DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Wednesday, 4 February 2015, 8.30 am

Community Services Building, Southland Hospital, Invercargill

A G E N D A

Tab

1. Welcome
2. Apologies
3. Interests Registers
4. Strategic Health Services Plan
5. Previous Minutes
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7. Review of Action Sheet
8. Planning & Funding Team Report
   8.1 Public Health South (PHS) Report
9. Financial Performance Report
10. Progress Report on DHB Annual Plan 2014/15 – Quarter Two
11. **Progress Report on Southern Māori Health Plan** 2014/15 – Quarter Two
12. Work Plan 2015
13. 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. Paid Family Carer Policy Review	To allow activities to be carried on without prejudice or disadvantage	As above, section 9(2)(j).

An apology has been received from Mr Neville Cook.

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	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 02.12.2014	1. Chairman, Southern PHO Community Advisory Committee and ex officio Southern PHO Board. 2. Secretary/Manager, Lakes District Air Rescue Trust. Daughter: 3. Registrar, Cardiothoracics, Southern DHB	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.

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).	

*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

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 16.07.2013 02.12.2014 02.12.2014 16.07.2013 16.07.2013 16.07.2013 16.07.2013 02.12.2014	1. Chair, WellSouth Primary Health Network 2. Director, Positiona Ltd 3. Chair, NZ Cricket 4. Chair, Pioneer Generation Ltd 5. Chair, University Bookshop Otago Ltd 6. Director, Southern Rural Fire Authority 7. Director, Triple Seven Distribution Ltd 8. Board Member, Otago Community Hospice 9. Chair, Infinite Energy NZ Ltd	1. WellSouth is contracted to the Southern DHB. 8. Hospice provides contracted services for Southern DHB.

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.

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SOUTHERN DISTRICT HEALTH BOARD

Title:	DRAFT FINAL SOUTHERN STRATEGIC HEALTH PLAN
Report to:	CPHAC
Date of Meeting:	04 Feb 2015

Summary:

The issues considered in this paper are:

- Revision of draft of Southern Strategic Health Plan in the light of consultation.

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

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

Document previously submitted to:	(Draft) to CPHAC and BOARD	Date: 01/10/2014
Approved by Chief Executive Officer:		Date: 28/01/2015

Prepared by: Health Partners Consulting (final draft) Dr Pim Allen (consultation report) Date: 28/01/2015	Presented by: Stephen McKernan & Chris Mules, Health Partners Consulting

RECOMMENDATION:

1. That CPHAC consider the final draft for recommendation to the Board for adoption.

Please find attached:

1. The report on the consultation process and findings for the draft report
2. Annex 1: A summary of key points raised in the consultation and how the draft has changed as a result
3. Annex 2: the independent analyst's report of the consultation feedback
4. The draft final Southern Strategic Health Plan

SOUTHERN STRATEGIC HEALTH SERVICES PLAN

CONSULTATION REPORT

January 2015

Pim Allen
Programme Director
Southern Strategic Health Services Plan

1

Southern Strategic Health Services Plan Development

Contents

Executive Summary

This report outlines the process and outcomes of the consultation exercise undertaken by Southern District Health Board on the draft Southern Strategic Health Services Plan (SSHSP). The plan suggests an overall direction for the Southern health system over the next ten years, together with six priorities for action to position the District Health Board to best meet its objectives and short- and medium-term challenges.

The consultation was the next step in the listen/test/refine process that has been used to date to develop the draft plan by presenting the draft widely to stakeholders, including the community, health providers and professionals, the tertiary education sector, unions, local government and other government agencies. The focus of the consultation was to test whether the proposed overall direction for the DHB, and especially the key areas for particular attention (termed ''priorities'' in the Plan) and action ("Headline Actions" in the Plan) over the next three years, were supported by stakeholders.

The DHB received over 900 comments and responses through online surveys, public meetings, direct submissions and routine DHB meetings. While many respondents addressed the questions posed in the survey, a number of other relevant, but operational, comments were also received. A few individual experiences or concerns were also received. Comments on topics outside the scope of the consultation will be referred to the relevant area for consideration.

Responses were analysed by an independent analyst through Public Health South and recommendations have been formulated based on the results and considered by the Steering Group and DHB Executive. This report lists the themes, comments on the matters raised and makes recommendations for the final draft of the strategic plan.

One theme in particular, concerning the overall balance for publically-funded health services in both maintaining good health and treating ill health, has resulted in a change to the name of the plan, which following the consultation has been renamed the Southern Strategic Health Plan by the Steering Group.

Background

The first stage in building the Southern Strategic Health Services Plan was developing the Health Profile for the district, which was completed in late 2013. The Profile took a population-level view, and considered Southland and Otago as one unified health district for the first time.

The district faces similar challenges to the rest of New Zealand in ensuring good health can be maintained and quality health services provided into the future. These include a generally aging population (including workforce) and growing demand due to long term conditions, but Southern district also has some unique features such as its thinly spread and often remote population and its history of fiscal challenge and disparate professional cultures.

DHBs' legislated responsibilities are to improve, promote and protect the health of their populations, including by promoting integrated health services, reducing inequalities and ensuring health services are high quality, and using resources efficiently to serve local, regional and national needs.

Balancing Southern's supply and demand needs suggested action on a limited number of priority areas would guide and shape the development of viable health care across the district into the medium term future. The Board therefore invited Health Partners Consulting to help develop a draft strategic health services plan.

The plan has been built up through a series of interviews and workshops involving a wide range of health providers and community representatives as well as complementary government agencies including MSD and Education. At the same time, in depth analysis of the clinical and financial performance of the DHB was compared with peer organisations. The process has been overseen by a multi-disciplinary and multi-agency steering group, including representatives of the university, urban and remote primary care and rural health services.

The DHB invited the community to consider and comment on the draft plan during October-November 2014, and this report presents the results.

1.1 Objectives of Consultation

- To inform stakeholders about the SHSP and its main points
- To explain how the SHSP can be considered as an appropriate response to the challenges facing the Southern health system
- To provide stakeholders with the opportunity to provide comments on the SHSP and suggest improvements to it
- To manage the overall consultation process effectively including presentation of the draft SHSP, receipt of feedback and incorporation of key points into a revised draft for the Board's consideration

2.0 Overview of Consultation Process

2.1 Purpose of Consultation

The purpose of this consultation was to provide the Southern District Health Board with stakeholders' views on the proposed development and long term plan for the Southern health system.

2.2 Target Audiences and Communication Strategies

The consultation aimed to be as broad as possible, testing the views of Southern health professionals, organisations, and the community as a whole.

The target audience included:

Southern district residents	Southern tertiary education providers
Southern DHB staff	Rural health trusts
Well South	Māori Health Care Providers
General practitioners and primary care professionals	Balclutha, Central Otago, Gore, Queenstown Lakes, Southland and Waitaki District Councils
Iwi health representatives	Dunedin and Invercargill City Councils
Pacific island trusts	Southern community organisations

2.3 Responsiveness to Māori

Māori health care providers and members of the SDHB Māori health team were involved in developing the priorities contained in the strategic health services plan. The DHB Iwi Governance Committee reviewed the Health Profile and draft strategy and provided comment. The Maori health care providers who participated in the discussion, development and commentary on the draft strategic health services plan included representatives from the following organisations:

- Nga Kete Matauranga Pounamu
- Uruuruwhenua Health
- Hokunui Runanga
- Murihiku marae
- Arai Te Uru marae

Two of the community consultation meetings were hosted by Murihiku and Arai Te Uru maraes respectively.

2.4 Consultation Methodology

A range of methods were used to ensure the consultation was as widely accessible as possible. Emails advertising the consultation were sent to all identified stakeholders, including all staff, general practitioners, WellSouth, rural hospitals, community organisations (including service, community interest, business and advocacy groups), Māori and Pacific

Island health care providers, Iwi representatives, District/Regional councils and all individual participants in the various workshops held during the development phase. Articles in Better Health, Facebook items (SDHB and some local councils) and Twitter feeds along with press releases, paid newspaper advertisements and poster displays in rural and base hospital foyers and local libraries were also used to encourage the community to access the consultation documents and participate in the consultation process. Local journalists were invited to every community meeting and the resulting coverage also helped advertise the process, as did a news interview by Cue TV.

Approximately 2,000 printed questionnaires and copies of the summary and full report were distributed.

On-line and print documents and questionnaires were widely distributed, including to every general practice in the district, all main and many branch libraries and book buses, councils, rural hospitals and DHB hospitals. The community roadshow visited every locality and offered at least two different meeting times in each; discussions were held with external groups at their invitation and with internal staff groups both at their invitation and also though routine inclusion on standard agendas. A number of individuals and organisations also offered formal submissions and one requested a formal presentation to the Board about a specific service-level matter. Comments were recorded at all meetings and included in the survey responses.

An independent observer attended most of the community meetings to confirm accuracy of recording the comments received and a second observer also double read a sample of written submissions to check reproducibility of coding comments to themes during the analysis.

Questionnaire:

Consulting on a strategic plan is challenging as setting principles and an overall direction are only really meaningful when the practical implications are clear. However, the details of any implementation are themselves subject to consultation and could in practice be a range of different solutions for different locations. To discuss details that can only be theoretical at best in advance of agreement about the overall direction assumes that direction has been agreed and compromises a genuine consultation.

The questionnaire was arranged in the following format:

- Demographic information (age, ethnicity, gender, location, occupation, whether SDHB employee)
- General overview question
- Six sets of questions, one set specific to each of the six individual priorities
- Questions about general conditions to facilitate implementation
- Invitation for any other comment.

The questionnaire was developed by the independent analyst, in consultation with a small sub-group of the Steering Group and included 25 questions concerning the six priorities proposed in the plan plus the opportunity for free text on each. The web-based Survey

Monkey software was used for the electronic format and a similar paper document produced. Unlike the electronic document, the hard copy questionnaire also included some key facts about the district and a one page summary of each strategy. All paper responses returned to the DHB were entered manually online to enable analysis.

Community Roadshow

A team from the DHB led by the CEO visited ten locations around the district to present the draft plan and explain the consultation. As Central Otago was the first of the roadshow visits, a second visit to Alexandra was added to the original schedule to accommodate those who felt they needed more time to consider the draft plan.

Each meeting included a visual presentation supported by hand-outs, and a question and answer session. Sessions were arranged with the advice of local council officers to ensure best available access and appropriate timing. All sessions were chaired by a local council, community board or community organisation member. Every meeting was attended by members of the DHB executive and DHB Board.

Formal Submission Process:

A full consultation document and summary was placed on the Southern DHB website on 14 October 2014. A link to the electronic submission questionnaire was added on 20 October.

Those wishing to make a formal submission could do so in the following ways:

- Complete a paper copy of the survey questionnaire and return it to the Programme director
- Complete an electronic survey questionnaire on Survey Monkey
- Write/email an individual submission response and send it to the Chief Executive

2.5 Consultation Timeline

The consultation plan was developed in September. The formal consultation process ran from 14 October to 21 November 2014. Unforeseen problems with the Survey Monkey software delayed some feedback, so any comments received up to 24 November were also included in the analysis.

Date	Actions
September 2014	Consultation Plan developed and approved by Steering Group
October	CPHAC and Board approve draft for consultation
13 October	Briefing on SHSP for senior clinicians and managers
14 October	SHSP released to DHB staff
15 October	Public release
20 October	On-line survey available for completion
23 October – 19 November	roadshow

28 November	Consultation period ended, all information entered online and forwarded for analysis
19 December	Analysis completed and key recommendations identified
January 2015	Consultation findings and report circulated to Steering Group with final draft report for comment
February 2015	Final draft considered by Board

3.0 Analysis of Feedback

All of the feedback was considered and analysed by an independent, professional public health analyst, who considered submissions irrespective of format submitted. All comments were evaluated quantitatively and qualitatively as described below. In order to verify the reproducibility of the qualitative evaluation, a random sample of submissions was evaluated separately by a second reader. A further quality check was included by ensuring public meetings were attended by a member of Health Partners, to verify the comments recorded during the meeting were accurate and unbiased.

3.1 Quantitative Analysis

Responses were gathered via locality meetings (10 locations with over 400 attendees), 210 people responded through the online survey and a further 93 written submissions were received.

3.2 Qualitative Analysis

All responses were entered into Nvivo 10 (QSR International). A thematic analysis was used to identify subjects of importance within the consultation responses. An inductive approach was used so that findings were allowed to emerge from frequent, dominant or significant themes in the raw data.

The following discussion is based on the report from the public health analyst.

4.0 Consultation findings and recommendations

In this section, responses to the consultation are presented, a commentary provided, and where within the scope of the consultation, recommendations are offered.

In some cases, feedback covered subjects already covered in the full document, suggesting some people may have preferred to consider the summary document alone.

A number of other responses, while not directly applicable to the present concerns, contributed to a rich resource of views, advice and preferences and are highly relevant to

aspects of implementation of this Plan. These responses will be made available to the teams leading relevant aspects of the implementation.

4.1 Strategic Priorities

Most respondents (73%) supported the proposed strategic priorities as the right direction for the DHB to adopt for a sustainable future. In particular, Priority 1 (develop a coherent Southern system of care) was strongly supported.

Respondents were less confident about the extent to which each of the proposed directions would contribute to the key objectives of improved access, population health outcomes, Māori health outcomes and clinical and financial sustainability, but over half considered all the priorities (except Living within our Means) would improve patient access and population health outcomes, and that priority 2 (Building the system on a foundation of strong primary and community care) would help improve Māori health outcomes. Clinical and financial sustainability was thought to be improved by securing sustainable access to specialist services, strengthening clinical leadership, engagement and quality improvement and, unsurprisingly, living within our means.

4.2.Alternative proposals

Thirty individual alternative suggestions were offered, including 18 alternative priorities (mostly from single respondents) and 12 suggestions for headline actions. Only a few people offered suggestions as to which proposed priority should be dropped in favour of their suggestion; those who did, focused on Living within our Means.

(a) Living within our means
Several respondents wanted to see living within our means (P6) removed as a strategic priority in its own right, either because it is a given, or because other priorities, particularly strengthening clinical leadership, engagement and quality improvement, were felt to deliver this outcome.

Comment: While the points made by commentators about living within our means are indisputably true, this DHB has manifestly been unable to achieve a balanced budget for many years. Addressing this must therefore be a key immediate focus for the Southern District Health Board, allowing that clinical leadership and quality improvement will certainly be major contributors.

Recommendation

1. **Priority 6, Living within our Means, should be retained.**

(b) Public/population health/preventative care
A number of respondents wished to see this as a new priority, expressed in a number of different ways. Commentators felt this to be a valuable means of

reducing demand and therefore achieving the DHB's goals of improving the health of the population.

Recommendation

2. **Revise priority 2 (Build the Southern health system on a foundation of primary and community care) to strengthen the population approach and add appropriate headline actions**

(c) Equity

This was suggested as a priority in various ways, including access to services irrespective of location and ability to pay.

Comment: DHBs' responsibilities under the Health and Disability Services Act 2000 are to improve the health of their populations by a number of objectives, including reducing inequalities. The Southern Strategic Health Services Plan is aimed at concentrating the system-wide effort on achieving this goal.

General primary care co-payment policy is set at national level and the DHB cannot act outside this national framework.

Recommendations

3. **Acknowledge the Strategic Plan is designed to improve the DHB's achievement of lessening inequality.**

4. **SDHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients.**

5. **Priority for access to services will be determined on the basis of need, ability to benefit and improved opportunity for independence of those with a disability.**

(d) Age

The need for a clearer plan to address the needs of various ages within the communities was suggested as an additional priority by several respondents. Commentators noted there is a need for a whole of system redesign, given the population age projections, including service capacity planning and development new models of nursing care to support aging in place and more support for advance care planning in primary and specialist care.

Comment: Once the overall DHB strategic priorities are agreed through this process, each service will need to review, or if necessary develop, their own individual plans to deliver the milestones described in the Roadmap and implementation plan, taking into account the district-wide, whole-of-system approach of the plan. Some services, including Health of Older People, have already begun this process.

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Recommendations

6. **Be more explicit about the needs of various ages within communities under Priority 2, (build the Southern health system on a foundation of primary and community care).**

7. **Ensure system-wide capacity planning (workforce, facilities), including the consequences for community-based care, health of older people and hospital facilities, is considered as services develop individualised implementation plans.**

(e) Broadening accountability and working in partnership

Several suggestions for alternative priorities addressed bringing different stakeholders in health care together to work more collaboratively and transparently together. In some cases, respondents wished to see the responsibilities of patients, carers and whānau explicitly included.

Comment: There is considerable evidence for better outcomes in many circumstances where patients and health professionals work collaboratively together, and the DHB is keen to encourage this. At a higher level, the DHB has begun to work more closely with other agencies and to broaden its approach, for example in the revised Alliance South membership, which now includes representatives from different health sectors as well as a process design specialist.

Recommendation

8. **Continue and strengthen partnership approach at all levels, building trust and transparency as a principle.**

4.3 Headline actions

The second part of the consultation asked respondents to comment on suggested headline actions and the extent to which they considered these would help the health system achieve its aims. Responses have been grouped into six themes: primary care, funding and finance, rural services and communities, relationships and pathways, specialist services and specific matters.

(a) Primary care

Commentators raised four broad issues: resourcing and accessibility; general practitioner capacity and workforce concerns; access to specialist advice and diagnostics; streamlined primary / community models.

(a.i) resourcing and accessibility
Respondents pointed to the need for adequate resourcing for primary and community based care if services and care are shifted into the community. This included resources following the patient and the variable cost to patients attending a general practice.

Comment: Appropriate consideration of all factors and sequencing of stages in shifting services and/or responsibility, including seed funding where necessary, is essential in this major change initiative. The question of what and how seed funding is made available in the present deficit position will be dealt with in the management's advice on implementation to the Board. As noted above, general primary care co-payment policy is set at national level and the DHB cannot act outside this national framework.

Recommendations

9. **Make headline actions under priority 2 (strong foundation of primary and community care) stronger and more explicit, including clarity that resources would have to move/relocate/refocus.**

10. **Include explicit capacity, skills, pathways and communication planning in the enablers supporting every service change**

11. **SDHB to confirm its policy stating future principles and standard processes applying to service development/change.**

12. **Acknowledge adopting the changes described in the Southern Strategic Health Services Plan cannot affect standard employment principles and practices.**

(a.ii) general practitioner capacity and health practitioner workforce

While respondents supported broadening the services provided in the community, concerns were identified about its practicability included aging clinical workforce, the investment needed to upskill GPs and primary care nurse providers and the existing limited capacity to enrol with a general practice in some locations. At the same time, people felt there are some good opportunities for role substitution with stronger links to new ways to deliver services, especially for nursing.

Comment: The small business model in primary care has its strengths, but also its limitations. Business models in the Southern region are already changing - as they have elsewhere in New Zealand - in response to the existing and approaching pressures. A cornerstone principle for success in implementing this plan is responsiveness to local needs and situations, together with a willingness to consider and develop different community-based service options where necessary and appropriate.

As the draft plan noted, Southern has three tertiary education providers that are major suppliers of the NZ workforce, and there is therefore considerable potential to attract and develop practitioners who are skilled and excited about rural and remote health care practice – a major demand area across Australasia.

Recommendations

13. Acknowledge headline actions under priority 5 (optimise system capability and capacity) that strengthen collaborative workforce development and future planning in collaboration with the DHB, PHO and education providers

(a.iii) access to specialist advice and diagnostics

Respondents pointed out the importance of improving relationships and communication in general between all healthcare groups across the Southern district, and also underlined the need for health practitioners, whose main work is in the community, to be able to use a broader range of diagnostics.

Recommendations

14. Explain locality networks as a mechanism to strengthen collaborative approach between organisations and between different contributors to the system as a whole

15. Underline the central importance of the clinical pathways initiative and prioritise this project as a key enabler.

(a.iv) streamlined primary / community models

Both duplication and gaps in services were identified in the feedback to the development of the plan and this draft.

Comment: As well as confusing individual patients who receive overlapping services, particularly at home, this is clearly a poor use of scarce resources. The proposed actions under priority 5 in particular to address such situations are thus supported. This will be a particular focus in the implementation as the way in which services are delivered is reviewed and changed.

Recommendations

16. Acknowledge the importance of comprehensively mapping, quantifying and prioritising existing services from all providers across the district under headline actions in priority 5

(b) Funding and finance

The themes identified by commentators in this area in order of frequency were the population based funding formula; investment in the Southern Strategic Health Services Plan; how funding decisions are made; the funding model; salaries; and waste.

13

(b.i) Population-based funding formula (PBFF)

Respondents were generally discontented with the current PBFF for a range of reasons and wished to see the DHB lobby for its change.

Comment: The overall national level of health funding is set by government. PBFF is a national policy issue. The policy is currently under review by a specialist technical advisory group that will be providing advice to Ministers. All 20 DHBs have been consulted during this review and changes to the present formula will take account of the latest census figures. Some changes to Southern's (and most other DHBs') funding are likely as a result. Within Southern DHB, resource distribution will reflect the strategic health services' plan priorities and its prioritisation policy.

(b.ii) intended investment in the Southern Strategic Health Services Plan

A number of reviewers, while supporting the overall approach and intent, were concerned about how the plan could be implemented without specific investment.

Comment: A number of aspects of the plan do not require additional investment or may already be in progress as part of existing plans. In some other cases, resources may be relocated or refocused. As the consultation document explained, in some cases, there will be implications for existing services and contracts that lie outside the identified direction and priorities, where disinvestment will release resources for higher priorities. Where disinvestment or significant change is required, the DHB will follow standard business processes including consultation as necessary.

(b.iii) how funding decisions are made

Most of the points raised in this area concerned how funding levels and contracting decisions are made across the DHB and between difference groups and localities.

Comments: Healthcare funding, including how funding is allocated throughout the system and which factors are within or beyond the control of individual DHBs, is quite complex and not necessarily intuitive. For example, the DHB must provide for very high cost interventions for a relatively small proportion of its population and at the same time, invest in long term preventative measures that will only show benefit many years in future. Most members of the community do not need healthcare services for most of their lives, so simply allocating funding by community population size shares would prejudice the DHB's ability to invest in very complex and expensive treatments that are only needed by a few of the district's population during any year.

Recommendation

17. Acknowledge health literacy, provider alliances and improving communications with and between stakeholders as key enablers for the successful delivery of the Southern Strategic Health Services Plan.

(b.iv) the funding model
This theme related to the perceived restrictiveness of the present funding / contracting models whereby unintended perverse incentives prevented providers moving to more responsive, contemporary models of care. One such example is those contracts that have historically been based on the number of beds occupied in a facility – whereas much best practice now avoids hospital admission and its associated risks to patients.

Comment: Work is already in progress within the DHB to understand within service groupings how providers apply their contracts, interact with other agencies and report on activity. Once the strategic health services plan has been adopted, greater flexibility in contracting is envisaged where significant contributions to achieving the plan's priorities can be demonstrated.

(b.v) salaries

General feeling amongst respondents suggested support for the DHB to contain its salary and wage costs. Where questions were raised, these addressed alleged excessive salary costs, or the absence of transparency about non-clinical groups.

Comment: All employment groups were considered in the financing section of the draft plan and were benchmarked against similar organisations, acknowledging different circumstances may affect different organisations.

(b.vi) waste

A very varied range of different aspects of apparent waste were identified in eight submissions.

Comment: Some of the items mentioned (eg the PHO changing its name) were outside the scope of the strategic health services plan, while others (eg the consultation exercise), are required by government, and were felt by others to be very valuable in improving relationships and communication between Southern DHB and its community.

Other aspects of waste raised by respondents included factors such as duplication, excess infrastructure and dysfunction services that are one of the main opportunities for improvements targeted in this plan. Case management was suggested as a strategy to co-ordinate domiciliary care, and clinical test results made available to all of a patient's agreed health professionals.

Reduction in clinical waste (such as patient and staff waiting and inefficient use of resources, for example through duplication and rework) is a cornerstone of improved clinical quality and highlighted in the Southern DHB's Performance Excellence and Quality Improvement Strategy.

Recommendation

18. Acknowledge waste reduction (in all forms) is a key quality improvement dimension

15

(c) Rural services and communities

Rural hospitals were well supported in the feedback. Comments addressed the range of local services available; travel; cost to rural people and locality networks.

(c.i) range of rural hospital services

Several people expressed concern about the plan's description of their provision of acute services. Comment tended to focus on the prime responsibility of being the first line of care in any locality for the seriously injured or unwell

Comment: This was a simple misunderstanding about the draft plan's proposals. The draft plan described rural hospitals' key role in providing a range of clinical services appropriately tailored to their own community's main needs and did not wish to see any narrowing of service provision – but rather clarity about what level of services is most appropriately provided in any location. This could certainly mean changes at individual facility level as changes occur in primary and community care as well as in base hospitals.

Recommendation

19. Under priority 1, clarify rural hospitals' key roles in their respective local communities in respect of both immediate care for seriously unwell and/or injured individuals as well as clarifying role delineation across the district to describe a range of other appropriate services depending on capacity and capability within facilities and the local community's profile and key needs.

(c.ii) travel

Distance, lack of consideration, inconvenience and cost were the main issues mentioned in relation to travel, with reports of unrealistic appointment times, lack of available and appropriate means of transport and brief or perfunctory interviews. Commentators suggested increasing telemedicine and/or visiting specialist clinics as ways to improve these factors.

Comment: The draft plan already notes the importance of better cross-departmental scheduling of appointments and minimising travel for rural people by increasing access to telemedicine and where viable, visiting specialists. Other options include telephone follow-up or via clinical pathways, appropriate discharge to primary care with suitable guidance and backup from specialist services.

There will always be instances when, despite all best efforts, the optimal transport means will simply not be available in a rural area. A planned approach to road and air transport for patients is needed, particularly from rural areas to the referral hospitals. The DHB has been working with St John over the last few months to develop a plan that will improve

arrangements for non-urgent transfers and thus free up resources to more easily respond to emergency demands.

Recommendations

20. Strengthen principle of respecting patients' time, endorse stronger cross-departmental scheduling and continue development of alternative modes for out-patient consultation

21. Conclude and publish revised transport arrangements for non-urgent transfers

22. Develop district plan for better linking base hospitals and rural providers under Priority 2

(c.iii) cost to rural people

Questions about rural cost of services concerned items that were available free of charge in the urban centres, but which were a cost to rural inhabitants. Additional services could be provided in some localities were funding to be available.

Comment: Part of the reason for this is that the service is provided by a different provider. For example, where a service is provided by a base hospital, there will be no direct cost to the patient. On the other hand, if a similar service is offered in through a general practice, the different business and funding arrangements mean there is likely to be an associated cost. Furthermore, offering a service for a significant number of patients is more cost effective than offering the same service on an intermittent or individual basis, and may affect pricing.

Nevertheless, the Minister has been clear that DHBs are expected to work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients. This is reflected in recommended revision (4) to the draft plan above.

(c.iv) locality networks

Support for more locally-based service planning and delivery was constant, but commentators recognised success would be dependent on good relationships and easy communication pathways with base hospital staff. Rural trusts advised they already practise multi-disciplinary models, while other and new enhanced nursing roles in particular could contribute. The concept of locality networks in the draft plan was not always well understood, and the details for defining and developing these required more work.

Comment: The roadmap in the draft plan identifies further work on the details of locality networks, including analysis of individual localities, populations and health care user flows and forecasts.

Recommendation

23. Include some more detail on locality networks in the final draft plan and glossary. Acknowledge development of a detailed approach already exists within the implementation roadmap

(d) Relationships and Pathways

Two themes stood out in this category: external relationships and information pathways. A few people mentioned internal relationships; policy relationships; clinical pathways; and models of care.

(d.i) external relationships

Commentators on priority 1 reflected on the lack of mutual respect between many health system groups across the district. This was not always directed solely at the DHB. On the other hand, a range of organisations expressed their enthusiasm to return to, or build, closer relationships with the DHB. The fact that there are many contributors to the determinants of health in addition to the DHB and PHO was mentioned by several.

At a clinical level, the roles of allied health and technical practitioners merited acknowledgement. Successful clinical pathway implementation also required better liaison between GPs and specialists, including better understanding of how patients move between services.

Alliancing as a model for service contracting was felt to be a good model for boosting integration.

Comment: This consultation exercise has shown Southern DHB's intention to interact more closely with its community and this has in general been well received. While there is room for improvement, the DHB's aim of working more closely with community groups, including Māori and Pacific, NGOs, the education sector and local and central government agencies has been clearly foreshadowed.

Alliance South, between the Southern DHB, WellSouth and others, has the lead role in the implementation of the strategic health services plan wherever integration matters arise (in practice, at all intersections between community, primary and secondary issues). Service level alliance teams contribute by encouraging and enabling integration at the level of individual disciplines. The alliance concept also has a role as a way of delivering individual contracts, for example, home and community support care for older people.

Key to building and maintaining good relationships, including mutual respect, is regular and meaningful reciprocal communication. Newsletters – as suggested by respondents – would be one ingredient during the implementation.

Recommendations

24. Priority 2 should be broadened to include Māori and Pacific island and inter-sectoral representation as well as population health.

25. **Recognise the importance of collaboration across the system more explicitly under priority 1.**

26. **Alliance South to be invited to publish its intended schedule for developing Service Level Agreement Teams.**

27. **A broader, system-wide framework for enhanced multi-directional communication should be developed as a headline action under priority 1, and included as an early action underpinning the roadmap.**

(d.ii) information pathways
Improved communication, particularly better sharing of clinical information, was a strong theme. A number of individual and group providers were keen to see easier and more frequent contact between DHB clinicians and community-based providers, including more personal contact. Similarly, the need to improve communication at primary and community level, including with patients, was also mentioned by some.

Recommendation

28. **Acknowledge the vital importance of prompt and accurate communication between providers in the provision of high quality clinical care**

(d.iii) internal relationships
Comments under this theme referred to the system having too many managers. Some advised further refining of the DHB's management system while others felt this had already been done thoroughly. Respondents noted the management structure in the DHB had not been discussed in the strategic health services plan.

Comment: While the management structure is outside the scope of the strategic health services plan, it is important to recognise managers and administrative staff help ensure the healthcare system functions: clinics and theatres operate, supplies are ordered and distributed, services and assets maintained, health and safety standards met and staff, invoices and suppliers paid, amongst many other functions. By enabling the system to function as smoothly as possible, management and administration staff contribute to the continuing development of the Southern Way, directorate clinical services and clinical networks.

Clearly, under- or over-employment of any staff group will contribute to the system functioning below its best. Comparing Southern DHB with similar organisations across NZ, shows that in comparison with the sector average, which takes account of large and small DHBs, Southern DHB's provider arm spends 0.5% more on management and administrative staff. When a peer example is considered, Southern spends 0.8% less than Waikato DHB, which is a similar size and serves a big rural population.

Shared objectives, accountabilities and constraints between all groups in the health system are key to its effective functioning. The successful implementation of this plan will benefit from genuine partnership between clinicians and managers.

(d.iv) policy relationships
A number of existing policies and projects with significant links with the proposals were not mentioned in the draft plan.

Comment: The development of the Strategic Plan adopted a 'build forward' approach, acknowledging many of the projects and programmes already in progress were congruent with the direction of the proposals, and that the plan was not being introduced in 'green field' circumstances. The proposed plan is intended to be considered in the context of the existing system and work programme, acknowledging that once adopted, priorities may alter in emphasis.

Recommendation

29. Acknowledge the plan builds on existing initiatives and policies.

(d.v) clinical pathways
Those commenting on clinical pathways supported the concept that enables more seamless and efficient patient services. It was important that pathways were used not just by primary care, and that consultation and agreement on suitable existing systems would be a useful step.

(d.vi) models of care
A number of options for improving the Southern system of care were suggested, including increasing access to diagnostics for GPs, facilitating GP follow-ups following specialist appointments and various nurse-led services. Staff currently providing these services within the DHB were concerned about changes to employment conditions. Commentators also proposed quality assurance standards for new models of care, including appropriate skilling and credentialing of new providers, strong partnerships between specialists and new service providers, the desire for Māori and Pacific Island services to contribute and for community service providers to contribute to developing pathways.

Comment: Services should remain at a similar or better standard of quality irrespective of the delivery location and appropriate monitoring and assurance systems may need to be developed to support this. Stronger partnerships, including between providers and between community groups, are important in building a responsive and coherent service.

Recommendation

30. Acknowledge the need to strengthen community-based service delivery, including by broadening the services provided, building and strengthening partnerships across service levels and assuring quality standards are maintained.

(e) Specialist services

This theme included comments about service access (both travel and prioritisation) and configuration, sustainability and the concept of hospital generalists.

(e.i) Travel and service access

The cost for patients living at a distance from health services was a particular concern, in terms of travel, accommodation and lost earnings. This was seen as potentially worsening if some services were rationalised across the whole south island. Commentators supported a balanced sharing of travel between specialists and patients where demand is sufficient.

The inability of every patient who could benefit from specialist services to receive an appointment was mentioned by both consumers and GPs. People also commented on the length of waiting lists.

Comment: Appropriate clinical pathways should reduce repeated travel for certain investigations before a specialist appointment and developing more ''one-stop shops'' would also contribute. Balancing the opportunity costs to the system, for example, where a specialist travels to a rural clinic, and the financial demand on individuals needs to be considered sensitively and fairly, and, as noted in earlier comments, best use of clinical pathways and available technology will also contribute. Focusing on waste, which includes the patient's time, is underlined in the Performance Excellence and Quality Improvement strategy.

The public health services are not presently funded to meet all clinical need, so at an individual specialty level, some fair means must be applied to try to ensure those most likely to benefit the most are treated first. At a population level, some balance is sought to meet the DHB's overall responsibilities of reducing inequalities and supporting population health gain.

Recommendations

31. Ensure the focus on valuing the patient's time and wherever possible, minimising the patient's cost to access a service is clear under priority 4

32. Strengthen Priority 4 in respect of clinical leadership and engagement in determining transparent principles of equity and maximising population health gain as an SDHB prioritisation policy and approach

33. Include explicit and common access criteria for elective procedures under priority 2

(e.ii) service configuration

Two different points of view were expressed on this topic: some respondents felt regionalising those services that are only rarely accessed made sense where skiils and funding are limited. Others were concerned about potential flow-on consequences for specific specialties and Otago University School of Medicine in particular. The opportunity

to identify sub-specialties suitable for Dunedin to act as regional referral centre was also mentioned.

Comment: The tension identified in the two facets of feedback underlines the careful balance that will need to be drawn, bearing in mind the government's expectation that wherever possible and appropriate, services that are only rarely accessed by most individuals should be regionalised. While the DHB and Otago University have complementary and mutually supportive aspects, it is important to recognise that they are separate organisations with differing functions, objectives, demands and governance.

Recommendation

34. Strengthen the key actions in prioritisation policy to ensure transparency of decision-making (as noted elsewhere in the consultation feedback).

(e.iii) sustainability

Respondents commented on different understandings of the concept of sustainability, and pointed out that, without a clearer definition, it was difficult to respond meaningfully. Others felt that recognising limited resources of all kinds, sustainability meant one safe service, rather than several more marginal ones.

Comment: For those attending the roadshow, sustainability of a service was defined as encompassing five factors: clinical safety, quality, full staffing, efficient delivery and affordable.

Recommendation

35. Define ''sustainability" more clearly in the final draft plan and include in the glossary of terms

(e.iv) hospital generalists

While few people commented on this subject, opinion was divided. Some were concerned that by developing a generalist model, individual health disciplines would be undermined in some way. Others pointed out that as specialists themselves age, many move to a more general practice of their discipline.

Comment: A generalist model of hospital practice recognises the increasing need for holistic care of patients, many of whom have multiple co-morbidities. A generalist (despite the name) is a specialist practitioner skilled in managing the complexity of such interacting conditions as distinct from the way in which much specialty medicine has developed where practice is concentred on one particular system or organ.

Across all of Australasia, the need is for just such practitioners, although many specialist training programmes still concentrate on developing practitioners best suited to highly complex metropolitan environments.

Both kinds of practitioner are needed for the future and the draft plan points to an opportunity for Southern district, in collaboration with its tertiary providers, to develop an innovative centre of excellence with the potential for international leadership.

(f) Individual issues

Grouped under this heading are a diverse range of specific needs in particular communities and specific issues in particular services. Items included Queenstown, public health, staff (training, health, value and work pressure), population (inequalities, minority groups and demographics) and elderly care, Māori health and specific other services (acute, pregnancy, disability)

Comment: The draft strategic health services plan is district-wide and strategic. As such, recommendations on individual issues in specific communities and services are outside the scope of the consultation.

Where examples are used in the draft plan, these are intended as illustrations or are identified as items of district-wide significance that will require resolution during the implementation of the plan. The question of an inland third hub is one such example, not just because of the factors influencing those communities, but also because of the flow-on consequences for coastal communities of changing service patterns.

The specific matters raised by respondents are nevertheless valued feedback to the DHB, and will be referred to the relevant area for further consideration, planning and action.

5.0 Reducing Māori Health Inequality

Feedback on Māori health issues specifically was limited, with ten written submissions including comment on Māori issues, and comments at five locality meetings. Feedback included comments on an apparent lack of visible recognition in the development of the Plan, Māori workforce development and specific mention of Māori clinical leadership, quality improvement and cultural responsiveness measures. Not all feedback supported targeted Māori identification and actions, preferring instead to focus efforts on areas of high deprivation / low socio-economic status that would include many Māori residents. Other issues related to operational questions outside the scope of the consultation.

Comment: There was Maori representation on the steering group throughout the plan's development, Maori representatives and providers participated in every stage during the development of the plan, including stakeholder interviews, mini-workshops and the leadership workshop. Invitations to consultation meetings were distributed through the Maori Health Directorate and two of the roadshow locality meetings were held on marae.

Development of the Southern Māori health plan was put on hold, pending the development of the whole of system strategic plan as clearly the two should align. This can and will now proceed. As the Health Profile 2013 noted, improving the health of Māori is one of the key opportunities for Southern DHB to improve the health of its population.

As noted by some respondents, the NZ Public Health and Disability Act 2000 includes in its statement of purpose, "to reduce health disparities by improving the health outcomes of

Māori and other population groups". As in all public services, the DHB has a partnership relationship with Māori.

Recommendations

36. Review relevant sections of the draft plan to better reflect the relationship with Māori, and strengthen partnership in headline actions.

6.0 Discussion

6.1 Limitations of Consultation Methodology

The consultation was planned with the advice and help of council community liaison and communications officers in each locality to try to be as responsive to local community preferences as practicable, and to reflect the commitment of the DHB to enable participation by as many different groups as possible. The diversity of responses – from the community, staff, health care providers, unions, health professionals and others – reflects this.

However, only a small percentage of the population actively participated in the process. This may be because people were generally content with the proposals, but all consultation methods have inherent weaknesses that can unintentionally limit the participation of certain groups, promote the participation of others or distort the data that is collected and analysed.

The strengths and limitations of the process used during the consultation are considered in a separate paper, *Lessons Learned*.

6.2 Closing the Loop

Annex 1 summarises the key themes raised during the consultation, the recommendations accepted by the Steering Group and Executive, and tracks how these have been reflected in the final draft plan.

7.0 List of Recommendations

1. Priority 6, Living within our Means, should be retained.
2. Revise priority 2 (Build the Southern health system on a foundation of primary and community care) to strengthen the population approach and add appropriate headline actions.
3. Acknowledge the Strategic Plan is designed to improve the DHB's achievement of lessening inequality.

4. SDHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients.
5. Priority for access to services will be determined on the basis of need, ability to benefit and improved opportunity for independence of those with a disability.
6. Be more explicit about the needs of various ages within communities under Priority 2, (build the Southern health system on a foundation of primary and community care).
7. Ensure system-wide capacity planning (workforce, facilities), including the consequences for community-based care, health of older people and hospital facilities, is considered as services develop individualised implementation plans.
8. Continue and strengthen partnership approach at all levels, building trust and transparency as a principle.
9. Make headline actions under priority 2 (strong foundation of primary and community care) stronger and more explicit, including clarity that resources would have to move/relocate/refocus.
10. Include explicit capacity, skills, pathways and communication planning in the enablers supporting every service change.
11. SDHB to confirm its policy stating future principles and standard processes applying to service development/change.
12. Acknowledge adopting the changes described in the Southern Strategic Health Services Plan cannot affect standard employment principles and practices.
13. Acknowledge headline actions under priority 5 (optimise system capability and capacity) that strengthen collaborative workforce development and future planning in collaboration with the DHB, PHO and education providers
14. Explain locality networks as a mechanism to strengthen collaborative approach between organisations and between different contributors to the system as a whole
15. Underline the central importance of the clinical pathways initiative and prioritise this project as a key enabler.
16. Acknowledge the importance of comprehensively mapping, quantifying and prioritising existing services from all providers across the district under headline actions in priority 5
17. Acknowledge health literacy, provider alliances and improving communications with and between stakeholders as key enablers for the successful delivery of the Southern Strategic Health Services Plan.
18. Acknowledge waste reduction (in all forms) is a key quality improvement dimension
19. Under priority 1, clarify rural hospitals' key roles in their respective local communities in respect of both immediate care for seriously unwell and/or injured individuals as well as clarifying role delineation across the district to describe a range of other appropriate services depending on capacity and capability within facilities and the local community's profile and key needs.
20. Strengthen principle of respecting patients' time, endorse stronger cross-departmental scheduling and continue development of alternative modes for out-patient consultation.
21. Conclude and publish revised transport arrangements for non-urgent transfers.
22. Develop district plan for better linking base hospitals and rural providers under Priority 2

25

23. Include some more detail on locality networks in the final draft plan and glossary. Acknowledge development of a detailed approach already exists within the implementation roadmap
24. Priority 2 should be broadened to include Māori and Pacific island and inter-sectoral representation as well as population health.
25. Recognise the importance of collaboration across the system more explicitly under priority 1.
26. Alliance South to be invited to publish its intended schedule for developing Service Level Agreement Teams.
27. A broader, system-wide framework for enhanced multi-directional communication should be developed as a headline action under priority 1, and included as an early action underpinning the roadmap.
28. Acknowledge the vital importance of prompt and accurate communication between providers in the provision of high quality clinical care
29. Acknowledge the plan builds on existing initiatives and policies.
30. Acknowledge the need to strengthen community-based service delivery, including by broadening the services provided, building and strengthening partnerships across service levels and assuring quality standards are maintained.
31. Ensure the focus on valuing the patient's time and wherever possible, minimising the patient's cost to access a service is clear under priority 4
32. Strengthen Priority 4 in respect of clinical leadership and engagement in determining transparent principles of equity and maximising population health gain as an SDHB prioritisation policy and approach
33. Include explicit and common access criteria for elective procedures under priority 2
34. Strengthen the key actions in prioritisation policy to ensure transparency of decision-making (as noted elsewhere in the consultation feedback).
35. Define ''sustainability" more clearly in the final draft plan and include in the glossary of terms
36. Review relevant sections of the draft plan to better reflect the relationship with Māori, and strengthen partnership in headline actions.

Annex 1: Feedback themes, recommendations and document changes

Item	Recommendation		Draft final report (or implementation)
Alternative strategies			
P[1]6: Living within our means unnecessary	1.	Retain this as a Priority	retained
P2 should have broader focus	2.	P2 to include population health; revise HA[2]	P2 revised; new HA (4) in support of intersectoral initiatives
Equity should be priority	3.	Strategic plan is designed to reduce inequality/inequity	Equity as government, regional and DHB focus in Introduction (p23); equity as a dimension of quality (p. 32) Section on reducing inequalities moved forwards to 2.4
	4.	Wider range of community-based services at no cost to patients	P2 new HA6 in support of wider range of services based in the community at no cost to patient
	5.	Priority for access determined by need, ability to benefit and improved independence	Included in Discussion, P2 (p9)
Recognition of aging population	6.	Needs of various ages explicit	Table 8 (p47)
System-wide capacity planning	7.	Ensure part of all implementation plans	P5 HA4 (facilities) Implementation: individual service plans for workforce
Stronger partnerships	8.	Continue and strengthen; build trust and transparency	Table 9 (p 58)
Alternative Headline actions			
Primary care resourcing	9.	Location of resources could change	
	10.	Individual service changes to include consideration of resource consequences	Best practice in change management will be a key aspect of implementation - see section 7 and implementation plan
	11.	Policy on principles and processes affecting service changes	
	12.	Acknowledge standard employment principles and practices	
GP capacity and health practitioner workforce	13.	Collaborative planning and development in partnership with	P5

[1] P = priority
[2] HA = headline actions

Item	Recommendation		Draft final report (or implementation)
		WellSouth and tertiary education providers	
Access to specialised advice and diagnostics	14.	Explain locality networks as means of strengthening inter-professional access	P4 HA6 Locality networks of clinicians to improve linkages and relations; discussion (p39) Role clarity (p9) and professional relationships (p 51)
	15.	Central importance of clinical pathways	P1 discussion; Clinical pathways (p41)
Streamlined models	16.	Map existing services to identify duplication and gaps	Implementation
Funding and finance including PBFF, investment, how funding decisions made	17.	Health literacy, alliances, improved communications are key enablers	Enabler 7.5; Table 9; Enabler 7.6 P6 HA2
Reducing waste	18.	Waste reduction key QI dimension	P6 HA1; P4 rigorous implementation of the Performance Excellence and Quality Improvement strategy
Range of rural hospital services	19.	Clarify rural hospitals' roles	Role clarity p37
Travel	20.	Reduce waste of patients' time Better cross-linking and alternative options for consultation	P4: Performance Excellence and Quality Improvement strategy Implementation
	21.	Conclude and publish revised transport arrangements	Enabler 7.2 (p60)
	22.	District plan for linking base and rural providers	Locality and acute care networks
Locality networks	23.	Include more detail	P4 HA 6; p.39; p46; Glossary
External relationships	24.	More explicit Māori and Pacific island involvement	Treaty obligations explicit (p5) 2.4 Reducing inequalities section
	25.	Collaboration explicit	Alliance relationships
	26.	Alliance South to publish schedule for SLATs	implementation
	27.	Better multi-directional communication	Enabler 7.6 (p62)
Information pathways	28.	Accurate communication to facilitate	Professional relationships (p51)

Item	Recommendation		Draft final report (or implementation)
		quality care	
Policy relationships	29.	Acknowledge existing work	Include in Forward
Models of care	30.	Strengthen community-based service delivery	Alliances; Locality networks; P2 new HA6 (wider range of services based in the community at no cost to patient)
Travel and access	31.	Focus on valuing patient's time and minimising cost to access	P4 – implicit in waste reduction dimension of Performance Excellence and Quality Improvement strategy; P2 HA6 as above
	32.	Strengthen clinical leadership and engagement in transparency of principles of equity and population health gain	Key aspect of the implementation of P6 HA3 - Develop a Southern DHB prioritisation framework to inform resource allocation, including relevant policies, processes and tools (incorporating the four-fold aim)
	33.	Include explicit and common access criteria for elective procedures	Prioritisation policy (P6 HA3 as above)
Service configuration	34.	Transparency of decision-making	Prioritisation policy P6 HA3 (as above); acknowledgement of both mutual and separate interests and objectives of the DHB and University (workforce discussion, p52)
Different understandings on sustainability	35.	Define sustainability	Section 1.2 (p18) and Glossary
Reducing Māori health inequality	36.	Better reflect relationship and partnership in plan	Treaty acknowledged; recognition of Māori participation in plan development already in full draft document and improving Māori health indicators listed in Health Profile 2013 and draft plan as one of top opportunities for improving health of Southern population; Māori section 5.5 added by Māori health directorate

Southern District Health Board

STRATEGIC HEALTH SERVICES PLAN

CONSULTATION FINDINGS

CONTENTS

INTRODUCTION

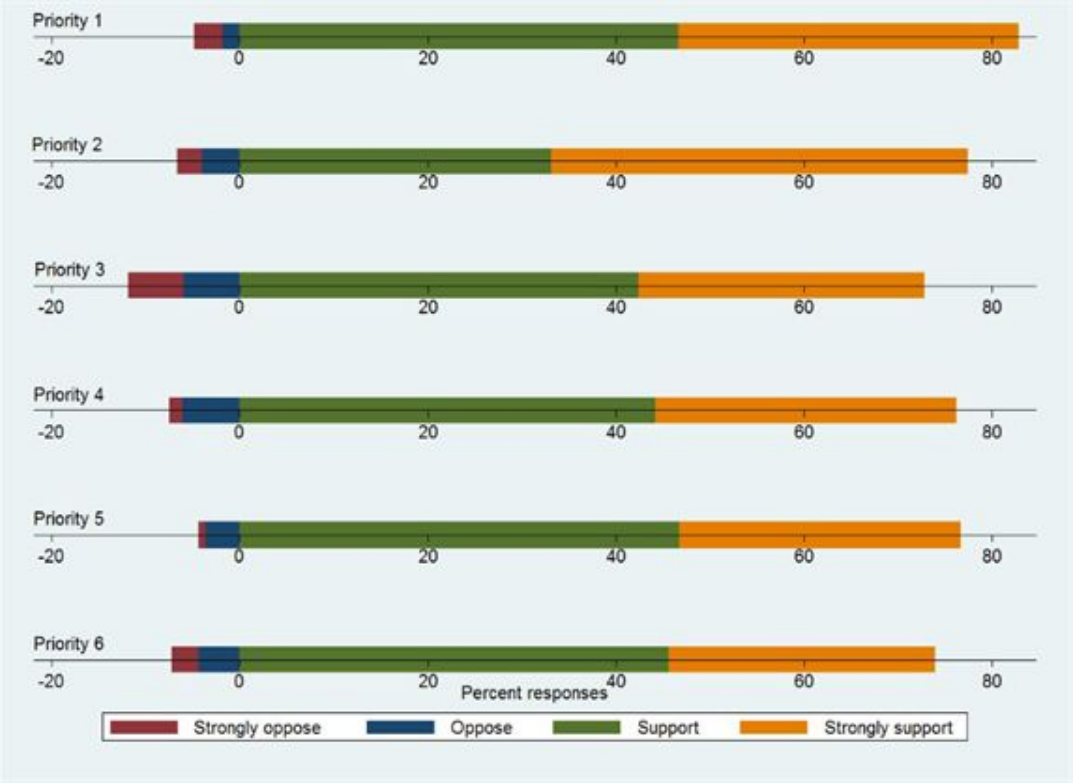
This document explores consultation responses to the SDHB's draft Southern Strategic Health Services Plan. Responses were gathered via ten locality meetings (over 400 attendees), an online survey (210 responses), and written submissions (93).

All responses were entered into Nvivo 10 (QSR International). A thematic analysis was used to identify subjects of importance within the consultation responses. An inductive approach was used—findings were allowed to emerge from frequent, dominant or significant themes in the raw data.

STRATEGIC PRIORITIES

The focus and intent of the consultation exercise was to seek the community's views on the overall future direction and shape of public health services across the Southern region, and to test whether the six priorities for attention particularly over the next three years would, in the community's view, put the District Health Board on track to deliver this direction.

Among survey respondents, 73% agreed that the six strategic priorities were the best areas for the Southern system to focus on. Survey respondents were also given the opportunity to indicate their level of support for each priority. The slide plot (below) shows support on the right of zero, and opposition on the left. Neutral responses are ignored. All priorities enjoy majority support. Priority 1 received the most support, Priorities 3 and 6 the least. Priority 3, in particular, has a marked prevalence of strong opposition.



The table below shows survey responses to items regarding each priority's perceived ability to meet specific goals. Overall, the percentages are quite low, particularly for priorities 3 and 6.

Goal	Priority 1	Priority 2	Priority 3	Priority 4	Priority 5	Priority 6
Improved patient access	69%	64%	53%	61%	59%	39%
Improved population health outcomes	62%	64%	52%	64%	61%	39%
Improved Maori health outcomes	48%	54%	37%	46%	46%	31%
Clinical and financial sustainability	46%	44%	54%	52%	49%	58%

ALTERNATIVE PRIORITIES

The following statements were made by submitters regarding alternative priorities:

- Access to primary health care through either free or subsidised access to general practitioners, either directly employed by SDHB itself or contracted to it (suggested by multiple submitters).
- Effective screening programmes for chronic but life-threatening conditions such as bowel cancer.
- Proper residential support services to people with disabilities who live in their own homes.
- Provision of mental health services that are attuned to the needs of patients.
- Climate change needs to be included under each priority.
- An additional strategy would be to be much better at informing and consulting with the public about health service decisions and issues.
- There needs to be more focus on rural and remote health services. Replaces optimise system capacity and capability.
- Live within our means is a given. It does not need to be included in this plan.
- Improving and protecting the health of the Southern DHB needs to be the first of the Strategic Priorities (Refer S22Q - Health and Disability Services Act 2000).
- Move priority 6 "Live within our means" so it is an outcome for Priority 4 "Strengthen clinical leadership engagement and quality'. Good work on Priority 4 will achieve results in Priority 6.
- Replace Priority 6 with "Reduce demand for health care services by keeping people well"

- Some headline actions would be
    - focus on vulnerable population groups
    - Linkages with organisations outside the health sector who influence health outcomes
    - strengthen efforts to improve health literacy
    - support community action to address local issues and build resilient communities
    - improve physical environments – air quality, water quality, safe roads etc
- A greater focus on a population health approach: identifying the needs of our population and working to address them through a range of appropriate measures (this was raised by many submitters).
- Add to the second priority. Build the southern health system on a foundation of public health, primary and community care
- The SDHB needs to focus on making patients and the public the number one priority as opposed to really being only one third of the energy (in the priorities as listed).
- Develop an efficient and effective system of care, replacing "Develop a coherent Southern system of care".
- Another priority should be that all ages should be cared and catered for within their community.
- "Ensure sustainable TIMELY access to ACUTE AND NON ACUTE specialist services."
- One strategy should be health access and engagement and the other patient and whanau accountability broadening responsibility across the health community.
- Funding staff training and ongoing professional development should be a long-term priority.
- Additional strategic plan is to prioritize the Pacific people health in affordable way and reach out service to the community.
- Develop a plan to address the need to improve and manage the health of the Southern District's aging population.
- Replace Priority 6 "Live within our means" as this is a basic business principle every household practises.
- I would like to see a goal encompassing education and bringing disparate factions together e.g. General Practice and Hospital Clinical Teams; discharge planning; trust around referrals; openness around planned surgery
- None of your priorities talk about the patients! I would like to see a priority to deliver best practice medical care to all patients.
- Equity of access to services regardless of geographic location.

In addition to the specific, system-wide, consultation questions, many other comments and suggestions were offered, many of which were relevant to aspects of the suggested implementation actions. Where relevant to the consultatoin, these have been analysed as emergent themes, discussed below. Other comments, though valuable to the DHB, addressed specific services, situations or concerns outside the scope of the consultation itself. These are being passed to the relevant area for response and management.

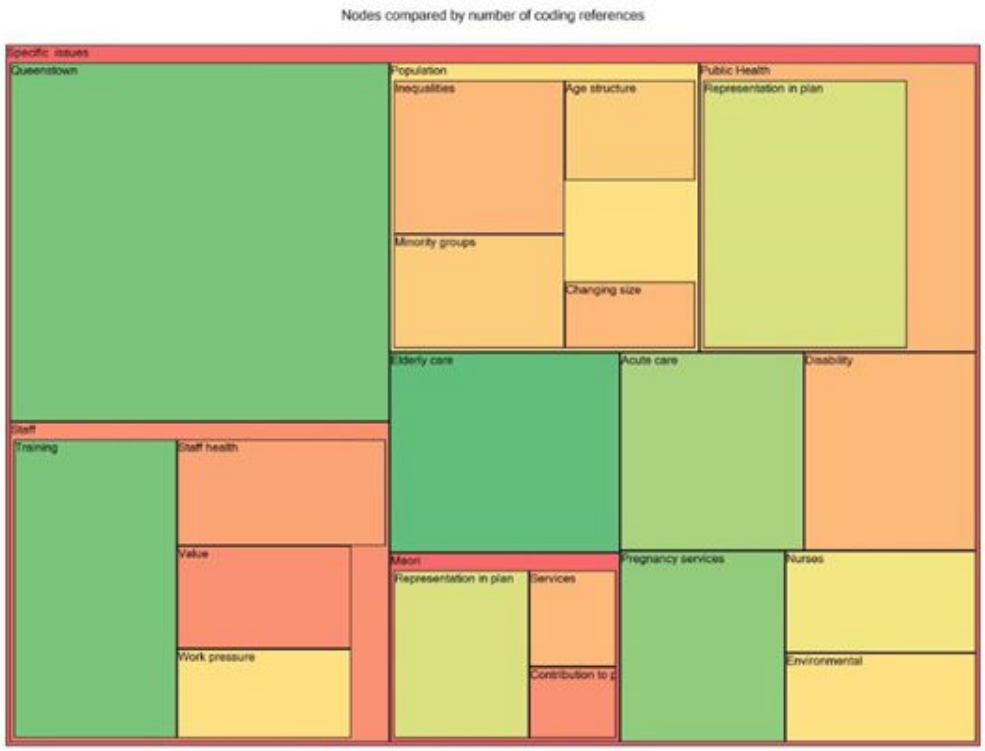
EMERGENT THEMES

Six themes emerged from the data. In order of references made, these are: specific issues (n references = 192), primary care (n = 113), funding and finance (n = 86), rural services and communities (n = 79), relationships and pathways (n = 77), specialist services (n = 55) and analysis and evidence (n = 31). The tree map (below) shows the relative weight of each theme in terms of number of references (size of the box) and number of items coded (color of the box, on a green-yellow-red scale, with green highest and red lowest). Multiple references can be made to a particular them within one item (i.e., written submission, survey response, meeting minutes)

Queenstown-specific issues, funding for primary care services and rural services stand out as themes discussed in many items. What follows is a discussion of each theme, presented in order of references made.

SPECIFIC ISSUES

This theme differs from the rest in that it captures comments about a diversity of issues, rather than a specific topic. The tree map shows that within the specific issues theme, Queenstown, public health, staff and population are important topics (based on the number of references made). Queenstown, elderly care, staff training and pregnancy services were mentioned by a relatively higher number of individuals or organizations compared with the other specific issues.



QUEENSTOWN

Fifty-six references were made to Queenstown-specific issues. Two topics were of importance—the impact of tourists and visitors on the district, and the need for increased service provision. It was felt that neither of these was adequately addressed in the plan:

"There is frustration amongst the community, the community is feeling neglect. We have a growing population but not increasing services." (Locality meeting attendee, Queenstown)

"Our daily average population is in fact double that shown in the census figures you quote, because of visitors. At peak times, this is triple. This means that by 2031, the last forecast mentioned in your strategic plan, Queenstown will not actually be rural - it will in fact be a city. Our average daily population will be greater than that of Invercargill. But with the added complications of distance from reliable transport infrastructure, in particular with regard to post earthquake response." (Submission [District Councillor], Queenstown)

Many references were also made to the Lakes District Hospital being operated as a rural trust. These were highly polarised with some advocating strongly for it, and others strongly against. Those against highlighted the rejection of the idea by the National Health Board, and argue that the wealthy population of Queenstown are not personally invested in the community (and may not contribute to local fundraising).

"Despite prolonged searching we are unable to find any mention of the 2011 National Health Board Report regarding Queenstown, although the NHB report which dealt with neurosurgical services in the South Island is discussed." (Submission [Senior Medical Officers], Queenstown)

One submitter requested that the following data is included in the plan:

"The SDHB costs of care and international patient numbers that are: a) Provided with care but not charged for because of reciprocal agreement, b) provided with care and the costs are not recouped, c) the above figures for Queenstown to be as separate from the cumulative SDHB district figures" (Submission, Queenstown)

The stand out theme among the many references to Queenstown is that the plan fails to offer a vision for health services in the area.

STAFF

Forty-seven references were made to staff issues. About half of these were related to staff training. Some consider that many performance areas could be improved via the up skilling of staff:

"I think nurses could be upgraded to do many of the jobs presently done by doctors." (Survey respondent, Dunedin)

Some highlight disconnect between training and competencies:

"Undergraduate education (particularly from a palliative care perspective) students seem to have no core competencies when they graduate." (Submission [Nurse], Dunedin)

And want better links made with training providers:

"Would be good to see a clear link between areas such as training institutes incl DSM/Otago Poly in terms of feeding into the workforce questions, along with link to HWNZ - perhaps they would like to partner in providing workforce intelligence around different models and evaluation of these? There is a real opportunity to be thinking about what a diverse system as Southern's should look like, with the role of training linked to this and opportunities for creating the nurses, doctors etc of the future in it, including use of IT and telemedicine." (Submission, Dunedin)

Seven references were made to staff already being overworked or under pressure. Ten were made to the SDHB not doing enough to look after the health of its staff.

In terms of valuing staff (eight references), most thought that the plan failed to recognise the value of non-clinical roles. The lack of recognition of the allied, technical, clerical and administrative workforces was highlighted.

PUBLIC HEALTH

Thirty-three references were made to public health, and the majority of these regarded the lack of representation in the plan.

"No acknowledgement of a population health approach. This can be easily incorporated in number 1, which should read: 'there would be a greater emphasis on public health approaches, primary and community care...'" (Survey respondent, Dunedin)

"Prevention is something not mentioned too often in your Plan." (Submission, South Otago)

"We were, however disappointed to find that the draft plan was weak in embracing or acknowledging the value of a public health model - i.e. one where the aim of the healthcare system is seen as being to improve the health of the population as a whole." (Submission, Public Health South, Dunedin)

The New Zealand Health and Disability Act 2000 was quoted as providing impetus for the inclusion of a Public Health Approach in the Plan.

POPULATION

Roughly half of the references under this theme expressed concerns about the impact of the aging and changing population on health services. The other half was related to inequalities and minority groups. Submitters felt that these issues were not adequately addressed in the plan, and many made reference to the New Zealand Public Health and Disability Act 2000. They felt that the plan failed to recognise its obligations under the act.

"This document barely mentions the need to reduce inequalities and focus on improving health outcomes for vulnerable population groups. " (Survey respondent, location not stated)

"There is also scant mention of how we will address disparities in health. It would be good to see more emphasis on how we will meet the needs of groups at risk in our community, including those on low-incomes, vulnerable elderly, and Maori and Pacific families."(Survey respondent, Cromwell)

MAORI

Like public health and inequalities, many submitters (n = 11) felt that there was a lack of recognition of Maori in the plan. Some also mentioned the lack of Maori contribution to the plan.

*"What is glaring is the lack of visible involvement of **Māori** in the development of this document. More specifically lack of acknowledgement in identifying the partnership between Mana whenua Kai Tahu (Iwi governance Group) Note we have "principals of relationship" document with Iwi." (Submission [SDHB staff member], Dunedin)*

"There is nothing around Māori Workforce development." (Submission [SDHB staff member], Dunedin)

"Strengthening clinical leadership, engagement and quality improvement must reflect effectiveness of services for Māori. It is essential that culturally appropriate practice is included as part of the quality measures." (Submission [SDHB staff member], Dunedin)

HEALTH OF OLDER PEOPLE

The delivery of elderly care received considerable attention. Many felt that the need for health system redesign to meet the needs of the aging and multi-morbid population needs to be emphasised in the plan:

"There is a need to recognise the changing nature of care being provided in Residential Services, particularly with respect to increased demand for palliative and dementia level care and the significant resource implications of providing such specialty services." (Submission, NGO, Dunedin)

"I am very concerned about the care of the elderly. They should be our most respected and cared for section of the community. Does your Strategic Plan reflect that?" (Survey respondent, Invercargill)

Other references to elderly care were in support of aging in place initiatives, but highlighted the need for home visits from nurses:

"District Nursing seems to be working for wound care. But we need a team of Nurses specialising in elder care that can be visiting those in the community especially with chronic illnesses." (Survey respondent, Glenorchy)

Advanced care plans were advocated by GPs to improve patient satisfaction and lessen the cost to DHBs. More funding to support advanced care plans was requested:

"Funding GP's to do ACP's, or having an experienced nurse assist with them, particular for people entering rest homes, would be useful. I think this needs much thought and work." (Submission [GP], Dunedin)

ACUTE CARE

Acute care was discussed in terms of the cost differential between GPs and EDs and its lack of availability in some areas:

"I think for communications, its access, after hours, we do take patients into hospital as that is the only place - but it is the wrong place. We need more after hour's services. We take them (patients) to A and E, A and E doesn't want them. We all need to contribute to after hours primary care." (Locality meeting attendee [Ambulance officer], Gore)

One rural hospital pointed out that the acute care network is already the responsibility of the Southern Region Emergency Care Coordination Team. They feel that duplication of this network would be less effective than adequate resourcing of the existing network.

Surprisingly, the 'third acute hub' concept received little attention among submitters. Two people expressed that they didn't understand the concept. Seven expressed support. One argued that there was no obvious need for one at present, citing recent growth and development in Central Otago and Queenstown Lakes District health services. One of the supporters is Dunstan Hospital:

"We strongly support the concept of an acute hub located in Central Lakes. We firmly believe that a networked, collaborative approach by Lakes and COHSL is the best way to ensure clinically safe and sustainable service levels for this remote location. Queenstown needs the opportunity to decide how they wish to engage with the infrastructure for hospital services and we are happy to provide whatever support would be of assistance while the Wakatipu community works through the options available to them." (Submission, Dunstan Hospital)

OTHER SPECIFIC ISSUES

Other issues were raised under this theme, to a lesser extent. Pregnancy services were discussed in two ways: in opposition to the abortion clinic in Southland, and in support of rural birthing clinics in Southland. Most references to disability related to its absence from the plan and argued for its inclusion, often quoting the New Zealand Health and Disability Act 2000. Similarly, references are made to the lack of acknowledgement of climate change in the draft Plan. Some talk of 'greening the service' and the environmental aspects of the hospital. It was argued that:

"SDHB should have as part of its strategic plan under priority 4 and 6 the goal of CEMARS[1] certification and carbon emissions reduction. This will help make SDHB a sustainable organisation both financially (Auckland War Memorial Museum has achieved $300,000 annual savings through CEMARS) and environmentally." (Submission, SDHB staff member, Dunedin)

Submitters also highlighted DHB obligations under the New Zealand Health and Disability Act regarding environmental responsibility.

Nurses were discussed in terms of support for the potential role or lack of specialist nurses:

"Nurse Practitioners and Clinical Nurse Specialist roles should be a priority where GP shortages exist. Hospital based specialist nurses can act as resource and give advice to nurses in rural communities to avoid people travelling to urban areas." (Submission, National Organisation)

"There is a lack of specialist nurses in the hospital and community. These nurses could be triaging, having conversations with patients (e.g. giving patient's blood results), and stopping unnecessary visits to hospital." (Submission [Nurse], Dunedin)

PRIMARY CARE

The primary care theme has obvious links with Priority 2, which enjoyed almost unanimous support among written submissions:

"I think goal number 2 (in Plan) is the key goal" (Submission, NGO)

"We welcome the focus on general practice/primary care and rural health in the strategic plan and the role of Alliance South. We consider DSM's Department of General Practice and Rural Health as well placed to provide Clinical Academic Leadership to support the stated objectives." (Submission, Dunedin School of Medicine)

"Maintaining patients in the community is essential and provides best care for patients."(Submission, SDHB staff member)

[1] Certified emissions measurement and reduction scheme

However, several interrelated issues clearly emerged regarding primary care. The tree map (above) shows feedback about primary and community care. Funding for services was the most discussed issue (largest box), by the highest number of sources (darkest green).

Broadly speaking, comments related to primary care were about the ability of primary care services and the population to cope with the proposed strategic direction:

"While ideal in theory, the potential shift of patient care and treatment to the community and to general practice may be fraught with difficulty. Unless the community sector is adequately resourced, they will not be in a position to cope." (Submission, Dunedin)

"The focus on the general practice as the patient's health care home is vital. To ensure everyone visits their GP in a timely fashion please make GP visits free for everyone and make prescriptions free of charge." (Survey respondent, Dunedin)

Other issues raised regarding primary care's ability to respond to the proposed changes include the aging GP population, the necessary up-skilling, and the willingness of GPs to take on more complex cases. For example:

"Our experience in paediatrics is GP's frankly won't touch them with a barge pole. The complexity of the cases that we are now dealing with is such that if we attempt to get the GP's to be involved we get a very quick letter back essentially saying thanks but no thanks." (Submission, SDHB staff member)

"Do we have a strategy plan with GPs to support them to care for patients in the community, and to cope with larger workloads, as we move into a community based care structure?" (Submission, SDHB staff member)

Submitters want assurance and explanation around how funds for services will be shifted from the provider arm into the primary and community context. Most were concerned that funding would not be made available to support primary care:

"But if there is a push to primary care, will there be more funding for GP's and rural hospitals?" (Locality meeting attendee, Alexandra)

"We would have to pay for facilities - there is lots of conversation needed before services are moved to primary care." (Locality meeting attendee [GP], Gore)

"We are willing and enthusiastic to take on roles, it works well for us. The risk is more work and no resources, no resources like education, up skilling, maintaining and enhancing our workforce, should be working at the top of our scope. But it is expensive and need money up front. Money needs to be first, seed money to make this happen." (Locality meeting attendee [GP], Wanaka)

The key message regarding funding for services was that money has to follow the patient.

Another much-raised issue was the cost to patients of attending primary care. Generally, reference was made to patients having to pay for GP services in the context of free hospital services. Many spoke of this issue in terms of people attending the ED for an issue amenable to GP treatment. Submitters were very concerned about people's ability and willingness to pay for primary care services:

"What about people who can't afford the $50-$70 to go to the GP? A lot of people can't afford that." (Locality meeting attendee, Queenstown)

"A home visit from a large Dunedin doctor surgery was $140. We have elderly in their homes that cannot get out to see a doctor and are not prepared to pay that for a home visit. Therefore they will wait until they have to go to hospital by ambulance before seeking treatment." (Survey respondent, Dunedin)

Some speculated that GP visits would become even more expensive as GPs up-skilled or in situations where GP follow-ups to specialist appointments took longer than 15 minutes.

Many raised the issue of access to GPs:

"If you are a new-comer to Invercargill it has always been difficult to enrol with a GP. When our GP retired we had to find a new GP. There were few options and we found that GPs had a choice to take you on or not." (Submission, Invercargill)

"Most of us have 'closed books', I.e., we are busier than we want to be looking after the patients we have without taking on more." (Submission [GP], Invercargill)

"In a lot of cases, patients are not able to see the same GP, and this creates anxiety particularly in the elderly." (Submission, SDHB staff member)

All comments regarding the scope of primary care services were supportive of their ability to expand into secondary care roles. The two main caveats were funding for services, and access to specialist advice and diagnostics. As such, the draft Plan's indication of improved access to specialist advice and investigations was strongly supported.

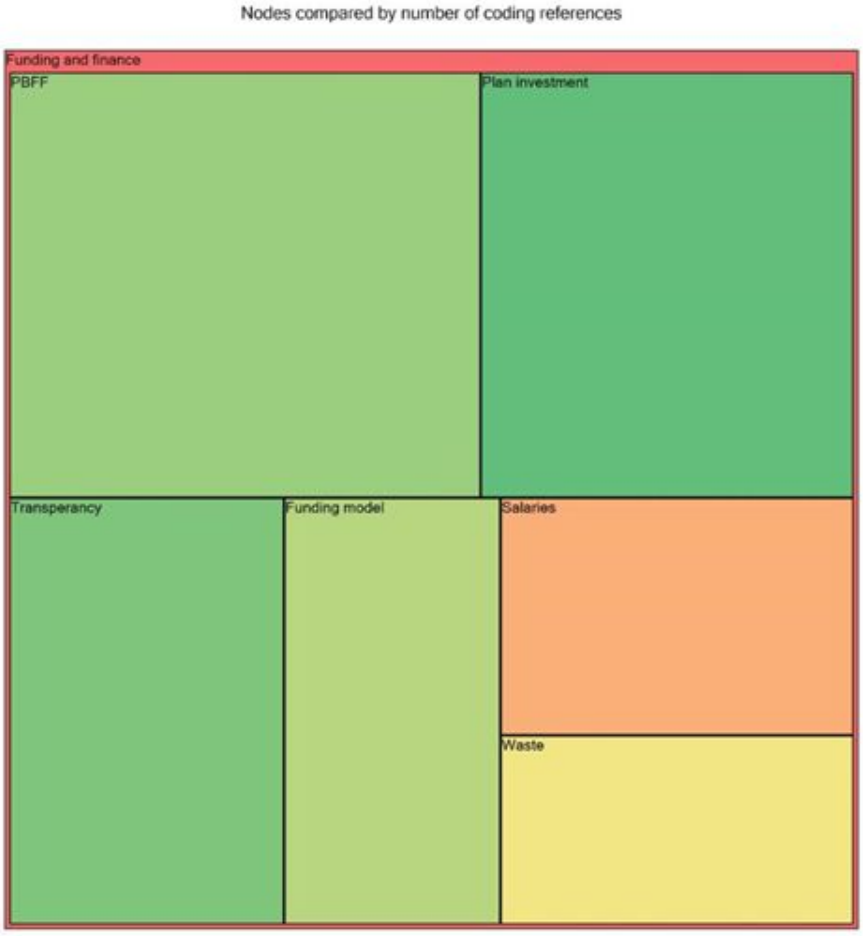
In terms of specific issues, three survey respondents indicated that the PHO is not the voice of general practice. For example:

"The SDHB needs to be very confident that PHO and GP have excellent communication, trust and relationship. We are a long way off." (Survey respondent [GP], Gore)

Finally, one submitter (Nurse, Dunedin) warned that the new model of care must be careful not to create a 'mini hospital', where an excessively large number of health care professionals are working with the patient. They feel that this situation becomes "overwhelming and confusing, particularly for the elderly".

FUNDING AND FINANCE

Six sub-themes were evident within the feedback about funding and finance. The most important of these (in terms of number of references made) was the population-based funding formula, closely followed by plan investment. The other four sub-themes, in order of references made, were transparency, funding model, salaries and waste. The tree diagram (below) shows the relative weight of these sub-themes within funding and finance.



POPULATION-BASED FUNDING FORMULA

Twenty-four references were made to the population-based funding formula (PBFF) by nine individuals or organisations. All of them express a negative attitude towards the PBFF. They argue that it is unfair for dispersed populations, that it isn't being fairly distributed by the SDHB (see accountability and transparency, below), that it ignores visitors and tourists, and that it is fundamentally inadequate for the level of services required.

Six submitters expressed desire for the SDHB to undertake lobbying activities to directly challenge the PBFF. For example:

"The DHB needs to consistently challenge population based funding as this is an unfair and inequitable distribution of funds to the people of the southern region." (Submission [Nurse], Dunedin)

PLAN INVESTMENT

All 19 references in this sub-theme are questioning the availability of funds for plan implementation. Submitters are struggling to understand how the plan will be implemented in a deficit environment. Some want to know if a cost analysis has been done. Many of them express a positive attitude towards the plan alongside a statement of the necessity of investment:

"Excellent priorities, but sadly to be achieved effectively the funding must be available if this sparsely populated, huge region is to move forward in servicing adequately our aging population." (Survey respondent [Retired], Alexandra)

TRANSPARENCY OF FUNDING DECISIONS

Fourteen references were made to transparency of funding decisions by ten individuals or organizations. The bulk of these relate to how the SDHB distributes funding across the regions.

Inequities in funding between medical practices in Queenstown and Te Anau were questioned repeatedly. Meanwhile, Queenstown residents questioned their allocation of funding, based on their visitor burden. A Maori respondent also questioned the prioritisation of government funding:

"What does "living in our means" mean, and how is funding prioritised? If you get $831 and there are 15% Maori shouldn't we get 15% of this $831million?"

It is clear from the comments in this sub-theme that people want the SDHB to be more transparent about how it determines its level of funding to various services.

FUNDING MODEL

Eleven references were made to the funding model by eight individuals or organisations. Three related frustration about the inflexibility of the current funding model. It was seen as an impediment to wider

integration, the ability to transfer patients from secondary care to rest home settings, and the ability to provide extra or different services. For example:

"The funding model is inflexible. We get funding, it is bulk based and we have volumes. We can't claim for night calls, for palliative care. There are different services here as we have no hospice for evenings, no GP, no hospital, no alternative options. Funding doesn't reflect these differences." (Locality meeting attendee, Balclutha)

Two references were made to the impact of the funding model on the ability to utilize community-based services:

"The funding must follow the patient and to demonstrate whether this is happening, or how it can best happen, further expansion of the funding model is necessary. For example, there are significant concerns with the funding model for primary care that is linked to an overreliance on hospital services and a reluctance to discharge some patients back into primary care where the patients may face financial barriers to access appropriate support in the community setting." (Submission, University of Otago)

"Specialist services at Southern DHB report that there is a group of clients who have an increased length of stay in hospital and/or premature admission to hospital because of barriers in available funded assistance to support this cohort from living safely at home."(Survey respondent, location not stated)

That the funding must follow the patient was argued by many submitters. Others commented on particular services being underfunded (rural hospitals, dementia care) and requested a review of the funding model.

SALARIES

Ten references were made to salaries by seven individuals or organisations. With the exception of two submitters, all questioned what they saw as excessive salary costs. There were some assertions that there were too many managers:

"Hard to live "within our means" unless management costs are not addressed as well. There is no breakdown in the Plan of personnel costs for non-clinical staff. Are there too many managers on high salaries?" (Survey respondent, Dunedin)

Two submitters have taken offence to what they believe is the draft Plan's inference that specialists are overpaid compared with other DHBs. However, the general sentiment among references in this category is that the SDHB should contain its salary and wage costs.

WASTE

In this category, eight references were made to a diverse range of examples of waste. These include health information pamphlets, the PHO changing its name, dysfunctional services, this consultation exercise, too many layers of infrastructure, staff training, the use of preferred suppliers and duplication.

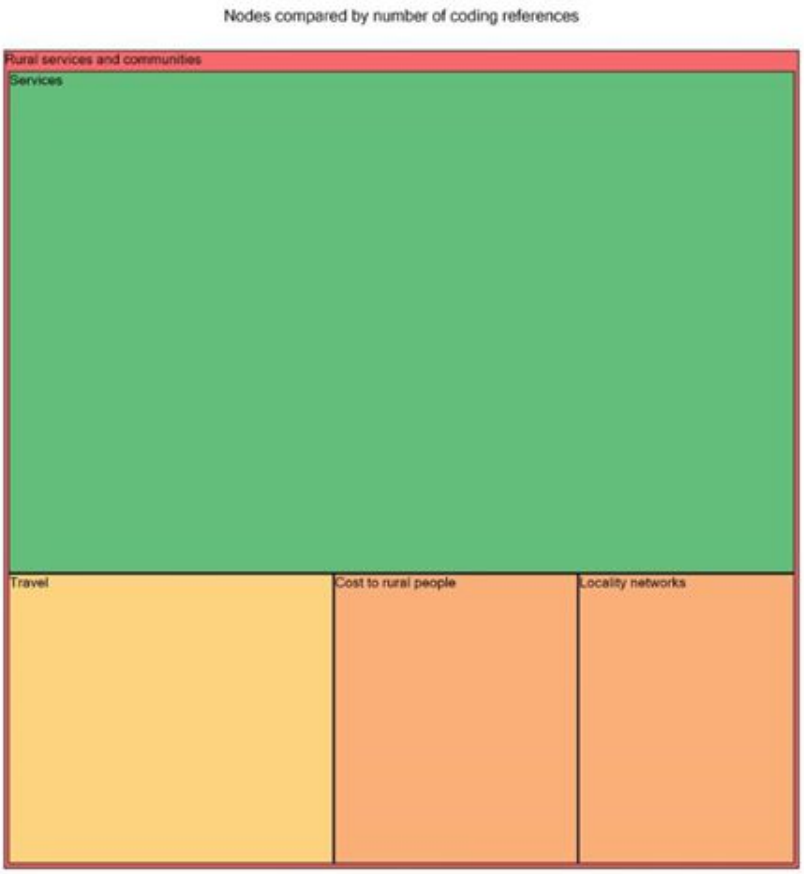
It was suggested that duplication can be avoided by the integration of services and shared IT platforms:

"Patients undergo a lot of tests that no-one ever looks at, or tests are duplicated, or unnecessary tests are undertaken. Need integration of systems so tests can be checked/view from one central point to stop unnecessary duplication and stress for patients." (Submission [Nurse], Dunedin)

One respondent suggested that the process of hiring and training new staff should be reviewed, as they believe inefficiencies are in existence.

RURAL SERVICES AND COMMUNITIES

Four sub-themes emerged from rural services and communities. The most important of these, comprising most of the references, was rural services. The interrelated sub-themes, cost to rural people and travel were also important themes. Locality networks were discussed to a slightly lesser extent.



RURAL SERVICES

There was overwhelming support for the development of rural hospitals. However, there was concern among submitters that the draft Plan's suggestion that rural hospitals should be used for short-stay acute admissions undermines and fails to recognise current non-tertiary acute and chronic internal medicine services.

"The consultants who undertook the study refused to visit rural hospitals. They don't understand what we do." (Locality meeting attendee, Oamaru)

"Rural's role is far more than stabilising and the getting patient ready for transport." (Locality meeting attendee, Wanaka)

"The SHSP's definition of the role of rural hospitals is limiting, and in our case incorrect. We are not defined by our emergency department service or by length of stay, but rather the range of services and treatment options that we can provide. We strongly oppose any suggestion that the rurals be downgraded to focusing primarily on emergency care and sub-acute rehabilitation (per Table 20) - this would be a significant backwards step from the level of service currently provided by Dunstan and completely unacceptable."

It was felt that limiting rural hospitals to short-stay acute admissions will result in more travel for rural patients, will impede recruitment of Fellows of Rural Hospital Medicine, and will increase the patient burden on Dunedin and Southland Hospitals:

"I do not believe our services should be downgraded so that most people have to go to Invercargill for Dunedin for hospital stays. The attendant costs of ambulance, family travelling and staying et cetera are again a privatisation of public health care." (Submission, Queenstown)

Further, the mismatch between the government's "Better, Sooner, More Convenient" policy and "Care closer to home" priority and the draft Plan's suggested narrowing of the role of rural hospitals was noted by submitters. Rural Hospitals were said to play a key role in ensuring delivery of healthcare services close to patients home. Particular reference was made to the changing age structure of the rural population, with its resultant need for increased local provision of in-patient services.

Rural hospitals see themselves as stable and ready to pick up a significant amount of services currently delivered only within base hospitals. They strongly feel that their ability to provide both short and long stay services with appropriate diagnostic equipment and specialist teams should be supported and utilized. The evolution of the Division of Rural Hospital Medicine in the Royal New Zealand College of General Practitioners was highlighted as giving a strong foundation for a general scope of rural hospital practice. One Wanaka-based submitter suggested that as part of the normal contracting process, the SDHB should be upgrading the scope in some rural hospitals to bring them up to a standard, to increase the work output of rural hospitals and to take more of the load off the regional hospitals.

Many agreed that immediate access to specialist advice from and greater collaboration with a major hospital were key enablers. It was suggested that GP and peripheral hospital support was part of the base hospital job description of specialist staff.

Much comment was centred on difficulty recruiting and retaining rural staff. It was felt that there was a place for rural nurse-led clinics, but that there was great shortage of nurses:

"Rural health providers will have to support and plan to have resources to retain rural nurses. If the aim is to have services close to home, then the workforce needs to be close to home." (Locality meeting attendee, Oamaru)

TRAVEL

Twelve references were made to travel by nine individuals or organisations. Three were directly related to the cost incurred by rural people when having to travel for care:

"I am daily told that (patients) went to Dunedin for a brief meeting, could be teleconference or another way. The cost is born by the individual when they travel." (Locality meeting attendee, Alexandra)

One highlighted the danger of having to travel in winter, and another the travel difficulties faced by the elderly. Three submitters complained about the inappropriate timing of outpatient appointments:

"I shouldn't be first appointment when I have to travel two plus hours to get to Invercargill." (Locality meeting attendee, Te Anau"

The inadequacy of ambulance services was raised by two submitters. A staff member from Lakes District Hospital spoke of having to transfer a patient to Invercargill in a taxi, because no ambulances were available.

From Senior Medical Officers at Lakes District Hospital:

"Patient transport is the crux of safe patient management in a region which takes hours to travel across by road. Despite this we can locate no significant mention of transport in the strategic plan. The transport service provided by St John from Queenstown struggles to cope with the current demand and, in the absence of a robust road transfer service; helicopters are increasingly used to transport patients who could be safely transferred by road. This is not a desirable situation in terms of cost or safety. Queenstown is the further from a base hospital than any other major town in New Zealand and is regularly subject to challenging weather conditions ... The absence of patient transport services in the strategic plan is a significant oversight."

Telemedicine and visiting specialist clinics are seen as ways of alleviating the travel burden upon rural people:

"People who choose to live at great distance from health facilities cannot expect all services to be brought to them but can be assisted by visiting specialist clinics or teleconference facilities where appropriate." (Submission, Wanaka)

COST TO RURAL PEOPLE

This sub-theme relates to the inequity between costs for rural and urban services. Many submitters highlighted the fact that rural people pay for services that urban people get for free (examples given include laboratory testing, venesection, GP call support, accident and emergency services):

"If the DHB is willing to fund a service in urban locations, it should also fund the service in rural locations." (Submission, Te Anau)

"Could the DHB please clarify why it currently funds a service for some of its population but not others? We request that it look at minimising occasions when (and the degree to which) rural patients pay for services that are free in the city." (Submission [Medical Practice], Te Anau)

A stated example was venesection treatment for patients with haemochormatosis, which is only free in some settings (via the NZ Blood Service). It is felt that rural clinics are capable of performing the same procedure and should be funded to do so.

One rural hospital expressed disgruntlement about the SDHB's failure to pass on increases in government funding for their share of the population, resulting in financial deficits for that hospital. They request fair and transparent allocation of funding over the regional health providers and hospitals.

LOCALITY NETWORKS

An increased focus on the use of local-based planning and service delivery enjoys fairly consistent support. Strong relationship and communication pathways with the Provider Arm are considered critical for the success of locality networks. Rural trusts are considered well-placed to become locality hubs as they are already engaged in multi- and inter-disciplinary initiatives to enhance local health services. The introduction of Clinical Nurse Specialist and Nurse Practitioner roles were advocated. It was said that locality planning needs to include a platform for Maori.

However, many submitters expressed confusion about what the proposed locality networks would actually look like in practice. One identified that to ensure network success, all providers, not just GPs, need to understand the referral pathways. Others highlighted that locality networks need to look beyond the health system.

There is strong sentiment among some providers that the data presented in the draft Plan should not be used to define locality networks. There is disagreement with the Plan's interpretation of patient flows. People in South Otago are particularly unhappy with the Plan's estimated resident population estimates. They argue that patient flow to Dunedin only holds true for secondary/tertiary care, which accounts for only 3% of total healthcare consumption:

"If volumes are shifted to Dunedin, it ignores such care as District Nurses, Physio etc. This is a large segment of care. It ignores this primary care and under represents the true needs and continued health services." (Locality meeting attendee, Balclutha)

There is also disagreement about locality boundaries for Waitaki. Some census area units are considered wrongfully excluded. Waitaki District Health Services' estimate of Oamaru's health catchment population is 27,000, not 19,800 as presented in the draft Plan.

RELATIONSHIPS AND PATHWAYS

Most comments about relationships were about the SDHBs relationships with external agencies (see below). Information pathways were also an important topic within this theme.

EXTERNAL RELATIONSHIPS

Comments about Priority 1 were strongly linked to comments about relationships. In particular, many respondents identified existing disconnects and lack of respect across the many health system groups:

"Mutual professional respect needs to be enhanced before we can achieve seamless and coherent care." (Survey respondent, location not stated)

A few comments were also made about disconnect between the SDHB and the community:

"A significant part of our problem has been lack of engagement from both the DHB and the PHO. Numerous meetings and attempts at communication with the health bureaucracy have left us feeling pretty frustrated and disenfranchised – emails often go unanswered entirely, which is simply rude, as well as being exasperating – and it feels like we are so low on the priority list as to be not even worthy of a "sorry, we are very busy" response." (Submission [Community group], Glenorchy)

Most submitting organisations have stated their desire to be *active* participants in the development of a coherent southern system of care:

"If the Southern DHB wishes to seriously address the poor health statistics of our Pacific island community, and follow the Canterbury DHB lead in attempting to "maximise outcomes within available resources", I believe a return to a more collaborative approach between the two organisations is required. Leadership, discussion and direction need to again happen at the highest level." (Submission, NGO)

A consistent theme emerged regarding the lack of engagement with, or acknowledgement of the Dunedin School of Medicine:

"A significant opportunity has been lost by the invisibility, within the plan, of the strategic, practical and collaborative relationship between DSM and SDHB" (Submission, University of Otago)

Some submitters felt that the draft Plan did not sufficiently acknowledge the importance of intersectoral action:

"This draft plan focuses predominantly on our relationship with the Primary Healthcare Organisation (PHO) to achieve this. The PHO do have an important role to play, but there are also a number of other non-government organisations (NGOs), including Maori health providers together with Local and Regional Councils and Government Departments, who all can have a positive impact on community health outcomes." (Submission, Public Health South)

"The prominent theme of engagement with other providers beyond the DHB is only the PHO, there are so many other organisation who influence the social determinants of health and these should be acknowledged" (Survey respondent, Dunedin)

"Would also like to see more links with local council particularly as they set the direction for environmental issues- climate change - housing / alcohol licensing/ water quality/ fluoridation - which prevents cavities in children's teeth and has long term oral health benefits." (Survey respondent, Dunedin)

It was also felt by many submitters that the draft plan lacked reference to allied and technical roles.

The establishment of service level alliances was supported in five references. Alliances were seen as a promising means of integrating services:

"We agree that the establishment of service level alliances to plan and develop services in prioritised areas and the application of the alliancing model through locality networks will enable the extension of the collaborative planning, decision-making and delivery of services." (Submission, Alliance South)

"It's very good to see Alliance South up front in there. Alliances I believe have the real capacity to weld things together and get clinicians involved in this." (Submission, Dunedin)

INTERNAL RELATIONSHIPS

Most comments about internal relationships were in reference to an overabundance of management structures:

"Look at reducing amount of managers so money goes back to addressing waiting list." (Survey respondent, Dunedin)

While some advocate for a structural change:

"We feel that it is unlikely that significant improvements will be made to the service until a single senior manager becomes responsible for local decision making." (Submission, Senior Medical Officers, LDH)

Others feel that:

"Plenty of time and money has already been spent changing and building management leadership." (Survey respondent, Invercargill)

It was identified that the draft Plan does not discuss management structure.

POLICY RELATIONSHIPS

The following policies were identified as having missing linkages with the draft SHSP:

- The Maori Health Plan
- The Ministry's "Healthy Start" and "Healthy Aging"
- Raise hope – the Mental Health and Addiction Strategy
- The Public Health and Disability Act 2000
- The South Island Health Service Plan 2014-2017

INFORMATION PATHWAYS

All 17 references to information pathways highlighted the need for better sharing of information by the SDHB. Some discussed what they saw as a poor referral process or a breakdown in communication between providers causing problems for the patient:

"Patient in hospital gets prescription, but there is insecurity that the hospital will not connect with other (rural) hospitals. Social Worker used to do this; you ended up with a note saying the District Nurse would come at 2pm. It is very important that the hospital activates things, sends out paper (with the patients)." (Locality meeting attendee, Alexandra)

"Current barriers to success are the unwillingness to share information with community based health professionals including physiotherapists." (Submission, South Otago)

Submitters highlighted the following needs / suggestions regarding information pathways:

- The SDHB needs to "broaden the lense" and communicate with NGOs, and the polytechnics. News letters were a suggested format.
- There needs to be interface between GP and specialist teams (this point was raised by many submitters). The interface was described in terms of shared forms, and of having a liaison person.
- The SDHB should hold regular meetings with people working in Primary Care:

  "However these need to be well publicised, i.e. with clear notification of who will be there, what it is about, or an agenda, well presented, "and useful/relevant to us" (Submission [GP], Invercargill)

- A "robust, multifaceted and agreed communication system" needs to be in place between the SDHB and contracted providers.
- There should be a clear communication channel for those in need:

  "Mention was instead made of funding being available through the PHO for those in need. However, those in need are rarely those most able to access the information to access the money…" (Submission, Queenstown)

- To stop unnecessary duplication, systems need to be integrated so that test results can be accessed at multiple sites.
- A case management model should be developed to co-ordinate care going into people's homes.

CLINICAL PATHWAYS

Eight submitters made reference to clinical pathways. They all agreed that clinical pathways are a good idea. Two agreed that clinical pathways are an important enabler to integration across primary and secondary services.

Submitters highlighted the following needs / suggestions regarding clinical pathways:

- Better liaison between specialists and GPs, and understanding how patients move between services.
- The SDHB should first "consult, agree on and adopt existing systems that seem to work well", then broaden with clinical management pathways.
- All providers will need to know the pathways—not just GPs.

Alliance South recognises the pivotal role they will play in strengthening integration of the various components of the health system. However, they would like the plan to include detail on Alliance South's role within each priority, and how integration is to be actioned. Others agree the plan does not provide sufficient information about what integration actually involves.

MODELS OF CARE

Six submitters commented on models of care. GP access to an increased range of diagnostics, GP follow-ups for specialist appointments and nurse-led services have been identified as important contributors to an improved Southern system of care.

There is concern that shifting to new models of community-based care will undermine employment conditions for those in care services:

"When services are moved out of DHBs, who have the statutory good employer obligations and collective employment agreements in place, to third sector providers, our members' experience is that terms and conditions are eroded over time, leading to lower quality jobs. It is hard to maintain service quality levels in this environment." (Submission, PSA)

The following elements were considered critical by submitters to the appropriate shifting of services to the community:

- There is no deterioration in quality of care
- Clinicians are up-skilled to deliver services and are credentialed appropriately
- Funding for clinician training and service delivery is shifted to new provider
- There is a strong partnership model in place between specialists and new clinical providers of service
- In remote rural settings the cost effectiveness of community and/or home-based care needs to be considered against the cost of aged residential and/or Hospital Level care, including respite options
- Maori and Pacific Island services should make a significant contribution
- Community providers should be included in care pathways

SPECIALIST SERVICES

Five sub-themes were evident within the feedback about specialist services. The most important of these (in terms of number of references made) were travel for and configuration of specialist services. Travel was discussed by a greater number of submitters than service configuration. The other three themes, in order of references made, were access, sustainability and generalists. The tree diagram (below) shows the relative weight of these sub-themes within specialist services.

TRAVEL FOR SPECIALIST SERVICES

Most comments about travel were related to the associated burden and hardship on affected patients and their families. For many, the cost of travel, accommodation and time off work was a significant or insurmountable problem:

"Get there (Dunedin) and the appointment is cancelled, so they sleep in their car. Security has had to bring them into the whanau room before. That is the reality for some people." (Locality meeting attendee, Invercargill)

"Parents have to travel to Invercargill to access public ENT services. Very often these parents have to lose a day's pay or close their business in order to do this therefore they find it cheaper to pay for a private appointment which many of the families I see cannot afford to do." (Submission, SDHB staff member)

In the event of specialist services 'shifting' to Christchurch, submitters want fair recompense for travel and accommodation—for the patient and their support people. Giving up income to accompany a patient to a treatment hospital is seen as burden enough. Submitters do not want the extra expenses associated with having to travel outside the district.

"We heard stories of people going to Dunedin five times for a knee operation, back and forward. Maybe it could be solved if someone here could prescribe a scan. Let's look at clinical pathways as these are just as important." (Locality meeting attendee, Queenstown)

The draft Plan's vision of a planned approach to specialist outpatient clinics that balances specialist and patient travel was supported by submitters. Many expressed desire for better co-ordinated services that would see specialists sharing the travel burden.

The inconsistency between the improved patient access and regionalisation of specialist services was raised by some:

"How will this improve patient access and population health outcomes if patients have to travel even further from their home base (as was the argument with Neurosurgical Services) to receive treatment? (Submission, SDHB staff member)

SPECIALIST SERVICE CONFIGURATION

Comments about specialist service configuration at a South Island regional level were highly polarised. Some submitters expressed that having tertiary services provided out of Canterbury makes good financial sense, and were comfortable with SDHB hospitals becoming secondary facilities:

"We have to accept that as a region we can only and should only deliver absolutely essential specialist services. We must accept that Canterbury DHB needs to become a South Island's specialist health home!" (Survey respondent, Gore)

However, others were against specialist service regionalisation, and concerned about the implications for the Dunedin School of Medicine:

"Our fear is that Otago/Southland could become a secondary facility, with tertiary services being provided out of Canterbury. Members are clear that immediate transfer to a tertiary hospital – within 60 minutes – must be retained; and Dunedin must retain cardio-thoracic surgery." (Submission, PSA)

"As stated previously, indications that patients requiring sub-speciality expertise will be transferred to regional referral hospitals in either Christchurch or Auckland (indicated in figure 27) are concerning to DSM and will require further clarification. Many of our joint clinical staff have expertise in sub-speciality areas and we see strong potential for Dunedin Hospital to act as a regional referral hospital for some sub- speciality areas." (Submission, University of Otago)

ACCESS TO SPECIALIST SERVICES

"I sit here and we talk about access, quality of care. It needs to be more reflected in the strategy. For people it's about hips, knees. At the marae I went into the kitchen and said "why aren't you at the presentation". They were like ahh, I could have told them about my hip." (Locality meeting attendee, Invercargill)

Ten references were made to access to specialist services. The vast majority of these were about the length of waiting lists, and the difficulty in getting put on them.

Three references were made by GPs, who were expressing dismay at the difficulties they face getting people specialist care. For example:

"There is a problem with the waiting list. I have patients with high risk of bowel cancer, blood in stool etc. We send referrals but they won't do it (the operation)." (Locality meeting attendee [GP], Winton)

References were made to prioritisation issues. A GP spoke of a patient having enough points, but getting declined at KEW. A specialist spoke of receiving referrals for patients who don't have enough points. Primary care and the DHB need to be using the same criteria.

SUSTAINABILITY OF SPECIALIST SERVICES

Seven references were made to the sustainability of specialist services. Three questioned how the SDHB was going to define sustainability. For example:

"The area of 'sustainability' is open to wide interpretation which leaves concern over what services may or may not be considered sustainable, what the alternatives might be, and what the process would be in ascertaining this. This is an area that we feel would need extensive further consultation throughout implementation." (Submission [Health trust], Te Anau)

Others discussed sustainability in terms of improvement, quality, and efficiency:

"The Southern DHB will not be clinically sustainable if we don't continue to improve the level of specialist services." (Survey respondent, Glenorchy)

"Everyone would prefer the best clinician/specialist staffing to be referred to in their time of need versus a team with low volumes, poor facilities, and a makeshift mentality. Sustainability across the South Island is possible!" (Survey respondent, location not stated)

GENERALISTS

Only four references were made to generalists. Three of these raised concern about the impact of a shift from specialist to generalist models on the Dunedin School of Medicine. For example:

"A further concern is that the important role of Otago University in teaching and training medicine, nursing, allied health and other health disciplines should not be undermined in a shift to generalist models and regional responsibility. These courses are nationally important to the whole of the health system, and must be internationally credible and recognised. They support the regional economy. We expect that the final plan will have addressed this matter and that the role of the university in shaping and supporting the local and national health workforce will be maintained." (Submission, PSA)

The remaining reference highlighted that older specialists often give up the "intricacies of sub-specialised work" and give value secondary generalist services in many hospital areas.

ANALYSIS AND EVIDENCE

Sixteen submitters highlighted the importance of needs analysis for preparation of the Plan, and for service planning in general. Some request a stock take of current services.

"However, to be most effective decisions must be made based on robust up to date intelligence on community health needs. This intelligence-led approach is vital for allocation of spending against health needs, prioritisation of service developments between competing needs, monitoring the effectiveness of services and demonstrating the success of the DHB's activities." (Submission, Public Health South)

"How is it possible to plan service delivery in the future without a robust needs analysis that can inform required capacity both people and facilities? SDHB planning needs to commit to establishing the on-going

mechanism to develop and maintain a comprehensive needs analysis for the Southern Region." (Submission, Rural Hospitals)

"There is a lack of acknowledgement of the need for an intelligence-led approach: one where data is available in good time for analysis and then used as the basis for decision-making." (Survey respondent, Dunedin)

Comments about outcomes analysis were strongly linked to Priority 6:

"'Live within our means;' There is a concern that there is no clear process that identifies how services will be measured regards priority, outcome and value. What will be the measurement tool regarding determining if a service is not cost effective?" (Submission, SDHB staff member)

Some questioned the outcome measures currently in use, such as the exclusion of trust hospitals from ED 6 hour time frames.

Others thought the draft Plan lacked measureable outcomes:

"The Implementation Roadmap is brief with no objectives, indicators, or targets. As this is arguably the crux of the strategic plan this is disappointing and will therefore be difficult to implement and then impossible to evaluate progress." (Survey respondent, Wellington)

"Alliance South recommends that the Plan includes a stronger focus on data needs, intelligence and analysis, with clear outcomes specified for each priority that state how we will know in 2025 that the outcomes have been achieved for the population." (Submission, Alliance South)

Two references were made about pilot programmes. One was in support of a greater commitment to planning, retaining, expanding and trialling new pilot services. The other expressed the opposite:

"Demonstration sites and "pilot studies" may prove an ineffective trial as it may take too long to implement and if the results failed, valuable time and resources wasted (e.g. the recent integrated care planned, IPC)."(Survey respondent, Gore)

GENERAL COMMENTS

An overwhelming number of references were made to the language used in the draft Plan. Submitters found it very difficult to understand, with many complaints made about jargon. Twice as many complaints were made about the lack of detail in the plan. Submitters found it difficult to comment on the draft Plan in the context of its lack of detail. Many expressed scepticism that the consultation was meaningful, or that the Plan would be implemented. However, positive comments were made! Many thought the plan was a good start, and congratulate the SDHB on its delivery.

Southern
Strategic Health Plan

DRAFT
27 January 2015

Contents

Foreword

(to be completed post Board approval. To be signed by Chair and CE)

Mihi

I te tīmatanga ko te kupu Ko te atua ano taua kupu Ko te atua anō te tīmatanga, me te whakamutunga o ngā mea katoa Kia whai korōria ki tōna ingoa.	In the beginning was the word And God is that word God is the beginning and the ending of all things. Glorified to his name
Ko te hunga ko wehe kua mene ki te po, kua hui atu ki te pūtahitanga ki rehua, moe mai. Okioki mai, ko tātou o te ao kikokiko, o te ao hurihuri tēnā tātou.	To our loved ones who have gathered in the night, rest now. To the living in this, the physical world, the ever changing world, greetings.
E te rau i te tini e te tapu, ko te reo karanga ko te reo mihi, nau mai haere mai.	To our distinguished readers, this is the voice of welcome, calling out to you a greeting.

Executive Summary

Kā tangi te tītī Kā tangi te kākā Kā tangi hoki ko ahau Tihei Mauri Ora	The mutton bird cries The parrot cries I also cry Behold there is life!
Te Poari Hauora ki te riu o te tonga, te ariatanga o te manu whakahirahira nei te pouākai, e topa, e tiu ana te mahere, mo te tekau tau. Ki tēnei putanga o te tuhinga hauora nei, ka aro atu ki te hauora o te tangata mai Ōtākou ki Murihiku, ki ngā whakaritenga me ngā wawata a te minita hauora me Te Waipounamu ā rohe hauora, koinei te tirohanga me te tautoko ki te pai, ki te ora.	The Southern Strategic Health Services Plan provides the strategic direction, objectives and planned activities towards improving the health of the Otago and Southland population for the next ten years. Our priorities for this period are guided by the expectations of the Minister of Health and the South Island Regional Health Services Plan, and are aligned with community, patient and organisational needs.
Tēnei te kaupapa kōrero hei awhi i ngā moemoeā me ngā whāinga mō te pai, mō nāianei hei oranga mō te whānau, hapu, Iwi. Nō reira tēnā koutou, tēnā koutou, tēnā tātou katoa.	This Strategic Plan shares the collective vision of 'Better, Sooner, and More Convenient' health and support systems, in its aim to deliver high quality and accessible health care in supporting more people to stay well. Greetings, thrice greetings to you all

Treaty of Waitangi relationship

As an agent of the Crown, Southern DHB is committed to fulfilling its role as a Treaty of Waitangi partner. Central to the Treaty relationship and implementation of Treaty principles is a shared understanding that health is a 'taonga' (treasure).

Southern DHB acknowledges the input and guidance of iwi as critical to the on-going development, scope and delivery of services to Māori. Te Rūnanga o Ngāi Tahu is the Iwi authority and overall representative governing body of Ngāi Tahu Whānui being descendants of the Ngāi Tahu, Ngāti Mamoe and Waitaha tribes. Te Rūnanga o Ngāi Tahu is made up of 18 Rūnanga papatipu, seven of which are in the Southern District:

- Te Rūnanga o Awarua (Bluff)
- Waihōpai Rūnaka (Invercargill)
- Ōraka Aparima Rūnaka (Colac Bay)
- Hokonui Rūnanga (Gore)
- Te Rūnanga o Ōtākou (Dunedin)
- Kāti Huirapa Rūnaka ki Puketeraki (Karitane)
- Te Rūnanga o Moeraki (Moeraki).

Southern DHB recognises and respects the principles of the Treaty of Waitangi: partnership, participation and protection and are committed to working in partnership with Iwi and local Māori to reduce health inequalities and improving health outcomes for Māori.

In May 2011, a Principles of Relationship agreement between Southern DHB and Manawhenua (Te Hauroa o Murihiku me Araiteuru Rūnaka) was signed by each of the seven Rūnanga papatipu. Collectively they are known as Te Hauroa o Murihiku me Araiteuru, and together with the Southern DHB they have formalised a Treaty partnership to work together in good faith to safeguard and improve the health status of Māori living in the Southern district. Through this agreement, Iwi and Southern DHB Board make decisions together to ensure:

- Services are appropriate and effective for Māori
- Relevant priorities for Māori are identified and targeted
- Resources are allocated accordingly to need
- Appropriate Māori representation on all Board committees and groups.

Te Hauroa o Murihiku me Araiteuru make up the Iwi Governance Committee (IGC) including board members that provides input into the Southern DHB strategic direction and operate at a governance level to ensure that Māori health issues are being addressed at all levels of the DHB.

WellSouth Primary Health Network have also formalised a relationship agreement with Ka Rūnaka to allow for better service integration, planning and support for Māori and their whānau. The closer alignment of health care services presents opportunities to deliver services more effectively, improve the continuum of care and improve outcomes for Māori across a range of areas.

Executive summary

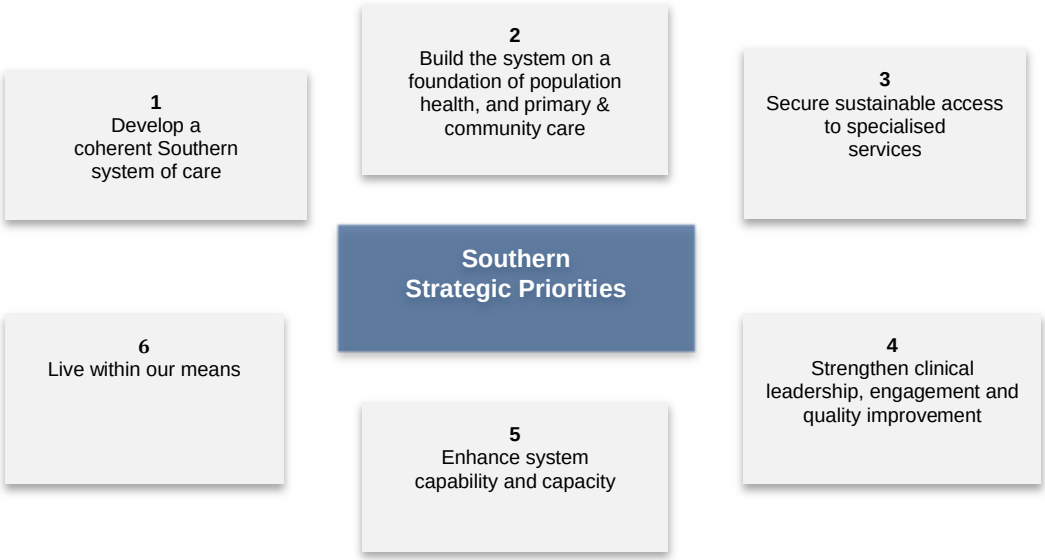
Introduction

The Southern Strategic Health Plan (SSHP) describes how Southern DHB will develop an effective and efficient system of care over the next decade. The Plan will guide the Southern health system's efforts to improve patient access and population health outcomes; and achieve clinical and financial sustainability.

Southern strategic priorities

The SSHP presents six priorities for the Southern health system, and includes:

- An Outcomes Framework (Table 11) with a 10-year goal for each priority, along with the headline actions, performance measures and enablers for the first 3 years; and
- An Implementation Roadmap (Table 12) depicting the work program for SSHP implementation over the first 3 years.



PRIORITY 1 | DEVELOP A COHERENT SOUTHERN SYSTEM OF CARE

Goal

Integrate services to ensure patient journeys are smooth through efficient and effective care pathways, and that the system is easy to use for providers

Headline actions

1. Define the intended future roles, capabilities, responsibilities and relationships of the core entities within the Southern health system
2. Align Alliance South's work programme with the SSHP's strategic priorities and Roadmap
3. Establish locality networks to improve planning and delivery of well-coordinated local services
4. Strengthen the planning and delivery of local and district-wide acute and urgent care, and link effectively with South Island services
5. Recognise and develop the rural hospitals' contribution to the Southern health system
6. Within the South Island Alliance, define the regional direction, key principles and care models that will inform specialist service configuration, development and infrastructure.

Discussion

The geography and demography of Southern district requires distributed delivery of the majority of its health services, rather than centralised models of care. In addition, the Southern health system comprises services delivered by a wide array of public, private and NGO entities. Together these factors indicate the need for a network approach that effectively links the various provider organisations, their services, and levels of care in a single unified system.

Role clarity

An important early contribution to increasing the coherence of the Southern heath system will be a clear description of its constituent parts, how they relate to each other, and how they are expected to evolve over the next 3-5 years. This includes key providers, services and sites/facilities (eg, primary and community services in rural and urban settings; the rural hospitals; and Dunedin and Southland hospitals). Alignment is essential between WellSouth Primary Health Network and the two 'arms' of Southern DHB (Provider, and Planning & Funding), and with other South Island DHBs. 'Alliance' partnerships are the preferred mechanism for achieving this alignment.

Strengthening of the structures, tools and processes that will link the components will also be important. These include district and regional clinical networks; shared electronic patient health records; shared care plans; and defined clinical pathways.

Alliances

Use of 'alliance' partnerships has been mandated by government health policy. Alliance South is in place as a partnership between Southern DHB, WellSouth and others, and is delivering its initial work programme. During implementation planning for this SSHP, the Alliance South work programme will be reviewed to ensure it includes the relevant headline actions from the 3-year Roadmap.

Southern DHB is also working with the other four South Island DHBs through the South Island Alliance on areas of common interest in service and infrastructure development.

Acute and urgent care

A vital part of any health system is the provision of acute and urgent care, with effective management of trauma and seriously unwell patients at its core. Acute and urgent care encompasses people whose existing medical conditions deteriorate, or who present severely unwell from a new diagnosis. Experience elsewhere in New Zealand has shown the benefits of a structured district and regional approach to acute and urgent care.

The effective management of trauma is one important component of this, and the Emergency Care Coordination Team (ECCT) in each of New Zealand's five regions is tasked with ensuring this. Southern's existing team and its functions could be further supported with significant gains.

An acute care workstream will be developed through the Performance Excellence and Quality Improvement Strategy (see Priority 4) to coordinate acute patient flow and management across the district and between providers and services. Options for pursuing this work include expanding the co-ordinating functions of the ECCT beyond pure emergency care to all acute care, or developing a new acute care network.

Three specific acute service areas for focus will be:

- Whether a Medical Assessment & Planning Unit (MAPU) or similar should be developed at Dunedin Hospital to improve access to urgent care
- Whether a third 'hub' (in addition to Dunedin and Invercargill) should be established in the Dunstan/Queenstown area to address the health needs of the growing resident and tourist population, and its significant distances from Southern DHB's major hospitals in Dunedin and Invercargill. If developing a third hub is considered desirable, the impact on these two major hospitals must also be assessed
- Development of a planned approach to road and air transport of patients, particularly from rural areas to Dunedin and Southland hospitals.

Southern DHB has not been meeting the national ED wait time target, although its performance is improving. Analysis shows that a significant proportion of ED patients could be seen more appropriately in general practice. Alliance South has now prioritised reducing acute hospital demand, and action is underway to promote earlier intervention in primary care settings.

Locality networks

Networks will be established in each of Southern's eight health localities to plan and coordinate local services across the various provider entities, and to engage with community stakeholders. They will build on historic structures and existing clinical relationships. Locality networks will be of particular importance in rural areas, given the demographic and geographic characteristics of Southern.

Rural health services

Community-based entities of various forms have operated Southern's rural hospitals in Balclutha, Dunstan, Gore, Oamaru and Ranfurly since the 1990s, while Southern DHB continues to operate Lakes Hospital in Queenstown. Southern DHB supports the rural hospitals' evolution to better integrate their services with local primary and community services, including through locality networks; and their desire for not only strengthened support from Southern DHB's Provider Arm (in areas such as telemedicine, visiting specialist clinics, patient pathways and professional leadership), but also more strategic direction and commitment from Planning & Funding.

The opportunity exists to strengthen the role of the rural hospitals within the Southern delivery systems, through:

- Reviewing referral and transfer pathways, which will vary by rural hospital to reflect local clinical capability
- Recognition of the core rural hospital role of triage, assessment and stabilisation of acute patients, with either discharge, transfer, or a short treatment stay
- Exploring opportunities for enhanced care capability through collaborative planning and networked delivery across Dunstan and Lakes hospitals
- Locality networks that will foster integration with general practice and community services
- Supporting improved access to 24/7 diagnostics (imaging; point-of-care testing)
- Developing the rural health workforce
- Ensuring access to responsive specialist advice from a major hospital, including through use of telemedicine.

PRIORITY 2 | BUILD THE SOUTHERN HEALTH SYSTEM ON A FOUNDATION OF POPULATION HEALTH, AND PRIMARY & COMMUNITY CARE

Goal

Strengthen population health approaches, and the core role of general practice as the 'health care home' for patients within the primary & community team

Headline actions

1. Within the Alliance South framework, develop further service level alliance teams as the key structure for collaborative service planning and development of new models of care
2. Through Alliance South, agree the future primary & community model for urgent care and after-hours care; health of older people services; community mental health services; management of long term conditions; and management of patients with high and complex needs
3. Include prevention and early intervention within the scope of the primary & community teams, and foster their linkage with Southern DHB's health promotion programmes
4. Support intersectoral initiatives that address the determinants of health, such as in housing and the physical environment
5. Implement a risk stratification tool that identifies the patient cohorts at greatest risk, and design care models commensurate with risk
6. SDHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients
7. Identify and support demonstration sites of agreed models of primary & community care, and spread successful innovation.

Discussion

Through Alliance South, support will be provided for introduction of new models of care within primary & community services, and for an increased emphasis on population health and reduction in health inequalities across the whole system. Emphasis will be given to working with other agencies to address the determinants of health through initiatives in areas such as housing and the physical environment. At the patient and family level, priority for access to services will be determined on the basis of need, ability to benefit and improved opportunity for independence of those with a disability.

Planned and structured care

The Southern health system will continue to treat people with injuries and established disease. However, Southern will move progressively to shift the balance will shift from a predominant focus on episodic care for individuals, to planned and structured care with a focus on the patients and families with high health needs. This approach will emphasise:

- Improved community health literacy to enable people to better manage their own health;
- Culturally appropriate care, particularly for Māori and Pacific Island patients and families/whanau;
- Prevention, early detection of health risks, and early intervention;
- Integrated health and social services (eg, through whānau ora); and
- The core place in the health system of continuity of holistic primary care, centred on general practice.

Health risk profiling at practice level will provide an information base for better understanding the different levels of health need in the local community. This allows identification of cohorts of the population with different levels of risk, and tailoring of models of care and resource intensity to match health needs and workforce capacity. Shared care plans will be personalised to individual patients based on their health

status, family support networks, and cultural preferences. For people and families with higher and more complex needs, the care model can be intensified to case management and broadened to include, for example, clinical pharmacy services, community mental health services, and social services.

Model of care change

Alliance South will lead model of care change in accord with *Better Sooner More Convenient* policy. Particular areas of opportunity include:

- Locality planning and networks
- Multi-disciplinary teams, with core membership from general practice, community nursing and allied health (including clinical pharmacy)
- Nurse-led services
- Referral and discharge management (supported by clinical pathways)
- Improved access to specialist advice, including through use of telemedicine
- Improving general practitioner (GP) access to investigations (eg, ultrasound, CT, MRI, exercise testing) based on agreed referral guidelines and criteria
- Minimising the need for specialist outpatient follow-up visits
- A planned approach to development of the GP with a special interest (GPSI) role
- Intersection of general practice with specialist and NGO services (eg, for mental health services; services for older people; Māori health services; Pacific Island services; St John)
- Draw on proven primary & community initiatives from elsewhere in New Zealand to tailor local solutions.

Locality networks will be an important vehicle for clinically-led change, supporting development of more effective working relationships. In rural areas this can be fostered through co-location of community services personnel with general practice, based on the local hospital campus where one exists. In urban areas the trend may be towards the development of 'neighbourhood hubs' to accommodate such personnel closer to general practice and to the patients they serve.

Use of demonstration sites, with evaluation and spread of successful solutions will be important aspects of model of care redesign and health system reconfiguration.

PRIORITY 3 | SECURE SUSTAINABLE ACCESS TO SPECIALISED SERVICES

Goal

Ensure that the Southern population has ongoing access to specialised services that have safe and viable staffing levels and activity volumes to treat complex conditions

Headline actions

1. Undertake analysis to inform planning of specialised service, including identification of services at risk of clinical and financial unsustainability; analysis of inter-district patient outflows; and updating of the Role Delineation Model assessment of Dunedin and Southland hospitals
2. Based on the analysis, identify whether action within Southern DHB or through South Island collaboration is the most appropriate avenue to pursue planning and development of particular specialised services
3. Continue South Island collaboration to refine governance, management and funding models that support provision of sustainable specialist services across DHB boundaries

4. Conduct a stocktake of visiting specialist outpatient clinics, and develop a planned approach by locality that supports equitable local access for patients to higher volume specialties, and that balances specialist and patient travel.

Discussion

A number of clinical specialty departments at Dunedin and Southland hospitals are struggling to maintain the activity volumes and staffing levels required for clinical viability. This includes both some core secondary services, and more complex and highly specialised services.

Specialist service sustainability is of increasing importance for Southern DHB for a number of reasons, including:

- The very low inflows of patients to Dunedin Hospital services from elsewhere in New Zealand means reliance on the Southern district's own population to support its specialist services
- Increasing sub-specialisation is challenging the critical mass of medical and surgical 'generalist' services, with a key consideration being the number of specialist practitioners needed to maintain a sustainable service
- The specialist workforce is increasingly attracted to work in larger centres, meaning Southern is facing recruitment challenges
- Funding constraints are placing pressure on hospital department budgets.

Overall, Dunedin Hospital's performance may be adversely affected by trying to maintain its own low volume specialties and high levels of clinical support services without sufficient population catchment to warrant adequate specialist staffing.

Assessment of the sustainability of specialist services will include clinical and financial criteria, such as:

- The catchment population required to generate sufficient volumes to warrant staffing levels that meet reasonable roster requirements, and practitioner quality standards
- Cost per case compared with benchmarks
- Comparative access/intervention rates to match New Zealand norms.

South Island collaboration

There is increasing collaboration among the South Island DHBs in relation to low volume specialties, driven by recognition that the South Island population is too small for duplication of standalone services, and that regionalisation is likely to assist in ensuring ongoing access. A range of collaborative South Island specialised service models are currently in use, including 'hub & spoke' and distributed models.

Effective South Island collaborative service models must include service funding and governance arrangements that ensure a voice for Southern DHB, viable access for Southern patients, clear clinical pathways, effective interaction with other Southern specialist and clinical support services, and affordable cost structures. Southern DHB already acts as a South Island centre for some low volume specialty services, including radiofrequency ablation and bariatric surgery, and now offers the only specialist paediatric endocrinology service.

Consideration of specialised service configuration will also include engagement with the University of Otago and the Dunedin School of Medicine in acknowledgement of their interests.

PRIORITY 4 | STRENGTHEN CLINICAL LEADERSHIP, ENGAGEMENT AND QUALITY IMPROVEMENT

Goal

Further develop a culture of clinically-led innovation, service planning and performance improvement across the Southern health system

Headline actions

1. Clarify the intended nature and role of clinical leadership in the Southern health system, and ensure supportive structures and processes are in place
2. Ensure clinical leaders have the time, skills and tools to deliver on the performance expectations of their roles
3. Revisit the Performance Excellence & Quality Improvement Strategy to ensure its relevance and adoption as a whole-of-system approach, with an appropriate governance structure and implementation plan, and linkage with the work of Alliance South
4. Position the Performance Excellence & Quality Improvement Strategy as a key vehicle for ensuring financial sustainability, by explicitly linking quality improvement with value gain
5. Identify the initial areas in which Southern DHB will lift its performance to world-class levels, and develop action plans for each
6. Develop locality networks as a forum for building the effective clinical relationships that will support local service improvement and integration
7. Through Alliance South, ensure clinical pathway development and implementation is underpinned by robust clinician engagement.

Discussion

Clinical leadership and engagement

The Southern Way introduced increased clinical leadership and engagement inside the Southern DHB Provider Arm through creation of the unified directorate structure. Full implementation of this model is at a relatively early stage, and the leadership roles, structures and processes that will underpin future performance are still maturing. Action is needed to further develop clinical leadership capacity and capability.

Performance improvement

A key vehicle for lifting the performance of the Southern health system will be the Performance Excellence & Quality Improvement Strategy. A review of Strategy implementation will be undertaken to ensure a more strategic and consistent approach to performance improvement across the whole Southern health system. Particular considerations will include:

- Ensure understanding of the Strategy across the Southern health system, and prioritise implementation initiatives
- The implementation plan will include a focus on supporting short and medium term financial recovery planning and action, in recognition that ‘good care costs less’
- Consideration will be given to establishment of a single Southern DHB decision support unit to ensure provision of timely data and analytical support for performance improvement
- Continuing emphasis on skills for change training for Southern DHB staff, and broadening of intake to include PHO and NGO personnel
- Effective linkage with national areas of focus led by the Health Quality and Safety Commission.

Increasing day surgery

A specific performance improvement area already identified by Southern DHB through the Southern Way is the need for a sustained increase in the proportion of surgical procedures that are done on a day case basis. A joint NHB/Southern DHB review was undertaken in 2013, and opportunities for improvement of the model of care and facility use were identified.

Professional relationships

Communication between the DHB's senior medical staff and general practitioners (GPs) will be strengthened. Opportunities for better structural and personal linkages will be pursued, including strengthening relationships and communication between primary, NGO and hospital-based clinicians, CME meetings, clinical pathway development, establishment of locality networks, and performance improvement initiatives. Alliance South and Southern DHB's Planning & Funding team will ensure service planning and clinical pathway development engage clinical leaders in taking a broader whole-of-system view across the continuum of primary and community, and hospital and specialist services.

PRIORITY 5 | ENHANCE SYSTEM CAPABILITY AND CAPACITY

Goal

Develop a workforce mix and facility configuration that matches future health needs, and recognise Southern's core role in teaching and learning

Headline actions

1. Mandate the existing Joint Education Committee (or equivalent) as the cross-organisational leadership body to collaboratively plan and develop the Southern health workforce based on intended models of care, workforce roles, and demand and supply forecasts
2. Develop a Southern health system workforce plan, beginning with a stocktake of the district's current health workers, and including clear priorities for workforce development based on the strategic direction presented in this SSHP
3. Expand Southern DHB professional leader roles to include a whole-system scope across primary care, NGOs and rural health services, with a focus on standards, credentialing, continuing professional development, and advice
4. Complete detailed district-wide facility capacity planning to inform business case development for an upgrade of prioritised Dunedin Hospital buildings.

Discussion

Workforce

Increasing service demand and ageing of the workforce requires planned replacement and expansion of workforce capacity, including through substitution and new roles within new models of care.

The Southern district is a major health sector teaching and training hub, including three tertiary education providers offering nine health professional streams, together with management and business disciplines. While recognising that the different focus and imperatives of the Education and Health sectors, build strategic alignment and effective operational relationships across the sectors and organisations, to develop the workforce that the future Southern health system will need. Particular issues to be addressed in joint planning include:

- Alignment of University of Otago and Southern DHB strategic planning for the medical workforce, with emphasis on general practice and rural medicine
- Management of joint academic/service employment, with an appropriate balance of clinical performance, teaching and research, and clarity about mutual expectations and accountabilities

- Accommodating clinical placements, including the increasing need for community placements
- Movement toward inter-professional learning from year 4 of Medical School, which will require complex organisational and professional collaboration
- Development of new workforce roles, building on the current training of enrolled nurses and health care assistants
- Consideration of whether clinical placements should be centrally coordinated across disciplines to ensure direct linkage with Southern system priorities and capacity
- Consideration of whether training technologies should be shared across disciplines
- Continuing promotion of an increase in the proportion of medical and nursing graduates entering general practice
- Effective Southern linkage with the South Island Alliance Training Hub, including establishment of a South Island e-learning platform to deliver professional development programmes.

In addition to strategic alignment for education and training of health professionals, other issues to be considered in workforce development include:

- Promotion of multi-disciplinary teams, rural services, and primary & community services
- Assessment of the feasibility of inter-disciplinary training (nursing, allied health, medical) in rural areas
- Building on the existing incubator programme to promote health careers in secondary schools, with a particular emphasis on lifting Māori and Pacific participation
- Addressing barriers to training of the rural workforce
- Providing advice to individual health workers to support career progression
- Support for career pathways and skill sets that support new models of care, including primary and community practitioners working at the top of their scopes.

Facilities

Southern DHB has a modern hospital facility in Invercargill that was purpose-built in 2004 (although further development of an education facility is required). In December 2013, a staged redevelopment plan of Dunedin facilities was completed, to bring some critical areas in line with quality standards. There have also been some key infrastructure upgrades at both the Dunedin and Wakari hospitals.

Recent national agency commitment to further capital investment in Dunedin Hospital has reinforced the need for a deliberate approach that ensures facility planning is strongly aligned with future demand forecasts, and with intended service configuration, and models of care.

Southern DHB has commenced a project that will develop a high-level facility master plan for the Dunedin Hospital campus. Planning for Dunedin Hospital will also look across the Southern district as a whole, and consider the impacts of:

- Forecast population changes, including ageing, and growth and shrinkage in particular localities
- Incidence and prevalence of long term conditions
- Model of care changes, such as hospital avoidance through strengthened primary care-based models; increased day surgical activity; and potential changes in rural hospital roles
- South Island planning of specialist service configuration.

PRIORITY 6 | LIVE WITHIN OUR MEANS

Goal

Improve the quality of the care and services we deliver using quality improvement principles and methodologies so that waste is substantially reduced, value for money is improved and the savings contribute to bringing our revenue and expenditure into alignment, complemented where necessary, by tight cost management, improved productivity and different resource allocation patterns.

Headline actions

1. Use the Performance Excellence & Quality Improvement Strategy as the framework for lifting performance to world-class levels in prioritised areas, and reducing waste
2. Strengthen analysis and communication of where Southern DHB funds are spent across the Southern health system, the outputs they deliver, and their outcomes and value
3. Develop a Southern DHB prioritisation framework to inform resource allocation, including relevant policies, processes and tools (incorporating the four-fold aim)
4. Tighten Provider Arm cost management including moderating recent FTE cost growth in key personnel areas
5. Increase use of benchmarking with other DHBs and providers as a basis for budget setting and productivity improvement
6. Develop a Strategic Investment Fund to support shift of resources to prioritised high value services

Discussion

Southern DHB has a history of its costs exceeding revenue, of positioning the problem as lying with the funding model rather than organisational and system performance, and of not meeting agreed financial targets. There is now widespread acceptance within Southern DHB that this cycle needs to be broken.

In the absence of a strategic framework, Southern DHB resource allocation and activity levels have remained largely based on historic patterns, and lacking a strong rationale. Resourcing needs to be more transparent and reflect the priorities of the Southern health system. In addition, benchmarking with other DHBs and peer organisations has received less focus than it should in informing performance improvement activities.

Based on recent trends, Southern DHB is forecast to continue incurring financial deficits over the next several years. The goals of reducing this deficit, reallocating resources, and preparing for the costs of the Dunedin Hospital upgrade will challenge the whole Southern system to deliver improved performance.

Areas of focus

Strategies to improve medium to long term financial performance will include:

- Rigorously implementing the Performance Excellence & Quality Improvement Strategy's Four-fold Aim in assessing the value and appropriateness of SDHB funded services and interventions
- Considering the potential for reducing spending on interventions that are either clinically ineffective or not cost-effective, and redirecting resources to higher value services and interventions
- Improving the quality of DHB Provider Arm services using lean (A3) methodology, with the expectation that this lead to better value for money (ie, less waste and improved efficiency)
- Focusing on those areas where Southern DHB expenditure is significantly higher than DHB benchmarks
- Improving performance against key efficiency indicators such as ambulatory sensitive hospitalisations, average length of stay, and same day surgery rates

- Scrutinising personnel cost growth in the Southern DHB Provider Arm, both in the numbers of staff and their relative cost, and understanding whether this represents value for money
- Developing clear strategies for capturing savings and redirecting them.

Strategic Investment Fund

When it can afford to do so, Southern DHB will create a Strategic Investment Fund to direct resources to prioritised services and models of care, with an emphasis on supporting cost-effective delivery in community settings in line with the SSHP. The Fund will also provide short-term transitional support where a change is being made to an existing model of care that enables it to be more productive in the future.

Enablers

Achievement of the Southern strategic priorities will be supported by enabling actions and infrastructure development in the following areas:

- Strengthening organisational relationships, both internally and externally
- Better planning of travel and transport
- Making better use of information
- Investing in information & communications technology
- Increasing health literacy in the community
- Improving communications.

Implementing the SSHP

Translation of the Plan into action will have the following dimensions:

- The Southern DHB Board will oversee the executive's implementation of the Plan, and support further development of the organisational alliances and other partnerships that will be fundamental to its success
- Collective accountability for SSHP implementation will sit with the Executive Leadership Team (ELT). Individual ELT members will be accountable for leading, planning and implementing each of the actions identified in the Plan. Alliance South will also lead and be accountable for actions that are relevant to its focus on integration of primary & community care with specialist services
- The Chief Executive will designate a single ELT member to be accountable for overall SSHP implementation and delivery. A programme manager will be appointed to coordinate and report on progress with Plan implementation and achievement
- Detailed implementation plans will be developed for each of the headline actions
- Key performance indicators (KPIs) and targets will be used to monitor the impact of SSHP at a strategic level. The KPIs and targets for them will be confirmed during detailed implementation planning and inform Southern DHB's annual plan and statement of intent.

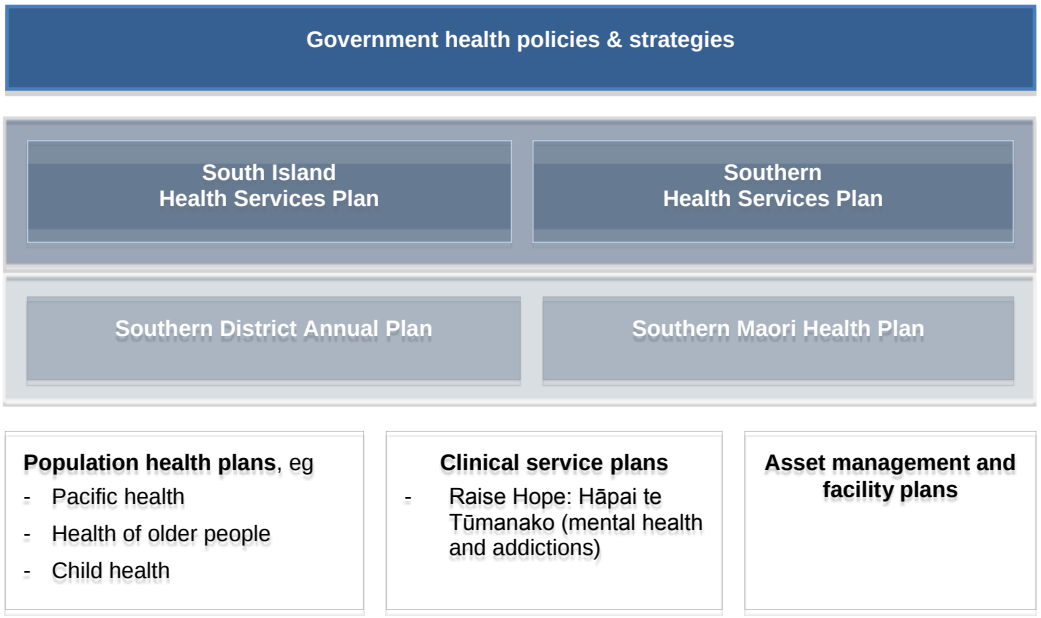
Areas for particular focus during implementation planning will include bolstering of decision support resources to ensure a strong analytical function to underpin further planning and action; support for the clinical leaders who will be actively engaged in driving service improvement through the Performance Excellence and Quality Improvement Strategy, and in developing and leading the initiatives outlined in the Implementation Roadmap; and continued evolution of Southern DHBs' Planning & Funding role towards support for alliancing and integrated care.

1. Introducing the SSHP

1.1 Purpose and focus

This Southern Strategic Heath Plan (SSHP) is the first long term plan for Southern District Health Board (Southern DHB) since its creation in 2010 through a merger of Otago and Southland DHBs. The SSHP will shape service configuration, models of care, resource allocation and capacity development for the Southern health system over the next decade. (See Figure 1 showing the place of the SSHP in Southern DHB planning.) The SSHP is intended to guide the Southern health system's efforts to improve patient access and population health outcomes; and achieve clinical and financial sustainability.

Figure 1: The place of the Southern Strategic Health Plan in Southern DHB planning



In developing the SSHP, the primary objectives have been to ensure that the identified longer term direction for Southern health services:

- Is practical and achievable
- Reflects Government policies and contemporary best practice
- Has been developed with active engagement of Southern's clinicians and communities
- Considers community health needs and priorities in the context of current service configuration, and the cost and effectiveness of interventions
- Uses information in a systematic way to inform prioritisation of competing demands for resources.

Development of the SSHP is essential at this time because:

- Clinical and managerial leaders of the Southern health system are acutely aware of the absence of a strategic framework to guide their work
- Development of a long term plan is a key marker of organisational capability development
- Southern DHB now has an 'alliance' partnership (Alliance South) in place with Southern Primary Health Organisation (now called WellSouth Primary Health Network), rural hospitals, residential aged care providers, St John and others, that can plan and action 'whole of health system' initiatives
- The SSHP will provide a strategic context for detailed service and capacity planning (including workforce, facilities and technology), and short and longer term financial planning.

While the SSHP presents priorities and goals within a 10-year planning horizon, its focus is on the actions over the next first 3 years (2014/15 to 2016/17) that will ensure the Southern health system takes the critical early steps that will lead it in the desired direction. The SSHP includes:

- An Outcomes Framework (Table 11) with a 10-year goal for each priority, along with the headline actions, performance measures and enablers for the first 3 years; and
- An Implementation Roadmap (Table 12) depicting the work program for SSHP implementation over the first 3 years.

1.2 Sustainability

A goal of the SSHP is to ensure a sustainable health system – one that can provide ongoing access for Southern district's resident population (and visitors to our district) to safe, effective and efficient services. Sustainability also requires the capability to anticipate and respond to a changing operating environment, and to contribute to the wider wellbeing of our communities. As is the case in all developed nations, the Southern health system is operating in a testing environment, with intensifying demand and constrained supply. Together these pressures - illustrated in Figure 2 – are challenging the clinical and financial sustainability of health systems.

Figure 2: Demand and supply pressures on health systems

In addition to these general demand and supply pressures, the Southern health system also faces two particular challenges.

Geographic and demographic challenges

The Southern health system delivers services to a large geographic area (the largest of any DHB) that is sparsely populated. Rural and remote health services face particular sustainability challenges arising from:

- Small communities with ageing and often reducing populations;
- The distances that people and health professionals must travel;
- Limited transport and health service infrastructure;
- Relatively high delivery costs, particularly for community services; and
- Difficulty in attracting and retaining a skilled workforce.

However, Southern's rural communities have advantages over many other such areas in New Zealand in that they generally do not have high levels of deprivation (although in some cases, disadvantaged

communities are obscured in analysis by their better-off surrounding population); Central Otago and Lakes in fact have growing populations; a number have health services operated by highly motivated local communities; and the Southern district has a well developed tertiary education sector with a strong focus on the health professions and rural health.

Financial challenges

Southern DHB has delivered financial deficits each year since its establishment in 2010, following a pattern established by its predecessor organisations (Otago and Southland DHBs). Southern DHB is the predominant funder of the Southern health system, so any deficit impacts on all publicly funded health services. While the annual deficit is relatively small as a percentage of the DHB's total revenue, it has proved persistent. Elimination of this deficit will be achieved through actions in the short-medium term that are congruent with the Southern health system's longer term direction presented in this Plan.

Furthermore, Southern DHB will need to invest to:

- Meet the additional operating costs arising from the essential upgrade of some of Dunedin Hospital's facilities that will take place over the next 5-10 years. A clear understanding of the intended future service configuration and associated capacity requirements, together with strong financial management disciplines, will ensure mitigation of the financial risks of capital investment for the organisation – as well as avoiding the opportunity costs associated with less than optimum models of care
- Meet the costs of implementing the change initiatives outlined in this SSHP, to be supported through establishment of a Strategic Investment Fund.

1.3 Recent changes impacting on the Southern health system

Several major health system changes at local, regional and national levels have affected Southern DHB since 2010. These include:

- Creation of a number of new national entities to strengthen health system leadership and support for DHB performance improvement and innovation. These include the National Health Board (NHB), Health Workforce New Zealand (HWNZ), National Health IT Board (NHITB), the Capital Investment Committee (CIC), the Health Quality and Safety Commission (HQSC), and the National Health Committee (NHC)
- Stronger direction from government to deliver on policies, priorities and expectations, most notably in respect of the national Health Targets
- Expectation that each DHB will lead and champion service integration through whole of system planning involving primary and community services as well as regional and sub-regional services, rather than focusing predominantly on its own Provider Arm
- Requirement for strengthening of clinical engagement and leadership to improve health service delivery
- Emphasis on regional and national DHB collaboration to gain efficiencies through shared 'backroom' services
- Requirement for collaborative DHB regional service planning, and an updated regional plan to be produced annually
- National planning and funding by the NHB for a small number of highly specialised, low volume services, such as paediatric sub-specialty services
- NHB-led intervention to determine the configuration of South Island neurosurgical services, and make recommendations about Wakatipu health services
- A joint NHB/Southern DHB assessment of systems at Dunedin Hospital
- National mandating of an alliance model for partnering between DHBs and PHOs

- Planning for the rebuilding of Christchurch Hospital post-earthquake, with consequences for all other South Island DHBs
- A commitment from government to capital investment in Dunedin Hospital facilities.

1.4 SSHP development

Development of this Plan has been overseen by a Steering Group comprising leaders from Southern DHB, WellSouth, University of Otago Medical School, urban and rural general practice, Māori, rural hospitals and public health services. The process has engaged a range of Southern DHB, primary care, Māori, Pacific Island and NGO stakeholders, together with local government leaders, and the tertiary education sector during its development. This input was extended to the wider community during consultation on the draft Plan in late 2014. The planning process and Steering Group membership are described further in the Appendix.

2. Operating environment

2.1 Legislative context

Southern DHB is one of New Zealand's 20 DHBs. Each DHB is a Crown Entity, owned by the Crown for the purposes of Section 7 of the Crown Entities Act 2004, and is accountable to the Minister of Health. The New Zealand Public Health & Disability Act 2000 defines the role of the DHBs, and the organisation of publicly funded health and disability services. It establishes DHBs with specified geographically-defined populations, and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees, and health sector provider organisations.

The New Zealand Public Health and Disability Amendment Act 2010 outlines the planning framework and requirements for DHBs. Southern DHB has a statutory responsibility to prepare an annual plan with a statement of intent (SOI), and a regional service plan in collaboration with the four other South Island DHBs. In these plans Southern DHB must:

- Address local, regional, and national priorities/needs for health services
- Show how health services will be properly co-ordinated to meet those priorities/needs
- Demonstrate the optimum arrangement for the most effective and efficient delivery of health services.

Through the New Zealand Public Health and Disability Act, Southern DHB is responsible for:

- Planning the most effective and efficient health and disability[1] services that will improve outcomes, in accord with national and regional priorities
- Taking a whole-of-system view, and across the service continuum
- Reducing health inequalities
- Working in partnership with stakeholders to determine the models of care and types of services that will lift performance and outcomes
- Investing in priority services, and disinvesting in lower priorities
- Funding services to be delivered by the DHB's Provider Arm, by NGOs, and by primary care providers through the PHO
- Achieving agreed performance levels as measured by national Health Targets and other indicators
- Managing within a finite budget
- Managing the Crown assets that it owns.

DHBs are guided by the New Zealand Health Strategy, Disability Strategy, and Māori Health Strategy (He Korowai Oranga). The outcomes the national health sector seeks are for all New Zealanders to lead longer, healthier and more independent lives; and for the health system to be cost effective and support a productive economy.

DHBs are expected to contribute to meeting these health sector outcomes and government commitments by increasing access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money.

[1] The focus of the SSHP is predominantly on health services, rather than disability support services for people aged under 65 years, for which the Ministry of Health has national planning and funding responsibility. Southern DHB has planning and funding responsibilities for health of older people services, which cover both personal health and disability support for people aged over 65 years, and which are within the scope of the SSHP.

2.2 Government health policy

Better, Sooner, More Convenient[2] is the Government's over-arching policy for health services. It seeks services that put the patient first, provide seamless integrated care closer to the person's home, and are good value for money. The Minister of Health's *Letter of Expectations* to DHBs signals specific annual priorities for the health sector that link with *Better Sooner More Convenient*, and that are to be responded to in the DHB's annual plan and statement of intent (SOI). In setting expectations for 2014/15, the Minister emphasised that the public health system must continue to deliver better, sooner and more convenient health care and lift health outcomes for patients within constrained funding increases.

Specific priorities for 2014/15 presented in the Minister's *Letter of Expectations* are:

- Better public services – in particular, increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children
- Care closer to home
- Health of older people
- Regional and national collaboration
- Living within our means.

Continuing emphasis is also given to delivering on the six national Health Targets:

- Shorter stays in hospital emergency departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Increased immunisation
- Better help for smokers to quit
- More heart and diabetes checks.

Government health policy is reflected in the Ministry of Health's Statement of Intent. The SOI for 2014-18 presents the strategic direction for the Ministry, work that will be undertaken to deliver key priorities, and how success will be measured. It identifies two outcomes for the health system and the Ministry: that New Zealanders live longer, healthier and more independent lives; and that the health system is cost-effective and supports a productive economy.

The improved wellbeing and health of New Zealanders will be achieved by the delivery of services that are accessible, safe, individual- and family-centred, clinically effective and cost-effective. Among the Ministry's priorities is implementation of the Minister's objectives for the sector, which are to:

- Maintain wellness for longer by improving prevention
- Improve the quality and safety of health services
- Make services more accessible, including more care closer to home
- Implement Rising to the Challenge (the national Mental Health and Addiction Service Development Plan 2012–2017)
- Support the health of older people
- Make the best use of information technology (IT) and ensure the security of patients' records
- Strengthen the health and disability workforce
- Support regional and national collaboration.

[2] *Better Sooner More Convenient: Health Discussion Paper* (New Zealand National Party (2007). A companion document *Better Sooner More Convenient Health Care in the Community* was published by the Ministry of Health in 2011 http://www.health.govt.nz/system/files/documents/publications/better-sooner-more-convenient-health-care_0.pdf

2.3 Regional planning and action – the South Island direction

Government policy is for increased regional and sub-regional collaboration and alignment between DHBs in the interests of improved integration and quality of care, and reduced service vulnerability and cost. While each DHB is individually responsible for its own population, working regionally enables them to better address their shared challenges and support improved patient care and more efficient use of resources. Effective regional governance, accountability and decision-making will set the direction for integrated models of care, which in turn will inform effective planning of information and communications technology (ICT), workforce and capital investments to enable a sustainable health system.

The South Island Alliance was established in 2011 by Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs, which together fund and provide services for just over 1 million people (almost 24% of the total New Zealand population). The South Island Alliance formalises the partnership between the five DHBs, and was developed further in 2013 with a framework that ensures all regional activity aligns to agreed goals. The DHBs are committed through the South Island Alliance to make the best use of all available resources, strengthen clinical and financial sustainability, and increase access to services for the South Island population.

The shared vision of '*Best for People, Best for System'* envisages a sustainable South Island health and disability system focused on keeping people well and providing equitable and timely access to safe, effective, high quality services, delivered as close to people's homes as possible**.** Closely aligned to the national direction, the shared outcome goals of the South Island Alliance are:

- Improved health and equity for all populations
- Improved quality, safety and experience of care
- Best value for public health system resources.

The success of the South Island Alliance relies on improving patient flows and the coordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models, and improving patient information systems to better connect the services and clinical teams involved in a patient's care. Regional activity is implemented through service level alliances and workstreams based around priority service areas. The work is clinically led, with multi-disciplinary representation from community and primary care, hospital and specialist services, and consumers.

Service areas that have been prioritised for South Island focus[3] include:

- Cancer
- Child health
- Health of older people
- Mental health
- Cardiac surgery
- Elective surgery
- Neurosurgery
- Public health
- Major trauma
- Stroke.

In addition, a regional approach is being taken to planning and development of ICT, support services, quality and safety, facility planning and workforce planning, which will contribute to improved delivery across all service areas.

[3] The South Island Health Services Plan is available from the South Island Alliance website: www.sialliance.health.nz.

In developing their Alliance framework, the South Island DHBs have identified four collective outcomes (see Table 1) where individual DHB performance will contribute to regional success, together with a core set of associated long-term outcome indicators which will demonstrate whether the DHBs are making a positive change in the health of their populations. To achieve these outcomes, the DHBs have agreed a number of strategies that will be delivered through regional initiatives and the collective activity of all five South Island DHBs. Each DHB sets 3-year local targets for each indicator in their annual plans.

Table 1 : South Island DHB outcome areas and indicators

OUTCOME 1: PEOPLE ARE HEALTHIER AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH
A reduction in smoking rates
A reduction in obesity rates
OUTCOME 2: PEOPLE STAY WELL IN THEIR OWN HOMES AND COMMUNITIES
A reduction in acute medical admission rates
OUTCOME 3: PEOPLE WITH COMPLEX ILLNESSES HAVE IMPROVED HEALTH OUTCOMES
A reduction in acute readmission rates
A reduction in all cause mortality rates
OUTCOME 4: PEOPLE EXPERIENCE OPTIMAL FUNCTIONAL INDEPENDENCE AND QUALITY OF LIFE
An increase in the proportion of the population over 75 living in their own homes

2.4 Reducing inequalities

As shown in the *Southern Health Profile*, Māori and Pacific people living in Southern experience significant health inequalities. Southern DHB is committed to reducing inequalities – including those experienced by Māori and Pacific peoples - through improving access to services, and directing resources to the populations and patients with the greatest health and support needs. Actions that will make a difference to Māori and Pacific health outcomes and reduction in inequalities will include:

- Use of the Health Equity Assessment Tool (HEAT), a planning tool that improves the ability of mainstream health policies, programmes and services to promote health equity. HEAT will be used during detailed planning for SSHP implementation
- Setting specific targets for improving health system performance for Māori and Pacific people in the SSHP's key performance indicators
- Defining the intended role of Māori health service providers within the Southern health system, and their relationship with mainstream providers
- Supporting Māori health providers to play an active role within locality networks, and build partnerships with mainstream providers
- Building the Southern health system's cultural competence, recognising that the majority of Māori and Pacific people receive most of their care from mainstream services
- Including measures that assess the effectiveness of services for Māori and Pacific people in review and implementation of the Performance Excellence and Quality Improvement Strategy
- Lifting the participation of Māori and Pacific people within the health workforce
- Continuing to ensure Māori leadership and engagement is reflected within all levels of decision-making
- Ensuring that whānau ora and promotion of healthy lifestyles is incorporated as a core component of the population health approach
- Collaboration of Southern DHB and WellSouth in developing annual plans for Māori Health and for Pacific Health, linked with the priorities presented in this SSHP.

3. The Southern people

The Southern district has a resident population of 306,430 (2013 Census estimated resident population) that is mainly European and slightly older than the national average. The average deprivation level is low compared with New Zealand as a whole, although there are pockets of relatively high deprivation within Southern district.

Population growth for the Southern district from 2006 to 2013 at 4% was lower than the national average growth of 6.2%. Growth in Southern is expected to slow markedly out to 2031, with growth for the next 18 years forecast to be the same as that of the past seven years. The populations of Central and Queenstown localities[4] are expected to grow by 6400 and 6170 people respectively over the next 18 years (although these numbers are small compared with the total Southern population, they represent local growth rates of 23% and 30%), reflecting potentially greater demand for health care services in the future. In contrast, the populations of Gore, Waitaki, Southland and Invercargill localities are projected to fall, suggesting reducing demand for health care in years to come.

Older people make up a growing proportion of the Southern population. Currently 14.7% are aged 65 and over, and this is expected to rise to 23.8% by 2031. This ageing of the population is expected to bring increasing demand for health services, and the need for new resource allocation patterns and models of care.

Life expectancy at birth for people living in Southern district was 81 years for 2010 to 2012, which is slightly lower than the New Zealand average of 81.2 years. Given the relatively low deprivation levels of the Southern population, a better result might be expected.

Population health priorities

An analysis of population risk factors, the chronic disease burden, and use of primary care and hospital services (published in early 2014 as the *Southern Health Profile*[5]) concluded that the most important areas for the health of Southern residents that Southern DHB and service providers can address include:

- Tobacco smoking
- Obesity and nutrition
- Hazardous alcohol consumption
- Chronic disease management – particularly diabetes and cardiovascular disease
- Access to and use of primary care – in-hours, and after-hours
- Māori health - particularly child health and chronic disease
- Pacific health - particularly child health and chronic disease
- Access to mental health services – particularly through strengthening of community services.

[4] Eight localities are described in this Plan, and will be used as a core component of future health service planning and delivery. See discussion in Priority 1.

[5] *The Southern Health Profile* is available on the Southern DHB website: www.southerndhb.govt.nz. It presents a detailed analysis of the demography of the Southern district.

4. Current Southern DHB services and performance

Southern DHB has three main roles in the health system - those of planner and funder; service provider; and owner of Crown assets. This Section of the Plan describes those roles and functions, and then briefly considers Southern DHB's current performance.

4.1 Southern DHB services

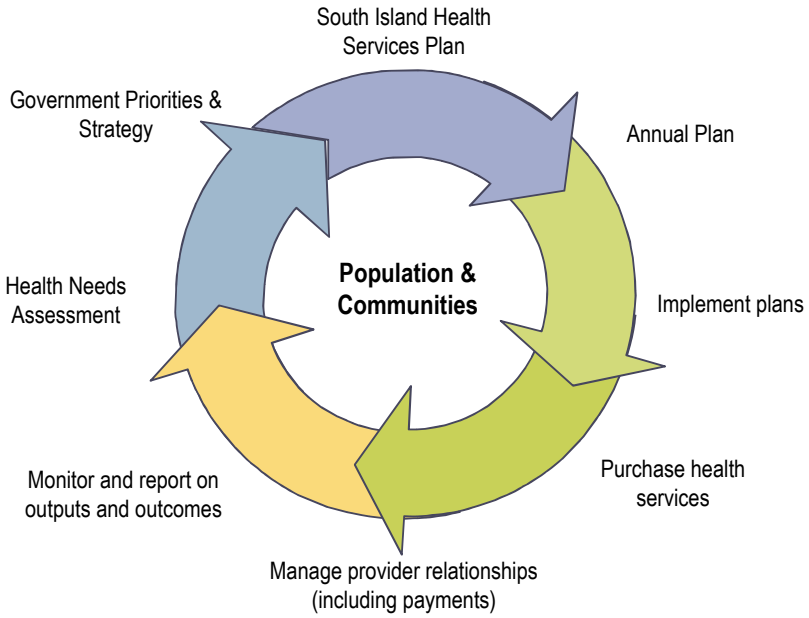
Planning and funding

Southern DHB has a statutory responsibility to base its planning and resource allocation on the health needs of the local population, and to seek the most effective and efficient delivery of health services that improve health outcomes. In doing so, the DHB also needs to align with government and regional priorities.

Southern DHB planning and funding takes a whole of system view, encompassing the service continuum from primary prevention and early intervention, through to specialist diagnostic and treatment services, rehabilitation, and end of life care. This broad view is becoming more important in light of growing demand and constrained supply (as discussed in Section 1), and the quest for better integrated and more cost-effective services.

Southern DHB's planning and funding role includes setting of resource allocation priorities, that in turn determines funding for services and capital investment (ie, in facilities, equipment and information systems). Part of that role is also to identify services that no longer align with priorities in that they don't contribute strongly to desired outcomes, fit with preferred models of care, or provide good value for money. In such circumstances, the DHB would seek to disinvest in these services in order to reallocate resources to higher priority areas. Figure 3 illustrates the Southern DHB planning and funding cycle.

Figure 3: Southern DHB planning and funding cycle



Operating within the finite funding available is a fundamental accountability area for Southern DHB. Southern DHB's Planning & Funding team is responsible for the allocation and management of $831m in funding for 2014/15. Approximately half of this funding is spent on health and disability services delivered by the DHB's own Provider Arm (see below), with the other 50% being spent on services delivered by NGOs, primary care providers and other DHBs for the Southern population.

In its funder role, Southern DHB purchases a wide range of health and disability services, delivered in institutional, community and home-based settings. Primary and community (including domiciliary) services funded by Southern DHB include:

- General practice services, through WellSouth
- Allied health services (eg, occupational therapy, physiotherapy, dietetics, speech language therapy, child development services, social work, orthotics, pharmacy, vision & hearing)
- Nurse specialist services (eg, cardiac, diabetes, respiratory, breast care)
- District nursing services
- Public health services (including health protection, health promotion, and preventative health services)
- Oral health services for children and adolescents
- Well child services
- Māori health services
- Pacific health services
- Community mental health services
- Home-based support services
- Other community support services for older people.

Institutional based services funded by Southern DHB include age-related residential care (delivered by private and NGO providers), and rural hospital services in Balclutha, Dunstan, Gore, Oamaru and Ranfurly (NGO providers).

Provider

Through its Provider Arm, Southern DHB is a major provider of health and disability services, and is one of the largest employers in the Southern district with over 4,500 staff. Services delivered by the Provider Arm include some of the community and home-based services listed above, and hospital-based specialist services. The latter include:

- Acute services for conditions that have an abrupt onset. They are usually of short duration, progress rapidly, and require urgent care – often needing an inpatient admission
- Emergency services delivered through hospital emergency departments (EDs). The district's main EDs are at Dunedin Hospital and Southland Hospital (Invercargill), which have the specialty services available to provide definitive care for most patients who require admission. Lakes District Hospital also provides an ED service.
- Elective (planned) services are for patients who do not require immediate hospital treatment, but rather diagnostic or treatment procedures that can be scheduled in advance. Some are performed on a day stay basis; others require one or more nights in hospital
- Non-admitted services (generally referred to as outpatient services) are generally non-urgent and do not require an overnight hospital stay. They include access to a wide range of specialties for provision of both treatment services, and patient assessment and advice to the referring GP.

Owner of Crown assets

Southern DHB is the owner of Crown assets and is accountable for managing them in a fiscally responsible manner. This includes planning and funding facility maintenance and future replacement. Southern DHB owns the following major facilities:

- **Dunedin Hospital**: A secondary/tertiary hospital facility with 371 resourced inpatient beds, located in central Dunedin and operated by Southern DHB's Provider Arm
- **Southland Hospital**: A secondary hospital with 157 resourced inpatient beds, located in Invercargill and operated by Southern DHB's Provider Arm
- **Lakes District Hospital**: A rural hospital located in Queenstown with 14 resourced inpatient beds and operated by Southern DHB's Provider Arm. (An aged care facility is also located on the Lakes campus, and operated by Bupa New Zealand.)
- **Wakari Hospital**: A satellite facility with 91 resourced beds including specialist inpatient mental health services and rehabilitation services. Wakari is located in the Dunedin hill suburbs and operated by Southern DHB's Provider Arm. (Southern DHB's corporate offices are also located at Wakari.)
- **Dunstan Hospital**: A rural hospital located in Clyde and operated by Central Otago Health Services Ltd.

4.2 Current performance of Southern DHB

In 2014 a review was undertaken of Southern DHB performance against a number of service and financial measures, with the information from the review informing this Plan's development.

Southern DHB (and its predecessor organisations) have recorded persistent operating deficits for a number of years. A number of areas were identified during the review in which Southern DHB expenditure patterns appeared significantly different to those of other DHBs (discuss briefly in Priority 6 of this SSHP). The DHB is now taking action to ensure reduction of its deficit.

5. Shaping the Southern response

5.1 Facing the challenge

The previous sections of the Plan have described the need for Southern DHB and the wider Southern health system to pursue new directions over the next 10 years in order to achieve improved results for the patients and communities they serve.

Southern DHB is at a pivotal point in its development, with the opportunity to define a longer term direction for the Southern health system that ensures:

- Service configuration and capacity are appropriate to meet the forecast increase in demand arising from population ageing and the increasing incidence, prevalence and complexity of long term conditions, and the locally changing demands due to population shifts within the district
- Southern's dispersed rural communities have ongoing access to services that reflect their changing demographics
- Specialist services are clinically and financially sustainable
- Improved performance in key national health policy areas and related KPIs and targets
- Financial management disciplines that eliminate the DHB's persistent deficit, and allow investment in priority service and outcome areas, and in the enabling infrastructure that will underpin improved system performance
- Deferred capital investment is addressed, and in particular upgrading of prioritised Dunedin Hospital facilities.

The Southern health system's focus has been on short term cost reduction. Adoption of this SSHP allows a concurrent focus on longer term service performance improvement, and alignment of capacity and configuration with contemporary care models and forecast demand. In this environment, the challenge for Southern DHB and its partner organisations will become one of planning and implementing actions of sufficient scale, scope and ambition to deliver the required performance improvement, while balancing short, medium and long term imperatives.

5.2 Trends in service design

Whilst the challenges facing Southern DHB and the Southern health system have some unique dimensions reflecting the district's special characteristics and circumstances, in general they are similar to the pressures on health systems throughout New Zealand and other developed nations (as discussed in Section 1).

As health systems rethink their strategic direction to ensure sustainability, the trend is towards models of care that shift activity and resources away from hospitals to earlier intervention in lower cost community and home-based settings, and that take advantage of new communications, monitoring and treatment technologies.

The broad service design responses by developed countries' health systems are similar[6], and include:

- Investment in improving the population's health literacy and strengthening patient self-management, prevention, early intervention, and home-based services
- Consolidation of primary and community services into larger health centres and networks, with multi-disciplinary teams, and services integrated with local hospitals in rural areas

[6] The challenges facing health systems and their responses are summarised in *Trends in Service Design and New Models of Care: A Review*, Ministry of Health (2010). This document provides a summary of international responses to the pressures and challenges facing the New Zealand health sector, to help guide DHB service planning. It is available at http://www.nationalhealthboard.govt.nz/sites/all/files/trends-service-design-new-models-care-jul2010.pdf

- Clustering of hospitals to share resources and expertise, and networking of practitioners across sites
- Consolidation of sub-specialist services across networked sites to create critical mass, with outreach to ensure access for local populations.

Health systems internationally are also seeking to better integrate services – both 'horizontally' across primary and community services, and 'vertically' across primary and secondary (specialist) care. Integration is seen as improving the Triple Aim dimensions - patient access, experience and outcomes; population outcomes; and resource use. For Southern this is highly relevant, as the Southern Way includes the dimensions of the Triple Aim (with the addition of a fourth aim - promotion of high quality teaching and learning, research and scholarship)[7].

Rural health services

Sustainable and effective rural health services are a particular focus for the Southern health system, given its large geographic area and dispersed population. Organisations delivering health services to rural communities face greater challenges in their quest for sustainability arising from:

- Geographic distance
- Low population density and (in many cases) population shrinkage, particularly in working age populations
- Limited infrastructure, including transport, telecommunications and facilities
- Difficulty in attracting and retaining a skilled clinical workforce.

In addition, rural health services tend to have higher community service delivery costs than those in urban areas because of such factors as lack of economies of scale and scope, direct travel costs and loss of productive time for staff, and the need for effective telecommunications and mobile services.

The policy response to the health needs of rural communities seeks to both strengthen locally available services, and support patient access to services in centralised locations.

The scope of services available locally in a rural community is determined largely by the volume of demand, and the available workforce, funding and infrastructure (facilities and technology in particular). Clinical safety is a key consideration. Experience internationally and in New Zealand shows that rural communities recognise the trade-offs that are necessary in determining service configuration. In general, they give priority to local availability of the comprehensive primary care services that they use most often, and are willing to travel to more specialised services that need a critical mass of demand and staffing, are capital intensive, and are used only very infrequently by local residents.

The trend – supported in New Zealand by government policy and increasingly evident in Southern district (for example in Balclutha) – is for integration of health services in rural communities to ensure a critical mass of health professionals, and ease of access for patients to safe and effective services. General practice is increasingly linked with provision of local hospital services, including emergency response and urgent care. Services are 'bulking up' into local micro-systems through co-location, shared care, and common governance, management and information. Collaborative support is being provided from a larger centre, and from peer organisations.

[7] The Triple Aim forms the basis for Southern's fourfold aim – see Section 5.4.

5.3 The Southern Way

The Southern Way framework was developed by Southern DHB in 2012 to address immediate developmental priorities associated with:

- Fully implementing the Otago-Southland DHB merger through building effective clinical-managerial partnerships through Southern DHB's Provider Arm directorate structure
- Establishing the Southern DHB/Southern PHO alliance ('Alliance South').

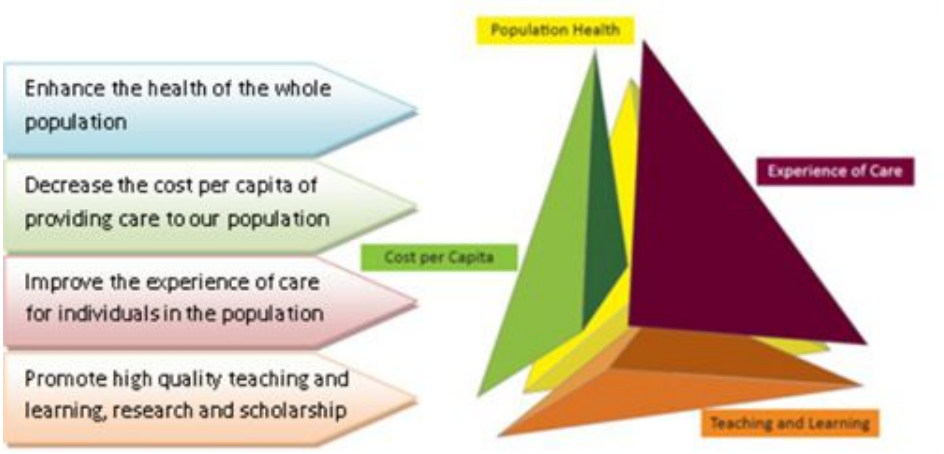
Table 2 : The Southern Way Framework

VISION
Better health, better lives, Whānau Ora
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
SOUTHERN WAY
The community and patients are at the centre of everything we do We are a single unified DHB which values and supports its staff We are a high performing organisation with a focus on quality We provide clinically and financially sustainable services to the community we serve We work closely with all primary care to provide the right care in the right place at the right time and to improve the health of the community

5.4 Performance Excellence and Quality Improvement Strategy

In the context of the Southern Way, in 2012 Southern DHB adopted a Performance Excellence and Quality Improvement Strategy[8] as a framework for lifting organisational performance to world class levels. The Strategy is driven by a fourfold aim[9] that guides service planning and delivery (Figure 4).

Figure 4: Southern DHB fourfold aim



[8] Available at http://www.southerndhb.govt.nz/files/20130320105142-1363729902-0.pdf
[9] Southern DHB's fourfold aim has four goals, based on the Triple Aim of the Institute for Healthcare Improvement (IHI), together with an additional goal recognising the key role of teaching and learning in Dunedin Hospital and across Southern district generally.

The fourfold aim defines the performance improvement outcomes Southern DHB is working towards. These four aims are underpinned by:

- Quality improvement activities, which are to be guided by the six dimensions of quality[10]: safety, effectiveness, patient centredness, timeliness, efficiency, and equity
- A performance excellence system, based on the Baldridge criteria for excellence: leadership, strategic planning, customer focus, measurement, analysis and knowledge management, workforce focus, operations focus and results; and
- Methodologies for quality improvement, such as 'lean', project and programme management, performance measurement, and the production of a quality account[11].

Southern DHB also participates in a number of sector benchmarking exercises (such as the New Zealand chapter of the Health Roundtable) to understand performance in the context of other DHBs and the wider health sector, and to inform performance improvement initiatives.

5.5 Improving Māori health

Māori make up 9.1% of the Southern population (approximately 27,000 Māori people). The Māori population is youthful with 75% being below 45 years, and only 5% being over 65 years of age. As shown in the *Southern Health Profile*, Māori experience significantly worse health outcomes than non-Māori.

In addition to recognition of the Treaty of Waitangi through the Iwi Governance Committee, Southern DHB also enacts a Treaty-based relationship at an operational level by establishment of a Management Advisory Group – Māori Health to provide appropriate advice to the Chief Executive and Iwi Governance Committee on Māori health matters. This is inclusive of maatawaka and contributes to the development and implementation of action plans to improve Māori health.

Southern DHB produces an annual Māori Health Plan that underpins the DHB's efforts to improve Māori health and reduce the disparities between Māori and non-Māori. In 2014, the first joint Southern Māori Health Plan was developed in partnership between Southern DHB and Southern PHO[12] with both Iwi and local Māori input, to address health issues in order to achieve indicator targets set nationally, regionally and locally.

Success in improving Māori health outcomes relies on improving health pathways and the coordination of health services across primary and secondary care. Māori health providers within the Southern district contribute to local and regional success, and together the DHB and primary health care services will continue to agree on key strategies and initiatives that will contribute to improved health care for Māori. In addition, specific projects and initiatives have been pursued to reduce inequalities, including:

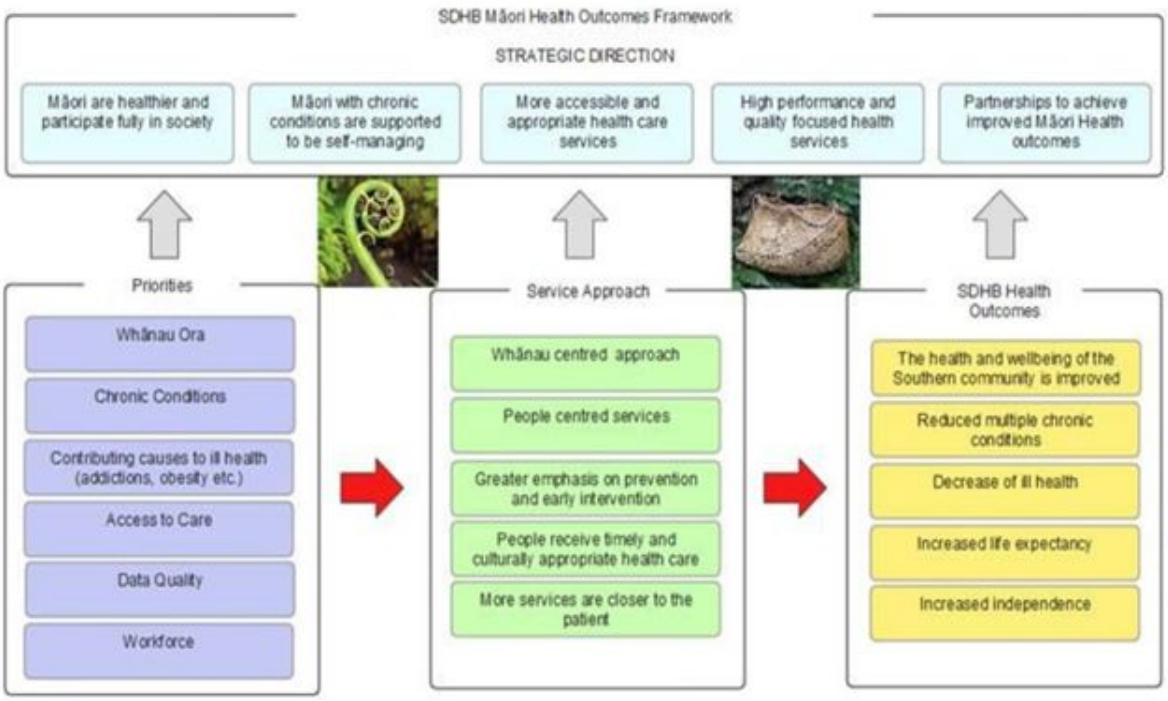
- Developing Māori provider capacity and capability
- Developing Te Kākano nurse-led clinics on marae, targeting lower socio-economic areas across the Southern district
- Establishing a voucher system for those unable to afford general practice and pharmacy costs
- Establishing a very low cost access (VLCA) general practice in Invercargill
- Establishing a high need adult dental programme
- Action to reduce the impact of respiratory disease (asthma in particular), and to improve early detection of diabetes
- Improving the accuracy of ethnicity data collection within both secondary and primary care databases.

[10] The Six Dimensions of Quality have been adapted from the Institute of Medicine report *Crossing the Quality Chasm* (2001).
[11] Quality accounts require health care providers to give an account for the quality of their services in a similar way to financial accounts. DHBs have been required to prepare an annual quality account since 2012/13. Southern DHB's accounts for 2013/14 are available at http://www.southerndhb.govt.nz/files/15103_2014121083204-1418153524.pdf.
[12] Southern Primary Health Care Organisation (Southern PHO) underwent a name change in 2014 to WellSouth Primary Health Network.

The profile of Māori health within the Southern health system has increased to a position where it is now represented at all levels of Southern DHB and across the Well South network, including a strong focus through Alliance South. Leaders in health care are better informed on Māori health issues through the establishment of Southern DHB's Māori Health Directorate, Māori advisory groups and Māori representation in many health areas and services.

The Southern DHB Māori Health Outcomes Framework (Figure 5), detailed below, underpins the strategic direction for Māori health within the Southern district. In order to achieve the desired outcomes, the focus is now shifting to ensure every primary and secondary health service plays its part in improving health outcomes for Māori.

Figure 5: The Southern DHB Māori Health Outcomes Framework



6. The Southern strategic direction

The future direction of the Southern health system builds on its underpinning strengths (Table 3). It has two key dimensions:

- Longer term planning to define a clear, system-wide direction, and a framework for action to pursue the strategic priorities, supported by a well-managed implementation work programme
- A focus on performance improvement, with the aim of lifting the Southern health system to world class levels.

Drawing together these two strands will ensure a sustained focus on:

- Quality improvement
- Reprioritising of low value spending
- Horizontal (primary and community) and vertical (primary, community and specialist) integration of services
- Delivery of the right care, at the right time, in the right setting
- 'Upstream' prevention and early intervention
- Service coordination for high needs patients and their families
- Facility and service networking, to provide better support for rural hospitals, and smoother patient journeys to and from the major hospitals
- Modernising of models of care to cater for the prioritised future health needs of the catchment populations
- 'Right-sizing' of workforce and facility capacity and capability, within a high performance environment.

Some changes in service configuration and capacity will occur over the 10-year horizon of this SSHP. These will emerge largely as byproducts of improved system performance, complemented by deliberate model of care redesign. Two specific aspects of focused service and facility planning will be:

- The upgrading of key buildings on the Dunedin Hospital campus
- Consideration of the future configuration of hospital services across the Central and Queenstown localities.

Table 3 : Underpinning strengths of the Southern health system

- Partnerships are in place with Iwi Māori, WellSouth, and the South Island DHBs
- The Performance Excellence and Quality Improvement Strategy provides a platform for stronger clinical and financial performance
- The Southern Way has introduced a clinical directorate structure across the Southern DHB Provider Arm
- Southern communities are very aware of their health services, and supportive of local health care institutions
- The presence in Southern district of a strong tertiary education sector supports access to a highly skilled clinical, technical and managerial workforce, and research capacity
- Southland Hospital is a modern and effective facility
- The rural hospital network is stable, and is increasingly linking with local primary and community services
- Southern district's overall population is growing at a modest rate, meaning a small but positive future health service funding path

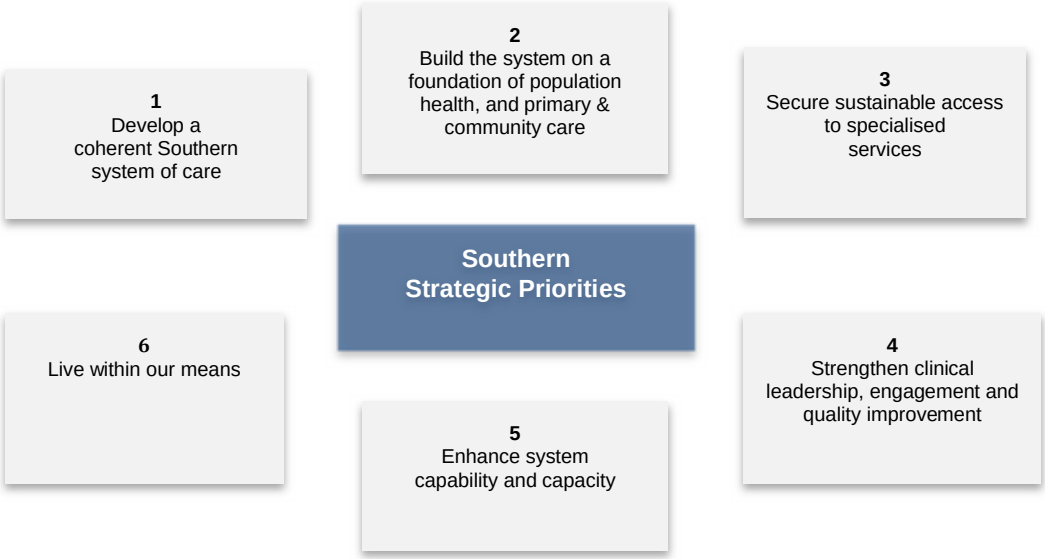
This Plan presents six strategic priorities for the Southern health system. These are:

1. Develop a coherent Southern system of care
2. Build the system on a foundation of population health, and primary & community care
3. Secure sustainable access to specialised services
4. Strengthen clinical leadership, engagement and quality improvement
5. Enhance system capability and capacity
6. Live within our means.

These strategic priorities are described below. For each, a 10-year outcome goal is presented, along with 'headline'[13] actions over the next 3 years (2014/15 to 2016/17) that will build momentum in the Southern health system towards that goal. Together the goals, headline actions, performance measures and enablers comprise the Southern Health Outcomes Framework (Table 11). An Implementation Roadmap for the SSHP is presented in Table 12.

The SSHP focuses on the actions Southern DHB and its partner organisations will work together to deliver over the next 3 years. While the Plan provides examples of particular services and localities, it does not prescribe solutions for specific issues in particular services, facilities or communities. Those will be the focus of more detailed district-wide and locality operational and capacity planning that will flow from this Plan. Similarly the goals, headline actions and indicators are intended to focus efforts, rather than capture all achievements and associated activity undertaken in each priority area.

Figure 6: The six Southern strategic priorities



[13] The term 'headline' is used to indicate that these are key strategic actions, that will be amplified as a project plan is developed for each.

Priority 1. Develop a coherent Southern system of care

Goal

Integrate services to ensure patient journeys are smooth through efficient and effective care pathways, and that the system is easy to use for providers

Headline actions

1. Define the intended future roles, capabilities, responsibilities and relationships of the core entities within the Southern health system
2. Align Alliance South's work programme with the SSHP's strategic priorities and Roadmap
3. Establish locality networks to improve planning and delivery of well-coordinated local services
4. Strengthen the planning and delivery of local and district-wide acute and urgent care, and link effectively with South Island services
5. Recognise and develop the rural hospitals' contribution to the Southern health system
6. Within the South Island Alliance, define the regional direction, key principles and care models that will inform specialist service configuration, development and infrastructure.

Discussion

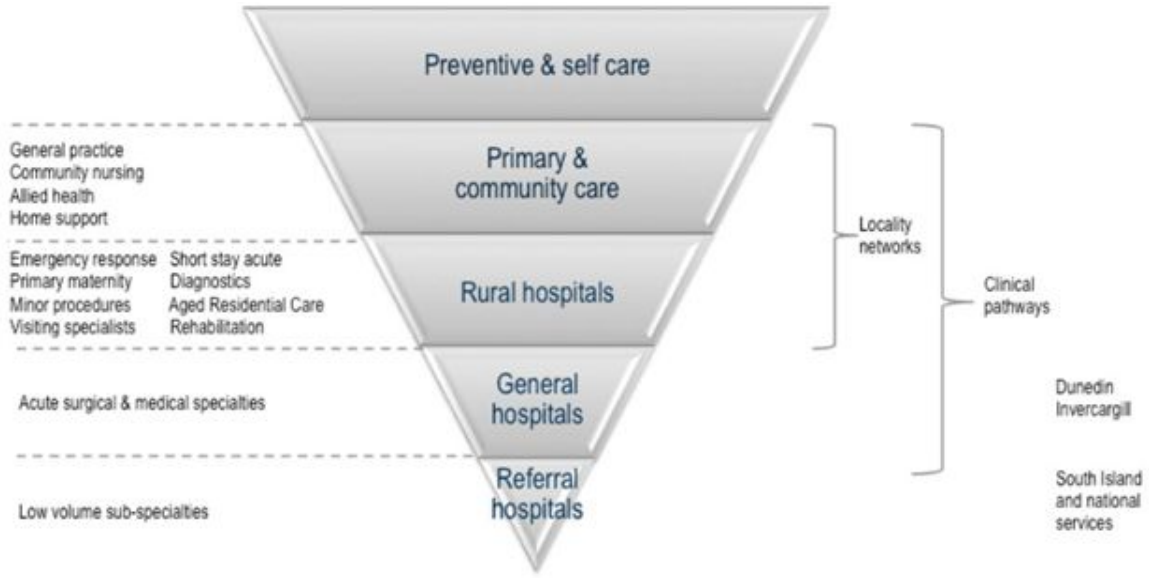
The geography and demography of Southern district requires distributed delivery of the majority of its health services, rather than centralised models of care. In addition, the Southern health system comprises services delivered by a wide array of public, private and NGO entities. Together these factors indicate the need for a network approach that effectively links the various provider organisations, their services, and levels of care in a single unified system.

The infrastructure that will align the components of the Southern system is at a relatively early stage of in its development. Examples include:

- The directorate structure to support a unified Southern DHB Provider Arm across multiple sites is still 'bedding in', particularly in Dunedin Hospital
- The Alliance South structure to support service integration has recently been reconstituted and is undertaking its first projects
- The first clinical pathways for referral from general practice to specialist care have been defined and made available in a low key manner, but many clinicians are yet to be engaged in a way that will ensure pathways become a strong feature of the Southern health system
- Southern DHB is actively collaborating with other South Island DHBs in a shared regional work programme
- There are no formal structures or resources to support collaboration or integration at the locality level, although a loose general practice framework remains from the former multi-PHO entities
- Southern DHB's Planning & Funding team is moving beyond its historic transactional and 'arms-length' approach to fostering closer strategic engagement with providers.

Figure 6 illustrates the various components of the Southern system of care. An important early contribution to development of a coherent Southern heath system will be a clear description of these constituent parts, how they relate to each other, and how they are expected to evolve over the next 3-5 years. This includes key provider sites and services (eg, Dunedin and Southland hospitals; the rural hospitals; and primary and community services in rural and urban settings); the two 'arms' of Southern DHB (Provider and Planning & Funding); Southern PHO; and Alliance South. Strengthening of the structures, tools and processes that will link the components will also be important. These include shared electronic patient health record summaries; shared care plans; defined clinical pathways; and clinical networks.

Figure 7: The Southern health system



Role clarity

An important early contribution to increasing the coherence of the Southern heath system will be a clear description of its constituent parts, how they relate to each other, and how they are expected to evolve over the next 3-5 years. This includes key providers, services and sites/facilities (eg, primary and community services in rural and urban settings; the rural hospitals; and Dunedin and Southland hospitals). Alignment is essential between WellSouth Primary Health Network and the two 'arms' of Southern DHB (Provider, and Planning & Funding), and with other South Island DHBs. 'Alliance' partnerships are the preferred mechanism for achieving this alignment.

Strengthening of the structures, tools and processes that will link the components will also be important. These include district and regional clinical networks; shared electronic patient health records; shared care plans; and defined clinical pathways.

Alliances

Health systems are seeking to strengthen integration of their various components, in order to contribute to improved patient access, population outcomes, and resource use. An important step in this across New Zealand has been mandating of 'alliance' relationships between the DHB and PHOs operating in its area.

Alliance South is in place, and delivering against its initial work programme (Table 4). During implementation planning for this SSHP, the Alliance South work programme will be reviewed to ensure it includes the relevant headline actions from the Implementation Roadmap.

Extension of the collaborative planning and decision-making relationships established and fostered through alliancing will be an important feature of the future Southern health system. Early actions will include:

- Application of the alliancing model through locality networks that will foster collaborative planning and delivery for local communities
- Establishment of service level alliances to plan and develop services in prioritised areas, including community mental health, and health of older people services.

Effective alliances and networks are also critical in Southern's relationships with other DHBs, and especially with the other South Island DHBs. The role and focus of the South Island Alliance is discussed in Section 2.3.

Table 4 : Role and membership of Alliance South

The Alliance Agreement between Southern DHB and WellSouth provides the foundation for an integrated system approach to the design and delivery of health services in the Southern district. Alliance South is the leadership and decision-making structure that provides oversight and coordination of the joint work programme. Its focus is on transformational change to develop a better integrated, more connected Southern health system with models of primary, community and secondary care that support better health for people and communities.

The work is generally undertaken by specially convened service level alliance teams. Following decisions made by Alliance South, implementation is progressed through Southern DHB's contracts with providers.

Membership

Southern DHB participates as a member of the Alliance and is represented on Alliance South by both Planning & Funding and Provider Arm personnel. The DHB retains some reserved powers in order to reflect its statutory roles and accountabilities. WellSouth also participates as an Alliance member. Other members include representatives of aged residential care, Maori clinicians, rural health trusts, public health, St John and a community leader.

Alliance South members are predominantly clinical, have an identified community of influence, and are drawn from a wide range of disciplines and localities across the Southern district. Members are chosen because of their skills, competencies and abilities to contribute to the broader aims of the Alliance. They are also expected to act as conduits of information and recommendations to their organisations and its networks.

Approach

Alliance South's work is guided by Southern DHB's fourfold aim for quality and service excellence (Section 5.4). Alliance South's guiding principles include:

- Best care and outcome for the patient: right care, right place, right provider
- A whanau/family-centred approach when making decisions to improve the health outcomes of our population
- Health professionals to drive system development
- Clinical leadership and involvement in the system design and development
- Clinical and financial sustainability
- Resource, workforce and money follows the patient
- A 'whole of system' integrated approach
- Reduce barriers of access
- Development within existing funding streams
- Best practice from New Zealand and internationally
- Te Tiriti o Waitangi and Whanau Ora will guide responses to Māori health issues
- An environment of safety, quality, performance and accountability, and low bureaucracy.

Work programme

Areas of focus for Alliance South during 2014/15 are shown in Table 6.

Acute and urgent care

A vital part of any health system is the provision of acute and urgent care, with effective management of trauma and seriously unwell patients at its core. A vital part of any health system is the provision of acute and urgent care, with effective management of trauma and seriously unwell patients at its core. Acute and urgent care encompasses people whose existing medical conditions deteriorate, or who present severely unwell from a new diagnosis. Experience elsewhere in New Zealand has shown the benefits of a structured district and regional approach to acute and urgent care.

The effective management of trauma is one important component of this, and the Emergency Care Coordination Team (ECCT) in each of five regions is tasked with ensuring this. Southern's existing team and its functions could be further supported in its work.

An acute care workstream will be developed through the Performance Excellence and Quality Improvement Strategy (see Priority 4) to coordinate acute patient flow and management across the district and between providers and services. Options for pursuing this work include expanding the co-ordinating functions of the ECCT beyond pure emergency care to all acute care, or developing a new acute care network.

Three specific acute service areas for focus will be:

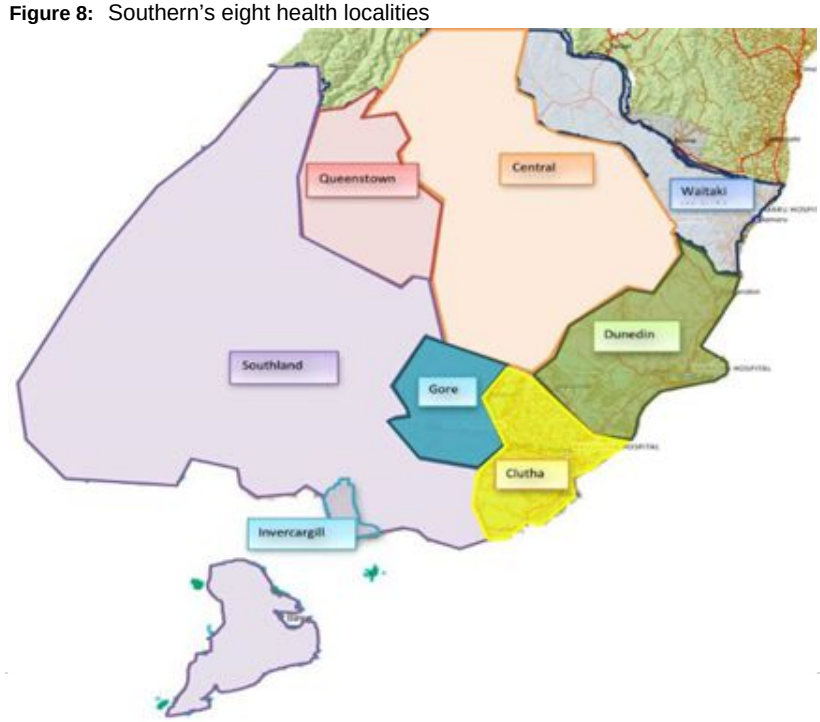
- Whether a Medical Assessment & Planning Unit (MAPU) or similar should be developed at Dunedin Hospital to improve access to urgent care
- Whether a third 'hub' (in addition to Dunedin and Invercargill) should be established in the Dunstan/Queenstown area to address the health needs of the growing resident and tourist population, and its significant distances from Southern DHB's major hospitals in Dunedin and Invercargill. If developing a third hub is considered desirable, the impact on these two major hospitals must also be assessed
- Development of a planned approach to road and air transport of patients, particularly from rural areas to Dunedin and Southland hospitals.

Southern DHB has not been meeting the national ED wait time target, although its performance is improving. Analysis shows that a significant proportion of ED patients could be seen more appropriately in general practice. Alliance South has now prioritised reducing acute hospital demand, and action is underway to promote earlier intervention in primary care settings.

Localities and rural health services

Locality networks will provide a useful vehicle for planning and development of local health services in Southern's eight health localities (Figure 8). Localities will become a focus for planning and coordination of local services across the various provider entities, and for engaging with community stakeholders. They will build on historic structures and existing relationships.

Figure 8: Southern's eight health localities



Locality networks will be of particular importance in rural areas, given the demographic and geographic characteristics of Southern. Local community-based entities of various forms have operated Southern's rural hospitals in Balclutha, Dunstan, Gore, Oamaru and Ranfurly since the 1990s, while Southern DHB continues to operate Lakes District Hospital in Queenstown. Southern DHB supports the rural hospitals' actions to better integrate their services with local primary and community services, and their desire for not only strengthened

support from Southern DHB's Provider Arm (in areas such as telemedicine, visiting specialist clinics, and clinical pathways), but also more strategic direction and commitment from Planning & Funding.

Rural health services are evolving, including in the role that the rural hospital plays (Table 5). While the range of services that are available in the rural hospital will vary from community to community, the opportunity exists to generally strengthen the role of the rural hospitals within the Southern delivery systems, through:

- Reviewing referral and transfer pathways, which will vary to reflect local clinical capability
- Developing the Southern acute care network and framework, including recognition of the core rural hospital role of triage, assessment and stabilisation of acute patients, with either discharge, transfer, or a short treatment stay
- Exploring opportunities for enhanced care capability through collaborative planning and networked delivery across Dunstan and Lakes hospitals
- Locality networks that will foster integration with general practice and community services
- Ensuring access to 24/7 diagnostics (imaging; point-of-care testing)
- Developing the rural health workforce (see Priority 5 – Enhance system capability and capacity)
- Ensuring access to responsive specialised advice from a major hospital, including through use of telemedicine.

Table 5 : The changing role of the rural hospital

In contemporary service delivery models, the core role of a rural hospital is in emergency care, offering initial assessment, stabilisation and short-stay observation of acute presentations, with advice from and transfer to a major referral hospital when required, and with short inpatient stays when local care is appropriate. Acute care is increasingly the role of the major hospital, which has better access to diagnostic equipment and specialised expertise. This – together with improvements in transport systems over the recent decades - has resulted in a reduced requirement for acute inpatient capacity in rural hospitals.

The range of other services that are available in the rural hospital will vary from community to community, and depend on local factors such as population size, composition and future trends; distance from other hospitals; and local availability of other primary, community and institutional services. The rural hospital campus is increasingly the base for integrated service delivery, the scope of which may include (in addition to acute care):

- General practice
- Southern DHB community services (including nursing, allied health and mental health)
- NGO community services
- Primary maternity
- Subacute care (see below)
- Visiting clinics by Southern DHB major hospital staff
- Aged residential care.

Transfers from a major hospital to a rural hospital for sub-acute care can be appropriate for palliative care, or where a further recovery/rehabilitation period is warranted, and the patient does not need the resource intensity and complexity of the larger hospital. However, such discharges, transfers and admissions carry costs for both the health system and patients, and active rehabilitation is required through a care plan agreed as part of the discharge planning process. The aim is not to fill available bed capacity at the rural hospital; rather it is to achieve good patient outcomes and efficient resource use.

Key to making cost-effective use of rural hospital capacity will be strengthening of discharge planning resources and processes. The aims are to minimise length of hospital stay and prevent readmissions across the system through:

- Timely discharge and transfer from the major hospital, and admission to the rural hospital
- Supported early discharge from the rural hospital
- Close liaison with local primary & community health services to ensure post-discharge follow-up.

Clinical pathways

An important component of service integration within Southern health system will be development and application of clinical pathways. The clinical pathway is a quality improvement tool to support standardisation of care and improve outcomes. Clinical pathways can contribute to service redesign and standardisation across primary and specialist care, across sites, and within specialist services. Clinical pathways (also referred to as care pathways) are usually focused on improving the management of common conditions in primary care, and ensuring high quality referrals are made for hospital level advice. This avoids duplication of diagnostics, supports a high conversion of assessment to treatment, and an improved patient experience.

Southern intends to take a broader approach to clinical pathways. As part of alignment within a single system of care across the district, the Southern pathways won't stop at the hospital door, but move inside the hospital and consider in particular how patients with complex needs (eg, co-morbidities) are best managed and discharged back to primary and community care (or to another provider). This will ensure evidence-based practice, reduced clinical variation and therefore reduced waste across the whole system.

Southern's clinical pathways – adapted from the Canterbury Health Pathway's model - will be developed through close collaboration between clinicians working in primary and hospital services, building better relationships between clinicians and ensuring the content applies locally. An overall project plan will be developed through Alliance South, including how the pathways will be implemented.

Priority 2. Build the Southern health system on a foundation of population health, and primary & community care

Goal

Strengthen population health approaches, and the core role of general practice as the 'health care home' for patients within the primary & community team

Headline actions

1. Within the Alliance South framework, develop further service level alliance teams as the key structure for collaborative service planning and development of new models of care
2. Through Alliance South, agree the future primary & community model for urgent care and after-hours care; health of older people services; community mental health services; management of long term conditions; and management of patients with high and complex needs
3. Include prevention and early intervention within the scope of the primary & community teams, and foster their linkage with Southern DHB's health promotion programmes
4. Support intersectoral initiatives that address the determinants of health, such as in housing and the physical environment
5. Implement a risk stratification tool that identifies the patient cohorts at greatest risk, and design care models commensurate with risk
6. SDHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients
7. Identify and support demonstration sites of agreed models of primary & community care, and spread successful innovation.

Discussion

Southern district's primary & community health sector has not developed over the past decade at the pace and scale seen in many other areas of New Zealand. Pockets of innovation are present, but primary care has been relatively slow to take the lead in promoting and adopting new models of care that will better meet future health needs and contribute to system sustainability. Reasons for this include a history of predominant Southern DHB focus on hospital and specialist services; loss of momentum associated with restructuring of the nine PHOs into the single WellSouth; and the Southern health system lacking a widespread understanding of the need for change, and a unifying strategic direction.

However, there is evidence of a new commitment and energy emerging:

- Key primary care and NGO entities support development of a more strategic approach and alliance partnerships with Southern DHB
- The Alliance South structure is in place, providing a basis for fostering clinically-led change, more trusting organisational relationships, and delivery of short (Table 6) and medium and long term work programmes
- WellSouth is now in place, covering all 89 general practices, and focused on lifting practice performance against national primary care KPIs
- New models of corporate ownership of general practice are emerging that offer the potential for practice consolidation to create the critical mass needed for general practitioners to be able to develop special interests (GPSI – see below), extended hours, training placements, and demonstration sites for clinical and operational innovation
- NGOs are recognised as key partners in health of older people and mental health service development

- Rural health service entities are broadening their focus beyond hospitals, and developing integrated service models.

Table 6 : Alliance South's 2014/15 work programme

• Acute demand, including acute respiratory conditions, the frail elderly, and development of Primary Options to Acute Care (POAC) • Minimum technology standards for providers • Rural health funding • Primary radiology referral guidelines • Community & hospital pharmaceutical prescribing • Child health • Youth health • Health pathways

Focus on high health needs

The Southern health system will always continue to treat people with injuries and established disease. However, the balance will shift from a predominant focus on the usually infrequent and episodic care for individuals, to planned and structured care with a focus on the patients and families with high health needs. This collaborative approach emphasises the importance of:

- Improved community health literacy;
- Integration of health and social services;
- Prevention, early detection of health risks, and early intervention; and
- The core place in the health system of continuity of holistic primary health care, and general practice in particular.

This approach is particularly important given the ageing Southern population; the increasing prevalence, incidence and complexity of long term conditions; and the pressing need to reduce persistent health inequalities. It is highly relevant for most of the priorities identified in the *Southern Health Profile*, including linking of population and personal health action to address:

- Tobacco smoking
- Obesity and nutrition
- Hazardous alcohol consumption
- Chronic disease management – particularly diabetes and CVD
- Access and use of primary care – in-hours, and after-hours
- Māori health - particularly child health and chronic disease
- Pacific health - particularly child health and chronic disease
- Access to mental health service access – particularly through strengthening of community services.

Planned and structured primary & community care

Working through Alliance South, Southern will move progressively to adoption of structured primary & community based care. Early actions will include:

- Identify an appropriate methodology for risk stratification, and ensure baseline data is of appropriate quality. This can include a mix of hospital and general practice based risk criteria, but the tool is best applied to the enrolled general practice population in line with the 'health care home' concept. (See further discussion of risk stratification below.)
- Design future models of care taking account of what already works well in rural and urban areas of Southern district

- Identify evidence-based models of care for different risk profiles and population groups (eg, frail older people; adults with diabetes or chronic obstructive pulmonary disease)

Table 7 : The future shape of Southern mental health services

Five strategic directions are identified in Raise HOPE, Southern DHB's mental health and addictions plan 2012-15:

- Prevent mental illness/addiction and intervene early
- Intervene in targeted, effective ways across the life course
- Locate support closer to consumers and in communities
- Work as one sector with a whole of systems approach
- Constantly improve sector quality, capability, productivity and capability

Target groups are identified as priority:

- Māori and people who, as a group, experience mental health and addiction inequalities
- Those with health inequalities
- Those where the system can intervene early (child and youth)
- Specific groups including:
  - Families and whānau with risk factors
  - Children with cognitive, developmental and behavioural disorders
  - Youth with risk factors
  - People with low prevalence, high severity psychiatric problems
  - People with alcohol and other drug problems
  - People involved in the forensic/justice system
  - People with organic degenerative conditions (eg, dementia)

Raise HOPE recognises the need to address mental health determinants, including working with other agencies at policy and operational levels, including education, housing, justice and social welfare

Raise HOPE's implementation framework encompasses activities in four major areas - systems, service, workforce and infrastructure:

- The **systems** model identifies the need for collaborative effort, and prescribes prevention, early targeted intervention, with a whole of sector approach. Services will be delivered in community settings where possible, with a culture of continuous improvement. To lead and embed the system and service model throughout Southern, a Network Leadership Group will be established, using the alliance framework
- The **service** model recognises the need to deliver more services in the primary and community setting, with new workforce models and roles. A stepped care approach will be used, intervening in the least intensive way through support for self-care, and increased resources and activity through early intervention by primary & community services. Specialist service capacity will be focused on those with more complex needs. Even fewer consumers will require access to highly specialised inpatient and crisis resolution services from time to time. Clear care pathways across primary, secondary and tertiary services will ensure effective access and ease of movement between the different levels of service provision
- A **workforce development** plan will ensure that the workforce has the capacity and capability to deliver new and existing services in different ways

The ability to work as a whole of sector with a systems approach relies on fit for purpose **infrastructure**, including:

- Timely, accurate and consistent information for planning, measuring performance, and as a basis for decision-making
- A continuous quality improvement focus to support system-wide and service improvements, whilst maintaining confidence that legislative guidelines are being met
- Use of telemedicine and other fixed and mobile communication options to enhance service effectiveness

- Define the scope and mix of health professionals at each level of risk stratification and associated models of care
- Identify varying methods of patient contact, including nurse-led models, home visits, mobile clinics, and 'virtual consults' (eg, telephone, email), and the suitability for patient groups
- Undertake a task and activity analysis to identify appropriate clinical and support staff input to models of care, and identify where possible staff substitution opportunities to improve efficiency and free-up time of more specialised professionals
- Size resource and utilisation intensity for different models of care to inform resource and funding allocation
- Align with urgent, after-hours and acute care, services for older people and nursing/allied health integration initiatives.

Risk stratification

A foundation for shifting to planned and preventive care is to develop understanding of the different levels of health need in the local community through use of health risk profiling. This allows identification of cohorts of the population with different levels of risk, and tailoring of models of care and resource intensity to match the varying levels of health need.

The objective is to help people achieve the best health and quality of life possible by preventing risk factors developing into long term conditions, and stabilising current chronic conditions to prevent disease progression. Importantly, adoption of risk stratification supports patient partnerships in designing the way care will be delivered and resourced, supports better integrated services, and minimises hospital attendances and admissions.

Figure 8 provides a stylised depiction of population risk stratification and the types of intervention that may effectively address the needs of groups with different risk profiles. As this is completed for each local population, care models for the different population segments can be developed to match their level and type of need, with more resources being required as the level of risk increases. Table 7 describes this approach for people with mental health needs, and Table 8 for older people.

Care plans are personalised to individual patients based on their health status, family support networks, and cultural preferences. The care team will include Māori and Pacific providers where appropriate. For people and families with higher and more complex needs, the care model can be intensified to case management, and include, for example, clinical pharmacy services, community mental health services, and social services.

Model of care change

WellSouth will lead model of care change in partnership with Southern DHB through Alliance South, and in accord with *Better Sooner More Convenient* policy. Particular areas of opportunity include:

- Locality planning and networks
- Multi-disciplinary teams, with core membership from general practice, community nursing and allied health (including clinical pharmacy)
- Nurse-led services
- Referral and discharge management (supported by clinical pathways)
- Improved access to specialist advice, including through use of telemedicine
- Improving general practitioner access to investigations (eg, ultrasound, CT, MRI, exercise testing)
- Minimising the need for specialist outpatient follow-up visits
- A planned approach to development of the general practitioner with a special interest (GPSI) role

- Managed intersection of general practice with specialist and NGO services (eg, mental health services; service for older people; Māori health services; services for Pacific people; St John)
- Accelerated development using proven primary & community initiatives from elsewhere in the South Island.

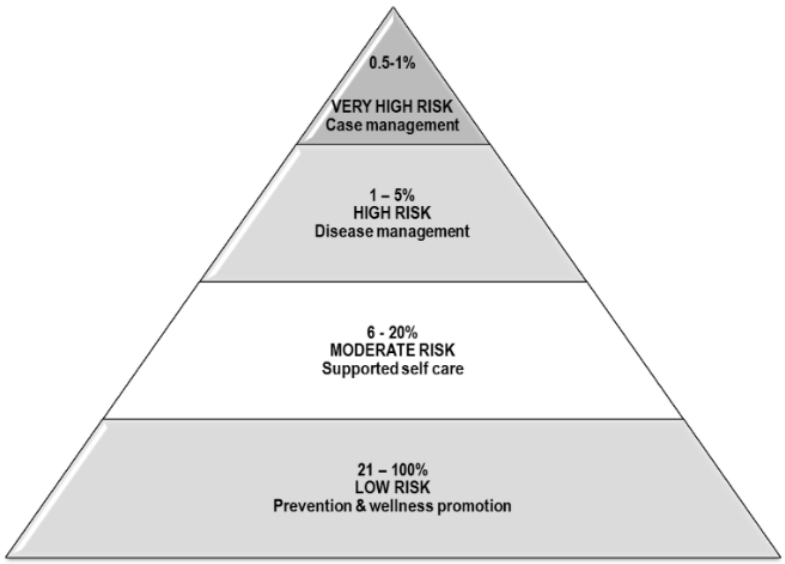
An area of particular challenge in designing future models of care will be how to simultaneously:

- Reinforce the role of general practice as the patient's 'health care home' and continuity of care; and
- Reorient DHB community services from a hospital discharge focus to a community focus as part of a primary health care multi-disciplinary team.

Locality networks will be important in this regard, supporting development of closer and more effective local working relationships. In rural areas this could be fostered through co-location of community services personnel with general practice on the local hospital campus (where one exists). In urban areas the trend is likely to be towards development of 'neighbourhood hubs' to accommodate such personnel closer to general practice and to the patients they serve.

The use of demonstration sites, with the opportunity to evaluate and encourage the spread of successful solutions, will be important aspects of model of care redesign and health system reconfiguration.

Figure 9: Stylised risk stratification profile and associated intervention model



Note that the percentages of the population in each group are not necessarily representative of the Southern population, and are for illustrative purposes only.

Table 8 : The future model of primary & community care for older people

A plan for future provision of community health services for older people was developed for Southern DHB[14] to address the future health needs of its older population. The aim was to identify a structure that will, within currently available funding, enable services to refocus around the needs of older people. The recommended structure builds on the strengths of existing primary and community services to enable improved integration between services, reduced duplication, and reduced risk of disconnection between multiple services involved in the older person's care.

Under the model, the older people with complex needs will have an identified care manager who works with the general practice and other providers to ensure that all the care is connected. The care manager will work with the general practices in a locality to support development of better working relationships and effective support from a locally based team of Southern DHB community nurses and allied health practitioners, community pharmacists, and NGO staff. The locality teams would be supported from a central 'hub' of professional leadership, and with specialised input from nurses and doctors.

This model is in accord with the strategic direction presented in this SSHP, and builds forward on infrastructure that is already in place in Southern – such as the increasing integration of services in rural communities; the trend in general practice to risk stratification and structured care; the increasing focus of some specialist services, such as geriatrics, to strengthen their outreach role in supporting community-based solutions; and the desire to better link clinical, community and home-based support services for older people.

Particular features of the model will be:

- Improved transfer of care will avoid hospitalisation of older people with acute needs, and reduce the risk of readmission
- Targeted medicines review by pharmacists, working within a multi-disciplinary team
- Improved primary health care support for aged residential care facilities to address acute needs of residents, and to prevent avoidable ED attendance and urgent admissions to an acute hospital
- Introduction of acute response services (eg, Primary Options for Acute Care, or POAC) to provide GP-initiated alternatives to ED referral and hospital admission.

[14] *Southern District Health Board: a model of care that integrates health and support services in the community for the older person.* S Jacobs et al. Auckland Uniservices (2011)

Priority 3. Secure sustainable access to specialised services

Goal

Ensure that the Southern population has ongoing access to specialised services that have safe and viable staffing levels and activity volumes to treat complex conditions

Headline actions

1. Undertake analysis to inform planning of specialised service, including identification of services at risk of clinical and financial unsustainability; analysis of inter-district patient outflows; and updating of the Role Delineation Model assessment of Dunedin and Southland hospitals
2. Based on the analysis, identify whether action within Southern DHB or through South Island collaboration is the most appropriate avenue to pursue planning and development of particular specialised services
3. Continue South Island collaboration to refine governance, management and funding models that support provision of sustainable hospital level services across DHB boundaries
4. Conduct a stocktake of visiting specialised outpatient clinics, and develop a planned approach by locality that supports equitable local access for patients to higher volume specialties, and that balances clinician and patient travel.

Discussion

A number of clinical specialty services at Dunedin and Southland hospitals are struggling to maintain the activity volumes and staffing levels required for clinical viability. This includes both some core secondary services, and more complex sub-specialty services. These issues were given a high profile during consideration of the future configuration of South Island neurosurgical services during 2008/09, and more recently in relation to breast screening.

Hospital level service sustainability is of increasing importance for Southern DHB for a number of reasons, including:

- The very low inflows of patients to Dunedin Hospital services from elsewhere in New Zealand means reliance on the Southern district's own population to support its hospital services. Whilst Southern is the sixth largest DHB by population and funding, because of the low numbers of inflows from other DHBs its clinicians serve a relatively small population catchment
- Increasing sub-specialisation is challenging the critical mass of medical and surgical 'generalist' services, with a key consideration being the number of specialist practitioners needed to maintain a sustainable service
- Funding constraints are placing pressure on hospital department budgets.

Overall, Dunedin Hospital's performance may be adversely affected by trying to maintain its own low volume specialties and high levels of clinical support services without sufficient population catchment to warrant adequate specialised staffing. An updating of the 2009 Role Delineation Model assessment will help identify any such imbalances.

Assessment of the sustainability of hospital services will include clinical and financial criteria, such as:

- The catchment population required to generate sufficient volumes to warrant staffing levels that meet reasonable roster requirements, and allow practitioners to maintain their skills
- Cost per case compared with benchmarks
- Comparative access/intervention rates to match New Zealand standards.

In response to these (and other) imperatives, Southern DHB has implemented a Provider Arm-wide directorate structure to unify operational planning and delivery of specialty services across Dunedin and Southland hospitals, and achieve a larger scale.

South Island collaboration

There is also increasing South Island DHB collaboration in low volume specialties, driven by recognition that the South Island population is too small for duplication of standalone services, and that regionalisation is likely to help ensure ongoing access. A range of collaborative South Island specialist service models is currently in use, including:

- 'Hub & spoke', with centralisation plus outreach
- A single service across multiple sites, with shared governance
- Outsourcing to a third party with delivery in multiple sites.

Hub & spoke models operated by Canterbury DHB for the South Island are proving effective for a number of services, including paediatric surgery; gynae-oncology; maternal foetal medicine; and renal transplants. Bariatric surgery has also recently been established as a South Island shared service, with the surgery being performed in Christchurch and Invercargill.

For neurosurgery, the NHB-commissioned panel concluded that Southern patient volumes were too small for a standalone service, and the solution was a merged South Island service, delivered in two sites (Dunedin, Christchurch) with a Dunedin-based professorial appointment at the University of Otago. Dunedin provides the neurosurgical stereotactic service for New Zealand.

Effective South Island collaborative service models must include service funding and governance arrangements that ensure a voice for Southern DHB, access for Southern patients, effective interaction with other Southern specialised and clinical support services, and affordable cost structures. In addition, any business case for a merged service needs to consider:

- Impact on teaching, training and research
- Impact on specialised nursing staff
- Impact on clinical support services
- Cost impact of delivery of inpatient services on more than one site
- Arrangements for rapid response to the needs of very acute patients with life-threatening conditions
- Use of telemedicine, clinical pathways and access to electronic patient records
- The balance of clinician and patient travel
- Development of local practitioner capability.

Priority 4. Strengthen clinical leadership, engagement and quality improvement

Goal

Further develop a culture of clinically-led innovation and improvement across the Southern health system

Headline actions

1. Clarify the intended nature and role of clinical leadership in the Southern health system, and ensure supportive structures and processes are in place
2. Ensure clinical leaders have the time, skills and tools to deliver on the performance expectations of their roles
3. Revisit the Performance Excellence & Quality Improvement Strategy to ensure its relevance and adoption as a whole-of-system approach, with an appropriate governance structure and implementation plan, and linkage with the work of Alliance South
4. Position the Performance Excellence & Quality Improvement Strategy as a key vehicle for ensuring resource sustainability, by matching expenditures within services to the revenue level, improving productivity, and preferentially investing in high priority services that demonstrate significant value gain
5. Identify the initial areas in which Southern DHB will lift its performance to world-class levels, and develop action plans for each
6. Develop locality networks as a forum for building the effective clinical relationships that will support local service improvement and integration
7. Through Alliance South, ensure clinical pathway development and implementation is underpinned by clinician leadership.

Discussion

Clinical leadership and engagement

One of the areas of focus of the Southern Way has been increased clinical leadership and engagement inside the Provider Arm through creation of the unified directorate structure. Full implementation of this model is at a relatively early stage, and the leadership roles, structures and processes that will underpin future performance are still maturing. Particular dimensions of the next stage of development will include action to:

- More explicitly define ‘clinical leadership’, and the organisation’s expectations of clinical leaders, including at departmental level
- Provide support for developing the skills and knowledge of clinical leaders
- Develop the recently established Clinical Council and establish processes for considering organisation-wide issues of concern to clinical leaders
- Increase engagement between clinical leaders and Southern DHB’s Planning & Funding Arm
- Close the gap between the formal leadership structure (ELT/directorates/departments) and front-line staff
- Build stronger mechanisms to link Dunedin and Southland hospitals, while recognising their distinct cultures and issues.

Performance improvement

As described in Section 5.4, a key vehicle for lifting the performance of the Southern health system will be the Performance Excellence & Quality Improvement Strategy. The Strategy is intentionally high level and aspirational, and was to be followed by an implementation structure and plan. An action plan has been developed, but implementation has not achieved the scope and scale originally envisaged.

A review will be undertaken to ensure a more strategic approach to performance improvement. Particular considerations will include:

- Building understanding of what the Strategy and its fourfold aims mean in practice across the Southern health system, and prioritising implementation initiatives in a systematic approach to evaluate and spread successful innovation
- The implementation plan will include a focus on supporting short and medium term financial recovery planning and action, in recognition that 'good care costs less'
- Encouraging uptake of the Strategy across organisations and professional groups. It should be a vital part of the Alliance South framework, enabling a joint approach across the Southern health system
- Transformational change through a quality improvement approach requires investment, data, skills and methodologies. Quality improvement initiatives in Southern DHB are hampered by difficulty in obtaining timely data and analytical support. Data is gathered, but is difficult to access and share. Consideration will be given to establishment of a single Southern DHB decision support unit (that would potentially encompass primary care as a partnership with WellSouth)
- Continuing emphasis on skills for change training for Southern DHB staff, and broadening of intake to include WellSouth Primary Health Network and NGO personnel
- National areas of focus through the Health Quality and Safety Commission will also be part of Strategy implementation and include:
    - Prevent falls and reduce harm from falls
    - Improve hand hygiene practices in order to reduce healthcare associated infections
    - Use the World Health Surgical Safety Checklist to enhance the surgical team's communication
    - Utilise effective antibiotic prophylaxis in lower limb joint replacements.
    - Utilise appropriate skin preparation in lower limb joint replacements.
    - Prevent harm caused by surgery by improving communication and feedback within teams
    - Preventing harm due to medication errors
    - Capturing people's health care experiences to identify how to use that information to develop new ideas, measure change and report back to consumers.

Alliance South provides a vehicle to broaden the scope of the Performance Excellence & Quality Improvement Strategy to encompass the whole Southern health system. Visible and active leadership by senior clinicians in both the Provider Arm and primary & community services will be critical to clinically led service integration, and to the unified approach to performance improvement that together will be key contributors to a sustainable Southern health system.

Increasing the day surgery rate

A specific performance improvement area already identified by Southern DHB through the Southern Way is a sustained increase in the proportion of surgical procedures that are done on a day case basis, in order to improve the patient experience and efficiency of services. A joint NHB/Southern DHB day surgery review was undertaken in 2013, and key issues for improvement of the model of care and facility use were identified. These included the need:

- For a 'day case mindset', with day surgery being seen as the default and overnight stay the exception
- To factor expansion of day case procedures into facility design at Dunedin Hospital (more theatres, fewer beds) and professional roles
- For improved connection with primary and community services to optimise pre- and post-surgical care.

Professional relationships

Communication between hospital and primary care clinicians will be strengthened. Opportunities for better structural and personal linkages will be pursued, including CME meetings, clinical pathway development, establishment of locality networks, and performance improvement initiatives. Alliance South and Southern DHB's Planning & Funding team will ensure service planning and clinical pathway development engage clinical leaders in taking a broader whole-of-system view across the continuum of primary & community, and hospital & sub-specialist services.

Priority 5. Optimise system capability and capacity

Goal

Develop a workforce mix and facility configuration that matches future health needs, and recognises Southern's core role in teaching and learning

Headline actions

1. Mandate the existing Joint Education Committee (or equivalent) as the cross-organisational leadership body to collaboratively plan and develop the Southern health workforce based on intended models of care, workforce roles, and demand and supply forecasts. Committee membership should include Southern DHB, primary care, and the three tertiary education providers
2. Develop a Southern health system workforce plan, beginning with a stocktake of the district's estimated 9000 current health workers, and including clear priorities for workforce development based on the strategic direction presented in this SSHP
3. Expand Southern DHB professional leader roles to include a whole-system scope across primary care, NGOs and rural health services, with a focus on standards, credentialing, continuing professional development, and advice
4. Complete detailed district-wide facility capacity planning to inform business case development for an upgrade of prioritised Dunedin Hospital buildings.

Discussion

Workforce

Increasing service demand and ageing of the existing workforce bring the need for planned replacement and expansion of workforce capacity, including through substitution and new roles within new models of care.

The Southern district is a major health sector teaching and training hub, including three tertiary education providers[15] (University of Otago, Otago Polytechnic, Southern Institute of Technology), and offering nine health professional streams (including medicine, nursing, midwifery, pharmacy, dentistry and physiotherapy), together with management and business disciplines. In addition to its large contribution to the national health workforce, this concentration of tertiary education gives the Southern district a significant strategic advantage, in having local access to a highly educated workforce, and the ability to shape teaching, training and learning curricula and approaches to align with future health needs and models of care.

Southern DHB and the University of Otago in particular have a long history of co-operation and collaboration. Many Southern DHB-employed health professionals are engaged in research and teaching, while a number also hold joint appointments across both institutions. As is often the case when two different but supportive organisations work closely together, many opportunities exist for mutual support and benefit, but it is important both parties are clear about their respective and different accountabilities.

The focus now is on achieving appropriate strategic alignment and effective operational relationships across the health and education sectors, to develop the workforce that the future health system will need. Particular issues to address in joint planning include:

- Alignment of University of Otago and Southern DHB strategic planning for medical specialties to ensure consistent and explicit assumptions regarding clinical services, teaching and research, whilst recognising that the two organisations have different but complementary priorities

[15] Health Workforce New Zealand also funds postgraduate education for Southern DHB staff through tertiary institutions elsewhere in New Zealand.

- Management of joint academic/service employment, with an appropriate balance of clinical performance, teaching and research, and clarity about separate accountabilities
- Accommodating clinical placements, including the increasing need for community placements
- Movement toward inter-professional learning from year 4 of Medical School, which will require complex organisational and professional collaboration
- Development of new workforce roles, building on the current training of enrolled nurses for acute hospital roles, and health care assistant training for aged care and acute hospital services
- Consideration of whether clinical placements should be centrally coordinated across disciplines to ensure direct linkage with Southern system priorities and capacity
- Consideration of whether training technologies should be shared across disciplines (eg, simulation)
- Continuing promotion of an increase in the proportion of medical and nursing graduates entering primary care
- Effective Southern linkage with the South Island Alliance Training Hub, including establishment of a South Island e-learning platform to deliver professional development programmes.

In addition to strategic alignment for education and training of health professionals, other issues to be considered in workforce development include:

- Promotion of multi-disciplinary teams, rural services, and primary & community services
- Assessment of the feasibility of inter-disciplinary training (nursing, allied health, medical) in rural areas
- Building on the existing incubator programme to grow the local health workforce (clinical, managerial and technical) through promotion of health careers in secondary schools, with a particular emphasis on lifting Māori and Pacific participation
- Addressing barriers to training of the rural workforce
- Providing advice to individual health workers to support career progression
- Support for career pathways and skill sets that support new models of care, including primary and community practitioners working at the top of their scopes.

Ensuring the sustainability of rural health services will be a particular priority for Southern DHB, WellSouth, and the rural health service provider organisations. Rural workforce issues to be addressed include:

- Support for the rural hospital medicine specialist role through increased registrar positions, and particularly to support joint rural hospital medicine/general practice training
- Further development of a rural nursing specialist role, building on existing practice (eg, on Stewart Island) and aligning with nurse practitioner and physician assistant roles, and with PRIME nurse training
- Increased support for self-employed Lead Maternity Carer (LMC) midwives in rural areas, who are struggling with on-call demands
- Deliberate and early succession planning locally, and at a strategic level through professional leaders and locality networks
- Overcoming barriers to rural training (eg, broadband, facilities, supervision). Access to videoconferencing and the internet are important to support ‘virtual’ training. The Mobile Surgical Bus is part of the solution, however training needs to be directly relevant to the population’s and practitioner’s needs, and with a focus on the generalist.

Facilities

Southern DHB has a modern hospital facility in Invercargill that was purpose-built in 2004 (although further development of an education facility is required on the campus). In December 2013, a staged redevelopment plan of Dunedin facilities ($24.4m) was completed, to bring some essential areas in line with quality standards. A new mental health acute inpatient ward was built on the Wakari Hospital site, and

the Neonatal Intensive Care Unit (NICU) and Paediatrics were relocated to a new ward on the first floor of the main Dunedin Hospital campus building. There have also been some key infrastructure upgrades at both the Dunedin and Wakari hospitals.

Recent national commitment to future capital investment in Dunedin Hospital has reinforced the need for a deliberate approach to facility planning to ensure it is strongly aligned with the intended service configuration, models of care, and staffing. In association with this SSHP, Southern DHB has commenced a project looking at the medium to longer term facility requirements and configuration in Dunedin and the necessary capital requirements to re-life or replace existing facilities. This will lead to a high-level facility master plan that includes staging and timing, spatial planning for the Dunedin Hospital site, a review of building condition and seismic strength assessment, and a refresh of population demographic demand models. These pieces of work will feed into the development of a new Southern DHB asset management plan.

Planning for Dunedin Hospital will also look across the Southern district as a whole, and consider the impacts of:

- Forecast population changes, including ageing, and growth and shrinkage in particular localities
- Incidence and prevalence of long term conditions
- Model of care changes, such as hospital avoidance through strengthened primary care-based models; increased day surgical activity; and potential changes in rural hospital roles (eg, strengthening of hospital services in the Queenstown/Dunstan area).

A particular issue that will be considered in facility capacity planning will be the potential contribution of the private hospital sector within the overall system. Dunedin and Invercargill have private specialist hospitals that offer surgical and diagnostic capacity. Capacity planning will ensure resources are used efficiently. For example, Dunedin Hospital currently has 11 operating theatres, and Mercy Hospital a further six theatres. Together this is a substantial capacity for the catchment of Dunedin's surgical services.

Previous facilities planning work has identified considerable financial hurdles to be overcome. Southern DHB will need to develop strategies to manage this, including ensuring existing bed capacity across the district is optimised. South Island capacity planning will also be an important feature of facilities planning, including consideration of specialist service configuration (see Priority 3 – Secure sustainable access to specialised services).

In addition to the physical building requirements, Southern DHB faces challenges in financing equipment replacements within normal asset life cycles. Many assets are currently utilised well beyond their technical use lives with replacements being made when the item breaks or loses complete functionality. As part of medium term financial planning, a prioritised proactive replacement cycle will be adopted.

Priority 6. Live within our means

Goal

Improve the quality of the care and services we deliver using quality improvement principles and methodologies so that waste is substantially reduced, value for money is improved and the savings contribute to bringing our revenue and expenditure into alignment, complemented where necessary, by tight cost management, improved productivity and different resource allocation patterns.

Headline actions

1. Use the Performance Excellence & Quality Improvement Strategy as the framework for lifting performance to world-class levels in prioritised areas, and reducing waste
2. Strengthen analysis and communication of where Southern DHB funds are spent across the Southern health system, the outputs they deliver, and their outcomes and value
3. Develop a Southern DHB prioritisation framework to inform resource allocation, including relevant policies, processes and tools (incorporating the four-fold aim)
4. Tighten Provider Arm cost management including moderating recent FTE cost growth in key personnel areas
5. Increase use of benchmarking with other DHBs and providers as a basis for budget setting and productivity improvement
6. Develop a Strategic Investment Fund to support shift of resources to prioritised high value services.

Discussion

Southern DHB (and its predecessor Otago and Southland DHBs) has a history of its costs exceeding revenue, of positioning the problem as lying with the population-based funding model rather than organisational and system performance, and of not meeting agreed financial targets. This has flowed through into Southern DHB's relationship with national agencies, and with the providers it funds. There is now widespread acceptance within Southern DHB that this cycle needs to be broken.

In the absence of a strategic framework, Southern DHB resource allocation and activity levels have remained largely based on historic patterns, and lacking a strong rationale. Resourcing needs to be more transparent and reflect the priorities of the Southern health system. Additionally, benchmarking with other DHBs has received less focus than it should in informing performance improvement activities.

Based on recent trends, Southern DHB is forecast to continue to incur financial deficits over the next several years. The DHB is pursuing a range of actions to achieve its 2014/15 and outyear financial targets agreed with the NHB. These actions will be supplemented by those arising from this SSHP, and provide the base for a revised medium-long term financial plan and budget.

Benchmarking of Southern DHB's financial performance and patterns of resource use has identified three areas where the DHB expenditure appeared significantly higher than sector norms:

- Age-related residential care
- Community pharmaceuticals
- Southern DHB personnel costs.

These are discussed briefly below. They will remain the focus of particular attention in Southern DHB's short to medium term planning and action to reduce its deficit, concurrent with actions to improve efficiency, shift spending to higher priority services and disinvest where returns or value are limited.

The goals of reducing the DHB's structural deficit, reallocating resources, and preparing for the costs of the Dunedin Hospital upgrade will challenge the whole Southern system to deliver improved performance. The actions outlined in this Plan are anticipated to have a positive material impact on the DHB's financial performance, ultimately enabling the DHB to live within its available funding.

Implementation of Southern DHB's Performance Excellence & Quality Improvement Strategy as described in Priority 4 will contribute significantly to improving medium to long term financial performance. Key actions will include:

- Rigorously implementing the Performance Excellence & Quality Improvement Strategy's Four-fold Aim in assessing the value and appropriateness of SDHB funded services and interventions
- Considering the potential for reducing spending on interventions that are either clinically ineffective or not cost-effective, and redirecting resources to higher value services and interventions
- Improving the quality of DHB Provider Arm services using lean (A3) methodology, with the expectation that this lead to better value for money (ie, less waste and improved efficiency)
- Focusing on those areas where Southern DHB expenditure is significantly higher than DHB benchmarks
- Improving performance against key efficiency indicators such as ambulatory sensitive hospitalisations, average length of stay, and same day surgery rates
- Scrutinising personnel cost growth in the Southern DHB Provider Arm, both in the numbers of staff and their relative cost, and understanding whether this represents value for money
- Developing clear strategies for capturing savings and redirecting them.

Areas of relatively high expenditure

Southern DHB has been spending more than the national average on rest home and hospital level **age-related residential care** (ARRC), with the fifth highest spend per person aged 65+ of New Zealand's DHBs. Above average spending was estimated to have been an additional $129 per person aged 65+ in 2012/13. Southern DHB is undertaking further analysis to better understand this spending pattern, and is considering how the mix of services for older people could be rebalanced in line with the national policy of 'ageing in place' and the future directions presented in this SSHP (such as those outlined in Table 8).

Southern DHB spends more on **community pharmaceuticals** than the national DHB average and also more than comparator DHBs. Reducing Southern DHB's community pharmaceutical spend to the population-based funding formula (PBFF) weighted sector average would save approximately $3.7M per year.

Across New Zealand, **DHB personnel costs** comprise around 39% of total DHB sector costs and around 63% of DHB Provider Arm costs (2012/13). As a consequence, effective management of personnel costs will be a crucial determinant of Southern DHB's ability to operate within available funding.

Southern DHB Provider Arm medical personnel cost growth has been increasing at almost three times the rate of revenue growth (5.9% per year compared with 2%) in period from 2008/09 to May 2014. Medical personnel costs are now 41% greater than they were in the year ended June 2009, with Southern DHB medical personnel full-time equivalents (FTEs) having increased by 88 over the period with a further 10 FTEs budgeted for 2014/15. The recent rate of average cost growth now means that Southern DHB spends significantly more per FTE per year than the sector as a whole and than other large DHBs.

Further more detailed investigation is underway to ascertain the reasons for Southern DHB's relatively high rate of medical FTE and cost growth between 2009 and 2014. (Southern DHB's nursing personnel FTE and cost growth has been more restrained since 2009, with FTEs increasing by 7% over the period and total nursing personnel costs increasing by 20%. FTE growth has been less than sector and large DHB averages while average cost per FTE has been higher.)

Improving efficiency

Improving efficiency of service delivery will also be an important component of Southern DHB's strategy to live within its available funding. This will include improving performance against key indicators of Provider Arm resource use such as average length of stay (ALOS) and day surgery rate. (Other areas of Southern health system performance for focus will be identified through the review of Performance Excellence and Quality Improvement Strategy – see Priority 4.)

Southern DHB has been steadily improving its **ALOS performance** since 2008/09, which has contributed to the DHB's efficiency improvement and cost saving strategy. However, further efficiencies can be made that will contribute to the DHB living within its means.

As discussed in Priority 4, Southern DHB has identified the opportunity to lift the proportion of its surgical procedures that are performed on a **day case** basis. This is more cost-effective than surgery involving an inpatient stay since the costs of overnight stay are not incurred.

Prioritisation and potential disinvestment

Ensuring Southern DHB's spending is prioritised towards higher value interventions will be a crucial component of its strategy for living within its means. Reducing spending on interventions that are either clinically ineffective or not cost-effective will free up DHB resources that can be redirected to services and interventions that are more likely to improve health outcomes and patient experience. In some instances, it may also enable Southern DHB to contain its overall expenditure growth, thereby contributing to the DHB living within its available funding.

The process for identifying lower value interventions and associated spending will be systematic and evidence-based. It will include using both New Zealand and international evidence as well as work undertaken nationally by the Ministry of Health, the National Health Committee and NHB.

Strategic Investment Fund

When its finances allow, Southern DHB will create a Strategic Investment Fund to shift resources to prioritised services and models of care, with an emphasis on supporting cost-effective delivery in community settings in line with the SSHP. The Fund will also provide short-term transitional support where a change is being made to an existing model of care that enables it to be more productive in the future.

7. Enablers

A range of enabling actions will support achievement of the six Southern strategic priorities.

7.1 Organisational relationships

Development of this Plan has been underpinned by engagement with the organisations and sectors that will be critical to its successful implementation. Southern DHB is committed to building stronger and more effective external relationships, including with rural health service providers, other NGOs, local government, and other government agencies.

Southern DHB's Treaty relationship with Iwi Māori is described at the start of the SSHP, and actions to address inequalities and Māori health in Sections 2.4 and 5.5.

Alliances

Relationships based on the 'alliance' framework are of increasing importance in the New Zealand health sector. The existing Alliance South relationship between Southern DHB, WellSouth and others is described in Table 4, and between Southern DHB and the other South Island DHBs in Section 2.3. Table 9 provides an overview of the alliance concept.

Table 9 : Alliances in the New Zealand health system

Alliance agreements have been used in the New Zealand health system since 2010 to support integrated care development. They are intended to create a 'high trust, low bureaucracy' environment with high quality and accountability, and represent a deliberate move away from the concept of an arms-length purchaser who holds providers independently accountable. Successful alliances are dependent on shared values, agreed outcomes and principles, and transparent processes and information sharing.

Importantly, the alliance is a means of effecting service change to improve performance without disrupting current organisational structures. This is intended to shorten timeframes for action, and avoid potentially disruptive debate between organisations and professional groups, allowing new arrangements to evolve over time. In addition, the alliance is intended to operate without formal legal incorporation, and without the need for additional resources.

The key goal of an alliance in a health sector context is to promote clinical leadership, alignment of clinical and financial accountability, and clinically-led decision-making.

An alliance reflects a group of organisations who have agreed to work together to achieve shared outcomes and use a shared decision-making forum (the Alliance Leadership Team or ALT). The parties to the alliance mandate the ALT to have over-arching decision-making authority within the agreed scope of the alliance. The role of an ALT is to:

- Provide leadership within a health community
- Assess needs of populations
- Plan and design health services in a district (or locality) at a high level, including decisions about prioritisation
- Establish, set goals for, and monitor service level alliances
- Identify opportunities for service development
- Identify the need for workstreams and service level alliances
- Problem solve.

ALTs involve clinical leaders who have a community of influence amongst their professional groups, and senior managers from the key organisations. They are committed to participating in the decision-making processes of the alliance in a way that is consistent with the principles of the alliance.

Service level alliances (SLAs) are established by the ALT as required to design and implement significant service change, and or specific service redesign. They are forums (either time-limited or ongoing) for organising groups of related health services, including decisions on contractual mechanisms and budgets. They involve the relevant health professionals and key managers who are needed to make robust decisions about service expectations, service development and redesign.

Tertiary education

Southern DHB's relationship with the tertiary education section providers in Southern is discussed in Priority 5 – Enhance system capability and capacity.

DHB Shared Services

DHB Shared Services (DHBSS) delivers services at a national level, and where appropriate, produces work for all District Health Boards. The overall purpose of DHBSS is to help the District Health Boards (DHBs) meet their objectives and accountabilities to the Crown.

DHBSS activity is guided by the Health Sector Work Plan agreed between DHBs, as endorsed by DHBs, the Minister and the Ministry of Health, and acts in the interests of DHBs on agreed national issues.

National agencies

Southern DHB is actively engaged in working with the various national health agencies listed in Section 1, and in particular those that have a strong role in shaping the DHB operating context and performance expectations, including:

- The *National Health Board* which is responsible for the funding, planning, and monitoring of DHBs including annual funding and planning processes
- The *Capital Investment Committee* of the NHB which is responsible for a centrally-led process for the national prioritisation and allocation of health capital investment in the health sector in future years leads the implementation and use of information systems across the health and disability sector. They ensure health sector policy is supported by appropriate health information and IT solutions.
- The *Health Quality & Safety Commission* which is responsible for leading and coordinating quality and safety improvement initiatives across public and private sector health and disability providers
- *Health Workforce New Zealand* which has overall responsibility for planning and development of the health workforce to ensure that staffing issues are aligned with planning on delivery of services and that the health workforce is fit for purpose
- The *National Health IT Board* that leads the implementation and use of information systems across the health and disability sector, and ensures health sector policy is supported by appropriate health information and IT solutions
- *PHARMAC* which is responsible for the management of the community pharmaceuticals budget, and whose role has been expanded to include hospital pharmaceuticals and some medical devices.

7.2 Travel and transport

The Southern district is characterised by small communities and large geographic distances. This necessitates a configuration that locates services as close to the communities as possible, but also means significant travel for patients and families to hospital services that must be centralised. The burden of travel must also be balanced between patients and clinicians, for both of whom travel means significant inconvenience and loss of productive time.

The need for travel will be minimised where feasible through increased use of telehealth (eg, for 'virtual' specialist consultations), better coordination of scheduling of hospital appointments and investigations for rural patients, and delegation of some followup specialised consultations to GPs.

In addition, a Southern patient road and air transport plan will be developed, including identification of planned alternatives for when an ambulance is not available in a rural area, when conditions prevent air travel, and when patient need is less complex and does not require the sophistication of an ambulance.

7.3 Use of information

Health system planning, decision-making and performance improvement must underpinned by robust information on health needs, resource allocation and use, clinical practice, service utilisation, patient experience, and patient and population outcomes. This information is needed at clinical, managerial and governance levels, and at practitioner, department, locality and district levels.

Leaders in the Southern health system recognise that current data have their limitations, and that a more deliberate approach to development of a culture of capture, reporting and use of timely and accurate data is required.

Specific areas of focus over the next 3 years will include:

- Review of progress with the Performance Excellence and Quality Improvement Strategy will include consideration of development of a single decision support unit (or 'health intelligence unit') to serve Southern DHB and potentially WellSouth
- Locality analysis and planning will require information about local services, population, and resource use. Locality networks will improve the accuracy and use of data at the local level, with sharing of analytical skills and information across primary, community and specialist services
- A set of key performance indicators will be used to measure overall SSHP implementation, and each headline action will have specific measures and targets.

7.4 Information & communications technology

Southern DHB's information & communications technology (ICT) development is planned on a regional basis through the South Island Alliance. Over the next 3 years, Southern DHB is giving priority to implementation of systems for:

- *Electronic reconciliation* of medicines on admission and discharge from hospital
- *A regional clinical workstation (CWS) and clinical data repository (CDR)*. The CWS is a web based system accessed via a single sign-on that connects multiple clinical applications and data sources to provide clinicians with secure access to patient data. A CDR is a database of patient identifiable clinical information such as medications, laboratory results, radiology reports, care plans, patient letters and discharge summaries
- *Patient administration* that manages the administrative details of a patient's encounter with a hospital or other DHB service. It supports the management of the resources used to provide patient care such as clinical staff, rooms, beds and equipment
- *National Patient Flow* will create a new national collection that provides a view of wait times, health events and outcomes in a patient's journey through secondary and tertiary care
- *Self-care portals*. These are on-line IT tools that enable individuals to have access to their own health information. When implemented, portals will also allow hospital-based services - in particular ED - to have access to a summary view of primary care patient information. In later phases, it will enable patients to communicate with their primary health practitioners and add information to their health record. General practice patient management systems are also developing patient portals.

Other areas of focus will be promotion of use of telehealth applications to support care in rural areas. This will be highly dependent on access to ultrafast broadband.

7.5 Health literacy

A key factor in improving population and individual health outcomes in Southern will be increased health literacy to encourage healthy lifestyles and self-care. Helping Southern communities to access, process

and understand health information will mean people are better prepared to make informed and appropriate health decisions, and therefore better able to manage their own health.

Use of new technologies will be an important contributor, including patient portals; a shared health record; new technologies for monitoring, assessment and treatment; plus web-based access to health education content.

7.6 Communications

The effective flow of information to and from organisations and practitioners in the health system, and the wider community will be essential for the successful implementation of the SSHP. Southern DHB will build on the connections made during Plan development with the aim of strengthening two-way communications to interact more closely with its communities, support transparent and well-informed decision-making, foster collaboration within the Southern heath system and with other agencies, and build shared understanding of the intended future direction. This will be closely linked with other enablers described above, including organisational relationships, use of information and health literacy.

7.7 Implementing the SSHP

This Plan outlines an ambitious programme of work that Southern DHB considers essential to achieving sustainable services, and improving access and outcomes for the people of the Southern district. Delivering on this Plan will require a whole of system commitment to the headline actions, and a sense of urgency. Inertia is the greatest threat to the future sustainability of the district's health system.

Translation of the Plan into action will have the following key dimensions.

Governance

The Southern DHB Board is the decision-maker and 'owner' of the SSHP. Given the extensive nature of the work programme in the Plan, the Board has a critical role to play in supporting the Executive to ensure management and clinician time is focused on delivering on the actions.

The Board will also support further development of the organisational alliances and other partnerships that will be fundamental to the success of the Plan.

Leadership

The Board has delegated implementation of the Plan to the Chief Executive who in turn will ensure performance accountability across the Executive Leadership Team (ELT). ELT will carry a collective accountability for delivery of the Plan, and individual ELT members will be accountable for leading, planning and implementing each of the actions identified in the Plan. Alliance South will also lead and be accountable for actions that are relevant to its focus.

Programme management

The Chief Executive will designate a single ELT member to be accountable for overall SSHP implementation and delivery. The first step will be development of a detailed work programme for each of the strategic priorities. A programme manager will be appointed to coordinate and report on progress with Plan implementation and achievement. Regular dashboard reports will be generated for the ELT and the Board

Key performance indicators

Table 11 provides examples of the key performance indicators (KPIs) and targets that will be used by senior leaders and the Board for monitoring the impact of the SSHP at a strategic level. The timing and

quantified targets (highlighted in yellow) will be confirmed during detailed implementation planning. Where relevant, specific targets will be set for the Māori and Pacific populations to ensure focus on reducing population health inequalities.

Organisational and system development

Effective implementation of the SSHP will require Southern DHB and its partners in the Southern system to have the capacity and capability to manage both current business and short term imperatives, and the longer term, strategic agenda arising from the SSHP.

Examples of areas for focus during implementation planning will include:

- Bolstering of Southern DHB's decision support resources to ensure a strong analytical function to underpin further planning and action. This capability and capacity could be developed as a shared resource with WellSouth
- Support for the clinical leaders who will be actively engaged in driving service improvement through the Performance Excellence and Quality Improvement Strategy, and in developing and leading the initiatives outlined in the Implementation Roadmap. Support will include skills development, and access to the analysis that will inform the change programme. As noted in the discussion regarding Priority 4, performance improvement will require a whole of system approach, with stronger clinical relationships and working to be developed both horizontally and vertically to facilitate gains in areas such as chronic conditions, elective procedures, acute care, and teaching and learning
- Continued evolution of Southern DHBs' Planning & Funding role towards support for alliancing and integrated care. In this environment, Planning & Funding is moving beyond the traditional arms-length 'purchasing' to work collaboratively with professional and organisational leaders to plan, design and invest in models of care, processes and systems that support improved performance and outcomes. While Planning & Funding's core transactional processes and capabilities are needed to enable implementation, these are increasingly seen as secondary to developing a commonality of purpose with shared leadership. New approaches, skills and relationships will be required in Planning & Funding to contribute effectively in advancing the Southern health system

Implementation Roadmap

The Roadmap in Table 12 provides an overview of the staging and sequencing of the 'headline actions' for each of the six strategic priorities. Implementation planning will be undertaken for each of the headline actions identified in the roadmap. The sequencing of actions will be strengthened when more detailed implementation planning is undertaken and the linkages and dependencies (and relationship to the enablers) are identified. This implementation planning will inform Southern DHB's annual plan, which will be the key document for Board governance purposes.

Whakataukī – Proverb

Koutou mā te ihu o te waka hauora e wāwāhi ana ngā ngaru o te moana, kia tau ai te waka ki uta.	The prow of the canoe that cuts through the waves of the sea, so that the canoe may land safely ashore.

Table 10 : Example indicators and targets for monitoring SSHP implementation at a strategic level

Indicator	Measure	Frequency	Current figure	Target
Population health				
1. Keeping people healthy and out of hospital	a) Acute hospitalisations per 1000 population b) Child ambulatory sensitive hospitalisation as % total	a) Quarterly b) Quarterly	a) x/100 population (2013/14) b) x% (2013/14)	Maintain below NZ average to 2018 Reduce to NZ average by 2018
2. Returning people to health and keeping them out of hospital	Unplanned or unexpected readmissions within 28 days of discharge as a % of all hospitalisations	Monthly	x% (2013/14)	Maintain at current level or less to 2018
3. Cardiovascular disease risk assessment	Proportion of eligible people assessed for cardiovascular disease risk in 5 year period	Quarterly	78% (Apr-Jun 2014)	90%+ by 2018
4. Reducing the impact of tobacco smoking	Smoking prevalence in adults aged 15+ (Māori, total)	Annually	15.6% total, 30% Māori (2013 Census)	Māori reduced by 5 % points, non- Māori by 3% by 2018
Patient experience				
5. Minimising waiting times	% of patients with total time in ED <=6 hours	Quarterly	90% (Apr-Jun 2014)	Improve to National target of 95% by 2015
6. Maintaining access to elective surgery	% of National Elective Surgical Target Volume	Quarterly	106% (Apr-Jun 2014)	Maintain above target of 100%
7. Patient safety	The rate of SAC level 1 and 2 fall incidents in Southern Hospitals	Quarterly	XX (2013/14)	0.026 by 2015/16
8. Customer satisfaction	Level of patient satisfaction in the Patient Experience Survey	Quarterly	Not reported as yet (survey commenced Q1 2014)	To be confirmed once baseline is set
Cost and productivity				
9. Managing to budget	YTD financial performance compared to budget	Monthly	-9m (Aug 2014)	Breakeven or better each year
10. Operating efficient inpatient services	a) Cost of outsourcing and agency staff as a % of total costs b) Cost of provider arm personnel as % total	Monthly	a) x% (2013/14) b) 66% (2013/ 014)	a) Reduce to y% by 2018 b) Reduce to 63% by 2018
11. Efficient inpatient capacity use	Acute ALOS	Monthly	3.8 days (2013)	Reduce by 3% pa to 2018
12. Ageing in place – improved home-based support	Rest home and hospital residential care bed days per 1000 65+ population	Quarterly	15,000 bed days/1000 (2013)	Reduce to 13,000 or less by 2018

Table 11 : Outcomes framework

Shared vision	***Better health, better lives, Whānau Ora***					
Strategic priorities	Develop a coherent Southern system of care	Build the Southern health system on a foundation of population health, and primary & community care	Secure sustainable access to specialist services	Strengthen clinical leadership, engagement and quality improvement	Enhance system capability and capacity	Live within our means
Goals	Integrate services to ensure patient journeys are smooth through efficient and effective care pathways, and that the system is easy to use for providers	Strengthen population health approaches, and the core role of general practice as the 'health care home' for patients within the primary & community team	Ensure that the Southern population has ongoing access to specialised services that have safe and viable staffing levels and activity volumes to treat complex conditions	Further develop a culture of clinically-led innovation, service planning and performance improvement across the Southern health system	Develop a workforce mix and facility configuration that matches future health needs, and recognise Southern's core role in teaching and learning	Improve the quality of the care and services we deliver using quality improvement principles and methodologies so that waste is substantially reduced, value for money is improved and the savings contribute to bringing our revenue and expenditure into alignment, complemented where necessary, by tight cost management, improved productivity and different resource allocation patterns.
Headline actions	1. Define the intended future roles, capabilities, responsibilities and relationships of the core entities within the Southern health system 2. Align Alliance South's work programme with the SSHP's strategic priorities and Roadmap 3. Establish locality networks to improve planning and delivery of well-coordinated local services 4. Strengthen the planning and delivery of local and district-wide acute and urgent care, and link effectively with South Island services 5. Recognise and develop the rural hospitals' contribution to the Southern health system 6. Within the South Island Alliance, define the regional direction, key principles and care models that will inform specialist service configuration, development and infrastructure.	1. Within the Alliance South framework, develop further service level alliance teams as the key structure for collaborative service planning and development of new models of care 2. Through Alliance South, agree the future primary & community model for urgent care and after-hours care; health of older people services; community mental health services; management of long term conditions; and management of patients with high and complex needs 3. Include prevention and early intervention within the scope of the primary & community teams, and foster their linkage with Southern DHB's health promotion programmes 4. Support intersectoral initiatives that address the determinants of health, such as in housing and the physical environment 5. Implement a risk stratification tool that identifies the patient cohorts at greatest risk, and design care models commensurate with risk 6. SDHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients 7. Identify and support demonstration sites of agreed models of primary & community care, and spread successful innovation.	1. Undertake analysis to inform planning of specialised service, including identification of services at risk of clinical and financial unsustainability; analysis of inter-district patient outflows; and updating of the Role Delineation Model assessment of Dunedin and Southland hospitals 2. Based on the analysis, identify whether action within Southern DHB or through South Island collaboration is the most appropriate avenue to pursue planning and development of particular specialised services 3. Continue South Island collaboration to refine governance, management and funding models that support provision of sustainable specialist services across DHB boundaries 4. Conduct a stocktake of visiting specialist outpatient clinics, and develop a planned approach by locality that supports equitable local access for patients to higher volume specialties, and that balances specialist and patient travel.	1. Clarify the intended nature and role of clinical leadership in the Southern health system, and ensure supportive structures and processes are in place 2. Ensure clinical leaders have the time, skills and tools to deliver on the performance expectations of their roles 3. Revisit the Performance Excellence & Quality Improvement Strategy to ensure its relevance and adoption as a whole-of-system approach, with an appropriate governance structure and implementation plan, and linkage with the work of Alliance South 4. Position the Performance Excellence & Quality Improvement Strategy as a key vehicle for ensuring financial sustainability, by explicitly linking quality improvement with value gain 5. Identify the initial areas in which Southern DHB will lift its performance to world-class levels, and develop action plans for each 6. Develop locality networks as a forum for building the effective clinical relationships that will support local service improvement and integration 7. Through Alliance South, ensure clinical pathway development and implementation is underpinned by robust clinician engagement.	1. Mandate the existing Joint Education Committee (or equivalent) as the cross-organisational leadership body to collaboratively plan and develop the Southern health workforce based on intended models of care, workforce roles, and demand and supply forecasts 2. Develop a Southern health system workforce plan, beginning with a stocktake of the district's current health workers, and including clear priorities for workforce development based on the strategic direction presented in this SSHP 3. Expand Southern DHB professional leader roles to include a whole-system scope across primary care, NGOs and rural health services, with a focus on standards, credentialing, continuing professional development, and advice 4. Complete detailed district-wide facility capacity planning to inform business case development for an upgrade of prioritised Dunedin Hospital buildings	1. Use the Performance Excellence & Quality Improvement Strategy as the framework for lifting performance to world-class levels in prioritised areas, and reducing waste 2. Strengthen analysis and communication of where Southern DHB funds are spent across the Southern health system, the outputs they deliver, and their outcomes and value 3. Develop a Southern DHB prioritisation framework to inform resource allocation, including relevant policies, processes and tools (incorporating the four-fold aim) 4. Tighten Provider Arm cost management including moderating recent FTE cost growth in key personnel areas 5. Increase use of benchmarking with other DHBs and providers as a basis for budget setting and productivity improvement 6. Develop a Strategic Investment Fund to support shift of resources to prioritised high value services.
Performance measures *(draft)*	• Increase in number of people with diabetes who have good glycaemic control • Dunedin MAPU feasibility study completed by September 2015 • Patient transport plan completed by December 2015 • Report on future Dunstan/ Queenstown hospital configuration completed by March 2016	• Increase in the proportion of SDHB funds allocated to primary and secondary prevention, and primary care services • Decrease in the rates of ED attendance, acute hospital admissions, and ASH in children • Increase in the proportion of the Southern population who don't smoke, and who have healthy BMIs • Decrease in the proportion of the Southern population who report hazardous alcohol consumption levels	• Achieve national access targets for ED, planned procedures, and cancer • Update of RDM assessment of Dunedin and Southland hospitals completed by November 2015 • Vulnerable services and IDF outflow analysis completed by November 2015 • Specialist outpatient clinic deployment plan completed by March 2016	• Clinical leader roles have documented job descriptions, accountabilities and dedicated time, and incumbents have training and support programmes in place by June 2015 • TIA clinical pathway documented, and 90% of eligible patients treated within 24 hours of an event • Increase in the proportion of patients with a long term condition who have had a medicines review • Increase in the number of people in aged residential care who have an advance care plan	• Increase in the proportion of GPs with vocational registration, and the proportion of rural hospital practitioners who have a rural hospital medicine qualification • First Southern workforce plan completed by March 2016 • Role delineation assessment of rural hospitals completed by June 2016 • Southern facility capacity requirements plan completed by December 2015	• Increase in the proportion of surgery performed as day case • Increase in the case-weighted output per FTE • Increase in the proportion of people aged 80 and over who are supported to live in community settings • Decrease in the community pharmaceutical expenditure per capita
Enablers	*Strengthening organisational relationships*	- Alliances at South Island and district levels - Iwi Governance Committee to lead action to reduce Māori health inequalities		- Strategic partnership with tertiary education sector - Membership of DHB Shared Services	- Effective working relationships with national agencies	
	Better planning of travel and transport	- Balanced impact of travel on specialists and patients - Equitable distribution of visiting specialist clinics		- Increased use of telehealth - Better scheduling of speciali appointments for rural patients	- Delegation of specialist follow-up appointments to GPs - Patient road and air transport plan	
	Making better use of information	- Culture of capture, reporting and use of timely and accurate data		- Consideration of a single decision support unit	- Availability and use of information at a locality level	
	Investing in ICT	- Southern implementation of South Island systems		- Telehealth applications to support rural care		
	Increasing health literacy	- Use of new technologies to encourage self-care and healthy lifestyles				
	Improving communications	- Link with communities - Support decision-making		- Foster collaboration - Build shared understanding		

Table 12 : The Implementation Roadmap

Strategic priority area	Goal	Headline actions	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4
Develop a coherent Southern system of care	Integrate services to ensure patient journeys are smooth through efficient and effective care pathways, and that the system is easy to use for providers	Define the intended future roles, capabilities, responsibilities and relationships of the core entities within the Southern health system									
		Align Alliance South's work programme with the SSHP's strategic priorities and Roadmap									
		Establish locality networks to improve planning and delivery of well-coordinated local services									
		Strengthen the planning and delivery of local and district-wide acute and urgent care, and link effectively with South Island services									
		Recognise and develop the rural hospitals' contribution to the Southern health system									
		Within the South Island Alliance, define the regional direction and key principles that will inform specialist service configuration, development and infrastructure									
Build the system on a foundation of primary and community care	Strengthen population health approaches, and the core role of general practice as the 'health care home' for patients within the primary & community team	Within the Alliance South framework, develop further service level alliance teams as the key structure for collaborative service planning and development of new models of care									
		Through Alliance South, agree the future primary & community model for urgent care and after-hours care; health of older people services; community mental health services; management of long term conditions; and management of patients with high and complex needs									
		Include prevention and early intervention within the scope of the primary & community teams, and foster their linkage with Southern DHB's health promotion programmes									
		Support intersectoral initiatives that address the determinants of health, such as in housing and the physical environment									
		Implement a risk stratification tool that identifies the patient cohorts at greatest risk, and design care models commensurate with risk									
		SDHB to develop a policy based on the Minister's expectations that the DHB will work with community and hospital clinicians to provide a wider range of services in community settings as appropriate and provide these services at no cost to patients									
		Identify and support demonstration sites of agreed models of primary & community care, and spre-									
Ensure access to sustainable specialist services	Ensure that the Southern population has ongoing access to specialised services that have safe and viable staffing levels and activity volumes to treat complex conditions	Undertake analysis to inform planning of specialised service, including identification of services at risk of clinical and financial unsustainability; analysis of inter-district patient outflows; and updating of the Role Delineation Model assessment of Dunedin and Southland hospitals									
		Based on the analysis, identify whether action within Southern DHB or through South Island collaboration is the most appropriate avenue to pursue planning and development of particular specialised services									
		Continue South Island collaboration to refine governance, management and funding models that support provision of sustainable specialist services across DHB boundaries									
		Conduct a stocktake of visiting specialist outpatient clinics, and develop a planned approach by locality that supports equitable local access for patients to higher volume specialties, and that balances specialist and patient travel.									
Strengthen clinical leadership, engagement and quality improvement	Further develop a culture of clinically-led innovation and performance improvement across the Southern health system	Clarify the intended nature and role of clinical leadership in the Southern health system, and ensure supportive structures and processes are in place									
		Ensure clinical leaders have the time, skills and tools to deliver on the performance expectations of their roles									
		Revisit the Performance Excellence & Quality Improvement Strategy to ensure its relevance and adoption as a whole-of-system approach, with an appropriate governance structure and implementation plan, and linkage with the work of Alliance South									
		Position the Performance Excellence & Quality Improvement Strategy as a key vehicle for ensuring financial sustainability, by explicitly linking quality improvement with value gain									
		Identify the initial areas in which Southern DHB will lift its performance to world-class levels, and develop action plans for each									
		Develop locality networks as a forum for building the effective clinical relationships that will support local service improvement and integration									
		Through Alliance South, ensure clinical pathway development and implementation is underpinned by robust clinician engagement.									
Optimise system capacity and capability	Plan for a workforce mix and facility configuration that is appropriate Southern's future health needs	Mandate the existing Joint Education Committee (or equivalent) as the cross-organisational leadership body to collaboratively plan and develop the Southern health workforce based on intended models of care, workforce roles, and demand and supply forecasts									
		Develop a Southern health system workforce plan, beginning with a stocktake of the district's current health workers, and including clear priorities for workforce development based on the strategic direction presented in this SSHP									
		Expand Southern DHB professional leader roles to include a whole-system scope across primary care, NGOs and rural health services, with a focus on standards, credentialing, continuing professional development, and advice									
		Complete detailed district-wide facility capacity planning to inform business case development for an upgrade of prioritised Dunedin Hospital buildings									
Live within our means	Improve the quality of the care and services we deliver using quality improvement principles and methodologies so that waste is substantially reduced, value for money is improved and the savings contribute to bringing our revenue and expenditure into alignment, complemented where necessary, by tight cost management, improved productivity and different resource allocation patterns.	Use the Performance Excellence & Quality Improvement Strategy as the framework for lifting performance to world class levels in prioritised areas, improving efficiency, and enhancing system monitoring and reporting									
		Strengthen analysis and communication of where Southern DHB funds are spent across the Southern health system, the outputs they deliver, and their outcomes and value									
		Develop a Southern DHB prioritisation framework to inform resource allocation, including relevant policies, processes and tools (incorporating the four-fold aim)									
		Tighten Provider Arm cost management including moderating recent FTE cost growth in key personnel areas									
		Increase use of benchmarking with other DHBs and providers as a basis for budget setting and productivity improvement									
		Develop a Strategic Investment Fund to support shift of resources to prioritised higher value services									

Appendix 1: Plan development

The process for development of the Southern Strategic Health Services Plan began with preparation of the *Southern Health Profile*, published in March 2014.

Other milestones in SSHP development during 2014 have included:

- Service and financial performance analysis
- Stakeholder interviews (individuals and groups)
- Workshop with Southern DHB's Community & Public Health Advisory Committee (CPHAC) and Board members
- Five workshops on specific topics with clinical and managerial leaders
- Workshop on the overall Plan with a group of Southern district leaders
- Plan drafting
- Public consultation on the draft Plan.

Preparation of the Plan has been overseen by a Steering Group with members comprising:

Who	Organisation
Carole Heatly (chair)	Chief Executive, Southern DHB
Stephen Graham	Rural/remote GP representative; Board member, WellSouth
David Tulloch	Chief Medical Officer / Southland clinical representative, Southern DHB
Leanne Samuel	Chief Nursing and Midwifery Officer, Southern DHB
Lexie O'Shea	Deputy CE and Executive Director Patient Services, Southern DHB
Sharon Kletchko Sandra Boardman	Executive Director - Planning and Funding, Southern DHB (resigned January 2014) Executive Director - Planning and Funding, Southern DHB (from February 2014)
Marion Poore	Medical Director, Public Health South and Medical Director, Women's Children's and Public Health directorate, Southern DHB
Ray Anton	Chair, Rural Health Services Network
Peter Beirne	Chief Financial Officer, Southern DHB
Donovan Clarke Pania Coote	Executive Director, Māori Health, Southern DHB (resigned December 2014) District Manager, Māori Health (from January 2015)
Jim Reid	Primary Care Advisor, Southern DHB
Mike Hunter	Otago clinical representative, Southern DHB and Otago University
Steve Addison	Executive Director - Communications, Southern DHB

Glossary

Age standardised rate (ASR)	Age standardisation is a widely used method for improving comparability between populations. The purpose of age standardisation is to remove the effects of different population age structures so that variations between populations in, for example, hospitalisation rates, are not directly attributable to differences in their age structures.
Alliance South	The Alliance Agreement between Southern DHB and WellSouth provides the foundation for an integrated system approach to the design and delivery of health services in the Southern district. Alliance South is the leadership and decision-making structure that provides oversight and coordination of the joint work programme. Its focus is on transformational change to develop a better integrated, more connected Southern health system with models of primary, community and secondary care that support better health for people and communities. A number of other provider groups are now represented within Alliance South and its service level alliance teams. Following decisions made by Alliance South, implementation is progressed through Southern DHB's contracts with providers.
Ambulatory sensitive hospitalisations (ASH)	Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially avoidable through preventive or therapeutic interventions deliverable in a primary care setting.
Average length of stay (ALOS)	Duration of a single episode of hospitalisation. Inpatient days are calculated by subtracting day of admission from day of discharge.
Capital Investment Committee (CIC)	The CIC is responsible for a centrally-led process for the national prioritisation and allocation of health capital investment in the New Zealand public health sector. The Committee's primary objective is driving better investment decisions in the health system through planning and prioritisation of capital funding, along with advising on investment and infrastructure matters to support the government's service planning direction.
Determinants of health	The multitude of different factors that determine a person's health. This means that people living in the same community, or people of the same age, can have vastly different chances of good health. Factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health services often have less of an impact.
Estimated resident population	An estimate of all people who usually live in New Zealand at a given date. This estimate *includes* all residents present in New Zealand and counted by the census (census usually resident population count), residents who are temporarily overseas (who are not included in the census), and an adjustment for residents missed or counted more than once by the census (net census undercount). Visitors from overseas are *excluded*. The estimated resident population at a given date after a census also *includes* an update for births, deaths and net migration (arrivals less departures) of residents during the period between census night and the given date.
Health localities	Geographic groupings in Southern district that are broadly based on local government areas but that have been adjusted to be consistent with current patient flows to health services. Eight localities have been identified for Southern: Waitaki, Dunedin, Clutha, Gore, Invercargill, Southland, Queenstown and Central.

Health Quality and Safety Commission (HQSC)	The Commission is a national agency responsible for: • providing advice to the Minister of Health on how quality and safety in health and disability support services may be improved • leading and coordinating improvements in safety and quality in health care • identifying key health and safety indicators (such as events resulting in injury or death) to inform and monitor improvements in safety and quality • reporting publicly on safety and quality, including performance against national indicators • sharing knowledge about and advocating for safety and quality.
Health Workforce New Zealand (HWNZ)	HWNZ has overall responsibility for planning and development of New Zealand's health workforce, ensuring that staffing issues are aligned with planning on delivery of services and that workforce is fit for purpose. HWNZ is directed by an independent board comprising senior clinicians and health sector leaders, appointed by and reporting to the Minister of Health.
Incidence	A measure of the probability of occurrence of a given medical condition in a population within a specified period of time.
Inter-district flows	Southern DHB is funded to provide care to all its residents. When a Southern DHB resident receives care outside the Southern district, this event is called an Inter-district Flow (or IDF). Southern DHB pays other DHBs for the services they provide to our residents at standard national prices. IDFs includes the complex treatment we don't provide in our hospitals, and health care provided when people are away from home (eg, commuters; holiday-makers going to ED or visiting a GP and collecting prescriptions outside our boundaries. Southern DHB also receives IDF payments for other residents of DHBs treated in Southern.
Locality network	A group of practitioners in a locality who work together to improve health services for the population they serve, through collaborative planning and action.
National Health Board (NHB)	The NHB is appointed by the Minister, and is supported by a dedicated business unit within the Ministry of Health. The NHB is responsible for overseeing the NHB business unit's work programme, which includes: • funding, monitoring and planning of DHBs, including annual planning and funding rounds • the planning and funding of designated national services • oversight of DHB regional service planning and arbitration over regional disputes • stronger alignment of service, capital and capacity planning • strengthening and accelerating the linkages between IT, workforce and facilities capacity investment • supporting the government initiative to reduce bureaucracy.
National Health Committee (NHC)	The NHC provides the Minister with independent advice on a broad spectrum of health and disability issues, and is explicitly responsible for providing advice on the kinds, and relative priorities, of public health services that should be publicly funded. Its current focus is strengthening the prioritisation of new and existing technologies and interventions, to provide the New Zealand people and the health sector with greater value for the money invested in health.
National Health IT Board (NHITB)	The NHITB provides strategic leadership on the implementation and use of information and information technology systems across the sector, and ensures IT strategy is reflected in capital allocation and capacity planning.
Planning and funding	A DHB function that concerns determining population health needs, setting priorities, allocate resources, contracting with service providers to achieve the best possible outcomes, and monitoring provider performance. The DHB's Planning and Funding team also leads service planning, and manages the implementation of national, regional and local health strategies.
Primary health care	Primary health care relates to the professional care provided in the community,

	usually from a general practitioner (GP), practice nurse, community nurse, pharmacist or other health professional working within a general practice or community setting. Primary health care covers a broad range of health services, including diagnosis and treatment, health education, counselling, disease prevention and screening. A strong primary health care system is seen as central to improving the health of all New Zealanders and reducing health inequalities between different groups.
Primary Options for Acute Care (POAC)	POAC is a service providing health professionals access to additional investigations, care or treatment for their patient, where the patient can be safely managed in the community and as an alternative to referral and/or admission to a hospital. The POAC programme has been active in a number of DHB areas for more than a decade, and has proven effective in avoiding unnecessary hospitalisations.
Prevalence	The proportion of a population found to have a condition (typically a disease such as diabetes, or a risk factor such as smoking). It is arrived at by comparing the number of people found to have the condition with the total number of people studied.
PRIME	The PRIME (Primary Response in Medical Emergency) scheme aims to ensure high quality access to pre-hospital emergency treatment in areas where there is a shortage of Advanced Life Saving (ALS) paramedics. PRIME is provided by specially trained GPs and practice nurses who assist ambulance services. It is a 24-hour a day, seven-day a week service with PRIME providers on an on-call roster.
Provider Arm	The division of a DHB that is responsible for delivery of health and support services. Southern DHB's Provider Arm is responsible for managing hospital, mental health and rehabilitation services based at Southland Hospital in Invercargill, Lakes District Hospital in Queenstown and Wakari and Dunedin Hospitals in Dunedin, and community nursing and allied health services throughout the district.
Region	New Zealand has four health regions – three in the North Island (Northern, Midland and Central), and one in the South (South Island). The regions provide a forum for collaborative DHB service and capacity planning.
Role delineation model (RDM)	The role delination model describes the clinical support services, staff profile, minimum safety standards and other requirements to ensure that hospital clinical services are provided safely and appropriately supported. The RDM describes five levels of care complexity and resource use.
Standardised discharge rate (SDR)	The level of certain hospital procedures provided to people in a DHB area compared to DHBs in other parts of New Zealand. Standardisation takes into account the particular sex, age, ethnicity and social deprivation mix of the DHB's population, and allows a 'like with like' comparison. The SDR measures the intervention rate – this does not necessarily indicate what the right rate might be, but compares individual DHBs with each other, taking DHB population demographics into account.
Secondary care services	Services provided by medical specialists and other health professionals who generally do not have first contact with patients. This includes acute care provided for a short period of time for a brief but serious illness, injury or other health condition. Most but not all DHB-funded secondary care services are provided on a hospital campus, and provided by the DHB's Provider Arm.
Service level alliance team (SLAT)	The work of an alliance (such as Alliance South) is generally undertaken by specially convened service level alliance teams (SLATS), which can have either an ongoing or fixed term role. Membership is from Southern DHB, and relevant provider organisations. They are clinically led expert teams looking at specific services areas, responsible for considering possible service delivery alternatives and innovations for patients and populations.

South Island Alliance	The South Island Alliance enables the region's five DHBs to work collaboratively to develop more innovative and efficient health services than could be achieved independently. By using our combined resources to jointly solve problems, we are better positioned to respond to changes in the technology and demographics that will have a significant impact on the health sector in the coming years.
South Island trauma network	A SLAT within the South Island Alliance that works together to ensure that seriously injured patients from around the region get to the best trauma services that can be provided in the South Island as quickly as possible.
Strategic Investment Fund	When its finances allow, Southern DHB will create a Strategic Investment Fund to shift resources to prioritised services and models of care, with an emphasis on supporting cost-effective delivery in community settings in line with the future direction described in the SSHP. The Fund will also provide short-term transitional support where a change is being made to an existing model of care that enables it to be more productive in the future.
Subregion	A smaller grouping of DHBs than exists at the regional level, who work together to address specific service issues of common interest.
Sustainability	A sustainable health system can provide ongoing access for a district's resident population (and visitors to the district) to safe, effective and efficient services. Sustainability also requires the capability to anticipate and respond to a changing operating environment, and to contribute to the wider wellbeing of communities.
Very low cost access (VCLA) general practice	The Very Low Cost Access (VLCA) scheme supports general practices with an enrolled population of 50% or more high needs patients, where the practice agrees to maintain patient fees at a low level. VLCA payments provide: • extra funding in return for general practices agreeing to maintain fees within the fees thresholds • recognition of the extra effort involved in providing services to high need populations, and keeping fees low for the people who can least afford primary health care and improving health outcomes for those most likely to have the worst health.

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 10 December 2014, commencing at 10.00 am, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Tim Ward	Acting Chair
	Mr Neville Cook	
	Mrs Kaye Crowther	
	Mr Stuart Heal	
In Attendance:	Mr Joe Butterfield	Board Chairman (until 10.30 am)
	Dr John Chambers	Board Member
	Mr Tony Hill	Board Member (from 10.25 am)
	Dr Jan White	Crown Monitor
	Mrs Sandra Boardman	Executive Director, Planning & Funding
	Mr Peter Beirne	Executive Director Finance
	Ms Carole Heatly	Chief Executive Officer
	Ms Jeanette Kloosterman	Board Secretary
	Mr Ian Macara	Chief Executive, WellSouth Primary Health Network

1.0 WELCOME

The Acting Chair welcomed everyone to the meeting.

2.0 APOLOGIES

Apologies were received from Ms Sandra Cook, Committee Chair, Dr Branko Sijnja, Committee Member, and Mr David Tulloch, Chief Medical Officer.

3.0 PRESENTATION – CANCER SERVICES

The Committees received a presentation from Ron Craft, Portfolio Manager, and Blair McLaren, Specialist, Oncology & Haematology, on the cancer planning framework and current priorities (tab 3). This included an overview of the:

- New Zealand Cancer Control Strategy
- Cancer Network structure
- Key strategic directions of the Southern Cancer Network and its programmes of work
- Role of the Otago/Southland Local Cancer Network and its goals
- Registrations by ethnicity for Southern and New Zealand 2005-07 for lung, breast, cervical, prostrate, colorectal and melanoma cancers

Mr Craft informed the Committees that their presentation had been prepared prior to the release the previous day of the Minister's Cancer Plan 2015-18, which they had yet to analyse.

The Committees:

- Noted that New Zealand has the highest rate of colorectal cancer in the world and Southern has the highest rate of colorectal cancer registrations in New Zealand;
- Noted that it was likely colorectal cancer screening would be funded by 2016;
- Requested that management report back on their planning for the follow-up services, including colonoscopy, that will be required following the introduction of colorectal cancer screening;
- Expressed their support for training nurses to undertake colonoscopies.

Mr Tony Hill joined the meeting at 10.25 am.

The Acting Chair thanked Messrs Craft and McLaren for the preparation that had gone into their informative presentation.

Mr Butterfield left the meeting at 10.30 am.

4.0 MEMBERS' DECLARATION OF INTEREST

It was resolved:

"That the Interests Register be noted."

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 5 November 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:

- Noted advice from the WellSouth Chief Executive that another Invercargill practice had joined the free after-hours care for under six-year olds, which reduced the number of Invercargill practices outside the scheme to two;
- Noted the Executive Director Planning & Funding's advice that Alliance South had a planning day scheduled for February and additional items may be added to their Work Plan as a result of that;
- Requested that Alliance South's A3 problem solving sheets, showing KPIs to measure progress, be submitted to the next meeting.

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:

- WellSouth announced on 11 November 2014 that a third Very Low Cost Access (VLCA) practice, Nga Kete Matauranga Pounamu Charitable Trust, had been established in the Southern district;
- Progress was being made to ensure rural health funding is allocated to where service needs are greatest;
- Consultation on the Southern Strategic Health Services Plan (SHSP) closed on 21 November 2014. Seventeen roadshows were held and 900 submissions received. The final draft plan will be submitted to Board in February 2015.

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

Public Health South Report

The Committees requested:

- That management check Well Child providers are promoting the BURP breastfeeding smartphone application;
- The KPIs for the initiatives referred to in Public Health South's report, eg the Stop Smoking Clinic.

9.0 QUARTER ONE DHB PERFORMANCE

The Executive Director Planning & Funding presented an overview of performance against health targets and indicators for quarter one 2014/15 (tab 9) and advised that there were data issues with the two targets not achieved.

Primary Health

Health Targets

Mr Heal informed the Committees that, for the first quarter, WellSouth had achieved four of its five health targets and the fifth was close to target.

The Chief Executive, WellSouth, reported that a plan had been agreed with the Ministry of Health to achieve the cardiovascular health target by June 2015.

After Hours Care

The Chief Executive, WellSouth, provided an update on after-hours care in the district.

It was resolved:

> "That the Committees note the quarter one DHB performance report."

10.0 FINANCIAL REPORT

The Executive Director Planning & Funding presented the Funder Financial Report for the period ended 31 October 2014 (tab 10) and provided the following updates:

- Inter district flows (IDFs), which had been negative in October, were positive in November;
- Travel and accommodation were again positive in November;
- Mental Health and Public Health were in line with budget for November;
- The trends in Disability Support were continuing, with aged residential care over budget but hospital level beds had been positive;
- The Pharmac forecast had been received. Further analysis of this was required but it indicated that there would be $600k further cost for the year.

The Executive Director Planning & Funding informed the Committees:

- That the Pharmac forecast did not include hospital medicines rebates, which would offset the adverse shift;
- Health Partners were analysing aged residential care to identify the areas SDHB should be targeting.

The Executive Director Finance and Executive Director Planning & Funding then took questions from members on the financial statements.

11.0 WORK PLAN

The Committees reviewed the DSAC/CPHAC work plan for 2015 (tab 11) and requested that actual dates be inserted in the "reporting frequency" column.

CONFIDENTIAL SESSION

At 11.40 am it was resolved that the public be excluded for the following agenda items.

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
2. 2015/16 Funder Financial Planning	To allow activities to be carried out without prejudice	As above, section 9(2)(i) and (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 January 2015

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Dec 2014	Cancer Services (Minute item 3.0)	Management to report on their planning for the follow-up services, including colonoscopy, that will be required following the introduction of colorectal cancer screening.	EDP&F/ EDPS	See Planning & Funding Report.	
Dec 2014	Alliance South (Minute item 7.0)	A3 problem solving sheets, showing KPIs, to be submitted to the Committees.	EDP&F	A3 Problem solving sheets and KPIs are yet to be finalised. It is anticipated that these will be agreed to and confirmed following the Alliance South planning workshop in February 2015.	
Dec 2014	Public Health (Minute item 8.0)	▪ Management to check Well Child providers are promoting the BURP breastfeeding smartphone application; ▪ KPIs to be provided for the initiatives referred to in the PHS report, eg Stop Smoking Clinic.	EDP&F/ PHS	▪ Premises are currently being signed up and their information is being loaded onto the BURP breastfeeding smart phone application. A variety of stakeholders including Well Child providers have been advised of BURP during this phase. A formal launch is being planned in February where the website will be promoted to a wide group of stakeholders including Well Child providers. ▪ The KPI is the number of people attending the clinics	Completed

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				to demonstrate an increase in numbers to achieve the maximum clinic numbers. The clinics will be evaluated quarterly to review the effectiveness of referrals pathways.	
Dec 2014	Work Plan (Minute item 11.0)	Actual dates to be inserted in the "reporting frequency" column.	EDP&F		Completed

SOUTHERN DISTRICT HEALTH BOARD

Title:	Planning and Funding Report
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	4 February 2015

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: 22 January 2015	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
February 2015

Health of Older People Portfolio

Aged Related Residential Care (ARRC) Forecasting Future Demand

Access to age related residential care (ARRC) is determined by the Needs Assessment and Service Coordination Unit according to individual clinical needs, which must be at a high level, complex and considered to be permanent. If an older person meets these national clinical criteria they are able to receive ARRC. Whether or not the DHB subsidises ARRC depends on eligibility under the Social Security Act 1964 and on the individual's income and assets. For people below the income and asset testing threshold the DHB fully subsidises ARRC. Some people will be private payers and for others the DHB may pay a top-up between the "maximum contribution" and the actual cost of care. An individual's subsidy can also change over time e.g. initially they may not be eligible for a subsidy, but later if income and assets fall below the threshold they may become eligible for subsidised care. Similarly an individual's needs change over time e.g. initially requiring rest home level care but later if cognitive impairment increases they may be reassessed as requiring dementia care. The cost of ARRC varies according to the type of care i.e. rest home, dementia, hospital and psychogeriatric beds have different bed day rates. In addition actual maximum contribution varies by Territorial Local Authority (TLA).

Forecasting future demand attempts to take all these factors into account. Information on prior years expenditure, known price increases, levels of occupancy for different types of care in different TLAs, projected population growth in over 65s and availability of home and community support services, are also taken into account.

The DHB has no control over supply of these services. ARRC contracts are evergreen and the only barrier to the market is that providers must be certified by the Ministry of Health. The DHB has no grounds to refuse a contract to a provider who can show that they have certification. Similarly we are unable to control the number and types of beds that providers operate. Access to ARRC is an entitlement based on nationally consistent criteria which are assessed by the DHB Needs Assessment and Coordination Unit using interRAI.

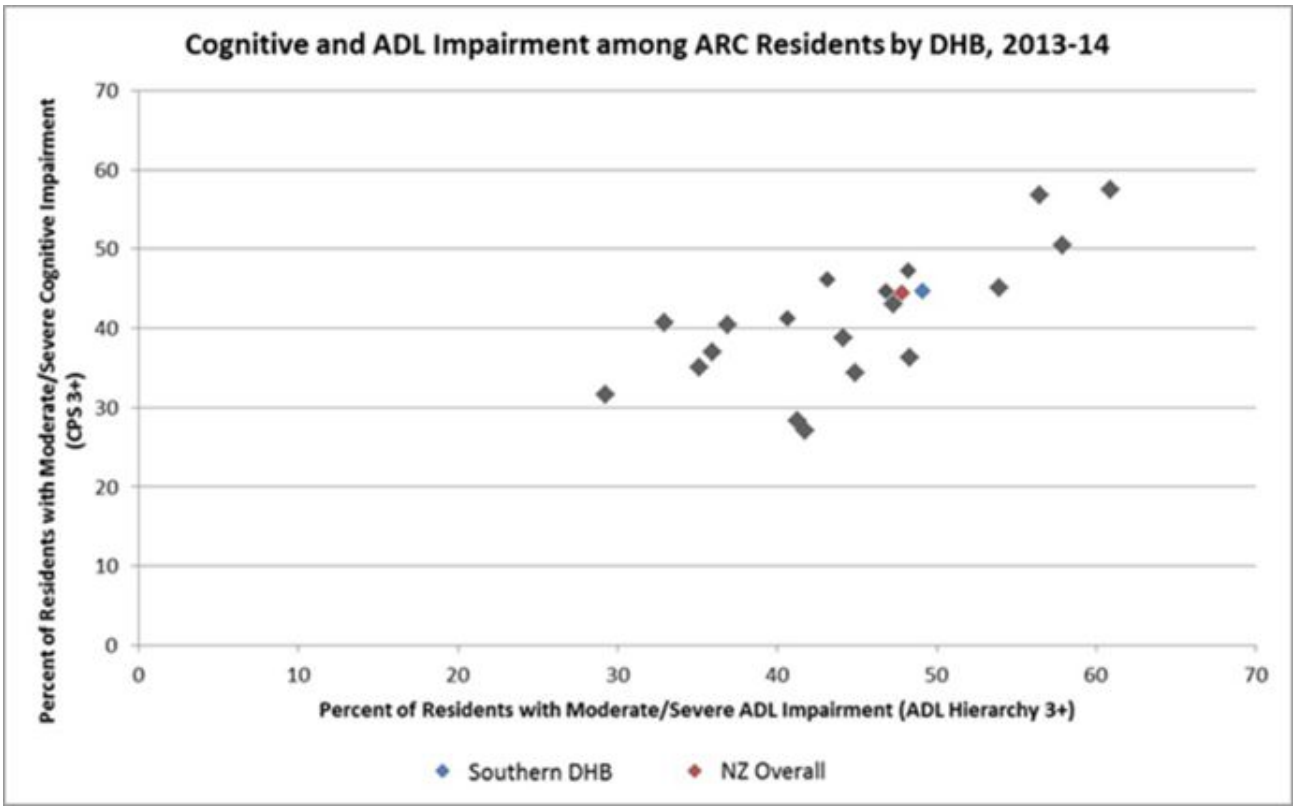
There will always be a level of risk associated with forecasting this type of expenditure due to the large number of variables, some of which can change during the financial year.

Aged Related Residential Care (ARRC) Comparison of Southern DHB Residents with other DHB Residents

As part of the investigation into Southern DHB's high usage of ARRC, assistance was sought from the lead Chief Executive for Health of Older Peoples Services. Chris Fleming asked the Principal Analyst for interRAI at DHB Shared Services to review the interRAI from Southern DHB to determine how the levels of complexity for Southern ARRC residents compared with other DHBs. The Principal Analyst concluded that:

- 89% of clients admitted in 2013/14 had at least one completed interRAI assessment completed between Q4 2012/13 and Q4 2013/14. This is high in comparison to many DHBs.
- The MAPLe (method for assigning priority levels) scores for those people admitted to ARRC in Southern in 2013/14 do not show that they have lower needs than people admitted elsewhere in the country.

- Considering overall populations in the ARC setting (not just those recently admitted), Southern DHB is very much in line with NZ totals overall, with just slightly more impairment.



The latest interRAI upgrade gives the ability to record level of care (rest home/hospital) from now on but historic data doesn't include that information. Overall though, looking at the characteristics of people who are admitted and also the characteristics of all residents in care, Southern DHB is very much in line with NZ averages overall.

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 December financials and assumes that month of invoice is the same as month of service. In fact the claims in any one month can arise from service delivery over several months. We are working with SIAPO to extract the data on the basis of month of service but this will take some time. In the meantime the graphs reflect how the data has been presented to the Committees since the start of the year.

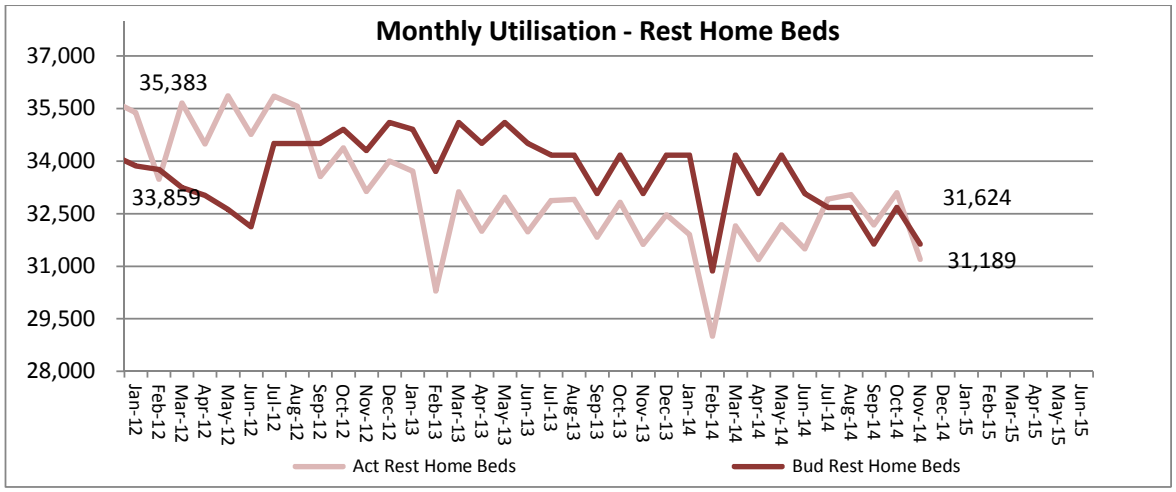
Aged Residential Care expenditure shows in two separate cost centres.

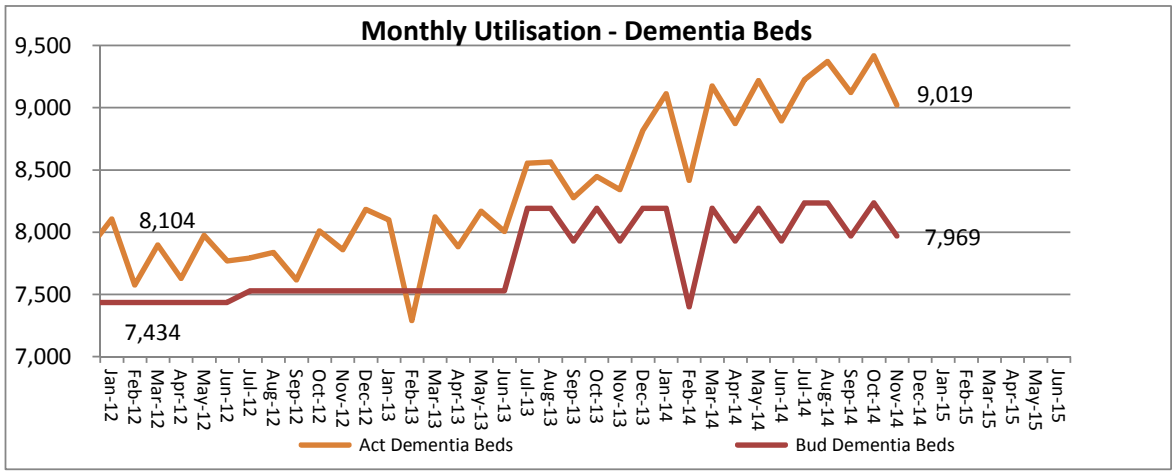
> Residential Care: Rest Homes (6640) includes both Rest Home Level and Secure Dementia Levels of Care.
>
> Residential Care: Hospitals (6650) includes Hospital Level Care and Psychogeriatric (Aged Continuing Care—Special) Care

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).

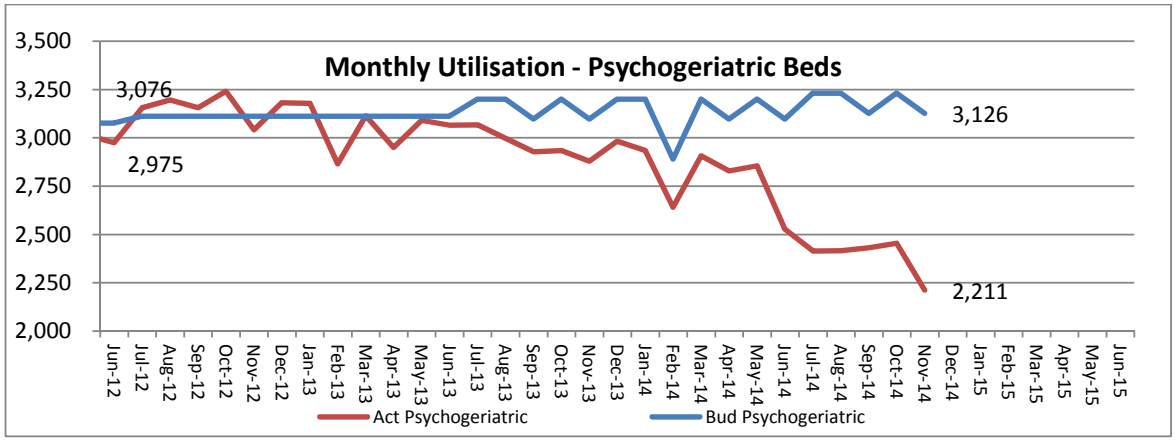
However, the graphs and utilisation figures show only the Aged Related Residential Clients.

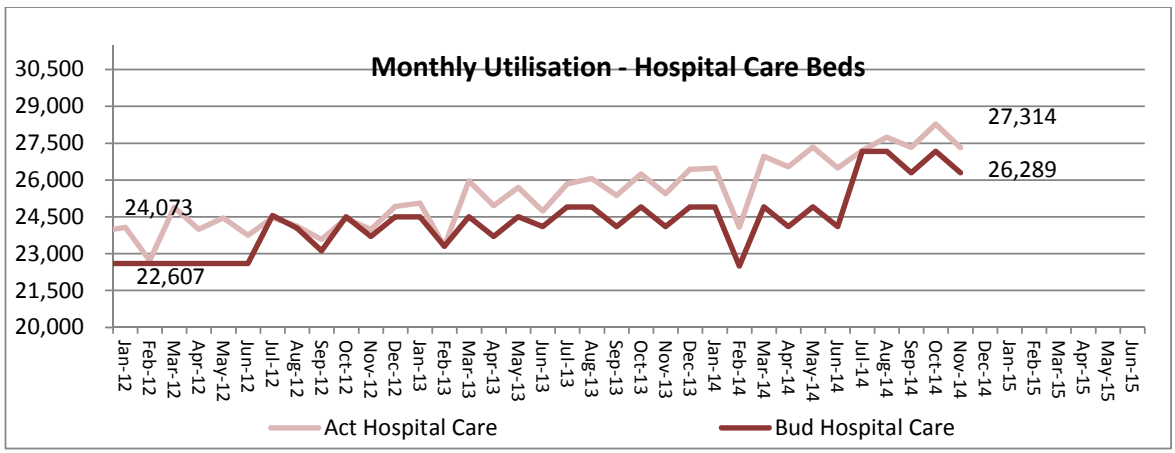
For Residential Care: Rest Homes, the graphs show that Rest Home utilisation continues to decrease, faster than anticipated by the budget. This is due to the use of interRAI as a Comprehensive Clinical Assessment Tool, the Ageing in Place Strategy and the community supports available through our Home & 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.





8

Age Related Residential Care (ARRC) Facilities

There have been a number of changes to the ARRC facilities in our District over recent months.

Albany House Rest Home in Gore and Woodhaugh Rest Home in Dunedin are both now certified to provide hospital level services in addition to Rest Home services. The main difference is the provision of 24/7 coverage by Registered Nurses.

Chateau Village in Balclutha is now certified to provide secure dementia care. This requires a secure unit and staff with additional training.

Winton Lifestyle has received provisional certification (contingent on a small number of corrective actions being completed prior to occupancy) for Rest Home level services in Central Southland. This is a new facility.

Home & Community Support Services (HCSS)

Contracts for HCSS have yet to be finalised for 2014/15 and continue to be paid in draft. Hours of service delivery for the bulk-funded HCSS for Older People are tracking below targeted levels. A letter and draft proposal for negotiation discussions was sent to HCSS Alliance Provider CEOs on 15 December 2014. No response has been received as at 22 January and so a reminder has been sent.

One of our Alliance Partners, Access Homehealth Limited was acquired by Green Cross Health Limited in December 2014. There has been no changes in our contracts or services as a result.

Palliative Care – Exceptional Circumstances

Planning & Funding is changing the way the DHB contracts for Exceptional Circumstances – Palliative Care with ARRC Hospital level facilities. Previously individual contracts for each client have been issued. In future a facility contract, will be used when an approved client is placed there, similar to how the ARRC and Long Term Support/Chronic Health Conditions contracts work. This will reduce the administrative workload for the contracts team in Planning & Funding.

At the same time, eligibility guidelines for residential placements for Palliative Care are being reviewed, to assure that they are consistent with other DHBs and with our guidelines for other services.

Mental Health, Addiction & Intellectual Disability Portfolio

Hapai te Tumanako - Raise HOPE Implementation

Recruitment to the District Networks overarching Network Leadership Group (NLG), including an Independent Chair, is now complete. The first meeting of the NLG is to be held on 28 January 2015.

The following key projects in the Raise HOPE Implementation Plan have been scoped and project plans will be finalised by the NLG at their initial meeting:

- Development of a Stepped Continuum of Care Model
- Development of a Workforce Development Plan for the Sector

Public and Population Health

Child and Youth Steering Group

Agreement was reached at the 11 December meeting of the existing Child and Youth Steering Group that this group will fulfil the requirements for a Youth Service Level Alliance Team (SLAT). It was also agreed that minor changes were required to the existing terms of reference and membership. This includes expanding representation to include Social Sector Trials, New Zealand Police and Child Youth and Family. These changes will be made in time for the next meeting scheduled for 29 January 2015.

At the December meeting, the Provider Arm provided an update report on Children's Action Plan initiatiives. These included:

- Implementation of the National Alert System
- Maternal and Children's Wellbeing Midwifery Group for vulnerable pregnant women and infants
- Investigations of ED presentations of children under 2 years of age
- Family Violence Intervention Programme

Well Child Tamariki Ora Quality Improvement Framework

Implementation of the Well Child Tamariki Ora Quality Improvement Framework continues with the following indicators:

Indicator #5: Children are enrolled with child oral health services

Indicator #21: B4 School Checks are started before children are age 4½

Indicator #19: Mothers are smokefree at two weeks postnatal

Generally good progress has been made in all three of these areas, as reported in the recently released Ministry of Health publication, *Indicators for the Well Child/Tamariki Ora Quality Improvement Framework, September 2014.* Implementation of specific activities to address Indicator #13 (infants are exclusively or fully breastfed at three months) in Southland through promotion of the Plunket Lactation Consultancy has now been completed as the Plunket Lactation Consultancy Service is no longer available. However, WCTO providers and LMCs routinely continue to protect, promote and support breastfeeding through their respective services.

Please see the attached link to the document 'Indicators for the Well Child/Tamariki Ora Quality Improvement Framework (September 2014).' This is now 'live' on the Ministry of Health website.

http://www.health.govt.nz/publication/indicators-well-child-tamariki-ora-quality-improvement-framework-september-2014

This is the third Well Child/Tamariki Ora Quality Indicators publication released by the Ministry and demonstrates areas of excellence and areas for improvement. The report is intended to support the Ministry of Health, DHBs and providers of Well Child/Tamariki Ora and related child health services to identify and prioritise areas for national and local quality improvement. Much of the data is retrospective, i.e. from 2013 or early 2014, so may not yet reflect any changes related to the work being carried out through WCTO Quality Improvement Framework Implementation plans.

Cancer

Colorectal cancer screening featured significantly as part of the discussion at the committee meeting in December. There was particular interest in the bowel screening pilot currently under way in Waitemata DHB.

This is a four year pilot study funded directly by the Ministry of Health where eligible residents of the DHB (i.e. those aged between 50 and 74) will be invited to participate in the programme. The Waitemata pilot is scheduled to conclude in 2015. Data from the pilot study will then be analysed to inform a decision on whether to launch a national bowel screening programme.

The Local Cancer Network of the Southern DHB awaits the decision with interest. In the meantime the Network will continue its planning activities at a local level with a particular focus on the implementation of the recently released 2015–2018 New Zealand Cancer Plan.

Primary and Community Portfolio

COMMUNITY PHARMACY

Community Pharmacy Services Agreement

The Stage 4 rollout of the Community Pharmacy Service Agreement (CPSA) has now been implemented and early information and data is being received regarding the modification to the funding model. That is, the introduction of Relative Value Units with a reversion to fee for service for designated services. This should not have a major impact on pharmaceutical expenditure, albeit SDHB will closely monitor expenditure in the next few months once pharmaceutical claims have been processed and reflected in the costs to DHBs.

The introduction of a new CPSA in July 2015 has been deferred until July 2016. This is to allow time for the changes to the current CPSA particularly Stage 4 to settle in and time to learn from the changes and make any adjustments, if necessary, to the new Agreement in 2016.

LABORATORY SERVICES

SDHB continues to work closely with the Clinical Laboratory Advisory Group (CLAG) to ensure new and unfunded tests are reviewed to ensure they are clinically appropriate and add value to diagnostic services. SDHB also intends to utilise the CLAG to assist with laboratory demand management in general, particularly the tests currently funded outside the Laboratory Contract.

PRIMARY CARE

WELLSOUTH:

WellSouth Primary Health Network completed the transition of IT systems in-house, on time for the 1 January 2015 change-over, with the installation of the software products DRINFO, Patient Dashboard and ERMS. This outcome was achieved during the busy lead-up to the holiday period.

The WellSouth Web Portal system has also been implemented for electronic claiming for programmes payments and associated data. This is available 'real-time' for practices running MedTech PMS's initially (i.e. 85% of WellSouth practices). Work will continue with the other PMS vendors to have this enhanced functionality available as soon as practicable for the non MedTech PMS practices.

There has been very positive feedback from general practices on the improved functionality, usefulness and speed of the WellSouth IS products. Thus the outcome to enhance practices' ability to provide better integrated and timely care for patients is being realised with the IS changes.

A critical strategic foundation of WellSouth's IT strategy is the migration to ERMS (Electronic Request Management System). Embedding ERMS as the only end-to-end electronic referral system in the region is critical for patients and primary/secondary care clinicians. WellSouth and SDHB have ERMS as a partnership IT priority for functionality and responsiveness, and also critically, this aligns to requirements of the South Island DHBs' IS strategy.

UNDER 6s

There has been further success in Invercargill with the final three practices joining the Under 6s 'Free' scheme: Vercoe, Brown and Associates from 1 January 2015, Victoria Avenue Medical

Centre from 1 February 2015 and Dr Terpstra's practice from 19 January 2015 – facilitated by the merger of his practice into the Invercargill Medical Centre which is in the scheme.

Mountain Lakes Medical Practice in Queenstown, which has 18 enrolled patients under six years of age as at 1 Oct 2014, have agreed to enter the scheme from 1 February 2015.

Therefore Southern DHB will have 100% population covered by the free under 6s scheme from 1 February.

ALLIANCE SOUTH

A planning workshop for Alliance South members, staff and Service Level Alliance Team (SLAT) Chairs has been scheduled for mid-February 2015. The focus will be on ensuring that the work plan is both agreed and aligns to the priorities of the Annual Plan, Ministry Targets, local priorities and the Draft Southern Strategic Health Services Plan.

Acute Demand

Professor Tim Stokes has agreed to commit to the role of Independent Chair and an interim meeting with him has occurred. It has been highlighted that the expertise and knowledge of a Physician would add value to this group and a call for expression of interest has now been issued.

The first meeting of the Acute Demand SLAT will be in early March 2015 and planning is now underway for what will be a problem identification and work priority areas workshop.

Rapid Response Service (RRS)

The rapid response service continues to grow, however referrals are still not at a level that would be considered either sustainable or at a stage where the numbers would be statistically significant enough for any decisions around future model/s of care to be made (to be expected with a new service in pilot phase). Alliance South agreed at their December meeting that due to the lower than expected volumes, and the time required to embed a new service, that the service be extended for a further six months without making any changes to the operational running of the service, and/or without investing any further resources. During this period, the following referral changes will be implemented to develop the service further:

- Pulling patients from ED (aligning with ESD service)
- Extending some geographical boundaries of service
- Taking referrals from Maori/pacific patients from 55+
- Taking referrals for patients who are close in age and interest
- Explore accepting referrals from other NGOs, Age Concern, etc
- Continued promotion and communication with referrers

Respiratory

A workshop of key stakeholders occurred on 3 December 2014. Discussion highlighted the gaps in adult respiratory services, the need for accurate data to support the decision making process, the importance of understanding current services, what the model of care/s may look like and how this would align with the Annual Plan, the Southern DHB Strategic Plan and other priorities. The group identified two problem statements that will now be further defined and worked through:

1) Patients with respiratory conditions are currently being managed in secondary care rather than primary care
2) Communication is a problem when introducing a change and/or new model of care

Community and Hospital Pharmaceuticals

The Demand Side Management Project has continued, with visits to prescribers in the Dunedin, Central and Invercargill localities. For 95% of practices this was the third round of visits to them, with discussions having been well received. The next analysis report is due in the coming weeks and this will be repeated over the coming months to capture any changes as a result of the activity that has been undertaken. This will be reported on once received.

At their December meeting, the Community and Hospital Pharmacy SLAT members considered a proposed plan for the Disposing of Unwanted Medications through Pharmacies (DUMP) campaign. There is some hesitancy to commit to funding this activity with members wishing to ensure that this is the best use of funds. Work on further developing the DUMP campaign plan and costs will continue while other activity such as Medicine Utilisation Reviews (MUR) are explored and investigated. A final decision will be made at the February 2015 meeting.

The first set of data that will form the baseline has been received and is in the process of being analysed for presentation to the Community and Hospital Pharmaceutical SLAT February meeting. There is a three month time lag with data, so any improvements or progress will not be evident for some months.

Rural Health

The Rural Health SLAT has developed a proposed model that was considered by Alliance South at their December 2014 meeting. Some adjustments will be made before this is then circulated to rural practices for consultation.

Attachments:

1. PHS Report

SOUTHERN DISTRICT HEALTH BOARD

Title:	PUBLIC HEALTH SERVICE REPORT
Report to:	Community & Public Health Advisory Committee
Date of Meeting:	4 February 2015

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:
Approved by Chief Executive Officer:	No	Date:

Prepared by: Lynette Finnie Date: 12/1/15	Presented by: Dr Keith Reid

RECOMMENDATIONS:

1. That CPHAC receive this report.

PUBLIC HEALTH SERVICE REPORT TO THE SOUTHERN DHB COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE 4 February 2015

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

Communicable Disease and Food Safety

Outcome 4 Reduce the impact and incidence of communicable disease

Public Health Reponses to outbreaks on Cruise Ships

Recent media reports in relation to the outbreak of norovirus on the Dawn Princess (Otago Daily Times, 9 December 2014) follow similar reports from the last cruise season. Cruise ships operate within New Zealand territorial waters and come under NZ and international public health regulations. It may be helpful to the Committee to understand the approach used in dealing with illness on board cruise ships.

When ships approach New Zealand from international waters they are required to make a health declaration. This is then reviewed by a Health Protection Officer and permission is given to the ship to enter New Zealand. This process is known as granting pratique.

Given the size of these ships and the number of passengers and crew aboard (the smallest has a complement of 688 and the largest 4295) there is generally a background level of illness reported. Once in New Zealand waters there is an expectation that the ships will keep public health authorities informed if illness levels differ significantly from those first declared.

The larger cruise ships have well equipped medical centres and usually have several medical and nursing staff aboard. They also have well developed protocols to manage outbreaks aboard. These are based on the stringent requirements of the United States' Center for Disease Control (CDC) and include measures to identify and isolate ill passengers, the maintenance of logs detailing numbers of affected passengers and crew, and the implementation of enhanced cleaning and other environmental measures to control spread.

On rare occasions the presence of Public Health staff on ships may be required. This occurs where: assurance is required as to the nature of an outbreak and microbiological specimens are required for testing; there is a need to liaise directly with medical staff over the extent of an outbreak; assurance is required over the effectiveness of measures put in place to control an outbreak or the ship has requested additional input to assist in implementing control measures. There is usually no added benefit or public health reason for the routine inspection or boarding of affected ships.

While there is no legal requirement for health authorities to notify third parties of the presence of an outbreak onboard a ship there has recently been dialogue about sharing such information with interested parties. Within Dunedin, The Cruise Action Group (a Dundedin City Council facilitated group of tourism operators who provide services to cruise ship passengers) has expressed a view that they would like to be informed where a ship docking at Port Chalmers has declared an outbreak. The practicalities of such an awareness raising mechanism are being explored.

Toursim operators have also been reminded that they should plan their operations on the basis that cruise ships are regularly affected by outbreaks of norovirus. The risk that someone who is incubating the illness may come ashore and develop symptoms while they are undertaking onshore activities is small but significant enough that planning how to deal with such an occurrence has value. There is no way to prevent apparently well passengers from disembarking nor to effectively screen passengers for illness.

Tourism Operators have been reminded that they need to maintain an excellent standard of hygiene and staff awareness of hygiene procedures and that this should be backed up by a Health and Safety Plan outlining actions to take in the event of sickness among one of their clients. A reference 'Gastroenteritis and Coach Travel – A guide for Tour Operators' has recently been updated by Public Health South.

Rhythm & Alps

On 30 and 31 December a major music festival, Rhythm and Alps, was held on the Robrosa Station in the Cardrona Valley, Wanaka. This was the second time that this event has been held in the Southern district with 5000 people attending over the two days.

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

SOUTHERN DISTRICT HEALTH BOARD

Title:	FINANCIAL REPORT
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	04 February 2015

Summary:

The issues considered in this paper are:

- December 2014 Funds result

9

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 Date: 26/01/2015	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

1. That the report be received.

DSAC / CPHAC FINANCIAL REPORT

Financial Report for: **December 2014**
Report Prepared by: **Peter Beirne**
Date: **21 January 2015**

Recommendations:

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

1. DHB Funds Result

The overall funder result follows;

Month				Year to Date			Annual
Actual $' 000	Budget $' 000	Variance $' 000		Actual $' 000	Budget $' 000	Variance $' 000	Budget $' 000
69,393	69,334	59	Revenue	417,073	416,276	797	832,283
(70,768)	(69,329)	(1,439)	Less Other Costs	(419,984)	(415,627)	(4,357)	(825,966)
(1,375)	5	(1,380)	Net Surplus / (Deficit)	(2,911)	649	(3,560)	6,317
			Expenses				
(49,850)	(49,464)	(386)	Personal Health	(298,158)	(296,608)	(1,550)	(588,785)
(7,143)	(7,090)	(53)	Mental Health	(42,722)	(42,537)	(185)	(85,075)
(599)	(624)	25	Public Health	(3,983)	(4,011)	28	(7,753)
(12,303)	(11,273)	(1,030)	Disability Support	(69,887)	(67,201)	(2,686)	(133,736)
(148)	(153)	5	Maori Health	(882)	(916)	34	(1,833)
(725)	(725)	0	Other	(4,353)	(4,353)	0	(8,784)
(70,768)	(69,329)	(1,439)	Expenses	(419,985)	(415,626)	(4,359)	(825,966)

Summary Comment:

For December the Funder had a deficit of $1.37m against a budget close to breakeven. Revenue was favourable by $0.06m and has cost offset. Costs overall were unfavourable by $1.44m in December and $4.4m year to date (YTD) with some revenue offsets.

Unfavourable Aged Residential Care Rest Homes $0.8m makes up most of the unfavourable expense variance in the month. The updated Pharmac forecast for 2014/15 has been utilised. The forecast has not been updated for dispensing fees. Although the Pharmac forecast has worsened by $0.6m, the impact on the monthly result is not significant as yet due to timing and lower hospital community pharmacy costs. Utilisation of the forecast remains a significant accrual estimate.

2. Results by Grouping

The following table shows revenue and expenditure by Output Class:

Month				Year to Date		
Actual $' 000	Budget $' 000	Variance $' 000		Actual $' 000	Budget $' 000	Variance $' 000
			Revenue			
60,785	60,834	(48)	Personal Health	365,536	364,998	538
7,048	7,040	9	Mental Health	42,274	42,237	36
660	705	(45)	Public Health	4,205	4,498	(293)
171	32	140	Disability Support	582	191	391
2	0	2	Maori Health	13	0	13
725	725	0	Funding and Governance	4,353	4,353	0
69,392	69,335	58	Revenue total	416,962	416,277	685
			Expenses			
(49,848)	(49,463)	(385)	Personal Health	(298,162)	(296,607)	(1,555)
(7,145)	(7,091)	(54)	Mental Health	(42,722)	(42,537)	(185)
(599)	(624)	25	Public Health	(3,981)	(4,010)	29
(12,302)	(11,272)	(1,030)	Disability Support	(69,888)	(67,199)	(2,689)
(148)	(153)	5	Maori Health	(882)	(916)	34
(725)	(725)	0	Funding and Governance	(4,353)	(4,353)	0
(70,767)	(69,328)	(1,439)	Expenses total	(419,988)	(415,622)	(4,366)
			Surplus (Deficit)			
10,937	11,371	(433)	Personal Health	67,374	68,391	(1,017)
(97)	(51)	(45)	Mental Health	(448)	(300)	(149)
61	81	(20)	Public Health	224	488	(264)
(12,131)	(11,240)	(890)	Disability Support	(69,306)	(67,008)	(2,298)
(146)	(153)	7	Maori Health	(869)	(916)	47
0	0	0	Funding and Governance	0	0	0
(1,375)	7	(1,381)		(3,026)	655	(3,681)

- Personal Health payments are unfavourable for the month by $0.385m. The majority of variance is the $0.25m per month for additional savings budgeted from November 2014. Other variances include Laboratory costs ($0.05m) and Travel and Accommodation $0.1m.
- Labs additional tests remain an estimate as all invoicing has yet to be received.
- Palliative care remained on budget for the month.
- Mental Health and Public Health were close to budget.
- DSS costs were unfavourable for the month, with home support ($0.08m), rest home ($0.8m) and hospital ($0.1m) 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
December 2014	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%
Personal Health - Provider Arm								
Child and Youth	(348)	(348)	0 F	(0%)	(2,091)	(2,091)	0 F	(0%)
Laboratory	-	-	0 F	(0%)	(2)	(2)	0 F	(0%)
Infertility Treatment Services	(92)	(92)	0 F	(0%)	(549)	(549)	0 F	(0%)
Maternity	(42)	(42)	0 F	(0%)	(249)	(249)	0 F	(0%)
Maternity (Tertiary & Secondary)	(1,380)	(1,380)	0 F	(0%)	(8,280)	(8,280)	0 F	(0%)
Pregnancy and Parenting Education	(3)	(3)	0 F	(0%)	(15)	(15)	0 F	(0%)
Neo Natal	(660)	(660)	0 F	(0%)	(3,962)	(3,962)	0 F	(0%)
Sexual Health	(87)	(87)	0 F	(0%)	(522)	(522)	0 F	(0%)
Adolescent Dental Benefit	(26)	(26)	0 F	(0%)	(158)	(158)	0 F	(0%)
Dental - Low Income Adult	(22)	(22)	0 F	(0%)	(134)	(134)	0 F	(0%)
Child (School) Dental Services	(595)	(595)	0 F	(0%)	(3,569)	(3,569)	0 F	(0%)
Secondary / Tertiary Dental	(116)	(116)	0 F	(0%)	(697)	(697)	0 F	(0%)
Pharmaceuticals	(125)	(292)	167 F	(57%)	(1,343)	(1,750)	407 F	(23%)
Pharmaceutical Cancer Treatment Drugs	(261)	(386)	125 F	(32%)	(2,274)	(2,314)	40 F	(2%)
Pharmacy Services	(9)	(9)	0 F	(0%)	(52)	(52)	0 F	(0%)
Primary Health Care Strategy - Health/SIA	-	-	0 F		(103)	-	103 F	
Rural Support for Primary Health Pro	(71)	(71)	0 F	(0%)	(424)	(424)	0 F	(0%)
Immunisation	(70)	(70)	0 F	(0%)	(418)	(418)	0 F	(0%)
Radiology	(268)	(268)	0 F	(0%)	(1,611)	(1,611)	0 F	(0%)
Palliative Care	(7)	(7)	0 F	(0%)	(41)	(41)	0 F	(0%)
Meals on Wheels	(33)	(33)	0 F	(0%)	(201)	(201)	0 F	(0%)
Domicilary & District Nursing	(994)	(994)	0 F	(0%)	(5,966)	(5,966)	0 F	(0%)
Community based Allied Health	(416)	(416)	0 F	(0%)	(2,497)	(2,497)	0 F	(0%)
Chronic Disease Management and Educa	(160)	(160)	0 F	(0%)	(962)	(962)	0 F	(0%)
Medical Inpatients	(5,653)	(5,653)	0 F	(0%)	(33,918)	(33,918)	0 F	(0%)
Medical Outpatients	(3,272)	(3,272)	0 F	(0%)	(19,632)	(19,632)	0 F	(0%)
Surgical Inpatients	(10,628)	(10,628)	0 F	(0%)	(63,769)	(63,769)	0 F	(0%)
Surgical Outpatients	(1,548)	(1,548)	0 F	(0%)	(9,285)	(9,285)	0 F	(0%)
Paediatric Inpatients	(644)	(644)	0 F	(0%)	(3,867)	(3,867)	0 F	(0%)
Paediatric Outpatients	(269)	(269)	0 F	(0%)	(1,613)	(1,613)	0 F	(0%)
Pacific Peoples' Health	(10)	(10)	0 F	(0%)	(59)	(59)	0 F	(0%)
Emergency Services	(1,478)	(1,478)	0 F	(0%)	(8,870)	(8,870)	0 F	(0%)
Minor Personal Health Expenditure	(26)	(26)	0 F	(0%)	(154)	(154)	0 F	(0%)
Price adjusters and Premium	(422)	(422)	0 F	(0%)	(2,531)	(2,531)	0 F	(0%)
Travel & Accomodation	(4)	(4)	0 F	(0%)	(26)	(26)	0 F	(0%)
	(29,739)	**(30,031)**	**292 F**	**1%**	**(179,844)**	**(180,188)**	**550 F**	**0%**
Personal Health NGO								
Personal Health to allocate	-	(83)	83 F	100%	-	(500)	500 F	100%
Child and Youth	(34)	(34)	0 F	(1%)	(207)	(204)	(3) U	(2%)
Laboratory	(1,520)	(1,465)	(55) U	(4%)	(9,280)	(8,789)	(491) U	(6%)
Infertility Treatment Services	-	(9)	9 F	100%	-	(54)	54 F	100%
Maternity	(220)	(220)	0 F	(0%)	(1,333)	(1,322)	(11) U	(1%)
Maternity (Tertiary & Secondary)	(1)	(14)	13 F	95%	(11)	(81)	70 F	87%
Pregnancy and Parenting Education	(13)	(10)	(3) U	(32%)	(58)	(59)	1 F	1%
Sexual Health	(2)	(1)	(1) U	(1%)	(9)	(9)	0 F	(1%)
Adolescent Dental Benefit	(165)	(187)	22 F	12%	(980)	(1,067)	87 F	8%
Dental - Low Income Adult	(54)	(55)	1 F	2%	(357)	(332)	(25) U	(7%)
Child (School) Dental Services	(14)	(35)	21 F	61%	(150)	(213)	63 F	30%
Secondary / Tertiary Dental	(139)	(126)	(13) U	(10%)	(1,109)	(756)	(353) U	(47%)
Pharmaceuticals	(6,602)	(6,434)	(168) U	(3%)	(37,281)	(36,837)	(444) U	(1%)
Pharmaceutical Cancer Treatment Drugs	(17)	-	(17) U	n/m	(17)	-	(17) U	n/m
Pharmacy Services	(67)	(61)	(6) U	(10%)	(290)	(364)	74 F	20%
Management Referred Services	-	250	(250) U	100%	-	500	(500) U	100%
General Medical Subsidy	(35)	(86)	51 F	60%	(462)	(514)	52 F	10%
Primary Practice Services - Capitated	(3,477)	(3,511)	34 F	1%	(21,039)	(21,066)	27 F	(0%)
Primary Health Care Strategy - Care	(323)	(318)	(5) U	(2%)	(1,912)	(1,907)	(5) U	(0%)
Primary Health Care Strategy - Health	(358)	(337)	(21) U	(6%)	(2,006)	(2,020)	14 F	1%
Primary Health Care Strategy - Other	(313)	(255)	(58) U	(23%)	(1,317)	(1,529)	212 F	14%
Practice Nurse Subsidy	(14)	(16)	2 F	17%	(82)	(98)	16 F	16%
Rural Support for Primary Health Pro	(1,305)	(1,313)	8 F	1%	(7,829)	(7,878)	49 F	1%
Immunisation	(104)	(104)	0 F	(0%)	(483)	(648)	165 F	25%
Radiology	(210)	(196)	(14) U	(7%)	(1,207)	(1,176)	(31) U	(3%)
Palliative Care	(501)	(488)	(13) U	(3%)	(3,098)	(2,930)	(168) U	(6%)
Meals on Wheels	(20)	(20)	0 F	(0%)	(120)	(120)	0 F	(0%)
Domicilary & District Nursing	(497)	(435)	(62) U	(14%)	(2,871)	(2,617)	(254) U	(10%)
Community based Allied Health	(168)	(168)	0 F	(0%)	(1,010)	(1,005)	(5) U	(0%)
Chronic Disease Management and Educa	(166)	(95)	(71) U	(75%)	(616)	(570)	(46) U	(8%)
Medical Outpatients	(428)	(397)	(31) U	(8%)	(2,509)	(2,384)	(125) U	(5%)
Surgical Inpatients	(2)	(19)	17 F	88%	(91)	(112)	21 F	19%
Surgical Outpatients	(139)	(146)	7 F	5%	(834)	(878)	44 F	5%
Paediatric Outpatients	(7)	-	(7) U	n/m	(7)	-	(7) U	n/m
Pacific Peoples' Health	(8)	(12)	4 F	36%	(53)	(70)	17 F	25%
Emergency Services	(159)	(156)	(3) U	(2%)	(981)	(933)	(48) U	(5%)
Minor Personal Health Expenditure	(39)	(74)	35 F	47%	(387)	(443)	56 F	13%
Price adjusters and Premium	(211)	(83)	(128) U	(153%)	(981)	(501)	(480) U	(96%)
Travel & Accomodation	(426)	(322)	(104) U	(33%)	(2,693)	(2,539)	(154) U	(6%)
Inter District Flow Personal Health	(2,353)	(2,399)	46 F	2%	(14,645)	(14,394)	(251) U	(2%)
	(20,111)	**(19,434)**	**(677) U**	**(3%)**	**(118,315)**	**(116,419)**	**(1,896) U**	**(2%)**
Total Personal Health	**(49,850)**	**(49,465)**	**(385) U**	**(1%)**	**(298,159)**	**(296,607)**	**(1,346) U**	**(0%)**

Costs for personal health were ahead of budget for December by $0.38m with additional Lab costs for send away and other unbudgeted tests $0.05m, the $0.25m per month for additional savings budgeted from November 2014 and Travel and Accommodation $0.1m. The adverse travel and accommodation cost is being reviewed as this line had returned to be close to budget in recent months.

Mental Health

	Current Month				Year to Date			
Mental Health	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance
December 2014	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%
Mental Health - Provider Arm								
Mental Health to allocate	9	9	0 F	(0%)	57	57	0 F	(0%)
Acute Mental Health Inpatients	(1,143)	(1,143)	0 F	(0%)	(6,860)	(6,860)	0 F	(0%)
Sub-Acute & Long Term Mental Health	(304)	(304)	0 F	(0%)	(1,823)	(1,823)	0 F	(0%)
Crisis Respite	(2)	(2)	0 F	(0%)	(13)	(13)	0 F	(0%)
Alcohol & Other Drugs - General	(272)	(272)	0 F	(0%)	(1,634)	(1,634)	0 F	(0%)
Methadone	(94)	(94)	0 F	(0%)	(566)	(566)	0 F	(0%)
Dual Diagnosis - Alcohol & Other Drugs	(8)	(8)	0 F	(0%)	(51)	(51)	0 F	(0%)
Dual Diagnosis - MH/ID	(5)	(5)	0 F	(0%)	(30)	(30)	0 F	(0%)
Child & Youth Mental Health Services	(579)	(579)	0 F	(0%)	(3,472)	(3,472)	0 F	(0%)
Forensic Services	(509)	(509)	0 F	(0%)	(3,055)	(3,055)	0 F	(0%)
Kaupapa Maori Mental Health Services	(146)	(146)	0 F	(0%)	(877)	(877)	0 F	(0%)
Mental Health Community Services	(1,752)	(1,752)	0 F	(0%)	(10,510)	(10,510)	0 F	(0%)
Prison/Court Liaison	(45)	(45)	0 F	(0%)	(267)	(267)	0 F	(0%)
Day Activity & Work Rehabilitation S	(63)	(63)	0 F	(0%)	(379)	(379)	0 F	(0%)
Mental Health Funded Services for Older P	(36)	(36)	0 F	(0%)	(214)	(214)	0 F	(0%)
Advocacy / Peer Support - Consumer	(35)	(35)	0 F	(0%)	(208)	(208)	0 F	(0%)
Other Home Based Residential Support	(58)	(58)	0 F	(0%)	(348)	(348)	0 F	(0%)
	(5,042)	**(5,042)**	0 F		**(30,250)**	**(30,250)**	0 F	
Mental Health - NGO								
Mental Health to allocate	-	(38)	38 F	100%	-	(228)	228 F	100%
Crisis Respite	(8)	(5)	(3) U	(70%)	(31)	(28)	(3) U	(13%)
Alcohol & Other Drugs - General	(55)	(55)	0 F	(0%)	(328)	(328)	0 F	(0%)
Alcohol & Other Drugs - Child & Youth	(102)	(102)	0 F	(0%)	(612)	(612)	0 F	(0%)
Dual Diagnosis - Alcohol & Other Drugs	(37)	(36)	(1) U	(1%)	(215)	(217)	2 F	1%
Eating Disorder	(30)	(16)	(14) U	(85%)	(90)	(96)	6 F	6%
Maternal Mental Health	(4)	(4)	0 F	(0%)	(22)	(22)	0 F	(0%)
Child & Youth Mental Health Services	(310)	(241)	(69) U	(28%)	(1,765)	(1,448)	(317) U	(22%)
Forensic Services	(4)	(4)	0 F	(0%)	(22)	(22)	0 F	(0%)
Kaupapa Maori Mental Health Services	(6)	(6)	0 F	(0%)	(37)	(37)	0 F	(0%)
Mental Health Community Services	(116)	(127)	11 F	8%	(720)	(759)	39 F	5%
Day Activity & Work Rehabilitation S	(136)	(136)	0 F	(0%)	(818)	(818)	0 F	(0%)
Advocacy / Peer Support - Consumer	(23)	(23)	0 F	(0%)	(139)	(140)	1 F	(0%)
Other Home Based Residential Support	(319)	(315)	(4) U	(1%)	(2,045)	(1,891)	(154) U	(8%)
Advocacy / Peer Support - Families	(52)	(52)	0 F	(0%)	(314)	(314)	0 F	(0%)
Community Residential Beds & Service	(471)	(457)	(14) U	(3%)	(2,708)	(2,739)	31 F	1%
Minor Mental Health Expenditure	(27)	(32)	5 F	15%	(189)	(191)	2 F	1%
Inter District Flow Mental Health	(403)	(399)	(4) U	(1%)	(2,416)	(2,396)	(20) U	(1%)
	(2,103)	**(2,048)**	**(55) U**	**(3%)**	**(12,471)**	**(12,286)**	**(185) U**	**(2%)**
Total Mental Health	**(7,145)**	**(7,090)**	**(55) U**	**(1%)**	**(42,721)**	**(42,536)**	**(185) 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 December.

Disability Support Services

	Current Month				Year to Date			
DSS	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance
December 2014	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%
Disability Support Services - Provider Arm								
AT & R (Assessment, Treatment and Re	(1,688)	(1,688)	-	(0%)	(10,130)	(10,130)	-	(0%)
Needs Assessment	(138)	(138)	-	(0%)	(828)	(828)	-	(0%)
Service Co-ordination	(19)	(19)	-	(0%)	(117)	(117)	-	(0%)
Long Term Chronic Conditions	(8)	(8)	-	(0%)	(48)	(48)	-	(0%)
Ageing in Place	(2)	(2)	-	(0%)	(15)	(15)	-	(0%)
Environmental Support Services	(2)	(2)	-	(0%)	(13)	(13)	-	(0%)
Minor Disability Support Expenditure	(8)	(8)	-	(0%)	(50)	(50)	-	(0%)
Community Health Services & Support	(21)	(21)	-	(0%)	(126)	(126)	-	(0%)
	(1,886)	**(1,886)**	-	(0%)	**(11,327)**	**(11,327)**	-	(0%)
Disability Support Services - NGO								
AT & R (Assessment, Treatment and Re	(297)	(297)	-	(0%)	(1,785)	(1,785)	-	(0%)
Information and Advisory	(12)	(12)	-	(0%)	(71)	(71)	-	(0%)
Needs Assessment	(31)	(22)	(9) U	(43%)	(271)	(130)	(141) U	109%
Service Co-ordination	-	-	-	n/m	(9)	-	(9) U	n/m
Home Support	(1,501)	(1,423)	(78) U	(6%)	(9,253)	(8,535)	(718) U	(8%)
Carer Support	(135)	(144)	9 F	7%	(817)	(865)	48 F	6%
Residential Care: Rest Homes	(3,797)	(2,995)	(802) U	(27%)	(19,977)	(17,780)	(2,197) U	(12%)
Residential Care: Loans Adjustment	19	23	(4) U	(14%)	91	136	(45) U	(33%)
Residential Care: Hospitals	(4,053)	(3,944)	(108) U	(3%)	(23,031)	(23,398)	367 F	2%
Environmental Support Services	(104)	(108)	4 F	4%	(603)	(646)	43 F	7%
Day Programmes	(38)	(45)	7 F	16%	(209)	(277)	68 F	25%
Minor Disability Support Expenditure	-	(9)	9 F	100%	-	(55)	55 F	100%
Respite Care	(125)	(95)	(30) U	(31%)	(819)	(571)	(248) U	(43%)
Community Health Services & Support	(64)	(60)	(4) U	(8%)	(232)	(357)	125 F	35%
Inter District Flow Disability Support	(280)	(256)	(24) U	(9%)	(1,575)	(1,538)	(37) U	(2%)
	(10,418)	**(9,387)**	**(1,030) U**	**(11%)**	**(58,561)**	**(55,872)**	**(2,689)**	**(5%)**
Total Disability Support Services	**(12,304)**	**(11,273)**	**(1,030) U**	**(9%)**	**(69,888)**	**(67,199)**	**(2,689) U**	**(4%)**

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

NGO costs are unfavourable in the month by $1.0m, with home support ($0.08m), rest home ($0.8m) and hospital ($0.1m) all adverse. Residential care hospitals is being reviewed against new date of service data to determine possible trend, as this had previously been a positive variance, and remains so year to date. The rest home variance is $2.2m year to date.

The significant rest home variance for the month is a combination of catch up in accruals year to date based on date of service information($793k YTD); the ongoing variance of $111k per month for the 5% price increase covered by revenue received; a new price variance related to the apparent difference between net cost of the price increase to SDHB and the revenue received of an estimated $52k per month, with 3 month catch up accrual of $156k all being recognised in the month; budget setting error relating to long term conditions, where the prior year budget rather than actuals was used; and an increase in the volume of activity largely due to the opening of additional dementia beds in the district. A forecast of likely ongoing monthly variance is being developed.

Public Health

	Current Month				Year to Date			
Public Health	**Actual**	**Budget**	**Variance**	**Variance**	**Actual**	**Budget**	**Variance**	**Variance**
December 2014	**$(000)**	**$(000)**	**$(000)**	**%**	**$(000)**	**$(000)**	**$(000)**	**%**
Public Health - Provider Arm								
Alcohol & Drug	(36)	(36)	0 F	(0%)	(215)	(215)	0 F	(0%)
Communicable Diseases	(97)	(97)	0 F	(0%)	(582)	(582)	0 F	(0%)
Injury Prevention	-	-	0 F		-	-	0 F	
Mental Health	(22)	(22)	0 F	(0%)	(133)	(133)	0 F	(0%)
Screening Programmes	(121)	(112)	(10) U	9%	(922)	(939)	17 F	(2%)
Nutrition and Physical Activity	(23)	(23)	0 F	(0%)	(136)	(136)	0 F	(0%)
Physical Environment	(36)	(36)	0 F	(0%)	(216)	(216)	0 F	(0%)
Public Health Infrastructure	(128)	(128)	0 F	(0%)	(766)	(766)	0 F	(0%)
Sexual Health	(12)	(12)	0 F	(0%)	(72)	(72)	0 F	(0%)
Social Environments	(38)	(38)	0 F	(0%)	(227)	(227)	0 F	(0%)
Tobacco Control	(81)	(81)	0 F	(0%)	(489)	(489)	0 F	(0%)
	(594)	**(585)**	**(10) U**	**(2%)**	**(3,758)**	**(3,775)**	**17 F**	**0%**
Public Health - NGO								
Nutrition and Physical Activity	(26)	(27)	1 F	4%	(154)	(161)	7 F	4%
Physical Environment	-	-	-	n/m	-	-	-	n/m
Public Health Infrastructure	-	-	-	n/m	-	-	-	n/m
Sexual Health	-	-	-	n/m	-	-	-	n/m
Social Environments	-	-	-	n/m	-	-	-	n/m
Tobacco Control	21	(12)	33 F	269%	(71)	(75)	4 F	6%
Well Child Promotion	**-**	**-**	-	**n/m**	**-**	**-**	-	**n/m**
	(5)	**(39)**	**34 F**	**87%**	**(225)**	**(236)**	**11 F**	**5%**
Total Public Health	**(599)**	**(624)**	**24 F**	**4%**	**(3,983)**	**(4,011)**	**28 F**	**1%**

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 December to Personal Health, under Child and Youth, where these costs were budgeted, and reversal of prior accruals.

SOUTHERN DISTRICT HEALTH BOARD

Title:	Progress on Delivering Priorities and Targets - DHB Annual Plan 2014/15
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	4 February 2015

Summary:

This report shows the progress in Quarter Two on delivering on the plans, actions and commitments in the Southern DHB 2014/15 Annual Plan. It highlights completed actions and achievements. Where activity is still to be completed, a brief narrative is provided on planned action and any issues affecting delivery and potentially impacting on the timing or ability to complete.

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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:		Date:

Prepared by: Planning & Funding Date: 28.01.2015	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

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

Quarter Two - Progress Report

Planning & Funding

DELIVERING ON PRIORITIES AND TARGETS

PROGRESS ON THE ANNUAL PLAN 2014/15

This template outlines how Planning and Funding is to monitor progress on delivering on the plans, actions and commitments in the Southern DHB 2014/15 Annual Plan.

A report will be produced at the end of each quarter that will contain an indication of progress against plan, and where necessary a brief narrative if activity is behind plan. This will highlight achievements and also flag any issues affecting delivery and potentially impacting on the timing or ability to complete.

CONTENTS

1 Immunisation

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Immunisation					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
1.1 Immunisation	1.1.1 Continue the Southern DHB Vaccine Preventable Disease (VPD) Steering Group	VPD Steering Group meets 3 times per year		●	
	1.1.2 All babies entered onto NIR are followed up to ensure a Practice of Enrolment			●	
	1.1.3 NIR contact General Practice regarding any babies not 'Accepted' for Enrolment´	% of babies enrolled at 3 months of age		●	
	1.1.4 Monthly internal audit of babies about to reach 8 Month target to ensure correct data entry, assess 'Decline' rate	Monthly review of Datamart Reports to regularly measure coverage		●	
	1.1.5 'Week day' review of Inpatient and weekly review of Outpatient Birth Cohort children to identify unvaccinated children. Where clinically appropriate, immunisations are delivered by paediatric nurses			●	
	1.1.6 Maintain positive working relationships between VPD Team; especially the Immunisation Coordinators with NGOs and introductory visits with government agencies.			●	
	1.1.7 Maintain active involvement with locality based Well Child Groups and Southern DHB Well Child Forum			●	
	1.1.8 Maternity providers/LMCs provide birth notification to NIR to a check list on registration			●	
	1.1.9 Regular 'as needed' communication with General Practice to ensure early engagement	% of new-born registered with a GP		●	
1.2 Rheumatic Fever	1.2.1 The Public Health Unit will undertake a review of each new identified case involving rheumatic fever	Report to Ministry of Health on actions taken and lessons learned		○	No cases reported this quarter
	1.2.2 Multi-stakeholder review of the implementation of rheumatic fever prevention and management plan	Multi-stakeholder meeting(s) held	Q4	●	
	1.2.3 Implement the South Island Rheumatic Fever Prevention Plan	All members of the Public Health partnership provide a surveillance function for rheumatic fever	Q2,Q4	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

2 Vulnerable Children and the Children´s Action Plan

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Vulnerable Children and the Children´s Action Plan					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
2.1 Reducing Assaults on Children	2.1.1 Maintain performance of current VIP programme	Conduct an independent Self audit of Southern DHB VIP using the AUT VIP audit tool		●	
		Participate in the AUT snapshot audit of children's and maternity wards	Q1	●	
	2.1.2 Inclusion of VIP in Southern DHB Orientation and clinical staff mandatory training days			●	
	2.1.3 Provide Ministry-accredited training for health professionals to recognise signs of abuse and maltreatment in designated services	Stock take to establish health professional VIP training levels in designated areas Q4		●	
	2.1.4 Implement the Child Injury Flow chart in the Emergency Departments (ED)	Child Injury Flow chart available in ED	Q3	●	
2.2 Implementing the Children's Action Plan	2.2.1 Recently established Child and Youth Steering Group to guide implementation of the Children´s Action Plan (CAP)	CAP is a standing agenda item on bi-monthly C&Y Steering Group meetings		●	
	2.2.2 Support pregnant women with complex needs through the establishment of a pilot site for the national Maternity Care Wellbeing and Child Protection Interagency groups	Work closely with the national VIP manager and the Office of the Privacy Commissioner in establishing pilot	Q4	●	
	2.2.3 Gateway Health Assessments for children referred from Child, Youth and Family strengthening interagency collaboration and access for children and young people to improved health and educational support	100% of Gateway Assessments for children aged 0-4 years completed within 4 weeks; aged over 5 years completed within 6 weeks		●	
	2.2.4 Establish weekly patient focused multi-disciplinary meetings (Mental health & addictions, Paediatrics, Ministry of Education and other providers as required)			●	
	2.2.5 Introduce a standard screening tool to identify parental status of mental health and addiction community clients	Screening tool implemented	Q3	●	
2.3 Child Protection	2.3.1 Implement the National Child Protection Alert System (NCPAS)	Implement NCPAS by June 2015	Q4	●	
	2.3.2 Develop a process to monitor the application and implementation of loading alerts into NCPAS	Policy on the application, use and removal of national child protection alert system (NCPAS) endorsed by DHB		●	
		Standardised documentation is in use		●	
	2.3.3 Collaborate with other agencies to plan, test and monitor assessment processes to support early response systems, assessment processes and delivery of coordinated services for vulnerable children	Establish protocols for NCPAS implementation by June 2015	Q4	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

3 Prime Minister's Youth Mental Health Project

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Prime Minister's Youth Mental Health Project					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
3.1 Primary Care Services for Youth	3.1.1 Establish a youth services Service Level Alliance Team (SLAT)	Youth services SLAT established	Q1	●	
	3.1.2 Review and update existing youth services stock take information	Youth services stocktake update	Q2	●	To be directed by the Youth SLAT once the SLAT is established
		Identify potential service issues - gaps and duplication	Q3	●	
	3.1.3 Develop a Youth Services SLAT action plan	Youth Services SLAT action plan developed	Q4	●	
	3.1.4 Continue HEADSSS assessments to vulnerable youth in Decile 1-3 schools, teen parent units and alternative education	-		●	HEADSSS assessments are provided with the exception of the te Wharekura O Arowhenua and decile 1a schools. The service is working to improve the relationship with the Kura and in 2015 services will recommence with help from the Māori Health directorate. The service is working to identify how resources can be best aligned to include the coverage of decile 1A schools
3.2 Youth Mental Health & Addiction	3.2.1 New district-wide services established as part of the Southern DHB youth exemplar initiative	Agreed protocols in place to deliver follow-up care plans to primary care providers	Q1	●	
		Link youth exemplar initiative into the Youth Services SLAT		●	Will be linked once Youth SLAT established
	3.2.2 Provide increased access to Youth Mental Health and AOD services in North Otago and Southland utilising new capacity provided by the youth exemplar initiative	Youth exemplar initiative delivering services in North Otago	Q1	●	
		Youth exemplar initiative delivering services in Southland	Q1	●	Youth Exemplar service currently consulting with wider Southland sector re appropriate Southland based initiatives
	3.2.3 Review transfer of care between CAFS and YSS secondary and primary and NGO services with a focus of ensuring safe transfer of care between providers	Review current processes	Q1	●	
		Trial a process of follow up calls with the primary provider to encourage prompt follow up	Q2	●	
		Trial a process of follow up calls with the patient/carer to ensure follow up by the primary service has commenced	Q2	●	
	3.2.4 Introduce a navigator role to support Pacific People around mental health and addiction services	Navigator commences in Invercargill	Q1	●	
		Navigator supports cultural assessments for MHA clients		●	
3.3 Social Sector Trials	3.3.1 Develop and implement a health promotion package	Health promotion package implemented	Q2	●	Now scheduled for Q3/4
	3.3.2 Develop and pilot a community resources "whanau pack"	Pilot completed	Q2	●	
		Completion of three campaigns aimed at parents by Dec 15		●	
	3.3.3 Utilising a multi–agency planning group develop a package of education initiatives	Development and implement plan for rolling out package	Q2	●	Now scheduled for Q3/4
	3.3.4 Develop an AOD clinical pathway	Youth AOD Pathway implemented	Q2	●	Awaiting implementation of WellSouth (PHN) new IT system in Q3
	3.3.5 Youth provider network to lead the development of an integrated referral processes	Integrated referral process implemented	Q4	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

4 Whānau Ora

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Whānau Ora					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
4.1 Developing Mature Providers	4.1.1 Improved access to primary health care services, more comprehensive whānau centred assessments by Kaiāwhina/navigators* and practitioners (identifying and responding to chronic conditions that previously wouldn´t have been picked up)	% of whānau accessing primary care services	Q4	●	
	4.1.2 Develop a referral pathway to navigators around follow-up support for Māori patients transitioning from hospital to home	Number of referrals to navigators	Q3	●	
	4.1.3 Support where possible career pathways and professional development for navigators	Number of Māori workforce enrol into tertiary education		●	
4.2 Supporting Strategic Planning	4.2.1 Model an integrated approach through relationship, back room support, best practice and delivery of services that respond to whānau needs (Iwi Governance, Management Advisory Group Māori Health, Māori Provider/Whānau Ora Collective participation	Māori Provider/Whānau Ora Collective develop a strategic or operational plan	Q2	●	
	4.2.2 Establish a Māori provider forum to progress Whānau Ora initiatives	Māori provider forum established	Q1	●	
	4.2.3 Develop a working relationship with South Island Whānau Ora Commissioning Agency Te Puhahitanga o Te Waipōunamu	Meeting attendance and participation	Q1	●	Meeting with Te Puhahitanga o Te Waipōunamu in November was rescheduled then cancelled. From the Te Herenga meeting discussion, we intend to continue focusing on the health determinants and acknowledged the impact social determinants have on Māori. However, we can support and influence the direction as it achieves Māori health outcomes. New invite is to be sent out to the CEO of Te Puhahitanga.
4.3 Provider Development	4.3.1 Work alongside Māori Providers and Whānau Ora Collectives to support initiatives	Number of hui to support initiatives		●	
	4.3.2 Building on existing service approaches by supporting navigators to reduce barriers to access by linking whānau into clinics and services that best respond to their needs (Tamariki Ora checks, general health checks, CVD and diabetes risk assessments)	% of whānau that have received health checks	Q3	●	
	4.3.3 Support Māori Providers and Whānau Ora Collectives in the establishment of Nurse-Led Clinics within designated rural high need areas	Number of Māori Providers with nurse-led clinics established in rural high needs areas	Q1	●	
		Number of whānau engaged in nurse-led clinics in rural high needs areas		●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

5 Improved Access to Diagnostics

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Improved Access to Diagnostics					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
5.1 Community Referred Diagnostic Imaging	5.1.1 Continue development of clinical pathways that facilitate or improve quality of direct access to plain film x-rays and ultrasound	Implement Community Acquired Pneumonia (CAP) pathway with clear criteria for urgent same day chest x-ray			
	5.1.2 Implement the Community and Primary Radiology Referral Guidelines once released	Develop and implement radiology e-referral (ERMS) templates with criteria			Being released my MOH
	5.1.3 Participate in the development and implementation of the National Patient Flow System	Submit data to the collection as required	Q1		
	5.1.4 Work with regional (South Island) and national clinical groups to contribute to the development of improvement programmes				
5.2 High Tech Imaging	5.2.1 Establish a district diagnostic imaging service delivery model that maximises utilisation of current resources	New service model established	Q4		
		Increase MRI scanner operational time to 12 hours per day	Q1		Commenced in January 2015.
	5.2.2 Develop a workforce and recruitment strategy for SMOs and other key roles to support diagnostic imaging service model	Workforce and recruitment strategy developed	Q2		
	5.2.3 Workshops to educate and raise awareness of appropriateness and over-use of imaging	Workshops completed	Q2		
	5.2.4 Implement new single IT platform with radiology information system (RIS) and Pictorial Archiving Computer System (PACS) applications	RIS and PACS implemented	Q3		
5.3 Cardiac Diagnostics	5.3.1 Commit to maintain performance of coronary angiography service	90% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)			
	5.3.2 Improve the data capture across multiple sites for echocardiograms exercise tolerance tests	Establish the baseline for performance	Q2		Working through issues – no clear way to capture data. Continuing to progress.
		Identify issues and set up quality improvement initiatives to achieve targets	Q4		

Completed Underway according to plan Behind plan Scheduled for Q3 or Q4

6 More Heart and Diabetes Checks

Progress on Delivering on Priorities and Targets: Annual Plan Actions

More Heart and Diabetes Checks					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
6.1 Identification	6.1.1 Increase the utilisation of existing IT software tools (BPI and Dr Info) to increase the number of patients at being risk identified and assessed	90% of practices utilising BPI or Dr Info	Q2	●	
	6.1.2 Practices utilise DRINFO to establish list of patients sorted by low, med, high and very high CVD risk for follow-up as appropriate			●	
	6.1.3 PHO establish a database to identify patients at risk of developing a long term condition and stratify enrolled service users (ESU) at practice and PHO level	Risk stratification database implemented	Q3	●	This remains a priority in the new IT environment. Note IT changeover was at 1 January 2015.
6.2 Management	6.2.1 Long Term Conditions Quality Improvement Teams established to improve long term conditions (particularly CVD and diabetes) services within general practice	Long Term Conditions Quality Improvement Teams established	Q1	●	
	6.2.2 Individualised practice reports with progress and achievement against CVDRA provided monthly	80% of practices receive monthly reports	Q2	●	
6.3 Enablers	6.3.1 Employ GP and nurse clinical champions to provide guidance to practices and other providers			●	
	6.3.2 Roll out of MoH sponsored online health toolkit providing advice, guidance and resources	Toolkit available to practices	Q2	●	
	6.3.3 DRINFO train the trainer sessions provided through visiting practices	Number of practice staff trained to use DRINFO		●	
	6.3.4 DHB funding for CVDRA and PHO Performance Programme funding will be used to support CVDRA achievement	Electronic decision support tools (DRINFO & BPI) are available for general practice	Q1	●	
	6.3.5 Maintain on-going CME programme for Cardiovascular Risk Assessment			●	

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● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

7 Diabetes and Long Term Conditions

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Diabetes and Long Term Conditions					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
7.1 Prevention & Identification	7.1.1 Develop a Green Prescription pathway	Green Prescription pathway implemented	Q1	●	
	7.1.2 Increase the utilisation of existing IT software tools (BPI and Dr Info) to increase the number of patients at being risk identified and assessed	90% of practices utilising BPI or Dr Info	Q2	●	
	7.1.3 PHO establish a database to identify patients at risk of developing a long term condition and stratify enrolled service users (ESU) at practice and PHO level	Risk stratification database implemented	Q3	●	This remains a priority in the new IT environment. Note IT changeover was at 1 January 2015.
	7.1.4 PHO and DHB share information to identify high health users for inclusion in the PHO Integrated Primary Care (IPC) Programme			●	
7.2 Management	7.2.1 Continue implementation of the Diabetes Care Improvement Package (DCIP)	80% of eligible people complete DCIP		●	This remains a priority in the new IT environment. Note IT changeover was at 1 January 2015.
	7.2.2 Increase the capacity and capability in primary care through referrals to funded services, e.g. podiatry, dietetics, green prescriptions and specialist nursing services	Podiatry and dietetics services available from utilisation of Budget 2013 funding of $197k pa		●	There has been a recent stocktake of all podiatry providers within the Southern District. This will inform SDHB of any gaps in podiatry services
		Number of referrals to accredited providers		●	
		DCIP pathways developed	Q1	●	
	7.2.3 Establishment in areas of high need multi-disciplinary teams (MDT) - clinical pharmacists, dieticians, podiatrist and specialist long-term conditions nurses - to support management of LTCs	MDT established in Mataura and Invercargill	Q1	●	
		MDT established in Otago	Q4	●	
	7.2.4 Review the DCIP including the parameters of the diabetes HBA1c management indicators, incentive model and reporting system	DCIP review completed	Q3	●	
7.3 Enablers	7.3.1 Employ GP and nurse clinical champions to provide guidance to practices and other providers			●	
	7.3.2 Roll out of MoH sponsored online health toolkit providing advice, guidance and resources	Toolkit available to practices	Q2	●	
	7.3.3 Implement GP CME and Practice Nurse education in support of identification, assessment and management of patients with diabetes and pre-diabetes	CME available	Q2	●	
	7.3.4 Develop a long-term conditions strategy that incorporates care in all settings	Strategy adopted by DHB and PHO	Q4	●	
	7.3.5 PHO to run regular meetings & workshops to connect practices with other community providers including Maori and Pacific health groups			●	
	7.3.6 Investigate IT solutions to integrate the work undertaken by clinicians working outside of general practice with general practice	Options identified	Q4	●	Developing a community CVDRA tool for other health providers to use that feeds information back in to General Practices.

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

8 Cardiac Services

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Cardiac Services					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
8.1 Acute Coronary Syndrome (ACS)	8.1.1 Phased introduction of Common Accelerated Chest Pain Pathways (ACCPs) in emergency departments (localised from the regionally developed pathway)	ACCP is developed and implemented	Q4	🟡	
	8.1.2 Heart failure pathway is developed to assist management in the community and reduce acute admissions/readmissions	Heart failure pathway implemented	Q1	🟢	
	8.1.3 Complete implementation of ANZAC QI and Dendrite databases (including staff training)	Reporting to ANZACS	Q1	🟢	
		Staff are trained	Q1	🟢	
		Verify data and report accuracy	Q3	🟡	
	8.1.4 Use data from ANZAC QI to review equity in access for rural patients and establish levels of compliance to high risk ACS patients			🟡	
8.2 Cardiac Surgery	8.2.1 As a cardiac surgery provider, sustain performance against cardiac surgery waiting list expectations	≥170 cardiac surgery discharges delivered	Q4	🟢	
	8.2.2 Monitor ESPIs and intervention rates to ensure equity of access and continued compliance with wait times	No patient waits more than 5 months for FSA or treatment during 2014, and no more than 4 months from January 2015		🟡	
		Cardiac surgery intervention rates (per 10,000) are achieved; Cardiac Surgery 6.5; Coronary Angiography 34.7; Percutaneous revascularisation 12.5		🟡	
	8.2.3 Maintain consistency of clinical prioritisation for cardiac surgery patients, by using the national cardiac CPAC tool, and treating patients in accordance with assigned priority and urgency timeframe			🟡	
8.3 Work with the South Island Cardiac Alliance Work stream and National Cardiac Network	8.3.1 Continue implementation of regionally agreed protocols and pathways for patients with Acute Coronary Syndrome (ACS) to ensure prompt risk stratification, stabilisation and appropriate transfer of ACS patients			🟡	
	8.3.2 Continue participation in the provision and collection of data for the national Cardiac (ANZACS QI) and Cath/PCI Registers to enable monitoring of intervention rates and quality of service delivery			🟡	
	8.3.3 Support development of a regional Common Accelerated Acute Chest Pathway and Percutaneous Coronary Intervention Pathway			🟡	
	8.3.4 Support a regional approach to the storage/sharing of ECGs			🔴	Awaiting capital plan approval
	8.3.5 Support development of a regional approach to cardiology nurse training through the Regional Training Hub			🔴	To be followed up

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

9 Stroke Services

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Stroke Services					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
9.1 Stroke Services Clinical Leadership	9.1.1 SDHB multi-disciplinary Stroke Governance Group continues the lead in development of stroke services across the DHB	Stroke Governance Group meets monthly		●	
		Stroke Governance Group supports education and staff development		●	
	9.1.2 Nursing and medical stroke leaders at each DHB hospital	Allied Health stroke leaders appointed	Q2	●	
9.2 Hyper Acute Stroke	9.2.1 Maintain stroke thrombolysis service across the district	24/7 stroke thrombolysis service at Dunedin Hospital including providing backup for district		●	
		24/7 stroke thrombolysis service at Oamaru Hospital		●	
		8am-10pm stroke thrombolysis service at Invercargill Hospital		●	
	9.2.2 Establish stroke thrombolysis service at Dunstan Hospital	Staff education plan in place	Q2	●	Main issue is concern from medical staff at Dunstan Hospital as to the efficacy of stroke thrombolysis. Lead stroke physician and SDHB stroke governance team are working with the Dunstan team to address these concerns. Education session completed
	9.2.3 All stroke thrombolysis services use agreed thrombolysis pathway and audit tool	All thrombolysis patients are audited		●	
	9.2.4 Ongoing training and education on the management of TIA and thrombolysis			●	
9.3 Acute Stroke	9.3.1 DHB wide use an evidence based acute stroke pathway, guidelines and audit tool	All hospitals use a dedicated acute stroke pathway		●	
		All hospitals begin rehabilitation at the time of admission to acute service to provide improved patient outcomes		●	
	9.3.2 DHB maintain dedicated acute stroke inpatient beds at Dunedin and Invercargill Hospitals			●	
	9.3.3 Establish nurse lead swallow screening	Established in Dunedin Stroke Unit	Q2	●	This target is behind schedule, but allied health and nursing leadership now working together on plan to have this completed and embedded by end of Qtr4
		Established across district	Q4	●	Establishment on track on Southland site
	9.3.4 Participate in the national acute stroke audit			●	
9.4 TIA Services	9.4.1 Develop stroke and TIA pathways for primary care (HealthPathways) which includes fast tracking to the vascular surgery team for carotid endarterectomy	Stroke pathway for primary care available on HealthPathways	Q3	●	
		TIA pathway for primary care available on HealthPathways	Q4	●	
	9.4.2 Outpatient TIA clinics are offered in Dunedin and Invercargill			●	
9.5 Stroke Rehabilitation	9.5.1 Review and monitor implementation of stroke pathways across ED, medical wards, rural hospitals and stroke units			●	Not yet started outside of ASU in Dunedin and stroke rehabilitation in Dunedin, Wakari and Invercargill
	9.5.2 Interdisciplinary team assesses all patients in stroke unit for rehabilitation	Proportion of people with acute stroke who are transferred to in-patient rehabilitation service		●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

Stroke Services					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
		60% of people with acute stroke are transferred to in-patient rehabilitation service and are transferred within 10 days of acute stroke admission.		●	
	9.5.3 Establish sustainable community based rehabilitation services	Establishment commenced	Q4	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

10 Shorter Stays in Emergency Departments

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Shorter Stays in Emergency Departments					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
10.1 Emergency Departments	10.1.1 Implement ED Suite of Quality Measures	All continuously (C) monitored measures	Q2	●	
		All regularly (R) reported measures	Q4	●	
	10.1.2 Provide targeted data to speciality services to increase visibility of issues and potential solutions	New reporting implemented	Q3	●	
	10.1.3 Review and standardise reporting across the District; daily reporting of breaches, and weekly analysis of breach information	Agree new suite of standardised reporting measures	Q1	●	
		Agree standardised trend analysis for dissemination	Q2	●	Daily information disseminated
	10.1.4 Examine potential to reconfigure models of care within the ED	Complete scoping work	Q2	●	
	10.1.5 Phased introduction of Accelerated Chest Pain Pathways (ACCPs) in emergency departments	ACCP is developed and implemented		●	
	10.1.6 Review ED clinical staffing models and numbers in Dunedin and Invercargill to ensure appropriate staffing	Review completed	Q2	●	
		Review implemented	Q4	●	
	10.1.7 Alignment of senior nursing roles in Dunedin and Invercargill	Role alignment completed	Q2	●	Regional senior nurse scoping underway. CNS roles are more closely aligned.
	10.1.8 Continue implementation of rapid rounds to prompt earlier discharge and free up beds	All medical areas to be undertaking daily rapid rounds	Q4	●	
	10.1.9 Explore opportunities for an automated delivery system for laboratory results in Invercargill to improve turnaround times	Options are identified	Q1	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

11 Acute Care and Demand

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Acute Care and Demand					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
11.1 Sustainable After-Hours Services	11.1.1 Promote general practice uptake of phone triage for after-hours services	75% of general practices utilising phone triage services		●	
	1.1.1 SPHO to utilise data on ED attendances to assist practices in providing a more responsive service	Identify frequent attenders to ED		●	SDHB to provide ED information as requested by WellSouth.
		Patients able to access primary care as required		●	WellSouth introduced voucher system to enable access to primary care.
	11.1.2 DHB and PHO to continue exploring opportunities for improved access to out-of-hours primary care coverage in Invercargill	Assess feasibility of nurse led clinics	Q1	●	WellSouth's proposal for a nurse-led solution is being progressed.
11.2 Primary Options to Acute Care	11.2.1 Develop pathways that provide primary care access to telephone advice from specialist services	Pathways developed for acute respiratory and frail elderly	Q1	●	
	11.2.2 Alliance commits flexible funding to POAC services	$200k invested in POAC services for 2014/15		●	
	11.2.3 Introduce rapid response teams that are able to see people in the community	Rapid response team implemented in Invercargill	Q1	●	
		Rapid response team implemented in Dunedin	Q2	●	
	11.2.4 Implement 7 day a week respiratory POAC service to initially target acute exacerbations of COPD	Respiratory POAC service implemented	Q1	●	
	11.2.5 For eligible at risk patients explore writing off bad debt with general practice to enable access to necessary acute care	Options for writing off bad debts identified	Q1	○	WellSouth considers this is an issue between the practice and the patient. WellSouth provides vouchers to ensure access to primary care isn't prohibited due to historical bad debts.
	11.2.6 Explore voucher system for GP follow up of discharged patients	Options for GP voucher system for discharged patients identified	Q1	●	
11.3 Frequent Attenders	11.3.1 Continued roll-out of the SPHO Integrated Primary Care (IPC) programme providing a wraparound service for people with complex needs	Number of practices with IPC		●	Planning continues to make the IPC programme available.
	11.3.2 Implementation of fully operational Early Supported Discharge (ESD) Southland service	Business case approved	Q2	●	The development of a business case for Southland ESD has been on hold pending the outcomes of a six month review of the Rapid Response Service (RRS) (December 2014), to enable the findings to be incorporated into wider planning of Wrap Around Services for Older People in Southland. Southland meanwhile continues to engage with Otago to learn from their ongoing ESD service review and is meeting with Otago colleagues early in 2015 to discuss in more detail.
		Southland ESD operational	Q4	●	
	11.3.3 Work with St John to develop a new service delivery model for the ambulance service with sector wide Patient Care Plans for those with high health needs, and who need a consistent approach from health			●	Future project – plan and timeframe to be developed.
	11.3.4 PHO and DHB share information to identify high health users for inclusion in the PHO Integrated Primary Care (IPC) Programme			●	Work has been underway re COPD and Frail Elderly. Plan and timeframe to be developed.
	11.3.5 Develop clinical pathways for common conditions that may lead to ED or hospital admission	Develop pathways for CHF, COPD, and respiratory infections		●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

10

12 Better Help for Smokers to Quit

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Better Help for Smokers to Quit					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
12.1 Hospitals	12.1.1 All Provider Arm directorates have the ABC target embedded in their quality plans with regular on-going monitoring	ABC question is embedded in nursing admission documentation; medical & surgical assessment		🟡	
	12.1.2 Include mandatory field on completing ABC in the hospital electronic discharge summary	Update electronic discharge summary when available		🟡	This is not available as it is not possible to drill down to individual LMC level as this information belongs to the LMC's. Aggregated information is provided by the individual LMC. Information not available to us.
	12.1.3 Smokefree coordinators provide ABC training to nursing, midwifery and allied health staff on mandatory training days	1000 staff receive ABC training in 2014/15		🟡	
	12.1.4 All new ward staff receive ABC training from online tool with support from ward champions	100% of new ward staff complete ABC online training module		🟡	
	12.1.5 Investigate feasibility of including ABC in the Emergency Department Information System (EDIS)	Feasibility study completed	Q1	🟢	
12.2 Primary	12.2.1 Increase the utilisation of existing IT software tools (BPI and Dr Info) to increase the number of patients identified as smokers and provided with ABC	90% of practices utilising BPI or Dr Info	Q2	🟢	
	12.2.2 Employ GP and nurse clinical champions to provide guidance to practices and other providers			🟢	
	12.2.3 Smokefree Coordinators and Outreach Nurses provide support and resources to general practice and community providers with high numbers of current smokers			🟡	
	12.2.4 SPHO to continue text to remind services			🟢	
	12.2.5 SPHO undertake audits of practice patient management systems			🟡	
	12.2.6 SPHO supports and collates ABC data from community providers	ABC data from community providers is reported to the Ministry of Health		🟡	
12.3 Community	12.3.1 Provide feedback to LMCs on the better help for smokers to quit maternity Health Target	Publish maternity Health Target results in LMC newsletters		🟢	
	12.3.2 Facilitate ABC training for LMCs not achieving the ¨better help for smokers to quit¨ maternity Health Target			🔴	It is not possible to get down to individual LMC level information not available as there is no functionality on the current patient management system to allow this to occur.
	12.3.3 Health promotion staff work with councils and local NGO's via smoke free networks to engage in smoke free 2025 initiatives			🟡	
	12.3.4 Assist workplaces to develop a smoke free 2025 approach to their interactions with both staff and clients.			🟡	
	12.3.5 Support providers contracted for DHB funded services to implement the new requirements around smoke free			🟡	
	12.3.6 Smoking cessation providers are promoted and referral pathways strengthened	Facilitate improved referral pathways between LMCs and smoking cessation providers		🟢	

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

Better Help for Smokers to Quit					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
12.4 Sector	12.4.1 Sector-wide refresh of the Tobacco Control Plan	Revised Tobacco Control Plan adopted	Q2		

13 Elective Surgery

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Elective Surgery					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
13.1 Elective Surgery	13.1.1 Delivery on the agreed electives volume schedule to meet the Electives Health Target	Monitor performance against the elective surgery production plan		🟡	
	13.1.2 Production plans are developed, monitored, and where necessary modified, based on achieving (or working towards) performance requirements and equity of access	Elective standardised intervention rates - SI4		🟡	
	13.1.3 Participate in the development and implementation of the National Patient Flow System	Submit data to the collection as required	Q1	🟡	
	13.1.4 Orthopaedic Pathway Programme (OPP) integrated into business as usual	Performance against KPIs maintained		🟡	
	13.1.5 Enhanced Day Surgery and Ambulatory Care (EDSAC) project	Increased proportion of elective and arranged surgeries are day of surgery admission - base 89% -	Q4	⚫	
	13.1.6 Maintain consistency of clinical prioritisation for elective surgery patients, by using the national Clinical Priority Access Criteria (CPAC) prioritisation tools, and treating patients in accordance with assigned priority and urgency timeframe			🟡	
	13.1.7 Principles from The Productive Operating Theatre (TPOT) are embedded into business as usual	Performance against KPIs maintained		🟡	
	13.1.8 Redesign of the surgical preadmission process at Dunedin Hospital incorporating learning's from a similar project in Invercargill			🟡	
	13.1.9 Implement the South Island eReferral tool Electronic Request Management System (ERMS) to help streamline and improve referral processes	ERMS implemented	Q1	🟡	
13.2 Work within the Regional Elective Services Alliance to align electives delivery across the South Island	13.2.1 Participate in the development of regional pathways that can then be localised to improve consistency in processes, equity of access and outcomes	Urology pathways developed and implemented locally	Q3	⚫	
	13.2.2 Support the establishment of regional major trauma work-stream and development of a three year action plan	Major Trauma work stream established	Q1	🟡	
		Major Trauma clinical leads identified	Q2	🔴	Southern DHB has representatives (nursing and medical) on this group however it is the alliance group that need to determine clinical leads as part of the regional elective services alliance group.
	13.2.3 Participate in the implementation of major trauma register including provision of local data as required	Major Trauma registry established	Q4	⚫	

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

14 Cancer Services

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Cancer Services					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
14.1 Faster Cancer Treatment (FCT)	14.1.1 Audit of the faster cancer treatment indicator to ensure data is captured in a consistent manner	Audit completed	Q1	●	
	14.1.2 Trial using METRIQ to gather data from various sources for reporting FCT	Trial completed	Q2	●	Local data collection method has changed
	14.1.3 Link cancer registry to METRIQ to ensure all patients are captured	Cancer registry linked	Q3	●	
	14.1.4 The national tumour standards of service provision are implemented. (including a focus on supportive care, palliative care and equity standards)	Breast, gastro-intestinal and, gynaecological tumour stream audits completed	Q4	●	
	14.1.5 Process maps for tumour streams and Central Otago patients to assist cancer nurse coordinators	Process maps are completed	Q2	●	
14.2 Shorter Waits for Cancer Treatment	14.2.1 Performance sustained against the radiotherapy and chemotherapy wait time targets			●	
	14.2.2 Maintain registrar training for medical physicists			●	
	14.2.3 Provide an additional two multidisciplinary meetings (MDMs) which comply with MOH guidelines.	Additional MDMs introduced	Q3	●	Delayed setting up of urology MDM, plan underway.
	14.2.4 Review electronic referrals and the capture of proforma data to improve compliance in MDM standards in all tumour streams	Meet the MDM standards in the 9 tumour streams		●	
14.3 Endoscopy and Colonoscopy Services	14.3.1 Implement priorities for the Endoscopy Quality Improvement (EQI) programme	Progress reported quarterly		●	
	14.3.2 Develop a single district referral centre utilising local prioritisation tools to meet the National Referral Criteria	Referral centre operational	Q3	●	
	14.3.3 Implement e-referrals for colonoscopy	e-referrals for colonoscopy established	Q2	●	Partially rolled out. Part of the South Island e-referrals project.
	14.3.4 Integrate data from MOSAIQ Medical Oncology system with other clinical information systems to streamline the workflow from first diagnosis and staging to treatment and follow-up	Data integration enabled	Q4	●	Not part of endoscopy and colonoscopy services. Remains source for oncology data.
14.4 Work with the Southern Cancer Network to align strategic activity across the South Island.	14.4.1 Maintain full cover for SCDHB patients to have long course radiotherapy at SDHB thus supporting agreed regional capacity sharing agreement			●	Averaging 1-2 referrals per months – calculated to be 4 per month. Escalation to Canterbury DHB is underway to understand why we have not had the referrals expected
	14.4.2 Support the regional review of three more tumour stream standards including provision of relevant data.	Regional audit against tumour standards complete	Q3	●	
	14.4.3 Review the Southern Cancer Network modelling, Regional Linear Accelerator Investment Plan and the National Radiation Oncology Plan to ensure Southern has appropriate radiation treatment capacity to meet future demand.			●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

15 Primary and Integrated Care

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Primary and Integrated Care					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
15.1 Strengthened Planning and Accountability	15.1.1 Southern Health Alliance completes an action work plan and agree utilisation of flexible funding	SHA work plan and flexible funding approved	Q1	🟡	Alliance South meeting February 2015 to review work plan. Flexible funding discussions on-going
	15.1.2 Establish Service Level Alliance Teams (SLAT) or work streams to support the Alliance work plan	Acute Demand & Pharmaceutical SLAT established 2013/14		🟢	
		Establish Rural Health, Radiology & Youth SLATs	Q1	🟢	Radiology SLAT yet to be developed
	15.1.3 Implement the Integrated Performance and Incentive Framework (IPIF)			🟢	
	15.1.4 Utilise the Hospital Ethnicity Data Audit Toolkit (HEDAT) to assess the quality of ethnicity data and systems for data collection, and provide guidance on quality improvement activities.	Steering group supporting HEDAT established	Q1	🟢	
		Audit completed and results published	Q3	⚫	
		90% accuracy of ethnicity data collection in DHB databases		⚫	
15.2 Care Closer to Home	15.2.1 Develop pathways that provide primary care access to telephone advice from specialist services	Pathways developed for acute respiratory and frail elderly	Q1	🟡	
	15.2.2 Embed GPSI services for skin lesions, Mirena insertions, and pipelle biopsies	1200 funded skin lesion procedures performed by GPSI service		🟢	
		75 funded Mirena insertions performed by GPSI service	Q3	⚫	
		75 funded pipelle biopsies performed by GPSI service	Q3	⚫	
	15.2.3 Implement 7 day a week respiratory POAC service to initially target acute exacerbations of COPD	Respiratory POAC service implemented	Q1	🟡	
	15.2.4 Maintain primary care access to radiology	Implement the Community and Primary Radiology Referral Guidelines once released		🟢	
	15.2.5 For eligible at risk patients explore writing off bad debt with general practice to enable access to necessary acute care	Options for writing off bad debts identified	Q1	🟢	WellSouth considers this is an issue between the practice and the patient. WellSouth provides vouchers to ensure access to primary care isn't prohibited due to historical bad debts.
	15.2.6 Explore voucher system for GP follow up of discharged patients	Options for GP voucher system for discharged patients identified	Q1	🟢	
15.3 Rural Health	15.3.1 Establish a Rural Service Level Alliance Team (SLAT)	Rural SLAT established	Q1	🟢	
	15.3.2 Rural SLAT to develop and implement a plan for distribution of the Rural Primary Care Funding according to the agreed processes in the PHO Services Agreement	Plan for distribution of Rural Primary Care Funding is agreed	Q4	⚫	
		Distribution of Rural Primary Care Funding is implemented	Q1 (15/16)	⚫	
	15.3.3 Work alongside the Rural SLAT to support the single practice that maybe excluded from rural funding from 1 July 2014 based on the In/Out Criteria (30 mins/30 kms from a base 2 hospital and/or population of 15,000 or less).			🟡	
15.4 Youth Health	15.4.1 Establish a youth services Service Level Alliance Team (SLAT)	Youth services SLAT established	Q1	🟢	Agreement achieved to change Child Youth Steering Group into SLAT. Membership extended to include SST lead, NZ Police and CYF

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

16 Health of Older People

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Health of Older People					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
16.1 Rapid Response and Discharge Management Services	16.1.1 Maintain Dunedin based Early Supported Discharge (ESD) service which was expanded from July13 to include inpatient services and Emergency Dept., and extension of service delivery hours into week day evenings and Saturdays.	Review ESD after 9 months (April 2014)		●	
		On-going Formal 6 monthly reviews with all stakeholders	Q2 & Q4	●	
	16.1.2 Implementation of fully operational Early Supported Discharge (ESD) Southland service	Business case approved	Q2	●	The development of a business case for Southland ESD has been on hold pending the outcomes of a six month review of the Rapid Response Service (RRS) (December 2014), to enable the findings to be incorporated into wider planning of Wrap Around Services for Older People in Southland. Southland meanwhile continues to engage with Otago to learn from their ongoing ESD service review and is meeting with Otago colleagues early in 2015 to discuss in more detail.
		Southland ESD operational	Q4	●	See above regarding delays due to RRS implementation.
16.2 Home and Community Support Services	16.2.1 HCSS provided through the HCSS Alliance provided with additional funding for cost pressures and demographic growth	Cost pressure and demographic adjustment of $1.2M provided to HCSS Alliance		●	
		Additional $382k from 2013 Budget has been fully utilised in the HCSS Alliance		●	
	16.2.2 Work with the DHB National HOP Steering Group in developing and implementing core quality measures for HCSS	HCSS core quality measures are developed and implemented		●	
16.3 Improved Care Pathways	16.3.1 A district wide multi-agency (secondary/primary/ACC/NGO sector) Falls Strategy Group formed in March 2014.			●	
	16.3.2 Falls Strategy Group incorporate Fracture Liaison Service (FLS) development into district Falls strategy and work plan to ensure cross sector involvement and critical links to overall Falls strategy	Falls Strategy completed	Q1	●	
		FLS business case develop and approved	Q3	●	
		FLS implementation	Q4	●	
		25 people assessed by FLS by 30 June 2015		●	
16.4 Supporting Community Providers	16.4.1 Support residential care facilities implementing comprehensive clinical assessments (InterRAI) through the provision of training facilities	100% of residential care facilities are trained and utilise InterRAI	Q4	●	
	16.4.2 CNS Wound Care staff provide on-going clinic services in rural hospitals, and an on-call advisory service to primary care and ARC sector			●	
	16.4.3 Nurse Practitioner continue to provide education sessions to ARC (historically on average 2 sessions a month)	Maintain 2 sessions per month		●	
		Number of sessions and attendance		●	
	16.4.4 Undertake survey to identify education and training needs in primary care. Engage with DHB education centre to review programme (currently an emphasis on chronic disease management, and health assessment)	Education programme reviewed and updated	Q3	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

Health of Older People					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
16.5 Work with the South Island Health of Older People Service Level Alliance	16.5.1 Develop a cognitive impairment pathway (incorporating dementia) for primary care consistent across South Island DHBs	Cognitive impairment pathway implemented	Q3	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

17 Mental Health and Addiction Service Development Plan

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Mental Health and Addiction Service Development Plan					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
17.1 Rising to the Challenge	17.1.1 Increase uptake of Health of the Nation Outcome Scale (HoNOS)			🟡	
	17.1.2 Complete Raise HOPE Implementation Plan including phased timeframes for service redesign and reallocation	Raise HOPE Implementation Plan completed	Q1	🟢	
	17.1.3 Develop clinical pathways to improve access from general practice to community mental health services	Pathways to community mental health providers developed	Q3	⚫	
		Youth AOD Pathway implemented	Q2	🟡	Awaiting implementation of WellSouth (PHN)new IT system in Q3
	17.1.4 Develop and implement actions from the review perinatal and infant mental health services	Implementation plan endorsed	Q1	🔴	Following review of the different models used in Otago and Southland, MHAID clinicians have commenced development of a perinatal and infant mental health services plan that includes increasing and improving linkages between Child Adolescent and Family Services and Adult Services working with this patient group. This will include improving data collection.
	17.1.5 Youth provider network to lead the development of an integrated referral processes	Integrated referral process implemented	Q4	⚫	
	17.1.6 Mental health and addiction needs assessment and service coordination (NASC) providers continue development of agreed referral pathways	MHA NASC providers implement agreed consistent referral pathways	Q2	🟢	
17.2 Suicide Prevention	17.2.1 Deliver a suicide prevention training programme designed for health workers and community stakeholders using QPR and Assist training packages	Two primary care focussed training programmes delivered	Q4	🟡	
	17.2.2 Continue work to support and build community postvention capacity	Two additional communities supported to develop postvention plans	Q4	🟡	
	17.2.3 Southern DHB suicide response plan developed for the management of suicide clusters/contagion	Southern DHB suicide response plan developed	Q4	🟡	
17.3 Supporting Government Work Programmes	17.3.1 Support the Social Sector Trials in South Dunedin and Gore			🟡	
	17.3.2 Develop and implement plan for improved integration of COPMIA services	Implement COPMIA plan	Q4	🟡	
17.4 Work with the South Island Mental Health Network	17.4.1 Develop a programme to support the reduction in use of seclusion and restraint	Identify current practices	Q1	🟢	
		% use of restraint or seclusion for Maori		🟢	
	17.4.2 Embed Youth Forensic Service hub based in Dunedin			🟢	
	17.4.3 Contribute to the South Island collaborative development of the pathway for Children of Parents with Mental Illness and Addiction	Pathway is localised and implemented	Q4	🟡	

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

18 Maternal and Child Health

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Maternal and Child Health					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
18.1 Pregnancy and Newborn Children	18.1.1 PHO to engage with LMC providers to develop opportunities to undertake data matching with practice records to identify pregnant women not registered with a LMC	80% of women register with an LMC by week 12 of their pregnancy		●	
	18.1.2 SPHO & NIR team develop regular reporting to identify babies not registered with a GP	Unregistered babies are identified and contact made with parents		●	
		98% of new-borns are enrolled with general practice by 3 months		●	
	18.1.3 Monitor practice registers to identify new-born babies with a "B" enrolment status for formal registration	PHO identifies B enrolment status and follows up with practices		●	
	18.1.4 Continue implementation of the Maternity Quality Safety Programme (MQSP)	Programme is embedded across the district	Q4	●	
		NZ maternity standards are implemented	Q4	●	
		Complete roll-out of South Island safe sleep policy	Q1	●	
	18.1.5 Once published, implement the national guidelines for the screening, diagnosis and management of gestational diabetes	Implement gestational diabetes guidelines once released		●	
18.2 Well Child Tamariki Ora	18.2.1 Increase breastfeeding rates in Invercargill through promotions to increase client awareness of free lactation consultant services including NGO Well Child providers	WCTO indicator 1: 54% of eligible children in Invercargill exclusively or fully breastfed at 3 months of age Q2; 60% by June 2016		●	
	18.2.2 Maintain coverage of B4 School Checks	WCTO indicator 2: 90% of eligible children receive B4 School Check, including at least 90% living in high deprivation areas		●	
18.3 Oral Health	18.3.1 Maintain existing evening clinics in Dunedin and establish an evening or weekend clinic in Invercargill	After hours clinic established	Q2	●	
	18.3.2 Complete an evaluation of need for transporting of high needs families. Develop district wide policy on transporting of high needs families	Policy is developed	Q3	●	
	18.3.3 Undertake district wide review of Did Not Attend (DNA) rates, and identify individual clinics with high DNA rates	DNA rates <15%		●	
	18.3.4 Oral health promotion team will work closely with Well Child Providers, Plunket, Maori providers and Pacific providers to promote enrolment with child oral health services	WCTO indicator 3: 86% of preschool children are enrolled with the Community Oral Health Service (COHS) Q4; 95% of eligible children are enrolled with COHS by June 2016		●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

19 Improving Quality

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Improving Quality					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
19.1 Falls Prevention	19.1.1 Review falls prevention policies, procedures and guidelines	Falls prevention review	Q2	🟡	
	19.1.2 Implement revised falls assessment and planning tool → Ask, Assess, Act	90% of older patients are given a falls risk assessment		🔴	Not yet 90% for this quarter, provisional audit results for next quarter show an improvement
		90% of at risk patients with individualised care plan		🔴	Not yet 90% for this quarter, provisional audit results for next quarter show an improvement
19.2 Surgical Safety Checklist	19.2.1 Continue utilisation of the three part surgical safety checklist in the main operating theatres in Dunedin and Invercargill. Commence implementation of surgical safety checklist to Day Surgery Units	Maintain 90% utilisation of the three part surgical safety checklist used in the main operating theatres		🟡	
		Attain 90% utilisation of the three part surgical safety checklist used in day surgery		🟡	
19.3 Hand Hygiene	19.3.1 Introduce monthly hand hygiene report into wards			🟡	
	19.3.2 Work with undergraduate training schools to standardise hand hygiene information and training	80% compliance with good hand hygiene practice		🟡	
19.4 Surgical Site Infection Programme (SSIP)	19.4.1 Establish monthly local data reporting for Surgical Site Infection (SSI)			🔴	Dependant on a national programme providing data – not yet provided
	19.4.2 Establish steering group to continue Surgical Site Infection (SSI) National Surveillance Programme implementation.	95% of hip and knee replacement patients receive cephazolin ≥ 2g as surgical prophylaxis		🟡	
		100% of hip and knee replacement patients have appropriate skin preparation		🟡	
		100% of patients receive antimicrobial prophylaxis 0-60 minutes before surgery		🟡	
19.5 Central Line Insertion Bundle (CLAB)	19.5.1 Dunedin Hospital and Southland Hospital main operating theatres & ICU implement insertion bundle and establish national reporting	90% compliance in Central Line Insertion Bundle to reduce Central Line Associated Bacteraemia (CLAB)		🟡	
19.6 E-medicine / E-prescribing	19.6.1 Electronic Prescribing and Administration (ePA) system is implemented in DHB hospital wards	ePA implemented at Dunedin Hospital	Q1	🟡	
		ePA implemented at Southland Hospital	Q2	🟡	
		ePA implemented at Wakari Hospital	Q3	🟡	
19.7 Patient Experience Indicators	19.7.1 Implement the HQSC national inpatient survey which contains the four "domains" of patient experience (communication, partnership, co-ordination and physical and emotional support)			🟢	
19.8 Quality Accounts	19.8.1 Quality Accounts are refined and further developed in line with HQSC expectations	Participation in national workshop		🟢	
		Quality Account is published with Annual Report		🟢	

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

20 Information Systems

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

Information Systems					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
20.1 eMedicines Reconciliation (eMR) with eDischarge Summary	20.1.1 DHB is committed to implementing electronic medicines reconciliation (eMR).			🔴	Not able to be scheduled yet as the DHB is awaiting either National or South Island activities/confirmation or decisions before proceeding.
	20.1.2 Install the Health Connect South Clinical Workstation (Concerto) which is a pre-requisite for eMR.	Health Connect South Clinical Workstation installed	Q3	🟡	
	20.1.3 Install and implement eMR (will be positioned as a project once HCS has been implemented)	Commence eMR project	Q4	⚫	
20.2 Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR)	20.2.1 The DHB commits to implementing the regional Clinical Workstation (CWS) (Concerto) and Clinical Data Repository (CDR).			🟡	
	20.2.2 Install the Health Connect South Clinical Workstation (Concerto), the Southern Regions Clinical Workstation solution.	Health Connect South Clinical Workstation installed	Q3	🟡	
	20.2.3 Regional Clinical Data Repository completed (as part of the Health Connect South Clinical Workstation project).	Clinical Data Repository completed	Q3	🟡	
20.3 Self-Care Portal	20.3.1 The DHB will develop an implementation plan with relevant PHOs to enable individuals to have access to their own health information and allow hospital based services, in particular, ED, to have access to a summary view of primary care information.			🔴	Not able to be scheduled yet as the DHB is awaiting either National or South Island activities/confirmation or decisions before proceeding.
20.4 National Patient Flow	20.4.1 The DHB commits to collecting First Specialist Assessment (FSA) referral information, including outcomes of referrals, from July 2014 (Phase 1); and to collecting Phase 2 information from July 2015.			🟡	

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

SOUTHERN DISTRICT HEALTH BOARD

Title:	Progress on Delivering Priorities and Targets - Southern **Māori Health Plan** 2014/15
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	4 February 2015

Summary:

This report shows the progress in Quarter Two on delivering on the plans, actions and commitments in the Southern DHB 2014/15 Māori Health Plan. It highlights completed actions and achievements. Where activity is still to be completed, a brief narrative is provided on planned action and any issues affecting delivery and potentially impacting on the timing or ability to complete.

11

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:		Date:

Prepared by: Planning & Funding Date: 28.01.2015	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

That the Committees note the progress in Quarter Two on delivering the **Māori** Health Plan 2014/15 and the intended actions where activity is incomplete.

Southern Māori Health Plan 2014/15 Progress Report
Quarter Two

Progress	Progress Indicator
●	Completed
●	Underway according to plan
●	Behind plan
●	Scheduled for Q3 or Q4
Ministry of health reporting schedule	
Quarter 1	July – September
Quarter 2	October – December
Quarter 3	January – March
Quarter 4	April - June

1 Data Quality

Progress on Delivering on National Māori Health Priorities: Māori Health Plan Actions

Data Quality				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
1.1 Data Quality	1.1.1 Complete ethnicity data audits of every practice by 30 June 2015 and develop a plan to address any issues identified in the audits.		🔴	Project delayed due to rollout of new IT platform to practices. The audits will be completed over a longer timeframe.
	1.1.2 Monitor the number of Māori enrolled in the Southern PHO quarterly, identify gaps and investigate ways to encourage Māori to enrol.		🟡	
	1.1.3 Actively encourage primary care to participate in ethnicity data collection training.		🟡	
	1.1.4 Investigate opportunities to match ethnicity data to identify areas of discrepancy between inpatient and primary care datasets by 30 June 2015.		🟡	
	1.1.5 Provide all practices with six monthly reports of their enrolled Māori patients and encourage them to ensure these patients are accessing targeted health programmes.		⚫	

2 Access to Care

Progress on Delivering on National Māori Health Priorities: Māori Health Plan Actions

Access to Care				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
2.1 Access to Care	2.1.1 Continue to engage with Māori Health providers across the region to engage with patients around their long term conditions, improving health literacy and providing support to access medical care as and when necessary (ongoing).		🟡	
	2.1.2 Actively work with practices to identify patients with long term conditions, to ensure appropriate health plans are in place and they are appropriately managed in the community. This will in time help reduce some of the hospital admissions (ongoing).		🟡	
	2.1.3 Continue the Integrated Primary Care Programme project designed to support practices to work with patients with high health needs with frequent hospital and ED admissions. This is an intensive primary care management programme over 12 months with extended nursing consultations and scheduled GP reviews	Q4	🟡	

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

Access to Care				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
	2.1.4 Develop pathways that provide primary care access to telephone advice from specialist services (Q2-4)	Q4	●	
	2.1.5 Implement 7 day week respiratory POAC service to initially target acute exacerbations of COPD	Q4	●	WellSouth PHN Long Term Conditions nurses have been contacting patients with COPD with a hospital admission in the previous 12 months and completing a COPD Blue Card with those patients that are appropriate for this intervention; this has been done in partnership with the patients General Practice. Currently there are no plans to implement a 7 day per week respiratory POAC service.

3 Child Health

Progress on Delivering on National Māori Health Priorities: Māori Health Plan Actions

Child Health				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
3.1 Child Health	3.1.1 Continue working with maternity facilities and alongside Tamariki Ora providers to identify strategies that will enhance service delivery pathways (ongoing).		●	
	3.1.2 Monitor breastfeeding rates against national DHB performance targets, and identify any gaps or trends that may require future attention and support (ongoing).		●	
	3.1.3 Review cultural appropriateness of Breastfeeding content of DHB antenatal classes/information, convene Māori focus group.	Q2	●	Awaiting full implantation of new Pregnancy and Parenting Education service specification.
	3.1.4 Increase community and institutional capacity to support breastfeeding by coordinating and funding peer counsellor programmes. Ethnicity information will be collected for all new enrolments as trained peer counsellors.		●	
	3.1.5 Support Kaupapa Māori Peer counsellor programme with a specific focus on Māori models of care and support.	Q4	●	
	3.1.6 Develop and implement initiatives which promote, protect and support breastfeeding.		●	
	3.1.7 Develop and implement breastfeeding initiatives and policies to encourage normalisation of breastfeeding in public and private settings.	Q4	●	
	3.1.8 Promote breastfeeding and increase access to appropriate antenatal education. This will include contracts with Māori and Well Child providers to deliver Antenatal breastfeeding classes.	Q4	●	
	3.1.9 Promote the availability of lactation consultancy services.		●	Lactation consultancy availability is variable across the district with some areas having PHO funded services. Previously Plunket provided lactation consultant services in Southland and Queenstown however funding for this has ceased.

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

4 Cardiovascular Disease (CVD)

Progress on Delivering on National Māori Health Priorities: Māori Health Plan Actions

Cardiovascular Disease (CVD)

Section	Actions/Activity	Time-frame	Progress	Progress Narrative
4.1 Cardiovascular Disease	4.1.1 Improve patient journey across the cardiac continuum of care by 31 December 2014.	Q2	●	
	4.1.2 Continue to support cardiac and stroke rehabilitation, with the aim for people to recover and regain independence.		●	
	4.1.3 Develop systems to measure waiting times for cardiac diagnostics.		●	
	4.1.4 Contract practices and accredited providers, offer CVDRA checks to eligible patients. Practice support teams will add additional resource to support this work in identified practices by 30 September 2014.	Q1	●	
	4.1.5 Provide CVDRA checks outside of general practices where opportunities arise. Information collected from the checks will be returned to practices for data entry and follow-up as appropriate (ongoing).		●	
	4.1.6 Provide IT solutions to practices to manage and fully utilise their diabetes registers including recalling patients by 31 December 2014.	Q2	●	
	4.1.7 Investigate opportunities to increase the uptake of Cardiovascular checks assessments by 31 December 2014.	Q2	●	
	4.1.8 Engage with community health care providers to achieve improvement in CVD target by 31 December 2014.	Q2	●	
	4.1.9 Develop systems to transfer patient clinical information collected during community and workplace clinics back to general practice by 31 December 2014.	Q2	●	
	4.1.10 Support general practices to carry out virtual risk assessments by 30 September 2014.	Q1	●	
	4.1.11 Liaise with PMS vendors to improve practice capability for undertaking assessments by 30 June 2015.	Q4	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

5 Cancer

PROGRESS ON DELIVERING ON NATIONAL MĀORI HEALTH PRIORITIES: MĀORI HEALTH PLAN ACTIONS

Cancer

Section		Actions/Activity		Time-frame	Progress	Progress Narrative
5.1 Breast Screening	5.1.1	Information mechanisms and linkages developed between Pacific Radiology Group (PRG) and Southern DHB to assist in meeting the goals of the breast screening programme (Q1-4).			🟡	
	5.1.2	Southern PHO will ensure all eligible women are enrolled onto the national breast screening programme and are screened (ongoing).			🟡	
	5.1.3	PRG will be responsible for undertaking data matching to identify women not registered in the national screening programme for follow-up as appropriate (Q4).			⚫	
5.2 Cervical Screening	5.2.1	Review and improve service plans that have been developed in collaboration with Māori. They are aimed to improve service collaboration and Māori women participation in cervical screening by 31 December 2014.			⚫	
	5.2.2	Via the NCSP District Coordination Steering Group continue to monitor Māori women's screening coverage and up take of funded cervical smears (ongoing).			🟡	
	5.2.3	Work in collaboration with community health care providers to encourage the participation of Māori women in cervical screening (ongoing).			🟡	
	5.2.4	Promote and monitor the uptake of the funded cervical smears in targeted populations including Māori, and under screened women (ongoing).			🟡	
	5.2.5	Support accredited providers, to offer clinics in settings outside of General practice or outside of normal hours to encourage uptake (ongoing).			🟡	
	5.2.6	Undertake data matching to identify under and unscreened women for follow-up as appropriate (ongoing).			🟡	
	5.2.7	Fund text reminder services for general practices to recall patients as they become due for screening (ongoing).			🟢	
	5.2.8	Increase the number of Māori smear takers available within practices and accredited providers by 31 December 2014.		Q2	🟢	

6 Smoking Cessation

PROGRESS ON DELIVERING ON NATIONAL MĀORI HEALTH PRIORITIES: MĀORI HEALTH PLAN ACTIONS

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

Smoking Cessation				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
6.1 Hospital	6.1.1 Implement the transition of secondary care smoke free coordination to provide additional support to the implementation of ABC in Primary health by 31 July 2014.	Q1	🟡	
	6.1.2 Provide targeted community-based cessation support to Māori through the Aukati Kaipaipa cessation programme - with increased enrolments onto the programme. Aukati Kaipaipa smoking cessation services have been contracted for South Otago, North Otago and Central Otago with the Ministry of Health funding services in Greater Dunedin and Southland. Referral pathways will continue to be promoted to all practices (ongoing).		🟡	
	6.1.3 Deliver support and training for providers in the community and clinical settings. Group based cessation treatment is facilitated in numerous settings, including primary care, community and hospital settings (ongoing).		🟡	
	6.1.4 Monitor the health target results monthly to ensure the target is being achieved for Māori.		🟡	
	6.1.5 At first contact with Lead Maternity Carers, Identify pregnant Māori women who smoke and ensure they are offered cessation support.		🟡	
6.2 Primary	6.2.1 Engage GP Smoke free Champions to provide clinical leadership to embed ABC as an essential element of clinical practice throughout primary care by 31 July 2014.	Q1	🟢	
	6.2.2 Provide on-going auahi kore education and workshops including referral pathways into Aukati Kai Paipa.		🟡	
	6.2.3 Utilise audit tools to identify Māori who smoke and ensure appropriate support is offered by 31 December 2014.	Q2	🟡	
	6.2.4 A designated nursing role within Primary health will be funded to support General Practices in Dunedin and North Otago to embed ABC by 31 July 2014.	Q1	🟢	
	6.2.5 Enhance existing primary care services utilising practice support clinicians, GP Smoke free Champion and Long Term Conditions Nurses, to work alongside general practice and pharmacy providers to increase cessation support to smokers (ongoing).		🟡	
	6.2.6 Continue to support smoking cessation programmes, such as Wero and group based programmes, with vouchers to access free GP consultations for cessation pharmacotherapies. Develop e-referral systems for streamlined referral pathways from general practices to Aukati Kaipaipa cessation providers by 30 September 2014.		🟡	
6.3 Community	6.3.1 We will support pregnant women to stop smoking through providing specific advice, information, resources and referral pathways by 30 September 2014.		🟡	
	6.3.2 Facilitate improved referral pathways between LMCs and local AKP providers by 31 December 2014.	Q2	🟡	

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q3 or Q4

11

Smoking Cessation				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
	6.3.3 Work with local Government agencies to promote ABC as a model of practice with their clients. Sessions will continue to happen within the community on an ongoing basis.		●	
	6.3.4 Undertake ongoing targeted interventions with groups identified as having high smoking rates (over 35%) in the 2013 Census, particularly Māori women and Māori men in Southland aged 20-39 years.		●	

7 Immunisation

Progress on Delivering on National Māori Health Priorities: Māori Health Plan Actions

Immunisation				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
7.1 Child Immunisation	7.1.1 Undertake ongoing health promotion activities around immunisation, with high priority given to Māori populations.		●	
	7.1.2 Monitor immunisation rates against the national health target to identify areas for improvement in service delivery and future planning (ongoing).		●	Achieved 95% for total population at 8 months and Maori coverage is 93% which is an increase of 2 % from the last quarter Achieved 95% for total population at 2year and Maori coverage is 95% for the quarter
	7.1.3 Ensure all new-born babies are enrolled with primary health by 2 weeks of age. The NIR will identify that all babies have a nominated GP, and that the GP accepts the birth nomination.		●	
	7.1.4 Continue to fund text reminder services to practices to recall patients for immunisations.		●	
	7.1.5 Maintain the Paediatric Project where all children admitted to Paediatric Services, or seen in Outpatient Clinics have their immunisation status reviewed, immunisation to be delivered as appropriate.		●	
	7.1.6 Māori representative on the VPD Steering Group. Each representative feeds back to their affiliated providers.		●	
	7.1.7 Continue to encourage the "On time Every time' message. Undertake health promotion activities around immunisation, with high priority given to Māori populations, especially in the Antenatal period, e.g. working with Mother and Pepi groups.		●	
	7.1.8 Increase immunisation education through general practices, antenatal education, Whānau Ora Services, Well Child Tamariki Ora services, Early Childhood Education, Kohanga reo and other services as appropriate.		●	
	7.1.9 Focus on "on time" immunisations.		●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

Immunisation				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
	7.1.10 Southern DHB and SPHO will work together to immunise hard to reach children and families through outreach services.		●	
7.2 Influenza Immunisation in Over 65 years	7.2.1 Work in collaboration with practices and Māori providers on increasing numbers of Māori aged 65+ who receive the influenza vaccine (ongoing).		●	
	7.2.2 Primary health practice support teams will utilise PMS audit tools to identify eligible patients for appropriate recall and identify the most appropriate service for delivery by 30 June 2015.		●	
	7.2.3 Promote free flu vaccinations for pregnant women and those with chronic condition eligibility, as well as for those over 65 eligible for funded influenza vaccine (ongoing).		●	

8 Rheumatic Fever

Progress on Delivering on National Māori Health Priorities: Māori Health Plan Actions

Rheumatic Fever				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
8.1 Rheumatic Fever	8.1.1 Implement the South Island Rheumatic Fever Prevention Plan (ongoing).		●	
	8.1.2 Implement protocol for rheumatic fever prophylaxis in the Southern district (Q2-4).		●	
	8.1.3 We will work in collaboration to identify Māori whānau with children living in poor conditions who may be at risk of rheumatic fever (ongoing).		●	Not applicable. Low incidence Rheumatic Fever area.
	8.1.4 Through a partnership with primary and community services we will ensure all whānau with children at high risk of rheumatic fever will be managed on the appropriate pathway as well as offered Māori cultural support services (O1-Q4).		●	Not applicable. Low incidence Rheumatic Fever area.

9 Oral Health

Progress on Delivering on National Māori Health Priorities: Māori Health Plan Actions

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

11

Oral Health				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
9.1 Oral Health	9.1.1 Undertake a district wide gap analysis of pre-school oral health enrolment (Q2-4).		●	
	9.1.2 Establish a process with oral health providers including Well Child/Tamariki Ora providers to identify high risk children and prioritise their treatment (Q1-4).		●	
	9.1.3 Improve the current enrolment levels of Māori children to access oral health services (ongoing).		●	
	9.1.4 Engage with all stakeholders including primary care, Well Child/Tamariki Ora, Public Health Service and other health promotion staff such as LMCs to promote oral health and encourage early oral health service enrolment (Q1-2).		●	
	9.1.5 Continue to fund the Oral Health programme which provides dental care to high needs patients with urgent dental care needs by 30 September 2014.		●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

10 Mental Health

Progress on Delivering on National Māori Health Priorities: Māori Health Plan Actions

Mental Health

Section	Actions/Activity	Time-frame	Progress	Progress Narrative
10.1 Mental Health	10.1.1 Undertake an analysis of section 29 Mental Health Act treatment orders to identify trends, current practices and number of indefinites (Q2-4).		●	
	10.1.2 Review tangata whaiora under section 29 of the Mental Health Act and if necessary develop amended care plan (ongoing).		●	Clinical and MHA reviews completed within required timeframes.
	10.1.3 To provide comprehensive cultural training for all staff utilising the Mental Health Act (Q1-2).		●	Cultural training sessions provided on on-going basis which are available to all staff.

11 Child Health

Progress on Delivering on Local Māori Health Priorities: Māori Health Plan Actions

Child Health

Section	Actions/Activity	Time-frame	Progress	Progress Narrative
11.1 Childhood Respiratory Disease	11.1.1 Southern DHB, PHO and community health providers will identify Māori whānau with children living in poor conditions who may be at risk of respiratory illness.		●	
	11.1.2 Monitor referrals to ensure early detection and intervention to reduce the impact of respiratory illness on wellbeing.		●	
	11.1.3 Raise awareness and reduce the incidence of respiratory disease through disease prevention and health promotion strategies which may include the development of new resources.		●	
	11.1.4 Ongoing support of smoking cessation initiatives at all stages of the Life Course, not only during pregnancy and early childhood.		●	
	11.1.5 Southern PHO will ascertain the number of Asthmatic patients across primary health.		●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

Child Health				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
	11.1.6 Actively work with practices to identify patients coded in their PMS as Asthmatic, and explore ways to work with them.		●	
11.2 Childhood Obesity	11.2.1 Facilitate community action that enables Māori to adopt and maintain healthier lifestyles, including good nutrition and physical activity.		●	
	11.2.2 Regularly monitor B4 School Check rates against the national target, and identify areas of significance for Māori to support future service planning and delivery.		●	
	11.2.3 Support community initiatives that are health and fitness focussed.		●	
	11.2.4 Work in collaboration with B4 School Check services to closely monitor access and referral patterns.		●	
	11.2.5 Record data on referrals made to paediatric triage from the B4 School check programme for tamariki with obesity (greater than BMI 19) across the Southern District.		●	
	11.2.6 Refine current weight referral pathway (B4School check) to specifically address whānau and tamariki values and services.		●	
	11.2.7 Aim towards recording regular weight height histories for tamariki (with BMI over 19) by plotting this on WHO standard charts and anthropometry (DHB iSOFT record for height and weight). This will provide early identification of any emerging endocrine health issues.		●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

12 Healthy Whānau

Progress on Delivering on Local Māori Health Priorities: Māori Health Plan Actions

Healthy Whānau				
Section	**Actions/Activity**	**Time-frame**	**Progress**	**Progress Narrative**
12.1 Diabetes	12.1.1 Implement GP CME and practice nurse education in support of identification, assessment and management of patients with diabetes and pre-diabetes.		●	
	12.1.2 Review performance every quarter as part of the primary health practice support and at the 12 month review attainment markers will indicate the level of payment for the practice.		●	
	12.1.3 Provide support to general practices to improve coding of diabetes and improve the accuracy of individual practice diabetes registers.		●	
	12.1.4 Liaise with the MoH to clean-up the virtual diabetes register as and when practices identify patients incorrectly identified as having diabetes.		●	
	12.1.5 Maintain a high level of patients having all of the components of diabetes care: BMI, HbA1c, BP, ACr, eGFR, Cholesterol, eye examination, foot examination and smoking status at least annually		●	
	12.1.6 Support accredited providers to develop capacity in both the areas of clinical delivery and data management.		●	
	12.1.7 Ensure consistent diabetes care which meets best practice standards and guidelines.		●	
	12.1.8 Improve the patient journey across the diabetes continuum of care.		●	
	12.1.9 Increase access to retinal screening for all patients with diabetes by data matching practice registers with the retinal screening register.		●	

11

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q3 or Q4

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 03 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 09 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 2016 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 01 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 01 July 2015 DSAC-CPHAC Committee Meeting
Southern Health Alliance Leadership Team (SHALT)	On-going	BiMonthly				A report/presentation will be submitted to the 01 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 30 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 30 September 2015 DSAC-CPHAC Committee Meeting.
Public Health South	Ongoing	Bi-Monthly				A report/presentation will be submitted to the 30 September 2015 DSAC-CPHAC Committee Meeting.