Community & Public Health Advisory Committee Meeting

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

01/02/2021 01:00 PM - 02:30 PM

APOLOGIES

No apologies had been received at the time of going to print.

FOR NOTING

Item: Interests Registers

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Community and Public Health Advisory Committee, 1 February 2021

Recommendation

That the Committee receive and note the Interests Registers.

Purpose

To disclose and manage interests as per statutory requirements and good practice.

Changes to Interests Registers over the last month:

- Terry King – Nga Kete Matauranga Pounamu Trust Board member

Background

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).

Appendice

- Board and Executive Leadership Team Interests Registers.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Pete Hodgson (Board Chair)	22.12.2020	Trustee, Koputai Lodge Trust (unpaid)	Mental Health Provider	
	22.12.2020	Chair, Callaghan Innovation Board (paid)		
	22.12.2020	Chair, Local Advisory Group, New Dunedin Hospital		
	22.12.2020	Member, Steering Group, New Dunedin Hospital		
	22.12.2020	Board Member, Otago Innovation Ltd		
David Perez (Deputy 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	
	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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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		
	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		
	12.01.2021	Nga Kete Matauranga Pounamu Trust Board Member		
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~~	(Chair role ended 04.12.2020)	
	09.12.2019	Chair, Te Rūnaka Otākou 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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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		
Andrew Connolly (Crown Monitor)	21.01.2020	Employee, Counties Manukau DHB		
	21.01.2020	Deputy Commissioner, Waikato DHB		
	21.01.2020	~~Southern Partnership Group~~	(Role ended December 2020)	
	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	Director Otākou Healther Services Ltd	
	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

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
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	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 Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	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

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
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	~~17.11.2017~~	~~Wife works for key technology supplier CCL~~	~~Nil~~
	18.12.2017	Daughter, medical student at Auckland University.	
	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.
	21.12.2020	Te Whare Tukutuku	Te Whare Tukutuku is sponsored by the NZ Drug Foundation and Te Rau Ora. Programme is designed to increase education and awareness on Maori illicit drug use to primary care and in Maori communities funded by MoH Workforce NZ.
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.

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
	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 Community and Public Health Advisory Committee held on Monday, 7 December 2020, commencing at 1.00 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Tuari Potiki	Chair
	Ms Ilka Beekhuis	Deputy Chair *(by Zoom)*
	Mr Terry King	
	Dr Lyndell Kelly	*(from 1.20 pm)*
	Dr Kim Ma'ia'i	
	Ms Odele Stehlin	
In Attendance:	Dr John Chambers	Board Member
	Mrs Kaye Crowther	Board Member
	Dr Moana Theodore	Board Member
	Dr David Perez	Acting Board Chair
	Miss Lesley Soper	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nigel Millar	Chief Medical Officer *(from 1.35 pm)*
	Dr Nicola Mutch	Executive Director Communications
	Mr Andrew Swanson-Dobbs	Chief Executive Officer, WellSouth Primary Health Network
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME AND KARAKIA

The meeting was opened with a karakia.

The Chair welcomed everyone to the meeting and advised that separate meetings of the Community and Public Health Advisory Committee (CPHAC) and Disability Support Advisory Committee (DSAC) was being trialled, primarily to ensure that justice was done to the work programmes of each committee.

2.0 APOLOGIES

Apologies were received from Mr Andrew Connolly and Mr Roger Jarrold, Crown Monitors.

Apologies for an early departure were received from Ms Beekhuis, who advised she would have to leave at 2.50 pm, and from Dr Perez for a departure at 1.30 pm.

3.0 DECLARATION OF INTERESTS

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

The Chair advised that he was no longer Chair of the New Zealand Drug Foundation.

Members were reminded of their obligation to advise the meeting should any potential conflict arise during discussions.

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 5 October 2020 be approved and adopted as a correct record."

T Potiki/I Beekhuis

5.0 MATTERS ARISING

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

6.0 REVIEW OF ACTION SHEET

The Committees reviewed the action sheet (tab 7) and received the following updates from the Executive Director Strategy, Primary and Community (EDSP&C).

- *Pēhea Tou Kāinga? How is Your Home? Central Otago Housing: The Human Story* – The quantitative report on the status of housing and housing need would be submitted to the Committee when available in the first half of 2021.
- *Strategy, Primary and Community Report* – A new reporting template had been developed, so this action was complete.
- *Invercargill Primary Care Access* – A couple of meetings, led by WellSouth, had been held on this issue. Progress reports would be submitted to the Committee.
- *WellSouth Primary Health Network* – an update on the new Health Improvement Practitioner and Health Coach roles would be covered in the presentation later in the meeting. The smoking cessation improvement dashboard had been completed.

The Chief Māori Health Strategy and Improvement Officer (CHS&IO) reported that the Iwi Governance Committee (IGC) had discussed equity that morning. A paper would be prepared for IGC and a provider perspective incorporated into the February 2021 CPHAC meeting.

7.0 PRESENTATION

The Mental Health Continuum of Care

In introducing the presenters, the EDSP&C advised that the presentation (tab 14) was designed to provide the Committee with a comprehensive overview of the Mental Health system, including perspectives from NGOs, Specialist Services, and Primary Care, to set the scene for a broader discussion on the Mental Health Review.

Mr John MacDonald, Independent Chair of the Mental Health Network Leadership Group, provided an overview of the Southern mental health and addiction system. This included an outline of the Network Leadership Group structure and priorities, which were aimed at achieving one district-wide system, supporting engagement

with the Southern Mental Health and Addiction Review, strengthening local networks, achieving transformation, and the rollout of He Ara Oranga.

Dr Kelly joined the meeting at 1.20 pm.

Mr MacDonald identified the following challenges faced by the MHAID system:

- Delivering services within the Mental Health ringfence;
- Rebalancing the spend across Specialist Services and Primary and Community;
- Achieving equity for Māori and vulnerable groups and those living in rural areas;
- Ensuring the right configuration/location of services to support a contemporary model of care;
- Capacity to respond to increasing acuity and complexity, and increased demand from young people;
- Implementing new models of care.

Mr Rob Willers, Manager of Synergy Wellness, presenting on behalf of NGO providers, gave an outline of the Mental Health and Addiction services provided by NGOs and the challenges they faced. These included:

- Clients with multiple and complex health issues
- Inflexibility of funding
- Service gaps and system inefficiencies
- Obstacles in the consumer journey
- Inequity of resources, and
- Lack of integration.

Mr Willers then outlined opportunities to improve outcomes through:

- Funding flexibility
- Improving accessibility
- Integration and collaboration, and
- Long term investment in NGO services.

The Chief Medical Officer joined the meeting at 1.35 pm.

Ms Louise Travers, General Manager, Mental Health, Addiction and Intellectual Disability, outlined the MHAID specialist services provided by Southern Health and the challenges they faced, which included:

- Patient and staff safety
- Patient flow
- Intoxicated patient presentation
- Physical health
- Rural after-hours crisis service delivery
- Changing profile of child and youth need
- Workforce issues – recruiting, retaining and sustaining, staff development
- The facilities on the Wakari site
- Electronic records – across whole of system required.

Ms Wendy Findlay, Director of Nursing, WellSouth Primary Care Network, then outlined the new way of supporting mental health and wellbeing in primary care. This included the introduction of:

- Health Improvement Practitioners (HIPS) – registered health professionals who could make recommendations to GPs about referral pathways;
- Health Coaches – to support people to take steps towards improving their health and wellbeing. They come from a range of health and wellbeing backgrounds;

- Community Support Workers – to support patients to connect with the wider community.

Ms Findlay then outlined:

- The governance structure for this work, which included those NGOs involved in the service delivery programme and others who would become involved as more roles became available;
- The Brief Intervention Mental Health Service and other Mental Health services provided by WellSouth.

Following their presentations, Mr MacDonald, Mr Willers, Ms Travers, and Ms Findlay responded to members' questions.

At 2.00 pm Ms Karen Browne, Chair of the Community Health Council, and Ms Gail Thomson, Executive Director Quality and Clinical Governance Solutions (EDQ&CGS), joined the meeting.

8.0 UPDATE ON THE MENTAL HEALTH REVIEW

The terms of reference for an independent review of the Southern Mental Health and Addiction System Continuum of Care were circulated with the agenda (tab 9).

Dr Clive Bensemann, Review Steering Group Chair, joined the meeting and spoke on his role, membership of the Steering Group, and his early thoughts on the review, during which he reported that:

- The intent of the Steering Group was to get a cross-sector and relatively independent view;
- The review would be carried out by an outside provider and a procurement process was under way for that;
- The first stage would be focused on stakeholder engagement, looking at data and coming up with high level recommendations;
- The second stage would be focused on implementation of the strategy;
- The process conducted by the external provider would take about six months.

Dr Bensemann advised that there were great opportunities to improve integration and address inequity but a change of this size, as he understood the aspirations of the review, would be challenging.

Mr Willers left the meeting at 2.10 pm.

Dr Bensemann and management then responded to members' questions on the review and the challenges faced by Mental Health services.

In thanking Dr Bensemann and the other presenters, the Chair advised that it was comforting to hear them talk about innovation and the scope of the review. On behalf of the Committee, he encouraged the review group to be as broad as they needed to be.

Dr Bensemann, Mr Macdonald, Ms Travers, and Ms Findlay left the meeting at 2.20 pm.

9.0 COMMUNITY HEALTH COUNCIL ANNUAL REPORT 2019/20

Ms Karen Brown, Chair of the Community Health Council (CHC), thanked Southern DHB and WellSouth for their continuing support and presented the Community Health Council's Annual Report for 2019/20, which included an overview of the achievements of the CHC and its learnings to date (tab 10).

Ms Brown then responded to questions.

The Community Health Council's support and contribution to the organisation was acknowledged by the Committee and management as exceptional.

Mrs Browne was thanked for her attendance and left the meeting at 2.30 pm.

10.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

The Strategy, Primary and Community Report (tab 11) was taken as read and the EDSP&C highlighted the following items.

- *Mental Health Review* – Dr Bensemann was currently undertaking orientation prior to the commencement of the review.
- *Population* Health - Focus was being placed on the MMR programme to increase uptake.
- *COVID-19* – Public Health and the PHO had responded admirably to preparing for any incursion of COVID-19 during the holiday break.
- *Resignation of General Manager Primary Care and Population Health* – Mary Cleary-Lyons was leaving the organisation, which would leave a significant gap in the team.
- *Primary Maternity Strategy* – The next step was to undertake engagement with Lead Maternity Carers (LMCs) and broader stakeholders around the operating model. A request for proposal (RfP) had been issued for an NGO or trust to partner on the delivery of that system.
- *Service Planning and Budgeting Processes* – An intensive series of pre-engagement sessions had been held with directorates.
- *Health Hubs* - The tender for health hub establishment was closing at the end of the day.

Management then answered questions on preparations for COVID-19 vaccination, oral health and fluoridation, rural radiology, the vacant Southland based MHAID Kaumatua position, and tobacco control.

The Committee requested:

- A paper on fluoridation and the options open to Southern DHB to improve coverage across the district;
- A presentation from Public Health on their business as usual;
- An update on the review of rural radiology services.

11.0 FINANCIAL REPORT

The EDSP&C presented the Strategy, Primary and Community (SP&C) financial results for October 2020 (tab 12) and outlined the contributing factors to the unfavourable variance.

The meeting closed at 2.50 pm.

Confirmed as a true and correct record:

Chair: _____

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 21 January 2021

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 are meeting with Central Otago District Council staff in February to discuss progress on the quantitative report and potential next steps.	April 2021
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.	Complete
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	The PHO will provide an update at the meeting	Complete
October 2020	**B4 School Checks Programme** (Action Sheet 7.0)	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	Update below – a more comprehensive update will be provided to the April meeting because we are awaiting feedback from the Ministry on our January report, as below. **Before school checks:** December 2020 Total target exceeded 423 checks ahead – 54.6% of target High Dep exceeded 21 ahead – 48.1% of target	April 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				Māori exceeded 24 ahead – 45.5% of target Pacific exceeded 7 ahead – 46.3% of target Healthy Weight Target - 95% met 6 monthly target – we are at 96% Māori 6 months we are at 94% not met however at 3 months we have met 96% target and back on track to recovery Pacific Island 6 months – 100% Currently awaiting January 2021 report from the Ministry of Health. Anticipated that January 2021 will be under target volume due to staff holidays and school holidays which normally impact this time of year. This is a normal seasonal variation.	
October 2020	**Oral Health** (Minutes item 15.0)	▪ A report is to be provided on District Oral Health Services following concerns raised around a perceived gap in service in Dunedin.	EDSP&C	The total enrolled in Community Oral Health Services within Otago and surrounding districts is 28,869 children. Arrears pre-COVID, and arrears created by the cessation of Dental work over the COVID 19 lockdown has compounded. Plans to address arrears include: • Rescheduling the mobile bus service along with the associated work force to areas of high arrears.	April 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				• Training up the Dental Assistant workforce to apply fluoride varnish to reduce the onset of dental decay. • Development of criteria for appropriately identified children who can safely move from 12month recalls to 18mths. • Placement of a new chair in the South Dunedin Clinic taking it from a three to four chair clinic. • Review of the Oral Health service workforce and resource allocation and funding placement. Further work is occurring to develop these plans for the next CPHAC meeting.	
December 2020	**Oral Health – Fluoridation** (Minutes item 9.0)	Paper to be submitted to Committee on fluoridation and options to improve coverage.	EDSP&C/ Deputy CMO	A presentation is being developed for the April Meeting	April 2021
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. Paper to be submitted to the Iwi Governance Committee.	1 Feb 2021
December 2020	**Public Health** (Minutes item 9.0)	Presentation to be made on Public Health BAU.	EDSP&C	A presentation is being developed for the April Meeting	April 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
December 2020	**Rural Radiology** (Minute item 9.0)	Update to be provided on the review of rural radiology services.	EDSP&C	Paper added to agenda for February 2021	Completed

FOR INFORMATION

Item: Maori PHO Enrolment within the Southern District

Proposed by: Lisa Gestro

Meeting of: CPHAC – 1 February 2021

Recommendation

That CPHAC notes the current level of PHO enrolment for SDHB's Maori population. That CPHAC accept that PHO enrolment as an indicator of positive engagement with primary care and the positive health outcomes associated with consumer access to primary care.

That CPHAC note the limitation related to reporting enrolments as a percentage of the total population, being that while enrolment data (the numerator) is based on actual enrolments, the estimated total populations (the denominator) are indeed that – "estimates". Consequently, Southern PHO enrolment could be at 100% of the population, but the estimated population size may be much greater than the actual population (see Discussion and Appendices below. Data sourced from – Ministry of Health: Enrolment in a primary health organisation.)

Purpose

1. To provide CPHAC with data to inform a discussion about PHO Maori enrolment in our district.

Specific Implications for Consideration

2. Financial

    - By reducing the unenrolled population, the required provision and cost of hospital services may decrease as a result of more timely and appropriate access to Primary Care.

3. Quality and Patient Safety

    - The overall quality of care is significantly increased by primary care access, as the patient experiences the dignity of receiving care when required and in the appropriate setting. In contrast, a patient who does not have access to primary care can become adrift and marginalised from the Southern Health System and thus suffer from preventable, yet chronic health conditions. Further, PHO enrolment reduces patient risk by the provision of care that is typically less complex than hospital-based (ED, secondary, tertiary) care, which may become necessary as a result of health issues not addressed in a timely manner within a primary care setting.

4. Operational Efficiency

    - Healthcare is notoriously complex. To eliminate unnecessary complexities and optimise efficiency, ensuring timely care in the most appropriate setting is fundamental to the overall system's efficiency. Indeed, one population's inability to access primary care has spill-over implications across an entire health system.

5. Workforce

    - It can be demoralising for hospital healthcare staff when treating patients whom they know are suffering from health issues that should have been addressed in primary care. In essence, they cynically become the ambulance at the bottom of the cliff.

- Further, primary care staff experience the tension of knowing that members of their community are not receiving the care they are working to actually provide. This can be especially poignant for primary care workers within rural communities; and, indeed, there are significant populations of Maori consumers living within SDHB's rural areas.

6. Equity

- Equity of access to primary care across any and all populations is arguably the bedrock for delivering healthcare that is inclusive and without bias.

7. Other

- Nil.

Background

8. This paper follows previous discussion at CPHAC on rates of Primary care engagement, and of improving Maori health gain.

Discussion

9. Southern DHB currently has the lowest percentage (79%) across all DHBs (National Avg = 85%) of Maori enrolment into a PHO. See Appendix 1 below. There are currently ~8K Maori consumers (total pop = 38,190) within the Southern District who are not enrolled for access to primary care.

10. The national average for PHO enrolment is 94% for the total population. Southern DHB's total population average is 92%. So while Southern's total population is below the national average, its Maori population is more significantly below the relevant national average (-6%). See Appendix 2 below.

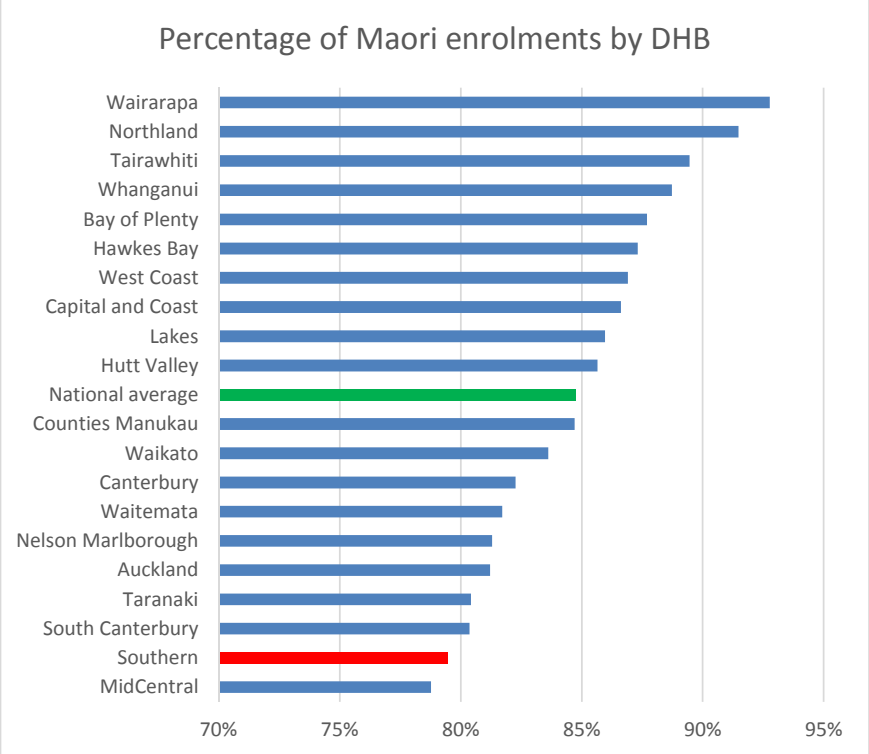
11. The DHB will continue to work with Wellsouth Primary Health Network and the IGC to determine what further actions can be taken in terms of engaging the non enrolled Māori population.

Next Steps & Actions

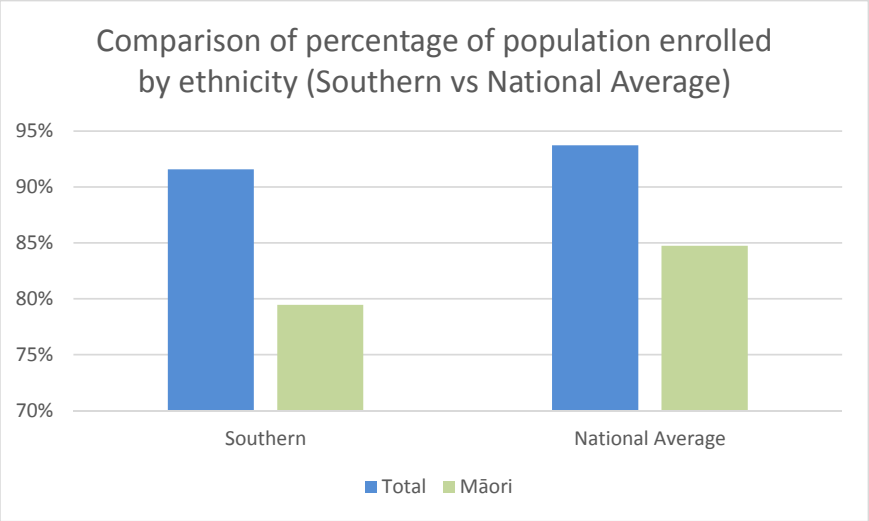
To be discussed and agreed.

Appendices – see page three below.

Appendix 1



Appendix 2



FOR INFORMATION

Item: Strategy, Primary & Community Report

Proposed by: Lisa Gestro, Executive Director Strategy, Primary & Community

Meeting of: Community and Public Health Advisory Committee, 1 February 2021

Recommendation

1. That the Community & Public Health Advisory Committee notes the attached report.

Purpose

2. The purpose of this report is to provide CPHAC with an overview of the range and breadth of activity that has been delivered or is underway, with a focus on operational performance and key strategic deliverables as per the work programme of the Strategy, Primary and Community Directorate.

Specific Implications For Consideration

3. Financial

   - Where these exist, any financial implications are specifically outlined in the body of the report. Please note that the Directorates finance report is contained in a separate report and this focuses more on the qualitative presentation of activity, updates and issues.

4. Quality and Patient Safety

   - Where these exist, any Quality and/or Patient safety implications are specifically outlined in the body of the report.

5. Operational Efficiency

   - Where these exist, and operational efficiency implications are specifically outlined in the body of the report.

6. Workforce

   Where these exist, any workforce implications are specifically outlined in the body of the report.

7. Equity

   - Where these exist, any equity implications are specifically outlined in the body of the report.

8. Other
   - Where these exist, any other implications are specifically outlined in the body of the report.

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

Significant planning occurred to ensure that we had adequate capacity and systems in place to support a Covid response should this be required over the Christmas/New Year break. This involved having a larger team of staff working and on-call over this period than normal, working with WellSouth to ensure access to testing was available across the district, and supporting event organisers and stakeholders with information. A plan was also put in place across the South Island Public Health Units to provide support for each other over this time should this be needed.

A table-top exercise was held on 16 December to work through a range of different Covid19 scenarios for the Rhythm and Alps event held at Cardrona from 29 Dec to 1 Jan 2021. This exercise included a range of agencies including representatives from Rhythm and Alps, Police, St Johns, Fire and Emergency NZ, Civil Defence, Queenstown Lakes District Council staff, WellSouth, Southern Community Laboratories, and primary and secondary care. The exercise provided a face-to-face opportunity for agencies to network and have robust discussions on who would be responsible for various activities and where resource would come from if there was a Covid case/outbreak at the event. This was a success with a lot of collaborative work occurring to ensure that all parties are prepared for such an event.

The maritime border continues to take up a large portion of the work in the Covid19 space as the increased testing and processes involved are often time consuming. Planning work is underway about what opening the borders to Australia could look like. This will involve a health presence at the border with likely entry and exit screening. Plans have been developed with Queenstown Airport around the logistics of this activity and additional staffing will be required when this commences.

We continue to build relationships with Māori Health providers across the district. A number of hui have now been held which have provided an opportunity for us to engage with each other and kōrero about our plans going forward. It also encouraged the providers to share with us what they experienced during the first wave, what plans they put in place, and any changes they have made from their past experiences. We were then able to look at ways we can support each other going forward if we were to get a positive Covid case in our Māori community.

Swabbing

Covid-10 Swabbing up to 31 December 2020.

There have been 4,464 swabs undertaken through this period including 328 at the maritime ports.

- 4,332 Simple assessments
- 104 Virtual assessments
- 1 Full assessment
- 27 No assessment undertaken

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 fact that reduced levels of funding 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)

Late December the Ministry of Health released the *New Zealand Aotearoa Aged Residential Care Pandemic Response Policy*. We will align the Southern DHB *Aged Residential Care COVID-19 Emergency Response Operations Manual* developed in 2020 this Policy. A desktop exercise to test the Response is planned for 27 January 2021.

Psychosocial Recovery

Work is continuing. Trust funding has been confirmed for the role of a Mental Wellbeing Navigator role. This role will be community focussed on establishing connections and information to support mental wellbeing within different communities. Alongside these relationships have been established across sectors including government (MOE, MSD), NGOs and Primary Health care providers.

DHB-Led Improvement Sustainability Funding

The DHB submitted a project proposal for 'the development of Tier One clinical partnerships to facilitate changed models of care' to the Ministry of Health for DHB-Led Improvement Sustainability Funding in November. Approval for the project was received on 21 December 2020, with $714,500 available via CFA Variation.

The aim of this project is to develop connected and responsive clinical partnerships from across the interlocking parts of the system to better meet the targeted health needs of our diverse population. We recognise that a key lever for Southern is to bring clinical teams together and enable a conversation to create system-wide collaboration in affecting sustainable change. The process is complex and adaptive, there is no single silver bullet.

This project will support and enable the current work around frail elderly, primary maternity, acute care and high needs, and will align with the Tier One approach to services outlined in the Health and Disability Review.

A Steering Group is being formed and project resource is being recruited.

Other Emerging Issues

Rural Health Projects

A Project Manager has been appointed. Prioritisation of projects across all the rural hospitals and Southern DHB will occur once the successful candidate has commenced their role.

A proposal to enable Rural Trust Hospitals to partner with Southern DHB to provide Radiology services has resulted in Clutha Health First and Gore Health Ltd planning to move away from Pacific Radiology as the provider of services and to bring them in-house. They are working with Southern DHB Radiology Department to plan for this change. The details of Information Technology (IT) support (PMS, PACS and RIS / Karisma), the reading and reporting of films (I-Telirad), contracting requirements, licensing of the services, radiographer employment options, physicist support, professional support and the details of equipment required are under discussion.

Waitaki District Health Care Services Ltd (WDHSL) and Central Otago Health Care Services Ltd (COHSL) plan to partner with Southern DHB in using I-Telerad to read and report their films in the future. Maniototo Health Services Ltd (MHSL) contract Radiology services from COHSL. This will not change.

Rural Hospital Capacity

In December there were several occasions when demand exceeded capacity, particularly in the Central Lakes region. Dunstan Hospital has routine capacity for 24 beds, but regularly reached 30+ inpatients. All strategies to manage the patient flow were utilised, but the demand continued. On several occasions patients from across Central Otago were diverted to Lakes District Hospital (LDH), but with only 10 inpatient beds and a busy service impacted by an influx of visitors during school holidays, LDH was able to be of only limited support. Gore was also significantly over capacity at times during the break, with Clutha Health First the only rural with any real capacity to speak of. This enabled the transition of some patients from both the two base hospitals as well as from Dunstan on several occasions over the holiday period.

Surge plans were developed, in conjunction with Southern DHB, that involved assessing capacity in other Rural hospitals and diverting stable patients to these areas so acute demand could still be managed locally. Whilst this is sensible, the logistics can be challenging, especially for hospitals over an hour from a base hospital or from each other.

Wanaka Hub Development

The challenge with providing after-hours primary care in Wanaka has provided an opportunity to explore ways Southern DHB and different Non-Government Organisations (NGOs) work together. Initial meetings have been held with key stakeholders to further scope out these opportunities, which will be explored alongside the refresh of the broader Southern Health strategy and in conjunction with the Central Lakes Locality Network to help paint a clearer picture for what integrated service provision for the Upper Clutha population.

Primary Maternity Facilities

The first two of four workshops, run by an independent facilitator, with midwives from Central Otago and Wanaka were held in December. The workshops were well attended and the DHB project team has undertaken to now further develop the design principles and ways of working that were co-created during the workshops ahead of the next workshops scheduled for February 10 & 11. These workshops aim to agree a high-level model of care for the proposed new primary maternity facilities and to give the DHB assurance that there is a workforce committed to staffing the units. It is anticipated that we will have a view in February 2021 if this can be achieved.

A business case for the associated capital spend cannot be progressed until there is confirmation of a two-unit plan. If this is not confirmed, a paper will be prepared for the March Board meeting asking them to consider the one unit options for progression to the Business case stage. The Project Manager is meeting with the Ministry of Health representative to discuss the Business Case development process in mid-January.

An Expression of Interest process seeking a service provider for the new unit(s) was released on GETS (Government Electronic Tender Service) in December and closed on 11 January 2021. With the support of the procurement team, the next stage is to progress to an RFP (Request for Proposals) process. The timing of this process will be aligned with the outcome of the workshops and a final single or two unit decision taken by the Board.

STRATEGY AND PLANNING

Annual Plan 20/21

The Ministry of Health has released 2021/22 Annual Plan and Planning Priorities Guidance, available on the nationwide service framework library website 2021/22 Planning Package | Nationwide Service Framework Library (health.govt.nz) There is no Regional Service Plan guidance this year, however the regional service plan will still underpin each DHB's annual plan..

For 2021/22 the Government's planning priority areas have been retained, however the focus of the guidance has been shifted away from business as usual. In the Annual Plans, DHBs will be expected to identify their most significant innovative activities that will improve equity and to embed key COVID-19 learnings across the Government's planning priorities. It is expected that these changes will significantly streamline both the Annual Plans and the planning processes.

Annual Plan templates have now been included on SharePoint through a number of links that are correlated with relevant sections. Completed templates are requested by 26 February, there will not be adequate time for ELT and the Board to review prior to 5 March so it will need to be submitted as very draft with no endorsement. ELT members have been asked to share Ministry of Health Annual Plan guidance through their networks (ALT, IGC, Clinical Council, Community Health Council).

Expectations on developing the actions within the templates:

- Address all requirements as instructed in the background information for each template
- Activities need to be SMART: specific, measurable, achievable, realistic and time bound
- Include one action and milestone per row on each template

Achieving Health Equity in DHB Annual Plans

The Ministry expects that achieving equity in health and wellness is a focus for all DHBs. DHBs are expected to apply an evidenced based equity lens as the plans are developed and to actively prioritise resources to achieving equity across their population groups. DHBs are expected to include evidenced-based equity actions focused on their Māori populations within each identified planning priority. Southern DHB's Iwi Governance Committee is currently developing a list of priorities for 21/22 – these will be sent to ELT and General Managers in mid- January.

In addition, there is also an expectation that where appropriate DHBs will include actions focused on disabled people in their population.

Service Planning

Weekly "equity and planning process" discussions will commence from 21st January 2021. The intention is to provide regular opportunities to align the Maori Health Action Plan and service plans so that everyone is pulling in the same direction. This requires back and forth exchange to ensure that the goals are well understood, that there is strong alignment between strategy and actions and that the performance indicators are meaningful and relevant. Staff will be able to request "discussion time" and/or will be invited to a discussion.

The combined team from Finance and Planning will continue to meet on a weekly basis. The benefits from this combined meeting are becoming apparent in the service planning process, as evidenced by the Medicine Women's and Children Directorate's approach on their Planning Day where budget prioritisation and service planning were debated together.

Other Directorates are also reviewing and updating their service plans. As in previous years, the Surgery and Radiology Directorate, and the Mental Health, Addictions and Intellectual Disability Directorate will update their comprehensive directorate plans for the 21/22 year.

The Service Plan template was updated for 20/21 year; no changes have been made for 21/22 year.

Operational Updates

Mental Health Addiction and Intellectual Disability (MHAID)

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

Southern DHB continues to progress the Independent Review of the Southern Mental Health and Addiction System Continuum of Care. Following approval of the Terms of Reference a Procurement Process commenced and a successful party to undertake the review has been confirmed as Synergia.

A Steering Group has been established, as per the terms of reference to oversee the review. This group is independently chaired by Dr Clive Bensemann and participated in the selection of the organisation to undertake the review. The Steering Group will link closely with Synergia throughout the review process. Dr Bensemann visited the Southern area in December to orientate to the Southern Mental Health and Addiction System.

The review will commence in January 2020 and we expect a draft report mid year.

Supported Accommodation Pressures

Following on from the meeting held in late November several potential solutions have been generated which may help to ease the issue of availability of supported accommodation. These potential solutions include a proposal to increase staffing at a PACT facility (North Road) to provide for 24-hour staffing (as opposed to the current daytime operating hours) and consideration of removal of funding silos at St Clair Park residential between HOP services and Mental Health and Addiction services to free up capacity for supported accommodation for mental health patients. These solutions will be the subject of further discussion in January.

Specialist Services Overview

The specialist services have continued to experience high demand and acuity although this has tapered off in the inpatient areas over recent weeks. All inpatient areas continue to report some ongoing acuity however and vacancies and other absences (e.g. staff on WRACC), and consequence demand for overtime, remains an issue. Beds remain capped at 9 on Ward 10A. Child and Youth Services remain as pressure point, particularly in the Central-Lakes rural District and a plan to manage service demand while recruitment continues is in place. SAS continues to manage high OST caseloads, but these are slowly reducing with controls in place and staff anxiety about their workload has reduced accordingly. Other service areas are relatively quiet with a number of staff taking leave over the Christmas period.

Mental Health - Ward 10A

Ward 10A continues to experience high acuity at times although this has reduced in the last couple of weeks. Vacancies remain an issue, but the situation is improving. Bed numbers remain capped at nine and this continues to be reviewed regularly.

Central Lakes – Child and Youth services

Recruitment and retention remain an issue with the Central Lakes child and youth service. The Queenstown component of the team has seen a complete change in personnel over recent months and one position remains unfilled with the incumbent finishing on Christmas Eve. This has been re-advertised following the withdrawal of the successful candidate. A comprehensive plan is in place

to support remaining staff and ensure continuity of service delivery while recruitment continues while the team is re-established.

Specialist Addiction Services (SAS)

Opioid Substitution Treatment (OST) remain high with steady progress in addressing this. There are currently 427 people as at end of November 2020 (December figures not yet available). The controls around managing the caseload has considerably eased staff anxiety.

Senior Medical Officer (SMO)

Recruitment is ongoing for the Southland vacancies. A long-term locum has been secured for March to December for the CAFS psychiatrist role.

The Otago (Adult) services has a number of part vacancies (0.2 FTE Oamaru, 0.2 FTE North CMHT, 0.3 FTE back fill for the current Clinical Leader). In addition there is a 0.5 FTE gap with the South CMHT bought about by long term unplanned sick leave. There is clinical risk in all these areas as a consequence of these part vacancies which the service works to mitigate on an ongoing basis.

Clinician Only caseloads

This project has confirmed a way to manage all new referrals into the service and ceasing the ongoing practice of allocating a single clinician model with there being certain exceptions with the criteria for this currently being developed. Once this is completed it will be trialled and if successful the second phase will involve a structured plan to gradually reduce current single clinician caseloads.

Zero Seclusion project

The use of seclusion continues to occur in our services continues to occur despite the considerable effort by our clinical teams over a number of years. Though the target period was initially identified as 2020 this work will continue. The failure to achieve Zero Seclusion was the subject of a media article over the holiday period.

Adult Community Forensic Step Down

Following on from the receipt of a revenue contract from MoH for the establishment of an adult community forensic step down earlier this year we recently issued an RFP to the market for proposals. The RFP closed on 18th December and one proposal was received.

An internal DHB evaluation panel has been established and will meet in early January 2021 to assess the proposal against the service criteria specified in the RFP document. The objective is to have a local service commissioned by the end of the first quarter of the calendar year.

Mental Health Crises Support for Emergency Departments

The recently appointed 0.7 FTE MHAID Educator based in the ED environments has spent the last three weeks orientating to this new position which has also involved meeting the clinical and non clinical staff of the two main ED departments (Dunedin and Invercargill) with a plan to extend this to Lakes Hospital in February. While orientating there has been a focus on scoping out what Mental Health training is already available in the ED areas and where the gaps are which will inform our plan for the 2021 year. The informal feedback indicates the ED areas have been very welcoming of this new service and are engaging positively with this new role.

A procurement process is underway to secure a contractor to assist with the development of the crisis capability plan which the Ministry of Health have provided funding for.

Public Health Service

Drinking Water

Several non-compliances for drinking water supplies were identified across the district. Drinking Water Assessors have been contacting the suppliers to get feedback on how they are planning to rectify these and the timeframes for doing this work. This will then be escalated to the designated officers as needed. The designated officers are working across the South Island on the best ways to address non-compliances that have been ongoing for a while and have continued to not be addressed.

Staff provided an analysis of evidence in support of fluoridation of water supplies that the Medical Officer of Health presented to the Clutha District Council who were facing cost issues over a need to change the dosing arrangements for adding fluoride to the Milton, Kaitangata, Balclutha, and Tapanui water supplies. The evidence was sufficient to support the additional costs to continue to fluoridate these supplies that in turn will protect the oral health of the population living in those communities.

Over recent years Public Health has advocated with Queenstown Lakes District Council for a reticulated water supply in the Cardona Area. This area has a number of small supplies that have had a number of outbreaks over the years. Through Public Health working with the council, the councillors unanimously agreed to start the process of establishing a community wide drinking water supply for this township.

Alcohol Harm Reduction

In response to findings that one in five New Zealander's reported drinking more alcohol than usual during Covid lockdown and the already high prevalence of hazardous drinking in the Southern district, the Dunedin Alcohol Harm Reduction Group (led and coordinated by Public Health staff) received funding to develop an alcohol-related harm reduction campaign focused in Dunedin. The project, 'Pour Choices Add Up', led by Southern DHB and the Cancer Society's Otago Southland Division, was aimed at increasing community awareness of the association between alcohol and cancer and illustrating what standard drinks are so that they are better informed to make decisions about their own alcohol consumption and what they pour for their family and friends.

Last week the report on the 'Pour Choices Add Up' campaign was completed and provided to the campaign funder Te Hiringa Hauora (Health Promotion Agency). The evaluation found that over half of those who saw the campaign either considered reducing how much alcohol they pour into vessels or actually made a reduction. Over half also either considered reducing how much alcohol they consume in general or actually made a reduction. Significantly more of the respondents who had seen the campaign correctly identified that alcohol does cause cancer and that it is linked to seven types than those who hadn't. Two-thirds of respondents who had seen the campaign had learnt what a standard drink is.

Healthy Food and Drink Policy Audit

Staff have been working to complete the annual monitoring of DHB-site cafés, following the implementation of the National Healthy Food and Drink Policy in 2016. This policy contributes to reducing the incidence of obesity in New Zealand and promotes healthy food and drink environments to external organisations.

The policy guidelines suggest that cafés should contain at least 55% green category items, which represents a healthy food and drink environment. To date one of the Dunedin cafes is the only café that contains more than the recommended green proportion (57%), with the others containing far more amber or red category items. Amber items are foods that are okay when eaten in moderation and should make up less than 45% of choices available. Red items are unhealthy foods and should not be sold. They are typically high in sugar, salt, fat or are large portion sizes, or the drinks are sweetened with sugar or carbonated.

In our reports we commend the cafés for their efforts in making changes so far and suggest simple changes to their food and drink environment to better meet the policy recommendations. Recommendations have included:

- Removing red category items completely or substituting them for other green or amber items.
- Displaying more green category items than amber (and no red) so the balance is predominantly green.
- Where able, substituting white varieties of pasta and rice for wholemeal/brown varieties.
- Ensuring there are always vegetarian protein options on offer.
- Introducing a formal customer feedback process/work with Communications if still experiencing complaints.
- Ensuring there are green items only at the point-of-sale (e.g., fruit bowls or water bottles).

Public Health South anticipates that the cafés will take our suggestions on board and make appropriate changes to ensure they continue to meet policy requirements. By adhering to the policy, the cafés are role-modelling healthy food and drink environments to the community. By next year's monitoring, we hope to see fewer red and amber category items and over 55% green category items in all cafés within the DHB.

Having this DHB-wide policy could lead to external workplaces/agencies adopting their own healthy food and drink policy. This is especially crucial in physical activity spaces (e.g., Council swimming pools). Public Health South are committed to helping create healthier food and drink environments for external organisations and will continue to seek opportunities to do so.

Violence Intervention Programme (VIP)

VIP continues to contribute to the Whangaia Ngā Pā Harakeke process in Dunedin and Invercargill. The Whāngaia Ngā Pā Harakeke model is an interagency response to family harm episodes to which the police are called out. Information may be shared regarding the victim, perpetrator and children involved. VIP has had representation at Dunedin Safety Assessment meetings since August and latterly in Southland. Processes include sharing of relevant DHB held health information to the Whāngaia process. When sharing of relevant high-risk information to DHB staff via phone or email communication and documentation, the format of the sharing is as follows:

- A brief synopsis of the information.
- Health plan (for example ensure Family Violence screen).
- Information about the lead agency who is following up with the family (in case staff require further information).

The Mental Health directorate has advertised for a position for the Dunedin site within the Whangaia process. Discussion continues about how to best manage this for optimal outcomes. Southland has input from Mental Health and the VIP staff there are working together to ensure that this occurs to maximise optimal outcomes.

A 0.5 FTE Team Leader has been appointed to the team.

Refugee Health

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

New quota refugee arrivals remain on hold while the global pandemic, Covid19, is being managed. There currently are 1,600 refugees awaiting resettlement in New Zealand. In the interim, a limited number of refugees are resettling into the Southern DHB region as emergency cases. In December there were resettlements of six emergency cases from Afghanistan. These cases completed the mandatory 14 days isolation.

The Mangere Refugee Resettlement Centre has undergone a name change, the new name is Te Ahuru Mowai O Aotearoa – meaning a safe haven and a calm, safe home.

A cross-government working group led by Immigration New Zealand (INZ) is preparing for the potential resumption of the quota refugee programme in 2021. This will be in line with Covid19 protocols, including smaller intakes and staggered arrivals to allow for 14-day managed isolation stays before transferred to Te Āhuru Mōwai O Aotearoa. It is expected that once global Covid19 impacts have declined, the wider quota programme will resume, and health arrangements (for up to 1,500 refugees) will be in place.

Ministry of Business, Innovation and Employment (MBIE) Language Assistance Services Project

In November, MBIE released a request for proposals (RFP) for Face-to-Face Interpreting. Currently, Southern DHB runs its own in-house interpreter service that supports over 50 languages and contracts with 191 interpreters. Interpreters are provided for any healthcare appointment within Dunedin and Invercargill. This includes non-DHB appointments, such as GP appointments. The Programme Lead is drafting a paper to be presented in the January Executive meeting.

Primary Care and Long-Term Conditions

Development of our Integrated Diabetes Response

The Ministry of Health (MoH) has formally responded to our recent Living Well with Diabetes-self-assessment. The MoH recommendations relate to Type 1 follow up delays, and access issues for high-risk Type 2 patients with diabetes.

A number of actions have been undertaken and implemented through 2019-2020 to address the gaps identified in our Diabetes services. They Include;

- The implementation of a new Multi-Disciplinary Team in Southland for the care of people with Diabetes
- A new health pathway for the diabetic foot into a single point of entry for all high risk and active disease of the foot.
- Coordination of all funded Podiatry services supporting the new health pathway for the diabetic foot
- Virtual clinics established between Dunedin and Invercargill Multi Disciplinary Team services.
- The re-establishment of a full Local Diabetes Team (LDT)
- A review of all standards has begun at the LDT
- A move to better understand the data around diabetes with a view to re-establish a virtual diabetes register.

Next steps are:

- Dunedin moves to a nurse led clinic model, similar to the successful nurse led service in Invercargill. With Senior Medical Officer (SMO) cover as required.
- A new SMO 0.5 FTE has been recruited in Invercargill and will start in June 2021.

Population Health

Measles Catch Up Campaign

The local communications campaign commenced as planned on 6 December 2020. The local campaign webpage went live on Southern Health, along with a secure form for uploaded historic immunisation records. Local influencers were identified, and nine (including one group) champions participating in promotional videos and photos for the social media campaign. The 12 videos produced will be used on Youtube as targeted advertisements to all 15-30 year olds in the Southern district over the summer.

As of 1s December 2020, we have 20 participating pharmacies across Southern, a Geomap of which pharmacies are participating has been set up on the website. Local radio advertisement will run from 18 December 2020 through to 1 February 2021 on 'The Edge'.

WellSouth completed data analysis, which identified that 55,324 of the current 73,254 projected eligible 15-30 year olds in Southern are enrolled in primary care. Of the 17,930 non enrolled target population 15,490 of these are based in Dunedin, and therefore likely to be the tertiary student population. Phase 3 of the Southern campaign will see targeted vaccination clinics in tertiary institutes commencing in February 2021.

The implementation plan has been converted to a plan on a page.

Public Health Nurses

Staff have spent the month focusing on meeting program targets. Public Health Nurses completed final consultations with schools and preschools, closing off clinical files, following through with coordinated care and referrals for children and young people while ensuring whānau were well supported during the festive season.

Noted that many children, young people and their whānau are still recovering from post Covid19 effects delays in healthcare and additional stress and anxiety. There has been good collegiality across the district with staff stepping up, working extra hours, travelling to cover workloads in different areas in order to catch up with delayed programs during Covid19 specifically in regard to Human Papillomavirus Vaccination (HPV 2) school based vaccination rescheduled program, Year 9 assessments and Before (B4) School Checks.

Gateway

December has been busy with Gateway and the number of referrals has increased. Two large rural clinics were undertaken in Central Otago where 10 children were seen. Gateway appointments continued then going into recess until the end of January.

Sexual Health

Model of Care review continues. Southern DHB Syphilis Action plan to be completed. The National syphilis in pregnancy guidelines are to be localised for Southern. Work continues to progress to electronic records via Med-tech Evolution.

Dunedin Campus has commenced opportunist HPV vaccinations.

District Oral Health Service

In-Service planning with the wider Oral Health staff has been undertaken this month, there is a significant focus on the recall arrears by the staff across the district and potential options to address them. An option favoured by all is a review of the efficiencies and development of equity-based philosophy as the core of the Oral Health service. After discussions with the teams the corner keystones for the service remain, considered placement of the mobile Dental Service for 2021, utilisation of the existing clinics, treatment options, centralised booking system to manage this process and increasing mobility of the workforce.

In the New Year we are looking to establish a district wide administrator for the Southern overseeing the administration of all the waiting lists.

The Professional Lead has worked hard this month on developing criteria for 18-month recall documentation alongside our senior Dentists, also the development of Antibiotic support standardising the process for Therapists and preparation for four new graduates starting in 2021 around planning and mentoring. Also, the Professional Lead has been asked to present to the Child and Youth forum about the Oral Health service.

Breast Feeding in the Southern district

The National Breastfeeding Strategy for New Zealand Aotearoa|Rautaki Whakamana Whāngote was released on 15 December. This online roadmap to action: 2020 and beyond will guide our work to protect, promote and support breast feeding in the Southern district. There are seven objectives:

- Increase the exclusivity and duration of breastfeeding in Aotearoa for this and future generations.
- Government policies and frameworks protect, promote and support breastfeeding and optimal infant feeding.
- Breastfeeding is a public health priority, and the determinants and barriers to breastfeeding are understood and mitigated.
- Consistent, evidence-based breastfeeding and infant feeding education is provided to all people working with pregnant women, infants and children.
- The positive impact of breastfeeding on health, development and wellbeing is valued by communities', whānau, hapū and iwi.
- Whānau have access to consistent, evidence-based, culturally responsive breastfeeding information and support.
- People feel comfortable and supported to breastfeed in any environment, including workplaces, health and education settings, and public spaces.

At the Southern district WCTO Steering Group meeting in November it was agreed that a survey would be undertaken to ascertain what supported new mothers to breast feed and what challenges they faced establishing and maintaining breast feeding. Work has occurred to develop the survey with the South Island Alliance WCTO/SUDI Co-ordinator. Testing will occur and then WCTO providers will get their nurses to ask those they engage with to complete the survey. This information will be analysed and feed into the district wide breast feeding hui to be held in quarter three.

Pacific

A meeting has held on the 9 December with CEO of Oamaru Hospital CEO and Hana Halalele representing the Oamaru Pacific community. The CEO detailed the five strategic priorities he was intending to focus on for Oamaru Hospital and Hana provided details about the Waitaki Pacific community. The Pacific community is young, fast growing and ethnically diverse. Lockdown highlighted many gaps and raised questions of how to keep the Pacific community safe and

prepared for future Covid19 activity. A lot of activity was undertaken informally by Pacific community members, but some funding has now been received for the employment of a part-time coordinator. The lack of Pacific specific services was highlighted for the district.

Agreed that Hana could be the interface with Pacific community if needed. Building relationships with key people was acknowledged as important and needs to be ongoing. Agreed not to over complicate issues, to get the right people in the room and to work through appropriate actions as and when required.

A meeting was held with Dr Helen Bray, Consultant Neonatologist, and the Pacific Trust Otago on the possibility of Helen holding community clinics to support sharing of knowledge and messaging for support of young pepi for Pacific whanau. This supports the community breast feeding pilot currently being run from Pacific Trust Otago (PTO), WCTO services, and the holding of pregnancy and parenting sessions from PTO premises. It also complements the MoH Community Dietician contract that has recently commenced.

Rural Health

Rural Radiology

A number of meetings have occurred between the respective Rural Hospitals and the Southern DHB Project Team to gather data and develop a complete picture of each of the Rural Hospital services. Analysis of non-financial and financial performance for each service has been completed. Each Rural Hospital has provided feedback on their service modelling. Analysis of all Radiology services resulted in identifying four possible configurations for the Rural Hospitals to consider. Each Rural scored the options against a number of factors to identify a preferred option. A follow up discussion at the most recent Rural Chief Executive meeting on 13 November 2020 resulted in agreement on the preferred model.

The Model chosen is Option 4 from the Rural Radiology Project Analysis. This is a hybrid model, in which:

- Ownership of radiology equipment will remain at a local level
- All staff are employed by the Rural Hospitals rather than by PRG

In addition to the above, there are a number of further elements that must come together by June 2021 for the model to successfully go live. Primarily this involves:

- Gore Health and Clutha Health First (CHF) source equipment;
    - There are some options open to Gore Health and Clutha Health First. Pacific Radiology has indicated that they will support a smooth transition and it is possible to purchase their existing equipment
    - I Telerad have indicated that they can source and provide all equipment if required
    - Once the values for each option are understood, the Rural Hospitals can undertake a financial analysis of each option
- Fit out and accreditation if required;
    - Accreditation is not a requirement for ACC revenue unless undertaking CT and fit out will not be required if the Pacific Radiology equipment is purchased.
- Gore Health and Clutha Health First IT solutions for their RIS and PACs (radiology software) implemented;
    - Southern DHB IT have indicated that they can support this work and it is possible to connect Gore Health and Clutha Health First into the new Southern DHB RIS and PACs system to meet their go live date of 1 July 2020
- Gore Health and Clutha Health First staff negotiation and recruitment;
    - Pacific Radiology have been approached by the Rural Hospitals to initiate negotiation. Following PRG communication to their staff, Gore Health and Clutha Health First will approach affected staff to begin negotiating their transition into the respective

organisations.

- Allied Health Team professional support Memorandum of Understanding put into place between Rural Hospitals and Southern DHB;
    - Meetings have occurred to initiate discussion around a single shared Allied Medical Radiation Technicians Charge Operational and Professional service to all Rural Hospitals, to be provided by Southern DHB staff. Southern DHB Allied Leadership teams have agreed in principle, however, a number of elements need to be finalised between all parties for this to be successful for all involved.
- Gore Health, Clutha Health First, Waitaki District Health Services and Central Otago Health Services Ltd reading and reporting alignment with the recent tele-radiology RFP. Contract and implementation with I Telerad;
    - This will form a part of the Southern DHB IT project supporting Gore Health and Clutha Health First into the RIS and PACs. They will establish I Telerad as their reading and reporting provider.
    - Central Otago Health Services Ltd and Waitaki District Health Services will transition onto this new reading and reporting service at a later date (currently PRG are the provider).
- Any new contracting arrangements will need to be completed. This may include;
    - Gore Health and Clutha Health First employment agreements.
    - All Rural Hospitals contracting with I Telerad.
    - All Rural Hospitals potentially contracting to purchase IT support and Allied Health Professional support from the Southern DHB.

The Southern DHB project team will remain involved to support this change process to its successful implementation. The Southern DHB Radiology Team have been approached to provide technical expertise as required through this phase of the project.

At this stage the project is on track to meet the deadline of 1st July 2021.

Lakes District Hospital

The outcome of the Allied Health Review is due – planning for the Allied Health Services for Queenstown will be informed by this report.

The impact on the workforce of increasing presentations to the Emergency Department is significant. Additional Senior Medical Officers (SMOs) have been rostered in the evenings to manage demand. The impact on Radiology staff and the administration team is also significant. A plan to align workforce to workload has been presented.

Security issues persist at Lakes ED. Over the Christmas to New Year period, security guards were on site at Lakes District Hospital overnight. This was really helpful, especially with the huge numbers of people presenting to ED affected by alcohol and drugs, particularly during Rhythm and Alps. A trespass Order has been put in place to try and prevent a local man frequenting the LDH facilities. He has threatened staff on numerous occasions. Despite this notice, he was still found using an outside shower within the hospital grounds. The long term arrangements for onsite site security is being considered in the organisation wide security review which is currently underway.

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.

Pharmaceutical Utilisation

Pharmaceutical Data and Analytics

Analysis of pharmaceutical data supplied by the MoH in November and December has revealed significant omissions preventing reliable analysis. MOH are working to identify and resolve the issue as soon as possible. More information will be available in the last week of January.

Ongoing delays to obtaining data suitable for analysis are causing slippage of milestones for key components of the pharms plan relating to dispensing and drug cost outlier work.

Quality Use of Medicines

The School of Pharmacy Clinic have shared the draft biannual report for Q1-Q2. Key metrics:

- 99 consultations to 88 patients
- 73% of referrals are active referrals up from previous periods.
- Approximately one third of referrals are patient self-referral

The service continues to fall short of expected consultation volumes and, consequently, system-level outcomes. The current agreement to fund a clinical pharmacist in the clinic concludes on 28 February 2021 and a decision whether to continue funding will be based on evaluation of the service. At this stage questions about whether we should cease this initiative as it has under delivered against expectations are being raised.

Older Persons Health and AT&R

Aged Residential Care Occupancy/Volume Analysis

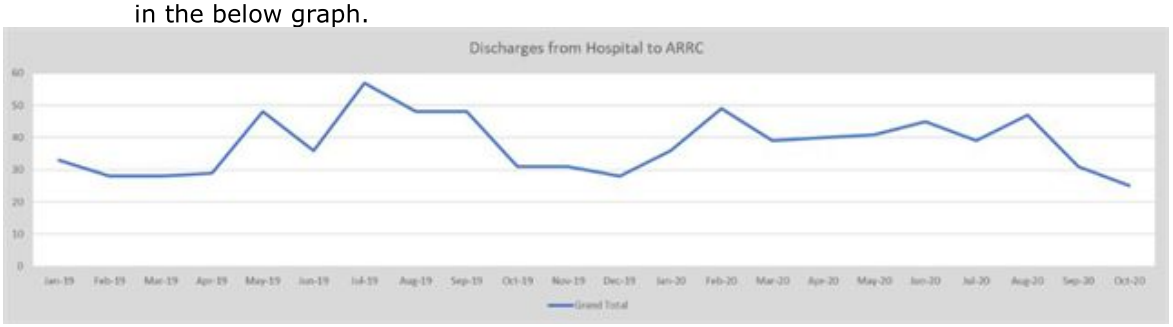
The DHB continues to experience elevated levels of occupancy in Aged Related Residential Care (ARRC), primarily at Hospital and Psychogeriatric levels of care. The team continues to investigate multiple avenues but to date has not reached any conclusions:

We continue to consider:

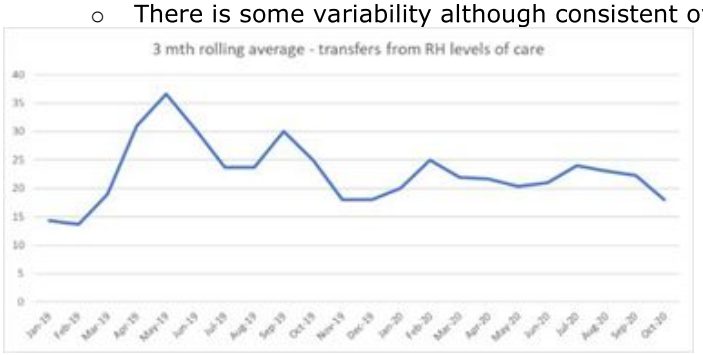
- Have there been fewer deaths?
  - For the 6 month period May-Oct 2019 there were 359 deaths, for the same period in 2020 there were 321 (variance of 38).
- Is there a backlog from the COVID lockdown that is starting to come through? Are patients enjoying better health due to lack of illness or worse health due to lack of socialisation and activity?
  - Work continues to better understand this.
- Has the time patients received Home Support increased so that by the time they enter care, they go in at Hospital Level rather than Rest Home Level?
  - There is an increased rate of admissions where Hospital level care is the first level of care.

- Are there more patients being discharged from Hospital into ARRC?

- The number of residents being admitted directly has stayed relatively stable, as shown in the below graph.

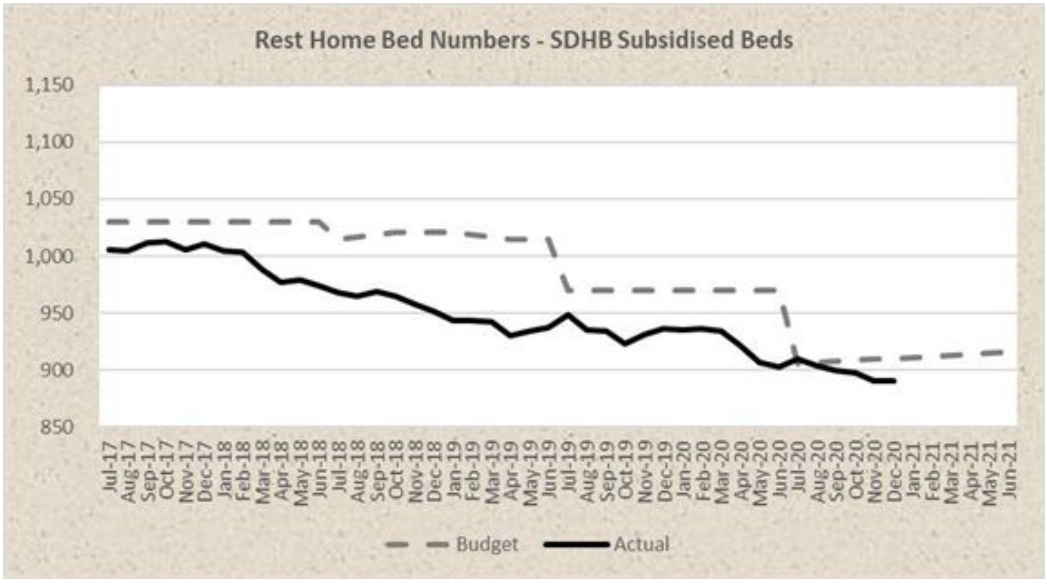


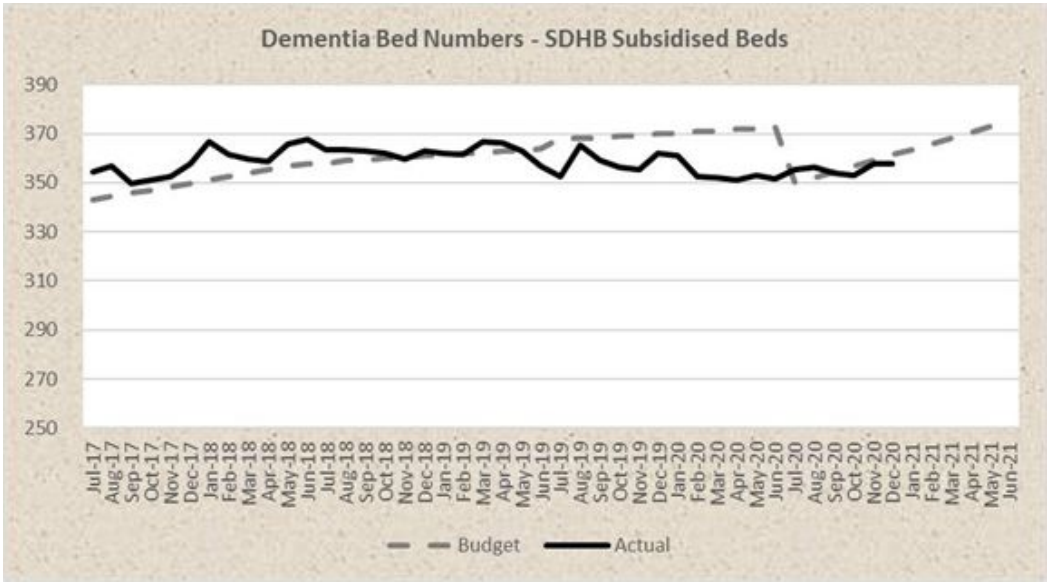
- As a result of the lockdown (isolation and decreased activities) have there been increased changes in level of care from rest home to hospital level care?
  - There is some variability although consistent over the last 6 months.

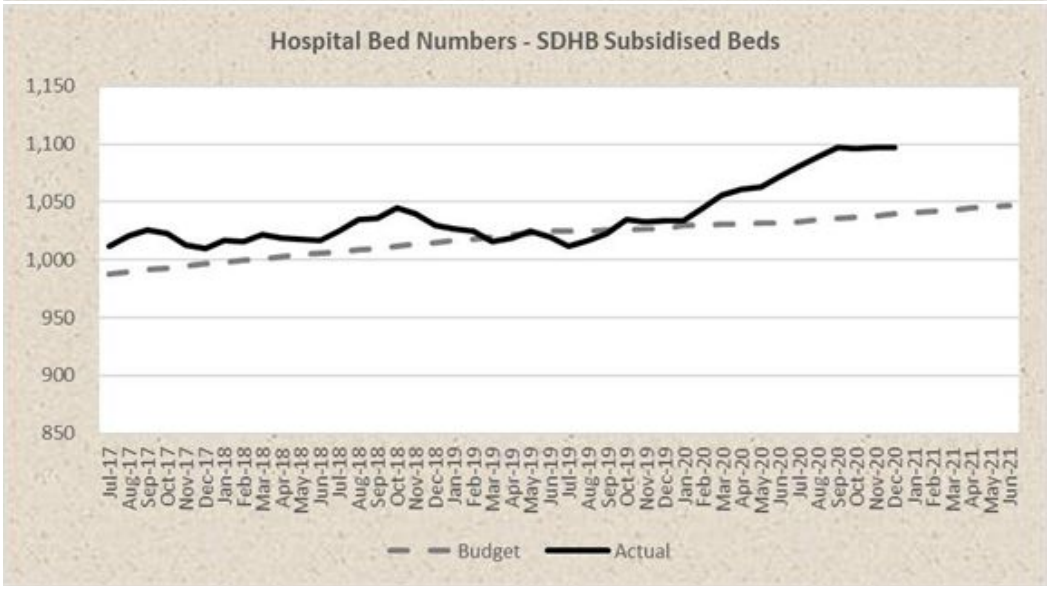


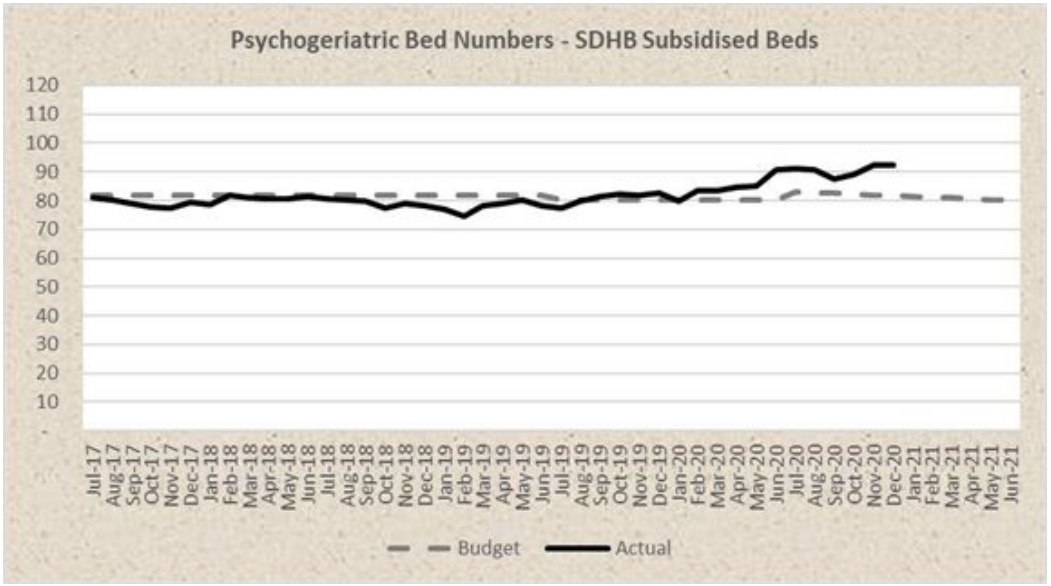
- What is the impact of supply induced demand?
  - Work continues to better understand this.

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
-
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

FOR INFORMATION

Item: Southern DHB –Financial Report For the month ended 31 December 2020

Proposed by: Lisa Gestro, Executive Director Strategy Primary & Community

Meeting of: Community and Public Health Advisory Committee, 1 February 2020

Recommendation

That the Community & Public Health Advisory Committee notes the attached report.

Purpose

1. To inform the Committee of the December 2020 Strategy Primary and Community financial performance

Specific Implications For Consideration

2. Financial
    - As set out in the report.
3. Workforce
    - No specific Implications
4. Equity
    - N/A
5. Other
    - N/A

Background

6. Strategy, Primary and Community report a provisional favourable bottom line variance of $0.48m for December and $2.11m favourable YTD

Discussion

7. There are no new significant areas of variance to budget.
8. Pharmaceutical section provides detail on consolidated DHB Pharmaceutical expenditure.
9. Per previous months there is offsetting revenue and expenditure in Mental Health for Primary Integrated MH & Addiction.
10. Continued high Hospital level bed numbers in ARRC.
11. Capital charge revenue $171k u for month. Expenditure offset sits in Finance directorate.

	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	94,629	91,930	2,699				558,441	551,580	6,861				1,103,159
IDF Revenue	2,515	1,983	532				12,677	11,895	782				23,790
Other Government	531	540	-9				3,287	3,453	-166				6,632
Total Government & Crown	**97,675**	**94,452**	**3,223**				**574,405**	**566,928**	**7,477**				**1,133,582**
Non Government & Crown Agency Revenue													
Patient related	28	21	7				115	125	-10				249
Other Income	68	80	-12				535	477	58				954
Total Non Government	96	100	-4				650	602	48				1,203
Internal Revenue													
Internal Revenue													
Total Internal Revenue	**8,613**	**8,518**	**95**				**51,346**	**51,107**	**239**				**102,215**
TOTAL REVENUE	**106,384**	**103,071**	**3,313**				**626,401**	**618,637**	**7,764**				**1,237,000**
EXPENSES													
Workforce													
Senior Medical Officers (SMO's)													
SMO - Direct	1,697	1,646	-51	62.66	64.97	2.31	9,135	9,125	-10	63.23	66.04	2.81	18,259
SMO - Indirect	133	91	-42				557	547	-10				1,095
SMO - Outsourced	82	47	-35				375	289	-86				561
Total SMO's	**1,912**	**1,784**	**-128**	**62.66**	**64.97**	**2.31**	**10,067**	**9,961**	**-106**	**63.23**	**66.04**	**2.81**	**19,915**
Registrars / House Officers (RMOs)													
RMO - Direct	262	239	-23	20.47	19.20	-1.27	1,402	1,377	-25	20.18	19.32	-0.86	2,818
RMO - Indirect	6	17	11				32	99	67				198
RMO - Outsourced													
Total RMOs	**268**	**256**	**-12**	**20.47**	**19.20**	**-1.27**	**1,435**	**1,477**	**42**	**20.18**	**19.32**	**-0.86**	**3,016**
Total Medical costs (incl outsourcing)	**2,180**	**2,040**	**-140**	**83.13**	**84.17**	**1.04**	**11,501**	**11,438**	**-63**	**83.41**	**85.36**	**1.95**	**22,931**
Nursing													
Nursing - Direct	5,029	4,579	-450	624.09	577.62	-46.47	28,094	27,131	-963	610.45	581.37	-29.09	54,904
Nursing - Indirect							10	2	-8				3
Nursing - Outsourced													
Total Nursing	**5,029**	**4,580**	**-449**	**624.09**	**577.62**	**-46.47**	**28,104**	**27,132**	**-972**	**610.45**	**581.37**	**-29.09**	**54,907**
Allied Health													
Allied Health - Direct	2,976	3,055	79	429.81	441.94	12.13	16,832	17,536	704	431.62	442.70	11.08	34,505
Allied Health - Indirect	27	29	2				142	176	34				633
Allied Health - Outsourced	28	16	-12				164	97	-67				192
Total Allied Health	**3,031**	**3,101**	**70**	**429.81**	**441.94**	**12.13**	**17,138**	**17,809**	**671**	**431.62**	**442.70**	**11.08**	**35,330**
Support													
Support - Direct	1	14	13	0.48	3.26	2.78	27	77	50	1.40	3.22	1.82	151
Support - Indirect													
Support - Outsourced													
Total Support	**1**	**14**	**13**	**0.48**	**3.26**	**2.78**	**27**	**78**	**51**	**1.40**	**3.22**	**1.82**	**151**
Management / Admin													
Management & Administration - Direct	1,201	1,179	-22	178.77	179.51	0.74	6,937	6,984	47	178.99	180.35	1.36	13,764
Management & Administration - Indirect	1	6	5				27	33	6				66
Management & Administration - Outsourced	10	1	-9				23	7	-16				13
Total Management / Admin	**1,212**	**1,185**	**-27**	**178.77**	**179.51**	**0.74**	**6,987**	**7,024**	**37**	**178.99**	**180.35**	**1.36**	**13,844**
Total Workforce Expenses	**11,453**	**10,920**	**-533**	**1,316.28**	**1,286.50**	**-29.78**	**63,757**	**63,481**	**-276**	**1,305.87**	**1,293.00**	**-12.88**	**127,162**
Non Personnel													
Outsourced Clinical Services	17	94	77				664	599	-65				1,185
Outsourced Corporate / Governance Services													
Outsourced Funder Services	1,200	1,206	6				7,199	7,235	36				14,470
Clinical Supplies	1,446	1,010	-436				8,075	5,969	-2,106				11,937
Infrastructure & Non-Clinical Supplies	673	702	29				4,140	4,237	97				8,410
Provider Payments													
Personal Health	68,690	67,204	-1,486				402,352	401,467	-885				800,836
Change Initiative Fund													
Mental Health	8,653	8,497	-156				52,060	50,983	-1,077				101,967
Public Health	115	84	-31				691	503	-188				1,007
Disability Support	16,260	15,970	-290				96,369	95,161	-1,208				189,737
Maori Health	189	174	-15				1,091	1,110	19				2,220
Non Operating Expenses													
Depreciation													
Capital charge													
Interest													
Total Non Personnel Expenses	**97,242**	**94,942**	**-2,300**				**572,642**	**567,265**	**-5,377**				**1,131,769**
TOTAL EXPENSES	**108,695**	**105,861**	**-2,834**				**636,399**	**630,745**	**-5,654**				**1,258,931**
Net Surplus / (Deficit)	**-2,311**	**-2,791**	**480**				**-9,998**	**-12,108**	**2,110**				**-21,931**

Requests awaiting approval - Items on Register

Summary

Strategy, Primary and Community report a provisional favourable bottom line variance of $0.48m for December and $2.11m favourable YTD.

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

Revenue

- IBT $79k favourable for December and $471k YTD
- CSC $43k favourable for December and $237k YTD
- Pharmacy $422k favourable for December and $2.53m YTD
- Mental Health $510k favourable for December and $1.96m YTD
- IDF $532k unfavourable for December and $782k YTD

Workforce

- SMO's $128k unfavourable for December and $106k unfavourable YTD
- Nursing $449k unfavourable for December and $972k unfavourable YTD
- Allied Health $70k favourable for December and $671k favourable YTD
- Management Admin $27k unfavourable December and $37k favourable YTD

Non Personnel

- Clinical Supplies $436k unfavourable for December and $2.11m YTD

Personal Health

- PHO's $62k unfavourable for December and $745k YTD
- Community Pharms $4k favourable for December and $804k favourable YTD
- Travel & Accom $103k favourable for December and $185k favourable YTD
- IDF's $120k unfavourable for December and $270k unfavourable YTD
- Haemophilia $130k unfavourable for December and $877k YTD

Mental Health

- Minor Mental Health $247k unfavourable for December and $1.51m YTD

Disability Support

- ARRC $371k unfavourable for December and $1.56m YTD
- Comm. Health Services $18k favourable for December and $192k favourable YTD

Pharmaceuticals

The SDHB Consolidated Pharmaceutical budget (including funder Haemophilia) is unfavourable to budget for December, with a $1.18m unfavourable variance to budget (YTD $3.97m).

After factoring additional revenue and the expenditure transferred to COVID, we see a largely breakeven position against budget.

	$000 YTD 2019/20	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
Clinical Supplies - Pharmaceuticals	$ 14,551.1	$ 16,077.7	$ 13,543.5	-$ 2,534.2
Provider Payments - Pharms	$ 36,485.4	$ 39,769.1	$ 39,108.2	-$ 660.9
Haemophillia (medical outpatients)	$ 738.9	$ 1,913.1	$ 1,135.6	-$ 777.5
Total	**$ 51,775.4**	**$ 57,759.9**	**$ 53,787.4**	**-$ 3,972.5**

Variance is made up of the following (estimate)

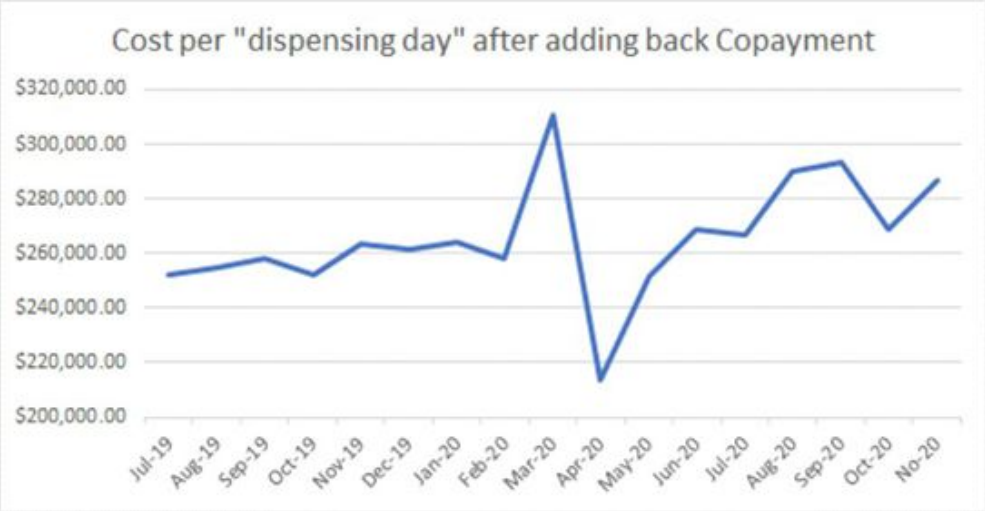
Pharms YTD		$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
PCT	$ 6,976.5	$ 7,029.7	$ 5,010.2	-$ 2,019.6
Community Pharms (DHB Outpatients)	$ 2,520.2	$ 3,184.8	$ 2,396.1	-$ 788.7
Hospital Inpatients	$ 5,054.4	$ 5,863.2	$ 6,137.3	$ 274.1
Community Pharms (excl DHB)	$ 36,485.4	$ 39,769.1	$ 39,108.2	-$ 660.9
Haemophillia (medical outpatients)	$ 738.9	$ 1,913.1	$ 1,135.6	-$ 777.5
Total	**$ 51,775.4**	**$ 57,759.9**	**$ 53,787.4**	**-$ 3,972.5**
Additional Unbudgeted Revenue - Tranche 1		$ 337.5	$ -	-$ 337.5
Additional Unbudgeted Revenue - Tranche 2		$ 2,194.0	$ -	-$ 2,194.0
Expenditure coded to Covid		$ 1,456.4	$ -	-$ 1,456.4
Adjusted Total (adjusting for unbudgeted revenue	**$ 51,775.4**	**$ 53,772.0**	**$ 53,787.4**	**$ 15.4**

Of note in December:

1) Continued high level of Casemix fees paid to pharmacies due to COVID related community pharmacy dispensing rule changes. Per last month, the increase experienced by SDHB is significantly greater than the amount TAS initially estimated.

Payment	relates to service in:	Actual Casemix		
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	$ 1,734,754
2019-10	2019-7	$ 1,580,530		
2019-11	2019-8	$ 1,539,177	Total Increase (7mths)	$ 1,705,462
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	November	$ 1,427,760
2020-08	2020-05	$ 1,563,929	December	$ 1,705,462
2020-09	2020-06	$ 1,882,364		
2020-10	2020-07	$ 2,027,151	**Impact for Current Month**	**$ 277,702**
2020-11	2020-08	$ 1,957,420	*(to be transferred to COVID)*	
2020-12	2020-09	$ 1,768,818		

2) Reimbursement claims being made by pharmacies have ticked back up after appearing to have moderated down towards historical levels last month. Analysis will be completed during the month to better understand this. The below graph shows the average daily gross expenditure for the main demand driven Pharmacy PUC's (after adding back co-payment estimate).



3) Hospital Pharmaceutical expenditure is significantly higher than budget, with cost pressure apparent in the outpatient setting. The below table shows expenditure for chemicals that cost greater than $100k per month. It shows that whilst there has been some decreases in Rituximab (gross price reduction), Trastuzumab & Pembrolizumab (both appear to be volume), there are now more chemicals costing greater than $100k per month, when comparing to the same period last year (with an increased overall cost).

Chemical	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Trastuzumab	$232	$267	$259	$247	$282	$186	$195	$182	$220	$252
Infliximab	$283	$294	$286	$289	$290	$367	$324	$457	$357	$454
Rituximab	$174	$117	$209	$210	$190	$168	$157	$77	$118	$148
Pembrolizumab	$215	$262	$253	$224	$233	$222	$139	$168	$209	$175
Aflibercept	$85	$74	$90	$83	$96	$146	$168	$158	$168	$160
Ivacaftor	-	-	-	-	-	$147	$88	$88	$147	$118
Ocrelizumab	-	-	-	-	$37	$47	$56	$56	$37	$113

Chemical	Variance	Comments
Trastuzumab	-20%	
Infliximab	36%	
Rituximab	-26%	Price Change
Pembrolizumab	-23%	
Aflibercept	87%	Engaging with Ophthalmology clinicians
Ivacaftor		Cystic Fibrosis - Funded from March 2020
Ocrelizumab	726%	MS - consultation to widen access as at Nov 20

The three Chemicals are either newly funded (Ivacaftor) or have had a change in access criteria. Whilst Pharmac are likely to have factored this into the overall CPB forecast, the do not appear to have been factored into the detailed (by budget grouping) Pharmac forecast.

Revenue

External Revenue –

Category	Dec Variance	YTD variance	Comment
IBT	$79k f	$471k f	Expenditure offset
Planned Care	$227k f	$0	Expenditure offset (internal expenditure)
CSC	$43k f	$237k f	Expenditure offset
Primary integrated MH & Addictions	$257k f	$1.51m f	6 months revenue with expense offset
MH Addictions Crisis Support	$8k f	$171k f	Programme development – new contract
Alcohol & Other Drugs		$195k f	One off on signing
Forensic Services	$254k f	$254k f	New programme
Measles Immunisation Campaign	$157k f	$471k F	Unbudgeted to be transferred to Population Health
Pharmaceutical funding (tranche 1)	$56k f	$337k f	Additional Covid funding
Pharmaceutical funding (tranche 2)	$366k f	$2.19m f	Additional Covid funding
Capital Charge	$171k u	$1.03m u	Reduction from 6% to 5%. Expense offset
Additional Funding for Recovery Plan	$1.30m f	$1.95m f	Expense offset
Hospice Palliative Care	$27 f	$161k f	New contract from Oct 20
Other	$66k f	$59k u	
Total	**$2.70m f**	**$ 6.86m f**	

IDF Revenue

$532k favourable due to:

- Inpatient inflows for November being $248k favourable ($109k Orthopaedics, $51k Cardiology).
- Recoding of some Inpatient inflows from prior periods.
- Outpatient inflows – submission of prior period events $117k.

Workforce Costs

	YTD Variance - FTE				
Workforce	Community Services	Primary Care & Population Health	Mental Health	Strategy Primary & Community Other	Total
Medical	-0.8	2.2	-0.2	0.7	1.9
Nursing	6.0	-12.1	-22.9	0.0	-29.0
Allied Health	3.7	9.2	-2.8	1.0	11.1
Support	1.8	0.0	-0.0	0.0	1.8
Mgt/Admin	1.1	2.5	-0.3	-2.0	1.3
Total	11.8	1.8	-26.2	-0.3	-12.9

The Unpaid Days accrual is impacting the overall workforce expenditure variance in December. We note this is a timing issue and that the YTD accrual is largely in-line with budget.

	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Nursing	(24)	(63)	221	(73)	(11)	(127)	(76)
Allied Health	93	(33)	(50)	62	20	(19)	73
Support	1	7	(7)	2	0	3	6
Management & Admin	46	(33)	15	23	(1)	(32)	17
Medical	(15)	2	(29)	66	13	(106)	(70)
Total	100	(121)	150	80	21	(281)	(51)

Medical SMO –

- 2.8 FTE favourable YTD.
- Ordinary time and training are the main drivers offset by overtime.
- $45k (YTD $47) relocation costs impacting indirect costs

Medical RMO –

- 0.9 FTE unfavourable to budget YTD.
- Ordinary time unfavourable by 1.6 FTE offset by training (0.5 fav) and overtime (0.19 fav)

Nursing –

- 29 FTE unfavourable YTD. The budget includes -34.95 FTE for MH savings and Vacancy Factor.
- YTD FTE variance mainly driven by Ordinary (9 FTE), Accident leave (9 FTE), sick leave (4FTE) and overtime (5FTE) unfavourable.
- YTD $972k unfavourable variance is mainly due to Ordinary ($189k f), Accident leave ($307k u), overtime ($324k u), back pays ($372k u), unpaid days accrual ($78k u) and other leave ($119k f).
- Skill mix and Annual leave revaluation favourable to budget is contributing to low $ per FTE variance.
- Lakes General Ward registered nurses are 3.5 FTE unfavourable and Health Service Assistants 2.5 FTE unfavourable. Compared to the same period for 19/20, nurses have increased 1.5 FTE and Health Service Assistants 1.25 FTE.

Allied Health –

- 11 FTE favourable YTD. YTD expenditure is $671k favourable.
- YTD FTE variance is mainly driven by Ordinary (16 FTE f) offset by overtime (1.1 FTE u) and sick leave (1.9 FTE u)

- YTD expenditure is $671k favourable and is mainly due to ordinary time ($862k fav) and Annual leave accrued ($93k fav), offset by overtime ($84k unfav), backpays ($138k unfav) and sick leave ($46k unfav).

Management/Admin –

- 1.4 FTE favourable YTD is mainly driven by other leave (1 FTE f) and sick leave (1.0 f) and training (1 FTE) offset by ordinary (1.69 FTE u).
- YTD expenditure is $37k fav and is mainly driven by annual leave accrued ($68k f) and sick leave ($49k f) offset by back pays ($44k u)

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	260	259	-1	1,734	1,619	-115	3,204
Diagnostic Supplies & Other Clinical Sup	8	6	-2	43	38	-5	74
Instruments & Equipment	65	68	3	334	405	71	807
Patient Appliances	119	166	47	921	865	-56	1,817
Implants & Prostheses	1		-1	5	3	-2	6
Other Clinical & Client Costs	34	27	-7	114	171	57	338
Total (excl pharmaceuticals)	487	526	39	3,151	3,101	-50	6,246

- Clinical Supplies – Dressings ($121k u), Ostomy ($40k u) and Continence ($34k u) offset by Clinical equipment ($69k f) are the main drivers of the unfavourable YTD variance.

Infrastructure & Non-Clinical Supplies

YTD expenditure $97k favourable with the main variances being:

- Consultants Fees $175k favourable
- Patient meals $98k favourable
- Electricity $55k favourable
- Accommodation & meals $62k unfavourable
- Telecommunications $60k unfavourable
- Security services $54k unfavourable

Provider Payments (NGO's)

Personal Health

- Dental - $525k favourable YTD - The University of Otago Dental School contracts and invoicing are getting closer to being sorted and the alignment of where expenditure should lie is now better reflected across the "Funder" and "Provider" arms.
- Primary Health Care Services – Services are $744k unfavourable to budget YTD. The majority of this is due to First Contact services ($327k unfav) and Community Services Card ($237k unfav). This extra expenditure is offset by a favourable variance in GMS ($243k YTD) and matching revenue for CSC. First Contact services forecast to become favourable to budget later in 20/21.
- Pharmaceuticals - $4k favourable for Dec and $0.80m favourable YTD. See previous comments.
- Travel & Accommodation - $185k favourable YTD. Demand driven.
- Immunisation – YTD expenditure $144k fav.
- Palliative care - $101k unfavourable YTD. Largely on budget.
- Medical Outpatients - $785k unfavourable YTD due to haemophilia national pool expenditure.
- Surgical Inpatients - $1.54m unfavourable foe December and $1.33m YTD due to pass through of funding for recovery action plan.
- Price adjusters - $478k favourable YTD. Due to pool for NGO increases where the actual costs are incurred across various lines.
- 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 ($125 k f YTD). Demand driven service.
- Other/Minor mental health ($1.51m u YTD) relates to 6 months of Primary Integrated MH & Addiction contract signed last in October. Offset by equivalent revenue.

Public Health

- The $188k unfavourable variance YTD is due to budgeted savings of $165k that have not been achieved within provider payments but have been achieved across Public Health in total.

Disability Support

- Pay Equity - $30k unfavourable to budget YTD, largely due to high utilisation in ARRC.
- ARRC - $371k for December and $1.56m unfavourable YTD.
    - Unfavourable Hospital level volumes are the most significant contributing factor to unfavourable variance.
    - The team continue to look to identify factors influencing increased Hospital level utilisation.
- Home Support - $23k favourable for December and $98k unfavourable YTD

Maori Health

- No significant variances.

Expenditure Management Plans – current performance and future actions

Savings category	Savings Target		Variance to budget	Comment
	Annual	YTD		
Pharmaceuticals	1,300k	650k	15k f	YTD savings fully achieved
ARRC	1,386k	693k	1.66m u	YTD savings not achieved
Public Health[2]	331k	165k	558k f	YTD savings **fully** achieved
Mental Health[2]	3,419k	1,709k	647k f	YTD savings **fully** achieved
Total	**6,436k**	**3,217k**	**440k u**	

[2]includes both Funder and Provider

Next Steps & Actions

Review forecast and actions against Savings Plans (Ongoing)

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 Dec 20					
	Month			YTD		
	Actual	Budget	variance	Actual	Budget	variance
Personal Health						
Labs	1,481	1,484	3	8,877	8,902	25
Pharms	6,800	6,804	4	38,304	39,108	804
Primary Care	6,820	6,758	(62)	40,791	40,047	(744)
Dental	1,335	1,374	39	7,973	8,498	525
Travel & Accommodation	369	472	103	2,666	2,851	185
IDF	3,230	3,110	(120)	18,929	18,659	(270)
Internal expenditure	44,794	43,266	(1,529)	261,649	259,598	(2,051)
Other	3,861	3,936	76	23,163	23,804	641
Total Personal Health	68,690	67,204	(1,486)	402,352	401,467	(885)
Change Initiative	0	0	0	0	0	0
Disability Support Services						
Pay Equity	1,565	1,601	36	9,466	9,436	(30)
Home & Community Support	2,427	2,450	23	14,735	14,637	(98)
Aged Residential Care	8,532	8,161	(371)	49,957	48,395	(1,562)
Respite	121	96	(25)	745	775	30
Carer Support	140	173	33	841	991	150
IDF	388	389	1	2,263	2,332	69
Internal expenditure	2,547	2,547	0	15,280	12,733	(2,547)
Other	540	553	13	3,082	5,862	2,780
Total Disability Support Services	16,260	15,970	(290)	96,369	95,161	(1,208)
Mental Health						
Alcohol & Drugs	468	470	2	2,810	2,827	17
Child & Youth	1,046	1,108	62	6,509	6,646	137
IDF	463	463	0	2,775	2,775	0
Internal expenditure	5,926	5,926	0	35,558	35,558	0
Other	750	530	(220)	4,408	3,177	(1,231)
Total Mental Health	8,653	8,497	(156)	52,060	50,983	(1,077)
Public Health	115	84	(31)	691	503	(188)
Maori Health	189	174	(15)	1,091	1,110	19
Total Funder	93,907	91,929	(1,978)	552,563	549,224	(3,339)

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.

Closed Session:

RESOLUTION:

That the Community and Public Health Advisory Committee move into committee to consider the agenda item listed below.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 32, Schedule 3 of the NZ Public Health and Disability Act (NZPHDA) 2000* for the passing of this resolution are as follows.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Covid-19 Vaccination Programme	To maintain the constitutional conventions protecting the confidentiality of advice tendered by Ministers of the Crown and officials (programme yet to be announced by Minister).	Sections 9(2)(f)(iv) of the Official Information Act.

*S 32(a), Schedule 3, of the NZ Public Health and Disability Act 2000, allows the Board to exclude the public if the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.

The Committee may also exclude the public if disclosure of information is contrary to a specified enactment or constitute contempt of court or the House of Representatives, is to consider a recommendation from an Ombudsman, communication from the Privacy Commissioner, or to enable the Board to deliberate in private on whether any of the above grounds are established.