SOUTHERN DISTRICT HEALTH BOARD

DISABILITY SUPPORT ADVISORY COMMITTEE
and
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Wednesday, 21 March 2018
commencing at the conclusion of the public
Hospital Advisory Committee meeting

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

A G E N D A

Lead Director: Lisa Gestro, Executive Director Strategy, Primary & Community

Item

1. **Apologies**

2. 10.00 am
   Presentation: *Home as my First Choice*
   Sally O'Connor, Director of Nursing, Strategy, Primary and Community

3. **Interests Register**

4. **Minutes of Previous Meeting**

5. **Matters Arising**

6. **Review of Action Sheet**

7. **Strategy, Primary & Community**
   7.1 Strategy, Primary & Community Report
   7.2 Public Health Report

8. **Community Health Council:**
   Community, Whānau and Patient Engagement Framework and Roadmap

9. **Performance Report - Quarter Two**

10. **Financial Report**

11. **Contracts Register**

Southern DHB Values			
Kind *Manaakitanga*	Open *Pono*	Positive *Whaiwhakaaro*	Community *Whanaungatanga*

APOLOGIES

No apologies had been received at the time of going to print.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Home as my First Choice**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	21 March 2018

Background

This initiative has grown on the back of some improvement work within Older People's Health around how we can better use our resources to prevent unnecessary hospital admissions and support people to remain in their own environments for as long as possible. National data has also shown us that Southern DHB is regularly in the top three DHBs in NZ for rates of admission into aged residential care facilities. What we have heard anecdotally (and has been confirmed by an audit of notes at the end of 2017) is that we have a culture in some of our health facilities of presuming that for many of our older, frailer people, aged residential care is the only option. These seeds tend to be sown before Clinical Needs Assessors are brought in, resulting in some resistance (from staff, family-whanau and even patients) to the concept that with the right supports, people could stay in their homes longer. The presentation you will see today explains this some more and is part of a programme we are launching no 13 March called "Home as my First Choice". We want to start having conversations, challenge thinking and shift the culture we have in Southern that tends to presume "aged residential care".

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

Financial:	Aiming to support more older people to live at home, thus reducing admissions to Aged Residential Care.
Workforce:	We realise that the biggest challenge in all of this is the culture we have around interacting with older people. We are not good to listening to what people are saying to us (e.g. "every older person who comes in here tells us they want to go home… but it's not feasible"). We are also aware that there is work to be done with our community supports i.e. having a better consistency of experience between different providers, engaging with the wider community to increase our capacity to support people in their own homes – including what informal supports (family/friends) can help.

Document previously submitted to:	SDHB Executive	**Date:** 01/03/2017

Prepared by: Sally O'Connor and Andrew Metcalfe **Date:** 07/03/2018	**Presented by:** Sally O'Connor

RECOMMENDATION:

1. That the report be received.

Restorative Care in the South Island

A Consumer Guide

May 2016

SOUTH ISLAND ALLIANCE

best for people, best for system

A restorative care approach to health supports older people to be independent, care for themselves and participate within their community, family and whānau for as long as possible.

The South Island Alliance is supporting health care providers across the South Island to adopt a restorative care approach to the services they provide to older people in their communities.

The following guide has been developed to help you understand what a restorative care approach is and what it means for you.

Best for people, best for system...

What is restorative care?

Restorative care is a flexible approach to health care that puts you and your needs at the centre of your care. It aims to help you maintain your independence for as long as possible.

This includes respecting your wishes at all times and supporting you to improve your mobility, and physical and mental functioning — which means you can enjoy life the way you want for longer.

International evidence shows that a restorative care approach to older persons' health improves an individual's health status and enables them to continue social and occupational activity, and remain confident and independent.

That's why we're supporting health care providers across the South Island to adopt a restorative care approach to the services they provide.

Elsie's Story

An older South Island resident who lives alone recalls how a restorative care approach supported her to achieve a full recovery from a heel injury.

"The care I received was very good. We faced several situations that needed a bit of initiative to overcome them, and my carer discussed these at the provider meeting and details were added to their care plans as well as mine. "The leg I suffered the injury to is now much better than my other leg, which I had an operation on many years ago.

"Although I had to wear the plaster moon boot for three months and have physiotherapy, now I don't limp—it's as good as new."

This is my life. I want to make my own choices with support from my whānau - Elsie

A restorative care approach to your health means

Your health care providers listen to you

Your voice, wishes and aspirations are at the centre of all decisions made about your care and treatment.

Your treatment plan helps you achieve your wellbeing potential

Your health care providers help you achieve your full potential for health, independence and connectedness. If you have a degenerative condition, your care plan supports you to stay healthy for longer and delay any avoidable decline in your health.

You feel valued

The care you receive is positive in its approach, promotes dignity and focuses on your strengths — valuing you as an individual.

Your care plan is holistic

Your health care providers take a holistic approach to your care. They recognise that a balance between physical, social, mental, cultural and spiritual health is important for overall wellbeing, and that maintaining connections with community, friends, family and whānau is crucial.

Your health care providers work as a team

You are treated by a team of professionals who all work together, share information and place your wishes at the centre of your treatment so you receive the best care possible.

Best for people, best for system...

How will we know if we're making progress?

Our success will be measured using a variety of methods, one of which is interRAI, an electronic assessment tool used by all district health boards in the South Island. The information provided by interRAI enables us to make improvements based on real clinical information. We also encourage older people to provide feedback to health care providers about their care experience.

If you believe your needs are not reflected in your care plan, consider taking this document to your health care provider to discuss how a restorative care approach could benefit your treatment.

This document has been produced by the Health of Older People Service Level Alliance (HOPSLA), which is part of the South Island Alliance.

HOPSLA is made up of experts in older persons' health from across the South Island, including district health boards, primary care, allied health, and community and consumer representatives.

We are dedicated to supporting South Island health care providers to help older people enjoy life the way they want for longer. For more information and contact details visit www.sialliance.health.nz

Restorative Care in the South Island

A guide for health professionals

May 2016

SOUTH ISLAND ALLIANCE
best for people, best for system

A restorative care approach to health supports older people to be independent, care for themselves and participate within their community, family and whānau for as long as possible.

The Health of Older People Service Level Alliance (HOPSLA), part of the South Island Alliance, is supporting health care providers across the South Island to adopt a restorative care approach to the services they provide to older people in their communities.

The following guide has been developed to help you understand what a South Island approach to restorative care looks like and how you can apply it to the services you provide.

Why restorative care?

Our population is ageing. By 2035, the number of people aged 65 and over is expected to double – to almost one in four.

We want older people to live well for longer. This will enable older people to keep contributing to society and enjoying life, and will help us maintain a sustainable health system. To do this, older people need equitable access to timely, high quality health care that helps them achieve their maximum potential for good health and wellbeing.

A restorative care approach works directly to achieve these goals. Some South Island health services already have effective restorative care programmes – others do not. To support the development and implementation of consistent, high quality restorative care programmes across the South Island, HOPSLA set out to define restorative care drawing on international research and first hand experience.

Best for people, best for system...

Restorative care - a definition

Restorative care means different things to different people. To make a genuine difference to the wellbeing of older people, we need a consistent definition that can be applied across the South Island to inform the development and provision of effective restorative care services.

HOPSLA defines restorative care as:

A flexible approach to health care that respects the individual, and supports them to obtain and maintain their highest level of function, live independently and contribute to their community for longer, and participate actively in decisions about their care.

A health care system based on restorative care looks like this:

- Ageing is celebrated and older people are valued – autonomy and choice are respected.
- Older people participate actively in decisions about their care and their experience guides service improvements – the individual's voice, wishes and aspirations are central to decision making.
- Older people have equal access to timely, safe, high quality health and disability services that meet their needs – care takes place within an individual's environment, social and cultural context.
- Advanced care planning ensures people die with dignity and in comfort, and their choices are honoured.
- There is a strong focus on maintaining optimal health, independence and social connectedness.
- Older people are empowered to make healthy lifestyle choices – useful, consumer friendly information is easily accessible.
- Older people know who to contact about their care and can communicate with them easily and directly.
- The health sector embraces the Te Whare Tapa Wha Māori health model for wellbeing – cultural and spiritual diversity are respected.
- Any avoidable decline is delayed through the use of innovation, adaption and problem solving.
- Care is positive, promotes dignity and is focused on the strengths of the individual.
- Health care providers across the health care continuum work as a team and are led by a shared focus guided by the individual's personal goals.
- Everyone involved in an individual's care shares a single care plan, preventing duplication and gaps in care.

How to integrate restorative care into your services

In the process of defining restorative care, HOPSLA identified a number of features common to effective restorative care programmes nationally and internationally. These features are listed below. We encourage you to explore how they could be applied to the services you provide.

- Older people are assessed through a comprehensive multidimensional assessment (interRAI).
- Care planning is goal-oriented and reflects the individual's needs and desires.
- Targeted, evidence-based interventions are used to optimise daily living functions. Interventions are delivered safely and balanced against potential risks. They are also culturally appropriate, flexible and responsive to the changing needs of the individual. If evidence-based research is not available, interventions based on best practice are used.
- Care is provided by a multi-disciplinary team, which includes but is not limited to general practice, registered nursing, physiotherapy, occupational therapy, dietetics, speech language therapy, pharmacy, social work and appropriate cultural support. Teams meet regularly to review challenging or resource-intensive cases and facilitate the input of other community organisations that could provide support.
- Education is encouraged for all older people, their carers and professional staff — for example, chronic disease self-management, healthy ageing, continence, nutrition management, use of medication, illness/accident prevention strategies and improvement or maintenance of skin integrity.
- Older people, their families and whānau, and their carers are encouraged to participate fully in all care decisions, promoting their sense of autonomy and reducing the need for ongoing in-person supervision.
- Active engagement in a range of daily living activities is promoted — task analysis, work simplification and assistive technology and telemedicine are used where appropriate.
- Strength, balance and endurance programmes are used to improve or maintain mobility.
- In time, it is hoped that each older person will have a single care plan, which provides a complete view of their care and is shared by all providers.

Best for people, best for system...

How will we know if we're making progress?

Success can be measured using a variety of methods, one of which is interRAI, the electronic assessment tool used by all South Island DHBs. The information provided by interRAI enables system improvements to be made based on real clinical information.

Feedback on how older people experience their care is another way to gauge progress. We encourage health care providers to develop their own patient experience collection methods and measures. A patient experience survey is a valuable tool to find out how a service has been experienced.

More information about the value of patient experience as an indicator of health service quality is available under Health Quality Evaluation on the Health, Quality & Safety Commission New Zealand website www.hqsc.govt.nz

About HOPSLA

This document has been produced by the Health of Older People Service Level Alliance (HOPSLA), which is part of the South Island Alliance. HOPSLA is made up of experts in older persons' health from across the South Island, including DHBs, primary care, allied health, and community and consumer representatives.

We are dedicated to supporting South Island health care providers to help older people enjoy life the way they want for longer.

More information

More information about HOPSLA and restorative care is available on the South Island Alliance website www.sialliance.health.nz

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	21 March 2018

Summary:

Commissioner, Committee and Executive Team members are required to declare any potential conflicts (pecuniary or non-pecuniary) and agree how these will be managed. A member who makes a disclosure must not take part in any decision relating to their declared interest.

Interests declarations, and how they are to be managed, are required to be recorded in the minutes and separate interests register (s36, Schedule 3, NZ Public Health and Disability Act 2000).

Changes to Interests Registers over the last month:

- Nil

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 09/03/2018

RECOMMENDATION:

1. That the Interests Registers be received and noted.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISSIONER TEAM

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Kathy GRANT	25.06.2015	Chair, Otago Polytechnic	Southern DHB has agreements with Otago Polytechnic for clinical placements and clinical lecturer cover.	
(Commissioner)	25.06.2015	Director, Dunedin City Holdings Limited	Nil	
	25.06.2015	Trustee of numerous private trusts	Nil	
	25.06.2015	Consultant, Gallaway Cook Allan	Nil	
	25.06.2015	Dunedin Sinfonia Board	Nil	
	25.06.2015	Director, Dunedin City Treasury Limited	Nil	
	18.09.2016	Food Safety Specialists Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Director, Warrington Estate Ltd	Nil - no pecuniary interest; provide legal services to the company.	
	18.09.2016	Tall Poppy Ideas Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Rangiora Lineside Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Otaki Three Limited	Nil. Co-trustee in client trusts - no pecuniary interest.	
		Spouse:		
	25.06.2015	Consultant, Gallaway Cook Allan	Nil (Updated 8 June 2017)	
	25.06.2015	Chair, Slinkskins Limited	Nil	
	25.06.2015	Chair, Parkside Quarries Limited	Nil	
	25.06.2015	Director, South Link Health Services Limited	A SLH entity, Southern Clinical Network, has applied for PHO status.	Step aside from decision-making (refer Commissioner's meeting minutes 02.09.2015).
	25.06.2015	Board Member, Warbirds Over Wanaka Community Trust	Nil	
	25.06.2015	Director, Warbirds Over Wanaka Limited	Nil	
	25.06.2015	Director, Warbirds Over Wanaka International Airshows Limited	Nil	
	25.06.2015	Board Member, Leslie Groves Home & Hospital	Leslie Groves has a contract with Southern DHB for aged care services.	
	25.06.2015	Board Member, Dunedin Diocesan Trust Board	Nil	
	25.06.2015	Director, Nominee companies associated with Gallaway Cook Allan	Nil	
	25.06.2015	Trustee of numerous private trusts	Nil	
	25.06.2015 (updated 22.04.2016)	President, Otago Racing Club Inc.	Nil	
Graham CROMBIE	27.06.2015	Independent Director, Surf Life Saving New Zealand	Nil	
(Deputy Commissioner)	25.06.2015	Chairman, Dunedin City Holdings Ltd	Nil	
	25.06.2015	Chairman, Otago Museum	Nil	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISSIONER TEAM

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	25.06.2015	Chairman, New Zealand Genomics Ltd	Nil	
	25.06.2015	Independent Chairman, Action Engineering Ltd	Nil	
	25.06.2015	Trustee, Orokonui Foundation	Nil	
	25.06.2015	Chairman, Dunedin City Treasury Ltd	Nil	
	25.06.2015	Independent Chair, Innovative Health Technologies (NZ) Ltd	Possible conflict if Southern DHB purchased this company's product.	
	~~25.06.2015~~	~~Associate Member, Commerce Commission~~	~~Potential conflict if complaint made against Southern DHB.~~	Removed 18.12.2017
	16.01.2017	Director, Dunedin Stadium Property Ltd (previously known as Dunedin Venues Ltd)	Nil	
	08.02.2017	Independent Chair, TANZ eCampus Ltd		
	13.03.2017	Chair, South Island Alliance Information Services		
	23.11.2017	Director, A G Foley Ltd	Possible conflict if Southern DHB contracts this company's services.	
	18.09.2016	Director and Shareholder, Innovatio Ltd	Vehicle for governance and consulting assignments. Clients listed above.	
Richard THOMSON (Deputy Commissioner)	13.12.2001	Managing Director, Thomson & Cessford Ltd	Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it.	
	13.12.2002	Chairperson and Trustee, Hawksbury Community Living Trust.	Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB.	
	23.09.2003	Trustee, HealthCare Otago Charitable Trust	Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations.	
	05.02.2015	One immediate family member is an employee of Dunedin Hospital (Anaesthetic Technician)		
	07.10.2015	Southern Partnership Group	The Southern Partnership Group will have governance oversight of the Dunedin Hospital rebuild and its decisions may conflict with some positions agreed by the DHB and approved by the Commissioner team.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
ADVISORY COMMITTEE MEMBERS

Committee Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Susie JOHNSTONE	21.08.2015	Independent Chair, Audit & Risk Committee, Dunedin City Council	Nil	
(Consultant, Finance Audit & Risk Committee)	21.08.2015	Board Member, REANNZ (Research & Education Advanced Network New Zealand)	REANNZ is the provider of Eduroam (education roaming) wireless network. SDHB has an agreement allowing the University to deploy access points in SDHB facilities.	
	21.08.2015	Advisor to a number of primary health provider clients in rural Otago	All of the primary health provider clients in rural Otago are likely to have a contract through Southern DHB and/or the WellSouth Primary Care Network.	
	18.01.2016	Audit and Risk Committee member, Office of the Auditor-General	Audit NZ, the DHB's auditor, is a business unit of the Office of the Auditor General.	
	16.09.2016	Director, Shand Thomson Ltd	Nil	
	16.09.2016	Director, Harrison Nominees Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, Abacus ST companies.	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, Shand Thomson Nominees Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, Johnstone Afforestation Co Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, Shand Thomson Nominees (2005) Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, McCrostie Nominees Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
		Spouse is Consultant / Advisor to:		
	21.08.2015	Tuapeka Community Health Co Ltd & Tuapeka Health Incorporated	Tuapeka Community Health Co Ltd & Tuapeka Health Incorporated have a contract with Southern DHB.	
	21.08.2015	Wyndham & Districts Community Rest Home Inc	Wyndham & Districts Community Rest Home Inc has a contract with Southern DHB.	
	21.08.2015	Roxburgh District Medical Services Trust	Roxburgh District Medical Services Trust has a contract with Southern DHB.	
	21.08.2015	West Otago Health Ltd & West Otago Health Trust	West Otago Health Ltd & West Otago Health Trust have a contract with Southern DHB.	
	21.08.2015	A number of primary health care providers in rural Otago	All of the primary health provider clients in rural Otago are likely to have a contract through Southern DHB and/or the WellSouth Primary Care Network.	
	21.08.2015	Director, Clutha Community Health Co. Ltd	Clutha Community Health Co. Ltd has a contract with Southern DHB.	
	26.09.2016	Director, Abacus ST companies.	Nil. Co-trustee in client trusts - no pecuniary interest.	
		Daughter:		
	21.08.2015	6th Year Medical School Student	(Updated 20.10.2017)	
Donna MATAHAERE-ATARIKI	27.02.2014	Trustee WellSouth	Possible conflict with PHO contract funding.	
(CPHAC/DSAC and IGC Member)	27.02.2014	Trustee Whare Hauora Board	Possible conflict with SDHB contract funding.	
	27.02.2014	Deputy Chair, NGO Council, Ministry of Health	Nil	
	27.02.2014	Council Member, University of Otago	Possible conflict between SDHB and University of Otago.	
	~~27.02.2014~~	~~Ahuru Mowai National Māori Leadership Group Cancer~~	~~Nil~~ REMOVED 23 February 2017	
	17.06.2014	Gambling Commissioner	Nil	
	05.09.2016	Board Member and Shareholder, Arai Te Uru Whare Hauora Limited	Possible conflict when contracts with Southern DHB come up for renewal.	
	05.09.2016	Board Member and Shareholder, Otākou Health Limited	Possible conflict when contracts with Southern DHB come up for renewal.	
	05.09.2016	Southern DHB, Iwi Governance Committee	Possible conflict with SDHB contract funding.	
	09.02.2017	Director and Shareholder, VIII(8) Limited	Nil	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
ADVISORY COMMITTEE MEMBERS

Committee Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	01.09.2016	Southern DHB, Disability and Support Advisory Committee	Possible conflict with SDHB contract funding.	
Odele STEHLIN	01.11.2010	Waihopai Runaka General Manager	Possible conflict when contracts with Southern DHB come up for renewal.	
Waihōpai Rūnaka – Chair IGC	01.11.2010	Waihopai Runaka Social Services Manager	Possible conflict with contract funding.	
	01.11.2010	WellSouth Iwi Governance Group	Nil	
	01.11.2010	Recognised Whānau Ora site	Nil	
	24.05.2016	Healthy Families Leadership Group member	Nil	
	23.02.2017	Te Rūnanga alternative representative for Waihopai Rūnaka on Ngai Tahu.	Nil	
	09.06.2017	Director, Waihopai Runaka Holdings Ltd	Possible conflict with contract funding.	
Sumaria BEATON	27.04.2017	Southland Warm Homes Trust	Nil	
IGC - Awarua Rūnaka	09.06.2017	Director and Shareholder, Sumaria Consultancy Ltd	Nil	
	09.06.2017	Director and Shareholder, Monkey Magic 8 Ltd	Nil	
Taare BRADSHAW	17.03.2017	Director, Murihiku Holdings Ltd	Nil	
IGC - Hokonui Rūnaka				
Victoria BRYANT	06.05.2015	Charge Nurse Manager, Otago Public Health	Nil	
IGC - Puketeraki Rūnaka	06.05.2015	Member - College of Primary Nursing (NZNO)	Nil	
	06.05.2015	Member - Te Rūnanga o Ōtākou	Nil	
	06.05.2015	Member Kati Huirapa Rūnaka ki Puketeraki	Nil	
	06.05.2015	President Fire in Ice Outrigger Canoe Club	Nil	
	24.05.2017	Puketeraki representative for Te Kaika VLCA located in College Street	Possible conflict with funding in health setting.	
	24.05.2017	Member, South Island Alliance - Raising Healthy Kids	Nil	
Justine CAMP	31.01.2017	Research Fellow - Dunedin School of Medicine - Better Start National Science Challenge	Nil	
IGC - Moeraki Rūnaka		Member - University of Otago (UoO) Treaty of Waitangi Committee and UoO Ngai Tahu Research Consultation Committee	Nil	
		Member - Dunedin City Council - Creative Partnership Dunedin	Nil	
		Moana Moko - Māori Art Gallery/Ta Moko Studio - looking at Whānau Ora funding and other funding in health setting	Possible conflict with funding in health setting.	
		Daughter is a member of the Community Health Council	Nil	
Terry NICHOLAS	06.05.2015	Treasurer, Hokonui Rūnanga Inc.	Nil	
IGC - Hokonui Rūnaka	06.05.2015	Member, TRoNT Audit and Risk Committee	Nil	
	06.05.2015	Director, Te Waipounamu Māori Cultural Heritage Centre	Nil	
	06.05.2015	Trustee, Hokonui Rūnanga Health & Social Services Trust	Possible conflict when contracts with Southern DHB come up for renewal.	
	06.05.2015	Trustee, Ancillary Claim Trust	Nil	
	06.05.2015	Director, Hokonui Rūnanga Research and Development Ltd	Nil	
	06.05.2015	Director, Rangimanuka Ltd	Nil	
	06.05.2015	Member, Te Here Komiti	Nil	
	06.05.2015	Member, Arahua Holdings Ltd	Nil	
	06.05.2015	Member, Liquid Media Patents Ltd	Nil	
	06.05.2015	Member, Liquid Media Operations Ltd	Nil	
	09.06.2017	Director, Murihiku Holdings Ltd	Nil	
	09.06.2017	Director and Shareholder, Real McCoy Owner Ltd	Nil	
	09.06.2017	Director and Shareholder, Real McCoy Operator Ltd	Nil	
Ann WAKEFIELD	03.10.2012	Executive member of Ōraka Aparima Rūnaka Inc.	Nil	
IGC - Ōraka Aparima Rūnaka	09.02.2011	Member of Māori Advisory Committee, Southern Cross	Nil	
	03.10.2012	Te Rūnanga representative for Ōraka-Aparima Rūnaka Inc. on Ngai Tahu.	Nil	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Management of staff conflicts of interest is covered by SDHB's Conflict of Interest Policy and Guidelines.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
Pania COOTE	~~26.05.2016~~	~~Ngai Tahu registered.~~	~~Nil~~
	08.12.2017	Ngāi Tahu, Ngāti Kauwhata and Ngāti Porou registered.	Nil
	30.09.2011	Member, South Island Alliance Southern Cancer Network	Nil
	30.09.2011	Member, Aotearoa New Zealand Association of Social Workers (ANZASW)	Nil
	30.09.2011	Member, SIT Social Work Committee	Nil
	29.06.2012	Member, Te Waipounamu Māori Cancer Leadership Group	Nil
	26.01.2015	National Māori Equity Group (National Screening Unit) – MEG.	Nil
	26.01.2015	SDHB Child and Youth Health Service Level Alliance Team	Nil
	19.09.2016	Shareholder (2%), Bluff Electrical 2005 Ltd	Nil
	08.12.2017	South Island Alliance, Strategic Planning and Integration Team (SPaIT)	Nil
Matapura ELLISON	12/02/2018	Director, Otākou Health Services Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	12/02/2018	Director, Otākou Health Ltd	Nil
	12/02/2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	12/02/2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki	Nil
	12/02/2018	Trustee, Araiteuru Kōkiri Trust	Nil
	12/02/2018	Otago Museum Māori Advisory Committee	Nil
	12/02/2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12/02/2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	
	25.09.2016	Deputy Chair, InterRAI NZ	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
Lisa GESTRO	06/09/2017	Nil	
Lynda McCUTCHEON	22.06.2012	Member of the University of Otago, School of Physiotherapy, Admissions Committee	Lead contact for University of Otago undergraduate clinical placements (Allied Health, Scientific & Technical professions) in Southern DHB.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	19.08.2015	Member of the National Directors of Allied Health	Nil
	04.07.2016	NZ Physiotherapy Board: Professional Conduct Committee (PCC) member	No perceived conflict. If complaint involves SDHB staff member or contractor, will not sit on PCC.
	18.09.2016	Shareholder, Marketing Business Ltd	Nil
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	04.07.2016	Clinical Lead for HQSC Atlas of Healthcare variation	HQSC conclusions or content in the Atlas may adversely affect the SDHB.
Nicola MUTCH	16.03.2016	Member, International Nominations	Nil
		Deputy Chair, Dunedin Fringe Trust	Nil
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	17.11.2017	Wife works for key technology supplier CCCL	Nil
	18.12.2017	Daughter, medical student at Auckland University and undertaking Otago research project over summer 2017/18.	
Dr Jim REID	22.01.2014	Director of both BPAC NZ and BPAC Inc	No conflict.
	22.01.2014	Director of the NZ Formulary	No conflict.
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
		Specified contractor for JER Limited in respect of:	
	31.10.2017	PWC New Zealand Limited to 31 December 2017	Nil
	31.10.2017	Ministry for Primary Industries to 31 December 2017	Nil
	31.10.2017	H G Leach Company Limited to termination	Nil
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Thursday, 25 January 2018, commencing at 10.00 am, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mrs Kathy Grant	Commissioner
	Mr Graham Crombie	Deputy Commissioner
	Mr Richard Thomson	Deputy Commissioner
	Ms Donna Matahaere-Atariki	Committee Member (until 11.30 am)
In Attendance:	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary & Community
	Dr Nigel Millar	Chief Medical Officer
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Jane Wilson	Chief Nursing & Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 APOLOGIES

Apologies were received from the Executive Director Finance, Procurement & Facilities and the Executive Director Communications.

2.0 PRESENTATION: *CONSUMER LED INTEGRATED CARE (CLIC) - PRIMARY CARE CHRONIC CARE MANAGEMENT PROGRAMME*

Sally O'Connor, Director of Nursing, Primary & Community, Stuart Barson, Support Manager, Alliance South, Greg Sheffield, General Manager, Primary Care and Population Health, and Dr Fiona Doolan-Noble, Senior Research Fellow, Department of General Practice and Rural Health, Dunedin School of Medicine, joined the meeting and gave a presentation on the new primary care long-term conditions programme: Consumer Led Integrated Care (CLIC) (tab 2).

During discussion, the Committees were advised that the goal was to have all general practices on the new programme by the end of 2018/19. It was noted that CLIC was only one part of the solution and a lot of work was still to be done in terms of continuing engagement with primary and community clinicians.

The Commissioner thanked the team for their presentation and invited Debbie George, Chief Executive, Age Concern Otago (in attendance as a member of the public) to comment. Ms George congratulated the CLIC project team on their effort and noted that Otago's volunteer effort set it apart from the rest of the country, with Age Concern Otago having 1,022 volunteers and 13 paid staff. The project team advised that, as they moved on with the programme, they would consider how they could work with Age Concern.

3.0 DECLARATION OF INTERESTS

The Interests Registers were circulated with the agenda and received at the preceding meeting of the Hospital Advisory Committee.

4.0 PREVIOUS MINUTES

Recommendation:

"That the minutes of the meeting held on 23 November 2017 be approved and adopted as a true and correct record."

Agreed

5.0 MATTERS ARISING AND REVIEW OF ACTION SHEET

The Committees reviewed the action sheet (tab 6) and noted advice from management that:

- A paper on Primary Maternity Services was submitted to the last Commissioner's meeting and another would be considered at the January meeting;
- The Urgent Care Primary Options for Acute Care (POAC) was progressing with the advent by the Primary and Community Strategy. A schedule would be available in the next few months for all practices, with the starting points being IV antibiotics, treatment for cellulitis, and ambulance diversion;
- The telehealth programme was under way.

6.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

Strategy, Primary & Community

In presenting her monthly report (tab 7.1), the Executive Director Strategy, Primary & Community (EDSP&C) highlighted:

- The draft Primary and Community Strategy and Action Plan - engagement with clinicians had commenced in the last week and district wide consultation with communities was scheduled for 31 January and 1 February 2018. Engagement with staff, the Iwi Governance Committee and NGOs was also being arranged.

The Committees requested further information on:

- Whether 32% of Aged Related Residential Care (ARRC) providers obtaining four year certification was a good result;
- Medical services coverage on Stewart Island, following the previously reported impending retirement of one or more of the nurses on the Island;
- Whether Well Child Tamariki Ora services had to be delivered by a registered nurse.

Public Health

A report on public health activity was circulated with the agenda and taken as read (tab 7.2).

Recommendation:

"That the reports be noted."

Agreed

7.0 FINANCIAL REPORT

In presenting the Funder financial results for December 2017 (tab 8), the Executive Director Strategy, Primary & Community (EDSP&C) commented that the two areas of concern were:

- Disability Support Services - Health of Older People, and
- Community Pharmacy, which also appeared to be an issue for other DHBs.

Recommendation:

"That the report be received."

Agreed

8.0 CONTRACTS REGISTER

The Funding contracts register for November-December 2017 was circulated with the agenda (tab 9) for information.

Recommendation:

"That the Contracts Register be noted."

Agreed

CONFIDENTIAL SESSION

At 11.00 am, it was resolved that the Disability Support and Community & Public Health Advisory Committees move into committee to consider the agenda items listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.

Confirmed as a true and correct record:

Commissioner: _____

Date: _____

Southern District Health Board

DISABILITY SUPPORT AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES MEETING

ACTION SHEET

As at 12 March 2018

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
22 Nov 2016	**Primary Maternity Services** (Minute item 6.0)	Draft report to be rewritten and released with a covering letter. New group to be established to develop a set of principles and recommendations.	EDSP&C	An update will be provided at the next meeting.	
26 Jan 2017	**Urgent Care: Primary Options for Acute Care** (Minute item 4.0)	Pathways to enable GP access to IV antibiotics, IV fluids and biopsies to be completed by quarter three.	EDSP&C	POAC Tier one service spec as well as tier two service specs for COPD discharge management, IV Fluids, Ambulance diversion, LARC, Pipelle biopsy, Cellulitis and catheterisation have been completed and are currently with Wellsouth and the POAC project Manager to provide feedback on the specs and clinical content. The next step will be to finalise the contract and funding for this prior to roll out.	
26 Jan 2017	**Telehealth Programme** (Minute item 4.0)	First work stream cardiology; paediatrics being considered – progress to be reported.	EDSP&C	A paper has been prepared and considered by the Executive in December on how to progress the implementation of telehealth across the DHB. The paper also proposed a funding framework for telehealth activities. The paper was endorsed by the Executive and the overall telehealth programme will be realigned and refocussed in the early part of 2018.	Underway

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
25 Jan 2018	**Aged Related Residential Care (ARRC)** (Minute item 6.0)	Whether 32% of ARRC providers obtaining four year certification is a good result to be clarified.	EDSP&C	32% receiving 4 year certifications is a great thing. Nationally, only 25% have four year certification. Historically, only about 15% of SDHB facilities had a four year certification. After audit, HealthCERT issues a certification for one, two, three or four years, based on findings at audit. To obtain a four year certification, a facility needs to have a clean audit (no findings) plus auditor's recognition of Continuous Quality Improvements	
25 Jan 2018	**Stewart Island Medical Services** (Minute item 6.0)	Information to be provided on current medical service coverage on Stewart Island, following previous reports of the impending retirement of the nurses on the Island.	EDSP&C	• There are quarterly Medical Clinics on the island led by Invercargill Medical Centre • Southern DHB have two nurses permanently employed (1.8 FTE total) that provide cover 7 days a week / 24 hours cover on rotation. • We continue to work on supporting cover to the area by having locally based prime nurses that can cover the area on rotation to the island, with accommodation provided (within above FTE). No nurse retirement issues. Nurse had change of plans that was facilitated by some service development. This including roster changes that enable nurses to get off the Island more often, providing a regular opportunity for the nurses to work in another rural environment and improvement in clinical guidelines.	
25 Jan 2018	**Well Child Tamariki Ora Services**	Committee to be advised whether these services have to	EDSP&C	Yes, this is a nursing role – registered nurses undertake specialist training for	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
	(Minute item 6.0)	be delivered by a registered nurse.		WellChild Tamariki Ora at Whitireia tertiary institute in Porirua.	

7.1

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Strategy, Primary & Community Report**		
Report to:	Commissioner Team		
Date of Meeting:	21 March 2018		
Summary: Monthly report on the Strategy, Primary & Community Directorate activity.			
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: Strategy, Primary & Community Team **Date:** 12 March 2018		**Presented by:** Lisa Gestro Executive Director Strategy, Primary & Community	
RECOMMENDATION: **That the Commissioner and Deputy Commissioners note the content of this paper.**			

1. COMMUNITY SERVICES

Allied Health

Recruitment is well underway for allied health with Strategy Primary and Community. As anticipated vacancies have increased whilst we recruit and on-board new staff which has meant that some teams are under a level of continuing pressure. Managers and professional leads are actively working to support teams as much as possible. Two speech language therapists (SLT) were successfully recruited (1.6 FTE) to Southland Hospital and commenced on 12 February 2018.

Health of Older People

Update Flooding at Radius Fulton

One hospital level wing at Radius Fulton re-opened on 26 February, with a second wing reopening on 5 March. Residents are beginning to return to those areas, with some residents choosing to remain in their new facilities. Other parts of the building, including the secure dementia area, will not reopen until April. This event has created significant pressure on the Dunedin Hospital wards as well as the broader sector given there are no vacant aged residential care beds in the Dunedin community. All parts of the system have been very cooperative and resident-focussed throughout.

Home & Community Support Services (HCSS) Alliance

Agreement has been reached with our HCSS Alliance for a Variation for the 17 18 year. This includes a price uplift, holds bulk-funded estimated volumes (based on experience), and reduces the Central Otago adjuster due to Pay Equity. The Variation will also allow providers to claim Pay Equity for the HCSS they provide to our mental health and addictions clients.

Refugee Services

The resettlement of refugees from Columbians to Invercargill has now commenced. The first family arrived in February with a further two families arriving in March. Former refugees will be arriving at 8-weekly intervals from then, with approximately 90 people resettling in Invercargill throughout 2018. The interpreter service at Invercargill hospital is now up and running with a number of Spanish speaking interpreters hired. The PHO has worked with Invercargill General Practices and a number have indicated they will enrol resettled families in their practices. Culturally and linguistically diverse (CALD) training sessions have been organised for the Invercargill health sector. This is to improve the competency and confidence of staff working with people with a CALD background. Uptake for these workshops has been good and the sessions have been fully subscribed to. An immediate priority is to refocus the Southern DHB refugee steering group to have a district focus, and to develop a plan for the next 3 years for the health sector to support refugee resettlement across Southern district.

3.0 STRATEGY AND PLANNING

Annual Plan

No update regarding the 2018/19 planning guidance or timelines is available from the MOH. Never the less, a programme of work has commenced to ensure that we are prepared for the advice when it arrives. A preliminary template, based on previously identified DHB priorities for 18/19 is being drafted and will be circulated to lead management representatives for completion.

Discussions with the DHB relationship manager are ongoing in respect of the timing/expectations on the 2018/19 Annual Plan.

Audit

Vulnerable Children Act 2014 (VCA)

The Southern DHB currently funds Central Region's Technical Advisory Services (Central TAS) Audit and Assurance team to deliver the NGO Provider Audit Programme on behalf of Southern DHB.

Southern DHB currently holds approx. 70 Combined Dental Agreements (CDA). These agreements now have a Vulnerable Children Act 2014 (VCA) clause (from 2015/16 variation). Southern DHB has obligations pursuant to the VCA.

The DHB is investigating whether Central TAS can undertake VCA audits (remotely) from 1 July 2018 and then on a 3 yearly cycle, to ensure that providers of CDAs in Southern are fulfilling their obligations pursuant to the VCA clause. (This may require an increase to the audit budget with Central TAS for 18/19.) For example, have a child protection policy, review the policy 3 yearly and post a copy of the child protection policy on their internet site, or if they do not have a website ensure a hard copy of their policy is available in their Practice.

Central TAS have also been discussing VCA audits of Pharmacies with Medsafe. Medsafe is the New Zealand Medicines and Medical Devices Safety Authority. It is a business unit of the Ministry of Health and is the authority responsible for regulating products used for a therapeutic purpose. For example, medicines, related products, medical devices and controlled drugs used as medicines. The Ministry will be forwarding an email to all DHBs to canvas the possible addition of criteria around this clause in the audit tool

Draft NGO Audit Plan to 2026/27

The Contracts team have developed a draft NGO Audit Plan to 2026/27.

The purpose of the audit plan is to:

1. Ensure providers are audited regularly - every 3/4 years (where appropriate)
2. Align audits with certification (if applicable) – to reduce compliance costs
3. Provide some long term planning to our NGO Audit programme

4 PRIMARY CARE

The primary and community care strategy is currently being discussed with a number of interested GP practices leading up to the release of the Expression of Interest in April. Judging by preliminary feedback there will be significant interest from practices in tranche one. The process around formalising locality networks is ongoing with a formal plan to be developed with some specific actions to implement. This will enable communication with those localities to progress, aligned to the strategy.

Changing the model of care for Invercargill after hours to reduce ED attendance rates

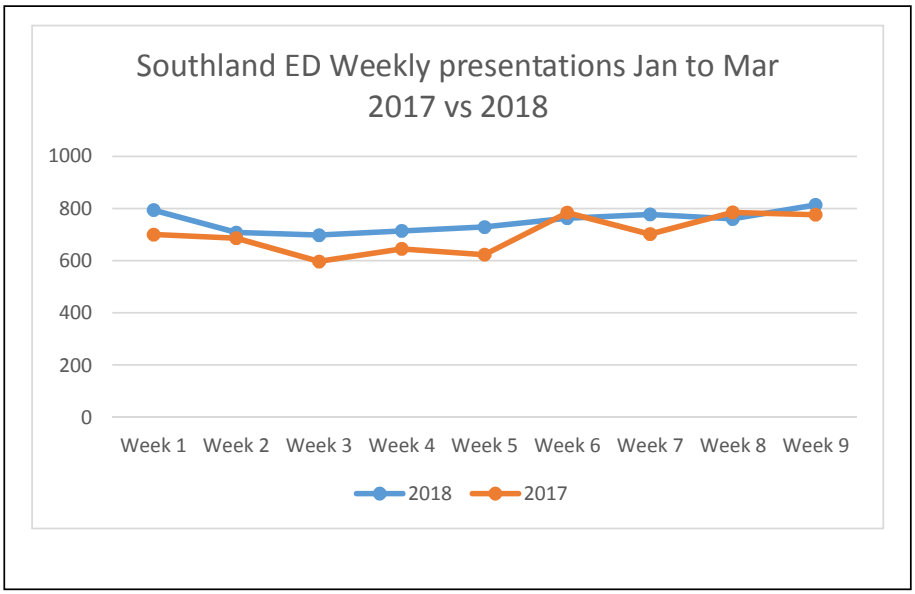
Work continues to try and better understand why we have such a large number of attendances each day to the ED department in Invercargill. Initial data gathering work has been undertaken, and solutions are now starting to be defined. Phase two awaits dates to be set for a processing mapping exercise with inpatient teams from the point of referral in ED to the point of admission or discharge. The Clinical Leads, Jo McLeod and Tim Mackay have been tasked with setting a date for the inpatient process mapping exercise, and inviting key members of inpatient teams to participate – an update has been requested. Phase three is being conducted in tandem by WellSouth, assessing primary care capacity.

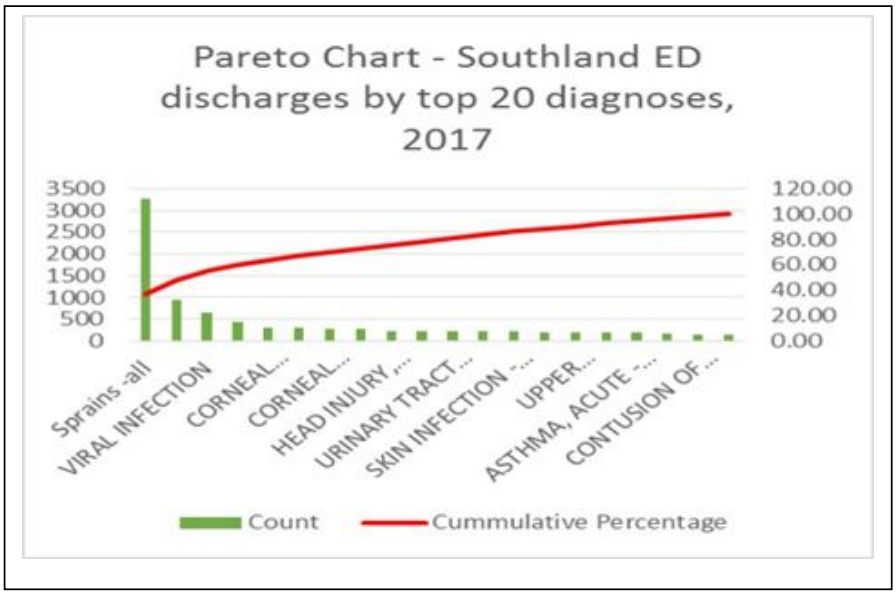
The following list details the A3 currently being worked on by Southland ED

- Triaging and admin processes – streamlining the process. Some minor facility changes have been identified that would enhance the Triage process.
- Mental Health pathways and backup plans – SMET service not always available to ED due to providing service elsewhere e.g. Queenstown.

- Backflow of hospital patients into ED - Hospital patients, both in and outpatients, flow into ED for admitting purposes. Surgical and Ortho Registrars not available overnight unless life and limb are possibly compromised.
- Paediatrics, including patient flow into paediatrics - PAU is a 5/7 service.
- Southern Community Laboratories - on-call for specific tests overnight, can delay decision making. Delays with provision of ABG results – data collection completed.
- Stranded Patients in ED – to address ongoing difficulties with complex admission being accepted by inpatient teams. Data collection continues.
- Radiology Pathways – to identify where there are delays in obtaining CTs both in hours and out of hours. Await data requested from Radiology.

On the Primary care side, work has been done by WellSouth to identify discharged patients and their diagnoses. There may be opportunities for primary care to modify their models of care to provide a service to some of these patients. An example of this is the high number of sprain injuries that are discharges from ED. Some of these will have been suspected fractures and would have required imaging to confirm a soft tissue injury.





HealthPathways

Recruitment for additional Clinical Editors has been completed with three new Clinical Editors (0.8 FTE) appointed and in place. Initial training and orientation has been completed with a full team planning day scheduled for 19TH March 2018.

A lead Clinical Editor has been assigned to each Directorate and will be the "go to person" for the Directorate:

- Surgical Services & Radiology- Dr Jenny Maybin
- Medicine, Women's & Children's Health- Dr Anu Shinnamon
- Mental Health, Addictions & Intellectual Disability- Dr Margaret Charles
- Strategy, Primary & Community-Dr Kate Dixon

Fourteen pathways went live February (a total of 489 are now live):

- Herpes Simplex Keratitis
- Acute Chest Pain
- Coeliac Disease in Children
- Cataracts
- Delirium
- Eye Problems in Children
- Glaucoma
- Plagiocephaly
- Occupational Therapy Driving Assessment
- Eye Examination
- Infantile Haemangioma
- Acute Dermatology Assessment
- Non-acute Dermatology Assessment
- Dermatology Advice

The 10 most frequently viewed pathways for the month of February are:

- Zoledronic Acid Infusion
- Acute Otitis Media
- Bowel Cancer Screening
- Hyperlipidaemia
- Atrial Fibrillation (AF)
- Constipation in Children
- Deep Vein Thrombosis (DVT)
- Otitis Media with Effusion (Glue ear)
- Bariatric Surgery
- Renal Colic

HealthPathways had 21,361 page views in February 2018 with an average page view per session of 4.39. Of the 1,277 users who viewed pages on HealthPathways, 665 of these were new users to the site. The number of sessions per user was 3.81.

Changes are being implemented to change the way that the team works. The key focus is the localisation of pathways with 960 pathways approximately to be localised. Our key localisation focus will be Core Priority Pathways as identified by StreamlIners:

Core High Priority Pathways (198)

Core Lower Priority Pathways (223)

Where there is a service redesign and/or change to the model the HealthPathways Team will work alongside and support the service rather than lead the work with future pathway development to be driven by data particularly in service areas where referral rates are high.

5. RURAL HEALTH

Lakes Hospital Rebuild

An operational group has been established to oversee the planning and development process for the rebuild of Lakes District Hospital. The group comprises of the clinical lead for Lakes District Hospital, the operations manager for the hospital, the contracted project manager, representation from the DHB's Procurement and Building and Property teams and the Rural Health Manager.

On site visits have now commenced with onsite clinical staff and the appointed design team. The project is now moving into the finalised design phase prior to going out to RFP for the construction phase.

Work is underway on determining fixtures and fittings and equipment for the refurbishment. This includes the acquisition of the CT machine. We have now received RFP responses for the CT machine and these will be considered by an expert panel who will make a recommendation on the preferred machine. We are also working on determining the necessary operational costs for the 2018/19 budget for operating a CT service on a 24 hour 7 days per week basis.

The project is on track for all phases to be completed by July 2019.

New Model of Care for Waitaki District Health Services Ltd – "Shifting the Focus"

There was a substantial body of work completed in 2017 in partnership with Waitaki District Health Services Ltd (WDHSL) developing a new model of care.

The model comprises six major areas of change, allowing for:

A) Community based Services – provided by establishing a community clinical care hub as a local point of entry with the aim of keeping people well and safe at home.

B) Coordinated urgent care – implementing a streamlined first response system to ensure people get the right care in the right place when they have urgent health needs.

C) Improved post hospital discharge – improved processes for e to reduce delays, avoid patient readmissions and support return home.

D) Services closer to home – increase specialist outpatient services provided locally to ensure access to care is as close to home as possible and people only travel when they need to.

E) System communication and coordination – improve systems for communication and coordination to provide patient centred care through better use of technology and enhancing relationships within the healthcare provider community.

F) Workforce enhancement – develop and maintain a workforce that will meet the needs of future service delivery.

Implementation meetings have commenced. These will be held at least quarterly and will be used to determine progress made by WDHSL in implementing the agreed model of care.

Telehealth

Virtual HealthCare to the Patient is kicking off with ConnectMED and Logic Studio to deliver an online facility for After Hours triage and Online G P consults which integrate with an Agnostic Patient Portal.

Next steps is the NZ version of this system to be developed and rolled out to participating GPs. This can extend to private specialists and Non-Government Social Services also. Ideally we would use this service for triage of afterhours services across the district.

Primary Maternity Project
On the 6 March 2018 Southern DHB released the plan for the implementation of the new Southern Maternity System of Care. This involved media releases, discussion with stakeholders directly affected by the plan and other key stakeholders.

Lumsden
Prior to release there was a meeting on the 5 March to advise Lumsden Maternity Service that the current facility in Lumsden would transition to become a maternal and child hub. There is to be a three week consultation period for feedback on the plan, which concludes on the 28 March 2018.

A public meeting to step through the proposed changes is scheduled for the evening of 21 March, in Lumsden.

In addition, we are preparing a template to introduce the detail of a hub focussing initially on possible maternal and child services but also indicating opportunities that may be possible with the implementation of the Primary, Community Strategy and Action Plan.

Wanaka
Engagement with LMCs in Wanaka continues as we work to find solutions to workforce challenges. A further meeting is scheduled for the 14 March in Cromwell where we will be discussing locum cover and development of the hub. Three locums have made themselves available from April through to June so we are working to secure their services. Employment is likely to be via the WellSouth PHO. It is anticipated that the hub will be located at Wanaka Medical Centre where the LMCs currently rent rooms. Discussion about what a hub should include have begun.

A meeting occurred with Laura Alione and Margo Kyle who are independent contractors specialising in midwifery services and supporting DHBs with the development of primary maternity services. Discussions are progressing to determine how they can provide independent, high level advice about the sustainable development of primary maternity services across Central Otago district – this will include analysis of what services are needed and how they could be funded. There is a particular focus on developing integrated and accessible services across this district. They are planning to meet midwives at Lakes Hospital and Wanaka on the 12th of March.

Southern DHB is to also contract them to undertake an options analysis for the development of a primary maternity birthing unit in Dunedin to inform the schedule of accommodation for the DBC for the rebuild.

7.2

SOUTHERN DISTRICT HEALTH BOARD

Title:	**PUBLIC HEALTH SERVICE REPORT**		
Report to:	Community and Public Health Advisory Committee		
Date of Meeting:	21 March 2018		
Summary: Considered in these papers are: ▪ Public Health Service Activity			
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:** n/a	
Approved by:	Lisa Gestro Executive Director Strategy, Primary and Community	**Date:**	
Prepared by: Lynette Finnie, Service Manager, Public Health Service Strategy, Primary and Community Directorate **Date:** 14/03/2018		**Presented by:** Lisa Gestro Executive Director Strategy, Primary & Community	
RECOMMENDATION: **1. That CPHAC receives the Public Health Service Activity Report.**			

PUBLIC HEALTH SERVICE REPORT TO THE SOUTHERN DHB
Community and Public Health Advisory Committee Report
21 March 2018

Joint Working Group Proposed for Drinking Water
In August 2016, there was a major outbreak of gastroenteritis associated with campylobacter infection in Havelock North. The Government established an Inquiry to investigate and report on the outbreak. The Inquiry was held in two stages. Stage one identified what happened, the cause of the outbreak, and an assessment of the conduct of those responsible for providing safe drinking water to Havelock North. Stage two focused on improvements to the safety of drinking water in New Zealand, lessons to be learned from the Havelock North outbreak, and changes which should be made to achieve those goals.

A number of recommendations were made in the stage two report released on 6 December 2017. Some of the Inquiry's recommendations involve changes to the existing law, while others could be implemented within existing regulatory frameworks. One of the latter is the Inquiry recommendation that District Health Boards with their Public Health Units (with the assistance of the Ministry of Health) should establish, as soon as practicable, together with local authorities a joint working group responsible for oversight of drinking water safety.

The Southern District Health Board encompasses eight territorial authorities and two regional councils with responsibility for over 200 registered water supplies. Establishing an effective joint working group is pivotal to enabling the collaborative approach necessary for the protection of our drinking water from 'source to sewer'.

The Southern District Health Board, through its Public Health Unit, proposes a single joint working group covering its entire population which recognises that significant volumes of water used for drinking purposes cross administrative boundaries. The approach proposed is supported across the district and is a whole of system approach where attention is paid to relevant factors that impact on water quality from 'source to tap'. A terms of reference have been drafted and key stakeholders approached to stimulate interest in this approach. The next stage is to set a date for the inaugural meeting, to agree the terms of reference and scope, and to establish a work plan.

The Community and Public Health Advisory Committee is asked to endorse this approach. Consideration is required as to how this joint working group will be supported and how its work will be reported into the DHB.

Drinking Water - International Accreditation New Zealand Assessment
International Accreditation New Zealand (IANZ) undertook both a Public Health South drinking water unit branch and a technical assessment of two Drinking Water Assessors. Under the Health Act, we are required to operate an IANZ accredited drinking water unit. We meet this requirement by being part of a wider IANZ accredited South Island Drinking Water Unit, comprising of the three South Island Public Health Units. In addition individual drinking water assessors must be assessed by IANZ for technical competence. There are currently four drinking water assessors and one trainee in Southern. There is a significant amount of work done in preparation for these audits. IANZ advised at the entry meeting that their focus was more stringent and focussed on technical competence following changes in their audit process implemented after the government inquiry into Havelock North. While a number of recommendations for improvement were made for individuals, the branch and the South Island Drinking Water Assessment Unit, the two individual Drinking Water Assessors were recommended for accreditation for a further three years.

Standardised Tobacco Products and Packaging
The New Zealand government has committed to a goal of being a smokefree nation by 2025. Smoking is the leading cause of preventable illness and premature death. Māori, Pacific and low income groups have the highest smoking prevalence and health inequities will not improve unless there is robust intervention.

On 14 March 2018, the regulations for standardised packaging of all tobacco products came into force. All packaging will be a dark brown/green colour, the same as in Australia. Brand and variant names are allowed but the type face, font size and colour, as well as where the wording is placed on the packaging is stipulated by the regulations. There are also new restrictions around the number of cigarettes contained in a packet with only a choice between 20 or 25 sticks. Loose tobacco will be available in 30g or 50g packets.

There are 14 new graphic images and warning messages; seven of these images will be rotated each year so consumer learning and awareness of the health effects of smoking are optimised. These will be enlarged to cover at least 75% of the packaging on the front and back, and the Quitline logo and freephone number will also be featured.

These changes to the way tobacco products look and how they are packaged is planned to de-normalise smoking by removing all the marketing and visual cues that entice people to use tobacco products.

National Pertussis Outbreak
Pertussis (whooping cough) is a bacterial illness that is always circulating in the community. In November 2017, the Ministry of Health declared a national outbreak due to higher than normal notifications of pertussis.

Pertussis is highly infectious and is spread by coughing and sneezing. Pertussis can affect anyone, although statistically in our region it occurs more commonly in people under the age of 19. Whooping cough can be very serious for babies and children – especially those under 1 year old.

An action plan for dealing with the outbreak was developed. The focus of activity was on promoting vaccination for vulnerable populations, specifically those under 1 year old or anyone living or working with those under 1 year old. We have been working directly with midwives, GPs and schools. At this stage of the outbreak Public Health South has capacity to continue to carry out case-by-case investigations to control the outbreak.

Resource packs for birthing units were sent out in December with packs for individual midwives following in February. Vaccination clinics for midwives have been scheduled across the district in March. Advice was also provided to schools at the start of the school year. A weekly email is sent to GP practices across the district letting them know the number of notifications and cases we have received.

Since 1 November 2017, 170 cases of suspected pertussis have been notified to us, with 111 subsequently confirmed. Cases have been dispersed across the region, with a higher than normal number of notifications in Queenstown Lakes area.

Submissions
Public Health South routinely makes submissions on behalf of Southern DHB on national and local government policy, plans and resource consent applications where there are potential impacts on public health. This is an opportunity to advocate for sustainable practices and policies that support health and wellbeing, improve Māori health outcomes and reduce disparities in our communities. A register is kept of all submissions lodged by the Southern DHB.

This year to date we submitted on the following:

- A proposed dairy farm expansion where we pointed out the risks of allowing such an expansion given the soil types and evidence of contamination of groundwater with nitrates.
- The Combined Otago-Southland Regional Land Transport Plan; this was particularly pleasing as it contained elements of what we had asked for in last year's iteration of the plan.
- The Eely Point (Wanaka) Management Plan where we supported drinking/bottle filling stations, restricted vehicle access and the provision of connected walking and cycling trails.
- The Queenstown-Lakes District Plan Change where we advocated in favour of active transport, smokefree and stronger policy on subdivision as it related to public health infrastructure.
- Queenstown Lakes District Council's disability policy where we suggested better ways of clarifying the content of the policy.
- The Central Otago District Council Clyde Reserves Management Plan where we highlighted that as the demography of Clyde was tending to an older population that the plan needed to reflect the physical activity needs of older people. It also drew attention to smokefree, the provision of drinking fountains, breastfeeding environments, bike racks and additional seating.
- The Otago Regional Council water allocation strategy for the Clutha River, where we drew attention to contamination risks from urban development upstream and the corresponding risks to water supplies drawn from downstream. This also drew attention to contemporary water quality risks including climate change, biodiversity, and policy on sewage disposal to internal river systems as well as urban growth.

Where possible we work with local authorities at policy development stages to incorporate our views prior to the documents being released for consultation as the submissions process is a very reactive way of addressing public health issues. While some submissions are undertaken as a response to a statutory process, the use of submissions as a principal vehicle for health advocacy is not best practice.

The Primary and Community Care Action Plan proposes the adoption of a Health in All Policies approach aimed at addressing the social determinants of health, including environmental determinants of health. This envisages the health sector adopting a programme of proactive engagement with local policy makers to influence policy development at the drafting stage. Such an approach is founded on the culturing of effective relationships between the health sector and civic partners and is a highly cost effective way of delivering improved health over a relatively short timescale. Implementation of a Health in All Policies Approach is commended to CPHAC as an initiative that should be resourced and implemented as a key approach to achieving health gain for our communities.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Community Health Council** Community, Whānau and Patient Engagement Framework and Roadmap
Report to:	Community and Public Health Advisory Committee
Date of Meeting:	21 March 2018

Summary:

The Community Health Council (CHC) is an advisory council to the Southern DHB and WellSouth PHN. The Council brings together people with diverse backgrounds, ages, health and social experiences to give our communities, whānau and patients across the Southern district a stronger voice.

Over the last few months the CHC has been involved with developing principles to guide their framework for broader community, whānau and patient engagement within the Southern health system. Consultation around the guiding principles occurred in the later months of 2017 and amendments have been made where appropriate.

Engagement with communities, whānau and patients can occur through a variety of methods and processes from informing, consulting, involving, collaborating right through to empowering.
The Roadmap is focussed on encouraging stronger engagement at the upper end of the engagement spectrum (collaborating and empowering).

This work connects with Southern Future priorities and the Primary and Community Care Strategy and Action Plan.

The CHC recently presented their proposed Framework and Roadmap to ELT and IGC and this was widely supported. This paper is to provide an update to the DHB Commissioners and seek endorsement to proceed.

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:	**Presented by:**
Professor Sarah Derrett Chair of Community Health Council Charlotte Adank Community Health and Clinical Council's Facilitator **Date:** 5 March 2018	Professor Sarah Derrett

RECOMMENDATION:
The CHC seeks endorsement from the Commissioner and Deputy Commissioners to finalise the Community, Whanau and Patient Engagement Framework & Roadmap and commence implementation.

Introduction

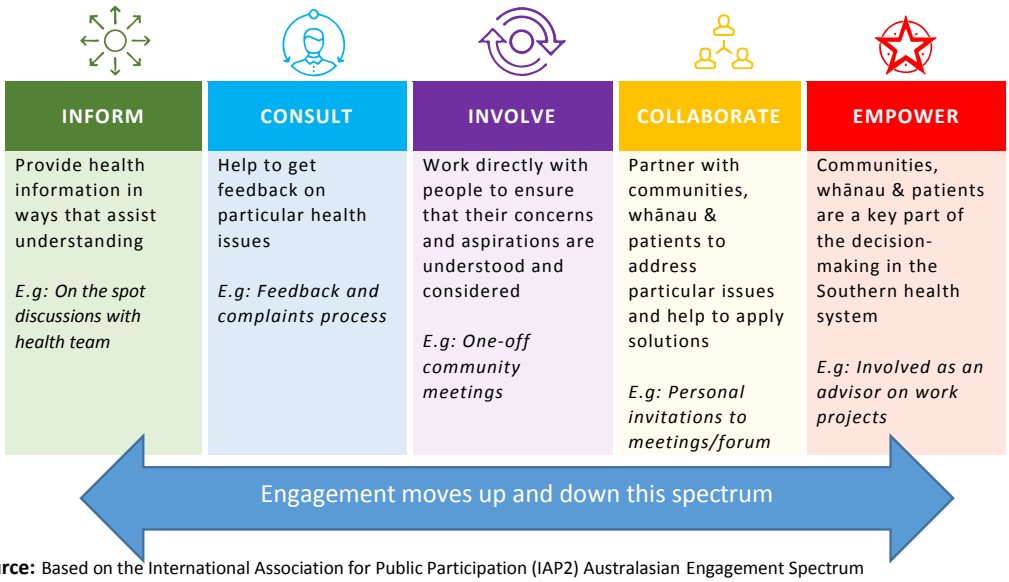
In the early stages of evolvement the CHC has received a number of requests from services for suitable community, whānau and patient advisor(s) on various working groups. It has been pleasing to see the willingness of services to engage with patients and allow this important aspect to feed into decision-making.

As the CHC develops its communication plan and more staff working for the Southern health system are aware of this Council we believe that demand will continue and it is unsustainable for members of the CHC to be on all working groups.

To enable a sustainable process for engagement to occur across the Southern health system the CHC has been working on refining their Community, Whānau and Patient Engagement Framework and developing a Roadmap to support this work.
This work connects in with the Southern Future priorities and the recently developed Primary and Community Care Strategy and Action Plan.

Levels of Engagement

There are different levels of engagement (illustrated in table below) occurring across the health system and the CHC is aware a lot of engagement is already occurring. The goal of the CHC Community, Whānau and Patient Engagement Framework is to strengthen and embed community, whānau and patient participation at all levels across our health system (particularly focussed on the upper levels of collaborating and empowering (and to have a shared approach to increase participation at every step along the way.



Source: Based on the International Association for Public Participation (IAP2) Australasian Engagement Spectrum
https://www.iap2.org.au/Tenant/C0000004/00000001/files/IAP2_Public_Participation_Spectrum.pdf

The CHC is aware there is already a number of projects occurring the health system that involve community, whānau and patient advisors. The CHC believes that it is important to have oversight of what is happening and that a systematic process is established to support advisors as well as health professionals to allow 'co-design' to flourish in our healthcare system.

Inviting in people as trusted advisors may at first appear to be laden with risk for health professionals and potentially the risks of partnership too often overshadow discussion on the rewards that come from partnership. If we do establish and nurture genuine, respectful, inclusive, meaningful and empowering engagement with our communities, whānau and patients the benefits can be extremely worthwhile:

- It humanises healthcare;

- It builds trust;
- It demystifies what communities, whānau and patients perceive and think of our health system, and
- Makes healthcare better.

Development of the CHC Community, Whānau and Patient Engagement Framework and Roadmap

In 2017, the CHC developed some guiding principles around what effective engagement would look like. Towards the end of the year the CHC hosted four public forums across the Southern district seeking feedback as to whether the guiding principles were accurate and amendments have been made based on this consultation.

In February, the Council spent time refining the Framework and developing the Roadmap to support implementing engagement across the health system.
The CHC has also begun developing resources to support staff and community, whānau and patient advisors with engagement i.e. flow charts to outline the process, confidentiality statements, position descriptions and feedback forms.

Feedback from ELT and IGC

The feedback from ELT and IGC was supportive for the CHC to progress with this work. One point was made that in order for meaningful engagement to take place the process needs to be simple for community, whānau and patients, as well as staff. It was acknowledged that in some cases of engagement more than one community, whānau and patient advisor may be needed to ensure their voice was heard.

Process from here

- The CHC will launch their Community, Whānau and Patient Engagement Framework and Roadmap (April 2018)
- The CHC believe some roadshows will need to be undertaken with staff outlining what is proposed and explaining processes.
- The CHC will connect with communities to keep them informed of what will happen.
- The CHC will refine material to be included in the Staff Information Pack and Welcome Pack for advisors. Once completed these resources could be piloted on a number of projects before making them readily available on the website.

The following pages outline the CHC Community, Whānau and Patient Engagement Framework, the guiding principles of engagement and a proposed Roadmap to support the processes around engaging community, whānau and patient advisors at a project level.

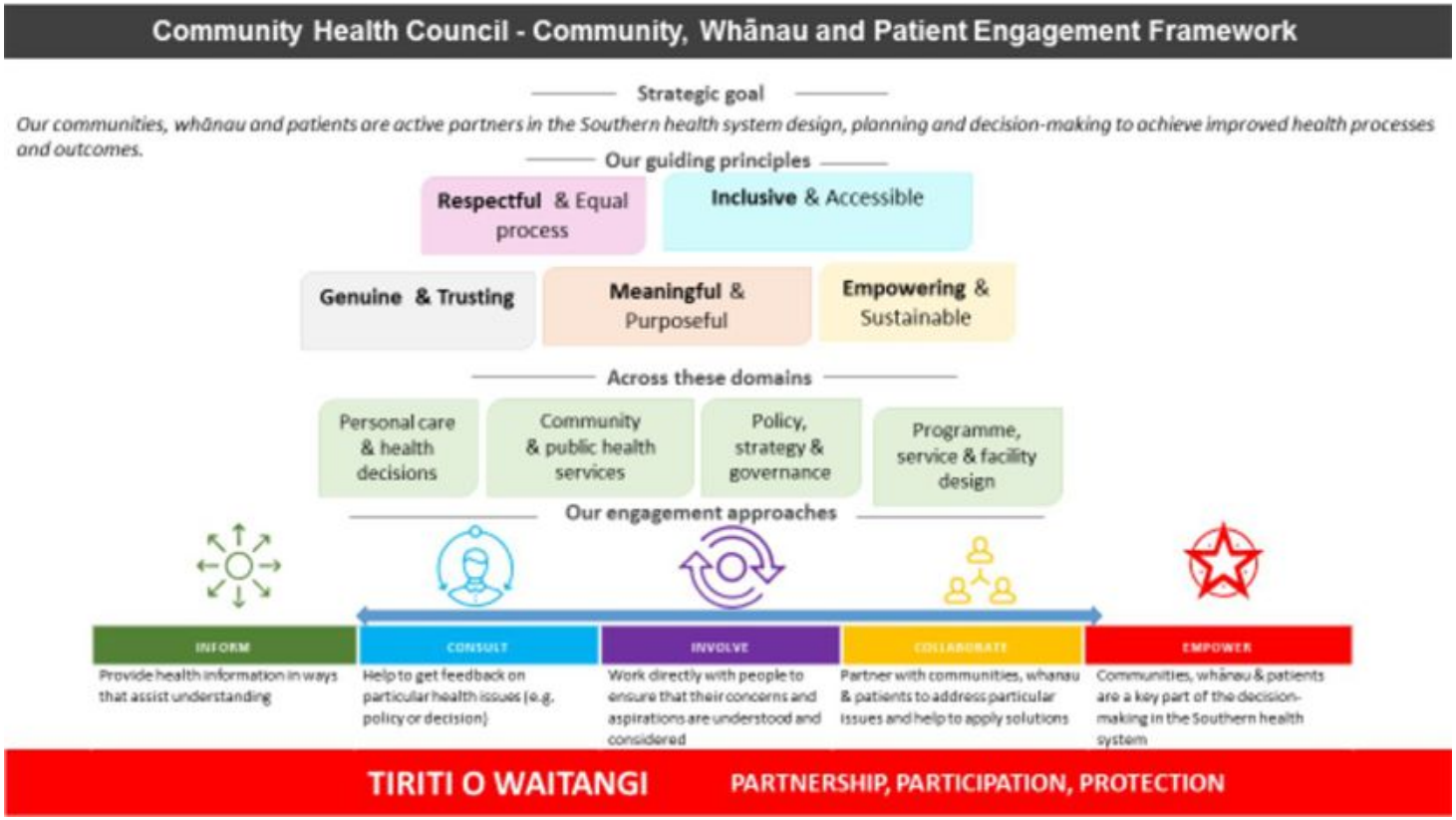
Appendix 1. CHC – Community, Whānau and Patient Engagement Framework

Appendix 2. Details around engagement principles

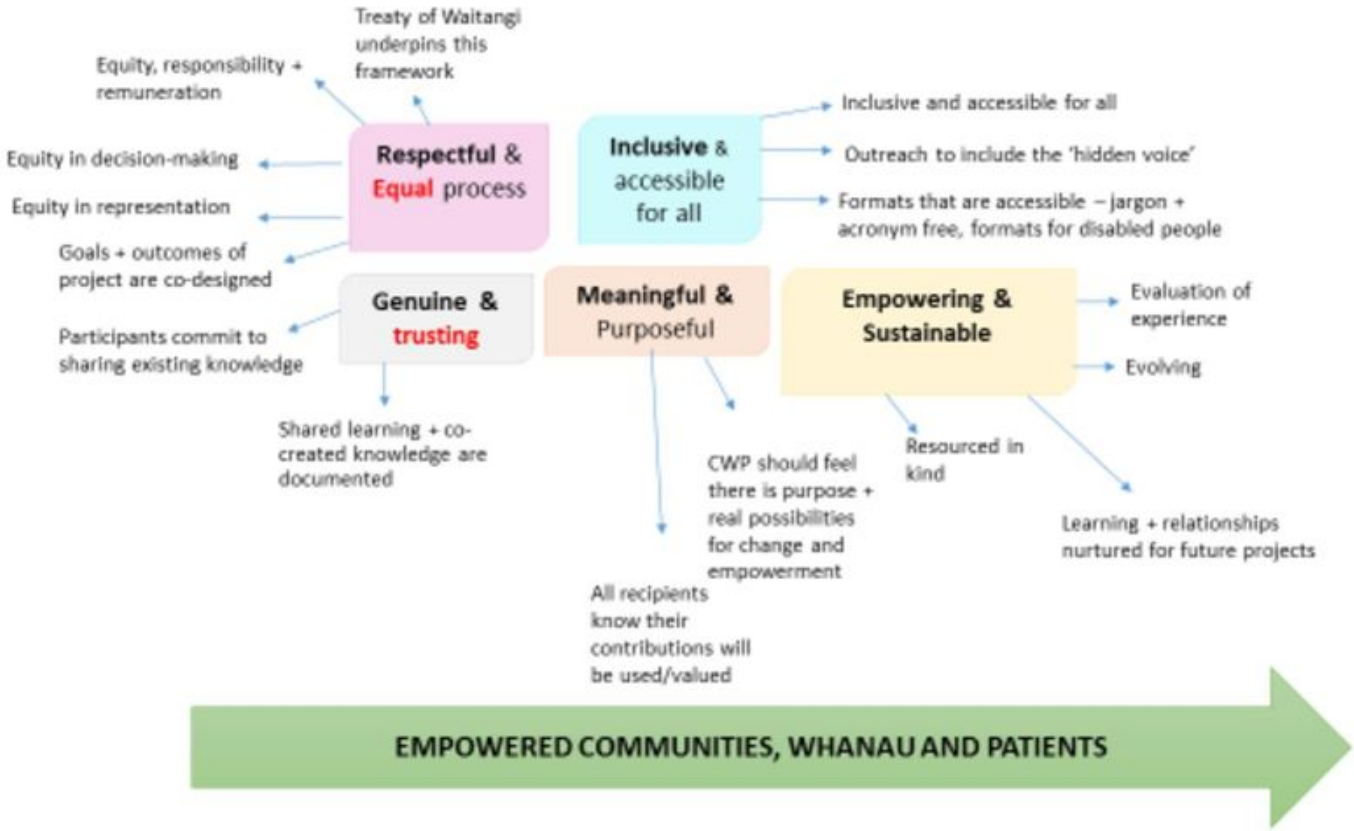
Appendix 3. Proposed Roadmap - CHC Community, Whānau and Patient Engagement

Appendix 4. Recognition of Community, whānau and patient contributions

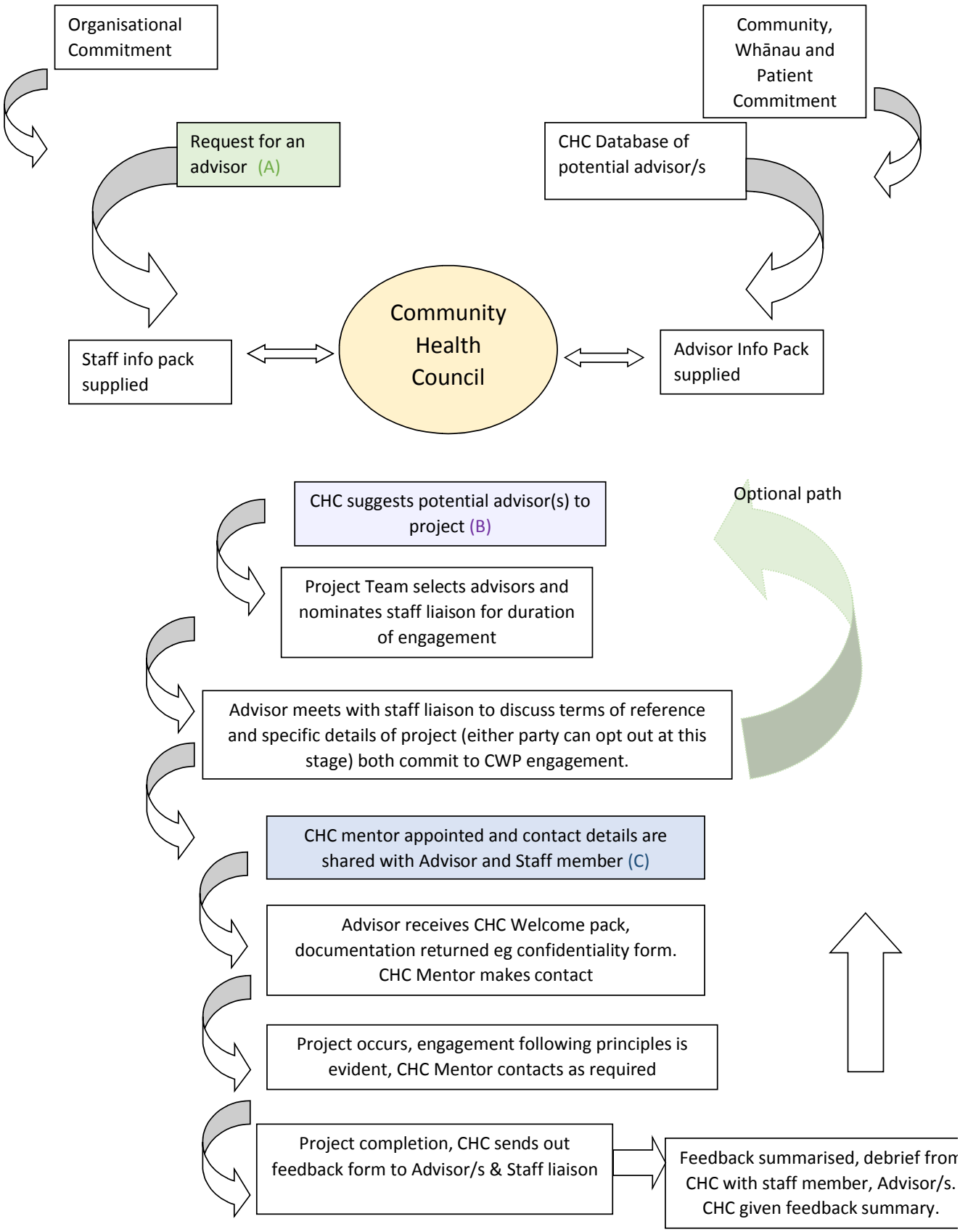
Appendix 1. CHC – Community, Whānau and Patient Engagement Framework



Appendix 2. Details around engagement principles



Appendix 3. Proposed Road Map – Community, Whānau and Patient Engagement



Appendix 4. Recognition of Community, whānau and patient contributions

	Type of activity	Type and extent of financial support or recognition DHB can provide	Paid by
1	**General invitation to a public meeting/hui**	Participation in a public consultation e.g. attending a public meeting, hui, fono or discussion group • No honorarium or koha • Accessibility needs for events should be met e.g. disability friendly venues • Assistance if requested with interpreters, or other supports that are essential for participation • Refreshments	
2	**Personalised invitation to one-off events**	Participation in focus groups, forum, workshops or meetings • A koha or small gift may be appropriate (is strongly encouraged if meeting exceeds 1 hour) e.g. invited to lunch, small gift • Reimbursement of reasonable out of pocket expenses i.e. to cover - Assistance if requested with taxis/transport for people who would otherwise not be able to attend. - Expenses may include travel and special aids e.g. interpreters or other supports for participation. • Refreshments	• Carpark pass if meeting is on hospital grounds • Taxi vouchers or other travel vouchers (e.g. bus tickets) posted out prior to the meeting where possible
3	**Invitation to ongoing group membership, partnership or collaboration**	**Advisors working at a project level** • Meeting time (including pre-reading) ½ day paid a maximum $125 (before tax) • Meeting time (including pre-reading) full day paid a maximum $250 (before tax) • Similarly for greater amounts of time >10hr Reimbursement of reasonable out of pocket expenses i.e. to cover - Assistance if requested with taxis/transport for people who would otherwise not be able to attend. - Expenses may include travel and special aids e.g. interpreters or other supports for participation. Travel expenses paid at IRD rates. Travel time excluded. Finance advice on claiming tax back will be provided for advisors.	• An Honorarium is paid in recognition of time made as tax deductible payment. • Expenses reimbursed are tax exempt. Paid retrospectively on invoice. • Carpark pass if meeting is on organised grounds

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Quarter Two 2017/18 Southern DHB Performance Reporting**		
Report to:	Commissioner Team		
Date of Meeting:	21 March 2018		
Summary: Overview of DHB Performance Reporting for **Quarter Two 2017/18** with brief comments where targets or expectations have not been met.			
Specific implications for consideration (financial/workforce/risk/legal etc.):			
Financial:	N/A		
Workforce:	N/A		
Other:	N/A		
Document previously submitted to:	N/A	**Date:**	
Approved by Chief Executive Officer:	N/A	**Date:**	
Prepared by: Strategy, Primary & Community Team **Date:** 12 March 2018		**Presented by:** Lisa Gestro Executive Director Strategy, Primary & Community	
RECOMMENDATION: **That the Commissioner and Deputy Commissioners note the content of this paper.**			

Summary of Southern DHB Performance Reporting – Quarter 2– 2017/18

Health Targets

Measure		Target	2016/17		2017/18		Final Rating	Ministry of Health Comments and DHB Responses
			Q3	Q4	Q1	Q2		
Better Help for Smokers to Quit	Primary Care	90%	73%	85.4%	91.3%	90.9%	A	Rank: 2nd out of 20 DHBs. Result is 90.9%. A decrease of 0.4% from last quarter.
	Maternity	90%	90%	85.1%	83.5%	88.0%	P	Rank: 16th out of 20 DHBs. Result is 88.0% were given brief advice and support to quit smoking. An increase of 4.5 % from last quarter. Data accuracy continues to be an ongoing issue with this target.
Improved Access to Elective Surgery		100%	98%	99%	97.6%	99.2%	P	Rank: 13th out of 20 DHBs. Result is 99.2%%. An increase of 1.6% from last quarter. A rating of Partially Achieved has been given following discussion with the Executive around elective performance. An update is required in Q3. Southern DHB achieved 6616 elective discharges for quarter one against a target of 6670, 54 discharges. This is behind plan but an improvement on the quarter one result.

Southern District Health Board
Piki Te Ora

Measure	Target	2016/17		2017/18		Final Rating	Ministry of Health Comments and DHB Responses
		Q3	Q4	Q1	Q2		
							Southern DHB is continuing to focus on long term sustainability to ensure that patients are treated within the promised timeframes and that the health target is met. There is a focus on production looking at the patient flow from acceptance for a first specialist assessment through to surgery. Workstreams with direct impact on the health target include – A focus on theatre productivity and utilisation – A focus on foundation work for theatre, e.g. starts on time, dropped lists, efficient environment/equipment – A focus on patient flow through beds including work streams on reducing length of stay, the stranded patient and minimising readmissions. – Using defined principles to increase theatre capacity with reduced costs including outsourcing and outplacing to private facilities

Measure	Target	2016/17		2017/18		Final Rating	Ministry of Health Comments and DHB Responses
		Q3	Q4	Q1	Q2		
Increased Immunisation	95%	94%	94%	94%	95%	A	Achievement of immunisation health target in Quarter 2. Rank: 2nd out of 20 DHBs. Result is 94%. National result 92%.
Shorter Stays in Emergency Departments	95%	92.1%	89.8%	88.8% NB: rating has been corrected to 93.4% for Q1	92.1%	P	Rank: 9 out of 20 DHBs. Result is 92.1%. A decrease of 1.3% from last quarter. The work the DHB has done during Q2 to support the Shorter Stays in EDs health target – Variance Response Management implemented across the hospital – Use of Fracture clinic agreed where escalation needed – Patient Flow/Quality projects prioritised into groups of strategic and operational objectives based on short term quick winds with medium and long term outcomes – IMAU improving patient journey and target performance – Discharge lounge on 8Med improving discharge rates – Overall EDLOS for Internal Medicine admitted patients measures has improved – NOF pathway implemented

Southern District Health Board
Piki Te Ora

Measure	Target	2016/17		2017/18		Final Rating	Ministry of Health Comments and DHB Responses
		Q3	Q4	Q1	Q2		
							– Dn Early Assessment Zone in place with increased nursing scope of practice – 7 days a week Allied Health team ED/IM improving discharge rates in Medicine/ED – Supported discharge processes in the inpatient ward areas – Continuation of Needs Assessor attending rapid rounds on 8 Med – Working with inpatient teams, especially medicine, to improve decision making in the ED The work the DHB will do Q2 to support the Shorter Stays in EDs health target – Ensure 7 day a week Allied Health team permanently in place in ED/IM – IMAU continuing to improve performance target in Dn ED – ECG transmission (an integral part of National Out –of-Hospital Stemi pathway) developed by National Cardiac network to be implemented in Dn ED – Work with primary care in Invercargill to look to reduce presentations

Measure	Target	2016/17		2017/18		Final Rating	Ministry of Health Comments and DHB Responses
		Q3	Q4	Q1	Q2		
							– Continue to work with inpatient teams to improve flow through the department Any barriers that the DHB has identified to achieving, or maintaining performance on, the health target and how these will be addressed – Availability of beds in Dunedin is still a significant factor in delaying length of stay in ED – Lack of bed access impacted Dunedin in November and December – Delays in accessing radiology in Dunedin – Access to speciality services such as surgical registrars and surgical subspecialties' including orthopaedics out of hours and on the weekend – Referrals into subspecialty teams out of hours

Measure	Target	2016/17		2017/18		Final Rating	Ministry of Health Comments and DHB Responses
		Q3	Q4	Q1	Q2		
Faster Cancer Treatment (from Oct 2014)	90%	83%	79%	86.2%	88.9%	P	Rank: 17th out of 20 DHBs. Result is 88.9%. An increase of 2.7% from last quarter. Upcoming work to achieve the 62 day target achievement: (monthly report 30 Jan 2018) – Looking at FCT patients who are also elective surgery patients, in conjunction with performance quality managers from the surgical directorate. – Mapping Upper GI patients to better understand the pathways and to look at any issues. Key Issues & Gaps Identified: A reduction in the number of 62-day cases as a proportion of the overall reported 31-day cases investigated to identify any issues with the electronic flagging of patients with a high suspicion of cancer, or any other issues. The number of 62-day records had begun to increase

Measure	Target	2016/17		2017/18		Final Rating	Ministry of Health Comments and DHB Responses
		Q3	Q4	Q1	Q2		
							in the last quarter, and this has continued in Q2 2017/18. – Work has been done to improve the flagging of FCT patients at referral. – There is new surgical representation on the Faster Cancer Treatment Steering Group Committee to boost surgical input. – Work has commenced with the other South Island DHBs, facilitated by the Southern Cancer Network, to look at the feasibility of a regional Faster Cancer treatment flag in Health Connect South. – Breach analysis of patients on the 62-day pathway has identified that the majority of patients who breach FCT 62-day timeframes have surgery as their first definitive treatment.
Raising Healthy Kids (By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions).	95%	78%	87%	92%	97.0%	O	Result is 97.0%. An increase of 5% from last quarter.

Indicators of DHB Performance

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

Measures of DHB Performance		
Measure	**Final Rating**	**Ministry of Health Comments and DHB Responses**
Policy Priorities Dimension		Achieving Government's priority goals/objectives and targets
PP6 Improving the mental health status of people with severe mental illness through improved access 17/18	A	
PP7 Improving mental health services using wellness and transition (discharge) planning	P	Result: 28.8% of clients had a transition (discharge) plan. 52.0% of clients had a wellness plan. Target is 95% of people will have a quality wellness plan or transition plan. – The service has developed a template for auditing the quality of Wellness Transition plans and is about to undertake an audit in February 2018. – The Directorate has begun the clinical, operational, PAS (Patient Administration System), and reporting work around SCR (Supplementary Consumer Record) data collection and are continuing to embed this into practice. – The Directorate does not currently audit closed files / discharged clients. Planning is currently underway with respect to this. Processes are being embedded to ensure 'Wellness Transition Planning' is in place at time of discharge. – The Directorate audits files for current clients, of which the presence of wellness, recovery, and relapse prevention plans are a component. Process is underway to ensure 'Wellness Transition Planning' is in place at our regular 3-month MDT client reviews. – We have a high confidence rating that wellness, recovery, and relapse prevention plans are in place for our long-term service users as demonstrated by the auditing of current

Measures of DHB Performance		
Measure	**Final Rating**	**Ministry of Health Comments and DHB Responses**
		clients that has been in place for many years. Currently in the process of moving from this number of plans to one district-wide 'Wellness Transition Plan'. This requires a significant degree of work that we will continue to embed – The presence of wellness, recovery, and relapse prevention plans that incorporate transition and discharge is currently being recorded via our local SCR collection. This collection is increasing over time, as SCR is further embedded. We expect to have a full SCR collection embedded well within 6 months. – Continuing the process of shifting from the wellness, recovery, and relapse prevention plans that we have in place towards a more aligned 'Wellness Transition Plan'. A critical success factor in enabling us to achieve this is our ongoing work around our Clinical Workstation (Health Connect South) Paper Lite project.
PP8 Shorter waits for non-urgent mental health and addiction services for 0 – 19 year olds	P	Mental Health Directorate result was 68.4% (last quarter 74.1%) of 0-19 year olds were seen within 3 weeks (target – 80%) and 88.8% (last quarter 90.0%) of 0-19 year olds were seen within 8 weeks (target – 95%). – Increase in referral volumes continue from last quarter across the district. – Wait times in some teams are longer due to increased demand and vacancies in some areas. Wait times are expected to improve with the new youth service in place in January 2018; this should have a positive follow on effect in the wider district. – Active recruitment and additional support to areas of priority demand is in place and planning for a review of workloads and staffing across the District continues.

PP20 Improved management for Long Term Conditions (LTC) (CVD, Diabetes and Stroke)	Focus Area: Long Term Conditions	A	
	Focus Area 2: Diabetes services	P	There have been unavoidable delays in implementing some 2017/18 Annual Plan actions. SDHB HbA1c report shows good ascertainment rates, suggesting a high concordance for estimates of diabetes prevalence between PHO data and the VDR. However, SDHB rates for people with diabetes who have had a HbA1c test within the last 12 months are low when compared nationally. An options paper for community podiatry has been developed but the proposed model of care (using Podiatry NZ as the procurer of services) is considered unviable. The provision of podiatry services will now be aligned to our Primary & Community Strategy and action plan and localised via locality networks. This is expected to occur in mid to late 2018. Five pilot sites across the district have worked through their enrolled population to ensure that, of the total population enrolled in the "Do the right thing" programme, at least 30% are Māori. Of the five pilot sites, 5% (12 of 248) are Maori. A review of ophthalmology services has occurred, and an action plan has been developed.
	Focus Area 3: Cardiovascular Health (previous CVD health target)	P	Result is 84.8% (target 90%). A decrease from 85.4% last quarter. 70.3% of Māori men aged 35-44 have received a CVDRA in the past 5 years (previous quarter: 67.0%). Rating is based on the achievement of the target for those Māori men. The rate for Māori men is very good in comparison to other DHBs. WellSouth has initiatives underway to increase performance including audit and reporting improvements. – WellSouth has developed a new audit and reporting tool called Health Cloud Reporter. It produces a dashboard that can be accessed by general practices, including access to patient level data.

			– WellSouth health target audits have identified an issue with patients transferring from one practice to another do not have their CVD RA scores transferred automatically and are seeking to rectify this. – WellSouth funds a CVD Management Programme for high needs patients who have a high CVD risk scores (15+). – WellSouth is user testing a new programme to manage long-term conditions that will replace the CarePlus programme; this will be extended to all practices in 2018. Client-Led Integrated Care is a stepped care model that will focus on patients with long-term conditions and will replace CarePlus.
	Focus Area 4: Acute Heart Services	A	
	Focus Area 5: Stroke Services	P	No Southern DHB hospital site met the definition of an organised Stroke Unit. Progress is being made to recruit to two stroke nurse lead positions, at Dunedin (0.8FTE) and Invercargill (0.5FTE), to support improving stroke services in SDHB. The draft South Island Acute Stroke Services Plan is being discussed and incudes options for telestroke and clot retrieval. Options are being investigated for telestroke across the district to support staff and improve thrombolysis rates. There is discussion re local awareness raising activity to sustainably improve thrombolysis for the SDHB population. Southern DHB does not currently have any Stroke specific community rehabilitation services; this is due to the population size and spread, which make Stroke specific services unachievable. Some of our community rehabilitation services i.e. those based on Dunedin, Wakari, and Southland hospital sites will meet some of the MoH expectations, but our rural hospital community teams will not.

PP21 Immunisation coverage (previous health target)	Focus Area 1 - Immunisation coverage at 2 years and 5 years of age	P	Southern DHB's result for immunisation target at the 2 year milestone is 94.1% (93.2% last quarter). Target is 95%. – Achievement of Māori coverage at 94.5% and Pacific coverage at 92.3% has maintained equity while Not Achieving Target. – The 9 Missed children have been accounted for and tracked – Southern DHB remains confident that we are 'Reaching Every Child' The result for immunisation target at 5 year milestone is 93.0% (94.2% last quarter). Target is 95%. – Maori coverage is reported at 90.1% and Pacific coverage at 97.5% – 51 (5%) children were opt off or declined. – 22 children are reported as missed with a significant number of these being immigrant children on active Catch Up programmes.
PP22 Improving System Integration and System Level Measures		N	The DHB has reported mitigations to get on track with implementation of the Systems Level Measures Improvement Plan in the following areas: ASH 0-4 year olds, Acute hospital bed days, Amenable mortality, Patient experience of care, Youth access to and utilisation of youth appropriate health services and Babies living in smoke-free homes at six weeks postnatal. Relevant groups will be reformed to review planned actions, as appropriate. The MoH has acknowledged the impact of the restructure on the implementation of the SLM plan but has requested that the SLM contact them to discuss.
PP23 Implementing the Healthy Ageing Strategy		A	
PP25 Prime Ministers youth mental health project	Initiative 1 – School Based Health Services in decile 1 to 3 secondary	A	

	schools, teen parent units & alternative education facilities		
	Initiative 5 – Improve responsiveness of primary care to youth	A	
PP26 Rising to the Challenge: The Mental Health and Addiction Service Development plan	Focus Area 1 – Primary Mental Health	P	MoH requested submission of ABI (Alcohol Brief Intervention) for youth and adults for quarter two and this was provided.
	Focus Area 2 – District Suicide Prevention & Postvention	A	
	Focus Area 3 – Improving Crisis response services	A	
	Focus Area 4 – Improve outcomes for children	A	

	Focus Area 5 – Improving employment and physical health needs of people with low prevalence conditions	A	
PP27 Supporting Vulnerable Children		A	
PP28 Reducing the incidence of first episode Rheumatic Fever		A	
PP29 Improving waiting times for diagnostic services	Coronary Angiography	P	Target has been exceeded every month in Quarter 2. There are no ongoing issues with timely access to cardiology diagnostic services. MoH will continue to engage with SDHB around angiography performance.
	CT / MRI	P	The Ministry expects a strong focus on ensuring that clinical risk is being managed and that patients waiting past clinical timeframes are reviewed. The Ministry will engage with SDHB on the recovery plan through the Elective Steering Group meeting. CT result is 72% (last quarter 76.7%) - target 95% of people accepted for a CT scan receive their scan in 42 days (six weeks) or less. Overall Q2 saw a marked improvement on Q1 and in performance against target. The continuing upwards trend reflects increased volumes of funded outpatient CT examinations being made available by Southern DHB at Oamaru and South Otago patient referrals now being handled at Southland Hospital. The variance in CT's current result from the required target is explained by several factors:

			High levels of urgent, high acuity outpatient demand for CT continuing to occur at Dunedin – Hours of operation do not allow for capacity increase to meet demand. – To improve/enhance performance in CT specifically, Radiology has submitted a business case to increase the core operating hours in CT. – Quarter two saw an improvement on Q1 17/18, however a consistent increase in performance was not able to be maintained. – Some further improvement is expected from January with the qualification of the first Southland MRI trainee. This will enable MRI capacity at Southland to be increased by 20% (i.e. to 40 hours per week). The variance in MRI from the required target is explained by several factors: – Ongoing staffing shortages at Southland Hospital. While Dunedin staff have continued to provide support to colleagues at Southland Hospital there continues to be reduced capacity at this site. – Acute MRI demand at Dunedin Hospital has increased over this period, placing strain on our capacity to undertake outpatient examinations. – Continuing recovery from disruptions to service arising from the replacement of the Dunedin Hospital MRI scanner. To improve/enhance performance in MRI specifically, Southern DHB has developed an MRI recovery plan, which is being implemented. Key strategies include: – Continuing to grow our own with training MRI techs at each site – Continued recruitment at Southland Hospital – Clinically led Radiology demand management project – Additional MRI sessions undertaken as staff availability and budget permits. Possibility of outsourcing to address backlog

	Colonoscopy	P	Southern DHB's result for urgent is 74.5%. Target is 90%. The urgent indicator is most influenced by patient factors and with a relatively small denominator the percentage is significantly influenced by small numbers of patients. Southern DHB's result for non-urgent is 75.6%. The target of 70.0% has been met. Southern DHB's result for surveillance is 62% (target is 70%). Significant work undertaken five years ago to address the surveillance waiting list has created a bolus of patients due follow up procedures at the same time. Additional scoping sessions have been scheduled to address this issue and it is anticipated that the issue will be resolved during the next quarter.
PP30 Faster Cancer Treatment		P	SDHB rating is 81.7 percent. Target is 85 percent. Refer to Faster Cancer Treatment Health Target (page 6).
PP31 Better Help for Smokers to Quit in public hospitals (previous health target).		N	Southern DHB's result is 90.7% (91% last quarter). Target is 95%. There has been a 0.4% drop in the result from Q1 and SDHB remains some way off meeting the target. Measures are being taken to improve this, for example the improvements in the Emergency Department Information System. Because of the failure to reach the target in recent quarters, SDHB is now required to report to the MoH on a monthly basis. The DHB believes the target results will be sustainable after 30 June 2018 with the appropriate systems in place to help achieve the target.
PP32 Improving the quality of ethnicity data collection in PHO and NHI registers 17/18		A	
PP33 Improving Māori involvement in PHOs to meet the national average of 90% 17/18		P	Two of the key initiatives to improve Maori enrolments within primary care have been the establishment of He Puna Waiora Wellness Centre and Mataora (Very Low Cost Access General practices) within the SDHB catchment. An action plan to Māori enrolments in the PHO is under development.

PP36 Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders		P	SDHB continues to monitor data. Reports are tabled for discussion with key staff. Māori Mental Health teams provide input re this group of clients.
PP38 Delivery of response actions and milestones agreed in the annual plan for each Government planning priority (Need to refer to Annual Plan 2017/18)	Healthy Mums and Babies	P	Thank you for your report. Please provide a comment and progress rating for the practice nurse and GP workshop in order to gain an achieved rating. Thank you for your report and the information provided on the rescheduled education courses for GPs and primary care nurses.
	Workforce	NR	We are unable to provide an initial rating or comment as there is no report to comment on. To complete reporting for this quarter, please could you state whether progress has been met (and provide commentary if progress is not met) for all actions with a milestone of Q2.
	Childhood Obesity Plan	NR	To complete reporting for this quarter, please could you state whether progress has been met (and provide commentary if progress is not met) for all actions with a milestone of Q2.
	IT	NR	No report on Q2 progress for rollout of EMRAM capabilities. To complete reporting for this quarter, please could you state whether progress has been met (and provide commentary if progress is not met) for all actions with a milestone of Q2.
	Pharmacy Action Plan	P	Work to develop the new pharmacy contract is still ongoing. The Ministry looks forward to you reporting progress against this action in Q4.
System Integration Dimension			Meeting service coverage requirements and supporting sector inter-connectedness
SI1 Ambulatory Sensitive Hospitalisations (ASH)		P	SDHB has been progressing pilot site testing of CLIC (long term conditions stratification and assisted interventions) in five locations. SDHB is about to launch our POAC programme (primary options for acute care) which is anticipated to better equip primary care to manage acute presentations and ergo effect our ASH cohort. SDHB is also looking to link our ASH cohort with Otago's Cosy Homes initiative, which should provide a larger portion of this cohort with free household insulation. SHDB also continues with existing programs, such as DESMOND, clinical

		pharmacists, our PHO based long term conditions team, and our voucher services for high needs/high system cost patients. MoH commented that reflection does not address equity gap for Māori; are there plans to address this?
SI3 Ensuring delivery of service coverage 17/18	P	The DHB provided a report documenting potential service coverage gaps for LMC midwifery. However, in Quarter 2, the MoH expected reports on provision of TAVI, sharps disposal services and implementation of Te Ara Whakapiri. DHBs were expected to provide an update on the progress made to implement guidelines around the provision of TAVI. In accordance with the 1998 Health (Needles and Syringes) Regulations, in particular Section 9(1), all DHBs are expected to fund a sharps disposal services for people using needles and syringes in the community, at no cost to the patient. Pharmacies and medical practitioners are responsible for the collection of sharps they dispense, and DHBs are responsible for their disposal. In Quarter 2, the Ministry requested as confirmation that DHBs are continuing to meet this requirement, including the name of the community providers the DHB is providing sharps disposal services for. Since Te Ara Whakapiri: Principles and guidance for the last days of life was launched in April 2017, some concerns have been raised about uptake and implementation. In Quarter 2, the Ministry requested confirmation that the DHB has a delivery plan and asked for an example of a key deliverable from the delivery plan.
SI5 Delivery of Whanau Ora	A	
SI10 Improving Cervical Screening Coverage	P	The overall coverage target is 80%. On 23 January 2018, SDHB coverage to 31 December 2017 was 78.1% overall (partially achieved), 82.2% for Pacific women (achieved), 64.2% for Māori women, 57.5% for Asian women, 81.1% for Other women. Coverage in Other and Pacific women has been achieved but is not achieved in Māori and Asian women. Southern DHB intends to achieve targets for all priority groups by working in partnership with WellSouth Primary Health

			Network, Māori health providers and Pacific Radiology Group. Additionally, the Cervical Screening Group has been replaced by a joint Steering Group for breast and cervical screening.
SI2 Delivery of Regional Service Plans		P	SIAPO reports on activity and progress on the South Island Health Services Plan.
SI11 Improving breast screening rates		P	The DHB has exceeded the coverage target of 70.0% for breast screening, with a total coverage rate of 75%. This includes a result of 75.5% coverage for Other women. However coverage for Māori women is 67.4% and coverage is 62.2% for Pacific women. A good range of initiatives are planned with targeted promotion of breast screening to priority group women.
SI4 Standardised Intervention rates		A	
Output Dimension			Purchasing the right mix and level of services within acceptable financial performance
OP1 Mental Health output Delivery against plan		P	The MoH has asked for an explanation for why FTE vacancies are high (8%).
Ownership Dimension			Providing quality services efficiently
OS3 Inpatient Average Length of Stay (ALOS) – days	Acute	P	The Acute ALOS (standardised for the data to the end of Quarter 2 for Southern was 2.38; this is an improvement on Q1 but above the quarter target of 2.34. The Acute ALOS is slightly higher than target but less than last quarter, which is a positive improvement. MoH notes there are good initiatives underway or planned to manage this. Southern DHB is currently undertaking a comprehensive productivity planning project across the district with a number of associated work streams. The work streams aimed to increase capacity within both Dunedin and Southland hospitals are expected to reduce the length of stay for both acute and elective patients. These work streams include: – Stranded patient – Weekend discharges

			– Effective daily board roundsDischarge education
	Elective	P	The Elective ALOS (standardised) for the data to the end of Q2 for Southern was 1.53. Target 1.48 days. See above (Acute) for strategies to increase capacity.
OS8 Reducing Acute Readmissions to Hospital		A	
OS10 Improving the quality of data provided to national collection systems	Focus area 1: Improving the quality of identity data within the NHI	O	
	Focus area 2: Improving the quality of the data submitted to National Collections	A	
	Focus area 3 – Improving the quality of the programme for the integration of Mental Health data (PRIMHD)	A	

Development Dimension			
DV4 Improving patient experience		A	
Delivery of New Zealand Health			
EHS – Supporting delivery of the New Zealand Health Strategy	People Powered	A	
	People Powered		
	Closer to Home		
	Value and High Performance		
	One Team		
	Smart System		

Crown Funding Agreements (CFA) Variations

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

Crown Funding Agreements (CFA) Variations		
Measure	**Final Rating**	**Ministry of Health Comments and DHB Responses**
B4 School Check Funding	S	
Health Services for Emergency Quota Refugees	A	
Well Child Tamariki Ora Services	S	
Appoint Cancer Nurse Coordinators	N	Reporting requirement for Q2 is as follows: Certification by the DHB's Chief Operating Officer that the DHB has met the Service requirements as set out in clause 3 is required. The DHB is required to provide a report with the following information: the requirements which have not been met; why the requirements have not been met; what is being done to meet the requirements; when the requirements will be met. No report was submitted.
Electives Initiative and Ambulatory Initiative Variation 17/18	S	
National Immunisation Register (NIR) Ongoing Administration Services	S	
Immunisation Coordination Service 17/18	S	
Disability Support Services Funding Increase 17/18	S	

Assessment Criteria/Ratings

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

Health Targets & Performance Measures

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

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

CFA Variations

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

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

SOUTHERN DISTRICT HEALTH BOARD

Title:	**FINANCIAL REPORT**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	21 March 2018

SUMMARY:

The issues considered in this paper are:

- February 2018 Funds result.

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SPECIFIC IMPLICATIONS FOR CONSIDERATION (FINANCIAL/WORKFORCE/RISK/LEGAL ETC):

FINANCIAL:	As set out in report.
WORKFORCE:	No specific implications
OTHER:	n/a

DOCUMENT PREVIOUSLY SUBMITTED TO:	Not applicable, report submitted directly to DSAC/CPHAC	**DATE:** N/A

PREPARED BY: Strategy, Primary & Community Team **DATE:** 14 March 2018	**PRESENTED BY:** Lisa Gestro Executive Director Strategy, Primary & Community

RECOMMENDATION:

1. That the report be received.

STRATEGY, PRIMARY & COMMUNITY REPORT
February 2018

1. Overview

The overall result follows;

Month				Year to Date		
Actual $' 000	Budget $' 000	Variance $' 000		Actual $' 000	Budget $' 000	Variance $' 000
75,462	75,002	460	Revenue	599,931	600,254	(323)
73,986	73,638	(346)	Less Expenses	607,027	607,884	857
1,476	1,323	114	Net Surplus / (Deficit)	(7,096)	(7,630)	534
			Expenses			
3,941	4,074	133	Personnel	33,973	34,683	710
84	80	(4)	Outsourced Clinical Services	635	666	31
1,003	994	(9)	Outsourced Funder Services	7,915	7,954	39
459	432	(27)	Clinical Supplies	3,732	3,549	(183)
388	363	(25)	Infrastructure & Non Clinical Supplies	3,581	3,356	(225)
			Provider Payments			
55,117	54,344	773	Personal Health	442,936	444,756	1,820
119	98	(21)	Public Health	745	782	37
12,763	13,128	365	Disability Support	112,625	111,142	(1,483)
112	125	13	Maori Health	885	996	111
73,986	73,638	(346)	Expenses	607,027	607,884	857

Summary Comment:

Strategy, Primary and Community had a surplus for February of $1.47m against a budget surplus of $1.32m which is $0.11m favourable. YTD there is a deficit of $7.09m against a budgeted deficit of $7.63m which is $0.53m favourable.

Revenue is favourable by $0.46m for February and $0.32m unfavourable YTD, with the main reason being electives revenue ($3.1m unfavourable YTD), offset by extra Refugee revenue ($1.02m YTD), In Between Travel ($0.99m YTD), Performance Management revenue ($0.24m YTD) and Rehab revenue ($0.45m YTD).

Expenditure for the month is unfavourable to budget by $0.35m with the main reasons being pharmaceuticals ($0.68m) offset by Refugee expenditure ($0.12m), Home Support ($0.28m)

YTD expenditure is $0.86m favourable to budget with the main reasons elective expenditure ($3.1m favourable) and personnel costs ($0.71m favourable) Pharmaceuticals & PCT ($0.8m unfavourable) Disability Support expenditure ($1.4m unfavourable) and Refugee expenditure ($1.02m unfavourable).

Personnel

Expenditure

Group	$000's Monthly actual	$000's Monthly budget	$000's Monthly variance	$000's YTD actual	$000's YTD budget	$000's YTD Variance
SMO's	542	544	2	4,787	4,652	(135)
RMO's	49	48	(1)	299	409	110
Nursing	1,433	1,504	71	12,463	12,924	461
Allied Health	1,402	1,429	27	12,040	12,072	32
Support	11	10	(1)	86	89	3
Management & Administration	504	538	34	4,297	4,537	240
Total	3,941	4,074	133	33,973	34,683	710

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FTE's

Group	YTD actual	YTD budget	YTD variance
SMO's	25	25	0
RMO's	4	5	1
Nursing	232	239	7
Allied Health	268	270	2
Support	3	3	0
Management & Administration	98	102	4
Total	629	643	14

Personnel costs are $0.71m favourable YTD which is reflective of the 14 FTE vacancies. Nursing is the main area affected with 7 FTE vacancies currently and an underspend of $0.46m YTD. The main area impacting on this variance is Nurse Managers and Nurse Educators where there is 4 FTE vacancies and an underspend YTD of $0.38m.

Management & Administration favourable variances are mainly in the Non Clinical Administration, Clerical and Secretarial area with 5 FTE vacancies and an underspend of $0.27m YTD.

Outsourced Services

Expenses

Group	$000's Monthly actual	$000's Monthly budget	$000's Monthly variance	$000's YTD actual	$000's YTD budget	$000's YTD variance
Clinical Services	84	80	(4)	635	666	31
Funder Services	1003	994	(9)	7,915	7,954	39
Total	1,087	1,074	(13)	8,550	8,620	70

No significant variance

Clinical Supplies

Expenses

Group	$000's Monthly actual	$000's Monthly budget	$000's Monthly variance	$000's YTD actual	$000's YTD budget	$000's YTD variance
Treatment Disposables	210	195	(15)	1,862	1,624	(237)
Diagnostic Supplies	3	5	2	33	41	8
Instruments & Equipment	47	55	8	395	435	40
Patient Appliances	156	127	(29)	1,088	1,039	(49)
Implants & Prostheses	0	0	0	3	1	(2)
Pharmaceuticals	37	34	(3)	280	286	6
Other Clinical Supplies	5	15	10	71	122	52
Total	459	432	(27)	3,732	3,549	(183)

Treatment disposables ($237k unfavourable YTD) with Continence & Hygiene Supplies ($109k unfavourable YTD), Dental Supplies ($67k unfavourable YTD) and dressings ($49k unfavourable) being the main drivers.

Infrastructure & Non Clinical Supplies

Expenses

Group	$000's Monthly actual	$000's Monthly budget	$000's Monthly variance	$000's YTD actual	$000's YTD budget	$000's YTD variance
Hotel Services, Laundry & Cleaning	156	158	3	1,358	1,365	7
Facilities	27	33	6	249	280	31
Transport	126	111	(15)	983	1,034	51
IT Systems and Telecommunications	33	29	(4)	286	233	(53)
Professional Fees & Expenses	16	35	19	448	279	(169)
Other Operating Expenses	27	(4)	(31)	253	162	(90)
Democracy	2	0	(2)	6	3	(3)
Total	388	363	(24)	3,581	3,356	(225)

Professional fees & expenses ($169k unfavourable YTD) mainly due to Consultants fees ($133k unfavourable YTD.)

Personal Expenditure NGO and Provider Payments

Personal Health February 2018	Current Month Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Year to Date Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Annual Budget $(000)	Variance Note
Personal Health - Provider Arm										
Personal Health to allocate	-	-			-	-				
Child and Youth	341	341			2,732	2,732			4,097	
Laboratory	-	-			-	-			0	
Infertility Treatment Services	-	-			-	-			0	
Maternity	23	23			181	181			271	
Maternity (Tertiary & Secondary)	1,379	1,379			11,032	11,032			16,548	
Pregnancy and Parenting Education	-	-			-	-			0	
Neo Natal	666	666			5,332	5,332			7,997	
Sexual Health	86	86			691	691			1,036	
Adolescent Dental Benefit	27	27			213	213			320	
Dental - Low Income Adult	28	28			226	226			339	
Child (School) Dental Services	601	601			4,807	4,807			7,211	
Secondary / Tertiary Dental	120	120			962	962			1,443	
Pharmaceuticals	445	372	(73) U	(20%)	3,468	2,979	(489) U	(16%)	4,469	2
Pharmaceutical Cancer Treatment Drugs	556	593	37 F	6%	4,555	4,736	181 F	4%	7,139	2
Pharmacy Services	-	-			-	-			0	
Primary Practice Services - Capitated	268	10	(258) U		335	77	(258) U		115	
Primary Health Care Strategy - Health/SIA	-	-			-	-			0	
Primary Health Care Strategy - Other	-	-			-	-			0	
Practice Nurse Subsidy	-	-			-	-			0	
Rural Support for Primary Health Pro	72	72			577	577			865	
Immunisation	69	69			554	554			831	
Radiology	279	279			2,232	2,232			3,348	
Palliative Care	-	-			-	-			0	
Meals on Wheels	35	35			283	283			424	
Domiciliary & District Nursing	1,125	1,125			8,929	8,929			13,429	
Community based Allied Health	557	557			4,126	4,126			6,356	
Chronic Disease Management and Educa	150	150			1,203	1,203			1,804	
Medical Inpatients	6,910	6,910			55,283	55,283			82,924	
Medical Outpatients	3,283	3,283			26,265	26,265			39,398	
Surgical Inpatients	11,879	11,716	(163) U	(1%)	90,652	93,728	3,076 F	3%	140,593	7
Surgical Outpatients	1,686	1,686			13,486	13,486			20,229	
Paediatric Inpatients	679	679			5,429	5,429			8,143	
Paediatric Outpatients	246	246			1,969	1,969			2,954	
Pacific Peoples' Health	10	10			80	80			120	
Emergency Services	1,715	1,715			13,717	13,717			20,576	
Minor Personal Health Expenditure	15	15			121	121			182	
Price adjusters and Premium	1,964	1,964			15,714	15,714			23,571	
Travel & Accomodation	8	8			64	64			96	
	35,222	34,765	(457) U	5%	275,218	277,728	2,510 F	1%	416,828	
Personal Health NGO										
Personal Health to allocate	-	-			-	-			0	
Child and Youth	40	35	(5) U	(14%)	191	280	89 F	32%	421	
Laboratory	1,493	1,505	12 F	1%	12,052	12,037	(15) U		18,056	
Infertility Treatment Services	8	8			64	64			96	
Maternity	208	206	(2) U	(1%)	1,548	1,646	98 F	6%	2,470	1
Maternity (Tertiary & Secondary)	4	1	(3) U	(300%)	49	5	(44) U	(880%)	8	
Pregnancy and Parenting Education	44	15			146	118	(28) U	(24%)	177	
Sexual Health	-	8	8 F		(9)	65	74 F	114%	98	
Adolescent Dental Benefit	107	156	49 F	31%	1,512	1,527	15 F	1%	2,117	
Dental - Low Income Adult	63	46	(17) U	(37%)	133	367	234 F	64%	550	3
Child (School) Dental Services	19	34	15 F	44%	219	282	63 F	22%	423	
Secondary / Tertiary Dental	136	133	(3) U	(2%)	1,132	1,067	(65) U	(6%)	1,601	
Pharmaceuticals	5,699	5,087	(612) U	(12%)	50,834	50,297	(537) U	(1%)	73,123	2
Pharmaceutical Cancer Treatment Drugs	-	-			(34)	-	34 F		-	2
Pharmacy Services	-	-			-	-			-	
Management Referred Services	167	167			1,333	1,333			2,000	
General Medical Subsidy	138	61	(77) U	(126%)	738	501	(237) U	(47%)	769	4
Primary Practice Services - Capitated	3,570	4,005	435 F	11%	32,047	32,039	(8) U		48,058	5
Primary Health Care Strategy - Care	376	348	(28) U	(8%)	2,976	2,783	(193) U	(7%)	4,175	5
Primary Health Care Strategy - Health	510	551	41 F	7%	4,386	4,410	24 F	1%	6,615	5
Primary Health Care Strategy - Other	59	89	30 F	34%	430	558	128 F	23%	912	5
Practice Nurse Subsidy	13	16	3 F	19%	155	130	(25) U	(19%)	195	
Rural Support for Primary Health Pro	1,412	1,353	(59) U	(4%)	11,293	10,823	(470) U	(4%)	16,235	6
Immunisation	81	97	16 F	16%	727	879	152 F	17%	2,135	
Radiology	331	206	(125) U	(61%)	1,880	1,603	(277) U	(17%)	2,390	
Palliative Care	459	542	83 F	15%	4,255	4,327	72 F	2%	6,491	
Meals on Wheels	21	21			167	170	3 F	2%	255	
Domiciliary & District Nursing	456	556	100 F	18%	4,385	4,452	67 F	2%	6,678	
Community based Allied Health	199	186	(13) U	(7%)	1,512	1,492	(20) U	(1%)	2,238	
Chronic Disease Management and Educa	123	94	(29) U	(31%)	984	755	(229) U	(30%)	1,132	
Medical Outpatients	402	413	11 F	3%	3,229	3,307	78 F	2%	4,960	
Surgical Inpatients	10	21	11 F	52%	76	164	88 F	54%	246	
Surgical Outpatients	155	190	35 F	18%	1,265	1,517	252 F	17%	2,276	
Paediatric Outpatients	-	-			3	-	(3) U		-	
Pacific Peoples' Health	3	11	8 F	73%	61	88	27 F	31%	132	
Emergency Services	156	164	8 F	5%	1,284	1,314	30 F	2%	1,971	
Minor Personal Health Expenditure	16	47	31 F	66%	307	374	67 F	18%	561	
Price adjusters and Premium	150	199	49 F	25%	1,151	1,589	438 F	28%	2,383	8
Travel & Accomodation	264	340	76 F	22%	3,204	3,334	130 F	4%	4,792	9
Inter District Flow Personal Health	3,000	2,666	(334) U	(13%)	22,034	21,327	(707) U	(3%)	31,991	10
	19,892	19,577	(315) U	(2%)	167,719	167,024	(695) U	(0%)	248,730	
Total Personal Health	55,114	54,342	(772) U	(0) U	442,937	444,752	1,815 F	0%	665,558	

Personal Health expenditure variance notes;

1. **Maternity -** $0.10m favourable
   Favourable variance due to discontinuation of Primary Maternity contract where there was an accrual up to 30 June 2017 and budget included in 2017/18. There is a partial offset in the Maternity (Tertiary Secondary) line for an unbudgeted contract for Maternity Support Services for the same provider.

2. **Pharmaceuticals & PCT (NGO & Provider) –** .$0.81m unfavourable YTD
   February expenditure is $0.65m unfavourable to budget and is mainly due to timing of payments.

3. **Low Income Dental-** $0.23m favourable YTD
   Price Volume Capped service where invoicing has been up to six months in arrears. Accruals have been based on the top of the capped level to avoid under accrual. The June 17 yearend accrual was overstated and is the main reason for the favourable variance.

4. **GMS -** $0.23m unfavourable YTD
   Demand driven service that also includes expenditure relating to Refugee's.

5. **PHO lines (Primary Practice Capitated & Primary Health Care) –** $0.30m unfavourable YTD
   Unfavourable variances across these lines is due to Careplus, Performance Management and Refugee expenditure where there are revenue offsets.

6. **Rural Support for Primary Health Providers**- $0.47m unfavourable YTD.
   Relates to Clutha Health expenditure incurred where the budget is sitting in Price adjusters and Premiums.

7. **Surgical Inpatients -** $3.16m favourable YTD.
   Due to 17/18 additional electives wash-up (offsetting revenue reduction).
   The total wash-up has been included in Surgical Inpatients at this time.
   YTD Elective and Ambulatory revenue is estimated to be $3.08m unfavourable to plan based on indicative MOH wash-up rules and YTD extracts from National Collections.

   The table below shows the breakdown of the under delivery:

YTD Electives Summary	Variance	Variance
Funding Stream	(CWD's)	(000')
Elective Initiative	-603.73	-$ 2,971.07
Orthopaedic Initiative	-70.30	-$ 345.96
Ambulatory Initiative		
Surgical FSA's		-$ 28.76
Medical FSA's		$ 296.83
Procedures		-$ 27.14
Tests		$ -
Total - EI, OI & AI		**-$ 3,076.10**

8. **Price Adjusters and Premium** - $0.43m favourable YTD.
   Mainly relates to Clutha health expenditure incurred in Rural Support.

Personal Health (continued)

9. **Travel & Accommodation -** $0.13m favourable YTD.
   Demand driven service.

10. **IDF's -** $0.71m unfavourable YTD.
    Expenditure includes YTD wash-up estimate.

Disability Support Services

DSS *February 2018*	Current Month Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Year to Date Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Annual Budget $(000)	Variance Note
Disability Support Services - Provider Arm										
AT & R (Assessment, Treatment and Re	1,900	1,900			15,204	15,204			22,806	
Information and Advisory	-	-			-	-			0	
Needs Assessment	108	108			881	881			1,315	
Service Co-ordination	20	20			158	158			236	
Home Support	-	-			-	-			0	
Carer Support	-	-			-	-			0	
Residential Care: Rest Homes	-	-			-	-			0	
Residential Care: Loans Adjustment	-	-			-	-			0	
Long Term Chronic Conditions	-	-			-	-			0	
Residential Care: Hospitals	-	-			-	-			0	
Ageing in Place	-	-			-	-			0	
Environmental Support Services	2	2			18	18			27	
Day Programmes	-	-			-	-			0	
Expenditure to Attend Treatment ETAT	-	-			-	-			0	
Minor Disability Support Expenditure	-	-			102	102			102	
Respite Care	-	-			-	-			0	
Child Development	90	90			719	719			1,078	
Community Health Services & Support	21	21			169	169			254	
	2,141	**2,141**	-		**17,251**	**17,251**			25,818	
Disability Support Services - NGO										
Disability Support - Pay Equity	1,095	1,155	60 F	5%	9,566	9,925	359 F	4%	15,000	
AT & R (Assessment, Treatment and Re	335	357	22 F	6%	2,686	2,856	170 F	6%	4,284	
Information and Advisory	11	12	1 F	8%	87	98	11 F	11%	147	
Needs Assessment	35	34	(1) U	(3%)	265	261	(4) U	(2%)	398	
Service Co-ordination	-	-			-	-			0	
Home Support	1,522	1,802	280 F	16%	16,028	15,411	(617) U	(4%)	23,911	11
Carer Support	112	136	24 F	18%	1,221	1,096	(125) U	(11%)	1,594	
Residential Care: Rest Homes	3,044	2,979	(65) U	(2%)	26,233	25,744	(489) U	(2%)	38,762	12
Residential Care: Loans Adjustment	(25)	(23)	2 F	(9%)	(191)	(184)	7 F	(4%)	-276	
Long Term Chronic Conditions	-	-			-	-			0	
Residential Care: Hospitals	4,009	3,921	(88) U	(2%)	34,905	33,865	(1,040) U	(3%)	51,020	13
Environmental Support Services	7	10	3 F	30%	58	82	24 F	29%	122	
Day Programmes	18	44	26 F	59%	240	348	108 F	31%	523	
Minor Disability Support Expenditure	8	9	1 F	11%	67	72	5 F	7%	107	
Respite Care	102	155	53 F	34%	1,066	1,149	83 F	7%	1,729	
Child Development	-	-			-	-			0	
Community Health Services & Support	19	52	33 F	63%	422	418	(4) U	(1%)	626	
Inter District Flow Disability Support	329	344	15 F	4%	2,722	2,753	31 F	1%	4,129	
	10,621	**10,987**	**366 F**	**3%**	**95,375**	**93,894**	**(1,481) U**	**(2%)**	**142,076**	
Total Disability Support Services	**12,762**	**13,128**	**366 F**	**3%**	**112,626**	**111,145**	**(1,481) U**	**(1%)**	**167,894**	

Disability Support Services expenditure variance notes;

11. **Home Support -** $0.62m unfavourable YTD.
    Due to over budget IBT expenditure (revenue offset).

12. **Residential Care Rest Homes** - $0.49m unfavourable YTD
    Due to a mix of price and volume variances to budget along with savings targets not met.

13. **Residential Care Hospitals -** $1.04m unfavourable YTD.
    Due to a mix of price and volume variances to budget along with savings targets not met.

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Public Health

Public Health February 2018	Current Month Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Year to Date Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Annual Budget $(000)	Variance Note
Public Health - Provider Arm										
Alcohol & Drug	-	-	- F		-	-	- F			
Communicable Diseases	37	4	(33) U		63	30	(33) U		44	
Mental Health	-	-			-	-				
Screening Programmes	-	-	- F		-	-	- F			
Nutrition and Physical Activity	-	-	- F		-	-	- F			
Physical Environment	-	-	- F		-	-	- F			
Public Health Infrastructure	-	-	- F		-	-	- F			
Sexual Health	-	-	- F		-	-	- F			
Social Environments	-	-	- F		-	-	- F			
Tobacco Control	34	34	-		273	273	-		410	
	71	38	(33) U		336	303	(33) U		454	
Public Health - NGO										
Mental Health	4	15	11 F		57	120	63 F	53%	180	
Nutrition and Physical Activity	37	38	1 F		300	303	3 F	1%	454	
Physical Environment	-	-			-	-			0	
Public Health Infrastructure	-	-			-	-			0	
Sexual Health	-	-			-	-			0	
Social Environments	-	-			-	-			0	
Tobacco Control	7	7			53	53			80	
Well Child Promotion	-	-			-	-				
	48	60	12 F	10%	410	476	66 F	14%	714	
Total Public Health	119	98	(21) U	6%	746	779	33 F	4%	1,168	

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Public health expenditure variance notes;

No significant variances.

Maori Health Expenditure

Maori Health February 2018	Current Month Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Year to Date Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Annual Budget $(000)	Variance Note
Maori Health - Provider Arm										
Maori Service development	16	16			128	128			191	
Maori Provider Assistance Infrastructure	-	-			-	-				
Maori Workforce Development	-	-			-	-				
Minor Maori Health Expenditure	-	-			-	-				
Whanau Ora Services	8	8			64	64			98	
Maori Health - Provider Arm Total	24	24			192	192			289	
Maori Health - NGO										
Maori Service development	21	21			164	165	1 F		250	
Maori Provider Assistance Infrastructure	-	-			-	-				
Maori Workforce Development	-	-			-	-				
Minor Maori Health Expenditure	-	-			-	-				
Whanau Ora Services	65	80	15 F	19%	527	639	112 F	-18%	956	
Maori Health - NGO Total	86	101	15 F	15%	691	804	113 F	14%	1,206	
Total Maori Health	110	125	15 F	12%	883	996	113 F	11%	1,495	

Maori Health Services expenditure variance notes;

No significant variances.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CONTRACTS REGISTER**
Report to:	Community & Public Health and Disability Support Advisory Committees
Date of Meeting:	21 March 2018

Summary:

Funding contracts signed under delegation by Executive Director Planning & Funding and Chief Executive Officer and contracts approved by the Commissioner executed since last report.

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

Financial:	Nil
Workforce:	Nil
Other:	Nil

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

Prepared by: Planning and Funding Staff **Date:** 7 March 2018	**Presented by:** Lisa Gestro Executive Director Strategy, Primary & Community

RECOMMENDATION:

1. That the Committees note the attached Contracts Register.

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) JANUARY - FEBRUARY 2018

PROVIDER NAME	DESCRIPTION OF SERVICES	ANNUAL AMOUNT	CONTRACT/VARIATION END DATE	APPROVED BY
Contract Value of - $0 - $100,000 (Level 3)				
Nga Kete Matauranga Pounamu Charitable Trust New Agreement	Stop Smoking Incentive Programme	$90,000.00	30-Nov-18	ED, SP&C 05-Dec-17
Arai Te Uru Whare Hauora Limited Variation to Agreement	Well Child Tamaraki Ora Services	$1,448.00	30-Jun-18	GM, PC&PH 28-Nov-17
Te Runaka O Awarua Charitable Trust Variation to Agreement	Well Child Tamariki Ora Services	$6,448.05	30-Jun-18	GM, PC&PH 29-Nov-17
Maniototo Health Services Ltd Variation to Agreement	Well Child Tamariki Ora Services	$374.50	30-Jun-18	GM, PC&PH 29-Nov-17
Pacific Trust Otago Variation to Agreement	Well Child Tamariki Ora Services	$1,448.05	30-Jun-18	GM, PC&PH 29-Nov-17
University of Otago - Student Health Services Variation to Agreement	Primary Care Services	$2,539.10	31-Mar-18	GM, PC&PH 12-Dec-17
Royal New Zealand Plunket Trust Assignment of Agreement	Perinatal Mental Health Specialist Community Service (Assigned from Royal NZ Plunket Society)	$13,933.33	30-Apr-18	GM, MHA&ID 05-Dec-17
PACT Group Variation to Agreement	Individual Funding Agreement for NHI AKQ6824	$13,970.70	28-Feb-18	GM, MHA&ID 05-Dec-17

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) JANUARY - FEBRUARY 2018

Otago Care Limited t-a Woodhaugh RH & H Variation to Agreement	Short Term Palliative Hospital Level Care	Demand Driven	03-Aug-20	GM, CS 28-Nov-17
Presbyterian Support Otago Inc Variation to Agreement	Dementia Day Activity	*Est* $27,000.00 Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
Presbyterian Support Otago Inc Variation to Agreement	Day Activity	*Est* $78,813.00 Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
Ripponburn Holdings Limited Variation to Agreement	Day Activity	*Est* $6,755.40 Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
Milton Elder Care Trust Variation to Agreement	Day Activity	*Est $17,043.00* Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
Parata Anglican Charitable Trust Board Variation to Agreement	Day Activity	*Est* $15,762.60 Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
Central Southland Hospital Charitable Trust Variation to Agreement	Day Activity	*Est* $13,523.25 Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
Mosgiel Elderly Care Trust Variation to Agreement	Day Activity	*Est $81,510.00* Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
Waiau Health Trust Limited Variation to Agreement	Day Activity	*Est $14,820.00* Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) JANUARY - FEBRUARY 2018

Central Otago Health Services Limited Variation to Agreement	Speech Language Therapy - Lakes District	$13,092.00	30-Jun-18	GM, PC&PH 21-Dec-17
The Oamaru Mental Health Support Charitable Trust Variation to Agreement	Adult Activity Based Rehabilitation	$58,764.46	30-Sep-18	GM, MH& ID 30-Jan-18
St John's Parish (Roslyn) Friends of the Aged & Needy Society t-a Leslie Groves Variation to Agreement	Day Activity	*Est* $61,924.5 Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
WellSouth Primary Health Network Variation to Service Schedule	GP Champions Mental Health & Addictions	$40,000.00 (Total Contract Value $12,000.00)	31-Mar-21	GM, MH& ID 01-Feb-18
WellSouth Primary Health Network Variation to Service Schedule	Reducing Inequalities Voucher Service	$35,555.00	31-Mar-19	ED, SP&C 15-Feb-18
Good Partners Senior Care Limited Variation to Agreement	Dementia Day Activity	*Est* $36,162.00 Demand Driven	30-Sep-18	ED, SP&C 10-Jan-18
	Total for Level 3	**$277,573.19**		
Contract Value of - $100,000 - $500,000 (Level 2)				
WellSouth Primary Health Network New Service Schedule	Urgent and Episodic Services	$143,801.84 (Total Contract Value $215,702.65)	30-Jun-19	ED, SP&C 30-Nov-17

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) JANUARY - FEBRUARY 2018

Royal New Zealand Plunket Trust Assignment of Agreement	Pregnancy & Parenting Education (Assigned from Royal NZ Plunket Society)	$131,250.00 (Total Contract Value $218,750.00)	31-Mar-19	ED, SP&C 05 Dec 17
Waitaki District Health Services Variation to Service Schedule	Community Rehabilitation & Older Peoples Service	$180,000.00	30-Jun-18	ED,SP&C 15-Feb-18
	Total for Level 2	**$ 311,250.00**		
Contract Value of - $500,000 - 1 Million (Level 1)				
	Total for Level 1	**$ -**		
Contract Value of - $1 Million and Over (Commissioner)				
	Total for Board Level	**$ -**		
	Grand Total	**$ 588,823.19**		

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Closed Session:

RESOLUTION:
That the Disability Support and Community & Public Health Advisory Committees reconvene at the conclusion of the public excluded section of the Hospital Advisory Committee meeting and 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 (NZPHA) 2000 for the passing of this resolution are as follows:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.