DISABILITY SUPPORT ADVISORY COMMITTEE

and

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

A G E N D A

Wednesday, 7 May 2014
10.00 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, 7 May 2014, 10.00 am

Community Services Building, Southland Hospital, Invercargill

A G E N D A

Closed Session:

RESOLUTION:
That the Disability Support Advisory Committee and Community & Public Health Advisory Committees move into committee to consider the agenda items listed below.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 34, Schedule 4 of the NZ Public Health and Disability Act 2000 for the passing of this resolution are as follows:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(i), 9(2)(j) and 9(2)(f)(iv) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations, and to maintain the constitutional convention protecting the confidentiality of advice tendered by Ministers of the Crown and officials.
2. Wakatipu Reference Group Update	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, section 9(2)(j).
3. Paid Family Carer Policy	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(j).
4. Orthotics Contract	To allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) 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.
Tim WARD (Deputy Chair)	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.
John CHAMBERS	09.12.2013	1. Employee Southern DHB and Vice President of ASMS (Otago Branch) 2. Employed 0.05 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.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
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. Is also a founding member of the Whānau Ora commissioning agency, Te Putahitanga o Te Waipounamu, established March 2014.
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) 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. **Daughter:** 3. Registrar, Dunedin Hospital.	1. Possible conflict with PHO contract funding. 2. Possible conflict with contract funding.
Tuari POTIKI	09.12.2013	1. University of Otago staff member. 2. Deputy Chair, Te Rūnaka o Ōtākou. 3. Chair, NZ Drug Foundation.	1. Possible Conflicts between Southern DHB and University interests. 2. Possible conflict with contract funding. 3. Nil.
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.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Richard THOMSON	13.12.2001 23.09.2003 29.03.2010 06.04.2011 21.11.2013 & 03.04.2014	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. Three immediate family members are employees of Dunedin Hospital (Radiographer and Anaesthetic Technician).	1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it. 2. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB. 3. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations. 4. May have some stores that deal with Southern DHB.
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 April 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 26.08.2013	1. Te Waipounamu Delegate, Te Piringa, National Māori Disability Advisory Group. 2. Chairman, Te Herenga Hauora (Regional Māori Health Managers' Forum). 3. Member, Southern Cancer Network Steering Group. 4. Board member, Te Rau Matatini. 5. Te Waipounamu Māori Cancer Leadership Group	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.
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.

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.
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 16.04.2014	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel. 3. Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	1. Southland Hospital Trust. 2. Nil. 3. 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 Wednesday, 5 March 2014, commencing at 9.00 am, in the Board Room, Southland Hospital Campus, Invercargill

Present:	Ms Sandra Cook	Chair
	Mrs Kaye Crowther	
	Dr Branko Sijnja	
	Mr Tim Ward	
In Attendance:	Mr Joe Butterfield	Board Chair (from 11.00 am)
	Dr John Chambers	Board Member
	Mrs Mary Gamble	Board Member
	Mr Tony Hill	Board Member
	Mr Tuari Potiki	Board Member
	Mr Richard Thomson	Board Member
	Dr Jan White	Crown Monitor
	Mrs Sandra Boardman	Executive Director, Planning & Funding
	Mr Peter Beirne	Executive Director Finance
	Ms Carole Heatly	Chief Executive Officer
	Mrs Lexie O'Shea	Deputy CEO/Executive Director Patient Services
	Mr Donovan Clarke	Executive Director Māori Health/Kaiwhakahaere Hauora Māori
	Mr Ian Macara	Chief Executive, Southern PHO (until 10.55 am)
	Dr Keith Reid	Medical Officer of Health, Public Health South (by videoconference until 10.55 am)
	Mr David Tulloch	Chief Medical Officer
	Ms Jeanette Kloosterman	Board Secretary (by videoconference)

1.0 WELCOME

The Chairperson welcomed everyone to the meeting.

2.0 APOLOGIES

Apologies were received from Messrs Neville Cook and Stuart Heal.

3.0 MEMBERS' DECLARATION OF INTEREST

Mr Richard Thomson informed the Committees that he was the Dunedin City Council representative on the South Dunedin Social Sector Trial.

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 4 February 2014 be approved and adopted as a true and correct record."

5.0 MATTERS ARISING

Rural Funding Mechanism for General Practices

The Executive Director Planning & Funding reported that the information provided to the previous meeting which inferred that Queenstown General Practices did not meet the new criteria for rural funding was incorrect. There were 15 practices that did not meet the criteria but none were from Southern DHB. A mistaken assumption was made based on modelling done by the collective DHBs in the previous year.

6.0 ACTION SHEET

The Committees reviewed the action sheet (agenda item 5) and requested timelines and more progressive action on pharmaceutical expenditure.

7.0 PLANNING & FUNDING REPORT

The Executive Director Planning & Funding presented the monthly report on Planning and Funding activities (agenda item 6), then took questions from members

The committees requested:

- A progress report on InterRAI, and
- Further information on the Clinical Laboratory Advisory Group for new lab tests.

8.0 SOUTHERN HEALTH ALLIANCE

The Committees considered a report from Prof Robin Gauld, Independent Chair of the Southern Health Alliance Leadership Team (SHALT), on SHALT activities and progress to date (agenda item 7) and:

- Indicated that they would like to see timelines and major KPIs included in future reports;

- Suggested that continuity of care and patient pathways should also be a focus of the acute demand work programme.

9.0 PUBLIC HEALTH

Dr Keith Reid, Medical Officer of Health, presented a report on Public Health South activity (agenda item 8), then took questions from members.

10.0 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.

Members expressed concern that some primary care health targets were not being met. Mr Macara advised that models of care and workforce development would be important for the future.

11.0 WORK PLAN

The Committees reviewed the draft DSAC/CPHAC work plan for 2014 (agenda item 10).

The Committees were informed that the Work Plan should be viewed alongside the reporting framework. Full reports on issues such as the Children's Action Plan would be submitted annually but progress would be included in the reporting framework.

12.0 TERMS OF REFERENCE

The Committees reviewed the terms of reference for the Disability Support Advisory Committee and Community & Public Health Advisory Committee (agenda item 11).

It was resolved:

"That the Committees recommend the Board approve the terms of reference, subject to the following further modifications:

- **That a minimum of eight meetings per year be held;**
- **That item 8 of the Community & Public Health Advisory Committees' responsibilities be amended to read, "Providing advice, *in collaboration with the Iwi Governance Committee*, on strategies to reduce disparities …"**

13.0 FINANCIAL REPORT

The Executive Director Finance presented the Funder Financial Report for the period ended 31 January 2014 (agenda item 12), then took questions from members.

14.0 SOUTHERN DISTRICT HEALTH PROFILE

Dr Pim Allen, Programme Director, Southern Strategic Health Services Plan, joined the meeting to present the health profile of people living in the Southern DHB area (agenda item 13), which would be used as a basis for strategy development and service planning. Dr Allen advised it was a dynamic document that would be updated as more information became available.

It was resolved:

"That the Committees recommend the Board ratify the Southern District Health Profile for DHB use."

15.0 INFORMATION ITEM

A report from the Controller and Auditor-General on *Regional services planning in the health sector* was circulated with the agenda for members' information (item 14) and was taken as read.

CONFIDENTIAL SESSION

At 10.45 am it was resolved that the public be excluded for the following agenda items.

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
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 and Government endorsement	As above, sections 9(2)(f)(iv) and 9(2)(j).

The meeting closed at 12.45 pm.

Confirmed as a correct record:

Chairperson ……

Date ……

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

ACTION SHEET

As at 23 April 2014

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
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.	
Nov 13 Feb 14 Mar 14	**Pharmaceutical Expenditure**	Comparative DHB drug costs to be defined per head of population in future reporting. Report to be submitted to March meeting. Timelines and more progressive action requested.	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. An Agreement with Bpac has been reached 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

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Mar 14	**Planning & Funding Report** ▪ **InterRaI** ▪ **Clinical Laboratory Advisory Group**	Progress report to be submitted on InterRAI. Further information to be provided on the CLAG for new lab tests	EDP&F	Please see the Planning & Funding Team Report. The first CLAG meeting is to be held 7th April to discuss SDHB medical laboratory diagnostic services in general but also to review the introduction of new tests. This is a process to ensure applications for new tests are clinically appropriate and add value to diagnostic testing.	Completed.
Mar 14	**Southern Health Alliance**	▪ Request timelines and major KPIs for future reports; ▪ Suggest that continuity of care and patient pathways be a focus of the acute demand work programme.	EDP&F	Noted.	Ongoing

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Planning and Funding Report**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	7 May 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:** 23 April 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: InterRai

- The Southern District Health Board's first InterRai Home-Care Assessment training session was conducted on the 24th day of May 2011**.**

- All Southern District Clinical Needs Assessors (CNAs) (Waitaki, Dunedin, Clutha, Gore, Invercargill, Queenstown, Central Otago) have completed training in the use of the InterRAI (Home Care Assessment (HC), Contact Assessment (CA) and Long Term Care Facility (LTCF)) tools. CNAs assess all complex Health of Older People clients.

- Home and Community Support Service (HCSS) Alliance Providers' (Access Homehealth, Health Care of NZ and Royal District Nursing Service NZ) Registered Health Professionals (RHPs) are trained in InterRAI CA (Contact Assessment) and are assessing all non-complex Health of Older People (HOP) clients

- It is envisaged that **by 30/06/2014, the Southern District Health Board will meet the Ministry of Health (PP18) target of 95%** of older people receiving long-term home support have a comprehensive clinical assessment and an individual care plan. 2013/2014 Quarter 2 result was **80.9%.** Quarter 3 results are not available.

- By 30 June 2014, all Aged Residential Care (ARC) facilities will be engaged in InterRAI training. All 66 Aged Related Residential Care facilities in Southern DHB have engaged in training in the InterRAI Long Term Care Facility (LTCF) tool. Currently, eight facilities are fully competent using InterRAI LTCF; 29 more facilities have at least one Registered Nurse who is InterRAI LTCF competent.

Mental Health, Addiction & Intellectual Disability Portfolio

Raise HOPE – Hapai te Tumanako

Raise HOPE – Hapai te Tumanako Implementation Advisory Group (IAG) is working with Planning and Funding to develop:

- a district wide network model for the sector and
- an Implementation Plan for Raise HOPE – Hapai te Tumanako

A draft Terms of Reference (ToR) for a proposed network model is in development and will be circulated to the MH & A sector in mid-April. Sector workshops arranged during May will provide opportunity for feedback and further development of the Network model. The final ToR, including network membership, will be confirmed by June 30.

The Implementation Plan is being developed and Planning and Funding will be engaging with all stakeholders to discuss the draft in early June. The plan is scheduled to be completed by 30 June 2014.

Public and Population Health Portfolio

Child and Youth Steering Group

The Child and Youth Steering Group met on 27 March 2014. Items of interest from this meeting include:

Healthy Families

- Invercargill has been selected as one of ten Healthy Families Communities (HFNZ) to be established in New Zealand.
- Healthy Families is a new Government initiative that aims to bring together leadership, information and resources to help people make healthier choices for themselves and their families.
- HFNZ is based on an Australian model and will support local leaders to implement voluntary initiatives that encourage families to live healthy, active lives. HFNZ involves investment in community partnerships and a skilled health promotion workforce.
- The Ministry of Health released a Registration of Interest (ROI) process in March 2014, in order to identify and short list organisations who could act as local lead providers for the implementation of HFNA in the selected communities.
- Public Health South is calling meeting in Invercargill on 2 April to engage the community in responding to the ROI.

Before Schools Checks (B4SC)

- Population Health Services delivered a presentation on B4SC. The B4SC programme is on target in Southern DHB. The service has a heightened focus on reaching children in the highest deprivation areas (quintile 4 and 5), as well as all Maori and Pacific children. The large population growth in Maori children in Southland was noted.
- The Ministry of Health produces monthly reports on the B4SC (previously submitted to CPHAC), as well as occasional Quality Improvement letters. The MoH is also in frequent contact through regular teleconferences with Planning and Funding and also with B4SC coordinators. B4Schools Clinical Advisory Groups in Otago and Southland provide clinical paediatric advice as required.

Well Child Tamariki Ora Quality Improvement Framework (WCQIF)

- The MoH Advisory Group acknowledged the work that went into developing the draft WCTO Quality Improvement Framework Implementation Plans, which were submitted in February 2014. The Advisory Group was supportive of the MoH approach of sharing good practice examples. There was no significant individual feedback to DHBs as the Advisory Group recognised the plans reflected local readiness and priorities. The Advisory Group is looking for those DHBs whose plans are in early stages of development to build on what other DHBs have done, and they have asked DHBs working on the same indicators to get in touch and share strategies.

Well Child Tamariki Ora (WCTO) Forum

- Planning and Funding convened a meeting of the WCTO forum on 18 March 2014.

- The purpose of the Forum is to provide a mechanism for discussion for all Well Child Tamariki Ora Providers, to facilitate communication and collaboration and to support implementation of the WCTO Quality Improvement Framework.
- The SDHB Midwifery Director presented an overview of the Maternity Quality Safety Programme.

Rheumatic Fever (RF)

The South Island has a much lower incidence of Rheumatic Fever than the rest of New Zealand. Over the three years from 1 July 2009 to 30 June 2012, the South Island's rate of initial hospitalisation for Rheumatic Fever was 0.4 per 100,000 people, compared with 4.0 per 100,000 for the whole of New Zealand.

As at 23 September 2013, there was an estimated 5 RF patients requiring prophylactic antibiotics for Rheumatic Fever in the Southern District. Southern DHB is in the process of rolling out the Health Pathways platform. When completed, this will act as the definitive source of up to date local advice on the management of conditions of public health importance, including the management of sore throats in high-risk children. For those requiring prophylactic antibiotics, care packages are created on a case by case basis to ensure that each patient has access to regular antibiotic cover and appropriate support.

Since the South Island has a low incidence of first attack acute Rheumatic Fever, South Island DHBs are expected to plan at a regional level rather than developing individual DHB plans. South Island Medical Officers of Health will facilitate implementation of the recently developed South Island RF Prevention and Management Plan. A business case has been developed and will be submitted to the SPaIT and the South Island Alliance Leadership Team in late April for 1) their endorsement of the SI Rheumatic Fever Prevention and Management Plan and 2) associated indicative patient costs.

Primary and Community Portfolio

LABORATORY SERVICES

Clinical Laboratory Advisory Group

The process to identify new tests which were not listed within the original laboratory contract (2006), and subsequent approval granted if they are deemed to be clinically appropriate, has now been completed. The list of approved tests will be discussed at the newly established Clinical Laboratory Advisory Group meeting in April.

The Clinical laboratory Advisory Group (CLAG) has now been established and 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 consultation paper has been sent out to Community Pharmacy for informal consultation. Feedback has now been received and is under consideration by DHB Shared Services Pharmacy Group. The paper with proposed service and funding models 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.

Once a decision has been made on a final service and funding model going forward a formal consultation process with stakeholders will commence in May 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.

PRIMARY CARE

More Heart and Diabetic Checks

SDHB is working with SPHO to increase the number of Cardiovascular Risk Assessments (CVDRA) with a target of 90% of eligible people within five years to have their CVDRAs completed by June 2014. SPHO has received additional funding and in the process of hiring additional resource to achieve the increased volumes. They are also introducing a new Information Software System to improve data accuracy and completeness.

Southern Health Alliance Leadership Team (SHALT)

SHALT met on 15 April and on the recommendations of primary and hospital clinicians agreed to prioritise two pieces of work prior to the start of winter:

- Respiratory - primarily focussed on developing model/s of care that integrates health and support services both within the hospital and community setting for people experiencing exacerbations of respiratory conditions. The aim being to reduce repeated unnecessary admissions to hospital for respiratory conditions.

- Frail elderly - primarily focussed on developing model/s of care that integrates health and support services both across the hospital and community settings for the older person (>65). The aim being to maintain optimal health/well being in the community and prevent inappropriate admission to hospital from home or rest homes.

The agreed process to complete each priority is through a one day facilitated Rapid Improvement Process (RIP) workshop. During the workshop, participants will map current processes and models of care and identify ideal future solutions using Lean methodology. Membership and draft terms of reference were agreed by SHALT and the RIP workshops booked for early May. Following the workshops draft proposals will be circulated to the wider sector for feedback. Feedback will be collated and final proposals recommended to SHALT in June, this will allow implementation of new models of care to begin in early winter.

The approach taken to this work is a new way of working for SHALT and aims to deliver rapid integration and improvements to patient care.

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:	7 May 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:** 04 April 2014	**Presented by:** Sandra Boardman Executive Director Planning & Funding

RECOMMENDATIONS:

That CPHAC / DSAC:

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.

Communication

Presentations by representatives of SHALT at the Grand Rounds at both Dunedin and Southland Hospital sites occurred on March 12 and 14 respectively. This provided a forum to engage with staff highlighting the role of SHALT, its goals and how staff could be involved.
This will be further supported with a more detailed planned communication strategy to be implemented over the coming months with the next stage being a website presence.

Integrated Performance Incentive Framework (IPIF)
The Integrated Performance Incentive Framework (IPIF), (an evolution of the PHO Performance Programme) is due to be implemented July 2014. At this time the final IPIF measures are still to be confirmed by the Ministry. SHALT will carry the responsibility for certain aspects of the implementation of the framework, particularly in relation to multi-provider care pathways.
It is currently recommended that the local components of the framework be governed by the district level alliances and as such the local elements will therefore be clinically led and agreed with a range of professional and community perspectives at the table.

Once the IPIF is confirmed, activities and measures as a result of this framework will be developed and incorporated into SHALT activity.

Service Level Alliance Teams (SLATS)

Community and Hospital Pharmaceuticals:

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

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 phase of activity is the Demand Side Management of Pharmaceutical Expenditure project. The initial task is to undertake a detailed analysis of both the data and the environment in which prescribing occurs within SDHB.
A Project Team has been established and the first set of data is anticipated to be available late April 2014. Data can then be analysed to develop specific objectives for

the programme. Objectives will be selected on the basis of there being sound evidence for the effectiveness of the alternative approach, feasibility of affecting change and potential to improve quality and realize savings in expenditure.

Rural Health:

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 is focusing on Rural Funding as the priority area with a plan to be in place July 2014. Draft Terms of reference are in the process of being finalised ready for approval by SHALT with the next step then being the appointment of members to the work stream group. It is anticipated that this will be in place late April 2014 in order to meet the 1 July 2014 deadline.

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

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

Initial activity is centred on the Community Enablers work stream.
The Community Enablers workstream is primarily focussed on developing a model/s of care that integrates health and support services both within the hospital and community setting for the older person (<65).

The first phase of activity has been to review and develop the potential for a Supported Discharge Service at the Southland Hospital site. Final data requirements and analysis is now underway to ensure that the correct solution and measurements will be in place. It is expected that a pilot of the proposed service will be implemented May 2014. Alongside this, preliminary work is commencing with St Johns to identify potential pathways to support acute demand management within the community setting for a selected group of patients and/or conditions.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**PUBLIC HEALTH SERVICE REPORT**
Report to:	Community & Public Health Advisory Committee
Date of Meeting:	7 May 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:** dd/mm/yy
Approved by Chief Executive Officer:	No	**Date:** dd/mm/yy

Prepared by: Lynette Finnie **Date:** 9/04/14	**Presented by:** Dr Keith Reid

RECOMMENDATIONS:

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

PUBLIC HEALTH SERVICE REPORT TO THE SOUTHERN DHB COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE 7 May 2014

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

Settings and Lifestyles

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

Primary Care Smokefree Coordination
The second WERO stop smoking competition started on 1 March with six teams competing across the southern region. In support of WERO the Southern PHO is funding the costs of participants seeing their GP for support of up to $35 per consult.

Quitcard training has been held across the district with 23 practitioners from health, education and NGOs completing the training. The training was delivered by the Southern District Health Board on behalf of the Heart Foundation. As a result of this training these people can now offer support to stop smoking to colleagues, clients, and customers, thus supporting and contributing to the achievement of the goal of a smokefree New Zealand by 2025.

Secondary Care Smokefree Coordination
Staff are currently preparing a plan to reduce their input into the secondary care target as the Ministry of Health has asked that this resource be directed to Primary Care. Staff are working with the wider Southern DHB staff to implement the changes that do need to occur. Currently we are tracking to be on target for the end of the quarter with some post-discharge follow up.

Smoking Affects Lives Pasifika Poster Series
Public Health South worked with the Pacific Trust Otago and the Samoan Advisory Council to create a Smoking Affects Lives Pasifika poster series. The posters portrayed 12 people of Pacific ethnicity based in Otago who each shared their personal story. The project was developed to increase quit attempts and lower smoking initiation rates, by having role models from the Pacific community to share their personal experiences in their Smokefree journey. Their stories reflect a variety of experiences – the reasons why individuals decided to quit smoking and their struggles and triumphs along the way, and the motivation for others to be Smokefree their entire life. The poster series will be promoted throughout the community.

Communicable Disease and Food Safety

Outcome 4 Reduce the impact and incidence of communicable disease

Southern DHB is Measles Free
Several countries around the world are currently experiencing measles outbreaks, including the Philippines, Australia, Europe, UK, Africa, Asia, India and North America. As of 2 April 2014, there have been 118 confirmed cases of measles in New Zealand since December

2013, most of which have been linked to international travel. All of the recent New Zealand cases have occurred in the North Island – 97 in Auckland, 15 in Bay of Plenty Lakes, four in Wellington, and two in Hawke's Bay. Of these cases, 19 have required hospital treatment; including one case with encephalitis.

Since December 2013, Public Health South has followed up several passengers who were on flights with a confirmed measles case, none of whom have subsequently become unwell. We have also investigated five individual cases of suspected measles in children, but laboratory testing did not confirm measles infection.

Measles is highly infectious, and one of the cornerstones of outbreak control is to isolate known cases and exposed non-immune contacts until they are past their infectious period. Because laboratory confirmation can take several days, doctors must notify Public Health South of all potential measles cases on suspicion, so that public health action can start without delay.

Immunisation is the best defence against measles. To be fully protected, two doses of the MMR vaccine are recommended, and are available free to any non-immune individuals. The MMR vaccine is not recommended for infants under 6 months of age or during pregnancy, but is safe to give to breastfeeding mothers. Those considered to be immune to measles include people:

- who have had confirmed measles in the past
- born before 1969 (this population is assumed to have had measles)
- who have received two doses of the MMR vaccine.

To prevent measles epidemics, 90% of the population needs to have immunity.

2014 Influenza Season

Influenza is a viral illness which circulates within the community year round. Seasonal peaks of illness occur each year in the winter months lasting for about 8 – 10 weeks or so. During a typical influenza season around 40,000 people will suffer from an influenza-like illness and around 400 deaths will occur as a result of influenza infection or its complications. This additional disease burden occurs at a time when healthcare services are already under pressure due to an increased number of acute presentations. Vaccination remains the mainstay of preventative approaches to reducing the impact of influenza in our communities. The 2014 influenza vaccination was made available in late February. Criteria for eligibility are similar to previous years: they include the over 65s; pregnant women; those suffering from a chronic condition (which includes respiratory, cardiac, and renal conditions, diabetes, and other conditions predisposing to complications), those under five with severe asthma. A number of employers offer occupational programmes to enable their staff to access influenza vaccination. Vaccination is also available, but not funded, to the general population through general practices and some retail pharmacists. The vaccine for 2014 season has been produced to comply with the WHO expert advisory recommendations. The influenza vaccine for the New Zealand/Australian 2014 influenza season contains the following three virus strains:

- A/California/7/2009 (H1N1)-like virus
- A/Texas/50/2012 (H3N2)-like virus
- B/Massachusetts/2/2012-like virus

Last year's influenza season showed a very low level of influenza-like illness across the country as a whole. The predominant strain in NZ was similar to that which caused elevated levels of morbidity and mortality in the elderly population in North America. However, a similar pattern of illness was not seen in New Zealand.

Influenza surveillance will be undertaken along similar lines as in previous seasons. This involves viral sampling undertaken on a selection of patients across seven practices in the Southern district. Practices are chosen to provide appropriate population and geographical cover. Surveillance will commence on 28 April and is scheduled to end on 28 September. Last year surveillance was extended because of the unusual pattern of disease and a late increase in numbers of patients presenting with influenza-like illnesses.

Last year saw a significant increase in the number of doses distributed to the population across New Zealand with 30% of the population receiving a vaccine. In Southern District this amounted to 83620 vaccinations, representing 28% of the population. Additionally, the uptake of vaccination among healthcare workers in Southern DHB was over 53% (58% for New Zealand as a whole, range 36 – 77%). This was the first year that a majority of health board staff received vaccination. However, within that overall figure are significant variations in uptake by staff group.

Uptake of vaccine amongst staff this year has not been at the same rate as last year. A verbal update on the current staff coverage will be given to the meeting.

Healthy Environments

Outcome 5 Promote safe and healthy social and physical environments

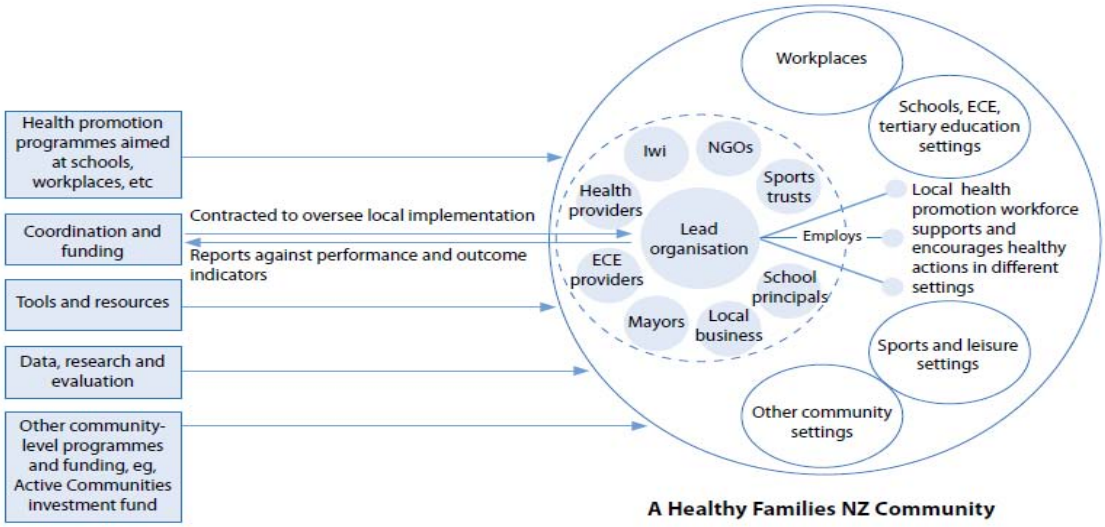
Healthy Families

The Healthy Families initiative was announced on 14 March 2014 by way of a press release from the Minister of Health. The Government acknowledged that programmes for individuals can be useful, but the benefits are often short term. To achieve sustained reductions in growth of preventable diseases, and to create lasting improvements in the health and wellbeing of people and communities, we need to not only promote healthier lifestyles but also improve the environments where people live, learn, work and play. The approach is consistent with the Health in All Policies that has been advocated for some years by Southern DHB's Public Health Service.

A number of locations have been selected for Healthy Families implementation in New Zealand. In the southern district Invercargill City has been selected as a site for the roll-out of the programme. Invercargill and the other nine sites in New Zealand selected for the programme have been selected on the basis of higher-than-average rates of preventable chronic diseases (such as diabetes), higher-than-average rates of risk factors for these diseases (such as smoking), and/or high levels of deprivation. It should also be noted that locations supported Social Sector Trails have been excluded from the selection process.

Implementation of Healthy Families is by way of a Registration of Interest (ROI) process that commenced on 14 March. Prospective providers are expected to employ a Health Promotion

workforce who will be working to promote Healthy Lifestyle issues in a number of settings:



District Health Board Public Health Service providers are recognised as key stakeholders in the process, but they are not encouraged to lead the ROI process.

The Public Health Service has been active in Invercargill in trying to get good engagement between local organisations with an interest in Healthy Families. A community meeting was held on 2 April at the Invercargill Public library. There was good participation from a number of stakeholder organisations including local Runaka, Maori Health Providers, Pacific Providers, Sport Southland, Barnardos, and a range of other Non-Government services in operation in Southland.

Public Health will continue to work to promote a transparent inclusive process that serves to engage as wide a cross-section of the community as is possible in the ethos of Healthy Families.

Dunedin Cosy Homes Steering Group

Poor housing conditions are associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and mental health. Addressing housing issues offers public health practitioners an opportunity to address an important social determinant of health. Public health has long been involved in housing issues[1].

The Dunedin Cosy Homes Steering Group has grown out of a desire from individuals, groups and organisations to pool resources and work together more effectively to render houses in Dunedin healthy. Dunedin is characterised by a significant stock of older housing that was constructed at a time when there was limited understanding of the health impacts of cold housing.

The key outcome from the inaugural cosy homes workshop in September 2013 was a leadership team/steering group with a mandate to ensure all homes in Dunedin were warm and cosy by 2025.

To date the group has developed a clear strategic direction; scoped potential governance models (and Governors) and drafted its Terms of Reference. The Public Health Service is a member of this group and has worked with key stakeholders to facilitate the establishment of

[1] James Krieger, MD, MPH and Donna L. Higgins, PhD; Am J Public Health. 2002 May; 92(5): 758–768; Housing and Health: Time Again for Public Health Action

the broader Governance group that will be supported by a steering group that will function as its advisory/operational arm. The Governance Group is only just being established. Health representation on it will include the Medical Officer of Health and the Chief Executive of Southern Primary Health Organisation. Other organisational interests include Social Service NGO's, the Dunedin City Council, Kai Tahu representation, Otago University, Private Sector Landlord representation, the Energy Efficiency and Conservation Authority (ECCA) and Community Trusts.

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

RECOMMENDATION:

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

1. STRATEGIC MATTERS

1. CONTRACTED PROVIDER AGREEMENT [CPA) - CONTRACT BETWEEN SPHO AND GENERAL PRACTICES.

The CPA *(formerly known as the Back-to-Back Agreement: B2B)* – final draft was concluded between SPHO lawyer Fraser Goldsmith, SPHO and South Link Health (via Conway Powell representing the Independent Practitioners Association as representative for many general practices) and circulated to all 87 providers for their review and feedback. A small number of responses were received by the cut-off date 31 March 13.

The finalised CPA will be circulated to each contracted provider the week commencing 7 Apr 14 for signature by the practice owner/s and SPHO.

2. INTERGRATED PERFORMANCE AND INCENTIVE FRAMEWORK (IPIF)

Legislation was passed by parliament on Monday 31 March 14 giving effect to the IPIF, which will be introduced under PHO/DHB Alliances in 2014, once the final policy protocols and business rules are agreed under the Ministry of Health's responsibility. Implementation is to commence on 1 July 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.

3. AFTER-HOURS AND UNDER 6s

Invercargill: A further meeting was held in Invercargill on 31 May 14. Attendees were: Cathy O'Malley (Deputy Director General of Health, MoH), Carole Heatly, David Tulloch, Lexie O'Shea, Sandra Boardman and Dr Jim Reid (SDHB), Dr Kevin Tyree (Chair) and Dr Marius Hill (both Invercargill Urgent Doctor Service [IUDS] Executive and Trustees), Dr Nic Terpstra (Invercargill GP), Prof Murray Tilyard (representing SHSL – the owner or part-owner of 7 Invercargill practices) and Ian Macara SPHO.

There was full discussion on potential options for the re-direction and management of 'primary' patients presenting at Southland Hospital ED, including for 'after-hours' times for general practice.

The service options to be explored further are:

1) An A&M (Accident and Medical) service provided from the new build development by the private provider South Link Health Services - the organisation that is owner or part owner of seven Invercargill general practices
2) Co-location at Southland Hospital

Ian Macara is preparing a briefing paper for the Invercargill Urgent Doctor Service Executive, in the first instance. Once discussion is completed between IUDS, SDHB Planning and Funding and SPHO, circulation will be to the wider Invercargill general practitioner community for their consideration and decision on an option that they could support.

Carole Heatly reaffirmed to the meeting that SDHB was committed to working constructively and supportively in partnership with GPs, IUDS and SPHO to achieve a sustainable solution.

Central Otago: Two key workstreams are underway:

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

ii) The two Wanaka general practices have commenced the Pilot project for the period 1 Apr – 30 Jun 2014. This is a GP-led after-hours service for the Wanaka region. The pilot will determine the outcomes achieved and issues, including data on the model of care and service sustainability into the future. Learnings from the pilot will be able to inform opportunities for the model elsewhere in our region.

iii) Confirmed wording is still 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.

4. 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. 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, via the Ministry of Health.

2. OPERATIONAL AND PROGRAMMES UPDATE

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

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

  - The January – March 2014 quarter reports are expected on 20th April 14.

  - SPHO staff have a focussed Achievement plan under action, with activity including working intensively with practices, and providing dedicated clinical resource in practices, to achieve the targets.

  - There is also a specific workplan under action to achieve 'High Needs' patient targets

  - Installation of Dr Info software into practices will enhance SPHO and Practices' Health Target Achievement Plan. Dr Info allows real time measurement of the performance of a Practice by providing accurate reporting of where a practices population health metric is for the specific Health Target indicators

3. SPHO FINANCIAL POSITION

SPHOs financial position remains strong report for the period ending 28 February 2014.

Month surplus:	$104,299
YTD surplus:	$1,237,341
YTD Equity:	$2,066,856

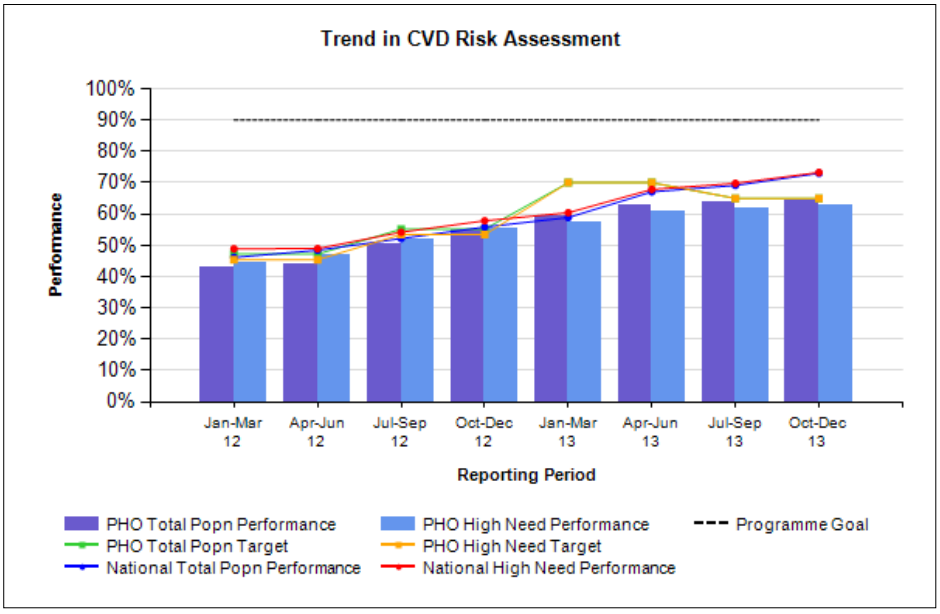
Please note: within the YTD Surplus and Equity values as at 28 Feb 14, SPHO has funding of $1,282,428 committed under contract to various providers for primary care health services delivery, programmes and initiatives into out-years. Therefore Net Equity is $784,428 ($2,066,856 - $1,282,428); this is slightly under SPHO Board Policy of Equity to equal two months working capital of $800,000.

Health Target Reporting – February, 2014

Priority Area	Key Performance Indicator	Activity	Progress against activity Feb14
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	• Dashboard reports for the period to 31/12/13 sent to all practices. • Practice visits to discuss results & confirm action plan for improved performance. • Contract negotiated with Dr Info & delivery commenced in some early start up practices. Initially the software will analyse the PMS data to identify patients with information recorded in the PMS to calculate a CVD risk. • Contracts received from the DHB for DCIP and Heart Check additional funding received. • Recruitment of additional clinical staff (RNs and Dieticians) from these new funding lines. • Stock-take project commenced to identify community resources available for patients with diabetes across the district. • Planning commenced to carry out health checks for truck drivers in conjunction with NZ Police in Mataura on Wednesday 12/03. Results will be returned to individual practices to update patient records. Vouchers will be given to people with high risk factors for a funded GP visit.
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 - ongoing. ▪ Further work with DHB based NIR Team to clarify newborn enrolment processes and identification of practice for follow-up.

Priority Area	Key Performance Indicator	Activity	Progress against activity Feb14
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.	▪ Liaison with South Link Health to identify why our smoking status rates have not increased in the past nine months although practices have been very focused on collecting and recording smoking status ▪ 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. ▪ Patient lists sent to practices of smokers discharged from secondary care provided with brief advice in hospital requiring follow up in primary care - ongoing. ▪ Meetings with the DHB to implement the primary care aspects of the Tobacco Control Plan. ▪ Recruitment commenced for a fixed term RN position based in Dunedin funded from the DHB's Tobacco Control Plan funding.

Southern PHO Health Target Trend Reporting

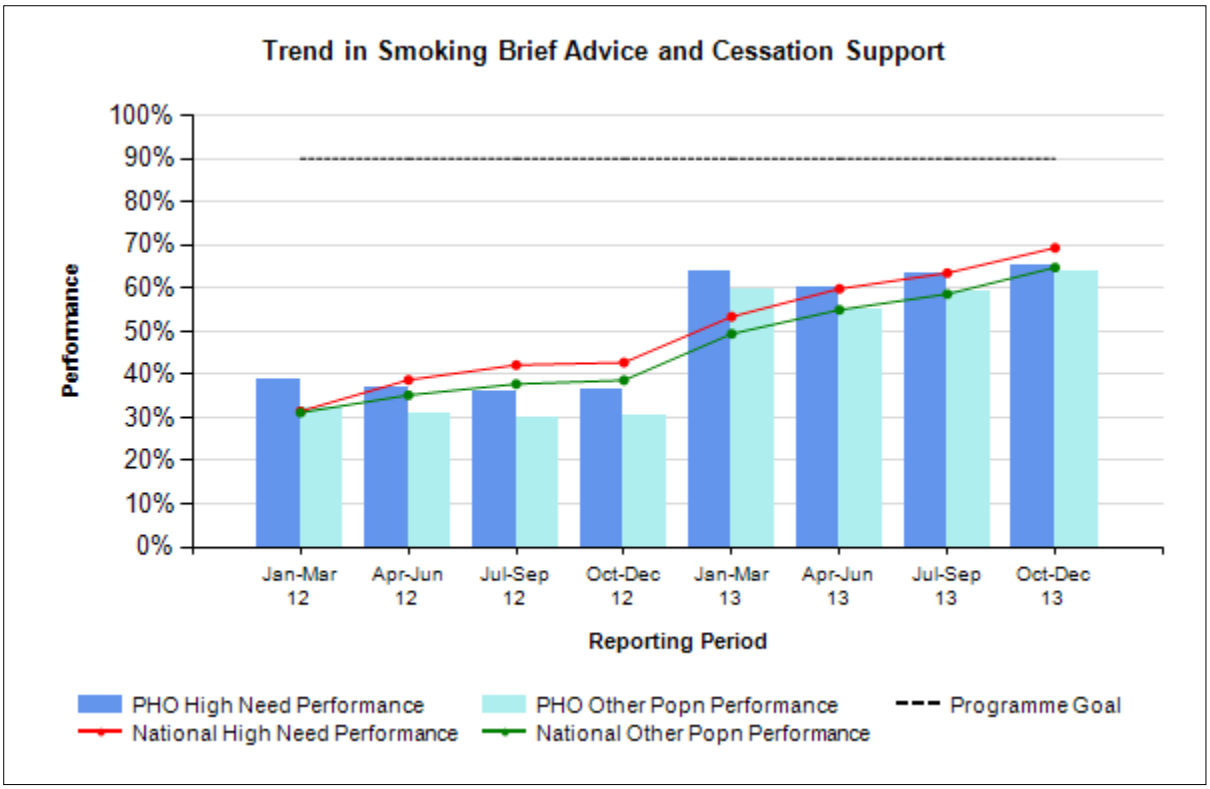


	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO Total Popn Performance	42.83%	44.13%	50.60%	54.84%	59.34%	62.84%	63.80%	64.22%
PHO Total Popn Target	47.19%	47.19%	55.19%	55.19%	70.00%	70.00%	65.00%	65.00%
National Total Popn Performance	46.14%	48.42%	52.18%	55.82%	58.86%	67.09%	69.13%	73.01%

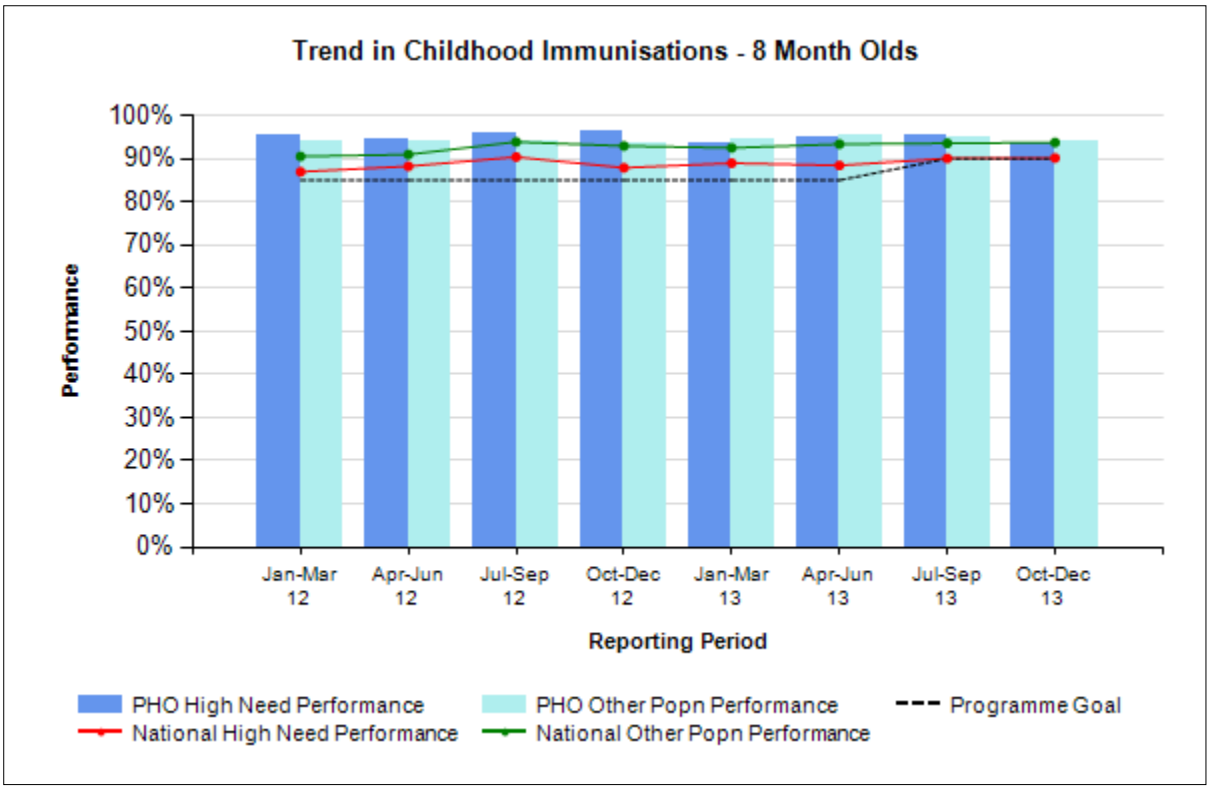
PHO High Need Performance	44.35%	46.90%	52.04%	55.31%	57.35%	60.75%	61.71%	62.62%
PHO High Need Target	45.42%	45.42%	53.42%	53.42%	70.00%	70.00%	65.00%	65.00%
National High Need Performance	48.90%	48.95%	54.20%	57.84%	60.42%	67.88%	69.81%	73.30%
Programme Goal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

PHO Enrolled Patient Numbers for this Indicator

Indicator	Number achieved in Bold	No. required to Achieve Target (90% by 30 June)
Total Population	**55431/**86313	22,251
High Needs Population	**8484/**13548	3,709



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO High Need Performance	38.88%	36.74%	36.18%	36.50%	63.87%	60.14%	63.20%	65.01%
National High Need Performance	31.48%	38.73%	42.16%	42.74%	53.36%	59.83%	63.48%	69.32%
PHO Other Popn Performance	32.16%	30.96%	29.91%	30.27%	59.84%	55.07%	59.01%	63.77%
National Other Popn Performance	31.16%	35.19%	37.78%	38.65%	49.38%	54.95%	58.61%	64.76%
Programme Goal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO High Need Performance	95.44%	94.64%	96.04%	96.28%	93.53%	94.69%	95.26%	93.72%
National High Need Performance	86.94%	88.23%	90.37%	87.87%	88.96%	88.43%	90.05%	90.15%
PHO Other Popn Performance	93.84%	93.79%	93.87%	93.55%	94.50%	95.54%	94.92%	94.10%
National Other Popn Performance	90.51%	90.96%	93.87%	92.91%	92.50%	93.36%	93.56%	93.73%
Programme Goal	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	90.00%	90.00%

PHO Enrolled Patient Numbers for this Indicator

Indicator	Number achieved in Bold
Total Population	**705/**750
High Needs Population	**179/**191

SOUTHERN DISTRICT HEALTH BOARD

Title:	**PHO PERFORMANCE PROGRAMME**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	7 May 2014

Summary:

The issues considered in this paper are:

- PHO Performance Programme results for the Southern PHO for the period October to December 2013

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

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

Document previously submitted to:	n/a	**Date:**

	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

1. **That DSAC/CPHAC note the report.**

PHO Performance Programme

Performance Results for

Southern PHO

for the period

October to December 2013

Overview

The PHO Performance Programme has been developed by District Health Boards (DHBs), the Ministry of Health and the primary health care sector to support improvements in the health of people enrolled in a Primary Health Organisation (PHO).

The Programme aims to:

- Encourage and reward improved performance by PHOs in line with evidence-based guidelines
- Measure and reward progress in reducing health inequalities by including a focus on high need populations

DHBs contract PHOs to deliver a range of health care services for people when they are unwell, to help people stay healthy and to reach out to groups of people in the community who have poor health or are missing out on primary health care.

The Programme has developed a number of performance indicators to measure PHO achievements over a six month period. Some performance indicators measured by the Programme look at services accessed by all PHO-enrolled patients while other indicators look at services specifically accessed by Māori, Pacific Island people or those living in lower socio-economic areas. These patients are referred to as 'high need' patients.

Evidence has shown that 'high need' patients have poorer health than non-Māori, non-Pacific Island people or people who do not live in a lower socio-economic area. One of the Programme's main objectives is to reduce the health 'gaps' between high need and non-high need patients so that all New Zealanders, whatever their ethnicity or living standard, can access the health services they need in order to be healthy.

The performance indicators which are included in this report are:

- Breast screening coverage
- Cervical screening coverage
- Ischaemic cardiovascular disease detection
- Cardiovascular disease risk assessment
- Diabetes detection
- Diabetes follow up after detection
- 65 years + influenza vaccination coverage
- Age appropriate vaccinations for 2 year olds
- Age appropriate vaccinations for 8 month olds
- Smoking status recorded
- Smoking brief advice and cessation support

Each indicator's performance result is structured as follows:

- **Indicator Name**
  The name of the indicator that has been measured
- **Description**
  A description of the indicator and why it is included
- **Target Population**
  Who within the PHO population meets the requirements to be 'counted'
- **Programme Goal**
  The desired overall target that all PHOs should be striving to achieve or exceed – the goal is based on what has been recommended to the Programme from evidence based analysis
- **Data Source**
  Where the Programme sources the data to measure the performance indicator
- **Cautions**
  The constraints or limitations encountered by the Programme when measuring the performance indicator
- **PHO Performance**
  A graphical representation of the PHO-level performance results versus overall DHB and national performance
- **PHO Narrative**
  An accompanying statement from the PHO explaining or commenting on its performance results

Breast Screening Coverage

Description

Early detection treatment of breast cancer lowers the rate of death from breast cancer. The national breast screening programme (BreastScreen Aotearoa) recommends women aged 45 to 69 have 2 yearly mammograms with the strongest evidence supporting the screening of women over the age of 50. The Programme now aligns its age band measures with Breastscreen Aotearoa, and reports performance for women aged between 50 and 69 years. Prior to 1st January 2011 the Programme only recorded women aged 50 to 64 years.

Target Population

- All women aged 50 to 69 years who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10).

Programme Goal

70% or more of the PHO's target population have had a mammography within 2 years.

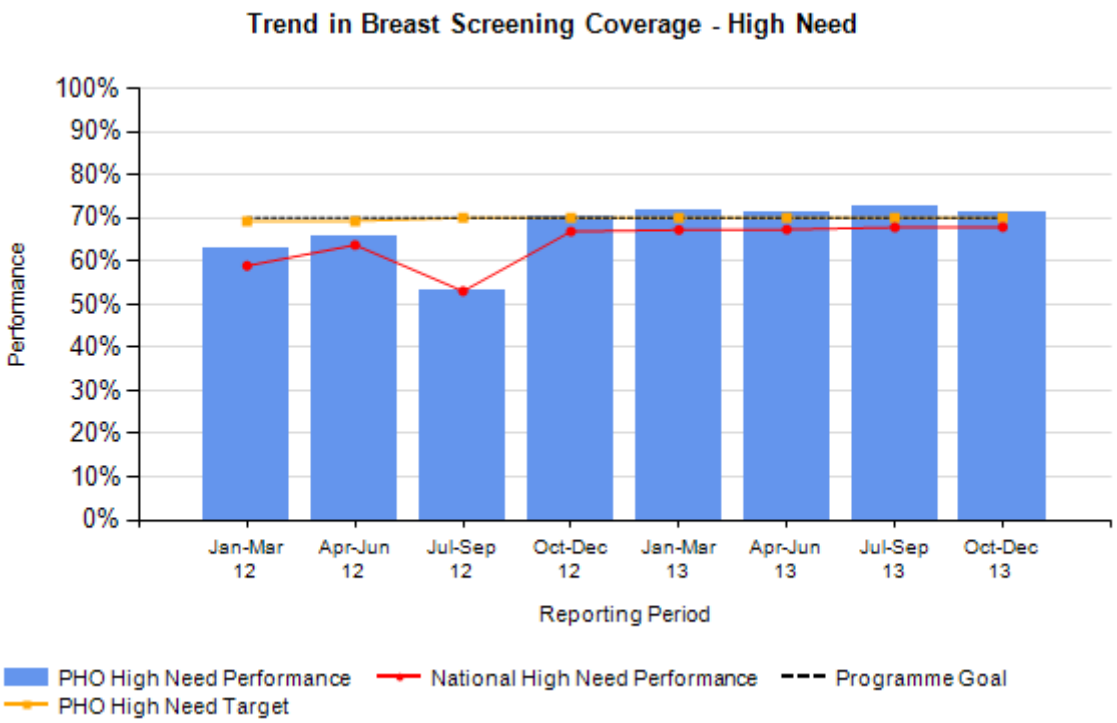
Data Source

To measure this indicator the Programme depends on data provided by the national screening programme.

Cautions

- National
  Some regions have infrequent access to mammography screenings due to the remoteness of their location. There is also no allowance in the measurement of this indicator for women who have had mastectomies.
- Data
  Only publicly funded mammography screenings performed by BreastScreen Aotearoa health carers are 'counted' by the Programme. Private mammography screenings are not counted.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO High Need Performance	62.82%	65.67%	53.27%	70.12%	71.58%	71.03%	72.61%	71.07%
PHO High Need Target	69.26%	69.26%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%
National High Need Performance	58.90%	63.72%	53.01%	66.84%	67.22%	67.31%	67.81%	67.88%
Programme Goal	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%

PHO Narrative

SPHO consistently achieves well for this indicator as a result of collaboration with the breast screening provider, the PHO and practice teams.

Activities underway in support of this indicator include:

- data matching to identify all eligible women not registered in the national screening programme for follow up by the practice to get them enrolled
- support to practices and rural patients to maximize attendance on the mobile screening bus
- Assistance for women to access the screening programme where transport is a barrier.

Cervical Screening Coverage

Description

Early detection and treatment of cervical cancer and other abnormalities lowers the rate of death from cervical cancer. The national cervical screening programme recommends women have three yearly cervical screens from the ages 20 to 69 years. This screening interval may alter if a smear result is abnormal.

Target Population

- All women aged 20 to 69 years.
- All women aged 20 to 69 years within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10).

Programme Goal

75% or more of a PHO's target population have had a cervical screen within 3 years.

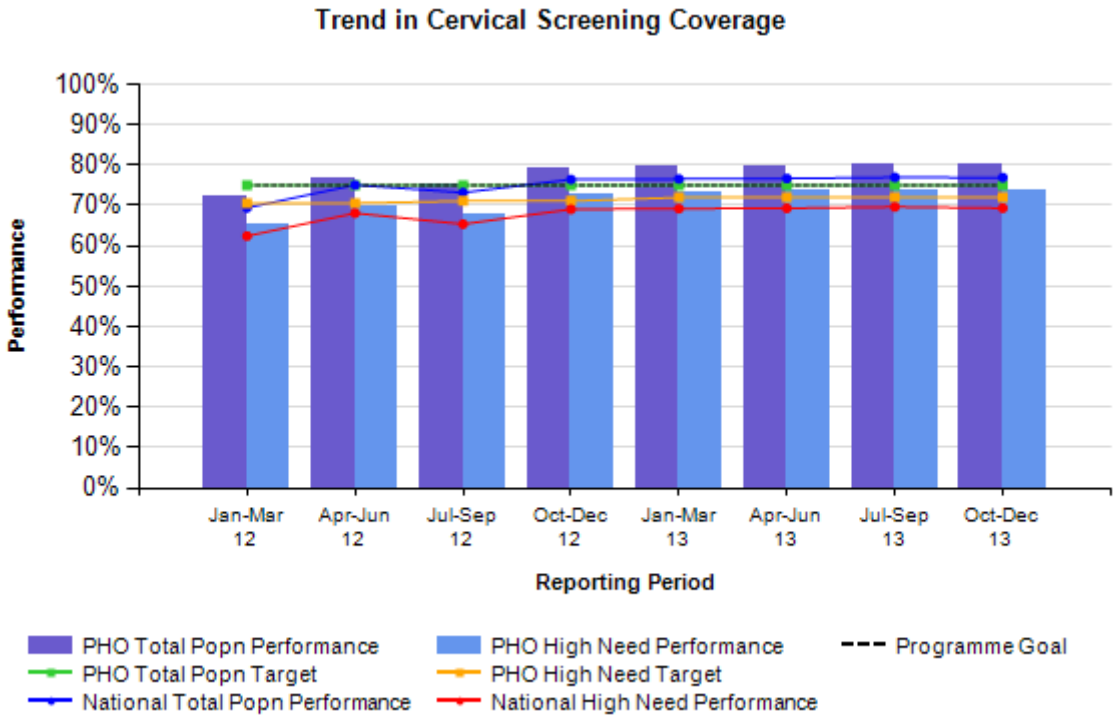
Data Source

To measure this indicator (both total population and high need population) the Programme depends on data provided by the national cervical screening programme.

Cautions

- National
  Many women who have had a hysterectomy do not need a cervical smear. The Programme does apply an adjustment calculation to allow for women with hysterectomies, based on the national rate. However since the rate of hysterectomies within each PHO may vary, this adjustment may not always be correct at the PHO level.
- Data
  Some patients choose to 'opt off' the national screening programme's register (which means that although they have had a cervical screen, they will not be 'counted' by the Programme).

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO Total Popn Performance	72.16%	76.73%	74.98%	79.30%	79.56%	79.83%	79.93%	79.96%
PHO Total Popn Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%
National Total Popn Performance	69.45%	75.08%	73.21%	76.47%	76.57%	76.72%	76.97%	76.91%
PHO High Need Performance	65.36%	69.98%	67.86%	72.66%	73.27%	73.60%	73.72%	73.73%
PHO High Need Target	70.61%	70.61%	71.11%	71.11%	72.00%	72.00%	72.00%	72.00%
National High Need Performance	62.43%	68.12%	65.39%	69.08%	69.22%	69.33%	69.66%	69.36%
Programme Goal	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%

PHO Narrative

The PHO has exceeded the PHO targets for both indicators.

The PHO and DHB work closely together on various initiatives to identify women overdue for smears and provide support including funding to practices to increase uptake of under and unscreened women.

Practices use technology to improve performance as follows:

- Patient Prompt helps identify women overdue for their smear
- Text to Remind used to invite women to come in for a smear in as they become due.

The PHO provides funding to practices to target Maori women overdue for smears.

Two cervical screening courses held in the past year have been well attended increasing the number of trained smear takers across the region.

Ischaemic Cardiovascular Disease Detection

Description

Ischaemic heart disease (IHD) is the leading single cause of death in New Zealand. Identifying people with ischaemic cardiovascular disease is important to enable the regular recall and review of all people who have this disease.

Target Population

- All people aged 30 to 79 years.
- All people aged 30 to 79 years who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10).

Programme Goal

90% or more of those estimated to have ischaemic cardiovascular disease have been identified and coded by their general practice or primary care provider.

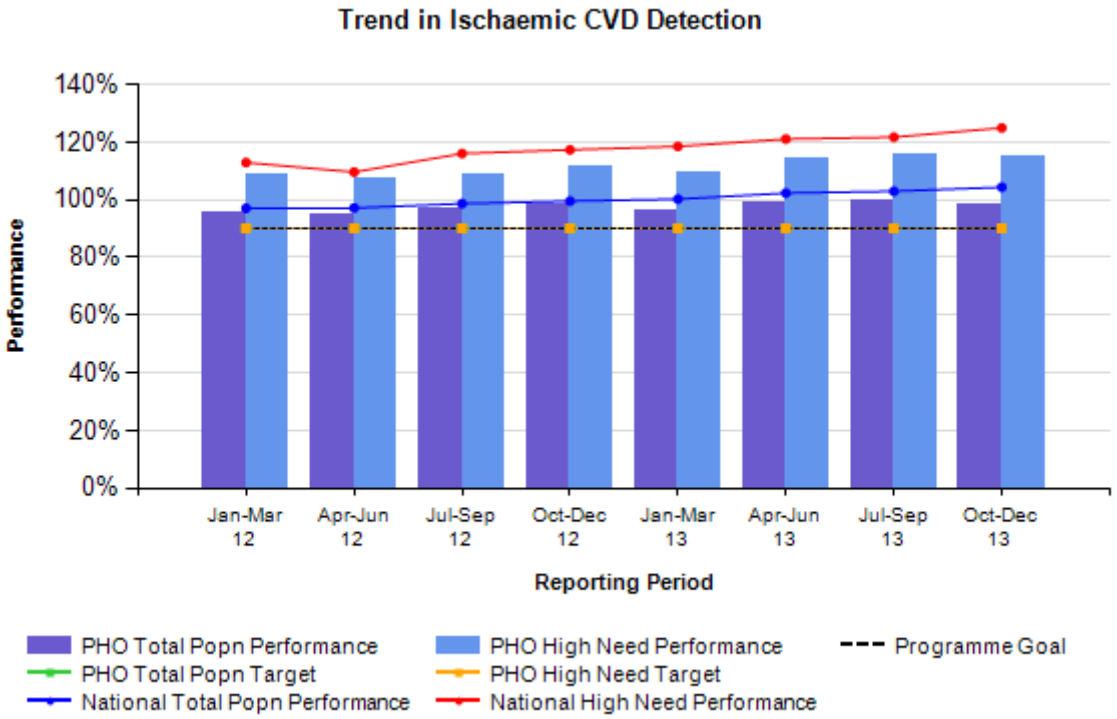
Data Source

To measure this indicator (both total population and high need population) the Programme depends on data provided through Primary Health Organisations.

Cautions

- National
  Estimations of people expected to have ischaemic cardiovascular disease are calculated by considering the ages, genders and ethnicities of PHO populations and applying ischaemic cardiovascular disease rates from the National Cardiovascular Disease Prevalence Data Model. When applying this model to small populations there may be inaccuracies. Currently PHOs are recording high levels of detection relative to the prevalence estimates. Work is being conducted to understand why such high rates are being reported to ensure that, in future, more realistic performance figures are produced by the Programme.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO Total Popn Performance	95.90%	94.89%	96.81%	98.14%	96.51%	99.23%	99.42%	98.34%
PHO Total Popn Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
National Total Popn Performance	97.06%	97.16%	98.66%	99.55%	100.24%	102.31%	102.94%	104.37%
PHO High Need Performance	108.60%	107.09%	108.95%	111.57%	109.25%	114.25%	115.88%	114.78%
PHO High Need Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
National High Need Performance	112.90%	109.61%	116.03%	117.34%	118.51%	121.08%	121.71%	124.92%
Programme Goal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

PHO Narrative

The PHO supports the work being undertaken by the Programme Team to understand the high levels of detection relative to the prevalence estimates.

Cardiovascular Disease Risk Assessment

Description

A Cardiovascular Risk Assessment (CVRA) is a tool for identifying individuals at high risk of a cardiovascular event (e.g. stroke, heart attack or angina) and enables health carers to provide appropriate patient management and support. Cardiovascular disease (CVD) is the leading cause of death in New Zealand - preventative treatment can increase life expectancy and quality of life for patients at risk of CVD.

Target Population

- Males of Māori, Pacific or Indian sub-continent ethnicity aged 35 to 74 years.
- Females of Māori, Pacific or Indian sub-continent ethnicity aged 45 to 74 years.
- Males of any other ethnicity aged 45 to 74 years.
- Females of any other ethnicity aged 55 to 74 years.

Programme Goal

90% or more of a PHO's target population have been assessed for their risk of developing cardiovascular disease by 1 July 2014.

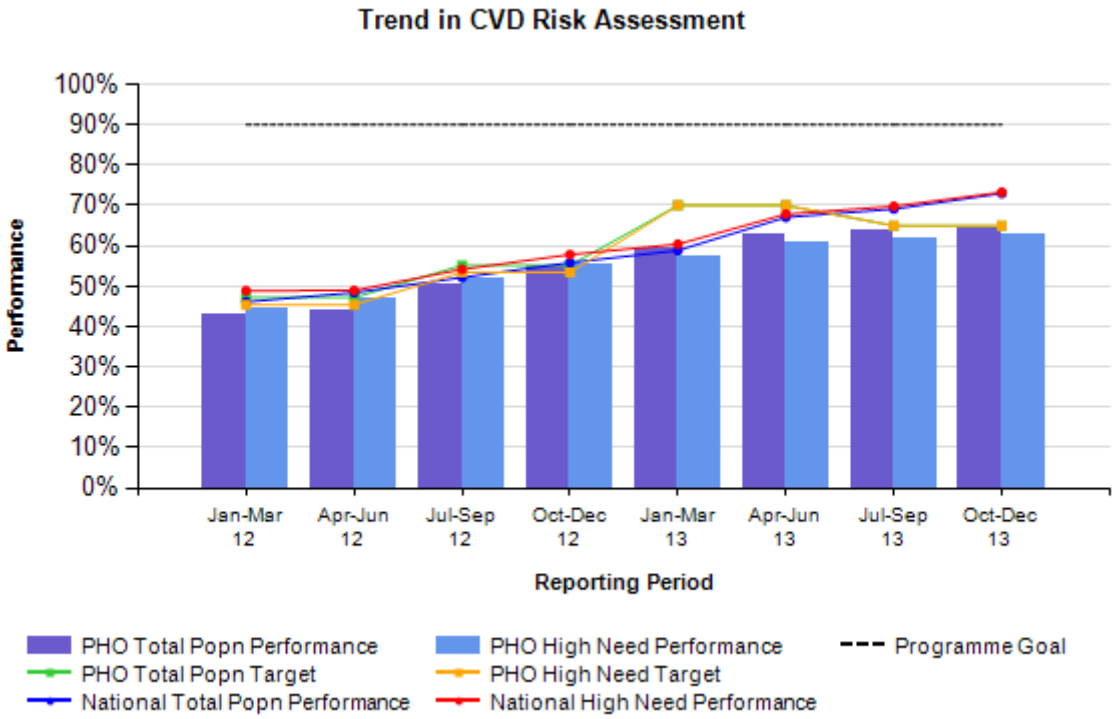
Data Source

To measure this indicator (both total population and high need population) the Programme depends on data provided through Primary Health Organisations.

Cautions

- National
  The Programme goal has been set for PHOs to achieve over a 5 year period in line with the primary care Health Target.
- Data
  There are currently technical computer software difficulties in collecting this data in some regions; these are being addressed.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO Total Popn Performance	42.83%	44.13%	50.60%	54.84%	59.34%	62.84%	63.80%	64.22%
PHO Total Popn Target	47.19%	47.19%	55.19%	55.19%	70.00%	70.00%	65.00%	65.00%
National Total Popn Performance	46.14%	48.42%	52.18%	55.82%	58.86%	67.09%	69.13%	73.01%
PHO High Need Performance	44.35%	46.90%	52.04%	55.31%	57.35%	60.75%	61.71%	62.62%
PHO High Need Target	45.42%	45.42%	53.42%	53.42%	70.00%	70.00%	65.00%	65.00%
National High Need Performance	48.90%	48.95%	54.20%	57.84%	60.42%	67.88%	69.81%	73.30%
Programme Goal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

PHO Narrative

The PHO is making slow progress toward the Health Target goal for this indicator. We are focused on supporting practices toward achievement of the 90% target required by 30 June 2014.

PHO support available to practices in support of the target includes:

- Electronic decision support tools to identify unscreened patients
- Funding to offer free appointments to High Need patients for an initial assessment
- Funded management programme for high risk patients
- Clinical and administration support to increase capacity

Practice level reporting available to the PHO indicates those practices offering free CVDRA's are showing the greatest improvement in the number of patients having a risk assessment.

Diabetes Detection

Description

Diabetes presents a serious health challenge for New Zealand. It is a significant cause of ill health and premature death. Diabetes affects about 200,000 people in New Zealand but only half of these people have been diagnosed. Identifying people with diabetes is important to both Type 1 Type 2 diabetes.

Target Population

- All people aged 15 to 79 years.
- All people aged 15 to 79 years who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10).

Programme Goal

90% or more of those observed to have diabetes have been identified and coded by their general practice or primary care provider.

Data Source

To measure this indicator (both total population and high need population) the Programme depends on data provided by Primary Health Organisations.

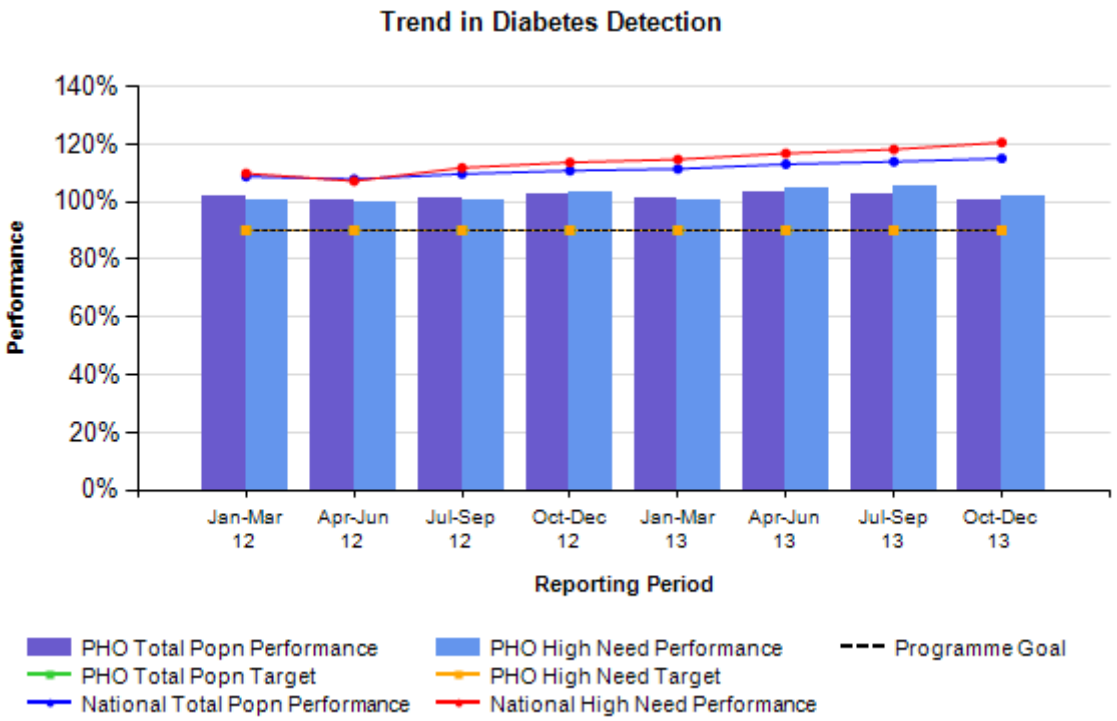
Cautions

- Data

  People observed to have diabetes are calculated by considering those who have had any form of health services contact in New Zealand or who were actively enrolled with a PHO, as documented in at least one of the following NHI linked national datasets:
  - On a PHO enrolment register (there will be a small number of people who are not resident but are enrolled, however they are greatly outweighed by including people enrolled with no contact in the last 12 months)
  - NMDS Public Hospital Event
  - NMDS Private Hospital Event
  - National Health Index List
  - National Mental Health Collection
  - Laboratory Testing Claims
  - Community Pharmaceutical Dispensing

  People with a health system contact were included unless they were without residency status.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO Total Popn Performance	101.62%	100.74%	101.42%	102.16%	100.80%	103.21%	102.44%	100.27%
PHO Total Popn Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
National Total Popn Performance	108.74%	107.83%	109.64%	110.78%	111.38%	113.04%	113.88%	115.03%
PHO High Need Performance	100.56%	99.44%	100.14%	103.52%	100.19%	104.67%	104.95%	101.80%
PHO High Need Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
National High Need Performance	109.84%	107.18%	111.76%	113.63%	114.67%	116.76%	118.14%	120.53%
Programme Goal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

PHO Narrative

The PHO and practices actively review the patients identified in the most recent Virtual Diabetes Register to ensure accuracy of the information in the register.

Diabetes Follow Up After Detection

Description

An appropriate diabetes review (follow up) gives people with Type 1 or Type 2 diabetes the opportunity for their GP or nurse to review their treatment and lifestyle advice, and update their care plans. The expected service requirements that constitute a diabetes review include, through the year, the measurement of certain blood and urine tests, retinal (eye) screening (every two years), review of cardiovascular risk, examination of the feet and review and updating of the patient's care plan. The care plan may include patient-specific goals related to diabetes control, exercise, diet etc. In some areas much of this service is provided at an "annual review". In other areas the service may be provided in parts at each quarterly visit.

Target Population

- All people aged 15 to 79 years identified as having diabetes.
- All people aged 15 to 79 years who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10) identified as having diabetes.

Programme Goal

90% or more of those observed to have diabetes have had a diabetes review.

Data Source

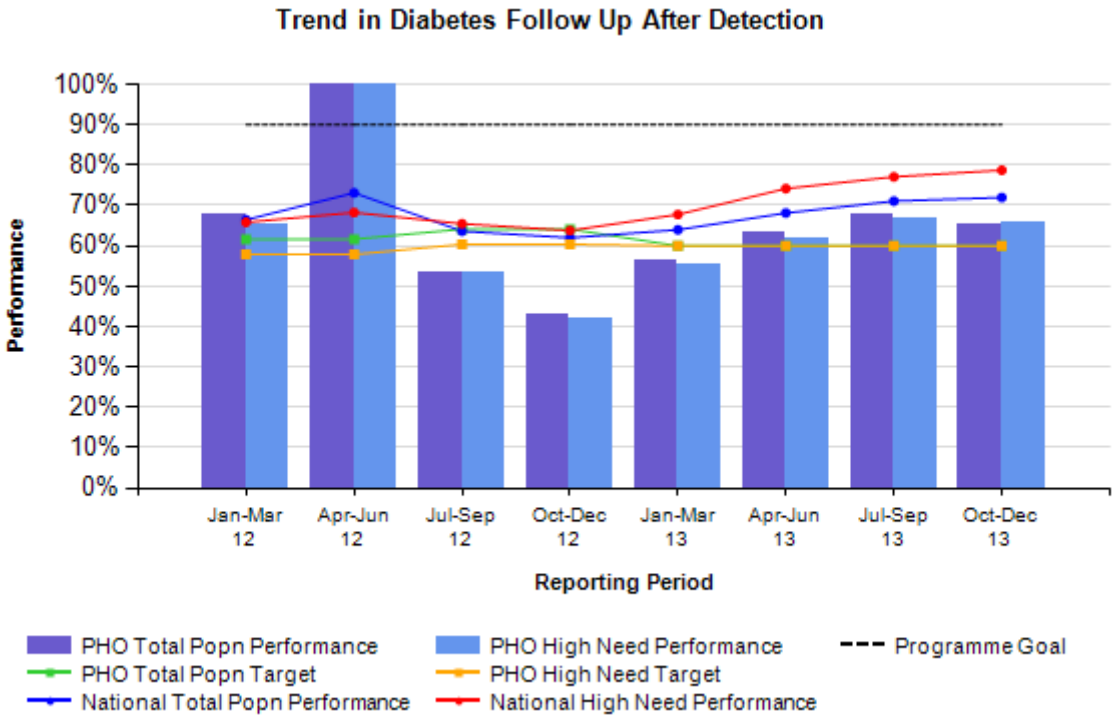
To measure this indicator (both total population and high need population) the Programme depends on data that is provided through Primary Health Organisations.

Cautions

- Data

  Currently there are technical difficulties in collecting this data from some PHOs; these difficulties are being addressed by the Programme on a case by case basis. The indicator currently measures the percentage of people observed to have diabetes who have had a review, rather than the percentage of those identified and recorded in general practices as having diabetes that have had a review. This may result in some regions having higher than expected diabetes review rates. Conversely if a region has not identified and recorded all their people who are observed to have diabetes, they will not be able to achieve high diabetes review rates.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO Total Popn Performance	67.62%	148.99%	53.57%	43.04%	56.11%	63.32%	67.60%	65.33%
PHO Total Popn Target	61.65%	61.65%	64.15%	64.15%	60.00%	60.00%	60.00%	60.00%
National Total Popn Performance	66.47%	73.14%	63.66%	62.00%	64.00%	68.16%	71.10%	72.00%
PHO High Need Performance	65.11%	136.05%	53.59%	41.88%	55.53%	62.01%	66.54%	65.57%
PHO High Need Target	57.89%	57.89%	60.39%	60.39%	60.00%	60.00%	60.00%	60.00%
National High Need Performance	65.86%	68.26%	65.47%	63.79%	67.77%	74.19%	77.11%	78.76%
Programme Goal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

PHO Narrative

Ongoing support is provided to practices to ensure they have robust systems in place to recall all diabetic patients for clinical review over the course of a year. The PHO actively supports practices to follow up with patients overdue for diabetes care.

Practices continue to enroll patients with diabetes onto the Care Plus Programme.

65 Years + Influenza Vaccination Coverage

Description

The complications of influenza (more commonly known as 'flu') in the elderly can be serious or life threatening. As a result, the Government funds the cost of influenza vaccines and their administration for people aged 65 and over and people of any age with certain chronic conditions. Only vaccinations provided to people aged 65 and over are counted by the Programme.

Target Population

- All people aged 65 years and over at the start of an annual influenza vaccination season.
- All people aged 65 years and over who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10) at the start of an annual influenza vaccination season.

An annual influenza season usually falls between 1 January and 30 June of any year.

Programme Goal

75% or more of a PHO's target population have had a flu vaccination by 30 June of any year.

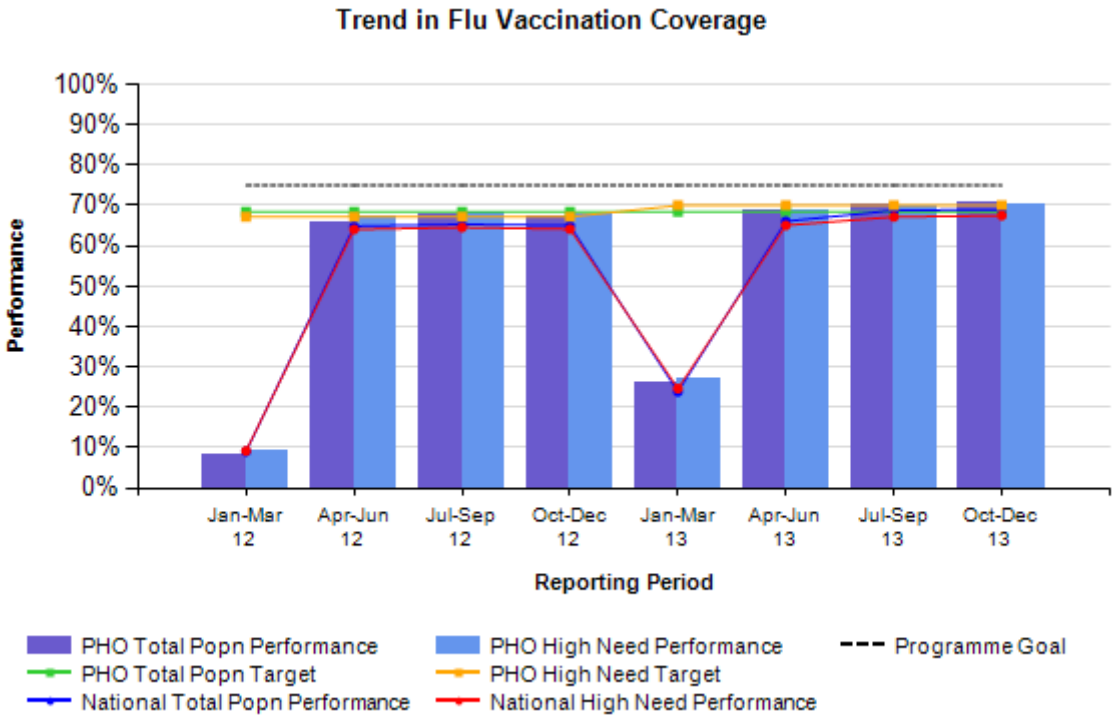
Data Source

To measure this indicator (both total population and high need population) the Programme depends on data provided by the Ministry of Health.

Cautions

- Data
  If a person within the PHO's target population chooses not to have a vaccination that person is still included as part of the PHO's target population. PHOs with a high number of declining patients will not fare well against this indicator.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO Total Popn Performance	8.08%	65.72%	67.65%	67.32%	26.16%	68.56%	70.28%	70.73%
PHO Total Popn Target	68.41%	68.41%	68.41%	68.41%	68.39%	68.39%	68.39%	68.39%
National Total Popn Performance	9.03%	64.89%	65.36%	65.03%	23.84%	66.09%	68.79%	69.02%
PHO High Need Performance	9.42%	67.18%	68.23%	67.81%	27.14%	68.97%	69.80%	70.30%
PHO High Need Target	67.22%	67.22%	67.22%	67.22%	70.00%	70.00%	70.00%	70.00%
National High Need Performance	9.18%	64.09%	64.59%	64.16%	24.64%	65.07%	67.19%	67.51%
Programme Goal	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%

PHO Narrative

The PHO exceeds the National Programme targets and has achieved the PHO targets for both high needs and total population.

Age Appropriate Vaccinations For 2 Year Olds

Description

Children who receive the complete set of final dose (fully immunised) age appropriate vaccinations (in this case for the 2 year old age group) are less likely to become ill from certain diseases. The vaccinations which fall within the 2 year old group are for measles, mumps, rubella, diphtheria, tetanus, whooping cough, polio, hepatitis b, pneumococcus and haemophilus influenza. A child must receive the complete set of 2 year old vaccinations to be counted by the Programme.

Target Population

- All children who had their second birthday during the reporting period.
- All children who had their second birthday during the reporting period and who were within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10).

Programme Goal

95% or more of a PHO's target population have received their complete set of age appropriate vaccinations.

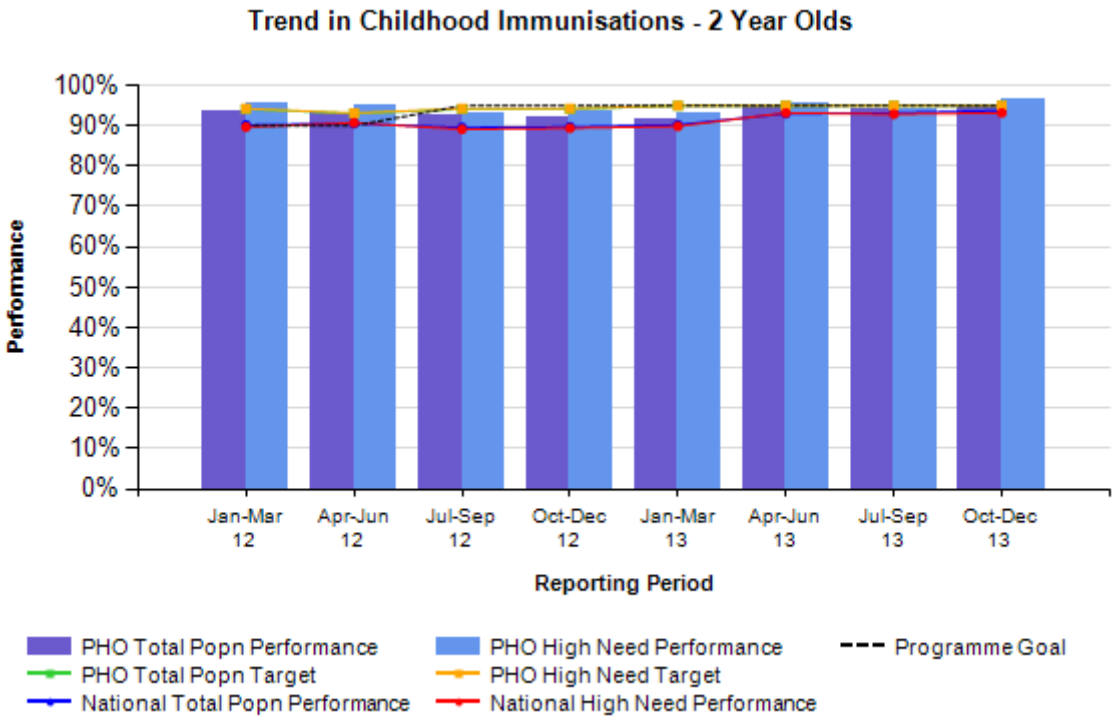
Data Source

All PHOs are measured using data from the National Immunisation Register.

Cautions

- Declines
  If the parent or caregiver of a child decides that their child is not to be vaccinated the Programme still includes that child as part of the PHO's eligible population.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO Total Popn Performance	93.67%	93.15%	92.43%	91.97%	91.58%	94.75%	94.12%	94.40%
PHO Total Popn Target	94.17%	93.05%	94.17%	94.17%	95.00%	95.00%	95.00%	95.00%
National Total Popn Performance	90.19%	90.58%	89.59%	89.77%	90.25%	93.02%	93.22%	93.79%
PHO High Need Performance	95.33%	94.92%	93.00%	93.68%	92.96%	95.56%	94.23%	96.52%
PHO High Need Target	94.27%	93.15%	94.27%	94.27%	95.00%	95.00%	95.00%	95.00%
National High Need Performance	89.71%	90.75%	89.15%	89.41%	89.90%	93.19%	92.90%	93.19%
Programme Goal	90.00%	90.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%

PHO Narrative

The PHO performs consistently well for all childhood immunization indicators which is largely due to the effort of our practices nurses in monitoring patients due and following up with those who are overdue.

Practice teams work closely with the Immunisation Coordinators who provide outreach too hard to reach patients.

Age Appropriate Vaccinations for 8 Month Olds

Description

Children who receive the complete set of final dose (fully immunised) age appropriate vaccinations (in this case for the 8 month old age group) are less likely to become ill from certain diseases. The vaccinations which fall within the 8 month old group are for diphtheria, tetanus, whooping cough, polio, hepatitis b, pneumococcus and haemophilus influenza. A child must receive the complete set of 8 month old vaccinations to be counted by the Programme.

Target Population

- All children who are within the 8 month old cohort during the reporting period and who were within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10).
- All children who are within the 8 month old cohort during the reporting period who are not classed as high need.

Programme Goal

90% or more of a DHB's target population have received their complete set of age appropriate vaccinations. This will increase to 95% from 1 July 2014.

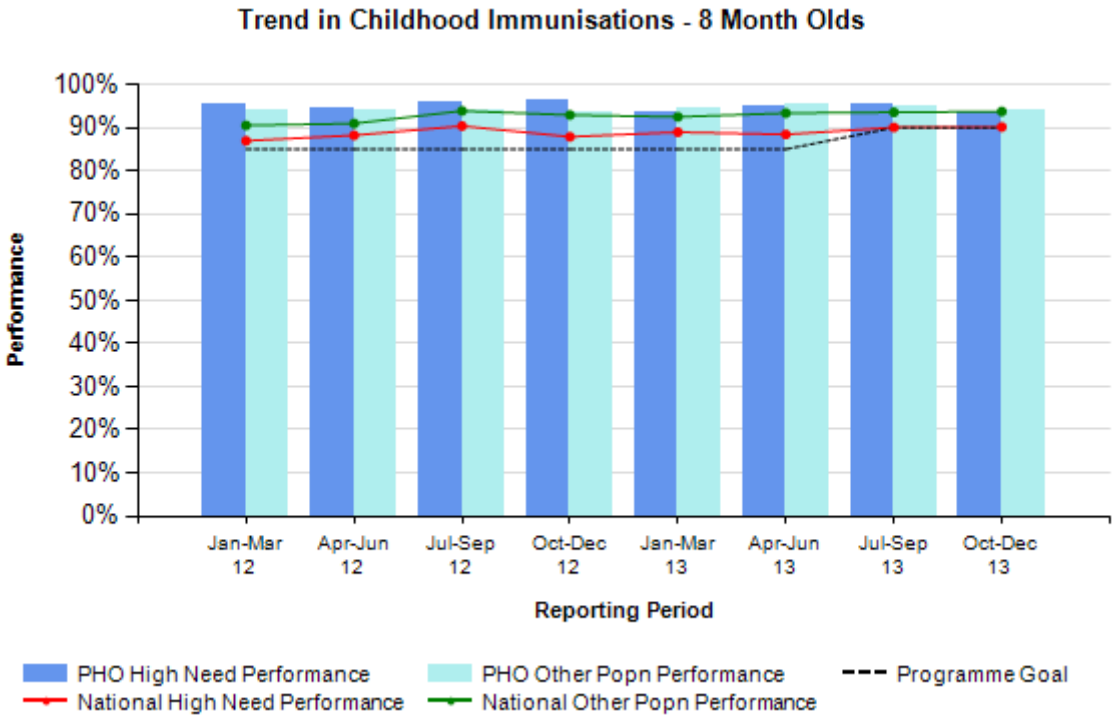
Data Source

All PHOs are measured using data from the National Immunisation Register.

Cautions

- Declines
  If the parent or caregiver of a child decides that their child is not to be vaccinated the Programme still includes that child as part of the PHO's eligible population.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO High Need Performance	95.44%	94.64%	96.04%	96.28%	93.53%	94.69%	95.26%	93.72%
National High Need Performance	86.94%	88.23%	90.37%	87.87%	88.96%	88.43%	90.05%	90.15%
PHO Other Popn Performance	93.84%	93.79%	93.87%	93.55%	94.50%	95.54%	94.92%	94.10%
National Other Popn Performance	90.51%	90.96%	93.87%	92.91%	92.50%	93.36%	93.56%	93.73%
Programme Goal	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	90.00%	90.00%

PHO Narrative

As outlined above the PHO performs consistently well for all childhood immunization indicators which is largely due to the effort of our practices nurses.

Smoking Status Recorded

Description

Smoking is the single biggest cause of preventable morbidity and mortality in New Zealand. It is estimated that half of all long-term smokers die of a smoking related illness. Accurately recording patients' smoking status is one of the first steps in helping smokers to quit.

Target Population

- All people aged 15 to 74 years who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10).
- All people aged 15 to 74 years who are within the other population.

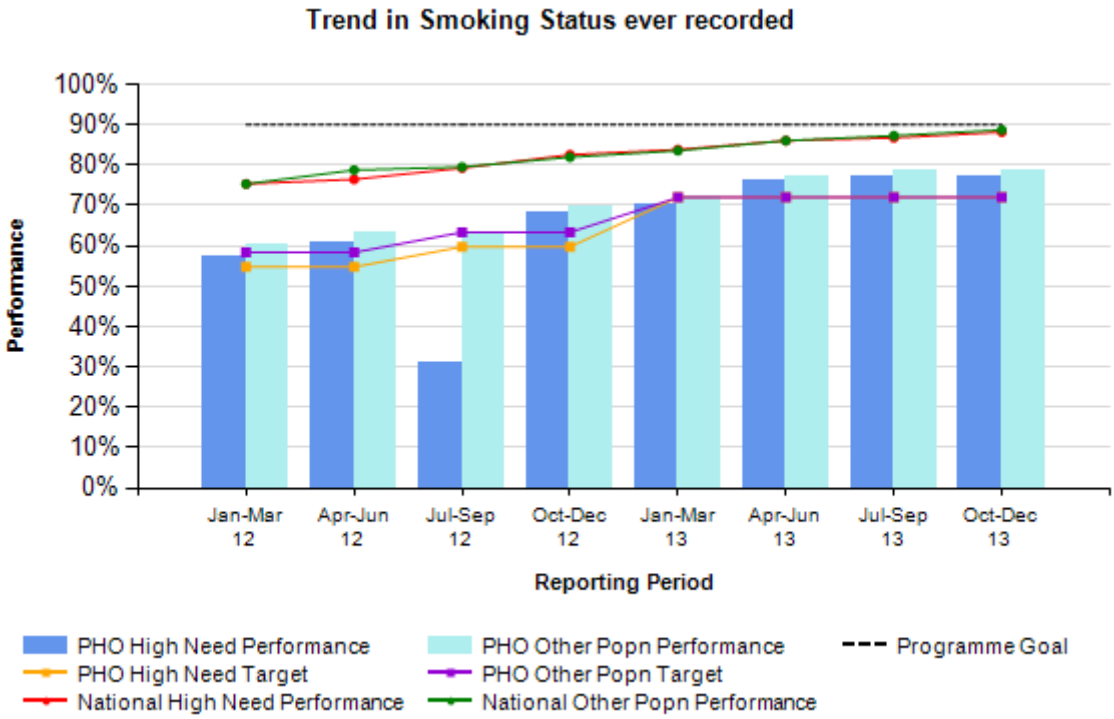
Programme Goal

90% or more of a PHO's target population will have had their smoking status recorded.

Data Source

To measure this indicator (both high need population and other population) the Programme depends on data that is provided through Primary Health Organisations.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO High Need Performance	57.55%	60.82%	30.82%	68.06%	70.18%	76.08%	77.18%	77.28%
PHO High Need Target	54.78%	54.78%	59.78%	59.78%	72.00%	72.00%	72.00%	72.00%
National High Need Performance	75.38%	76.50%	79.27%	82.60%	83.87%	86.06%	86.77%	88.18%
PHO Other Popn Performance	60.28%	63.05%	63.13%	69.96%	72.26%	77.10%	78.62%	78.75%
PHO Other Popn Target	58.37%	58.37%	63.37%	63.37%	72.00%	72.00%	72.00%	72.00%
National Other Popn Performance	75.35%	78.78%	79.57%	81.99%	83.60%	86.07%	87.30%	88.73%
Programme Goal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

PHO Narrative

The PHO will investigate with our IT provider why there is almost no change in the number of patients with their smoking status recorded despite immense effort at practice level to record smoking status of patients.

Smoking Brief Advice and Cessation Support

Description

Stopping smoking confers immediate benefits on those who already have smoking related diseases and future health benefits on all smokers. Helping people who smoke stop, is a leading national health goal.

Target Population

- All people aged 15 to 74 years who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10) whose most recent smoking status is recorded as current smoker.
- All people aged 15 to 74 years who are within the other population whose most recent smoking status is recorded as current smoker.

Programme Goal

90% or more of a PHO's target population who have been seen in general practice and whose most recent smoking status is recorded as current smoker, will have been offered brief advice and/or cessation support services within the last 12 months.

Data Source

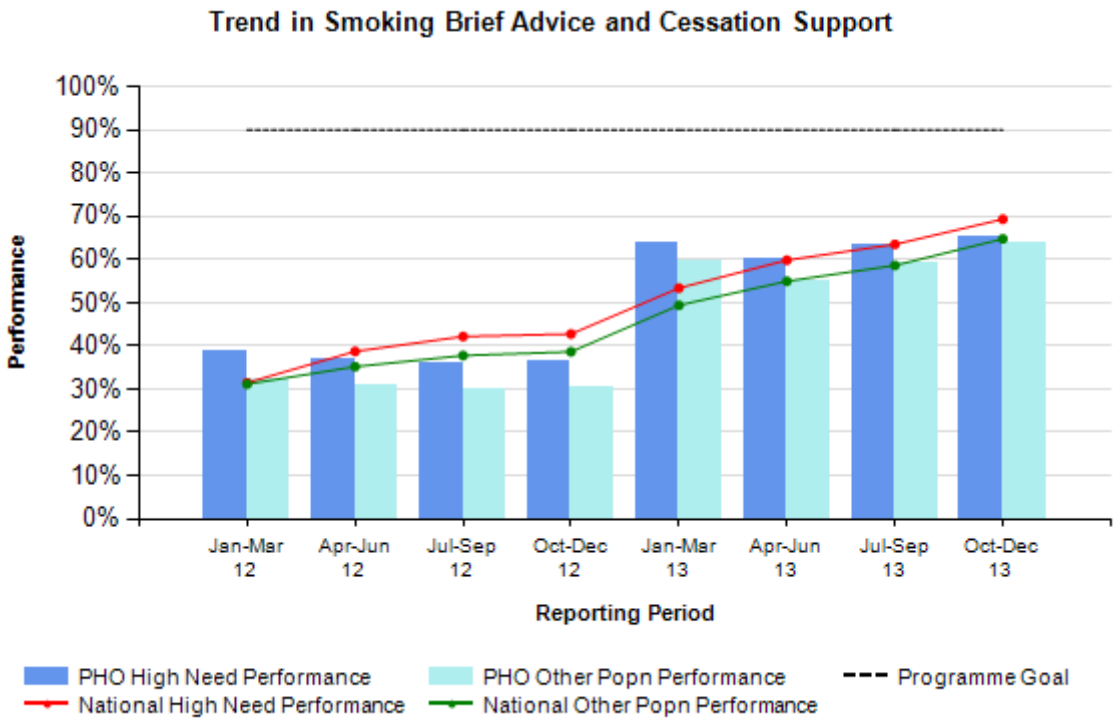
To measure this indicator (both high need population and other population) the Programme depends on data that is provided through Primary Health Organisations.

Cautions

- Data

  The Programme is working with a number of PHOs regarding their information processes to ensure the data is a true reflection of their service delivery. Alignment of this smoking indicator with the primary care health target was reached in December 2011 as part of an integrated alignment approach between the Ministry of Health and the Programme. The number of current smokers is adjusted to reflect anticipated utilisation of this population – this means coverage of greater than 100% is technically feasible.

PHO Performance



	Jan-Mar 12	Apr-Jun 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13
PHO High Need Performance	38.88%	36.74%	36.18%	36.50%	63.87%	60.14%	63.20%	65.01%
National High Need Performance	31.48%	38.73%	42.16%	42.74%	53.36%	59.83%	63.48%	69.32%
PHO Other Popn Performance	32.16%	30.96%	29.91%	30.27%	59.84%	55.07%	59.01%	63.77%
National Other Popn Performance	31.16%	35.19%	37.78%	38.65%	49.38%	54.95%	58.61%	64.76%
Programme Goal	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

PHO Narrative

The number of practices utilising e-tools to record B's and C's is increasing which is contributing toward the increase in performance for this indicator although we still have a long way to go toward achieving the Health Target by 30 June, 2014.

Practices are provided with clinical support from SPHO and SDHB to improve systems and their increase their capacity to provide cessation support to smokers.

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 September 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:	**DHB Performance Reporting Quarter 2**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	7 May 2014

Summary:

Overview of DHB Performance Reporting for Quarter Two 2013/14 with brief comments where targets or expectations have not been met.

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: Glenn Symon Planning & Funding **Date:** 16.4.14	**Presented by:** Sandra Boardman Executive Director Planning & Funding Executive Director Planning & Funding

RECOMMENDATIONS:

That the Committees note the results for Quarter Two DHB Performance Reporting

Summary of DHB Performance Reporting – Quarter 2 2013/14

Health Targets

Health Targets			
Measure		**Final Rating**	**Comments**
Better help for smokers to quit	Primary care	P	Q2 result is 64.6% compared with 59.9% in the last quarter. This represents a 4.7% increase on last quarter's result. The Ministry of Health, including the target champion, were invited to Southern. A joint meeting with the DHB and PHO discussed approaches to significantly improve performance.
	Secondary	A	
	Maternity	NA	
Improved access to elective surgery		A	
Increased immunisation		A	
More heart and diabetes checks		P	The result for Q2 was 64.2% which was an increase of 0.4% from Q1. The Ministry of Health, including the target champion, were invited to Southern. A joint meeting with the DHB and PHO discussed approaches to significantly improve performance.
Shorter stays in Emergency Departments		P	The DHB quarter two published result was 92% which compares to the national rate of 94%. The comprehensive plan to reach 95% is supported by the Ministry of Health and will require good leadership, shared vision and collaboration.
Shorter waits for cancer treatment radiotherapy and chemotherapy		A	

Indicators of DHB Performance

The four dimensions of DHB performance, that reflect DHBs' functions as owners, funders and providers of health and disability services are:

Measures of DHB Performance		
Measure	**Final Rating**	**Comments**
Policy Priorities Dimension		Achieving Government's priority goals/objectives and targets
PP6 Improving the health status of people with severe mental illness through improved access	A	
PP7 Improving mental health services using relapse prevention planning 13/14	A	
PP8 Shorter waits for non-urgent mental health and addiction services	A	
PP18 Improving community support to maintain the independence of older people	A	
PP20 Improved management for long term conditions (CVD, diabetes and Stroke)	P	The data for the diabetes management indicator (HbA1c) was not available from Southern PHO in time for reporting.
PP21 Immunisation coverage (previous health target)	P	Southern DHB achieved 94 percent coverage of two- year-olds and was one of six that were only one percent away from achieving target of 95 percent this quarter.
PP22 Improving System Integration	A	
PP23 Improving Wrap Around Services – Health of Older People	A	

PP24 Improving waiting times - Cancer MDMs		A	
PP25 Prime Minister's youth mental health project		A	
PP26 Rising to the Challenge: The Mental Health and Addiction Service Development plan		A	
PP27 Delivery of the children's action plan		A	
PP28 Reducing Rheumatic Fever		A	
System Integration Dimension			Meeting service coverage requirements and supporting sector inter-connectedness
SI1 Ambulatory sensitive (avoidable) hospital admissions 13/14		A	
SI2 Delivery of Regional Service plans		P	National Priorities: all national priorities achieved. Regional Priorities: Child Health partially achieved; other priorities achieved. Enabler/Foundational Priorities: Workforce and Information Systems partially achieved; other priorities achieved.
S13 Ensuring delivery of Service Coverage 13/14		A	
SI4 Standardised Intervention rates		A	
Output Dimension			Purchasing the right mix and level of services within acceptable financial performance
OP1 Mental Health output Delivery against plan		A	
Ownership Dimension			Providing quality services efficiently
OS3 Inpatient average length of stay (ALOS)	Acute	P	Southern DHB has requested that the recalculated baseline of 3.91 days be accepted as the improvement target rather than the target of 3.75 days. The baseline was recalculated due to an error in previous calculation when the new OS3 definition was adopted for 2013/14. The performance has continued to improve each quarter and if accepted the DHB will achieve the proposed target in Q3.
	Elective	A	
OS8 Reducing Acute readmissions to hospital	Total Population	N	Performance for Q3 is 7.3%, a 0.68% variance on the improvement target of 6.64% and below the national readmission rate of 8.2%. Q2 performance was 7.1%. Local, district wide and community initiatives are underway to improve performance.
	75 +	P	
OS10 Improving the quality of data provided to national collection systems		A	
Development Dimension			
DV1 Faster cancer treatment		A	

Crown Funding Agreements (CFA) Variations

The non-financial quarterly reporting process is also used to collect and assess reports on CFA variations. All CFA variations with a reporting component, and created since the 2009/10 year, are required to have their reports collected as part of the non-financial quarterly reporting process.

Crown Funding Agreements (CFA) Variations		
Measure	**Final Rating**	**Comments**
B4 School Check Funding	S	
Electives Initiative and Ambulatory Initiative Variation	S	
Establishment of Green Prescription Initiative	S	
Well Child Tamariki Ora Services	S	
Appoint Cancer Nurse Coordinators 13/14	S	
Immunisation Coordination Service 13/14	S	
Oral Health Business Case for Investment in Child and Adolescent Oral Health Services 13/14	S	
Additional on-going funding for Alcohol Brief Interventions in Primary Care 13/14	B	Additional funding and volumes as per this agreement have been incorporated into the overall Southern PHO Mental Health Brief Intervention Service. However due to a misunderstanding the volume data is not available for reporting in Q2. This issue has been discussed with the MOH and SDHB will be working with the PHO to establish the required reporting for Q3.
Primary Mental Health Initiative (PMHI) Service 13/14	S	

Assessment Criteria/Ratings

There are two sets of Assessment Criteria/Ratings for reporting, one for health targets and performance measures, and another for CFA Variations.

Health Targets & Performance Measures

Progress towards each target or measure will be assessed and reported to the Minister of Health according to the reporting frequency outlined in the indicator dictionary for each performance dimension (found on the NSFL). Health Target progress will be publicly reported on the Ministry's website.

Rating	Abbrev	Criteria
Outstanding performer/sector leader	O	1. This rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations. 2. Note: this rating can only be applied in the fourth quarter for measures that are reported quarterly or six-monthly. Measures reported annually can receive an 'O' rating, irrespective of when the reporting is due.
Achieved	A	1. Deliverable demonstrates targets / expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partial achievement	P	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on track to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved – escalation required	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

CFA Variations

The assessment criteria for CFA variation reporting are different to the criteria applied to health targets and performance measures. The progress and developmental reporting nature for CFA variations is more compliance based, and therefore the target-oriented nature of health target and performance measure assessment is not considered appropriate.

Category	Abbrev	Criteria
Satisfactory	S	1. The report is assessed as up to expectations 2. Information as requested has been submitted in full
Further work required	B	1. Although the report has been received, clarification is required 2. Some expectations are not fully met
Not Acceptable	N	1. There is no report 2. The explanation for no report is not considered valid.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**FINANCIAL REPORT**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	7 May 2014

Summary:

The issues considered in this paper are:

- Funds March 2014 year to date financial position.

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

Financial:	As set out in report.
Workforce:	No specific implications
Other:	n/a

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

Prepared by: David Dickson Finance Manager **Date:** 15/04/14	**Presented by:** Peter Beirne Executive Director Finance

RECOMMENDATION:

1. **That the report be received.**

DSAC / CPHAC FINANCIAL REPORT

Financial Report as at: **31 March 2014**
Report Prepared by: **David Dickson**
Date: **15 April 2014**

Recommendations:

- **That the Committee's note the Financial Report**

1. DHB Funds Result

Month Actual $' 000	Month Budget $' 000	Month Variance $' 000		Year to Date Actual $' 000	Year to Date Budget $' 000	Year to Date Variance $' 000	Annual Budget $' 000
68,678	68,107	571	Revenue	615,902	612,963	2,939	817,283
(67,941)	(68,454)	513	Less Other Costs	(613,928)	(612,859)	(1,069)	(818,387)
737	(347)	1,084	Net Surplus / (Deficit)	1,974	104	1,870	(1,104)
			Expenses				
(47,747)	(48,488)	741	Personal Health	(434,811)	(433,997)	(814)	(580,071)
(7,166)	(7,269)	103	Mental Health	(63,965)	(65,422)	1,457	(87,232)
(1,001)	(864)	(137)	Public Health	(8,641)	(7,772)	(869)	(10,363)
(11,176)	(10,982)	(194)	Disability Support	(98,855)	(98,005)	(850)	(130,502)
(153)	(154)	1	Maori Health	(1,373)	(1,379)	6	(1,840)
(698)	(698)	0	Other	(6,283)	(6,283)	0	(8,379)
(67,941)	(68,455)	514	Expenses	(613,928)	(612,858)	(1,070)	(818,387)

Summary Comment:
The March result was a surplus of $0.7m and is favourable to budget by $1.0m. The year to date funder result is a surplus of $1.9m against a budgeted surplus of $0.1m

Key variances year to date are:

- ($0.8m) of unfavourable home support costs, with some revenue offset
- ($0.6m) of unfavourable public health for screening programmes, with offset in revenue
- ($0.5m) pharmaceutical costs, relating to 2012/2013 expenditure
- ($0.3m) of unfavourable radiology costs, with offset in revenue
- $1.9m of below budget provider-arm mental health expenditure from unfilled FTE positions
- $2.9m of additional subcontract revenue

Revenue
YTD revenue, excluding IDFs is $3.3m ahead of budget however most of this has associated cost offsets.

Item	$m	Expense Line Offset (Y/N/Partial)
PHO Performance Management funding	0.2	Y, Personal Health PHO Other
Elective Funding – Bariatric 12-13	0.3	N
Care plus funding	0.3	Y, Personal Health
Screening revenues	0.6	Y, Public Health expenditure
Revenue to reduce imaging wait times	0.3	Y, Transfer to provider arm
Aged Care Home Support Funding	0.3	Y, DSS
Sleepover settlement	0.4	Y, DSS
Aged care and dementia funding	0.1	Y, DSS
Public Health Services contract	0.1	Y, Public Health
Aged care home support funding	0.2	Y,DSS
Enhanced Alcohol and Drug Services	0.2	Y, Mental Health expenditure
National Patient Flow Year one	0.1	Y will be spent on NPF
Total Revenue Variation	**3.3**	

Personal Health Payments
Personal Health is favourable to budget for the month ($0.7m), due to medical outpatients and the National Haemophilia Management Group costs being funded from pharmac in 2013-14.

The year to date is $0.8m unfavourable relating to;

- Laboratory costs ($0.4m u), due to additional tests,
- Pharmaceuticals ($0.5m u) due to the impact of 2012/13 costs,
- Radiology ($0.3m u) which has a revenue offset,
- Price adjustors and premiums ($0.4m u), again having revenue offset relating to the sleepover settlement funding received.
- IDF are 0.4m unfavourable,
- Partly offsetting these is Medical Outpatients ($1.0m f) relating to the Haemophilia credit as above

Mental Health
Mental Health costs for March are favourable due to the wash-up with the provider arm. YTD this is now of $1.9m.

Disability Support
Disability support services costs are unfavourable in March with Hospital residential care unfavourable by $0.2m due to volume. Year to date DSS costs are also unfavourable ($0.8m), due to home support costs, and hospital residential care costs above budget.

Additional revenue for price and volume increases ($0.3m) partly offsets the unfavourable variance.

Public Health
The expenditure variance year to date of $0.9m is offset by revenue for screening programmes which is paid to the provider.

2. DHB Funds Result split by NGO and Provider

Month				Year to Date			Annual
Actual	Budget	Variance		Actual	Budget	Variance	Budget
$' 000	$' 000	$' 000		$' 000	$' 000	$' 000	$' 000
68,678	68,107	571	Revenue	615,902	612,963	2,939	817,283
(67,941)	(68,454)	513	Less Other Costs	(613,928)	(612,859)	(1,069)	(818,387)
737	(347)	1,084	Net Surplus / (Deficit)	1,974	104	1,870	(1,104)
			Expenses				
(19,394)	(20,011)	617	Personal Health - NGO	(179,060)	(177,700)	(1,360)	(238,341)
(28,353)	(28,477)	124	Personal Health - Provider	(255,751)	(256,297)	546	(341,730)
(47,747)	**(48,488)**	**741**	**Personal Health - Total**	**(434,811)**	**(433,997)**	**(814)**	**(580,071)**
(2,148)	(2,026)	(122)	Mental Health - NGO	(18,671)	(18,234)	(437)	(24,315)
(5,018)	(5,243)	225	Mental Health - Provider	(45,294)	(47,188)	1,894	(62,917)
(7,166)	**(7,269)**	**103**	**Mental Health - Total**	**(63,965)**	**(65,422)**	**1,457**	**(87,232)**
(61)	(36)	(26)	Public Health - NGO	(476)	(316)	(160)	(422)
(940)	(828)	(111)	Public Health - Provider	(8,165)	(7,456)	(709)	(9,941)
(1,001)	**(864)**	**(137)**	**Public Health - Total**	**(8,641)**	**(7,772)**	**(869)**	**(10,363)**
(9,299)	(9,101)	(198)	Disability Support - NGO	(81,966)	(81,078)	(888)	(107,933)
(1,877)	(1,881)	4	Disability Support - Provider	(16,889)	(16,927)	38	(22,569)
(11,176)	**(10,982)**	**(194)**	**Disability Support - Total**	**(98,855)**	**(98,005)**	**(850)**	**(130,502)**
(129)	**(130)**	1	Maori Health - NGO	**(1,160)**	**(1,166)**	6	**(1,556)**
(24)	**(24)**	0	Maori Health - Provider	**(213)**	**(213)**	0	**(284)**
(153)	**(154)**	**1**	**Maori Health**	**(1,373)**	**(1,379)**	**6**	**(1,840)**
(698)	**(698)**	**0**	**Other**	**(6,283)**	**(6,283)**	**0**	**(8,379)**
(67,941)	**(68,455)**	**514**	**Expenses**	**(613,928)**	**(612,858)**	**(1,070)**	**(818,387)**

The table above splits funder expenditure into NGO and Provider arm. For Personal Health the provider variance is due to favourable Community Pharmacy and PCT, partly offset by additional transfers for contracts with additional funding.
Mental Health provider expenditure is under budget due to the wash-up of funding which occurs monthly.
Public Health over budget provider expenditure is due mostly to screening programmes, for which additional revenue has been received.

3. Financial Statements

The financial summary for the funder result is attached.

Southern District Health Board

Mar-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	56,402	56,335	67 F		507,482	507,011	471 F		676,014
MoH - Vote Health Mental Health	7,057	7,062	(5) U		63,513	63,558	(45) U		84,744
PBF Adjustments	-	-			-	-			-
MoH Funding Subcontracts	3,717	3,124	593 F	19%	31,038	28,116	2,922 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	**67,176**	**66,521**	**655 F**	**1%**	**602,032**	**598,685**	**3,348 F**	**1%**	**798,246**
Other Government									
IDF's - Mental Health Services	144	144			1,292	1,292			1,723
IDF's - All others (non Mental health)	1,359	1,443	(84) U	(6%)	12,577	12,986	(408) U	(3%)	17,314
Other DHB's	-	-			-	-			-
Training Fees and Subsidies	-	-			-	-			-
Accident Insurance	-	-			-	-			-
Other Government	-	-			-	-			-
Other Government Total	**1,503**	**1,586**	**(84) U**	**(5%)**	**13,870**	**14,278**	**(408) U**	**(3%)**	**19,037**
Government and Crown Agency Sourced Total	**68,678**	**68,107**	**571 F**	**1%**	**615,902**	**612,963**	**2,939 F**		**817,283**
Other Revenue									
Patient / Consumer Sourced	-	-			-	-			-
Other Income	-	-			-	-			-
Other Revenue Total	**-**	**-**			**-**	**-**			**-**
REVENUE TOTAL	**68,678**	**68,107**	**571 F**	**1%**	**615,902**	**612,963**	**2,939 F**		**817,283**
EXPENSES									
Outsourced Expenses									
Outsourced Funder Services	(698)	(698)			(6,284)	(6,284)			(8,379)
Other Outsourced Expenses	-	-			-	-			-
Other Expenses	-	-			-	-			-
Payments to Providers									
Personal Health									
Child and Youth	(383)	(375)	(8) U	(2%)	(3,411)	(3,378)	(33) U	(1%)	(4,504)
Laboratory	(2,682)	(2,639)	(43) U	(2%)	(24,189)	(23,755)	(434) U	(2%)	(31,674)
Infertility Treatment Services	(91)	(100)	9 F	9%	(819)	(900)	81 F	9%	(1,200)
Maternity	(262)	(261)			(2,354)	(2,351)	(3) U		(3,135)
Maternity (Tertiary & Secondary)	(1,374)	(1,385)	11 F	1%	(12,367)	(12,466)	100 F	1%	(16,622)
Pregnancy and Parenting Education	(9)	(12)	3 F	26%	(96)	(111)	15 F	13%	(148)
Maternity Payment Schedule	-	-			-	-			-
Neo Natal	(656)	(656)			(5,906)	(5,906)			(7,875)
Sexual Health	(88)	(88)			(792)	(792)			(1,055)
Adolescent Dental Benefit	(151)	(216)	65 F	30%	(1,629)	(1,746)	117 F	7%	(2,425)
Other Dental Services	-	-			-	-			-
Dental - Low Income Adult	(110)	(90)	(20) U	(22%)	(734)	(810)	76 F	9%	(1,083)
Child (School) Dental Services	(585)	(619)	34 F	5%	(5,545)	(5,720)	174 F	3%	(7,608)
Secondary / Tertiary Dental	(254)	(245)	(9) U	(4%)	(2,286)	(2,209)	(77) U	(4%)	(2,950)
Pharmaceuticals	(6,413)	(6,407)	(5) U		(56,803)	(56,328)	(475) U	(1%)	(75,312)
Pharmaceutical Cancer Treatment Drugs	(367)	(358)	(9) U	(3%)	(3,283)	(3,225)	(58) U	(2%)	(4,300)
Pharmacy Services	(28)	(68)	40 F	59%	(383)	(616)	233 F	38%	(821)
Management Referred Services	-	-			-	-			-
General Medical Subsidy	(75)	(127)	52 F	41%	(696)	(1,233)	537 F	44%	(1,650)
Primary Practice Services - Capitated	(3,437)	(3,431)	(6) U		(30,780)	(30,879)	99 F		(41,172)
Primary Health Care Strategy - Care	(284)	(240)	(44) U	(18%)	(2,480)	(2,162)	(318) U	(15%)	(2,883)
Primary Health Care Strategy - Health	(337)	(286)	(51) U	(18%)	(3,178)	(2,574)	(604) U	(23%)	(3,432)
Primary Health Care Strategy - Other	(368)	(207)	(161) U	(78%)	(2,282)	(1,863)	(419) U	(23%)	(2,484)
Practice Nurse Subsidy	(16)	(17)		3%	(152)	(149)	(3) U	(2%)	(198)
Rural Support for Primary Health Pro	(1,370)	(1,371)	1 F		(12,351)	(12,339)	(12) U		(16,452)
Immunisation	(217)	(216)	(2) U	(1%)	(1,279)	(1,256)	(23) U	(2%)	(2,651)
Radiology	(440)	(457)	17 F	4%	(4,456)	(4,114)	(342) U	(8%)	(5,486)
Palliative Care	(506)	(495)	(11) U	(2%)	(4,427)	(4,457)	30 F	1%	(5,942)
Meals on Wheels	(53)	(53)	(1) U	(1%)	(480)	(474)	(6) U	(1%)	(632)
Domicilary & District Nursing	(1,378)	(1,436)	58 F	4%	(12,752)	(12,925)	173 F	1%	(17,233)
Community based Allied Health	(581)	(581)			(5,232)	(5,229)	(3) U		(6,972)
Chronic Disease Management and Educa	(240)	(241)	1 F		(2,159)	(2,171)	12 F	1%	(2,894)
Medical Inpatients	(5,619)	(5,619)			(50,568)	(50,568)			(67,425)
Medical Outpatients	(2,956)	(3,617)	661 F	18%	(31,568)	(32,554)	985 F	3%	(43,405)
Surgical Inpatients	(10,431)	(10,426)	(5) U		(93,827)	(93,832)	5 F		(125,110)
Surgical Outpatients	(1,711)	(1,716)	5 F		(15,403)	(15,444)	41 F		(20,592)
Paediatric Inpatients	(641)	(641)			(5,765)	(5,765)			(7,686)
Paediatric Outpatients	(267)	(267)			(2,405)	(2,405)			(3,207)
Pacific Peoples' Health	(17)	(22)	4 F	20%	(162)	(194)	32 F	17%	(258)
Emergency Services	(1,621)	(1,630)	9 F	1%	(14,626)	(14,668)	42 F		(19,557)
Minor Personal Health Expenditure	(82)	(89)	7 F	7%	(756)	(797)	41 F	5%	(1,062)
Price adjusters and Premium	824	795	28 F	4%	6,709	7,157	(448) U	(6%)	9,543
Travel & Accomodation	(322)	(430)	108 F	25%	(3,401)	(3,457)	55 F	2%	(4,741)
Inter District Flow Personal Health	(2,149)	(2,148)	(1) U		(19,737)	(19,335)	(402) U	(2%)	(25,780)
Personal Health Total	**(47,748)**	**(48,488)**	**740 F**	**2%**	**(434,810)**	**(433,997)**	**(813) U**		**(580,072)**

Southern District Health Board

Mar-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)			(11,687)	(11,687)			(15,583)
Sub-Acute & Long Term Mental Health	(362)	(362)			(3,262)	(3,262)			(4,349)
Crisis Respite	(6)	(7)		5%	(61)	(61)	1 F	1%	(82)
Alcohol & Other Drugs - General	(328)	(330)	2 F	1%	(3,080)	(2,967)	(113) U	(4%)	(3,955)
Alcohol & Other Drugs - Child & Youth	(24)	(24)			(309)	(214)	(94) U	(44%)	(286)
Methadone	(94)	(94)			(844)	(844)			(1,125)
Dual Diagnosis - Alcohol & Other Drugs	(12)	(45)	33 F	74%	(119)	(402)	283 F	70%	(536)
Dual Diagnosis - MH/ID	(8)	(5)	(3) U	(60%)	(71)	(44)	(27) U	(60%)	(59)
Eating Disorder	(14)	(14)			(125)	(126)			(168)
Maternal Mental Health	(4)	(4)			(33)	(33)			(44)
Child & Youth Mental Health Services	(938)	(856)	(82) U	(10%)	(7,706)	(7,704)	(2) U		(10,272)
Forensic Services	(506)	(510)	4 F	1%	(4,512)	(4,588)	76 F	2%	(6,117)
Kaupapa Maori Mental Health Services	(98)	(152)	54 F	36%	(989)	(1,364)	375 F	28%	(1,818)
Kaupapa Maori Mental Health - Residential	-	-			-	-			-
Kaupapa Maori Mental Health - Inpati	-	-			-	-			-
Mental Health Community Services	(1,745)	(1,877)	132 F	7%	(15,804)	(16,891)	1,088 F	6%	(22,522)
Prison/Court Liaison	(46)	(44)	(2) U	(4%)	(415)	(398)	(17) U	(4%)	(531)
Mental Health Workforce Development	(1)	-	(1) U		(1)	-	(1) U		-
Day Activity & Work Rehabilitation S	(191)	(197)	7 F	3%	(1,751)	(1,777)	26 F	1%	(2,369)
Mental Health Funded Services for Older People	(35)	(35)			(319)	(319)			(426)
Advocacy / Peer Support - Consumer	(53)	(57)	4 F	7%	(476)	(513)	37 F	7%	(684)
Other Home Based Residential Support	(469)	(374)	(95) U	(25%)	(3,643)	(3,369)	(274) U	(8%)	(4,492)
Advocacy / Peer Support - Families	(52)	(60)	8 F	13%	(468)	(539)	71 F	13%	(720)
Community Residential Beds & Service	(394)	(451)	57 F	13%	(3,923)	(4,058)	135 F	3%	(5,411)
Minor Mental Health Expenditure	(46)	(32)	(14) U	(44%)	(397)	(290)	(106) U	(37%)	(388)
Inter District Flow Mental Health	(441)	(441)			(3,971)	(3,971)			(5,294)
Mental Health Total	**(7,166)**	**(7,269)**	**103 F**	**1%**	**(63,965)**	**(65,422)**	**1,457 F**	**2%**	**(87,232)**
Public Health									
Alcohol & Drug	(110)	(26)	(84) U	(318%)	(322)	(238)	(84) U	(35%)	(317)
Communicable Diseases	(96)	(96)			(868)	(868)			(1,158)
Injury Prevention	-	-			-	-			-
Screening Programmes	(395)	(368)	(27) U	(7%)	(3,919)	(3,310)	(608) U	(18%)	(4,414)
Mental Health	(22)	(22)			(199)	(199)			(265)
Nutrition and Physical Activity	(49)	(45)	(4) U	(9%)	(442)	(406)	(36) U	(9%)	(542)
Physical Environment	(36)	(36)			(321)	(321)			(428)
Public Health Infrastructure	(127)	(127)			(1,142)	(1,142)			(1,523)
Sexual Health	(12)	(12)			(107)	(107)			(143)
Social Environments	(38)	(38)			(339)	(339)			(452)
Tobacco Control	(116)	(93)	(22) U	(24%)	(981)	(841)	(141) U	(17%)	(1,121)
Well Child Promotion	-	-			-	-			-
Meningococcal	-	-			-	-			-
Public Health Total	**(1,001)**	**(864)**	**(137) U**	**(16%)**	**(8,641)**	**(7,772)**	**(869) U**	**(11%)**	**(10,363)**
Disability Support Services									
AT & R (Assessment, Treatment and Re	(1,976)	(1,976)			(17,780)	(17,780)			(23,707)
Information and Advisory	(12)	(13)	1 F	9%	(84)	(117)	33 F	28%	(156)
Needs Assessment	(171)	(163)	(8) U	(5%)	(1,535)	(1,467)	(67) U	(5%)	(1,956)
Service Co-ordination	(18)	(19)	2 F	8%	(181)	(174)	(7) U	(4%)	(233)
Home Support	(1,502)	(1,267)	(235) U	(19%)	(12,525)	(11,703)	(822) U	(7%)	(15,504)
Carer Support	(147)	(156)	9 F	6%	(1,183)	(1,405)	222 F	16%	(1,874)
Residential Care: Rest Homes	(2,800)	(3,047)	247 F	8%	(26,147)	(26,935)	788 F	3%	(35,880)
Residential Care: Loans Adjustment	9	22	(13) U	(60%)	141	200	(58) U	(29%)	266
Long Term Chronic Conditions	(100)	(93)	(8) U	(9%)	(1,202)	(833)	(369) U	(44%)	(1,111)
Residential Care: Hospitals	(3,874)	(3,628)	(247) U	(7%)	(33,106)	(32,064)	(1,042) U	(3%)	(42,714)
Ageing in Place	(2)	(2)			(22)	(22)			(30)
Environmental Support Services	(108)	(101)	(7) U	(7%)	(911)	(910)	(1) U		(1,218)
Day Programmes	-	-			-	-			-
Expenditure to Attend Treatment ETAT	-	-			-	-			-
Minor Disability Support Expenditure	(8)	(26)	17 F	68%	(81)	(232)	151 F	65%	(309)
Respite Care	(144)	(147)	3 F	2%	(1,309)	(1,271)	(38) U	(3%)	(1,691)
Community Health Services & Support	(63)	(105)	42 F	40%	(558)	(944)	386 F	41%	(1,259)
Inter District Flow Disability Support	(258)	(261)	3 F	1%	(2,371)	(2,346)	(26) U	(1%)	(3,128)
Disability Support Other	-	-			-	-			-
Disability Support Services Total	**(11,176)**	**(10,982)**	**(194) U**	**(2%)**	**(98,855)**	**(98,005)**	**(850) U**	**(1%)**	**(130,502)**
Maori Health									
Maori Service Development	(38)	(38)			(340)	(341)			(454)
Maori Provider Assistance Infrastruc	-	-			-	-			-
Maori Workforce Development	-	-			-	-			-
Minor Maori Health Expenditure	-	-			-	-			-
Whanau Ora Services	(115)	(116)	1 F	1%	(1,033)	(1,039)	6 F	1%	(1,386)
Maori Health Total	**(153)**	**(154)**	**1 F**	**1%**	**(1,373)**	**(1,379)**	**6 F**		**(1,840)**
Internal Allocations	-	-			-	-			-
Total Expenses	**(67,941)**	**(68,454)**	**513 F**	**1%**	**(613,928)**	**(612,859)**	**(1,069) U**		**(818,387)**
Summary of Results									
Subtotal of IDF Revenue	1,503	1,586	(84) U	(5%)	13,870	14,278	(408) U	(3%)	19,037
Subtotal all other Revenue	67,176	66,521	655 F	1%	602,032	598,685	3,348 F	1%	798,246
Revenue Total	**68,678**	**68,107**	**571 F**	**1%**	**615,902**	**612,963**	**2,939 F**		**817,283**
Subtotal of IDF Expenditure	(2,848)	(2,850)	2 F		(26,079)	(25,651)	(427) U	(2%)	(34,202)
Subtotal all other Expenditure	(65,093)	(65,604)	511 F	1%	(587,849)	(587,207)	(642) U		(784,185)
Expenses Total	**(67,941)**	**(68,454)**	**513 F**	**1%**	**(613,928)**	**(612,859)**	**(1,069) U**		**(818,387)**
Net Surplus/ (Deficit)	**737**	**(347)**	**1,084 F**	**312%**	**1,974**	**104**	**1,870 F**		**(1,104)**