Community & Public Health Advisory Committee Meeting

Board Room, Level 2, Main Block
Wakari Hospital Campus, Dunedin

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

04/10/2021 01:00 PM - 03:00 PM

APOLOGIES

Apologies have been received from:

- Dr Doug Hill, Committee Member
- Mr Andrew Swanson-Dobbs, CEO, WellSouth Primary Health Network

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Community and Public Health Advisory Committee, 4 October 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: Nil

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).

Appendices

- Board, Executive Leadership Team, and external CPHAC members' 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 (updated 26.08.2021)	Ex-officio Member, Executive 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	Member, Expert Advisory Group for WAI claimants related to historical underfunding of Māori PHOs (appointed September 2020)		
	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		
	25.06.2021	Director and Shareholder, Kiwood Limited	Nil (farm forestry plot).	
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	Member, Spokes Dunedin (cycling advocacy group)		
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
	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.	
	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		
	25.06.2021	Trustee, New Zealand Brain Tumour Trust		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
	03.04.2020	Client, Royal District Nursing Service NZ Ltd		
	12.01.2021	Nga Kete Matauranga Pounamu Trust Board Member		
Jean O'Callaghan	13.05.2019	St John Volunteer, Lakes District Hospital	No involvement in any decision making.	
	26.08.2021	Idea Services Board of IHC	Possible conflict with contracts and service delivery models.	
Tuari Potiki	09.12.2019	Employee, University of Otago		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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		
	09.123.2019	*Shareholder in Te Kaika		
	24.06.2021	Te Rau Ora Directorship		
	24.06.2021	Needle Exchange Services Trust (NEST) member		
	28.08.2021	Chair, NZ Drug Foundation (3 month appointment)		
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~~	Removed 01.07.2021	
	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 (updated 02.06.2021)	Employee, Counties Manukau DHB. Currently seconded to Ministry of Health as Acting Chief Medical Officer		
	21.01.2020 (updated 02.06.2021)	Clinical Advisor to the Board, Waikato DHB		
	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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Roger Jarrold (Crown Monitor)	16.01.2020 (Updated 28.01.2021)	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)	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		
	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		
	18.06.2021	Treasury: Health Reform Challenge Panel		
	26.08.2021	Advisor to Health Transition Unit on Finance/Procurement		
Benjamin Pearson (Crown Monitor)	21.07.2021	Consultant Paediatrician, South Canterbury DHB		

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	25.02.2021	Portobello Maintenance Company	Nil, Body Corporate for residential area.
Kaye CHEETHAM		Nil	
Rory DOWDING	18.01.2021	Change Quest Ltd	Stepfather (Ross Hanson) and his trading entity (Change Quest Ltd) are at times employed as a contractor to SDHB HR Directorate
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 Health Services Ltd~~	Removed 28.06.2021.
	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.
	28.06.2021	Director, Te Kura Taka Pini Limited	100% owned by Te Rūnanga o Ngai Tahu.
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	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017 (updated 26.08.2021)	Ex-officio Member, Executive Steering Group, New Dunedin Hospital	
	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)
Hywel LLOYD	16.06.2021	GP, Mosgiel Health Centre	
	16.0.2021	Wife, Nurse, Paediatric Outpatients	
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
	27.01.2021	Daughter, is a junior doctor in Auckland and is involved in orthopaedic and general surgery research and occasionally publishes papers	

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
	23.07.2020	Wife, Chief Data Architect, Inde Technology	Inde is part of WSP's Digital Health Collective, the consultancy service supporting the NDH Digital Infrastructure and Digital Facility Services
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.
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
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 (Updated 17.04.2021)	Royal NZ College of GPs- accredited teacher		
	30.03.2021	SPHO – Minor surgery GPSI contract		
	30.03.2021	ACC- Orthopaedic GPSI contract		
	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 (includes Medical Funds Management Ltd, Medical Insurance Society Ltd and Medical Life Assurance Society Ltd)		
	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	
	28.06.2021	Director and Shareholder, D J Hill Medical Practitioner Ltd		
	28.06.2021	Shareholder, Medasoty Securities Ltd		

Southern District Health Board

Minutes of the Community and Public Health Advisory Committee Meeting held on Monday, 2 August 2021, commencing at 1.00 pm, in the Board Room, Southland Hospital Campus, Invercargill

Present:	Mr Tuari Potiki	Chair
	Ms Ilka Beekhuis	Deputy Chair
	Prof Peter Crampton	
	Mrs Kaye Crowther	
	Dr Doug Hill	
	Dr Lyndell Kelly	
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Dr John Chambers	Board Member
	Mrs Jean O'Callaghan	Board Member *(by Zoom)*
	Ms Lesley Soper	Board Member
	Dr Moana Theodore	Board Member
	Mr Chris Fleming	Chief Executive Officer
	Mr Rory Dowding	Acting Executive Director Strategy, Primary and Community
	Dr Hywel Lloyd	Interim Executive Director Quality and Clinical Governance Solutions *(from 3.15 pm)*
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications *(from 3.15 pm)*
	Mr Andrew Swanson-Dobbs	CEO, WellSouth Primary Health Network
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer/Acting Executive Director MHAID
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chair welcomed everyone, and the meeting was opened with a karakia.

2.0 APOLOGIES

Apologies were received from Mr Roger Jarrold, Crown Monitor, Dr Ben Pearson, Crown Monitor, Ms Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer, and Mrs Jane Wilson, Chief Nursing and Midwifery Officer.

An apology for lateness was received from Dr Nicola Mutch, Executive Director Communications.

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 June 2021 be approved and adopted as a correct record."

T Potiki/I Beekhuis

5.0 MATTERS ARISING

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

6.0 CHAIR'S UPDATE

The Chair noted that there were increased expectations of Rūnaka from the Health system reform, the new Dunedin Hospital, etc, which was creating pressure, as there were a limited number of whānau to cover these issues.

7.0 REVIEW OF ACTION SHEET

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

Mental Health and Addiction Services Waiting Times

The Acting Executive Director, Mental Health, Addictions and Intellectual Disability (MHAID) reported that the Methadone Programme was funded for 323 clients but currently had 419 clients. 40 new referrals were received each year, so there was a waiting list to access the programme.

Population Health Recovery

The Acting Executive Director Strategy, Primary and Community (EDSP&C) reported that Population Health believed they could manage the recovery within the existing team. Additional resources would be considered if required.

The Committee requested:

- Information on the oral health contract with the University of Otago Dental School, including what they are contracted to do and what they deliver;
- That updates on Mental Health and Addiction Services waiting times remain on the action sheet and become a standing agenda item.

8.0 STRATEGY, PRIMARY AND COMMUNITY REPORT

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

- *COVID-19 Vaccination Programme* - The programme being led by SDHB and WellSouth Primary Health Network (PHN) was gaining momentum, with many GPs and pharmacies coming on stream. There had been a few challenges arising from vaccine supply, moving to the new national booking system, nursing workforce shortages, and the impact of quarantine free travel. A lot of

work was going into ensuring equity, however that had not translated into results yet.

The CEO reported that, since the report was written, mariners aboard a ship docked in Bluff had tested positive for COVID-19 and two admitted to Southland Hospital. Any more would have had to be transferred to Dunedin Hospital.

- *Health Needs Analysis* – A prototype had been loaded to an internal website. It had two parts: a self-service data portal and a high level narrative, and would be made publicly accessible.

Management were asked to clarify how people in retirement villages were receiving information on COVID-19 vaccination.

9.0 PRESENTATIONS

Population Health and Water Fluoridation

The Committee received a presentation via Zoom from Dr Rob Beaglehole, National Public Health Advocate for DHB CEs and Chairs, on population health issues (tab 15.1).

Dr Beaglehole outlined the status of the 2020/21 work programme actions to:

- Establish the National Public Health Advocacy Team
- Tackle alcohol related harm
- Address the obesogenic environment, and
- Help achieve the Smokefree 2025 goal.

During his presentation, Dr Beaglehole advised that sugar reduction would decrease tooth decay, obesity and type 2 diabetes but would require years of public policy interventions, whereas water fluoridation would have an immediate and significant impact if implemented nationally. Ministry of Health data showed that it would reduce tooth decay rates in children by 40%.

The Committee was informed that the water fluoridation Bill was being re-introduced to Parliament the following week.

Dr Beaglehole recommended that Southern DHB adopt a water, unflavoured milk, tea and coffee only policy and advised that there was new evidence that artificially sweetened beverages and juices contributed to tooth decay, obesity and type 2 diabetes just as much as full sugar drinks.

Dr Beaglehole then responded to questions from members. During discussion, members noted their support, and willingness to show leadership, for fluoridating water supplies across the whole district.

The Committee requested that a paper on adopting a water only beverage policy be submitted to the Board. This is to include information on artificially sweetened beverages, which Dr Beaglehole offered to supply.

Dr Beaglehole was thanked for his presentation.

Partnered Primary Care Service for Invercargill

Mr Andrew Swanson-Dobbs, Chief Executive, WellSouth, Mr Terry Nicholas, Te Rūnanga o Ngāi Tahu representative and trustee, and Manager/Co-ordinator of Hokonui Rūnaka, Ms Mata Cherrington, Awarua Whānau Services, and Ms Helen

Telford, Project Lead, were welcomed to the meeting and updated the Committee on progress in setting up a daytime partnered primary care service in Invercargill (tab 15.2). This included an outline of their vision for the service and rationale for being part of it, the revised model of care to address the needs of whānau and the community, the expected benefits and outcomes, the work under way, and current and future investment options.

Members of the Partnered Primary Care Service then responded to questions from Committee members on the proposed model, the challenges to success, and any assistance they may require.

Members expressed support for the development and noted the progress made.

10.0 STRATEGY, PRIMARY AND COMMUNITY REPORT (continued)

The Acting EDSP&C gave updates on the following issues.

Allied Health Vacancies

Three offers had been accepted by overseas candidates and emphasis was being placed on the new graduate intake.

Aged Residential Care Bed Availability

The number of people waiting for psychogeriatric care had reduced from 18 to 8.

Community Pharmacy

Southern DHB did not have a policy limiting the number of pharmacy contracts within the district. Advice on this issue would be submitted to the September Board meeting.

Waiting Times

The Committee requested further advice, including possible solutions, on:

1. The methadone waiting list, and
2. The Southland Dental Unit's general anaesthetic waiting list (to be submitted to the September Hospital Advisory Committee meeting).

11.0 PHO PERFORMANCE UPDATE

A report on primary care performance (tab 10) was taken as read and the Acting EDSP&C took questions.

It was agreed that the PHO would provide information to the next meeting on access to after-hours care within the district, including Central Otago.

The Executive Director Communications and Interim Executive Director Quality and Clinical Governance Solutions joined the meeting at 3.15 pm.

12.0 MĀORI HEALTH UPDATE

The Committee received a report on Māori Health Directorate activity and an update on Māori primary care enrolment (tab 11).

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) reported that information on General Practice enrolment was being collected at COVID-19 vaccination clinics and people not enrolled were being supported to get enrolled.

The Committee requested information on kaupapa Māori services provided within the district, including advice on gaps in service provision.

13.0 MENTAL HEALTH REVIEW

The Committee received a verbal update from the Acting Executive Director Mental Health and Intellectual Disability (MHAID) Services, on the Mental Health Review.

It was noted that the Review report would be released to stakeholders on Friday, 6 August 2021.

14.0 FINANCE REPORT

A report on Strategy, Primary and Community financial performance to 30 June 2021 (tab 13) was taken as read.

The Acting EDSP&C advised that pharmaceuticals were the biggest financial risk for 2021/22.

15.0 ITEMS FOR NOTING

Combined Oral Health Arrears and Spatial Equity Project Report

The Committee received an update on the recovery process for children overdue for their scheduled oral health examinations due to the impact of COVID-19 (tab 14.1).

Population Health Update

The Committee received an update on the impact of COVID-19 on Population Health service provision during 2021/21, specifically B4 School Checks and the measles immunisation campaign, and work under way or planned by Population Health to catch up on targets whilst continuing to support the COVID-19 vaccination programme (tab 14.2).

The meeting closed at 3.30 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 22 September 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 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 was tabled at the June 2021 meeting. A full update on housing work in general will be presented at the October 2021 meeting.	October 2021 Completed
May 2021 Aug 2021	**Mental Health** (Board Minute 8.0) (Minute 7.0)	CPHAC to be provided with updates on Mental Health and Addiction Services waiting times. To be a standing agenda item.	Acting ED MHAID	Noted	Completed
August 2021	**Oral Health** (Minute 7.0)	Information to be provided on the contract with the Dental School, including what they are contracted to do and what they deliver.	EDSP&C	Paper has been drafted for Public Excluded session.	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
August 2021	**COVID-19 Vaccination Programme** (Minute 8.0)	Clarification to be provided on how people in retirement villages are receiving information on COVID-19 vaccination.	EDSP&C	Residents are invited individually. The Vaccine Implementation Programme advise that the Retirement Villages within SDHB have also now been contacted and provided with relevant information	Complete
August 2021	**Healthy Food and Beverage Environments Policy** (Minute 9.0)	Paper on adopting a water, unflavoured milk, tea and coffee only policy to be submitted to Board. To include information on artificially sweetened beverages (from Dr Beaglehole).	EDCS/ EDSP&C	A policy is being developed for presentation at the December CPHAC meeting. Early engagement with Retailers and Contractors has commenced.	December
August 2021	**Methadone Treatment Waiting List** (Minute 10.0)	Further advice, including possible solutions, to be submitted to Board.	Acting ED MHAID	Presentation – MHAID	Completed
August 2021	**Southland Dental Unit's General Anaesthetic Waiting List** (Minute 10.0)	Further advice, including possible solutions, to be submitted to the September HAC meeting.	EDSP&C/ EDSS	Transferred to HAC action sheet. Paper tabled at HAC but will need to be updated due to COVID resurgence impacts.	Complete
August 2021	**Access to After-Hours Primary Care** (Minute 11.0)	Information to be provided on accessing after-hours primary care within the district, including Central Otago.	EDSP&C/ PHO	A paper focussing on Central Otago Lakes has been drafted but additional context re district wide provision would add significant value to this paper. WIP.	December
August 2021	**Kaupapa Māori Service Provision** (Minute 12.0)	Report to be provided on Kaupapa Māori health services within the district, including any gaps.	CMHS&IO	Update included in agenda papers.	
Sept 2021	**Opioid Substitution Treatment Waiting Times** (Board minute 6.0)	Report to be submitted to October CPHAC meeting with corrected data and how waiting times are best addressed, eg through budget reprioritisation, involvement of the PHO.	Acting ED MHAID	Presentation – MHAID	Completed

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2021	**Review of action sheet – Southland Dental Unit's General Anaesthetic Waiting List** (HAC minute item 6.0)	The report being prepared for CPHAC is to include the possibility of the Dental School providing dental chairs further south.	EDSPC	Will be factored into future reports.	December 2021

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, 4 October 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.

Staffing over Level Three and Four Lockdown

It has been pleasing to see how staff have supported each other across the services throughout the lockdown, particularly in the areas of contact tracing where significant and immediate support was required, COVAX immunisation and screening at hospital sites for visitors once we moved to Level 3. Staff across these services have been responsive and flexible in stepping up to help where most needed and have demonstrated the core values of this organisation.

Public Health Covid-19 Response – Auckland Outbreak

On 17 August New Zealand entered level 4 lockdown after a community case of Covid-19 delta variant was discovered. A nationwide public health response was launched to support the Auckland Public Health team.

Public Health South moved to operating over a seven-day week as part of the national response. An Emergency Operations Centre was set up. This ensures we coordinate our teams and have the correct capacity and processes in place to manage the work being assigned to us. This involves several roles including an incident controller, operations lead, administration, logistics, planning and intelligence, and welfare roles.

Staff were rostered over a seven-day period to ensure we could meet Ministry of Health capacity expectations for Southern. We were required to follow up: 12 cases daily, 137 new contacts daily, 597 contacts in follow up daily, and to surge to 50% more on each. Each of these contacts are followed up for their 14 days of isolation.

Eighty staff worked on contact tracing. Thirty-two were from the Public Health Service, complimented by 39 staff from around the Southern DHB and two staff from Queenstown Lakes District Council. Due to the recent pause on all Quarantine Free Travel, seven of the Queenstown airport health team were also able to be redeployed to this work.

The majority of the work that was assigned to Southern was contact tracing. This included contacting people who had been identified as close contacts and following up symptomatic contacts for the remainder of their isolation period. Daily follow up contact was made via email or phone to monitor people's health and welfare, compliance and to ensure that the required testing was completed. Staff use the National Contact Tracing Solution (NCTS) for this work. This is a national system that enables work to be delegated to the various public health units and then to staff who are assigned people to follow up. The system records all interactions with people who are cases or contacts.

Southern was also assigned 33 exposure events to assess. This is where a location of interest has been identified and involves determining the classification of contacts at the exposure, providing information to the location concerned, ensuring any public notification via the Covid-19 App or bluetooth is completed and that the location of interest has been published as required by the classification of risk.

A significant amount of staff training was required; partly because many changes have been made in a large upgrade to the NCTS system. For many of the staff involved it had been some time since they had completed their training, and many were new to contact tracing or case management.

A total of 97 staff received some sort of training. This included:

- Refresher case management and monitoring: 20
- Refresher contact tracing: 44
- New recruit contact tracing: 53

Between 17 August and 16 September, we managed up to 1394 contacts, and 33 exposure events. At our peak we managed 808 calls a day.

Number of contacts who isolated in Southern DHB: 141 - all of which have finished their required isolation period. Five contacts requested welfare assistance via the contact tracers. This resulted in food parcels, referral to an external agency for psychosocial support, and information and contact details for financial assistance available through the Ministry of Social Development.

Public Health has a number of staff who are part of a new National Outbreak Response Team. Four staff (a Medical Officer of Health, and three staff who are experienced contact tracers and/or superusers of NCTS) have been deployed to Auckland to assist the teams at Auckland Regional Public Health. Each person has been deployed for a 2-week period.

During the outbreak a Community Supported Isolation and Quarantine Coordination Manager was appointed and commenced their role. This is a new role that is being appointed into each District Health Board. In Southern this position is based in the Public Health Service. The new manager has a critical role working with other agencies and stakeholders in Southern to ensure we can accommodate and support Covid-19 cases and/or contacts to isolate or quarantine safety in Southern. Southern DHB does not have a managed isolation or quarantine facility and the closest are located in Christchurch. For this outbreak, the Ministry of Health directed us to have capacity to manage up to 10 cases or 5 bubbles in the Southern DHB catchment. To achieve this if required, accommodation has been secured in Invercargill, Dunedin and Queenstown for a small number of cases in each locality.

Next steps
As of 16 September, the service is continuing to manage a small number of contacts and are the single point of contact for a number of exposure events to support the national response. At this stage we are unclear how long we will be required to provide this support. We have scaled back our response and released the majority of staff back to their normal work.

The focus has now shifted to reviewing how we managed our response and the previous Mattina response. This is to identify any gaps and areas for improvements for the future so we can be as prepared and effective as possible.

All staff involved have been asked to provide feedback around what worked well and areas for improvement. This is currently being compiled.

We have already identified a number of areas that require improvement. This includes rostering planning, looking at ways we can deploy staff faster, improving our processes for scaling up and down response teams, and ensuring that our trained workforce (including surge workforce) are kept up to date with any changes in practice and competency in using NCTS. Further work is required about how our workforce needs to look to be prepared to regularly surge to respond to Covid-19 outbreaks.

We also need to consider the likely scenarios we might face in the future to ensure we can be as prepared as we can be for these and put in place some desk top exercises to practice our plans.

Finally, it should be noted that this is intensive work. It is a concern that staff are tired with the cumulative impact of responses over the last 18 months. This is also being reported nationally across other units. We need to look at how we can support staff welfare, balanced with the need to have staff ready to respond each week. Additional workforce is being recruited to boost overall capacity around Covid-19 responses which will assist with this.

Covid-19 Cases on MV Mattina - Update

As previously reported Public Health has been responding to positive cases of Covid-19 in crew on board the MV Mattina ship in Bluff. All cases and contacts have now been released from self-isolation and quarantine and on 19 August, the ship was granted pratique, which means the ship is now eligible to have dealings with a port. The response to this has raised a number of issues that need to be resolved for the future including clinical oversight of cases, accommodation and transport. Unfortunately, due to the Auckland August Covid-19 outbreak this debrief has been postponed.

Covid-19 Vaccination Programme

The COVID-19 vaccination programme entered August 2021 with the aim to significantly increase vaccinations, and to regain ground lost from the previous vaccination slow down. Figures 1 and 2 highlight how we have achieved this, and the effect that a COVID-19 outbreak as had on the programme. Figure 3 shows the percentage of vaccinations we have completed per Territorial Local Authority (TLA), our focus is to decrease disparity across the region.

The programme now has over 100 vaccination sites across the Southern district with multiple delivery streams; this is the largest number out of any District Health Board in the country. This has enabled us to be flexible during the COVID-19 Alert Level 4 announcement, when the large majority of General Practice (GP) delivery streams were severely impacted by the outbreak and were prioritising Covid-19 swabbing. Our 36 pharmacy streams continued vaccination and increased production over the coming days until General Practice recovered. Pharmacies ramped up vaccinating efforts and have communicated their ability to continue with this higher capacity for the foreseeable future (irrespective of alert levels). Many have also had workplaces approach them to organise them to get their vaccinations at a pharmacy. In Level 4, this has been essential workers.

From 23-30 August, we broke records with our largest number of vaccinations to date with over 55,541 administered and our largest day ever with 9,674 vaccinations delivered in one day.

Figure 1

Figure 2

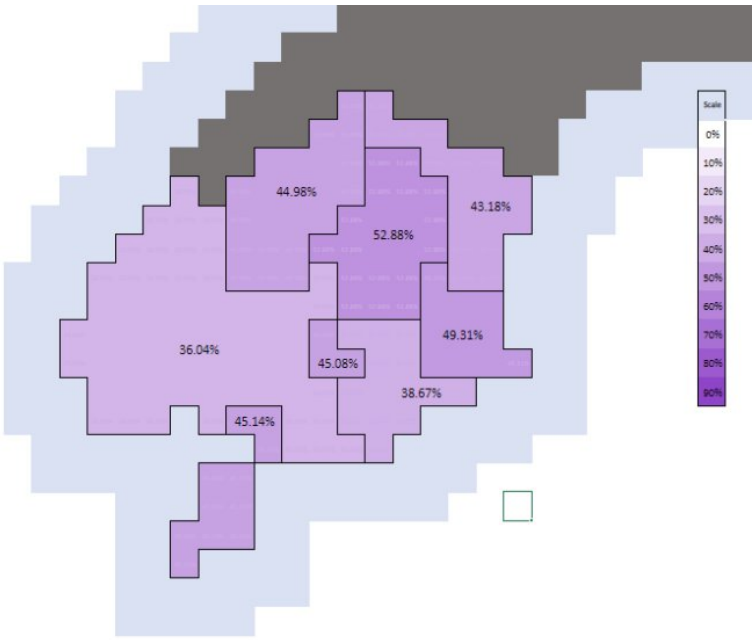


Figure 3

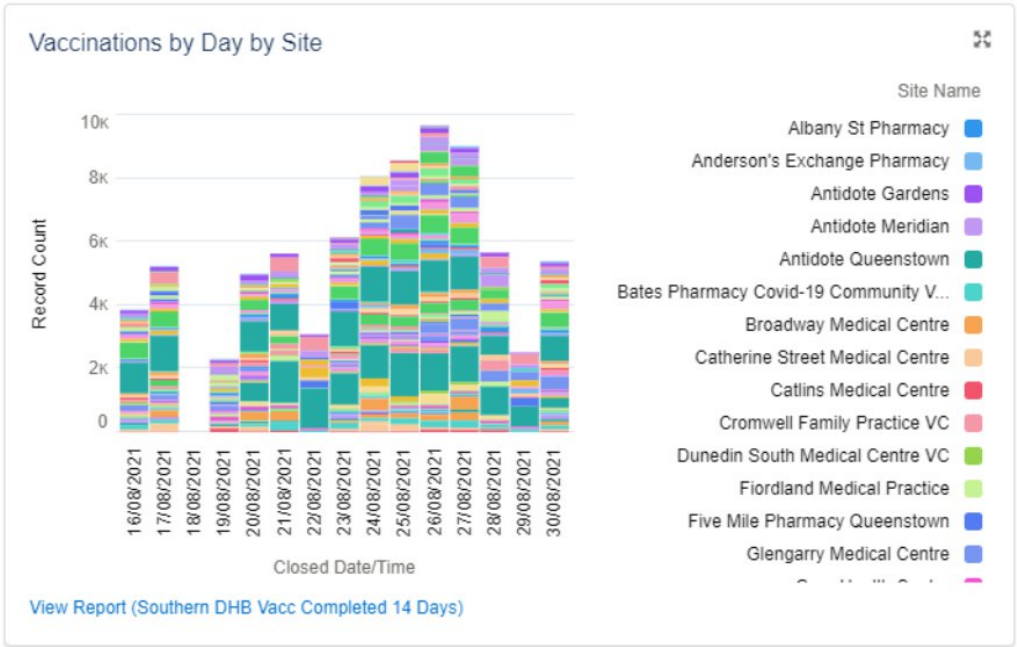


Figure 4

Māori and Pacific Population Rollout

August saw new clinics open at the Pacific Island Advisory Cultural Trust, Invercargill; Pacific Trust Otago, Caversham; and Te Rau Aroha Marae. Level 4 lockdown saw two significant drive through pop-ups open, one operated by Otakau Health Services vaccinating up to 1,300 people per day at the Edgar Centre, and another run by Debbie Swain-Rewi, Occupational Health Nurse, located in Queenstown. These took considerable pressure off local General Practices which could not deliver large volumes of swabbing along with vaccinations.

Level 4 has placed barriers for some clinics with the Stewart Island community unable to receive their 2nd dose as the outbreak occurred. Plans are underway to organise another clinic.

Aged Residential Care

Vaccinations of our older populations at Aged Residential Care facilities are complete. Our teams vaccinated residents and staff onsite, with the vaccine delivery supported by General Practices, pharmacies and flying squads. All 65 facilities across the Southern district have had first and second clinics onsite. There is a process being embedded that will allow new residents to be vaccinated through until the end of the year.

Disability Residential Support Services

Of the almost 1,000 Disability Residential Support Services recipients in the Southern district, most live in a residential facility. Their providers have all been contacted, and a mixed delivery model will be used to suit each provider, including vaccination clinics at tailored community-based locations. The vaccine delivery will be supported by General Practices, pharmacies and mobile teams. Arrangements are in place for 90% of this cohort, and good progress is being made on arrangements for the remainder.

Mental Health Residential

All mental health residential services in the Southern district have been contacted regarding their resident's eligibility for vaccination and booking information has been supplied. In some cases, we have arranged onsite vaccinations by pharmacists and GP practices, where attendance at the mass clinics was not appropriate for individuals.

Ethnic Communities, including migrants and refugees

Planning is underway for targeted ethnic community clinics at tailored community-based locations across the Southern district. Through a collaborative approach, clinics will be attended by key community leaders within the ethnic community, interpreters and resources in various languages will be provided.

Workplaces

To date, we have worked with 40 workplaces across the district. There has been a range of solutions for getting their staff vaccinated, including onsite clinics and priority access to established clinics in the community. We ran a Queenstown specific expressions of interest process with support from the Queenstown Chamber of Commerce and have connected eligible workplaces with a local occupational health provider.

Covid-19 Vaccination Workforce

Clinic staffing is currently at full capacity. Under Alert Level 4 no Mandatory Training or Orientation Training is taking place. Mass vaccination sites are fully staffed and these staff will be reassigned to outreach vaccination clinics as demand at the mass centres declines over the next couple of months.

Primary Maternity Unit Business Case

The business case for Ministry of Health (MoH) funding for construction of two rural Primary Birthing Units has been drafted and has been sent to the MoH for feedback before final submission. The business case is based off the updated Options Paper approved by the Board in June 2021 and has been formatted into the Better Business Case format. This Business Case is also to be presented to the Executive Leadership Team (ELT) at their September meeting.

The Southern DHB drafts people are currently working on a design for the new birthing unit which will be sent to a Quantity Surveyor for a more robust estimate of costs.

Preparations are underway for Requests for Proposal (RFP) for both Service Provider(s) and Design/Architectural services. The RFP for the service provider is taking precedence to ensure that the successful party(ies) can be involved meaningfully in the design process. Work is underway to identify suitable land in Wanaka and discussions between various stakeholders are ongoing.

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. There has been a lot of effort put into recruitment which is starting to show results. Five offers from overseas have been accepted, with the first arriving in Invercargill at the end of August. The others are still waiting for MIQ placements, placing a significant amount of uncertainty of when they will arrive. Recruitment for new graduates has commenced with a good number of applications received.

Staff from Dunedin continue to support their colleagues in Invercargill with a rotational roster with a senior physiotherapist travelling to Invercargill for 5 days each week. This has been interrupted temporarily during Level4 & 3 lockdown, but the impact of this has been minimised by reduced work, and hence reallocation across the existing team.

Aged Residential Care RN Workforce

The RN shortage in Aged Residential Care (ARC) continues to worsen with a very limited pool of available nurses. The number of shifts not covered by an RN continue to increase. Even with mitigations put in place, this is concerning.

The following report explains the situation in greater depth - Appendix 1 - Aged Residential Care Registered Nurse Recruitment and Retention Survey Results 1 January 2021 to 30 June 2021

The ARC RN Workforce Steering Group continues to meet and has developed a well-supported action plan. Actions that have resulted from our ARC RN Workforce Steering Group are:

- Workforce Co-ordinator 0.6 FTE started 25/8/2021 for six months and an additional 0.5 FTE will commence in October
- Workforce Co-ordinator is going to work to identify and support Internationally qualified nurses (IQNs) who haven't achieved registration in NZ.
- Work continues with Nurse Advisor from the Ministry of Health who is seeking advice regarding strategies to support the sector. Advice has been provided on IQN's, Nursing Council processes and supported mentorship linking to the rotational programme and bonding schemes.
- ARC Workforce Steering Group has linked with MBIE who may write a Workforce Insights report based on the ARC survey results alongside sharing information on retention programmes for the sector

Aged Residential Care Bed Availability

Bed availability in aged residential care continues to be problematic, exasperated by the RN Shortage.

Waiting Lists for Aged Residential Care as of 26 August 2021

	In Hospital	At Wrong Level in ARC	At Home in Community/ Hospice	Total
Psychogeriatric Care (D6) District	2	2	1	5
Hospital Level Care (Dunedin)	4	5	0	9
Hospital Level Care (Southland)	5	1	1	7
Secure Dementia Care (Dunedin)	0	1	1	2

Secure Dementia Care (Southland)	0	0	5	5
Rest Home Care (Dunedin)	1		3	4
Total	12	9		

Infection Prevention and Control Support to Aged Residential Care

The Aged Residential Care (ARC) Infection Prevention and Control (IPC) Clinical Nurse Specialists have been particularly valuable to the ARC sector this month:

- Supporting 17 Acute Respiratory Infection Outbreaks in facilities. Currently there are seven active outbreaks. With the Public Health team prioritising Covid-19 work, the IPC Clinical Nurse Specialists have supported facilities through these outbreaks.
- Providing excellent advice and support to facilities in Alert Level 4, answering questions and concerns, facilitating conversations between hospital wards and ARCs, supporting patient flow.
- Supporting facilities to safely allow visiting for end of life residents in alert level four

STRATEGY AND PLANNING

Annual Plan 21/22

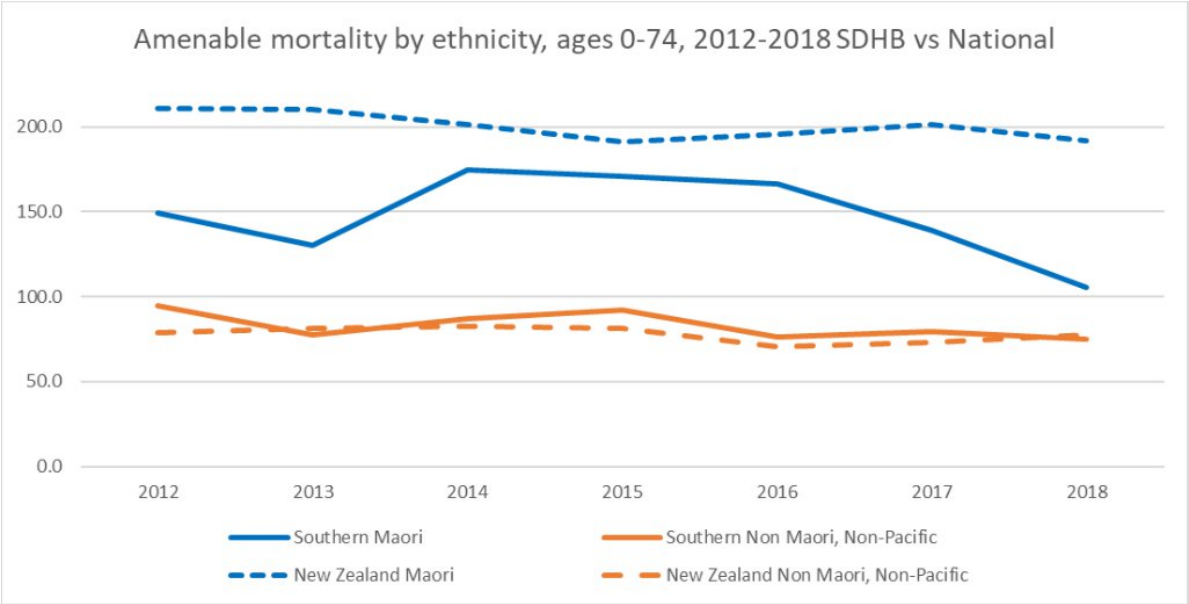
A complete Board signed Annual Plan was submitted to the Ministry of Health, for Ministerial Approval, on 10 August.

Statement of Service Performance

The team is in the final stages of completion for the 20/21 Statement of Service Performance (SSP). The 20/21 SSP is required for review by auditors on 30 August. The compilation of the SSP has been impacted by the recent COVID lockdown, with staff redirected to Contact Tracing and Public Health EOC duties.

The SSP will include the most recent MoH release of the Amenable Mortality data, which includes previously unreleased 2017 and 2018 years. Per previous releases, the most recent years data is stated to be provisional, as nationally there are a number of cases (337 at the time of extract) still awaiting final coroners' findings. A small number (13) had no known cause.

An unacceptably high variation in rates between Māori and non-Māori remains although there has been a reduction in this variation based on the 2017 and 2018 years.



Based off the MoH tables provided (excerpt below) SDHB has the 12th lowest rate for non-Māori non-Pacific and the 4th lowest rate for Māori over the period 2014-2018.

Amenable mortality, ages 0-74, 2014-2018
Calculated using 2016 population
data
With 99% confidence intervals

	Māori				non-Maori, non-Pacific			
DHB of domicile	Deaths	Rate	LCB	UCB	Deaths	Rate	LCB	UCB
Southern	200	150.4	123.0	177.8	1685	82.3	77.1	87.5
Total New Zealand	6367	197.0	…	…	19424	73.1	…	…

Rates per 100,000 age standardised to WHO world standard population

Service Planning

The annual cycle for service planning for 22/23 has started, with an October workshop planned for the Medicine Women's and Children Directorate, and one for Surgery and Radiology at a later date. The aspiration is to have early alignment of the budget and Capex process with the service planning annual timetable; regular catch-ups with the CFO are established to assist in this.

A brief discussion with the Clinical Council this month on service planning and changes in models of care prior to moving to New Dunedin Hospital was very useful. Service planning will include proposed changes to models of care; the challenge is how to involve the stakeholders from across Directorates and across the sector (primary and community).

Operational Updates

Public Health Service

Communicable Disease

There has been a large number of Respiratory Syncytial Virus (RSV) cases and outbreaks in early childhood centres (ECC's) in the district. RSV is a common respiratory virus that causes respiratory tract infections, including the common cold, and is highly contagious. However, very young children and premature babies can become very sick and may require hospitalisation. In this age group RSV can cause bronchiolitis (inflammation of small breathing tubes of the lung) and pneumonia (infection of the lung). A person is usually infectious for up to 10 days after symptoms begin. Health Protection Officers (HPOs) have provided public health advice to ECC's and continue to work with centres to help manage these outbreaks. This includes collecting details of those that are unwell by recording information in the form of a case log, working in collaboration with public health nurses who have a very close relationship with ECC's, and ensuring the appropriate control measures are in place to help prevent further spread of the virus.

There have been 17 Acute Respiratory Infection (ARI) outbreaks at Aged Residential Care facilities that are being followed up by Health Protection Officers. ARI's are infections that can affect the upper and/or lower respiratory system. This infection can be particularly dangerous for older adults and people with immune system disorders. HPOs who manage these outbreaks work collaboratively with infection prevention and control (IPC) nurses, ensuring that the appropriate control measures are in place. They also work closely with the nurse manager at the aged residential care facility, who provides daily updates, and case logs to help keep records of the number of staff and residents who are unwell.

Alcohol

'Don't Guess the Yes' is a programme focused on changing attitudes and behaviours towards alcohol consumption and sexual consent. Staff met with Hospitality NZ, Police, and Queenstown Lakes District Council who plan to launch the campaign before Christmas. Training will be given to hospitality staff on consent, alcohol and sexual harm. The campaign is designed to share messages and get the community talking about how informed consent is required for any sexual activity, how excessive alcohol consumption affects decision making, how to keep others safe, and call out attitudes and behaviour that support sexual violence.

Public Health staff attended the Alexandra Youth Expo on behalf of the Central Otago Drugs and Alcohol network. To engage with the students, staff brought games to test their knowledge about alcohol harm, as well as surveys about their habits with alcohol, smoking, and vaping. One hundred survey responses were collected, with the following preliminary findings: young people are mostly getting alcohol from their parents, most young people are drinking, and when young people drink, they tend to binge. Most youth have never smoked, but more have tried vaping. Young people are getting vape products from friends, shops, and online; and they report that people their age are vaping everywhere including and especially at schools. Young people from this survey are vaping nicotine at strong levels.

Transport and Sustainability

Public Health South was invited to attend a number of events in the Queenstown-Lakes area related to the future of transport and sustainability in the district. Two events were hosted by the 'Shaping our Futures' group, to discuss mode shift in transportation. Another event was hosted by Queenstown Lakes District Council's Climate Reference Group, where the focus was on Vision 2050, one component of which is a low-carbon transport system. Public Health was able to offer an insight into the health benefits of active and public transport, as well as the co-benefits to health that come along with most environmental actions. These events provided the opportunity for staff to connect with council members, staff, and other community groups.

Community Resilience

Public Health staff have been undertaking community resilience scoping work in rural areas with community workers, schools and community members. There are identified areas where health promotion work can be further undertaken including sexual health and mental health (leading into Mental Health Awareness Week next month). Isolation, lack of transport options to access services, and lack of counselling options remain issues in rural areas. This engagement provided the opportunity to promote accessible resources such as '1737'. This work has been particularly useful in that it helps inform our priorities for the locality work that is being planned for the future.

Violence Intervention Programme (VIP)

The Whāngaia Ngā Pā Harakeke model is an interagency response to family harm episodes to which the police are called out. The VIP team have received positive feedback from the Police about their engagement in this work. Southland are piloting a new youth project, which will require significant involvement of the VIP team. This is an exciting piece of collaborative work to be involved in which is aimed at high risk youth offenders who have been either exposed to family harm or involved themselves. This work also includes identifying all agencies and services who have been involved throughout their lives and determining what has been beneficial or harmful. Based on this information, plans will be developed with the aim of reducing the risk of offending and breaking cycles of repeat offending against or by them. Current FTE resourcing would not enable ongoing commitment to this work.

Refugee Health

Mental Health

The Invercargill Colombian migrant and refugee community have organised into a grassroots Non Government Organisation (NGO) – Migrants and Refugees of Colombia (MaR). Southern DHB and WellSouth Primary Health Organisation (PHO) have met with MaR a number of times in 2021. A consistent issue raised by MaR involves the mental health challenges of the Colombian community and access to mental health care.

Colombian refugees, and often refugees in general, experience two distinct psychological stressors: trauma experienced in their country of origin and integration challenges in New Zealand. Research has shown that from a quantitative standpoint more refugees suffer mental health issues as a result of integration stressor versus trauma experienced in their country of origin.

What we are seeing, and what MaR is reporting, is both trauma and integration challenges and a blend of the two for some refugees. Fortunately, these issues are being presented and discussed. Of note, former refugee Colombian communities have a strong, positive history in New Zealand (NZ) of advocating and exhibiting high levels of commitment to integration into NZ society.

WellSouth has developed their mental health services in Invercargill to support Colombian former refugees considerably since resettlement began in 2017. Nonetheless, there are challenges to meet the relatively unique issues which former refugees face. Indeed, it is apparent that referrals being accepted into the Southern DHB outpatient Mental Health service can be a bit of a challenge.

Afghanistan

As widely reported in the media, the Taliban has taken control of Afghanistan. In Dunedin, we are accepting and supporting the resettlement of Afghan refugees. These refugees are predominantly from the Hazara tribe and there is a long history of their persecution under the Taliban. Thus, recent events have been highly unsettling for this community in Dunedin.

In response, through the WellSouth bilingual Afghan Cross-Cultural Navigator, and via WhatsApp, we have been advising the Afghan former refugee community in Dunedin of mental and social wellness support as well as translating official NZ government announcements of potential support for Afghans who may be in imminent danger.

Covid Lockdown

On a practical level, a lockdown situation can be challenging for former refugees. In particular, accessing primary care and concerns around hospital appointment cancellations are particularly difficult when there are language barriers coupled with lockdown. It must be noted, however, that former refugees have developed high resilience as a result of the extraordinary challenges they have faced in the past. Consequently, the refugee communities in the Southern district – Afghan, Colombian, and Syrian – have responded to lockdowns in proactive and resilient ways.

The Cross-Cultural Navigators are very effective in supporting the former refugees in the practical challenges noted above. Right now, the Navigators are encouraging and helping to organise the refugees in accessing Covid-19 vaccinations. Finally, the Navigators are also a conduit for native language government briefs. These are shared in Arabic, Dari/Farsi, and Spanish via WhatsApp social media.

Population Health Service

Highlights

Population Health areas looking at Strategic Planning workshops to inform their service practice and models of care. Staff are continuing to review processes for Opportunities for Improvement.

Since Alert Level 4, Population Health has scaled down services in response and prioritised core services. Population Health leadership has looked to increase available capacity to support priority areas of Contact Tracing and Covid-19 vaccinations and administration support. Population Health leadership are reviewing plans to catch up where possible at Alert Level 2 onwards.

Measles Campaign 15 to 30 year olds

Southern DHB has received the variation agreement to sign for the National Measles Campaign. This is to recommence the Southern campaign that had previously been put on hold at the direction of the Ministry of Health due to Covid-19 prioritisation. Planning work had looked to recommence in August to reviewing previous campaign plans. However, has been put on hold in interim while Covid-19 level resourcing into priority areas has taken precedence.

Public Health Nurses

Busy month again for staff dealing with complex high needs families. There are families who are struggling financially along with more families being unwell due to the Respiratory Syncytial Virus (RSV) outbreak and cold weather. Prior to Alert Level 4, staff had already been asked to assist in various Covid-19 vaccination clinics over the region, including weekend work to support Covid-19 vaccination priorities. Southland has moved offices and are just sorting finer details in this area.

In response to August Covid-19 Outbreak, Alert Level 4:

Services scaled down (such as Before School Checks, Youth Clinics, in schools) with core service and priority follow ups maintained. Staff have mostly been redeployed into Contact Tracing to support Public Health South colleagues, and Covid-19 vaccinating. Will look to recommence with catch up plans for all work in Alert Level 2.

School Based Human Papillomavirus Vaccination Programme (HPV) Otago

Round two to commence shortly. However, some planning is underway to accommodate potential changes to roll out dates in schools if Covid-19 restrictions continue. Furthermore, the inclusion of

12–15-year-olds into the Covid-19 vaccination program requires additional precautions around spacing of vaccinations and updated communications to schools and whanau.

In response to August Covid-19 Outbreak, Alert Level 4:

Services scaled down with staff having been mostly redeployed into Contact Tracing to support Public Health South colleagues. Will look to recommence with catch up plan in Alert Level 2.

School Based Services Contract

Year 9 assessments in decile 5 and below schools are well underway for the year (pre-lockdown). Some disruptions anticipated in Southland to this program with staff resignations, deployment, and retirement. Recruitment for these roles is complete and staff will begin their orientation at beginning of September.

In response to August Covid-19 Outbreak, Alert Level 4:

Services scaled down with staff having been mostly redeployed into Contact Tracing to support Public Health South colleagues. Will look to recommence with catch up plan in Alert Level 2.

Immunisation Outreach and Vaccine Preventable Disease (VPD) team

The VPD Immunisation team continue to provide support to the Covid-19 vaccination programme, particularly in the Immunisation Coordinator space throughout August. There continues to be high demand on our VPD immunisation service including Public Health Nurses and work is planned in this space to increase capacity. Work has begun with the National Immunisation Coordinator looking at trend analysis for targeting priority follow ups.

In response to August Covid-19 Outbreak, Alert Level 4:

Staff continue to support the Covid-19 vaccination programme through Alert Level 4, in Immunisation Coordination and vaccinating. This includes support rural General Practices who have had unplanned resource constraints in Alert Level 4 on a case-by-case basis. During Alert Level 4 Childhood Immunisation remains a priority and have continued priority follow ups to ensure this continues.

Puketai

Previously Puketai Nurses had organised a small Covid-19 clinic to catch staff who were still required their first or second Covid-19 vaccination on 8 July 2021. This went well. Now that the Covid-19 vaccinations are available to 12–15-year old's a plan is in place to vaccinate these young people on site.

In response to August Covid-19 Outbreak, Alert Level 4:

Currently, there are 8 young people and the residence is full. Puketai is in lockdown during Covid-19 Level 4. There are no new admissions at Puketai under the current alert level. Some referrals are on hold, telehealth is occurring where possible and there are no discharges at level 4. The Nurse is attending the residence 2-3 hours a day and the rest is carried out by telehealth.

Gateway

It is pleasing to note that in July 17 referrals were received. Once again this continues a pleasing trend and means that if this continues, contractual numbers will be met for the 2021-2022 year. Urban Dunedin referral numbers are increasing, and Invercargill continues to have large numbers of referrals. The Otago Gateway coordinator is undertaking clinics in Invercargill to assist with this. Multidisciplinary meetings continue to go well across the district and continue to include staff from health, education, Oranga Tamariki as well as primary level mental health workers.

In response to August Covid-19 Outbreak, Alert Level 4:

Gateway referrals continue with priority follow ups, throughout Covid-19 Level 4 with Telehealth priority.

Cervical Screening

Ministry of Health Southland Colposcopy Audit completed and to be reviewed for improvements.

Planned introduction of HPV as the primary screen is scheduled 2024. Trial of HPV as primary test continues in North Island using dry swabs and media. The Cervical Screening Register will be updated (2024) with new guidelines.

In response to August Covid-19 Outbreak, Alert Level 4:

National Cervical Screening Programme (NCSP) Work List Tasks continue to be completed. Where there are heightened concerns and queries for patients, these are being directed to clinicians as priority.

Hearing and Vision Screening

Newborn Screening and Vision Hearing teams are continuing to report to Population Health Service Manager. Continuing to work with Human Resources and Director Allied Health around resourcing constraints. Project Hector audit work completed in conjunction with Antenatal and Newborn Screening National Screening Unit. Planning underway for Southern-wide Strategic Planning session for Vision Hearing, October 2021.

In response to August Covid-19 Outbreak, Alert Level 4:

Newborn Hearing Screening – Community clinics cancelled. Staff have switched to staggered 7-day roster in Dunedin and Southland maternity wards to maintain coverage. Will look to catch up missed babies in Community clinics, audiology referrals as per 2020 Covid-19 processes.

Vision Hearing Technicians – As schools and early childhood centres are closed, staff have mostly been redeployed into Covid-19 Contact Tracing and professional development. Work will recommence with catch up plan when possible.

Sexual Health

National Guidelines on management of syphilis in pregnancy have been released. It is anticipated that a health pathway will be written nationally and then localised for Southern once available.

In response to August Covid-19 Outbreak, Alert Level 4:

Scaled down service provision with staggered staff coverage in clinics. Telehealth provision as priority where needed as drop-in clinics cancelled. Appointments are only being provided in person to those needing treatment or with symptoms requiring examinations.

Child Health (0-5years)

Well Child Tamariki Ora (WCTO)

WCTO is an essential service under Alert Level 4. The Ministry of Health (MoH) has refreshed advice for the sector with the main aim of minimising community spread of Covid-19 to protect whanau and maintaining the safety of the clinical workforce. MoH have advised WCTO nurses should only be deployed to other Covid-19 related services if necessary and where there is capacity after priority work is covered.

In-person WCTO visits are mostly delayed during Alert Level 4. WCTO services continue via virtual contacts (phone, telehealth) with whānau who have new pēpi. Lead Maternity Carers (LMCs) are to notify vulnerable whānau to the WCTO provider at two weeks postnatally. LMCs and WCTO should work together, so whānau are supported collaboratively by both services in the first six weeks. Priority is based on the following criteria for whānau with pēpi aged between birth and three months who are:

- Māori and/or Pacific
- First time parents
- Living in areas of high deprivation
- Any whānau where the LMC or WCTO nurse has assessed high long-term need or risk to child health and wellbeing outcomes.

Only in exceptional circumstances under Alert Level 4 can face to face contact be made. Decisions for this are based on the clinical judgement of the WCTO nurse, the LMC, midwife and or General Practitioner (GP). Priority is given to:

- Pēpi born preterm or discharged from a Special Baby Care Unit
- Pēpi with feeding and weight gain issues
- Māmā with post-natal depression or other mental health and wellbeing needs
- Any whānau where the LMC or WCTO nurse has assessed high long-term need or risk to child health and wellbeing outcomes.

Timely completion of all scheduled childhood immunisations continues to be a priority. Immunisation rates, particularly for pēpi Māori, have been negatively affected during the Covid-19 period. Therefore, whānau should be encouraged and supported to liaise with their local GP regarding timing of the six week immunisation and pēpi check.

Non-contact components of the Before School Checks (B4SCs) continue during Alert Level 4 using virtual telehealth technology. In-person contact, including clinical assessment, will need to be completed subsequently. B4SCs and Vision Hearing Test (VHT) screening is being deferred during Alert Level 4.

The Portfolio Manager, Child and Youth is in contact with local WCTO providers offering support to solve any challenges and ensuring distribution of updated information occurs.

Safe Sleep Programme

Sudden unexpected death in infancy (SUDI) prevention and the distribution of safe sleep spaces remains a priority during Alert Level 4. Southern DHB continues to support whānau with safe sleep spaces to ensure every sleep is a safe sleep.

Discussions have been held with the MoH about how to get updated data on confirmed SUDI deaths as we currently only receive provisional coronial data. It is important to get this data to provide the sector with updated advice on what our SUDI prevention activity is achieving.

The Southern district breast feeding Hui for key stakeholders scheduled for 31 August has been postponed.

Oral Health

Southern DHB Community Oral Health Service (COHS) August Figures

- New Enrolments for month = 338
- Total Enrolments = 47,917
- Patient contacts for month = 5,173
- Does of Fluoride Varnish given for month = 2,449

Oral Health Summary

Oral Health has continued to work hard to reduce the arrears over the past year and have mainly been successful, evidenced by having a steady reduction in arrears on a monthly basis, but this has slowed due to recent staffing relocating and resignations combined with the added complication of a snap lockdown. As a service we have commenced developing our recovery plan. Currently the Oral Health service staff have been deployed to assist with the Covid-19 response, so the management team are taking this time to work on developing initiatives, such as tele-dentistry that we can initiate prior to recommencing Business as Usual (BAU) in level 2. Other projects in this report are currently on hold until we can come back together

Planning

A senior clinical and dental assistant meeting was held to encourage staff to take ownership and have input in running their service. This was welcomed and planning is underway to put in place set guidelines for all Oral Health staff. They especially want to look at addressing options for encouraging staff to come to Southern DHB and how we could retain them. Also the concerns they have regarding equity for our patients who are referred out of the service for sedation or General Anaesthetics (GA). This effects the Otago patients mainly as Southland have a sedation clinic in Queenstown and the Dental Unit but Otago patients are referred to the Dental School and the patients are on very long waiting lists.

Kia ora Hauora program – Oral Health will participate in this fantastic initiative to get young Maori into health careers.

The pilot project for a drop-in clinic planned for Invercargill is an ongoing piece of work, the pilot project is still in the planning stage, and the identification of pilot site underway.

There was a meeting with Central Otago Community Oral Health Service (COHS) team in June. A double mobile unit at Wakatipu has been in place since 9 August and this will be staffed from other areas that are less in arrears. We are in the process of permanently moving some vacancies of both Therapist and Assistants to work in Central Otago area as populations are still growing in this area.

Planning is underway for 4th clinic room refurbishment in the Dental Unit. Quotes for equipment have been done and plans have been drawn up. This may now rollover to 2022, and with an increased chair in this region this will certainly have a huge impact on being able to reduce arrears and support the increasing population.

Projects

Tele-Dentistry: - Project ramping up and next level work with Matthew Pettersson who is the new telehealth project manager for the Southern DHB to get our systems and processes up and running and aligned with the rest of the Southern DHB. Teams established and evidence gathered of success of Tele-Dentistry from across the world.

Spatial Equity: - Meetings held with Strategy and Planning Team. Agreement to proceed with a pilot project with them on service distribution regarding population, access to service, distribution, and equity.

Professional Development:

Final year Bachelor of Oral Health students on placement with us this month, two in Invercargill and one in Dunedin. The students spend four weeks with the service while being mentored by our Therapists to enable them to get an insight into our Southern DHB Oral Health Service.

RED FLAGS

Staffing:

Overall staffing shortages are still a concern, not only in our service, but also as there is a shortage of Dentists in the Southland Area overall, with six vacant positions in private practices still unfilled. The impact of this results in patients coming onto the Dental Unit as private Dentists deflect non-patients away from already overloaded patient lists.

Arrears:

While arrears overall were reducing, due to staffing shortages there are pockets of concern. Last month we were at 20.26%, an increase from the previous month, and now lockdown has resulted in any ground we made up will be lost and we will see numbers increase again.

Rural Health

Primary Maternity Facilities

Work is well underway to design the new Primary Birthing Unit in Clyde, which the Central Otago Maternity Unit (COMU) in Alexandra will transition across to. A design will be circulated to steering group members for feedback, and priced by a Quantity Surveyor, by the end of August.

Monthly telehealth clinics have been available in Wanaka for the past year. This service is now being trialled in Lumsden, to be accessed by women in the Lumsden and Te Anau area who would usually travel to Invercargill for secondary care appointments. There is also equipment and training in place to establish telehealth clinics in COMU.

Work is being finalised on an updated Service Specification for Child and Maternal Hubs, which will provide a level of consistency across providers, whilst retaining the ability for these spaces to be community-led.

During lockdown activity has continued in our Primary Birthing Units. Three births in COMU within a week when everyone else was in Level 4 lockdown, was welcomed by the team.

Lakes District Hospital (LDH)

August continued to be extremely busy in LDH, especially the Emergency Department with presentations increased by 17% compared with 2020. Then Level 4 lockdown occurred on 17 August and presentations reduced by 30-40%. The reduction during the Level 4 lockdown in 2020 was much greater, so hopefully the impact will be less in the longer term.

Level 4 has seen a rapid reassessment of all resurgence plans for the hospital. The Delta variant meant much of the planning done in 2020 was no longer applicable. Working with the Infection Prevention and Control team, linking into the Southern DHB Technical Advisory Group and participating in the Southern DHB Incident Management Team has enabled solutions to be found and processes to be implemented to ensure safety of patients and staff.

Security guards have been established at the main door to assist with screening of everyone who presents to the facility. This has been invaluable.

Rural Hospitals

Rural Trust Hospitals activated their Emergency Operations Centres in response to the Level 4 lockdown. Adjustments to plans to manage the risk of airborne spread of Covid-19 is challenging in facilities with no negative pressure rooms. The Hospitals have collaborated to share information to mitigate these risks. The decision by the Technical Advisory Group (TAG) that Rural Trust Hospitals would transfer Covid-19 positive patients who needed hospitalisation to Dunedin Hospital, has meant their planning needed to target management of High Index Suspicion patients whilst awaiting test results.

Primary Care

Community pharmacies request for contracting or commissioning policy Southern DHB.

A letter was received on 29 June sent on behalf of 57 community pharmacies in Southern requesting that the DHB consider a policy and contracting or commissioning process around the approval of new pharmacies. The letter noted that a number of DHBs have a process for this.

The letter also asked that a moratorium be placed on new pharmacy contracts for the foreseeable future while a policy and process is developed. Local pharmacy owners are very keen to work with the DHB in this regard and have the opportunity to express their concerns with the current situation.

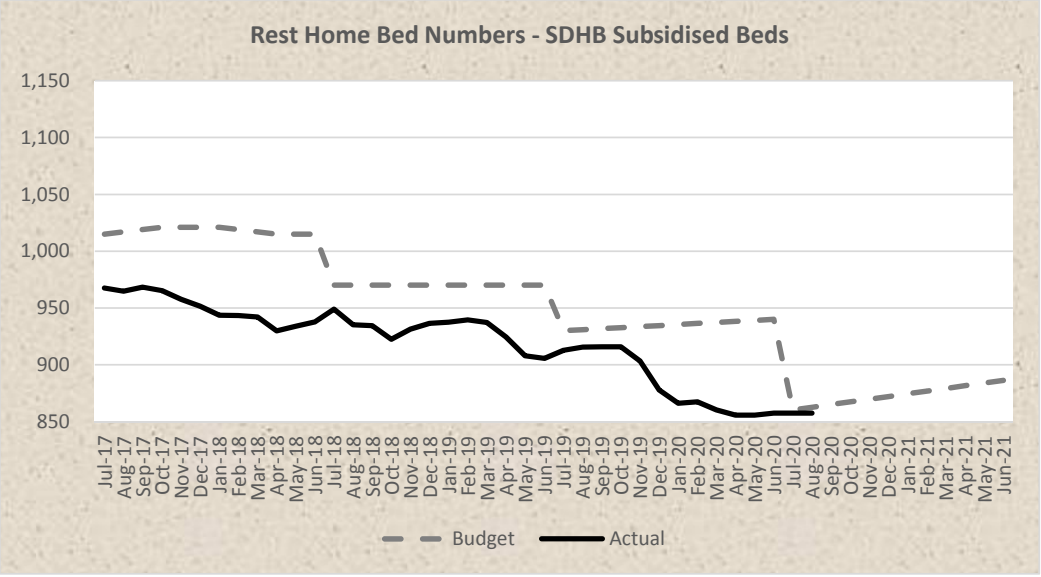
Older Persons Health and AT&R

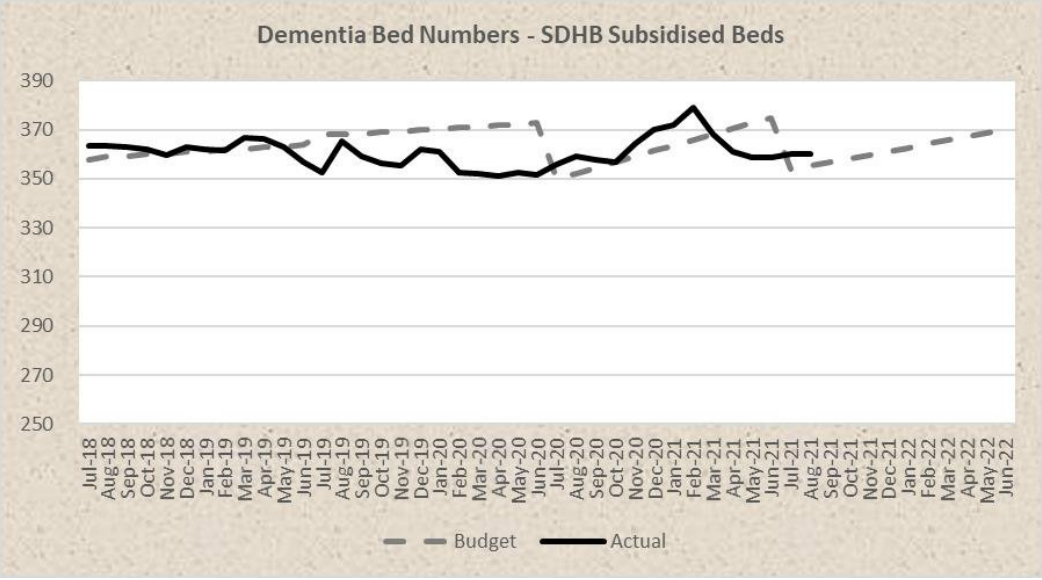
Aged Residential Care Occupancy/Volume Analysis

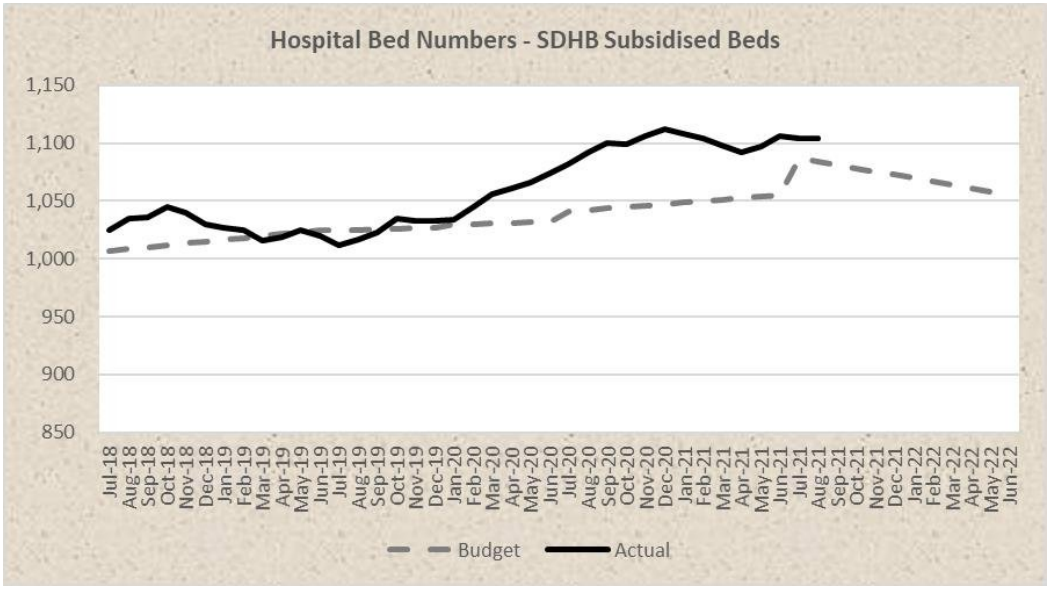
The levels of occupancy in Aged Related Residential Care (ARRC) have stabilised and we are seeing an overall decline in bed utilisation compared to six months ago. Total utilisation has reduced by 35 beds since December 2020, albeit with a slightly different mix. Rest Home level continues with a gradual reduction. Both Hospital Level Care (HLC) and Dementia utilisation have stabilised after growing in the first half of the last financial year. 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.

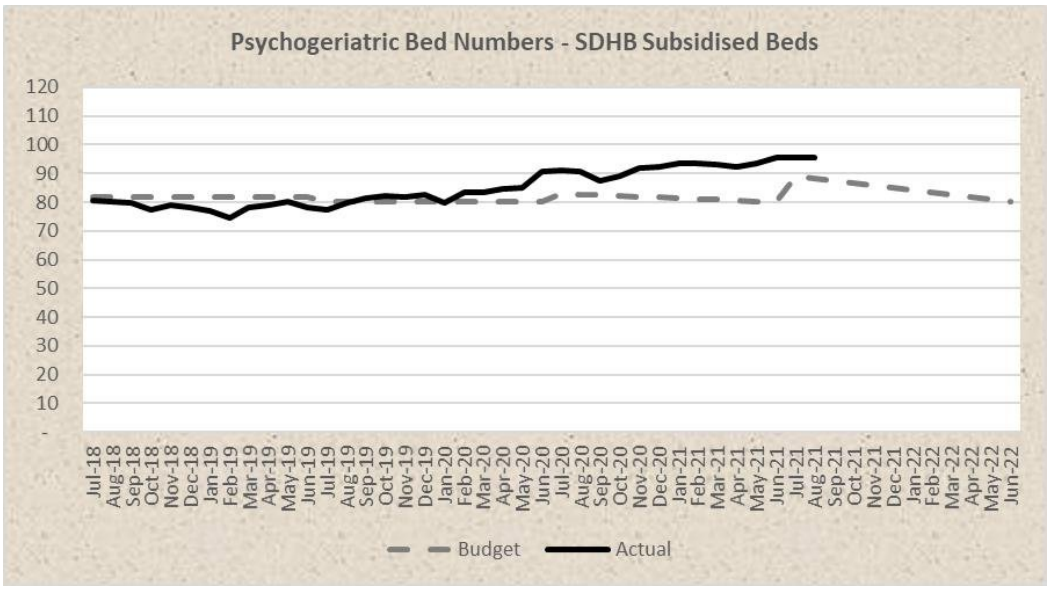
The data and analysis are complex with many individual journeys within the system. While we are getting a better view of what is happening, understanding why is more challenging.

Golden View is a new ARC facility in Cromwell that started accepting new Dementia and Hospital level residents in August. Many of the residents have transferred from other facilities in the Central Otago area, but there are a number of new dementia residents who had been supported in the community whilst the new facility was under construction. As observed elsewhere when a new facility opens, there is an overall increase in bed occupancy.









Allied Health

Work on the relocation of Dunedin Physiotherapy Outpatients continues and has evolved into two substantial projects involving a large number of teams and services. A high-level plan for the Outpatients space has been developed taking into account the constraints and limitations of the existing facility. We are about to engage with the wider teams on the plans and seek input in more detailed design.

Aged Residential Care Registered Nurse Recruitment and Retention Survey Results 1 January 2021 to 30 June 2021

Background

The Southern District Health Board Aged Residential Care (ARC) Workforce Steering Group was formed in 2019 in response to recruitment and retention issues in ARC. The ARC Workforce Steering Group has broad representation from ARC, Tertiary Education Providers, Ministry of Health, and SDHB employees including the Director of Nursing for Strategy Primary and Community, Portfolio Manager for Health of Older People and Nurse Entry to Practice Programme leads. ARC recruitment and retention issues have deteriorated significantly with COVID-19 border closures and wider pressure on the health sector linked to COVID-19, DHB nursing shortages and lack of pay parity.

Concerns regarding safe staffing in ARC were continually being elevated to the Portfolio Manager for Health of Older People where there have been 35.5 shifts in hospital level facilities with no Registered Nurse on site notified by a Section 31 during the period January through June of 2021. Notifications of another 27.5 shifts uncovered occurred during July 2021. Section 31 (5) of the Health and Disability Services Act 2001 requires certified providers to notify the Director General of Health about any health and safety risk to residents or a situation that puts (or could potentially put) the health and safety of people at risk.

To get a better understanding of the SDHB region situation the ARC Workforce Steering Group surveyed the ARC providers in July 2021 to identify current staffing, recruitment, and retention issues with the Registered Nurse Workforce. The survey asked for information for the period 1 January 2021 to 30 June 2021.

Method

An electronic survey was sent out to 65 Facilities across the SDHB region. Facilities were given two weeks to respond with a reminder email sent. The survey requested quantitative and qualitative information.

Reponses were received from 39 facilities representing a 60 % Response rate.

Results

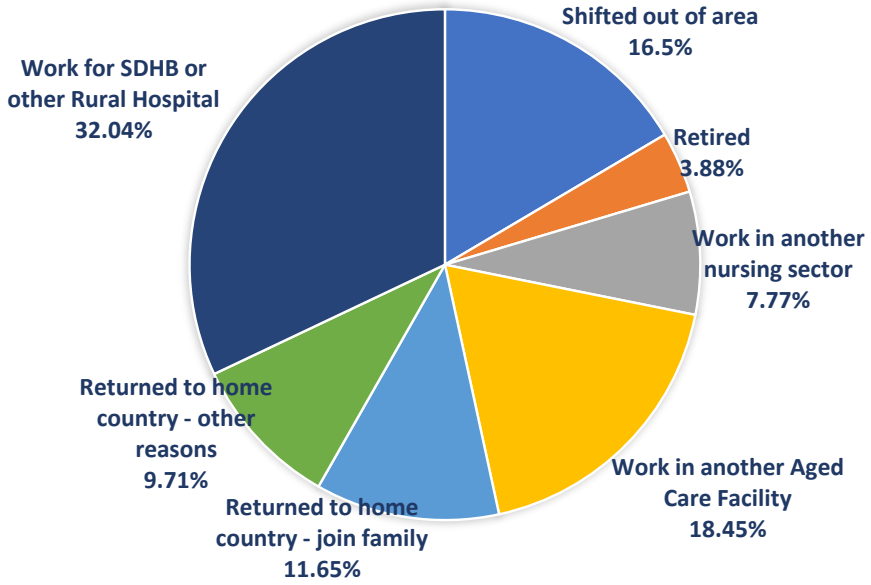
a) Current Registered Nurse Staffing Status

The results found 59 % of facilities do not have the required Registered Nurse full time equivalents (FTE) to safely staff the facility without the need for them to work extended hours. Due to this, 47% of facilities reported that the Registered Nurses were regularly working more than 40 hours a week. While the survey did not specifically address nurses working above contracted hours it was noted in the comments that while many are not working more than 40 hours a week, they are working more than their contracted hours. Alongside this, 83 % of Clinical Managers are doing more than one clinical shift a week due to a shortage of Registered Nurses. Analysis of required FTE compared to actual FTE across all the facilities demonstrated a current gap of 49.8 FTE, this represents a 20% shortfall between required and actual FTE. Please note that these actual numbers only cover the 60% of facilities who responded to the survey. As facilities are not able to provide sustained safe staffing 21% of facilities surveyed have reported that they have denied admissions.

b) Retention of Registered Nurses

The survey results demonstrate that 100 nurses or 73.6% FTE resigned from ARC between 1 January 2021 to 30 June 2021. As demonstrated in Graph One 32% of nurses moved to work within the DHB or rural hospital, with 18% moving to another Aged Residential Care facility and 20% returning to their home country for family or other reasons.

Graph One



Recruitment of Registered Nurses

Since January 2021 56% of facilities reported that they have been able to recruit Registered Nurses in contrast to 44% of facilities that have not. Facilities were asked where new recruits had come from. The largest source of Registered Nurses was from each other (nurses moving between ARC facilities), this was followed by new graduates, then Internationally Qualified Nurses who had completed a Competency Assessment Programme (CAP), followed by movement from other sectors such as community nursing and nurses who are returning to the workforce.

Facilities reported that it takes several months to recruit new nurses, with most facilities reporting that it takes 3 to 6 months to fill vacancies. Four facilities reported challenges with recruiting Internationally Qualified Nurses linked to Nursing Council processes, visas, arranging travel and securing space in Managed Isolation Quarantine (MIQ). One facility reported that they were supporting three nurses through the visa process and before they even commenced employment, they were recruited by the SDHB.

During an advertising period 68% of facilities received no applicants. Facilities reported advertising on all the usual recruitment sites. Several facilities reported supporting travel, visa, accommodation, relocation (nationally) and paying for MIQ to make the roles more attractive. In return some facilities are bonding for between 6-18 months

Suggestions for improvement

Suggestions were sought from survey participants on what could be done to improve Registered Nurse recruitment and retention for ARC. Most participants who responded to this question considered that pay parity with DHB nurses would make a significant difference. The other key theme was suggesting more Government support to get Internationally Qualified Nurses into New Zealand, along with increased number of CAP, access to MIQ, funded MIQ, increased promotion of the voluntary bonding systems and support for overseas recruitment.

Discussion

The survey results confirm the magnitude of the recruitment and retention challenges for ARC in the Southern District. For the facilities who responded there is a 50 FTE gap and 59% of facilities do not have the required number of Registered Nurses to deliver safe care without the nurses working extended hours and/or the facility reducing capacity. Without some deliberate action the challenges to provide sustained safe staffing within the sector will continue to deteriorate. Given that ARC is caring for our most vulnerable older people with high health needs this situation is particularly concerning. Under normal circumstances ARC facilities run a staffing model that is predominately Health Care Assistants with a minimal Registered Nurse workforce compared to public hospital-based services.

Southern DHB and HealthCERT have acknowledged that two of our hospital level facilities will have approximately 33% of their shifts without an RN on site over the next month. We have discussed the risk and the mitigations put in place to counter the risk. Downgrading these facilities to Rest Home level until their staffing recovers is not an option as there are no available hospital level beds to accommodate those residents.

The greatest source of recruitment for ARC was recruiting nurses from an existing ARC facility. While this approach immediately solves one facility's problem, it creates another problem elsewhere and does nothing to improve the system. Similarly, SDHB recruited 33 of the 100 nurses who left ARC in the first six months of 2021. SDHB Senior Nurse Leaders have been made aware of the challenges in ARC and steps have been recently put in place to ensure a more considered approach to recruitment. These steps include a recruitment advisor to talk to the ARC facility to negotiate a start date, along with having a more centralised recruitment process (in the process of being implemented) so wider system impacts are more visible. The driver for the movement between ARC providers needs to be better understood.

Next Steps

While the Workforce Survey was being completed, the Aged Residential Care sector has put a call out to Registered Nurses who have not obtained New Zealand Nursing Council Registration who are in our Southern District or out of District who would be prepared to move. The response has been overwhelming with 100 coming forward across our District (30 for Southland and 70 for Dunedin). With a potential Registered Nurse workforce source identified, better understanding of the barriers that exist for this cohort need to be worked through. Support in the form of a Workforce Co-ordinator will be put in place to support this cohort through all the requirements.

The ARC Workforce Steering Group has representative membership from the Ministry of Health Chief Nurses Office. The representative is committed to understanding the barriers and is meeting with Nursing Council to better understand issues from Council. Once the ARC Workforce Steering Group better understands the barriers for potential RN cohort then potential solutions can be developed.

Facilities have been approached to understand how many would be prepared to support the potential RN cohort through offering a position and other types of support that may include, visa support, CAP fee support or accommodation support. There will be a process that will be facilitated by the ARC Workforce Co-ordinator and ARC Sector leaders that matches potential candidates to facilities.

Recommendations

1. **SDHB supports the recruitment of a 1.0 FTE ARC Workforce Co-ordinator for six months to support potential Registered Nurses through the NZ requirements to attain Nursing Council Registration.**

2. **ARC Facilities consider their current vacancies and how they may be able to support a potential Registered Nurse through to registration and a position in their facility**

3. **ARC Workforce Steering Group advocate locally and nationally for interventions that will support potential RN workforce.**

4. **ARC Workforce Steering Group stays informed re the national risk assessment tool that is going to be developed to identify risks when ARCs are understaffed. Interventions need to be developed to support different levels of risk.**

5. **Report to be shared with ARC Sector, SDHB Executive, Ministry of Health, Ministry of Business Innovation and Employment, HealthCERT, HOP Steering Group, NZNO, Chief Nurses Office, Aged Residential Care Nursing Leadership Group and Nursing Council.**

6. **Advocate Nationally for increased numbers into Registered Nurse and Enrolled Nurse programmes.**

7. **Investigate opportunities to improve recruitment and retention through working with the Otago Regional Skills Leadership Group, Ministry of Business Innovation and Employment.**

8. **Advocate Nationally, and with NZNO, for pay parity for Aged Residential Care workers.**

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

EXECUTIVE SUMMARY *Lead Executive: Rory Dowding*

These health services and their associated measures below are monitored by both Ministry of Health (MoH) and SDHB. Performance is shown as red when unfavourable to target. For further comments and activities that are in place to address these issues, see page 2.

Service Measures	Quarter 4 2020-21	Target / Nat Avg	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% Target National Not Published	↑	• WellSouth have notified the DHB that Invercargill Urgent Doctors have agreed to offer zero fees for ≤ 14 year old after hours. This will increase coverage to 100% in Southern DHB.
Percentage of the eligible population who have had a CVD risk Assessment in the last 5 years	75% (Maori) 73% (Total Pop)	90% Target National Not Published	→ →	• 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.	50% (Maori) 57% (Total Pop)	60% Target National Not Published	↑ ↑	• 3% below target • Equity disparity. • See p2 – WellSouth Call Centre. • See p2 – Clinical Risk.

Continued

Service	Quarter 4 2020-21	Target / Nat Avg	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) 80% (Total Pop)	90% Target National Not Published	→ ↑	• 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.	82% (Maori) 85% (Total Pop)	74% (Maori) >90% Target 77% (Total)	↑ ↑	• 19% below target. • See p2 – WellSouth Call Centre. • PHO Position: Maori – 12/35; Total Pop – 13/35.
Percentage of people ≥ 65 having received a flu vaccine	59% (Maori) 65% (Total)	60% (Maori) >75% Target 68% (Total)	Q1 2020-21 Data Only Q1 2020-21 Data Only	• 10% below target. • Equity disparity. • See p2 – WellSouth Call Centre. • DHB Position: Maori – 14/20; Total Pop – 18/20.
Ambulatory sensitive hospitalisations (ASH) – Adults 45 to 64	4,492/100K (Maori) 2,850/100K (Total Pop)	6,777 (Maori) No Target 3,622 (Total)	→ →	• DHB Position: Maori – 6/20; Total – 2/20. • 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%	80% (Maori) 92% (Total Pop)	85% (Maori) 90% Target 94% (Total)	→ →	• Equity disparity that has significant flow-on effects (as above). • Third lowest performing rate nationally for Maori and second lowest for Total Population (noting impacy of Uni

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

SP&C Services – Primary Care report Aug 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.
- Follow-ups for unredeemed GP consultation vouchers.
- 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.

In the most recent period the WellSouth Call Centre has been heavily involved in the COVID resurgence work and COVID Vaccination support.

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

- SDHB and WellSouth have approved a brief business case for a cloud-based platform called Emergency Q, which provides real time reporting on wait times for Emergency Departments (ED), Urgent and Primary Care Facilities. This platform allows ED staff to digitally transfer appropriately clinically triaged patients to another service (e.g. urgent care facility or general practice) using a voucher for access to subsidised care. The intention of this service is to reduce the number patients receiving treatment in the ED by creating an opportunity to triage people to primary care providers. Rollout is planned for Dunedin and Invercargill, with Emergency Q being implemented in Dunedin before Invercargill first. The DHB are working with WellSouth to ensure that there is sufficient Primary Care supply in Invercargill to allow for success.
- Invercargill After Hours Primary Care – Access challenges increase presentations to Southland Hospital Emergency Department (ED). To address, WellSouth is partnering with Oraka Aparima Rūnaka, Hokonui Rūnanga, Waihōpai Rūnaka and Awarua Rūnaka in its development of a new primary care service. These partnerships will provide an equity-based collaborative approach to integrated service plans and models of care that are whānau-centred.
- 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.

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

Service Delivery	Quarter 4	Quarter 3	Quarter 2	Quarter 1
% of Pop enrolled w/ GP	91.94%	91.76%	91.60%	91.34%
% of VLCA Practices	6%	6%	6%	6.2%
% of Practices in CSC Prog.	93%	93%	93%	92.6%

Refugee Primary Health Services

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

- WellSouth Former Refugee Mental Health and Wellbeing Conference, May 2021:
- "Working Together, Learning from Each Other" – 80 attendees from multiple sectors within Southern and other districts.
- SDHB, WellSouth and Ministry of Ethnic Affairs organised community meeting with Colombian former refugees in Invercargill, June 2021.

FOR INFORMATION

Item: Māori Health Update

Proposed by: Gilbert Taurua, Chief Māori Health Strategy & Improvement Officer (CMHSIO)

Rory Dowding, Acting Executive Director Strategy Primary & Community

Meeting of: Community and Public Health Advisory Committee, 4 October 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, including operational performance and key strategic deliverables as per the work programme of the Māori Health Directorate and an update on Māori primary care enrolment.

Specific Implication for Consideration

Financial

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

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

- This report outlines some of the key activity underway in Māori Health Directorate and within Strategy Primary & Community

Other

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

Māori Enrolment update

The below table shows Māori enrolment and is based of monthly files from the National Enrolment Service (register of national enrolment and health idendity/demographic data).

We are seeing a continued increase in Māori enrolment numbers, with significant growth (6.7%) in the Queenstown Lakes TLA over the most recent six month period.

	Feb-21	Apr-21	Jun-21	Aug-21
Central Otago	1,877	1,893	1,881	1,918
Clutha	1,838	1,856	1,863	1,855
Dunedin	9,495	9,530	9,597	9,611
Gore	1,821	1,843	1,861	1,854
Invercargill	9,291	9,356	9,353	9,363
Queenstown Lakes	1,932	1,969	2,019	2,062
Southland	1,760	1,785	1,817	1,835
Waitaki	1,924	1,930	1,917	1,941
Total	**29,938**	**30,162**	**30,308**	**30,439**

Source: NES file from the MoH

Ethnicity - Maori (21111)

Files used are dated 1st of the month following except February which is dated February

Te Kaika Wellbeing Hub

In December 2020, Ōtākou Health Limited – Te Kāika (OHL) provided the successful response to the SDHB initiated RFP for a community wellness hub in Dunedin. OHL is the runaka owned entity that was founded to develop Te Kāika (the village), an integrated site of health, social and educational services in Dunedin for Māori, Pasifika and low-income Whānau.

The property co-design phase is currently a key project focus to ensure that the project is completed at the specified end date. A change of architect and additional resource consent requirements has occurred recently and this has enabled a robust schedule of accommodation to be created. The SDHB property team, alongside the MSD and Te Kāika teams have indicated key clinical and operational requirements to ensure this process is successful. It is anticipated that a frozen floor plan is provided to the Project Board by the end of October 2021. A start date for the build has not yet been identified.

Initial clinical co-design meetings have been held with key SDHB teams (Mental Health, Paediatrics and Outpatients), MSD and Te Kāika to support the property design and ensure the building form fits the function of the hub. A clinical co-design programme/ schedule is currently being developed by the Lead Project Manager (MSD) and project managers from each organisation. This will also include a collaborative communication plan for the project.

COVID-19 Vaccination Programme

Significant ongoing effort is going into the COVID-19 Vaccination implementation equity approach and SDHB is performing favourable against other DHB's and national performance. Based on available information released by the MOH, the total Māori vaccination rate is lower than "European or Other" despite vaccination rates for Māori for all the age cohorts being higher. This may seem counter intuitive but reflects different population compositions. It also highlights the challenges of initially working to a national age based sequencing framework.

As at 23:59 Sun 12 Sep 2021		Māori					
		65+	50-64	35-49	20-34	12-19	All Ages (12+)
National	Population	49,290	107,835	124,826	176,459	112,642	**571,052**
	Dose 1 #	42,290	74,086	58,628	54,494	36,376	**265,874**
	Dose 2 #	35,962	46,451	23,347	18,266	3,989	**128,015**
	Dose 1 %	86	69	47	31	32	**47**
	Dose 2 %	73	43	19	10	4	**22**
	Dose 1 RR	0.9	0.9	0.7	0.6	0.6	**0.7**
	Dose 2 RR	1.0	1.0	0.9	0.7	0.8	**0.6**
Southern	Population	1,954	4,175	5,046	7,540	4,931	**23,646**
	Dose 1 #	1,760	3,146	2,877	3,381	2,167	**13,331**
	Dose 2 #	1,469	1,963	1,424	1,284	343	**6,483**
	Dose 1 %	90	75	57	45	44	**56**
	Dose 2 %	75	47	28	17	7	**27**
	Dose 1 RR	1.0	0.9	0.8	0.7	0.7	**0.8**
	Dose 2 RR	0.9	1.0	1.1	0.9	1.1	**0.7**

Current activity includes:

- Commencing a workplace vaccination programme – multiple workplaces have responded to the EOI and we have 65 programme prioritised by equity/rurality and access.
- Outreach programmes for vulnerable groups targeting areas based on utilisation analysis to identify unvaccinated populations groups.
- WellSouth call centre to contact Māori and Pacifica/practices to invite for a vaccine (staffed by Māori and Pacifica) and to invite them to enrol.
- Interrogation of the vaccine utilisation data has identified approximately 1600 unenrolled Māori and this team will contact them and offer them an enrollment in a practice (if possible) and develop a targeted marketing campagin.
- Our Māori providers have commenced discussions with schools and their boards which have high numbers of Māori and Pacifika students.

Review of Māori Health Provider Contracts

The Māori Health Directorate has engaged South Island Alliance Project Office to review our Kaupapa Māori provider contracts. The manager undertaking the analysis has extensive Māori health experience and current contract knowledge responsible for the Canterbury DHB Māori health contracts. The contracts being reviewed are our Mauri Ora, Tamariki Ora, mental health and nurse practitioner contracts. An initial desktop review of all our provider contracts was completed. An initial report went to the ELT meeting in August and will go to Iwi Governance Committee with a view to a discussion with the Māori health providers on implementing the report recommendations.

Pou Whakatere Māori Public Health Role

The Southern DHB Public Health service has made an appointment to the role of Public Health Pou Whakatere that will work with the Service Manager, CMHSIO and leadership team to drive strategies and initiatives to improve population health outcomes for Southern. This role was created in a 2020 restructure of the Public Health team and but

has taken some time to recruit a suitable candidate. The role has an emphasis on improving health equity and outcomes for Māori and will provide strategic oversight to advances public health action that improves the health and wellbeing of Māori and their whānau across the Southern Health System. The role aims to utilise Te Pae Mahutonga, the principles of the Ottawa Charter, health in all policies frameworks, community development and collaborative partnership approaches. The role will maintain a strategic relationship with the Māori Health Directorate and clearly will need to develop and maintain strategic relationships with Te Runanga o Ngai Tahu, its constituent papatipu Runaka, the Iwi Governance Committee, Māori Health Providers, Aukaha, Te Ao Mārama all of which will support health in all policies and collaborative approaches to address the social, economic and environmental determinants of health. The role will support Public Health with their recruitment strategy and workforce development plan to actively improve cultural safety practices among Public Health and increase Māori workforce within this directorate.

FOR INFORMATION

Item:	Mental Health Addiction and Intellectual Disability Directorate Wait Times
Proposed by:	Gilbert Taurua, Chief Maori Health Strategy and Improvement Officer
Meeting of:	Community Public Health Advisory Committee 4 October 2021

Recommendation

That CPHAC notes this paper and provides direction to management.

Purpose

1. To provide an overview of MHAID Wait Times as discussed at the August 2021 CPHAC meeting in Invercargill.

Specific Implications For Consideration

2. Financial

- There are financial implications associated with any proposed changes associated with MHAID wait times.

3. Workforce

- There are workforce consideration associated with the increase in service coverage and/or MHAID wait times.

4. Equity

- Maori experience higher levels of mental illness and addiction than non-Maori.

5. Other

- Services for Children and Young People are experiencing increased referrals which staff advise are more complex than they were pre covid.
- Addiction Services, particularly the Opioid Substitution Programmes are under pressure, particularly in Dunedin and Queenstown.

Background

6. MHAID services across New Zealand are reporting increased demand and this is reflected in the Southern area. Adult MHAID team referrals are remaining stable, we suspect are due to the increased interventions provided in the Primary setting. This is also the case to a lesser extent for Children and Young People. However, Clinical staff advise the referrals to Addiction Service from the Primary (Mental Health and Addiction Brief Intervention and Access and Choice) and NGO sectors have increased.

Discussion

7. Overall Southern DHB MHAID see 74.5% of people referred within three weeks of referral with an average wait time of 17.1 days.

8. Child and Youth Services are experiencing the longest wait time at 28.4 days, followed by Specialist Addiction Services at 20 days. Opioid Substation Programmes have the longest wait time at 45.4 days with people in Dunedin and Queenstown waiting the longest.

Next Steps & Actions

Table this paper to the next CPHAC meeting in October 2021.

Appendices

Appendix 1	Mental Health Wait Times – National and DHB
Appendix 2	Opioid Substitution Programme

Appendix one

Mental Health Wait Times - National / DHB

All teams and team types
2 years combined - March 2019 to February 2021
Data source: Ministry of Health

Measure 1 : Average days wait

DHB	Average wait (days)	Rank
Nationally / All DHBs	18.3	
Hawkes Bay DHB	10.8	1st
MidCentral DHB	13.3	2nd
Bay of Plenty DHB	15.0	3rd
Waitemata DHB	15.0	4th
South Canterbury DHB	15.4	5th
Whanganui DHB	15.8	6th
Counties Manukau DHB	16.0	7th
Northland DHB	16.3	8th
Southern DHB	17.1	9th
Auckland DHB	17.4	10th
Taranaki DHB	17.6	11th
Tairawhiti DHB	18.1	12th
West Coast DHB	19.3	13th
Hutt Valley DHB	19.9	14th
Waikato DHB	20.1	15th
Wairarapa DHB	23.0	16th
Capital and Coast DHB	24.4	17th
Canterbury DHB	26.5	18th
Lakes DHB	27.7	19th
Nelson Marlborough DHB	32.0	20th

Measure 2 : Percentage seen within 3 weeks

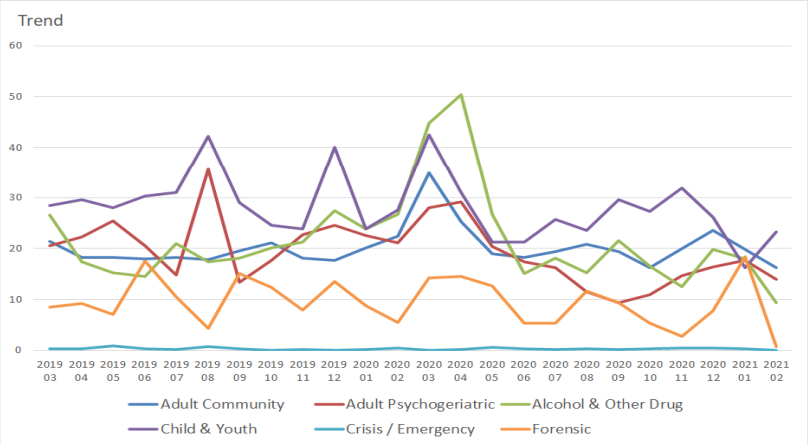
DHB	% seen within 3 weeks	Rank
Nationally / All DHBs	74.7%	
Hawkes Bay DHB	85.6%	1st
South Canterbury DHB	81.1%	2nd
MidCentral DHB	80.7%	3rd
Waitemata DHB	79.0%	4th
Counties Manukau DHB	78.6%	5th
Auckland DHB	78.1%	6th
Whanganui DHB	77.5%	7th
Bay of Plenty DHB	76.6%	8th
Taranaki DHB	75.7%	9th
Southern DHB	74.5%	10th
West Coast DHB	74.3%	11th
Northland DHB	74.1%	12th
Waikato DHB	74.0%	13th
Tairawhiti DHB	71.2%	14th
Hutt Valley DHB	70.0%	15th
Wairarapa DHB	68.9%	16th
Canterbury DHB	68.9%	17th
Capital and Coast DHB	67.1%	18th
Lakes DHB	57.3%	19th
Nelson Marlborough DHB	52.5%	20th

Mental Health Wait Times - Local

Community Treating and Crisis Teams
2 years combined - March 2019 to February 2021
Data source: Southern DHB

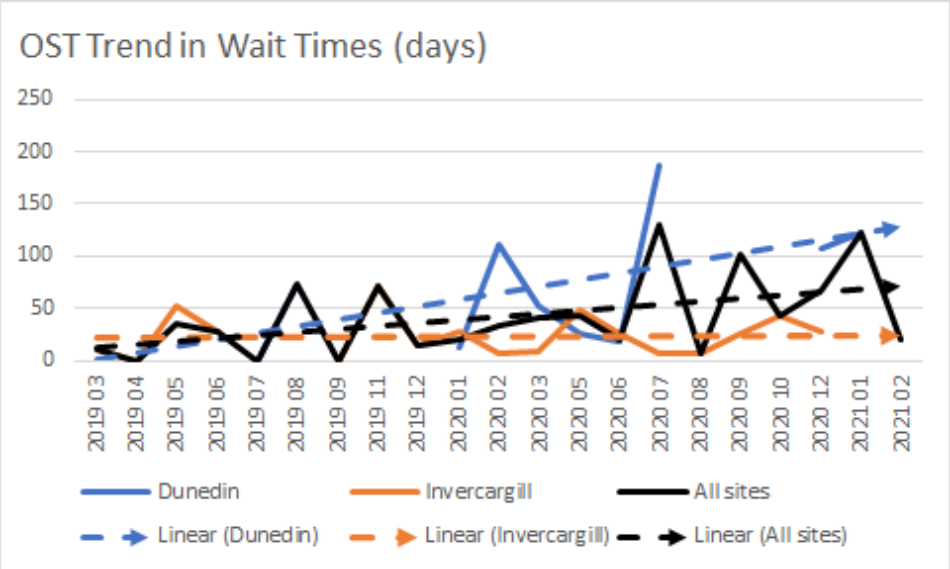
Measure : Average days wait

Group	Average wait (days)
Crisis / Emergency	0.3
Forensic	9.6
Adult Psychogeriatric	18.9
Adult Community	19.9
Alcohol & Other Drug	20.0
Child & Youth	28.4



Appendix two

Opiod Substitution Treatment Referral site	Nr referrals received (2 year period)	Average days wait
Queenstown	2	207.5
Invercargill	31	25.2
Dunedin	22	59.1
Grand Total	**55**	**45.4**



Specialist Addiction Services (SAS) –

SAS (Dunedin and Queenstown) have experienced a period of sustained high workload demand.

Opioid Substitution Treatment (OST) numbers remain well above contracted volumes and the team is actively working to reduce numbers, although this is creating a backlog of referrals for the programme.

There is a plan in place in the Dunedin based service which includes Queenstown to reduce the numbers and the wait time, but it will take time to have a significant impact. Recent resignations and retirements have exacerbated workload pressure in Dunedin. The vacancies have been advertised and Directorate and SAS leadership meetings are occurring to enhance the robustness of the service moving forward.

The current OST caseloads are:

	Specialist Services Actual Caseload (as at end of May 2021	General Practice Actual Caseload (as at end of May 2021
Otago	*385*	35
Southland	*108*	5
Total	*493*	40

FOR INFORMATION

Item: Housing update

Proposed by: Lynette Finnie, Service Manager Public Health

Meeting of: 4 October 2021

Recommendation

That the CPHAC notes the attached paper on housing.

Purpose

1. To provide an update to the Community and Public Health Advisory Committee on the work being undertaken by the Public Health Service in relation to housing.

Specific Implications For Consideration

2. Financial
    - nil
3. Workforce
    - nil
4. Equity
    - Housing is a key determinant of health and is central to the health and wellbeing of whānau.
5. Other
    - nil

Background

6. This report summarises the range of work that is being undertaken in the Public Health Service in relation to housing.

Discussion

7. Housing is a key factor that influences health and wellbeing.

8. Public health has the ability to influence healthy housing via a broad range of approaches. This includes research and advocacy, as well as projects like Kia Haumaru Te Kāika. Our work has looked at the homes themselves, how they impact

the environment and their occupants, and the neighbourhoods and communities in which they are situated.

Next Steps & Actions

9. In the future we will be focusing on neighbourhoods as a setting and the use of spatial analysis will provide a more comprehensive picture of risk and disadvantage. It will also provide a tool that can be used in consultation and planning activities.

10. From July 2022, the Government will roll-out the Healthy Homes Initiative (HHI) nationwide to reduce avoidable ill health due to housing-related conditions. HHI providers identify eligible whānau, undertake a housing/whānau assessment and work to facilitate access to a range of interventions, to help make their homes healthier. The learnings from Kia Haumaru Te Kāika will be beneficial in supporting the establishment of HHI in Southern.

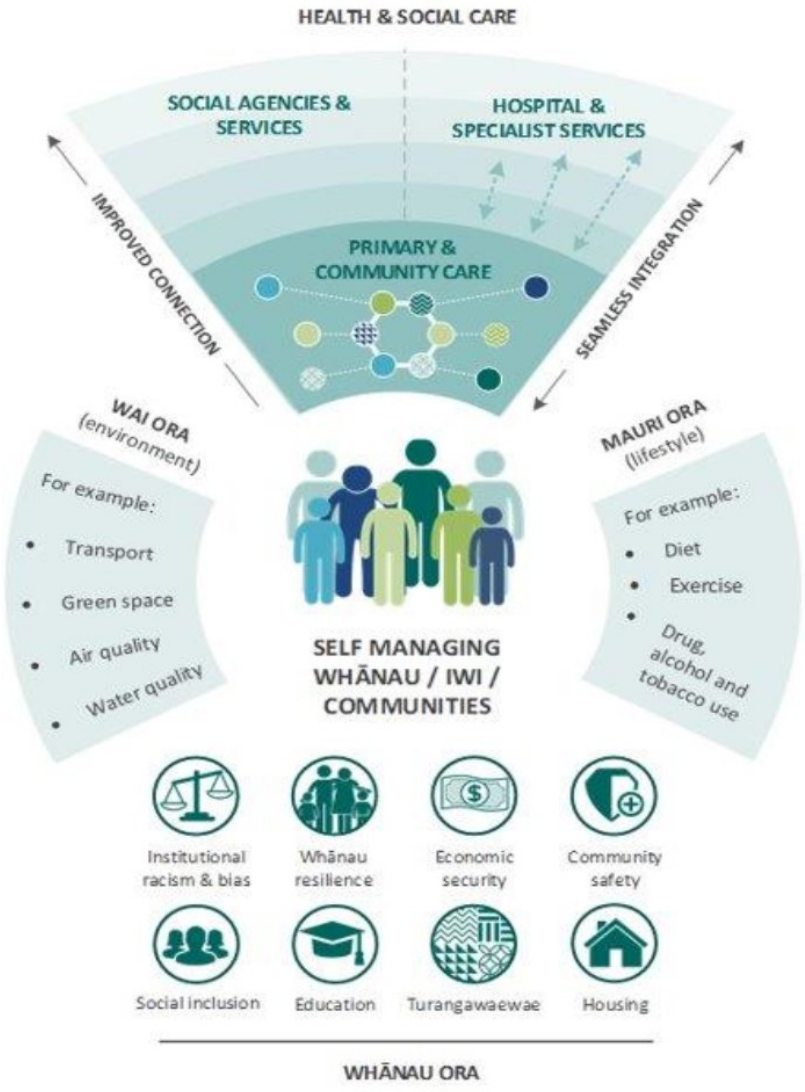
Housing- A Wide Scope of Work

Why housing?

Improved housing conditions can reduce hospitalisations, save lives, reduce poverty, increase quality of life, reduce inequality, and help mitigate climate change. Public Health South takes a broad view of housing. We look beyond individual dwellings to neighbourhoods and communities as these also influence our health and behaviour. Housing is a fundamental human right and impacts of inadequate housing will impact those who are more disadvantaged.

13

This is also recognised in the health reforms coming into effect in 2022 where housing is a key factor that influences health of whānau/iwi/communities. Locality plans for communities will need to consider these broader socio and economic factors.



This report summarises our interventions that try to acknowledge our obligations under the Te Tiriti o Waitangi and address housing needs of those who are less well serviced. We conclude with a brief overview of the work we'd like to do in the future.

Pēhea tou kāinga? (How's your home?)

Central Otago and Queenstown Lakes

Early in 2019, growing anecdotal evidence of housing-related hardship in Central Otago and Queenstown Lakes prompted Public Health South to undertake qualitative research to gain a deep understanding of the situation. We interviewed 57 key informants from non-government organisations, the Ministry of Social Development, Oranga Tamariki, Central Otago (CODC) and

Queenstown Lakes (QLDC) district councils, Southern DHB, Police, schools, early childcare centres, and local industry. To gather housing information from the broader community, we also conducted a survey of 358 residents via convenience sampling. Our work captured the voices of those who are often not heard and informed a set of recommendations aimed at helping community organisations address the identified housing issues. The final report for Central Otago was used by the community to secure funding for a local Housing Coordinator (an identified need). After receiving the report and conducting their own analyses, CODC agreed that they had a mandate to improve local housing conditions and supply. QLDC used our Queenstown Lakes report to inform their draft Queenstown Lakes Homes Strategy and Action Plan.

Kia Haumaru Te Kāika (A safe and secure home)

Dunedin and Invercargill

Too many children are hospitalised due to housing-related conditions and discharged back to the environment that made them sick. Between 2013 and 2017, 3,158 unique children were hospitalised (total of 3,906 hospitalisations) across SDHB with a housing-related condition (for example, chronic bronchiolitis due to dampness and mould). Eighteen per cent were re-hospitalised. Public Health South, in partnership with Habitat for Humanity and Aukaha (Dunedin) and Awarua Whānau Services and Awarua Synergy (Invercargill), are delivering Kia Haumaru Te Kāika, an intervention aiming to reduce re-hospitalisations due to poor housing. Families of children aged 0–14 years hospitalised with a possible housing-related condition are offered a housing assessment by a trained Home Performance Advisor. Together they develop an action plan for home improvement via the provision of minor capital interventions and education for behaviour change. This exciting intervention has just launched, with three Dunedin families receiving home assessments in July 2021. Kia Haumaru Te Kāika is funded by the Healthcare Otago Charitable Trust and the Southland Warm Homes Trust. There is sufficient funding to work with 50 families in Dunedin and 20 in Invercargill.

Wood smoke pollution and respiratory health study

Central Otago

Wood smoke exposure has known adverse respiratory health effects. Woodburners are commonly used for domestic heating in New Zealand, impacting air quality in some areas. Public Health South has conducted a study to investigate whether wood smoke exposure at levels encountered in a small township has health effects. We analysed daily wood smoke concentrations and General Practitioner visits for acute respiratory tract infections over five consecutive winters (May–August 2014–2018) to identify risks associated with exposure in one Otago town. Increased wood smoke pollution was associated with increased risk of acute respiratory tract infection, particularly for females and Māori of both sexes. We also found that with each additional wood-burning household per hectare, the risk for all residents increased by 17%. For the sake of our health and the environment, we need to move away from burning wood for domestic heating. However, we cannot rapidly do so until our houses have considerably improved thermal efficiency. Reducing wood smoke must not come at the cost of warm homes. The results of this study will be used to advocate for subsided insulation retrofits and other policy options. Insulated houses need less energy to heat and have been associated with warmer indoor air temperatures and reduced hospital admissions.

Exposure to indoor air pollution across socioeconomic groups study

Central Otago & Southland

Public Health South knows from our previous work in Central Otago that wood smoke exposure has health risks. Scientists at the National Institute of Water and Atmospheric Research Ltd (NIWA) identified that the amount of outdoor wood smoke emitted from domestic heating that gets inside differs between homes. Variation in indoor air quality is especially problematic if a greater burden falls on populations of lower socioeconomic status (SES). Disadvantaged individuals are at higher risk of adverse health impacts from exposure due to underlying health inequities. They may also be exposed to higher levels of outdoor air pollution due to where they live. Disparities in air pollution exposure by SES have been observed in other developed countries. We are partnering with NIWA to identify whether indoor air quality differs by SES in Cromwell and Invercargill. Approximately 85 households in each of Cromwell and Invercargill (170 households in total) are expected to have their indoor air quality monitored for three weeks and complete a survey about their homes and SES. Our findings will be used to assess potential health and equity impacts arising from air quality policy changes or housing interventions. Findings may also be used to inform smoking cessation interventions. Data collection began in May 2021 and is scheduled to run through to late September 2021.

General advocacy work

District wide

Southern District Health Board, via Public Health South, regularly submit on resource consent applications, and council and government plans and policies that affect homes, neighbourhoods, and communities. The Resource Management Act 1991 (currently being repealed to be replaced by the Strategic Planning Act, Natural and Built Environments Act and Climate Change Adaption Act) provides the over-arching governance for housing related matters. From 2019 to the present, we have made 16 submissions on proposed plans or activities that affect housing.

Public Health South also have facilitated air quality hui once a year with various stakeholders across the SDHB catchment, including Regional Councils, NIWA, Iwi, Māori Health and Social Services. The purpose is to provide a collective forum to share research, learnings, policy and plans on improving air quality. The next hui is planned for September 2021 at Te Whanau a Hokonui Marae near Gore.

Cromwell case study

In 2019, a private development firm lodged a district plan change application for a 900-unit residential development in Cromwell, located next to a Speedway arena and a motorsport entertainment park. Both activities are sources of significant, but sporadic noise. The proposed development was also located on the boundary of a large fruit orchard, and was some distance from the Cromwell town centre, accessible easily only via the state highway. With the Cromwell population projected to more than double in the next 15 years, the CODC began developing a spatial plan for Cromwell at the same time as the development application.

There were many submissions on the proposed residential development, with 90% in opposition. Public Health South opposed the district plan change and instead supported the proposed spatial plan for Cromwell. A specialist planning consultant was engaged to help prepare our submissions on the proposed residential development. Specifically, we supported Cromwell expanding from the centre out, with existing active transport networks preserved and extended. We provided multiple expert witnesses for the application hearing. We also used Manatū Hauora analysis and advice services to gather data for noise and air quality in the area to support our case.

The application for the district plan change was declined and Cromwell was able to avoid a large subdivision in a noisy environment with the potential for spray drift.

Challenges and constraints

One key challenge in the housing space relates to the multitude of stakeholders and the complexity of the overall situation. Actual responsibility for housing quality, supply, delivery, and policy does not lie with Public Health South. We do our best to influence decision-makers, but sometimes our priorities do not align. It can be difficult to convince those with responsibility for housing to take responsibility for housing. For example, it was not until housing issues were highlighted in the Pēhea tou kāinga? reports that CODC recognised that it should expand its leadership in a broader approach to housing. In another example, some time ago QLDC placed responsibility for sewage and water infrastructure on developers. It was not until a private sewerage scheme in Cardrona failed leading to a community outbreak of Norovirus that Council began exercising its obligation to provide essential sewerage and drinking water infrastructure to new subdivisions.

Public Health South are currently actively building relationships with Local Government with a view to be able to influence their policy upstream and before it is in the public arena. Longer term we are working to create a legal mandate to do this through our submission on the current exposure draft of the Natural and Built Environment Act. Given the fast-track Special Housing process that was designed to circumvent public participation of the consent process, Public Health South were unable to provide advice regarding the provision of green spaces and active transport (for example) in the Shotover Country, Arthurs Point, Longview and other Special Housing Areas. Consequently, these subdivisions went ahead with less-than-ideal provisions for health and wellbeing. Some lack green spaces and are inaccessible to public transport due to design constraints.

Future work

Public Health South aims to take a broad view of housing. Our work has looked at the homes themselves, how they impact the environment and their occupants, and the neighbourhoods and communities in which they are situated. Our next phase involves seeing neighbourhoods as a setting in which health behaviours occur. Setting-based approaches to health promotion involve holistic and multidisciplinary methods which integrate action across risk factors.

This work will use some of our spatial analysis capabilities to target interventions that reduce inequity. We intend to focus on areas with multiple social and physical risk factors to inform the development of integrated settings-based initiatives. The spatial analysis will provide a more comprehensive picture of risk and disadvantage than what has been previously available and provide a tool that can be used in consultation and planning activities.

From July 2022, the Government will roll-out the Healthy Homes Initiative (HHI) nationwide to reduce avoidable ill health due to housing-related conditions. HHI providers identify eligible whānau, undertake a housing/whānau assessment and work to facilitate access to a range of interventions, to help make their homes healthier. The learnings from Kia Haumaru Te Kāika will be beneficial in supporting the establishment of HHI in Southern.

FOR INFORMATION

Item: Public Health - Health Promotion Update

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

Meeting of: 4 October 2021

Recommendation

That the Community & Public Health Advisory Committee notes the contents of this update paper.

Purpose

To provide an update of Health Promotion activity to the Community & Public Health Advisory Committee

Specific Implications For Consideration

Financial

- Nil

Quality and Patient Safety

- Nil

Operational Efficiency

- Nil

Workforce

- Nil

Equity

- Nil

Other

- Nil

Background

1. Dr Rob Beaglehole presented to the August CPHAC committee in his leadership capacity in the National Public Health Advocacy Team, which complements the work of the Health Promotion Agency and activity completed by DHB's at a local level.

2. Regular updates of the Public Health advocacy / Health Promotion work was requested by the committee.

Discussion

3. DHB Chairs and Chief Executives have adopted a position statement on the Sale and Supply of Alcohol Act. A copy of the position statement is included as Appendix 1. An update regarding District Health Board actions to support the Smokefree Aotearoa 2025 Goal has also been attached as Appendix 2.

4. SDHB is progressing the development of a water, unflavoured milk, tea and coffee only policy, with a policy due at the December CPHAC meeting. Some initial engagement with impacted retailers and contractors has commenced.

5. At a local level the Public Health team continue Health Promotion activity:

Smokefree cars

From 28 November it will be illegal to smoke and vape in a vehicle that has children and young people (under 18 years old) in it, whether the vehicle is moving or not. The aim of this legislation is to limit children's exposure to second-hand smoke.

Smoking (or vaping) in a vehicle carrying a child occupant may result in the individual being liable for a fine of $50, or a court can impose a fine of up to $100. Public Health staff have been working with local networks to support this work in our region. Joint work is occurring around the following areas:

- Sharing information about the impending law change by print/social/radio/online/podcasts media.
- Communication to support the national campaign "Drive smokefree for Tamariki" and engaging with local Runaka to help distribute these messages.
- Using local events to connect with communities about the law change.
- Being present at car seat checks with other providers and letting parents know about the upcoming changes.
- Engaging with local schools, early childhood education centres, Kura, and Kohanga – as well as providing online templates and ideas for curriculum activities.
- Providing information to pharmacies, GP's and businesses in the district (posters, cards emails.)

Vaping

On 11 August significant changes come into force in the Smokefree Legislation around vaping.

New regulations prohibit general retailers from selling vaping or smokeless tobacco products that contain flavours other than tobacco, mint and menthol. Transitional and approved Specialist Vape Retailers may continue to sell products of any flavour that have not been prohibited (no flavours have been prohibited at this stage). Legislation covering signage will also be in place this month.

Regulatory staff have planned education visits with dairies, petrol stations supermarkets etc to check if they are selling any vape flavours and provide education about the Ministry of health guidelines. This is planned across all areas for both regulated retailers and specialist retailers. This will be followed up with vaping/smokefree control purchase operations (CPOs) that are planned to commence from the upcoming school holidays. CPOs generally cover about 15 retailers with a risk lens used to determine which retailers are selected for the CPO.

Water fluoridation bill update

A Bill that was intended to mandate the fluoridation of public water supplies was introduced to the House in November 2016. It was a Bill that would amend the Health Act 1956 to mandate District Health Boards to require Local Authorities to fluoridate their water supplies as directed. A supplementary order paper that sought to move the authority to require fluoridation of water from District Health Boards to the Director-General of Health led to a second reading that was held in June 2021. Southern DHB provided a submission that supported this stance. The matter is now before a Committee of the whole house. The timeline for scheduling the whole of house reading is unclear, and except that it is on the current Parliamentary calendar.

Next Steps & Actions

The Public Health South continue their Public Health Promotion work at a local level, working in conjunction with Regional and National groups where applicable.

Appendices

Appendix 1 DHB Position Statement on the Sale and Supply of Alcohol Act

Appendix 2 DHBs and the Smokefree Aotearoa 2025 Goal_12 August Final

IN-CONFIDENCE

All District Health Boards

DHB Position Statement on the Sale and Supply of Alcohol Act

To:	DHB Chief Executives and Chairs
From:	Nick Chamberlain, CE NDHB and Lead CE for Public Health
Subject:	DHB Position Statement on the Sale and Supply of Alcohol Act
Date:	12 August 2021

Decision ☒	**Discussion** ☐		**Information** ☐	
Seeking Funding	**Yes**	☐	**No**	☐
Funding Implications	**Yes**	☐	**No**	☐

Recommendation

It is recommended that DHB Chief Executives and Chairs:

- **Note** that a paper summarising alcohol related harm and considering gaps and opportunities to reduce this was presented to DHB CEs and Chairs in November 2020.
- **Note** that at that meeting DHB CEs and Chairs agreed to advocate for a review of the Sale and Supply of Alcohol Act 2012 (the Act) as one of 3 priority areas of action in relation to alcohol.
- **Note** that the Minister of Justice and the Minister of Health have expressed a willingness to review the Act and that this is likely to be a mid-range review focusing on amending the current Act rather than undertaking a full review.
- **Note** that unless we can create a sense of urgency, the review is likely to occur late in this electoral cycle.
- **Agree** to the Position Statement on the Sale and Supply of Alcohol Act 2012 (Appendix 1) asking for a review of the Act
- **Agree** that the top priorities for changes to the Act should be:

1. ***Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:***
   - Embedding Te Tiriti O Waitangi principles in the object of the Act
   - Ensuring the health system supports, invests in and enables:
     - Māori leadership and decision-making
     - Whanau-centred service provision and kaupapa Māori models of care
     - Workforce development, provider development and equitable funding
   - Including Māori as Te Tiriti o Waitangi partners who must be represented on all decision making panels and heard as public objectors at any hearings

- Criteria for oppositional matters should include Te Tiriti o Waitangi under s 105, 131, and 142 of the Act.

2. ***Reduce the harm from high alcohol availability by:***
   - Reducing the default maximum national trading hours, especially the closing hour (e.g. to 9pm for off licences and 2am for on licences and club licences).
   - Abolish the Local Alcohol Policy (LAP) appeals process and mandate LAP development by Territorial Authorities
   - Enabling licence numbers to be lowered in vulnerable or high deprivation locations
   - Enabling community participation in licensing decisions by amending the District Licensing Committee structure and hearing process; and
     - Restricting online sale of alcohol and aligning the restrictions across all types of online alcohol retailers

3. ***Reduce the harm from alcohol advertising and sponsorship by:***
   - Strengthening section 237 of the Act (irresponsible promotion of alcohol) to implement comprehensive restrictions to alcohol advertising including sponsorship of sports and events.

- **Agree** to advocate for a full review of the Act by an independent external agency such as the Law Commission as a subsequent stage following finalisation of the immediate changes to the act.
- **Agree** to also advocate to implement the Law Commission Recommendations on alcohol pricing at the earliest opportunity, including minimum unit pricing (MUP) and increasing alcohol excise tax, as part of broader changes to address alcohol related harm.
- **Request** that the Director General of Health provides advice to the Minister of Health and Minister of Justice to support a review of the Act.
- **Engage** in an advocacy process where all DHBs collaborate for collective action on alcohol harm reduction.

Summary

The Sale and Supply of Alcohol Act 2012 is widely acknowledged to have failed in its objective to minimise alcohol related harm. In a recent media statement Minister of Justice Kris Faafoi has expressed a willingness to review the Act. It is understood that this is likely to be a mid-range review focusing on amending the current Act rather than a full review of the Act.

This paper follows an earlier paper to DHB Chairs and CEs summarising the gaps and opportunities for DHBs to address alcohol related harm. The paper briefly summarises the Act, outlines some of the problems and deficiencies in the current Act, and proposes recommended changes to the Act in order to better address alcohol related harm. A position statement is proposed for DHB Chairs and CEs that calls for an urgent review to the Act, outlines a number of specific changes and also calls for a number of broader changes to address alcohol related harm and its inequities.

A wide range of people have contributed to the development of this paper including the prioritisation of recommended changes to the act. The paper has been widely circulated for input including to: the National Public Health Advocacy Steering Group, Te Hiringa Hauora (Health Promotion Agency), Public Health Clinical Network, Te Tumu Whakarae, Alcohol Healthwatch, Health Coalition Aotearoa and the Ministry of Health.

Background

Alcohol Related Harm

Alcohol is the most widely used drug in New Zealand and is a group 1 carcinogen. Every year more than 800 deaths are caused and more than 60,000 disability adjusted life years are estimated to be lost due to alcohol consumption. The consequences of hazardous alcohol consumption are borne by whānau, families and friends of those involved and exacerbates family harm, sexual assault, and is a major risk factor for suicide.

One in five New Zealanders aged 15 years and over are hazardous drinkers. Among the drinking population, one-quarter (25%) were found to drink hazardously. In 2019/20, this equated to 838,000 adults aged 15 years and over. Significant inequities exist and persist in drinking patterns. In 2019/20, Māori men and women were 1.6 times and 2.2 times more likely to drink hazardously when compared to non-Māori men and women, respectively.

Harmful alcohol use is a significant burden to society – its misuse is estimated to cost the government $7.8 billion per year.[1] By comparison, alcohol excise revenue was $1.064 billion in 2020, Alcohol also puts considerable pressure on the health sector, particularly emergency services, as well as on our police and justice systems.

Law Commission Report: Alcohol in our Lives: Curbing the Harm

In 2008, the Law Commission undertook a broad and comprehensive review of the role of alcohol in New Zealand led by Sir Geoffrey Palmer. This review was undertaken after nearly twenty years of liquor law liberalisation that occurred as a result of a review of liquor laws in the mid-1980s. The report to Parliament, 'Alcohol in our Lives: Curbing the Harm'[2], recommended significant changes to the sale and supply of liquor including reducing alcohol affordability and availability and restricting advertising and sponsorship.

Key policy recommendations included:

1. the introduction of a new Alcohol Harm Reduction Act;
2. raising the price of alcohol by an average of 10% through excise tax increases;
3. regulating irresponsible promotions that encourage the excessive consumption, or purchase, of alcohol;
4. returning the minimum purchase age for alcohol to 20 years;
5. strengthening the rights and responsibilities of parents for the supply of alcohol to minors;
6. introducing national maximum closing hours for both on and off-licences; (4am and 10pm respectively)
7. increasing the ability of local people to influence how and where alcohol is sold in their communities;
8. increasing personal responsibility for unacceptable or harmful behaviours induced by alcohol, including a civil cost-recovery regime for those picked up by the police when grossly intoxicated;
9. moving over time (5 years) to implement comprehensive restrictions to alcohol advertising and sponsorship.

Three Acts were agreed by parliament in response to the Law Commission's recommendations including:

[1] Nana, G. (2018). Alcohol costs - but, who pays? Presented at the Alcohol Action NZ Conference, Wellington, New Zealand.
[2] New Zealand Law Commission. Alcohol In Our Lives: Curbing the Harm, 2010.

1. Sale and Supply of Alcohol Act
2. Local Government (Alcohol Reform) Amendment Act
3. Summary Offences (Alcohol Reform) Amendment Act.

While the Act incorporates many of the recommendations from the Law Commission report, fundamental harm reduction recommendations were not implemented. These included the raising of the purchase age to 20 and limiting advertising to objective product information only. In 2014, the Ministerial Forum on Advertising and Sponsorship made comprehensive recommendations on banning alcohol advertising and sponsorship, which have not been responded to.

World Health Organisation SAFER Framework

The World Health Organization (WHO) SAFER Framework released in 2018 outlines five high-impact strategies to help governments reduce the harmful use of alcohol and related health, social and economic consequences.[3] The 5 high impact strategies are:

1. **S**trengthen restrictions on alcohol availability
2. **A**dvance and enforce drink driving counter measures
3. **F**acilitate access to screening, brief interventions and treatment
4. **E**nforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion
5. **R**aise prices on alcohol through excise taxes and pricing policies.

New Zealand has made some progress in implementing aspects of WHO recommended best practice but there needs to be a comprehensive, evidence-based review of how the country protects it citizens against these harms – including a review of the provisions of the Act.

Public Support for reducing Alcohol related harm

There is strong public support for policies and approaches that reduce alcohol related harm as summarised in the table below.

Policy/strategy	**Law Commission submissions**	**Public Opinion Surveys**
Restricting/reducing hours of trading	78% for all off-licences 52% for on-licences	65.6% (support or strongly support) – HPA public opinion survey
Reducing number of outlets	69% for off-licences particularly small grocery stores/diaries	64.6% (thought there were too many) – HSC public opinion survey
Alcohol sponsorship		68% of New Zealanders support banning alcohol-related sponsorship at events that people under 18 may attend.
Increasing the price of alcohol		61% of persons polled supported increasing the price of alcohol if the revenue was earmarked for the funding of mental health and addiction services - UMR public opinion polling (February 2019)

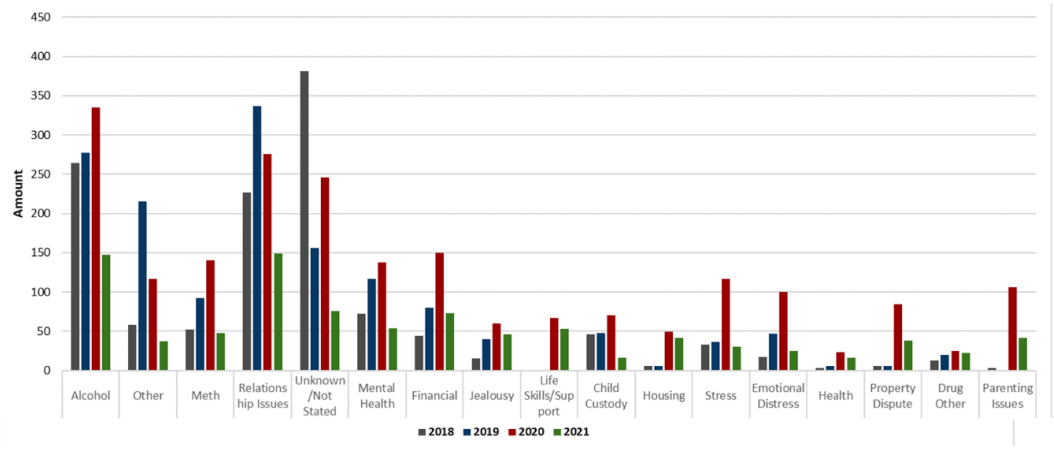
[3] World Health Organization. The SAFER initiative Geneva: WHO; 2018. http://www.who.int/substance_abuse/safer/en/

Inter-agency support for reducing Alcohol related harm

The following is a report on Whiria Te Muka which is an interagency programme in the Far North (Te Hiku) region which demonstrates that Alcohol is by far the highest reason for family violence incidents.

He Muka

Figure 2: Pressure points of incidents entered into Whiria Te Muka



- Alcohol remains the top pressure point for reported family violence in Te Hiku
- Relationship issues as a pressure point spiked in 2019 but has been steadily declining since
- Meth harm spiked as a pressure point to reported whānau harm in May 2020

Sale and Supply of Alcohol Act 2012

The Sale and Supply of Alcohol Act 2012 is administered by the Minister of Justice and replaced the Sale of Liquor Act 1989. The objectives of the Act are that:

a) The sale, supply, and consumption of alcohol should be undertaken safely and responsibly; and
b) The harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

Key features of the Sale and Supply of Alcohol Act 2012 include:

1. increasing the ability of communities to have a say about alcohol licensing in their local area
2. allowing local-level decision-making for all licence applications
3. requiring the consent of a parent or guardian before supplying alcohol to a minor
4. requiring anyone who supplies alcohol to under 18-year-olds to do so responsibly
5. strengthening the rules around the types of stores allowed to sell alcohol
6. introducing maximum default trading hours for licensed premises (8am-4am for on licences and club licences and 7am -11pm for off licences)
7. restricting supermarket and grocery store alcohol displays to a single area.

However, the Act made little or no change to the most cost-effective policy areas for reducing harm, including alcohol taxation, the minimum purchase age and control of alcohol marketing.

Problems with the Sale and Supply of Alcohol Act

The Sale and Supply of Alcohol Act has failed to deliver on its intended objective. Between 2011/12 and 2015/16, hazardous drinking prevalence increased every year and by 2014/15 and 2015/16 was significantly higher in the total population than in 2011/12. Marked increases in this period were found among wahine Māori and middle aged and older adults. Since 2015/16, hazardous drinking prevalence has remained stable.

Various reports have recommended changes to strengthen the Act[4,5,6]. That the Act is not performing as it was intended is widely acknowledged by numerous groups including health, non-government, community advocates, Medical Officers of Health, alcohol treatment services and politicians alike. In a recent media statement Minister of Justice Kris Faafoi said: [7]

"I consider it would be beneficial to review the Sale and Supply of Alcohol Act and I'm assessing the ability to do that within what is already a fairly full work programme in the Justice portfolio… I want to ensure alcohol regulation in New Zealand is fit for purpose and operates effectively."

As a demonstration of how poorly the Act regulates industry, products and social harms it was also used as an example of 'what not to do' during the development of the proposed cannabis legislation, developed for last year's referendum.

Te Tiriti o Waitangi

Colonisation and breaches of Te Tiriti o Waitangi have contributed to the disproportionate impact of alcohol-related harm on Māori. In response to this, Te Tiriti o Waitangi Healthcare claim Wai 2624 (Wai 2575)[8] has called for the government to work in partnership with iwi, hapū, whānau and communities, to reduce alcohol-related inequities for Māori.

The Act does not address the disproportionate impact that alcohol has on Māori, nor does it uphold and honour the Crown's obligations under Te Tiriti o Waitangi. There is no role for Māori leadership or consultation processes to ensure Māori voices are heard and involved in decision making. The object of the Act should incorporate the importance of the Crown and Māori relationship in considering sale and supply of alcohol and this commitment needs to be operationalised within the Act with urgency.

Lack of community input into local alcohol licensing decisions

A priority objective of Aotearoa New Zealand's liquor law reforms in 2012 was to "improve community input into local alcohol licensing decisions". Eight years later, this objective has been far from realised. Alcohol licences have not become "harder to get and easier to lose". In 2020, there were more than 11,000 businesses that sold alcohol in Aotearoa New Zealand. There are more places to buy alcohol in our most socio-economically deprived communities. Community members continue to take time out of their busy lives to object to alcohol licence applications in their neighbourhood, rarely achieving success.

4 *He Ara Oranga - the* Government *Inquiry into Mental Health and Addiction* (2018).
5 *Reducing* Alcohol-*Related Harm* (New Zealand Medical Association, 2015).
6 Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).
7 https://www.newsroom.co.nz/targeting-irresponsible-alcohol-promos
8 https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_148205985/Wai%202624%2C%202.5.003.pdf

The 2019 Alcohol Regulatory and Licensing Authority annual report[9] noted the following:

"The Authority notes that the number of applications refused for new licences is very low compared to the number of applications being granted. The same can be said for applications for licence renewals and new manager's certificates. The reasons why there are so few refusals may be worthy of some investigation by policy officials to see if this is consistent with what was envisaged at the date of commencement of the Act"

Legalistic and ineffective Local Alcohol Policy Process

Provisions under the Act allow a Territorial Authority to adopt a Local Alcohol Policy (LAP) in consultation with their local community to control the number and location of premises in a district, the clustering of premises and trading hours. These legislative provisions offered Councils much hope to implement best practice measures to reduce alcohol harm. Development of a LAP is not mandatory.

However, experience suggests that the development of Local Alcohol Policies (LAPs) has been time consuming, expensive, overly legalistic and largely ineffective. The two big supermarket chains and the alcohol industry have blocked local government from minimising alcohol related harm through Local Alcohol Policies (LAPs) by funding expensive appeals.

As of May 2021, 41 (61%) of the 67 Councils in New Zealand have LAPs in place. The majority of policies have been watered down as they proceeded through the legal appeals process. Fifteen Councils have chosen not to proceed to developing a LAP. Our four largest population centres – Wellington, Hamilton City, Christchurch and Auckland – have no LAP in place. Christchurch City Council abandoned their policy after spending more than $1 million fighting it, Hamilton City have aborted too, as has the Far North District Council.

The legal fight has been lengthy and costly for ratepayers. In Auckland, a four-week public hearing before the Alcohol Regulatory and Licensing Authority in February 2017 has since proceeded to judicial review before the High Court. It has been heard at the Court of Appeal in June 2021. It is therefore unsurprising that in 2018 and 2019, two Local Government NZ remits were passed calling for urgent change to the appeal provision and review of the Act.

There are also problems with the level of evidence that is required to support Provisional LAPs, with the apparent insistence and weight being placed on available local data by both Industry and ARLA. For example, local 'proof' is required that particular off licence restrictions will result in the minimisation of harm, or that purchase of alcohol between 7am-9am results in direct harm.

Proposed changes to the Sale and Supply of Alcohol Act

It is clear that the Act has had little impact on the alcohol environment since being introduced other than a small reduction in on-licence and off-licence trading hours in urban centres (resulting from the end of 24-hour trading hours) and alcohol no longer being sold from premises that resemble dairies. By taking action to amend and strengthen sections of the Act, health outcomes across the population, particularly in vulnerable communities, can be improved.

Four key areas could potentially be addressed by amendments to the Act. These are:

---

[9] Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).

1. Give effect to Te Tiriti O Waitangi in alcohol legislation
2. Reduce the harm from high alcohol availability
3. Reduce the harm from alcohol advertising and sponsorship
4. Reduce the harm from cheap alcohol.

Consideration of these areas and potential changes to the Act is provided in the remainder of this section. This has been informed by key documents including the Law Commission's 2010 review *Alcohol in our Lives: Curbing the harm*, the World Health Organisation's global alcohol strategy and their *SAFER* guidelines, the New Zealand Medical Association report *Reducing Alcohol-Related Harm* and by Alcohol Healthwatch's recent report entitled *Evidence-based alcohol polices: building a fairer and healthier future for Aotearoa New Zealand.*[10].

The relative impact and cost effectiveness of various changes has also been considered. The graph below presents selected interventions from the University of Otago BODE[3] Cost Effectiveness Study comparing the benefits, potential savings and costs from a range of interventions in relation to alcohol. Most of the studies used have been developed in the Australian context.

This illustrates that taxation increases would deliver the greatest health benefits (220,000 quality adjusted life years) and potentially save the health system $3.58 billion dollars. Taxation increases however are likely to exceed the scope of a mid-range review and may need to be considered as part of a broader review of the Act.

Summary of the health impacts and cost effectiveness of alcohol interventions from the University of Otago BODE[3] Cost Effectiveness Study.

Intervention	Health Gain (QALYs)	Health system savings / costs	Intervention Costs	ICER
Tax increase	220,000	-3,580,000,000		Cost-saving
Comprehensive advertising ban	7,800	-16,400,000	20,000,000	Cost-saving
Licensing controls to restrict operating hours	2,700	11,900,000	20,000,000	4,504
Random breath testing	2,300		71,000,000	35,490
Mass media 'drink driving' campaigns	1,500	38,200,000	39,000,000	19,110
Residential treatment	460	75,100,000	59,000,000	163,804
Brief intervention by a GP	340	4,780,000	6,100,000	13,650
Increase in minimum legal drinking age	150	-218,000	640,000	Cost-saving

The tax increase is modelled on; 'applying an equal tax rate to all beverages equivalent to a 10% increase in the current excise applicable to spirits and ready-to-drink products'. This is calculated to result in a 50% increase in taxation (which is similar to the amount recommended by the Law Commission) and a 10.6% reduction in consumption.

Comprehensive advertising bans and licensing controls to restrict operating hours are the next most important interventions in terms of health gain. The evidence consistently shows that interventions to address alcohol related harm are highly cost effective and that taxation and regulatory changes at the national level show greatest health gain and cost effectiveness compared to health promotion or clinical interventions. By addressing the alcohol environment, they produce sustainable changes to population norms of drinking for this generation and the next to benefit.

10 Alcohol Healthwatch. *Evidence-based alcohol policies: Building a fairer and healthier future for Aotearoa New Zealand* (Alcohol Healthwatch, 2021).

1. Give effect to Te Tiriti O Waitangi in alcohol legislation

The Crown is currently failing in its duty to actively protect Māori from alcohol related harm. Māori are one of the groups most adversely affected by alcohol and yet the Act makes no special consideration or recognition of their place as tangata whenua. Emerging research has demonstrated links between Māori who face racism and alienation, and heavy drinking.

It would also be important to give effect to Te Tiriti principles in the act in a number of ways. This could include for example the following:

1. Māori have effective agency to self-determine the place of alcohol sale and supply (Tino Rangatiratanga)
2. Reduce levels of excessive consumption and alcohol related harm for Māori, reduce to at least the level of non-Māori, and differentials in the density of alcohol sale and promotion outlets to these communities are eliminated (Equity)
3. Regulators act to the fullest extent and err on the side of preventing harm with a precautionary principle where there is uncertainty (Active Protection)
4. Attention and mitigation is given to the specific pathways of harm for Māori not simply general pathways of harm for all communities (Options)
5. Māori – and all local communities – communities have equal power and agency on decisions, relative to commercial interests seeking to promote alcohol sale and use. Regulators must have a duty to hear and heed the quieter voices of those who have a legacy of feeling powerless (Partnership).

Te Hiringa Hauora (Health Promotion Agency) have work underway to identify what would be required to give effect to Te Tiriti O Waitangi. The recommendation below will be updated to align with the position advocated for by Te Hiringa Hauora. The National Māori Authority have also signalled that they are calling for a review of the Act and will begin consultation soon.[11] A partnership approach is needed for example having members of DLCs who are Māori .

Recommendation: Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:

- Embedding Te Tiriti O Waitangi principles in the object of the Act
- Ensuring the health system supports, invests in and enables:
    - Māori leadership and decision-making
    - Whanau-centred service provision and kaupapa Māori models of care
    - Workforce development, provider development and equitable funding
- Including Māori as Te Tiriti o Waitangi partners who must be represented on all decision making panels and heard as public objectors at any hearings
- Criteria for oppositional matters should include Te Tiriti o Waitangi under s 105, 131, and 142 of the Act.

2. Reduce the harm from high alcohol availability

The next four recommendations in this section focus on reducing the availability of alcohol by reducing the default national maximum trading hours, removing the LAPs (local alcohol policies) appeals process and making LAPs mandatory, changing the District Licensing Committee structure and hearings process, and lifting the legal purchase age. Each of these initiatives will minimise alcohol harm by reducing its accessibility and enabling greater community participation in decision-making processes regarding alcohol availability.

[11] http://www.voxy.co.nz/national/5/387572

Hours of sale
Aotearoa New Zealand's legislated default national trading hours (in the absence of a Local Alcohol Policy) are 8am to 4am for on-licences and club licences and 7am to 11pm for off -licences. Reducing the national trading hours can reduce harm and save lives. Many/all of the LAP appeals sought to establish longer trading hours than communities wanted. This could be circumvented by reducing the hours of sale at a national level via a legislative change.

Recommendation: Advocate for a reduction in the minimum default closing hours to 9pm for off licences and 2am for on licences and club licences

Number of licences
In New Zealand, the number of outlets licensed to sell alcohol more than doubled from 6,296 in 1990 to 14,424 in 2010.[12] A higher density of outlets is associated with increased consumption, particularly among young people, higher levels of harmful drinking as evidenced by more alcohol-related crime or anti-social behaviours, or a variety of secondary harms that can undermine community wellbeing.[13] [14]

New Zealand research has demonstrated that higher outlet density is more common in lower socio-economic neighbourhoods than in higher socio-economic neighbourhoods. Unsurprisingly, higher outlet density is associated with lower alcohol prices and longer opening hours. Where there are several outlets in one area, particularly off-licence outlets, alcohol discounting is one commonly used means for outlets to compete with each other. Lower prices can stimulate demand and facilitate heavier consumption.

Regulating the physical availability of alcohol is, therefore, a major tool available to reduce alcohol-related harms. Introducing a cap or a sinking lid on the number of off-licences available in a given area would limit the proliferation of new stores. We could for example argue a future trajectory for total number of off-licences which includes reducing density of the highest deprivation areas to those of the lowest – and that would mean every time a licence was given up it would not be replaced if an area was above its target level.

Recommendation: Advocate to enable the number of licences to be lowered particularly in vulnerable or high deprivation areas.

For example, by requiring the existing levels of density to be considered in licensing applications, beyond its effects on amenity and good order; and explicitly requiring the level of deprivation in the locality to be considered in licensing decisions.

LAP appeals process
As previously discussed the current LAP process is highly legalistic and not working as intended. Removing the appeals process would bring the LAP development and implementation process in line with other locality-specific social harm policies such as that which governs gambling, prostitution and psychoactive substances. Importantly these local government policies do not have an appeals process.

Removing the LAP appeals process and making them mandatory would enable Councils to use stronger controls to limit or reduce alcohol availability, especially in areas that have outlet high

[12] New Zealand Law Commission. 2009. Chapter 2. The Context for Reform. Information provided by the Liquor Licensing Authority.
[13] Connor JL, et al. Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand: a national study. J Epidemiol Community Health. 2011 Oct;65(10):841–6.
[14] Donnelly N, et al. Liquor Outlet Concentrations and Alcohol-related Neighbourhood Problems. Alcohol studies bulletin 2006, no. 8.

proliferation. A greater number of Territorial Authorities could look to set caps on the number of alcohol outlets in their districts, or even introduce sinking lid policies to reduce the existing density of outlets. Proximity controls (i.e. required distances between premises) and location controls (i.e. proximity to sensitive sites such as schools), may also be used to a greater extent following the removal of the LAP appeals process.

Recommendation: Advocate for the abolition of the Local Alcohol Policy appeals process and require LAPs to be mandatory

Community input into local alcohol licensing decisions
Despite the priority objective of the Alcohol Reform Bill being to "improve community input into local alcohol licensing decisions", communities still face many challenges in their participation in these processes.

Firstly, it is difficult for communities to become aware of licence applications in their neighbourhood. Once they do become aware, they have 15 working days to submit their objection. Once the application proceeds to a public hearing before a District Licensing Committee (DLC), they face a highly-legalistic process with cross-examination by well-resourced lawyers acting for the licence applicant.

Changes are required to the Act to enable greater community participation in matters of local alcohol availability. Cross-examination should be prohibited in the Act and District Licensing Committees should be replaced with a national panel of Commissioners, to ensure consistency in evaluation and decision-making and put an end to local government elected officials sitting on DLCs.

Recommendation: Amend the structure of District Licensing Committees and remove cross-examination from public hearings.

Age
The minimum purchase age in NZ is currently 18 years. The Law Commission Review recommended that this should be increased to 20. Given the inequities in consumption and harm experienced by rangatahi Māori, increasing the legal purchase age should be considered as pro-equity.

Evidence suggests that the longer a young person delays drinking, the more they are protected from alcohol harm and that each year a young person delays drinking, they are estimated to reduce their risk of becoming dependent on alcohol by 9–21%[15]. Studies have shown that the 1999 law change in Aotearoa New Zealand that lowered the purchase age from 20 to 18 years was associated with an increase in a number of alcohol-related harms for young people, including alcohol-related hospitalisations[16], prosecutions for driving with excess alcohol and disorder[17], and traffic crashes[18]. New Zealand research shows that almost 50% of all cases of alcohol abuse and dependence develop by the age of 20 years and 70% by the age of 25. As such, this is a critical and vulnerable period for the development of alcohol use disorders in New Zealand.

Recommendation: Advocate for an increase in the minimum purchase age to 20 as recommended by the Law Commission Report.

---

15 Donaldson, L. Guidance on the consumption of alcohol by children and young people. London, UK: Department of Health, 2009.
16 Everitt, R., & Jones, P. (2002). Changing the minimum legal drinking age - its effect on a central city emergency department. New Zealand Medical Journal, 115(1146), 9-11.
17 Huckle, T, Pledger, M, & Casswell, S. (2006). Trends in alcohol-related harms and offences in a liberalized alcohol environment. Addiction, 101(2), 232-240.
18 Kypri, K, Davie, G, McElduff , P, Langley, J, & Connor, J. (2017). Long-term effects of lowering the alcohol minimum purchasing age on traffic crash injury rates in New Zealand. Drug and alcohol review, 36(2):178185.

Remote sales (also called online sales)

The writers of the Act, which received Royal Assent in 2012, began development of the Act in 2010 and were guided by the Law Commission's recommendations, could not have conceived of the role the internet would play in facilitating alcohol purchasing and consumption in Aotearoa New Zealand. This has been further exacerbated as a result of COVID 19 with alcohol sellers diversifying their business models. The rate of growth in the number of online alcohol sellers has been exponential. Currently, only retailers with a Section 40 endorsed liquor licence (i.e. online only sellers) are required to state their intention to sell online. All other physical off-licences (e.g. supermarkets, grocery stores, bottle stores), are permitted to sell online but are not required to register that they are selling online. As such, there is a substantial lack of information as to which premises are selling online and to which regions in New Zealand. Determining compliance with the Act is therefore challenging.

The Act needs to be modernised to take into account the various delivery services that deliver alcohol to residential addresses. As alcohol can be currently purchased online and delivered without any face-to-face interaction, there is a risk that underage or intoxicated persons may purchase and consume alcohol. Also, it is currently possible to have alcohol delivered in less than 30 minutes from time of purchase.

Recommendation: Restrict online alcohol sales and align the requirements for online alcohol sales with in-person sales including:

1. Require all online alcohol sellers to obtain a section 40 (remote sellers) liquor licence
2. Require the buyer and receiver to verify their age (i.e. make this mandatory in legislation)
3. Prohibit alcohol products to be left unattended at delivery
4. Require an intoxication assessment of the person who receives alcohol
5. Prohibit same day delivery
6. Require that the delivery should only occur within permitted trading hours of the physical premises or for online only sellers the more restrictive of the default national maximum trading hours or local alcohol policy.

3. Reduce the harm from alcohol advertising and sponsorship

Exposure to alcohol advertising is causally associated with earlier drinking initiation among adolescents and heavier drinking among adolescents who drink.[19] [20] Alcohol advertising also serves to normalise drinking and maintain our heavy drinking culture. Controls over the marketing of alcohol are important for delaying drinking initiation for young people and those who want to cut down or stop drinking. Around 80% of New Zealanders support increasing restrictions on alcohol advertising or promotion seen or heard by people under 18.[21]

Replacing alcohol sports sponsorship could be achieved through increasing the existing Health Promotion Agency levy that is placed on all alcohol products sold in Aotearoa New Zealand (for the purposes of undertaking activities to reduce alcohol harm). Funding the replacement of alcohol sports sponsorship would add as little as 6 cents to a bottle of wine, 2 cents to a can of beer, 2 cents to an RTD, and 7 cents to a bottle of spirits.

---

19 Stautz K, Brown KG, King SE, Shemilt I, Marteau TM. Immediate effects of alcohol marketing communications and media portrayals on consumption and cognition: a systematic review and meta analysis of experimental studies. BMC Public Health 2016; 16: 465.

20 Sargent JD, Babor TF. The Relationship Between Exposure to Alcohol Marketing and Underage Drinking Is Causal. J Stud Alcohol Drugs Suppl 2020; 113–24.

21 Health and Lifestyles survey Alcohol-related attitudes over time. See https://www.hpa.org.nz/sites/default/files/Alcohol-related%20attitudes%20over%20time%20October%202018.pdf

The Law Commission Report recommended that a phased programme should be in place with 5 years to limit exposure to alcohol promotion and restrict the content of alcohol promotion messages including alcohol related sponsorship. The Commission recommended a 3 stage programme be implemented. Only stage 1 of this programme has been implemented to date. Stage 2 measures are primarily aimed at reducing exposure to advertising particularly for young people. Stage 3 measures prohibits any alcohol advertising in any media other than advertising that communicates objective product information, including the characteristics of the beverage, the manner of its production and its price.

Alcohol advertising is currently addressed in section 237 of the Act. This section should be extended to prohibit all alcohol marketing across all media, as per requirements for tobacco and vaping products in New Zealand.

Recommendation: Advocate to strengthen section 237 of the Act by prohibiting alcohol marketing across all media, as per requirements for tobacco and vaping products.

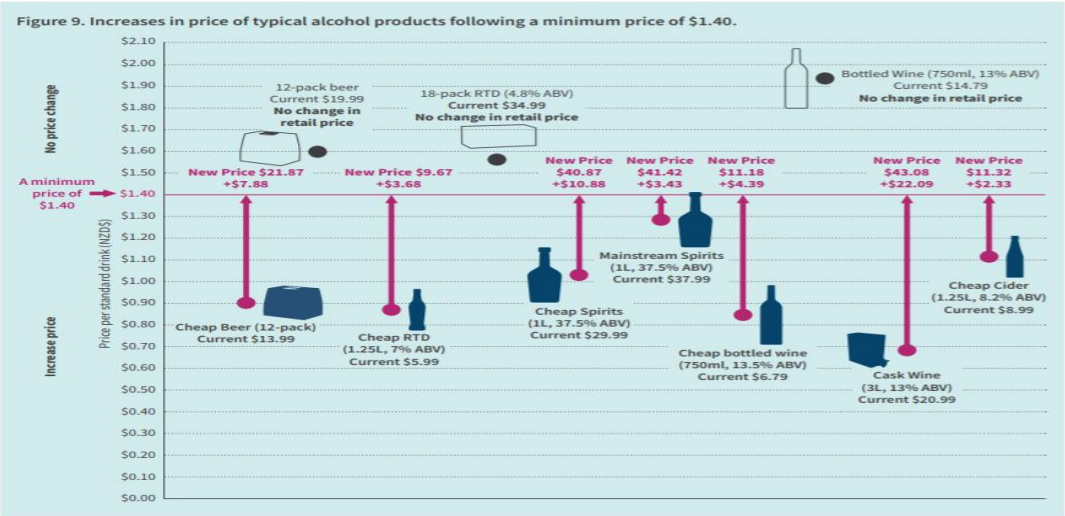
4. Reduce the harm from cheap alcohol

Pricing is one of the most influential drivers of alcohol consumption in the population. There are two complementary ways to tackle this issue –introducing a minimum unit price to address the harms from the cheapest alcohol for sale alongside increasing excise tax to shift population level patterns of consumption. Pricing changes could be introduced through the Sale and Supply of Alcohol Act but they are unlikely to be addressed as part of the mid-range review signalled by the government and therefore they should pursued by other means such as specific legislative initiatives.

Minimum Unit Pricing

Many countries and jurisdictions throughout the world have adopted legislation to set a floor price (minimum price) that alcohol can be sold. These policies are important in relation to cheap sales of alcohol from off-licences; where 84% of all alcohol is now purchased from in New Zealand. Research from Scotland demonstrates the positive impacts of Minimum Unit Pricing (MUP), especially on equity.[22]

Alcohol Health Watch, Roadmap for Alcohol Pricing Policies.=



[22] O'Donnell A, Anderson P, Jané-Llopis E, Manthey J, Kaner E, Rehm J. Immediate impact of minimum unit pricing on alcohol purchases in Scotland: Controlled interrupted time series analysis for 2015-18. BMJ 2019; l5274.

In the first year of MUP in Scotland, purchases of alcohol reduced the most among low income, heavy drinking households. Because the policy has the greatest impact on the purchases of very cheap alcohol (i.e. especially by low-income heavy drinkers), the positive impacts on health inequities from MUP are considerable, given the disproportionate harm that these drinkers experience. In particular, MUP is shown to be the most pro-equity alcohol pricing policy – having the potential to narrow socio-economic, alcohol-related health inequities the most. In a United Kingdom modelling study, it was estimated that 90% of the lives saved from MUP would be from lower socio-economic groups.

MUP should be introduced to lift the low cost of alcohol sold at off-licences, and predominantly purchased by heavy drinkers who buy the cheapest alcohol available - cask wine. This can be bought for 68c per standard drink. Very low priced bottled wine (beginning at $6.79), some RTDs (ready to drink ie. Spirit and soft drink pre-mixers) and some cheap beer would also be strongly affected by this increase. It will have a marginal affect or no effect on most other beverages, and will not generally affect the hospitality sector as their drinks are sold at prices well above these levels.

Recommendation: Advocate for the introduction of Minimum Unit Pricing

Increase Alcohol Excise taxes

Raising the price of alcohol is the most cost-effective measure to reduce alcohol consumption (in terms of cost per health life-years gained).[23] Increasing the price of alcohol has been shown to be associated with reductions in alcohol-related disease and injury outcomes, alcohol-impaired driving, motor vehicle crashes and injuries, death from cirrhosis, alcohol dependence, sexually transmitted infections, suicide, and violence (including rape, robbery, and violence towards children).[24] [25]

In 2017, all alcohol was more affordable than ever before. Currently, around 15-25% of the price of mainstream beers, wines and Ready to Drinks (RTDs) is excise tax. Due to the higher tax rate on high-strength spirits, around half of the price of a bottle of spirits is excise tax.

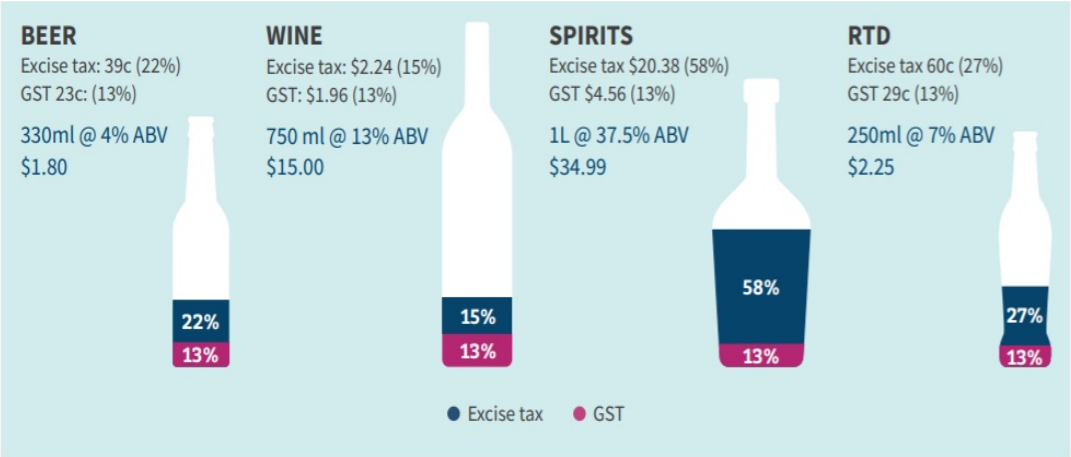
The Law Commission recommended that the alcohol excise tax rates increase by 50% – this would, on average, increase alcohol prices by around 10% and reduce overall consumption by 5%.22 A 50% tax increase would raise the price of a 12-pack of beer by <$3, a bottle of wine by $1.30, a bottle of spirits by $12 and a 12-pack of RTD by $4 (as at July 2020).

[23] Chisholm D, Moro D, Bertram M, et al. Are the "Best Buys" for Alcohol Control Still Valid? An Update on the Comparative Cost-Effectiveness of Alcohol Control Strategies at the Global Level. J Stud Alcohol Drugs 2018; 79: 514–22.

[24] Elder RW, Lawrence B, Ferguson A, et al. The effectiveness of tax policy interventions for reducing excessive alcohol consumption and related harms. Am J Prev Med 2010; 38: 217–29.

[25] Wagenaar AC, Salois MJ, Komro KA. Effects of beverage alcohol price and tax levels on drinking: a meta analysis of 1003 estimates from 112 studies. Addiction 2009; 104: 179–90.

Alcohol excise rates in Aotearoa New Zealand, Alcohol Health Watch, Roadmap for Alcohol Pricing Policies



The Ministry of Justice examined the effects of an 82% excise tax increase[26] and estimated that:

1. Harmful drinkers would reduce their annual consumption the most, by around 13.1%;
2. Low-risk drinkers would pay an additional $1.77 per week, increased risk drinkers $5.87 per week, and harmful drinkers $13.65 extra per week; and
3. Net cost savings to society from reduced harm were estimated to be $339 million in the first year, and $2.45 billion over ten years. The majority of these savings were from reduced costs to ACC, the justice sector and health system.

Tax prices are currently set through Customs and Excise but the Act could be amended to include a requirement that alcohol taxes are imposed to ensure that the price of alcohol remains at a level that is consistent with the Object of the Act.

Recommendation: Advocate for a substantive increase to alcohol excise in line with that recommended by the Law Commission.

Proposed DHB Position Statement

Appendix 1. sets out a proposed DHB position statement re the Sale and Supply of Alcohol Act. The intention is that DHBs collectively adopt the position statement in order to begin advocating for a modification and strengthening of the Act and eventually a full review of the Act. It is crucial to use this opportunity to position alcohol law reform as a key public health issue that offers significant potential to improve Māori health gain and reduce alcohol harm inequities. It is also intended that this position statement is circulated with health leaders and others to build consensus on the scope of the review.

[26] White J, Lynn R, Ong S-W, Whittington P, Clare C, Joy S. The Effectiveness of Alcohol Pricing Policies. 2014.https://www.justice.govt.nz/assets/Documents/Publications/effectiveness-of-alcohol-pricing policies.pdf (accessed April 30, 2018).

Currently 18 of the 20 DHBs have alcohol position statements. In November 2020, Hauora Tairawhiti conducted a stocktake that showed that all the current position statements noted the significance of alcohol related harm and advocated for national population-based policy changes including changes to tax, minimum age, and marketing. However, many of the statements did not specifically list the changes needed.

This position statement provides a brief, evidence-based, high level statement about the changes needed to the Act. This statement has been reviewed by alcohol-related harm experts. It provides a strong base for the Public Health Advocacy Team, DHBs and health leaders to advocate for alcohol harm minimisation work by clearly stating the policies and actions that the DHBs, and later Health NZ, should take.

These changes are informed by key documents including the Law Commission's 2010 review *Alcohol in our Lives: curbing the harm*, the World Health Organisation's global alcohol strategy and their *SAFER* guidelines, and by Alcohol Healthwatch's recent report entitled *Evidence-based alcohol polices: building a fairer and healthier future for Aotearoa New Zealand.*

Further work on reducing alcohol-related harm, such as reducing social harms, improvements to health services, alcohol and addiction treatments, and legislation beyond the Act are outside the scope of this paper.

Health sector leaders should have a collective view on what the review should entail, and one that is publicly available. This position statement will provide direction for the amendments to the Act.

Given that we are already eight months into this 36-month term it is likely that work to scope the terms of the review could begin by the end of this calendar year. It's therefore essential that DHB health leaders have a clear and collective view on what we want from this review.

Appendix 1. Proposed DHB Sale and Supply of Alcohol Act 2012 Position Statement

We, the Chairs and Chief Executives of the 20 District Health Boards, believe that the Sale and Supply of Alcohol Act 2012 must be amended and strengthened in order to prevent and minimise alcohol-related harm and inequities in Aotearoa New Zealand and uphold our obligations to Te Tiriti o Waitangi.

We are guided by the science, data and research:

1. Alcohol is a toxin and an intoxicant
2. Alcohol is a carcinogen
3. Alcohol causes premature death, disability, and injuries
4. Alcohol regulation must be understood as a (mental) health (and addictions) issue
5. Alcohol is New Zealand's most harmful drug.

Specific changes we want to see are:

Give effect to Te Tiriti O Waitangi in such a way that the health system is held accountable for reducing inequities in alcohol related harm by:

- Embedding Te Tiriti O Waitangi principles in the object of the Act
- Ensuring the health system supports, invests in and enables:
    - Māori leadership and decision-making
    - Whanau-centred service provision and kaupapa Māori models of care
    - Workforce development, provider development and equitable funding

Reduce the harm from high alcohol availability by

1. Reducing the default national maximum trading hours, by requiring the closing hours of 9pm for off licences and 2am for on licences and club licences.
2. Abolishing the appeals process for Local Alcohol Policies (LAPs) and make LAPs mandatory
3. Increasing the legal purchase age for alcohol from 18 years to 20 years.
4. Enabling community participation in licensing decisions by amending the District Licensing Committee structure and hearing process;
5. Restricting the online sale of alcohol and align the restrictions across all types of online alcohol retailers.

Reduce the harm from alcohol advertising and sponsorship by:

6. Strengthening section 237 of the Act by prohibiting alcohol marketing across all media.

A full review of the Act by an independent external agency such as the Law Commission is also called for. This should be undertaken as a subsequent stage following finalisation of the immediate changes to the act.

We also want to see the Law Commission Recommendations on alcohol pricing implemented at the earliest opportunity, including minimum unit pricing and increasing alcohol excise tax, as part of broader changes to address alcohol related harm.

END

All District Health Boards

DHBs and the Smokefree Aotearoa 2025 Goal

To:	DHB Chief Executives and Chairs
From:	Nick Chamberlain, CE NDHB and Lead CE for Public Health
Subject:	District Health Board action to support the Smokefree Aotearoa 2025 Goal
Date:	12 August 2021

Decision ☒	**Discussion** ☐		**Information** ☐	
Seeking Funding	**Yes**	☐	**No**	☐
Funding Implications	**Yes**	☐	**No**	☐

1. Recommendations

It is recommended that DHB Chief Executives and Chairs:

- **Note** that cigarette smoking is the most readily preventable cause of health inequities in New Zealand and is responsible for at least two years of the life expectancy disadvantage experienced by Māori.
- **Note** that NZ is not on track to achieve the Smokefree Aotearoa 2025 Goal and that Māori are currently not forecast to reach the target until 2060.
- **Note** that the Government has recently consulted on a Smokefree Aotearoa 2025 Action Plan which is likely to greatly accelerate progress towards the Smokefree 2025 Goal and significantly reduce smoking related harm and health inequities.
- **Note** that Dr Nick Chamberlain, as agreed at the combined DHB CE/Chairs meeting on 13 May 2021, submitted a submission on behalf of the DHB CEs on the Government's proposed Action Plan.
- **Note** that achieving the Smokefree 2025 Goal will require a fourfold increase in the number of successful quitters and a proportionate increase in stop smoking services and funding.
- **Note** that additional government funding has been allocated for stop smoking services in budget 2021, but this is not available until 2022/23 and that significant further increases or reprioritisation of resources are needed to achieve the Smokefree 2025 Goal.
- **Note** that stop smoking services are highly cost effective, every dollar spent on smoking cessation saves $10 in future healthcare costs and health gain, and the long term quit rate of smokers who access face to face group based stop smoking services is 4 times higher than those who do not participate in a programme.
- **Note** that only one DHB is currently achieving the Better help for smokers to quit – Primary Care health target**.**

- **Note** that there is considerable variation (up to 10 fold variation) across DHBs in the referral rate to stop smoking services, quit rates, and costs per quitter by stop smoking provider.
- **Agree** to advocate for full implementation of the Smokefree Aotearoa 2025 Action Plan.
- **Agree** to the National Public Health Advocacy team and DHB leads working collaboratively with the MOH to support the development of an investment plan for stop smoking services.
- **Agree** to fully support the MOH in future funding bids for stop smoking services.
- **Agree** to review DHB tobacco control expenditure and ensure that this is being optimally used to support Smokefree 2025 where possible within budgetary constraints.
- **Agree** to review stop smoking pathways and services locally and support development of local plans to deliver a fourfold increase in the number of smoking quitters. This should include consideration of opportunities to:
    - Increase the quality and quantity of referrals to stop smoking services, for example, by following up primary care attendees, hospital discharges, and opportunistic clinical interventions with appropriate support
    - Proactively engage with smokers to reduce drop off from referrals including developing dedicated pathways and providers for Māori and Pasifika smokers
    - Scale up the capacity and capability of smoking cessation services
    - Support the adoption of best practice and local innovation and flexibility
    - Limit the public promotion of vaping products and less harmful nicotine delivery devices to only smokers who want to quit
    - Accelerate public health promotion to young people, non-smokers, and non-vapers to dissuade them from taking up vaping or smoking in the first instance.
    - Rigorously measure progress to support improvement.
- **Agree** to advocate to Pharmac to reduce the cost of nicotine replacement therapies (NRT), e.g. gums, patches, and mists.
- **Agree** to mental health and addiction service users being added to priority populations for stop smoking services due to the very high rates of smoking and within this population.
- **Note** the Ministry of Health vaping statements:
    - The best thing you can do for your health is to be smokefree and vape free
    - Vaping is not for children and young people
    - Vaping can help some people quit smoking
    - Vaping is not harmless, but it is much less harmful than smoking
    - Vaping is not for non-smokers.

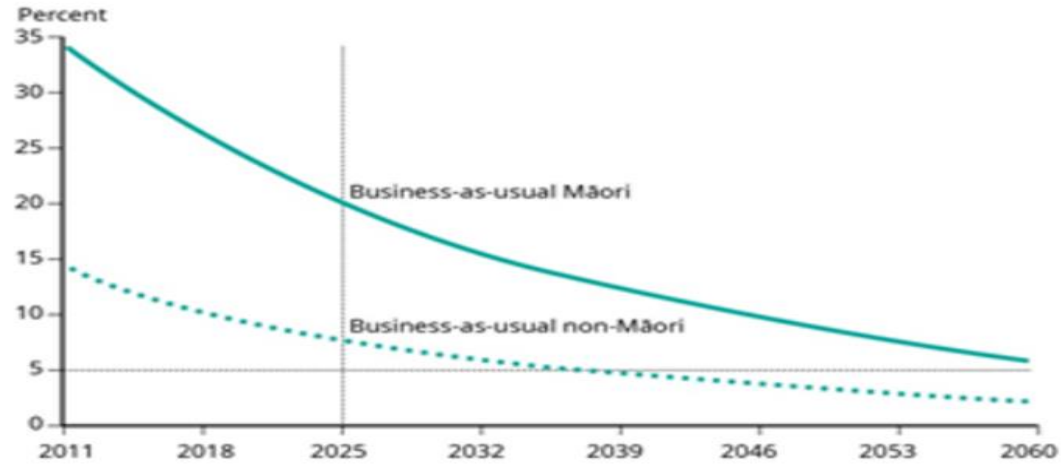
2. Background

In 2011 the Government adopted the Smokefree 2025 Goal of a minimal adult cigarette smoking rate which is widely interpreted as being less than 5% for all New Zealanders.

Cigarette smoking is uniquely harmful and kills 14 New Zealanders every day; 2 in 3 cigarette smokers will die as a result of smoking, each losing about ten years of life expectancy. Cigarette smoking is the most readily preventable cause of health inequity in New Zealand and is responsible for at least two years of the life expectancy disadvantage experience by Māori. People smoke for the nicotine, but die from the toxic ingredients in burnt tobacco.

It is possible to readily reduce the health and economic burdens from smoked tobacco. Over the last decade many important cigarette smoking control policies have been introduced including annual tax increases, point of sale ad bans, plain packaging. Adult daily smoking rates have declined since 2011 from 20% to 11.6% in 2019/20 but we have enormous remaining inequities with adult Māori and Pasifika smoking rates of 30% and 20% respectively. There have been noteworthy successes in reducing smoking rates in young people. In the 2019 ASH Year Ten Survey 2% of 14 and 15 year olds were daily cigarette smokers, with higher rates in Māori and Pasifika youth.

Projections of adult smoking prevalence (for daily smoking) for Māori and non-Māori to 2060



Source: Blakely et al 2018

Critically, we are not currently on track to achieve the Smokefree 2025 goal, especially for Māori, Pasifika and people on low incomes – cigarette smoking is essentially a marker of social and economic disadvantage. Mental health and addiction service users have particularly high rates of smoking with a rate of smoking of about 43% total population, rising to 70% for Māori and 59% for Pacific (WDHB data, March 2021). At the current rate of progress Māori are not forecast to achieve the target until 2060, as shown in the graph below.

3. The National Plan to Achieve the Smokefree Aotearoa 2025 Goal

In April 2021 the Government released a draft discussion document on a national plan for achieving the Smokefree Aotearoa 2025 Goal. The plan recognises the importance of ongoing evidence based interventions to encourage more cigarette smokers to make more quit attempts more often through mass and targeted media campaigns supported by the wider availability of cessation support including the use of reduced harm products. The plan proposes 5 key action areas including:

- Strengthening the tobacco control system
- Making smoked tobacco products less available
- Making smoked tobacco products less addictive and less appealing
- Making tobacco products less affordable
- Enhancing existing initiatives

If the action plan and the actions proposed in it can be successfully implemented it will greatly accelerate progress towards the Smokefree 2025 Goal and significantly reduce smoking related harm and health inequities. Achieving the Smokefree 2025 Goal will however require a fourfold increase in the number of smoking quitters and a proportionate increase in smoking cessation services and funding as outlined below.

Additional funding has been provided in the recent budget as shown in the table below. However, this is insufficient to achieve the scale of the increase in smoking quitters required. A $4.625m investment per year, at median cost per quitter of $4473 would yield 2635 additional quitters per year compared to the additional 40,000 quitters per annum that are required to meet the target as outlined below.

	2021/22	2022/23	23/24	24/25	**Total**
Scale up stop smoking services	n/a	4.625	4.625	4.625	**13.875**

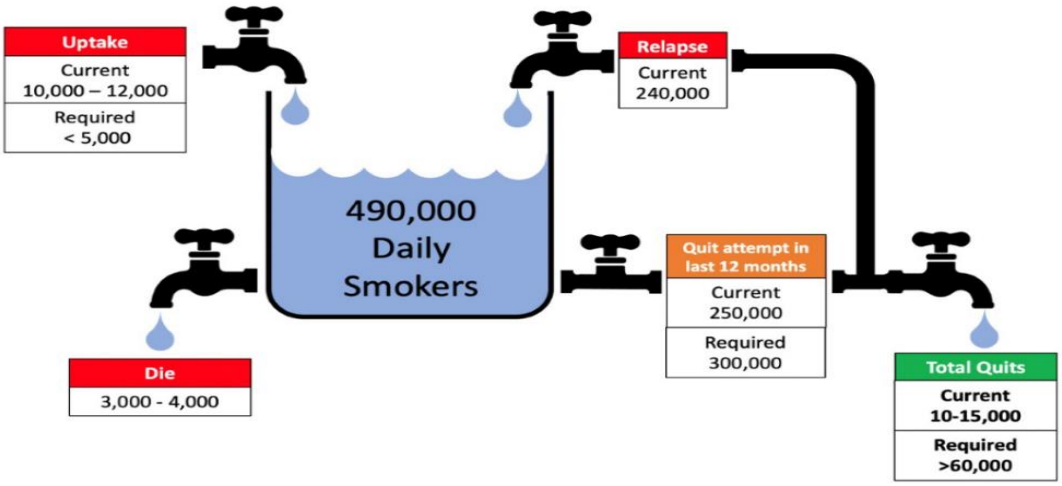
4. Increasing quit rates: the key to achieving Smokefree 2025

There are approximately 500,000 daily cigarette smokers in New Zealand. Reaching the 5% goal requires approximately 300,000 cigarette smokers to quit permanently by the end of 2025, i.e., in 4.5 years. This equates to roughly 60,000 successful quitters each year. At present we are achieving approximately 15,000 quitters each year. Thus, we need to dramatically increase successful quitting numbers by at least 40,000 a year; half the quitters must be Māori and one third Pasifika to achieve equitable cigarette smoking rates.

The Ministry of Health funds stop smoking providers to deliver multi-sessional behaviour support and NRT to people who want to quit smoking. The Ministry of Health priority audiences for service are young Māori wāhine (18 to 30), pregnant women, Māori, and Pasifika. Ready Steady Quit (WDHB and ADHB) are only able to see priority groups and plan to refer all other smokers to Quitline.

The Ministry of Health also provides tobacco control funding to all 20 DHBs to provide Tobacco Control Leadership and Coordination and support the Governments Health Targets. Funding for Smokefree Enforcement Officers is also provided to Public Health Units to enforce the Smokefree Environments Act.

Smoking quitters required to achieve the Smokefree Aotearoa 2025 Goal (Source: ASH)



Stop Smoking Services have been shown to be cost effective both internationally and in New Zealand. The cost of providing Stop Smoking Services is significantly less than the health costs of tobacco related diseases. According to the National Institute for Clinical Excellence (NICE) in the UK, every £1 spent on smoking cessation saves £10 in future health care costs and health gains.[1] A New Zealand modelling study has estimated that a targeted stop smoking support intervention that costs $100,000 a year would only need to support three to four people who smoke to quit to break even ($25 - $33,000/quitter). The MOH contracted face-to-face Stop Smoking Services currently cost significantly less than this, ranging from $653 - $3857 per quitter (median cost $1755) for the period July to December 2020.

Group based smoking cessation programmes provide the most effective smoking cessation support. The long term quit rate of smokers who access face to face group based smoking cessation services is 4 times higher than those who do not receive support to quit.[2]

DHBs, with their 'captive' smoking populations (information on admission and in primary health care), are in a unique position to encourage and support cigarette smokers to transition towards less harmful alternatives and smokefree status. Over 500,000 people who smoke are seen in primary care every quarter. There are also approximately 150,000 middle-aged patients discharged from public hospitals each year with smoking induced conditions such as cardiovascular and many cancers, and patients with mental illnesses who have very high smoking rates. These patients are a priority for becoming smokefree but will need DHB and community-based support and encouragement. Consideration should be given to funding DHB/hospital services to provide cessation support, so that there is continuity in care as there is a large drop-off upon referral from hospital to an external stop smoking service.

[1] Health Economics Research Group, Estimating Return on Investment of Tobacco Control: Tobacco Control Return on Investment tool, NICE 2014

[2] Bauld et al, English Stop-Smoking Services: One-Year Outcomes. International Journal of Environmental Research and Public Health, 2016 Dec; 13(12): 1175.

5. Tobacco harm minimisation

People smoke for the nicotine, but die from the tar. Nicotine is not a cause of disease. In terms of tobacco harm minimisation less harmful alternatives to cigarettes such as patches, gum, lozenges, nicotine sprays and now newer vaping products need to be made available to smokers who want to quit tobacco.

The Ministry of Health has produced a national position statement on vaping in the context of Smokefree 2025 (see Appendix 1). This is currently being reviewed and revised. Key messages in the position statement include:

- The best thing smokers can do is to quit smoking for good
- Vaping products are intended for smokers only
- Vaping products carry much less risk than smoking cigarettes but are not risk free
- Stop smoking services must support smokers who choose to use vaping products to quit
- There is not international evidence that vaping products are undermining the long term decline in cigarette smoking, and may in fact be contributing to it.

Current evidence states that vaping is 95% less harmful than cigarettes[3]. Nick Wilson and colleagues have recently reviewed the health risks associated with vaping and suggested that the overall harm to health from vaping was estimated to be 33% that of smoking.[4] They state that this should be considered to be the likely upper level of vaping risk.

The Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020 came into force in November 2020, amending the Smoke-free Environments Act 1990. The new Act strikes a balance between ensuring vaping products are available for smokers who want to quit smoking, and making sure these products aren't marketed or sold to non-smokers, especially young people under the age of 18 years. Minister Verrall has requested that public health units initiate controlled purchase orders (CPOs) of vaping outlets to ensure that vaping products are being sold in accordance with the Act.

DHBs and Smoking Cessation Services are ideally placed to help distribute vaping products to those that have been unable to quit smoking and to those identified in primary or secondary care services. A number of DHBs are currently utilising vaping products as part of their armamentarium in helping smokers quit tobacco.

The cost of NRT is a barrier for whānau, with a course of NRT costing more than a packet of cigarettes. Pharmac currently subsidises some but not all NRT products. Mists and inhalers for instance are not currently subsidised and some interventions are known to work better for some groups than others.

In summary, the health and economic benefits to middle aged and older patients of successful quitting are immense. The economic benefits to the DHBs from reduced readmissions after quitting are also immense and occur in the short-term, i.e., in the months after quitting.

---

[3] PH England report

[4] Wilson N., et al. Improving on estimates of the potential relative harm to health from using modern ENDS (vaping) compared to tobacco smoking. MedRxiv preprint 27 June 2021. https://www.medrxiv.org/content/10.1101/2020.12.22.20248737v2

6. Accelerating progress towards the Smokefree 2025 Goal is possible

Several potential drivers of success are now available:

1. The Government is explicitly committed to the goal as evidenced by comments by Associate Health Minister Hon Ayesha Verrall, the Minister responsible for Smokefree 2025.
2. The options available to cigarette smokers who want to quit are increasing rapidly including vaping devices. These alternative nicotine delivery devices are effective in helping some smokers quit, are cheaper and much less harmful than conventional cigarettes.
3. Legislation was passed in 2020 to ensure that these alternative nicotine products will be widely available, safe and fully regulated. In addition, the legislation and associated regulations will do much to prevent young people from becoming dependent on these alternative nicotine products.
4. Most cigarette smokers express a desire to quit and have already made multiple attempts. The increased range of options now available will increase successful quit rates.

7. DHB Smokefree 2025 priorities

DHBs can and should do much more to accelerate progress towards the Smokefree 2025 Goal. Better help for smokers to quit – Primary Care continues to be a DHB health target. Only one DHB is currently achieving the 90% target and performance varies across DHBs from 56.1% to 91.4% (see appendix 2. for the full data). 395,000 were given brief advice to quit in Q2 2020/21, meeting the 90% target would have resulted in an additional 65,000 smokers receiving brief advice to quit. There is also considerable variation in the performance of stop smoking services as shown in Appendix 3, including an 8 fold variation in referral rates, a 10 fold variation in quit rates and a 6 fold variation in cost per quitter by DHB.

The Ministry of Health funds stop smoking services directly and also provides tobacco control funding to DHBs. The Ministry currently funds 16 stop smoking providers, with a number covering more than one DHB. Five of the 16 are DHB services, the others are a mix of PHOs, Whānau Ora providers or Māori Health Providers. Consideration could be given to amending existing contracts for high performing services with no ceiling on number of quitters per year, and conditional funding per patient for services that achieve beyond their annual targets to cover the additional costs that would be efficiently incurred to achieve more, provided there is evidence of growing their own workforce.

DHBs also have a responsibility for the health of their local population and commission and provide broader health services that refer to stop smoking services. There are challenges linking up these different services at a local level. There is also a lack of visibility and information sharing about how funding is utilised and services are provided. There is therefore a need to work collaboratively at a local level to optimise delivery of stop smoking services.

Counties Manukau Health Living Smokefree Service (LSS) is an example of best practice nationally and is described in Appendix 4. Given inequitable access to health services including primary care it is important that efforts to scale up stop smoking services are complemented by broader efforts to improve access to health services such as whānau ora.

Recommended areas for action

It is recommended that DHBs review stop smoking pathways and services locally and support development of local plans to deliver a fourfold increase in the number of smoking quitters. This should include consideration of opportunities to:

1. *Increase the quality and quantity of referrals to stop smoking services – systematic identification of people who smoke and referral to stop smoking services.*
    - Increasing referrals from primary and community services eg GPs, pharmacies, mental health providers, NGOs with a particular focus on achieving the Better help for smokers to quit health target.
    - Increasing referrals from secondary care by ensuring that all patients who are admitted as cigarette smokers should be encouraged and supported within hospital to be smokefree at all times and referred to smoking cessation.
    - Utilising other opportunistic clinical interventions to provide brief advice and referral to smoking cessation services.
2. *Proactively engage with smokers to reduce drop off in engagement from referrals including developing dedicated pathways and providers for Māori and Pasifika smokers.*
    - Developing dedicated pathways and providers for Maori and Pacific smokers.
    - Reaching into Māori and Pacific communities to provide stop smoking support groups in their communities e.g. Kava groups, Pacific churches and marae.
    - Rigorously following up all smokers referred and supporting them to access stop smoking services that meet their needs at a convenient time, place and setting.
3. *Scale up stop smoking services to deliver the 4 fold increase in smoking quitters required assuming that additional funding is available to deliver this and being careful to ensure a genuine expansion in the trained workforce.*
    - Planning for and establishing smoking cessation services on a sufficient size and scale to deliver the Smokefree 2025 Goal.
    - Recruiting, training, and developing an expanded workforce.
4. *Support the adoption of best practice and supporting local innovation and flexibility.*
    - Developing and training a culturally representative and responsive workforce who are flexible to the needs of clients and their whānau.
    - Ensuring that smoking cessation services are offered in a variety of settings (for example, phone assessments followed up with face to face support, drop-in-clinics in local communities, group-based programmes in workplaces, churches, sports club etc) and in a flexible way (for example, client contact after hours) to reduce barriers to accessing services.
    - Services also need to be tailored to meet the specific needs of the people they are supporting e.g. mental health and addiction service users often need a longer period of support, including support to reduce the amount they smoke before making a quit attempt.

- A variety of cessation methods and tools should be available for all patients, including modern alternative nicotine delivery devices.
- The use of incentives should be encouraged, including vouchers, nicotine replacement therapies, and free vaping starter kits.

5. *Limit the public promotion of vaping products only to smokers who want to quit*
   - Educate staff on the benefits of vaping products as a tool to help smokers quit.
   - Adopt vaping as a specific tool in the armamentarium of the Stop Smoking Services.
   - Provide free vaping products to key priority groups, with a particular focus on pregnant Māori woman and middle-aged people most at risk of disease and early death.
6. *Accelerate public health promotion to young people, non-smokers and non-vapers, to dissuade them from taking up vaping or smoking in the first instance.*
   - Educate the population on the importance of non-smokers not using vapes, particularly youth.
7. *Rigorously measure progress to support improvement.*
   - Ensure the availability of comprehensive and up-to-date cigarette smoking data including by age, sex, ethnicity, and deprivation. NZ Health Survey data will be useful but may require supplementation from other sources.
   - Regularly assess progress towards the Smokefree 2025 Goal.
   - Review DHB Smokefree activities and resources to ensure that the are operating at optimal efficiency and effectiveness.
   - Ministry of Health information should guide all DHB activities, including on lower risk alternatives to cigarettes.

Appendix 1:
The Ministry of Health's national position statement on vaping in the context of Smokefree 2025.

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

9 July 2021

To: DHB Chief Executives

Kia ora koutou katoa

I am writing in support of the Associate Minister of Health, Hon Dr Ayesha Verrall's, Smokefree 2025 priority.

The Government is committed to achieving an equitable Smokefree 2025. This requires us to reduce the burden of preventable death and disease caused by smoking, and to eliminate the health inequities associated with smoking.

Consultation on *Proposals for a Smokefree Aotearoa 2025 Action Plan* closed on 31 March and my officials are analysing these to inform the final action plan. Over 5,000 submissions were received. Thank you for your own well considered submission and for the joint work district health boards have underway to support Smokefree 2025.

It is my expectation that, as part of this work, district health boards will actively support the Government's position that vaping has a role to play in reducing the harm caused by smoking.

Health sector position statements

The following statements, agreed to by all district health boards as part of the development of the Vaping Facts website, remain a sound basis for your approach to vaping:

- the best thing you can do for your health is to be smokefree and vape free
- vaping is not for children or young people
- vaping can help some people quit smoking
- vaping is not harmless but it is much less harmful than smoking
- vaping is not for non-smokers.

The Ministry of Health's position statement (available on its website), which expands on these core statements, is under review and will be updated to take account of legislative developments and any changes in evidence.

Compliance and enforcement of the Smokefree Environments and Regulated Products Act 1990

The Smokefree Environments and Regulated Products Act 1990 (the Act) now regulates vaping products and smokeless tobacco devices, in addition to tobacco products and herbal smoking products.

The Act aims to balance the needs of adult smokers who want to quit using vaping or switch to a less harmful alternative with discouraging non-smokers, especially children and young people, from taking up vaping.

I expect public health units and the Ministry of Health to actively enforce the Act's smoking and vaping provisions, such as the prohibitions on sales to minors and the advertising and promotion restrictions (including online).

I understand that the Ministry is working with public health units to clarify expectations on enforcement activities related to the Act, including the new regulatory controls on vaping and vaping products.

Detailed information about the regulatory regime for vaping products can be found on the Ministry of Health's website: Vaping Regulatory Authority

Monitoring of vaping-related incidents

Please remind health workers to report any adverse vaping events to the Centre for Adverse Reactions Monitoring. This system is used to monitor vaping-related incidents. A specific form for reporting adverse reactions to vaping products is available on CARM's home page: New Zealand Pharmacovigilance Centre. To date, no reports of adverse events in minors from vaping products have been made.

Supporting schools

The Ministry is looking at how the health sector can better support schools to keep students vapefree. I am advised that public health units have been invited to participate in this work and look forward to seeing a coordinated approach develop, together with the education sector.

New regulations

Finally, proposals for regulations under the Act have been consulted on, and the final regulations are due to be approved by Cabinet shortly. I expect the regulations to be publicly notified on 13 July, before taking effect from 11 August 2021.

From that date, manufacturers and importers of vaping products may begin notifying their products and, to continue to be sold in New Zealand, all products must be notified before 11 February 2022. Products are required meet new safety standards before they can be notified.

If you have any questions or require further information about this letter, please contact Sally Stewart, Manager, Tobacco Control (sally.stewart@health.govt.nz).

Nāku noa, nā

Deborah Woodley
Deputy Director-General
Population Health and Prevention

Appendix 2:
Health Target Performance, Better help for smokers to quit - Primary care (Quarter 2 2020/21)

DHB Name	Target %	Achievement %
Auckland	90%	82.3%
Bay of Plenty	90%	87.3%
Canterbury	90%	71.2%
Capital & Coast	90%	80.2%
Counties Manukau	90%	84.3%
Hawke's Bay	90%	56.1%
Hutt Valley	90%	88.3%
Lakes	90%	69.3%
MidCentral	90%	82.9%
Nelson Marlborough	90%	72.9%
Northland	90%	68.5%
South Canterbury	90%	78.8%
Southern	90%	75.5%
Tairawhiti	90%	71.1%
Taranaki	90%	79.7%
Waikato	90%	80.0%
Wairarapa	90%	87.3%
Waitemata	90%	78.9%
West Coast	90%	91.4%
Whanganui	90%	76.9%
National	90%	78.0%

Appendix 3:
Smoking Cessation Performance by Provider, July to December 2020.

	Popn	Referrals	Referral rate per 100,000	Enrolments	CO Validated Quitters	Quit Rate per 100,000 popn	% Quitters	Cost per Quitter
Northland	181,640	764	421	438	108	59	25%	$1,667
ADHB WDHB	1233000	2571	209	1315	277	22	21%	$1,353
CMDHB	586930	3379	576	1046	434	74	41%	$653
Waikato - Tairawhiti	481145	1633	339	834	176	37	21%	$1,651
Bay of Plenty	245290	728	297	375	62	25	17%	$2,139
Lakes	117990	590	500	289	78	66	27%	$1,029
Taranaki	121065	275	227	126	31	26	25%	$2,208
Hawkes Bay	167020	168	101	122	74	44	61%	
Midcentral	181070	669	369	424	55	30	13%	$1,755
Whanaganui	64510	537	832	130	39	60	30%	$2,179
Capital and Coast - Hutt - Wairarapa	521120	1156	222	341	58	11	17%	$3,857
Nelson Marlborough	152920	341	223	216	44	29	20%	$1,931
Canterbury	589060	2061	350	721	180	31	25%	$2,584
South Canterbury	60,940	281	461	174	20	33	11%	$1,776
West Coast	32365	159	491	159	33	102	21%	$1,484
Southern	325770	1105	339	386	183	56	47%	$968

Appendix 4: Case Study: Counties Manukau Health

CM Health is currently funded by the Ministry of Health to provide both core tobacco control activities and the provision of Stop Smoking Services. CM Health employs a team of 8.5 FTE who provide tobacco control leadership, planning and strategy, analysis, support to achieve health targets, delivery of a triage service, health promotion, and national service development work. The Living Smokefree Service (LSS) employs a team of 10 FTE and delivers stop smoking services in individual, whānau or group settings with face to face, phone or digital support. The service currently receives over 7000 referrals per annum.

The LSS has one of the highest quit rates in New Zealand, with a 76.4% CO-validated quit rate at four weeks in 2019/20205. The cost per quitter for the period 2017/18 to 2019/20 was $1275.73, significantly less than the national average. The LSS is successful at equitably enrolling and supporting priority populations who smoke (Māori, Pacific peoples, pregnant women, people with mental illness and/or addictions, youth.

The collaboration between core tobacco control activities and the LSS service is a key enabler of the services success. This ensures that a whole-of-systems approach is used to implement the Smokefree Ask, Brief advice and Cessation support (ABC) in primary, secondary, maternity, mental health, community health and non-health settings. The core tobacco control advisors have strong relationships with staff in these different settings, support workforce development and training, and provide clinical supervision.

Achieving equity is a key focus area for the LSS, and this is achieved through a focus on the priority populations previously outlined, and training a culturally representative and responsive workforce who are flexible to the needs of clients and their whānau. This includes employing a holistic approach to addressing the broader health, social, and cultural needs of whānau.

Services are offered in a variety of settings (for example, phone assessments followed up with face to face support, drop-in-clinics in local communities, group-based programmes in workplaces) and in a flexible way (for example, client contact after hours) to reduce barriers to accessing services. The LSS also champions innovative approaches for smoking cessation, including unique contracting (for example outcome based contracting with incentives for community providers), incentive based programmes, and the use of e-cigarettes in smoking cessation.

[5] Quit rate denominator - people who smoke who set a quit date

FOR INFORMATION

Item: Community Pharmacy Commissioning

Proposed by: Rory Dowding

Meeting of: 4 October 2021

Recommendation

That the CPHAC notes the attached report and endorse the next steps and actions.

Purpose

To provide a response to correspondence from 57 community pharmacies that wrote to the Southern District Health Board requesting that Southern DHB place an urgent moratorium on the issuing of new pharmacy contracts.

Specific Implications For Consideration

Financial

- Any specific Financial implications are included in the report

Quality and Patient Safety

- Any specific Quality and Patient Safety implications are included in the report

Operational Efficiency

- Any specific Operational Efficiency implications are included in the report

Workforce

- Any specific Workforce implications are included in the report

Equity

- Any specific Equity implications are included in the report

Other

- Any Other implications are included in the report

Background

On 29 June, 57 community pharmacies wrote to the Southern District Health Board to request that Southern DHB place an urgent moratorium on the issuing of new pharmacy contracts while an effective local pharmacy contracting policy is developed and introduced to ensure patient safety, access and equity.

Discussion

The New Zealand Health Strategy, SDHB Primary & Community Care Strategy, NZ Pharmacy Action Plan 2016-2020, and the Integrated Pharmacist Services in the Community (ICPSA) contract outline a future in which pharmacist services, as an essential part of an integrated model of care, are delivered in innovative ways, across a broad range of settings, so that all New Zealanders have equitable access to medicines and healthcare services.

ICPSA is a nationally negotiated and agreed contract. It was introduced nationally on 1 October 2018 and is an evergreen contract. IPSCA contains two major parts. The core dispensing and medicines management components are nationally agreed and consistent to all pharmacies. There is also provision for commissioning specific services locally, which can be used to target specific issues, e.g. location, access, unmet need.

Currently, Southern DHB enters into an ICPSA with all pharmacies that apply for an agreement. The application process requires the applicant to meet legislative and regulatory requirements, at which point an application is made to the DHB.

The notion of a DHB policy restricting access to pharmacy contracts has been around for decades. Historically the sector, largely represented by the Pharmacy Guild, have been against any such policy, advocating that market forces should prevail. As competition has increased, both from other pharmacies, and the broader retail sector, the pharmacy sectors position on restricting access to new pharmacy contracts has progressively softened. The letter from local community pharmacy owners specifically mentions the potential entry of a new competitor to the market as the reason for this approach now.

DHBs contract specific pharmacist services funded primarily through dispensing prescription medicines. It is important to note DHBs do not contract for a pharmacy but for specific pharmacist services that are provide by the pharmacy. Pharmacies also provide a range of services and products not funded by DHBs. Most central city pharmacies tend to generate significant portions of their revenue from retail.

Community pharmacy providers in Southern (and nationally) have identified specific issues that have arisen from commissioning services from providers without a policy. These include:

- Location of pharmacies that does not necessarily reflect population need.
- Dilution of workforce
- Impacts on operational efficiency and ability to provide current and future advanced services e.g. minor ailments service or Covid-19 vaccination.

These issues have always been present, and market forces have worked to date. In essence community pharmacy is asking the DHB to manage the market on their behalf. From a DHB perspective there is no evidence that a blunt tool of restricting access to new contracts will have the desired outcome. If we take the rationale that the above issues should be considered on new pharmacy contracts, we could also take this into account for existing contracts and go to market. As stated in their letter, there are 13 pharmacies within a 1.6km radius in Central Dunedin. Applying the criteria above, the DHB would most likely not be able to justify continuing to contract with so many providers. However, in addition to the DHB funded services, they provide a large range of other health and retail services and merchandise, and it is the market that determines and continues to support this. So the discussion on pharmacy contracts is more nuanced and complex than just restricting access to a pharmacy agreement to next potential competitor.

Some DHBs have introduced policies on new pharmacies, with varying impact. Enquiries to a couple of DHBs indicates very few, if any, applications for new pharmacy contracts are rejected. There is risk to legal challenge, especially if there has been an investment made. If a moratorium was put in place, timing could be important. Effective immediately and someone who has started under the current process in good faith could challenge a moratorium.

From a funder perspective, the development of a local community pharmacy strategy or commissioning policy is an opportunity. This would ensure services are commissioned to that meet DHB-specific priorities such as addressing health inequities. It would be then up to the market to determine how this is best achieved. However, with the move Health NZ in nine months, there appears to be little gained in in commencing developing a local strategy at this time.

Next Steps & Actions

1. That Southern DHB continues to offer new Integrated Community Pharmacy Services Agreements to all applicants who meet the legislative and regulatory requirements.
2. Advocate for Health NZ to develop a national strategy and policy on commissioning community pharmacist services that allows for local commissioning to meet specific local needs.
3. Management respond to the community pharmacies that wrote to the Southern DHB.

FOR INFORMATION

Item: Southern DHB –Financial Report For the month ended 31st August 2021

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

Meeting of: Community and Public Health Advisory Committee, 4 October 2021

Recommendation

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

Purpose

To inform the Committee of the August 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

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

- Overall variance of $309k unfavourable for August and $70k unfavourable YTD (excl COVAX)
- Surgical Inpatients YTD $3.28m favourable relates to internal Planned Care expenditure
- Allied Health $372k favourable YTD (excl COVAX)
- PHO services $438k unfavourable YTD.

Discussion

- Public Health covid revenue of $160k recognised in August. This is an informed estimate as information re actual expenditure. A reconciliation and any required adjustment will be done to recognise the correct amount during September.
- Nursing FTE is 8 FTE over budget (excl COVAX), with over 3 FTE being attributable to overtime relating to Covid and 4FTE due to sick leave and accident leave. Additional 3 FTE is effectively budgeted but in outsourced clinical (increased school-based services).
- Allied Health favourable variance reflects recruitment challenges.

Strategy Primary & Community (Excl Covax)														
Exec Hierarchy - LEVEL 3			Actual $000's MTD	Budget $000's MTD	Variance $000's MTD - Fav / (Unfav)	Actual FTE MTD	Budget FTE MTD	Variance FTE MTD	Actual $000's YTD	Budget $000's YTD	Variance $000's YTD - Fav / (Unfav)	YTD Actual FTE	YTD Budget FTE	YTD Variance FTE	Annual Budget
Exec Hierarchy - LEVEL 1	Exec Hierarchy - LEVEL 2	Exec Hierarchy - DESCRIPTION													
Revenue	Government & Crown	MoH Revenue	(84,780)	(88,187)	(3,407)				(173,055)	(176,373)	(3,318)				(1,058,240)
		IDF Revenue	(2,440)	(2,215)	224				(4,646)	(4,431)	215				(26,586)
		Other Government	(715)	(581)	134				(1,386)	(1,183)	203				(6,840)
	Government & Crown Total		(87,934)	(90,983)	(3,049)				(179,087)	(181,987)	(2,901)				(1,091,666)
	Non Government	Other Income	(11)	(36)	(25)				(25)	(73)	(48)				(437)
		Patient related	(18)	(21)	(3)				(26)	(42)	(16)				(253)
	Non Government Total		(29)	(57)	(28)				(51)	(115)	(64)				(690)
	Internal Revenue	Internal Revenue	(2,790)	(2,630)	160				(5,543)	(5,261)	282				(31,564)
	Internal Revenue Total		(2,790)	(2,630)	160				(5,543)	(5,261)	282				(31,564)
Revenue Total			(90,754)	(93,671)	(2,917)				(184,680)	(187,363)	(2,683)				(1,123,920)
Workforce Expenses	Senior Medical Officers (SMO's)	SMO - Direct	713	690	(22)	31.75	32.21	0.46	1,401	1,386	(15)	33.38	32.55	(0.83)	8,247
		SMO - Indirect	37	41	3				83	81	(2)				489
		SMO - Outsourced	6	31	25				19	62	43				336
	Senior Medical Officers (SMO's) Total		756	762	6	31.75	32.21	0.46	1,503	1,530	26	33.38	32.55	(0.83)	9,072
	Registrars / House Officers (RMOs)	RMO - Direct	72	38	(33)	4.79	3.24	(1.55)	138	77	(61)	4.94	3.27	(1.68)	472
		RMO - Indirect	0	2	2				2	4	1				23
	Registrars / House Officers (RMOs) Total		72	40	(32)	4.79	3.24	(1.55)	140	81	(59)	4.94	3.27	(1.68)	494
	Nursing	Nursing - Direct	1,963	2,047	84	255.79	246.29	(9.50)	3,951	3,955	4	259.13	246.49	(12.64)	23,602
		Nursing - Indirect	(4)		4				2		(2)				
		Nursing - Outsourced							1		(1)				
	Nursing Total		1,959	2,047	88	255.79	246.29	(9.50)	3,954	3,955	1	259.13	246.49	(12.64)	23,602
	Allied Health	Allied Health - Direct	1,926	2,140	214	307.84	336.05	28.21	3,881	4,276	395	305.31	336.04	30.73	25,750
		Allied Health - Indirect	14	16	2				41	33	(8)				370
		Allied Health - Outsourced	38	16	(22)				48	33	(15)				193
	Allied Health Total		1,978	2,173	194	307.84	336.05	28.21	3,970	4,341	371	305.31	336.04	30.73	26,312
	Support	Support - Direct	5	1	(4)	0.88	0.21	(0.67)	6	3	(3)	0.64	0.21	(0.43)	10
		Support - Indirect		0	0					0	0				0
		Support - Outsourced	30		(30)				45		(45)				
	Support Total		35	1	(34)	0.88	0.21	(0.67)	51	3	(48)	0.64	0.21	(0.43)	11
	Management & Admin	Management & Administration - Direct	839	807	(32)	119.73	120.89	1.16	1,624	1,665	40	118.75	120.22	1.46	9,611
		Management & Administration - Indirect	1	3	1				4	5	2				32
		Management & Administration - Outsourced	6	1	(5)				18	2	(15)				13
	Management & Admin Total		846	811	(36)	119.73	120.89	1.16	1,645	1,672	27	118.75	120.22	1.46	9,656
Workforce Expenses Total			5,647	5,833	186	720.78	738.89	18.11	11,263	11,582	318	722.15	738.77	16.62	69,147
Non Personnel Expenses	Non Personnel Expenses	Outsourced Clinical Services	138	119	(19)				197	236	39				1,409
		Outsourced Funder Services	1,313	1,267	(45)				2,626	2,535	(91)				15,210
		Clinical Supplies	1,221	1,030	(191)				2,427	2,051	(376)				11,769
		Infrastructure & Non-Clinical Supplies	403	450	48				824	904	79				5,275
	Non Personnel Expenses Total		3,075	2,867	(207)				6,075	5,727	(348)				33,663
	Provider Payments	Personal Health	66,792	69,676	2,884				136,216	139,212	2,996				832,193
		Disability Support	17,055	17,037	(18)				34,054	34,098	45				202,188
		Public Health	281	90	(191)				523	179	(344)				1,077
		Maori Health	292	246	(46)				615	561	(54)				3,228
	Provider Payments Total		84,419	87,048	2,629				171,408	174,051	2,643				1,038,685
Non Personnel Expenses Total			87,494	89,915	2,422				177,483	179,778	2,294				1,072,348
Net (Surplus) / Deficit			2,386	2,077	(309)	720.78	738.89	18.11	4,066	3,996	(70)	722.15	738.77	16.62	17,574

Strategy Primary & Community (Covax)															
Exec Hierarchy - LEVEL 3			Actual $000's MTD	Budget $000's MTD	Variance $000's MTD - Fav / (Unfav)	Actual FTE MTD	Budget FTE MTD	Variance FTE MTD	Actual $000's YTD	Budget $000's YTD	Variance $000's YTD - Fav / (Unfav)	YTD Actual FTE	YTD Budget FTE	YTD Variance FTE	Annual Budget
	Exec Hierarchy - LEVEL 1	Exec Hierarchy - DESCRIPTION													
Revenue	Government & Crown	MoH Revenue	(3,299)		3,299				(4,337)		4,337				
	Government & Crown Total		**(3,299)**		**3,299**				**(4,337)**		**4,337**				
	Internal Revenue	Internal Revenue	(1,403)		1,403				(2,307)		2,307				
	Internal Revenue Total		**(1,403)**		**1,403**				**(2,307)**		**2,307**				
Revenue Total			**(4,702)**		**4,702**				**(6,644)**		**6,644**				
Workforce Expenses	Senior Medical Officers (SMO's)	SMO - Direct	0		(0)				(0)		0				
	Senior Medical Officers (SMO's) Total		**0**		**(0)**				**(0)**		**0**				
	Nursing	Nursing - Direct	584		(584)	70.99		(70.99)	949		(949)	62.20		(62.20)	
		Nursing - Indirect	(0)		0				(0)		0				
	Nursing Total		**584**		**(584)**	**70.99**		**(70.99)**	**949**		**(949)**	**62.20**		**(62.20)**	
	Management & Admin	Management & Administration - Direct	487		(487)	85.22		(85.22)	825		(825)	74.10		(74.10)	
		Management & Administration - Indirect	2		(2)				(2)		2				
		Management & Administration - Outsourced	24		(24)				26		(26)				
	Management & Admin Total		**513**		**(513)**	**85.22**		**(85.22)**	**849**		**(849)**	**74.10**		**(74.10)**	
Workforce Expenses Total			**1,097**		**(1,097)**	**156.21**		**(156.21)**	**1,798**		**(1,798)**	**136.29**		**(136.29)**	
Non Personnel Expenses	Non Personnel Expenses	Outsourced Clinical Services	63		(63)				95		(95)				
		Outsourced Corporate / Governance Services	44		(44)				44		(44)				
		Clinical Supplies	12		(12)				18		(18)				
		Infrastructure & Non-Clinical Supplies	181		(181)				367		(367)				
	Non Personnel Expenses Total		**300**		**(300)**				**524**		**(524)**				
	Provider Payments	Public Health	3,413		(3,413)				4,317		(4,317)				
		Maori Health	(114)		114				0		0				
	Provider Payments Total		**3,299**		**(3,299)**				**4,317**		**(4,317)**				
Non Personnel Expenses Total			**3,599**		**(3,599)**				**4,841**		**(4,841)**				
Net (Surplus) / Deficit			**(6)**		**6**	**156.21**		**(156.21)**	**(5)**		**5**	**136.29**		**(136.29)**	

Requests awaiting approval - Items on Register

Summary

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

- Overall variance of $309k unfavourable for August and $70k unfavourable YTD (excl COVAX)
- Surgical Inpatients YTD $3.28m favourable relates to internal revenue
- Allied Health $372k favourable YTD (excl COVAX)
- PHO services $438k unfavourable YTD.
- Unfavourable PBF adjustment due to a change in the way MOH are funding COVID related Pharmaceutical expenditure.

Comments for discussion

- Public Health covid revenue of $160k recognised in August. This is an informed estimate as information re actual expenditure. A reconciliation and any required adjustment will be done to recognise the correct amount during September.
- Nursing FTE is 8 FTE over budget (excl COVAX), with over 3 FTE being attributable to overtime relating to Covid and 4FTE due to sick leave and accident leave. Additional 3 FTE is effectively budgeted but in outsourced clinical (increased school-based services).
- Allied Health favourable variance reflects recruitment challenges.

Revenue

External Revenue

- ACC revenue $203k favourable YTD. YTD includes $267k of unbudgeted TBIR revenue.
- Planned Care revenue $3.06m unfavourable offset by favourable expenditure.

Internal Revenue

- $282k favourable relates to Public Health Covid revenue.

Workforce Costs

Medical SMO – $6k favourable and 0.46 FTE favourable for the month and $26k favourable YTD. Mainly driven by Ordinary and training offset by overtime, penal & allowances.

Medical RMO – $32k unfavourable and 1.5FTE unfavourable for the month and $59k unfavourable YTD (excl COVAX). Mainly relates to Dental Surgery cost centre which is $58k unfavourable YTD and 1.25 FTE unfavourable.

Nursing – Excluding COVAX expenditure - $88k favourable for August and on budget YTD. 9 FTE unfavourable for August . The main variances are due to:

- The favourable variance for August of $88k when compared to the unfavourable (9 FTE) appears to be due to different mix of nursing staff compared to budget.
- Lakes Nursing 2.6 FTE unfavourable ($5k u). This is down from the prior 3 month average variance of 8.2 FTE
- Vacancy factor budget – Budget includes VF of 3.7 FTE ($48k)
- Southland Rehab ward – 1.4 FTE unfavourable mainly due to Health Service Assistants (2.4 FTE u) offset by Enrolled nurses (1.3FTE f). 5 staff on long term sick leave. 2 have return to work plans with one now exiting organisation. This is expected to resolve over coming months.

- Te Punaka Oraka - Senior nurses (0.6 FTE u), Registered nurses (2.4 FTE u) and Health Service Assistants (0.7 FTE u). Mainly due to additional school based funding where the budget was put against outsourced services and has not been realigned to FTE's .The overall FTE's employed was 3 FTE with the equivalent $$ budgeted in outsourced services. Whilst nursing is $8k over budget, outsourced clinical services are $61k under budget YTD.

Allied Health - $194k and 28 FTE favourable to budget for August and $372k favourable YTD

- Physiotherapists (6 FTE f), Therapists (7 FTE f), Occupational Therapists (6FTE f) and Dental Therapists (4 FTE f) and the main drivers of the favourable variance.

Management/Admin – $40k and 1.1 FTE favourable YTD

Pharmaceuticals

	$000 YTD 2020/21	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
Clinical Supplies - Pharmaceuticals	$ 2,548.2	$ 5,623.7	$ 5,667.0	$ 43.3
Provider Payments - Pharms	$ 6,266.1	$ 13,393.4	$ 13,355.6	-$ 37.8
Haemophillia (medical outpatients)	$ 266.2	$ 659.7	$ 545.7	-$ 114.0
Total	**$ 9,080.5**	**$ 19,676.8**	**$ 19,568.3**	**-$ 108.5**

Variance is made up of the following (estimate)

Pharms YTD		$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
PCT	$ 1,166.8	$ 2,666.5	$ 1,625.3	-$ 1,041.2
Community Pharms (DHB Outpatients)	$ 704.3	$ 1,411.0	$ 1,063.0	-$ 348.0
Hospital Inpatients	$ 677.1	$ 1,546.2	$ 2,978.7	$ 1,432.5
Community Pharms (excl DHB)	$ 6,266.1	$ 13,393.4	$ 13,355.6	-$ 37.8
Haemophillia (medical outpatients)	$ 266.2	$ 659.7	$ 545.7	-$ 114.0
Total	**$ 9,080.5**	**$ 19,676.8**	**$ 19,568.3**	**-$ 108.5**

Community pharmaceuticals are $38k unfavourable.

The Clinical supplies pharmaceuticals unfavourable variance for SPC is $348k, noting the DHB wide Clinical supplies pharmaceuticals favourable variance is $43k.

Outsourced Funder Services

YTD variance $91k unfavourable due to SIAPO payments.

Clinical Supplies (excluding Pharms)

YTD variance $28k unfavourable

Continence($47k) YTD is the main contributor.

Infrastructure & Non-Clinical Supplies

- $48k favourable for August and $79k YTD. Mainly due to patient meals ($31k f) for the month and ($59k f YTD).

Provider Payments (NGO's)

Personal Health

- $2.88m favourable for August and $3.0m favourable YTD.
- PHO lines are $253k unfavourable for August and $438k unfavourable YTD.
    - The majority of the PHO variance is due to Community Service Card ($235k YTD) and VLCA ($100k YTD) expenditure which is offset by extra revenue. $1.5m of the $3.5m primary care savings has not got a firm plan.
- Medical Outpatients are $102k unfavourable YTD due to Haemophilia pool payments.
- Surgical Inpatients $3.06m favourable for August due to Planned Care offset by unfavourable revenue variance.
- Travel and accommodation $224k fav for August and $126k YTD, demand driven and not unexpected due to impact of Covid.
- IDF expenditure is $164k unfavourable for August and $303k YTD due to FFS washups.

Public Health

- $191k unfavourable for August and $344k unfavourable YTD. Unfavourable variance is mainly due to the internal charge expenditure relating to the extra Covid revenue received YTD of $282k. The balance of the variance is due to savings of $53k that have not been attained (noting Public Health Service overall is favourable).

Disability Support

- YTD variance of $46k favourable is due to Residential Care Services $171k favourable , Community Health Services and Support $73k and Carer support $79k favourable offset by Pay Equity $242k unfavourable.

Maori Health

- No significant variances

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:*
Oral Health Services Contracts	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.

*S 34(a), Schedule 4, of the NZ Public Health and Disability Act 2000, allows the Committee 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.