SOUTHERN DISTRICT HEALTH BOARD

DISABILITY SUPPORT ADVISORY COMMITTEE
and
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Wednesday, 25 May 2016
commencing at the conclusion of the public
Hospital Advisory Committee meeting

Board Room, Level 2, West Wing, Main Block,
Wakari Hospital Campus, 371 Taieri Road, Dunedin

A G E N D A

Lead Director: Sandra Boardman

Item

1. **Apologies**
2. **Interests Register**
3. **Review of Terms of Reference**
4. **Planning & Funding Report**
   3.1 Planning & Funding Activity
   3.2 Public Health South Report
5. **Annual Plan 2015/16 Progress Report**
6. **Contracts Register**

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. Confidential Planning & Funding Report ▪ Pharmaceuticals ▪ Primary Maternity ▪ Long Term Conditions	To allow activities and negotiations (including commercial and industrial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act (OIA) 1982.
2. 2016/17 Annual Plan Update	Annual Plan is subject to Ministerial approval.	Section 9(2)(f) of the OIA.
3. Contract Approvals	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Section 9(2)(j) of the OIA.

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:	25 May 2016

Summary:

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 since the last meeting:

- Nil

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

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

Document previously submitted to:	Commissioner's Meeting	**Date:** 22/04/16

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 13/05/16

RECOMMENDATION:

1. **That the Interests Registers be received and noted.**

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISIONER TEAM CONSULTANT/CHAIR FAR COMMITTEE

Board 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 International Airport Limited~~ (Ended 31.10.2015)	Nil	
	25.06.2015	Director, Dunedin City Holdings Limited	Nil	
	25.06.2015	Trustee, Sport Otago	Nil	
	25.06.2015	Trustee of numerous private trusts	Nil	
	25.06.2015	Consultant, Gallaway Cook Allan	Nil	
	25.06.2015	Dunedin Sinfonia Board	Nil	
	25.06.2015	Director, Dunedin City Treasury Limited	Nil	
	25.06.2015	Director, Dunedin Venues Limited	Nil	
		Spouse:		
	25.06.2015	Partner, Gallaway Cook Allan	Nil	
	25.06.2015	Chair, Slinkskins Limited	Nil	
	25.06.2015	Chair, Parkside Quarries Limited	Nil	
	25.06.2015	Director, South Link Health Services Limited	A SLH entity, Southern Clinical Network, has applied for PHO status.	Step aside from decision-making (refer Commissioner's meeting minutes 02.09.2015).
	25.06.2015	Board Member, Warbirds Over Wanaka Community Trust	Nil	
	25.06.2015	Director, Warbirds Over Wanaka Limited	Nil	
	25.06.2015	Director, Warbirds Over Wanaka International Airshows Limited	Nil	
	25.06.2015	Board Member, Leslie Groves Home & Hospital	Leslie Groves has a contract with Southern DHB for aged care services.	
	25.06.2015	Board Member, Dunedin Diocesan Trust Board	Nil	
	25.06.2015	Director, Nominee companies associated with Gallaway Cook Allan	Nil	
	25.06.2015	Trustee of numerous private trusts	Nil	
	25.06.2015 (updated 22.04.2016)	President, Otago Racing Club Inc.	Nil	
Graham CROMBIE	27.06.2015	Independent Director, Surf Life Saving New Zealand	Nil	
(Deputy Commissioner)	25.06.2015	Chairman, Dunedin City Holdings Ltd	Nil	
	25.06.2015	Chairman, Otago Museum	Nil	
	25.06.2015	Chairman, New Zealand Genomics Ltd	Nil	
	25.06.2015	Independent Chairman, Action Engineering Ltd	Nil	
	25.06.2015	~~Trustee, Arai Te Uru Kokiri Centre~~ - DELETED 02.09.2015	n/a	
	25.06.2015	Trustee, Orokonui Foundation	Nil	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISIONER TEAM CONSULTANT/CHAIR FAR COMMITTEE

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	25.06.2015	Chairman, Dunedin City Treasury Ltd	Nil	
	25.06.2015	Chairman, Dunedin Venues 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.	
	23.11.2015	~~Director, Dunedin Venues Management Ltd~~ - DELETED 26.02.2016	Nil	
Angela PITCHFORD (Deputy Commissioner)	03.08.2015	National Clinical Director of Emergency Department Services, Ministry of Health (2/10ths).	Target Champion for 'Shorter Stays in Emergency Departments' Health Target	
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.	
	29.03.2010	~~Chairman, Composite Retail Group (Removed 21.12.2015)~~	~~May have some stores that deal with Southern DHB.~~	
	06.04.2011	Councillor, Dunedin City Council		
	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 CSB rebuild and its decisions may conflict with some positions agreed by the DHB and approved by the Commissioner team.	
Susie Johnstone	21.08.2015	Independent Chair, Audit & Risk Committee, Dunedin City Council	Nil	
(Consultant, Finance Audit & Risk Committee)	21.08.2015	Trustee, Community Trust of Otago	Southern DHB may apply for funding.	
	21.08.2015	Board Member, REANNZ (Research & Education Advanced Network New Zealand)	Nil	
	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	Nil	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISIONER TEAM CONSULTANT/CHAIR FAR COMMITTEE

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
		Spouse is Consultant/Advisor to:		
	21.08.2015	Tuapeka Community Health Co Ltd & Tuapeka Health Incorporated	Tuapeka Community Health Co Ltd & Tuapeka Health Incorporated have a contract with Southern DHB.	
	21.08.2015	Wyndham & Districts Community Rest Home Inc	Wyndham & Districts Community Rest Home Inc has a contract with Southern DHB.	
	21.08.2015	Roxburgh District Medical Services Trust	Roxburgh District Medical Services Trust has a contract with Southern DHB.	
	21.08.2015	West Otago Health Ltd & West Otago Health Trust	West Otago Health Ltd & West Otago Health Trust have a contract with Southern DHB.	
	21.08.2015	A number of primary health care providers in rural Otago	All of the primary health provider clients in rural Otago are likely to have a contract through Southern DHB and/or the WellSouth Primary Care Network.	
	21.08.2015	Director, Clutha Community Health Co. Ltd	Clutha Community Health Co. Ltd has a contract with Southern DHB.	
		Daughter:		
	21.08.2015	3rd Year Medical School Student		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE MANAGEMENT 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
Sandra BOARDMAN	07.02.2014	Nil	
Pania COOTE	30.09.2011	Affiliation to Awarua, Puketeraki and Moeraki Rūnaka	Possible conflict when contract with Southern DHB comes up for renewal.
	30.09.2011	Member, 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
	26.01.2015	South Island DHBs Medical Diagnostic Laboratory Steering Group.	Nil
	26.01.2015	Various SDHB operational Advisory Committees	Nil
Richard BUNTON	17.03.2004	Managing Director of Rockburn Wines Ltd	The only potential conflict would be if the Southern DHB decided to use this product for Southern DHB functions.
	17.03.2004	Director of Mainland Cardiothoracic Associates Ltd	This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract.
	17.03.2004	Director of the Southern Cardiothoracic Institute Ltd	This company provides private cardiological services to Otago and Southland. A potential conflict would exist if the Southern DHB were to contract with this company.
	17.03.2004	Director of Wholehearted Ltd	This company is one used for personal trading and apart from issues raised in second line above no conflict exists.
	22.06.2012	Chairman, Board of Cardiothoracic Surgery, RACS	No conflict.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE MANAGEMENT TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	29.04.2010	Trustee, Dunedin Heart Unit Trust	No conflict.
	29.04.2010	Chairman, Dunedin Basic Medical Sciences Trust	No conflict.
Carole HEATLY	11.02.2014	Trustee, Southern Health Welfare Trust	Southland Hospital Trust.
Wayne LEACH	14.10.2015	Nil	
Lynda McCUTHEON	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.
	19.08.2015	Member of the National Directors of Allied Health	Nil
Nigel MILLAR		TBA	
Nicola MUTCH	16.03.2016	Member, International Nominations Committee, Amnesty International	Nil
		Trustee, Blueskin Resilient Communities Trust	Nil
		Deputy Chair, Dunedin Fringe Trust	Nil
Lexie O'SHEA	01.07.2007	Trustee, Gilmour Trust	Southland Hospital Trust, no perceived conflict.
Dr Jim REID	22.01.2014	Director of both BPAC NZ and BPAC Inc	No conflict.
		Director of the NZ Formulary	No conflict.
		Trustee of the Waitaki District Health Trust	Possible conflict in negotiation of new contract.
		Employed 2/10 by the University of Otago and am now Deputy Dean of the Dunedin School of Medicine	Possible conflict in any negotiations with Dunedin School of Medicine.
		Partner at Caversham Medical Centre and a Director of RMC Medical Research Ltd.	No conflict.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE MANAGEMENT TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Leanne SAMUEL	01.07.2007	Trustee, Southern Health Welfare Trust	Southland Hospital Trust
	01.07.2007	Member of Community Trust of Southland Health Scholarships Panel.	Nil
	16.04.2014	Member National Lead Directors of Nursing	Nil
Clive SMITH	31.03.2016	Nil	

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Terms of Reference Review**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	25 May 2016

Summary:

The Terms of Reference (ToR) for the Disability Support and Community & Public Health Advisory Committees were last reviewed and modified in March 2014. Minor amendments are recommended to reflect the Commissioner's appointment.

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: Jeanette Kloosterman Board Secretary **Date:** 13.05.2016	**Presented by:** Sandra Boardman Executive Director Planning & Funding

RECOMMENDATION:

That the Commissioner approve the amended terms of reference for the Disability Support and Community & Public Health Advisory Committees.

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

Terms of Reference

Accountability

The Community & Public Health Advisory Committee is constituted by section 34, part 3, of The New Zealand Public Health and Disability Act 2000 (The Act).

The procedures of the Committee shall also comply with Schedule 4 of the Act.

The Committee is to further comply with the standing orders of the Southern DHB which may not be inconsistent with the Act.

Function and Scope

1) The statutory functions of CPHAC is to give the ~~Board~~Commissioner advice on:

   a) the needs, and any factors that the Committee believes may adversely affect the health status, of the resident population of the Southern DHB; and

   b) priorities for use of the limited health funding provided.

2) The statutory aim of CPHAC's advice is to ensure that the following maximise the overall health gain for the population the Committee serves:

   a) all service interventions the Southern DHB has provided or funded or could provide or fund for that population;

   b) all policies the DHB has adopted or could adopt for that population.

3) CPHAC's advice may not be inconsistent with the New Zealand Health Strategy.

Responsibilities

The Committee is responsible for:

1) Taking an overview of the population and health improvement;

2) Providing recommendations for new initiatives in community and public health improvement;

3) Addressing the prevention of inappropriate hospital admissions through health promotion and community care interventions;

4) Examining the role that primary care, disability support, public health and other community services - as well as hospital services - can play in achieving health improvement;

5) Ensuring better co-ordination across the interface between services and providers;

6) Focusing on the needs of the populations and developing principles on which to determine priorities for using finite health funding;

7) Interpreting the local implications of the nation-wide and sector-wide health goals and performance expectations;

8) Providing advice, in collaboration with the Iwi Governance Committee, on strategies to reduce the disparities in health status; especially relating to Maori and Pacific Island peoples;

9) Providing advice on priorities for health improvement and independence as part of the strategic planning process;

10) Ensuring the processes and systems are put in place for effective and efficient management of health information in the Southern DHB district, including policies regarding data ownership and security;

11) Ensuring the priorities of the community are reflected in the Annual Plan of the Southern DHB, and to ensure that appropriate processes are followed in preparation of the plan.

12) Ensuring that recommendations for significant change or strategic issues have noted input from key stakeholders and consultation has occurred in accordance with statutory requirements and Ministry guidelines.

Membership

All members of the Committee are to be appointed by the ~~Board~~Commissioner. The ~~Board~~Commissioner will appoint the chairperson.

The Committee is to comprise of ~~Board members~~the Commissioner and Deputy Commissioners, supplemented with external appointees as required.

Membership will provide for Māori representation on the Committee. The Committee may obtain additional advice as and when required.

Where a person, who is not a ~~Board member~~Deputy Commissioner, is appointed to the Committee, the person must give the ~~Board~~Commissioner a statement that discloses any present or future conflict of interest, or a statement that no such conflicts exist or are likely to exist in the future.

Conflicts of Interest

Where a potential conflict of interest exists with an agenda item, these are to be declared by members and staff. A register of interests shall form part of each Committee meeting agenda.

Quorum

The quorum of members of a committee is,—

(a) if the total number of members of the committee is an even number, half that number; but
(b) if the total number of members of the committee is an odd number, a majority of the members.

Meetings

A minimum of eight meetings per year are to be held.

Review

The Terms of Reference for this Committee shall be reviewed at the beginning of each new Board term.

Management Support

The Chief Executive Officer shall ensure adequate provision of management and administrative support to the Committee.

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC)

Terms of Reference

Accountability

The Disability Support Advisory Committee is constituted by section 35, part 3, of The New Zealand Public Health and Disability Act 2000 (The Act).

The procedures of the Committee shall also comply with Schedule 4 of the Act.

The Committee is to further comply with the standing orders of the Southern DHB which may not be inconsistent with the Act.

Function and Scope

1) The statutory functions of DSAC are to give the ~~Board~~Commissioner advice on:
   a) The disability support needs of the resident population of the Southern DHB
   b) Priorities for use of the disability support funding provided.

2) The aim of the Committee's advice will be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the Southern DHB's resident population:
   a) the kinds of disability support services the Southern DHB has provided or funded or could provide or fund for those people;
   b) all policies the Southern DHB has adopted or could adopt for those people.

3) The Committee's advice may not be inconsistent with the New Zealand Disability Strategy.

Responsibilities

The Committee is responsible for:

1) Providing advice on the overall performance of the disability support services delivered by or through the Southern DHB;

2) Providing advice on strategic issues related to the delivery of disability support services delivered by or through the Southern DHB;

3) Focusing on the disability support needs of the population and developing principles on which to determine priorities for using finite disability support funding;

4) Ensuring that the District Annual Plans (DAPs) of the Southern DHB demonstrate how people with disability will access health services and how the Southern DHB will ensure that the disability support services they fund or provide are co-ordinated with the services of other providers to meet the needs of people with disabilities;

5) Assessing the disability support services' performance against expectations set in the relevant accountability documents, documented standards and legislation;

6) Ensuring that recommendations for significant change or strategic issues have noted input from key stakeholders and consultation has occurred in accordance with statutory requirements and Ministry guidelines.

Membership

All members of the Committee are to be appointed by the ~~Board~~Commissioner. The ~~Board~~Commissioner will appoint the chairperson.

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Meetings

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Review

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Management Support

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SOUTHERN DISTRICT HEALTH BOARD

Title:	**Planning and Funding Report**		
Report to:	Disability Support and Community & Public Health Advisory Committees		
Date of Meeting:	25 May 2016		
Summary: Monthly report on the Planning and Funding activities and progress to date.			
Specific implications for consideration (financial/workforce/risk/legal etc.):			
Financial:	N/A		
Workforce:	N/A		
Other:	N/A		
Document previously submitted to:	N/A	**Date:**	
Approved by Chief Executive Officer:	N/A	**Date:**	
Prepared by: Planning & Funding Team **Date:** 13 May 2016		**Presented by:** Sandra Boardman Executive Director Planning & Funding	
RECOMMENDATION: **That the Commissioner and Deputy Commissioners note the content of this paper.**			

PLANNING AND FUNDING REPORT
May 2016

Current System Priorities

Priority Area	**Aim** • **Why?** • **Intended benefit**	**Approach** • **Planned approach** • **Overall timeline**	**Activity undertaken this month and planned for next**
Outpatients Project	The funding and delivery of outpatient services has remained unchanged for several years. Current volumes are based on historical patterns of funding. This project will seek to ensure equity of access to outpatient services across the Southern district utilising funding available to achieve optimal outcomes.	Draft report and analysis on current state and proposed future state has been completed with input/feedback from several stakeholder meetings. The draft report has been considered by the SDHB Executive Leadership team. Timelines have been set for short term activity over the remainder of 2015/16 (as per activities in next column). Achieving the strategic objectives (such as a single waiting list across the district) are scheduled for commencement in 2016/17.	Initial engagement with both the Provider Arm and rural hospitals has occurred. It is proposed that P&F will design and develop a system improvement planning event. This will be held late June early July, the anticipated outcome will be an agreed programme of implementation with key stakeholders. The agreed programme will start with focussing on localised and specific specialties where ensuring improved access is likely to most benefit rural populations, for example, a district wide Cardiology service.
Radiology Systems Project	Aim is to configure a district wide radiology system that is clinically effective, supports convenient access for patients and clinicians, best utilises existing equipment and is financially sustainable.	Project team was established. The team developed a series of key discussion areas. Subsequently held a series of discussion based workshops across the district to discuss key issues. Feedback used to inform the development of a series of strategic	Draft strategic report circulated to stakeholders. Project Team has developed a draft implementation plan which takes each of the strategic recommendations and allocates them to an individual workstream. Workstreams include: Workstream 1 Areas of work: Improved use of Health Pathways,

Priority Area	Aim • **Why?** • **Intended benefit**	Approach • **Planned approach** • **Overall timeline**	**Activity undertaken this month and planned for next**
		recommendations. Strategic recommendations have been accepted in principle by the DHB Executive Leadership Team. Project team has now been tasked with developing a detailed implementation plan with specific timelines.	Use of ERMS (Electronic Request Management System), Adoption of National Community Referred Guidelines to ensure appropriate referral Outcomes: Direct access for GPs, appropriate and timely referrals made Workstream 2 Areas of work: Single point of entry for management of capacity vs wait vs clinical need, Integration of IT systems, integration of radiology team Outcomes: Single consistent process for referral, integrated information systems visible across the health system, patient access improved as capacity better managed Workstream 3 Areas of work: Increased access to hi-tech imaging in Waitaki and Central Outcomes: Population need understood, funding models support population need, access to hi-tech imaging improved for the Waitaki and Central populations
Raise HOPE – Stepped Care Implementation	Hapai te Tumanako Raise HOPE Strategic Plan identified the need for improved access to and appropriate utilisation of multiple mental health and addiction services. A district wide tiered service	Stepped Care Model design (completed) Sector consultation (underway) Implementation plan (underway)	Sector consultation - survey and focus groups, 5 April-20 April completed. Rapid Improvement Event was held on 28 April. The RIE brought together a wide range of sector participants including families, service users and providers to co-create what a Stepped Care experience might look like in the southern district

Priority Area	Aim • **Why?** • **Intended benefit**	Approach • **Planned approach** • **Overall timeline**	**Activity undertaken this month and planned for next**
	model (Stepped Care) will improve consumer outcomes as services are better connected and integrated across the continuum intervening in the least intrusive way from self-care to specialist support		and allowed participants to build an understanding of the changes we need to make Stepped Care a reality. Initial draft Implementation Plan will be ready for feedback on 23 May and will be circulated to Project Sponsor, Executive Team and Commissioning Team on that day. Feedback opportunities for Alliance South, WellSouth, senior clinicians scheduled to occur on 24 and 25 May. Finalisation of Implementation Plan draft and sign off NLG/SLAT 16 June. (As a result of stakeholder feedback the timeframe for completion of the Implementation Plan has been extended by two weeks to allow additional feedback opportunities for key stakeholder groups.)
Raise HOPE – Growing Community Rehab Options	A project to develop and implement a strengthened model for community based rehabilitation (recovery) services with a focus on supporting people (adults) in the community with high/ complex/ long term mental health needs. The model will provide safe, timely & effective support to people whose needs cannot be met by less intensive mainstream adult mental health	Phase 1. Development of a proposed strengthened model for community based rehabilitation services by end May 2016 Phase 2. Provider service change processes including formal consultation affected parties by end November 2016 Phase 3. Implementation - phased from early 2017 (dependent on any related procurement processes) by end	Following feedback from the project working group and steering group the proposed draft model is undergoing further development; this is now expected to be completed by the end of May 2016 A business case for implementation will then be tabled with Project Sponsors for consideration End June 2016 – dependent on business case approval move to phase 2 of project – implementation including formal consultation with affected staff/providers

Priority Area	**Aim** • **Why?** • **Intended benefit**	**Approach** • **Planned approach** • **Overall timeline**	**Activity undertaken this month and planned for next**
	services & who would otherwise be long term users of inpatient services	December 2017	
Health of Older People	To develop a model of care that ensures Older People are supported to live well, get well and stay well in their homes and communities, for as long as possible and achieve optimal health outcomes. The model of care will focus also on enhanced wellbeing and independence through proactive services that reduce acute hospital admissions and delay/prevent entry to long-term residential care Services will be integrated across the continuum of care and promote smooth transitions between the interfaces in different care settings	An initial work plan has now been developed. Key points: • March - May 2016 – Define an approach for reorienting HOP services in Southern district , aligning with National HOP Strategy and integrating LTC tiered approach with a focus on the interface between hospital/community care/primary care for people who are acutely unwell or deteriorating • June – Present approach to ALT in June for appraisal, input and confirmation • June - August - Consult with provider and community stakeholders across district • July onwards - Plan implementation phasing, and actions over 16/17 for agreed work plan.	Work has continued on developing and planning the redesign of our ESD/EDRS/Rapid Response service. Draft options model paper that aligns to the National Health of Older People Strategy is under development with key priority areas identified. The HOP SLAT is working closely with the LTC SLAT on tiered approach to primary care (May - June 2016)
Urgent Care	Develop an implementable acute care network service design that is consistent and equitable	Stakeholder consultation and engagement (December 2015-	Initial stakeholder consultation completed (April 2016)

Priority Area	Aim • **Why?** • **Intended benefit**	Approach • **Planned approach** • **Overall timeline**	**Activity undertaken this month and planned for next**
	across the district. Current data shows patients using the Emergency Departments for non-urgent cases by default. A key focus will be to ensure patients have convenient access to urgent care at the right time by the right provider and in the right place.	April 2016) Review of the literature and models of care (December 2015-April 2016) Draft model of care option paper developed (May 2016). Implementation of recommendations (July 2016)	Draft options paper and recommendation is currently being developed and will be presented to the ALT May 2016 meeting. The SLAT has been meeting weekly to ensure deliverable dates are met. Communication plan and strategy being developed with this being aligned to ensure that communication and stakeholder engagement from each of the SLATs is coordinated reducing risk of duplication and consultation "overload"
Rural Health	The Rural SLAT is investigating how rural networks could work to improve the ways the various parts of the system work together will a goal to: • improve the patient journey • improve resilience & sustainability of services • remove inequities of access for rural people	Initial work will focus on completing a stocktake of services in rural Southern district and using this information to identify communities where services are at-risk, once this is completed the SLAT will make recommendations that will improve resilience in these services. (June 2016)	Stocktake of primary health services (General Practice, District Nursing, Allied Health) – looking for anomalies between rural care clusters and between urban/rural communities (May 2016) Data to assist with analysis and understanding the issues and current situation is progressing. This has been somewhat challenging in ensuring that the data is useful, meaningful and comparative. While this has caused some delay in the development phase a recommendation will be presented to the ALT June meeting as planned,
Child and Youth	To provide strategic oversight and coordination for relevant child and youth health service planning in the Southern District	Work plan is in the process of being developed and will be finalised in June 2016. Key	Scoping of the work required under the headings of child obesity service alignment has continued. A work group that will take a whole of system approach to identify ways to reduce the prevalence

Priority Area	Aim • **Why?** • **Intended benefit**	Approach • **Planned approach** • **Overall timeline**	**Activity undertaken this month and planned for next**
	in order to improve health outcomes for children and young people.	emerging focus areas include: Reviewing prevention and management relating to child obesity across the district Reviewing the provision of community paediatric services across the district Taking a whole-of-system approach to a district-wide youth support model	of child/youth obesity across the district is being convened. In early May, Child/Youth members hosted the Healthy Weight Roadshow on behalf of the South Island Alliance. Further defining and developing of the work plan and work groups around specific child and youth health priority areas is continuing. (May-June 2016)
Health Pathways	HealthPathways is a clinician led, management supported process which involves groups from general practice working with their hospital colleagues to identify, agree, and implement opportunities for standardisation and improvement of the management of patients across the primary-secondary interface. The outcome is documentation of those agreements as easy-to-follow guidelines in a website localised to our district.	Work plan and priorities agreed for 16/17 year (complete) Pathway development nomination form implemented (March 2016) Priorities identified for implementation in the 16/17 year: • Skin lesions • Renal Impairment • Spirometry • Carpal Tunnel • Back pain • COPD In parallel to the development of the above prioritised pathways, work will continue on the	Continue to progress the review of GPSIs Skin Lesion service – complete by June 16 Implementing change to pathway development process (March 2016 - April 2016) has been completed. Communication around this and wider HealthPathways activity will now be developed and is considered a priority. 16/17 Work programme finalised. Resource and approach required to progress pathways across the district is being reviewed. (May 2016) Develop POAC (Primary Options for Acute Care) service further to include DVT, Epistaxis and in-dwelling Catheters (June 2016)

Priority Area	**Aim** • **Why?** • **Intended benefit**	**Approach** • **Planned approach** • **Overall timeline**	**Activity undertaken this month and planned for next**
		localisation of pathways as identified by the SLATs and work streams to support the implementation of new models of care.	
Health Outcomes Framework	The development of a Health Outcomes Framework is intended to deliver the following benefits: • Driving desired and agreed change in the Southern health system over the next ten years • Allowing all stakeholders to see where the system is going and how their contribution at an individual, team, and service level might fit with that • Prioritising our system and service level improvement efforts to ensure cohesion • Improved use of data for driving improvement, and a visible methodology for understanding whether improvements are actually being made	A small project team has been working with some identified subject matter experts on the initial development of the Framework. The Framework needs to be further developed and refined through wider socialisation and input via focus groups. Focus groups are planned for May-June 2016. The place of the Framework within our system needs to be determined: how can we integrate it into all of our improvement work? Discussions are being held with the Alliance South Leadership Team on 26 April 2016.	This month: Presentations have been delivered in the Alliance South Leadership Team, Well South Board, and Commissioners in order to highlight the potential future use of the Framework in driving system improvement. In the next month: Further work will occur on refining the current Level 3 Strategic Measures, and the Framework will be tested with the Long Term Conditions SLAT developing the Level 4 and 5 Organisational and Project level measures.

Priority Area	**Aim** • **Why?** • **Intended benefit**	**Approach** • **Planned approach** • **Overall timeline**	**Activity undertaken this month and planned for next**
Investing For Outcomes	Establishing a locality network covering Central Otago and Lakes in order to enable provider organisations and individuals in that area to work together and take action to improve overall health outcomes whilst containing and reducing overall health system costs. The group provides an opportunity for local system leaders to be involved in both health system innovation and longer term health service development for the area; the Network will design an innovative rural health system for the future.	There will be an Expressions of Interest process to determine the membership of the group. The group will consider current and changing needs of the population and how services might need to respond over time. This includes how the role of the two rural hospitals in that area might change and be developed. The group will build on work already completed, initially focussing on: the development of primary care (home of health), improving access to services through localised health pathways, and reviewing workforce development opportunities. The timelines for this work will be determined by the group once established.	This month: a selection panel, including input from the Mayors of both Queenstown Lakes and Central Otago, met to review over 30 expressions of interest for joining the Locality Network and agree membership. On 11th May the first meeting was held and initial areas of priority were determined as: • Developing a one region view for Central /Lakes/Queenstown including completion of a localised health needs analysis • Equity of access for services such as outpatients, radiology, after hours • Improved access to mental health services Next month: the group will meet again to review data around population growth, understand where they can link with other work underway (e.g. Radiology Project) and to initiate the health needs analysis

Service/Quality Improvement Initiatives

Health of Older People

Age Related Residential Care (ARRC): Compliance with the requirement that aged care facilities conduct interRAI Comprehensive Clinical Assessments on residents six monthly is at 76% for the Jan-Mar 2016 quarter. This is up from 71% last quarter and better than the NZ compliance rate of 73%. Follow up with every facility has occurred with plans requested to assure compliance.

Falls: The Southern Alliance Falls and Fractures Prevention Steering Group has arranged a Falls Education Day for Aged Residential Care Providers on 26 May in Dunedin and 27 May in Invercargill. Speakers from Northern Region Alliance and local aged care facilities will present.

Primary and Community Care

A range of new system level measures are being introduced by the Ministry of Health (MOH) for 2016/17. A working group has been established under PSAAP to review the financial incentives for these measures, noting that the MOH have ringfenced the IPIF funding pool.

Health Targets

For the quarter ending 31 March, 2016:

WellSouth Primary Health Network	Result	Target
More Heart and Diabetes Checks	87.7%	90%
Better Help for Smokers to Quit	90.1%	90%

This was a very welcome result for Southern given the efforts of all concerned in the smoking target. The 90.1% result was an increase of 3.1% since the December 2015 quarter.

GP involvement in Raise HOPE: A GP has indicated their interest in the GP MH Liaison position. Discussions continue with the GP on the appointment, but these are delayed until setting up their new general practice is complete.

He Puna Waiora (Invercargill VLCA practice): He Puna Waiora are still working to recruit a permanent GP. WellSouth continues to provide clinical support to the practice in the interim.

Te Mata Ora (new VLCA practice in South Dunedin): Te Mata Ora continues to work through the development of the College Street site in Caversham. Te Runanga o Ngai Tahu (TRoNT) has put forward a proposal that the University should be a partner/shareholder in the project on the basis that the University would fund, and benefit from, teaching spaces for its health professional students The University is actively exploring the option of putting dental chairs into the facility to provide high quality, low-cost dental care and student teaching, and converting the library to a physiotherapy gym.

Physiotherapy Outpatients at Southland Hospital: Recently discussions held between GM Older Persons and Community Services Directorate and his team and WellSouth Nurse Director

regarding moving outpatient physiotherapy services at Southland Hospital to WellSouth. This work is being undertaken to strengthen WellSouth's proposal to the MOH for the Mobility Action Plan project. This would involve having a Clinical Lead position (currently in Southland Hospital) across both organisations. Currently, the outpatient hospital physiotherapy service is 4 FTE down and they have difficulty with recruitment. The proposal is that WellSouth and SDHB will jointly recruit a community position to try and improve the prospects of attracting applicants. These positions would still be employed by SDHB but located at WellSouth.

After Hours (including primary presentations to ED at all hours): Invercargill After-hours meeting - on the 6th April 2016 WellSouth convened an evening meeting with Invercargill General Practitioners to discuss a way forward to provide a sustainable, safe and accessible after hours service. There was a good turnout of GPs and the meeting was very positive. The GP's who attended expressed their buy-in, so it is important to keep up the momentum and provide tangible results.

Other Strategic Priorities

Ministry of Health requirements

Social Sector Trials Update

Over recent months the Government has been discussing the future of the 16 Social Sector Trials across New Zealand. A decision has been made to end six Trials and support the remaining ten, who have been successful and are ready to move locally led models. The two Trials in the Southern DHB district (South Dunedin and Gore), will be transitioned to a locally-led model from 1 July to 31 December 2016.

The Trials will receive reduced central funding to transition into the new model. Further details about this will be provided to the DHB shortly. As the Trials are transitioned the DHB has been encouraged to work with local key stakeholders to determine, which parts of the Trials should continue. This needs to include any funding and/or support for these services as central funding will cease from 1 January 2017.

Living within Our Means

Age Related Residential Care (ARRC): Please see Appendix 1. Expenditure continues under budget for Age Related Residential Care. 16/17 Budget has been adjusted to account for lower than expected utilisation this year, with corresponding adjustments made to our Home & Community Support Services budgets for 16/17.

Waitaki Review of Services: Work continues on the draft Terms of Reference for this review and the first of four planned workshops will be held in Oamaru on 19 May. The current planned approach is for three workshops followed by broader community and health system opportunities for co-design in late June. It is anticipated that there will be some high level outcomes of the review available in early August.

Appendix 1: Southern Residential Care April 16

Rest Home Level - 6640

Rest Home Beds	Actual	Budget	Variance	
April 16 - Bed nights	31,800	32,633	833	Fav
YTD - Bed nights	323,453	327,160	3,707	Fav
April 16 - Beds per day	1,060	1,087.77	28	Fav
YTD - Beds per day	1,061	1,072.66	12	Fav

Dementia Beds	Actual	Budget	Variance	
April 16 - Bed nights	9,600	9,867	267	Fav
YTD - Bed nights	96,893	97,557	664	Fav
April 16 - Beds per day	320.00	328.90	9	Fav
YTD - Beds per day	318	320	2	Fav

Total 6640	Actual	Budget	Variance	
Total Beds				
April 16 - Bed nights	41,400	42,500	1,100	Fav
YTD - Bed nights	420,345	424,716	4,371	Fav
15 /16 YE Forecast - Bed nights	505,344	512,239	6,895	Fav

Finanical Year-General Ledger	Actual	Budget	Variance	
11/12 Year	35,731,858	34,169,680	- 1,562,178	Unfav
12/13 Year	34,889,991	36,213,476	1,323,485	Fav
13/14 Year	34,459,963	35,880,081	1,420,118	Fav
14/15 Year	39,203,324	35,274,468	- 3,928,855	Unfav
15/16 YTD	32,022,207	32,595,550	573,343	Fav

Variance Analysis -YTD vs Budget			14/15 FY		15/16 Estimate	
YTD Rest Home - Price Variance	105,022	Fav	- 761,244	Unfav	**185,845**	**Fav**
YTD Dementia - Price Variance	- 114,465	Unfav	139,827	Fav	- **101,286**	**Unfav**
YTD Rest Home - Volume Variance	261,329	Fav	- 539,815	Unfav	**381,725**	**Fav**
YTD Dementia - Volume Variance	60,042	Fav	- 1,305,741	Unfav	**133,848**	**Fav**
YTD LTS-CHC Variance	335,666	Fav	- 214,408	Unfav	**419,902**	**Fav**
Variance -$ Service vs Budget	**647,594**	**Fav**				
Other	- 74,251	Unfav	- 1,247,474.49		- **74,251**	
Variance - $ Ledger vs Budget (as per accounts)	**573,343**	Fav	- **3,928,855**	Unfav	**945,783**	**Fav**

Variance Analysis - YTD vs. Budget			14/15 FY		15/16 Estimate	
YTD Hospital Care - Price Variance	- 9,143	Unfav	- 1,401,411	Fav	**26,328**	**Fav**
YTD Psychogeriatric - Price Variance	103,362	Fav	- 4,569	Unfav	**132,888**	**Fav**
YTD Hospital Care - Volume Variance	1,660,563	Fav	- 2,255,297	Unfav	**2,109,265**	**Fav**
YTD Psychogeriatric - Volume Variance	- 62,405	Unfav	- 1,386,976	Fav	- **43,467**	**Unfav**
YTD LTC-CHC Variance	110,688	Fav	- 370,375	Unfav	**124,684**	**Fav**
Variance -$ Service vs Budget	**1,803,066**	Fav				
Other (Bupa accrued twice $45 14/15, over accrual 14/15 $189)	282,197	Fav	- 517,647		**282,197**	
Variance - $ Ledger vs Budget (as per accounts)	**2,085,263**	Fav	- **359,501**	Unfav	**2,631,896**	**Fav**

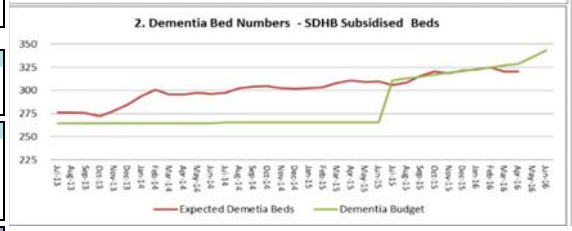
Hospital Level - 6650

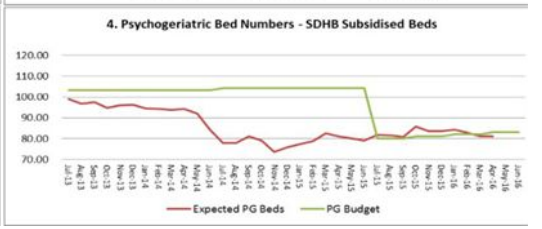
Hospital Care Beds	Actual	Budget	Variance	
April 16 - Bed nights	28,230	30,060	1,830	Fav
YTD - Bed nights	285,281	298,715	13,434	Fav
April 16 - Beds per day	941	1,002	61	Fav
YTD - Beds per day	935	979	44	Fav

Psychogeriatric Beds	Actual	Budget	Variance	
April 16 - Bed nights	2,433	2,494	61	Fav
YTD - Bed nights	25,219	24,808	- 411	Unfav
April 16 - Beds per day	81	83	2	Fav
YTD - Beds per day	83	81	- 1	Unfav

Total 6650	Actual	Budget	Variance	
Total Beds				
April 16 - Bed nights	30,663	32,554	1,891	Fav
YTD - Bed nights	310,500	323,523	13,023	Fav
15 /16 YE Forecast - Bed nights	373,667	390,444	16,777	Fav

Financial Year-General Ledger	Actual	Budget	Variance	
11/12 Year	40,489,080	39,188,664	- 1,300,416	Unfav
12/13 Year	42,364,651	41,939,535	- 425,116	Unfav
13/14 Year	44,844,798	42,713,656	- 2,131,142	Unfav
14/15 Year	46,775,238	46,415,737	- 359,501	Unfav
15/16 YTD	39,181,941	41,267,204	2,085,263	Fav





Aged Residential Care – Performance against budget – Risks and mitigants

• Calculation of Accrual:
Volume: The month of payment is often not the month of service due to the nature of the invoicing systems and processes. To accurately calculate the correct accrual care is needed to predict the current and prior month's volumes. SDHB have created a model to help predict volume of ARC categories (basis for accrual calculations).
Average subsidy levels: The average subsidy paid by SDHB changes every month, primarily due to the mix of Maximum Contributors (residents who do not qualify for Residential Care Subsidy) & Subsidised Residents changing constantly.
• Nature of service: ARC is a demand driven service, where (subject to needs assessment and availability of beds) the DHB is obliged to pay for residents care (less resident contribution).
• The utilisation of ARC facilities can be seasonal and somewhat variable and illnesses that affect the older people population can have major impact on level of utilisation. This winter we experienced a relatively severe "flu season" and we are still uncertain how this will affect utilisation. On one hand utilisation could go down if existing residents passed away due to the flu but on the other hand utilisation could go up if older people in the community become unwell to a degree that they needed to be admitted to an ARC facility. Due to invoicing lag it maybe some months until we can be certain of the level of ARC utilisation.
• Supply induced demand: SDHB has found from recent experience that an increase in supply of ARC beds will increase the demand for these beds. SDHB has improved budgeting processes and now factors in known bed increases/changes.

Data Table		Invoiced			Expected			Budget			Bed days			Avg DHB Subsidy $		DHB Subsidy $ Budget		Total $ based on month of service							
Month	Days in month	Rest Home Southern	Dementia Beds Southern	Total Rest Home and Dementia	Rest Home Southern	Dementia Beds Southern	Total Rest Home and Dementia	Rest Home Southern	Dementia Beds Southern	Total Rest Home and Dementia	# Rest Home Bed Days	# Dementia Beds Days	Total bed days	Rest Home	Dementia	Rest Home	Dementia	Rest Home	Dementia	Total	SERVICE BASED ON FORECAST BEDS	General ledger	Budget	Variance Service vs Ledger	Variance Ledger vs budget
11/12 Total		**425,318**	**92,222**	**517,540**				**408,333**	**89,208**	**497,541**	**13,985**	**3,033**	**17,019**	**65.61**	**86.04**	**-**	**-**	**27,907,275**	**7,931,516**	**35,838,791**		**35,731,858**	**34,169,680**	**106,933**	**1,562,178**
12/13 Total		**400,526**	**94,862**	**495,388**				**415,600**	**90,353**	**505,953**	**13,165**	**3,119**	**16,284**	**66.26**	**90.70**	**-**	**-**	**26,538,971**	**8,602,714**	**35,141,685**		**34,889,991**	**36,213,476**	**251,694**	**1,323,485**
13/14 Total		**382,691**	**104,680**	**487,130**				**402,310**	**96,448**	**498,758**	**12,581**	**3,443**	**16,016**	**66.10**	**89.92**	**67.00**	**92.55**	**25,297,603**	**9,412,109**	**34,709,712**		**34,459,963**	**35,880,081**	**249,749**	**1,420,118**
14/15 Total		**392,781**	**111,208**	**503,989**				**384,754**	**96,951**	**481,705**	**12,913**	**3,656**	**16,570**	**69.18**	**90.33**	**67.25**	**91.59**	**27,174,490**	**10,045,468**	**37,955,849**		**39,203,324**	**35,274,468**	**1,247,474**	**3,928,855**
Jul-15	31	33,013	9,486	42,498	33,013	9,486	42,498	33,045	9,638	42,682	1,065	306	1,371	70.27	92.10	70.49	90.46	2,319,671.97	873,592.45	3,248,955	3,248,955	3,318,403	3,271,784	69,448	46,619
Aug-15	31	33,023	9,564	42,586	33,023	9,564	42,586	33,169	9,700	42,868	1,065	309	1,374	70.18	92.29	70.49	90.46	2,317,591.90	882,656.49	3,252,604	3,252,604	3,408,809	3,286,133	156,205	122,676
Sep-15	30	31,718	9,469	41,187	31,718	9,469	41,187	31,793	9,447	41,240	1,057	316	1,373	70.15	92.11	70.49	90.46	2,225,161.22	872,211.49	3,136,253	3,136,253	3,129,217	3,164,015	- 7,036	34,798
Oct-15	31	32,967	9,925	42,892	32,967	9,925	42,892	32,991	9,824	42,815	1,063	320	1,384	70.13	91.36	70.49	90.46	2,312,159.09	906,715.79	3,254,661	3,254,661	3,303,028	3,284,831	48,367	18,197
Nov-15	30	31,757	9,555	41,312	31,757	9,555	41,312	32,033	9,567	41,600	1,059	319	1,377	70.23	92.13	70.49	90.46	2,230,232.74	880,360.36	3,142,695	3,142,695	3,166,169	3,191,788	23,474	25,619
Dec-15	31	32,713	9,968	42,681	33,015	9,967	42,982	33,239	9,948	43,187	1,055	322	1,377	70.33	92.73	70.49	90.46	2,300,867.93	924,313.16	3,256,277	3,277,375	3,171,459	3,313,530	- 105,917	142,071
Jan-16	31	32,070	9,999	42,069	32,705	9,998	42,703	33,363	10,010	43,373	1,035	323	1,357	70.38	91.94	70.49	90.46	2,256,927.54	919,317.93	3,209,226	3,253,794	3,254,062	3,331,242	268	77,181
Feb-16	29	29,414	9,372	38,786	30,595	9,411	40,006	31,284	9,422	40,706	1,014	323	1,337	70.29	91.33	70.49	90.46	2,067,571.06	855,889.71	2,955,587	3,042,118	3,047,413	3,127,812	5,295	80,399
Mar-16	31	30,736	9,787	40,523	32,860	9,920	42,780	33,611	10,134	43,745	991	316	1,307	70.42	90.62	70.49	90.46	2,164,334.82	886,948.15	3,081,966	3,243,585	3,150,466	3,359,941	- 93,119	209,475
Apr-16	30	8,734	2,816	11,550	31,800	9,600	41,400	32,633	9,867	42,500	291	94	385	69.25	89.80	70.49	90.46	604,818.72	252,867.94	888,370	3,094,844	3,073,181	3,264,474	- 21,663	191,294
May-16	31	-	-	-	-	-	-				-	-	-			70.49	90.46					-			
Jun-16	30	-	-	-	-	-	-				-	-	-			70.49	90.46					-			
15/16 YTD		**296,144**	**89,940**	**386,085**	**323,453**	**96,893**	**420,345**	**327,160**	**97,557**	**424,716**	**9,696**	**2,946**	**12,642**	**70.23**	**91.78**	**70.49**	**90.46**	**20,799,337**	**8,254,873**	**29,426,593**	**31,946,884**	**32,022,207**	**32,595,550**	**75,322**	**573,343**

Data Table		Invoiced			Expected			Budget			Bed days			Avg DHB Subsidy $		DHB Subsidy $ Budget		Total $ based on month of service							
Month	Days in month	Hospital Care	Psychogeriatric	Total Hospital and Psychogeriatric	Hospital Care	Psychogeriatric	Total Hospital and Psychogeriatric	Hospital Care	Psychogeriatric	Total Hospital and Psychogeriatric	# Hospital Care Bed Days	# Psychogeriatric Beds Days	Total bed days	Hospital Care	Psychogeriatric	Hospital Care	Psychogeriatric	Hospital Care	Psychogeriatric	Total	SERVICE BASED ON FORECAST BEDS	General ledger	Budget	Variance Service vs. Ledger	Variance Ledger vs. budget
11/12 Total		**286,188**	**35,836**	**322,024**				**271,284**	**36,912**	**308,196**	**9,411**	**1,178**	**10,590**	**123.69**	**147.50**	**-**	**-**	**35,398,400**	**5,285,054**	**40,683,455**		**40,489,080**	**39,188,664**	**194,375**	**1,300,416**
12/13 Total		**295,187**	**37,233**	**332,420**				**289,005**	**37,340**	**326,345**	**9,707**	**1,224**	**10,931**	**125.56**	**149.59**	**-**	**-**	**37,065,204**	**5,569,574**	**42,634,779**		**42,364,651**	**41,939,535**	**270,127**	**425,116**
13/14 Total		**313,255**	**34,480**	**347,735**				**293,165**	**37,674**	**330,839**	**10,300**	**1,133**	**11,433**	**125.23**	**146.70**	**126.38**	**150.32**	**39,226,272**	**5,059,765**	**44,286,037**		**44,844,798**	**42,713,656**	**558,761**	**2,131,142**
14/15 Total		**337,593**	**28,743**	**366,336**				**319,846**	**38,038**	**357,884**	**11,101**	**945**	**12,046**	**122.94**	**149.38**	**127.08**	**149.22**	**41,500,402**	**4,293,598**	**45,794,000**		**46,775,238**	**46,415,737**	**517,647**	**359,501**
Jul-15	31	29,259	2,541	31,800	29,259	2,541	31,800	29,667	2,484	32,151	944	82	1,026	123.92	148.57	123.61	151.72	3,625,900	377,513	4,003,413	4,025,646	3,995,083	4,100,880	- 30,563	105,797
Aug-15	31	29,150	2,527	31,677	29,150	2,527	31,677	29,822	2,484	32,306	940	82	1,022	123.88	148.38	123.61	151.72	3,611,027	374,953	3,985,979	4,006,441	3,761,245	4,120,039	- 245,196	358,794
Sep-15	30	27,843	2,424	30,267	27,843	2,424	30,267	29,010	2,404	31,414	928	81	1,009	123.55	148.26	123.61	151.72	3,440,043	359,386	3,799,429	3,819,230	3,870,891	4,005,675	51,661	134,784
Oct-15	31	28,621	2,659	31,280	28,621	2,659	31,280	30,132	2,515	32,647	923	86	1,009	123.42	149.25	123.61	151.72	3,532,395	396,848	3,929,243	3,958,052	4,015,345	4,163,061	57,293	147,716
Nov-15	30	27,845	2,511	30,356	27,845	2,511	30,356	29,310	2,434	31,744	928	84	1,012	123.56	150.55	123.61	151.72	3,440,631	378,019	3,818,650	3,847,876	3,909,737	4,047,400	61,862	137,663
Dec-15	31	28,728	2,594	31,322	28,768	2,594	31,362	30,442	2,515	32,957	927	84	1,010	124.00	147.19	123.61	151.72	3,562,276	381,810	3,944,086	3,979,363	3,944,629	4,201,380	- 34,734	256,752
Jan-16	31	29,015	2,612	31,627	29,047	2,612	31,659	30,597	2,546	33,143	936	84	1,020	123.90	145.86	123.61	151.72	3,594,959	380,975	3,975,934	4,010,246	3,977,100	4,230,597	- 33,146	253,497
Feb-16	29	27,261	2,404	29,665	27,347	2,404	29,751	28,768	2,382	31,150	940	83	1,023	123.65	145.99	123.61	151.72	3,370,823	350,971	3,721,794	3,760,847	3,841,366	3,974,955	- 80,520	133,589
Mar-16	31	28,997	2,514	31,511	29,171	2,514	31,685	30,907	2,546	33,453	935	81	1,016	123.50	146.33	123.61	151.72	3,581,130	367,883	3,949,013	4,005,644	3,970,854	4,268,916	- 34,790	298,062
Apr-16	30	8,266	734	9,000	28,230	2,433	30,663	30,060	2,494	32,554	276	24	300	123.00	145.76	123.61	151.72	1,016,718	106,985	1,123,703	3,862,043	3,895,690	4,154,301	33,648	258,611
May-16	31	-	-	-	-	-	-				-	-	-			123.61	151.72					-			
Jun-16	30	-	-	-	-	-	-				-	-	-			123.61	151.72					-			
15/16 YTD		**264,985**	**23,520**	**288,505**	**285,281**	**25,219**	**310,500**	**298,715**	**24,808**	**323,523**	**8,677**	**770**	**9,447**	**123.64**	**147.61**	**123.61**	**151.72**	**32,775,901**	**3,475,343**	**36,251,243**	**39,275,387**	**39,181,941**	**41,267,204**	**- 93,446**	**2,085,263**

4.2

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Public Health Report**	
Report to:	Community & Public Health Advisory Committee	
Date of Meeting:	25 May 2016	
Summary: Considered in these papers are: ▪ Public Health Service Activity		
Specific implications for consideration (financial/workforce/risk/legal etc):		
Financial:	n/a	
Workforce:	n/a	
Other:	n/a	
Document previously submitted to:	n/a	**Date:** n/a
Approved by:	Elaine Chisnall General Manager, Women's, Children's, Public Health and Support Directorate	**Date:**
Prepared by: Lynette Finnie, Service Manager, Public Health Service. Women's, Children's, Public Health and Support Directorate **Date:** 28/4/2016	**Presented by:** Sandra Boardman Executive Director Planning & Funding	
RECOMMENDATION: **1. That the Commissioner notes the Public Health Service Activity Report.**		

PUBLIC HEALTH SERVICE REPORT TO THE SOUTHERN DHB
DSAC/CPHAC
25 May 2016

Influenza Surveillance

Influenza surveillance is an essential public health tool for assessing and implementing strategies to control influenza. Influenza viruses can cause significant morbidity and mortality within communities in a short timeframe. New strains of influenza appear regularly as the virus undergoes frequent antigenic changes, as was apparent in 2015 with the late unexpected arrival of the B/Brisbane strain.

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

Public Health South have recruited six sentinel GP practices from across the district to participate in 2016. The national coordination unit is trialling electronic reporting from these practices, with weekly reporting back to individual public health units.

In addition to coordinating influenza surveillance, Public Health South has a number of programmes aimed at reducing the duration and scale of any outbreaks. Outbreak management training is provided to community based aged care and early childhood providers to reduce the duration and scale of both influenza and other outbreaks in these settings. We work closely with hospital based infection control teams to ensure consistent public health messages are disseminated, and to provide support during outbreaks.

Health Promoting Schools - Accelerated Equity Hui

Health Promoting Schools is the World Health Organisation mandated programme that is delivered in New Zealand. The settings-based programme works with schools to encourage them to take ownership of health issues affecting their pupils. In taking ownership it is intended schools will exercise leadership in addressing health issues in their wider community. In the Southern district we have three staff working to support schools to implement the Health Promoting Schools programme. Staff work under a national framework that is led by the Cognition Education Trust – an education consultancy organisation that is contracted by the Ministry of Health.

It has been recognised for some time that good education outcomes lead to good health outcomes (and vice versa). Working on this assumption Cognition Education have engaged a former Principal, who has worked in the far North and South Auckland and is a recognised authority on equity in a learning environment, to run a series of workshops across New Zealand. In the South our Health Promoting Schools staff worked with Cognition Education to facilitate three Accelerated Equity Hui/workshops in Oamaru, Invercargill and Dunedin in March.

The workshops proved very popular with a wide range of schools attending. For many participants it was reported that the content had shifted the paradigm in the way they viewed equity and as result a number of schools are already implementing strategies they believe will improve equitable outcomes for students. There are a number of things a school can do to improve equity, but one that was strongly advocated was working

hard to get all parents engaged in their child's learning with a specific focus on those pupils who are not participating effectively in education.

Cognition Education see these workshops as a series aimed at providing tools for schools to exercise leadership in Health and Education in their communities. Health Promoting School's staff will continue to work with schools on their strategies aimed at improving equity and will be identifying further things they need to do to support them.

Refugee Resettlement Planning Update
The first cohort of people from a refugee background from Syria have now arrived in Dunedin and this marks the beginning of a shared journey with the Southern DHB.

SDHB Planning has taken a needs-based approach focussing on how the whole health sector can make a valuable contribution to meeting the health needs of former refugees.

WellSouth, Public Health Nurses and Red Cross and affected SDHB provider services have been working to develop coordinated approaches for care on arrival within the primary care setting.

A Health Steering Committee is being established to support the implementation of health service planning and ensure that implementation reflects the values and principles embedded in planning. A community reference group will be formed for the duration of early planning and implementation.

Planning and Funding has been actively engaged with the planning process to access the resources and tools that are needed by the health sector to provide care. The early focus has been on resourcing fundamental needs such as interpreters and primary care.

Southern DHB now has a funded face-to-face interpreter service available to the whole health sector so that people from a refugee background can have a quality interaction with health care providers. This was developed in response to an expressed need by the whole health sector to have access to face-to-face interpreters. This was supported by research which concluded that access to face-to-face interpreters in primary care and is more likely to assist in keeping people well in the community.

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SOUTHERN DISTRICT HEALTH BOARD

Title:	**Progress on delivering priorities and targets - Southern DHB Annual Plan 2015/16 & Southern Māori Health Plan 2015/16**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	25 May 2016

Summary:

These reports show the progress in **Quarter Three** on delivering on the plans, actions and commitments in the Southern DHB 2015/16 Annual Plan and the joint DHB/PHO Southern Māori Health Plan 2015/16. It highlights completed actions and achievements. Where activity is still to be completed, a brief narrative is provided on planned action and any issues affecting delivery and potentially impacting on the timing or ability to complete.

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

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

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

Prepared by: Planning & Funding **Date:** 29/04/2016	**Presented by:** Sandra Boardman Executive Director Planning & Funding

RECOMMENDATIONS:

That the Commissioner note the progress in Quarter Three in delivering the Southern DHB Annual Plan 2015/16 and Southern Māori Health Plan 2015/16 and the intended actions where activity is incomplete.

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

Southern DHB Annual Plan 2015/16 –Progress Report Quarter 3

Quarter 3 - Progress Report

Planning & Funding

Delivering on Priorities and Targets

Progress on the Annual Plan 2015/16

This template outlines how Planning and Funding is to monitor progress on delivering on the plans, actions and commitments in the Southern DHB 2015/16 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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1 Increased Immunisation

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
1.1 Increased Immunisation	1.1.1 Maintain immunisation coverage above targets for children at 8 months, 2 years and four years			🔴	For Quarter 3 Southern DHB has missed the 8 month old target by one child, however two year old and four year old targets achieved
	1.1.2 NIR to provide WellSouth with details of patients not fully immunised at 6 months, 2 years and 5 years for follow-up with practices **NB: This measure is also in the 2015/16 Maori Health Plan Section 7.1.1. The narrative and performance reporting may differ**			🟡	
	1.1.3 Continue the Southern DHB Vaccine Preventable Disease (VPD) Steering Group to monitor immunisation coverage **NB: This measure is also in the 2015/16 Maori Health Plan Section 7.1.3. The narrative and performance reporting may differ**	VPD Steering Group meets 3 times per year		🟢	
	1.1.4 Maternity providers/LMCs provide birth notification to NIR to a check list on registration			🟢	
	1.1.5 All babies entered onto NIR are followed up to ensure a Practice of Enrolment **NB: This measure is also in the 2015/16 Maori Health Plan Section 7.1.6. The narrative and performance reporting may differ**			🟢	
	1.1.6 NIR contact General Practice regarding any babies not 'Accepted' for Enrolment´ **This measure is also in the 2015/16 Maori Health Plan Section 7.1.7. The narrative and performance reporting may differ**	98% of newborns are enrolled with a PHO, general practice, WCTO provider and COHS by 3 months		🟢	
	1.1.7 NIR do monthly audit of babies about to reach 8 Month target to ensure correct data entry, assess 'Decline' rate	Monthly review of Datamart Reports to regularly measure coverage		🟢	
	1.1.8 B4SC check immunisation status for 4 year olds and refer as necessary			🟢	
	1.1.9 Maintain positive working relationships between VPD Team; especially the Immunisation Coordinators with NGOs (Maori and Pacific Providers, Plunket and WCTO Providers, Antenatal Educators, WellSouth (PHO) & Practices, Locality Well Child Networks, Family Works, Kindergarten Associations & IMAC) and regular visits with government agencies.			🔴	Team to progress plan to achieve target by Q4.

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

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
	1.1.10 'Week day' review of Inpatient and weekly review of Outpatient Birth Cohort children to identify unvaccinated children. Where clinically appropriate, immunisations are delivered by paediatric nurses	A referral process will be developed and implemented for children presenting at ED who are identified as being overdue for vaccination		🟡	
	1.1.11 Promote HPV online learning tools to increase knowledge of the benefits of the HPV programme	65% of eligible girls fully immunised with 3 doses of HPV vaccine by June 2016		🔴	The impact of an orchestrated public anti vaccination campaign at the beginning of the HPV Programme roll out has impacted on coverage, strategies being identified to manage the effect of them.
	1.1.12 Support Immunisation Week (April 2016)	A narrative report will be provided of the interagency activities planned for Immunisation Week	Q4	🟡	
1.2 Reducing Rheumatic Fever	1.2.1 Maintain a register of patients with rheumatic fever			🟢	
	1.2.2 WellSouth to maintain programme to fund general practice services and prescription in relation to rheumatic fever at no cost to patients			🟢	
	1.2.3 The Public Health Unit will undertake a review of each new identified case involving rheumatic fever	Report to Ministry of Health on the root cause analysis of each new rheumatic fever case, including actions taken and lessons learned (PP28)		🟡	
	1.2.4 Multi-stakeholder review of the rheumatic fever prevention and management plan undertaken annually	Multi-stakeholder meeting(s) held	Q4	🟡	
	1.2.5 Continued implementation of the South Island Rheumatic Fever Prevention Plan	All members of the Public Health partnership provide a surveillance function for rheumatic fever	Q2, Q4	🟡	

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

2 Vulnerable Children and the Children´s Action Plan

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
2.1 Reducing Assaults on Children	2.1.1 Maintain performance of current VIP programme	Conduct a self-audit of Southern DHB VIP using the AUT VIP audit tool	Q2	🟢	
	2.1.2 Inclusion of VIP in Southern DHB Orientation and clinical staff mandatory training days			🟢	
	2.1.3 Staff working in child health and other services dealing with vulnerable children have comprehensive safety check completed (Clean Slate Act doesn't apply)	% of new staff who have a comprehensive check done		🟢	
	2.1.4 Provide Ministry-accredited training for health professionals to recognise signs of abuse and maltreatment in designated services	Stock take to establish health professional VIP training levels in designated areas	Q4	🟡	
	2.1.5 Audit the implementation of the Child Injury Flow chart in the Emergency Departments (ED)	ED child Injury Flow chart audit completed	Q2	🔴	Will be implemented in Q4.
2.2 Implementing the Children´s Action Plan	2.2.1 In Readiness, governance arrangements are in place in readiness for Children's Teams	Child and Youth Steering Group meetings occur bi-monthly		🟢	
	2.2.2 Gateway Health Assessments for children referred from Child, Youth and Family strengthening interagency collaboration and access for children and young people to improved health and educational support	100% of Gateway Assessments for children aged 0-4 years completed within 4 weeks; aged over 5 years completed within 6 weeks		🔴	This has been impacted by school holidays but a plan is being developed to catch-up.
2.3 Child Protection	2.3.1 Complete the implementation of the National Child Protection Alert System (NCPAS)	Monitor NCPAS implementation		🔴	Staff training levels in ED must be about 50% before the CPAS in Southern can be signed off. This will be completed in Q4
	2.3.2 Child protection alert face-to-face MDT meetings	100% of Reports of Concern (RoCs) presented to MDT face-to-face meeting		🔴	MDTs not formally able to start until CPAS signed off. MDT has been set up in anticipation of sign off of CPAS.
2.4 Child Services	2.4.1 Support pregnant women with complex needs through Maternity Care Wellbeing and Child Protection groups. Multi-agency maternal well-being and child protection group receives referrals from health professionals and provides advice for women with children up to six weeks of age			🟢	
	2.4.2 Develop a Southern DHB Stepped Continuum of Care Model for Mental Health services to guide service design, funding & service delivery	Stepped Continuum of Care Model documented which includes services targeted to children with mental health and behavioural problems	Q2	🟢	
		Implementation Plan developed and commenced	Q4	🟡	
	2.4.3 Work with the Ministry COPMIA Guidelines and embed the use of SDHB COPMIA guidelines manual and screening tool	Stepped Care Implementation Plan agreed	Q3	🟡	
		Undertake audit (SDHB provider)of clinical records	Q4	🟢	
		Initiate with Adult Residential and Community Support services implementation of Ministry COPMIA Guidelines	Q4	🟡	

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

3 Whānau Ora

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
3.1 Whānau Ora Provider Collectives	3.1.1 South Island DHBs will work with Whānau Ora / Māori Provider(s)	Relationship agreement signed	Q4	●	
		Southern DHB will include Whānau Ora Collectives and Maori Providers in the Strategic Planning process	Q3	●	
	3.1.2 Continue to support local activity across the Southern District	Implement Ipu Whenua (container for placenta and umbilical cord) project	Q2	●	Yet to be fully rolled out, will be reported in Q4.
		Support the operations of Te Kākano Nurse Led Clinics by providing clinical support and connecting specialist services to participate	Q4	●	
	3.1.3 Identify opportunities to implement improvements such as Southern DHB working with Whānau Ora Collectives to improve IT platforms	Undertake a stocktake of Māori Provider/Collectives IT systems across the Southern district	Q3	●	
3.2 Collaboration with Whānau Ora Commissioning Agencies	3.2.1 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 on-going relationship between South Island DHBs and Te Putahitanga, to be signed	Q4	●	
		Yearly strategic planning forum established	Q4	●	
	3.2.2 Support greater alignment of projects and activities across Te Waipounamu	On-going 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	●	
3.3 Whānau Ora Implementation	3.3.1 South Island DHBs participate in processes led by the Ministry and Te Pūtahitanga o te Waipounamu on progressing Whānau Ora initiatives	Support the implementation of the Whānau Ora Information System		●	
		Work with Whanau Ora Collectives and Māori Providers to support the establishment of Low Cost GP clinics within the Southern district	Q4	●	

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

4 Prime Minister´s Youth Mental Health Project

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
4.1 School Based Health Services	4.1.1 Continue HEADSSS assessments to vulnerable youth in existing Decile 1-3 schools, teen parent units and Te Wharekura O Arowhenua	Report progress quarterly (PP25)		🟡	
	4.1.2 Introduce HEADSSS assessments for vulnerable youth into schools which has recently been reclassified as a decile 3 school	HEADSSS assessments introduced to the single new decile 3 school		🟢	
	4.1.3 Increase school based health assessment for youth in secondary schools including Teen parenting Unit and Te Wharekura O Arowhenua			🟡	
	4.1.4 Implement "Youth Healthcare in Secondary Schools: A framework for continuous quality improvement".	One PDSA cycle per SBHS school to be implemented and any identified gaps to be addressed		🟡	
4.2 Youth Primary Mental Health	4.2.1 Deliver “Making the Link” programme to secondary schools in Invercargill, Gore area, and Dunedin	Making the Link implemented	Q2	🟢	
		Evaluate Making the Link implementation	Q4	🟡	
	4.2.2 Provide training for front line staff in community, primary health, social support services, youth training providers using SACS Brief Intervention Tool – Invercargill, Gore district, Dunedin	SACS Brief Intervention Tool delivered	Q2	🟢	
		Evaluate the SACS Brief Intervention Tool programme	Q4	🟡	
	4.2.3 Revised service model for youth brief intervention agreed	Contracts in place with providers		🟡	
4.3 CAMHS and Youth AOD Services	4.3.1 SDHB Provider phone contact trial is extended into practice for young people and their families while waiting for specialist services			🟡	
	4.3.2 Embed the practice of having transition plans between the provider arm specialist child and adolescent services, NGOs, and other agencies in the sector	SDHB provider child and youth clients have a Transition Plan in place - Q1 40%; Q2 50%; Q3 60%; Q4 70%		🟢	
	4.3.3 Build capacity to collect transition plan data electronically	Electronic collection of transition data commences	Q2	🟢	
		Extended to include primary providers	Q3	🟡	
4.4 Improve the Responsiveness of Primary Care to Youth	4.4.1 Child & Youth Steering Group to complete stocktake and gaps analysis for services that deliver for youth and make recommendations to ALT	Stocktake and gaps analysis completed	Q1	🟢	
		Recommendations to ALT		⚫	

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

5

5 Social Sector Trials

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
5.1 Engagement and Consultation	5.1.1 Continue SDHB membership on Gore SST and South Dunedin Advisory Groups with attendance at bi-monthly meetings			●	
	5.1.2 SDHB representatives from Public Health South, Mental Health and Population Health to continue membership of Gore SST local managers group with attendance at bi-monthly meetings			●	
	5.1.3 SSTs are key stakeholders and participants in the Mental Health and Addiction network model			●	
	5.1.4 SST leads will have membership in key Alliance South SLATs or work streams and contribute to development services and the work plan	SST lead is member of the Child and Youth Steering Group		●	
		The Gore SST Chair continues as chair of the Rural Alliance SLA		●	
	5.1.5 SDHB will organise an annual workshop to review progress and update SST leads on issues relating to child and youth health	Annual workshop occurs with participation of different SDHB and primary service areas		●	
5.2 Monitoring	5.2.1 Regular updates on both Gore SST and South Dunedin SST are provided to the Child & Youth Steering Group	SST on agenda for C&Y steering group bimonthly meeting		●	
	5.2.2 Annual update is provided to DSAC/CPHAC committee	In-depth report or presentation on SST activity and achievements is provided annually		●	
	5.2.3 SDHB will complete reporting in collaboration with the SST lead for the Mechanism Implementation quarterly monitoring report	SST quarterly reporting is completed		●	
	5.2.4 SST leads will participate in monitoring and/or evaluation of service delivery where appropriate			●	
5.3 Service Design and Delivery	5.3.1 SDHB staff will consult SST leads on the development and enhancement of health services for young people	Attendance at SST organised sub group meetings for identification of opportunities for change		●	
		SDHB will lead some initiatives within the Gore and South Dunedin SST Action Plans		●	
	5.3.2 Deliver "Making the Link" programme to secondary schools in Invercargill, Gore area, and Dunedin	Making the Link implemented	Q2	●	Please see Action/ Activity 4.2.1 above
		Evaluate Making the Link implementation	Q4	●	Please see Action/ Activity 4.2.1 above
	5.3.3 Provide training for front line staff in community, primary health, social support services, youth training providers using SACS Brief Intervention Tool – Invercargill, Gore district, Dunedin	SACS Brief Intervention Tool delivered	Q2	●	Please see Action/ Activity 4.2.2 above
		Evaluate the SACS Brief Intervention Tool programme	Q4	●	Please see Action/ Activity 4.2.2 above

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

6 More Heart and Diabetes Checks

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
6.1 PHO IT Systems	6.1.1 Increase the utilisation of the DRINFO (up from 63 practices) to increase the number of patients at risk being identified and assessed			●	
	6.1.2 Enable Profile and Houston practices access to the same information available via DRINFO	90% of practices utilising DRINFO (or access same information)	Q4	●	
	6.1.3 Practices utilise Patient Dashboard to establish list of patients sorted by low, med, high and very high CVD risk for follow-up as appropriate			●	
	6.1.4 WellSouth to continue database development to identify patients at risk of developing a long term condition and stratify enrolled service users (ESU) at practice and PHO level	Risk stratification utilised		●	
6.2 PHO Clinical Programmes	6.2.1 WellSouth funds cardiovascular management programme for high needs patients with high risk factors.			●	
	6.2.2 Continue the establishment of the Collaborative Clinical Practice Team			●	The CCPT has morphed into the Long Term Conditions Team
	6.2.3 Utilise HealthPathways for referrals to NGOs focussed on prevention and lifestyle modification			●	
6.3 Supporting Providers	6.3.1 GP and nurse clinical champions to provide guidance to practices and other providers			●	
	6.3.2 Patient Dashboard train the trainer sessions provided through visiting practices	Number of practice staff trained to use Patient Dashboard		●	
	6.3.3 DHB funding for CVDRA funding will be used to support CVDRA achievement	Electronic decision support tools via the Patient Dashboard are available for general practice		●	
	6.3.4 Maintain on-going CME and CNE programme for Cardiovascular Risk Assessment			●	

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

5

7 Long Term Conditions and Diabetes Care Improvement Packages

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
7.1 Long-Term Conditions	7.1.1 WellSouth to continue database development to identify patients at risk of developing a long term condition and stratify enrolled service users (ESU) at practice and PHO level			●	Please see Action/ Activity 6.1.4 above
	7.1.2 DRINFO analyses data and identifies patients who are not being well managed.			●	
	7.1.3 GP and nurse clinical champions to provide guidance to practices and other providers			●	Please see Action/ Activity 6.3.1 above
	7.1.4 LTC nurse working to build capacity for diabetes management in practices			●	
	7.1.5 Utilise HealthPathways for referrals to NGOs focussed on prevention and lifestyle modification			●	Please see Action/ Activity 6.2.3 above
	7.1.6 Alliance South has established a Long-Term Conditions (LTC) Service Level Alliance. The SLA will be responsible for transformational change around models of care and service delivery. WellSouth will continue with core services and well as supporting the SLA	Support the LTC SLA in its work plan, incorporating existing work from the DHB, PHO, and LDT		●	The LTC SLAT's first initiative is *Enhanced LTC*. It is a refinement and extension of the existing Care Plus programme and other flexible funding arrangements. *Enhanced LTC* is for complex patients with long-term conditions, the frail elderly and those at high risk of unplanned (re)admission. The key benefits are improved care coordination and enhanced self-management for patients. The core approach is standardised packages of care, primarily by general practice, but also with secondary and community care, and supported patient self-management. *Enhanced LTC* prioritises the most complex patients and those with the greatest ability to benefit by the identification and stratification of patients; then linking flexible funding to packages of care tailored to each level of stratification.
7.2 Diabetes Care Improvement Packages	7.2.1 WellSouth will roll-out an updated DCIP programme which includes retinal screening, foot checks, and renal function tests			●	
	7.2.2 PHO fund DESMOND on an on-going basis			●	
	7.2.3 Increase utilisation of DESMOND which is a suite of self-management tools and services - online tools, LTC nurses, one-on-one, groups & workshops			●	
	7.2.4 Clean up the virtual diabetes register (VDR)	VDR project completed	Q4	●	
	7.2.5 WellSouth to continue linkages with local Diabetes Groups to ensure community input in to design of Diabetes programmes & services.			●	
	7.2.6 Continue on-going development of community based rural and urban diabetes nurse specialist clinics for both type 1 and type 2 diabetes			●	
	7.2.7 Continue GPSI insulin initiation service for both type 1 and type 2 diabetics			●	

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

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
	7.2.8 Embed Diabetes Physician phone consult service for General practice for complex diabetic patients		Q3	●	
	7.2.9 Commence implementation of the 20 Quality Standards for Diabetes Care			●	
	7.2.10 Review existing CME and CNE for Diabetes with a view to aligning with the 20 Quality Standards for Diabetes Care			●	

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

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8 Stroke

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
8.1 Stroke Services Clinical Leadership	8.1.1 SDHB multi-disciplinary Stroke Governance Group continues the lead in development of stroke services across the district	Stroke Governance Group meets monthly		🟢	
		Stroke Governance Group supports education and staff development		🟡	
	8.1.2 National and South Island clinical stroke networks are supported	Attendance at national and SI meetings		🟢	
8.2 Hyper Acute Stroke	8.2.1 Maintain stroke thrombolysis service across the district	24/7 stroke thrombolysis service at Dunedin Hospital including providing backup for district		🟢	
		24/7 stroke thrombolysis service at Oamaru Hospital		🟢	
		24/7 stroke thrombolysis service at Invercargill Hospital		🟡	
	8.2.2 Establish stroke thrombolysis service at Dunstan Hospital	Thrombolysis service established	Q4	🟡	
	8.2.3 All stroke thrombolysis services use agreed thrombolysis pathway and audit tool	All thrombolysis patients are audited		🟢	
8.3 TIA Services	8.3.1 Maintain outpatient TIA clinics in Dunedin			🟢	
	8.3.2 Outpatient TIA clinics are further developed in Invercargill	TIA clinics are available in Invercargill	Q4	🟢	
	8.3.3 Support development of TIA clinics in Dunstan and Oamaru	TIA clinics are offered in Dunstan and Oamaru	Q4	⚫	
	8.3.4 Improve access to carotid duplex scanning across the district	Stocktake of access to carotid duplex scanning across the district, including an audit of referral forms	Q3	🔴	Stocktake commencing Q4
		Gap analysis, report and recommendations	Q4	⚫	
8.4 Acute Stroke & Rehabilitation	8.4.1 DHB wide use an evidence based acute stroke pathway, guidelines and audit tool	All hospitals use a dedicated acute stroke pathway		🟢	
		All hospitals begin rehabilitation at the time of admission to acute service to provide improved patient outcomes		🟡	
	8.4.2 Maintain nurse-led swallow screening using acute swallow tool across the district	Audit of nurse led swallow screening process		🟡	
	8.4.3 Review and monitor implementation of stroke pathways across ED, medical wards, rural hospitals and stroke units and the community			🟡	
	8.4.4 Interdisciplinary team assesses all patients in stroke unit for rehabilitation	Develop & implement joint Allied Health Assessment process for inpatients with Stroke	Q2	🟡	
		60% of people with acute stroke are transferred to in-patient rehabilitation service and are transferred within 10 days of acute stroke admission.		🟢	
	8.4.5 Extend the present acute stroke pathway to include inpatient and community rehabilitation	Commence development of extended pathway on the Dunedin site	Q1-Q4	🟡	

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

9 Cardiac Services

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
9.1 Acute Coronary Syndrome (ACS)	9.1.1 Embed the use of Common Accelerated Chest Pain Pathways (ACCPs) in emergency departments (localised from the regionally developed pathway)			●	
	9.1.2 Improve chest pain pathways for both local and regional services through triaging of patients that are placed on the transfer list from outlying hospitals			●	
	9.1.3 Implementation of ANZAC QI database is completed. Continue staff training to complete the Dendrite database.	Verify data and report accuracy of Dendrite database	Q3	●	
9.2 Cardiac Diagnostics	9.2.1 Commit to maintain performance of coronary angiography service	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)		●	
	9.2.2 Commit to ensuring appropriate access to cardiac diagnostics			●	
	9.2.3 Improve the data capture across all sites for echocardiograms and exercise tolerance tests	Establish the baseline for performance	Q2	●	
		Identify issues and set up quality improvement initiatives to achieve targets	Q4	●	
		85% patients receive echocardiograms within 90 days		●	
9.3 Cardiac Surgery	9.3.1 As a cardiac surgery provider, sustain performance against cardiac surgery waiting list expectations	A minimum of 204 cardiac surgery discharges delivered	Q4	●	
		Patient wait no longer than 4 months for a cardiology FSA or for cardiac surgery (ESPI 2 & ESPI 5)		●	
		Cardiac surgery intervention rates (per 10,000) are achieved; Cardiac Surgery 6.5; Coronary Angiography 34.7; Percutaneous revascularisation 12.5		●	
	9.3.2 Maintain consistency of clinical prioritisation for cardiac surgery patients, by using the national cardiac CPAC tool, and treating patients in accordance with assigned priority and urgency timeframe	Proportion of patients scored using the national cardiac surgery Clinical Priority Access (CPAC) tool, and proportion of patients treated within assigned urgency timeframe		●	
	9.3.3 Support the South Island DHBs working group in working towards a regional service model South Island cardiac services.			●	
	9.3.4 Implement locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure optimal management of patients with heart failure.			●	

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

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10 Shorter Stays in Emergency Departments

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
10.1 Emergency Department Quality Framework	10.1.1 Continue implementation of the ED Quality Framework	All continuously (C) monitored measures	Q2	●	
		All regularly (R) reported measures	Q4	●	
	10.1.2 Maintain targeted data to speciality services to increase visibility of issues and potential solutions.	New reporting implemented	Q3	●	
	10.1.3 Continue phased introduction of Accelerated Chest Pain Pathways (ACCPs) in emergency departments	ACCP implementation is complete	Q2	●	
10.2 Emergency Departments (ED)	10.2.1 Daily leadership ¨huddle¨ meetings in ED to review previous 24 hours; highlight issues and potential solutions	Leadership meetings occur daily at 8:40am		●	
	10.2.2 Identify patient pathways to reduce time in ED	ACCP implementation is complete	Q2	●	
		Implement orthopaedic pathways for overnight care	Q4	●	
	10.2.3 Inclusion of ED programmes of work in the 'saving 6000 bed day' campaign			●	
10.3 Southland Hospital Emergency Department	10.3.1 Change workforce configuration in ED with implementation of new model of care	Phased implementation over the year	Q4	●	
	10.3.2 Joint programme of work with the PHO focussing on the high ED attendance rate in Southland ED	Monitor frequently attending patients		●	
	10.3.3 Explore opportunities for an automated delivery system for laboratory results in Invercargill to improve turnaround times			●	
10.4 Dunedin Hospital Emergency Department	10.4.1 Better patient flow in ED for short stay patients by improved utilisation of Short Stay Units	Observation Unit hours of operation reviewed	Q2	●	
	10.4.2 Refine plans for influx of student numbers at certain times of the year	Meet regularly with Student Health and University of Otago		●	

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

11 Better Help for Smokers to Quit

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
11.1 Hospitals	11.1.1 All Provider Arm directorates have the ABC target embedded in their quality plans with regular on-going monitoring	ABC question is embedded in nursing admission documentation; medical & surgical assessment		●	
	11.1.2 Embed and monitor ABC for all admissions including facilitating or referring to cessation services			●	
	11.1.3 ABC training to nursing, midwifery and allied health staff on mandatory training days	1000 staff receive ABC training		●	
	11.1.4 All new ward staff receive ABC training from online tool with support from ward champions	100% of new ward staff complete ABC online training module		●	
11.2 Primary Care	11.2.1 DRINFO provides individualised practice reports with progress and achievement on the number of patients identified as smokers and provided with help to quit	90% of practices utilising DRINFO (or access same information) Q4		●	
	11.2.2 GP and nurse clinical champions to provide guidance to practices and other providers			●	Please see Action/ Activity 6.3.1 above
	11.2.3 Smokefree Coordinators and Outreach Nurses provide support and resources to general practice and community providers with high numbers of current smokers **N.B. This measure is also in the 2015/16 Maori Health Plan Section 6.1.2. The narrative and performance reporting may differ**			●	
	11.2.4 WellSouth to continue text to remind services **N.B. This measure is also in the 2015/16 Maori Health Plan Section 6.1.5. The narrative and performance reporting may differ**			●	
	11.2.5 WellSouth to analyse data to identify smokers demographics			●	
	11.2.6 WellSouth supports WERO challenge (team based stop smoking challenge)			●	
	11.2.7 Continue to support the health promotion programme Little Lungs - Pūkahukahu Iti in preschools **N.B. This measure is also in the 2015/16 Maori Health Plan Section 6.1.6. The narrative and performance reporting may differ**			●	
11.3 Community	11.3.1 Provide feedback to LMCs on the ¨better help for smokers to quit¨ maternity Health Target	Publish maternity Health Target results in LMC newsletters		●	
	11.3.2 Facilitate ABC training for LMCs not achieving the ¨better help for smokers to quit¨ maternity Health Target			●	.

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

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
	11.3.3 Health promotion staff work with councils and local NGO's via smokefree networks to engage in smokefree 2025 initiatives including focus on young people			●	
	11.3.4 Assist workplaces to develop a smokefree 2025 approach to their interactions with both staff and clients including focus on young			●	
	11.3.5 Support providers contracted for DHB funded services to implement the new requirements around smokefree clauses			●	
	11.3.6 Smoking cessation providers are promoted and referral pathways strengthened	Facilitate improved referral pathways between LMCs and smoking cessation providers		●	

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

12 Improved Access to Elective Surgery

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
12.1 Elective Surgery	12.1.1 Delivery on the agreed electives volume schedule to meet the Electives Health Target	Monitor performance against the elective surgery production plan – on-going		🟡	
	12.1.2 Production plans are developed, monitored, and where necessary modified, based on achieving (or working towards) performance requirements and equity of access	Elective standardised intervention rates - SI4 – on-going		🟡	
	12.1.3 On-going participation in the National Patient Flow System	Patient level data is reported into the National Patient Flow collection, in line with specific requirements		🟡	
	12.1.4 Maintain consistency of clinical prioritisation for elective surgery patients, by using the national Clinical Priority Access Criteria (CPAC) prioritisation tools, and treating patients in accordance with assigned priority and urgency timeframe	Uptake of latest national CPAC tools to improve consistency in prioritisation decisions		🟡	
	12.1.5 Continue refinement of the e-Referral tool Electronic Request Management System (ERMS) to help streamline and improve referral processes	Number of e-referrals logged		⚫	
	12.1.6 Subject to the outcome of the consultation with staff on Theatres and Critical Care (June 2015), review and develop plan for theatre utilisation, coordination and rostering	Review completed	Q2	🔴	Previous business case to increase acute theatre to be refreshed and resubmitted.
		Business plan to increase access to acute theatre to be implemented	Q2	🟡	
	12.1.7 Aligned with the Dunedin Hospital ICU build, the day surgery and ambulatory care facilities and models of care will be reviewed in order to streamline the services	Review completed	Q4	⚫	
12.2 Work within the Regional Elective Services Alliance to align electives delivery across the South Island	12.2.1 Participate in the development of regional pathways that can then be localised to improve consistency in processes, equity of access and outcomes			🟡	
	12.2.2 Support the regional major trauma work-stream and the development and implementation of a three year action plan	Agree and develop regional clinical guidelines for the management of trauma	Q4	⚫	
		Commence capturing and recording data for the NZ Major Trauma Minimum Dataset	Q4	⚫	
	12.2.3 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.			🟡	

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

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13 Improved Access to Diagnostics

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
13.1 National Initiatives	13.1.1 On-going participation in the National Patient Flow System	Patient level data is reported into the National Patient Flow collection, in line with specific requirements		🟡	Please see Action/ Activity 12.1.3 above (SURD)
	13.1.2 Work with regional (South Island) and national clinical groups to contribute to the development of improvement programmes	Representation, attendance and participation in national, regional clinical group activities		🟢	
13.2 Community Referred Diagnostic Imaging	13.2.1 Implement the National Access Criteria for Community Referral Diagnostics	Develop and implement radiology e-referral (ERMS) templates with access criteria	Q3	⚫	
	13.2.2 Continue development of clinical pathways that facilitate or improve quality of direct access to plain film x-rays and ultrasound	Embed radiology access criteria into relevant pathways		🟡	
13.3 National Radiology Service Improvement Initiative	13.3.1 Meet the agreed project outputs and outcomes of the National Radiology Service Improvement Initiative			🟡	
	13.3.2 Embed functionality of project Governance Group to provide organisation wide perspective on provision of sustainable high tech imaging services	NRSI governance group meets monthly		🟢	
	13.3.3 Establish production planning processes for CT, MRI and other high tech imaging modalities	Complete capacity and demand stocktake for CT and MRI	Q1	🟢	
		Identify and action areas identified for improvement based on on-going data collection and analysis	Q2	🟡	
	13.3.4 Develop and implement access criteria and referral management processes for CT and MRI	Improved clinical utilisation of ultrasound, CT and MRI	Q3	🟡	
13.4 Colonoscopy & Endoscopy	13.4.1 National Endoscopy Quality Improvement Programme (NEQIP)			🟢	
	13.4.2 Continue current initiatives including single point of triage, single point of entry, use of national colonoscopy guidelines for triage and other quality activities identified by the NZGRS tool to maintain performance in meeting MoH targets for colonoscopy			🟢	
	13.4.3 Continue to investigate and actively pursue the potential of Nurse endoscopists			🟢	
	13.4.4 Undertake detailed planning for a new 2 theatre endoscopy unit in Dunedin	Endoscopy plans are approved	Q4	🟢	

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

14 Faster Cancer Treatment & Cancer Services

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
14.1 Faster Cancer Treatment (FCT)	14.1.1 Continue to audit the quarterly faster cancer treatment indicator to ensure data is captured in a consistent manner	Audit completed	Q1, Q2, Q3, Q4	●	
	14.1.2 Continue progress on meeting the 62 day indicator target of 85% by June 2016	Planned progress is 70% Q1, 75% Q2, 80% Q3, 85% Q4		●	
	14.1.3 Support the regional review of two tumour stream standards including provision of relevant data	Regional audit against tumour standards complete	Q4	●	
	14.1.4 Undertake process mapping for the lung tumour stream to identify any gaps in service provision or improvements that can be made within the service			●	
	14.1.5 The national tumour standards of service provision are implemented. (including a focus on supportive care, palliative care and equity standards)			●	
	14.1.6 Collect data demonstrating compliance with priority areas of tumour standards	Tumour streams and priorities to be identified		●	
14.2 Shorter Waits for Cancer Treatment	14.2.1 Continued commitment to delivering timely access to both radiotherapy and chemotherapy and providing robust feedback data on both modalities	All patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy (PP30)		●	
	14.2.2 Improve the functionality and coverage of MDMs by introducing the remaining outstanding MDM meetings	Additional MDMs introduced	Q3	●	
		All MDMs comply with Ministry guidelines		●	
		MDMs are aligned with the regionally agreed MDM priorities.		●	
	14.2.3 Review electronic referrals and the capture of proforma data to improve compliance in MDM standards in all tumour streams	Meet the MDM standards in all tumour streams		●	
	14.2.4 Detailed planning is underway for the purchase and installation of the next scheduled replacement linear accelerator			●	
	14.2.5 Establish a nurse practitioner role to further enhance timeliness of access to chemotherapy			●	
14.3 Cancer Patient Pathway	14.3.1 Commence implementation of the Cancer Health Information Strategy when the guidelines are released			●	Guidelines have not been released as yet
	14.3.2 Commit to implementing the supportive care services for cancer patients once released	Additional roles in place	Q3	●	
	14.3.3 Implement the guidance on active surveillance for prostate cancer when released by the Ministry of Health in mid-2015			●	
	14.3.4 Application of the Equity of Health Care for Māori: A framework			●	

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

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15 System Integration

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
15.1 Shifting Services	15.1.1 Complete indicative business case for establishing a community based where NIR, Immunisation Outreach based within primary care (WellSouth)	Indicative business case developed and decision is made if to proceed	Q2	🟡	
		Q3 & Q4 milestones developed in business case		🟡	
	15.1.2 Complete indicative business case for establishing a single district-wide school based HPV service based within primary care (WellSouth)	Indicative business case developed and decision is made if to proceed	Q2	🟡	
		Q3 & Q4 milestones developed in business case		🟡	
	15.1.3 Reconfigure all pregnancy and parenting services into community settings with updated services specs	Appropriately select providers for community based service	Q2	🟢	
		Community based pregnancy & parenting services in place	Q4	🟢	
	15.1.4 Develop a Southern DHB Stepped Continuum of Care Model for Mental Health services to guide service design, funding & service delivery	Develop proposed model of care	Q2	🟢	Please see Action/ Activity 2.4.2 above
		Consult on proposed model of care	Q3	🟢	Please see Action/ Activity 2.4.2 above
		Implementation Plan developed and commenced	Q4	🟡	Please see Action/ Activity 2.4.2 above
15.2 Integrated Performance & Incentive Framework	15.2.1 Work with the Ministry of Health and WellSouth to implement IPIF			🟢	MOH changed implementation plan for IPIF. Amended to 5 pre-existing measures
15.3 Community Referred Diagnostic Imaging	15.3.1 Implement the National Access Criteria for Community Referral Diagnostics	Develop and implement radiology e-referral (ERMS) templates with access criteria	Q3	⚫	Please see Action/ Activity 13.2.1 above
	15.3.2 Continue development of clinical pathways that facilitate or improve quality of direct access to plain film x-rays and ultrasound	Embed radiology access criteria into relevant pathways (on-going)		🟡	
15.4 Improving Access	15.4.1 Develop pathways that include primary care direct access using HealthPathways			🟡	
	15.4.2 Develop pathways that include easy access to specialist nurse and/or doctor advice using HealthPathways			🟡	
	15.4.3 WellSouth to facilitate implementation of a GP led IT telehealth solution in partnership with specialists			🟡	

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

16 Primary Care

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
16.1 Improved Access for Children	16.1.1 In partnership with WellSouth, facilitate local sustainable solutions to implement free general practice visits for children under 13 years of age (day-time and after-hours)			●	
	16.1.2 Regularly engage with practices to facilitate uptake of the under 13 scheme	Number of practices in U13 scheme		●	
	N.B. This measure is also in the 2015/16 Maori Health Plan Section 2.2.2. The narrative and performance reporting may differ	Percentage of U13 population with no cost access to general practice visits		●	100% coverage achieved in Q3
	16.1.3 Implement free prescription co-payments for children under 13 years of age	Policy implemented to meet Ministry expectations		●	
16.2 Improving Access	16.2.1 WellSouth to implement the National Enrolment Service **N.B. This measure is also in the 2015/16 Maori Health Plan Section 2.1.2. The narrative and performance reporting may differ**	PHO e-Enrolment Service is implemented		●	
16.3 Rural Health	16.3.1 Continue to support the Rural Service Level Alliance Team (SLAT) to develop and implement a plan for distribution of the Rural Primary Care Funding according to the agreed processes in the PHO Services Agreement	Distribution of Rural Primary Care Funding is implemented	Q1	●	All after hours funding has been distributed as per the recommendation of the Rural SLAT, and a contract is in place with WellSouth
		Establish after hours network in Central Otago	Q3	●	A rural after hours model has been agreed and implemented as per the recommendation of the Rural SLAT

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

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17 Health of Older People

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
17.1 Home and Community Support Services	17.1.1 HCSS providers receive additional funding for in-between travel settlement that will be transferred to qualifying employees for qualified travel time and qualified travel costs	Funding is transferred as per the settlement agreement		🟡	
	17.1.2 Older people referred for an InterRAI assessment to access publicly funded care services will undergo the assessment and have a service allocated/declined in a timely manner	High Risk: within 5 working days for assessment; maximum 5 working days to service coordination		🔴	There continues to be greater demand than capacity in all referral types across the district. The centralised triage process has been reviewed and updated to ensure accurate reporting which will be reflected in Quarter 4 data. The non-complex triage process is not aligned with the MoH targets. Our non-complex patient's interRAI assessment triage process is under review and will be updated to match the MoH criteria.
		Low risk: within 15 working days for assessment; maximum 15 working days to service		🔴	As above
	17.1.3 Use InterRAI data to measure progress on a regular basis including benchmarking against other DHBs	Work with national InterRAI reporting group to develop standardised reporting and benchmarking across DHBs	Q2	🟡	
17.2 Dementia	17.2.1 People referred to the Alzheimer's Society have a diagnosis of dementia	90% of those referred to Alzheimer's Society have a diagnosis		🟡	
	17.2.2 Contribute to South Island dementia care pathway group	Participate in the bi-annual South Island Dementia Framework meetings		🟡	
17.3 Provide on-going support to residential care facilities implementing comprehensive clinical assessments (InterRAI)	17.3.1 Provide on-going support to residential care facilities implementing comprehensive clinical assessments (InterRAI)	The number and % of older people who have received long-term support (home or residential) in the last three months who have had an InterRAI homecare or contact assessment and completed care plan		🟢	
		The % of older people in aged residential care by facility who have a second InterRAI LTCF assessment completed 230 days after admission		🟡	
	17.3.2 CNS Wound Care staff provide on-going clinic services in rural hospitals, and an on-call advisory service to primary care and ARC sector			🟡	
	17.3.3 Nurse Practitioner continue to provide education sessions to ARC (historically on average 2 sessions a month)	Number of sessions and attendance		🟡	
	17.3.4 Take information from survey (Apr-May 2015) and identify education and training needs in primary care			🟢	
	17.3.5 Develop updated plan for education and training in community and primary care	Updated training plan completed	Q3	🔴	Timetabled for 16/17 will be completed in Q4.
17.4 Fracture Liaison Service	17.4.1 Maintain the district wide multi-agency (secondary/primary/ACC/NGO sector) Falls Strategy Group to lead service improvement and monitor/evaluate effectiveness.			🟢	

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

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
	17.4.2 Development of Fragility Fracture Pathway	Fragility Fracture Pathway developed in HealthPathways	Q2		
	17.4.3 Recruitment of Falls Co-ordinator positions to WellSouth PHN	Falls Co-ordinators commence	Q1		
	17.4.4 Introduce FLS pilot in 4-5 practices	FLS pilot introduced	Q1		Pilot practices have been identified and FLS Coordinators are working with them to initiate the pilot.
	17.4.5 Develop IT platform (WellSouth) to capture and share data/information for the FLS	FLS IT platform operational	Q2		
		Manually collect and collate FLS referrals from WellSouth payments system as an interim measure	Q1		
	17.4.6 Expand the FLS pilot to full FLS implementation	FLS implementation completed	Q4		Full rollout is expected in the 2016/17 year.

Completed Underway according to plan Behind plan Scheduled for Q4

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18 Rising to the Challenge

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
18.1 Service Development	18.1.1 Develop a Southern DHB Stepped Continuum of Care Model for Mental Health services to guide service design, funding & service delivery	Implementation Plan developed and commenced	Q4	🟡	Please see Action/ Activity 2.4.2 above
	18.1.2 Develop a Workforce Development Plan for the Southern District mental health & addictions sector (including upskilling GPs)	Workforce Plan developed	Q2	🟡	Draft Workforce Development Plan developed - will be distributed for sector feedback prior to final approval May 2016
	18.1.3 The implementation for all Hapai te Tumanako-Raise HOPE Strategic Plan initiatives incorporates robust business planning to support a capable and sustainable NGO sector			🟢	
18.2 Increased Access	18.2.1 Enhance the delivery and integration of specialist mental health and addiction services with Clinical Pathways developed, completed and implemented for ADHD, Anxiety, Depression, and Anorexia Nervosa	Pathways developed	Q4	🟡	
18.3 Resilience & Recovery	18.3.1 Continue to embed the programme based on the Six Core Strategies to reduce the use of seclusion and restraint, including Māori **N.B. This measure is also in the 2015/16 Maori Health Plan Section 10.1.3. The narrative and performance reporting may differ**		Q3	🟡	
	18.3.2 Review and document an updated model of support services so more people experience purposeful employment and activities		Q3	🔴	Reprioritised for 16/17 work programme
18.4 Support service users in their role as parents	18.4.1 Work with the Ministry COPMIA Guidelines and embed the use of SDHB COPMIA guidelines manual and screening tool			🟢	Please see Action/ Activity 2.4.3 above
	18.4.2 Undertake audit of clinical records sample to gauge uptake by MHAID clinical teams of COPMIA programme	Target compliance of 30% by Q3 and 40% by Q4	Q3, Q4	🟢	
18.5 Suicide Prevention	18.5.1 SDHB Suicide prevention action plan is finalised and communicated to all relevant Southern groups	Submit final district Suicide Prevention & Postvention Plan to MOH by 20 July 2015		🟢	
		Approved SDHB Suicide Prevention Action Plan is widely circulated to all key stakeholders and accessible on the SDHB website	Q2	🟢	
	18.5.2 Postvention plans in place for all community postvention groups	One new community postvention group, using the postvention plan, is developed	Q4	🟡	
	18.5.3 Annual programme of training developed and circulated to key agencies by the Suicide Prevention Coordinator	Training programme developed and communicated	Q4	🟡	
	18.5.4 Training occurs in targeted areas of need (increased suicide rates)	Suicide Prevention/Postvention training agencies are able to respond to need in a timely and effective way	Q4	🟡	
	18.5.5 SDHB continues to develop formal and informal relationships with key state and community agencies			🟡	

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

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
	to ensure effective information flow and risk reduction				

5

19 Maternal and Child Health

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
19.1 Maternal Health	19.1.1 Promote the ¨Find Your Midwife¨ website¨ through general practice, Māori and Pacific providers, and other appropriate health providers			●	
	19.1.2 Work with Māori and Pacific providers to encourage pregnant women registering with an LMC in the first trimester			●	
	19.1.3 Work with Queenstown GPs to encourage pregnant women registering with an LMC in the first trimester	80% of women register with an LMC by week 12 of their pregnancy		●	
		95% of pregnant women receive continuity of primary maternity care through a community or DHB LMC		●	
	19.1.4 Maternity Quality & Safety Programme (MQSP) continues to be imbedded into business as usual throughout the district			●	
	19.1.5 Investigate options to simplify for parents registration for newborns to PHO, GP, Well Child Tamariki Ora (WCTO), and community oral health services (COHS)	Options for simplified registration developed	Q1	●	
	19.1.6 Review Pregnancy and Parenting Education services with a focus on high needs population groups **N.B. This measure is also in the 2015/16 Maori Health Plan Section 3.1.4. The narrative and performance reporting may differ**	Pregnancy and parenting services are reviewed and contracts are amended accordingly	Q4	●	
	19.1.7 Require pregnancy and parenting providers to develop a service plan that outlines how they are to engage and educate Māori, Pacific, and teens	Providers develop and submit plans to the DHB		●	
		Providers report as required		●	
	19.1.8 Implement the recommendations in the Gestational Diabetes Mellitus National Clinical Guidelines	GDM guidelines implemented	Q1	●	
	19.1.9 NZ maternity standards and the PMMRC recommendations will be implemented along with any other directives from the National Maternity Monitoring Group			●	
19.2 Child Health	19.2.1 Well South and Public Health South to promote BURP (Breastfeeding Ultimate Refuel Place) smart-phone application to GPs, health providers, and communities **N.B. This measure is also in the 2015/16 Maori Health Plan Section 3.1.1. The narrative and performance reporting may differ**			●	
	19.2.2 Continue engagement with the Well Child Tamariki Ora providers	WCTO forum quarterly		●	
	19.2.3 Work with all related providers to ensure that Well Child Tamariki Ora Quality Framework national			●	

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

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
	targets are achieved or that Southern DHB performances are improved				
	19.2.4 Work with the South Island WCTO Quality Improvement project manager			●	
	19.2.5 Maintain coverage of B4 School Checks			●	

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

20 Improving Quality

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
20.1 Falls Prevention	20.1.1 Maintain the district wide multi-agency (secondary/primary/ACC/NGO sector) Falls Strategy Group to lead service improvement and monitor/evaluate effectiveness			🟢	Please see Action/ Activity 17.4.1 above
	20.1.2 Real time data measurement and display on Visual Management Boards (Patient Safety Boards)			🟡	
	20.1.3 Frontline leadership with one on one follow up to imbed assessment and planning practice	90 percent of older patients are given a falls risk assessment		🔴	65.4% (↓18.6%) Trendcare access issues. IT working to improve.
		98 percent of older patients assessed as at risk of falling receive an individualised care plan addressing these risks		🔴	72% (↑4%) Patient Safety/Releasing Time to Care integrated steering group commenced planning and to improve the fall process makers. Improved clarity of leadership and accountability and improved reporting first actions to be taken
20.2 Perioperative Harm	20.2.1 Sustain achievement at or above the old QSM threshold of all three parts of the WHO surgical safety checklist and ensure it is used as a teamwork & communication too	Surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90 percent of operations		🟡	
	20.2.2 Work with the HQSC to implement the new perioperative harm QSM to introduce briefing & debriefing for each theatre list during 2015/16, for public reporting in 2016/17			🟡	
20.3 Hand Hygiene	20.3.1 Improved family of measures to identify and focus on specific improvement actions			🟡	
	20.3.2 Promote good hand hygiene practice to staff, patients and visitors			🟡	
	20.3.3 Maintain the appropriate number of trained hand hygiene auditors	80 percent compliance with good hand hygiene practice		🟡	
20.4 Surgical Site Infections	20.4.1 Sustain achievement at or above the QSM threshold for clinical standards specified by the Surgical Site Infection Improvement Programme			🔴	Mixed results as below
	20.4.2 One-on-One follow up and conversations to standardise practice	95 percent of hip and knee replacement patients receive cefazolin ≥ 2g as surgical prophylaxis		🟡	
		100 percent of hip and knee replacement patients have recommended skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine		🔴	97% (↓1%) Incomplete documentation impacted on results that do not yet meet the target. Surgical teams working to improve processes.
		100 percent of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision		🔴	92% (↓1%) Incomplete documentation impacted on results that do not yet meet the target. Surgical team working to improve processes.
20.5 Medication Safety	20.5.1 Participate in the National Opioid Collaborative to reduce harm associated with Opioid Medications			🟡	
	20.5.2 Complete implementation for ePrescibing	ePrescribing implemented	Q2	🟡	
	20.5.3 eMedicine Reconcilliation (eMR) implementation will commence once Health Connect South (HCS) is installed	eMR implementation commences Q4		⚫	

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

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
20.6 National Systems	20.6.1 Quality Accounts are developed with HQSC guidance and are informed by appropriate consumer engagement	Quality Account is published	Q2	●	
	20.6.2 Maintain appropriate mortality & morbidity review systems, and supporting National Mortality & Morbidity Review processes			●	
	20.6.3 Continue to undertake District Mortality & Morbidity Reviews within specialties			●	
	20.6.4 Continue to participate in and work to increasing electronic responses to the national inpatient experience survey	Maintain > 8 rating on all four domains of the patient experience indicators		●	
	20.6.5 Provide access at service level to the detailed service feedback within the National Patient Survey			●	

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

5

21 Actions to Support Delivery of Regional Priorities

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
21.1 Major Trauma	21.1.1 Support the regional major trauma work-stream and the development and implementation of a three year action plan			●	Please see Action/ Activity 12.2.2 above
	21.1.2 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.			●	Please see Action/ Activity 12.2.3 above
21.2 Workforce	21.2.1 Support the establishment of an eLearning platform			●	
	21.2.2 Increase PGY2 placements in the community			●	
	21.2.3 Introduce Lippincott on-line evidenced based nursing procedure manual			●	
21.3 Information Systems	21.3.1 Continue with transition planning for the National Infrastructure Platform (NIP) Programme	NIP transition planning completed	Q1 16/17	●	National Project under review by Department of Internal Affairs and Government Chief Information Officer
		NIP implementation completed	Q1 17/18	●	scheduled for 16/17
21.4 Health Connect South	21.4.1 Replacement of the current SDHB Clinical Desktop with a regional solution covering all SI DHBs	SDHB migration completed	Q1	●	
21.5 Patient Administration Systems	21.5.1 Continue development and progressive implementation across DHBs of the South Island Patient Management System (PICS)	Business case for SDHB implementation is scheduled for 16/17		●	scheduled for 16/17
21.6 eMedicines Programme	21.6.1 Continue MedChart roll-out to Dunedin Hospital and Southland Hospital wards			●	Please see Action/ Activity 20.5.2 above
	21.6.2 Commence MedChart roll-out to rural hospitals			●	Please see Action/ Activity 20.5.2 above
	21.6.3 SDHB continue to lead the regional roll out of the South Island ePrescribing and Administration system			●	Please see Action/ Activity 20.5.2 above
21.7 HealthOne (formally eSRVC)	21.7.1 Investigate the feasibility of implementing HealthOne in conjunction with the Health Connect South project.	Business case for early implementation of HealthOne alongside HCS completed		●	

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

Southern Māori Health Plan 2015/16 –Progress Report Quarter 3

Quarter 3 - Progress Report

Planning & Funding

DELIVERING ON PRIORITIES AND TARGETS

PROGRESS ON THE MĀORI HEALTH PLAN 2015/16

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

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3 CHILD HEALTH 4
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6 SMOKING CESSATION 7
7 IMMUNISATION 8
8 REDUCING RHEUMATIC FEVER 9
9 ORAL HEALTH 10
10 MENTAL HEALTH 11

1 Data Quality

PROGRESS ON DELIVERING ON PRIORITIES AND TARGETS: ANNUAL PLAN ACTIONS

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
1.1 Ethnicity Audits	1.1.1. The Primary Care Ethnicity Data Audit Toolkit will be implemented at all practices alongside the Foundation Standard	100% of WellSouth practices have completed the Primary Care Ethnicity Data Audit by 30 June 2016	Q4	●	
	1.1.2. Complete practice ethnicity audits as scheduled	Ethnicity audits completed	Q1	●	
	1.1.3. Collate EDAT results and complete a register of practices in order to track and monitor performance	WellSouth to monitor quarterly and report to Senior Management Team (SMT) and Te Hauora Matua - WellSouth Iwi Governance Group		●	
	1.1.4. Facilitate sharing of best practice process across Southern practices	Best practice shared quarterly		●	
	1.1.5. Reconcile data-sets between primary, secondary, and others as identified	Track primary care enrolments on a quarterly basis		●	

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

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2 Access to Care

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
2.1 PHO Enrolment	2.1.1 WellSouth to ensure all eligible Māori are enrolled by working with Maori providers to ensure all of their clients are enrolled	WellSouth to monitor quarterly and report to Senior Management Team (SMT) and Te Hauora Matua - WellSouth Iwi Governance Group		🟡	
	2.1.2 WellSouth to implement the National Enrolment Service	PHO e-Enrolment Service is implemented		🟡	
		Monitor total number of Māori enrolments quarterly		🟢	
	2.1.3 Advise Māori Providers which practices have capacity for new enrolments			🟡	
	2.1.4 Compare PHO enrolments with Census 2013 data (available Dec 2015) to identify enrolment gaps by ethnicity, gender, and geographic location	Complete enrolment gap analysis		🟡	
	2.1.5 Utilise the WellSouth voucher programme to encourage enrolment			🟢	
	2.1.6 WellSouth to partner with Department of General Practice at the University of Otago in a research project to identify any specific clusters of unenrolled Māori and target enrolled when identified	Research project agreed between partners		🟡	
2.2 Improving Access	2.2.1 WellSouth to continue to develop access to sustainable low cost primary care services			🟡	
	2.2.2 Regularly engage with practices to facilitate uptake of the under 13 scheme	Number of practices in U13 scheme		🟢	
	2.2.3 WellSouth to continue to fund voucher programme to improve access to GP services, urgent care and prescriptions for the most at risk populations			🟢	
	2.2.4 WellSouth to work with Invercargill based VLCA practices to support evening clinics and improve access to urgent care			🟢	
	2.2.5 WellSouth to continue to review SIA funding is appropriately targeted to improve access for Māori, Pacific and Dep 9 and 10 populations			🟢	
	2.2.6 SDHB and WellSouth to support Te Kākano nurse led clinics			🟡	
	2.2.7 WellSouth to support and develop newly established VLCA practices in Invercargill and South Dunedin			🟡	
	2.2.8 Monitor WellSouth clinical programmes to ensure equitable access for Māori and develop plans to ensure equitable access if required			🟡	

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

3 Child Health

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
3.1 Breastfeeding	3.1.1 Well South and Public Health South to promote BURP (Breastfeeding Ultimate Refuel Place) smart-phone application to GPs, health providers, and communities			●	
	3.1.2 Well South to continue to advocate for appropriate settings that are available for breastfeeding – workplace/ cafes (BURP) / maraes			●	
	3.1.3 SDHB to roll-out Pepi pods project for pregnant women who have been identified as smokers by LMCs - key messages from Safe Start will include breastfeeding, sleeping & immunisation	Pepi pod project implemented	Q1	●	
	3.1.4 Review Pregnancy and Parenting Education services with a focus on high needs population groups	Pregnancy and parenting services are reviewed and contracts are amended accordingly	Q4	●	
	3.1.5 Maintain baby-friendly hospital (BFHI) accreditation			●	
	3.1.6 Continue to support Kaupapa Māori Peer counsellor programme with a specific focus on Māori models of care and support			●	
3.2 Health Promotion	3.2.1 Continue to support the smokefree programme Little Lungs –pukahukahu iti - programme in kohanga reo and other early childhood learning centres			●	
	3.2.2 Fund Heart Foundation to deliver Health Heart Awards/Tohu Manawa Ora Kohungahunga			●	

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

5

4 Cardiovascular Disease

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section		Actions/Activity		Measures	Time-frame	Progress	Progress Narrative
4.1	CVD Health Literacy	4.1.1	All Maori at high risk are referred to Long Term Conditions Nurses for intensive health literacy about CVD risk and management with a particular focus on medications	% of Māori at high risk of CVD who are referred to a Long Term Conditions Nurse for intensive health literacy intervention		🟡	Practices are being encouraged to enrol all Māori at high risk into the CVD management programme and this has been included in practice Māori Health plans
		4.1.2	Provide targeted ABC and/or Aukati Kai Paipa cessation support to Māori at high risk of CVD	% of Māori who have accessed smoking cessation services		🟡	
4.2	CVD Management Programme	4.2.1	All Maori at high risk of heart disease are enrolled in the CVD management programme - Eligible patients are entitled to four free GP visits to assess, manage and minimise their risk of heart disease	% of Māori at high risk of CVD enrolled in the CVD management programme		🟡	CVD management programme is now available in the WellSouth web-portal and enrolment of all Māori with high risk is incorporated as a target in the practice's Māori Health Plan.
		4.2.2	Review prescribed lipid medication with patient and increase and/or change and/or add additional lipid lowering medication	% of Māori at high risk with LDL measure of less than 2		🟡	
		4.2.3	Review prescribed Blood Pressure lowering medication and increase and/or add another and/or change as indicated	% of Māori at high risk with B/P > 130/80 (Diabetes, previous CVD event) or B/P > 140/85 without a clinical CVD or Diabetes		🟡	
		4.2.4	Provide targeted ABC and/or Aukati Kaipaipa cessation support to Māori at high risk of CVD who are smokers			🟡	
4.3	Cardiovascular Disease	4.3.1	Monitor CVDRA targets and develop a plan to ensure Māori CVDRA rates are above target	> 90% of eligible Māori have had their cardiovascular risk assessed within the previous five years		🟡	
		4.3.2	WellSouth to continue to fund free CVDRA for eligible Māori			🟢	
		4.3.3	WellSouth to continue supporting Māori Providers to carry out CVDRA and report back to GP (and enter data into PMS)			🟡	
		4.3.4	Increase the utilisation of the DRINFO (up from 63 practices) to increase the number of Māori at risk being identified and assessed			🟡	
		4.3.5	Using DRINFO WellSouth to monitor practice activity in targeting CVDRA for eligible Māori men aged 35-44 years quarterly			🟡	
		4.3.6	WellSouth to continue to fund the voucher programme to ensure access to GP services and prescriptions			🟢	
		4.3.7	Improve ACS rates for Maori above the current 70% by working on improved chest pain pathways and transfer protocols	Continue to report ACS rates for Māori		🟢	
				Review chest pain pathways and transfer protocols	Q4	⚫	

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

5 Cancer Screening

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
5.1 Cervical Screening	5.1.1 Promote and monitor the uptake of the funded cervical smears in targeted populations including Māori, & under screened women			🟡	
	5.1.2 Increase the number of Māori smear takers available within practices & accredited providers by 31 December 2015			🟢	
	5.1.3 WellSouth to utilise data matching to identify unscreened enrolled women and support practices to facilitate their screening			🟡	
	5.1.4 Work in collaboration with community health care providers to encourage the participation of Māori women in cervical screening			🟡	
	5.1.5 The NCSP District Coordination Steering Group to monitor, plan and improve activities across the cervical screening pathway	NCSP group to meet quarterly		🟡	
	5.1.6 SDHB to follow-up women supported by colposcopy services through satisfaction surveys	Satisfaction survey results annually		🟡	
	5.1.7 Promote HPV immunisation			🟡	
5.2 Breast Screening	5.2.1 Ensure enrolled and eligible Māori women are enrolled on the national breast screening programme			🟡	
	5.2.2 WellSouth to utilise data matching to identify unscreened enrolled women and support practices to facilitate their enrolment in the programme	Data matching report completed quarterly		🟡	
	5.2.3 SDHB & WellSouth to maintain relationships with BreastScreen Otago Southland	Meetings held quarterly		🟢	

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

5

6 Smoking Cessation

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
6.1 Smoking Cessation	6.1.1 Utilise DRINFO and patient dashboard to increase the number of Māori patients identified as smokers and provided with ABC	90% of practices utilising DRINFO (or access same information)	Q4	🟡	
	6.1.2 Smokefree Coordinators and Outreach Nurses provide support and resources to general practice and community providers with high numbers of current smokers			🟡	
	6.1.3 Ensure that all LMCs and WCTO providers are up to date with quit card training and connected with AKP providers	Facilitate improved referral pathways between LMCs and smoking cessation providers		🟢	
	6.1.4 SDHB to roll-out Pepi pods project for pregnant women who have been identified as smokers by LMCs - key messages from Safe Start will include breastfeeding, sleeping & immunisation	Pepi pod project implemented	Q1	🟡	
	6.1.5 WellSouth to continue text to remind services			🟢	
	6.1.6 Continue to support the health promotion programme Little Lungs - Pūkahukahu Iti in preschools			🟡	

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

7 Immunisation

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
7.1 Childhood Immunisation	7.1.1 NIR to provide WellSouth with details of patients not fully immunised at 6 months, 2 years and 5 years for follow-up with practices			●	
	7.1.2 WellSouth to utilise DRINFO to monitor and identify patients that are due for immunisation			●	
	7.1.3 Continue the Southern DHB Vaccine Preventable Disease (VPD) Steering Group to monitor immunisation coverage	VPD Steering Group meets quarterly		●	
	7.1.4 WellSouth to use vouchers to remove cost barriers & support Māori Providers to assist			●	
	7.1.5 WellSouth to facilitate specific clinics for Māori as the need arises			●	
	7.1.6 All babies entered onto NIR are followed up to ensure a Practice of Enrolment			●	
	7.1.7 NIR contact General Practice regarding any babies not 'Accepted' for Enrolment´	98% of newborns are enrolled with a PHO, general practice, WCTO provider and COHS by 3 months		●	
7.2 Influenza Immunisation	7.2.1 WellSouth to utilise DRINFO to monitor and identify patients that are due for immunisation			●	
	7.2.2 WellSouth to continue supporting practices to increase the numbers of Māori receiving the influenza immunisation			●	
	7.2.3 WellSouth to use vouchers to remove cost barriers & support Māori Providers to assist			●	

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

5

8 Reducing Rheumatic Fever

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
8.1 Reducing Rheumatic Fever	8.1.1 Maintain a register of patients with rheumatic fever			●	
	8.1.2 WellSouth to maintain programme to fund general practice services and prescription in relation to rheumatic fever at no cost to patients			●	
	8.1.3 The Public Health Unit will undertake a review of each new identified case involving rheumatic fever	Report to Ministry of Health on the root cause analysis of each new rheumatic fever case, including actions taken and lessons learned (PP28)		●	
	8.1.4 Multi-stakeholder review of the rheumatic fever prevention and management plan undertaken annually	Multi-stakeholder meeting(s) held Q4		●	
	8.1.5 Continued implementation of the South Island Rheumatic Fever Prevention Plan	All members of the Public Health partnership provide a surveillance function for rheumatic fever Q2,Q4		●	

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

9 Oral Health

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
9.1	9.1.1 Engage with all stakeholders including primary care, Well Child/Tamariki Ora, Public Health Service and other health promotion staff such as LMCs to promote oral health and encourage early oral health service enrolment				
	9.1.2 SDHB to undertake data matching with WellSouth to identify children not enrolled in oral health services				
	9.1.3 Provide education to trainee Midwives at Otago Polytech around oral health and enrolment				
	9.1.4 Support Kohanga Reo in providing tooth brushing programme – all children will brush once per day at Kohanga in the Southern district.				
	9.1.5 DHB produces quarterly oral health newsletters for ECEs				
	9.1.6 Continue to fund the Oral Health programme which provides dental care to high needs patients with urgent dental care needs				

Completed Underway according to plan Behind plan Scheduled for Q4

5

10 Mental Health

Progress on Delivering on Priorities and Targets: Annual Plan Actions

Section	Actions/Activity	Measures	Time-frame	Progress	Progress Narrative
10.1	10.1.1 Continue to support the brief intervention service to increase the number of Māori referrals			🟡	
	10.1.2 Establish brief intervention service delivery within Māori Providers	Brief intervention service delivery with Māori Providers established	Q3	🟡	Youth Brief Intervention Review completed. Business case developed which highlights opportunities for enhanced service provision for Māori and other vulnerable youth district wide
	10.1.3 Continue to embed the programme based on the Six Core Strategies to reduce the use of seclusion and restraint, including Māori			🟡	
	10.1.4 Data collection and analysis by DAMHS	Completed and reviewed quarterly		🟢	
	10.1.5 Formal agreement between MHAID and MHD to ensure access for patients to MHD staff	Agreement in place	Q1	🔴	In Southland the MHD are present at the SPOE and key points of interfacing with service users. Delays in Dunedin relate to staff vacancies.

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

SOUTHERN DISTRICT HEALTH BOARD

6

Title:	**CONTRACTS REGISTER**		
Report to:	Commissioner Team		
Date of Meeting:	25 May 2016		
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:**	
Prepared by: Sandra Boardman Executive Director Planning and Funding **Date:** 13 May 2016		**Presented by:** Sandra Boardman Executive Director Planning and Funding	
RECOMMENDATION: **1. That the Commissioner note the attached Contracts Register.**			

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) MAY 2016

PROVIDER NAME	DESCRIPTION OF SERVICES	ANNUAL AMOUNT	CONTRACT/VARIATION END DATE	APPROVED BY
Contract Value of - $0 - $100,000 (Level 3)				
Access Homehealth Limited Variation to Service Schedule	HCSS - Palliative Care Service	$2,337.44 (Total Contract Value $5,259.24 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16
Access Homehealth Limited Variation to Service Schedule	HCSS - Short Term Care Service	$18,599.36 Total Contract Value $41,848.56 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16
Access Homehealth Limited Variation to Service Schedule	HCSS - Long Term Support-Chronic Health Conditions	$5,659.28 (Total Contract Value $12,733.38 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16
Royal District Nursing Service New Zealand Variation to Service Schedule	HCSS - Palliative Care Service	$3,078.60 (Total Contract Value $6,926.85 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16
Royal District Nursing Service New Zealand Variation to Service Schedule	HCSS - Short Term Care Service	$41,744.08 (Total Contract Value $93,924.18 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16
Royal District Nursing Service New Zealand Variation to Service Schedule	HCSS - Mental Health & Addiction Service	$39149.52 (Total Contract Value $88,086.42 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) MAY 2016

Royal District Nursing Service New Zealand Variation to Service Schedule	HCSS - Long Term Support - Chronic Health Conditions	$10,824.04 (Total Contract Value $24,354.09 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16
Royal District Nursing Service New Zealand Variation to Service Schedule	HCSS - Health of Older People Service	-$120,970.68 (Total Contract Value -$362,912.04 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16
BUPA Care Services NZ Ltd Variation to Agreement	Residential Care for Named Individual Community Based housing and recovery focused support services	$38,569.55	31.03.16	Executive Director Planning & Funding 23.03.16
Wyndham & Districts Community Rest Home Inc New Agreement	Residential care for named individual	$1,113.50	28.01.16	Executive Director Planning & Funding 21.04.16
WellSouth Primary Health Network Variation to Agreement	General Practitioner Special Interest	$82,500.00	30.06.16	Executive Director Planning & Funding 20.04.16
	Total for Level 3	**$ 143,119.85**		
Contract Value of - $100,000 - $500,000 (Level 2)				
Access Homehealth Limited Variation to Service Schedule	HCSS - Mental Health and Addiction Service	$56,748.40 (Total Contract Value $127,683.90 Estimated)	30.06.18	Executive Director Planning & Funding 23.03.16

FUNDING ADMINISTRATION
CONTRACTS REGISTER (EXPENSES) MAY 2016

Pacific Island Advisory & Cultural Trust Variation to Agreement	Pacifica Community Services	$318,839.01	31.01.19	Executive Director Planning & Funding 23.03.16
International Waste Limited Variation to Agreement	Collection and Disposal of Sharps and Unused Pharmaceuticals	$140,229.50	30.06.17	Executive Director Planning & Funding 23.03.16
	Total for Level 2	**$ 515,816.91**		
Contract Value of - $500,000 - 1 Million (Level 1)				
Healthcare of New Zealand Ltd - Variation to Service Schedule	HCSS - Long Term Support - Chronic Health Conditions	$71,392.04 (Total Contract Value $166,581.43) Estimated		Commissioner 26.02.16
Roxburgh District Medical Services Trust Board Variation to Agreement	Community Health Services Main Agreement	$223,671.99 (Total Contract Value $559,179.98)		Chief Executive Officer 13.04.16
	Total for Level 1	**$ 295,064.03**		
Contract Value of - $1 Million and Over (Commissioner)				
				Commissioner
	Total for Board Level	**$ -**		
	Grand Total	**$ 954,000.79**		