SOUTHERN DISTRICT HEALTH BOARD

DISABILITY SUPPORT ADVISORY COMMITTEE
and
COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Monday, 3 February 2020
1.30pm

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

A G E N D A

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

Item

1. **Opening Karakia**
2. **Apologies**
3. **Interests Register**
4. **Presentation: Overview of the Directorate and Presentation on the Primary and Community Strategy – Lisa Gestro**
5. **Minutes of Previous Meeting**
6. **Matters Arising**
7. **Review of Action Sheet**
8. **Review of Committees' Terms of Reference**
   8.1 Community and Public Health Advisory Committee
   8.2 Disability Support Advisory Committee
9. **Strategy, Primary and Community Report**
10. **New Primary Maternity System of Care**
11. **SDHB Draft Disability Strategy**
12. **Financial Report**

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

APOLOGIES

Apologies have been received from:

- Dr Nigel Millar, Chief Medical Officer. Dr Tim McKay, Deputy Chief Medical Officer, will be in attendance.
- Mr Roger Jarrold, Crown Monitor.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Community & Public Health and Disability Support Advisory Committees
Date of Meeting:	3 February 2020

Summary:

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

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

Changes to Interests Registers over the last month:

- New Board Members and Crown Monitors added.

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 24/01/2020

RECOMMENDATION:

1. That the Interests Registers be received and noted.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Dave Cull (Board Chair)	09.12.2019	Daughter-in-law works for Southern DHB		
David Perez (Deputy Chair)	13.05.2019	Director, Mercy Hospital, Dunedin	SDHB holds contracts with Mercy Hospital.	Step aside from decision making.
	13.05.2019	Fellow, Royal Australasian College of Physicians		
	13.05.2019	Trustee for several private trusts		
Ilka Beekhuis	09.12.2019	Patient Advisor, Primary Birthing FiT Group for Dunedin Hospital Rebuild		
	09.12.2019	Member, Otago Property Investors Association		
	09.12.2019	Secretary, Spokes Dunedin (cycling advocacy group)		
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
John Chambers	09.12.2019	Employed as an Emergency Medicine Specialist, Dunedin Hospital		
	09.12.2019	Employed as Honorary Senior Clinical Lecturer, Dunedin School of Medicine	Possible conflicts between SDHB and University interests.	
	09.12.2019	Elected Vice President, Otago Branch, Association of Salaried Medical Specialists	Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals.	
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	09.12.2019	Employee, Findex NZ		
	14.01.2020	Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust		
	14.01.2020	Member, National Council of Women, Southland Branch		
Lyndell Kelly	09.12.2019	Employed as Specialist, Radiation Oncology, Southern DHB	Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB.	
	18.01.2020	Honorary Senior Lecturer, Otago Universtiy School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	09.12.2019	No conflicts of interest with Southern DHB.		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Jean O'Callaghan	13.05.2019	Employee of Geneva Health	Provides care in the community; supports one long term client but has no financial or management input.	
	13.05.2019	St John Volunteer, Lakes District Hospital	Nil	Taking six months' leave.
Tuari Potiki	09.12.2019	Employee, Otago University		
	09.12.2019	Chair, NZ Drug Foundation		
	09.12.2019	Chair, Te Rūnaka Ōtākou Company*		
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.12.2019	*Shareholder in Te Kaika		
Lesley Soper	09.12.2019	Elected Member, Invercargill City Council		
	09.12.2019	Board Member, Southland Warm Homes Trust		
	09.12.2019	Employee, Southland ACC Advocacy Trust		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	Sister-in-law, Employee of SDHB (Clinical Nurse Specialist Acute Mental Health)		
	15.01.2019	Shareholder, RST Ventures Limited		
Andrew Connolly (Crown Monitor)	21.01.2020	Employee, Counties Manukau DHB		
	21.01.2020	Deputy Commissioner, Waikato DHB		
	21.01.2020	Southern Partnership Group		
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
Roger Jarrold (Crown Monitor)	16.01.2020	CFO, Fletcher Construction Company Limited		
	16.01.2020	Member, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christrchurch		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

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

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Kaye CHEETHAM	08.07.2019	Ministry of Health Appointed Member of the Occupational Therapy Board	
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
	01.07.2019	Capable NZ Assessor	Asked from time to time to assess students, bachelor and masters students final presentation for Capable NZ.
Matapura ELLISON	12.02.2018	Director, Otākou Health Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki (Note: Kāti Huirapa Rūnaka ki Puketeraki Inc owns Pūketeraki Ltd - 100% share).	Nil
	12.02.2018	Trustee, Araiteuru Kokiri Trust	Nil
	12.02.2018	National Māori Equity Group (National Screening Unit)	
	12.02.2018	SDHB Child and Youth Health Service Level Alliance Team	
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	
	25.09.2016	Deputy Chair, InterRAI NZ	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
Lisa GESTRO	06.06.2018	Lead GM National Travel and Accommodation Programme	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	NASO Governance Group Member	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	Lead GM Perinatal Pathology	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
	12.12.2019	Daughter employed by Harrison-Grierson	A NZ construction and civil engineering consultancy - may be involved in tenders for DHB or new Dunedin Hospital rebuild work
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	17.11.2017	Wife works for key technology supplier CCL	Nil
	18.12.2017	Daughter, medical student at Auckland University and undertaking Otago research project over summer 2017/18.	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
	23.10.2018	Shareholder and Director, Barr Burgess & Stewart Limited	Accounting services
		Specified contractor for JER Limited in respect of:	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	31.10.2017	H G Leach Company Limited to termination	Nil, Quarry and Contracting.
	21.10.2019	Member, Chartered Accountants Advisory Group	
Gilbert TAURUA	05.12.2018	Prostate Cancer Outcomes Registry (New Zealand) - Steering Committee	Nil
	05.04.2019	South Island HepC Steering Group	Nil
	03.05.2019	Member of WellSouth's Senior Management Team	Reports to Chief Executives of SDHB and WellSouth.
Gail THOMSON	19.10.2018	Member Chartered Management Institute UK	Nil
	22.11.2019	Deputy Chair Otago Civil Defence Emergency Management Group, Coordinating Executive Group	
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil

Presentation: Overview of the Directorate and Presentation on the Primary and Community Strategy

- Lisa Gestro, Executive Director Strategy, Primary and Community

5

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 23 October 2019, commencing at 9.00 am, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mrs Kathy Grant	Commissioner
	Mrs Jean O'Callaghan	Deputy Commissioner
	Dr David Perez	Deputy Commissioner
	Mr Richard Thomson	Deputy Commissioner
In Attendance:	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer (by videoconference)
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Commissioner welcomed Dr Lyndell Kelly and Mrs Kaye Crowther (by videoconference) to the public gallery and congratulated them on their success in the recent Board elections.

2.0 APOLOGIES

An apology was received from Ms Justine Camp, Committee Member.

3.0 PUBLIC FORUM

No applications were received to speak at the public forum.

4.0 DECLARATION OF INTERESTS

The Interests Registers were circulated with the agenda (tab 3) and noted.

The Commissioner asked for any changes to the registers and reminded everyone of their obligation to advise the meeting should any potential conflict arise during discussions.

Recommendation:

"That the Interests Registers be received and noted."

5.0 PREVIOUS MINUTES

Recommendation:

"That the minutes of the meeting held on 29 August 2019 be approved and adopted as a true and correct record."

Agreed

6.0 REVIEW OF ACTION SHEET

The Committees reviewed the action sheet (tab 7) and received the following updates from management.

Southland Hospital Emergency Department Building Work

The Committees were assured that everything possible had been done to comply with the Invercargill City Council's consent process for the Southland Hospital Emergency Department building work.

Whāngaia Ngā Pā Harakeke

The Executive Director Strategy Primary and Community (EDSP&C) explained that Whāngaia Ngā Pā Harakeke was an inter-sectoral district initiative led by New Zealand Police, aimed at ensuring a robust, joined up response to issues, particularly family violence. She reported that the programme was continuing to be strengthened, although Southern DHB was not yet able to routinely participate in daily operational meetings due to other demands on staff. The Māori Health Directorate were now involved and the Chief Māori Health Strategy and Improvement Officer (CMHS&IO) had been asked to sit on the governance group.

The CMHS&IO advised that he had a background in social work and expressed his interest in taking a leadership role in the programme.

MRI - Utilisation of Private Facility in Frankton

The Chief Executive Officer (CEO) reported that he was endeavouring to negotiate an arrangement to obtain some MRI capacity from Pacific Radiology in Frankton in order to take pressure off Southern DHB's radiology services in Invercargill and Dunedin and reduce travel for patients. For family reasons, the CEO of Pacific Radiology had been unable to meet with him during the month.

Waitaki District Health Services

The EDSP&C reported that the impact on whānau of hospital transfers had been considered as part of Waitaki District Health Services' proposal for change.

Dr John Chambers, Board Member Elect, was welcomed to the public meeting.

7.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

The Strategy, Primary and Community Report (tab 8) was taken as read and the following items were highlighted during discussion.

Development of Models of Care to Inform the Development of Community Health Hubs

The EDSP&C reported that three workshops had been held to develop a set of principles that could be applied to underpin and inform changes to models of care and the positioning of services. These could be applied in a number of settings, eg when a service was undertaking planning for future service delivery. It had been agreed that a two pronged approach would be taken:

1. A "deeper dive" into models of care for Child Health, Mental Health and Health of Older People, with a subset around urgent care;

2. A more formal working group would be formed to consider the process for Community Health Hubs, in consultation with the Clinical Leadership Group (CLG) and the Alliance Leadership Team (ALT), and would make recommendations on placement of Community Health Hubs, order of start-up, etc.

8.0 PRESENTATION: TELEMEDICINE AND HEALTH PATHWAYS

Gail Thomson, Executive Director Quality and Clinical Governance Solutions, Ron Craft, Service Manager Rural Health, Jack Devereux, IT Business Solutions Manager, Bridget-Mary McGown, HealthPathways Manager, and Dr Peter Gent, GP Mornington Health Centre and Clinical Lead, Primary Care, Southern HealthPathways, joined the meeting and, with the EDSP&C, presented an update on telehealth, the role of rural hospitals, HealthPathways, models of care development and service planning, and the next steps in bringing these together (tab 12).

The presentation was followed by questions. During discussion, the Chief Māori Health Strategy and Improvement Officer advised that an equity lens needed to be put across the whole health pathway and whānau included in conversations.

In thanking the EDSP&C and her team for their presentation, the Commissioner commented that it was reassuring to see the discussion had matured and telehealth and HealthPathways were moving forward as part of the integrated care concept.

9.0 STRATEGY, PRIMARY AND COMMUNITY REPORT (Continued)

Lakes District Hospital Emergency Department Attendances

The EDSP&C reported that there had been a spike in presentations to the Emergency Department (ED) at Lakes District Hospital. Consideration was being given to future models of care to support what appeared to be sustained growth in demand in Queenstown.

Primary Maternity

Consideration was being given to the primary maternity system of care in Central Otago. The Lakes Locality Network were taking an interest in this and had presented their work programme to the Alliance Leadership Team (ALT) the previous week.

Health of Older People

The changes in 6ATR/Older Person's Health had been a success and the team were now focused on reviewing the community model, which would lead into the retendering of Home and Community Support Services (HCSS) when the current contract expired in 2020.

Southern Measles Outbreak

The EDSP&C informed the Committees that the Public Health team had done an outstanding job in containing the spread of measles, with no new cases reported over the last week.

During discussion, the Committees:

- Requested that the action to develop an overarching strategy prior to drafting an action plan in response to the report *Pēhea Tou Kāinga? How is Your Home? Central Otago Housing: The Human Story* be added to the Committee's action sheet;
- Sought clarification on whether Public Health were working with organisations other than the Dunedin City Council on the physical activity initiative to get schools and students more engaged with active travel.

10.0 INVERCARGILL URGENT CARE

The Committees considered a report on improving access to urgent care services in Invercargill (tab 9). It was noted that this work was being sponsored by the Alliance Leadership Team (ALT).

Recommendation:

"That the Committees:

- **Note the progress to date;**
- **Note the relationship between this programme and the existing Valuing Patients Time programme focused on moving patients through ED;**
- **Agree to support the programme moving forward, including the receipt of regular progress reports from key personnel."**

Agreed

11.0 FINANCIAL REPORT

The EDSP&C presented the Strategy, Primary and Community financial results for September 2019 (tab 10), then answered questions on the financial statements.

The Committees requested that the presentation of the "forecast" table at the end of the report be reviewed.

Recommendation:

"That the report be received."

Agreed

CONFIDENTIAL SESSION

At 10.55 am, it was resolved that the Disability Support and Community & Public Health Advisory Committees move into committee to consider the agenda item listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
2. Primary Maternity	To allow activities to be carried on without prejudice or disadvantage.	S 32(a), Schedule 3, 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)(j) of the Official Information Act 1982

Confirmed as a true and correct record:

Commissioner: _____

Date: _____

Southern District Health Board

DISABILITY SUPPORT AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES MEETING

ACTION SHEET

As at 24 January 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Jan 2019 May 2019 Aug 2019	**Changing Invercargill Model of Care to Reduce Emergency Department (ED) Attendance** (Minute item 4.0) (Minute item 5.0) (Minute item 6.0)	Progress report to be provided on the building work for this project.	EDFP&F	Consent received from the Invercargill City Council November 2019 and work scheduled.	Completed
March 2019	**MRI - Utilisation of Private Facility at Frankton** (Minute item 5.0)	To be followed up.	CEO	Met with CEO of Pacific Radiology. Limited appetite for doing anything other than fee for service. This is disappointing, as we proposed an innovative option of sharing both public CT and private MRI for the benefit of the wider community. Awaiting further communication from PRG.	Completed
October 2019	**Pēhea Tou Kāinga? How is Your Home? Central Otago Housing: The Human Story** (Minute item 9.0)	An overarching strategy to be developed prior to drafting an action plan.	EDSP&C	One of the key recommendations from the report was to form a multi-agency taskforce and develop an Action Plan. Following this a multiagency housing meeting took place in Alexandra in late November. The meeting was a starting point to get key stakeholders together to discuss the report findings. Participants included representatives from a number of	July 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				government and non-government agencies and Queenstown Lakes and Central Otago District Councils. While the report was initiated by Southern DHB and the outcomes are health related, the levers to make a difference are not controlled by Southern DHB and it is anticipated it could take some time to develop the action plan. Southern DHB will facilitate a second multiagency meeting in March 2020 to continue the collaborative. An update will be provided in July 2020.	
October 2019	**Physical Activity Initiative** (Minute item 9.0)	Whether Public Health are working with organisations other than DCC on the physical activity initiative to get schools and student more engaged with active travel to be clarified.	EDSP&C	At this stage this is a pilot programme being completed in the Dunedin City area with three schools. Based on feedback we will look at extending this to other Dunedin Schools in 2020.	Completed
October 2019	**Financial Report** (Minute item 11.0)	Presentation of the "forecast" table to be reviewed.	EDSP&C	Table now presented monthly, as per organisational format.	Completed

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

Terms of Reference

Accountability

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

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

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

Function and Scope

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

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

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

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

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

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

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

Responsibilities

The Committee is responsible for:

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

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

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

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

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

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

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

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

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

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

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

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

Membership

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

The Committee is to comprise of a number of Board members as determined by the Board Chair, supplemented with external appointees as required.

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

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

Conflicts of Interest

Where a potential conflict of interest exists with an agenda item, these are to be declared by members and staff. A register of interests shall form part of each Committee meeting agenda, and it is the responsibility of each member to disclose any new interests which may give rise to a conflict.

Quorum

The quorum of members of a committee is —

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

Meetings

Bi-monthly meetings, held collectively with the Disability Support Advisory Committee (DiSAC) will be scheduled, however the Committee may determine to hold additional meetings if deemed necessary by the Chair, with or without DiSAC, up to a maximum of ten meetings per year.

Review

The Terms of Reference for this Committee shall be reviewed as and when required.

Management Support

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

DISABILITY SUPPORT ADVISORY COMMITTEE (DiSAC)

Terms of Reference

Accountability

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

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

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

Function and Scope

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

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

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

Responsibilities

The Committee is responsible for:

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

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

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

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

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

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

Membership

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

The Committee is to comprise a number of Board members as determined by the Board Chair, supplemented with external appointees as required.

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

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

Conflicts of Interest

Where a potential conflict of interest exists with an agenda item, these are to be declared by members and staff. A register of interests shall form part of each Committee meeting agenda, and it is the responsibility of each member to disclose any new interests which may give rise to a conflict.

Quorum

The quorum of members of a committee is —

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

(b) if the total number of members of the committee is an odd number, a majority of the members.

Meetings

Bi-monthly meetings, held collectively with the Community & Public Health Advisory Committee (CPHAC) will be scheduled, however the committee may determine to hold additional meetings if deemed necessary by the Chair, with or without CPHAC, up to a maximum of ten meetings per year.

Review

The Terms of Reference for this Committee shall be reviewed as and when required.

Management Support

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

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Strategy, Primary & Community Report**		
Report to:	Disability Support and Community & Public Health Advisory Committees		
Date of Meeting:	3 February 2020		
Summary: Monthly report on the Strategy, Primary & Community Directorate activity.			
Specific implications for consideration (FINANCIAL/WORKFORCE/RISK/LEGAL ETC.):			
Financial:	N/A		
Workforce:	N/A		
Other:	N/A		
Document previously submitted to:	Chris Fleming	**DATE:** 16 January 2020	
Approved by Chief Executive Officer:		**DATE:**	
Prepared by: Strategy, Primary & Community Team **Date:** 21st January 2020		**Presented by:** Lisa Gestro Executive Director Strategy, Primary & Community	
RECOMMENDATION: **That the Committees note the content of this paper.**			

9

IMPLEMENTATION OF THE PRIMARY AND COMMUNITY STRATEGY

Key Highlights:

Meetings of interested primary care teams and key clinical personnel from specialist services commenced in December with a plan for them to now be held monthly, with an open invitation to all who are interested. The idea is that the group will work together to identify better ways of working together to develop improved outcomes for patients, and to inform what services might be appropriate to deliver from a community health hub, once these are established. There was a clear commitment shown from both WellSouth and DHB management to eliminating the barriers that prevent teams from working together effectively and efficiently.

In the intial meeting the wide ranging conversation included:

- The importance of health pathways, and the opportunity to super-charge this framework in future
- Artificial, contractual and system barriers to integration exist but are not insurmountable and need to support new models of care
- The bricks and mortar conversations need to happen in tandem to conversations about models of care to ensure that the two streams come together in a timely way.
- The opportunities for workforce development go hand in hand with the integration approach
- There is a need to find space for services outside the new hospital rebuild, but co-location without integration will be a missed opportunity
- There are services that are absolutely keen to develop an integrated model right now. These are where general practice teams and hospital teams agree there is opportunity for new ways to work.
- While resources ideally need to follow the patient, this needs to be clearly understood for the 'transition' period where services are being increasingly delivered from a community setting, but costs remain caught in the inpatient hospital setting until scale is reached to enable a tipping point.
- We need to fast track the identification of solutions to problems in respect of information sharing that will help to enable integration

The group will meet again on the evening of the 27th of January with a focus on the following areas, who have been identified as early apodpters for the new model, in addition to the previously identified areas of Health of Older People, Mental Health and Child Health.

- Diabetes
- Wound care
- Rheumatology
- Respiratory

Conversations are also underway as to how we enhance our pathways strategy to facilitate the development of integrated models of care across these services.

Healthcare Home highlights

- Amity Practice have now implemented full GP Triage for all same day appointment requests. The feedback has been positive with the practice manager saying the waiting room is calmer and a less stressful environment to work in.
- Gore Medical has reviewed the patients within their practice who have had an Ambulatory Sensitive Hospitalisation. Gore Medical are now doing some work to drill deeper into these presentations and find what services were in place prior to presentation.
- Junction Health Centre are developing their postnatal project. Junction plan to invite eligible women for a free postnatal consultation with the GP and Nurse within 6 weeks of giving birth.
- Clutha Health First sent a survey to staff regarding huddles and 14 out of 14 responders' answered yes when asked if they found the huddles useful.

- HealthCentral (a GP practice in Alexandra) have met their huge in-house target of 800 portal sign-ups in the month of November, with 808 patients being signed up to the portal.
- Tranche 2 continue to get some great early results including;
    - 4/6 practices had a Multi-Disciplinary Team meeting in November.
    - 1475 appointments were booked using a portal for the month of November across the 6 practices.
    - IMC and Te Kāika have started GP Triage, resulting in

    131 patients not having to come into the practice for an appointment as a result.

System Level Measures

The SLM programme provides the national framework from which to deliver on the Government's priority of ***Improving the well-being of New Zealanders and their families***. This priority aims to provide equitable access to healthcare, and a healthy and safe home and community environment that ensures New Zealanders can realise their potential. Achieving this goal requires an acknowledgment of the social determinants of health, a commitment to achieve equity and the drive to productively work with not only within the health system (hospitals, primary care, community and NGOs) but across government agencies such as education, justice, housing and social development. Collaborative way of working through district alliances, the underpinning enabler for the SLM programme, is an ideal forum to engage all the appropriate parties in discussions based on robust analytics that look at equity, identify service gaps and designing system-wide services that improves the wellbeing of New Zealanders and their families.

SLM programme provides a framework for continuous quality improvement and integration across the health system. Equity gaps for Māori and Pacific populations are evident in all SLMs and in nearly all districts. This programme provides a great opportunity for DHBs and PHOs to work with health system partners in their district to address equity gaps, one of the government priorities. Where equity gaps exist, the district alliances are expected to focus their improvement milestone, quality improvement activities and contributory measures specifically to address these gaps.

For SDHB, the System Level Measures that we have chosen to focus on for our District in the 2019/20 years are as follows:

1. First 1,000 days: Specifically Ambulatory Sensitive Hospital (ASH) Admissions 0-4 and Babies Living in Smoke Free Homes.

   Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting. Determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure. It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers

   Locally, The WellChild Network has been identified as the appropriate group to take responsibility for these SLM Domains and to use the SLM framework as a part of their planning and actions in the future. The SLM concept was socialised at their most recent meeting and the attendees were very receptive to using this framework to support their work. Thelma Brown will now continue to work with the members to encourage a structured approach supporting SDHB annual planning for SLMs.

2. Acute Hospital Bed Days and Amenable Mortality.

   Amenable mortality is defined as premature deaths (deaths under age 75) that could potentially be avoided, given effective and timely healthcare. That is, early deaths from causes (diseases or injuries) for which effective health care interventions exist and are accessible to New Zealanders in need.

Not all deaths from these causes could be avoided in practice. For example, because of comorbidity, frailty and patient preference. However, a higher than expected rate of such deaths in a District Health Board (DHB) may indicate that improvements are needed with access to care, or quality of care.

The Maori Health Directorate has taken responsibility to manage these SLM Domains. It is unclear if the stated action of 'forming a Clinical Maori Strategy Group' has been achieved. The Clinical Maori Strategy Group was identified as the responsible owner of these SLM Domains.

3. Quality: Patient Experience of Care.

   Growing evidence tells us that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes

   In Southern, we use patient experience surveys across both specialist services and Primary health Care as indicators for this measure. These surveys continue as BAU. The Quality team has not formally taken over this SLM Domain but contribute to addressing the lowest scoring result.

4. Youth: Specifically Youth and Self harm

   The MH network has formed a subgroup to take ownership of this Domain. An initial meeting has occurred and an analysis of the data around youth self-harming will be undertaken. Data telling the story (either the youth self-harm presentation at ED or something similar that informs that story). How and why the presentation ended up in ED and what happened when they got there will be undertaken.

Local Diabetes Team

In 2015 the government launched Living Well with Diabetes, a plan for people at high risk of or living with diabetes 2015–2020. The plan contains a number of quality standards. Standard 11 refers to foot care.

A small diabetes team has been working on addressing the issues identified in the recent Ministry of Health review of our Diabetes services. The diabetic foot was chosen as the first project, ensuring the SDHB delivered the best possible care for people with high risk and diseased feet.

This work is now complete and a proposal is available that aligns SDHB services across the district. Ensuring a sustainable Multi-Disciplinary Team service is available in Dunedin and Invercargill forms the focus of this proposal.

The next steps are a wider LDT is being pulled together to look at the whole model of care for Diabetics in SDHB.

The final Ministry of Health visit to review of our response to the 'Living well with Diabetes' plan is scheduled to be on the 17th February.

Primary Maternity Project

Primary Maternity Strategy Implementation

The EY report on the implementation of the first phase of our Primary Maternity Strategy was received late last year and each of the recommendations were subsequently accepted by the Commissioner Team. The recommendations are currently working to assimilate the recommendations into a new work programme, the essence of which is outlined below. Key areas that are currently being worked through include resourcing across key priority areas such as Maternity leadership and accountability, which have clear dependencies on the successful delivery of the remainder of the programme. This is currently being agreed, and will include the development of more robust reporting structures including a reformed steering group, with strengthened Clinical Leadership.

Recruitment is underway for a Project Manager to support implementation of the Primary Maternity System of Care. Work has commenced on the delivery of Action 7 of the strategy which is that 'Consideration to be given to the most appropriate location for a primary maternity facility within the Central Lakes district, and this piece of work is the subject of a separate, more detailed paper that will be presented to CPHAC at its meeting on the 3rd of February. The work will be led by the Central Lakes Locality Network working closely with the Maternity, Quality and Safety Governance group. In February and March engagement will take place with stakeholders to develop a shortlist of potential options. View from stakeholders and the public will be sought throughout April and May to inform recommendations to the Board. Other highlights and activity re implementation of the strategy are as follows:

Action	Action - Update
Work with the communities of Wanaka, Lumsden, Te Anau, Maniototo and Waiu to establish maternal and child hubs	All hubs now exist, albeit there is still a transition to occur for the Wanaka LMC's once the custom fit out of the new hub on Gordon Road is completed. In the meantime LMC's in this area have extended access to additional space as required in the Wanaka Medical Centre. Hub Coordinators are in place across all hubs.
Implement a sustainability package for LMCs who are serving rural remote women in our district	Completed. This will be subject to review to ensure the scheme is adding the greatest possible value to LMC's once the Project Manager is in place.
Dedicate resources to the ongoing quality improvement of primary maternity resources and leadership support provided to the LMC workforce. Specific resources will be secured to implement the primary maternity system of care	A new clinical leadership structure is being implemented across Maternity, with the addition of an Associate Director of Midwifery, reporting to the new Director of Midwifery role, which will have responsibility for a whole of system strategic view. The Project Manager responsible for the implementation of the Strategy is in the final stages of being filled.
Develop a robust communications plan for primary maternity services in the southern district	Dedicated resource for the programme to focus on Comms has been identified, and a comms plan is currently being drafted, focussing initially on supporting the Central Otago activity under Action 7.
Take the lead on development of a recruitment and retention strategy for the LMC workforce across the southern district	This has been enacted, with limited success given the self-employed nature of the LMC workforce. We have however been relatively successful in bringing locum LMC's into the District, some of which has expressed an ongoing interest in the region and are continuing to work as relief midwives for the broader system.
Give consideration to the most appropriate location for	Now underway – this action is subject to a separate more detailed paper in today's meeting pack.

Action	Action - Update
a primary maternity facility in the Central Lakes district	
Facilitate agreement on an equalisation model to address traditional funding inequalities across the primary birthing facilities in the district	Ongoing – phase one was completed in 2018/19 with additional revenue being made available to 3 of our facilities as an initial step towards parity in the current financial year.
Give consideration to a primary birthing unit in Dunedin in conjunct the Dunedin Hospital rebuild	Complete. This discussion was managed in conjunction with the Clinical Leadership Group responsible for advising on critical design elements of the new Dunedin Hospital.

COMMUNITY SERVICES

Health of Older People

Age Related Residential Care

2019 was a good year for aged care facilities in Southern, with 52% (34 of our 65 facilities) achieving a four year certification.

Major changes in bed capacity during the year:

- Takitimu (Rest Home in Invercargill) closed in April
- Observatory Village (Oamaru) opened 20 new dual use (rest home or hospital level care) beds in April
- Rose Lodge (Invercargill) reconfigured 29 beds from rest home to dual use in August
- Kimberley (Palmerston) reconfigured 10 beds from secure dementia to Rest Home in September
- Aspiring Enliven (Wanaka) opened 12 new dual use beds in December
- Oxford Court (Dunedin) opened 22 new dual use beds in December
- Peacehaven (Invercargill) reopening 10 psychogeriatric beds in December/January 2020

Change of Ownership:

- Glenbrae (Invercargill) sold to Kyber, which already owns Waikiwi Gardens, in June
- Kimberley (Palmerston) sold from one private owner to another in August

Change of Facility Manager

There was high turnover of Facility Managers in 2019, with 23% of facilities appointing a new Facility Manager: Kimberley, Oxford Court, Teviot, Summerset, Cargill, Thornbury, St Andrews, Vickery Court, Peacehaven, Walmsley, Resthaven, Ascot, Mossbrae, Windsor, and Leslie Groves. Facilities also experienced high turnover of Clinical Managers.

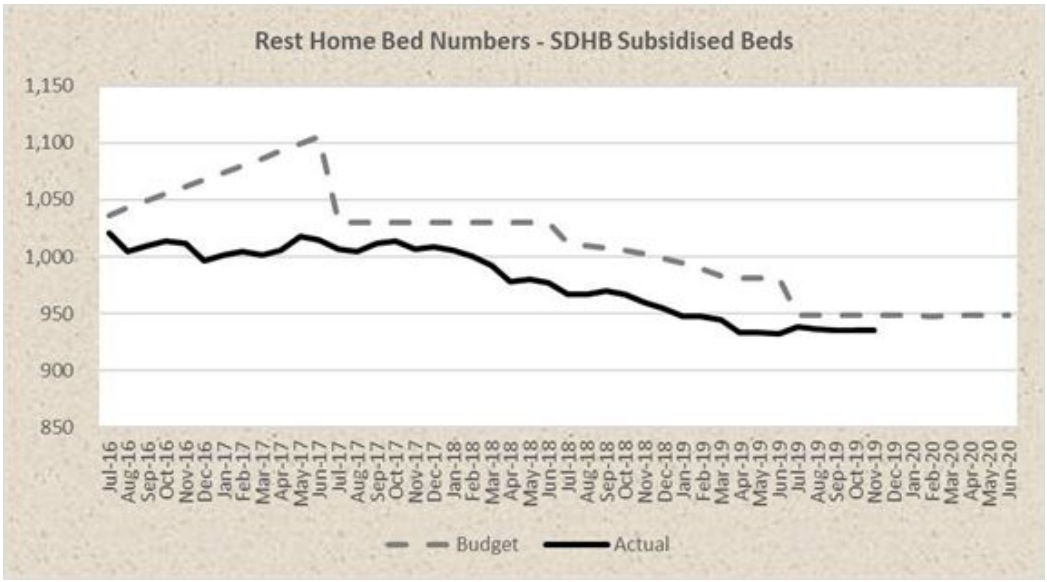
The most significant issue of the year has been the recruitment and retention of Registered Nurses in aged care facilities.

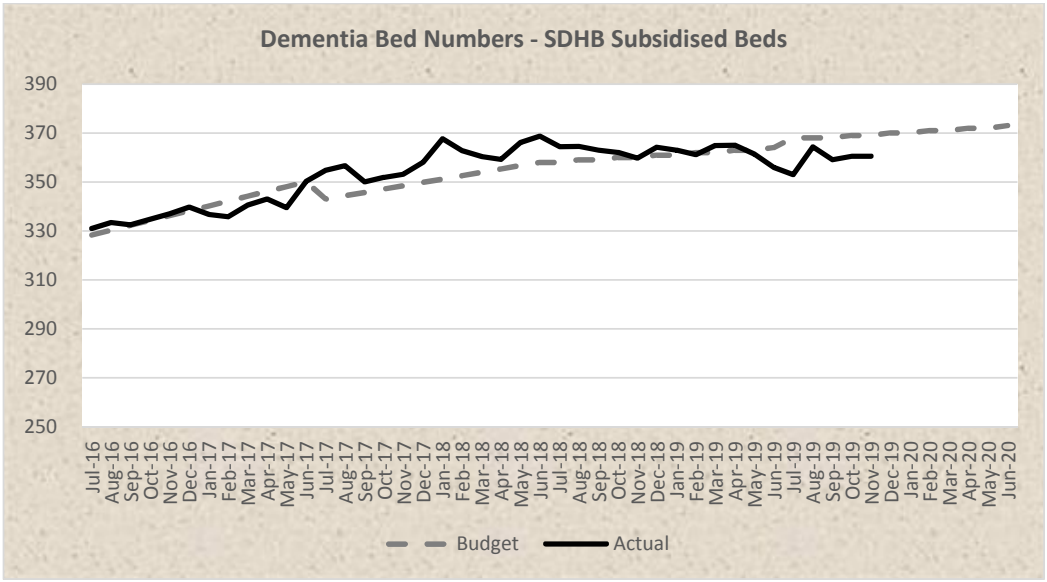
Southern DHB is supporting facilities by

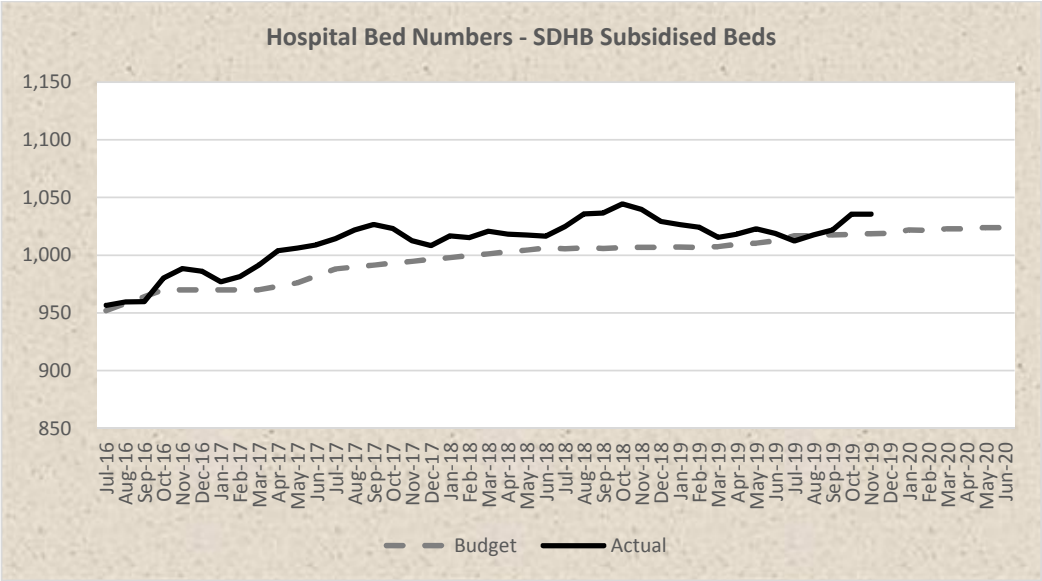
- Appointing a Nurse Practitioner in Otago to work in the community. A Nurse Practitioner also exists in Southland for this purpose.
- Bringing together the Nurse Practitioners who work in Mental Health for Older People, Older People and the Hospice CNSs who support aged care facilities
- Piloting an Older People's Health Nursing Development Programme with Presbyterian Support Otago

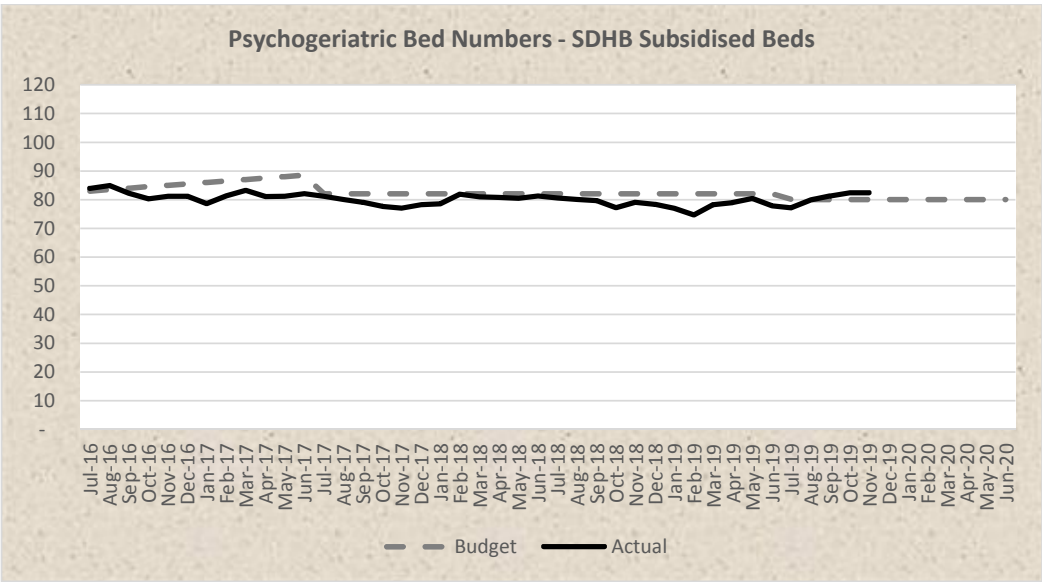
Aged Residential Care Occupancy/Volume Analysis

SDHB has historically had one of the highest rates of Aged Related Residential Care (ARRC) utilisation in New Zealand over a sustained period. The reduction over the last couple of years in funded Rest Home level care utilisation as outlined below can be attributed to multiple factors, including the current work programmes "Home as my First Choice" and the "Home Team" but also due to the increase in Residential Property prices. Residents admitted to ARRC can apply for a Residential Care subsidy, which is both asset and income tested. The increase in residential property prices will have seen a reduction in the number of residents being able to access the subsidy, this reduces our funded bed utilisation at the Rest Home level of care.









Refugee Health

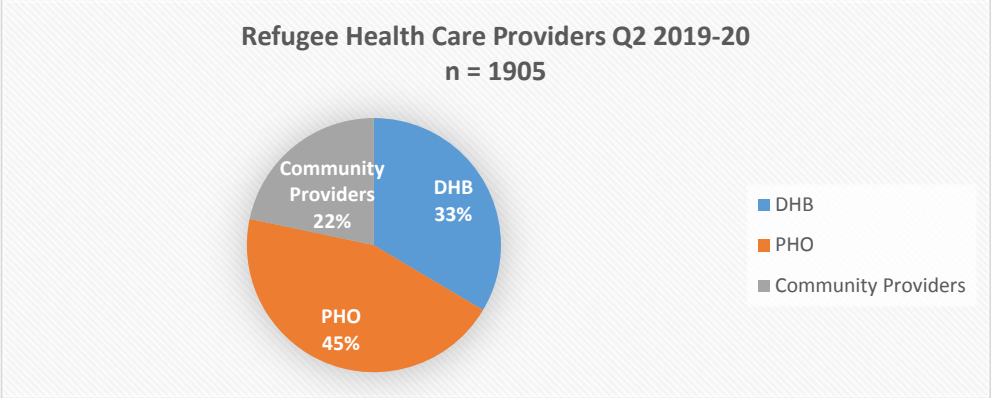
Southern DHB is receiving and helping to settle more refugees (190/annum) than any other DHB in NZ. Colombians are resettling in Invercargill, while Dunedin receives Syrians and Afghanis, along with small numbers of Palestinians. The SDHB Refugee Health Programme addresses refugee health issues of acuity while supporting refugee integration into the NZ health system. SDHB is able to provide these services through specific MoH funding that is additional to the population based funding.

SDHB has developed a unique rights-based strategy for refugees who often arrive with vulnerabilities and health conditions exacerbated by war and dislocation. Rather than creating specific refugee health services, the DHB works to ensure refugees, who become permanent residents upon arrival, have full access to the health services that are available to all New Zealanders.

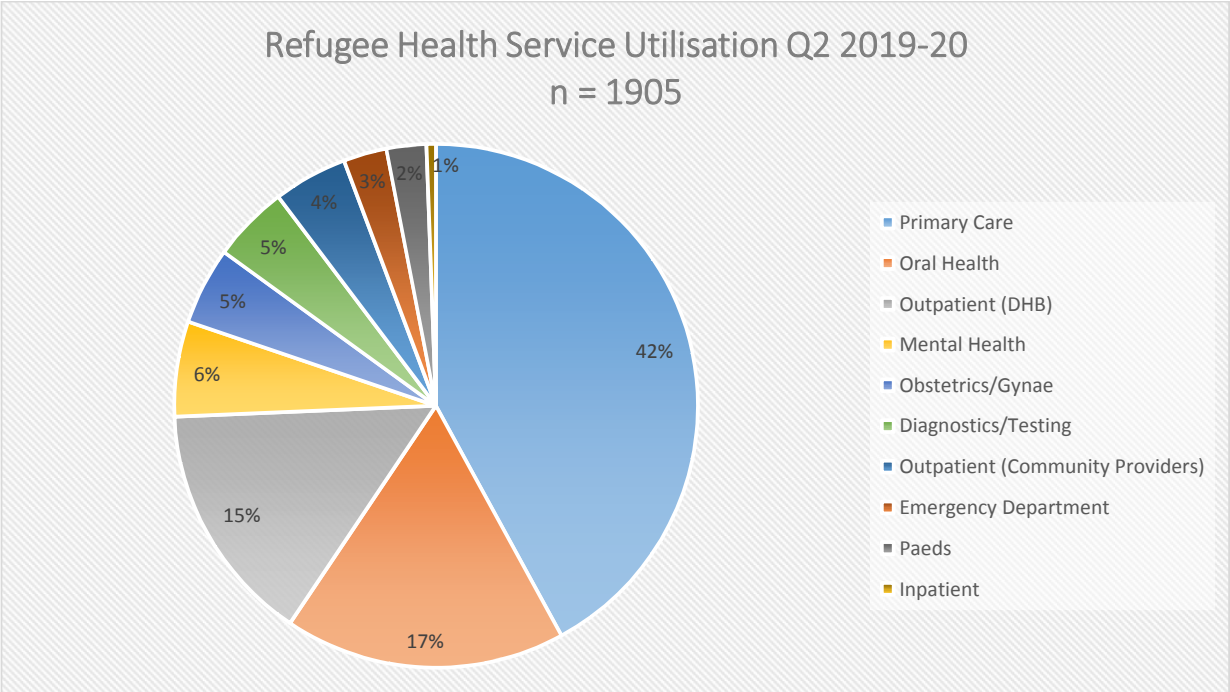
The DHB partners with the PHO in the provision of primary health services that financially support GP access, pharmaceuticals, face-to-face interpreters and health navigators who assist in refugee integration and who are also able to identify and address any pathway access issues encountered by refugees. The DHB also contracts with the University of Otago Dental School in addressing the oral health issues that former refugees more often than not suffer from. Finally, the DHB invests in

packages of care in mental health so that former refugees are able to receive support for trauma experienced off-shore that would have typically been covered by ACC if such trauma took place in New Zealand.

For Quarter 2 of this year, there were a total of 798 refugees requiring 1905 appointments across all health services within and beyond the DHB. Southern DHB's face-to-face interpreting service was provided for all but 19 of these appointments (99%). Patient DNAs (did not attend) for refugees remain lower than the general population (4% vs 9%). This is indicative of strong former refugee engagement with a health system that is new and quite different from their countries of origin. Further, most care is taking place in a community setting, either via the PHO (45%) or Community Providers (22%).



Primary care is by far the most prevalent type of care being delivered to former refugees (42%). Due to pre-existent issues upon arrival in NZ, oral health is quite high (17%). ED (3%) and inpatient (1%) are highly favourable, suggesting that care requirements are being met in the community setting. Outpatient – DHB (15%) and Outpatient – Community Providers (4%) reflect outpatient services not otherwise specified by other noted types (e.g., oral health, mental health, diagnostics, etc.).



Public Health

Southern Measles Outbreak - Update

The measles outbreak consisted of 72 confirmed cases with measles in the Southern district and is officially considered to be over as there has been four full incubation periods after the last case associated with the outbreak. The Emergency Operations Centre (EOC) continued to operate until 9 December as it was responsible for authorising the distribution of MMR vaccine that had been allocated to the district for primary care. This has now returned to business as usual. There were 4,200 doses of extra vaccines provided to the district since the start of November to help improve coverage in the priority groups for vaccination. We have been advocating with the Ministry of Health for increasing the priority group for vaccination to include 19 – 30 year olds but we have not received approval for this to occur as the Ministry has advised they will be looking at a catch up campaign for this age group in 2020.

Legionella Update

As reported last month there has been a noticeable increase in legionella cases across the district. Legionnaires' disease is a flu-like illness that can develop into severe pneumonia. The risk is higher for people over age 60 (especially in men), those who smoke, and those with compromised immune systems. In NZ the most common way of developing Legionnaires' disease is through inhaling dust particles in soil, potting mix and compost containing the Legionella bacteria, however, it can also be caused by breathing in water particles/mist from water systems. Due to this increase in cases staff have developed a poster identifying the risks and providing advice on how to protect themselves when handling potting mix/soils. This is in the process of being printed and distributed across the district to retail outlets that sell potting mix.

Fresh Air Project Relaunch

The Fresh Air Project is a collaborative project between PHS and Cancer Society (Otago and Southland division) which encourages hospitality venues to promote their outdoor dining areas as smokefree. A pilot was launched on 1 November 2018 where 20 hospitality venues in Dunedin, Queenstown and Invercargill participated and promoted their venue as smokefree. During the pilot, feedback was collected from both business owners and managers, as well as customers dining at these venues. Evaluation data showed that 94% of customers supported free outdoor dining and 67% responded that they were more likely to visit venues again because of smokefree outdoor dining. Also, as a result of the project, there are now 47 smokefree outdoor dining venues across Dunedin, Queenstown and Invercargill. The evaluation for this project was used to advocate for change in council's smokefree policies.

Due to the success of the project, the Fresh Air Project is being relaunched this summer. Venues have been visited to offer support and window decals have been developed to help customers identify venues that offer smokefree dining.

Smokefree Beaches

Queenstown Lakes District Council (QLDC) has approved a smokefree beaches trial for this summer, running from 16 December 2019 to 31 March 2020. The QLDC Councillors took the proposal further and have included vaping. The purpose of the trial is to test which outdoor spaces may become smokefree in the future. The trial aims to discourage smoking at four destination beaches during summer 2019-2020 in Queenstown, Wanaka, Frankton and Glenorchy, and will focus on education and awareness rather than taking a punitive approach. Support for this trial, plus the evidence from the Fresh Air Project (2018-19) will help QLDC to draft and enact a new smokefree policy for QLDC in 2020.

Drugs in Bars Update

A seminar for Queenstown Lakes bar owners was held on the growing issues of drugs in bars. Information was provided about the type of drugs being sold, effects on the body, and how to manage an overdose situation. Practical strategies were also provided to reduce intoxication in bars. Evaluation showed that respondents rated the relevance of the seminar highly. Ninety-three per cent reported that the seminar had provided them with realistic ways to help minimise intoxication in their venue, and many bar owners and managers were implementing changes in order to reduce drug harm. Attendees valued the information provided on behaviour associated with drug intoxication and the length of time it takes for short term effects of particular drugs to cease. Feedback showed that there is still a need for further education in this area with suggestions for seminars for bar staff (rather than management staff) as they share a responsibility for monitoring the bar environment. Regular seminars covering similar content have been suggested for Queenstown in particular as they have a large turnover of bar staff.

Liquor Licensing

Over the last few weeks the liquor licensing team across the district have been meeting with the police, council licensing staff and special licence applicants to ensure that upcoming events have plans to reduce the chance of alcohol related harm occurring. This is achieved by talking through food options, crowd control, security measures, travel options and reducing consumption of alcohol and places of safety for those who may need them. These discussions have been deemed successful given the number of large events that have taken place in recent weeks such as the Gibbston Valley Summer series concerts and Rhythm and Alps with minimal alcohol related incident.

The Plan

'The Plan' is a new initiative for a safe party season that aims to support parents to delay drinking and reduce alcohol related risk to their teens. This is based on the Nelson project with the same name and is funded and supported by the Health Promotion Agency. It encourages and supports parents to 'make a plan and stick with it' – and provides information on parents' legal responsibilities and the importance of express consent. 'The Plan' is currently being piloted in Invercargill and will be rolled out across the Southern district in the New Year. It is a joint initiative led by WellSouth and Public Health South (SDHB) and supported by ILT (Invercargill Licensing Trust), Police and James Hargest High School. Resources are being distributed through bottle stores and will also be promoted via social media and in the media. Resources for parents are available from selected bottle-stores in Invercargill or from www.nosafelimit.co.nz

Plan Change 13 – Update

Plan Change 13 to Central Otago District Council's Operative District Plan had an applicant intending to establish a residential subdivision adjacent to the Highlands Motor Sport Park and the Cromwell Speedway on one side and the Freeway Orchard on the other side. Southern DHB opposed this application due to potential serious public health risks relating to noise, orchard spray-drift and connectivity with the rest of Cromwell. Supported by Ministry of Health funded experts in noise and air quality and a Southern DHB funded planning consultant, we participated in hearings in June and July 2019 before independent Commissioners appointed by the Central Otago District Council. The commissioner's decision has just been announced and the proposed Plan Change has not been accepted. It is our expectation that there will be an appeal. We will need to review our position on that in February. It should be noted the decision is based on noise and connectivity with the rest of Cromwell – these were two of the three main points that were raised in our submission.

Housing

A draft research report - 'Pehea Tou Kainga – How's your Home' was undertaken by Public Health and released in September. Findings showed significant concerns about housing shortages and that housing is a key contributor to poor health outcomes and inequity in Central Otago. One of the key recommendations from the report was to form a multi-agency taskforce and develop a Central Otago Housing Action Plan. Following this a multiagency housing meeting took place in Alexandra in late November. The meeting was a good starting point for getting key stakeholders together to discuss

the report findings. Participants included representatives from a number of government and non-government agencies and Queenstown Lakes and Central Otago District Councils. While the report was initiated by Southern DHB and the outcomes are health related, the levers to make a difference are not controlled by Southern DHB. By working together, we can better influence the decision-making required to make positive changes to the housing situation in the Central Otago and Queenstown Lakes Districts. Southern DHB will facilitate a second multiagency meeting in March 2020 to continue the collaborative approach.

Healthy Active Learning

With the transition from Health Promoting Schools to Healthy Active Learning in 2020, meetings were held between three Dunedin organisations working in the physical activity and active transport area in schools to look at sharing information and working together more closely in this space. The Dunedin City Council Safe and Sustainable Travel Coordinator, the Sport Otago Community and Schools Advisor, and Health Promotion Advisors got together to share what their organisations are doing and how they could collaborate on projects in the future. Information was exchanged around the Walking Time Zone Mapping project piloted by Health Promotion Advisors, the traffic safety projects around some Dunedin schools, planning for a back to school transport safety campaign in term 1, and Sport Otago's Walk and Wheel week. The aim of the collaboration is to increase impact and create more momentum by aligning individual initiatives in future.

Population Health Service

The population health service delivers a range of services to support health for families, school age children and young people. The service includes the New Born Hearing Screening Team, Public Health Nursing, immunisation register, immunisation services such as delivery of the immunisation programme for Human papillomavirus (HPV) and sexual health services. Public Health Nurses deliver a range of interventions such as the nursing services in schools, Before Schools check and Gateway assessments which is a process to support children and young people entering care, already in care, or at risk of coming into Child, Youth and Family care. The service also provides the health service to Puketai School which is a Care and Protection residence located in Dunedin. The service also manages delivery of the cervical screening programme.

The service is funded through a combination of core funding from DHB Population based Funding and individual service agreements with the MoH for specific programmes.

In December 2020 the New Born Hearing Screening team were under pressure due to long term leave of two of the five employees. The impact of this on service delivery targets will be reviewed in January 2020.

The Te Punaka Oraka (Public Health Nursing) service has secured two New Zealand Nursing Entry to Practice Programme (NetP) nursing graduates for 2020. This programme ensures new graduate nurses begin their careers well-supported, safe, skilled and confident in their clinical practice, equipped for further learning and professional development. Securing the new graduates is important to the long term development of this important service. This will help ensure the service can deliver the recent extension of the schools based services contract to include decile 5 schools.

The service put plans in place over the period between 20th December 2019 and 6th January 2020 to ensure the DHB would be able to respond promptly should an outbreak of measles reoccur. While management of measles outbreaks is primarily managed via the Public Health service, the immunisation and nursing staff of the population health service have been critical to the DHB responses to the measles outbreak in 2019.

The immunisation coordinators have completed training on the new catch up calculator. The next step is developing a plan in 2020 with to progress the use of catch up calculator for practice nurses. This will support the district to continue to achieve high rates of immunisation coverage.

District Oral Health Service

The Community Oral Health service provides free basic dental care to children from birth until Year 8 who meet the eligibility criteria for publically funded health services. Basic care includes an annual check-up, oral health advice, examination and dental x-rays if required, preventative treatment such as topical fluoride and fissure sealants and where required restorations (fillings) and extractions. Services for adolescents are provided by private dentists contracted by the DHB.

At May 2018 the service had arrears of 23% against a national target of 10%. Consistent work has been undertaken to address this for the last 18 months with good improvement and by mid-2019 this had reduced to 11%. At November 2019 the arrears were at 14% reflecting some issues with recruitment and retention of staff. Despite the staffing issues the service has retained its commitment to ensuring equitable access for rural children and the service mobile buses will deliver their full schedule across the district in 2020. The work to support this such as booking in times with schools, scheduling staff to work away from base and logistics to support this have been a main area of work in December 2019. The mobiles are currently at Abbotsford, Wakari, TeWhare Kura and Southland Ascot. The mobiles are all due for their yearly maintenance which is organised by Dental and Medical.

Changes at the dental school in 2019 have resulted in the service taking back in house the delivery of services to some Dunedin children who previously attended the dental school. To support this the team are working with Building and Property on a Dunedin South 4th clinic room.

The dental Unit (Southland) capex requests have been submitted for two clinics.

A Pacific Outreach Clinic has been introduced in late 2019 in South Dunedin. This clinic will resume again in February 2020 and a new therapist has been introduced to the clinic allowing for greater flexibility with rostering. This clinic has been well received and it is hoped will support greater levels of uptake of services in this area.

The service is working hard to increase availability of fluoride varnish which is an important element of preventative care for children. A training programme is being developed and the professional lead is looking at writing a Calderdale Framework, Clinical Task Instruction. This has been discussed with Northland DHB Service Manager and they also use Calderdale and feel it would be good to have a CTI for assistants applying fluoride varnish. The team are reviewing what we are doing across the district to streamline processes with a view to expanding the reach of this preventative method. This will include the training of Dental Assistants to place the varnish as delegated by the therapist. Brainstorming sessions have taken place and the documentation is currently being consulted on.

Child Health (0-5years)

We continue to progress extending the Southern Stop Smoking Service (SSSS) Incentive Scheme for pregnant women. Portfolio Managers for Primary Care and Child Health met with the SSSS CEO and established that there is enough funding available in the existing contract to continue and extend the scheme to include three vouchers post birth. This extension will ensure support is available to women and whanau to remain smokefree once baby is born. We also discussed moving to a more high trust relationship to ensure incentives are given at the right time for different women and their whanau, whilst retaining the maximum number of vouchers available.

Sudden Unexplained Death in Infants (SUDI) - we have been given a possible date (31 January) for local Dunedin weavers wānanga to meet and discuss their capacity to supply wahakura for us and how to hold wānanga with the community; We have now received 80 of the 120 purchased wahakura from the North Island weavers. Once the hui with local weavers has occurred we will launch distribution of wahakura across the district. It is anticipated that this will be very well received.

Pepi-pods are continuing to be distributed in increased numbers following a series of distributor meetings and engagement with key stakeholders.
The South Island Alliance Programme Office (SIAPO) South Island SUDI coordinator has discussed the Change for Our Children Pepi Pod Programme Participation Agreement with the Canterbury DHB lawyer; we are awaiting an update on the interpretation and meaning of some of the clauses in the

agreement; without a signed participation agreement we will not be able to purchase any more pepi pods or associated products in 2020 but we have good supplies of pods to cover demand for some time.

The Child and Youth Network met on the 12 December and there was a good response from members to ensuring strategic alignment across agencies for System Level Measures (SLM) activities. We will discuss opportunities for the 2020/21 SLM plan at the next meeting in February and will record how activity in different government agencies support the two SLM outcomes relating to children and young people i.e. ASH rates for under four year old and smokefree homes at six weeks.

Well Child Tamariki Ora (WCTO) Steering Group met on the 29 November and were also supportive of ensuring strategic alignment with SLM activity in 2020/21. Whilst the group won't be responsible for this work, there is understanding that activities carried out in different agencies contributes to outcomes, such as reducing ASH rates and supporting smokefree homes.

SIAPO Child and Youth have sent their draft Child Health Plan for 2020/21 for consideration. Clarification has been sought on a number of issues within the plan, including large budget bids for some of the projects being considered.

Pregnancy and Parenting – a small contract has been established with Pacific Trust Otago to deliver a community based breast feeding support pilot. It will provide one-on-one consultations with women to support the establishment and maintenance of breast feeding for priority women; it will link across systems to support women and also provide breast feeding support to other health professionals in the community. It is jointly funded by Pacific Trust Otago and SDHB SUDI funding.

Perinatal Post Mortem

SDHB perinatal services (excluding coronial) are currently undergoing a redesign to align with the National centralised model of delivery, which is a hub and spoke model, required by the Ministry of Health. This will mean that services will be managed for our DHB by Canterbury DHB, although procedures will still be undertaken locally for the majority of cases.

MENTAL HEALTH

EXECUTIVE HIGHLIGHTS

- **State of the Nation (Year in review) –** This annual event was well attended in December with staff joining by video conference across several sites.

- **Future Directions Southland Mental Health and Addiction Network workshop** – The existing future directions team held a workshop attended by Louise Travers, General Manger, John MacDonald, Chair, Southern Mental Health and Addiction Network Leadership Group (NLG) and Ron Craft as Relationship Manager, along with external agencies. The focus was on the existing terms of reference, aligning these with the thoughts of the Network Leadership Group and Raise Hope – Hāpai te Tūmanako as well as ensuring the right people are part of the group. After a productive session the beginnings of a plan have been developed for the group for 2020.

- **Service Planning Hui –** Work has commenced for a whole of system mental health and addiction planning day with One Hui Four sites, joined by video conference to occur in March 2020. This will bring all aspects of the Southern Mental Health and Addiction system together, including, Tangata Whaiora, Whanau, Primary, Community, Specialist Services, Non-Government Organisations (NGOs) and other Government agencies.

- **Ministry of Health – He Ara Oranga–** Two Requests for Proposals have been submitted. The first was for an Integrated Primary Mental Health programme developed collaboratively by WellSouth, Southern DHB and NGOs which will commence implementation in tranche two. The outcome of the second RFP for expansion and/or replication of existing Māori and Pacific primary services is pending.

- **Continuum of Care Review Planning –** The draft terms of reference have been further updated following discussion at Alliance South. These will now be discussed at the January NLG meeting, MHAID team and Unions for input.

- **Transition Planning** – In March 2017 the office of the Auditor General presented a performance audit entitled "Mental health: Effectiveness of the planning to discharge people from hospital" The report contained three main recommendations, each of which has become a requirement for DHB's:

    1. Inpatient and community mental health teams to work together more effectively to prepare and implement discharge plans
    2. Staff are supported with guidance and tools to support discharge planning (including IS) so the information needed for discharge planning can be bought together easily and efficiently
    3. DHBs regularly review the standard of discharge planning and follow up work to identify and make improvements.

  A performance indicator was subsequently established (PP7), changed to MH02 in the 2019-20 reporting year, requiring al DHBs to report on their performance. SDHB MHAID has not performed at all well in this target and was also an outlier in the Health Select Committee sessions earlier this year.

By the end of Quarter 3, 31 March 2020

- Referrals open longer than three months with three or more face to face contacts will have a relapse/wellness/transition plan in place.
- 95 % of clients discharged will have a transition plan
- SDHB MHAID will not be a national outlier

Improving compliance continues to be a priority for the MHADI with close monitoring and review of data by Service Managers. December's data shows a small increase in two of the three categories (Closed referrals with three or more face to face referrals – 48%, Open referrals longer than one year with three or more face to face contacts – 68% and open referrals longer than three months with three or more face to face contacts – 51%)

- **Learning from Adverse Events (Health Quality Safety Commission (HQSC) project) –** Project group finalised and meetings commenced. Preparation for co-design sessions and planning for February regional workshop is underway
- **Connecting Care (HQSC project) –** Connecting Care project group has been expanded with a workshop scheduled in January. The initial focus has been on documentation and developing Plan Do Study Act (PDSA) cycles.

Health Quality Safety Commission (HQSC) Zero Seclusion Programme – The service continues its endeavours to reduce the use of seclusion through the use of quality improvement tools and as the above graph shows the people secluded and number of seclusion episodes has either reduced or stayed the same as the previous month. The area of concern for November was the total hours of seclusion for the month. This is explained by acuity of presentations and the very limited options available to manage what is often aggression. Again this highlights the inadequate environments we are delivering services from and unless this is addressed it will remain challenging to reach the aspirational goal of zero seclusion.

Health Connect South (HCS) Steering Group – The steering group have agreed some key action points. Developing guidelines regarding uploading into HCS, trialling the usability of personalised care plans for MHAID service and gather a full risk set that informs the regional summary. The PCPs have been trialled and feedback provided. The plan is now to adapt the plan and for it to become a South Island prototype.

Ombudsman visit – In December the Office of the Ombudsman spent two days talking to senior staff associated with the Intellectual Disability Service in relation to the Ombudsman's investigation into the Ministry of Health's oversight of facilities and services for intellectually disabled people with high and complex needs. The Ombudsman expects to complete the investigation early in 2020 and a report will subsequently be completed and available to stakeholder groups including the Southern DHB.

RISKS AND ISSUES

Risk Area	Summary of Risk	Likelihood (Low, Moderate, High, Extreme)	Mitigation Strategies
Public Health Communicable Disease Nurse Capacity	There have been an increasing number of communicable disease outbreaks and cases requiring contact tracing and follow-up delivered via our nursing workforce.	Moderate	We are currently working to develop a plan for when additional surge capacity is required in responses.
Registered Nurse Coverage in Aged Care Facilities	Although we have only received one Section 31 notification, which was in November 2019, where we assisted renegotiating start dates with one new RN (from aged care) to assist the facility's staffing, we are aware that this is a problem across much of the sector, not assisted by recent MECA settlements for secondary care nurses.	High	Backup systems put in place for specific incidents. Facilities are using all methods available to recruit within their resources. This has been discussed at our Provider meetings and at the national Director of Nurses' Forums.
Waiting Lists for allied health therapies due to staff shortages	Waiting lists for allied health therapies have been increasing well beyond good practice and Ministry guidelines.	Moderate	Active recruitment for physio therapy in Invercargill. Four new graduates to start 2020. Reviewing referrals and wait lists.

Nursing pay parity for NGO sector to come into line with NZNO and DHB settlement. Risk of industrial action by nursing workforce in NGO sector	Expectation from most/all providers that employ nursing staff that the Terms and Conditions of the recently renegotiated settlement will trickle down to non DHB employed nursing staff	High	Clear and consistent communication about what is occurring at a national level on this issue. Funding was prioritised in the 2019/20 budget for a range of NGOs to facilitate movement towards pay parity in relation to nursing, whilst we await further national developments.
Population Health Service - Community Paediatrician	The Community Paediatrician role which currently sits under Child Health - 1.0FTE (0.5FTE in both Southland and Otago) across the district has now been vacant for a significant amount of time leaving the service without Medical cover. This is important because Clinical lead support is required to oversee both the operational, legislative and strategic functions of key programmes.	Moderate	Work is underway to identify GPs with child health diplomas whom may be able to support the service.
District Oral Health Service – Enrolments & Arrears	The arrears are creeping upwards due to Dental Therpaist vacancies and the amount of enrolments of new children are also a factor.	Low	Continue with recruiting for senior Dental therapists and looking to new graduates who will fit into the team once they are registered later in the year.

Assaults and Aggression to Staff, Staff Injuries	Patient and staff safety continues to be a focus with the work of previous months continuing on.		
Wait times – Mental Health	Wait times in the specialist services vary significantly across Otago as a result of local referrals and/or vacancies.		Work is occurring with individual teams to increase compliance.
Mental Health: Rural After Hours Change Proposal (2016)	The implementation of this which involves the Lakes area being serviced by a local overnight on call team, replacing coverage provided by the Invercargill on call clinicians has stalled indefinitely while the service attempts to work through the issues raised by the PSA and NZNO.		A meeting occurred involving Human Resources, Service Manager, PSA and NZNO in an effort to get some clarity about the issues to progress the changes. Human Resources are continuing to support the process

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Update on the Implementation of the Primary Maternity System of Care – process for the selection of a Primary Birthing Unit or Units in Central Otago**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	4 February 2020

Summary:

In developing the Integrated Primary Maternity System of Care, extensive consultation was undertaken with both the community and health care providers to establish principles for a reformed configuration of services. These endorsed principles are:

- Critical mass:
  understanding our population across the district and projected birthing numbers;
  meeting the Ministry of Health birthing population standards as outlined in the National Service Coverage Schedule; and
  ensuring that there are sufficient numbers for both a viable service and sustainable workforce
- Equity for disadvantaged communities
- Acceptable travel distances to a facility – in the context of improved support for home birthing, and acknowledging the preference for travel towards secondary care locations.

Attached is an outline project and communications plan that sets out the main steps and timelines to deliver a decision on a key aspect of the next phase of the implementation of the overall strategy, which is to identify the location for primary birthing unit in Central Lakes (action 7 of the Integrated Primary Maternity System of Care which states that 'Consideration to be given to the most appropriate location for a primary maternity facility within the Central Lakes district').

The Central Lakes Locality Network will partner with the DHB through the Primary Care and Population Health team to undertake the work required to reach a recommendation. The Maternity, Quality and Safety Governance Group will be a key stakeholder to provide expert input into the development of options.

Recruitment is underway for a Project Manager to support this work stream and the other outstanding elements of the overall Primary Maternity strategy and at the time of writing it looks like we would successfully appoint someone into the role before CPHAC are due to meet. An update on this will be provided at the meeting.

Specific implications for consideration (FINANCIAL/WORKFORCE/RISK/LEGAL ETC.):	
Financial:	N/A
Workforce:	N/A
Other:	Key risks for CPHAC to note include the ongoing level of community and media attention to this issue as well as the ability to achieve the desired deadline of June 2020 for a recommendation to the Board for a decision. This needs to be balanced against the need to meaningfully engage and consult with key stakeholders.

10

Document previously submitted to:	N/A	**DATE:**
Approved by Chief Executive Officer:	Chris Fleming	**DATE:** 21 January 2020

Prepared by:	**Presented by:**
Mary Cleary-Lyons GM Primary Care and Population Health Helen Telford Chair, Central Lakes Locality Network **Date:** 10 January 2020	Mary Cleary-Lyons GM Primary Care and Population Health

RECOMMENDATION:

That the Committee supports the milestones and deliverables as outlined in the paper.

1. Introduction

The broader Central lakes district which comprises Queenstown, Alexandra, Cromwell, Clyde, Ranfurly and Roxburgh is currently serviced by two primary birthing facilities –one in Alexandra (Charlotte Jean Maternity Unit) and one in Queenstown, as part of the SDHB Lakes District Hospital. Because of historic DHB boundaries, as a general rule of thumb the growing areas of Wanaka and surrounds are generally served by Charlotte Jean, which is approximately 60 minutes away by road.

Population growth in the Central Lakes area provides impetus for us to consider what the best configuration of service provision is within this district to better service current and future demand.

Whilst it is not feasible to have a facility in each sub locality within the district, overall pregnancy and birthing numbers within these areas suggest that a decision needs to be made, which will provide increased access to primary maternity services within the Central region.

Further investigative work needs to be undertaken to decide where best a facility or facilities should be located (phase one, work stream one, as outlined in the paper). Stakeholder engagement is clearly required to determine the locality that would best service all the areas above, and a process in line with procurement guidelines would need to be followed.

National Policy Requirements

The specifics of our obligation to provide maternity care to our population are outlined in the National Service Coverage Schedule (SCS), which is a critical part of the Operating Policy Framework that supports the relationship between the Ministry of Health and the 20 DHB's. The relevant section on Primary maternity from the SCS is as follows:

The DHB is required to provide or fund primary maternity facilities for urban or rural communities with a catchment of:

- 200 pregnancies where the facility is 30 minutes from a secondary service,
- 100 pregnancies where the facility is 60 minutes from a secondary service

Because of the burgeoning populations in Central Otago and Queenstown Lakes District, depending on how the identified are 'catchments' are treated, it is entirely probable that for sub-localities within this part of the District that we are no longer meeting this part of our SCS requirement.

The Role of the Maternity Quality and Safety Programme

Local maternity quality and safety programmes have been operating in each DHB since 2012 and have raised the profile of maternity quality and safety by establishing more effective governance structures, enhanced clinical leadership and better engagement with the sector and consumers.

In 2014/15, the Ministry contracted Allen + Clarke Policy and Regulatory Specialists to evaluate the impact of the local maternity quality and safety programmes. They found that the programmes had started to deliver meaningful improvements and there was significant value in continued Ministry of Health investment and support.

The report highlights some of the challenges DHBs have faced in implementing the local maternity quality and safety programmes and provides useful information for DHBs as they move into the next phase of their local programmes.

In mid-2015 the Ministry of Health confirmed ongoing funding for DHB maternity quality and safety programmes.

A Committee of key midwifery stakeholders exists locally to oversee and administer the MQSP programme, and this group will be key advisors to the Board in respect of this decision, alongside the Central Lakes Locality Network.

2. Our Approach

Phase one: Developing Scenarios

In order to develop potential scenarios for consultation of what provision of primary birthing facilities might look like, two distinct but related pieces of work need to be undertaken. These are outlined in the following work streams:

Work stream one: Gathering information

Considerable information exists to inform this decision in the form of birth volumes, workforce trends, travel times, rates of transfer to secondary services. This will largely be a desk top exercise to pull together existing information, and draw additional metrics from policy documents and demographic data.

Work stream two: Learning from key stakeholders

Building on the principles of critical mass, equity, and acceptability of travel distances, considered alongside existing data and information, it is proposed that the project undertakes focused interviews and workshops with key stakeholders to gain additional insights and perspectives.

The stakeholder group that will be consulted with at this stage of the project are as follows:

Maternity Quality and Safety Committee	This is a key stakeholder group, who will be actively involved in generating options for consideration. This is likely to involve a presentation at an MQSP meeting to elicit feedback as well as an open invitation being made available for members to submit views via the online web form.
Wanaka Maternal and Child Hub	Face to face meeting with LMCs as well as Hub Coordinator, as well as invitation through web form as above
Central Otago midwives	Presentation to be made at Central Otago NZCOM meeting, invite further thoughts through web form as above
Southern DHB obstetric specialists	Meet with clinical leaders and key personnel as nominated by clinical leaders. Email to wider teams, invite further thoughts through web form
Iwi Governance	Presentation to meeting of Iwi Governance Committee

Community Health Council	Present to a meeting of the Community Health Council Invite Community Health Council to email web form to broader database of advisors and stakeholders
Ministry of Health	Keep informed and updated of progress Request support for policy interpretation and guidance as required.
Alliance Leadership Team (ALT)	Regular updates (monthly for the duration of the programme). Advice/support for key decision points Endorsement of eventual recommendation prior to submission to ELT/Board
WellSouth/GPs	Discuss with WellSouth how they wish to participate/partner with the DHB in this programme. Suggest Email to GPs, Primary and Community newsletter, invite further thoughts through web form
Women	Meeting with Save our Midwives group. Invite further thoughts through web form -Parents Centre -Plunket -Peer support groups eg. Mums4mums,
Central Lakes Trust	Invite to workshop and involve in problem solving solutions
St John	Face to face meeting, invite further thoughts through web form
Community input	Media release, promotion of web form

Based on the information and insights gained, a shortlist of options will be generated.

Phase two: Feedback on scenarios

This will involve the presentation of the shortlisted options to a broader group of stakeholders, and for a more formal consultation to be undertaken. In summary, the means for achieving this will be a combination of the following engagement and consultation methods:

- Workshop(s) with wider stakeholders
- Public meeting(s)
- The sharing and distributing of information through dedicated website material, with the ability for people to engage and respond to that information electronically
- Media engagement

PROPOSED TIMELINE

Activity	Lead	Date
PHASE ONE		
Initial data pack available to project team/Locality network	Decision Support	By 24 January 2020 (Complete)
Locality Network to discuss and agree approach	Helen and Mary to present to the Locality Network	29 January 2020
Communication to stakeholders • Letters to stakeholders • Presentation for stakeholder group meetings ready • Preparation of presentation • Preparation of web form questions Wider communications: • Website • Media	Locality Network and DHB – co-signed by Mary and Helen DHB	By 31 January 2020 Live by 5 February 2020
Presentation of approach to Community Health Council	Mary Cleary-Lyons	29 January 2020
Endorsement of approach by CPHAC	Lisa Gestro Mary Cleary Lyons Helen Telford	4 February 2020
Initial stakeholder individual and focus group meetings	DHB and Locality Network	By 14 February 2020
Update to Alliance Leadership Team	DHB and Locality Network	22 February 2020
Web form feedback closes Analysis of feedback/interviews	DHB Project team	By 29 February 2020
Develop scenarios	DHB Locality Network and MQSP	By 10 March Set Locality Network date for this

Develop Presentation Present to Locality Network and MQSP – finalise scenarios	Comms team to draft and agreed with Locality Network	March meetings
PHASE TWO		
Workshop with stakeholders Statements to media	Locality Network and DHB Joint	25 March (pre-Easter 9 April) To coincide with date above
Public meeting	Locality Network and DHB	2 April 2020
Update to CPHAC	Locality Network and DHB	6 April 2020
Update to ALT	Locality Network and DHB	17 April 2020
Feedback on consultation to close		**30 April 2020**
Locality network to finalise recommendation and liaise with MQSP for alignment	Locality Network	By 6 May 2020
Discussion on draft recommendation with SDHB obstetrics team	DHB/Locality Network/MQSP	Between 6 May and 11 May 2020
Presentation to Clinical Council for endorsement	DHB/Locality Network/MQSP	11 May 2020
Presentation to ALT for endorsement	DHB/Locality Network/MQSP	15 May 2020
Presentation to IGC and CPHAC for endorsement	DHB/Locality Network/MQSP	2 June 2020
Approval of Decision by MoH	DHB	2 June 2020
Approval of Decision by Board meeting	DHB	3 June 2020
Key messaging finalised, implementation plan drafted and decision released	**DHB**	**By 30 June 2020**

SOUTHERN DISTRICT HEALTH BOARD

Title:	Disability Strategy & Action Plan - Update
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	3rd February 2020

Summary:

The Donald Beasley Institute were contracted in August 2018 to develop a Disability Strategy and Action Plan for Southern DHB.

Key phases pf the development to date have included:

- Convening a Disability Strategy Steering Group
- Engagement with Southern DHB leadership team throughout
- Review of relevant International and National documentation such as the UN Convention of Rights of Persons with Disabilities
- Undertaking of a series of regional forums across the Southern District
- Undertaking of a series of engagement with IWI governance and local Runanga
- Engage with a wide range of Southern DHB staff (clinical, building & property, IT, administration, management etc)
- Engagement with WellSouth
- Rounds of consultation with key stakeholders to develop a draft document

A number of events that occurred in 2019 disrupted the original timeline, such as the Christchurch Mosque shootings, but the development is now back on track.

The attached report is the DRAFT Southern DHB's Disability Action Plan as of November 2019. Note that this report has received further feedback that is currently being incorporated.

The next phase is one of making it publically available for a period of time to enable feedback.

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

Financial:	TBD on completion and acceptance of final document
Workforce:	TBD on completion and acceptance of final document
Other:	n/a

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

Prepared by: Gail Thomson Executive Director of Quality & Clinical Governance Solutions **Date:** December 2019	**Presented by:** Gail Thomson Executive Director of Quality & Clinical Governance Solutions

RECOMMENDATION:

That the Committee note the report.

Southern District Health Board
Piki Te Ora

Southern Health
He hauora, he kuru pounamu

DRAFT FOR CONSULTATION
November 2019

Disability Strategy and Action Plan

2019

Contents

Foreword from the the Board and Chief Executive

Tēnā Koutou katoa,

We are pleased to present the Southern District Health Board Disability Strategy and Action Plan, which describes our vision, goals and the actions we will take to provide equitable health and disability services throughout the southern district. The vision recognises the need to remove barriers for disabled people and provide well integrated services that are responsive to them and their whānau, enabling them to live well and participate within their community.

The Strategy and Action Plan, developed in line with the New Zealand Disability Strategy 2001 and the United Nations Convention on the rights of People with Disability, also aligns with, and will sit alongside a number of Southern DHB initiatives. These include the Primary and Community Care Strategy and Action Plan; the Southern Strategic Health Plan; the Southern DHB Quality Framework; the Southern Digital Strategy; and the Southern Workforce Strategy. All these initiatives focus on developing an equitable and coherent system of care across the southern district.

Consultation with the community has led the development of this strategy and action plan. The goals and actions incorporated into the Disability Strategy and Action Plan reflect the request of disabled people, whānau, family, disability and health support providers to recognise and address the unique situation of each individual. The community requested that Southern DHB provide leadership in moving the district to one where disabled people are able to achieve their goals and aspirations.

The goals and actions will take time to achieve and will require prioritising. Some actions will be able to be addressed within the short term, while others might take longer to achieve. We are committed to achieving all actions and leading the southern district into a future where disabled people, whānau and families are living well within our community, barriers are eliminated, and individuals have the ability to access appropriate services.

David Cull
Board Chair

Chris Fleming
Chief Executive

Introduction

Whakatauki – from the Iwi Governance Group

I ānga mai rā te Mātauranga
I o tātou mātua tūpuna
Hei hono I te ao wairua
Ki te ao kikokiko nei.

Kō te Hononga o te hau ora
Ki te ao kikokiko nei
He whakaoreore I te
Hinengaro rā
Kia tū pakari ai, kia tū toa
Te tangata, me te ira wairua.

Ahakoa kō ngā tāimaha tānga
Me ngā ngoikoretanga o te rā
Kei waenganui I a tātou katoa
He oranga hei whāki tānga
Kia hāpai ake te wairua auē.

Our knowledge has come
From our ancestors
To join the spiritual world
To this our mortal realm.

The linking of wellbeing
To this living world
Is a means of awakening the mind
So that we may stand
Tall and proud
People and Spirit.

Although there are trials and
Tribulations
Around and among us all
A wellbeing that must be spoken of
To raise our spirits

“It’s not an optional extra to understand someone entering the health system has a condition or impairment. I think acknowledging vulnerability needs to start from management down. It needs to be shown in how management speak to it, the language we use and the language we don’t use. People with disabilities – we are all people. This is our community.”

- Quote from consultation

Introduction cont.

Rationale

Disabled people, tāngata whaikaha and Deaf people, have the right to fully access services provided by the Southern District Health Board (Southern DHB) and to participate within their community. The Southern DHB Disability Strategy and Action Plan provides a framework for ensuring that disabled people, tāngata whaikaha and Deaf people within the Southern DHB district are engaged with the services of the Southern DHB, have the support they require to participate in their community, and are represented at all levels of the Southern DHB.

Introduction

The personal experience of health and disability services drives the focus for this strategy. Acknowledging the importance of hearing from disabled people, tāngata whaikaha, Deaf People, whānau and the wider community, the Strategy has been developed through a process of consultation. Appreciating the value of an open consultation process, the Southern DHB commissioned the Donald Beasley Institute (DBI), a Dunedin-based disability research organisation, to facilitate the development of the Strategy. http://www.donaldbeasley.org.nz

Consultation followed a co-design approach and included people with diverse experience of the health and disability sectors both as consumers and providers.

A strong message from the people who participated in consultation was that they wanted a Strategy that would drive the longer term goal of the New Zealand Disability Strategy for disabled people to be fully included within society. To achieve this goal within the Southern DHB district, the Strategy includes a number of actions to which the Southern DHB commits. Some actions will be immediate, while others will take longer to enact. All actions will be evaluated and reported through appropriate workplans.

People being consulted also asked for clarification about the term 'disability' as many people who require reasonable accommodations might not consider themselves disabled. For the purpose of the Strategy, people with physical, intellectual, cognitive, mental or sensory impairments, people with long-term (chronic) or psycho-social conditions, or any other impairment are included. The Strategy does recognise that a person's impairment will not necessarily inform their identity. People belong within various groups which might more strongly influence their identity.

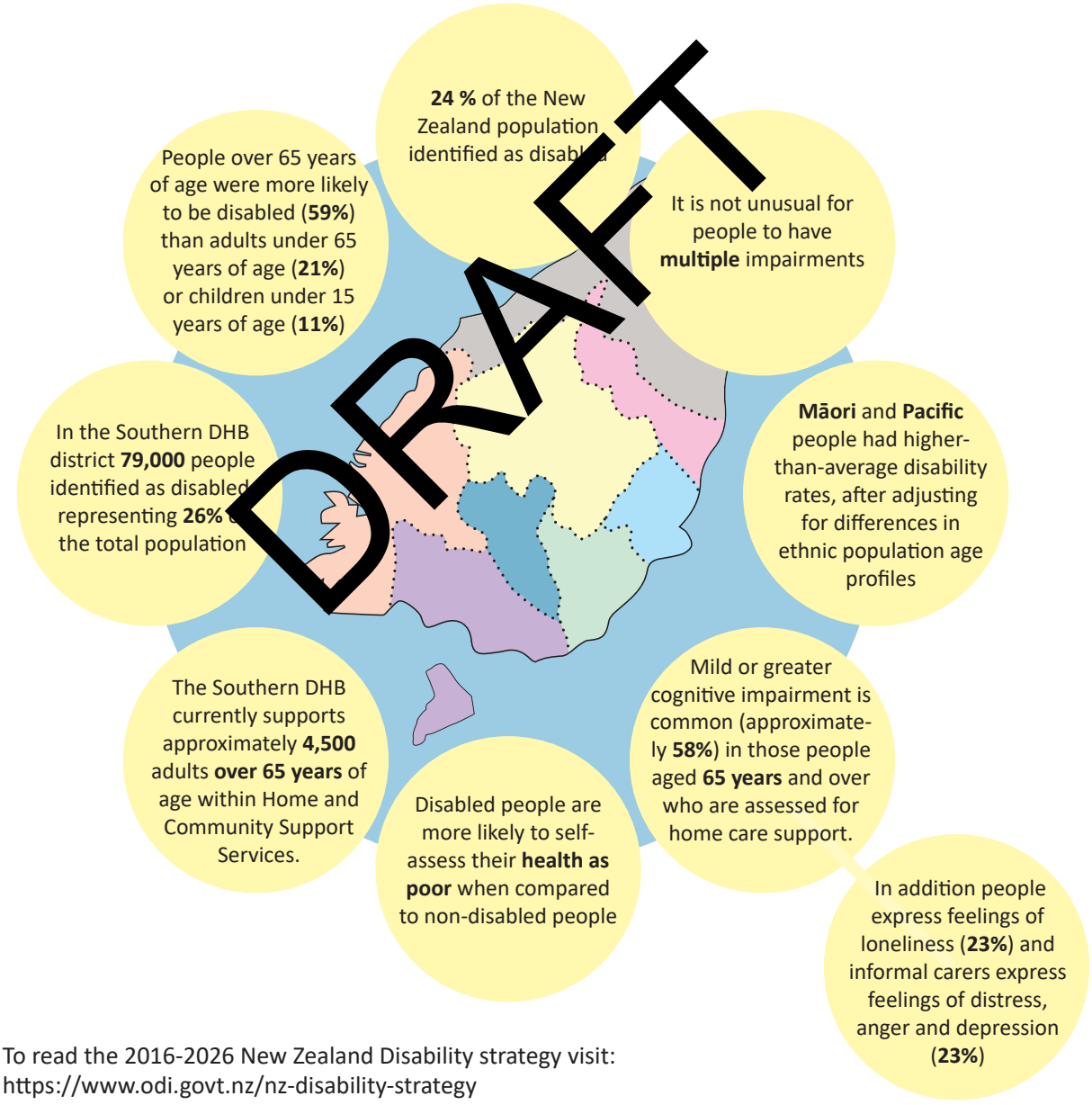
People who are engaged with their health and disability service are more likely to have positive care experiences and subsequently better health outcomes. The Strategy includes actions that focus on the experiences of disabled people, tāngata whaikaha and Deaf people to ensure that they and their family or whānau feel informed, engaged and supported to manage their health and are able to live satisfying lives within their community.

Quick Facts about Disability in New Zealand

Southern DHB is responsible for planning, funding and providing health and disability services to the population living south of the Waitaki river (over 300,000 people). It is the largest DHB in New Zealand by geographical area.

The New Zealand Disability Strategy was first released in 2001 with an updated Action Plan released in 2016 with the aim to make New Zealand a more inclusive and accessible society.

Using data from the 2013 New Zealand Disability Survey, interRai and the Southern DHB we know that:



To read the 2016-2026 New Zealand Disability strategy visit:
https://www.odi.govt.nz/nz-disability-strategy

Definitions used in this Strategy

Co-design
Co-design is defined as a method for partnering with patients, consumers and service users right from the beginning of service planning to ensure a closer alignment of service delivery with what will work best for service users.
(From healthnavigator.org.nz)

Deaf
For many Deaf people their Deafness is not seen by them as a disability, they form a distinct community, having their own culture and language (New Zealand Sign Language). (Adapted from Deaf Aotearoa website.)

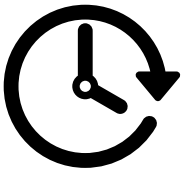
Disability
Long-term physical, mental, intellectual or sensory impairment which in interaction with various barriers may hinder the person's full and effective participation in society on an equal basis with others. (Adapted from the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the NZ Disability Strategy 2016-2026.)

Equity
Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. (From Ministry of Health, 2019.)

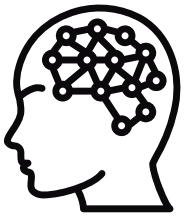
Hard of hearing
A hearing impairment that is defined by the World Health Organisation to be moderate or worse hearing in the better ear.

Hidden Disability
Hidden (invisible) disabilities include fatigue, pain, cognitive and mental impairments, hearing and visual impairments, and psychosocial impairments that might not be obvious but that impact on the person's movement, senses or activities. (Adapted from https://invisibledisabilities.org/what-is-an-invisible-disability .)

Health
Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (From https://www.who.int/about/who-we-are/constitution.)



Long-term (or chronic) conditions
Long-term conditions are ongoing, long-term or recurring conditions that can have a significant impact on people's lives. (Ministry of Health, 2018.)



Psychosocial disability
The UNCRPD describes psychosocial disability as the experience of people with impairments and participation restrictions related to mental health conditions. These impairments can include a loss of ability to function, think clearly, experience full physical health, and manage the social and emotional aspects of their lives

Reasonable Accommodation
Reasonable accommodation means necessary and appropriate modification and adjustments to ensure persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and freedoms. (Adapted from the UNCRPD.)

Tāngata whaikaha
Tāngata whaikaha is the term used in the Whāia Te Ao Mārama (Māori Disability Strategy) to describe a Māori person with a disability. The term refers to people who are determined to do well and create their own opportunities.

Universal design
Universal design means the design of products, environments, programmes, and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design. It includes assistive devices for particular groups of persons with disabilities where this is needed. (Adapted from the UNCRPD.)

Policy Context for New Zealand

Underpinning the Southern DHB Disability Strategy and Action Plan are important international and national documents that address the rights of disabled people.

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

New Zealand ratified the UNCRPD in 2008. Under this international convention, New Zealand is expected to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity".

The UNCRPD is based on the social model of disability alongside rights-based models. The social model of disability recognises the person as having an impairment, but it is through their experience of barriers to their participation that they are disabled. This shifts the focus from the individual's deficiencies (as assumed by the medical model of disability), to identifying and removing the barriers that prevent their participation within society.

Within the UNCRPD there are a number of articles relevant to the Southern DHB Disability Strategy and Action Plan. The relevant article(s) are identified alongside the Southern DHB action.

Te Tiriti O Waitangi

Te Tiriti O Waitangi as the founding document of Aotearoa New Zealand sets out the relationship between Māori and the Crown. Whāia Te Ao Mārama 2018-2022 (The Māori Disability Action Plan; MDAP), provides a vision for tāngata whaikaha to pursue a good life with support. Importantly, Whāia Te Ao Marama reinforces that most tāngata whaikaha identify as Māori first. The importance of their cultural identity, which encompasses language, whānau, cultural principles, practices, and linkages to the land through genealogy, is paramount to how they live their day to day lives in both Te Ao Māori and Te Ao Pakeha. In order to achieve a good life with support, Whāia Te Ao Mārama incorporates six goals, three of which relate to participation, in health and disability services (goal 1), Te Ao Māori (goal 3), and their community (goal 4). Further goals aim for tāngata whaikaha to have control over their disability support (goal 2), receive disability support services that are responsive to Te Ao Māori (goal 5), and have informed and responsive communities (goal 6). Overall the goals reflect the Articles of Te Tiriti, which have been interpreted as the principles of participation, protection and partnership. These six goals are incorporated into the Southern DHB Disability Strategy and Action Plan.

New Zealand Strategies and Policies

The New Zealand Public Health and Disability Act 2000 established District Health Boards and set out requirements for disability support, including that each Board was to have a Disability Support Advisory Committee (DSAC). The New Zealand Disability Strategy 2001 (updated in 2016) was aimed at government departments and agencies (including District Health Boards) to encourage actions that would promote a more inclusive society. The 2016 update of the Disability Strategy expressed the aim for New Zealand to be a non-disabling society ... "a place where all disabled people have an equal opportunity to achieve their goals and aspirations, and all of New

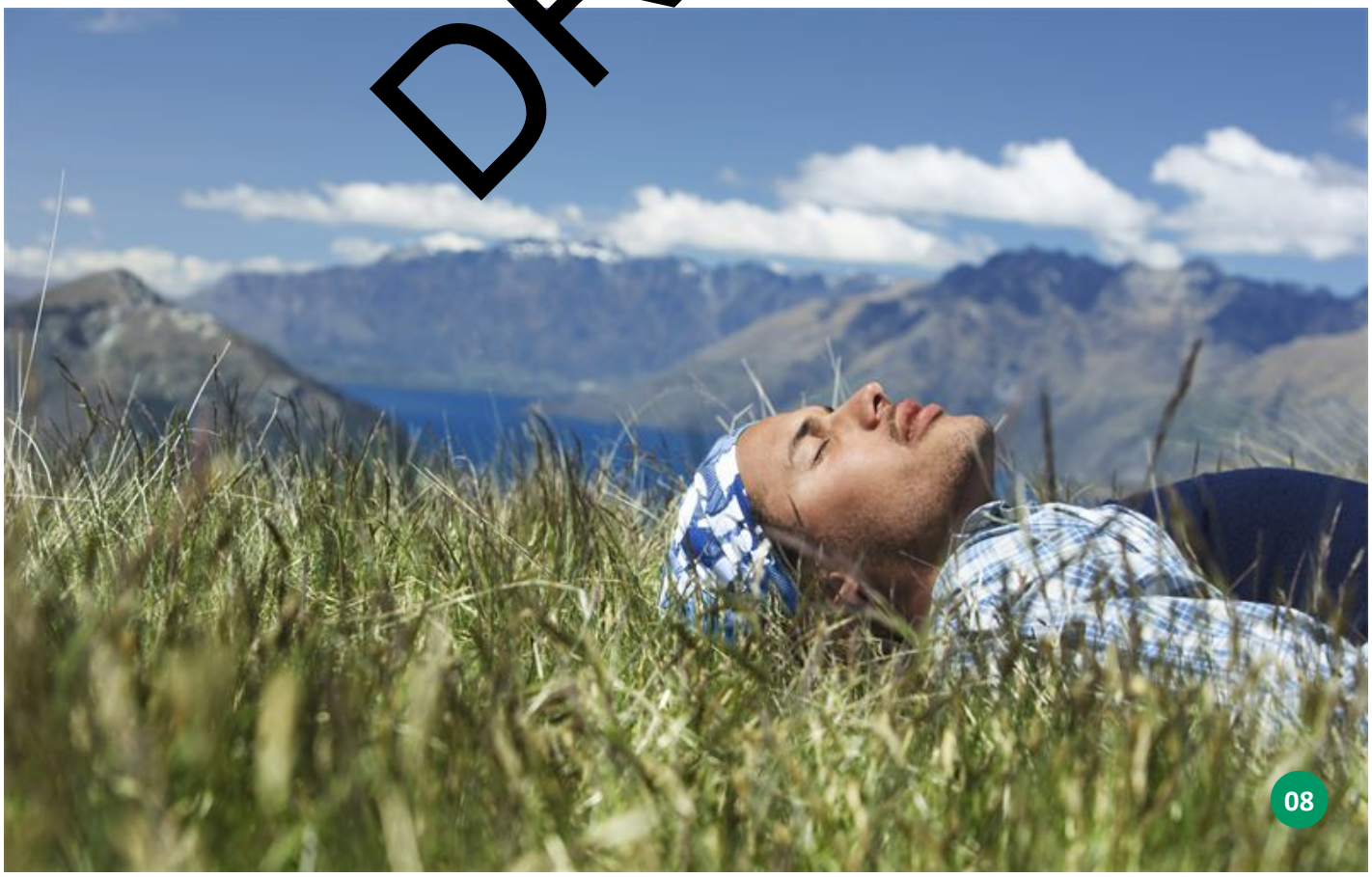
Zealand works together to make this happen." From the Disability Strategy, the government has approved a Disability Action Plan (DAP). The 2014-2018 (DAP) identifies eight outcomes as a focus for government departments and agencies. These outcomes are related to:

1. Education
2. Employment
3. Health and wellbeing
4. Justice
5. Accessibility
6. Attitudes
7. Choice and control
8. Leadership

The Southern DHB Disability Strategy and Action Plan identifies the relevant outcome alongside Southern DHB actions.

Whānau Ora is a cross-government programme that includes the Ministry of Health, Te Puni Kōkiri, and the Ministry of Social Development. Whānau Ora approaches health from a cultural perspective, is shaped by Māori world-views, cultural norms, traditions and heritage.

In addition to the foundational documents, there are a range of relevant strategies and action plans released by the Ministry of Health and available on their website.



Current Southern DHB Context

The Southern DHB Disability Strategy and Action Plan has a specific focus on actions that will improve the lives of disabled people, tāngata whaikaha, and Deaf people within the district. In addition to the Disability Strategy, Southern DHB has, or is in the process of implementing, a number of initiatives which will go some way to address the concerns that disabled people, tāngata whaikaha and Deaf people and their family or whānau raised through the community consultation process.

The Southern Strategic Health Plan/Piki te Ora (2015-2025) provides the guidelines for developing an integrated healthcare system for the whole district.

The Southern Primary and Community Care Strategy further identifies strategies for better integration of services and consumer-led health and disability services.

Within the Southern DHB Quality Framework, the **Disability Strategy and Action Plan** will drive the development of equitable care, one of the six identified domains of quality.

Actions within the Strategy have direct relationship to the six goals identified in the **Southern Workforce Strategy** for the development of a workforce that will support the transformation of Southern Health:

WSG2.2 - Actively support and pursue diversity
WSG2.3 - Data to support diversity
WSG2.6 - Disability Support Services

Our pathway towards enabling
Better health, better lives, Whānau Ora
What have our people asked for?*
Southern Future
It's up to us
• better coordinated care across providers, with less wasted time
• care closer to home
• communication that makes sense and is respect
• a calm, compassionate and dignified experience
• high quality, equitable health services.
*Southern Future listening sessions, 2016
How will we get there?
THE SOUTHERN STRATEGIC HEALTH PLAN
Improving experience and outcomes:
Creating an environment for health
The environment and society we live in supports health and wellbeing.
Primary & Community Care
Care is more accessible, coordinated and closer to home.
Clin service re-design
Pri and secondary/tertiary services better connected and integrated.
Patients exp ce high quality, efficient services pathways that value th e.
Enabling success:
Enabling r peo
Our wo rce, skills, port and passion to d er the e our co unities have asked for.
Systems for success
Our systems make it easy for people to manage care, and to work ether safely.
Facilities for the future
Including Dunedin Hospital, Lakes District Hospital redevelopment and community health hubs to accommodate and adapt to new models of care.
By 2026:
We work in partnership
to create a truly integrated,
patient-centred health care system
A health-enabling society, within which we deliver:
More accessible, extensive primary and community care with the right secondary and tertiary care when it's needed.
So that our people:
• are healthier and take greater responsibility for their own health
• stay well in their own homes and communities
• with complex illness have improved health outcomes.
Southern Health
He hauora, he kuru pounamu
Kind - Manaakitanga
Open - Pono
Positive - Whaiwhakaaro
Community - Whanaungatanga
DRAFT

Southern DHB Disability Strategy and Action Plan

Vision

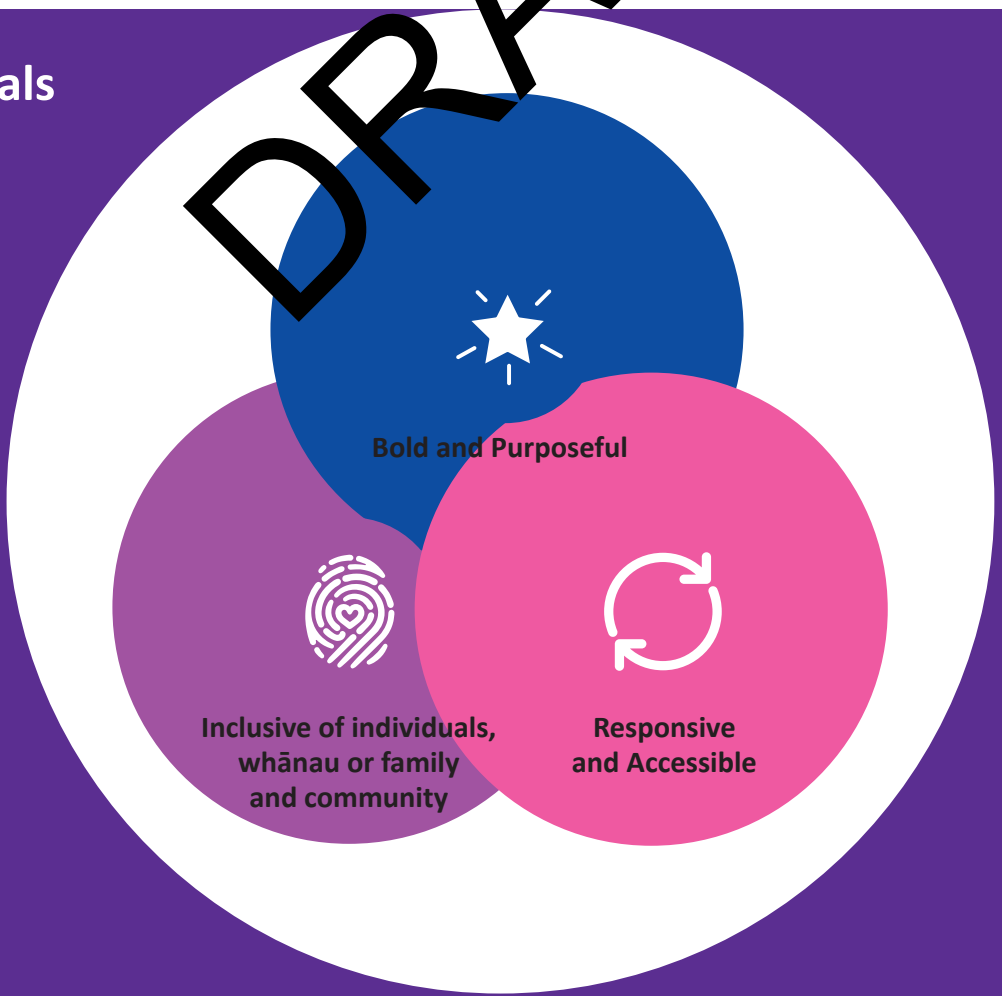
Within the southern district all disabled people, tāngata whaikaha, and Deaf people will have an equal opportunity to achieve their best possible health outcomes, enabling their participation within their community. Health and disability support services will recognise the agency of disabled people, tāngata whaikaha, and Deaf people and their family or whānau through responding to their diverse requirements and removing disabling barriers.

Priorities

From the consultation process three goals were identified as important for Southern DHB to include in their programme of work. For each of these goals there are a number of actions. Each goal is presented with a rationale based on what the community spoke about at consultation meetings, followed by a list of actions.

Goals and actions are not isolated. To achieve an equitable health and disability service for disabled people, tāngata whaikaha, and Deaf people within the Southern DHB district requires integration of all three goals.

Goals



12

Bold and

Goal:

The southern district will be seen as a leader in the provision of health and disability services for disabled people, tāngata whaikaha and Deaf people.

Rationale:

Consultation identified that people saw the Southern DHB as having a responsibility for taking a leadership role within the Southern district and to develop a Disability Strategy that would provide a model for the development of an inclusive community. Both immediate actions and long-term planning are required to achieve this broad goal. It also requires the Southern DHB to work with local organisations and Runaka to ensure an all-of-community response.

This will mean:

- All Southern DHB planning will utilise a co-design approach, which will be incorporated into all the actions that follow where applicable. [DAP 3,5; MDAP 1]

- Southern DHB will actively encourage inclusive practice including the promotion of disabled leadership at all levels of the organisation. [DAP3; UNCRPD Art 27 (e, g); MDAP 1]

- The Executive Leadership Team will identify a member of their team to monitor and ensure that the Disability Strategy is incorporated into all the work of the organisation and in future contractual relationships. Monitoring will include regular reporting to the Community Health Council (who represent a diverse group of consumers within the Southern DHB district); the Disability Support Advisory Committee (DSAC); and the Southern DHB Māori Health Directorate [DAP 8; MDAP 1]

- The newly appointed Southern DHB Board (following the Local Body Elections in 2019) will promote inclusive membership of the Disability Support Advisory Committee (DSAC) through consultation with Disabled and Deaf people in Otago and Southland. [DAP 3; UNCRPD Art 29; MDAP 5]

- Southern DHB will continue to develop robust data collection processes to enable more confident planning that will ensure equity for disabled people, tāngata whaikaha, and Deaf people accessing services, products or employment opportunities. [DAP 3, 5; UNCRPD Art 5, 31; MDAP 5]

- All Southern DHB planning will incorporate principles of Te Tiriti o Waitangi, universal design, reasonable accommodation, and auditing processes to ensure that the plan is accessible, addresses equity and provides a voice for disabled people, tāngata whaikaha and their family or whānau. [DAP 5; UNCRPD Art 25; MDAP 5]

- Southern DHB will continue to implement the Workforce Strategy and Action Plan to achieve a representative proportion of disabled employees at an organisational level. The plan will be inclusive of appropriate support from recruitment through to establishing the person in the workplace with appropriate equipment and / or other accommodations. [DAP 2; UNCRPD Art 27; MDAP 1]

- Staff education will include raising staff awareness of disabled people, tāngata whaikaha and Deaf people and their rights under the UNCRPD, the NZ Disability Strategy and Whāia Te Ao Mārama, continuing with development of the education strategy outlined in the Workforce Strategy and Action Plan, which will incorporate mandatory components. [DAP 6; UNCRPD Art 8; MDAP 5]

- Through the adoption of a learning organisation approach, staff will develop their knowledge and skills in working with disabled people, tāngata whaikaha and Deaf people by way of relationships with consumer groups, iwi, the University of Otago and Otago Polytechnic. [DAP 6; UNCRPD Art 8, 25(d); MDAP 5, 6]

- Southern DHB will plan resources to allow for prompt development and dissemination of new information or technology that might improve the quality of life of disabled people, tāngata whaikaha and Deaf people. [DAP 3, UNCRPD Art 4, 9 (g); MDAP 5,6]

- Staff at all levels of the Southern DHB will be encouraged to use a co-design approach to identify, engage with and influence community groups, city and regional councils, developers and any other relevant organisation or group to ensure an accessible region. [DAP 5, 6; UNCRPD Art 3, 26, 29, 30; MDAP 4,6]

DAP - Disability Action Plan
UNCRPD - United Nations Convention on the Rights of Persons with Disabilities
MDAP - The Māori Disability Action Plan

11

Inclus au or Family a

Goal:

Disabled people, tāngata whaikaha, and Deaf people and their family or whānau will have access to the support they require to live well within their community.

Rationale:

There was a strong message from the consultation process that disabled people, tāngata whaikaha and Deaf people and their whānau wanted better integration of services and recognition of their unique situation. Whānau Ora is a model that draws together a community around a person, enabling people to live their lives within their family and their community. The principles of this model could be seen as the way forward as it recognises that there might be a range of people and services (including wider social services) who can support the disabled person. While valuing the individual's rights to confidential services, people who contributed to the consultation emphasised the supporting role of family or whānau and their wider community. Community organisations also requested greater awareness and recognition of the work that they currently do to support people within their homes and communities in order that the capacity and capabilities of their organisations are fully realised.

This will mean:

- The development of person, family or whānau centred services, integrating the concepts of Whānau Ora, will be incorporated into all future policy and procedures, including pathways of care, to allow for flexibility that recognises every person's life context, including their culture [DAP 3, DAP 7; UNCRPD Art 28; MDAP 1,2,3,4,5]

- Regardless of funding models and focus, staff of the Southern DHB and contracted services will work in the interests of the disabled person, tāngata whaikaha, and their family or whānau towards developing seamless processes between health and disability services, social welfare (Ministry of Social Development), education (Ministry of Education) and other identified support [DAP 3; UNCRPD Art 26; MDAP 1,2,5]

- Family or whānau will be informed and active participants in the disabled person's care, with the permission of the disabled person. In recognition of the shifting health status of people when they are admitted into health services, staff training will include consent procedures and supported decision-making, with recognition that consent decisions can change over time [DAP 3, DAP 7; UNCRPD Art 25(d); MDAP 5]

- Disabled people, tāngata whaikaha will be encouraged and assisted to complete a Health Passport as an option to express their individual preferences and needs (a roll out strategy will be developed). Health professionals will learn about, request and utilise Health Passports as routine care (to be included in staff education) [DAP 3, DAP 6; MDAP 1,2,5,6]

- Disabled people, tāngata whaikaha and their family or whānau will have clear instructions on discharge from services, including how to access supports, readmission procedures, and other options, for example, if it is their preference to leave a service. When appropriate all discharge planning will be inclusive of family, whānau or disability support services [DAP 3; MDAP 1,6]

- To enable a full and satisfying life, disabled people, tāngata whaikaha, and Deaf people will be able to access appropriate support close to their home [DAP 3; UNCRPD Art 25(c); MDAP 1,3,4]

- Southern DHB staff and contracted services will have and provide up-to-date information on community-based services and initiate contact (with permission of the person) where that is the preference of the disabled person and/or their family or whānau. [DAP 3, DAP 7; MDAP 2]

DAP - Disability Action Plan
UNCRPD - United Nations Convention on the Rights of Persons with Disabilities
MDAP - The Māori Disability Action Plan

Respons

Goal:

Through prompt and effe[illegible] disabled people, tāngata whaikaha,and Deaf people will have access to health a[illegible]ation and services that promote their health and wellbeing.

Rationale:

Disabled people, tāngata whaikaha, and whānau across the district request that health and disability services are culturally responsive to their needs in order to enable them to live meaningful and productive lives. Te Taha Wairua (spirituality) holds special significance for Māori wellbeing and is reflected in relationships with people and their environment. Supporting wairua means respecting tikanga (customary practices) and leads to enhanced mana. The principle of equity requires that the Southern DHB provides the additional support that disabled people, tāngata whaikaha, and Deaf people might need to access their services and to maintain and promote their health, including strategies that address health literacy. The consultation process drew out the concerns of rural and urban communities and identified both similar and different issues for disabled people between these regions. Overall, there was a clear message that disabled people, tāngata whaikaha, their family or whānau, and other informal or formal supporters want the Southern DHB to address equity, accessibility and responsiveness for and to them as part of their Disability Strategy. The UNCRPD, the NZ DAP and Whāia Te Ao Mārama were considered to be fundamental to the development of audit processes that should be used across all services for which the Southern DHB has responsibility.

This will mean:

- The principle of universal design will be incorporated into all planning, including information technology, building and built environments, a current priority being the new hospital to be built in Dunedin. Using co-design will ensure final products meet the needs of disabled people, tāngata whaikaha, Deaf people and their whānau [DAP 5; UNCRPD Art 9; MDAP 1,2,5]

- Staff education will include practical information, including but not limited to, tikanga, how to access interpreter services, guidelines to ensure that people's requests are attended to promptly, and use of specialised equipment. The staff education plan will identify components that are mandatory for all staff and those that are necessary for specific groups of staff [DAP 3; UNCRPD Art 4 (i); UNCRPD 25(d); DAP 6]

- Information systems will track requests for support, structural alterations or equipment both for the purpose of ensuring prompt responses to meet the person's needs and as auditable data for later evaluation of the Southern DHB Disability Strategy [DAP 3]

- Southern DHB will ensure that all disabled people are able to access necessary health information, including health promotion, through having available multiple formats and strategies for dissemination. Formats will include Māori and a range of spoken languages commonly used in the district, New Zealand Sign Language, Braille and Easy Read versions [DAP 5; UNCRPD Art 9(2)(f); MDAP 1,6]

- Information technology services will develop a process for disabled people and tāngata whaikaha to identify their disability and any special assistance that they require when accessing Southern DHB services or communicating with the Southern DHB. This identification will be at the choice of the disabled person [DAP 5; DAP 7; MDAP 1,5]

- Principles of universal design will ensure that disabled people, tāngata whaikaha, Deaf people, and whānau can access all technology, including websites and portals for personal health information. Support to enable access will be available as will alternative means for those people that prefer to communicate with health services via telephone or mail [DAP 5; MDAP 1,2,6]

- Disabled people and tāngata whaikaha and Deaf people living outside of the main cities will have equity with city residents in terms of access to the services that they need to live well. For those who have frequent outpatient appointments, reasonable accommodation means that their appointments will be arranged with consideration of their unique situation [DAP 3, DAP 5; UNCRPD Art 25(c); MDAP 1,5]

- Southern DHB will undertake a review of how people access assistance and allowances to develop a straightforward process to enable people to navigate their systems with ease and receive the support available to them. [DAP 3; MDAP 5]

DAP - Disability Action Plan
UNCRPD - United Nations Convention on the Rights of Persons with Disabilities
MDAP - The Māori Disability Action Plan

Southern DHB Values

Achievement of these goals through the planned actions will result in a health system in the Southern district that upholds the values to which Southern DHB is committed. Being a part of the Southern DHB means being genuine, nurturing and maintaining relationships to promote and build on all the strengths available across the Southern DHB community.

The four values are stated as:

Kind / Manaakitanga
Open / Pono
Positive / Whaiwhakaaro
Community / Whanaungatanga

These values are consistent with how disabled people and their families or whānau would like to be respected. The following table incorporates quotes from the Strategy consultation process and illustrates how people do or would like to experience their health journey.

Our Values	What we want to see from each other, at our best ...
Kind / Manaakitanga	
Looking after our people: we respect and support each other. Our hospitality and kindness foster better care.	"I go to a medical centre – normally my doctor will come out and tap me on the arm and I go in with her. So that's a relationship we built up – she comes out and sees me personally" (blind woman) "Specialists, doctors and nurses were incredibly kind to us, allowing my husband, our baby and my mother to stay both on the ward and later in a room at the rehabilitation unit." (woman newly disabled)
Open / Pono	
Being sincere: we listen, hear and communicate openly and honestly. Treat people how they would like to be treated.	"The other thing is just asking a disabled person about what they need – just talk to them! Talk to them like anybody else and they'll talk back to you." "Understanding there are diverse people who will need different supports. Our people struggle to understand lots of information and visual information is much better – catering to many different needs and understanding there are differences and diversity."
Positive / Whaiwhakaaro	
Best action: we are thoughtful, bring a positive attitude and are always looking to do things better.	"There's a nurse on the ward who's brilliant – she goes the extra mile, understands disability, communicates really well." "Just in terms of culturally responsive service delivering in terms of providing the staff with support to upskill in practice and being comfortable with working with diversity."
Community / Whanaungatanga	
As family: we are genuine, nurture and maintain relationships to promote and build on all the strengths in our community.	"Speaking as a mother of a child with major health issues and disabilities. I want a more coordinated approach of where you are actually aware of what's available and how to access it."


DRAFT

SOUTHERN DISTRICT HEALTH BOARD

Title:	**FINANCIAL REPORT**
Report to:	Disability Support Advisory Committee and Community & Public Health Advisory Committee
Date of Meeting:	3rd February 2020

Summary:

The issues considered in this paper are:

- December 2019 Funds Result

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

Financial:	As set out in report.
Workforce:	No specific implications
Other:	n/a

Document previously submitted to:	Not applicable, report submitted directly to DSAC/CPHAC	**Date: NA**

Prepared by: Strategy, Primary & Community Team **Date:** 24th January 2020	**Presented by:** Lisa Gestro Executive Director Planning & Funding

RECOMMENDATION:

1. **That the report be received.**

12

Southern District Health Board – Monthly Financial Report
For the month ended 31 December 2019

Strategy,Primary & Community	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	Monthly Actual FTE	Monthly Budget FTE	Monthly Variance FTE	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	YTD Actual FTE	YTD Budget FTE	YTD Variance FTE	Annual Budget $
REVENUE													
Government & Crown Agency Sourced													
MoH Revenue	85,453	84,927	526				512,078	509,580	2,498				1,019,135
IDF Revenue	1,914	1,914					11,228	11,482	-254				22,964
Other Government	446	527	-81				3,167	3,370	-203				6,475
Total Government & Crown	**87,814**	**87,368**	**446**				**526,474**	**524,432**	**2,042**				**1,048,574**
Non Government & Crown Agency Revenue													
Patient related	13	20	-7				116	122	-6				244
Other Income	35	26	9				218	158	60				313
Total Non Government	48	46	2				334	280	54				556
Internal Revenue													
Internal Revenue													
Total Internal Revenue	**8,021**	**8,015**	**6**				**47,209**	**47,170**	**39**				**95,457**
TOTAL REVENUE	**95,883**	**95,429**	**454**				**574,017**	**571,882**	**2,135**				**1,144,588**
EXPENSES													
Workforce													
Senior Medical Officers (SMO's)													
SMO - Direct	1,576	1,658	82	59	65	6	8,611	8,948	337	60	66	6	18,026
SMO - Indirect	101	89	-12				517	537	20				1,073
SMO - Outsourced	136	42	-94				420	281	-139				547
Total SMO's	**1,813**	**1,789**	**-24**	**59**	**65**	**6**	**9,548**	**9,766**	**218**	**60**	**66**	**6**	**19,646**
Registrars / House Officers (RMOs)													
RMO - Direct	251	219	-32	21	17	-3	1,260	1,246	-14	19	18	-1	2,549
RMO - Indirect	13	17	4				64	104	40				209
RMO - Outsourced													
Total RMOs	**264**	**237**	**-27**	**21**	**17**	**-3**	**1,324**	**1,350**	**26**	**19**	**18**	**-1**	**2,758**
Total Medical costs (incl outsourcing)	**2,077**	**2,026**	**-51**	**80**	**83**	**3**	**10,871**	**11,116**	**245**	**79**	**84**	**5**	**22,404**
Nursing													
Nursing - Direct	4,511	4,388	-123	595	576	-20	26,594	26,535	-59	598	579	-19	54,279
Nursing - Indirect								1	1				3
Nursing - Outsourced													
Total Nursing	**4,511**	**4,389**	**-122**	**595**	**576**	**-20**	**26,593**	**26,536**	**-57**	**598**	**579**	**-19**	**54,282**
Allied Health													
Allied Health - Direct	2,522	2,839	317	395	429	34	15,224	15,905	681	407	432	25	32,012
Allied Health - Indirect	41	29	-12				259	171	-88				617
Allied Health - Outsourced	31	33	2				179	193	14				384
Total Allied Health	**2,593**	**2,900**	**307**	**395**	**429**	**34**	**15,662**	**16,270**	**608**	**407**	**432**	**25**	**33,013**
Support													
Support - Direct	14	13	-1	4	3	-0	78	75	-3	3	3	-0	149
Support - Indirect													1
Support - Outsourced													
Total Support	**14**	**13**	**-1**	**4**	**3**	**-0**	**78**	**75**	**-3**	**3**	**3**	**-0**	**150**
Management / Admin													
Management & Administration - Direct	1,055	1,100	45	172	175	3	6,450	6,425	-25	175	177	2	12,777
Management & Administration - Indirect	1	9	8				24	56	32				113
Management & Administration - Outsourced	1	1					7	7					13
Total Management / Admin	**1,057**	**1,111**	**54**	**172**	**175**	**3**	**6,480**	**6,488**	**8**	**175**	**177**	**2**	**12,903**
Total Workforce Expenses	**10,252**	**10,438**	**186**	**1,246**	**1,267**	**20**	**59,685**	**60,485**	**800**	**1,263**	**1,275**	**12**	**122,752**
Non Personnel													
Outsourced Clinical Services	96	82	-14				709	597	-112				1,160
Outsourced Corporate / Governance Services													
Outsourced Funder Services	1,093	1,096	3				6,650	6,668	18				13,457
Clinical Supplies	1,080	956	-124				6,495	5,823	-672				11,651
Infrastructure & Non-Clinical Supplies	685	711	26				4,254	4,311	57				8,569
Provider Payments													
Personal Health	60,008	59,728	-280				359,811	359,317	-494				715,607
Change Initiative Fund	212	212					1,269	1,269					2,539
Mental Health	8,281	8,250	-31				48,632	48,580	-52				98,276
Public Health	109	82	-27				653	492	-161				983
Disability Support	15,478	15,256	-222				91,617	90,775	-842				181,009
Maori Health	151	121	-30				824	786	-38				1,572
Non Operating Expenses													
Depreciation													
Capital charge													
Interest													
Total Non Personnel Expenses	**87,191**	**86,492**	**-699**				**520,914**	**518,619**	**-2,295**				**1,034,823**
TOTAL EXPENSES	**97,444**	**96,930**	**-514**				**580,599**	**579,105**	**-1,494**				**1,157,575**
Net Surplus / (Deficit)	**-1,561**	**-1,501**	**-60**				**-6,583**	**-7,223**	**640**				**-12,987**

Summary

Strategy, Primary and Community report a provisional unfavourable bottom line variance of $0.06m for December.

Significant contributors to the favourable/unfavourable variances for the month are:

Revenue

- Pay Equity $192k f refer comments for discussion.
- IBT $176k f refer comments for discussion

Workforce

- Nursing $122k u refer workforce
- Allied Health $307k f refer workforce

Personal Health

- Dental $43k f refer provider payments section
- PHO's $95k u refer provider payments section

Disability Support

- HCSS $252k u refer provider payments section

Comments for discussion

- IDF Inflow Revenue – Neurosurgery $99k u ($281k u YTD). Broadly in-line with expectations, given Specialist Services capacity constraints. Overall IDFs from SCDHB are down $409 YTD.
- We are currently accruing $132k of PE "underspend" to contribute towards development of national HCSS framework. This is in relation to a national spend of $6.40m (based on SDHB contributing PBF share).

Revenue

MOH Revenue –

Category	December Variance	YTD variance	Comment
Pay Equity	$192k f	$1.21m f	Expenditure offset
IBT	$175 f	$508k f	Expenditure offset
Electives	$40k f	$240k f	Reflects 19/20 funding pool
B4 Schools	$0k f	$103k f	Under accrual in June
Careplus	$40k f	$223k f	Expenditure offset
IBT Impact on min. wage	$39k f	$235k f	
Other	$40k f	$21k u	Includes CSC and U14's
Total	**$526 f**	**$2,498 f**	

Workforce Costs

Stategy Primary & Community FTE - as at 31 December 2019

Workforce	YTD Variance - FTE				
	Community Services	Primary Care & Population Health	Mental Health	Stategy Primary & Community Other	Total
Medical	0.73	0.68	2.48	0.70	4.59
Nursing	-2.25	-3.99	-12.93	0.00	-19.17
Allied Health	18.00	7.61	-1.75	1.00	24.86
Support	-0.12	0.00	-0.03	0.00	-0.15
Mgt/Admin	1.64	0.74	2.20	-2.68	1.90
Total	18.00	5.04	-10.03	-0.98	12.03

Medical SMO

- 6 FTE favourable and $82k favourable for December. 6 FTE and $336k favourable YTD.
- Ordinary time is the main driver offset by overtime, penal and outsourced.

Medical RMO

- 3 FTE unfavourable to budget for December and 1 FTE unfavourable YTD.
- $26k favourable YTD mainly driven by course fees and professional memberships.

Nursing

- 20 FTE for December and 19 FTE YTD unfavourable.
- December FTE variance mainly driven by ordinary time (8FTE), sick leave (3FTE) and overtime (3FTE).
- YTD FTE variance mainly driven by ordinary time (6 FTE), sick leave (3FTE) and overtime (4FTE).
- Although there is only a $57k unfavourable variance YTD there are a number of contributors to this variance with the main ones being overtime ($314k) accident leave ($72k), training ($67k) unfavourable to budget. These overspends are offset by a favourable variance in ordinary ($77k) and Annual leave accrued ($346k).
- Lakes General Ward ($87k u) Mental Health Nursing Resource Unit ($180k u) are the main contributors offset by favourable variances in Ward 6B ($160k f) and Community Nursing ($75k f).

Allied Health

- 34 FTE favourable for December and 25 FTE YTD. December expenditure is $307k favourable.
- YTD expenditure is $608k favourable and is in line with the favourable FTE variance.

Management/Admin –

- 3 FTE favourable in December and 2 FTE YTD.

Pharmaceuticals

- Consolidated monthly variance shows unfavourable position ($342k) for the month ($468k YTD).
- An error in the stock calculation has been found by the Finance team which should alleviate the large fluctuations in the monthly stock figure going forward.

		Values					
Ledger Type	Sub	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Actual	Drug Purchases	2,504,787	2,370,638	2,353,857	2,636,810	2,402,028	2,617,063
	INT	12,507	-45,383	-13,803	10,814	15,176	23,486
	PCASH		4				
	STK	-129,154	21,135	-34,887	-399,710	303,728	-95,142
	VAC				-8,520		
Actual Total		2,388,140	2,346,394	2,305,167	2,239,395	2,720,932	2,545,408
Budget	Drug Purchases	2,325,534	2,353,419	2,409,186	2,364,570	2,442,649	2,211,209
	INT	6,301	36,186	-6,484	-787	-22,581	-7,839
	STK	-9,269	-9,380	-9,601	-9,424	-9,735	-8,812
	VAC	-803	-813	-832	-817	-844	-764
Budget Total		2,321,763	2,379,412	2,392,269	2,353,542	2,409,489	2,193,794

- Rebate per Pharmac's new Nov 19 forecast.
- Other items from Nov Forecast include:
    - Overall Net Reimbursement cost is $1.43m higher than the last forecast, noting $1.35m of additional MoH revenue (so largely offsetting).
    - Pharmac are expecting a DPF payment at year-end of $764k.
    - There is still a portion of expenditure (SDHB share $860k) that Pharmac has not contracted. On this basis all of the expenditure is sitting in their forecast to be spent in June (this doesn't help with how we recognise the additional revenue during 19/20).
    - Pharmac are forecasting true pharmaceutical expenditure of $98.3m vs DHB budget of $98.3m (although, per previous forecasts, we think they are understating the PCT/Hospital side).
- Consolidated monthly variance shows:

	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD	3 chemical re-alignment	Adjusted variance
Clinical Supplies - Pharmaceuticals	$ 14,551.9	$ 14,050.3	-$ 501.6	$ -	-$ 501.6
Provider Payments - Pharms	$ 36,485.4	$ 36,519.0	$ 33.7	$ -	$ 33.7
Total	**$ 51,037.3**	**$ 50,569.3**	**-$ 468.0**	$ -	**-$ 468.0**

Variance is made up of the following (estimate)

Pharms YTD	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD	3 chemical re-alignment	Adjusted variance
PCT	$ 6,976.5	$ 4,657.7	-$ 2,318.7	$ 2,859.0	$ 540.3
Community Pharms (DHB Outpatients)	$ 2,520.2	$ 2,318.7	-$ 201.5		-$ 201.5
Hospital Inpatients	$ 5,055.2	$ 7,073.8	$ 2,018.6	-$ 2,859.0	-$ 840.4
Community Pharms (excl DHB)	$ 36,485.4	$ 36,519.0	$ 33.7		$ 33.7
Total	**$ 51,037.3**	**$ 50,569.3**	**-$ 468.0**		**-$ 468.0**

Clinical Supplies (excluding Pharms)

Clinical Supplies	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Treatment Disposables	290	249	-41	1,719	1,531	-188	3,051
Diagnostic Supplies & Other Clinical Supplies	8	6	-2	40	37	-3	72
Instruments & Equipment	42	67	25	332	391	59	788
Patient Appliances	155	155		975	802	-173	1,686
Implants & Prostheses	1		-1	4	3	-1	6
Other Clinical & Client Costs	19	24	5	152	154	2	305
Total Clinical Supplies (excl pharmaceuticals)	515	501	-14	3,222	2,918	-304	5,908

- Clinical Supplies – Ostomy and Continence – Work programmes are underway to reduce waitlists and patient time within service, noting this may take some months to fully realise efficiencies.

Infrastructure & Non-Clinical Supplies

- Legal Fees $79k favourable YTD.
- Electricity $54k favourable YTD
- Telecommunications $101k unfavourable YTD

Provider Payments (NGO's)

Personal Health

- Immunisation - $20k unfavourable to budget YTD is demand driven and the budget is understated compared to expected expenditure. This is in part being driven by additional measles related expenditure.
- Dental - $409k favourable to budget YTD – Due to June & July accruals being overstated (significant invoicing lag meant accrual was large). Demand driven CDA services are showing positive variance against budget.
- Primary Health Care Services – Services are $396k unfavourable to budget YTD. The majority of this is due to Careplus ($224k over YTD with revenue offset) and First Contact services ($162k over YTD).
- Medical Outpatients - $231k unfavourable YTD due to haemophilia national pool expenditure being higher than Pharmac forecast.

Mental Health

- Pay equity expenditure $200k over budget YTD with a revenue offset.
- Mental Health Community Services $99k (f), Child Youth and Mental Health Services $52k (f) include demand driven services.

Public Health

- The $161k unfavourable variance YTD is due to budgeted savings of $157k that have not been achieved.

Disability Support

- Pay Equity - $55k unfavourable to budget for the month ($960k YTD) with full revenue offset. $132k of this variance YTD is due to accruing PE underspend, which will be applied to national HCSS model of care programme.
- Home Support - $252k unfavourable to budget for the month ($1.02m YTD), due to IBT expenditure being $724k unfavourable to budget (YTD) and impact of unbudgeted component of HCSS contract uplift ($201k YTD). Note $508k favourable IBT revenue, which partially offsets this variance.
- ARRC volumes favourable to budget at RH and Dem levels but unfavourable at Hospital and PG levels, which contributes to $107k favourable monthly variance ($754 favourable YTD).

Maori Health

- $38k unfavourable to budget YTD

Expenditure Management Plans – current performance and future actions

Summary of progress for the month; tracking to budget; issues; plans; forecast

Savings category	Savings Target		Variance to budget	Comment
	Annual	YTD		
Procurement	237k	134k	12k u	YTD savings **partially** achieved
Pharmaceuticals	2,395k	1,197k	468k u	YTD savings **partially** achieved
ARRC	1,000k	500k	754k f	YTD savings **fully** achieved
Public Health[1]	283k	141k	161k u	YTD savings **not** achieved
Total	**3,914k**	**1,972k**		

[1]Includes both Funder and Provider.

12

Risks

- Measles risk removed, costs quantified per previous sections.

Forecast

The following table is to inform a discussion relating to MOH forecast submission.

- The below forecast makes up the basis of SPC portion of the previous DHB forecast. No substantive changes are proposed.

Revenue	**January**	**February**	**March**	**April**	**May**	**June**	
	$	**$**	**$**	**$**	**$**	**$**	
Electives	40	40	40	40	40	40	240
IBT	50	50	50	50	50	50	300
Pay Equity	200	200	200	200	200	200	1,200
MECA settlements	35	35	35	35	35	35	210
	325	325	325	325	325	325	1,950
Allied Health FTE	20	10	10	10	10	10	70
SMO	20	20	20				60
Personal Health							
Haemophilia	-(35)	-(35)	-(35)	-(35)	-(35)	-(35)	-(210)
Dental	20	20	20				
Labs (original variance)	14	14	14	14	14	14	84
Labs (half of extra 1%)	20	20	20	20	20	20	118
IDF Out (neuro)	-(39)	-(39)	-(39)	-(39)	-(39)	-(39)	-(232)
Immunisations			-(25)	-(50)	-(75)	-(50)	-(200)
	-(20)	-(20)	-(45)	-(90)	-(115)	-(90)	-(440)
DSS							
HCSS	-(38)	-(38)	-(38)	-(38)	-(38)	-(38)	-(225)
IBT	-(100)	-(100)	-(100)	-(100)	-(100)	-(100)	-(600)
ARRC	100	100	100	140	140	140	720
Pay Equity	-(100)	-(100)	-(100)	-(100)	-(100)	-(100)	-(600)
	-(138)	-(138)	-(138)	-(98)	-(98)	-(98)	-(705)
NET EFFECT OF ADJUSTMENTS	207	197	172	147	122	147	935

Glossary of Acronyms

- IBT – In between Travel
- MOH – Ministry of Health
- YTD – Year to Date
- PHOs – Primary Health Organisation
- HCSS – Home & Community Support Services
- IDF – Inter District Flows
- FTE – Full Time Employee
- SMO – Senior Medical Officer
- RMO – Registered Medical Officer
- DPF – Discretionary Pharmaceutical Fund
- PCT – Pharmaceutical Cancer Treatment