DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Wednesday, 10 December 2014, 10.00 am

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

A G E N D A

Tab		
1.	Welcome	
2.	Apologies	
3.	Presentation – Cancer Services	
4.	Interests Registers	
5.	Previous Minutes	
6.	Matters Arising	
7.	Review of Action Sheet	
	7.1 Alliance South Work Plan	
8.	Planning & Funding Team Report	
	8.1 Public Health South (PHS) Report	
9.	Quarter One DHB Performance Reporting	
10.	Financial Performance Report	
11.	Work Plan	
12.	Resolution to Exclude the Public	

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. 2015/16 Funder Financial Planning	To allow activities to be carried out without prejudice	As above, section 9(2)(i) and (j).

An apology has been received from Sandra Cook, Chair.

PRESENTATION: CANCER SERVICES

- Ron Craft, Portfolio Manager

- Blair McLaren, Specialist, Oncology & Haematology

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	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	1. Partner, BDO Invercargill, Chartered Accountants. 2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT).	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)	1. Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals. 2. Possible conflicts between SDHB and University interests. 3. Consultancy includes performing expert reviews and reports regarding patient care at the request of other DHBs and the Office of the Health and Disability Commissioner.
Neville COOK	04.03.2008 26.03.2008 11.02.2014	1. Councillor, Environment Southland. 2. Trustee, Norman Jones Foundation. 3. Southern Health Welfare Trust (Trustee).	1. Nil. 2. Possible conflict with funding requests. 3. Southland Hospital Trust.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
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.	1. Possible conflict with PHO contract funding. 2. Possible conflict with contract funding.
Tuari POTIKI	09.12.2013 05.08.2014	1. University of Otago staff member. 2. Deputy Chair, Te Rūnaka o Ōtākou. 3. Chair, NZ Drug Foundation. 4. Director, Te Tapuae o Rehua Ltd 5. Director Te Rūnaka Ōtākou Ltd	1. Possible Conflicts between Southern DHB and University interests. 2. Possible conflict with contract funding. 3. Nil. 4. Nil 5. Nil
Branko SIJNJA*	07.02.2008 04.02.2009 22.06.2010 08.05.2014	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. President, New Zealand Medical Association	1. Operates publicly funded secondary health services under contract to Southern DHB. 2. Possible conflicts between Southern DHB and University interests. 3. Employed as a part-time GP.
Richard THOMSON	13.12.2001 23.09.2003	1. Managing Director, Thomson & Cessford Ltd. 2. Chairperson and Trustee, Hawksbury Community Living Trust. 3. Trustee, HealthCare Otago Charitable Trust.	1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	29.03.2010 06.04.2011 21.11.2013 & 03.04.2014	4. Chairman, Composite Retail Group. 5. Councillor, Dunedin City Council. 6. Three immediate family members are employees of Dunedin Hospital (Radiographer and Anaesthetic Technician).	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).	

*Mr Ward and Dr Sijnja have both tendered their resignations from SCL Otago Southland Ltd (SCLOS) but these cannot be effected until contract variation executed by SDHB and SCLOS constitution varied.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at November 2014

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Steve Addison	16.08.2014	1. Chair, Board of Trustees, Columba College 2. Mother-in-law, Gore District Councillor	
Peter Beirne	20.06.2013	Nil	
Sandra Boardman	07.02.2014	Nil	
Richard Bunton	17.03.2004 22.06.2012 29.04.2010	3. Managing Director of Rockburn Wines Ltd. 4. Director of Mainland Cardiothoracic Associates Ltd. 5. Director of the Southern Cardiothoracic Institute Ltd. 6. Director of Wholehearted Ltd. 7. Chairman, Board of Cardiothoracic Surgery, RACS. 8. Trustee, Dunedin Heart Unit Trust. 9. 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.
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.
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	

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
		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

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

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 5 November 2014, commencing at 10.00 am, in the Board Room, Southland Hospital Campus, Invercargill

Present:	Ms Sandra Cook	Chair
	Mr Neville Cook	
	Mrs Kaye Crowther	
	Dr Branko Sijnja	
	Mr Tim Ward	
In Attendance:	Mr Paul Menzies	WellSouth Primary Health Network
	Mr Joe Butterfield	Board Chairman
	Dr John Chambers	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 (from 10.50 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

An apology for lateness was received from Ms Carole Heatly, Chief Executive Officer.

3.0 PRESENTATION – PUBLIC & POPULATION HEALTH

The Committees received a presentation (tab 3) from the Executive Director Planning & Funding on:

1. Well Child/Tamariki Ora services
2. The Children's Action Plan to identify, support and protect vulnerable children.

This was followed by a presentation by videoconference on the Social Sector Trials (SST) and their local implementation in South Dunedin and Gore (tab 3) from Mary-Ann McKibben, Ministry of Social Development, lead for the South Dunedin SST.

The Committee discussed the DHB's role in the future development of inter-sector collaboration across the whole Southern district and it was agreed that this issue should be considered as part of the draft Southern Strategic Health Services Plan.

Ms Carole Heatly, Chief Executive Officer, joined the meeting at 10.50 am.

4.0 MEMBERS' DECLARATION OF INTEREST

It was resolved:

"That the Interests Register be noted."

It was agreed that the Board Chair would discuss PHO representation on the committees with the Chair of the WellSouth Primary Health Network.

5.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the joint meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on 1 October 2014 be approved and adopted as a true and correct record."

6.0 MATTERS ARISING

There were no items arising from the previous minutes that were not covered by the agenda.

7.0 ACTION SHEET

The Committees reviewed the action sheet (tab 7) and requested:

- Timeframes for the SHALT work plan;
- Clarification of the numbers of children affected by general practices charging for after-hours care for under six year-olds.

8.0 PLANNING & FUNDING REPORT

The Planning and Funding report (tab 8) was taken as read and the Executive Director Planning and Funding highlighted the following items.

- Ranui Home & Hospital had received a second four-year certification;
- The Community Pharmacy Services Agreement (CPSA) was due to expire on 30 June 2015; however DHBs wished to review the current model before the introduction of the new agreement, as there was concern it had deviated from the original intent. To allow this to occur, the current agreement would be rolled over until 1 July 2016.

The Executive Director Planning & Funding then took questions from members.

9.0 ANNUAL PLAN QUARTERLY REPORT

A progress report for Quarter One against the plans, actions and commitments in the Southern DHB 2014/15 Annual Plan was circulated with the agenda (tab 9). The Executive Director Planning & Funding highlighted the achievements in the following areas:

- Immunisation;
- Appointment of a navigator role to support Pacific people in mental health and addiction services;
- Establishment of nurse-led clinics by Māori providers in rural high needs areas;
- Cardiac diagnostics;
- Primary Care, eg more heart and diabetes checks;
- The early implementation of rapid rounds to prompt earlier hospital discharge.

The Executive Director Planning & Funding reported that, as the progress report covered the whole of the Annual Plan and therefore straddled two advisory committees (DSAC/CPHAC and HAC), the Executive Team were considering dividing it up.

It was resolved:

> "That the Committees note the progress in Quarter One on delivering the Annual Plan 2014/15 and the intended actions where activity is incomplete."

10.0 FINANCIAL REPORT

The Executive Director Planning & Funding presented the Funder Financial Report for the period ended 30 September 2014 (tab 10), then took questions from members.

The Committees discussed the accrual and budgeting processes, and noted that management had taken steps to obtain more robust business analysis.

11.0 WORK PLAN

The Committees reviewed the DSAC/CPHAC work plan for 2014 (tab 11).

The Executive Director Planning & Funding advised that a Southern Alliance report/presentation would be added to the work programme for March.

CONFIDENTIAL SESSION

At 11.45 am it was resolved that the public be excluded for the following agenda item.

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.

The meeting closed at 12.00 noon.

Confirmed as a correct record:

Chairperson ……

Date ……

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

ACTION SHEET

As at 28 November 2014

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Oct 14 Nov 14	Under 6s (Minute item 8.0)	Actual number (not %) of children affected by general practices charging for after-hours care for under six year-olds. Status to be clarified.	EDP&F	As at 1 Oct 2014, the number of enrolled patients aged under 6 years affected by charging for after-hours services: 5,192 (22 general practices via Invercargill After-hours Doctors: 5,174; 1 general practice at Queenstown: 18). Total SPHO under 6 years enrolled: 21,847. There are 20,587 6 year olds enrolled and 813 of these patients not receiving free under 6 year old care	 Completed
Nov 14	Inter-Sector Collaboration (Minute item 3.0)	The DHB's role in the future development of inter-sector collaboration across the whole Southern district to be considered as part of the draft Strategic Health Services Plan.	EDP&F	Noted	Completed
Nov-14	SHALT (Minute item 7.0)	Timeframes requested for the SHALT work plan.	EDP&F	See attached 007.1	Completed

As at Nov 14

Alliance South Work Plan 14-15

Priority Area	Actions	Outcome/s	Time-frame	Progress
Acute Demand	Establish an Acute Demand Service Level Alliance Team	Acute Demand Service level Alliance Team established	Q2	
	Planning day to identify Acute Demand work priorities	Work Programme Agreed	Q2	
	Rapid Response Service: 1) 6 month Rapid Response Pilot 2) Recommendation to Alliance South on future Model/s of care 3) Implement recommendation for Rapid Response Service	Rapid Response Service implemented	Q1-3	
	Respiratory Services (Adult): 1) Planning workshop to identify future model/s of care for respiratory services. 2) Recommendation to Alliance South on future model/s of care. 3) Implement recommendation for Respiratory Services	District wide adult respiratory service model/s of care agreed and implemented	Q2-3	
	Primary Options for Acute Care (POAC): 1) Develop cellulitis pathway as first POAC service 2) Pilot cellulitis pathway in 5 pilot practices 3) Implement district wide cellulitis pathway under a POAC service. 4) Identify other Potential POAC services for development.	POAC Service established	Q1-4	
Community & Hospital Pharmaceuticals	Demand Side Management of Pharmaceutical Expenditure in SDHB: 1) Develop and implement a series of 6 key targeted campaigns aimed at reducing the volume and average per item cost of prescriptions and to develop campaigns around each of these targets. 2) Identify targets for interventions for the Responsible Use of Pharmaceuticals programme. 3) Top 10 priority areas identified and targeted.	Rational prescribing according to best practice guidelines resulting in reduced patient harm, waste and drug expenditure per capita	Q1-Q2	
	Polypharmacy: 1) Review medicines prescribed to the elderly population (≥75) to identify high volume medicines	Reduction in the number of people in the elderly population (≥) receiving five or more long term medications in SDHB	Q2-Q3	

Completed Underway according to plan Underway but progress is not as planned Not started and behind plan

As at Nov 14

	Disposal of Unwanted Medicines through Pharmacies (DUMP): 1) DUMP Campaign	DUMP Campaign completed that identifies: 1) Medicines in the community that have not been taken and the associated costs 2) Waste by therapeutic groups and clinical areas. 3) Reasons medications not taken 4) Potential work streams	Q2-Q3	
Rural Health	Establish Rural Service Alliance Team (SLAT)	Rural Service Alliance Team established	Q2	
	Identify and develop future rural funding model/s	Proposed future rural funding model of care agreed for consultation	Q2	
	Future rural funding model recommendation to Alliance South	Agreed funding model of care implemented	Q4/Q1 (15/16)	
Child/Youth	Establish Child/Youth Service Level Alliance team	Child/Youth Service level Alliance Team established	Q2	
	Align Child Youth Health Steering Group activity to Child/Youth Service Level Alliance	Work programmes and activity for Child/Youth services aligned	Q2	
Older Persons Health	Stocktake of current services for Older Person's Health undertaken	Stocktake of current services for Older Person's health completed	Q2-3	
	Establish Older Person's Health Service Level Alliance team	Older Persons Health Service Level Team established	Q3	
	Priorities for Older Person's Health identified	Work programme agreed	Q3-4	

Completed Underway according to plan Underway but progress is not as planned Not started and behind plan

SOUTHERN DISTRICT HEALTH BOARD

Title:	Planning and Funding Report
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	10 December 2014

Summary:

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

8

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: 24 November 2014	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

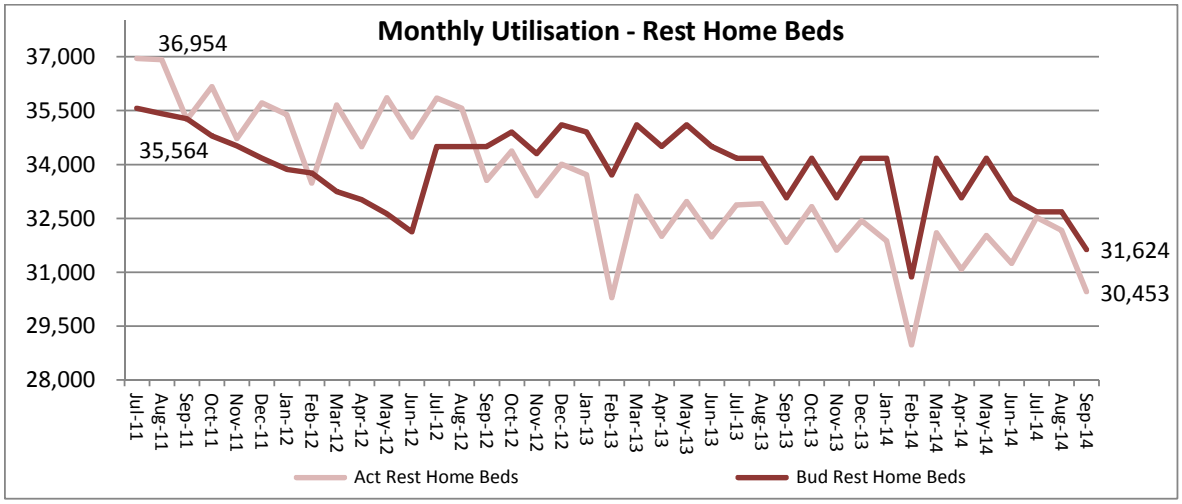
That CPHAC/DSAC note the content of this paper.

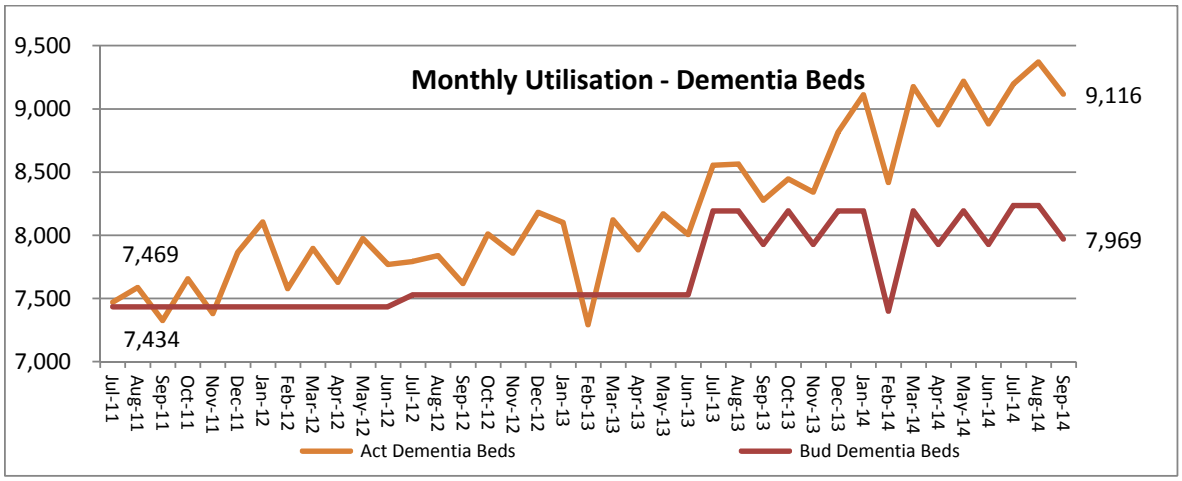
PLANNING AND FUNDING REPORT TO THE DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
December 2014

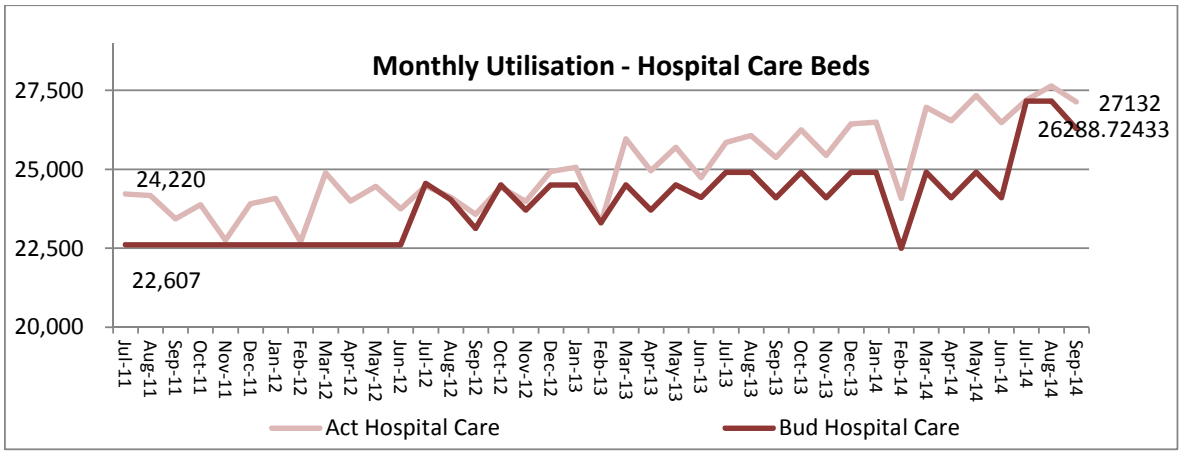
Health of Older People Portfolio

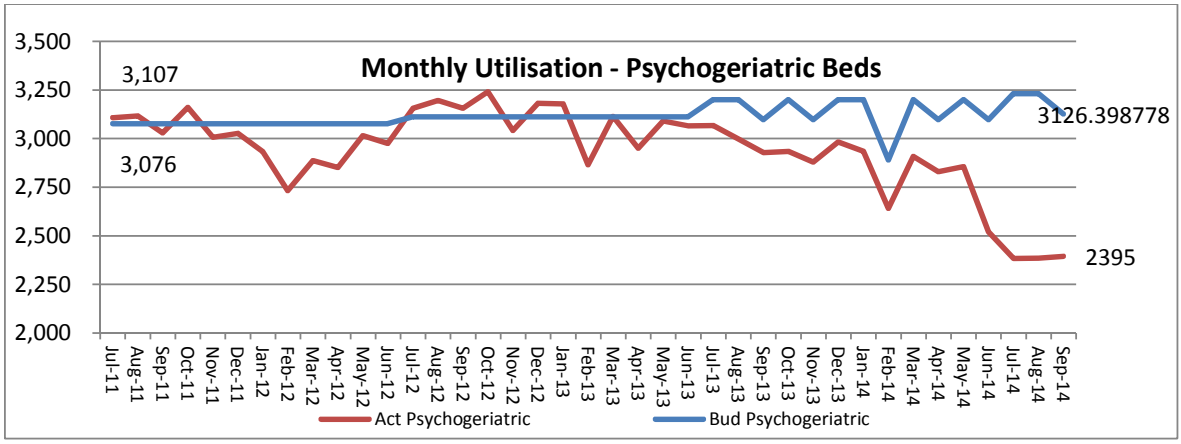
Bed day utilisation for Age Related Residential Care

The following graphs show the monthly bed utilisation rates for each category of age related residential care against the budget assumptions. The data is drawn from Sector Operations. It should be noted that the data is one month behind that shown in the October financials, which also reflect the impact of 2013/14 expenditure carried forward into the current financial year.









Aged Residential Care expenditure shows in two separate cost centres.

> Residential Care: Rest Homes (6640) includes both Rest Home Level and Secure Dementia Levels of Care.
>
> Residential Care: Hospitals (6650) includes Hospital Level Care and Psychogeriatric (Aged Continuing Care—Special) Care

This year, Long Term Support/Chronic Health Conditions clients requiring residential care have been included in these General Ledger lines (both the expense and the budget).

However, the graphs and utilisation figures show only the Aged Related Residential Clients.

For Residential Care: Rest Homes, the graphs show that Rest Home utilisation continues to decrease, faster than anticipated by the budget. This is due to the use of interRAI as a Comprehensive Clinical Assessment Tool, the Ageing in Place Strategy and the community supports available through our Home & Community Support Services (HCSS) Alliance. Utilisation of beds in Secure Dementia Units continues to increase at a rate higher than anticipated in the budget. Overall these two areas combined are tracking under budget.

For Residential Care: Hospitals, the graphs show that utilisation of Residential Hospital Care Beds is tracking just above budget. Utilisation of beds in Secure Psychogeriatric Units is tracking significantly below budget (note that this is a relatively small volume). Overall these two areas are tracking under budget.

Age Related Residential Care (ARRC)

Historically, there were four aged care providers in Southern providing a 'mixed' dementia/psychogeriatric service. Advice from MOH states that this is not best practice and recent audits have found issues in service provision. Over the past months, all four providers have decided to withdraw from psychogeriatric service provision, with the last provider ceasing to provide psychogeriatric services as part of a 'mixed' service as of 1 December 2014. This will result in only one provider of psychogeriatric services in Southland, Peacehaven in Invercargill. In the past, this service was also provided in Riverton and Gore. We contract with three providers in Dunedin for residential psychogeriatric services. All four providers (one remaining in Invercargill and three in Dunedin) have vacancies at present. While geographic accessibility is lessened by these changes, quality of service provision is increased.

St Andrews Home & Hospital, owned and managed by Presbyterian Support Otago, celebrated a four year certification result. This is the longest certification period awarded which requires no audit findings and evidence of continuous improvement. St Andrews in one of only six facilities in Southern to hold a four year certification.

Home & Community Support Services

Contracts for HCSS have yet to be finalised and are being paid in draft. Hours of service delivery for the bulk-funded HCSS for Older People are tracking below targeted levels.

HCSS In Between Travel

Ministry DSS, 20 DHBs and 3 individual private providers have ratified the agreement to pay for in between travel for support workers. Other providers and unions reported difficulty in ratifying by 30 November. It was agreed that ratification would be moved out until mid-March 2015 to provide sufficient time for a robust engagement with employees and providers.

The Ministry of Health has established a Steering Group to drive the In Between Travel programme. The Steering Group will oversee 5 work streams being:

1. The ratification of the Settlement Agreement
2. The Independent Assessment by KPMG
    a. Director General's Reference Group work streams – Report due 1 July 2015
    b. Review of HCSS Transition to Regularised Workforce
3. Implementation of Package (Operationalising Part A)
4. Enactment of Legislation

The DHB HOP Steering Group (representing all of NZ) will provide wraparound support to the DHB nominees on each workstream to ensure DHBs' input to each of the work streams is complete.

KPMG is progressing the independent review scheduled for completion 30 November. Providers have signalled that many smaller providers are likely to have difficulty providing the data required due to low-tech systems. MOH has provided data on expenditure and volumes for the past 3 years. DHBs will have the opportunity to participate and provide data for the review. Any assumptions used in the review need to be validated with a robust outcome assured. The Group has agreed to extend the date until mid-December with further review to be considered if necessary.

The Ministry will have overall responsibility for implementing the package, however acknowledges that it will require expertise and support from providers, DHBs and unions.

Mental Health, Addiction & Intellectual Disability Portfolio

Hapai te Tumanako - Raise HOPE Implementation

The process for recruiting to the District Networks overarching Network Leadership Group (NLG) is near completion. The majority of representatives from the sector have been identified. Planning and Funding is contacting potential interim representatives where there are gaps. Arrangements are underway for the first meeting of the NLG to be held in January 2015. Recruitment to the 0.2 FTE Independent Chair position is being advertised, with a goal of completing recruitment by the end of December.

The Raise HOPE Implementation Project Manager role is now in place within Planning and Funding. Priority projects include the establishment of the NLG, support for the four geographical areas to become established and project scoping re Hāpai te Tūmanako - Raise HOPE Implementation. Recruitment to the 0.5 FTE Administration role will be completed in December.

Primary and Community Portfolio

COMMUNITY PHARMACY

Stage 4 Roll out Consultation

SDHB along with DHB Shared Service Pharmacy Programme and MoH staff have conducted a roadshow to cover the payment mechanism for Stage 4 of the Community Pharmacy Service Agreement (CPSA). This will permit community pharmacists to claim an additional fee (Relative Value Unit) for dispensing multiple medication items. As indicated in a previous report, there is concern that this a move back to a payment on a dispensing model.

There was also discussion regarding the extension of the current CPSA to allow more time to make any changes to the new contract which was scheduled for the 1st July 2015. The new contract will not now be introduced until 1st July 2016.

Recent financial modelling projecting the impact of the Stage 4 Rollout indicates that there are a few pharmacies which will struggle with business sustainability. This applies more to rural pharmacies and SDHB continues to meet with pharmacy owners to discuss their business models and how they might make changes to manage decreasing revenues.

Impacted Community Pharmacies

There continue to be pharmacies which have been substantially impacted by the A3/J3 claiming anomaly. Negative A3/J3 prescriptions come from specialists, dentists and prison contracts, where the drug costs less than the co-payment. These prescriptions do not qualify for a share of the transition pool or an interim core services fee under the Community Pharmacy Services Agreement. However the national payments process resulted in payments being made against negative A3/J3 due to errors in: transposition from manual to automated process; the calculation of Transition payments and Interim Core Service Fees; and because the payments process was managed by both Sector Services and the CPS Programme, with different approaches being applied.

There are two pharmacies in Dunedin which will have to refund between $20,000 and $45,000 after the 2013/14 wash-up process is completed in February 2015.

SDHB is working with the pharmacies to determine to spread the impact of the recovery process across a number of months.

Laboratory Services

SDHB has agreed to extend the Laboratory Contract for an additional two years. The contract price was set in the original contract for this period of time. However, SDHB has decided not to incorporate the laboratory costs incurred which were not part of the original Laboratory Contract (tests not part of the 2006 test list). This could have been done by calculating the quantum of historical test volumes, and their price, and adding this to the base contract price. However, SDHB, through the Clinical Laboratory Advisory Group, intends to implement best practice guidelines regarding the use of these tests. This is expected to reduce the ordering of these tests which will reduce overall laboratory costs. Therefore it would not have been possible to define volumes only based on historical data. Additional tests will therefore continue to be claimed on a fee for service basis.

PRIMARY CARE

WELLSOUTH (SOUTHERN PHO):

VLCA Practice

WellSouth notified the DHB on 11 November that they had approved the establishment of a new Very Low Cost Access (VLCA) Practice by Nga Kete Matauranga Pounamu Charitable Trust in Invercargill.

To qualify for VLCA, the practice must have at least 50% Maori, Pacific and Dep. 9 and 10 patients enrolled. The practice will be paid on a capitation basis, at a higher rate than non-VLCA practices. Funding flows from the DHB to the PHO and then on to the practice, on the basis of the register of enrolled patients. The first register will be submitted in February 2015 and is expected to include 300 enrolled patients. This will be paid to the provider for the quarter starting 1 April 2015. Over time the PHO estimates that the enrolled population will build to 1200 – 1500.

High Needs Adult Dental Programme to Continue

A successful 12 month pilot programme funded by WellSouth to improve access to oral health care services for Māori, Pacific People and other at-risk populations (Dep 9 and 10 ranking) has made a significant difference in the south.

Dr Tim Mackay, Oral Health Clinical Lead for health services at the Southern DHB, led the pilot. The aim was to provide basic dentistry services to fix oral health issues for people experiencing financial hardship, with patients referred via GPs and Maori and Pacific Health providers.

"The SDHB has an emergency fund which deals with dental care in emergency situations, but it doesn't help the unmet need for basic dentistry such as fillings and extractions for some of our at-risk population. Meeting this need helps to prevent people from getting to the stage of needing emergency treatment in a lot of cases. It was very satisfying to see smiles from people who had been trying to hide bad teeth; in many cases after only half an hour's work."

The programme is aimed at reducing health inequalities and improving overall health status, and has enabled these types of discussion to be initiated with recipients. While enabling

improved oral health, the programme has also assisted in building effective therapeutic relationships between our most at-risk populations and primary care.

Action to reduce the impact of alcohol related harm

Alcohol is a contributing cause of more than 200 illnesses defined by the International Classification of Diseases (ICD-10). For most of these conditions, the more alcohol consumed, the higher the risks for disease. In addition, the harmful use of alcohol can have serious negative effects on families and communities.

A quarter of the Southern population are hazardous drinkers, which is the highest prevalence of any DHB area in New Zealand (25.1% compared to the national average of 17%).

The rates of alcohol-related hospital admissions in the Southern Region are increasing beyond what would be expected for our population growth. For instance:

• Otago has a higher rate of alcohol-related hospital admissions in young people aged 15–24 years (215.3 per 100,000), compared to the national average (199.5 per 100,000 population).

• Southland's rate is much higher than the national average, at 317.6 per 100,000.

One of the most effective ways of reducing alcohol related harm is through the identification of hazardous drinking and the offer of brief advice, particularly in the primary care setting.

Dr John McMenamin (who is the Ministry of Health's Primary Care Champion for Tobacco Control) and others have developed an Alcohol ABC module, following roughly the same principles as the ABC for smoking cessation. This module utilises the AUDIT questionnaire, the basis of most alcohol screening programmes in the general population. This has been specifically developed and validated for primary care environments and is used internationality. Even just using the AUDIT without any subsequent intervention has been shown to have a positive effect on reducing or moderating patients' drinking.

WellSouth will make the Alcohol ABC module available to all Medtech practices from 1 March 2015.

ALLIANCE SOUTH

Draft Southern Health Services Strategic Plan

Members of Alliance South reviewed the Strategic Health Services Plan with a particular focus on areas where it has been identified that Alliance South would take a lead role and have a level of responsibility to deliver. Feedback and discussion from this review will be collated and submitted to ensure an Alliance South perspective is captured.

Acute Demand

Shortlisting and confirmation of members for the Acute Demand Service Level Alliance Team has occurred with membership being as follows:

Chair/Clinical lead	Dr Tim Stokes – Elaine Gurr Professor of General Practice, Otago University.

Clinicians-SMOs/Nursing/Allied Health/GP	Dr Anne Marie Tangney- GP Dr James Armstrong-GP Dr Ben Wilson- SMO Dr Adam McLeay-SMO Eileen Richardson-RN Maureen McNeill- RN (Primary Care)
St John	Rachel Nicolson-Hitt
Aged Care	Lyneta Russell Eleanor McTavish
Quality Improvement	Janine Cochrane
Planning & Funding	To be advised by P&F

Appointments are as yet to be made in the areas of Pharmacy, Palliative Care and Consumer Representation to this group.

Rapid Response Service (RRS)

The Rapid Response Service Pilot was originally scheduled to end 28th November, however the Older Persons Health Directorate have decided to extend the rapid response nurses contracts through until February to enable time for any decision to be reached about any future service and for any final recommendations made to be considered. This will ensure that there is no disruption to the service while the decision making process occurs.

A frail elderly review workshop has been bringing the original Rapid Improvement Process (RIP) workshop group together and including some additional members to discuss and endorse any key recommendations that need to be considered for the provision of future services. This information will be captured in the final report and recommendation.

To provide input to the final report from both a referrer and patient perspective, referrer survey monkey audit and patient satisfaction audits have been sent out and are in the process of being collated. A presentation by the trainee interns on their health evaluation project's findings and recommendations around the Rapid Response Service has occurred and along with the audits will help inform the final report and recommendation.

The final report and recommendation on a future model of care will be collated and ready for Alliance South's meeting in December.

Respiratory

Intensive care management for the 119 patients identified as Frail Elderly with COPD with the Well South Long Term Conditions Nurses continuing to work alongside the General Practices to deliver health interventions and the COPD Blue Card to this group of patients. Patients who have had contact with the Long Term Conditions Nurses are now registered on Care Plus where possible.

A workshop of key stakeholders has been scheduled for 3rd December in order to develop a work plan that prioritises the key activity that is required to develop a system solution for respiratory services across the district. Recommendations from this workshop will be presented to Alliance South in February 2015.

Community & Hospital Pharmaceuticals

The Demand Side Management Project continues, with 373 visits to prescribers to date. Visits over the next month in primary care will also focus on a campaign around polypharmacy.

Visits to secondary care clinicians have also commenced with neurology, respiratory, ED and cardiovascular physicians having now had some initial conversations. These visits will continue over the coming month with Older Persons Health and Dermatology to also be targeted.

At their November meeting, the Community and Hospital Pharmacy SLAT members agreed to the scoping of the Disposing of Unwanted Medications through Pharmacies (DUMP) campaign and activity is now commencing in this area.

Access to pharmaceutical data required for reporting has been somewhat difficult, however issues have been worked through and we are confident that the data will be available. It should be noted that there is a three month time lag with data, so any improvements or progress will not be evident for some months.

Rural Health

At their last meeting, members participated in an A3 Problem Solving session to assist with defining the future state and what the group wished to achieve with rural funding. Members were able to agree that the problem was that currently rural practices provide many services that in the main centres are provided by secondary care, yet the rural funding does not compensate for this. What they hope to achieve with the work that they are undertaking is that the funding model ensures transparent funding for rurality, and separates out the primary care provision of secondary care services. The next steps were identified as being:

1) Use the Canterbury funding model to theoretically "allocate" rural funding to our rural practices and compare the results with the current allocation

2) Develop a definition of what the rural funding compensates providers for

3) Define a clear set of expectations for providers receiving rural funds

Following that meeting, a rural funding model has been developed, based on the Rural Canterbury model. The model takes account of patient access to services, the degree of rural isolation and, to a lesser extent, patient population. The southern region rural funding amounts have been added to the model so that the group can make adjustments at its next meeting scheduled for mid-November in order to see if the model can work for our region. If agreement is reached at the meeting this will then be taken out to rural practices for consultation, and in turn forwarded to Alliance South for consideration.

Integrated Performance Incentive Framework Update

Joint Project Steering Group Co-chairs Update

The Joint Project Steering Group (JPSG) have met twice since the August sector update and have further advanced the discussion and development work for IPIF. The areas of development that were covered at these meetings included:

- potential measures for 15/16 and 16/17
- incentives and the role they play in the IPIF
- the approach IPIF should take around management of change
- the process for undertaking self-assessment and peer review of the PHO minimum requirement.

Southern Strategic Health Services Plan

The consultation on the draft plan closed on 21 November after 17 roadshow presentations to a total of 445 people in 11 locations across the district. Meetings at two different times of day were offered in most communities to accommodate availability. With very few exceptions, media reporting has been fair and accurate and many communities have welcomed the chance to discuss health services with the DHB. Many of the community conversations have not concentrated heavily on local issues, but have also explored some wider concepts and themes. In several cases, the meeting appears to have fostered communities discussing local solutions amongst themselves.

A review of the consultation process is now being undertaken to ensure the strengths and weaknesses of the exercise are recorded to inform future exercises.

All feedback, including written submissions and electronic questionnaire results will be analysed for themes and a report prepared for the Board meeting in February. The analysis will also inform the next and final draft of the plan, also due in February.

Attachments:

1. PHS Report

SOUTHERN DISTRICT HEALTH BOARD

Title:	PUBLIC HEALTH SERVICE REPORT
Report to:	Community & Public Health Advisory Committee
Date of Meeting:	10 December 2014

Summary:

The issues considered in this paper are:

- Public Health Service activity

8.1

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: 18/11/14	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
10 December 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

BURP – Breastfeeding Smartphone Application

A new smartphone application (app) to direct mums to breastfeeding friendly facilities is to be launched in early December. The BURP (Breastfeeding's Ultimate Refuel Place) app is a joint venture between the Southern District Health Board and WellSouth Primary Health Network. The BURP app was developed after evaluation of the current 'Baby and Breastfeeding Friendly' brochure and allows this print resource to be portable, current and consistent for mothers throughout the Southern district. Research shows that there are high levels of smartphone usage across all socio-economic areas so this is anticipated to be a new way of engagement with all sectors of the community.

The BURP app will be free to download and allow the user to see the closest breastfeeding friendly facility whether it be a cafe, library or swimming pool and lists what they additionally offer e.g. change table, pram friendly, comfortable seating etc. Pictures of the facility and an opportunity for users to provide feedback will be available. The BURP information and feedback will be managed by Public Health South and WellSouth Primary Network.

A BURP website (www.burpapp.co.nz) has also been developed alongside the app which provides links to local breastfeeding support and promotes the latest breastfeeding news and events in the Southern region.

Stop Smoking Clinic

A Stop Smoking Clinic at Southland Hospital has been running since February and is held on Wednesdays from 10am to noon. The original aim of the clinic was to offer support to patients on the surgical waiting list who are often advised they need to stop smoking prior to surgery. While this group still forms a large part of the programme with 7 out of 10 participants waiting for surgery, the clinic is open to everyone and is being promoted in primary and secondary care, as well as in community settings. People can self-refer to the programme and get free support and nicotine products for as long as they require.

The programme is run with the support of Nga Kete Pounamu Charitable Trust and participants attending are offered options of group, telephone or individual sessions. Recently, post-surgical patients have also been referred to the service. They may not be able to attend the group clinic but still get all the individual support they need to be smokefree. Feedback about the programme has been very positive and we are planning to provide a similar service in Dunedin from January 2015.

Communicable Disease and Food Safety

Outcome 4 Reduce the impact and incidence of communicable disease

Dedicated Needle Exchanges

One of the key strategic elements of a Hepatitis C programme is the use of needle exchanges as a mechanism to reduce the harm associated with injecting drugs. Within the Southern district there are two dedicated needle exchange service providers. For the rural community there is provision through some community pharmacies who offer a service on a voluntary basis.

The dedicated needle exchange programmes that operate in the Southern district are funded directly by the Ministry of Health and delivered to a national service specification. These services are extremely important in reducing the harm associated with personal self-administration of drugs such as opioids or steroids.

Potential harm comes from the risk of infection, particularly blood-borne viruses, from the re-use or sharing of needles and other paraphernalia. Needle Exchange Programmes are thus a key intervention to reduce the incidence of blood-borne Hepatitis and HIV infections. Both the Invercargill and Dunedin Needle Exchanges are being visited during November 2014 in recognition of the importance of their role and in order to maintain a close relationship between the Southern District Health Board and this important local health service. Both services currently operate to a high standard and deliver valuable interventions that extend beyond simple needle exchange to include health advice. They provide a vital bridge to a section of the community which is easy to ignore and which may not engage well with mainstream service providers but which has high health needs.

Medical Officers of Health are responsible for authorising local dedicated needle exchanges but the service specification and contracting are undertaken at a national level by the Ministry of Health. We work with the Ministry and lead agency to ensure current service delivery is effective.

Ebola Response Preparations

The risk of a case of Ebola arriving in New Zealand remains low. There is on average, one person arriving in New Zealand from the affected countries every week. Border personnel are undertaking health screening of arrivals and the Ministry of Health have issued detailed protocols for the management of suspected cases that arrive at the New Zealand border and instructions for those who have travelled from the affected area but are well upon arrival in New Zealand.

Within the Southern DHB a coordination group has been established to provide oversight of the planning across the local health sector with leadership from the executive team. The group includes representatives from each of the Southern DHB hospital facilities, from the rural hospitals and WellSouth. This group is complemented by a local Ebola Technical Advisory Group (ETAG) which comprises local experts in microbiology, infectious diseases, infection prevention and control, emergency planning and public health. The role of the ETAG is to provide technical advice and to peer-review local protocols.

The national response approach requires that suspected cases are, wherever possible, treated at one of four designated tertiary hospitals. For the South Island the designated centre is Christchurch Hospital. The logistics of direct transfer of a suspected case to Christchurch from within the Southern District are complex. Provision has been made within the Emergency Department at Dunedin Hospital for suspected cases to be isolated in a negative pressure facility. Onward transport will then be arranged after a clinical assessment and any immediate necessary treatment and in close liaison with colleagues from

Christchurch and St John. A negative pressure facility within the Emergency Department at Southland Hospital has been allocated as an area where a suspected case can be held pending transfer to another facility. Arrangements are in place at Lakes District Hospital to isolate suspected cases.

SOUTHERN DISTRICT HEALTH BOARD

Title:	Quarter One DHB Performance Reporting
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	10 December 2014

Summary:

Overview of DHB Performance Reporting for Quarter One 2014/15 with brief comments where targets or expectations have not been met.

9

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:

Prepared by: Planning & Funding Date: 24.11.14	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATIONS:

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

Summary of DHB Performance Reporting – Quarter 1 2014/15

Health Targets

Health Targets								
Measure		Target	Results				Final Rating	Comments
			13/14			14/15		
			Q2	Q3	Q4	Q1		
Better help for smokers to quit	Primary care	90%	64.2%	63.5%	71.2%	76.2%	P	The Q1 result is a 5% increase on last quarter's result. Response from the Ministry states "Both the DHB and the PHO have made significant investment in improving the target result and have put many best practice systems and strategies in place."
	Secondary	95%	95.8%	95.3%	95.1%	95.2%	A	
	Maternity	90%	96.6%	96.3%	96.3%	99.2%	A	
Improved access to elective surgery		100%	100.9%	101.9%	105.8%	100.3%	A	
Increased immunisation		95%	92.7%	93.7%	93.0%	93.8%	P	Response from the Ministry states "Reaching the December 95% target for full immunisation of infants aged 8 months is achievable for your region based on the immunisation status of the October, November and December cohorts of children turning 8 months of age."
More heart and diabetes checks		90%	64.2%	69.1%	77.6%	79.6%	P	Response from the Ministry states "Pleased to read of the enhanced use of IT tools to improve CVDRA delivery and data capture, the appointment of Health Target Champions, increased monitoring and reporting, and the education and support provided to practice staff."
Shorter stays in Emergency Departments		95%	92%	93%	91%	93%	P	
Shorter waits for cancer treatment radiotherapy and chemotherapy		100%	100%	100%	100%	100%	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
PP7 Improving mental health services using transition (discharge) planning and employment		P	Locally, the specific work around 'Transition Planning' was commenced from July 2014. The full components of transition planning are now being incorporated into clinical work, discharges, and clinical files. We expect to see a demonstrable improvement over time as the evolved components of 'Transition Planning' are fully incorporated into service delivery and treatment processes.
PP8 Shorter waits for non-urgent mental health and addiction services		P	PRIMHD compliance and completeness continues to be an issue and is being actively addressed in both DHB and NGO services.
PP18 Improving community support to maintain the independence of older people		A	
PP20 Improved management for long term conditions (CVD, diabetes and Stroke)	Focus Area 1: LTC & DCIP	P	A plan for improvement in DCIP is expected next quarter.
	Focus Area 3: Acute Coronary Syndrome	A	
	Focus Area 4: Stroke	P	The available stroke data is not confirmed at this time. Response from the Ministry states "the stroke services provided by the DHB are very good. More work is obviously needed to include an improvement in service provision outside Dunedin Hospital."
PP21 Immunisation coverage (previous health target)		A	
PP22 Improving System Integration		A	
PP23 Improving Wrap Around Services – Health of Older People		A	
PP24 Improving waiting times - Cancer MDMs		A	
PP25 Prime Ministers youth mental health project		A	

Measures of DHB Performance			
Measure		**Final Rating**	**Comments**
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	
PP29 Improving waiting times for diagnostic services	Angiography	A	
	CT / MRI	P	Neither the CT or MRI indicator expectations were met in September; however there was an improvement in the MRI result.
	Colonoscopy	A	
PP30 Faster Cancer Treatment		N	Data submitted (14%) shows less than 15% of expected cancer registrations for the quarter. The Ministry has signalled to DHBs that a minimum of 15% of expected cancer patients are expected to fall within the 62-day pathway, rising to 25% over time. SDHB is working with the MoH to review and improve data capture and reporting.
System Integration Dimension			Meeting service coverage requirements and supporting sector inter-connectedness
SI2 Delivery of Regional Service plans			
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) - days	Acute	A	
	Elective	A	
OS8 Reducing Acute readmissions to hospital	Total Population	A	
	75 +	A	
OS10 Improving the quality of data provided to	Focus area 1: NHI	O	
	Focus area 2:	N	This result is directly related to issues we encountered in the loading of files within the first month after NCAMP. These

Measures of DHB Performance			
Measure		**Final Rating**	**Comments**
national collection systems	National collections		issues have been identified and corrected and we expect to regain Achieved or higher in the next quarter.
	Focus area 3: PRIMHD	A	
Development Dimension			
DV4 Improving patient experience		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	
Well Child Tamariki Ora Services	S	
Funding for Dementia Respite Care	S	
National Patient Flow	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:	10 December 2014

Summary:

The issues considered in this paper are:

- October 2014 Funds result

10

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: Peter Beirne Executive Director Finance and Sandra Boardman Executive Director Planning & Funding Date: 27/11/2014	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

1. That the report be received.

DSAC / CPHAC FINANCIAL REPORT

Financial Report for: **October 2014**
Report Prepared by: **Peter Beirne**
Date: **21 November 2014**

Recommendations:

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

1. DHB Funds Result

The overall funder result follows;

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
69,646	69,334	312	Revenue	278,062	277,607	455	832,283
(70,150)	(69,379)	(771)	Less Other Costs	(279,672)	(277,442)	(2,230)	(825,966)
(504)	(45)	(459)	Net Surplus / (Deficit)	(1,610)	165	(1,775)	6,317
			Expenses				
(49,980)	(49,512)	(468)	Personal Health	(198,864)	(197,931)	(933)	(588,785)
(7,119)	(7,089)	(30)	Mental Health	(28,492)	(28,358)	(134)	(85,075)
(635)	(624)	(11)	Public Health	(2,760)	(2,764)	4	(7,753)
(11,567)	(11,276)	(291)	Disability Support	(46,044)	(44,876)	(1,168)	(133,736)
(124)	(153)	29	Maori Health	(610)	(611)	1	(1,833)
(725)	(725)	0	Other	(2,902)	(2,902)	0	(8,784)
(70,150)	(69,379)	(771)	Expenses	(279,672)	(277,442)	(2,230)	(825,966)

Summary Comment:

For October the Funder had a deficit of $0.46m against a budget close to breakeven. Revenue was favourable by $0.3m and has cost offset. Costs overall were unfavourable by $0.77m in October and $2.2m year to date (YTD) with some revenue offsets.

Year to date to October there are appropriately $0.8m of prior year costs impacting in the current year including DSS $0.4m, labs $0.1m and pharmaceuticals $0.2m higher than year end accruals. IDF inflows and outflows included in this month's variance were collectively $0.38m worse than budget making up the majority of the worse than budget performance of $0.46m. This is the first month IDF information has been available and this does not necessarily signal a trend. The updated Pharmac forecast for 2014/15 is not yet available and the June forecast has been utilised. This is a significant accrual estimate.

2. Results by Grouping

The following table shows revenue and expenditure by Output Class:

Month Actual $' 000	Month Budget $' 000	Month Variance $' 000		Year to Date Actual $' 000	Year to Date Budget $' 000	Year to Date Variance $' 000
			Revenue			
60,995	60,834	161	Personal Health	243,599	243,331	267
7,048	7,040	9	Mental Health	28,192	28,157	35
696	705	(8)	Public Health	2,978	3,088	(111)
179	32	148	Disability Support	383	127	255
2	0	2	Maori Health	9	0	9
725	725	0	Funding and Governance	2,902	2,902	0
69,646	69,335	311	Revenue total	278,062	277,606	455
			Expenses			
(49,980)	(49,511)	(469)	Personal Health	(198,864)	(197,931)	(933)
(7,118)	(7,090)	(28)	Mental Health	(28,492)	(28,358)	(134)
(635)	(624)	(11)	Public Health	(2,760)	(2,764)	4
(11,567)	(11,276)	(291)	Disability Support	(46,044)	(44,876)	(1,168)
(124)	(153)	29	Maori Health	(610)	(611)	1
(725)	(725)	0	Funding and Governance	(2,902)	(2,902)	0
(70,149)	(69,379)	(770)	Expenses total	(279,672)	(277,442)	(2,230)
			Surplus (Deficit)			
11,015	11,323	(308)	Personal Health	44,735	45,400	(666)
(70)	(50)	(19)	Mental Health	(300)	(201)	(99)
61	81	(19)	Public Health	218	324	(107)
(11,388)	(11,244)	(143)	Disability Support	(45,661)	(44,749)	(913)
(122)	(153)	31	Maori Health	(601)	(611)	10
0	0	0	Funding and Governance	0	0	0
(503)	(44)	(459)		(1,610)	164	(1,775)

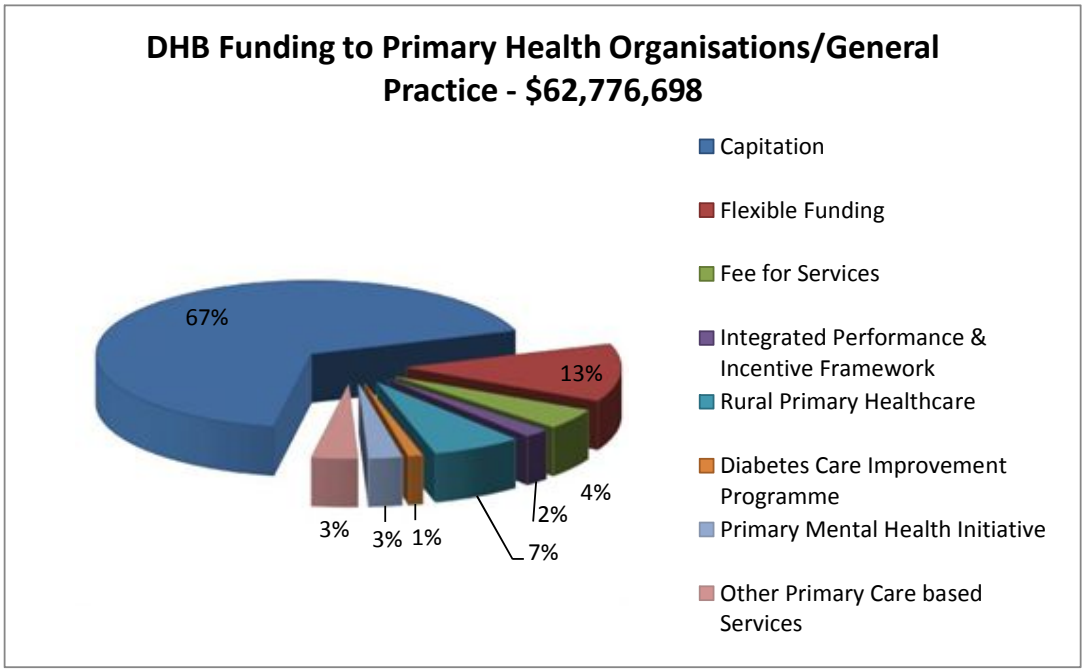
- Personal Health payments are unfavourable for the month by $0.468m. Laboratory costs ($0.1m) and IDF outflows ($0.3m) make up much of the variance. Prior year costs in Personal Health are approximately $0.35m, of which Pharmaceuticals ($0.2m) is a timing difference with Pharmac advising this is expected to reduce throughout the year.
- Labs additional tests remain an estimate of $0.4m for the first four months, as invoicing has yet to be received.
- Palliative care returned to be in line for budget for the month as did Travel and Accommodation. Both remain forecast to be adverse for the full year.
- Mental Health and Public Health were close to budget.
- DSS costs were unfavourable for the month, with home support, rest home and hospital all adverse.

3. DHB Funds Result split by NGO and Provider

	Current Month				Year to Date			
Personal Health	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance
Oct-14	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%
Personal Health - Provider Arm								
Child and Youth	(348)	(348)			(1,394)	(1,394)		
Laboratory	-	-			(1)	(1)		
Infertility Treatment Services	(92)	(92)			(366)	(366)		
Maternity	(42)	(42)			(166)	(166)		
Maternity (Tertiary & Secondary)	(1,380)	(1,380)			(5,520)	(5,520)		
Pregnancy and Parenting Education	(3)	(3)			(10)	(10)		
Neo Natal	(660)	(660)			(2,641)	(2,641)		
Sexual Health	(87)	(87)			(348)	(348)		
Adolescent Dental Benefit	(26)	(26)			(106)	(106)		
Dental - Low Income Adult	(22)	(22)			(89)	(89)		
Child (School) Dental Services	(595)	(595)			(2,379)	(2,379)		
Secondary / Tertiary Dental	(116)	(116)			(465)	(465)		
Pharmaceuticals	(364)	(292)	(72) U	24%	(1,073)	(1,167)	94 F	(8%)
Pharmaceutical Cancer Treatment Drugs	(488)	(386)	(102) U	26%	(1,694)	(1,542)	(152) U	10%
Pharmacy Services	(9)	(9)			(35)	(35)		
Rural Support for Primary Health Pro	(71)	(71)			(283)	(283)		
Immunisation	(70)	(70)			(279)	(279)		
Radiology	(268)	(268)			(1,074)	(1,074)		
Palliative Care	(7)	(7)			(28)	(28)		
Meals on Wheels	(33)	(33)			(134)	(134)		
Domicilary & District Nursing	(994)	(994)			(3,977)	(3,977)		
Community based Allied Health	(416)	(416)			(1,665)	(1,665)		
Chronic Disease Management and Educa	(160)	(160)			(641)	(641)		
Medical Inpatients	(5,653)	(5,653)			(22,612)	(22,612)		
Medical Outpatients	(3,272)	(3,272)			(13,088)	(13,088)		
Surgical Inpatients	(10,628)	(10,628)			(42,513)	(42,513)		
Surgical Outpatients	(1,548)	(1,548)			(6,190)	(6,190)		
Paediatric Inpatients	(644)	(644)			(2,578)	(2,578)		
Paediatric Outpatients	(269)	(269)			(1,075)	(1,075)		
Pacific Peoples' Health	(10)	(10)			(40)	(40)		
Emergency Services	(1,478)	(1,478)			(5,913)	(5,913)		
Minor Personal Health Expenditure	(26)	(26)			(103)	(103)		
Price adjusters and Premium	(422)	(422)			(1,687)	(1,687)		
Travel & Accomodation	(4)	(4)			(17)	(17)		
	(30,308)	**(30,031)**	**(277) U**	**(1%)**	**(120,287)**	**(120,126)**	**(161) U**	**(0%)**
Personal Health NGO								
Personal Health to allocate	-	(83)	83 F		-	(333)	333 F	
Child and Youth	(34)	(34)		1%	(119)	(136)	17 F	13%
Laboratory	(1,560)	(1,465)	(96) U	(7%)	(6,241)	(5,859)	(382) U	(7%)
Infertility Treatment Services	-	(9)	9 F		-	(36)	36 F	
Maternity	(220)	(220)			(893)	(881)	(12) U	(1%)
Maternity (Tertiary & Secondary)	(1)	(14)	13 F	95%	(9)	(54)	45 F	83%
Pregnancy and Parenting Education	(16)	(10)	(6) U	(60%)	(37)	(39)	2 F	6%
Maternity Payment Schedule	-	-			-	-		
Neo Natal	-	-			-	-		
Sexual Health	(2)	(1)		(1%)	(6)	(6)		
Adolescent Dental Benefit	(139)	(175)	36 F	20%	(653)	(706)	53 F	8%
Other Dental Services	-	-			-	-		
Dental - Low Income Adult	(51)	(55)	5 F	9%	(212)	(222)	9 F	4%
Child (School) Dental Services	(35)	(35)	1 F	2%	(102)	(142)	41 F	28%
Secondary / Tertiary Dental	(126)	(126)			(504)	(504)		
Pharmaceuticals	(6,059)	(6,112)	52 F	1%	(24,609)	(24,331)	(279) U	(1%)
Pharmaceutical Cancer Treatment Drugs	-	-			-	-		
Pharmacy Services	(96)	(61)	(35) U	(58%)	(162)	(243)	80 F	33%
Management Referred Services	-	-			-	-		
General Medical Subsidy	(90)	(92)	3 F	3%	(328)	(347)	19 F	5%
Primary Practice Services - Capitated	(3,494)	(3,511)	17 F		(14,099)	(14,044)	(55) U	
Primary Health Care Strategy - Care	(323)	(318)	(5) U	(2%)	(1,266)	(1,271)	5 F	
Primary Health Care Strategy - Health	(256)	(337)	81 F	24%	(1,269)	(1,347)	77 F	6%
Primary Health Care Strategy - Other	(175)	(255)	80 F	31%	(926)	(1,019)	93 F	9%
Practice Nurse Subsidy	(14)	(16)	2 F	15%	(53)	(65)	12 F	19%
Rural Support for Primary Health Pro	(1,312)	(1,313)	1 F		(5,218)	(5,252)	34 F	1%
Immunisation	(56)	(99)	43 F	43%	(329)	(447)	118 F	26%
Radiology	(218)	(196)	(22) U	(11%)	(809)	(784)	(25) U	(3%)
Palliative Care	(484)	(488)	4 F	1%	(2,130)	(1,953)	(176) U	(9%)
Meals on Wheels	(20)	(20)			(80)	(80)		
Domicilary & District Nursing	(527)	(435)	(92) U	(21%)	(1,872)	(1,747)	(125) U	(7%)
Community based Allied Health	(168)	(168)	(1) U		(673)	(670)	(3) U	
Chronic Disease Management and Educa	(96)	(95)	(1) U	(1%)	(361)	(380)	19 F	5%
Medical Inpatients	-	-			-	-		
Medical Outpatients	(410)	(397)	(13) U	(3%)	(1,647)	(1,590)	(57) U	(4%)
Surgical Inpatients	(14)	(19)	5 F	26%	(67)	(75)	8 F	10%
Surgical Outpatients	(139)	(146)	7 F	5%	(556)	(585)	29 F	5%
Paediatric Inpatients	-	-			-	-		
Paediatric Outpatients	-	-			-	-		
Pacific Peoples' Health	(11)	(12)		4%	(34)	(47)	13 F	28%
Emergency Services	(159)	(156)	(4) U	(2%)	(663)	(622)	(41) U	(7%)
Minor Personal Health Expenditure	(59)	(74)	15 F	21%	(279)	(295)	16 F	6%
Price adjusters and Premium	(162)	(83)	(79) U	(94%)	(585)	(334)	(251) U	(75%)
Travel & Accomodation	(453)	(451)	(2) U		(1,882)	(1,763)	(119) U	(7%)
Inter District Flow Personal Health	(2,695)	(2,399)	(296) U	(12%)	(9,906)	(9,596)	(311) U	(3%)
	(19,674)	**(19,480)**	**(194) U**	**(1%)**	**(78,579)**	**(77,805)**	**(774) U**	**(1%)**
Total Personal Health	**(49,982)**	**(49,511)**	**(471) U**	**(1%)**	**(198,866)**	**(197,931)**	**(935) U**	**(0%)**

Costs for personal health were ahead of budget for October by $0.47m with additional Lab costs for send away and other unbudgeted tests $0.1m and IDF outflows $0.3m unfavourable. Child and youth costs have been transferred in the month with the YTD now close to budget. Travel and Accommodation costs, previously adverse, were in line with budget for the month. Palliative care, also previously adverse, was in line with budget for the month, with YTD now $0.2m unfavourable.

Description of Primary Healthcare Funding Streams



Funding Table

Capitation	$ 42,090,027.08
Flexible Funding	$ 7,971,341.74
Fee for Service	$ 2,818,690.00
Integrated Performance & Incentive Framework	$ 1,200,000.00
Rural Primary Healthcare	$ 4,231,768.70
Diabetes Care Improvement Programme	$ 685,082.08
Primary Mental Health Initiative	$ 1,593,798.00
Other Primary Care based Services	$ 2,185,990.30
Grand Total	**$ 62,776,697.91**

In Southern all GP Practices, except the Polytechnic Student Health Services and University Student Health Services (Student Health Services) and Dunedin Urgent Drs, are affiliated to a Primary Health Organisation (PHO). There are 89 GP Practices affiliated with the WellSouth Primary Health Network (formally known as Southern PHO) of which 35 are classified as Rural Providers.

Capitation Funding

PHOs are funded a capitation payment for each Enrolled Service User (ESU). Patients are enrolled with a PHO when they first attend a GP Practice. If a patient does not attend a GP for three years they are removed as an ESU from that PHO. PHO's submit their registers of ESU's quarterly to the Southern DHB via the Ministry of Health Sector Operations. Sector Operations then calculates the funding for each ESU and the PHO is funded through the PHO Services Agreement with the DHB. GP Practices are funded by the PHO for services to patients through PHO to Practice contracting arrangements.

Additional capitation payments are made to PHOs for practices that offer zero fees for under sixes and/or are very low cost access practices, this is also calculated on PHO under sixes and very low cost practices ESUs. In Southern 86 practices offer zero fees of under sixes and 3 practices are very low cost access practices.

Flexible Funding
In addition to the capitation payment for each ESU, Services to Improve Access Funding, Careplus Funding, Management Fees and Health Promotion Funding are all calculated using the number of ESUs in the PHO's quarterly register. These funding streams are all paid to the PHO to support PHO services and activities as well as enable the DHB to PHO Alliance Agreement.

Fee for Services
General Medical Service (GMS) fees are claimable for casual patients not enrolled with a PHO and immunisations are funded for each vaccination episode administered.

Student Health Services and Dunedin Urgent Drs are contracted for General Medical Services and Immunisation Services through a Section 88 Notice with the Southern DHB and submit a claim form to the DHB via the Ministry of Health Sector Operations for each consultation undertaken. Student Health Services are also able to claim a Practice Nurse subsidy. All other GP Practices in Southern are funded for General Medical Services and Immunisation Services through their affiliation with a PHO and the PHO Services Agreement.

Integrated Performance and Incentive Framework
This initiative replaced the previous PHO Performance Programme from 1 July 2014 and implements the following measures and targets for each PHO to achieve for their eligible Enrolled Service Users (ESU):

- More Heart and diabetes checks (target 90 percent)
- Better help for smokers to quit (target 90 percent)
- Increased Immunisation rates at 8 months old (target 95 percent)
- Increase immunisation rates at 2 years old (target 95 percent)
- Cervical screening coverage (target 80 percent).

PHOs are expected to meet and/or maintain performance at the national target by 30 June 2015. Quarterly Targets will be set for individual PHOs to enable them to reach the national targets after four quarters. Each quarterly payment is calculated on the basis of the PHO's performance in each quarterly period during the year in relation to the PHO's Quarterly target.

Rural Primary Healthcare Funding
Rural Primary Healthcare Funding is made up of 3 parts

- The Rural Premium
- Provision of Rural After Hours Primary Health Care
- Rural Bonus subsidy

The Rural Premium is a flexible PHO Fund, and consists of Reasonable Roster Funding, a targeted resource aimed at those experiencing onerous on call arrangements, and Rural Workforce Retention a flexible resource for supporting and retaining the primary health care team calculated annually based on the each Rural practices ESUs.

Rural After Hours Primary Health Care Funding is determined annually for each practice by the Ministry of Health with a requirement to pass on 100% of funding to the Eligible Rural General Practice. Both of these funding streams are paid to the PHO for their management and administration

Eligible General Practitioners can apply annually to the Southern DHB for the Rural Bonus subsidy; this is calculated based on their completion of a Rural Subsidy Score Worksheet. The Rural Bonus Subsidy is paid monthly from Southern DHB to the eligible General Practitioner.

Diabetes Care Improvement Programme
Southern DHB funds the PHO to provide a Diabetes Care Improvement Programme (DCIP).
The DCIP utilises a rewards based funding model focused on improving clinical outcomes for people with diabetes. The DCIP will evolve and markers will change, with annual evaluation and amendment to drive continuous improvement in the provision of primary care services to people with diabetes. The aim of the DCIP is to ensure consistent diabetes care in a primary care setting which meets best practice standards and guidelines.

Primary Mental Health Initiative
Primary mental health services funding is for the development and provision of mental health responses, such as employment of mental health professionals and funding of packages of care for eligible patients who have mild to moderate mental illness in a primary health care setting.

Other Primary Care Based Services
Southern DHB has agreements to support the PHO and GP Practice teams to provide sustainable services to their ESUs. These agreements are all with the PHO who then provide the services or contract with their affiliated GP Practices to provide the services being purchased by Southern DHB. These additionally funded service lines are listed below:

- Provision of free after-hours medical care for children under six years-old
- Nightcaps Nurse Led Clinic Service
- Glenorchy Clinic
- GPSI (General Practitioner with a Special Interest) Skin Lesion Programme
- Smoking Cessation Support Services
- Primary Care Workforce Development
- Reducing Inequalities Voucher Services
- Assistance to Implement the Primary Care Ethnicity Data Audit tool
- Rheumatic Fever - General Medical Services
- General Practice Palliative Care
- More Heart and Diabetes Checks
- After Hours Primary Health Care Initiatives
- Telephone Nursing Triage Services (HML)
- School based HPV Immunisation programme - Southland

Southern DHB has agreements to fund Student Health Services for After Hours Primary Health Care Initiatives, Diabetes Services, Sexual Health Services, and Mental Health Services.

Fiordland Medical Centre is also contracted for ambulatory integrated medical services and maintenance of radiological equipment (x-ray equipment).

Dunedin Urgent Drs Ltd is contracted for Practice Nurse Services.

These agreements with Student Health Services, Fiordland Medical Centre and Dunedin Urgent Drs Ltd are the only agreements Southern DHB has directly with a General Practice.

General Practice Funding Outside of the DHB

Primary Health Care General Practices have funding streams outside of the DHB. These funding streams are not visible to the DHB, as General Practices are private businesses.

These include, but are not limited to:

- Co-payments by patients for a GP consultation
- Co-payments by patients for Nurse consultation
- Payments for repeat prescriptions
- Funding from ACC
- Funding from other agencies such as Work & Income, insurance companies, etc.

Mental Health

Mental Health	Current Month				Year to Date			
	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance
Oct-14	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%
Mental Health - Provider Arm								
Mental Health to allocate	9	9			38	38		
Acute Mental Health Inpatients	(1,143)	(1,143)			(4,573)	(4,573)		
Sub-Acute & Long Term Mental Health	(304)	(304)			(1,215)	(1,215)		
Crisis Respite	(2)	(2)			(8)	(8)		
Alcohol & Other Drugs - General	(272)	(272)			(1,089)	(1,089)		
Methadone	(94)	(94)			(377)	(377)		
Dual Diagnosis - Alcohol & Other Drugs	(8)	(8)			(34)	(34)		
Dual Diagnosis - MH/ID	(5)	(5)			(20)	(20)		
Child & Youth Mental Health Services	(579)	(579)			(2,314)	(2,314)		
Forensic Services	(509)	(509)			(2,037)	(2,037)		
Kaupapa Maori Mental Health Services	(146)	(146)			(584)	(584)		
Mental Health Community Services	(1,752)	(1,752)			(7,007)	(7,007)		
Prison/Court Liaison	(45)	(45)			(178)	(178)		
Day Activity & Work Rehabilitation S	(63)	(63)			(253)	(253)		
Mental Health Funded Services for Older P	(36)	(36)			(143)	(143)		
Advocacy / Peer Support - Consumer	(35)	(35)			(139)	(139)		
Other Home Based Residential Support	(58)	(58)			(232)	(232)		
	(5,042)	**(5,042)**			**(20,165)**	**(20,165)**		
Mental Health - NGO								
Mental Health to allocate	-	(38)	38 F		-	(152)	152 F	
Crisis Respite	(5)	(5)			(19)	(18)		(6%)
Alcohol & Other Drugs - General	(114)	(55)	(59) U	(108%)	(248)	(219)	(29) U	(13%)
Alcohol & Other Drugs - Child & Youth	(65)	(102)	37 F	36%	(390)	(408)	19 F	5%
Dual Diagnosis - Alcohol & Other Drugs	29	(36)	65 F	180%	(110)	(145)	35 F	24%
Eating Disorder	(11)	(16)	5 F	33%	(50)	(64)	15 F	23%
Maternal Mental Health	(4)	(4)			(15)	(15)		
Child & Youth Mental Health Services	(334)	(241)	(92) U	(38%)	(1,165)	(965)	(199) U	(21%)
Forensic Services	-	(4)	4 F		-	(14)	14 F	
Kaupapa Maori Mental Health Services	(6)	(6)			(25)	(25)		
Mental Health Community Services	(107)	(127)	20 F	15%	(508)	(506)	(1) U	
Day Activity & Work Rehabilitation S	(136)	(136)			(545)	(545)		
Advocacy / Peer Support - Consumer	(24)	(23)	(1) U	(2%)	(93)	(93)		
Other Home Based Residential Support	(356)	(315)	(41) U	(13%)	(1,416)	(1,261)	(155) U	(12%)
Advocacy / Peer Support - Families	(52)	(52)			(210)	(210)		
Community Residential Beds & Service	(444)	(457)	12 F	3%	(1,788)	(1,826)	38 F	2%
Minor Mental Health Expenditure	(45)	(32)	(13) U	(42%)	(136)	(127)	(9) U	(7%)
Inter District Flow Mental Health	(403)	(399)	(3) U	(1%)	(1,611)	(1,598)	(13) U	(1%)
	(2,077)	**(2,048)**	**(28) U**	**(1%)**	**(8,329)**	**(8,191)**	**(133) U**	**(2%)**
Total Mental Health	**(7,119)**	**(7,090)**	**(28) U**	**(0%)**	**(28,494)**	**(28,356)**	**(133) U**	**(0%)**

Mental Health Expenditure;

- Provider arm, with no wash-up occurring this financial year, mental health within the provider arm match budget.
- NGO providers are close to budget in October.

Disability Support Services

DSS	Current Month				Year to Date			
	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance
Oct-14	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%
Disability Support Services - Provider Arm								
AT & R (Assessment, Treatment and Re	(1,688)	(1,688)			(6,753)	(6,753)		
Needs Assessment	(138)	(138)			(552)	(552)		
Service Co-ordination	(19)	(19)			(78)	(78)		
Long Term Chronic Conditions	(8)	(8)			(32)	(32)		
Ageing in Place	(2)	(2)			(10)	(10)		
Environmental Support Services	(2)	(2)			(9)	(9)		
Minor Disability Support Expenditure	(8)	(8)			(34)	(34)		
Community Health Services & Support	(21)	(21)			(84)	(84)		
	(1,886)	**(1,886)**			**(7,552)**	**(7,552)**		
Disability Support Services - NGO								
AT & R (Assessment, Treatment and Re	(297)	(297)			(1,190)	(1,190)		
Information and Advisory	(12)	(12)			(48)	(48)		
Needs Assessment	(35)	(22)	(13) U	(62%)	(203)	(87)	(117) U	(133%)
Service Co-ordination	(3)	-	(3) U		(9)	-	(9) U	
Home Support	(1,583)	(1,423)	(160) U	(11%)	(6,244)	(5,690)	(554) U	(10%)
Carer Support	(130)	(144)	14 F	10%	(534)	(577)	43 F	7%
Residential Care: Rest Homes	(3,146)	(2,995)	(151) U	(5%)	(12,756)	(11,885)	(871) U	(7%)
Residential Care: Loans Adjustment	15	23	(7) U	32%	58	91	(32) U	36%
Long Term Chronic Conditions	-	-			-	-		
Residential Care: Hospitals	(3,977)	(3,944)	(32) U	(1%)	(15,317)	(15,641)	324 F	2%
Ageing in Place	-	-			-	-		
Environmental Support Services	(105)	(108)	3 F	2%	(399)	(430)	32 F	7%
Day Programmes	(34)	(48)	14 F	29%	(126)	(186)	60 F	32%
Expenditure to Attend Treatment ETAT	-	-			-	-		
Minor Disability Support Expenditure	-	(9)	9 F		-	(36)	36 F	
Respite Care	(152)	(95)	(56) U	(59%)	(569)	(381)	(188) U	(49%)
Community Health Services & Support	40	(60)	100 F	168%	(123)	(238)	115 F	48%
Inter District Flow Disability Support	(264)	(256)	(7) U	(3%)	(1,033)	(1,026)	(7) U	(1%)
Disability Support Other	-	-			-	-		
	(9,683)	**(9,390)**	**(289) U**	**(3%)**	**(38,493)**	**(37,324)**	**(1,168)**	**(3%)**
Total Disability Support Services	**(11,569)**	**(11,276)**	**(289) U**	**(3%)**	**(46,045)**	**(44,876)**	**(1,168) U**	**(3%)**

DSS expenditure is on budget for the Provider Arm, with transfers as per budget.

NGO costs are unfavourable in the month by $0.29m, with home support, needs assessment and environmental support services (which is a transfer to Personal Health in the month and on budget YTD) all unfavourable. Rest home and hospital variances totalled $0.18m for the month and a combined $0.55m unfavourable variance YTD with approximately $0.1m in revenue offsets. Respite care is also ahead of budget for the month and YTD ($0.19m).

Public Health

Public Health *Oct-14*	Current Month Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Year to Date Actual $(000)	Budget $(000)	Variance $(000)	Variance %
Public Health - Provider Arm								
Alcohol & Drug	(36)	(36)			(144)	(144)		
Communicable Diseases	(97)	(97)			(388)	(388)		
Injury Prevention	-	-			-	-		
Mental Health	(22)	(22)			(89)	(89)		
Screening Programmes	(115)	(112)	(4) U	4%	(696)	(716)	20 F	3%
Nutrition and Physical Activity	(23)	(23)			(90)	(90)		
Physical Environment	(36)	(36)			(144)	(144)		
Public Health Infrastructure	(128)	(128)			(511)	(511)		
Sexual Health	(12)	(12)			(48)	(48)		
Social Environments	(38)	(38)			(152)	(152)		
Tobacco Control	(81)	(81)			(326)	(326)		
	(588)	**(585)**	**(4) U**	**(1%)**	**(2,588)**	**(2,608)**	**20 F**	**1%**
Public Health - NGO								
Nutrition and Physical Activity	(26)	(27)	1 F	4%	(103)	(107)	4 F	4%
Tobacco Control	(21)	(12)	(8) U	(67%)	(71)	(50)	(21) U	(42%)
Well Child Promotion	-	-			-	-		
	(47)	**(39)**	**(7) U**	**(18%)**	**(174)**	**(157)**	**(17) U**	**(11%)**
Total Public Health	**(635)**	**(624)**	**(11) U**	**(2%)**	**(2,762)**	**(2,765)**	**3 F**	**0%**

Public Health Expenditure;

- Provider Arm, the small screening favourable variance is offset with less revenue in the month and YTD than budgeted.
- NGO, close to budget for the YTD, with well child promotion costs transferred in October to Personal Health, under Child and Youth, where these costs were budgeted.

DSAC / CPHAC Work Plan 2015						
Output	**Timeframe**	**Reporting Frequency**	**Progress**			**Reports / Presentation Schedule**
			Behind	On Target	Complete	
Annual Plan/ Statement of Intent - Planning Guidance - Proposed Funding Allocation - 1st Draft Annual Plan - Final Annual Plan	 Feb 2015 Feb 2015 April 2015 June 2015					
Child & Youth Child and Youth Steering Group Social Sector Trials Compass Children's Action Plan	 On-going On-going On-going On-going	 Quarterly Quarterly Annual Annual				A report/presentation will be submitted to the June 2015 DSAC-CPHAC Committee Meeting
Cancer Services - Cancer Networks (local & SCN) - SDHB Cancer Control Plan	 On-going On-going	 Quarterly Quarterly				A report/presentation will be submitted to the December 2015 DSAC-CPHAC Committee Meeting
Health of Older Persons - Age Related Residential Care - Home & Community Support Services Alliance - Palliative Care - Dementia		 Bimonthly Bimonthly Annual Annual				A report/presentation on residential care will be submitted to the February 2015 DSAC-CPHAC Committee Meeting
Mental Health - Phased implementation of Raise HOPE - Implementation Prime Ministers Youth Mental Health project initiatives - Suicide prevention	 On-going On-going On-going	 Bimonthly update Quarterly six monthly				A report/presentation will be submitted to the April 2015 DSAC-CPHAC Committee Meeting
Primary Care - PHO - After Hours Services - Rural Services Alliance - Community Pharmaceuticals - Laboratory Services	 On-going On-going On-going On-going On-going	 Bimonthly Annual Annual Bimonthly Bimonthly				A report/presentation will be submitted to the July 2015 DSAC-CPHAC Committee Meeting
Southern Health Alliance Leadership Team (SHALT)	On-going	BiMonthly				A report/presentation will be submitted to the July 2015 DSAC-CPHAC Committee Meeting
Rural Health - - Rural hospital trusts – performance monitoring	 Ongoing	 Quarterly				
Performance Monitoring - Indicators of DHB Performance - IPIF - Health Targets	 Ongoing	 Quarterly				
Maori Health - Maori Health Plan - Whanau Ora		Six monthly				A report/presentation will be submitted to the September 2015 DSAC-CPHAC Committee

DSAC / CPHAC Work Plan 2015						
Output	**Timeframe**	**Reporting Frequency**	**Progress**			**Reports / Presentation Schedule**
			Behind	On Target	Complete	
						Meeting.
Population Health - Tobacco - Vaccine Preventable Disease - Screening programmes - Sexual health services		Six monthly				A report/presentation will be submitted to the September 2015 DSAC-CPHAC Committee Meeting.
Public Health South	Ongoing	Bi-Monthly				A report/presentation will be submitted to the September 2015 DSAC-CPHAC Committee Meeting.