Community & Public Health Advisory Committee Meeting

By Zoom

Lead Director: Andrew Lesperance, Executive Director Planning, Funding and Population/Public Health

01/03/2022 01:00 PM - 03:10 PM

APOLOGIES

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

FOR INFORMATION/NOTING

Item: **Interests Registers**

Proposed by: Jeanette Kloosterman, Board Secretary

Meeting of: Community and Public Health Advisory Committee, 1 March 2022

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 since the last Board meeting:

- 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, Committee and Executive Leadership Team Interests Registers

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Pete Hodgson (Board Chair)	22.12.2020	Trustee, Koputai Lodge Trust (unpaid)	Mental Health Provider	
	22.12.2020	Chair, Callaghan Innovation Board (paid)		
	22.12.2020	Chair, Local Advisory Group, New Dunedin Hospital		
	22.12.2020 (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)~~	Removed 09.12.2021	
	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		
	02.11.2021	Wife, Alison Douglass, Barrister	Has had involvement with SDHB when representing patients.	
	25.06.2021	Director and Shareholder, Kiwood Limited	Nil (farm forestry plot).	
	09.12.2021	Member, Transition Unit's Funding Flows and Incentives Expert Panel (appointed December 2021)		
	09.12.2021	Member: Transition Unit's Primary and Community Expert Panel (appointed October 2021)		
	09.12.2021	Member: Transition Unit's Review of the Primary Care Capitation Formula Expert Panel (appointed October 2021)		
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 Updated 04.12.2021	~~Employed as Specialist, Radiation Oncology~~, Locum SMO, Southern DHB	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~~	Updated 29/10/2021	
	25.06.2021	~~Trustee, New Zealand Brain Tumour Trust~~	Updated 29/10/2021 (Resigned as Trustee)	
	04.12.2021	Trustee, Healthcare Otago Charitable 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.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Tuari Potiki	09.12.2019	Employee, University of Otago		
	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	Employment: Associate Professor, University of Otago	Updated 08.12.2021	
	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)~~	Removed 08.12.2021	
	17.08.2020	Health Research Council Fellow		
	14.01.2022	Sister-in-law, Charge Nurse Manager, Wakari, SDHB		
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.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		
Roger Jarrold (Crown Monitor)	16.01.2020 (Updated 28.01.2021)	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		
	13.01.2022	Chief Medical Officer, 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	
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 Māori 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
	26.10.2017	Nephew, Tax Advisor, Treasury	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	18.12.2017 (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)
John EASTWOOD	19.01.2022	Clinical Director Localities, Interim Health New Zealand	Conflict with matters related to establishment of Localities. Possible conflict with matters related to the Health Reforms and the establishment of Māori Health Authority and Health New Zealand
	19.01.2022	Clinical Professor Department of Preventative and Social Medicine, University of Otago	Conflict with matters related to Department of Preventative and Social Medicine, and possible conflict with matters related to the three UoO Clinical Schools and the University of Otago
	19.01.2022	Adjunct Professor University of New South Wales	Nil
	19.01.2022	Clinical Professor University of Sydney, Sydney, Australia	Nil
	19.01.2022	Executive Clinical Advisor Sydney Local Health District, Sydney, Australia	Nil
	19.01.2022	Director Early Years Research Group, Ingham Institute of Applied Medical Science, Liverpool, New South Wales, Australia	Nil
	19.01.2022	Director of Centre of Research Excellence for Health and Social Care Integration, Sydney, Australia	Nil
	19.01.2022	Co-Chair Sydney Institute for Women Children and their Families, Sydney Local Health District	Nil
	19.01.2022	Co-Chair International Foundation of Integrated Care - Australia	Nil
	19.01.2022	Co-Chair International Foundation of Integrated Care - Aotearoa Steering Committee	Nil
	19.01.2022	Member Royal Australasian College of Physicians Policy and Advocacy Committee (CPAC)	Nil
	19.01.2022	Executive Member of the International Society of Social Paediatrics and Child Health (ISSOP)	Nil
	19.01.2022	Consultant to the World Health Organization, Geneva	Nil
	19.01.2022	Fellow of the New Zealand College of Public Health Medicine	Nil
	19.01.2022	Fellow of the Australasian Faculty of Public Health Medicine	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
	19.01.2022	Fellow of the Royal Australasian College of Physicians	Nil
	19.01.2022	Fellow of the Royal Australasian College of Medical Administrators	Nil
	19.01.2022	Fellow and Certified Health Executive of the Australasian College of Health Services Managers	Nil
	19.01.2022	Wife - General Practitioner at Mosgiel Health Centre, Mosgiel	Possible conflict with any SDHB contract negotiations with the General Practice
	19.01.2022	Wife - Contracted medical educator for the Royal New Zealand College of General Practice	Nil
	19.01.2022	Member of the Medical Assurance Society (MAS)	Nil
David GOW	07.12.2021	Private Clinic, Mercy Hospital	
	07.12.2021	Wife employed by SDHB as Nurse Consultant for Quality Improvement	
Andrew LESPERANCE	20.12.2021	Son, employee, HR Department, Ministry of Health (working with IT team recruitment)	
	20.12.2021	Director, Secretan Family Trust	
	20.12.2021	Former Director, North Island PHO (resigned when appointed to SDHB)	
	20.12.2021	Daughter, Project Co-ordinator, Ministry of Education	
	20.12.2021	Son, student, University of Otago (accounting major)	
Hywel LLOYD	16.06.2021	GP, Mosgiel Health Centre	
	16.0.2021	Wife, Nurse, Paediatric Outpatients	
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	
	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.

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
	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 Māori illicit drug use to primary care and in Māori 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

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, 6 December 2021, commencing at 1.00 pm, in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mr Tuari Potiki	Chair
	A/Prof Moana Theodore	Deputy Chair
	Prof Peter Crampton	
	Mrs Kaye Crowther	
	Dr Lyndell Kelly	
	Mr Terry King	
In Attendance:	Mr Pete Hodgson	Board Chair
	Dr John Chambers	Board Member
	Mrs Jean O'Callaghan	Board Member
	Ms Lesley Soper	Board Member *(by Zoom)*
	Mr Roger Jarrold	Crown Monitor *(by Zoom)*
	Mr Chris Fleming	Chief Executive Officer
	Mr Rory Dowding	Acting Executive Director Planning, Funding and Population/Public Health
	Mr Andrew Lesperance	Executive Director Planning, Funding and Population/Public Health
	Prof John Eastwood	Chief Medical Officer
	Dr Hywel Lloyd	Director Quality and Clinical Governance Solutions
	Dr Nicola Mutch	Executive Director Communications
	Mr Andrew Swanson-Dobbs	Chief Executive, WellSouth Primary Health Network *(until 3.10 pm)*
	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:

- Dr Ben Pearson, Crown Monitor
- Dr Doug Hill, who advised he was absenting himself due to his conflict with agenda item 10, Access to After Hours Primary Care
- Ms Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer
- Ms Jane Wilson, Chief Nursing and Midwifery Officer

3.0 DECLARATION OF INTERESTS

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

The Chair asked that any changes to the registers be sent to the Board Secretary and reminded everyone of their obligation to advise the meeting should any potential conflict arise during discussions.

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the meeting held on 4 October 2021 be approved and adopted as a correct record."

T Potiki/L Kelly

5.0 MATTERS ARISING

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

6.0 REVIEW OF ACTION SHEET

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

- *Dental Waiting List* – Oral health issues were still being worked through collaboratively with the Dental School to determine how services would be provided in the future.
- *Opioid Substitution Treatment* – an update should be available for the next meeting.

7.0 PLANNING, FUNDING AND POPULATION/PUBLIC HEALTH REPORT

The Planning, Funding and Population/Public Health Report (tab 9) was taken as read and the Acting Executive Director, Planning, Funding and Population/Public Health (EDPF&P/PH) highlighted the following items.

- *Public Health COVID-19 Response* - A significant amount of work was going into endemic planning whilst trying to maintain business as usual (BAU).
- *COVID-19 Vaccination Programme* – Southern DHB had reached 89.5% double vaccinated, with 76% of Māori double vaccinated. The focus of the programme had changed from mass vaccination to a targeted approach.
- *Public Health* – As Public Health staff were focused on COVID-19 activity, most of their business as usual had ceased. Efforts were being made to bolster the Public Health team.
- *Allied Health* – Southland physiotherapy recruitment continued to be a challenge. Two physiotherapists had commenced in the past month and another had arrived in Invercargill after clearing MIQ. Five new graduates, who would need to be supported by a clinical coach, would be starting in late January.
- *Aged Residential Care (ARC) Registered Nurse Workforce* – The COVID vaccination mandate had added another layer of complexity to recruiting and retaining ARC registered nurses. The Health of Older People Portfolio Manager and Director of Nursing, Planning, Funding, and Population/Public Health, were putting considerable effort into addressing this issue and a part-time workforce

co-ordinator had been employed to assist approximately 150 international nurses within the district gain registration.

Management responded to questions on resourcing for COVID community welfare checks, long COVID, community isolation facilities, and retaining medical and allied health graduates in the district.

8.0 PRESENTATIONS

New Zealand Police

Superintendent Paul Basham, District Commander, Southern Police District, Ian Futcher, Senior Advisor Partnerships and Harm Prevention, Senior Sergeant Cynthia Fairley, District Co-ordinator for Resilience to Organised Crime in Communities (ROCC), Marissa Cliff, National Drug Intelligence Bureau, and Constable Kerry Fegan, were welcomed to the meeting and a round of introductions followed.

In presenting the *Resilience to Organised Crime in Communities (ROCC)* programme (tab 17.2), Superintendent Basham advised that traditionally Police were the lead in dealing with organised crime, however over the years they had found enforcement on its own was insufficient to reduce harm from the illicit drug trade and demand needed to be "dialled down". They had therefore introduced a kaupapa for building resilience to organised crime in communities and were interested in partnering with others who had a good understanding of the issues.

ROCC was a Cabinet mandated response to the harm in communities and latterly had been weighted towards a programme rolled out in Northland called *Te Ara Oranga*, a joint programme between Police, the local DHB and other agencies with an interest in the problem of drug addiction and harm. ROCC was focused on partnering with iwi, central and local government and other agencies, and on community support and solutions. Three conditions for its success had been identified:

1. Understanding community aspirations
2. Strong local governance and leadership
3. Sustained investment and local decision making.

Mr Futcher advised that analysis had shown the programme in Northland to be successful.

Superintendent Basham sought Southern DHB's support for two things: increasing wastewater testing in the Southern district, particularly in areas where there was deprivation, to gain an understanding of the actual harm occurring in communities and, secondly, he invited Southern DHB to think about whether the *Te Ara Oranga* programme could be applied locally. Superintendent Basham advised that they came into the kaupapa with an open mind and were keen to be a good partner in reducing harm from illicit drugs.

The Police team then responded to questions on illicit drug use in the district, the health versus legal pathway for dealing with it, their views on local mental health and addiction services, equity and engagement with iwi, mechanisms and models for implementation, and what produced results.

The Chair thanked Superintendent Basham and his team for their presentation and noted the Committee's support for looking at opportunities to work together to help people. He noted sharing information from wastewater testing to inform the

provision of health services as an opportunity to achieve a mutually beneficial result.

Managing COVID-19 in the Community

The Committee received a high level presentation from Dr Hywel Lloyd, Director Quality and Clinical Governance Solutions, on the work being undertaken, and the interactions required, to support COVID-19 positive people and whānau in the community. This included an outline of the underpinning principles and the core components of managing COVID-19 in the community, ie community care (welfare and wellbeing), primary care (clinical support), public health, and specialist and hospital services (tab 17.1).

Dr Lloyd then responded to questions on support for community isolation/quarantine (SIQ) facilities and support for primary care.

The Committee thanked Dr Lloyd and his team, the PHO, and MSD for their hard work.

9.0 PLANNING, FUNDING AND POPULATION/PUBLIC HEALTH REPORT (Continued)

The Acting Executive Director, Planning, Funding and Population/Public Health (EDPF&P/PH) highlighted the following items from his report (tab 9), then took questions.

- *Annual Plan* - The Ministers of Health and Finance had approved and signed the Southern DHB Annual Plan for 2021/22.

- *Hepatitis C* – A query had been received about access to Hepatitis C treatments in Southern DHB and the team were currently collating that information.

  The Chair noted that Southern DHB had the highest incidence of Hepatitis C in the country and theoretically it was possible to eliminate it with the treatment now available.

10.0 ACCESS TO AFTER-HOURS PRIMARY HEALTH CARE IN SOUTHERN

The Acting EDPF&P/PH presented a report on current arrangements for the provision of, and access to, after-hours primary health care within the Southern district (tab 10). He advised that the paper had been written in response to a request for information from the Committee; it deliberately set out the facts and did not attempt to provide any answers.

Members thanked the Acting EDPF&P/PH for his report and noted the inequity across the district, the constraints, and pressures on the after-hours primary care system.

11.0 PHO PERFORMANCE UPDATE

The Acting EDPF&P/PH presented a report on primary care performance (tab 11), noting the work was undertaken in the context of COVID endemic preparations and the vaccination effort.

12.0 PUBLIC HEALTH UPDATE

The Committee received updates on public health issues, including the Water Fluoridation Bill, Taumata Arowai, the new drinking water regulator for Aotearoa, and the Vincent Spatial Plan (tab 14).

The Acting EDPF&P/PH reported that most of the Population/Public Health Service's 'business as usual' activity had been paused to respond to the Delta outbreak.

13.0 FINANCE REPORT

A report on Planning, Funding and Population/Public Health financial performance to 31 October 2021 (tab 15) was taken as read. The Acting EDPF&P/PH commented on the variances, then responded to questions.

ASD Treatment

In response to a member's query, the Acting Executive Director Mental Health, Addictions and Intellectual Disability (ED MHAID) and Chief Executive, WellSouth, agreed to report back on access to treatment for autism spectrum disorder (ASD).

The Chief Executive, WellSouth Primary Health Network, left the meeting at 3.10 pm.

14.0 MĀORI HEALTH UPDATE

The Chief Māori Health Strategy and Improvement Officer (CMHS&IO) presented an update on the Māori Health Directorate work programme and Māori primary care enrolment (tab 12), and reported the Iwi Governance Committee had a good meeting that morning.

The Committee congratulated the team on their work, particularly their COVID vaccination efforts, and acknowledged the leadership provided by the CMHS&IO and Professor Sue Crengle.

The CMHS&IO noted his concern about the welfare of the workforce and the risk of staff burnout.

15.0 GENERAL

Mr Rory Dowding was thanked for his work and commitment during his time as Acting Executive Director Planning, Funding and Population/Public Health.

PUBLIC EXCLUDED SESSION

***At 3.20 pm it* was *resolved*:**

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.
Healthy Food and Drink Policy	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.

T Potiki/T King

***It* was *resolved*:**

"That the Committee resume in open meeting and the business transacted in committee be confirmed."

The meeting closed at 3.30 pm.

Confirmed as a true and correct record:

Chair: _____

Date: _____

Southern District Health Board

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE MEETING

ACTION SHEET

As at 17 February 2022

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
August 2021	**Dental General Anaesthetic Waiting List** (Minute 10.0)	Further advice, including possible solutions, to be submitted to the September HAC meeting.	EDPFP/PH	Paper submitted to March meeting	Completed
Sept 2021	(HAC minute 6.0)	The report being prepared for CPHAC is to include the possibility of the Dental School providing dental chairs further south.		Will be factored into future service planning regarding the Dental School.	Completed
October 2021	**Opioid Substitution Treatment** (Minute 9.0)	Management to report back on proposed solutions.	Acting MHAID	Any prioritisation of new investment needs to be through Time For Change not isolated area by area requests.	
December 2021	**Autism Spectrum Disorder (ASD)** (Minute 13.0)	Information to be provided on access to ASD treatment within the district.	Acting MHAID/ WellSouth CEO		

FOR INFORMATION

Item: Dental General Anaesthetic Waiting List Action

Proposed by: Toni McKillop, Oral Health Service Manager

Meeting of: Community and Public Health Advisory Committee, 1 March 2022

Recommendation

That the Community & Public Health Advisory Committee (CPHAC) notes the attached report and endorse next steps.

Purpose

To provide an update to the Community and Public Health Advisory Committee of the recommended process and ongoing management for children overdue for their scheduled examinations on the Paediatric General Anaesthetic Sedation waiting list, currently managed by the Faculty of Dentistry (FOD).

Progress report regards the review of the Oral Health Heads agreement and its subcontracts, in respect of overall management, expectations and reporting requirements of all the subcontracts that come under the Heads of agreement between the Faculty of Dentistry and the Southern District Health Board.

Specific Implication for Consideration

1. Financial
    - An alternative to the current funding model between South District Health Board (SDHB) and FOD is outlined in this report.
2. Quality and Patient Safety
    - More appropriately targeted resource allocation and provide improved timeframes for patient review and treatment.
3. Operational Efficiency
    - Improved efficiency for the ongoing management of the referral list of children between the FOD and the SDHB specifically related to the Sedation list.
4. Workforce
    - The planning and sourcing of oral health services for children on the Sedation list in Dunedin will be impacted.
5. Equity
    - Ensuring the ongoing management of the sedation referral list meets the needs of the patients referred in a timely and efficient manner.
6. Other
    - Nil

Background

The Southern District Health Board and Otago University continue to have a collegial relationship around the management of children referred from the Community Oral Health Service (COHS) to the Faculty of Dentistry (FOD) for specialised dental care. Both the FOD and the SDHB recognises the need to work alongside each other to ensure prompt and appropriate care is provided in a timely manner. The Southern District Health Board and the University look forward to continuing a long and high trust relationship both collegial and professional.

Discussion

As a result of the last CPHAC presentation Oral Health was asked to review the Oral Health Heads agreement and associated contracts including:

- Oral Health Heads agreement
- Refugee Contract
- Sleep Apnoea Contract
- Emergency Dental Service Contract
- Inpatients/Outpatients Hospital Service Contract

Currently all the contracts are in draft form and are in the process of being reviewed and commented on by Oral Health and Faculty of Dentistry management, all contracts are aligned and reflect the lasts MOH specifications in Oral Health.

As a result of this, SDHB Oral Health and the Faculty of Dentistry are working alongside Project Manager Becky Wilson to provide an external pathway for managing the Sedation list in the Otago area. Currently the proposed pathway consists of:

An administrator overseeing the sedation waitlist process (this being district wide, fixed term position)

An administrator to oversee the process and support with the effective implementation of the change process, oversight and management of all incoming and outgoing emails. Network and coordinate closely with other surgical waitlist services involved in the management of the district wide sedation service

- A single point of entry (SPOE) for all sedation lists district wide.

This enables closer monitoring of incoming and outgoing referrals, oversight of which provider the referrals have gone to, the timeframes are adhered to, and which service is treating.

- Clinical triage team on a weekly rotation reviewing the referrals.

Currently we are looking at 3 senior clinicians to clinically manage the SPOE triage system, these clinicians will rotate 1 week on, over a 3-week period, providing the clinical insight for the referrals, advice and discussions between providers regarding any cases for problem solving, potential for tele-dentistry with patients and their parents for clinical and priority assessment.

- Shared Titanium access between the faculty and SDHB

Sharing would enable both faculty and external providers to enter treatment notes directly into the SDHB titanium (electronic oral health record) in real time providing an accurate and up to date clinical record.

- Preferred providers in the community

  A service to provide another option of care and support in Dunedin, as private providers they are efficient at treating and discharging the cases given them back to Community Oral Health, and provide invaluable, efficient and competent support.

- Reviewing theatre space, if required

  Currently the faculty uses its own theatres to manage these cases, but Oral Health is also working alongside other providers to manage the Southland sedation list (eg surgical bus). Going forward we are looking to review and consolidate this activity.

- Reporting and auditing feedback loop to manage timeframes, identify any issues and elevate to the appropriate people to sort for prompt and timely manner.

  We are currently working closely with the faculty to establish quarterly and annual reporting from all the current contracts being reviewed with the intention of providing up to date data for performance against the contract's specifications, budget management, avenues for effective communication and more rapid identification of any issues.

The Oral Health and Faculty teams are working closely together to achieve an improved and robust Oral Health Service across Otago, it is anticipated that once we have delivered the contracts on the 31st of March 2022, a transition period will be required to enable both organisations to align their services with the new processes.

Added to this report is Project Manager Becky Report – Appendix 1

Next Steps & Actions 2021-2022

New Contracts agreed and completed by the 31st of March 2022

Establish a fixed term administrator into position to manage and support the process in the background.

SDHB will continue to work in partnership with the FOD, to identify solutions and continue to refer patients to the FOD within the faculty's capacity to deliver on these.

For the SDHB Oral Health and the Faculty of Dentistry to establish a timeframe for a transition period and expectations for both organisation on completion of that date.

Board Update February 2022

Paediatric General Anaesthetic and Sedation Contract and Process Changes

Current Issue: -

Due to ongoing concerns around visibility of referrals into the Otago University School of Dentistry/Faculty of Dentistry (FoD) for Paediatric General Anaesthetic and sedation a project has been initiated in 2021 to clarify the root cause of these issues and find solutions. The early planning phase of this project was completed between Oct 21-Jan 22. Key issues identified included FoD capacity concerns and lack of visibility of referrals into this system.

Stake holders consulted with during the planning phase of this project included internal Southern DHB Community Oral Health teams, and FoD.

The scope of this project within phase one, was Paediatric General Anaesthetic and Sedation wait list. The new process that has been developed aims to be implemented at the end of March 2022. The current contracts are due expire on the 31 March 2022, new contracts will be provided at this point that will outline the new procedure, timeframes, and reporting schedule.

It is anticipated that due to this new process the true capacity of the Dental School will be visible, subsequently there now needs to be a process to ensure the capacity is met elsewhere. As a consequence, to streamlining the FOD GA wait and sedation, addition support through Dental Private Practice within the community is currently underway.

New General Anaesthetic/Sedation process: - Proposed process – go live end of March 2022.

1) Single point of entry

All referrals for Paediatric sedation and General Anaesthetic. will be internally entered in Titanium by Community Oral Health Teams as per current process. Referrals from external Dental Private Practices will be requested to go through a central email (currently set up) and upload into Titanium by Admin teams. This will ensure true visibility of referrals into the system. Referrals will be triaged by current internal DHB Dentists (Nick Tim, Mitten) to ascertain correct direction for referral, this may include further investigation through Telehealth as required (FoD or Preferred Provider).

2) Shared Titanium platform use

The FoD and Preferred Providers will have access into the Southern DHB Titanium platform to review triaged referrals on a daily basis and accept or decline these referrals depending on their capacity. This new process will be monitored by Oral Health Administration and escalated to Dental Team as required. The FoD and Preferred provider would utilise Southern DHB titanium systems to complete clinical notes on procedures completed and close the referral within the Titanium platform system within time frames specified within their contract.

FOR INFORMATION

Item: Planning, Funding & Population/Public Health Report

Proposed by: Andrew Lesperance, Executive Director Planning, Funding & Population/Public Health

Meeting of: Community and Public Health Advisory Committee, 1 March 2022

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 Planning, Funding & Population/Public Health 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

Through the month of January there have been 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. At the time of writing, our first Covid + patient / case has been announced.

Endemic COVID Planning

A number of the team within the Planning, Funding and Public/Population Health directorate have been supporting organisations across the health system with endemic COVD planning. Focus areas include Patient Transport (via St John ambulance), Rural Health, Public Health and Managing COVID-19 in the community (eg Aged Residential Care).

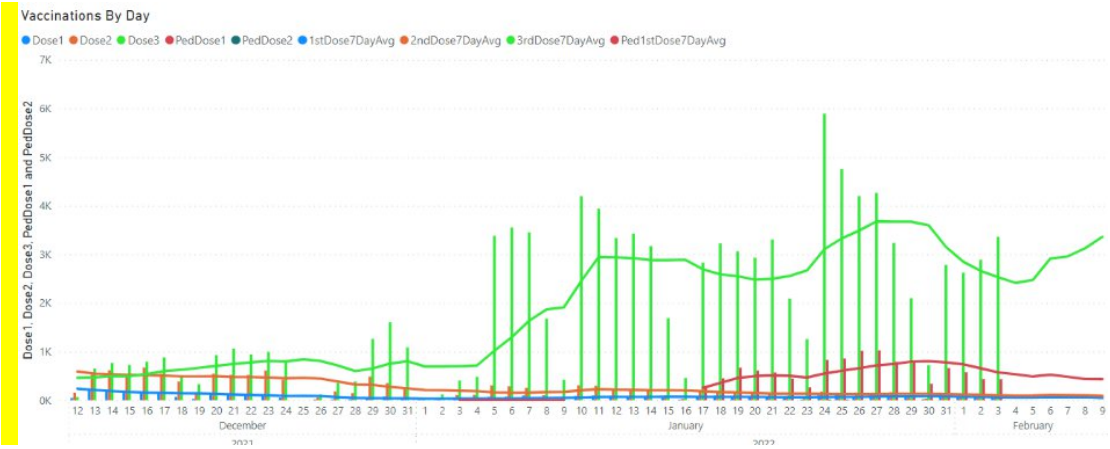
Since the implementation of New Zealand's COVID 19 elimination strategy, almost all COVID 19 positive people have been managed through dedicated quarantine facilities. This has included managing their health needs, accommodation support, welfare, and any broader needs. As New Zealand's double vaccination rate approaches 90% nationally, the government has signalled moving into a new phase where we will be managing COVID 19 more flexibly in the community. A coordinated and responsive delivery of quarantine support options is required when cases arise.

The below image is illustrative of the managing COVID in the community components interact.

Covid-19 Vaccination Programme

The month of January saw our booster demand significantly increase to numbers we have not seen since October. The graph below shows the daily demand for January.

.



5-11 Vaccinations

The phased rollout began in the Southern district on 17 January 2022, with 20 providers delivering 5-11 year old vaccinations in the first week, increasing to 61 providers by the end of January. We have continued to actively bring new General Practice and Pharmacy sites on-board to deliver 5–11-year-old vaccinations. Delivering vaccines for our youth, while running business as usual has proven challenging for some businesses. We have had some providers pull-out from offering vaccinations to this age cohort within some key areas. This increases the need for our mass vaccination centres and demand for outreach clinics.

Specialist Paediatric Covid-19 Vaccination Clinics have been organised at Dunedin Hospital and Southland Hospital to assist tamariki unable to receive their Covid-19 vaccination through community clinics or home visits. Play Specialists, Paediatricians (for sedation where necessary) and Psychologists will be available for input alongside the Covid-19 vaccinators. General Practice can refer to these clinics via Electronic Referral Management System (ERMS).

Pharmacies and 5–11-year-old Immunisations

From 18 January 2022 pharmacy providers who had opted to deliver paediatric Covid-19 immunisations started vaccinating. The rollout occurred in a staggered approach due to Immunisation Coordination resource and provider timeliness in completing the training and necessary documents. As a result, 19 of 35 pharmacies now offer 5–11-year-old immunisations in the Southern district.

We are grateful for the primary and community workforce efforts including PHO, GP practices and pharmacies in progressing this essential service across our community.

Māori and Pacific Population Rollout

Māori and Pacific Health Providers continue to deliver outstanding services for 5-11 years olds across the district. Māori Health Providers continue to undertake large drive through models that accommodate both the 5-11 year old and adult vaccinations, this is very effective and currently providing large numbers of vaccinations. This includes:

- Te Kaika Drive Through, Dunedin, 5 days a week 9am – 6pm;
- Awarua Whānau Services Drive through in Invercargill, 7 days a week 11am – 7pm.
- He Puna Waiora, Invercargill, have 5 days a week clinics 9am – 6pm and one late night

Two Māori Health Providers have partnered to provide vaccination services across Rural Southland with a focus on 5-11 years and boosters. Māori Health Provider Outreach Services continue to provide vaccinations including Measles, Mumps and Rubella (MMR) and Human Papillomavirus Vaccination (HPV) in the home for 5–11-year-olds and their whānau. Clinic hours pivot to meet Māori community demands with Drive through, onsite clinics and outreach clinics changing hours and venues across the district as needed.

We are planning for Whānau Days for Māori communities in each locality, led by local Rūnuka and Māori Health Providers.

Southern District Health Board (Southern DHB) has engaged with Te Rūnanga o Ngāi Tahu (TRONT) to obtain up to date data on the schools who have children aged 5-11 years old and 12-15 years who whakapapa to Ngāi Tahu (see below). We have engaged with the Ministry of Education to obtain school ethnicity data to inform an effective rollout of the 5–11-year-old vaccination programme for Southern. Our Māori and Pacific Providers have existing relationships with schools and will continue to seek consent to offer vaccinations in a manner that would work for schools and communities.

Aged Residential Care

Booster doses in Aged Residential Care facilities began on 1 December 2021. We anticipate booster dose clinics to have been held at all 66 facilities in our district by 2 February 2022.

Mental Health and Addictions

Administration of booster doses in Mental Health and Addiction facilities began on 12 December. We anticipate booster dose clinics to have been held at all facilities we have worked with previously in February.

Disability

Administration of booster doses in partnership with Disability Support Services providers for their community and residential clients began on 17 December. Some providers have chosen to utilise client's General Practitioners (GPs) who were not vaccinating initially. We anticipate booster dose clinics for this cohort to be complete at the end of February.

Covid-19 Vaccination Outreach Service

The Covid-19 Vaccination Outreach Service has recommenced following a break over Christmas. In 2021 the Outreach Service administered 4,773 vaccinations to hard-to-reach individuals and health care workers. An outstanding effort!

All-In Vaccinations

Initial discussions were held with the newly appointed Measles Campaign Coordinator on consolidating vaccinations into both the Meridian and Victoria room clinics, including our in-home visits and rural outreach. This would involve bringing the Covid-19 Pfizer vaccine into Public Health nursing and the MMR, flu vaccine, and childhood immunisations into the Covid-19 vaccination providers. In addition, we expect Covid Immunisation Register (CIR) to be linked into National Immunisation Register (NIR) through a new system in April 2022; it will be simpler to record multiple vaccinations at one time.

Public Health Response

Covid-19 Response – Update

The Public Health team continues to support the national Covid-19 response for case and contact management. Public Health South currently have two teams operating on a 7-day roster. They are currently supporting Bay of Plenty (Toi Te Ora) with their cases and will respond to Southern cases when they occur (recalling we have one case at the time of writing). The decision to move our support to Toi Te Ora was based on getting our response teams working in a 'stamp it out' model which is the model our service would follow when we start getting cases in the Southern district. In addition, the team are investigating any exposure events that have occurred in the Southern district. This has happened when people have been holidaying in our district and tested positive when they returned home.

Planning is underway for an Omicron outbreak. This is largely reliant on information being available from the Ministry of Health and what direction they are wanting Public Health Units to take to support a national and local response. We are currently planning for two stages with the first few cases following the 'stamp it out' model and moving to a 'manage it' model as soon as we have community transmission. The manage it model is being reviewed to see if we need to break this into two phases.

As part of this planning a large amount of training and upskilling will be undertaken. This is to align with the Ministry of Health guidance that when we have community transmission the Public Health Units will move to predominantly focusing on high-risk exposure events and outbreak management. We will also need to support vulnerable or disabled populations who are unable to use the online system that will be implemented for self-registration/self-management for positive cases.

We have had a number of new staff who have started over the past month in the Covid response unit. These staff have started their training and are currently based in our Dunedin office. These additional staff have given us the ability to release some of our Public Health staff back to business as usual.

The Queenstown airport health team continue to be utilised in the case and contact management teams and as vaccinators at the vaccination clinics. The Regulatory and Protection team are working closely with the airport stakeholders and Ministry of Health in preparation for 're-connecting New Zealand.'

Community Supported Isolation/Quarantine

Alternative accommodation in Queenstown and Invercargill has been used to isolate contacts as required. The activation of a coordination hub will be established as numbers needing this support rise. Aaron Lodge is set up for accommodating cases if people are required to isolate and require alternative accommodation.

The Ministry of Social Development have taken delivery of welfare for cases and contacts isolating in our district. We are continuing to work closely with the Ministry of Social Development to ensure there are no gaps in the system. We are continuing to engage with local community groups and agencies to keep them updated on the situation and assist in developing plans for a Covid-19 response.

The Community Supported Isolation/Quarantine (SIQ) function now falls under "Care in the Community" in the Ministry of Health.

Covid-19 Community Resiliency

With a shift in focus of our interventions into Covid–19 with the threat of the Omicron strain, our work on the resiliency project reported in November and December has taken on a new urgency in that many of the settings that we have developed relationships with will be priority when we move into the 'manage-it' phase of the Omicron pandemic. Our relationships with transitional housing providers, boarding-houses, early learning services, Kohanga Reo, and disability services networks will be useful in terms of dissemination of planning information and providing a point of contact to understand the impact of Omicron and subsequently supporting effective interventions for its management as we move into the 'manage it' phases. We have a database of these locations that connect with the national Covid-19 case management system (NTCS).

Frailty Pathway

This project's objective is to develop a best practice pathway for our frail older population accessing supports from the Southern DHB. Initially the scope of this project was centred on people living in the community. However, a recent evaluation by the Frailty Steering Committee (both community and hospital based) indicated that a change in governance approach is now needed. This is to enable a streamlined 'whole of system' based approach to Frailty, therefore a Frailty Council has now been created to unify other frailty steering groups within the Southern DHB (community and hospital based). Key work streams include maximising system wide communication through the use of electronic Shared Care Plans (within Health Connect South) and reducing fractures and falls in our frail population. The Frailty Council will report to the Clinical Council on direction and outcomes.

Other Emerging Issues

Allied Health

Recruitment to Southland physiotherapy is now showing results. Four new graduate physiotherapists started work in late January. While numbers have increased, several of these staff are new to the profession. Therefore we are putting in place additional staff supports.

Outsourcing of outpatient work continues. This outsourcing will be reduced as DHB capacity increases.

Dunedin is also noting some increasing challenges recruiting allied health, especially for people with higher/specialist skill levels.

Aged Residential Care (ARC) Workforce Shortages and Omicron Readiness

Efforts over January focussed on supporting ARCs to plan and manage, despite their current workforce shortages, during the upcoming Omicron Outbreak.

Registered nurse shifts in some hospital level facilities continue to be uncovered, beds continue to be closed due to lack of staffing, and admissions delayed/denied. Routine audits are now also identifying more issues than in the past. Corrective Actions from audit are delayed due to management covering RN shifts on the floors.

The Sector has developed a Recruitment Code of Conduct, to create a climate of 'fair play' for all as the Sector competes for limited workforce. To date, five ARCs have signed, with many others considering.

Ongoing attempts to secure N95s for ARC resulted in two pallets of PPE arriving with SDHB Procurement. These are intended for ARC facilities with an outbreak of covid-positive residents, ongoing supply of PPE will then occur directly from MOH to the affected ARC.

Whilst FiT testing is a requirement under NZS1715:2009, the MoH has acknowledged the potentially limited benefits in the current circumstances and has provided guidance on risk assessment and seal testing where Fit Testing is not a realistic option. Some ARCs have obtained Fit Testing Kits and trained Fit Testers, but the lack of supply of masks prohibits best practice from occurring. ARC facilities are mentioning funding for meeting the requirements of NZS1715:2009 is an issue.

A daily survey of ARCs to give SDHB ECC (Emergency Coordination Centre) visibility of issues has been developed, socialised with the Sector and will be put in place on 4 February 2022. Responses will be automatically uploaded and Power BI reports created.

Home & Community Support Services (HCSS) Workforce and Service Delivery

Workforce Shortages continue to plague the HCSS Sector, with more staff leaving due to the additional Booster requirement to the Mandatory Vaccination Order.

Agencies are prioritising supports based on client need, circumstances and workforce availability. All referrals for domestic services have not been accepted since November 2020 and are unlikely to be considered until the workforce recovers, post-Omicron.

We continue to seek confirmation of how the HCSS Sector will access N95 masks as we expect them to continue to support their clients when they are covid-positive.

STRATEGY AND PLANNING

Service Planning

The Surgery and Radiology Directorate and the Medicine Directorate have held all-of-Directorate presentations and discussions during 2021, and draft Directorate plans continue to be developed. In addition, the 21/22 individual Service Plans for General Medicine, Endocrinology and Rheumatology have been reviewed and updated, and the reviews of Service Plans for Emergency Departments and Cardiology are progressing. The Southern Blood and Cancer (SBCS) Service Plan is on track with key objectives and work plans. The SDHB has recently commissioned Ernst Young to provide advice on the development of a three-year action plan for the SBCS looking at workforce resourcing relative to service delivery, with recommendations for action between 2022-2024.

From an overall service planning perspective there are three areas for development suggested:

1. Guidance on constraints and directions of the new health reforms, and the delivery of specialist services.
2. Information and direction from the executive leadership team, and which is communicated to all levels, on models of care (e.g. new Dunedin Hospital MOC and implications for Southland, hub and spoke, regional or local, IDF volume), strategic aims, key principles. This may overlap with findings from our latest Strategic Review.
3. Build in expectation of routine discussion/communications within each Directorate of progress against service plan and the Directorate Plan, and checking alignment to the strategic goals.

Health Needs Assessment

Progress delivering the Health Needs Assessment has been slower than expected due to staff being reallocated to covid related duties.

This said, the Project Lead has engaged with communications to support with a soft-style launch for the 40 indicators that are deployed on the website and have draft narratives appended.

Final QA is still pending to ensure data integrity. A presentation on the HNA will be provided to the CPHAC

Regional Planning

There is an increasing drive from MOH to ensure our work is collaborative and joined up regionally. A review of the regional priorities / areas of work is currently underway and will be reported on next month.

Operational Updates

Public Health Service

Locality Prototypes

Staff have been working to support the establishment of Locality prototypes in the Southern District. There is a requirement that these are Iwi driven and partnership based and prototypes are currently being led by the Hokonui and Moeraki Runaka. We have established relationships with leaders in both Runaka and our approach has been to offer whatever support we can for applications to Health New Zealand. To date this has been the production of a data informed narrative that Te Rūnanga o Moeraki can take to their Manawhenua groups to inform discussion that in turn will inform their application. We are securing high level data that will combine data from the Gore and Clutha districts to inform the Hokonui proposal if that is requested. The Iwi Governance group have been leading the discussions around locality "boundaries". The first tranche of applications need to be lodged by 18 February 2022 with the new Transition Unit at the MOH.

Refugee Health

Contract negotiations with Ministry of Health are currently underway. The mutual intent is to renew the Refugee Health contract for two to three years.

WellSouth has successfully recruited a Cross-Cultural Navigator role for the Afghani refugee community in Dunedin. They continue to search to fill a similar role in Invercargill. This position supports the Colombian refugee community. Interpreter support for Non-Government Organisations (NGOs) in Invercargill continues to be a significant service gap in the overall resettlement programme in this city. In contrast, NGOs are able to access Southern DHB interpreters via Dunedin City Council funding. It is anticipated that the Programme Lead will be trying other funding streams to resolve this access issue.

Population Health Service

Highlights

Staff continue their catch-up plans post Covid-19 lockdown and are tracking well. Strategic planning continues for some Population Health services.

Preparation is underway for Omicron in terms of ensuring services are minimally disrupted, and alternative ways of working are implemented. Capacity planning has taken place to assess viability to support Public Health and Covid-19 Vaccination programme whilst maintaining essential Population Health services.

Measles Mumps Rubella (MMR) Campaign 15 to 30 year olds

Measles Mumps Rubella (MMR) campaign – Ministry of Health (MoH) has extended the contract timeframe once again, out to June 2022 (previously March 2022). The enhanced Youth Health clinics are planning to support the MMR program in rural areas. An initial contact has occurred with Covid-19 Vaccination team, pharmacies, and equity providers to explore concomitant Covid-19 and MMR vaccination. Revision of MMR plans are underway for 2022 with the contract extension in mind.

Public Health Nurses – Te Punaka Oraka

Towards the end of 2021, Public Health Nursing staff increased efforts to complete the catch up of services disrupted by Covid-19. Catch up has included a backlog of B4 School checks, Outreach Immunisation, additional school-based youth assessments, Youth Health clinics, home visiting ensuring priority children, young people, and their whānau had their health and wellbeing needs met.

There has been an increase in needs for brief primary mental health support for anxious children, young people and their stressed whānau, necessitating more complex health interventions and support including referral pathways. The focus has been on high need children, young people in urban areas and in rural areas where there is a lack of services. Initial data review of 2021 year shows reduction in nursing referral acceptance and interventions in urban areas in comparison to pre-Covid data. This is significant as it shows the impact of re-deployments to the Covid-19 response has had on community well-child, youth and whānau health services. There has also been an increase in the number of child and youth referrals in Central Lakes areas. There is a noted increase in population in the Central Lakes area, reflected in increased Schools and Early Childhood enrolments.

School Based Human Papillomavirus Vaccination (HPV) Programme Otago

Staff in Otago have been working on the planning tasks ahead for HPV for 2022 regarding school communications, booking dates and equipment audits.

School Based Services Contract

Despite disruptions to the school year due to Covid-19, we have managed to complete our Year 9 assessments in decile 5 and below schools and alternative education providers. There are a number of students who have been difficult to engage with due to disruptions and absences. There is a plan in place to follow up in 2022.

Immunisation Outreach, Vaccine Preventable Disease (VPD), National Immunisation Register (NIR) Teams.

Immunisation Outreach and VPD teams are working to meet service delivery priorities including mitigating for future disruptions due to Covid-19 community outbreaks. The goal is to continue momentum from the previous quarter.

Southern was:

- 2nd in New Zealand for 8-month child immunisations,
- 1st for 24-month child immunisations
- 2nd for 5-year immunisations overall

For Māori Tamariki:

- 2nd for 8-month
- 3rd for 24-month
- 2nd for 5-year immunisations

all of which are very pleasing results and we extend our sincere thanks to the team for their significant efforts!

Puketai

Cardiopulmonary resuscitation (CPR) training education session was provided to the young people at Puketai by nursing staff. Feedback from the young people was positive and noted this was a useful life skill for them to have and be prepared for. Nurses organised for all young people eligible for Covid-19 to receive their vaccination onsite, and Puketai and Oranga Tamariki staff were invited to participate.

Gateway

There are multiple clinics booked for January 2022 and this is due to the high number of referrals that continue to occur. Assessments and Multi-disciplinary Team (MDT) meetings have resumed for 2022.

The MDT meetings continue to go well with health (including Primary Mental Health and Functional Family Therapy), education and Oranga Tamariki. Working collaboratively ensures whānau and tamariki health need requirements are actioned. Additional professionals also attend these meetings as required.

Cervical Screening

Two Southern DHB staff have been invited to join the Register Guideline Redevelopment Project led by the National Cervical Screening Programme.

Hearing and Vision Screening

A Vision Hearing Pilot is occurring in Invercargill around processing of data to identify opportunities for capacity gains.

Newborn Hearing service is being relocated in Southland Maternity ward to assist with supporting the critical staffing of Midwifery.

Sexual Health

The Sexual Health Strategy review is underway with the purpose of refining Model of Care and strategic aspirations of the service to increase access to Sexual Health services across the Southern district.

The Dunedin site is not part of the hospital rebuild. This will be reviewed within the Strategy review including integrating into primary care/locality networks.

Resourcing constraints continue due to Covid-19 mandate and Dunedin vacancies are continuing.

A Registered Nurse in Dunedin Sexual Health Clinic is now officially a Registered Nurse prescriber. It is positive for the service that there are now two Registered Nurse prescribers. This is good for the service and demonstrates the DHB commitment to supporting staff in their career aspirations.

Multiple student placements continue in the clinic for medical, nursing and midwifery students and colleagues with very positive feedback.

The Service continues to be impacted by the vaccination mandate order.

Child Health (0-5years)

Well Child Tamariki Ora (WCTO)

WCTO is an essential service that has to be maintained at Traffic Light Red. Core contacts should continue to be offered in person with appropriate pre-visit screening. Limited face to face time is to occur to minimise risk. Telehealth approaches can also be used to reduce contact time. The Ministry of Health (MoH) provides regular updates for providers to ensure there is no confusion on service delivery requirements.

Pacifica Health Dunedin

Interest is being expressed in the community on how to improve Pacific health outcomes in Dunedin. Enquires have been received about the service model based at the Pacific Island Advisory and Cultural Trust (PIACT) in Invercargill. Southern DHB Community Health Nurses deliver weekly clinics at PIACT premises supported by a Community Linkage position and a Social Worker. Of particular interest is the Community Linkage position, which is contracted to PIACT. The health goal for this contact is to improve and protect the health of Pacific People by linking clients with appropriate providers including primary care. This is achieved by working to remove barriers for Pacific people to access health and social services.

Pacific Invercargill

The appointment of a Social Worker to support Pacific peoples is a collaborative process between Southern DHB and PIACT. This process is underway. The development of a Memorandum of Understanding is also needed.

Sudden Unexplained Death in Infants (SUDI) - Safe Sleep Programme

SUDI prevention is also an essential service to be maintained at Traffic Light Red.

Distribution of safe sleep spaces was considerably lower in the last quarter of 2021. Reasons for this are being investigated. Ngāi Tahu and HAPAI Haoura are also distributing safe sleep spaces in the Southern district, which is outside of the Southern DHBs safe sleep programme.

Ensuring an ongoing supply of safe sleep spaces is an integral component of the Safe Sleep Programme. Work continues with local weavers to try and ensure supply of wahakura. To achieve this, we are supporting weaving wānanga. The most recent one was held in Invercargill in January 2022.

Planning has begun on developing the 2022/2023 SUDI Plan. The intention is to only supply wahakura to whānau.

Oral Health

Southern DHB Community Oral Health Service (COHS) January 2022 Figures

- New Enrolments for month = **247**
- Total Enrolments = **45,335**
- Patient contacts for month = **1,459**
- Doses of Fluoride Varnish given for month = **704**

Oral Health Summary

Oral Health anticipates an impact of covid, resulting in possible service disruption.

The Mobile Surgical Bus visited Southerland Hospital site and has worked for the past week on the Oral Health General Anesthetic list. The combined effort between Southland Oral Health and the Surgical bus managed to complete 40 children over that period reducing the General Anesthetic list to 140, even though this is an improvement, ongoing planning is required to reduce this list further. The team from the Mobile Surgical services feel this was a great success and are eager to return again.

.

Projects

The Faculty of Dentistry Project is on track.

The service is finalising plans for a fourth clinic room refurbishment in the Dental Unit

The Tele-Dentistry project continuing – no further progress to date, although this way of reaching our community is part of our endemic delivery for Oral Health care to the Southern population.

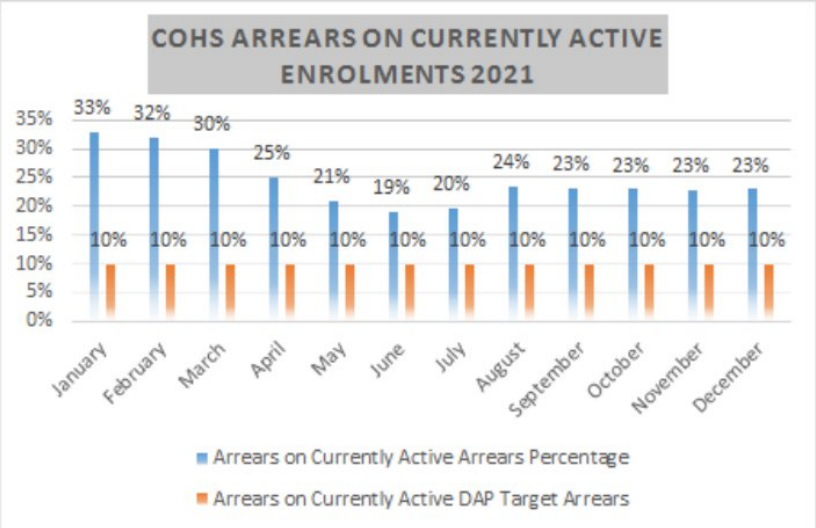
The Spatial Equity project continues, and we are near to finalising this project with a meeting held in November which was the last one for 2021.

Drop-In Clinic: A pilot project for drop-in clinic is planned for Invercargill – this is still in the planning stage with identification of a site for the project underway.

Fluoride Varnishing Programme: Fluoride varnish training for Dental Assistants continues. This has progressed much slower than had hoped, however, half of the staff have completed the Clinical Task Instruction.

PERFORMANCE

Health Targets: Arrears – National target 10%, Southern Oral Health currently sitting at 23% post Covid-19



Rural Health

Primary Maternity

We experienced a busy month for Central Otago Maternity Unit (COMU) with 7 births and 22 Postnatal stays.

Covid-19 preparations are well underway. Key areas focused on include considering of staff, women and babies being safe in primary birthing units.

Unfortunately there is now no local midwifery support in Te Anau. Winton Lead Maternity Carers (LMC) travel to Lumsden or Te Anau to run clinics for Te Anau women. They also will book women into appointments at their Winton office. There is still access to emergency birthing equipment at Fiordland Medical Centre.

Maternity services are experiencing a workforce shortage, which is being felt across the district.

Central Otago Primary Birthing Units Build

As previously advised the DHB has secured funding for two new birthing units across the district. The Request for Proposals (RFP) for Architectural providers concluded on 28 January 2022. The evaluation panel will meet in February select from the three providers who submitted proposals. There will be a steering group set up to oversee decisions regarding the Birthing Units, moving forward. We are pleased with progress in this area.

Lakes District Hospital

There were 1,255 Emergency Department (ED) presentations in January. Of note, total presentations for 2021 were equivalent to 2019 at 12,936. This number was reached with lockdowns in Auckland and closed borders impacting on the number of visitors to Queenstown. High numbers in ED meant X-ray

and computerised tomography scan were also busy. Social work had a high number of community referrals with complex issues and needs.

The general ward had a total of 83 patients with average Length of Stay (LOS) of 1.61 days.

Covid-19 resurgence planning continues. Screening of the public is occurring at the new Emergency Department (ED) entrance. Additional communications have been sent to the Queenstown based media, to ensure the public know how to access the hospital in an emergency, and to remind people of the channels for Covid-19 support, and to keep the ED for emergencies.

A new entrance to the Maternity wing, bypassing the Main Entrance to the hospital, has also been established for presentations between 1800 – 0800 when there is no screening at the front door. This is aimed to protect women from potential exposure to Covid-19.

Work continues to ensure the facility is fit for purpose and flexible enough to meet the changing demands this virus creates. This includes consideration for workforce (nursing and medical) as well as patient transport services.

Rural Hospitals

Covid-19 preparedness remains a focus for Rural Trust Hospitals. Emergency Operations Centres (EOCs) have been trialled, in preparation for a full EOC / Emergency Coordination Centre (ECC) being established to manage the services once Omicron arrives. Linkages between Rural Trust Hospitals and Base Hospitals are vital to ensure a coordinated response to the staffing and clinical challenges that may occur.

A process to address funding of infrastructure costs incurred by Rural Trust Hospitals to prepare for Covid-19 is underway. Likewise the management of ambulance and patient transport services require additional consideration due to possible increases in covid related patient need.

Primary Care

WellSouth continues their fantastic work in establishing the Covid-19 Care in the Community programme. They are prepared with clinicians on hand and the ability to surge their testing resources at short notice. Through GP practices, they continue to deliver strong vaccine and booster vaccine volumes.

Pharmacy

Pharmacies are being recruited into the Measles Mumps and Rubella (MMR) program, with all outstanding Pharmacies being offered the variation contract to take part. Population Health have also employed an MMR Coordinator to support the program in the community which includes this person visiting Pharmacies and providing information and support where they can. This has been received positively from all involved.

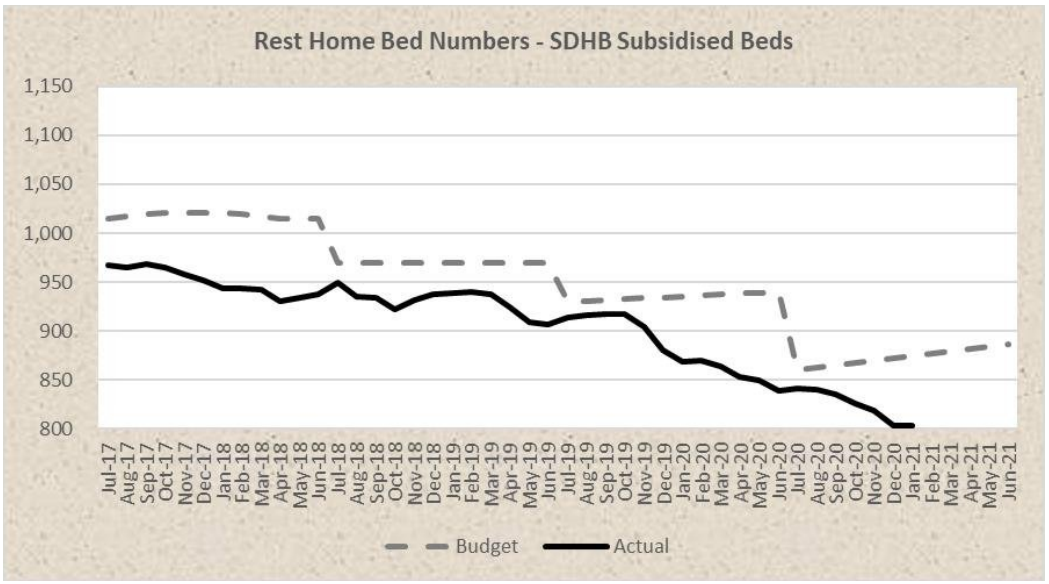
Guidance on RAT testing stock and useage for GP practices, Aged Care, Pharmacies and the NGO sector is awaited from the MOH.

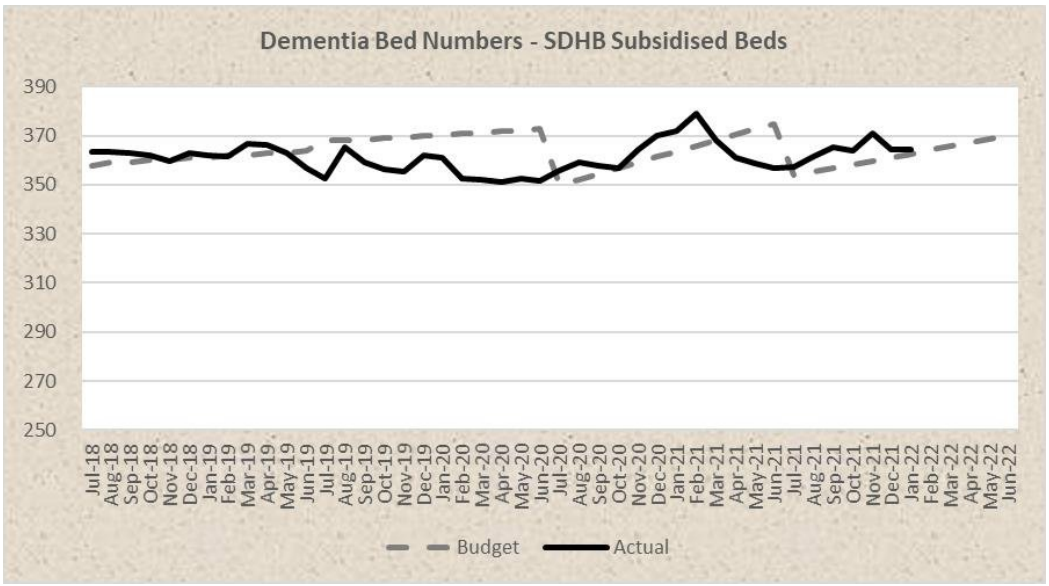
Older Persons Health and AT&R

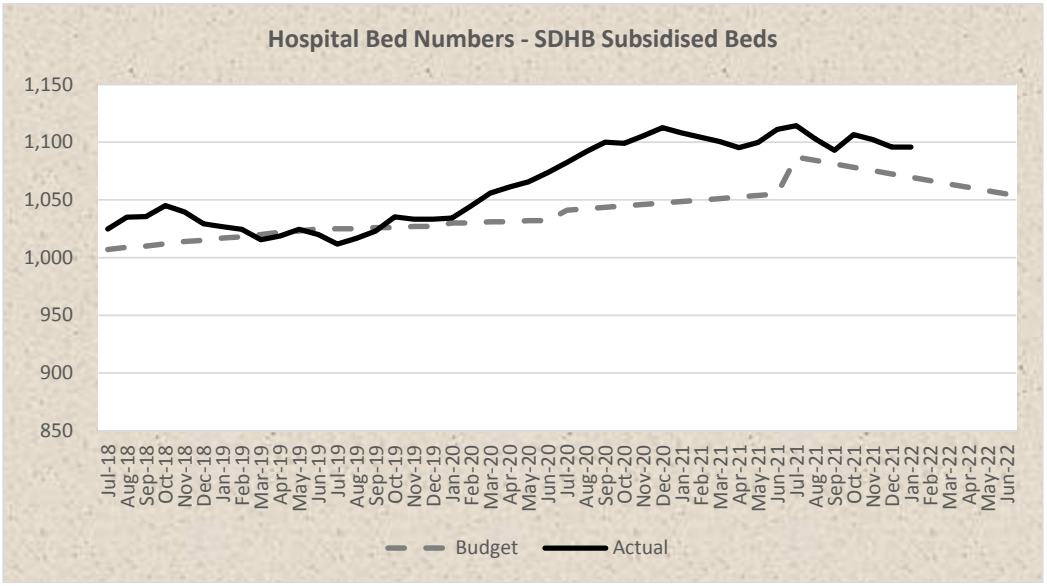
Aged Residential Care Occupancy/Volume Analysis

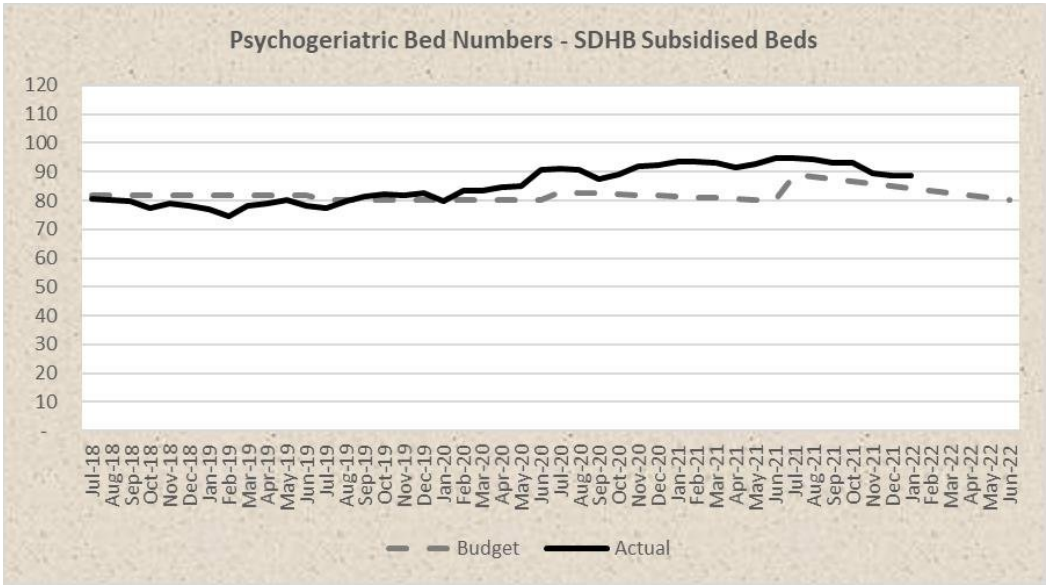
The levels of occupancy in Aged Related Residential Care (ARRC) continue to decline. Reduction is available beds due to staffing shortages is now potentially influencing bed utilisation is some areas, especially with changes to levels of care.

Total bed numbers are down since July by over 50 beds, but the mix of bed utilisation doesn't align to the budget. There has been a greater reduction in Rest home level care than forecast (budgeted to increase), and Hospital level care has plateaued (forecast to decrease). So while bed numbers have reduced, the different bed mix hasn't resulted in the financial gains budgeted.









Allied Health

Two services remain in the Fraser Building while their new premises off site are prepared. The Care Coordination Centre is relocating to leased premises across the road in Hanover Street. Work is underway on relocation but a move date is dependent on installation of data and some fixtures and fittings.

Southland AT&R

The decision has been made to open an additional 12 beds in the AT&R ward in Southland. A proposal for change was undertaken with staff as the model of service delivery intends to be novel and will eventually include partnering with SIT with using tutors and students on the ward as well as additional nursing leadership.

Recruitment to the necessary roles to enable opening of the beds continues to be a challenge. We have been unable to open additional beds as initially planned. It is now hoped we can secure

additional staff to enable four beds to be opened in March, and then the other beds as staff are recruited. The students with the SIT supervisors commenced on the AT&R ward 8 February and are being incorporated in the ward in the interim until the additional beds can be opened.

A GENERAL NOTE

Several services were closed from 23 December through to 10 January 2022 so that staff could take the opportunity to have a well-earned break. Many staff have also taken extended leave through to end of January. We would like to take the opportunity to thank all our staff for their sterling efforts over the past several months as we work to balance our pandemic response with the need to continue our business as usual service provision.

Andrew Lesperance

Executive Director –Planning, Funding & Population/Public Health

FOR INFORMATION

Item: Māori Health Update

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

Meeting of: Community and Public Health Advisory Committee, 1 March 2022

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 update

---

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.

COVID-19 Vaccination Programme
Our Māori providers continue to deliver a significant proportion of vaccines as we sit on the threshold of meeting the 90% 2nd vaccination for our over 12 Māori vaccination rates. Te Kaika Caversham have continued with their Victoria Road clinic as well as staffing the vaccination bus. They have been working closely with Dunedin city council and Southern DHB to develop a schedule based on our postcode level data to target the highest number of outstanding populations, including outreach to Clutha TLA to provide workplace vaccinations, rural clinics, and school-based clinics. He Puna Waiora and Awarua whanau services have continued activity in both Invercargill and Southland rural areas also utilizing data provided by Southern DHB. These providers continue to support with COVID testing in collaboration with the WellSouth Primary Health Network.

Public Health Nurses
Te Punaka Oraka Public Health Nursing Staff and Immunisation Coordinators have been working alongside Pacific Community Trust in the immunisation space. Looking to continue to strengthen relationship to embed outreach services, one Māori staff member has been released to external Māori Health Provider Te Kāika until end of 2022. This is to support a partnership model between SDHB and Te Kāika to support their growing workforce and skillset in immunisation cold chain processes. Feedback has been well received. The service is looking for further opportunities to partner across the region with other Māori and Pacific providers to increase positive Population health outcomes.

Hauora Direct
The Southern DHB is working to award the Hauora Direct contract to a Southland based provider. This contract aims to improve health outcomes for Māori. In 2020 Nelson Marlborough DHB, funded a trial of the Hauora Direct programme (in conjunction with several community providers) as "pop-up" events at eight Nelson and Marlborough community locations. The initiative aligns with two of the eight Whakamaua priority areas and supports four of the actions. Hauora Direct assessments are to identify physical and mental health, and social and wellbeing concerns. The assessment is to identify whānau needs to be addressed, and health and social services they are eligible to receive. The assessment will include a risk-identification process for possible and probable health issues so whānau can access early support. The contract aims to support on the spot interventions to include immunisations for children and adults, blood tests for diabetes, cardiovascular screening, cervical smears, smoking cessation support and tamariki hearing and vision testing. Whānau will be referred to other services where issues cannot be dealt with immediately. The contract is being considered by the team currently with view to working with our Māori providers to support service delivery. The Southern DHB is working with Nelson Marlborough on IT solution to improve data collection quality and systems.

Cultural Connector Position

The Public Health Service has appointed two fixed term employees with a primary focus on the COVID-19 response. One of these positions will focus on Māori with the other focused on Pacific. The Māori role will take an active role in building strong relationships with manawhenua, Iwi and Māori Health providers in the Southern district. The role will support staff with their understanding and application of te reo me ōna tikanga Māori. To ensure any projects associated with COVID-19 address equity for Māori and meet Te Tiriti o Waitangi obligations. Advocating timely/appropriate manaaki and well-being support for cases, contacts, and whānau who are Māori. Leading a coordinated approach to develop and evaluate manaaki plans and pathways. Support the COVID-19 response team to deliver culturally appropriate services. The Pacific role will provide cultural liaison support to the Public Health Service with a primary focus on the COVID-19 response and responsible for providing guidance and leadership in this space. They will support contact tracing with Pacific fanau, to advise and inform the development of processes and procedures that supports ongoing engagement with Pacific fanau in contact tracing and case management.

Updated Māori Enrolment Data

	Feb-21	Apr-21	Jun-21	Aug-21	Nov-21	Feb-22
Central Otago	1,877	1,893	1,881	1,918	1,939	1,954
Clutha	1,838	1,856	1,863	1,855	1,844	1,868
Dunedin	9,495	9,530	9,597	9,611	9,655	9,646
Gore	1,821	1,843	1,861	1,854	1,860	1,894
Invercargill	9,291	9,356	9,353	9,363	9,363	9,433
Queenstown Lakes	1,932	1,969	2,019	2,062	2,054	2,102
Southland	1,760	1,785	1,817	1,835	1,845	1,877
Waitaki	1,924	1,930	1,917	1,941	1,966	1,999
SDHB	**29,938**	**30,162**	**30,308**	**30,439**	**30,526**	**30,773**

Source: NES file from the MoH
Ethnicity - Maori (21111)
Files used are dated 1st of the month following except February which is dated February

CMHSIO
The Chief Executive is working with the Chair of IGC to advance a replacement solution for the outgoing CMHSIO position. His final day with the DHB will be 11 March 2022. At this stage WellSouth has indicated their preference to separate the role away from the Southern DHB. Toni Gutschlag will take up her new appointment as the Executive Director MHAID services on 21 February 2022.

Clinical Nurse Specialist Roles
The CMHSIO and DoN have ratified an RFR for two Kaiārahi Nāhi, Clinical Nurse Specialist roles. The RVR has adopted an expression of interest (EOI) approach to either appointing a Clinical Nurse Specialist (Kaiārahi Nāhi) role or Clinical Nurse Specialist trainee intern positions. The aim to this approach is based on our aspirations to reduce preventable deaths including a focus on cardiovascular, cancer and respiratory disease in Māori patients that are admitted into our hospitals. The EOI process has been initiated as we have no current Māori Clinical Nurse Specialist roles within the Southern DHB, therefore this approach aims to build our workforce capacity into the future. The Position Descriptions is attached to this paper based on the Auckland DHB Māori health model.

Kaiawhina Positions
The Māori Health Directorate has been successful in making two appointments to the Kaiawhina positions in Invercargill and Dunedin after readvertising. This leaves only one Kaiawhina vacancy in Invercargill and we have uploaded another RFR. Our.6 FTE position that has been on long term sick leave has thankfully returned back to work. The Māori Health Directorate welcomed Roger Fitzgerald and Lisa Whatuira by way of mihi whakatau at Te Taihoaho at Wakari on the 18th January. This was also an opportunity to welcome Maryann Rangi who has taken up a Kaioranga Hauora as part of Te Korowai Hou Ora, whom no longer have any vacancies.

Māori Workforce Development Specialist Partner
We have loaded an RFR for the recruitment of a Māori Workforce Development Specialist role. The position will be responsible for leading, in partnership with People and Culture, a Māori workforce development strategy for the organisation. This includes strategic planning responsibilities, the ongoing development and delivery of initiatives and the monitoring and evaluation of programmes focused on increasing and developing our Māori workforce. The primary objectives of this position include:

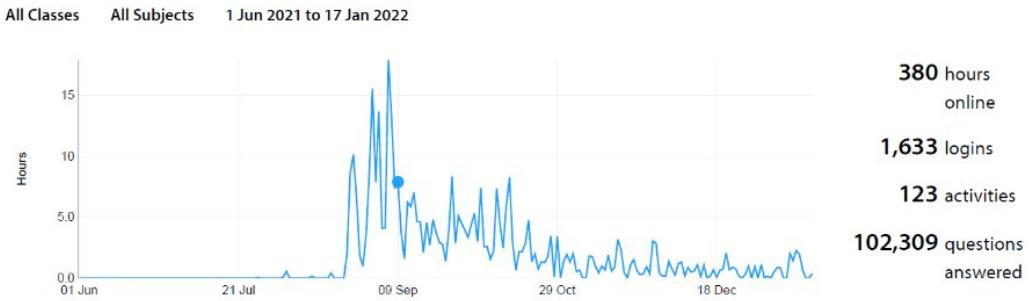
- To lead, develop and implement strategy and programmes to improve the capacity and capability of Māori in the health workforce across the Southern district in line with a Māori workforce strategy.

- Ensure expert Māori leadership and advice is provided across workforce development planning for SDHB.
- Oversee all Māori workforce development reporting requirements from operations through to governance groups.
- Lead a continued focus on reducing inequalities and the integration of Māori values and worldview in across recruitment and retention processes in collaboration with the recruitment and HR teams.
- To build the Māori workforce pipeline from students in year 7 and 8's through to staff employed into the health sector.
- Develop processes and systems and provide support for hospital services to recruit more Māori into the workforce particularly in services where there is high utilisation by Māori.
- Work collaboratively to build the necessary relationships with tertiary education institutions, the Māori Alliance Leadership Team, Iwi and Māori Health Providers and other key stakeholders to assist with the workforce pipeline development.
- To oversee the administration and contracting of the HWNZ Hauora Māori funding through the Ministry of Health.

The position will report to the Executive Director People and Capability and the Chief Māori Health Strategy & Improvement Officer.

Te Reo Māori Education

A collective response from WellSouth, Allied Health, Nursing and the Māori Health Directorate has provided 200 enrolments into an online platform, to support cultural education and address the need to persist with addressing equity and differential outcomes experienced by Māori. The training is being delivered in collaboration with Te Rau-o-te-Rangi Winterburn from Ōtaki. The training has a focus on cultural practices, NZ history, myths and legends, grammar and is a pipeline as well as higher level immersion. Each kete kōrero (learning module) contains vocabulary, comprehension, writing and speaking activities. They are broken into beginner and intermediate level learners. The platform is user friendly, flexible to meet the needs of busy staff, and has been reviewed by our Pou Taki and found to deliver a sound education program with good pedagogy and methodology. At stage we can report 380 online hours of engagement, learners have logged in 1,633 times, and answered more than 102,309 questions in Te Reo Māori successfully. Staff feedback and participation is providing confidence the platform is engaging learners well and supporting them on their reo journey's.



SP&C Services – Primary Care report Jan 2022

EXECUTIVE SUMMARY *Lead Executive: Andrew Lesperance*

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 2 2021-22	Target / Nat Avg	Trend - Over 3 Reported Q's	Commentary
After-hours primary care initiatives	100% of ≤ 14 year old children within SDHB have access to zero fees for after-hours	100% Target National Not Published	↑	• Invercargill Urgent Doctors are now providing zero fees for ≤ 14 year old after hours. This has increased coverage to 100% in Southern DHB.
Newborns enrolled at 6 weeks of age	69% total population Māori rate 58% (DHB level data only)	55% target 70% total Māori 56%	↑	• 14% above target total population; equity disparity • PHO Position 25=/36 • DHB Position: Māori – 9/20
Newborns enrolled at 3 months of age	92% total population Māori rate 73% (DHB level data only)	85% target 88% total Māori 73%	↑	• 7% above target total population; equity disparity • PHO Position total Pop – 27/36 • DHB Position: Māori – 8/20
Percentage of the eligible population who have had a CVD risk Assessment in the last 5 years Q2 21.22 data	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. • 15% below target.
Percentage of the population identified with diabetes having good or acceptable glycaemic control. Q2 21.22 data	54% (Maori) 56% (Total Pop)	60% Target National Not Published	↑ ↑	• 4% below target • Equity disparity.

Continued

Service	Quarter 1 2021-22	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 Q2 21.22 data	57% (Maori) 58% (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. • 32% below target.
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.	73% (Maori) 81% (Total Pop)	75% (Māori) >90% Target 76% (Total)	↑ ↑	• 9% below target. • PHO Position: Maori – 12/36; Total Pop – 12/36.
Percentage of people ≥ 65 having received a flu vaccine Q1 21.22 (reported annually)	56% (Maori) 62% (Total)	53% (Māori) >75% Target 63% (Total)	Q1 2021-22 Data Only Q1 2021-22 Data Only	• 13% below target. • Equity disparity. • DHB Position: Maori – 10/20; Total Pop – 14/20.
Ambulatory sensitive hospitalisations (ASH) – Adults 45 to 64 Q4 20.21 data	4,116/100K (Maori) 2,843/100K (Total Pop)	7824 (Māori) No Target 3659 (Total)	→ →	• PHO Position: Maori – 7/35; Total – 8/35. • 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% Q2 21.22 data	80% (Maori) 92% (Total Pop)	85% (Māori) 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 impact of Uni

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

EXECUTIVE SUMMARY *Lead Executive: Andrew Lesperance*

Activities and Services of Note

COVID Care in the Community

- In December 2021 the Ministry of Health released the COVID-19 Care in the Community Framework for managing COVID-19 positive people and whanau in their communities.
- WellSouth has developed the COVID Care in the Community program for the Southern District Health Board in partnership with the Ministry of Social Development and other support agencies such as marae-based services and iwi support organisations.
- The program provides a clinical network of General Practitioners, Nurse Practitioners and practice nurses who provide care support and advice to those in the community isolating with COVID, with the provision to be 24/7 and include unenrolled/visiting patients.

Clinical Risk Populations

Client-Led Integrated Care (CLIC)

- The CLIC programme is almost fully implemented across all 81 Practices. The Long Term Condition (LTC) Team have been working closely with practices to increase utilisation of the CLIC programme in each practice.
- A recent change to the programme criteria has been implemented to support increased Maori health outcomes, all Maori above the age of 45 are entitled to have a Comprehensive Health Assessment.
- The foundation of CLIC is built on the patient's own declared self-management capability via Flinders Partners in Health tool.

Glycaemic control (Diabetes)

- DESMOND (diabetes self-management) and Walking Away patient education courses continue to be facilitated across the district to improve diabetes self-management.
- The LTC nurse has delivered Diabetes Nuts and Bolts education to practice nurses this quarter, and provided Diabetes specific education to Maori and Pasifika NGO providers. Patients seen by the LTC nurse are provided with a management plan which is implemented by either the LTC nurse, or the patients' practice team depending on the needs of the patient and the practice.
- Insulin starts are done within general practice and supported by the LTC nurse if required by the practice team, 27 insulin programme registrations were done across WellSouth practices this quarter.

The number of patient interactions this quarter is slightly down, this is due to a number of contributing factors, largely COVID affecting proactive care, as practices experience increased pressure with swabbing and vaccination demands.

Primary Care Access

- Invercargill After Hours Primary Care – 100% of under 14's now have access to free after-hours primary care in Invercargill.
- The Invercargill Community Health Hub initial clinical scoping project has concluded with the report currently being completed so it can be presented to the Executive Leadership Team for consideration and informing the next step in the service design.

Refugee Primary Health Services

- Ministry of Health has funded PHO a 1 FTE 6-month fixed term position to provide COVID endemic support to the refugee communities in Dunedin and Invercargill.
- There are a small but significant number of families who have been resettled for several years who are not thriving. These families are struggling with language and understanding NZ culture and structures. Due to their stress from this, they subsequently get referred to mental health services.
- PHO successfully recruited a replacement for the Afghan Navigator role in Dunedin.
- Recruitment is in the final stages for a fixed-term Colombian Navigator role in Invercargill.

FOR INFORMATION

Item: Progress report from the Steering Group overseeing the Evaluation of the Implementation of the Primary and Community Care Strategy.

Proposed by: Carol Atmore (Medical Director WellSouth)

Meeting of: Community and Public Health Advisory Committee 1 March 2022

Recommendation

That CPHAC notes the findings from these research projects as they will be useful in tailoring future developments in these areas.

Purpose

To inform the committee on the mid-point findings from three projects still underway (Consumer Lead Integrated Care CLIC, Home Team and Health Care Homes) and the findings from two completed projects (Locality Networks and Community Health Hubs).

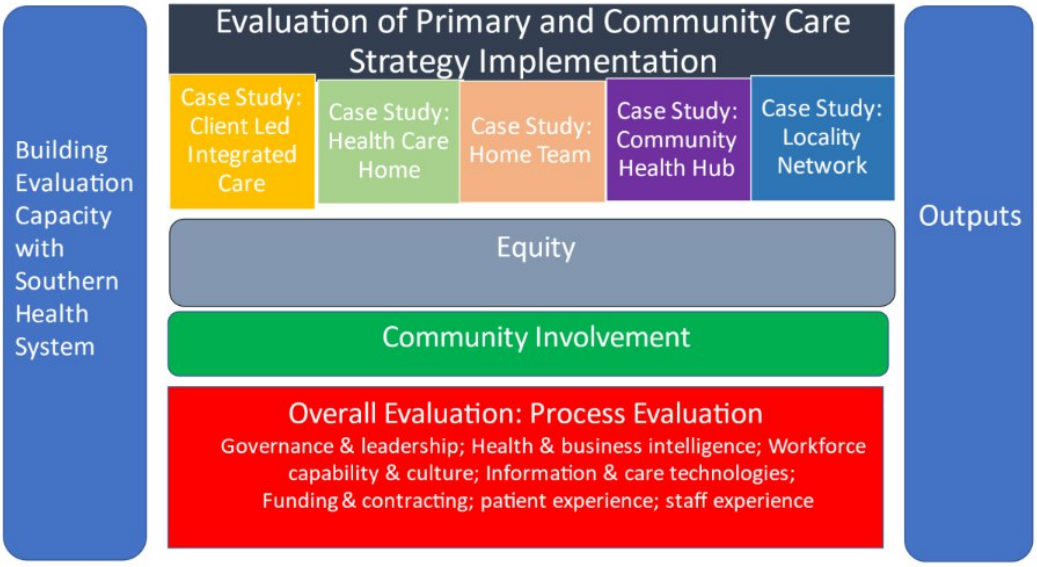
These five projects are part of a suite of eight projects evaluating the Implementation of the Primary and Community Care Strategy.

Background

The introduction of the Primary and Community Care Strategy (PCCS) involves a significant change in the provision of health services to the Southern region. This evaluation is a joint project between Alliance South (Southern District Health Board (SDHB) and WellSouth Primary Health Network (WellSouth) and CHeST (Centre of Health Systems and Technology) representing the University of Otago and the Otago Polytechnic and Southern Institute of Technology.

This work includes a number of separate but related projects as seen in Figure 1.

Figure 1. the schema for the overall programme of work being undertaken for this evaluation



Discussion

The work on the suite of research projects commenced in 2019, there have been two significant factors influencing the health climate over this time, COVID-19 and the announcements of major changes to the New Zealand health system.

a. The impact of COVID-19 continues to be felt with repercussions in the health sector.

b. The release of Health and Disability System Reviews final report in April 2021and the following governmental announcement of the impending changes to the New Zealand Health system had an unanticipated impact of shifting individuals thought processes over to the 'new' system and in some cases the security of their employment.

However, we believe the direction for the health system remains unchanged. The policies that lead to the four main high level goals of the Strategy will undoubtably continuing long after the DHBs are replaced by the new HealthNZ demonstrating the ongoing relevance of the work that has been and is being undertaken.

Appendices

Appendix 1	Report from the Colloquium held Mid - 2021, mid-point reports from FOUR projects presented (includes CLIC, Home Team, Health Care Homes and Locality Networks projects)
Appendix 2	Executive Summary from Locality Networks project completed end 2021
Appendix 3	Executive Summary from Community Health Hub project completed end 2021
Appendix 4	Timeline for completion of all projects.

Appendix 1.

Centre for Health Systems and Technology (CHeST)

Health Research South

11

Report from

Evaluation of the Primary and Community Care Strategy Implementation

Mid-Point Progress Colloquium

Held Friday 16th April 2021 9 am – 1 pm
Boardroom, Level Two, Otago Business School, University of Otago, Corner Clyde and Union St, Dunedin

Purpose: To share mid-point feedback on the evaluation of the Primary and Community Care Strategy (PCCS) implementation, learn of progress in other contexts, and discuss where to from here

Executive Summary

N.B. This Colloquium took place immediately prior to the announcement of the health reforms.

The mid-point evaluation of the implementation of the primary and community care strategy (PCCS) identified several common threads:

- Greater focus on equity needed, particularly for Māori, and to partner with Māori as Te Tiriti partners
- Change takes time
- Changes that improved teamwork, provided wrap around services, (e.g. clinical pharmacists, Health Improvement Practitioners, health coaches, community support workers) and improved integration between primary, community and hospital care were valued
- Clarity of purpose and scope of projects important

There was a general agreement that building research and evaluation capacity within the Southern health system, in partnership with the University of Otago, Otago Polytechnic and Southern Institute of Technology should be pursued, in a 'Ko Awatea of the South' concept. Translating research and evaluation into practice would be key. This could be built around Health Research South but would need an expanded role beyond locality assessments and funding and be broader than SDHB and Dunedin School of Medicine, to include the whole Southern health system, and the academic institutions more broadly.

PROGRAMME

8.45 Tea and coffee

Part 1: Progress to date in PCCS Implementation Evaluation Project

9.00 Welcome, outline for the morning - Carol Atmore

9.10 Background to the evaluation of the PCCS - Carol Atmore, Stuart Barson

9.25 Project updates: What have we learnt so far? - The evaluation team

- CLIC
- Health Care Homes
- Home Team
- Community Health Hubs
- Locality Networks

10.40 Morning Tea

Part 2: Experiences from colleagues

11.10 The Stewart Island project. A report on a Community Development Project undertaken by 3rd year Nursing Students - Jean Ross and colleague

11.25 Building research and evaluation capacity within a district health board – Brooke Hayward, Senior Evaluation Officer, Ko Awatea

11.45 Creation of a knowledge broker role to support translation of research into projects and programmes. Ko Awatea experience - Maria Larcombe

Part 3: So what, and where next?

12.00 Group discussion led by expert panel (Professor Peter Crampton, Professor Jo Baxter, Gail Thompson, Gilbert Taurua)

How will these findings impact on the ongoing implementation of the PCCS and maximise equity? How can we increase Southern Health System research and evaluation capacity?

12.55-1.00 Closing remarks

Summary

This was an opportunity to share with a wider audience the findings from some of the projects that are included in the evaluation of the implementation of the Primary and Community Care Strategy. The formal part of the morning was made up of presentations from four of the individual projects being undertaken as part of the evaluation. Three of the reporting projects are midway through and one (a shorter project) is nearly completed. These projects were augmented with presentations on the experiences from one of the Otago Polytechnic 3rd year nursing students' projects and staff from Ko Awatea based at Counties Manukau DHB. This made up the formal part of the morning.

The morning concluded with a panel discussion, involving invited experts, that looked at the work that had been presented on the day and explored the direction to take from here.

The presentations were attended by both Southern DHB and WellSouth executives and staff, University of Otago staff and students, members of the public who had been involved in the PCCS development and research staff.

There was general support for exploring what would be required to establish a 'Ko Awatea of the South'.

Introduction from Dr Carol Atmore

Carol Atmore is the Academic Lead for the Implementation Evaluation project and presented background to the Primary and Community Care Strategy.

The PCCS has been a long time in the making and has involved numerous groups and individuals. It had its roots in the 2017-2027 NZ Health Research Strategy. Vision for the Strategy: - *"Excellent primary and community care that empowers people in our diverse communities to live well, stay well, get well and die well, through integrated ways of working, rapid learning and effective use of technology."*

The four strategic goals of the PCCS are:

1. Consumers, whānau and communities are empowered to drive and own their care and wellbeing
2. Primary and community care works in partnership to provide holistic, team-based care
3. Secondary and tertiary care is integrated into primary and community care models
4. The health system is technology-enabled

The Evaluation

Evaluating the implementation of the Southern Primary and Community Care Strategy 2019-2022 – has 2 parts and 3 goals

Part 1:- Evaluate the implementation of the PCCS

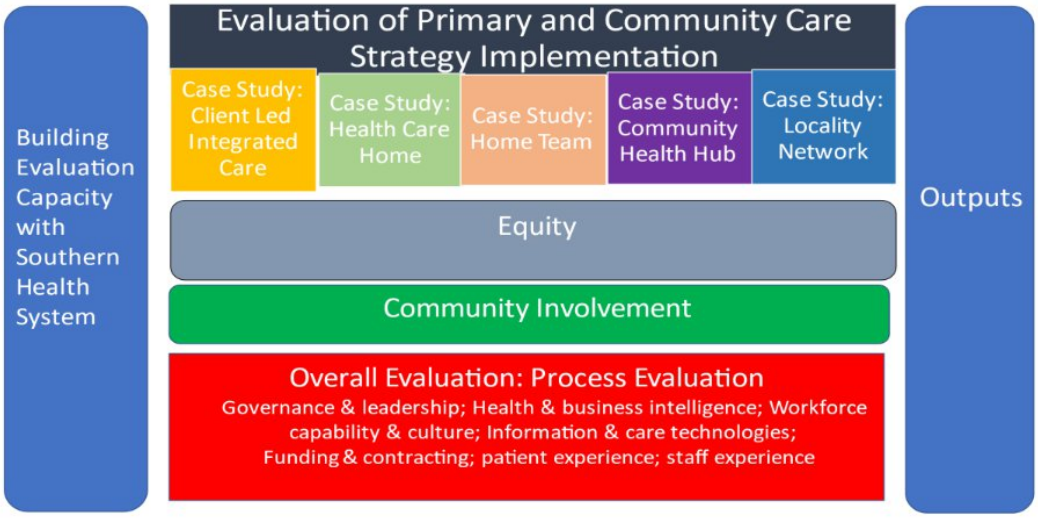
Goal: - Improved health and equity outcomes for people of Southern district

Part 2: - Build evaluation capacity within the Southern Health System

Goal:- Increased capacity and capability within SDHB and WellSouth

Goal:- Ongoing collaboration – Southern Health System Research Network

This evaluation research is funded by Health Research South and consists of eight related projects as outlined below.



The presentations reported on the work from FOUR of the projects so far.

Research Projects

1. **CLIC = Consumer Led Integrated Care**

Presented by: Anna Askerud.

Academic lead and support: Associate Professor Chrystal Jaye, Dr Fiona Doolan-Noble, and Associate Professor Eileen McKinlay.

Service provider lead - Wendy Findlay, WellSouth: Primary Health Network

The research question: - Do personalised care plans within the Southern District's (CLIC) programme support acceptable and effective long-term conditions care, enhance the patient care experience and improve the patients' ability to self-manage their condition?

Anna interviewed patients, Registered nurses in GP practices and GPs.

Learnings so far.

Logistical difficulties - from a practice organisation perspective – onerous administration of CLIC, three care plans, IT hiccups, reconciliation for payment. Has taken time for practices to restructure and develop CLIC to work with their community. Practices feel that they didn't get enough support or guidance around this. Slowly developing a workable programme but this has taken time.

Time – the CHA takes a long time to complete and some patients are unable to finish it. Practices developing a Quick CLIC. Can follow up over the phone.

Patient ID and stratification - some feel that CLIC is targeted at those who are most invested in their own health. Cultural safety of this programme queried.

Education and Support - many nurses feel they do not have the right set of skills to successfully manage this programme.

Primary/Secondary integration - GPs are sceptical whether secondary care is reviewing the care plans.

Level 3 patients – frail elderly – little evidence of case management at this level.

Level 1 patients – previously were on Care Plus where they usually received four subsidised appointments per year. If patients come out at level one then do not quality for any financial or support.

Support services are slowly coming online and are hugely beneficial – clinical pharmacists, HIP's, health coaches, community support. These roles support the nurses and provides a referral pathway where needed.

2. Health care Homes

Presented by: Stuart Barson, WellSouth PHO and Gagan Gurung, University of Otago

Academic Support: Tim Stokes, University of Otago

Service provider lead: Marc Haughey, WellSouth PHO

Health Care Homes: is a structured programme that aims to re-engineer how general practices deliver their services. The programme incorporates four elements: urgent and unplanned care, proactive care, routine and preventive care and business efficiency.

Research Questions: Has the HCH initiative been implemented as intended? What are the impacts and benefits of HCH? What are the facilitators and/or barriers to HCH implementation?

Learning so far

There were positive view on most of the programmes changes: GP triage, daily huddles, patient portal, lean process. Also positive views of the tools that support the changes and good support from WellSouth/HCH implementation team. Every practice is different therefore flexibility around service elements is important. The existing primary care funding model a barrier to fully realise HCH concept

Two key areas of learnings:

1. Perceived benefits
    - Helped to think differently about how practice provide services
    - Provided a structure to streamline services
    - Greatest benefits to patients – choice, convenience, access, improved patient journey
    - Improved team-work and problem solving, coordination and communication
    - Increased efficiency e.g. free up nurses and Drs time, smarter service.
2. Change management
    - Too many changes in a short period can be overwhelming
    - Staff initial resistance with changes
    - Initial period of HCH funding support very helpful
    - Whole team engagement from the beginning important
    - Positive organisation culture
    - Organisation champions

Equity

- Practices reported struggling to engage with Māori patients and acknowledged that a different model of engagement necessary. However, they reported that HCH helped to make practical efforts in this area.
- Work is continuing to focus on how to make practice culturally welcoming and it was recommended that it was important to measure efforts made by practices on equity not only outcomes

Covid derailed some of the HCH progress, but gave an opportunity to move forward quickly with some of the applications e.g. telephone triage and telehealth

Recommendations.

- More focus on lean and change management
- Flexibility about adaptation of tools
- Consideration of financial implications and opportunity cost of implemented changes
- Patient education
- DHB has to dialogue with practices and take actions to devolve more services from secondary to primary care
- Continued support of HCH implementation team to liaise HCH with DHB and support ongoing implementation issues

3. Home Team

Presented by: Gagan Gurung, University of Otago

Academic Support: Pauline Norris, University of Otago

Service provider lead: Glenn Symon, SDHB

Home Team is: - A team of nurses, physiotherapists, occupational therapists, rehabilitations assistants and social workers based in Dunedin and Invercargill. They work with older people to maintain and regain their independence, support their discharge from hospital to home and work with patients to avoid hospitalisation.

They can provide equipment, assess patients, link people to other services, provide home care and fill in gaps until other services arrive

Research questions. Has the Home Team initiative been implemented as intended? What are the views and experiences of people using Home Team services/ families and carers? What are the views and experiences of Home Team and other stakeholders about the impact the service is making? What are the facilitators and/or barriers to implementing the Home Team initiative?

Preliminary work

- The home collaborative group involving many different disciplines
- Collaborative research between the University and DHB has an advantage with sharing skills and challenges with communication
- Learning to work within resource constraints for the research
- Home Team identity has proved interesting as other staff and patients don't recognise the name
- Challenges of interviewing this patient group due to age, hearing, cognitive impairment.

Equity focus

- Trying to include Māori and Pacific patients and whānau
- There will be more questions about equity in second interviews with team
- Ensuring our projects dovetails with a larger project on equity

4. Locality Network

Presented by: Dr Fiona Doolan-Noble

Academic Support: Dr Carol Atmore, University of Otago and Professor Robin Gauld, University of Otago

Research Question: To determine how effective the implementation of and establishment of the Central Lakes Locality Network leadership group has been.

This is the second iteration of the central lakes network, the first developed somewhat organically and this one was set up by the Alliance South Leadership Team.

Preliminary findings: -

Tension emerged in all interviews.

- It appeared that there was an element of disconnect between the Alliance and CLLN in terms of values and basic assumptions.
- Tension existed between the Alliance and the network because of the lack of clarity from the Alliance around how the network was to operate versus how network members felt they could contribute more meaningfully to their locality.
- Members of the network felt that they were identifying issues relevant to their locality but were not supported by the Alliance to move on these.
- A lesser tension was around the way the network meetings were run.

There are three networks in the Central Lakes Locality: CLLN, a mental health network and a COVID response group.

> ➨ *"Something speaks to the fact that we haven't got it right, when these other groups feel the need to exist*". Stakeholder 2.

Equity

- In terms of addressing equity for Māori this was overshadowed by the focus on geographical and financial equity.
- Geographical and financial equity was significantly influenced by the makeup of the group. As a consequence the differences between the 2 rural hospitals either side of the gorge dominated a lot of discussions.

Makeup of the network

- In terms of engagement, the recruitment process was viewed sceptically by many as far a representation, however individuals believed there was a good skill mix within the CLLN.

Strong personalities

- There are strong personalities involved in leadership at the local health system level and within the network which has impacted on the success of the network.

Lack of clarity

- There were mixed interpretations about what a locality network was, but all believed it had a purpose in improving the health and wellbeing of individuals and communities within the locality.
- The Primary and Community Strategy laid out a vision for the Locality Networks (p26 of the related Action Plan).

  "*Now somewhere between strategy and setting it up it seemed to have morphed*". Stakeholder1

- Addressing issues worked best when there was a clear focus on problem, and when a partnership approach was taken by the DHB and the network, for example the maternity services review.

Recommendations

- This study provides insights into the key elements when establishing future networks and progressing CLLN.
- The perception of local people as to the relative advantage of establishing this second network versus maintaining the initial network was low.
- The mandate for the group was not well thought out and poorly communicated. Therefore, there is a need for clarity of purpose, for example, is it is an advisory or a doing group.
- How to effectively engage with and address the issue of equity for Māori.
- Agreement on resources required to fulfil purpose.
- Matching the skills and knowledge around the table with what will be required going forward in terms of the strategy and implementing the Health and Disability Services Review recommendations.

Other presentations

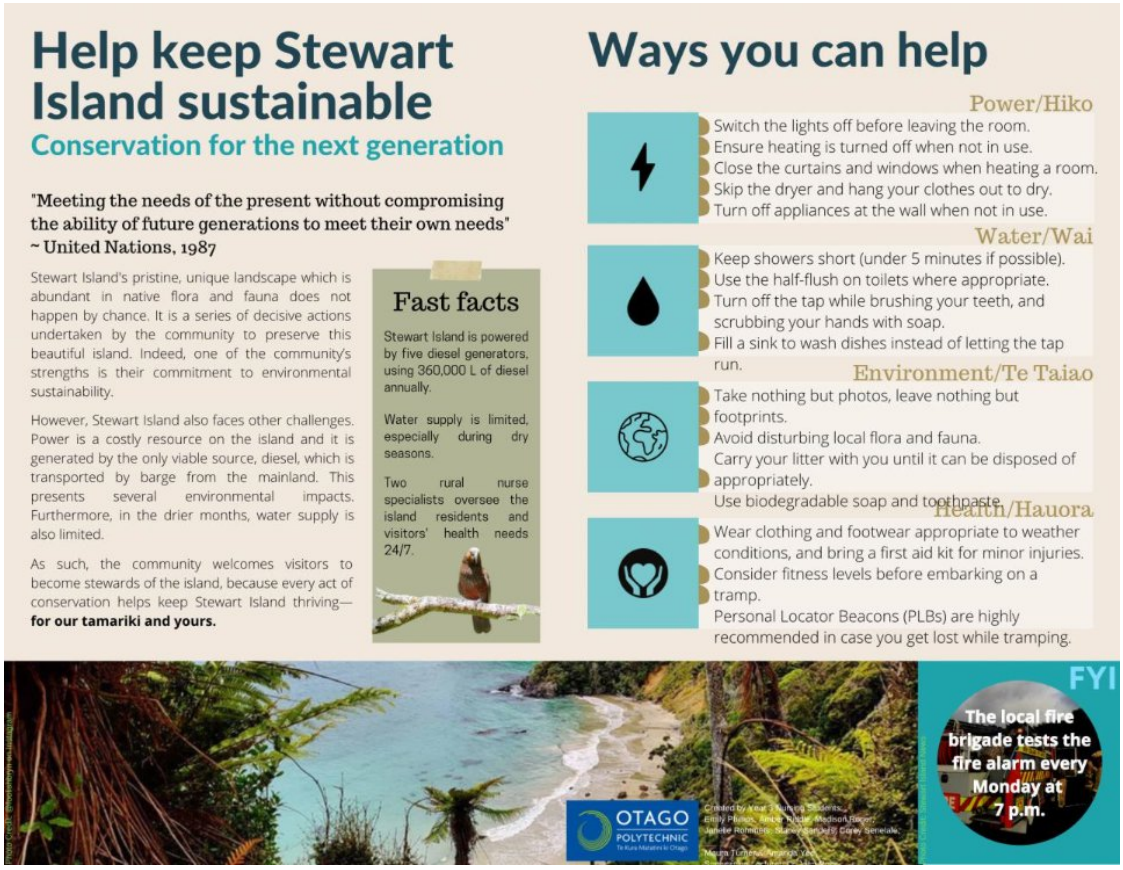
1) Nursing project, Otago Polytechnic, Stewart Island project

Presented by Dr Jean Ross, Otago Polytechnic

Third year nursing students working as a group, undertake a research project working with a local community. It has a public health view and covers a wide variety of topics.

Aim: To uncover health care needs and health disparities, Maori and non - Maori while working alongside and with community members that make a difference to health care and reduces health disparities. These projects need to be sustainable once the team leave.

A project undertaken in Stewart Island project was reported on and as part of the project the students produced an information pamphlet for visitors to encourage the conservation of scarce resources like power and water.



2) Ko Awatea

Presented by Brooke Hayward, Senior Evaluation Officer, Ko Awatea

A second focus of the larger research project that this evaluation is part of looks to increase the evaluation and research capacity within the DHB and WellSouth. Ko Awatea provide evaluation and research support within the Counties Manukau DHB alongside fostering a culture of improvement.

"Ko Awatea's purpose is to enable and support individuals and teams within CM Health to continuously improve the service and care we deliver to our patients, whanau and Counties Manukau community"

Systems thinking and approaches apply here to build a culture of evaluation.

1. Resources:
   time and funding are key barrier to clinician led research and evaluation. (This clinician led work facilitates change being put into practice)
2. Workforce: skills and capability
   There is immense potential with the staff given their local knowledge, lived experience and on the job learning. Everything they carry with them as institutional knowledge is important to research.
3. Relationships:
   Important to build relationships with tertiary partners, services and divisions to foster wider research. The relationships are key to promoting the service. Also, frontline staff and key contact relationships are essential as it is them who are needed to facilitate collection of data. Putting evaluation findings into practice relies on relationships as well.
4. Knowledge and data:
   Knowledge and data to support informed decision-making, with evidence, is something that is quite widely accepted. This is needed to grow our team and ensure visibility of the work, build a robust business case for resource, demonstrate our value to the wider organisation
5. Leadership
   Critical to setting expectations around evaluation, role modelling and culture development. Also, essential to facilitate the ability to have discussions about racism (a term that can be difficult to talk about) and addressing the equity issues. Supportive leadership is necessary to advocate for change, evaluation can disrupt the status quo, and this can be challenging for researchers.

3) Creation of a knowledge broker role to support translation of research into projects and programmes. Ko Awatea experience.

Presented by Maria Larcombe

Maria outlined her previous role at Ko Awatea and gave details about the concept of evidence informed decision making.

Evidence Informed Decision making is "evidence from published or unpublish literature, normally accessed from a database or a journal It is a deliberative process that provides guidance for decision making and using best research evidence."

Evidence based vs evidence informed, this is different in that evidence informed "recognises that research evidence is rarely complete enough to be used as it is so instead the conclusions have to be modified for the local context"

For Ko Awatea projects, a team (and a budget) is brought together, this will include clinical staff, research support (librarian, knowledge broker, evaluator), analytical assistance and an overall project manager. A project is identified, planned and carried out.

There are many challenges in the translation of research into practice. One of the solutions used here was the role of the knowledge broker. This role facilitates the exchange of information between researchers and end users. The knowledge broker is part of the project teams; provides education on research evidence integration, evidence reviews, a model for EIDM and increasing ties with academia.

Panel discussion
The panel consisted of Professor Peter Crampton, Professor Jo Baxter, Gail Thompson, (SDHB) Gilbert Taurua (SDHB) and Brooke Hayward (Ko Awatea). Nb. This meeting took place the week before the announcement of the restructure of the New Zealand health system.

Gilbert:

- the primary and hospital settings are inter-related and what happens in primary care impacts what happens in hospital and vice versa
- equity is a complex concept
- there are complex challenges including Māori in research as it is a small community with a small number of individuals
- to make changes there are still courageous conversations to come

Gail:

- important to make sure there is 'right fit' with service provision
- Currently we are good at keeping people moving through the system, rather than looking at what people want and how we can work differently.
- Start capturing data and use for continued improvement to achieve desired outcomes
- We sometimes miss the time for reflection/evaluation of whether the project/improvement has actually improved outcomes
- Increasing capacity and ability to achieve this is essential

Jo:

- This group of projects have several advantages. It is beneficial to get together and learn what other research is going on, so we avoid missing some important knowledge. This group of projects is fortunate in that regard as there is value in thinking about them all together, in terms of the landscape – what are the pieces of PCC that exist?; the ecosystem – how do they all inter-relate and interact? and optimising the ecosystem – is almost a project in itself
- Equity- intention and attention. The system has been seriously missing the needs of Māori. In the past there has been identification that there are poor outcomes for Māori but it has been seen as 'unfortunate' and no real change has happened. This can be awkward to address.
- Need to change the framing of the issue and change the narrative. Use words like unjust and racist and roll up our sleeves and do something.
- Important to design projects with Māori in mind especially when it is identified as not working for Māori. Need to be evidence based with evidence to benefit Māori included in the design.
- Moving forward there is an obligation to do something about equity for Māori as Treaty partners, to ensure they are treated as partners
- Suggested reading - https://www.health.govt.nz/our-work/populations/maori-health/whakamaua-maori-health-action-plan-2020-2025

Peter:

- Need to note that political and policy context has changed immensely over the time of these projects. This has an impact on emphasis and priorities. Particularly the incorporation of Treaty perspectives into research
- Next week's health announcement will have an impact. And will intersect with ideas given today and equity issues
- Building capacity and evaluation capacity. It would be good to have a Ko Awatea type group in the South as it brings significant intellectual capital

- Health Research South would need to be reimagined to become a Ko Awatea model.
- Building capacity is about building relationships, the question is what it would look like and what relationships to build
    - Within the university, the polytechnic and other tertiary institutions
    - within the DHB (Ko Awatea like)
    - with other groups external to these areas, i.e. Iwi

Brooke:

- Deadlines and timeline pressures from organisations can be challenging to getting research and evaluation completed. Need to slow down to do research well.
- Still room for improvement at Ko Awatea and learnings so far would mean developing it differently if starting over again. We could learn from this.
- We have the advantage of being able to work together and create a clearer marriage between the team that deliver the care and interact directly with patients and those doing the evaluations. This is a great facilitator for translational change, combining evaluation, evidence and practice
- Addition of consumer perspective is a strength of these projects and it will be interesting to see how these are incorporated into practice especially around cultural safety

General Discussion:

- Rapid evaluation techniques not highly valued in the university environment.
- Could fund a Ko Awatea like organisation by moving funds from external consultants to a research group
- Currently the strategic refresh of the health system is being designed by Synergia (consultants). This presents the issues of not being transparent or having robust processes and is not accountable.
- Ko Awatea is funded by the DHB. This is not protected funding and could be pulled at any time. They work in a constant environment of potentially being dissolved at any time as they are non-essential and not frontline care and may be seen as expendable. An environment of needing to prove their value all the time.
- The evaluation of PCCS is a combination of funding that employs research staff (Health Research South grant) and ‘in kind’ time and some resources from both University, WellSouth and DHB staff.
- Need to up our game on equity

Recommendations/ where to from here

- Develop a Ko Awatea type service in the south.
- Explore if this could be built around HRS but expanded role beyond locality assessments and funding, and broader than SDHB and Dunedin School of Medicine
- Building capacity within the organisations is essential.
- Needs a long-term view with substantial investment over time to build capacity within the health system
- Needs strong leadership within the organisation to support such a development
- University could support research, however their time should be bought rather than 'in kind'
- Need to investigate how to make it sustainable in the future
- Research and evaluation vs improvement science. The later can be much more useful to the people on the ground. Therefore, need to identify how do we make research translate into practice (it was noted that it can be very hard to change clinicians' behaviours)
- Develop a position paper/summary of the colloquium to initiate a conversation with Health Research South, SDHB and WellSouth, regarding how to progress this kaupapa.

Appendix 2

Executive summary- Locality Networks

In New Zealand, as in other developed countries health and care systems are coming under intensifying pressure from ageing populations, high incidence of long-term conditions, especially multimorbidity and an increasing number of people having to live with both medical and social complexity. In addition, inequalities are increasing, driven by escalating socioeconomic, cultural and environmental determinants of health. As a consequence, health system are shifting their focus increasingly towards promoting collaboration within local health and care systems.

In Southern the Southern District Health Board and WellSouth Primary Health Network have come together and jointly developed a strategy for tackling the key health and health care issues in the region. The aim of the strategy is to join up planning and service delivery across historic divides: primary and specialist care, physical and mental health, urban and rural, health and social care. Enhancing support for people to effectively self-care and preventive care so that people can live healthier and more independent daily lives is also a key focus.

The Strategy defines three models of care it will focus on alongside the development of enabling infrastructure and support for the adoption of the models of care to achieve the aim of the strategy. The three models of care are: enhancing individuals' ability to self-care; the development and spread of the health care home model and the establishment of locality networks. This evaluation considers the development, implementation and early establishment of the Central Lakes Locality Network (CLLN), the first to be established in the Southern region.

Our goals were to:

- Establish if the locality network model was fit for purpose.
- Determine if it had the potential to deliver on the stated outcomes (plan and deliver care closer to where people live, work and play and use risk stratification to identify people who will benefit most from integrated care, using a stepped care approach).
- Describe the strengths and weaknesses of the model at the point in time of the evaluation.

These questions are important to understand as claims of effectiveness of networks tends to be theoretical or conceptual as opposed to being grounded in experience.

Our approach

This evaluation consisted of the following:

- An overview of published literature (research studies and reports) exploring locality networks or place-based working in health care.
- A document review of existing documents related to the development, implementation and establishment of the CLLN. These included hard and electronic copies of the following: reports, meeting minutes, terms of reference and expressions of interest.
- Conversations with stakeholders and members of the CLLN to understand their experiences and views on the development, implementation and establishment of the CLLN.

Our findings

The network does not reflect the vision of the Alliance. This was due to an inability to translate the vision into reality and anxiety at the thought of managing an interdisciplinary group of providers.

In addition, to the above point, the decision to move away from the description of a network in the strategy led to the circulation of an expressions of interest that did not target the individuals required to form a network as described in the strategy.

While the network was clear on its role as an advisory group to the Alliance, key stakeholders described being unclear what it was they wanted of the network. Furthermore, expectations articulated in the terms of reference, such as, liaising with the local communities to identified issues and gaps in services were discouraged by key stakeholders for fear of additional workload.

[redacted]

Most of the literature and indeed the Health and Disability System Review: Proposals for Reform refer to networks of providers, so while some within the group work for different providers, they were specifically instructed they were not there to represent their organisation

The network was never resourced adequately across multiple domains – financial; information/data; administratively and time.

The makeup of the group and District Health Board 'hot-potatoes' drove the focus of the work, as a result work addressing the stated equity priorities, Māori/those living in socioeconomic disadvantage/rural and remote communities, had not commenced at the time of this evaluation.

Lack of clarity across the different phases of development drove a sense of confusion which impacted the relationship between the network and Alliance South resulting in tension and frustration for both entities.

To sum up, through development to establishment this network faced multiple challenges and while it is too early to consider achievement of outcomes, some successes were achieved in very difficult circumstances.

Prepared by Dr Fiona Doolan-Noble

Appendix 3.

Executive Summary – Community Health Hubs

The development and design of a Community Health Hub (CHH) was outlined in the Primary and Community Care Strategy, and its associated plan. Hubs were viewed as a way of providing integrated healthcare models tailored to the needs of individual communities. This was one of the essential facets of the plan to improve and provide a sustainable healthcare delivery model for the peoples of the Southern region. This project investigated the early planning phase of development of an urban hub in Dunedin city, using document review and rapid thematic analysis of semi-structured key stakeholder interviews. Those interviewed included staff from both executive and clinical roles, from hospital and primary care settings, as well as the consumer perspective.

The strategy described Hubs as containing a variety of co-located services including but not limited to:-

- Core primary care (Health Care Home expanded primary care team)
- Enhanced urgent care
- On-site pharmacy
- Diagnostics
- Space for hospital specialist
- Space for minor procedures

These co-located services utilising multidisciplinary teams would provide mobile services (e.g. community nursing home visits) and in-clinic services (e.g. rehabilitation) and aged residential care.

It was noted at that time (2018) that the concept of the Hub was not well defined and there needed to be a clear understanding of which core services would be in a Hub. Development of the Hubs in different areas was originally seen to be the role of the corresponding locality network. By mid-2021 these networks had not been developed for all areas, with the Central Lakes locality network currently the only one in place in the Southern region. At this time the planning for hubs was being driven by the needs of the ageing community, with the development of the New Dunedin Hospital design giving the process additional impetus to establish Dunedin hubs. The design of the New Dunedin Hospital relies on some existing services that are currently within the hospital being moved into primary care. Some or all of these 'out of scope' services could be relocated into a community hub.

What would a Hub look like?

The literature suggests some options for providing integrated care. Integrated care models can be identified as belonging to three potential models of care[1] (ref. Gagan).

1) **transfer**: of services or elements of services from secondary to primary care;

2) **relocation**: shifting the venue of specialist care from outpatient clinics to primary care without changing the people who deliver the service and

3) **liaison/joint working**: joint working between specialists and primary care practitioners, or within primary community care practitioners to provide care to individual patients.

The proposed Southern Community Health Hub model could include some or all of these models.

[1] Gurung, G. et al. (2020), Integrated ambulatory care I the New Zealand Health system: a scooping review. J Int Care.Vol.28 No. 3, pp.253-280

Discussion has been held with various groups to determine the concept design of a Hub as outlined in the Strategy. Since its release many subsequent discussions have taken place to refine the initial design but so far there has been little consensus on what this will look like. Different groups involved have their own preferences for what services should be included in a Hub and how they should be provided.

Moving services closer to people's homes is seen as one of the principles for the development of Community Health Hubs, with the movement of some previously hospital-based services out into primary care.

This is also driven in part by the need to accommodate some services that were deemed 'out of scope' in the design of the New Dunedin Hospital. These services would be included in those provided with a Hub.

Those interviewed agreed that it was essential a hub was more than just the site of medical services, patients and whānau need to have non-health issues addressed as well, 'Need to be more than health, need to have a social component to hub, just health will not meet the needs and complexities of our people and what is happening in their lives.' (Participant 2)

Interviewees acknowledged that Māori are not well served by the current healthcare model and a move to a more whānau based model is needed.

Providing integrated care

It is currently unclear what integrated care will look like across the region. Will it be a set of co-located services in the same building or a series of services linked up by high quality IT?

The introduction of telehealth services has demonstrated that not all services need to be provided in person, however there are many advantages to having services co-located in the same or adjacent buildings. A mixture of both makes the best of both options and provides flexibility for both patients and clinicians.

There is not one specific model of care or design for a hub that will work for all the potential services that may be contained in or associated with a hub. Each service will need to decide which option or options to choose to meet the needs of their community; to do this they will need resources.

Key elements to progress development

To progress this development and establish greater clarity of what a Hub will look like requires a series of key elements, these include:

1. Leadership, there is currently no one in charge.
2. Ability to share information between providers (a technologically enabled system).
3. Time, including dedicated staff to get hubs set up.
4. Development of funding that is flexible to accommodate new models of care and service delivery.
5. Creative thinking on the part of staff and a willingness to try something different.
6. The building of relationships between groups and individuals involved in the care of the patient.

But **most important** will be the ability to share and coordinate a patient and the care of their whānau. This requires a stable IT system to facilitate the sharing of patient information and care plans between all involved in providing care; hospital services, community and GP services and any allied and social

services required by the patient and their whānau. Without the ability to share information to aid the provision of co-ordinated patient centred care Hubs will not work as desired.

At the time of writing there in no CHH in place in Dunedin but after a stalled process there appears to be progress towards development of an initial hub. Several factors have delayed development, with redeployment of key staff to the fight against COVID-19 having a significant impact.

Prepared by Dr Patti Napier

Appendix 4

Anticipated Timeline All Project, Evaluation of PCCS

Progress to January 2022 and planned future work

	2019			2020						2021						2022			
	Jul -Aug	Sept Oct	Nov-Dec	Jan-Feb	Mar-Apr	May-Jun	Jul -Aug	Sept Oct	Nov -Dec	Jan-Feb	Mar-Apr	May-Jun	Jul -Aug	Sept Oct	Nov -Dec	Jan-Feb	Mar-Apr	May-Jun	Ongoing
Health Care Homes			#	*			*		#*	*					#▽		☼	☼▽	
CLIC			#	*			*		#*	*					#▽		☼	☼▽	
Home Team			#	*			*		#*	*					#▽		☼	☼▽	
Engagement			#	*			*		#*	*					#▽		☼	☼▽	
Community Hubs			#	*			*		#*	*					#▽		☼	☼▽	
Locality Networks			#	*			*		#*	*					#▽		☼	☼▽	
Equity			#	*			*		#*	*					#▽		☼	☼▽	
OVERALL			#	*			*		#*	*					#▽		☼	☼▽	
Report Due			Nov	Feb		$$$	Jul/Aug		Nov	Feb	$$$	May	Aug		Nov	Feb	Mar	May	

Key Planning Data Collection Data analysis Deferred Final report

* Report delivery to ALT (3 monthly) # Report delivery to Funder HRS (annually) - May report to ALT deferred due to Covid-19

▽ report to WellSouth Board (bi-monthly) ☼ report to CPHAC (2 monthly)

FOR INFORMATION

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

Proposed by: Andrew Lesperance, Executive Director Planning, Funding & Population/Public Health

Meeting of: Community and Public Health Advisory Committee, 1 March 2022

Recommendation

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

Purpose

To inform the Committee of the 31 January 2022 Planning, Funding & Population/Public Health financial performance

Specific Implications for Consideration

Financial

- As set out in the report.

Workforce

- No specific Implications

Equity

- N/A

Other

- N/A

Planning Funding, Population/Public Health (excl Covid)

Exec Hierarchy - LEVEL 3	Exec Hierarchy - LEVEL 1	Exec Hierarchy - DESCRIPTION	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)	Actual FTE YTD	Budget FTE YTD	Variance FTE YTD	Annual Budget
Revenue	Government & Crown	MoH Revenue	(89,216)	(88,187)	1,030				(635,966)	(617,307)	18,659				(1,058,240)
		IDF Revenue	(1,851)	(2,215)	(364)				(14,579)	(15,508)	(929)				(26,586)
		Other Government	(1,132)	(416)	716				(6,532)	(3,984)	2,548				(6,840)
	Government & Crown Total		(92,199)	(90,818)	1,381				(657,077)	(636,799)	20,278				(1,091,666)
	Non Government	Other Income	(10)	(36)	(27)				(84)	(255)	(171)				(437)
		Patient related	(8)	(21)	(14)				(70)	(148)	(78)				(253)
	Non Government Total		(17)	(57)	(40)				(154)	(402)	(248)				(690)
	Internal Revenue	Internal Revenue	(2,869)	(2,630)	239				(21,632)	(18,413)	3,220				(31,564)
	Internal Revenue Total		(2,869)	(2,630)	239				(21,632)	(18,413)	3,220				(31,564)
Revenue Total			(95,085)	(93,506)	1,579				(678,863)	(655,614)	23,249				(1,123,920)
Workforce Expenses	Senior Medical Officers (SMO's)	SMO - Direct	694	617	(77)	33.11	28.31	(4.80)	5,124	4,795	(329)	32.50	31.77	(0.73)	8,247
		SMO - Indirect	38	41	3				258	285	27				489
		SMO - Outsourced	33	24	(9)				97	201	103				336
	Senior Medical Officers (SMO's) Total		765	682	(83)	33.11	28.31	(4.80)	5,479	5,281	(198)	32.50	31.77	(0.73)	9,072
	Registrars / House Officers (RMOs)	RMO - Direct	31	38	7	5.16	3.21	(1.95)	485	270	(214)	5.58	3.21	(2.37)	472
		RMO - Indirect	(1)	2	3				5	13	8				23
		RMO - Outsourced	0		(0)				0		(0)				
	Registrars / House Officers (RMOs) Total		30	40	10	5.16	3.21	(1.95)	490	284	(206)	5.58	3.21	(2.37)	494
	Nursing	Nursing - Direct	2,453	2,108	(345)	269.92	257.86	(12.06)	16,428	13,772	(2,656)	264.57	248.37	(16.20)	23,602
		Nursing - Indirect	0		(0)				33		(33)				
		Nursing - Outsourced	2		(2)				32		(32)				
	Nursing Total		2,454	2,108	(346)	269.92	257.86	(12.06)	16,492	13,772	(2,720)	264.57	248.37	(16.20)	23,602
	Allied Health	Allied Health - Direct	1,564	1,800	235	261.02	295.73	34.71	13,538	14,843	1,305	298.25	329.29	31.04	25,750
		Allied Health - Indirect	27	16	(10)				93	115	21				370
		Allied Health - Outsourced	46	16	(29)				272	114	(159)				193
	Allied Health Total		1,637	1,832	195	261.02	295.73	34.71	13,904	15,072	1,168	298.25	329.29	31.04	26,312
	Support	Support - Direct	1	1	(1)	0.64	0.18	(0.46)	23	7	(16)	0.78	0.20	(0.58)	10
		Support - Indirect	0	0	0				0	0	0				0
		Support - Outsourced	39		(39)				211		(211)				
	Support Total		40	1	(39)	0.64	0.18	(0.46)	234	7	(227)	0.78	0.20	(0.58)	11
	Management & Admin	Management & Administration - Direct	585	689	104	97.62	110.19	12.57	5,594	5,574	(20)	117.80	119.15	1.35	9,611
		Management & Administration - Indirect	1	3	1				164	19	(146)				32
		Management & Administration - Outsourced	19	1	(18)				78	8	(70)				13
	Management & Admin Total		605	693	88	97.62	110.19	12.57	5,836	5,601	(236)	117.80	119.15	1.35	9,656
Workforce Expenses Total			5,531	5,356	(175)	667.47	695.48	28.01	42,434	40,015	(2,419)	719.47	731.99	12.51	69,147
Non Personnel Expenses	Non Personnel Expenses	Outsourced Clinical Services	193	101	(92)				1,614	811	(803)				1,403
		Outsourced Corporate / Governance Services	0		(0)				0		(0)				
		Outsourced Funder Services	1,315	1,267	(47)				8,969	8,872	(96)				15,210
		Clinical Supplies	1,298	537	(761)				8,788	6,704	(2,085)				11,769
		Infrastructure & Non-Clinical Supplies	292	429	137				3,323	3,089	(235)				5,271
	Non Personnel Expenses Total		3,097	2,335	(763)				22,695	19,476	(3,219)				33,653
	Provider Payments	Personal Health	70,137	68,875	(1,263)				504,832	486,571	(18,261)				832,193
		Disability Support	17,013	17,006	(8)				119,391	118,555	(836)				202,188
		Public Health	296	90	(206)				1,806	628	(1,178)				1,077
		Maori Health	302	315	13				1,905	1,929	24				3,228
	Provider Payments Total		87,748	86,285	(1,463)				627,933	607,683	(20,250)				1,038,685
Non Personnel Expenses Total			90,846	88,619	(2,226)				650,628	627,159	(23,469)				1,072,338
(blank)	(blank)	(blank)													
	(blank) Total														
(blank) Total															
Net (Surplus) / Deficit			1,291	469	(822)	667.47	695.48	28.01	14,199	11,561	(2,638)	719.47	731.99	12.51	17,565

Covid Vaccination Cost Centres

Group3	Group2	Group1	Payroll	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	Monthly Actual FTE	Monthly Budget FTE	Monthly FTE Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD	YTD Actual FTE	YTD Budget FTE	YTD FTE Variance	$000 Full Year Budget
Revenue	Government & Crown Agency Sourced			3,171	0	3,171				26,468		26,468				0
	Non Government & Crown Agency Rev	Other Income			0	0				1		1				0
	Non Government & Crown Agency Revenue Total				**0**	**0**				**1**		**1**				**0**
	Internal Revenue	Internal Revenue		719	0	719				7,322		7,322				0
	Internal Revenue Total			**719**	**0**	**719**				**7,322**		**7,322**				**0**
Revenue Total				**3,891**	**0**	**3,891**				**33,791**		**33,791**				**0**
Workforce Expenses	Medical - SMO	Medical - SMO	Direct	0	0	0				0		0				0
	Medical - SMO Total			**0**	**0**	**0**				**0**		**0**				**0**
	Medical - RMO	Medical - RMO	Direct	(33)	0	(33)	2.00		(2.00)	(33)		(33)	0.29		(0.29)	0
			Indirect	(1)	0	(1)				(1)		(1)				0
	Medical - RMO Total			**(34)**	**0**	**(34)**	**2.00**		**(2.00)**	**(34)**		**(34)**	**0.29**		**(0.29)**	**0**
	Nursing	Nursing	Direct	(269)	0	(269)	40.64		(40.64)	(3,005)		(3,005)	55.71		(55.71)	0
			Indirect	(1)	0	(1)				(2)		(2)				0
	Nursing Total			**(270)**	**0**	**(270)**	**40.64**		**(40.64)**	**(3,006)**		**(3,006)**	**55.71**		**(55.71)**	**0**
	Allied Health	Allied Health	Direct		0	0				(5)		(5)	0.10		(0.10)	0
			Indirect		0	0				(0)		(0)				0
	Allied Health Total				**0**	**0**				**(5)**		**(5)**	**0.10**		**(0.10)**	**0**
	Support	Support	Indirect		0	0				(3)		(3)				0
			Outsourced		0	0				(26)		(26)				0
	Support Total				**0**	**0**				**(29)**		**(29)**				**0**
	Management & Admin	Management & Admin	Direct	(299)	0	(299)	55.36		(55.36)	(2,614)		(2,614)	68.09		(68.09)	0
			Indirect		0	0				(2)		(2)				0
			Outsourced	15	0	15				(41)		(41)				0
	Management & Admin Total			**(285)**	**0**	**(285)**	**55.36**		**(55.36)**	**(2,657)**		**(2,657)**	**68.09**		**(68.09)**	**0**
Workforce Expenses Total				**(589)**	**0**	**(589)**	**98.00**		**(98.00)**	**(5,732)**		**(5,732)**	**124.19**		**(124.19)**	**0**
Non Personnel Expenditure	Outsourced Services			(20)	0	(20)				(489)		(489)				0
	Clinical Supplies			(20)	0	(20)				(87)		(87)				0
	Infrastructure & Non-Clinical Supplies			(129)	(0)	(128)				(1,161)	(2)	(1,159)				(4)
	Provider Payments	Payments to Providers - Public Health		(3,167)	0	(3,167)				(26,356)		(26,356)				0
		Payments to Providers - Hauora Maori Servic			0	0										0
	Provider Payments Total			**(3,167)**	**0**	**(3,167)**				**(26,356)**		**(26,356)**				**0**
Non Personnel Expenditure Total				**(3,336)**	**(0)**	**(3,336)**				**(28,092)**	**(2)**	**(28,090)**				**(4)**
Net Surplus / (Deficit)				**(34)**	**(0)**	**(34)**	**98.00**		**(98.00)**	**(33)**	**(2)**	**(31)**	**124.19**		**(124.19)**	**(4)**

Requests awaiting approval - Items on Register

Summary

The Planning, Funding & Population/Public Health directorate has an unfavourable variance to budget for the month of $0.82m and $2.64m unfavourable YTD (prior to accrual adjustments)

Significant contributors to the unfavourable variances for the month are:

- Pharmaceuticals $415k unfavourable for January in Strategy, Primary & Community. YTD revenue includes extra $470k accrual in relation to latest Pharmac forecast of impact of Covid expenditure on expenditure.
- Pharmaceutical Clinical supplies has a significant unfavourable variance of $568k for SPC and $2.3m for the total DHB for the month due to a significant phasing issue in the budget.
- Non Acute Rehabilitation revenue includes a nett favourable impact of $1.1m due to a significant ACC price increase (backdated to December 2020) notified in late December.
- DSS provider payments on budget for January but include unfavourable variance in Residential Care Hospitals ($445k u) offset by Residential Care Rest Homes $218k favourable and Pay Equity $197k favourable.

Comments for discussion

- The latest Pharmac forecast received in December includes $3.36m of revenue for Covid related costs. $2.1m of this has been recognised as revenue as at January YTD . The Overall workforce excluding COVAX is largely on budget with notable variances in Nursing and Allied.
    - Nursing FTE is 16 FTE over budget YTD (excl COVAX Additional) 3 FTE is effectively budgeted but in outsourced clinical (increased school-based services).
    - Allied Health favourable variance reflects recruitment challenges largely in Physio and Oral Health.

Revenue

External Revenue

- MOH revenue $1.2m fav for January mainly due to Nurse pay equity ($824k) offset by expenditure in price adjusters. Covid pharmaceutical revenue of $400k is the other contributor.
- ACC revenue $565k favourable for the month and $2.4m favourable YTD. The favourable variance is due to the price increase notified by ACC in December (backdated to Dec 2020). The extra revenue is offset by increased payments to Rural Trusts ($500k) relating to the price increase.
- Non devolved Primary Care funding (VLCA, Careplus & CSC) continues to track above budgeted levels ($155k for the month, $1.15m YTD) noting this has direct expenditure offset, so no impact on bottom line.

Internal Revenue

- $810k YTD favourable relates to Public Health Covid revenue where there is an expenditure offset. The balance relates to revenue offsetting MECA backpayments.

Workforce Costs

Medical SMO – $83k unfavourable and 4.8 FTE unfavourable for the month and $198k unfavourable YTD and 0.73 FTE unfavourable. Mainly due to overtime, penal & allowances offset YTD by Ordinary time.

- January includes 1.42FTE and $17k of Public Health Covid expense.
- Lakes SMO's use a self-cover system, based off the calendar year. All self-cover shifts have been exhausted and additional duties are now being paid. This is due to unbudgeted but approved "princess" shift.
- Clinical Lead and another SMO released for times to complete Endemic Planning. The team is still working on quantifying this.

Medical RMO – $10k favourable and 2FTE unfavourable for the month and $209k unfavourable YTD (excl COVAX) and 2.4 FTE unfavourable YTD.

- Mainly relates to Dental Surgery cost centre which is $158k unfavourable YTD and 1.24 FTE unfavourable.
- Includes Lakes 0.77 FTE YTD, which is approved but unbudgeted

Nursing – Excluding COVAX expenditure - $86k unfavourable for the month and $2.72m unfavourable YTD. 12 FTE unfavourable for the month and 16 FTE YTD.

- Expenditure includes payments for Pay Equity and back payments of $1.9m YTD offset by extra revenue.
- COVID Public Health 1.3 FTE and $79k YTD (with offsetting revenue).
- Lakes Nursing 3.3 FTE unfavourable YTD. Training (.3 FTE YTD), Ordinary (0.76 FTE YTD) and Overtime (1.1 FTE & $89k YTD) are the main drivers, noting FTE now same as levels experienced in 20/21.
- Vacancy factor budget – Budget includes VF of 3.7 FTE ($163k) YTD
- Southland Rehab ward – 1.3 FTE unfavourable YTD mainly due to Health Service Assistants (2.4 FTE u) offset by Enrolled nurses (1.1FTE f).
- Te Punaka Oraka - $173k unfavourable and 1.67 FTE unfavourable YTD. Mainly due to Additional School Based funding where the budget was put against outsourced services and has not been realigned to FTE's. January was $108k fav and 9 FTE fav due to leave taken (10 FTE and $72k fav) resulting in Ordinary time being 10 FTE fav for the month bringing YTD FTE closer to budget. Additional School based funding budget was put against outsourced services which is $203k fav YTD. The overall FTEs employed for ASB was 3 FTE
- Central Otago Maternity Services are 1.3 FTE unfavourable YTD and $122k unfavourable. This is due to the budget having to match the previous NGO budget. Estimated expenditure was calculated to be $167k higher p.a which is in line with the YTD overspend.
- Ward 6B Geriatric ATR – 1.6 FTE unfavourable for the month and 3.9 FTE YTD. Includes 2.2 FTE unbudgeted Accident Leave. High number of patient watches also contributing.
- Puawai Rehabilitation Unit – 0.8 FTE unfavourable for the month and 1.4 FTE & $162k YTD.

Allied Health - $195k and 34.7 FTE favourable to budget for the month and $1.14m and 31 FTE favourable YTD. Due to ongoing vacancies

- Physiotherapists (8 FTE f), Therapists aids & assistants (8 FTE f), Occupational Therapists (7FTE f) and Dental Therapists (5 FTE f) and the main drivers of the favourable variance.

Management/Admin – $88k and 12.6 FTE favourable for the month, 1.35 FTE favourable and $238k unfavourable YTD.

- The monthly FTE variance is due to leave taken being 10 FTE unfav which impacts on Ordinary time 12 FTE and $88k fav for the month.
- $134k YTD relates to Public Health Covid which is offset by revenue. $133k YTD relates to settlement payments.
- 2FTE relates to leadership team, who are reporting through to CEO.

Pharmaceuticals

	$000 YTD 2020/21	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
Clinical Supplies - Pharmaceuticals	$ 18,545.7	$ 19,991.0	$ 16,808.0	-$ 3,183.0
Provider Payments - Pharms	$ 45,621.5	$ 48,720.0	$ 46,426.0	-$ 2,294.0
Haemophillia (medical outpatients)	$ 2,232.0	$ 2,303.0	$ 1,909.8	-$ 393.1
Total	**$ 66,399.2**	**$ 71,014.0**	**$ 65,143.8**	**-$ 5,870.1**

Variance is made up of the following (estimate)

Pharms YTD		$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
PCT	$ 8,309.0	$ 8,395.0	$ 5,688.7	-$ 2,706.3
Community Pharms (DHB Outpatients)	$ 4,163.8	$ 4,929.0	$ 3,152.0	-$ 1,777.0
Hospital Inpatients	$ 6,944.0	$ 6,667.0	$ 7,967.3	$ 1,300.3
Community Pharms (excl DHB)	$ 45,621.5	$ 48,720.0	$ 46,426.0	-$ 2,294.0
Haemophillia (medical outpatients)	$ 2,232.0	$ 2,303.0	$ 1,909.8	-$ 393.1
Total	**$ 67,270.3**	**$ 71,014.0**	**$ 65,143.8**	**-$ 5,870.1**

Pharmaceuticals January 22

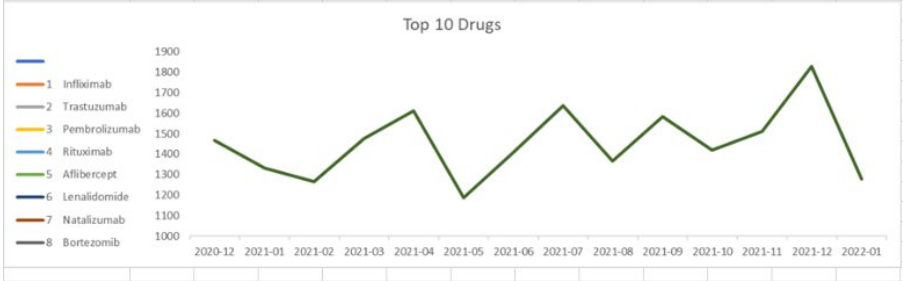
Category	**Variance to budget for pharmaceuticals $000's**	
	SPC	**DHB**
Community	-415	-415
Clinical Supplies	-568	-2345
Covid revenue	-434	-434
Total	-1417	-3194

Covid revenue as per the Pharmac forecast along with previous reduction adjustments made in January to recognise the nett impact of those adjustments YTD. The monthly impact for the rest of the financial year will be $154k unfavourable.

Clinical supplies significantly unfavourable in January due to a phasing error in the budget across the whole DHB which will have an ongoing impact for the rest of the financial year.

Utilisation of the top 10 chemicals within the DHB (clinical supplies) decreased significantly in January from December ($272k) with Infliximab ($209k), Lenalidomide ($72k), Trastuzumab ($69k) and Aflibercept ($54k) being the main decreases.

MonthYear	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01
1 Infliximab	$454	$395	$335	$426	$672	$190	$375	$532	$402	$515	$426	$430	$639	$366
2 Trastuzumab	$252	$241	$220	$256	$225	$278	$239	$231	$206	$264	$226	$214	$255	$186
3 Pembrolizumab	$175	$130	$164	$215	$139	$146	$193	$178	$154	$120	$135	$131	$157	$133
4 Rituximab	$148	$139	$140	$104	$101	$114	$110	$168	$121	$103	$132	$190	$151	$107
5 Aflibercept	$160	$180	$176	$204	$184	$195	$195	$220	$193	$241	$238	$258	$296	$243
6 Lenalidomide	$48	$53	$42	$78	$66	$59	$59	$83	$71	$91	$83	$77	$131	$72
7 Natalizumab	$84	$71	$62	$87	$80	$83	$61	$92	$87	$80	$68	$82	$82	$76
8 Bortezomib	$8	$7	$8	$9	$10	$9	$12	$9	$8	$9	$7	$7	$8	$5
9 Taligucerase	$75	$75	$62	$46	$76	$71	$79	$71	$61	$97	$53	$70	$88	$72
10 Octreotide	$62	$40	$56	$52	$57	$41	$84	$54	$64	$63	$52	$54	$22	$19
Total	**$1,467**	**$1,332**	**$1,265**	**$1,476**	**$1,610**	**$1,187**	**$1,408**	**$1,637**	**$1,367**	**$1,583**	**$1,418**	**$1,512**	**$1,829**	**$1,279**



Outsourced Clinical Services

$823k unfavourable YTD. Relates to NAR claiming and washups which were previously expensed as a reduction of revenue. December includes an adjustment relating to NAR price increase for Rural Trusts as mentioned above in the NAR revenue comments.

Clinical Supplies (excluding Pharms)

YTD variance $309k unfavourable. Mainly due to Ostomy Supplies ($138k), bandages & dressings ($76k) and Continence ($71k)

Infrastructure & Non-Clinical Supplies

- $220k favourable for January and 39k unfavourable YTD. January mainly due to Business related travel $90k fav along with Food Groceries $49k fav and patient meals $62k in January.

Provider Payments (NGO's)

Personal Health - $1.38m unfavourable for January and $18.38m unfavourable YTD.

- $15.8m (814k in January) relates to expenditure matching the MECA pay equity revenue received for the DHB.
- PHO lines are $348k unfavourable for January and $2.33m unfavourable YTD. The majority of the PHO variance is due to Community Service Card ($755k YTD) and VLCA ($309k YTD) expenditure which is offset by extra revenue. There is still a component of the Primary Care savings plan that has no identified source.
- Medical Outpatients are $372k unfavourable YTD due to Haemophilia pool payments.

- Surgical Inpatients are $383k unfavourable YTD due to Planned Care. Offset by favourable revenue variance.
- Travel and accommodation $132k fav for January and $675k fav YTD, demand driven and not unexpected due to impact of Covid. Highly volatile from month to month due to variable nature of claiming.
- Adolescent Dental is significantly favourable ($276k) YTD due to over accrual in prior periods, along with lower utilisation due to COVID restrictions.
- Maternity favourable variance reflects the reduction in Rural LMC sustainability payments (due to increase in section 88 payments).

Public Health - $0.26m unfavourable for January and $1.18m unfavourable YTD.

- Unfavourable variance is mainly due to the internal charge expenditure relating to the extra Covid revenue received YTD of $800k. $184k of the YTD variance is due to savings that have not been attained (noting Public Health Service overall is favourable

Disability Support - $8k unfavourable for January and $836k unfavourable YTD.

- IBT $484k unfavourable variance YTD
- Carer Support $342k fav YTD
- ARRC provider payments $227k unfavourable for January and $727k YTD
- Pay Equity YTD variance ($387k) is exacerbated by large number of historic claims received in October. These were above what had been allowed for in previous months.

Closed Session:

RESOLUTION:

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

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Minutes of Previous Public Excluded Meeting	As set out in previous agenda.	As set out in previous agenda.

*S 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.