Southern District Health Board

DISABILITY SUPPORT ADVISORY COMMITTEE
and
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

A G E N D A

Tuesday, 4 February 2014
10.00 am

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

Our Vision:
Better Health, Better Lives, Whānau Ora

Our Mission:
We work in partnership with people and communities to achieve their optimum health and wellbeing. We seek excellence through a culture of learning, inquiry, service and caring.

DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Tuesday, 4 February, 10.00 am

Board Room, Level 2, Main Building,
Wakari Hospital, Dunedin

A G E N D A

Closed Session:

RESOLUTION:
That the Disability Support Advisory Committee and Community & Public Health Advisory Committees 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 34, Schedule 4 of the NZ Public Health and Disability Act 2000 for the passing of this resolution are as follows:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that 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)(i), 9(2)(j) and 9(2)(f)(iv) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations, and to maintain the constitutional convention protecting the confidentiality of advice tendered by Ministers of the Crown and officials.
2. Annual Plan – Verbal Update	Plan is subject to Ministerial approval.	As above, sections 9(2)(f)(iv) and 9(2)(j).
3. Wakatipu Reference Group Update	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, section 9(2)(j).

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Joe BUTTERFIELD (Chairman)	21.11.2013 06.12.2010	Membership/Directorship/Trusteeship: 1. Beverley Hill Investments Ltd 2. Footes Nominees Ltd 3. Footes Trustees Ltd 4. Ritchies Transport Holdings Ltd (alternate) 5. Ritchies Coachlines Ltd 6. Ritchies Intercity ltd 7. Robert Butterfield Design Ltd 8. SMP Holdings ltd 9. Burnett Valley Trust 10. Burnett Family Charitable Trusts **Son-in-law:** 11. Partner, Polson Higgs, Chartered Accountants. 12. Trustee, Corstorphine Baptist Community Trust	1. Nil 2. Nil 3. Nil 4. Nil 5. Nil 6. Nil 7. Nil 8. Nil 9. Nil 10. Nil 11. Does some accounting work for Southern PHO. 12. Has a mental health contract with Southern DHB.
John CHAMBERS	09.12.2013	1. Employee Southern DHB and Vice President of ASMS (Otago Branch) 2. Employed 0.1 FTE as an Honorary Lecturer of the Dunedin Medical School 3. Director of Chambers Consultancy Ltd **Wife:** 4. Employed by the Southern DHB (NIR Co-ordinator) **Daughter:** 5. Employed by the Southern DHB (Radiographer)	1. 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. 2. Possible conflicts between SDHB and University interests. 3. Consultancy includes performing expert reviews and reports regarding patient care at the request of other DHBs and the Office of the Health and Disability Commissioner.
Neville COOK	04.03.2008 26.03.2008	1. Councillor, Environment Southland. 2. Trustee, Norman Jones Foundation.	1. Nil. 2. Possible conflict with funding requests.
Sandra COOK	01.09.2011	1. Te Runanga o Ngāi Tahu	1. Holds a "right of first refusal" over certain Crown properties. Also seen as a Treaty partner and affiliates may hold contracts from Southern DHB from time to time.
Kaye CROWTHER	09.11.2007 14.08.2008 12.02.2009	1. Employee of Crowe Horwath NZ Ltd 2. Trustee of Wakatipu Plunket Charitable Trust. 3. Corresponding member for Health and Family Affairs, National Council of Women.	1. Possible conflict if DHB contracts HR services from JCL and Progressive Consulting, which are subsidiaries of Crowe Horwath NZ Ltd 2. Nil.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	05.09.2012 01.03.2012	4. Trustee for No 10 Youth Health Centre, Invercargill. 5. DHB representative on the Gore Social Sector Trial Stakeholder Group.	3. Nil. 4. Possible conflict with funding requests. 5. Nil.
Mary GAMBLE	09.12.2013	1. Member, Rural Women New Zealand.	1. RWNZ is the owner of Access Home Health Ltd, which has a contract with the Southern DHB to deliver home care.
Anthony (Tony) Evan HILL	09.12.2013	1. Chairman, Southern PHO Community Advisory Committee and ex officio Southern PHO Board. 2. Secretary/Manager, Lakes District Air Rescue Trust. 3. Community Representative, National Health Board Review Group, Lakes District Hospital. **Daughter:** 4. Registrar, Dunedin Hospital.	1. Possible conflict with PHO contract funding. 2. Possible conflict with contract funding. 3. Possible conflicts between Southern DHB and local Lakes District Hospital community interests.
Tuari Lyall POTIKI	09.12.2013	1. University of Otago staff member. 2. Deputy Chair, Te Rūnaka o Ōtākou. 3. Chair, NZ Drug Foundation. **Wife:** 4. CEO of Māori Health Provider, Otepoti.	1. Possible Conflicts between Southern DHB and University interests. 2. Possible conflict with contract funding. 3. Nil. 4. Possible conflict with contract funding.
Branko SIJNJA	07.02.2008 04.02.2009 22.06.2010 07.06.2012	1. Director, Clutha Community Health Company Limited. 2. 0.8 FTE Director Rural Medical Immersion Programme, University of Otago School of Medicine. 3. 0.2 FTE Employee, Clutha Health First General Practice. 4. Director of Southern Community Laboratories.	1. Operates publicly funded secondary health services under contract to Southern DHB. 2. Possible conflicts between Southern DHB and University interests. 3. Employed as a part-time GP.
Richard THOMSON	13.12.2001 23.09.2003 29.03.2010 06.04.2011 21.11.2013	1. Managing Director, Thomson & Cessford Ltd. 2. Chairperson and Trustee, Hawksbury Community Living Trust. 3. Trustee, HealthCare Otago Charitable Trust. 4. Chairman, Composite Retail Group. 5. Councillor, Dunedin City Council. 6. Two immediate family members are employees of Dunedin Hospital (Radiographer and Anaesthetic Technician).	1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it. 2. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB. 3. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations. 4. May have some stores that deal with Southern DHB.
Tim WARD	14.09.2009	1. Partner, BDO Invercargill, Chartered Accountants.	1. May have some Southern DHB patients and staff as clients.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	01.05.2010 01.05.2010 10.12.2012	2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT). 4. Director of Southern Community Laboratories Otago-Southland.	2. Verdon is a participant in the employment incubator programme. 3. Supply of goods and services between Southern DHB and SIT.
Janis Mary WHITE (Crown Monitor)	31.07.2013	1. Member, Pharmac Board. 2. Chair, CTAS (Central Technical Advisory Service).	

SOUTHERN DISTRICT HEALTH BOARD

DISABILITY SUPPORT ADVISORY COMMITTEE
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE
APPOINTED MEMBERS

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Stuart HEAL	16.07.2013	1. Chair, Southern PHO 2. Director, Positiona Ltd 3. Director, NZ Cricket 4. Director, Pioneer Generation Ltd 5. Chair, University Bookshop Otago Ltd 6. Director, Southern Rural Fire authority 7. Director, Triple Seven Distribution Ltd 8. Director, Speak Easy Cellars Ltd 9. Board Member, Otago Community Hospice	1. PHO is contracted to the Southern DHB. 9. Hospice provides contracted services for Southern DHB.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at November 2013

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Peter Beirne	20.06.2013	Nil	
Richard Bunton	17.03.2004 22.06.2012 29.04.2010	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd. 5. Chairman, Board of Cardiothoracic Surgery, RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	1. The only potential conflict would be if the Southern DHB decided to use this product for Southern DHB functions. 2. This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract. 3. This company provides private cardiological services to Otago and Southland. A potential conflict would exist if the Southern DHB were to contract with this company. 4. This company is one used for personal trading and apart from issues raised in '2' no conflict exists. 5. No conflict. 6. No conflict. 7. No conflict.
Donovan Clarke	02.02.2011 18.12.2012 05.04.2013 26.08.2013	1. Te Waipounamu Delegate, Te Piringa, National Maori Disability Advisory Group. 2. Director, Great Western Steakhouse, New Lynn, Auckland. 3. The Child and Youth Health Compass Steering Group. 4. Cancer Care Co-ordinator Evaluation Advisory Group. 5. Chairman, Te Herenga Hauora (Regional Māori Health Managers' Forum)	1. Nil. 2. Nil. 3. Nil. 4. Nil. 5. Nil.
Carole Heatly	14.03.2012	Nil.	
Sharon Kletchko		1. GM Strategy & Planning Nelson Marlborough DHB	

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
		2. Chair, SI Alliance GMs P&F Network (supported by SIAPO) 3. Chair, National GMs P&F Network (supported by DHBSS) 4. Member, SIA Service Planning & Integration Team 5. Member, Southern Cancer Network Steering Group 6. Member, National Cancer Coordination Steering Group 7. Deputy Chair NZ Standards Council 8. Registered Health Professional - Specialist Medical 9. Member Royal Australasian College of Physicians (RACP) - NZ Executive 10. Deputy Chair RACP - NZ Policy and Advocacy Committee 11. Chair, Medicines Review Statutory Committee (Minister of Health appointment) 12. Member, Named Pharmaceutical Patient Access (NPPA) Panel 13. Board Member, EVIDEM Collaboration (International group on multi-criteria decision-making)	
Lexie O'Shea	01.07.2007	1. Trustee, Gilmour Trust.	1. Southland Hospital Trust.
Lynda McCutcheon	22.06.2012	1. Member of the University of Otago, School of Physiotherapy, Admissions Committee.	1. Lead contact for University of Otago undergraduate clinical placements (Allied Health, Scientific & Technical professions) in Southern DHB.
John Pine	17.11.201	Nil.	
Leanne Samuel	01.07.2007 01.07.2007	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel.	1. Southland Hospital Trust. 2. Nil.
David Tulloch	23.11.2010	1. Southland Urology (Director). 2. Southern Surgical Services (Director).	1. Potential conflict if DHB purchases services. 2. Potential conflict if DHB purchases services.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	02.06.2011 17.08.2012	3. UA Central Otago Urology Services Limited (Director). 4. Trustee, Gilmour Trust.	3. Potential conflict if DHB purchases services. 4. Southland Hospital Trust.

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 6 November 2013, commencing at 10.00 am, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Dr Malcolm Macpherson	Chairman
	Mr Neville Cook	
	Ms Sandra Cook	
	Mrs Kaye Crowther	
	Mrs Mary Flannery	
	Mr Stuart Heal	
In Attendance:	Mr Joe Butterfield	Board Chair
	Dr Sharon Kletchko	Executive Director, Strategy Integration & Funding
	Ms Carole Heatly	Chief Executive Officer (from 10.40 am)
	Mrs Lexie O'Shea	Deputy CEO/Executive Director Patient Services (from 10.20 am)
	Mr Peter Beirne	Executive Director Finance
	Mr Ian Macara	Chief Executive, Southern PHO
	Dr Keith Reid	Medical Officer of Health (until 11.55 am)
	Mr David Tulloch	Chief Medical Officer
	Ms Sharon Adler	Portfolio Manager, Health of Older People, Planning & Funding (until 11.55 am)
	Ms Gemma Griffin-Dzikiewicz	Portfolio Manager, Mental Health, Addiction & Intellectual Disability, Planning & Funding (until 11.55 am)
	Mr Glenn Symon	Service Development Manager, Planning & Funding
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chairman welcomed everyone to the last meeting of the Committees for the triennium.

2.0 APOLOGIES

There were no apologies.

3.0 MEMBERS' DECLARATION OF INTEREST

Dr Macpherson informed the Committees that there were a number of items on the agenda relating to primary care that he had an interest in.

Mr Cook requested that the Invercargill Licensing Trust (ILT) and ILT Foundation be removed from his entry in the Interests Register.

It was resolved:

"That the Interests Register be noted."

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the joint meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on 1 August 2013 be approved and adopted as a true and correct record."

5.0 ACTION SHEET

The Committees reviewed the action sheet (agenda item 5) and noted management's advice:

- That the rural trusts would be invited to present to the Committees when the Rural Health Strategy was finalised;
- That progress reports on the implementation of the restorative model of Home and Community Support Services would be submitted to every second meeting;
- That the wording of the smokefree clauses in NGO contracts had not changed from that approved by the Board.

6.0 COMMITTEE REPORTING FRAMEWORK

The Executive Director, Strategy, Integration & Funding outlined a proposed reporting framework, which was designed to provide the Committees with an overview of DHB performance and progress on actions in the Annual Plan (agenda item 6).

The Committees:

- Requested that, as well as a focus on targets, achievements and impacts, they be kept informed of activities and changes occurring in the community that their constituents were likely to raise with them;
- Expressed the view that DSAC/CPHAC should meet monthly in the new triennium, given the issues that would be facing the incoming Board;
- Agreed that the PHO and SHALT should submit monthly reports.

It was resolved:

"That the proposed reporting measures and timeframes be approved and adopted by the incoming Disability Support and Community & Public Health Advisory Committees."

Mrs Lexie O'Shea, Deputy CEO/Executive Director Patient Services, joined the meeting at 10.20 am.

7.0 SOUTHERN HEALTH ALLIANCE

The Committees considered a report from Prof Robin Gauld, Independent Chair of the Southern Health Alliance Leadership Team (SHALT), on SHALT activities and progress to date.

The Executive Director Strategy, Integration & Funding highlighted SHALT's work plan priorities (item 9), which are: (1) care co-ordination, (2) after hours and acute demand and, (3) referrals for laboratory, imaging and diagnostics.

Members observed that to achieve the transformational change required to align primary and secondary care, the SHALT would need to focus on the big picture by maintaining a "helicopter" view.

It was resolved:

"That the report be noted."

8.0 ANNUAL PLAN PROGRESS

Health of Older People

Ms Sharon Adler, Portfolio Manager, presented her report on Health of Older People initiatives, which included an update on the implementation of the restorative model for home and community support services (agenda item 8).

A graph depicting home care support services and aged residential care funding and expenditure by DHB was tabled.

Ms Carole Heatly, Chief Executive Officer, joined the meeting at 10.40 am.

In response to questions from members, management advised:

- That all new clients were InterRAI assessed and 70% of the remainder had been InterRAI assessed. The goal was to achieve 100% before June 2013;
- The provider transfer process had been monitored closely to ensure no clients were overlooked.

It was resolved:

"That the report be noted."

9.0 SOUTHERN PRIMARY HEALTH ORGANISATION

Dr Macpherson reminded the Committees of his interest in the topics covered under this item.

Mr Ian Macara, Chief Executive, Southern PHO, presented a report on Southern PHO strategic and governance matters, an update on programmes and operational activity, and the PHO's financial position (agenda item 10), then took questions from members.

The Committees were informed:

- That the Integrated Performance and Incentive Framework (IPIF) would replace the PHO Performance Programme, and would recast expectations of primary care providers, and DHB and PHO performance measurement;

- That the PHO had circulated a proposal on under six year-olds and after-hours care in Invercargill, and it was hoped that these issues would be solved through a collaborative approach;

- That more should be known about the detail of the new rural ranking score within the next couple of months and it was likely that ACC funding would be aligned to the new ranking score.

It was resolved:

"That the report be noted."

10.0 SOUTHERN DHB PHARMACEUTICAL EXPENDITURE

The Committees received a presentation from Dr Sharon Kletchko, Executive Director, Strategy Integration and Funding, outlining Southern DHB's pharmaceutical budget and expenditure (*copy attached*).

The Chief Medical Officer advised that pharmaceutical expenditure should not be viewed in isolation, as drug treatment could prevent costly hospital care, eg in rheumatoid arthritis.

The Committees requested that comparative DHB drug costs be defined per head of population in future reporting.

It was resolved:

"That the presentation be noted."

11.0 SMOKEFREE/AUAHI KORE POSITION STATEMENT

Dr Keith Reid, Medical Officer of Health, presented a report and recommendations on the adoption of a Smokefree/Auahi Kore position statement (agenda item 11).

The Committees suggested that the position statement be moved to the start of the document, so the DHB's position is clear to the public.

It was resolved:

"That the Disability Support and Community and Public Health Advisory Committees:

1. **Endorse the draft Southern DHB Smokefree/Auahi Kore position statement;**

2. **Recommend that the Board adopt the draft Southern DHB Smokefree/Auahi Kore position statement, noting that there will be some re-ordering of the content."**

12.0 PORTFOLIO REPORTS

Raise HOPE Implementation

Ms Gemma Griffin-Dzikiewicz, Portfolio Manager, Mental Health, Addiction & Intellectual Disability, presented a progress report on the implementation of Raise HOPE (Health Outcomes, Performance and Equity): Hapaia te Tumanako – Southern DHB's Mental Health and Addiction Strategic Plan (agenda item 12), then took questions from members.

Copies of Future Directions (the Southland mental health and addictions network) *Strategic Quality Plan 2013-14* were tabled.

It was resolved:

"That the report be noted."

Public Health South Report

The Committees considered a report on Public Health service activity for June to September 2013.

It was resolved:

"That the report be noted."

13.0 FINANCIAL REPORT

The Executive Director Finance presented the Funder Financial Report for the period ended 30 September 2013 (agenda item 13), then took questions from members.

Pharmaceutical Expenditure

Management advised that a revised forecast had been received in August, which predicted there would be 14,000 patients with complex long-term conditions who would be managed by community pharmacies, however the actual numbers were around 8,000. The forecast had therefore been revised down and numbers were being monitored closely.

Disability Support

The Executive Director of Finance informed the Committees that there had been a double payment to a provider in May, which had adversely affected the previously reported Disability Support expenditure and forecast. This had now been corrected.

It was resolved:

"That the report be noted."

CONFIDENTIAL SESSION

At 11.55 am it was resolved that the public be excluded for the following agenda items:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that 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)(i), 9(2)(j) and 9(2)(f)(iv) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations, and to maintain the constitutional convention protecting the confidentiality of advice tendered by Ministers of the Crown and officials.
2. Laboratory Contract	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and (j).
3. PACT Group Contract Update	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and (j).

The meeting closed at 12.35 pm.

Confirmed as a correct record:

Chairman .....

Date .....

SDHB Pharmaceutical Management

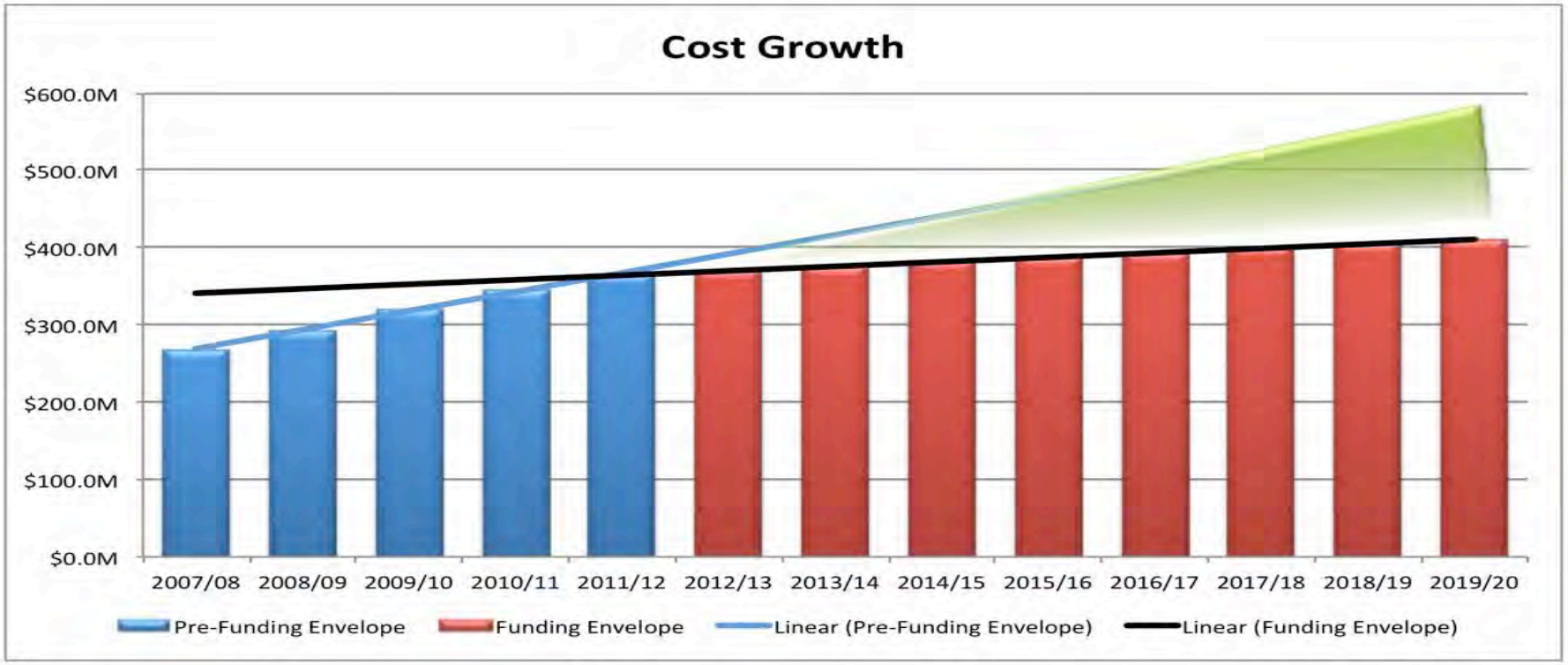
CPHAC/DSAC & SDHB Board

06 Nov 2013

The Challenge

1. The PHARMAC national forecast indicates that the SDHB is tracking towards a lower expenditure on the Pharmaceutical budget for 2013/14 than previous years (the forecast decrease is a result of national policy changes (co-payment changes) and PHARMAC investment decisions) .
2. Locally dispensing and community pharmacy fees are still increasing
3. The SDHB has limited room for direct/ swift action to reduce the Pharmaceutical budget moving forward.
4. Immediate action to manage cost growth going forward requires **a whole of system approach**, to ensure safe, effective use and supply of pharmaceuticals,.

National Envelope (Community Pharmacy)

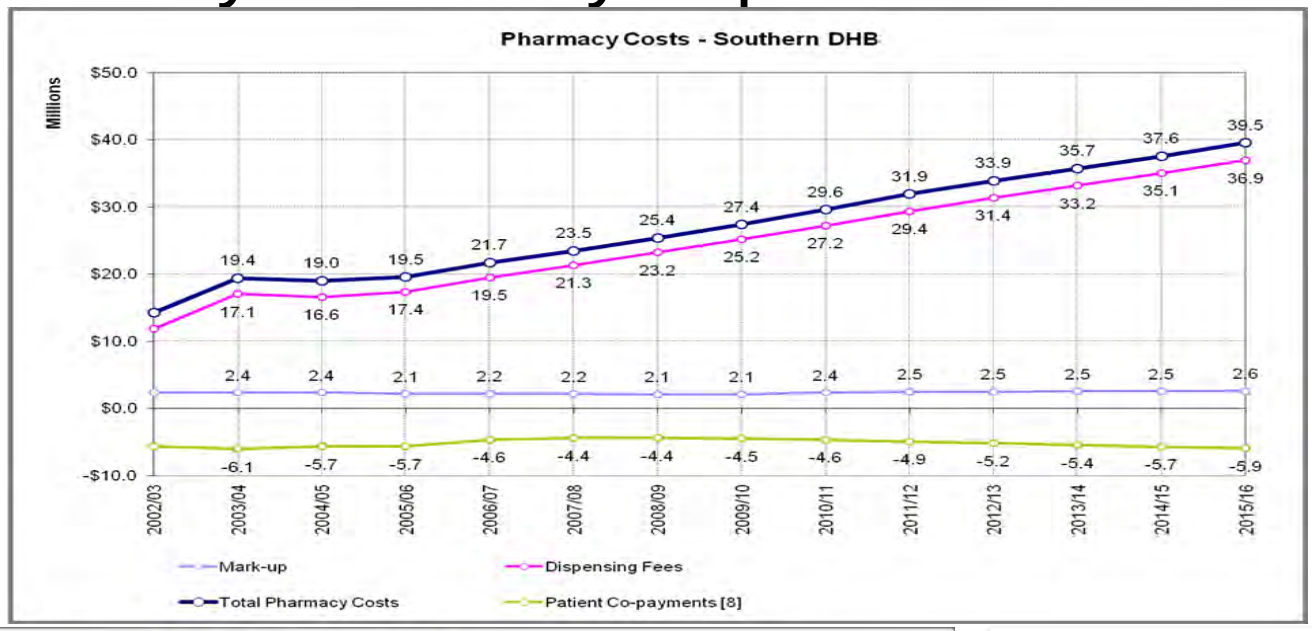


Impact of the national envelope for Community Pharmacy Services

- the national envelope has reduced the growth in expenditure.
- The chart above highlights the savings DHBs have made against the forecast of expenditure compared to before the current agreement (CPSA) and the actual expenditure.
- DHBs have agreed to the national envelope as part of the current CPSA. The current agreement is due to expire in 2015.

Community Pharmacy Expenditure

Chart A: The forecast community pharmacy expenditure for SDHB under the term and conditions of the previous pharmacy agreement.



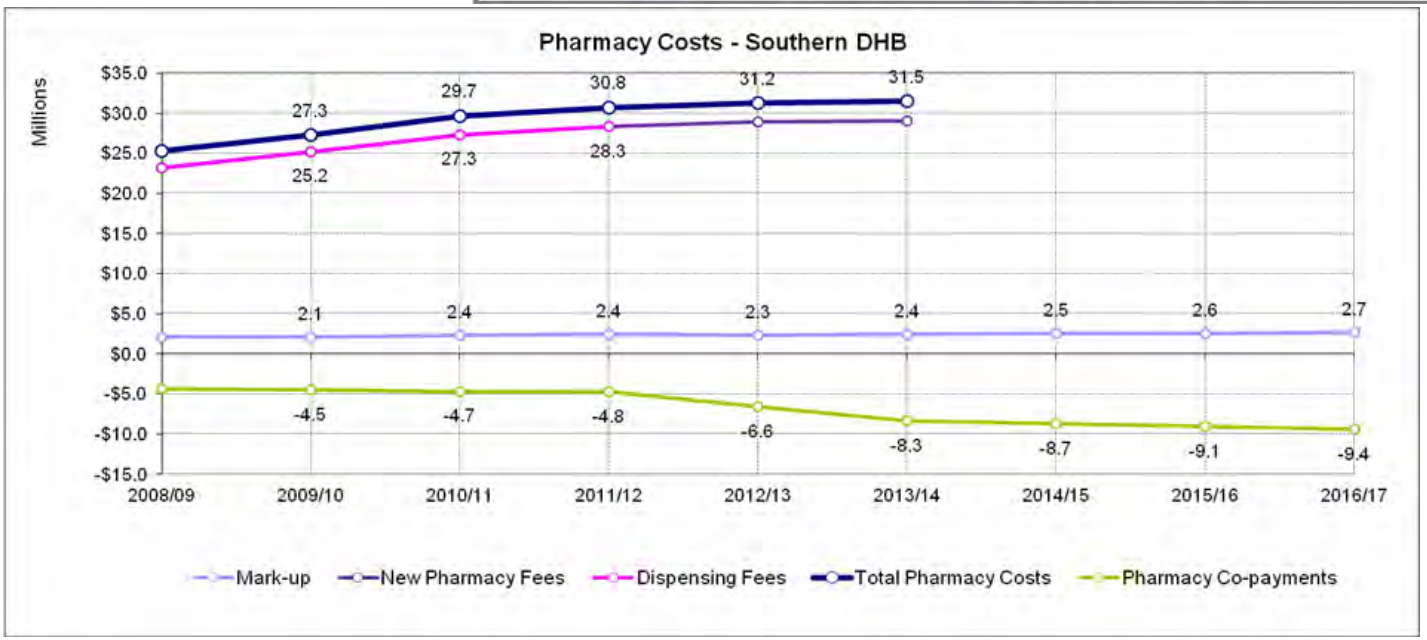


Chart B: The forecast community pharmacy expenditure for SDHB under the term and conditions of the current pharmacy agreement.

SDHB Community dispensed pharmaceuticals per quarter 2011-2013

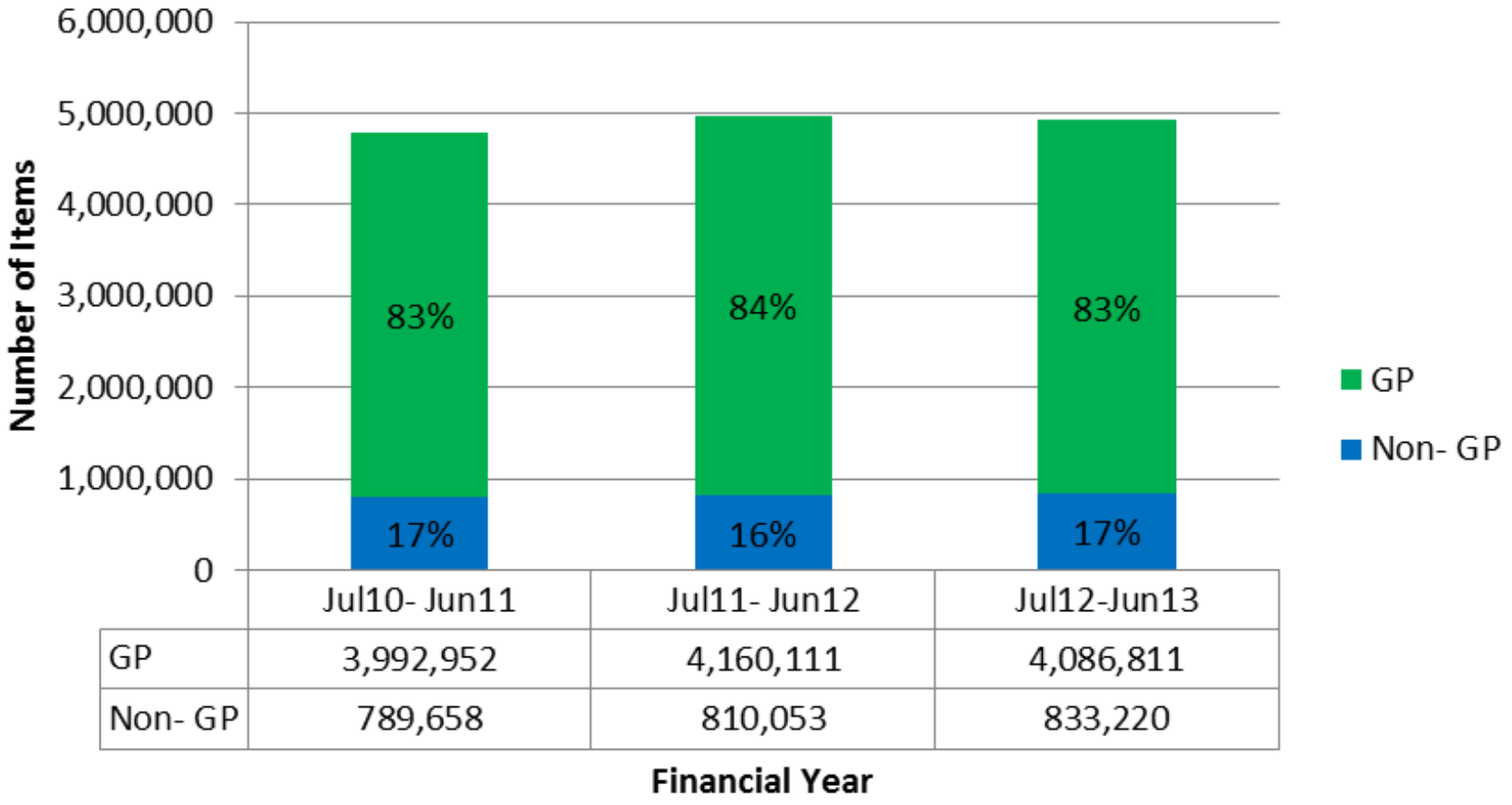
Number of Items	1204810	1283923	1328517	1344148	1271919	1316065	1331369	1342039	1205156	1248046
Average cost per item	$12.37	$12.54	$12.19	$12.42	$12.57	$12.68	$12.56	$12.35	$12.71	$12.75

it is not the # **of dispensed medicines** but rather the **$ per item** that is increasing the SDHB pharmaceutical spend over the last 3 years

DHB	Cost per Patient* Jul 12-Jun 13	Total Items Jul 12-Jun 13	Total Cost Jul 12-Jun 13
Waitemata	$ 415.18	6599643	$ 97,420,821
Hutt	$ 264.77	2152371	$ 31,049,164
Mid Central	$ 239.95	2835481	$ 36,662,416
Counties Manukau	$ 237.96	6845218	$ 85,501,953
Wairarapa	$ 234.96	749063	$ 9,816,213
Tairawhiti	$ 229.27	767821	$ 7,951,661
Hawkes Bay	$ 228.80	2711440	$ 34,828,472
Whanganui	$ 228.31	1029199	$ 12,895,332
Southern	$ 225.77	5126610	$ 64,535,762
Waikato	$ 223.16	5370945	$ 73,375,039
Taranaki	$ 222.62	1821669	$ 22,305,671
Bay of Plenty	$ 221.77	3342601	$ 44,811,498
South Canterbury	$ 219.69	1222030	$ 12,334,496
Northland	$ 216.18	2424649	$ 33,369,582
Nelson Marlborough	$ 213.30	2080624	$ 29,277,891
West Coast	$ 206.40	579104	$ 6,462,302
Canterbury	$ 202.17	7733839	$ 97,992,157
Lakes	$ 194.29	1330982	$ 20,434,518
Capital and Coast	$ 187.51	3298589	$ 56,868,694
Auckland	$ 88.37	5567498	$ 81,548,135

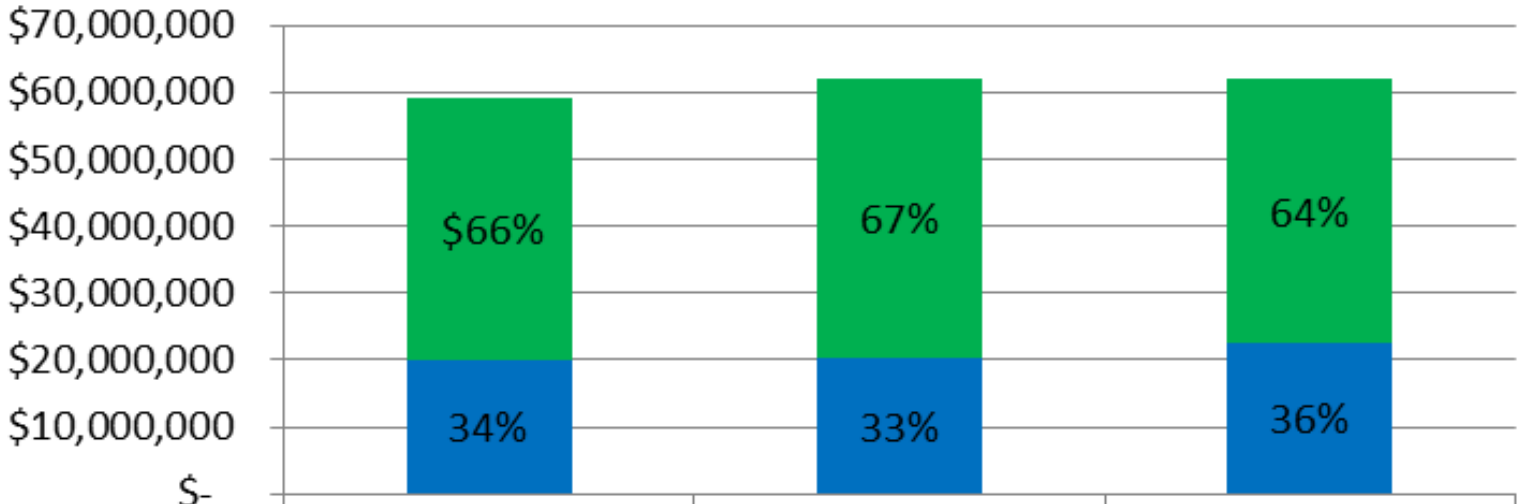
*patient numbers obtained from the Ministry of Health age-sex register

Number of items prescribed by GPs and doctors-non GP in the SDHB



	Jul10- Jun11	Jul11- Jun12	Jul12-Jun13
GP	3,992,952	4,160,111	4,086,811
Non- GP	789,658	810,053	833,220

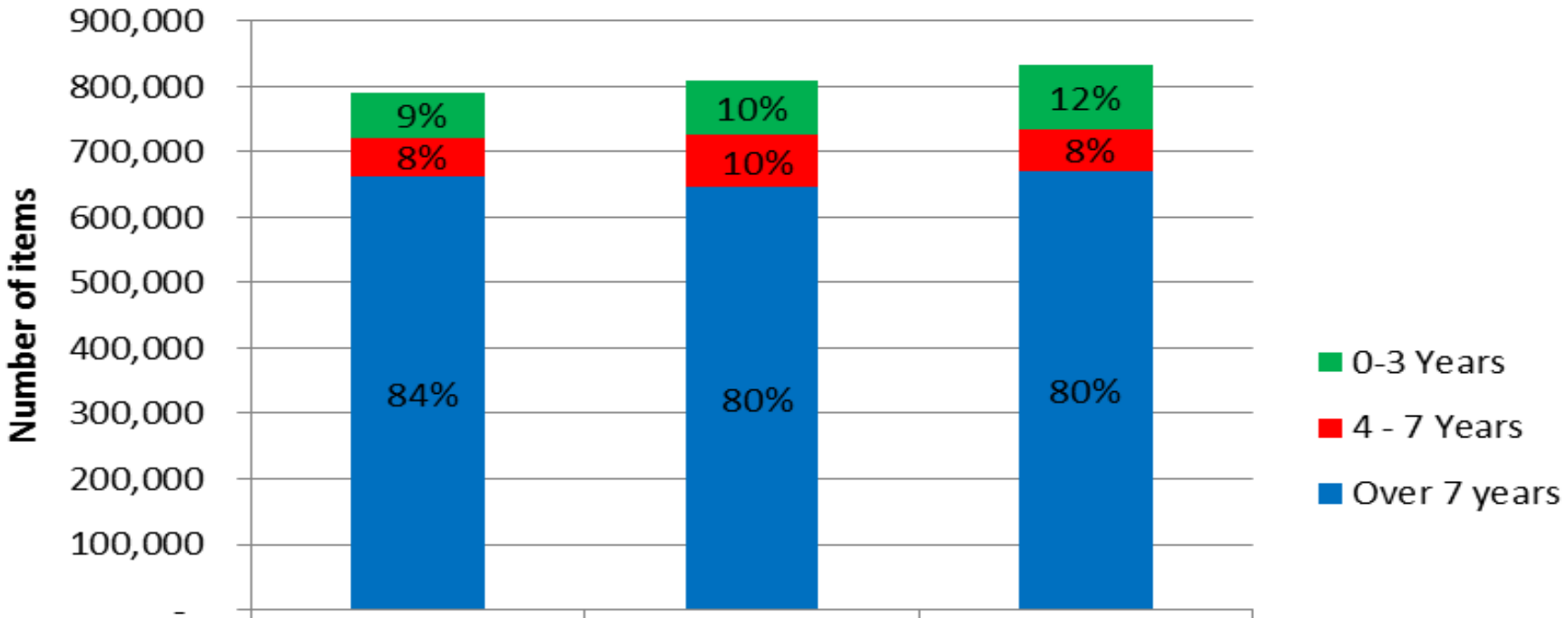
Cost of pharmaceuticals prescribed by GPs and doctors- non GP in the SDHB



	Jul10- Jun11	Jul11- Jun12	Jul12-Jun13
GP	$39,128,510	$41,539,324	$39,457,817
Non- GP	$19,949,573	$20,429,640	$22,512,875

Financial Year

Number of items prescribed by Junior and Senior doctors (non-GP) in the SDHB



	Jul10-Jun11	Jul11-Jun12	Jul12-Jun13
0-3 Years	67,358	84,117	97,939
4 - 7 Years	60,132	80,301	66,044
Over 7 years	662,168	645,635	669,237

There has been an increase in the number of items and total cost of pharmaceuticals prescribed by junior (0-3 years since graduation) hospital doctors

Future Signals on Growth

- recent reductions in initial item (first prescription) growth are considered to be temporary & a result of behavioural changes of patients, prescribers & pharmacists in response to the new pharmacy agreement, changes to the PHARMAC rules re: stat list and relaxing stat rules, and the co-payment increase.
- PHARMAC have, informally, signalled a 4% growth in initial dispensings over the medium term, once the current changes have become embedded in the system.

- Demand on pharmaceuticals are expected to increase due to:
  - more people with more conditions requiring drugs,
  - use of drugs to prevent Long Term Conditions from progressing to more severe conditions
  - use of drugs to assist in keeping people well
  - Use of drugs to assist with better managing health/ treatment at home.

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC) AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

ACTION SHEET

As at 17 January 2014

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
	"Deep Dive" Presentations	Consideration to be given to inviting representatives from: - Rural Trusts - B4 Schools Checks - Mental Health Residential Services (DHB/PACT) - Implementation of the HCSS model	EDSIF	DCIP and Hep C presentations completed. Other presentations will be scheduled as appropriate.	Ongoing
May 13	**Public & Population Health**	A copy of the C&Y Compass Questionnaire to be submitted to DSAC/CPHAC when completed.	PM-PPH	The Compass tool has been forwarded to the Children's Commissioner. Consideration is being given to how the SDHB might use the tool as a checklist report to the Board through the Advisory Committees, noting it is a complex tool that should inform operations, tactics and also strategy.	
Aug 13	**Free Care for Under Six Year-Olds**	Suggestion to be added to SHA agenda that GP fees be presented in a consolidated format on the PHO website to make it easier for people to find which practices offer free care for under six year-olds.	EDSIF/ PHO	Under action by SPHO within the revision schedule for the SPHO website. Completion expected by mid February 2014.	
Aug 13	**Orientation of NGO Contracts to Support Smokefree Health Targets**	To be brought back to DSAC/CPHAC if any significant changes are proposed to the smokefree clauses following consultation with providers.	PM-PPH	Work in Progress	March 2014

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Nov 13	**Committee Reporting Framework**	▪ As well as a focus on targets, achievements and impacts, Committees to be kept informed of activities and changes occurring in the community that their constituents are likely to raise with them. ▪ PHO and SHALT reports to be included in each agenda.	EDSIF/ PMs	• Noted and completed. • Completed.	Ongoing
Nov 13	**Pharmaceutical Expenditure**	Comparative DHB drug costs to be defined per head of population in future reporting.	EDSIF	Developing a process to obtain comparative information for future reporting. Predict first report in February 2014.	
Nov 13	**Smokefree / Auahi Kore Position Statement**	Position statement to be moved to the start of the document, so the DHB's position is clear to the public.	PHS	Completed as requested.	Completed

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Community Pharmacy Service Agreement – Proposed Stage 4 Roll Out**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	4 February 2014

Summary:

The purpose of this paper is to provide an overview of the proposed Stage 4 Roll Out of the Community Pharmacy Service Agreement (CPSA).

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

Financial:	Continue to work within the CPSA revenue envelope. There should continue to be savings in community expenditure for SDHB.
Workforce:	SDHB will continue to work closely with Community Pharmacists to ensure service sustainability and effectiveness.
Other:	

Document previously submitted to:	NA	
Approved by Chief Executive Officer:		**Date:** 21/01/2014

Prepared by: Jim Hurring Portfolio Manager – Primary & Community **Date: 14/01/2014**	**Presented by:** Sandra Boardman Executive Director Planning & Funding Supported by Jim Hurring

RECOMMENDATION:

1. **That CPHAC/DSAC note the progressive implementation of the Community Pharmacy Service Agreement and proposed roll out of Stage Four.**

Community Pharmacy Service Agreement (CPSA)

14th January 2014

Discussion

Background

The Community Pharmacy Service Agreement (CPSA) was introduced in July 2012. This was designed to support a "service-based patient-centred" model of care which incentivised Community Pharmacists as the experts in medicines management. The CPSA has a three year timeframe to safely transition Community Pharmacy from the old "fee per dispensed item" business model to the new "service delivery" model.

To date three stages of the CPSA have been rolled out since introduction of the CPSA. This has been achieved within the original funding envelope. The change in funding model has been largely managed through the "Transition Payment" which has replaced the funding of dispensing of individual items with the exception of services such as clozapine, methadone, etc. which continue to paid as a dispensing fee. The Transition Payment is based on previous Community Pharmacist dispensing volumes (2011) and the Community Pharmacist's historical market share.

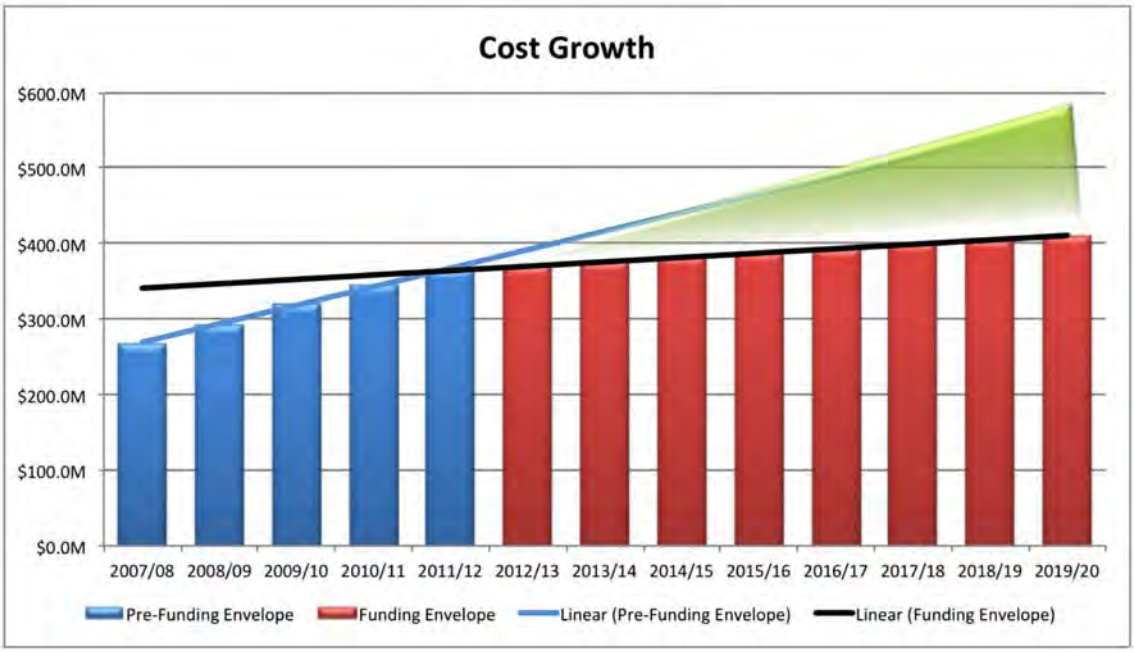
The roll out of the three stages has permitted the gradual introduction and funding of new services such as Long Term Conditions (LTC), Community Anticoagulation Management Programme (CPAM) and Community Pharmacy High Needs Adherence Programme (PHAMS). Until these services were developed and funding levels allocated this revenue was initially retained within the Transition Payment. Once the services were introduced through Stages Two and Three, the Transition Payment revenue level has decreased and Community Pharmacists funded specifically for each of these services.

Subsequently, there have been 133,000 Long Term Condition patients registered with Community Pharmacists throughout NZ resulting in improvements in each patient's medicine management. Together with the introduction of the other services mentioned above, will ensure greater patient compliance to ensure greater effectiveness of their medications with improved health outcomes and reduced self-harm. LTC registration for SDHB Community Pharmacists is satisfactory, although some pharmacies in different geographical areas still struggle to achieve registration targets.

Greater input by Community Pharmacists into patient medication management has resulted in the reduction in the frequency and volumes of repeat medicines, which have reduced by 15%. This, with an overall decrease nationally, of initial scripts, has resulted in a significant decrease in community pharmaceutical

expenditure. There has also been a decrease in community pharmaceutical spend by SDHB due to a decrease in repeat prescriptions however, initial items continue to increase but not to the same levels previously.

The graph below shows the projected costs savings over time just for the Community Pharmacist' Services let alone the benefit to patients and the system related to better medications' management.



The next phase of the CPSA programme is the roll out of Stage Four and a further development of the SPSA programme.

Stage Four of the CPSA

Stage Four will be the continuation of refinement of the current CPSA services and agreement on their funding levels. It will ensure a commitment to an enduring service delivery and funding model principles for the duration of the implementation period and beyond.

A review has been undertaken by DHB Shared Services Pharmacy Group of the impact of the changes made with the three stages to date. This includes examination of the new CPSA services introduced since the inception of the CPSA and ensuring they are achieving their initial purpose and their funding levels remains appropriate and delivered within the revenue envelope.

The Stage Four proposal will consider the following:

I. Additional service and funding model principles to be adopted to support Stage Four of the CPSA programme and delivery of the service and funding model post 2015.

II. A funding envelope is retained beyond Stage Four and a discretionary funding pool is introduced to enable demand and growth to be managed within the funding envelope.

III. That during the development of options for Stage Four and beyond, DHBs agree that the Funding Setting and Monitoring Group consider the variation in patient cohorts and pharmacy settings and should not include the option of an additional patient service fee.

IV. Potential of the CPSA programme to complete the development of a revised community pharmacy service and funding model for Age Related Residential Care.

V. To note the increasing primary care and public health service role that community pharmacy is undertaking.

Stage Four will also consider:

I. Any changes to the management and funding of the Long Term Condition (LTC) programme now set at $360 a patient annually, the Core Service Fee set at $2.50 per item and specialities such as PHAMS, Community Residential Care (CRC), Exceptional Circumstances (EC), CPAM and Co-dispensed medicines for Opioid dependent patients.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Changes to the current Rural Funding mechanism for Rural General Practices**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	4 February 2014

Summary:

The purpose of this paper is to provide an overview of the proposed changes to the current Rural Funding mechanism for Rural GP Practices.

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

Financial:	SDHB will receive an additional $300,000 sustainable funding which we are required to fully allocate to rural primary care. The expectation is this will be done through a formal Rural Service Level Alliance reporting to the Southern Health Alliance leadership Team (SHALT).
Workforce:	
Other:	Queenstown will relinquish its rural status, albeit will continue to receive rural transitional payments for a further two years.

Document previously submitted to:	NA	
Approved by Chief Executive Officer:		**Date:** 21/01/2014

Prepared by: Jim Hurring Portfolio Manager – Primary & Community **Date: 14/01/2014**	**Presented by:** Sandra Boardman Executive Director Planning & Funding Supported by Jim Hurring

RECOMMENDATIONS:

1. **That CPHAC/DSAC note the changes to the Rural Funding mechanism and process for primary care rural funding for 2014/15.**

Background

On September 2013, the national Rural Advisory Group (RAG) recommended to Ministers that the national rural ranking score (RRS) mechanism, which has been used over the past decade to distribute funding to support and sustain rural general practices, should be replaced by local rural service level alliancing arrangements.

On 24 October 2013, Minister Jo Goodhew announced the government's support for a new way of allocating rural funding through local Alliances and that extra rural funding would be provided. The Minister noted that there was a consensus that the long–standing rules of the RRS were out-dated.

The government's investment is to help rural general practices better retain clinical staff and services and includes:

- An extra $2 million funding per annum from 1 July 2014
- Transition funding over two years to support any practices that are within 30 kms/mins from a base hospital and/or have a population of more than 15,000 residents and are not included in an alliance arrangement going forward

The additional $2 million will be allocated to DHBs using the Urban/Rural profiles from Statistics NZ population estimates, plus a deprivation weighting.

In addition, the Ministry agreed that all available rural funding should be available for rural service level alliancing discussions and will devolve:

- $5 million rural after–hours funding to DHBs
- $9 million after–hours funding to DHBs

This funding will be devolved to DHBs, as it is currently allocated, from 1st July 2014. The Southern DHB has been advised of the amounts they will receive of the new funding.

Currently, SDHB spends $4,284,235 rural funding for rural general practices. SDHB has been allocated an additional $300,000 of the new funding.

The current level of funding is staying the same but decisions on the allocation, including the additional $2 million funding (national), will be through a shared decision–making forum, the Alliance Leadership Team (SHALT). The SHALT will receive advice from the local rural service level alliance or an existing similar collaborative process already operational in a DHB area.

Until agreement is reached within the scope of a rural service alliance, the status quo will continue for rural funding in accordance with the current PHO Services Agreement. The DHB share of the $2 million will be held by the SDHB.

Negotiations will take place on 12/13 February 2014 to agree any variations required to the PHO Services Agreement to reflect these rural funding changes. Although Ministers have made funding decisions and have supported the move to Alliance decision–making, how much national prescription and how much local autonomy is left to local determination in the actual rural services contractual framework will need to be determined in these PHO Service Agreement discussions.

The Rural Advisory Group (RAG) will have an on-going role in providing advice at a national level on rural primary health care funding and Alliances. It will also develop a work programme that includes a workforce survey and advising on strategic decisions relating to rural service delivery. The on-going RAG Terms of Reference will be part of the PHO Services Agreement negotiations.

Potential implications for SDHB

Decisions recommended by the Rural Advisory Group and accepted by the Minister, which excludes any general practice within 35 kms/mins from a base hospital and/or have a population of more than 15,000 residents, means that Queenstown will no longer be considered rural. Queenstown general practices will receive transition funding for two years after which all rural funding will cease.

There are rural areas such as Te Anau and Wanaka which have unique circumstances which may require a review by the Alliance Leadership Team to ensure current rural funding meets these needs.

Otherwise, the changes will mean more flexibility for SDHB, through the Alliance mechanism, to allocate rural funding more equitably across the region.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Southern Health Alliance Leadership Team Update (SHALT)**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	4 February 2014

Summary:

Monthly report for CPHAC/DSAC on the SHALT activities and progress to date

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

Financial:	NA
Workforce:	N/A
Other:	NA

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

Prepared by: Robin Gauld Independent Chair Southern Health Alliance Leadership Team **Date:** 17 January 2014	**Presented by:** N/A

RECOMMENDATIONS:

That CPHAC /DSAC:

1. Note the content of this paper

Key Areas
The addition of a Programme Manager to SHALT in December is providing the much needed resource to lead, manage and coordinate the organisation, direction and implementation of the work streams/ projects that will form the SHALT portfolio of work. At their December meeting SHALT Members approved five key priorities of work that will form the basis of the first Service Level Alliance Teams (SLATS) with these being: ➢ Community Enablers ➢ Community and Hospital Pharmaceuticals ➢ Diagnostics ➢ Outpatients ➢ Rural Health A work plan for each SLAT is now in the process of being developed. The transition to a flexible funding model has been highlighted as a priority. A detailed plan to enable this is being developed and it is anticipated that the transition to this funding model will commence in the 2013/14 fourth quarter. Engagement and communication with stakeholders is being planned. As a first step, the SHALT Chair has met with the Otago Daily Times and a recent article published.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CPHAC REPORT - OCTOBER TO DECEMBER 2013**
Report to:	Community & Public Health Advisory Committee
Date of Meeting:	4 February 2014

Summary:

The issues considered in this paper are:

- Public Health Service activity for October to December 2013

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

Financial:	Nil
Workforce:	Nil
Other:	Nil

Document previously submitted to:	N/A	**Date:** dd/mm/yy
Approved by Chief Executive Officer:	No	**Date:** dd/mm/yy

Prepared by: Stephen Jenkins **Date:** 10/1/14	**Presented by:** N/A

RECOMMENDATIONS:

1. **That CPHAC accept this report.**

PUBLIC HEALTH SOUTH REPORT TO THE SOUTHERN DHB COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
October to December 2013

RECOMMENDATION:
It is recommended that the Community and Public Health Advisory Committee note this report.

Public Health Services (Southern)

Following recent local government elections, the Public Health Service has revised its booklet *Southern District Health Board Public Health Services Information for Councillors* for distribution to newly elected Councils in early 2014. A copy of the booklet is affixed to this report for the information of the Committee.

Settings and Lifestyles

Outcome 1	Reduce the impact and incidence of smoking related disease
Outcome 2	Reduce the impact and incident of obesity and overweight
Outcome 3	Reduce the impact and incidence of harm from alcohol and other drugs

Liquor Licensing

The Object of the Sale and Supply of Alcohol Act 2012 is "*the sale, supply, and consumption of alcohol should be undertaken safely and responsibly; and*" that "*the harm caused by the excessive or inappropriate consumption of alcohol should be minimised*." The definition of harm within the act is broad covering crime, damage, as well as death disease illness or injury either caused or contributed to by excessive or inappropriate consumption of alcohol. Additionally, the scope of the legislation covers both harms to individuals and effects on society and communities. This scope of legislation is far broader than previous laws and it places Public Health as being central to achieving the objects of the new regime.

The new licensing regime is intended to be more restrictive than previous legislation but it also provides for more community based regulation of the sale and supply of alcohol. This includes permitting local communities to regulate licensing through the implementation of a Local Alcohol Plan (LAP). But it also requires Police, Health and District Councils to collaborate on the development and implementation of harm minimisation strategies for communities.

As part of this approach Medical Officers of Health are required by the legislation to provide information to Local Authorities on the Health Impact of Alcohol caused in each area on request. This is in order to inform the development of Local Alcohol Plans. In Southern district, the Public Health Service prepared the document, The Impact of Alcohol on the Health of Southern Communities to provide this information at a district level. Public Health South continues to engage with all District Councils and Police at a local level to develop collaborative approaches to tackling alcohol harms even where a LAP is not currently being developed.

Also, for the first time, a district wide, multi agency meeting, convened by Public Health South, was held between all licensing stakeholders to discuss the practical implementation of the legisaltion.

Under previous legislation, formal public health involvement in liquor licensing was limited to applications for on licenses, but at the time of this report this has been extended to include special license applications and applications for off licenses. Medical Officers of Health along with Police are required by the Act to inquire into each application for a liquor on- or off-licence and may inquire into special licence applications. The mandated timescale for these inquiries is 15 working days from receipt of application, which must be adhered to if opposition is to be considered.

This has significantly contributed to the workloads of Medical Officers of Health and those Health Promotion Advisors involved in liquor licensing, with an additional 613 (special) license applications assessed since 19 June 2013. The Service has redeployed Health Promotion and Administration FTE to provide additional capacity to manage increased workloads and is considering other strategies to manage higher volumes in a more sustainable way. This will include an evaluation of existing systems and processes used in liquor licensing to ensure our work is conducted as efficiently and effectively as possible.

Communicable Disease and Food Safety

Outcome 4 Reduce the impact and incidence of communicable disease

Rhythm and Alps

On 30 and 31 December a major music festival, Rhythm and Alps, was held on the Robrosa Station in the Cardrona Valley, Wanaka. This was the first time that this event has been held in the Southern district and was a sell out with 10000 people attending, including up to 7000 people camping at the site over the two days.

A co-ordinated planning approach was taken by Southern District Health Board Emergency Planner and Public Health Service. This involved having liaison meetings with the Southern PHO, St John, Police, Queenstown Lakes Hospital and Dunstan Hospital. The purpose of this approach was to ensure that all agencies were aware of each other's management plans around the event and to identify any gaps that needed to be addressed with the organisers and agencies. The key benefit of this approach was increased communication and coordination across the health sector which reduced the possibility of impacting adversely on local health services.

A debrief meeting will be held early in 2014 to identify any areas for improvement for Rhythm and Alps events.

Healthy Environments

Outcome 5 Promote safe and healthy social and physical environments

Review of the Legal Framework for Burial and Cremation

Public Health South recently submitted on the first significant review of the Burial and Cremation Sector Legislation in NZ. The 'First Principles' review by the New Zealand Law Commission covered a number of areas where the current legislation dates back to the 1940's and hence is due for review.

The review covered several areas, including:

- Opening up the provision of cemeteries to the private sector, including 'natural burials'
- The licensing and regulation of crematoria and the funeral sector
- Easing the criteria for burial on private land

- Review of the process for dealing with serious burial disputes

Under current law the Ministry of Health is the body for legislative control. The Public Health Service made the submission that the running of cemeteries and crematoria should more appropriately fall under the licensing and control of the Territorial Local Authorities (TLA). In addition to this the submission did not discount the possibility that there may be other providers (e.g. recognised charities, not-for-profit organisations and religious groups) that could, under new legislation, run their own cemeteries. In all instances, the licensing and control should fall under the TLA so that in the event of negligence the requirement to maintain the cemetery would remain with the TLA.

Similarly the Public Health Service's submission expressed the view that those running crematoria should be registered or licensed so that minimum standards of operation (including dignity and respect to those who have passed) are maintained. Minimum standards for mortuaries and qualifications for staff running funeral services have also been endorsed, as well as openness concerning affiliation with national associations so that the public are well informed and can feel confident that their family matters have been attended to in an appropriate way.

The submission also supported burials on private rural land, provided the burial process adheres to resource consent requirements.

While cremation is common in NZ and very few complaints are received in relation to the process and final disposal of ashes, further controls have been advised in the form of a National Environmental Standard (NES), so that there is adequate scope to suit the family but at the same time limiting the potential for nuisance caused by breaching cultural expectations – such as the direct disposal of ashes to a waterway.

Currently, Public Health Units (contracted by the Ministry of Health) facilitate applications for disinterment. Before allowing a disinterment to proceed, the staff member needs to ensure that all immediate/close family has been consulted in the decision. Family relationships can be quite complex, and relatives can hold strongly differing views regarding a loved one's final resting place, so that achieving a consensus can be difficult. Making these decisions lies outside the expertise of Public Health Unit staff, and the Services' submission supported the Law Commission's proposal that disputes around burial and disinterment would be better handled by the Family Court.

Vaccine Preventable Disease (VPD) Programme

Immunisation Health Target Results

Southern DHB achieved 94% immunisation coverage at Quarter 1 2013/14; exceeding the 85% Immunisation Health Target for 'Children at 8 Months of Age'. The DHB also achieved 94% Coverage for the 2 year old Target. Pleasingly the coverage for Maori, Pacific and children living in Dep 9 and 10 areas remains high; demonstrating equity of care.

Ministry of Health feedback was again positive: "*Southern DHB continued to perform well in this target period, although it experienced a slight decrease in coverage to 94 percent. This remains an exceptional effort and positions Southern DHB well to achieve and maintain 95 percent total coverage by December 2014. Please pass on our appreciation to the immunisation teams as excellent systems and processes appear to be in place to ensure timely immunisation of infants. These systems are clearly having a positive effect on results.*"

2014 Changes to the National Immunisation Schedule (NIS)
PHARMAC has announced the following changes to the National Immunisation Schedule effective 1 July 2014:

New vaccines to be listed in the NIS:

- Rotavirus vaccine for all eligible patients
- Varicella vaccine for patients at high risk of infection
- Hepatitis A vaccine for eligible patients
- A higher strength hepatitis B vaccine for the vaccination of dialysis patients and patients who have had a liver or kidney transplant
- A monovalent conjugated meningococcal C vaccine.

Changes to funding for vaccines currently listed in the NIS:

- The eligibility age for funding for HPV (Gardisil) vaccine for females will be changed to 'up to 18 years'
- Revaccination of children following significant immunosuppression (for example as a result of chemotherapy).

Other changes:

- The 10 valent pneumococcal vaccine (Synflorix) vaccine will be replaced with the 13 valent (Prevenar 13) pneumococcal vaccine
- The currently listed polysaccharide meningococcal; A, C, Y and W-135 (Menomune) vaccine will be replaced with the conjugate meningococcal A, C, Y and W-135 (Menactra) vaccine.

Full details can be found:
http://www.pharmac.health.nz/news/item/national-immunisation-schedule-changes

The Vaccine Preventable Disease Steering Group Annual Report: 1 July 2012 – 31 July 2013 is attached.

Smokefree Coordination

Better Help for Smokers to Quit Health Target:
95% of in-patients in secondary care who smoke will receive advice and/or support to quit smoking. Quarter one 2013-14 saw Southern DHB achieve the target with 96% of smokers seen in secondary care settings provided with advice and/or support to quit. A similar level of performance is expected for Quarter two, the results for which are being collated at the time of this report. The focus for the remainder of the reporting year will be on maintaining this level of performance and shifting the focus of staff currently working on the Secondary care target to support achievement of the Primary care target. A short term action plan regarding this change in focus was prepared in partnership with Southern PHO. The action plan has been submitted to and approved by the Ministry of Health and is in the process of being implemented. A key feature in sustaining this result will be integrating ABC recording with information systems.

90% of patients in primary care who smoke will receive advice and/or support to quit smoking. In Quarter one 2013-14 60% of patients seen in general practices in Southern District were provided with advice and/or support to quit. This is an increase on 3.7% on the previous quarter. While this is a continuation of a positive upwards trend, considerable progress will be required in the remaining three quarters of 2013-14 in order to achieve the target by the end of the year. The refocus of overall smokefree coordination resources on performance in Primary Care in addition to new initiatives being undertaken by Southern PHO in coming months will mean that this aim, while ambitious, is achievable.

An example of the planned joint activities between Southern District Health Board and Southern Primary Health Organisation was the recent trial of a 7 week smoking cessation programme to community members from 22 October – 3 December 2013. The group was promoted to local GP Practices, to Southern District Health Board staff, and via local networks including workplaces and Smokefree Otago.

Eleven people registered their interest in attending the programme; 8 attended session one and 5 continued. Of the 5 who did attend all heard about the programme from the flyer and email sent to their workplace by Public Health South. The small number of participants in this group reflects the short lead-in time for promotion and the time of year. Future programmes would include promotion over a longer period and would take place earlier in the year.

At week 7 four participants were smokefree, 80% of participants who attended after week 1. A follow up session will take place three months after the programme. Group based smoking cessation treatment is well established as an effective way to quit smoking. Feedback from participants was very positive and highlighted the value of increased social support along with cessation medication to become smokefree.

Cervical Screening Programme

The most recent Cervical Screening Coverage data available from the National Screening Unit (to September 2013) shows that Southern DHB has moved up to 8th place on the national table after several years at 10th position or below. We are hoping that this trend will continue in the coming months as a woman's best protection against developing cervical cancer is having regular cervical smears tests. Cervical cancer is one of the most preventable of all cancers.

Coverage in the Southern DHB for 25-69 year old women screened in the three years to 30 September 2013 is as follows:

	31 Mar 13	30 Jun 13	30 Sep 13
Asian	62.2%	63.2%	64.2%
Maori	59.3%	59.4%	60.2%
European/Other	81.2%	80.9%	81.3%
Pacific	78.5%	79.1%	79.3%
Total	**78.8%**	**78.5%**	**79%**

The National Screening Unit target is 80% coverage of all ethnicities by December 2014.

The Free/Subsidised Smear programme for priority group women has exceeded its target of 500 smears for 2013/14 financial year. The number of smears subsidised was 650.

Southern District Health Board Public Health Services

Information for Councillors

Public Health Services in the Southern District (Otago & Southland)

Contents

1. Southern way

The Southern District Health Board's (DHB) vision is:

Better Health, Better Lives, Whānau Ora

The Southern DHB's focus is:

- Patients are at the centre of everything we do
- Create a high performing organisation with a focus on quality
- Become a single unified DHB
- Provide financially and clinically sustainable services to the community we serve.

Public Health South (PHS), the Southern DHB public health service, strives to work towards this vision.

2. Purpose of this document

The purpose of this document is to provide Councillors with information about:

- the public health service provided to the Southern communities of Otago and Southland
- the public health activities and responsibilities of local authorities
- the ways in which local authorities and Public Health South work together.

3. Meaning of public health

"Health begins at home, in schools and workplaces – long before we need to see a doctor or go to the hospital".

Dr Marion Poore, Medical Officer of Health

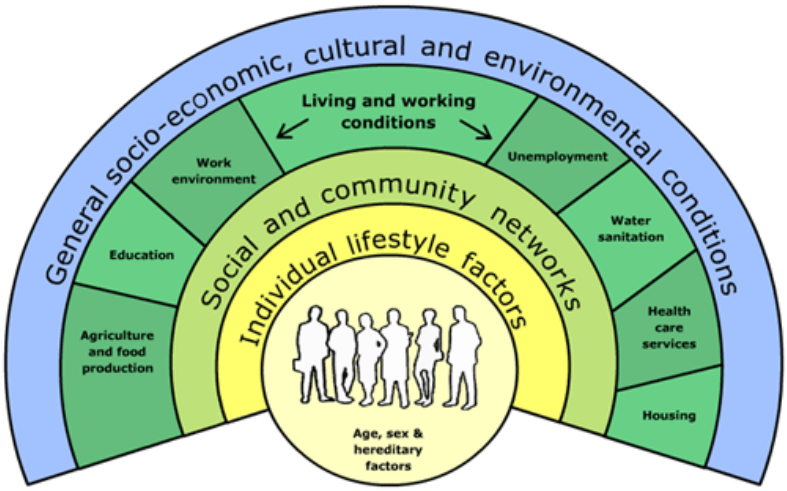
A commonly used definition of public health is "the organised local and global efforts to prevent death, disease and injury, and promote the health of populations" (Beaglehole & Bonita 2004).

Our work focuses on population groups rather than medical treatment of sick people, and looks beyond health care services to the aspects of society, environment, culture, economy and community that shape the health status of populations. We focus on creating conditions that enable people to contribute and participate, and this requires the input of agencies beyond the health sector (Ministry of Health, 2009).

Public health is about making the healthy choice the easy choice.

Various agencies and organisations influence a population's health status. Issues such as water supply, waste disposal, food safety, housing, social cohesion, education, employment, income, transport and access to recreational facilities all have a major influence on community wellbeing.

Factors that influence health



4. Public Health South

Public Health South (PHS) is a service of the Southern District Health Board (DHB) and is contracted by the Ministry of Health to provide public health services to the population south of the Waitaki River(Otago and Southland). Key roles include:

Health Protection Officers respond to public health concerns involving environmental health, communicable diseases and food safety. They carry out a regulatory role and have the power to undertake investigations on behalf of the Director-General of Health.

Health Promotion Advisors support communities to improve their health and wellbeing by using evidence-based strategies to influence lifestyle and the environment in which people live.

Medical Officers of Health are doctors who specialise in public health medicine and are designated by the Director-General of Health to fulfil certain responsibilities under a range of legalisation, primarily the Health Act 1956. Hence they provide leadership and guidance for both regulatory public health and health promotion.

We have offices in Dunedin, Invercargill and Queenstown.

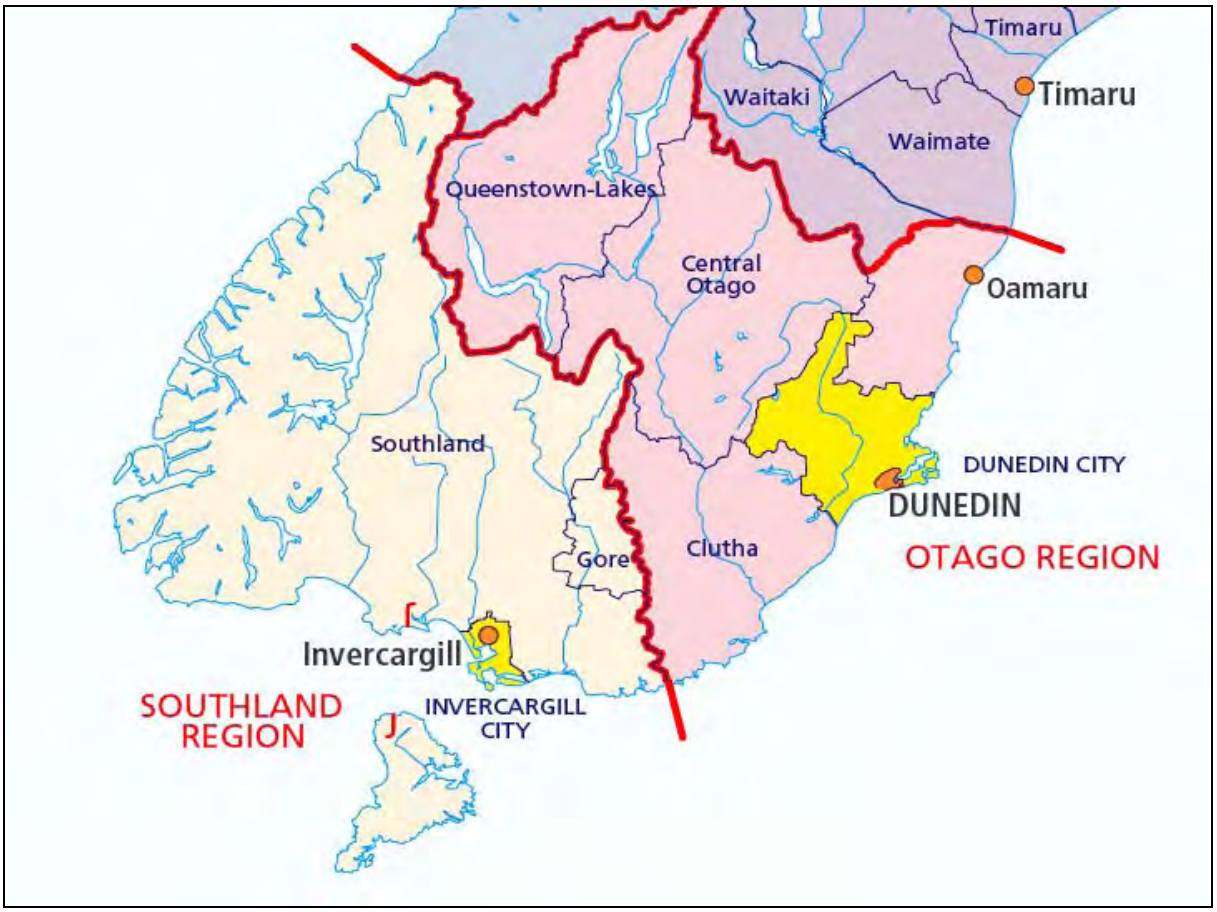
Priority population groups

We work to ensure everyone throughout our region has a fair chance to live a healthy life. As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand (Ministry of Health, 2002). PHS works towards reducing such inequalities in the Southern district.

Particular focus is given to children and youth, Māori and Pacific peoples, rural communities and families who struggle financially.

Public Health South and local government boundaries

REGIONAL COUNCILS	TERRITORIAL AUTHORITIES
OTAGO REGIONAL COUNCIL ENVIRONMENT SOUTHLAND ENVIRONMENT CANTERBURY (SOUTH OF THE WAITAKI RIVER)	DUNEDIN CITY COUNCIL INVERCARGILL CITY COUNCIL CENTRAL OTAGO DISTRICT COUNCIL CLUTHA DISTRICT COUNCIL GORE DISTRICT COUNCIL QUEENSTOWN LAKES DISTRICT COUNCIL SOUTHLAND DISTRICT COUNCIL WAITAKI DISTRICT COUNCIL


Timaru
Timaru
Waitaki
Waimate
Queenstown-Lakes
Central Otago
Oamaru
Southland
DUNEDIN CITY
DUNEDIN
OTAGO REGION
Gore
Clutha
Invercargill
SOUTHLAND REGION
INVERCARGILL CITY

5. The role of local government

Health starts were we live, work and play. Therefore, the opportunity to improve health falls across a range of stakeholders, such as the government, education sector, transport sector and local authorities.

Local government has played a crucial role to improve community health since the 19th century, through the development and maintenance of water supply and waste management infrastructure.

"The fundamental need for safe drinking water and clean air to achieving good health is undisputed. The expertise of local council staff in managing these aspects of city infrastructure is just so important".

Dr Marion Poore, Medical Officer of Health

This responsibility is ever more important as our population grows, tourism becomes more important and we have migrants from many parts of the world. Today, local government's core activities that promote community health have been substantially expanded to include; resource management, recreation facilities, housing, liquor licensing, emergency management, gambling control, food safety and a range of other activities that influence the health of our communities.

Legislative requirements

The Health Act 1956 and the Local Government Act 2002 provide the legislative framework for territorial authorities to improve, promote, and protect the health and wellbeing of communities.

Other legislation provides for the specific community health roles and duties of local authorities, including the:

- Health Act 1956
- Local Government Act 2002
- Civil Defence Emergency Management Act 2002
- Sale of Liquor Act 1989
- Building Act 2004
- Food Act 1981
- Hazardous Substances and New Organisms Act 1996
- Land Transport Management Act 2003
- Land Transport Management Amendment Act 2008
- Resource Management Act 1991

- Smokefree Environments Act 2004
- Prostitution Reform Act 2003
- Waste Minimisation Act 2008.

Health related roles of local authorities

Four areas of particular relevance in the South are highlighted below.

Alcohol & liquor licensing
Hazardous use of alcohol can fuel anti-social behaviour such as violence, increase accidents and other injuries, and result in short and long term impacts on health. This places significant burden on Police and health services. For example in 2011, there were 199 alcohol-affected presentations at Dunedin Hospital Emergency Department, 48% of those were under 25 years and the average length of stay was 5 hours 20 minutes with an average cost to the taxpayer of $1,000 to $2,000.

Regulatory framework is incredibly important in providing a safe drinking environment. We anticipate continued strong working relationships between Liquor Licensing Inspectors, Medical Officers of Health (or representatives of) and Police under the Sale and Supply of Alcohol Act 2012 to reduce the burden of hazardous drinking on Police, health and community services.

Developing effective and consistent alcohol plans throughout our region is one way territorial authorities, Police and Public Health South can work together to reduce the burden of hazardous drinking on Police, health and community services.

Emergency response
The southern population is exposed to numerous natural and human created hazards that have public health implications, such as earthquakes, flooding, snow, wind, coastal erosion, and outbreaks of infectious disease including Influenza A H1N1 (swine flu).

"Good levels of mutual understanding and cooperation between councils and public health are necessary to ensure a coordinated, effective and efficient response in times of emergency".

Dr Derek Bell, Medical Officer of Health

Both local authorities and Public Health South have significant roles in emergency management for the region. In particular, Medical Officers of Health may be granted extended powers in times of state emergency or epidemic. These include the power to:

- Require people to submit to medical examination
- Restrict the movement of people and vehicles
- Set up emergency hospitals
- Restrict public gatherings
- Close premises such as schools and workplaces.

Housing

It is well documented that living in homes that are insufficiently insulated and heated can lead to poor health outcomes for families, particularly those with respiratory illness or young children. This is a particular concern in our region, where the cooler climate and older housing stock can make heating homes a significant financial burden for families.

National and local government play a key role in influencing health through housing initiatives, such as housing vulnerable people, stipulating minimum building standards and providing support to retrofit homes. Developing a minimum standard for housing throughout the region, tenancy standards and a code of practice for landlords are other ways local government can address housing issues.

A multi-agency strategy is required in each territorial authority area to ensure that the population has warm homes and clean air. Healthy housing is a critical component in the Government's drive to reduce the incidence of Rheumatic fever in New Zealand.

Urban design

The way in which cities and towns are planned and laid out influences people's life choices, and consequently impacts the health of communities (Public Health Advisory Committee, 2010). For example, increased reliance on cars can lead to physical inactivity and increasing levels of obesity, and cause air pollution (MOH, 2009).

Local government can improve a community's social cohesion through design of buildings, town centres, transport networks, recreational spaces, and access to public transport, roads, and bridges (MOH, 2009). Public Health South can support this process at the urban design planning phase.

PHS has been working with Smokefree Otago, Smokefree Murihiku and local authorities advocating for healthy urban environments. Recent successes include the adoption of smokefree parks and playgrounds in Dunedin, Clutha, Central Otago, Queenstown Lakes, Gore and Invercargill district.

6. Working together

Public Health South works with local authorities on a range of issues. Effective working relationships between local government and health occur at the governance, executive and management, and operational level.

"We view Public Health South's relationships with councils as extremely important. The mutual interests of our organisations are highlighted by the Local Government Act, which identifies promoting community wellbeing as a key purpose of local government".

Dr Derek Bell, Medical Officer of Health

Governance
Relationships and networking between Councillors and District Health Board Members at the governance level can provide leadership for the ways in which local government and health work together. Working in a consistence and collaborative manner at a governance level can enhance our outcomes and the outcomes of other stakeholders.

Executive and management
Executives and Service Managers can work together to facilitate joint strategic planning. This enables local government and health to align their activities for better overall outcomes for the community.

Operational
Operational level working relationships include the day to day regulatory and environmental health activities Health Protection Officers and Environmental Health Officers undertake jointly on food safety, drinking water quality, bio-security, and hazardous substances. An example of a project undertaken at the operational level is the work Health Promotion Advisors, Council staff and Councillors undertook to progress a smokefree playgrounds and sports fields policy for Dunedin, Clutha, Central Otago, Queenstown Lakes, Gore and Invercargill district.

Regulatory roles & environmental health

Public health staff and local authorities work jointly on numerous regulatory and environmental health issues, including:

- Liquor licensing/alcohol
- Emergency response
- Food safety & administration
- Planning & infrastructure
- Drinking water quality
- Hazardous substances
- Bio-security issues
- Nuisance complaints
- Communicable disease
- Food borne illnesses
- Resource management.

Submissions

Public Health South takes a keen interest in the various policies, strategies, and plans that councils request submissions on. We support Southern DHB to develop evidence-based submissions on a wide range of topics including:

- Long Term Council Community Plans
- Government policies and proposals
- Alcohol policies and plans
- Transport strategies
- Land use
- Discharge to land/water/air.

We can also contribute our expertise by working with council staff during planning and document preparation phases.

Planning and policy making

Health Impact Assessment (HIA) is a powerful tool that enables council and public health staff to work in partnership with key stakeholders to provide decision makers with valuable information. HIA is a combination of procedures, methods and tools that systematically assesses potential positive and negative effects of a policy, plan, programme or project on the health and wellbeing of a population. The outcome of an HIA is a set of evidence-based recommendations to mitigate potential negative effects and enhance positive effects.

Public health staff have collaborated with Dunedin City Council staff on two HIAs (liquor restriction extensions and speed restrictions) and have applied the HIA screening framework (on farm disposal of carcasses and offal) in Southland. PHS are able to provide public health expertise, research capacity, report writing, meeting facilitation and administrative support for HIA projects.

7. Further reading and information

Ministry of Health. 2009. *Public Health in New Zealand: Local Government's Contribution to Wellbeing.* Wellington: Ministry of Health.

Public Health Advisory Committee. 2010. *Healthy Places, Healthy Lives: Urban environments and wellbeing*. Wellington: Ministry of Health.

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Public Health Association. 2012. *Living in a health environment*. Wellington: Public Health Association. Available from: www.pha.org.nz

Public Health South. 2010. *Annual Highlights 2009/10.*
Public Health South. 2012. *Annual Highlights 2011/12.*
Available from: www.southerndhb.govt.nz

Robert Wood Johnson Foundation. 2010. *A new way to talk about the social determinants of health.* New York: Robert Wood John Foundation. Available from: www.rwjf.org

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Queenstown office		
Suite 2, level 3, Building 7 Hawthorne Drive Remarkables Park Town Centre Queenstown 9300	PO Box 2180 Frankton, Queenstown 9349	Ph: 03 450 9156 Fax: 03 450 9169

website: **www.southerndhb.govt.nz**

Southern District Health Board Vaccine Preventable Diseases Team Steering Group
Summary Report to Planning and Funding July 2012 – June 2013

Main Points

1) Southern DHB continues to achieve positive outcomes for the Ministry of Health Immunisation Targets
    a. 'Children fully vaccinated by 8 Months' Target introduced 1 July 2012.
       2012/13 target of 85% exceeded by Southern DHB in all Reporting Quarters
    b. Maintenance of 95% coverage for the 2 Year old Target. Southern DHB achieved 93 – 95% coverage across the Reporting Quarters
        i. Change of parameters led to all DHBs having a slight reduction in 2 year old coverage

2) New Zealand has been experiencing an outbreak of whooping cough (pertussis) since September 2011.

3) Co-ordination of service planning and delivery remains evident, with good clinical outcomes.

4) Acknowledgement of the commitment and dedication by all health professionals across the sector in the successes of the Southern DHB immunisation programmes

Introduction

The Southern DHB Vaccine Preventable Disease Programme (VPD) team, created in late 2010, is now well established and achieving sustainable high immunisation coverage. This supports the reduction of vaccine preventable diseases for the total population, but most importantly the children of the District. The team is led by the District Programme Leader and incorporates DHB employed Immunisation Coordinators, National Immunisation Register (NIR) and Immunisation Outreach roles in a District wide team as shown below.

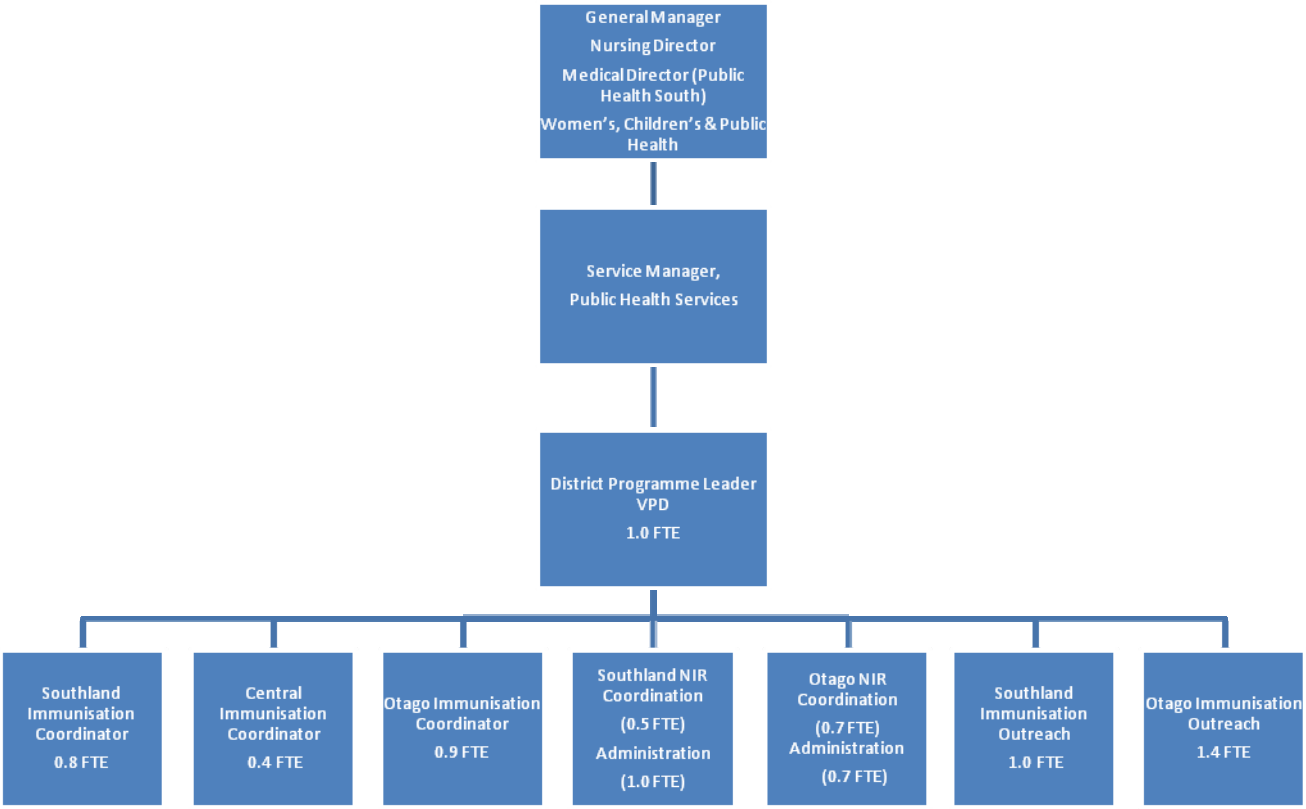
A team effort

A District Steering Group provides clinical governance and leadership for immunisation programmes. The group meets three times a year by videoconference, and their valued contribution to the work of the VPD team is acknowledged.

This year has seen a number of changes in the group:

- The Steering Group Sponsor responsibilities continue to sit with the Director; Planning and Funding following the resignation of Robert Mackway-Jones
- Dr Marion Poore stood down as the Chair at the end of the year due to changing work priorities – we thank Marion for her foresight and vision as one of the developers of the VPD Team and Steering Group
- Dr Keith Reid accepted the responsibility of Chair of the Steering Group, in his role as Public Health Physician / Medical Officer of Health
- Thelma Brown handed Planning and Funding representation to Janet Gafford
- Trinie Moore passed on Well Child provider representation to Jenny Insall

The VPD Team is now an established group within the Public Health Service, and continues to be led by Jillian Boniface. This past year has seen a number of staffing changes in the team; Ryan McLane and Sam Horne commenced in the Immunisation Coordinator roles in June 2012, with Ryan resigning June 2013 to take up a role as Senior Advisor to the Chief Nurse at the Ministry of Health. At 30 June the role remains unfilled, with secondment arrangements in place while recruitment continues. A resignation has been received from June Dean, one of the Southland Outreach Nurses effective early August 2013. The NIR staff has experienced minor movement due to maternity leave arrangements.



Immunisation Health Target Achievements

Early Childhood:

2012/13 saw the introduction of the new 85% target for coverage at 8 Months. Southern DHB is delighted to have achieved 95% coverage for this milestone by Quarter 4, having maintained at least 93% for each preceding quarter. Additionally the DHB has been able to maintain coverage above 93% for the 2 Year Old Milestone and again achieved 95% coverage by Quarter 4. This ranks Southern DHB as one of the leading achievers for this important Health Target. Coverage by ethnicity and deprivation index continues to remain at or above the coverage for the total population, indicating minimal inequalities for vulnerable children.

This is an outstanding achievement and full credit must be given to all members of the sector. While VPD team members make a significant contribution through their roles, the Practice Nurses, GPs and Non Government Organisations (NGOs) who promote and deliver the immunisations are critical to the effective delivery of the National Immunisation Programme. Their dedication, professionalism and continued efforts are highly valued.

Influenza:

The VPD team again supported the 2013 Southern DHB and PHO Influenza Vaccination Programme with clinical support and some vaccinator capacity. It is promising to see a 7% increase; to 53% coverage for the Southern DHB Staff Programme. Early aims for the 2014 programme will focus on an expectation that all staff will be vaccinated, based on the need to protect themselves, their clients and their families. Initial data from the PHO Performance Programme indicate 68% coverage for the Over 65 population.

The reclassification of influenza vaccine to make it a non-prescription medicine when administered by a pharmacist was gazetted on 7th February 2013. The requirement is that the pharmacist undertakes vaccinator training and complies with the guidelines in the immunisation handbook. However, influenza vaccination undertaken by pharmacists exists outside of the authorised vaccinator programme overseen by the Medical Officer of Health and is currently operating in somewhat of a governance vacuum. Locally we have been encouraging pharmacist vaccinators to voluntarily participate in the authorised off-site vaccinator programme.

Human Papilloma Virus (HPV) vaccination programme:

The HPV programme continues to be delivered in schools to year 8 students in Southern DHB using two models of care – a Public Health Nurse led programme in Otago and a PHO led programme in Southland.
The School Based (Year 8) 2013 targets are 70% for dose 1, 65% for dose 2 and 60% for dose 3 across all ethnic groups. At 31 August 2013 the Southern DHB coverage for dose 1 was 68% with 75% Maori and 100% Pacific coverage and 67% for dose 2 with 73% Maori and 100% Pacific coverage. Data on delivery of dose 3 is too interim to be meaningful.
General practices also deliver vaccinations to girls in the eligible age range and the Outreach Nurses remain alert for eligible girls in the homes they visit. The Immunisation Coordinators continue to provide clinical support to the programmes as required.

VPD Team Activities and Achievements

Newborn Enrolment Policy / PHO Enrolment by 2 Weeks of Age:
On 1 October 2012 the National Newborn Enrolment Policy was implemented to enable GPs to enter a newborn into their Practice Management System (PMS) as a 'B Code' on their enrolment register, to ensure funded health services before the mother has completed the formal enrolment process. The GP has until the next quarter to complete the full enrolment process.
Review in September 2012, of timelines of the Southland Maternity Services Data System revealed that due to a number of other organizational priorities, the system was creating delays of 14+ days for the data input and subsequent messaging to the Ministry and NIR.
We were advised that in its current format the Southland Healthwares System would always struggle to meet the 2 week enrolment expectation and were further informed that an earlier intention to change to Mat+ in Southland had been put on hold awaiting a new national system being scoped by the National IT Working Party –which is scheduled to take at least 2 years.
Despite a number of data clean-up process and staffing reminders, with only slight improvements, a manual inputting of data at 'Birth Discharge' was instigated and has resolved the issue. The Ministry was following this situation closely and are pleased with the improvements, which support early enrolment and on time vaccinations.
The Otago Maternity Services, using the 'Maternity Plus' (Mat+) IT System generally meets the required timelines.

Immunisation One Off Funding
In 2011/12 the Ministry of Health allocated a 'One Off Funding' allocation for achievement of 95% Coverage for 2 Year Olds at 30 June 2012 and an additional amount to support the development of strategies to address the new 8 Month Target
Southern DHB utilisation of the funding included:

- 120 framed Achievement Certificates were distributed to General Practices and other immunisation promoters in recognition of their efforts to improve immunisation coverage
- Txt2 Remind Set Up Costs for General Practices – funding was provided to the PHO for set up costs for 69 Practices to join the Txt2Remind service. Southern PHO has committed to fund the ongoing operational costs
- Human Vaccinology Paper; University of Auckland – the three Immunisation Coordinator completed the Vaccinology Paper to enhance their understanding of this core immunisation topic. Each Coordinator additionally received local Medical Foundation funding support
- While Maternity Sector Relationship development was initially identified as a priority, the funding was eventually used to cover colour printing costs of the Boostrix for Pregnant Women poster; edited with permission from one developed by Canterbury DHB.

International Immunisation Week was again celebrated in mid April. Notice board displays were created, a number of newspaper/media articles published and 3 'Buzzy for Shots' gifts were donated to Practices. The team took this promotional opportunity to distribute the Boostrix for Pregnant Women posters.
Cold Chain Management:

A series of national Cold Chain Management documents were released during the year. The 'National Guidelines for Vaccine Storage and Distribution' were released in September 2012 with the newly formatted 'Cold Chain Policy Template' released in March 2013. The Provider Self Assessment Tool and CCA Immunisation Provider Review Templates are in draft and expected to be released in September 2013.This will provide a completely updated set of documents; confirming the requirement that all vaccination providers store vaccines in a pharmaceutical fridge.

3 yearly Cold Chain Accreditation (CCA) was achieved for most of the General Practices, who have pharmaceutical fridges and been undergoing this review for a number of years. A number of Occupational Health and Pharmacists who don't have pharmaceutical fridges have received one Year Accreditation, with Remedial Plans needing to be put in place.

Pharmaceutical Fridge Replacement:
In 2004 the Ministry of Health provided one off funding to purchase pharmaceutical fridges for all General Practices; ahead of the rollout of the MeNZB Programme. These fridges are now nearing the end of their functional life and Practices are expected to develop a replacement plan. The Ministry of Health has been exploring a bulk purchasing discount through Health Benefits Ltd (HBL) but has struck difficulties purchasing on behalf of non DHB / private providers. Southern PHO is supporting Practices secure a good price on fridge replacements.
Vaccinator Authorisation / Application for Community Outreach (off Site) Immunisation Programme
The Immunisation Coordinators; in conjunction with the Medical Officer of Health have been working on a Quality Improvement Programme in regards Vaccinator Authorisation renewal and applications for Community Outreach Immunisation (Special) Programmes. All documentation has been reviewed in the past year, with Authorisation applications, Provider CCA and Special Programme applications aligned. A reminder system has also been developed for expiring Authorisations.

Relationships

The VPD team recognise the importance of strong sector relationships and has regular interaction with Practice staff, Well Child /Tamariki Ora providers, Public Health and Occupational Nursing staff as well as Paediatric services and a other provider arm vaccinators. We have continued to strengthen relationships with the Southern PHO and the maternity sector.
Dr Pam Jackson and Dr Vili Sotutu continue to be our Immunisation Champions and their willingness to provide a clinical perspective is much appreciated.
Linda Hill the South Island Advisor for the Immunisation Advisory Centre (IMAC) provides valuable clinical support for the team and facilitates the delivery of Vaccinator Training Courses and Update sessions. The Immunisation Coordinators assess clinical practice as part of applications for Authorised Vaccinator status on behalf of the Medical Officers of Health.
The National Immunisation Register (NIR) continues to provide reliable coverage data. The functioning NIR remains separate for Otago and Southland, allowing staff to manage smaller data sets and maintain relationships with the health professionals in each locality. In August 2012 Datamart was upgraded to provide Southern DHB coverage reporting.
Immunisation Outreach provides a valuable service for families having difficulties accessing primary health care services. This is a short-term intervention, with the staff committed to linking families back to General Practice and Well Child Providers. Services are delivered across the district from either Dunedin or Invercargill with numbers of children referred and vaccinated remaining stable.

Notifications of Vaccine Preventable Disease for the period 1 July 2012 to 30 June 2013

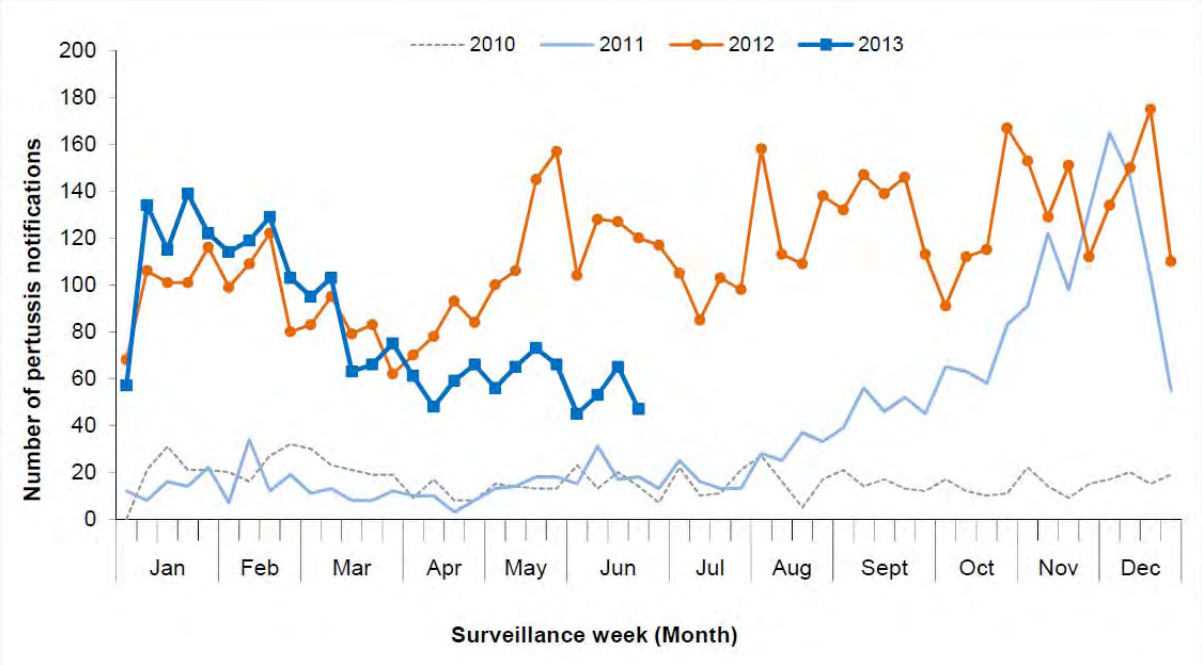
Currently all cases of vaccine preventable disease are notifiable to the Medical Officer of Health. All cases are investigated and a case report form submitted to ESR for national surveillance purposes. Summary information by DHB is publicly available on www.esr.cri.nz/. This section of the report describes relevant information from Southern DHB.

Pertussis

New Zealand has been experiencing an outbreak of whooping cough (pertussis) since September 2011. The last outbreaks were in 2004 and 2000. Southern DHB has seen an increase in cases since September 2011 but rates have been lower than in all other parts of the South Island. West Coast and Nelson Marlborough had especially high rates of disease during July 2012- June 2013 with high numbers of cases in all South Island DHBs.

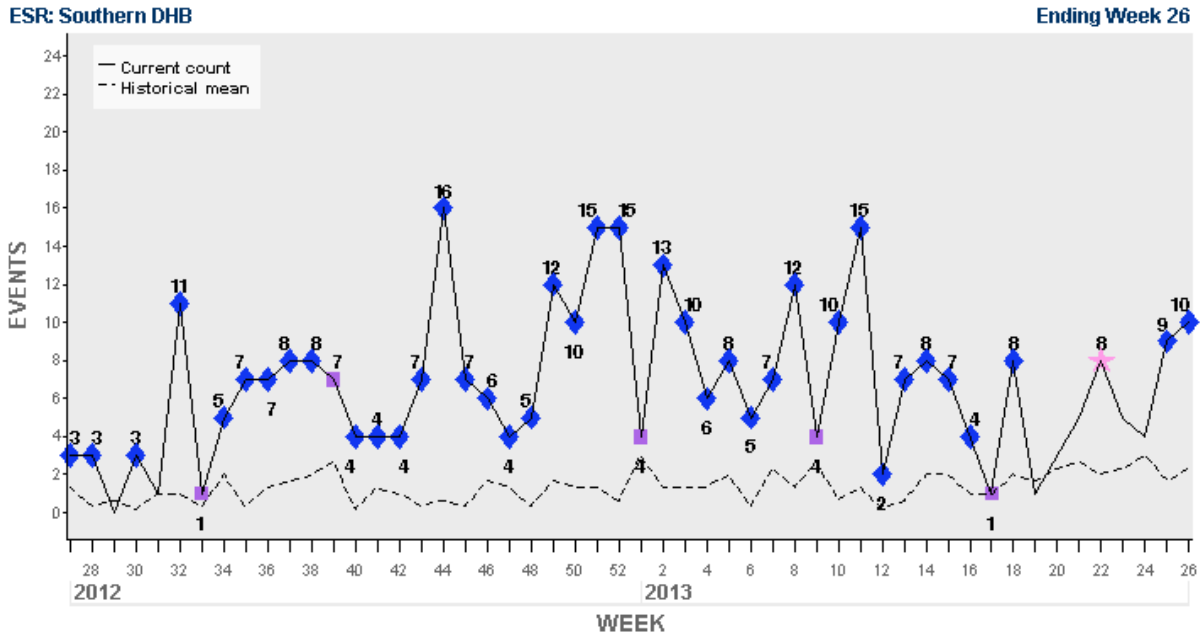
Nationally for the six months from Jan to June 2013 there were 2016 pertussis notifications, down from the figure of 2359 for the comparable period in 2012. Nationally there is a clear trend for a reduction in numbers of cases as can be seen in Figure 1.

Figure 1 – Number of pertussis notifications in New Zealand from January 2010 to July 2013



During the period Jan to Jun 2013, 148 (7.3%) cases were in the less than 1 year age group, 117 cases were - hospitalised and there were no deaths. In Southern DHB 163 cases were notified from Jan to June 2013 (up from 89 for the same period in 2012) and figure 1 shows the pattern compared to historical levels.

Figure 2 Number of Pertussis cases by week for Southern DHB (July 2012 - June 2013) Source: ESR



National notifications by age confirm that those under one year of age have the highest rates of infection, 78 cases per 100,000 population during Apr-Jun 2013 (down from 167 cases per 100,000 population during Jan –Mar 2013). There were three infants under one year hospitalised in Southern District during Jan to June 2013. However, the highest number of cases has arisen in the adult working age population because this is a much larger population than the infant population.

Measles, Mumps and Rubella

In Southern DHB there were no confirmed cases of measles during the period of this report. Vigilance continues to be exercised in relation to the importation of measles from overseas. The potential vulnerability of a cohort within the population who may be at risk due to the historical dip in MMR uptake was emphasised with events in Wales. Cases of measles were also reported in Victoria, Australia and there is a direct air link to Queenstown from Melbourne.

There were no confirmed cases of Mumps during the period of the report. Clinicians continue to notify a small number of cases on clinical suspicion but the levels of confirmatory testing are disappointingly low.

There were no notified cases of Rubella during the reporting period.

Invasive Pneumococcal Disease

There have been 39 confirmed cases in Southern DHB between July 2012 and June 2013. The gender ratio was 21:18 female to male. The majority were in those of European descent with only 3 cases in Maori and one case of Asian ethnicity. Five cases were in those 18 years or less. In five cases death occurred during the infective episode but this was thought in each case to be unrelated to the infection.

Figure 3 - Age distribution for notified cases of IPD in Southern DHB Source: ESR

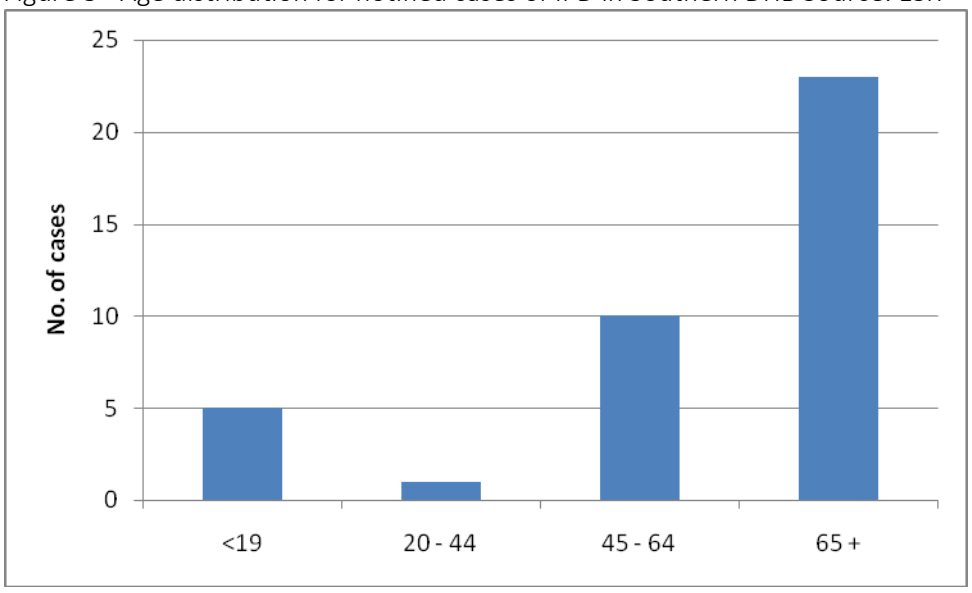
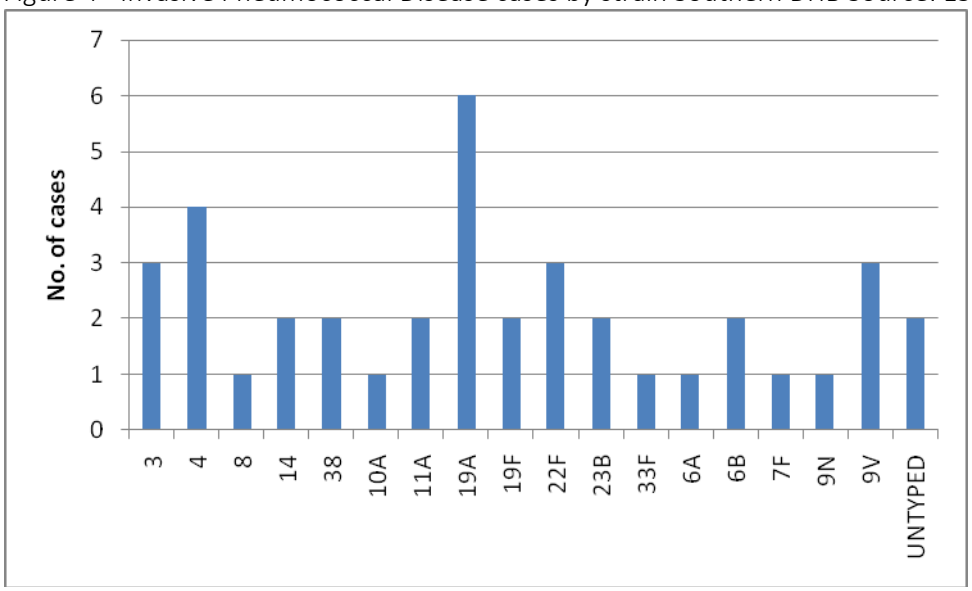


Figure 4 - Invasive Pneumococcal Disease cases by strain Southern DHB Source: ESR



Meningococcal Disease

There have been 6 cases of meningococcal disease notified between July 2012 and June 2013. All were of European ethnicity, only one case was in a child. The predominant type was group B (3) with one group Y and two cases not able to be typed.

Hepatitis B

There have been two confirmed cases notified in the period of this report, both in adults. One was in an overseas national but appeared to have been contracted in New Zealand.

Haemophilus influenza B

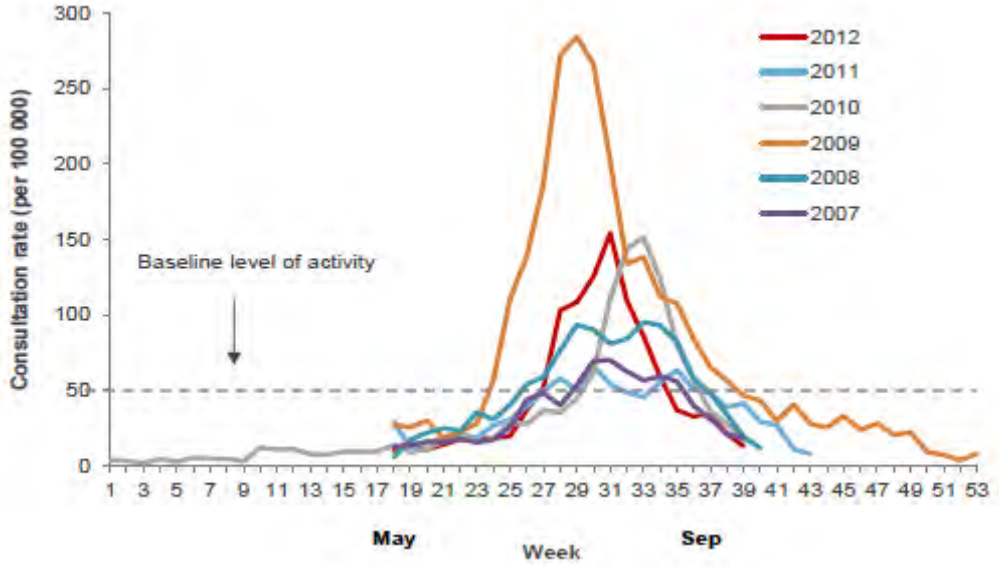
There was one confirmed case of Haemophilus influenza B notified in this period. This case had been fully vaccinated. The bacterium was isolated from a tonsillar abscess.

Influenza

This report relates to the 2012 Influenza season. Once again seven general practices in Southern DHB contributed data to the national influenza surveillance programme from May to the end of the 'flu season in

September. The purpose of this is to track trends of illness through the influenza season and collect viral samples to help determine the composition of future vaccine. Each practice takes viral swabs and counts the numbers of influenza like illness cases seen each week. Public Health South collates these data for ESR. Figure 5 compares rates of influenza like illness in NZ for 2012 with those for NZ in previous years. In most years rates of influenza like illness increase from mid July.

Figure 5 - Rates of influenza like illness for NZ for 2007 – 2012 Source: ESR, Influenza Report 2012



In 2012 the influenza season was considered to be of moderate severity. The average weekly influenza consultation rate for NZ was 50.2 per 100 000 patient population. The peak weekly consultation rate of 154.1 per 100 000 patient population in late July / early August 2012 was lower than the peaks in 2009 and 2010. Consultations for Influenza Like Illness in Southern DHB at 59.4 per 100,000 population were higher than the New Zealand average (50.2 per 100,000). In 2012, 45% of Southern DHB staff received influenza vaccination.

In 2012 the predominant influenza virus identified was A (H3N2) (74% of viruses typed). Influenza A (H1N1pdm009) – representing a pandemic strain from 2009, was next most common Influenza A isolate (11.6%). Influenza B accounted for 14.4% of viral isolates. While this pattern of circulating virus produced only a moderately severe season in New Zealand it led to considerable mortality in the elderly in North America in the northern 'flu season 2012-13.

Neonatal BCG vaccinations

Over this period 144 BCG vaccinations were given to babies identified as at risk.

Appendix: The Vaccine Preventable Disease Steering Group as at 30 June 2013

The Steering Group Sponsor is: General Manager, Planning and Funding

VPD Steering Group Membership

- Dr Keith Reid — Public Health Physician (chair)
- Janet Gafford — Funding and Planning representative
- Katrina Grant — Southern PHO representative
- Dr Vili Sotutu — Paediatrician
- Meg Paulin — Nurse leader – Immunisation Co-ordinator
- Nadine Goldsmith — Maori advisor
- Aniva Ripley — Pacific Island advisor

- Jenny Insall Well Child provider
- Jenny Humphries Midwifery representative
- Victoria Bryant Public Health Nursing representative
- Jillian Boniface PD Programme Leader (Secretariat)

Title:	**Southern Primary Health Organisation (SPHO) Report**
Report to:	Southern DHB DSAC/CPHAC
Date of Meeting:	4 February 2014

Summary:

The issues advised in this paper are:

- SPHO Strategic and Governance Matters
- Programmes and Operational Update
- Financial Position

Prepared by: Ian Macara, Chief Executive **Date:** 20 January 2014	**Presented by:** Stuart Heal, Chair SPHO

RECOMMENDATION:

1. **That CPHAC/DSAC receives this report**

1. STRATEGIC MATTERS

1. SOUTHERN HEALTH CARE ALLIANCE LEADERSHIP TEAM (SHALT)

Bridget-Mary McGown, the recently appointed Programme Manager for SHALT attended SPHO's 18 Dec 13 Board meeting and discussed:

- SHALT met on 17 Dec 13.
- SHALT signed off 5 Service Level Alliance Teams (SLATs) at its 17 Dec 13 meeting: Community Enablers, Hospital and Community Pharmaceuticals, Outpatients, Rural Services, and Diagnostics.
- Communications about the work of SHALT to stakeholders is a priority and Bridget-Mary is working with Steve Addison, SDHB Communications Manager and SHALT Chair Prof. Robin Gauld, on getting key messages out early in 2014.
- SPHO's view is that the CEO of SDHB needs to be on SHALT. SPHO has asked Carole to consider this.
- Flexible funding is under discussion, especially the SPHO funding streams [Services to Improve Access (SIA), Health Promotion (HP), Management Services (MS) and CarePlus]. Potential additional funding that may be immediately availability is some CarePlus funding (the difference between "eligible" and "enrolled" patients). SPHO funding streams for SIA, HP, MS and the majority of CarePlus are committed to out-years.

SPHO Board is very supportive of Bridget-Mary in her role. Bridget-Mary agreed to attend SPHO Board meetings every 2 months to provide updates on SHALT.

2. BACK-TO-BACK (B2B) CONTRACT BETWEEN SPHO AND GENERAL PRACTICES.

The required new contract (B2B) between SPHO and General Practice Providers is in its final draft iteration following adaption of the suggested Ministry of Health template and review between SPHO, the providers Representative Independent Practitioners Organisation and SPHOs lawyer Fraser Goldsmith Law. The new B2B will then be circulated to all 93 General Practice Providers in our region for their feedback. With the supportive involvement of the local IPA first, it is anticipated ratification will be timely and execution of contracts will during February and March 2014.

3. PRIMARY MENTAL HEALTH SERVICES

Southern Health Services Ltd (Family Mental Health Services, Mosgiel)
Southern Health Services Ltd Board met on 18 Nov 13.

FMHS financial position for the month ending 31 Oct 13 was sound – y.t.d. deficit of ($11,673) and equity of $99,775.

Referrals remained steady for the month, 31 referrals: 55% from GPs, 32% self-referrals, 10% other referrers and SDHB 3%.

Primary Mental Health Services Review [Family Mental Health Services (FMHS) and SPHO Primary Mental Health Brief Intervention Services (PMHBIS)].

The Rapid Appraisal Report commissioned by SPHO from Professor Tony Dowall, was presented to the Primary Mental Health Review Group on 16 Dec 13. The Report was received and included key recommendations that SPHO and FMHS will now implement. The key issues to be considered and resolved are:

1. Differing operational methods for service delivery and improved levels of involvement in a stepped care model from general practice teams.
2. Potential criteria governing client entry to the PMHBIS and FMHS services. (e.g. financial, ethnicity - Community Services Card holders, Maori, Pasifika, youth etc)
3. The current PMHBIS service delivery model is financially unsustainable.

4. SPHO TRUSTEE APPOINTMENTS AND ROTATION.

Donna Matahaere-Atariki was reappointed as one of the two Trustees to represent Maori on the SPHO Board. The process for appointment was managed by the seven local Runaka in accordance with SPHO's Constitution requirement: *'Papatipu Runaka act as the Appointing Body, and are required to 'collectively' nominate the Trustee.'* Note: Sally Wast is the other Trustee representing Maori and is due to retire, by rotation, in 2014.

Amanda McCracken was seconded as the Nurse Trustee representative on the resignation of Wendy Findlay in Dec 14 (Wendy is now employed as SPHOs Nursing Director, Primary Health Care). Amanda is a Nurse Practitioner based in Western Southland and is also a member of SPHOs Advisory Group.

5. INTERGRATED PERFORMANCE AND INCENTIVE FRAMEWORK (IPIF)

Along with SDHB staff, key SPHO attended the Southern regional workshop held on 7 Nov 13 in Christchurch. The Ministry of Health are preparing the final protocols which are expected to be circulated to the sector from the Expert Advisory Group in early 2014.

The new IPIF will be introduced under PHO/DHB Alliances in 2014, once the final policy is agreed. The policy is expected in early 2014, with implementation from 1 Jul 14.

SPHO and SDHB will work collaboratively under the Alliance to more effectively achieve Health Targets and outcomes locally.

6. SPHO ANNUAL GENERAL MEETING

SPHO's 2013 AGM was held on Wednesday 30 Oct 13 at the SPHO Office in Invercargill. SPHOs annual Report for the year ending 30 June 2013 is available on our website: http://www.southernpho.health.nz/downloads/southern_pho_annual_report_2013.pdf

7. SPHO STRATEGIC ALIGNMENT WITH SDHB

In support of the Alliance Agreement between SDHB and SPHO, SDHB Chief Medical Officer Mr David Tulloch and SPHO Chief Executive Ian Macara completed eight locality meetings across the district (Oamaru, Dunedin, Balclutha, Cromwell, Queenstown, Lumsden, Gore and Invercargill) in December 2013 to engage with key primary care stakeholders. David's presentation 'Deep dive and rise to the top for SDHB' was the basis for discussion at meetings and it was very well received as the outline of the whole of sector, working together approach required to meet the challenges to be resolved. Key messages included affirmation of 'putting patients at the centre of what we all do' and enhancing a 'seamless wellness system' that has health interventions based on a 'home to home' premise.

Feedback from provider attendees at the meetings was that the majority of them understood and acknowledged that the proposed changes were necessary. There was acknowledgement that many innovative service initiatives had already been introduced and requested by general practice, particularly rural practices. Changes like immediate access to Specialists for advice and the ability of GPs to order tests for diagnostic purposes e.g. imaging will be welcomed, especially to assist acute care management and reduce hospital admissions.

8. AFTER-HOURS AND UNDER 6s

Invercargill: SPHO is preparing to re-engage with Invercargill GPs to seek progress on the circulated SPHO position paper. A meeting is to be arranged as soon as practicable in early 2014. Details and a business case on how a nurse-led clinic can be commenced, including financial sustainability, are being prepared. SPHO and SDHB staff, including Southland Hospital ED Clinical Director Dr Adam McLeay and SDHB Executive Director, Nursing and Midwifery Leanne Samuel, are presently reviewing patient attendance data and patterns, and service cost information in preparation for meetings.

Note: the position paper has the proposed objectives: redirection of triaged patients to general practice (keeping emergency department for emergencies), reviewed models of

care for more effective out-of-hours services for patients, including nurse-led clinics with general practitioner support and overnight support from SDHB.

Central Otago: Former SPHO Manager Jen Brown is leading two key workstreams under contract to SPHO:

i) Cromwell and Alexandra general practices – Jen continues work with the practices and Dunstan hospital staff to formulate an after-hours initiative to suit that region.

ii) The Wanaka general practices have confirmed a Letter of Agreement with SPHO that provides an interim month by month increase in funding from 8 Nov 13 to 1 Jul 14. A meeting is set for 23 Jan 14 to continue work on sustainability of the service for the future.

iii) Overall consideration and reallocation of Rural After-hours funding will come under the Alliance work plan and consideration of Rural Funding, SDHBs Rural Health Strategy and Health Needs Assessment, and review of service models etc. While there is no new funding available, the current funding of $3.072m *(Rural after-hours $1.463m, HML Procare $135k, Rural Workforce Retention $1.474*) is to be reviewed.

Note: After-hours and acute care services are a priority work-stream under the Alliance.

Under 6s: No change – 5 practices in Invercargill continue to charge Under 6s during usual business hours. To be followed up in early 2014 by SPHO – in late 2013 a detailed financial breakdown was provided to each practice showing increased funding levels available to them under the scheme compared to their part-charge regime.

9. RURAL FUNDING

On 6 Dec 13, Deputy Director General of Health Cathy O'Malley confirmed that the Ministry of Health is finalising guidelines to enable local flexibility (i.e. Southern DHB region) on how Rural Funding can be allocated and utilised. Cathy also confirmed an additional $197k was available to SPHO (in addition to the recently announced $9m nationally over 4 years).

Rural Funding is able to be combined into a flexible funding pool comprising current rural funding streams of rural bonus, workforce retention, reasonable roster and rural after hours. The national Rural Ranking score system will be replaced by Alliances.

Under the Alliance, a Rural Work Group (Service Level Alliance Team) will be established to consider how funding can be allocated for rural primary care services and make a recommendation/s to the Alliance Leadership Team

2. OPERATIONAL AND PROGRAMMES UPDATE

Updates as reported to SPHOs Clinical Review Sub-committee (CRC) in December 2013 on the progress of work activities and relationships are as follows:

Key activities of the reporting period included:

- *PHO Performance Programme:* Payments for the January-June 2013 quarter have been made to practices.

- *Smokefree:* SPHO Primary Health Services Manager Kaylene Holland and Dr Keith Abbott (SPHO GP Smokefree Champion) met the Ministry of Health regarding smoking status. Keith is working on a number of incentives to encourage practices to increase their performance on this target, including identifying a "Smokefree Champion" within each practice, and investigating better ways of capturing data. Increasing performance in this target area will increase revenue for SPHO practices.

- *Cancer Navigators:* The two contracts are in place with Arai Te Uru Whare Hauora and Nga Kete Matauranga Pounamu. The funding is $120k across the two contracts for a 12 month period. The 12 month period began on 1 Nov 13 and will involve two 0.6 FTE (Otago/Southland) "navigators" to support Maori patients on the cancer journey.

- New National Draft Quality Standards for diabetic care have been received. SPHO to circulate these to key stakeholders.

- Jodie Black started as SPHO's Workforce Development Coordinator on 11 Nov 13. Jodie is surveying stakeholders about their education needs for 2014.

- *Venesection:* SPHO Nursing Director Primary Health Care Wendy Findlay and Kaylene Holland have met with Southern Community Laboratories on this issue. Practices charge between $30 and $80 per venesection in practice. SCL get $60 per venesection and the bus service $90. Wendy and Kaylene are working with SCL to unravel these issues on funding discrepancies. There is also a need to ensure consistency of referral criteria, as it appears practices and SCL use different criteria to assess need. This is work in progress.

- *DVT D-Dimer:* Wendy Findlay is to contact the D-dimer kits supplier. Once SPHO purchases the kits, SPHO will consider how best to manage distribution and supply and whether SPHO should act as "wholesaler" for these kits. Distribution/stock management through pharmacies could be an option and will be investigated.

- *Cellulitis:* This work is tied in to the health pathway work at SDHB. Wendy Findlay is working with SDHB on the pathway and will identify pilot practices in 2014.

- *Rural Health Development:* Dr Stephen Graham is working on a policy for use of this fund, which is tagged funding from former PHOs for primary care rural health workforce development. It was suggested that SPHO could investigate holding an

annual rural seminar with some of these funds. SPHO Clinical Advisor Prof Campbell Murdoch will assist Stephen develop the policy.

- *Collaborative Clinical Practice Teams (renamed from "Practice support Southland Pharmacy Pilot"):* A meeting was held with Gore Health to finalise the practice as a pilot site. Gore Health's Board is meeting to sign off before Christmas (*note: Gore Health has now signed off as the first pilot practice)*. SPHO will contract the workforce to ensure consistency.

3. SPHO FINANCIAL POSITION

SPHOs financial position remains strong report for the period ending 30 Nov 13. Month surplus of $73,130. YTD surplus of $710,943. YTD Equity of $1,539,329.

SOUTHERN DISTRICT HEALTH BOARD

RECOMMENDATION: **That the committees note this report.**			
Briefing to:	Disability Support Advisory Committee and Community and Public Health Advisory Committees		
Subject:	B4 Schools Check		
Author:	Thelma Brown	**Date:**	16 October 2013
Purpose of Report :	**√ For Information Only**		√ Decision Required

Key Issues

B4 Schools Check

Background information is included on the B4 Schools Check as below.

The B4 School Check (B4SC) is a nationwide programme offering a free health and development check for four-year olds. The B4 School Check is the eighth and final check of the Well Child Schedule and serves as a comprehensive health check, behavioural and developmental check to identify and address any health, behavioural, social or developmental concerns. It includes general health assessment, immunisation check, vision and hearing, oral health screen, height and weight, general developmental screen, behavioural screen, health promotion support and advice, referrals, tracking and follow-up processes. There are nationally defined protocols and referral pathways. Data is entered into a national database and reports are generated monthly.

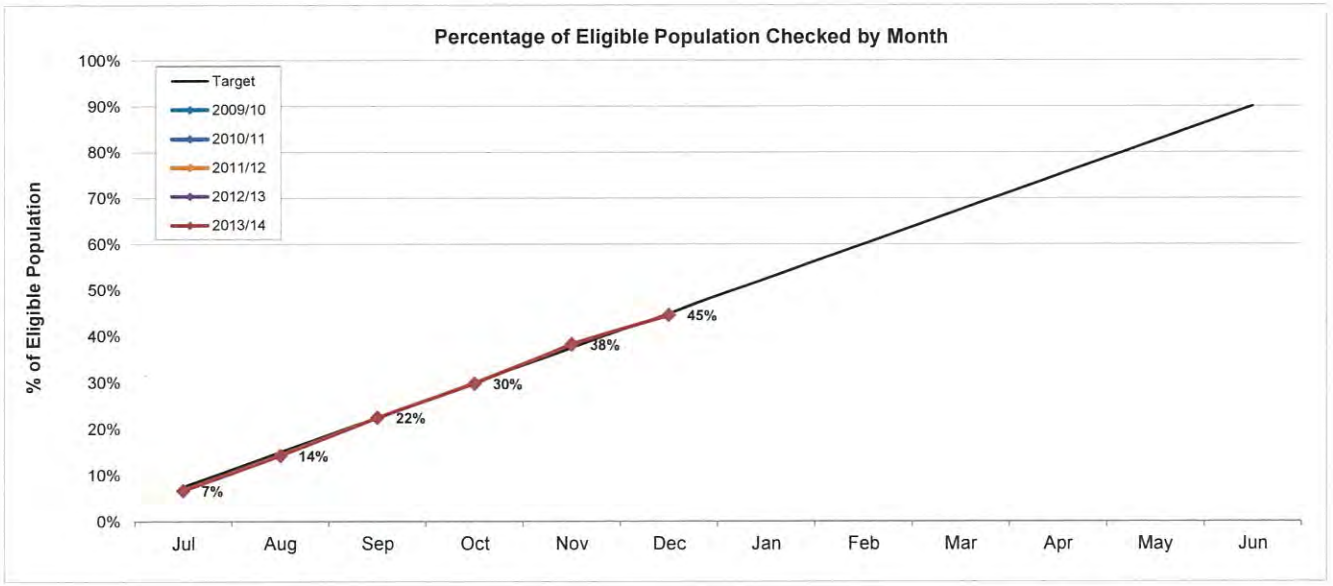
The Ministry of Health is committed to improving the overall quality of the Well Child Tamariki Ora (WCTO) programme, including B4SC, in order to ensure the best possible outcomes for children. Nationally, there is a quite rigorous schedule of monitoring B4School Check Reports in order to evaluate the quality of the programme across the country.

One of the aims of the programme is to provide a nationally consistent programme with minimal variability in programme delivery. Delivering the programme requires a well trained and experienced workforce who can work with families to screen children effectively and efficiently and make referrals as appropriate. The service is offered through the Public Health Nursing Service in Otago and Southland.

The Ministry of Health has established B4School targets for both the general population (90% of all eligible children) and high deprivation population (90% of all eligible children in quintile 5) and Southern DHB is one of the standout DHBs in terms of achieving these targets.

DHB: All DHBs

Group: All Deprivation Levels



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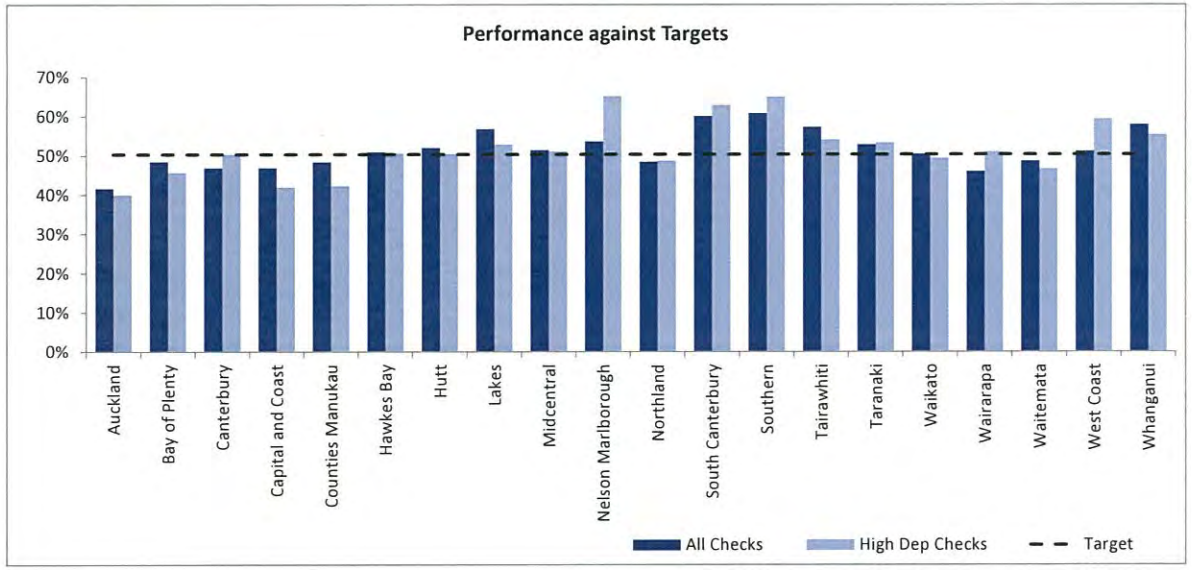
- ☐ Show 2010/11 Line
- ☐ Show 2011/12 Line
- ☐ Show 2012/13 Line
- ☑ Show 2013/14 Line

	Checks					Cummulative Checks					% of Eligible Population				
Month	2009/10	2010/11	2011/12	2012/13	2013/14	2009/10	2010/11	2011/12	2012/13	2013/14	2009/10	2010/11	2011/12	2012/13	2013/14
Jul	1,930	2,271	4,019	3,629	4,368	1,930	2,271	4,019	3,629	4,368	3%	4%	6%	6%	7%
Aug	1,845	3,023	4,057	4,461	4,954	3,775	5,294	8,076	8,090	9,322	6%	8%	12%	12%	14%
Sep	4,902	3,663	5,100	5,114	5,344	8,677	8,957	13,176	13,204	14,666	14%	14%	20%	20%	22%
Oct	4,182	3,401	3,740	4,143	4,813	12,859	12,358	16,916	17,347	19,479	21%	19%	26%	27%	30%
Nov	2,641	5,319	4,862	4,931	5,517	15,500	17,677	21,778	22,278	24,996	26%	28%	33%	34%	38%
Dec	3,964	3,617	3,343	3,630	4,200	19,464	21,294	25,121	25,908	29,196	32%	33%	39%	40%	45%
Jan	1,668	2,127	2,420	3,679		21,132	23,421	27,541	29,587		35%	37%	42%	46%	
Feb	2,317	3,076	4,157	3,679		23,449	26,497	31,698	33,265		39%	42%	49%	51%	
Mar	3,330	4,889	5,524	4,801		26,779	31,386	37,222	38,066		44%	49%	57%	59%	
Apr	3,322	4,461	3,280	4,316		30,101	35,847	40,502	42,382		50%	56%	62%	65%	
May	4,217	4,472	5,547	4,924		34,318	40,319	46,049	47,306		57%	63%	71%	73%	
Jun	5,847	5,536	5,412	4,840		40,165	45,855	51,461	52,146		67%	72%	79%	80%	

Performance

Data as of midnight 7 Jan 2014

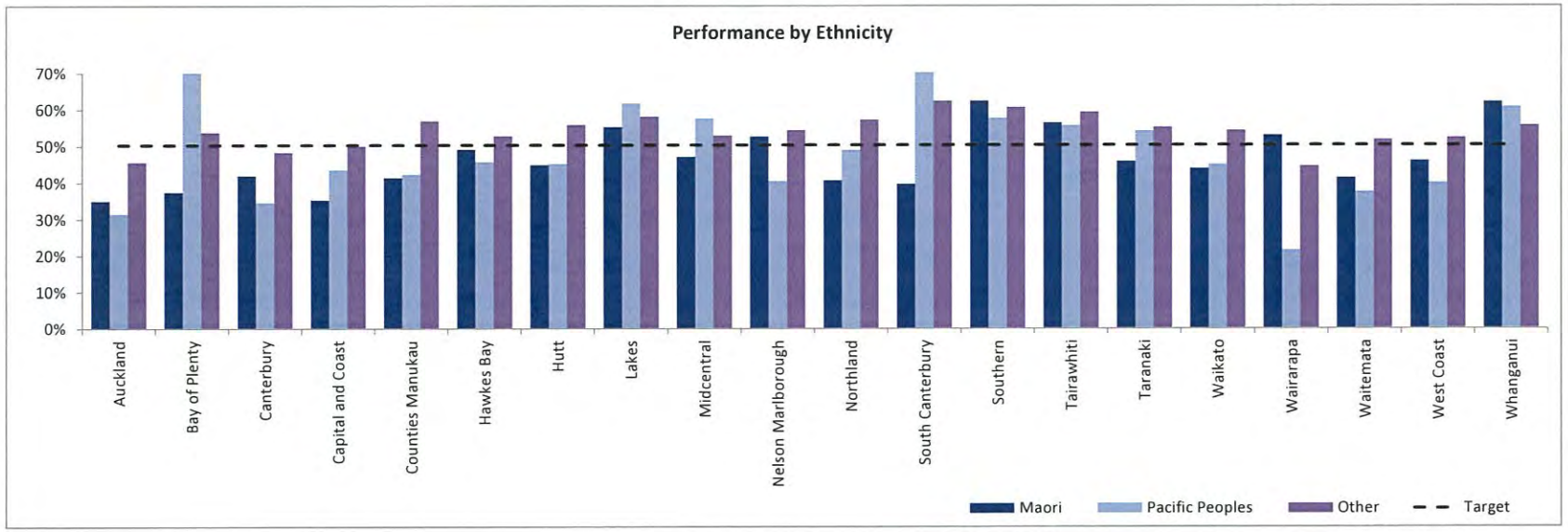
DHB	Eligible Population		Target Population		Total	
	Checked (%)	Checked (High Dep %)	Checked (%)	Checked (High Dep %)	Checked	Checked (High Dep)
Auckland	37%	36%	42%	40%	2,411	554
Bay of Plenty	44%	41%	48%	46%	1,331	333
Canterbury	42%	45%	47%	50%	2,810	380
Capital and Coast	42%	38%	47%	42%	1,663	258
Counties Manukau	44%	38%	48%	42%	3,902	1,528
Hawkes Bay	46%	46%	51%	51%	1,129	380
Hutt	47%	45%	52%	50%	1,075	266
Lakes	51%	47%	57%	53%	871	284
Midcentral	46%	46%	51%	51%	1,099	253
Nelson Marlborough	48%	59%	54%	65%	865	84
Northland	44%	44%	48%	49%	1,099	406
South Canterbury	54%	57%	60%	63%	387	39
Southern	55%	59%	61%	65%	2,158	264
Tairawhiti	52%	49%	57%	54%	420	207
Taranaki	48%	48%	53%	53%	784	128
Waikato	45%	44%	50%	49%	2,600	669
Wairarapa	41%	46%	46%	51%	247	49
Waitemata	44%	42%	49%	47%	3,639	372
West Coast	46%	53%	51%	59%	213	35
Whanganui	52%	50%	58%	55%	493	181
All DHBs	45%	43%	50%	47%	29,196	6,670



Performance - Ethnicity

Data as of midnight 7 Jan 2014

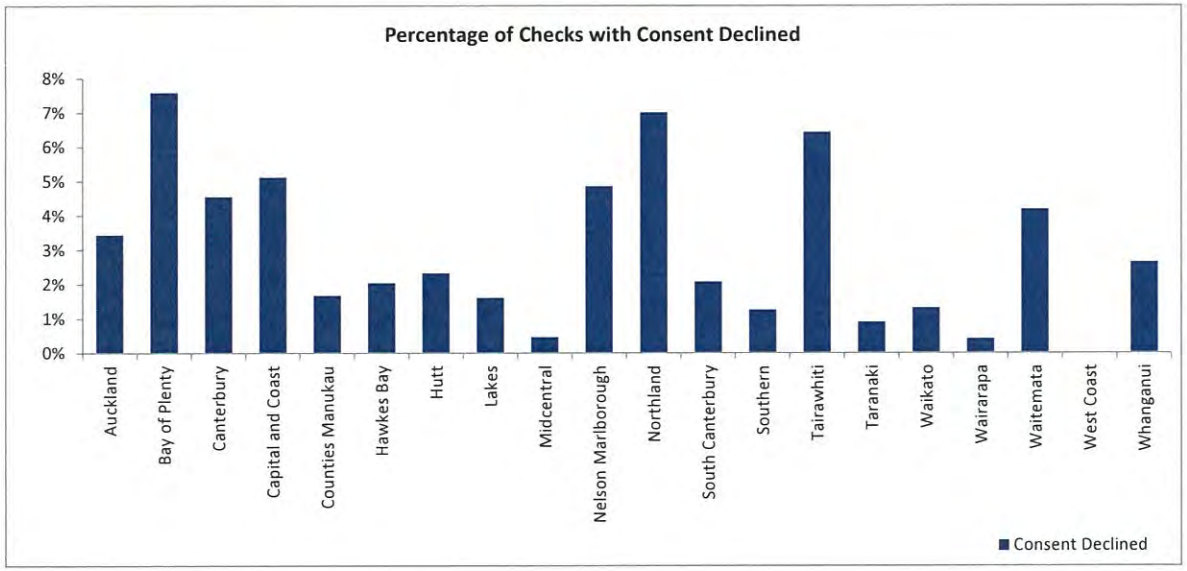
DHB	Eligible Population			Target Population			Total		
	Maori	Pacific Peoples	Other	Maori	Pacific Peoples	Other	Maori	Pacific Peoples	Other
Auckland	32%	28%	41%	35%	31%	46%	185	394	1,832
Bay of Plenty	34%	89%	48%	37%	100%	54%	396	59	876
Canterbury	38%	31%	43%	42%	35%	48%	302	93	2,415
Capital and Coast	32%	39%	45%	35%	44%	50%	202	162	1,299
Counties Manukau	37%	38%	51%	41%	42%	57%	727	1,190	1,985
Hawkes Bay	44%	41%	48%	49%	46%	53%	445	64	620
Hutt	40%	41%	50%	45%	45%	56%	220	108	747
Lakes	50%	56%	52%	55%	62%	58%	406	29	436
Midcentral	42%	52%	48%	47%	58%	53%	297	57	745
Nelson Marlborough	47%	37%	49%	53%	40%	54%	138	19	708
Northland	37%	44%	52%	41%	49%	57%	478	23	598
South Canterbury	36%	69%	56%	40%	75%	62%	27	9	351
Southern	56%	52%	55%	62%	58%	61%	302	53	1,803
Tairawhiti	51%	50%	53%	56%	56%	59%	267	10	143
Taranaki	41%	48%	50%	46%	54%	55%	173	13	598
Waikato	40%	41%	49%	44%	45%	54%	745	90	1,765
Wairarapa	48%	19%	40%	53%	21%	45%	71	3	173
Waitemata	37%	34%	47%	41%	38%	52%	429	341	2,869
West Coast	41%	40%	47%	46%	40%	52%	29	2	182
Whanganui	56%	55%	50%	62%	61%	56%	177	17	299
All DHBs	40%	37%	48%	45%	41%	53%	6,016	2,736	20,444



Performance - Consent Declined

Data as of midnight 7 Jan 2014

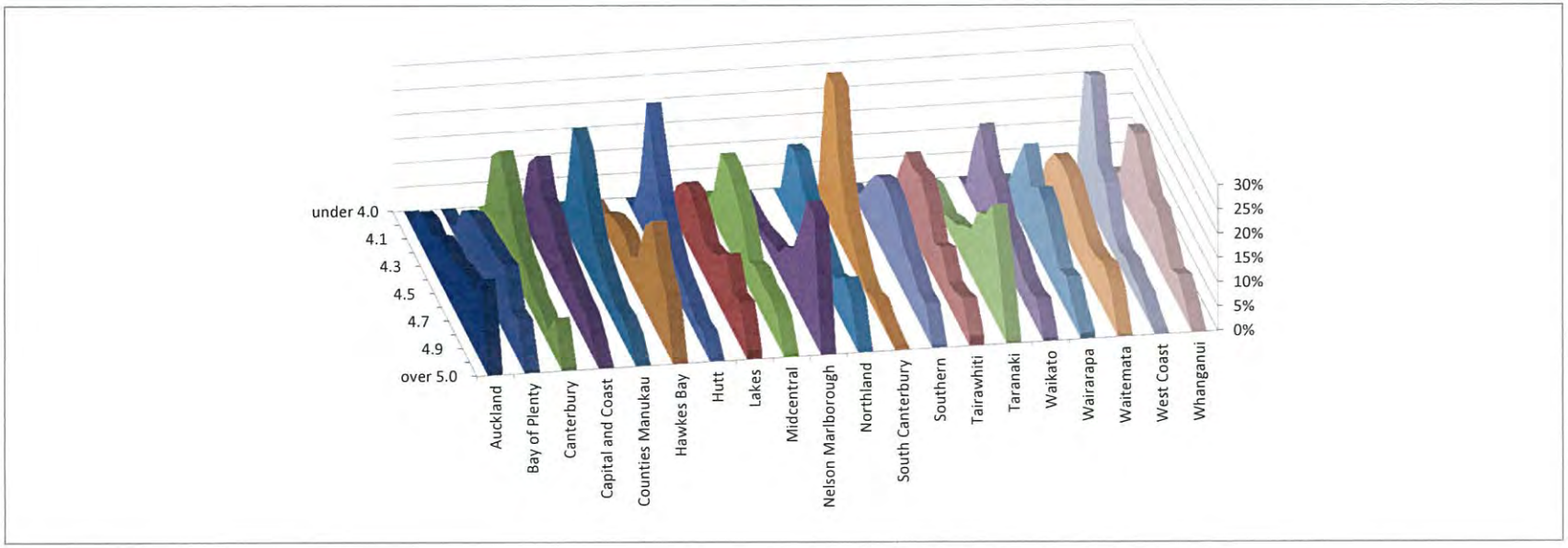
DHB	All	Checks Consent Declined	Consent Declined %
Auckland	2,411	83	3%
Bay of Plenty	1,331	101	8%
Canterbury	2,810	128	5%
Capital and Coast	1,663	85	5%
Counties Manukau	3,902	65	2%
Hawkes Bay	1,129	23	2%
Hutt	1,075	25	2%
Lakes	871	14	2%
Midcentral	1,099	5	0%
Nelson Marlborough	865	42	5%
Northland	1,099	77	7%
South Canterbury	387	8	2%
Southern	2,158	27	1%
Tairawhiti	420	27	6%
Taranaki	784	7	1%
Waikato	2,600	34	1%
Wairarapa	247	1	0%
Waitemata	3,639	152	4%
West Coast	213	0	0%
Whanganui	493	13	3%
All DHBs	29,196	917	3%



Quality - Timeliness

Completed checks in the last 6 months

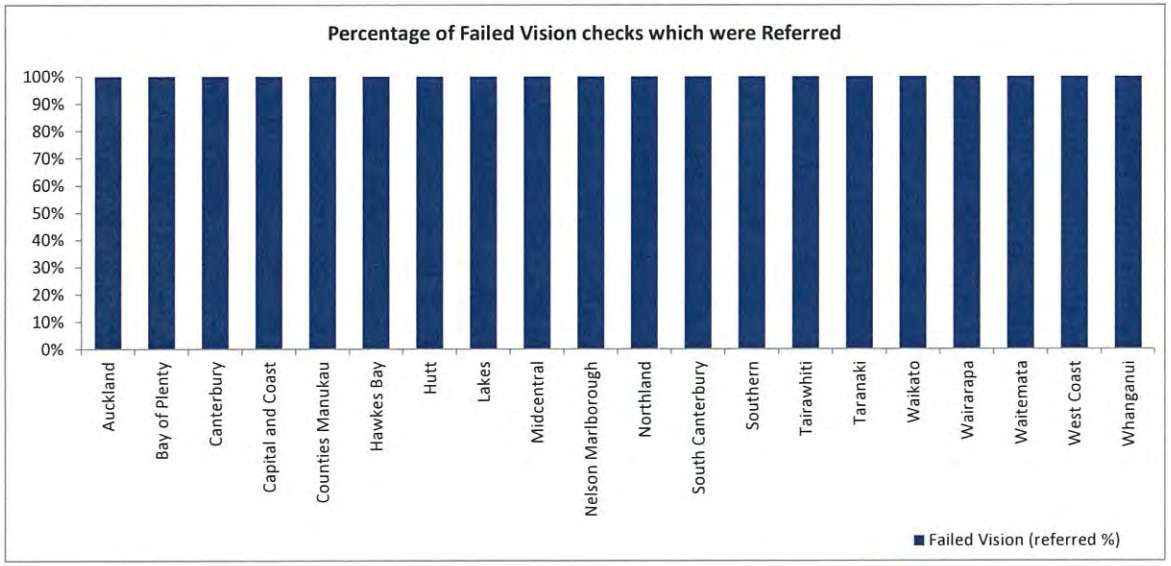
DHB	under 4.0	4.0	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8	4.9	5.0	over 5.0	Within Target Age Band
Auckland	0%	0%	6%	7%	6%	9%	10%	10%	11%	12%	12%	17%	1%	38%
Bay of Plenty	0%	0%	2%	8%	11%	12%	12%	13%	13%	14%	8%	8%	0%	44%
Canterbury	0%	3%	16%	20%	16%	11%	7%	6%	4%	4%	3%	8%	1%	74%
Capital and Coast	0%	3%	14%	18%	13%	12%	9%	8%	7%	6%	6%	4%	0%	69%
Counties Manukau	0%	0%	6%	24%	22%	14%	9%	7%	5%	4%	5%	4%	0%	75%
Hawkes Bay	0%	0%	3%	5%	7%	7%	5%	8%	17%	21%	14%	12%	0%	28%
Hutt	0%	0%	9%	28%	19%	13%	9%	6%	5%	4%	3%	4%	0%	78%
Lakes	0%	1%	8%	11%	12%	10%	7%	8%	10%	13%	8%	9%	2%	49%
Midcentral	0%	1%	6%	17%	17%	15%	12%	6%	7%	6%	7%	6%	0%	67%
Nelson Marlborough	0%	0%	0%	1%	2%	3%	4%	8%	11%	18%	26%	26%	0%	11%
Northland	0%	3%	15%	16%	13%	9%	8%	6%	5%	7%	10%	8%	0%	63%
South Canterbury	0%	0%	26%	37%	17%	8%	5%	2%	1%	2%	1%	0%	0%	94%
Southern	0%	0%	4%	9%	13%	15%	15%	13%	10%	8%	6%	7%	0%	56%
Tairawhiti	0%	0%	8%	15%	14%	15%	13%	7%	9%	5%	6%	7%	2%	65%
Taranaki	0%	2%	2%	1%	3%	5%	7%	10%	16%	18%	23%	13%	0%	20%
Waikato	0%	1%	11%	19%	14%	13%	9%	9%	7%	5%	5%	6%	1%	67%
Wairarapa	0%	0%	4%	11%	18%	12%	14%	13%	10%	6%	7%	4%	1%	59%
Waitemata	0%	1%	8%	12%	13%	13%	11%	9%	7%	8%	10%	7%	0%	58%
West Coast	0%	3%	26%	28%	13%	12%	5%	3%	4%	3%	3%	1%	0%	85%
Whanganui	0%	0%	5%	17%	18%	14%	11%	11%	8%	5%	6%	4%	0%	66%
All DHBs	0%	1%	8%	15%	14%	12%	9%	8%	8%	8%	8%	8%	0%	59%



Quality - Vision

Completed checks in the last 6 months

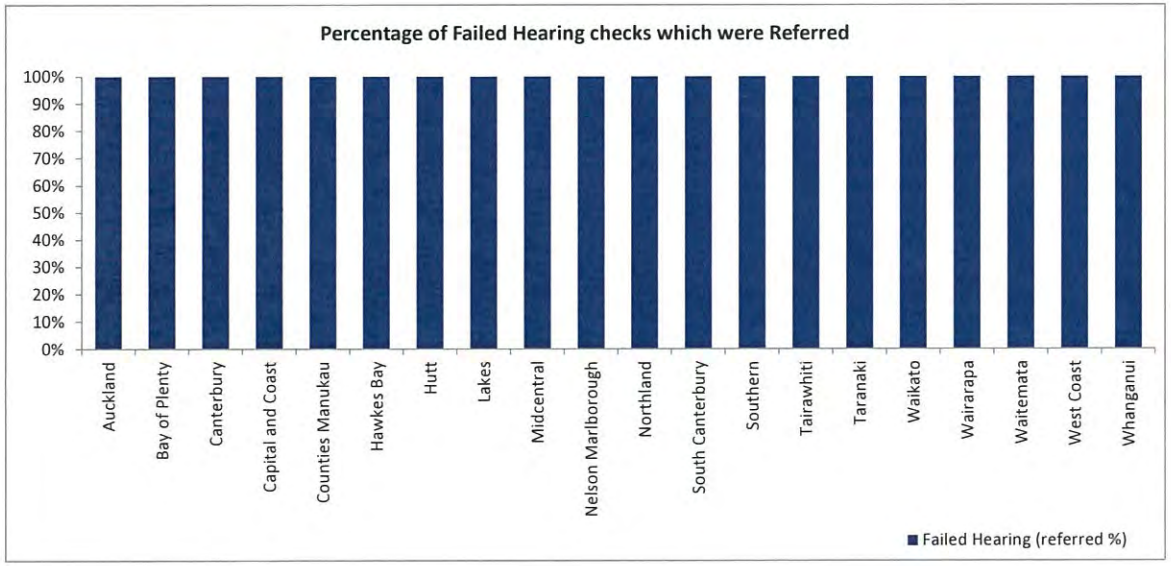
DHB	Checks	Checks (Rescreens)	Checks (Rescreens %)	Failed Vision (all)	Failed Vision (under care)	Failed Vision (should be referred)	Failed Vision (referred)	Failed Vision (referred %)
Auckland	2,076	168	8%	145	45	100	100	100%
Bay of Plenty	1,317	65	5%	84	20	64	64	100%
Canterbury	2,507	272	11%	227	61	166	166	100%
Capital and Coast	1,565	176	11%	157	50	107	107	100%
Counties Manukau	3,461	366	11%	365	48	317	317	100%
Hawkes Bay	1,108	39	4%	175	20	155	155	100%
Hutt	1,058	96	9%	115	48	67	67	100%
Lakes	844	82	10%	97	28	69	69	100%
Midcentral	1,048	162	15%	123	35	88	88	100%
Nelson Marlborough	840	25	3%	56	42	14	14	100%
Northland	958	56	6%	46	8	38	38	100%
South Canterbury	353	19	5%	33	5	28	28	100%
Southern	2,052	41	2%	162	82	80	80	100%
Tairawhiti	414	21	5%	33	19	14	14	100%
Taranaki	752	0	0%	75	18	57	57	100%
Waikato	2,585	105	4%	233	165	68	68	100%
Wairarapa	250	50	20%	28	12	16	16	100%
Waitemata	3,558	248	7%	243	117	126	126	100%
West Coast	190	9	5%	16	6	10	10	100%
Whanganui	425	71	17%	24	6	18	18	100%
All DHBs	27,361	2,071	8%	2,437	835	1,602	1,602	100%



Quality - Hearing

Completed checks in the last 6 months

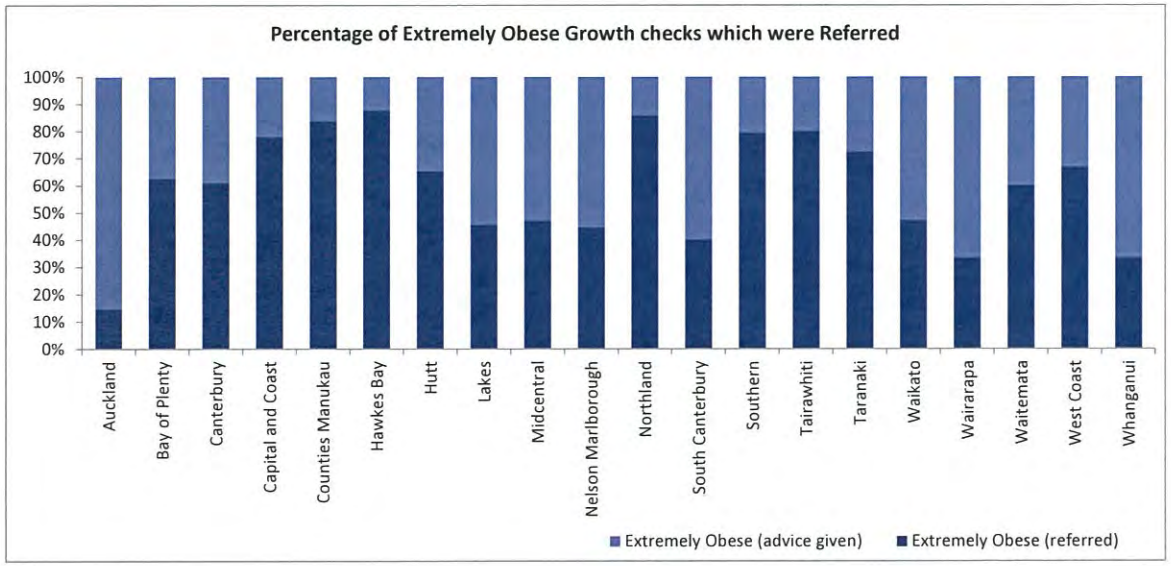
DHB	Checks	Checks (Rescreens)	Checks (Rescreens %)	Failed Hearing (all)	Failed Hearing (under care)	Failed Hearing (should be referred)	Failed Hearing (referred)	Failed Hearing (referred %)
Auckland	2,094	207	10%	147	56	91	91	100%
Bay of Plenty	1,318	168	13%	75	22	53	53	100%
Canterbury	2,509	407	16%	193	48	145	145	100%
Capital and Coast	1,566	276	18%	132	71	61	61	100%
Counties Manukau	3,459	724	21%	273	44	229	229	100%
Hawkes Bay	1,110	133	12%	224	24	200	200	100%
Hutt	1,060	168	16%	113	82	31	31	100%
Lakes	844	105	12%	83	30	53	53	100%
Midcentral	1,049	171	16%	104	37	67	67	100%
Nelson Marlborough	840	58	7%	65	37	28	28	100%
Northland	957	78	8%	75	41	34	34	100%
South Canterbury	356	40	11%	51	18	33	33	100%
Southern	2,054	66	3%	196	94	102	102	100%
Tairawhiti	414	30	7%	37	21	16	16	100%
Taranaki	749	0	0%	171	25	146	146	100%
Waikato	2,583	139	5%	306	161	145	145	100%
Wairarapa	250	53	21%	14	12	2	2	100%
Waitemata	3,556	262	7%	199	54	145	145	100%
West Coast	190	37	19%	9	5	4	4	100%
Whanganui	433	81	19%	16	7	9	9	100%
All DHBs	27,391	3,203	12%	2,483	889	1,594	1,594	100%



Quality - Growth

Completed checks in the last 6 months

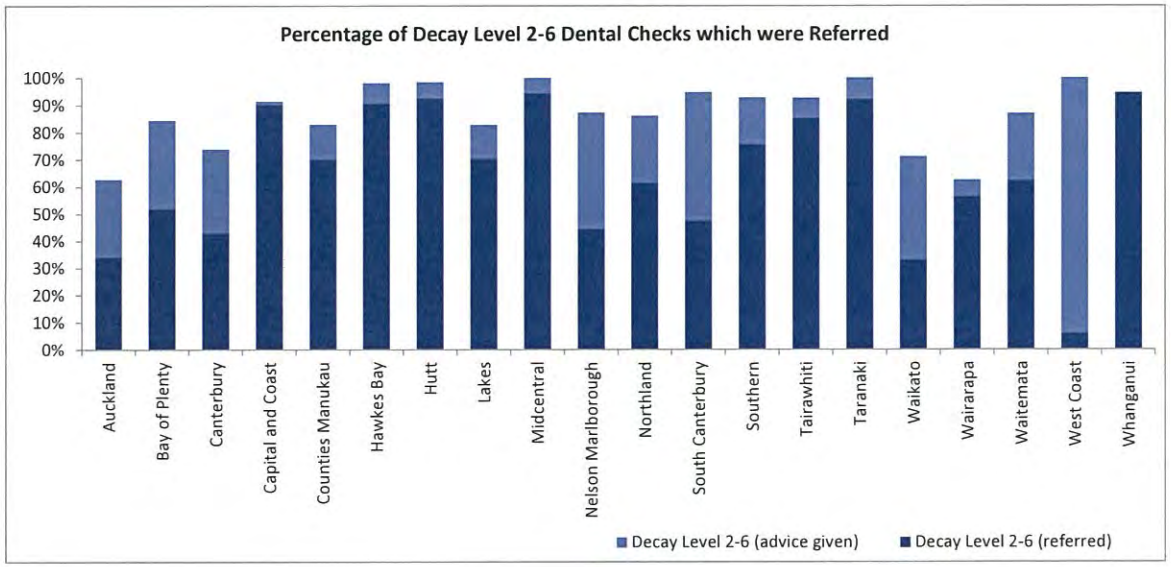
DHB	Checks	Extremely Obese (all)	Extremely Obese (under care)	Extremely Obese (should be referred)	Extremely Obese (advice given)	Extremely Obese (referred)	Extremely Obese (advice given %)	Extremely Obese (referred %)
Auckland	2,260	49	1	48	41	7	85%	15%
Bay of Plenty	1,218	16	0	16	6	10	38%	63%
Canterbury	2,600	26	3	23	9	14	39%	61%
Capital and Coast	1,562	24	6	18	4	14	22%	78%
Counties Manukau	3,587	110	6	104	17	87	16%	84%
Hawkes Bay	1,098	16	0	16	2	14	13%	88%
Hutt	1,043	25	2	23	8	15	35%	65%
Lakes	823	12	1	11	6	5	55%	45%
Midcentral	1,032	18	1	17	9	8	53%	47%
Nelson Marlborough	808	9	0	9	5	4	56%	44%
Northland	965	14	0	14	2	12	14%	86%
South Canterbury	350	5	0	5	3	2	60%	40%
Southern	2,000	30	1	29	6	23	21%	79%
Tairawhiti	397	7	2	5	1	4	20%	80%
Taranaki	763	19	1	18	5	13	28%	72%
Waikato	2,555	54	3	51	27	24	53%	47%
Wairarapa	248	3	0	3	2	1	67%	33%
Waitemata	3,456	43	3	40	16	24	40%	60%
West Coast	188	3	0	3	1	2	33%	67%
Whanganui	466	7	4	3	2	1	67%	33%
All DHBs	27,419	490	34	456	172	284	38%	62%



Quality - Dental

Completed checks in the last 6 months

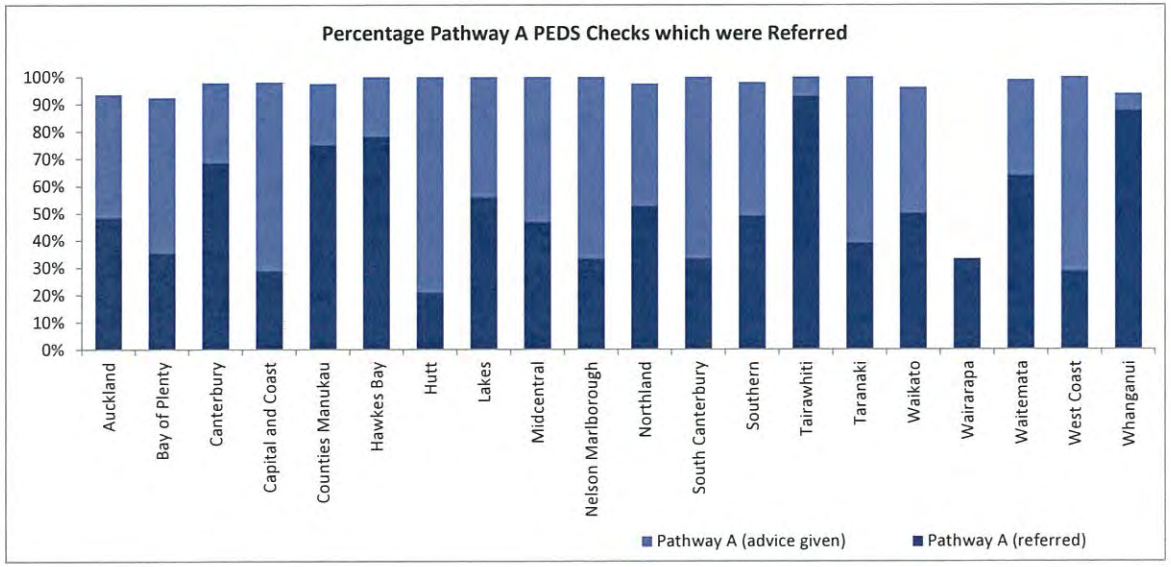
DHB	Checks	Decay Level 2-6 (all)	Decay Level 2-6 (under care)	Decay Level 2-6 (should be referred)	Decay Level 2-6 (advice given)	Decay Level 2-6 (referred)	Decay Level 2-6 (advice given %)	Decay Level 2-6 (referred %)
Auckland	2,257	373	67	306	88	104	29%	34%
Bay of Plenty	1,222	171	61	110	36	57	33%	52%
Canterbury	2,607	321	76	245	76	105	31%	43%
Capital and Coast	1,557	188	36	152	2	137	1%	90%
Counties Manukau	3,595	732	221	511	66	358	13%	70%
Hawkes Bay	1,100	200	147	53	4	48	8%	91%
Hutt	1,047	105	40	65	4	60	6%	92%
Lakes	828	114	50	64	8	45	13%	70%
Midcentral	1,029	124	72	52	3	49	6%	94%
Nelson Marlborough	811	85	6	79	34	35	43%	44%
Northland	965	231	94	137	34	84	25%	61%
South Canterbury	348	32	13	19	9	9	47%	47%
Southern	1,982	132	50	82	14	62	17%	76%
Tairawhiti	398	61	34	27	2	23	7%	85%
Taranaki	751	67	4	63	5	58	8%	92%
Waikato	2,568	313	46	267	102	88	38%	33%
Wairarapa	249	38	22	16	1	9	6%	56%
Waitemata	3,457	369	139	230	57	143	25%	62%
West Coast	189	18	1	17	16	1	94%	6%
Whanganui	461	65	11	54	0	51	-	94%
All DHBs	27,421	3,739	1,190	2,549	561	1,526	22%	60%



Quality - PEDS

Completed checks in the last 6 months

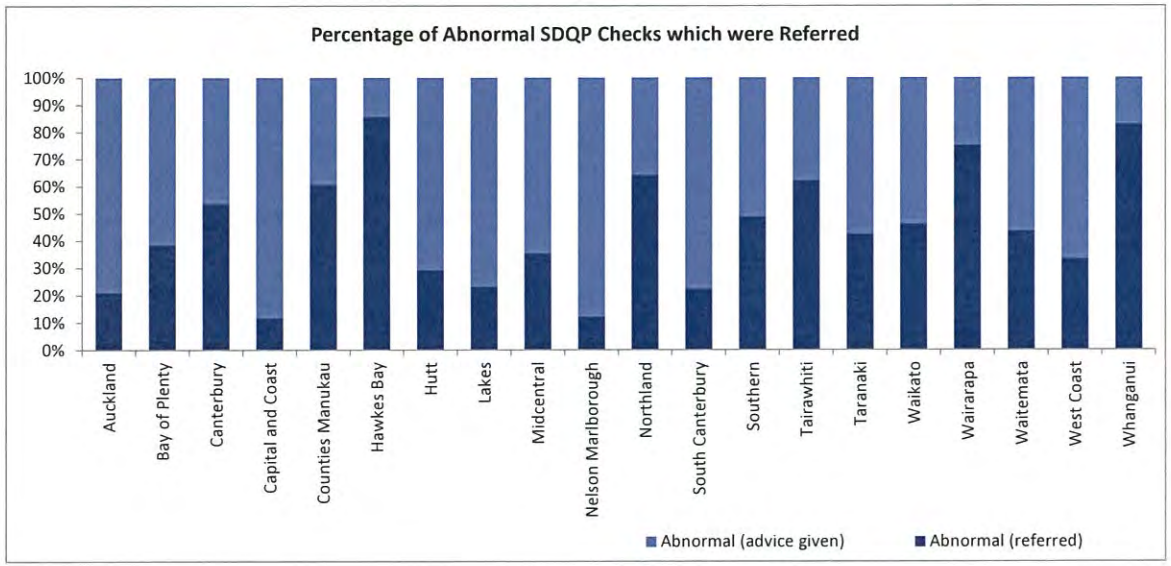
DHB	Checks	Pathway A (all)	Pathway A (under care)	Pathway A (should be referred)	Pathway A (advice given)	Pathway A (referred)	Pathway A (advice given %)	Pathway A (referred %)
Auckland	2,268	84	22	62	28	30	45%	48%
Bay of Plenty	1,221	79	14	65	37	23	57%	35%
Canterbury	2,611	139	47	92	27	63	29%	68%
Capital and Coast	1,558	80	28	52	36	15	69%	29%
Counties Manukau	3,595	133	53	80	18	60	23%	75%
Hawkes Bay	1,102	86	4	82	18	64	22%	78%
Hutt	1,052	68	20	48	38	10	79%	21%
Lakes	823	56	22	34	15	19	44%	56%
Midcentral	998	44	14	30	16	14	53%	47%
Nelson Marlborough	812	39	6	33	22	11	67%	33%
Northland	965	66	26	40	18	21	45%	53%
South Canterbury	354	31	7	24	16	8	67%	33%
Southern	2,010	90	41	49	24	24	49%	49%
Tairawhiti	399	20	6	14	1	13	7%	93%
Taranaki	764	54	0	54	33	21	61%	39%
Waikato	2,570	113	35	78	36	39	46%	50%
Wairarapa	249	5	2	3	0	1	-	33%
Waitemata	3,469	159	65	94	33	60	35%	64%
West Coast	189	15	1	14	10	4	71%	29%
Whanganui	465	27	11	16	1	14	6%	88%
All DHBs	27,474	1,388	424	964	427	514	44%	53%



Quality - SDQP

Completed checks in the last 6 months

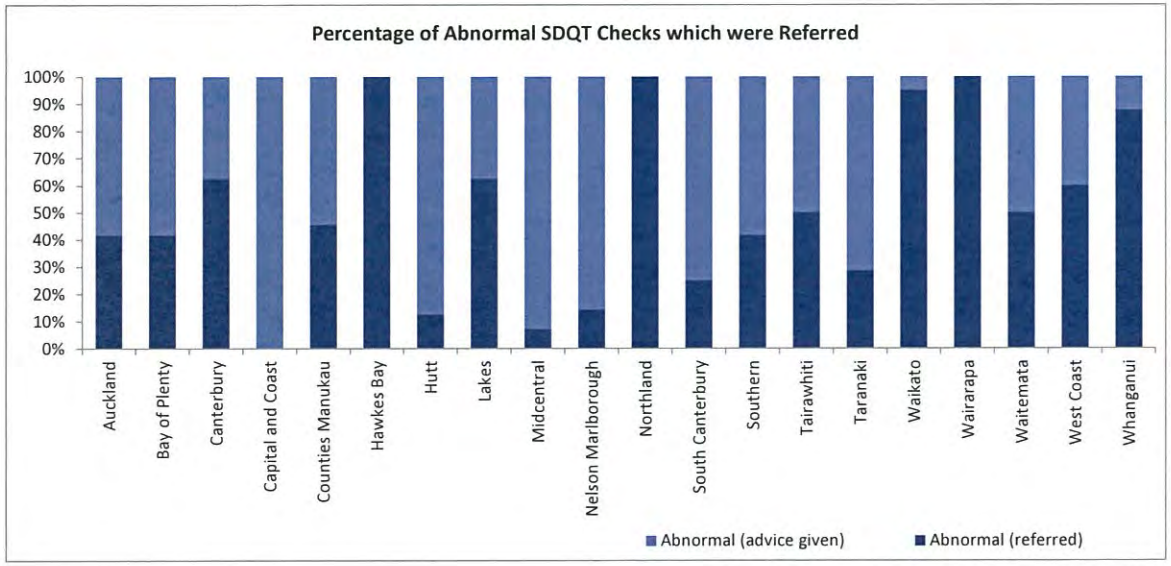
DHB	Checks	Abnormal (all)	Abnormal (under care)	Abnormal (should be referred)	Abnormal (advice given)	Abnormal (referred)	Abnormal (advice given %)	Abnormal (referred %)	SDQT and SDQP Completed %
Auckland	2,242	50	7	43	34	9	79%	21%	45%
Bay of Plenty	1,213	64	4	60	37	23	62%	38%	49%
Canterbury	2,604	73	15	58	27	31	47%	53%	77%
Capital and Coast	1,555	37	11	26	23	3	88%	12%	66%
Counties Manukau	3,565	160	36	124	49	75	40%	60%	49%
Hawkes Bay	1,102	72	3	69	10	59	14%	86%	51%
Hutt	1,047	40	9	31	22	9	71%	29%	65%
Lakes	818	65	13	52	40	12	77%	23%	52%
Midcentral	999	63	12	51	33	18	65%	35%	51%
Nelson Marlborough	808	27	2	25	22	3	88%	12%	85%
Northland	956	46	7	39	14	25	36%	64%	48%
South Canterbury	353	20	2	18	14	4	78%	22%	84%
Southern	2,006	55	12	43	22	21	51%	49%	85%
Tairawhiti	399	31	2	29	11	18	38%	62%	93%
Taranaki	757	59	0	59	34	25	58%	42%	86%
Waikato	2,553	107	20	87	47	40	54%	46%	54%
Wairarapa	246	5	1	4	1	3	25%	75%	60%
Waitemata	3,467	112	22	90	51	39	57%	43%	92%
West Coast	189	7	1	6	4	2	67%	33%	99%
Whanganui	464	35	6	29	5	24	17%	83%	78%
All DHBs	27,343	1,128	185	943	500	443	53%	47%	63%



Quality - SDQT

Completed checks in the last 6 months

DHB	Checks	Abnormal (all)	Abnormal (under care)	Abnormal (should be referred)	Abnormal (advice given)	Abnormal (referred)	Abnormal (advice given %)	Abnormal (referred %)	SDQT and SDQP Completed %
Auckland	934	16	4	12	7	5	58%	42%	45%
Bay of Plenty	557	20	8	12	7	5	58%	42%	49%
Canterbury	1,959	29	13	16	6	10	38%	63%	77%
Capital and Coast	1,007	20	7	13	13	0	100%	-	66%
Counties Manukau	1,308	48	26	22	12	10	55%	45%	49%
Hawkes Bay	529	39	3	36	0	36	-	100%	51%
Hutt	674	22	6	16	14	2	88%	13%	65%
Lakes	258	9	1	8	3	5	38%	63%	52%
Midcentral	489	15	1	14	13	1	93%	7%	51%
Nelson Marlborough	658	17	3	14	12	2	86%	14%	85%
Northland	354	14	6	8	0	8	-	100%	48%
South Canterbury	287	5	1	4	3	1	75%	25%	84%
Southern	1,733	54	18	36	21	15	58%	42%	85%
Tairawhiti	272	11	5	6	3	3	50%	50%	93%
Taranaki	577	21	0	21	15	6	71%	29%	86%
Waikato	1,356	44	4	40	2	38	5%	95%	54%
Wairarapa	141	3	1	2	0	2	-	100%	60%
Waitemata	533	8	2	6	3	3	50%	50%	92%
West Coast	153	6	1	5	2	3	40%	60%	99%
Whanganui	310	28	12	16	2	14	13%	88%	78%
All DHBs	14,089	429	122	307	138	169	45%	55%	63%



DSAC / CPHAC FINANCIAL REPORT

Financial Report as at: **31 December 2013**
Report Prepared by: **David Dickson**
Date: **22 January 2014**

Recommendations:

- **That the Committees note the Financial Report**

1. DHB Funds Result

Month				Year to Date			Annual
Actual	Budget	Variance		Actual	Budget	Variance	Budget
$' 000	$' 000	$' 000		$' 000	$' 000	$' 000	$' 000
67,975	68,107	(132)	Revenue	409,769	408,642	1,127	817,283
(68,385)	(68,463)	78	Less Other Costs	(411,084)	(409,703)	(1,381)	(818,387)
(410)	(356)	(54)	Net Surplus / (Deficit)	(1,315)	(1,061)	(254)	(1,104)
			Expenses				
(48,653)	(48,459)	(194)	Personal Health	(291,525)	(290,076)	(1,449)	(580,071)
(7,132)	(7,269)	137	Mental Health	(42,425)	(43,614)	1,189	(87,232)
(826)	(864)	38	Public Health	(5,779)	(5,182)	(597)	(10,363)
(10,923)	(11,020)	97	Disability Support	(66,250)	(65,723)	(527)	(130,502)
(153)	(153)	0	Maori Health	(916)	(919)	3	(1,840)
(698)	(698)	0	Other	(4,189)	(4,189)	0	(8,379)
(68,385)	(68,463)	78	Expenses	(411,084)	(409,703)	(1,381)	(818,387)

Summary Comment:
The December result was a deficit of $0.4m which was close to budget for the month. Year to date the result is a deficit of $1.3m which is $0.3m unfavourable to budget.

Key variances year to date are:

- ($0.7m) IDF revenue wash-up including $0.2m relating to the 2012-13 year
- ($0.6m) pharmaceutical costs, relating to 2012/2013 expenditure
- ($0.6m) of unfavourable public health for screening programmes, offset in revenue
- ($0.6m) of unfavourable home support costs
- ($0.3m) of unfavourable radiology costs, offset in revenue
- $1.2m of below budget provider-arm mental health expenditure from unfilled FTE positions
- $1.8m of additional revenue (excluding IDFs)

Revenue
YTD, revenue, excluding IDFs is $1.9m ahead of budget however most of this has associated cost offsets.

Item	$m	Expense Line Offset (Y/N/Partial)
PHO Performance Management funding	0.1	Y, Personal Health PHO Other
Elective Funding – Bariatric 12-13	0.3	N
Careplus funding	0.2	Y, Personal Health
Screening revenues	0.5	Y, Public Health expenditure
Revenue to reduce imaging wait times	0.3	Y, Transfer to provider arm
Sleepover settlement	0.4	Y, DSS
Aged care and dementia funding	0.1	Y, DSS
Total Revenue Variation	1.9	

Personal Health Payments
Personal Health is unfavourable for the month due to an unfavourable IDF wash-up of $0.3m. The IDF year to date position is now $0.2m unfavourable made up of acute/arranged variances of $0.3m partly offset by favourable variances in electives $0.1m. A table is included below showing the make up by DHB of the IDF variance.

Year to date personal health costs are unfavourable $1.4m with pharmaceuticals $0.6m relating to 2012-13, IDF's ($0.2m) radiology ($0.3m), which is offset with revenue, and additional laboratory costs ($0.3m).

Mental Health
Mental Health costs are favourable year to date due to the wash-up with the provider arm of $1.2m.

Disability Support
Disability support services costs were favourable in December with rest home residential care contributing the largest variance. Year to date DSS costs remain unfavourable ($0.5m), due to home support costs, and hospital residential care above budget.

Additional revenue for price and volume increases is yet to be received and will partly offset this. The full year forecast has been increased as a result, but will mostly be offset with the additional revenue.

Public Health
The expenditure variance of $0.6m is offset by revenue for screening programmes which is paid to the provider.

IDF Summary

The following tables show the IDF outflow (inpatient) wash-up for the period July-November. The net position is an unfavourable wash-up of $248k.

IDF Outflow summary for the period July- November 2013			
Sum of Variance in Dollars	Admission type		
DHB Name	Acute/arranged	Elective	Total
Auckland	-369,361	115,179	-254,182
Bay of Plenty	-3,912	3,364	-548
Canterbury	49,017	-95,128	-46,110
Capital and Coast	-25,106	-9,519	-34,625
Counties Manukau	77,827	-9,445	68,382
Hawkes Bay	11,251	3,312	14,564
Hutt Valley	-19,171	22,878	3,707
Lakes	-106,392	8,091	-98,301
MidCentral	9,605	5,990	15,595
Nelson Marlborough	-18,506	853	-17,653
Northland	13,047		13,047
South Canterbury	31,871	-32,113	-242
Tairawhiti	7,547		7,547
Taranaki	15,686		15,686
Waikato	-15,729	69,571	53,842
Wairarapa	1,266		1,266
Waitemata	4,017	7,036	11,053
West Coast	-1,770		-1,770
Total	-338,812	90,071	-248,742

The following table shows the IDF inflow (inpatient) wash-up for the period July- November. This shows an unfavourable wash-up of $568k, most of which relates to Canterbury DHB with large unfavourable wash-ups in General Surgery and Orthopaedics.

IDF Inflow summary for the period July- November 2013			
Sum of Variance in Dollars	Admission type		
DHB Name	Acute/arranged	Elective	Total
Auckland	-39,587		-39,587
Bay of Plenty	-14,691		-14,691
Canterbury	-273,583	-259,174	-532,757
Capital and Coast	17,542	569	18,111
Counties Manukau	-52,927	10,249	-42,678
Hawkes Bay	-23,885		-23,885
Hutt Valley	-13,001	-660	-13,661
Lakes	74,735	14,523	89,258
MidCentral	32,341	-4,839	27,503
Nelson Marlborough	-41,250	-1,582	-42,832
Northland	-18,431	816	-17,616
South Canterbury	119,830	-23,517	96,313
Tairawhiti	-7,711		-7,711
Taranaki	9,566	-7,624	1,941
Waikato	-75,239		-75,239
Wairarapa	4,285		4,285
Waitemata	15,569	1,369	16,938
West Coast	-47,626	31,814	-15,812
Whanganui	3,184		3,184
Total	-330,878	-238,057	-568,935

2. Financial Statements

The financial summary for the funder result is attached.

Southern District Health Board

Dec-13

Part 3: DHB Funds	Current Month Actual $(000)	Current Month Budget $(000)	Current Month Variance $(000)	Current Month Variance %	Year to Date Actual $(000)	Year to Date Budget $(000)	Year to Date Variance $(000)	Year to Date Variance %	Annual Budget $(000)
Part 3.1: Statement of Financial Performance									
REVENUE									
Ministry of Health									
MoH - Vote Health Non Mental Health	56,391	56,335	57 F		338,292	338,007	285 F		676,014
MoH - Vote Health Mental Health	7,057	7,062	(5) U		42,342	42,372	(30) U		84,744
PBF Adjustments	-	-			-	-			-
MoH Funding Subcontracts	3,106	3,124	(18) U	(1%)	20,343	18,744	1,599 F	9%	37,488
MoH - Personal Health	-	-			-	-			-
MoH - Mental Health	-	-			-	-			-
MoH - Public Health	-	-			-	-			-
MoH - Disability Support Services	-	-			-	-			-
MoH - Maori Health	-	-			-	-			-
Clinical Training Agency	-	-			-	-			-
Internal - DHB Funder to DHB Provider	-	-			-	-			-
Ministry of Health Total	**66,554**	**66,521**	**33 F**		**400,977**	**399,123**	**1,854 F**		**798,246**
Other Government									
IDF's - Mental Health Services	144	144			862	862			1,723
IDF's - All others (non Mental health)	1,278	1,443	(165) U	(11%)	7,930	8,657	(727) U	(8%)	17,314
Other DHB's	-	-			-	-			-
Training Fees and Subsidies	-	-			-	-			-
Accident Insurance	-	-			-	-			-
Other Government	-	-			-	-			-
Other Government Total	**1,421**	**1,586**	**(165) U**	**(10%)**	**8,792**	**9,519**	**(727) U**	**(8%)**	**19,037**
Government and Crown Agency Sourced Total	**67,975**	**68,107**	**(132) U**		**409,769**	**408,642**	**1,127 F**		**817,283**
Other Revenue									
Patient / Consumer Sourced	-	-			-	-			-
Other Income	-	-			-	-			-
Other Revenue Total	**-**	**-**			**-**	**-**			**-**
REVENUE TOTAL	**67,975**	**68,107**	**(132) U**		**409,769**	**408,642**	**1,127 F**		**817,283**
EXPENSES									
Outsourced Expenses									
Outsourced Funder Services	(698)	(698)			(4,189)	(4,189)			(8,379)
Other Outsourced Expenses	-	-			-	-			-
Other Expenses	-	-			-	-			-
Payments to Providers									
Personal Health									
Child and Youth	(381)	(375)	(6) U	(2%)	(2,266)	(2,252)	(15) U	(1%)	(4,504)
Laboratory	(2,666)	(2,639)	(27) U	(1%)	(16,145)	(15,837)	(308) U	(2%)	(31,674)
Infertility Treatment Services	(91)	(100)	9 F	9%	(546)	(600)	54 F	9%	(1,200)
Maternity	(262)	(261)			(1,569)	(1,567)	(2) U		(3,135)
Maternity (Tertiary & Secondary)	(1,372)	(1,385)	13 F	1%	(8,247)	(8,311)	64 F	1%	(16,622)
Pregnancy and Parenting Education	(8)	(12)	5 F	37%	(65)	(74)	9 F	12%	(148)
Maternity Payment Schedule	-	-			-	-			-
Neo Natal	(656)	(656)			(3,938)	(3,938)			(7,875)
Sexual Health	(88)	(88)			(528)	(528)			(1,055)
Adolescent Dental Benefit	(197)	(235)	38 F	16%	(1,130)	(1,311)	181 F	14%	(2,425)
Other Dental Services	-	-			-	-			-
Dental - Low Income Adult	(5)	(90)	85 F	94%	(450)	(540)	90 F	17%	(1,083)
Child (School) Dental Services	(629)	(646)	18 F	3%	(3,801)	(3,846)	45 F	1%	(7,608)
Secondary / Tertiary Dental	(254)	(245)	(9) U	(4%)	(1,524)	(1,473)	(52) U	(4%)	(2,950)
Pharmaceuticals	(6,478)	(6,464)	(14) U		(38,729)	(38,078)	(650) U	(2%)	(75,312)
Pharmaceutical Cancer Treatment Drugs	(297)	(358)	62 F	17%	(2,117)	(2,150)	33 F	2%	(4,300)
Pharmacy Services	(28)	(68)	40 F	59%	(298)	(411)	112 F	27%	(821)
Management Referred Services	-	-			-	-			-
General Medical Subsidy	(75)	(149)	75 F	50%	(530)	(869)	339 F	39%	(1,650)
Primary Practice Services - Capitated	(3,427)	(3,431)	4 F		(20,455)	(20,586)	131 F	1%	(41,172)
Primary Health Care Strategy - Care	(280)	(240)	(40) U	(17%)	(1,629)	(1,441)	(187) U	(13%)	(2,883)
Primary Health Care Strategy - Health	(331)	(286)	(45) U	(16%)	(1,968)	(1,716)	(252) U	(15%)	(3,432)
Primary Health Care Strategy - Other	(223)	(207)	(16) U	(8%)	(1,469)	(1,242)	(227) U	(18%)	(2,484)
Practice Nurse Subsidy	(16)	(17)		3%	(103)	(99)	(4) U	(4%)	(198)
Rural Support for Primary Health Pro	(1,375)	(1,371)	(4) U		(8,237)	(8,226)	(11) U		(16,452)
Immunisation	(128)	(129)			(828)	(808)	(20) U	(2%)	(2,651)
Radiology	(466)	(457)	(9) U	(2%)	(3,012)	(2,743)	(269) U	(10%)	(5,486)
Palliative Care	(451)	(495)	44 F	9%	(3,037)	(2,971)	(66) U	(2%)	(5,942)
Meals on Wheels	(54)	(53)	(1) U	(2%)	(320)	(316)	(4) U	(1%)	(632)
Domicilary & District Nursing	(1,378)	(1,436)	58 F	4%	(8,554)	(8,617)	62 F	1%	(17,233)
Community based Allied Health	(581)	(581)			(3,489)	(3,486)	(3) U		(6,972)
Chronic Disease Management and Educa	(240)	(241)	1 F		(1,439)	(1,447)	8 F	1%	(2,894)
Medical Inpatients	(5,619)	(5,619)			(33,712)	(33,712)			(67,425)
Medical Outpatients	(3,609)	(3,617)	8 F		(21,548)	(21,703)	155 F	1%	(43,405)
Surgical Inpatients	(10,482)	(10,426)	(56) U	(1%)	(62,620)	(62,555)	(65) U		(125,110)
Surgical Outpatients	(1,711)	(1,716)	5 F		(10,267)	(10,296)	29 F		(20,592)
Paediatric Inpatients	(641)	(641)			(3,843)	(3,843)			(7,686)
Paediatric Outpatients	(267)	(267)			(1,603)	(1,603)			(3,207)
Pacific Peoples' Health	(17)	(21)	4 F	19%	(110)	(129)	19 F	15%	(258)
Emergency Services	(1,621)	(1,630)	9 F	1%	(9,764)	(9,779)	15 F		(19,557)
Minor Personal Health Expenditure	(99)	(89)	(11) U	(12%)	(504)	(531)	27 F	5%	(1,062)
Price adjusters and Premium	748	795	(47) U	(6%)	4,393	4,772	(379) U	(8%)	9,543
Travel & Accomodation	(394)	(362)	(31) U	(9%)	(2,390)	(2,326)	(64) U	(3%)	(4,741)
Inter District Flow Personal Health	(2,505)	(2,148)	(357) U	(17%)	(13,132)	(12,890)	(242) U	(2%)	(25,780)
Personal Health Total	**(48,652)**	**(48,458)**	**(194) U**		**(291,525)**	**(290,076)**	**(1,449) U**		**(580,072)**

Southern District Health Board

Dec-13

Part 3: DHB Funds	Current Month				Year to Date				Annual
	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance	Budget
	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%	$(000)
Mental Health									
Mental Health to allocate	-	-			-	-			-
Acute Mental Health Inpatients	(1,299)	(1,299)			(7,792)	(7,792)			(15,583)
Sub-Acute & Long Term Mental Health	(362)	(362)			(2,174)	(2,174)			(4,349)
Crisis Respite	(7)	(7)		2%	(40)	(41)		1%	(82)
Alcohol & Other Drugs - General	(346)	(330)	(16) U	(5%)	(2,100)	(1,978)	(122) U	(6%)	(3,955)
Alcohol & Other Drugs - Child & Youth	(40)	(24)	(16) U	(66%)	(237)	(143)	(94) U	(66%)	(286)
Methadone	(94)	(94)			(562)	(562)			(1,125)
Dual Diagnosis - Alcohol & Other Drugs	(19)	(45)	26 F	59%	(81)	(268)	187 F	70%	(536)
Dual Diagnosis - MH/ID	(8)	(5)	(3) U	(60%)	(47)	(30)	(18) U	(60%)	(59)
Eating Disorder	(14)	(14)			(84)	(84)			(168)
Maternal Mental Health	(4)	(4)			(22)	(22)			(44)
Child & Youth Mental Health Services	(899)	(856)	(43) U	(5%)	(4,854)	(5,136)	282 F	5%	(10,272)
Forensic Services	(497)	(510)	12 F	2%	(2,985)	(3,059)	74 F	2%	(6,117)
Kaupapa Maori Mental Health Services	(115)	(152)	37 F	24%	(687)	(909)	222 F	24%	(1,818)
Kaupapa Maori Mental Health - Residential	-	-			-	-			-
Kaupapa Maori Mental Health - Inpati	-	-			-	-			-
Mental Health Community Services	(1,773)	(1,877)	103 F	6%	(10,667)	(11,261)	594 F	5%	(22,522)
Prison/Court Liaison	(46)	(44)	(2) U	(4%)	(277)	(266)	(11) U	(4%)	(531)
Mental Health Workforce Development	-	-			-	-			-
Day Activity & Work Rehabilitation S	(198)	(197)			(1,185)	(1,184)	(1) U		(2,369)
Mental Health Funded Services for Older People	(35)	(35)			(213)	(213)			(426)
Advocacy / Peer Support - Consumer	(52)	(57)	5 F	9%	(312)	(342)	30 F	9%	(684)
Other Home Based Residential Support	(371)	(374)	3 F	1%	(2,383)	(2,246)	(137) U	(6%)	(4,492)
Advocacy / Peer Support - Families	(52)	(60)	8 F	13%	(311)	(359)	48 F	13%	(720)
Community Residential Beds & Service	(439)	(451)	12 F	3%	(2,619)	(2,706)	86 F	3%	(5,411)
Minor Mental Health Expenditure	(22)	(32)	10 F	31%	(144)	(194)	49 F	25%	(388)
Inter District Flow Mental Health	(441)	(441)			(2,647)	(2,647)			(5,294)
Mental Health Total	**(7,132)**	**(7,269)**	**137 F**	**2%**	**(42,425)**	**(43,614)**	**1,189 F**	**3%**	**(87,232)**
Public Health									
Alcohol & Drug	(26)	(26)			(159)	(159)			(317)
Communicable Diseases	(96)	(96)			(579)	(579)			(1,158)
Injury Prevention	-	-			-	-			-
Screening Programmes	(309)	(368)	59 F	16%	(2,690)	(2,207)	(483) U	(22%)	(4,414)
Mental Health	(22)	(22)			(133)	(133)			(265)
Nutrition and Physical Activity	(49)	(45)	(4) U	(9%)	(295)	(271)	(24) U	(9%)	(542)
Physical Environment	(36)	(36)			(214)	(214)			(428)
Public Health Infrastructure	(127)	(127)			(762)	(762)			(1,523)
Sexual Health	(12)	(12)			(71)	(71)			(143)
Social Environments	(38)	(38)			(226)	(226)			(452)
Tobacco Control	(111)	(93)	(17) U	(19%)	(651)	(561)	(90) U	(16%)	(1,121)
Well Child Promotion	-	-			-	-			-
Meningococcal	-	-			-	-			-
Public Health Total	**(826)**	**(864)**	**37 F**	**4%**	**(5,779)**	**(5,182)**	**(597) U**	**(12%)**	**(10,363)**
Disability Support Services									
AT & R (Assessment, Treatment and Re	(1,976)	(1,976)			(11,854)	(11,854)			(23,707)
Information and Advisory	(12)	(13)	1 F	9%	(49)	(78)	30 F	38%	(156)
Needs Assessment	(161)	(163)	2 F	1%	(1,016)	(978)	(38) U	(4%)	(1,956)
Service Co-ordination	(21)	(19)	(2) U	(8%)	(122)	(116)	(6) U	(5%)	(233)
Home Support	(1,337)	(1,317)	(20) U	(1%)	(8,512)	(7,902)	(610) U	(8%)	(15,504)
Carer Support	(136)	(156)	20 F	13%	(773)	(937)	164 F	17%	(1,874)
Residential Care: Rest Homes	(2,945)	(3,047)	103 F	3%	(17,811)	(18,087)	276 F	2%	(35,880)
Residential Care: Loans Adjustment	10	22	(12) U	(56%)	110	133	(23) U	(17%)	266
Long Term Chronic Conditions	(154)	(93)	(61) U	(66%)	(830)	(555)	(274) U	(49%)	(1,111)
Residential Care: Hospitals	(3,631)	(3,628)	(3) U		(21,938)	(21,532)	(405) U	(2%)	(42,714)
Ageing in Place	(2)	(2)			(15)	(15)			(30)
Environmental Support Services	(99)	(101)	3 F	3%	(606)	(607)	1 F		(1,218)
Day Programmes	-	-			-	-			-
Expenditure to Attend Treatment ETAT	-	-			-	-			-
Minor Disability Support Expenditure	(8)	(26)	17 F	68%	(56)	(155)	99 F	64%	(309)
Respite Care	(127)	(135)	8 F	6%	(906)	(847)	(59) U	(7%)	(1,691)
Community Health Services & Support	(65)	(105)	40 F	38%	(335)	(629)	294 F	47%	(1,259)
Inter District Flow Disability Support	(261)	(261)			(1,539)	(1,564)	25 F	2%	(3,128)
Disability Support Other	-	-			-	-			-
Disability Support Services Total	**(10,923)**	**(11,020)**	**97 F**	**1%**	**(66,250)**	**(65,723)**	**(527) U**	**(1%)**	**(130,502)**
Maori Health									
Maori Service Development	(38)	(38)			(227)	(227)			(454)
Maori Provider Assistance Infrastruc	-	-			-	-			-
Maori Workforce Development	-	-			-	-			-
Minor Maori Health Expenditure	-	-			-	-			-
Whanau Ora Services	(115)	(116)	1 F	1%	(689)	(692)	3 F		(1,386)
Maori Health Total	**(153)**	**(153)**	**1 F**	**1%**	**(916)**	**(919)**	**3 F**		**(1,840)**
Internal Allocations	-	-			-	-			-
Total Expenses	**(68,385)**	**(68,463)**	**78 F**		**(411,084)**	**(409,703)**	**(1,381) U**		**(818,387)**
Summary of Results									
Subtotal of IDF Revenue	1,421	1,586	(165) U	(10%)	8,792	9,519	(727) U	(8%)	19,037
Subtotal all other Revenue	66,554	66,521	33 F		400,977	399,123	1,854 F		798,246
Revenue Total	**67,975**	**68,107**	**(132) U**		**409,769**	**408,642**	**1,127 F**		**817,283**
Subtotal of IDF Expenditure	(3,207)	(2,850)	(357) U	(13%)	(17,318)	(17,101)	(217) U	(1%)	(34,202)
Subtotal all other Expenditure	(65,178)	(65,612)	434 F	1%	(393,766)	(392,602)	(1,164) U		(784,185)
Expenses Total	**(68,385)**	**(68,463)**	**78 F**		**(411,084)**	**(409,703)**	**(1,381) U**		**(818,387)**
Net Surplus/ (Deficit)	**(410)**	**(356)**	**(54) U**	**(15%)**	**(1,315)**	**(1,062)**	**(254) U**	**(24%)**	**(1,104)**