DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Wednesday, 3 June 2015, 10.00 am

Board Room, Community Services Building,
Southland Hospital Campus, Invercargill

A G E N D A

Tab

1. Welcome

2. Apologies

3. Interests Registers

4. Presentation: Social Sector Trial
   - Lisa McKenzie

5. Previous Minutes

6. Matters Arising

7. Review of Action Sheet

8. Planning & Funding Team Report
   - 8.2 Public Health South (PHS) Report
   - 8.3 Child & Youth Summary Report – as per Workplan
   - 8.4 2014/15 Quarter 3 – Annual Plan Progress Report

9. Southern Strategic Health Plan – Implementation Plan

10. Financial Performance Report

11. Work Plan 2015

12. Resolution to Exclude the Public

Closed Session:

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

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(i), 9(2)(j) and 9(2)(f)(iv) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations, and to maintain the constitutional convention protecting the confidentiality of advice tendered by Ministers of the Crown and officials.
2. Draft Annual Plan 2015/16	Plan is subject to Ministerial approval	As above, section 9(2)(f).
3. Draft Māori Health Plan 2015/16	Plan is subject to Ministerial approval	As above, section 9(2)(f).
4. Draft South Island Health Services Plan 2015/16	Plan is subject to Ministerial approval	As above, section 9(2)(f).
5. Funder Savings Plan	To allow negotiations to be carried out without prejudice.	As above, section 9(2)(j)

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Joe BUTTERFIELD (Chairman)	21.11.2013 06.12.2010	Membership/Directorship/Trusteeship: 1. Beverley Hill Investments Ltd 2. Footes Nominees Ltd 3. Footes Trustees Ltd 4. Ritchies Transport Holdings Ltd 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 05.02.2015	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. One immediate family member is an employee of Dunedin Hospital (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) and are not receiving directorship fees. SCLOS have advised their resigantions 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.
Paul MENZIES	27.01.2015	1. Trustee, WellSouth Primary Health Network 2. Board Member, Clutha Health First Limited 3. Chairman, Rugby Southland 4. Director Owner, South Island Legal Locums Ltd 5. Wife Trustee of Youth One Stop Shop Southland 6. Wife Member of Child Mortality Panel 7. Wife Manager Southland Group Services Education 8. Wife Chairperson of Youth Offending Team Panel	1. Appointed as a trustee by Southern DHB. WellSouth is contracted to the Southern DHB. 2. Operates publicly funded health services under contract to Southern DHB. 5. Possible conflict with funding requests.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at May 2015

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	08.04.2015	1. Wife employed as Team Leader, Public Health South	
Sandra Boardman	07.02.2014	Nil	
Pania Coote	30.09.2011 30.09.2011 30.09.2011 30.09.2011 29.06.2012 26.01.2015 26.01.2015 26.01.2015 26.01.2015	1. Affiliation to Awarua, Puketeraki and Moeraki Rūnaka. 2. Member, Southern Cancer Network. 3. Member, Aotearoa New Zealand Association of Social Workers (ANZASW). 4. Member, SIT Social Work Committee. 5. Member, Te Waipounamu Māori Cancer Leadership Group. 6. National Māori Equity Group (National Screening Unit) – MEG. 7. SDHB Child and Youth Health Service Level Alliance Team 8. South Island DHBs Medcal Diagnostic Laboratory Steering Group. 9. Various SDHB operational Advisory Committees.	1. Possible conflict when contract with Southern DHB comes up for renewal. 2. Nil. 3. Nil. 4. Nil. 5. Nil. 6. Nil. 7. Nil. 8. Nil. 9. Nil.
Richard Bunton	17.03.2004	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd.	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

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	22.06.2012 29.04.2010	5. Chairman, Board of Cardiothoracic Surgery, RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	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 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.

5

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 1 April 2015, 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	
In Attendance:	Dr John Chambers	Board Member
	Mr Tony Hill	Board Member (from 11.05 am)
	Mr Tuari Potiki	Board Member
	Dr Jan White	Crown Monitor
	Mr Peter Beirne	Executive Director Finance (from 11.00 am)
	Ms Liz Disney	Senior Manager Service Integration & Innovation, Planning & Funding (until 11.50 am)
	Ms Carole Heatly	Chief Executive Officer
	Mr Glenn Symon	Senior Manager Funder Support & Intelligence, Planning & Funding
	Mr David Tulloch	Chief Medical Officer
	Dr Keith Reid	Medical Officer of Health, Public Health South
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Acting Chair welcomed everyone to the meeting.

2.0 APOLOGIES

Apologies were received from Ms Sandra Cook, Dr Branko Sijnja, Messrs Stuart Heal and Paul Menzies.

3.0 MEMBERS' DECLARATION OF INTEREST

It was resolved:

"That the Interests Register be noted."

4.0 PRESENTATION: MENTAL HEALTH & ADDICTIONS

The Committees received an update from Ms Judy Walker, Portfolio Manager, Planning & Funding, on Hāpai te Tūmanako - Raise HOPE, Southern DHB's Mental Health and Addictions Strategic Plan. Ms Walker's presentation included an overview of the key milestones and initial implementation actions for 2015 (tab 4).

The Acting Chair thanked Ms Walker and advised that the Committees looked forward to receiving further updates.

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 4 February 2015 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).

Alliance South

The Senior Manager Funder Support & Intelligence reported that Alliance South had met in March and were developing their work plan. Key performance indicators (KPIs) would flow from that.

Southern Strategic Health Plan

It was noted that the Chief Executive and senior staff had been travelling around the district consulting on the finalised Southern Strategic Health Plan.

8.0 PLANNING & FUNDING REPORT

The Senior Manager Funder Support & Intelligence presented the Planning and Funding report (tab 8) and highlighted the additional information provided on health of older people. He also reported that meetings had been held with pharmacists in Dunedin, Invercargill and Central Otago regarding the Community Pharmacy Services Agreement.

Free GP Care

The Senior Manager Funder Support & Intelligence noted that there was full free GP care for under 6 year-olds across the district and this scheme would be extended to under 13 year-olds from 1 July 2015. The details of the extended scheme were still awaited.

Primary Care Health Targets

The Committees noted that the adverse result reported for the *Better Help for Smokers to Quit (Primary Care)* target was due to a data issue and it was expected this would be resolved for the next report.

Public Health

A report on Public Health Service activity (tab 8.1) was taken as read.

Dr Keith Reid, Medical Officer of Health, answered members' questions on the inter-sector approach to reducing harm associated with student Orientation Week in Dunedin.

9.0 SUICIDE PREVENTION AND POSTVENTION PLAN 2014-18

Mr Paul Martin, Suicide Prevention Co-ordinator, joined the meeting for this item.

Dr Keith Reid and Mr Paul Martin presented the Southern DHB draft Suicide Prevention and Postvention Plan 2014-17 (tab 9) for the Committees' consideration, then answered members' questions on the proposed plan and how it would be implemented.

Mr Peter Beirne, Director of Finance, joined the meeting at 11.00 am.

Mr Tony Hill, Board Member, joined the meeting at 11.05 am.

It was resolved:

"That the Committees recommend the Board approve the Southern DHB's Suicide Prevention and Postvention Plan, pending final approval by the Ministry of Health."

10.0 SOUTHERN STRATEGIC HEALTH PLAN – STRATEGIC IMPLEMENTATION PLAN

The Chief Executive reported that roadshows on the Southern Strategic Health Plan had been held in Alexandra, Balclutha, Winton, Invercargill, Murihiku Marae, Te Anau, Dunedin, Aria te Uru Marae, Gore, Oamaru, Wanaka, and Queenstown. There had been good community engagement and useful feedback was received.

Ms Liz Disney, Senior Manager Service Integration & Innovation, presented the draft Southern Strategic Health Plan (SSHP) Strategic Implementation Plan (tab 10), then management answered questions from members on: progress reporting, community and stakeholder engagement, establishment of locality networks, and synergies with national planning and the Annual Plan.

The Committees requested that risk assessments be completed for the SSHP work streams.

It was resolved:

"That the Committees:

1. Note the Southern Strategic Health Plan (SSHP) Implementation Plan;

2. Note the following key dates for reports to be presented for consideration:

a. June 2015 – Implementation Plan for Performance Excellence and Quality Improvement Strategy
b. August 2015 – Leadership Action Plan
c. October 2015 – one page conceptual graphic of the future Southern health system
d. March 2016 – proposal around development of a 'third hub' in addition to Dunedin and Invercargill
e. June 2016 – proposal around role of rural hospitals
f. June 2016 – proposal around role and service provision within Southern DHB Hospitals
g. September 2016 – proposed Southern Workforce Plan
h. December 2016 – proposal outlining the required development and upgrade of Dunedin Hospital produced."

Ms Liz Disney, Senior Manager Service Integration & Innovation, left the meeting at 11.50 am.

11.0 FINANCIAL REPORT

The Executive Director Finance presented the Funder Financial Report for the period ended 28 February 2015 (tab 11), then took questions from members.

It was resolved:

"That the Financial Report be received."

12.0 PERFORMANCE REPORTING 2014/15 – QUARTER TWO

The Committees considered an overview of DHB performance for Quarter Two 2014/15 (tab 12).

It was resolved:

"That the Committees note the results for Quarter Two DHB performance reporting."

13.0 WORK PLAN

The Committees reviewed the DSAC/CPHAC work plan for 2015 (tab 13).

CONFIDENTIAL SESSION

At 12.00 noon it was resolved that the public be excluded for the following agenda items.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(i), 9(2)(j) and 9(2)(f)(iv) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations, and to maintain the constitutional convention protecting the confidentiality of advice tendered by Ministers of the Crown and officials.
2. Draft Annual Plan 2015/16	Plan is subject to Ministerial approval	As above, section 9(2)(f).
3. Draft Māori Health Plan 2015/16	Plan is subject to Ministerial approval	As above, section 9(2)(f).
4. Draft South Island Health Services Plan 2015/16	Plan is subject to Ministerial approval	As above, section 9(2)(f).

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 21 May 2015

MEETING	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Dec 2014	Alliance South (Minute item 7.0)	A3 problem solving sheets, showing KPIs, to be submitted to the Committees.	EDP&F	Appended to Planning & Funding report.	
Feb 2015	Southern Strategic Health Plan (Minute item 4.0)	KPIs to monitor implementation to be submitted to Board for approval.	EDP&F	KPIs being worked upon as part of an overall outcomes framework in partnership with University of Otago – concept ready to test late May	
Apr 2015	(Minute item 10.0)	Risk assessments to be completed for the SSHP implementation work streams.		Included with current version of Implementation Plan for review	
324-2014/12	Annual Plan 2014-15 – Financials (Board confidential minute item 18.0)	Audit & Compliance Unit to be invited to speak to DSAC/CPHAC.	EDP&F	Invitation extended.	July 2015

SOUTHERN DISTRICT HEALTH BOARD

Title:	Planning and Funding Report		
Report to:	Disability Support and Community & Public Health Advisory Committees		
Date of Meeting:	3 June 2015		
Summary: Monthly report on the Planning and Funding activities and progress to date.			
Specific implications for consideration (financial/workforce/risk/legal etc.):			
Financial:	N/A		
Workforce:	N/A		
Other:	N/A		
Document previously submitted to:	N/A	Date:	
Approved by Chief Executive Officer:	N/A	Date:	
Prepared by: Planning & Funding Team Date: 19 May 2015		Presented by: Sandra Boardman Executive Director Planning & Funding	
RECOMMENDATION: That CPHAC/DSAC note the content of this paper.			

8

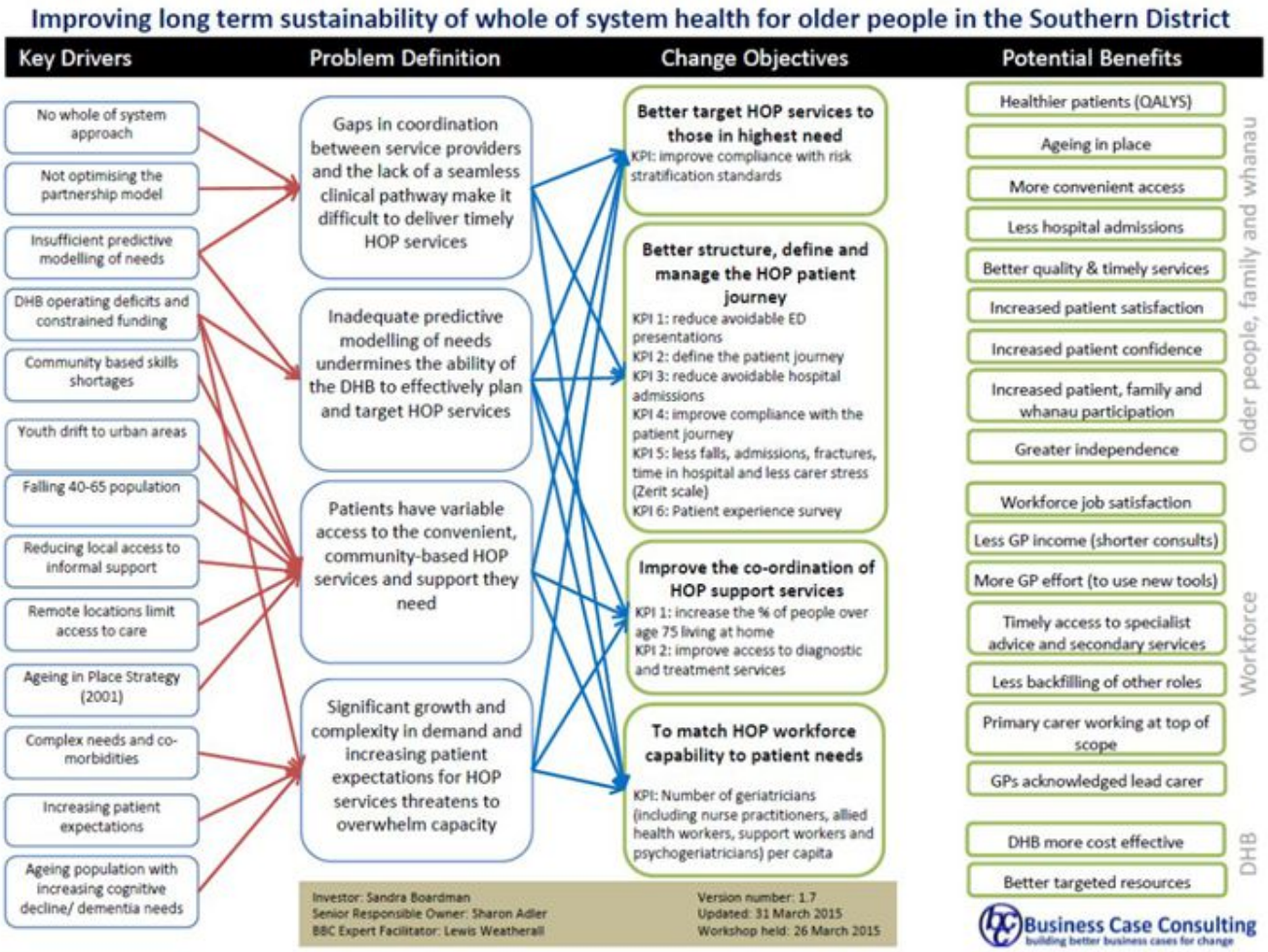
PLANNING AND FUNDING REPORT TO THE DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE June 2015

Health of Older People Portfolio

Health of Older People Strategy

Work has begun on developing a Health of Older People Strategy for Southern DHB, using the Better Business Case methodology. Lewis Weatherall, of Business Case Consulting Ltd, has facilitated five sessions with a small clinically-led work group comprised of clinicians and management from Provider Arm (Older Persons Health and Community, Mental Health and Medical Directorates), WellSouth and Planning & Funding.

The group has identified Key Drivers, Problem Definitions, Change Objectives and Potential Benefits as shown below.



The next step for the work group is to refine the strategic options that have been identified to inform a recommendation for implementation of a cohesive group of programmes and projects to go out for consultation. Using PDSA (Plan, Do, Study, Act) cycles to test innovative ideas on a small scale before making major changes is seen as the preferred way forward.

Age Related Residential Care

Oxford Court Lifecare has received a four year certification from Ministry of Health for a spotless certification audit showing continuous improvement.

Public Health South is scheduling training sessions in Infectious Outbreak Management for Aged Residential Care Facilities. In addition, Public Health South is developing a weekly reporting system for facilities to inform them about infectious outbreaks in the community.

The second cohort of Walking in Anothers Shoes, Dementia Education Training for Support Workers in Aged Care Facilities has been completed and a third cohort is about to begin in Southland. Feedback from the first two programmes has been excellent. Providing this training has highlighted both how very valuable it is and how much it is needed.

Age Related Residential Care Financials

Please see Appendix 1 and Appendix 2 for Financial Reports on Aged Residential Care.

Appendix 1 shows information for General Ledger Code 6640 which included Rest Home and Secure Dementia Care. The capacity or number of rest home beds in the community has been decreasing as providers reconfigure their beds for hospital level care or 'dual use' beds are used for hospital level care. Capacity for dementia beds in the community is increasing as providers reconfigure unused rest home level beds for secure dementia care. Rest Home utilisation remains steady, while dementia utilisation continues to increase.

Appendix 2 shows information for General Ledger Code 6650 which includes Hospital Level and Psychogeriatric Care. Hospital level care bed capacity in the community continues to increase as rest home level beds are reconfigured or 'dual use' beds are used for hospital level care. Utilisation for hospital level care appears to be leveling but it may be too soon to be certain of a trend. Psychogeriatric bed numbers have stabilized, as has the utilisation in this area.

Home & Community Support Services (HCSS)

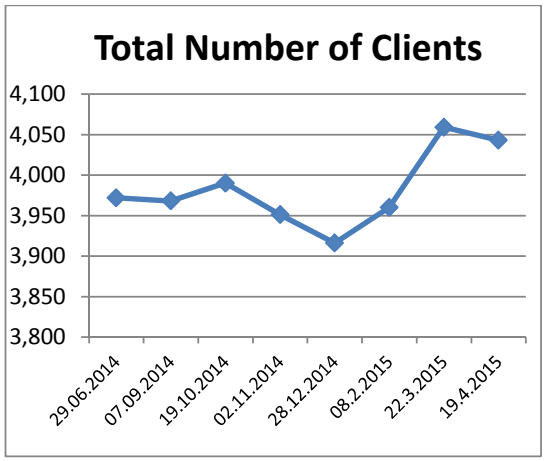
Work is progressing nationally to implement the In-between Travel payments to Support Workers. The key focus at present is to ensure payment for in-between travel can occur from 1 July 2015. For this to occur, an interim arrangement is likely. We expect that funding will be dispersed centrally as part of an interim approach. We have been assured that there will be no risk to DHBs from a centralised approach in the interim phase.

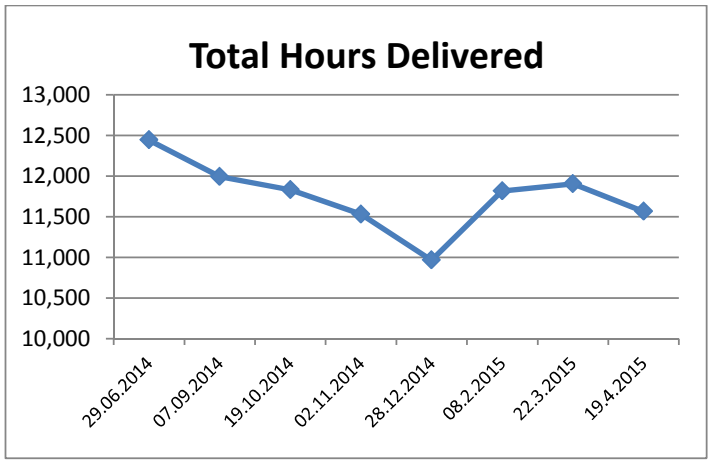
Part of this process will be the repatriation of the 2005/2006 fair travel policy funding. This will be complicated for Southern DHB, as we have some fee for service and some bulk funded Home and Community Support Services. The Ministry will work with us to determine the amount of funding to remove from our contracts with providers.

A related part of this project is the Review of Home & Community Services and Regularisation of the Workforce. A Director-General's Reference Group has been established to provide governance on this work, with two working groups that will report, by 30 June 2015, on a Review of HCSS and Regularisation of the workforce.

The Southern DHB HCSS Alliance Service Development Group has received and reviewed the second 6 monthly Quality Indicators Report from the three providers, showing that over 99% of long term aged care clients have care plans with goals identified. The number of support workers with Level 2 and 3 NZCQ Qualifications continues to increase.

Home & Community Support Services Financials





For the latest fortnight reported (19 April 2015), the total number of older people receiving HCSS services under the bulk-funded restorative service has increased from our expectations but the hours of service delivery per fortnight has remained well within the hours that informed the bulk fund. We determined the bulk funding based on 630,823 hours of service delivery for the year. We are currently forecasting hours at 613,550 hours for the 14/15 year.

Mental Health and Addiction Portfolio

Hapai te Tumanako – Raise HOPE Implementation Update

The district wide Network Leadership Group (NLG) is well established and had its third full meeting on 6 May. NLG members are providing strong commitment and leadership to support the Raise HOPE Implementation work programme.

Each of the four geographic Networks making up the district wide network model are now established and meeting regularly.

The NLG Independent Chair, John MacDonald, and the Alliance South Independent Chair, Robin Gauld, met in early May to discuss how the two groups could work together to deliver on the Southern DHB Strategic Plan. Formal communication mechanisms have been agreed.

A full work programme is now being delivered by the Planning and Funding Raise HOPE Implementation team – please refer to Appendix 3 for an updated Progress/Monitoring Report.

A new project "Growing community based adult mental health rehabilitation service options" has commenced as part of the work programme. Phase one will incorporate analysis of current adult mental health rehabilitation services, needs analysis of people with high/complex and long term rehabilitation needs and the design of a proposed service delivery model. Phases two and three of the project (dependent on the features of any proposed service delivery model) are expected to involve formal consultation and potentially commissioning of new services.

Population Health

Social Sector Trials

Social Development Minister, Anne Tolley, has announced that the Social Sector Trials taking place in 16 communities around New Zealand are being extended for a year from 1 July.

The trials involve a number of agencies working together on the ground in communities to produce better results in delivering social services.

"The Social Sector Trials are demonstrating that a community-based approach can better coordinate Government resources to the people who need them," says Mrs Tolley.

"With a view to adopting permanent structures, over the next twelve months we will take a close look at what is effective in the trial areas and analyse how the trials can work alongside other initiatives such as Children's Teams and Whānau Ora, in the changing social sector landscape.

"Feedback over the next year from those involved in the trials will be extremely important, and I want to thank those communities who are embracing this new way of working together."

* The 16 Trial communities are: Kaikohe; Ranui (West Auckland); Waikato District; Waitomo; Taumarunui; Rotorua; South Waikato; Whakatane; Kawerau; Gisborne; South Taranaki; Horowhenua; Wairarapa; Porirua; South Dunedin; Gore District.

Cancer

Funding of Abiraterone (Zytiga)

PHARMAC will begin funding for the new prostate cancer treatment abiraterone (Zytiga) from 1 May 2015.

Funding for abiraterone will be for men with an advanced form of prostate cancer, called metastatic castration resistant prostate cancer (mCRPC). We expect up to 1000 men per year would receive funded abiraterone.

At a recent meeting with Chief Medical Officers (CMOs) we discussed the current clinical pathway for patients with mCRPC and changes that may occur if abiraterone were funded. We are aware that current mCRPC patients are referred to Medical Oncology services. Based on clinical advice we have received, patients on abiraterone will be able to be initiated and managed by Urologists and Radiation Oncologists as well as Medical Oncologists.

Because of its relatively high list price, there will be relatively high distribution costs through community pharmacy for abiraterone. However, we anticipate overall DHB spend on pharmaceutical distribution costs will decrease over time due to our continued focus on reducing the costs of medicines, for example via our annual tender process.

More information about the abiraterone funding decision can be found in the notification here: http://www.pharmac.health.nz/news/notification-2015-04-08-various/

Southern Cancer Network – Regional Proposal for Additional Psychological and Social Support Services for the South Island

As part of the Faster Cancer Treatment programme, additional funding is being provided for one FTE clinical psychologist in each of the six cancer centres in New Zealand. There is also funding available for up to 20 additional FTE in psychological and social support positions across New Zealand.

The new positions are intended to build on and support existing services in DHBs and will provide services for patients whose cancer has a large psychological and/or social impact on their lives.

Southern DHB, as part of the regional Southern Cancer Network, is working with the other South Island DHBs on a proposal to the Ministry of Health on how these additional services might best be provided. The proposal is due with the Ministry of Health on 19 May. We will provide a further update on progress in a subsequent report.

Primary and Community Portfolio

Community Pharmacy

The original proposal for the extension of the Community Pharmacy Service Agreement (CPSA) has been modified subsequent to considerable feedback from the Pharmacy Sector. This was in response to the consultation process. The DHB CEOs accepted that the original duration of 18 months for the contract extension was not popular with community pharmacists given the expiry date of 31 December 2016.

Accordingly, the CEOs agreed to an initial extension of 12 month with a 1.07% uplift for 12 months and agreement to fund a further 1.0 % up to an additional 12 months if an agreement could not be reached on a new CPSA.

All other components of the Agreement remain the same.

There remains substantial noise however, regarding the pharmacy drug margin issue which is being dealt with by a separate working group. Pharmacists wanted the matter dealt with as part of the CPSA extension.

Urgent Care

The second meeting of the Urgent Care SLAT occurred early May 2015 with the Better Business Cases methodology approach being followed. The Group has worked through the key drivers and has now developed problem definitions, change objectives and potential benefits that will now be further investigated and worked through.

All work streams and SLAs are required to submit a work plan within two months of their formation for Alliance South consideration and annually thereafter, however as this group is currently meeting bi-monthly it is anticipated that a work plan will not be submitted until after the next scheduled meeting. While the detail of the work plan is yet to be determined it will be guided by the SHSHP implementation plan timelines.

Strategies as agreed and updated referral processes have been worked through and implemented with a resultant steady increase in referrals over recent weeks. One change that is working well is St John referring medically safe patients that they have seen overnight who would have been referred to the Rapid Response Nurse during normal hours to the RRS Nurse in the morning following the callout, where previously they would have been taken to the Emergency Department (ED).

A recommendation on the future direction of the service is anticipated to be presented to the Alliance South May 2015 meeting, however it has been signalled that this may not occur until July 2015, at the conclusion of the extended six month pilot period.

The Demand Side Management project has now been completed and as a result the membership and terms of reference for this work stream is in the process of being revised and agreed. A revised work plan is being developed and will be agreed by 31 May 2015.

Consultation with practices has commenced prior to practices having to vote on the proposed changes. The SLAT is still working to have the model agreed to by 1 July 2015. Transition and timing of the implementation of the changes if agreed will be carefully managed taking into account timing of Practice Budget planning, other practice pressures and demands and compliance with contract variation requirements. The implementation date therefore will be later than the 1 July 2015 date for agreement to the changes. Guidance around timelines and implementation will be provided by WellSouth Primary Health Network as the contract holder.

Under 13s

The Ministry of Health (MoH) is to fund DHBs for zero fees for Under 13 year olds. The MoH will fund free under 13 year old visits using the same contracting approach used for free under 6 year olds, which will include capitation funding through PHOs for normal business hours and fund after-hours activities through DHBs.

The MoH will fund an additional subsidy rate of $35 based on a utilisation rate of 2 visits annually and fund an additional ACC contribution of $24 for injury-related under 13 year old visits.

The MoH has allocated $474,704 to Southern DHB towards after-hours visits which have been based on Population Based Funding Formula (PBFF). Southern DHB is in discussions with WellSouth to develop a contract for provision of free under 13 year old after-hours visits.

SDHB will also discuss with community pharmacies, which provide after-hours pharmaceutical services, to agree a mechanism to fund the $5 patient prescription co-payment for the 6-12 age group.

These arrangements will need to be in place before 1 July 2015.

At 18 May 2015, 54 practices have indicated they will join the scheme from 1 July. One practice initially advised they will not join the scheme and WellSouth management is following through with that practice. There are 85 practices in total.

HEALTH PATHWAYS

The primary care clinical lead convened the second Health Pathways meeting for clinicians, and this was held in Gore on 13 May 2015. The meeting continued to foster collegial relationships and set priority areas for health pathways work. WellSouth's Clinical Advisor advised that Health Pathways continues to have some vocal opponents, especially within the secondary care sector, but he is confident that with continued support from WellSouth, effective clinical leadership from primary and provider sectors, pathways will gain traction and should win the battle for hearts and minds.

The cellulitis portal has been fully drafted by Health Systems Solutions. This programme has been specifically designed with input from key clinical individuals. Implementation will be at practices, fully electronic via WellSouth's web portal and will go live in practices very soon.

Integrated and Performance Incentive Framework (IPIF) Health Targets and Clinical Programmes Report

Ministry of Health (MoH) reports for the quarter ending 31 March 2015:

The verified Well South Quarter 3, 2014/15 (to March 2015) results were:

			Target
- More Heart and Diabetes Checks:	83.1%	*(63% at 1 Jul 2014)*	90%
- Better Help for Smoker to Quit:	63.3%*	*(57% at 1 Jul 2014)*	90%
- Increased Immunisation 8 months:	(94.2%)	*(95% at 1 Jul 2014)*	95%
- Increased Immunisation 2 years:	(95%)	*(95% at 1 Jul 2014)*	95%
- Cervical Screening:	(81.7%)	*(new target)*	80%

* As previously noted, WellSouth recorded a drop of 18% from Q1 (76%) to Q2 (57.7%). A detailed investigation ascertained that the 57.7% was the correct position. As a result of WellSouth's Practice Support Team concentrating on the Smoking target as a priority, it was pleasing to achieve a 5.6% increase in the last quarter.

As at 18 May 2015, the Immunisation and Screening results are not known. Quarter 2 results are shown in the table above in parentheses. This information comes from the NIR and national screening programme via MoH and we are expecting this by late May 2015.

Attached – Appendix 4 - are copies of the barometer reports for CVD and Smoking targets. These show the respective changes from quarter to quarter graphically, and form the basis of individual 'league table' reports that go to each practice, identifying their own practice's position compared to all WellSouth practices.

NEW GENERAL PRACTICE – OAMARU

A new general practice: Oamaru Doctors opened in Oamaru on 1 May 2015. The practice will submit their first register in May for 1 July 2015. The majority of the staff (nursing and medical) transferred from Central Medical.

ALLIANCE SOUTH

Please see the attached Appendices 5, 6 and 7 in response to the following action:

8

Dec 2014	Alliance South (Minute item 7.0)	A3 problem solving sheets, showing KPIs, to be submitted to the Committees.	

Attachments:

Appendix 1 Rest Home Level Apr 15
Appendix 2 Two Hospital Level Apr 15
Appendix 3 NLG Work Programme Progress
Appendix 4 CVD and Smoking Targets
Appendix 5 COPD Work Stream May 2015 update A3
Appendix 6 Community Hospital Pharmaceuticals A3
Appendix 7 BBC Map Urgent Care Case for Change 14 May 2015
Appendix 8 PHS Report

Appendix 1: Southern Residential Care – Rest Home Level Apr 15

Rest Home Beds	Actual	Budget	Variance	
Apr 15 - Bed nights	31,954	31,624	- 330	Unfav
YTD - Bed nights	328,132	320,452	- 7,679	Unfav
Apr 15 - Beds per day	1,065.13	1,054	- 11	Unfav
YTD - Beds per day	1,079	1,054	- 25	Unfav

Rest Home bed utilitsation continues the trend of tracking over budget.

Dementia Beds	Actual	Budget	Variance	
Apr 15 - Bed nights	9,291	7,969	- 1,322	Unfav
YTD - Bed nights	92,285	80,748	- 11,536	Unfav
Apr 15 - Beds per day	309.70	265.62	- 44	Unfav
YTD - Beds per day	304	265.62	- 38	Unfav

Dementia bed utilitsation continues the trend of tracking over budget.

Total Beds	Actual	Budget	Variance	
Apr 15 - Bed nights	41,245	39,592	- 1,653	Unfav
YTD - Bed nights	420,417	401,201	- 19,216	Unfav
14 /15 YE Forecast - Bed nights	504,290	481,705	- 22,585	Unfav
YTD - $ Ledger vs Budget	32,819,637	29,379,521	- 3,440,115	Unfav
YTD - $ Service vs Ledger	31,598,795	32,819,637	1,220,841	Fav
YTD - $ Total Variance			- **2,219,274**	Unfav

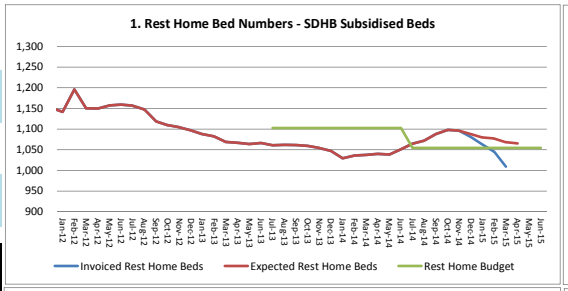
Please note that Graphs 3-6 have been created utilising data from Eldernet and data has not been verified as being complete

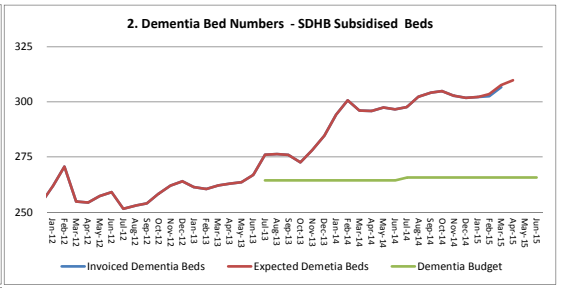
Variance Analysis -YTD vs Budget			13/14 FY		14/15 Estimate	
YTD Rest Home - Price Variance	- 658,268	Unfav	341,877	Fav	- 889,132	Unfav
YTD Dementia - Price Variance	162,231	Fav	275,567	Fav	242,034	Fav
YTD Rest Home - Volume Variance	- 516,416	Unfav	1,330,622	Fav	- 561,562	Unfav
YTD Dementia - Volume Variance	- 1,056,599	Unfav	- 761,851	Unfav	- 1,302,855	Unfav
YTD LTS-CHC Variance	- 150,222	Unfav			- 166,723	Unfav
Variance -$ Service vs Budget	- **2,219,274**	**Unfav**				
Other (including Under accrued prior year expenses of $867)	- 1,220,841	Unfav			- 1,220,841	
Variance - $ Ledger vs Budget (as per accounts)	- **3,440,115**	Unfav	**1,186,215**	Fav	- **3,899,080**	Unfav
+ YTD additional funding for MOH price increase	888,889					
Adjusted Variance (ledger vs budget)	- 2,551,226	Unfav				

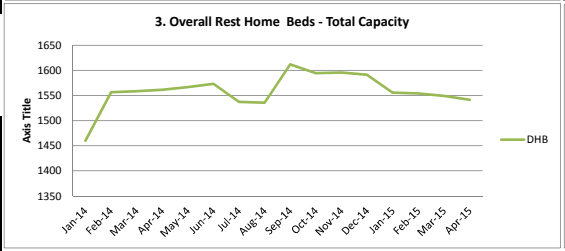
Finanical Year-General Ledger	Actual	Budget	Variance	
11/12 Year	35,731,858	34,169,680	- 1,562,178	Unfav
12/13 Year	34,889,991	36,213,476	1,323,485	Fav
13/14 Year	34,459,963	35,880,081	1,420,118	Fav
14/15 YTD	32,819,637	29,379,521	- 3,440,115	Unfav
14/15 Forecast	39,405,156	35,274,468	- 4,130,687	Unfav

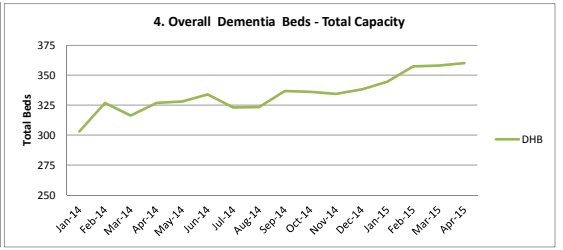
MOH 5% price increase.

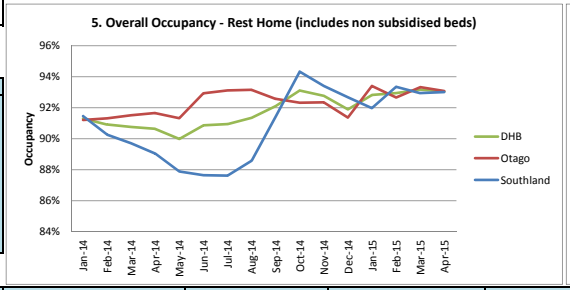
- MOH price increase had had negative effect on ave subsidy for Rest Home but positive effect on ave subsidy for Dementia. Additional funding ($111 per month for 10/14-06/15) has largely offset Rest Home price increase and when taking into account reduction in ave subsidy in other bed types due to price increase (Dementia, Hospital, PG) the additional cost has been fully offset.

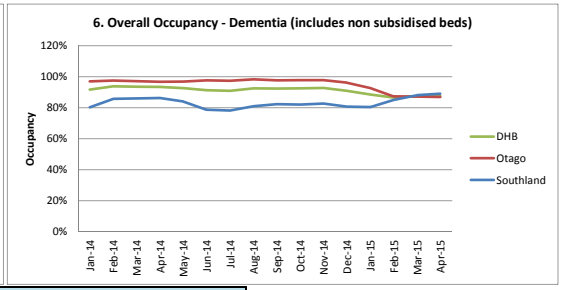












Data Table		Invoiced			Expected			Budget			Bed days			Avg DHB Subsidy $		DHB Subsidy $ Budget		Total $ based on month of service							
Month	Days in month	Rest Home Southern	Dementia Beds Southern	Total Rest Home and Dementia	Rest Home Southern	Dementia Beds Southern	Total Rest Home and Dementia	Rest Home Southern	Dementia Beds Southern	Total Rest Home and Dementia	# Rest Home Bed Days	# Dementia Beds Days	Total bed days	Rest Home	Dementia	Rest Home	Dementia	Rest Home	Dementia	Total	SERVICE BASED ON FORECAST BEDS	General ledger	Budget	Variance Service vs Ledger	Variance Ledger vs budget
11/12 Total		**425,318**	**92,222**	**517,540**				**408,333**	**89,208**	**497,541**	**13,985**	**3,033**	**17,019**	**65.61**	**86.04**	-	-	**27,907,275**	**7,931,516**	**35,838,791**		**35,731,858**	**34,169,680**	**106,933**	**1,562,178**
12/13 Total		**400,526**	**94,862**	**495,388**				**415,600**	**90,353**	**505,953**	**13,165**	**3,119**	**16,284**	**66.26**	**90.70**	-	-	**26,538,971**	**8,602,714**	**35,141,685**		**34,889,991**	**36,213,476**	**251,694**	- **1,323,485**
13/14 Total		**382,450**	**104,680**	**487,130**				**402,310**	**96,448**	**498,758**	**12,573**	**3,443**	**16,016**	**66.10**	**89.92**	**67.00**	**92.55**	**25,281,757**	**9,412,109**	**34,693,866**		**34,459,963**	**35,880,081**	- **233,903**	**1,420,118**
Jul-14	31	32,996	9,224	42,220	32,996	9,224	42,220	32,678	8,234	40,912	1,064	298	1,362	65.94	91.03	67.25	91.59	2,175,665	839,650	3,084,233	3,084,233	2,973,857	2,995,080	- 110,376	21,223
Aug-14	31	33,227	9,371	42,598	33,227	9,371	42,598	32,678	8,234	40,912	1,072	302	1,374	65.82	91.88	67.25	91.59	2,187,118	860,968	3,118,587	3,118,587	3,247,337	2,995,080	128,750	- 252,256
Sep-14	30	32,628	9,121	41,749	32,628	9,121	41,749	31,624	7,969	39,592	1,088	304	1,392	65.73	91.55	67.25	91.59	2,144,508	835,027	3,046,881	3,046,881	3,389,292	2,899,867	342,410	- 489,425
Oct-14	31	34,027	9,450	43,477	34,027	9,450	43,477	32,678	8,234	40,912	1,098	305	1,402	70.94	89.77	67.25	91.59	2,413,766	848,316	3,330,510	3,330,510	3,145,867	2,995,080	- 184,643	- 150,786
Nov-14	30	32,867	9,079	41,946	32,867	9,079	41,946	31,624	7,969	39,592	1,096	303	1,398	70.80	90.48	67.25	91.59	2,326,909	821,477	3,212,994	3,212,994	3,423,145	2,899,867	210,151	- 523,279
Dec-14	31	33,509	9,352	42,861	33,726	9,352	43,078	32,678	8,234	40,912	1,081	302	1,383	70.62	90.18	67.25	91.59	2,366,272	843,387	3,269,526	3,284,850	3,797,104	2,995,080	512,255	- 802,024
Jan-15	31	32,929	9,365	42,294	33,456	9,365	42,821	32,678	8,234	40,912	1,062	302	1,364	70.60	89.66	67.25	91.59	2,324,634	839,663	3,223,437	3,260,641	3,414,857	2,995,080	154,216	- 419,776
Feb-15	28	29,257	8,470	37,727	30,153	8,498	38,651	29,515	7,437	36,953	1,045	302	1,347	70.65	88.91	67.25	91.59	2,067,132	753,049	2,871,889	2,937,683	2,996,353	2,709,439	58,670	- 286,914
Mar-15	31	31,269	9,503	40,772	33,098	9,534	42,632	32,678	8,234	40,912	1,009	307	1,315	70.70	87.50	67.25	91.59	2,210,593	831,515	3,097,294	3,229,311	3,244,109	2,995,080	14,797	- 249,028
Apr-15	30	10,926	3,362	14,288	31,954	9,291	41,245	31,624	7,969	39,592	364	112	476	70.80	87.36	67.25	91.59	773,561	293,716	1,086,367	3,093,105	3,187,717	2,899,867	94,612	- 287,850
May-15	31	-	-	-							-	-	-								-	-	-		
Jun-15	30	-	-	-							-	-	-								-	-	-		
14/15 YTD		**303,635**	**86,297**	**389,932**	**328,132**	**92,285**	**420,417**	**320,452**	**80,748**	**401,201**	**9,978**	**2,836**	**12,814**	**69.13**	**90.00**	**67.25**	**91.59**	**20,990,159**	**7,766,767**	**29,341,718**	**31,598,795**	**32,819,637**	**29,379,521**	**1,220,841**	- **3,440,115**
14/15 Forecast		**364,562**	**103,613**	**468,175**	**393,974**	**110,803**	**504,777**	**384,754**	**96,951**	**481,705**	**11,980**	**3,405**	**15,385**	**69.13**	**90.00**	**67.25**	**91.59**	**25,202,000**	**9,325,230**	**34,527,231**	**37,939,343**	**39,405,156**	**35,274,468**	**4,877,925**	- **4,130,687**

Appendix 2: Southern Residential Care – Hospital Level Apr 15

Hospital Care Beds	Actual	Budget	Variance	
Apr 15- Bed nights	28,242	26,289	- 1,953	Unfav
YTD - Bed nights	279,492	266,392	- 13,100	Unfav
Apr 15 - Beds per day	941	876	- 65	Unfav
YTD - Beds per day	919	876	- 43	Unfav

Hospital Care bed utilisation continues the trend of tracking over budget.

Psychogeriatric Beds	Actual	Budget	Variance	
Apr 15- Bed nights	2,409	3,126	717	Fav
YTD - Bed nights	23,819	31,681	7,861	Fav
Apr 15 - Beds per day	80	104	24	Fav
YTD - Beds per day	78	104	26	Fav

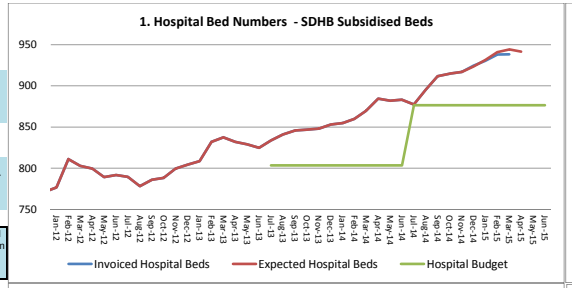
Psychogeriatric bed utilisation continues the trend of tracking under budget.

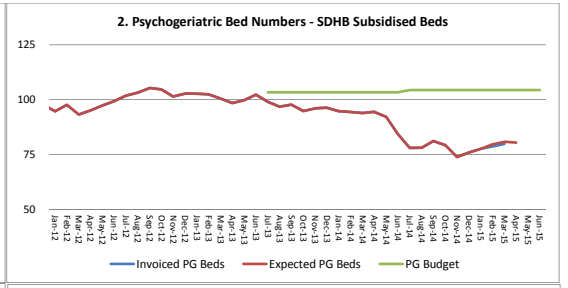
Please note that Graphs 3-6 have been created utilising data from Eldernet and data has not been verified as being complete

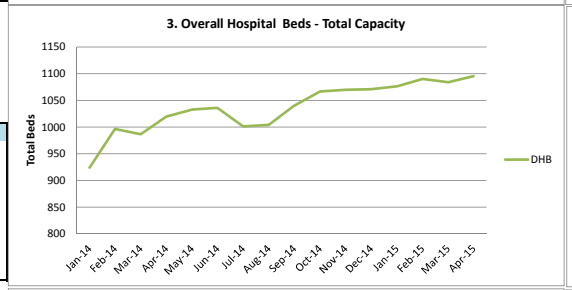
Total Beds	Actual	Budget	Variance	
Apr 15- Bed nights	30,651	29,415	- 1,236	Unfav
YTD - Bed nights	304,112	298,073	- 6,039	Unfav
14 /15 YE Forecast - Bed nights	365,710	357,884	- 7,826	Unfav
YTD - $ Ledger vs. Budget	38,528,403	38,658,629	130,227	Fav
YTD - $ Service vs. Ledger	38,008,439	38,528,403	519,963	Fav
YTD - $ Total Variance			**650,190**	Fav

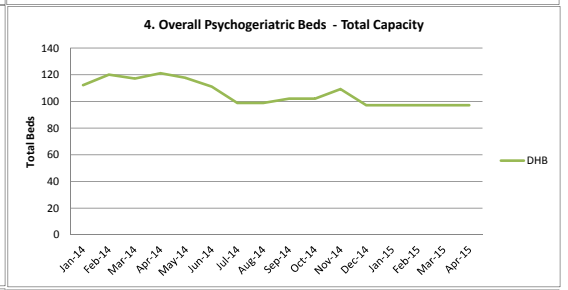
Variance Analysis - YTD vs. Budget			13/14 FY		14/15 Estimate	
YTD Hospital Care - Price Variance		1,275,152	Fav	363,303	Fav	1,595,670	Fav
YTD Psychogeriatric - Price Variance		42,054	Fav	123,210	Fav	36,093	Fav
YTD Hospital Care - Volume Variance	-	1,664,725	Unfav	- 2,538,824	Unfav	- 2,169,468	Unfav
YTD Psychogeriatric - Volume Variance		1,173,088	Fav	480,057	Fav	1,390,645	Fav
YTD LTC-CHC Variance	-	175,379	Unfav			- 174,370	Unfav
Variance -$ Service vs Budget		**650,190**	Fav				
Other (including Under accrued prior year expenses of $283) & BUPA	-	519,963	Unfav			- 519,963	Unfav
Variance - $ Ledger vs Budget (as per accounts)		**130,227**	Fav	**- 1,572,254**	Unfav	**158,608**	Fav

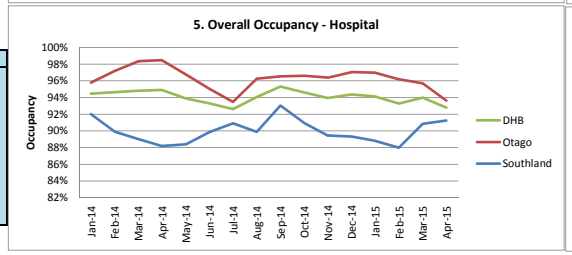
Financial Year-General Ledger	Actual	Budget	Variance	
11/12 Year	40,489,080	39,188,664	- 1,300,416	Unfav
12/13 Year	42,364,651	41,939,535	- 425,116	Unfav
13/14 Year	44,844,798	42,713,656	- 2,131,142	Unfav
14/15 YTD	38,528,403	38,658,629	130,227	Fav
14/15 Forecast	46,259,431	46,415,737	156,307	Fav

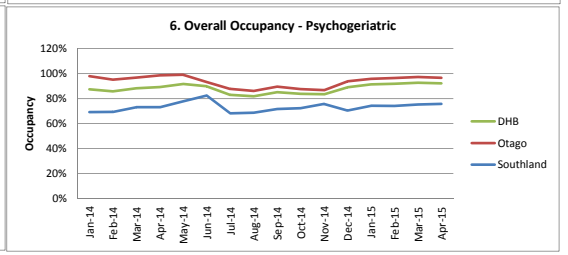












Data Table		Invoiced			Expected			Budget			Bed days			Avg DHB Subsidy $		DHB Subsidy $ Budget		Total $ based on month of service							
Month	Days in month	Hospital Care	Psychogeriatric	Total Hospital and Psychogeriatric	Hospital Care	Psychogeriatric	Total Hospital and Psychogeriatric	Hospital Care	Psychogeriatric	Total Hospital and Psychogeriatric	# Hospital Care Bed Days	Psychogeriatric Beds Days	Total bed days	Hospital Care	Psychogeriatric	Hospital Care	Psychogeriatric	Hospital Care	Psychogeriatric	Total	BASED ON FORECAST BEDS	General ledger	Budget	Variance Service vs. Ledger	Variance Ledger vs. budget
11/12 Total		**286,188**	**35,836**	**322,024**				**271,284**	**36,912**	**308,196**	**9,411**	**1,178**	**10,590**	**123.69**	**147.50**	-	-	**35,398,400**	**5,285,054**	**40,683,455**		**40,489,080**	**39,188,664**	**194,375**	**1,300,416**
12/13 Total		**295,187**	**37,233**	**332,420**				**289,005**	**37,340**	**326,345**	**9,707**	**1,224**	**10,931**	**125.56**	**149.59**	-	-	**37,065,204**	**5,569,574**	**42,634,779**		**42,364,651**	**41,939,535**	**270,127**	**425,116**
13/14 Total		**313,254**	**34,480**	**347,734**				**293,165**	**37,674**	**330,839**	**10,300**	**1,133**	**11,433**	**125.23**	**146.70**	**126.38**	**150.32**	**39,226,145**	**5,059,765**	**44,285,910**		**44,844,798**	**42,713,656**	- **558,888**	**2,131,142**
Jul-14	31	27,192	2,414	29,606	27,192	2,414	29,606	27,165	3,231	30,396	877	78	955	124.77	147.07	127.08	149.22	3,392,656	355,031	3,747,687	3,769,985	3,872,980	3,942,010	102,995	69,030
Aug-14	31	27,754	2,416	30,170	27,754	2,416	30,971	27,165	3,231	30,396	895	78	973	124.42	146.29	127.08	149.22	3,453,245	353,448	3,806,693	3,833,706	4,086,648	3,942,010	252,942	- 144,638
Sep-14	30	27,347	2,431	29,778	27,347	2,431	29,778	26,289	3,126	29,415	912	81	993	124.00	144.55	127.08	149.22	3,390,895	351,406	3,742,301	3,776,094	3,383,166	3,815,099	- 392,928	431,933
Oct-14	31	28,357	2,456	30,812	28,357	2,456	30,812	27,165	3,231	30,396	915	79	994	122.24	143.37	127.08	149.22	3,466,453	352,047	3,818,500	3,850,445	3,974,375	3,942,010	123,930	- 32,366
Nov-14	30	27,498	2,213	29,712	27,498	2,213	29,712	26,289	3,126	29,415	917	74	990	122.33	146.95	127.08	149.22	3,363,876	325,272	3,689,148	3,719,105	3,663,363	3,815,099	- 55,742	151,735
Dec-14	31	28,652	2,350	31,002	28,621	2,350	30,971	27,165	3,231	30,396	924	76	1,000	122.30	148.60	127.08	149.22	3,504,150	349,173	3,853,322	3,877,672	4,050,155	3,942,010	172,484	- 108,146
Jan-15	31	28,840	2,401	31,241	28,871	2,401	31,272	27,165	3,231	30,396	930	77	1,008	121.77	149.08	127.08	149.22	3,511,981	357,965	3,869,946	3,899,880	3,944,406	3,942,010	44,526	- 2,396
Feb-15	28	26,259	2,199	28,458	26,343	2,227	28,570	24,536	2,918	27,454	938	79	1,016	121.01	148.21	127.08	149.22	3,177,563	325,920	3,503,483	3,541,426	3,603,392	3,561,276	61,967	- 42,116
Mar-15	31	29,081	2,471	31,552	29,267	2,502	31,769	27,165	3,231	30,396	938	80	1,018	120.98	150.04	127.08	149.22	3,518,228	370,751	3,888,978	3,938,994	4,110,402	3,942,010	171,408	- 168,393
Apr-15	30	10,089	861	10,950	28,242	2,409	30,651	26,289	3,126	29,415	336	29	365	121.50	150.44	127.08	149.22	1,225,814	129,526	1,355,340	3,801,132	3,839,515	3,815,099	38,383	- 24,416
May-15	31	-	-	-							-	-	-									-		-	
Jun-15	30	-	-	-							-	-	-									-		-	
14/15 YTD		**261,069**	**22,212**	**283,281**	**279,492**	**23,819**	**304,112**	**266,392**	**31,681**	**298,073**	**8,582**	**730**	**9,312**	**122.53**	**147.46**	**127.08**	**149.22**	**32,004,861**	**3,270,538**	**35,275,399**	**38,008,439**	**38,528,403**	**38,658,629**	**519,963**	**130,227**
14/15 Forecast		**313,455**	**26,669**	**340,124**	**335,574**	**28,599**	**365,135**	**319,846**	**38,038**	**357,884**	**10,304**	**877**	**11,181**	**122.53**	**147.46**	**127.08**	**149.22**	**38,408,338**	**3,932,621**	**42,340,959**	**45,635,133**	**46,259,431**	**46,415,737**	**3,918,472**	**156,307**

Hapai te Tumanako - Raise HOPE: Network Leadership Group - Work Programme

Progress/Monitoring Reporting 18 May 2015

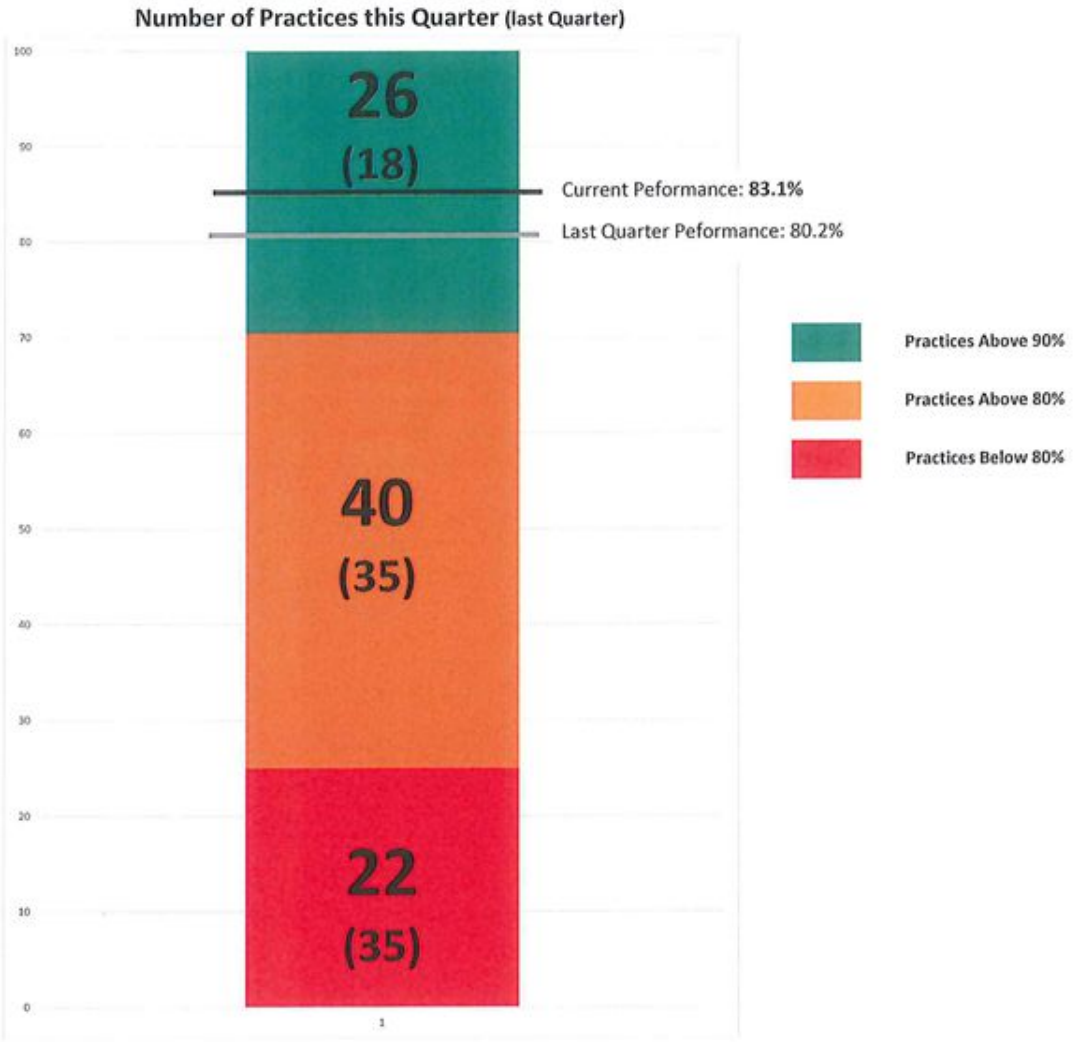
Completed | Underway according to plan | Behind Schedule | Scheduled for....

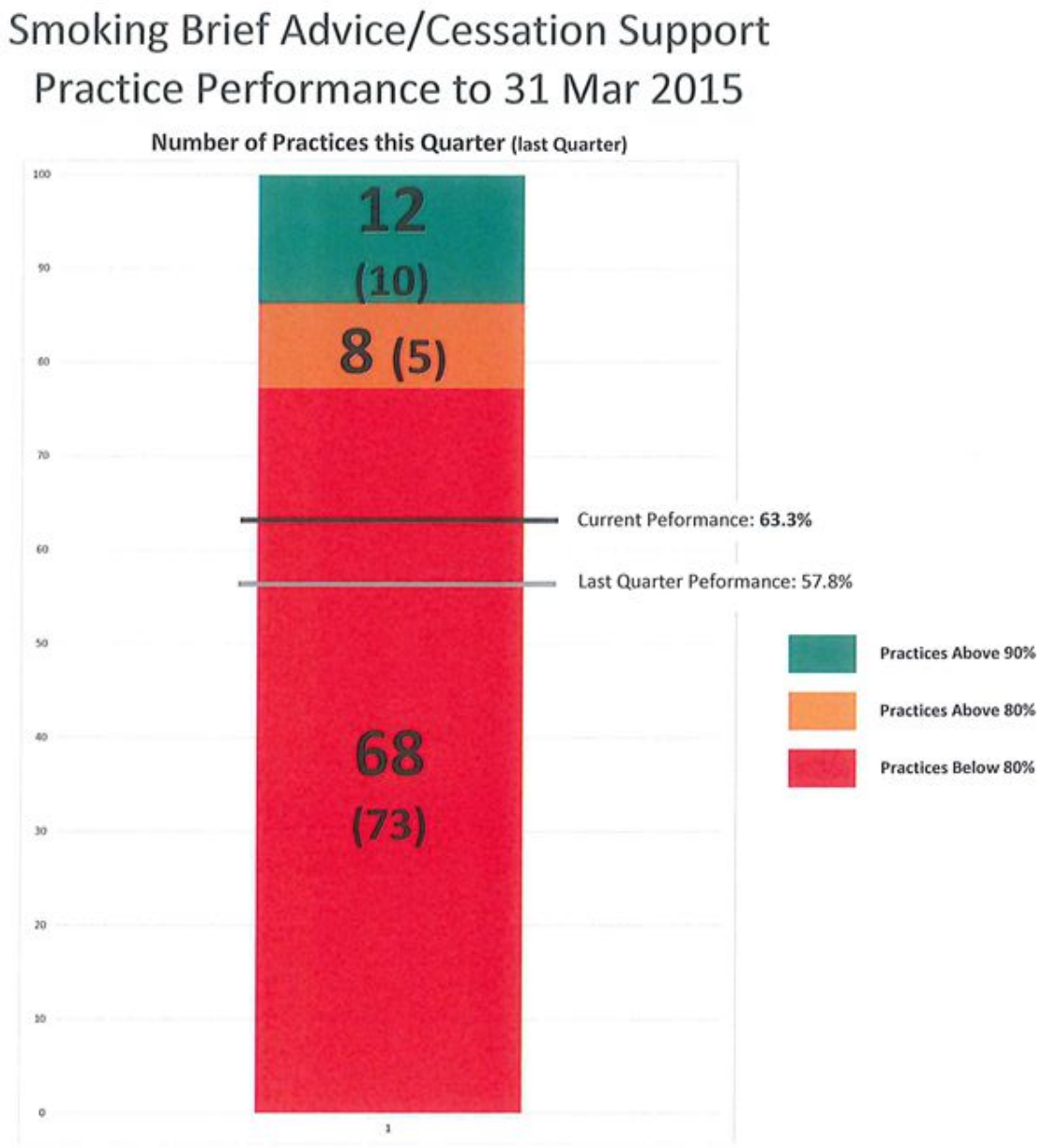
Project	Action	Timeframe	Responsibility	Progress	Progress Narrative
1. Establish 3 Geographical Networks	***1.1** Initial Meetings completed in each Geographical Network area*	*By end of March 2015*	*Kelly Mitchell* *Richard Harris* *Judy Walker*		*Completed*
	***1.2** Each Geographic Network has a Terms of Reference and Network implemented*		*Geographic Network Group*		*Southland-completed; Wataki – completed; Dunedin- in progress; Central/Lakes –in progress*
	***1.3** Chairs to be appointed/elected*		*Geographic Network Group*		*Completed*
2. Stepped Care Model	***2.1** Project Plan for Stepped Care signed off by Planning & Funding*	*By 11 March 2015*	*Planning & Funding*		*Completed 5/2/2015*
	***2.2** Project Working Group members confirmed*	*By 11 March 2015*	*Planning & Funding*		*Completed*
	***2.3** Communications Plan Developed*	*By 1 April 2015*	*Planning and Funding*		*First draft completed however some changes/updates currently being made*
	***2.4** Develop a first draft of proposed Stepped Care Model(s)*	*By 22 May 2015*	*Project Working Group*		*22/5/2015*
	***2.5** Feedback on draft Model*	*By 26 June 2015*	*Project Working Group*		*26/6/2015*
	***2.6** Final Version of the Stepped Care Model tabled and endorsed by Planning and*	*By 26 June 2015*	*NLG/ Planning and Funding*		*26/6/2015*

	Funding Director				
	***2.7** Success Measures identified and detailed range of success measures for the implementation of the Stepped Care Model*	*28 August 2015*	*Project Working Group*		*28/8/2015*
	***2.8** Final Plan completed and signed off by Planning and Funding Director, copies distributed to sector and key stakeholders*	*30 October*	*Planning and Funding Executive Director*		*30/10/2015*
3. Workforce Development	***3.1** Project Plan for WFD signed off by Planning and Funding*	*By 11 March 2015*	*Planning & Funding*		*Completed 5/2/2015*
	***3.2** Project Working Group members confirmed*	*By 11 March 2015*	*Planning & Funding*		*Working Group members confirmed – group has held two meetings*
	***3.3** Communications Plan Implemented*	*1 April 1015*	*Planning and Funding*		*First draft completed however some changes/updates currently being made*
	***3.4** Collection of relevant data information to support the Workforce Development Plan*	*26 June 2015*	*Planning and Funding*		*26/6/2015*
	***3.5** Draft Workforce Development Plan completed*	*7 August 2015*	*Planning and Funding*		*7/8/2015*
	***3.6** Final Workforce Development Plan completed and signed off*	*28 August 2015*	*Planning and Funding*		*28/8/2015*
4. Raise HOPE Outcome Measures	***4.1** Raise HOPE outcome measures agreed and process in place to commence regular reporting*	*By 16 March 2015*	*Richard Harris* *(Planning and Funding)*		*The NLG rejected the first draft of the outcome measures and held its own workshop on May 4. First draft of the proposed new outcome measures tabled at the NLG meeting May 6. Planning and Funding will progress a regular collation of agreed measures from 1 July 2015 with the development of a quarterly reporting template.*
5. Growing Community- Based Adult Mental Health Rehabilitation Service Options	***4.1** Project set-up*	*By 22 May 2015*	*Michelle O'Brien* *(Planning and Funding)*		*Draft Project Plan developed- Executive sponsors sign-off pending* *Project Steering Groups and Working Groups in establishment*
	***4.2** Research best practice/undertake analysis*	*By 30 June 2015*	*Michelle O'Brien with support Working Group*		

Phase One: development of a proposed strengthened model for adult community based rehabilitation services			*(Planning and Funding)*		
	***4.3** Sector wide discussions concerning options for model*		*Michelle O'Brien with support Steering & Working Group* *(Planning and Funding)*		*June 2015*
	***4.4** Development of proposed draft model*	*By 31 July 2015*	*Michelle O'Brien with support Steering & Working Group* *(Planning and Funding)*		*June 2015*
	***4.5** Sign-off Executive Sponsors & approval to move to phase two*	*By 31 August 2015*	*Sandra Boardman* *Lexi O'Shea*		*24 August 2015*

CVD Practice Performance to 31 Mar 2015




Smoking Brief Advice/Cessation Support
Practice Performance to 31 Mar 2015
Number of Practices this Quarter (last Quarter)
12
(10)
8 (5)
68
(73)
Current Peformance: 63.3%
Last Quarter Peformance: 57.8%
Practices Above 90%
Practices Above 80%
Practices Below 80%
100
90
80
70
60
50
40
30
20
10
0
1

Respiratory Services – COPD Adult

AllianceSouth

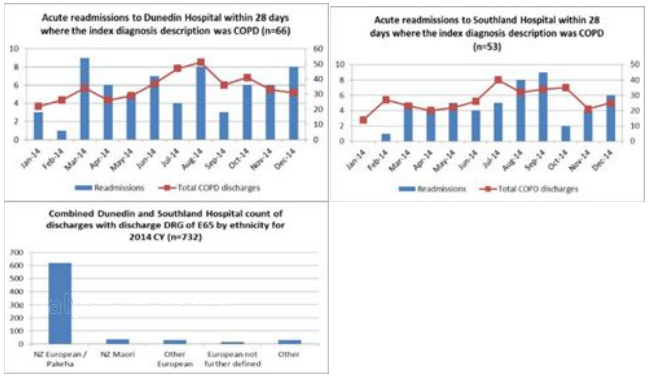
Version:1 Updated: 18/05/2015

Author: Nancy Todd

What are the Problems?

- A large number of patients/whānau with acute acerbations of COPD are being managed in secondary care rather than primary care.
- Communication and resource allocation is a problem when introducing change and/or a new model of respiratory care.

Evidence



732 COPD discharges during 2014 calendar year, with 413 in Dunedin and 319 in Southland hospitals. Many patients had more than 1 discharge from hospital, there were 14 in Dunedin & 15 in Southland who had >4 discharges. There was 1 patient in both Dunedin & Southland discharged 9 times in the 2014 calendar year. COPD Re-Admission rates for Dunedin & Southland hospitals for the 2014 calendar year.

Analysis of Issues:

- Patients/whānau do not routinely have COPD care plans, medications and support to manage acute acerbations at home.
- Patients/whānau have limited/no access to after hour GP services for acute acerbations.
- General Practice and internal hospital referrals continue to increase the workload of hospital Respiratory Specialists
- COPD is not a SDHB health priority, therefore a disincentive to provide COPD services in primary care occurs.
- There are no COPD Health Pathways/models of care (as yet) to ensure consistency of referral process/services district wide.
- Primary care require clinical education on the management of COPD including when to refer to respiratory specialist services
- There is limited awareness and access to community pulmonary rehabilitation programmes/services.

Target Condition (Outcomes):

Improved patient/whānau understanding of COPD and engagement with their primary care provider, to receive the right care and support at the right time and place closer to home.

Reduce unnecessary hospital admissions for patients/whānau with acute acerbations of COPD through the integration of respiratory services across the Southern region.

Proposed Solutions:

- Develop an integrated respiratory service between secondary, primary, rural and community services for the care management of patients/whānau with acute exacerbations of COPD.
- Improve communication and referral pathways to ensure efficient use of existing resources.

Implementation Plan/Activity to Date:

1. Risk stratification of COPD hospital data by General Practice to identify the number of patients with >8 hospital admission and length of stays in a calendar year (2013) completed.
2. Extended general practice consultation for patients identified from risk stratification exercise
3. COPD Blue Card (Care plan) by General Practice in 2014/15 to address the >8 hospital admission/length of stay patients implemented.
4. Gathered the lived experiences of patients/whānau with acute exacerbations of COPD through a narrative process and complete.
5. Snapshot of General Practice clinicians views/perceptions of how to address COPD captured
6. Snapshot of COPD respiratory services and models of care including referral pathways to best understand how to integrate and transform services to address acute acerbations that result in acute admissions to hospital captured
7. Evaluation of the effectiveness of the COPD Blue Card to date underway
8. Risk stratification to occur of COPD hospital discharge and acute re-admission data from both Dunedin and Southland Hospitals for the calendar year of 2014 comparative analysis underway to evaluate effectiveness of intervention.
9. Recommendation to Alliance South June 2015

Results (Outcome of intervention)

Sign off: Date:

8

Title: Community & Hospital Pharmaceuticals

Version:2
Author: Bridget-Mary McGown

Version 1: 14 May 2015

What is the problem:

The continuity and sustainability of health services is a key priority for SDHB and its community. Southern DHB currently sits above the national average for per capita drug expenditure (Currently SDHB is at $227 while the national average is $205).

Additionally, while prescribing across the SDHB district generally conforms to a standard pattern, there are a number of identified outlier prescribing patterns.

Evidence proving the problem:

	Southern DHB
	1 Mar 2013 – 28 Feb 2014
Total drug cost	$65,187,814.70
Total # of items	5,088,746
Total # of prescribers	8,309
# of patients enrolled	286,582
Total # of patients dispensed meds	233,170 (81.4%)
Cost per patient enrolled	$227.47
Cost per patient treated	$279.57
# of items per patient treated	21.82

	Canterbury DHB
	1 March 2013 – 28 Feb 2014
Total drug cost	$96,702,177.37
Total # of items	7,509,899
Total # of prescribers	9,324
# of patients enrolled	487,062
Total # of patients dispensed meds	381,163 (78.3%)
Cost per patient enrolled	$198.54
Cost per patient treated	$253.70
# of items per patient treated	19.70

DHB	Cost per Patient Jul 12-Jun 13
Hutt	$ 264.77
MidCentral	$ 239.95
Counties Manukau	$ 237.96
Wairarapa	$ 234.96
Tairawhiti	$ 229.27
Hawkes Bay	$ 228.80
Whanganui	$ 228.31
Southern	$ 225.77
Waikato	$ 223.16
Taranaki	$ 222.62
Bay of Plenty	$ 221.77
South Canterbury	$ 219.69
Northland	$ 216.18
Nelson Marlborough	$ 213.30
West Coast	$ 206.40
Canterbury	$ 202.17
Lakes	$ 194.29
Capital and Coast	$ 187.51

Current Activity:

1) Analysis of data to evaluate effectiveness of demand side management programme
2) Terms of reference and membership being reviewed by Alliance South by 31 May 2015
3) Revised work plan and priorities agreed with Alliance South by 31 May 2015

Target condition:

To reduce SDHB per capita community pharmaceutical expenditure to a level commensurate with those DHBs with a comparable population demographic

Proposed solution:

1. Analysis of the way medicines are prescribed in the Southern region and an assessment of the potential to improve the value .
2. Comparing patterns to best practice recommendations/use in other similar populations.
3. Identifying changes that could lead to more optimal prescribing
4. Recommendation to Alliance South on future activity

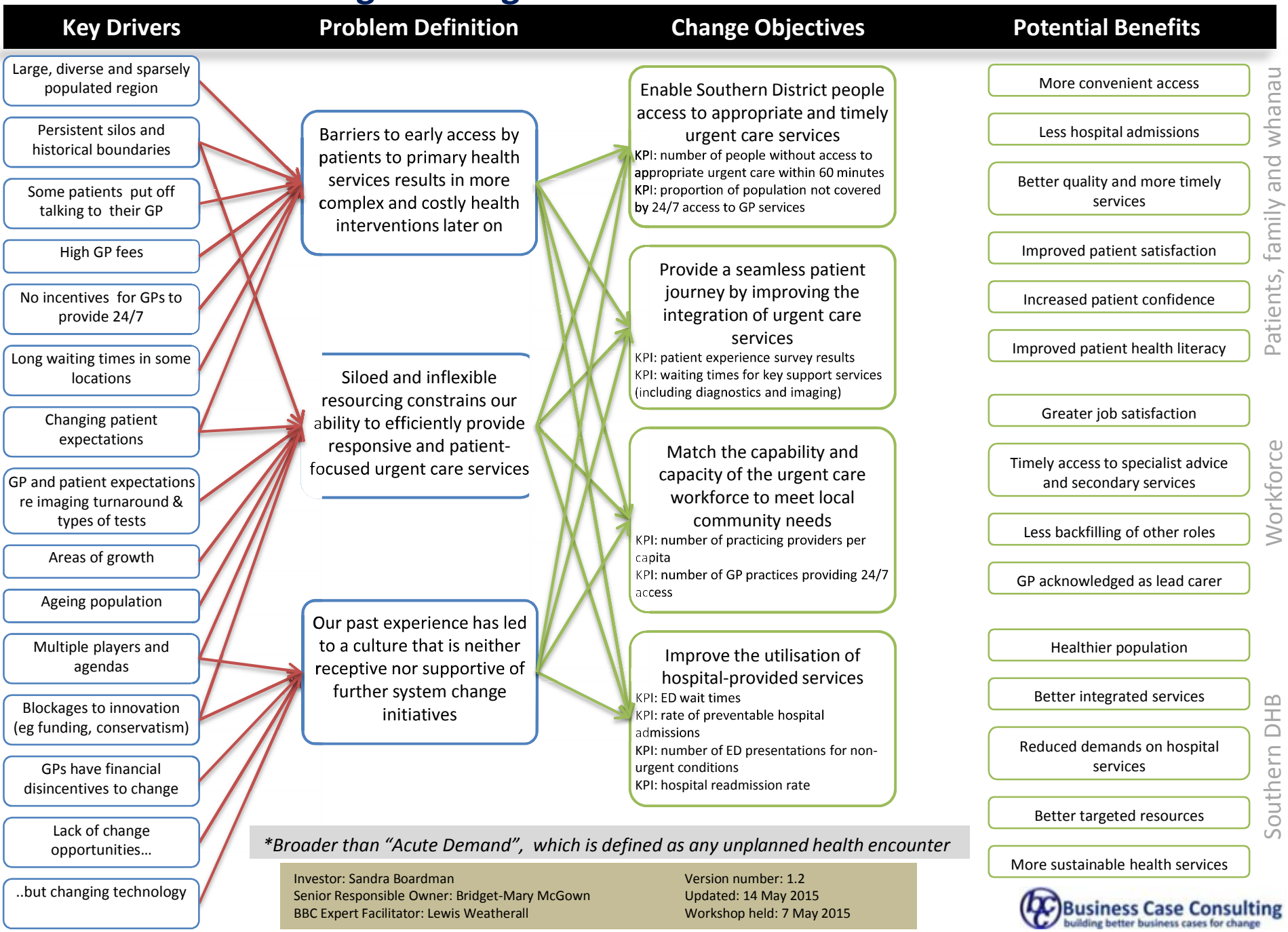
Implementation plan:

1. Establish a Community Pharmaceutical Workstream to provide clinical governance for a Demand Side Management Programme
2. Implement a Demand Side Management programme
2. Develop and implement a series of targeted campaigns aimed at reducing the volume and average per item cost of prescriptions
3. Comparative data analysis to evaluate effectiveness of programme
3. Identify and recommend future areas of activity to reduce pharmaceutical wastage

Results:

1) 373 visits to primary care clinicians completed focusing on specific drugs
2) Visits to secondary care clinicians in neurology, respiratory, ED, cardiovascular physicians Older Persons Health and Dermatology completed and/or progressed

The Case for Change for Urgent Care* Services in the Southern District



Broader than "Acute Demand", which is defined as any unplanned health encounter

Investor: Sandra Boardman	Version number: 1.2
Senior Responsible Owner: Bridget-Mary McGown	Updated: 14 May 2015
BBC Expert Facilitator: Lewis Weatherall	Workshop held: 7 May 2015

Business Case Consulting
building better business cases for change

SOUTHERN DISTRICT HEALTH BOARD

Title:	PUBLIC HEALTH SERVICE REPORT
Report to:	Community & Public Health Advisory Committee
Date of Meeting:	03 June 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: dd/mm/yy
Approved by Chief Executive Officer:	No	Date: dd/mm/yy

Prepared by: Lynette Finnie Service Manager, Public Health Service Date: 1/5/2015	Presented by: Dr Keith Reid Clinical Leader, Public Health Service

RECOMMENDATIONS:

1. That CPHAC note this report.

PUBLIC HEALTH SERVICE REPORT TO THE SOUTHERN DHB
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
3 June 2015

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

Monitoring and Tracking of Influenza like Illness

Influenza surveillance is an essential public health tool for assessing and implementing strategies to control influenza. Influenza viruses can cause significant morbidity and mortality within communities in a short time frame. New strains of influenza appear regularly as the virus undergoes frequent antigenic changes.

The Public Health Service (PHS) contributes to the national sentinel general practitioner (GP) based surveillance, which was established in 1991 as part of the World Health Organization's (WHO) Global Influenza Programme. Six sentinel GP practices have been recruited for the Southern District Health Board region for 2015.

The purpose of this sentinel surveillance is to:

- Improve knowledge of the incidence and distribution of influenza in the community to assist in developing strategies to control influenza through immunisation;
- Enable early detection of influenza epidemics within the community to guide the development and implementation of public health measures; and
- Provide an indication of the predominant strains of influenza virus in the community to help in planning for the most effective influenza vaccine for the subsequent year.

The Influenza surveillance programme provides an estimate of the numbers of influenza-like illnesses occurring within our District (and across the country) and how this changes over time. It is a useful tool to chart the progress of the seasonal influenza epidemic. Information on the predominant influenza strains circulating at any point in time is derived from two sources: samples submitted as part of the surveillance programme combined with sample submitted as part of the diagnostic process in treating severely-ill patients. Taken together these samples, although small in number compared with the overall number of influenza cases, provide a reliable guide as to which strains are causing illness and how this changes through the influenza season.

In addition to coordinating influenza surveillance, the Public Health Service has a number of programmes aimed at reducing the duration and scale of any outbreaks. The Public Health Service works closely with hospital based infection control teams to ensure consistent public health messages are disseminated. Outbreak management training is provided to community based aged care and early childhood providers to reduce the duration and scale of influenza and other outbreaks in these institutional settings. Additional resources have been developed following feedback from these training sessions. Outbreaks are notified by providers and key public health messages are reinforced with staff.

The Public Health Service is currently looking at alternative ways of delivering information relating to influenza outbreak tracking and management including social media platforms.

SOUTHERN DISTRICT HEALTH BOARD

Title:	Child and Youth Summary Report
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	3 June 2015

Summary:

Child and youth summary report.

8.2

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: Thelma Brown Planning & Funding Team Date: 19 May 2015	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

That CPHAC/DSAC note the content of this paper.

Well Child Tamariki Ora

Healthy Conversations

Healthy Conversations (HCS) is Gravida's new Ministry of Health-funded workforce development project, which provides maternity and child healthcare professionals with skills to support behaviour change that they can practice every day with their clients. HCS shows health professionals how to support and empower women and families to plan for themselves what small steps they could take and make healthy choices that fit with their lives.

Participants in the training are shown how to approach nutrition and physical activity conversations, create opportunities to discuss health behaviours, use open questions to better understand a client or family's situation, listen, reflect and encourage them to set their own goals. HCS training helps staff responsible for building relationships with pregnant women, whānau and parents of young children and is helpful at every contact – whether at clinics, home visits, on marae or opportunistically.

Gravida are working with Southern DHB's Midwifery Director and Planning and Funding staff to deliver this training in late September 2015.

Appendix One: Health Conversations Workshop Flyer

Well Child Tamariki Ora Bath Mat Project

The bath mat project, a joint initiative between Water Safety NZ and NZ Plunket and commenced in 2010. Since then around 150,000 mats have been distributed to families at the Core 4 check (five months of age) with the Plunket nurse. ACC in conjunction with Water Safety NZ secured funding to extend this initiative to all Well Child Tamariki Ora providers.

A non-slip bath/shower mat is being provided to each family at the time of the five month core check by the Well Child Tamariki Ora nurse. The mat has the message "Always supervise children around water….always" "Tiakina ngā tamariki ki te taha wai i ngā wā katoa". When the mat is given to the family, the nurse verbally reinforces the water safety messages emphasising the need to actively supervise children in and around water and keep a hand on baby at bath time. Parents are also provided with a water safety reminder sticker at the next core check, Core 5 (nine months of age) that can be placed in their child's Well Child Tamariki Ora book.

Southern District Well Child Tamariki Ora providers received the training at the quarterly Well Child Tamariki Ora Forum held in Balclutha in March 2015. After this initial training session the bath mats were made available for distribution.

Well Child Tamariki Ora Quality Improvement Project Manager

The MoH has agreed to fund four Well Child Tamariki Ora Quality Improvement Project Managers nationally to support DHBs in their WCTO Quality Improvement Framework (QIF) implementation. The project manager positions will be hosted by one DHB in each region. The positions are for a fixed-term of two and a half years and the host DHB will be funded to cover the salary and overheads. The Ministry will separately fund quality improvement training and support for these positions. The positions will provide quality improvement training to DHB staff involved in the WCTO QIF, support closer engagement

between the DHB and the wider child health sector and maintain close links to the Ministry of Health Child & Family Programmes team.

Canterbury DHB has accepted the Ministry of Health contract for the South Island position and has entered into a recruitment process. It is anticipated the appointment will be made shortly.

Before School Checks (B4SC)

The B4SC, the final core Well Child contact, is a comprehensive screening and health education check for children turning four years old and their parents. The check includes measurement of height and weight, screening for vision and hearing concerns, oral health, and an assessment of emotional/behavioural and development status. The purpose of the check is to promote health and wellbeing in preschool children, ensure that children and their families are prepared for school, and to identify any health, emotional/behavioural or developmental concerns that may adversely affect a child's ability to learn in the school environment. The check will be followed by timely referrals to improve child health and education outcomes, and reduce inequalities.

Southern DHB B4SC programme is provided by public health nurses based in the provider arm. Screening of the eligible population and the high deprivation group exceed target by Southern DHB on an annual basis.

The Ministry of Health issues a quarterly Quality letter written by Dr Pat Tuohy, Chief Advisor, Child and Youth Health. The latest Quality Letter highlights achievements and areas for quality improvement based on the results of the B4SC for the first six months of the 2014/15 year. The Quality Letter is attached for information.

Appendix Two: B4SC Quality Letter Jan 2015

Child and Youth General

Child and Youth Steering Group (CYSG)

The CYSG, established in late 2013, continues to meet two monthly. This multiagency group is chaired by Dr David Barker, clinical lead for paediatrics[1] and has representation from education, NZ Police, Ministry of Social Development, primary care, NGO providers, primary care, Social Sector Trials and the Southern DHB including community paediatricians, population health services, midwifery and Planning and Funding.

The CYSG is to become a workstream of Alliance South. Draft terms of reference were considered at the last meeting of the group on the 14 May 2015. Robin Gauld, Chair or Alliance South, attended the meeting to discuss responsibilities of an Alliance workstream. Alliance workstreams require strong clinical leadership to provide guidance in a defined area of health and social service for a defined population group, in this instance child and youth. The CYSG will have responsibility to bring together data and ideas on issues for child and youth and to propose transformational service improvement by identifying areas requiring redesign and innovation.

The CYSG also has responsibility to establish a workplan for 2015/2016. The CYSG will prioritise its workplan based on the South Island Child Health Alliance 2015/2016 workplan, national initiatives such as the Children's Action Plan requirements and the Health Quality and Safety Commissions national initiative on consumer engagement, themes identified within the 2013 Compass Report, and requirements within Alliance South's workplan. Local initiatives are also being considered, for example, the relationship and interface with primary care for those working with children and youth, child respiratory readmissions to secondary care, opportunities in telemedicine and youth transition services. The CYSG will also place emphasis on strengthening interagency relationships and engagement to improve outcomes of children and youth. An example of this was raised at the last CYSG when the head of the Ministry of Education advised that there was to be a national review of Special Education services. It was advised that there would be an opportunity for relevant local health representatives to be engaged with the review process to ensure that those children and youth people with special needs are able to get the most appropriate range of services to ensure they succeed.

The 2015/2016 workplan of the South Island Child Health Alliance is attached for your information.

Appendix Three: South Island CHSLA Workplan 2015-16

Emergency Departments Alcohol Project (HPA)

The Emergency Department (ED) Alcohol project, which commenced in March 2015, takes a broad look at how South Island emergency departments are managing the presentation of young people with alcohol related issues.

The project is being directed by the South Island Alliance's Child Health and Public Health work streams, and consists of child health and public health experts from Southern, Canterbury, Nelson Marlborough, South Canterbury and West Coast DHBs, who have come together for this project.

[1] Dr Barker is also currently the Chair of the South Island Child Health Alliance.

The HPA has provided funding and Emergency Medicine Specialist Dr Paul Quigley has been appointed to provide medical consultancy for this work. There is a scoping report due by the end of June 2015.

This project follows on from the 2012 signing of a unified position statement on alcohol by each of the South Island DHBs, which committed them to reducing the alcohol-related harm experienced by people within their district.

In addition, each DHB committed to identifying and recording alcohol-related presentations within their district in a consistent manner.

Project objectives are as follows:

1. Review the capacity and capability of South Island Emergency Departments (EDs) to be able to engage and respond to patients that present with alcohol related issues.
2. Scope the range and nature of issues identified with young people presenting with alcohol related harm, document issues, patterns and suggested recommendations that would improve patient outcomes, systems and policy.
3. Identify the referral pathways for young people identified with alcohol (and drug) issues presenting to South Island EDs, including pathways that link with local services.
4. Identify a range of interventions that are effective for young people within these settings.
5. Identify what barriers exist to ED staff undertaking screening, intervention and/or referral of people identified with alcohol (and drug) issues.
6. Scope the range of issues associated with alcohol data collection for youth alcohol ED presentations and review current systems used to capture alcohol data.
7. Scope any professional development needs for health professionals working in EDs including those working in emergency medicine, child/adolescent health and allied health professionals.
8. Identify examples of best practice in ED management within the South Island, including the Dunedin Hospital and interface with the University of Otago student population.
9. Explore the interface between alcohol ED presentations and health promotion.
10. Develop recommendations for improving screening, brief intervention and referral in South Island EDs, including the Alcohol Drug Helpline.

SPARX

SPARX (Smart, Positive, Active, Realistic, X-factor thoughts) is an online e-therapy tool provided by the University of Auckland, as an initiative under the Prime Ministers Youth Mental Health Project. It helps young people with mild to moderate depression learn skills to deal with feeling down, depressed or feeling stressed. SPARX was developed to be used either separately or alongside counselling. It is a programme for those young people who would not or cannot talk with someone about how they are feeling.

SPARX is unique in that it uses a fantasy gaming environment to teach different life skills. At the end of this fantasy-world, a Guide shows you how to take the skills they've learned into the real-world. There are 7 levels within SPARX, each offering new skill sets. At Level 1, 4 and 7 there is a mood quiz so that the users can monitor their progress in mood

improvement. Where their scores indicate high levels of depression, or are at risk of self-harm or suicide, they are strongly encouraged to seek help immediately with information on where they can get help and how to ask for it.

SPARX is free to all young people living in New Zealand and all they need is a computer with internet access to use it.

Utilisation of SPARX by young people living in the southern district will soon be available.

www.sparx.org.nz

Childrens Action Plan

The Government released the White Paper for Vulnerable Children in October 2012 along with the Children's Action Plan. In 2014 the Vulnerable Children Act also made sweeping changes to protect vulnerable children. Five government departments are now accountable for protecting and improving the lives of vulnerable children and the NZ Police and the Ministries of Health, Education, Justice, and Social Development have new, legislated responsibilities. These responsibilities are working to ensure a better life for the most vulnerable children in New Zealand.

Children's Action Teams are a new way of working with families/whānau and children. Children's Action teams are a joint approach as it is recognised that no single agency alone can protect vulnerable children. Nor can all the issues facing vulnerable children and their families/whānau be addressed from one aspect only. Children's Action Teams bring together professionals from iwi/Māori health, education, welfare and social service agencies to work with children, and their families. Trained people in the community refer children to local professionals who work with families/whānau to help and support the child.

Service design for each Children's Action Team may be a little different but the focus is always on:

- the individual child;
- getting the right people working together;
- including iwi/Māori, health, education, welfare and social services;
- making a plan to support each child using the local community;
- keeping the plan on track;
- the safety and wellbeing of each child they work with.

Each child identified as 'vulnerable' has their own individualised plan. This sets out the things they need and who will be responsible for delivering the services. The Children's Action Team assigns a Lead Professional for each child and their family/whānau to make sure they receive the right support, protection and care. Working with the child, the Lead Professional brings together a Child Action Team of people who will work together for the best result for the child.

There are now four Children's Teams up and running throughout the country; Rotorua, Whangarei, Horowhenua/Otaki and Marlborough. Six more are planned by the end of 2015; Hamilton, Eastern Bay of Plenty, Tairawhiti, Whangarei, Clendon/Manurewa/Papakura and Christchurch.

Whilst the Southern district does not have a Children's Team at this time, preparation is occurring in a number of areas to support implementation if it is announced that this district was to establish one.

National Child Protection Alert System (NCPAS)

The NCPAS is to be established within the Southern DHB by June 2015. Alerts draw the attention of clinical staff to child protection concerns already known within the health system so they can decide their relevance to the latest presentation. The purpose of entering alerts on the National Health Index Medical Warning System is to make relevant health information available to Southern DHB clinicians and clinicians in other DHBs if a child moves around New Zealand. A multi-disciplinary team makes the decision to place an alert on the system.

NCPAS policies ensure that safe and consistent national practices are followed when staff are placing, responding to and removing child protection alerts on clinical files. Policies outline basic principles that inform the NCPAS and describe the steps to be followed when Southern DHB staff considers an alert should be placed and the steps to follow when an alert is identified.

Shaken Baby Prevention Programme

The Shaken Baby Prevention Programme is a New Zealand education programme which provides an opportunity to deliver effective, simple and consistent education about infant crying and the harm caused by shaking a baby. Caregivers are also provided with helpful tips to support them if they are feeling stressed and where they can go for help.

Education is provided face-to-face, on line, or in a group setting and participants are offered an opportunity to watch a DVD (Never, ever shake a baby; You have the power to protect). The DVD features New Zealand families whose lives have been affected by shaken baby syndrome and gives helpful tips on how to cope with a crying baby.

The Southern DHB is working to roll the Shaken Baby Programme out across the district. The aim is to have education and awareness of the programme delivered to everyone engaging with families/whanau caring for young babies.

Appendix Four: Children's Action Plan Newsletter April 2015

More information on the Children's Action Plan and Vulnerable Children's Act 2014 can be found at: www.childrensactionplan.govt.nz

Appendix On: Healthy Conversation Workshop Flyer

Healthy Conversation Skills (HCS) Training

How can you better support women and families to make healthy choices?

Gravida
HEALTHY START WORKFORCE PROJECT
A healthy start to life starts with all of us
Māu, māku, mā tātou e ora ai
An initiative funded by the Ministry of Health

You are invited to attend *Healthy Conversation Skills* (HCS) training, delivered free of charge by Gravida to Well Child Tamariki Ora providers and midwifery educators and other maternal and child health workforce groups.

Healthy Conversation Skills training is all about skills to support behaviour change and shows you how to encourage women and families to make their own plans and consider healthy choices in nutrition and physical activity that fit with their own culture and world view. *HCS* training will be invaluable for staff responsible for building relationships with pregnant women, parents of young children and whanau.

Previous NZ attendees say:

"Great training – can be used in every aspect of life"

"I enjoyed learning new ways to communicate with clients to encourage more positive health outcomes"

"I can see how the strands of Healthy Conversation skills weave in with the whanau ora approach"

How can I use HCS with families?

- *HCS* shows you how to approach nutrition and physical activity conversations, use open discovery questions, listen, reflect and encourage goal setting: empowering women and families to consider and plan what small steps they could take that fit with their lives
- *HCS* techniques are simple to understand and time-saving, and will support your everyday practice – whether in clinics, on home visits, on marae and/or opportunistically. It includes skills to help you reflect on your practice
- With its flexible framework, *HCS* can be applied to conversations about all types of health priorities, for e.g. smoking or diabetes.

Register now for this training opportunity in your region:

Tuesday 29 September. 8.45 – 3.30pm, Room 6, 3rd floor, **Waikari Hospital,** Main Block, 371 Taieri Road, Dunedin.

Morning tea, lunch and afternoon tea will be provided. Also, for any participants who need to stay in Dunedin the night before to be able to attend this training, dinner at a local restaurant will also be provided if you wish to attend.

Registration: You must register to participate via this online registration form.

Find out more about Gravida's Healthy Start Workforce Project at www.healthystartworkforce.org.nz

*Healthy Conversation Skills (HCS) was developed by the Medical Research Council Lifecourse Epidemiology Unit, University of Southampton, UK (**www.mrc.soton.ac.uk** for publication details).*

The B4SC Quality letter

January 2015

Appendix Two: B4SC Quality Letter Jan 2015

Progress to date

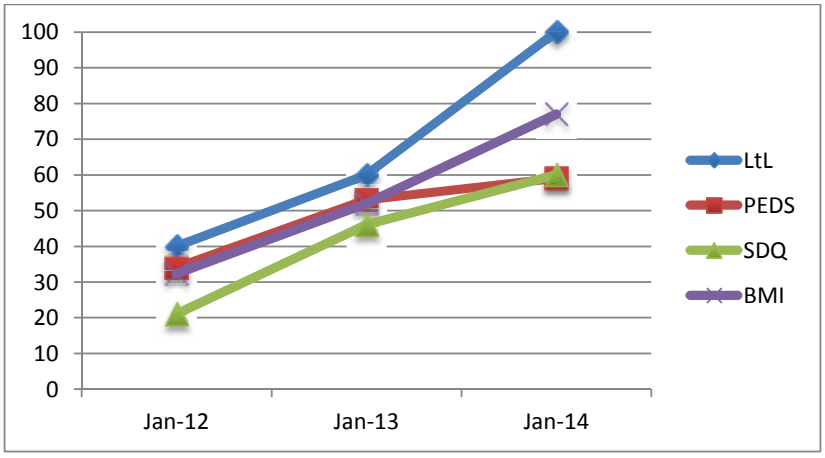
Quality highlights

The highlight for this report must be the 100% achievement in Lift the Lip referrals. This shows what can be done with a closer focus on referral pathways and a well-trained and willing workforce. Over the last few years we have worked hard as a Child Health community to support the inclusion of child oral health as a key component of Well Child Tamariki Ora programme. Although there has been information for parents about oral health in the Well Child book for a long time, it was the Lift the Lip programme which brought about this important collaboration between WCTO nurses and Community Oral Health services. I expect we should soon be seeing the benefits of this early identification and referral, as long as the Community Oral Health services can keep up.

Headline indicators

The headline referral indicators are showing a mixed picture. The Lift the Lip referrals have now reached 100% and will be discontinued in the headline indicators for the next report. The PEDS and SDQ referrals have plateaued at around 60% since the last report in August 2014 and clearly need some ongoing work. The BMI trend is looking very promising, but in order for this indicator to reach much higher rates there will need to be robust referral pathways in every DHB.

Figure 1 - Headline referral indicators



What's next?

The refresh of the B4 School Check messages and the development of new promotional material and tools are almost complete and will be on the ground 6 April. The new promotional material and tools includes Māori and Pacific families sharing their experiences of B4 School Checks in a new series of videos aimed at further increasing the number of children getting checked. There will also be new web content, and print resources, as well as targeted media activity to Māori and Pacific audiences (radio, outdoor Ad shells, and Facebook) for the month of April.

The Ministry is to fund a train the trainer programme and the development of training resources for B4SC Clinical Educators. The aim is to ensure that all B4SC clinical educators in each DHB region are able to train registered health professionals in the delivery of the B4SC to a nationally consistent standard, and that the clinicians undertaking the training have current and evidence based resources to support their practice. The training will take place later this year.

National coverage

The overall national coverage for the first 6 months of the 2014/15 year is exceeding our target, and consistently running a couple of percentage points ahead of last year, although the coverage for the High Deprivation target is lagging a little behind.

Figure 2 - National coverage

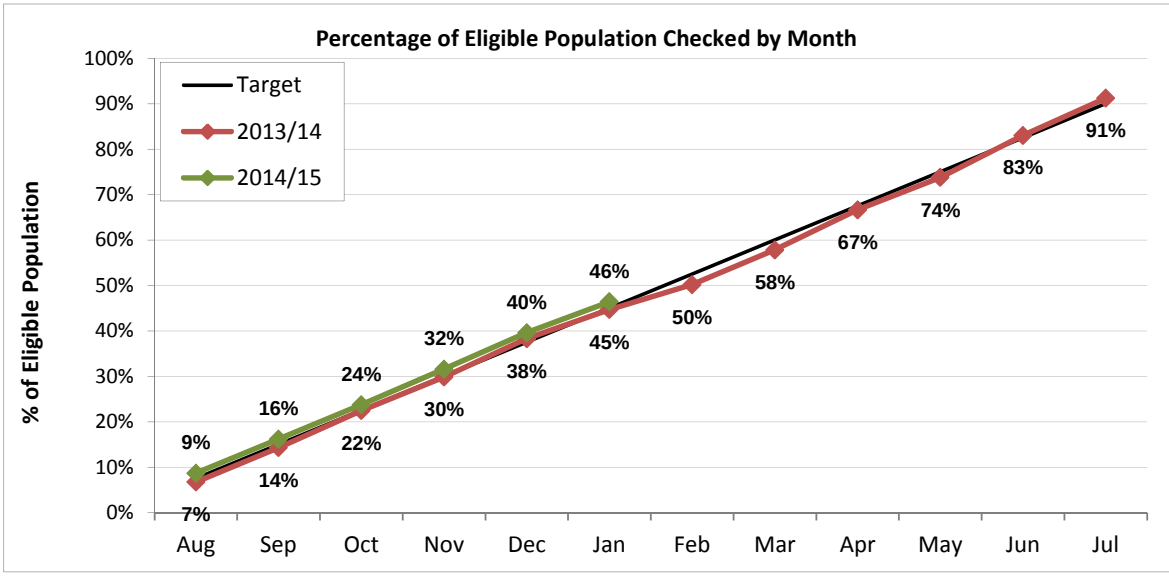
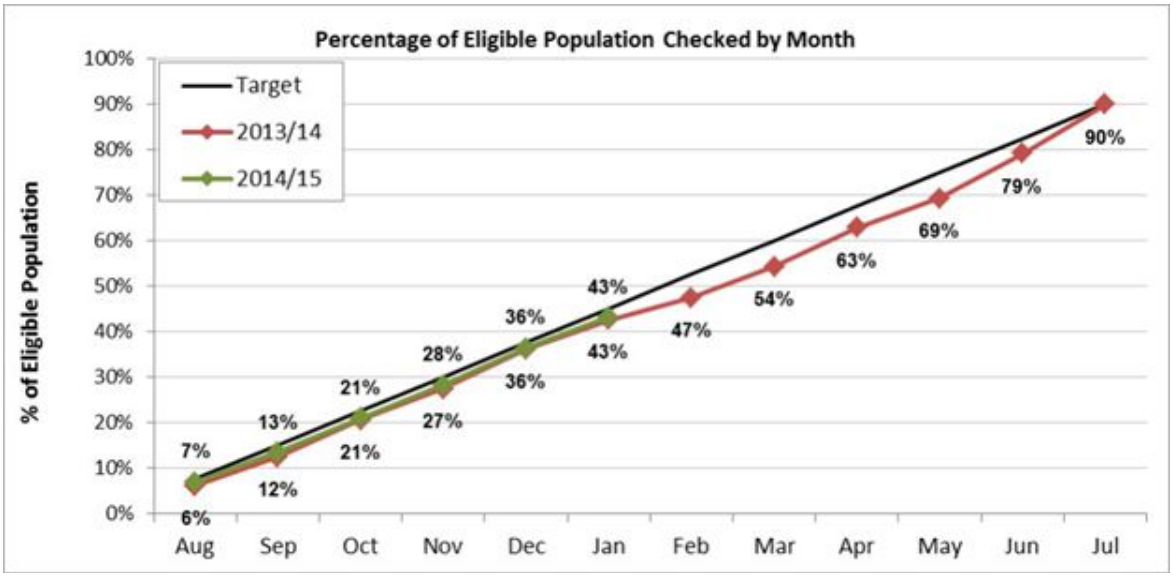
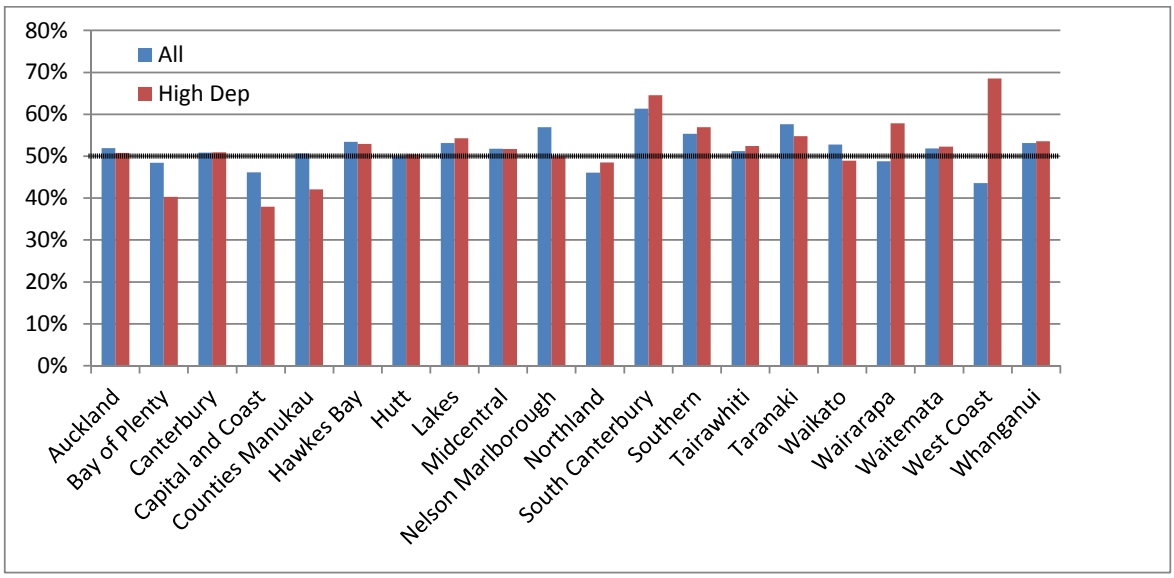


Figure 3 - National coverage for High Deprivation population



With respect to District level coverage, the target at 6 months is 45% coverage and as can be seen from the graph below most DHBs are delivering the B4SC at or above the target level. Auckland DHB have made dramatic improvements since the last report, but several DHBs in particular Capital and Coast, Bay of Plenty and Northland previous excellent results have dropped back over the last 2 quarters. Fifteen DHBs are delivering on target for high deprivation children, which is a great result.

Figure 4 - Performance by DHB against target

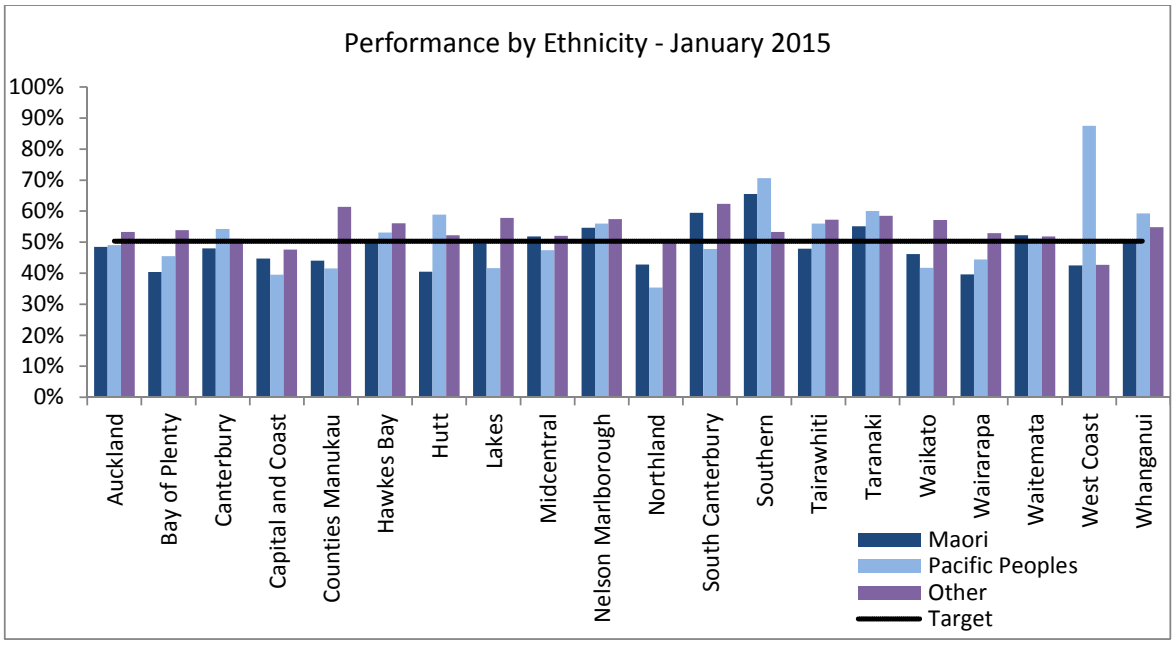


B4SC delivery for tamariki Māori and Pacific children

Programme coverage for tamariki Māori has improved significantly over the last 2 quarters since July 2014. Overall 12 out of the 20 DHBs are delivering the B4SC to tamariki Māori at rates which are pro-equity (close to target), with marked improvements seen in Auckland and Capital and Coast, although these DHBs remain below the target. Mid-Central, Nelson Marlborough, South Canterbury, Southern, Taranaki and Waitemata DHBs are all delivering the B4SC to tamariki Māori above target.

Coverage for Pacifika children fluctuates in many DHBs because of the low numbers of children, although 11 DHBs are delivering at or above target. The graph below shows the district coverage from latest results in Figure 5.

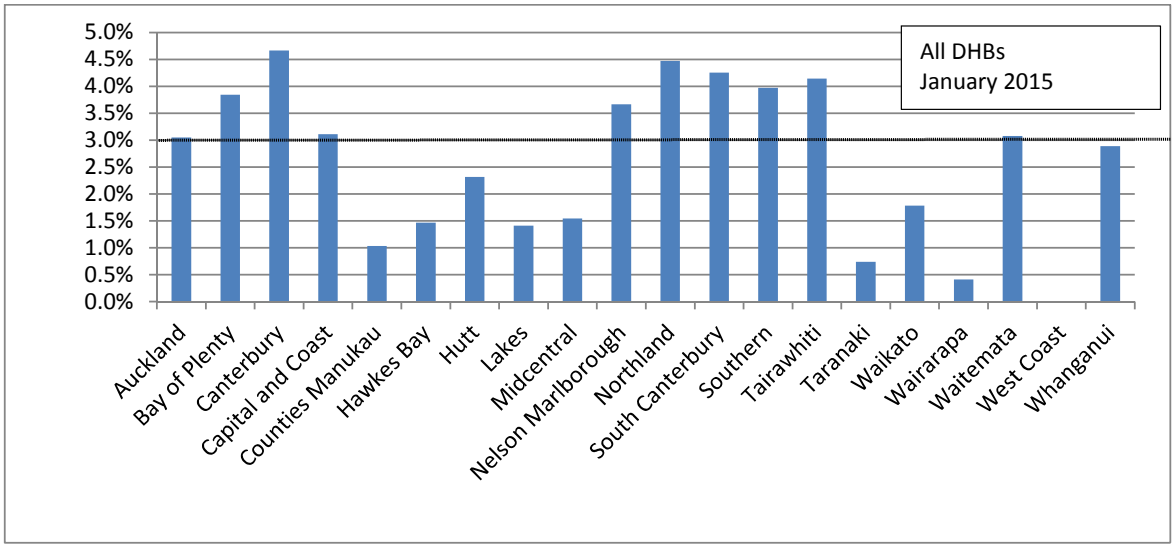
Figure 5 - District coverage by ethnicity – January 2015



Declines

Overall decline rates remain low with a mean of 3%, which is very reassuring, and in general the DHBs with higher declines have seen this rate reduce. Noticeable in this regard are the Bay of Plenty, who have historically had high declines falling from 6% to 4%, and Capital and Coast from 5% to 3%. Several other DHBs are showing small 1% fluctuations which are probably not significant. Overall it appears that variation in decline rates across the country is falling as shown below in Figure 6.

Figure 6 - Declines by DHB



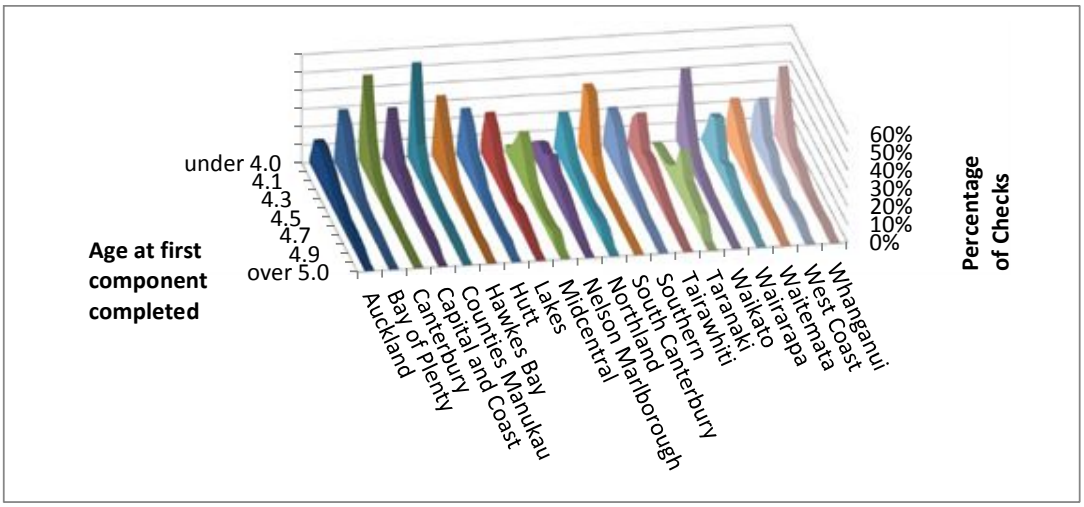
Timeliness of checks

This report is the first to show the timeliness of checks based on when the check was commenced rather than completed. It shows that most children started the check early in their 5th year of life, as expected, with the exception of Taranaki and Northland. These two DHBs are aware of their issues and are taking steps to streamline the referral process into the check.

Table 1 – proportion of checks done before 4.6 years of age

DHB	Checks before 4.6 years
Auckland	85%
Bay of Plenty	94%
Canterbury	98%
Capital and Coast	86%
Counties Manukau	93%
Hawkes Bay	95%
Hutt	91%
Lakes	84%
Mid-central	84%
Nelson Marlborough	80%
Northland	78%
South Canterbury	98%
Southern	92%
Tairawhiti	88%
Taranaki	54%
Waikato	96%
Wairarapa	88%
Waitemata	91%
West Coast	90%
Whanganui	94%
All DHBs	90%

Figure 7 - Timeliness of B4SC delivery by DHB

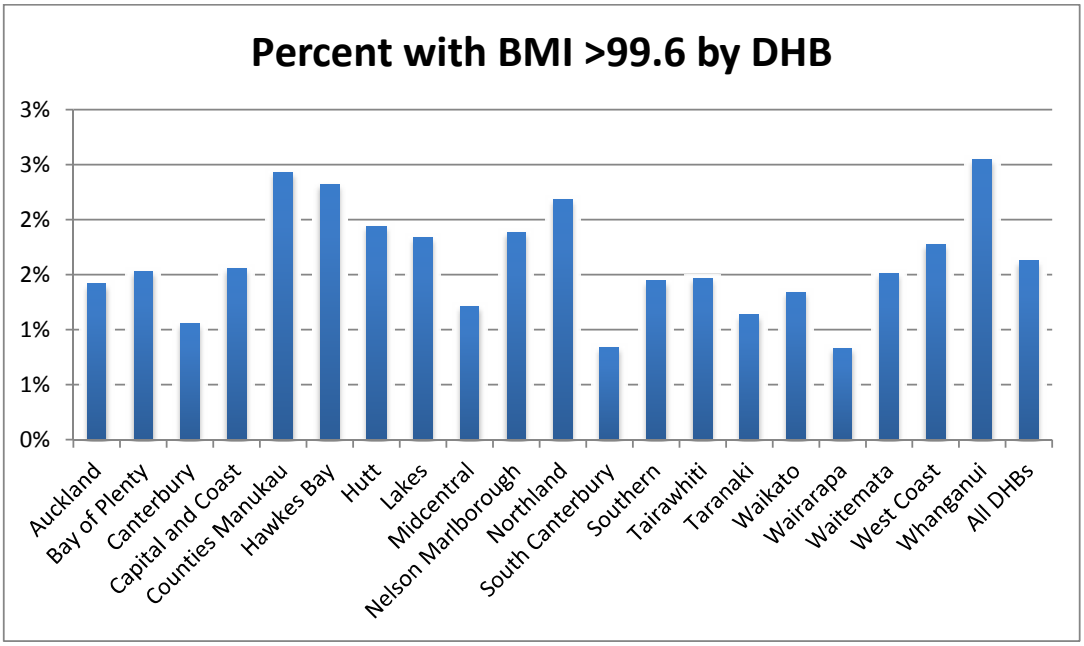


Growth (BMI) monitoring

The Ministry is currently developing a strategy for addressing Childhood Obesity and a Technical Advisory group has been appointed and will meet in early April to provide advice to the Ministry. We have just been informed that the WHO Committee on Childhood Obesity which is co-chaired by Professor Sir Peter Gluckman, has just released their interim report on ending childhood obesity. You can go straight to the site using this QR code or it is available on this website. *http://www.who.int/end-childhood-obesity/commission-ending-childhood-obesity-interim-report.pdf*

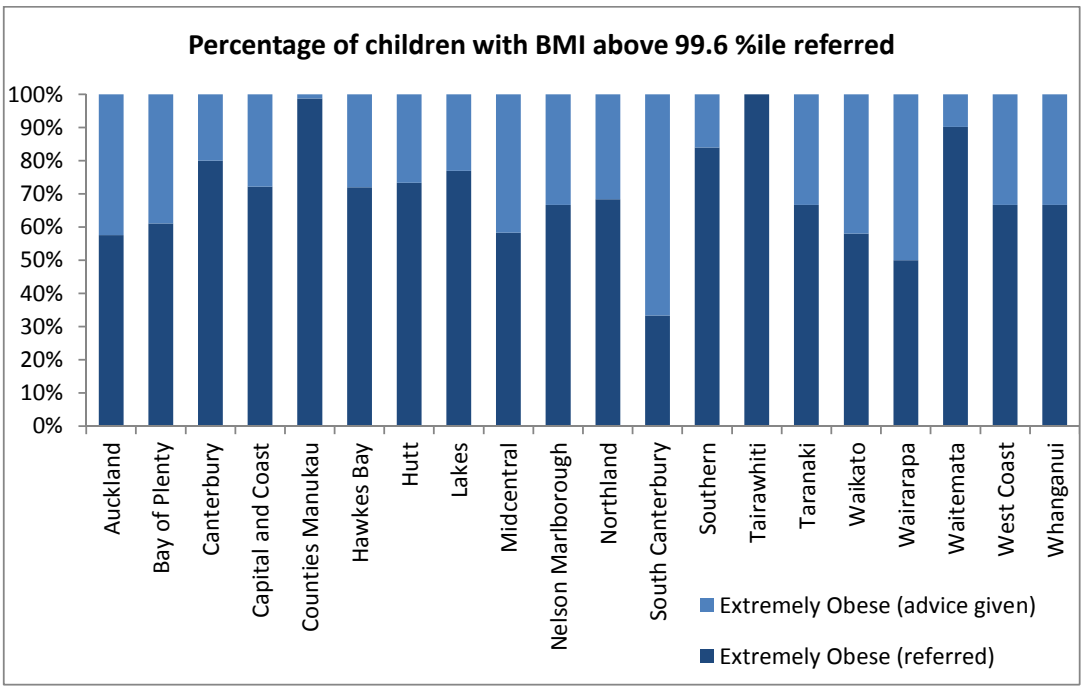
The prevalence of extreme obesity is shown below. Overall the rates are low, and there is little variability across DHBs. Rates tend to be higher in areas of high deprivation, and higher Maori and Pacific populations, as expected from the known demographics.

Figure 8 - Extreme obese rates by DHB



The referral results have risen to 77% for the last 6 months which is a significant improvement, and maintains a strong upward trend. I am aware that a number of DHBs have now developed and implemented local referral pathways, and as more GPs and Paediatricians gain confidence about their clinical options when these children are referred for assessment and follow-up, this figure will continue to increase.

Figure 9 - Extreme obese referral by DHB



Variability across DHBs with respect to obesity referrals is diminishing with only one DHB (South Canterbury), referring fewer than 50% of extremely obese children for assessment and follow-up. Canterbury, Counties Manukau, Northland, Southern, Tairawhitii, and Waitemata are all doing very well with over 80% of these children referred.

Dental checks – Lift the lip

Table 2 - Lift the Lip decay rates by DHB

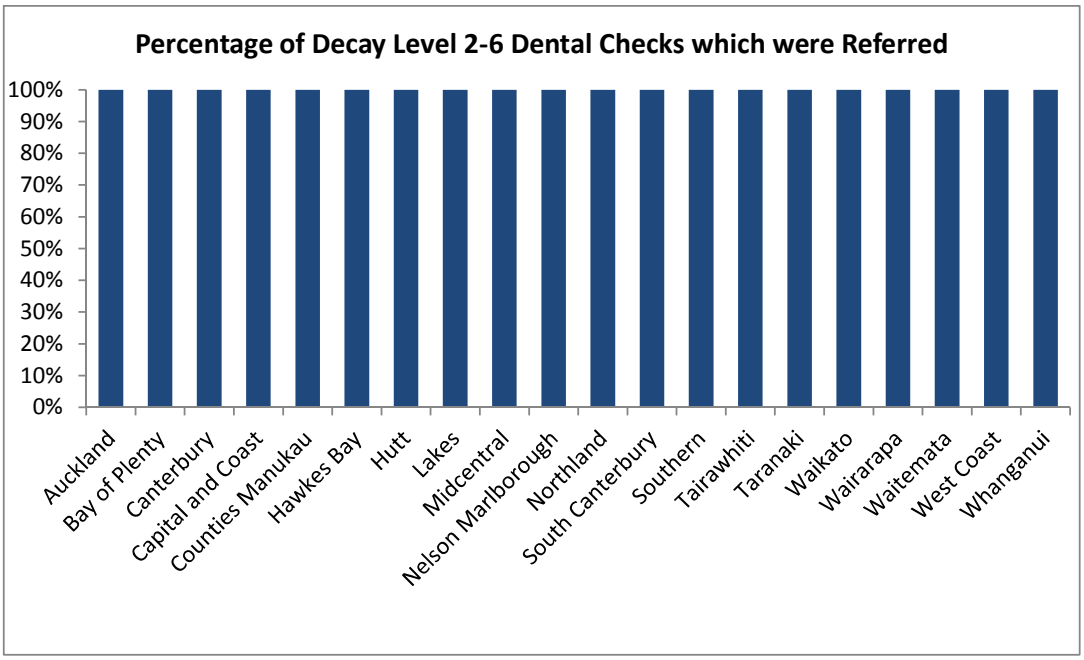
DHB	Decay Level 2-6 (all)
Auckland	15%
Bay of Plenty	9%
Canterbury	13%
Capital and Coast	11%
Counties Manukau	22%
Hawkes Bay	16%
Hutt	9%
Lakes	14%
Mid-central	28%
Nelson Marlborough	8%
Northland	28%
South Canterbury	6%
Southern	9%
Tairawhiti	21%
Taranaki	6%
Waikato	11%
Wairarapa	17%

Waitemata	9%
West Coast	9%
Whanganui	15%
All DHBs	14%

The referral rates to oral health services have increased to 100% since the software change in the B4SC database has been implemented. This is a great result and will build on the close relationships which have been developed between Well-Child/Tamariki Ora and the children's oral health services in DHBs.

Despite the increased awareness of the importance of oral health as a component of the Well Child Tamariki Ora programme, several DHBs (Counties, Mid-Central, Northland and Tairawhiti) continue to record high rates of tooth decay (over 20%). Closer liaison between the Well Child Tamariki Ora programme and the preschool oral health service in these DHBs and some joint problem solving is needed here.

Figure 5 - Tooth decay referral rates by DHB



Hearing and Vision screening

The VHT regional hubs are proving to be an excellent opportunity for networking and VHT focussed in-service training and VHT attendance is strongly endorsed by the Ministry. Due to cost and work pressures the VHT national conference/workshop has been reduced to every two years, which means that some VHTs risk disconnection from the wider workforce. It is therefore important that DHBs ensure VHT and vision and hearing services are well connected nationally and that information is flowing effectively to all those involved in planning and providing the service.

Hearing screening

Table 3 - Hearing screening by DHB

DHB	Checks (rescreens)	Failed Hearing (all)	Failed Hearing (under care)	Failed Hearing (referred)
Auckland	14%	9%	26%	100%
Bay of Plenty	18%	7%	37%	100%
Canterbury	14%	12%	36%	100%
Capital and Coast	16%	14%	57%	100%
Counties Manukau	18%	10%	21%	100%
Hawkes Bay	8%	15%	16%	100%
Hutt	17%	15%	75%	100%
Lakes	7%	16%	29%	100%
Mid-central	14%	11%	33%	100%
Nelson Marlborough	11%	6%	61%	100%
Northland	11%	10%	47%	100%
South Canterbury	6%	9%	23%	100%
Southern	5%	14%	38%	100%
Tairawhiti	10%	13%	51%	100%
Taranaki	4%	20%	13%	100%
Waikato	6%	13%	49%	100%
Wairarapa	13%	14%	55%	100%
Waitemata	8%	7%	24%	100%
West Coast	11%	6%	56%	100%
Whanganui	16%	5%	50%	100%
All DHBs	12%	11%	36%	100%

The B4SC hearing screening continues to perform well although there is still some unexplained variation. Fail rates remain low, in general and the variability is more or less as expected by socio-demographic factors. The fail rates in Taranaki are reducing with changes made to data entry, with rescreens no longer entered as 'fails', however the 'fail' rates remain high (20%) which is double the national average.. The rescreen rates are showing reduced variation, but several DHBs still have high rates with Bay of Plenty, Counties and Hutt sitting around 50% above the national average.

One issue which has emerged recently is the practice of recording children who fail as "Under care" if an appointment is made and accepted by the ENT or audiology services. This is not the purpose of the "Under care" report. This report should only be used to cover two scenarios. The first is when a child presents for screening with a hearing aid or cochlear implants. Clearly these children have a hearing problem and don't need to be screened or referred. By definition they are "Under care". The second scenario is if a child is screened but the VHT learns later (usually on referral, because they will record a fail) that the child is under care. They might not have been wearing their hearing

aid that day or they might have grommets in place. These children can also be reported as "Under care". There are no other scenarios that apply here.

Vision screening

Vision screening results continue to be of high quality, with consistent and appropriate levels of referrals of 9% of screened children, 7% rescreens, and 100% referral rates for vision screen fails. There is very little variability in the rates of vision screen fails across the country. Rescreens remain a little more variable across DHBs, although this is not a significant issue.

Table 4 - Vision screening by DHB

DHB	Checks (rescreens)	Failed Vision (all)	Failed Vision (under care)	Failed Vision (referred)
Auckland	8%	10%	21%	100%
Bay of Plenty	6%	8%	36%	100%
Canterbury	7%	9%	40%	100%
Capital and Coast	10%	10%	36%	100%
Counties Manukau	7%	9%	17%	100%
Hawkes Bay	3%	8%	26%	100%
Hutt	7%	12%	41%	100%
Lakes	6%	11%	18%	100%
Mid-central	9%	11%	20%	100%
Nelson Marlborough	9%	9%	67%	100%
Northland	8%	7%	26%	100%
South Canterbury	3%	10%	38%	100%
Southern	2%	9%	55%	100%
Tairawhiti	7%	11%	54%	100%
Taranaki	3%	11%	24%	100%
Waikato	6%	10%	66%	100%
Wairarapa	9%	9%	37%	100%
Waitemata	7%	8%	35%	100%
West Coast	7%	8%	42%	100%
Whanganui	10%	8%	27%	100%
All DHBs	7%	9%	35%	100%

There is still a need to undertake ongoing evaluation of the vision screening programme to identify the false positive and negative rates. These are important measures in any screening programme, and can assist us to continuously improve the quality of the programme. I remain confident that the competence of the screeners is high, but ongoing evaluation and consideration of the best testing options is still being researched in New Zealand and internationally. Auckland University are currently researching preschool vision screening tests using tablets (iPads) and some exciting possibilities are emerging. I will keep you all informed of progress in this research.

Developmental surveillance (PEDS)

The percentage of children with a Pathway A result is fairly consistent across the country at around 5%, and have stood at this level for some time now. Despite this, referral rates for PEDS pathway A still show marked variability and the national referral rates remains relatively stable at 59% as shown below in Table 5.

Table 5 - PEDS Pathway A results and referrals by DHB

DHB	Pathway A (all)	Pathway A (advice given)	Pathway A (referred)
Auckland	5%	50%	48%
Bay of Plenty	6%	48%	52%
Canterbury	5%	25%	73%
Capital and Coast	6%	69%	31%
Counties Manukau	3%	8%	92%
Hawkes Bay	7%	22%	78%
Hutt	3%	62%	38%
Lakes	5%	70%	30%
Mid-central	4%	26%	67%
Nelson Marlborough	4%	50%	50%
Northland	5%	23%	71%
South Canterbury	3%	44%	56%
Southern	4%	49%	51%
Tairawhiti	7%	50%	50%
Taranaki	7%	66%	34%
Waikato	5%	30%	67%
Wairarapa	5%	33%	33%
Waitemata	7%	31%	64%
West Coast	10%	50%	42%
Whanganui	5%	25%	75%
All DHBs	5%	39%	59%

There are a few DHBs still sitting with low referral rates, with no discernible pattern. Capital and Coast, Hutt, Lakes, Wairarapa and Taranaki are all low referrers (in the 30% range) for these children, and I think it is worth repeating my suggestion from the last Quality letter that these 3 DHBs look at how these services are linking to the Child Development Teams in their areas.

Emotional and Behavioural concerns (SDQ)

SDQ-P results

Table 6 - SDQ–P results by DHB

DHB	Concerning (all)	Concerning (advice given)	Concerning (referred)
Auckland	2%	62%	38%
Bay of Plenty	4%	53%	48%
Canterbury	3%	30%	70%
Capital and Coast	3%	74%	26%
Counties Manukau	4%	24%	76%
Hawkes Bay	5%	31%	69%
Hutt	2%	60%	40%
Lakes	5%	61%	39%
Midcentral	6%	33%	67%
Nelson Marlborough	2%	100%	0%
Northland	5%	21%	79%
South Canterbury	4%	92%	8%
Southern	3%	43%	57%
Tairawhiti	9%	50%	50%
Taranaki	8%	70%	30%
Waikato	4%	48%	52%
Wairarapa	1%	0%	100%
Waitemata	3%	26%	74%
West Coast	2%	0%	100%
Whanganui	6%	13%	88%
All DHBs	4%	43%	57%

The overall rate of SDQ-P screens in the “Significant concern” range (total score >17) has fallen further to below 4% over the last 6 months. Decline rates are encouraging at 1% overall, but some DHBs (Mid-Central, South Canterbury and Southern) have decline rates 3-4 times higher than this.

The referral rate for children with significant concerns has increased from the last report to 57% with the remainder of the children and parents being offered support and advice by the nurse at the time of the check. As shown in the table and graph there remains significant variability in referral rates. It appears that Nelson Marlborough has an anomalous result which needs to be explained, and the referral rates in South Canterbury remain very low. The Ministry team would like a report-back on whether this is a data issue or represents differences in clinical practice in the region.

Figure 11 - SDQ-P 'significant concern' referred

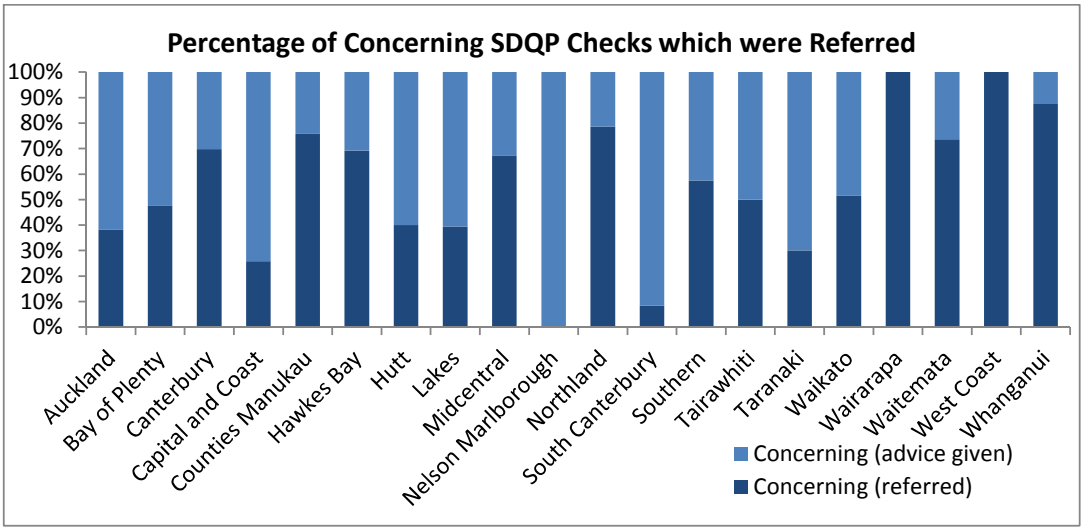
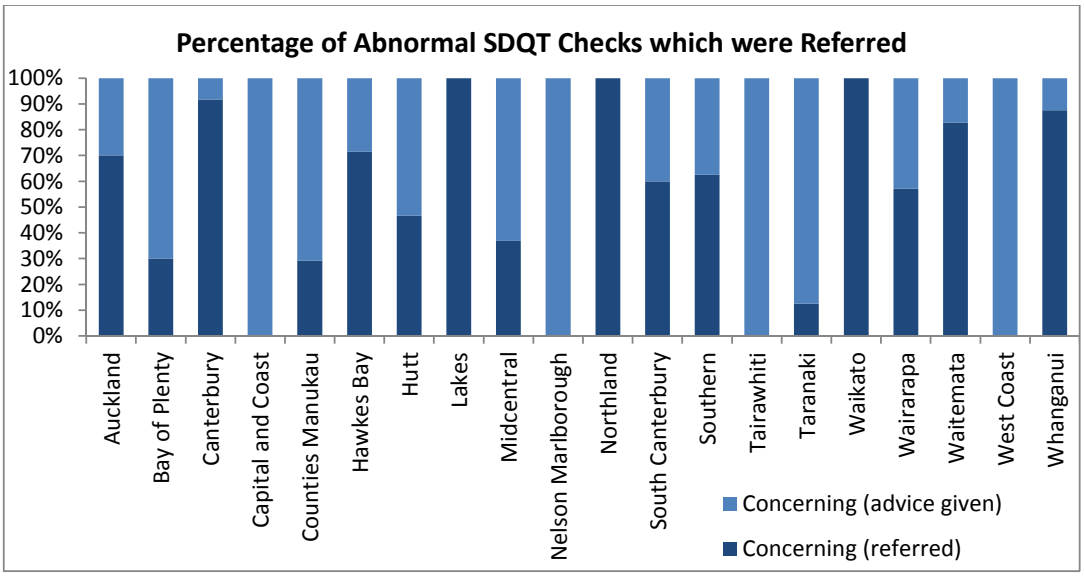


Table 7 - SDQ-T uptake by DHB

DHB	SDQT and SDQP Completed
Auckland	71%
Bay of Plenty	59%
Canterbury	80%
Capital and Coast	56%
Counties Manukau	34%
Hawkes Bay	52%
Hutt	63%
Lakes	57%
Midcentral	60%
Nelson Marlborough	86%
Northland	45%
South Canterbury	84%
Southern	89%
Tairawhiti	63%
Taranaki	88%
Waikato	60%
Wairarapa	69%
Waitemata	98%
West Coast	99%
Whanganui	84%
All DHBs	65%

Completion of both the SDQ-P and T remains much the same as last report, although the total has improved slightly at 65%. There has been a lot of discussion about what to do if the SDQ-T reports are not returned by the school in a timely fashion, if at all. Some DHBs e.g Auckland are marking this as 'Not Applicable', but this is not a universal practice. Unfortunately this muddies the reported results, and makes it hard to get a coherent national picture. Achieving a consensus on the agreed approach will need to be a focus of the next few national teleconferences.

Figure 12 - SDQ-T 'significant concern' referred



Appendix Three: South Island CHSLA Workplan 2015-2016

South Island Alliance 2015-16 South Island Child Health Alliance Annual Plan									
Actions to deliver	**ITEM NO**	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**ACTIVITIES TO ACHIEVE DELIVERABLE** (INCLUDING QUARTER MILESTONES)	**IDENTIFY OUTCOME/S & MEASURES**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**	**HEALTHPATHWAY**
CLINICAL SERVICES: SUSTAINABILITY & CLINICAL INTEGRATION									
CHILD HEALTH SERVICES									
GROWING UP HEALTHY **responding to national strategies for improving children's health outcomes and preventing child abuse**									
South Island Children's Action Plan (Government strategy) **Healthy Families New Zealand aims to improve people's health where they live, learn, work and play in order to prevent chronic disease**									
South island Children's Action Plan (Government Strategy)	1	*Identify and monitor the implementation of agreed South Island regional interventions to better manage safety, reduce family violence and childhood poverty.*	**Q4**	To disseminate learnings from the Blenheim and Christchurch Children's Action Teams as they evolve **Q4** Assess regionally Healthy Homes activities **Q1** Review SI DHB housing position statements and comment in conjunction with SI PHA **Q2**	Improved environments to support children at risk. *Measure* Monitor the number of children seen by the Children's Teams and the interventions required.	Continuous evaluation of outcomes	Continuous evaluation of outcomes	Contributor: SI CHA SI PHA Reported in :SIHSP	No
Regional Sudden and Unexpected Death in Infants (SUDI) rates continue to trend downwards									

South Island Alliance 2015-16 South Island Child Health Alliance Annual Plan									
Actions to deliver	**ITEM NO**	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**ACTIVITIES TO ACHIEVE DELIVERABLE** (INCLUDING QUARTER MILESTONES)	**IDENTIFY OUTCOME/S & MEASURES**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**	**HEALTHPATHWAY**
Regional Sudden and Unexpected Death in Infants (SUDI) rates continue to trend downwards in SI	2	Implement the findings of the audit of the SI sudden death in infancy policy.	**Q2**	Undertake audit of safe sleep practice in DHBs in SI	Babies are protected from harm and needless death *Measure* Incidence of SUDI per live birth in the SI DHB's Audit outcome: proportion of babies in a safe sleep place and % of mothers who received parent education.	Ongoing monitoring and evaluation of audit outcomes	Ongoing monitoring and evaluation of audit outcomes	Contributors: CHSLA (Facilitator) Reported in: SIHSP	No
YOUNG PERSONS HEALTH **responding to the Prime Ministers youth Mental Health project**									
Pathway to improve health outcomes for Māori and Pacific Island youth with mental health conditions									
Pathway to improve health outcomes for Maori and Pacific island youth with mental health conditions. *One primary care mental health disease prevention approach agreed and implemented.*	3	Evaluation and implementation of an e tool that would meet the needs of youth, in particular Māori and Pacific Island, health outcomes.	**Q4**	Support the uptake of either BRAVE and / or SPARX within primary care **Q2** Assess access of e tools and uptake by ethnicity and recorded improvements in mental health **Q4**	People are protected from harm or needless death *Measure* The number of Maori and Pacific accessing e tools BRAVE and SPARX	Implementation of agreed mechanisms Continuous evaluation of outcomes	Implementation of agreed mechanisms Continuous evaluation of outcomes	Contributors: CHSLA & MHSLA Reported in: SIHSP	No
Support programmes which reduce youth risk taking resulting in injury/disease from smoking, alcohol, drug and sexual diseases									

South Island Alliance 2015-16 South Island Child Health Alliance Annual Plan									
Actions to deliver	**ITEM NO**	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**ACTIVITIES TO ACHIEVE DELIVERABLE** (INCLUDING QUARTER MILESTONES)	**IDENTIFY OUTCOME/S & MEASURES**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**	**HEALTHPATHWAY**
Support equitable and accessible programmes across the SI which reduce youth risk taking resulting in injury/disease/sexual health outcomes from alcohol and drug use.	4	Downward trend in youth alcohol related presentations to hospital and improved uptake of referral from EDs to alcohol services in the South Island. Reduced teen pregnancy and referrals to Sexual health.	Q3	In partnership with Health Promotion AgencySI PH SLA and SI MHA implement findings of SI ED scoping exercise **Q1** To Advocate for primary care funding for sexual health visits 15-21 years **Q2**	Young people are screened for alcohol and drug risk taking. *Measure* Reduction in alcohol related presentations to ED/After hours clinics. An increase in referrals from ED and primary care to Alcohol support agencies. Monitor rates of pregnancy 15-24 and terminations of pregnancy.	Implementation of agreed findings Continuous evaluation of mechanisms in place	Implementation of agreed findings Continuous evaluation of mechanisms in place	Contributors: CHSLA & MHSLA SI PH SLA HPA Reported in:SIHSP	No

South Island Alliance 2015-16 South Island Child Health Alliance Annual Plan									
Actions to deliver	**ITEM NO**	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**ACTIVITIES TO ACHIEVE DELIVERABLE** (INCLUDING QUARTER MILESTONES)	**IDENTIFY OUTCOME/S & MEASURES**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**	**HEALTHPATHWAY**
ACCESS TO CHILD HEALTH SERVICES **supporting innovation, good practice and equity based on the Children's Commissioner Compass report 2013**									
Interventions to reduce hospital admission for skin infections and respiratory conditions with emphasis on at risk children and families, Māori and Pacific									
Interventions to reduce hospital admission for skin infections and respiratory conditions with emphasis on at risk children and families, Maori and Pacific.	5a	Downward trend in avoidable hospital admissions for children across the South Island with Dermatitis and Eczema	Q3	CH Pathway exists in Cantebrury to be reviewed for SI Healthpathway site **Q1** Increase GP training on Dermatitis and Eczema **Q2** Monitoring and evaluation to ensure a continuing downward trend of avoidable hospital admissions **Q3**	Babies, Children and Young People have prevented/delayed burden of long term conditions *Measures* Reduction in presentation to ED. Reduction in admissions to hospital	Ongoing monitoring of hospital admission rates and ED presentations	Ongoing monitoring of hospital admission rates and ED presentations	Contributors: CHSLA Reported in: SIHSP	Yes

South Island Alliance 2015-16 South Island Child Health Alliance Annual Plan									
Actions to deliver	**ITEM NO**	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**ACTIVITIES TO ACHIEVE DELIVERABLE** (INCLUDING QUARTER MILESTONES)	**IDENTIFY OUTCOME/S & MEASURES**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**	**HEALTHPATHWAY**
To address the service provision in the South Island for Paediatric and Adolescent Diabetes Mellitus	5b	A SI Diabetes Working Group established to improve systems across SI for young people with Diabetes in particular Type 1.	Q4	Support the Working Group representative of the 5 DHBs in SI established in 2014/15 **Q4** Identify gaps in the SI and make recommendations to SI CHA on: Inequalities, access, service design and implications for resources and funding **Q3**	Children and Young People have increased access to planned care *Measure* HBA1c levels monitored by DHB. Percentage seen according to working group model.	Implement findings of Working Group	Review further and implement findings of Working Group	Contributors: CHSLA Diabetes Working Group Reported in: SIHSP	Yes
Assess the triage process of referrals from primary to secondary care.	5c	Scope the triage activity in each SI DHB.	Q4	Triage criteria and tool established for referral to COPD, linking with appropriate pathways **Q4** New pathways identified **Q4**	Babies Children and Young People have increased access to planned care *Measure* Proportion of referrals triaged to return to GP. Proportion of those re-referred.	Continuous evaluation of triage process	Continuous evaluation of triage process	Contributors: CH SLA Reported in: SIHSP	Yes
A regional integrated obesity management programme									

South Island Alliance 2015-16 South Island Child Health Alliance Annual Plan									
Actions to deliver	**ITEM NO**	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**ACTIVITIES TO ACHIEVE DELIVERABLE** (INCLUDING QUARTER MILESTONES)	**IDENTIFY OUTCOME/S & MEASURES**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**	**HEALTHPATHWAY**
A regional integrated obesity management programme.	6a	A regional integrated obesity management programme developed. Enhance collaboration with child dental health services. Monitor healthy family initiatives in Heathcote Spreydon and Invercargill.	Q4	Implement a regional obesity programme (including an educational component for primary, secondary and dental staff) across the 5 DHBs within the SI **Q4** Create a SI Health pathway for child and youth obesity **Q4** Share learnings from healthy families to all DHB's **Q2**	Children and Young People have prevented/delayed burden of long term conditions *Measure* The level of obesity in children at age 4 through the B4 school check reports. Tooth decay at school entry	Ongoing monitoring and evaluation of programme	Ongoing monitoring and evaluation of programme	Contributors: CHSLA SI PH Alliance Reported in: SIHSP CDHB lead (dependent on funding)	yes
A regional electronic growth chart that will become part of a National solution to recording growth from birth.	6b	Electronic Growth chart	Q1	Work in collaboration with the IS SLA to implement a South Island e growth chart. Either the Southern tool or Sysmex.**Q1**	No wasted resource. Reduce risk from implementation of paperless clinical records. *Measure* SI regional e growth chart in place.	Project will be completed	Project will be completed	Contributors: CHSLA, SI IS SLA Reported in: SIHSP	No
Successful transition into healthy adulthood for children with lifelong health conditions (for example, implementation of cystic fibrous pathway)									
To provide youth specific services and transition planning/clinics to young people with a range of diseases									

South Island Alliance 2015-16 South Island Child Health Alliance Annual Plan									
Actions to deliver	**ITEM NO**	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**ACTIVITIES TO ACHIEVE DELIVERABLE** (INCLUDING QUARTER MILESTONES)	**IDENTIFY OUTCOME/S & MEASURES**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**	**HEALTHPATHWAY**
Successful transition into healthy adulthood for Multi handicapped children with lifelong health conditions.	7	Agreed transition pathway implemented.	Q4	Evaluation of pathway for multi handicapped children. Transition Group will report back **Q3 2014/15** SI CHA will progress those findings **Q4 2014/2015**	Young people have increased access to planned care. *Measure* To be developed following the 2014/2015 findings.	Ongoing monitoring and evaluation of Healthpathway	Ongoing monitoring and evaluation of Healthpathway	Contributors: CHSLA Reported in: SIHSP	yes
To adequately address the challenges of behavioural problems in children and young people. Child development and Disability Child and Youth Health Compass report 2013									
Strengthen models of care within primary care Right place Right time Right Service									
Scope under 5 behavioural referrals	8	Develop a SI under 5 behavioural pathway	Q4	Scope current referral activity in each DHB**Q2** Streamline referral process from Primary to Secondary care **Q4**	Children and Young People have increased access to planned care. *Measure* To be decided.	To be decided	To be decided	Contributors: CHSLA Reported in: SIHSP	Yes
Consumer Consultation									
To include children, young people and whanau in the planning , delivery and evaluation of health services									

8.2

South Island Alliance 2015-16 South Island Child Health Alliance Annual Plan									
Actions to deliver	**ITEM NO**	**DELIVERABLE 2015-2016**	**APPROVED SCHEDULE**	**ACTIVITIES TO ACHIEVE DELIVERABLE** (INCLUDING QUARTER MILESTONES)	**IDENTIFY OUTCOME/S & MEASURES**	**DELIVERABLE 2016-2017**	**DELIVERABLE 2017-2018**	**RESPONSIBILITIES**	**HEALTHPATHWAY**
What do consumers really want from the Child Health Service?	9	Develop a parent/care giver survey.	Q3/4	Link consumer representatives of CH SLA with SI consumer groups **Q2**	Children and Young People have increased access to planned care. *Measure:* Identify future areas to achieve improved customer satisfaction	Ongoing consultation with consumers and input into workplan	Ongoing consultation with consumers and input into workplan	Contributors: CHSLA Reported in: SIHSP	No

Appendix Four: Children's Action Plan Newsletter Jan 2015

Children's Action Plan

Identifying, Supporting and Protecting Vulnerable Children

April/May 2015

Working together for vulnerable children

14th Australasian Conference on Child Abuse and Neglect (ACCAN) 29 March - 1 April 2015

Social Development Minister Anne Tolley (above) with Social Development Chief Executive Brendan Boyle at ACCAN 2015

Vulnerable Children's Board (VCB) Chief Executives (top right) Chai Chuah, Health, Peter Hughes, Education and Brendan Boyle, Social Development held a panel discussion about the role of the VCB in getting results for vulnerable children.

National Children's Director, Sue Mackwell, and members of the Whangarei and Horowhenua/Otaki Children's Teams gave a presentation introducing the purpose and establishment of Children's Teams.

The presenting team (above right) included Children's Team Directors (from far left), Mahalia Paewai (Rotorua), Jacqui Moynihan (Horowhenua/Otaki) and Lianne Egli (Whangarei).

Also in the back row (L-R) are Children's Team members from Horowhenua/Otaki, George Davis and Rob Fifita-Tovo and Daniel Gotz, Lead Professional from Whangarei.

In the front row also from Whangarei are (L-R) Mariameno Kapa-Kingi, Cultural Advisor, Tracey Poutama, Service Broker Education, and Nikki Beazley, Service Broker Health.

In this issue:

- ACCAN 2015
- First phase of safety checking regulations begins 1 July 2015
- Modernising Child, Youth and Family Expert Panel
- Rotorua Children's Team update
- Hamilton Children's Team preparation
- Core Competency Framework Design team

First phase of safety checking regulations begins 1 July 2015

Standard safety checks will make it easier to identify people who are a risk to children.

The first phase of improved safety checking for children's workers is now confirmed as starting on 1 July 2015. Every child deserves to be protected from abuse and neglect and the safety checking regulations are part of the Children's Action Plan to better support and protect vulnerable children.

From 1 July 2015 phase one of new government regulations made under the Vulnerable Children's Act 2014 will require organisations to ensure core children's workers starting a job with them (as employees or contractors) are safety checked before they start their employment.

Core children's workers are paid, or funded by, state sector agencies (either directly or indirectly) and work alone with children or have primary responsibility or authority over them. This may include people such as teachers, nurses, and youth counsellors. While this doesn't include volunteers working with children, it does include unpaid workers on vocational training or placements.

Safety checking is being phased in over several years. Employers have three to four years to have their entire existing workforce checked.

All existing core children's workers must be safety checked by 1 July 2018 and all non-core children's workers by 1 July 2019. After each initial check employers will also be required to update their workers' checks every three years. Government agencies will be taking an educative approach to supporting organisations to comply.

The safety checking regulations are currently being written and will be published at the end of May, a month before the start date. Advice for interpreting and applying the regulations will be available to assist employers.

The regulations will require good practice for pre-employment checking which includes: verifying a candidate's identity, gathering information about their history and behaviour, including reference checks, evaluating this information and re-assessing the information periodically every three years.

From 1 July 2015, the Act also prohibits people with certain child abuse, sexual offending or violence convictions from starting a new job as a core children's worker. From 1 July 2016 this prohibition will be extended to workers already employed or engaged in core workforce roles to allow them the opportunity to seek an exemption.

This means anyone convicted of the listed offences won't be able to work in core children's roles unless they are granted an exemption before the dates above. An exemption process is being developed now, led by the Ministry of Social Development, which will be available when the restriction comes into force on 1 July 2015.

The vision of the Children's Action Plan is that every child deserves to be protected from abuse and neglect. The new safety checking regulations support the children's workforce to better protect and support all children.

Additional details, guidance and a guideline on safety checking are available on our website: www.childrensactionplan.govt.nz/childrens-workforce/

Modernising CYF Expert Panel

Social Development Minister Anne Tolley recently appointed an independent advisory panel to investigate the development and implementation of a new operating model to modernise Child, Youth and Family.

The panel is led by Paula Rebstock. The other panel members are: Police Commissioner, Mike Bush; Chief Executive Officer of Who Cares? Scotland, Duncan Dunlop; Specialist Advisor to Te Runanga o Ngai Tahu, Helen Leahy; and the Ministry of Social Development's Chief Science Advisor, Professor Richie Poulton.

The panel will provide an initial high level business case to the Minister for Social Development Anne Tolley by 30 July 2015.

Read more on the MSD website: https://www.msd.govt.nz/about-msd-and-our-work/newsroom/media-releases/2015/cyf-panel.html

Rotorua Children's Team update

Minister Anne Tolley and Rotorua MP Todd McClay with Rotorua Children's Team Director Mahalia Paewai and members of the Executive Management Group
From left to right: Graham Parker Acting Education Manager Ministry of Education; Children's Team member Sonia Hawkins Clinical Manager Manaaki Ora Trust - Tipu Ora; Bruce Horne District Commander NZ Police; Rachel Jones Regional Manager Te Puni Kōkiri; Sue Critchley Regional Manager, Child Youth and Family; Peter Waru Regional Community Investment Manager MSD; Willie Kirk, Minister Tolley's Advisor.

Rotorua Children's Team was the first to go live in July 2013. Social Development Minister Anne Tolley visited the team in April to talk about their progress.

The Minister met with Rotorua Children's Team Director, Mahalia Paewai, the Executive Management Group and Children's Team members (pictured above).

They discussed how the Rotorua site is working and reflected on the team's achievements and key lessons learned. They also talked about some of the current issues the team is facing. Securing Lead Professionals has been one of the big challenges for the Rotorua team. They are working on building capacity.

The Children's Team doesn't create more new services but instead, it provides the opportunity for government agencies, iwi and non-government organisations to bring together their existing services and resources for vulnerable children into one personalised plan for each child and their family or whānau.

Mahalia says "I am always overwhelmed by the generosity of spirit of the Rotorua Team and our community, and the absolute passion that is so evident around wanting to get it 'right' and 'make a difference' for the children and families we work with."

Children's Team member, Mala Grant

Rotorua Children's Team member and Manager of Te Arawa Whānau Ora collective, Mala Grant has been with the team from the start.

One of seven on the Children's Team panel in Rotorua, Mala meets them every Wednesday. The panel of managers and senior practitioners decide on referrals for new children and discuss Tuituia assessments, Child's Plans and transitions for children currently being supported by the team.

Mala's organisation provides Lead Professionals to the Rotorua Children's Team – an essential role for bringing existing services together into one personalised plan for each vulnerable child. Working with the Lead Professional means the family only has to tell their story once.

Mala says "In the beginning it was a testing time for everyone involved. As time has gone on it has become easier to tap into different systems and networks. Many people from the community want the Children's Team to work and as a result have invested a lot of dedicated time into making this happen."

Hamilton Children's Team preparation

Preparations are underway to go live with the Hamilton Children's Team this year. Children's Team Director Cathy Holland and her team are doing a great job behind the scenes getting the Team ready for the first referrals of Hamilton's vulnerable children.

Hamilton will be the first big city Children's Team in New Zealand and the first Team to operate at full volume. That means they will be identifying, supporting and protecting up to 1400 vulnerable children when they get to scale.

In order to do all that, Hamilton has been chosen to trial a new information sharing system and new hub triage processes. We are developing an Approved Information Sharing Agreement to enable the Team to share information securely and confidently.

It's a big job for Hamilton but they're up to the challenge and we will update you on the Hamilton team's progress in the coming months.

Core Competency Framework Design Team

The Core Competency Framework Design Team is supporting the Children's Action Plan in our development of a safe and competent workforce. The cross-sector team is designing a national tiered core competency framework.

The first phase of development will be a consultation with key stakeholders in the next few weeks. Look out for more information in our next newsletter.

From left to right they are: (back row) Dr Brian Annan University of Auckland, Kenneth Ward Children's Action Plan, Eva Hartshorn-Sanders Post Primary Teachers' Association, Julie Hook Education Special Needs, Rob Calder NZ School Trustees Association, (front row) Kay Howard State Services Commission, Dr Nicola Atwool University of Otago, Gill Genet Careerforce, Jenny Thomas NZ Teachers Council.

Chatter update

In the next few months we will be posting updates from our work programme on Chatter. This will include documents for your information and consultation. Watch this space!

If would like to join Chatter, please contact us at admin@childrensactionplan.govt.nz

FEEDBACK

We welcome feedback about this newsletter or any aspect of the programme. If you have any comments or questions for us, or want to join Chatter (our closed online community for information sharing and dialogue), email us: admin@childrensactionplan.govt.nz

To find out more on the Children's Action Plan visit: www.childrensactionplan.govt.nz

To find out more about the Vulnerable Children's Act 2014 visit: http://www.legislation.govt.nz/act/public/2014/0040/latest/whole.html

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:	3 June 2015

8.3

Summary:

This report shows the progress in Quarter Three 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.

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

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

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

Prepared by: Planning & Funding Date: 20/04/2015	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATIONS:

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

Progress	Progress Indicator
●	Completed
●	Underway according to plan
●	Behind plan
●	Scheduled for Q4
Ministry of Health Reporting Schedule	
Quarter 1	July – September
Quarter 2	October – December
Quarter 3	January – March
Quarter 4	April - June

Progress Report on Delivering the Southern DHB Annual Plan 2014/15

Quarter Three - 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			●	On track in Southland for further planning in Otago
	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		●	
	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 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	●	Significant COPMIA work completed last quarter
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 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	●	Revised stock-take currently under development. Expect complete by end Q4
		Identify potential service issues - gaps and duplication	Q3	●	Revised stock-take currently under development. Expect complete by end Q4
	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	-		●	This is occurring in some schools but not in the Invercargill Kura and decile 1a schools. There has been an addition decile 3 school added from July 2015 that will need to be covered. This is being worked through with the Māori health team for the last year. The service has employed a Māori nurse who we hope will be able to provide clinics in the future at the Kura.
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		●	
	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	●	
	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	●	There has been some whole of community education through community newspapers which is being augmented through the development of a social marketing package. Funds to deliver this have been identified and planning is underway with marketing consultants.
	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	●	
	3.3.4 Develop an AOD clinical pathway	Youth AOD Pathway implemented	Q2	●	Discussion to occur with sector providers re prioritisation of this clinical pathway

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q4

Prime Minister's Youth Mental Health Project					
Section	**Actions/Activity**	**Measures**	**Time-frame**	**Progress**	**Progress Narrative**
	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 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	●	
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 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		🟡	
	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	🟢	
	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	🔴	Awaiting software releases.
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	🟡	
		Identify issues and set up quality improvement initiatives to achieve targets	Q4	🟢	

8.3

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for 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	●	
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			●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for 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	●	
	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		●	
	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. The stock take has been reviewed and a plan developed and agreed to address service gaps
		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	●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q4

8.3

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			●	
	8.3.5 Support development of a regional approach to cardiology nurse training through the Regional Training Hub			●	

● Completed ● Underway according to plan ● Behind plan ● Scheduled for 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	●	
	9.2.3	All stroke thrombolysis services use agreed thrombolysis pathway and audit tool	All thrombolysis patients are audited		●	
	9.2.4	On-going 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	●	
			Established across district	Q4	●	
	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			●	
	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 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 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	●	
	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	●	
	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	●	For review in 2015 - 2016 capital expenditure process

8.3

● Completed ● Underway according to plan ● Behind plan ● Scheduled for 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		🔴	WellSouth has capability to analyse admissions data to identify frequent ED attenders then follow-up with appropriate practices once this information is available.
		Patients able to access primary care as required		🟡	
	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	🔴	Discussions with local (Invercargill) practices seeking their input into the establishment of nurse led clinics are on-going.
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	🟡	A programme has been established through Alliance South. To be implemented during next quarter
	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	🟡	
	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		🟡	
	11.3.2 Implementation of fully operational Early Supported Discharge (ESD) Southland service	Business case approved	Q2	🔴	Awaiting outcome of 6 month review of Rapid Response Service to enable findings to be incorporated into wider planning for wrap around services for older people in Southland. Data has been collected and a working group set up to work on this over the next quarter.
		Southland ESD operational	Q4	🔴	As above
	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			🟡	
	11.3.4 PHO and DHB share information to identify high health users for inclusion in the PHO Integrated Primary Care (IPC) Programme			🟢	
	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 Q4

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		🟢	
	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			🔴	More clarity for reporting sought. We are awaiting the 3rd quarter report. Regardless of that information individual LMC's are not identifiable so this expectation cannot be achieved.
	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 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	●	The draft has been submitted to MoH for approval. Feedback is expected in early May 2015

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q4

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	🟢	
	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 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	●	
	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	●	
	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	●	
	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	●	
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			●	
	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 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	🔴	Work Plan agreed. Flexible funding use to be agreed by Q4
	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	🟢	
	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	🔴	Further planning and work on this will occur later in the quarter.
		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	🔴	Progress is underway. Delayed due to complexity of providing training and accreditation
		75 funded pipelle biopsies performed by GPSI service	Q3	🔴	Progress is underway. Delayed due to complexity of providing training and accreditation
	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	🟢	
	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)	⚫	The Rural SLAT has developed a rural funding model. This model will now be discussed/ consulted with all rural practices. Final decision by May 2015.
	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).			🟡	The Rural SLAT has recommended that Outram Medical Centre will no longer receive rural funding. To be confirmed during consultation process as per above (15.3.2).
15.4 Youth Health	15.4.1 Establish a youth services Service Level Alliance Team (SLAT)	Youth services SLAT established	Q1	🟢	

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q4

8.3

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	●	Awaiting outcome of 6 month review of Rapid Response Service to enable findings to be incorporated into wider planning for wrap around services for older people in Southland. Data has been collected and a working group set up to work on this over the next quarter.
		Southland ESD operational	Q4	●	As above
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		●	The DHB National HOP Steering Group has not provided a progress report on this action
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	●	
16.5 Work with the South Island Health of Older People Service Level	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 Q4

Health of Older People					
Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Alliance					

8.3

Completed Underway according to plan Behind plan Scheduled for 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	🔴	Discussion to occur with sector providers re prioritisation of this clinical pathway
	17.1.4 Develop and implement actions from the review perinatal and infant mental health services	Implementation plan endorsed	Q1	🔴	Mental Health Services continue to build relationships with this group of clients and ensure easy access on the two base sites. Staff are well linked into relevant Ante-Natal and Post-natal meetings. COPMIA initiatives are in implementation stage.
	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 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		🔴	Working towards target in conjunction with other stakeholders.

8.3

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for 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		🟡	
		90% of at risk patients with individualised care plan		🔴	Further work underway to meet threshold
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			🟡	Excellent progress on hand hygiene improvement. Current result 77.6% - on track to meet June threshold of 80%.
	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)			🟡	
	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 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).			🔴	Awaiting national direction.
	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.			🔴	Awaiting regional direction.
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.			🟡	

8.3

🟢 Completed 🟡 Underway according to plan 🔴 Behind plan ⚫ Scheduled for Q4

Southern Māori Health Plan 2014/15 Progress Report
Quarter Three

Progress	Progress Indicator
●	Completed
●	Underway according to plan
●	Behind plan
●	Scheduled for Q4
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 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	●	SPHO 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 is no plan 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	●	
	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.		●	For further planning.

● Completed ● Underway according to plan ● Behind plan ● Scheduled for 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 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 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 Q4

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).		🟢	
	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 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).			

8.3

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 Q4

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 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).		🟢	
	10.1.3 To provide comprehensive cultural training for all staff utilising the Mental Health Act (Q1-2).		🟢	

8.3

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 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.		●	Referral pathway underway Paediatrics inputting.
	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 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.		●	

8.3

● Completed ● Underway according to plan ● Behind plan ● Scheduled for Q4

SOUTHERN DISTRICT HEALTH BOARD

Title:	Southern Strategic Health Plan (SSHP) Implementation Plan
Report to:	CPHAC/DSAC
Date of Meeting:	3 June 2015

Summary:

The final SSHP Implementation Plan is attached. This sets out:

- The tasks, actions and outputs required for the delivery of the SSHP
- The success factors for SSHP implementation

9

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

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

Document previously submitted to:	DSAC/CPHAC	Date: 01 /04/15

Prepared by: Liz Disney, Senior Manager Integration and Innovation Date: 19/05/15	Presented by: Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

1. That the Committees note the final SSHP Implementation Plan and key reporting dates.

Southern District Health Board

southern way

Southern Strategic Health Plan
Piki te Ora

Strategic Implementation Plan

southerndhb.govt.nz

Contents

May 2015

Prepared by Liz Disney, Senior Manager System Integration and Innovation

Introduction

The Southern Strategic Health Plan Pike te Ora (SSHP) details the challenges we face in the coming years and the strategies and service development that is required to meet future health needs of our Southern population. The purpose of the SSHP is to ensure we can:

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

Purpose of this Implementation Plan

This Strategic Implementation Plan (SIP) indicates a series of actions, tasks and outputs which will enable the DHB to transform health care provision; it details a high level approach allowing us to empower our organisation and stakeholders to transform the 'What' and the 'Why contained in the SSHP into the 'How' of action.

The SSHP will be used to inform all other organisational plans and be influential sector wide. This SIP demonstrates how we can realise our vision utilising the skills of our people.

Approach

Each of the agreed six priorities in the SSHP has its own Action Plan. The sequences of tasks are documented in line with the SSHP Roadmap contained within the SSHP (Figure 10).

Each of the Action Plans will be developed over time, with further discussion and engagement to be completed over the coming months. Action Plans will need to be updated as groups progress the tasks including more specific detail and new actions around the development, testing and implementation of any new models of care or service proposals.

Overall timeline

Phases of implementation

Phase One

For completion by end June 2015

- Begin working on success factors (see later section Success Factors for Implementation)
- Set up governance structure for the implementation of the SSHP
- Agree more detailed work programmes with key stakeholders to deliver the Plan's headline actions and any additional necessary actions
- Produce an overall Gantt Chart (included as Appendix One) for SSHP Implementation showing key milestones and dependencies

Phase Two

For completion by end December 2015

- Continue working on success factors
- Deliver short/medium-term actions detailed in work programmes
- Development of a monitoring framework including agreeing the performance measures for the SSHP implementation and production of measure reports

Phase Three

For completion by end December 2016

- Continue working on success factors
- Deliver medium/longer-term actions detailed in work programmes
- Full application of monitoring framework

Phase Four

- Continue working on success factors
- Deliver longer-term actions detailed in work programmes
- Begin work on further round of actions to fully achieve the vision of the SSHP

Key Milestones

The following table shows the key milestones in the SIP up until December 2016. The milestones are in chronological order of planned delivery.

Action Plan Ref	Deliverable	Date delivered
4.4	XcelR8 leadership training programme underway	May 2015
1.2	Alliance South produces work programme aligned with the SSHP priorities	June 2015
4.2	Improvement Network formed and produces Implementation Plan for the Performance Excellence and Quality Improvement Strategy	June 2015
4.4	Role of DHB Clinical Council formalised	June 2015
1.5	Clinical Locality Networks and Consumer Locality Networks are formed and begin meeting	July 2015
4.4	Leadership Action Plan produced	August 2015
1.3	A documented conceptual vision of the future shape of health services including answering key questions around the expectations of primary care, rural provision, and specialist and tertiary services is produced	October 2015
4.1	Provider Arm work plans in place to lift performance	December 2015
1.4	Alliance South Acute Demand Service Level Alliance Team (SLAT) produce a report and analysis on whether a third hub (in addition to Dunedin and Invercargill) should be developed	March 2016
1.6	Service provision at each Rural Hospital determined (report and recommendations produced)	June 2016
2.2	SLATs and Work streams complete agreed pieces of work (as prioritised in the SSHP) using recognised methodology	June 2016
3.2	Future of specialist Hospital services to be delivered within Southern DHB understood and planned for (report and recommendations produced)	June 2016
5.4	Workforce Plan produced	Sept 2016
5.3	Report outlining the required development and upgrade of Dunedin Hospital produced	December 2016

Action Plans

The following Action Plans relate to each of the six priority areas identified in the SSHP. These Action Plans will guide our activities over the coming months and will be updated regularly, following on-going discussion and engagement.

Priority One: Develop a coherent Southern system of care

1	Headline Action and Outcome	Tasks	DHB Executive Leadership Team Owner	Stakeholders/participants	Milestones/ progress	Completed by:
1.1	Within the South Island Alliance, define the regional direction and key principles that will inform specialist service configuration, development and infrastructure Outcome: Southern DHB has arrangements in place for sustainable specialist service provision	Understand the impact of the South Island Alliance specialist regional work priorities for 2015/16: cardiac services, elective surgery, palliative care, stroke and major trauma services	Executive Director Planning and Funding (EDP&F) Executive Director of Patient Services (EDPS)	South Island Alliance DHB Provider Arm DHB Planning and Funding	Feedback from regional working informs work of Alliance South throughout implementation	On-going
1.2	Align Alliance South's work programme with the SSHP's strategic priorities and roadmap Outcome: Alliance work programme delivers strategically relevant pieces of work	Workshop with Alliance South around content of SSHP and intended single organisational planning framework	EDP&F EDPS	Alliance South Strategic Executive	Workshop held	May 2015
		Alliance South produces work programme aligned with SSHP	EDP&F EDPS PHOCEO	Alliance South	Work programme produced	June 2015
		Establish use of care pathways and a work programme for Health Pathways	EDP&F EDPS	Alliance South	Prioritised list of pathways for	Oct 2015

			PHO CEO		development produced	
1.3	Define intended future roles , capabilities, responsibilities, and relationships of the core entities within the Southern health system Outcome: A documented vision of the future shape of health services including answering key questions around what are the expectations of primary care, rural provision, and specialist and tertiary services	Hold a series of professionally facilitated workshops involving clinicians, managers and consumers. Key questions to be answered: - What do we need from primary care services, rural services and specialist and tertiary services over the next five to ten years? - How does our system need to work together and what tools do we need to help with this? - What will successful implementation of the SSHP look like?	EDP&F EDPS	DHB Planning and Funding DHB Provider Arm DHB Communications WellSouth PHO GPs Rural Hospitals Alliance South Aged Residential Care Community health providers NGOs Consumer groups	Workshops held with key questions addressed	Oct 2015
		Produce a one-page infographic which is conceptual and non-specific to location. Infographic shows the planned future roles, responsibilities and relationships between tertiary services, Southern DHB Hospitals, rural Hospitals, and primary and community care	Executive Director Communications (EDC)	DHB Communications	Infographic produced and shared as part of planned communication updates	Nov 2015
1.4	Strengthen the planning and delivery of local and district-wide acute and urgent care, and link effectively with South Island services	Alliance South Acute Demand Service Level Alliance Team (SLAT) produce a report and analysis on whether a third hub (in addition to Dunedin and Invercargill) should be developed	EDP&F EDPS	Alliance South	Report reviewed by Alliance Leadership Team	March 2016
		Feasibility study produced for a	EDPS	DHB Provider Arm	Feasibility study	December

	Outcome: Clear system for delivery of acute and urgent care for personal and mental health	Medical Assessment and Planning Unit (MAPU) at Dunedin Hospital		WellSouth PHO GPs	reviewed by ELT for potential Business Case requirement and implementation in 2016	2015
		Work with current Emergency Care Coordination Team (ECCT) to understand what extra support they need to achieve most effective management of trauma and emergency patients. ECCT to develop a work programme to ensure effective management of trauma patients	EDPS	DHB Provider Arm Other DHBs St Johns Transport providers	ECCT have work programme reviewed under overall DHB Provider work plan	December 2015
1.5	Establish locality networks to improve planning and delivery of well-coordinated local services Outcome: local provider and community engagement in how to best provide locality level health services	Establish the following for <u>Clinical</u> Locality networks in each of the Southern localities: - Clinical Chairperson - Invite list of providers to participate in the networks including local hospitals, GPs, community health providers, aged residential care facilities, NGOs, local Mayor - Terms of Reference Objectives specific to the local network informed by work from the workshops (1.3) and from the Urgent Care SLAT on third hub feasibility (1.4)	EDP&F	DHB Planning and Funding Local Hospitals WellSouth PHO GPs Community Health Providers Aged Residential Care NGOs Mayors	Locality Clinical Networks are set-up and understand their role	June 2015
		- Clinical network meetings	EDP&F	DHB Planning and Funding	Locality Clinical	July 2015

		commence		Local Hospitals WellSouth PHO GPs Community Health Providers Aged Residential Care NGOs Mayors	Networks are meeting every other month	
		Establish the following for <u>Consumer</u> Locality networks in each of the Southern localities: - Mayor as the Chairperson - Invite list of individuals from the local community or ask for nominations - Terms of Reference Objectives specific to the local network informed by work from the workshops (1.3)	EDP&F	DHB Planning and Funding Mayors Local community groups Local community	Locality Consumer Networks are set-up and understand their role	June 2015
		- Consumer network meetings commence	EDP&F	DHB Planning and Funding Local Hospitals WellSouth PHO GPs Community Health Providers Aged Residential Care NGOs Mayors	Locality Clinical Networks are meeting every other month	July 2015
		Clinical and Consumer Networks	EDP&F	DHB Planning and Funding	Local solutions	Beginning

		provide recommendations to the SSHP Steering Group on localisation of proposed service models including localised expertise on: - Community-based service development and engagement between providers - Clinical pathways to be managed locally - Concept of 'one-stop shop' within locality areas - Role of local hospitals in triage, assessment and stabilisation of acute patients - Use of telemedicine - Referral and transfer pathways		Local Hospitals WellSouth PHO GPs Community Health Providers Aged Residential Care NGOs Mayors Local community groups Local community	developed by locality networks	January 2016
1.6	Recognise and develop the rural hospitals' contribution to the Southern health system Outcome: Service provision at each Rural Hospital determined	- Utilise the decision making from the workshops (1.3) and from the Urgent Care SLAT on third hub feasibility (1.4) as a framework for working locally on the service model for each Rural Hospital	EDP&F	DHB Planning and Funding Rural Hospitals	Future contribution of Rural Hospitals known	June 2016
		Review how the following initiatives may provide enhanced services at Rural Hospitals: - Access to specialised advice including the use of telemedicine for patients with long term conditions	EDP&F	DHB Planning and Funding Rural Hospitals DHB Provider Arm	Appropriate localised enhanced care models in place in Rural Hospitals	September 2016

		- Strengthening discharge planning processes and developing early supported discharge teams for older people returning home or to an aged-care facility - Access to appropriate 24/7 diagnostics to support early diagnosis of patients and direction onto appropriate Health Pathway				

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

2	Headline Action and Outcome	Tasks	DHB Executive Leadership Team Owner	Stakeholders/participants	Milestones/ progress	Completed by:
2.1	Through Alliance South, define the future primary & community model for: - Urgent all-hours care - Health of Older Peoples services - Community Mental health services - Management of long term conditions - Management of patients with high and complex needs	Alliance South to refocus their work programme by determining the respective scopes for pieces of work on: - Urgent all-hours care - Health of Older Peoples services - Community Mental health services - Management of long term conditions - Management of patients with high and complex needs	EDP&F EDPS	Alliance South	Alliance South work programme includes a piece of work for either an existing Service Level Alliance Team (SLAT) or a Work stream	June 2015

	Outcome: Alliance South completes strategically relevant pieces of work	Linked to action 1.2				
2.2	Within the Alliance South framework, develop service level alliances as the key structure for collaborative service planning and development of new models of care Outcome: Service models produced for high needs or high user groups	SLATs and Work streams complete agreed pieces of work using recognised methodology to guide them (Better Business Cases, The Model for Improvement, A3 Problem Solving). Recommendations will be evidence-based.	EDP&F EDPS	Alliance South Alliance South SLATs Alliance South Work streams	Strategic visions and service models produced	June 2016
2.3	Implement a risk stratification tool that identifies the patient cohorts at greatest risk, and design care models commensurate with risk Outcome: Risk profiling is used to inform teams around the health need in the local community in order to produce effective recommendations for service redesign	Risk profiling trialled with a GP practice to understand where there may be opportunities for greater tailoring of packages of care and for completion of gap analysis as to whether the care model exists – to inform SLAT work	EDP&F	DHB Planning and Funding WellSouth GPs	Risk profiling trialled at local level with recommendation for service model change to meet needs of risk profiled population	Feb 2016
		Risk profiling used by SLATs when designing service models	EDP&F EDPS	Alliance South	Risk profiling evident in solutions presented from SLATs	June 2016
2.4	Include prevention and early intervention within the scope of	Utilise the risk profiling data around low risk and moderate risk population	EDP&F	DHB Planning and Funding Locality Networks	Risk profiling data is used in	April 2016

	the primary & community teams, and foster their linkage with SDHB's health promotions programmes Outcome: people are kept well and where needed early intervention services are available	groups in one locality area to define the scope and mix of health professionals that would be required to deliver preventative and early intervention services			one area to understand the opportunity for enhanced preventative and early intervention service models	
		Complete a task and activity analysis for the same locality area to identify appropriate clinical and support staff input to models of care, and identify where possible staff substitution opportunities to free up time of more specialised staff may exist	EDP&F	DHB Planning and Funding Locality Networks	Staff skills profile for early intervention services understood	Jan 2016

Priority Three: Ensure access to sustainable specialised services

3	Headline Action and Outcome	Tasks	DHB Executive Leadership Team Owner	Stakeholders/participants	Milestones/ progress	Completed by:
3.1	Undertake analysis to inform specialist service planning including: - Identification of services at risk of clinical and financial unsustainability - Analysis of inter-district (IDF) patient outflows - Updating the Role Delineation	Small analytical team to complete SWOT/PEST analysis around clinical services identified as being provided on the edge of the secondary/tertiary continuum, including understanding the impact and historical trends of IDF outflows. Analysis to include: - The required demand to generate sufficient volumes to warrant	Chief Medical Officer (CMO) EDPS	DHB Provider Arm DHB Planning and Funding	Analysis complete	Oct 2015

	Model assessment of Dunedin and Southland Hospitals Outcome: Risk status of current Hospital service provision understood	staffing levels that meet reasonable roster requirements and allow practitioners to maintain their skills - Cost per case compared with benchmarks - Comparative access rates to match other DHB standards				
		Update the Role Delineation Model seeking to: - Expose gaps or discrepancies in services provided - Resources available and how well matched they are to provision - Services for possible discontinuation and movement out of the Hospital Note: this work is likely to be produced from the Population Based Funding Formula national review	EDPS	DHB Provider Arm DHB Planning and Funding	Role Delineation Model updated	Dec 2015
3.2	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 Outcome: future of specialist Hospital services to be delivered	Utilise results of analysis to produce proposal around provision of specialist Hospital services answering the following questions: - What are the expectations of secondary and tertiary delivery across the Southern Region? - How can these services be delivered? - What are the implications on our	EDPS	DHB Provider Arm DHB Planning and Funding WellSouth PHO	Proposal for provision of specialist services within Southern region produced	June 2016

	within Southern DHB planned for	current models of care and resources including cost of provision? - What are the implications for our staff? Link to 1.4, 1.6 and 2.2 for total system description				
3.3	Continue South Island collaboration to refine governance, management and funding models that support provision of sustainable specialist services across DHB boundaries Outcome: future of specialist Hospital services to be delivered outside Southern DHB planned for	Work with other DHBs with results of analysis to propose which specialised services could be provided outside of Southern DHB including: - A single service across multiple sites - Outsourcing to a third party	EDPS	DHB Provider Arm DHB Planning and Funding	Proposal for provision of specialised services outside of Southern region produced	June 2016

Priority Four: Strengthen clinical leadership, engagement and quality improvement

4	Headline Action and Outcome	Tasks	DHB Executive Leadership Team Owner	Stakeholders/participants	Milestones/ progress	Completed by:
4.1	Identify the initial areas in which SDHB will lift its performance to world-class levels and develop action plans for each	Utilise the Performance Excellence Team to facilitate a workshop to identify: - What are the appropriate KPIs for measuring 'world-class' performance?	EDPS	DHB Provider Arm	KPIs developed, measurement commences, and ideas for change developed	Sept 2015

	Outcome: performance lifted to world-class levels through use of quality improvement methodology	- How can we measure them? - What are our goals? - What is the root cause of why we get the performance we do? - Can we review evidence and develop new ideas to raise our performance?				
		Utilise information from above Workshops to inform work plan for completion by each directorate/department/service	EDPS	DHB Provider Arm	Work plans produced	Dec 2015
4.2	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 Outcome: Performance Excellence and Quality Improvement Strategy positioned as central to quality improvement activities and raising performance. There is an organised approach to improvement work across the sector.	Improvement Network (individuals from across the health sector with an interest and expertise in quality improvement) formed to review the Strategy to produce a proposal addressing the following: - How can we actualise the strategy? - Do we have the required resources and skills to implement? - What tools do we need to develop?	EDPS EDP&F Executive Director Human Resources (EDHR)	DHB Provider Arm DHB Planning and Funding	Improvement Network formed and proposal for implementation of the Performance Excellence & Quality Improvement Strategy produced and agreed by DHB Board	June 2015
		Incorporate a statement about the fourfold aim into all planning document templates	EDPS EDP&F	DHB Provider Arm DHB Planning and Funding	Templates designed and agreed	July 2015
		Improvement Network designs and	EDPS	DHB Provider Arm	Consistent and	July 2015

		implements an organised approach to improvement initiatives underway in the DHB. This includes producing an Improvement Framework for all developmental programmes of work, plans, projects and initiatives. Approach includes: - Stratification of the type of improvement being proposed - The delivery mechanism for the improvement - The categorisation and prioritisation of the improvement - Standardised planning of the improvement	EDP&F	DHB Planning and Funding	structured organisation wide programme management approach adopted – Improvement Framework produced	
		Improvement Network uses a specific project to showcase the benefits of the Improvement Framework	EDPS	DHB Provider Arm DHB Planning and Funding	Day Case Project successful in increasing the day case surgery rate	Dec 2015
4.3	Position the Performance Excellence & Quality Improvement Strategy as a key vehicle for ensuring financial sustainability, by explicitly linking quality improvement with value gain Outcome: Performance Excellence and Quality Improvement Strategy makes a difference to the progress	Proposal for Implementation of Performance Excellence & Quality Improvement Strategy and Improvement Framework applied to existing DHB savings plans and used to enhance plans	EDPS EDP&F	DHB Provider Arm DHB Planning and Funding	Savings plans bolstered through structured approach	July 2015

	of the DHB's savings plans					
4.4	Clarify the intended nature and role of clinical leadership in the Southern health system, and ensure supportive structures and processes are in place Outcome: clinical leaders are highly effective in steering the organisation in partnership with managerial colleagues	Survey current DHB Senior Doctors around their current engagement, their perceptions of clinical leadership and how it could be enhanced	EDHR CMO	DHB Provider Arm Better Medical Engagement Group	Survey completed and responses analysed	June 2015
		Utilise the results of the survey and any new ideas through development of a leadership action plan. Plan aims to explicitly define the organisation's expectations of clinical leaders and endorse a series of activities to support leadership	EDHR CMO	DHB Provider Arm DHB Planning and Funding WellSouth PHO	Leadership Action Plan produced	Aug 2015
		Understand and formalise the role of the DHB Clinical Council including setting one year objectives	Chief Executive Officer (CEO) EDP&F CMO Executive Director of Nursing and Midwifery (EDON) Executive Director of Allied Health, Scientific and Technical (EDAH)	DHB Provider Arm DHB Planning and Funding	Role and function of Clinical Council understood, one-year objectives set	June 2015
		Provide leadership training for clinical and managerial leaders through programme adopted from Canterbury DHB's XcelR8 Programme. Include Performance Excellence Team staff in the localisation of the Programme	EDHR	DHB Provider Arm DHB Planning and Funding WellSouth PHO	Leadership training underway including clinicians and managers from	May 2015

					the DHB and PHO	
4.5	Develop locality networks as a forum for building the effective clinical relationships that will support local service improvement and integration	See action 1.5	See action 1.5	See action 1.5	See action 1.5	July 2015

Priority Five: Optimise system capacity and capability

5	Headline Action and Outcome	Tasks	DHB Executive Leadership Team Owner	Stakeholders/participants	Milestones/ progress	Completed by:
5.1	Establish a Workforce Reference Group as the cross-organisational leadership body to collaboratively plan and develop the Southern workforce based on intended models of care, workforce roles, and demand and supply forecasts Outcome: Effective operational relationships are formed across the health and education sector for workforce planning purposes	Workforce Reference Group established and introduced to the Implementation Plan for the SSHP and the intended input for workforce planning	EDHR CMO	DHB Provider Arm DHB Planning and Funding University of Otago	Workforce Reference Group established	June 2015
		Workforce Reference Group are involved in actions 1.4 (Third Hub discussions), 1.6 (Rural Hospital provision), 2.2 (SLAT priorities) and 3.2 (Southern Hospital service provision) in relation to workforce planning	EDHR	DHB Provider Arm DHB Planning and Funding Southern Education Providers	Workforce planning informs actions 1.4, 1.6, 2.2 and 3.2	June 2016
5.2	Expand SDHB professional leader roles to include whole-system scope across primary care, NGOs and rural health services , with a focus on standards, credentialing,	Identify and consult professional leaders on how to move from current to whole-system scope including identifying the benefits and risks	CMO EDON EDAH	DHB Provider Arm WellSouth PHO NGOs	Opportunity for expansion of professional leader role understood	Dec 2015

	continuing professional development and advice Outcome: supervision and support available across the care continuum					
5.3	Complete detailed district-wide facility capacity planning to inform business case development of an upgrade of prioritised Dunedin Hospital buildings Outcome: requirement for upgraded building understood	Output of actions 1.4 (Third Hub discussions), 1.6 (Rural Hospital provision), 2.2 (SLAT priorities) and 3.2 (Southern Hospital service provision) used to produce recommendations report on planning for Dunedin Hospital including: - Forecasting population changes - Incidence and prevalence of long term conditions	EDPS	DHB Provider Arm DHB Planning and Funding	Report on recommending requirements for Dunedin Hospital development	Dec 2016
5.4	Develop a Southern health system workforce plan, beginning with a stock take of the district's current health workers, and including clear priorities for workforce development based on the strategic direction in the SSHP Outcome: innovative approach to workforce planning aligned to new models of care	Southern Workforce Plan developed taking into account system redesign. Includes addressing: - Promotion of multidisciplinary teams, rural services and primary & community services - Assessment of interdisciplinary training in rural areas - Building on the existing Incubator Programme - Accommodating clinical placements - Development of new workforce	EDHR CMO EDON EDAH	DHB Provider Arm DHB Planning and Funding University of Otago WellSouth PHO Rural Hospitals	Workforce Plan produced	Sept 2016

		roles - Development of increased rural health service roles including hospital medicine specialists, increased registrar positions, general practice training and rural nursing and allied health specialist roles				

Priority Six: Living within our means

6	Headline Action and Outcome	Tasks	DHB Executive Leadership Team Owner	Stakeholders/participants	Milestones/ progress	Completed by:
6.1	Strengthen analysis and communication of where SDHB funds are spent across the Southern health system, the outputs delivered, and the outcomes and value Outcome: information is useful, shared regularly and used appropriately for decision making	Focussed activity with key operational managers and clinical leaders to understand: - What information do they require? - How frequently? - How should it be presented?	EDP&F EDPS Executive Director, Finance (EDF)	DHB Provider Arm	Reports provided on regular basis to operational managers and clinical leaders	June 2015
		Production Planning adopted for all elective/planned services	EDPS	DHB Provider Arm	Production planning	Oct 2015
		Reports and Production Plans available for all managerial meetings and tabled quarterly at clinical department meetings (wherever appropriate)	EDPS	DHB Provider Arm	Reports reviewed on a regular basis at operational and clinical meetings	Oct 2015

6.2	Increase use of benchmarking with other DHBs and providers as a basis for budget setting and productivity improvement Outcome: SDHB improves productivity and focuses on known areas of high spend	Analysis to be completed of overall DHB funding allocation including understanding spend by output class	EDP&F	DHB Planning and Funding	Analysis report on spend produced	June 2015
		Health Round Table data to be utilised for benchmarking key KPIs. KPIs to be agreed in partnership with managers, clinicians and Improvement Network for planning purposes	EDPS	DHB Provider Arm	KPIs reviewed and benchmarked to ascertain improvement goal	July 2015
		Specific focus projects to be scoped around current spending on: - Age-residential care - Community pharmaceuticals - Southern DHB personnel costs Aim to better understand situation and set specific pieces of improvement work	EDPS EDP&F	DHB Provider Arm DHB Planning and Funding	Project scopes produced (may be incorporated in Alliance South work plan)	Sept 2015
6.3	Develop a SDHB prioritisation framework to inform resource allocation Outcome: new ideas, pieces of work and resource utilisation are prioritised accordingly	Explore options around use of 1000 Minds prioritisation tool (or similar) for prioritising: - Model of care change proposals - Capital spend ideas - Programme Office resource - Disinvestment decisions	EDP&F EDPS	DHB Planning and Funding DHB Provider Arm	1000 Minds tool (or alternative) in place	Oct 2015
6.4	Tighten Provider Arm cost management including moderating recent FTE cost growth in key personnel areas Outcome: costs are understood	Investigate and appraise options for a DHB wide costing system	EDF	DHB Finance Team	Costing system implemented	Dec 2015
		Produce relevant costing reports showing budget holders their current position and the impact of volume	EDF	DHB Finance Team DHB Provider Arm	Costing system reports available	March 2016

	and reduced	(delivery) combined with cost				
6.5	Use the Performance Excellence and Quality Improvement Strategy as the framework for lifting performance to world-class levels in prioritised areas and to reduce waste Outcome: organisational focus on improving productivity and reducing waste through improving quality	Define organisational KPIs, utilise statistical process control as a method of measurement and consider an organisational programme of work to raise performance. Indicators may include Ambulatory Sensitive Hospitalisations, Average Length of stay, readmission rate, admissions, day case surgery rate and bed occupancy	EDPS	DHB Provider Arm	Provider-arm programme of work underway	April 2016
6.6	Develop a Strategic Investment Fund to support shift of resource to prioritised high value services	Examine opportunities for and the potential role of a Strategic Investment Fund	EDP&F EDPS	DHB-wide	Strategic Investment Fund role understood	June 2016

Success Factors for SSHP Implementation

It is vitally important that we consider the success factors for the implementation of the SSHP. These factors should be treated with as high a degree of importance as the Action Plans themselves with adequate time and resource made available. Resource will be needed for explicitly working on development areas such as clinical leadership, evaluation frameworks and governance structures and also for provision of regular communications updates. Specific Action Plans for this are included as Appendix Two.

1. Our people: ownership and participation

We need to invest time and creative thought into how we can embark upon organisational will-building and buy-in. We should recognise that there are people both within and outside of our organisation that are unaware, don't understand, don't care for and are not engaged with the Plan. Time should be invested in utilising the proposed Communications Plan and also holding some workshop style sessions with a cross-section of the organisation; engaging staff in order to spread a sense of ownership and participation in the Plan's implementation.

We need to ask:

- Do you want to make a difference?
- Do you care about making a difference?
- Will you do what it takes to make a difference?

Alongside these questions we need to take action around making the right thing the easy thing, and allowing our people the time and space to think about their role in the delivery of the Plan and what it means for them.

2. Our people: community engagement and leadership

We need to increasingly welcome the view of the consumer into our decision making processes. We should be developing from an informative/engagement model through to a collaborative model where we partner with consumers and communities using co-design principles.

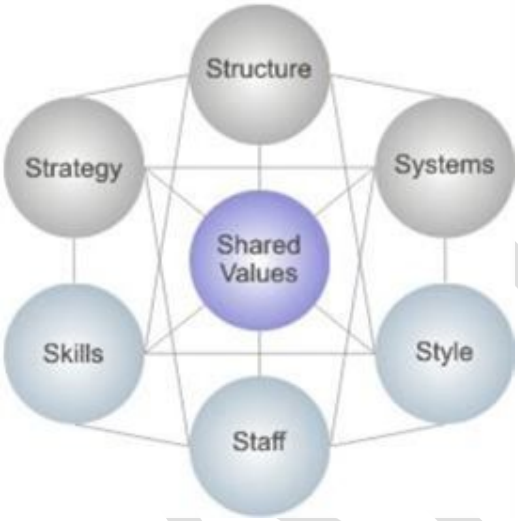
The following practical recommendations would allow greater consumer involvement:

- Asking consumers to review any publications, presentations or documents that have the purpose of communicating with the public
- Inviting consumers to participate in project teams, committees and in the development of work programmes
- Inviting a consumer to sit on the proposed SSHP Steering Group
- Using real stories to highlight success and areas for improvement
- Utilising the proposed Consumer Locality Networks for local solutions developed by local communities

3. Our people: clinical leadership and managerial partnership

We need to work closely with existing clinical and managerial leaders to elevate the understanding of the role of leadership within our organisation. The 7-S Model proposed by McKinsey (and shown below in Figure 1) suggests there are 7 inter-dependent elements that should be considered when working on improving a particular facet of an organisation.

Figure 1: The McKinsey 7S Model



Whilst we have begun to develop the relevant structures and staff roles for effective leadership, the 7-S model may assist us in considering the remaining factors for leadership including the required strategy and systems, and the softer elements of skills, style, and shared values.

The Action Plans included in this SIP outline a task around the localisation and delivery of the Canterbury XcelR8 programme and the development of a Leadership Action Plan. We will need to develop further explicit actions around the development of clinical leadership and how clinicians and managers will work in partnership.

4. Our Mission, Vision and Values

We need to build on the publication of the Southern Way and revitalise a sense of mission, vision and values within the organisation. We should begin work on a Mission Statement that encapsulates in a short sentence why we are here and what we will do. Furthermore, our organisational values should be revisited to answer 'how we do things here' and also 'what's important to us'. A one-line message about the intention and purpose of the SSHP should also be developed giving a clear sense of the SSHP's objective.

5. Our Communications Plan

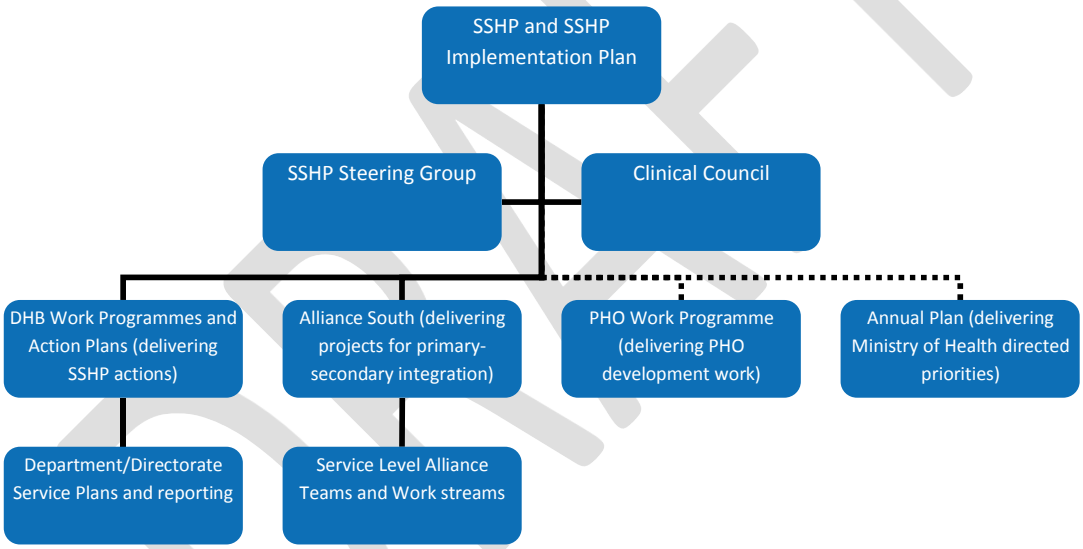
Our Communications Plan should have two areas of focus:

1. Key messaging around 'what does the Plan mean for me'
2. Mechanisms for updating people on the Plan's progress

The Communications Plan will be produced by June 2015. We need to recognise the public's desire for answers to key questions such as 'what is happening with Dunedin Hospital?', 'Will my local hospital still be open?', 'Where will I have to go for certain services?' Our Communications Plan should provide some clarity around when the answers to these types of question will be available and what the DHB is doing in the lead-up.

6. A single Southern health planning framework

The publication of the SSHP has heralded a new beginning in the planning and implementation of the DHB's work. We must now realign our work programmes, groups, committees, projects and every day work around the strategic intention of the SSHP, and cascade planning should become the norm. The SSHP should direct every piece of strategic development work completed by the DHB. Individuals within the DHB should be able to know how and what they are contributing to the SSHP through the development of relevant Service Level Plans both within the DHB Provider Arm and Planning and Funding. The following planning framework is proposed with a dashed line showing the relationship of WellSouth's work and the priorities as included in the Annual Plan.



7. The Implementation Plan and Māori and Pacific Health

There is an expectation that the actual implementation of the Action Plans will apply relevant guidance from Equity of Health Care for Māori: A Framework. Where there are specific service changes recommended, the Health Equity Assessment Tool (HEAT) should also be employed to ensure health access gain for Māori and Pacifica. There will be Māori representation on the SSHP Implementation Steering Group and input will be sought into the development of relevant KPIs to ensure reduction in health inequalities.

8. SSHP Implementation Governance and managing risk

It is proposed that a SSHP Implementation Steering Group be formed that will have the following role:

- Responsible for scrutinising the overall progress of the SIP
- Responsible for monitoring and evaluation of the SSHP's success
- Responsible for understanding any emerging risks or critical issues which may compromise implementation success and to provide advice on remedial action
- Receive status updates from key pieces of work contributing to each of the SSHP priorities as outlined in the Action Plans
- Work on the Success Factors outlined in this SIP
- Understand the linkages between pieces of work to ensure no duplication of effort
- Provide recommendation on resource requirements for delivery of the SSHP action plans

The Group will be chaired by the Chief Executive and owners of actions contained in this Plan will be required to provide status updates for progress monitoring and application of a Programme Management approach.

Risk Management for SSHP Implementation

Risk	Impact and Likelihood	Mitigation Strategy
Potential for negative opinion and misunderstanding in relation to: • Any new proposed models of care • Implications of recommended system changes • Relationship between managing our finances and the implementation of strategy	Medium and High	• A clear communications plan will be utilised to ensure all stakeholders are kept up to date with SSHP implementation • Locality Networks will be utilised for engagement with providers and consumers around how any new models of care might be localised • Project methodology is robust and transparent delivering clear results • Agreed communications around our purpose when we are working on new initiatives – use the Quadruple Aim to assist in demonstrating the balance between health outcomes, experience of care, cost and teaching and learning
Current health planning processes and mechanisms for delivery are still maturing	High and Medium	• SSHP Steering Group to dedicate focus to the success factors – engaging our people, prioritising workload and understanding resource requirements • Workshop to be held with Alliance South around strengthening capacity and capability using the 7-S Model • Utilise learning opportunities from other DHBs around alliancing and transformational change
External and internal factors influence our action plan priorities and the timeliness of commencement and delivery of tasks	Medium and Medium	• SSHP Steering Group to review Action Plans and consider adjusting the start and end dates of tasks and initiatives • SSHP Steering Group to review status reports monthly in order to mitigate any emerging risks, delays or resource issues
Our clinical teams, groups, SLATs and workstreams are unable to work collaboratively and/or collectively	High and Low	• The SSHP Steering Group and/or Alliance South Leadership Team will manage any conflict or disagreements between members • The groups will be guided by agreed terms of reference, clarity on deliverables and clear scopes

Appendix One – SSHP Implementation Gantt Chart

Attached separately

Appendix Two – Success Factors Action Plans

Our People - Ownership and Participation

Success Factor 1	Outcome	Tasks	DHB Executive Leadership Team Owner	Milestones/ progress	Completed by:
SF 1.1	DHB staff are aware of the objectives and key tasks for delivery of the SSHP	The SSHP Communications Plan contains focussed actions to ensure regular communication on progress of the implementation of the SSHP	EDC	Communications Plan finalised	June 2015
		A one-page infographic of the SSHP's objectives and key tasks is produced	EDC	Infographic produced	June 2015
		Consideration given to including an update on the SSHP implementation as a standing agenda item for all DHB meetings	CEO	Decision on inclusion on meeting agendas taken	June 2015
SF 1.2	DHB staff have the opportunity to influence the implementation of the SSHP thus taking ownership of the strategic direction	Expression of Interest process used alongside invitation for the set up of: - Alliance South SLATs and Work stream membership - Locality Provider and Consumer Networks	CEO	DHB staff members on formal SSHP implementation groups	June 2015
SF 1.3	DHB staff have the time and resource to work on the delivery of the SSHP	Executive Management Team to consider required support mechanisms for staff around delivery of operational requirements versus strategic development	CEO	Balanced approach to operational delivery and strategic development	April 2015
		Departments/directorates/teams/units review their current pieces of work (projects and initiatives) in the form of a Stock take	EDPS EDP&F CMO EDON EDAH	Stock take completed	May 2015

		Stock take information reviewed by Executive Management Team to ensure alignment with SSHP priorities and to determine position within single Southern health planning framework	CEO	All current work reviewed by EMT and supported, refocused or ceased	June 2015

Our People – Community Engagement and Leadership

Success Factor 2	Outcome	Tasks	DHB Executive Leadership Team Owner	Milestones/ progress	Completed by:
SF 2.1	SDHB partners with consumers and communities using co-design principles	Consumer representatives invited on to: - Alliance South SLATs and Work streams - Groups reviewing total service models for population groups and/or condition groups e.g. Health of Older People's strategy group	CEO EDP&F EDPS	Consumer views represented on decision making and steering groups	June 2015
		Quarterly SSHP implementation updates and presentations for the public are reviewed by a Consumer before being published/shared	EDC	Communications consistently reviewed by a Consumer	Ongoing
SF 2.2	Locality Networks (provider and consumer) successfully support the implementation of the SSHP	A senior manager from the DHB (Planning and Funding Portfolio Managers or Provider Arm General/Service Managers) are linked to one locality area to be the contact point and conduit of information both out from and in to the DHB	EDP&F EDPS	Each locality has a named DHB Support Manager	April 2015
SF 2.3	Chairs and leaders from groups/committees implementing the SSHP have a standardised induction to their role	Workshop sessions run every six months for Chairs and leading members of existing and new groups (including consumers where appropriate) covering the following: - Managing relationships in diverse groups - Consumer engagement and co-design - Use of HEAT for ensuring no increase in health inequalities - Use of population risk profiling for service model design	EDHR	All Chairs and leaders implementing the SSHP are trained and have an opportunity to meet	Commenced August 2015

		- Methods and approaches for quality improvement			

Our Mission, Vision and Values

Success Factor 3	Outcome	Tasks	DHB Executive Leadership Team Owner	Milestones/ progress	Completed by:
SF 3.1	A Southern DHB Mission Statement that inspires, motivates and supports improvement	Organisation wide process asking staff to input one line suggested mission statements covering the following four key questions: - What do we do? - How do we do it? - Whom do we do it for? - What value are we bringing?	CEO	Mission Statement agreed in support of SSHP implementation and SDHB vision	October 2015
SF 3.2	Revised organisational values	Review The Southern Way to ensure applicability and currency in line with the SSHP	EDHR	The Southern Way revitalised as the DHB's approach	December 2015
SF 3.3	One-line objective for the SSHP	SSHP Implementation Steering Group to determine a one-line objective for the SSHP	CEO	SSHP objective developed	June 2015

The Implementation Plan and Māori and Pacific Health

Success Factor 4	Outcome	Tasks	DHB Executive Leadership Team Owner	Milestones/ progress	Completed by:
SF 4.1	Service changes do not	SSHP Implementation Steering Group and Alliance South to	CEO	Significant change	Ongoing

	result in further health inequalities	ensure proposals for change have considered guidance from Equity of Health Care for Māori: A Framework, and utilisation of HEAT.		proposals use Equity of Health Care for Māori: A Framework	

SSHP Implementation Governance

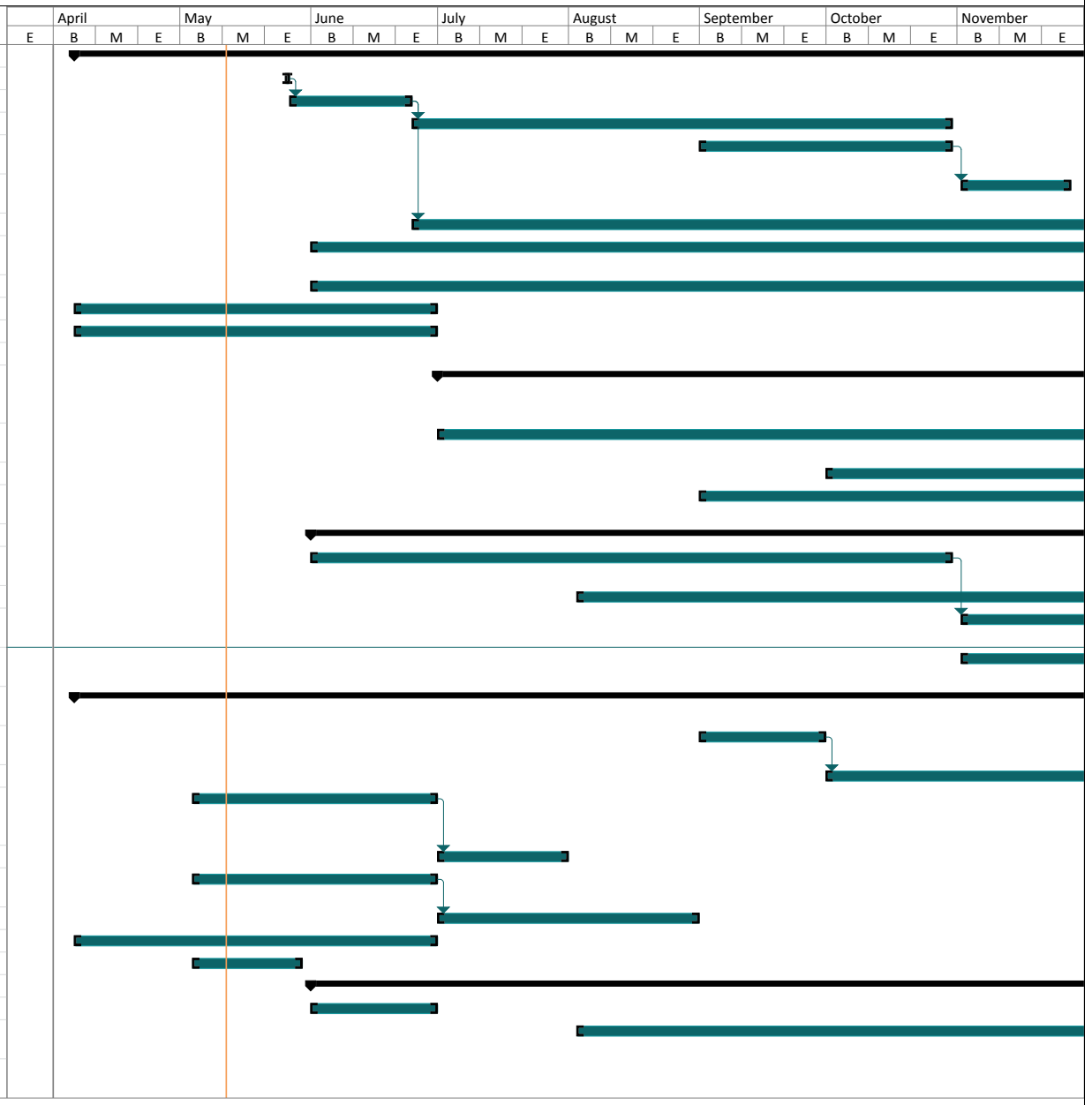
Success Factor 5	Outcome	Tasks	DHB Executive Leadership Team Owner	Milestones/ progress	Completed by:
SF 5.1	SSHP Implementation Steering Group monitors SSHP implementation progress	Terms of Reference (TOR) for SSHP Implementation Steering Group developed	CEO	TOR agreed	May 2015
		Steering Group to devise progress monitoring/status reporting framework for scrutinising overall progress and monitoring and evaluating success	CEO	Monitoring framework in place	July 2015

Risk	Likelihood	Strategy
Potential for negative public opinion in relation to: • The proposed new model • Implications of the model • The process that this project is following	High	• Authorised staff will manage how information is disseminated to the sector and public • Affected internal and external stakeholders kept informed of progress in liaison with the Southern District Health Board Communications Team • The wider community is kept informed in a consistent way, with messages that clearly link to the relevant national and local strategies • Project methodology is robust and transparent
A model is developed that doesn't meet the needs of our people	Low	• Information used to form trend and profile analysis is clean and useful • The process engages with people 'at the coalface' to identify: o What's working well with current services o Our needs o Gaps and bottlenecks in current services o Opportunities for improvement • The process checks in with the Steering Group to sound out thoughts or report progress • The process checks in with the wider geographical networks and the network leadership group • Once a reasonable model is defined, it is tested within a pilot or via a process walk through
We are unable to obtain meaningful input into the proposed model in a timely fashion (e.g. proposed discussion groups are poorly attended or the weather results in cancellation of sessions)	Medium	• Sessions will be arranged as in advance with reasonable notice to encourage and enable full participation and engagement by the sector • Sessions are widely communicated, via the network leadership group and geographical networks
The working group is unable to work collaboratively and collectively and the project stalls.	Low	• Planning & Funding, with the support of the Steering Group will manage any conflict or disagreements between members • The group will be guided by an agreed terms of reference
Internal Southern District Health Board staff and contracted NGO provider staff undertake work that has linkages to or impacts on	Medium	• Communication links with all relevant stakeholders within the DHB will be open and maintained • Where possible, any links or impacts

Risk	Likelihood	Strategy
this project, but the project team is not aware		will be leveraged to the benefit of this project
Changes to/loss of project staff	Low	• Planning and Funding will ensure they have the available resources to commit to the project required • Planning and Funding will ensure that the project team follow proper information and document processes (i.e. key documentation or working documents are easily sourced), and that updates on progress are continually provided
Management of conflict of interest	Medium	• Steering Group and Working Group members will be guided by a Terms of Reference document • Conflicts of interest will be clearly identified up front and appropriate management strategies identified

Southern Strategic Health Plan Implementation
Gantt Chart

ID	SIP Ref	Task Name	Start	Finish	Owner
1	**1**	**Develop a coherent Southern system of care**	**6/04/15**	**29/06/16**	
2	1.2	Workshop with Alliance South	26/05/15	26/05/15	S Boardman
3	1.2	Alliance South work programme agreed	27/05/15	24/06/15	S Boardman
4	1.2	Health Pathways work programme agreed	25/06/15	30/10/15	
5	1.3	Workshops with teams to create visual representation of future system	1/09/15	30/10/15	
6	1.3	One page infographic depicting conceptual represenation of future system	2/11/15	27/11/15	
7	1.4	Third Hub Analysis presented to Board	25/06/15	31/03/16	
8	1.4	Feasibility study for Medical Assessment and Planning Unit	1/06/15	31/12/15	
9	1.4	ECCT work programme	1/06/15	31/12/15	
10	1.5	Establish Clinical Locality Networks	6/04/15	30/06/15	S Boardman
11	1.5	Establish Consumer Locality Networks	6/04/15	30/06/15	S Boardman
12	1.6	Service model for each Rural Hospital defined	1/04/16	29/06/16	
13	**2**	**Build the Southern health system on a foundation of population health, and primary and community care**	**1/07/15**	**29/07/16**	
14	2.2	Alliance South completes prioritised pieces of service redesign work from Work Programme	1/07/15	29/07/16	
15	2.3	Risk profiling trial with GP concludes	1/10/15	29/02/16	
16	2.4	Locality trial - risk profile data for early intervention services including workforce design	1/09/15	29/01/16	
17	**3**	**Ensure access to sustainable specialised services**	**1/06/15**	**30/06/16**	
18	3.1	Analysis completed (SWOT/PEST) on secondary/tertiary boundary services	1/06/15	30/10/15	
19	3.2	Update role delineation model	3/08/15	31/12/15	
20	3.2	Proposed service outline for specialist Hospital services provided in Southern	2/11/15	30/06/16	
21	3.3	Proposed service outline for specialist Hospital services provided outside of Southern	2/11/15	30/06/16	
22	**4**	**Strenghten clinical leadership, engagement and quality improvement**	**6/04/15**	**31/12/15**	
23	4.1	Workshop to develop Provider arm work plans for raised performance	1/09/15	30/09/15	
24	4.1	Work plans produced for Provider arm	1/10/15	31/12/15	
25	4.2	Establishment of Improvement Network and production of implementation plan of PE&QI Strategy	4/05/15	30/06/15	L O'Shea
26	4.2	Improvement Framework produced	1/07/15	31/07/15	
27	4.4	Survey current medical workforce around engagement	4/05/15	30/06/15	D Bunton
28	4.4	Produce Leadership Action Plan	1/07/15	31/08/15	
29	4.4	Formalise role of Clinical Council	6/04/15	30/06/15	C Heatly
30	4.4	Leadership training (XcelR8)	4/05/15	29/05/15	J Pine
31	**5**	**Optimise system capacity and capability**	**1/06/15**	**31/12/16**	
32	5.1	Establish Workforce Reference Group	1/06/15	30/06/15	J Pine
33	5.2	Consult with professional leaders on whole-of-system scope role potential	3/08/15	31/12/15	
34	5.3	Report outlining required development and upgrade of Dunedin Hospital	1/07/16	31/12/16	



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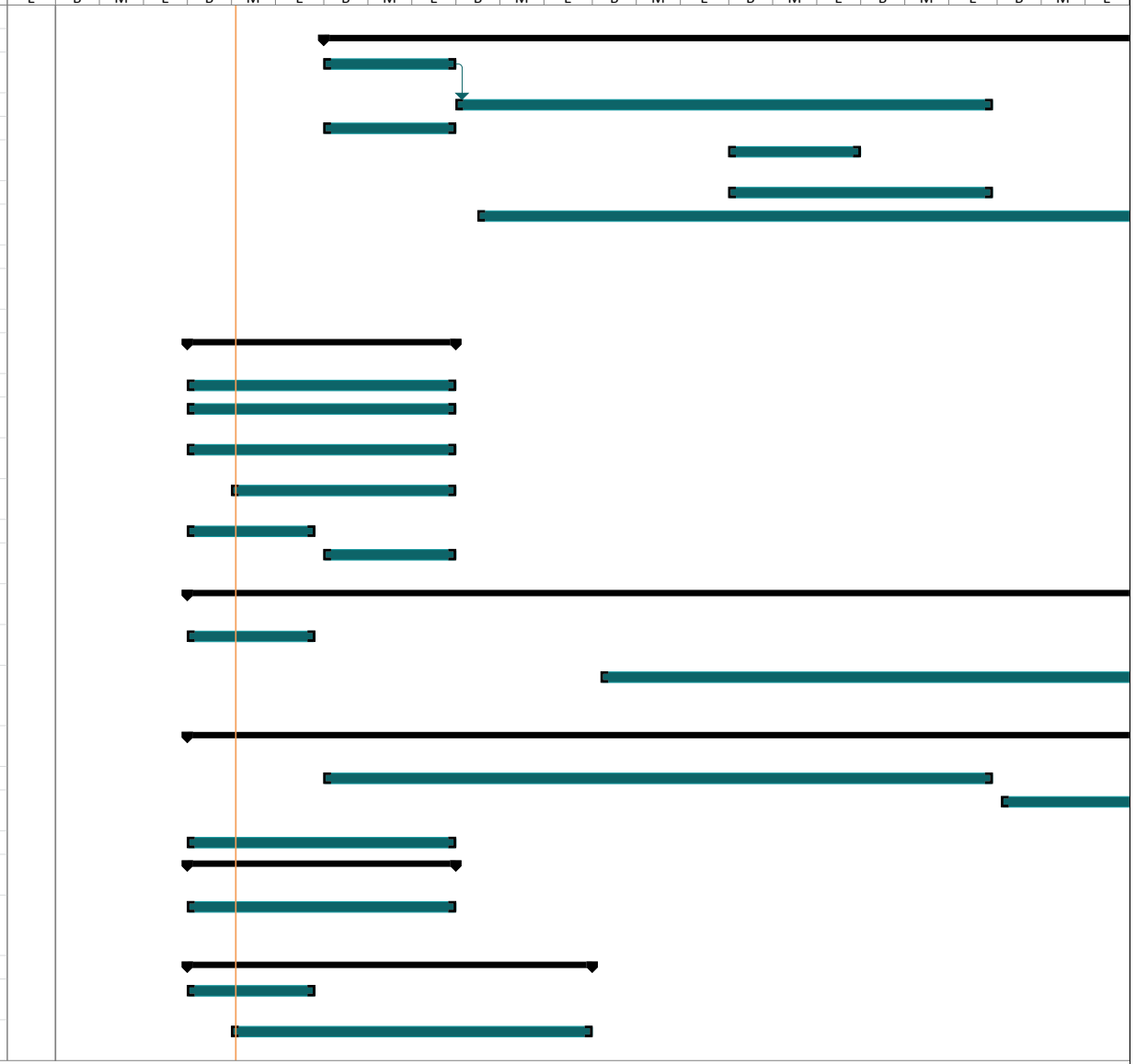
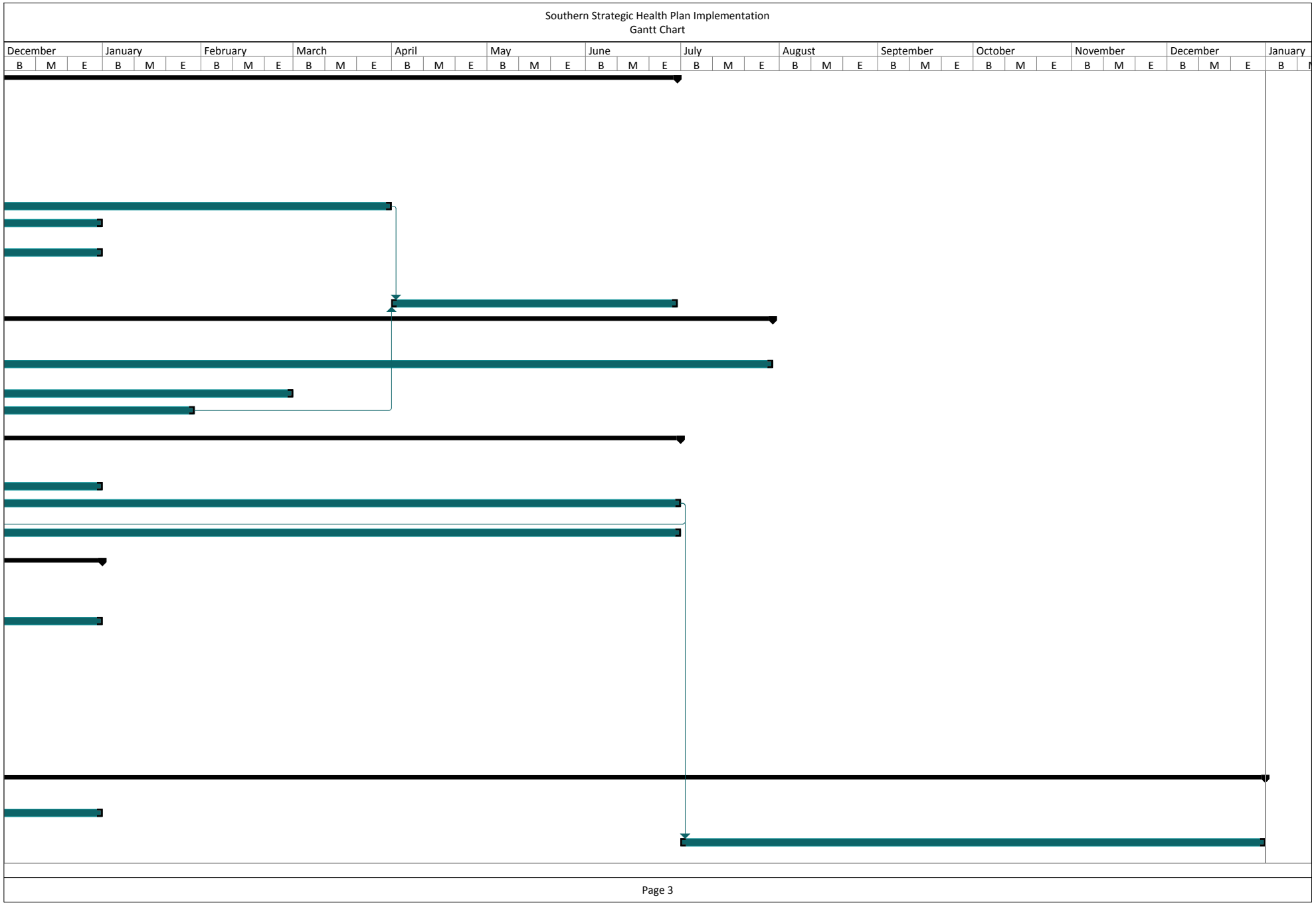
Southern Strategic Health Plan Implementation
Gantt Chart

ID	SIP Ref	Task Name	Start	Finish	Owner
35	5.4	Southern health system workforce plan	1/07/16	30/09/16	
36	**6**	**Living Within Our Means**	**1/06/15**	**30/06/16**	
37	6.1	Focussed activity with operational managers to understand data requirements	1/06/15	30/06/15	L O'Shea
38	6.1	Production Planning adopted	1/07/15	30/10/15	
39	6.2	Analysis of overall DHB funding allocation	1/06/15	30/06/15	S Boardman
40	6.2	Project scopes around funding of prioirised areas for review	1/09/15	30/09/15	
41	6.3	Prioritisation framework for resource allocation	1/09/15	30/10/15	
42	6.4	Investigate and appraise options for DHB wide costing system	6/07/15	31/12/15	
43	6.4	Production of costing reports	1/01/16	31/03/16	
44	6.5	Define provider arm efficiency KPIs, measurement system and projects	4/01/16	29/04/16	
45	6.6	Strategic Investment Fund established	4/04/16	30/06/16	
46	**SF1**	**Success Factor One - Ownership and Participation**	**1/05/15**	**30/06/15**	
47	SF 1.1	Communications Plan developed	1/05/15	30/06/15	S Addison
48	SF 1.1	One page infographic of SSHP objectives and key tasks	1/05/15	30/06/15	S Addison
49	SF 1.1	SSHP included as a standing agenda item across the organisation	1/05/15	30/06/15	C Heatly
50	SF 1.3	Required resource for delivery of SSHP quantified and presented to Board	11/05/15	30/06/15	C Heatly
51	SF 1.3	Stocktake of current work completed	1/05/15	29/05/15	L O'Shea
52	SF 1.3	Workload reprioritised and understood within single Southern health planning framework	1/06/15	30/06/15	L O'Shea
53	**SF2**	**Success Factor Two - Community Engagement and Leadership**	**1/05/15**	**30/09/16**	
54	SF 2.2	Senior Manager from DHB linked to each Locality Network	1/05/15	29/05/15	S Boardman
55	SF 2.3	Standardised training and induction for Chairs and members of SLATs, workstreams and groups working on SSHP	3/08/15	30/09/16	
56	**SF3**	**Success Factor Three - Our Mission, Vision and Values**	**1/05/15**	**31/12/15**	
57	SF 3.1	One line Mission Statement developed	1/06/15	30/10/15	
58	SF 3.2	Review the Southern Way to ensure applicability and currency in line with SSHP	2/11/15	31/12/15	
59	SF 3.3	One line objective for the SSHP developed	1/05/15	30/06/15	C Heatly
60	**SF4**	**Success Factor Four - Maori and Pacific Health**	**1/05/15**	**30/06/15**	
61	SF 4.1	Process developed to ensure proposals for change have considered guidance from Equity of Health Care for Maori: A Framework	1/05/15	30/06/15	C Heatly
62	**SF5**	**Success Factor Five**	**1/05/15**	**31/07/15**	
63	SF 5.1	TOR for SSHP Implementation Steering Group developed	1/05/15	29/05/15	S Boardman
64	SF 5.1	Process for monitoring/status reporting in place to ensure progress with SSHP	11/05/15	31/07/15	S Boardman




Southern Strategic Health Plan Implementation
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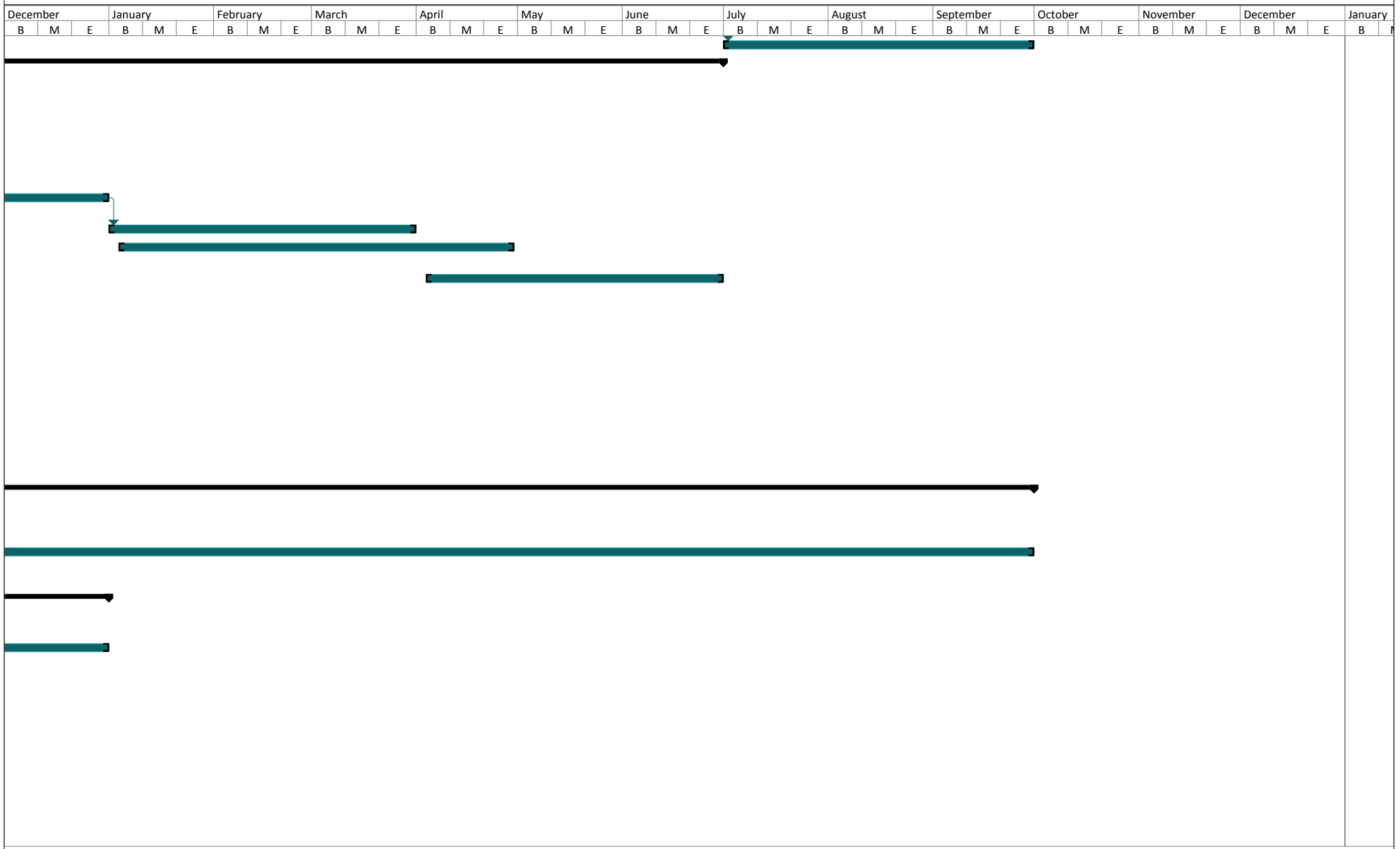
Southern Strategic Health Plan Implementation
Gantt Chart



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FUNDER FINANCIAL REPORT – APRIL 2015

Recommendations:

- **That the Committee note the Funder Financial Report**

1. DHB Funder Result

The overall funder result follows;

Month Actual $' 000	Month Budget $' 000	Month Variance $' 000		Year to Date Actual $' 000	Year to Date Budget $' 000	Year to Date Variance $' 000	Annual Budget $' 000
69,369	69,335	34	Revenue	695,093	693,613	1,478	832,283
(69,079)	(68,471)	(608)	Less Other Costs	(695,960)	(688,326)	(7,634)	(825,966)
290	864	(574)	Net Surplus / (Deficit)	(867)	5,287	(6,156)	6,317
			Expenses				
(49,018)	(48,828)	(190)	Personal Health	(494,102)	(490,734)	(3,181)	(588,785)
(7,061)	(7,091)	30	Mental Health	(71,201)	(70,895)	(304)	(85,075)
(577)	(624)	47	Public Health	(6,310)	(6,505)	195	(7,753)
(11,587)	(11,051)	(538)	Disability Support	(115,801)	(111,409)	(4,392)	(133,736)
(110)	(153)	43	Maori Health	(1,287)	(1,527)	240	(1,833)
(725)	(725)	0	Other	(7,254)	(7,254)	0	(8,784)
(69,079)	(68,471)	(608)	Expenses	(695,960)	(688,324)	(7,636)	(825,966)

Summary Comment:

For April the Funder had a surplus of $0.29m against a budget surplus of $0.867m which is $0.574m unfavourable.YTD the Funder is $6.156m unfavourable with a deficit of $0.869m against a budgeted surplus of $5.287m

YTD Revenue is favourable by $1.48m and this is offset by additional costs. Costs overall were unfavourable by $0.61m in April and $7.63m (YTD) with some revenue offsets.

For the month expenditure for Aged Residential Care Rest Homes is $0.29m unfavourable and Home Support $0.259m unfavourable are the main contributors to the April overspend.

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			
61,789	60,834	(45)	Personal Health	609,147	608,329	859
7,060	7,040	20	Mental Health	70,609	70,395	194
646	705	(59)	Public Health	6,819	7,317	(440)
143	32	111	Disability Support	1,239	318	809
4	0	4	Maori Health	24	0	18
725	725	0	Funding and Governance	7,254	7,254	0
69,369	69,336	33	Revenue total	695,092	693,613	1,479
			Expenses			
(49,018)	(48,827)	(191)	Personal Health	(494,102)	(480,734)	(3,368)
(7,061)	(7,091)	30	Mental Health	(71,201)	(70,895)	(306)
(577)	(624)	47	Public Health	(6,310)	(6,505)	195
(11,587)	(11,051)	(536)	Disability Support	(115,801)	(111,409)	(4,392)
(110)	(153)	43	Maori Health	(1,287)	(1,527)	240
(725)	(725)	0	Funding and Governance	(7,254)	(7,254)	0
(69,078)	(68,471)	(607)	Expenses total	(695,955)	(688,324)	(7,631)
			Surplus (Deficit)			
11,771	12,007	(700)	Personal Health	115,045	117,595	(2,550)
(1)	(51)	13	Mental Health	(592)	(500)	(91)
69	81	(7)	Public Health	409	812	(303)
(11,444)	(11,019)	(352)	Disability Support	(114,562)	(111,091)	(3,471)
(106)	(153)	41	Maori Health	(1,263)	(1,527)	264
0	0	0	Funding and Governance	0	0	0
291	865	(573)		(863)	5,289	(6,151)

- Revenue YTD is $1.48m above budget. The following additional revenue contracts are the main reason for the favourable variance: Exemplar CEP Enhanced Alcohol & Other Drug Service, Rural Sustainability Support, Sleepover settlement, Orthopaedic Pathway Programme, ARC Rest Home price increase from October 2014, National Patient Flow System Development, Radiology Service Improvement Initiative and One off funding for Alcohol & Drug Services. These additional revenue contracts are offset by corresponding additional expenditure.
- Personal Health payments are unfavourable for April by $0.191m. Surgical outpatients ($264k unfavourable) is the main driver. This was due to volume relating to extra revenue received for Bariatric and National Patient Flow.
- Mental Health and Public Health expenditure was close to budget.
- DSS costs were $0.352m unfavourable for April with rest home ($0.28m) and Home Support ($0.259m) being the main drivers.

3. DHB Funds Result split by NGO and Provider

Personal Health April 2015	Current Month Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Year to Date Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Variance Note
Personal Health - Provider Arm									
Child and Youth	(348)	(348)			(3,485)	(3,485)			
Laboratory	-	-			(4)	(4)			
Infertility Treatment Services	(92)	-	(92) U		(915)	(549)	(366) U	(67%)	3
Maternity	(42)	(42)			(415)	(415)			
Maternity (Tertiary & Secondary)	(1,380)	(1,380)			(13,800)	(13,800)			
Pregnancy and Parenting Education	(3)	(3)			(26)	(26)			
Neo Natal	(660)	(660)			(6,603)	(6,603)			
Sexual Health	(87)	(87)			(870)	(870)			
Adolescent Dental Benefit	(26)	(26)			(264)	(264)			
Dental - Low Income Adult	(22)	(22)			(223)	(223)			
Child (School) Dental Services	(595)	(595)			(5,949)	(5,949)			
Secondary / Tertiary Dental	(116)	(116)			(1,162)	(1,162)			
Pharmaceuticals	(291)	(292)			(2,707)	(2,917)	210 F	(7%)	6
Pharmaceutical Cancer Treatment Drugs	(521)	(386)	(135) U	(35%)	(3,837)	(3,857)	20 F	(1%)	
Pharmacy Services	(9)	(9)			(87)	(87)			
Primary Health Care Strategy - Health/SIA	-	-			(265)	-	(265) U		11
Rural Support for Primary Health Pro	(71)	(71)			(707)	(707)			
Immunisation	(70)	(70)			(697)	(697)			
Radiology	(268)	(268)			(2,685)	(2,685)			
Palliative Care	(7)	(7)			(69)	(69)			
Meals on Wheels	(33)	(33)			(334)	(334)			
Domicilary & District Nursing	(994)	(994)			(9,943)	(9,943)			
Community based Allied Health	(416)	(416)			(4,161)	(4,161)			
Chronic Disease Management and Educa	(160)	(160)			(1,603)	(1,603)			
Medical Inpatients	(5,653)	(5,653)			(56,530)	(56,530)			
Medical Outpatients	(3,272)	(3,272)			(32,721)	(32,721)			
Surgical Inpatients	(10,628)	(10,628)			(106,282)	(106,282)			
Surgical Outpatients	(1,819)	(1,548)	(271) U	(18%)	(15,747)	(15,475)	(271) U	(2%)	15
Paediatric Inpatients	(644)	(644)			(6,444)	(6,444)			
Paediatric Outpatients	(269)	(269)			(2,689)	(2,689)			
Pacific Peoples' Health	(10)	(10)			(99)	(99)			
Emergency Services	(1,478)	(1,478)			(14,783)	(14,783)			
Minor Personal Health Expenditure	(26)	(26)			(257)	(257)			
Price adjusters and Premium	(422)	(422)			(4,218)	(4,218)			
Travel & Accomodation	(4)	(4)			(43)	(43)			
	(30,436)	(29,939)	(498) U	(2%)	(300,624)	(299,951)	(672) U	(0%)	
Personal Health NGO									
Personal Health to allocate	-	(83)	83 F		-	(833)	833 F		1
Child and Youth	(34)	(34)			(346)	(340)	(6) U	(2%)	
Laboratory	(1,504)	(1,465)	(39) U	(3%)	(15,376)	(14,648)	(728) U	(5%)	2
Infertility Treatment Services	-	(101)	101 F		-	(456)	456 F		3
Maternity	(229)	(220)	(8) U	(4%)	(2,215)	(2,203)	(12) U	(1%)	
Maternity (Tertiary & Secondary)	(1)	(14)	13 F	95%	(21)	(136)	115 F	85%	
Pregnancy and Parenting Education	(7)	(10)	3 F	31%	(77)	(98)	21 F	22%	
Sexual Health	(2)	(1)		(1%)	(14)	(15)	1 F	9%	
Adolescent Dental Benefit	(145)	(196)	50 F	26%	(1,527)	(1,753)	226 F	13%	4
Dental - Low Income Adult	(57)	(55)	(1) U	(2%)	(562)	(554)	(9) U	(2%)	
Child (School) Dental Services	(35)	(33)	(2) U	(6%)	(279)	(374)	95 F	25%	
Secondary / Tertiary Dental	(139)	(126)	(13) U	(10%)	(1,663)	(1,260)	(403) U	(32%)	5
Pharmaceuticals	(5,235)	(5,496)	262 F	5%	(59,280)	(58,435)	(845) U	(1%)	6
Pharmaceutical Cancer Treatment Drugs	-	-			(17)	-	(17) U		
Pharmacy Services	(40)	(61)	20 F	33%	(445)	(607)	162 F	27%	7
Management Referred Services	-	250	(250) U		-	1,500	(1,500) U		8
General Medical Subsidy	(19)	(79)	59 F	75%	(622)	(792)	170 F	21%	9
Primary Practice Services - Capitated	(3,479)	(3,511)	32 F	1%	(34,946)	(35,110)	165 F		
Primary Health Care Strategy - Care	(328)	(318)	(10) U	(3%)	(3,221)	(3,179)	(43) U	(1%)	10
Primary Health Care Strategy - Health	(438)	(337)	(101) U	(30%)	(3,366)	(3,367)	1 F		10
Primary Health Care Strategy - Other	(233)	(255)	22 F	9%	(2,238)	(2,548)	310 F	12%	10
Practice Nurse Subsidy	(14)	(16)	2 F	15%	(140)	(163)	23 F	14%	
Rural Support for Primary Health Pro	(1,310)	(1,313)	3 F		(13,048)	(13,130)	82 F	1%	
Immunisation	(433)	(433)			(1,288)	(1,436)	149 F	10%	11
Radiology	(156)	(196)	40 F	20%	(1,998)	(1,961)	(37) U	(2%)	
Palliative Care	(477)	(488)	12 F	2%	(5,187)	(4,883)	(303) U	(6%)	12
Meals on Wheels	(20)	(20)			(201)	(200)			
Domicilary & District Nursing	(469)	(435)	(34) U	(8%)	(4,773)	(4,358)	(416) U	(10%)	13
Community based Allied Health	(173)	(168)	(6) U	(3%)	(1,688)	(1,676)	(13) U	(1%)	
Chronic Disease Management and Educa	(115)	(95)	(20) U	(21%)	(1,007)	(950)	(57) U	(6%)	
Medical Outpatients	(409)	(397)	(11) U	(3%)	(4,128)	(3,974)	(154) U	(4%)	14
Surgical Inpatients	(19)	(19)		1%	(163)	(186)	23 F	12%	
Surgical Outpatients	(139)	(146)	7 F	5%	(1,407)	(1,463)	57 F	4%	15
Paediatric Outpatients	(7)	-	(7) U		(14)	-	(14) U		
Pacific Peoples' Health	(15)	(12)	(3) U	(29%)	(79)	(117)	38 F	33%	
Emergency Services	(159)	(156)	(4) U	(2%)	(1,619)	(1,556)	(63) U	(4%)	
Minor Personal Health Expenditure	94	(74)	168 F	228%	(436)	(739)	302 F	41%	16
Price adjusters and Premium	(77)	(83)	6 F	8%	(1,463)	(835)	(628) U	(75%)	17
Travel & Accomodation	(327)	(294)	(33) U	(11%)	(4,222)	(3,964)	(258) U	(7%)	
Inter District Flow Personal Health	(2,434)	(2,399)	(35) U	(1%)	(24,411)	(23,989)	(421) U	(2%)	
	(18,584)	(18,889)	305 F	2%	(193,487)	(190,788)	(2,699) U	(1%)	
Total Personal Health	(49,020)	(48,828)	(193) U	(0%)	(494,111)	(490,739)	(3,371) U	(1%)	

Personal Health expenditure variance notes;

1. **Personal Health to allocate** - $833k favourable YTD
   Unallocated budget.
2. **Laboratory** - $728k unfavourable YTD.
   Due to the budget for send-away tests being set too low.
3. **Infertility Treatment Services –** Provider Arm $0.366m unfavourable and NGO $0.456m favourable. The variances are due to anticipated changes in the provider of the service not occurring when expected. Expenditure was budgeted in the Provider until December 2014 and then in the Funder from January with the expectation that the service would be provided by NGO's from January 2015. Change in the provider is now expected from July 2015.

4. **Adolescent Dental** - $226k favourable YTD.
   Comparisons to 2013/14 YTD spend as at end of April shows that the two financial years are very similar at this stage of the financial year. If this trend of lower utilisation continues expenditure would be approximately $240k under budget at year end.
5. **Secondary /Tertiary dental** - $403k unfavourable YTD.
   No accruals in May/June 2013 and therefore current year (2014/15) includes 2013/14 expenditure of $280k which makes up the majority of the unfavourable variance. A comparison of 2014/15 YTD expenditure ($280k accrual error excluded) to the corresponding period in 2013/14 indicates that expenditure will be approximately $150k higher than budget at year end. This means total expenditure will be approximately $430k over budget.
6. **Pharmaceuticals (Provider & NGO combined)** – $635k unfavourable YTD.
   Expenditure based on latest Pharmac forecast plus it also includes accruals for pharmacy depot services, medical device funding, pharmacy operating costs etc that are not included in Pharmac forecast (accrual calculation Appendix 1) . Some expenditure attributed to this line was budgeted in pharmacy services – see note 7 below.
   - Provider pharmaceutical expenditure is under budget due to pharmaceuticals dispensed from the hospital dispensary being expensed against the NGO line as part of community pharmaceutical expenditure.
7. **Pharmacy Services -** $162k favourable YTD.
   Pharmacy depot budget is included in this line but expenditure has been included in pharmaceuticals line – see note 6 above.
8. **Management of Referred Services -** $1.5m unfavourable YTD.
   This line is a placeholder for budget savings. Savings are not expected to be made and this line will have an unfavourable variance of $2m at year end.
9. **General Medical Subsidy -** $170k favourable YTD.
   Demand driven service.
10. **Primary Health Care Strategy (All Provider and NGO lines combined)-** $4k favourable YTD.
    These service lines form part of the PHO contract. When all lines are consolidated the overall result is $4k favourable against YTD budget of $9.04m.
11. **Immunisation -** $149k favourable YTD.
    The YTD underspend includes accruals to ensure expenditure has matched budget for the last three months. Even though the budget was phased heavily in the latter part of the financial year, we are still below budget. The delayed availability of Flu vaccines may be a contributing factor and expenditure is likely to increase significantly in the last months of the year.

12. **Palliative Care** - $303k unfavourable YTD.
    Expenditure includes demand driven Home and Community Support Service (HCSS) expenditure ($150k YTD) that was not included in the budget. Other palliative care contracts are $153k unfavourable.

13. **Domiciliary & District Nursing -** $416k unfavourable YTD.
    Overspend driven by Home & Community Support Services which are $396k unfavourable YTD.

14. **Medical Outpatients -** $154k unfavourable YTD.
    Due to National Haemophilia contributions being higher than budgeted amount.

15. **Surgical Outpatients -** $214k unfavourable YTD.
    Due to extra volumes in the Provider for Bariatric and National Patient Flow. These volumes relate to extra revenue received from MOH.

16. **Minor Personal Health Expenditure -** $302k favourable YTD.
    The underspend relates to a budget of $260k YTD for “after hours primary care initiative”. This is a result of an error where an expense has been budgeted for twice.

17. **Price Adjusters & Premiums** - $628k unfavourable YTD.
    Due predominantly to the sleepover settlement. Additional Ministry funding was announced in September 2014 and hence unbudgeted expenditure. The sleepovers settlement is the main driver of the overspend ($279k). The expenditure is offset by unbudgeted revenue of $279k YTD.

    Unbudgeted transitional funding to support agreed model of care and rural premium expenditure are the other main drivers of the overspend.

Mental Health

	Current Month				Year to Date				
Mental Health	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance	Variance Note
April 2015	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%	
Mental Health - Provider Arm									
Mental Health to allocate	9	9			95	95			
Acute Mental Health Inpatients	(1,143)	(1,143)			(11,433)	(11,433)			
Sub-Acute & Long Term Mental Health	(304)	(304)			(3,038)	(3,038)			
Crisis Respite	(2)	(2)			(21)	(21)			
Alcohol & Other Drugs - General	(272)	(272)			(2,723)	(2,723)			
Methadone	(94)	(94)			(943)	(943)			
Dual Diagnosis - Alcohol & Other Drugs	(8)	(8)			(84)	(84)			
Dual Diagnosis - MH/ID	(5)	(5)			(50)	(50)			
Child & Youth Mental Health Services	(579)	(579)			(5,786)	(5,786)			
Forensic Services	(509)	(509)			(5,092)	(5,092)			
Kaupapa Maori Mental Health Services	(146)	(146)			(1,461)	(1,461)			
Mental Health Community Services	(1,752)	(1,752)			(17,517)	(17,517)			
Prison/Court Liaison	(45)	(45)			(445)	(445)			
Day Activity & Work Rehabilitation S	(63)	(63)			(632)	(632)			
Mental Health Funded Services for Older P	(36)	(36)			(357)	(357)			
Advocacy / Peer Support - Consumer	(35)	(35)			(347)	(347)			
Other Home Based Residential Support	(58)	(58)			(581)	(581)			
	(5,042)	(5,042)			(50,415)	(50,415)			
Mental Health - NGO									
Mental Health to allocate	-	(38)	38 F		-	(381)	381 F		18
Crisis Respite	(5)	(5)		(2%)	(47)	(46)		(1%)	
Alcohol & Other Drugs - General	(61)	(55)	(7) U	(12%)	(554)	(547)	(7) U	(1%)	
Alcohol & Other Drugs - Child & Youth	(102)	(102)			(1,083)	(1,020)	(63) U	(6%)	
Dual Diagnosis - Alcohol & Other Drugs	(35)	(36)	1 F	2%	(358)	(362)	4 F	1%	
Eating Disorder	(11)	(16)	5 F	33%	(115)	(161)	46 F	29%	
Maternal Mental Health	(4)	(4)			(37)	(37)			
Child & Youth Mental Health Services	(304)	(241)	(63) U	(26%)	(2,999)	(2,413)	(585) U	(24%)	19
Forensic Services	(4)	(4)			(36)	(36)			
Kaupapa Maori Mental Health Services	(6)	(6)			(61)	(61)			
Mental Health Community Services	(94)	(127)	32 F	25%	(1,118)	(1,265)	147 F	12%	
Day Activity & Work Rehabilitation S	(136)	(136)			(1,364)	(1,363)	(1) U		
Advocacy / Peer Support - Consumer	(23)	(23)			(232)	(233)	1 F		
Other Home Based Residential Support	(342)	(315)	(27) U	(8%)	(3,418)	(3,152)	(267) U	(8%)	20
Advocacy / Peer Support - Families	(52)	(52)			(524)	(524)			
Community Residential Beds & Service	(391)	(457)	66 F	14%	(4,461)	(4,565)	105 F	2%	
Minor Mental Health Expenditure	(40)	(32)	(8) U	(25%)	(322)	(318)	(3) U	(1%)	
Inter District Flow Mental Health	(406)	(399)	(6) U	(2%)	(4,057)	(3,994)	(63) U	(2%)	
	(2,016)	(2,048)	31 F	2%	(20,786)	(20,478)	(305) U	(1%)	
Total Mental Health	(7,058)	(7,090)	31 F	0%	(71,201)	(70,893)	(305) U	(0%)	

Mental Health expenditure variance notes;

18. Mental Health to allocate - $381k favourable YTD.

Unallocated budget.

19. Child & Youth Mental Health Services - $585k unfavourable YTD.

This overspend is mainly due to a budgeting error where $500k was removed from the annual budget but the expenditure remained unchanged, accounting for $417k of the YTD overspend. An unbudgeted contract plus another contract where the budget was understated, contribute to the rest of the overspend.

20. Other Home Based Residential Support - $267k unfavourable YTD.

Demand driven service.

Disability Support Services

DSS	Current Month				Year to Date				Variance Note
April 2015	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	
Disability Support Services - Provider Arm									
AT & R (Assessment, Treatment and Re	(1,688)	(1,688)			(16,884)	(16,884)			
Needs Assessment	(138)	(138)			(1,380)	(1,380)			
Service Co-ordination	(19)	(19)			(195)	(195)			
Long Term Chronic Conditions	(8)	(8)			(80)	(80)			
Ageing in Place	(2)	(2)			(25)	(25)			
Environmental Support Services	(2)	(2)			(22)	(22)			
Minor Disability Support Expenditure	(8)	(8)			(84)	(84)			
Community Health Services & Support	(21)	(21)			(210)	(210)			
	(1,886)	(1,886)			(18,880)	(18,880)			
Disability Support Services - NGO									
AT & R (Assessment, Treatment and Re	(297)	(297)			(2,974)	(2,974)			
Information and Advisory	(12)	(12)			(119)	(119)			
Needs Assessment	(42)	(22)	(21) U	(96%)	(394)	(216)	(178) U	(82%)	21
Service Co-ordination	-	-			(10)	-	(10) U		
Home Support	(1,681)	(1,423)	(259) U	(18%)	(15,420)	(14,225)	(1,195) U	(8%)	22
Carer Support	(145)	(144)	(1) U	(1%)	(1,291)	(1,442)	151 F	10%	
Residential Care: Rest Homes	(3,188)	(2,900)	(288) U	(10%)	(32,820)	(29,380)	(3,440) U	(12%)	23
Residential Care: Loans Adjustment	23	23		(2%)	157	227	(70) U	31%	
Residential Care: Hospitals	(3,843)	(3,817)	(24) U	(1%)	(38,528)	(38,659)	130 F		24
Environmental Support Services	(110)	(108)	(2) U	(2%)	(1,015)	(1,076)	61 F	6%	
Day Programmes	(34)	(46)	11 F	24%	(340)	(462)	122 F	26%	25
Minor Disability Support Expenditure	-	(9)	9 F		-	(91)	91 F		
Respite Care	(87)	(95)	8 F	8%	(1,214)	(952)	(261) U	(27%)	26
Community Health Services & Support	(44)	(60)	16 F	26%	(384)	(595)	211 F	35%	
Inter District Flow Disability Support	(243)	(256)	13 F	5%	(2,569)	(2,564)	(5) U		
	(9,703)	(9,166)	(538) U	(6%)	(96,921)	(92,528)	(4,393)	(5%)	
Total Disability Support Services	(11,589)	(11,052)	(538) U	(5%)	(115,801)	(111,408)	(4,393) U	(4%)	

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Disability Support Services expenditure variance notes;

21. Needs Assessment - $178k unfavourable YTD.

The overspend relates to InterRAI assessments ($111k) where there is no budget along with a contract where the expenditure exceeded the budget by $35k YTD.

22. Home Support - $1.195m unfavourable YTD.

Demand driven service where the budget was significantly understated and activity has increased.

23. Residential Care: Rest Homes - $3.44m unfavourable YTD.

The significant rest home variance for the YTD is the combination of a number of factors:

The first of these is the Ministry initiated 5% price increase effective from 1 October 2014 (announced 25 August 2014) for which we are receiving $111k revenue per month. Based on YTD actual volumes and prices, the increase has cost the SDHB $1.143m extra YTD, therefore the price increase is costing an extra $52k per month over and above the additional funding received from the Ministry. The impact of the price variance on the YTD expenditure result however, is only $685k as the budget was based on a higher price than the actual price we were paying before the price increase was bought in.

Dementia prices have been lower than the budgeted price and have had a favourable impact on the YTD result of $142k

Rest Home and Dementia volumes are both up significantly against forecast which has resulted in an unfavourable impact on the budget of $1.54m YTD. Dementia is unfavourable ($1.06m) and is the major contributor.

Long Term Conditions are unfavourable ($410k) due to the budget being set based on the prior year budget as opposed to prior year actuals.

The 2013/14 year end accruals were understated and therefore $867k of 2013/14 expenditure is included in the current financial year.

24. Residential Care: Hospitals - $130k favourable YTD.

The under spend is a mix of price and volume variance in both hospitals and Psycho-geriatric expenditure. Hospital prices are under budget ($1.26m) – because of a higher level of resident contribution - while volumes are over budget ($1.57m). Psycho-geriatric prices are under budget ($15k) and volumes are under budget ($1.174m). An under accrual of $283k in June 2014 and unbudgeted BUPA expenditure reduce the under budget variance.

25. Day Programmes - $122k favourable YTD.

Demand driven service. Expenditure reflects actual.

26. Respite Care - $261k unfavourable YTD.

Demand driven service. The year to date position reflects higher expenditure in prior months with February-April close to budget.

Public Health

	Current Month				Year to Date				
Public Health	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance	Variance Note
April 2015	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%	
Public Health - Provider Arm									
Alcohol & Drug	(36)	(36)	0 F	(0%)	(359)	(359)	0 F	(0%)	
Communicable Diseases	(97)	(97)	0 F	(0%)	(971)	(971)	0 F	(0%)	
Mental Health	(22)	(22)	0 F	(0%)	(222)	(222)	0 F	(0%)	
Screening Programmes	(42)	(112)	69 F	(62%)	(1,167)	(1,386)	218 F	(16%)	27
Nutrition and Physical Activity	(23)	(23)	0 F	(0%)	(226)	(226)	0 F	(0%)	
Physical Environment	(36)	(36)	0 F	(0%)	(359)	(359)	0 F	(0%)	
Public Health Infrastructure	(128)	(128)	0 F	(0%)	(1,277)	(1,277)	0 F	(0%)	
Sexual Health	(12)	(12)	0 F	(0%)	(120)	(120)	0 F	(0%)	
Social Environments	(38)	(38)	0 F	(0%)	(379)	(379)	0 F	(0%)	
Tobacco Control	(81)	(81)	0 F	(0%)	(814)	(814)	0 F	(0%)	
	(515)	(585)	69 F	12%	(5,894)	(6,113)	218 F	4%	
Public Health - NGO									
Nutrition and Physical Activity	(26)	(27)	1 F	4%	(256)	(268)	11 F	4%	
Tobacco Control	(36)	(12)	(23) U	(188%)	(159)	(125)	(34) U	(28%)	
	(63)	(39)	(23) U	(59%)	(415)	(393)	(23) U	(6%)	
Total Public Health	(578)	(624)	46 F	7%	(6,309)	(6,506)	195 F	3%	

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Public health expenditure variance notes;

27. **Screening Programmes** - $218k favourable YTD.

The favourable variance relates to the provider arm and is offset by less revenue in the month and YTD.

Maori Health Expenditure

	Current Month				Year to Date			
Maori Health	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance
March 2015	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%
Maori Health - Provider Arm								
Maori Service development	(16)	(16)	0 F	(0%)	(157)	(157)	0 F	(0%)
Maori Provider Assistance Infrastructure	-	-	0 F	(0%)	-	-	0 F	(0%)
Maori Workforce Development	-	-	0 F	(0%)	-	-	0 F	(0%)
Minor Maori Health Expenditure	-	-	0 F	(0%)	-	-	0 F	(0%)
Whanau Ora Services	(8)	(8)	0 F	(0%)	(79)	(80)	1 F	(0%)
Maori Health - Provider Arm Total	**(24)**	**(24)**	0 F	(0%)	**(236)**	**(237)**	**1 F**	(0%)
Maori Health - NGO								
Maori Service development	(8)	(22)	14 F	64%	(196)	(222)	26 F	12%
Maori Provider Assistance Infrastructure								
Maori Workforce Development								
Minor Maori Health Expenditure								
Whanau Ora Services	(78)	(107)	29 F	27%	(855)	(1,068)	213 F	20%
Maori Health - NGO Total	**(86)**	**(129)**	**43**	**(46%)**	**(1,051)**	**(1,290)**	239 F	19%
Total Maori Health	**(110)**	**(153)**	**43**	**5%**	**(1,287)**	**(1,527)**	240 F	16%

Maori Health Services expenditure variance notes;

28. Whanau Ora Services - $ 240k favourable YTD.

The budget includes $175k YTD for adjusters that are being expensed in the Price Adjusters and Premium line in Personal Health.

Expenditure also includes $39k repaid by a provider for an overpayment.

Pharmaceuticals accrual - 30 April 2015 **APPENDIX 1**

Funder expenditure before adjusting accrual

Pharmaceuticals	61,670,036
PCT	3,854,230
Pharmacy Serices	531,613
Total	66,055,879

Expected expenditure based on Pharmac forecast (February)

	Annual	YTD expected
Pharmac forecast to 31 March	81,000,000	67,684,471
Adjustment (not split monthly in Pharmac)	130,000	108,629
less Haemophilia (included in medical outpatients)	-1,800,000	-1,504,099
less Vaccines Influenza	-448,549	-361,065
Total	78,881,451	65,927,936

Other (not included in Pharmac)

Pharmac Promoting responsible use of pharmaceuticals	126,498	126,498
Pharmacy Depot Services	189,342	157,785
Unused medicine disposal	40,000	30,435
Pharmac Operating costs	230,000	191,752
E Prescriptions	268,555	222,569
Medical devices	140,000	116,667
Hospital dispensing	104,228	86,857
	1,098,623	932,563
Total expected as at 31 March 2015	79,980,074	66,860,499
Variance to GL		804,620

Adjustment

Provider PCT expenditure	3,936,237
Pharmac forecast of PCT (before rebate) includes	4,423,722
Variance (reduction of total expected)	487,485
Adjusted total expenditure expected	66,373,014

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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.