One DHB Consultation Document

Southland DHB and Otago DHB

November 2009

Mihi

E kā waka, e kā reo, e kā karakataka o te rohe, tēnā koutou, tēnā koutou.
Ko tēnei a mātou mihi ki ia a koutou i ruka i te ahuataka o te atua.

Ko kā roimata e heke iho ki o mātou paparika, he tohu. He tohu maumahara ki ia a koutou kua whetūrakitia. Haere atu ra ki te hono ki wairua. Moe mai, okioki mai, kāti. Rātou ki a rātou, tātou ki a tātou.

Ko te whetu o te marama. Kaua e waiho ki te mahaka harakeke, kei kaika e te ua, whitikia ai e te ra pakapaka, takihia te hau ka motu. Ekari waiho i te mahaka ti, mahaka whitikia e te ra, kia takihia e te hau, kia uaina te ua e kore e motu.

Nō reira,
e taua mā, e poua mā, rakatira mā, whānauka mā, e hoa mā,
mauri ora ki a tātou.

Our greetings to the many people of the regions.

The tears down our cheeks remind us of those who have departed this life for another. Go peacefully.

The star sitting above the moon. Do not leave your prey to a trap made of undressed flax to be rained on, beaten on by the sun, blown by the wind and then broken. Instead you should make a trap from dressed flax or cabbage tree leaves so the sun can bear down, the wind can blow, the rain beat down and it will never snap.

Therefore,
May we all be well

Executive Summary

The Southland and Otago District Health Boards (DHBs) are seeking submissions from the communities of the Southland and Otago regions and the staff of both DHBs as to whether they would support or oppose the establishment of a single DHB for the Southland and Otago regions.

The Southland and Otago DHBs face many of the same challenges and both DHBs have been directed to manage services within the allocated funding from Government. The priority is for funding to be directed towards front line services.

The Southland and Otago DHBs could achieve the following by forming one DHB:

1. Keep health services in the South as close to our communities as possible;
2. Provide our communities with a greater choice of where they can access DHB provided health services;
3. Provide and contract health services that are appropriate, safe and clinically sustainable;
4. Reduce administration and bureaucracy costs so funding can be directed to frontline health services;
5. Improve financial sustainability; and
6. Support our key relationships with the University of Otago, and in particular the Division of Health Sciences.

Southland and Otago DHBs have already been working closely on a formal basis since 2007 under the virtual entity *Southern Alliance,* but still have two separate Governance structures.

The aim of this consultation document is to seek feedback as to whether the communities and staff would support the merging of the two DHBs into a new single DHB. The process of consultation or how feedback can be provided is outlined at the end of this document.

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Introduction

The Southland and Otago District Health Boards (DHBs) are seeking feedback from the communities of the Southland and Otago regions and staff of the Southland and Otago DHBs as to whether they support or oppose the merging to one DHB - rather than the current two – to ensure a more sustainable future of health services.

Both the Southland and Otago DHBs face many of the same challenges and all DHBs have been directed to manage their services within the allocated funding from Government. The priority is for funding to be directed towards front line services.

By combining, the Southland and Otago DHBs can provide more choice on where to access services, help keep services in the South and as close to our communities as possible whilst also making savings through reduced bureaucracy and duplication, and assist to break-even financially.

Southland and Otago DHBs have already been working closely every day since before February 2007 under the virtual entity *Southern Alliance* but still have two separate Governance structures, although almost all board committees now operate jointly. We could be more efficient and effective if we combine the DHBs.

The aim of this document is to seek feedback on whether the communities of the Southland and Otago regions and staff of the DHBs support or oppose the establishment of one DHB for the Southland and Otago regions. This document outlines the challenges both DHBs face, what we are trying to achieve, and the benefits and possible disadvantages of combining the DHBs.

All feedback will be collated and summarised into a report for the DHB Boards to assist their decision making and recommendation to the Minister of Health. A copy of the report will be made available on the Southland DHB and Otago DHB websites.

The process of consultation or how you can provide feedback is outlined at the end of this document.

What is a District Health Board?

A DHB is responsible for the planning and delivery of publicly funded health services in their regions. The statutory purpose of DHBs is to:

- Improve, promote and protect the health of its population, i.e. to promote the integration of health services across primary (community-based) and secondary care (hospital-based) services

- Promote effective care and support for people in need of personal health or disability services

- To reduce health outcome disparities

- Manage national strategies and implementation plans

- Develop and implement strategies for the specific health needs of the local population.

A DHB is governed by a Board of up to 11 members. Up to four members are appointed by the Minister of Health and seven are elected every three years, with the next election in October 2010. The Chair and Deputy Chair are appointed by the Minister of Health.

The Southland and Otago DHBs also have a Regional Executive Management Team which implements the Boards' policies and strategies.

The Southland DHB has about 1,400 staff while the Otago DHB has a staff of about 3,000 people.

Components of a DHB

A DHB has three distinct arms with specific tasks, responsibilities and accountabilities; the Governance Arm, the Funder Arm and the Provider Arm.

Governance Arm

The Boards of the Southland and Otago DHBs have primary responsibility for developing policy and strategy and the overall governance of the Provider and Funder Arms within its region. Three statutory committees support the Board:

- Disability Support Advisory Committee (DSAC)
- Community and Public Health Advisory Committee (CPHAC)
- Hospital Advisory Committee (HAC)

The Boards also have the following committees:

- Audit, Finance and Risk Management (AFRM) Committee
- Mäori Health Governance Committees

Funder Arm

The Funder is primarily responsible for determining health needs, prioritising needs, and allocating the money. The Funder contracts with service providers to achieve the best possible health outcomes for the population. A single planning and funding team operates regionally across Southland and Otago.

- About 50% of funding is applied to traditional hospital and mental health services
- About 50% of funding is distributed to a range of community-based health services, including the rural hospitals based in Oamaru, Balclutha, Dunstan, Ranfurly, Gore and Queenstown, Primary Health Organisations (PHOs) and other Non-Government Organisations' (NGOs) services such as mental health providers, pharmacies and rest homes.

Provider Arm

The Provider Arm services are mostly based at Southland Hospital and Lakes District Hospital in Southland, and Dunedin Hospital and Wakari Hospital in Otago. They include public health, personal health, mental health and some community-based services. A number of community and outpatient services are also delivered from rural centres.

One Governance, Funder and Provider Arm

Following consultation, the two Boards will consider the feedback and if they decide that there should be one DHB, they will make a recommendation to the Minister of Health to change the geographical boundaries of the DHBs so there is only one. This would subsequently result in one Governance function, one Funder and one Provider Arm, but with multiple sites across Southland and Otago.

The Challenges We Face

The Southland and Otago DHBs are required to be clinically and financially sustainable.

- **Clinical Sustainability**
  Our population size, make-up and distribution mean that we do not have large services, particularly for areas of medicine where sub-specialisation is occurring, e.g. ophthalmology. It is difficult to attract staff to smaller services and ensure they can maintain their skills while working with relatively few patients and the types of health and disability issues they may have. Those factors combined make it difficult to keep some services going long-term – which is what we are meaning when we mention the term 'clinical sustainability'.

- **Financial Sustainability**
  Financial sustainability means we are able to operate within the funding provided to us by Government on an ongoing basis.

The Southland and Otago DHBs face a number of similar challenges related to clinical and financial sustainability.

Population

The number of people living in Southland-Otago is forecast to increase only marginally compared to many other DHBs, but the distribution of our population is going to change. Dunedin and the Central Otago/Lakes regions predict low and medium growth respectively over the longer term, with a declining population occurring in many areas, particularly Invercargill, Oamaru, Gore and Balclutha.

High proportion of people older than 75
We have a higher proportion of people older than 75 (6.5%) compared to the national average (5.6%) and this age group is forecast to increase in the next 20 years.

This age group uses more health services than any other age groups and requires a broad range of supports. Southland DHB is already spending about $4.5 million more than the national average and Otago DHB about $9 million more than the national average on support services for older people, such as rest home beds and home support.

Highly sophisticated hospital services
The combined Southland-Otago population for the regions (290,000 from the 2006 Census) is considered only marginally large enough to support sophisticated hospital services such as radiation therapy. Southland and Dunedin Hospitals on their own lack the economies of scale of larger hospitals that support such services.

Small services
There are a number of small services in the current separate DHB structures. These services are vulnerable to the loss of key clinicians potentially leading to the entire service failing. If one or two staff members are ill or on leave this can affect our ability to assess and treat patients in a timely way. Small services also pose difficulties for specialists because they need a certain number of patients with different medical problems to maintain and develop their skills. It can also be difficult for small services to do research and teach students.

Workforce
The current global shortage of health staff means Southland and Otago have difficulty finding health professionals. Even though we think this is the best place in the world to live and work, many clinical staff do not want to work in the south of the South Island, due to geographic and professional isolation. We are competing for highly skilled staff in a competitive global

marketplace where larger economies can provide higher salaries and the benefits of working in large metropolitan areas.

Funding

Health funding is allocated to DHBs under a Population-Based Funding Formula (PBFF). This is a complex calculation which includes parameters such as the number of people living in the DHB's area, whether they live in rural or urban areas, their age, ethnicity and socioeconomic status. The aim of this formula is to ensure equitable funding for all New Zealanders, irrespective of where they live.

Under the PBFF some DHBs have been deemed historically to have been receiving too much funding relative to their counterparts.

In July 2009 Southland and Otago DHBs have been deemed as over funded in comparison to other DHBs, Southland by $3.4 million and Otago by $13.1 million. Although the funding to each DHB is not reduced, the DHBs do not get the same level of additional funding as they might otherwise be entitled to. The funding for our regions is therefore decreasing in real terms compared to some other DHBs until it falls into line with that determined by the PBFF formula as being equitable with other DHBs.

The Government has also signaled uncertainty in the level of future funding increases for health services due to the global economic recession. It is anticipated that further funding will be insufficient to meet cost increases if we continue to work in the same way as we do now. This means that change is essential to our future clinical and financial sustainability. This proposal is one of those initiatives aimed at reducing our ongoing costs to assist our future clinical and financial sustainability.

Messages from Government

The economic crisis of the past year is having a significant impact on the future funding of health services. Treasury says the recession is believed to have lost the country four years of growth and it is not predicting a fast recovery because the international financial turmoil is widespread.

The government has signaled that as a country we simply do not have the resources to continue spending on the public health and disability system at the rate which we have in the past. The Minister of Health the Hon. Tony Ryall has indicated that DHBs must operate within their means and any deficit is unacceptable. DHBs are required to stay within budget while delivering quality health services. For those DHBs with deficits the mechanism that is available to achieve sustainability is the ability to change the way services are delivered.

The government has already recommended that changes in structure take place with the aim of reducing waste and bureaucracy, improving safety and quality, and enhancing clinical and financial viability.

These include new models of patient care, the shifting of resources to the front line by reducing the cost of 'back office' services for DHBs and reducing the duplication of functions carried out across the country. The Health Minister has already told DHBs not to increase the number of managers and administration staff so that funding can be targeted at front line patient care.

Spending

Rural Health Care

By New Zealand standards we have a highly dispersed population over a large area with more than half of the Southland community and about a third of the Otago community living in rural

areas. Rural health services are more expensive to operate. As the services are smaller they have a limited ability to make savings through economies of scale.

Ageing Population and Chronic Disease Increase
Southland and Otago have an ageing population. As people age they develop chronic (long-term) conditions such as heart disease and diabetes – so use health services more and increase health service costs.

Workforce
We are in competition with the rest of the world for skilled healthcare professionals. The DHBs often struggle to recruit staff. Health professionals are a scarce and expensive resource. Staff wage costs comprise about 65% of healthcare costs.

Ultimate Goal

All-in-all our funding and spending in areas that are difficult to control contribute to both DHBs' financial problems. These financial problems will not be solved by just meeting the expectation of no deficit in 2011/12; we need to break even each and every year in the future. While we have a range of initiatives underway to help us break even, long term clinical and financial sustainability is not certain and must be our ultimate goal.

The Southern Alliance

With the Southland and Otago DHBs facing a number of similar challenges, we jointly created the virtual entity Southern Alliance on 1 February 2007. The Southern Alliance allows the DHBs to plan and work more closely together - to provide better health services for southerners using the money available – while remaining legally autonomous as separate DHBs.

Regional Executive Management Team

Through the Southern Alliance, the DHBs now have a single Regional Executive Management Team and share support functions, such as finance (including purchasing), human resources, information technology, and planning and funding. The DHBs also share one Chief Executive Officer.

Regional Clinical Services

The first formal cross-region (Southland-Otago) clinical service set up under Southern Alliance, the Southern Blood and Cancer Service, has been hugely successful for patients. Nearly all patients' waiting times to see cancer and blood specialists were virtually eliminated or dropped significantly after the service was started in December 2007.

Other projects the two DHBs have worked on jointly or are currently working on include:

- Creating more cross-region hospital-based services
- Recruiting staff through the *healthdownsouth* campaign
- Replacing existing school-based dental clinics with state-of-the-art fixed clinics and mobile clinics, using Ministry of Health funding allocated specifically for that purpose
- Having one laboratory service for both hospital and community laboratory services in Otago-Southland – labs test body fluids and tissue to help diagnose and treat people's

conditions. The savings from having one laboratory service are over $4 million per year for 10 years.
- Planning how to deal with increasing numbers of people with long-term illnesses
- Planning for sustainable rural hospital services

Southland and Otago also have one public health service across both regions (Public Health South) and one breast care service.

The Southland and Otago DHBs consulted with staff across both organisations in December 2008 on the concept of further regional clinical services. The vast majority of the submissions were positive and supportive of the concept. Based on the feedback the Boards supported the recommendation to proceed with planning for Regional Clinical Services and this planning is now well underway.

Combining to make more clinical services a regional service will mean that our communities have more equitable access to sustainable services as close to their home as is practically possible.

Our small population and some small services pose challenges for both DHBs. By combining services so that they are regional would result in less disruption in assessing and treating people. Clinicians would be combined into one service, increasing the total pool of medical staff available and reducing vulnerability to staff illness and leave. There would also be better peer support for staff and sharing of clinical information; with the outcome for patients being that the best possible clinical practice approach in health care delivery is utilised.

What are we trying to achieve?

Clear message of change required

The message is clear that Southland and Otago DHBs, like all DHBs across the country, need to significantly change the way we do things so we can operate within budget while providing quality health care. The work at national and South Island levels indicates the need to work together more effectively with neighboring DHBs.

This message has also been conveyed by the Minister of Health in a letter approving both Southland and Otago DHBs' separate 2009/10 District Annual Plans. He states that "I expect to see a high degree of collaboration with other South Island DHBs" (Hon Tony Ryall, August 2009).

Clinical and Financial sustainability

Southland and Otago DHBs are facing critical issues of clinical and financial sustainability of health services. What we are trying to achieve is six-fold:

1. to keep health services in the South as close to our communities as possible;
2. provide our communities with a greater choice of where they can access DHB provided health services;
3. to provide and contract for health services that are appropriate, safe and clinically sustainable;
4. reduce administration and bureaucracy costs so funding can be directed to maintain frontline health services;
5. to be financially sustainable for the long term; and
6. support our key relationships with the University of Otago and in particular the Division of Health Sciences.

We want to be responsive to our communities' expectations and needs. We believe having one southern DHB will help us do that. We also want to be proactive – so we get to make the necessary decisions and changes for ourselves.

One DHB is only one of our initiatives

We have a range of initiatives already underway to improve clinical service delivery and the quality of care provided. Examples of such initiatives are the move to regionalise more hospital-based services and planning how we will deal with the increasing numbers of people with long-term illnesses. In the community, the recent decision by the Boards to reduce the number of PHOs is another example.

The establishment of one DHB across the two regions is an initiative that will enable us to preserve and enhance front line health services by helping reduce the financial gap so we can meet the requirement to break even from 2011/12.

Health service planning

The six South Island DHBs are currently working together to plan long-term, sustainable health services across the mainland with an initiative called the South Island Health Services Plan.

All six DHBs recognise that closer links with all our South Island DHB neighbours is vital for on-going future service sustainability. The plan is examining what health services need to look like in the future to ensure that people across the South Island have an equal opportunity to get the health services they need within the South Island, our overall population being both small and relatively static compared to the North Island.

Benefits of One DHB

There are a number of benefits to forming one DHB, these are as follows.

Greater Choice

Under one DHB people accessing DHB provided health services will have a choice on where they can access the service regardless of whether they live in Southland or Otago. For example, people who live in Queenstown and require chemotherapy currently have to access the service at Invercargill Hospital due to funding allocation. If there were one DHB they may choose to access elements of the service at Dunstan Hospital rather than travel further to Invercargill. There is a greater choice of where people can access health services that is suitable to their lifestyle.

Strengthened Relationships

The proposal for one DHB would mean the Southland community would also receive the benefit that the Otago community reaps with the relationship between the Otago DHB and the University of Otago. The relationship enhances the quality of the teaching, research and health care services offered by the two institutions. The outcome for patients is that the best possible clinical practice approach is utilised in the health services they receive.

Keeping Services – Clinical Sustainability

The larger combined population base from the two regions will help keep health services in the South and as close to our communities as possible. This particularly applies to the more sophisticated hospital-based services such as radiation therapy.

As previously mentioned under the Southern Alliance by combining clinical services within Southland and Otago there is a larger pool of staff in smaller services which will help overcome the difficulties that these services currently face.

Financial Sustainability

One DHB for Southland and Otago is one of a number of initiatives that will help us to become financially viable for the long-term. Both Southland and Otago DHBs face less funding due to the Population Based Funding Formula, and less of a percentage increase to keep up with rising costs. Combined with increased costs that are difficult to control, such as the needs of our aging population and the increasing incidence of chronic disease, the Southland and Otago DHBs need to proactively make changes to the way we provide services.

If we were to combine we would save a significant amount of money each and every year and these savings can ultimately be redirected back to front-line health services.

Savings

The potential direct annual savings, each and every year, are estimated at over $500,000. This is attributable to reduced Board and Committee fees, election costs, internal and external audit fees, certification and accreditation costs, and administration. We acknowledge the identified savings are small in the overall scheme of the budgets being managed by the Southland and Otago DHBs but nevertheless it is a significant benefit.

Other significant financial benefits not yet quantified will include sharing more costs, simplifying the management structure across hospital-based services, reducing duplication in accounting processes by unifying management and annual financial reporting needs and halving management time in Board meetings. It is anticipated that these indirect cost savings will equal or exceed the more easily identified direct savings.

Savings in these areas will ultimately mean that money can be directed to improving frontline services for our communities.

Less duplication

A one DHB structure will reduce duplication.

Most committees already meet jointly, and the DHBs have common Board/Committee members. However, more meetings could be held jointly under one southern DHB which would avoid duplication and save money.

Having one board would streamline decision-making and ensure messages to the regional management team were clear and more immediately actionable. Issues would be addressed once rather than by two boards meeting in different places and at different times. This means that bureaucracy does not hold up important decisions that impact on the delivery of health care.

A single DHB would simplify contracting – for hospital supplies, community-based mental health and disability support services, etc. Some contracts have to be considered by both the Southland and Otago Boards, which meet separately. There will be benefits for providers operating in both Otago and Southland; less reporting to the DHB, and fewer audits.

Having one Board would mean less duplication for other agencies or organisations such as the Ministry of Health, Crown Health Financing Agency, District Health Boards New Zealand, Unions, and Audit New Zealand. That duplication is particularly evident during our business planning rounds (District Annual Plan, Statement of Intent and District Strategic Plan). A single DHB would also have a significant reduction in the amount of reporting to the Ministry of Health currently experienced under the regional (back-office functions such as Planning & Funding and Human Resources) model for the two DHBs.

Accounting practices would be simplified with one DHB. Recording and splitting costs for each DHB – especially for services and expenses they already share – is complex and time-consuming. It is also sometimes difficult to interpret the complex information.

Economies of Scale

When negotiating to purchase supplies, such as bandages and catheters, or for services, such as supply of clean linen to the hospitals, we are better positioned to negotiate a more competitive contract because our purchasing power has increased.

Organisational Culture

From the perspective of engaging the hearts and minds of employees, the move to one Board would validate and complete the messages of the last few years. A clear statement of vision for the region (e.g. we are one) will stabilise both organisations by providing compatibility between the everyday, operational activities and the long-term regional vision.

Under one DHB, Southland Hospital and Dunedin Hospital would remain distinct. However, the move to one DHB would embed a culture of one organisation with one vision, improving clinical and financial sustainability for the region.

Should we proceed with one DHB consideration will be given to the name, logo, branding, etc., of the combined DHB to convey the clear message that 'we are one'.

Possible Concerns

Unequal Representation

Local communities may feel that there is some potential to lose representation and the ability to influence decision making about health governance and delivery. This already occurs within the individual Southland and Otago regions under STV (Single Transferable Vote) as there is no assurance that urban and rural areas are represented in proportion to their community sizes. In the Otago region the STV system has resulted in the opposite to what may be expected, with greater representation of Board members from outside Dunedin (see Appendix 2 for the full list of Board members and where they reside).

The establishment of a single DHB across both Southland and Otago will not be a take-over and it will not only be about cost-cutting. It will be about making the most of our combined resources to provide the best possible health service to all our communities. Each community can vote for their representatives to become Board members during the elections every three years and each member is accountable to the Minister of Health, both individually and collectively as a Board.

Increased travel costs and logistics

The combined region is geographically large and Board and Committee members will face increased travel for meetings which will cause some logistical and cost issues. However, video-conferencing technology and the reduction in overall meetings will help mitigate this.

Differences in Organisational Culture and approaches

Differences in the culture and approaches within each DHB may be deeply held and difficult to overcome meaning some staff do not buy-in to a single DHB and keep a narrower provincial focus.

It is important that we acknowledge that differences are accepted and celebrated while also ensuring those differences do not affect or prevent our communities getting the best possible access and quality of health care.

Cost to implement one DHB

There will be some one-off costs involved in establishing one DHB across the two regions. These have not been examined at this stage although possible examples include items such as new logos and signage. These costs are not anticipated to be significant and would not out-weigh the identified ongoing clinical and financial sustainability benefits.

Possible uncertainty for staff

Some staff may feel anxious as this paper does not cover the details of changes to service structure that may evolve in the move from two DHBs to one. If the establishment of one DHB goes ahead there will be further consultation processes with staff and unions about how the move to one DHB is implemented. If one DHB were to occur the likely change will be that all staff employed by either the Southland or Otago DHBs will have a change of employer to the newly formed one DHB.

Regional clinical services will continue to progress and evolve whether there are two DHBs or whether they combine into one DHB and consultation regarding this will occur as required.

How to achieve a single DHB – the process

There are two main activities that need to occur:

1. Consultation with the Southland and Otago communities and staff of the Southland and Otago DHBs. All submissions and feedback will be collated and summarised into a report to assist the Boards in their decision making.

2. If the Boards decide to proceed the next step is to request the Minister of Health to seek an Order in Council for a boundary change uniting the Boards. Once the boundary change comes into force, Board members from both DHBs would constitute one united Board until the next nationwide board elections in October 2010.

Consultation Process

You can make a submission on this consultation by:

- Attending one of the public meetings scheduled during November 2009 and stating your views, which will be recorded.

  Meetings are scheduled in:

  - Dunedin — 5th November at 4.30pm in the Fulwood Room, The Dunedin Centre
  - Oamaru — 5th November at 7.30pm in the Lindis Room, Kingsgate Brydone Hotel
  - Balclutha — 10th November at 4.30pm at the Rose Bank Lodge
  - Alexandra — 10th November at 7.30pm in the Centennial Court Motor Inn
  - Queenstown — 11th November at 7.30pm in the Wakatipu St John Rooms
  - Invercargill — 12th November at 5.30pm in the Oreti Room, Ascot Park Hotel
  - Wanaka — 13th November at 12.00pm in the Summit Room at the Edgewater Resort, Sargood Drive
  - Gore — 16th November at 4.30pm in the Lecture Theatre, James Cumming Wing of the Gore District Council
  - Lumsden — 16th November at 7.30pm in the Lumsden Memorial Hall, 8 Meadow St (access through the Supper Room Door)
  - Tuatapere — 17th November at 4.30pm in the Hall, Tuatapere Community College
  - Te Anau — 17th November at 7.30 pm in the Lounge at the Fiordland Events Centre

- The DHBs will consult with Maori through established runanga relationship links. You may attend hui in Otago and Southland. Details of these meetings will be determined by the runanga.

- Making a written submission by 5pm Friday 11 December 2009. While we have attached a questionnaire (Appendix 1) to help you in providing your views all written submissions will be accepted.

  Send hard copy to:

  Viv Allen-Kelly
  EA to Regional CEO
  Private Bag 1921
  Dunedin 9054

- Electronic copy: Completing the consultation questionnaire online using the link http://feedback.osdhbs.govt.nz/ or the DHB's websites (www.southlandhealth.co.nz or www.otagodhb.govt.nz).

Further details of this consultation, including the meeting schedule, plus electronic copies of the discussion document and questionnaire are available from both the Otago DHB website (www.otagodhb.govt.nz) and the Southland DHB website (www.southlandhealth.co.nz).

Any queries on the consultation process can be made to Viv Allen-Kelly on 03 4709154.

All questionnaires and submissions will be collated and summarised into a report for the DHB Boards to assist their decision making and recommendation to the Minister of Health. A copy of the report will be made available on the Southland DHB and Otago DHB websites.

Appendix 1

- Questionnaire –

Consideration to Combine the Southland District Health Board and Otago District Health Board

The Southland District Health Board and the Otago District Health Board (DHBs) are considering uniting under one DHB - rather than the current two – to ensure a more sustainable future of health services.

We are seeking your feedback on the consideration to combine the DHBs.

This questionnaire is to help you to provide your views. If you require more space to write your comments please use additional paper and attach it to the questionnaire.

All written submissions will also be accepted if you do not wish to use the questionnaire.

Your submission will be available publicly unless you specifically indicate you want your name withheld as a Questionnaire/Submission contributor.

1. In which region do you normally reside? Please circle one of the following:

   Southland Otago

2. Are you answering this questionnaire on behalf of yourself or an organisation? Please circle one of the following:

   Individual Organisation

3. If you are answering on behalf of an organisation, what is the name of the organisation?

4. Are you a staff member of the Southland DHB or Otago DHB? Please circle one of the following:

   Yes No (if you answered 'No' please go to Question 6)

5. If you are a staff member, as indicated in Question 4 above, which DHB is your primary or domicile employer? Please circle one of the following:

   Southland DHB   Otago DHB

6. Do you support the establishment of one southern DHB in place of the Southland DHB and Otago DHB? Please circle one of the following:

   Yes   No   Not Sure

7. Please state your reasons why you answered the way you did in Question 6 above (bullet-point style is acceptable here).

8. Are there possible disadvantages of creating one DHB that have not been considered in the consultation document? (Bullet-point style is acceptable)

9. Of the disadvantages, that you mentioned in Question 8 above, what could the Southland DHB and Otago DHB do to ensure these are either minimised or overcome? (Bullet-point style is acceptable)

10. Are there benefits of creating one DHB that have not been considered in the consultation document? (Bullet-point style is acceptable)

11. If you have any further comments please write them below (Bullet-point style is acceptable)

12. Name:

Address: and/or Contact details:

13. We may wish to attribute your views to you in our report to the DHB Boards. Do you wish your name/details to be withheld from the summary report to the DHB Boards?

Yes No

Submit your completed questionnaire or written submission by 5pm Friday 11 December 2009.

Send hard copy to:

Viv Allen-Kelly
EA to Regional CEO
Private Bag 1921
Dunedin 9054

Electronic copy:

Can be completed on-line through the link:

http://feedback.osdhbs.govt.nz/

Or on both DHB websites:

www.southlandhealth.co.nz or

www.otagodhb.govt.nz

All questionnaires and submissions will be collated and summarised into a report for the DHB Boards to assist their decision making and recommendation to the Minister of Health. A copy of the report will be made available on the Southland DHB and Otago DHB websites.

Appendix 2, Board Members

Southland DHB Members

Sajan Bhatia	Invercargill (e)
Neville Cook	Invercargill (e)
Kaye Crowther	Invercargill (e)
Karen Goffe	Invercargill (a)
Susie Johnstone	Balclutha (a)
Fiona McArthur	Queenstown (e)
Paul Menzies	Winton (e)
Katie O'Connor	Kingston Crossing, Gore (e)
Tahu Potiki	Portobello, Dunedin (a)
Tim Ward	Invercargill (a)
Dot Wilson	Invercargill (e)

Otago DHB Members

Helen Algar	Oamaru (a)
Peter Barron	Dunedin (e)
Louise Carr	Dunedin (e)
Susie Johnstone	Balclutha (a)
Malcolm Macpherson	Alexandra (e)
Judith Medlicott	Dunedin (e)
Errol Millar	Ranfurly (a)
Tahu Poitiki	Portobello, Dunedin (a)
Louise Rousson	Cromwell (e)
Branko Sijnja	Balclutha (e)
Richard Thomson	Dunedin (e)

An 'a' or 'e' denotes whether the Board member is appointed by the Minister of Health or is elected by the community.