide workforce strategy to articulate the pathway to one-health team • Traditional funding pathways that do not support modern ways of working with NGO's/Primary care
Linked assumptions: • SDHB will, during 2020, refresh its overarching strategy to incorporate and integrate the principles and strategic directions of existing strategies and plans into a cohesive and clear Strategic Plan with supporting action plans • New Dunedin Hospital's Digital Hospital programme will provide background solution and information architecture; • A system-wide workforce strategy will be implemented to ensure the future system workforce is reflective of changes to models of care;
Linked dependencies: • ICT Digital Hospital Programme (Early Works Programme) • Delivery of a southern health system workforce strategy and action plan • New Dunedin Hospital project planning milestones (Functional Design and Design Phases, including Out of Scope Services)

Closed Session:

RESOLUTION:

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

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Public Excluded Advisory Committee Meetings: a) Finance, Audit & Risk Committee, ▪ 21 May 2020 verbal report ▪ 29 April 2020 minutes	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
South Island Patient Information Care System (SI PICS)	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.