SOUTHERN DISTRICT HEALTH BOARD

DISABILITY SUPPORT ADVISORY COMMITTEE
and
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Thursday, 24 May 2018
commencing at the conclusion of the public
Hospital Advisory Committee meeting

Board Room, Community Services Building,
Wakari Campus, Dunedin

A G E N D A

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

Item

1. **Apologies**
2. **Interests Register**
3. **Minutes of Previous Meeting**
4. **Matters Arising**
5. **Review of Action Sheet**
6. **Strategy, Primary & Community Report**
7. **Annual Plan 2017/18 Progress Report (Q2)**
8. **Financial Report**
9. **Community Health Council**
   - 9.1. First Year
   - 9.2. Engagement Forums with Staff and Communities
10. **Southern Primary & Community Strategy & Action Plan**
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:	**INTERESTS REGISTERS**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	24 May 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:

- Kathy Grant - Dunedin Sinfonia Board removed and spouse's interests updated;
- Susie Johnstone - West Otago Health Ltd, West Otago Health Trust and Clutha Community Health Co Ltd removed.

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 08/05/2018

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 (Deleted 16 April 2018)	
	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 (Deleted 16 April 2018)	
	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~~, Chair Dunedin Diocesan Trust Board	Nil (Updated 16 April 2018)	
	25.06.2015	~~Director, Nominee companies associated with Gallaway Cook Allan~~	Nil (Deleted 16 April 2018)	
	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~~ Removed 16.04.2018	~~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~~ Removed 16.04.2018.	~~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	
	01.09.2016	Southern DHB, Disability and Support Advisory Committee	Possible conflict with SDHB contract funding.	

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
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.	
HAC Member	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~~	Deleted - change of title - 6/3/2018
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	
	06.03.2018	SDHB, Te Punaka Oraka, Public Health Nursing, Charge Nurse Manager	Nil	
	06.03.2018	Member of the New Zealand Nurses Organisation	Possible conflict when negotiations are taking place.	
	06.03.2018	Member of the Public Service Association (PSA)	Possible conflict when negotiations are taking place.	
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	

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
	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.	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust

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	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 Wednesday, 21 March 2018, commencing at 10.05 am, in the Board Room, Southland Hospital Campus, Invercargill

Present:	Mrs Kathy Grant	Commissioner
	Mr Richard Thomson	Deputy Commissioner
	Ms Donna Matahaere-Atariki	Committee Member (by videoconference until 11.20 am)
In Attendance:	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary & Community
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Julie Rickman	Executive Director Finance, Procurement & Facilities (by videoconfernce)
	Mrs Jane Wilson	Chief Nursing & Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary (by videoconference)

1.0 APOLOGIES

An apology was received from Mr Graham Crombie, Deputy Commissioner.

2.0 PRESENTATION: *HOME AS MY FIRST CHOICE*

Sally O'Connor, Director of Nursing, Primary & Community, gave a presentation on *Home as my first choice*, an initiative to support older people to remain in their own home as long as possible and prevent unnecessary rest home or hospital admissions (tab 2). The initiative was due to be officially launched on 9 April 2018 and would be linked to other programmes such as *Falls prevention* and *Releasing time to care.*

Following her presentation, Ms O'Connor answered questions about home care, and engagement with the Community Health Council, residential care providers, Age Concern, and Grey Power.

The Chief Medical Officer advised that the next step was broader community development and engagement to help older people achieve what they want to do.

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 25 January 2018 be approved and adopted as a true and correct record."

Agreed

5.0 MATTERS ARISING AND REVIEW OF ACTION SHEET

The Committees reviewed and noted the action sheet (tab 6).

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

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 following items.

- The planning package for 2018/19 had still not been received from the Ministry of Health, nevertheless work had commenced on the draft 2018/19 Annual Plan.
- The draft annual NGO Audit Plan would be submitted to the Finance, Audit & Risk Committee in April.
- Implementation of the Primary and Community Care Strategy was continuing. An invitation for expressions of interest for healthcare homes was being prepared to be released in April, with a view to going live with tranche one practices on 1 July 2018. Plans for engagement on locality networks were also being prepared.
- A business case to achieve better utilisation and integration of primary care and Emergency Department access in Invercargill would be submitted to the Commissioner's meeting in April.
- The proposed model of care and final consultation document on primary maternity care was released during the month and had resulted in significant interest, with a large number of submissions received. A presentation to the Lumsden community was scheduled for that evening.
- The DHB was engaging with Lead Maternity Carers (LMCs) in Wanaka in regard to their workforce issues. SDHB would be providing 90 day locum cover for the area and supporting them with recruitment. To assist the situation, the development of a maternal and child hub in Wanaka was being fast-tracked.
- Consultation on the new national pharmacy agreement had commenced.

In response to questions from Committee members, the EDSP&C:

- Outlined WellSouth's plans to increase the uptake of influenza vaccination;
- Advised that the Lakes District Hospital rebuild operational group was set up to oversee day to day operational matters and ensure issues were being escalated appropriately; it was not a governance group.

Public Health

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

Joint Working Group for Drinking Water

The Committees endorsed the proposed approach to set up a joint working group to enable a collaborative approach across the district to protecting drinking water.

7.0 COMMUNITY HEALTH COUNCIL

P*rofessor Sarah Derrett, Chair, and Charlotte Adank, Facilitator, Community Health Council, were in attendance for this item.*

Community, Whānau and Patient Engagement Framework and Roadmap

Professor Derrett presented a proposed framework and roadmap for community, whānau and patient engagement (tab 8). She outlined the process for developing the principles guiding the framework and the consultation that had taken place on them. Professor Derrett advised that it would be an evolving process and the Community Health Council was keen to set up a mechanism for feedback.

Recommendation:

"That the Commissioner endorse the finalisation of the community, whānau and patient engagement framework and roadmap, and implementation."

Agreed

8.0 PERFORMANCE REPORT – QUARTER TWO

An overview of performance against Health Targets and performance measures for the second quarter of 2017/18 was circulated with the agenda (tab 9) and noted as work in progress.

The Commissioner observed that:

- The provision of community podiatry services had been mooted for some time;
- Reporting against system level measures was required for the Annual Report.

9.0 FINANCIAL REPORT

The Funder financial results for February 2018 (tab 10) were taken as read and the EDSP&C took questions.

Recommendation:

"That the report be received."

Agreed

10.0 CONTRACTS REGISTER

The Funding contracts register for January-February 2018 was circulated with the agenda (tab 11) for information.

Recommendation:

"That the Contracts Register be noted."

Agreed

CONFIDENTIAL SESSION

At 11.15 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 11 May 2018

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
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.	POAC will roll out through WellSouth 1 July 2018.

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SOUTHERN DISTRICT HEALTH BOARD

Title:	**Strategy, Primary & Community Report**		
Report to:	Commissioner Team		
Date of Meeting:	24 May 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:** 14th May 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

Health of Older People

Home & Community Support Services – additional services

Due to our forecasted hours for Bulk Funded HCSS for older people being lower than expected, we have agreed with our Alliance providers to trial some overnights shifts and large packages of care on a temporary basis, to see if this will make a difference to keeping older people in their homes for longer. The trial will start immediately and go through the end of this financial year. We often hear that a lack of overnight care and large packages are barriers to keeping older people at home. This will give us better information to determine if these services are effective, and should help to see the positive trend in aged care admissions continue in the near future, giving us a clear run to year end as we reset our budget expectations in this area.

Home & Community Support Services – Workplan for 18/19 year

Our HCSS Alliance has agreed to the following workplan for the 18/19 year, spreading the work across the Alliance. In addition, there is agreement to trial Future Models of Care per the anticipated MOH Framework.

1. Develop on Outcomes/Reporting Framework

   Client Focussed/Client Experience

   Results Based Accountability Framework

   - What do we do?
   - How well do we do it?
   - Is anyone better off?

   Consider evaluation/baseline state

2. Develop Best Practice Guidelines

   Refer to interRAI Visualisation Tool and "Characteristics" infographic

   Examples, STOP and WATCH, Carer Stress Tool, IBT

3. Consider Funding Models (BF vs FFS) for all contracts, and Palliative vs Short Term
4. Integrating HCSS in Hospital Avoidance and Early Supported Discharge (HOME)/Exploring Options for One Team developments

Age Related Residential Care (ARRC) and Emergency Department (ED) Presentations

As part of "Home as my first choice" we have now begun to more robustly analyse ED Presentation from ARRCs. This has shown quite a variance in rate of residents presenting to EDs between facilities. This information has been presented to facilities at regular meetings in Dunedin and Invercargill and follow up with "high presenting facilities" has been scheduled to identify issues that may be resulting in unnecessary ED presentations for their residents.

Public Health Service

Joint Working Group Proposed for Drinking Water - Update

Further to our last report, the inaugural joint southern agency drinking water group meeting was held via videoconference on 19 April. This had good attendance from all regional and local Councils and the intention to cooperate with each other was high. A common issue for the agencies was a lack of depth in the staff available across New Zealand, across all levels from operator to consultancy expertise. This is slowing progress on infrastructure design and decision making. The group agreed to focus on risk management, and interagency response plans and communication protocols including common escalation processes was high priority for all. The group will meet again once the government response to the Havelock North Inquiry is released to discuss any recommendations and their implications.

Home Performance and Health Workshop

In May, Southern DHB with the support of the Cosy Homes Trust ran a series of four workshops (three in Dunedin and one in Invercargill) on Home Performance and Health. This was jointly funded through Public Health and Sudden Unexpected Death in Infancy (SUDI) funding. This recognises the impact cold and damp housing has on the health and welfare of our whanau and communities, and realises the potential that our community providers have to engage with families about how to keep their homes warmer and dryer to improve health outcomes.

A wide range of community services and agencies attended the workshops. This included Non-Government Organisations, Māori and Pacific providers, Well Child Tamariki Ora providers, social services and DHB staff. Just under 70 people attended across the four sessions. Feedback from participants has been extremely positive with many reflecting on not only how they will use this information to support their clients, but with their own homes and whanau.

Participants will be invited back to a follow up workshop in June to share their experiences and identify other issues around housing that may need to be addressed.

Hepatitis A Outbreak

The Communicable disease team was kept very busy with high profile outbreaks this month. Two cases of hepatitis A were notified and followed up in Oamaru. During contact tracing it was noticed that the children of the second case attended the same kindergarten as the first case. Following a review of the Ashburton outbreak in 2013 which involved vaccinating over 1500 people over six months, it was decided more information was required before vaccinating all children attending the kindergarten. A key learning from Ashburton was the role children had in transmitting infection because they often have asymptomatic or unrecognised infections.

Public Health attended a staff and parent meeting at the kindergarten to determine a way forward. By the end of the session everyone was comfortable with public health staff undertaking screening for hepatitis A prior to vaccination. A phlebotomy clinic was held on Tuesday 10 April staffed by two experienced phlebotomists from Southern Community Laboratories (SCL), where 55 children were screened and a medical officer of health was on site to answer queries. Kindergarten staff managed the rotation of children to a local medical centre for vaccination. SCL staff fast tracked the blood testing and had the results to public health staff that evening. Three further cases of Hepatitis A were identified through the screening process. Vaccination clinics were held on 12 and 13 April with the kindergarten, again with the support of the local medical centre.

We took the opportunity to undertake a clinical assessment of the Oamaru public health nurses to vaccinate under 9 year olds by having an immunisation coordinator on site during

the clinics. More than 20 additional contacts have been identified that are associated with these new cases and follow up is progressing. No new cases have occurred.

Measles

Over the past month measles cases have been reported in reported in Southern, Canterbury, Nelson-Marlborough, Hamilton and Auckland districts. Fourteen cases have been linked to an outbreak associated with Queenstown and Christchurch airports. Further cases, from contact with current known cases, are likely and may present up until the end of May.

Public health units have responded by interviewing cases, conducting contact tracing, and providing information and advice about vaccination and how to prevent spreading the disease. Canterbury has taken on the role of incident controller for this outbreak as this was the origin of the first case.

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.

Since our last report we have submitted on the following:

- Long Term Plans for Southland District Council, Queenstown Lakes District Council, Dunedin City Council, Invercargill City Council, Central Otago District Council, Clutha District Council, Gore District Council and Otago Regional Council.
- Queenstown Lakes District Council: Draft Reserve Management Plan, Wanaka Recreation Reserves.
- Invercargill City Council Health and Hygiene Bylaw.
- Environment Southland: Tokanui discharge permit and land use consent for disposal of wastewater from Tokanui township sewage system.
- Central Otago District Council Draft Waste Management and Minimisation Plan.
- Sale and Supply of Alcohol amendment Bill.
- National Cervical Screening Programme Amendment Bill.
- Child Poverty Reduction Bill.

2. STRATEGY AND PLANNING

Annual Plan

The MOH published its draft 2018/19 planning guidance on 11th May and at the time of writing the guidance is still being analysed. A high level outline of the 2018/19 Government Priorities and a timeline for review/submission dates has been provided in the interim. A timeline is currently being worked up to ensure that there is adequate time for the required internal sign-off before submission to the MOH.

Government Priorty	Status of Priority
Mental Health	Existing
Child Health	Existing
Healthy Ageing	Existing
Disability Support Services	Existing
Pharmacy Action Plan	Existing
Improving Quality	Existing
Primary Care Access	Was Primary Care Integration in 2017/18
Fiscal Responsibility	Was Living Within our Means in 2017/18
Public Delivery of Health Services	**New**
School-Based Health Services	**New**
Climate Change	**New**
Waste Disposal	**New**
Budget 18 Initiatives once confirmed	TBC
Health Targets once confirmed	TBC
Cross-Government Targets once confirmed	TBC

Submission / Review Timeframe

Activity	Date
DHB are to provide the final Statement of Performance Expectations	By 29 June 2018
Submit final System Level Measure Improvement Plan	By 29 June 2018
System Level Plan approved	31 July 2018
DHBs submit draft Annual Plans, including budgets, updated Statements of Performance Expectations, Regional Service Plans, and Public Health Unit Annual Plans to the Ministry.	Monday 16 July 2018
Ministry expects to provide informal feedback to DHB and Regional Planners	From Monday 13 August 2018
Ministry expects to facilitate formal feedback on DHBs draft Annual Plans, Regional Service Plans and, Public Health Unit Annual Plans.	Week beginning Monday 3 September 2018

Audit

Routine NGO Audits Programme – contracted via **Central Region's Technical Advisory Services (Central TAS)** - Central TAS Audit and Assurance team delivers the NGO Provider Audit Programme on behalf of Southern DHB. These audits focus on quality and risk management systems under the Health and Disability Services (Safety) Act 2001 and the provision of healthcare services by NGO providers. Where an NGO provider also selects Central TAS as their Designated Audit Agency (DAA) for certification a combined audit is scheduled. While routine audits and evaluations are planned and conducted annually issues-based audits and reviews may arise from ongoing complaints or concerns about the service the provider is delivering. These focus on specific areas of the services.

Strategy and Planning have confirmed the 2018/19 Audit Plan with Central TAS, this will be submitted to Financial Audit and Risk Committee's (FARC) 28 May 2018 meeting for endorsement.

Vulnerable Children Act 2014 (VCA)

As reported in the February report, 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 Contracts team met with the Central TAS Manager of the Provider Audit Programme on 18 April 2018 to discuss VCA audits

Central TAS will develop a brief outlining the scope, methodology, people involved and responsibility, cost & timelines for providing 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 will be submitted to FARC's 28 June 2018 meeting for their consideration/decision.

3. PRIMARY CARE

The primary and community care strategy is currently being discussed with a number of interested GP practices, the Strategy is still in Draft. An expression of interest has gone out to the sector, with tranche one being split into two intakes. Practices that are not successful in tranche one, if there are any, will be supported through the POAC and CLIC programmes as well as support to develop some programmes in readiness for moving formally onto the HCH programme.

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. A view to what the end point looks like is being developed to focus the work within locality development. This is ongoing.

Pharmacy

The Pharmacy Action Plan 2016-2020 sees pharmacist services as a critical part of an integrated model of care, delivered in innovative ways so all New Zealanders have access to medicine and health care services. We are proposing a new pharmacist services contract to support pharmacists as experts in medicine management.

Consultation has closed and a significant number of responses are now being analysed. Due to the volume and time required it is expected that a three month extension will be taken to the market for the existing contract. Some variation to the proposed new contract is expected following analysis of the consultation feedback.

The one off funding in 2017-18 that expires June 2018 will need to be reviewed. Initial planning was for this funding to only be available through the new contract (schedule 3c). Given the planned extension to the existing contract for a further three months we will need to plan how to use this funding (currently includes LTC, Smoking cessation and workforce development). This represents an opportunity to progress consultation at a local level, improving relations with the sector and developing a set of pharmacy services that are developed in partnership with our local community pharmacies.

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

Work continues progressing through the data collection stage to solutions being defined. Phase two is an SDHB process to secure engagement with inpatient teams. Internal Medicine is likely to be the first to participate. Phase three is being conducted in tandem by WellSouth, assessing primary care capacity.

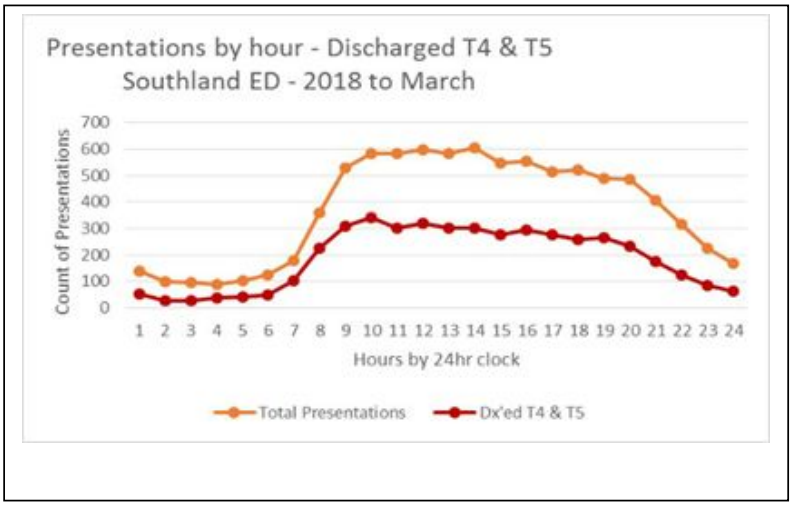
We have encountered an issue with relocating the Triage space within ED. The preferred room has a fire rated window that would ideally be a sliding window to enable the triage function. Costing are pending but are likely to be greater than initially thought. A new work stream has

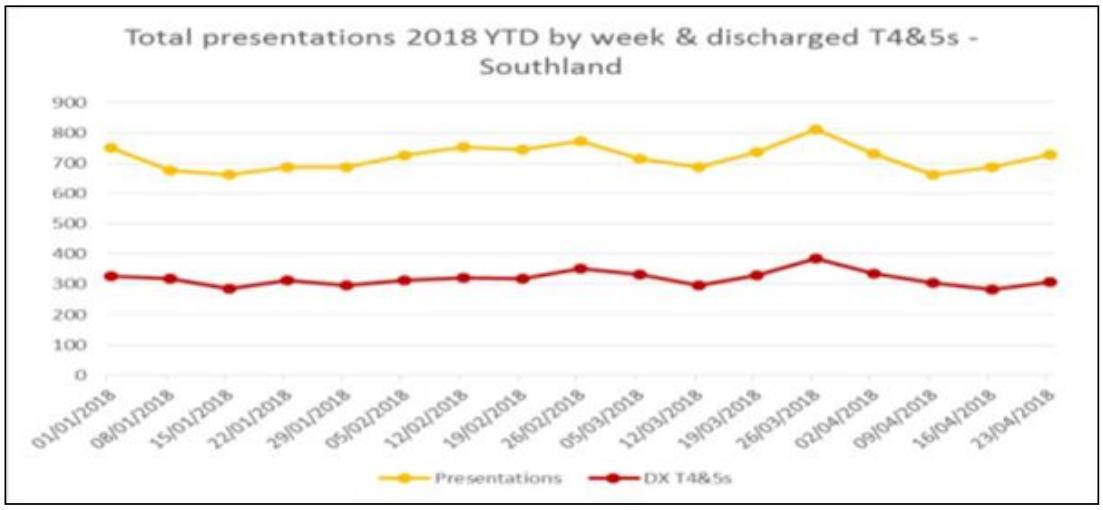
been identified by the CNM to move the Eye Room into a trial space in a large storeroom. This will add an additional treatment space in the ambulatory section of the ED.

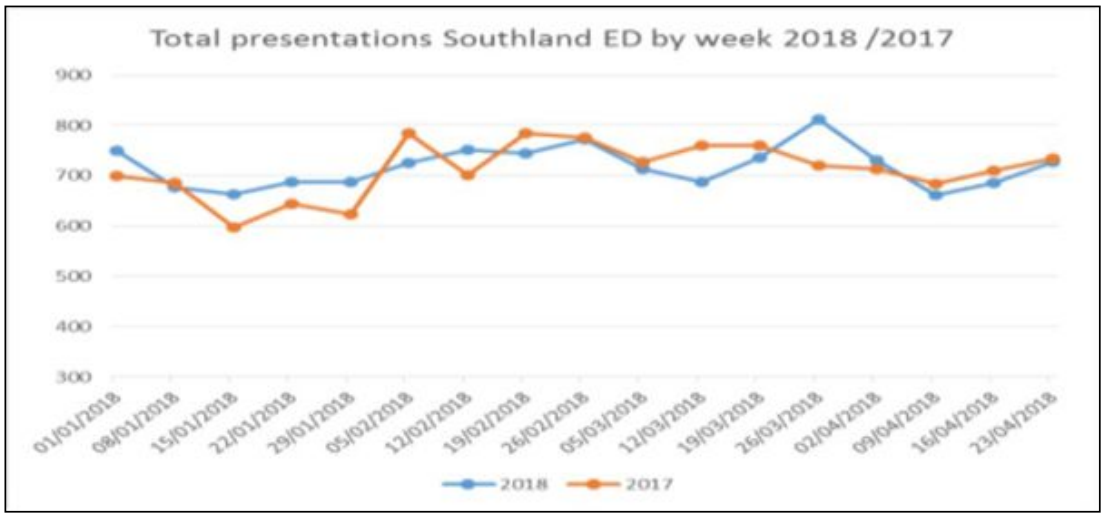
The following list details the A3 currently being worked on by Southland ED

- Triaging and admin processes – streamlining the process. Some minor facility changes have been identified that would enhance the Triage process – currently awaiting quotes from Dunedin to implement changes.
- Mental Health pathways and backup plans – SMET service not always available to ED due to providing service elsewhere e.g. Queenstown. Good progress has been made with the SMET service and availability has improved. A repeat of data collection will be done in April/May to assess if this improvement has been sustained.
- 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. The focus on this issue has led to an improvement with few occurrences recently, however data collection continues, mainly to keep this issue current.
- 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. Data has been received and is being analysed.

The focus is currently on after hour's care, however the presentation data indicates that there is a need for improved access to acute primary care from 8am right through to 9pm with a quick tapering off of numbers closer to mid-night. The collection of discharged Triage 4 & 5s provides a crude measure of potential primary care patient, but is an indicator of where gains could potentially be made.







HealthPathways

Twelve pathways went live in April (a total of 515 are now live):

- Allergic Rhinitis/Nasal Obstruction
- Allergy
- Anticoagulation Therapy for DVT and PE
- B4 School Check
- Depression in Older Persons
- Infectious Keratitis
- IV Iron Infusion
- Rhinosinusitis
- National Bowel Screening Programme (NBSP)
- ST-elevation Myocardial Infarction (STEMI)
- Vaginal Candidiasis
- Warfarin Over-anticoagulation

The 10 most frequently viewed pathways for the month of April were:

1. Zoledronic Acid Infusion
2. Acute Otitis Media
3. Bowel Cancer Screening
4. Hyperlipidaemia

5. Atrial Fibrillation (AF)
6. Constipation in Children
7. Deep Vein Thrombosis (DVT)
8. Otitis Media with Effusion (Glue ear)
9. Bariatric Surgery
10. Renal Colic

HealthPathways had 23,987 page views in April 2018 with an average page view per session of 4.56. Of the 1,402 users who viewed pages on HealthPathways, 770 (54.9%) of these were new users to the site. The number of sessions per user was 3.75.

Initial discussions with Radiology to agree Ultrasound pathways that could be worked on to assist with the high volume of ultrasound referrals has occurred. A meeting with identified key people will be the first step to progress this further.

Members of the HealthPathways team presented an overview and introduction to HealthPathways and an update on HealthInfo to the Community Health Council which was well received. Of particular interest was HealthInfo with a desire from the Council to be involved and updated on progress.

4. RURAL HEALTH

Rural Managers' Network – Changes to Non Acute Rehabilitation (NAR) funding by ACC

Facilitation of a discussion between the Rural Manager's Network and ACC on the proposed changes to NAR funding.

ACC are proposing a move away from their traditional method of funding for this activity to a system which will improve their clients' experience and outcomes. This will principally be done by;

- Development of new pathways by co design for these patients.
- Developing an outcome based quality improvement approach
- Development of alternative funding models (casemix model)

ACC are proposing a new interim contract from December 2018 with a gradual move to casemix based contracts by November 2022. ACC are seeking our support and endorsement of this approach.

Primary Maternity Project
The Primary Maternity Project is progressing with a focus on a number of work areas:

1. Oamaru

Oamaru Maternity Centre is currently experiencing decreased staffing levels. They are employing locums as and where able. The difficulty with this is that there is a nationwide shortage of midwives so roster coverage is proving challenging for the service.

The situation is being reviewed regularly in conjunction with the Director of Midwifery and the Portfolio Manager Child, Youth and Maternity. Changes have been made to the teams within the service and women and all other relevant services are being asked to support the following contingencies:

- Women are asked to confirm with their midwife appropriate timeframes for calling when in labour;
- Hospital medical and nursing staff at Oamaru Hospital are asked to continue provide emergency support to maternity when necessary;
- Queen Mary staff are asked to provide distance support, including support for labour transfers if required;

- St John are asked to provide transport assistance as and when needed, including air transport arrangements.

2. Queenstown

Queenstown LMCs have indicated that there will be a shortage of LMCs in late May, June and July. A meeting was held with core midwives from Lakes District Hospital and local LMCs where they agreed some principles for picking up secondary care tasks whilst on shift. This will offer time relief to LMCs. The issue of LMCs undertaking secondary care activity is arising as a district wide issue.

Monthly meetings with the Executive Director, Strategy Primary and Community and the Director of Midwifery and local LMCs continue.

3. Wanaka/Central Otago

Work relating to the DHB provision of locum support in Wanaka continues to occur. Considerable time and effort has been expended in engaging with locum LMCs and local LMCs, establishing and procuring equipment to the locum kits. This work has been well supported by WellSouth PHO who are employing the locums.

Work also continues on the establishment of a maternal and child hub in Wanaka. Physical space for the hub within the medical centre has been secured and about the LMCs are engaging with the practice about how they can be more integrated with local primary care services. Development of precisely what the hub will be and how it will work with and for the community continues.

Independent contractors Laura Aileone and Margo Kylie have submitted their draft report on workforce sustainability approaches for the Central Otago (Wanaka, Queenstown Lakes and Alexandra) area. We also extended the contract to include the Lumsden and Te Anau area. Recommendations within the report are currently being considered.

4. Lumsden/Northern Southland

Workforce sustainability issues for LMCs within the Northern Southland district are now included within the larger piece of work being completed by Laura Aileone and Margo Kylie. This will help inform decision making in relation to the future of primary maternity birthing at the Lumsden Maternity Centre (LMC).

Consideration of safety issues relating to travel distances across the Northern Southland district, especially in relation to travel distances for women from the Te Anau district, are being investigated to inform final decision making in relation to LMC.

5. Feasibility study – establishment of primary maternity birthing in Dunedin

Laura Aileone and Margo Kylie have commenced work on a feasibility study of primary maternity birthing in Dunedin. They will produce a report which will include an analysis of the following three Dunedin primary maternity facility options:

1. Dunedin Hospital Rebuild collocation with secondary and tertiary services
2. DHB funded and owned standalone primary maternity facility
3. Third party capital with DHB contract for standalone primary maternity facility.

The final report will provide initial information for Southern DHB ELT to review with consideration as to whether a more detailed feasibility study should be commissioned. The report will provide enough detail to allow decisions on next steps to be made and a full feasibility may not be deemed appropriate. The report will also include a comprehensive literature search.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Quarter Three 2017/18 Southern DHB Annual Plan Reporting**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	24 May 2018

Summary:

Overview of DHB Annual Plan Reporting for **Quarter Three 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:** 11 May 2018	**Presented by:** Lisa Gestro Executive Director Strategy, Primary and Community

RECOMMENDATIONS:

That the Disability Support and Community & Public Health Advisory Committees note the content of this paper.

Progress	Milestones Dashboard
●	On Target
●	Caution
●	Critical
●	Complete
●	Not Started
Reporting Schedule	
Quarter 1	July – September
Quarter 2	October – December
Quarter 3	January – March
Quarter 4	April - June

Southern DHB Annual Plan 2017/18 –Progress Report Quarter 3

Quarter 3 - Progress Report

Strategy, Primary and Community

Delivering on Priorities and Targets

Progress on the Annual Plan 2017/18

This template outlines how Planning and Funding is to monitor progress on delivering on the plans, actions and commitments in the Southern DHB 2016/17 Annual Plan.

A report will be produced at the end of each quarter that will contain an indication of progress against plan, and where necessary a brief narrative if activity is behind plan. This will highlight achievements (useful for reporting to the Ministry of Health/NHB) and also flag any issues affecting delivery and potentially impacting on the timing or ability to complete.

Each action is directly from the Annual Plan and will have an identified executive **accountable** for delivery. A nominated person within the service will be **responsible** for delivery and will be the key contact for progress reports and data.

Key quantitative measures will be added as the data becomes available to show outputs and impacts of actions. These are linked to another spread sheet which is being used to collate all the data for performance measures into a single point. This will assist our obligations in reporting on the Statement of Performance Expectations and the expectations of Audit New Zealand.

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PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

1 Increased Immunisation

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Increased Immunisation	Maintain immunisation coverage targets for children at eight months old	95% of eight month olds are fully immunised	Q_4	●	Results continue to fluctuate between 94% and 95% coverage. The team are reaching every child and documenting valid reasons children are not fully immunised at eight months.
	Achieve immunisation coverage targets for children at two and four years old.	95% of two year olds are fully immunised Q_4. 95% of four year olds are fully immunised Q_4.	Q_4	●	Quarter results so far this year fluctuate between 92-94%. The team remains confident they are 'Reaching Every Child.' The largest impact on the results continues to be the Immigrant / Refugee children who are either awaiting documented proof of overseas immunisation history or on active Catch Up Programmes. These children, while 'Missing Target,' are being managed in a clinically appropriate manner.
	Implementation of a targeted programme for seasonal influenza vaccine, especially those aged 65+ and Māori people. (EOA)	WellSouth PHN to work with practices on a targeted programme	Q_2	●	WellSouth is managing this as a priority.
	Increase coverage of Human papillomavirus (HPV) by ongoing engagement with the health and education sector, with a focus on Y7 and Y8 boy only schools.	Increase coverage for eligible boys and girls	Q_4	●	

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

2 Improving Access to Elective Surgery

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Improved Access to Elective Surgery	Delivery against agreed service volume schedule to meet the Electives Health Target.	Deliver 13,190[1] elective discharges	Q4	🟢	Volumes of discharges on track.
	Southern DHB to participate in the national elective initiative to improve production planning.	Programme plan developed by 31 July 2017	Q1	🔵	
		Implementation of the improved production planning process	Q3	🔴	Delivery of actual case weights to plan is behind on an YTD basis. Monitoring daily and working to recover.
	Southern DHB to continue the introduction of national scoring tools as they become available.	General Surgery tool to be rolled out in line with MoH expectations.	MoH timeframe	🟡	Some delay but planning to correct in Q4
	Complete a review of access to elective surgery for Māori and non-Māori DHB population using age-sex standardisation rates. (EOA)	Review undertaken	Q2	🟡	Accessing technical skills, expected to be complete by Q4
		Review findings will be investigated and improvements made as applicable	Q3		
	Increase Dunedin Hospital theatre capacity through the extension of theatre days and an additional weekend acute session.	Recruitment of workforce	Q2	🔵	
		Implementation	Q3	🟡	Additional Acute theatre list on Sunday has reduced the pre-operative length of stay considerably. Extension to theatre days in place and has reduced late cancellations on lists. Optimisation of lists to increase productivity is underway in some specialties however difficulties with beds has impacted on consistently utilising this capacity in theatre.

[1] This target includes the DHB and the indicative figures for the SI Regional Component and may vary.

🟢 On Target 🟡 Caution 🔴 Critical 🔵 Completed ⚪

Elective Surgery	Delivery on the agreed electives volume schedule to meet the Electives Health Target	Monitor performance against the elective surgery production plan - ongoing			Remains circa 400 CW behind. Close monitoring of theatre utilisation, additional outsourcing and close scrutiny of coded patient is being undertaken at all levels in the organisation.
	Production plans are developed, monitored, and where necessary modified, based on achieving (or working towards) performance requirements and equity of access	Elective standardised intervention rates - SI4 - ongoing			See above. However intervention rates are expected to have been achieved for most specialities.
	Prioritise patients using national, or nationally recognised tools, treating in accordance with assigned priority and waiting time, and implementing national tools as they become available				
	Continue refinement of the e-Referral tool Electronic Request Management System (ERMS) to help streamline and improve referral processes	Number of e-Referrals logged			
	Ongoing participation in the National Patient Flow System	Patient level data is reported into the National Patient Flow collection, in line with specific requirements			
	Undertake a district wide review of outpatient services focusing on equity of access; including a review of FSA to follow up ratios based on comparisons with the NZ ratio of first to follow ups	Engage with stakeholders and providers on implementing equitable volumes for sub-populations	Q2		Unable to be carried out due to other priorities. To start this work in Q4.
		Test feasibility of a single district wide waiting list for outpatient services	Q2		Unable to be carried out due to other priorities. To start this work in Q4.
	Implement Mobility Action Programme (MAP) as wrap-around (i.e. multi-disciplinary) approach to patients with osteoarthritis based in a community setting	Commence implementation of Mobility Action Plan (dependent on approval and funding from MoH)			WellSouth and the DHB were unsuccessful in their Request For Proposal (RFP). Contract was awarded to Rata South.
		Recruit lead Physiotherapist			WellSouth and the DHB were unsuccessful in their Request For Proposal (RFP). Contract was awarded to Rata South.
		MAP sessions planned and commenced	Q2		WellSouth and the DHB were unsuccessful in their Request For Proposal (RFP). Contract was awarded to Rata South.
		Evaluate MAP implementation	Q4		WellSouth and the DHB were unsuccessful in their Request For Proposal (RFP). Contract was awarded to Rata South.
Align Electives Delivery across the South Island	Continue active participation in the development of regional pathways that can then be localised to improve consistency in processes, equity of access and outcomes				We continue to develop agreements with other DHBs for Cardiac surgery (CDHB), General Surgery/Orthopaedics (South Canterbury) and private providers.
	Support the regional major trauma work-stream and the development and implementation of a three year action plan	Agree regional clinical guidelines for the management of trauma	Q4		
		Commence capturing and recording data for the NZ Major Trauma Minimum Dataset			
	Work with South Island DHBs to support the regional delivery of additional elective surgical discharges		Q4		At December the services were 410 case weights behind the production plan. There has been significant deterioration in January. Further work is required to bring this back into line.
	Support the South Island Alliance and Canterbury DHB working alongside Counties Manukau DHB, the Ministry of Health, ACC and the St John Ambulance Service to implement the national Spinal Cord Impairment Action Plan.				

On Target Caution Critical Completed

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

3 Shorter Stays in Emergency Departments

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Shorter Stays in Emergency Departments	**Develop and refine community-based acute demand services to reduce unnecessary hospital presentations**				
	Project Management Group established to reduce Invercargill ED presentations.	Project Group established and work plan developed.	Q1	●	Project management group established and regular meetings being held.
		WellSouth to work with Invercargill Urgent Doctors to build increased capacity for sustainable after-hours services	Q2	●	WellSouth are in discussion with IUD; there are plans for a Nurse led winter clinic.
	Continue to invest in acute demand services that provide primary care with options to support people to access appropriate urgent care in the community rather than in hospital.	Acute demand service Business Case finalised and agreed.	Q1	●	Complete
		Phased plan developed and implemented	Q2	●	Very close, roll out 1 July
		Review results with WellSouth and agree a management plan for those unscheduled patients who are more appropriately followed up by their General Practitioner.	Q2	●	
	Ensuring high-needs populations (Māori, in the first instance) are enrolled with primary care.	A data matching project will be undertaken to identify Māori ED attendances by NHI, address and ethnicity with a referral to WellSouth for un-enrolled patients.	Q2	●	Working through a process with ED. Potential risk as data matching is reliant on IT referral pathways.
	Undertake bed use analysis on the flow of patients from the community	Share results with WellSouth to improve understanding on contributors to bed block	Q1	●	From last report
	Implement a marketing campaign to remind and educate the community on the appropriate use of ED and alternative options	ED marketing campaign underway	Q3	●	Still to be commenced
	Shorter Waits in Emergency Departments				
	Develop a Medical Admission Unit (MAU) at Dunedin Hospital	Implement	Q2	●	MAU established at Dunedin Hospital.
		Review effectiveness of MAU	Q4	●	Effectiveness still be evaluated however there is ongoing weekly data capture and monthly review and discussion of efficiency and utilisation.
	Undertake quality improvement projects focussed on reducing delays and improved patient flow.	Projects to be confirmed to MoH (not required)	Q1	●	Number of projects underway.
	Installation of Lamson Tube System at Southland ED for transportation of blood test results.	Installation of system	Q2	●	Planning for implementation of Lamson Lube underway.
	Increase the number of allied health workforce in Dunedin ED.	Implement.	Q1	●	Home team established in the Emergency Department comprising of one physio and one OT. Currently temporary resource until June 2018 pending business case to extend.
		Evaluate impact of additional allied health workforce.	Q2	●	Not yet fully evaluated.
	Utilise the bed analysis tool and develop standardised processes to ensure bed capacity is utilised efficiently.	Implementation	Q1	●	Bed analysis tool is being utilised in Dunedin on a daily basis and it appears to accurately capture the data. Implementing variable response management in process.

● On Target ● Caution ● Critical ● Completed ●

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
		Review	Q3-4.		Review to commence at the end of the year.
	Review Accelerated Chest Pain Pathways (ACCPs) in emergency departments	Scheduled for auditing in 16/17 following the implementation in 15/16	Q4	●	Completed
	Complete the implementation of the ED Quality Framework	ED Quality Framework implemented	Q4	●	Work well underway anticipated to be completed by Q4
		Systems are in place to monitor all the mandatory and non-mandatory measures	Q4	●	Work well underway anticipated to be completed by Q4
		Report ED health target performance by Māori and Pacific ethnicity	Q1	●	
	Implement orthopaedic pathways for overnight care in ED	Introduce pathway for fractured neck of femur (NOF)	Q1	●	Operational on both sites
	Provide appropriate additional resource to improve performance of Invercargill ED	Introduce a community based attachment (second year House Officer) at Invercargill Medical Centre	Q2	●	Community runs are in place
		Extend FACEM hours	Q2	●	Extended to 16hrs a day

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

4 Faster Cancer Treatment

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Faster Cancer Treatment	Support the implementation of the Radiation Oncology National Linear Accelerator and Workforce Plan.	Radiation Oncology – review and evaluate heterogeneity of practice across South Island	Q4	●	This is being worked through.
	Review Multi-Disciplinary Meeting (MDM) system against national specification	Complete the rollout of regionally agreed MDM recommendations and service improvement initiatives	Q3	●	Completed.
	Plan for replacement of two Linear Accelerator	Replace Linear Accelerator at Dunedin site Q4.	Q4	●	On track.
		Second Linear Accelerator to be replaced at Dunedin site in 2018.		●	On track.
	A targeted approach for Māori using Faster Cancer Treatment (FCT) pathways. (EOA)	Provide a report on how many Māori have used FCT pathways.	Q2	●	Report complete (awaiting sign off to send to MOH).
		Assessment of gaps and implement changes where appropriate	Q4	●	Will be monitoring breaches in FCT for Māori.

5 Better Help for Smokers to Quit

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Better Help for Smokers to Quit	Development of an enhanced data analysis system that allows General Practices and PHO to drill down into smoking data at practice and clinician-level to highlight performance, improve smoking status recalls at 15 months and improve volume of referrals to Southern Stop Smoking Service	Analytics tool is fully functioning and reporting data	Q1	●	Completed. GPs are using smoking dashboard on a real time basis. Target exceeded for past three quarters and should be exceeded this quarter as well.
	Target priority populations through: Strengthening referral pathways between primary, secondary and community based care;	Well established and utilised referral pathways	Q4	●	
	Targeting young Māori pregnant woman to access the Southern Stop Smoking Service via Lead Maternity Carer (LMC) referrals; (EOA)	Increase referrals from LMCs to Southern Stop Smoking Service	Q3	●	Stop Smoking Service has a presence in both Maternity Units on a weekly basis to meet with women. Incentive scheme reintroduced.
	Utilising data intelligence from PHS and WellSouth PHN to target areas with high numbers of smokers.	Co-ordinated targeting of 'hot spots'	Q4	●	
	Improved linkages between Southern Stop Smoking Service and General Practice.	Southern Stop Smoking Service Coaches collaborating with General Practices and promoting their service.	Q4	●	
	Development of an outcomes framework for tobacco whereby performance of smoke free activity can be measured.	System wide outcomes framework established and utilised by smokefree steering committee	Q2	●	

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

6 Raising Healthy Kids

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Raising Healthy Kids	Establish a review process to monitor referrals and make necessary improvements to reduce decline rates.	Review process implemented.	Q1	●	
	Develop consistent key health messages, for providers working across the children's sector (0-5 years) with a focus on our Māori and Pacific populations, to support healthy weight guidance. (EOA)	Key messages are developed.	Q3	●	
		PHS to lead on this project and to work across the system with key stakeholders.	Q4	●	
	Evaluate the effectiveness of home visits (for children over 98th percentile) as part of the Share Care Model (Public Health Nurses-GPs).	Evaluation framework completed	Q3.	●	Delayed due to staffing shortages. Aimed to complete by end of quarter 4.

7 Childhood Obesity Plan

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Childhood Obesity Plan	Southern DHB to continue offering access to nutrition and physical activity programmes for families e.g. Active Families	Up to 90 families offered access to Active Families	Q4.	●	
	Evaluate the implementation of gestational diabetes screening of pregnant women across the Southern district.	Audit indicators in the guidelines	Q3.	●	Most indicator data is not available to SDHB as not collected by the laboratory or others.
		Audit the uptake of the guidelines	Q3	●	
	Normalise breastfeeding through the use of the app/ website BURP (Breastfeeding's Ultimate Refuel Place) [2] to advise partners of breastfeeding friendly places.	Number of users of app / website.	Q4	●	Numbers of users is growing.
		Number of contacts with venues	Q4.	●	
	Normalise healthy eating through Southern DHB role models ensuring good practice is shown around healthy food and beverage choices for staff, patients, whānau and visitors.	Removal of artificial sweetened beverages and carbonated drinks on DHB sites.	Q1	●	Work continuing. ASBs all removed.
		Introduction of healthy options for both food and beverages in vending machines.	Q1	●	Not complete. Discussion initiated with preferred supplier.
		Phase 2 implementation of healthy food and beverage environment policy	Q2-4.	●	Policy endorsed – note: doesn't include patients
	Newborn enrolment form[3] and processes completed ensure that all children (incl. priority populations Māori, Pacific and Oranga Tamariki) will be enrolled and offered consistent key health messages around nutrition and healthy lifestyles. (EOA)	100 percent Māori and other children will be identified for enrolment into newborn services	Q2	●	

[2] The BURP website providing breastfeeding support across Otago and Southland http://www.burpapp.co.nz/
[3] One enrolment form for Well Child- Tamariki Ora, National immunisation register, Oral health, General Practice and Newborn hearing – allowing parent/ caregivers an opt-out option.

● On Target ● Caution ● Critical ● Completed ●

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PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

8 Child Health

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Child Health	Work with Oranga Tamariki[4], to support development of cross-sector engagement for the most vulnerable children, young people and families.(EOA)	Bi-monthly Child and Youth Network meetings to provide governance/engagement across agencies working with vulnerable children / Oranga Tamariki.			
	Undertake planning work to identify barriers for accessing timely care for young people and their families serviced by Oranga Tamariki. (EOA)	Provide WellChild Quality Improvement Indicators (Māori and non-Māori) updates to inter-agency Child and Youth Network for consideration of quality improvement initiatives	Q2, Q4.		
	Quality core health services to support children, young people and families with additional needs, for example, Well Child Tamariki Ora, (EOA)	Implement roll-out of newborn enrolment form which will enable identification of vulnerable children not engaged in these services	Q2		
	Continue to build cross-sector relationships with Oranga Tamariki staff (i.e Social Workers) for children in care to raise awareness of core health services. (EOA)	Establish a cross-agency Well Child Tamariki Ora Operational group to share information that supports vulnerable children, whānau and families	Q4.		

9 Healthy Mums and Babies

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Healthy Mums and Babies	Education and resources provided to GPs and Nurses working in primary care about care and advice for women in early pregnancy – Quality in Early Pregnancy Care Project.	50 GP practice nurses and GPs to have attended workshop	Q2.		Early pregnancy workshops held in Dunedin and Invercargill with 25 Practice Nurse and GP participants. Rural workshops were delayed to wait for outcome of maternity project and are planned for June 2018.
	Focus groups to be undertaken across the district to identify barriers for Māori women accessing early engagement with LMCs. (EOA)	Focus groups to be completed	Q3		First focus group planned for Bluff marae- date still being negotiated; planning and consultation with key stakeholders in progress. MHD review has impacted on progress on this target.
		Consider suggestions and develop appropriate implementation plans	Q3-4.		
	Information resources (leaflets, poster or app) developed to support new families, who are entering the Southern district, how to engage with maternal and Well Child Tamariki Ora services. In particular people with English as their second language, refugees, migrants and people needing extra help to engage.	Information resources developed	Q3		
		Begin circulation of resources	Q4.		

[4] Ministry of Social Development – Oranga Tamariki - https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-children/

On Target Caution Critical Completed

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

10 Keeping Kids Healthy

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Keeping Kids Healthy	Develop a program for children aged 0-4 who present to ED more than twice a year with asthma symptoms to help their general practices manage their asthma more effectively in primary care.	Programme rolled out to all practices	Q3	●	Still some difficulty matching ED presentation data to WellSouth data; this is being worked through.
	Deliver training to practices on respiratory management to ensure high standards of identification and management of asthmatic symptoms	Training to be delivered to all practices in Southern district	Q1.	●	
	Newborn enrolment form and processes completed ensure that all children (incl. priority populations Māori, Pacific and Oranga Tamariki) will be enrolled and offered consistent key health messages around nutrition and healthy lifestyles. (EOA)	100 percent Māori and other children will be identified for enrolment into newborn services.	Q2	●	
	A cross-sector group[5] to develop a practical information leaflet to be used across health and other sectors e.g. early child hood, of how people can keep their homes warm and drier throughout the year.	Information leaflet to be completed.	Q2	●	Pamphlet developed. Awaiting printing.
		Leaflet circulated across health and other sectors	Q3-4		

11 Reducing Unintended Pregnancy

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Reducing Unintended Pregnancy	Establishment of a cross-sector sexual and reproductive health steering group with clinical leadership to develop a plan covering the continuum of care i.e. prevention to management and support.	Steering group established. Plan is developed and actions identified with key stakeholders within health and with cross-sector partners through community consultation	Q1	●	
				●	
	Increase the capacity of health practitioners (primary care, NGOs, Sexual Health Clinic) able to insert Long Acting Reversible Contraceptives (LARCs).	Training undertaken with health practitioners	Q2	●	Now included in POAC 1st tranche. There is a small risk around suitable training to ensure effective and appropriate insertion and removal.
	Increase access to LARCs for high needs groups (high dep, Māori, Pacific and young people. (EOA)	LARCs are accessible for high needs groups	Q2	●	Will be more readily available once training has been completed.
	Establish district wide enhanced youth clinics. These are predominantly nurse-led but have the support of local GPs. (These clinics are free of charge for people <25 years and provide free contraception, Emergency Contraceptive Pill (ECP) and Sexually Transmissible Infection (STI) screening services).	Enhanced youth clinics are established across the district and operational throughout the year	Q4	●	

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

12 Prime Minister's Youth Mental Health Project

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Prime Minister's Mental Health Project	Commit to continue delivering on activities relating to the Prime Minister's Youth Mental Health Project				
	Implement Southland Child, Youth and Family Mental Health and Addiction Stepped Care Model. The Stepped Care Model identifies five steps of service delivery intervening in the least intensive way from self-care and across primary, community and specialist services	- Develop and implement a Southland Child, Youth & Family Mental Health and Addiction Charter Q_2. - Up to date, high quality and relevant local service information is included on the national Health Point website Q_2.			Following the design and implementation of this approach several years ago there has been a steady integration of the concept into the working of the whole mental health and addiction system. More recently adjustments to the concept to ensure its applicability have included the importance of ensuring that people get the most relevant service, in the appropriate location, for the right outcomes matched to their needs. The stepped care approach continues to be an important component for the continuing development of the mental health and addiction system. It has now been augmented with a consumer and whānau centric system map which is focussed on a dynamic and adaptable system to meet needs.
	Maintain school-based health services in Alternative Education, Teen Parent Units and Decile 1-3 secondary schools including Te Wharekura o Arowhenua.(EOA)	Implement "Youth healthcare in Secondary Schools" - a quality improvement framework implementing PDSA cycle	Q_{1-4}.		
	Implement mental health and addiction brief intervention services district wide for all young people.	Procure services	Q_2.		Service provider confirmed in Q2.
		Implement services district-wide.	Q_3		Service Implemented in Q3
	Develop a Southern district Youth Strategy and Action Plan across sector.	Commence development by Youth Health Network	Q_1.		
		Youth Strategy and Action Plan finalised	Q_4		
	Increase consumer (youth, whānau) engagement through the system-wide Community Health Council	Ongoing.	Q_{1-4}		The CHC has recently appointed a youth representative who is a 1st year University of Otago student and has connections with secondary schools, University of Otago groups (such as Queer Support) and the DCC Youth Council. The CHC member and CHC Facilitator plan to do a presentation to DCC Youth Council and explore opportunities for information to flow from this network into the CHC on health related issues and vice versa for information to be shared with DCC Council.
	Improve population mental health, especially for priority populations incl vulnerable children, youth, Māori and Pacifica				
	Implement Southland Child, Youth & Family Mental Health and Addiction Stepped Care Model.	Develop and implement a Southland Child, Youth & Family Mental Health and Addiction Charter	Q_2.		Draft developed and now is connected in the work occurring as detailed above.
		Up to date, high quality and relevant local service information is included on the national Health Point website Q_2.			Completed and now business as usual.
	Implement the Clutha locality Mental Health and Addiction Stepped Care Model.	- One service and one team model approach implemented in Clutha locality Q_4.			Draft developed and now is connected in the work occurring as detailed above.

On Target Caution Critical Completed

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

13 Mental Health

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Mental Health	Reduce the use of seclusion				SDHB is part of the national programme, working towards the national goal of Zero seclusion.
	Extend the scope of the current working group to be a system-wide group focussed on reducing the use of seclusion.	Revised membership and work plan developed.	Q1		Introduction of the safe wards domains in restraint and seclusion event review provides opportunity for feedback to the inpatient ward team on flash points and environmental barriers. As the seclusion rates decrease the panel also review physical restraint events and environmental restraint events. We intend to look at acuity and seclusion on an individual level e.g. acuity measure / Seclusion rates to determine a prediction and have prevention in place.
	All treatment plans will identify early warning signs and the expectations of all service users and the clinical and support staff response.	NGO training plans to identify activity.	Q4		
	Deliver appropriate education and support to strengthen NGO / community capability to manage high acuity clients including de-escalation.	NGO training plans to identify actions and reported to working group	Q4.		
	Implement initiatives which broaden the skills of ED and Emergency Psychiatric Services (EPS) to respond to people presenting who are severely affected by mental illness and/or addiction.	Number of staff in ED and EPS receiving training on guidelines	Q2		MHAID training has focused on assessment and management of risk to self and others in the Risk Minimization Workshops that run six times per year. Motivational Interview training also gives clinician's skills to work effectively with consumers who are at risk of suicide. Triage and SADPERSONS assessment tools also enable ED staff to appropriately screen and signpost consumers who are at risk of suicide. Suicide prevention training to SDHB staff is scheduled for 2018. This will focus on screening, assessment and treatment and safety planning for consumers which will have a prevention focus across our services. Mental health triage guidelines and scale updated across the district. Training to staff has been completed.
		Six-monthly quality audits initiated for guidelines compliance	Q4		
	Improve the responsiveness and capability of Mental Health and Addiction Services to ensure tangata whaiora presenting with high acuity have timely access to cultural assessment and support, including traditional Māori treatment processes. (EOA)	-Undertake a review of current practice and availability	Q2		The SDHB has undertaken a review of Maori Health Services which includes Maori Mental Health Services.
		Implement recommendations from review	Q3		This review is now with the executive, with next steps pending.

On Target Caution Critical Completed

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

14 Living Well with Diabetes

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Living Well with Diabetes	Establish a system-wide Diabetes Service Improvement Group to monitor progress against agreed indicators and population outcomes and participate in service planning.	Service improvement group established	Q_2.		This action has been delayed, and will now take effect Q3 and 4. A significant re-structure within Southern DHB has led to a number of key personnel changes, and the DHB is currently working through roles and responsibilities, as well as defining processes within the new structure.
		Work plan developed	Q_3.		There is a lot of work occurring in the diabetes space that has progressed well over the year but it does not represent a system wide view between primary, secondary and tertiary care.
	An options paper and business case for changes to the delivery of community podiatry services will be developed. This will aim to improve equity of access across the Southern district and ensure greater alignment of services to population need. (EOA)	Review model of care and options developed	Q_1.		
	Five pilot sites across the district will look to ensure that of the total population enrolled in the "Do the right thing" programme, at least 30% are Māori. This will be achieved through active identification and prioritisation of Māori eligible for the service. (EOA)	Each of the five pilot sites will enrol 30% Māori in the "Do the right thing" programme.	Q_3		The trial has been completed across five pilot sites. This programme is now called CLIC (replacing Care Plus) and currently has 11 practices signed up to this new model of care. During the pilot WellSouth did not achieve 30% Maori enrolment. The programme pilot relied upon voluntary participation in the sample. There was significant difficulty getting Maori patients to participate on a voluntary basis. WellSouth are undertaking planning to increase Maori uptake via an analysis of eligible Maori and some direct intervention. As more practices sign to CLIC a larger percentage of the enrolled population will automatically participate in CLIC.
	Improving access to, and ensuring consistent standard of, Diabetic Multi-Disciplinary Team (MDT) input for children.	MDT clinics across the district, with clear and consistent standards.	Q_4		This action has been delayed, and will now take effect Q3 and 4. A significant re-structure within Southern DHB has led to a number of key personnel changes, and the DHB is currently working through roles and responsibilities, as well as defining processes within the new structure.
	Develop an options paper and business case recommending changes to delivery of diabetic retinal screening services in order to improve equity of access, improve patient outcomes and maintain sustainability of service.	Business case developed.	Q_2		A review of ophthalmology services has occurred, and action plan has been developed.

On Target Caution Critical Completed

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

15 Healthy Ageing

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Healthy Ageing	Southern DHB commits to the delivery of relevant actions in the Health of Older Persons section of the SI Regional Services Plan 2017/18				
	Further develop our primary-based Falls and Fracture Prevention Treatment Service.	Implement the Home Based Falls Prevention Programme	Q_3.		
	Support the MoH to develop future models of home and community support services (as per Part B of the In-Between Travel Settlement Agreement)	Ongoing support to MoH timeframes.	Q_{1-4}		
	SDHB will investigate possible barriers to Māori people being referred for or accessing interRAI assessments. (EOA)	Review of possible barriers to accessing interRAI assessments.	Q_1		Behind schedule. Staff turnover and other priorities have left this behind schedule.
		Southern DHB will reduce the barriers identified to increase the number of Māori receiving interRAI assessments	Q_{2-4}.		Behind schedule. Staff turnover and other priorities have left this behind schedule.

On Target Caution Critical Completed

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PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

16 Service Configuration including Shifting Services

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Bowel Screening	Business case is completed to support bowel screening programme.	Final business case is completed and approved by MoH.	Q2	●	Complete.
	Development of referral and notification processes for the bowel screening programme.	Agreement of GP role in notification process.	Q2	●	Complete
	Increase workforce capacity for the delivery of colonoscopies.	Recruit 1.0 FTE endoscopy	Q3	●	Endoscopist commenced, nurse coordinators commenced.
		Recruit other staff as required	Q3		Phased recruitment continues.
	Māori and priority populations (60-74 years) will be targeted to participate in Bowel Screening services. Specific equity promotion roles will be created to promote and encourage participation in the identified priority populations. Engagement will be guided by Māori Health Directorate at Southern DHB. (EOA)	Health promotion implementation plan completed	Q3	●	Communication plan and Equity plan completed and submitted to the MOH.
		Health promotion implemented via local and national groups	Q4	●	Health Promotion activities have commenced to promote the Programme. WellSouth contracted to provide active follow-up and engagement with Māori Health providers.
	South Island planning to support Bowel Screening Regional Centre development and implementation and subsequent roll-out to SI DHB's to be in years 2018/19 and 2019/20.	Confirm roles and responsibilities.	Q3	●	Programme Manager appointed. Regular South Island clinical leads meetings for colonoscopy continue for which Bowel Screening is a standing item.
		Recruitment into roles.	Q4		
	Southern DHB IT department to support the National Bowel Screening Programme (NBSP) and include the Programme on the SDHB's IT work plan. The SDHB IT department will work with the Ministry to enable the necessary IT integration	NBSP and solution will be functional in SDHB to allow for commencement of bowel screening	Q4	●	IT solution for Southern DHB rollout requires little IT input. Subsequent Bowel Screening IT solution will not be available until 2019/20. South Island ISSLA and IT department engaged. Update – The Bowel Screening programme went live at SDHB on 24th April. The Ministry has endorsed the IT readiness for this programme for SDHB.
	Southern DHB to join the NBSP	2018	Q4	●	Due to commence April 2018.

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

17 Disability Support Services

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Disability Support Services	Southern DHB has introduced Health Connect South [6] which allows GPs and hospitals to access information about patients and view historic information. (EOA)			●	Completed.
	All patients that are admitted to hospital have to complete a 'My Care Plan' which outlines if a patient requires specific support for hearing, vision, communication, interpreters (including sign language support). Support will be provided as required. (EOA)			●	The 'my care plan' has been rolled out to (physical health) inpatient wards along with bedside handover. However, completion is variable.
	Southern DHBs audiology service ensures children and young people with hearing impairment are accurately diagnosed and have access to hearing assistive devices. (EOA)			●	Completed.
	Southern DHB to develop a local Disability Strategy. (EOA)	Disability Strategy completed.	Q_4	●	The DHB, alongside a working group of CHC members, have worked together to select a provider to undertake this important piece of work. The provider is expected to commence work on this in May with the completion date being October 2018.

[6] Health Connect South http://www.sialliance.health.nz/our-priorities/information-services/health-connect-south-/

● On Target ● Caution ● Critical ● Completed ●

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PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

18 Whānau Ora

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Collaboration with Whānau Ora Commissioning Agencies	South Island DHBs will negotiate a Strategic Alliance Agreement with Te Pūtahitanga o te Waipounamu	Strategic Alliance agreement will set out the framework for an ongoing relationship between South Island DHBs and Te Putahitanga, to be signed	Q4		Partnership Agreement with Te Putahitanga in draft.
		Yearly strategic planning forum established	Q4		Change of focus with Te Putahitanga participating in Alliance workstreams.
	Support greater alignment of projects and activities across Te Waipounamu	Ongoing meetings as determined by the relationship agreement to create and foster a high trust environment which allows both parties to work together on projects aimed to support Māori achieve their maximum health and wellbeing	Q4		
	Identify a joint project with Te Putahitanga that can advance the Whānau Ora approach across Te Waipounamu	One joint project completed	Q4		Discussions have commenced to confirm a joint project.
Oral Health	Scope new birth enrolments with a view to identify opportunities to increase enrolments	Increase in the number of Māori and Pacific 5 year old children who are caries free at age 5			
		Review baseline enrolment data on a quarterly basis			
Tobacco	Undertake a stock of initiatives aimed to reduce the up-take of tobacco use with a view to equip and support LMCs to offer smokefree support to pregnant women	Better support for 95% of all pregnant Māori women to quit smoking (smoke free at two weeks post-natal)			This is no longer a Well Child Tamariki Ora indicator; data are no longer collected.
		Monitor Indicator 19 of the WCTO Quality Improvement Framework			This is no longer a Well Child Tamariki Ora indicator; data are no longer collected.
Mental Health	Develop referral pathway to Māori Mental Health Services	Reduced rate of Māori committed to compulsory treatment relative to non-Māori			
		Referral pathway agreed and implemented	Q4		
Childhood Obesity	Establish a healthy weight working group which is inclusive of Whānau Ora values				
	Development and implementation of healthy weight pathways, interventions and resources across secondary, primary and community care services	By December 2017, 95 percent of obese Māori children identified in B4 School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions services			
Asthma	Promote better asthma management through General Practices and Well Child/Tamariki Ora providers	Reduced asthma and wheeze admission rates for Māori and Pacific children (ASH 0-4 years)			Progressing piece of work.
	Support and align Healthy Home Project activity	Monitor progress for enrolment rates and ASH rate for respiratory conditions quarterly			Process of matching WellSouth enrolment data with ED presentation data for this population

On Target Caution Critical Completed

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

19 Improved Access to Diagnostics

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
National Radiology Service Improvement Initiative	Undertake a district wide radiology system review to assess equity of access, distribution of radiology services (across publicly funded providers) and streamline patient referrals for service	Review contractual arrangements with providers to determine how funding arrangements will try to reflect recommendation	Q_1- Q_4	🟡	The DHB RFP is in the final stages of release. This RFP was to identify more providers in the right place for less cost. To be progressed through Q3 and Q4 into next financial year.
	Continue implementation the National Access Criteria for Community Referral Diagnostics			🔴	Supply of ultra sound is of concern across the district and is impacting on our ability to deliver community referred diagnostics.
	Continue development of clinical pathways that facilitate or improve quality of direct access to plain film x-rays and ultrasound	Develop 2 pathways during the course of the year including musculoskeletal medicine and access to ultrasound	Q_3	🟡	This has not been prioritised this year so far. Healthy Pathway for ultrasound agreed as a priority by both Clinical leaders and is expected to be completed in Q4.
	Ongoing participation in the National Patient Flow System	Patient level data is reported into the National Patient Flow collection, in line with specific requirements		🟢	We are working with National patient Flow across all specialty areas.
Radiology	Continue to progress activities related to National Radiology Service Improvement Initiative for high tech imaging	Quality Analyst appointed		🔴	This has not been prioritised this year.
		Production planning activity in line with MoH expectations		🔴	A formal production plan has not been developed. Targeted plans to reduce MRI waiting times have been approved and will be implemented over the next 6 months. Waiting times are expected to reduce. CT waiting times are almost compliant with the MoH 42 day timeframe.
		Develop reporting framework and KPIs	Q_1	🟡	Linked to the Quality Analyst.
	Complete implementation of district PACs reporting system to enable real time reading and reporting		Q_1	🔵	Complete.
	Expand CT core operational hours to increase CT scanning capacity	CT hours increased by 40 hours per week		🟢	Approved, recruitment underway.
	Increase work activity in CT to manage remaining people waiting greater than 147 days	Develop a reporting system which enables monitoring of referrals and exits from the service		🟢	Waiting list reducing due to increase in supply.
Colonoscopy & Endoscopy	Build new 3 theatre endoscopy unit to provide additional capacity, increase functional capability and improve patient experience	Commission new endoscopy unit	Q_3	🟡	Due for completion May 22, 2018. Delayed from end March 2018.
	Continue to develop the service in line with the NEQiP (National Endoscopy Quality Improvement Programme) quality domains as outlined in the GRS (Global Ratings Score)	Establish endoscopy users group	Q_1	🔵	EUG group established with regular meetings.
		Develop Gastroenterology Operations Manual/Framework	Q_1	🔵	Work on the manual underway in conjunction with a review of departmental guidelines. These will not be able to be finalised until moved into new unit.
		Revision of departmental guidelines	Q_2	⚪	
	Continue annual patient and staff surveys			🔵	Surveys planned.
	Continue to utilise national access criteria (National Guidelines for Colonoscopy) at single point of triage	Work closely with South Island group to improve wait times		🔵	National Access Criteria used for all colonoscopy referrals (non-bowel screening).

🟢 On Target 🟡 Caution 🔴 Critical 🔵 Completed ⚪

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
	Support nurse endoscopy training	Develop and maintain nurse endoscopy training programme over next 3 years		●	Nurse endoscopist continues to be trained within the department.

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

20 Pharmacy Action Plan

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Pharmacy Action Plan	Implement national pharmacy contracting arrangements as agreed. The contract will change to enable the development of patient-centric services and local DHB commissioning for integrated pharmacist services to meet population needs.	Existing contract extended to enable smooth transition to new contract.	Q_1	●	
		New contract in place for 1 July 2018		●	Looks to be delayed 3 months until 1 October due to volume of consultation feedback and issues raised during consultation.
	Develop local pharmacist services strategies which align with the Pharmacy Action Plan and the "Integrated Pharmacist Services in the Community."	Local pharmacy services plan developed.	Q_4	●	We established new part P variations to the CPSA during this year. This is planned to move entirely into Schedule 3 of the new contract.

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

21 Improving Quality

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Improving Quality	Establishment of a system-wide Community Health Council to advise the southern health system (EOA).	Work plan for Council is developed.	Q_1	●	The Community Health Council has developed a draft workplan for the 18/19 period which they will share with Executive Leadership Teams at the DHB and WellSouth. The workplan has been developed to allow flexibility for new pieces of work to flow into it either from a community or DHB/PHO perspective. A key piece of work the council will be guiding through 2018/19 is the CHC Community, Whānau and Patient Framework and Roadmap – which will provide systems and process for staff to undertake co-design work with the support of the CHC. The CHC will be providing updates to the Commissioners on a quarterly basis to ensure they are kept informed of the work of the Council.
	Improve Patient Experience of Care Category – Communication. The sub-category Medication Side Effects Information prior to Discharge. This will be integrated into the Releasing Time to Care (RTTC) Discharge and Medication modules across Southland and Dunedin sites.	Within the RTTC Programme modules, Discharge and Medication, there is an action plan that will improve this measure.	Q_1	●	April 2017 to December 2017 Monthly patient surveys demonstrated a 23% increase in Dunedin and 11% in Southland to the 'Yes' response to receiving discharge and medication information. These surveys have been pushed to quarterly in 2018. The medication module group recently met. This has been flagged as a priority to ensure addressed. Pharmacy discussion is that inadequate FTE to discuss medicines reconciliation with all patients, so a prioritisation process is in place. This is also a responsibility of the prescriber.
	Improve Patient Experience of Care Category – Coordination. The sub-category Information on Management of Condition prior to Discharge. This will be integrated into the RTTC Ward Round and Admission and Discharge Modules across the Southland and Dunedin sites.	Within the RTTC Programme modules, Ward Round, Admission and Discharge module, there is an action plan that will aim to improve this measure.	Q_1	●	April 2017 to December 2017 monthly patient survey demonstrated a 17% increase in Dunedin and 30% increase in Southland to the 'Yes' response to receiving information on managing their condition. The survey has been moved to quarterly in 2018. Work has been undertaken with Clinical Nurse Specialists (CNS), but further work is needed
	Improve Patient Experience of Care Category – Partnership. The sub-category Hospital Staff includes family/whanau or someone close to the patient in discussions about care. This will be integrated into RTTC Ward Round and Admission and Discharge modules across the Southland and Dunedin sites.	Within the RTTC Programme modules, Ward Round, Admission and Discharge module, there is an action plan that will aim to improve this measure.	Q_1	●	The My Care Plan encourages family/whanau collaboration in care and planning. Bedside Handover introduced this past year also facilitates the discussions around care. The Ward Round module was postponed as it was decided by senior medical staff that medical teams could not support this at this time. In the HQSC patient experience survey published April 2018, the question on 'co-ordination' has risen within Southern to 9.2 against the national average 8.5.

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

22 Primary Care Integration

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Primary care integration	Alliance South will continue working to move care closer to home for people through integration with the health and disability sector.				
	Development of Primary and Community Health Strategy and Action Plan	Strategy and Action Plan finalised.	Q3		
		Implementation plans commence	Q4		
	Southern DHB and WellSouth to engage with St John Ambulance to develop alternative referral pathways across the Southern district. Initial pathways to be developed in the areas of falls prevention and cardiovascular disease. Other pathways to be investigated include smokefree, age-related residential care call outs and Chronic Obstructive Pulmonary Disease (COPD).	Implementation of pathways	Q1	●	Part of the POAC roll out.
		Communication with stakeholders of alternative pathways	Q1	●	
	Implement Southern DHB Mental Health and Addiction Stepped Care Action Plan 2016-20. Re-orient and redesign services and models of care to ensure they are flexible and can be delivered in community and primary care settings.	Development of Stepped Care Locality Based design (Dunedin)	Q4		
		Complete any proposals required for investment including local services and systems redesign.	Q4		
	Expand the use of telemedicine through video technology across the district to 12 new services ensuring equity of access (i.e. rural populations), reduced patient and clinician travel, improved patient experience, and reduced green measures, e.g. reduced carbon emissions (EOA).	Telemedicine technology is made available across the district.	Q1	●	
		Documentation to conduct telemedicine consults developed.	Q2	●	
		12 services will have access to telemedicine	Q4	●	
		Patient experience monitored.	Q4	●	
	Implementation of System Level Measures (SLM) Improvement Plan	Quarterly reporting to Alliance Leadership Team and MoH on the SLMS			

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

23 Delivery of Regional Service Plans

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Delivery of Regional Service Plans	Southern DHB's commitment in terms of the regional direction is outlined in the South Island Health Services Plan, and key deliverables are also highlighted in this section of the Annual Plan.				
	1. Cardiac: Input into the development and implementation of a SI model of care for cardiac services, ensuring appropriate access to cardiac surgery, percutaneous revascularisation and coronary angiography.	Complete project work associated with the SI Cardiac Model of Care	Q_2- Q_4		
		Optimal Health Pathways	Q_2		
		Ensure access to angiography for high risk population groups such as Māori, Pacific and Asian people	Q_4		
	2. Major Trauma: Collection of agreed data and input into national major trauma registry. Input into implementation of regional Destination Policies in collaboration with DHBs, Ambulances and Air Transport providers. Review of data and trauma outcomes for SI patients.	SI DHBs major trauma clinical leaders, co-ordinators and administrators appointed	Q_1		
		Trauma Committees established in SDHB	Q_2		
		Agreed regional clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region	Q_1-Q_4		
	3. Hepatitis C: To design and implement integrated assessment and treatment services for people with Hepatitis C in the South Island. This includes a single clinical pathway.	Raise Southern community and GP awareness and education of the Hepatitis C virus and the risk factors for infection	Q_3		Nurse Coordinator for Hepatitis C commence and providing education across Southern DHB.
		Enhance use of fibroscanning services across the Southern district	Q_4		Access to fibroscanning is good across the district and is currently provided in Southland and Dunedin Hospitals.
		Implement integrated Hepatitis C assessment and treatment services across community, primary and secondary services	Q_4		Nurse Coordinator leading integrated assessment and treatment services.
	4. Stroke: Southern DHB commits to delivering on the activities outlined in the SI Health Service Plan for stroke	People with stroke admitted to hospital are treated in a stroke unit and/or in the setting of an organised stroke service	Q_1-Q_4	●	A stroke CNS has commenced in Southland. Recruitment for a stroke CNS at Dunedin is ongoing.
		All eligible people with stroke receive early active rehabilitation services and equitable access to community stroke service	Q_1-Q_4	●	Ministry has just provided clarity on definitions for community stroke services. Active discussions and planning for the "One Team" which is a single service that is coordinated and focused on supported discharge.

● On Target ● Caution ● Critical ● Completed ●

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PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

24 Information Technology

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Information Technology	Implement ePharmacy into Southern DHB using a single regional system to enable the management of medication safety from a shared South Island perspective	Implementation of ePharmacy across DHBs	Q4	●	Update – DXC (Vendor) are starting the Implementation Planning Study that will become the full plan for the South Island solution. There will be two instances, SDHB hosting SCDHB and CDHB hosting WCDHB and NMDHB.
	Implement eTriage – referrals received through the RMS module in Health Connect South with triage functionality	Complete SDHB eTriage implementation	Q3	●	Update – Work has started with Dermatology being the pilot service and details of the full rollout plan to be confirmed by end of Q4.
	Investigate accelerating migration of Southern DHBs implementation business case for SI Patient Information Care System (PICS)	Business case completed	Q4	●	Update – SDHB is currently reviewing the regional Business Case along with the local Business Cases from CDHB and NMDHB with a view to creating a Business Case for SDHB by the end of Q4.
	Continue the roll out EMRAM Stage 3 and 4 capabilities through the hospital.				Nothing to update.

● On Target ● Caution ● Critical ● Completed ●

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

25 Workforce

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
Workforce	Workforce issues to be addressed at a local level				
	Build and align the capability and capacity of the workforce to deliver new models of care and priorities outlined in the New Zealand Health Strategy	Identify through resource planning a sustainable workforce that is reflective of the communities we serve, deliver on patient needs and plans	Q3	●	Initiatives within new workforce development strategy.
	Grow the capacity and capability of Māori in the health workforce (EOA)	Development of a Southern Māori Health Workforce Strategy and Action Plan for the Southern district	Q4	●	
	Strengthen health leadership through regional and local collaboration	Establishment of a leadership framework to drive and align to 'Owning our Future'	Q1-Q3	●	
		Developing Medical leaders through implementation of Senior Medical Officer engagement forums and review of clinical leadership model	Q1-Q4	●	
	Build a positive culture of professional behaviours and productive work environment	Education workforce on preventing and managing discrimination, harassment and bullying through Speak Up, Speak Out programme	Q1-Q4	●	
		Develop safe and healthy work environment through potential support office framework	Q2	●	
		Build on foundations of the Good Employer elements	Q3	●	
	Training of kaiawhina workforce in home and community support services				
	Allied Health Assistants (AHAs) working across the SI health system have access to appropriate NZQA Level 3 training	AHAs are fully utilised in the delivery of care (AHAs Position Descriptions have NZQA Level 3 as a requirement)	Q4	●	Complete.
	The Careerforce NZQA Level 4 Health and Wellbeing qualification (in Rehabilitation/Brain Injury) is included in the AHA development framework	The Level 4 AHA training and development framework for Rehabilitation/Brain Injury is 100% implemented in the service	Q4	●	Complete
	AHAs: An effective delegation model is in place for services where Calderdale Framework has been implemented (Calderdale is an effective model for the use of delegation. The model of delegation is in place for services where Calderdale Framework has been implemented.)	Evaluation of the clinical task delegation model is undertaken When to Stop (Clinical Task) is implemented. Delegation Model is introduced.	Q4	● ● ●	Complete Will be transferred to next year's AP as introduction of When to Stop was the first step and a priority

● On Target ● Caution ● Critical ● Completed ●

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On Target Caution Critical Completed

SOUTHERN DISTRICT HEALTH BOARD

Title:	**FINANCIAL REPORT**		
Report to:	Commissioner Team		
Date of Meeting:	24 May 2018		
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:** 11 May 2018		**PRESENTED BY:** Lisa Gestro Executive Director Strategy, Primary & Community	
RECOMMENDATION: 1. **That the report be received.**			

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STRATEGY, PRIMARY & COMMUNITY REPORT
April 2018

1. Overview

The overall result follows;

Month				Year to Date		
Actual $' 000	Budget $' 000	Variance $' 000		Actual $' 000	Budget $' 000	Variance $' 000
74,433	75,039	(606)	Revenue	750,479	750,313	166
75,714	75,280	(434)	Less Expenses	758,253	758,839	586
(1,281)	(241)	(1,040)	Net Surplus / (Deficit)	(7,775)	(8,526)	751
			Expenses			
4,369	4,473	104	Personnel	42,879	43,787	908
79	81	2	Outsourced Clinical Services	735	833	98
995	994	(1)	Outsourced Funder Services	9,905	9,942	37
504	439	(65)	Clinical Supplies	4,742	4,444	(298)
422	411	(11)	Infrastructure & Non Clinical Supplies	4,396	4,184	(212)
			Provider Payments			
55,535	54,815	(720)	Personal Health	553,341	554,363	1,022
90	98	8	Public Health	925	977	52
13,603	13,846	243	Disability Support	140,216	139,064	(1,152)
117	125	8	Maori Health	1,115	1,245	130
75,714	75,280	(434)	Expenses	758,253	758,839	586

Summary Comment:

Strategy, Primary and Community had a deficit for April of $1.28m against a budget deficit of $0.24m which is $1.04m unfavourable. YTD there is a deficit of $7.75m against a budgeted deficit of $8.52m which is $0.75m favourable.

Revenue is unfavourable by $0.61m for April and $0.16m favourable YTD, with the main reasons being extra Refugee revenue ($1.27m favourable YTD), In Between Travel ($1.23m favourable YTD), Performance Management revenue ($0.30m favourable YTD) offset by Electives revenue ($1.95m unfavourable YTD) and Capital Charge revaluation ($1.0m)

Expenditure for the month is unfavourable to budget by $0.43m with the main reasons being pharmaceuticals & PCT ($0.43m unfav) and travel & accommodation ($0.12m unfav) offset by Immunisation ($0.31m fav)

YTD expenditure is $0.59m favourable to budget with the main reasons elective expenditure ($1.95m favourable) and personnel costs ($0.9m favourable), Disability Support expenditure ($1.15m unfavourable) and Refugee expenditure ($1.27m 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	662	585	(77)	6,043	5,846	(197)
RMO's	41	53	12	370	513	143
Nursing	1,637	1,701	64	15,918	16,336	418
Allied Health	1,458	1,559	101	15,034	15,265	231
Support	12	11	(1)	110	112	2
Management & Administration	558	563	5	5,403	5,714	311
Total	4,369	4,473	104	42,879	43,787	908

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	265	270	5
Support	3	3	0
Management & Administration	98	102	4
Total	626	642	17

Personnel costs are $0.90m favourable YTD which is reflective of the 17 FTE vacancies. Nursing is the main area affected with 7 FTE vacancies currently and an underspend of $0.42m YTD. The main area impacting on this variance is Nurse Managers and Nurse Educators where there is 6 FTE vacancies and an underspend YTD of $0.48m.

Management & Administration favourable variances are mainly in the Non Clinical Administration, Clerical and Secretarial area with 6 FTE vacancies and an underspend of $0.36m 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	79	81	2	735	833	98
Funder Services	995	994	(1)	9,905	9,942	37
Total	1,074	1,075	1	10,640	10,775	135

Outsourced clinical services - other ($98k fav YTD).

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	242	198	(42)	2,343	2,032	(311)
Diagnostic Supplies	3	5	2	41	51	10
Instruments & Equipment	57	56	(1)	515	546	31
Patient Appliances	144	130	(14)	1,384	1,303	(82)
Implants & Prostheses	1	0	(1)	5	2	(4)
Pharmaceuticals	49	35	(14)	366	358	(9)
Other Clinical Supplies	10	15	5	87	153	66
Total	504	439	(65)	4,742	4,444	(298)

Treatment disposables ($313k unfavourable YTD) with Continence & Hygiene Supplies ($133k unfavourable YTD), Dental Supplies ($89k unfavourable YTD) and dressings ($69k 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	169	169	(0)	1,691	1,708	16
Facilities	41	36	(5)	323	350	28
Transport	122	140	18	1,239	1,310	71
IT Systems and Telecommunications	33	29	(4)	351	291	(60)
Professional Fees & Expenses	19	35	16	463	348	(115)
Other Operating Expenses	38	3	(25)	323	172	(151)
Democracy	0	0	(1)	7	4	(3)
Total	422	411	(11)	4,396	4,184	(212)

Professional fees & expenses ($115k unfavourable YTD) mainly due to Consultants fees ($82k unfavourable YTD.)

Personal Expenditure NGO and Provider Payments

Personal Health April 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			3,414	3,414			4,097	
Laboratory	-	-			-	-			0	
Infertility Treatment Services	-	-			-	-			0	
Maternity	23	23			226	226			271	
Maternity (Tertiary & Secondary)	1,379	1,379			13,790	13,790			16,548	
Pregnancy and Parenting Education	-	-			-	-			0	
Neo Natal	666	666			6,664	6,664			7,997	
Sexual Health	86	86			864	864			1,036	
Adolescent Dental Benefit	27	27			267	267			320	
Dental - Low Income Adult	28	28			283	283			339	
Child (School) Dental Services	601	601			6,009	6,009			7,211	
Secondary / Tertiary Dental	120	120			1,203	1,203			1,443	
Pharmaceuticals	466	372	(94) U	(25%)	4,372	3,724	(648) U	(17%)	4,469	2
Pharmaceutical Cancer Treatment Drugs	723	600	(123) U	(21%)	5,965	5,934	(31) U	(1%)	7,139	2
Pharmacy Services	-	-			-	-			0	
Primary Practice Services - Capitated	42	10	(32) U	(320%)	419	96	(323) U	(336%)	115	5
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			721	721			865	
Immunisation	69	69			693	693			831	
Radiology	279	279			2,790	2,790			3,348	
Palliative Care	-	-			-	-			0	
Meals on Wheels	35	35			353	353			424	
Domiciliary & District Nursing	1,125	1,125			11,179	11,179			13,429	
Community based Allied Health	557	557			5,241	5,241			6,356	
Chronic Disease Management and Educa	150	150			1,504	1,504			1,804	
Medical Inpatients	6,910	6,910			69,103	69,103			82,924	
Medical Outpatients	3,283	3,283			32,832	32,832			39,398	
Surgical Inpatients	12,223	11,716	(507) U	(4%)	115,219	117,161	1,942 F	2%	140,593	7
Surgical Outpatients	1,686	1,686			16,857	16,857			20,229	
Paediatric Inpatients	679	679			6,786	6,786			8,143	
Paediatric Outpatients	246	246			2,462	2,462			2,954	
Pacific Peoples' Health	10	10			100	100			120	
Emergency Services	1,715	1,715			17,146	17,146			20,576	
Minor Personal Health Expenditure	15	15			152	152			182	
Price adjusters and Premium	1,964	1,964			19,643	19,643			23,571	
Travel & Accomodation	8	8			80	80			96	
	35,528	34,772	(756) U	5%	346,337	347,277	940 F	0%	416,828	
Personal Health NGO										
Personal Health to allocate	-	-			-	-			0	
Child and Youth	46	35	(11) U	(31%)	274	350	76 F	22%	421	
Laboratory	1,505	1,505			15,064	15,047	(17) U		18,056	
Infertility Treatment Services	8	8			80	80			96	
Maternity	225	206	(19) U	(9%)	1,981	2,058	77 F	4%	2,470	1
Maternity (Tertiary & Secondary)	4	1	(3) U	(300%)	57	7	(50) U	(714%)	8	
Pregnancy and Parenting Education	29	15			204	147	(57) U	(39%)	177	
Sexual Health	-	8	8 F		(9)	82	91 F	111%	98	
Adolescent Dental Benefit	106	98	(8) U	(8%)	1,768	1,764	(4) U	(0%)	2,117	
Dental - Low Income Adult	43	46	3 F	7%	163	459	296 F	64%	550	3
Child (School) Dental Services	62	36	(26) U	(72%)	311	353	42 F	12%	423	
Secondary / Tertiary Dental	44	133	89 F	67%	1,318	1,334	16 F	1%	1,601	
Pharmaceuticals	5,430	5,215	(215) U	(4%)	60,825	61,013	188 F	0%	73,123	2
Pharmaceutical Cancer Treatment Drugs	-	-			-	-			-	2
Pharmacy Services	4	-			4	-	(4) U		-	
Management Referred Services	167	167			1,667	1,667			2,000	
General Medical Subsidy	95	59	(36) U	(61%)	937	614	(323) U	(53%)	769	4
Primary Practice Services - Capitated	4,292	4,005	(287) U	(7%)	40,270	40,048	(222) U	(1%)	48,058	5
Primary Health Care Strategy - Care	376	348	(28) U	(8%)	3,728	3,479	(249) U	(7%)	4,175	5
Primary Health Care Strategy - Health	310	551	241 F	44%	5,300	5,513	213 F	4%	6,615	5
Primary Health Care Strategy - Other	62	89	27 F	30%	542	735	193 F	26%	912	5
Practice Nurse Subsidy	18	16	(2) U	(13%)	183	163	(20) U	(12%)	195	
Rural Support for Primary Health Pro	1,412	1,353	(59) U	(4%)	14,116	13,529	(587) U	(4%)	16,235	6
Immunisation	201	508	307 F	60%	1,002	1,533	531 F	35%	2,135	
Radiology	233	196	(37) U	(19%)	2,348	1,998	(350) U	(18%)	2,390	8
Palliative Care	538	548	10 F	2%	5,319	5,404	85 F	2%	6,491	
Meals on Wheels	21	21			209	212	3 F	1%	255	
Domiciliary & District Nursing	536	556	20 F	4%	5,479	5,565	86 F	2%	6,678	
Community based Allied Health	178	186	8 F	4%	1,873	1,865	(8) U	(0%)	2,238	
Chronic Disease Management and Educa	123	94	(29) U	(31%)	1,230	944	(286) U	(30%)	1,132	
Medical Outpatients	401	413	12 F	3%	4,026	4,134	108 F	3%	4,960	
Surgical Inpatients	41	21	(20) U	(95%)	121	205	84 F	41%	246	
Surgical Outpatients	155	190	35 F	18%	1,575	1,897	322 F	17%	2,276	
Paediatric Outpatients	-	-			3	-	(3) U		-	
Pacific Peoples' Health	11	11			90	110	20 F	18%	132	
Emergency Services	156	164	8 F	5%	1,596	1,642	46 F	3%	1,971	
Minor Personal Health Expenditure	16	47	31 F	66%	358	468	110 F	24%	561	
Price adjusters and Premium	151	199	48 F	24%	1,564	1,986	422 F	21%	2,383	9
Travel & Accomodation	446	328	(118) U	(36%)	4,194	4,024	(170) U	(4%)	4,792	10
Inter District Flow Personal Health	2,701	2,666	(35) U	(1%)	27,237	26,659	(578) U	(2%)	31,991	11
	20,146	20,042	(104) U	(1%)	207,007	207,088	81 F	0%	248,730	
Total Personal Health	55,674	54,814	(860) U	(0) U	553,344	554,365	1,021 F	0%	665,558	

Personal Health expenditure variance notes;

1. **Maternity -** $0.08m 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) –** .$0.49m unfavourable YTD
   April expenditure is $0.43m unfavourable to budget.

3. **Low Income Dental-** $0.29m 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 -** $0.32m unfavourable YTD
   Demand driven service that also includes expenditure relating to Refugee's.

5. **PHO lines (Primary Practice Capitated & Primary Health Care) –** $0.39m 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**- $0.59m unfavourable YTD.
   Relates to Clutha Health expenditure incurred where the budget is sitting in Price adjusters and Premiums.

7. **Surgical Inpatients -** $.94m 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 $1.94m 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	-456.8	-$ 2,247.99
Orthopaedic Initiative		
Ambulatory Initiative		
Surgical FSA's		-$ 39.89
Medical FSA's		$ 345.90
Procedures		-$ -
Tests		$ -
Total - EI, OI & AI		**-$ 1,941.98**

8. **Radiology** - $0.35m unfavourable YTD.
   Mainly due to extra costs incurred in Central Otago wash-up with regards to CT scanner.

9. **Price Adjusters and Premium** - $0.42m favourable YTD.
   Mainly relates to Clutha health expenditure incurred in Rural Support.

10. **Travel & Accommodation -** $0.17m unfavourable YTD.
    Demand driven service.

11. **IDF's -** $0.58m unfavourable YTD.
    Expenditure includes YTD wash-up estimate.

Disability Support Services

DSS *April 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			19,005	19,005			22,806	
Information and Advisory	-	-			-	-			0	
Needs Assessment	108	108			1,098	1,098			1,315	
Service Co-ordination	20	20			197	197			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			23	23			27	
Day Programmes	-	-			-	-			0	
Expenditure to Attend Treatment ETAT	-	-			-	-			0	
Minor Disability Support Expenditure	-	-			102	102			102	
Respite Care	-	-			-	-			0	
Child Development	90	90			899	899			1,078	
Community Health Services & Support	21	21			211	211			254	
	2,141	2,141	-		21,535	21,535			25,818	
Disability Support Services - NGO										
Disability Support - Pay Equity	1,169	1,215	46 F	4%	12,181	12,380	199 F	2%	15,000	
AT & R (Assessment, Treatment and Re	335	357	22 F	6%	3,356	3,570	214 F	6%	4,284	
Information and Advisory	11	12	1 F	8%	109	122	13 F	11%	147	
Needs Assessment	35	34	(1) U	(3%)	335	329	(6) U	(2%)	398	
Service Co-ordination	-	-			-	-			0	
Home Support	1,934	2,018	84 F	4%	19,707	19,396	(311) U	(2%)	23,911	12
Carer Support	139	115	(24) U	(21%)	1,490	1,324	(166) U	(13%)	1,594	
Residential Care: Rest Homes	3,127	3,199	72 F	2%	32,567	32,245	(322) U	(1%)	38,762	13
Residential Care: Loans Adjustment	(48)	(23)	25 F	109%	(261)	(230)	31 F	13%	-276	
Long Term Chronic Conditions	-	-			-	-			0	
Residential Care: Hospitals	4,225	4,215	(10) U	(0%)	43,584	42,430	(1,154) U	(3%)	51,020	14
Environmental Support Services	-	10	10 F		65	102	37 F	36%	122	
Day Programmes	36	44	8 F	18%	315	435	120 F	28%	523	
Minor Disability Support Expenditure	8	9	1 F	11%	83	90	7 F	8%	107	
Respite Care	97	102	5 F	5%	1,255	1,373	118 F	9%	1,729	
Child Development	-	-			-	-			0	
Community Health Services & Support	64	52	(12) U	(23%)	531	522	(9) U	(2%)	626	
Inter District Flow Disability Support	329	344	15 F	4%	3,364	3,441	77 F	2%	4,129	
	11,461	11,703	242 F	2%	118,681	117,529	(1,152) U	(1%)	142,076	
Total Disability Support Services	13,602	13,844	242 F	2%	140,216	139,064	(1,152) U	(1%)	167,894	

Disability Support Services expenditure variance notes;

12. **Home Support -** $0.31m unfavourable YTD.
    Due to over budget IBT expenditure (revenue offset). Expenditure expected to continue to be favourable for rest of financial year.

13. **Residential Care Rest Homes** - $0.32m unfavourable YTD
    Due to a mix of price and volume variances to budget along with savings targets not met.

14. **Residential Care Hospitals -** $1.15m unfavourable YTD.
    Due to a mix of price and volume variances to budget along with savings targets not met.

Public Health

Public Health April 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	8	4	(4) U		79	37	(42) U		44	
Mental Health	-	-	- F		-	-	- F			
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	-		341	341	-		410	
	42	38	(4) U		420	378	(42) U		454	
Public Health - NGO										
Mental Health	4	15	11 F		64	150	86 F	57%	180	15
Nutrition and Physical Activity	37	38	1 F		374	378	4 F	1%	454	
Physical Environment	-	-	-	n/m	-	-	-	n/m	0	
Public Health Infrastructure	-	-	-	n/m	-	-	-	n/m	0	
Sexual Health	-	-	-	n/m	-	-	-	n/m	0	
Social Environments	-	-	-	n/m	-	-	-	n/m	0	
Tobacco Control	7	7	-		67	67	-		80	
Well Child Promotion	-	-	-	n/m	-	-	-	n/m		
	48	60	12 F	10%	505	595	90 F	15%	714	
Total Public Health	90	98	8 F	6%	925	973	48 F	5%	1,168	

Public health expenditure variance notes;

15. Mental Health -$0.08m favourable YTD – Suicide prevention contract now expensed in Mental Health directorate.

Maori Health Expenditure

Maori Health April 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	-		160	160	-		191	
Maori Provider Assistance Infrastructure	-	-	-		-	-	-			
Maori Workforce Development	-	-	-		-	-	-			
Minor Maori Health Expenditure	-	-	-		-	-	-			
Whanau Ora Services	8	8	-		80	80	-		98	
Maori Health - Provider Arm Total	24	24	-		240	240	-		289	
Maori Health - NGO										
Maori Service development	20	21	-		204	207	3 F		250	
Maori Provider Assistance Infrastructure	-	-	-		-	-	-			
Maori Workforce Development	-	-	-		-	-	-			
Minor Maori Health Expenditure	-	-	-		-	-	-			
Whanau Ora Services	73	80	7 F	9%	670	799	129 F	-16%	956	
Maori Health - NGO Total	93	101	8 F	8%	874	1,006	132 F	13%	1,206	
Total Maori Health	117	125	8 F	6%	1,114	1,246	132 F	11%	1,495	

Maori Health Services expenditure variance notes;

16. Whanau Ora - $129k favourable YTD – Waihopai Hauora under budget.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Community Health Council - Our First Year**
Report to:	Commissioner Team
Date of Meeting:	24 May 2018

Summary:

The Community Health Council (CHC) is an advisory council to the Southern DHB and WellSouth Primary Health Network (PHN). The Council was formed in February 2017, with the appointment of eight members and the Establishment Chair Professor Sarah Derrett.

The Council now has eleven members, who are from a diverse range of backgrounds and geographical locations. These members all come with strong community connections and personal experiences with the health system, either as an individual or through caring for whānau.

To recognise the work of this new Council we have profiled their first year in the attached document.

The Chair and Facilitator would like to acknowledge the work and commitment of all Council members who have gone beyond the requirements of their roles to make the first year of the CHC a success. The Council also acknowledges the support from the DHB and WellSouth Executives in this new way of working and look forward to the opportunities that lie ahead.

In the next year, the Council would like to see further engagement occurring between staff and community, whānau and patients on projects as we move into a phase of co-design. Working together will help us achieve better health outcomes for our population.

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: Professor Sarah Derrett Chair of Community Health Council Charlotte Adank Community Health and Clinical Council's Facilitator **Date: 8** May 2018	**Presented by:**

RECOMMENDATION:

That the Commissioner and Deputy Commissioners note the content of this paper.

WellSouth Primary Health Network
Hauora Matua Ki Te Tonga

Southern District Health Board
Piki Te Ora

Community Health Council

Back row (left to right): Nigel Miller (Chief Medical Officer), Emily Gill (Executive Assistant), Jason Searle, Ilka Fedor, Sarah Derrett, Bronnie Grant, Martin Burke, Hana Halalele. Front row: Matt Matahaere, Rosa Flaherty, Paula Waby, Lesley Gray, Kelly Takurua, Charlotte Adank (CHC and Clinical Council's Facilitator)

The Community Health Council (CHC) is an advisory council for the Southern District Health Board (DHB) and WellSouth Primary Health Network (hospital and community health services including GPs) and has enabled a stronger patient voice to be heard across the Southern district. The CHC was established in February 2017, with the appointment of eight community members and the Establishment Chair, Professor Sarah Derrett.

> *The CHC is a great opportunity for our community to have input into a system we partake in. I think there is a great future ahead where community voices like ours will become part of the systems that will be created* - **Kelly Takurua**

We were very fortunate to have so many willing and engaged people to apply to be on the Council and members of the CHC want to maintain these connections going forward. The selection process involved a group interview in which applicants took part in a number of exercises. Ensuring there was diversity on the Council was of great importance, as well as having geographical representation from across the district which we believe we have now attained. Throughout the year, further members were recruited to the CHC; and we now have eleven members.

The CHC meet monthly and our views and recommendations are listened to by a forum made up of DHB and WellSouth Executives (including but not exclusively, the DHB CEO- Chris Fleming, WellSouth CE- Ian Macara, DHB Chief Medical Officer of Health- Dr Nigel Miller). Our opinions and viewpoints are not always in agreement but it is an opportunity to allow our community and whānau voices to be heard across the table, and listen and respect decisions that need to be made.

We believe our biggest achievement for the year has been the development of our CHC Community, Whānau and Patient Engagement Framework and Roadmap. This sets a benchmark for what the CHC believes is true community, whānau and patient engagement and puts the patient at the centre of everything we do. The CHC has a range of networks and people that want to be involved in decision-making and help to make a difference to the way the Southern health system delivers better quality services.

Current members:

Mr Martin Burke. Dunedin.
Term commenced: Feb 2017

Martin has held regional and national positions in Mental Health Addictions Service / Consumer Advisory roles. He holds Post Graduate qualifications in both Physical Education and Public Health. Martin is currently a member of the Health Quality and Safety Commissions Consumer Advisory Group in Mental Health and Addictions. Martin's health fields of interest include alcohol and drugs, long-term conditions and men's health.

Professor Sarah Derrett (Establishment Chair). Dunedin.
Term commenced: Feb 2017

Sarah teaches health systems and public policy, and is Director of the Injury Prevention Research Unit, at the Department of Preventive and Social Medicine, University of Otago. Sarah's research and health interests are focused on patient-reported health and social service experiences, outcomes, and equity. She sits on the Executive of a national patient and family-led charity (Bowel Cancer New Zealand), and the Board of a community mental health respite service (Kōputai Lodge) in Port Chalmers.

Ms Ilka Fedor. Dunedin.
Term commenced: Feb 2017

Ilka has completed her Master's degree at Otago University and is also trained as a Primary School teacher. Ilka is actively involved with a number of community committees in Dunedin including the cycling advocacy group SPOKEs and the Caversham Toy Library. Ilka is also a mother to three young children. Ilka's health fields of interest include youth and children, and women's health.

Ms Rosa Flaherty. Dunedin.
Term commenced: Feb 2018

Rosa Flaherty is 17 years old and is pursuing a Bachelor of Law at Otago University. Rosa has been involved in community radio at Otago Access Radio. While at school she established a Lesbian, Gay, Bisexual, Trans, Queer, Questioning and Others (LGBTQ+) support group for students and went on to facilitate a Rainbow Leadership group with other schools across Dunedin. Rosa's health fields of interest include LGBTQ+ rights within the health system, mental health, and youth representation within the health system.

Mrs Bronnie Grant. Gore.
Term commenced: Feb 2017

Bronnie is a secondary school trained physical education teacher who has worked both in Southland and overseas. Bronnie has been out of teaching for seven years, raising her three children on a farm outside of Gore. Most recently, Bronnie has been involved with co-leading the establishment of the Gore Kids Hub project which was successfully completed and opened in February 2016. Bronnie's health fields of interest include youth and children, women's health, and rural health.

Mrs Lesley Gray. Invercargill.
Term commenced: Feb 2017

Lesley is a retired registered general & obstetric nurse, with a certificate of Social Work from the University of Otago. Lesley is actively involved in a number of community groups such as Seniornet, Cardiac Club, Combined Fellowship Club, Meals on Wheels, Coffee Club, U3A and Women's Club. Lesley has a supportive husband and family and enjoys community activities. Lesley's health fields of interest include older persons and women's health.

Mrs Hana Halalele. Oamaru.
Term commenced: Oct 2017

Hana has over 15 years' experience working as a Probation Officer for the Department of Corrections. Hana is a New Zealand born Samoan and is involved with the Waitaki community through the Oamaru Pacific Island Community Group, Oamaru North School Board of Trustees, Waitaki Safer Community Trust, St Pauls Otepoti Presbyterian Church, and is Co-Chair of the Oamaru Pacific Island Network Group. Hana's health fields of interest include mental health, alcohol and drugs, Pacific Peoples' health, youth and children.

Mr Matt Matahaere. Dunedin.
Term commenced: Apr 2018

Matt works at the University of Otago in the Office of Māori Development where he is working on projects focused on the recruitment, retention, and success of Māori students. Matt has a Bachelor of Arts and a Masters in Peace and Conflict Studies. His interest in health developed through work he did for Māori and Pacific health providers and the Alcohol Liquor Advisory Council. He is affiliated with Ngāi Tahu and Te Rūnanga o Ōtākou. Matt's health fields of interest include mental health, Māori health, youth and children.

Mr Jason Searle. Cromwell.
Term commenced: Apr 2018

Jason works as a surveyor in Cromwell. He has a Bachelor of Science majoring in Zoology and Ecology at Massey University. Jason has a strong sporting background and has recently completed the GODZONE endurance race. He is part of the Clyde Rugby Team and a volunteer of the Urban Fire Brigade. Jason's health fields of interest include rural health and men's health.

Mrs Kelly Takurua. Tapanui.
Term commenced: Feb 2017

Kelly was born and raised in Gore until her family moved to Tapanui. Kelly has undertaken a number of courses relating to social services and mental health addictions in Dunedin and Invercargill. Kelly is currently working as a Social Worker/Manager for Te Iho Awhi Rito Social Service, a marae-based social service provider in rural Southland. Kelly's health fields of interest include mental health, alcohol and drugs, Māori health, and primary health.

Ms Paula Waby. Dunedin.
Term commenced: Feb 2017

Paula has lived experience of disability. She is the Local Coordinator for Otago Blindness Network, President of the Dunedin branch of the Disabled Person's Assembly, and representative on the World Blind Union. Paula works as an audio transcriber and runs a small business offering braille production and technology training for the blind. Paula's health fields of interest include disability, older persons, women's health, and primary health.

Previous Members:

Mrs Takiwai Russell-Camp
Dunedin. Term: Feb - Dec 2017

Mr Russell MacPherson
Winton. Term: Feb - Aug 2017

The Year Ahead 2018/19

The Council is excited about the year ahead especially to progress their Community, Whānau and Patient Engagement Roadmap, which has the full support of the DHB Commissioners, Iwi Governance, Clinical Council, and the Executive Leadership Teams at both the DHB and WellSouth. The Roadmap is focused on staff involving community, whānau and patients in decision-making throughout the Southern health system. Since their inception, CHC members have been assisting with requests from services for community, whānau and patient advisors, however this is not sustainable, hence the roadmap was developed. It has been a great experience to engage with a range of people to understand what worked and how we can achieve better health outcomes.

> *I feel that patients have such a wealth of knowledge when it comes to how healthcare can be planned, as we are the ultimate users of the system and the ones effected by the policies created* **- Ilka Fedor**

The CHC will have oversight of engagement activities across the health system to ensure the principles of engagement and quality improvement changes are made.

There are plans for the Council to host a symposium in February 2019, where all advisors will share and learn from their experiences, participating in projects.

It is expected the CHC will be involved with the upcoming Mental Health Inquiry and the Hospital rebuild at the Dunedin site. The CHC will be working alongside the DHB in the development of a local Disability Action Plan.

Community Health Council Participation

Throughout 2017/18 the Council has provided advice, recommendations and/or support for pieces of work being undertaken within the Southern health system. Outlined below are some key highlights from the last 12 months:

Southern Health Website

Some members of the Council were involved with the procurement for a supplier to undertake this work. The CHC will be involved with this project as it develops.

Staff Recruitment

A number of CHC members were involved with the recruitment process for staff members during the Southern DHB restructure.

Discussion Paper on Family, Whānau Accommodation for the Dunedin Public Hospital Rebuild

The CHC developed a joint discussion paper with the Clinical Leadership Group around what accommodation requirements were needed for family/whānau in the development of the new hospital. This was accepted by the Southern DHB Facilities Redevelopment Executive.

Patient Stories

CHC members have been strong advocates for this project. The new patient series provide individuals the opportunity to tell their stories, good and bad, to help improve our services. These stories are to be used in a variety of forums (e.g. staff education purposes) and some will be used in a wider communication campaign where the general public can view them. Some members of the Council have even told their own personal stories.

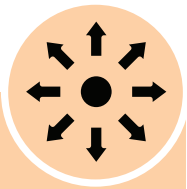
www.southerndhb.govt.nz/pages/patient-stories

Primary and Community Care Strategy & Action Plan

A CHC member sat on the Steering Group for this work and the Council offered advice throughout the development and engagement stages. The CHC plan to be involved with the implementation of this significant piece of work.

DHB Feedback Brochure

Members provided feedback on the DHB Feedback brochure that is provided to patients after they have experienced care at any Southern DHB site, or for anyone that is visiting and wants to provide feedback.



External Projects:

Health Consumer Councils NZ (HCCNZ)

The CHC Chair and Facilitator are part of the HCCNZ group. This group is made up of representatives of DHB Consumer Councils, Health Quality & Safety Commission and Ministry of Health (MoH). This network provides the opportunity to learn from other places or share work that is being undertaken.

MoH Electronic record

The Ministry of Health sought consumer input into information required for a digital health record. A workshop was held in Dunedin, as part of a national roadshow, which a number of CHC members participated.

Choosing Wisely

The CHC Chair attended a forum focused on the implementation of Choosing Wisely and this topic has been discussed at Clinical and Community Health Councils.

Membership of Southern health system Standing Committees:

Clinical Council

The CHC Chair attends the DHB Clinical Council which is focused on clinical governance across the organisation.

Sexual Health Services Governance Group

A CHC member sits on this group which has a purpose to improve sexual and reproductive health outcomes for people living in the Southern district with the principle of equity underpinning service planning and delivery.

Podcasts - Otago Access Radio

- **Southern Health Future - Community health Council.** July 2017. http://www.accessradio.org/Player.aspx?eid=5cabf81e-8689-4afe-9d27-08ba659ed69d
- **Notable Access Show with Chris Ford - Community Health Council.** November 2017. http://www.accessradio.org/ProgrammePage.aspx?PID=71e3a91e-b09f-4cdb-982c-8dc5425c1d19
- **Southern Health Future - Community health Council.** November 2017. http://www.accessradio.org/ProgrammePage.aspx?PID=f1a30c72-6c86-45f3-9d63-6e72b4494227

Papers/ Articles by CHC

- **Key Messages** are published on the DHB website after each meeting. https://www.southerndhb.govt.nz/pages/community-health-council/
- **Representatives chosen for Southern Community Health Council**. December 2016. https://www.stuff.co.nz/southland-times/news/87660673/Representatives-chosen-for-Southern-Community-Health-Council
- **Southern DHB press release**. February 2017. https://www.southerndhb.govt.nz/news/media-releases/community-health-council-holds-inaugural-meeting/
- **Southern DHB Better Health**. April 2017. https://www.southerndhb.govt.nz/files/19736_20170421121457-1492733697.pdf
- **Aim to up community health sector voice**. June 2017. https://www.odt.co.nz/news/dunedin/aim-community-health-sector-voice
- **Article published in Health Quality and Safety Commissioner Newsletter**. July 2017. https://www.hqsc.govt.nz/our-programmes/partners-in-care/news-and-events/news/2997/
- **Introducing the CHC members**. October 2017. https://www.youtube.com/watch?v=gfCMuvhy11M
- **Health Watch – Southland Express**. Dec 2017. Short article and photo about the People's Caucus meeting held in Invercargill.
- **CHC- Community, Whānau and Patient Engagement Framework & Roadmap.** March 2018. https://www.southerndhb.govt.nz/files/22315_20180319100713-1521407233.pdf

Presentations by the CHC

- **Administrators Symposium,** Dunedin. 11 October 2017
- **Administrators Symposium,** Invercargill. 12 October 2017
- **People's Caucus Forum,** Invercargill. 18 November 2017
- **People's Caucus Forum,** Cromwell. 25 November 2017
- **People's Caucus Forum,** Dunedin. 2 December 2017
- **People's Caucus Forum,** Cromwell. 2 December 2017
- **Iwi Governance, People's Caucus Forum,** Dunedin. 6 December 2017
- **Xcelr8 Training Course,** Dunedin. 29 January 2018
- **Executive Leadership Team,** Dunedin. 1 March 2018
- **Iwi Governance,** Dunedin. 6 March 2018
- **Clinical Council,** Dunedin. 9 March 2018
- **Southern DHB Community, Public Health Advisory Committee,** Dunedin. 21 March 2018

Reflections

As we move to reduce the inequities in our health system, the CHC is a critical component of this and ensuring whānau voice, is a voice of change. Thank you for all the work that has taken place so far, it is a journey and a necessary and fundamental one.

Odele Stehlin, Chair of Iwi Governance Committee

CHC has already made a positive impact, further representing patients and whānau in the Southern health system. As we move towards greater integration of health services, the council's work will continue to influence how we can best provide healthcare services to meet the needs of people and communities across Otago and Southland.

Ian Macara, Chief Executive, WellSouth

The Community Health Council has made an exceptional start in establishing itself as what I am sure will become a genuinely transformational force for the delivery of health services in our district.

Their role is to ensure that the experience of patients and health care users remains at the centre of the strategies, initiatives and services we offer. They have participated in critical organisational discussions, and developed systems to ensure the patient voice extends far beyond their team.

Already, they have made a difference to the culture at the DHB, with the comment, 'We need to hear from the Community Health Council' becoming increasingly second nature as issues are proposed and discussed across many forums.

I congratulate the Community Health Council on their work, and look forward to further developing our partnership with them in the years ahead.

Chris Fleming Chief Executive, Southern DHB

I would like to acknowledge the work and commitment of all Council members who have gone beyond the requirements of their roles to make the first year of the CHC a success. I would also like to acknowledge the encouraging support we have received from all DHB and WellSouth staff in this new way of working and look forward to the opportunities that lie ahead.

Sarah Derrett, Establishment Chair of CHC

Community Health Council
Community, Whānau and Patient Engagement Framework

Our Strategic Goal

Our communities, whānau and patients are active partners in the Southern health system design, planning and decision-making to achieve improved health processes and outcomes.

Our Guiding Principals

- Respectful & Equal process
- Genuine & Trusting
- Meaningful & Purposeful
- Empowering & Sustainable
- Inclusive & Accessible

Across These Domains

- Personal care & health decisions
- Community & public health services
- Policy, strategy & governance
- Programme, service & facility design

Our Engagement Approaches

Provide health information in ways that assist understanding

Help to get feedback on particular health issues (e.g. policy or decision)

Work directly with people to ensure that their concerns & aspirations are understood & considered

Partner with communities, whānau & patients to address particular issues and help to apply solutions

Communities, whānau & patients are a key part of the decision-making in the Southern health system

TIRITI O WAITANGI **PARTNERSHIP, PARTICIPATION, PROTECTION**

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Community Health Council Community, Whānau and Patient Engagement Framework and Roadmap**
Report to:	Commissioner Team
Date of Meeting:	24 May 2018

Summary:

The Community Health Council (CHC) is an advisory council to the Southern DHB and WellSouth Primary Health Network (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.

The CHC developed some guiding principles for their framework for community, whānau and patient engagement within the Southern Health System. Consultation around these principles occurred in the later months of 2017 and amendments were made. The CHC are in the final stages of refining their Roadmap which outlines processes and steps to how engagement could occur. This work connects with Southern Future priorities and the Primary and Community Care Strategy and Action Plan.
The CHC is moving forwards with the implementation of this work by engaging with staff both at the DHB and WellSouth. The CHC have developed resources to support both staff and advisors to achieve successful engagement. Engagement forums with staff are scheduled to occur in May.

The CHC plans to reconnect with local communities to update them on how this work has progressed and this will also be an opportunity for community members to put their names forward to be an advisor to work with staff on projects.

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: Professor Sarah Derrett Chair of Community Health Council Charlotte Adank Community Health and Clinical Council's Facilitator **Date:** 8 May 2018	**Presented by:**

RECOMMENDATION:
That the Commissioner and Deputy Commissioners note the content of this paper.

9.2

Introduction

In the early stages of evolvement the CHC received a number of requests from services for suitable community, whānau and patient advisor(s) on various working groups. It was a great experience for CHC members to gain an understanding of what worked and what steps allowed successful engagement to occur.

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

To enable a sustainable process for engagement 'co-design' 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.

Implementation of Community, Whānau and Patient Engagement Framework and Roadmap

The Roadmap is being finalised alongside the Communications Team and the CHC envisage having a plan on one page. Alongside the Roadmap will be tools and resources to support staff and advisors with engagement.
The Council has been working on refining resources which would support both staff and advisors as they work together on projects. Table 1 outlines resources that have been developed for both groups.

Table 1. Resources contained in the Staff Information Pack and the Advisor Welcome Pack

Staff Information Pack	**Advisor Welcome Pack**
• Staff Information Sheet and Checklist	
• Staff Flowchart	• Advisor Flowchart
• Advisor Position Description	• Advisor Position Description
• Advisor Confidentiality Agreement	• Advisor Confidentiality Agreement
• Advisor CHC Mentoring Programme	• Advisor CHC Mentoring Programme
• Staff Feedback Form	• Advisor Feedback Form

The CHC plan to set up a site on Pulse for staff to access some of this information. In order for the Council to have oversight of all engagement work occurring across the organisation, a staff member will need to go through the CHC Facilitator to access additional information and to appoint a CHC Mentor to support the advisor.

Currently the DHB website has a designated site for the CHC and further information will be uploaded here for our communities to find out more about how to get involved

- *Organisational Commitment*

There is commitment from leaders at both the DHB and WellSouth to progress this work. The next step is to promote a culture change across the Southern Health System, whereby staff understand the benefits of engaging with community, whānau and patients and are guided/supported through a process of successful engagement. The CHC Chair and Facilitator plan to do a series of presentations with specific leadership groups within the Southern DHB and WellSouth and this will be followed by some open staff forums so that any staff member can attend if they want to find out more about engaging with community, whānau and patients in their work. These staff engagement forums are scheduled to occur throughout May and early June.

As well as staff engagement forums, the CHC plan to have foyer displays at the Dunedin, Invercargill and Lakes hospital sites at some later dates. Information will be circulated to GP

practices via WellSouth channels and there will be a range of other communication avenues such as radio, posters, newsletters and emails.

- *Community, Whānau and Patient Commitment*

The CHC have plans to reconnect with communities across the district in mid-June through a series of forums such as those held in 2017. It is proposed that these will be held in Invercargill, Dunedin Oamaru and Central Otago. The purpose of these forums will be to update communities on the progress that has been made by the CHC on the Community, Whānau and Patient Engagement Framework and Roadmap. At the same time it will be an opportunity for community members to nominate themselves to go on the database of people who are willing to be advisors on projects.

Process from here

- **Communicate and Connect**
  The CHC and Facilitator will work closely with the Communications Team to ensure communication continues through appropriate channels.
  CHC members, through their networks, will connect and communicate information about how community, whānau and patients can be involved.

- **Database Updated and Maintained**
  The database will need to be updated with relevant information from people who agree to have their names put forward as advisors. The database will be stored in a secure and safe place with the CHC Facilitator.

- **Evaluate and Monitor**
  The CHC and Facilitator will continually monitor and evaluate the roll-out of the Community, Whānau and Patient Engagement Framework and Roadmap. Progress will be evaluated through feedback forms from both staff, advisors and CHC members acting as mentors. Necessary amendments will be made throughout the process.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Primary and Community Care Strategy and Action Plan**
Report to:	Commissioner Team
Date of Meeting:	10 May 2018

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

Attached are the final Primary and Community Care Strategy and Action Plan. These documents have been updated to accommodate the 83 formal submissions received, as well as the feedback provided by attendees in each of the second round of presentations.

Broadly, there are no significant changes to either document, but the Action Plan has been amended to include more simplified language and to more accurately break the work into appropriate phases of activity, in line with work already underway. No headline actions have been added, removed or amended and accountable owners for all actions have directly authorised any changes to their respective content.

Other changes include:

- Inclusion of more overt references to the Dunedin Hospital Rebuild
- Clarity around the difference between HCH our preferred model of GP practice and Community Care Hub as the physical location of additional services in the document. The concept of health care home hub removed as is confusing.
- Locality network clarification aligning to our ongoing work.

It is proposed to make the final Primary and Community Care Strategy and Action Plan public in early June, and a communications plan is being drafted to support this.

The PHO Board has reviewed and endorsed the final documents in advance of this submission.

Financial:	
Workforce:	
Other:	

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

Prepared by: Stuart Barson WellSouth and SDHB **Date:** 9 May 2018	**Presented by:** Lisa Gestro Executive Director Strategy, Primary and Community

RECOMMENDATION:

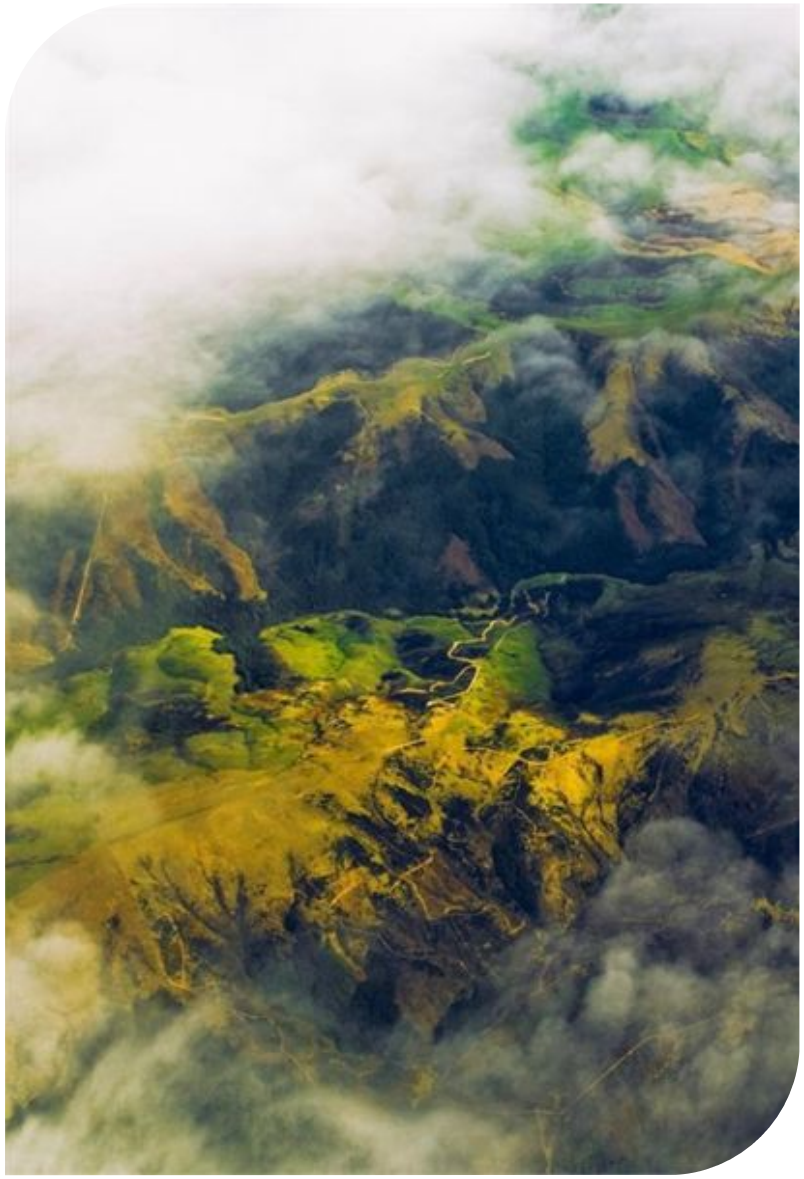
That the Commissioner approve the attached Primary and Community Care Strategy and Action Plan.


Southern Primary & Community Care Strategy
Southern District Health Board
Piki Te Ora
WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Mihi

Karanga atu rā ki ngā tangata o te taitonga;
Nei rā mātou, e mihi kau ana ki ā koutou tīpuna kua wehe atu ki tua o Paerau.
Tēnā koutou katoa!

We call to you, the people of the south;
We greet and acknowledge all of our ancestors who have passed beyond the veil.
Greetings to you all!



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Overview

Foreword

Tēnā koutou katoa,

We are pleased to present the Southern Primary and Community Care Strategy, which describes our vision for primary and community care in the Southern health system. This vision centres around our consumers, their whānau and communities, and the role the Southern health system needs to play in caring for and empowering them to live well, stay well, get well and die well. It reflects the call from our communities for better integrated services, and from our workforce to strengthen the capacity and capability of primary and community care to contribute to the wider Southern health system.

Given the challenges facing the Southern health system, and the generational opportunity that the rebuild of Dunedin Hospital presents, we have developed a bold and aspirational Primary and Community Care Strategy. Fundamentally, we want to focus primary and community services on fostering wellness, reducing health inequities (particularly for Māori), and providing timely, holistic care close to people's homes. Our aspiration is that consumers will experience primary and community care that is more responsive to their needs, is delivered by practitioners who work in partnership with them, and who in turn are better supported by our hospital services. To develop a Strategy that reflects this aspiration, we have been guided by five questions:

1. What can consumers, whānau and communities achieve for themselves?
2. What can technology help consumers and the workforce to do more effectively?
3. How can care be provided closer to home?
4. How can we develop a more integrated system of care for our population?
5. How can we develop the culture and leadership needed to deliver on this vision?

These questions are important, because we recognise that for too long we have taken the capabilities of our population, whānau, and primary and community services for granted, and have not consistently prioritised investments and other actions that could most cost-effectively improve access and outcomes.

This Strategy has been developed jointly by Southern District Health Board and WellSouth Primary Health Network, with support from the University of Otago, reflecting our commitment to working together to improve the contribution of primary and community care to the wider Southern health system. It recognises our history, and the challenges we face in responding to the changing needs of our communities, the increasing pressures on our health workforce, and our responsibility to provide equitable access to services across our large and diverse district.

Our ability to implement the actions underpinning this Strategy will depend on whether we are bold enough and prepared to make tough prioritisation decisions. We will work with our communities and other stakeholders to make these prioritisation decisions, which will require all of us to challenge our attitudes, beliefs and ways of working. We are committed to doing our part in changing how we operate as leaders of the Southern health system, and look forward to working with you to make a positive difference to primary and community services that we can all be proud of. Mauri ora!

Chris Fleming
Chief Executive
Southern DHB

Ian Macara
Chief Executive
WellSouth PHN

Kathy Grant
Commissioner
Southern DHB

Dr. Douglas Hill
Chair
WellSouth PHN

The Southern Primary & Community Care Strategy and Action Plan

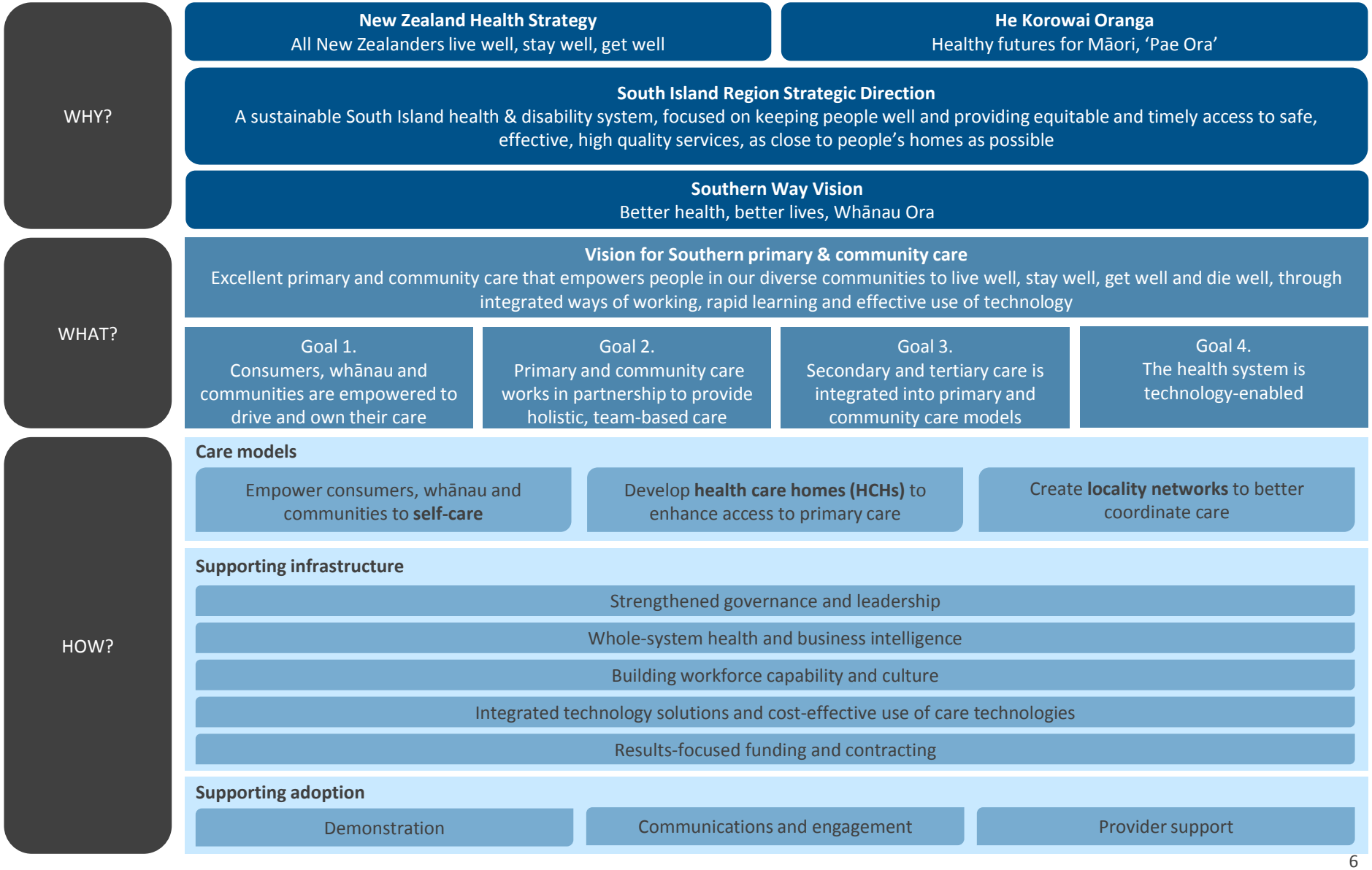

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Table of key definitions

Term	Definition
Primary care	Primary care relates to the professional health care provided in the community, usually from a general practitioner (GP), practice nurse, pharmacist or other health professional working within a general practice
Community care	Wide-ranging care provided in a community setting, from supporting consumers to manage long-term conditions, to treating those who are seriously ill with complex conditions, much of which takes place in people's homes
Secondary care	Care provided by a specialist or facility on referral from primary care (usually by a GP), requiring more specialised knowledge, skills, or equipment than can be provided in primary care. This can be provided either by visiting specialists, or in Dunedin, Invercargill, or some rural hospitals in the Southern district
Tertiary care	Specialised care (investigation and treatment) usually provided on referral from clinicians in primary or secondary care by visiting specialists, or in Dunedin Hospital (with some services provided outside the district e.g., highly specialised paediatric care at Starship Hospital in Auckland)
Multi-disciplinary	A team comprised of people from across disciplines within the health sector, supporting the delivery of holistic health care. This could include, for example, GPs, PNs, DNs, pharmacists, health care assistants, allied health and other relevant representatives
Inter-disciplinary	A team comprised of people from the health and social sector, supporting the delivery of holistic health and social care. This could include, for example, multi-disciplinary teams, plus representatives from MSD, Corrections, Housing, Ministry for Vulnerable Children, Oranga Tamariki and other agencies
Care coordination	Supporting the coordinated delivery of consumer / whānau care, either within or across providers. A Care Coordination Centre (CCC) will support this function across primary, community, secondary and tertiary care in the Southern district
Stepped care	A care model approach that segments populations into increasing levels of health (and social) need, with defined care responses matched to population segments. The higher the level of need, the more intense the care response.
Health Care Home (HCH)	A team-based model of care by primary care with strong strategic and operational relationships with community, hospital and specialist services, with the intent to provide the right level of proactive, comprehensive and continuous health care to patients
Locality network	The strategic and operational network of providers and services required to provide timely, responsive care to defined populations based on an agreed minimum level of care, with some local variation for particular health needs and service contexts
HCH community hub	The potential physical infrastructure required to enable integrated ways of working within locality networks, with modification of the scale and scope of the hub determined by population size and existing infrastructure

Introduction

Introducing the Southern Primary & Community Care Strategy and Action Plan

Development of the Southern Primary & Community Care Strategy and accompanying Action Plan has been led by the Southern District Health Board (DHB) and Well South Primary Health Network (PHN), with support from the University of Otago, reflecting each organisation's critical role in shaping health care in the Southern health system, commitment to collaboration, and unique teaching and learning environment. Both organisations have recognised the Dunedin Hospital rebuild as a generational opportunity to redistribute investment across the system, and do things differently in primary and community care - delivering a broader range of services through approaches and settings that are effective and convenient for consumers and whānau, and foster professional satisfaction.

Development of this Strategy has required a different way of thinking and actively engaging with consumers, whānau, iwi, tertiary providers, and representatives from across primary, community and secondary care. This approach will be maintained through implementation, and extended to include engagement with social and private sectors.

The Strategy is aligned with the government's priorities and policies, including the New Zealand Health Strategy and He Korowai Oranga. It has been developed to address the unique needs and circumstances of the diverse Southern district, New Zealand's largest DHB area, and with over 40% of its population living rurally. The Strategy and accompanying Action Plan is strongly evidence-based, building upon leading examples of primary and community care in New Zealand and internationally, and analysis of demographic, access and outcome data.

The Strategy recognises that Southern primary and community care performs well in many respects. Most people have timely access to good quality care provided by hard-working and well-intentioned health providers and practitioners. However, the strain on some services is apparent, and in other instances, care providers can improve their responsiveness to population and individual needs. Trusting relationships between many providers are broken or do not exist, and in many cases a provider- or service-centric approach is taken, rather than planning with consumers and whānau at the centre of care. In particular, there remain longstanding inequities of access and outcomes for Māori, rural and remote populations.

Looking to the future, changes in demographics, disease prevalence and workforce capacity will increase the strain on primary and community care, if current care models persist. Changing how primary and community care providers interact, the services they are capable of delivering, and their relationship with hospital and specialist services is fundamental to meeting tomorrow's challenges.

Stakeholder engagement, research on leading models of primary and community care, and analytics of access and outcomes across the district have led to a focus on:

- Empowering consumers, whānau and communities
- Strengthening the ability of primary care to provide a broader scope of services close to home
- Integrating care across primary, community and secondary care.

The underlying direction is enabling primary and community care to focus itself on population health and wellness, delivering care closer to home, and being able to successfully transition people across care settings. This will require changes to the way in which:

- Consumer and whānau needs are interpreted and met
- Services are planned, funded and contracted
- Providers and practitioners interact across primary, secondary and community care.

This direction is articulated through a vision and set of strategic goals. The accompanying Action Plan sets out the headline actions and supporting activities that will be progressed during initial phases of executing the Strategy. Through implementation, the Southern health system will be one, collaborating to help consumers and whānau live well, stay well, get well and die well.

Developing the Primary and Community Care Strategy and Action Plan

Literature scan
- Key national and international trends in contemporary models of care

Stakeholder feedback
- Engaged approx. 525 consumers and primary, community and secondary care stakeholders to understand their aspirations

Analytical profile
- Profiled demand, access, equity and capacity across primary and community care, and relevant interfaces with secondary care in the Southern district

Case studies
- 10 relevant case studies from NZ, Australia, the US and UK
- Innovative changes in models of care

Planning Framework
- Collated and analysed key themes to inform Strategy and Action Plan development

Strategy
- Enhance primary care
- Team-based ways of working
- Integrating care across settings
- Integrated IT solutions
- Virtual health
- Home-based care (including remote-monitoring)
- Locality approaches to care delivery

Action Plan
Being innovative, courageous and rapidly learning as implementation progresses

Building a critical mass of inter-locked initiatives that together transform care delivery

Ongoing engagement
This occurred throughout the process at key points, with a Steering Group, a Working Group, consumers, and primary, community, and secondary care stakeholders

How the Strategy relates to other national, regional and district strategies and plans

New Zealand Health Strategy (NZHS)

He Korowai Oranga

South Island Regional Health Services Plan

Southern Strategic Health Plan (SSHP) 2015 - 2025 and Implementation Plan

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

Southern Strategic Services Plan

Southern Primary and Community Care Strategy

Southern Primary and Community Care Action Plan

Detailed Services Plans A & B

Indicative Business Case

Detailed Business Case (TBC)

Dunedin Hospital Rebuild

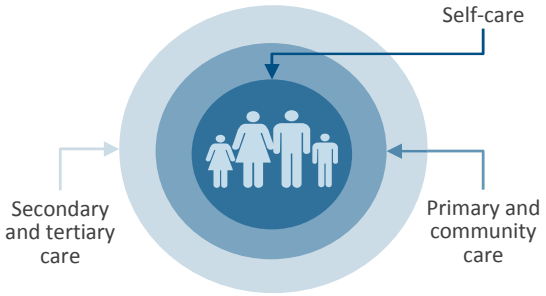
Southern Workforce Strategy and Action Plan (June 2018)

Southern Digital Strategy (June 2018)

We can do better for the people of the Southern district…

Challenges

1 Consumers and whānau expect a more consistent care experience, in which they play a more active role



2 Ageing and increasing complexity suggests a significant increase in demand for health care

>1/6
…Older people live with 3+ chronic conditions

73%
… increase in GP consultations expected for 65+ population by 2036 under current models of care

3 Significant variation in the Southern health system in terms of access, experience and outcomes

11+
medications dispensed on average to Southerners aged 85+ years (2014)

**Darker shading = higher rate of use*

3-fold
… variation in medical / surgical discharge rates by enrolled general practice populations, which can't be explained by age, ethnicity or deprivation

Māori are **3x** more likely to die for amenable reasons

Opportunities

4 Southern as a national hub for education and training of health professionals can design local approaches to address workforce shortages and development needs including building the Māori health workforce

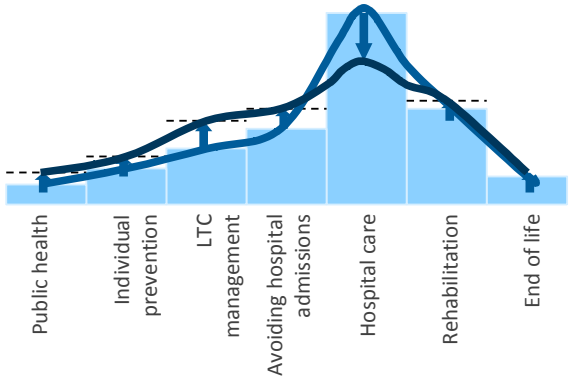
494 … Māori DHB employees per 100,000 Māori population^

193 … DHB allied health professionals per 100,000 population*

40% … of Southern GPs intend to retire in the next 8 years

^cf. 510 in Nelson Marlborough & 392 in Canterbury
*cf. 197 in Nelson Marlborough & 280 in Canterbury

5 The rebuild of Dunedin Hospital is a major opportunity to optimise the mix of services across settings



6 Consumers want to receive care in new ways, supporting the use of new service, workforce, business and funding models

We need a new approach…

	If we maintain the status quo…	If we take a new approach…
1	Disjointed approaches across sectors result in a growing health inequity gap, particularly for Māori	Joined up approaches across health, social and education sectors enable collective action to address factors that contribute to inequity of access and outcomes
2	Health risk factors such as obesity continue to increase and demand for treatment services grows	Consumers, whānau and communities understand how to live well, and are supported by preventive care in the community
3	There remain many points of entry to the system , and health services continue to operate in 'silos', with limited connections with social services	Consumers and whānau are able to easily navigate the system, which provides cohesive care across services, settings and organisations, supported by integrated systems and processes
4	Our GP, nursing and allied health workforce struggles to deliver timely access to services – creating further pressure on hospitals, and making primary and community care careers unattractive to the next generation of the workforce	Our primary and community workforce is engaged and aligned through new models of care, allowing health professionals to focus on higher skilled clinical work through new ways of working and support from new roles (e.g. health care assistants; clinical pharmacists)
5	Health services continue to be provided in traditional ways, despite technological advances which could improve access, quality and efficiency	New digital technologies support community health literacy and provide 'virtual' links between consumers and services, supporting the delivery of care in home and community settings
6	Southern DHB struggles to live within its available funding, and DHB hospital services consume an ever-increasing share of resources, limiting investment opportunities in primary and community care	Investment is planned and prioritised across the system to drive an optimal mix of community and hospital-based services
7	Hospital care cannot keep up with increasing acute demand, exacerbated by primary and community care capacity shortages, and the increasing number of consumers with complex needs and long-term conditions	Primary and community care is delivered from fit-for-purpose facilities, enabling team-based ways of working, and providing a broader range of services in out-of-hospital settings, allowing hospital care to be focused on those with the highest needs
8	New initiatives are not regularly monitored and adjusted, and scaled or stopped depending on performance, resulting in inefficient resource use	A culture of continuous improvement is supported by the monitoring and rapid evaluation of new initiatives, informed by consistent data and use of evidence-based evaluation tools

The Strategy

The Strategy: Vision and strategic goals

The Southern health system is built on an overarching vision…

Better health, better lives, Whānau Ora

The vision for primary and community care is…

Excellent primary and community care that empowers people in our diverse communities to live well, stay well, get well and die well, through integrated ways of working, rapid learning and effective use of technology

The strategic goals supporting this vision are…

1. **Consumers, whānau and communities are empowered to drive and own their care**
2. **Primary and community care works in partnership to provide holistic, team-based care**
3. **Secondary and tertiary care is integrated into primary and community care models**
4. **The health system is technology-enabled**

Goal 1. Consumers, whānau and communities are empowered to drive and own their care

Southern consumers, whānau and communities are supported to drive their own care and wellbeing, and the overall performance of Southern primary and community care

What this will mean:

- Consumers will be involved in design and review of primary and community health services
- Consumers with more complex needs will have a lead carer coordinating services across the care team according to a shared care plan
- Consumers and whānau will:
    1. have access to culturally-appropriate services to improve their health literacy, and the self-management skills of those with a long-term condition(s)
    2. have a single point of online contact through a portal to access their health information, including shared care plans connected to their health care records; initial diagnosis, triaging and care options; and other reliable health-related information
    3. be able to participate in peer groups of consumers (e.g. via social media, community meetings, and professional-led sessions)
    4. be able to shape the improvement of primary and community care through regular feedback mechanisms, and access to provider performance results
- Consumers, whānau and communities will be supported to have greater involvement in caring for others through technology support, access to time- and skill-sharing volunteer opportunities, enhancing social participation and resilience.

Goal 2. Primary and community care works in partnership to provide holistic, team-based care

Primary and community care is working in partnership to provide holistic care tailored to individual needs, through team-based ways of working across home, clinic and community settings

What this will mean:

- Primary and community care will be:
  1. able to proactively match resources with care needs through new ways of working (e.g. extended consultations; extended hours; team-based care; virtual health), and new team roles (e.g. health care assistant, health coach; clinical pharmacist; allied health professionals) based on a HCH model of care
  2. using diagnostic and virtual health technologies to provide efficient and convenient care
  3. using whole-system care pathways tailored to the Southern context
  4. organised into integrated multi-disciplinary teams wrapped around general practice, which provide 24/7 holistic and culturally-appropriate stepped care, with team membership based on skills and capabilities rather than professional demarcation
  5. delivered through integrated primary and community care hubs that foster closer alignment of DHB and NGO community services, and - where cost-effective - ambulatory secondary care services from Dunedin and Invercargill hospitals
  6. able to effectively respond to acute crises (e.g. paramedics and PRIME-trained practitioners in rural communities; access to community diagnostics; clinical observation in a centre or hub)
  7. equipped with enhanced access to clinical advice from secondary and tertiary care
  8. able to provide an increased scope of clinical interventions through defined clinical protocols
  9. delivered in ways that recognise the importance of Te Ao Māori (the Māori world view), te reo Māori, and in settings that recognise the importance of cultural safety and familiarity (e.g. marae; integrated Māori health service clinics)
  10. engaged in teaching and learning
- Primary and community care will be at the heart of rural hospital care provision. Within a district-wide planning framework, they will be able to provide an expanded scope of diagnostics, and step-up / -down care for their catchment populations, with a workforce developed to deliver this model of care, with capacity matched to population needs
- Primary and community care will be planned to respond effectively to the needs of Māori, Pacifica, rural and remote population groups
- Community pharmacy, aged care, mental health & addictions, and palliative care community providers will be fully integrated into team-based care models
- Effective intersectoral partnerships will be effectively addressing the social determinants of health, including introducing an explicit Health in All Policies (HiAP) component to all public sector policy development processes.

Goal 3. Secondary and tertiary care is integrated into primary and community care models

Secondary and tertiary services join the primary and community team to provide support to enable consumers with complex needs to access timely care close to home

What this will mean:

- Secondary and tertiary care will:

1. be active supporters of primary and community care teams, providing specialist advice, episodic care for consumers with more complex needs virtually and in clinic-based settings, and contributing to the development and implementation of care pathways
2. support regulated health care professionals to extend their scopes of practice and inter-professional working (e.g. development of nurse practitioner, GP and PN with special interest roles, and allied-nursing inter-professional skills / competencies for shared tasks)
3. have a clear understanding of the range of community options available for consumers, and prioritise community care where clinically appropriate, including step-up / -down care
4. have a single clear point of access for primary and community care providers seeking rapid advice
5. integrated teaching, learning and research
6. accommodate the distinct needs of rural communities through:
    a) patient-determined primary and community care bookings, and coordination of specialist appointments*
    b) local outreach clinics (virtual or visiting)
    c) tailoring outpatient clinics to the needs of Māori
    d) preparedness for emergency transfer or retrieval
    e) arrangement of travel and accommodation options.

*patient-determined bookings will be across both primary and secondary care, with primary care bookings able to be self-initiated, while patients are prompted to make secondary bookings through a clear single point of access

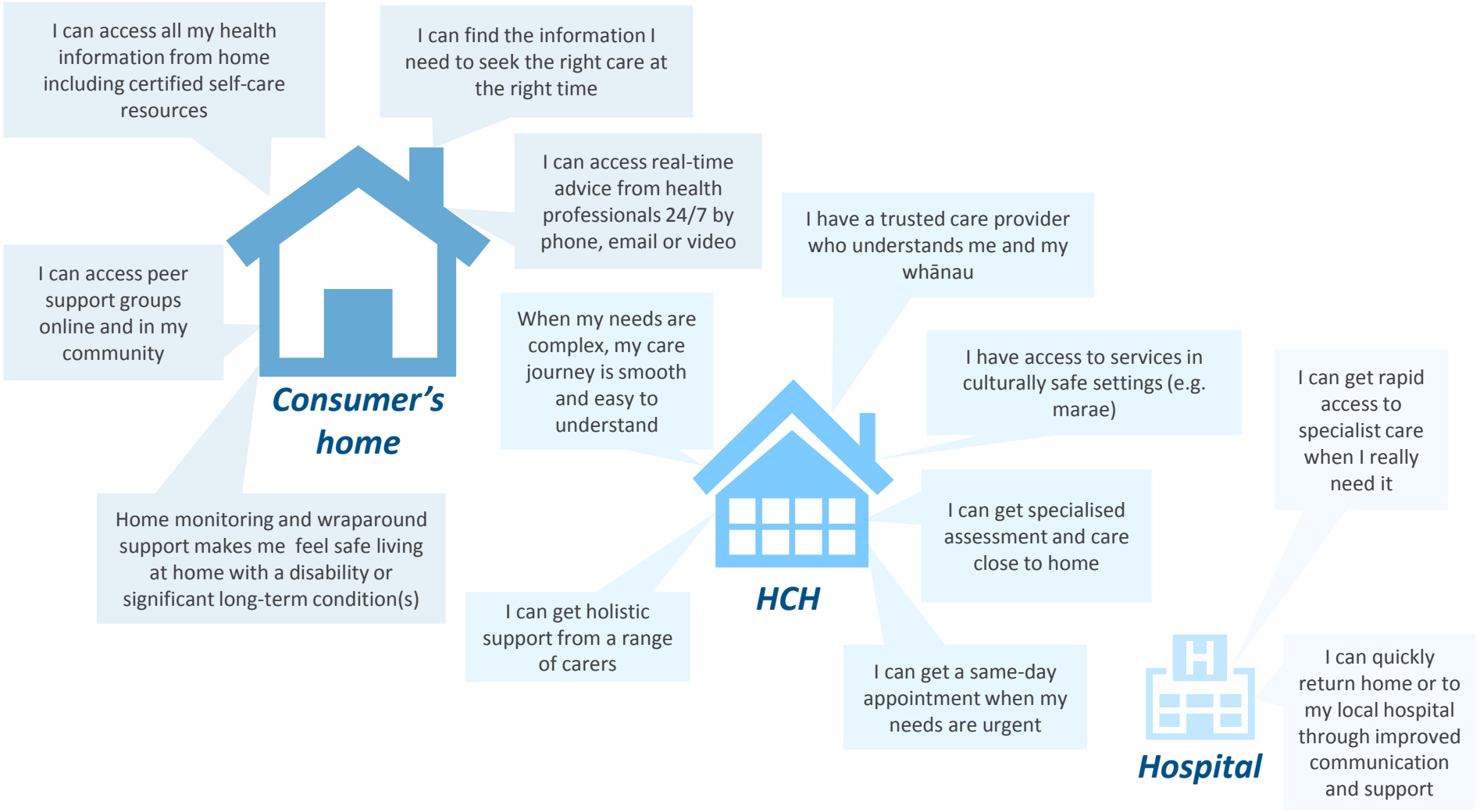
Goal 4. The health system is technology enabled

Technology solutions are systematically deployed to support seamless care and continuous improvement of primary and community care

What this will mean:

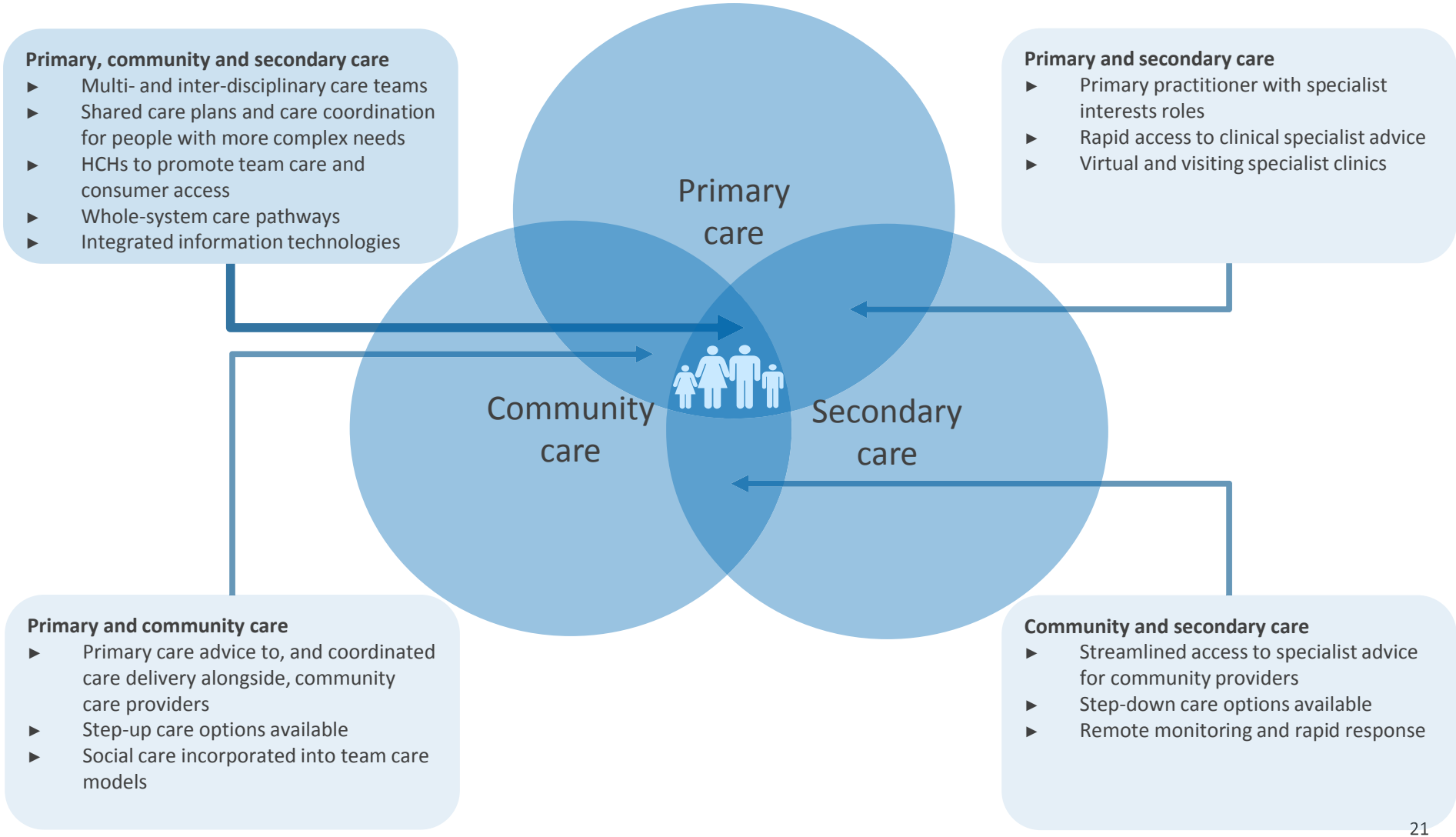
- Every consumer will have an electronic health record (EHR) accessible to them and members of their care team, accessible from any device, and with a consumer-nominated lead carer as custodian
- The health workforce will use digital platforms for professional development and fostering of peer support networks
- An integrated set of technology solutions will enable a single point of contact to the Southern health system, shared care planning and efficient administration. It will support e-ordering and instant communication regardless of device, reducing barriers to access and supporting the primary and community workforce to operate at the top of their scopes
- Virtual health technologies supporting the delivery of virtual consultations by the primary, community, secondary and tertiary care workforce
- Clearly specified processes for data collection, analysis, and performance improvement initiatives driven by insights, with the use of AI to augment human input
- New technologies to support home-based care and remote monitoring will be commonplace, including in-home sensors for people with relevant physical and/or cognitive needs (e.g. heart disease; dementia), with real-time data being collected and acted on by care professionals
- Consumer genomic information and health data from both home-based and wearable technologies will be incorporated into the consumer's EHR, informing discussions and decisions with their care team
- Where feasible, cost-effective emerging technologies will be in use by consumers (e.g. home-based support for older people) and by providers (e.g. community pharmacy)
- The introduction of emerging technologies will have a clear process for prioritisation, seed funding, structured adoption, and evaluation (including return on investment)
- Southern will be a fast-follower of national and other regional trends, adopting others' proven solutions where possible and innovating as required, depending on needs and technology trends.

Bringing it all together – the consumer and whānau experience



Bringing it all together - integration of primary, community and secondary care

The delivery of better coordinated ways of working across primary, community and secondary care will improve efficiency and consumer experience. Core components are shown below.



Transforming primary and community care for Māori

Whilst there has been improvement in Māori health outcomes over the past three decades, the fact that significant inequities remain is of great concern. Transforming primary and community care for Māori is therefore a priority in addressing these long-term issues. Within the context of this Strategy, efforts to eliminate these persistent inequities will require focusing on the social determinants of health, lifting the capability and performance of both Māori health and mainstream services, and building more effective ways of working these services. The key ways to achieve this will be a willingness to understand those measures that haven't worked well enough, and leadership in respect of approaching and implementing those that may. Data, analysis and reporting will be used to help drive a concerted focus in this regard.

Addressing the social determinants of health will include working with health and social sectors using a Health in All Policies approach, which focuses on addressing the major determinants of health inequities. Iwi will be actively engaged through this process to help design and implement effective and innovative approaches for connecting with Māori whānau and communities.

Building the capability of the Māori provider sector will include:

- Strengthening the breadth and depth of delivery of care from Māori health clinics through HCH development
- Integration of Māori health providers into locality networks supported by care pathways aligned with the stepped care model, allowing kaupapa Māori support for consumers with complex needs
- Workforce development, including increasing Māori participation and fostering greater cultural inclusivity
- Recognising the role of rongoā Māori and other traditional Māori health care practices in care models.

Lifting the responsiveness of mainstream primary and community care services will include:

- HCH model of care design to reduce barriers to equity of access by (for example) targeting high risk populations, including Māori, through stratification and stepped care
- Locality network models to include explicit key performance indicators for improving Māori health access, experience and outcomes
- Increasing workforce capability, particularly in relation to cultural competency, and understanding and using te reo Māori and te ao Māori values.

Transparent equity analysis and reporting will include:

- Health and business intelligence to quantify and benchmark Māori and non-Māori access and outcomes
- Locality health needs and service profile analysis to include assessment of current and future Māori health needs and service gaps.

With Māori consumer feedback speaking clearly to feelings of lack of understanding and respect (and consequent loss of mana), geographical isolation and distance from their traditional methods of health care, efforts to address these issues is vital. Enabling Southern Māori to regain their aspirational health focus, feel culturally safe and respected, and access primary and community health services without undue barriers through the HCH and implementation of effective technology will begin (at least) to address the inequities in meaningful ways.

Transforming primary and community care in rural communities

Rural models of care will be progressively based on a district-wide planning framework, with tailoring for the unique needs of different communities. The planning framework will include the transformation of primary care into HCH models of care, and, as appropriate, development of community care hubs that co-locate a broader range of services. There will also be planned development of primary and community care practitioners with special interests that deliver care from and across HCHs and community care hubs. Rural hospitals will increasingly operate in an integrated way with primary and community health services, with medical staffing by rural hospital medicine specialists who are part of the unified medical team serving the catchment population. This will include ensuring appropriate medical support for health centres operating in more remote towns.

Within each locality, delivery of a minimum set of services will be required, with funding and contracting arrangements to support broadening scopes of practice, increased access to cost-effective clinical technologies, and locally tailored service interventions. There will be an explicit focus on reducing rural and remote inequities related to cost, transport, and other access barriers. In some cases, more specialised services will operate across multiple communities or HCHs in order to be cost-effective - while still delivering care close to home for consumers.

Care models will be based on a stepped care approach, supported by care pathways, shared care planning and delivery, EHRs, and other key enablers. This will not only support the integration of the rural hospital with other primary care services, but also the extension of primary and community care through stronger strategic and operational connections with local providers, and local support services (e.g. health of older people) and social care services (e.g. housing, MSD, education).

As part of the primary and community service for the catchment population, the rural hospital will offer acute care integrated with local primary care services, extended diagnostics, and have the clinical capability to deliver care at an appropriate level of acuity.

The rural hospital's clinical capability will increase with the distance from a base hospital, and the size and structure of its population.

Other considerations in defining the range of services to be offered by rural hospitals include:

- Moderately specialised procedures could be delivered locally, such as chemotherapy infusions under the supervision of the Southern regional blood and cancer service, minor operations for skin lesions, and injections for wet macular degeneration (in some instances, HCHs may provide some of these services)
- Expanded diagnostics would save time, enhance local care, and provide visiting or remote specialists with additional clinical information. Electrocardiograms for tests of heart conditions and spirometry for respiratory function could be available. Some level of imaging, such as X-ray, CT scanning (where the workforce permits), and less complex ultrasound is desirable. Over time, the ability to perform a wider range of 'scopes' is likely
- Close local management of acute presentations, aligned with an integrated ED network across the district, would reduce the need for transfer and transport, and ensure patients who do need care from a base hospital are sent to the correct destination. Rural hospitals could offer primary care acute management backed up with support from Invercargill and Dunedin hospital EDs, close on-site integration with St John paramedic capacity, and short-stay observation/assessment beds
- Depending on local circumstances, the acute capability of the rural hospital could be complemented by: 'step-down' subacute capacity, including rehabilitation following an acute medical or surgical intervention at Invercargill and Dunedin hospitals; aged residential care; and primary birthing. Such co-location of services could provide the scale needed to meet clinical and financial requirements
- An enhanced 'hospital in the home' community nursing service could provide acute, sub-acute and post-acute care to adults and children to avoid the need for inpatient care in a rural (or base) hospital
- Locality planning will also work within district-wide parameters to determine the availability of specialist clinics (visiting and virtual) to match population needs.

Strategic aspirations and success factors

	We will be able to say…	We will know we've been successful when…
1	Our population has equitable access to primary and community care, and specialist support when needed	We have significantly reduced inequities of access for rural and remote communities, Māori and other vulnerable populations
2	Primary and community care responds effectively to the needs of Māori	Our primary and community care workforce is culturally competent, and is addressing the needs of Māori in partnership with (rather than dependent on) Māori and other specialised care providers
3	Primary and community care responds effectively to the needs of other vulnerable population groups (e.g. Pacifica, rural, remote, and disabled)	Our primary and community care workforce is culturally competent, and is addressing the needs of, Pacifica rural, remote and disabled population groups in partnership with specialised care providers
4	Our consumers, whānau and communities know how to live well, and are actively participating in caring for themselves and others	As a result of consumer aspirations, more of our population is supported to effectively self-manage their health and wellbeing
5	Our health workforce is working as 'one team', within an integrated system of care, and with delivery through team-based care (including health and broader social service representation)	We have implemented proactive risk stratification and stepped care models based on health and social needs, including care coordination for people with complex conditions
6	We have better matched our workforce capacity, capability and mix to population physical, mental, and social needs	We have a planned approach to workforce development that is based on the desired models of care, new workforce roles and system priorities, and is strongly linked with education and training providers and professional bodies
7	Virtual health care approaches have become pervasive across our system, supporting consumers to gain faster and more convenient access to health information, advice and care	Consumers and whānau say it is quicker and easier to get the health care and advice they need in community settings
8	We have become a nimble and sustainable system, able to make effective investment decisions that ensure ongoing improvement in population health outcomes and cost-effective use of resources	Our investment in primary and community care has significantly reduced the rate of acute demand for hospital services, and has enabled a greater number of older people to live safely at home
9	We are actively involved in training our future workforce, and research is actively supported to improve health and outcomes	We are recognised for the responsive development of a workforce matched to population needs, and a commitment to continuous learning

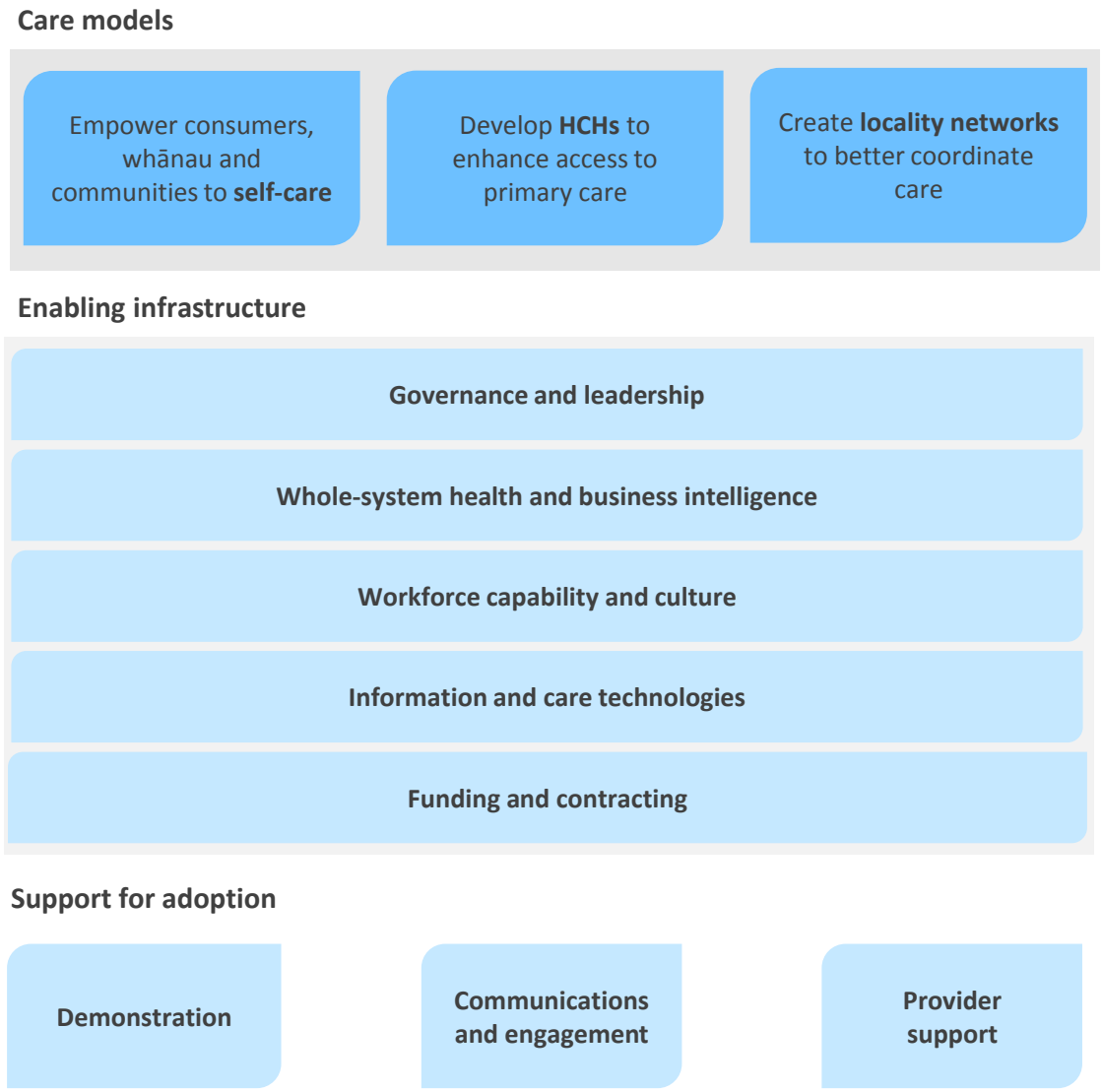
Executing the Strategy: The Action Plan

The Strategy describes our vision and strategic goals for transforming primary and community care services, within the context of the overall Southern health system. An Action Plan to deliver on the vision and goals has been developed. In developing the Action Plan, we have considered:

- How the system is best configured
- The importance of consumers, clinicians and providers understanding the rationale for change, and supporting its direction
- How to build a critical mass of inter-linked actions
- Actions that need to be:
  - District-wide
  - Tailored to local community needs
  - Targeted to specific population groups
- Learnings from previous planning and action in Southern
- The experiences of other health systems in improving primary and community care.

Three action areas have been identified for delivering on the Strategy (see right): care models; enabling infrastructure; and support for adoption. These action areas form the basis of the Action Plan. The action areas will be progressed concurrently, with sequencing of activities and milestones. Roll-out of new care models will be undertaken in tranches to enable manageable design, adoption and evaluation.

A roadmap for each of the action areas for the initial phases of executing the Strategy has been developed to guide early progress on achieving the vision for primary and community care in Southern (see the Primary & Community Care Action Plan).

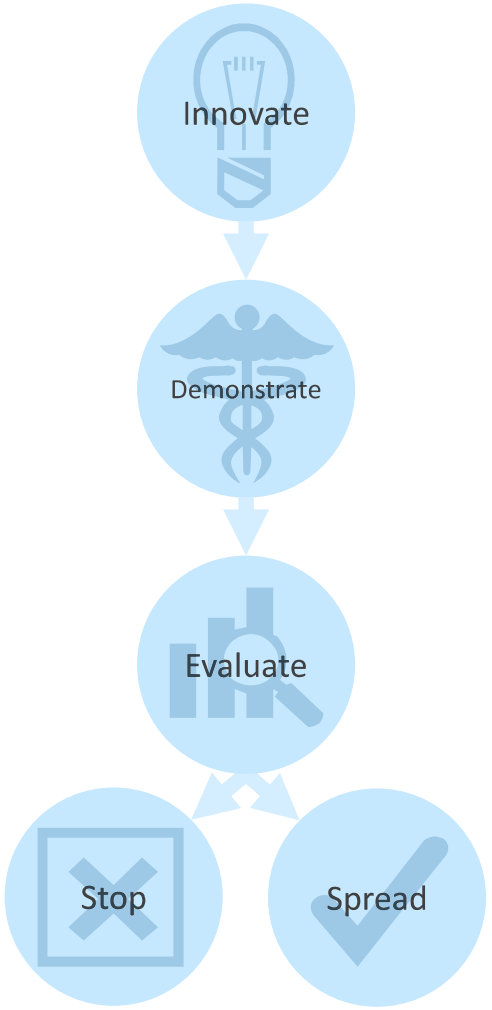


Executing the Strategy: Our commitment

Take a principled approach

- Improve equity of outcomes, particularly for Māori and rural communities
- Provide equitable access to appropriate 24/7 care across the district
- Make our health system easy to use
- Support our population to live well and self-care
- Make all decisions in the best interests of our population and consumers (using the quadruple aim)
- Take an investment approach that prioritises evidence-based interventions to improve long-term outcomes
- Move from traditional ways of working to be fit-for-the-future
- Treat each other with trust and respect
- Operate as one system, making the best use of available resources
- Utilise our education partners to develop a workforce matched to population need

Innovate and be courageous



Align incentives

Funding and contracting approaches will progressively incentivise primary, community and hospital care to work collaboratively to achieve the optimal mix of services across settings, and to improve access, outcomes and resource use

Appendix - Planning framework

How the Strategy was developed

A wide range of information informed the development of the Strategy and its supporting Action Plan. This information is included in the Planning Framework that accompanies the Strategy and Action Plan.

A review of key national, regional and local strategies and plans was undertaken, with relevant themes from these documents being used to help identify focus areas for Strategy development. In particular, the New Zealand Health Strategy and it's five pillars ('people-powered', 'close to home', 'value and performance', 'one team' and 'smart system') and the He Korowai Oranga framework (overall aim of 'Pae Ora', supported by 'Wai Ora', 'Whānau Ora', and 'Mauri Ora') informed the priorities of the Strategy, alongside service planning work undertaken to inform the Dunedin Hospital Indicative Business Case.

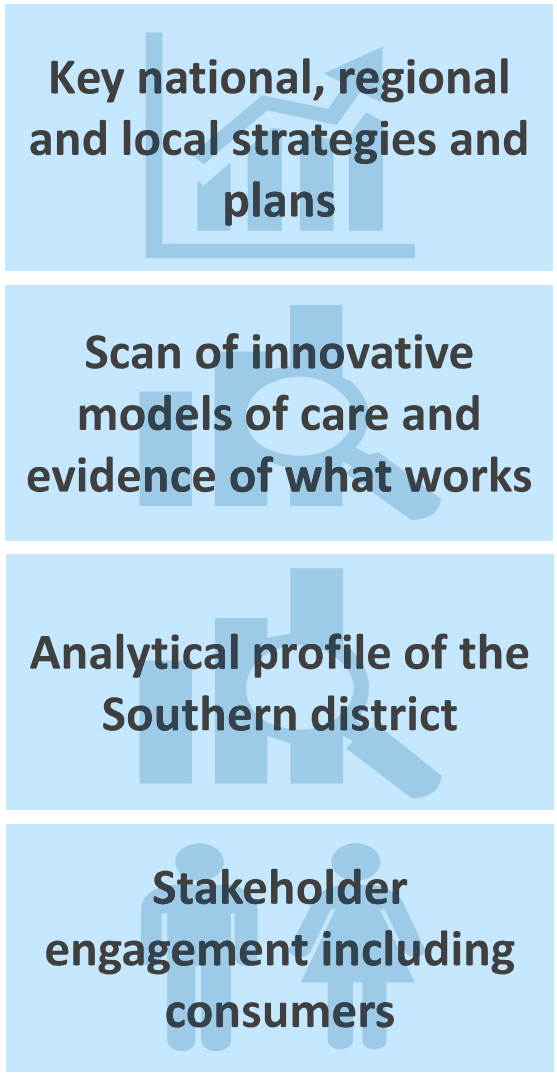
A scan of local and international literature was undertaken to identify innovative models of care and evidence for what works in improving access, quality and outcomes, including learnings for how to transform models of care and system design. Case studies of innovative care models from New Zealand, Australia, the United Kingdom and the United States were also developed to provide a practical sense of what changes other local health systems and providers are undertaking.

An analytical profile of the Southern district was also developed, updating relevant parts of the 2013 Southern Health Needs and Service Profile. The analytical profile examined demographic trends, population health risk factors, and service use across a range of primary, community and hospital services. The profile informed the Strategy and Action Plan through sizing current and future opportunities for improving system performance, and matching care with population needs across the Southern district. A snapshot of key findings from the profile is provided on page 34.

A key part of developing the Strategy was gaining the perspectives of stakeholders on what is most important for further developing primary and community care in Southern. Stakeholder engagement activities included:

- Four consumer focus groups, with 32 participants
- Four in-depth interviews with consumers with existing health and/or disability conditions
- Two wānanga with approximately 50 Māori consumers
- A direction-setting workshop with Southern DHB Commissioners, WellSouth PHN Board, Southern DHB executive team and the project's Steering Group
- Eight workshops with sector representatives
- Online forum for sector representatives, and follow-up in-depth interviews
- A roadshow of the initial strategic thinking in Dunedin, Invercargill and Central Otago, with more than 300 stakeholders providing feedback.

Key inputs…



National strategies and plans

The **New Zealand Health Strategy (NZHS)** and **He Korowai Oranga** were used in combination as a key conceptual framework for translating national and regional aspirations into local priorities for primary and community care in Southern.

The NZHS reflects the government's commitment to addressing the health system sustainability challenge, and ultimately shifting towards a better integrated model of care centred on consumers and their whānau. It's vision is that all New Zealanders live well, stay well, and get well in a system that is **people-powered**, provides services **closer to home**, is designed for **value and high performance**, and works as **one team** in a **smart system**.

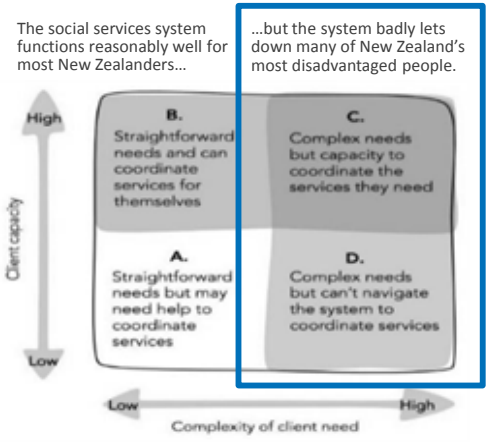
He Korowai Oranga is New Zealand's Māori Health Strategy, setting the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. It's overall aim is **Pae Ora,** 'healthy futures for Māori', recognising the multifaceted needs of Māori through a holistic approach and three interconnected elements: **mauri ora** (healthy individuals), **whānau ora** (healthy families), and **wai ora** (healthy environments). The approach reinforces the need to ensure that Māori are involved in both decision-making and service delivery. Pae Ora guided thinking on how the Strategy needs to address the needs of Māori in Southern.

The NZHS and He Korowai Oranga provide the framework for a range of more specific national strategies and plans such as the Healthy Ageing Strategy, Pharmacy Action Plan, and the Mental Health & Addictions Service Development Plan. These strategies and plans were also considered during Strategy development.

The government's **social investment policy** acknowledges that traditional approaches are not meeting the needs of the most vulnerable – particularly children and youth. In response, government has challenged agencies to:

- Prioritise efforts for improving the lives of the most vulnerable
- Take a data- and evidence-led approach to commissioning and contracting for outcomes
- Join up planning and action across agencies and sectors including integrated funding and contracting models
- Design new models of care that overcome barriers to access for people with the most complex needs
- Involve individuals, whānau and communities in priority setting and service design.

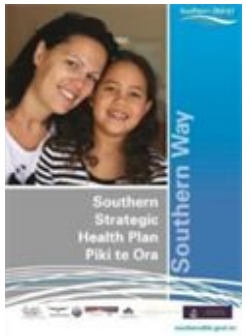
This thinking has been incorporated into the Strategy through recognising that some members of our communities will require more time, effort and resources than others, to lift their health and social outcomes.



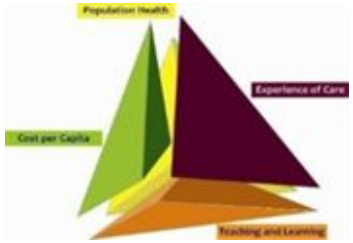
Local strategies and plans

Within the context of the Southern Way, the **Southern Strategic Health Plan** describes how health services in Southern should evolve between 2015 and 2025. It describes a system in which family doctors, community health and disability providers, and hospital care work together around community health and disability needs. The Plan has six priority areas, with the most relevant ones for the Strategy being:

1. Developing a coherent Southern system of care
2. Building the system on a foundation of population health, and primary and community care.



The Southern health system has adopted a **Quadruple Aim framework** to guide planning and decision-making. The four dimensions of the framework are: population health; experience of care; cost per capita; and teaching and learning. The purpose of the framework is to ensure that each of these dimensions is considered simultaneously when deciding priorities and actions. The framework has been used to help shape the Strategy and Action Plan.



Alliance South is a partnership between Southern DHB and WellSouth PHN to drive collaboration and progress on key initiatives across the Southern health system. The Alliance has driven collaboration and progress through a number of networks focused on particular parts of the Southern health system. Across these networks, it's priority areas of focus have been: care planning and management of complex consumers, enablers, a locality approach, communication, and care closer to home. Alliance achievements and learnings have been factored into the development of the Strategy and Action Plan.

AllianceSouth
Better health together

A number of strategy and planning documents have been developed to inform the **rebuild of Dunedin Hospital** business case process. These include:

- A Strategic Services Plan
- Detailed Service Plans (A&B) for Dunedin Hospital services
- An Indicative Business Case for the Hospital rebuild
- A number of clinically-led position papers regarding possible future models of care.

These documents point to the significant opportunity the rebuild presents to radically redesign care models both within the Dunedin Hospital setting and in primary and community care. From a strategic perspective, the Strategic Services Plan made the following recommendations related to primary and community care:

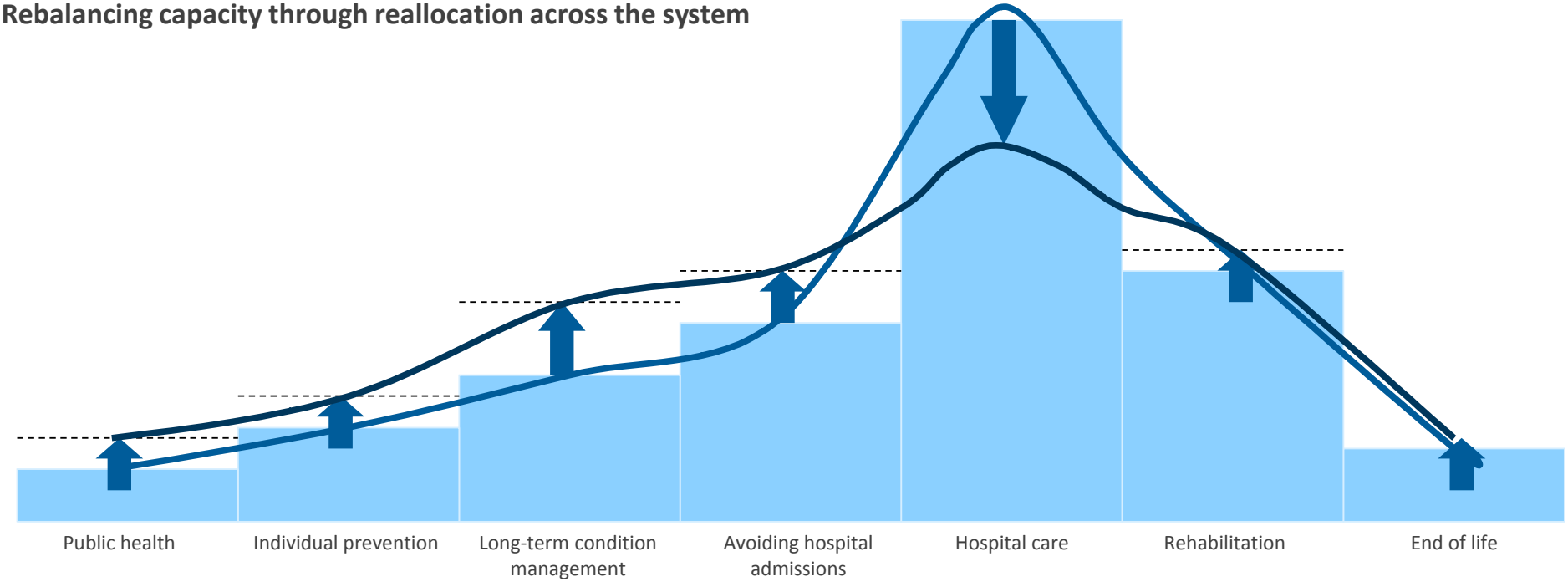
a) Actively support aggregation of general practices into larger groupings and invest in enhanced models of primary care
b) Proactively deliver well-organised and connected primary care through the development of leadership positions and networks
c) Consider comprehensive wraparound services for highly complex consumers, including partnerships with community or hospital-based pharmacy
d) Consider a clinically-led review of how Health Pathways are determined, marketed and utilised, and establish near-term priorities for further expansion of pathways.

The Strategy and Action Plan have incorporated the thinking emerging from the business case process, while also considering district-wide issues and opportunities, and the particular nuances of Southern's diverse communities.

Trends in system design

Health systems are focusing on better integrating care across professions, services and settings, with a strong focus on moving investment 'upstream' to prevention and strengthened primary and community care delivery. There is also a strong emphasis on active rehabilitation that reduces risk of recurrent acute presentations, and end-of-life care that provides people with appropriate supports to enable a dignified death. Achieving these outcomes requires prioritising future investments towards prevention and community-based models of care.

Rebalancing capacity through reallocation across the system



"The cost of providing health services through the current model is unsustainable in the long term. The Treasury estimates that, if nothing were to change in the way we fund and deliver services, government health spending would rise from about 7 percent of GDP now, to about 11 percent of GDP in 2060. It is essential that we find new and sustainable ways to deliver services, investing resources in a way that will provide the best outcomes possible for peoples' health and wider wellbeing."

The New Zealand Health Strategy: Future Direction (Ministry of Health, 2016)

Trends in models of care

Innovative care models are emerging in New Zealand and internationally. These were scanned to see what other systems have being doing or are trialing, and their lessons and learnings. Some key themes emerged from the scan, irrespective of jurisdiction or system. These themes include:

- Actively involving consumers and whānau in determining care needs and approaches
- Taking a population health focus that prioritises wellness, prevention, health literacy and self-management
- Focusing on individuals and populations rather than specific conditions such as diabetes, heart failure or depression
- Reinforcing the pivotal role of primary health care in the health system through approaches such as the HCH
- Proactively targeting resources to individual and population needs through risk stratification – led from primary health care
- Building the primary and community care workforce through new workforce roles (e.g., clinical pharmacy; health coaches; kaiāwhina) and enabling practitioners to work at the top of their scopes of practice
- Using team-based approaches for people with more complex needs, which integrate skills and capabilities from across the health and social sectors
- Maximising the use of technology to support consumers and the wider health and social care team
- Developing fit-for-purpose facilities that enable integrated ways of working
- Simplifying the system for both consumers and carers through mechanisms such as consumer portals, single points of access, and care pathways
- Re-engineering clinical and business processes to streamline consumer flow, releasing time to care
- Organising services around defined populations, including on a locality basis.

Many of these innovative models are new. However, there are early signs of success, such as:

- Improved consumer satisfaction with access and experience of care
- Improved workforce satisfaction resulting in better recruitment and retention
- Increased capacity within primary and community care as evidenced by more consumer interactions within similar resources
- Some evidence of reductions in:
  - Urgent care
  - Polypharmacy
  - Acute hospitalisations
  - Hospital bed-days
  - Entry into aged-related residential care.

These leading practice design features of contemporary models of care have been incorporated in the Strategy and Action Plan.

New and emerging technologies

New and emerging technologies are rapidly transforming how people engage with each other and the services they use. In health care, this means how people access health information (including their own records), how they engage with services, and the health checks (like simple diagnostics) they can do for themselves. Together these trends, and the further promise of new technologies, have the potential to radically change consumer experience of care. The promise of these technologies is a health system that can more efficiently and effectively deliver consumer-centred care, making the best use of workforce and infrastructure. Some of the changes that new technology promises are as follows:

- People are more actively involved in managing their lifelong health and wellness. They can drive their health experience through use of tools like wearable technologies, online access to their health and wellness information, and games that support memory function, pain relief, and self-management of long-term conditions
- Social networking mechanisms that support peer-to-peer shared experiences, information and motivational encouragement
- Encouraging a strengthened relationship between consumers and the health workforce that enables consumers to be co-producers of their wellness, with physicians as expert advisors
- At a service delivery level, technologies such as clinical and decision-making algorithms, artificial intelligence (AI) diagnostics, and online pathways and service directories to systematise care delivery systems and processes efficiently and effectively
- People with long-term conditions being able to monitor clinical measures (e.g., temperature, blood pressure) and relay these in real-time through smart devices to their care team, with their care team being able to respond when there are clinically meaningful changes in a person's health status. This frees up both consumer and provider time
- The 'internet of things' enabling safe and effective home monitoring of people who historically would have needed short-term care in a hospital setting or long-term care in a residential setting
- New robotic technologies are making possible a vast range of new ways to provide care and deliver system efficiency improvements. This includes robots that provide companionship for people living alone, robots that support care delivery (e.g. helping people have safe transitions out of bed in aged care), and drones that can deliver medicines to consumers
- AI and machine learning offer the promise of analysing vast amounts of data quickly, improving health and business intelligence.

Consumer interest in using new technologies*

Interested	Interest in service	Not interested
87%	Make an appointment online to see a doctor or organise a hospital service/appointment	13%
83%	Complete doctor or hospital registration details online before your visit	17%
74%	Use an at –home diagnostic test kit (e.g. for strep throat , cholesterol levels) and send the information to your doctor	26%
70%	Communicate electronically with a doctor or other health professional (e.g. email, text, social media site)	30%
70%	Order prescription drug refills using mobile apps on your phone	30%
66%	Use a device that connects to your smartphone (e.g. temperature, blood pressure or heart rate) and send the information to your doctor	34%
61%	Consult a doctor by video on your computer rather than in-person in a clinic	39%
60%	Send a photo of your injury/heath problem to a doctor using your computer or mobile device	40%

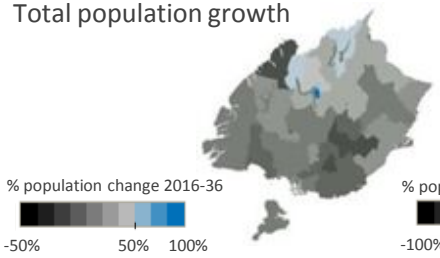
See for more information: Health care: the cross-currents of convergence deliver participatory health: A second paper in the Health Reimagined series, 2017, EY.

Southern analytics profile: key findings

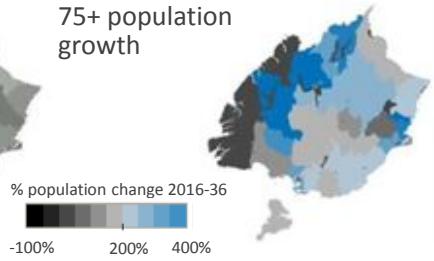
A Southern analytics profile was developed to inform priority setting for the Strategy. This considered a range of measures across primary and community care in the Southern district, and also broader system measures related to use of hospital services. It shows that we perform well on many measures; however, there remains ample room for improvement, particularly in the context of rising demand for services and emerging capacity issues. Key findings are summarised below.

1 Demographic change will be uneven across the district

Total population growth



75+ population growth



2 Variation in access and outcomes is evident

29%

… of Southern consumers experienced an unmet primary care need in the past 12 months

3-fold

… variation in medical / surgical discharges by enrolled general practice populations

3 Utilisation rates are higher than peer districts on some key measures

11+ medications aged 85+ years - 2014

*Darker shading = higher rate of use

2nd

… highest low urgency ED attendance rate of peer DHBs

2nd

… highest aged residential care use of peer DHBs

4 Urgent care demand is increasing

33%

…increase in non-admitted ED attendances at Dunedin, Southland and Lakes Hospitals from 2014 - 2016

In 2016/17 there are approximately …

56

… more non-admitted ED attendances per day than in 2013/14

5 Workforce capacity issues exist, and will intensify in the context of rising demand

40%

… of Southern GPs intended to retire in the next 10 years in 2015

Highest rate of…

Rural GP vacancies

… per capita

73%

… increase in GP consults for 65+ population with current care models by 2036

6 Many small-scale primary and community providers exist, presenting an opportunity for consolidation to broaden the scale and scope of services

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Stakeholder perspectives

A wide range of stakeholders were engaged during the development of the Strategy, including consumers, health professionals, non-governmental organisations (NGOs), and DHB and PHN staff. Stakeholders shared their perspectives on their experience of primary and community services, and opportunities for the future. A number of key themes emerged from conversations with Southern stakeholders:

- Consumers continue to experience barriers to accessing services, particularly those who live in more rural settings
- Consumers report inconsistent experiences of care from similar providers
- Māori consumers continue to experience prejudice and disrespect, and would value greater access to rongoā Māori / traditional Māori medicine and practitioners
- One size does not fit all for Māori consumers, and many feel that the current model of care does not cater to their needs
- Consumers desire greater empowerment in their care, and the information and support needed to realise this
- There is a general view that health services have been slow to adapt to changing health needs and consumer preferences
- All stakeholders are united in their desire for greater sharing of clinical information through means such as an electronic heath record
- There is a general desire to develop a more collaborative and integrated system, founded on a shared purpose and set of values
- While good progress has been made on particular service areas, there remains a pressing need to describe the overarching organisation of care delivery in primary and community settings, and their relationship with hospital services
- There are significant opportunities to improve how primary and community care providers and practitioners work in terms of clinical and business models
- People are excited by the promise of new technologies, and their ability to improve access to information and care.

Direction setting workshop

Using technology to enhance current interactions…
"Having to drive to Invercargill for two hours for appointments that can sometimes only be 10 minutes long can put you at risk. I'd much prefer this."
(Queenstown consumer)

Co-located services…
"I like this but some services can cost more at the GP – I went to hospital for eye tests and it was way cheaper, so as long as the price doesn't go up…"
(Dunedin consumer)

Wananga

Steering Group, Working Group and University of Otago

This project was overseen by a Steering Group with broad representation from across the Southern district. A Working Group co-developed the detailed activity tables to support implementation of the first three years of the Action Plan. To assist with demonstrating change, the University of Otago developed five case studies to support Strategy and Action Plan development.

Steering Group

The Steering Group guided development of the Strategy and Action Plan, reviewing and providing feedback on key documentation, meeting five times at key points across the project. Membership was as follows:

- Chris Fleming (SDHB, CEO)
- Lisa Gestro (SDHB, Executive Director Strategy, Primary and Community)
- Ian Macara (WSPHN, CEO)
- Wendy Findlay (WSPHN, DON)
- Professor Barry Taylor (University of Otago, Dean Medical School)
- Bronnie Grant (Consumer representative)
- Sue Crengle (Provider and iwi representative)
- Karl Metzler (Rural Hospital representative)
- Dr. Murray Tilyard (GP)
- Dr. Nigel Millar (SDHB, CMO)

Working Group

A Working Group was established to support Action Plan development, with representation from across primary, community and secondary care. In particular, this group supported development of the detailed activity tables.

University of Otago

Representatives from the University of Otago developed five case studies as part of the Planning Framework, used to support Strategy and Action Plan development.

*Liz Disney (SDHB ED P&F (Acting)) was a Steering Group member until leaving in October 2017


Southern District
Health Board
Piki Te Ora
WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga


Southern Primary & Community Care
Action Plan
Southern District
Health Board
Piki Te Ora
WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Mihi

Karanga atu rā ki ngā tangata o te taitonga;
Nei rā mātou, e mihi kau ana ki ā koutou tīpuna kua wehe atu ki tua o Paerau.
Tēnā koutou katoa!

_____

We call to you, the people of the south;
We greet and acknowledge all of our ancestors who have passed beyond the veil.
Greetings to you all!

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Introduction

Introduction

Tēnā koutou katoa,

We are pleased to present the Southern Primary and Community Care Action Plan, which describes how we will deliver on the vision for primary and community care in the Southern health system outlined in Southern Primary and Community Care Strategy. The Strategy's vision centres around our consumers, their whānau and communities, and the role the Southern health system needs to play in caring for and empowering them to live well, stay well, get well and die well. It reflects the call from our communities for better integrated services, and from our workforce to strengthen the capacity and capability of primary and community care to contribute to the wider Southern health system.

In developing this Action Plan to execute the Strategy, we have considered:

- How the system needs to be organised
- How to work with stakeholders to co-design viable care models
- How to build a critical mass of inter-linked actions to deliver improvements at pace and scale
- Actions that need to be:
  - District-wide
  - Tailored to local community needs
  - Targeted to specific population groups
- Learnings from previous planning and action in Southern
- The experiences of other health systems in improving primary and community care.

The Strategy and Action Plan have been developed jointly by Southern District Health Board and WellSouth Primary Health Network, with support from the University of Otago, reflecting our commitment to working together to improve the contribution of primary and community care to the wider Southern health system. They recognise our history, and the challenges we face in responding to the changing needs of our communities, the increasing pressures on our health workforce, and our responsibility to provide equitable access to services across our large and diverse district.

Our ability to implement the actions underpinning this Action Plan will depend on whether we are bold enough and prepared to make tough prioritisation decisions. Given our available funding, we will need to create a virtuous cycle of saving to invest and through our investments, creating new savings to further invest. We will also need to carefully invest any additional funding we receive. Our intention is preferentially invest any additional funding we receive in the actions set out in this Action Plan. In undertaking this approach, we are committed working with our communities and other stakeholders to deliver on this Action Plan. Mauri ora!

Chris Fleming
Chief Executive
Southern DHB

Ian Macara
Chief Executive
WellSouth PHN

Kathy Grant
Commissioner
Southern DHB

Dr. Douglas Hill
Chair
WellSouth PHN

The Southern Primary & Community Care Strategy and Action Plan

WHY?

New Zealand Health Strategy
All New Zealanders live well, stay well, get well

He Korowai Oranga
Healthy futures for Māori, 'Pae Ora'

South Island Region Strategic Direction
A sustainable South Island health & disability system, focused on keeping people well and providing equitable and timely access to safe, effective, high quality services, as close to people's homes as possible

Southern Way Vision
Better health, better lives, Whānau Ora

WHAT?

Vision for Southern primary & community care
Excellent primary and community care that empowers people in our diverse communities to live well, stay well, get well and die well, through integrated ways of working, rapid learning and effective use of technology

Goal 1.	Goal 2.	Goal 3.	Goal 4.
Consumers, whānau and communities are empowered to drive and own their care	Primary and community care works in partnership to provide holistic, team-based care	Secondary and tertiary care is integrated into primary and community care models	The health system is technology-enabled

HOW?

Care models

- Empower consumers, whānau and communities to **self-care**
- Develop **health care homes (HCHs)** to enhance access to primary care
- Create **locality networks** to better coordinate care

Supporting infrastructure

- Strengthened governance and leadership
- Whole-system health and business intelligence
- Building workforce capability and culture
- Integrated technology solutions and cost-effective use of care technologies
- Results-focused funding and contracting

Supporting adoption

- Demonstration
- Communications and engagement
- Provider support

Table of key definitions

Term	Definition
Primary care	Primary care relates to the professional health care provided in the community, usually from a general practitioner (GP), practice nurse, pharmacist or other health professional working within a general practice
Community care	Wide-ranging care provided in a community setting, from supporting consumers to manage long-term conditions, to treating those who are seriously ill with complex conditions, much of which takes place in people's homes
Secondary care	Care provided by a specialist or facility on referral from primary care (usually by a GP), requiring more specialised knowledge, skills, or equipment than can be provided in primary care. This can be provided either by visiting specialists, or in Dunedin, Invercargill, or some rural hospitals in the Southern district
Tertiary care	Specialised care (investigation and treatment) usually provided on referral from clinicians in primary or secondary care by visiting specialists, or in Dunedin Hospital (with some services provided outside the district e.g., highly specialised paediatric care at Starship Hospital in Auckland)
Multi-disciplinary	A team comprised of people from across disciplines within the health sector, supporting the delivery of holistic health care. This could include, for example, GPs, PNs, DNs, pharmacists, health care assistants, allied health and other relevant representatives
Inter-disciplinary	A team comprised of people from the health and social sector, supporting the delivery of holistic health and social care. This could include, for example, multi-disciplinary teams, plus representatives from MSD, Corrections, Housing, Ministry for Vulnerable Children, Oranga Tamariki and other agencies
Care coordination	Supporting the coordinated delivery of consumer / whānau care, either within or across providers. A care coordination service will support this function across primary, community, secondary and tertiary care in the Southern district
Stepped care	A care model approach that segments populations into increasing levels of health (and social) need, with defined care responses matched to population segments. The higher the level of need, the more intense the care response.
Health Care Home (HCH)	A team-based model of care by primary care with strong strategic and operational relationships with community, hospital and specialist services, with the intent to provide the right level of proactive, comprehensive and continuous health care to patients
Locality network	The strategic and operational network of providers and services required to provide timely, responsive care to defined populations based on an agreed minimum level of care, with some local variation for particular health needs and service contexts
Community Care Hub	The potential physical infrastructure required to enable integrated ways of working within locality networks, with modification of the scale and scope of the hub determined by population size and existing infrastructure

Action Plan

Introducing the Action Plan

The Southern Primary and Community Care Strategy describes our vision and goals for transforming primary and community care services, within the context of the overall Southern health system. This Action Plan sets out the initial phases for achieving this vision.

The Action Plan has three action areas for delivering on the Strategy (see right): care models; enabling infrastructure; and support for adoption. These action areas form the basis of the Action Plan.

The action areas will be progressed concurrently, with sequencing of activities and milestones. Roll-out of new care models will be undertaken in tranches to enable manageable design, adoption and evaluation.

A roadmap for each of the action areas is presented in this Action Plan to guide early progress on achieving the Strategy.

Overall, delivering on our vision and goals for primary and community care will require reconfiguring how parts of the system fit together. This will include:

- How health services are organised
- Care processes and systems that support care models
- Governance and leadership of the system
- Health and business intelligence to support planning, funding and delivery
- Information and communications systems to enable enhanced access to information for consumers and the workforce
- Funding and contracting arrangements that support integrated ways of working and improved performance.

Care models

- Empower consumers, whānau and communities to **self-care**
- Develop **HCHs** to enhance access to primary care
- Create **locality networks** to better coordinate care

Enabling infrastructure

- **Governance and leadership**
- **Whole-system health and business intelligence**
- **Workforce capability and culture**
- **Information and care technologies**
- **Funding and contracting**

Support for adoption

- **Demonstration**
- **Communications and engagement**
- **Provider support**

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The Action Plan: Transforming primary and community care

The system is configured to enable new care models, and implementation of the Strategy at pace and scale

The **organisation of health services** will reinforce the concept that primary care is consumers' first point of contact for addressing their needs and their source of continuity of holistic care. In the future, the preferred model of general practice will be the Health Care Home (HCH) model. Wrapped around the HCH will be a locality network to integrate services for people with more complex needs, and enable effective step-up and step-down care. Locality networks will bring together personal health, mental health & addictions services, palliative care, and aged care services, with access to specialist support. In some instances, some services will be co-located in Community Care Hubs.

Care processes and systems will be based on risk stratification and a stepped care approach. This will be the linchpin that links the HCH and locality network, and access to specialist support. Needs assessment and care planning processes will be consumer-focused, and determine the level and type of support a person requires. Shared care plans, care pathways ('HealthPathways') and service directories will support timely and smooth consumer access to care. A key focus will be on prevention and early intervention.

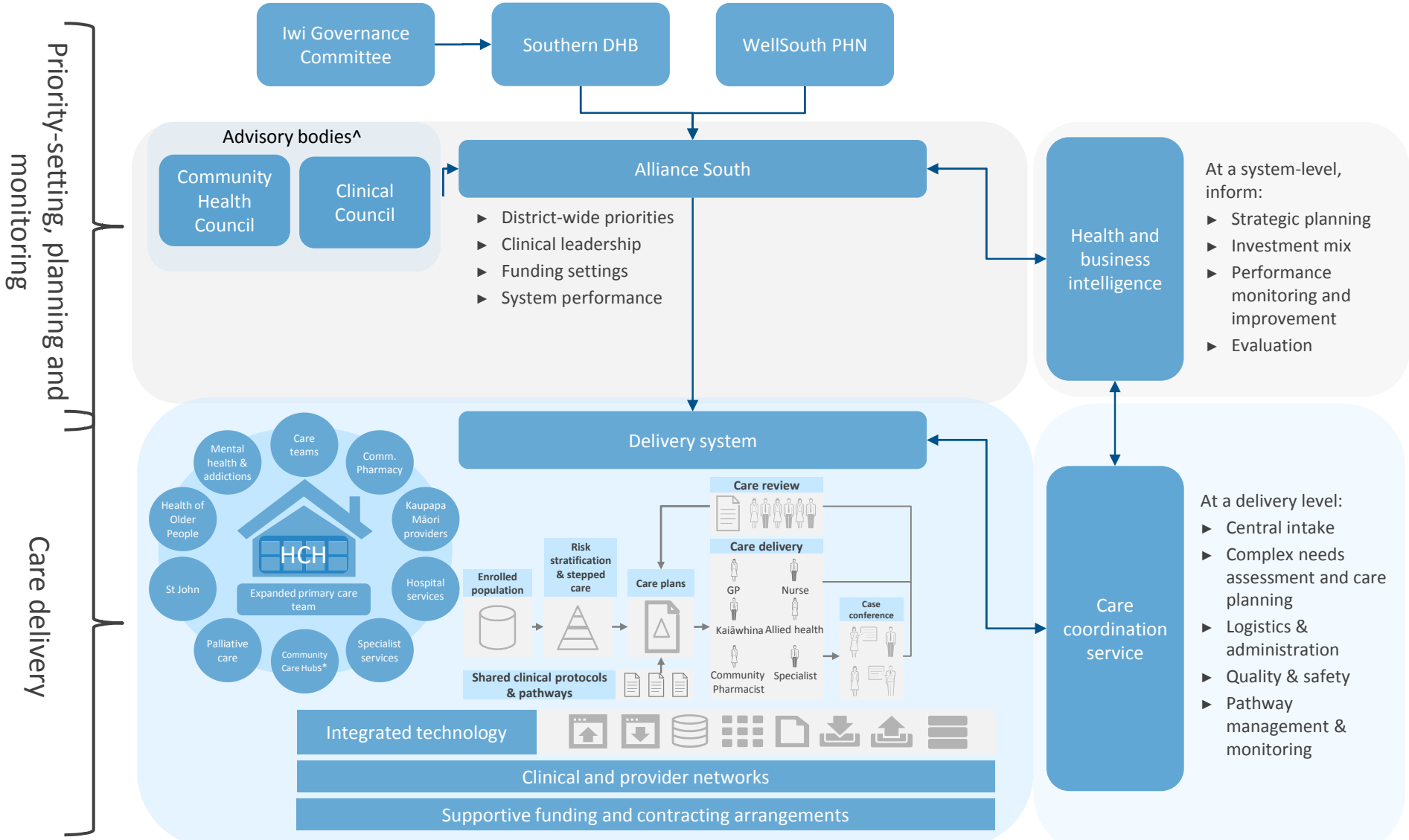
To provide coherence to the system, **governance and leadership** at the district level will be revised to better plan and prioritise resources to address population health needs. The Alliance South arrangement between Southern DHB and WellSouth PHN will be revised. The Alliance will determine district-wide primary and community care priorities, set the parameters for service planning, and track and monitor overall system performance, including delivery on the Strategy and Action Plan. At a delivery level, locality networks will be used to translate district-wide priorities into service planning and actions. For particular high priority disease groupings (e.g. cardiovascular and respiratory disease) and population groups (e.g., vulnerable children, frail elderly), clinical and provider networks could support district-wide consistency in care access and outcomes, as well as sharing learnings and innovations. This will complement locality networks.

Health and business intelligence will be strengthened at strategic and operational levels through development of a shared health and business intelligence function, and an expanded and enhanced care coordination service. The health and business intelligence function will inform planning, prioritisation and performance improvement at district-wide, locality and primary care levels, including Alliance South. A care coordination service will support the smooth operation of the primary and community care system, working with HCHs and locality networks to coordinate complex needs assessment and care planning, administration, logistics, resourcing, and monitoring of care.

Information systems will enable primary care, locality networks and specialist services to access and share information related to consumer care, and for consumers to access this information through an online portal. A key development will be an electronic health record (EHR) for each consumer. The increasing comprehensiveness of this record will eventually allow collection of information from consumer devices, genetics and other factors related to an individual's health. A single data repository and technology solution for enabling enhanced health and business intelligence will be implemented. More integrated communication systems will facilitate consumers to access the right care at the right time for their needs.

Funding and contracting approaches will be revised to reduce duplication of effort and resources, and enable collaboration between providers and care model innovation. They will become more results-focused, and aligned with a transparent performance and incentive framework, cascading from district to locality to provider and practitioner levels.

The Action Plan: How the system will be configured



*Community Care Hub infrastructure to be determined.

^ Also provides advice directly to Southern DHB on matters outside the scope of the Alliance South work programme

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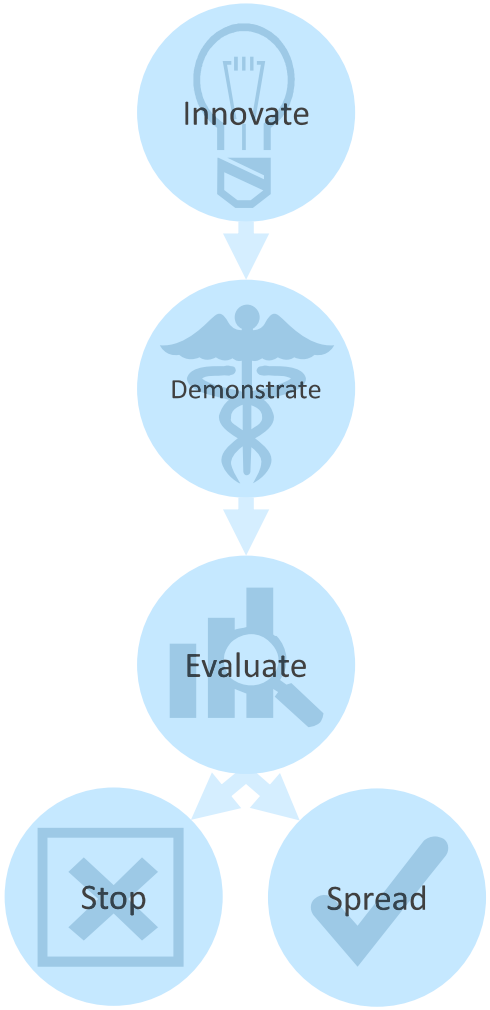
Our commitment

Take a principled approach: We will…

- Improve equity of outcomes, particularly for Māori and rural communities
- Provide equitable access to appropriate 24/7 care across the district
- Make our health system easy to use
- Support our population to live well and self-care
- Make all decisions in the best interests of our population and consumers (using the quadruple aim)
- Take an investment approach that prioritises evidence-based interventions to improve long-term outcomes
- Move from traditional ways of working to be fit-for-the-future
- Treat each other with trust and respect
- Operate as one system, making the best use of available resources
- Utilise our education partners to develop a workforce matched to population need

Innovate and be courageous



Align incentives

Funding and contracting approaches will progressively incentivise primary, community and hospital care to work collaboratively to achieve the optimal mix of services across settings, and to improve access, outcomes and resource use

Action area 1: Care models

Support consumers and whānau to self-care

Helping people develop or further build their **health literacy** is critical for enabling health maintenance, and to knowing when and how to access services. Broadly, health literacy means the ability to access, process and utilise information to make appropriate and informed decisions. People with good health literacy can make informed and appropriate health decisions, and better manage their own health. This leads to better consumer and whānau outcomes and more effective use of health resources. Strengthening health literacy will have two core components:

- A targeted focus on public education about the core role of primary care, including when, how, and where to access services for urgent needs
- Developing the health literacy competencies of the health workforce, particularly in regards to working with Māori (see Workforce Capability Development).

To make it easier for consumers and whānau to participate in their health and well-being, and access services more conveniently, **consumer portal** access and technology will be expanded and enhanced. Over time this will become a single point of 'virtual' contact for consumers with the Southern health system.

Through a staged development path, the consumer portal will provide consumers with access to:

- Their health-related information, and eventually, their relevant social care information
- Certified self-care information related to health risks and conditions
- Virtual health consultations (e.g. email, video, telephone)
- Initial diagnosis, triage and care options (public and private)
- Navigation to the right care for their health needs
- Education and research opportunities.

For people with long-term conditions or who suffer from mental health and/or addiction issues, evidence suggests that **peer support approaches** can improve self-management and adherence with care plans. Opportunities to enable peer support through vehicles such as consumer networks, group sessions and social media will be explored and progressed. Efforts will be directed towards conditions and issues where evidence suggests the best self-care gains can be made.

Supporting consumers and whānau to self-care will be achieved through taking a **Health in All Policies (HiAP)** approach, strengthening health literacy, encouraging peer support, and providing enhanced access to care and information for consumers through an online portal.

A HiAP approach to working with other sectors will be used to address the major risk factors that contribute to inequities, avoidable acute demand and amenable mortality. HiAP will form the basis of a joint work programme between Public Health South and WellSouth PHN.

Initial areas of focus will include:

- Health-promoting environments (tobacco control; nutrition and physical activity; alcohol; housing)
- Supporting economic and social development to improve income and employment outcomes
- Improving community resilience to build mental health and wellness
- Building community participation and networking
- Establishing the health sector as one of a number of civic agencies (including local government, education, other government agencies and local NGO and business leaders) that act in concert to improve health and wellbeing.

Making a difference in these areas will require bringing public health, population health and personal health services closer together, as well as building partnerships with community organisations and other sectors including local government.

Support consumers and whānau to self-care – *Building health literacy*

Headline action	Activity		Phases		
			1	2	3
Headline action 1.1 – Build the health literacy of the Southern population and workforce with a particular focus on acute demand management	a.	Identify gaps in existing health literacy information, and develop targeted, culturally appropriate resources (including for people with disabilities), with consumer and provider involvement, taking into consideration the proposed consumer online portal and existing and planned health promotion activities.	■		
	b.	Using positive messages, actively promote appropriate use of health services, reinforcing primary care as a consumer's gateway to other health care, with tailoring of content to key pressures and priorities. For example, discouraging lower urgency presentations to the Dunedin and Invercargill Emergency Departments.	■		
	c.	Develop whole of system website, more easily directing users to the services they need.		■	
	d.	Upskill the health workforce in building community, whānau and consumer health literacy, and making it an expected competency of all health workers - competence in working with Māori and Pacifica being a key area for development (see: Headline Action 5.2, c-d)			■

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Support consumers and whānau to self-care – *Expanding and enhancing consumer portal access*

Headline action	Activity	Phases		
		1	2	3
Headline action 1.2 – Expand and enhance consumer portal access to provide consumers with access to all of their health information and care team	a. Encourage uptake of the existing consumer portal, based on successful uptake approaches used in New Zealand and internationally	■		
	b. Provide consumers with access to self-care information related to priority health conditions (e.g., diabetes; cardiovascular disease; COPD; asthma; depression; anxiety)	■		
	c. Introduce consumer access to virtual health consultations (e.g. email, video, telephone, appointment bookings)	■		
	d. Progressively integrate community care information into the consumer portal, aligned with HCH and locality network development, and accessible via a whole of system web site		■	
	e. Provide consumers with artificial intelligence-supported access to initial diagnosis, triage and care options (public and private)			■
	f. In addition to their health record, provide consumers with access to their relevant social care information			■

Support consumers and whānau to self-care – *Strengthening peer support*

Headline action	Activity		Phases		
			1	2	3
Headline action 1.3 – Strengthen peer support mechanisms for people experiencing: i. Mental health issues ii. Addiction issues iii. Significant prioritised long-term conditions (COPD, heart failure, stroke) or multi co-morbidities iv. Social isolation v. Obesity	a.	Engage with consumers, whānau, communities, and the wider social sector, considering existing initiatives (e.g. *Raise HOPE*) to understand what will work best for peer support including enlisting people into peer support approaches, settings (e.g. church, home, clinic, marae), delivery channels (e.g., social media), and how such approaches can be culturally and socially relevant for different cohorts (e.g., Māori, youth, older people)			
	b.	Work with stakeholders to introduce new peer support mechanisms as agreed, (e.g. group sessions and social media-based groups), reviewing and evaluating these (including obtaining feedback from people engaged in the groups) annually or at other agreed intervals, and adjust, scale or stop these depending on their uptake and value.			

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Support consumers and whānau to self-care – *Taking a Health in All Policies approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 1.4 – Take a Health In All Policies (HiAP) Approach to address the major risk factors that contribute to inequities, avoidable acute demand and amenable mortality.	a. Develop and implement a Health in All Policies Action Plan to support effective inter-sectoral action on: i. Health-promoting environments (tobacco control; nutrition and physical activity; alcohol; housing) ii. Supporting economic and social development to improve income and employment outcomes iii. Improving community resilience to build mental health and wellness iv. Building community participation and networking v. Establishing the health sector as one of a number of civic agencies (including local government, other Government Ministries and local NGO and business leaders) that act in concert to improve health and wellbeing (and reduce demand pressure on healthcare services)			
	b. Develop a Southern District Health Promotion Strategy outlining how Public Health , WellSouth PHN and other key stakeholders will work together			
	c. Public Health South and WellSouth are co-located (virtually or physically), working together to reduce inefficiencies and avoid duplication			
	d. Review and evaluate HiAP initiatives annually or at other agreed intervals, and adjust, scale or stop initiatives depending on performance			

Development of health care home

To enable general practice to better match care with need and provide opportunities for professionally rewarding practice, the development of HCHs will be encouraged and supported. This will reinforce and reinvigorate general practice's role as the key source of continuity of holistic care and gateway to the wider health system for people and their whānau.

The HCH model will enhance the capacity and capability of general practice through development of new roles, skills, and ways of working. This will include new clinical and non-regulated workforce roles to support the traditional practice team members (GP, practice nurse, and receptionist) - enabling clinicians to work at top of their scopes of practice, and freeing up resources to enable timely and responsive care.

The HCH model will also have a strong focus on making the best use of digital technologies, through promotion of 'virtual health' approaches such as telephone, email, and video consultations, and system generated consumer contacts (e.g. screening reminders), and data-driven risk stratification to identify and target people most at-risk of poorer outcomes.

The development of HCHs in Southern will be informed by New Zealand and international models including the model of care requirements set out by the New Zealand Health Care Home Collaborative*. The Collaborative's model of care has four domains:

- Ready access to urgent and unplanned care
- Proactive care for those with more complex needs
- Better routine and preventative care
- Improved business efficiency for sustainability.

Each domain has a set of elements, characteristics, and measures. The requirements also describe a practice credentialing process that can lead to certification as an HCH. The requirements build on the Royal New Zealand College of General Practitioners Foundation and Cornerstone accreditation standards. General practices in Southern will be encouraged to develop in-line with the Collaborative's requirements, with application of these tailored for practice context.

Key components of the HCH model to be developed in Southern will include:

- Being the key source of holistic care for consumers
- Using risk stratification and formalised needs assessment to target workforce time and effort to people with higher needs
- An expanded primary care team through introduction of new workforce roles
- Development of higher skills within scopes of practice, and delegation of clinical and non-clinical functions within the team
- Active engagement in the education of undergraduate and postgraduate students, as well as participation in primary care research networks
- Redesigned processes that streamline operations within the HCH, and enable urgent and extended consultations
- Use of virtual health approaches to enhance access
- Use of system-generated contacts to support proactive practice engagement with consumers
- Use of evidence-based care pathways
- Active involvement in care planning and delivery with DHB and NGO services as part of locality networks
- Working in a hub and spoke model through alignment with large Community Care Hubs networked with other locality providers (see overleaf).

HCH development will be undertaken in tranches via a contestable expressions of interest process. The first tranche will be considered demonstrators of the new model. Between four and eight HCHs are likely to be selected in tranche 1.

* See for more information: New Zealand Health Care Home Collaborative model of care requirements: http://www.healthcarehome.co.nz/resources/

Development of health care home – *Designing and implementing a Southern Health Care Home model*

Headline action	Activity	Phases		
		1	2	3
Headline action 2.1 - Early adopter general practices are enlisted to demonstrate and fine-tune the HCH model, with the aim that early adopters to cover about one-third of the Southern population	a. Through a contestable process, identify early adopter Tranche 1 general practices, willing to explore innovative service models and co-design the HCH model in-line with the Health Care Home Collaborative's four domains: i. Urgent and unplanned care ii. Proactive care for those with more complex needs iii. Routine and preventative care iv. Business efficiency			
	b. Understand the population that will be served by a specific Tranche 1 HCH, considering: i. Health and social needs ii. Use of primary, community and hospital care iii. Risk factors for poorer health and social outcomes iv. Access and service preferences			

Development of health care home – *Designing and implementing a Southern Health Care Home model cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 2.1 *cont'd* - Early adopter general practices are enlisted to demonstrate and fine-tune the HCH model, with the aim that early adopters to cover about one-third of the Southern population	c. Working with potential Tranche 1 HCHs: i. Apply the Health Care Home Collaborative's maturity matrix to assess the maturity of the practice's model of care ii. Map current workflows, workforce resourcing and use of technology to identify priorities for redesign iii. Undertake co-design workshops to redesign care and workforce models iv. Provide confidential financial modelling support for the potential HCH practice to understand the business implications of transforming their model of care v. Determine the likely strategic and operational relationships and transition steps within a locality network vi. Develop a transition plan to meet the requirements of a HCH			
	d. Commence implementation of Tranche 1 HCH models of care			
	e. Evaluate HCH progress and adjust the approach depending on progress and performance			
	f. Identify Tranche 2 general practices for HCH development			
	g. Begin co-design work with Tranche 2 HCHs			

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Development of Community Care Hubs

It is likely that the future primary care system will include practices or configurations of practices that serve populations of, ideally, between 7,500 and 30,000 enrolled service users (this may vary slightly according to their location and connection with other services, and will need to be flexible enough to respond to varying geography and the local service context). The larger this configuration, the more opportunity there will be to deliver a broader scope of services, culminating in designation as a Community Care Hub, which co-locates relevant DHB and NGO community services, and provides for a level of ambulatory specialist care (either by primary practitioners with special interests or DHB / private specialists). Community Care Hubs will be developed through either existing infrastructure or new sites. In rural areas, rural hospitals may act as a hub but with the explicit expectation that this includes primary care delivering the HCH model of care. In Dunedin and Invercargill, purpose-built facilities may be developed, which may include delivery of some specialist outpatient services, possibly in collaboration with the University of Otago. The expected set of services to be delivered from Community Care Hubs include:

- General practice using a HCH model of care, with facility and technology enablers to support the care model (see previous page), and ensuring links with other local general practices
- Onsite community and clinical pharmacy services
- Community diagnostics (e.g. radiology; laboratory specimen collection), where this is economically feasible
- Space for visiting specialist clinics and minor procedures, matched to population needs and economic viability (i.e. not duplicating existing infrastructure which cannot be scaled back e.g. Southland Hospital outpatient facility space)
- Provide space for 'housing' DHB and NGO community health services (e.g. district nursing; physiotherapy) including staff, vehicles and supplies, with 'housing' arrangements designed to maximise building strong team-based ways of working with the HCH team
- Urgent care capacity to a suitable scope to handle clinically appropriate emergency care cases (e.g., resuscitation capacity)
- Observation beds, and where a rural hospital is acting as the Community Care Hub, clinically appropriate overnight stay capacity.

A rule-set for determining the optimal mix and distribution of Community Care Hubs across the district will be developed. Key principles for Hub selection and development are likely to include:

- Primary and community care will be integrated as part of a Community Care Hub, and will be delivering a HCH model of care
- Primary care operating within each Community Care Hub will have strong operational relationships with non-Community Care Hub practices and will accept all consumers referred to Community Care Hub services irrespective of where they are enrolled
- Community Care Hub services will not seek to encourage consumers enrolled with another practice to enrol at the hub. Where a consumer elects to enrol with the Community Care Hub, a standard enrolment stand-down period will apply (i.e. 3-months)
- All practices operating within a locality served by a Community Care Hub will contribute to a shared extended hours / after-hours care roster (delivered from the Community Care Hub), with defined capitation 'clawbacks' or other mechanisms to ensure financial viability (it is expected to be fiscally neutral within capitated funding streams)
- Where DHB-funded specialist services are provided from a Community Care Hub, the DHB and hub will have a formal agreement related to leasing of clinic space including any financial costs
- The Community Care Hub will operate a transparent and agreed co-payment policy for DHB services transferred to the hub.

In Dunedin, a key consideration for Community Care Hub design will be any development of ambulatory care infrastructure as part of the hospital rebuild. There will be a range of options that could work, and as planning for the hospital rebuild progresses these will be explored.

Community Care Hub model and relationship with locality networks

** Community nursing, allied health (e.g., physiotherapy, dieticians, occupational therapy), health promotion, dental*

Community Care Hub infrastructure will differ given geographic context, population size and existing infrastructure. The figure opposite provides a stylised example of a Community Care Hub model.

As an illustration of how this could work in practice, a Community Care Hub model could be developed in Invercargill. This model would consolidate a number of general practices and their enrolled populations to provide sufficient scale for a wide range of collocated and visiting services. The hub could be developed in north Invercargill to avoid duplication with Southland Hospital services. The hub would provide core primary care bolstered by enhanced urgent care capacity (including clinically appropriate ambulance referrals through defined clinical protocols), on-site pharmacy and diagnostics, and clinical space for hospital specialist care and minor procedures.

A critical component of Community Care Hub development would be co-location and integration of community health services, which would provide both mobile services (e.g. community nursing home visits) and in-clinic services such as rehabilitation. With the HCH expanded primary care team, these community services would form the core of multidisciplinary teams delivering care in clinic and home-based settings, including aged residential care.

Through locality network development, the Community Care Hub and other health and social services would develop strategic and operational relationships for care delivery for the catchment population. This will include developing appropriate relationships with other general practices within the locality including cross referrals to primary and community practitioners with special interests.

With the increased scale of physical infrastructure, the Community Care Hub would include spaces for peer support sessions, teaching and learning activities, and team-building.

In other settings, hub infrastructure might be configured around a rural hospital site or as a standalone facility incorporating community health and ambulatory care services.

Development of Community Care Hub infrastructure

Headline action	Activity	Phases		
		1	2	3
Headline action 2.2 – Encourage the development of Community Care Hub infrastructure to support locality networks	a. Develop a rule-set to determine the optimal mix and distribution of Community Care Hubs to support locality networks including: i. Catchment population size ii. Distance from an acute hospital iii. Alignment with existing or proposed infrastructure including any ambulatory care hubs developed as part of the Dunedin Hospital rebuild iv. Scope of services proposed to be included in a Community Care Hub v. Potential to promote integrated ways of working across primary, community and secondary care vi. Principles to guide care model design Note that: i. Potential infrastructure could be developed using Southern DHB, WellSouth PHN, or private funding (including the University of Otago) ii. Rural hospital facilities or large rural general practices may be designated as Community Care Hubs, with any development needs identified during locality network design			

Development of Community Care Hub infrastructure *cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 2.2 *cont'd* – Encourage the development of Community Care Hub infrastructure to support locality networks	b. Apply the rule-set to determine efficient configuration of Community Care Hubs, including consideration of including ambulatory secondary care within the scope of service (with suitable alignment with any development of ambulatory care hubs in Dunedin), with early priorities being*: i. Orthopaedics (e.g. fracture clinics) ii. Dermatology iii. Ophthalmology iv. ENT v. Women's health vi. Mental health & addictions vii. High volume, low complexity medical services viii. Geriatrics			
	c. Identify design, financing and implementation options, and develop a procurement approach for prioritised Community Care Hub development either as physical infrastructure or as services			
	d. Enact procurement approach			

** These priorities have been identified through prior planning work e.g. the Southern Strategic Services Plan, Southern Detailed Service Plans A&B, Clinical Leadership Group position papers, scan of national and international literature, and engagement with stakeholders.*

Create locality networks to better coordinate care

The Southern district is large, with a diverse range of communities and service contexts. Demographic information suggests that different communities will face very different challenges into the future:

- Dunedin and Invercargill will grow slowly but age significantly
- Queenstown-Lakes will grow rapidly, and likely become the second largest population centre in the district (after Dunedin)
- North and Central Otago will also grow, and age
- Other rural areas of Southern may decline in population, but will age significantly.

Service models also vary considerably across the district, with much of this variation the result of historic decisions rather than reflecting the current or future needs of different communities. Addressing these issues is at the heart of locality network development, which is intended to better align models of care with population health needs within a clear, overall district-wide model of care.

The aim of locality networks will be to plan and deliver care closer to where people live, work and play. Risk stratification will be used to identify people who will benefit most from wraparound, integrated care, within a stepped care model. This will build on work that has been progressing through Alliance South, including *Client-led Integrated Care*, *Raise Hope*, and *Health of Older People Wraparound Support.*

Locality networks will bring together personal health, mental health & addictions, health of older people services and palliative care. Core components of the locality networks will be:

- Primary care
- Multi-disciplinary teams, including primary care, community nursing, allied health, community midwifery, and community mental health & addictions services
- NGO providers (e.g. child health; community pharmacy; midwifery; home-based support; hospice; Māori providers)
- Emergency retrieval and transport services
- Residential care and supported living providers
- Primary maternity services (including primary birthing facilities)
- Lower-complexity hospital services.

The locality networks will be supported by an expanded and enhanced care coordination service (see: Supporting Infrastructure), which will provide a point of intake to and deployment of relevant locality services, as well as oversight of community care delivery.

Integrated care teams will have the strongest operational linkage with HCHs, providing rapid response for acute crises, in-reach to inpatient services to support early discharge, short and long-term restorative care in community settings, and end-of-life care. In a staged approach, the following services will be integrated into community teams:

- Southern DHB Community Health Services (e.g. district nursing; allied health; mental health & addictions services)
- DHB-funded NGO services (e.g. child health; long-term conditions services delivered through WellSouth PHN; home-based support services; palliative care)
- Social care.

Key components of integrated community team development will include:

- Creating strong relationships with HCHs based on defined care pathways and shared care models, and supporting ongoing professional development with an emphasis on team care
- Consolidating significant primary and community health workforces that serve a locality, to deliver the benefits of critical mass, interdisciplinary teamwork, local responsiveness, and shared care for consumers and whānau
- Quality and standard design and implementation
- Identifying and actioning education and learning development opportunities
- Enabling community step-down models of acute care (mental health, older people, and lower acuity medical needs) through tailored support packages for people in their place of residence.

The integrated care teams will include the care coordinator role which will act as a navigator and broker of the journey for people with complex needs. The coordinator will work with HCHs, other locality providers and the care coordination service to ensure that consumers' care is delivered in line with their care plans.

Create locality networks to better coordinate care *cont'd*

DHB specialist advice and support will be available to HCHs and integrated care teams for people who require this. Key specialist services - including cardiology, respiratory, psychiatry, paediatrics, endocrinology (diabetes) and geriatrics - will support primary and community care.

Over time, teamwork within the locality network may be further enhanced by co-location of the interdisciplinary team in a Community Care Hub. Where the size of a HCH supports it, the team could be co-located with a HCH (as is the case now for some services at larger general practice sites). In rural areas, the Community Care Hub is likely to be the local rural hospital, where one exists, or larger HCHs where distance makes it more cost-effective to integrate services in this way. In Dunedin and Invercargill, purpose-built facilities may be developed, which may include delivery of some specialist outpatient services, possibly in collaboration with the University of Otago. Key development steps for locality networks will include:

- Determining the scope of locality networks
- Prioritising and sequencing service development within localities
- Understanding current and future demand, capacity and capabilities within each network, and priority gaps to be addressed. These may include future-proofing locality infrastructure by increasing the capacity and / or scope of services in anticipation of demand, or laying the foundation for future expansion in-line with population needs
- The workforce and capability development needed to meet locality network requirements and the necessary supports from tertiary programmes, such as the University of Otago's rural health training and inter-professional learning programmes
- Determining strategic and operational relationships that are required to support the effective functioning of a network
- Exploring the potential for Community Care Hub infrastructure, including the placement of primary birthing facilities and the infrastructure required to support delivery of ambulatory secondary care
- Aligning funding and contracting arrangements to the locality network model, with a progressive focus on shared accountability for population access and outcomes.

Locality network development will be staged. The prioritisation, sequencing, design and implementation of this will take into consideration:

- Size and scale to make a material difference to health and social outcomes
- Readiness of the services to proceed at pace and scale
- Alignment with primary care
- Defining the role of rural hospitals in integrated models of primary and community care for their catchment populations
- Ability to translate learnings from service integration to other services to be progressively included within the locality network
- Alignment with proof of concept locality network initiatives (see below)
- The capability of Southern DHB and WellSouth PHN to successfully advance locality network development over the three year period.

The learnings from implementation of services will enable the number of services in the future to increase. Two 'proof of concept' service models will be also be advanced to test and demonstrate more integrated ways of working across services and settings:

- An integrated respiratory service, which brings together primary, community and secondary care for people with significant lung disease
- An integrated rapid response and enablement team, bringing together primary care, community nursing and allied health, and secondary care specialists, with a focus on the frail elderly.

*

Create locality networks to better coordinate care – *Defining locality network services*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.1 – Define locality network services, and prioritise implementation sequence	a. Define a minimum set of service and workforce requirements and associated models of care to form a locality network, with this expected to include (on a staged basis): i. Integration of DHB Community Services and WellSouth PHN community services (e.g. LTC service) into multidisciplinary teams wrapped around primary care ii. Formal specialist support for primary and community care from prioritised secondary care services*: i. Emergency medicine ii. Cardiology iii. Respiratory iv. ENT v. Paediatrics vi. Geriatrics vii. Women's Health iii. Development of advanced primary and community care practitioner roles iv. Integrating rural hospitals in rural primary and community models of care, and strengthening their relationships with Dunedin and Invercargill hospitals v. Further development opportunities for rural primary care supporting increased access to technology-enabled clinical interventions vi. Integration with public health, population health and NGO community services vii. Coordinated ways of working with social sector providers (e.g. representatives from or clear referral pathways to Housing, MSD, Corrections etc.) viii. Primary care research network development ix. Learning and training network development			
	b. Considering geography, population size and other agreed factors, and through engagement with key stakeholders (e.g. health and wider social sector representatives, community representatives), clearly define the coverage of population-bound locality networks			
	c. Develop for each defined locality a strategic view of: i. Population health needs ii. Service use iii. Service availability and configuration iv. An explicit equity of access and outcome assessment (see: 8.4.a).			

** These priorities have been identified through prior planning work e.g. the Southern Strategic Services Plan, Southern Detailed Service Plans A&B, Clinical Leadership Group position papers, scan of national and international literature, and engagement with stakeholders.*

Create locality networks to better coordinate care – *Defining locality network services cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.1 *cont'd* – Define locality network services, and prioritise implementation sequence	d. Based on activities a through c, prioritise the design and implementation of services to be progressively incorporated into locality networks, with consideration of: i. Size and scale to make a material difference on health and social outcomes ii. Readiness of the services to proceed at pace and scale iii. Alignment with primary care iv. Defining the role of rural hospitals in integrated models of primary and community care for their catchment populations v. Ability to translate learnings from service integration to other services to be progressively included within the locality network vi. Alignment with proof of concept locality network initiatives vii. The capability of Southern DHB and WellSouth PHN to successfully advance locality network development over the three year period viii. Quality and safety requirements ix. Education and learning development opportunities			

Create locality networks to better coordinate care - *Design and implement locality network services*

Headline action	Activity		Phases		
			1	2	3
Headline action 3.2 - Design and implementation of locality network services, which integrate care for defined populations	a.	For locality network services, develop a comprehensive understanding of current and future population health needs for their covered population			
	b.	Understand the scope and capacity of locality network services and workforces, and their existing operational configuration, including service catchments, policies and procedures, and current engagement with primary care. Identify significant service and workforce gaps based on projected future population health needs			
	c.	Conduct a quality assessment to determine the extent that services within locality network services are addressing population health needs through evidence-based, culturally responsive and coordinated ways of working			
	d.	Refine as necessary existing risk stratification and stepped care approaches used in Southern to enable locality network operations			
	e.	Ensure shared care planning processes and systems are in place to enable integrated ways of working between locality network providers			
	f.	Extend Health Pathways to become whole-system pathways to support safe and effective transitions of care for locality services			

Create locality networks to better coordinate care – *Design and implement locality network services cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.2 *cont'd* - Design and implementation of locality network services, which integrate care for defined populations	g. Identify potential NGO capability requirements to deliver on proposed models of care for initial services, including *inter alia*: i. Retrieval and transfer infrastructure (e.g. air and land ambulances and storage facilities) to support efficient flows ii. Rural Hospital redevelopment as appropriate to meet future demand needs and enable delivery of broader services as agreed within role development, based on catchment population need iii. Increasing the capability and capacity of aged residential care providers to provide step-up or step-down care for older patients, through redevelopment of existing facilities or development of additional ARC capacity iv. Working with the NGO sector and wider social agencies to provide an increased range of accommodation options (including respite care) for people with mental health and/or addiction needs, and end of life care, across the Southern district		■	
	h. Initial locality network services operational implementation commenced		■	
	i. Additional locality network service planning started			■

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Create locality networks to better coordinate care – *Design and implement integrated respiratory service*

Headline action	Activity		Phases		
			1	2	3
Headline action 3.3 – Working through a clinically-led Service Development Group, design and implement proof of concept integrated respiratory service to generate early improvement, and inform ongoing service design and implementation	a.	Ensure 90% of smokers with a respiratory illness diagnosis are offered smoking cessation advice and referral to the Southern Smoking Cessation Service at every clinical interaction, including by St John	■		
	b.	Establish a funded SDHB-credentialed community-based spirometry service, which accommodates appropriate close to home access to this service	■		
	c.	Establish a community pulmonary rehabilitation programme to standardised and agreed criteria of assessment and programme delivery based on international standards	■		
	d.	Ensure an ambulance diversion pathway for COPD is operational in all localities	■		
	e.	Ensure planned care initiatives for respiratory patients are in place, including personalised care plans, acute plans, blue cards, medicines optimisation, and advance care plans	■		
	f.	Ensure a discharge bundle is in place for all patients with a primary diagnosis of COPD	■		
	g.	Work with stakeholders to determine extent and time of introducing an integrated cardiology service			■

Create locality networks to better coordinate care – *Design and implement rapid response and enablement service*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.4 – Design and implement proof of concept integrated rapid response and enablement community service to generate early improvement, and inform ongoing locality network design and implementation	a. Map and consolidate existing DHB rapid response and enablement services	■		
	b. Select proof of concept testing locality	■		
	c. Design the service model required to deliver an enhanced rapid response and enablement service (including POAC), with a transition plan for progressively including: i. DHB services ii. WSPHN services iii. NGO services	■		
	d. Test (as a proof of concept) an enhanced rapid response and enablement service	■		
	e. With the support of the shared health and business intelligence function, test and evaluate the performance of the integrated rapid response and enablement service		■	
	f. Consider scaling the proof of concept service to additional localities for further refinement and testing		■	

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Create locality networks to better coordinate care – *Design and initial implementation of a new primary maternity system of care*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.5 – Design and begin implementation of a new primary maternity system of care	a. Applying the principles of critical mass, future population trends and promoting equity for communities, develop a plan for future development of a primary maternity system across the district. The system will be midwifery-led, woman- and-family centred, promote primary birthing facilities and home birth for well women with normal pregnancies, use consistent policies procedures and quality improvement frameworks while operating as a network across all facilities. Services will be provided in i. Tier 1 – non birthing units ii. Tier 2- primary birthing units iii. Tier 3 – obstetric services units			
	b. Map the overall network of maternity services including LMC midwives, rural hospitals, emergency services, PRIME doctors, laboratory and imaging services, pregnancy and parenting community-based breastfeeding support, and general practices. Identify gaps and: i. strengthen information technology platforms to link the network – telemedicine ii. develop a communications strategy / plan to promote primary birthing iii. gather information for feasibility studies in Invercargill and Dunedin and complete iv. agree the business model and implement			
	c. Work with local stakeholders, to implement the system of care – tier 1 and tier 2 – and ensure they are well linked to tier 3 obstetric services			
	d. Feasibility study to determine the need for a primary birthing facility in Dunedin, and determine the impact of both Balclutha and Winton primary birthing facilities			

Create locality networks to better coordinate care – *Design and initial implementation of access to diagnostics (ATD) programme*

Headline action	Activity		Phases		
			1	2	3
Headline action 3.6 – Develop an access to diagnostics (ATD) programme to improve ATD in primary and community care settings	a.	Establish a clinical partnership group to develop clinical guidance for the programme, and a framework for the programme moving forward	■		
	b.	Identify conditions for which diagnostics can be ordered and delivered in the community as a safe and more convenient alternative to referral to secondary care outpatients services	■		
	c.	Develop processes for payment and claiming specifications in line with POAC	■		
	d.	Align the ATD criteria with the hospital referral criteria to ensure consistency of access	■		
	e.	Develop clinical audit processes to monitor appropriateness of use	■		
	f.	Establish shared governance for the routine review of the programme, as well as risk management	■		
	g.	Develop a systems approach to ATD in-line with the development of Health Pathways, to shift an increasing number of diagnostics to the community, and to accommodate key enablers of Health Pathways as these are developed		■	

Create locality networks to better coordinate care – *Deliver on optimisation of Primary, Urgent Care and Emergency Care Services in Invercargill*

Headline action	Activity	Phases		
		1	2	3
Headline action 3.7 – Deliver on optimisation of Primary and Emergency Care Services in Invercargill	i. Based on the review of primary, urgent care and emergency care demand and capacity undertaken in early 2018: i. Address gaps and barriers to achieving high quality and equitable access to primary care such as workforce issues, funding settings, and standards of care ii. Address barriers that impede urgent and acute patient flow across the system and best practice recommendations to address barriers iii. Undertake actions to improve an integrated and clear pathway of care between primary care and Southland Hospital ED, and into an inpatient setting where required iv. Consider the potential for reducing variation through the identification of priority Health Pathways			
	b. Align work undertaken to optimise primary, urgent care, and emergency care services in Invercargill with actions planned for development of HCHs and locality networks			

Action area 2: Supporting infrastructure

Governance and leadership

Given the Southern district's geography and dispersed population, the primary and community care system needs a clear district-wide framework for planning, funding and monitoring system performance and care delivery. The framework needs clear roles and responsibilities for prioritising resources, leading overall development of services to address population health needs, and continuous quality improvement (CQI). At a delivery level, clinical and provider relationships need to be fostered through building local champions and leaders that can successfully translate district priorities into local action.

At a **district level**, the alliancing approach between Southern DHB and WellSouth PHN will be refreshed. This will include revising Alliance leadership structures, membership and terms of reference. The Alliance approach will provide the district-wide framework for planning, funding and monitoring system performance and care delivery. The overarching role of the Alliance will be driving, overseeing, and supporting the delivery of the actions and activities outlined in this Action Plan, and the longer term strategic direction of the Strategy and its links to other district priorities including the new Dunedin Hospital. In fulfilling this role, the Alliance will ensure that the system remains focused on the Strategy and Action Plan, and where any new initiatives or calls for funding are proposed, these are stringently prioritised against the direction of the Strategy and the Action Plan's headline actions.

The other roles of the Alliance are expected to be:

- Setting funding parameters to inform delivery on the Action Plan
- Providing advice to the Southern DHB Board and WellSouth PHN Board regarding investment decisions to achieve the Strategy and Action Plan
- Convening service-level teams to drive particular planning and design initiatives
- Driving and monitoring progress on the Strategy and Action Plan, and the performance of primary and community care
- Fostering consumer and clinical engagement, and leadership
- Holding locality networks to account for delivering measurable improvement in consumer access, outcomes and system sustainability.

Over time, the Alliance will build partnerships with the wider social sector and local government to support closer multi-agency engagement and a more holistic understanding of the health and social needs of our consumers. This will improve the health literacy of broader social agencies and create a foundation for targeted joint planning and co-investment, both in health and social initiatives, and initiatives that combine the two.

Strong **clinical and provider leadership** will be essential to effect the transformational change that will be required in the system at district and locality levels. Changing workforce behaviours requires acceptance of the need for new ways of working, and recognition of personal and professional responsibilities. Identifying key leaders throughout Southern, building their leadership capability, and providing the support they require will be a critical investment to support execution of the Strategy. This will include:

- Southern DHB's Clinical Council being a mechanism for district-wide clinical leadership through the reconfigured Alliance, with the Council's terms of reference and membership to be extended to a whole-of-system role
- Clinically-led service level teams to drive particular planning and design initiatives
- Active engagement of key providers and practitioners in locality networks.

Building clinical and provider leadership and engagement will:

- Align the culture of primary, community and secondary health services across Southern with the principles of transparency, comparison, learning and improvement
- Articulate a clear and consistent vision at the 'coal face'
- Build trusting inter-organisational, -professional and -personal relationships , and create a culture of learning from each other
- Demonstrate, enable and communicate the future vision for primary and community care in the district
- Generate momentum by modelling new ways of working.

Governance & leadership – *Refresh alliancing approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 4.1 – Refresh the alliancing approach implemented in Southern, including terms of reference, membership and structure	a. Determine the future Terms of Reference (ToR) for alliancing in Southern including: i. Purpose ii. Guiding principles iii. Scope and objectives iv. Decision-making framework v. Dispute resolution mechanisms vi. Clarifying progress, performance and other agreed reporting lines vii. Relationship with other bodies in the Southern health system including but not limited to the Iwi Governance Committee, Community Health Council and Clinical Council			
	b. Refresh Alliance membership (including at least members from Southern DHB, WellSouth PHN and the University of Otago) and ensure all members have undergone alliancing training			
	c. Clarify and delegate accountabilities for delivering on the Primary & Community Care Strategy and Action Plan either through: i. Service level leadership teams for time-bound initiatives ii. Dedicated workstreams for enduring activity			
	d. Confirm an investment strategy and joint approach for delivering on the Primary & Community Care Strategy and Action Plan			
	e. Implement a simplified and consistent business case process for Alliance service-level and workstream activity development and decision-making			

Governance & leadership – *Encourage establishment of clinical and provider networks*

Headline action	Activity	Phases		
		1	2	3
Headline action 4.2 – Encourage clinical and provider networks to support locality network strategic and operational delivery	a. Identify and build the capability of local leaders and champions of integrated approaches to care delivery, as envisaged by locality networks, through a leadership development programme. Key roles for local leaders and champions to include: i. Aligning the culture of primary, community and secondary health services across Southern with the values of transparency, comparison, learning and improvement ii. Articulating a clear and consistent vision at the 'coal face' iii. Building trusting inter-organisational, -professional and -personal relationships , and creating a culture of learning from each other iv. Demonstrating, enabling and communicating the future vision for primary and community care in the district v. Generating momentum by modelling new ways of working vi. Develop visual resources to reflect the shared purpose of participants across the sector, for use across all providers' communications materials			
	b. Through the shared health and business intelligence function, provide regular transparent analytics reports to locality networks that benchmark locality performance on agreed measures. The reports are to be available to all members of the locality network			
	c. Encourage participation in professional development activities that include but are not limited to: i. Peer review ii. Fostering team based ways of working iii. Professional relationships across care settings (e.g., nursing) iv. Research and learning			
	d. Review and align funding and contracts across locality network providers with a focus on moving towards a results-based model for locality networks, with the intention that this supports local problem solving and service development			

Workforce capability and culture

Delivering on the Strategy will require development of new care models and workforce roles, and additional workforce capacity. Currently workforce planning is fragmented across services and organisations. It is also reactive to emerging issues rather than proactive in aligning capability and capacity with planned future care models.

A **Southern Workforce Strategy and Action Plan** will be developed in 2018. The Strategy and Action Plan are expected to determine the workforce roles, capacity and capability needed across the system to deliver the intended care models, access and outcomes, and development needs at district and locality levels. This will include the training needs of existing staff, the roles they need to perform in the future, and the number of staff needed with different skills to deliver within the new care models.

From a primary and community care perspective, the key considerations for the Southern Workforce Strategy and Action Plan Plan will include:

- Better matching workforce distribution with population need through a primary and community care workforce census and projected development survey to establish current demographic and clinical/business needs. This will be supported by a gap analysis to inform and deliver further training/development/workforce needs
- Expanding the primary care team through the HCH model
- Promoting top of scope practice including designated pathways for regulated health professionals to extend their scopes of practice (e.g. nurse practitioner, GPSI, PNSI, rural hospital medicine, pharmacist)
- Enabling care to be delivered in ways which recognise the importance of te reo Māori and provide for its appropriate use, including the potential to introduce mandatory training for the health workforce
- Promoting non-regulated workforce roles such as health care assistants, health coaches, kaiāwhina and physician assistants
- Increasing Māori and Pacific peoples' participation in the regulated and unregulated workforce
- Addressing any existing local policy settings that get in the way of the efficient use of resources and team based ways of working
- Identifying the appropriate balance between generalism and specialism within the workforce
- Developing capabilities in team-based ways of working across primary, community, secondary and social care
- Developing a technology-capable health workforce
- How the professional development curricula and delivery media can help to build relationships within the primary and community care workforce (district-wide and locality specific), support new care models, and provide training for emerging clinical leaders
- Opportunities to better support teaching, training and research in primary and community care, including in partnership with the University of Otago
- Fostering capable primary and community clinical leaders
- Recognise changing professional expectations such as: feminisation; work / life balance; and employment rather than ownership
- Describing the actions needed to foster a workforce culture that is:
  - Consumer-focused, including promoting health literacy and self-care
  - Committed to reducing inequities and population health
  - Collaborative
  - Identifying opportunities to increase community volunteering activity to support participation and resilience.

Workforce capacity and capability development will need to be supported by tertiary programmes (e.g. the University of Otago's rural health training and inter-professional learning programmes). Strong engagement with tertiary education institutions will therefore be critical during Strategy and Action Plan development to ensure alignment between workforce requirements, and education and training programmes.

Workforce capability and culture - *Build the primary and community care workforce*

Headline action	Activity	Phases		
		1	2	3
Headline action 5.1 - Build the primary and community care workforce in-line with the Southern Health System Workforce Strategy & Action Plan and implementation of HCH and locality networks	a. Undertake a primary and community care Demographic and Workforce Development Survey to establish current demographic and clinical/workforce development needs. As part of this, undertake a gap analysis on the data provided to inform and deliver further training/development/workforce needs	■		
	b. Partner with tertiary and education providers to ensure a sufficient future supply of primary and community care professionals aligned with desired models of care and future demand, and to better support teaching and learning	■		
	c. Promote interprofessional top of scope practice through designated pathways for regulated health professionals to extend their scopes of practice (e.g. nurse practitioner, GPSI, PNSI, rural hospital medicine, advanced allied health professionals, pharmacist)		■	
	d. Promote and develop a framework for interprofessional clinical practice and safe delegation/skill sharing (e.g. interprofessional team models, use of Calderdale Framework for skill sharing/delegation).		■	
	e. Develop a primary care research network in partnership with Health Research South		■	
	f. Health of older people: i. Provide support to upskill the Aged Residential Care nursing workforce through: a. professional development opportunities b. increased visiting presence of clinical nurse specialists in care facilities c. streamlined access to specialist advice to manage more complex residents ii. Closer working relationships between home-based support services and community health services, as progressed through locality network development		■	
	g. Primary maternity care: i. Strengthen the primary maternity workforce based on current and projected population needs, including appropriate integration with other primary and community care services *(see: Primary Maternity Strategy)* ii. Encourage provider and facility networks to support the development of a primary maternity system of care		■	

Workforce capability and culture - *Build the primary and community care workforce cont'd*

Headline action	Activity	Phases		
		1	2	3
Headline action 5.1 *cont'd* - Build the primary and community care workforce in-line with the Southern Health System Workforce Strategy & Action Plan and implementation of HCH and locality networks	h. Pharmacy: i. Implement as appropriate *Integrated Pharmacist Services in the Community* including: - promoting clinical pharmacy roles as part of HCH and locality network development - participation in shared care planning - locally determined services to be developed from pharmacies (e.g. medicines optimisation; minor ailment interventions) i. As applicable, encourage the use of pharmacy technicians to free up pharmacist time to provide higher complexity services ii. Encourage pharmacies' role in promoting improved population health		■	
	i. Emergency care: i. Work with St Johns to upskill their workforce to enable top of scope practice ii. Support the ongoing development of the PRIME-trained workforce in rural and remote areas		■	
	j. Address immediate capacity pressures in: i. Rural primary maternity care ii. Allied health services iii. GP and nursing cover in rural and remote areas		■	
	k. Actively promote, and preferentially invest in, growing the Māori and Pacifica primary and community care workforce in partnership with education providers, including potential incentives or priority placements to encourage Māori/Pacifica students to develop in required roles, or existing Māori/Pacifica members of the workforce to develop into extended roles (engage with iwi and community agencies and other key stakeholders in relation to this)	■		
	l. Through locality network development, identify workforce capacity development needs to deliver desired models of care, and put in place action plans to address these needs		■	
	m. Work with wider social sector representatives to identify and action opportunities to increase community volunteering activity to support participation and resilience (e.g. visiting ARC facilities, Meals on Wheels)		■	

Workforce capability and culture – *Identify actions to develop the workforce culture*

Headline action	Activity	Phases		
		1	2	3
Headline action 5.2 - Identification of actions needed to develop the workforce culture required to deliver on the Strategy	a. Identify and implement evidence-based ways of promoting effective team working between primary, community and secondary care as part of HCH and locality network design and implementation		■	
	b. Develop a values-based charter that outlines the expected behaviour of all workforce participants, and a training module to introduce existing and new workforce members to these new ways of working, with this to include commitments to: i. person-centred care delivery ii. eliminate inequities in access and outcomes, particularly for Māori iii. work collaboratively across professions, organisations and sectors iv. constructively engage in open and honest appraisal of data, performance and opportunities for improvement	■		
	c. Develop mandatory education modules to train all workforce members on values-based ways of working, and engaging in a respectful way with Māori people, understanding their world view to enable the delivery of culturally appropriate care	■		
	d. Require completion of both the values-based and Māori education modules by all existing staff, and new staff through induction activities		■	
	e. Create a channel for ongoing feedback from all system participants (workforce and consumers), encouraging transparency around performance in relation to both the system value-set and ways of working, and engaging with Māori		■	
	f. Leverage expertise within the University of Otago to promote quality and safety, research, and evaluation		■	

Health and business intelligence

Health and business intelligence plays a vital role in supporting evidence-based planning, funding and care delivery, including supporting the rapid evaluation of initiatives and provision of feedback for performance improvement. This requires a robust system of data collection, analysis, interpretation and reporting. Improved health and business intelligence will be progressed at two levels in the Southern system:

- Strategic: development of a shared health and business intelligence function
- Operational: an expanded and enhanced care coordination service.

A shared health and business intelligence function will be developed across Southern DHB and WellSouth PHN, and potentially with the University of Otago (e.g. evaluation; research; health economics). The function will consolidate existing resources to drive efficiencies and best use of scarce skills. The key roles of the function will be:

- Maintaining and improving the quality of source data within key databases (including from PMSs), managing access to data, and developing analytical tools
- Supporting strategic planning through the provision of analytical and evidence-based advice, including identifying opportunities to reprioritise investment to achieve better population health access and outcomes
- Supporting performance improvement through data analysis and interpretation; assistance in developing key indicators, health need and services profiles; and identifying unwarranted variation in access and outcomes
- Supporting planning and development within individual services and localities, including making information publicly available
- Providing performance and health outcome information on organisational priorities, including through the System Level Measures Framework
- Supporting the rapid, evidence-based evaluation of initiatives, programmes and models of care. This would include recommendations to adjust, continue, scale or stop, depending on performance over a reasonable time period, potentially through collaboration with the University of Otago.

To support the health and business intelligence function, data will be integrated across the system into a single data repository. Data will be integrated at an individual consumer level, with need, activity, experience and cost information. This will allow health and care analysis at a population level, as well as locality and consumer cohort levels.

The foundation of the data repository will be consumer level data from general practice, developed to consistent data specifications and business rules. This data will then be integrated with Southern DHB hospital, specialist and community health data. Over time, health and support data from kaupapa Māori providers and other NGOs will also be incorporated into the dataset (including social care where possible).

The dataset will be used to understand how Southern compares with other health systems and how access, quality, and outcomes vary across the district. The dataset will also be used to benchmark general practice, community providers and hospital services against desired metrics, and for defining and actively monitoring performance against appropriate KPIs to identify opportunities for improving access, quality and costs. Performance against KPIs will be shown for Māori and non-Māori populations. This will be linked to the System Level Measures Framework and local contributory measures.

At an operational level, informed by the shared health and business intelligence function, an expanded and enhanced care coordination service will be progressed. The key roles of the service will be:

- Central intake of consumers requiring wraparound care from locality network services
- Assessment of consumers with complex needs, and deployment of resources
- Administrative management of funding streams and packages of care
- Maintenance and monitoring of care pathways
- Logistics related to consumer transport and accommodation
- Oversight of community care performance.

Health & business intelligence – *Establish a shared health intelligence function*

Headline action	Activity		Phases		
			1	2	3
Headline action 6.1 – Establish a shared health and business intelligence function to guide district-wide and specific service or population analysis	a.	Define the scope and objectives of the shared health and business intelligence function, informed by New Zealand and international leading practice, including an equity approach to support improving access and outcomes for Māori and rural populations. Scope and objectives to include consideration of: i. Strategic population needs assessment (includes equity considerations) ii. Overall health system outcomes iii. Operational health system operational performance iv. Ability to match expenditure and resource allocation to service utilisation and outcomes.			
	b.	Map capabilities required for the health and business intelligence function with existing Southern DHB and WellSouth PHN health and business intelligence capabilities (people, process, technology), and explore opportunities to work with the University of Otago			
	c.	Based on capability mapping, identify and action the necessary development steps for the shared health & business intelligence function			
	d.	Determine governance, structure and location of the shared health and business intelligence function			
	e.	Establish a quality improvement framework aligned with the quadruple aim approach, to underpin Action Plan delivery (see: 8.4.a)			
	f.	Develop and implement a formal plan for monitoring for equity for Māori and rural populations. This will include a process for collecting data, agreed methods for comparison, an agreed process for identifying areas for action, and a process for monitoring and feeding back on outcomes and progress.			
	g.	Develop an integrated system-wide data repository design brief and implementation plan to support the health and business intelligence function, utilising existing infrastructure where possible			
	h.	Commence development of the integrated system-wide data repository			
	i.	Analytical support provided to Tranche 1 HCH sites			
	j.	Analytical support provided to initial locality networks			

Health & business intelligence – *Establish a care coordination approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 6.2 – Establish a care coordination approach	a. Scope the establishment of an expanded and enhanced district-wide care coordination approach with the following possible functions: i. Central intake of consumers requiring wraparound care from locality network services ii. Consistent assessment of consumers with complex needs, and deployment of resources iii. Administrative management of funding streams and packages of care iv. Scheduling and rostering of community based teams v. Maintenance and monitoring of care pathways vi. Logistics related to consumer transport and accommodation vii. Oversight of community care operational performance			
	b. Determine the additional services to be covered by a care coordination approach, with early areas of focus being: i. Rapid enablement and response service ii. POAC levels 2 and 3 iii. Supported discharge planning			
	c. Develop an implementation plan for an expanded and enhanced care coordination approach			
	d. Commence implementation of the expended and enhanced care coordination approach			

10

Information and care technologies

New and emerging technologies are rapidly transforming how people engage with each other and with the services they use. In health care, this means how people access health information (including their own records), how they engage with health services, how they interact with people with similar needs, and the health checks (like simple diagnostics) they can do for themselves. It also is transforming how the health workforce interacts with each other, and the range of information they can use to diagnose and care for people.

It is easy to be overly optimistic about technologies in the short-term. However, in the long-term the transformational impact on health care through technology can be easily under-estimated. Given this, a structured and considered approach will be taken to introducing new technology into the Southern health system.

A **Southern Technology Strategy and Action Plan** will be developed in 2018. The Strategy and Action Plan are expected to determine the technology capacity and capability needed across the system to deliver desired care models and ways of working. The Strategy and Action Plan will consider the technology development needs for the system as a whole, and more specific areas of focus such as primary and community care integration with hospital and specialist services.

The South Island health system is comparatively advanced in **information sharing** across the health workforce, with many professionals able to quickly access relevant consumer information across care settings. Our primary health care workforce can also access a wide range of clinical pathways and referral guidelines through Health Pathways, helping them make timely, evidence-based decisions for their registered populations. While we have made progress on improving clinician access to patient information and aspects of clinical communication, we have yet to fully develop the communications and information technology infrastructure to support shared care planning and care delivery, and consumer access to their information.

Approaches to **virtual health**, such as through smart phone, video and email consultations are rapidly being implemented internationally and in New Zealand. Such approaches are underway in Southern, although this tends to be at the margins of care delivery. As part of improving access to services, particularly for our rural populations, we will encourage the development of virtual health approaches. For example, we will encourage the use of online video consultations for consumers to access timely advice, with such approaches expected to be a core specification for HCH development. We will also encourage the use of technology in 'front-door' flows at HCHs (e.g. smart kiosks), and preparing HCHs and locality networks for the gradual introduction of technology-enabled home care approaches.

More use of **home care technologies** that enable consumers to safely care for themselves in their own homes, with support from their HCH and locality networks, will be encouraged. This will include consumers with chronic disease monitoring and managing their physiological markers, and health professionals remotely monitoring consumers with dementia at home so that they can intervene quickly to reduce the risk of adverse events.

In the longer-term we will also explore opportunities:

- to encourage the introduction of emerging technologies:
  - into care delivery (e.g. dispensing in community pharmacy)
  - to support consumers to live well at home (e.g. 'smart home' technology)
  - into the supply chain to provide quicker access to medicines and clinical supplies for consumers and the health workforce (e.g. drones; self-driving cars)
- to incorporate genomic information into consumer health care records to enable more personalised care approaches tailored to individual biology (e.g. medicine management based on a person's genomic profile)
- the use of artificial intelligence (AI) in health and business intelligence, operational management and clinical decision support.

Information and care technologies – *Prioritise and introduce new technologies*

Headline action	Activity		Phases		
			1	2	3
Headline action 7.1 – Prioritise and roll-out new technologies in primary and community care in-line with the Southern Digital Health Strategy and implementation of HCH and locality networks	a.	Through development and delivery of the Southern Health System Digital Health Strategy, leverage existing infrastructure, and where required design and implement new ways of working to develop the integrated set of technology solutions that provide a consumer-owned EHR	■		
	b.	Establish an R&D project in partnership with University of Otago and other international partners to determine appropriate health technology enablement opportunities aligned with HCH, integrated care and home-based care models		■	
	c.	As part of locality networks, develop secondary outreach services delivered through a structured telehealth outreach model via fixed to mobile end-points established on the DHB network. e.g. Vidyo		■	
	d.	Develop consumer access to health care through Consumer Portal Telehealth Services, with fluid access to Online Doctor and Virtual After-Hours Services, accessible via an integrated Southern health system online communications framework			■
	e.	Develop remote monitoring capability of inpatient beds and step down facilities in rural and regional areas. This should utilise proactive data analytics and bi-directional video conferencing to alleviate occupancy pressures on Dunedin and Invercargill hospitals			■
	f.	Implement remote telehealth support for paramedic and emergency clinicians to improve remote triage of patients in their communities			■
	g.	Explore opportunities to develop Healthpod-style kiosks for routine self-service checks, leveraging existing connected health services or new initiatives through the Southern Technology Strategy			■
	h.	Begin to explore the potential of emerging technologies and opportunities to leverage artificial intelligence			■

Funding and contracting

Implementation of the care models and supporting infrastructure envisaged by the Strategy will require changes in funding and contracting approaches. Existing funding and contracting models lead to duplication of effort and resources, are too output-focused, and restrict collaboration between providers and innovation in care models. Actions to promote new funding and contracting approaches will include:

- Supporting the development of HCHs - for example, through enhanced capitation, transitional resources, and performance incentives
- Addressing urgent care needs and avoiding hospital demand through design and roll-out of a tailored Primary Options for Acute Care model, including as appropriate mechanisms to address consumer cost barriers (in-line with national policy developments)
- Introducing a funding model that supports extension of scopes of practice
- Designing a funding and contracting approach for rural hospitals that reflects and incentivises the desired scale and mix of services, integration with primary and community services, and effective linkages with base hospital acute and visiting specialist services
- Improving service coordination and reducing duplication - for example, through locality network fund-holding; and/or packages of care approaches with a lead provider(s) for defined populations and/or consolidation of services under a single provider arrangement, supported by the care coordination service
- Increasing accountability for improving outcomes such as through results-focused funding and contracting arrangements
- Exploring opportunities to use multi-year funding and contracting arrangements. These arrangements are intended to provide a level of financial security to enable provider investment in innovation, broadening the scope and/or scale of services offered, and fostering integrated care approaches
- Exploring opportunities to pool funding across health and social care at a district-level, operationalised at a locality network level, to support holistic care for more vulnerable populations.

Any adjustments to funding and contracting settings will be married to transparent performance evaluation delivered through the proposed shared health and business intelligence function, and operationalised through HCH and locality network development. They will also consider the cost to consumers of accessing services, and will make consumer service costs more consistent across the district (particularly for after-hours services).

Funding and contracting – *Develop HCH funding approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 8.1 – Develop a HCH funding approach tied to model of care and performance specification	a. Discuss with other implementers of HCH models of care (e.g. Health Care Home Collaborative) to understand transitional funding arrangements and how they have been linked to performance expectations			
	b. Design and implement the funding arrangements for Tranche 1 HCHs, with this expected to include: i. Adoption of the Health Care Home Collaborative's national dataset measures ii. Locally determined performance measures iii. Funding arrangements explicitly tied to model of care development milestones iv. Co-sharing of HCH model of care design costs through financial recognition of clinical participation in the process v. Collaboration values between Southern DHB, WellSouth PHN and HCHs			
	c. Review the funding arrangements for Tranche 1 HCHs and confirm funding approach for Tranche 2			

Funding and contracting – *Roll out Primary Options for Acute Care programme*

Headline action	Activity	Phases		
		1	2	3
Headline action 8.2 – Roll-out Primary Options for Acute Care programme	a. Confirm the design of the Primary Options for Acute Care (POAC) model, at the following three levels: • Level 3: Most acute patients - the patient requires access to enhanced community supports such as the rapid response and enablement service, community allied health, a medical assessment and planning unit (MAPU), or an Accident and Medical Centre • Level 2: Moderately acute patients - the patient requires extra support coordinated by general practice. This will include additional support from an allied health team (whether based in primary or secondary care, likely locality-based) that would provide capacity, particularly to smaller practices • Level 1: Least acute patients - the patient requires a one-off service or activity such as IV antibiotics, diagnostic test, or direct access to specialist advice			
	b. Confirm and implement priority services for level 1 POAC services			
	c. Working with locality networks, design and commence implementation of level 2 and 3 POAC services			
	d. Supported by the health and business intelligence function, evaluate and adjust POAC initiatives depending on their cost-effectiveness and integration with related services e.g. rapid response and enablement service and urgent and emergency care			

Funding and contracting – *Introduce a funding model to support the designated pathway for extended scopes of practice*

Headline action	Activity		Phases		
			1	2	3
Headline action 8.3 – Introduce a funding model to support the designated pathway for the extension of scopes of practice (e.g. GPSI / PNSI / NPSI)	a.	Develop an appropriate funding model for GPSI / PNSI / NPSI roles matched to current and / or future demand			
	b.	Follow an expression of interest (EoI) process to identify opportunities for role development and select appropriate people within and outside of the existing workforce to develop into these roles. For existing members of the workforce, the potential to train where they live and work must be considered, either extramurally or through training by visiting specialists in their chosen area(s) of expertise			
	c.	Supported by the health and business intelligence function, evaluate and improve the cost-effectiveness, and approach to development for / funding of these roles			

Funding and contracting – *Introduce a results-based funding approach*

Headline action	Activity	Phases		
		1	2	3
Headline action 8.4 – Institute a results-based approach to funding and contracting to support alignment of locality network delivery with district-wide and local priorities	a. Determine a performance framework for locality networks which: i. Shares accountability for whole of system outcomes ii. Enhances and incentivises integrated network decision-making iii. Stipulates responsibilities for locality network clinical oversight and quality improvement iv. Takes a lifecourse approach to better aligning service delivery with desired population health outcomes v. Enables improvement in capacity and capability			
	b. Apply the locality network performance framework with initial localities to inform model of care design			
	c. Identify and address funding and contracting barriers to locality network collaboration and duplication of service delivery			
	d. Determine locality network-wide KPIs to be incorporated into all contracts held by network providers to support integrated ways of working			
	e. Formulate a funding model to support the locality network performance framework, with appropriate consideration of factors that influence delivery costs			
	f. Explore opportunities for risk / gain sharing approaches at a locality network or provider level			

Action area 3: Supporting adoption

Supporting adoption

Proof of concept

HCH demonstration sites and localities will have a proof of concept (POC) role. This will involve testing of HCH and locality network models to ensure they are feasible for wider application, and fine-tuning the models based on this experience. POC can be thought of as trialling a prototype of a new model in the field to establish operational viability, identify and resolve technical issues, and suggest overall direction. POC involves extensive review to inform fine-tuning of the prototype, as well as providing feedback for decision-making processes.

Design and implementation at the demonstration sites or localities will involve putting in place site-specific supporting infrastructure, so that they can deliver the intended model of care. It will also involve the application of district-wide supporting infrastructure such as early stage whole-system health and business intelligence. As implementation progresses, care models and infrastructure will continue to evolve both through a planned development path, and in response to learnings from review and feedback.

Learnings from the demonstration sites will play a central role in shaping delivery of primary and community care in Southern, and in contributing to realisation of the Strategy's vision. Minimum requirements for demonstration site selection are likely to include:

- Local clinical champion(s) committed to innovative service redesign
- Commitment to the key directions of the Primary and Community Care Strategy
- Economy of scale to undertake early testing and development of new care models and infrastructure
- Cooperative working relationships with DHB services
- Cooperative working relationships with other locality providers
- Evidence of participation in primary and community care innovation, or intention to participate in the near future
- Support for the shift of service activity from secondary to primary care (especially for long-term condition management)
- Willingness to share data
- Standard and quality of information systems and facilities, and willingness to invest where required.

The number and sequencing of demonstration sites will be determined during the first 12 months of Action Plan implementation, which will include an expression of interest (EoI) process for HCHs, and an engagement process to define and prioritise locality network development. As part of creating locality networks, a small set of service-based POCs (integrated respiratory services and rapid response / enablement teams) will be designed and implemented for trialing before potentially being scaled district-wide.

Consumer engagement and communications

Communications and engagement with consumers and communities will be critical to the design and application of new care models and supporting infrastructure. A 'one team' approach will be taken to communications and engagement with consumers, as 'Southern Health' rather than individual organisations. In the first instance, model of care co-design approaches with consumers and communities will provide an avenue through which to do this, and the values-based charter will provide the framework for consistent, ongoing engagement.

Consumer engagement with the district-wide Alliance will be encouraged through Southern DHB's Community Health Council; and through consumer participation in the DHB's Clinical Council.

Consideration will be given to how this consumer participation can be extended to the locality level, where close engagement with local government in particular will enable community leaders to identify, advocate and support local health priorities and initiatives. Social care providers will also be engaged at the locality level.

Supporting adoption *cont'd*

Workforce engagement and communications

The health care workforce will be actively engaged in the design and application of care models and supporting infrastructure. The focus of engagement will be on breaking down the traditional silos that characterise relationships between primary, community, and secondary care. This will be achieved through:

- Co-design methodologies, which bring health care representatives together to challenge traditional ways of working, and identify practical approaches to delivering on the Strategy. Co-design will be facilitated through HCH and locality networks design and execution
- Development of a clear strategic direction for secondary and tertiary care, aligned with the Primary and Community Care Strategy over the same time horizon, and work undertaken as part of the Dunedin Hospital rebuild process
- Specially convened Alliance service development activities (e.g. access to diagnostics) which involve primary and hospital clinicians in design and implementation, with a focus on building trust-based relationships
- Workforce development, including lifting capabilities in clinical leadership and in team-based care.

Over time the social care sector will be progressively involved in co-design approaches.

Iwi engagement

Southern DHB and Ngāi Tahu have a history of working together, largely through their engagement with the Iwi Governance Committee. This working relationship will be enhanced through active engagement with the Committee during detailed design and implementation of the Strategy and Action Plan. In the context of Strategy and Action Plan implementation, this will mean:

- Continuing to build the network of kaupapa Māori providers across Southern through specific development work, and integration with other health and social services
- Strengthening the Māori consumer voice in model of care design
- Lifting the performance of mainstream service providers so that they are effectively meeting the specific needs of Māori
- Identifying and actioning opportunities for iwi to participate in innovative models of health and social care.

Co-design approach

A structured approach to co-design will be progressed for HCH and locality network development (including POC initiatives). The approach will involve six steps:

1. Engage – proactively establishing and maintaining meaningful relationships with consumers, whānau, the health workforce (e.g. clinicians, non-clinical staff), iwi, tertiary providers, and wider social sector agencies ('key stakeholders') to understand health and service needs, and identify opportunities to lift performance
2. Explore – exploring the experiences of key stakeholders (particularly consumers and whānau) to identify model of care design and performance improvement activities
3. Develop – working with key stakeholders to turn ideas into improvements and better consumer and whānau experiences
4. Decide – using a transparent engagement process, prioritise model of care design and performance improvement activities in line with the principled approach set out on page 9.
5. Plan – work with key stakeholders to plan model of care design and performance improvement activities, including implementation steps and delivery
6. Change – work with key stakeholders to turn model of care design and performance improvement activities into action, supported by resourced change management capability.

Supporting adoption *cont'd*

Provider capability development

To encourage adoption of new care models and supporting infrastructure, some provision of transitional investment will be made available to early adopter HCHs and locality network participants. Investment will be linked to a transition plan that sets out agreed model of care specifications, timeframes, provider co-investment of time and effort, and potentially capital. Over time the transitional investments will be translated into incentives for outcomes following certification of a practice as an HCH.

Technical support will be provided to early adopter HCHs and locality networks. This support will include:

- Health intelligence: locality needs assessment and service profiles, and practice benchmarking
- Evaluation expertise: support to assess the maturity of existing systems and processes, and priorities for transformation
- Business intelligence: financial modelling to help providers understand how to optimise care and business models
- Redesign expertise: dedicated professional support to help facilitate change in care models
- Data management: assistance with improving data capture and accuracy.

Transitional investment and technical support will help to guide the implementation of tailored solutions to ensure HCH and locality network sustainability and performance.

Planning & funding

Southern DHB, the main funder of health services for the Southern population, is unlikely to receive a significant increase in its available funding, given the demographic characteristics of the district. Moreover, the DHB is still working towards a break-even financial position after a long period of spending more than it receives in revenue. Overall, this means that the DHB, and the health system more broadly, needs to do better within existing resources, while prioritising any additional discretionary funding to areas of greatest return in improving health outcomes and sustainability. Delivering on the Primary and Community Care Strategy and Action Plan will require:

- Doing better with the funding already available in the system through new care models and more integrated ways of working
- Prioritising investment of any discretionary funding to initiatives that will:
    - Modify demand for acute hospital services, which will unlock additional resources over time
    - Cost-effectively substitute demand for hospital care, reducing the need for additional hospital capacity
    - Improve longer-term health outcomes through targeted investments that reduce the burden of disease.

As a consequence, there will be an early review of funding levels and contracting within the system to test their alignment with the Primary and Community Care Strategy and Action Plan. This will inform the proposed investment strategy and joint approach between Southern DHB and WellSouth PHN (through the Alliance) for delivering on the Strategy & Action Plan.

As Southern DHB receives its funding and planning package each year from the Ministry of Health, the size of available discretionary funding will become clearer. It is expected that delivering on the goals and actions of the Strategy and Action Plan will be prioritised for preferential investment within the DHB's overall available funding.

The extent of available funding will determine how quickly actions in the Action Plan can be advanced. If more funding becomes available, then some actions will be brought forward. In other instances, it may mean some are deferred. These decisions will be progressed through the Alliance, and codified through the DHB's annual planning cycle. This will ensure that they are factored into each year's Annual Plan and budget, and associated monitoring and reporting.


Southern District
Health Board
Piki Te Ora
WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

SOUTHERN DISTRICT HEALTH BOARD

Title:	**CONTRACTS REGISTER**
Report to:	Community & Public Health and Disability Support Advisory Committees
Date of Meeting:	24 May 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:** 15 May 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) MARCH - APRIL 2018

PROVIDER NAME	DESCRIPTION OF SERVICES	ANNUAL AMOUNT	CONTRACT/VARIATION END DATE	APPROVED BY
Contract Value of - $0 - $100,000 (Level 3)				
Volunteering Otago Trust Variation to Agreement	Activity Based Rehabilitation through Volunteering	$17,740.93	30-Sep-18	Louise Travers 30-Jan-18
Ryman Healthcare Ltd t.a. Yvette Williams Variation to Agreement	Long Term Support - Chronic Health Conditions (LTS - CHC)	Est $65,084.98	Evergreen	Lisa Gestro 01-Mar-18
Dunedin Community Care Trust t.a CCT Letter of Agreement	Transitional Funding for NHI: QRT0715	$8,892.80	21-Apr-18	Louise Travers 12-Mar-18
Creative Arts Trust Variation to Agreement	Arts Based Day Activities	$113,103.89	30-Sep-18	Patrick Ng 13-Mar-18
WellSouth Primary Health Network Variation to Agreement	DCIP - Free GP Annual Check Review - Student Health	$12,695.49	30-Jun-19	Lisa Gestro 16-Mar-18
Ballie & Lewis 2002 Ltd Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Quins Gore Pharmacy ltd t.a. Unichem Quins Gore Pharmacy Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) MARCH - APRIL 2018

Antidote (nz) Limited t.a. Antidote South Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Elwyn Bates Group Ltd t.a. Elwyn Bated Pharmacy Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Antidote (nz) Limited t.a. Antidote Octagon Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Antidote (nz) Limited t.a. Antidote North Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Antidote (nz) Limited t.a. Antidote Gardens Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Antidote (nz) Limited t.a. Antidote Central Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Antidote (nz) No.2 Limited t.a. Antidote Meridian Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
B&N 14 Limited t.a. Anderson's Exchange Pharmacy Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) MARCH - APRIL 2018

Mornington Pharmacy Ltd t.a. Unichem Mornington Pharmacy Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Waiau Health Trust Limited Variation to Agreement	Maternity Resource Centre	$17,200.00	30-Sep-18	Lisa Gestro 28-Mar-18
Roslyn Village Pharmacy Ltd t.a. Unichem Roslyn Pharmacy Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Centre City Pharmacy (2004) Ltd t.a. Centre City Pharmacy Variation to Agreement	Pharmacist Health Education Services - Smoking Cessation	$2,400.00	30-Jun-18	Lisa Gestro 28-Mar-18
Southern Community Laboratory's Variation to Agreement	Bowel Screening Programme	EST. $50,000.00	30-Jun-18	Lisa Gestro 07-Apr-18
	Total for Level 3	**$200,833.11**		
Contract Value of - $100,000 - $500,000 (Level 2)				
Royal New Zealand Plunket Trust Variation to Agreement	Perinatal Health Specialist Community Service	$125,400.00	30-Apr-21	Patrick Ng 01-Feb-18
Pact Group Renews Services - under new Contract	Individual Funding Agreement for NHI AKQ6824	*191,880.00*	28-Feb-21	Patrick Ng 21-Mar-18
	Total for Level 2	**$317,280.00**		

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) MARCH - APRIL 2018

Contract Value of - $500,000 - 1 Million (Level 1)				
	Total for Level 1	**$ -**		
Contract Value of - $1 Million and Over (Commissioner)				
WellSouth Primary Health Network Variation to Agreement	Refugee Primary Care Services	$1,094,452.00	30.06.18	Commissioners 28.02.18
	Total for Board Level	**$ 1,094,452.00**		
	Grand Total	**$ 1,612,565.11**		

11

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.