Community & Public Health Advisory Committee Meeting

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

07/12/2020 01:00 PM - 02:45 PM

APOLOGIES

An apology has been received from Andrew Connolly, Crown Monitor.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Community and Public Health and Disability Support Advisory Committees
Date of Meeting:	7 December 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.

Interest 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:

- Jean O'Callaghan – resigned from Geneva Health, effective August 2020
- Tuari Potiki – resigned from District Licensing Committee, DCC, November 2020

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 25/11/2020

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
David Perez (Acting Board 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~~, Member, Spokes Dunedin (cycling advocacy group)		Updated 22.10.2020
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
	07.07.2020	Trustee, HealthCare Otago Charitable Trust		
	12.09.2020	Co-Director, OffTrack MTB Ltd	No conflict (Husband's bike tourism company).	
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		
	07.10.2020	Trustee, Southern Health Welfare Trust	Trust for Southland employees - owns holiday homes and makes educational grants.	
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 University School of Medicine		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
	03.04.2020	Client, Royal District Nursing Service NZ Ltd		
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.~~	Resigned, effective August 2020
	13.05.2019	St John Volunteer, Lakes District Hospital	No involvement in any decision making.	~~Taking six months' leave.~~ Recommencing 22.08.2020.
Tuari Potiki	09.12.2019	Employee, Otago University		
	09.12.2019	Chair, NZ Drug Foundation		
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	~~08.09.2020~~	~~Member, District Licensing Committee, Dunedin City Council (1 September 2020 to 31 May 2023)~~		Resigned 06.11.2020
	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		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.07.2020	Shareholder 1%, Piermont Holdings ltd	Coporate Body for apartment, Wellington	
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)~~	Removed 07/09/2020	
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
	17.08.2020	Health Research Council Fellow		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
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		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		
Roger Jarrold (Crown Monitor)	16.01.2020	CFO, Fletcher Construction Company Limited	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	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, Christchurch		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	

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
Hamish BROWN	22.09.2020	Nil	
Kaye CHEETHAM	~~08.07.2019~~	~~Ministry of Health Appointed Member of the Occupational Therapy Board~~	(05/08/2020 - Stood down from 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.
	21.05.2020	Director, New Zealand Institute of Skills and Technology	
	20.11.2020	Chair, South Island CIOs	
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.
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~~	Removed 23.09.2020
	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

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
	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.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
	23.09.2020	Arvida Group (aged residential care provider)	Sister works for Arvida Group (North Island only)
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 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~~

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
	18.12.2017	Daughter, medical student at Auckland University.	
	23.07.2020	Wife, Chief Data Architect, Inde Technology	
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
	04.08.2020	Shareholder and Director, Inversionne Limited	Nil, clothing wholesaler.
		Specified contractor for JER Limited in respect of:	
	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
Greer HARPER	24.08.2020	Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE EXTERNAL APPOINTEES

Committee Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Kim Ma'ia'I (External Appointee)	03.08.2020	Medical Director, Te Kaika Clinic, Caversham		
Odele STEHLIN	01.11.2010	Waihopai Rūnaka General Manager	Possible conflict with contract funding.	
	01.11.2010	Waihopai Rūnaka Social Services Manager	Possible conflict with contract funding.	
	01.11.2010	WellSouth Iwi Governance Group	Nil	
	01.11.2010	Recognised Whānau Ora site	Nil	
	24.05.2016	Healthy Families Leadership Group member	Nil	
	23.02.2017	Te Rūnanga alternative representative for Waihopa	Nil	
	09.06.2017	Director, Waihopai Runaka Holdings Ltd	Possible conflict with contract funding.	
	07.06.2018	Director of Waihopai Hauora.	Possible conflict with contract funding.	

Southern District Health Board

Minutes of the Joint Meeting of the Community & Public Health Advisory Committee and Disability Support Advisory Committee held on Monday, 5 October 2020, commencing at 1.30 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Dr Moana Theodore	Chair, Disability Support Advisory Committee (DSAC) *(Meeting Chair)*
	Mr Tuari Potiki	Chair, Community & Public Health Advisory Committee (CPHAC)
	Ms Ilka Beekhuis	Deputy Chair, CPHAC
	Mrs Kaye Crowther	Deputy Chair, DSAC (*by Zoom*)
	Dr John Chambers	Member, DSAC
	Mr Terry King	Member, CPHAC
	Dr Lyndell Kelly	Member, CPHAC
	Ms Odele Stehlin	Member, DSAC and CPHAC
	Ms Paula Waby	Member, DSAC
In Attendance:	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nigel Millar	Chief Medical Officer *(by Zoom)*
	Dr Nicola Mutch	Executive Director Communications
	Mr David Perez	Board Member, Southern DHB
	Mr Andrew Swanson-Dobbs	Chief Executive Officer, WellSouth Primary Health Network
	Ms Lesley Soper	Board Member, Southern DHB *(by Zoom)*
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Gail Thomson	Executive Director Quality & Clinical Governance Solutions
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Mrs Joanne Fannin	Personal Assistant (Minute Taker)

1.0 WELCOME AND KARAKIA

The Chair welcomed everyone and the meeting was then opened by Mr Gilbert Taurua with a karakia. A warm welcome was extended to new Committee member, Odele Stehlin, Iwi Governance Committee (IGC) Chair and the IGC representative on the DSAC/CPHAC.

2.0 APOLOGIES

Apologies were received from Mr Kiringāua Cassidy, Mr Dave Cull and Dr Kim Ma'ia'i.

It was resolved:

"That the apologies be accepted."

M Theodore/L Kelly

3.0 DECLARATION OF INTERESTS

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

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

It was resolved:

"That the Interests Registers be received and noted."

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 3 August 2020 be approved and adopted as a correct record."

M Theodore/T Potiki

5.0 CHAIRS' UPDATE

Disability Support Advisory Committee (DSAC)

Dr Moana Theodore, DSAC Chair, provided a brief report, noting the presentations that will be made during the meeting and inviting DSAC members to contact her if they have any queries relating to the meeting or any matters they would like raised at a future meeting.

Community and Public Health Advisory Committee (CPHAC)

Mr Tuari Potiki, CPHAC Chair, advised that he had nothing further to add in relation to CPHAC and noted the discussion points that would take place later in the meeting.

6.0 MATTERS ARISING FROM THE PREVIOUS MINUTES

There were no matters arising that were not already covered by the action sheet.

7.0 REVIEW OF ACTION SHEET

The Committees received the action sheet updates (tab 7). The Executive Director Strategy Primary and Community (EDSPC), Mrs Lisa Gestro, reported that:

- Pēhea Tou Kainga? How is your home? Central Otago Housing: The Human Story – work is ongoing and the EDSPC will provide a completion date for the report.
- The reporting template, informed by the new DAP will be presented to the December 2020 DSAC/CPHAC meeting.
- Invercargill Primary Care Access – some progress has been made, a consultant has been contracted and the next step is for an options paper to be provided.
- B4 School Checks Programme – a catch-up plan is in progress. The Programme remains at risk due to the demands on staff in this area due to the COVID-19 pandemic. A testing strategy is being developed to ensure that ongoing testing obligations are met and business as usual continues in all areas of health, alongside COVID-19 planning and response. The EDSPC responded to concerns raised by Mrs Kaye Crowther in relation to the B4 School Checks Programme and acknowledged by the Chair. Southern DHB has pro-actively reached out to parents in terms of re-engagement. The EDSPC is to provide data for the B4 School Checks Programme and other services impacted by the COVID-19

response over the course of the next two meetings to show how Southern DHB is tracking and to monitor to ensure inequity is not created as a result.

- The items marked as completed were taken as read and will be removed from the action sheet.

Mr Dave Keen from DPA, Dunedin, joined the meeting at 1.42pm.

- Oral Health - the EDSPC responded to a query related to the monitoring of preventive treatment for caries and advised that she would refer back to the District Annual Plan (DAP) and provide an update on the deliverables. Southern DHB relied heavily on Dental Therapists to support the COVID-19 response. The Chair noted her interest and advised that a previous audit of the Dental School had highlighted inequity of access, including preventive treatments, for Māori, Pasifika and lower socio economic people. A request was made for an update on what parts of the Southern District have fluoridated water.

It was resolved:

"That the Action Sheet be received and noted."

M Theodore/I Beekhuis

8.0 SNAPSHOT OF DISABILITY SERVICES

The Executive Director Quality and Clinical Governance Solutions (EDQ&CGS), Gail Thomson, presented a report outlining disability initiatives under way at Southern DHB and future plans for the coming year to achieve the goals of the Disability Strategy (tab 8). The report was taken as read and additional comments were noted as follows:

- The report is a snapshot of where Southern DHB is with Disability Services.
- The snapshot is timely with the recent approval of the Disability Strategy, which has highlighted there is a lot of work to be done.
- Data to inform decision making and the work being done nationally that will shape the work done within Southern DHB. The collective national thought is about having an alerts solution attached to the National Health Index (NHI) so that it goes beyond DHBs into the wider health arena.
- Employment – for just over a year staff have been asked to record if they have a disability. This should result in Southern DHB having a better picture going forward. The wishes of staff who don't want to be identified as disabled must be respected.
- Disability Confident Organisations – outlined in Table 1 on page 2 of the report.
- Equal Employment Opportunities – a policy is in place, but there is a concern relating to access to a number of older buildings.
- Staff awareness, education and training – a disability awareness training module was included with the staff mandatory induction training package in 2019. Further work will be done to ensure that the training is mandated to staff who have been working for Southern DHB for a number of years.
- Concern was raised around the difficulty in getting information from Southern DHB staff related to travel and assistance support which is funded by the MoH. The EDQCGS is to look into this and report back to members.
- Feedback was provided on the work being done on the content of patient letters, the language being used and the Community Health Council have been engaged in that work. There is a need to ask disabled persons what works for them and the section on how patients want to be communicated with was highlighted.
- The high level timeline of what needs to happen to implement the Disability Strategy. A number of the actions required are being actioned concurrently.

The timeline could be used as a guide for what the Committee is updated on at future meetings.

- A Steering Group is to be established to develop the actions and implement the key points from the Disability Strategy.
- Appendix 1 outlines a summary of the Southern District, taken from the 2013 census and highlights selected measures of disability for people in private households. The total numbers relate to people with more than one disability.
- Southern DHB does not currently have a Disability Advocate/Facilitator, but that will be considered as work progresses to establish what resource is required. The Community Health Council does a lot of advocacy in this area.
- Ms Paula Waby confirmed she had input some time ago into the Disability Training and she noted the feedback was in the form of a tick box that was very light. The EDQCGS confirmed alternatives are being considered to provide something more substantive.
- The Chair requested that a workshop be held for the DSAC to move the work on the Disability Strategy forward and to feed in to the District Annual Plan.

It was resolved:

"That the snapshot of disability services at Southern DHB be noted and shared with the entire Board."

I Beekhuis/L Kelly

Ms Karen Browne joined the meeting at 2.08pm.

9.0 COMMUNITY HEALTH COUNCIL QUARTERLY REPORT

Ms Karen Browne, Chair of the Community Health Council (CHC) presented the CHC's quarterly report (tab 9) and responded to questions. Key areas highlighted included:

- The CHC Planning Session held in August 2020 where the draft Annual Plan and draft Work Plan (tab 9, appendix 1) for the year were decided.
- The update for the quarter with Rheumatology highlighted as a key service that the CHC were actively involved with.
- The CHC involvement with COVID-19 and testing in the community. Letters of appreciation from the CHC were sent to the CEO, the CE and the Public Health Service for the manner in which they handled COVID-19 across the district.
- Business as usual for the CHC is the work outlined in the Action Plan and the round table sessions where members provide comment from their respective communities and decide in discussion where further action is required.
- The CEO commended the CHC on their work and noted they have become self-perpetuating and compared favourably to other DHBs nationally.
- An update was provided on how the CHC will reach out to the Māori and Pasifika communities, given the limited feedback from them on the Disability Strategy. IGC Chair and Committee member, Odele Stehlin, confirmed that IGC will be appointing a member to the CHC.
- WellSouth CE, Mr Andrew Swanson-Dodds, provided a vote of thanks and appreciation to the CHC and in particular, Hana Halalele, who assisted with the testing strategy to increase the number of Pasifika people tested in the community in Oamaru. 20.5% of the population tested on the day were Pasifika. In partnership with Public Health and doing influenza vaccinations on the day, many people not enrolled with a General Practice showed up and are now enrolled and engaged with the WellSouth system.
- Discussion was held on the need for the CHC to have more of an input into Children's Health.
- The Chair thanked Ms Browne for her presentation.

Ms Karen Browne left the meeting at 2.20pm.

Mr Doug Funnell joined the meeting at 2.21pm.

10.0 PRESENTATION: MINISTRY OF HEALTH FUNDER

The Committee received a presentation from Mr Doug Funnell, Portfolio Manager, Disability Directorate, Ministry of Health (MoH), on the disability services funded by the Ministry of Health. Mr Funnell spoke to his presentation and responded to questions:

- Mr Funnell is responsible for the disability services funded contracts across Otago and Southland and does some work across NZ with Needs Assessment Service Co-ordination services.
- The slide presentation covered the following:
  - The MoH population group.
  - Statistics showing annual funding and numbers supported. There is an increase in the number of people seeking funding support.
  - Disability Supports – national framework.
  - Enabling Good Lives – a principle based approach. A joined up funding approach between the MoH and the Ministry of Social Development (MSD). New roles have been introduced, e.g. a connector role, assisting families and individuals plan for a better future.
  - Strategic Direction.
  - Success and what it looks like.
  - Family – enabling good lives. A patient story – Baker – Hungry Hamish.
  - Further information is available at https://www.health.govt.nz/our-work/disability-services
  - A hearing aid subsidy is available.
  - Service gaps were identified as follow:
    - High and complex needs that fall between Disability and Mental Health.
    - Disabled people accessing Mental Health services – there is a disconnect between service providers.
    - Disabled people with chronic health needs. A pool of funding has been set up and devolved to DHBs, which is assisting.
    - Ongoing support services for people with Autism is a growth area.
    - Support for people with Foetal Alcohol Syndrome Disorder (FASD). Only those diagnosed with an intellectual disability as well as FASD are entitled to assistance. FASD currently sits with Corrections.
  - Referrals are accepted from anybody – there is not a clinical based approach. Those referring in would have proof of diagnosis.
  - There is no direct relationship with Primary Care and referrals are received from Primary and Secondary Care services.
  - Disabled should not be excluded from anything and they should be able to access any mainstream service that is available.
  - There is limited overlap of services, but not often due to limited funding.
  - The service does not work directly with employers.
  - It is believed that COVID-19 has disproportionately affected disabled people, especially in the area of employment, but there are no statistics available to prove that at the current time.
- The Chair thanked Mr Funnell for his presentation.

Mr Doug Funnell left the meeting at 2.50pm.

Dr Katherine Graham and Mr Rory Dowding joined the meeting at 3.00pm.

11.0 PRESENTATION: SOUTHERN HEALTH NEEDS ASSESSMENT

The Committee received a presentation from Dr Katherine Graham, Public Health Registrar, overviewing the Southern Health Needs Assessment project (tab 11). Dr Graham spoke to her presentation and responded to questions and additional comments were noted as follows:

- Dr Graham is a Medical Director in training in Public Health Medicine. She was accompanied by Mr Rory Dowding, Strategy and Planning Manager and disclosed that she was being assessed on her presentation, as part of her training, by Dr Mavis Duncanson and Professor Brian Cox.
- The slide presentation covered the following:
  - Overview.
  - Background – what is a Health Needs Assessments (HNA). The last HNA was undertaken in 2013.
  - The Southern HNA is being led by Southern DHB, in partnership with WellSouth PHN and oversight by Alliance South.
  - Purpose – to bring information together on one site to inform and provide direction, highlight and improve health equity and outcomes. The intent is to have a web-based living document that will be constantly updated.
  - Scope – district wide at a population level.
  - Indicators – there are over 70 indicators in four main groups – Demography, Health Status, Health Drivers and Health Services.
  - Process – acquiring and analysing data, interpreting and writing the story. Engagement with stakeholders along the way is key.
  - Challenges – data, COVID-19 and expectations.
  - Presentation and narrative – explaining in a way that people understand and being descriptive, but not judgmental.
  - Proof of Concept – video presentation giving an example through Power BI – Southern population demographics.
  - Acknowledgements and thanks.
  - The work done has been based on work done in Northland, but has been expanded to take a wider view and more interactive technology is being used.
  - Data is being accessed from a number of external and internal sources.
  - Ultimately the tool will have a twofold purpose – public facing work where the narrative is continually updated and internally for Southern DHB staff to use as a Business Intelligence Tool.
  - Ambulatory Sensitive Hospitalisation (ASH) rates and the importance of awareness and working to keep people out of hospital. An update was provided on the process for data collection.
  - The CMO, Dr Nigel Millar, advised that statistically there should be less admissions if the determinants of health were optimised (e.g. smoking, housing, etc.) and you have good primary healthcare and preventative services.
  - Data is being obtained from both internal and external sources.
  - It is intended to update the HNA on an annual basis.
  - Mr Dowding noted the request for the historic data to be archived as the HNA is updated and undertook to put a process in place.
  - Dr Graham advised that obtaining data in relation to disability has been challenging and consultation is on-going to obtain the best and most

recent information available. She sought assistance from the Committee in terms of how best to access disability information. The Chair confirmed that the DSAC will have on-going discussions in terms of how the tool can be used.

- The Chair thanked Dr Graham, Mr Dowding and the assessors.

Dr Katherine Graham, Mr Rory Dowding and assessors left the meeting at 3.26pm.

12.0 MĀORI HEALTH

The Committee received a verbal update from the Chief Māori Health Strategy and Improvement Officer (CMHS&IO). Mr Gilbert Taurua reported:

- That there are currently 10 contracted Māori Health Providers across the district, plus WellSouth is funded for the reducing inequalities voucher programme.
- That the total Māori Health spend is $3.757M and when the Provider Arm is included (covering Mental and General Health across Southland and Dunedin Hospitals), the total Māori Health spend is $5.35M.
- That there is no annual review of the Māori Health Provider contracts and appears to be no correlation between what the Māori Health Providers are contracted for against the health priorities Southern DHB is required to report on.
- That Te Kaika has recently achieved Kaupapa Māori authority, but Southern DHB does not contract with them because of their very low cost access service funding.
- That Southern DHB relies heavily on Kaupapa Māori Health Providers to support the more vulnerable Māori Health communities.
- There is some consistency in contracting of services across the district with two providers contracted to provide Well Child Tamariki Ora services and two providers contracted to provide Te Kākano Nurse Led Clinics.
- On the nature and scope of the Te Kākano Nurse Led Clinics and the Māori Health Providers.
- On the need to review the nature and scope of the services to ensure that Southern DHB's priorities are aligned to what is at the forefront of services for the Māori Health Providers.
- On the need to invest additional equity resource into the contracts with Māori Health Providers.
- That work is underway and should continue to more closely link Māori Health Providers to secondary and tertiary health services.
- On the District Annual Plan (DAP) guidance looking to expand and extend contracts provided in the community based on Tiriti o Waitangi and feedback out of the Wai 2575 process.
- Māori Health Providers are audited on a regular basis, but the way they currently report does not necessarily meet Southern DHB's strategic goal requirements.
- That it would be useful to have a couple of the Māori Health Providers present to DSAC/CPHAC on the nature and scope of the services they provide.
- On the benefit of "Māori for Māori" services.
- On the essential work undertaken by Māori Health Providers in response to COVID-19.
- That there is a gap in Kaupapa Māori services in the Central Otago area.

Mr Tuari Potiki advised the need to understand the current investment and for adequate resourcing to be provided to address inequity and the priority areas identified for Māori. How does the funding provided support the Māori Health goals identified locally across Southern DHB? Accurate reporting is essential to investing in the right areas to improve Māori Health outcomes.

Mrs Kaye Crowther noted the strategic planning and the first 1000 days' initiative referred to in the Board papers and advised the need for Māori and Pasifika to be included in that. She advised the importance of looking at not just Māori Provider services, but all services being provided to Māori families for tamariki. Mr Tuari Potiki responded that non-Maori services have been providing services to Māori for decades and that has created disparity. He advised the need to strengthen Kaupapa Māori Health services and ensure that all other services who see Māori as a part of their generic services are held to account. The CMHS&IO advised on the disparity with funding for Tamariki, especially in Southland, noting that the Māori Health Providers are dealing with both rurality issues and the most vulnerable families and the funding needs to reflect that.

Committee member and Iwi Governance Committee (IGC) Chair, Odele Stehlin, acknowledged the report from the CMHS&IO and looks forward to a more detailed discussion at the next IGC meeting. At the IGC meeting on 5 October 2020 discussion was held on aligning the priorities to the District Annual Plan (DAP) and the recently released Māori Health Action Plan (MHAP). She acknowledged the kōrero around the table and the importance of that.

The CEO advised the challenges with prioritisation and the need for the Board to provide direction noting the conflicting priorities between investment in initiatives such as 1000 days and an increase in elective surgery.

The Chair advised the need for further discussion to be held on equity, short term versus long term priorities and models of care for the longer term as we move into the strategic review process.

13.0 WELLSOUTH PHO

A verbal update was provided by the CE WellSouth. Mr Andrew Swanson-Dobbs reported:

- On the on-going work with Public Health on the COVID-19 response and ensuring that expectations are met in terms of surveillance and the testing strategy.
- On the Integrated Mental Health contract and the new roles of Health Improvement Practitioners (HIPS) and Health Coaches. It is a significant opportunity within Southern to introduce new roles within General Practice to support the whole system. An update is to be provided to a future CPHAC meeting to highlight what the new roles are achieving. The greatest impact from the new roles is changing the narrative within the practice and a position of "any client is the right client". The roles within the General Practices are assisting GPs and nurses to support the person within the Practice so they are less likely to have to refer out. The service is free.
- Tranche 3 of the Health Care Homes is being rolled out, targeting a lot of General Practices with significant high need populations.

14.0 PRIMARY MATERNITY UPDATE

The Committee received a report on the second phase of consultation on possible options for the location of a new primary maternity facility in the Central Otago/Wanaka area (tab 14).

The Executive Director Strategy, Primary and Community referred to the written report and advised on the status of the consultation and feedback. The team are on track to provide a recommendation paper to the November 2020 Board meeting for consideration and ratification.

Management advised that the one-month slippage is due to the impact of the COVID-19 response on staff time. Additional consultation with a sub-group in the area was also undertaken due to the significant level of interest from the Wanaka/Lake Hawea area.

It was resolved:

"That the Committees:

- **Note the completion of the second round of public consultation on the question: *Where should we locate primary maternity facilities in Central Otago/Wanaka?***
- **Note that the Central Lakes Locality Network and the DHB Project Team will make a joint recommendation, taking into account public feedback, on the best option in November 2020."**

M Theodore/I Beekhuis

15.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

The Strategy, Primary and Community Report (tab 15.1) and attachments (15.1.1 – Alliance Leadership Team Minutes and 15.1.2 – WellSouth Performance Dashboard) were taken as read and the EDSP&C took questions. The following items were highlighted during discussion.

- The CE WellSouth provided an update on progress with Power BI and the dashboards. The COVID and Health Care Homes dashboards are already live and the remaining dashboards will be operationalised within the next two weeks. The dashboards in the report are an example only and the information portrayed on them is not accurate.
- Southern DHB has requested that a dashboard for smoking cessation improvement be included in the suite of dashboards and the WellSouth CE acknowledged that the results have deteriorated, due to some extent on the need to focus on the COVID-19 response. The WellSouth team has a plan to progress an improvement in the results.
- Management responded to concerns raised regarding a perceived gap in dental services in Dunedin, acknowledging that work is required and noting that a review of the service has been commissioned by the new Dean of the Dental School in Dunedin and the commitment by the University to look at the issue in an open and transparent way. A request was made for a report to be provided on District Oral Health Services.
- The CE WellSouth responded to concerns raised in relation to the Primary Care/Health Care Home reconfiguration and the perceived lack of understanding by the public on the model. He advised on a change to the model being done at a national level and noted that the next tranche of General Practices will be greater and is due to go live on 1 November 2020.

He also responded to concerns related to Care Plus and Client Led Integrated Care (CLIC) and advised on the review undertaken pre-COVID and the proposed pathway forward.

- Management concurred with concerns raised that representation of DHB Clinicians on the Alliance Leadership Team is light and the CE WellSouth responded to concerns regarding overnight GP coverage in Wanaka, noting the challenge is across the board with workforce depletion and younger GPs not wanting to work 24/7.

It was resolved:

"That the report and attachments be received."

M Theodore/T Potiki

16.0 FINANCIAL REPORT

In presenting the Strategy, Primary and Community (SP&C) financial results for August 2020 (tab 15), the EDSP&C advised:

- That the result for SP&C for the month of August 2020 and year-to-date is favourable.
- That the "comments for discussion" section is the most important section of the report.
- That the key areas of risk in the report are Pharmaceuticals, Aged Care and Mental Health.
- On the change strategy initiatives embedded in the day to day work programmes, promoting significant lines of quality improvement in an effort to run in the most efficient way possible.

It was resolved:

"That the report be accepted."

M Theodore/I Beekhuis

17.0 AGED RESIDENTIAL CARE FACILITIES – COVID-19 PREPAREDNESS

The EDSP&C presented the results of Aged Residential Care (ARC) facilities' COVID-19 preparedness assessments (tab 15) and advised on the work done to prepare in case of future outbreaks. Members noted comments from the CMO highlighting that the COVID issues in the Aged Residential Care sector were equally as complex as those in the Hospitals and health professionals in both sectors were equally important. Management responded to concerns raised around those in care requiring support and supply of PPE. Committee member and IGC Chair, Odele Stehlin, commended management on the paper, but noted concern that equity was not considered to be a driver as noted on the cover sheet. Management acknowledged the concern and agreed with the need for evidence that consideration has been given to equity.

It was resolved:

"That the report be noted."

M Theodore/L Kelly

The Chair thanked management and members for their input and noted that a workshop is to be held prior to the next meeting.

A closing karakia was provided by the CMHS&IO, Mr Gilbert Taurua and the meeting closed at 4.25 pm.

The next meeting is to be held on 7 December 2020 commencing at 1.30pm.

Confirmed as a true and correct record:

Chair, Community & Public Health Advisory Committee: _____

Date: _____

Chair, Disability Support Advisory Committee: _____

Date: _____

Chair's Update

- Verbal report from Tuari Potiki, Chair of the Community & Public Health Advisory Committee

Southern District Health Board

DISABILITY SUPPORT AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEES MEETING

ACTION SHEET

As 27 November 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Oct 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	Public Health met with Central Otago District Council in September. Housing was covered as part of discussions about CODC's long term plan. Council are currently preparing a quantitative report that will be presented to Council in the new year. This covers the status of housing and the housing need.	To be determined
Feb 2020	**Strategy, Primary and Community Report** (Minute item 10.0)	Report to be more focused by tying activity to the goals or targets that were trying to be achieved.	EDSP&C	A new reporting template, informed by the new DAP will be used from quarter 1, 2020/21. The remaining format will be used for the remainder of the 19/20 year, but key goals will be highlighted.	December 2020
June 2020	**Southern Health Entities** (Minute item 10.0)	Slide explaining the different Southern Health entities (incl. the Alliance Leadership Team), and how they assist Board to achieve its objectives, to be submitted to Board.	EDSP&C	Completed, included in December Board Agenda.	Completed
August 2020	(Minute item 6.0)	Further information to be provided on each entity's role, responsibilities and accountabilities and the diagram to be broadened, eg to include SIAPO, and to be circulated to all Board Members.			Completed

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
June 2020 FAR 593 October 2020	**Invercargill Primary Care Access** (FAR Committee Minute item 9.0) (Action Sheet 7.0)	Paper on the issues, with clear action steps and accountabilities, to be submitted to CPHAC.	EDSP&C	A verbal update will be provided to the meeting.	
August 2020 October 2020	**B4 School Checks Programme** (Minute item 11.0) (Action Sheet 7.0)	Management to report back on when B4 School Checks would be caught up. Following the update at the meeting on 5 October 2020, data is to be provided for the B4 School Checks Programme and other services impacted by the COVID-19 response over the course of the next two meetings to show how Southern DHB is tracking and to monitor to ensure inequity is not created as a result.	EDSP&C	 Data will be provided at February meeting	Complete February 2021
October 2020	**Oral Health** (Minute item 7.0) (Minutes item 15.0)	▪ Oral Health - Monitoring of preventive treatment for caries – refer back to the DAP and provide an update on the deliverables. Equity to be to the forefront. ▪ An update is to be provided on what areas of the Southern District have fluoridated water. ▪ A report is to be provided on District Oral Health Services following concerns raised around a perceived gap in service in Dunedin.	EDSP&C EDSP&C	Included in the Strategy, Primary & Community Report. Included in the Strategy, Primary & Community Report.	Completed Completed

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
October 2020	**Māori Health** (Minutes item 12.0)	▪ Arrange for Maori Health Providers to present to future DSAC/CPHAC meetings on the nature and scope of the services they provide. ▪ Further discussion is to be held on equity, short term vs long term priorities and models of care for the longer term to help inform the strategic review process.	EDSP&C/ CMHSIO	CMHSIO to contact providers to offer them the opportunity to present in the new year. EDSP&C and CMHSIO to discuss timing of this and whether it should be dealt with as part of the workshop.	1 Feb 2021 Timing to be confirmed.
October 2020	**WellSouth PHN** (Minutes item 13.0)	An update is to be provided for CPHAC on what is being achieved through the new Health Improvement Practitioner and Health Coach roles in General Practices.	CE WellSouth		
October 2020	**WellSouth PHN** (Minutes item 15.0)	A dashboard for progress on smoking cessation improvement is to be included in the agenda for the next CPHAC meeting.	CE WellSouth		

1.15 pm

Presentation - Overview of Mental Health Services: System, Structure, Key Opportunities

- John McDonald, Independent Chair of the Mental Health Network Leadership Group

8.1

1.25 pm

Presentation - Specialist Services

- Louise Travers, General Manager Mental Health

1.35 pm

Mental Health Primary Care - Access and Choice

- Wendy Findlay, Director of Nursing, WellSouth

8.3

Update on the Mental Health Review

- Dr Clive Bensemann, Review Steering Group Chair

Terms of Reference

For the independent review of the Southern Mental Health and Addiction System Continuum of Care

November 2020

1. Overview

The DHB CEO, with the support of the Southern District Health Board, the Chairs of the Iwi Governance Committee and Southern Alliance wish to engage in an independent review of the mental health and addiction continuum of care in the South.

The purpose of the Review is to examine the current Southern Mental Health and Addiction System service configuration and delivery and:

- Bring a forward-looking lens to undertake a comprehensive review, culminating in a set of actionable recommendations that will support transformational change of the Southern Mental Health and Addiction system. It will be underpinned by robust stakeholder engagement (co-design) process and align with the direction set by the Government's decisions on the recommendations made in *He Ara Oranga* (2018) which places tangata whaiora and whānau at the centre of the system.
- Identify and articulate what would enable the elements and culture of the system to work better, including the steps needed to redesign a continuum of care that delivers well integrated pathways; safe, equitable, purposeful and appropriate resources across the district; and recognises our rural profile with tangata whaiora and whānau at the centre of the system and brings interventions earlier and closer to home in primary and community settings. This will include advice on potential models of care for further consideration.
- Undertake this review with an equity lens to ensure that equitable outcomes for youth, Māori, Pacifica, rural and remote populations are considered underpinned by a strong commitment to understanding the needs and actions required to improve the experience of tangata whaiora, Māori and whānau, Māori who access mental health and services.
- Consider the current range of services across the mental health and addiction continuum in Southern, across all areas of the district and all populations, how they are configured, and what can/should be developed sustainably to support the people of Southern better, now and into the future.
- Identify examples of excellent work and systems, particularly those which provide a spring board to build capacity, equity and consistency across Southern.
- Review previous reviews and work undertaken, particularly in the Specialist Services, for example, Model of Care work and Rural Crisis After Hours Services, Mental Health Analysis Paper (Alma Consulting). This review may include review of complex cases.
- Undertake an evaluation that is consistent with contemporary models of care, practices, systems and service delivery, is integrated and seamless, efficient and effective, across the whole continuum ensuring transition between services reflects a system where the lived experience of service users is valued and integrated every step of the way.

- Recognises that the culture of any system is integral to achieving transformational change and is ready to embrace the challenge that will be needed. Input from staff and people with lived experience across the sector will be a key component.
- Identifies the structure and resources required to sustain leadership and sustainable change.
- Identifies a pathway to implementation of recommendations.

2. Focus of the Review

This review will be undertaken with regard to the context and direction for mental health and addiction services - as per the key strategic documents (see appendix one) listed below:

- Crown copyright New Zealand (2018) *He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction:* New Zealand
- Southern District Health Board (2019) *Raise Hope Hāpai Te Tūmanako System Strategic Plan Southern Mental Health and Addiction System 2019-2023:* Dunedin New Zealand and the original Raise Hope Hāpai Te Tūmanako (2012).
- Southern District Health Board (2018) *Southern Primary and Community Care Strategy:* Dunedin New Zealand
- Southern District Health Board (2018) *Southern Primary and Community Care Action Plan:* Dunedin New Zealand
- Health and Disability System Review. 2020. *Health and Disability System Review - Final Report. Pūrongo Whakatunga.* Wellington: HDSR.

The focus will be on all mental health and addiction services that are funded by the Southern District Health Board (see appendix two) with a view to identifying opportunities for system improvement including better access to services at all points across the continuum of care and better integration between primary, community and acute services.

3. Background

The Southern Mental Health and Addiction System, like many elsewhere in New Zealand, and indeed internationally, is under pressure. Whilst it is clear that the DHB faces some challenges in terms of the potentially outdated models of care and the large geographic area it covers, the Southern Mental Health and Addiction System is fortunate to have many valuable strengths to build on. Many people receive good care every day from our skilled and committed primary, specialist (secondary) and NGO workforce. For this reason it is important that the review also acknowledges existing good practice and identifies pockets of innovation and excellence so that these can be shared with the rest of the system.

However, it is acknowledged that the DHB has a number of issues and road blocks that are symptomatic of a system under pressure that it is keen to explore in more depth - with a view to developing a better understanding of the underlying root causes and how we might do a number of things better:

- The Office of the Health and Disability Commissioner has signalled concerns around the increasing number of complaints it receives related to the services that are provided by Southern DHB, particularly the services provided by the MHAID. The pattern of issues of concern relate to discharge planning, complex case management, risk management, family/whanau engagement and communication with consumers and family/whanau. The provision of inpatient care in the Wakari inpatient units, cover in Lakes District and the interface between MHAID and the Emergency Department have been signalled as particular areas of concern.
- It is important for us to understand the culture of the system and how this impacts on outcomes for people as they access one or more services and transition between services.
- We want to ensure that we have a culture that supports engagement between the people who access and work in the Southern mental health and addiction system.
- Increasing access to services, especially for vulnerable groups, to services with lengthy wait times across the continuum, from Primary Mental Health Brief Intervention to NGOs to Specialist. It is important every part of the system is working well and to capacity, for example, if people cannot access mental health and addiction services at a primary level in a timely way this flows through and puts other parts of the system under pressure.
- Integration within and between clinical multidisciplinary teams, NGOs and Primary Health.
- It remains a challenge to find suitable support and accommodation to support accommodation needs for people. This ranges from crisis accommodation, respite through to private landlords to long term accommodation, and homes for life for long term complex people whose needs are not able to be met adequately through current configuration and funding arrangements for service providers. In Dunedin the trend continues for people who have complex and challenging behaviours to return to hospital as a result of a break down in their living arrangements with a residential provider. This puts added pressure on our inpatient resources. There are good interface processes with providers but ultimately they feel they are not adequately resourced or supported.
- Information systems have challenged and continue to challenge the mental health and addiction system and the way information systems do and do not connect across primary, NGO and DHB provided services. Within the DHB many specialist staff work with two patient management systems. Current work relates to Health Connect

South and the implementation of the Mental Health Solution - moving towards Paper Less. NGOs do not have access to Health Connect South.

- Delivering an equitable service across a widespread geographic area is challenging. The increasing demand for crisis mental health services in each locality (including emergency out-of-hours crisis services) is creating a variance in service delivery levels.
- Similarly, the Model of Care, particularly for Specialist Services, varies across the District, particularly in our two main centres of Dunedin and Invercargill. Although this is a feature that has largely come about through history, it means that Tangata Whaiora are not always receiving the level of access and range of services between and across sites that is consistent.
- Likewise recruiting and retaining workforce, particularly in rural areas or in towns that have high living costs is challenging.
- Facilities, particularly the inpatient units on the Wakari site, some of which have been identified as needing urgent attention to support contemporary care given their age and condition.

4. What will the review identify?

It is critical that the review of our mental health and addiction system is undertaken in way that recognises the pressures on services and, at the same time, supports the current work to implement new models of care.

The review will take a whole of district whole of system view and consider:

1. The conditions that support current pockets of innovative and/or excellent practice.
2. The pressure points in the mental health and addiction system and their underlying root causes, identifying barriers, connectivity, gaps and opportunities for service development, configuration which is equitable across the Southern area.
3. The changes and/or improvements that need to be made to the model of care in order to better meet the needs of the population in each locality.
4. The best structure and mix/configuration of resources and services and the preferred model of service delivery in each locality.
5. What Governance and Leadership should look like in order to ensure that modern, contemporary clinical practice can be delivered effectively.

5. Key principles underpinning the Review

This review will be underpinned by the key principles set out in *Raise Hope – Hāpai te Tūmanko* as follows:

- Treaty of Waitangi principles based on the stage one report for the Wai 2575 (Health Services and Outcomes Kaupapa Inquiry) tino rangatiratanga, equity, active protection, options and partnership
- Working to eliminate societal influences on poor mental health.
- Preventing mental distress, and addiction through early intervention.
- Intervening in targeted, effective ways across the life course.
- Working as one, with a systemic approach.
- Striving to improve outcome quality, service capability, productivity, and capacity.
- Equitable outcomes for remote populations.

The Southern DHB recognises that Māori experience significantly higher rates of mental illness, higher rates of suicide and greater prevalence of addictions. While the prevalence of mental distress among Māori is almost 50% higher than among non-Māori, Māori are 30% more likely than other ethnic groups to have their mental illness undiagnosed. We support the acceleration and delivery of Kaupapa Māori services and options. The inclusion of whānau and significant others in the recovery pathway and building our peer support capacity and capability.

6. Methodology

The review will be sponsored by the CEO of the DHB, with the Executive Director, Strategy, Primary and Community acting as the key conduit for day to day management of the programme, accountable to the Project Steering group.

A steering group will be established as will review team will be established by Southern DHB. This team will be external to the Southern Mental Health and Addiction system with a skill set that includes extensive experience in delivering and leading mental health and addiction strategy, service development and transformation. Southern DHB will provide support to the team, liaison and access to key informants and information as requested.

The review will likely include, but is not limited to, the following components:

- A desktop review of relevant data / information / previous reviews in order to better understand the Mental Health and Addiction services that are being provided in the Southern district (including the current service mix/configuration, service utilisation patterns, referral pathways, potential gaps, feedback including complaints, population need and the population served).
- Benchmarking of existing level and mix of services against similar services nationally.

- Face-to-face interviews and/or group forums with key stakeholders in each of the four localities (Dunedin, Southland, Waitaki, South Otago and the Central Lakes areas). It is expected that the review team will physically visit these sites.
- Surveys of broader staff and key groups to obtain and triangulate views.
- Obtain the perspective of service users and family / whanau, particularly tangata whaiora, Māori and whanau Māori.
- Produce a final report which includes the findings of the review and offers recommendations relating to contemporary models of care and service delivery. The final report will also identify current pockets of excellence as well as identifying areas for possible improvement.

Input into these terms of reference has been sought from the Ministry of Health, the Health and Disability Commission, Southern Mental Health and Addiction Network Leadership Group and the, Iwi Governance Committee.

Appendix one – Key strategic documents

1. He Ara Oranga

He Ara Oranga report of the Government Inquiry into Mental Health and Addiction was published in November 2018. This report signals a turning point for New Zealand and indeed our Southern communities who have told us they too are concerned about distress and addiction affecting many of our whanau and that we need to take action to ensure practical help and support when people need it.

2. Raise Hope – Hāpai te Tūmanko

Raise Hope – Hāpai te Tūmanko is the Southern DHB Mental Health and Addiction Strategic plan. The Mental Health and Addiction Network Leadership Group (NLG) have worked hard since the release of He Ara Oranga to refresh Raise Hope – Hāpai te Tūmanko II and signal the work programme for the sector over the next four years. The other key alignment for Raise Hope – Hāpai te Tūmanko is with the Southern Primary and Community Strategy and Action Plan which is about integration within the Southern Health System.

Raise Hope – Hāpai te Tūmanko II is clear that it has an outcomes focus and is committed to co-designing a Southern Mental Health and Addiction system. The three priorities, but not the only areas of focus are:

- More tangata whaiora with mental distress, addiction issues, and resulting challenges will experience better physical health.
- More tangata whaiora with mental distress, addiction issues, and resulting challenges will experience a recovery focused approach.

Whānau are better enabled to support and care for each other.

3. Primary and Community Care Strategy and Action Plan

In 2017 the DHB released its Primary and Community Care Strategy and Action Plan that sets out a very clear articulation of the future strategic directions and programmes of work that are required to transform the way in which services are delivered across the health system. Mental Health is very much at the forefront of this future strategic direction, and we envisage that in the future a significant portion of our Mental Health services will be delivered in a more integrated way with our Primary Care and NGO partners.

A new delivery system, as outlined in the Primary and Community Strategy will enable the effective colocation of community health services, both mobile and in-clinic services (e.g. rehabilitation), hospital specialist care, onsite pharmacy and diagnostics, enhanced urgent care and minor procedures. Community Health Hubs will be developed through either existing infrastructure or new sites. In rural areas, rural hospitals may act as a hub but with the explicit expectation that this includes primary care delivering the HCH model of care1.

[1] Southern DHB Primary and Community Care Action Plan.

The DHB have been progressing the design of the Community Health Hubs. The Community Health (Care) Hubs Strategic brief and the plan for Phase 1 of the start-up of Community Health Hubs (30 October 2019) states that "Community Health Hubs will be developed sequentially and incrementally across the Southern district". The plan outlines a two phased approach as follows:

- Phase one will focus on new Models of Care for Child Health, Mental Health and Health of Older People. This phase will also gather information for infrastructure development as well as interest from potential providers of services.

- Phase two is yet to be designed. It is likely to include development of new Models of Care for other health areas or services, as well as to further explore and develop (in partnership with key stakeholders) the Community Health Hub infrastructure.

4. Health and Disability System Review Interim Report

The review will also need to be cognisant of the issues raised in the *Health and Disability System Review Final Report* published in 2020.

Appendix two – More information about Southern DHB

The Southern DHB is one of 20 DHBs in New Zealand. Southern DHB has the largest geographic area and serves a population of 320,000. In 2010 the former Southland and Otago District Health Boards merged to become Southern DHB. The Planning and Funding functions (including mental health) merged around this time.

Towards the end of 2012 the Otago and Southland Mental Health Addiction and Intellectual Disability services merged to become the Southern Mental Health Addiction and Intellectual Disability Directorate (MHAID).

In 2017 there was another restructure, which integrated mental health and addiction planning and funding functions with the Specialist MHAID services. This restructure signalled the need for a more connected Southern Mental Health and Addiction System within the Southern health system.

More recently MHAID was reassigned from the Executive Director of Specialist Services to the Strategy, Primary and Community group to better reflect its alignment with the wider health system.

The MHAID specialist service provided by the DHB include:

- Mental health and addiction services across a widespread rural area, Waitaki, Central Otago, Southern Lakes, Balclutha and Gore, with two main urban hubs, Dunedin and Invercargill.

- 106 inpatient beds – Ward 9c acute unit (16 beds), Ward 9b intensive care and acute (17 beds), Ward 9a Forensic Medium Secure (13 beds), Ward 10a Intellectual Disability Medium Secure (12 beds), Helensburgh Cottage Intellectual Disability Community Secure (4 beds), Ward 11 (16 beds) Sub-acute, clinical rehabilitation located on the Wakari site in Dunedin, Ward 6c Mental Health Older Persons (12 beds) located in Dunedin Hospital and the Southland Mental Health Inpatient Unit (16 beds) on the Southland Hospital campus. Inpatient services maintain a length of stay and readmission rate below the national average. Seclusion is tracking down with it not being unusual for particular inpatient units to have a month of no seclusion now.

- Full range of community mental health services including Adult Community Mental Health Teams (two in Dunedin, one in Invercargill, Central Lakes (2 sites), Southern Rivers (2 sites) and Oamaru.

- Crisis Mental Health Services are provided by Emergency Psychiatric Services

- Full range of community specialist services including Community Forensic Services, Child and Youth Services, Early Intervention, Maternal Mental Health, Mental Health Older Persons

Other mental health and addiction services provided by NGOs include:

A range of NGO services are delivered:

PROVIDER	ADDRESS	SERVICES
ABLE	34 Prince Albert Road St Kilda Dunedin 9012	Family Whanau support – education, information and advocacy Adult, Infant, Child and Adolescent Mental Health Activity Based Recovery Support Mental Health Promotion and Suicide Prevention
ADVENTURE DEVELOPMENT	599 Princes Street Dunedin 9054 (PO Box 189)	Child Adolescent and Youth Alcohol and Drug Community Services - Southland Community child, adolescent and youth service for co-existing problems - Southland and Otago
AROHA KI TE TAMARIKI CHARITABLE TRUST (trading as Mirror Services)	Evan Parry House Level 8/43 Princes Street Dunedin 9016	Children and Youth Alcohol and Drug Community Services Children and Youth planned respite services for day programme users Children and Youth Mental Health Counselling Programmes Exemplar CEP Enhanced Youth Alcohol and other Drug Service
ASHBURN HALL CHARITABLE TRUST	496 Taieri Road Halfway Bush Dunedin 9010	Community service for eating disorders (Southern Support Eating Disorders Service) Alcohol and Drug Managed Withdrawal and Community Service
BAINFIELD ORGANIC GARDENS	Invercargill Christian Centre 165 Leet Street Invercargill	Vocational Support
BAINFIELD PARK RESIDENTIAL CARE LTD	500 North Road Waikiwi	Housing and Recovery Day/Awake Night Support

	Lorneville Invercargill 9810	
CORSTOPHINE BAPTIST COMMUNITY TRUST	336 South Road Caversham Dunedin	Child, Adolescent and Youth Mental Health Community Care with an Accommodation Component Housing and Recovery Services Daytime/Responsive Night Support Clinical Rehabilitation Service Community Based Adult Community Support Child, Adolescent and Youth Community Support Services
CARROLL ST TRUST	91 Carroll Street Dunedin 9016	Housing and Recovery Services Day/Awake Night Support Housing and Recovery Services Daytime/Responsive Night Support - Carroll St - Forbury Road Adult community Support Supportive Landlord Service
CREATIVE ARTS TRUST (ARTSENTA)	462 Princes Street Dunedin 9016	Activity based recovery support services
DOWNIE STEWART FOUNDATION (Moana House)	401 High Street Dunedin 9016	Community Alcohol and Drug Service Residential Alcohol and Drug Treatment Programme Community Alcohol and Other Drug Service – transition and continuing care
GORE & DISTRICTS COMMUNITY COUNSELLING CENTRE	13 Traford Street East Gore Gore 9710	Community based alcohol and other drug specialist services
KOPUTAI ANNEXE (Lodge) TRUST	41 Ajax Road Port Chalmers Dunedin	Planned Adult Respite Community support packages of care
SOCIAL GOOD CO. SYNERGY WELLNESS	66 Prince Albert Road Dunedin	Adult Needs Assessment and Service Co-ordination – Otago and Waitaki Infant/Child Adolescent and Youth Needs Assessment and Service Co-ordination – Otago and Waitaki

NGA KETE MATAURANGA POUNAMU CHARITABLE TRUST	92 Spey Street Invercargill	Kaupapa Māori Alcohol & Drug Services Kaupapa Māori Mental Health Services Tamariki & Rangatahi
OAMARU MENTAL HEALTH SUPPORT CHARITABLE TRUST	21 Itchen Street Oamaru	Adult activity based recovery services/rehabilitation
OTAGO ACCOMMODATION TRUST	PO Box 2321 South Dunedin Dunedin 9044	Supportive Landlord Service
OTAGO MENTAL HEALTH SUPPORT TRUST	Floor 3 109 Princes Street Dunedin 9016	Consumer leadership, consultancy & liaison Peer support service Consumer leadership, consultancy & liaison
Otago Youth Wellness Trust	20 Parry Street Dunedin 9016	Community based youth health support service
PACT	80 Filleul Street Dunedin 9016	Adult community support services –Otago and Southland Kaupapa Māori community clinical support service - Otago Activity based recovery support services -Balclutha and Dunedin Supportive landlord service – Otago and Southland Planned adult respite – Otago and Southland Adult crisis respite – Oamaru and Otago Housing and recovery services daytime/responsive night support Balclutha/Otago/Southland Housing and recovery services daytime/awake night support – Otago/Southland Women's service package of care - Otago Infant, child, adolescents and youth community mental health services - Southland Child, adolescents and youth community based activity service -Southland Infant, child, adolescent and

		youth community mental health services - Southland Infant, child, adolescent & youth community mental health services – peer support. Child, adolescent and youth mental health community care with and accommodation component - Southland. Infant, child, adolescent and youth crisis respite -Southland. Consumer leadership.
PRESBYTERIAN SUPPORT OTAGO INCORPORATED	407 Moray Place Dunedin 9016	Activity based recovery support services Vocational support services Adult community support
ST CLAIR PARK RESIDENTIAL CENTRE	287 Middleton Road Dunedin	Housing and recovery services daytime/awake nights
TE KAKAKURA TRUST (TRADING AS TE KAHUI REO WHAKAKOTAKI O TE KAKAKURA)	25 Queens Drive Invercargill	Planned adult respite Adult community support services - cultural support staff Housing and recovery services daytime/responsive night support
UNIVERSITY OF OTAGO COMMUNITY MENTAL HEALTH SERVICE	Student Health Service Cnr Walsh & Albany Streets Dunedin 9054	The mental health support provided is funded by the University. SDHB funds a small part of SMO FTE
VOLUNTEERING OTAGO TRUST	Dunedin Community House 1/283-301 Moray Place Dunedin 9016	Activity based recovery support services

9

Mental health and addiction services provided by Primary care services

WellSouth Primary Health Organisation provides Mental Health Brief Intervention across the district and also holds the contract for Suicide Prevention and Postvention.

Local initiatives and partnerships

To support the transformation, the specialist services, often in partnership with NGO and Primary Partners, have made significant in-roads into improving the quality, safety and integration of mental health and addiction services. Examples of this are as follows:

- A Mental Health and Addiction Network Leadership Group (NLG) supported by four locality groups provides leadership for the southern mental health and addiction system. Membership includes service users, whanau, and primary, NGO, specialist services, Māori and an independent chair. A cross government forum also sits with the NLG. The NLG is currently strengthening its connection with the Southern Health Alliance.
- Service User Network established across the Southern district
- HQSC projects: Working towards Zero Seclusion, Connecting Care – Improving transitions between services and Learning from Adverse Events.
- Implementation of Safe Wards, SafeSide Suicide Prevention Training, Trauma Informed Care focus, Supporting Parents Healthy Children, Increasing Access to Psychological Therapy, pilot of shared Personal Plan in conjunction with WellSouth PHO.
- Mental Health and Addiction Key Performance Indicator programme – Active in three streams – Adult, Child and Youth and Forensic.
- Marama Realtime Feedback has been implemented albeit with some technical issues that are now being resolved, enabling Southern DHB (4.24 in November 2019) to benchmark with other DHBs and the national average score (4.39 in November 2019).
- Co-design workshops for whole of system design – nine workshops held across the district in the 2018-19 year with a focus on whole of system, Day and Vocational Activity Services, Mental Health Needs Assessment Service Co-ordination and Suicide Prevention.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Community Health Council – Annual Report 2019-20**
Report to:	Disability Support and Community & Public Health Advisory Committees
Date of Meeting:	7 December 2020

Summary:

The Community Health Council (CHC) is an advisory council to the Southern DHB and WellSouth PHN. The Council was formed in February 2017, and currently has eleven members including the Chair Karen Browne.

Membership of the council is from a diverse range of backgrounds and geographical locations. These members all come with strong community connections and personal experiences with the health system, either as an individual or through supporting whānau and family.

To recognise and celebrate the achievements of the last year the CHC has drafted an Annual Report for the 2019-20 year. The Chair and Facilitator again want to acknowledge the work and commitment of all Council members and CHC advisors who have gone beyond the requirements of their roles to ensure the work of the CHC continues to grow.

The Council also acknowledges the support from Executives at the DHB and WellSouth in supporting and encouraging the work of the CHC.

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

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

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

Prepared by: Karen Browne Chair of Community Health Council Charlotte Adank Community Health and Clinical Council's Facilitator **Date:** 27 November 2020	**Presented by:** Karen Browne Chair of Community Health Council

RECOMMENDATION:
That the Committees note the Annual Report.

Southern Health
He hauora, he kuru pounamu

Community Health Council

June 2019 - July 2020

WellSouth Primary Health Network
Hauora Matua Ki Te Tonga

Southern District Health Board
Piki Te Ora

Back: Jason Searle, Bob Barlin, June Mills, Kelly Takurua, Jocelyn Driscoll, Hana Halalele, Chris Fleming (CEO). Middle: Lesley Vehekite, Toni Hulls, Gail Thomson (ED Quality & Clinical Governance Solutions), Charlotte Adank (Community Health & Clinical Council's Facilitator), Paula Waby. Front: Rosa Flaherty, Karen Browne

Contents

Message from the Community Health Council Chair
Karen Browne

2020 has so far been a year of rapid response to change due to Covid-19. The southern region was hard hit by two clusters of infection very early on in the pandemic in New Zealand, and we are very grateful to our Public Health team, Primary Health Organisation and the DHB for the rapid and successful containment of the virus. Much of the CHC project work understandably ceased or slowed during this time. Some CHC members worked in their communities in a variety of ways, to assist those in need, and are commended for this effort.

Covid-19 changed the course of some of our planned activities, such as travelling through the region to inform communities of CHC and the work we do, but has also provided other opportunities to assist in progressing with gains made in the period March to June; in areas such as Telehealth and continuing progress with Health Care Homes. The CHC will be actively involved in implementing the Health Quality and Safety Consumer Engagement Marker, and with our Engagement Framework, feel comfortable that this will assist in the data required to be submitted.

Shortly after taking the role as Chair, preparations began for CHC to host a Symposium in October 2019, for all CHC members and Advisors, with guests from a similar consumer council in West Sydney. The Symposium was greatly appreciated by all attendees, and some valuable learnings came from it, which will form the basis of education and training for both CHC advisors, and staff, for future work.

Work has progressed on evaluating consumer engagement to ensure this is meaningful and not “tick box” or tokenistic. This evaluation becomes even more relevant, as Health Quality and Safety Commission is now collecting data from all DHBs on consumer engagement.

CHC members and Advisors do report positively on the work they are involved with, and staff value their input and the importance of applying the consumer lens to services provided. The new Dunedin Hospital build has many CHC members and Advisors working in a wide variety of groups, and all concerned are commended for their accelerated learning to cope with architectural drawings, plans, patient flows, and the myriad of other health building related aspects of the work they are part of!

CHC achievements and the solid engagement in various workstreams is reliant on the members giving their time so generously and ably, and the knowledge and guidance of our Facilitator Charlotte Adank. My sincere thanks to this team. My thanks to both Executive Teams and staff that continue to support the work of the CHC.

- Karen Browne, CHC Chair

Message from Andrew Swanson Dobbs

Community Health Council continues to be a valuable resource for WellSouth and general practice in the region.

Karen and Charlotte and the other Council members help ensure the voice and views of patients and the public are well-represented when we have reviewed and further developed key programmes this year. Council members helped us to interview community representatives for our board of trustees and provided guidance to general practices in our network when they were setting up their own patient engagement groups.

The CHC is always willing to help and we are very grateful for their ongoing support.

- Andrew Swanson Dobbs, CEO, WellSouth Primary Health Network

Message from Chris Fleming

Congratulations to the Community Health Council on another year of making a difference to the health services available to the people of the Southern district.

This is a year that has tested us all, and again, the importance of ensuring the voices of the people who use our services has proven its value.

At times this has occurred through your calls for enhanced services that are more accessible, better coordinated and closer to home – making sure these expectations are squarely on the agenda in the design of health services. At other times the Council has served as an invaluable and trusted sounding board, allowing leaders to gauge reaction to initiatives ranging from new configurations for the Emergency Department to prioritisation processes for identifying those most at need of elective surgery.

Elsewhere, members and advisers have contributed directly to working groups, such as co-designing improvements to services such as rheumatology, or developing a disability strategy that provides a vision and guidance for the Southern Health system, or contributing to the design of the new Dunedin Hospital.

And at all times, the Council has remained an advocate for the principle of community consultation, which we have sought to honour as we addressed questions such as where best to locate primary maternity facilities in the Central Otago/ Wanaka area.

On behalf of Southern DHB, we thank you for all of your input. Together we can ensure the right perspectives are around the table, and that the Southern health system – that serves us all – is stronger for it.

He waka eke noa.

- Chris Fleming, CEO, Southern DHB

Summary of the Year

Who we are

The Community Health Council (CHC) is an advisory council for the Southern District Health Board (DHB) and WellSouth Primary Health Network (hospital and community health services including GPs) and has enabled a stronger community, whānau and patient voice to be heard in decision-making across the Southern health system.

Since forming three years ago, the CHC has had another productive year, although some plans were put on hold with Covid-19. This report provides an overview of some of the activities that have been undertaken.

The CHC continues to have rotational membership, with members representing different areas of health, as well as geographical representation from across the district. Current CHC membership is outlined in Appendix 1. As well as the CHC members on the Council the ever-growing database of CHC advisors continues to expand, and we are constantly grateful for the time and effort people put into having the voice of the community heard at often quite difficult meetings and project engagement. Appendix 2 provides a summary of listed CHC advisors.

Our Strategic Goal

Our communities, whānau and patients are active parteners in the Southern Health System design, planning and decison-making to achieve improved health processes and outcomes.

Our Guiding Principles

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

Why is engagement with community, wh nau and patients important?

Informed, engaged patients and whānau make better choices and are able to work in partnership with professionals to make better health decisions for themselves and their whānau. Additionally, working together in partnership helps us to create and deliver better quality health services. Sometimes this is at a reduced cost as everything is done properly the first time which works out better for all.

When Southern DHB and WellSouth Staff work alongside community, whānau and patients who use the health service to build a partnership together, several things happen including:

1. Staff members have a better understanding of the needs of their community, whānau and patients and can work collaboratively to make health services more helpful.

2. Communities, whānau and patients gain a greater understanding of how the health system works and gain a better understanding of what health services can and cannot provide.

3. Community, whānau and patient involvement improves all the paperwork used to communicate with communities across the district.

4. Health services will improve for you and other people living in the Southern district. Services become safer and the health outcomes for the population improves. Health services become easier for people to access and are more likely to meet your health care needs regardless of your cultural or social background.

"If quality is to be at the heart of everything we do, it must be understood from the perspective of patients."
- Darzi next stage review[1]

What the CHC has done to support engagement?

Through the development of a CHC Engagement Framework & Roadmap[2], the CHC has enabled staff to engage with a range of community, whānau and patients (CHC Advisors) from across the district.

The number of people who have expressed an interest in being a CHC Advisor has grown to over 100. It should be noted, the Council is aware that the people who are registered to be CHC Advisors to date are not representative of the Southern population but the CHC is able to provide guidance for services to better connect with other groups i.e. Pacifica, Māori, disability as required.

This year, Council members revised the CHC Welcome Packs for Advisors, incorporating a code of conduct of how CHC advisors should conduct themselves when engaged with projects. Staff also have a code of conduct which they agree to when they become an employee of the DHB or WellSouth.

As well as connecting CHC Advisors into projects, the Council has been collecting feedback on the experiences of both staff and CHC Advisors involved with engagement activities.

A selection of feedback we are receiving from CHC Advisors involved in project includes:

- Consumer input is very important, but many decisions will rest with clinicians, nurses and technical staff who will understand practicalities of what is proposed in new build
- Being involved is too good an opportunity to help change things for the better
- I am unsure if I had all of the information, but I have never felt excluded
- I do think that CHC advisors need to have actual experience with the particular service they are working with in order to provide valuable feedback.
- We need more time to talk through items
- I was welcomed to my first meeting by several different people, and my views were sought two or three times during that first meeting
- Finding my way around the Teams files has been a learning experience, and the mix of files in Teams and emailed reports has been a bit confusing. Working out the most effective way for me to manage these documents onscreen during Teams meetings has also been a bit of a challenge.

Some of the feedback from staff included:

- We had name badges, which helped with the process of introductions
- Introduction sessions have been very helpful. We would strongly recommend CHC members attend the introduction session before beginning involvement in a FiT Group (otherwise they can easily become overwhelmed)
- Timeliness of papers was certainly something that could have been improved. Plans are in place to sharpen up in this area in the future
- Their (CHC Advisors) feedback about how we can improve should be incorporated into future versions of documents that are shared to ensure they're pitched appropriately
- Due to DHB workload and time pressures, information has been late in being sent out and we need to do better
- We want the CHC advisors to speak up, don't be afraid.

The feedback that comes in from staff and CHC Advisors allows the Council to monitor how the engagement is going but also where further support may need to be directed. Based on the feedback received, the CHC would like to do more training with CHC Advisors – support them to understand the kind of questions they could be asking, have better understanding of the health system and question the status quo.

Additionally, with staff, more work needs to be done to support them working in this way. It may appear strange that staff are sometimes daunted by the thought of a non-staff member being present in planning meetings but the relationship at the clinical session is different from a planning session. The CHC has some ideas about show casing examples of work where working in partnership with CHC Advisors has reaped some positive outcomes.

CHC Symposium

A key highlight over the last year was hosting the first CHC Symposium for CHC Advisors. This was held in Dunedin, October 2019, which did prevent some people outside of Dunedin attending. The purpose of the symposium was to celebrate the achievements since the launch of the CHC Engagement Framework and Roadmap, learn from engagement activities to date and to look ahead to what improvements could be made with the process and support systems. This event was well attended, and positive feedback was received from both staff and CHC advisors. Further details about the CHC Symposium can be found on the next page.

[1.] Department of Health. High quality care for all NHS next stage review final report. UK: Department of Health, 2008.
[2.] https://www.southernhealth.nz/about-us/about-southern-health/community-health-council/chc-engagement-framework-road-map

Community Health Council Symposium 2019

The purpose of the CHC Symposium was to celebrate two years of engaging community, whānau and patients at the Southern DHB and WellSouth to celebrate our achievements and to shape our future.

In October 2019, the CHC hosted their first Symposium inviting all CHC advisors to attend. Approximately 50 CHC advisors were in attendance and the day involved hearing from both clinicians and CHC advisors what they had learnt from the process of engaging together on a variety of projects. Other guests included Pete Hodgson (Chair of Southern Partnership Group overseeing new Dunedin Hospital), Gillian Adams (Advocate for Health and Disability Commission), Brigit Mirfin-Veitch and Jenny Condor (Donald Beasley Institute, University of Otago) to discuss the development of the Disability Strategy for the Southern DHB. Both Executive Teams from the Southern DHB and WellSouth attended and welcomed visitors to this event.

The CHC were fortunate to have some visitors from a Consumer Council in Sydney, Australia – Coralie Wales, Manager (Community and Consumer Partnerships, Western Sydney Local Health District), Peter Johnson (Chair of Consumer Council) and Janet Johnson (Consumer representative).

A panel discussion occurred in the afternoon which involved clinicians, staff and CHC advisors answering the question 'How do we know we are moving engagement with CHC advisors from a tick box exercise (tokenism) along the continuum of engagement to being meaningful and empowering?' This question resonates today as we want to ensure that this engagement between community, whānau and patients is genuine, meaningful and making a difference.

A number of resources have been developed from workshop sessions at the Symposium including Learnings & Insights from staff who have engaged with CHC advisors and Lessons Learnt from CHC Advisors about their experiences of engagement. These are profiled on the following pages and the CHC plan to use these resources for staff and new CHC Advisors to support them with future engagement exercises

Guests from a consumer council in Australia presented at the Symposium outlining processes they have established and work they have undertaken with staff, evaluations they have undertaken include reviewing what a difference consumer engagement is making to decision-making in the health system. The day after the Symposium, members of the Australian consumer council met with staff across the organisation including the Executive team and the Project Management Office for the new build of the hospital.

We thank everyone that gave up their time to attend this event. It is hoped to make our symposium a biennial event, to celebrate our successes and progress valuable learning from the process.

How to successfully engage community, whānau and patients in building quality improvement initiatives

Southern Health He hauora, he kuru pounamu | Community Health Council

LESSONS LEARNED FROM CHC ADVISORS

1. Clarify my role

Clearly communicate why CHC advisors have been invited, what the purpose of the engagement is, and what is expected of them. CHC advisors will most likely be able to add value to work going on if they feel prepared, confident and trusted in their role.

2. Build a relationship with me

Communicate with me regularly, even if it may seem there's not that much to update me on. Ensure there is a time for me to provide an update.

3. Educate others on my role and the value I bring

Team members should understand the unique role CHC advisors bring to the table in terms of improvement. Ensure all team members are aware why a CHC advisor is engaged, how to respect their expertise and experience, how to solicit and appreciate their input and how to incorporate their perspective. Realise CHC members also want the best for community and staff.

4. Involve me from the beginning

CHC advisors want to be involved from the beginning of an initiative to provide their viewpoints. This works in a partnership model rather than a top-down approach.

5. Communicate clearly

Please talk in plain English and if you are using jargons/ acronyms- please provide a list of abbreviations before we meet. We may see you less often than other staff members so ensure we are kept updated with any changes as best as possible.

6. Including one CHC advisor is good; including more is better

If possible, include more than one CHC advisor on any initiative to gain more diverse range of perspectives. Additionally, having more than one means they can support each other.

7. Sustain the engagement throughout the process

Regular team meetings foster the ongoing involvement of CHC advisors and allow for the development of relationships and commitment from all team members.

8. Make engagement activities accessible and provide options for how I can get involved

Ensuring CHC advisors are recognised for any out of pocket resources is a key principle of the CHC Roadmap. This involves covering expenses and trying to eliminate other barriers with participation as best can. Meetings don't always need to be face-to-face, so ask the option of whether technology meetings are possible either via zoom and or phone. Etiquette on how these meetings are chaired is important.

9. Promote networking opportunities

Opportunities will arise for CHC advisors to network with team members which can further promote the role of the CHC advisors.

10. Close the loop - Continue to work with us once the project is finished

Continue working with CHC advisors once the project is finished. Let the CHC Advisor know the outcome of their involvement whether it is providing feedback or providing a copy of the final report and any future plans.

1. Recognise the value of community, whānau and patient engagement

Clearly communicate why Community Health Council (CHC) advisors have been invited, what the purpose of the engagement is, and what is expected of them. CHC advisors will most likely be able to add value to work going on if they feel prepared, confident and trusted in their role.

2. Consider CHC Advisors to be members of the team

Healthcare teams that consider CHC advisors as part of their team will see most of the sustained participation. Fully integrate CHC advisors into team meetings, communication and decision-making.

3. Work together to co-design improvements

Staff and Clinical Leaders stated that working together with CHC advisors led to more innovative ideas and recommendations. A collaboration of working together allows for innovation and questioning the status quo.

4. Engage CHC advisors early and involve them throughout the project

Engage CHC advisors as early as possible and discuss how they envisage their role and contributions. Early engagement allows a good understanding of what is trying to be achieved and allows their input and perspectives to shape the initiative from the outset not as an afterthought.

It is important for the lead staff member to meet with the CHC advisor before the project has started, have an informal chat and brief them on the work that is to follow.

5. Support and role model engagement

Strong and inspired clinical leadership is necessary to overcome any barriers to successful engagement. This leadership is essential to create the culture we are trying to encourage.

6. Understand the experience of care through the eyes of the community, whānau and patient

CHC advisors have expertise from 'experience' so it is important to consider their viewpoints. Patient stories provide a window into their experience and can motivate and inspire healthcare providers to consider how experiences shared by patients can be improved. Storytelling can be powerful tool for change, especially when stories are acted on to help improve the health system.

7. Provide CHC advisors with on-going support

Support for CHC advisors can be provided in the form of staff checking in to see if the CHC advisor feels supported and comfortable, debriefing CHC advisors before and after meetings, supporting CHC advisors with any questions they may have between meetings, offering flexible ways of CHC Aadvisors being able to connect in with meetings. CHC advisors are also supported through CHC members on an as needs basis.

8. Provide staff with on-going support

For many clinicians and staff, having CHC advisors as members of a planning and implementation team is new and can be daunting.

Staff are provided with a CHC Staff Information Pack which outlines key things to think about when engaging with patients, whānau and community.

The CHC Facilitator is available to assist staff through the various steps and support them with engaging with community, whānau and patients.

A number of Clinical Champions are available to talk with staff about their experiences.

9. Evaluate your engagement efforts

As part of the CHC engagement Roadmap and Framework, the CHC Facilitator will be requesting feedback on how the engagement is going with the CHC advisor. This is to ensure that our processes are working appropriately and whether we need to change anything.

Community Health Council Participation 2019/20

During the 2019-20 year the Council has provided advice, guidance and support into an ever-growing number of projects within the Southern health system. We have provided a showcase of some key highlights, a complete list of engagement activities can be found in Appendix 3.

The environment and society we live in supports health and well-being.

Pacifica engagement with Covid testing

At the beginning of the Covid-19 pandemic, the whole of New Zealand was awakened to the way we engage and communicate with our communities. It was clear in Southern as it was in the rest of New Zealand, using the same information and communication techniques does not work for all population groups and different engagement approaches needed to happen with different communities. The Pacific community which represents 2% of the Southern DHB population live across the Southern district. Hana Halalele, Southern CHC member, President of the Oamaru Pacific Islands Community Group and recently appointed Waitaki District Councilor played a pivotal role with supporting and guiding both WellSouth and the DHB with their response to engaging with the Pacifica community for Covid testing in the Waitaki district. Hana stated it was team effort from the various community groups- OPICG Inc including Waitaki District Council, Safer Waitaki, Waitaki Tongan Community Trust, Oamaru Tuvalu Community Group and Oamaru Fijian Community Group, Waitaki Multicultural Council.

Hana Halalele volunteered time and supported WellSouth and the DHB to communicate to members of the Fijian community, the Tuvalu community and tangata whenua but ideally all should feel welcome to take part and support each other.

"We found that at the last testing clinic especially at Alliance, our Pacific people felt comfortable with having our local people around to be able to help with translating and support if need be and familiar faces. Our target for the Oamaru testing is approximately 450 people so will be great to have this met and it is open for all non-Pacific as well."

Care is more accessible, coordinated and closer to home.

Primary Care After-Hours Care

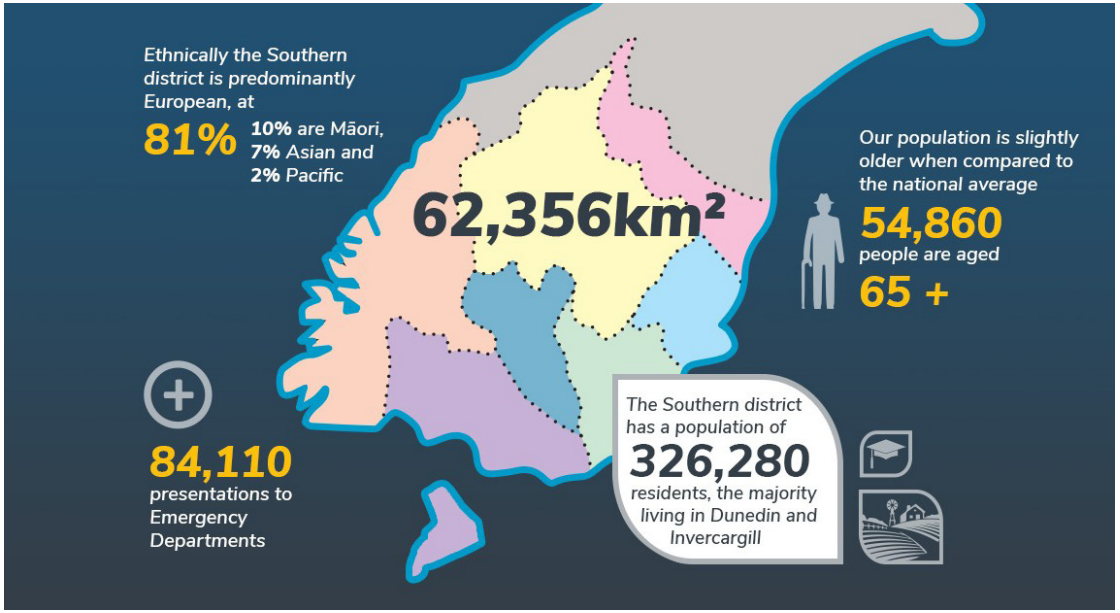
The CHC continues to question the DHB about equity of health services provided across the Southern district. In the last year, the CHC has had a particular focus on primary care after hours which is overseen by WellSouth. Although the Southern district covers a larger geographic region, than any other DHB, it does not seem fair that a person living in Invercargill should have to pay more than a person living in Dunedin pays to access after-hours primary care services. New Zealand prides itself on not being a post-code lottery for health care services, but is apparent there are significant differences in access across the Southern district.

Two CHC members, Jocelyn and Lesley both based in Southland, have dedicated their time to be active members on a steering group which is looking for solutions in the Southland area. Both Jocelyn and Lesley are providing examples to the group of what issues are arising within the community they live. Sometimes frustration with how long things are taking is expressed by both CHC member but they are there to ensure a solution is found.

This however does not address the problems arising in the Central Otago area. The CHC will continue to monitor what happens in this area and raise issues up to the relevant CEOs.

Why is it important to have CHC advisors engaged with this work?

I believe is it important to have CHC advisors in this work. It's great the DHB and WellSouth have the data, but that's it. It's meaningless to have the data without the "Why" and the "Story" behind the data. Hence the importance of having CHC members involved in this work. We see things DHB and WellSouth do not see, CHC can be the eyes and ears for both health organisations and the voice for the community. I believe CHC members are field workers, gathering information backed up by real situations feeding it back to the DHB and WellSouth.
(Lesley Vehekite– CHC member)



Our workforce have the skills, support and passion to deliver the care our communities have asked for.

Case Study of developing a Southern Disability Strategy

Viewpoint from Waby, Chris Ford, Jasmin Taylor – CHC Advisors on steering group that supported the development of the Disability Strategy.

Overview of the Service

Since the inception of the CHC, members have heard about the issues and barriers encountered by people with disabilities when they have accessed care at the Southern DHB. All members agreed this was not acceptable and more should be done to make the experience better for these people. It was agreed by the Executive Leadership Team that the DHB should develop a Disability Strategy to guide the organisation on how to make services and the workplace more accessible for disabled people.

Consumer Engagement in Action

A steering group was set up and membership included consumers with lived experience of disability (including deaf people), including ourselves. This group worked alongside the Donald Beasley Institute (DBI) in developing the strategy.

A number of workshops and forums were held with the community around disability needs and there were some delays due to Covid-19. The Disability Strategy will be officially launched in early 2021 after a number of actions are completed.

Did it achieve what we sought?

Yes, in terms of setting up a strategy. We're looking forward to the strategy being implemented and becoming a living document which has an action plan set up and one that is regularly reviewed by a group of disabled people.

Positives of being engaged and working with DBI?

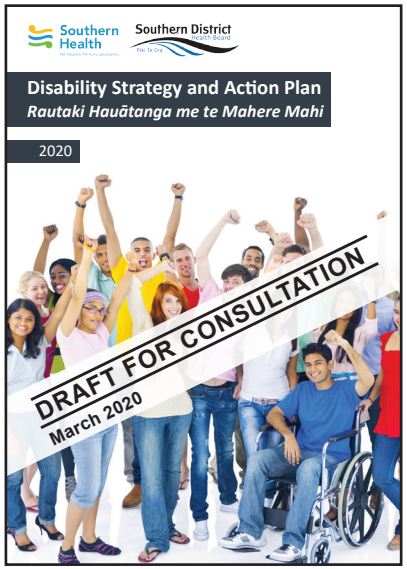
For us, these centred around meeting and working with the staff at DBI and the team of people on the steering committee. It felt like we could all share our different perspectives, and the value of our lived experience was recognised and respected.

What could be done better?

We would have loved more NZ Sign Language (NZSL) translation of both the draft and consultation questions. We look forward to the strategy being made accessible via NZSL, so that subsequent reviews of the strategy can then take on board further feedback.

Most notably, Paula is now a member of the Disability Support Advisory Committee (DSAC) at Southern DHB and will be following closely the next steps in implementation.

In August 2020, a draft copy of the strategy was presented to DSAC outlining feedback that had been received during the consultation. An official launch will occur at the beginning of 2021.



Our systems make it easy for our people to manage care, and work together safely.

Telehealth Steering group

In response to the COVID-19 outbreak the use of telehealth became essential for the continuation of the delivery of patient care and to minimise staff exposure to the virus. Telehealth had previously been used in an ad hoc manner within the DHB with no standardisation or guidelines as to how it should be implemented or utilised. The requirement to use telehealth as a means of delivering care to patients during the COVID-19 outbreak effectively served as an enforced trial of utilising telehealth. Feedback from this 'trial' has been more positive than anticipated. Telehealth has been met with a significant level of satisfaction from the clinicians involved and anecdotally from the patients too.

The current situation provides an opportunity to embrace telehealth and harness its full potential within the DHB. To do this a framework needs to be established to allow for the provision of optimal telehealth services. As part of a steering group to guide this process, two CHC members were appointed to this group.

Telehealth
for the Southern Health System
He Hautoka, he hauora

Five minutes with Lesley Vehekit

Lesley is a Community Health Council member on the Telehealth Steering Group.

What made you interested in telehealth?

I want to learn about its purpose and to hear what difference it can make for the community.

How do you think we can ensure all patients who want to use telehealth can have access to it?

There are a number of things we can do including:

- Ensuring language used is not too technical for the patients
- Making the patients feel you care about them, especially for elderly and patients from countries where English is not their first language
- We need to cater for all age groups, ethnicity and genders.

How can you help in your role as a Community Health Council Advisor?

I'm able to provide regular updates to the Council, share information and ask for feedback.

How would you like to see telehealth used throughout the Southern Health system in the future?

I'd really like to see telehealth well-utilised by the community and for it to help the Southern Health system to improve its service and care for the community.

What's your advice to anyone thinking of using telehealth?

Just try it- it's a good platform, there are options available. For example- translation services. You don't have to leave home, it saves time and it's stress free.

Primary and secondary/tertiary services are better connected and integrated. Patients experience high quality, efficient services and care pathways that value their time.

Involvement of CHC advisors in service design is beginning to happen in a few service areas and is something the CHC is keen to be more involved with. This year the CHC has chosen to profile a service that has engaged early, has had strong Clinical Leadership that embraced engagement with community, whānau and patients, as well as engaging well with other clinical services and primary care. Over time we expect that they will achieve great results due to the early engagement and responsiveness.

Case Study of Rheumatology Service and Consumer Engagement

By Karen Browne, Chair, Community Health Council.

Overview of the Service

The Rheumatology Service in the Southern region has clinics in Oamaru, Dunedin, and Invercargill. The area covered is the largest geographical area of all the DHBs in New Zealand, and has a population base of ~330,000. Both in-patient and out-patient services are provided, with the core work being out- patients

Why Review the Service?

More patients benefit under the care of the Rheumatology service as a result of improvements in treatments plus availability of new and improved medicines. It is timely to redesign the Rheumatology service, and in doing so, take into consideration:

- Patients who are experiencing delays for follow up appointments.
- The increase in number of patients entering the service each year who have chronic conditions.
- The increasingly complex treatments which become available; these require on-going monitoring and more frequent clinic review. The numbers of patients who are regularly seen in clinic is increasing.
- The increased life expectancy of the population, and therefore an increase in the number of older persons who have long term medical conditions such as rheumatology.
- The challenges of a small specialist service to provide a district-wide care across a large region.

Aim of the redesign

The aim of the redesign is to develop and implement an integrated model of care for patients with rheumatological conditions, across primary and specialist services. The model of care will be consistent with the values of the DHB, the vision of the department and the NZ Triple Aim of quality; it will underpin a sustainable, high quality service that meets the needs of the patient.

Consumer Engagement in Action

In late 2018, the Clinical Director of Rheumatology contacted the CHC Facilitator to discuss planned actions to redesign the Rheumatology Service in the SDHB, addressing service delivery challenges and inequities, and engaging a consumer advisor to work with the Rheumatology team. The consumer was invited to the planning day in early 2019, and from

there a group of consumers was convened to meet with Rheumatology staff. The engagement process was very inclusive, with a consumer (Karen Browne) asked to chair this group, thus maintaining close contact with both the Clinical Director and the consumer group members.

At the initial meeting with consumers, in July 2019, the Clinical Director presented background information about the SDHB Rheumatology service and its challenges and opportunities. The work to date within the department was shared with the consumer group – this included detail of the engagement with GP practices across the region which had occurred, the results of which indicated their support to develop integrated care.

Within the service, much thought had been given to how to be a responsive and agile service to patients and primary care, and to continuously improve the system for seamless and efficient flow, and thereby improve the patient experience.

This means being able to meet target waiting times for new and follow up appointments, and the ability to respond to acute problems in a timely manner. To the consumers, this was evidence of a very responsive and cohesive staff, and all consumers committed to the journey.

The Chair of the consumer group and Clinical Director worked together to formulate a Terms of Reference for all consumers. The Chair, with input from the Clinical Director, also was responsible for publishing the agenda, keeping the actions list updated, and drafting minutes. The Chair also liaised with all consumer members by sending out pre-meeting documents, collating feedback and forwarding this to the Clinical Director, and keeping all parties informed.

In February 2020, consumers were invited to the Rheumatology Department Annual Planning Day. Again, consumer input was actively sought around updating the vision, looking at a SWOT[3] analysis, identifying areas of the service that could be improved and discussing actions to that end. Since convening, the consumer group has been consulted on several key plans, reviewed many letters, pamphlets and patient questionnaires, and actively assisted in developing new surveys- some 15 pieces of work.

The Clinical Director and consumers presented at the CHC Symposium in October 2019 about what they have achieved and this was clear evidence of how successful consumer engagement can be.

To date, the SDHB Rheumatology Review is widely applauded and recognised by DHB executive staff as being the “gold standard” of a service engaging with consumers as challenges and opportunities are recognised. From the consumers’ perspective, this project has been one of feeling valued, included, informed and appreciated.

[3] Strength, Weaknesses, Opportunities and Threats Analysis

Including Dunedin Hospital, Lakes District Hospital redevelopment and community hubs to accommodate and adapt to new models of care.

The new build of Dunedin Hospital is a once in a lifetime event. Engagement with the new hospital build has commenced with CHC advisors becoming involved with the concept design stage. It was confirmed in March 2019 that the Programme Management Office would work with the CHC to engage community, whānau and patients in the Facilities in Transformation (FiT) groups as part of the concept design stage.

The number of CHC advisors engaged with this work has increased to over 30 people. There are two CHC advisors who are members of the Clinical Leadership Group (CLG). The CLG is the key clinical and service decision-making and advisory group for the New Dunedin Hospital project. There will be many more opportunities for the community, whānau and patient voice to be heard as we move forward with this project.

Some words from Jo Millar, one of the CHC advisors on the CLG for the new Dunedin Hospital

I have been President of Grey Power Otago for the last 15 years. I also represent Zone 7 (an area which encompasses 7 Grey Power Association within the Southern District Health Board) as their representative on the Grey Power Federation Board. My responsibility on the Board is to Chair the Health National Advisory Group for Grey Power so all aspects of health have become very interesting and at times also challenging.

Due to my interest I was very pleased to be appointed as a Community Health Council advisor on the Clinical Leadership Group (CLG) of the new build of the hospital. It has been very gratifying to be able to participate as a consumer as the Ministry of Health has a policy of the patient being the focus and priority in all facets of health treatment.

I must admit I found the technical terms and discussions a little daunting at the beginning but all the members are very helpful and not at all fazed by the lack of medical knowledge I had. They were more than happy to assist, and the Chair Dr John Adams organised a tour of the current hospital so I had a better understanding of the present layout so I could fully understand the way the new hospital was being designed.

It is a pleasure to work with the members of CLG who are very ably led by Dr Adams. I have no doubt those who need to use the facilities in the new hospital will be very grateful for the work and effort put in by the Project Management Office and Clinicians on the CLG to ensure they receive the very best treatment in very well designed and equipped premises.

Some words from Dr John Adams, Chair of the CLG for the new Build of Dunedin Hospital

The New Dunedin Hospital project is fortunate to have CHC advisors working directly with the clinical teams in the Facilities in Transition (FiT) groups, and at the Clinical Leadership Group (CLG) oversight level. There is no doubt that the advisors, in both contexts, have made significant impacts on planning and design. While the patient focus is an absolute basis of planning, staff inevitably concentrate on their own area and the clinical aspects of care. Our lay patient voice often brings in sensible and crucial issues of access, adequacy and quality that have to be attended to.

The advisors' input has made significant difference. CHC advisors are often able to raise basic questions that complement the approach from hospital staff. Several areas have had changes in design and direction as a result of CHC advisor input. In CLG, the CHC Advisors input has been 'grounding'. There have been clear reminders that this hospital is for the people of the region. The support of our lay advisors to decisions that are having to be made, has also been very important to clinicians. Sometimes clinicians worry when they are having to make compromises, that the public will not understand why something has been done, and the participation of the advisors in those conversations is reassuring. Advisors' opinions also give clinicians strength to stand up for what is needed, when hard conversations are necessary. We would hope that CHC advisor input is not only maintained but increased into the future, and we congratulate the CHC on the quality and capacity for involvement of the people selected for these roles.

The CHC has connected in over 30 CHC advisors on this large project, and support is in place for these advisors. We would like to acknowledge the time and effort that the they commit to being part of a FiT group – we realise it is not always easy coming in for a meeting when they are not working on site – video conferencing has helped with this a little, especially when New Zealand was in lockdown.

Below are some view points from CHC advisors engaged with the build of the new Dunedin Hospital. With so many elements to consider in the design of a new hospital, expert opinion and consultation is highly valued. At the outset of the design stage of the New Dunedin Hospital Project, FiT groups were established. They were initially made up of groups of people who have specialist knowledge in an these clinical areas. In early 2019, the community voice via CHC advisors was added to these groups. They have been working with clinicians, health planners, architects, and the Project Management Office, to make decisions and offer recommendations on design elements that affect their specific area of concern.

Barbara Gee – CHC Advisor - Public Spaces and Amenities FiT group

How long have you been involved?

Since around June 2019. When I was asked, I said "wow, yes!" Our family has a really, really big stake in health services and if we can make sure we're going to have a really accessible and inclusive, top class hospital facility then this is an great opportunity. I was happy to put my hand up.

What's your background?

My first introduction to health was when I trained as a registered comprehensive nurse quite a long time ago. I worked in mental health for a few years, then stopped to have children. Both our sons who are now 18 and 21 have severe cerebral palsy, and they're both profoundly deaf, so for the past 21 years I've been a full time family caregiver.

We've had very strong links with many parts of the hospital, with the boys going through many departments as inpatients, as outpatients, and as visitors. Some of those were good experiences, some were not good, and we've learnt from all of them. Through this I've formed a picture of what does and doesn't work.

I've had advisory roles with the Ministry of Education on their Parent Reference Group, and I've been on the Trust board for the Complex Care Group Trust, which is a Support and Information Network of families nationwide who care for children/young people with high and complex needs. Not only am I aware of the issues around my boys, but I'm aware of the issues around lots of children and young people who have complex disabilities.

Aside from all of that, my husband works with the rescue helicopters, so there are a lot of connections. We're a health family!

What motivated you to become involved in this FiT group?

Just wanting to see a new hospital that's built to work well for everyone. A place where everyone, no matter what their circumstances, should be able to step through that door and have this hospital work for them.

How have you found the process of working in a FiT group?

It's been really good. There's been a lot of consultation. I definitely feel the weight of responsibility on my shoulders (laughing)! But really, I can see everyone is working enthusiastically together, and listening to a lot of opinions, and pulling it all together.

It's very early stages, but I do feel that whenever I've said something I have been listened to, so that's really good.

What excites you most about the New Dunedin Hospital Project?

We have such a great opportunity to put something together that could work really well. I love Dunedin, and we deserve a top class facility. I think it's just exciting to be part of building one.

Chris Ford
- CHC Advisor Front of House FiT Group

Chris Ford is a Senior kaituitui with the Disabled Persons Assembly NZ. Chris is also a member of the Front of House FiT Group. (Interview conducted 23/8/2019)

How long have you been involved with the Front of House FiT Group?

Since July 2019.

What is your background – why are you involved with this particular FiT group?

Well this FiT Group probably fits me, in terms of the fact that as a disabled person I can provide input into the process from a disability perspective. I can also go into my community networks and contacts for further insight. Also, as a member of the public it's good to bring my perspective too, because ultimately it will be the people of Ōtepoti, Otago, Southland, and so forth, who will be using this facility. So our voices are as important as any other stakeholder in this process.

How have you found the process, so far?

Well it's a learning curve for everyone involved. I think it's good having an active dialogue rather than just being talked to about the design. It's really important to have the information to inform the context, and as well as that, the discussion that will inform the wider planning process.

What excites you most about the New Dunedin Hospital project?

I think it's well overdue. I was a former employee of the old Otago District Health Board, about 10 years ago, and I remember working in the hospital on the first floor seeing that the infrastructure was beginning to age even back then. For example, in the office where I worked, because we were directly underneath Queen Mary Maternity Unit, one of my colleagues who sat in the corner used to get drips on his head from the spa they sometimes used for birthing (laughs). But it was just indicative that of the fact that the place was starting to age. You can't have the building and property guys keeping this place together with sticking plaster in some places!

It'll be really good to have a sustainable facility that will meet the health needs of our population going forward for the next 40-50 years.

What opportunities do you see in this project for something completely different?

I'm quite excited by the 'digital hospital' idea that's been mooted. However, with technology there are some challenges. For example, for people who aren't technologically proficient there will be some challenges.

I think that for everybody who works within the new facility- clinical staff, non-medical staff, and also patients and health users- it will enable people to keep in contact with their family and other networks if they're in hospital.

I think there are a lot of exciting new opportunities, and the new hospital will hopefully be a role model for others throughout Aotearoa, and perhaps internationally.

The Year Ahead 2020/21

> The Council is again optimistic about the year ahead and the opportunities that will arise for community engagement. Community engagement with the build of the new Dunedin Hospital is something the CHC has actively been engaged with and will continue to follow through the next stages of design.

The CHC will be following and monitoring progress with the implementation of the local Disability Strategy throughout this year.

The CHC plans to begin an active process of collecting stories from patients and whānau that can be shared with staff and learnt from.

The CHC will be an active partner in forming a governance group to oversee the implementation of the Health Quality Safety Commission (HQSC)- Quality Safety Marker for Consumer engagement[4]. This is a Quality Improvement tool and SDHB will, over time, be able to measure the difference consumer engagement makes in the quality of service delivery to patients and whānau.

There are a number of projects the CHC will see through to completion and a number of new projects that it will be encouraging the DHB and WellSouth to work together on.

Members of the Council also look forward to connecting with our communities again in the not too distant future when we will update you on what has been happening with engagement projects.

We are not sure what 2020/21 will bring but the CHC members and CHC advisors continue to bring their voices to the table to be heard.

Kia huri a maatau kupu katoa ki nga mahi me te whakahaere i a tatou i tawhiti o nga tupuhi

May all our words turn to actions and steer us far from storms .

[4]https://www.hqsc.govt.nz/our-programmes/partners-in-care/consumer-engagement-qsm/

Kia huri a maatau kupu katoa ki nga mahi me te whakahaere i a tatou i tawhiti o nga tupuhi

Appendix 1 – Community Health Council Membership
Current Members

Mrs Karen Browne
(Chair)
Dunedin
Term commenced:
Feb 2019

Karen has worked in various locations around New Zealand as an Enrolled Nurse, Cardio-pulmonary Technician, CPR trainer, Ambulance Officer and as a shift supervisor of the Wellington Free Ambulance Communications Centre.

Karen has worked in health administration, and more recently, until retiring in mid-2018, at the Otago Medical School.

The health system has always played a huge part of her working life, and, in more recent years, as a consumer of health services. She is well positioned to bring both a consumer perspective to discussions around health provision and service, particularly around musculoskeletal and long-term conditions, as well as an understanding of the delivery of health services.

Karen has worked on various projects through being a member of the Health Consumer Advisory Service of Health Navigator, and also has been involved locally as a consumer voice on the Client-Led Integrated Care programme (CLIC) for WellSouth. Karen is also a member of the Health and Disability Commissioner's Consumer Group, and has recently been appointed to the Health Quality and Safety Commission Leadership Group for Aged Residential Care.

Karen's health fields of interest include long term conditions, older person's health and primary health.

Mr Bob Barlin
(MNZM) for humanitarian activities
Dunedin
Term commenced:
Feb 2020

Bob is a retired Army Officer who has worked for various humanitarian aid agencies such as the United Nations and International Federation of Red Cross and Red Crescent Societies (IFRC) in many disaster zones throughout the world.

Bob is a vice president of the Dunedin RSA and a committee member of the Otago Officers Club. Bob is also a Member of the New Zealand Order of Merit for humanitarian activities.

Bob has undertaken roles in Logistics, Operations and Management during his service and is currently a Logistics advisor on the new hospital build. His years of work have impressed on him the need to provide care to those who need it.

Bob has seen at first hand that improvements in logistics supply, processes and procedures can increase savings that can then be channelled into direct medical funding.

In the case of Veterans, Bob is keen to help alleviate their medical concerns and to develop systems that will be of use in the future. Bob believes that we must learn from what has been, to better prepare for what is yet to come.

Mrs Jocelyn Driscoll
Winton
Term commenced:
July 2019

Jocelyn is a trained physiotherapist, dairy farm owner operator with her husband Tim, and mother to four young boys. Her fifteen year career spans diverse areas of caring for people- including acute, community, child development, mental health, and more recently a small rural private physiotherapy clinic.

Jocelyn Chairs the Southland branch of Physiotherapy NZ (PNZ), is involved with Makarewa playcentre, Winton football club, both as a coach and a player; and St Thomas Aquinas School PTA. Both Jocelyn and her husband are part of a small dairy farm discussion group where they are challenged to create a sustainable and profitable farming business.

Jocelyn is passionate about rural people accessing both services and information to assist with living healthy lifestyles. As both a provider for and consumer of our health service, her observation is rural people can miss out on opportunities to learn as well as access to services that would assist them to make good decisions regarding their current and future health.

Jocelyn's health fields of interest include youth and children's health, rural health, primary health, long term conditions, disability, older person's health, men's and women's health.

Ms Rosa Flaherty
Dunedin
Term commenced:
Feb 2018

Rosa Flaherty is 20 years old. She was born at 24 weeks prematurity, in Hammersmith Hospital in London, and her family moved back to Dunedin when she was 15 months.

She attended Sacred Heart primary school and Kavanagh College high school, and is now pursuing a Bachelor of Laws at Otago University.

Rosa has been involved in community radio at Otago Access Radio for three years and will continue this year. During her time at Kavanagh College, she established a Lesbian, Gay, Bisexual, Trans, Queer/ Questioning and Others (LGBTQ+) support group for students. This group enabled her to participate in an Otago University Students Association (OUSA) facilitated Rainbow Leadership group involving leaders of LGBTQ+ groups in schools across Dunedin, which she hopes to continue this year.

Rosa is also looking forward to joining several OUSA clubs, including United Nations Youth, and starting volunteering at Queer Support at OUSA.

Rosa's interests include LGBTQ+ rights and health care/representation within the health system, mental health (especially among LGBTQ+ youth), and youth representation within the health system.

Appendix 1 – Community Health Council Membership
Current Members

Mrs Hana Halalele
Oamaru
Term commenced:
Oct 2017

Hana lives in Oamaru with her husband and two children and has over 15 years' experience working as a Probation Officer for the Department of Corrections.

Hana has recently been elected to the Waitaki District Council as a Councillor. Hana is a New Zealand born Samoan and is an active member of the Waitaki community through her involvement with the Oamaru Pacific Island Community Group, Waitaki Safer Community Trust, St Pauls Otepoti Presbyterian Church, and is Co-Chair of the Oamaru Pacific Island Network Group.

Hana's health fields of interest include mental health, alcohol and drugs, Pacifica and Māori health and children's health.

Ms Toni Hulls
Oamaru
Term commenced:
Feb 2020

Toni is a mother, grandmother and wife. She has lived experience of mental distress and an Acquired Brain Injury (ABI). Toni is an advocate and wellness champion.

In earlier years Toni was a Child Support Worker (Pallative) with Nurse Maude. She worked for IHC as a support worker both vocational and residential.She has volunteered as a trainer for Youthline for 6 years.

Toni's husband had terminal cancer and she cared for him in the home. They were living rurally. She was widowed in her mid 30s. About the same time, she contracted Encephamylitis and has spent 20 years rehabilitating and recovering from an ABI. In later years she has volunteered in numerous roles.

Toni is involved with Waitaki Mental Health Support Group and Waitaki Mental Health and Addictions Network Group. She is a tall tree and regional leader with Rakau Roroa which is part of Changing Minds. Toni is recently married; her partner is living with long term health conditions.

Toni is an Intentional Peer Support worker at Otago Mental Health Trust (Waitaki) and a Yale "fellow" Programme for Recovery and Community Health.

Toni's health field area of interest is MHAID, equality and equity disabilities and rural health.

Appendix 1 – Community Health Council Membership
Current Members

Mrs June Mills
QSM
Dunedin
Term commenced:
May 2019

June has worked in the Radio and Television industry for over 20 years in a variety of diverse professional roles including production and news directing.

June has also worked as an employee in the role of Income Development and Promotions, both divisionally and nationally, followed by six years on the Cancer Society Board with the role of chair of Income Development and Strategic Planning.

June has been a Rotarian for 24 years and is a member of the Rotary Club of Dunedin holding local and District (9980) roles during those years. June was the first woman to be inducted into the Club and the first woman president of the Club (2001-2002).

June was manager for seven years for Otago Peninsula Trust, Glenfalloch Gardens which included the role of Supervisor for the WINZ work scheme mainstreaming clients from institutions into the workforce.

Community involvement includes: volunteer with Presbyterian Support, Meals on Wheels, previous PACT Board member (10 years), previous Board Trustee for 10 years East Taieri Church, Saddle Hill Foundation Trust which developed and supports Youth Ministry for the East Taieri Church.

June's health fields of interest include long term conditions, palliative care and community support services.

Mr Jason Searle
Cromwell
Term commenced:
Apr 2018

Jason was born in Clyde and raised in Cromwell. He attended St Kevins College in Oamaru before completing a Bachelor of Science majoring in zoology and ecology at Massey University.

Jason has returned home to Cromwell to work for a local company. He has a strong sporting background and has recently completed the GODZONE endurance race.

He is part of the Clyde Rugby Team and a volunteer of the Urban Fire Brigade.

Jason's health fields of interest include rural health and men's health.

Mrs Kelly Takurua
Tapanui
Term commenced:
Feb 2017

Kelly was born and raised in Gore until her family moved to Tapanui. This was followed by some time studying in Dunedin.

Kelly has undertaken a number of courses relating to social services and mental health addictions in Dunedin and Invercargill.

Kelly is currently working as a Social Worker/Manager for Te Iho Awhi Rito Social Service, a Marae-based Social Service provider in rural Southland.

Kelly's health fields of interest include mental health, alcohol and drugs, Māori health and primary health.

Appendix 1 – Community Health Council Membership
Current Members

Ms Paula Waby
Dunedin
Term commenced:
Feb 2017

Paula has lived experience of disability and is involved in a number of disability-related organisations, locally and nationally.

Paula has been involved with the Association of Blind Citizens of NZ, setting up an Audio Book Club at Dunedin Public Library, involved with the Disability Issues Advisory Group for the DCC and an active participant in the Otago Branch of Blind Citizens.

Paula is currently the Local Coordinator for the newly established Otago Blindness Network and President of the Dunedin branch of the Disabled Person's Assembly.

Paula's health fields of interest include disability (sensory, physical and intellectual), women's health, and primary health.

Mrs Lesley Vehekite
Invercargill
Term commenced:
July 2019

Lesley is trained as a qualified accountant in Invercargill. Through her work she has had connections with Tongan, Cook Island and Samoan, Kiribati and Fijian communities to find out and support their health and social needs.

Lesley is a member of the Free Church of Tonga and her husband is an ordained Minister and both of them have been working and managing the Youth and Sunday school for over 20 years as well as raising their six children.

Lesley has found out through her community visits with work that there is a lack of knowledge regarding health, education and the government system and wants to support Pasifika families and communities to achieve maximum well-being and healthy lifestyle.

Lesley's health fields of interest include youth and children's health, Pacific health, primary health, mental health and long term conditions.

Appendix 2
– List of Registered CHC Advisors, 2019/20

*denotes currently involved in project

Jennifer Anderson
LJ (Leo Junior) Apaipo *
Catkin Bartlett
Marie Baynes
Winsome Blair
Caz Brigham
Gemma Carroll
Jay Conway *
Anne Coup *
Leslie Cowper
Rachel Cuthbertson
Susan Davidson
Sarah Derrett *
Kingi Dirks *
Naomi Duckett
Emily Duncan
Tina East *
Sue Edwards *
Norman Evans
John Falloon *
Joyce Falloon
Yvonne Fell
Lisa-Mdee Fleck
Chris Ford
Shona Fordyce
Barbara Gee
Patsy Gordon
Bronnie Grant *
Margaret Hathaway
Angela Hendry *
Adrian Hindes *
Kerry Hodge *
Stephen Hoffman
Lynley Hood
Chris Horan
Greg Hughson *
Emma Hunter
Denise Ives
Jo Jennings
Andrea Johnston *
Lynn (George) Kerr *
David King *
Colin Lind *
Azlyn Lind *
David Little
Rania Loughnan
Bill Lu
John Marrable
Sally Mason
Anne McCracken
Tim McEvoy
Lisa McEvoy
Deborah Mcleod
Chris Middlemiss
Jo Millar *
Kylie Murdoch
Kris NIicolau
Georgina Northcoat
Mary O'Brien
Gerald O'connor
Jeanette Olga Bell
Sue O'Neil
Trish O'Neill
Nora Paicu
Jean Park
Tanea Paterson
Gillian Perica
Tracey Peters
Issabella Prattelly
Brendon Reid
Lorie Roberts
Anna Rumbold
Jo Shone
Hazel Sinclair *
Peter Small
Sue Smith
Josh Spence
Megan Spence
Jo St Baker
Linda Strang
Marie Sutherland
Nicholas Tulloch
Annette Tulloch
Kath Tuna
Gemma Van Den Heuuel
Kathryn Van Beek
David Vaugh
Marie Wales
Anna Walls
Ainsley Webb
Carolyn Weston
Leah White
David Williams *
Tess Williamson
Margaret Willoughby
Kirsty Wing
Trish Wright

Appendix 3
– Projects CHC and CHC advisors have been involved with 2019/20

Project partnership	Brief description	Representative		Status
Strategic Projects				
Clinical Council	Clinical Council provides advice on clinical governance for the DHB.	CHC chair	District wide	Ongoing
Clinical Leadership Group (CLG)	CLG provides clinical oversight and service inputs and puts recommendations to the Southern Partnership Group.	2 CHC advisors	District wide	Ongoing
Alliance South	Is the partnership between Southern DHB and WellSouth primary health network, overseeing the implementation of the Primary and Community Care Strategy.	1 CHC advisor	District wide	Ongoing
Digital Strategy Governance Group	Digital Strategy Governance Group which is guiding how the IT systems will function across the district.	1 CHC member	District wide	Ongoing
Falls Governance Group	The Clinical Operations Advisory Group has the following	2 CHC advisors	District wide	Ongoing
Disability Action Plan Steering group	Steering group has been formed to support development of disability strategy.	4 CHC advisors	District wide	Completed April 2020
Pressure Injury Prevention Steering group	To support the development of and agree to a sector wide pressure injury prevention programme for the southern district	1 CHC advisor	District wide	Ongoing
Maternity Quality & Safety Programme	This is a national programme which establishes and builds upon both national and local maternity quality improvement activities at a local level.	3 CHC advisors	District wide	Ongoing
CPHAC/DSAC	Community representative with lived experience of disability on this committee	1 CHC advisor	District wide	Ongoing
WellSouth Board member	On recruitment panel	CHC Chair	District wide	complete
WellSouth Board member	On recruitment panel	CHC Chair	District wide	complete
Allied Health Director	On recruitment panel	CHC Chair	District wide	complete

Appendix 3
– *Projects CHC and CHC advisors have been involved with 2019/20*

Evaluation/ review				
Steering group for evaluation of implementation of Primary and Community Care Strategy	Various groups are evaluating the implementation of aspects of this strategy.	1 CHC advisor	District wide	complete
Evaluation of Allied Health Uniforms	CHC member worked alongside staff to make decisions on Allied Health staff uniforms	CHC member	District wide	complete
New Systems and processes				
Telehealth Steering Group	Two CHC advisors sit on this steering group advising from a patient/ whānau perspective	2 CHC advisors	District wide	ongoing
Service Co-design projects				
Rheumatology service rede-sign	A patient advisory group established to support staff with designing service from a patient/ whānau perspective	6 CHC advisors	District wide	Nearing completion
Clinical Rehab pathways	Group established looking at a clinical rehab pathway for our Non acute Rehab ACC patients across the district	1 CHC member	Dunedin	complete
Endoscopy User Group	Two CHC advisors were appointed to this group in mid-2020.	2 CHC advisors	District wide	ongoing
After-hours Primary Care Steering Group Southland	Two CHC members are on this steering group	2 CHC members	Southland	ongoing
Mental Health Review	One CHC member is sitting on panel reviewing the RfPs.	1 CHC member	District wide	ongoing
New Build Dunedin Hospital				
Facilities in Transformation (FiTs)	Engagement of CHC members and CHC advisors on the concept design stage of the new build of Dunedin Hospital workstreams has been occurring since May 2019	4 CHC members 20 CHC advisors	District wide	Ongoing
Clinical Leadership Group	Two CHC advisors are members of the Clinical Leadership Group	2 CHC advisors	District wide	Ongoing

Appendix 3
– Projects CHC and CHC advisors have been involved with 2019/20

Pieces of work CHC has been informed about, advised on, and or provided feedback on throughout 2019/20

Community Health Hubs – progress updates throughout year
Primary Maternity Updates – progress updates throughout year and CHC has provided feedback on decision-making process
Joint workshop with Clinical Council
Policy document- Informed Consent – one off time to provided feedback
Health info – CHC members informed about what this was
Health Needs Assessment Brief – CHC members informed and asked for any feedback
Education Centre in Southland- CHC members informed
Disability Strategy- progress updates throughout year and CHC provided feedback during consultation process
HealthCare Homes, progress updates throughout year
Consumer Input on Access to Patient Information and data sharing, CHC members asked to provide feedback
Introduction of the Ministry of Health, First Specialist Assessment prioritisation tool, CHC members were updated and provided feedback
Feedback on New Dunedin Hospital Principles, CHC members asked to provide feedback
Feedback on Consumer Complaints Policy, CHC members asked to provide feedback
Primary care after hours Southland, CHC members were informed and then two members sitting on steering group
Digital Hospital and what this means for consumers, progress updates throughout year
MoH National Health Platform and what this means as consumers, CHC members asked to provide feedback
New Hospital Build – Breastfeeding Rooms
Contact Tracing – Covid-19 – CHC members informed
Public Health Covid-19 response- CHC members informed
Primary Health Covid-19 response- CHC members informed
DHB wide Covid-19 response- CHC members informed and feedback was received of any issues in the community.

Appendix 4
– Publications by CHC and/or About the CHC

- **Health council still sees important role to play. Oct 2019**
  https://www.odt.co.nz/news/dunedin/health-council-still-sees-important-role-play

- **New chair for Community Health Council named. Feb 2019**
  https://www.odt.co.nz/news/dunedin/new-chairwoman-health-council-named

- **CPHAC/DSAC meeting. Mar 2019**
  https://www.southerndhb.govt.nz/files/24191_2019032292424-1553199864.pdf

- **CPHAC/DSAC meeting. Aug 2019**
  https://www.southerndhb.govt.nz/files/22955_20180807155221-1533613941.pdf

- **CPHAC/DSAC meeting. Jun 2020**
  https://www.southernhealth.nz/sites/default/files/2020-05/2020-06-02%20SDHB%20CPHAC-DSAC%20Agenda.pdf

- **Health Quality & Safety Commissioner, Progressing consumer engagement in primary care, 2019.**
  https://www.hqsc.govt.nz/assets/Consumer-Engagement/Publications/Progressing-consumer-engagement-in-primary-care.pdf

- **The role and functions of Community Health Councils in New Zealand, Gagan Gurung, Sarah Derrett, Robin Gauld, 2020.**
  https://www.nzma.org.nz/journal-articles/the-role-and-functions-of-community-health-councils-in-new-zealands-health-system-a-document-analysis

- **Chatsford Publication. Dec 2019**
  https://www.chatsford.co.nz/assets/newsletters/xmas19.pdf

Presentations by the CHC

- **Pete Hodgson addresses CHC regarding new Dunedin Hospital. Sept 2019**
  https://newdunedinhospital.nz/latest-news/pete-hodgson-addresses-community-health-council/

- **Presentation at Integrated Care Conference, San Sebastian, Spain. 4 Apr 2019**

- **Dunedin Rotary Club, presentation about the CHC Sept 2019**

- **Mosgiel Rotary Club, presentation about the CHC, Oct 2019**

- **East Dunedin Rotary Club, presentation about the CHC, Oct 2019**

- **Winton Rotary Club, presentation about the CHC, Nov 2019**

Live Interviews

- **Radio Dunedin, June & Aug 2019.**

Southern Health
He hauora, he kuru pounamu

Community Health Council

Community Health Council – Community, Whānau and Patient Engagement Framework

Our Strategic Goal

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

Our Guiding Principles

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

Across These Domains

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

Our Engagement Approaches

Provide health information in ways that assist understanding

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

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

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

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

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

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Strategy, Primary & Community Report**		
Report to:	Disability Support and Community & Public Health Advisory Committees		
Date of Meeting:	7 December 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		
Equity:			
Other:	N/A		
Document previously submitted to:	Chris Fleming	**DATE:** 13 July 2020	
Approved by Chief Executive Officer:		**DATE:**	
Prepared by: Strategy, Primary & Community Team **Date:** 13 November 2020		**Presented by:** Lisa Gestro Executive Director Strategy, Primary & Community	
RECOMMENDATION: **That the Committees note the content of this paper.**			

11

STRATEGIC HIGHLIGHTS

Our Ongoing Coronavirus Management Response

There is currently no transmission of Covid-19 in the community in Southern DHB area. A significant amount of work continues in this area, which is outlined in the following sections.

Public Health Response

The recent Maritime worker cluster in New Zealand has led to increased national interest in the Maritime border. Work is underway with WellSouth to establish a sustainable testing regime for all port workers at Port Otago, Southport and Tiwai. This must occur every two weeks for all individuals that work directly with international ships. Due to changes in the border order from the Ministry of Health there is also a requirement for any crew requesting shore leave to meet a series of requirements including negative Covid19 tests of all crew on-board. This has led to a large increase in work for on-call Health Protection Officers and a rapid development of processes and procedures to assist with this work.

Public Health continues work on an escalation plan to ensure that we have an appropriate number of teams to respond quickly to a second wave of cases. As reported previously we have developed a training programme for other District Health Board (DHB) staff that would be unable to work in their usual roles during a localised outbreak. Currently we have 22 wider DHB staff members who have either already been training or who are booked into training for case management, case monitoring or contract tracing over the coming weeks. A process has been developed with Human Resources (HR) and recruitment for the release of these staff so that this is streamlined if the situation arises where they are required to assist with Covid response work. Scenario training on the national contact tracing service system is ongoing for Public Health staff and Public Health Nurses to ensure they are they retaining their competency with the system.

A staffing plan for Christmas through to the end of January is being finalised to ensure that we have capacity in place to respond to Covid cases should they occur during this time.

Public Health continues to assist the national response. In addition to Dr Susan Jack providing Medical Officer of Health assistance to Auckland, four other staff have been deployed to Auckland to assist with contact tracing.

The first draft of a research report describing the early epidemiology of Covid19 transmission in the Southern district in the context of the national public health response has been completed. In total, 216 Covid19 cases were reported between 11 March and 17 April 2020. We found a serial interval of 5 days before, and 3.9 days after lockdown, coupled with a significant shortening of the period between symptom onset and Covid19 testing. The incubation period was estimated as 3.1 days, with 95% of cases developing symptoms within 9 days of infection. The median time to recovery was 19.7 days.

Overall, 1,060 close contacts were identified for Southern's Covid19 cases. 56 of these contacts subsequently tested positive which is a secondary attack rate of 5%. Attack rates for households almost doubled during lockdown, from 8% to 15%. Workplace contacts carried a relatively low risk of transmission, at 2% overall. 66% of secondary transmission was attributed to only 11% of the Covid19 cases. Our research highlights the importance of effective home-based quarantine guidance, especially in the context of lockdowns, during which secondary infection risk appears to increase for household members.

Swabbing

Current volumes of swabbing undertaken in Primary Care through the period 1 July to 30 September include 23,596 simple, 646 virtual and 84 full assessments.

Based on the Primary Care volumes for the period covered by the MoH funding above ($2,111,410), the cost to date is $2,891,280.00. Plus, student health costs of approximately $272,250.00 for July to September. Approximate total cost to date of $3,163,530.00. Variance approx. ($1,052,120.00).

Following from the first quarter period, October has seen a further 3,501 simple and 51 virtual assessments delivered in primary care. The estimated cost (excluding Student Health) is $423,180.00 to 27th October.

The total variance to MoH funding since 1 July is approximately ($1,475,000.00).

Testing Strategy

A testing strategy is currently being developed for Executive Leadership Team (ELT) sign off. It is imperative that the ongoing requirement to maintain sufficient surveillance in our community, as well as undertake the required level of port and border testing, alongside the need to deliver regular pop ups in high tourism areas, such as Queenstown, means that we need to transition Covid testing into more of a business as usual approach. It is also imperative that staff who were previously being diverted from their core service delivery to swabbing activities need to focus on the recovery of volumes that may have been lost during our Covid response.

Given the likelihood of no further funds being made available for testing, it is imperative that our strategy focuses on the most efficient way to deliver the required level of testing in the most cost-effective way.

Aged Residential Care (ARC)

The Ministry of Health has released guidance for implementing asymptomatic surveillance testing for staff in ARC. This would be for Level 2 and above. Community Services, Public Health South, and WellSouth have already done some preliminary planning for Covid-19 testing in ARC. Over 180 nurses in ARC have received training to undertake Covid-19 tests from WellSouth. Each facility is required to develop their own testing plan.

Appointments have been made to the ARC infection Prevention and Control Clinical Nurse Specialist positions in Dunedin and Invercargill and the Sector is keen to work closely with this staff.

Health Pathways have been updated to remain current with the evolving Covid situation and advice. Further work on education about Health Pathways is required to embed its use in the Sector, to become a common language between Primary Care, ARC and Secondary Care Services.

Psychosocial Recovery

The Central Lakes Mental Wellbeing recovery group met face to face in October. The focus was on confirming a TOR and confirming the workplan. The group will focus is on supplying briefing notes and information sharing, advocacy for mental health well-being plans regularly for sharing to ensure correct information is circulated widely and shared consistently in the various forums. In addition, there is the clearly identified need to support amplifying and targeting wellbeing resources to sectors of our community and a Mental Wellbeing Navigator role has been proposed and funding sought to support this role in the Wakatipu area.

Other Emerging Issues

Rural Health Projects:

The Chief Executives (CEs) of the Rural Trust Hospital Trusts in the Southern region are meeting with key Southern DHB leaders from Strategy, Primary and Community Directorate to agree a programme of work that will enhance opportunities for the populations we serve.

The Aim of this partnership group

Within available resources to:-

- Deliver a cohesive, seamless health system which maximises efficiencies and quality of care provided to the rural communities each organisation serves
- Maximise services delivered as close to home that is safe and efficient to do so
- Provide a coherent rural hospital voice.

Key projects under discussion are:

- Develop a joint Southern Rural Health Strategy including the location and future role of rural hospitals, noting this needs to be within the scope of the Southern District Health Boards Strategic Refresh
- Medical staffing to ensure a sustainable supply of medical staff
- Clinical leadership across rural southern hospitals
- Radiology review – underway
- Allied Health review
- Patient Transfer Service

Senior Medical Officer cover to Rural Hospitals throughout the District

Dependence on locum cover for Rural Trust Hospitals in Gore, Balclutha and Oamaru persists. An initiative to explore a shared Full Time Equivalent (FTE) between Central Otago Health Services Ltd and Waitaki District Health Services Ltd is being explored. In addition the issue of whether a registrar level medical cover should be included in the Lakes roster has been raised and the information from this is being shared with the other Rural Hospitals. Therefore a review of how the wider Rural Medical Workforce is required to ensure that it is balanced and sustainable.

Wanaka After Hours Primary Care

WellSouth Primary Health Organisation (PHO) and the Wanaka General Practices (GP) have agreed to continue to provide urgent after hours coverage to their population as specified in their contract.

Allied Health

A Request for Proposal (RfP) was been issued on GETS for an Allied Health Activity Tracker system, with responses closing 28 October. The Allied Health Review in 2018 identified that the capture of allied health activity was poor due to outdated and incomplete systems. This proposal has been developed over the past 12 months in partnership between senior allied health clinicians, Community Services management, and IT. Next step is evaluation of the proposals.

Primary Maternity Facilities Consultation

The project team and the Central Lakes Locality Network reached consensus on a preferred option and presented this to the Executive Leadership Team (ELT) for agreement on the 15th of October. Subsequently the recommendation has been agreed by the Board at their November meeting. Work is underway to develop implementation plans.

Independent review of the Southern Mental Health and Addiction System Continuum of Care

The Steering Group has been established and had its first meeting. Dr Clive Bensemann has been appointed as the Chair. The first task for the steering group will be to evaluate the proposals to undertake this review and identify a supplier. This meeting was held on the 12th of November and we are now finalising arrangements with the successful vendor.

New Guidelines for Mental Health (Compulsory Assessment and Treatment) Act (MHA) and Human Rights Guidelines

The new guidelines were released by the Ministry of Health in early September. While the Mental Health Act has not changed these guidelines have been released in anticipation of the Act being reviewed, with and increased focus on several key areas:

- Increased emphasis on the rights of the individual and the role of clinicians in supported decision-making.
- Alignment of practice to meet obligations of the Treaty of Waitangi, emphasising self-determination, partnership, active protection, options and equity.
- Reiterating the importance of family/whanau involvement, with particular onus on the responsible clinician (RC) to ensure that consultation is ongoing, responsive to the needs of the consumer and responsive to cultural values.

The companion Human Rights and MHA document details further discussion regarding rights-based and recovery approaches, and has a comprehensive section further discussing supported decision-making. To date the guidelines have been distributed widely, and a Journal Club presentation was completed by Dr Julie Norris for the Medical staff. Ongoing education will occur as part of the scheduled Duly Authorised Officers Training Day in November 2020. Further training will be provided across the MHAID as education needs are identified.

Co-location of the Stroke Units

Planning has commenced on establishing a Comprehensive Stroke Unit on the 6th floor. Agreement in principle was reached between Internal Medicine, Operation, and OPH on progressing this work. This means bring the acute stroke unit (8th floor) and rehabilitation stroke unit (6th floor and Wakari) services together. Planning work shows a combined single stroke unit in itself is entirely feasible and desirable with real potential benefits for improved patient flow, journey, experience, and outcomes. However, this would require significant reconfiguration of other services. It is the impact on the other services that does not allow for the establishment of a single stroke unit at this time.

Currently there are limited options to bring other patients to Wakari as they need to be medically stable. The number of occupied beds would reduce at Wakari, creating some efficiency and viability issues. It would be difficult to effectively and safely staff less than 10 beds. This continues to be worked through and there is commitment from all services to try and achieve this.

Mental Health - Ward 10A

Ward 10A continues to experience high acuity compounded by a number of Registered Nurse (RN)vacancies. Two significant events have occurred on the Ward during the month:

1. A special patient transferred from Wellington while renovations occur on the unit there. He presents significant risks to staff and of absconding and offending. The Ministry has agreed to provide a security presence on the Ward through the Forensic Coordination Service (FCS) discretionary fund. This continues and is having a significant beneficial impact.

2. Another patient seriously assaulted staff and is currently in Corrections custody while going through Court proceedings. Staff continue to be supported and have had a formal debriefing. The Ward remains capped at nine beds although will accept Intellectual Disability (Compulsory Care and Rehabilitation) (IDCCR) Act admissions above that number if required.

Ligature Points

Ligature point audits continue to occur and teams are developing plans to minimise risks in individual areas, including involving Building and Property in the removal of points where practical.

Inpatient Mental Health Unit in Southland continues to monitor these and has identified new risk with fence being built around old nurses home.

Coroners Hearing

MHAID are involved with two high profile coroners' cases. MHAID were an interested party to an inquest into the death of a prisoner in Invercargill prison in 2016. The Medical Director, MHAID was in attendance at the hearing which commenced in early October and has been adjourned to February 2021.

The DHB continues to prepare for the second case which related to the death of a young person several years ago. This is scheduled for December 2020.

STRATEGY AND PLANNING

Annual Plan 20/21

The 2020/21 Annual Plan was approved by the Ministry of Health. Annual Planning advice for 21/22 is expected from the MoH in December, along with timetables for the production of the Annual Plan.

Service Plan

A small team from Finance and Planning has been working together to facilitate a more joined up process of budgeting, annual planning and service planning. The aim is for a single, coherent and achievable process for consultation and prioritisation decisions. A key focus is to ensure that service planning is patient outcome driven, rather than cost savings driven, with clinical outcomes linked to financial planning. Planning processes also need to be coordinated with planning for the new Dunedin Hospital.

The timeline and processes for development of the budget, Annual Plan and Service was presented to SLT on 7 October. Initially, the small planning team (finance, SP&C) will work primarily with the Medicine, Women's and Children's Directorate to refine information and processes for service plan development. The MWC Directorate will hold a planning day in early December to commence service planning processes. The planning team will also respond to requests from other Directorates as well as pass on learnings from the work with MWC.

The current Service Plan template has been updated to include New Dunedin Hospital and Health, Safety & Welfare. Planning will be aligned with Government priorities (or likely priorities if not formally communicated). Key areas of focus are:

- Where you are now and where you want your service to be, for the short term and medium term/long term
- Whole of service - include other services which are/could be affected, e.g. hospital wards, community, primary care, radiology
- Improving quality of service – more patient centric outcomes

	SERVICE CHANGE	COSTS AND VOLUMES	SERVICE PLAN	ANNUAL PLAN
Supported by	Finance; Strategy and Planning	Finance; Strategy and Planning	Finance; Strategy and Planning	Finance; Strategy and Planning
Month				
August	Monthly, review progress on service changes. If alterations are needed and not within mandate then escalate decisions as needed	Commence work for next FY volumes and budgets. Start review of assumptions	Monthly, review progress on service plan. If changes needed and not within mandate then escalate decisions as needed	Templates for quarter reports, and reporting to ELT and Board
September				
October	Services review previous year, and develop high level aims, and proposed service changes Include stakeholders as appropriate	Baseline information on financial budget, volumes, actuals. Draft delivery volumes to understand capacity, and costs. Assumptions Guidance and forecast budget ($)	Review current service plan	Quarter reports and MOH feedback
November	High level proposals for service change are drafted according to template All of Directorate workshops (plus stakeholders)	Preparation of next year's budget and volumes, alignment with strategic priorities and change proposals Submission to CEO (plus proposals)	Indicative alignment of service change proposals, service plan, and strategic priorities Check against current Annual Plan to identify gaps/possible issues	Review current annual plan
December	Check and update service change proposals against draft budget, annual plan advice, outcomes of workshop, and advice from CEO	Update budget and volumes Highlights of changes in expectations/assumptions	Update service plans	Annual plan advice from MOH
February	All of Directorate workshop – review service change proposals	Review budget and agree volumes	Review updated service plans	Update draft Annual Plan
March	ELT, Board Committees and ALT feedback on proposed service changes	Finalise budget and agree volumes	ELT, Board Committees and ALT feedback on service plans	Draft Annual Plan
April	ELT view and endorse proposed service changes	ELT view and endorse budget and volumes	ELT view and endorse service plans	Annual plan to MOH
May	Revisions as needed by ELT	Revisions as needed by ELT	Revisions as needed by ELT	Revisions as needed by MOH
June				Annual Plan approved by MOH

Operational Issues

Mental Health Addiction and Intellectual Disability (MHAID)

Demand for MHAID System Across the District

Demand for services across the service continues to be monitored by the Mental Health and Addiction Network Leadership Group (NLG). Most adult services (NGO and DHB provided) are steady compared to last year with the exception of young people. Youth services across the system report increased numbers of referrals and complexity. Primary Brief Intervention services are experiencing increased rates of referrals. A particular area of concern is the Central Lakes area which experienced a 40% increase in referrals over the same time last year with a three to seven week wait time which is similar to last year. Hot spots are Wanaka, Cromwell and Alexandra. The appointment of Health Improvement Practitioners and Health Coaches is expected to make a significant difference.

Supported Accommodation Pressures

We continue to manage a waiting list of patients currently being managed in the DHB's mental health and addiction facilities that could more appropriately be managed in supported accommodation facilities in the community. There is very little or no change in the waiting list on a month by month basis.

The sector continues to work through the challenges in finding suitable supported accommodation and packages of support for people with enduring mental illness so they can move from hospital to the community. This is a focus for the Mental Health and Addiction Network Leadership Group (NLG) and the Chair will meet during November with the Dunedin SPOE group. A proportion of this group who are now living longer, often find their lives are complicated by physical health issues. A meeting also occurred with the Health of Older Person with a commitment to develop a more integrated pathway to provide clarity and framework for people who sit or may sit across both Mental Health and Aged Care. We expect these interfaces will be a subject of focus during the Southern Mental Health and Addiction System Review.

Child and Family Service (CAFS) team demand on services

Child and Adolescent services continue to have referrals with high acuity, this is challenging within Southland with the lack of SMO coverage and the pressure this puts on services. Services in Otago are also experiencing high demand and Central Lakes remains a particular area of concern with a number of vacancies. A plan is in place to support local service provision while recruitment occurs.

Police Response Issues

The service continues to liaise with the Police on relevant issues as they occur and are worked through in a timely manner. The service continues to request assistance to support with the management of volatile situations which continues to highlight

the services inability to manage these times without additional help. Initial work is underway to explore the option of a Combined Response Team, modelled on the Wellington pilot, being established in our district.

Nursing

Vacancies are decreasing overall, good interest locally, nationally and internationally. We have had double the interest from new graduate nurses for 2021 programme and an additional midyear intake is being planned. Nursing staff continue to express frustration at the lack of high care options available in community NGO sector as evidenced by wait list for supported accommodation.

Double shifts

The occurrence double shifts have decreased in all areas with the exception of ward 10a which experienced a marked increase during October. The latest workforce/vacancy update indicates improvement in vacancies and recruitment by February 2021. The capacity to flex up rapidly is still an issue as is managing the patient mix in this area.

Integrated Mental Health and Addiction Primary Mental Health and Addiction System

From a contracting perspective, the agreement between the MoH and Southern DHB was received and has subsequently been signed off by the Board. We have prepared and issued a back-to-back agreement between the District Health Board and WellSouth. This is currently with the provider for signing

This agreement provides for 25.3 FTE, being a mix of Health Improvement Practitioners (HIPS), Health Coaches and Community Support workers, as well as funding for implementation costs. The initial agreement has a term of one year and an annual value of $3.055. In essence, the programme provides same day access for supporting mental health and wellbeing in primary care.

In terms of progress in implementing the programme, the following practices have HIPS to support their patients:

- Te Kaika – Dunedin
- Invercargill Medical Centre
- Broadway Medical Centre - Dunedin
- Mornington Medical Centre - Dunedin
- Queenstown Medical Centre
- Wanaka Medical Centre
- Aspiring Medical Centre – Wanaka
- Clutha Health First – Balclutha
- He Puna – Invercargill
- Bluff Medical
- Health Central – Alexandra
- Alexandra Family Medical
- Green Island Medical – Dunedin
- Meridian Medical – Dunedin
- South Hill Medical – Oamaru

- Oamaru Doctors

WellSouth have recruited and placed 10.5 FTE of HIPS and are on target to have placed 11 Health Coaches and 5.2 Community Support workers by mid-November. WellSouth recently advised that they have the first nationally accredited HIP trainer in the South Island.

We are meeting regularly with WellSouth to monitor progress in implementing the programme and to work with them on developing further aspects that were detailed in the RFP such as scaling up of a Single Point of Entry (SPOE) to allow for improved referral pathways.

Resignation of Southland based MHAID Kaumatua

Mohi Timoko the Kaumatua for Te Korowai Hou Ora is retiring on the 20 November 2020. He has been part of services for many years and his contribution has been greatly valued.

Clinician Only Caseloads

The clinician only caseload project continues to proceed albeit slowly. The Dunedin community teams are putting a greater focus on discharge planning clients that are single clinician only. There is increased emphasis on individual clinicians who feature as outliers on this matter and understandably the service needs to approach this in a sensitive and supportive manner. The work of the documentation working group complements the direction of travel

Documentation Working Group update

The first part of this project has been completed with recommendations for improvement identified. Medical staff continue to work on their pathway (documentation) processes. The next stage is prioritising the recommendations and identifying a small group to complete the second stage of using the Safe Side model to merge processes/forms to reduce current clinical forms.

Health Quality Safety Commission (HQSC) Mental Health and Addiction Quality Improvement Programme:

Zero Seclusion

The zero seclusion programme continues to focus on the three areas that are used to measure progress with these being the number of individual people secluded, the overall number of seclusion events and the time seclusion is used. The service continues to see a reduction in the length of events but not so with the other two categories Members of the project group assisted in the delivery of a workshop involving a number of Ward 9a (Forensic Unit) staff that led to a number of Plan Do Study Act cycle suggestions. One of these is related to there being no easily identified pathway to seeking Pacific Island cultural support. This is particularly important for Ward 9a where the majority of seclusion events have involved Pacific Island people. The Service Manager for Adult services and the Quality Lead continue to attend clinical meetings on Ward 9b three times a week to understand the drivers of seclusion events. The Ward 9b team continue to be responsible for the care and treatment of the most challenging patients.

Public Health Service

Proposal for Change – Update

As previously reported, the implementation of the new way of working commenced on 14 September. Team Leader positions for the Policy, Strategy and Support, and Communities teams have been confirmed and interviews are being held for the Regulatory and Protection Team Leader next month. Other vacancies due to changes in roles (analyst and Pou Whakatere roles) and from recent staff departures are being recruited to over the next month. An implementation plan is being developed which will cover the transition phase over the next 6-12 months.

Alcohol Harm

A media release was published on the impact of alcohol on southern DHB Emergency Departments. Lakes District Hospital has the highest rate of alcohol related Emergency Department presentations (one in 20 patients), followed by Dunedin Hospital (one in 25 patients) and Southland Hospital (one in 55 patients). The busiest times for alcohol related cases presenting to Southern DHB Emergency Departments in total were Saturday nights and Sunday mornings. The release highlighted the fact the drunk patients were difficult to manage and put pressure on those who needed to attend Emergency Departments for other reasons.

Recreational Water Monitoring

Public Health South hosted a pre-season bathing water monitoring meeting. All but two local authorities were represented and both regional councils. The meeting included an appraisal of disease caused though contact recreation, the impact of the National Policy Statement for Freshwater 2020 on monitoring programmes and communications/public warnings. It was agreed that an advisory (as opposed to a warning) approach would be taken at bathing water sites. Messages will include no contact recreation after heavy rain (or you can't see your toes in the water) or if the readings from the LAWA (Land, Air, Water Aotearoa) website indicate the water is unsuitable for bathing.

Work was also done on the approaches regional councils were taking to communicate the health risks of cyanobacteria blooms in rivers and some of the shallower lakes in the summer. This meeting will be followed up by a post-bathing water season meeting in March. In the meantime, Public Health and the regional councils will be working on getting a Memorandum of Understanding between themselves, Public Health South and the local authorities that clearly delineates the roles and responsibilities of the various agencies.

Violence Intervention Programme (VIP)

Preparation is underway for the biennial review of the Southern DHB child protection system. This is undertaken with the national VIP coordinator and participating VIP staff and paediatricians. This includes confirming that child protection alert policies have been reviewed, fortnightly multidisciplinary meetings are being held with a paediatrician present, the documentation process is being undertaken consistently, alerts are visible on DHB systems, and staff are trained appropriately.

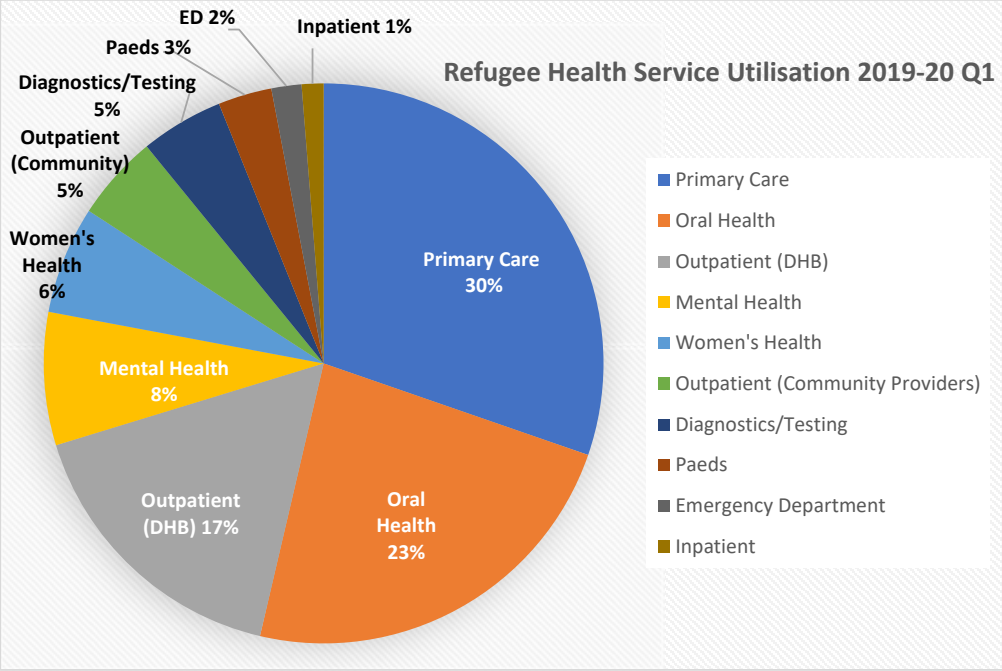
Refugee Health

Ministry of Business, Innovation and Employment (MBIE) Refugee Resettlement Programme

New quota refugee arrivals remain on hold while the global pandemic, Covid, is being managed. There currently are 1,600 refugees awaiting resettlement in New Zealand. In the interim, the Government has agreed to resettle a limited number of quota refugee emergency cases referred by the United Nations refugee agency (UNHCR). All refugees who come under the refugee quota programme are granted permanent residence, so no border exemption is required for New Zealand under the current border restrictions. The first emergency case arrived on 17 October and travel dates have been booked for the next cases. After the required time in the Managed Isolation facility, families will stay briefly at the Mangere Refugee Centre while we finalise housing and settlement assessments.

Refugee Service Utilisation

Trends for both Dunedin and Invercargill resettlement sites remain static and positive, with most care being delivered via Primary Care. Oral Health, while still second most utilised service, was lower during Covid as access was limited and/or unavailable during much of Quarter 4. Consequently, there has been a tremendous push to make-up for cancelled appointments and closed services during Lockdown (discussed in "Oral Health" below). Mental health appointments have come down modestly (11% to 8%), but when post-Lockdown increases in other services (i.e. Oral Health) this drop is negligible.



Finally, Quarter 1, the appointment 'Did Not Attend' (DNA) rate for former refugees has remained steady and very favourable at 4% for all appointments across both resettlement cities. This is one third of the general population DNA rate of 9.5%.

Refugee Oral Health

There was a tremendous push made by both the Southern DHB Children's Oral Health Service and the University of Otago Dental School to make-up for Covid-related impacts in the previous quarter. See below:

Service	Appointments Q1 2020-21	Appointments Q4 2019-20
Dental Unit - Invercargill	19	37
Dental School - Dunedin	**293**	72
Community Oral Health	**104**	11

Refugee Interpreting

There was a total of 1,908 interpreter appointments provided for refugee healthcare across the cities of Dunedin and Invercargill. 19 of these appointments were completed by Ezi-speak telephone interpreting (1%); whereas, Ezi-speak delivered 58 non-refugee related telephone interpreter provided healthcare appointments.

Diabetes

The MoH has formally responded to our recent Living Well with Diabetes-self-assessment and their recommendations will go to the LDT at the October meeting. The MoH recommendations relate to Type 1 follow up delays, and access issues for high risk Type 2 patients with diabetes.

Rural Radiology

A review of the Rural Radiology service is underway**.** Currently, the Southern District Health Board (Southern DHB) contracts for radiology services with a number of providers, including Clutha Health First, Central Otago Health Services Ltd., Gore Health, Maniototo Health Services Ltd, and Waitaki District Health Services. It also provides services at Queenstown Lakes Hospital.

Recent funding pressures has resulted in the rural hospital Chief Executives (CEs) agreeing to undertake a review of radiology services with a view to determining what the future configuration of Radiology services should be to ensure ongoing sustainability.

The project review has been completed, a final document and four options have been identified, this has been provided to the rural Hospitals for their consideration. The four options identified will be scored by each Rural Hospital using a decision matrix tool, each option will be considered against a number of factors and weighting applied to each factor. Next steps are to debate the merits of each option at a workshop in November, resulting in an agreed single option for future radiology services. The agreed option will need to be modelled and costed, including any issues that need to be addressed for successful implementation.

Population Health

Service Planning

Population Health leaders from across the district attended a facilitated service planning workshop on 23 October 2020. This was the first time some of the clinical leaders and senior nurses had met each other. Feedback from the team was that the time was invaluable, enabling them to identify synergies and opportunities to work differently across the programmes/service. Keys points from the workshop have been summarised and an action plan drafted.

Measles Campaign 15 – 30-year olds

The draft Measles implementation plan is currently out for consultation with the Southern Campaign Implementation Group for final additions and changes. With General Practice recalling their enrolled population, the initial focus is on ensuring all immunisation events are recorded on the National Immunisation Register. In preparation for the delivery of community pop up clinics, capacity has been built with the Māori Health Providers and contracts are being put in place for them and other identified community providers, to deliver off site vaccination clinics.

Public Health Nurses

The service has seen an increase in referrals for children and young people experiencing anxiety post Covid lockdown. Additionally, there are an increased number of families requiring complex case management as their children and young people are being affected by social economic pressures. The service continues to liaise regularly with the Ministry of Education and are working collaboratively with new learning clusters to ensure health and educational supports and working together. The Maniototo PHN has reported an increasing level of worry and anxiety from farming families over their futures.

Some rural PHN's are participating in the 'ROCK ON' program designed as a collaborative interagency approach to reduce truancy, youth offending and increase engagement in education. With parent consent PHN's provide health support, assessment and advice for at risk young people as part of this program.

PHN have noted an increase in Years 9 and 10 students presenting at youth clinics across the district, proactively seeking assistance as they are becoming sexually active. Alexandra now has a new venue for Enhanced Youth Health Clinics.

District Oral Health Service

The service continues to work hard on the back log of patients and all community clinics are operating to full capacity. The arrears are still very high, and this is likely to continue for some time. Patient cancellations and staff sickness is impacting on appointment numbers.

The Dental Unit continue to work to capacity, annual leave, vacancy, and illness continue to impact on the numbers of patients being seen and the stress levels in staff. Significant pressure and demand continues for the Emergency Dental Service resulting in the need to set an eligibility criteria focusing on the most in need, people on benefits or a gold card with expiry date that is expected to be a fixed-term for the next 6 months. Interviews are underway for the vacant Dentist position. Planning is ongoing for clearing the backlog of the Children waiting to be seen from the Dental School Paediatric General Anaesthetic waiting list. Currently we are employing the Mobile Surgical bus to help clear part of the list. We are also working toward a plan to support a transparent and equitable district wide oversight of Dental GA waitlist for Southern children. Interviews are underway for extra Dental Assistant/Admin to free up admin support and provide District wide GA waitlist co-ordination.

The Oral Health Service Administrator position has been advertised, interviews and testing are completed and the successful applicant with be informed by the end of the week.

Information Technology (IT) have been working on the Power-BI and Titanium reporting framework and have drafted up a sample dashboard. We have had to wait awhile for this to happen, however, this project is now underway and we are looking forward to a more robust reporting and relevant dashboard for Oral Health.

Interviews for Therapist vacancies in Invercargill, Dunedin and Oamaru have been completed, all positions filled except one of two in Invercargill remains unfilled. We will re-advertise again around that position, however, are delighted to have positions filled in Invercargill and Oamaru as these are very hard areas to employ to.

Training for surveillance testing will be completed for all the Oral Health staff who have not yet completed it at both in-services in Dunedin and Invercargill by the end of November. Once completed all staff in Oral Health will have the capacity if required to do testing and a number are trained to contact trace.

The Professional Lead has been asked to participate in a review of the Oral Health Service at South Canterbury DHB, she is looking forward to this and believes that this will potentially allow her to bring back any learnings she may have to the DHB.

The full time Health Promoter is now in position and we are looking to developing the Health Promotion team to its full capacity supporting and promoting good Oral Health.

Update on Oral Health Deliverables

- *Evaluate the impact on Pacific children of the pilot community oral health outreach clinic established at Pacific Trust Otago (PTO) (EOA):*

The Oral health Professional Lead is the lone therapist who set up and currently runs this programme reports, that even though the numbers are small she has good engagement with the community.

Having a presence has significantly improved the Oral Health relationship with those members of the community who attend and she has managed to enrol the pre-schoolers attending with their families.

- *Establish a monthly community oral health outreach clinic for Māori, (utilising the findings from the PTO evaluation), attached to Southland Te Kakano Nurse Led Clinic (EOA):*

  Delays have occurred due to staff stepping up around the DHB COVID response but we are back on track and planning for the establishment of the outreach clinic are back and underway. Once again the Oral health Professional Lead is heading this project and we are currently looking to locate a Dental therapist in Southland to run this clinic and a suitable location.

  We are also working alongside the Māori Health Directorate for guidance and advise.

- *Investigate the establishment of a pilot programme for the Community Oral Health Service to be delivered via a mobile vehicle on two Southern District Marae (location to be determined) to increase access for Māori children aged 0-18 year (EOA) [Refer also 2.1.1 Māori Health Action Plan]:*

  This is a duel project between the Māori Health Directorate and Oral Health, the Māori Health are to approach Iwi Governance for the decision around which Marae would be most appropriate, currently Oral Health potentially has funding for a bollard and Māori Health have expressed a commitment to support another bollard, details like rationalising the current mobile bus service to try and free up a mobile and staff to be able to rotate onto these sites and help with existing arrears district wide.

- *Oral Health – Monitoring preventative treatment for caries.*

  A training package is currently underway to train all Dental Assistances to apply fluoride vanishing to children. Six monthly applications on children's teeth to reduce / prevent the formation of caries. Southland DA's are first to be trained and then Otago DA's. This stops the disease from continuing to erode the tooth and it is anticipated this results in improved outcomes for the children and resource.

Fluoridated Water in the Southern Region

- Waitaki District - non fluoridated
- Queenstown District - non fluoridated
- Clutha District - non fluoridated (55% had been fluoridated then stopped Dec 2019 not restarted)
- Central Otago District - non fluoridated
- Gore District - non fluoridated
- Southland District - non fluoridated

Child Health (0-5years)

Well Child Tamariki Ora (WCTO) and Sudden Unexplained Death in Infants (SUDI)

The launch of wahakura in the Southern district is now confirmed for 4 December, National Safe Sleep Day at Hokonui Rūnanga in Gore. Following this wahakura will be made available to Māori and Pacific whanau by a limited number of distributors.

Discussions have begun on planning of wahakura wānanga, which will be held in different communities across the district. Under the Safe Sleep Programme work we will engage with communities to identify their needs in relation to development of harm reduction messaging for pēpi. An example of this could include the gifting of wahakura to marae and support to introduce marae based safe sleep champions.

Pacific

Engagement with Pacific communities is continuing in preparedness for any future Covid activity. Oamaru and Balclutha are the focus of engagement going forward. It is more challenging in smaller communities with less numbers of Pacific whanau.

Pacific Trust Otago have commenced a three-year Ministry of Health funded community dietitian clinic. Connections have been facilitated with Sport Otago as a pathway for referrals of these identified at the clinic as needing additional support with physical activity and wellbeing. Nursing support is being provided to the clinic from WellSouth.

The Pacific Island Advisory and Cultural Trust in Invercargill have been unable to recruit a Social Worker to the vacant position. Discussion has occurred within the Southern DHB on how to support the community nurses who run clinics at the Trust premises.

The community breast feeding pilot based at Pacific Trust Otago is successfully working with Māori, Pacific, refugee women and women from high deprivation areas. Planning has also begun with the Clinical Lead of Otago Paediatrics and a new Neonatologist to establish a community based "feeding" clinic, which could be held in a Pacific setting.

Green Prescription and Active Families

A number of referrals for green prescription for both Sport Otago and Southland have been begun to rise since the decrease in numbers over lockdown. Both providers have increased engagement with key general practices particularly in rural areas. This has resulted in increased engagement with Tuatapere, Bluff, Gore and Oamaru. Sport Southland area are also investigating how to better respond to Queenstown.

A meeting has been facilitated with both providers and Public Health nurses who support the Before School Checks Programme to ensure up to date information on Active Families is available and to ensure referral pathways are working to support wahanau.

Both providers have increased their equity focus with Sport Southland setting an internal target of 14% Māori clients but have reached 23%. Both providers are working more closely with Māori providers and the two Pacific Trusts.

Sport Otago and Southland continually highlight Green Prescription and Active Families as a preventative measure for long-term conditions through physical activity and healthy eating.

Service Planning and Alliance South First 1000 Days project

Planning has begun on identification of the various work streams across Southern DHB and WellSouth that contribute to outcome improvements for Alliance South's First 1,000 days project. A meeting to establish governance and strategic leadership is to be held in early November. Preparatory work has also begun on identification of resources currently allocated to the First 1000 days work streams.

Discussions have also occurred on the relationship of the First 1,000 days work and general Service Planning for Child and Youth. This has focussed on the accountabilities and dependencies between Service Plans, Alliance South First 1,000 days and the South Island Alliance Programme of work for Well Child Tamariki Ora, Sudden Unexplained Death in Infants and Child and Youth. The complexity is highlighted by the number of those involved in child and youth activity – Maori Health, Maternity, Mental Health, Oral Health, Public Health, Population Health, Paediatrics - Otago and Southland, community providers, government agencies and the non-government organisations.

Rural Health

Lakes District Hospital

The Allied Health review of Lakes District Hospital will include a site visit by the Chief Allied Health, Scientific and Technical Officer for Southern DHB, Kaye Cheetham, on 29 and 30 October. The outcome of this review is expected by December.

A review of Radiology leadership roles at Lakes District Hospital (LDH) was conducted by the Charge Medical Radiation Technologist for Southern DHB. Her report identified the responsibilities of certain roles at LDH Radiology mirrored those of the leadership roles in Radiology in Dunedin and Southland Hospitals. The comparable roles at LDH have not been recognised, to date. Recommendations from this report are being considered.

A review of the Administration Team at LDH is underway. The current hours of service coverage do not reflect the clinical peaks, and the Admin Team are integral to managing this workload. Results are expected by early December 2020.

A project to identify the opportunities or risks of introducing a second tier of medical staff / nurse practitioners to the Emergency Department at LDH has just commenced.

Primary Care

Community Pharmacy

The Client Led Integrated Care – Long Term Conditions (CLIC_LTC) pilot is progressing well in Gore. General Practices (GP) and local community pharmacies in Gore have been engaged in this project and are now able to implement the new model of care. This work is supported by a small team of Southern DHB and WellSouth staff.

The main objectives are to ensure that Medicines support for our LTC patients is provided through Community pharmacy integrated into the wider Multi-Disciplinary Team (MDT).

The Ministry of Health has made funding available to DHBs to support critical pharmacies if they are imminently going to have to close and/or cease services that are deemed critical, due to the impact of Covid. The Southern DHB pharmacy portfolio manager will work closely with any pharmacy that applies for access to this resource. Any applicant will have to demonstrate that their financial position is critical as well as demonstrating that their services are critical to the community, and that access will be significantly compromised for their population on closure. As of the 27 October there have been no applications for this funding.

Southern Community Laboratories (SCL)

SCL has performed extremely well through the Covid period. Covid testing volumes have exceeded 140,000 for the entire group while maintaining turnaround times. Their capacity to scale up if required has been increased with additional capability being established within the laboratory.

The Community Operational Advisory Group has continued its work supporting the two DHB contracts. Projects progressing include;

- Electronic Lab ordering
- Collection centres
- New test requesting process

SCL continue to be a part of the New Dunedin Hospital (NDH) process through the Super Fit and Fit groups.

Tobacco control

The Southern DHB has received a rollover of the tobacco control Crown Funding Agreement (CFA) for 2020-21. We will continue to support the WellSouth General Practice (GP) champion and the Public Health team with this funding. In addition the Vape to Quit pilot will be funded through this revenue contract. The implementation of this pilot has been delayed due to Covid, however, it is expected that the pilot will go live in late 2020. The aim is to support smokers over 18yrs to quit using a vape device, supplied through community pharmacies. Key stakeholders involved in this pilot include the Southern Stop Smoking Service, Public Health South, Southern DHB Mental Health services, Maori Non-Government Organisations (NGOs) and General Practices.

Older Persons Health and AT&R

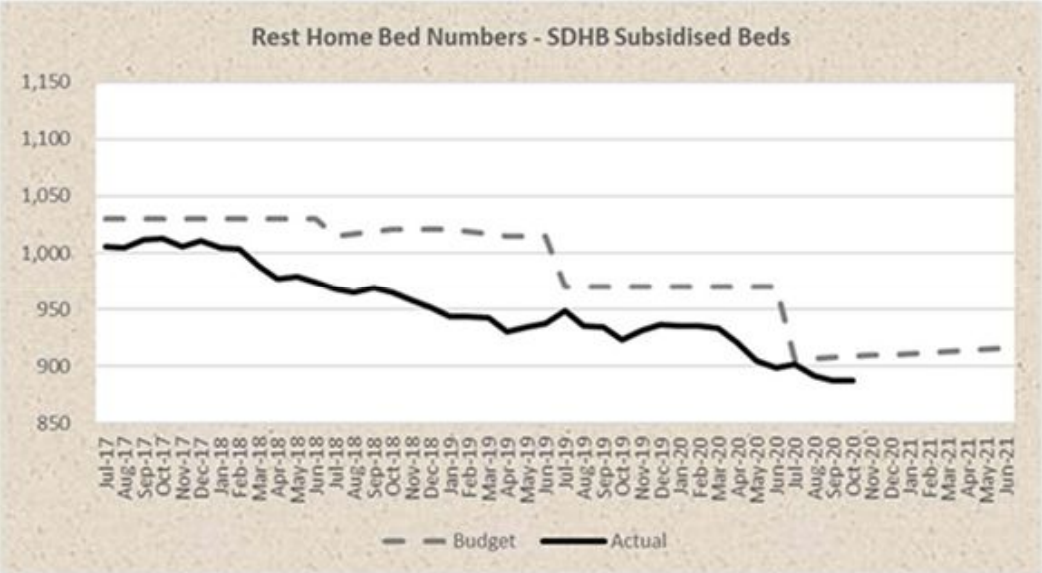
Aged Residential Care Occupancy / Volume Analysis

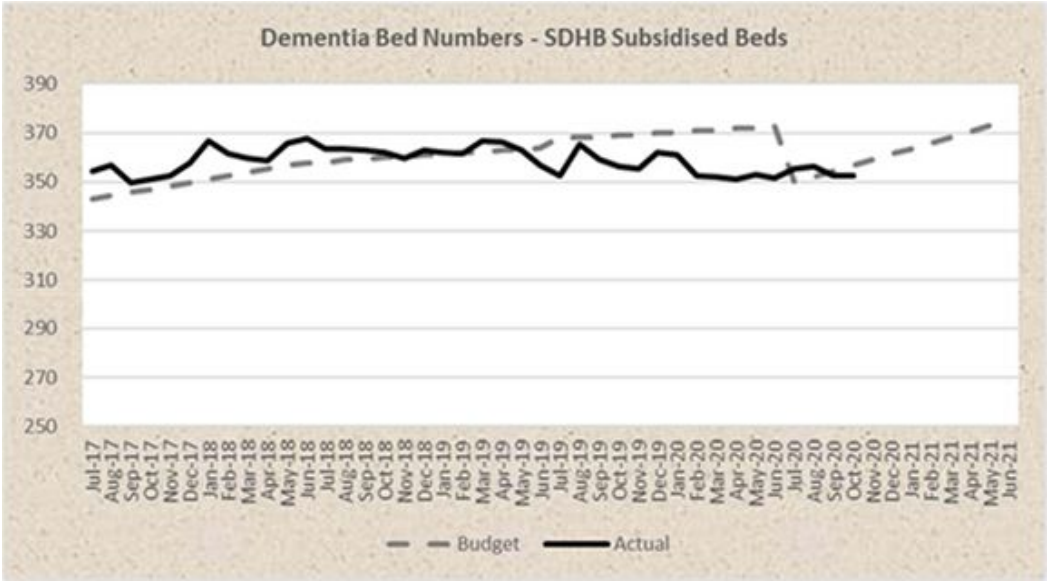
The DHB continues to experience elevated levels of occupancy in Aged Related Residential Care (ARRC), primarily at Hospital and Psychogeriatric levels of care, noting there has been an improvement in the unfavourable deficit to budget in October. The team continues to investigate multiple avenues but to date has not reached any conclusions:

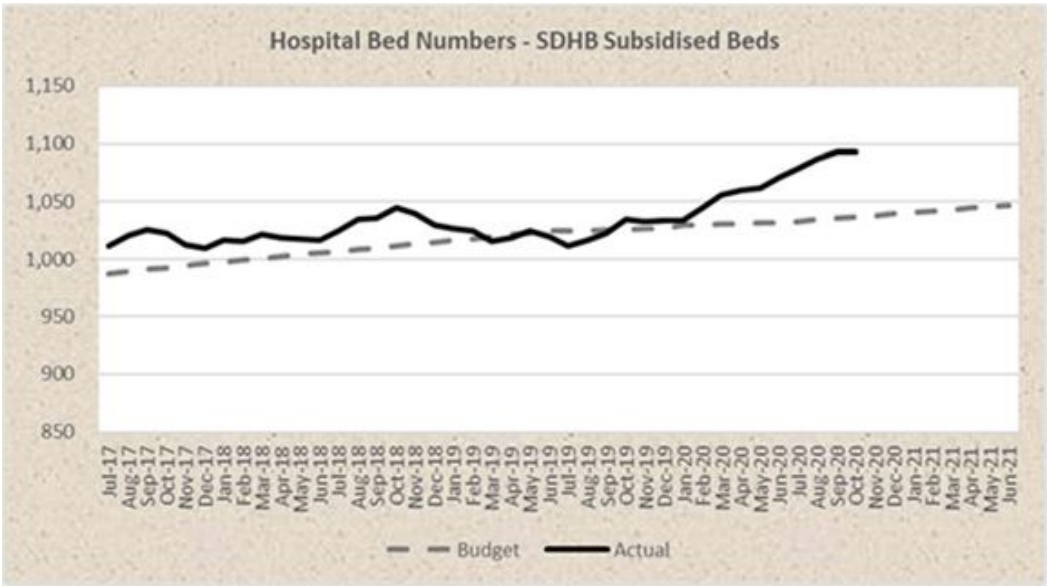
We continue to consider:

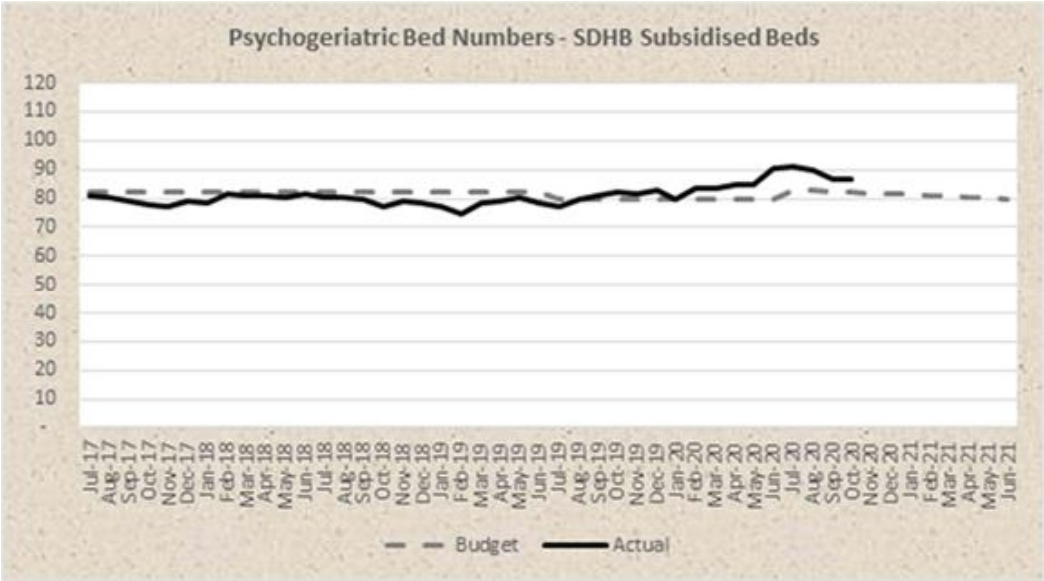
- Have there been fewer deaths?
- Is there a backlog from the COVID lockdown that is starting to come through? Are patients enjoying better health due to lack of illness or worse health due to lack of socialisation and activity?
- Has the time patients receive Home Support increased so that by the time they enter care, they go in at Hospital Level rather than Rest Home Level?
- Are there more patients being discharged from Hospital into ARRC?
- As a result of the lockdown (isolation and decreased activities) have there been increased changes in level of care from rest home to hospital level care?
- What is the impact of supply induced demand?

In addition we continue to interrogate national datasets and the ARRC demand planner to establish how SDHB's position compares to other DHB's.




Dementia Bed Numbers - SDHB Subsidised Beds
390
370
350
330
310
290
270
250
Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21
Budget
Actual


Hospital Bed Numbers - SDHB Subsidised Beds
1,150
1,100
1,050
1,000
950
900
850
Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21
Budget
Actual


Psychogeriatric Bed Numbers - SDHB Subsidised Beds
120
110
100
90
80
70
60
50
40
30
20
10
-
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Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
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May-21
Jun-21
Budget
Actual

SOUTHERN DISTRICT HEALTH BOARD

Title:	**FINANCIAL REPORT**
Report to:	Disability Support Advisory Committee and Community & Public Health Advisory Committee
Date of Meeting:	7 December 2020

Summary:

The issues considered in this paper are:

- October 2020 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: 13 November 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 October 2020

Strategy,Primary & Community Oct-20	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	92,969	91,930	1,039				371,328	367,720	3,608				1,103,159
IDF Revenue	2,280	1,983	297				8,349	7,930	419				23,790
Other Government	512	576	-64				2,283	2,316	-33				6,632
Total Government & Crown	**95,762**	**94,488**	**1,274**				**381,960**	**377,966**	**3,994**				**1,133,582**
Non Government & Crown Agency Revenue													
Patient related	17	21	-4				72	83	-11				249
Other Income	88	80	8				363	318	45				954
Total Non Government	105	100	5				435	401	34				1,203
Internal Revenue													
Internal Revenue													
Total Internal Revenue	**8,662**	**8,518**	**144**				**34,216**	**34,072**	**144**				**102,215**
TOTAL REVENUE	**104,529**	**103,106**	**1,423**				**416,610**	**412,438**	**4,172**				**1,237,000**
EXPENSES													
Workforce													
Senior Medical Officers (SMO's)													
SMO - Direct	1,455	1,481	26	61.05	64.63	3.58	6,002	6,029	27	62.76	66.18	3.43	18,259
SMO - Indirect	80	91	11				333	365	32				1,095
SMO - Outsourced	52	47	-5				258	195	-63				561
Total SMO's	**1,587**	**1,619**	**32**	**61.05**	**64.63**	**3.58**	**6,593**	**6,590**	**-3**	**62.76**	**66.18**	**3.43**	**19,915**
Registrars / House Officers (RMOs)													
RMO - Direct	231	231		19.87	19.44	-0.43	921	912	-9	19.98	19.24	-0.73	2,818
RMO - Indirect	1	17	16				24	66	42				198
RMO - Outsourced													
Total RMOs	**232**	**248**	**16**	**19.87**	**19.44**	**-0.43**	**945**	**979**	**34**	**19.98**	**19.24**	**-0.73**	**3,016**
Total Medical costs (incl outsourcing)	**1,819**	**1,867**	**48**	**80.92**	**84.07**	**3.15**	**7,537**	**7,568**	**31**	**82.73**	**85.43**	**2.69**	**22,931**
Nursing													
Nursing - Direct	4,539	4,403	-136	594.41	577.33	-17.08	18,455	18,143	-312	604.06	579.41	-24.64	54,904
Nursing - Indirect	3		-3				10	1	-9				3
Nursing - Outsourced													
Total Nursing	**4,542**	**4,403**	**-139**	**594.41**	**577.33**	**-17.08**	**18,465**	**18,144**	**-321**	**604.06**	**579.41**	**-24.64**	**54,907**
Allied Health													
Allied Health - Direct	2,706	2,845	139	424.05	433.61	9.56	11,079	11,421	342	432.39	442.34	9.95	34,505
Allied Health - Indirect	21	29	8				92	118	26				633
Allied Health - Outsourced	24	16	-8				110	65	-45				192
Total Allied Health	**2,751**	**2,891**	**140**	**424.05**	**433.61**	**9.56**	**11,282**	**11,604**	**322**	**432.39**	**442.34**	**9.95**	**35,330**
Support													
Support - Direct	3	13	10	0.92	3.25	2.33	22	51	29	1.77	3.21	1.44	151
Support - Indirect													
Support - Outsourced													
Total Support	**3**	**13**	**10**	**0.92**	**3.25**	**2.33**	**22**	**51**	**29**	**1.77**	**3.21**	**1.44**	**151**
Management / Admin													
Management & Administration - Direct	1,121	1,149	28	175.51	178.40	2.89	4,578	4,685	107	178.08	179.77	1.70	13,764
Management & Administration - Indirect		6	6				4	22	18				66
Management & Administration - Outsourced	1	1					5	5					13
Total Management / Admin	**1,122**	**1,155**	**33**	**175.51**	**178.40**	**2.89**	**4,587**	**4,712**	**125**	**178.08**	**179.77**	**1.70**	**13,844**
Total Workforce Expenses	**10,238**	**10,329**	**91**	**1,275.81**	**1,276.66**	**0.85**	**41,893**	**42,079**	**186**	**1,299.03**	**1,290.17**	**-8.86**	**127,162**
Non Personnel													
Outsourced Clinical Services	76	100	24				309	402	93				1,185
Outsourced Corporate / Governance Services													
Outsourced Funder Services	1,200	1,206	6				4,799	4,823	24				14,470
Clinical Supplies	1,398	1,008	-390				5,311	3,985	-1,326				11,937
Infrastructure & Non-Clinical Supplies	694	691	-3				2,760	2,838	78				8,410
Provider Payments													
Personal Health	67,208	66,911	-297				267,904	267,278	-626				800,836
Change Initiative Fund													
Mental Health	8,762	8,497	-265				34,663	33,989	-674				101,967
Public Health	115	84	-31				461	336	-125				1,007
Disability Support	16,119	15,914	-205				64,288	63,548	-740				189,737
Maori Health	201	206	5				706	761	55				2,220
Non Operating Expenses													
Depreciation													
Capital charge													
Interest													
Total Non Personnel Expenses	**95,774**	**94,618**	**-1,156**				**381,202**	**377,960**	**-3,242**				**1,131,769**
TOTAL EXPENSES	**106,012**	**104,948**	**-1,064**				**423,095**	**420,038**	**-3,057**				**1,258,931**
Net Surplus / (Deficit)	**-1,483**	**-1,841**	**358**				**-6,484**	**-7,600**	**1,116**				**-21,931**

[Requests awaiting approval - Items on Register]

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Summary

Strategy, Primary and Community report a provisional unfavourable bottom line variance of $0.36m for October and $1.12m favourable YTD.

Significant contributors to the favourable/unfavourable variances for October and YTD are:

Revenue

- IBT $119k favourable for October and $225k YTD
- CSC $62k favourable for October and $185k YTD
- Pharmacy $422k favourable for October and $1.69m YTD
- Mental Health $265k favourable for October and $1.163m YTD
- IDF $297k favourable for October and $419k YTD

Workforce

- SMO's $32k favourable for October and $3k unfavourable YTD
- Nursing $139k unfavourable for October and $321k unfavourable YTD
- Allied Health $140k favourable for October and $322k favourable YTD
- Management Admin $33k favourable October and $125k favourable YTD

Non personnel

- Clinical Supplies $390k unfavourable for October and $1.33m YTD

Personal Health

- PHO's $72k unfavourable for October and $647k YTD
- Community Pharms $19k favourable for October and $35k favourable YTD
- Travel & Accom $134k favourable for October and $200k favourable YTD
- IDF's $137k unfavourable for October and $312k YTD
- Haemophilia $276k unfavourable for October and $507k YTD

Mental Health

- Minor Mental Health $284k unfavourable for October and $1.03m YTD

Disability Support

- ARRC $236k unfavourable for October and $1.05m YTD
- Comm. Health Services $27k favourable for October and $141k favourable YTD

Comments for discussion

- Please see Pharms section on next page for all Pharms commentary, including:
  - Explanations for variance
  - Recommendation of adjustment to rebate accrual methodology.
- Per last month there is offsetting revenue and expenditure in Mental Health for Primary Integrated MH & Addiction.
- Significant Dental accruals remain due to University claiming lag although this is becoming clearer as contracts teamwork with Oral Health service and Dental School.
- Unfavourable ARRC variance largely per September forecast, with continued high Hospital level bed numbers.

Pharmaceuticals

The SDHB Consolidated Pharmaceutical budget (including funder Haemophilia) is significantly unfavourable to budget for October, with a $1.36m unfavourable variance to budget (YTD $2.37m)

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	$000 YTD 2019/20	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
Clinical Supplies - Pharmaceuticals	$ 9,279.4	$ 10,315.4	$ 9,132.2	-$ 1,183.1
Provider Payments - Pharms	$ 24,080.0	$ 26,437.0	$ 25,750.9	-$ 686.1
Haemophillia (medical outpatients)	$ 738.9	$ 1,264.7	$ 757.1	-$ 507.6
Total	**$ 34,098.3**	**$ 38,017.0**	**$ 35,640.2**	**-$ 2,376.8**

Variance is made up of the following (estimate)

Pharms YTD		$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
PCT	$ 4,624.0	$ 4,818.9	$ 3,341.9	-$ 1,477.0
Community Pharms (DHB Outpatients)	$ 1,643.1	$ 2,121.2	$ 1,597.4	-$ 523.8
Hospital Inpatients	$ 3,012.4	$ 3,375.3	$ 4,192.9	$ 817.6
Community Pharms (excl DHB)	$ 24,080.0	$ 26,437.0	$ 25,750.9	-$ 686.1
Haemophillia (medical outpatients)	$ 738.9	$ 1,264.7	$ 757.1	-$ 507.6
Total	**$ 34,098.3**	**$ 38,017.0**	**$ 35,640.2**	**-$ 2,376.8**
Additional Unbudgeted Revenue - Tranche 1		$ 225.0	$ -	-$ 225.0
Additional Unbudgeted Revenue - Tranche 2		$ 1,462.7	$ -	-$ 1,462.7
Adjusted Total (adjusting for unbudgeted revenue	**$ 34,098.3**	**$ 36,329.4**	**$ 35,640.2**	**-$ 689.2**

There are multiple contributing factors to this variance, including:

1) Correspondence (12th Oct) from the Chair of the NHMG to DHB CE's requesting $632k increase in contribution to the NHMG pool (SDHB's share). We have accrued YTD portion ($211k) of this request. *Please note this is in addition to existing budget variance of ~$80k per month.*

   There is some logic to the DHB considering accruing additional rebate to reflect the additional expenditure but we note the following passage that was included in the letter from NHMG "*…However PHARMAC are unable to provide rebate details or even a total rebate figure expected in relation to haemophilia products. Each DHB will receive all rebates however we are not able to confirm if all the additional costs expected for 2020/21 will be fully covered by additional rebates."*

   Analysis of both the most recent Pharmac forecast (the basis of our rebate recognition) and the NHMG budget show a disconnect between expected gross cost of Recombinant Products but the uncertainty from the above statement makes recognising additional rebate based on this alone a reasonably high risk position to take.

2) Significant increase in Casemix fees paid to pharmacies due to COVID related community pharmacy dispensing rule changes (please refer Appendix 1 for additional information).

   Case mix fees are paid as follows:
   - An **advance** payment calculated based on the actual case mix fees for the month 3 months prior.
   - **Reversal** of the advance payment from 3 months prior.
   - Payment of the interim **actual** case mix fees for the month 3 months prior.

   The **advance** payment is $300k higher than normal and is expected to reverse itself out in three months' time. On this basis we have reduced our accrual by $300k. The sum of the **reversal** for July (based on low April volumes) and the **actual** for July is over $600k, which is higher than expected.

The following table was provided to DHB's by TAS (June) to inform the estimated impact on dispensing fees of the COVID community pharmacy dispensing rule changes.

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Funding DHB	Total of additional dispensing fees (Est)	Estimated spread of additional dispensing fees				
		May-20	Jun-20	Jul-20	Aug-20	Sep-20
Auckland	$ 442,197	$ 50,389	$ 104,919	$ 110,520	$ 116,180	$ 60,190
Bay of Plenty	$ 245,544	$ 28,068	$ 57,413	$ 60,558	$ 65,359	$ 34,146
Canterbury	$ 747,051	$ 86,398	$ 179,633	$ 188,308	$ 193,892	$ 98,819
Capital and Coast	$ 287,371	$ 32,298	$ 67,977	$ 72,702	$ 75,709	$ 38,686
Counties Manukau	$ 450,829	$ 51,589	$ 107,132	$ 113,324	$ 118,282	$ 60,501
Hawkes Bay	$ 223,808	$ 25,892	$ 53,954	$ 56,523	$ 57,950	$ 29,488
Hutt Valley	$ 155,368	$ 17,942	$ 37,102	$ 39,026	$ 40,582	$ 20,716
Lakes	$ 113,249	$ 12,787	$ 26,734	$ 28,536	$ 29,890	$ 15,302
MidCentral	$ 241,705	$ 27,793	$ 58,428	$ 61,114	$ 62,424	$ 31,945
Nelson Marlborough	$ 160,906	$ 18,499	$ 37,985	$ 39,630	$ 42,468	$ 22,324
Northland	$ 207,446	$ 23,539	$ 49,220	$ 52,298	$ 54,503	$ 27,885
South Canterbury	$ 81,061	$ 9,490	$ 19,603	$ 20,211	$ 20,927	$ 10,830
Southern	$ 415,366	$ 47,750	$ 99,070	$ 104,658	$ 108,613	$ 55,275
Tairawhiti	$ 45,984	$ 5,472	$ 11,243	$ 11,407	$ 11,749	$ 6,113
Taranaki	$ 137,630	$ 15,351	$ 32,698	$ 34,640	$ 36,118	$ 18,824
Waikato	$ 503,009	$ 58,011	$ 120,348	$ 125,789	$ 131,156	$ 67,705
Wairarapa	$ 49,756	$ 5,756	$ 11,755	$ 12,264	$ 13,123	$ 6,858
Waitemata	$ 553,710	$ 63,535	$ 132,396	$ 139,241	$ 144,459	$ 74,080
West Coast	$ 35,091	$ 4,115	$ 8,476	$ 8,663	$ 9,069	$ 4,768
Whanganui	$ 91,122	$ 10,303	$ 21,578	$ 22,526	$ 23,983	$ 12,732
Total	**$ 5,188,201**	**$ 594,977**	**$ 1,237,665**	**$ 1,301,938**	**$ 1,356,436**	**$ 697,185**

The increase experienced by SDHB is significantly greater than the amount TAS estimated. It should be noted that this has only become clear over the last 2 months, as we have experienced the extraordinary levels of Casemix (actual) payments in September and October.

2019-7	2019-4	$ 1,428,380	Average pre COVID casemix fee	$ 1,491,116
2019-8	2019-5	$ 1,615,385		
2019-9	2019-6	$ 1,385,563	Average Post COVID casemix fee	$ 1,683,407
2019-10	2019-7	$ 1,580,530		
2019-11	2019-8	$ 1,539,177	Total Increase (5mths)	$ 961,456
2019-12	2019-9	$ 1,471,243		
2020-01	2019-10	$ 1,560,359	Cumulative impact	
2020-02	2019-11	$ 1,473,887	June	$ 240,036
2020-03	2019-12	$ 1,546,774	July	-$ 38,639
2020-04	2020-01	$ 1,457,514	August	$ 34,173
2020-05	2020-02	$ 1,343,465	September	$ 425,420
2020-06	2020-03	$ 1,731,152	October	$ 961,456
2020-07	2020-04	$ 1,212,441		
2020-08	2020-05	$ 1,563,929		
2020-09	2020-06	$ 1,882,364		
2020-10	2020-07	$ 2,027,151		

It must be also be noted that to the best of our knowledge this expenditure is unfunded as the dispensing fees sit outside of the CPB and (all known additional Pharms funding is for the CPB).

3) Significant increase in reimbursement claims being made by pharmacies. The impact of this on this month's financial performance has been amplified, as last month's accrual is now known to be $800k understated. What is driving this increase is not exactly known but the changes to the Pharmac dispensing frequency rules are certainly a contributing factor.

The below graph shows the average daily gross expenditure for the main demand driven Pharmacy PUC's (after adding back co-payment estimate). It shows that for the period July 19- Feb 20, the average cost was between $252k and $264k (steady state) and that COVID has had a major impact on the dispensing costs. Stockpiling in March resulted in expenditure of $310k per day and after an initial

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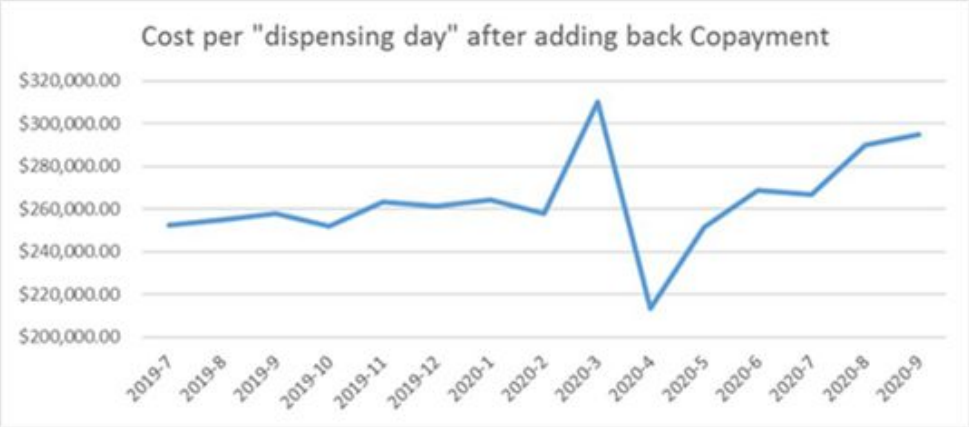
lockdown induced reduction we are seeing a steady increase back up to $295k per dispensing day in September. Further analysis will be completed when the non-cash information becomes available.



Whilst based on the above factors the SDHB Consolidated Pharmaceutical budget (including funder Haemophilia) is now $2.37m unfavourable to budget, we have received $1.69m of additional revenue YTD offsetting some of this unfavourable variance.

Per the comments for discussion section, we are reverting back to the historical calculation for the rebate accrual. The current Pharmac forecast states there is an estimated $2.5m of expenditure for SDHB, where Pharmac are unable to state the timing of the expenditure, and as a default, forecast the expenditure to be incurred in June 2021. We had previously altered the rebate accrual methodology so that there is an offsetting $2.5m of rebate being recognised in June 21. Given the elevated levels of gross cash expenditure it is our assessment that our current approach is now not suitable. Reverting back to the historical calculation has reduced the expenditure variance by $848k and brings the overall unfavourable variance down to ~$689k (after accounting for additional funding).

The next triannual Pharmac forecast is due in November and will provide an important update to DHB's. It is entirely plausible that the next forecast will show a higher level of rebates given the current levels of expenditure being experienced by DHB's.

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Revenue

External Revenue –

Category	Oct Variance	YTD variance	Comment
IBT	$119k f	$225k f	Expenditure offset
Careplus	$4k f	$7k f	Expenditure offset
VLCA U 14's	$5k f	$20kf	Expenditure offset
CSC	$62k f	$185k f	Expenditure offset
Primary integrated MH & Addictions	$257k	$1m	4 months revenue with expense offset
MH Addictions Crisis Support	$8k f	$163k f	Programme development – new contract
Disability contracts	$55k f	215k f	ID FFS beds
Pharmaceutical funding (tranche 1)	$56k f	$225k f	Additional Covid funding
Pharmaceutical funding (tranche 2)	$366k f	$1.46m f	Additional Covid funding
Other	$108k f	$110k f	
Total	**$1.04m f**	**$ 3.61m f**	

Workforce Costs

	YTD Variance - FTE				
Workforce	Community Services	Primary Care & Population Health	Mental Health	Strategy Primary & Community Other	Total
Medical	-0.8	3.0	-0.2	0.7	2.7
Nursing	6.0	-10.3	-20.3	0.0	-24.6
Allied Health	4.0	7.5	-2.6	1.0	9.9
Support	1.4	0.0	-0.0	0.0	1.4
Mgt/Admin	0.6	3.5	-0.3	-2.2	1.7
Total	11.2	3.7	-23.4	-0.5	-8.9

Medical SMO –

- 3.4 FTE favourable YTD.
- Ordinary time and training are the main drivers offset by overtime.

Medical RMO –

- 0.7 FTE unfavourable to budget YTD.
- Ordinary time unfavourable by 1.4 FTE offset by training (0.6 fav) and overtime (0.12 unfav)

Nursing –

- 25 FTE unfavourable YTD. The budget includes -34.95 FTE for MH savings and Vacancy Factor.

- YTD FTE variance mainly driven by Ordinary (8 FTE), Accident leave (9 FTE), sick leave (3FTE) and overtime (4FTE) unfavourable.
- YTD $321k unfavourable variance is mainly due to Ordinary ($148k f), Accident leave ($187k u), overtime ($167k u), back pays ($204k u) and unpaid days accrual ($60k f).
- Skill mix and Annual leave revaluation favourable to budget is contributing to low $ per FTE variance.
- Lakes General Ward registered nurses are 3.0 FTE unfavourable and Health Service Assistants 2.6 FTE unfavourable. Compared to the same period for 19/20, nurses have increased 1.5 FTE and Health Service Assistants 1.25 FTE. Further analysis is required to better understand the overall increase in FTE's in Lakes.

Allied Health –

- 10 FTE favourable YTD. YTD expenditure is $322k favourable.
- YTD FTE variance is mainly driven by Ordinary (14 FTE f) offset by overtime (1.1 FTE u) and sick leave (1.2 FTE u)
- YTD expenditure is $322k favourable and is mainly due to ordinary time ($478k fav) offset by Annual leave accrued ($82k unfav), and overtime ($50k unfav).

Management/Admin –

- 1.7 FTE favourable YTD is mainly driven by other leave (0.85 FTE f) and other leave (1.05 f) and training (1.19 FTE) offset by ordinary (1.61FTE u).
- YTD expenditure is $125k fav and is mainly driven by annual leave accrued ($83k f) and unpaid days accrual ($50k f)

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Clinical Supplies (excluding Pharms)

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Treatment Disposables	275	272	-3	1,172	1,084	-88	3,204
Diagnostic Supplies & Other Clinical Sup	7	6	-1	27	25	-2	74
Instruments & Equipment	74	67	-7	307	269	-38	807
Patient Appliances	167	150	-17	646	573	-73	1,817
Implants & Prostheses	1		-1	3	2	-1	6
Other Clinical & Client Costs	23	29	6	64	115	51	338
Total (excluding pharmaceuticals)	547	524	-23	2,219	2,068	-151	6,246

- Clinical Supplies – Dressings ($73k u), Ostomy ($58k u) and Continence ($41k u) main drivers of the unfavourable YTD variance.

Infrastructure & Non-Clinical Supplies

YTD expenditure $78k favourable with the main variances being:

- Consultants Fees $117k favourable
- Patient meals $75k favourable
- Accommodation & meals $39k unfavourable
- Telecommunications $38k unfavourable

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Provider Payments (NGO's)

Personal Health

- Dental - $235k favourable in YTD - The University of Otago Dental School is significantly behind with invoicing in both Funder and Provider Arm contracts (invoicing going back to 2018/19). Accruals at the end of 19/20 and for October across both arms were very difficult to ascertain, but based on latest information received there are sufficient accruals to cover expected invoices. There may however be some movement of expense between the two arms compared to where the accruals currently sit.
- Primary Health Care Services – Services are $647k unfavourable to budget YTD. The majority of this is due to First Contact services ($383k unfav) and Community Services Card ($156k fav). This extra expenditure is offset by a favourable variance in GMS ($188k YTD) and matching revenue for CSC. First Contact services forecast to become favourable to budget later in 20/21.
- Pharmaceuticals - $0.02m unfavourable for October and $0.04m unfavourable YTD. See previous comments.
- Travel & Accommodation - $193k favourable YTD. Demand driven.
- Immunisation – YTD expenditure $98k fav.
- Palliative care - $99k unfavourable for October due to missed accrual in September. YTD largely on budget.
- Medical Outpatients - $513k unfavourable YTD due to haemophilia national pool expenditure.
- IDF washup estimates are based on source files from SIAPO and then adjusted to reflect unapproved (but budgeted) service changes:
    - Reduction in Cardiology Outflows – CDHB
    - Increase in Neurosurgery Outflows – CDHB
    - Reduction in Neurosurgery Inflows - SCDHB

Mental Health

- Community Residential Beds ($128 k f YTD). Demand driven service.
- Minor mental health ($1.03m u YTD) relates to 4 months of Primary Integrated MH & Addiction contract signed this month. Offset by equivalent revenue.

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Public Health

- The $125k unfavourable variance YTD is due to budgeted savings of $112k that have not been achieved.

Disability Support

- Pay Equity - $44k unfavourable to budget YTD.
- ARRC - $236k for October and $975K unfavourable YTD
    - Unfavourable Hospital level volumes are the most significant contributing factor to unfavourable variance making up $200 of overall variance.
- IDF favourable due to recoding of CDHB ATR events.
- Home Support - $116k unfavourable for October and $105k unfavourable YTD. High level of prior period invoicing for FFS LTSCHC, which exceeded accrual. Expected to be largely one-off.

Maori Health

- No significant variances.

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Expenditure Management Plans – current performance and future actions

Savings category	Savings Target		Variance to budget	Comment
	Annual	YTD		
Pharmaceuticals	1,300k	438k	689 u	YTD savings not achieved
ARRC	1,400k	467k	975k u	YTD savings not achieved
Public Health[2]	331k	110k	371k f	YTD savings **fully** achieved
Mental Health[2]	3,418k	1,144k	378k f	YTD savings **fully** achieved
Total	**6,449k**	**2,159k**	**915k u**	

[2]includes both Funder and Provider

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The below table has been generated based on request from DSAC/CPHAC committees to have additional breakdown of Provider Payments.

Funder services	$000's					
	Strategy Primary & Community as at Oct 20					
	Month			YTD		
	Actual	Budget	variance	Actual	Budget	variance
Personal Health						
Labs	1,467	1,484	17	5,904	5,935	31
Pharms	6,375	6,394	(19)	25,716	25,751	(35)
Primary Care	6,789	6,717	(72)	27,178	26,531	(647)
Dental	1,346	1,404	58	5,479	5,714	235
Travel & Accommodation	441	569	128	1,740	1,933	193
IDF	3,247	3,110	(137)	12,752	12,439	(313)
Internal expenditure	43,368	43,266	(102)	174,260	173,063	(1,197)
Other	4,175	3,967	(208)	14,875	15,912	1,037
Total Personal Health	67,208	66,911	(297)	267,904	267,278	(626)
Change Initiative	0	0	0	0	0	0
Disability Support Services						
Pay Equity	1,594	1,590	(4)	6,358	6,314	(44)
Home & Community Support	2,563	2,447	(116)	9,870	9,765	(105)
Aged Residential Care	8,390	8,154	(236)	33,312	32,337	(975)
Respite	126	113	(13)	519	552	33
Carer Support	76	122	46	529	628	99
IDF	305	389	84	1,496	1,555	59
Internal expenditure	2,547	2,547	0	10,187	10,187	0
Other	518	552	34	2,017	2,210	193
Total Disability Support Services	16,119	15,914	(205)	64,288	63,548	(740)

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Mental Health						
Alcohol & Drugs	468	470	2	1,873	1,885	12
Child & Youth	1,100	1,108	8	4,356	4,431	75
IDF	463	463	0	1,850	1,850	0
Internal expenditure	5,926	5,926	0	23,706	23,706	0
Other	805	530	(275)	2,878	2,117	(761)
Total Mental Health	8,762	8,497	(265)	34,663	33,989	(674)
Public Health	115	84	(31)	461	336	(125)
Maori Health	201	206	5	706	761	55
Total Funder	92,405	91,612	(794)	368,022	365,912	(2,110)

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COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

Terms of Reference

Accountability

The Community and Public Health Advisory Committee (CPHAC) 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 are 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 Māori 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. The Board 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 (DSAC) will be scheduled, however the Committee may determine to hold additional meetings if deemed necessary by the Chair, with or without DSAC, 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.