DISABILITY SUPPORT ADVISORY COMMITTEE

and

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

A G E N D A

Wednesday, 5 March 2014

9.00 am

Board Room
Community Services Building
Southland Hospital Campus, Invercargill

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

Wednesday, 5 March, 9.00 am

Community Services Building, Southland Hospital, Invercargill

A G E N D A

Item		Page No.
1.	**Welcome**	
2.	**Apologies -** Neville Cook	
3.	**Interests Registers**	
4.	**Previous Minutes**	
5.	**Review of Action Sheet**	
6.	**Planning & Funding Team Report**	
7.	**Southern Health Alliance Leadership Team (SHALT) Update**	
8.	**Public Health South Report**	
9.	**Southern PHO Report** *(Late paper)*	
10.	**Work Plan**	
11.	**Review of Advisory Terms of Reference**	
12.	**Financial Performance Report**	
13.	**Southern DHB Health Profile**	
14.	**Information Item:**	

- Auditor-General Performance Audit Report: *Regional services planning in the health sector*

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. Wakatipu Reference Group Update	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, section 9(2)(j).
3. Laboratories Contract	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
4. Annual Plan 2014/15	Plan is subject to Ministerial approval.	As above, sections 9(2)(f)(iv) and 9(2)(j).
5. Māori Health Plan 2014/15	As above.	As above.
6. South Island Health Services Plan 2014/15	As above.	As above.
7. Funding Envelope 2014/15 & Planning Assumptions for 2015/16 & 2016/17	Subject to Cabinet endorsement and the Government	As above, sections 9(2)(f)(iv) and 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 11.02.2014	1. Councillor, Environment Southland. 2. Trustee, Norman Jones Foundation. 3. Southern Health Welfare Trust (Trustee).	1. Nil. 2. Possible conflict with funding requests. 3. Southland Hospital Trust.
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.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Kaye CROWTHER	09.11.2007 14.08.2008 12.02.2009 05.09.2012 01.03.2012	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. 4. Trustee for No 10 Youth Health Centre, Invercargill. 5. DHB representative on the Gore Social Sector Trial Stakeholder Group.	1. Possible conflict if DHB contracts HR services from JCL and Progressive Consulting, which are subsidiaries of Crowe Horwath NZ Ltd 2. Nil. 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

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
			organisations. 4. May have some stores that deal with Southern DHB.
Tim WARD	14.09.2009 01.05.2010 01.05.2010 10.12.2012	1. Partner, BDO Invercargill, Chartered Accountants. 2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT). 4. Director of Southern Community Laboratories Otago-Southland.	1. May have some Southern DHB patients and staff as clients. 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 February 2014

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Peter Beirne	20.06.2013	Nil	
Sandra Boardman	07.02.2014	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	11.02.2014	1. Southern Health Welfare Trust (Trustee).	1. Southland Hospital Trust.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
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.	
Dr Jim Reid	22.01.2014	1. Director of both BPAC NZ and BPAC Inc 2. Director of the NZ Formulary 3. Trustee of the Waitaki District Health Trust 4. Employed 2/10 by the University of Otago and am now Deputy Dean of the Dunedin School of Medicine. 5. Partner at Caversham Medical Centre and a Director of RMC Medical Research Ltd.	
Leanne Samuel	01.07.2007 01.07.2007	2. Southern Health Welfare Trust (Trustee). 3. Member of Community Trust of Southland Health Scholarships Panel.	1. Southland Hospital Trust. 2. Nil.
David Tulloch	23.11.2010 02.06.2011 17.08.2012	1. Southland Urology (Director). 2. Southern Surgical Services (Director). 3. UA Central Otago Urology Services Limited (Director). 4. Trustee, Gilmour Trust.	1. Potential conflict if DHB purchases services. 2. Potential conflict if DHB purchases services. 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 Tuesday, 4 February 2014, commencing at 10.00 am, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Ms Sandra Cook	Chair
	Mr Neville Cook	
	Mrs Kaye Crowther	
	Dr Branko Sijnja	
	Mr Tim Ward	
In Attendance:	Mr Joe Butterfield	Board Chair (from 10.10 am)
	Dr John Chambers	Board Member
	Mr Tony Hill	Board Member (from 11.00 am)
	Mr Tuari Potiki	Board Member
	Mr Richard Thomson	Board Member
	Dr Jan White	Crown Monitor
	Mrs Sandra Boardman	Executive Director, Planning & Funding
	Mr David Dickson	Finance Manager (until 10.50 am)
	Ms Carole Heatly	Chief Executive Officer
	Mr Jim Hurring	Portfolio Manager, Primary & Community (until 10.40 am)
	Mrs Lexie O'Shea	Deputy CEO/Executive Director Patient Services
	Mr Ian Macara	Chief Executive, Southern PHO (until 10.50 am)
	Dr Keith Reid	Medical Officer of Health, Public Health South (until 10.50 am)
	Mr David Tulloch	Chief Medical Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chairperson welcomed everyone to the first meeting of the Committees for the new Board term and extended a special welcome to Sandra Boardman, who had recently taken up the position of Executive Director, Planning & Funding.

2.0 APOLOGIES

An apology was received from Mr Stuart Heal.

3.0 MEMBERS' DECLARATION OF INTEREST

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 6 November 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 a draft work plan for the Committees would be submitted to the next meeting. This would inform a programme of "deep dive" presentations around specific topics;
- That a report on pharmaceutical expenditure would be submitted to the next meeting. An invitation would also be extended to the Chief Executive of Pharmac to meet with the Committees;
- That a clinical advisory group would be set up to oversee pharmaceutical usage;
- That the Executive Director Planning & Funding would follow up the Child & Youth Compass questionnaire action point.

Mr Joe Butterfield, Board Chair, joined the meeting at 10.10 am.

6.0 PLANNING & FUNDING PORTFOLIO REPORT – PRIMARY AND COMMUNITY

Community Pharmacy Service Agreement – Proposed Stage 4 Rollout

The Executive Director Planning & Funding presented a report overviewing the proposed stage 4 rollout of the Community Pharmacy Service Agreement (agenda item 6a), then took questions from members.

It was resolved:

"That the report be received."

Rural Funding Mechanism for General Practices

Dr Sijnja reminded members of his interest in this item.

The Executive Director Planning & Funding presented a paper outlining changes to the current funding mechanisms for rural GP practices (agenda item 6b), then took questions from members.

The Committees noted management's advice:

- That under the new criteria Queenstown would no longer be considered rural. There would be a transitional period of two years and the DHB would be working with the PHO to mitigate any risks arising from that change;

- That an alliance involving the DHB, PHO and GPs would determine how the funding received would be allocated to support rural practices and that review would include Queenstown.

It was resolved:

"That the report be received."

7.0 SOUTHERN HEALTH ALLIANCE

A report from Prof Robin Gauld, Independent Chair of the Southern Health Alliance Leadership Team (SHALT), on SHALT activities and progress to date was circulated with the agenda (item 7).

The Committees expressed their disappointment with the report and indicated they required more information to discharge their duty to oversee SHALT.

It was resolved:

"That the report be received."

8.0 PUBLIC HEALTH

Dr Keith Reid, Medical Officer of Health, presented a report on Public Health South activity for October to December 2013, information for local body councillors, and a report on vaccine preventable disease (agenda item 8), then took questions from members.

The Committees noted advice from management:

- That the Southern PHO had appointed a smokefree champion to focus on improving performance against the Primary Care Better Help for Smokers to Quit Health Target;

- That an Alcohol Programme Leader had been appointed and one of their responsibilities would be to develop a Southern DHB alcohol harm reduction strategy.

It was resolved:

"That the report be received."

9.0 SOUTHERN PRIMARY HEALTH ORGANISATION

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 9), then took questions from members.

Mr Macara recorded his thanked to Mr Tulloch, Chief Medical Officer, for attending the locality meetings with primary care stakeholders around the district.

It was resolved:

"That the report be noted."

10.0 BEFORE (B4) SCHOOL CHECKS

A report on performance against the B4 School Check targets was circulated with the agenda (item 10) for members' information.

It was resolved:

"That the report be received."

11.0 FINANCIAL REPORT

The Finance Manager presented the Funder Financial Report for the period ended 31 December 2013 (agenda item 11), then took questions from members.

The Committees:

- Noted the Finance Manager's advice that the current year-end forecast for the Funder was a $0.7m deficit;
- Requested a report on the Health of Older Persons changes and how that had impacted on the budget and client outcomes.

It was resolved:

"That the report be noted."

CONFIDENTIAL SESSION

At 10.50 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.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
2. Annual Plan 2014/15	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and (j).
3. Wakatipu Reference Group Update	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, section (j).

The meeting closed at 11.15 a.m.

Confirmed as a correct record:

Chairperson .....

Date .....

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

ACTION SHEET

As at February 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	EDP&F	Now incorporated as part of workplan.	Completed.
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.	Completed
Feb 14		To be followed up.	EDP&F	Copy emailed to members 12.02.2014	
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.	PHO	Under action by SPHO within the revision schedule for the SPHO website.	
Aug 13	**Orientation of NGO Contracts to Support Smokefree Health**	To be brought back to DSAC/CPHAC if any significant changes are proposed to the smokefree clauses following consultation	PM-PPH	There were no significant changes proposed in the feedback received from NGOs	Completed

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
	Targets	with providers.		about the smokefree clauses and in fact, there was considerable support indicated by the NGOs for the to the proposed changes. Smokefree clauses will now be included in all new Southern DHB contracts and will be included in all existing contracts when they are renewed.	
Nov 13 Feb 14	**Pharmaceutical Expenditure**	Comparative DHB drug costs to be defined per head of population in future reporting. Report to be submitted to March meeting.	EDP&F	A Service Level Alliance Team is being established, which will oversee work streams including the detailed analysis of prescribing trends within the SDHB district. A proposal has been received from Bpac to undertake the analysis and establish mechanisms to ensure prescribing trends are in line with national trends. Bpac will report to the SDHB in April identifying any prescribing outliers, and a process to develop alternative prescribing approaches to align with national prescribing trends.	Ongoing
Feb 24	**Health of Older Persons** (Minute item 11.0)	A status update to be provided on the HOP changes and how that has impacted on the budget and client outcomes.	EDP&F	Please see The Planning and Funding Team Report for status update	Completed

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Planning and Funding Report**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	5th March 2014

Summary:

Monthly report on the Planning and Funding activities and progress to date.

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

Financial:	N/A
Workforce:	N/A
Other:	N/A

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

Prepared by: Planning & Funding Team **Date:** 19th February 2014	**Presented by:** Sandra Boardman Executive Director Planning & Funding

RECOMMENDATIONS:

That CPHAC/DSAC:

Note the content of this paper.

PLANNING AND FUNDING REPORT TO THE DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
March 2014

RECOMMENDATION:

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

Health of Older People Portfolio

Action Response: A status update to be provided on the HOP changes and how that has impacted on the budget and client outcomes.

HOP Changes: As a result of the recommendations from the June 2011 *Auckland Uniservices Report*, the June 2012 *Home and Community Support Services Proposal for Change*, the September 2012 *Expression of Interest* document and the October 2012 *Request for Proposal (RFP) for the Supply and Provision of Home and Community Support Services*, a five year Alliance Agreement was negotiated with our three successful providers, Access Homehealth Ltd, Healthcare NZ, and Royal District Nursing Service NZ (RDNS) to provide a Restorative Model of Home and Community Support Services (HCSS) as of 1 July 2013.

From March of 2013, we transitioned HCSS clients from 17 former providers to the 3 Alliance providers (2 of those providers were existing providers). As of July 2013, all clients were receiving service from HCSS Alliance providers and training of that staff in the Restorative Model occurred through the end of 2013.

The changes from the former HCSS contracts with the 17 providers to the new contracts are:

- The HCSS Alliance provides service throughout the Southern Region.
- Providers employ Registered Health Professionals who are responsible for Care Planning for clients,
- Services are based on the results of a Comprehensive Clinical Assessment (InterRAI),
- Services are tailored to meet the clients' identified needs from their assessment, and their goals, to support them to retain and use everyday abilities to enable people to live in their own homes,
- Services use a strengths-based 'do with' philosophy rather than a 'do for' philosophy,
- Clients are reviewed on a schedule to assure that their care plan meets their ongoing needs
- Service is not limited to allocated hours, but can flex up or down to meet changing needs

Budget: From October of 2013, the HCSS for Older People has been bulk funded. There was unexplained growth in the number of hours of HCSS service delivery in the months immediately preceding the change to bulk funding. Providers are now reviewing packages of care to make the service sustainable. There is an expectation that providers will manage demand within the contracted funding. Future funding assumptions will take into account the growing aging population and the increased number of older people aging in place.

Historically, Southern District Health Board has had a higher than average occupancy (and therefore spend) in Aged Residential Care. Rest Home level bed occupancy has steadily decreased over the past two years, despite a growth in the aged population.

Service Development Group: The HCSS Alliance has a Service Development Group that will review patient outcomes and key performance indicators over the next few months.

Hospital and Specialist Services Portfolio

A series of meetings will be held with each of the Southern rural hospital trusts to agree contracting arrangements for the 2014/15 financial year. It is proposed that this next set of agreements will, in effect, be interim arrangements pending the completion of the health needs analysis and the resultant DHB Strategic Plan later this year. Rural hospitals are expected to be a key component of any future integrated model of care.

Work is also underway with the Provider Arm to agree the range and volume of secondary services that will be funded during 2014/15. This includes the requirements to meet the relevant Health Targets for the 14/15 period.

Mental Health, Addiction & Intellectual Disability Portfolio

Work is progressing on implementing Raise HOPE (the Southern DHB Mental Health and Addictions Strategic Plan). The Raise HOPE Implementation Advisory Group continues to support this process and a comprehensive implementation plan including phased milestones and timeframes for key initiatives will be in place by July 2014.

In January 2014 the Minister of Health officially announced the successful providers of the Youth Exemplar initiatives (Ministry of Health additional funding Prime Minister's Youth Mental Health Project). Mirror Counselling (Aroha ki te Tamariki) a Dunedin based service was the only successful South Island proposal. Additional funding for a period of two and a half years will allow development of district wide services for youth with an aim to improve access to youth for drug and alcohol and other drug services, reduce fragmentation and establish a critical hub of youth AOD services. Updates will be reported to the Committees as this project progresses.

Public and Population Health Portfolio

CHILD and YOUTH

Expansion of School Based Health Services

The School Based Health Services programme is delivered through Public Health Nursing Services in Southern DHB providing services to a decile one high school (Invercargill), the Kura Kaupapa (Invercargill), the Teen Parent Unit (Invercargill) and through alternative education in Otago and Southland. The Ministries of Health, Education and Social Development have worked together with other non governmental agencies to develop a framework for the continuous quality improvement of youth health services in secondary schools. Work will begin to help health services and schools to use the framework to continuously improve the quality of health services for young people in secondary schools and share best practice initiatives.

Children and Youth Steering Group

Southern DHB has established an intersectoral Child and Youth Health Steering Group to provide strategic overview and direction for relevant child and youth health service planning and delivery in the Southern district in order to improve health outcomes for children and young people. It is envisaged that this group will lead implementation of Children's Action Plan initiatives.

Well Child Tamariki Ora Quality Improvement Framework

The Child and Youth Steering Group noted the report the Ministry of Health released in August 2013 on the WCTO Quality Improvement Framework as a driver for improvements in the quality of well child services for children from birth to age 5. Southern DHB features well in many areas although there are several areas which clearly need attention e.g. access to free primary care for under sixes.

The Ministry of Health has asked each DHB to select one indicator from each quality dimension (outcomes, access and quality) and develop an implementation plan for these indicators by 21 February 2014. Southern DHB has agreed to develop an implementation plan for each of the following indicators:

Indicator	Responsible service
Mothers are smoke free at two weeks postnatal	Midwifery Services
Preschool children are enrolled with child oral health services	Oral Health Services Manager
B4School Checks are delivered before children are age 4 ½.	Population Health Services Manager
Infants are exclusively breastfed at three months of age	Southland Well Child Tamariki Ora Providers

Work on these indicators aligns with the well child objectives in the 2013/13 Annual Plan.

Compass

The Compass is a benchmarking exercise being undertaken by DHBs in partnership between the Office of the Children's Commissioner, the Paediatric Society of New Zealand, and Ko Awatea – Centre for Health System Innovation and Improvement, with guidance and support from the Health Quality and Safety Commission, and the New Zealand Child and Youth Epidemiology Service. The aim of the Compass is to identify, showcase and share innovation and good practice in child and youth health across NZ. Ultimately it aims to promote the improvement in health services provided by District Health Boards (DHBs) and reduce health inequities for children and young people.

All District Health Boards (DHBs) were asked to complete the Compass Questionnaire Tool that contained an open-ended question for each domain, the framework of current good practice, and sought supporting evidence for the DHBs' responses. Each DHB was asked to self-identify as leading, progressing or emerging for a number of domains. The collaborative quality improvement model envisages that those DHBs who self-identify as leading to take on a supporting/teaching role (tuakana) for DHBs that identify themselves as learners (teina) in that particular domain. Southern DHB, like a number of other DHBs, has identified as a learner across all domains. The Child and Youth Steering Group will undertake a process to prioritise actions in relation to Compass.

Before Schools Check (B4SC)

The Ministry of Health has begun a review of the B4SC. The review will focus on ways to enhance, develop and maintain workforce standards and competencies in the delivery and coordination of the B4SC. The purpose of the review is to enable the Ministry to help increase the quality and consistency of B4SC assessment and referral decisions, reduce national assessment and referral variation, and establish more effective practices in B4SC

coordination and administration. The B4SC programme is delivered by Public Health Nurses across the Southern District and we regularly exceed targets set for this programme.

SOCIAL SECTOR TRIALS

Gore Social Sector Trial

On 17 December 2013 it was announced that Tranche 1 Social Sector Trials areas would be extended until 30 June 2015. The extension gave the opportunity to brand and expand the Trials model at a local level to meet the needs of the Gore District. This opportunity focussed on changing the location, target group and outcome areas. Trial leads were expected to consult with their Advisory Group and key stakeholders and then to submit a proposal for scope change in January 2014.

The Gore proposal, which is yet to be approved, requested an expansion of the target age range down to five years in all current outcome areas; an expansion of the target age up to 24 years in the current drug and alcohol harm reduction outcome area; and the addition of another outcome to "improve child/youth wellbeing and safety", with a target range of 5-18 year olds.

South Dunedin Social Sector Trial

The Social Sector Trial Youth Action Plan for South Dunedin has been completed and an official launch is to be held on the 21 February 2014. The Plan is an agreed approach by key players and provides a transparent document for the community to access. It is an accountability mechanism to ensure outcome commitments are honoured.

Southern DHB has lead responsibilities in the outcome area of reducing alcohol and drug use and is a key partner in many other outcome areas of responsibility.

Maori Health

New service specifications are about to be rolled out to contracted Maori providers, these contracts have been aligned to better achieve the outcomes of the DHB/PHO Maori Health Plan. Monitoring of these contracts will occur over the next year. The new service specifications will closely support Southern PHO achievement of health targets '*more heart and diabetes checks and better help to smokers to quit'*.

The DHB is working alongside the Ministry of Health to establish nurse-led clinics with Maori providers who are currently not funded for any clinical services. The launch of these clinics is expected to occur in March 2014. The clinics will provide opportunities for increased engagement with primary care and other social services.

Pacific Health

Pacific Trust Otago, SPHO and SDHB are working together to introduce a nurse lead clinic for Pacific peoples. The new service specifications will closely support Southern PHO achievement of health targets.

TOBACCO CONTROL

Review of Tobacco Control Services

The MoH has commissioned the SHORE and Whariki Research Centre to undertake a national review of Tobacco Control Services. The review consists of: evidence review, mapping of tobacco control services, analysis of gaps and opportunities; and consultation with the sector. The information collected will assist the MoH with leading the sector towards achieving the Smokefree Aotearoa 2025 goal. Southern DHB information was submitted to the review on 21 January.

Smokefree Clauses in DHB NGO contracts

All NGO providers the DHB contracts with directly were consulted about smokefree clauses in November 2013. On the whole, consultation was positive with a number of

providers stating they were already undertaking this work. A final briefing paper recommended that these clauses be inserted into new or varied contracts from January 2014; this has now commenced.

Primary and Community Portfolio

Maternity Quality and Safety Framework

Clinical Governance Structure is in place with the first meeting of the overseeing group scheduled for late February when the work plan for the coming year will be tabled for confirmation. The work plan will reflect the direction given by the National Maternity Monitoring Group.

Consumer participation in the programme continues with consumer and community groups meeting throughout the district.

The primary maternity units are well engaged in the programme and are seeing benefits in the information sharing and support given by the programme and the coordinator

LABORATORY SERVICES

Clinical Laboratory Advisory Group

There have been increasing volumes of new tests, especially molecular and genetic tests, which are currently funded outside the laboratory contract. Laboratory expenditure was $364K unfavourable to plan at the end of January. An interim process has been established to identify any new test which was not listed within the original laboratory contract signed in 2006. The majority of these tests are hospital clinician referrals.

The interim process requires clinicians to make applications for any new test (on-going or one off) which is then approved by the chief medical officer as clinically appropriate. This process will conclude at the end of February 2014.

A Clinical Laboratory Advisory Group (CLAG) is being established which will be responsible for on-going endorsement of any new test referral. Once endorsement is obtained from the CLAG the new test application is then referred to Senior Management to approve funding. Applications declined by CLAG will be communicated to the referrer.

COMMUNITY PHARMACY

Stage 4 Roll out Consultation

A paper was previously circulated to CPHAC-DSAC members at the February meeting which provided information on the proposed Stage four roll out of the Community Pharmacy Services Agreement.

This proposal has now been sent out to Community Pharmacy for informal consultation. The proposed model is the result of many hours of analysis, testing, discussion and debate from people within the community pharmacy sector and experts in the field over a significant period. This includes members of the Funding Fee Setting and Monitoring (FFSM) Group, representatives from the Community Pharmacy Sector, DHBs, the Ministry of Health, the Community Pharmacy Services Operational Group (CPSOG), Governance Group (CPSGG) and Community Pharmacy Service (CPS) Programme Team.

All stakeholder representatives within the Governance Groups including community pharmacy agents supported the proposed funding model being put forward for informal engagement. Feedback on the proposal was due on 19 February 2014.

This will be followed by a formal Consultation Process from April 2014 as outlined below.

- formal consultation document via email that will include information on the framework and
- proposed fees
- roadshows across the country hosted by the DHBs
- webinars (for those pharmacists unable to attend the roadshows)
- website updates reflecting 'thread of consultation conversation'
- Discussion with the CPS Programme Team, Pharmacy sector agents and DHB Portfolio Managers.

Commerce Commission Publically announced decision on the CPSA

On Friday 14th February the Commerce Commission publicly announced the outcome of the 2012 Community Pharmacy Services Agreement (PSA) investigation that began last year.

The investigation was launched due to a possible breach of the Commerce Act by clauses included in the PSA prohibiting the discounting of the prescription co-payment and offering inducements, specifically clauses H4.4 and M1.3.

Pharmaceuticals are subsidised by government funding. The prescription co-payment is the amount that patients pay towards their medicines. The maximum amount of the co-payment is set by the government.

During the PSA consultation process the DHBs took responsibility to ensure the PSA complied with law including the Commerce Act, and the Pharmacy Guild & DHBs relied on this legal advice.

Once the unintentional breach was identified in January last year, the DHBs immediately announced that they would not enforce the clauses. The Guild fully supported the DHBs' decision and this change was formalised in a revised contract.

Subsequently Southern DHB has received a letter of warning from the Commerce Commission which is attached as appendix 1 to this report

PRIMARY CARE

Very Low Cost Access Sustainability Initiative

The government has implemented a new VLCA Practice Sustainability Initiative for Very low Cost Access Practices (VLCA) with 50% or more high need enrolees. Southern DHB has two practices that meet this criteria and has received $10.902.00 p.a. (excl GST) for this initiative. The overall objective of this funding is to support and maintain the sustainability of VLCA practices that are serving our most vulnerable populations and have sustainability challenges. The PHO is expected to administer this funding and 100 percent of the funding will be used to implement each VLCA practices sustainability Support Plan.

COMMERCE COMMISSION
NEW ZEALAND

13 February 2014

Southern District Health Board
Carole Heatly
Chief Executive Officer
Private Bag 1921
Dunedin 9054

17 FEB 2014

Dear Carole Heatly

Commerce Act 1986: Warning

1. The purpose of this letter is to warn Southern District Health Board that it has likely breached section 27 of the Commerce Act 1986 (the Act) by entering into the 2012 Community Pharmacy Services Agreement (CPSA) with individual community pharmacies.

2. We have reached this view after investigating the 'no discounting' provisions in the District Health Boards (DHBs) 2012 CPSA with individual community pharmacies. Our view is that provisions M1.3 and H4.4 of the CPSA (the 'no discounting' provisions) had the likely effect of substantially lessening competition for the dispensing of prescription medication.

3. In making a decision to warn rather than to take some other enforcement action, we have taken into account that the extent of the detriment was limited. Following our intervention and the DHBs' prompt response to our concerns, the provisions were not enforced by DHBs from December 2012 and the provisions were removed from the CPSA with effect from 1 March 2013.

Commission warning

4. Section 27 of the Act prohibits contracts arrangements or understandings containing a provision that has the purpose, effect or likely effect of substantially lessening competition in a market in New Zealand.

5. In our view, the 'no discounting' provisions were drafted to ensure that pharmacies did not discount the co-payment or try to encourage customers with some other form of inducement to obtain prescriptions from their pharmacy.

6. In the Commission's view, pharmacies compete with each other in localised markets and the no discounting provisions had the likely effect of substantially lessening competition during the time they were in force.

7. Before the CPSA was signed, some pharmacies competed on the price of prescription medication, typically by discounting the patient co-payment. This competition was in our view beneficial, especially to those customers in low-income communities.

8. Following the signing of the CPSA, some pharmacies who had discounted, observed a decline in prescriptions dispensed while the no discounting provisions were in operation.

Commission view

9. Competition between firms typically derives from rivalry on price, quality, service, choice and other offerings. Conduct which substantially lessens competition can be detrimental to consumers.

10. To avoid breaching the Act in future, we recommend that Southern District Health Board review its current practices and policies that affect competition. We urge you to carefully consider, before entering into such agreements, whether there are any provisions that may have the effect of substantially lessening competition. If in doubt, you should always seek advice.

11. We remind you that pharmacies are in competition with other pharmacies in their local area for dispensing and for non-prescription products. Each pharmacy needs to reach independent pricing decisions to avoid the risk of breaching the Act.

12. We also encourage you to take an interest in what member associations or pharmacy groups may be advocating in consultation processes with DHBs. If a member delegates to an association to reach terms on their behalf, that member may be bound into an agreement that breaches the Act.

Further action by the Commission and other parties

13. Only the courts can decide whether the Act has been breached or not. This warning letter does not represent a ruling of law.

14. The Commission does not intend to take any further action against Southern District Health Board for this conduct. However, you should be aware that our decision to issue this warning letter does not prevent any other person or entity from taking private action through the courts. We may draw this warning to the attention of a court in any subsequent proceedings brought by the Commission against Southern District Health Board.

15. The court can impose penalties where it finds the law has been broken. An individual can be fined a maximum of $500,000 and/or be prohibited from being a company director or a manager of a company. A body corporate can be fined the greater of $10 million, or three times the commercial gain from the breach (if this cannot be easily established, 10% of turnover). Every separate breach of the Act may incur a penalty.

16. The Commission will also be warning all other DHBs and all individual pharmacies who entered into the 2012 CPSA that they have likely breached the Act. The Pharmacy Guild of New Zealand will also be warned for aiding, abetting, counselling or procuring DHBs and/or its members to include the provisions.

Publication

17. The warning letters are public information and a generic version of the letter to DHBs, pharmacies and the letter to the Guild will be published on our website. We also intend to make public comment including issuing a media release and making comment to media.

Yours sincerely

Ritchie Hutton
Head of Investigations
Commerce Commission

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:	5 March 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:** Sandra Boardman Executive Director Planning & Funding

RECOMMENDATIONS:

That DSAC/CPHAC:

1. **Note the content of this paper**

Key Areas

AIM: SHALT is a mechanism for collaboration between Southern DHB and SPHO, with aims of building 'whole of system' approaches to service planning and delivery.

Internal communications will commence across SDHB, SPHO and the University of Otago with presentations at the Grand Rounds at both the Dunedin and Southland Hospitals sites scheduled for March. This will be further supported with a more detailed planned communication strategy to be implemented over the coming months.

With the Integrated Performance Incentive Framework (IPIF) due to be implemented July 2014, the SHALT agreed to map these measures to the SLAT framework. This will occur once the final IPIF measures are confirmed.

Work has continued on further developing the Service Level Alliance Teams (SLATs) with three SLATs are now moving to the establishment phase.

<u>Community and Hospital Pharmaceuticals</u>

Problem Definition: Southern DHB spends more on pharmaceuticals per head of population than other DHBs. This is unaffordable.

The aim of the Community and Hospital Pharmaceuticals work programme is to achieve better utilisation of Pharmaceuticals in order to:

- Reduce variation in pharmaceutical per capita drug expenditure to the national average Reduce outlier prescribing patterns
- Develop a post discharge medication policy

Rational prescribing according to Best Practice Guidelines, will improve patient outcomes, reduce patient harm, reduce waste and ultimately save money.
The first step in this process is the Demand Side Management of Pharmaceutical Expenditure project.

<u>Rural Health</u>

Problem Definition: People living in rural parts of Southland and Otago have less access to services than those living in urban areas.

The aim of the Rural Health Service Level Alliance will be to ensure rural communities of our district have equitable and effective access to healthcare services.

This will result in:

- Equity of access to secondary care services between people living rurally and those living in urban centres.

- Primary care services in rural areas being comprehensive, sustainable and providing continuity of care by the right person, at the right time, in the right place
- Rural communities resourced at a level that enables providers to provide the services required and within the available funding.

The first work stream under this SLAT will focus on Rural Funding as the priority area.

Acute Demand

Problem Definition: Some patients are unable to receive timely care with a general practice and others rely on ED departments for treatment, including long term conditions.

The aim of the Acute Demand work programme is to improve Acute Demand Service Provision to ensure patients receive appropriate care at the point of need. A set of key strategic principles to consider and inform decisions on district wide Acute Care services provision were agreed to by SHALT to enable this :

- Best outcome for the patient: Right Care, Right Place, Right Provider
- Consistent and equitable SDHB district-wide protocols, as far as practical
- Clinical and financial sustainability of services is a pre-requisite
- Emergency departments are for emergency care
- Money follows the patient
- A “whole of system” integrated approach is demonstrated
- Patients to see their primary care provider early
- All health professionals work at the “top of scope” of their practice

Having reviewed the work and priority areas that were to be progressed under the Community Enablers SLAT, it has now been agreed that this work will be better placed under the Acute Demand SLAT and not as a separate work programme.

The focus of the Acute Demand work programme will be:

- To provide timely access to urgent care in the right place at the right time with the right person/provider
- Financial barriers to access minimised
- To integrate the health system across primary, secondary care and ambulance
- To ensure appropriate inpatient admissions and appropriate inpatient bed utilisation

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Public Health South Report**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	5 March 2014

Summary:

The issues considered in this paper are:

- Public Health Service Activity

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

Financial:	Nil
Workforce:	Nil
Other:	Nil

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

Prepared by: Stephen Jenkins **Date:** 12 February 2014	**Presented by:** Dr Keith Reid Medical Officer of Health

RECOMMENDATIONS:

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

PUBLIC HEALTH SOUTH REPORT TO THE SOUTHERN DHB COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE 5 March 2014

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

Communicable Disease and Food Safety

Outcome 4 Reduce the impact and incidence of communicable disease

Pertussis
This report provides an update on the briefing on pertussis provided to CPHAC and considered at its meeting of 7 February 2013.

Background:
Pertussis (whooping cough) is a respiratory infection caused by the bacteria Bordetella pertussis. Infection usually follows a pattern of an initial upper respiratory tract infection (URTI) runny nose and inflamed sore throat which develops over a period of several days into the characteristic coughing fits accompanied by a "whooping" sound, breathlessness and/or post-cough vomiting. The illness can be severe, most often in young infants who have not been immunised or previously infected. In New Zealand, one infant under 6 weeks of age died in 2011, and an infant under 6 weeks of age who was born prematurely and an unimmunised 3-year old with chronic lung disease died in 2012. No deaths from pertussis were reported in 2013.

A vaccine for pertussis is part of the New Zealand national immunisation schedule, and is given at 6 weeks, 3 months and 5 months, with boosters at 4 and 11 years of age. It is important to note that immunity to pertussis wanes after both vaccination and natural infection, and the Ministry of Health recommends (but does not fund) additional boosters at 10-yearly intervals for those whose work involves regular contact with infants (e.g. early childhood and health care sectors). A booster vaccination is also advised for pregnant women (in the last trimester of pregnancy and currently funded) and household contacts of newborns (unfunded). This strategy aims to surround infants with a "cocoon" of immune people until they have been fully immunised themselves. Childhood immunisation against pertussis is undertaken as part of the national immunisation schedule with vaccinations at 6 weeks, 3 months and 5 months.

Recent Trends:
New Zealand has recently been experiencing a pertussis epidemic. Pertussis rates in New Zealand rose above normal levels (around 20 cases per 100,000 people per year) in mid-2011, and continued to rise throughout 2012. Over this time period the infection rates in the Southern DHB also rose, but were lower than the national average - 85 versus 133 cases per 100,000 in 2012. Annual rates for 2013 were at a similar level in Southern DHB - 83 cases per 100,000 but had declined significantly at a national level to below 80 cases per 100,000. In the Southern region, the number of notifications peaked in December 2012, with 54 cases reported in that month (Figure 1). There has been an almost steady decline in monthly notifications throughout 2013, with only five cases notified in December 2013 which has been sustained through January 2014. It appears that infection rates are returning to their normal background level.

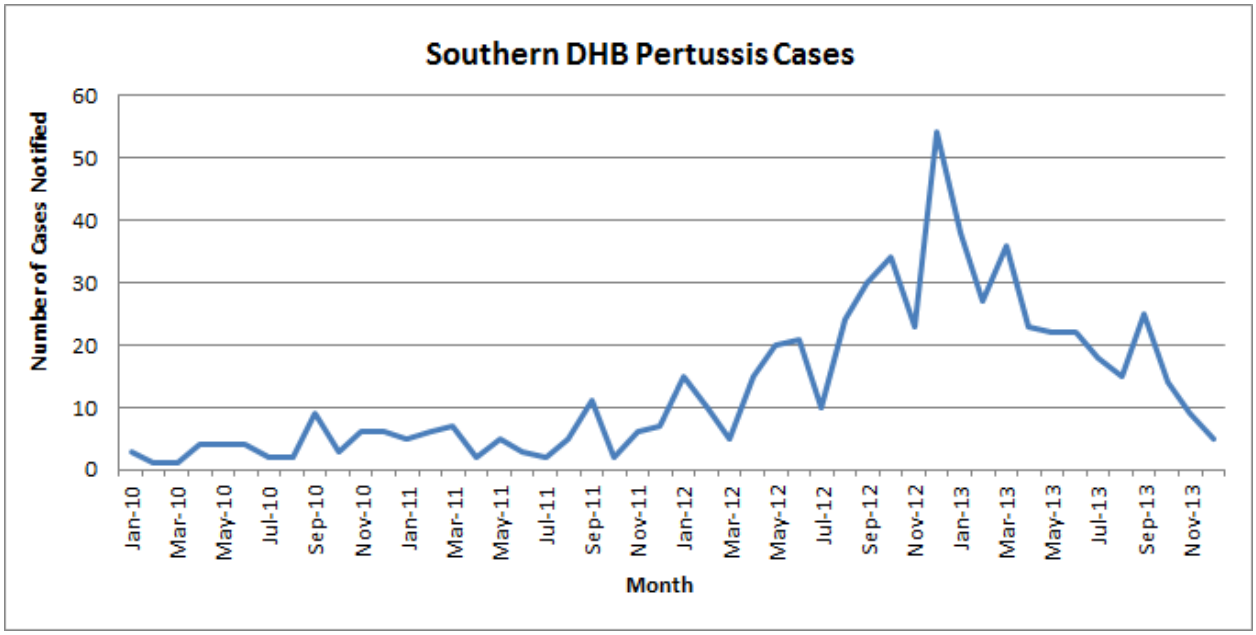


Figure 1. The number of pertussis cases notified per month in the Southern DHB from January 2010 to December 2013.

In total, 254 cases were notified in the Southern DHB during 2013. Of these, 60% had been immunised and 18% were not immunised, with uncertain immunisation status in another 22% of cases. All age ranges were affected, particularly adults in their 40s (Table 1). However, the four patients who were hospitalised with pertussis in the Southern DHB were all children, three of whom were 2-month old infants and one who was an unimmunised 5 year old. This data supports that young children are more likely to experience severe illness, and highlights the importance of both on-time and complete childhood vaccination to provide protection. In adults, booster vaccinations can also provide protection to both unimmunised children and adults who may no longer have effective immunity. However, the most important adult target group is pregnant women.

Table 1. Age group distribution of pertussis cases in the Southern DHB, 2013.

Age Group (years)	Percent of Cases
<1	4.3%
1 to 4	12.6%
5 to 9	6.3%
10 to 14	5.1%
15 to 19	6.3%
20 to 29	12.2%
30 to 39	10.6%
40 to 49	22.4%
50 to 59	9.4%
60 to 69	5.9%
> 70	4.7%

Healthy Environments

Outcome 5 Promote safe and healthy social and physical environments

South Dunedin Social Sector Trial

Public Health South is a contributor to several projects that fall under the Dunedin Social Sector Trial. The Social Sector Trial involves the Ministries of Education, Health, Justice and Social Development, and the New Zealand Police working together to change the way that social services are delivered. The Trial tests what happens when a local organisation or individual directs cross-agency resources, as well as local organisations and government agencies to deliver collaborative social services.

South Dunedin has recently been identified as a site for the delivery of a Social Sector Trial and is being coordinated by a staff member who is employed by the Ministry of Social Development. A governance group has been established which is chaired by Dunedin's mayor. The project plan has been prepared and will be officially launched on 21 February.

All Social Sector Trials focus on outcomes for youth and in the South Dunedin case the age group is 12 to 18 years. Public Health South's contribution to date has involved joint leadership with ACC on a project working in high school settings on a project relating to alcohol and drugs. It is acknowledged that in the absence of school zoning, youth in South Dunedin could be impacted by any high school in Dunedin. A steering group comprising of public health staff, ACC, police and the Dunedin City Council has been established and has met twice. To date Health Promoting Schools staff have agreed to conduct an assessment of the things schools do as it relates to protective factors for alcohol and drug use.

It is recognised that interventions based on teaching resources are least effective in producing good public health outcomes in schools, whilst whole school approaches and activities aimed at building resiliency in pupils are known to be effective. It is hoped the assessment will identify gaps in protective interventions that the project team will work collaboratively to address.

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 of concern in our district, 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. Public Health South is developing a multi-agency project to address some of the health issues related to housing in our district.

Public Health South is working in partnership with Kai Tahu Ki Otago in Dunedin and Te Ao Marama in Invercargill. During 2013 staff met regularly to consider the most appropriate and effective way we can all utilise our respective skills to contribute to the over arching goal of assisting whanau and hapu to improve their quality of housing. We have commenced an innovative process that creatively utilises the Whanau Ora Health Impact Assessment process at a micro project level to drive the building of relevant healthy public policy for housing in Otago and Southland.

Public Health South is also working collaboratively with the Blueskin Community Resilience Trust and the Dunedin City Council who hosted a Cosy Homes workshop that Public Health South attended. Public Health South was nominated on to a steering group formed from this workshop that aims to develop a leadership/governance body and programme that aspires to ensure that every Dunedin home is warm and cosy by 2025. This initiative is about changing the health and wellbeing of vulnerable people in Otago and also changing the energy culture of the district.

Title:	**Southern Primary Health Organisation (SPHO) Report**
Report to:	Southern DHB DSAC/CPHAC
Date of Meeting:	5 March 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:** 27 February 2014	**Presented by:** Stuart Heal, Chair SPHO

RECOMMENDATION:

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

1. STRATEGIC MATTERS

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

The B2B Agreement is concluded between SPHO lawyer Fraser Goldsmith, SPHO and SLH (via Conway Powell representing the IPA as representative for many general practices).

The national PSAAP (PHO Services Agreement Amendment Protocol Group) met on 12/13 Feb in Wellington. Circulation of the B2B was held off until after the PSAAP meeting in the event any change was required. No change was necessary.

The B2B will be circulated to the 93 providers for their review, with a cover letter explaining the changes between the new and existing B2Bs. Target for the execution of B2B contracts is during March 2014.

2. PRIMARY MENTAL HEALTH SERVICES

Southern Health Services Ltd (Family Mental Health Services, Mosgiel)
Southern Health Services Ltd Board met on 17 February 14. Progress is satisfactory towards 'wind-up' of the SHSL company. SPHO is the sole shareholder of SHSL after assignment from Taieri and Strath Taieri PHO. Contract Assignment documents were received from the Ministry of Health on 20 Feb 14 and these will be executed all three parties: SDHB, SHSL and SPHO. Finance, Accounting and Payroll function are already transferred to SPHO.

Referrals into Family Mental Health Services remained steady for the month - 76 referrals: 58 Adults, a8 child and youth. 53% from GPs, 31% self-referrals, 9% other referrers and SDHB 7%.

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

The recommendations from the Rapid Appraisal Report by Professor Tony Dowall are being implemented to resolve the following matters:

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.

3. INTERGRATED PERFORMANCE AND INCENTIVE FRAMEWORK (IPIF)

The new IPIF will be introduced under PHO/DHB Alliances in 2014, once the final policy is agreed. The Ministry of Health are preparing the final protocols which are to be circulated to the sector from the Expert Advisory Group in early 2014. Implementation is set for 1 Jul 14.

SPHO and SDHB will work collaboratively under the Alliance to more effectively achieve Health Targets and outcomes locally. IPIF will replace the PHO Performance Programme and go wider, requiring more extensive and comprehensive linkages between PHO and DHB for performance targets, services and systems integration and quality improvement.

The IPIF initiative presently is going through the Cabinet process, under the Ministry of Health's guidance. The Ministry will advise stakeholders on this as soon as possible.

PHO Performance Programme revenue for SPHO is budgeted at $1.1m for the 13/14 financial year.

4. AFTER-HOURS AND UNDER 6s

Invercargill: A meeting is to be held between SPHO and SDHB staff, including Southland Hospital ED Clinical Director Dr Adam McLeay and SDHB Executive Director, Nursing and Midwifery Leanne Samuel to review patient attendance data and patterns, service cost information and consider operational options priori to SPHO re-engaging with Invercargill GPs to seek progress on the circulated SPHO position paper. Details and a business case on how a nurse-led clinic can be commenced, including financial sustainability, will be prepared, if this is the agreed model of service provision.

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: Under contract, former SPHO Manager Jen Brown leads two key workstreams:

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 two Wanaka general practices have agreed the details of a Pilot project for the period 1 Apr – 30 Jun 2014 for a GP-led after-hours service for their region. There has been excellent collaboration as planning meetings developed the structure and business model. The pilot will determine the outcomes achieved and issues, including data on model and service sustainability into the future. Learning from the pilot will also inform opportunities for the model elsewhere in our region.

iii) Confirmed wording is awaited from the PSAAP (PHO Services Agreement Amendment Protocol Group) negotiations for the 'rules' for consideration and potential reallocation of Rural Funding that will come under the Alliance Work Plan and responsibility.

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. In late 2013 SPHO provided 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. Note all general practice fees are listed on SPHOs website.

5. RURAL FUNDING

The Ministry of Health finalised guidelines are awaited. These will enable local flexibility (i.e. Southern DHB region) on how Rural Funding can be allocated and utilised. Rural Funding is then 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.

Of note the specification requires that any change to Rural Funding allocations within Alliances would require a 75% agreement a vote from all affected parties. The exact wording on this is awaited from the PSAAP group.

6. SOUTHERN HEALTH CARE ALLIANCE LEADERSHIP TEAM (SHALT)

The Alliance Meeting of 18 Feb 14 is now reported via SDHB Executive Director, Planning and Funding.

2. OPERATIONAL AND PROGRAMMES UPDATE

Updates as reported to SPHOs Clinical Review Sub-committee (CRC) and Board in February 2014 were as follows:

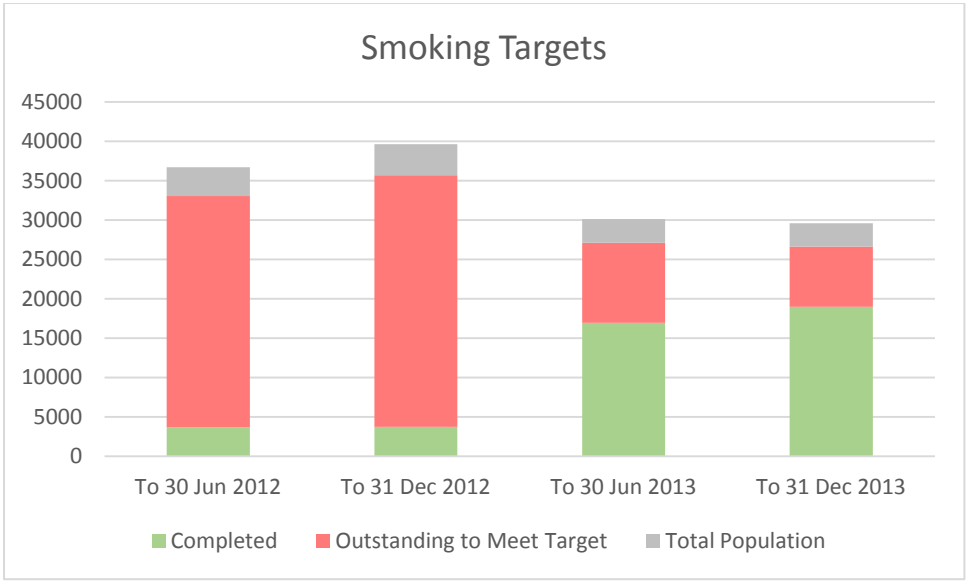
- **Health Targets** – More Heart and Diabetes Checks; Increased Immunisation; and Better Help for Smokers to Quit (see attached Commentary Report, Status and Trend Report, and PHO Performance Programme Dashboards to 31 Dec 13)

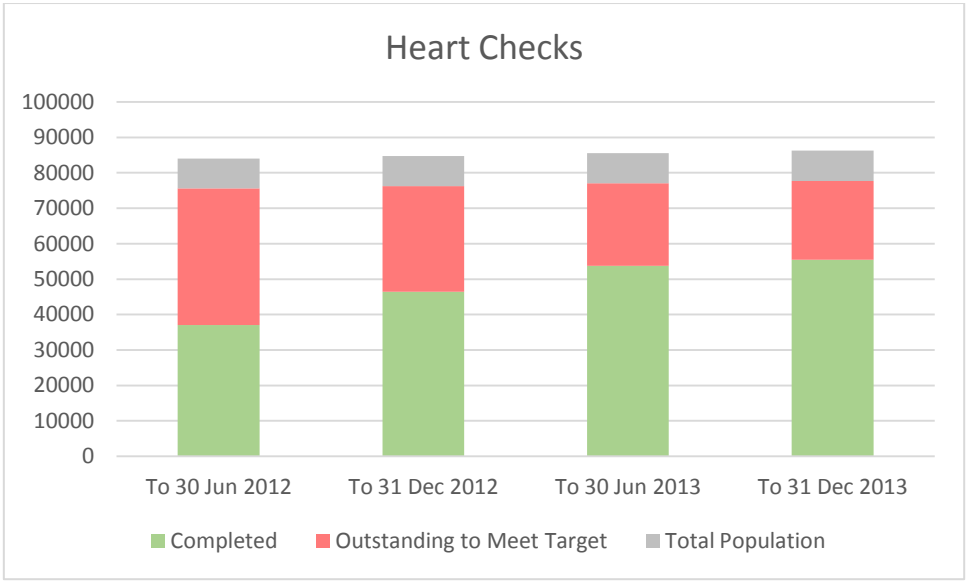
- **Contracted Services and Programmes** (see attached Commentary Report)

3. SPHO FINANCIAL POSITION

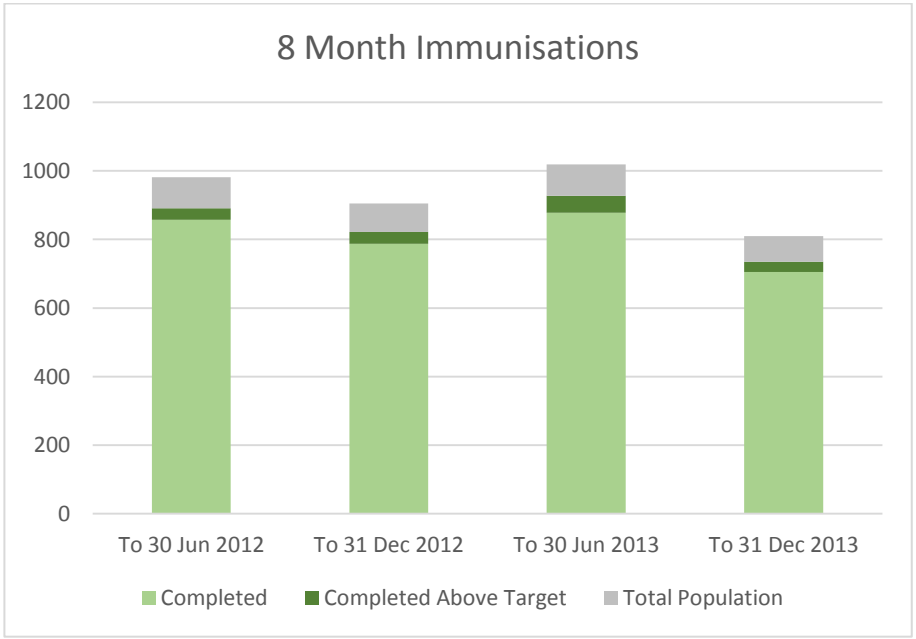
SPHOs financial position remains strong report for the period ending 31 January 14.

Month surplus:	$83,484
YTD surplus:	$1,133,042
YTD Equity:	$1,962,556

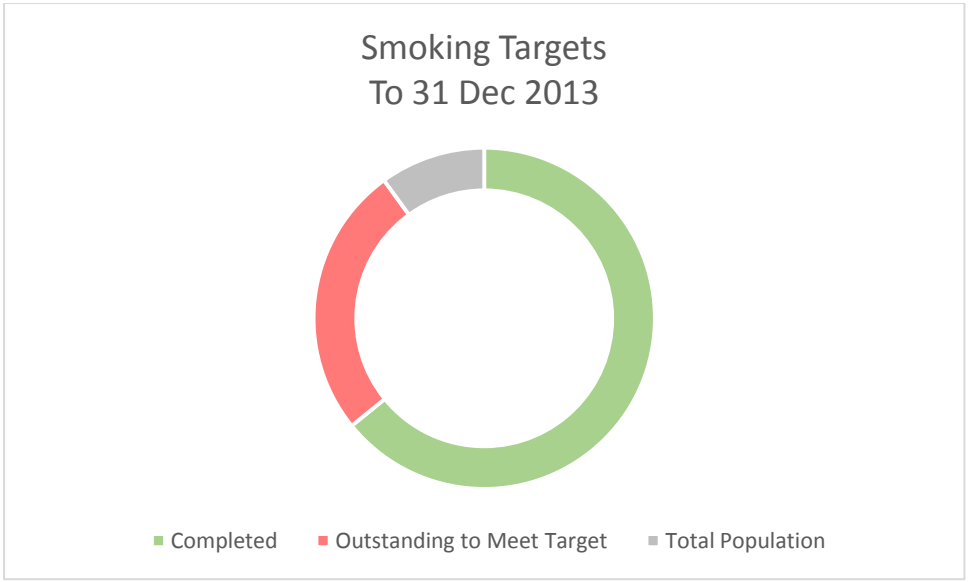


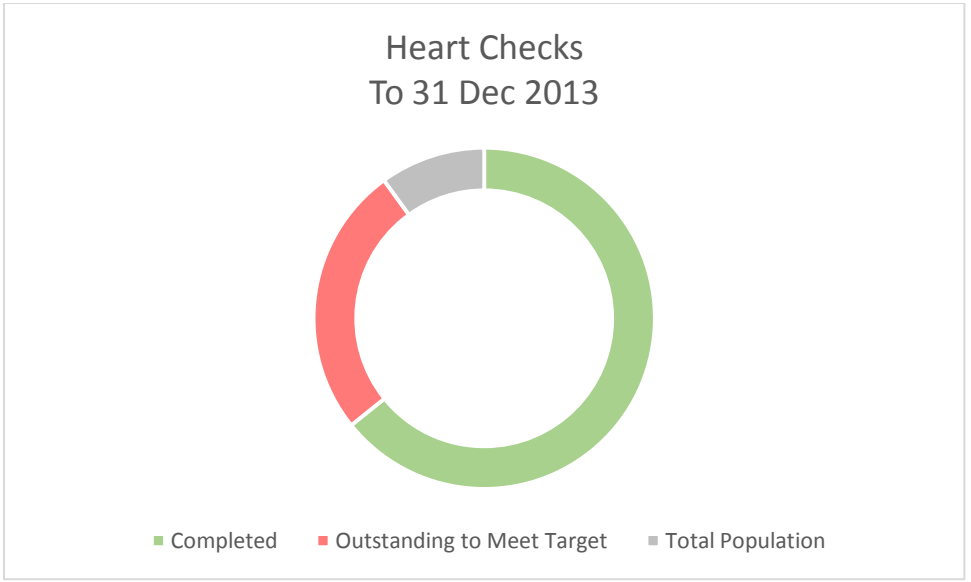


Note: Figures for the period "To 31 Dec 2013" only include Brief Advice where other periods include Brief Advice and/or Cessation Support

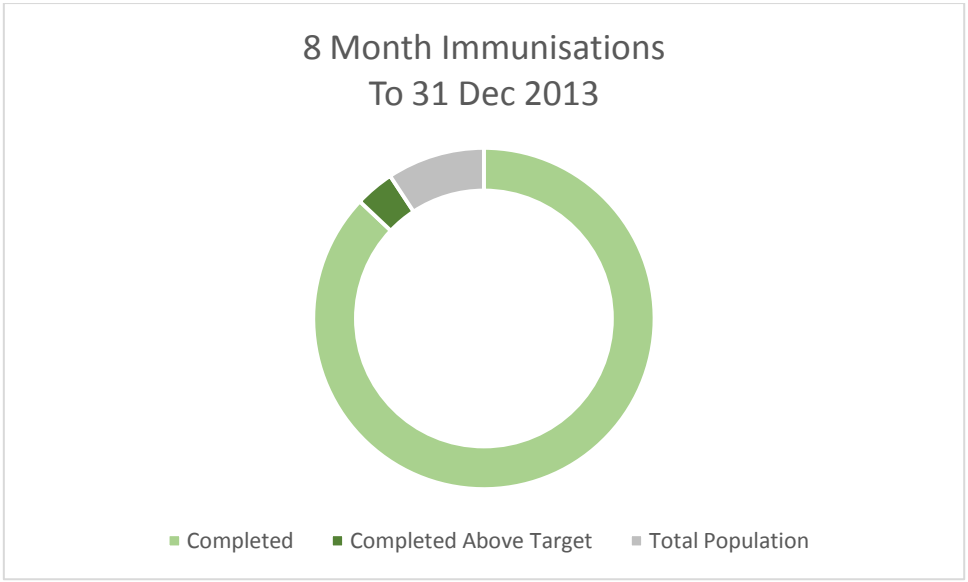


HEALTH TARGET TREND REPORT





Note: Brief Advice only



HEALTH TARGET STATUS REPORT

Health Target Reporting – February, 2014

Priority Area	Key Performance Indicator	Activity	Progress against activity Jan/Feb 14
National Health Targets as required by the Ministry of Health			
1. **More Heart & Diabetes Checks**: Identify and implement actions to improve CVD risk assessment rates.	• 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years to be achieved by July 2014.	1.1 Monitor practice performance & follow up where performance is not improving 1.2 Investigate potential data integrity issues 1.2 Agree an action plan with each practice on what they can do to achieve the targets 1.3 Provide support to practices as & when required	• CPI reports submitted from practices for the period Oct-Dec13 - follow-up with outliers as appropriate. • Intensive liaison with two providers prior to the CPI being re-submitted to DHBNZ. • Promotion of CVD Quick reactivation to practices. • Communication to practices advising the number of required risk assessments to be completed to achieve the health target by 30 June, 2014. • Practice visits to discuss previous quarter's results & confirm action plan for improved performance. • Software (Dr Info) reviewed to investigate how this programme software can rapidly improve RA rates by carrying out virtual CVDRAs from information already available in the PMS and capturing clinical information collection outside of general practices to write back into the PMS. • Practice projects commenced as previously approved. • Brief health checks carried out at the Waimumu Field Days. Results returned to individual practices & vouchers provided to people with high risk factors for a funded GP visit. • Meetings with DHB Planning & Funding to consider how to use additional long term conditions funding opportunities in support of achieving the health targets.

Priority Area	Key Performance Indicator	Activity	Progress against activity Jan/Feb 14
2. **Increased Immunisations**: Identify and implement actions to improve immunisation rates.	• 90 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by July 2014 and 95 percent by December 2014.	2.1 Monitoring of the National Immunisation Register (NIR) and service improvements are identified and implemented.	▪ Follow up with practices with low immunisation rates. ▪ Discussions with the DHB based NIR Team to clarify newborn enrolment processes.
3. **Brief Advice to Quit Smoking:** Identify and implement actions to improve CVD risk assessment rates in primary care.	• 90 percent of patients who smoker and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.	3.1 Keeping practices up to date with their achievement against the target. 3.2 Supporting practices to audit the PMS to ensure all practice smoking activity is entered correctly for extraction 3.2 Cessation services provided outside of general practice are reported to practices for recording in patient records. 3.3 Smokers not offered brief advice or cessation support are identified and followed-up.	▪ Practices support to audit patient records to identify patients offered advice or support to quit but not coded correctly for extraction. ▪ Follow up with practices with low rates of recorded smoking cessation activity. ▪ Brief advice & cessation support provided to smokers at the Field Days. Data returned to practices for recording and follow up as required. ▪ Patient lists sent to practices of smokers discharged from secondary care provided with brief advice in hospital requiring follow up in primary care. ▪ Liaison with contracted community providers seeking their support with the health targets. ▪ Meetings with the DHB to implement the primary care aspects of the Tobacco Control Plan.

PHO

Southern PHO

CVD Risk Assessment - Total Population

PHO Level

December 13	
Data Period	Oct 13 - Dec 13
Age	Eligible Table
Gender	ALL
PHO Baseline	50.60
PHO Target (Current Period)	65.00
Performance (Current Period)	64.22
Programme Goal	≥90

PHO

Southern PHO

CVD Risk Assessment - High Need

PHO Level

December 13	
Data Period	Oct 13 - Dec 13
Age	Eligible Table
Gender	ALL
PHO Baseline	52.04
PHO Target (Current Period)	65.00
Performance (Current Period)	62.62
Programme Goal	≥90

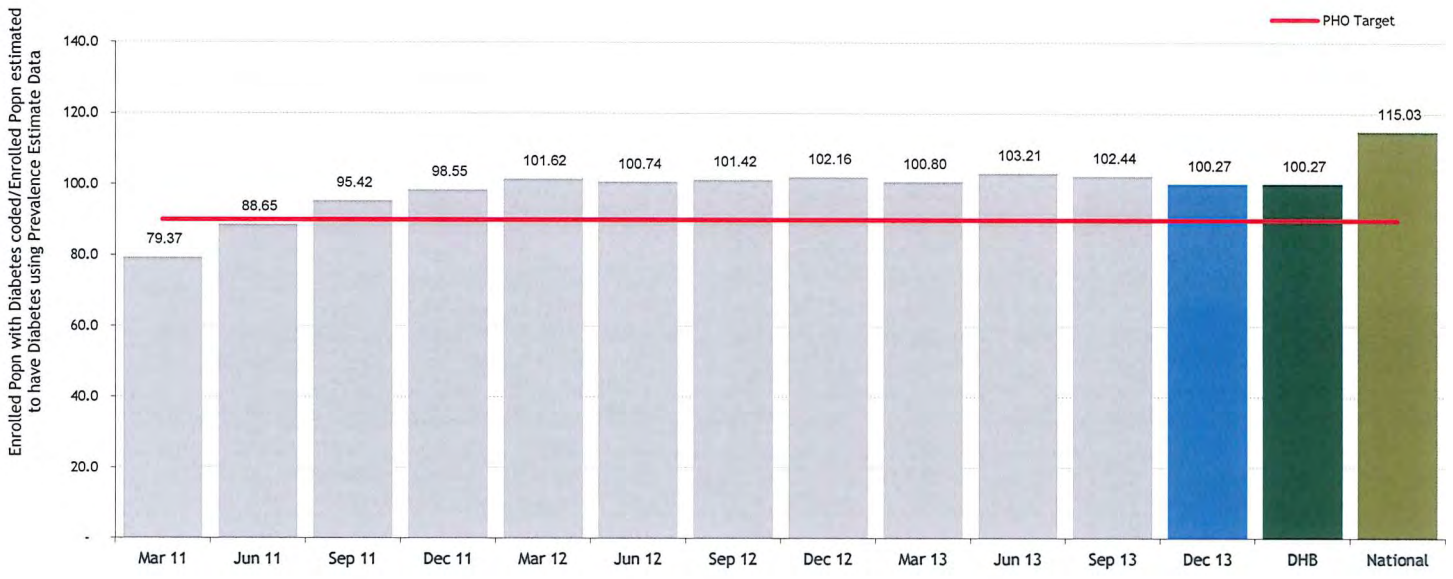
PHO

Southern PHO

Diabetes Detection - Total Population

PHO Level

December 13	
Data Period	Oct 13 - Dec 13
Age	15-79
Gender	ALL
PHO Baseline	101.42
PHO Target (Current Period)	90.00
Performance (Current Period)	100.27
Programme Goal	≥90



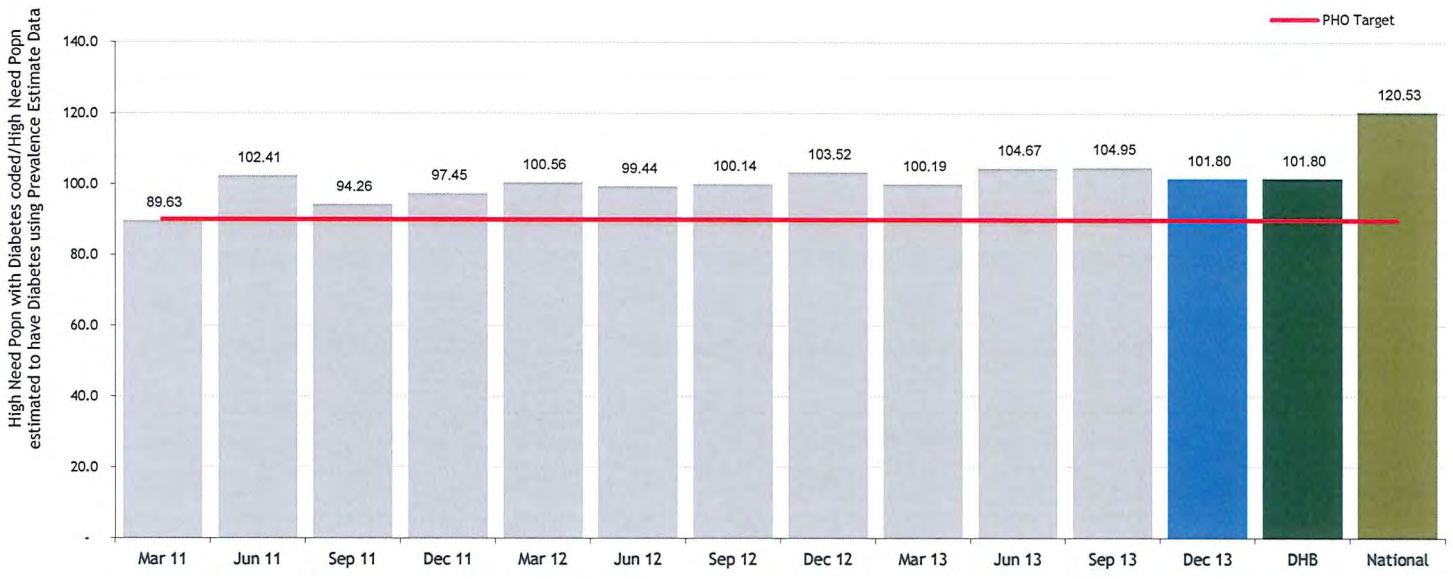
PHO

Southern PHO

Diabetes Detection - High Need

PHO Level

December 13	
Data Period	Oct 13 - Dec 13
Age	15-79
Gender	ALL
PHO Baseline	100.14
PHO Target (Current Period)	90.00
Performance (Current Period)	101.80
Programme Goal	≥90



PHO

Southern PHO

Diabetes Follow Up After Detection - Total Population

PHO Level

December 13	
Data Period	Oct 13 - Dec 13
Age	15-79
Gender	ALL
PHO Baseline	53.57
PHO Target (Current Period)	60.00
Performance (Current Period)	65.33
Programme Goal	≥90

PHO

Southern PHO

Diabetes Follow Up After Detection - High Need

PHO Level

December 13	
Data Period	Oct 13 - Dec 13
Age	15-79
Gender	ALL
PHO Baseline	53.59
PHO Target (Current Period)	60.00
Performance (Current Period)	65.57
Programme Goal	≥90

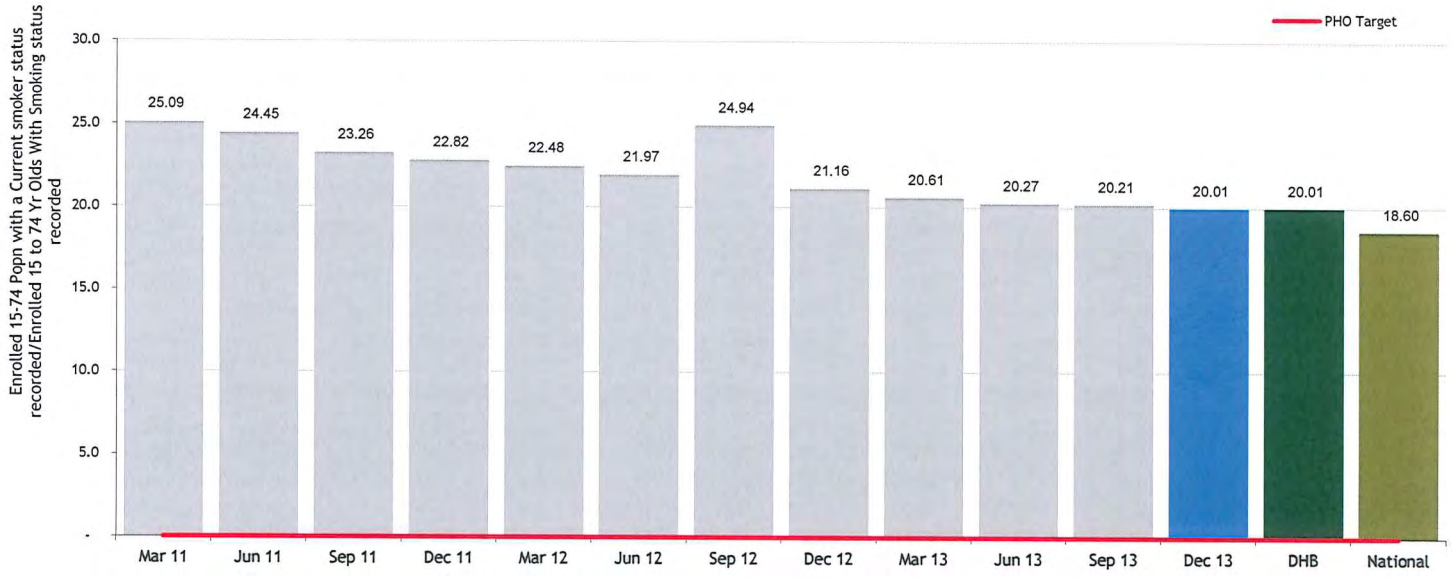
PHO

Southern PHO

Current smoker status recorded - Total Population

PHO Level

December 13	
Data Period	Oct 13 - Dec 13
Age	15-75
Gender	ALL
PHO Baseline	-
PHO Target (Current Period)	-
Performance (Current Period)	20.01
Programme Goal	-



PHO

Southern PHO

Current smoker status recorded - High Need

PHO Level

December 13	
Data Period	Oct 13 - Dec 13
Age	15-75
Gender	ALL
PHO Baseline	-
PHO Target (Current Period)	-
Performance (Current Period)	34.00
Programme Goal	-

PHO

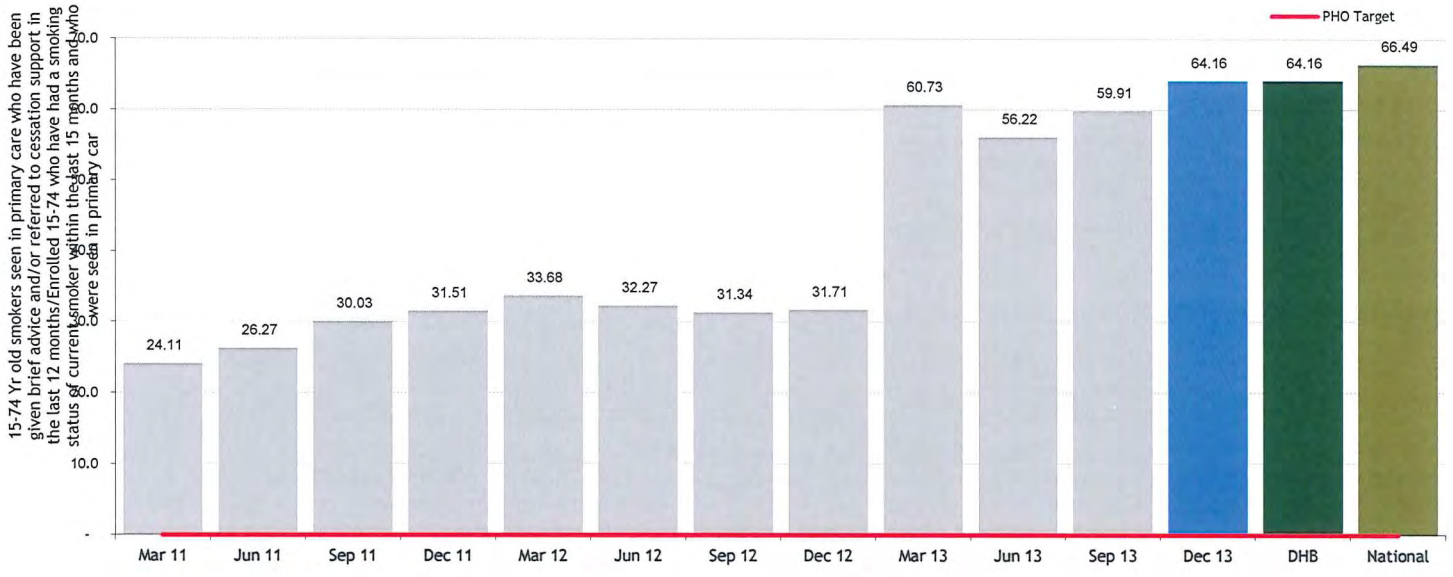
Southern PHO

Brief Advice and/or Cessation Support/Referral provided to patients seen in last 12 months - Total Population

PHO Level

December 13

Data Period	Oct 13 - Dec 13
Age	15-75
Gender	ALL
PHO Baseline	-
PHO Target (Current Period)	-
Performance (Current Period)	64.16
Programme Goal	≥90



Southern PHO

Brief Advice and/or Cessation Support/Referral provided to patients seen in last 12 months - High Need

PHO Level

December 13	
Data Period	#N/A
Age	15-75
Gender	ALL
PHO Baseline	-
PHO Target (Current Period)	-
Performance (Current Period)	65.01
Programme Goal	≥90

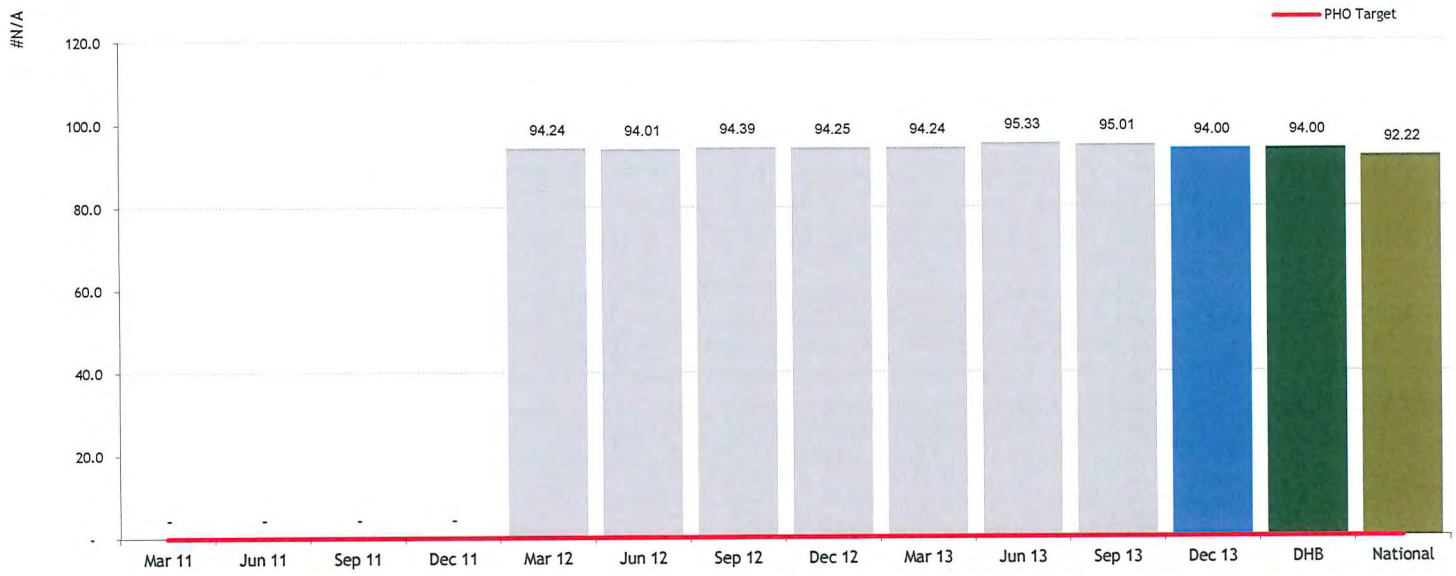
PHO

Southern PHO

Age Appropriate Vaccinations - 8M Olds - Total Population

PHO Level

December 13	
Data Period	#N/A
Age	8M
Gender	ALL
PHO Baseline	-
PHO Target (Current Period)	-
Performance (Current Period)	94.00
Programme Goal	≥90



PHO

Southern PHO

Age Appropriate Vaccinations - 8M Olds - High Need

PHO Level

December 13	
Data Period	#N/A
Age	8M
Gender	ALL
PHO Baseline	-
PHO Target (Current Period)	-
Performance (Current Period)	93.72
Programme Goal	≥90

Contracted Services & Programmes Reporting

Service Area	Key Performance Indicator	Activity	Progress against activity Jan/Feb 14
Services are delivered as contracted			
1 **Health Promotion**: Implement the PHO's 2013/14 Health Promotion plan as approved by the Board and Southern DHB.	• HP programmes and activities are implemented.	1.1 Little Lungs 1.2 Books On Prescription 1.3 Voucher system 1.4 Breast Feeding initiatives 1.5 Senior Chef Programme 1.6 Alcohol Awareness Programmes & Activities	• Attendance at District Smokefree Workshop • Voucher programme set up in Invercargill • Submissions to CODC on Local Alcohol Policy • Mental Health Literacy partnership discussions commenced with Federated Farmers. • Delivery of 'Little Lungs' professional development to 85 teachers from 22 Kindergartens. • Newspaper interviews regarding Alcohol policies and workshops. • Evaluation of Senior Chef Programme/s • Books on Prescription promotion • Development of the Breastfeeding Peer Counsellor Programme branding (logo) • Contracts finalised for Breastfeeding Support Training in Alexandra and Dunedin.
2 **Services to Improve Access (SIA)**: Implement the Board approved programmes to eliminate barriers to access for high need populations	• Reduced or diminished barriers to access for high need patients • Increased uptake of programmes targeted at high needs patients	2.1 Sexual Health Programme & Clinics 2.2 High Needs CVDRA Programme 2.3 Language Line 2.4 Text Reminder Programme 2.5 Cancer Kaiarahi Coordinators 2.6 Funded smear	▪ Promotion of the programmes to practice teams and accredited providers ▪ Financial reporting developed to monitor practice participation in SIA funded programmes. ▪ Follow-up with practices not offering the programmes to eligible patients. ▪ Practice level data matching to identify under and un-screened women eligible for funded smears.

Service Area	Key Performance Indicator	Activity	Progress against activity Jan/Feb 14
		programme (Maori only) 2.7 Insulin Initiation 2.8 Oral Health Programme	▪ Community programmes and activities delivered via contracts with accredited providers.
3 **GPSI Skin Lesion Programme**: Ongoing implementation of the Skin Lesion Programme.	• The Skin Lesion Programme is delivered equitably across the district within available funding	3.1 Active management of GPSI allocations, referrals & fee for service payments.	▪ Referral & payment information is collected, recorded and processed. ▪ Practice and GPSI volume queries dealt. ▪ Implementation of e-referral processes. ▪ Progress made on GPSI e-referral GPSI pathway.
4 PHO Performance Programme: Targets are achieved to maximise PPP income to the PHO	• Achievement of Performance Programme Targets • All practices are actively engaged in achievement of the targets	4.1 Data Matching 4.2 Practice dashboard reporting 4.3 Clinical & management support to practices and other providers 4.4 Collaborative relationship in support of target achievement	• Cervical and Breast screening programme data matching completed for many practices in conjunction with the DHB's screening teams. • Follow-up with practices not achieving the targets to agree actions toward improved performance. • Clinical support & education provided to practices on a case by case basis. • Meetings with DHB provider arm teams to share resources and expertise where appropriate in support of practices achieving the targets. • Promotion of funded programmes in support of the targets. • Monitoring of BPI data and liaison with South Link Health to iron out issues. • Liaison with MOH, DHB Shared Services & other PHOs around various aspects of the programme indicators and targets. • 2014 PPP targets negotiated with the DHB. • Attended District Cervical Screening Steering Group meeting.

Service Area	Key Performance Indicator	Activity	Progress against activity Jan/Feb 14
5 CarePlus	• Patients with ongoing chronic health conditions are supported to have maintain regular contact with their GP • Patients at risk of frequent hospital admissions are enrolled in an intensive management programme to reduce the likelihood of further hospital admissions.	5.1 Active management of CarePlus claims, allocations and 'fee for service' payments 5.2 Integrated Practice Support (YoY) Project in selected practices 5.3 Active Management of the Palliative Care Programme	▪ Enrolments monitored and payments processed. ▪ Trouble shooting of outstanding payment and enrolment issues for several practices has been taken up a lot of PHO staff time in recent months. ▪ Ongoing engagement with the IPS early starter practices.
6 Diabetes Care; Implementation of the Diabetes Care Improvement Programme (DCIP) and Insulin Initiation Programme	• Patients diagnosed with diabetes receive timely, high quality & relevant health care.	6.1 DCIP support to practices	• Quarterly payment made to practices in January for the period Oct to Dec13. • Monitoring of provider performance and follow up as required. • Attendance at LDT meeting to discuss 2012/13 LDT annual report. • Diabetes data issues in BPI followed up with SLH. • Development of position descriptions for new primary care diabetes roles (nursing, dietician & podiatry) – recruitment pending.
7 HPV Programme: Ongoing implementation of the HPV Programme in Southland	• Delivery of an equitable, ongoing immunisation programme for girls in school year 8 and facilitating uptake or girls eligible girls to provide protection against HPV infection and the subsequent development of cervical cancer.	7.1 Planning and delivery of the School Based Programme through an appropriately qualified nursing service 7.2 Planning and implementing a delivery schedule that ensures prioritisation of delivery to	• Nurse Coordinator joined the team • 2014 programme schedule confirmed with local schools. • Review of all programme documentation & equipment used by the team

Service Area	Key Performance Indicator	Activity	Progress against activity Jan/Feb 14
		all schools.	
8 Workforce Development: Implementation of the PHO's Workforce Development Plan	• Development of a highly skilled multidisciplinary primary care workforce.	8.1 Workforce Development Plan 8.2 Appropriate communication with clinicians	• Clinician survey completed to determine and prioritise education needs & workforce development. • Workforce Development Plan revised to incorporate feedback from practice teams. • Clinician contact database developed. • GP Newsletter produced and circulated to all providers. • Meeting with local PMANZ to deliver an education programme to Managers and Administrators in 2014
9 **Ethnicity Audits:** Implement the ethnicity project as contracted.	• All SPHO practices audited to ensure accuracy of ethnicity recording systems and processes.	9.1 Auditing of practice records.	• Project templates and documentation developed. • Scope of audit project expanded to review entire enrolment processes in each practice. • Project commenced in mid January in six early starter practices. • Post audit actions completed as required.
10 Mental Health Brief Intervention: Implementation of the BIS service as contracted	• Delivery of services to eligible clients with a mild to moderate mental health illness.	10.1 Brief Intervention service delivery	• Progress commenced to consider the recommendations in the Tony Dowell report and review the current model of service/s delivery, operational structure and access criteria within contract and funding constraints. • Briefing paper prepared to discuss contract funding with Planning & Funding. • Individual workforce development applications approved & processed on an ongoing basis. • DHB quarterly (Oct-Dec13) reporting submitted

Service Area	Key Performance Indicator	Activity	Progress against activity Jan/Feb 14
			in January. • RFPs sought from existing PMS vendors to provide a common patient management system for the brief intervention team. • Regular meeting with DHB provider arm to discuss the shared BIS arrangement in Southland and Queenstown. • Reassignment of clinicians to meet service demand in Central Otago.

DSAC / CPHAC Workplan 2014

Output	Timeframe	Reporting Frequency	Progress			Reports / Presentation Schedule
			Behind	On Target	Complete	
Child & Youth Child and Youth Steering Group - Develop communications strategy - Complete stocktake of child and youth health services - Develop Child & Youth Strategies - WCTO Quality Improvement Framework Social Sector Trials Compass Childrens Action Plan	 Meets six weekly In progress TBC Ongoing Ongoing Ongoing Ongoing	 Quarterly Quarterly Six monthly Annual Annual				A report/presentation will be submitted to the November 2014 DSAC-CPHAC Committee Meeting
Cancer Services - Cancer Networks (local & SCN) - SDHB Cancer Control Plan	 Ongoing Ongoing	 Quarterly Quarterly				A report/presentation will be submitted to the December 2014 DSAC-CPHAC Committee Meeting
Health of Older Persons - Age Related Residential Care - Home & Community Support Services Alliance - Palliative Care - Dementia		 Annual Six month Annual Annual				A report/presentation on residential care will be submitted to the May 2014 DSAC-CPHAC Committee Meeting
Mental Health - Development of implementation plan for Raise HOPE (MH&A Strategic Plan) - Phased implementation of Raise HOPE - Implementation Prime Ministers Youth Mental Health project initiatives - Suicide prevention	 June 2014 ongoing	 Bimonthly update Quarterly six monthly six monthly				A report/presentation will be submitted to the July 2014 DSAC-CPHAC Committee Meeting
Primary Care - PHO Clinical Programmes - After Hours Services - Rural Services Alliance - Long-term Conditions - Primary Maternity Clinical Quality Network - Integration, BSMC service development - Community Pharmaceuticals - Laboratory Services	 On-going On-going June 14 On-going On-going On-going On-going	 Quarterly Six Monthly Bi Monthly Quarterly Quarterly Monthly Quarterly				A report/presentation will be submitted to the October 2014 DSAC-CPHAC Committee Meeting
Southern PHO	On-going	Monthly				
Southern Health Alliance Leadership Team (SHALT)	On-going	Monthly				

DSAC / CPHAC Workplan 2014

Output	Timeframe	Reporting Frequency	Progress			Reports / Presentation Schedule
			Behind	On Target	Complete	
Rural Health - - Rural hospital trusts – performance monitoring	Ongoing	Quarterly				
Performance Monitoring - SOI Indicators / DAP Measures - PHO Performance Programme - Health Targets (Diabetes, Smoking, CVD, Immunisation)						
Public Health - Family Violence Intervention Programme - Hep C - Needle Exchange		Six monthly Annual Annual				A report/presentation will be submitted to the September 2014 DSAC-CPHAC Committee Meeting.
Maori Health - Maori Health Plan - Whanau Ora - Nurse-led Clinics		Six monthly				
Pacific Health - General Update		Six monthly				
Population Health - Before Schools Check - School Based Health Services - Vaccine Preventable Disease - Screening programmes - Child Mortality Review Group - Sexual health services		Six monthly				
Public Health South	Ongoing	Bi-Monthly				

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Terms of Reference Review**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	5 March 2014

Summary:

The Terms of Reference (ToR) for each committee were last reviewed and modified in February 2012. Minor amendments have been made to the current Terms of Reference.

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

Financial:	N/A
Workforce:	N/A
Other:	N/A

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

Prepared by: Board Secretary **Date:** 13.02.14	**Presented by:** Sandra Boardman Executive Director Planning & Funding

RECOMMENDATIONS:

That the Committees endorse the Terms of Reference as modified and recommend the Board approve them.

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC)

Terms of Reference

Accountability

The Disability Support Advisory Committee is constituted by section 35, part 3, of The New Zealand Public Health and Disability Act 2000 (The Act).

The procedures of the Committee shall also comply with Schedule 4 of the Act.

The Committee is to further comply with the standing orders of the Southern DHB which may not be inconsistent with the Act.

Function and Scope

1) The statutory functions of DSAC are to give the Boards advice on:
   a) The disability support needs of the resident population of the Southern DHB
   b) Priorities for use of the disability support funding provided.

2) The aim of the Committee's advice will be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the Southern DHB's resident population:
   a) the kinds of disability support services the Southern DHB has provided or funded or could provide or fund for those people;
   b) all policies the Southern DHB has adopted or could adopt for those people.

3) The Committee's advice may not be inconsistent with the New Zealand Disability Strategy.

Responsibilities

The Committee is responsible for:

1) Providing advice on the overall performance of the disability support services delivered by or through the Southern DHB;

2) Providing advice on strategic issues related to the delivery of disability support services delivered by or through the Southern DHB;

3) Focusing on the disability support needs of the population and developing principles on which to determine priorities for using finite disability support funding;

4) Ensuring that the District Annual Plans (DAPs) of the Southern DHB demonstrate how people with disability will access health services and how the Southern DHB will ensure that the disability support services they fund or provide are co-ordinated with the services of other providers to meet the needs of people with disabilities;

5) Assessing the disability support services' performance against expectations set in the relevant accountability documents, documented standards and legislation;

6) Ensuring that recommendations for significant change or strategic issues have noted input from key stakeholders and consultation has occurred in accordance with statutory requirements and Ministry guidelines.

Membership

All members of the Committee are to be appointed by the Board. The Board will appoint the chairperson.

The Committee is to comprise of Board members, supplemented with external appointees as required.

Membership will provide for Māaori representation on the Committee. The Committee may obtain additional advice as and when required.

Where a person, who is not a Board member, is appointed to the Committee, the person must give the Board a statement that discloses any present or future conflict of interest, or a statement that no such conflicts exist or are likely to exist in the future.

Conflicts of Interest

Where a potential conflict of interest exists with an agenda item, these are to be declared by members and staff. A register of interests shall form part of each Committee meeting agenda.

Quorum

The quorum of members of a committee is,—

(a) if the total number of members of the committee is an even number, half that number; but

(b) if the total number of members of the committee is an odd number, a majority of the members.

Meetings

Meetings for this Committee are generally held bi-monthly.

Review

The Terms of Reference for this Committee shall be reviewed at the beginning of each new Board term.

Management Support

The Chief Executive Officer shall ensure adequate provision of management and administrative support to the Committee.

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

Terms of Reference

Accountability

The Community & Public Health Advisory Committee is constituted by section 34, part 3, of The New Zealand Public Health and Disability Act 2000 (The Act).

The procedures of the Committee shall also comply with Schedule 4 of the Act.

The Committee is to further comply with the standing orders of the Southern DHB which may not be inconsistent with the Act.

Function and Scope

1) The statutory functions of CPHAC is to give the Board advice on:

   a) the needs, and any factors that the Committee believes may adversely affect the health status, of the resident population of the Southern DHB; and

   b) priorities for use of the limited health funding provided.

2) The statutory aim of CPHAC's advice is to ensure that the following maximise the overall health gain for the population the Committee serves:

   a) all service interventions the Southern DHB has provided or funded or could provide or fund for that population;

   b) all policies the DHB has adopted or could adopt for that population.

3) CPHAC's advice may not be inconsistent with the New Zealand Health Strategy.

Responsibilities

The Committee is responsible for:

1) Taking an overview of the population and health improvement;

2) Providing recommendations for new initiatives in community and public health improvement;

3) Addressing the prevention of inappropriate hospital admissions through health promotion and community care interventions;

4) Examining the role that primary care, disability support, public health and other community services - as well as hospital services - can play in achieving health improvement;

5) Ensuring better co-ordination across the interface between services and providers;

6) Focusing on the needs of the populations and developing principles on which to determine priorities for using finite health funding;

7) Interpreting the local implications of the nation-wide and sector-wide health goals and performance expectations;

8) Providing advice on strategies to reduce the disparities in health status; especially relating to Maori and Pacific Island peoples;

9) Providing advice on priorities for health improvement and independence as part of the strategic planning process;

10) Ensuring the processes and systems are put in place for effective and efficient management of health information in the Southern DHB district, including policies regarding data ownership and security;

11) Ensuring the priorities of the community are reflected in the Annual Plan of the Southern DHB, and to ensure that appropriate processes are followed in preparation of the plan.

12) Ensuring that recommendations for significant change or strategic issues have noted input from key stakeholders and consultation has occurred in accordance with statutory requirements and Ministry guidelines.

Membership

All members of the Committee are to be appointed by the Board. The Board will appoint the chairperson.

The Committee is to comprise of Board members, supplemented with external appointees as required.

Membership will provide for Māaori representation on the Committee. The Committee may obtain additional advice as and when required.

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Conflicts of Interest

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Quorum

The quorum of members of a committee is,—

(a) if the total number of members of the committee is an even number, half that number; but
(b) if the total number of members of the committee is an odd number, a majority of the members.

Meetings

Meetings for this Committee are generally held bi-monthly.

Review

The Terms of Reference for this Committee shall be reviewed at the beginning of each new Board term.

Management Support

The Chief Executive Officer shall ensure adequate provision of management and administrative support to the Committee.

DSAC / CPHAC FINANCIAL REPORT

Financial Report as at: **31 January 2014**
Report Prepared by: **David Dickson**
Date: **18 February 2014**

Recommendations:

- **That the Committee's 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
68,851	68,107	744	Revenue	478,619	476,749	1,870	817,283
(68,040)	(67,724)	(316)	Less Other Costs	(479,124)	(477,427)	(1,697)	(818,387)
811	383	428	Net Surplus / (Deficit)	(505)	(678)	173	(1,104)
			Expenses				
(47,849)	(47,759)	(90)	Personal Health	(339,374)	(337,836)	(1,538)	(580,071)
(7,317)	(7,269)	(48)	Mental Health	(49,742)	(50,883)	1,141	(87,232)
(930)	(864)	(66)	Public Health	(6,709)	(6,045)	(664)	(10,363)
(11,094)	(10,980)	(114)	Disability Support	(77,344)	(76,704)	(640)	(130,502)
(153)	(154)	1	Maori Health	(1,068)	(1,072)	4	(1,840)
(698)	(698)	0	Other	(4,887)	(4,887)	0	(8,379)
(68,041)	(67,724)	(317)	Expenses	(479,124)	(477,427)	(1,697)	(818,387)

Summary Comment:
The January result was a surplus of $0.8m and was favourable to budget by $0.4m. The year to date funder result is a deficit of $0.5m against a budgeted deficit of $0.7m

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
- ($0.7m) of unfavourable public health for screening programmes, offset in revenue
- ($0.7m) of unfavourable home support costs, with some revenue offset
- ($0.3m) of unfavourable radiology costs, offset in revenue
- $1.4m of below budget provider-arm mental health expenditure from unfilled FTE positions
- $2.5m of additional revenue (excluding IDF's)

Revenue
YTD revenue, excluding IDFs is $2.5m 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
Care plus funding	0.2	Y, Personal Health
Screening revenues	0.6	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
Aged care home support funding	0.2	Y,DSS
Enhanced Alcohol and Drug Services	0.2	Y, Mental Health expenditure
Total Revenue Variation	**2.5**	

Personal Health Payments
Personal Health is close to budget for the month. The year to date remains $1.5m unfavourable with variances in laboratory costs ($0.4m), due to additional tests, Pharmaceuticals ($0.6m) due to the impact of 2012/13 costs, Radiology ($0.3m) which has a revenue offset, price adjustors and premiums ($0.3m), again having revenue offset relating to the sleepover settlement funding received. IDF are 0.3m unfavourable, with only minor movement in January.

Mental Health
Mental Health costs for January are unfavourable due to a new contract for Enhanced Alcohol and Drug services commencing, which has revenue offset. Year to date costs are favourable due to the wash-up with the provider arm of $1.4m.

Disability Support
Disability support services costs are unfavourable in January with Hospital residential care unfavourable by $0.1m due to volume. Year to date DSS costs remain unfavourable ($0.6m), due to home support costs, and hospital residential care above budget.

Additional revenue for price and volume increases received in January ($0.2m) partly offsets the unfavourable variance.

Public Health
The expenditure variance of $0.7m is offset by revenue for screening programmes which is paid to the provider.

IDF Summary
The IDF inpatient wash-up for January shows inflows improved slightly in the month. Year to date there is an unfavourable $0.5m provision.

IDF outflows worsened against budget by a similar amount to the inflows to make the net impact nil for January. The year to date wash-up for outflows is unfavourable by $0.3m.

Outpatient data is still being validated with no wash-up currently provided for.

Forecast

The funder January result was better than forecast by $0.3m. This mostly relates to additional revenue received, some of which was offset with Mental Health expenditure. A summary of the January result compared to forecast follows.

Funder Description	January Actual	January Forecast	Variance to Forecast January
Revenue			
Government & Crown Agency Sourced	68,851	68,173	677
Revenue Total	**68,851**	**68,173**	**677**
Expenditure			0
Outsourced Services	(698)	(698)	(0)
Provider Payments			0
Payments to Providers - Personal Health	(47,849)	(47,894)	45
Payments to Providers - Public Health	(930)	(870)	(60)
Payments to Providers - Mental Health	(7,317)	(7,048)	(269)
Payments to Providers - Disability Support	(11,094)	(11,051)	(43)
Payments to Providers - Hauora Maori Services	(153)	(153)	0
Expenditure Total	**(68,040)**	**(67,714)**	**(326)**
Net Surplus / (Deficit)	**810**	**460**	**351**

The full year forecast is for a deficit of $0.4m which is $0.6m better than budget. This is also $0.5m ahead of the remaining budget for the year.

2. Financial Statements

The financial summary for the funder result is attached.

Southern District Health Board

Jan-14

Part 3: DHB Funds	Current Month				Year to Date				Annual
	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Budget $(000)
Part 3.1: Statement of Financial Performance									
REVENUE									
Ministry of Health									
MoH - Vote Health Non Mental Health	56,397	56,335	62 F		394,689	394,342	347 F		676,014
MoH - Vote Health Mental Health	7,057	7,062	(5) U		49,399	49,434	(35) U		84,744
PBF Adjustments	-	-			-	-			-
MoH Funding Subcontracts	3,747	3,124	623 F	20%	24,089	21,868	2,221 F	10%	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	**67,200**	**66,521**	**680 F**	**1%**	**468,177**	**465,644**	**2,533 F**	**1%**	**798,246**
Other Government									
IDF's - Mental Health Services	144	144			1,005	1,005			1,723
IDF's - All others (non Mental health)	1,507	1,443	64 F	4%	9,437	10,100	(663) U	(7%)	17,314
Other DHB's	-	-			-	-			-
Training Fees and Subsidies	-	-			-	-			-
Accident Insurance	-	-			-	-			-
Other Government	-	-			-	-			-
Other Government Total	**1,650**	**1,586**	**64 F**	**4%**	**10,442**	**11,105**	**(663) U**	**(6%)**	**19,037**
Government and Crown Agency Sourced Total	**68,851**	**68,107**	**744 F**	**1%**	**478,619**	**476,749**	**1,871 F**		**817,283**
Other Revenue									
Patient / Consumer Sourced	-	-			-	-			-
Other Income	-	-			-	-			-
Other Revenue Total	**-**	**-**			**-**	**-**			**-**
REVENUE TOTAL	**68,851**	**68,107**	**744 F**	**1%**	**478,619**	**476,749**	**1,871 F**		**817,283**
EXPENSES									
Outsourced Expenses									
Outsourced Funder Services	(698)	(698)			(4,888)	(4,888)			(8,379)
Other Outsourced Expenses	-	-			-	-			-
Other Expenses	-	-			-	-			-
Payments to Providers									
Personal Health									
Child and Youth	(381)	(375)	(6) U	(2%)	(2,647)	(2,627)	(20) U	(1%)	(4,504)
Laboratory	(2,695)	(2,639)	(56) U	(2%)	(18,840)	(18,476)	(364) U	(2%)	(31,674)
Infertility Treatment Services	(91)	(100)	9 F	9%	(637)	(700)	63 F	9%	(1,200)
Maternity	(262)	(261)			(1,831)	(1,828)	(3) U		(3,135)
Maternity (Tertiary & Secondary)	(1,374)	(1,385)	11 F	1%	(9,621)	(9,696)	75 F	1%	(16,622)
Pregnancy and Parenting Education	(10)	(12)	2 F	17%	(76)	(86)	11 F	12%	(148)
Maternity Payment Schedule	-	-			-	-			-
Neo Natal	(656)	(656)			(4,594)	(4,594)			(7,875)
Sexual Health	(88)	(88)			(616)	(616)			(1,055)
Adolescent Dental Benefit	(171)	(142)	(29) U	(20%)	(1,301)	(1,453)	152 F	10%	(2,425)
Other Dental Services	-	-			-	-			-
Dental - Low Income Adult	(108)	(90)	(18) U	(20%)	(558)	(630)	72 F	11%	(1,083)
Child (School) Dental Services	(531)	(635)	103 F	16%	(4,332)	(4,480)	148 F	3%	(7,608)
Secondary / Tertiary Dental	(254)	(245)	(9) U	(4%)	(1,778)	(1,718)	(60) U	(4%)	(2,950)
Pharmaceuticals	(5,844)	(5,897)	52 F	1%	(44,573)	(43,975)	(598) U	(1%)	(75,312)
Pharmaceutical Cancer Treatment Drugs	(361)	(358)	(3) U	(1%)	(2,479)	(2,508)	30 F	1%	(4,300)
Pharmacy Services	(28)	(68)	40 F	59%	(327)	(479)	153 F	32%	(821)
Management Referred Services	-	-			-	-			-
General Medical Subsidy	(50)	(110)	60 F	54%	(581)	(979)	398 F	41%	(1,650)
Primary Practice Services - Capitated	(3,431)	(3,431)			(23,886)	(24,017)	131 F	1%	(41,172)
Primary Health Care Strategy - Care	(283)	(240)	(43) U	(18%)	(1,912)	(1,681)	(231) U	(14%)	(2,883)
Primary Health Care Strategy - Health	(532)	(286)	(246) U	(86%)	(2,500)	(2,002)	(498) U	(25%)	(3,432)
Primary Health Care Strategy - Other	(223)	(207)	(16) U	(8%)	(1,691)	(1,449)	(243) U	(17%)	(2,484)
Practice Nurse Subsidy	(16)	(17)		3%	(119)	(116)	(4) U	(3%)	(198)
Rural Support for Primary Health Pro	(1,374)	(1,371)	(3) U		(9,611)	(9,597)	(14) U		(16,452)
Immunisation	(116)	(105)	(11) U	(10%)	(944)	(913)	(31) U	(3%)	(2,651)
Radiology	(536)	(457)	(79) U	(17%)	(3,548)	(3,200)	(348) U	(11%)	(5,486)
Palliative Care	(430)	(495)	66 F	13%	(3,467)	(3,466)	(1) U		(5,942)
Meals on Wheels	(53)	(53)	(1) U	(1%)	(373)	(368)	(5) U	(1%)	(632)
Domicilary & District Nursing	(1,441)	(1,436)	(5) U		(9,996)	(10,053)	57 F	1%	(17,233)
Community based Allied Health	(581)	(581)			(4,070)	(4,067)	(3) U		(6,972)
Chronic Disease Management and Educa	(239)	(241)	2 F	1%	(1,679)	(1,688)	10 F	1%	(2,894)
Medical Inpatients	(5,619)	(5,619)			(39,331)	(39,331)			(67,425)
Medical Outpatients	(3,609)	(3,617)	8 F		(25,157)	(25,320)	163 F	1%	(43,405)
Surgical Inpatients	(10,361)	(10,426)	65 F	1%	(72,981)	(72,981)			(125,110)
Surgical Outpatients	(1,715)	(1,716)	1 F		(11,982)	(12,012)	30 F		(20,592)
Paediatric Inpatients	(641)	(641)			(4,484)	(4,484)			(7,686)
Paediatric Outpatients	(267)	(267)			(1,871)	(1,871)			(3,207)
Pacific Peoples' Health	(17)	(21)	4 F	19%	(127)	(150)	24 F	16%	(258)
Emergency Services	(1,621)	(1,630)	9 F	1%	(11,385)	(11,408)	24 F		(19,557)
Minor Personal Health Expenditure	(84)	(89)	4 F	5%	(588)	(620)	32 F	5%	(1,062)
Price adjusters and Premium	828	795	33 F	4%	5,221	5,567	(346) U	(6%)	9,543
Travel & Accomodation	(391)	(397)	6 F	2%	(2,782)	(2,724)	(58) U	(2%)	(4,741)
Inter District Flow Personal Health	(2,192)	(2,148)	(43) U	(2%)	(15,323)	(15,038)	(285) U	(2%)	(25,780)
Personal Health Total	**(47,849)**	**(47,759)**	**(90) U**		**(339,374)**	**(337,835)**	**(1,539) U**		**(580,072)**

Southern District Health Board

Jan-14

Part 3: DHB Funds	Current Month				Year to Date				Annual
	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Budget $(000)
Mental Health									
Mental Health to allocate	-	-			-	-			-
Acute Mental Health Inpatients	(1,299)	(1,299)			(9,090)	(9,090)			(15,583)
Sub-Acute & Long Term Mental Health	(362)	(362)			(2,537)	(2,537)			(4,349)
Crisis Respite	(7)	(7)			(47)	(48)		1%	(82)
Alcohol & Other Drugs - General	(335)	(330)	(5) U	(2%)	(2,434)	(2,307)	(127) U	(6%)	(3,955)
Alcohol & Other Drugs - Child & Youth	(40)	(24)	(16) U	(66%)	(277)	(167)	(110) U	(66%)	(286)
Methadone	(94)	(94)			(656)	(656)			(1,125)
Dual Diagnosis - Alcohol & Other Drugs	(15)	(45)	30 F	66%	(96)	(313)	217 F	69%	(536)
Dual Diagnosis - MH/ID	(8)	(5)	(3) U	(60%)	(55)	(35)	(21) U	(60%)	(59)
Eating Disorder	(14)	(14)			(98)	(98)			(168)
Maternal Mental Health	(4)	(4)			(26)	(26)			(44)
Child & Youth Mental Health Services	(890)	(856)	(34) U	(4%)	(5,744)	(5,992)	248 F	4%	(10,272)
Forensic Services	(515)	(510)	(5) U	(1%)	(3,500)	(3,568)	69 F	2%	(6,117)
Kaupapa Maori Mental Health Services	(106)	(152)	46 F	30%	(793)	(1,061)	268 F	25%	(1,818)
Kaupapa Maori Mental Health - Residential	-	-			-	-			-
Kaupapa Maori Mental Health - Inpati	-	-			-	-			-
Mental Health Community Services	(1,760)	(1,877)	116 F	6%	(12,428)	(13,138)	710 F	5%	(22,522)
Prison/Court Liaison	(46)	(44)	(2) U	(4%)	(323)	(310)	(13) U	(4%)	(531)
Mental Health Workforce Development	-	-			-	-			-
Day Activity & Work Rehabilitation S	(184)	(197)	14 F	7%	(1,369)	(1,382)	13 F	1%	(2,369)
Mental Health Funded Services for Older People	(35)	(35)			(248)	(248)			(426)
Advocacy / Peer Support - Consumer	(55)	(57)	2 F	3%	(367)	(399)	32 F	8%	(684)
Other Home Based Residential Support	(410)	(374)	(36) U	(10%)	(2,793)	(2,620)	(173) U	(7%)	(4,492)
Advocacy / Peer Support - Families	(52)	(60)	8 F	13%	(364)	(419)	56 F	13%	(720)
Community Residential Beds & Service	(459)	(451)	(8) U	(2%)	(3,078)	(3,156)	78 F	2%	(5,411)
Minor Mental Health Expenditure	(186)	(32)	(153) U	(475%)	(330)	(226)	(104) U	(46%)	(388)
Inter District Flow Mental Health	(441)	(441)			(3,088)	(3,088)			(5,294)
Mental Health Total	**(7,317)**	**(7,269)**	**(48) U**	**(1%)**	**(49,742)**	**(50,883)**	**1,142 F**	**2%**	**(87,232)**
Public Health									
Alcohol & Drug	(26)	(26)			(185)	(185)			(317)
Communicable Diseases	(96)	(96)			(675)	(675)			(1,158)
Injury Prevention	-	-			-	-			-
Screening Programmes	(414)	(368)	(46) U	(13%)	(3,104)	(2,575)	(529) U	(21%)	(4,414)
Mental Health	(22)	(22)			(155)	(155)			(265)
Nutrition and Physical Activity	(49)	(45)	(4) U	(9%)	(344)	(316)	(28) U	(9%)	(542)
Physical Environment	(36)	(36)			(250)	(250)			(428)
Public Health Infrastructure	(127)	(127)			(889)	(889)			(1,523)
Sexual Health	(12)	(12)			(83)	(83)			(143)
Social Environments	(38)	(38)			(264)	(264)			(452)
Tobacco Control	(110)	(93)	(16) U	(18%)	(761)	(654)	(107) U	(16%)	(1,121)
Well Child Promotion	-	-			-	-			-
Meningococcal	-	-			-	-			-
Public Health Total	**(930)**	**(864)**	**(67) U**	**(8%)**	**(6,709)**	**(6,045)**	**(664) U**	**(11%)**	**(10,363)**
Disability Support Services									
AT & R (Assessment, Treatment and Re	(1,976)	(1,976)			(13,829)	(13,829)			(23,707)
Information and Advisory	(12)	(13)	1 F	9%	(61)	(91)	31 F	34%	(156)
Needs Assessment	(171)	(163)	(8) U	(5%)	(1,187)	(1,141)	(46) U	(4%)	(1,956)
Service Co-ordination	(23)	(19)	(4) U	(19%)	(145)	(136)	(9) U	(7%)	(233)
Home Support	(1,308)	(1,267)	(41) U	(3%)	(9,820)	(9,169)	(651) U	(7%)	(15,504)
Carer Support	(145)	(156)	11 F	7%	(918)	(1,093)	175 F	16%	(1,874)
Residential Care: Rest Homes	(2,983)	(3,047)	64 F	2%	(20,795)	(21,135)	340 F	2%	(35,880)
Residential Care: Loans Adjustment	13	22	(9) U	(40%)	124	155	(32) U	(20%)	266
Long Term Chronic Conditions	(169)	(93)	(76) U	(82%)	(999)	(648)	(351) U	(54%)	(1,111)
Residential Care: Hospitals	(3,724)	(3,628)	(96) U	(3%)	(25,661)	(25,160)	(501) U	(2%)	(42,714)
Ageing in Place	(2)	(2)			(17)	(17)			(30)
Environmental Support Services	(99)	(101)	3 F	3%	(704)	(708)	4 F	1%	(1,218)
Day Programmes	-	-			-	-			-
Expenditure to Attend Treatment ETAT	-	-			-	-			-
Minor Disability Support Expenditure	(8)	(26)	17 F	68%	(64)	(180)	116 F	64%	(309)
Respite Care	(101)	(146)	45 F	31%	(1,008)	(993)	(14) U	(1%)	(1,691)
Community Health Services & Support	(94)	(105)	11 F	11%	(429)	(734)	305 F	42%	(1,259)
Inter District Flow Disability Support	(292)	(261)	(32) U	(12%)	(1,831)	(1,825)	(7) U		(3,128)
Disability Support Other	-	-			-	-			-
Disability Support Services Total	**(11,094)**	**(10,980)**	**(113) U**	**(1%)**	**(77,344)**	**(76,704)**	**(640) U**	**(1%)**	**(130,502)**
Maori Health									
Maori Service Development	(38)	(38)			(265)	(265)			(454)
Maori Provider Assistance Infrastruc	-	-			-	-			-
Maori Workforce Development	-	-			-	-			-
Minor Maori Health Expenditure	-	-			-	-			-
Whanau Ora Services	(115)	(116)	1 F	1%	(804)	(807)	4 F		(1,386)
Maori Health Total	**(153)**	**(154)**	**1 F**	**1%**	**(1,068)**	**(1,072)**	**4 F**		**(1,840)**
Internal Allocations	-	-			-	-			-
Total Expenses	**(68,040)**	**(67,724)**	**(317) U**		**(479,124)**	**(477,427)**	**(1,697) U**		**(818,387)**
Summary of Results									
Subtotal of IDF Revenue	1,650	1,586	64 F	4%	10,442	11,105	(663) U	(6%)	19,037
Subtotal all other Revenue	67,200	66,521	680 F	1%	468,177	465,644	2,533 F	1%	798,246
Revenue Total	**68,851**	**68,107**	**744 F**	**1%**	**478,619**	**476,749**	**1,871 F**		**817,283**
Subtotal of IDF Expenditure	(2,925)	(2,850)	(75) U	(3%)	(20,243)	(19,951)	(292) U	(1%)	(34,202)
Subtotal all other Expenditure	(65,115)	(64,873)	(242) U		(458,881)	(457,476)	(1,405) U		(784,185)
Expenses Total	**(68,040)**	**(67,724)**	**(317) U**		**(479,124)**	**(477,427)**	**(1,697) U**		**(818,387)**
Net Surplus/ (Deficit)	**810**	**383**	**427 F**	**111%**	**(505)**	**(678)**	**173 F**	**26%**	**(1,104)**

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Southern District Health Profile**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	05 March 2014

Summary:

The issues considered in this paper are:

- Key evidence basis for DHB planning

A guide to the Health Profile is attached. The full Health Profile has been circulated separately.

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

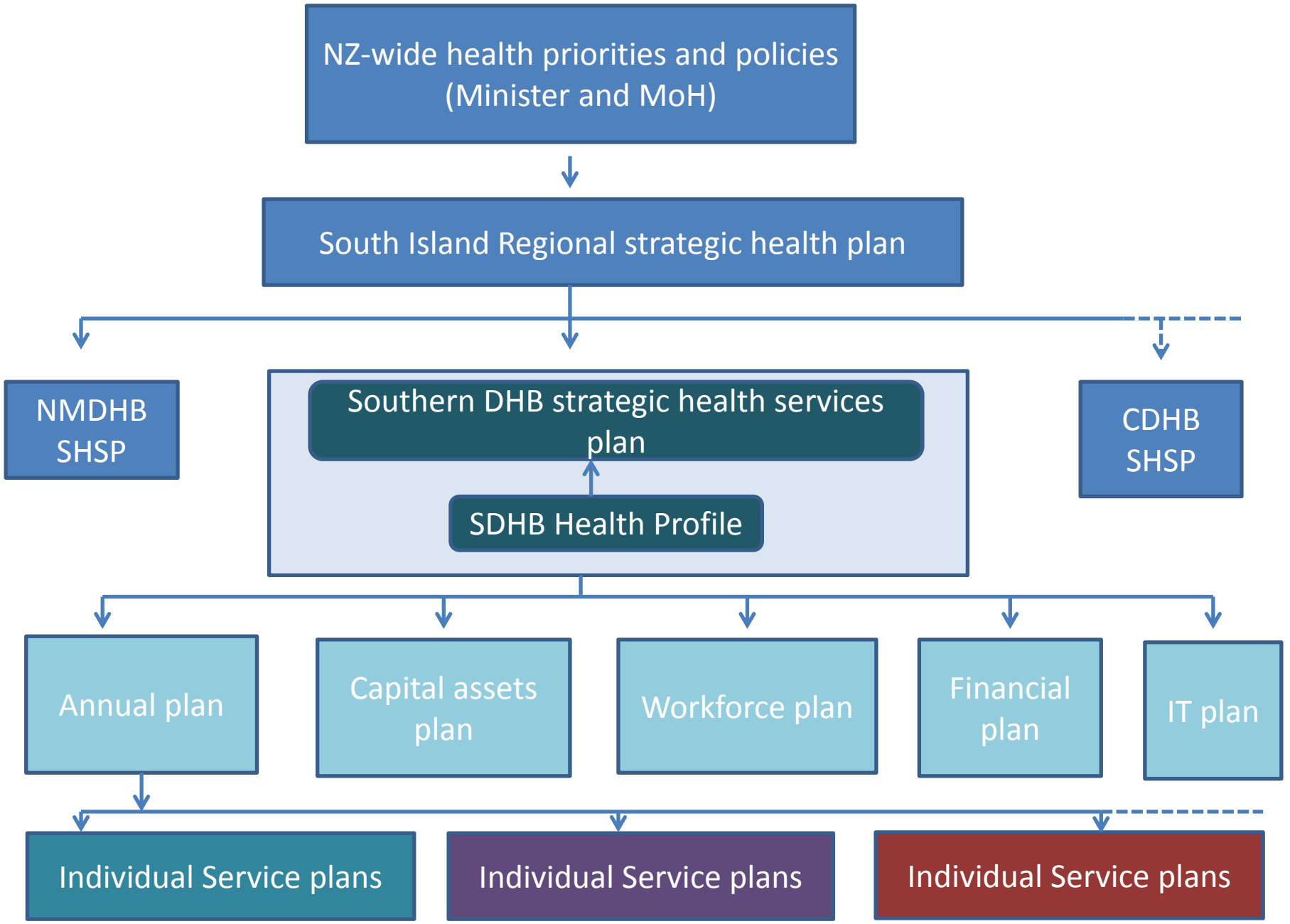
Financial:	n/a
Workforce:	n/a
Other:	

Document previously submitted to:	CPHAC hosted Board workshop	**Date:** 04/02/14
Approved by Chief Executive Officer:		**Date:** dd/mm/yy

Prepared by: Health Partners Consulting **Date:** 18/02/2014	**Presented by:** Carole Heatly

RECOMMENDATIONS:

1. **That the Committees recommend the Board ratify this document for DHB use.**


NZ-wide health priorities and policies (Minister and MoH)
South Island Regional strategic health plan
NMDHB SHSP
Southern DHB strategic health services plan
SDHB Health Profile
CDHB SHSP
Annual plan
Capital assets plan
Workforce plan
Financial plan
IT plan
Individual Service plans
Individual Service plans
Individual Service plans

Guide for the Southern DHB health profile

Introduction

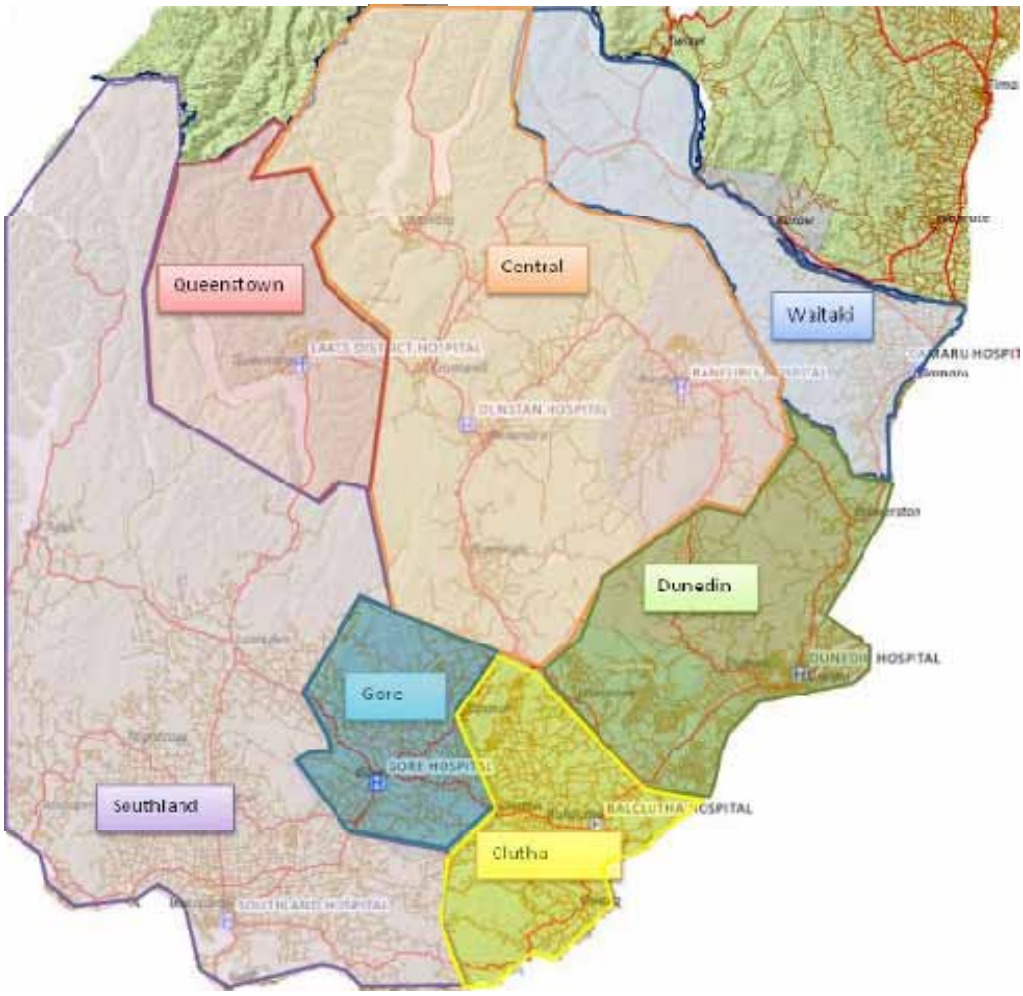
What is a health needs assessment?

A health needs assessment or "health profile" is a process to review the health issues facing a population. By summarising key health information that reflects the current health state of people living in the Southern DHB it will inform the Board and DHB about the best opportunities for improving the district population's health and reducing inequalities. The DHB can thus decide on its top priorities and ensure resources are allocated appropriately.

Methods

The analysis was primarily conducted by localities below (Figure 1), which are geographical groupings broadly based on local government areas, that have been adjusted to be consistent with current population flows (of that locality) to healthcare services. Communities which typically use health services outside their local government area have also been taken into account during the analysis. The DHB was also compared with other DHBs across New Zealand and/or the national average.

Figure 1 Boundary map of the seven localities



Note: Stewart Island and Fiordland included in the Southland locality

The health differences between Māori and non-Māori have been highlighted in the profile, along with health differences for Pacific Peoples. Combined findings for Māori and Pacific were reported for some measures for statistical purposes (due to low numbers). However, it must be noted that the health sector responses and interventions needed will be different for each group, and may vary from locality to locality. Combining the groups in this way does not in any way hinder the special relationship Southern DHB has with Mana Whenua.

Findings

Patient demography

Southern DHB combines the previous Otago and Southland DHBs to cover the largest geographic DHB area in New Zealand spanning a land area of over 62, 356 square kilometres. Southern DHB serves an estimated resident population of 308,600 (2013 estimate), mainly European and slightly older than the national average. Māori people make up 9.1% of the population in the Southern district, and Pacific 1.5%. Combined, this is less than 11%, significantly lower than the New Zealand average of 22%. The average deprivation level is low - Southern DHB has only 13% of its total population living in quintile 5 (most deprived), much less than the national average of 20%. In contrast 24% live in quintile 1 areas (least deprived), above the national average of 20%.

Population growth

It is important to consider population projections when planning local and regional services as they are likely to affect future health service funding and service demand. The populations of Central and Queenstown show large growth rates of 20% and 26% respectively over the next 18 years (although actual numbers are small compared with the whole population), reflecting potentially greater demand for health care services in the future. In contrast the population of Gore is projected to fall by 13% suggesting potentially reduced healthcare demand in years to come (Table 1). While the population is ageing it is also seeing lower mortality (death) rates and improved health, so a smaller increase in health care provision is likely to be needed than would otherwise be the case.

Table 1 2013 Estimated resident population and projections to 2031

Locality	Estimated resident population (ERP) 2013	Projected ERP 2031	2013-2031 % change
Waitaki	20,100	18,600	-7%
Dunedin	131,400	134,900	3%
Clutha	10,600	10,200	-4%
Gore	14,600	12,600	-13%
Central	28,700	34,400	20%
Queenstown	19,400	26,400	36%
Southland	83,800	81,300	-3%
Total	308,600	318,400	3%

Life expectancy

Life expectancy is used as an overall gauge of health for a population. Life expectancy at birth is used to compare current mortality rates across different populations. Life expectancy at birth for people living in Southern DHB was 81 years for 2010 to 2012 which is slightly less than the New Zealand average of 81.2 years. Given the relatively low deprivation levels of the Southern population one might have expected a better result. Additionally, males continue to lag behind females with a

difference in life expectancy at birth of 3.9 years. While the gap between males and females has fallen over the last decade, there is still a marked health shortfall for men in Southern DHB.

Amenable mortality

The concept of 'amenable mortality' refers to deaths that 'should not have occurred given available health care services'. Amenable mortality rates for Southern DHB are in line with the average level of deprivation in the district. This suggests services are catering well for the level of need in the district. Māori results for Southern DHB are better than for Māori elsewhere in the country, but remain twice as high as their non-Māori counterparts.

The main causes of avoidable mortality for residents of Southern DHB were similar to those for New Zealand as a whole. These included ischaemic heart disease, suicide and self-inflicted injuries, lung cancer and motor vehicle accidents. Colorectal cancer was an additional leading cause for Southern DHB residents along with diabetes for Māori.

Population risk factors

While the rate of tobacco smoking is falling in Southern, it is not falling quite as fast as New Zealand as a whole. The 2013Census results for Southern show 15.6% of adults smoking daily, higher than the New Zealand rate of 15.1%. The Southland rate of 19.2% is much higher than the Otago rate of 14%. Smoking remains the single largest cause of premature mortality and ill health in Southern DHB, but may soon be overtaken by obesity and nutrition-related conditions.

In Southern DHB, 29.8% of all adults (aged 15+) in 2011/12 were classified as obese, compared with the national average of 28.4%. This is 4% more of the population obese than in 2006/07. There are estimated to be more than 13,000 morbidly obese people in Southern DHB. These people are at serious risk of poor health and premature mortality.

Overall a quarter of adults (25.1%) in the Southern district population in 2011/12 were estimated to be hazardous drinkers. This is significantly higher than the national average of 17%, and higher than any of the other large DHBs. Hospital admissions for conditions associated with alcohol use rose considerably over the past five years.

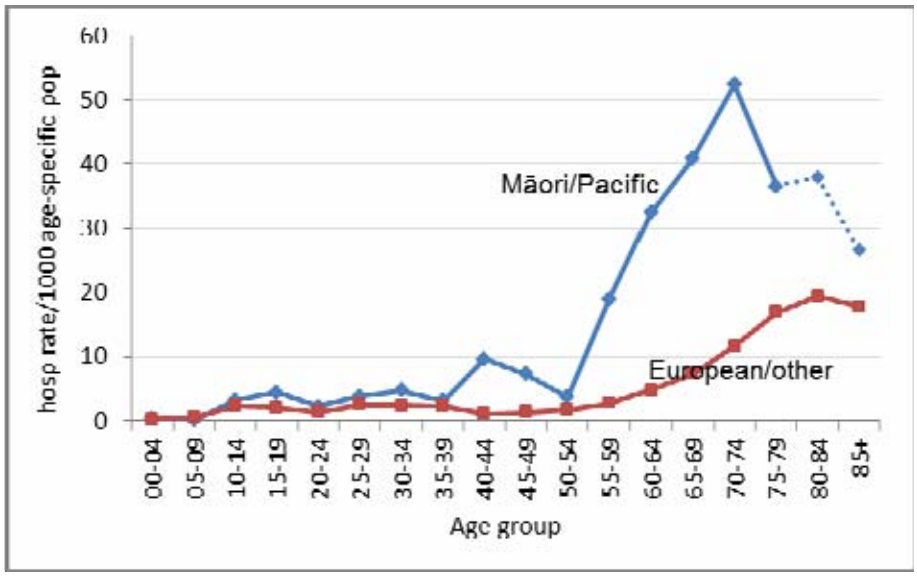
Two-thirds of Southern DHB adults (67%) reported meeting recommended physical exercise levels in 2011/12. This is much higher than the national average and is the only major population risk factor to be better than the national average in the Health Survey data.

Nationally more Māori and Pacific peoples are at risk because of increased rates of smoking, hazardous alcohol drinking, obesity and poor nutrition. This is likely to be mirrored in Māori and Pacific living in the Southern DHB area.

Long term conditions

Rates of chronic disease in Southern DHB residents are similar to the national average. Southern DHB has seen a 4.8% increase in the proportion of the population with diabetes in the past five years. This means the Southern district has an estimated 14,700 people living with diabetes. Rates of hospital admissions related to diabetes are much greater for those living in high deprivation areasand for Māori and Pacific populations. Diabetes is a major factor in the greater health loss among Māori people, and in the health gap between Māori and non-Māori people. The onset of diabetes occurs earlier among Māori than non- Māori in the Southern district, and can be seen with hospital admissions due to diabetes rising steeply at an earlier age for Māori and Pacific people.

Figure 2 Diabetes related hospital admissions rate by age and ethnicity, Southern DHB 2011-2013



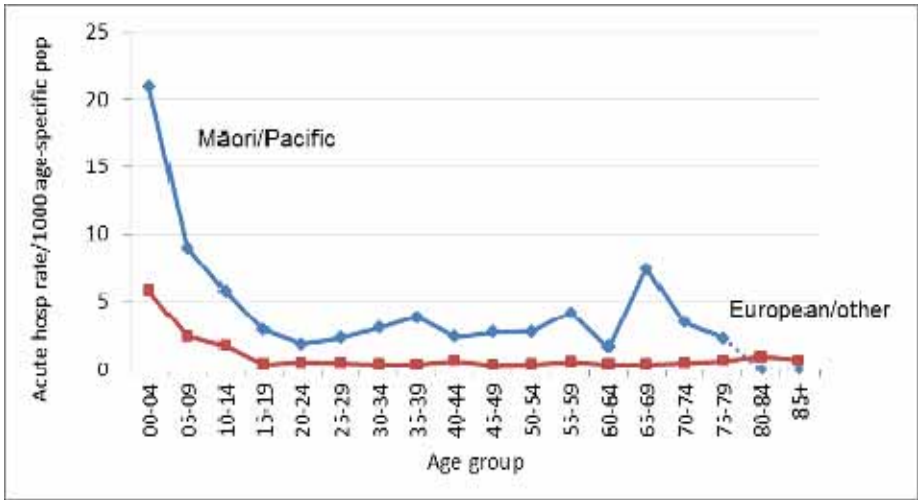
Cardiovascular disease (CVD) is a term used to describe all diseases affecting the heart and blood vessels. While rates continue to fall, CVD is the leading cause of death in Southern DHB and remains the most important cause of preventable mortality and illness. Māori and Pacific people have a higher average rate of CVD hospital admission than non-Māori at 18 hospital admissions per 1000 people. This reaches a peak between the ages of 70-79 years, when the hospital admission rate is three times greater than that for non-Māori non-Pacific people . , Māori and Pacific people with CVD in the Southern district may thus have worse outcomes which is consistent with national data.

On the other hand, Southern DHB has fewer residents who have suffered a stroke than the national average and the district has also seen a further fall in the past five years, so that most recent figures show only 1.1% of the population are affected. Similar trends have been seen for stroke related hospital admissions rates of Māori and Pacific peoples, a positive sign.

Despite fewer cancer deaths and a rise in cancer survival over time, this is still the most important cause of preventable mortality and illness alongside CVD. Lung cancer accounts for the most deaths from cancer for the Southern DHB population (18.2 percent), followed by colorectal cancer (17.4 percent) and prostate cancer (7.7 percent). Colorectal cancer caused the highest number of deaths among women (18.6 percent) followed by breast cancer (15.3 percent) and then lung cancer (14.7 percent). The most common cause of death from cancer for men was lung cancer (21.3 percent) followed by colorectal cancer (16.3 percent) and then prostate cancer (14.4 percent). Cancer registration rates were similar for Southern DHB residents compared to national rates, apart from colorectal cancer, which had a significantly higher rate.

Figure shows the asthma related hospital admissions for the Southern district described by age and ethnicity. Three times more Māori and Pacific children are admitted to hospital and a higher rate of admission continues for all ages up to 79 years. The NZ Health Survey shows the proportion of the population with asthma in Southern district to be 12.3%, which is higher than the national average of 11.2%.

Figure 3 Asthma related hospital admissions per year by age and ethnicity, Southern DHB 2011-2013



Chronic obstructive pulmonary disease (COPD) is a progressive lung disease mainly caused by cigarette smoking. The rate of COPD has been slowly falling as fewer New Zealanders smoke. However, as more Māori smoke, they are also affected by COPD to a greater extent. This is seen in Southern residents with increased rates of COPD hospital admissions at an average rate that is four times higher for Māori and Pacific than non-Māori non-Pacific over the age of 50 years.

Primary care access and use

A health system strongly directed towards primary care (community health services) improves overall health outcomes, reduces health inequalities, and reduces the overall health system cost. A single primary health organisation, Southern PHO, serves Southern DHB primary care services. PHO enrolment is sometimes used as a measure of access to primary care services. Comparing this with the estimated resident population of the Southern district shows primary care enrolments to be relatively low, though this may in part relate to the high student population (who are less likely to be enrolled). The proportion of the population visiting a general practitioner in any one year has fallen over the last five years. 30.3% of Southern residents reported they could not visit the GP when they felt they needed to in the past year, compared with a national average of 26.6%. Reasons can be found in Table 2:

Table 2 Unmet need for primary care, Southern district compared to New Zealand 2011/12

Reason	Southern DHB	National average	P-value
Experienced unmet need for primary health care in the past 12 months (any of the following)	30.3%	26.6%	0.06
- Unable to get appointment at usual medical centre within 24 hours in the past 12 months	16.7%	15.4%	0.50
- Unmet need for GP services due to cost in the past 12 months	16.7%	13.8%	0.15
- Unmet need for GP services due to lack of transport in the past 12 months	2.5%	3.4%	0.19
- Unmet need for after-hours services due to cost in the past 12 months	7.5%	6.9%	0.57
- Unmet need for after-hours services due to lack of transport in the past 12 months	1.3%	1.7%	0.38

Unfilled prescription due to cost in the past 12 months	5.7%	7.4%	0.09

Source: MOH, New Zealand Health Survey 2011/12.

Southern district has more general practitioners than the national average. A GP working full-time is estimated to look after approximately 1,000 patients compared with 1,300 patients for general practitioners working full time nationally. Primary care quality indicators, which are measures used to ensure general practices are carrying out proven assessments and interventions, were generally good for Southern DHB practitioners compared with national averages (Table 3).

Table 3 PHO Performance Programme results comparing Southern PHO with historical trends and national average, 2013

Indicators	Goal	Southern PHO performance	Trend from previous period	National average performance	Southern relative to national
Breast cancer screening coverage	≥ 70%	77%	Decreased	73%	Higher
Cervical cancer screening coverage	≥ 75%	80%	Same	77%	Higher
Ischaemic cardiovascular disease detection	≥ 90%	99%	Increased	102%	Same
Cardiovascular disease risk assessment	≥ 90%	63%	Increased	67%	Lower
Diabetes detection	≥ 90%	103%	Increased	113%	Same
Diabetes follow up after detection	≥ 90%	63%	Increased	68%	Lower
65 years + influenza vaccination coverage	≥ 75%	69%	Increased	66%	Higher
Age appropriate vaccinations for 2 year olds	≥ 95%	95%	Increased	93%	Higher
Smoking status recorded	≥ 90%	77%	Increased	86%	Lower
Smoking brief advice and cessation support	≥ 90%	55%	Decreased	55%	Same

Source: Ministry of Health - Southern PHO Q2 2013 PHO Performance Programme (PPP) results

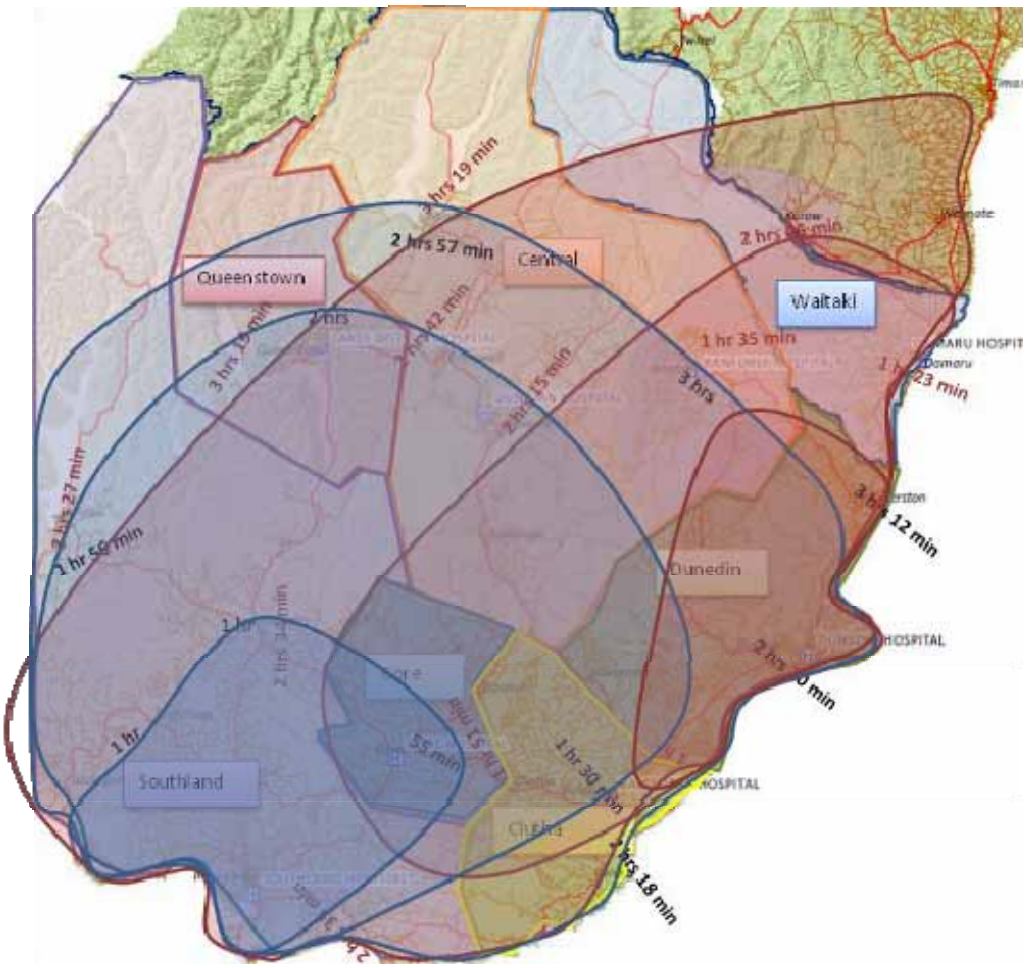
While the DHB is often concerned about access to care, sometimes over-medicalisation and over-treatment can cause harm. One locally-concerning example is the high rate of medicine use in the elderly population. In Southern DHB, an average of 41% of those aged 65 and over take five or more medicines at a time. This placed the DHB second highest in the country, well over the national average of 37%.

Secondary and tertiary care services

Southern DHB has a network of facilities covering the hospital care requirements of its population. Dunedin Hospital with its associated Dunedin School of Medicine is the main referral hospital for Southern DHB. The other major general hospital is the Southland Hospital in Invercargill, which provides a large range of secondary care services. A network of smaller hospitals provides some inpatient and outpatient medical care. These include Lakes District Hospital in Queenstown owned by the DHB, and others managed by local community trusts in Balclutha, Dunstan, Gore, Oamaru and Ranfurly.

Approximate average travel times to get to Southland and Dunedin Hospitals are shown in Figure 4. Around three-quarters of the population (74%) live within one hour's drive of either Southland (inner blue line) or Dunedin hospital (inner red line), with a further 14% within two hours. The remaining 11% or around 36,000 people are more than two hours from a major hospital, mainly in the Queenstown and Central Otago localities. There are no direct regular provincial air flights between Queenstown and Dunedin or Invercargill – the closest common destination is Christchurch.

Figure 4 Map of approximate travel times to Southland and Dunedin hospitals



Approximate travelling times by road in maroon to Dunedin hospital and in blue/black to Southland Hospital. Each isocline represents 1 hour travel. Times from SDHB website and Google Maps. Stewart Island 1 hour ferry trip to Bluff.

Hospital admissions

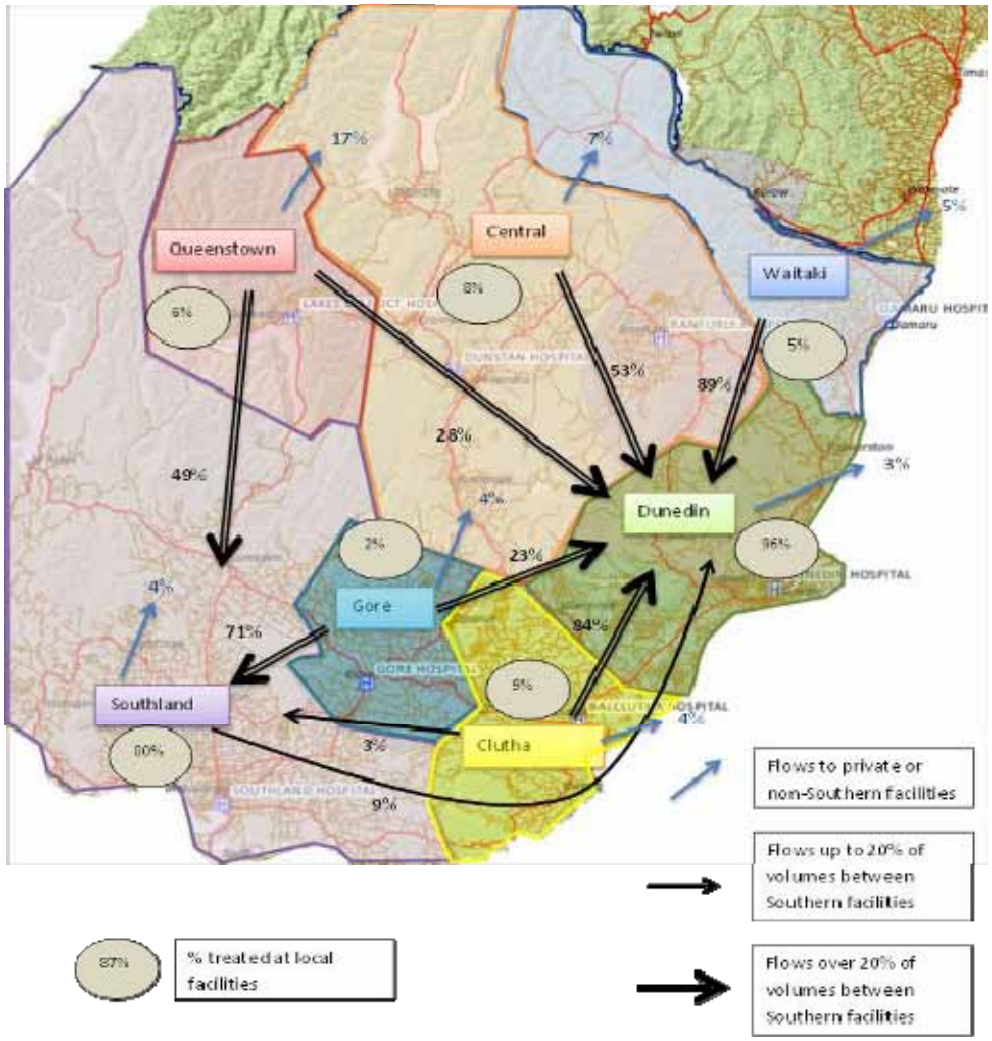
Having an illness severe enough to need hospital admission is an important (negative) marker of health. Southern DHB residents had 38,600 unplanned medical and surgical hospitalisations per year from 2010/11 to 2012/13. This is the equivalent to 12.6% of the Southern district population being admitted to hospital in any one year, which is similar to the New Zealand average. Māori and Pacific people had a higher hospital admission rate at every age group apart from the very old (related to the very small numbers of this population in this age group). At the locality level, Queenstown appears to have a higher hospitalisation rate than expected which is due, in part, to a high injury rate.

Ambulatory sensitive hospitalisations (ASH) are described as unplanned hospital admissions that might be prevented by effective delivery of services in primary care or the community. Early diagnosis and treatment can prevent a patient becoming sick enough to need hospital admission for

investigation or treatment. This also saves the patient the risks and inconveniences of a hospital admission, and allows the health system to make better use of its resources. These ASH admissions can be affected by a range of factors including access to high quality affordable primary health care, income, age, ethnicity; deprivation; and housing and social circumstances. Southern had one of the lowest adult ambulatory sensitive rates in the country. Around 11% of all unplanned medical-surgical admissions were considered to be ASH in Southern, compared with 15% nationally. This in part relates to relative non-deprivation in Southern, but also suggests effective primary care services are available, despite the higher rate of reported unmet need for primary care in the NZ Health Survey as noted above.

Compared with other DHBs Southern has had relatively high publicly-funded planned (also termed "elective") surgery rates in the past. In recent years the DHB has met all its surgical National Health Targets, but is now slightly below the national average. Over the three years 2010/11 to 2012/13 there were an average of 12,400 elective medical-surgical hospital admissions a year. People living in the Waitaki, Clutha and Queenstown localities appear to have lower publicly-funded planned hospital admissions than the Southern average. However privately-funded surgery is not included in these population rates. This will be one of the factors contributing to the areas of low deprivation areas having lower publicly-funded planned surgery rates, along with expected lower rates of illness and injury. Māori and Pacific residents of Southern have nearly twice the rate of publicly-funded planned hospitalisations as non-Māori. This is high, but not as big a difference as seen in the unplanned hospital admission rates.

Figure 5 Adult planned (elective) hospital admission flows, Southern DHB 2010-13



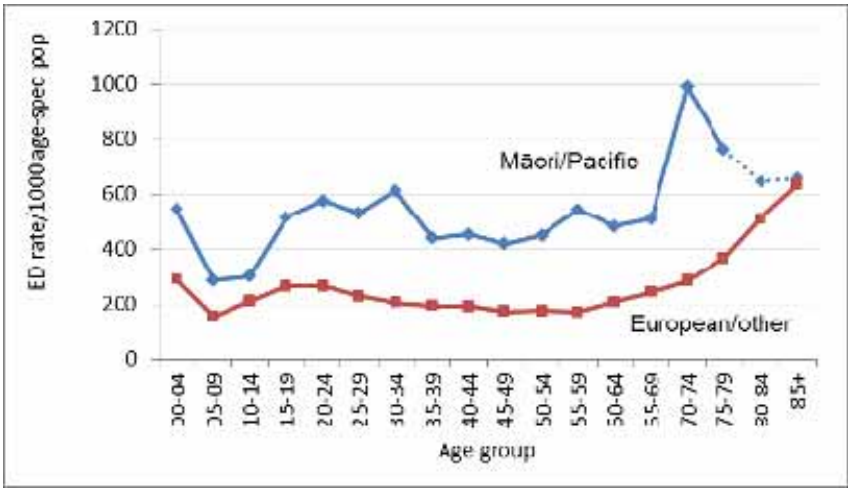
Most publicly funded planned hospital admissions for Southern residents are at Dunedin Hospital (64%) and Southland Hospital (30%), while 5% went to private facilities or other DHBs. For the Queenstown locality 17% of planned hospital admissions were in private or other DHB facilities, higher than any other locality. The Mobile Surgical Unit carries out around 170 cases a year, 1.4% of volumes, represented in Figure 5, flows by locality, as the "% treated at local facilities".

For children aged 0-14 living in Southern there was an average of 4,500 unplanned ("acute") medical-surgical hospital admissions per year from 2010/11 to 2012/13. This is equivalent to 8% of children residing in Southern being admitted each year, which is similar to national rates when adjusted for differences in ethnicity and deprivation. Children living in areas of highest deprivation within the Southern district have over twice the hospital admission rates as those living in the lowest deprivation areas. Māori and Pacific children have similar hospital admission rates to those living in areas of highest deprivation, around twice their non-Māori, non-Pacific counterparts. Ambulatory sensitive hospitalisations (ASH) for Southern children accounted for 32% of unplanned hospital admissions, compared with 30% nationally.

Emergency Department (ED) Attendances

Emergency care attendances can be used as a marker of ill-health. Attendances at ED by Southern residents vary by age as expected, with Māori and Pacific People having higher attendance rates at every age, more than twofold and up to 3-fold in the 55-64 age groups (Figure 7).

Figure 7 ED attendances per 1000 population, Southern DHB residents 2012



Source: SDHB data. Māori and Pacific combined compared to all others, line dotted where numbers are small.

ED attendances have seen an increase in volumes over the past three years – 11% at Dunedin, 15% at Lakes and 13% at Invercargill. Most of this increase comes from local residents, despite population growth only being around 0.2%, 3% and 0.6% per annum respectively in the local areas. The recent increase in volumes may reflect some of the access barriers to primary care noted previously.

Although overseas tourists make up less than 1% of the ED volumes for Dunedin and Invercargill, 13% of Lakes District Hospital ED attendances are by overseas residents. However if anything, overseas attendances have fallen slightly at Lakes over the past three years, so the rise in ED attendances in Queenstown is not explained by increased tourism.

Health of the elderly

Older people make up a growing proportion of the Southern population. Currently 14.7% are aged 65 and over, and this is expected to rise to 23.8% by 2031. Most of those aged 65 and over are of European extraction – only 1.7% were of Māori or Pacific ethnicity.

Around 6% of the Southern population aged 65 and over are in aged residential care (ARC) – that is rest homes or private hospital care. This is markedly higher than the national average of 5.2% and is the third highest rate of any DHB. Rates of use rise sharply by age - at present around 10% of those aged 75 and over and 28% of those aged 85 and over living in Southern are in ARC, compared with 10.6% and 25.2% nationally respectively. However less rest home level of care and a smaller rise in hospital level care is occurring. This is likely due to both better 'ageing in place' and home-based support services, and a generally healthier cohort of older people, so there is less demand for rest home level care around New Zealand and in Southern. Given the expected growth in the older population of Southern there is likely to be an increase in the need for ARC beds, but this will be curbed by the expected continued health improvements that should reduce the need for such rest home beds.

Maternity

Southern women have a relatively low fertility rate at 1.66 births per women, compared with the national average at just over two. Maternity clinical outcome indicators compare well nationally for Southern mothers. The rate of teenage births overall is low at 16 births per 1000 15-19 year olds, but is moderately high at around 30 births per 1000 for Māori and Pacific teenagers, and for Gore and Southland teenagers. Abortion rates in Southern are lower than national rates.

Mental health

People from Southern DHB replying to the New Zealand Health Survey reported more anxiety or depressive disorders than the national average: 8% compared with 5.7% of the total population. Women in the Southern district are almost twice as likely to be under psychological distress as males, putting them at higher risk.

Adequate access to the appropriate mental health services is vital to reduce the impact of mental health disorders. Good access was seen in Southern, with 3.31% and 3.28% of the Otago and Southland populations respectively, accessing mental health services in a 12 month period. This was higher than the New Zealand average of 2.75%.

Conclusion

Overall the health of the population of Southern DHB compares very well with the rest of New Zealand – the differences listed above notwithstanding. These differences suggest areas where the population and the DHB can work together to get past the "doing well, could do better" tag. Southern DHB appears to be in a strong position to take its health services forward.

At a glance

Overall health for Southern DHB residents compares well with other New Zealanders. Given the relative deprivation levels one might have expected slightly better health outcomes, giving areas for the DHB to work on. Based on the findings of this report, and previous work, the most important areas for the health of Southern DHB residents that the DHB will need to address include:

1. Tobacco smoking
2. Obesity and nutrition
3. Hazardous alcohol consumption
4. Access and use of primary care – in-hours, after-hours
5. Māori health, particularly child health, chronic disease
6. Pacific health, particularly child health, chronic disease
7. Mental health service access
8. Chronic disease management – diabetes, CVD
9. High rates of aged residential care use

Locality (taking into account patient flows)	Population	Chronic conditions	Primary care	Secondary care
Waitaki (Waitaki District less Palmerston and Nenthorn CAUs[1])	20,100 estimated population in 2013, little growth in past 5 years, expected small reduction in future years. Low Māori and Pacific (8%). Moderate deprivation average – quintile 3.	Relatively low asthma hospitalisation rate.	Relatively high enrolment (96%). Moderate panel size (1240 patients per FTE GP)	Relatively low unplanned hospitalisation rates for adults and children, low outpatient rate.
Dunedin (Dunedin City plus Palmerston, Nenthorn, Bruce and Milton CAUs)	131,400 estimated population in 2013, little growth in past 5 years, expected small growth in future years. Low Māori and Pacific (8%). Moderate deprivation average – quintile 3.	High mental health service utilisation. High rate of alcohol-related ED presentations	Relatively low enrolment (88%). Small panel size (960 patients per FTE GP)	Moderately high ASH rate.
Clutha (Clutha District less Bruce and Milton)	10,600 estimated population in 2013, little growth in past 5 years, expected small reduction in future years. Relatively higher Māori and Pacific (14%). Moderate deprivation average – quintile 3.	Relatively low diabetes hospitalisation rate, but higher CVD rate. Lower asthma hospitalisation rate.	High enrolment with in-flows from other areas. Moderate panel size (1200 patients per FTE GP)	Relatively low unplanned hospitalisation rate, low ASH rate, low child hospitalisation rate, low outpatient rate.
Gore (Gore District less Kaweku CAU)	14,600 estimated population in 2013, reduced in past 5 years, expected further reduction in future years Low Māori and Pacific (8%). Moderate deprivation average – quintile 3.	Moderate to high diabetes hospitalisation rate. Moderate asthma hospitalisation rate.	High enrolment with in-flows from other areas. Large panel size (1700 patients per FTE GP)	Relatively high teen pregnancy rate, high fertility rate

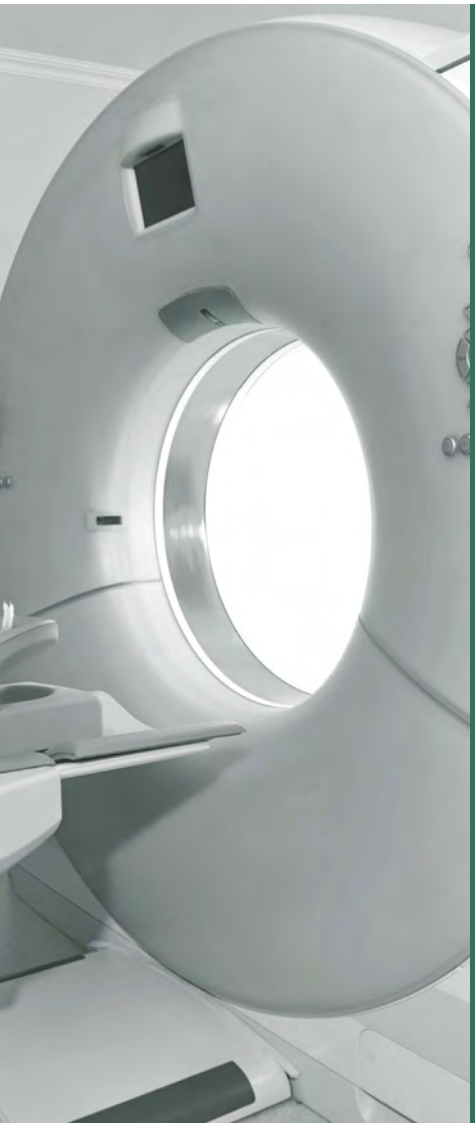
[1] CAU – Census Area Unit

Central (includes Central Otago District plus Wanaka and Hawea CAUs)	28,700 estimated population in 2013, significant growth in past 5 years, expected 20% increase in next 20 years. Low Māori and Pacific (9%). Low deprivation average – quintile 2.	Low diabetes hospitalisation rate. Low asthma hospitalisation rate.	Relatively high enrolment (96%). Small panel size (800 patients per FTE GP)	Low ASH rate, low child hospitalisation rate, low outpatient rate
Queenstown (Queenstown-Lakes District less Wanaka and Hawea CAUs)	19,400 estimated population in 2013, significant growth in past 5 years, expected 36% increase in next 20 years Very low Māori and Pacific (6%). Very low deprivation average – quintile 1.	Low diabetes hospitalisation rate. Asthma and COPD hospitalisation rate higher than expected for deprivation level. High rate of alcohol-related ED presentations.	Relatively high enrolment (98%). Moderate panel size (1150 patients per FTE GP)	Relatively high unplanned hospitalisation rate for deprivation level of area, including a high injury hospitalisation rate. ASH rate OK. Low child hospitalisation rate, low outpatient rate.
Southland (Southland District, Invercargill City, and Kaweku CAU)	83,800 estimated population in 2013, little growth in past 5 years, expected small reduction in future years. Relatively higher Māori and Pacific (15%). Moderate deprivation average – quintile 3.	Moderate to high diabetes and CVD hospitalisation rate. Higher asthma and COPD hospitalisation rate.	Relatively low enrolment (88%). Moderate panel size (1400 patients per FTE GP)	Relatively high unplanned hospitalisation rate for adults and children, and higher ASH rate. Relatively high teen pregnancy rate, high fertility rate

The full Health Needs Assessment report is available on the Southern DHB website: www.SouthernDHB.govt.nz.

Controller and Auditor-General
Tumuaki o te Mana Arotake

Regional services planning in the health sector



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Regional services planning in the health sector

This is an independent assurance report about a performance audit carried out under section 16 of the Public Audit Act 2001.

November 2013

ISBN 978-0-478-41041-9 (print)
ISBN 978-0-478-41042-6 (online)

Contents

Auditor-General's overview

Health is important to New Zealanders personally and collectively. Demands on our health services are increasing, driven by causes such as an ageing society and the rising prevalence of long-lasting health conditions. The health budget was $14.655 billion in 2013, so it is important that services are designed and delivered without unnecessary waste.

To support effective and efficient design and delivery, changes to encourage regional services planning were introduced into the health sector in 2011. The expectation was that the separate district health boards would plan together to deliver services to reduce service vulnerability, reduce costs, and improve the quality of care.

In the health context, there are four regions – Northern, Midland, Central, and the South Island. Their populations range from about 850,000 to 1.7 million people.

This report describes how well regional services planning is working in practice. The work was part of my theme for 2012/13, *Our future needs – is the public sector ready?*

Some signs of success, but not as much progress as expected

The Ministry of Health and district health boards have put effort into creating the conditions for success. Collaboration within and between district health boards has increased. It has worked best where there was a combination of trust, good leadership, financial incentives, and a strong common cause.

The work of regional shared services agencies and Health Benefits Limited is producing savings, and regions are collaborating to save money through collective buying. With capital investment, the national arrangements to approve large projects are improving. The planning of information technology systems to support health care delivery is now more co-ordinated.

There is a small but growing number of regional clinical and service initiatives under way. However, regional services planning is not yet business as usual for some.

Overall, I expected to see more – more tangible examples of services that were planned regionally rather than at a district level, and more evidence that the expected benefits were emerging.

Challenges that need to be overcome

In 2009, Cabinet noted that it could take up to three years for the benefits of regional planning to be realised. In 2013, my staff found the Ministry of Health had not been systematically monitoring and quantifying the benefits achieved

by regional services planning. A lack of baseline information means that the contribution of regional services planning to reducing service vulnerability, reducing costs, and improving the quality of care is unproven.

In my view, the Ministry needed to do better in setting the direction for district health boards and in providing guidance. District health boards do not consider that enough attention has been given to defining the long-term national, regional, and local components of the health system. More work needs to be done in integrating and streamlining the different levels of planning work carried out by district health boards.

When my staff looked closely at capital planning, they learned that there is a shortage of people with the right skills to support good governance of capital projects. This was particularly acute in business case development and in supporting board members throughout the health sector.

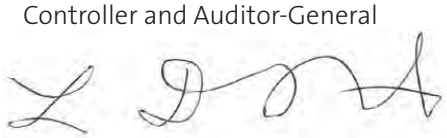
Good planning requires good information, based on data that is complete, reliable, consistent, and comparable. My staff found a wide range of problems when they looked at how data is used in planning services. The data we looked at was not always consistent, complete, or comparable – but this is important for planning and reporting purposes. Some well-known and systemic problems need to be resolved to ensure that data can form a sound basis for planning and decision-making.

My staff expected and looked for evidence of outcomes that would not have happened without regional services planning. However, much of the evidence the health sector entities provided as signs of success was about getting ready to deliver outcomes. This report reflects those different expectations about pace.

I make seven recommendations to help the Ministry of Health and district health boards as they continue with regional services planning. I expect to follow up on their progress in early 2016.

I thank the many people in the Ministry, National Health Board, Capital Investment Committee, regional planning support groups, and district health boards for their help and co-operation.

Lyn Provost
Controller and Auditor-General



12 November 2013

Our recommendations

Recommendation 1: We recommend that the Ministry of Health and district health boards work together to achieve good governance of capital investment, by ensuring that decision-makers can:

- get strategic advice at an early stage on capital projects; and
- get support at crucial decision points.

Recommendation 2: We recommend that the Ministry of Health and district health boards work together to improve the quality of data for planning and reporting, by exploring whether our overall findings on data quality apply to other information collected to inform decision-making.

Recommendation 3: We recommend that the Ministry of Health and district health boards work together to report on how they will improve the quality of data used for planning and reporting.

Recommendation 4: We recommend that the Ministry of Health refine the guidance on Faster Cancer Treatment indicators to remove ambiguity about the definitions.

Recommendation 5: We recommend that the Ministry of Health and district health boards discuss and agree how to apply the definitions of the Faster Cancer Treatment indicators consistently, so that indicators are comparable between district health boards.

Recommendation 6: We recommend that the Ministry of Health and district health boards work together to review, amend, and improve the timing and content of the Ministry's regional services planning guidance for district health boards so that the guidance is:

- provided within a time frame that enables regional services plans to inform other plans that district health boards need to prepare; and
- more in line with the intended effects of regional services planning.

Recommendation 7: We recommend that the Ministry of Health and district health boards work together to prepare an evaluation framework and use it to work out whether regional services planning is having the intended effects.

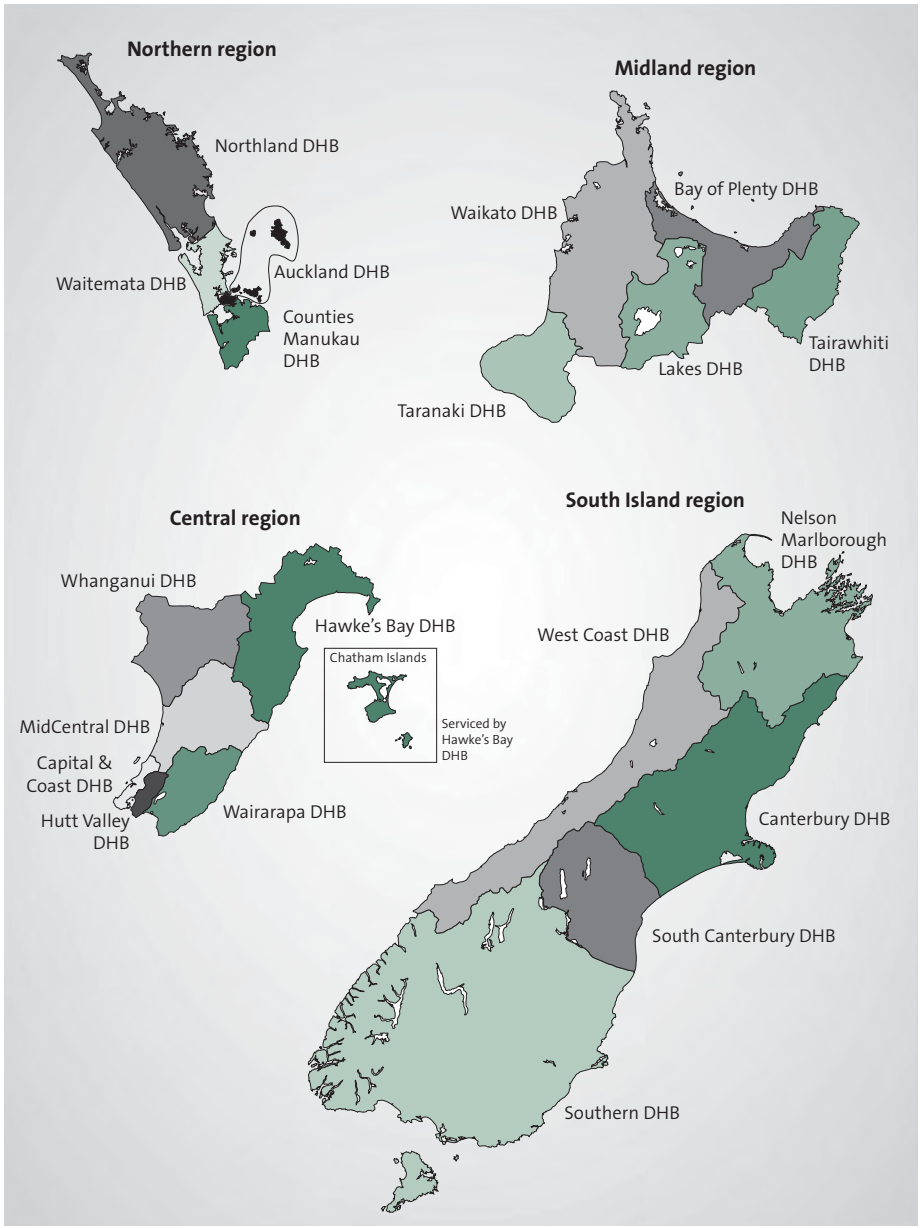
Glossary

Assessment, Treatment, and Rehabilitation (AT&R)	We use this term to mean beds in a hospital setting where patients are not suffering from an acute illness or disease, but cannot return home until they have had their needs assessed (and a plan to manage those needs has been put in place). Before leaving, they may need some ongoing medical treatment after surgery, or therapy to enable them to resume some normal daily living tasks. Most AT&R beds in the health system are used for patients over 65.
Bariatric surgery	One of several types of weight loss surgery performed on people who are dangerously overweight, to restrict or reduce food intake and or absorption.
Clinical pathway	There are many definitions but, in the context of this report, we mean a "road map" for a patient through the health system, which is informed by clinical evidence about what will work best for them. Pathways are used to manage quality by standardising processes.
Clinical protocols	Guidelines based on evidence that help to inform clinical decisions on diagnosis and treatment. Protocols are another tool to help standardise medical care, improve quality, and reduce risk to patients.
Clinical threshold	A set of criteria that a patient must meet, or exceed, before they can access a service or procedure. It should mean those with the best possible clinical outcomes are selected for a given treatment. It can also be a way of rationing scarce resources. A clinical threshold can also be the amount of measurable improvement expected from a clinical procedure.
Elective surgery	Surgery that is planned well before it takes place because it does not involve a medical emergency.
E-referral	An electronic way of making referrals, usually from primary health care, such as GPs to a hospital. Has advantages over paper-based referral, such as less duplication of data input and less likely to get lost.
Imaging	The collective term used to describe images such as X-rays, computed tomography (CT scans), ultrasound scans, and magnetic resonance imaging (MRIs).
Model of care	A systematic way of thinking that brings together people, processes, and specialisations to improve the effectiveness, efficiency, quality, and safety of the patient's care. It proposes where services will be provided, who will be involved in care delivery, and how care will be delivered. The aim is to make sure high-quality services can be delivered sustainably.
Primary health care	The professional health care received in the community, usually from a general practitioner or practice nurse. Primary health care covers a broad range of health and preventative services, including health education, counselling, disease prevention, and screening.
Sub-regional working	More than one of the district health boards in a region working together.

Tertiary hospital	A major hospital that provides consultant-led care throughout most specialist and sub-specialty services. Tertiary hospitals are unlikely to need to transfer patients elsewhere for specialist care, including major trauma and specialist surgery, like heart surgery.
Workstream	The organisation of various distinct, and often unrelated, work groups around a common purpose – for example, bringing together managers and clinical staff to plan improvements in the health of older people.

Figure 1
Map of the four health sector regions and their district health boards

District health boards are grouped into four regions – Northern, Midland, Central, and the South Island. The regions' populations range from about 850,000 to 1.7 million people.



Part 1
Introduction

1.1 In this Part, we discuss:

- the purpose of our audit;
- the context for regional services planning;
- the intended effects of regional services planning;
- how regional planning works in the health sector; and
- how we carried out our audit.

The purpose of our audit

1.2 In our annual plan for 2012/13, we proposed to audit the leadership that the Ministry of Health (the Ministry) provides to district health boards (DHBs) in co-ordinating asset management throughout the health and disability sector and integrating it with service delivery, including how this affects how DHBs manage assets.

1.3 In scoping our work, we saw that models of service delivery were being reconsidered to help ensure the future sustainability of the health and disability system. DHBs were being encouraged to collaborate regionally and sub-regionally where it made sense to do so (see Figure 1). This policy would inform DHBs' long-term investing in major assets, such as hospitals.

1.4 We learned that regional services plans would be strategic documents setting out changes in service delivery, and would increasingly influence decisions about capital investment. Therefore, we decided to look at the leadership the Ministry was giving to DHBs on regional services planning and what that planning was intended to achieve.

1.5 We maintained a focus on service delivery, capital investment, and the availability of good quality data that would support decision-making in those aspects.

The context for regional services planning

1.6 The Appendix shows the present structure of New Zealand's health and disability sector, the major public entities in the sector, and the relationship between those public entities.

1.7 In 2009, a Ministerial Review Group (the Review Group) reported to the Minister of Health (the Minister) through a report called *Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand*.[1]

1 The report is available at the Ministry of Health's website, www.moh.govt.nz.

1.8 The Minister asked the Review Group to identify what would:

- improve performance and quality in health and disability services;
- improve the health system's capacity to deliver services; and
- increase spending to support frontline care by reducing back-office costs.

1.9 The Review Group reported that:

> *Unless we change the way services are provided, it will become increasingly difficult to meet public expectations for improved service within a sustainable funding growth path.*

1.10 Simply put, as a country, we would not be able to afford New Zealanders' future health needs if nothing changed. The Treasury's 2013 report on long-term government finances showed that health care spending is projected to grow from 6.8% of Gross Domestic Product in 2010 to 10.8% in 2060.[2]

1.11 The Review Group's report highlighted many opportunities to:

- reduce costs by reducing fragmentation and duplication of services (which had arisen because of having 20 autonomous DHBs);
- reduce variations in the quality of care and access to elective (planned) surgery between DHBs and within regions;
- reduce the risk of some "vulnerable services" collapsing;[3] and
- prevent local interests of individual DHBs taking inappropriate priority over regional or national planning.

1.12 The Review Group proposed changes to:

- encourage changes in culture and ways of working in DHBs, including better integrating primary care and hospital-based care; and
- introduce national support structures to help reduce waste, improve safety and quality, and enhance clinical and financial viability.

1.13 In response, the New Zealand Public Health and Disability Act 2000 was amended, and new planning regulations came into force on 1 June 2011. Among the Review Group's recommendations that were put in place were:

- setting up the National Health Board (NHB), supported by specialist advisory committees to deal with matters such as workforce, information services, and capital investment;
- requiring DHBs to plan sub-regionally or regionally;

2 The Treasury (2013), *Affording Our Future: Statement on New Zealand's Long-term Fiscal Position*, available at the Treasury's website, www.treasury.govt.nz.

3 Usually, services are vulnerable because of not having enough specialist staff. However, services can be vulnerable because of circumstances, such as many staff retiring over a short time, being in an isolated area, and overall skill shortages.

- DHBs putting in place the governance and support arrangements to deliver those plans; and
- the Minister acquiring the power to direct DHBs on matters to do with delivering regional services.

1.14 The Review Group found a strong consensus in the health sector about making the DHB model work better. Regional services planning was introduced into a complex system as an alternative to structural change for the 20 DHBs. Funding and governance arrangements were kept much as before, which offered stability to the sector. The Review Group saw advantages, in that DHBs could get regional planning under way immediately, without losing time and effort that might otherwise have gone into restructuring.

1.15 However, the Review Group was not certain that the changes it recommended would take the sector "far and fast enough". Based on a Review Group recommendation, Cabinet agreed to a review of the DHB model within three years. This would assess:

> *... whether more fundamental reform will be needed to create strong enough incentives for efficiency and to enable the sector to lift its performance within a more sustainable growth track.*

Intended effects of regional services planning

1.16 Regional services planning requires DHBs to work together, and with other health providers, in a more integrated way. The regional services plans outline how DHBs will plan, fund, and deliver services regionally to:

- reduce service vulnerability;
- reduce cost; and
- improve quality of care.

1.17 The Ministry's guidance is that it is up to DHBs to plan services, but, in doing so, they must consider what services are appropriate and financially sustainable for the size of the region's population.

How regional planning works in the health sector

1.18 The NHB is responsible for:

- funding and monitoring DHBs and overseeing their planning (such as annual funding and planning rounds, including regional services planning);
- bringing together various aspects of the health delivery system (information technology, facilities, planning) so that they work together in a way that will meet health service needs;
- providing guidance on which services should be planned, funded, and provided nationally, regionally, and locally, and how that should change over time; and
- ensuring that regional services planning is in line with decisions about capital investment and workforce capacity.

1.19 The NHB is supported by a dedicated business unit within the Ministry. In this report, we refer to the Ministry unless we specifically mean the NHB.

1.20 Specialist committees support the NHB. In this report, we refer to:

- the Capital Investment Committee (CIC), for capital investment decision-making;
- the National Health Information Technology Board (NHITB), for information technology investment; and
- Health Workforce New Zealand (HWNZ), for health workforce planning.

1.21 We also refer to Health Benefits Limited (HBL). This is a Crown company set up to work with the health system to achieve $700 million of savings in its first five years by reducing administration and support costs.

National Health Board regional services planning guidance

1.22 The Review Group's report in 2009 was followed by the Health Sector Framework 2010.[4] This contains an outline of the intended legislative and regulatory changes following on from the Review Group's report. The framework envisages that the Ministry will prepare resources (such as planning templates and guidelines) to help DHBs reduce the costs of planning, and to better integrate health planning at different levels of the health sector.

1.23 The Ministry has taken an evolutionary approach to introducing regional services planning since the New Zealand Public Health and Disability (Planning) Regulations 2011 came into effect on 1 June 2011. The Ministry publishes an annual guidance document to guide DHBs on the minimum content of regional services plans, based on the regulations. The guidance is detailed, and regions are able to include more information if they wish.

4 The Health Sector Framework is available at www.nationalhealthboard.govt.nz.

1.24 The Ministry did not issue regional services planning guidance in 2011/12 as part of the overall planning pack for DHBs.[5] Instead, guidance was given:

- in a letter;
- by way of conversations with DHBs; and
- through aspects of the operational policy framework document (a set of business rules and policy guidelines by which all DHBs must work).

1.25 The first regional services plans were prepared in 2011/12. That year was seen as a "transitional year", given that the regulations requiring regional services plans came into effect only a few weeks before the start of 2011/12. The Review Group's report and subsequent Cabinet papers saw a focus on planning and funding vulnerable services as a priority for the content of the first-year regional services plans, and this was reflected in the Ministry's requirements.

1.26 The Ministry identified 2012/13 as a "step increase" year, and 2013/14 as a "comprehensive and detailed" year for regional services planning.

1.27 The Ministry chose to have this phased approach, because not all DHBs and regions were ready to work consistently at a regional level. Some DHBs had worked well at a regional level before the introduction of regional services plans. However, the Review Group had found that the improvements arising from the natural evolution of regional collaboration were slow and uneven, and considered that regional services plans would be the way to lock in and accelerate progress.

1.28 The Ministry monitors aspects of performance against the regional services plans four times a year. It selects topics to discuss further and gives comments in writing (a letter and a dashboard report) and has telephone discussions or face-to-face meetings with lead regional DHB chief executives. The Ministry can take a more challenging approach if it considers progress to be slow.

How we carried out our audit

1.29 We carried out our audit by looking at regional services planning in the South Island and Northern regions. We chose these two regions because:

- they have different characteristics and face different challenges, so looking at these two regions would give us a clear sense of whether the system for planning was flexible enough to encompass these differences; and
- the Ministry told us that most of the medium-term health capital investment in buildings would take place in those regions.

5 The DHBs' financial year runs from 1 July to 30 June.

1.30 We collected our evidence in three ways:

- We interviewed 90 people from DHBs, regional organisations, the CIC, the Ministry, and the DHB shared-services organisation.
- We reviewed more than 550 documents and analysed financial information that the Ministry provided to us.
- We audited patient records in four DHBs. We did this to test the quality of the raw data available from DHBs' information systems. Looking at the way data was recorded, collected, and collated enabled us to see how easy it was to get good quality information to inform planning. We chose a new measure (see paragraphs 5.17-5.22) because we were interested in seeing what data was like without significant, and targeted, additional investment of cost and time.

1.31 It would not have been cost-effective to audit every workstream in the regional services plans. Instead, we looked broadly at regional services planning and then at the workstreams relating to capital investment decisions for buildings and cancer treatment.

1.32 Using capital effectively and efficiently is important, especially when large amounts of money are involved. Our investigation into capital focused mainly on investment in buildings. This is because:

- investment in buildings has long-term ramifications for health services;
- capital funding is constrained because the Government aims to return to budget surplus in 2014/15 and beyond (so it is more important than ever to prioritise investment); and
- borrowing to fund capital projects already contributes to some DHBs' deficits.

1.33 We chose cancer treatment because it is a service of great importance to New Zealanders. Cancer is the leading cause of early death in New Zealand. In 2009, more than 20,800 people were diagnosed with cancer in New Zealand and 8437 people died of the disease. Shorter waits for cancer treatment has been a health target for the period that regional services planning has been in place. Regional cancer-services networks were set up in 2006 and 2007. They lead service improvement and planning, support the achievement of health targets and policy priorities, and link to national and regional governance structures. We discuss these networks more fully in Part 4.

What we expected to find

1.34 This is the third year of regional services planning, with two years of plans delivered and the third year's plans agreed. Given the Ministry's intention to ramp up efforts in years two and three (see paragraph 1.26), we expected to find:

- evidence that the plans were achieving their intended effects, as defined in the guidance supplied by the Ministry (these effects include improvements in resilience and quality of service, and reduced costs, as well as changes in behaviour in DHBs);
- that the Ministry was able to show how effective regional services plans had been in contributing to lifting performance in the health and disability sector;
- that regional services plans are used to help make capital investment decisions for buildings; and
- that relevant and good quality information is used when planning regional services.

1.35 During this audit, we looked hard to find out whether regional service planning was leading to changes, or something else. This meant that we looked for evidence, causes, and effect of change.

What we did not audit

1.36 Our audit focused on administrative planning. We did not audit clinical decision-making or clinical safety. Where we discuss improvements in quality of care, it is about improvements as described by DHBs. We did not test these with patients or service users.

Structure of this report

1.37 In Part 2, we discuss our findings on whether regional services planning is increasing collaborative working between the organisations, networks, and workstreams that make up the health delivery system.

1.38 In Part 3, we discuss our findings on whether regional services plans guide capital investment decisions in the health sector.

1.39 In Part 4, we look at what introducing regional services planning has done to regional cancer-services networks – a long-established workstream with its own funding and lines of accountability.

1.40 In Part 5, we discuss our findings about the availability and reliability of good quality data and information used in regional services planning.

1.41 In Part 6, we look at how the Ministry has led and guided the process of regional services planning.

1.42 In Part 7, we discuss our findings on whether the Ministry knows if regional services planning is delivering the intended effects successfully.

Part 2
Are district health boards planning, funding, and delivering services together?

2.1 In this Part, we discuss our findings about whether regional services planning is, as intended, increasing collaborative working between the organisations, networks, and workstreams that make up public health and disability services. We discuss:

- the extent to which organisations are planning together;
- whether resources are in place to fund those regional services plans; and
- whether changes in service delivery are happening because of regional services planning.

2.2 Although the extent of collaborative working had increased, it was not yet business as usual in some regional activities. Those we spoke to about what drives collaborative working cited factors such as the strength and duration of previous relationships, commitment and dedication, trust, financial incentives, good leadership – and sometimes crisis. Some saw regional services planning requirements as the "glue to make things stick". Others viewed it as an administrative procedure not linked to accountabilities.

Planning together

2.3 The Review Group envisaged that some long-term planning would inform whether services should be provided at local, sub-regional, or regional level. Although it is not a specific requirement of regional services plans, we expected to see evidence of those decisions having been made by year three, together with a supporting narrative of the rationale and the benefits to be gained.

2.4 We expected that reviews of models of care would be well under way as a forerunner to changes. Canterbury DHB is well advanced in this, with more than 480 care and clinical pathways set up in the Canterbury sub-region. The Midland region has a "map of medicine" project under way to prepare clinical pathways starting in primary care. All regions were taking part in this sort of activity to some extent.

2.5 We visited the Northern region and the South Island region and reviewed the regional services plans of all four regions. All four regions had changed how they made decisions to take account of regional services planning. Figure 2 describes the approach taken by the South Island region.

Figure 2
South Island Alliance model of governance

In the South Island, an alliance framework has been adopted to put regional services planning into effect. The region chose the alliance approach because it had learned that the approach could enable complex services to be put into effect quickly without having to disrupt organisational structures. The South Island DHBs felt that such a framework was needed to work out where regional priorities should be placed, because the South Island DHBs are dispersed and are at different stages of integration.

The South Island Alliance is governed by an Alliance Board and is led by a Leadership Team. A set of core principles based on "best for patients; best for system" guides the Alliance. The Alliance's Strategic Planning and Integration Team provides a strategic and integrated view to the Alliance's approach to putting regional planning into effect. Clinical leadership is represented in the Service Level Alliances, or workstreams. The Service Level Alliances support the planning and funding functions of the DHBs. The Programme Office, which is hosted by Canterbury DHB, provides support for regional activities. All DHBs contribute their skills, expertise, and resources as required. The Alliance arrangement has allowed the South Island DHBs to have collective ownership of risks and outcomes, joint decision-making, and an open approach to sharing information. The region reports that this has led to more trust among the region's DHBs.

In 2012, the Alliance evaluated how effective it was. The results show that, although most agree on the need for a common and complementary capacity for the region, roles and responsibilities could be better understood. It is important that the region prepares an overall outcomes framework to ensure that the Alliance is meeting its purpose. We understand that this work is under way.

2.6 We found the speed of change to be quicker where:

- There were already positive and trusting relationships. Sometimes, this was the result of having worked together in the past to solve a shared problem. Where this had happened, people reported that the region spoke with "one voice".
- Relationships were relaxed and more informal – for example, people picking up the phone rather than setting up a meeting, and chief executives having a pragmatic leadership style.
- The DHBs in a region are geographically close to one another – it was easier to discuss collaborating on services in a large metropolitan area than in a region with two major centres of population.
- Historical levels of capital investment in buildings had been high. In areas with buildings in poor condition, there was a tendency to be more parochial. This was because there was a greater pressure to put the local population first.
- There was a clear understanding, based on sound evidence from clinicians, of where it made sense to collaborate regionally, sub-regionally, or locally.
- There was clear ownership and leadership of the regional services plan within the region.
- There was active clinical leadership from chief medical officers and other clinicians on regional governance groups and at the head of service and clinical networks.

- Regional chairpersons, chief executives, and chief financial officers met regularly, gave time to strategic and operational thinking, and had ways to resolve disputes. Face-to-face meetings were easier in the metropolitan areas than elsewhere.

2.7 Some of the problems we found were:

- Planning took place in isolation – with people not talking to one another about connections between plans. For example, in one region, the cancer-services network was not taking part in discussions about information systems and the network's activities were poorly represented in the draft regional services plan.
- Regional services planning was not being considered as "business as usual". Evidence of this was that some elements of regional plans were little more than an aggregation of items from individual DHB plans. Regions told us that incentives to plan together were sometimes not strong enough.
- Meetings of decision-makers were rare or irregular.
- It was rare for primary health organisations to be involved in regional services planning discussions, and even more so for private sector providers. This can mean that the regional services plans are too focused on hospital activity, when new models of care need a wider variety of settings and providers.
- There was a lack of measurable targets and some long time frames for action.

Allocating resources to deliver regional services

2.8 We expected that DHBs would identify areas of joint investment in services. Good progress had been made in administrative, planning, and other back-office functions. As we noted in paragraph 1.8, the Review Group considered how to reduce back-office costs to increase spending on frontline care. We found that:

- all regions have put resources into regional support arrangements for joint planning, monitoring, and information systems;
- one DHB was sharing with other DHBs a patient administration system that it had paid for;
- one region centralised buying to replace expensive equipment throughout the region, and the region's DHBs were jointly investing in radiology services;
- three regions have each agreed to pool their information technology capacity and management arrangements;
- regional investment in information technology is happening, in line with NHITB priority programmes such as patient administration systems, imaging, and e-referrals; and
- DHBs are all required to use some national services and contracts led by HBL.

2.9 To test whether the benefits were being redirected to the front line, we asked the regional offices for details of their costs, compared to the previous arrangements, but net of any savings arising from regional services planning. We were told that this information was not available, so we were unable to assess whether the intended effects were being realised.

2.10 We saw limited evidence of DHBs and others funding services together. Some alternatives to pooling money were in place, such as sharing staff or initiating service-level agreements between DHBs or between DHBs and other agencies (where a service is provided in return for a payment).

2.11 A successful initiative was the pooling of money for bariatric (weight loss) surgery. Each region had pooled the money available, and had devised jointly agreed criteria to ensure equity of access.

2.12 The most significant barriers to funding together were expressed as:

- DHBs prioritise spending on their local population. They are not always able to meet local demand and had to balance the books – so regional funding would not be a priority, nor would paying for a regional facility from just one host DHB.
- Outside the metropolitan areas, moving people (and their caregivers) or clinical teams around is more difficult, and conflicts with initiatives for care to be more convenient.
- Inter-district flows are the default way that money follows patients around the health system, irrespective of where the patients are treated. However, inter-district flows can be a barrier in several ways. For example, a DHB in financial deficit may want to retain patients (as a way of keeping money assigned to a patient within their DHB). This can undermine regional approaches to elective surgery, which aim to ensure that hospital operating theatres throughout the region are used efficiently to treat more people sooner.

Changes in how services are delivered because of regional services planning

2.13 We looked at two aspects of service delivery – access and patient flows.

Access

2.14 We expected to see that work was taking place to agree regional thresholds for patients' access to services. We expected this agreement to be followed by a common set of clinical protocols. Having the agreed thresholds and protocols would make it easier for patients to travel between points in the health system, irrespective of where they live in a region. The thresholds and protocols are important for ensuring equitable access to health care.

2.15 We saw clear evidence of regional approaches to cancer services where regional planning was already routine before the introduction of regional services planning (see Part 4).

2.16 Apart from cancer services, those we spoke to provided limited evidence of using or preparing regional thresholds and protocols. Canterbury and West Coast DHBs are working closely on a model of care that increases sharing of resources. The Central region is working on a single service for orthopaedics. This could mean one sub-regional or regional waiting list, or that patients can travel to other hospitals, to get a better match between resources and demand. The South Island region is beginning to draw up service agreements through its alliance framework.

2.17 We saw a few other examples of regional access during our fieldwork and during consultation about this report. Some of the basic building blocks needed to support regional service delivery have been slow to develop.

2.18 However, some projects under way will help to support better access (see paragraph 7.30). As pathways and thresholds become more standardised throughout regions, it should be easier to build good systems to manage patient access and information.

Patient flows

2.19 We looked into the pattern of inter-district flows of patients.

2.20 Regional services planning envisages that people go to large tertiary hospitals for complex care and to smaller district hospitals for less complex needs. The aim of this approach is two-fold:

- to make district hospitals more sustainable by carrying out uncomplicated, planned surgery – such as hernia repairs – for patients who live outside the district as well as local people; and
- to help ensure that medical and surgical staff at large hospitals preserve their specialist competencies – by making sure that staff see enough patients with complex needs.

2.21 Because funding follows the patient to where they receive treatment, this should remove one of the barriers to working regionally. In our view, if nothing had changed in the inter-district flow data, it would suggest regional services planning was having little, if any, effect.

2.22 We expected that, after putting regional services plans into effect, the Ministry would track the proportion of patients accessing regional resources outside their home DHB.

2.23 We analysed some data about inter-district flows, which indicated that patient flows to tertiary hospitals were increasing, but flows away from them were not. This information was not easily accessible, so we concluded that the Ministry was not tracking regional flows.

2.24 However, we found out that the Ministry was comprehensively monitoring, and doing some good quality analysis, of patient activity to ensure that DHBs met the national target for elective surgery. This information contains details of patient flows within, and outside, each region. The Ministry uses this information to work out whether regionally agreed targets for the number of operations are being delivered. It would seem to be relatively straightforward to modify this analysis to include a section on how patient flows change over time. There is further potential to enrich this picture, by capturing information about patient flows that do not depend on the default way of moving money around – for example, by monitoring new models of care such as telehealth and community outreach clinics.

2.25 In Part 3 and Part 4, we look at the specific effects of regional services planning on two workstreams – capital investment and cancer treatment.

Part 3
Is regional services planning influencing capital investment?

3.1 In this Part, we discuss our findings about whether regional services plans guide capital investment decisions in the health sector as intended. We discuss whether:

- regions are reaching consensus on capital asset needs and prioritising resources, based on regional ways of working;
- connections between regional services planning and capital investment are clear;
- the approvals procedure is becoming more efficient; and
- enough people with the right skills are available to produce and approve high-quality business cases for capital investment that meet the needs of all decision-makers.

3.2 Capital investment in buildings based on regional services planning is at an early stage. Regional capital committees (RCCs) are being set up to guide regional capital investment. RCCs are beginning to understand the full range of assets held throughout their region, but the links to capital planning are not yet clear.

Using regional ways of working to reach consensus about capital asset needs and prioritising resources

3.3 Regions have put in place RCCs, which allow DHBs to explore opportunities and priorities for capital investment regionally. Much effort is going into creating organisational and governance approaches to support this planning.

3.4 Regions are starting to have discussions (through RCCs) about which capital projects are worthwhile. Some DHB projects have been in the pipeline for up to 10 years, long before the introduction of regional services plans. It is unsurprising that these projects appear to lack a regional perspective.

3.5 There are big demands on capital for major repairs to buildings that are beyond their economic life, to meet seismic standards, and to upgrade them to support modern standards of care. There are tensions between getting on with these repairs and waiting to decide the best use of assets arising from new ways of working (based on clinical pathways and new models of care).

3.6 There is some joint planning of projects needing capital investment. For example, West Coast and Canterbury DHBs worked together on the proposal for Grey Hospital development. However, RCCs are not yet influencing or setting priorities for major investment in buildings based on regional services planning. The Ministry and one of the regions confirmed that the first year's focus on vulnerable services in regional services plans had a limited effect on "bricks and mortar".

3.7 National capital funding that cuts across regions complicates the process of making decisions. Paediatrics, cancer, information technology – and, more recently, HBL's efficiency projects – all place demands on capital funding. The Health Sector Forum heard concerns that DHBs could not afford their share of capital needed for all these projects and initiatives. The NHITB and HBL are investigating ways to spread the upfront investment. The effects of the national initiatives are not always fully reflected in regional plans. For example, one region had only around two-thirds of the information required for NHITB capital investments in its regional plan. This meant that the national picture could not be drawn.

3.8 Cabinet sets a "capital envelope" for the health and disability sector from which the Minister and the Minister of Finance can approve funding. Further funding is possible if a case for it is made to Cabinet, as in the Canterbury hospitals rebuild. Within that framework, each DHB works to its "affordability" amount for capital projects – that is, the amount of money it has to spend or can afford to borrow.

3.9 In 2012, each region was asked to agree a list of intended capital spending for the next 10 years, based on a notional budget for each region. This was CIC's attempt to require DHBs within regions to prioritise. Each region attended a CIC meeting to discuss priorities. The way that those regional spending intentions were agreed does not clearly identify what was omitted or scaled back because of the notional budgetary constraint. Therefore, it is not clear whether regions are making difficult decisions about the future of some of their buildings or challenging traditional models of care.

3.10 Occasionally, the regions have agreed their collective priority (for example, setting up the Taharoto mental health facility in the Northern region). However, the regional lists of intended capital spending generally lack a regional prioritisation or focus. Instead, regional lists look more like a summation of the separate DHB plans.

3.11 Therefore, spending intentions do not yet reflect how regional collaboration on new ways of delivering services might affect the need for new or redeveloped buildings.

Connecting regional services planning and capital investment

3.12 Capital expenditure planning is often taking place before service planning. Some elements of capital planning are done nationally (for example, by HBL and NHITB), and others locally (through DHBs). Regional services planning sits between the two. This means capital planning is a mix of top-down, bottom-up, and somewhere in the middle – all at the same time.

3.13 It is forecast that HBL projects will eventually save money, but there are some short-term capital implications. The improvement projects led by NHITB also have significant capital requirements, and should support service improvements and new ways of working. A DHB asset plan is "bottom up" and influenced by clearly identified changes in service delivery. Regional services planning takes place in the "middle" – and it is here that investment decisions on capital should flow from wider changes in service delivery in the medium and long term. It is worth noting that the regions lack budgets of their own, but need to agree priorities within the overall limits of what DHBs can afford and the overall capital envelope.

3.14 Few projects have been approved recently, so it is difficult to see a strong connection between regional services plans and capital investment. We recognise that the Canterbury earthquakes meant that the period was not typical. The money needed for the rebuild of Canterbury hospitals meant little could be committed for anything else in the last few years.

3.15 Each region will tend to focus on its priorities, but there is also a need to agree national priorities. The CIC is the specialist committee that advises the Minister. The CIC's main role is to approve health capital funding for all projects that cost more than $10 million, irrespective of the source of funding.

3.16 The CIC placed other projects on a slower track until it became clear how much money was going to be needed for the Canterbury hospitals rebuild. Most of the other projects that have advanced have been for buildings that provide district services. These projects include new mental health facilities at Hawkes Bay and Taharoto and the Kaikōura family health centre.

3.17 The plans for Grey Hospital had a distinctly sub-regional flavour, where West Coast and Canterbury DHBs jointly worked on proposals. Exploration of new ways of delivering services, such as telemedicine and shared clinical teams, is under way. This aims to reduce West Coast DHB's risk of isolation and clinical instability, one of the intended effects of regional services planning.

Getting a more effective procedure for approvals

3.18 National decision-making on capital investment linked to regional planning is becoming more effective. However, progress on a National Asset Management Plan has been slow, making it difficult for the CIC to prioritise spending.

3.19 The CIC is helping to ensure that regional opportunities get consideration in new approvals for capital. Before it gives consent for a DHB to prepare a full business case, the CIC considers the DHB's outline proposals. If these proposals lack an expected regional perspective, or consideration of how information technology

and new ways of working could lead to changes in requirements, the CIC does not give its support. For example, the CIC asked Nelson-Marlborough DHB to include more on regional working in its recent proposal for surgical beds. Likewise, Canterbury DHB had to include more details on information technology and workforce changes. If DHBs do not co-operate when appropriate, they will not get CIC support to get the capital they want.

3.20 At the time of our audit, the CIC was trying to devise a National Asset Management Plan, but there were gaps in the base information from DHBs and private health care providers. This means that the CIC has to make some assumptions that are not based on solid data when working out future needs. The information used for budgetary purposes is an aggregated list of what capital DHBs would spend if they had the money in the next 10 years. That was not enough detail to support the CIC to set priorities.

3.21 A first attempt at a National Asset Management Plan has been in draft form since 2012, and the Ministry told us an annual update was now part of its work plan. More recently, the CIC asked for help from the Ministry in interpreting the information in the National Asset Management Plan. Work is under way on producing a dashboard report for each DHB, and for each region, to help in the discussion of DHB intentions in November 2013. The CIC has reported some difficulty with trying to agree a long-term capital plan and setting priorities for investment without a long-term service plan for health. For the 2012/13 budget, it evaluated proposals based on a set of assessment criteria to agree a prioritised list.

3.22 The Ministry has told the CIC that there is no appetite for a long-term health sector plan. Without a national level plan, at the time of our audit, the CIC was still deciding how best to help DHBs to prioritise.

Capacity and capability to produce and approve high-quality business cases to meet decision-makers' needs

3.23 In our view, internal capacity and capability within the health sector to put together high-quality business cases is not improving. The needs of decision-makers are not always well met.

3.24 Guidance on producing business cases follows industry best practice – it is by necessity complicated and rigorous. Although some DHBs reported that they found it demanding, others valued the challenge it brought to their beliefs and assumptions.

3.25 Meeting the needs of all agencies involved in preparing and approving business cases is difficult. This is because, within the health sector, there are too few people who have the necessary skills for writing business cases. Neither DHBs nor the Ministry have in-depth expertise to project manage large-scale business cases for building projects. This means that they rely heavily on consultants, advisors, and experts.

3.26 On one large project, a lot of duplicated effort could have been avoided if all those with national governance oversight, and the DHB in question, had negotiated an agreed set of requirements for the project. The Ministry learned from this, and tried out a partnership group aimed at improving transparency, providing earlier advice, support, and more rigour in analysing alternatives. West Coast DHB proposals for improvements to Grey and Buller hospitals involved staff from the Treasury, the DHBs, and the Ministry. This approach has the potential to reduce spending on advisors.

3.27 The quality of business cases that the CIC receives is variable, which suggests that consultant involvement does not guarantee a robust analysis of all the options. Consultants can act only on the brief they are given, and may not be up to date with expectations about changing models of care. However, peer review by clinicians from another region has sometimes been used to good effect.

3.28 RCC chairpersons, DHB chairpersons, and other board members might not be able to analyse critically the business cases that they see. They all need to be "smart buyers", supported by appropriate expertise. A lack of suitable analytical skills could result in poor decisions about capital investment and waste and poor use of funding and resources.

3.29 Almost everyone we spoke to mentioned a nationwide lack of people with skills in preparing core business cases and managing and governing projects. This contributed to the delays in preparing good business cases. However, there are varying views about what core capacity is necessary, and where that should be located. Additionally, the unpredictable availability of capital funding makes it difficult to set up core capacity.

3.30 Project management has been a problem. The Ministry made some changes to guidance by learning from other projects. It is tightening up on "scope creep" – projects slipping by small amounts but eventually including far more than originally agreed. It has targeted long project time frames and budgetary inflation.

3.31 In December 2012, the Minister and the Minister of Finance commissioned a working group to look at all aspects of capital planning in health. The scope of the group's work includes financing, decision-making, project management expertise, and asset management skills. This should go some way to addressing the matters raised in this report. However, the review could take some time to finish, and it could take even longer for its recommendations to be acted on.

Recommendation 1

We recommend that the Ministry of Health and district health boards work together to achieve good governance of capital investment, by ensuring that decision-makers can:

- get strategic advice at an early stage on capital projects; and
- get support at crucial decision points.

Part 4
Is regional services planning integrated with regional cancer-services planning?

4.1 In this Part, we look at what the introduction of regional services planning has meant to regional cancer-services networks – a long-established workstream, with its own regional funding and lines of accountability.

4.2 The planning for cancer services is contributing to achieving the intended effects of regional services planning. This is partly because regional planning for cancer treatment has been working successfully since well before regional services planning was set up.

Regional networks to treat cancer

4.3 Regional networks to treat cancer were set up in 2006 and 2007. The networks have separate funding dedicated to achieving their co-ordination and improvement functions throughout the health sector as a whole, not just with DHBs. They also get dedicated funding to carry out projects that are in line with the national cancer work plan. The strong relationship between the networks and the Ministry is characterised by regular communication, clear lines of responsibility, and a co-operative working relationship. This is an important contributor to having effective cancer-services networks.

4.4 The regional cancer-services networks lead service improvement and planning, support the achievement of health targets and policy priorities, and link to national and regional governance structures. The networks' governance arrangements were expected to be in line with regional services planning before July 2012. At the time of our fieldwork (early 2013), this had been done in the Northern region, but not in the South Island.

4.5 In the South Island, we saw the potential for inconsistency between regional services planning and how regional cancer-service planning works. For example, separate accountability and governance for cancer-services planning was apparent. By contrast, integrating the Northern regional cancer-services network into regional services planning avoided these problems.

4.6 The problems in the South Island reinforced a message repeated to us – that setting up successful relationships is an important part of improving regional service delivery, whether through regional services planning or some other mechanism.

4.7 In our view, the regional cancer-services networks and DHBs are planning for cancer services in a way that is in line with the intended effects of regional services planning. Examples include devising consistent clinical protocols for access to services and increasing use of multidisciplinary meetings to decide on

treatment for patients suspected of having cancer.[6] Multidisciplinary meetings are known to improve the survival rates of patients, and using these meetings more is part of the national cancer work plan.

4.8 Although these efforts contribute to achieving the intended effects of regional services planning, in our view, they did not happen because of regional services planning. Instead, these efforts are part of a workstream that was set up and put in place well before the introduction of regional services planning.

Integrating regional information services and information technology

4.9 Information technology is crucial for the regional delivery of services and improving the quality of care. It enables changes in working practices and the use of buildings. We expected that the information technology workstream would use regional clinical priorities as the basis of work priorities. We found that, although information technology initiatives are under way to improve regional delivery of cancer services, there are difficulties. In the South Island and Northern regions, these difficulties are mostly to do with integrating cancer-services network information technology requirements with regional information technology work.

4.10 The cancer-services network staff and regional information technology staff spoke of problems with setting priorities and a lack of communication. Cancer-services networks had information technology projects outside the regional information technology workstream. Cancer-services network staff and regional information staff told us that the problems would be addressed by having one system. The Ministry later told us that it expected there would be a national contract by 2014, although consultation had not started. This highlights the potential for discord when accountability is divided and communication is lacking.

Data for planning

4.11 To help prepare good-quality plans for cancer services, the cancer-services networks have put a lot of effort into collecting and analysing data and carrying out research to set up a good information base. Our audit confirmed problems with data completeness in some DHBs. In Part 5, we discuss those problems.

Progress

4.12 Regional services planning and cancer-services planning are becoming more in line. Getting them in line is relatively straightforward because these two types of planning have similar intentions.

6 A multidisciplinary team meeting is a deliberate, regular, face-to-face (or videoconference) meeting involving a range of health professionals with expertise in a range of different specialties to discuss the options for patients' treatment in real time.

4.13 Within regional services plans generally, the cancer workstream is more in line with the intended effects of regional services planning than other clinical workstreams. Many measures focus on quality of care. However, the cancer-services sections of the regional services plans say nothing about the effect on costs. This means that we could not see evidence of any plans for reducing costs or getting greater efficiency for the same money.

Part 5
Is good quality data and information enabling regional services planning?

5.1 In this Part, we look at whether regional services plans are based on good quality data and analysis. A lack of robust data leads to imprecision and inaccuracy. This, in turn, can lead to false assumptions, followed by poor decision-making.

5.2 Our research revealed that there are concerns about health data throughout the health system. Although we did not carry out a system-wide review of data, we found problems where we did look. Based on our limited testing, we share the concerns raised with us by people in the health and disability sector. These concerns were mostly about completeness of data, information technology systems, coding errors, and timeliness.

Why good quality data and information is important

5.3 Good quality data benefits patients, for example, in diagnosis, treatment, and learning from what works and what does not. The aggregation of patient and service data supports improvement in performance, service delivery, and planning. As funding and accountability systems become more complicated, the demand for good quality information – based on valid and reliable data – increases. Good quality data and information provides users and decision-makers with assurances about effectiveness, efficiency, and economy.

What we knew and what we did

5.4 The Review Group's report noted that the health sector has a history of poor execution of information technology projects. Because of this, many information systems are incomplete and inconsistent. This limits their usefulness to support clinical workstreams. Some DHBs are using old and outdated patient management systems. Some DHBs have been unable to access information systems in their regions. The uneven progress has resulted in disjointed systems that contribute to poor-quality data and information. There is a lack of information connectedness between DHBs and the primary and private health sectors.

5.5 In our early fieldwork, people from the Ministry, regional agencies, and DHBs told us that it was challenging to get good quality data to support planning. Except for some national data, there is little confidence, generally, in the quality of data. In some instances, this meant staff had to rely more on their experience than the available data.

5.6 We tested the quality of data by:

- auditing patient records in four DHBs.
- looking at two samples of data and information used to support capital planning; and
- reviewing one region's information strategies.

5.7 We audited patient records in four DHBs to test the quality of the raw data available from DHB information systems. Looking at the way source data was recorded, collected, and collated allowed us to see how easy it was to get good quality information to inform planning. We chose a new measure because we were interested in seeing what data was like without significant, and targeted, further investment of cost and time.

What our work revealed about data quality

5.8 There are recognised flaws in the quality of health-related data when it comes to measuring the quality of the nation's health services. The New Zealand Health Quality and Safety Commission states that:

> *The availability of data is our biggest challenge, in particular the balance between imperfect but readily available data and high-quality, very specific data which is difficult to collect*.

5.9 People in DHBs and regional networks who work with the data available to support regional services planning do not trust its quality. This is because there are significant gaps and limitations in the data. This could limit how effectively regional services are planned.

Our concerns about the quality of data and information

5.10 We found a variety of problems in the samples of data we tested. These problems included:

- discrepancies between source data and reported data;
- a lack of understanding, leading to different interpretations of what should reasonably be recorded;[7]
- not enough training or support for those responsible for collecting the data and reporting on the indicators;
- underestimating the time required to get data definitions right, even if the clinical events seemed relatively straightforward; and
- people having to collect data manually because it was too difficult to get data from the official computer systems.

7 The lack of understanding covered many aspects, such as what the data was supposed to show, exactly what data needed to be collected and recorded, and for what reasons.

5.11 During our fieldwork, we found a widespread awareness of data quality problems and many reasons contributing to those problems, including:

- completeness of data – for example, in one instance, up to 20% of records could have incomplete data, with one or two incomplete fields in about 15% of cases and wrong data in about 5% (this was attributed to busy staff being under pressure);
- information technology systems – including old and unreliable systems that did not talk to each other;
- coding errors – mistakes in coding data or poor record-keeping making the coding task more difficult;
- inpatient referrals, where it was more difficult to find out the date of the first specialist appointment or assessment;
- some referrals that came in from the private sector were missing information or difficult to find; and
- timeliness – in many instances, there was a direct trade-off between the speed of data being available and its quality.

5.12 We observed the effects of system limitations faced by some of the DHBs. For instance, in one DHB, the system could only show information about individual appointments for a patient rather than their whole period of care. Staff had to access many systems to pull the appropriate data together. In another DHB, some staff could not get information because it was held offline.

5.13 We identified problems other than clinical data. For example, we reviewed an early CIC attempt to pull together information for a national asset management plan. We found problems with common definitions and gaps in data. That early CIC attempt was based on assumptions of no changes in where services were located or the way they were delivered, because of a lack of information. The private sector's capacity for delivery had to be estimated, because private sector providers do not always give data to the Ministry.

5.14 Based on that finding, we looked into one region's early planning for Assessment, Treatment, and Rehabilitation (AT&R). We chose this because the capital requirements already feature in outline plans for spending. In the region, four DHBs had begun looking at what inpatient beds they needed for AT&R. An ageing population is the main reason given to justify more beds, but working out exactly how many more beds causes some difficulties.

5.15 The difficulties arise because each DHB uses different definitions of AT&R. Each DHB uses the beds differently. Different DHBs use different methods to predict how many beds are needed. As a result, there are differing assumptions about how patients move across DHB boundaries for care. This could lead to double

counting. All of this has a major effect on capital planning, because DHBs could be understating or overstating their requirements.

5.16 One of the regional information strategies notes concerns that population health data available to the health sector is poor quality, fragmented, and difficult to get. The strategy says:

> *Individual practitioners can, after major effort, collect and report on some of the population health information some of the time, but none can take a district wide or regional comprehensive and aggregated view of population health status, trends and determinants of ill health and wellness.*

Faster Cancer Treatment indicators

5.17 The Ministry is preparing Faster Cancer Treatment (FCT) indicators, which are important new measures for tracking how quickly cancer patients get treatment. Until now, it has been difficult to measure how long it takes for patients to see a specialist from the time their doctor suspects they have cancer and refers them to a specialist, to the start of their first cancer treatment. There has been no national approach to collecting this information, and DHBs have been collecting and reporting data in different ways. The lack of consistent information has made it difficult to identify where improvements can be made. Decision-makers do not yet rely on the indicators.

5.18 We chose to examine these new measures because we wanted to test the quality of "readily available" data in DHBs' systems. To help to inform the development of the FCT indicators, we looked at whether the information was relevant, understandable, comparable, and reliable.

5.19 The reason for the FCT indicators is highly relevant. The Ministry's website (www.health.govt.nz) states:

> *Cancer is a major health issue for New Zealanders. One in three New Zealanders will have some experience of cancer, either personally or through a relative or friend. Cancer is the country's leading cause of death (28.9 per cent) and a major cause of hospitalisation. Improving the timeliness of access to services for cancer patients is important. If it takes too long for a patient with suspected cancer to receive treatment this may affect their outcome and cause unnecessary stress for them and their families and whānau.*

5.20 The guidance on FCT indicators was difficult to understand, with complicated and ambiguous definitions. Each of the four DHBs whose patient records we audited had interpreted the definitions differently.

5.21 We found various "teething issues" with reliability. Information about cancer treatment timeliness was not comparable, because individual DHBs "started and stopped the clock" at different points. There were many copies of guidance in circulation, between and within DHBs. We found discrepancies in, and missing, data. Some DHBs had to access many separate in-house information systems to extract data, but did not always have access to the electronic and paper information systems that they needed to verify dates.

5.22 Making the measures more reliable before they could be used as indicators has taken time. A description of the FCT indicators was released in December 2011. More guidance followed in March and October 2012. The Ministry told us that its analysis of the first collection of FCT data from DHBs in mid-2013 showed problems with data quality. This means that the Ministry will need to increase support to those putting the indicators into effect.

Improving data quality

5.23 For information technology to improve service delivery, agreed approaches to clinical and administrative procedures must be in place first. Progress putting information technology projects into effect is mixed but improving.

5.24 Before regional services planning was introduced, each DHB invested in its own information technology systems. This unco-ordinated investment was sometimes not enough. Now, investing in regional information technology systems means that the quality of data available is improving. However, good information technology systems are only part of the solution. Human action – or inaction – caused many of the factors affecting data quality that we identified. However, a good information technology system can ensure that some of these errors are prevented, by ensuring that expected entries are well defined and that reporting happens quickly on what appear to be outliers.

5.25 Information needs to be sought after, valued, and in regular use if accuracy is to improve. In our view, when practitioners stop using data, there is no urgency to get it right – and the people producing it might not know it is wrong. We heard about other efforts to improve the accuracy of data, but most of these were time-consuming attempts to "clean up" poor data for use.

5.26 Regional collaboration on information technology projects is improving under regional services planning. The NHITB is showing clear leadership about the direction for information technology investment in the health sector. It has a national plan and a clear set of priorities that have remained stable. This gives more certainty to the sector. The NHITB is aware that it makes demands on a limited pool of money, and that it needs to be clear about how it decides to do

things. It is working with DHBs to help with prioritising and to build capability to carry out information technology projects. At the same time, the NHITB shows a determination to keep people focused on what is important.

Recommendation 2

We recommend that the Ministry of Health and district health boards work together to improve the quality of data for planning and reporting, by exploring whether our overall findings on data quality apply to other information collected to inform decision-making.

Recommendation 3

We recommend that the Ministry of Health and district health boards work together to report on how they will improve the quality of data used for planning and reporting.

Recommendation 4

We recommend that the Ministry of Health refine the guidance on Faster Cancer Treatment indicators to remove ambiguity about the definitions.

Recommendation 5

We recommend that the Ministry of Health and district health boards discuss and agree how to apply the definitions of the Faster Cancer Treatment indicators consistently, so that indicators are comparable between district health boards.

Part 6
Is the Ministry of Health's leadership and guidance enabling regional services planning?

6.1 Good leadership and guidance are important if regional services planning is to be effective and efficient. In this Part, we look at the Ministry's leadership and guidance of the regional services planning process.

6.2 Regions expressed dissatisfaction with aspects of the NHB's leadership, most specifically about it not setting a longer-term, strategic view. In our view, the Ministry's regional services planning guidance has not yet significantly increased the integration of health service planning at different levels of the health sector, although relationships have improved. The guidance is not in line enough with other DHB and regional planning activities, and is too detailed and prescriptive.

Ministry guidance and the intended effects of regional services planning

6.3 The Ministry is the main authority providing guidance and leadership when it comes to regional services planning.

6.4 The senior people we spoke to in the health system identified several problems with how the Ministry leads regional services planning through the guidance provided, including:

- not enough attention being given to defining the national, regional, and local components of the health system; and
- a lack of a strong strategic focus on the whole health system.

6.5 These wider problems were identified in the Performance Improvement Framework review of the Ministry of Health in 2012.[8] The Ministry has worked to address these concerns, in terms of its organisational development and the way in which it engages with the health sector more widely. There have been improvements in setting up opportunities for better engagement, such as the Health Sector Forum of senior leaders and face-to-face meetings about strategic priorities with DHB chief executives and chairpersons. However, senior managers still voicing concerns in early 2013 would suggest that there remains some way to go.

6.6 The problem we heard most about was that the Ministry was over-prescriptive when it was unnecessary, and did not give enough detail when detail was needed. This is a difficult balance for the Ministry to get right, but it is an important aspect to address because the Ministry is the health sector leader. The Ministry told us that the level of prescription was needed to improve consistency where regional collaboration had been less advanced in the past. Our evaluation of the plans and our fieldwork indicate that the approach has ensured compliance with a standard.

8 State Services Commission, the Treasury, and the Department of the Prime Minister and Cabinet (2012), *Formal Review of Manatū Hauroa the Ministry of Health (the Ministry)*, available at www.ssc.govt.nz.

However, the regions that had advanced beyond that standard were probably the most frustrated by the level of prescription.

6.7 Our evidence shows that many people think that the Ministry's regional services planning guidance is not forward-focused, strategic, or clear enough about future national health services and needs. Some of the people we spoke to expected a long-term health sector plan from the Ministry. Such a plan was referred to in the Health Sector Framework 2010 document, and the Ministry had said it was working on preparing such a plan until June 2011. About then, it seems a decision was made that the plan was no longer useful, but we could not find evidence of where that decision was taken or who was consulted. This lack of clarity could have contributed to the comments we received about how effective the NHB's leadership has been.

6.8 The Ministry's regional services planning guidance requires regional services plans to address the need for:

- local, regional, and national services;
- co-ordinating those services effectively and efficiently; and
- the best possible arrangement of health services for delivering services effectively and efficiently.

6.9 The Ministry has stated that the intended outcomes of regional services planning are improved quality of care, reduced service vulnerability, and lower costs.

6.10 The Ministry's regional services planning guidance is not in keeping with these intended outcomes of regional services planning. We do understand that the guidance is driven by the planning regulations. However, we also understand that a regulatory approach was taken to enable changes to be made, if necessary, without having to change primary legislation.

6.11 The Ministry publishes a DHB planning pack every year. The pack contains guidance for regional services plans and district annual plans. The guidance is followed soon after by a letter from the Minister setting out his expectations for the next 12 months. Regional services plans and district annual plans are submitted within a few weeks of each other. In practice, DHBs have a short time to prepare and complete their regional services plan and their annual plan, including getting the contributions of the regional networks. The Minister approves the plans at the same time, as long as they are satisfactory.

6.12 We understand that the regional services plan should be significantly more strategic and long term, whereas DHB plans reflect the operational requirements falling within that year. However, the regional services plans are also required to

have an implementation plan, mostly to hold regions accountable for progress. The regional services plans only reflect part of the DHBs' regional activities. Despite this, many of the regional services plans exceed 150 pages when all the prescribed content and discretionary content is included.

6.13 Other problems with the guidance are that it:

- says little about the intended effects of regional services planning other than cost effects; and
- does not pay enough heed to the scale and speed of change needed to move to regional services that are clinically and financially sustainable.

6.14 In our view, the Ministry cannot show that regional services planning guidance has reduced the administrative costs of planning, although we acknowledge that DHBs no longer need to submit district strategic plans. We cannot see that the Ministry has significantly increased the integration of health service planning at different levels of the health sector. However, we acknowledge that the requirement to carry out regional services planning has increased communication within and between DHBs, with some improvement in relationships reported.

6.15 The detail that the Ministry's regional services planning guidance and time frames require means that DHBs might focus on complying with each of the extensive requirements rather than working with other DHBs to plan how a region will deliver services. The Ministry recognises this risk, and has increased the amount, and nature, of engagement it has with regions during the planning cycle.

Recommendation 6

We recommend that the Ministry of Health and district health boards work together to review, amend, and improve the timing and content of the Ministry's regional services planning guidance for district health boards so that the guidance is:

- provided within a time frame that enables regional services plans to inform other plans that district health boards need to prepare; and
- more in line with the intended effects of regional services planning.

Part 7
Is regional services planning delivering the intended effects?

7.1 In this Part, we discuss our findings about how well the Ministry knows whether regional services planning has been successful in delivering the intended effects.

7.2 The descriptions of the intended effects have moved somewhat over time. However, to recap, they are to secure future improvements in clinical and financial sustainability by focusing on:

- making vulnerable services more resilient;
- reductions in cost by service, compared with previous trends; and
- improving quality of patient care.

7.3 Three years on, the Ministry does not know whether regional service planning is working as intended. This is because:

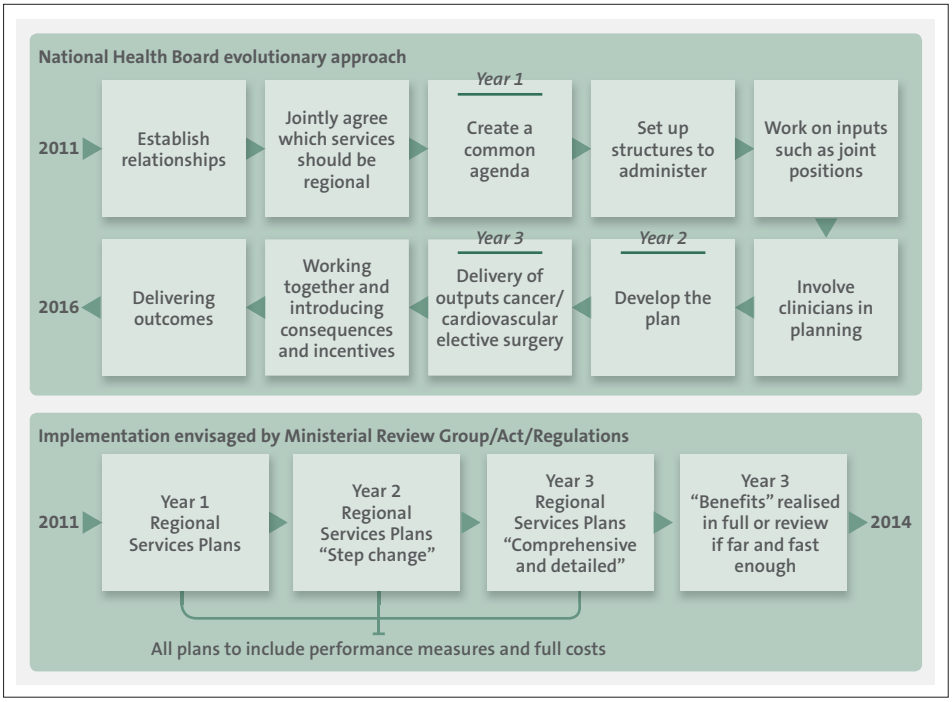
- the Ministry's evolutionary approach to regional services planning will take longer to show results;
- the Ministry did not define the desired benefits expected from regional services planning in a measurable way (either quantitatively or qualitatively), outside the back-office work;
- the Ministry does not monitor clinical and financial sustainability through regional services plans (instead, the Ministry monitors sustainability through other operational plans, activities to achieve the aims of those plans, and performance towards some national targets); and
- there is little evidence of measurable change in clinical and financial sustainability – this is partly because the first regional services plans had no baselines to compare with.

The evolutionary and regulatory approaches

7.4 The Ministry's monitoring of regional services plans has changed since 2011. However, the Ministry's monitoring remains focused on activities, rather than the intended effects or outcomes of regional services planning. This means that it is difficult to find evidence of the extent to which regional services planning is helping to improve performance in the health and disability sector.

7.5 Figure 3 shows the main steps in the evolutionary approach the Ministry has taken to putting regional services planning into effect, and compares it to the approach implied by the Review Group's report, amendments to the Act, the regulations, and the Ministry's written guidance.

Figure 3
Putting regional services planning into effect



7.6 The main difference between the approaches is the stage at which it will be possible to see measurable changes resulting from regional services planning. The evolutionary approach will see full measurement of outcomes by June 2016 in three services, whereas the regulatory approach anticipated full benefits by June 2014.

7.7 The Ministry considers that progress on regional collaboration within the first few years was in line with expectations. It considers that the Review Group's expectation of full benefits emerging in about three years was too optimistic. The NHB saw the building of relationships created during planning as being more important than the specific content of the plans. The Ministry points to creating the right foundations to support links between regions, including building capacity and capability. It took a deliberately slower path to putting regional services plans into effect in full, to ensure consistency of approach, and to secure the involvement of clinicians.

7.8 Although we do not disagree with the importance of these elements, we were looking for more objective evidence, even if that was qualitative rather than quantitative. In 2013, the Prime Minister's Chief Science Advisor stated that

"without objective evidence, the options and the implications of various policy initiatives cannot be measured".[9] He went on to say that, without objective evidence, judgement is often based on opinion or belief. He recommended planned evaluation to ensure that the desired effects of the policy are being realised, especially where complexity makes forming policy particularly challenging.

7.9 Without evaluation, we cannot say whether the Ministry's leadership is taking the health sector far or fast enough. In the remainder of this Part, we discuss the problems we had in trying to locate measurable results for the intended effects.

Vulnerable services and clinical sustainability

7.10 We expected to see evidence in regional services plans that regions were setting up sustainable solutions to strengthen vulnerable services. We expected to see that vulnerable services had been defined and identified. We then expected to see plans addressing those services. One expected outcome was that services that needed to be planned and funded nationally or regionally were identified.

7.11 DHBs are not required to use the Ministry's definition of vulnerable services. The four 2013/14 regional services plans address vulnerable services differently and have done so in each of the three rounds of regional services planning. The regional services plans for 2013/14 show some evidence that the Northern, Midland, and Central regions remain focused on clinical services that they consider vulnerable. The Midland region has a focus on information technology as a vulnerable service. The South Island region identifies the workforce in general as being vulnerable.

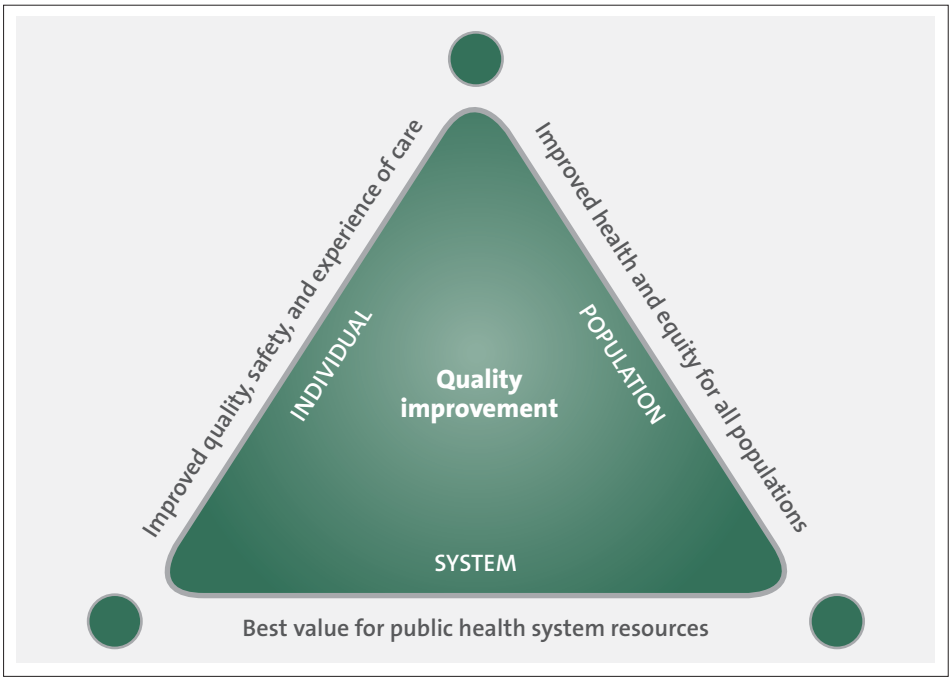
7.12 The Ministry's guidance for 2013/14 focuses on future financial and clinical viability of a safe, quality public health and disability service, rather than vulnerable services specifically. Noting that DHBs "have responded quickly to identify service vulnerabilities", the guidance mentions vulnerable services only as a subset of mental health services.

7.13 This mirrors what we found in our fieldwork and analysis of documents. The Ministry and the regions had moved on to thinking about vulnerable services as part of their "whole of system" approach to improve quality. This follows the New Zealand "Triple Aim" objectives (see Figure 4).[10]

9 Gluckman, P. (2013), *The Role of Evidence in Policy Formation and Implementation*, Office of the Prime Minister's Science Advisory Committee, available at www.pmcsa.org.nz.

10 The United States Institute for Healthcare Improvement prepared the Triple Aim Initiative framework. The Ministry of Health is a partner in the Initiative.

Figure 4
New Zealand Triple Aim Initiative objectives



Sources: United States Institute for Healthcare Improvement Triple Aim Initiative, Ministry of Health

7.14 We found some good examples of a sustained focus on a vulnerable service, such as the Central region's continued work to strengthen its Women's Health Service. However, the approach to identifying and monitoring vulnerable services was so variable that we could not verify whether the Minister's intention of strengthening vulnerable services had been met.

7.15 Where regions include a reference to vulnerable services, the Ministry will provide feedback through monitoring. However, if a regional services plan is silent on vulnerable services, the Ministry does not challenge this. We could not consistently track reduction in the vulnerability of services in the 2012/13 plans or the 2013/14 plans.

7.16 Regions told us that services become vulnerable or are no longer vulnerable for many reasons. Although we understand this comment, we would expect to see a narrative on services that have moved in or out of vulnerability. This could be in the regional services plans or a regional risk register, if more appropriate. Although we make no specific recommendation, we encourage the Ministry to consider whether it has made enough progress in identifying those services that need to be planned nationally and regionally.

The changing rate of increase in health spending

7.17 We expected to find that regions were reducing the rate of increase in costs of health and disability services, compared with previous trends. We also expected that chief financial officers would be:

- aware and have evidence of this intended effect; and
- able to identify cost-benefits from delivering services regionally.

7.18 We were not looking exclusively for absolute cost reductions, although we thought we might have seen some of this – for example, as procurement savings filtered down into service delivery.

7.19 During our fieldwork, we asked for examples of this intended effect. We were given just one example arising from a regional services planning initiative (see Figure 5). The Ministry, regional offices, and DHBs were unable to provide other examples.

Figure 5
The Northern region's First Do No Harm programme

The Northern region launched the First Do No Harm programme in December 2011. Putting this programme into effect successfully is one of the main goals of the Northern Regional Health plan. The First Do No Harm website states that there is clear evidence that certain interventions, if systematically applied, will improve patient safety, reduce costs, and save patient lives. A study carried out in 2009 of hospital discharges in Otago in 1998 found that 12.9% had adverse events. Of those, 15% were permanent or fatal and 33% were significantly avoidable. At an average cost of $13,000 for each adverse event, the cost of preventable events is estimated to be $573 million a year.

First Do No Harm focuses on reducing harm from falls and pressure injuries in hospitals and residential aged care, reducing health-care-associated infections in acute care, improving medication safety, and improving safety during case transitions. The programme is planned, funded, and delivered through the Northern DHB support agency, working with primary health care as well as DHBs and aged residential care. The agency is in turn funded by contributions from the four DHBs.

The Northern region has clear targets related to improving quality of care and "return on investment". The region has calculated that, if it met the targets for the project (reducing harm and, therefore, improving quality of care), it would see a 1% reduction in expenditure in the four Northern region DHBs, "which would result in a payback of around 250% on the $0.9 million budget in 2012/13".

Did First Do No Harm contribute to the intended effects of regional services planning?	
Plan, fund, deliver	☑
Quality of care	☑
Reduce costs	☑
Measure outcomes	☑

7.20 We saw no Ministry monitoring of changes in cost by service arising from regional services plans. DHB financial break-even is an objective (and measure) in the regional services planning guidance and is monitored through DHB annual plans. The Ministry told us that, because the starting point of DHBs for regional collaboration was so uneven, it was unrealistic to expect the first regional services plans to include a full range of quantitative measures, such as costs. However, the planning regulations required the plans to be fully costed from the start. This "implementation lag" is why we have had difficulty finding evidence that the intended effects had happened.

7.21 Some quantified savings are forecast in back-office support services, such as banking services, insurance, and information systems.[11] These flow from the work of HBL. HBL reaches agreement with each DHB on the costs and benefits expected from HBL initiatives. By July 2013, HBL was reporting achievement of $213.4 million of savings in the first three years. The reporting of savings is based on (unaudited) returns that DHBs submit to HBL. We say more on this in *Health sector: Results of the 2011/12 audits*.[12]

7.22 In addition to the HBL savings, regional shared services agencies also use joint procurement and supply to drive down costs. Examples include joint purchasing of expensive radiology and information technology systems and equipment.

7.23 The Ministry and DHBs gave us the following main reasons for the lack of information on costs in health and disability services in regional services plans:

- It is difficult to attribute changes in costs to any one thing, including regional services planning.
- It is too early to see cost savings from regional services plans.
- It is too difficult to get the data from information systems.
- Costs are increasing as more interventions take place.
- Although costs are actually increasing, productivity or throughput is increasing for the same resources (the Ministry and the DHBs did not provide any evidence of increasing productivity).

Improving patient care

7.24 We expected to see evidence of improvements in the quality of care that could be attributed to regional services planning. As quality can be interpreted differently, we looked specifically at improvements in timeliness and equity of access. We use equity of access to describe how people are able to access services, irrespective of where they live in the region. We did not audit clinical safety because the

11 We say more about how HBL has set up collective insurance arrangements in our June 2013 report, *Insuring public assets,* available at www.oag.govt.nz.

12 Controller and Auditor-General (2013), *Health sector: Results of the 2011/12 audits*, available at www.oag.govt.nz.

work of the Health Quality and Safety Commission was outside the scope of our performance audit. The Health Quality and Safety Commission works with the health sector, with the overriding aim of reducing preventable harm to patients and service users.

7.25 On timeliness, we looked for quantitative evidence of performance improvement from one year to the next. For example, we looked for increases in numbers or percentages of patients receiving timely, high-quality treatment. We did find some examples of changed targets in initiatives that had been running for some years (in workstreams such as cancer services, cardiac services, and stroke services). For example, the Northern region action plan for cardiovascular disease set a target of 90% of outpatient coronary angiograms to be seen within three months in 2013/14. This was up 5% on the previous year's achievement. However, we saw few measures outside well-established workstreams.

7.26 On equity of access, we found few examples of initiatives outside the cancer services workstream. For instance, we saw little evidence of new regional clinical protocols that would increase equity of access to care.

7.27 Where improvements were being achieved, they were often the result of other nationally led initiatives, many of which had further funding attached, such as:

- the Better, Sooner, More Convenient policy aimed at treating people more quickly and closer to home – this includes integrated health centres, intended to provide a full range of services, including specialist assessments by general practitioners, minor surgery, walk-in access, chronic care, increased nursing, and selected social services;
- targets to increase the number of elective operations, with financial incentives for those DHBs that meet them;
- further resources for older people, specifically for dementia;
- Better Public Services initiatives, particularly for vulnerable children; and
- the Maternity Quality Initiative.

7.28 This is not an exhaustive list, but gives a flavour of the complicated policy landscape within health and disability services. This reflects the Review Group's observation that "funding for new national initiatives also tends to be 'layered' on top of existing DHB activity". It also shows that there are few, direct incentives linked to regional services planning.

7.29 We tested our findings about equity of access with staff from regional offices, the Ministry, and DHB senior managers. Almost all said that it was too early to see evidence of regional services planning having a positive effect on quality of care.

7.30 We heard a lot about work in progress, particularly on information technology systems, that would help to speed up access to services, and between points in the health and disability system. These included:

- GP2GP file transfer – so that medical records move swiftly between general practices if a patient changes their general practitioner (about 820 general practices are using this technology);
- maternity clinical information system – due to be phased in towards the end of 2013;
- patient portals, due by 2014, which enable patients, as well as those involved in their care, to see their medical records; and
- the national shared-care planning programme.

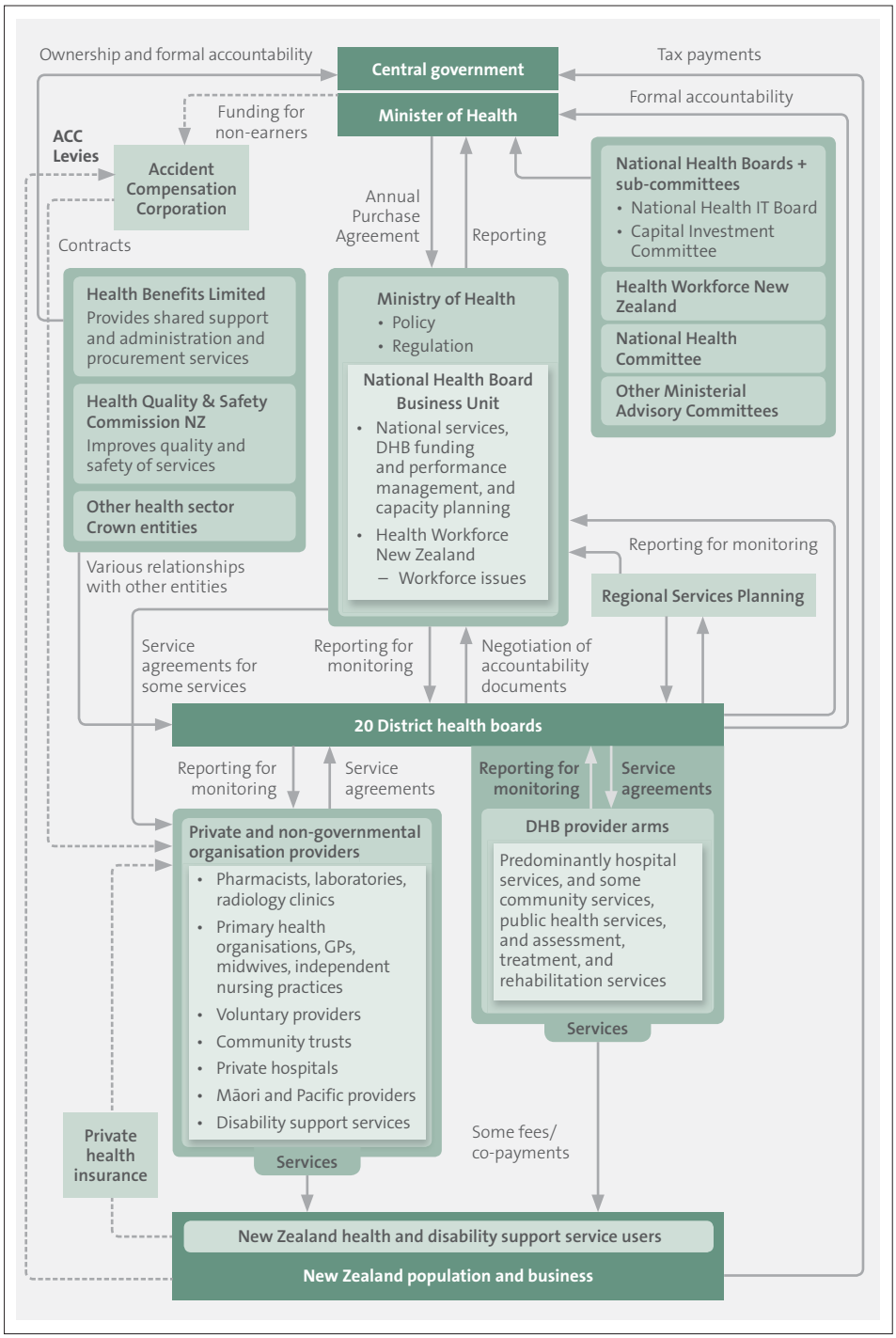
7.31 Many of these initiatives are relatively new or not put into effect fully. A recent evaluation found that the national shared-care planning programme had been slow to take off. The evaluation highlighted factors beyond the information technology systems, such as workforce development, getting appropriate funding, and understanding the patient's point of view. However, some clear benefits are possible, and some earlier changes, such as making referrals electronically, are becoming well established.

7.32 Regions had some good ideas about how improvements in performance could be recorded more systematically for a range of initiatives and plans. Clinical leadership of networks is starting to lead to a more evidenced-based approach to auditing for improved outcomes. A common comment from many senior staff was that they would like the plans to evolve to have a longer-term view with fewer mandatory priorities. We consider that this is a good time for the Ministry and the regions to consider how they can show progress. In 2016, we will return to the topic of regional services planning.

Recommendation 7

We recommend that the Ministry of Health and district health boards work together to prepare an evaluation framework and use it to work out whether regional services planning is having the intended effects.

Appendix
Structure of the health sector



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