Community & Public Health Advisory Committee Meeting

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

Lead Director: Rory Dowding, Acting Executive Director Strategy, Primary & Community

01/06/2021 01:00 PM - 02:40 PM

APOLOGIES

An apology has been received from Dr Nigel Millar, Chief Medical Officer.

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Community and Public Health Advisory Committee, 1 June 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:

- Kaye Crowther – Findex NZ removed
- Kim Ma'ia'i – removed from register
- Doug Hill – entry amended
- Julie Rickman, former Executive Director Finance, Procurement and Facilities, removed
- Nigel Trainor, Executive Director Finance, Procurement and Facilities, added

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).

Appendix

- Board, CPHAC 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 (paid)		
	25.02.2021	Board Member, Quitta Ltd (unpaid)	Nicotine replacement therapy under development.	
Peter Crampton (Deputy Board Chair)	16.04.2021	Employment: Professor, Kōhatu Centre for Hauora Māori, University of Otago (appointed July 2018)		
	16.04.2021	Member, Health Quality and Safety Commission Board (appointed April 2020)		
	16.04.2021	Chair, Executive of Medical Deans Australia and New Zealand Social Accountability Committee		
	16.04.2021	Member, Expert Advisory Group for WAI claimants related to historical underfunding of Māori PHOs (appointed September 2020)		
	16.04.2021	Member, Board of the National Science Challenge - A Better Start (appointed 2015)		
	16.04.2021	Honorary Fellow, Royal New Zealand College of General Practitioners		
	16.04.2021	Fellow, New Zealand College of Public Health Medicine		
	16.04.2021	Wife, Alison Douglass, is a member of the Health Practitioners Disciplinary Tribunal		
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.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	09.12.2019	Elected Vice President, Otago Branch, Association of Salaried Medical Specialists	Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals.	
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	09.12.2019	~~Employee, Findex NZ~~	Removed 21/05/21 (retired).	
	14.01.2020	Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust		
	14.01.2020	Member, National Council of Women, Southland Branch		
	07.10.2020	Trustee, Southern Health Welfare Trust	Trust for Southland employees - owns holiday homes and makes educational grants.	
Lyndell Kelly	09.12.2019	Employed as Specialist, Radiation Oncology, Southern DHB	Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB.	
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	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	
	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, University of Otago		
	09.12.2019	~~Chair, NZ Drug Foundation~~	(Chair role ended 04.12.2020)	
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	~~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	Corporate Body for apartment, Wellington	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	~~Sister-in-law, Employee of SDHB (Clinical Nurse Specialist Acute Mental Health)~~	Removed 07/09/2020	
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		
	17.08.2020	Health Research Council Fellow		
Andrew Connolly (Advisor)	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 (Updated 28.01.2021)	~~CFO,~~ Advisor to Fletcher Construction Company Limited	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	16.01.2020 (Updated 28.01.2021)	~~Member~~, Chair, 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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	
	05.04.2021	Financial Advisor, DHB Performance, Ministry of Health		

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)
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
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	~~17.11.2017~~	~~Wife works for key technology supplier CCL~~	~~Nil~~

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	~~18.12.2017~~	~~Daughter, medical student at Auckland University.~~	
	27.01.2021	Daughter, is a junior doctor in Auckland and is involved in orthopaedic and general surgery research and occasionally publishes papers	
	23.07.2020	Wife, Chief Data Architect, Inde Technology	
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	
Nigel TRAINOR	17.05.2021	Daughter, Sonographer (works part-time for Dunstan Hospital)	
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil
Greer HARPER	24.08.2020	Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs.	

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

Committee Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
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.	
Doug Hill	30.03.2021	Director Broadway Medical Centre		
	30.03.2021	Member- Dunedin After Hours Guild		
	30.03.2021	Member- South Link Health		
	30.03.2021	Royal NZ College of GPs- accredited teacher~~/ fellowship censor/ Primex examiner~~	Amended 17.04.2021	
	30.03.2021	SPHO – Minor surgery GPSI contract		
	30.03.2021	ACC- orthopaedic GPSI contract		
	~~30.03.2021~~	~~Established local management centre for obesity management.~~	Removed 17.04.2021	
	30.03.2021	Southern Cross Accredited provider of GPSI		
	30.03.2021	Member of NZ Advisory Group for Skin Cancer College of Australasia		
	30.03.2021	Trustee of Medical Assurance Society		
	30.03.2021	Wife employed with SDHB as a Psychiatric Registrar		
	30.03.2021	Contracted provider - Southern rehab for GPSI services		
	30.03.2021	Chair, WellSouth Primary Health Network		
	17.04.2021	Chair, Columba College Board of Proprietors (since 2018)		
	17.04.2021	Director/Shareholder, Toitu Investments Ltd	Owns medical commercial premises	

Southern District Health Board

Minutes of the Community and Public Health Advisory Committee Meeting held on Wednesday, 7 April 2021, commencing at 2.00 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Tuari Potiki	Chair
	Ms Ilka Beekhuis	Deputy Chair
	Dr Doug Hill	
	Dr Lyndell Kelly	
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Mr Kiringāua Cassidy	DSAC Member
	Dr John Chambers	Board Member
	Mrs Kaye Crowther	Board Member
	Mr Roger Jarrold	Crown Monitor
	Dr Moana Theodore	Board Member
	Mrs Jean O'Callaghan	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Ms Gail Thomson	Executive Director Quality and Clinical Governance Solutions
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chair welcomed everyone to the meeting and extended a special welcome to Dr Doug Hill, recent appointee to the Committee.

2.0 APOLOGIES

Apologies were received from Ms Odele Stehlin, Committee Member, and Ms Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer.

3.0 DECLARATION OF INTERESTS

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

The Chair asked that any changes to the registers be sent to the Board Secretary and reminded everyone 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 1 February 2021 be approved and adopted as a correct record."

5.0 REVIEW OF ACTION SHEET

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

- *Invercargill Primary Care Access* – The CEO of WellSouth had offered to give a more detailed presentation to the next meeting on primary care activity in Invercargill.
- *B4 School Checks* – There was a risk that performance against targets could slip again due to staff involvement in the COVID-19 vaccination programme.
- *Fluoridation and Public Health* – These actions had been deferred to the next meeting, as Public Health were preoccupied with COVID-19 vaccination.

6.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

The Strategy, Primary and Community Report (tab 8) was taken as read. The EDSP&C provided the following updates, then took questions.

- *COVID-19 Vaccination Programme* – The team had once again risen to the challenge of a large logistical undertaking and worked long hours to set up a vaccination clinic in the Meridian Mall, Dunedin.

  The focus now was on trying to onboard a significant number of new staff to work on the programme over the next 12-18 months, so seconded staff could transition back to their substantive roles.

  The Invercargill clinic was being stood up and there was intense planning for coverage of rural areas. Vaccination would commence in Queenstown on 10 April 2021.
- *Aged Residential Care (ARC)* – There were some pinch points in access to aged residential care, particularly psychogeriatric beds.

Management responded to questions on the COVID-19 vaccination programme and booking system, projected health care demand with an ageing population, psychogeriatric care, Mental Health, Addiction and Intellectual Disability (MHAID) bed capacity and transition plans, specialist addiction services, and cervical screening.

The EDSP&C advised that she would clarify the meaning of "open referrals" mentioned in the MHAID Transition Plans report.

Kaupapa Māori Primary Mental Health and Addiction Services

Mr King's interest in this matter was noted.

In response to concerns about the process followed by the Ministry of Health, particularly around cultural issues, for the Access and Choice Request for Proposal (RfP), the CEO suggested that this matter be referred to the Iwi Governance Committee to take up with the Ministry.

7.0 FINANCE REPORT

A report on Strategy, Primary and Community financial performance to 28 February 2021 (tab 9) was taken as read and the EDSP&C took questions.

The EDSP&C and her team were congratulated for their performance against savings targets.

8.0 REPORTING

The Board Chair asked the Committee to consider whether the current reporting format meets its needs.

9.0 INFORMATION UPDATES

Updates and information on the following issues (tab 10) were taken as read:

1. Māori primary care enrolment
2. Primary care in Invercargill
3. Waikouaiti/Karitane/Hawksbury Village – lead in water supply
4. Mental Health Review
5. Continuation and expansion of Integrated Primary Mental Health and Addiction Services

It was agreed that items 1 and 2 would be carried over to the next meeting.

Mental Health Review

The EDSP&C reported that the Mental Health Review had reached its mid-point and the review panel were writing a preliminary report. The second phase of the review would look at co-designed solutions.

The EDSP&C and Chief Māori Health Strategy and Improvement Officer (CMHS&IO) responded to questions on how the Review was progressing and Māori engagement.

PUBLIC EXCLUDED SESSION

***At 2.53 pm it* was *resolved*:**

"That the public be excluded from the meeting for consideration of the following agenda items."

General subject:	***Reason for passing this resolution:***	***Grounds for passing the resolution:***
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Health Hub Request for Proposal (RfP)	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
2020-21 PHO Performance Summary	To allow activities to be carried on without prejudice or disadvantage	Section 9(2)(j) of the Official Information Act.

T Potiki/T King

The meeting closed at 3.00 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

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE MEETING

ACTION SHEET

As at 24 May 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 is engaged with Central Otago District Council in an ongoing way regarding housing. This includes working with them on the review of the district plan. A parallel piece of research – Pēhea Tou Kāinga? How's your home? Queenstown Lakes Housing: The Human Story has also occurred. This report is being tabled at this meeting (21/05). A full update on housing work in general will be presented at the October 2021 meeting. Update at June meeting.	October 2021
June 2020 FAR 593 Oct 2020 Feb 2021	**Invercargill Primary Care Access** (FAR Committee Minute item 9.0) (Action Sheet 7.0) (Minute item 6.0)	Paper on the issues, with clear action steps and accountabilities, to be submitted to CPHAC.	EDSP&C	Paper included in April meeting agenda. CEO WellSouth has offered to give a presentation at the June meeting. June Update: Presentation is agenda item 10b.	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Oct 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	Performance as below, latest quarter is due shortly. Please note that this workforce is again now leading the vaccine response, and non-critical activity has temporarily been deferred. **<u>Before school checks:</u>** December 2020 Total target exceeded 423 checks ahead – 54.6% of target High Dep exceeded 21 ahead – 48.1% of target 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% June Update: Agreed with Chair to present update at August Meeting, incorporating Spatial Equity project.	August 2021
October 2020	**Oral Health** (Minute 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.	June 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				Arrears pre-COVID, and arrears created by the cessation of Dental work over the COVID 19 lockdown has compounded. The following is now underway: • The mobile bus has been located in Wanaka. Further work underway to determine which areas will be deployed next. • Some Dental Assistants still need to complete training for applying fluoride varnish to reduce the onset of dental decay. This is scheduled to happen at the next in service for staff. • Children are now being assessed against criteria to identify those who can safely move from 12 month recalls to 18 months. This process seems to be working well. • A new chair will be installed in the South Dunedin Clinic from 13 April. ▪ Review of the Oral Health service workforce and resource allocation and funding placement is still to be completed. Further work is occurring to develop these plans for the next CPHAC meeting. June Update: Agreed with Chair to present update at August Meeting	August 2021

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
December 2020	**Oral Health – Fluoridation** (Minute item 9.0)	Paper to be submitted to Committee on fluoridation and options to improve coverage.	EDSP&C/ Deputy CMO	Agenda item 13	Complete
December 2020	**Public Health** (Minute item 9.0)	Presentation to be made on Public Health BAU.	EDSP&C	Agenda item 10a	Complete
February 2021	**Breast Feeding** (Minute item 8.0)	Information to be provided on local feedback on Plunket's lactation consultancy service.	EDSP&C	Update to be provided at next meeting	August 2021
April 2021	**MHAID Transition Plans** (Minute item 6.0)	Meaning of 'open referrals' to be clarified.	EDSP&C	Open referral means current (open) referrals that have been open for 12 months or more and are in active treatment with three or more contacts with our services. Therefore, patients in our care.	Complete
April 2021	**Information Updates** (Minute item 9.0)	The following updates to be carried over to the next meeting: ▪ Māori primary care enrolment ▪ Primary care in Invercargill	EDSP&C	Agenda item 12 Agenda item 10b	Complete

FOR INFORMATION

Item: Strategy, Primary & Community Report

Proposed by: Rory Dowding, Acting Executive Director Strategy, Primary & Community

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

Recommendation

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

Purpose

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 Implication for Consideration

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.

Quality and Patient Safety

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

Operational Efficiency

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

Workforce

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

Equity

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

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.

Covid-19 Vaccination Programme

In the first week of May Southern DHB reached a milestone of 20,000 vaccinations. The large majority (78%) of these were completed through a super clinic based in either Dunedin or Invercargill. WellSouth Primary Health Organisation's mobile outreach is conducting a growing number (22%) to rural areas and general practices.

Regarding our Priority 2b group in Aged Residential Care (approx. 3,000 people in 65 facilities), sixteen facilities (25%) have had their first vaccination. We expect first vaccination in all aged care facilities to be completed by the end of May. Discussions are being held with mental health and disability leads to plan for mobile clinics into their services.

Workforce planning and sourcing still remain a challenge combined with a highly manual process requiring multiple interfaces with individuals to keep the information updated and accurate and onboarded. Collaborating with WellSouth to provide a workforce for rural clinics is ongoing. The onboarding of a clinical workforce for Invercargill is significantly challenging, and progress there is slower than for Dunedin. Rostering for this workforce will require dedicated resource for the duration of the programme.

The programme has gone live with ServiceNow and Homecare Medical Limited (HML) to book all appointments from 17 May forwards. Initially just for Dunedin and Invercargill but will include new clinics as they go live. HML will still be providing an option for those who do not have internet access.

Public Health Response

Queenstown airport opened to international flights for 'green zone' flights on 19 April for Quarantine Free Travel (Trans-Tasman bubble). A huge amount of collaborative work was put in by Public Health, Ministry of Health and airport stakeholders to make this happen.

The roles and responsibilities of health at the border is to encourage passengers and aircrew to wear, change and remove face coverings as required, conduct random temperature checks on 20% of passengers, and to conduct secondary health assessments and make recommendations to any passenger that appears unwell, is symptomatic or is identified as having a temperature of 38 degrees celsius or higher as part of screening at arrival. At this stage flights consist of up to four flights per day over seven days.

A significant piece of work was the development of all of the standard operating procedures (SOPs) and processes to ensure that everything ran smoothly, and all staff understood what was required. This included flow-charts of what would happen if a passenger became symptomatic while in the international arrival terminals. The SOP's continue to be adapted as national guidance continues to change.

A team of new staff were recruited for this response. Orientation and training was done by the Public Health and Infection Prevention and Control staff in the Queenstown office and from the wider DHB. The Public Health staff in Queenstown have continued to take a lead and support this response until the new staff are comfortable with the new process.

A desktop exercise was held on 22 April with the Ministry of Health, Public Health South, Ministry of Business, Innovation and Employment (MBIE), and Southern DHB as transport and managed isolation/quarantine continues to be an issue for the Southern district. We look forward to seeing progress in this space.

Swabbing

Covid19 Swabbing for the month of April 2021.

There have been 4,085 assessments undertaken through this period including 464 at the maritime ports.

- 4,000 Simple assessments
- 60 Virtual assessments
- 0 Full assessments
- 25 No assessment undertaken

Aged Residential Care (ARC)

The focus for April has been on both the Flu and Covid-19 Vaccination Programmes. Most facilities chose to proceed with Flu Vaccinations for other over 65s from 14 April, completing those by 30 April. Those facilities will be ready for Covid-19 Vaccinations 14 days after their last resident was vaccinated for Flu, in line with Ministry guidance. Some of our Invercargill, Central Otago and Dunedin facilities choose to get in early for Covid-19 Vaccinations, with 12 of our 65 facilities receiving their first dose of Covid-19 Vaccination during April. We are working closely with the DHB Vaccination Teams, WellSouth and community pharmacies to vaccinate the rest of the ARC residents during May. Active learning has been a positive feature of the programme to date.

OTHER EMERGING ISSUES

Allied Health

Southland physiotherapy continues to have vacancies that are currently impacting on service delivery and staff wellbeing, especially for the inpatient team. Two Rehab Assistants and an acting clinical coordinator have been put in place. Staff from Dunedin have been supporting their colleagues in Invercargill where possible with a rotational roster with a senior physiotherapist travelling to Invercargill for 3 days most weeks. This interim solution will cease in mid-May as it is now impacting on the Dunedin teams.

There has also been a series of meetings to look at options to improve retention and recruitment, especially at Southland Hospital, where this has been a longstanding issue.

Primary Maternity Facilities

In recent months, further consultation with midwives across the district has occurred, and further analysis on possible models of care for the district has been undertaken.

A paper was initially intended to be presented at the April Board meeting, however, the timeframe has been extended to enable more detailed analysis to be included. Once the paper has been endorsed by the Board, the next steps to developing the agreed primary birthing services in the area can begin. The delay of the paper is unfortunate, however, we needed to ensure the themes that arose from our consultation process were well considered so the Board has the detail they need to inform their decisions.

A business case for the associated capital spend and the next steps in the Request for Proposal provider process cannot be progressed until there is confirmation of a two unit or single-unit plan.

The managers of Charlotte Jean Maternity Hospital in Alexandra have given notice of their intention to exit their contract to provide primary birthing services in Central Otago. They have agreed that from July 2021 the Southern DHB will be leasing the Charlotte Jean premises in Alexandra. The service will continue as normal but will be managed by the Southern DHB from July 2021.

Both parties believe it is in the interests of the community to begin a seamless transition process now, prior to the commissioning of the new maternity facility or facilities. This will provide certainty for the community that there will be no disruption to maternity services in the interim. There will be no discernible change to the care provided at the Charlotte Jean Maternity Hospital.

A new Maternal and Child Hub is to open in Wanaka at the end of April. It is centrally located and will provide a welcome facility for Lead Maternity Carers to work from. Other health services may be able to be accommodated in the future.

Aged Residential Care Bed Availability

This month saw good news on the residential psychogeriatric front. As of the end of April, there are no patients waiting in hospital for residential psychogeriatric beds, and only one resident waiting at another level of care in residential care. Waiting lists as long as 15 have been in effect for seven months, and it is a relief to see older people accessing the care they need in a timely manner. The hospital and aged residential care is to be thanked for their extra efforts in managing older people in the wrong environments, in some cases, for many months.

Aged Residential Care RN Workforce

There is continued pressure on RN staffing in aged residential care. Patient flow continues to be negatively impacted by a lack of staffing in many aged care facilities, with beds not always available in a timely manner, or at all.

RN staffing shortages (sometimes due to aged residential care nurses moving to employment at the DHB) in facilities has resulted in vacant beds not available and admissions being delayed as the

remaining workforce prioritise existing resident's needs over admissions of new residents. The number of shifts in hospital level facilities without RN coverage is increasing, putting those residents at risk and creating additional stress for the remaining staff. This is particularly an issue in Southland.

This has been highlighted to our Chief Nursing and Midwifery Officer, who is balancing the requirement to meet the safe staffing needs of patients and staff at the DHB (e.g. implementation of CCDM), with the resulting needs of residents and staff in aged residential care. With the current global pandemic, and resulting border issues, the pool of RN staff is limited, and increased staffing in any one area results in decreased staffing in another part of the system, in this case, aged residential care.

Bariatric Residents in ARC

Patient flow is also hindered by special needs of complex patients that aged residential care facilities feel unable to appropriately care for, especially those with bariatric needs. Special negotiations and funding will be required to facilitate long term placements for these patients.

Population Health Recovery – COVID Vaccination

The ongoing use of the Public Health Nursing team in the Covid vaccination clinics is having some impact on areas such as the outreach immunisation rates and before schools check programme due to staff not undertaking these activities. The Catch-up MMR programme is on hold until October 2021. The sexual health clinic is also seeing an increase in appointments due to the enhanced youth clinics not being held in Schools. Over May, as the stand alone Covid19 vaccination workforce increases, the Public Health nurses are returning to their normal duties. A plan will need to be developed and resources to get these programmes back on track for this year.

STRATEGY AND PLANNING

Annual Plan 21/22

The Ministry of Health provided feedback on the first draft of the 21/22 Annual Plan on 7 April. Overall MoH deemed that our initial draft plan provided a good response across most of the Minister's priorities. The Ministry has provided some detailed technical feedback and has also provided updated guidance on a number of areas, including

- Immunisation (new action)
- Drinking Water (new action)
- Environmental and Border Control (amendment to the COVID-19 Guidance and new action)
- CCDM (new section)
- Te Aho o Te Kahu – Cancer Control Agency (revised guidance)
- Health workforce (new action)
- Performance measures (updated table).

There are a small number of areas where our initial draft annual plan did not provide the expected information. MoH has asked for an update for each these areas by Friday 7 May:

- actions to improve sustainability and information on the financial impacts of the actions identified
- information on FTE movements that were expected to be included in the service change section of the plans and also in the supporting narrative requested to be provided with summary financial templates
- Financial information
- lack of a complete production plan; We are concerned that some DHBs are awaiting the annual funding allocation before completing their production planning process. Population health need alongside annual planning assumptions should underpin service planning.

The full final draft plan will be submitted on 25 June, incorporating feedback from the Ministry of Health and from the CEO/Board/IGC.

Timeframe for completion of Annual Plan

Activity	Date
Updated sections for Service Change/FTE, Sustainability, Production Plans etc as advised in our feedback	7 May
Feedback on the updated sections ahead of the final draft	21 May
Final draft plans and templates due to the Ministry for review and feedback	25 June
DHB Board signed SPE to be published on DHB websites	Before 30 June
Ministry provides feedback on final draft plans	16 July
Ministry approval of SLM Plan	31 July
DHB Board approved plans put forward for Ministerial approval	From mid July
20/21 SPEs tabled with 20/21 Annual Reports	December

OPERATIONAL UPDATES

Public Health Service

Drinking water

Feedback has come from the Ministry and Taumata Arowai that the Water Services Bill may not come into effect until closer to September this year. The impact of this is that Public Health is likely to be continuing to manage drinking water until closer to the end of 2021. There is still concern about the interface with the new agency. While they will undertake drinking water assessor activities, should a health issue arise this will be the responsibility of the public health unit to respond to.

Drinking Water Assessors are focusing on identifying work that needs to be closed off and completed before handing over to Taumata Arowai. As a South Island Drinking Water Assessment Unit, work is also being undertaken to assess how this might affect the compliance of a drinking water supplier if work is unable to be completed. There is still uncertainty around whether the funding associated with Drinking Water Assessors is likely to be taken away from Public Health which impacts on the team.

In Queenstown and Wanaka, a tri-agency education evening was run for small drinking water suppliers. Experts from Queenstown Lakes District Council, Otago Regional Council and Public Health South presented on the roles and responsibilities of each agency as well as that of the suppliers themselves. This was well received, and we are considering replicating this in other areas as well.

Alcohol/Mental Health in Schools

The Whole School Approach to Alcohol in School Communities professional development days are held annually for high schools and alternative education providers in Otago. This also supports the Tūturu project (an intensive multi-level project working with high schools on alcohol and drugs) that is being implemented by Mirror Head Quarters in Dunedin. Public Health South provides some funding for the day and assists in the planning and facilitation of the event. This year there were 30 participants from ten schools, one alternative education provider and two agencies. Topics included an introduction to alcohol and other drugs, Tūturu whole school approach projects in Dunedin, the evidence around illicit drug use, health education (community consultation and critical thinking), the impact of anxiety and social media on schools, and motivational interviewing. Public Health South is currently analysing the feedback from participants.

Drugs in Bars Seminar

A Drugs in Bars seminar was held in Queenstown. Five speakers specialising in drug harm prevention spoke to over sixty-five bar owners, bar managers, event organisers, Police and first responders. This was held at the Queenstown Police station and it was suggested that next time this is held in a bigger venue so that attendance can be expanded to include community focus groups, schools and youth groups. Police recorded an interview with a drug dealer in which his face and voice are disguised. He is asked how he started dealing, who and where he targets. Police would like to use this in future seminars. Evaluation of the session showed that attendees learned practical tips to reduce drug use and intoxication in their venues.

Smokefree Support Stickers

In a bid to address the environmental pollution that occurs when cigarette butts are discarded in our community, Public Health South has been working with Quitline to develop stickers for cigarette butt bins/general waste bins that support people to dispose of them safely. The stickers have been put on cigarette butt receptacles in Port Chalmers (collaborating with West Harbour Community Board) and we have received verbal confirmation from the Dunedin City Council and Invercargill City Council that stickers can be put on all rubbish bins in these cities. The Quitline contact details are on the sticker as Quitline will refer people in our district to the Southern Stop Smoking Service if they wish to meet with a local coach. Quitline are going to let us know referral numbers for people who mention 'stickers' or

'bins' on the 'where did you hear about us?' question so that we can assess if this is a successful approach to increase referrals.

Work is underway with Invercargill City Council to establish auahi kore/smokefree signage across the city (including the central business district, all parks and reserves, playgrounds, sportsgrounds and Splash Palace pool and carpark). This is to extend previous policy declaring the central business district, parks and playgrounds to be auahi kore/smokefree.

Staff have been working with Southland District Council (SDC) to support a review of their Smokefree Open Spaces Policy and implementation across local communities. Staff have provided smokefree/vapefree signage for SDC to put up in Te Anau and are working with Stewart Island Community Board to establish smokefree spaces on the Island. We are working with SDC after concern was expressed at the number of cigarette butts littering the water around the wharf.

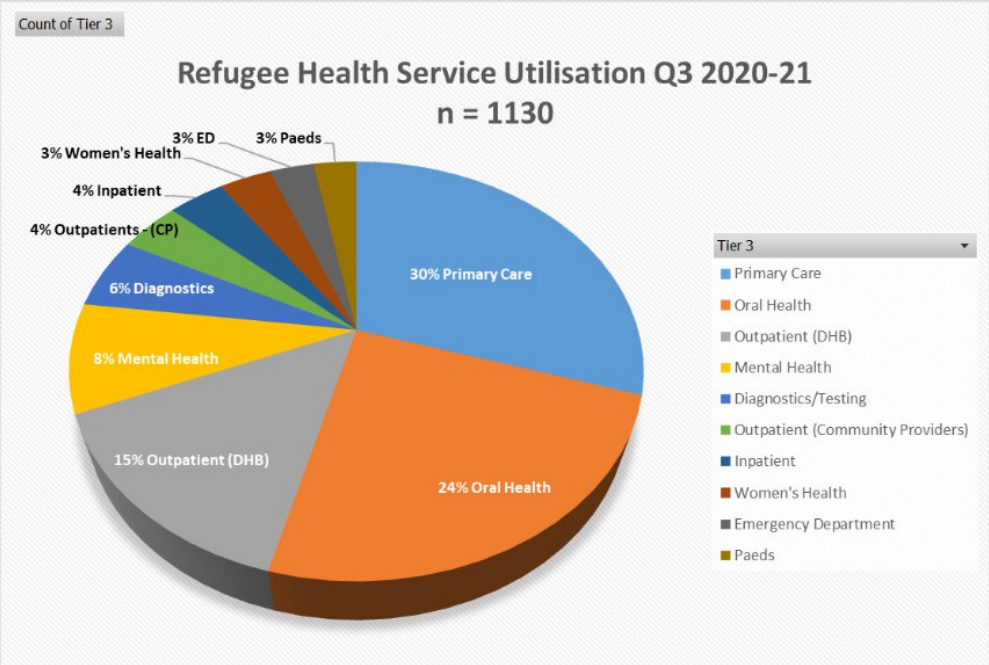
Safe in the South

Safe in the South and the Safer Waitaki Network are part of a network of Safer Communities throughout Aotearoa/New Zealand. They are supported by the Accident Compensation Corporation and are accredited to the National Safer Communities Programme. The Waitaki Network has been in place since 2013 and the model is so successful that there has been interest from several other territorial authorities. At a recent Safe in the South Group meeting, discussion was held about whether a similar model to the Safer Waitaki Network could be adapted for Southland. Our strategic direction includes a focus on resilience and being safe with the things we can control in our community. We will continue our work reducing meth related harm (and widen to include reducing harm related to alcohol, drugs and violence). These would fit with two of the nine focus areas of Safer Waitaki and could be an excellent way to begin adapting to their service model. The principal issues are the need to have an effective coordinator and how this group will progress after the funding from the Accident Compensation Corporation ends in June. It is hoped that the three participating Councils will maintain and ideally increase their funding for the group, and Public Health is advocating for this in the long-term planning process for the Southland Councils.

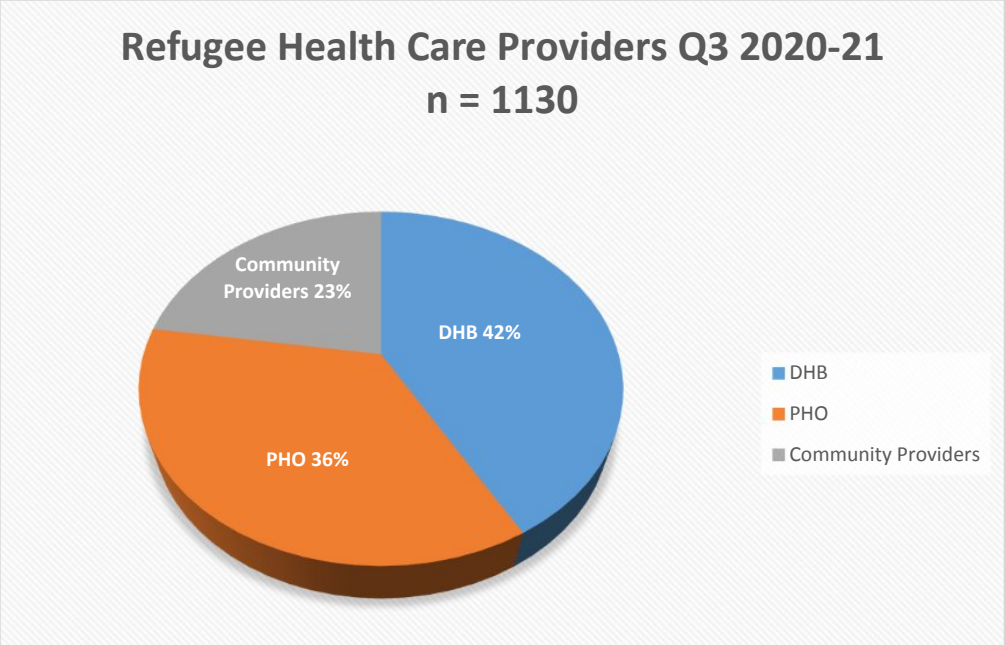
Refugee Health

Quarter 3 Health Service Utilisation

Trends for both Dunedin and Invercargill resettlement sites remain relatively static and positive, with most care being delivered where it should be – Primary Care. Oral Health remains the second most utilised service. Key to the delivery of these services is interpreting and initial investments in adult oral health and General Practitioner subsidised appointments. The fact that services outside of the DHB, Primary Care and the University of Otago Dental School, are able to access interpreters through the DHB supports the high engagement in these types of care. Further, and very encouragingly, former refugees are foregoing Emergency Departments (ED) and continuing with their primary care engagement after their subsidies expire. Also, the inpatient rate for this quarter is above 1% for the first time. This will be explored further and monitored closely.



Of note, also, while Primary Care continues to be the most utilised service, this quarter DHB services collectively provided more healthcare appointments than the Primary Health Organisation (see below). This will be monitored to ensure that any trends indicative of primary care access challenges is addressed.



Finally, Quarter 3, the appointment Did Not Attend (DNA) rate for former refugees was highly favourable at 2% for all appointments across both resettlement cities. DNA rate is used as a metric to measure patient engagement in their healthcare. This is especially relevant for populations that are understood as being at risk, whether that be from legacies of discrimination and/or drifting into marginalisation.

WellSouth Primary Health Organisation (PHO)

In late March, WellSouth PHO held a workshop, with Southern DHB participation, that was facilitated by Lauralie Richard, Senior Research Fellow at Otago University. The workshop's purpose was to explore ways of addressing wellbeing and social integration challenges; and determining how ongoing measurement of wellbeing and integration can be carried out. This was a rich discussion about wellbeing and what it meant to each of us, what the data is telling us, and reflections from front-line workers on the refugee experience of integrating into our health system and the broader social challenges. Lauralie also presented portions of her research on the former refugee experience of the Southern Health System.

WellSouth has completed the development of its portal to capture claims by practices for consultations provided to former refugees within their first 2 years of settlement. All clients who are still within their first 2 years since arrival have been entered into the portal and the practices are using this new system without any issues. The Pharmacy piece of this is also complete, however, comms to this group is ongoing so the portal is not in full use in pharmacies but will be during Quarter 4.

Plans are well underway to offer Trauma Informed Care Training at the end of May. This will be offered to all those working with Former Refugee clients, but particularly aimed at Mental Health Providers across the sector. This will aim to further build capacity and capability across health care settings. This will be delivered by a psychologist from Refugees as Survivors New Zealand (RASNZ), experienced in child, adolescent and adult mental health care for clients and families from refugee backgrounds. The PHO Mental Health Clinical Coordinator will co-deliver the session.

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

The refugee resettlement programme has resumed. Currently, there are limited intakes, as the Covid pandemic is being managed.

It is anticipated that a prospectus for 2021-22 will be released in May 2021. This will include nationalities, intake volumes, and cohort volumes for respective resettlement cities.

Dunedin City Council

The Dunedin City Council held its second workshop in April in development of 2021 – 2023 Refugee Resettlement Action Plan.

The Programme Lead of Refugee Health presented to the Dunedin Refugee Steering Group around the social determinants of health and how these may impact on the former refugee population as they resettle in the coming years. For example, the unemployment rate of former refugees is 60%. The Programme Lead also raised concerns around integration struggles along with the extraordinary identity changes required for former refugees to meaningfully integrate and resettle in Dunedin. Finally, it was suggested that the Dunedin City Council encourage greater former refugee participation in planning, while also using the Refugee Steering Group as a medium to advocate on national strategic decisions relating to refugee resettlement.

Community Engagement

On 20 April, the Programme Lead of Refugee Health and the Regional Advisor for the Office of Ethnic Affairs (imminently becoming Ministry of Ethnic Affairs) met with the Colombian former refugee community in Invercargill.

The issues raised included:

- Interpreter quality and availability
- Lack of primary care options
- Refugee mental health model
- Surgery delays
- Cultural awareness issues.

The Programme Lead is investigating these issues and will be meeting with the Office of Ethnic Affairs in May and responding to the community in June. Overall, however, the community was pleased with the healthcare they have access to. The Programme Lead views the community's strong turn-out to the meeting as a proactive and engaged example of the former refugee's interest in managing personal wellness.

Population Health Service

Highlights

Community service delivery programmes in Population Health continue to be disrupted whilst staff are deployed to support the roll out of the New Zealand Covid-19 Vaccination Campaign within our district. Roles include vaccinators, vaccination trainers and administration staff. As the Southern DHB newly recruited staff are being trained in these areas, the Population Health staff will be released to Business as Usual (BAU).

The Digital team in Southern DHB are currently assessing encryption for Population Health emails as part of "axe the fax" campaign. The plan is for these email addresses to be made available to external and internal health care providers for any non-referral communications (to replace current faxing). The mechanism for this will hopefully be HealthPoint: www.healthpoint.co.nz

Measles Campaign 15 – 30 year olds

Measles Mumps Rubella (MMR) Campaign is on hold within the Southern DHB. However, General Practices and Pharmacies continue to vaccinate. This is likely to resume in October

Public Health Nurses

April 2021 most BAU activities ceased to support the Covid vaccination clinics.

School Based Human Papillomavirus Vaccination Programme (HPV) Otago

The HPV vaccination programme in Otago schools, has been supported by Public Health Nurses across the district and has been able to continue as planned.

School Based Services Contract

Programmes ceased at present whilst Public Health Nurses are supporting the Covid-19 Vaccination Campaign.

Immunisation Outreach and Vaccine Preventable Disease (VPD) team:

Outreach clinics that were paused due to Covid-19 Vaccination programme have partially resumed in April.

Quarter 3 reporting indicates equity gap of 10% for 8-month old immunisations for Māori which is an increase of 7% from Quarter 2, this is correlated to a decrease in overall 8 month vaccinations from 91% to 85%.

Gateway

Referrals remain low and the Gateway staff continue to encourage referrals to ensure that the children can receive the best health, education and social outcomes.

Cervical Screening

Ministry of Health Colposcopy Audit preparation is underway in April for 27 and 28 May 2021.

Otago/Southland Community Oral Health Service

Service Highlights

- New Enrolments for month = **349**
- Total Enrolments = **46,907**
- Patient contacts for month = **3,950**
- Doses of Fluoride Varnish given for month = **1,852**

Fluoride Varnish Programmes: Maheno Kindergarten and Glen Warren Kindergarten have recommenced their Fluoride Varnish Programmes for this year. Thirty children in total had fluoride varnish applied.

Spacial Equity Project: Work continues in this area, with a brief presentation planned for a future CPHAC meeting.

Automation & Processes:

- E-triaging and E-referrals Project: still underway – currently no opportunity for Dental Referrals to be made electronically, this is being developed so that external referrers can have a central electronic referral. This happens already for other services, but dental have yet to implement this. We have missed the May release but hope to be in the June one
- Titanium: Preparing the information for the business case to upgrade this system. Reviewed the release notes from the updated version and prepared a series of bullet points to identify the advantages and disadvantages of upgrading
- Tele Dentistry: Initial guidelines being drafted regarding Tele Dentistry, once drafted and all supports in place to proceed with this, we will look to pilot at first and then expand out to all areas across the district for our very young children.
- Quarterly Reporting: assisting Service Manager in obtaining correct data from Titanium to complete the Ministry reports. This is, as usual, quite difficult but anticipate significant improvement when we get the Power BI Dashboard.

Community:

- A 4th Chair is now in place at South Dunedin. The final touches are now being worked through and patients will start next month
- Pilot project for drop-in clinic planned for Invercargill is currently being worked on by the Professional Lead

Work Force Development:

- Education: Met with WellSouth Nurse Educator to look at providing clinical education sessions on Oral Health for WellSouth Nurses
- Working with the Charge/Senior Dental Assistant to support her with appraisals and Leading the Team of Assistants in the Unit. Monthly meeting planned to support her development
- New Zealand School and Community Oral Health Services Society Forum in Nelson, celebrating 100 years – great opportunity to network with other DHB Services across the country. All areas are behind and struggling with staffing etc. Our service appears to be in a good place compared to some others. Suppliers attend which allows us to look at new equipment available
- Professional development opportunities being explored, hope to have staff access to a day's webinar series from Australia on Prevention and Restorative dentistry
- Monitoring Sedated Patients: 3 Dental Assistants have applied to attend a one-day course in Dunedin. This course will give them the knowledge they need to monitor the patient's recovery correctly. We do IV sedations in the Dental Unit, the patients used to go up to Day Surgery recovery after the treatment. We are no longer able to do this, and our Dental Assistants require training to provide appropriate post sedation monitoring and care
- Fluoride varnish training for assistants continues – This has progressed much slower than I had hoped but approximately half the staff have completed the Clinical Task Instruction

Arrears:

Arrears across the district continue to be high. There is inequity across the district with some clinics being up to date and others are behind. This is improving in some areas who are receiving considerable focused resource over the first part of this year to improve and catch-up. Forward planning involves

a reassessment of staffing and distribution and review of our service in regard to meeting the needs of our population in an equitable way.

Rural Health

Lakes District Hospital (LDH)

The government decision to open the borders to Australia has resulted in increased preparedness for managing the potential risk of Covid-19 positive patients arriving in Queenstown. Border staff have been vaccinated as have health care professionals working in the hospital and in primary care.

Presentations to the Emergency Department have been similar to 2019 numbers in April. Numbers are anticipated to increase with the easing of restrictions between Australia and New Zealand.

Opportunities to increase access to Outpatient Specialist services for the Queenstown population are being explored, in conjunction with colleagues in Southland. A Nurse Practitioner who specialises in diabetes has been recruited to work across primary and hospital services in Queenstown. She will also work with the specialist nurse in Central Otago to provide a comprehensive service to this high-risk cohort of patients.

A Whānau Room has been developed at Lakes District Hospital. The Whānau Room is the result of a request and support from the Queenstown community. Queenstown has long been a popular place to visit however, this can mean that when people stay in this picturesque region, they and their families are a long way from home. The new Whānau Room means emergency accommodation can be provided for family members of patients receiving care at Lakes District Hospital in Queenstown.

The room has been funded through the generous support of Lakes Hospital Foundation which, through community donations, supports the hospital to go beyond its immediate needs, working with Southern DHB to enhance and improve services. We are very grateful for this support.

Rural Hospitals

The roll out of Covid-19 vaccinations in rural communities has been welcomed by Rural Trust Hospitals and other Rural Health providers. This roll out has involved the Southern DHB Emergency Operations Centre, WellSouth, the Rural Hospitals Project Manager, Primary Care and some rural hospital staff. The cooperation between primary and hospital staff in rural areas has been helpful in enabling these clinics to be established.

Radiology solutions for rural hospitals have resulted in two rural hospitals contracting directly with a private provider, whilst two other rural hospitals will continue to employ radiology staff directly, but link to Southern DHB for some aspects of the service and to access professional support. The fifth rural hospital will continue with the sub-contract arrangement it currently has in place. The process of reviewing this service across the rural region has been positive.

The increased cost of providing Inter-hospital Patient Transfers remains a concern for rural hospitals. A project to review the requirements, costs and identify options for improved service provision will begin shortly.

Central Lakes Localities Network

Continues to work on projects to improve health services in Central Otago and Queenstown Lakes areas. They respond to issues that are flagged by the community. Recently some community members have raised concerns about a lack of secondary maternity services in the area. Any major service development such as this must be linked to a broader strategic view of services across the district. Highlighting gaps is useful, to help inform strategic direction and decision making.

Their work-plan includes a focus on:

- Identifying ways to promote equity to services for Māori

- Increasing access to specialist Outpatient services
- Identifying risks with sole practitioner services e.g. primary care in Roxburgh
- Advocating for Primary Options for Acute Care funding to assist a rural model of Primary Care that is responsive to the diverse presentations within the rural setting
- Identifying barriers to accessing services
- Working on projects with Southern DHB to ensure service development is informed by public consultation, such as the development of primary maternity services in Central Otago and Wanaka.

Pharmaceutical Utilisation

Pharmaceutical Data and Analytics

DHB Pharmacy advisor has been seconded to COVID Vaccine programme, with recruitment underway for backfill.

Needs Assessment

Pip Greco (Unit Manager) and PJ Shittu (Clinical Coordinator) attended the Needs Assessment Service Coordination Association Annual General Meeting. This provided a valuable opportunity for learning and sharing information with Needs Assessment Service Coordination regarding service delivery and initiatives. It was noted many other regions are struggling with extensive waitlists for Needs Assessment Service Coordination (up to 700). The other services have requested further information regarding SDHB successes including Home as My First Choice, Home to Assess, Home Team and Discharge supports.

Older Persons Health and AT&R

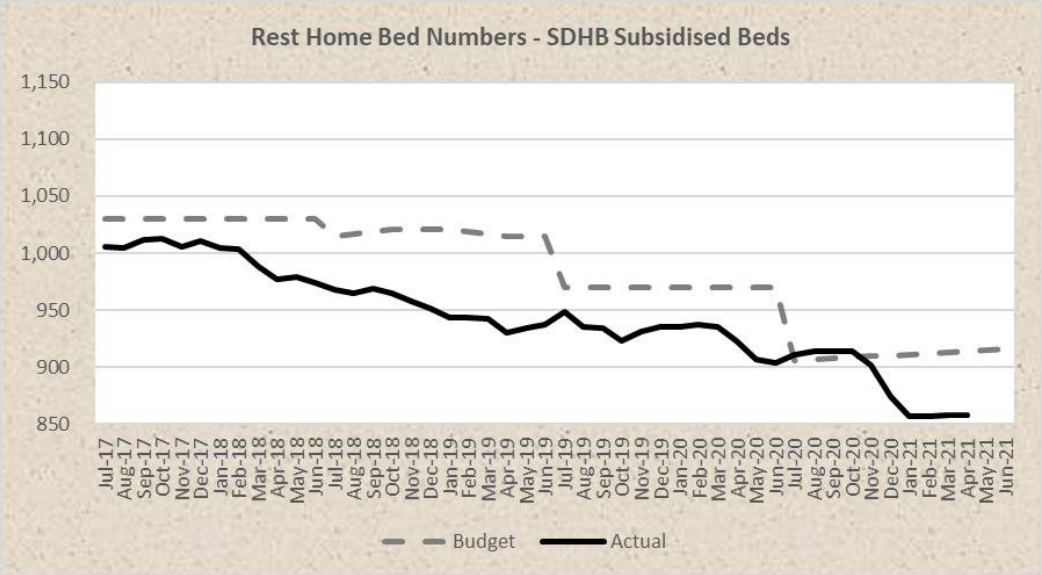
Aged Residential Care Occupancy/Volume Analysis

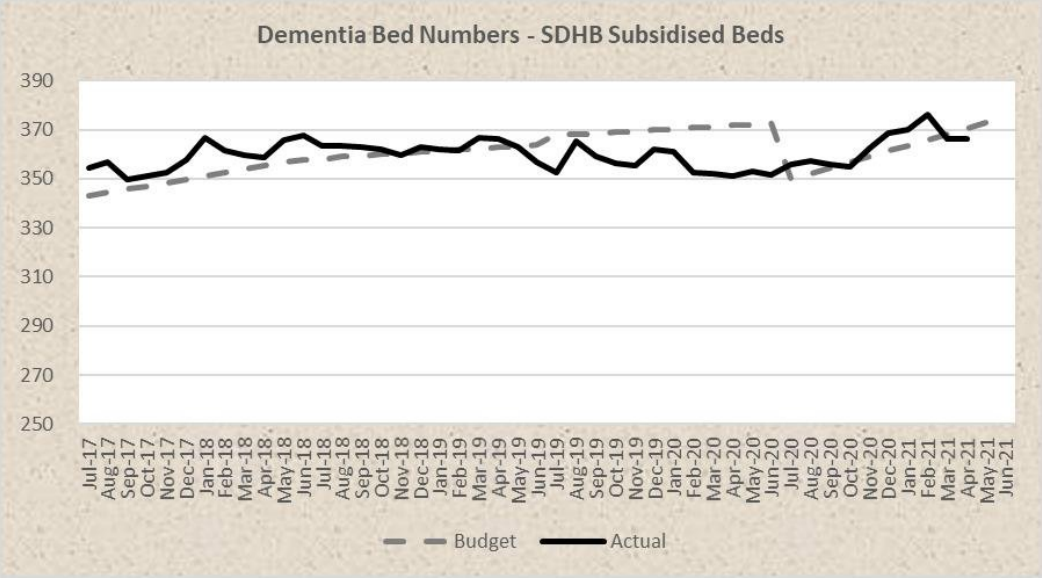
The DHB continues to experience elevated levels of occupancy in Aged Related Residential Care (ARRC), although at slightly improved levels when compared to previous months. Elevated levels of occupancy do persist at Hospital and Psychogeriatric levels of care. After the increases in the first half of 2020, total bed utilisation has remained relatively stable for the past 6 months. Power BI is being utilised in the analysis of the complex datasets, which is providing useful insights, and then further questions. The tools are being continually refined.

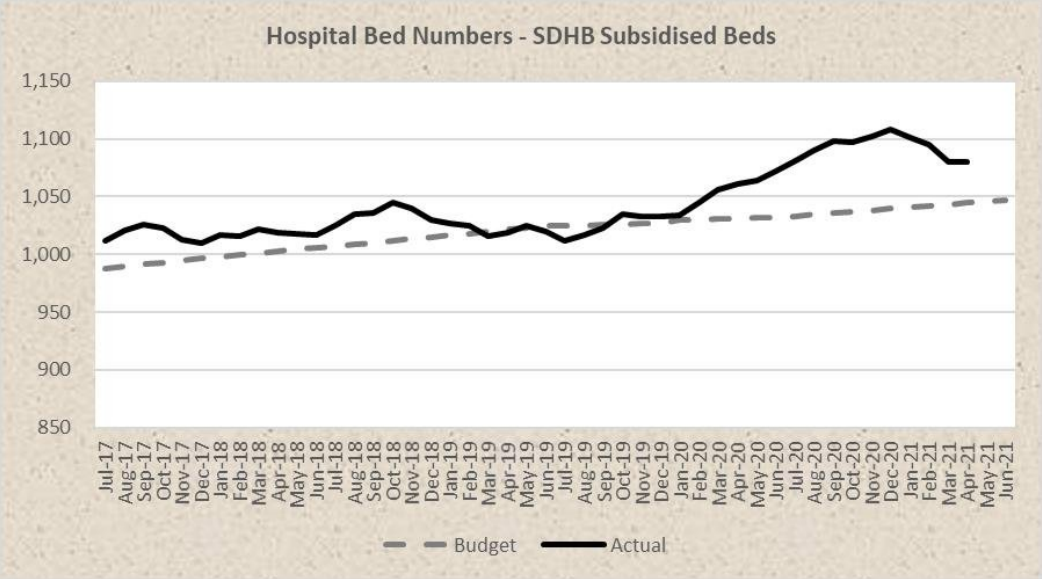
Some high level observations include:

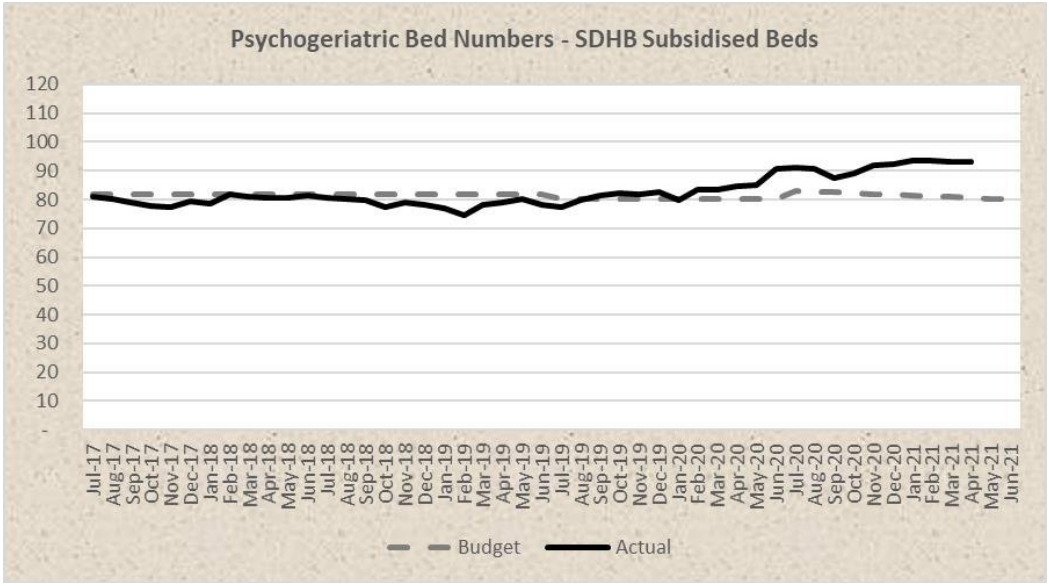
- Fewer people are entering ARC at Rest Home level care
- More people are entering ARC directly to Hospital level care
- More people at Rest Home level care are moving to Hospital level care

The data and analysis are complex with many individual journeys within the system. While we are getting a better view of what is happening, understanding why is more challenging.


Rest Home 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


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



Allied Health

Work on the relocation of Dunedin Physiotherapy Outpatients continues and has evolved into a substantial project involving a large number of teams and services. Given the scale of the project, discussions are in progress on project scope and governance, including facility design/development, Models of Care/clinical, Workforce/HR, and IT/digital.

A decant plan was presented to ELT which required more engagement with ELT members and teams. An architect has been engaged with design as adapting the existing building is providing some challenges and is waiting to commence once ELT have approved the decant plan. It is intended to run user groups to assist with the design process which will take 2-3 months. The work to move the Physio Outpatients and partner services is significant and carries risks that may impact timelines, and therefore vacating the space for the MAU. Already Building & Property forecast the timelines are into 2022, which is starting to create tensions with the MAU project.

FOR INFORMATION

Item: PHO Performance Update

Proposed by: Rory Dowding, Acting Executive Director Strategy, Primary & Community

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

Recommendation

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

Purpose

The purpose of this report is to provide CPHAC with an overview of Primary Care for Quarter 3, 2020-21

SP&C Services – Primary Care report Q3 2020-21

EXECUTIVE SUMMARY *Lead Executive: Rory Dowding*

These health services and their associated measures below are noted as below targets. They are closely monitored by both Ministry of Health (MoH) and SDHB. For further comments and activities that are in place to address these issues, see page 2.

Service Measures	Quarter 3 2020-21	Target	Trend - Over 3 Reported Q's	Commentary
After-hours primary care initiatives	79% of ≤ 14 year old children within SDHB have access to zero fees for after-hours	100%	↑	• MoH rates this performance as "B – Further work required" and has asked for a substantial plan on how this issue will be eliminated. • The lack of primary care access for ≤ 14 year old children is concentrated in Invercargill. Invercargill Urgent Doctor Service is the only after-hours provider that charges under-14s for services. All other parts of Southern District provide free care to under 14 patients after hours. • See p2 – Primary Care Access
Percentage of the eligible population who have had a CVD risk Assessment in the last 5 years	75% (Maori) 74% (Total Pop)	90%	→ →	• Absolute CVD risk assessment is an integrated approach that estimates the cumulative risk of multiple risk factors to predict a heart attack or stroke event in the next five years. • 16% below target. • See p2 – Clinical Risk.
Percentage of the population identified with diabetes having good or acceptable glycaemic control.	49% (Maori) 55% (Total Pop)	60%	↑ ↑	• 5% below target • Equity disparity. • See p2 – WellSouth Call Centre. • See p2 – Clinical Risk.

Continued

Service	Quarter 3 2020-21	Target	Trend - Over 3 Reported Q's	Commentary
Percentage of the diabetic population who have had at least one HbA1c measurement in the last year	77% (Maori) 79% (Total Pop)	90%	↑ ↑	• HbA1c is a measure of how well controlled a patient's blood sugar has been over a period of about 3 months. It essentially gives a good idea how high or low, on average, blood glucose levels have been. • 11% below target. • See p2 – WellSouth Call Centre. • See p2 – Clinical Risk.
Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care and offered brief advice and support to quit smoking.	79% (Maori) 81% (Total Pop)	>90%	↑ ↑	• 19% below target. • See p2 – WellSouth Call Centre.
Percentage of people ≥ 65 having received a flu vaccine	59% (Maori, Q1 Data) 65% (Total, Q1 Data)	>75%	Q1 Data Only Q1 Data Only	• 10% below target. • Equity disparity. • See p2 – WellSouth Call Centre.
Ambulatory sensitive hospitalisations (ASH) – Adults 45 to 64	4,472/100K (Maori) 2,905/100K (Total Pop)	NA	→ →	• Maori rate is in line with national benchmarks. • This Maori equity disparity is correlated with low rates of primary care enrolment for Maori (see below).
Improving Maori enrolment in PHOs to meet the national average of 90%	79% (Maori) 92% (Total Pop)	90%	→ →	• Equity disparity that has significant flow-on effects (as above). • Second lowest performing rate nationally.. • See p2 – Service Delivery.

Trend Legend: ↑ Improving; → No Change; ↓ Deteriorating.

SP&C Services – Primary Care report Q3 2020-21 - page 2

EXECUTIVE SUMMARY *Lead Executive: Rory Dowding*

Activities and Services of Note

WellSouth Call Centre

In response to below target performance across indicators noted on page 1, the PHO has set up a call centre to support GP practices. Activities of the Call Centre include:

- Maori Wellness Checks, Covid Swabbing requests and Unenrolled support.
- In November WellSouth engaged its Call Centre to contact patients on practices' behalf to encourage relevant patients to stop smoking. Since December 2020, the Call Centre has contacted 2048 patients, of which 198 consumers were referred to the Southern Stop Smoking Service.
- Follow-ups for unredeemed GP consultation vouchers.

It is suggested that WellSouth utilise the Call Centre to:

- Follow-up with patients who have not had cervical screening in <5 years
- Follow-up ≥65 year-old patients who have not received a flu vaccine for Q4.

A quarterly update from the PHO advising of both measured effectiveness of the Call Centre and targets and services that are being addressed is suggested for consideration.

Clinical Risk Populations

A CVD risk assessment (CVDRA) tool has been developed and has now been implemented

- WellSouth has recently extended the eligibility for claiming CVDRA's to include all people with severe and enduring mental health and people of South Asian ethnicity as reflected in the guidelines. This has helped with an increase in the number of completed CVDRAs.

Glycaemic control (Diabetes)

- The Long-Term Care (LTC) Nurse will be rolling out an education package (on-line and in-person) on insulin initiation mentoring (insulin initiation is the term used for starting a new patient on prescribed insulin).
- As noted on p1, HbA1c results have not been achieved. In response to this, a new Local Diabetes Team has been established with PHO involvement. This group has supported a number of initiatives that support the wellbeing of patients with diabetes. PHO relevant initiatives include:
    - WellSouth PHO has created a Diabetes Strategic Working Group who have been analysing and reviewing our Annual Diabetes Review (DAR) data to highlight gaps in service delivery. We have taken a whole of organisation approach to supporting diabetes in primary care. The group has developed project objectives:
        - Every person with diabetes has an annual DAR
        - To understand why DARS have reduced at all levels: patients, practices and PHO
        - To support practices with a range of ideas to increase DARs.

Primary Care Access

- Invercargill After Hours Primary Care – Due to there being challenges in accessing after-hours service primary care, a significant volume of the community uses the Southland Hospital Emergency Department (ED). This negatively impacts the smooth and effective operation of ED and compromises clinical safety for the population of Invercargill. Invercargill primary care providers have written to WellSouth indicating that their After-hours Service is not sustainable and are working with the PHO on a new model for sustainable after-hours and urgent care services.
- Rural Premium Service (SDHB funds $4.6M for this service, which is not tagged to specific activities)
    - PHO advises that providing after-hours services for rural practices that are isolated from hospitals is an ongoing challenge.
- After-hours Wanaka Service continues to struggle to find staffing for its overnight service. Wanaka primary care providers have written to WellSouth indicating that their After-hours Service is not sustainable and are working with the PHO on a new model for sustainable after-hours and urgent care services.
- Nurse Practitioner led service in Invercargill is currently being established by WellSouth PHO to initially address the population who cannot enrol into a primary care provider.

Service Delivery – Total Enrolment, Very Low Cost Access (VLCA) & Community Services Card (CSC) Practice Rates

Service Delivery	Quarter 3	Quarter 2	Quarter 1
% of Pop enrolled w/ GP	91.76%	91.60%	91.34%
% of VLCA Practices	6%	6%	6.2%
% of Practices in CSC Prog.	93%	93%	92.6%

Refugee Primary Health Services

Following an underspend, WellSouth has fully recruited to roles. Other activities and issues of note:

- WellSouth provided a constructive improvement proposal in late 2020.
- A service model/delivery workshop was held in March 2021.
- Current service contract has now been signed by WellSouth.

1.30 pm

Presentation: Business as Usual (BAU) of Public Health South

- Lynette Finnie
  Acting General Manager, Public Health, Population Health, Oral Health and Women & Children Portfolio Manager

1.45 pm

Presentation: Primary Care in Invercargill

- Andrew Swanson-Dobbs
  CEO, WellSouth Primary Health Network

FOR INFORMATION

Item: General Practice Workforce Update

Proposed by: Andrew Swanson-Dobbs, CEO WellSouth

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

Recommendation

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

Background

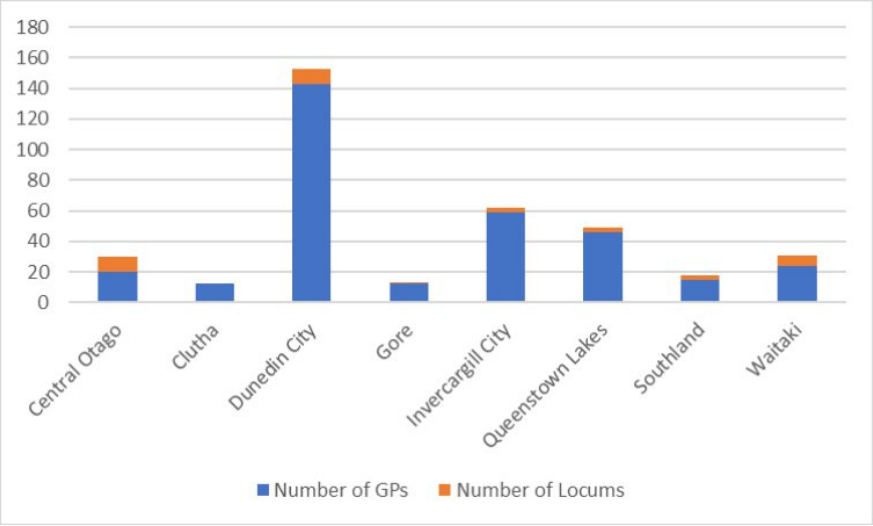
GP Workforce in Southern

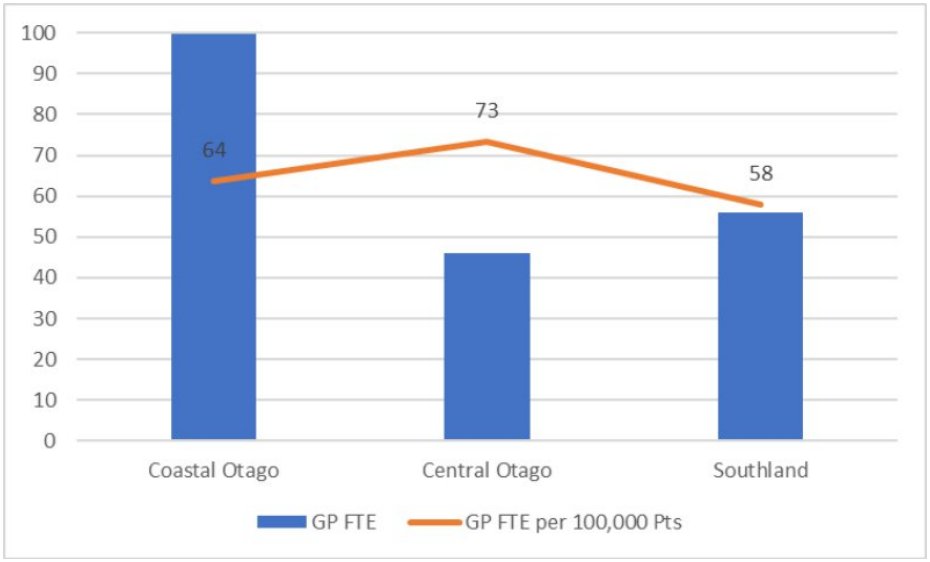
Each quarter general practices provide a list of their staff, both clinical and administrative, who are working in practice.

We ask for demographic information, including age, gender and self-identified ethnicity to inform our picture of the workforce. This data relates to the Jan quarter.

General Practitioners

Practices themselves identify a GP as either employed (or an owner) or a locum. While the definitions of locum and employed GP are open to interpretation, generally a locum is in place to fill a short-term gap in workforce, and GP has a long-term employment arrangement with the practice. Over the district there are 331 GPs working in our practices, representing 201.65 FTE, and 37 locums.





The number of GPs only tells part of the story. Based on GPs per 100,000 population, there is variability in the ratio of patients to GPs. Given mobility of the workforce, the TLA-level data doesn't tell much of a story, so we have separated the District into three localities: Coastal Otago (Waitaki, Dunedin, Clutha), Central Otago (Central Otago, Queenstown Lakes) and Southland (Invercargill, Southland, Gore). Southland has the fewest GPs per 100,000 patients. Southland also has access to less than 20% of the locums in Southern.

GP Demographics

Across Southern, the average age of GPs is just over 50 years. On average, the most experienced GP workforce is in Invercargill, where the average age is 52.4 years, and the youngest workforce is in Queenstown Lakes where the average age is 46 years. Across the District, 20% (37 individuals) of the GP workforce is aged under 40 years, and 22% (42 individuals) is aged over 60 years.

By way of comparison, the 2018 General Practice Workforce Survey[1] found that the median age of GPs across the country was 52 years, with 25% aged over 60 years.

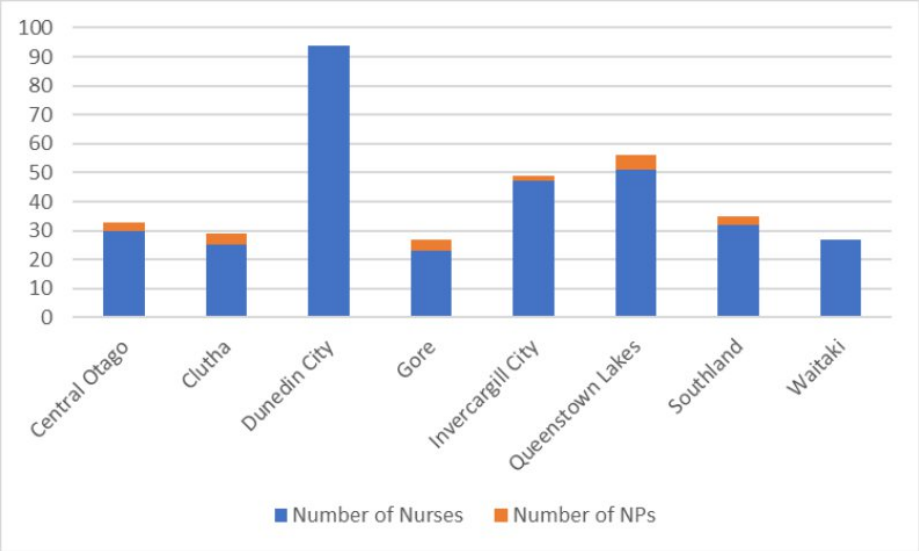
The workforce is slightly more female than male, with 52% of the GPs identified as women. Across New Zealand, 55% of GPs are women, according to the Survey.

Practices were less likely to respond to questions about ethnicity, but anecdotal evidence suggests that Southern is in a similar position to New Zealand overall with Maori and Pacific people less represented in the GP workforce than their proportion of the population suggests.

[1] https://www.rnzcgp.org.nz/gpdocs/New-website/Publications/GP-Workforce/WorkforceSurvey2018Report1-revised-July-20194web.pdf

Nurses and Nurse Practitioners

Returns report 329 nurses across the District, representing 180 FTE. There are 21 Nurse Practitioners working in primary care in Southern District, the majority of whom are in our rural areas.



Across the District there are 0.89 nurse FTE per GP FTE, with the lowest Nurse:GP ratios in our urban practices, where the ratio is three nurses for every four GPs. In Clutha and Gore there 1.9 and 1.6 nurses per GP respectively.

Nurse Demographics

The primary nursing workforce is overwhelmingly female with less than 1% of nurses being men.

The average age of the nursing workforce is 46.7 years, with TLAs ranging from an average age of 43 years in Southland and 49 years in Dunedin.

For Information:

Item: Maori Enrolment

Proposed by: Andrew Swanson-Dobbs

Meeting: CPHAC

Recommendation:

That the Board:

- **Notes** the background information on the issues with data collection
- **Notes** activity currently underway to increase enrolment

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Background:

Enrolment in a primary health organisation (PHO) is voluntary. Most New Zealanders are however enrolled with a PHO via their general practice and gain the benefits associated with belonging to a PHO, which can include cheaper doctors' visits, reduced costs of prescription medicines and access to screening and other clinical programmes to support health and wellbeing.

The national enrolment target is 90%.

WellSouth enrolment data shows Māori enrolments increased to 29,938 on 1 February 2021.

Ethnicity	Patients
Asian	17890
European	256110
Maori	29938
Other	5035
Pacific Island	7167
Unknown	531
Total	**316671**

MoH data estimates that only 79% of NZ Māori that are projected to live in the Southern region are enrolled in a PHO using population projections provided by stats NZ in December 2020.

This data includes people domiciled in the region but enrolled in a practice outside of the region.

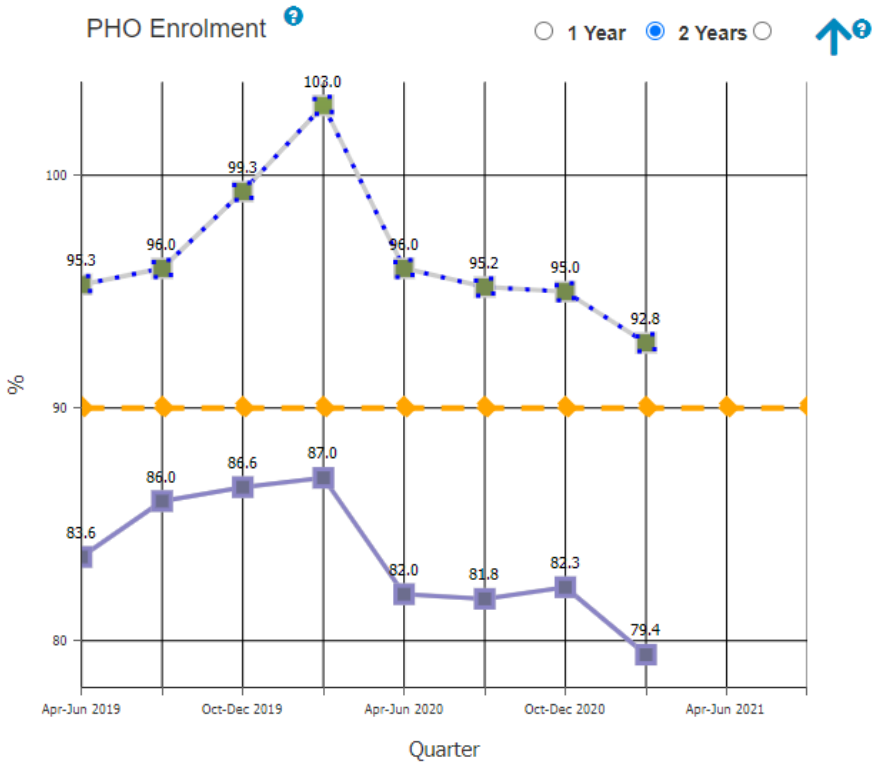
Access to Primary Care by Ethnicity (January 2021)

This report shows the number and estimated percentage of the New Zealand population (based on Stats NZ population projections) who are enrolled in a PHO by ethnicity.

	Total			Maori			Pacific			Other		
DHB of Domicile	Total Enrolled	Total Population	%	Total Enrolled	Total Population	%	Total Enrolled	Total Population	%	Total Enrolled	Total Population	%
Auckland	464,549	507,370	92%	33,566	41,330	81%	55,651	55,820	100%	375,332	410,220	91%
Bay of Plenty	248,395	265,110	94%	60,240	68,690	88%	4,383	4,890	90%	183,772	191,530	96%
Canterbury	547,664	585,000	94%	47,933	58,270	82%	15,958	17,170	93%	483,773	509,560	95%
Capital and Coast	302,067	325,540	93%	33,470	38,640	87%	22,648	23,490	96%	245,949	263,410	93%
Counties Manukau	568,896	598,520	95%	82,562	97,470	85%	143,041	132,020	108%	343,293	369,030	93%
Hawkes Bay	167,634	179,050	94%	43,650	49,990	87%	6,203	7,800	80%	117,781	121,260	97%
Hutt Valley	150,816	159,490	95%	24,574	28,690	86%	11,865	12,540	95%	114,377	118,260	97%
Lakes	109,631	118,000	93%	37,954	44,150	86%	2,758	2,970	93%	68,919	70,880	97%
MidCentral	174,112	187,840	93%	31,666	40,200	79%	5,446	6,160	88%	137,000	141,480	97%
Nelson Marlborough	152,712	161,610	94%	14,894	18,320	81%	2,454	3,320	74%	135,364	139,970	97%
Northland	186,947	195,290	96%	65,283	71,360	91%	3,668	4,100	89%	117,996	119,830	98%
South Canterbury	59,768	62,090	96%	4,653	5,790	80%	1,096	1,010	109%	54,019	55,290	98%
Southern	321,419	350,940	92%	30,341	38,190	79%	7,438	8,150	91%	283,640	304,600	93%
Tairawhiti	49,530	51,025	97%	24,869	27,800	89%	1,052	1,215	87%	23,609	22,010	107%
Taranaki	117,776	125,100	94%	20,949	26,050	80%	1,579	1,800	88%	95,248	97,250	98%
Waikato	415,856	440,240	94%	90,061	107,710	84%	13,052	13,500	97%	312,743	319,030	98%
Wairarapa	47,485	49,010	97%	8,396	9,050	93%	1,008	1,050	96%	38,081	38,910	98%
Waitemata	603,249	643,020	94%	53,045	64,910	82%	45,624	46,720	98%	504,580	531,390	95%
West Coast	31,408	32,395	97%	3,546	4,080	87%	343	375	91%	27,519	27,940	98%
Whanganui	65,455	68,740	95%	17,223	19,410	89%	1,695	1,990	85%	46,537	47,340	98%
National	**4,785,369**	**5,105,380**	**94%**	**728,875**	**860,100**	**85%**	**346,962**	**346,090**	**100%**	**3,709,532**	**3,899,190**	**95%**

Note: The estimated percentage of those who are enrolled in a PHO may exceed 100% as data is sourced from two different places (Ministry of Health & Stats NZ). Population is based on projections provided by Stats NZ in Dec 2020.

According to Trendly dataset (https://www.trendly.co.nz/Home/ViewReport) a further 4,030 Māori enrolments or an improvement of 10.6% is required to reach the national target of of 90%.



PHO Enrolment for Māori in Southern DHB reached 79.4% in the Jan-Mar 2021 period. This represents a -2.9% difference since Oct-Dec 2020.

An improvement of 10.6% is needed to reach the national target of 90.0% in Southern This would require enrolling an additional 4,030 Māori.

Wairarapa was the best performer for PHO Enrolment in the most recent period, reaching 92.8% for its Māori population.

Detailed Analysis of the Maori Population as of March 2021:

Ethnicity Data Challenges:

The ethnicity data in the general practice management system (PMS) may not reflect the ethnicity data in the Census data due to the way information is coded by clinicians in the PMS system.

- For Medtech PMS there are issues with Linktech that affect the transmission of ethnicity data from the PMS to the PHO for example the coding has the ability to acknowledge up to 3 separate Ethnicity groups for example within a PMS Ethnicity 1 may be recorded as European and Ethnicity 2 as Maori. When the LinkTech application in Medtech gathers the information from the PMS to upload it to the PHO it may only be picking up Ethnicity 1, leading to underreporting of Maori ethnicity data.
- Some practices admin staff may not fully aware in collecting and inputting ethnicity data leading to inaccuracies in General Practice this needs to be addressed in consistent coding.

Factors which reduce the projections in the district:

Factors	Numbers	Comments
SIT	Unknown	Unknown at this stage but there is a population here which would have been counted in the projections but are not enrolled in the district due to being enrolled elsewhere
University of Otago	1662	University of Otago Maori population not recognised in enrolment due to being enrolled elsewhere but counted in projections as they were in Otago studying at the time of census.
PMS and National Enrolment Service (NES) discrepancy	994	PMS shows this number as Maori in the PMS which hasn't updated the National Enrolment Service where stats gets there numbers from to use in the projection.
Enrolled elsewhere (Hawkes Bay, Canterbury etc)	1528	Maori actually enrolled elsewhere but domiciled in Southern (Note some of these wil be duplicates with the UNI and SIT data.)
TOTAL	**4,184**	Total of Maori accounted for in relation to projected data.
Previously projected Maori Population (denominator)	**38190**	
Current Enrolled in WellSouth (numerator)	**30341**	
New projected Maori Population based on contributing factors (new denominator)	**34006**	
Percentage of Maori enrolled after contributing factors	**89%**	

Figure 1 – District Averages

Numbers (Trendly NZ)
Displays the absolute number of cases making up the results for this indicator.

Average 2021 85%

Range	Apr-Jun 2020		Jul-Sep 2020		Oct-Dec 2020		Jan-Mar 2021	
Māori (Southern)								
Numerator	29920	82%	30070	82%	30361	82%	30341	79%
Denominator	36545		36740		36910		38190	
Māori (Northland)								
Numerator	64408	94%	64642	94%	64966	94%	65283	91%
Denominator	68355		68630		68895		71360	
Māori (Waitemata)								
Numerator	52719	84%	52856	83%	52976	83%	53045	82%
Denominator	63110		63390		63660		64910	
Māori (Auckland)								
Numerator	32995	82%	33050	82%	33336	83%	33566	81%
Denominator	40155		40250		40345		41330	
Māori (Counties Manukau)								
Numerator	83184	89%	83071	89%	82772	88%	82562	85%
Denominator	93180		93560		93905		97470	
Māori (Waikato)								
Numerator	89646	87%	89695	87%	89925	86%	90061	84%
Denominator	103035		103510		103965		107710	
Māori (Lakes)								
Numerator	37630	89%	37701	89%	37837	88%	37954	86%
Denominator	42405		42580		42755		44150	
Māori (Bay of Plenty)								
Numerator	59586	91%	59579	91%	59894	91%	60240	88%
Denominator	65485		65740		66000		68690	
Māori (Tairawhiti)								
Numerator	24728	94%	24706	93%	24760	93%	24869	89%
Denominator	26360		26430		26515		27800	
Māori (Taranaki)								
Numerator	20683	83%	20722	83%	20855	83%	20949	80%
Denominator	24835		24960		25055		26050	
Māori (Hawke's Bay)								
Numerator	43518	92%	43605	92%	43601	91%	43650	87%
Denominator	47395		47550		47690		49990	
Māori (Whanganui)								
Numerator	17107	92%	17101	92%	17168	92%	17223	89%
Denominator	18575		18640		18670		19410	
Māori (Mid Central)								
Numerator	31003	80%	31164	80%	31537	81%	31666	79%

Denominator	38515		38720		38895		40200	
Māori (Hutt Valley)								
Numerator	24483	88%	24460	88%	24515	88%	24574	86%
Denominator	27705		27810		27910		28690	
Māori (Capital & Coast)								
Numerator	33277	89%	33287	89%	33501	89%	33470	87%
Denominator	37415		37580		37715		38640	
Māori (Wairarapa)								
Numerator	8403	96%	8364	95%	8383	95%	8396	93%
Denominator	8745		8790		8825		9050	
Māori (Nelson Marlborough)								
Numerator	14569	83%	14714	84%	14808	84%	14894	81%
Denominator	17470		17550		17665		18320	
Māori (West Coast)								
Numerator	3447	89%	3482	90%	3519	90%	3546	87%
Denominator	3885		3890		3890		4080	
Māori (Canterbury)								
Numerator	46934	84%	47281	84%	47588	84%	47933	82%
Denominator	55665		56020		56365		58270	
Māori (South Canterbury)								
Numerator	4585	82%	4589	82%	4623	82%	4653	80%
Denominator	5565		5620		5665		5790	

Initiatives to increase Maori Enrolments

Maori Health Provider:

WellSouth will continue to fund all Māori health providers in the district to:

- Increase the number of Māori enrolled in primary care
- Increase the timely utilisation of primary health care service by Māori
- Work with key health care providers to enhance the effectiveness of referral pathways and models of care for Māori communities.
- Increase the ownership and capacity (skills and knowledge) of Māori communities to help improve and protect their wellbeing.

These services will target Māori either not enrolled in a Practice and/or not attending the Practice for regular health or screening programmes.

The providers:

- Identify Māori who are not enrolled with a primary care practice or not actively accessing appropriate health services.
- Educate and inform Māori about health services, health issues and general health matters
- Assist Māori to become familiar with, and become comfortable using, primary health services.
- Work with primary care and other health services to remove barriers to access for Māori.

- Assist Māori to attend appointments and to carry out advice from health professionals.

HAUORA MATUA KI TE TONGA (WELLSOUTH PRIMARY HEALTH NETWORK)

New Invercargill Primary Care Service
Supporting general practices, their patients and whānau in Invercargill, WellSouth is launching a new primary care service for unenrolled patients.

The new service is aimed at supporting patients who are not currently enrolled with a practice, providing access to care and the same funded programmes delivered at most other general practices. These include vaccinations, screening programmes, support for long-term conditions, such as diabetes, and other preventative care services. Other benefits of enrolment include lower fees for appointments and continuity of care – as providers will know more about patients, their health history and personal circumstances.

Very Low Cost Access Practices (VLCA)
WellSouth continues to provide some additional funding to support the ongoing success of the five VLCA practices across the region- Bluff Medical Centre, He Puna Waiora, Dunedin Community Support, Servants and Te Kaika.

Maintain current enrolments
WellSouth's practice network team continues to work to encourage general practice to ensure their existing Māori enrolments are maintained. Practices are encouraged to utilise the reports available to them, identifying Māori who will shortly become unenrolled, and to actively re-enrol them.

To assist with this, WellSouth will contact all Māori that have fallen off a practices enrolled population and support them to enrol whenever possible.

Data quality education
Assistance program for General Practice to ensure good quality coding for ethnicity in General Practice. Monitoring and spot checks of NES vs PMS data on a monthly basis. A consistent approach to data analysis to ensure all parties are referencing the correct data linkages.

Fund initial consultation
WellSouth will fund a 45 minute extended consultation for all new Māori (and Pacific) enrolments as well as those who have been actively re-enrolled to ensure their engagement/reengagement with the practice, and access to clinical and screening programmes.

Vouchers
The WellSouth voucher programme continues to target Māori, Pacific and other priority populations. The programme supports patients who are unable to pay, and without the voucher would not visit their GP/Practice Nurse or pharmacy.

Vouchers can be issued by a range of community providers including Māori and Pacific health providers, public health nurses, community mental health, community probation, corrections, MSD/WINZ and social sector agencies.

Vouchers can also be used to support enrolment and one of the conditions of use is that the issuer supports the person receiving the vouchers enrolment if necessary.

WellSouth will work with voucher issuers to ensure the ongoing focus on enrolment for anyone receiving a voucher.

Outreach Team
The WellSouth Outreach team will check the enrolment status of any whānau members in the household of clients they are working with and facilitate their enrolment when necessary.

Hauora Wellness Checks
Hauora wellness checks targeting Māori over 55 will check the enrolment status of others within the whānau household and facilitate their enrolment when necessary.

Call Centre/electronic enrolment form
An 0800 number (**0800 478 256**) has been launched for anyone in the community to call if they are having difficulty enrolling in a practice in the southern region.

An electronic enrolment form will also be added to the wellsouth website.

Cards and posters have been produced and are being distributed to advertise the call centre.

Social Sector and other agencies
WellSouth will work with social sector and other agencies who may be working with the unenrolled and encourage them to promote the benefits of enrolment to their clients and support them to become enrolled when necessary.

GEN2040
The Generation 2040 project (Gen2040) is leading the national rollout of a suite of electronic pregnancy assessment tools called the Best Start Kōwae. These tools facilitate significant improvements across health services, ensuring all pēpī, especially pēpī Māori, are given the best start in life. The tool provide financial incentives for pēpī Māori

WellSouth will support the roll out of the project across the southern region.

COVID-19 Vaccination Programme
The immunisation programme will provide an opportunity to check enrolment status of all Māori being immunised and to facilitate enrolment when needed.

PIKI TE ORA (SOUTHERN DISTRICT HEALTH BOARD)

A project to be initiated to data check the enrolment status of all Māori ED attendances, Outpatient attendances and Inpatient admissions, and facilitate enrolment when necessary.

In addition, Te Ara Hauora, Te Huinga Tahi, He Korowai Oranga and Te Oranga Tonu Tanga will also promote the benefits of enrolment to whānau thyey are working with and support them to become enrolled if necessary.

FOR APPROVAL

Item: Community Water Supply Fluoridation

Proposed by: Tom Scott, Team Leader Policy, Strategy and Support

Meeting of: 1 June 2021

Recommendation

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

Purpose

To provide an update on the fluoridation status of community water supplies in the Southern District and its link to child oral health status.

Specific Implication for Consideration

Financial

- Nil

Quality and Patient Safety

- Nil

Operational Efficiency

- Nil

Workforce

- Nil

Equity

- As a population health intervention, it is well recognised that the fluoridation of community water supplies leads to equity within the affected population.

Other

- Nil

Background

- There is compelling evidence that fluoridation of water at established and recommended levels produces broad health benefits for the dental health of New Zealanders
- The Minister of Health will soon be introducing legislation that will mandate the Director General of Health to require that community water supplies are fluoridated. This will remove the mandate from Local Authorities.

- This paper identifies that 58% of the population of Southern DHB drink fluoridated water. The highest proportion of the population with fluoridated water are Invercargill City (100%). The lowest proportion of the population with fluoridated water are in the Waitaki, Central Otago, Queenstown-Lakes, Gore and Southland Districts (no community water supplies are fluoridated). It needs to be noted that a number of people who live rurally in the Southern District live in houses that have their own water supplies.

- Child oral health data from the Southern District indicates there are serious inequalities between the total population and Māori and Pacific populations.

- Southern DHB Annual and Long-Term Plan submissions routinely advocate for fluoridation of non-fluoridated water supplies.

Discussion

More detailed work is currently underway to relate data from the Southern Child Oral Health Patient management system to the oral health status of the communities' children live in. This information will be a useful tool to prioritize those unfluoridated communities for future fluoridation.

Next Steps & Actions

Public Health South is currently in regular dialogue with officials in most Southern Local Authorities. We will be taking the opportunity to articulate fluoridation in those Councils where there is potential for population health gains in fluoridating some of their community water supplies.

Appendices

Appendix 1	Community water supply fluoridation: information for CPHAC

Community water supply fluoridation: information for CPHAC

Community water fluoridation is the process of adjusting the level of fluoride in the supply to between 0.7 mg/L and 1.0 mg/L to prevent tooth decay. The amount added is monitored to make sure that the levels stay within that range.

Fluoridation of community water supplies improves oral health
"There is compelling evidence that fluoridation of water at the established and recommended levels produces broad health benefits for the dental health of New Zealanders." Royal Society of New Zealand, 2014[1]

Research into fluoridation has been conducted around the world for many years. Although research questions remain, the weight of scientific evidence supports community water fluoridation as a safe and cost-effective method of improving oral health and reducing inequities in oral health status. Community water fluoridation benefits individuals throughout their lifespan. This is of increasing importance now that more people are retaining their teeth into later life. No other options can compete with community water fluoridation in terms of population coverage and overall clinical effectiveness. Community water fluoridation is supported by a wide range of national and international authorities, including the World Health Organisation.

A review[2] of 59 studies published worldwide between 1990 and 2010 confirmed the effectiveness of community water fluoridation in the prevention of dental caries (holes in teeth). Caries reduction for primary (baby) teeth was 30-59%, and for permanent teeth was 40-49%. An Invercargill study[3] reported a caries reduction in primary teeth of 33% and permanent teeth of 50%. Another New Zealand study[4] showed that Dunedin children had significantly fewer dental lesions if they lived in a fluoridated area. Conversely, children in non-fluoridated areas had more severe dental problems and at a younger age.

Dental caries is the most common chronic disease among New Zealanders of all ages. It causes pain, infection, impaired chewing ability, tooth loss, compromised appearance, and absence from work or school.[1] Studies from around the world and New Zealand have consistently found that people who live in areas where water is fluoridated have fewer dental caries compared to those in non-fluoridated areas.

Fluoridation of community water supplies is cost-effective
A recent study[5] of the costs and benefits of community water fluoridation in New Zealand found that it is cost-effective for populations of 500 or greater. Earlier New Zealand studies[6–8] reported higher break-even population sizes, but they were based on limited and now outdated data. The latest re-evaluation compared forecasted health benefits over 20 years based on peer-reviewed, published epidemiological data against fluoridation costs in terms of a) set up and capital, b) the ongoing supply of fluoride, and c) ongoing operational costs (Table 1). Cost data were supplied by local authorities and the New Zealand Dental Association.

Table 1. Estimated cost of water fluoridation via sodium fluoride by plant size[5]

Plant size	Population	Total capital set-up costs	Annual operating costs	Annual fluoride supply cost per m^3/day
Neighbourhood	<100	$112,500	$6700	$3.57
Small	101–500	$117,500	$7100	$3.46
Minor	501–5000	$170,000	$8200	$3.41

For neighbourhood and small plants, the cost of fluoridation is greater than the estimated cost offsets from averted dental costs. **For minor plants, there is a net cost saving**. The break-even point is reached by minor plants supplying a population of over 500. For a minor plant serving a population of 2500, a net saving of $591,000 is forecast over a 20-year horizon (based on an estimated fluoridation cost of $348,000 and dental care cost of $939,000).

Fluoridation of community water supplies is considered safe at recommended levels
Some people are worried about the potential health risks of community water fluoridation. Concerns have been raised about cancer, cardiovascular and renal disease risk, and reproductive and endocrine system effects. These concerns have been extensively reviewed by experts[1] who concluded that they are not supported by current scientific evidence.

Two very recent scientific reviews[9,10] of the evidence for developmental fluoride toxicity reached inconsistent conclusions. The first[10] recommends that neurotoxic risks should be considered in determining the safety of community water fluoridation. Included studies are suggestive of dose-dependent fluoride neurotoxicity, but most are cross-sectional and based on populations with fluoride exposures higher than those provided in community water supplies. Results of the two most relevant studies[11,12] (due to directly evaluating community water supply fluoridation) are conflicting. One was a Dunedin-based prospective study,[11] where no statistically significant differences in IQ due to fluoride exposure were observed. The other was a prospective birth cohort study in Canada,[12] where higher fluoride exposure during pregnancy was associated with modestly lower IQ scores in boys aged 3–4 years. Neither study considered maternal IQ, and they were heterogeneous in their assessment of intelligence and other important confounders.

The second recent review[9] concluded that current evidence does not support the view that fluoride exposure at currently recommended levels is neurotoxic. Epidemiological studies (most of which were included in the other review), animal experiments and in vitro analyses were considered. Although the majority of epidemiological studies reported an association of higher fluoride exposure with lower intelligence, these were considered to be of low quality and inadequately designed to test hypotheses. The experimental evidence suggested that current recommended fluoride exposure levels are clearly below the threshold required to lead to adverse effects in vitro or animals.

There is a possibility of mild fluorosis (white spotting of teeth) due to fluoride. The association between ingestion of low levels of fluoride and the potential for dental fluorosis has been well known for more than 70 years. Children in fluoridated communities show a 15–30% prevalence of dental fluorosis of a few teeth – mostly of the very mild to questionable category by the Deans Index. It should also be noted that fluorosis in children in communities without water fluoridation is also substantial, albeit lower than that seen in fluoridated communities.

For children who are exclusively formula-fed for the first six months of life and where the formula is made up with fluoridated water from any source, there is a theoretical risk that the cumulative fluoride ingestion will exceed the recommended limit. The potential consequence is an increased risk of mild fluorosis (mild white spotting on teeth) which has no impact on tooth structure, function or health, and aesthetically is of no consequence. The number of children in the Southern district who are potentially at risk from this situation at any one time is likely to be small, assuming six months to weaning and based on current breastfeeding rates.

In New Zealand, fluoride is not permitted as an additive to infant formula. There are recommendations elsewhere in the world that exclusively formula-fed infants should have formula constituted from non-fluoridated water. These recommendations have been considered by the Ministry of Health; however, they have not been adopted in New Zealand as it is not considered to be a safety concern. The Ministry of Health will continue to monitor the issue.

It is important to understand that fluoride intake via community water fluoridation is very low, considerably lower than that potentially linked to negative health outcomes. For example, there is an association between very high fluoride intake and skeletal fluorosis. An intake of at least 10 mg of fluoride daily for 10 years seems necessary for preclinical skeletal fluorosis. This is considerably higher than people would consume through drinking fluoridated water and brushing teeth with fluoridated toothpaste at the levels recommended in New Zealand. For adults in New Zealand,[13] the normal amount of fluoride ingested per day through diet and drinking fluoridated water is about 1.4 to 2.5 mg/day. If they also use fluoridated toothpaste there would be an

additional 0.1 to 0.3 mg/day, giving **an average total amount of up to 2.8 mg/day** – well below the upper limit of 10 mg/day.

Fluoridation of community water supplies in SDHB
Some community water supplies servicing the SDHB population are fluoridated (Table 2).

The Dunedin and Invercargill City councils add fluoride to their water supplies. Prior to Dec 2019, the Clutha District Council fluoridated supplies in Balclutha (pop 3918), Kaitangata (pop 812), Milton (pop 2529) and Tapanui (pop 726). During 2018–2019 the chemical standard for drinking water was breached in Balclutha and Tapanui due to fluoride exceeding the MAV. At the recommendation of Public Health South, the Council voted in Dec 2020 to reinstate fluoridation of the four supplies.

There is no single source of data on access to fluoridated water by ethnicity across the SDHB. However, we can use 2018 Census place summaries[14] and access to fluoridated drinking-water information published by Massey University[15] to make crude estimates. From these sources, approximately 60% of the total SDHB population and 65% of the Māori SDHB population have access to fluoridated drinking water.

Table 2. Population size and fluoridation coverage by Local Authority (2018)

Local Authority	Total	Māori	Fluoridation coverage 2018–2019
Queenstown-Lakes District	39,153	2091	0%
Central Otago District	21,558	1815	0%
Waitaki District	22,308	1824	0%
Gore District	12,396	1606	0%
Southland District	30,864	3432	0%
Invercargill	54,204	9444	100%
Clutha District	17,667	2193	58.7%
Dunedin City	126,490	11,730	96.7%
Total	324,640	34,135	

Fluoridation and child oral health in the SDHB
The Ministry of Health[16] provides statistics on the mean number of decayed, missing and filled teeth (dmft/DMFT) from the Community Oral Health Service for 5-year-olds and children in school year 8. The data are presented by ethnicity and fluoridation status, with the most recent data being from 2019.

On average 5-year-olds in SDHB have better oral health than their national counterparts (Figure 1). Yet inequities exist within our district. Mean dmft is considerably higher (i.e., oral health is poorer) in Maori and Pacifika 5-year-olds than in all children of that age. Community water fluoridation has the potential to raise the bar for everyone, but the biggest gains in oral health are likely to felt where they are most needed—at least among young children. Figure 1 shows substantially lower mean dmft (i.e., better oral health) among 5-year-old Maori and Pacifika children attending school in fluoridated areas compared with their counterparts with non-fluoridated school water supplies. In school year 8, inequities in oral health status remain, but the effect of fluoride is less pronounced (Figure 2).

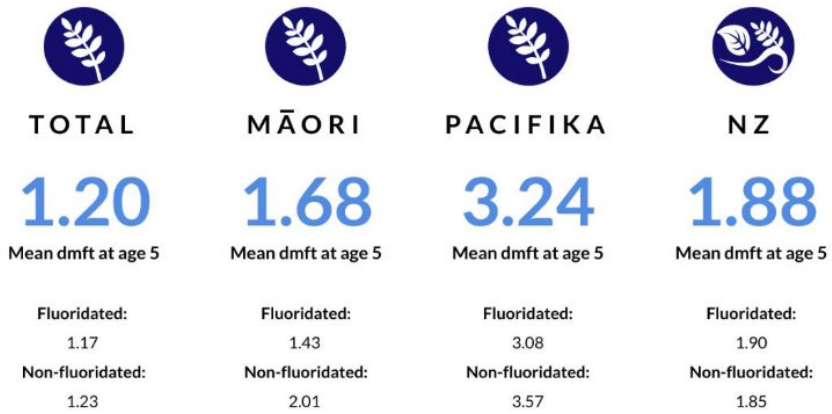


Figure 1. Mean number of decayed, missing and filled teeth (dmft) at age 5 for a) all SDHB 5-year-olds ("Total"), Maori 5-year-olds ("Maori") Pacifika 5-year-olds ("Pacifika"), and 5-year-olds nationwide ("NZ"). Lower rows show mean dmft by school water fluoridation status. Source Ministry of Health and Community Oral Health Service, 2019.

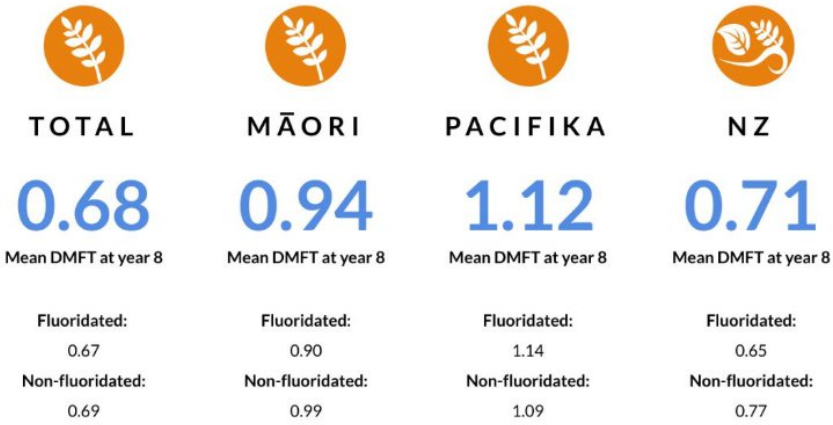


Figure 2. Mean number of decayed, missing and filled teeth (DMFT) in school year 8 children for a) all SDHB ("Total"), Maori ("Maori") Pacifika ("Pacifika"), and nationwide ("NZ"). Lower rows show mean DMFT by school water fluoridation status. Source Ministry of Health and Community Oral Health Service, 2019.

Options to improve community water supply fluoridation coverage

There is no legislation in New Zealand requiring the addition of fluoride to a water supply. Although the current Government is considering policy changes that would give District Health Boards authority over community water fluoridation, the decision to fluoridate is currently held by drinking water suppliers (Local Authorities and other owners).

To improve community water supply fluoridation coverage, the District Health Board could use Community Oral Health Service data to identify the populations in the district where children's oral health status is poorest and encourage water suppliers in those areas to fluoridate.

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FOR INFORMATION

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

Proposed by: Rory Dowding, Acting Executive Director Strategy Primary & Community

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

Recommendation

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

Purpose

To inform the Committee of the April 2021 Strategy Primary and Community financial performance

Specific Implications for Consideration

Financial

- As set out in the report.

Workforce

- No specific Implications

Equity

- N/A

Other

- N/A

Background

Strategy, Primary and Community report a provisional favourable bottom-line variance of $0.78m for April and $2.40m favourable YTD.

Discussion

- Latest Pharmac forecast has a $310k increase in rebates which has been reflected in YTD expenditure.
- Approximately $666k expenditure (and offsetting revenue) incurred by COVAX programme. Note this shows in SPC accounts as $1,184 expenditure (Funder and Provider expenditure).
- Public Health Service (excluding COVAX programme) is 5 FTE higher than previous YTD levels, contributing factors includes COVID preparedness.
- ARRC volumes have improved slightly this month.

Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

	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	93,903	91,930	1,973				926,336	919,299	7,037				1,103,159
IDF Revenue	2,138	1,983	155				22,053	19,825	2,228				23,790
Other Government	523	556	-33				5,465	5,460	5				6,632
Total Government & Crown	**96,564**	**94,468**	**2,096**				**953,854**	**944,585**	**9,269**				**1,133,582**
Non Government & Crown Agency Revenue													
Patient related	17	21	-4				187	208	-21				249
Other Income	-227	80	-307				511	795	-284				954
Total Non Government	-209	100	-309				698	1,003	-305				1,203
Internal Revenue													
Internal Revenue													
Total Internal Revenue	**9,045**	**8,518**	**527**				**86,280**	**85,179**	**1,101**				**102,215**
TOTAL REVENUE	**105,400**	**103,086**	**2,314**				**1,040,832**	**1,030,767**	**10,065**				**1,237,000**
EXPENSES													
Workforce													
Senior Medical Officers (SMO's)													
SMO - Direct	1,637	1,671	34	69.51	66.00	-3.51	14,916	15,186	270	63.54	65.14	1.60	18,259
SMO - Indirect	105	91	-14				966	912	-54				1,095
SMO - Outsourced	35	43	8				640	467	-173				561
Total SMO's	**1,777**	**1,804**	**27**	**69.51**	**66.00**	**-3.51**	**16,522**	**16,565**	**43**	**63.54**	**65.14**	**1.60**	**19,915**
Registrars / House Officers (RMOs)													
RMO - Direct	287	264	-23	23.16	20.29	-2.87	2,470	2,339	-131	20.97	19.60	-1.37	2,818
RMO - Indirect	13	17	4				94	165	71				198
RMO - Outsourced													
Total RMOs	**300**	**280**	**-20**	**23.16**	**20.29**	**-2.87**	**2,564**	**2,505**	**-59**	**20.97**	**19.60**	**-1.37**	**3,016**
Total Medical costs (incl outsourcing)	**2,077**	**2,085**	**8**	**92.67**	**86.29**	**-6.38**	**19,085**	**19,069**	**-16**	**84.50**	**84.74**	**0.23**	**22,931**
Nursing													
Nursing - Direct	5,233	4,800	-433	674.25	609.20	-65.05	47,689	45,838	-1,851	622.22	587.59	-34.63	54,904
Nursing - Indirect	11		-11				24	3	-21				3
Nursing - Outsourced	25		-25				78		-78				
Total Nursing	**5,270**	**4,800**	**-470**	**674.25**	**609.20**	**-65.05**	**47,791**	**45,841**	**-1,950**	**622.22**	**587.59**	**-34.63**	**54,907**
Allied Health													
Allied Health - Direct	2,947	2,958	11	436.12	440.62	4.50	27,707	28,644	937	424.11	436.88	12.77	34,505
Allied Health - Indirect	12	29	17				456	574	118				633
Allied Health - Outsourced	21	16	-5				265	160	-105				192
Total Allied Health	**2,980**	**3,004**	**24**	**436.12**	**440.62**	**4.50**	**28,428**	**29,378**	**950**	**424.11**	**436.88**	**12.77**	**35,330**
Support													
Support - Direct	1	13	12	0.22	3.22	3.00	34	124	90	1.03	3.18	2.15	151
Support - Indirect													
Support - Outsourced													
Total Support	**1**	**13**	**12**	**0.22**	**3.22**	**3.00**	**34**	**125**	**91**	**1.03**	**3.18**	**2.15**	**151**
Management / Admin													
Management & Administration - Direct	1,489	1,184	-305	203.45	180.79	-22.66	11,798	11,443	-355	180.39	178.66	-1.72	13,764
Management & Administration - Indirect	2	6	4				48	55	7				66
Management & Administration - Outsourced	50	1	-49				110	11	-99				13
Total Management / Admin	**1,541**	**1,190**	**-351**	**203.45**	**180.79**	**-22.66**	**11,956**	**11,509**	**-447**	**180.39**	**178.66**	**-1.72**	**13,844**
Total Workforce Expenses	**11,868**	**11,092**	**-776**	**1,406.71**	**1,320.12**	**-86.59**	**107,296**	**105,922**	**-1,374**	**1,312.25**	**1,291.05**	**-21.21**	**127,162**
Non Personnel													
Outsourced Clinical Services	41	96	55				912	978	66				1,185
Outsourced Corporate / Governance Services													
Outsourced Funder Services	1,200	1,206	6				11,998	12,059	61				14,470
Clinical Supplies	1,453	995	-458				13,798	9,942	-3,856				11,937
Infrastructure & Non-Clinical Supplies	815	707	-108				7,196	6,985	-211				8,410
Provider Payments													
Personal Health	66,003	66,533	530				664,010	666,640	2,630				800,836
Change Initiative Fund													
Mental Health	8,633	8,497	-136				86,721	84,972	-1,749				101,967
Public Health	667	84	-583				1,797	839	-958				1,007
Disability Support	15,716	15,580	-136				160,121	157,852	-2,269				189,737
Maori Health	187	206	19				1,841	1,871	30				2,220
Non Operating Expenses													
Depreciation													
Capital charge													
Interest													
Total Non Personnel Expenses	**94,715**	**93,904**	**-811**				**948,394**	**942,137**	**-6,257**				**1,131,769**
TOTAL EXPENSES	**106,583**	**104,996**	**-1,587**				**1,055,690**	**1,048,059**	**-7,631**				**1,258,931**
Net Surplus / (Deficit)	**-1,183**	**-1,910**	**727**				**-14,858**	**-17,292**	**2,434**				**-21,931**

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Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

Covid-19 Vaccination Programme - Apr-21	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	521		521				666		666				
IDF Revenue													
Other Government													
Total Government & Crown	**521**		**521**				**666**		**666**				
Non Government & Crown Agency Revenue													
Patient related													
Other Income													
Total Non Government													
Internal Revenue													
Internal Revenue													
Total Internal Revenue	**393**		**393**				**517**		**517**				
TOTAL REVENUE	**913**		**913**				**1,184**		**1,184**				
EXPENSES													
Workforce													
Nursing													
Nursing - Direct	120		-120	11.82		-11.82	142		-142	1.31		-1.31	
Nursing - Indirect	7		-7				7		-7				
Nursing - Outsourced													
Total Nursing	**127**		**-127**	**11.82**		**-11.82**	**149**		**-149**	**1.31**		**-1.31**	
Management / Admin													
Management & Administration - Direct	133		-133	17.88		-17.88	214		-214	2.63		-2.63	
Management & Administration - Indirect													
Management & Administration - Outsourced	44		-44				44		-44				
Total Management / Admin	**178**		**-178**	**17.88**		**-17.88**	**258**		**-258**	**2.63**		**-2.63**	
Total Workforce Expenses	**305**		**-305**	**29.70**		**-29.70**	**408**		**-408**	**3.94**		**-3.94**	
Non Personnel													
Outsourced Clinical Services													
Outsourced Corporate / Governance Services													
Outsourced Funder Services													
Clinical Supplies	2		-2				3		-3				
Infrastructure & Non-Clinical Supplies	86		-86				106		-106				
Provider Payments													
Personal Health	-16		16										
Change Initiative Fund													
Mental Health													
Public Health	537		-537				666		-666				
Disability Support													
Maori Health													
Total Non Personnel Expenses	**609**		**-609**				**776**		**-776**				
TOTAL EXPENSES	**913**		**-913**				**1,184**		**-1,184**				
Net Surplus / (Deficit)													

Summary

Strategy, Primary and Community report a provisional favourable bottom line variance of $0.78m for April and $2.40m favourable YTD.

Comments for discussion

- Latest Pharmac forecast has a $310k increase in rebates which has been reflected in YTD expenditure.
- Approximately $666k expenditure (and offsetting revenue) incurred by COVAX programme. Note this shows in SPC accounts as $1,184 expenditure (Funder and Provider expenditure).
- Public Health Service (excluding COVAX programme) is 5 FTE higher than previous YTD levels, Contributing factors includes COVID preparedness.
- ARRC volumes have improved slightly this month.

Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

Revenue

External Revenue –

Category	Apr Variance	YTD variance	Comment
IBT	$78k f	$786k f	Expenditure offset
CSC	$52k f	$466k f	Expenditure offset
Primary integrated MH & Addictions	$257k f	$2.54m f	10 months revenue with expense offset
MH Addictions Crisis Support	$179k f	$226k f	Programme development – new contract
Alcohol & Other Drugs	$98k f	$293k f	One off on signing
Forensic Services	$85k f	$592k f	New programme
Youth Forensic services	$17k f	$256k f	
Measles Immunisation Campaign		$271k F	Unbudgeted to be transferred to Population Health
Pharmaceutical funding (tranche 1)	$56k f	$562k f	Additional Covid funding
Pharmaceutical funding (tranche 2)	$232k f	$2.28m f	Additional Covid funding.
Capital Charge	$171k u	$1.71m u	Reduction from 6% to 5%. Expense offset
Planned Care	$257k u	$2.31m u	
Covid 19 Vaccination Funding	$521k f	$666k f	
Reduce Pressure on Fees	$9k f	$91k f	
Pay Equity	$511k f	$511k f	Release Apr 21
Hospice Palliative Care	$27 f	$269k f	New contract from Oct 20
DSS side contracts	$60k f	$488k f	
Improvement Action Plan		$454k f	
Other	$219k f	$306k f	
Total	**$1.97m f**	**$ 7.04m f**	

Additional School Based funding ($352k YTD) was transferred from “Other Income” to “MOH revenue” in April.

IDF Revenue

$155k favourable for the month.

- Inflows – 33.2 CWD for March for Canterbury DHB domiciled patients under Orthopaedics, with 63.3 total from Canterbury.

Pharmaceuticals

The SDHB Consolidated Pharmaceutical budget (including funder Haemophilia) is unfavourable to budget for April, with a $0.61m unfavourable variance to budget (YTD $6.69m).

Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

After factoring additional revenue and the expenditure previously transferred to COVID, we see a $2.39 unfavourable variance to budget. Additional revenue was adjusted down in March and April ($1.37m) to align to MOH advice reducing the total to be received for the year by $1.65m. This was due to "Pharmac 's latest assessment that the increased costs being driven by global supply issues through the Covid-19 pandemic have been revised down".

	$000 YTD 2019/20	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
Clinical Supplies - Pharmaceuticals	$ 21,885.2	$ 26,605.2	$ 21,426.8	-$ 5,178.4
Provider Payments - Pharms	$ 51,921.9	$ 62,362.0	$ 62,141.8	-$ 220.2
Haemophillia (medical outpatients)	$ 1,662.6	$ 3,188.5	$ 1,892.7	-$ 1,295.8
Total	**$ 75,469.6**	**$ 92,155.7**	**$ 85,461.3**	**-$ 6,694.4**
Variance is made up of the following (estimate)				
Pharms YTD		$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
PCT	$ 10,047.8	$ 11,464.9	$ 8,264.3	-$ 3,200.6
Community Pharms (DHB Outpatients)	$ 3,936.0	$ 6,628.2	$ 3,993.4	-$ 2,634.8
Hospital Inpatients	$ 7,901.4	$ 8,512.0	$ 9,169.0	$ 657.1
Community Pharms (excl DHB)	$ 51,921.9	$ 62,362.0	$ 62,141.8	-$ 220.2
Haemophillia (medical outpatients)	$ 1,662.6	$ 3,188.5	$ 1,892.7	-$ 1,295.8
Total	**$ 75,469.6**	**$ 92,155.7**	**$ 85,461.3**	**-$ 6,694.4**
Additional Unbudgeted Revenue - Tranche 1		$ 562.5	$ -	-$ 562.5
Additional Unbudgeted Revenue - Tranche 2		$ 2,285.8	$ -	-$ 2,285.8
Expenditure coded to Covid		$ 1,456.4	$ -	-$ 1,456.4
Adjusted Total (adjusting for unbudgeted revenue	**$ 75,469.6**	**$ 87,850.9**	**$ 85,461.3**	**-$ 2,389.6**

Ivacaftor – the consultation document from Pharmac can be located at

https://pharmac.govt.nz/news-and-resources/consultations-and-decisions/proposal-to-fund-ivacaftor-kalydeco-for-the-treatment-of-patients-with-cystic-fibrosis-with-the-g551d-mutation/?type=Consultation&subject=2&page=3&status=closed

Within the document under the heading 'What would the effect be?' Pharmac estimates that there are 30 patients in NZ eligible for the treatment, equating to 2.0 patients for SDHB. Southern have a greater number of patients on this medication, contributing to an unfavourable variance.

Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

Workforce Costs

	YTD Variance - FTE				
Workforce	Community Services	Primary Care & Population Health	Mental Health	Strategy Primary & Community Other	Total
Medical	-0.8	1.0	-0.6	0.6	0.2
Nursing	4.7	-14.7	-24.4	-0.2	-34.6
Allied Health	5.4	9.9	-3.4	0.9	12.8
Support	2.2	0.0	0.0	0.0	2.2
Mgt/Admin	1.6	-2.3	-0	-1.1	-1.8
Total	13.1	-6.1	-28.4	0.2	-21.2

Medical SMO –

- 1.6 FTE favourable YTD. Dental Surgery cost centre favourable variance offset in RMO's
- Lakes SMO's are 3.82FTE u for April and 0.7 FTE u YTD. This is due to a mismatch of actual stat leave compared to budget.
- Ordinary time and training are the main drivers offset by overtime.
- $80k YTD relocation costs impacting indirect costs.

Medical RMO –

- 1.4 FTE unfavourable to budget YTD. Dental Surgery unfavourable variance offset in SMO's
- Ordinary time unfavourable by 1.8 FTE offset by training (0.4 fav)

Nursing –

- The 65FTE unfavourable impact in April was due to various reasons that are not all due to increase in FTE numbers, including stat leave that was 16 FTE unfavourable. There were 3 stat days in Otago and 4 in Southland where a mismatch to budget has occurred which has increased the unfavourable FTE variance in April. There were also extra staff on call for the quarantine and covid cost centres. There were also extra nurses rostered on call for patient flows.
- The budget includes -34.95 FTE for MH savings and Vacancy Factor.
- Public Health Covid Implementation cost centre include 9 FTE and the Covid Vaccination cost centres include 3 FTE for April.
- April FTE variance mainly driven by Health Service Assistants (26 FTE u) being mainly ordinary time (20 FTE u). Registered nurses are 14 FTE unfavourable mainly due to Statutory (12FTE u), and overtime (6FTE u).
- April $432k unfavourable variance is due to Accident leave ($49ku), backpays ($106k u), overtime ($80k u) and AL accrued ($45k u) ,statutory ($95k u) and Penal ($57k u).
- YTD FTE variance (35 u) mainly driven by Ordinary (11 FTE), Accident leave (10 FTE) sick leave (4FTE) and overtime (5FTE) unfavourable.
- YTD $1.84m unfavourable variance is mainly due to Accident leave ($566k u), overtime ($568k u), back pays ($699k u) and AL accrued ($295k u) offset by Ordinary ($457k f), unpaid days accrual ($104k f) and other leave ($237k f).
- Skill mix and Annual leave revaluation favourable to budget is contributing to low $ per FTE variance.
- Lakes General Ward registered nurses are 4 FTE unfavourable and Health Service Assistants 2.6 FTE unfavourable. Compared to the same period for 19/20, nurses have increased 2 FTE and Health Service Assistants 1 FTE.

Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

Allied Health –

- 13 FTE favourable YTD. YTD expenditure is $950k favourable.
- YTD FTE variance is mainly driven by Ordinary (17 FTE f) offset by overtime (1.4 FTE u) and sick leave (0.9 FTE u) and Long Service leave (0.9 FTE u)
- YTD expenditure is $950k favourable and is mainly due to ordinary time ($1.55m fav) and Statutory (time in lieu) ($59k fav), offset by overtime ($179k unfav), backpays ($402k unfav) and allowances ($77k unfav).

Management/Admin –

- April expenditure is $350k u. Ordinary time ($123k) and backpays ($105k)
- YTD expenditure is $447k u. Mainly due to Ordinary ($148k u), Backpays ($177k u) and overtime ($101k u).
- Covax cost centres account for 18 unbudgeted FTE and $209k unbudgeted expenditure YTD.

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	268	261	-7	2,862	2,651	-211	3,204
Diagnostic Supplies & Other Clinic	7	6	-1	65	61	-4	74
Instruments & Equipment	66	69	3	617	673	56	807
Patient Appliances	178	163	-15	1,629	1,534	-95	1,817
Implants & Prostheses				9	5	-4	6
Other Clinical & Client Costs	20	27	7	245	279	34	338
	539	526	-13	5,427	5,203	-224	6,246

- Clinical Supplies – Dressings ($164k u), Ostomy ($76k u) and Continence ($98k u) offset by Clinical equipment ($93k f) are the main drivers of the unfavourable YTD variance.
- As forecast Negative Pressure Wound Injury Therapy investment has reduced consumables.

Infrastructure & Non-Clinical Supplies

YTD expenditure $211k unfavourable with the main variances being:

- Consultants Fees $129k favourable
- Patient meals $165k favourable
- Electricity $63k favourable
- Accommodation & meals $129k unfavourable
- Domestic travel $70k unfavourable
- Security services $63k unfavourable
- Uniforms $40k unfavourable
- Cleaning $36k unfavourable
- Rents $47k unfavourable
- Other Equipment $63k unfavourable

Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

Provider Payments (NGO's)

Personal Health

- Dental - $664k favourable YTD - Contract and invoicing process issues 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 $684k unfavourable to budget YTD. Community Services Card ($466k unfav), VLCA $103k unfavourable and Careplus $51k unfavourable. This extra expenditure is offset by a favourable variance in GMS ($339k YTD) and matching revenue for CSC.
- Pharmaceuticals – See previous comments.
- Travel & Accommodation - $194k favourable YTD. Demand driven.
- Immunisation – YTD expenditure $241k fav. Accrual was increased to account for the delayed start of Flu vaccinations.
- Palliative care - $122k unfavourable YTD.
- Medical Outpatients - $1.31m unfavourable YTD due to haemophilia national pool expenditure.
- Surgical Inpatients - $1.58m favourable YTD due to reduction of pass through of funding for recovery action plan.
- Price adjusters - $749k favourable YTD. Due to pool for NGO increases where the actual costs are incurred across various lines. Gore Health accrual ($188k in March) was discontinued in this line as the expenditure was already being incurred within another line of the contract.
- 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
  - Outflows are tracking behind budget to Auckland (90.9 CWD) although this is offset by Canterbury (88.9 CWD unfavourable after adjustment).

Mental Health

- Community Residential Beds ($276 k f YTD). Demand driven service.
- Other/Minor mental health ($2.54m u YTD) relates to 10 months of Primary Integrated MH & Addiction contract signed last in October. Offset by equivalent revenue.

Public Health

- YTD expenditure is $0.96m unfavourable.
- Covid Vaccination Programme cost centre accounts for $666k of the unfavourable variance.
- Budgeted savings of $273k that have not been achieved within provider payments but have been achieved across Public Health in total. Able Mental Health Charitable Trust payments $39k unfavourable due to budget currently in Mental Health directorate. Tobacco control unfavourable due to unbudgeted Vape Quit contract (signed off after budget completed).Total tobacco expenditure across the Funder and Provider Arms is less than the actual revenue received from MOH.

Disability Support

- Pay Equity - $222k unfavourable to budget YTD, largely due to high utilisation in ARRC.
- ARRC - $59k favourable for April and $2.11m unfavourable YTD.

Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

- The decline of Hospital level beds since the peak in November 2020 continues. Currently sitting at about 25 beds over budget, down from 30 over budget last month.
- Since November 2020 Dementia bed nights have also been increasing, and these peaked on 25 February 2021 at 379 which is four above our year end budget. Since then the volumes have declined to a more expected volume.
- Rest Home beds continue to be significantly down on budget, but as per above, being offset by Hospital and Dementia beds.
- The team continue to look to identify factors influencing increased Hospital level utilisation.

- Home Support - $153k unfavourable for April and $648k unfavourable YTD.
  - YTD IBT is unfavourable $404k and FFS $346k while the Bulk Fund is $102k favourable.
  - All outstanding 2019/2020 FFS washups have been paid in line with the accrual.

Maori Health

- No significant variances.

Expenditure Management Plans – current performance and future actions

	Savings Target		Variance to budget	
Savings category	**Annual**	**YTD**		**Comment**
Pharmaceuticals	1,300k	1,192k	2,389k u	YTD savings not achieved
ARRC	1,386k	1,155k	2,114k u	YTD savings not achieved
Public Health[2]	331k	276k	1,436k f	YTD savings **fully** achieved
Mental Health[2]	3,419k	2,838k	1,154k f	YTD savings **fully** achieved
Total	**6,436k**	**5,461k**	**1,913k u**	

[2]includes both Funder and Provider

Southern District Health Board – Monthly Financial Report
For the month ended 30 April 2021

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 Apr 21					
	Month			YTD		
	Actual	Budget	variance	Actual	Budget	variance
Personal Health						
Labs	1,473	1,484	11	14,770	14,836	66
Pharms	5,412	5,549	137	60,944	62,142	1,198
Primary Care	6,769	6,843	74	68,015	67,331	(684)
Dental	1,325	1,356	31	13,264	13,928	664
Travel & Accommodation	427	447	20	4,322	4,516	194
IDF	2,853	3,110	257	31,548	31,098	(450)
Internal expenditure	45,257	44,458	(799)	449,504	444,915	(4,589)
Other	2,487	3,286	799	21,643	27,874	6,231
Total Personal Health	66,003	66,533	530	664,010	666,640	2,630
Change Initiative	0	0	0	0	0	0
Disability Support Services						
Pay Equity	1,644	1,517	(127)	15,733	15,511	(222)
Home & Community Support	2,580	2,427	(153)	24,982	24,334	(648)
Aged Residential Care	7,859	7,920	61	82,433	80,319	(2,114)
Respite	66	90	24	1,094	1,217	123
Carer Support	112	138	26	1,441	1,593	152
IDF	377	389	12	3,812	3,887	75
Internal expenditure	2,547	2,547	0	25,467	25,467	0
Other	531	552	21	5,159	5,524	365
Total Disability Support Services	15,716	15,580	(136)	160,121	157,852	(2,269)
Mental Health						
Alcohol & Drugs	468	470	2	4,682	4,711	29
Child & Youth	1,122	1,108	(14)	10,957	11,077	120
IDF	463	463	0	4,625	4,625	0
Internal expenditure	5,926	5,926	0	59,264	59,264	0
Other	654	530	(124)	7,193	5,295	(1,898)
Total Mental Health	8,633	8,497	(136)	86,721	84,972	(1,749)
Public Health	667	84	(583)	1,797	839	(958)
Maori Health	187	206	19	1,841	1,871	30
Total Funder	91,206	90,900	(306)	914,490	912,174	(2,316)

FOR APPROVAL

Item: **Queenstown Lakes District Housing Report**

Proposed by: Lynette Finnie, Acting General Manager, Public Health, Population Health, Oral Health and Women & Children Portfolio Manager

Meeting of: 1 June 2021

Recommendation

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

Purpose

To provide an update to the Community and Public Health Advisory Committee on housing pressures for vulnerable populations in the Queenstown-Lakes District

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Specific Implication for Consideration

Financial

- Nil

Quality and Patient Safety

- Nil

Operational Efficiency

- Nil

Workforce

- Nil

Equity

The report highlights housing issues for a snapshot of the Queenstown-Lakes population. The report highlights equity issues between those who own their own homes and those who do not.

Other

- Nil

Background

This report is a parallel report to one that was completed for the Central Otago District Council and reported to the combined Disability Advisory Committee and the Community and Public Health Advisory at their October 2019 meeting.

Although this research was completed in 2019, it was not able to be reported until November 2020 as it was disrupted through the introduction of Covid-19 in New Zealand in March 2020.

The report uses mixed-methods methodology that is both quantitative and qualitative. The methodology allows for focus on vulnerable populations as data is sourced through Social Service providers in the Queenstown-Lakes District.

Discussion

- The report highlights that housing needs in Queenstown and Wanaka exhibit characteristics identified in the literature as 'Boomtowns' with the boom driven by high levels of migration.

- Migration into Queenstown and Wanaka is of two types. Amenity migrations is from relatively wealthy migrants who are drawn to live in the District due to its high amenity value.

- Other newcomers are labour migrants, who are generally not wealthy and do not enjoy high wages, but come to fill the growing demand for labour supply. Some labour migrants come from elsewhere in New Zealand, but many arrive from overseas.

- Queenstown-Lakes tends to have low wage economy in an environment where the costs of living are high.

- The report identifies that housing issues in Queenstown-Lakes were driven more by affordability rather that hosing supply as it was in the Central Otago report. This obviously will impact the labour migrants most severely.

- It is hard to speculate what impact Covid-19 will have on the research findings, but it is strongly suspected that it will impact most severely on the labour migrants and medium to long term locals that rely on boarders to help pay their mortgage/rent.

- Effects would be compounded due job losses and cutbacks on work hours. Anecdotal evidence suggests that outward migration led to losses in boarders and flatmates which in turn increases housing costs for those who remain.

- We are aware that soon after Covid-19 more rental properties became available in the Queenstown Market as operators released more rental accommodation on to the market. Rents remained high though. It is likely this scenario will reverse as tourism opens up again, leading to a wave of displaced residents.

- Through the Queenstown-Lakes housing trust there are active strategies aimed at making housing more accessible in the Queenstown-Lakes District. The Queenstown-Lakes District Council is also active in assuming leadership on housing issues and is a strong advocate on this matter.
- Through Covid19 the snapshot provided through this report is most likely to have made the issues worse for the vulnerable groups described in the report.

- As the Queenstown-lakes District Council are taking leadership in housing issues, this report will at best help inform their policy approach to housing. Already the Queenstown-lakes District Council and the Queenstown-Lakes housing trust have been supporting the Central Otago District Council with its housing issues.

Next Steps & Actions

This report be released to the Queenstown-Lakes District Council and other Government Departments (including Kāinga Ora, Ministry of Social Development, Ministry of Business Innovation and Employment, Te Puni Kōkiri) with an interest in Housing.

Meeting will be scheduled with these agencies and other stakeholders to identify what further actions will need to be taken.

Appendices

Appendix 1 Queenstown Lakes Housing: The Human Story: Pēha tou Kāianga: How's Your Home

PĒHEA TOU KĀINGA?
HOW'S YOUR HOME?

Queenstown Lakes Housing: The Human Story

Nov 2020

Southern District Health Board
Piki Te Ora

Acknowledgements

This research was conducted by Public Health Analyst, Dr Vanessa Hammond, and Health Promotion Advisor, Emily Nelson, and was initiated by the Medical Officer of Health at the time, Dr Marion Poore. It was supported by a literature review completed by Health Promotion Advisor, Danielle Smith. We are indebted to many people for their help with this research. First, to the 29 interviewees from 21 health and social service agencies who gave their time to tell us about what they were seeing in the community. They are the local experts on the housing experiences of the most vulnerable. Without their support this report would not have been possible. Further, their day-to-day efforts to improve local people's lives must be acknowledged. We thank the 158 survey respondents for telling us about their homes and housing experiences. It was the efforts of Central Otago and Queenstown Lakes Public Health Nurses and Oral Health Clinic staff that enabled this survey to happen. Like the interviewees, these people are working hard to improve people's lives. We are so grateful for their contribution to this project. We thank Gillian Sim, Victoria Bryant and Irene Wilson for encouraging their teams to promote survey recruitment. Finally, Dr Susan Jack provided valuable feedback on report drafts.

ii Queenstown Lakes Housing: The Human Story

Please note that this research was conducted prior to the introduction of COVID-19 to New Zealand. The housing situation in Queenstown Lakes may have changed in response to COVID-19 impacts.

Executive Summary

The Queenstown Lakes District was the fastest growing New Zealand Territorial Authority in 2018—its neighbour, the Central Otago District, was the third fastest. Migration drives this population boom in both districts. Some newcomers are relatively wealthy amenity migrants who come for the two districts' high natural values and perceived quality of life benefits. Their arrival tends to increase the local median income, leading to false perceptions of improvement to overall quality of life and shared prosperity. Other newcomers are labour migrants, who are generally not wealthy and do not enjoy high wages, but come to fill the growing demand for labour supply. Some labour migrants come from elsewhere in New Zealand, but many arrive from overseas. Typical of population 'boomtowns', local housing supply is considered unaffordable for many. In particular, local families and labour migrants are negatively affected as house and rent prices constantly trend upwards and affordable properties become increasingly scarce.

Early in 2019, growing anecdotal evidence of housing-related hardship from local social agencies and health professionals prompted the Southern District Health Board to undertake social science research to gain a deeper understanding of the situation. We conducted qualitative interviews with 29 key informants from non-government organisations, local Iwi, Oranga Tamariki, Southern District Health Board, Police, schools, and local housing providers. To gather housing information from the broader community, we also conducted a survey of 158 residents via convenience sampling.

Our analysis identified that a lack of affordable homes is severely impacting the quality of life of local residents and migrants in Queenstown Lakes. Unlike neighbouring Central Otago, which suffers a lack of availability in general, there are homes available in Queenstown Lakes—but they are not considered affordable. Lack of affordable housing is driving negative health and social consequences related to crowding, quality, cost, disempowerment, and homelessness. The housing problem is most affecting families, children, migrants and middle-aged single men. For migrants and single parents, the housing problem is exacerbated by disempowerment, discrimination and low income.

The most common consequences of the lack of affordable homes are people being forced into financial hardship or into crowding their homes to make rent affordable. Homelessness, although uncommon, was also described by interviewees. Financial hardship is a well-established correlate of poor health outcomes. In Queenstown Lakes, described outcomes were mostly related to mental health. Crowding is also a known correlate of poor health. Some interviewees described instances of scabies and other infectious diseases in relation to household crowding. Finally, described homelessness took the form of living on the street, in vehicles, in tents, and in cabins at campgrounds.

Many local population groups are disempowered, some in multiple ways. The lack of affordable housing alternatives creates a power imbalance between landlords and tenants. Tenant disempowerment was evident in accounts of rule setting, discrimination, and perceived inability to approach landlords about housing quality issues. Some single parent

families are disempowered by Family Court orders preventing them from leaving the district for more affordable living. Some women can't leave violent partners because they can't afford to house their children alone. Many migrants are unable to better their circumstances due to the conditions of their work visa. They are commonly tied to one employer, meaning that they can't seek better pay, working or housing conditions elsewhere. The situation is especially acute for single parents and ethnic migrants as they are also challenged by discrimination in the rental market. Finally, accounts were reported of flatmates disadvantaged by head tenants in situations where flat sharing agreements were not signed.

Contents

List of figures

16.1

1 Introduction

In 2018 the Queenstown Lakes District was the fastest growing territorial authority area in New Zealand.[1] This population boom is due to the migration of two groups—those coming for amenity values and those coming for work. Amenity migrants are relatively wealthy people moving to Queenstown Lakes for its perceived lifestyle benefits. The amenity migration boom demands its own labour supply, bringing further migrants to the district. Unlike typical amenity migrants, labour supply migrants are not wealthy. They need somewhere affordable to live.

Typical for a 'boomtown', Queenstown Lakes' economic indicators look rosy.[2] In 2018, the region enjoyed over 6% growth in each of GDP and employment, and Income was up 4.6%. But these benefits are not universally bestowed. Increased inequality commonly occurs in boomtowns.[3–7] Further, amenity migrants usually have higher incomes and education levels than the majority of long-term residents.[8,9] This increases the boomtown median income, creating false perceptions of local income growth.

Boomtowns are also associated with increased housing pressure, living costs and social divide. Migrants and locals in natural amenity boomtowns often have conflicting priorities and needs due to cultural, value and attitudinal differences.[10] Other common impacts include increasing need causing shortages of key social services and displacement of those who can no longer afford to live in the area.[8,9,11] During amenity migration booms, population displacement due to unaffordable housing usually results in residents moving to neighbouring towns and commuting to work. For example, Cromwell is increasingly supplying housing for the Queenstown Lakes workforce. Housing pressure then extends to these neighbouring towns, traffic congestion is increased, and quality of life is lost.[6] Negative boomtown impacts on neighbouring towns can occur without the corresponding economic benefits.[12]

Health and social service professionals working in Queenstown Lakes are increasingly telling stories of local hardship that are typical of boomtowns. These stories are not captured by commonly reported housing affordability statistics. Complex situations such as the human experience of local housing pressure require a depth of understanding that qualitative approaches are best placed to offer. Therefore, we used key informant interviews supported by a community survey to investigate how people are affected by local housing pressure and how they are responding to the challenges faced. Our aim was to identify and describe the housing experiences of Queenstown Lakes residents. This could be used to inform multi-sectorial action.

2 Methods

2.1 Research design

This research is of a concurrent embedded mixed methods design. This means that we used both qualitative (interviews) and quantitative (survey) methods to meet our research aims. Our primary data collection method was qualitative interviews. While undertaking these, we also conducted a survey to support or refute our qualitative findings. This research was conducted according to National Ethics Advisory Committee Guidelines.[13]

2.2 Qualitative interviews

We used face-to-face semi-structured interviews to explore what interviewees have seen in terms of, a) how people are living, and b) how their lives are affected by their housing situation (Table 1).

Table 1 Semi structured interview prompts by topic

Topic	
Living conditions	**Living condition impacts**
Type of dwelling	Health impacts
Quality of dwelling – condition, size	Mental health impacts
Warmth of dwelling	Relationship impacts
Crowding	Impacts on children
Affordability	Material and financial impacts
Availability	Flow on effects – jobs, commuting
Other comments on conditions	Other comments on impacts

We used purposive sampling to select individuals with first-hand knowledge of the Queenstown Lakes housing situation and its impacts. Local knowledge was used to identify government and non-government organisations (including Police), Iwi, schools and property managers. Collegial contacts, referrals and snowballing were used to recruit individuals within those organisations and add new organisations to the list. The interviews were conducted during July to September 2019.

Twenty-nine people representing twenty-one organisations were interviewed. Some interviews were conducted as a group. Organisations represented were from government (n = 5), non-government (n = 10), education (n = 4) and accommodation (n = 2) sectors. Each interview, rather than interviewee was provided with an ID number, which is presented in parentheses to attribute quotes in this report. VH and EN conducted and transcribed the interviews, which lasted between 20 and 90 minutes. Two researchers (VH and ES) reviewed the data then discussed coding strategy. An agreed code list was devised and applied to the complete dataset. Qualitative analysis for identifying commonly recurring patterns and themes was conducted by VH using the methods outlined in Braun & Clarke.[14] Both inductive (linking themes to the data) and deductive (linking themes to the research question) processes were used to guide theme development. For example, discrimination was an inductive subtheme of the deductive theme of availability. Interviewees were provided with the draft results for sense checking with the final draft amended according to their feedback.

2.3 Quantitative survey

A 13-item community survey was developed to investigate housing and living conditions in Queenstown Lakes and Central Otago (the Central Otago results are published separately). It was open to any Queenstown Lakes resident and available online and in paper form.

Recruitment avenues included community oral health clinics, public health nurses, social service agencies, school and early childhood centre parent email databases and messages in local social media, newspapers and school newsletters. The survey was open from March through May 2019.

Most survey items were quantitative, but one open-ended question was included, 'Do you have any comments on the local housing situation?' Responses to this question were analysed in the same thematic way as the qualitative interview data and presented alongside it.

3 Qualitative results

3.1 The housing situation

Housing was described as 'the most common issue in Queenstown' (I1), 'a big concern' (I12), and 'one of our biggest problems' (I14). One interviewee said he 'would use the word crisis' (I17). According to another, 'precarious housing situations are on the increase' (I9). Consistent depictions were made of 'unaffordable' (I8), 'over-priced' (I21) and 'expensive' (I22) housing. 'There is a lot of stress around housing. There is nowhere to go, so it just ramps everything up' (I23). According to one survey respondent, 'Housing in Wanaka and Hawea is shit. It's over-priced, cold, damp in winter and unaffordable' (S4).

Rather than discussing availability in its own right, interviewee's generally linked availability to affordability, 'there's not an accommodation shortage, there is a shortage of affordable accommodation' (I7); 'there is nothing available they can afford' (I1); 'there is nothing out there anywhere near affordable' (I15). Where availability was discussed in terms of actual housing stock, it was in reference to a 'lack of state housing' (I13), 'emergency accommodation' [I2] and smaller houses ('there's very few small houses available ... just big fancy homes that have to be filled with flatmates' [I11]).

Another availability problem that appeared to be unique to Wanaka is that 'you can't be guaranteed 12 month's rent because of the holiday house situation' (I14). Interviewees explained that 'ten-month leases are quite common' (I14) and 'people need to leave their rentals so the landlords can have the houses for summer' (I22). Further, 'evictions at short notice are increasing. They tend to happen at peak periods' (I13).

Under the current housing conditions people are 'having to do extraordinary things to survive' (I6). These include crowding or sharing homes, sleeping in vehicles or tents, working multiple jobs, putting very young children in daycare for 10 or more hours a day, living in poor quality homes or leaving town altogether. Social and health consequences were described in relation to all of these responses to housing affordability. They were most felt by families, migrants and middle-aged single men. Single parent families and ethnic migrants often faced other life challenges, such as disempowerment and discrimination.

3.1.1 Crowding and house sharing

The most common response to the affordability problem is filling houses with extra people to share the cost. Interviewees spoke negatively of the impact of crowding and house sharing—with one exception, 'they got boarders to help pay rent but actually its good for her safety' [I13]. Negative depictions about crowding and house sharing were found in talk about mental

health, physical health and child safety. Crowding and house sharing were always attributed to affordability, rather than availability. For example, 'with rent costing so much … people are filling their homes' (I20), 'the rents are so high, how else can they afford it?' (I23). Accounts of overcrowding were restricted to Queenstown. No instances of it were described in Wanaka by interviewees or survey respondents.

Overcrowding is considered 'a big problem in Queenstown' (I21) that interviewees 'see a whole lot of' (I23). 'Overcrowding slum landlords' (I2) were described, as well as houses with '3 to 4 people per room' (I2), '10 to 15 people in it … with illness rife' (I3), and '3 bedrooms and 12 people in it' (I23). One interviewee described an individual 'living in a house of 27 … with one kitchen' (I1). Hot bedding is also said to be '… rife. They are doing it to afford to be here. They call it being part of the bug train. They get rashes' (I23). Other observed health consequences of overcrowding included 'scabies and the flu' (I23), and 'bedbugs' (I7). One interviewee noted that 'too many people in the houses creates moisture and condensation. [People are] not able to wash and dry their clothes' (I6). Asthma was said to be 'always mentioned as a result of housing. They can't afford a GP so it goes untreated' (I1).

There were many accounts of families house sharing. 'Families are living with boarders in uncomfortable situations to pay the mortgage or have a reasonable lifestyle. They are unwanted tenants but they need them there' (I3). 'Rents are ludicrous, families have to have flatmates to survive—even in the cheaper low quality housing' (S1). Common situations included kids sharing rooms to make other rooms available for flatmates, who were 'whoever they can get … with a high turnover' (I1). Sometimes children in joint custody live with two sets of flatmates, 'a 2-year old daughter, living with flatmates. It's the same at Dads' (I1). Entire families have been seen living in one room when sharing a house with others. Instances of four-person families in a room were described, typically among migrant populations. A couple of interviewees noted that they 'see parents and children bed sharing a bit' (I14). Sometimes it was for 'warmth' (I14), but in other situations it is 'because there was no room in the house' (I13). A strong unease was evident in the way interviewees described flatmates, boarders or AirBnb guests (although no direct accounts of harm were made). For example, they '… may not be suitable. Strangers are a high risk to children' (I4); 'there's risk for families with strangers coming into their homes …' (I6); 'taking in boarders is a risk … predatory behaviors and drug and alcohol issues in the house …' (I8); '… a stranger in your house' (I20). Some youth (aged 10 to 13 years) are being exposed to flatmates who 'bring in friends, so the house becomes a party with alcohol' (I12).

Also commonly described were houses with two or more families living in them. For example, 'there's a mother and son sharing with two other women with kids living in the same house. It creates stresses' (I9). House sharing doesn't always completely relieve financial pressure. One single parent family of three was said to be paying '$700 per week for two rooms in a shared house' (I13). One multi-family household still couldn't afford gas so used 'a plug in element for cost' (I2). In house sharing situations, lounges are often given up for bedrooms, 'one family bought in another to live in the lounge. There's no place to gather as the lounge is now a bedroom' (I5). Similarly, 'kids are missing private conversations with parents as there are always other people around' (I5).

Some interviewees identified that 'people don't necessarily want to live with other people' (I15), 'but they have to get income to cover costs' (I12). 'House sharing creates possible conflict, including on parenting if there's multiple families' (I12). Boarders were also considered problematic, 'the mental health impact of living with boarders is terrible.

Teenagers with boarders [in the house] have no safe secure space and they struggle. Parent's don't really want them there either so there's tension which the kids pick up on' (I1).

3.1.2 Quality

The way interviewees described rental properties they had seen suggests that housing quality is an issue in Queenstown Lakes. Accounts of cold, mouldy and damp houses were most common. 'I walk into a home and they are just so cold' (I13). Survey respondents commonly referenced poor quality homes in terms such as 'substandard' (S6), 'badly kept' (S7) and 'in desperate condition' (S8). Many Queenstown Lakes residents are living in poor quality houses because they have 'no options' (I9). For some, 'the quality is so poor that they are living in unhealthy situations. Their houses are cold, mouldy and damp' (I9). Direct health consequences were typically described among children, 'if they are in a poor quality house we are seeing them for communication issues. They can't hear because they are ill, so they are not developing language' (I9). Others also linked quality to 'kids health problems, respiratory stuff exacerbated by housing quality' (I14).

Interviewees often linked cold houses with the financial hardship associated with high rent. For example, 'rents are high so tenants are very particular about heating use. People are living in cold conditions' (I2) that they 'can't afford to heat' (I3). Cold houses were often described alongside other life challenges. For example, 'the house is cold, the kids have asthma and mum has black eyes. They just live in the lounge' (I23).

3.1.3 Financial and material hardship

High housing costs interact with low wages to create desperate financial and material hardship amongst its core workforce. 'Word is out amongst the services industry. Queenstown is becoming known for its terrible living conditions and low pay. The advice is to come for a holiday but don't try to live here' (I12). 'Housing is too expensive for wages' (I18). Interviewees commonly discussed the lack of living wage in Queenstown, and noted that 'minimum wage is big here' (I14). Sometimes hardship was linked to employer actions beyond hourly pay rate. The hotel and ski industry were identified as bringing staff into the district 'but not providing accommodation or enough hours to live on' (I8).

It was noted that hardship was also 'driven by the cost of fuel, food, cost to heat houses' (I9), and that 'the basics are not being sold in the towns [Wanaka and surrounds], which is more burden for the people' (I14). Hardship was linked to relationship strain, 'they have no food and argue all the time' (I15). Similarly, 'people are paying rent that is unaffordable. Parents are playing tag on work, there's relationship tension, alcohol use, an overwhelming sense of desperation, domestic violence. The children are neglected or taking on parents' stress' (I8). 'Financial pressure from big mortgages leads to domestic disputes and potentially violence' (S2).

Many residents are supported by social services '… with food to survive. We produce 30 food bags on Fridays; they typically go to families' (I1). People are 'getting a food parcel just to allow them to pay rent or buy fuel' (I13). Some people 'hide the food parcels from their partners for fear of violence' (I14). A lack of food prevents some children from going to school, 'we follow up on absent children. It's because they have no food to put in their lunch box. It's because they pay so much in rent' (I15).

They way interviewees described hardship suggested that it was increasing in prevalence. 'There are more low income people needing help' (I4). Some people are said to be 'accessing their KiwiSaver due to hardship' (I15). Other responses are to 'work three jobs and use drugs to keep going' (I23), 'tag team day and night' (I5) or do 'huge hours … on the brink' (I12).

An 'income gap' (I14) was commonly referenced. For example, 'you've got the super wealthy and their kids here. Kids with 20 mil versus kids living in a bus. That can't be particularly nice' (I17). One interviewee described the Queenstown Lakes District's treatment of migrant workers as 'capitalism turned into feudalism. I don't think I've seen destitution in Pakeha families, but I have in Filipinos and Fijian Indians. It annoys me when they work for wealthy land or business owners who are New Zealanders. Their domestic staff are destitute. They are choosing to pay them minimum wage or less when they know that they are near homeless. We aren't a class society' (I18).

Financial hardship and housing stress were linked by some interviewees to family violence. 'Do you know why there is so much family violence? It's because of housing. People are just so tired and stressed' (I14). 'People struggle to leave bad relationships because of the financial shackles' (I20).

'Parents are working multiple jobs' (I5) and 'go back to work soon after babies are born' (I4). Some children are in daycare '10 to 11 hours per day' (I9). When the 'kids get sick there is even more pressure as the parents can't work' (I4). Due to the extreme need for parents to work, some 'kids under 13 are being left at home' (I5). 'Kids don't get to school because no one is getting them up and getting them going. Or they are not going to school because they are embarrassed about having no lunch' (I14).

'Parents are making choices they wouldn't normally make. Like kids left home alone as parents work, and parents not being available for kid's needs. They need money so they are working longer hours. Guidance is not there for kids, and anxiety and stress from parents is put onto them. The kids are dealing with adult issues. This issue is the epicenter of many issues seen in kids in Queenstown. It's driven by low wages and high cost of living. There are issues with the middle incomes, not just the true poor. There's a working poor' (I12).

3.1.4 Disempowerment and discrimination

Many people are disempowered or discriminated against in Queenstown Lakes' tight housing market. Often this burden falls on population groups with other life challenges, such as migrants and single parents. Disempowerment occurs in landlord—tenant relationships, between flatmates, and between separated parents.

Landlords were considered by interviewees to be at a clear advantage in Queenstown Lakes. 'Rent is at the whim of the landlord' (I6). 'Landlords can just charge what they want. People will pay. They are just so desperate' (I14). According to one survey respondent, 'we are at the mercy of landlords' (S60). In contrast to the generally negative sentiment towards landlords, one interviewee pointed out that 'landlords shouldn't be seen as charity. They have to make ends meet too' (I14). Landlord influence was described beyond rent. Interviewees agreed that a lack of alternatives means that 'no one wants to say anything about quality because they just want somewhere to live' (I14). 'A lot of the time you can't get maintenance on a house. The landlords won't do it' (I14). One survey respondent expressed that 'we can't flag issues to our landlord because they'd just replace us' (S3). The new Healthy Homes Standards were considered unlikely to work in Queenstown Lakes because the 'tenants feel insecure so won't

report their private landlord [for non-compliance]' (I1). Accounts of quick evictions were common, but some doubt or confusion about how landlords were getting away with it was relayed, 'could it be that they [the tenants] are lying to us?' (I13).

Disempowerment was also evident between tenants without flat sharing agreements. 'Landlords often work with a head tenant who manages the flatmates. The head tenants have control over costs associated with sharing. Sometimes they refuse to give bond back' (I2). Flatmates under head tenants 'don't have normal rights' (I2).

Discrimination in the housing market was identified as an issue for single parents and labour migrants by many interviewees. With the 'decreased availability of stock landlords have choices over tenants, so it's hard for single parents' (I12). There's a 'stigma around solo parents, landlords are more likely to rent to families' (I22). 'Single mums and people on benefits find it difficult to get housing in Queenstown. There is discrimination and low-key racism' (I8). Some single parents are unable to leave the district to find more sustainable and stable housing due to family court orders. 'I can think of several where they aren't allowed to leave. Two of them have flatmates to help them pay' (I18). In desperation, some find themselves in tents or other makeshift housing, '… she is living in a garage with the kids but can't leave as it's a custody issue' (I4). It's 'often a power and control thing between parents' (I14).

3.1.5 Homelessness

In general, homelessness takes three forms in Queenstown Lakes. First, are single men, typically middle-aged, living rough on the streets and 'under trees in the gardens' (I1). 'There is a derelict men problem in Queenstown, some live in cars, some don't. Some have health issues' (I18). Single men weren't considered to have a place in Queenstown's housing market, 'they find it harder to find a place in shared living, but can't afford anything of their own' (I1).

Second, are the people living in cars or tents. There are 'quite a few families living in tents in Albert Town' (I22) and 'people living in cars above Sunshine Bay, the Fernhill area' (I2). Third, are families living in cabins at campgrounds. These families typically plan to live in a cabin 'while they wait for a rental' (I15) but end up in 'quite challenging living conditions' (I20). 'There are multiple kids living in camping grounds. Most of these kids are being seen by [service] for behavioural issues. The precariousness of housing creates an inability to create a stable environment for kids. There is more chance of developing challenging behaviours. As a service we don't get many kids who are living in a stable environment' (I9).

4 Quantitative results

4.1 Responses, household composition, home ownership status

The survey was completed by 158 people. Most (61%) were living in family situations (

Table 2). Only thirty-nine percent of respondents were renters (Figure 1). In this way they differ from the population previously described by interviewees, which was almost entirely

renters rather than owner-occupiers. Where indicated, survey results are presented by home ownership status.

Table 2 Proportion of survey respondents identifying living with others (n = 156)

	%	#
My partner (married, de facto, civil union, boyfriend or girlfriend)	85%	133
My mother and/or father	3%	4
My son(s) and/or daughter(s)	61%	95
My brother(s) and/or sister(s)	0%	0
My flatmates	10%	16
None of the above - I live alone	1%	2
Other (e.g., grandmother, boarder, mother-in-law)	8%	12

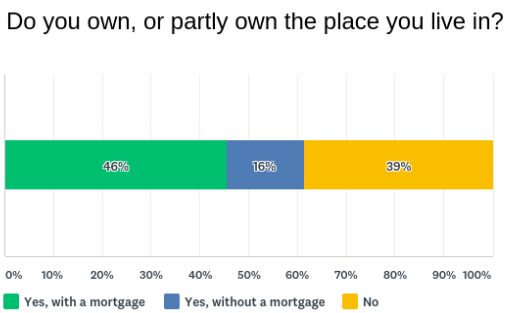

Figure 1 Proportion of survey respondents by home ownership status (n = 158)

16.1

4.2 Residential mobility

Almost half (46%) of the respondents had moved at least once in the past two years (Figure 2). The most common reason for moving was their purchase of their own home or section (27%). A quarter of those who had moved in the past two years did so for reasons out of their control, such as their landlord selling their house, their rent increasing or their lease being terminated.

8 Queenstown Lakes Housing: The Human Story

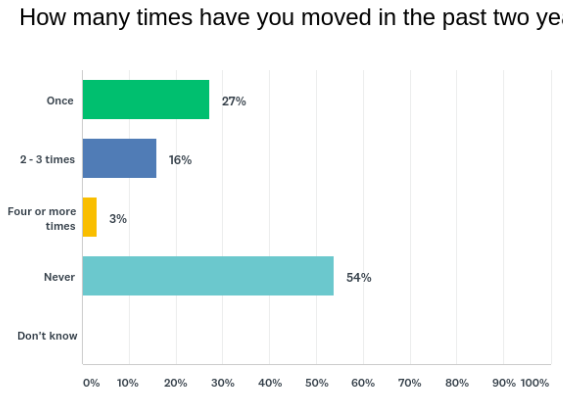

Figure 2 Proportion of survey respondents who have moved in the past two years (n = 200)

Table 3 Reasons survey respondents moved in the past two years. Respondents could select multiple reasons (n = 109)

Reason for moving	Percentage	Number
For employment/work/business	18%	20
We bought our own house/section	27%	16
We moved for financial reasons	11%	12
We lived in a rental property and it was sold	5%	6
We wanted to move into a different sized property/house	6%	7
To have more family support nearby	1%	1
Our lease on our rental property expired and/or we were given notice by our landlord (for reason other than the property being sold)	9%	10
We lived in a rental property and our rent was increased	11%	12
Because of the breakdown of a marriage or relationship	3%	3
We wanted to move into a warmer, drier and/or safer house	15%	16
We moved in with family	2%	2
We wanted to move to a different neighbourhood	8%	9
Because of a new marriage or relationship	1%	1
To be closer to a particular school	3%	3

4.3 Quality

In agreement with interviewee accounts, over half (63%) of the renters in the survey reported that their home was often or always colder than they would like—significantly less homeowners reported this (Figure 3, $p = 0.05$). Renters were more likely than homeowners to report that their homes needed maintenance or repair (Figure 4), or that their homes smelt mouldy or damp (Figure 5). However, 30% of the homeowners indicated that some repairs and maintenance were needed to their home.

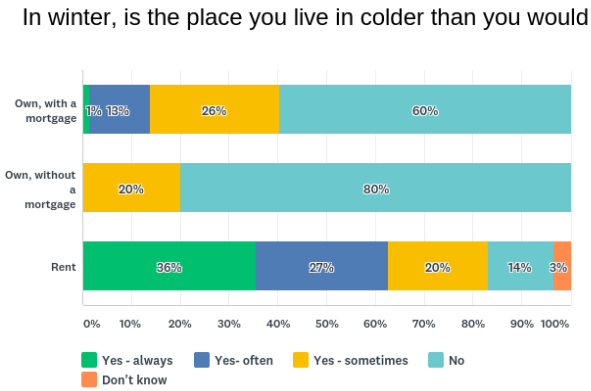

Figure 3 Proportion of survey respondents identifying coldness in the place they live, by ownership status (n = 156)

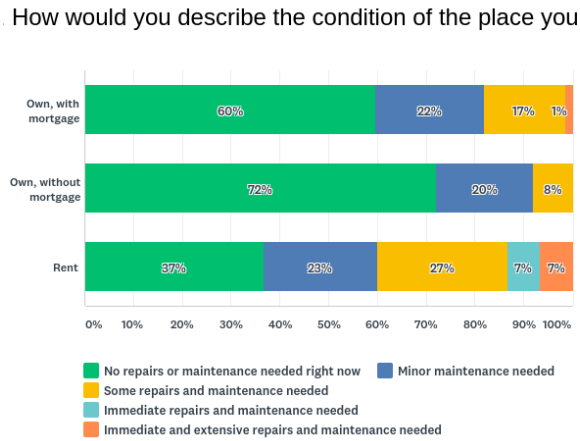

Figure 4 Proportion of survey respondents identifying condition of place they live in, by home ownership status (n = 157)

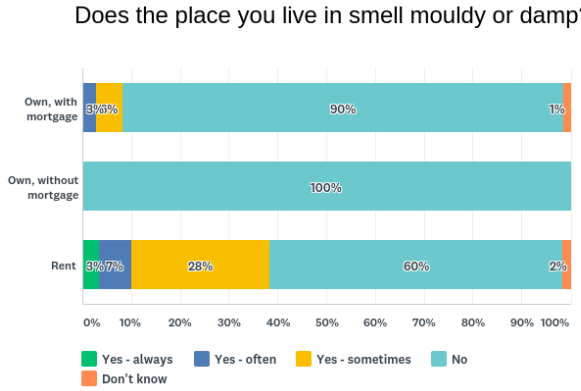

Figure 5 Proportion of survey respondents identifying mouldy or damp smells in the place they live in, by ownership status (n = 157)

10 Queenstown Lakes Housing: The Human Story

4.4 Crowding

Twenty-three percent of renters (n = 14) regularly used rooms other than bedrooms for sleeping (Figure 6), most commonly the lounge or living space. By contrast, only 2% of owner occupiers reported this practice. Having three or more people regularly sleeping in any one area was common to both renters (36%) and owner occupiers with a mortgage (27%, Figure 7).

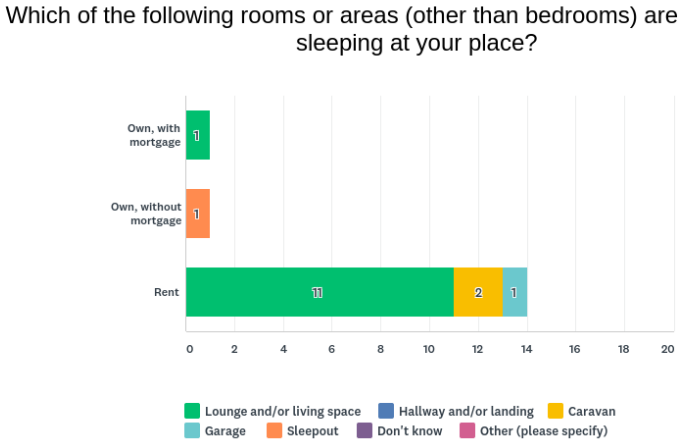

Figure 6 Number of survey respondents regularly using rooms other than bedrooms for sleeping (n = 158)

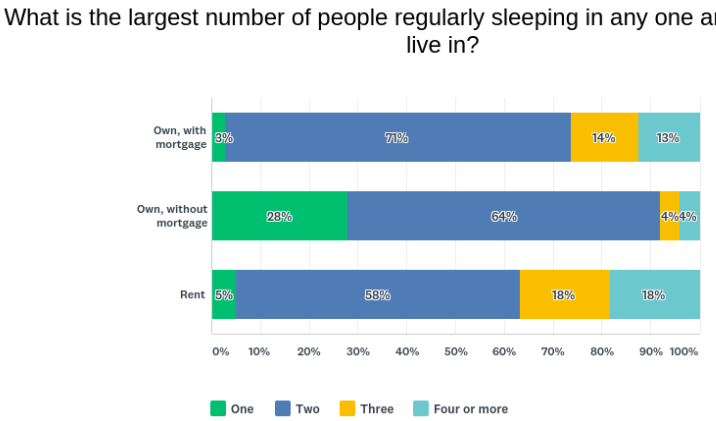

Figure 7 Proportion of survey respondents reporting largest number of people sleeping in any one area (including bedrooms) (n = 158)

5 Conclusions

The Queenstown Lakes District is experiencing rapid population growth coupled with grossly inadequate affordable and rental housing infrastructure. Our research design allowed us to understand how residents are responding to the pressures they face as reported by key informants. The most common response to alleviate the pressures is to crowd homes to improve affordability. Some families are sharing a house with another family to make ends meet. Boarders are common among families. Described consequences included poor physical and mental health outcomes and adverse social impacts. Some people are living in tents or

vehicles, or in cabins at campgrounds. Many accounts were made of material hardship. The low wage economy is exacerbated by the cost of housing. To pay the rent, people are going without heat, food, and health care. Increased mental stress and anxiety was reported as a very common response to housing pressure. In turn, this was linked to domestic violence.

We were also able to establish who is reported to be the most affected by the housing crisis. Unsurprisingly, migrants and single parent families are most impacted in terms of increased financial hardship, material deprivation, poor quality housing and access to housing. All families (except the very wealthy) are affected by the price of housing, with many turning to house sharing to share the costs. Concerns were expressed about child development, safety and quality of life under these circumstances. Single middle aged men struggle to find a space in the social dynamics of the Queenstown Lakes housing market, especially if they have other challenges, such as poor mental health.

Our data support the recommendations of the Mayoral Housing Affordability Taskforce.[15] We further encourage the Queenstown-Lakes and Central Otago District Councils to work collaboratively in their efforts to improve housing availability and affordability in their jurisdictions.

5.1 Research strengths and limitations

Our methods captured the voice of the most vulnerable through interviewing service providers who work directly with them. Unlike pre-written surveys, the interviews were not restricted to specific questions. The researcher was able to guide and redirect the interviews in real time. This allowed the complexity of the housing situation to unfold, and for the issues to be examined with depth and detail.

The researchers (VH & EN) both live in the Queenstown Lakes district. This may have led to increased sensitivity to housing stress in specific circumstances. However, we used a number of methods to ensure this research was academically rigorous. The lead researcher (VH) is qualitatively trained, and received independent project advice from a highly experienced qualitative researcher based at the University of Otago. To check for bias, EN read the entire dataset, and discussed coding with VH for comparison. Further, we used respondent validation to ensure that our findings are an accurate representation of Queenstown Lakes housing experiences. This involved allowing the interviewees to read through the analysis and provide feedback on our interpretation of their accounts.

We obtained almost complete representation of government and non-government organisations among interviewees. This means that the experiences of the most vulnerable Queenstown Lakes residents were very well captured in the data. The interviewees very commonly described other issues that were occurring in Queenstown Lakes. However, these were considered beyond the remit of this report and were not described. In brief, described issues related to parenting, drugs, newcomer expectations, service impacts, social isolation, and community and transience.

The quantitative survey was used as a secondary approach to support the qualitative findings. The survey used pre-tested questions from national surveys to produce reliable results. However, it was based on convenience sampling and recruitment primarily targeted families. Oral health clinics, Public Health Nurses, the media and schools were used to obtain a broader social economic sample than what would otherwise have been obtained by social services alone. Because such a high proportion of survey respondents were homeowners, we were

successful in this regard. However it must also be noted that those with housing stress may have been more motivated to complete the survey. The survey data are not representative of the whole Queenstown Lakes population. The findings must be recognized only as a snapshot of the experiences of participants, who were primarily couples or families.

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16.1

14 Queenstown Lakes Housing: The Human Story

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:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.

*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.