DISABILITY SUPPORT ADVISORY COMMITTEE

and

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

A G E N D A

Tuesday, 26 October 2010
10.30 am

Board Room, 1st Floor, Dunedin Hospital
201 Great King Street

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DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Tuesday, 26 October 2010, 10.30 am

Board Room, 1st Floor, Dunedin Hospital

A G E N D A

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10.30 am	**Welcome**	
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Closed Session:

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

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Confidential Minutes 2. Southern PHO Contract 3. Risk Report	▪ To allow negotiations and activities to be carried on without prejudice or disadvantage	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(i) and 9(2)(j) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Leonard Errol MILLAR (Chairman)	12.12.2007 12.12.2007 12.12.2007 07.08.2008	1. Aquestra Ltd (Managing Director). 2. Philips Search & Rescue Trust (Chairman and Trustee). 3. Southern Community Laboratories Otago Southland Ltd (Director). 4. Millar Paterson Properties Ltd, trading as Hawkdun Lodge, Ranfurly (Director).	1. Management Consultants, Wellington. 2. Central North Island Charitable Trust providing helicopter and fixed wing air ambulance/rescue services out of bases at Hamilton, Tauranga, Rotorua, Taupo and Palmerston North. 3. Appointed as Southern DHB nominated Director. 4. Provider of modern accommodation/conference/ training facilities used occasionally by health sector entities, including Southern DHB.
Paul MENZIES (Deputy Chairman)	10.02.2010 10.02.2010	1. Wife a member on the Southland Child Youth Mortality Review Group. 2. Wife a member on the Child and Youth Health Advisory Committee.	1. Nil. 2. Nil.
Helen Marie ALGAR	16.12.2004 06.04.2006 19.02.2008 05.06.2008	1. Waitaki District Health Services Forum (Muscular Dystrophy Association Representative). 2. Rural Women New Zealand (Associate Member). 3. Physical Activity Project Co-ordinator, Waitaki District Council.	1. Nil. 2. Nil. 3. Nil.
Peter Alexander BARRON	20.06.2010	1. The Otago Group Limited (Managing Director) 2. The Mackenzie Group Limited (Shareholder) 3. South Island Pharmacists Association (Executive and Member) 4. Green Island Pharmacy Limited (Director) 5. Catlins (now Southland) Pharmacy Ltd (Shareholder and Director) 6. Pharmacy Automation Limited (Director) 7. Southland Pharmacy Limited (Shareholder and Director) 8. Dunedin Associated Chemists Ltd (Urgent Pharmacy) (Shareholder)	1. Holding company. It has no dealings with Southern DHB. 2. The Mackenzie Group is a shareholder in Dunedin Pharmacy Ltd, Aspiring Pharmacy Ltd, Otago Pharmacy Ltd, South Canterbury Pharmacy Ltd, Mackenzie Pharmacy (2001) Ltd, Catlins Pharmacy Ltd, Green Island Pharmacy Ltd. Dunedin Pharmacy Limited contracts to the Southern DHB to provide Pharmacy Services. Aspiring Pharmacy Limited contracts to the Southern DHB to provide Pharmacy Services. Mackenzie Pharmacy Limited contracts to the LDHB to provide Pharmacy Services. Mackenzie Pharmacy until Jan 2007 was contracted to ODHB to provide pharmacy services via Elwyn Bates Pharmacy Otago Pharmacy Limited contracts to the SCDHB to

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
			provide Pharmacy Services. Otago Pharmacy until Oct 2006 was contracted to ODHB to provide pharmacy Services via Cameron Wilkies Pharmacy 3. SIPA was involved in negotiations with the ODHB for a new Pharmacy Contract. 4. Until Sept 2005 Green Island Pharmacy was contracted to provide Pharmacy Services to the ODHB. 5. Until Jan 2007 Catlins Pharmacy was contracted to ODHB to provide pharmacy services. 6. Pharmacy Automation is involved in the distribution of pharmacy robots within NZ and may have DHBs as customers for these products. 7. Southland Pharmacy Limited contracts to the Southern DHB to provide Pharmacy Services. 8. The Urgent Pharmacy is contracted to Southern DHB to provide pharmacy services.
Sajan BHATIA	16.12.2004 16.12.2004	1. Mobile Surgical Services Ltd. 2. Mobile Technology Ltd.	1. Work involved in smaller centres. 2. Work involved in smaller centres.
Maria Louise CARR	15.12.2007 07.02.2008 01.03.2010	1. PACT (Chief Executive Officer). 2. Personal Advocacy Trust Board (Trustee). **Spouse:** 3. Uruuruwhenua Health Incorporated (Manager).	1. Contracted to the Otago DHB to provide mental health services to Otago residents. 2. Nil. 3. Receives funding from Southern DHB.
Neville COOK	04.03.2008 04.03.2008 04.03.2008 26.03.2008	1. Board Member, Invercargill Licensing Trust. 2. Board Member, Invercargill Licensing Trust Foundation. 3. Councillor, Environment Southland. 4. Trustee, Norman Jones Foundation.	1. Possible conflict with funding requests. 2. Possible conflict with funding requests. 3. Nil. 4. Possible conflict with funding requests.
Kaye CROWTHER	09.11.2007 14.08.2008 14.08.2008 14.08.2008 12.02.2009	1. Employee of WHK south (Internal Auditors). 2. Trustee of Plunket Foundation. 3. Chair of the Management Committee for the car seat rental scheme for Plunket Southland. 4. Trustee of Wakatipu Plunket Charitable Trust. 5. Corresponding member for health and family affairs, National Council of Women.	1. Possible conflict when contract comes up for renewal. 2. Nil. 3. Nil. 4. Nil. 5. Nil.
Karen GOFFE	14.12.2006 01.05 2010	1. Iwi member of the Community Trust of Southland Health Scholarship Panel. 2. Employee of Nga Kete Matauranga Pounamu Charitable Trust (Wakatipu Business Development Manager).	1. Nil. 2. Possible conflict when contracts with Southern DHB come up for renewal.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Susan JOHNSTONE	 28.01.2008 06.11.2009 28.01.2008 16.12.2004	1. Otago Polytechnic (Deputy Chair). 2. Shand Thomson Ltd (Principal). 3. Clutha Community Health Company Ltd (Accountant via Shand Thomson; Consultant/Employee of Shand Thomson, Brian Dodds is Chairman). 4. Clutha Health Incorporated (Accountant via Shand Thomson, Consultant/Employee, of Shand Thomson, Brian Dodds is a Trustee;). 5. Shand Thomson Nominees Ltd; Shand Thomson Nominees (2005) Ltd; Abacus ST01 Ltd; Abacus ST02 Ltd, Abacus ST03 Ltd, Abacus ST04 Ltd Abacus ST05 Ltd; Abacus ST06 Ltd; Abacus ST99 Ltd. 6. Johnstone Afforestation Ltd (Director and Shareholder). **Spouse:** 7. Tuapeka Community Health Co Ltd (Consultant/Accountant via Shand Thomson). 8. Tuapeka Health Incorporated (Consultant/Accountant via Shand Thomson). 9. West Otago Health Ltd (Consultant/Accountant via Shand Thomson). 10. Roxburgh & Districts Medical Services Trust Board (Consultant/Accountant via Shand Thomson). 11. Wyndham Rest Home Incorporated (Consultant/Accountant via Shand Thomson).	1. OP places nursing trainees with Southern DHB. 2. Shand Thomson is a Chartered Accountancy practice. Clients can include general. practitioners and pharmacists, and do include Otago Southern Region PHO, Clutha Community Health Co Ltd and Clutha Health Incorporated. 3. CCHC receives nearly all its funding from Southern DHB. 4. CHI is the sole shareholder of CCHC. 5. Corporate Trustee Companies for Shand Thomson that potentially may be co trustees in trusts that hold shares in client companies that have contracts with Southern DHB – e.g. client pharmacy companies. 6. Personal forestry investment. No conflict. 7. Includes bullets 8 to 11 - these entities all receive funding from Southern DHB.
Fiona McARTHUR		1. Theme and event work, HZNZ Ltd. 2. Event work, Focus NZ (part of Grand Pacific Tours). 3. Working group member for Queenstown Plunket Rooms. 4. Trustee and Board Member, Disabilities Resource Centre, Queenstown. 5. Volunteer, Wakatipu Victim Support.	1. Nil. 2. Nil. 3. Nil. 4. Nil. 5. Nil.
James Malcolm MACPHERSON	23.11.2004 28.06.2005 06.10.2005 28.08.2007	1. Mayor, Central Otago District. 2. Otago Polytechnic. 3. Otago Forward (Member, Past Chairman). 4. Brilliant New Zealand Ltd (Principal).	1. Advocate for district interests, occasionally represent both consumers and suppliers of health services, explicitly link board membership with elected CODC position. No personal interest.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	07.08.2008 16.10.2009 13.12.2001 22.04.2003	5. Medco Ltd (part-owner of property). 6. Otago Community Hospice (Trustee). **Spouse:** 7. Centennial Health, Alexandra (General Practitioner). 8. Branch Medical Officer, ACC.	2. OP has training interests in common with the DHB, some potential for advocacy on behalf of the polytechnic. No personal interest. 3. Theoretical influence at policy level. No personal interest. 4. A consultancy which may have an involvement with health sector organisations. 5. Medco owns a building in Alexandra, intended for tenancy by primary health service providers, including Centennial Health Ltd. Potential conflict similar to that listed for spouse's involvement with Centennial Health Ltd. 6. OCH provides contracted services for Southern DHB. 7. Any DHB decisions relating to or involving primary health providers, PHOs or primary referred services likely to have a direct personal effect. Declare and withdraw as a matter of course. 8. ACC is a major customer of the DHB. Remote possibility of an influence, no personal interest.
Judith MEDLICOTT	13.12.2001 23.11.2004 13.12.2001 11.05.2007 11.05.2007	1. Ashburn Hall Charitable Trust (Trustee). 2. Medlicotts, Lawyers (Partner). **Daughter:** 3. Senior Clinical Psychologist, Intellectual Disability Service, Southern DHB. **Sons:** 4. Elder son, Partner in Medlicotts. 5. Younger son, General Practitioner, Island Bay, Wellington.	1. Private Psychiatric Hospital which contracts with Southern DHB to provide care for patients. Strong professional links between staff of the two institutions. 2. Law firm which has some Southern DHB patients and staff as clients. These clients may require careful assessment or referral to another firm. 3. Is employed to provide psychological services to Southern DHB patients and others in Otago/Southland. Some are also clients of Medlicotts Lawyers. 4. Lawyer for Karori PHO, Wellington – no likely conflict. 5. Partner at Island Bay Medical Centre – no likely conflict.
Katie O'CONNOR	11.05.2006 14.08.2008	1. Chair, Tui Motu: Independent Catholic Magazine Ltd. 2. Guidance Counsellor, St Peter's College, Gore.	1. Nil. 2. Nil.
Tahu POTIKI	15.12.2007 03.04.2008 24.11.2009 03.06.2010	1. Arataki Associates (Director). 2. Representative to Te Runanga o Ngai Tahu. 3. Trustee of Ngai Tahu Charitable Trust. 4. Board Member, Relationship Services NZ. 5. Board Member, Environmental Science and Research	1. Contracted to Southern DHB, funded provider in the past ie Araiteuru Whare Hauora Ltd. 2. & 3. Treaty Partner - affiliated providers may contract to Southern DHB. Te Runanga o Ngai Tahu has right of first refusal on disposal of property. 4. No apparent conflict. 5. CRI involved in public health research.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Marie-Louise ROSSON	17.04.2007 05.06.2007	1. Virgin Gold Ltd (Director). 2. The Otago Community Trust (Trustee). 3. Biosecurity Ministerial Advisory Committee (Member).	1. Nil. 2. Nil. 3. Nil.
Branko SIJNJA	07.02.2008 04.02.2009 22.06.2010	1. Clutha Community Health Company Limited (Director). 2. Clutha Health Incorporated (Board Member). 3. Rural Immersion Programme, Otago University School of Medicine (0.5 FTE Director). 4. Balclutha General Practitioners Limited (Employee).	1. Operates publicly funded secondary health services under contract to Southern DHB. 2. Owns for the Clutha community, the Health facility in Balclutha from which GP services are provided. 3. Possible conflicts between Southern DHB and University interests. 4. Employed as a part-time GP.
Richard John THOMSON	13.12.2001 23.09.2003 29.03.2010	1. Thomson & Cessford Ltd (Managing Director). 2. Susanna Shaya Imports Ltd (Directors). 3. Hawksbury Community Living Trust (Chairperson and Trustee). 4. HealthCare Otago Charitable Trust (Trustee). 5. Composite Retail Group (Director).	1. Thomson & Cessford Ltd is the Company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it. 2. Susanna Shaya Imports is a homeware importing Company. It has no dealings with Southern DHB. 3. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB. 4. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations. 5. May have some stores that deal with Southern DHB.
Tim WARD	14.09.2009 01.05.2010 01.05.2010	1. Partner, BDO Invercargill, Chartered Accountants. 2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT).	1. May have some Southern DHB patients and staff as clients. 2. Verdon is a participant in the employment incubator programme. 3. Supply of goods and services between Southern DHB and SIT.
Dot WILSON	12.03.2009 14.12.2006 14.08.2008	1. Member of National Executive Committee, Disabled Persons' Assembly (DPA). 2. Secretary of DPA Southland. 3. DPA representative on Workbridge Council. 4. President of Workbridge. 5. District Advisor for the Personal Advocacy Trust. 6. Workplace Support Chaplain.	1. Nil. 2. Nil. 3. Nil. 4. Nil. 5. Nil. 6. Nil. 7. Nil

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at October 2010

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
John Adams	27.05.2003 24.02.2004 23.11.2004 22.04.2008 18.02.2010	1. Dunedin School of Medicine (Dean). 2. Southern DHB Mental Health Service (staff member). 3. Ashburn Hall Charitable Trust (Trustee). 4. NZ Institute of Rural Health (Trustee). 5. Medical Council of New Zealand (Chair).	1. Possible conflicts between Southern DHB and University interests. 2. Possible differences in priorities and view between governance and employee. 3. The Ashburn Clinic is both a contractor to and provides similar services to the Southern DHB. 4. DHBs contract NZIRH to provide services. 5. At times, NZMC policy or opinion may conflict with or be critical of Southern DHB policy.
Vivian Blake	23.04.2007 17.03.2008 08.02.2009	1. Close association (husband) with Project Manager, DHBNZ. 2. Executive Director on the Board of the Health Roundtable (HRT). 3. Executive Member of the RDA MoU. 4. New Zealand Benchmarking Group (Chair).	1. Portfolio includes DHB National Procurement Strategy 2. The HRT facilitates benchmarking activity for 130 Australasian hospitals. 3. The MoU Executive provides advice to DHBs and considers strategies to improve the employment, recruitment and retention of Resident Medical Officers. 4. NZBG is the New Zealand Chapter of the Australasian Health Roundtable.
Richard Bunton	17.03.2004 29.04.2010	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd. 5. Deputy Chairman, Board of Cardiothoracic Surgery, RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	1. The only potential conflict would be if the Southern DHB decided to use this product for Southern DHB functions. 2. This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract. 3. This company provides private cardiological services to Otago and Southland. A potential conflict would exist if the Southern DHB were to contract with this company. 4. This company is one used for personal trading and apart from issues raised in '2' no conflict exists. 5. No conflict.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	23.02.2010	8. Otago Rugby Union (Director).	6. No conflict. 7. No conflict. 8. No conflict.
Alan Clarke	20.06.2010	Nil	
Murray Fosbender	03.02.2010	1. Private Orthopaedic Surgeon, Queens Park Medical Centre. 2. Owner operator Dog Tail Farm, Deep Water Marine Mussel Farms Limited.	1. Private/public contract accessed via Southern Cross Hospital. 2. Nil.
Robert Mackway-Jones	28.08.2007	1. Close association (wife) employed by Southland Hospital.	1. Reporting line to Purchasing Team leader.
Lexie O'Shea	01.07.2007	1. Trustee, Gilmour Trust.	1. Southland Hospital Trust.
Karyn Penno	17.12.2009	1. Fusee Rouge Café, Cromwell (Owner).	1. Nil.
Brian Rousseau	23.07.2004 09.03.2007 17.10.2008	1. Director of South Island Shared Services Agency Limited (SISSAL). 2. New Zealand Institute of Rural Health (NZIRH) (Trustee). 3. Southern Health Welfare Trust (Trustee).	1. SISSAL is owned jointly by the SI DHBs, and conducts planning and funding work and provider arm project work for the DHBs. 2. Otago DHB was a founding sponsor of the NZIRH. DHBs contract NZIRH to provide services. 3. Southland Hospital Trust.
Leanne Samuel	01.07.2007 01.07.2007 01.07.2007 29.10.2009 01.10.2010	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel. 3. Member of Board of Studies at Southern Institute of Technology. 4. Southland Medical Foundation Inc (Member) 5. Member of National Elective Services Productivity and Workforce Programme Steering Group.	1. Southland Hospital Trust. 2. Nil. 3. Potential conflict if the DHB purchases services from this organisation. 4. Southland Trust. 5. Nil.
John Simpson		Nil	
Ian Macara (in attendance at EMT as CEO of the Southern PHO)	26.08.2010	Nil	

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Tuesday, 28 September 2010, commencing at 10.30 am, in the Board Room, Southland Hospital Campus, Invercargill

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Present:	Mr L E Millar	Chairman
	Mrs H M Algar	
	Mr P A Barron	
	Ms M L Carr	
	Mr N M Cook	
	Mrs K J Crowther	
	Dr B Sijnja	
	Ms D A Wilson	
In Attendance:	Mr R Mackway-Jones	General Manager, Finance & Funding
	Mr B D Rousseau	Chief Executive Officer (from 11.10 am)
	Ms L Illingworth	Portfolio Manager, Planning & Funding
	Ms J Harvey	Regional Communications Officer (by videolink)
	Ms J Kloosterman	Board Secretary (by videolink)

Unconfirmed

1.0 WELCOME

The Chairman welcomed everyone to the meeting.

2.0 APOLOGIES

There were no apologies.

3.0 MEMBERS' DECLARATION OF INTEREST

The Chairman called for any adjustments or amendments to the Interests Registers. None were advised.

The Chairman asked if Committee members were aware of any agenda items with which they may have a potential conflict and reminded them of their responsibility to advise the meeting immediately should any potential conflict, actual or perceived, arise during discussions.

It was resolved:

> **"That the Interests Register be noted".**

Carried

4.0 PRESENTATION – PSA HOME SUPPORT WORKERS

Ms Jo Taylor, Organiser, Dunedin Office, PSA, presented a letter to the Committees (***Appendix 1***) requesting that the DHB make an investment in home support services so their members could improve their qualifications and receive remuneration that reflected the skills they needed to do the job, to ensure a quality service.

Ms Taylor informed the Committees that since writing her letter she had been informed that there had been no increase in funding during the current contracting round.

Mr R Mackway-Jones, General Manager, Finance & Funding, advised that the Government had provided additional funding to increase the wages of home support workers in the past and providers had received a small increase from 1 July 2010.

During discussion, Ms Taylor and management answered questions from members about the funding of home support services, pay rates, contractual quality standards and vocational training.

In response to the representations made, members sympathised with the position of home support workers and acknowledged the important contribution they made. The PSA was advised to raise their concerns with their employers, as the DHB could not interfere with the employment relationship between providers and their staff.

Ms Taylor was thanked for attending the meeting.

Mr B D Rousseau, Chief Executive Officer, joined the meeting at 11.10 am.

Unconfirmed

5.0 PREVIOUS MINUTES

Minutes of the joint meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee meeting held on 24 August 2010, were circulated with the agenda (tab 2) and taken as read.

It was resolved:

> **"That the minutes of the Disability Support Advisory Committee and Community & Public Health Advisory Committee meeting held on 24 August 2010 be approved and adopted as a true and correct record."**

Moved: Dr B Sijnja
Seconded: Ms M L Carr
Carried

6.0 MATTERS ARISING

Rural Primary Maternity Review

Mr R Mackway-Jones, General Manager, Finance & Funding, reported that he had made contact with Venture Southland. They would be sharing data and information on rural maternity services and the person they engaged would be invited to the DHB's workshops.

Public Health South

The Chairman requested clarification on whether the submission made by Public Health South on the Review of National Air Quality Standards should have been submitted to Board for approval.

It was suggested that the previous policy of the Otago DHB requiring submissions made in the District Health Board's name to be submitted to the Board for approval, be discussed at the next Board workshop.

7.0 ACTION SHEET

The Committees reviewed the status of the action sheet (tab 3) and requested a presentation to the next meeting from BPAC on managing community pharmaceuticals.

8.0 WORK PLAN

The Committees considered the work plan update and noted the following advice from management.

- Progress was being made on the Health Profile/Health Needs Assessment and consideration was being given to refreshing these on an annual basis in future.
- Proposed changes to the NZ Public Health and Disability Act 2000 would require DHBs to produce District Annual Plans (DAPs) that were not inconsistent with regional health service plans, and the National Health Board was reviewing Statement of Intent (SOI), DAP and strategic plan requirements, with a view to aligning these documents.
- To match resources to the work plan, and after a full consultation process, the Planning & Funding team had been realigned into five portfolios (Hospital and Specialist Services, Health of Older People and Disability, Public and Population Health, Primary/Community, and Mental Health), supported by a Service Development Manager and contracting team. Whilst, Planning & Funding had been centralised in Dunedin, Provider Arm service delivery would be on a "one service/many sites" basis, and engagement with Southland providers would not be reduced.
- Work on the review of existing Child & Youth Strategy would be completed during October and November, and recommendations made to the incoming Board.
- The General Manager, Finance & Funding, had met with the Otago Mental Health Non-Government Organisation (NGO) group and would be meeting with the Southland NGO group that afternoon to discuss the Mental Health Review. Following that, a discussion document would be developed and submitted to the Committees for approval.
- The Primary Health Organisation (PHO) assignment process had been completed and a single patient register (excluding Mornington PHO) was submitted in August for the quarter commencing 1 October.

Unconfirmed

The Committees requested a summary of the programmes that would be delivered by the Southern PHO.

Developing Services to Support Ageing in Place – Project Plan

Ms L Illingworth, Portfolio Manager, Health of Older People and Disability, presented the project plan for future planning and development of health of older people services, which was circulated with the agenda as Appendix 1.

During discussion management reported that:

- With the support of the Ministry, implementation of InterRAI had been brought forward to the current year and a "road show" would go out to internal and external providers to explain this assessment tool. It was anticipated that it would take 12-24 months to implement and realise results from InterRAI;

- The other work in the Project Plan focused on models of care, which would occur within overarching national strategy, the strategic direction set in the District Annual Plan (DAP) and the work plan approved by the Board;

- Planning & Funding staff were meeting with providers and a communications plan would be developed;

- The DSS expenditure recovery plan was on track.

Unconfirmed

It was resolved:

> **"That the Committees endorse the 'Developing Services to Support Ageing in Place' Project Plan'."**

Moved: Dr B Sijnja
Seconded: Ms M L Carr
Carried

Southern Primary Health Organisation (PHO) Update

An update from Mr I Macara, Chief Executive of the Southern PHO, was circulated with the agenda.

The Committees noted:

- That the Southern PHO had established a Community Advisory Group and were in the process of establishing a Maori Health Advisory Group and a Clinical Governance Group;

- That the Mornington PHO would continue to operate in its current form until the end of December, then it would join the Southern PHO.

Ms D A Wilson tabled a copy of *Inclusive Communities: What New Zealand local authorities and district health boards need to know about the rights of disabled people* (Disabled Persons Assembly (New Zealand) Inc, August 2010, third edition) and requested that this be raised with the PHO.

Health Profile

A progress report on the Health Profile and draft sections on cancer and child & youth were circulated with the agenda.

Mr R Mackway-Jones, General Manager, Finance & Funding, advised that the completion of the Health Profile was a huge undertaking and the sections completed were still in draft form. He asked members to email any feedback they had to him.

It was resolved:

> **"That the work plan and progress reports be noted."**

Moved: Mr N M Cook
Seconded: Mrs K J Crowther
Carried

9.0 NATIONAL REVIEW/REPORT OF AGED RESIDENTIAL CARE

The Executive Summary and key findings of the Aged Residential Service Review (September 2010) completed by Grant Thornton New Zealand Ltd was circulated with the agenda (tab 5) for members' information.

Members noted the document as informative but questioned whether the "over 65" population was still the appropriate starting point to measure the impact on aged care services, given that people were now healthier and more active at that age than in the past.

Unconfirmed

10.0 PUBLIC HEALTH SOUTH

The Committees considered a report on Public Health South's activities for August 2010 (tab 5) and noted:

- That Campylobacterosis incidence remained high;
- That Hokonui Horizons, a healthy community initiative, had failed to secure funding for a paid co-ordinator; however it still planned to continue functioning.

11.0 MONTHLY/QUARTERLY REPORTS

Financial Report

A financial summary report for the period ended 31 August 2010 was circulated with the agenda (tab 7) and was taken as read.

It was resolved:

> **"That the Financial Report be noted."**

Carried

12.0 GENERAL BUSINESS

Waitaki District Health Services Ltd (WDHSL) – Health Warrant of Fitness

In response to a query about WDHSL's initiative to offer Waitaki residents a "health warrant of fitness" at Oamaru Hospital, Mr R Mackway-Jones General Manager, Finance & Funding, said that he would ensure the laboratory test costs for these checks did not flow through to the DHB.

Primary Care Information System

In response to a query about work being undertaken on the West Coast on the interface between primary and secondary care information systems, Mr B D Rousseau, Chief Executive Officer, advised that he was not aware of that particular initiative but a lot of work was occurring at a national level on communication between the two systems.

13.0 NEXT MEETING

Tuesday, 26 October 2010, in Dunedin.

At 12.40 pm it was resolved that the public be excluded for the following agenda item:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Confidential Minutes	To allow activities to be carried on without prejudice or disadvantage	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(i) and 9(2)(j) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations.

Carried

The meeting closed at 12.43 pm.

Confirmed as a correct record:

Chairman ....

Date ....

Unconfirmed

PSA
Te Pūkenga Here Tikanga Mahi

24 September 2010

Mr Errol Millar
Chairperson
Southern District Health Board
Private Bag 1921
Dunedin 9054

Dear Errol

We are writing to you on behalf of PSA members working as home support workers within the catchment of the Southern District Health Board. PSA members work for a variety of home support providers in your region. They all receive funding for this service from the Southern District Health Board. We understand the funding contracts for the delivery of home support services are currently being considered and renegotiated with providers.

As frontline staff delivering this vitally important service in your area we request the opportunity to meet with the District Health Board or representatives of the Board. We would like to meet with you to present a picture of the aspects of our work and how our home support contributes to the functioning of the health service as a whole. We believe investing in home support services is a critical part of providing good health and disability services across the region and is an important component in improving the health status of our local population.

The support our members provide may include equipment, such as wheelchairs, housing or vehicle adjustments, or someone coming to the clients' home to help them with managing their home or with personal care. Where there is a primary carer home support workers may also cover that person taking a break.

As you will be aware DHB funded services provide support to those aged 65 and over, although many of the providers also provide home support to people with disabilities aged under 65, who are funded via the Ministry of Health. This can lead to a variation in the remuneration paid to workers employed in different parts of the same organisation, who may be performing largely similar work.

Precarious hours of work are a feature of home support services. An Auckland University study in 2004 found that home support workers were predominantly part time, casual (paid by client contact) and that 75% worked less than 25 hours a week[1]. Hours of work fluctuate depending on the changing circumstances and needs of people being supported. There is a lack of standard hours and workers have no guarantee of hours of work in the home care sector. Home support workers can arrive at a client's house and be advised "not today" or that the client is in hospital or even dead. In these circumstances the worker may not be paid.

There is a recent history of very high turnover in the sector. In 2004 turnover was 39% in home based services compared with 29%[2] in residential care (aged care and disability). While this figure is likely to have reduced with the recession it will not reflect greater employment satisfaction.

[1] Chal J. (2004) *Disability Support Services in New Zealand: The workforce survey,* Wellington

[2] ibid

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Our members in home support are low paid, both in real terms and relative to the level of responsibility and skills involved with the job. In the Auckland University study in 2004 wanting better pay was the most common reason given by workers interviewed for thinking that they might leave their job. Other reasons included difficulties with client, the physical demands of the job and the stress.

Home support workers need a wide range of skills including problem solving, physical dexterity, being observant to changes in behaviour or well being and judging how best to respond (as well as reporting on this). The type of skills required are often difficult to identify, which contributes to their being undervalued. This is not unusual for low paid predominantly female occupations and work has been done on describing and recognising them as 'articulation skills'.

> *…much service sector work… is best analysed through the conceptual framework of articulation work. This framework emphasises that integrating the elements of individual tasks and roles, and folding them into the ongoing flow of one's own work and that of the workplace, is a special 'supra' form of work*[3]*.*

This means not only recognising the elements of the tasks and challenges home support workers face but also the skill involved in integrating these into getting the job done effectively.

The way to ensure that home support workers acquire these skills in a systematic way is to provide resources for adequate training and for improved wages in acknowledgement of that. Funding is therefore inevitably linked to decent work and a quality service. There is a real need to fund these services so that steps can be taken to improve both wages and conditions.

However we are aware that these representations are being made to you at a time when the health sector is subject to financial constraints. We are also aware that many DHBs see home support services as one area in which savings can be made. Your DHB has already implemented cuts to these services. We believe this to be short-sighted because it will compromise the quality of the service available to vulnerable members of society and make it more likely that elderly people will require more expensive residential care earlier than they might otherwise do so. This has a direct impact on the number of hours providers can then offer home support workers compounding the problem.

Our request is that the DHB make an investment in home support services in order that our members may improve their qualifications and receive remuneration that reflects the skills that they need to do the job. The result will be a quality service that we can all be proud of.

We trust that you are willing to invite us in to make these representations to you in person and to have the opportunity to describe the work our members undertake.

Yours sincerely,

Jo Taylor
Organiser
Dunedin Office

c.c. Disability Support Advisory Committee

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[3] Hampson, I., Junor, A. and Barnes (2007), *Articulation Work Skills and the Recognition of Call Centre Competencies in Australia*, Sydney, UNSW p. 4 . See also the work of Anne Junor for the Pay and Employment Equity Unit of the Department of Labour , *Report on the Service Sector Skills Identification Project* http://www.dol.govt.nz/services/PayAndEmploymentEquity/resources/peeu-forum-presentations/junor.pdf

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC) AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

ACTION SHEET

As at October 2010

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
CPHAC 66-10/08	**Presentations** (Minute item 14.0)	Consideration to be given to inviting representatives of the rural hospital trusts to present to the Committees.	GMFF	Presentations for information will be scheduled as appropriate around the agreed workplan.	Ongoing
CPHAC 127-11/09	(Minute item 8.0)	Order of St John to be invited to present.	GMFF		
144-11/09	(Minute item 13.0)	Consideration to be given to inviting BPAC to present to the Committees.	GMFF		
CPHAC 146-04/10	(Minute item 5.0)	Department of Corrections to be invited to present on the implications of the planned capacity expansion at Milburn Prison.	GMFF		
CPHAC 153-05/10	(Workshop item 4.0)	Consideration to be given to inviting Public Health South (PHS) to present to the Committees, with a focus on South Island strategies and PHO interfaces.	GMFF		
CPHAC 145-03/10	**Community Pharmaceuticals** (Minute item 13.0)	Suggestion that letter to GPs be followed up with some practical advice on areas GPs could focus on, based on data from BPAC or other sources, to be discussed with Prof Murray Tilyard.	GMFF	Proposal still in development. Data being reviewed to inform proposal.	Ongoing
17-2010/09		Presentation to be made to the October meeting.	GMFF	Scheduled.	Completed
CPHAC 149-04/10	**Local Diabetes Teams** (Minute item 8.0)	Important data for Southland, particularly in relation to Māori, to continue to be available in future.	GMFF	Discussion with Southern PHO.	To be advised

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
CPHAC 154-05/10	**Child & Youth** (Workshop item 4.0)	Consideration to be given to including mental health and disability representation on the regional Child & Youth Advisory Group.	GMFF	Regional committee planned for 2011.	To be advised.
CPHAC 155-05/10	**Agenda Items** (Workshop item 5.0)	The following item to be put on a future agenda: ▪ Information on the Whanau Ora programme	GMFF	Information not yet received and hence implications and actions not developed.	To be advised.
011-2010/08	**DSS Utilisation** (Minute item 7.0)	Consideration to be given to a better way of presenting the information, eg by including commentary.	GMFF		
012-2010/08	**Disability Issues** (Minute item 7.0)	▪ Work Plan output to be amended to, "Strategies to implement UN Convention ***rights*** for people with disabilities", and ▪ Consideration to be given to how this will be implemented and prioritised.	GMFF	Completed.	Completed To be advised.
014-2010/09	**Public Health South** (Minute item 6.0)	▪ Clarification to be provided on whether the submission made by PHS on the Review of National Air Quality Standards should have been submitted to the Board for approval. ▪ The previous policy of the Otago DHB requiring submissions made in the DHB's name to be submitted to the Board for approval, to be considered at the November Board workshop.	GMFF CEO		
015-2010/09	**Primary Health Organisation (PHO)** (Minute item 8.0)	▪ Summary to be provided of the programmes to be delivered by the Southern PHO. ▪ *Inclusive Communities: What New Zealand local authorities and district health boards need to know about the rights of disabled people* (Disabled Persons Assembly; August 2010, third edition) to be brought to the attention of Southern PHO.	GMFF	Agenda item. Completed.	Completed Completed

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
016-2010/09	**WDHSL – Health Warrant of Fitness** (Minute item 12.0)	Check to be made that the laboratory test cost for these checks do not flow through to the DHB.	GMFF	In progress.	

DSAC / CPHAC Workplan 2010/11						
Output	**Timeframe**	**Reporting Frequency**	**Progress**			**Comment**
			Behind	**On Target**	**Complete**	
Child & Youth						Recommendations report due December. Southland review complete, Stock take to be undertaken at Otago 18 Oct to 19 Nov.
- Review Existing Child & Youth Strategy	Dec 2010					
Community Pharmaceuticals				√		Working within national initiative plus some local work scoped with BPAC. BPAC to attend DSAC/CPHAC October meeting
Disability Issues						
- Strategies to Implement UN Convention rights for People with Disabilities						
DSP / RSP						
- Outcomes Framework				√		Sector template developed and included in SOI
- Health Profile	Nov 2010		√			
- Health Needs Assessment			√			To start following profile work, essentially a gap analysis
- Stakeholder Consultation				√		Not scheduled as yet
Health of Older Persons						
- DSS Expenditure Levels	Oct 2010	Monthly		√		
- Developing Services to Support Ageing in Place.	Nov 2010			√		
- InterRAI Implementation	2011			√		To be assessed for earlier implementation
- South Island HOP Network				√		
Mental Health						
- Establish Single NASC Provider			√			Part of the wider review
- Standardise NASC Eligibility Criteria			√			Part of the wider review
- Project to Review Service Funding Configuration	Mar 2011			√		ASMS feedback being considered
- South Island Regional Service Models of Care	Oct 2010			√		Recommendations report due end Sept
- PRIMHD, Mental Health Data Programme						
Primary Care						
- PHO Development	Oct 2010	Monthly	√			
- After Hours	TBA		√			Pending PHO establishment
- Primary Maternity	Jun 2011		√			Workshops being scheduled
- Shifting Services from Hospital to Community			√			
- Long-term Conditions			√			
Rural Health						
- Lakes District Hospital			√			Managed by CEO/COO
- Dunstan				√		
- Oamaru				√		Schedule review WIP
- Clutha				√		
- Gore						

DSAC / CPHAC Workplan 2010/11						
Output	**Timeframe**	**Reporting Frequency**	**Progress**			**Comment**
			Behind	**On Target**	**Complete**	
- Smaller rural trusts	Dec 2010		√			Schedule review WIP
Performance Monitoring - SOI Indicators / DAP Measures - Accountability Documents Reporting / Health Target - Contract Performance (by exception) - PHO Performance Programme - Auditing Activity (by exception) - Oral Health - Before Schools Checks Programme	Quarterly					

Briefing to:	Disability Support Advisory Committee and Community and Public Health Advisory Committee		
Subject:	Summary of programmes to be delivered by Southern PHO		
Author:	Kiri Young	**Date:**	15 October 2010
Purpose of Report :	√ **For Information Only**		**Decision Required**
Recommendation:	That the committee note this report in respect to action point no. 015-2010/09		

Key Issues

No known Issues

Key Activity in this Reporting Period

1. Establishment of a Single PHO " Southern PHO on 1 October 2010

2. Executed Deed of assignment between Southern PHO and eight PHOs across Otago and Southland effective e 1 October as follows

   (a) Hokonui PHO Limited
   (b) Invercargill – Te Ara a Kewa PHO Limited
   (c) Takitimu PHO Limited
   (d) Wakatipu PHO Limited
   (e) The Otago Southern Region Primary Health Organisation
   (f) Rural Otago PHO
   (g) Taieri and Strath Taieri Primary Health Organisation
   (h) Dunedin PHO t/a Well Dunedin PHO

3. Mornington PHO/Practice to join Southern PHO on 1 January 2011

Key Upcoming Activity

Attached summary outlines the programmes that have been assigned by the previous eight PHOs to Southern PHO as at 1 October 2010. All of these programmes will be provided between 1 October 2010 to 31 December 2010 ("the preparatory phase") in accordance with each programme plan previously approved between the assigning PHO and Southern DHB.

Southern PHO will prepare programme plans for Southern PHO activity and continued programmes from 1 January 2010 during the preparatory phase (1 October 2010 to 31 December 2010). Southern PHOs programme plans are to be submitted to Southern DHB for our comment and approval in November 2010.

Southern PHO Programmes as at 1 October:
as per Deeds of Assignment

Service Line	Specific Programmes	Assigning PHO
Careplus		All PHOs
Health Promotion	Active Families (Sport Southland)	Well Dunedin
	Celebrating Seniors (TaiChi)	Invercargill - Te Ara a Kewa
	Diabetes Patient Education	Hokonui/Invercargill - Te Ara a Kewa /Takitimu/ Wakatipu
	Green Prescription	Well Dunedin
	Health Promotion Coordinator	Rural Otago
	Healthy Families Programmes (a number of Projects per PHO)	Hokonui/Invercargill - Te Ara a Kewa /Takitimu/ Wakatipu
	Healthy Lifestyles/OISA	Well Dunedin
	Youth Support Programmes	Invercargill - Te Ara a Kewa/Takitimu/
HPV Programme (Southland)	HPV Onging immunisation programme	Southland x 4
Other Contract Lines	Annual Diabetes Review	Well Dunedin/ All Southland PHOs
	Diabetes Workforce Development	Well Dunedin/All Southland PHOs
	Palliative Care	All PHOs
	Puketai Residence Health	Well Dunedin
PHO Performance Programme	CVD RA	Well Dunedin/Rural Otago/Otago Southern Region/All Southland PHOs
	24 Hour Blood Pressure Monitor	Well Dunedin
	Practice Support	Otago Southern Region
Primary Mental Health	PMH HML Procare	Rural Otago
	PMH Initiatives and Innovations	All PHOs
	PMH Workforce Development	OSRPHO/ PHO MSSL
Rural Service Lines	HML Procare - Telephone Triage	OSR/RO/TST/WD/HK/TK PHOs
	Middlemarch Nursing Service	TSTPHO
	Rural Health Development	All PHOs
	Rural Reasonable Roster	All PHOs
	Research & Sabbatical	All PHOs
	Rural Workforce Retention	All PHOs
	Rural After Hours Overnight	All PHOs
	Specialist Nurse Development	OSR/RO/HK/TK/WK

Services to Improve Access	Bluff Community Vehicle	Invercargill
	Breastfeeding Peer Support	Invercargill - Te Ara a Kewa /Wakatipu
	Care Vouchers	Invercargill - Te Ara a Kewa
	Cervical Smears	Otago Southern Region/Hokonui
	Chronic Health Management Project	Taieri & Strath Taieri
	Community Wellbeing	Takitimu
	Dunedin After Hours Overnight	Well Dunedin/TSTPHO
	Early Intervention/Prevention Nursing Service	Hokonui
	Emergency Prescription	Well Dunedin/TSTPHO
	Falls Prevention	Takitimu
	Families & Children Initiative	Wakatipu
	Foot Clinic	Hokonui
	Free Targeted Health Check	Well Dunedin/Takitimu
	Get Dotted	Wakatipu
	Glenorchy Community Nurse	Wakatipu
	Gore School Clinic	Hokonui
	I-TAaK Community Nurse	Invercargill
	Kurow Area Mobile Nurse Clinics	Rural Otago
	Language Line	Well Dunedin/Taieri & Strath Taieri
	Linkage Worker	Takitimu
	Maori Symposium	Invercargill - Te Ara a Kewa
	Maori Youth Leadership Programme	Otago Southern Region
	Marae & Community Health Days	Invercargill
	Migrant Population	Takitimu
	Milford Clinic	Takitimu
	Mobile Nurse Clinic	Hokonui
	Murihiku Marae Vehicle	Invercargill
	Pacific Island Trust Vehicle	Invercargill
	PIACT Linkage Worker	Invercargill
	Polypharmacy	Wakatipu
	Respite Care	Invercargill - Te Ara a Kewa
	Sexual Health Services - Wanaka	Rural Otago
	Sport Clutha Programme (Sport Otago)	Otago Southern Region
	Subsidised Podiatry Programme	Taieri & Strath Taieri
	Tai Chi	Invercargill - Te Ara a Kewa/Wakatipu
	Taieri College Sexual Health Programme (Nursing Services)	Taieri & Strath Taieri
	Transport Assistance Scheme	Well Dunedin/TSTPHO
	Under 25 Sexual Health	Well Dunedin/TSTPHO
	Wakatipu Sexual Health Clinic	Wakatipu
	Year of Care Pilot	Taieri & Strath Taieri

Southern District Health Board

Briefing to:	Disability Support Advisory Committee and Community and Public Health Advisory Committee
Subject:	New Zealand Disability Strategy / United Nations Convention on Rights of Persons with Disabilities – Provider Arm Stock take
Author:	Leanne Illingworth, Portfolio Manager
Date:	14 October 2010
Purpose of Report :	**√ For Information Only** **Decision Required**
Recommendation:	**That the Committee note the contents of this report.**

Key Issues

Disability issues and ensuring that the Southern DHB is progressing activity to ensure implementation of the United Nations Convention on Rights of Persons with Disabilities is a key area of activity within the Southern DHB CPHAC / DSAC work plan for 2010/11.

Key Activity in this Reporting Period

A survey led by Planning and Funding was undertaken across both sites of the Provider Arm to ascertain from the respective Provider Arms activity that is currently in place or planned to be progressed with regards to the New Zealand Disability Strategy and UN Convention on Rights of Persons with Disabilities.

The template for the stock-take was based on the following objectives of the current Southern DHB NZDS work plan:

1. Workforce development focused on raising disability awareness and capability.
2. All health and disability services are accessible to people regardless of their disability.
3. Southern DHB Planning and Funding and Provider Arm staff are well connected to the external disability networks and regularly meet with them to have mutual understanding and the achievement of the DSAC's objectives.

Responses from both the respective Provider Arm sites are attached as **appendix 1**.

Key Upcoming Activity

The current Southern DHB NZDS work plan will be updated to reflect the information provided by the Provider Arm, and will also include NGO activity.

The work plan will then be reported to the Committee on a six-monthly basis.

DSAC – New Zealand Disability Strategy / United Nations Convention on Rights of Persons with Disabilities

Stocktake – Southern DHB (Sept / Oct 2010)

Southland Provider Arm:

Objective	Comment – for updating
1. Workforce development focused on raising disability awareness and capability	Clinical staff can complete a self directed learning package on the Health and Disability Services Act including the Code. Newsletters from various organisations e.g. DRC, MS society etc are widely available Annual education is provided in some areas External training via community organisations A disability awareness video is available for presentation at staff meeting and has been used widely throughput the organisation Lessons learnt through other organisations e.g. HDC reports are discussed and implemented as appropriate Southland/Lakes Hospital has attained certification and accreditation against the Health and Disability sector standards including the provision of information on access and health and disability services.
2. All health and disability services are accessible to people regardless of their disability	OT's trained in barrier free access who have assessed the organisation and given recommendations regarding access. Home visits are conducted where necessary. There is regular networking with community groups re access for those with physical and intellectual impairments.
3. OSDHB P&F and Provider Arm are well connected to external disability networks and regularly meet with them to enhance mutual understanding and the achievement of DSACs objectives.	Southland Provider Arm staff representatives attend Southland Combined Disability Group meetings. The Future Directions Mental Health Network provides a strong platform to maintain connections. In addition the provider arm MHS has a regular presence in a number of interagency forums and regional forums.

DSAC – New Zealand Disability Strategy / United Nations Convention on Rights of Persons with Disabilities

Stocktake – Southern DHB (Sept / Oct 2010)

Otago Provider Arm:

Objective	Comment
1. Workforce development focused on raising disability awareness and capability	**The Knowledge Centre has included a session on disability awareness in the mandatory training modules for staff.** **Application has been made to Te Pou (who now fund disability training) to undertake a staff workshop locally for disability awareness.** **This is ongoing.** **Allied Health:** **Physiotherapy / Occupational Therapy and Speech & Language Therapy. Training and credentialing to meet the MOH, Disability Support Services new accreditation framework for health professionals undertaking assessments that may then result in applications for equipment and modification services for people with disabilities. This includes basic through to complex equipment across the lifespan.** **Application through Te Pou for funding of a Stroke Study Day for staff and Rehabilitation Assistants. Course run by a CHCH based OT (Sarah Mather)**
2. All health and disability services are *accessible* to people regardless of their disability	**All Buildings meet compliance standards for disability access.** **No access issues were identified during the last certification audit completed in 2010.**
3. OSDHB P&F and Provider Arm are well connected to external disability networks and regularly meet with them to enhance mutual understanding and the achievement of DSACs objectives.	**Two senior representatives identified to meet with the Disability Network Group.**

PUBLIC HEALTH SOUTH
PUBLIC HEALTH SERVICE REPORT TO THE SOUTHERN DHB
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
September 2010

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

Settings and Lifestyles

Outcome 1	Reduce the impact and incidence of smoking related disease
Outcome 2	Reduce the impact and incident of obesity and overweight
Outcome 3	Reduce the impact and incidence of harm from alcohol and other drugs

Alcohol

- A public forum was organised in Queenstown to discuss the policy statement from the Minister of Justice relating to alcohol which was released in response to the law commission review 'Alcohol in our Lives'. The forum was organised by the Queenstown Youth Access to Alcohol group and the Queenstown United in Violence and Alcohol Reduction group and chaired by Public Health South. The members of these groups come from a variety of government and non-government organisations. The guest speakers were Clive Geddes (Mayor of Queenstown) Russell Gray (Director of Good Group Ltd) and John Fookes (Senior Sergeant Queenstown Police) and each speaker spoke about alcohol issues from their perspective. The purpose of the meeting was to increase understanding and raise awareness about the proposed alcohol law reforms.

Smokefree

- The Murihiku Smokefree Coalition (of which Public Health South is a member) identified Dental Therapists as suitable recipients of ABC training given their level of interaction with the community and the opportunity for them to provide smoking cessation advice. The ABC approach prompts health professionals to:
  - A – **Ask** patients about their smoking status
  - B – Give **brief** advice to stop smoking to all people who smoke, regardless of their desire or motivation to quit
  - C – Offer and provide, or refer for evidence-based **cessation** support. This includes the offer of Nicotine Replacement Therapy and referral to a cessation provider or Quitline.

  Consequently the Southland Primary Care Smokefree Coordinator provided this training as part of a professional development day for Dental Therapists. The Dental Therapists were also provided with the new smoking cessation services cards which were developed by the Murihiku Smokefree Coalition using three images from Public Health South's Smoking Affects Lives campaign.

Nutrition & Physical Activity

- Public Health South staff in Invercargill were involved with the Pacific Island Advisory and Cultural Trust 'Healthy Food for Pacific People' day. Staff were involved with a cooking demonstration showing how to prepare Pacific Island food in a healthy way. This also provided an opportunity to promote the food security fruit and vegetable project where families from this community can obtain a week's worth of fruit and vegetables for the cost of $15. Support was also given to the organisers to ensure food available on the day was appropriate.

Communicable Disease and Food Safety

Outcome 4 Reduce the impact and incidence of communicable disease

Biosecurity

- Eight vessels travelling through international waters where the first ports of call in New Zealand were Otago and Southland have been issued with a pratique, a quarantine clearance. This is required under the New Zealand Health (Quarantine) Regulations 1983, to be granted before most vessels travelling from an overseas port are allowed to land alongside a New Zealand port and have crew or passengers disembark.

Communicable Disease

- Influenza-like illness rates are declining and rates for the Southern DHB area are now at baseline levels which are less than 50 cases per 100,000 people. A small number of confirmed cases of H1N1 have been detected through sentinel surveillance.
- Attached below is a table of the cases of suspected and confirmed diseases notified to the Medical Officers of Health in Otago and Southland for September 2010.

	September 2010									September 2009 Total
Disease	Waitaki District	Central Otago District	Queenstown-Lakes District	Dunedin City	Clutha District	Southland District	Gore District	Invercargill City	Total	
Campylobacteriosis	3	5	3	9	7	8	4	5	44	27
Cryptosporidiosis	1				2	2			5	8
Dengue Fever				2					2	-
Gastroenteritis - unknown cause				1				1	2	-
Giardiasis			4	2		1	2	1	10	7
Hepatitis C						1			1	-
Invasive pneumococcal disease	1	1		2		3	1		8	7
Lead absorption				5					5	1
Legionellosis		1		2					3	1
Meningococcal Disease									-	1
Non Seasonal influenza A (H1N1)			2	4				1	7	1
Pertussis			1	4				5	10	3
Salmonellosis		2		11		5	4	1	23	17
Shigellosis									-	1
Tuberculosis				1					1	-
VTEC/STEC infection									-	1
Yersiniosis								1	1	2
Grand Total	5	9	10	43	9	20	11	15	122	78

Healthy Environments

Outcome 5 Promote safe and healthy social and physical environments

Hunga Tiaki Waka Hauora a Tonga – Maori Environmental Health Contract

- The partnership approach to working together between Public Health South and Papatipu Runaka organisations Kai Tahu Ki Otago Ltd and Te Ao Marama Inc is manifested in the above contract with the Ministry of Health. All three organisations have an interest in monitoring and improving aspects of Otago and Southland's physical environment which impact upon public health. In September the three organisations commenced a regional environmental health profile which will identify those aspects of the environment which are of most concern to Maori and have the greatest impact upon health. This will involve consultation with each of the Runaka in Otago and Southland as well as key stakeholders identified by the Runaka. The completed profile will inform a shared action plan to be implemented over the remainder of the contract period.

Health Promoting Schools

- Public Health South is coordinating four workshops next term for student and teacher health leaders, in collaboration with Sport Otago, Heart Foundation, Cancer Society and University of Otago Department of Preventative Medicine. The purpose of the workshops is to develop health promotion leadership in participating schools. To encourage implementation of the learning outcomes provided at the workshop, the University of Otago has made funding available to the value of $500 to four of the participating schools. One workshop will be specific to schools with year 7 and 8 students and intermediate schools; two for other primary schools and if there is sufficient interest a workshop will be held in Oamaru. Invitations have been sent out to 40 schools, with applications closing at the end of the third term.

Resource Management

- Public Health South's Professional Director for Health Protection made a presentation to a leadership team from Hawkes Bay Health at their request regarding Public Health South's Submissions Committee and the process used to assess and submit on consents. Public Health South established this system in 2008 in order to ensure all resource consent applications received were suitably screened and any submissions made in response were approved by senior District Health Board management. Hawkes Bay Health felt this was a good template for their service to follow as the processes appear robust and proven and have indicated a similar process will be implemented.

Mental Health

- Public Health South has been working with the rural community in Southland on the Rural Men's project which has involved workshops, provision of resources, and support to men living in rural Southland. This group had previously been identified as vulnerable to mental heath issues due to a low level of access to services, high alcohol use and a culture of minimising stressful events. As a follow on from this and in response to the declaration of the adverse weather situation recently experienced in Southland, staff have been actively supporting the rural recovery group led by the Otago and Southern Rural Support Trusts (Federated Farmers). Public Health South has agreed to supply and distribute resources, contribute to planned community seminars and events, provide material for media releases and newsletters as well as supporting planning. It is anticipated that an 18 month response plan will be required at the very least with anticipated extra demand on mental health (including suicide prevention), alcohol and addiction services, social work, family violence and community services. First responders (i.e. those first coming into contact with affected farmers) are particularly concerned with obtaining knowledge and strategies to provide assistance without escalating fears and concerns among those they are working with.

  Public Health South provided concerned first responders with information on the Primary Health Organisation's Brief Intervention Service, which is likely to be an extremely valuable resource in these circumstances. The Primary Health Brief Intervention Service is a joint initiative between Southern DHB Mental Health Services and the Primary Health Organisation. The service offers free

access to the Brief Intervention Team with up to five sessions of support, assessment, treatment or referral to appropriate agencies.

PUBLIC HEALTH SOUTH
SMOKEFREE DHB REPORT
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE
August and September 2010

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

Smokefree Steering Group

- During August and September the DHB Smokefree Steering Group met twice. The group continues to provide support and direction for achieving the Better Help for Smokers to Quit health target and developing a regional Tobacco Control plan.

Smokefree Coordination in Primary Care

- To implement the ABC for Smoking Cessation model in primary care PHOs are aiming for a goal of 80% of identified smokers in primary care being offered advice and help to quit smoking, measured through the PHO Performance Programme.
- Over 80% of practice nurses across the Southern DHB region are now registered Quit Card Providers, and have been trained in the ABC approach to Smoking Cessation by the Primary Care Smokefree Coordinators
- The Ministry of Health has provided all general practices with resources to support the implementation of the ABC approach in primary care, and information system updates to capture smoking indicators in patient notes.
- The Primary Care Smokefree Coordinators have been working at getting buy-in from GPs

Health Targets & ABC Strategy

- The Health Target requires DHBs to provide 80% of all hospitalised smokers advice and support to quit smoking by July 2010; 90% by July 2011 and 95% by July 2012.
- Progress towards the health target is slow, with both Otago and Southland decreasing slightly between August and September. Results for August and September for Southern DHB (bold), and Otago and Southland areas are presented below.

Target	**% hospitalised smokers identified** 19.4% Otago, 23.8% Southland	**% smokers receiving ABC** 90% Advice and help to Quit
August 2010	**15.5%**	**66.2%**
Otago	15.5	66.3
Southland	15.5	66.0
September 2010	**15.0%**	**64.7%**
Otago	14.4	66.1
Southland	15.9	62.5

- A report and action plan outlining work to be undertaken to achieve the health target was submitted to the CEO in September 2010.
- During Quarter 4 Southland was ranked 6th (62% advice and help to quit) and Otago 15th (52%) nationally for DHB performance towards the Better Help for Smokers to Quit health target. Two DHBs met the target of 80% in 2009/10.

Southern DHB Consolidated Financial Performance September 2010

Month Actual $' 000	Month Budget $' 000	Month Variance $' 000		Year to Date Actual $' 000	Year to Date Budget $' 000	Year to Date Variance $' 000	Annual Budget $' 000
67,202	67,317	(115)	Revenue	202,894	203,133	(239)	808,467
(24,414)	(24,759)	345	Less Personnel Costs	(73,476)	(74,634)	1,158	(298,050)
(43,250)	(43,602)	352	Less Other Costs	(131,642)	(130,961)	(681)	(525,332)
(462)	(1,044)	582	Net Surplus / (Deficit)	(2,224)	(2,462)	238	(14,915)

The annual plan has been re-submitted and is not yet approved. This report is against the resubmitted plan.
The YTD result is a deficit of $2.2 million, and slightly better than the budgeted deficit of $2.4 million

Summary of Results

Month Actual $' 000	Month Budget $' 000	Month Variance $' 000		Year to Date Actual $' 000	Year to Date Budget $' 000	Year to Date Variance $' 000	Annual Budget $' 000
25	(33)	58	Governance	186	(100)	286	0
(1,527)	(1,617)	90	Funds	(4,594)	(4,204)	(390)	(16,255)
1,040	606	434	Provider	2,184	1,842	342	1,340
(462)	(1,044)	582	Net Surplus / (Deficit)	(2,224)	(2,462)	238	(14,915)

DHB Governance

Month Actual $' 000	Month Budget $' 000	Month Variance $' 000		Year to Date Actual $' 000	Year to Date Budget $' 000	Year to Date Variance $' 000	Annual Budget $' 000
706	705	1	Revenue	2,024	2,024	0	7,645
(316)	(320)	4	Less Personnel Costs	(791)	(959)	168	(3,736)
(365)	(418)	53	Less Other Costs	(1,047)	(1,165)	118	(3,909)
25	(33)	58	Net Surplus / (Deficit)	186	(100)	286	0

Comment
There are some one off salary costs in the month, YTD variance due to FTE 5 less than budget
Transport & Democracy costs are also below budget, both for month and YTD

DHB Funds

Month Actual $' 000	Month Budget $' 000	Month Variance $' 000		Year to Date Actual $' 000	Year to Date Budget $' 000	Year to Date Variance $' 000	Annual Budget $' 000
63,695	63,476	219	Revenue	191,414	191,444	(30)	763,431
0	0	0	Less Personnel Costs	0	0	0	0
(65,222)	(65,093)	(129)	Less Other Costs	(196,008)	(195,648)	(360)	(779,686)
(1,527)	(1,617)	90	Net Surplus / (Deficit)	(4,594)	(4,204)	(390)	(16,255)
			Expenses				
(46,549)	(45,843)	(706)	Personal Health	(138,962)	(137,684)	(1,278)	(550,731)
(7,148)	(7,313)	165	Mental Health	(21,622)	(21,963)	341	(87,660)
(968)	(994)	26	Public Health	(2,976)	(3,155)	179	(11,484)
(9,697)	(10,075)	378	Disability Support	(29,942)	(30,333)	391	(120,204)
(155)	(163)	8	Maori Health	(482)	(489)	7	(1,962)
(705)	(705)	0	Other	(2,024)	(2,024)	0	(7,645)
(65,222)	(65,093)	(129)	Expenses	(196,008)	(195,648)	(360)	(779,686)

Comment / Key Variances

Community Pharmaceuticals for the month was more in line with budget, however YTD is $519k unfavourable

Rest Home ARC however continues to track unfavourably against budget with the YTD variance now $760k

Revenue
The revenue variance has offsetting expenditure variances in the public health area

Personal Health Payments
Community Pharms is $519k unfavourable YTD, but is still viewed as a possible timing issue.
There is a PHO management fee variance due to delays in the PHO start up but this is expected to be clawed back by year end

The travel and accommodation budget continues to be under pressure with a 9% YTD unfavourable variance

Mental Health
MH is again underspent, due to continued FTE vacancies in the provider-arm for which funding is clawed back

Domestic assistance support allocated from MH NASC is now captured in the MH area along with the budget

DSS Payments
Home support costs are now $576k favourable to budget YTD
Rest home level residential care costs are $761k over budget (10%)
The rest home variance is not related to the home support variance

DHB Provider

Month				Year to Date			Annual
Actual $' 000	Budget $' 000	Variance $' 000		Actual $' 000	Budget $' 000	Variance $' 000	Budget $' 000
38,661	38,804	(143)	Revenue	116,089	116,458	(369)	464,013
(24,098)	(24,439)	341	Less Personnel Costs	(72,685)	(73,676)	991	(294,314)
(13,523)	(13,759)	236	Less Other Costs	(41,220)	(40,940)	(280)	(168,359)
1,040	606	434	Net Surplus / (Deficit)	2,184	1,842	342	1,340

Comment / Key Variances
FTE are 89 under budget which drives the favourable salary variance and bottom line result
Clinical supplies are 7% or $1,288k overspent for the three months

Revenue

The bulk of the revenue variance relates to the clawed back mental health funding from unfilled FTE positions
ACC revenue is also down due to lower demand

Personnel
Medical salaries and outsourced costs overall are below budget
Nursing salaries are $362k under budget driven by below budget FTEs
Allied Health is $598k under budget and again is attributable to below budget FTE levels
Management / Admin FTE are 29 below budget with costs also below budget by $128k

Outsourced Costs
Locum costs are $307k below budget with some difference in the mix allowed between locum costs and those in staff numbers

Outsourced clinical services are also favourable to budget ($254k), due to no costs incurred to date (Mercy Hospital).

Clinical Supplies
Treatment disposable costs and Implants and Prosthesis costs are significantly over budget

Infrastructure / Non clinical costs
All categories are within budget

20 District Health Boards

12th October 2010

COMMUNITY PHARMACY PROGRESS UPDATE

This update contains information about

1. **Progress implementing the 2010 Pharmacy Services Agreement**
2. **Progress on the strategic work for the 2011 Pharmacy Services Agreement: five agreed projects with four discussion documents being released for comment during October 2010**
3. **Expected timeframe for consultation on Pharmacy Services Agreement 2011.**

Your pharmacy representatives support this update being sent, and are closely involved with the processes. DHBs and PHARMAC are committed to working with the sector through the next phases, and express this as joint signatories to the update, and inclusion of the activity in the 20 DHBs Annual Plan 2010/11 and PHARMAC's work programme.

In the past year community pharmacy representatives, DHBs, PHARMAC, Ministry of Health and a prescriber representative have met regularly. The meetings focus on national directions for the Pharmacy Agreement. They do not cover policy matters, nor local DHB-Pharmacy arrangements.

The following principles guide these meetings:

a) Maximising value to patients, with emphasis on improving safety, and self management
b) Open transparent processes, with decision making processes clear
c) Stakeholder involvement
d) Explicitly valuing pharmacists' clinical skills and contribution to primary care delivery
e) The need for prioritized, affordable development of community pharmacy services within DHB funding parameters, with risks managed.

We are all operating in a tight financial environment. The 2011 Pharmacy Agreement package needs to be achievable within DHBs' funding envelopes.

The work we have been doing together, the better understanding we have of each other's positions, and the time we have available to plan change are all positives. Achieving change will be a challenge but our shared goal of sustainable pharmacy services to all New Zealanders, and the productive working relationships that we have invested in, will spur us to meet it.

Progress Report: Pharmacy Services Agreement 2010 Package

Considerable progress has been made in implementing the current Pharmacy Agreement.

Deliverables Issues Register 2009; Pharmacy Agreement 2010 Package	Status
Agreement 1 March 2010 – 31 August 2011	Achieved
DHBs will not intervene to lower forecast dispensing fee volumes/expenditure growth rate	Achieved
DHBs will not ask PHARMAC to intervene but PHARMAC will do usual business	Achieved
DHBs will continue to undertake local initiatives that improve prescribing quality and patient outcomes	Achieved
NRT paid at $5.30	Achieved
Online claiming	Achieved
Four claim periods per month	Achieved
Final payment from remaining Wholesale Uplift Fee fund	Achieved
New funding of $500,000 for 2010/11 to manage the additional costs being passed onto community pharmacies by wholesalers, while PHARMAC undertakes Special Foods, HP1 and HP3 consultation processes	Achieved
Brandswitch Pool 2010/11 (up to $3M)	Achieved
"Ordinary Business Hours" specified; removal of Urgent & After Hours distinction	Achieved
Audit Reports: DHBs will respond within 20 days of receipt from A&C	Achieved
Faxed Scripts	Not achieved
Charging provisions to be adhered to and no blanket charging	Partially achieved
Generic substitution agreements encouraged	Achievement in progress
Process to be paid for Uncollected Medicines	Not achieved
Date of Dispensing definition: date the medication handed to patient, rather than date of processing	Not achieved
Declining services clarified	Achieved
Close Control provisions unchanged; Pharmaceutical Schedule rules review project underway	Achieved
Patients Near Death: when claims can be made	Achieved
Funding Model Project under auspices of multiparty Steering Group	Achieved

Note: Faxed scripts changes are dependent on the Medicines Act being amended. The Date of Dispensing definition and process for Uncollected Medicines cannot be practically implemented by the Pharmacy Services Advisory Group working with software vendors during the term of the current Agreement. They will remain on the Issues Register for discussion for 2011.

2. Progress Report: Strategic Projects for Pharmacy Services Agreement 2011

Five projects are underway. They will inform the Pharmacy Services Agreement 2011 consultation process. The Steering Group has agreed that the projects will be led either by PHARMAC or by DHBs. Community pharmacy representatives will be involved.

You are invited to be involved by responding to the four discussion documents out from October 2010 with staggered response dates to December 2010. Formal consultation proposals will then follow from December 2010 to March 2011. The fifth project depends on the outcome of the first four, so a process and timeframe have not yet been developed.

PROJECT	LEAD
Review of Pharmaceutical Schedule Rules: Special Foods	PHARMAC
Review of Pharmaceutical Schedule Rules: Close Control	PHARMAC
Review of Pharmaceutical Schedule Rules: Distribution of Higher Cost Medicines to Patients	PHARMAC
Pharmacy Services to People in Residential Care	DHBs
Pharmacy Services Agreement: Service, Funding & Contracting proposals	DHBs

The process described is similar to that used for the 2009 PHARMAC Pharmaceutical Subsidy, Eligibility & Delivery Review, and later consultation proposals on Special Foods, HP1 & HP3 Pharmacies, Supply Orders and Widening Prescribers.

Pharmacy representative organisations are expecting these documents and are aware of the tight timeframe for responses.

3. Key Dates: Pharmacy Agreement 2011

Key dates to develop the Pharmacy Services Agreement 2011 are

March 2011	Issues Register developed with community pharmacy
March 2011	Community pharmacy agents mandated
April - May 2011	Pharmacy Agreement 2011 consultation process
May - June 2011	DHBs' decision making
End July 2011	Agreement sent to pharmacies for signing
1 September 2011	New Agreement into effect

Please contact your pharmacy representatives on the Steering Group if you have any queries:

Annabel Young, Ian Johnson, Grant Short, Ken Orr	Pharmacy Guild
David Mitchell	PharmacyPartners
Mike Seymour	Radius Group
Des Adams	Care Chemists

or Matthew Wood, Steering Group Chair (matthew.wood@sissal.govt.nz; 03 372 3039).

Yours sincerely

Dr Sharon Kletchko — Lead GM Planning & Funding, Pharmacy

Matthew Brougham — Chief Executive, PHARMAC

Effectiveness of the Get Checked diabetes programme

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September 2010

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Auditor-General's overview

My staff have prepared this document to help district health boards (DHBs) further improve the effectiveness of the Get Checked diabetes programme.

This document follows a report my Office produced in 2007, entitled *Ministry of Health and district health boards: Effectiveness of the "Get Checked" diabetes programme*. That report had 17 recommendations for DHBs.

This document clearly sets out the intent behind those recommendations. It also includes examples of actions that some DHBs reported to us in 2009, which they were carrying out to meet the intent of our recommendations. I encourage all DHBs to share their experiences of improving the effectiveness of the Get Checked programme.

DHBs can use the contents of this document, and the questions posed in it, to consider their progress and identify how the Get Checked programme could be improved.

This document is a new approach for my Office, so I am also interested in feedback from DHBs, and any other organisations involved in the Get Checked programme, on this document's usefulness. I would be grateful if you could send your feedback to diabetesguidefeedback@oag.govt.nz by 1 December 2010. We will use your feedback to inform our future approach to sharing our findings with public entities.

I thank all the DHBs for providing my staff with information about their progress with the recommendations made in our 2007 report.

I would like to acknowledge the expert assistance and advice that the late Professor Sir Donald Beaven provided to my staff while we were preparing our original report on the Get Checked diabetes programme. He was always very conscious of the need for effective public health initiatives to improve the health outcomes of people with diabetes. Sir Donald Beaven showed tireless enthusiasm and energy in holding public health entities accountable for the resources allocated to improving diabetes management and treatment.

Lyn Provost
Controller and Auditor-General

24 September 2010

Part 1
Introduction

1.1 In June 2007, we presented a performance audit report to Parliament on the effectiveness of the Get Checked diabetes programme, *Ministry of Health and district health boards: Effectiveness of the "Get Checked" diabetes programme* (the Get Checked report). In 2008, we followed up on the actions that the Ministry of Health (the Ministry) had taken in response to the recommendations we made in the Get Checked report. We included the results from this follow-up in *Performance audits from 2007: Follow-up report*, which we published in March 2009.

1.2 In *Performance audits from 2007*, we said that we would follow up on the responses to our recommendations for district health boards (DHBs). Accordingly, in 2009, we asked DHBs to report to us on their progress with the recommendations. This document is the result of our follow-up work with DHBs.

About our 2007 Get Checked report

1.3 In the Get Checked report, we reported that the Get Checked programme (the programme) had, in general, improved certain aspects of diabetes management. These improvements included:

- an increase in the number of people taking part in the programme;
- a heightened awareness of diabetes;
- improved monitoring of patients;
- better guidance provided to general practitioners (GPs) on diabetes treatment and referrals to specialist diabetes services; and
- the use, in some areas, of innovative programmes to remove barriers for people accessing diabetes care, particularly Māori and Pacific Island peoples.

1.4 We made 18 recommendations[1] to improve the quality of the programme data and the effectiveness of the programme. We consulted with diabetes expert Professor Sir Donald Beaven when drafting the report and forming our recommendations.

Structure of this document

1.5 The information presented in this document is based on the DHBs' representation of the actions, as reported to us in 2009, that they had taken in response to our recommendations.

1.6 We have grouped the recommendations into five parts. In Part 2, we discuss our recommendations about DHBs identifying who has been diagnosed with diabetes and whether they are getting checked.

1 One of the recommendations was aimed only at the Ministry and we do not deal with that recommendation in this document.

1.7 In Part 3, we discuss our recommendations about DHBs analysing, reporting, and using information from their diabetes services.

1.8 In Part 4, we discuss our recommendations about DHBs checking the quality of diabetes services provided to patients diagnosed with diabetes.

1.9 In Part 5, we discuss our recommendations about DHBs making it easier for patients diagnosed with diabetes to take part in the programme.

1.10 In Part 6, we discuss our recommendations about DHBs working more effectively with their local diabetes teams (LDTs).

1.11 Appendix 1 sets out how the recommendations from the Get Checked report correspond to the sections of this document.

1.12 In each Part, we pose questions that DHBs can use to consider how effectively they are implementing the programme. Appendix 2 lists all the questions we pose.

Part 2

Knowing who has been diagnosed with diabetes and whether they are getting checked

Identifying people who have been diagnosed with diabetes

2.1 In our Get Checked report, we considered that all DHBs should be able to identify the actual number of people who have been diagnosed with diabetes in their district.

2.2 The programme has now been running for more than nine years. It is important that DHBs know the actual number of people diagnosed with diabetes in their districts so they can accurately assess the coverage of the programme.

2.3 Without this information, DHBs cannot be certain that all people diagnosed with diabetes have been offered the opportunity to take part in the programme. Equally, DHBs might be overestimating the programme's coverage. It is also important that DHBs know the actual number of people with diabetes so they can plan for the likely future demand for services, especially for treating complications from diabetes.

2.4 In 2009, most DHBs reported examples of work that they, their Get Checked programme administrators (programme administrators), or primary health organisations (PHOs) were carrying out to improve GPs' coding and recording of patients diagnosed with diabetes. Figure 1 sets out the different ways that DHBs were doing this. See also the case studies in Figures 2 and 3.

Figure 1
Examples of work to improve GPs' coding and recording of patients diagnosed with diabetes

Common action DHBs had taken included:

- increasing the funding to general practices for annual checks to improve the recording of those checks;
- funding information technology positions to support general practices;
- assisting general practices to build their electronic patient management systems;
- providing regular reports to general practices that benchmark their performance against other general practices;
- introducing software into patient management systems to prompt GPs to code patients as having been diagnosed with diabetes; and
- putting in place a local quality indicator programme, which includes diabetes coding as a quality indicator.

2.5 Some DHBs reported that the national PHO Performance Programme provides an incentive for their PHOs to identify people diagnosed with diabetes in their GPs' patient management systems.

2.6 The PHO Performance Programme, which started in 2006, was designed to improve the health of people enrolled with a PHO and reduce inequalities in health outcomes. If PHOs improve their performance against nationally consistent indicators, including two diabetes indicators, they receive incentive payments.

2.7 All but one PHOs participate in the diabetes part of the PHO Performance Programme.

2.8 Some DHBs told us that they check how complete their diabetes register is by comparing it to the Ministry's register. The Ministry's register includes a list of people who have had:

- diabetes-specific medications dispensed;
- a hospital discharge recorded;
- four or more HbA1c tests[2] in a two-year period; or
- a diabetes-specific outpatient appointment.

2.9 We consider it good practice for DHBs to use this information to ensure that they have identified all those diagnosed with diabetes in their district.

Ensuring that diabetes registers are accurate and up to date

2.10 In our Get Checked report, we recommended that DHBs work to ensure that their diabetes registers are accurate and up to date, which is essential to identify patients who have been diagnosed with diabetes.

2.11 In 2009, many DHBs reported examples of work that they were carrying out to ensure that their diabetes registers were accurate and up to date. Much of this work was aimed at helping GPs correctly code those diagnosed with diabetes in their patient management system (see Figure 1).

Question to consider:

1. Have you identified all of the people in your district who have been diagnosed with diabetes by ensuring your diabetes register is accurate and up to date?

---

2 An HbA1c test is a blood test to measure a person's glycosylated haemoglobin level. The test indicates how well a person has been managing their blood glucose levels, and the results are given as a percentage.

Identifying people diagnosed with diabetes who are not getting checked

2.12 In our Get Checked report, we considered that DHBs, their programme administrators, and PHOs should be able to identify those people diagnosed with diabetes who were not taking part in the programme. This would allow DHBs to know the real coverage of the programme in their district, rather than the coverage of the number of people estimated to have diabetes. Patients not taking part in the programme could then be asked to join, if they had not been asked already.

2.13 In 2009, some DHBs reported examples of work to identify those diagnosed with diabetes who were not attending the free annual health check that the programme offers. The case studies in Figures 2 and 3 show how two DHBs were carrying out this work.

Figure 2
Counties Manukau District Health Board – Known Diabetes project

Counties Manukau DHB set up the Known Diabetes project to identify the number of patients in its district diagnosed with diabetes. The DHB used several local databases to identify diabetes patients, including Counties Manukau DHB inpatients, diabetes and ophthalmology diabetes outpatients, diabetes waitlist and referrals, enrolees in the diabetes Chronic Care Management programme, enrolees in the Get Checked programme, and retinal screening patients.

The results from the project were then triangulated with other surveys, databases, and data sets, such as the Let's Beat Diabetes baseline survey that interviewed 2500 adults living in the Counties Manukau DHB district. Counties Manukau DHB told us that this triangulation showed that the data from the Known Diabetes project aligned closely with the other data sets.

The results of the Known Diabetes project identified that there were about 25,000 people diagnosed with diabetes living in the Counties Manukau DHB district. The data also showed a very high prevalence of diabetes for the Pacific and Indian populations (at 11% and 9% respectively of those aged over 15). Overall, of the Counties Manukau DHB population over the age of 60, around 20% have been diagnosed with diabetes.

Because of the Known Diabetes project, Counties Manukau DHB was able to provide all its PHOs with lists of patients (by National Health Index number* at general practice level) who were on its "known diabetes" list but who were not enrolled in the Get Checked programme. PHOs have used these lists to update their registers and to contact individual patients and encourage them to have the free annual health check. Counties Manukau DHB told us that it employed two medical students to update registers for its largest PHO and contact these patients to offer them the free annual health check.

* The National Health Index number is an alphanumeric unique identifier used in the New Zealand health system.

Figure 3
Otago District Health Board – Data matching project

Otago DHB reported that its LDT was carrying out a data matching project that included the PHOs, general practices, and the DHB. The data matching project compares the Ministry's 2008 diabetes data for Otago against the programme data for the same period to identify people with diabetes who have not accessed the programme during 2008.

Otago DHB told us that it intended to review the results of the matching process, and that each PHO would discuss the findings with the relevant general practice and determine how each general practice would investigate those who had not accessed the programme.

Otago DHB hoped that, once this was completed, the PHOs and general practices would have a much better understanding of who was not accessing the programme and how they might increase the number of eligible people accessing the programme.

Question to consider:

2. Have you identified those patients diagnosed with diabetes who are not taking part in the programme and made sure they have been asked if they would like to take part?

2.14 In paragraphs 5.1-5.5, we discuss identifying why people diagnosed with diabetes are not taking part in the Get Checked programme.

Encouraging people to participate in the programme

2.15 In our Get Checked report, we identified that some GPs were not encouraging patients to take part in the programme. The main reason for their reluctance was that the GPs believed that the fee paid for carrying out the free annual health check was not enough to cover the costs of the check or the costs of completing the documentation that accompanied it. Other issues reported to us included:

- some GPs saw the reviews as an information-collecting exercise;
- technology problems sometimes meant that data from the free annual health check was not submitted to the PHO or DHB and the fee was not paid to the general practice; and
- a higher proportion of people failed to attend the pre-arranged appointment for the free annual health check than failed to attend appointments made for existing conditions.

2.16 In our view, all people diagnosed with diabetes should be offered a chance to take part in the programme. DHBs and their programme administrators or PHOs need to work with general practices to address concerns about the programme, where possible.

2.17 In our 2009 survey, one DHB told us that low participation in the programme by general practices was still an issue. This DHB reported to us that its GPs view the checks as an administrative data collection exercise and the wrong driver for better diabetes management. Although the GPs see the individual measures in the review as valid, they do not support the concept of an annual review about a single disease when people with diabetes may have other conditions, and need ongoing management of all of them.

2.18 Some DHBs reported that they had taken some steps to encourage GPs to promote and support the programme. Several DHBs reported to us that they have increased the funding to general practices for each free annual health check to better reflect the work involved. Waikato DHB told us that it has encouraged its PHOs to ensure that patients diagnosed with diabetes, especially Māori and Pacific Island patients, are encouraged to join the programme by way of its local quality indicator programme.

Question to consider:

3. Where GPs may not be promoting and supporting those diagnosed with diabetes to take part in the programme, have you (or your programme administrator or PHOs) considered whether you need to address concerns that GPs in your district might have about the Get Checked programme?

Part 3
Analysing, reporting, and using information from diabetes services

Regular reporting of programme data to general practitioners

3.1 In our Get Checked report, we recommended that programme administrators (or PHOs) regularly analyse and report information from the programme to GPs to enable them to benchmark their performance.

3.2 In 2009, most DHBs reported to us that programme administrators (or PHOs) are regularly analysing and reporting data from the programme to GPs. Most DHBs told us that the frequency of reporting to general practices was either monthly or quarterly. In our view, this frequency is appropriate.

3.3 Only one DHB told us that its programme administrator was not regularly reporting information from the programme to GPs. We encourage this DHB, and any others where programme administrators or PHOs are not reporting to GPs, to work with programme administrators or PHOs to achieve regular reporting to GPs.

Question to consider:

4. If the GPs in your district are not receiving regular reports on the Get Checked programme, have you identified what needs to be done to achieve regular reporting and are you addressing the problem?

Identifying improvements to the programme

3.4 In our Get Checked report, we recommended that the Ministry and DHBs analyse data from the programme to better understand how the programme and other factors contributing to diabetes care are linked, and to identify how diabetes care can be improved further (including how the programme can be improved).

3.5 We suggested that cohort analysis[3] might be helpful in showing whether the programme was leading to more effective management of diabetes.

3.6 Since our Get Checked report, the Health Research Council[4] commissioned a national study of a group of people in the programme who have Type 2 diabetes. The study examined changes in the health status and management of the group over two years. The results of the study were published in September 2008. The study concluded that participating in the free annual health check may have contributed to improving the clinical management of the group and reduced

3 A cohort analysis follows a defined population, in this case defined by the year the people started participating in the programme, to establish whether there is any change in the recorded results over time.

4 The Health Research Council is the Crown agency responsible for managing investment in public good health research. The Minister of Health is responsible for the Health Research Council, with most of its funding coming from Vote Research, Science and Technology.

disparities. The study acknowledged that removing restrictions on the use of statin in 2002, and introducing diabetes management guidelines in 2003, may also have improved the management standards.

3.7 In 2009, some DHBs reported to us that they had analysed the treatment and outcomes of patients taking part in the programme. For example, Waitemata DHB told us that it had compared data about patients who were taking part in the programme with those who were not. It found that those taking part in the programme had better process measures of care (for example, retinal screening rates) but that differences in intermediate outcomes (such as HbA1c levels) were small or non-existent. The DHB noted in its study that it was difficult to determine what caused the differences because these two patient groups may have been different for reasons other than participating in the programme.

3.8 No DHB reported to us that they had carried out cohort analysis using the data from the programme.

Question to consider:

5. Have you considered (either individually or with other DHBs or organisations) carrying out further analysis (for example, cohort analysis) using the data from the Get Checked programme to identify improvements that could be made to diabetes care?

Managing service demand

Current demand

3.9 In our Get Checked report, we said that DHBs should collect information from their specialist diabetes services about:

- the number of patients attending the service;
- the complexity of patients' conditions; and
- waiting times.

3.10 This would allow DHBs to identify whether there is a need for more services and, if necessary, to take action to provide more services.

3.11 In 2009, most DHBs reported that they were working towards collecting this information. For example, Capital and Coast DHB reported that its specialist diabetes team records information about its patients, including the reason for referral and waiting time. This information can be accessed when needed. The DHB's specialist diabetes team was also working on creating a program that will automatically analyse the information.

Question to consider:

6. Are you collecting enough information to identify any shortages in your specialist diabetes services and taking action to provide more services where they are needed?

Future demand

3.12 In our Get Checked report, we said that DHBs should be using information from the programme about the number of people who are likely to suffer certain complications from diabetes. For example, the programme was collecting information on the number of people who may develop diabetic kidney disease. It is important that DHBs collect and use this type of information when planning services to treat patients with certain diabetes complications.

3.13 We recognise that some DHBs may be using this information already but did not report it to us in 2009.

Question to consider:

7. Are you using information about the potential incidence of complications from diabetes to inform your service planning?

Part 4
Checking the quality of the service

Clinical audit of diabetes care

4.1 In our Get Checked report, we recommended that DHBs (or their programme administrators or PHOs) use information in diabetes registers to identify general practices that may need extra support to manage patients diagnosed with diabetes. We then expected DHBs to carry out a more focused audit of the diabetes care that these general practices provide, to discover what the issue was and what support the DHB needed to provide.

4.2 In 2009, some DHBs told us that they carry out audits like this. For example, Counties Manukau DHB reported that it was working with its local provider, the Diabetes Project Trust,[5] to focus its audits of GPs on general practices that PHOs had highlighted as needing clinical assistance. The Diabetes Project Trust had initially identified those general practices with case management rates under 55% and those with retinal screening rates under 60% as needing clinical assistance.

4.3 We also understand that all PHOs are required to carry out clinical audits of their general practices under the DHB-PHO agreement. In our view, DHBs should use the information from these audits to identify general practices that need extra support to manage patients diagnosed with diabetes.

4.4 Many DHBs reported that they tend to provide support and education to general practices rather than auditing their clinical care to ensure that it is of an acceptable quality. Figure 4 sets out examples of this support and education.

Figure 4
Examples of quality improvement support that district health boards provided to general practices

DHBs have told us that they have:

- resourced providers of local diabetes education to educate primary and secondary care clinicians;
- increased resourcing of PHO diabetes nurse educators who work with general practices to improve their management of diabetes patients;
- worked with the sector to prepare standardised assessment and care planning templates;
- employed diabetes co-ordinators to work with general practices on diabetes planning and management;
- funded software in general practices that supports diabetes assessment;
- diabetes specialists working with primary health care practitioners to promote, educate, and support best practice care in line with the guidelines;
- the LDT actively working with general practices and acting as a resource on effectively managing their diabetic population; and
- provided national-guidelines-based education to primary and secondary health care nurses.

5 The Diabetes Project Trust is a non-governmental organisation that runs and manages the Diabetes Care Support Audit (see page 37 in the Get Checked report).

4.5 We consider this work appropriate, but note that it is also important to ensure that patients receive diabetes care in line with the evidence-based best practice guidelines and national referral guidelines. In our view, an audit component would strengthen this work.

4.6 An audit component would also allow DHBs to identify where general practices need support and education in their diabetes care. Providing support and education will be more effective if it addresses identified issues of quality.

Question to consider:

8. Have you considered whether you or your PHO(s) should inform and complement the support and education for general practices with more in-depth audits of their diabetes care?

Checking diabetes treatment plans

4.7 In our Get Checked report, we recommended that DHBs, their programme administrators, or their PHOs check that patients taking part in the programme were getting treatment plans and that the treatment plans were of an acceptable quality. Treatment plans can make a considerable contribution to the success of the programme. They encourage patients to effectively manage their diabetes and control their blood glucose levels.

4.8 Few DHBs reported to us in 2009 that they checked this. The ones that did told us that they have checked that patients were getting treatment plans, but have not checked the quality of those plans.

Question to consider:

9. Are you, your programme administrator, or your PHO(s) checking that diabetes treatment plans are of an acceptable quality?

Establishing the effectiveness of treatment plans

4.9 In our Get Checked report, we recommended that DHBs (or their programme administrators or PHOs) monitor the effectiveness of the treatment plans in improving self-management of diabetes through lifestyle changes. Indicators of improved self-management may include reducing body mass indexes, reducing the number of people smoking, and improving HbA1c levels.

4.10 After we published the Get Checked report, the Government introduced Health Targets for diabetes care. All DHBs must now record and report each year the

proportion of people who have had a free annual health check with satisfactory or better diabetes control (as indicated by HbA1c levels).

4.11 A few DHBs reported using other indicators to monitor the effectiveness of treatment plans, such as lifestyle changes. For example, West Coast DHB told us that its PHO monitors the effectiveness of treatment plans by analysing information collected through the programme, such as smoking rates, medication rates, lipid levels, HbA1c levels, and blood pressure levels. This analysis is fed back to general practices with peer comparisons on a quarterly basis.

4.12 Auckland DHB also analyses information collected by its PHOs, such as smoking cessation rates, medication prescription rates, and HbA1c levels. The DHB shares this information with its PHOs and LDT annually.

4.13 Where the evidence indicates a lack of progress in improving self-management, DHBs (and their programme administrators or PHOs) need to work to improve it. In the Get Checked report, we reported examples of work to improve HbA1c levels. Figure 5 sets out these examples.

Figure 5
Examples of work to try to improve self-management of diabetes

Counties Manukau DHB had offered a payment to general practices as an incentive to reduce HbA1c levels for a trial period. The incentive covered patients who had been enrolled in the Chronic Care Management programme because they had an HbA1c level greater than 9% and who had been in the Chronic Care Management programme for at least one year. For each general practice, the DHB planned to calculate the average HbA1c level for the group of qualifying patients at the time of their enrolment and pay $20 for each patient in the group whose HbA1c level decreased by at least 1.5%.

South Link Health Incorporated introduced an Enhanced Diabetes Programme on 1 April 2005. The Enhanced Diabetes Programme provided an additional subsidised visit for patients who had an HbA1c level greater than 8% for two consecutive free annual health checks. The main purpose of this extra visit was to focus on lifestyle and medication changes.

Question to consider:

10. Are you, your programme administrator, or your PHO(s) working to improve the effectiveness of the treatment plans in improving self-management of diabetes where there is evidence of a lack of progress?

Part 5

Making it easier to take part in the programme

Recording why people decline the free annual health check

5.1 In our Get Checked report, we recommended that DHBs record the reasons patients give for turning down the free annual health check. Having this information would allow DHBs to recognise any common barriers to people accessing that check and to take action to remove these barriers, if possible.

5.2 We recognise that people diagnosed with diabetes have the right to decide whether they take part in the programme. However, some people may not take part in the programme because of reasons outside of their control. For example, a patient may decline a free annual health check because they cannot easily attend an appointment during their GP's normal opening hours because of work or family commitments.

5.3 In our 2009 survey, few DHBs provided us with information about whether GPs in their district were recording the reasons why patients declined to take part in the programme. One DHB told us that its PHO collects the general reasons for patients declining to take part in the programme.

5.4 Some DHBs reported that they carry out other activities to discover why people were not getting checked. These activities were often targeted at particular groups with low uptake of the programme, such as Māori and Pacific Island groups. For example, Canterbury DHB told us that it had contracted a market research company to survey patients diagnosed with diabetes. The survey's aim was to examine the lack of uptake of programmes for primary care diabetes management, such as the Get Checked programme. Capital and Coast DHB told us that it supports an annual Pacific Diabetes Fono, during which issues about accessing diabetes care are discussed.

5.5 We support the use of these methods and consider that they may be effective and efficient in discovering why people are not taking part in the programme.

Question to consider:

11. Are you working to identify why patients are not taking part in the Get Checked programme?

Removing barriers for Māori and Pacific Island peoples to diabetes care

5.6 In our Get Checked report, we said that DHBs should have initiatives to remove barriers to Māori and Pacific Island peoples accessing diabetes care. It is important that Māori and Pacific Island peoples have access to diabetes care because they have significantly worse health outcomes than other people with diabetes.

5.7 In our 2009 survey, most DHBs told us that they had initiatives to reduce barriers to accessing diabetes care for their Māori and Pacific Island populations. They had different approaches to this, although several had a focus on providing diabetes care through services other than general practices. Figure 6 sets out some examples of DHBs' initiatives to improve access to diabetes care for Māori and Pacific Island peoples.

Figure 6
Examples of initiatives to remove barriers for Māori and Pacific Island peoples diagnosed with diabetes

Auckland DHB told us that it had adopted strategies to optimise access for high-needs groups (including Māori and Pacific Island peoples). These strategies included access to interpreting services in primary health care, increasing the capacity of general practices in high-needs areas with large Māori and Pacific populations to provide appointments outside of traditional opening hours, and providing courses on diabetes self-management.

Bay of Plenty DHB reported that its transportation scheme for patients in a low socio-economic area of its district was proving very successful.

Capital and Coast DHB told us that, among other initiatives, it had established Diabetes Nurse Educator roles to provide clinical and general-practice-based support for Māori and Pacific peoples to improve diabetes management.

Nelson Marlborough DHB reported that both of its PHOs had established good links with Māori health providers and local marae for delivering diabetes services to Māori diagnosed with diabetes in an appropriate setting. In Marlborough, the Tane Ora conference and the Vascular Risk Assessment service (delivered through practices and community venues) have identified Māori with diabetes, or at risk of developing diabetes, and supported them to enter the care of a general practice. Kimi Hauora Wairau (Marlborough PHO) provides funding, training, and professional development for the nurses of two Māori health providers working in diabetes care, supporting the provision of diabetes care in a kaupapa Māori environment.

Waikato DHB told us that it had given PHOs an incentive, through a local quality indicator programme, to target Māori and Pacific Island peoples to have an annual review.

5.8 However, it is not always clear how effective these initiatives have been in removing barriers for Māori and Pacific Island peoples accessing diabetes care. We discuss the evaluation of such initiatives in paragraphs 5.15-5.18.

Question to consider:

12. Do you have initiatives in place to remove barriers to diabetes care for Māori and Pacific Island peoples?

Removing barriers for other groups to diabetes care

5.9 In our Get Checked report, we recommended that DHBs consider whether any other groups had trouble accessing the programme and create initiatives to improve access for those groups, if possible. In particular, we noted that some Asian ethnic groups had a high prevalence of diabetes.

5.10 In 2009, Auckland DHB told us that it had identified a need for additional support for the Asian ethnic group to access diabetes care. Auckland DHB reported that it had employed a diabetes nurse specialist since 2008 specifically to work with this ethnic group, and with providers with a high proportion of people from this ethnic group in their general practices. This DHB has the highest proportion of Asian people in its population. In our view, this is a positive step towards supporting this ethnic group to access diabetes care.

5.11 Some other DHBs reported that they did not have initiatives to support other population groups to access diabetes care. This was because they had high numbers of Māori and Pacific Island peoples or small numbers of other groups, or both. However, only one of these DHBs told us that it had information that the Asian community in its district was satisfactorily accessing primary health care. DHBs need to provide additional support to groups where there is evidence that these groups are not satisfactorily accessing diabetes care.

5.12 Some DHBs reported to us that they had identified other groups needing extra support to access annual checks, such as:

- those living in low income areas;
- refugees and migrants;
- children and adolescents;
- seasonal workers; and
- those living in rural areas.

5.13 Figure 7 sets out the groups some DHBs had identified and the support they reported having in place.

Figure 7
Other groups identified as needing support to access diabetes care and initiatives to support access

Capital and Coast DHB reported that its other high-needs populations, including those in low income areas and refugees, are able to access some additional support. A high number of this population live in one of the targeted areas for the diabetes nurse specialists that is also provided with a PHO diabetes nurse.

Hutt DHB reported that it has created specific services for children and adolescents with diabetes. It reported that “Paediatric clinics are clustered around age-banded cohorts with joint child and parent sessions run prior to Outpatient clinics, which increases practical day to day supports within this vulnerable group”. It also had services to send text messages to adolescents. Its LDT had identified that the DHB needs to consider the needs of migrants and refugees in the future.

Nelson Marlborough DHB reported that the needs of its other low-income populations are served by existing Māori health providers and, in rural areas, by the DHB’s rural services. In rural Marlborough, people receive care from satellite medical clinics in Havelock and Seddon. Eligible seasonal workers in Marlborough receive care from the range of general practices in Marlborough.

5.14 Other DHBs should consider whether other groups within their district need additional support to access diabetes care.

Question to consider:

13. Have you established whether groups other than Māori and Pacific Island peoples in your district are satisfactorily accessing diabetes care, and do you have arrangements to support access by these groups where it is needed?

Evaluating and sharing successful initiatives to remove barriers to diabetes care

5.15 In our Get Checked report, we recommended that initiatives to help certain groups to access diabetes care be evaluated to test whether they are achieving their goal. Such evaluation would also identify any improvements that could be made to the programme. Without knowing how effective initiatives are, DHBs and PHOs may be wasting their resources.

5.16 Few DHBs reported to us in 2009 that they had measures to evaluate initiatives for removing barriers to accessing diabetes care. No DHBs provided detailed information on their work.

5.17 In our view, any initiatives evaluated as successful should be shared with other DHBs and PHOs to see whether they could be successful in other districts.

5.18 Some DHBs told us that they were sharing successful initiatives. Figure 8 sets out some examples of the ways DHBs reported sharing successful initiatives.

Figure 8
Examples of sharing successful initiatives for removing barriers to accessing diabetes care

Auckland DHB reported that it had set up an information network and various forums where PHOs and other organisations can share their experiences and highlight what is working for them.

Capital and Coast DHB told us that it supported discussion about existing initiatives at various forums within its district, including LDT meetings, the PHO Advisory Group, and the Primary/Secondary Clinical Governance Group.

MidCentral DHB reported that it and its PHO had been sharing with other DHBs its successes with the programme and with the Diabetes Service Plan.

Question to consider:

14. Do you know whether initiatives you and your PHOs have to remove barriers to accessing diabetes care are effective, and are you sharing successful initiatives within your district and with other DHBs?

Part 6
Working with local diabetes teams

Improving the effectiveness of local diabetes teams

6.1 In our Get Checked report, we found that none of the LDTs we visited were as effective as they could have been. For example, none of the LDTs were fully meeting the requirements set out in the LDT service specification. We recommended that DHBs ensure that their LDT was as effective as possible.

6.2 Many DHBs told us in 2009 that they were working to review or improve the effectiveness of their LDTs. For example, Southland DHB told us that the management of its LDT moved from the DHB's Planning and Funding team to the PHO in January 2009 to provide greater independence for the LDT. Waitemata DHB reported that it had reviewed its LDT in 2008 and created a new group called the Diabetes Clinical Advisory Group that includes all the roles of the LDT. This group includes representatives of all stakeholders and has an increased strategic role.

Question to consider:

15. If your LDT is not working as effectively as it should be, what are you doing to help it be more effective?

Analysis by local diabetes teams of secondary diabetes service gaps

6.3 In our Get Checked report, we considered that LDTs should meet the service specification requirement to include analysis of primary care data and other clinical information in their annual report. For "other clinical information", LDTs are required to collect and analyse information from specialist diabetes services. Analysing this information would enable shortages in services provided at a secondary care level to be identified. This would also allow a picture of patients diagnosed with diabetes treated in secondary care to be established and enable comparisons between secondary care units throughout the country.

6.4 In 2009, 18 out of 21 DHBs had LDTs. Only a few of the 18 DHBs reported that their LDTs were identifying shortages at both the primary and secondary care levels. However, we have reviewed the annual reports from these few LDTs for the 2008/09 year, and they do not indicate that they have analysed the demand and supply for secondary diabetes services.

Question to consider:

16. Are you helping your LDT to analyse information from secondary care to identify service shortages?

Listening to your local diabetes team

6.5 In our Get Checked report, we reported that most of the LDTs we talked to found it hard to get DHBs to listen to their recommendations. We recommended that DHBs give due consideration to recommendations that their LDTs make so that the resources that are dedicated to LDTs are not going to waste. We consider that DHBs responding to their LDT's reports in a timely manner is good practice.

6.6 In 2009, many DHBs told us that they were working with their LDTs to include their advice when planning diabetes services. Several DHBs told us that their LDTs' recommendations were put into effect through the direct involvement of the DHB's planning and funding staff in the LDT, or through the annual planning process. For example, Canterbury DHB has a dedicated staff member within its Planning and Funding division who liaises with the LDT. Also, the DHB's planned diabetes outputs for 2009/10 were aligned with working towards the LDT's recommendations.

6.7 Waitemata DHB told us that there was an agreed expectation that the DHB will provide a response to the LDT's recommendations but that the recommendations cannot be binding. Waikato DHB reported that, when its LDT submitted its next report to the DHB Community and Public Health Advisory Committee, the DHB would submit an action plan detailing the DHB's response to the recommendations made.

Question to consider:

17. Are you giving your LDT's reports, including any recommendations, due consideration and responding to them in a timely manner?

Appendix 1
How our recommendations correspond to sections in this document

Original recommendations		Sections in this document
1	We recommend that district health boards work with programme administrators to identify those patients in patient management systems who have been diagnosed with diabetes.	Identifying people who have been diagnosed with diabetes (Part 2)
2	We recommend that district health boards work with programme administrators to identify those people in the population diagnosed with diabetes who are not taking part in the programme, ensure that they have been invited to join the Get Checked programme, and (if possible) note and address their reasons for declining.	Identifying people diagnosed with diabetes who are not getting checked (Part 2) Encouraging people to participate in the programme (Part 2) Recording why people decline the free annual health check (Part 5)
3	We recommend that district health boards work with primary health organisations to monitor the preparation and audit the quality of treatment plans, and establish the effectiveness of these plans over time.	Checking diabetes treatment plans (Part 4) Establishing the effectiveness of treatment plans (Part 4)
4	We recommend that the Ministry of Health review and, if necessary, update the national referral guidelines.	Not discussed in this document because the recommendation is for the Ministry of Health.
5	We recommend that district health board specialist diabetes services maintain enough data on the numbers of patients attending their clinics, the complexity of patients' conditions, and waiting times to enable the district health board to identify and plan for the funding and resources needed to provide adequate diabetes services at this level.	Managing service demand (Part 3)
6	We recommend that those district health boards where there are shortfalls in specialist diabetes services investigate the shortfalls and provide additional services as considered necessary.	Managing service demand (Part 3)
7	We recommend that district health boards ensure that the information in their diabetes registers is accurate and updated, and work with programme administrators to identify, clarify, and resolve current problems affecting data quality.	Ensuring that diabetes registers are accurate and up to date (Part 2)
8	We recommend that district health boards ensure that enough audit processes are in place to verify that payments are being made for genuine annual checks, and that they work with their programme administrators to achieve this.	Not discussed in this document because our focus here is on improving the effectiveness of the programme.

Original recommendations		Sections in this document
9	We recommend that district health boards work with programme administrators to ensure that the data from the Get Checked programme is thoroughly analysed and the results regularly reported back to general practices to improve diabetes care.	Regular reporting of programme data to general practitioners (Part 3)
10	We recommend that district health boards work with primary health organisations and programme administrators to ensure that adequate clinical audit is carried out to provide assurance that general practices are providing diabetes care in line with the evidence-based best practice guidelines and national referral guidelines.	Clinical audit of diabetes care (Part 4)
11	We recommend that district health boards work with local diabetes teams to carry out a more robust analysis of supply and demand for diabetes services at both the primary and secondary care levels, so that any shortages in services provided at both the primary and secondary care levels can be identified.	Analysis by local diabetes teams of secondary diabetes service gaps (Part 6)
12	We recommend that the Ministry of Health and district health boards review the role of the local diabetes teams to establish how these teams are best able to adequately fulfil the role of providing advice on the effectiveness of healthcare services for people with diabetes.	Improving the effectiveness of local diabetes teams (Part 6)
13	We recommend that the Ministry of Health and district health boards consider how to improve the adoption of the local diabetes teams' recommendations.	Listening to your local diabetes teams (Part 6)
14	We recommend that district health boards work with primary health organisations to continue to focus on removing the barriers to Māori and Pacific Island peoples accessing the Get Checked programme.	Removing barriers for Māori and Pacific Island peoples to diabetes care (Part 5)
15	We recommend that the Ministry of Health and district health boards work with primary health organisations to evaluate existing initiatives for removing barriers to accessing diabetes care, and ensure that there is a mechanism in place to disseminate successful initiatives throughout district health boards and primary health organisations.	Evaluating and sharing successful initiatives to remove barriers to diabetes care (Part 5)

Original recommendations		Sections in this document
16	We recommend that district health boards consider whether initiatives need to be put in place for populations within their districts other than Māori and Pacific Island peoples who also experience barriers to accessing diabetes care.	Removing barriers for other groups to diabetes care (Part 5)
17	We recommend that district health boards and the Ministry of Health carry out further analysis (for example, cohort analysis) of the effect that the Get Checked programme has had on diabetes care and management, to better understand how the programme and other factors contributing to diabetes care are linked and to identify what further improvements can be made in diabetes care and management.	Identifying improvements to the programme (Part 3)
18	We recommend that district health boards work with local diabetes teams and programme administrators to make more use of the data available from the Get Checked programme to plan their diabetes services.	Managing service demand (Part 3)

Appendix 2
Index of questions to consider

Knowing who has been diagnosed with diabetes and whether they are getting checked	
1	Have you identified all of the people in your district who have been diagnosed with diabetes by ensuring your diabetes register is accurate and up to date?
2	Have you identified those patients diagnosed with diabetes who are not taking part in the programme and made sure they have been asked if they would like to take part?
3	Where GPs may not be promoting and supporting those diagnosed with diabetes to take part in the programme, have you (or your programme administrator or PHOs) considered whether you need to address concerns that GPs in your district might have about the Get Checked programme?
Analysing, reporting, and using information from diabetes services	
4	If the GPs in your district are not receiving regular reports on the Get Checked programme, have you identified what needs to be done to achieve regular reporting and are you addressing the problem?
5	Have you considered (either individually or with other DHBs or organisations) carrying out further analysis (for example, cohort analysis) using the data from the Get Checked programme to identify improvements that could be made to diabetes care?
6	Are you collecting enough information to identify any shortages in your specialist diabetes services and taking action to provide more services where they are needed?
7	Are you using information about the potential incidence of complications from diabetes to inform your service planning?
Checking the quality of the service	
8	Have you considered whether you or your PHO(s) should inform and complement the support and education for general practices with more in-depth audits of their diabetes care?
9	Are you, your programme administrator, or your PHO(s) checking that diabetes treatment plans are of an acceptable quality?
10	Are you, your programme administrator, or your PHO(s) working to improve the effectiveness of the treatment plans in improving self-management of diabetes where there is evidence of a lack of progress?
Making it easier to take part in the programme	
11	Are you working to identify why patients are not taking part in the Get Checked programme?
12	Do you have initiatives in place to remove barriers to diabetes care for Māori and Pacific Island peoples?
13	Have you established whether groups other than Māori and Pacific Island peoples in your district are satisfactorily accessing diabetes care, and do you have arrangements to support access by these groups where it is needed?
14	Do you know whether initiatives you and your PHOs have to remove barriers to accessing diabetes care are effective, and are you sharing successful initiatives within your district and with other DHBs?
Working with local diabetes teams	
15	If your LDT is not working as effectively as it should be, what are you doing to help it be more effective?
16	Are you helping your LDT to analyse information from secondary care to identify service shortages?
17	Are you giving your LDT's reports, including any recommendations, due consideration and responding to them in a timely manner?