DISABILITY SUPPORT ADVISORY COMMITTEE

and

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

A G E N D A

Wednesday, 4 April 2012
10.00 am

Conference Room 1, Copthorne Hotel
corner Frankton Road and Adelaide Street
Queenstown

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DISABILITY SUPPORT ADVISORY COMMITTEE AND COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

Wednesday, 4 April, 10.00 am

Copthorne Hotel, Queenstown

A G E N D A

Closed Session:

RESOLUTION:
That the Disability Support Advisory Committee and Community & Public Health Advisory Committees move into committee to consider the agenda items 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 34, Schedule 4 of the NZ Public Health and Disability Act 2000 for the passing of this resolution are as follows:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Minutes	As per reasons set out in previous agenda.	S 34(a), Schedule 4, NZ Public Health and Disability Act 2000 – that 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)(i) and 9(2)(j) of the Official Information Act 1982, that is, the withholding of the information is necessary to enable a Minister of the Crown or any Department or organisation holding the information to carry out, without prejudice or disadvantage, commercial activities and negotiations.
2. Provider Agreements and Funding	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage.	As above, sections 9(2)(i) and 9(2)(j).

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Joe BUTTERFIELD (Chairman)	01.03.2012 06.12.2010	1. Member, South Island Neurosurgical Board **Son-in-law:** 2. Partner, Polson Higgs, Chartered Accountants. 3. Trustee, Corstorphine Baptist Community Trust	1. 2. Does some accounting work for Southern PHO. 3. Has a mental health contract with Southern DHB.
Paul MENZIES (Deputy Chairman)	10.02.2010 10.02.2010 06.10.2011	1. Wife a member on the Southland Child Youth Mortality Review Group. 2. Wife a member on the Child and Youth Health Advisory Committee. 3. Trustee, Southern PHO	1. Nil. 2. Nil. 3. Appointed as a trustee by Southern DHB. PHO is contracted to the DHB.
Neville COOK	04.03.2008 04.03.2008 04.03.2008 26.03.2008	1. Board Member, Invercargill Licensing Trust. 2. Board Member, Invercargill Licensing Trust Foundation. 3. Councillor, Environment Southland. 4. Trustee, Norman Jones Foundation.	1. Possible conflict with funding requests. 2. Possible conflict with funding requests. 3. Nil. 4. Possible conflict with funding requests.
Sandra Cook	01.09.2011	1. Te Runanga o Ngāi Tahu	1. Holds a "right of first refusal" over certain Crown properties. Also seen as a Treaty partner and affiliates may hold contracts from Southern DHB from time to time.
Kaye CROWTHER	09.11.2007 14.08.2008 14.08.2008 12.02.2009 05.12.2010 01.03.2012	1. Employee of WHK South. 2. Trustee of Plunket Foundation. 3. Trustee of Wakatipu Plunket Charitable Trust. 4. Corresponding member for health and family affairs, National Council of Women. 5. Member of advisory panel for No 10, Invercargill. 6. DHB representative on the Gore Social Sector Trial	1. Possible conflict if DHB contracts HR services from JCL and Progressive Consulting, which are subsidiaries of WHK. 2. Nil. 3. Nil. 4. Nil.
Mary FLANNERY	17.11.2010 10.11.2011	1. Trustee, Rural Otago Primary Health Organisation 2. Associate Solicitor, Bodkins Alexandra. 3. Partner, Tayside Farm Partnership. 4. New Zealand Irrigation Board	1. Was contracted to Southern DHB – contracts assigned to Southern PHO (will be wound up) 2. Nil 3. Nil 4. Nil
James <u>Malcolm</u> MACPHERSON	28.06.2005 09.03.2011 25.11.2010	1. Member Otago Polytechnic Council. 2. Contractor and Tutor, Otago Polytechnic. 3. Member Central Lakes Trust.	1. (OP has training interests in common with the DHB, no) 2. (personal interest.) 3. CLT is a community funder in its region, which includes

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	25.11.2010 25.11.2010 28.08.2007 09.03.2011 09.03.2011 09.03.2011 13.12.2001 22.04.2003	4. Member Roxburgh Gorge Trail Charitable Trust. 5. Part owner, Alexandra Medical Centre. 6. Co-Principal, Brilliant New Zealand Ltd. 7. Chairman, Jolendale Charitable Trust. 8. Shareholder, Medco Properties Ltd 9. Director, Centennial Health Ltd **Spouse - Susan Elizabeth Macpherson:** 10. GP Principal, Centennial Health Ltd, Alexandra. 11. Branch Medical Advisor, ACC, Alexandra.	Dunstan and Lakes District Hospitals, plus a wide range of community and primary services and service providers, and is a possible future funder. 4. Nil. 5. The AMC is tenanted by all of Alexandra's GPs and a pharmacy, and is also occasionally used by related service providers, including midwives and the University of Otago Medical School. A range of potential conflicts. 6. BNZL is a consultancy which may have an involvement with health sector organisations. 7. Nil. 8. MPL will be responsible for the tenancy of all of Alexandra's current GPs and a pharmacy and may also house other related service providers, including midwives and the University of Otago Medical School. A range of potential conflicts, real and theoretical. 9. & 10. Board discussions relating to primary health providers or primary referred services may involve conflicts of interest. Declare where appropriate and withdraw where prudent. 11. ACC is a major customer of the DHB. Remote possibility of an influence, no personal interest.
Tahu POTIKI	15.12.2007 03.04.2008 24.11.2009 03.06.2010	1. Director, Arataki Associates. 2. Representative to Te Runanga o Ngai Tahu. 3. Trustee of Ngai Tahu Charitable Trust. 4. Board Member, Relationship Services NZ. 5. Board Member, Environmental Science and Research	1. Contracted to Southern DHB, funded provider in the past ie Araiteuru Whare Hauora Ltd. 2. & 3. Treaty Partner - affiliated providers may contract to Southern DHB. Te Runanga o Ngai Tahu has right of first refusal on disposal of property. 4. No apparent conflict. 5. CRI involved in public health research.
Branko SIJNJA	07.02.2008 04.02.2009 22.06.2010	1. Director, Clutha Community Health Company Limited. 2. 0.5 FTE Director Rural Immersion Programme, Otago University School of Medicine. 3. Employee, Balclutha General Practitioners Limited	1. Operates publicly funded secondary health services under contract to Southern DHB. 2. Possible conflicts between Southern DHB and University interests. 3. Employed as a part-time GP.
Richard John THOMSON	13.12.2001	1. Managing Director, Thomson & Cessford Ltd. 2. Director, Susanna Shaya Imports Ltd 3. Chairperson and Trustee, Hawksbury Community Living Trust.	1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
	23.09.2003 29.03.2010 06.04.2011	4. Trustee, HealthCare Otago Charitable Trust. 5. Director, Composite Retail Group. 6. Councillor, Dunedin City Council.	2. Susanna Shaya Imports is a homeware importing company. It has no dealings with Southern DHB. 3. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB. 4. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations. 5. May have some stores that deal with Southern DHB.
Tim WARD	14.09.2009 01.05.2010 01.05.2010	1. Partner, BDO Invercargill, Chartered Accountants. 2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT).	1. May have some Southern DHB patients and staff as clients. 2. Verdon is a participant in the employment incubator programme. 3. Supply of goods and services between Southern DHB and SIT.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at March 2012

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
John Adams	27.05.2003 24.02.2004 23.11.2004 22.04.2008 18.02.2010	1. Dunedin School of Medicine (Dean). 2. Southern DHB Mental Health Service (staff member). 3. Ashburn Hall Charitable Trust (Trustee). 4. NZ Institute of Rural Health (Trustee). 5. Medical Council of New Zealand (Chair).	1. Possible conflicts between Southern DHB and University interests. 2. Possible differences in priorities and view between governance and employee. 3. The Ashburn Clinic is both a contractor to and provides similar services to the Southern DHB. 4. DHBs contract NZIRH to provide services. 5. At times, NZMC policy or opinion may conflict with or be critical of Southern DHB policy.
Steve Addison	21.02.2012	1. Mother-in-law (Anne Gover) Gore District Councillor 2. Father-in-law (Keith Gover) on Board of Gore Counselling Centre	
Vivian Blake	23.04.2007 08.02.2009	1. Executive Director on the Board of the Health Roundtable (HRT). 2. New Zealand Benchmarking Group (Chair).	1. The HRT facilitates benchmarking activity for 130 Australasian hospitals. 2. NZBG is the New Zealand Chapter of the Australasian Health Roundtable.
Richard Bunton	17.03.2004 29.04.2010	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd. 5. Deputy Chairman, Board of Cardiothoracic Surgery, RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	1. The only potential conflict would be if the Southern DHB decided to use this product for Southern DHB functions. 2. This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract. 3. This company provides private cardiological services to Otago and Southland. A potential conflict would exist if the Southern DHB were to contract with this company. 4. This company is one used for personal trading and apart from issues raised in '2' no conflict exists. 5. No conflict.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	23.02.2010	8. Otago Rugby Union (Director).	6. No conflict. 7. No conflict. 8. No conflict.
Donovan Clarke	02.02.2011	1. Te Waipounamu Delegate, Te Piringa, National Maori Disability Advisory Group. 2. Director, Great Western Steakhouse, New Lynn, Auckland.	1. Nil. 2. Nil.
Tina Gilbertson	16.11.2011	Nil	
Carole Heatly	14.03.2012	Nil	1.
Robert Mackway-Jones	28.08.2007	1. Close association (wife) employed by Dunedin Hospital.	2. Reporting line to Purchasing Team leader.
Lexie O'Shea	01.07.2007	1. Trustee, Gilmour Trust.	1. Southland Hospital Trust.
Lynda McCutcheon	24.01.2012	Nil	
John Pine	17.11.201	Nil	
Leanne Samuel	01.07.2007 01.07.2007 01.07.2007 29.10.2009 01.10.2010	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel. 3. Member of Board of Studies at Southern Institute of Technology. 4. Southland Medical Foundation Inc (Member) 5. Member of National Elective Services Productivity and Workforce Programme Steering Group.	1. Southland Hospital Trust. 2. Nil. 3. Potential conflict if the DHB purchases services from this organisation. 4. Southland Trust. 5. Nil.
John Simpson		Nil	
David Tulloch	23.11.2010 02.06.2011	1. Southland Urology (Director) 2. Southern Surgical Services (Director) 3. UA Central Otago Urology Services Limited (Director)	1. Potential conflict if DHB purchases services. 2. Potential conflict if DHB purchases services. 3. Potential conflict if DHB purchases services.
Ian Macara (in attendance at EMT as CEO of the Southern PHO)	26.08.2010	Nil	

Southern District Health Board

Minutes of the Joint Meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on Wednesday, 1 February 2012, commencing at 9.00 am, in the Board Room, Dunedin Hospital

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Present:	Dr Malcolm Macpherson	Chairman
	Mr Neville Cook	
	Ms Sandra Cook	(from 9.35 am)
	Mrs Kaye Crowther	
	Mrs Mary Flannery	
In Attendance:	Mr Joe Butterfield	Board Chairman (from 10.30 am)
	Mr Robert Mackway-Jones	General Manager, Finance & Funding
	Mrs Lexie O'Shea	Acting Chief Executive Officer (from 9.50 am to 10.30 am)
	Ms Jeanette Kloosterman	Board Secretary
	Ms Nyia Strachan	Acting Communications Officer

1.0 WELCOME

The Chairman welcomed everyone to the first meeting for 2012.

2.0 APOLOGIES

An apology for lateness was received from Ms Sandra Cook.

3.0 MEMBERS' DECLARATION OF INTEREST

The Chairman called for any adjustments or amendments to the Interests Register. There were none.

The Chairman asked if Committee members were aware of any agenda items with which they may have a potential conflict and reminded them of their responsibility to advise the meeting immediately should any potential conflict, actual or perceived, arise during discussions.

4.0 PREVIOUS MINUTES

It was resolved:

"That the minutes of the joint meeting of the Disability Support Advisory Committee and Community & Public Health Advisory Committee held on 4 August 2011 be approved and adopted as a true and correct record."

Moved: Mr N Cook
Seconded: Mrs M Flannery

5.0 ACTION SHEET

The Committees reviewed and noted the action sheet (agenda item 5).

The General Manager, Finance & Funding reported that the regional Child and Youth Advisory Group was in its formative stages. Its terms of reference would be submitted to the next DSAC/CPHAC meeting.

6.0 WORK PLAN

The Committees reviewed the work plan for 2011/12 (agenda item 6). The General Manager, Finance & Funding answered members' questions on the various work streams and outputs status.

7.0 PHO PERFORMANCE PROGRAMME

The Committees considered a report on Primary Health Organisation (PHO) Performance Programme results for the Southern PHO as at 30 June 2011 (agenda item 7).

The General Manager, Finance & Funding informed the Committees that the PHO Performance Programme report covered a subset of the PHO performance indicators and he would include the entire set in the next agenda.

Ms Sandra Cook joined the meeting at 9.35 am.

8.0 SUBMISSIONS PROCESS

The Committees considered a report outlining a set of recommended principles for a public health submissions process (agenda item 8).

The Committees:

- Requested a copy of the proposed submission process policy and risk assessment prior to making a recommendation to Board;
- Noted the report.

9.0 HEALTH OF OLDER PEOPLE PORTFOLIO COMMUNITY MODELS OF CARE SERVICE DEVELOPMENT PLAN

The Committees considered a progress report on the Health of Older People (HOP) Portfolio Community Models of Care (CMC) Service Development Plan (agenda item 9.0).

The General Manager, Finance & Funding reported that the first meeting of the HOP Planning Advisory Committee had been held the previous week in Balclutha and some modifications to the Committee's terms of reference had been agreed to.

Mrs Lexie O'Shea, Acting Chief Executive Officer, joined the meeting at 9.50 am.

Members requested that they be added to the distribution list for the *HOP News*.

10.0 DIABETES SERVICE DEVELOPMENT

The General Manager, Finance & Funding answered members' questions on the progress report on diabetes service development circulated with the agenda (item 10).

The Committees noted the report.

11.0 SUBMISSION ON THE GREEN PAPER FOR VULNERABLE CHILDREN

The Committees considered a draft submission on the Green Paper for Vulnerable Children (agenda item 11) and suggested that the following be added to it:

- Reference to the Southland Well Child providers group in section 6, pages 8-9 of the report;
- Support for policies around Whānau Ora care.

12.0 PUBLIC HEALTH SOUTH (PHS)

A report from Public Health South (PHS) for November and December 2011 was circulated with the agenda (item 12) and was taken as read.

The Committees queried whether the notifiable disease data contained in the report was for the month or year, and whether it was available in trend format.

13.0 IMMUNISATION HEALTH TARGET 2010/11

The Committees noted that the Southern DHB had been awarded a certificate by the Ministry of Health recognising achievement of the Immunisation Health Target for 2010/11 (agenda item 13) and requested that their congratulations be conveyed to all the parties who worked to accomplish this.

14.0 TERMS OF REFERENCE

The Committees reviewed their terms of reference and recommended changes to them (agenda item 14).

It was resolved:

"That with the following further amendment the Committees endorse the terms of reference as modified and recommend the Board approve them:

- **The 'Review' section to read, "The Terms of Reference for this Committee shall be reviewed at the beginning of each new Board term."**

Moved: Mrs M Flannery
Seconded: Mrs K Crowther

Mrs L O'Shea, Acting Chief Executive Officer, left the meeting and Mr J Butterfield, Board Chairman, joined the meeting.

At 10.30 am it was resolved that the public be excluded for the following agenda items:

General subject:	***Reasons for passing this resolution:***	***Grounds for passing the resolution:***
Previous Public Excluded Minutes	To allow activities and negotiations to be carried on without prejudice or disadvantage.	S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that 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)(i), 9(2)(j) and 9(2)(f)(iv) of the Official Information Act 1982, that is withholding the information is necessary 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, and to maintain the constitutional convention protecting the confidentiality of advice tendered by ministers of the Crown and officials.
Mental Health & Addictions Draft Strategic Plan	To allow activities to be carried out without prejudice or disadvantage	As above, sections 9(2)(i), 9(2)(j), 9(2)(f)(iv).
PHO Clinical Programme Proposal	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage.	As above, sections 9(2)(i), 9(2)(j).

Moved: Dr M Macpherson
Seconded: Mrs M Flannery

The meeting closed at 11.05 am.

Confirmed as a correct record:

Chairman .....

Date .....

DISABILITY SUPPORT ADVISORY COMMITTEE (DSAC) AND COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC)

ACTION SHEET

As at 20 March 2012

Meeting	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
	Presentations	Consideration to be given to inviting representatives: Rural Trusts, St Johns, Milburn Prison.	GMFF	Presentations for information will be scheduled as appropriate.	Ongoing
154-05/10 1 Feb 12	**Child & Youth** (Workshop item 4.0) (Agenda item 5)	Consideration to be given to including mental health and disability representation on the regional Child & Youth Advisory Group. Terms of Reference	GMFF	Terms of reference drafted. Initial meeting of DHB staff to discuss approach. The wider nominations to be sought.	In progress
1 Feb 12	**PHO** (Agenda Item 7)	Full set of PHO performance indicators	GMFF	Contained in excluded agenda until publicly released by PHO Performance programme.	Complete.
1 Feb 12	**DHB Submissions** (Agenda item 8)	Formal policy required.	PHS	Policy in agenda for recommendation to Board.	Complete.
1 Feb 12	**HOP Newsletter** (Agenda item 9)	Committee members to be included on Health of Older People newsletter.	PM – HOP	Distribution list updated.	Complete.
1 Feb 12	**PHS Report** (Agenda item 12)	Disease reporting to have trend information.	GMFF	Not requested in time for current report.	
1 Feb 12	**Immunisation** (Agenda item 13)	Thank you letter to be issued to the teams contributing to the successful target achievement.	GMFF	Actioned on behalf of the Committee.	Complete.

Southern DHB Submissions Policy and Submissions Committee Terms of Reference

RECOMMENDATION:

That the Committee's:

- Endorse the draft Southern DHB Submissions Policy and Public Health Submissions Committee Terms of Reference and,
- Recommend its approval to the Board

Briefing to:	**Southern DHB Executive Management Team**	
Subject:	Submissions Policy and Process	
Author:	Pip Stewart , General Manager, WCPH and Dr Marion Poore, Medical Director Public Health	Date 15 March 2012
Purpose of Report :	Decision Required	

Key Issues

In 2007 the Otago DHB issued a policy statement requiring the Board approve all submissions whereby a stance of support or oppose is taken. This was specifically aimed at Public Health submissions practice.

In 2011, the Board Chairman recommended the policy be reviewed. The Public Health service has canvassed the practice of other NZ Public Health Units and has adapted these to develop the attached DHB policy and associated Terms of Reference.

The draft policy would apply to all across the DHB. The Terms of Reference would apply to the Public Health Submissions Committee.

Executive Management Team endorsement of these two documents has been obtained and is presented to DSAC/CPHAC for consideration and recommendation to the Board for approval.

Key Activity in this Reporting Period

N/A

Key Upcoming Activity

N/A

Southern District Health Board's Submissions Policy (District)

Southern District Health Board (DHB) is accountable for any documentation that is produced in its name. Submissions are often public documents that clearly state the position of Southern DHB and as such have the potential to have that view expressed in the media. The Southern DHB Submission Policy is developed to guide staff who may be making submissions to external agencies of the need to consider the perspectives of Southern DHB. Making a submission is an important contribution to civic society and the democratic process. There is nothing to stop individuals making a personal submission, however this would not be presented on Southern DHB letterhead.

Purpose The purpose of this policy is to guide staff as they develop submissions so that there is a standardised and co-ordinated organisational approach to any submission that is being sent on behalf of the Southern DHB.

Scope The 'submissions' covered within this policy include written or oral presentations intended to influence public policy decision makers at national, regional or local level. These may include by are not limited to:

- National level: Bills, Parliamentary select committee inquiries on health and related legislation, Government Department plans and strategies, standards, policies and protocols.

- Regional & Local level: Resource management applications/consents; public policies; Local Authority regional and district plans and strategies (such as Local Annual Plans, public policy, priority by-laws, Long Term Council Community Plans (LTCCP); environment and transport strategies).

Policy Applies to All employees of Southern DHB, including temporary employees, contractors and tenants must comply with this policy. The policy extends to all Southern DHB board members. It also applies to any person who is involved in the operation of Southern DHB, including joint appointments, visiting staff, volunteers, students and those people with honorary or unpaid staff status.

Policy Considerations

Only one submission will be made by Southern DHB on national level bills, parliamentary select committee inquiries on health and related legislation, plans and strategies, standards, policies and protocols. Where there is interest in issues across departments every effort needs to be made to collaborate to create a joint submission.

In making a decision whether to prepare a submission on behalf of Southern DHB staff need to consider:

1. Political implications. For submissions on parliamentary bills or to Select Committee Inquiries, submissions are to be forwarded to the Chief Executive's office for inclusion in the relevant committee agenda prior to its recommendation to the Board. Public service departments are not permitted to make submissions on a bill without the specific approval of the Cabinet Legislation Committee. In the case of officials (public servants and personnel in Crown entities – including DHBs) from agencies in the wider state sector, who wish (or are invited) to make a submission to a select committee on any health related matter, they are

expected to discuss the matter first with the Ministry of Health[i]. This is to ensure that the officials manage the risks and spring no surprises on the Minister. This can be done by the author contacting one of the Minister's private secretaries and also to send a copy of any correspondence to the Director of Public Health at the Ministry of Health.

2. The probability of other staff or departments having an interest in lodging a submission. Multiple submissions from Southern DHB are counterproductive. If the submission relates to a Select Committee enquiry or a proposal in the community there is a high probability the Public Health Service will already be considering it and may be able to co-ordinate a single submission on behalf of other departments.

3. Political neutrality of the state service must be maintained, that is, written (and oral) submissions must be consistent with, and maintain political neutrality[ii].

4. All submissions need to take into account the principles of Te Tiriti o Waitangi; kaitiakitanga and recognise and provide for the relationship of Maori to water, wahi tapu, sites, ancestral lands and other taonga[iii]. Submissions should reflect an undertaking to protect, adopt partnerships with, and encourage participation of, Maori in submissions. This can be achieved by reference to the General Manager, Maori Health, Southern DHB.

5. Best practice[iv] in developing a successful submission requires meeting two complementary objectives:

    - Technical accuracy
    - Engage the target audience

    *Technical accuracy: A*ny submission must present constructive recommendations based on a sound evidence base. The submissions policy sets out how appropriate technical and clinical staff are to be involved in the preparation of submissions.

    Engage the target audience: Being technically accurate is however, not sufficient if Southern DHB's submission is not recognised by the decision maker. For some submission opportunities a Southern DHB submission will sit alongside several thousand other submissions. Unless Southern DHB's submission communicates effectively with its audience, the resources staff have invested may be wasted. Southern DHB can meet the engagement challenge through two routes:
        - Southern DHB reputation –Southern DHB needs to ensure it has a reputation for clear, evidence-based submissions, and is an organisation whose views should be listened to, and
        - Clarity of presentation – any Southern DHB submission must be clearly written and well presented to capture the reviewers' and decision makers' attention.

Process Considerations

All submissions will be subject to approval by the relevant General Manager's in the service or funding area.

The approval is to ensure:

- Establish the need for a Southern DHB submission
- Assess the risk to Southern DHB of making (or not making) a submission

- Ensure the draft submission is reviewed by appropriate management and professional/clinical leadership
- Notify Chief Operating Officers, General Manager, Finance and Funding or Chief Executive of risk at the appropriate stage of the process
- Report the outcome of the submissions process and file the completed submission in a central repository

An electronic register is to be held by the Chief Executive Officer's office of all submissions considered by staff or services with Southern DHB. The responsibility for maintaining the register shall be with the Public Health Service.

[i] State Services Commission: Officials and Select Committee – Guidelines, 2007 www.ssc.govt.nz

[ii] State Services Code of Conduct (http://www.ssc.govt.nz/display/document.asp?DocID=7063) TDHB Human Resources Policies and Procedures

[iii] Tools for greater Maori participation and future proactive steps for Maori participation in RMA can be retrieved from http://www.mfe.govt.nz/publications/rma/ki-teuo-te0hiahia/html/index.html

[iv] Making a Submission to a Select committee; 2010; retrieved from http://www.parliament.nz/NR/rdonlyres/6092F83E-CE78-4C66-A50A-CC4490DC9034/164978/makingasubmission2010_3.pdf

Appendix 1

Risk Assessment Matrix for Submissions

All submissions will be subject to approval by the Southern DHB through a process approved by the by relevant General Manager in the service or funding area. Approval can be delegated to different levels of management depending on the degree of risk posed by the submission.

Risk Level	Issues for Submission	Approval	Sign-off
High	• Royal Commissions • Select Committee Enquiries • Submissions on Parliamentary Bills or Regulations • Applications for High Profile Resource Consents	District Health Board through the Chief Executive's office	Chief Executive
Medium	• Submissions on Government Policy • Submission on Standards or Guidelines promulgated by a Government Department or National Agency • Regional Policy Statements • Local Government District Plans • Regional Government Regional Plans	Relevant General Manager/Medical/Nurse/ Midwifery/ Allied Health Director upon development of a risk appraisal by the author.	Author of submission with countersignature from approver
Low	• Applications for Resource Consent • Local and Regional Government Annual Plans	Service Manager – Public Health Service (subject to approval of a process for managing submissions)	Author of submission

Terms of Reference

Southern District Health Board Public Health Service Submissions Committee

Background

Public health practitioners have an important role in contributing to the development of healthy public policy through advocacy and making submissions is one aspect of this.

The Ministry of Health contracts Southern District Heath Board (DHB) to provide public health services through an agreed schedule of services. The Public Health Service Plan is completed after consultation with the Ministry and the Southern DHB and is in turn based on the Public Health Service Handbook (the Handbook) and the Nationwide Service Framework Library Draft Public Health Service Specifications (Service Specifications).

Both the Handbook and the Service Specifications require that public health units are actively involved in attempting to contribute to the development of public policy across the spectrum of public health functions. The Handbook refers to submissions in a number of places using wording such as:

> *"Make timely and professional submissions on national and regional plans and policies, district plans and policies and where appropriate resource consent applications to ensure that the public health effects of activities are considered and managed."*[1]

The Service Specifications also contains wording including:

> "*Submissions and advice to Territorial Authorities, central government and other agencies."*[2]

Staff at the Public Health Service make submissions on a range of documents. These include, but are not limited to: Resource Management Applications, Local Authority Annual Plans, Strategies and Bylaws, Draft Legislation and Draft Strategy Documents.

Since December 2007 a Submissions Committee has co-ordinated the development of all submissions at the public health service. The following Terms of Reference describe the way in which this committee will operate.

Purpose

1. To identify opportunities for public health advocacy and the development of healthy public policy at a national, regional and district level.
2. To co-ordinate the development of submissions on a range of documents including but not limited to:
    - Resource Management Applications
    - Local Authority Annual Plans
    - Local Government Strategies, Policy Statements and Bylaws
    - Draft Legislation
    - Select Committee Enquiries
    - Draft National Strategy Documents
    - Government mandated enquiries

[1] Extract from Public Health Service Handbook 2003-04, one of nine similarly worded sections. Accessible at http://www.moh.govt.nz/moh.nsf/0/B13E45ADA9BC8943CC256EC4000A8749/$File/2003-04Handbook.pdf

[2] Extract from Communicable Disease Draft Service Specification accessible at http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/288/$File/Communicable+diseases+APR+09.doc

Key Functions

The key functions of the submissions committee are detailed as follows:

a. To provide an assessment of the organisational risk posed by the public health advocacy issue in question.
b. Where appropriate to actively seek wider public health and Southern DHB input into public health advocacy opportunities listed under "purpose" above.
c. To peer review formal input into the public health advocacy opportunities listed under "purpose" above before submitting to the Southern DHB approval process.

Membership

Permanent membership of the Public Health Submissions committee shall consist of:

- A Medical Officer of Health
- The Professional Director for Health Protection
- A Public Health Researcher
- Sufficient staff from Southern District Health Board Public Health Service locality offices so as to ensure appropriate geographical representation.
- A Team Leader or Service Manager who shall hold the role of chair
- A representative of Te Ao Marama and/or Kai Tahu ki Otago may be brought in on matters of mutual interest.
- A secretary

Meeting Management

- A weekly teleconference shall be hosted by the secretary.

Quorum

The meeting shall not be held unless a minimum of four permanent members as described above are present.

Whilst meetings should not be held if there are fewer than four participants, in the event there are applications to be processed that function shall be delegated to the Chair or his/her designate.

Where possible, representation from the three locality offices should be actively sought for meetings.

Agenda and Minutes

An agenda consisting of details of new applications shall be circulated in the afternoon prior to the meeting. The agenda for the meeting will followed a standardised format with items for consideration submitted by the Chair.

Draft meeting minutes shall be circulated within 48 hours of the meeting taking place by the secretary.

Decisions

Where possible decision-making shall be by consensus. Where a vote is required, the chair shall have the casting vote. Obviously this process can be overridden by any statutory process of the Medical Officer of Health where there is an obligation to do so. An example of this mandate is made under

the provisions of the Health Act 1956 and is would only be utilised in extreme situations where there is an immediate threat to public health (for example in situations where there is threat of spread of infectious disease). There is a also requirement under the Local Government Act 2002 where there is an obligation of Local Government to consult the Medical Officer of Health on certain matters of public health importance. There is other legislation where there are obligations to consult with the Medical Officer of Health

Process

The committee will consider what risk the Southern DHB might have in the matters under consideration including[3]:

1. Where there is a decision not to proceed the item shall be clearly identified in the minutes as the Southern DHB having "no further interest."

2. In **all** situations where a submission is considered warranted by the committee, the committee will determine whether the resulting submission would:

    (i) be, or have the potential to be, in conflict with the interests of Southern DHB staff or governance members;

    (ii) be construed as supporting or opposing the interests of any political affiliation that exists at the time;

    (iii) be of a large scale and intensity;

    (iv) be likely to conflict with established contemporary societal beliefs;

    (v) be likely to be reflected unfavourably in the media;

3. Where the conditions above are not present and the submission is of a technical nature or relates to compliance with public health legislation, the item shall be clearly identified in the minutes as the Southern District Health Board being of "low risk". (Examples might include routine Resource Management Act (RMA) 1991 applications or Local Authority Annual Plan Reviews). When the submission is completed, risk is to be reassessed by the authoriser, who may then escalate the submission to the next level up for approval.

4. Where the submission is indentified as posing a possible organisational risk, by the presence of any or all of the above conditions (or any other relevant factor) the item is identified in the minutes as having "medium risk" (examples might include certain Local Authority District Plans, larger scale RMA applications or Government Department processes). At this point information on the submission and perceived risk is to be passed on to the Service Manager for escalation to the General Manager Women's, Children's (Otago) and Public Health (Southern). When the submission is completed, risk is to be reassessed by the authoriser, who may then escalate the submission to the next level up for approval.

5. Where it is identified that a Southern DHB mandate for the submission to be more appropriate (due to the presence of any or all of the conditions above or any other relevant factor) the item shall be identified in the minutes as requiring a "governance mandate" (examples of high risk submissions may include Select Committee enquiries, submissions on Green Papers, regionally or nationally significant RMA applications etc.). At this point information on the submission and perceived risk is to be passed on to the General Manager

[3] Refer Southern District Health Board Submissions Policy (Risk Assessment Framework)

Women's, Children's (Otago) and Public Health (Southern) for escalation to the DHB through the Chief Executive's office.

In the event the matters under consideration identify possible organisational risk or that they require a governance mandate (categories 1, 4 and 5), the committee will coordinate the development of the submission and upon approving it will forward it to the Service Manager / General Manager who will then submit it to the CEO.

Consultation and Peer Review

The submissions committee expects input from all members of the committee. Other staff will be included in committee processes as required. For this reason all electronic documents relating to the process shall be actively circulated to all committee members. Documents include:

- Draft submissions
- Submissions committee processes and procedures
- Stakeholder meetings and/or dialogue
- Public health advice provided as part of a pre-planning process.

Sign Off

The process in which submissions are managed by the Public Health Service is outlined in Appendix 1.

Low risk submissions are to be approved the Service Manager who will return them back to the Chair of the Submissions Committee. The Chair of the Submissions Committee will ensure the register is updated and forward the approved submission to the author for sign-off. In the event the author is a trainee Health Protection Officer, the submission will be countersigned by the Chair of the Submissions Committee.

Medium risk submissions will be accompanied by a risk appraisal and sent to the General Manager Women's Children's (Otago) and Public Health (Southern) via the Service Manager. The General Manager will approve or escalate the submission according to the degree of risk. Upon approval the submissions will be passed back to the Chair of the Submissions Committee who shall ensure the register is updated and forward the approved submission to the author for sign-off. In the event the author is a trainee Health Protection Officer, the submission will be countersigned by the Chair of the Submissions Committee.

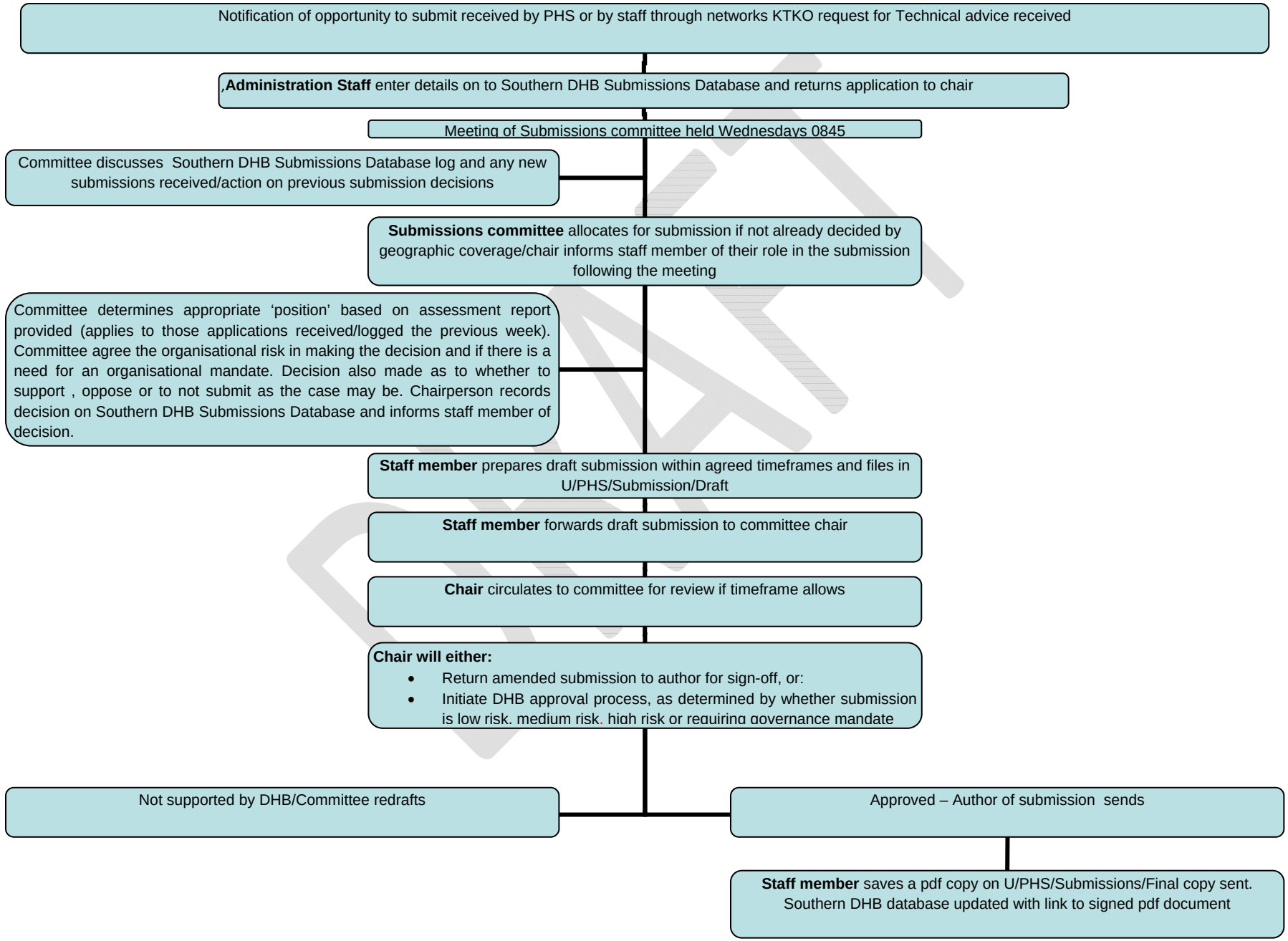
High risk submissions will be forward through the General Manager Women's Children's (Otago) and Public Health (Southern) who will then pass it though the CEO office. Sign-off will depend on the nature of the process chosen to secure Southern District Health Board approval of the submission. In all cases the final document will be returned to the Chair of the Submissions Committee who shall ensure the register is updated

Review

This Terms of Reference shall be reviewed 12 months following implementation date.

Date:xxxxxxx

Appendix 1


Notification of opportunity to submit received by PHS or by staff through networks KTKO request for Technical advice received
,**Administration Staff** enter details on to Southern DHB Submissions Database and returns application to chair
Meeting of Submissions committee held Wednesdays 0845
Committee discusses Southern DHB Submissions Database log and any new submissions received/action on previous submission decisions
Submissions committee allocates for submission if not already decided by geographic coverage/chair informs staff member of their role in the submission following the meeting
Committee determines appropriate 'position' based on assessment report provided (applies to those applications received/logged the previous week). Committee agree the organisational risk in making the decision and if there is a need for an organisational mandate. Decision also made as to whether to support , oppose or to not submit as the case may be. Chairperson records decision on Southern DHB Submissions Database and informs staff member of decision.
Staff member prepares draft submission within agreed timeframes and files in U/PHS/Submission/Draft
Staff member forwards draft submission to committee chair
Chair circulates to committee for review if timeframe allows
Chair will either:
• Return amended submission to author for sign-off, or:
• Initiate DHB approval process, as determined by whether submission is low risk, medium risk, high risk or requiring governance mandate
Not supported by DHB/Committee redrafts
Approved – Author of submission sends
Staff member saves a pdf copy on U/PHS/Submissions/Final copy sent. Southern DHB database updated with link to signed pdf document

SOUTHERN DISTRICT HEALTH BOARD TOBACCO CONTROL PLAN 2011 -14

RECOMMENDATION: That the Committees recommend the Board approve the Southern DHB Tobacco Control Plan 2011-14.			
Briefing to:	Southern District Health Board		
Subject:	Southern DHB Tobacco Control Plan 2011-14		
Author:	Willow Macdonald – District Programme Leader - Smokefree	Date	19 March 2012
Purpose of Report :To seek approval of the Southern District Health Board Tobacco Control Plan 2011-14	☐ **For Information Only Required**	☒ **Decision**	

Key Issues

The Southern DHB Tobacco Control Plan (TCP) has been signed off by the Southern District Health Board's Smokefree Steering Group with input from the District Programme Leader- Smokefree, Planning & Funding and Public Health South. This document sets out the direction for tobacco control activity for Southern DHB over the 2011-14 financial years. It pulls in key smokefree actions from the Public Health South Service Plan 2009-12, and also the Southern DHB Māori Health Action Plan 2011-12.

Vision of the TCP
Otago and Southland are places where Smokefree lifestyles are the norm, and harm from and exposure to tobacco smoke is eradicated. Southern DHB shares the Government's vision of a smoke-free New Zealand by 2025.

Outcomes of the TCP
The Plan sets out the following long-term, intermediate and short-term outcomes:

Long-term outcomes
- Decreased smoking prevalence
- Decreased exposure to second hand tobacco smoke

Intermediate outcomes
- Increased cessation in youth and adults
- Reduced smoking initiation in youth
- Increased smokefree environments
- Increased leadership for smokefree

Short-term outcomes
- Increased quit attempts
- Knowledge and attitude change
- Reduced availability of tobacco and visibility of smoking

Consultation
The Tobacco Control Plan was sent out for consultation to local Smoking Cessation Providers (Nga Kete Matauranga Pounamu and Te Roopu Tautoko Ki Te Tonga), Dunedin Hospital Smokefree Committee, Southern PHO and local Smokefree Networks (Smokefree Otago and Smokefree Murihiku- Southland). Membership of the local Smokefree Networks includes; Cancer Society, National Heart Foundation, Diabetes New Zealand, Mornington Health Centre, Otago Asthma Society, Otago Polytechnic, Pacific Trust, Plunket, Southern PHO, Public Health South, Tu Mai Ora (Waikouaiti based Māori Provider) University of Otago, and Nga Kete Matauranga Pounamu.

Southern District Health Board

TOBACCO CONTROL PLAN

July 2011 – June 2014

Introduction

Tobacco use is the single most preventable cause of death in New Zealand. An estimated 5,000 New Zealanders die each year as a direct result of tobacco smoking, and significantly more have reduced quality of life due to smoking-related illness. Smokers have a life expectancy an average 14 years less than non-smokers, which represents a major social problem and opportunity cost to the health and other sectors. The burden of cancer, cardiovascular disease and respiratory illness in New Zealand is attributable to high rates of smoking.

Exposure to second hand tobacco smoke also accounts for significant illness, with children and young people most susceptible to conditions caused or exacerbated by tobacco smoke, including low birth weight, Sudden Infant Death Syndrome, respiratory infections and glue ear.

Significant inequalities exist in tobacco use in New Zealand, with several priority populations being at higher risk of adverse related health outcomes. Tobacco control remains an important opportunity to reduce inequalities and improve Māori health.

This document builds on the work that has been undertaken in tobacco control within the previous Otago and Southland District Health Boards (DHBs). The 2011-2014 Southern DHB Tobacco Control Plan is intended as a living document that will guide tobacco control activity across the Southern DHB area. The plan will be used by the District Smokefree Programme by working collaboratively with other tobacco control stakeholders towards the vision of Smokefree Southern DHB.

Vision

Otago and Southland are places where Smokefree lifestyles are the norm, and harm from and exposure to tobacco smoke is eradicated. Southern DHB shares the Government's vision of a smoke-free New Zealand by 2025.

Outcomes

The following long-term, intermediate and short-term outcomes have been identified for this plan:

Long-term outcomes

- Decreased smoking prevalence
- Decreased exposure to second hand tobacco smoke

Intermediate outcomes

- Increased cessation in youth and adults
- Reduced smoking initiation in youth
- Increased smokefree environments
- Increased leadership for smokefree

Short-term outcomes

- Increased quit attempts
- Knowledge and attitude change
- Reduced availability of tobacco and visibility of smoking

A tobacco outcomes framework is presented at the end of this document, and demonstrates the relationship between this plan, the wider tobacco control sector, and the outcomes identified above.

Background

The Ministry of Health is committed to reducing smoking rates. Smoking was identified as a key priority area in the New Zealand Health Strategy (2000) and is one of six Government health targets, "Better Help for Smokers to Quit".

The New Zealand Smoking Cessation Guidelines were revised in 2007 and introduced ABC for Smoking Cessation[1], an approach based on national and international evidence that in order to decrease smoking prevalence in the New Zealand population initiating more quit attempts is crucial. The Guidelines highlight the role that health professionals have in addressing smoking with their patients as part of best practice. The Guidelines were followed by a framework and implementation plan for the ABC approach for Smoking Cessation.

The health target "Better Help for Smokers to Quit" uses the ABC approach to provide more opportunities for more smokers to make successful quit attempts, and focuses on implementing a population health approach in standard clinical practice.

New Zealand has achieved significant progress in tobacco control over the past two decades, and the Government has recently committed to achieving a tobacco-free New Zealand by 2025. There are a number of actions planned to realise this goal; amendments to the Smokefree Environments Act (Controls and Enforcement) in 2011 will allow for better controls on tobacco retailing and reduce access to tobacco through initiatives such as increasing tobacco excise tax, banning retail displays of tobacco products, and the Government is also considering implementing plain tobacco packaging. These measures will reduce smoking initiation, reduce exposure to second-hand tobacco smoke, and increase the number of New Zealanders who quit smoking every year.

Local context

Since 2007 District Health Boards have been working to develop tobacco control at local levels. The Southern DHB has identified reducing smoking as a key priority area for improving health in the Otago and Southland districts. Health profiles developed prior to this plan highlight local disparities in smoking rates, including ethnic and geographical differences in smoking rates across the districts. Smoking in pregnancy has also been highlighted as a key area for focus.

The Southern DHB Māori Health Action Plan 2011/12 addresses smoking by focussing on achieving the Better Help for Smokers to Quit health target for Māori patients identified as current smokers, and also through increasing smokefree environments. One of the workstreams within the plan is Auahi Kore Marae, which will work across the health spectrum to reduce exposure to second hand smoke, and prevent smoking initiation. The Māori Action

[1] Healthcare workers are prompted to **A**sk all people about their smoking status, give **B**rief advice to quit to all people who smoke, and to offer **C**essation support.

Plan also identifies the three Whānau Ora Collectives within the Southern District; Te Waipounamu Whānau Ora Collective: He Oranga Pounamu (Canterbury, Otago and Southland based), three of the 22 providers reside across the Southern district; He Waka Kotuia Araiteuru (Otago based), and Te Poha Oranga (Southland based). The Southern DHB is committed to working with the Whānau Ora collectives to provide a more effective and efficient whānau-centred approach to smokefree initiatives.

The Southern DHB Annual Plan 2011-12 outlines education for clinical staff in primary and secondary care as key activities to achieve the tobacco control health target, and also promotes tobacco control activities in the wider community and enforcement of the Smokefree Environments Act as components to supporting local gains in tobacco control.

Smoking rates

Rates of smoking in the Southern DHB differ geographically, with 19.6% of Otago residents daily smokers compared to 23.8% of Southland residents. The national daily smoking rate is 20.7% (2006 Census).

Significant ethnic and population disparities exist in smoking. The daily smoking rates for Māori in Otago (36.7%) and Southland (42.1%) are double the whole population rates for the district. In Southland, Māori smoking rates are comparable with those seen across New Zealand (45.5% for females, 38.5% for males). Numerous rural and urban areas have exceptionally high Māori smoking rates; while Southland Māori are more likely than Otago Māori to smoke, in Otago these Māori are mainly living in rural areas, whereas in Southland the Māori smoking populations are centred in Invercargill and Mataura.

While rates of smoking overall are higher for men in the Southern DHB area, Māori women are significantly more likely to smoke than males or any other ethnic group. In particular, women of childbearing age are most likely to smoke.

The number of Pacific peoples living in Otago and Southland is low (4,605 in total), however Pacific peoples are also significantly more likely to smoke than the whole population.

Smoking prevalence increases as deprivation increases, although this is likely to be affected by high rates of smoking in Māori, who are overrepresented in the most deprived NZDep quintiles.

Tobacco control measures must target populations of greater deprivation, women of childbearing age and their whānau, and Māori and Pacific peoples. This will require both geographical and settings-based approaches.

To achieve the outcomes identified in the Southern DHB Tobacco Control Plan an appropriate blend of national and local priorities need to be considered. The following priority populations are proposed:

- Māori
- Pacific peoples
- Pregnant women and their whānau
- Mental health consumers
- Rural populations

In order to appropriately address these populations and target interventions and measures to reduce inequalities the following priority environments are proposed:

- Primary health care
- Secondary health services, with a focus on mental health services
- Settings; including homes, cars, marae, workplaces, communities and health and education facilities

How to read this Tobacco Control Plan

This plan has been developed by identifying main workstreams for activity. These are presented as Interventions, with each intervention outlining mechanisms for achieving the planned outcomes. Each intervention identifies intermediate outcomes of note, and key activities which will be undertaken to achieve these. A person or organisation responsible for each activity is identified, and resources made available to achieve the activities are set out. We propose that on a six-monthly basis progress in the plan is summarised and made publicly available on the Southern District Health Board website (www.southerndhb.govt.nz).

The following six interventions are proposed to achieve the goals of this Tobacco Control Plan:

1. Provide effective leadership for smokefree activity
2. Develop capacity to provide effective cessation support to smokers
3. Implement and develop effective smokefree systems in primary, secondary and community health settings
4. Increase consumer demand for cessation and increase the number of smokefree environments
5. Reduce smoking initiation
6. Increase compliance with the Smokefree Environments Act and its amendments

Interventions four through six are based on the tobacco section of the Public Health South Service Plan 2009-2012. Public Health South is the public health unit which operates out of the Southern DHB, and provides smokefree regulatory and health promotion services across Otago and Southland. Resources identified under these interventions are allocated to support the work of the smokefree health promotion advisors, to fund health promotion projects that are identified by Public Health South and the local collaborative Smokefree networks: Smokefree Otago and Smokefree Murihiku. Smokefree staffing within Public Health South is outlined in the section below.

Current Staffing

Ministry of Health funded tobacco control services within the Southern DHB for 2011/12 include:

Service	Resources
DHB Smokefree Coordination and Hospital Cessation	• Operational costs to implement the Smokefree DHB contract, plus FTE: Both districts District Programme Leader – Smokefree (1.0 FTE) Primary Care Smokefree Coordinator (1.0 FTE) Otago Smokefree Clinical Coordinator (1.0 FTE) Hospital Smokefree Coordinator (1.0 FTE) Southland Southland Smokefree Coordinator (0.5 FTE) Hospital Smokefree Coordinator (0.5 FTE)
Tobacco Health Promotion and Enforcement	• Operational costs to implement the core Public Health contract, plus FTE: Otago Smokefree/Auahi Kore Health Promotion advisors (2.0 FTE) Tobacco Enforcement Officer (0.5 FTE) Southland Smokefree/Auahi Kore Health Promotion Advisors (1.5 FTE) Tobacco Enforcement Officer (0.5 FTE)

Other publicly-funded tobacco control services in Otago and Southland

Service	Provider	Target Population	Delivery Area
Aukati Kaipaipa Intensive smoking cessation service	Te Roopu Tautoko ki te Tonga Inc.	Māori whānau, hapu and iwi	Greater Dunedin area
Aukati Kaipaipa Intensive smoking cessation service	Nga Kete Matauranga Pounamu Charitable Trust	Predominantly Māori and women of childbearing age	Southland region
Wahine Hapu Intensive smoking cessation service targeting pregnant women who smoke	Nga Kete Matauranga Pounamu Charitable Trust	Māori, Pacific and pregnant women and their families/whānau who smoke	Southland region
Quitline Telephone and text based smoking cessation service	The Quit Group	All New Zealanders	National

Intervention 1

Provide effective leadership for smokefree activity

Intermediate Outcomes	Short-term Outcomes	Key Activities	Responsibility	Short-term Outcome Indicators	Resources / Comment
Increased cessation in youth and adults Reduced smoking initiation in youth Increased smokefree environments	1.1 Increased clinical and community leadership in smokefree	Maintain and strengthen the DHB Smokefree Steering Group	District Programme Leader – Smokefree	DHB Smokefree Steering group functions effectively and meets quarterly	
				DHB Smokefree Steering Group has Māori representation	
				DHB Smokefree Steering Group has representation from community NGO sector	
		Provide coordination for local smokefree activity across Otago and Southland	DHB Smokefree Steering Group Team Leader – Settings & Lifestyle	Southern DHB Smokefree Programme functions effectively	FTE and coordination costs for District Programme Leader – Smokefree
		Support local smokefree networks	DHB Smokefree Steering Group Team Leader – Settings & Lifestyle	Southern DHB maintains representation on Smokefree Murihiku and Smokefree Otago	
		Develop and maintain collaborative relationships with local smoking cessation providers	District Programme Leader – Smokefree Planning & Funding	Smoking cessation providers are involved in smokefree systems development	
		Identify key medical staff within primary and secondary care to champion the ABC approach	District Programme Leader – Smokefree Southern PHO	Medical staff support the use of the ABC approach in primary and secondary care	FTE costs for clinical ABC champions
		Work collaboratively with Southern PHO to ensure linkages in smokefree activities across primary and secondary care		Southern DHB provides leadership for smokefree activity in primary care	Refer to *Intervention 3.1*
		Identify nurse ABC champions within secondary care to support effective smokefree systems	District Programme Leader – Smokefree	The ABC Approach to Smoking Cessation is incorporated into standard clinical practice	Coordination and training costs for ABC Champions
		Identify key maternity ABC champion(s) within Otago and/or Southland to coordinate	District Programme Leader – Smokefree	Community-based LMCs actively support patients and their whānau to access smokefree support during	FTE costs for maternity ABC champion(s)

			pregnancy	
1.2 Increased leadership for smokefree in non-health organisations	Engage with local bodies	Public Health South – Settings & Lifestyle team	Smokefree initiatives are prioritised in local body plans	
	Consult and include key local organisations in decision-making around smokefree initiatives	DHB Smokefree Steering Group	Smokefree initiatives are supported by local organisations	
	Make relevant smokefree submissions to local and national bodies when opportunities arise	DHB Smokefree Steering Group Public Health South	Southern DHB provides strategic direction for smokefree initiatives	
	Engage with non-health organisations delivering services to priority populations	Southern DHB Smokefree Programme PHS – Settings & Lifestyle team	Smokefree messages are consistent across many sectors (community, education, social service, corrections, commerce)	
1.3 Increased Māori leadership for local smokefree initiatives	Consult the Southern DHB Iwi Management Group for decision-making around smokefree initiatives	DHB Smokefree Steering Group	Initiatives and projects are consistent with and contribute to priority areas in the Southern DHB Māori Health Action Plan 2011/12	
	Engage with local runaka to set priorities for health promotion and cessation initiatives targeting Māori communities	District Programme Leader – Smokefree Public Health South – Settings & Lifestyle team Planning & Funding	Local runaka provide input into smokefree initiatives	
	Recruit Māori champions to provide leadership in relation to smokefree marae initiatives	General Manager – Māori Health	Identify factors for success which are implemented by marae with effective smokefree policies	From *Southern DHB Māori Health Action Plan 2011/12 – Local Health Priority Area 6.2*
			Identify barriers to smokefree marae	
			Identify interventions to introduce smokefree policies for Southern DHB area marae	
1.4 Increased number of evidence-based, effective smokefree initiatives	Undertake a stocktake of local tobacco control services to review current service delivery	District Programme Leader – Smokefree	Gaps in current service delivery are identified	
	Develop evidence and needs-based local smokefree initiatives	District Programme Leader – Smokefree Team Leader – Settings and Lifestyle	Appropriate initiatives are developed and implemented in a timely manner	Refer to *Interventions 3.4 and 4.3*
			High-needs population	

			groups are prioritised for initiatives	
			Initiatives are evaluated and adapted	Funding for evaluation of key initiatives funded through this plan
1.5 Increased Southern DHB leadership for smokefree initiatives	Strengthen the Southern DHB Smokefree Policy to increase focus on smokefree support	DHB Smokefree Steering Group Hospital Smokefree Committees	Southern DHB staff comply with Smokefree Policy	
		District Programme Leader – Smokefree	Staff, visitors and contractors are supported to remain smokefree while on Southern DHB premises	Funding for NRT for staff, visitors and contractors
			Patients are treated in a totally smokefree environment	
			Patients who smoke remain smokefree during their hospital stay	
	Prioritise smokefree in DHB strategic and policy documents	DHB Smokefree Steering Group	Smokefree is included as a key outcome in relevant documents	
			Position statements relating to smokefree outcomes developed for Southern District Health Board	
	Advocate for smokefree site clause in all Southern DHB contracts with health providers		Discussions had with Planning & Funding to establish smokefree site clause	
	Develop a resource to support health facilities funded by DHB to establish smokefree environments	Public Health South – Settings & Lifestyle team	Support is provided to organisations contracted by Southern DHB to develop smokefree policies	Refer to *Intervention 4.2*
	Approach unions to discuss including a smokefree clause in collective employment agreements	District Programme Leader – Smokefree	Southern DHB employees are supported to remain smokefree while at work	
1.6 Increased promotion of local smokefree initiatives	Develop a communications strategy for local smokefree initiatives	Southern DHB Smokefree Programme Public Health South	Local communities are aware of and involved in local and national smokefree initiatives	Funding to implement smokefree communications plan, including paid media
			Southern DHB is recognised as a smokefree role model by general public	

		National smokefree campaigns are promoted locals (e.g. World Smokefree Day, Face the Facts, Smoking Affects Lives)	Public Health South – Settings & Lifestyle team	Vulnerable communities are prioritised for promotion activities	

Intervention 2

Develop capacity to provide effective cessation support to smokers

Intermediate Outcomes	Short-term Outcomes	Key Activities	Responsibility	Short-term Outcome Indicators	Resources Required
Increased cessation in youth and adults	2.1 Increased generalist smoking cessation skills in health workers[2]	Provide ongoing training in the ABC Approach to Smoking Cessation for health professionals in primary and secondary care	District Programme Leader – Smokefree	Staff working in primary and secondary health services are trained in the ABC approach	Refer to *Intervention 3.1*
				Increased proportion of smokers admitted to hospital or presenting at GP practices are offered support to quit smoking	
		Engage with relevant tertiary training institutions to include ABC as part of student education		Graduate health professionals are trained in the ABC approach	
		Deliver training in the ABC approach to health professionals working in settings (e.g. workplaces, corrections facilities, supported living facilities, education facilities)		Increased number of Quitcard Providers in community settings	
		Promote and provide local coordination for National Heart Foundation cessation training		Non-registered health care workers become Quitcard Providers	Grants for attendance at cessation training
	2.2 Increased smokefree workforce in the community	Provide training in generalist smoking cessation skills to non-health workers		Increased number of Quitcard Providers in community settings Increased number of Māori Quitcard Providers	
		Work with community		Community organisations	

[2] Generalist skills are those covered by training in the ABC Approach to Smoking Cessation

		organisations to facilitate smokefree support for clients in priority population groups		refer clients to Quitline	
				Community organisations provide Quitcards to clients	
				Increased numbers of Māori accessing Quitline and local cessation services	
		Promote and provide local coordination for National Heart Foundation cessation training		Non-registered health care workers become Quitcard Providers	
		Promote and provide local coordination for National Heart Foundation group facilitation cessation training	Southern DHB Smokefree Programme Public Health South – Settings & Lifestyle team	Representatives from community organisations attend NHF group facilitation training	
	2.3 Increased access to intensive cessation counselling services	Develop a Cessation Plan to cover existing gaps in intensive smoking cessation services across Otago and Southland	District Programme Leader – Smokefree Planning & Funding	Gaps in service delivery are identified and addressed	Funding for rural Otago smoking cessation services Funding for additional smoking cessation services
				Key population groups are prioritised for access to cessation services: - *Māori* - *Mental health consumers* - *Pregnant women & their whānau*	
				Communities are supported to offer cessation support to high needs populations.	Funding for community cessation projects
		Ensure specialist cessation service providers contracted by the Southern DHB have quality improvement plans in place		Clients are surveyed about the effectiveness of services offered	
				Referral agents are surveyed on the response from services for clients	
				Feedback is used to improve specialist smoking cessation services	

Intervention 3

Implement and develop effective smokefree systems in primary and secondary health services, and community settings

Intermediate Outcomes	Short-term Outcomes	Key Activities	Responsibility	Short-term Outcome Indicators	Resources / Comment
Increased cessation in youth and adults	3.1 More smokers accessing primary health services are supported to quit	Implement and develop the ABC strategy throughout primary health services	Southern DHB Smokefree Programme Southern PHO	Southern PHO achieves the health target: 90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit by July 2012;	FTE and coordination costs for Primary Care Smokefree Coordinator
		Provide education on the ABC approach to general practice staff	Southern DHB Smokefree Programme	95% of practice nurses in the Southern PHO have completed ABC training by July 2012	
		Provide education on the ABC approach to other practice-based registered health professionals (e.g. allied health, occupational health nurses)		Registered health professionals working in primary health services are trained in the ABC approach	
		Provide information about smoking cessation to all smokers accessing primary health services	Southern DHB Smokefree Programme Southern PHO	All smokers leave primary health services with one or all of the following: - Completed Quitcard or prescription for NRT or other cessation medication - Information about cessation services - Referral sent to cessation service	
	3.2 More smokers accessing secondary health services are supported to quit	Further develop the ABC strategy in secondary heath services to embed it into hospital processes	Southern DHB Smokefree Programme	All services have a sustainable system to ensure smokers are given advice and help to quit	FTE and coordination costs for Otago/Southland Smokefree Coordinators FTE and coordination costs for Hospital Smokefree Coordinators
				ABC is integrated into Southern DHB quality frameworks	
		Provide information about smoking cessation to all		All smokers are discharged with one or all of the	

	smokers accessing secondary health services		following: - Completed Quitcard - Information about cessation services - Referral sent to cessation service	
3.3 More smokers accessing community services are supported to quit	Develop a smokefree training package for non-registered health workers	Southern DHB Smokefree Programme	Training programme is developed and signed off by the Ministry of Health	Refer to *Intervention 3.1*
	Work alongside the Settings & Lifestyle team to support cessation pathways in community settings		Community workers are provided with training to become Quitcard Providers	Refer to *Intervention 3.4*
3.4 More smokers in key population groups are supported to quit:	Facilitate access for cessation providers to deliver services within environments frequented by priority groups: - *Māori* - *Mental health consumers* - *Pregnant women & their whānau*	Public Health South – Settings & Lifestyle team Southern DHB Smokefree Programme		Refer to *Intervention 3.3*
- *Maori*	Develop robust systems to ensure Māori smokers are identified and provided with advice and help to quit	Southern DHB Smokefree Programme Māori Health Liaison teams General Manager – Māori Health Southern PHO	The smoking status of all Māori patients is identified	Refer to *Interventions 3.1 and 3.2*
			Māori who smoke are provided with information on and offered a referral to appropriate cessation services	Consistent with *Southern DHB Māori Health Action Plan 2011/12 – National Health Priority Area 4.7*
	Identify and develop initiatives in health services to ensure Māori access appropriate smoking cessation support		Māori patients and their whānau who smoke access appropriate cessation support services	Funding for cessation projects targeting Maori
- *Mental health consumers*	Further develop systems in secondary and community mental health services to ensure consumers are supported to quit smoking	Southern DHB Smokefree Programme Southern DHB Mental Health Directorates (Otago and Southland)	Mental health services have robust smokefree policies and systems for managing nicotine withdrawal syndrome in mental health consumers who smoke	Refer to *Intervention 3.1*
			Mental health consumers who smoke are provided with information on and offered a referral to appropriate cessation services	Refer to *Interventions 2.4 and 3.1*

	- *Pregnant women & their whānau*	Develop relationship with Local Colleges of Midwives (Otago/Southland) to ensure consistency of smokefree messages to pregnant women and their whānau	Southern DHB Smokefree Programme	Pregnant women are admitted to secondary maternity facilities using appropriate cessation support medications or already smokefree	
		Further develop systems in primary and secondary maternity services to ensure women and their whānau are supported to quit smoking		Pregnant women and their whānau are provided with information on and offered a referral to appropriate cessation services	Refer to *Interventions 2.4, 3.1 and 3.2*
	3.5 Effective cessation pathways for smokers between primary and secondary health services, and community settings	Promote referrals from health facilities to cessation providers	Southern DHB Smokefree Programme	Increased number of smokers access specialist smoking cessation services	
		Facilitate access for cessation providers to deliver services within environments frequented by priority groups: - *Māori* - *Mental health consumers* - *Pregnant women & their whānau*	Public Health South – Settings & Lifestyle team		Refer to *Intervention 4.3*

Intervention 4

Increase consumer demand for cessation and increase the number of smokefree environments

Intermediate Outcomes	Short-term Outcomes	Key Activities	Responsibility	Short-term Outcome Indicators	Resources / Comment
Increased cessation in youth and adults Increased smokefree environments	4.1 Increased adoption of policies which reduce exposure to second hand smoke	Undertake a needs analysis using smoking prevalence data for Otago and Southland	PHS – Settings & Lifestyle team	Needs analysis identifies areas of high smoking prevalence and priority populations	From *Public Health South Annual Plan 2011/12 – Smokefree and Tobacco Control Intermediate Outcome 1.1*
		Advocate for smokefree cars and home		Smokefree cars and homes message is endorsed within settings	
	4.2 Increase in the number of smokefree environments	Advocate for smokefree policies within workplaces and other settings	District Programme Leader – Smokefree Team Leader – Settings and Lifestyle	PHS engages with management around smokefree policies	From *Public Health South Annual Plan 2011/12 – Smokefree and Tobacco Control Intermediate Outcome 1.2* Funding to support smokefree policy development in contracted Southern DHB providers
		Provide information, support and resources to develop smokefree policies		PHS engages with key personal i.e. workplace nurses Health promoters have identified and engage with organisations to develop smokefree policies	
		Advocate for local and regional councils to increase the number of smokefree outdoor spaces		PHS engages with councils	
		Where relevant submissions will include tobacco control		Tobacco control included in relevant submissions	
		Provide support for Southern DHB area marae to become smokefree	General Manager – Māori Health	All *Mana Whenua* marae in are smokefree with policies developed by June 2012	From *Southern DHB Māori Health Action Plan 2011/12 – Local Health Priority Area 6.2* Refer to *Intervention 1.3*
	4.3 Increased promotion of quit attempts in the Māori community and areas with high smoking prevalence	Local initiatives to support quit attempts are developed, reviewed and improved. The promotion of Nicotine Replacement Therapy (NRT) is included	PHS – Settings & Lifestyle team	Project plans are developed and – · Reflect the promotion of the use of NRT during quit attempts · Capture local needs · Collaborate with other stakeholders	From *Public Health South Annual Plan 2011/12 – Smokefree and Tobacco Control Intermediate Outcome 1.3* Refer to *Intervention 2.3* Funding to support relevant

				· Add to the body of knowledge regarding local needs	health promotion projects Funding to develop community projects
		Promote the range of quit services available		PHS engages with key providers of quit services (both national and local)	From *Public Health South Annual Plan 2011/12 – Smokefree and Tobacco Control Intermediate Outcome 1.3*
		Build a local emphasis for national campaigns		PHS collaborates with key stakeholders	
		Work will be prioritised amongst Māori health providers and the Māori community		PHS collaborates with key Māori stakeholders	From *Public Health South Annual Plan 2011/12 – Smokefree and Tobacco Control Intermediate Outcome 1.3* Consistent with activities outlined in *Southern DHB Māori Health Action Plan 2011/12 – Local Health Priority Area 6.2*

Intervention 5

Reduce smoking initiation

Intermediate Outcomes	Short-term Outcomes	Key Activities	Responsibility	Short-term Outcome Indicators	Resources / Comment
Reduced smoking initiation in youth	5.1 Increased normalisation of *Auahi Kore*	Promote Te Kiwai within the Māori community	PHS – Settings & Lifestyle team	Māori communities uptake Te Kiwai sponsorship	From *Public Health South Annual Plan 2011/12 – Smokefree and Tobacco Control Intermediate Outcome 2.1*
		Work alongside Māori and other providers to promote Auahi Kore		PHS has regular contact with Māori and other providers	
		Recruit Auahi Kore role models annually		Possible candidates identified by the Māori community are approached and provided with support and Auahi Kore resources	
		Encourage and support Auahi Kore role models		Auahi Kore role models are engaged in promotion/projects	
		Support event organisers to ensure a supportive Auahi Kore environment is created, such as providing or lending resources		All parties sign a standard Auahi Kore contract for events which sets clear expectations	
		Facilitate district and local network hui, Smokefree Otago and Smokefree Murihiku meetings		Opportunities are provided to network and share information with others in the smokefree sector	
				A forum is provided for sharing planning and developing projects collaboratively within the local sector	
				PHS invites other key stakeholders, such as Māori providers, Southern Primary Health Organisation, non-government organisations	

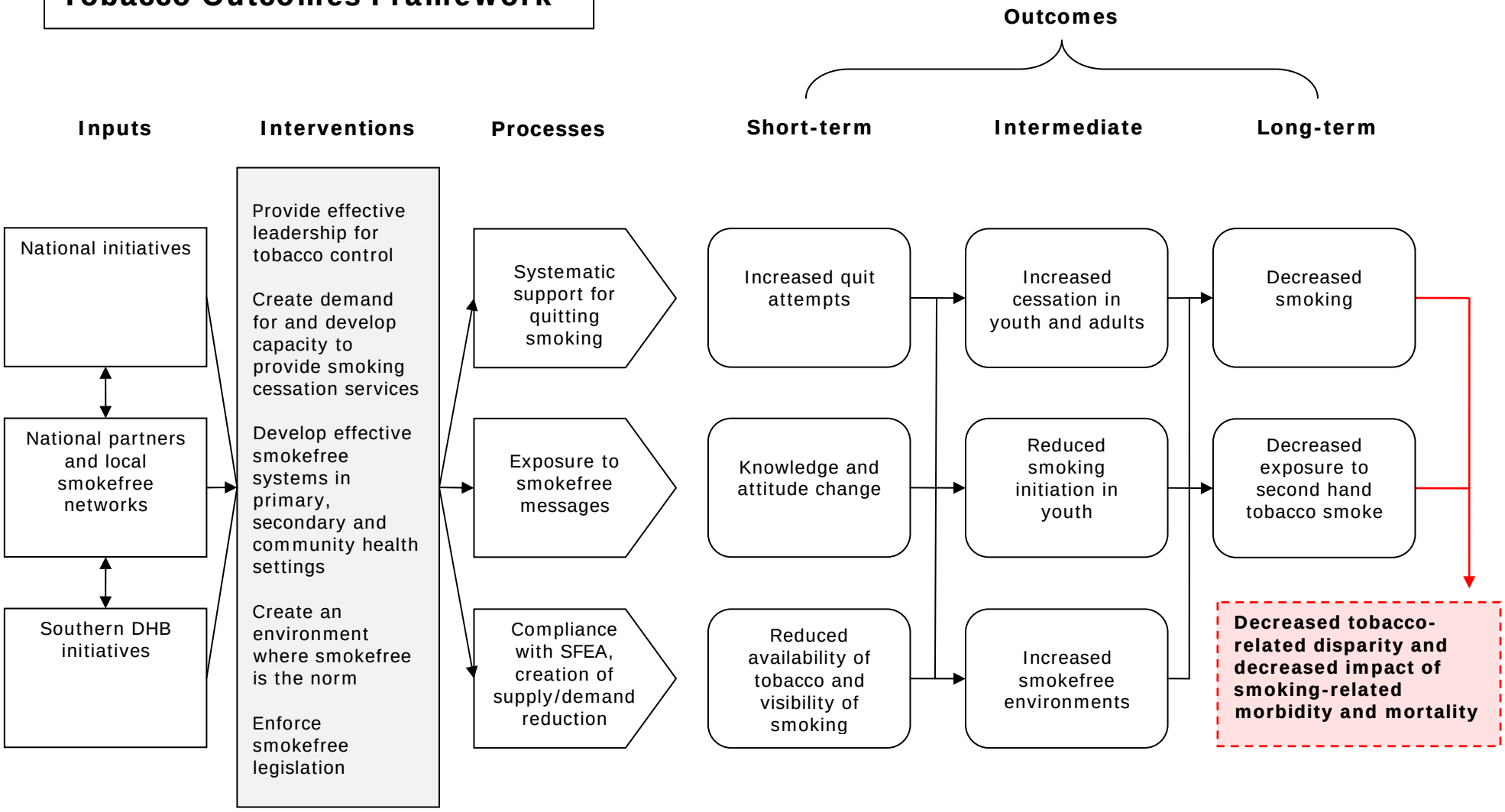
Intervention 6

Increase compliance with the Smokefree Environments Act and its amendments

Intermediate Outcomes	Short-term Outcomes	Key Activities	Responsibility	Short-term Outcome Indicators	Resources / Comment
Increased smokefree environments	6.1 Reduced availability of tobacco and visibility of smoking	New tobacco retailers within the Otago and Southland districts are recorded on PHS local retailer list	PHS – Settings & Lifestyle team	Up to date list of retailers maintained by PHS	From *Public Health South Annual Plan 2011/12 – Smokefree and Tobacco Control Intermediate Outcome 3.1*
		Retailer education is conducted in accordance with the Ministry of Health's Smokefree Compliance and Enforcement Manual		A district CPO[3] plan is developed and implemented, this includes following PHS prioritising criteria	
		CPO's are conducted in accordance with the Ministry of Health's Smokefree Compliance and Enforcement Manual		Ten percent of tobacco retailers will receive retailer education annually across the district Ministry of Health targets are achieved, with CPO's conducted amongst 10% of all retailers	
		Follow up all complaints of workplaces not complying with SFEA		Requirements of Smokefree Enforcement Manual are met when following up complaints	
		Complaints and enquiries are dealt with in an effective manner		Complaints, enquiries and actions followed are recorded	
		Ensure staff are adequately trained and attend appropriate meetings		PHS will have a minimum of three qualified enforcement officers on staff	
		When monitoring licensed premises, tobacco compliance will be reviewed		Significant breaches of the SFEA are brought to the attention and followed up by the Smokefree Enforcement Officers	
				Compliance is recorded in licence files (providing an in-depth record of premises)	

[3] Controlled Purchase Operation

Tobacco Outcomes Framework



Briefing to:	**Disability Support Advisory Committee and Community and Public Health Advisory Committee**	
Subject:	Primary & Community Portfolio Update	
Author:	Adele Knowles	Date: 15/3/12
Purpose of Report :	√ For Information Only	Decision Required

Key Issues

Dietetic input

- The limited ability for dietician input has been flagged as an issue in many services, including older person's health, mental health, and diabetes services. This is to be investigated further.

PHARMAC consultation

- Consultation documents widely distributed about funding for a single model of glucose meter has caused concern about the education of patients for the changeover
- Consultation document circulated about funding of a single type of insulin pump and consumables- as none currently funded that has been almost universally accepted as a good idea.

Key Activity in this Reporting Period

Community Services (District Nursing and Allied Health)
Annual review of contracts with a variety of providers is underway. Use of high cost consumable remains steady.
National Review of service specifications for Community Nursing services is happening at present, District Nursing complete, Domiciliary Oxygen currently in progress.
Emerging issues- limited dietetic services impacting on many services, including older person's health, mental health, primary care and secondary care where clinical requirements are increasingly specialised.

Dental
CDA (Combined Dental Agreement) The contract team is currently in the process of renewing all dental agreements. The Oral Health business case project has largely been completed and the project is being wound with activity converting to business as usual.

Pharmacy
The national agreement process is now postponed, with variations going to all community pharmacists for the period 1 April until 1 July at which point the new agreement will be able to be implemented. Road shows are postponed, beginning 26th March at this stage, with no confirmed dates for the Southern region. Once dates are confirmed consultation and implementation meetings can begin.

Maternity
Good progress on aligning contracts for all of the Primary Facilities in the District. The contracts now require collaboration between providers and they are all keen to work together. Discussions continue with the Waiau Trust in Tuatapere about potential future services.

The Maternity Quality and Safety Framework funding will provide coordination for services across the district in quality improvement activities, clinical networking and relationship building. Consumer representation will be an essential part of the network.

Southern Community Laboratories
The National work which was looking at a list of tests publicly funded across the country has not been progressed at this stage. With SCL winning tenders for service provision in Canterbury there is potential for some cost savings where tests will now be done in house rather than referred.

Regular meetings with management are scheduled to ensure that the needs of SDHB are not subsumed by new business. A routine audit of the laboratory contract is being planned at the moment.

Southern PHO.
Active communication and engagement with the PHO continues but in some areas traction on information required for the annual plan has been slower than anticipated.

Southern PHO delegated Dr Hywel Lloyd to attend the Clinical Pathways workshop along with various DHB staff. Dr Lloyd has also subsequently agreed to attend LDT meetings, attending for the first time this week.

Primary / Secondary Integration – Clinical Pathways

This work has been supported by the DHB and PHO. Following the team visit to the Canterbury hosted workshop, a paper outlining the approach and scope for the pathways development is being finalised. It is hoped to have this scope agreed by the DHB and PHO within the next month and begin recruitment of the resource team to lead this work.

SIA and Health Promotion Plans

The full funding has still not been "turned on "for these funding streams. $400,000 (per annum) has been allocated to the Clinical Programmes proposal to date. After considerable dialogue and with the support Of Clinical Advisor Dr Marion Poore, a high level Health Promotion plan has been submitted for DHB approval.

Clinical Programmes Proposal

Approval and funding was given from October 2011 for the clinical programmes diabetes (initiating Insulin in Primary Care), Sexual Health and CVD risk assessments. Provision of the sexual Health services and CVD risk assessments has started, with no reporting available as yet. The diabetes information for initiating insulin is below.

Initiating Insulin in Primary Care
This SPHO programme is for people over the age of 18 with type 2 diabetes with poor glycaemic control. The intervention is six month process and is delivered via eight consultations. The programme began 1 October 2011.

Current activity for patients engaged in the Insulin Programme

Number currently engaged in programme	20
Number completed programme	0
Number completed Registration and referral	3
Number currently at planning appointment	6
Number currently at first insulin appointment	1
Number currently at telephone consult	3
Number currently at consultation 7-10 days following insulin appointment	2
Number currently at consultation 25-30 days following insulin appointment	4
Number of males engaged in programme	7
Number of females engaged in programme	13

Replacement of Get Checked in General Practice

The funding (for patients) of an annual diabetes review which has been available through the Performance programme will not be funded from July1 2012. There is an expectation from the minister that the checks will continue, and DHBs may use the funding (approximately $400,000) to provide services in Primary care which support improved patient outcomes
The PHO Clinical Governance group have delegated Dr Hywel Lloyd to develop a model for consideration. The Clinical Governance group have not yet approved the proposal but it has been presented for discussion by the LDT (Local Diabetes Team). A special meeting of the LDT has been arranged next week to consider recommendations to SDHB for replacement of get checked.

Free Under 6 visits after hours

This initiative must also be in place from the beginning of July. After discussion with the PHO agreement was reached that the PHO would engage directly with GPs to ask for ideas about implementation, and this is in progress now. This will also tie into current work with the PHO review of after-hours services. The target is to have 60% access by 1 July 2012.

Key Upcoming Activity

Diabetes Strategy

Plans for consultation with key stakeholders are developed and consultation will begin once a communication strategy is agreed. Consultation will include the development of a Diabetes Care improvement package.

Recently the DHB has provided funding for a diabetic nurse specialist in the central Otago area. This follows the expiry of old PHO funding which runs out in June. The specialist role will provide support to primary care teams across the Queenstown, Wakatipu basin and Central Otago area. The role also provides support for the hospital services in the area. The specialist nurse commenced on 5 March and the role is facilitated by employment via Central Otago Health Services Limited.

Health of Older People (HOP) Portfolio Update

Briefing to:	Disability Support and Community & Public Health Advisory Committees		
Subject:	HOP Portfolio Update		
Author:	Leanne Illingworth, Portfolio Manager	Date	15 March 2012
Purpose of Report :	√ **For Information Only**	☐ **Decision Required**	

Key Issues

This paper serves as an update for Committee members in relation HOP Portfolio activity.

Key Activity in this Reporting Period

1. HOP Community Models of Care (CMC) Service Development Plan activity:

Significant focus within the portfolio at present is on the progression of the HOP CMC Service Development Plan activity, in particular work-stream number 2. *'Identification, Assessment and Care Coordination'* and work-stream number 4. *'HOP Service Provision'* including *(i) Secondary and Intermediate Care Services and (ii) Community Care Services.*

- **Work-stream #2 - Identification, Assessment and Care Coordination** – this work-stream includes the implementation of the InterRAI, along with the development and implementation of the DHB Care Coordination Centre (CCC) and single point of entry (SPOE).

  InterRAI Assessment Tool
  Implementation of the InterRAI assessment tool continues with the initial roll-out phase ceasing as at 30 June 2012. All Clinical Needs Assessor (CNA) staff across the district including those employed by the rural hospitals are now trained, with the focus now being on the on bedding down of the assessment tool into the day-to-day operations. All assessments being completed for community age related services are by the InterRAI tool (either the Contact Assessment or Home Care Assessment tools).

  Information Systems (IS) server issues which have caused significant disruption previously have now largely been resolved. Only minimal issues remain which are being managed on a case by case basis. New laptops have been purchased and rolled out for all CNA staff which has assisted with local IS issues.

  A direct impact of the ongoing InterRAI implementation has included a significant back-log of activity within the needs assessment service coordination service, including both new referrals and reviews of exisitng clients. A priority of management at present is to address and maintain service activity going forward, including the management of the current waiting lists for new referrals and reviews.

  In addition the DHB is also focused on a number of InterRAI related activites including working with DHB contracted age related residential care facilities who are part of the MoH 'Long Term Care Facility' InterRAI tool roll-out; wider planning for the roll-out of the InterRAI CA and HC assessment tools both within DHB services and primary care, and further developing reporting capcacity from the InterRAI to be used in operational and strategic activity going forward.

  Care Coordination Centre (CCC)
  The DHB continues to progress implementation of the CCC. As outlined to the Committee previously the purpose of the CCC is to provide consistent processes, practices and access to community based treatment, assessment and support within the DHB by developing a single point of entry and pathway for services. It is expected that the service will be in place by 30 June 2012, followed by an evaluation of the service in October 2012. A Steering Group has been established to oversee the development and implementation of the service, and in addition two working groups are in place specifically with regards to the SPOE systems and processes and also a further group focused on the assessment tool utilised within the CCC. This group is the current InterRAI project steering group. At the point of initial implementation the service will include all referrals for Southern wide age related services, exceptional services (including palliative care), long term chronic

conditions (LTCC), close-in-interest and personal health (Dunedin – Provider Arm only) services.

- **Work-stream #4 - HOP Service Provision**

  As noted previously this work-stream is the focus of much activity at present specifically in relation to the planned implementation of the South Island restorative home based support service specifications, and also developments around age related day activity services (both general and dementia).

  Restorative HBSS
  Planning and Funding is currently testing the workability of the South Island service specifications from a Southern DHB context through an established task team, along with the input of the Health of Older People Advisory Committee (HOPAC). Work is also being progressed in tandemn around a new funding model going forward, along with the proposed RFP process for service provision. It is anticipated that the DHB will formally commence the RFP process in late April / early May 2012.

  Age Related Day Activity Services
  Planning and Funding are progressing activity in relation to the implementation of the recently revised national age related day activity service specifications. Initial activity is with existing day activity providers but with the view to look at the provision of age related day activity services across the district over the next 12 months. A briefing paper seeking feedback from HOPAC members is being prepared for the April meeting.

- **Age Related Residential Care**

  Annual Contract Review – the annual ARRC contract review process is continuing for the 12/13 year.

  ARRC development – DHB has received formal notification by national aged care provider BUPA Care Services of the intention to build an aged care facility, along with an associated village in Invercargill City. The facility will include hospital, dementia and psychogeriatric services. There is no date for completion of the facility at this point in time.

- **Health of Older People Advisory Committee (HOPAC)**

The Committee met for the second time on the 12th March 2012. During this meeting the Committee terms of reference were agreed, and also membership confirmed for GP, Practice Nurse and Pharmacy representation. Maori representation remains to be advised ongoing however an DHB Iwi Governance member is attending in the interim. As noted earlier the current focus for the Committee is on activity included with the HOP CMC Service Development Plan, specifically at present on the restorative HBSS and age related day activity services (general and dementia).

Key Upcoming Activity

- Upcoming HOPAC meeting (18 April 2012)
- Ongoing progress towards HOP CMC Service Development Plan activity with specific focus on work-stream #2 and work-stream #3 including commencement of restorative HBSS RFP.

Public & Population Health Portfolio Update

RECOMMENDATION: For noting	
Briefing to: Public & Public Health Advisory Committee + Disability Support Advisory Committee	
Subject: Population Health Portfolio Update	
Author: Bronwyn Portfolio Manager	**Date:** March 2012
☒ **For Information Only** ☐ **Decision Required**	

Key Issues

- Uncertainty around HEHA funding beyond 30 June 2012 is creating planning difficulties. We are waiting confirmation from the MoH about this.
- Moving towards district wide approach continues to present a number of challenges in some areas.

Key Activity in this Reporting Period (February- March)

Child and Young Persons Health

- Contributing to Ministry of Health quality reviews of service provision for Well Child Tamariki Ora service providers, School Based Health Checks and Before School Checks.
- Gateway Assessment Programme – ongoing planning for the implementation of this new programme of work for children and young people who come to the attention of Child, Youth and Family when entering care. This programme also includes those already in care, or those being referred for a Care and Protection Family Group Conference.
- Ongoing involvement in Gore Social Sector Trial to improve outcomes for young people aged 12-18 years by reducing truancy, offending, consumption of alcohol and other drug abuse and increasing participation in education, training and employment.
- Working on the establishment of DHB child and youth steering group/s.

Sexual Health

- A stocktake of sexual health services provided across the district is being undertaken.

Family Violence Intervention Programme (FVIP)

- Stocktake of family violence and child protection services provided across the district is being undertaken.
- Working with the MoH contract manager around renewal of the FVIP contract for 1/7/12 – 30/6/15.

Tobacco

- From mid January 2012 responsibility for smoke free planning and associated activities was transferred to Planning and Funding and Public Health South. We are working together to support the achievement of the national health target (secondary and primary) and implementation of the tobacco control plan.
- Implementation of additional rural Otago smoking cessation services for Māori has commenced.
- A pilot is being implemented to establish referral pathways from the DHB to a community smoking cessation provider.
- Establishing a Te Kiwai funding round to support Māori develop positive smoke free attitudes, behaviours and settings.
- Planning for a district wide communication plan for all smoke free activities has commenced.

Public Health

- PHS are developing their annual plan for 2012/2013 year – we are working to ensure alignment of this with DHB annual planning processes.

Māori Health

- A stocktake of all Māori provider contracts is being undertaken.
- Provided support for the development of Māori Health Implementation Plan and review of outcomes framework.
- Contributing to SDHB Māori Provider Development Scheme (MPDS) district wide project in collaboration with the Māori Health Directorate.

Pacific Health

- Established contract with Pacific Island Advisory and Cultural Trust in Southland for community liaison position.
- Meeting with MoH regarding their contract (health promotion – physical activity and nutrition) with the Pacific Trust Otago and relating it to HEHA support to the Trust.
- Working with Well Dunedin PHO on funding grant for Pacific Trust Otago.

Healthy Eating Healthy Action (HEHA)

Breastfeeding

- Coordination and delivery of four workshops on Māori perspectives on breastfeeding.
- Development of Southern district Breastfeeding Plan.
- Work with Public Health South to implement a Breastfeeding Friendly Workplaces initiative in Southland.
- Advising lactation consultants across Southern district regarding professional development opportunities.

Māori Community Action

- Contract initiated with Sport Southland, and provided nga Rūnaka/Rūnangaki Murihiku funding for each marae to develop a Māori Traditional Games programme.
- Development of Kaupapa Māori gardening workshop.
- Formalised scholarships for Māori dietetic students.

Leadership & Coordination

- Funded Southland Pacific Island Advisory and Cultural Trust (PIACT) for various projects.
- Continuing to work with MOH and Pacific Trust Otago on service delivery.
- Investigating potential for an Invercargill Physical Activity Strategy (PAS).
- Advising on Dunedin City Council Annual Plan.

Internal HEHA

- Sitting on project group for vending machine request for proposal across Southern DHB.
- Bikewise and local physical activity opportunities promoted to all Southern DHB staff.

Screening

- Meetings with National Screening Unit regarding National Cervical Screening Programme, New Born Hearing Screening Programme and Antenatal HIV - received feedback on monitoring reporting.
- First meeting of BreastScreen Health Care district wide co-ordination group.
- Reviewing draft terms of reference for establishment of district wide steering group for cervical screening.

Key Upcoming Activity

Child and Young Persons Health

- Ongoing contributing to MoH quality reviews of service provision for Well Child Tamariki Ora service providers, School Based Health Checks and Before School Checks.
- Gateway Assessment Programme – ongoing planning for the implementation of this new programme of work.
- Ongoing involvement in Gore Social Sector Trial.

Sexual Health

- Meeting with key DHB staff to discuss the stocktake and to identify opportunities and gaps to enhance district wide services.

Family Violence Intervention Programme

- Ongoing discussion with MoH regarding contract renewal.
- Stocktake activities to continue.

Tobacco

- Contract/s to be established for rural Otago smoking cessation services following RFP processes.
- Referrals to commence from DHB to community smoking cessation provider.
- Progress Te Kiwai funding round.
- Communication plan – working group to begin development of a strategy identifying key stakeholders, key messages and methods of communication for the tobacco control plan.
- Investigation into any service delivery gaps across the district.

Māori Health

- Meetings with all providers to discuss the stocktake document and to engage them on identification of unmet health needs. This will enable better alignment and responsiveness to need for Māori across the district.
- Attend two collective and three district hui for MPDS district wide project.

Pacific Health

- Ongoing support for development of services.

HEHA

- Processing breastfeeding grants applications following recent funding round.
- Māori Community Action Project (MCAP) Grant rounds closing March (Otago) and April (Southland).
- Investigating hosting a Māori Traditional Games Workshop in Southland.

PUBLIC HEALTH SOUTH REPORT TO THE SOUTHERN DHB COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
January-February 2012

RECOMMENDATION:
It is recommended that the Community and Public Health Advisory Committee note this report.

Public Health Services (Southern)

South Island Public Health Unit Project

This Ministry of Health funded project continues to move forward on a number of initiatives intended to reduce duplication of effort through increased communication, coordination and collaboration of the three South Island Public Health Units. The management group is planning a meeting next month to revisit the scope and structure of the initiative. A face to face meeting of the alcohol workgroup has been postponed until after a larger scale Ministry of Health organised meeting has taken place. South Island Public Health Units continue to deliver Whanau Ora tool training to local staff, with sessions planned in both Dunedin and Queenstown.

Settings and Lifestyles

Outcome 1	Reduce the impact and incidence of smoking related disease
Outcome 2	Reduce the impact and incident of obesity and overweight
Outcome 3	Reduce the impact and incidence of harm from alcohol and other drugs

Nutrition & Physical Activity

The Heart of the Pacific programme was a six month pilot project run 2-3 times a week involving Pacific Island families that had been identified by the Pacific Island nurses. The family members were overweight and/or had various medical conditions and were open to making changes in their lives. The aim of the project was to increase physical activity, improve the range of healthy foods consumed and engage the whole family in food preparation and shopping. All members of the family were involved in a fun competition incorporating mainly nutrition and physical activity but also supplemented with a small amount of budgeting and financial advice, as well as smokefree and mental health components. The evaluation of this project has been completed with pleasing results. The adult survey showed families felt their children were more involved in household tasks such as shopping and preparing food and also reported a positive change in eating habits within their families. The familes also reported that they are interested in using their knowledge and experience to run activities within their community. Half of the adults are participating in physical activity up to four times a week. Prior to the programme 100% of the families were eating takeaways one or more times a week compared to 40% after the programme. The children's results showed that 89% of the children said they had become more involved in household tasks (food shopping, cooking dinner, making lunch etc) since being in the project. Sixty-seven percent said their eating habits had improved and 80% said they were participating in some form of physical activity more than 4 times a week after completion of the programme. All the children felt they had learned new information about nutrition and food since the start of the programme. Public Health South staff will continue to support the Pacific Trust in any future projects of this nature.

Communicable Disease and Food Safety

Outcome 4	Reduce the impact and incidence of communicable disease

Biosecurity

In January and February 2012, 206 larval site assessments were completed at international ports and airports in Otago and Southland. Mosquitoes were detected at 49 sites but all were a local species Culex perfringens and are not a public health risk. This surveillance work is part of a national programme where sites around

international ports and airports in Otago and Southland are identified and checked regularly for the presence exotic mosquitoes that are of public health risk. Surveillance frequency is higher over summer months due to higher insect activity.

A total of 37 vessels travelling through international waters where the first ports of call in New Zealand were Otago and Southland have been issued with a pratique, a quarantine clearance. This is required under the New Zealand Health (Quarantine) Regulations 1983, to be granted before most vessels travelling from an overseas port is allowed land alongside a New Zealand port and have crew or passengers disembark.

Communicable Disease

Measles
Between October and November 2011 Public Health South was involved in investigating 18 cases of measles in the Dunedin city area. All cases were in people who were not immunised or not fully immunised and were linked back to an infectious person with measles who visited Dunedin in mid September. No further cases have been notified since the November and the local outbreak is now over. Nationally the number of cases of measles cases is declining after peaking in November 2011. Measles is highly infectious and immunisation is the most effective way to prevent the infection.

Pertussis
Nationally notifications of pertussis (whooping cough) have increased with a total of 930 cases reported since the first week of 2012 compared to 145 for the same period in 2011. In the Otago and Southland district 25 notifications have been received in January and February 2012 compared to 11 for the same period in 2011. This represents an increase but is not at a level which would indicate wide spread community outbreak. Immunisation remains an important defence against the spread of pertussis. Parents should ensure that children receive their vaccinations on time.

Below is a table of diseases notified to the Medical Officer of Health in January and February 2012.

	January and February 2012									January and February 2011 Total
Disease	Waitaki District	Otago Central District	Queenstown-Lakes District	Dunedin City	Clutha District	Southland District	Gore District	Invercargill City	Total	
Campylobacteriosis	7	9	19	55	21	20	8	13	152	110
Cryptosporidiosis	1					1			2	2
Dengue Fever			1						1	-
Gastroenteritis unknown case				1					1	5
Giardiasis		2	10	3		2	3	2	22	34
Hepatitis C				3					3	-
Invasive pneumococcal disease				1		1			2	6
Lead absorption				2					2	2
Legionellosis				1					1	9
Malaria									-	1
Meningococcal disease			1						1	-
Pertussis			5	4	8	1		7	25	11
Salmonellosis	3	6	3	11	3	2	1	3	32	47
Shigellosis				1		1			2	1

Tuberculosis disease - new case			1					2	3	-
VTEC/STEC					1				1	1
Yersiniosis				3					3	3
Grand Total	11	17	40	85	33	28	12	27	253	232

Healthy Environments

Outcome 5 Promote safe and healthy social and physical environments

Submissions Policy

At the request of the District Health Board, Public Health South has been working to draft a District Health Board-wide policy for the management of this advocacy process. The policy will allow for the approval and lodgement of submission to be managed according to the risk they pose. (Eg: technical submissions could be approved by the Service Manager of Public Health South, approvals for submissions to select committees from the governance level of the organisation through a process via the CEO.

With consent applications lodged under the Resource Management Act 1991 there has been an increasing trend us to work with applicants before applications for consent are lodged. This has saved applicants a lot of time and money and is also a far more collaborative way of working.

Chemical Incidents

Public Health South has a role in ensuring incidents involving hazardous substances are managed in such a way as to ensure the protection of public health. Fortunately these situations rarely occur.

A recent example occurred in Southland where an earthmoving contractor inadvertently unearthed and ruptured some drums of formaldehyde that had been buried some time before. Incidents of this sort require a multi-agency response that is driven by the risk posed by the particular chemical concerned. In the majority of incidents involving chemicals the responsibility for stabilising the risk falls with the New Zealand Fire Service. In this situation both the Department of Labour (the situation was a workplace) and Environment Southland (who had concerns regarding potential contamination of groundwater) provided the immediate response after the Fire Service. Public Health South's role in this situation was to evaluate the public health risk, ensure the relevant agencies were addressing those risks, and ensure that the required preliminary report was completed for the Environmental Protection Agency in a timely manner. The situation resulted in a worker attending the Emergency Department at Invercargill Hospital. The New Zealand Army have taken responsibility for the disposal of unaffected chemical and the site cleanup.

Vaccine Preventable Disease (VPD) Programme

The Southern District Health Board was awarded an Outstanding Achievement Award for the 2010/11 Immunisation Health Target. This award was presented for consistently meeting and exceeding the 90% target immunisation coverage for 2 year old children for July 2010 to June 2011. Further to this the Southern District Health Board has achieved 94% for Quarter 2 this year, striving for the 95% target by 30 June 2012. The Vaccine Preventable Disease Team acknowledges the dedicated and passionate work by all in the sector who make this achievement possible.

Dr Pam Jackson (Otago) and Dr Vili Sotutu (Southland) have now accepted invitations to be Southern District Health Board Immunisation Champions. The role provides the District Health Board with advocates for immunisation, with the first activities promoting the 2012 Influenza immunisation programme.

Smokefree Coordination

Southern District Health Board is making good progress towards achieving the Health Target "95 percent of hospitalised smokers will be provided with advice and help to quit by July 2012," with 87.6% being achieved at the end of the last quarter (October to December 2011). Hospital Smokefree Coordinators continued their work alongside clinical staff in achieving this result. In order to reach the remaining ten percent of hospitalised smokers, Coordinators and clinicians are looking to increase the number of smokefree champions, among other initiatives. Smokefree Coordinators are also meeting with the current champions to support them to assist staff to make improvements in progress towards the target.

The Inpatient Mental Health Unit at Southland Hospital became completely smokefree this year, a significant achievement by the staff and patients. While there have been some issues with patients smoking on the grounds, staff are reminding them of the policy change. There has been an increase in the amount of Nicotine replacement therapy prescribed to the patients in the mental health inpatient unit since the policy change.

In the Primary sector, Southern PHO has made a considerable effort to provide information to identify the areas that will require increased support to achieve the primary care target. The Primary Smokefree coordinator is working with Southern PHO staff to devise ways to engage the primary sector and offer them the support they need.

Cervical Screening Programme

The National Cervical Screening Programme (NCSP) has developed a draft strategic district plan (2011-2014) which has been submitted to the National Screening Unit with positive feedback from the Performance Manager. The next stage is for the strategic district plan to be agreed on by the NCSP District Co-ordination Steering Group. The Steering Group intends to meet for the first time by end of June 2012.

Mental Health and Addiction Portfolio Update

RECOMMENDATION: That the committee note the update.			
Briefing to:	CPHAC/DSAC		
Subject:	Mental Health and Addiction Portfolio Update		
Author:	Planning & Funding (Mental Health and Addiction)	Date	20 March 2012
Purpose of Report :	☒ **For Information Only**	☐ **Decision Required**	

Key Issues

- *Raise Hope: Hapaia te Tumanako* – the Mental Health and Addiction Draft Strategic Plan was released on February 17th and is now undergoing Public Consultation
- A number of national-level documents (Blueprint II by the Mental Health Commission and the Service Development Plan by the Ministry of Health) are also being developed. This is creating a degree of uncertainty re alignment of local planning, however we are engaging with these projects to ensure our local work is not inconsistent.

Key Activity in this Reporting Period (February-March)

- Public drop-in meetings held in Invercargill, Te Anau, Cromwell, Oamaru and Dunedin.
- Sector workshops for managers and leaders of contracted mental health and addiction providers held in Dunedin and Invercargill.
- Focus groups held with people who are currently using inpatient services held in Wards 9A, 9B, 9C, 11 (Dunedin) and the Invercargill Mental Health Inpatient Unit.
- Informal meeting held with consumer group in Alexandra.
- Over 300 hard copies of plan distributed.
- Numerous responses to enquiries re plan and consultation process.
- Submission made to Mental Health Commission re Blueprint II consultation.

Key Upcoming Activity

- Submissions on the Mental Health and Addiction Draft Strategic Plan close on April 11th.
- Submissions will be analysed from April 12th onwards, and will inform the next version of the plan.
- We anticipate that a final draft of the plan will be presented to CPHAC/DSAC for consideration in May, however a special meeting may be needed for that purpose.

DSAC / CPHAC FINANCIAL REPORT

Financial Report as at: **29 February 2012**
Report Prepared by: **Robert Mackway-Jones, GM Finance & Funding**
Date: **23 March 2012**

Recommendations:

- **That the Committee's note the Financial Report**

1. DHB Funds Result

The summary tables below have been split to show the components of the DHB funder result that are paid to the DHB provider-arm and those paid to other providers.

This is to show what portion of the total funder spend may be considered to be within the remit of the Community & Disability Advisory Committee. Within the amounts classified as "NGO's" some payments are made via inter district flows to tother DHBs. These are either for specialist services or for regional services such as some of the mental health services, e.g. Odyssey House in Christchurch which is a specialist Child & Youth residential service.

Month of February	To / From Provider-arm			To / From NGOs			Total		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000
Revenue	35,947	35,915	32	29,540	29,396	144	65,487	65,311	176
Less Expenses									
Personal Health	(27,594)	(27,490)	(104)	(18,284)	(18,584)	300	(45,878)	(46,074)	196
Mental Health	(5,024)	(5,112)	88	(2,102)	(2,035)	(67)	(7,126)	(7,147)	21
Disability Support	(1,838)	(1,838)	0	(8,532)	(8,560)	28	(10,370)	(10,398)	28
Public Health	(922)	(935)	13	(1)	(14)	13	(923)	(949)	26
Maori Health	(23)	(23)	0	(140)	(143)	3	(163)	(166)	3
Other	(546)	(517)	(29)	0	0	0	(546)	(517)	(29)
Expenses	(35,947)	(35,915)	(32)	(29,059)	(29,336)	277	(65,006)	(65,251)	245
Net Surplus / (Deficit)	(0)	0	(0)	481	60	421	481	60	421

Year to Date (February)	To / From Provider-arm			To / From NGOs			Total			Annual
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance	Budget
	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000	$' 000
Revenue	287,519	287,408	111	237,646	235,078	2,568	525,165	522,486	2,679	783,729
Less Expenses										
Personal Health	(221,006)	(220,006)	(1,000)	(154,315)	(155,633)	1,318	(375,321)	(375,639)	318	(564,492)
Mental Health	(39,864)	(40,894)	1,030	(15,713)	(16,259)	546	(55,577)	(57,153)	1,576	(85,752)
Disability Support	(14,702)	(14,702)	0	(69,887)	(68,711)	(1,176)	(84,589)	(83,413)	(1,176)	(124,876)
Public Health	(7,394)	(7,482)	88	(3)	(110)	107	(7,397)	(7,592)	195	(11,388)
Maori Health	(185)	(185)	0	(1,108)	(1,142)	34	(1,293)	(1,327)	34	(1,993)
Other	(4,368)	(4,139)	(229)	0	0	0	(4,368)	(4,139)	(229)	(6,209)
Expenses	(287,519)	(287,408)	(111)	(241,026)	(241,855)	829	(528,545)	(529,263)	718	(794,710)
Net Surplus / (Deficit)	0	0	0	(3,380)	(6,777)	3,397	(3,380)	(6,777)	3,397	(10,981)

Equally, some of the payments made to the provider also could be considered to be within the remit of the Committee's, as some payments relate to the delivery of the programmes, such as the Before Schools Checks. This is provided by the DHB provide-arm via Public Health South and the Public Health Nurses in the Well Child Service. Hence, planning & funding (and consequently the Community Advisory Committee) have an interest in the successful performance of the programme as do the provider-arm staff (and consequently HAC) delivering the service.

Also, issues such as the variance show in mental health expenditure to the provider-arm ultimately will interest the Disability Advisory Committee. The variance arises from financial claw backs as FTE positions that receive funding for the FTE input are vacant; consequently the funder claws this money back from the provider and can reinvest it in other mental health services.

This financial report will concentrate on variances relating to the "NGO" section and the detailed expenditure sheet is just that component rather than the full DHB funder results previously reported to the DHB Board.

Summary Comment:
The YTD "NGO" result is favourable to budget by $3.4m. The year-end forecast result is expected to be better than budget by $4.4m. However it is important to note the actual result is in deficit.

Key drivers of this YTD variance include:

- $1.0m of revenue for personal health expenditure in 10/11 and other miscellaneous revenue
- $0.5m of other favourable mental health expenditure
- $0.9m of lower net payments to PHO, mainly SIA/HP payments
- $0.4m of laboratory expenditure for non-schedule testing and share of national claims from un-coded NHI events
- $0.6m of below budget home support allocations
- $0.5m of lower than budgeted pricing impacts
- $0.2m of immunisation (timing issue)
- ($0.5m) of net pharmaceutical expenditure
- ($0.4m) of net residential care / ageing in place expenditure
- ($0.8m) of unfavourable IDF wash-up provision for 11/12

The February result was a surplus of $481k, this compared to the prior forecast result for a deficit of ($67k). The improvement was due to lower IDF outflows, lower pharmaceutical expenditure and lower adolescent dental claiming following contract review.

Revenue
YTD, revenue is $2.6m above budget however the bulk of this has associated cost offsets.

Item	$'m	Expense Line Offset (Y/N/Partial)
IDF's from Canterbury for ARC	0.5	Y, DSS ARC expenditure
IDF wash-up earthquake related personal health	0.5	N, Various but 10/11
Dementia Funding	0.5	Y, DSS ARC Rest Homes
Long Term Conditions funding	0.8	Y, DSS, Chronic Conditions
PHO Very Low Cost Access Funding	0.1	Y, PHO Health
PHO Performance Management funding	(0.3)	Y, PHO Other
All other revenue variances	0.5	N
Total Revenue Variation	2.6	

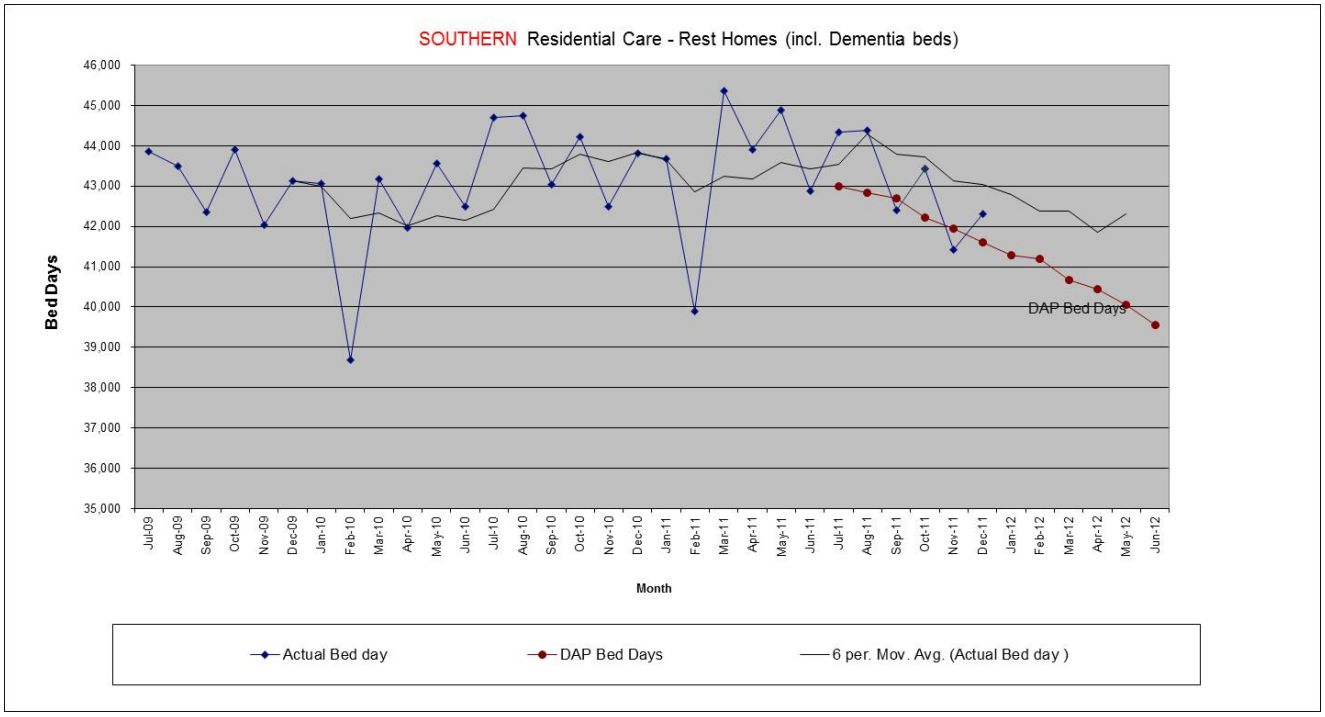
Expenditure

Mental Health
The $0.5m YTD variance related to NGO contracts is mainly ($0.3m) related to the residential bed funding line. There have been a number of other contractual changes made resulting in the residual ($0.2m) favourable expenditure variance.

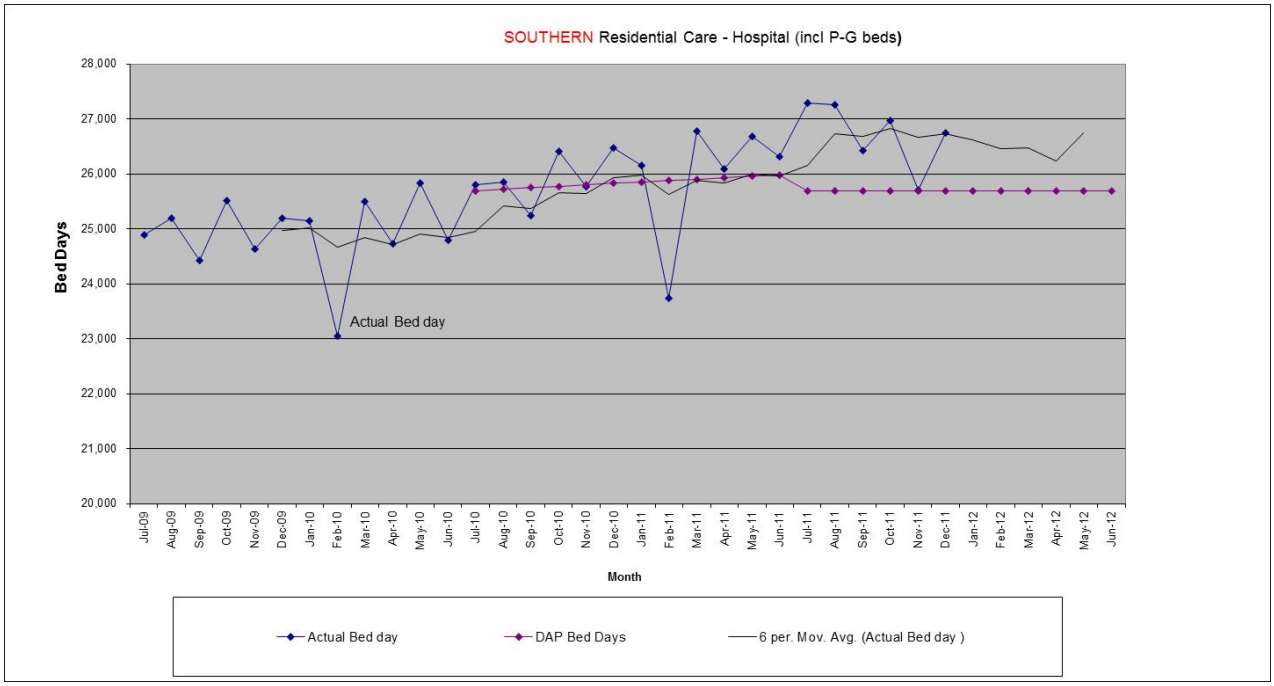
The variance in Alcohol & Drug Child & Youth services is offset against the Child & Youth line due to purchase unit changes within a contract.

Disability Support

Rest home level residential care services has a $0.9m unfavourable variance to February. This includes the pricing impact of the additional dementia funding of $0.5m leaving a residual deficit of $0.4m. Utilisation (for 6 months shown below) is running 1.6% higher than plan (but at levels lower (1.3%) than last year), and there are offsets for this expenditure in the community services line and day programmes line plus some offset with the IDF funding from Canterbury.



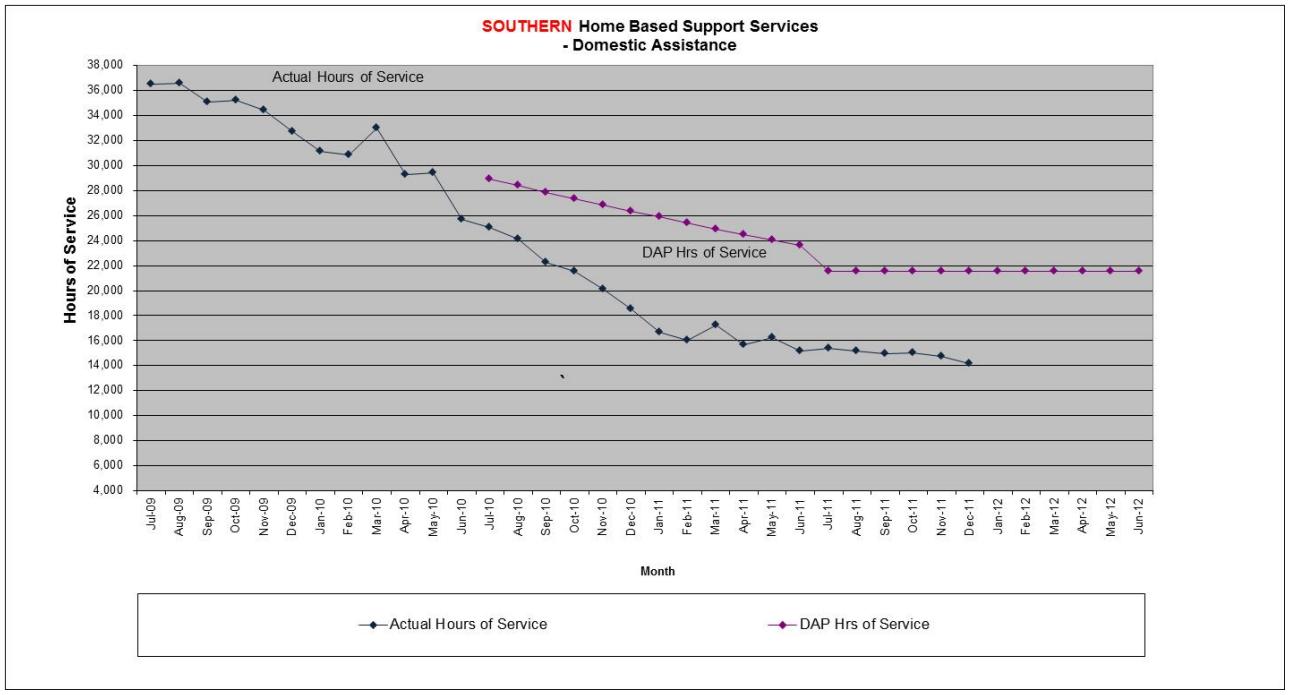
Hospital level residential care is $0.8m over budget.



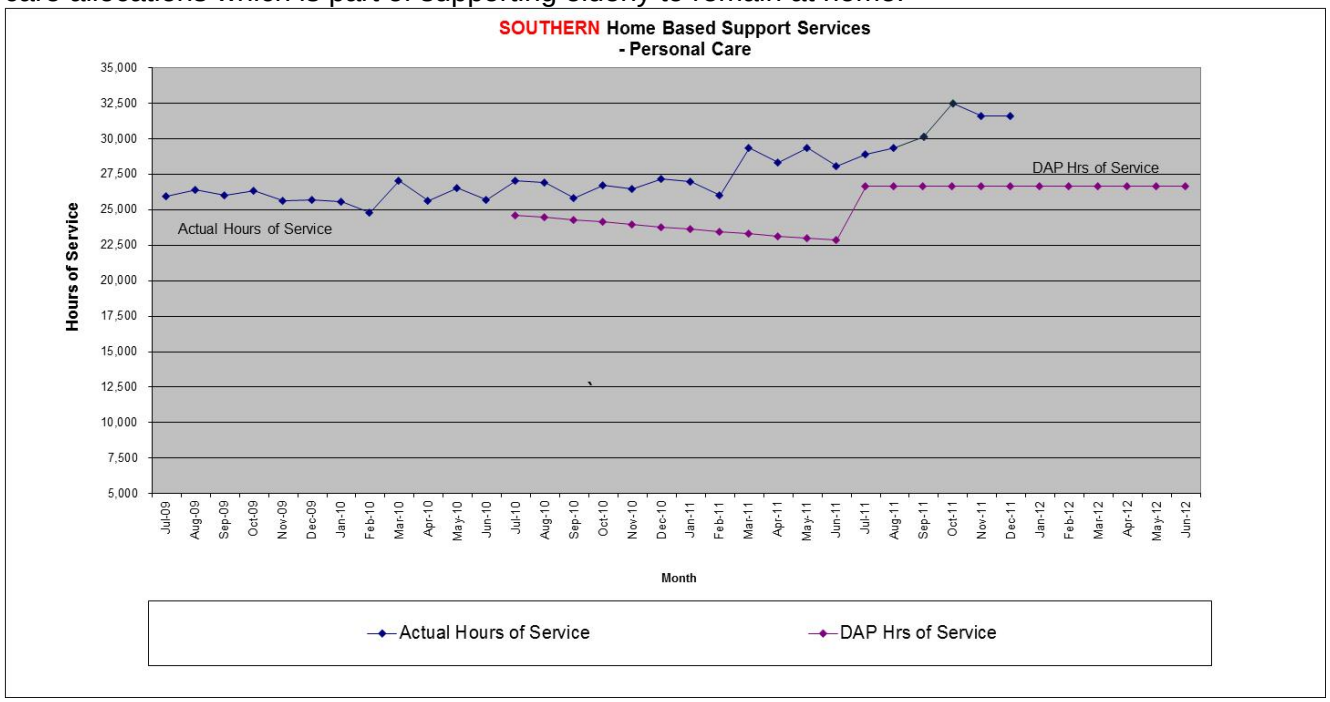
Utilisation is running 4% above plan for 6 months. The plan (in hindsight) has been set at slightly lower levels than actuals in 2010/11. There has also been some reclassification of rest home level patients into hospital level care. A portion of the IDF funding from Canterbury also relates to hospital level care.

Between the two categories, the total variance is $1.7m of which $1.0m is offset by additional funding and a further $0.3m in other expenditure areas. The net unfavourable variance of $0.4m is less than 1% of the total budget.

Home support allocations continue to be managed within budget; the favourable financial variance is $0.6m.



Domestic assistance utilisation has more than halved compared to July 2008 levels. Criteria changes were introduced in late 2009 and early 2010. Average monthly expenditure has reduced to $323k compared to $797k in mid-2008. This funding reprioritisation has allowed growth in personal care allocations which is part of supporting elderly to remain at home.



Personal care utilisation has increased by 32% since July 2008 levels. Average monthly expenditure is now around $807k compared to $592k in mid-2008.

At the time the criteria changes were introduced, additional monitoring of aged presentations to ED was put in place as was various audits of residential care placements to ensure no adverse or unexpected consequences resulted from the domestic assistance policy change.

Personal Health
Some of the expenditure variances are impacting the bottom line; some of the more significant ones include:

- The PHO Health line has a $1.1m has a favourable variance of which $0.8m relates to SIA/HP funds to the PHO. There is some unrelated offset from GMS claiming and PHO capitation payments.

- The rural support line contains the budget for a number of inflationary based adjustments to contracts that will progress over the course of the year. Some of the favourable variance in this line offsets the palliative care line which includes increased hospice funding approved as well as a number of other lines. There is minimal net variance projected by year end.

- Laboratory expenditure is below budget, claiming for non-schedule tests and other budgeted allowances are below planned level reflecting the demand driven nature of this service.

- The minor personal health expenditure line contains funding for primary care after hours support and workforce development. Workforce development funding has commenced from 1 November. The after-hours funding is being used for phone triage support and some of the ED volume in various hospitals is supported by this funding line as an interim step. This line also contains a number of small allowances for discretionary/special case expenditure that to date have not been required.

- A large rebate for PCT drugs ($0.3m) is reflected in the YTD result. Actual expenditure was also tracking below budget, although this was a lot closer to budget in January.

- The community pharmaceuticals lines is over budget by $0.5m, but when split between schedule claiming to the hospital pharmacy and other community pharmacies, the community pharmacy proportion presents as unfavourable by $0.9m. This is always somewhat of an arbitrary split. Expenditure is now projected to track closer back to budget by year-end.

IDF Inflows/Outflows

<u>Inflows</u>
IDF revenue is $1m favourable to budget. This is represented by $0.5m from Canterbury DHB for ARC and a further $0.5m from Canterbury DHB relating to personal health costs (Labs, Pharms, GM subsidies etc.) as a result of resident movements following the Christchurch earthquake. The 11/12 volumes and revenue overall has minimal YTD variance ($34k); although there are difference at a DHB level as shown in the following table.

DHB Name	Actuals	Budget	Variances	Variance in Dollars
Auckland	45.71	24.75	20.96	95,746
Bay of Plenty	7.81	18.05	-10.24	(46,770)
Canterbury	316.73	278.36	38.38	175,287
Capital and Coast	15.81	24.66	-8.84	(40,398)
Counties Manukau	14.80	19.33	-4.53	(20,688)
Hawkes Bay	6.46	7.55	-1.09	(4,956)
Hutt Valley	7.33	7.48	-0.15	(707)
Lakes	7.78	5.35	2.43	11,097
MidCentral	8.06	2.59	5.47	24,964
Nelson Marlborough	41.24	46.26	-5.02	(22,917)
Northland	3.79	14.11	-10.32	(47,139)
South Canterbury	137.43	158.93	-21.49	(98,174)
Tairawhiti	0.93	2.68	-1.75	(8,006)
Taranaki	5.99	5.52	0.47	2,158
Waikato	20.04	19.45	0.59	2,701
Wairarapa	0.47	1.99	-1.52	(6,920)
Waitemata	17.40	40.58	-23.17	(105,852)
West Coast	37.06	22.26	14.79	67,560
Whanganui	0.61	3.17	-2.55	(11,657)
Total	695.47	703.06	-7.59	(34,669)

Outflows

DHB Name	Actuals	Budget	Variances	Variance in Dollars
Auckland	345.40	320.35	-25.05	(114,428)
Bay of Plenty	10.39	9.03	-1.36	(6,210)
Canterbury	1025.93	1050.74	24.81	113,317
Capital and Coast	52.94	31.34	-21.60	(98,650)
Counties Manukau	18.46	44.58	26.12	119,283
Hawkes Bay	11.45	4.09	-7.36	(33,616)
Hutt Valley	24.32	13.09	-11.22	(51,255)
Lakes	11.72	6.27	-5.45	(24,897)
MidCentral	6.02	6.79	0.76	3,489
Nelson Marlborough	17.80	25.20	7.39	33,775
Northland	5.17	8.85	3.69	16,839
South Canterbury	35.00	25.99	-9.01	(41,156)
Tairawhiti	2.06	1.21	-0.85	(3,872)
Taranaki	8.06	2.15	-5.91	(26,980)
Waikato	57.29	28.01	-29.28	(133,749)
Wairarapa	1.94	3.01	1.07	4,895
Waitemata	15.85	13.56	-2.29	(10,471)
West Coast	13.07	10.60	-2.47	(11,298)
Whanganui	0.00	6.76	6.76	30,890
Total	1662.87	1611.61	-51.25	(234,096)

The table above shows an overall unfavourable wash-up to the default IDF position of $0.2m which is $0.3m better than the prior month.

The financials show a variance of $0.8m; this is because the budget was adjusted downwards by $0.8m ($0.5m YTD) for lower cardiology volumes than the default position.

For the seven (one month data lag); this component is tracking $0.3m unfavourably with all other services tracking unfavourably by $0.5m which is now the value of the overall acute variance. There is still some $0.2m of unfavourable variance in elective ENT volumes which are offset by other elective categories.

2. Year End Forecast

The Year-end total funder forecast has been updated and the expected result is summarised:

$'000	Prior Forecast	Forecast	Budget
Funder Result	(7,360)	(6,585)	(10,981)

The YE result is expected to be $4.4m better than budget. The $0.8m expected improvement from the prior forecast results from:

- Improved Pharmac forecasts ($0.2m)
- Lower projected dental claiming ($0.3m)
- Lower projected IDF outflows ($0.4m)
- Worse mental health position (more FTE positions funded) - $0.4m
- Lower projected rest home utilisation ($0.4m)

Funder	YTD Variance $' 000	Forecast Mar-June 12 $' 000	Budget Mar-June 12 $' 000	Variance Mar-June 12 $' 000	YE Forecast $' 000	Annual Budget $' 000	Forecast Variance $' 000
Revenue	**2,680**	**262,179**	**261,244**	**936**	**787,345**	**783,729**	**3,616**
less Expenses							
Personal Health Expenses	319	(188,041)	(188,852)	811	(563,362)	(564,492)	1,130
Mental Health Expenses	1,576	(28,128)	(28,600)	471	(83,705)	(85,752)	2,047
Public Health Expenses	195	(3,795)	(3,796)	1	(11,192)	(11,388)	196
Disability Support Expenses	(1,178)	(42,590)	(41,464)	(1,126)	(127,179)	(124,875)	(2,304)
Maori Health Expenses	35	(646)	(665)	19	(1,939)	(1,993)	54
Other Expenses	(229)	(2,184)	(2,070)	(114)	(6,552)	(6,209)	(343)
Total Expenses	**718**	**(265,384)**	**(265,446)**	**62**	**(793,929)**	**(794,710)**	**780**
Net Surplus / (Deficit)	**3,398**	**(3,205)**	**(4,203)**	**998**	**(6,585)**	**(10,981)**	**4,396**

The $4.4m improved result to budget is attributable to:

- $0.5m of IDF revenue for personal health expenditure in 10/11
- $2.0m of below budget MH expenditure ($1.4m being from provider-arm payments)
- $0.8m of lower pharmaceutical payments ($0.6m from hospital PCT claiming)
- $0.4m of below budget non-schedule laboratory testing
- $1.0m of lower net payments to PHO, mainly SIA/HP payments
- ($1.3m) of higher personal health IDF outflow payments

The $2.3m unfavourable expenditure variance in DSS does not significantly impact the bottom line result. Of the $2.3m; $1.1m is for the long term conditions funding devolvement. The residual variance of $1.2m relates to aged residential care, home support and the DHB's ageing in place strategy, for which additional IDF funding of $0.5m and $0.5m of additional funding for dementia services will have been received. Hence the net variance is around $0.2m and is due to the planning assumptions used in the ageing in place strategy. This has an expenditure shift out of rest home level care and more community based support options in place. This work has commenced within the planning & funding portfolio area, but many of these supports and restorative approach to home support are needed to be fully in place to provide alternative options to residential care placement. The InterRAI assessment tool is also required to support the strategy with this now live.

3. Financial Statements

The financial summary is an extract of the non DHB provider-arm expenditure payments.

Southern District Health Board

Feb-12

	Current Month				Year to Date				Annual
	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Budget $(000)
Payments to Non DHB Provider-arm Providers									
Personal Health									
Child and Youth	(40)	(43)	3 F	8%	(324)	(341)	17 F	5%	(512)
Laboratory	(2,521)	(2,583)	63 F	2%	(20,306)	(20,668)	362 F	2%	(31,002)
Infertility Treatment Services	-	-			-	-			-
Maternity	(147)	(143)	(4) U	(3%)	(1,170)	(1,143)	(27) U	(2%)	(1,717)
Maternity (Tertiary & Secondary)	(74)	(69)	(5) U	(7%)	(563)	(553)	(10) U	(2%)	(833)
Pregnancy and Parenting Education	(5)	(7)	3 F	36%	(44)	(59)	16 F	26%	(89)
Maternity Payment Schedule	-	-			-	-			-
Neo Natal	-	-			-	-			-
Sexual Health	-	(2)	2 F		-	(13)	13 F	102%	(19)
Adolescent Dental Benefit	(80)	(177)	97 F	55%	(1,182)	(1,340)	158 F	12%	(2,231)
Other Dental Services	-	-			-	-			-
Dental - Low Income Adult	(56)	(58)	2 F	3%	(508)	(457)	(51) U	(11%)	(688)
Child (School) Dental Services	(18)	(46)	28 F	61%	(411)	(407)	(4) U	(1%)	(653)
Secondary / Tertiary Dental	(139)	(141)	3 F	2%	(1,109)	(1,119)	11 F	1%	(1,684)
Pharmaceuticals	(5,836)	(5,411)	(426) U	(8%)	(50,153)	(49,259)	(894) U	(2%)	(73,554)
Pharmaceutical Cancer Treatment Drugs	-	-			361	-	361 F		-
Management Referred Services	-	-			-	-			-
General Medical Subsidy	(175)	(94)	(81) U	(86%)	(1,116)	(844)	(272) U	(32%)	(1,344)
Primary Practice Services - Capitated	(3,301)	(3,255)	(46) U	(1%)	(26,142)	(26,042)	(100) U		(39,063)
Primary Health Care Strategy - Care	(252)	(263)	10 F	4%	(2,009)	(2,100)	92 F	4%	(3,151)
Primary Health Care Strategy - Health	(156)	(165)	9 F	5%	(1,088)	(2,231)	1,143 F	51%	(3,195)
Primary Health Care Strategy - Other	(229)	(287)	58 F	20%	(2,104)	(2,307)	203 F	9%	(3,454)
Practice Nurse Subsidy	(18)	(15)	(4) U	(25%)	(144)	(135)	(9) U	(7%)	(211)
Rural Support for Primary Health Pro	(1,185)	(1,290)	105 F	8%	(9,477)	(10,320)	843 F	8%	(15,479)
Immunisation	24	(63)	86 F	138%	(301)	(510)	209 F	41%	(1,969)
Radiology	(149)	(143)	(6) U	(4%)	(1,190)	(1,141)	(49) U	(4%)	(1,712)
Palliative Care	(414)	(391)	(23) U	(6%)	(3,463)	(3,126)	(337) U	(11%)	(4,689)
Meals on Wheels	(20)	(24)	4 F	15%	(166)	(190)	24 F	13%	(285)
Domicilary & District Nursing	(405)	(400)	(6) U	(1%)	(3,366)	(3,194)	(172) U	(5%)	(4,792)
Community based Allied Health	(162)	(183)	21 F	12%	(1,298)	(1,465)	167 F	11%	(2,197)
Chronic Disease Management and Educa	(69)	(79)	9 F	12%	(618)	(627)	9 F	1%	(942)
Medical Inpatients	-	-			-	-			-
Medical Outpatients	(347)	(341)	(7) U	(2%)	(2,781)	(2,725)	(56) U	(2%)	(4,087)
Surgical Inpatients	(6)	(10)	4 F	43%	(44)	(78)	34 F	43%	(117)
Surgical Outpatients	(145)	(137)	(8) U	(6%)	(1,122)	(1,099)	(23) U	(2%)	(1,648)
Paediatric Inpatients	-	-			-	-			-
Paediatric Outpatients	-	-			-	-			-
Pacific Peoples' Health	-	-			-	-			-
Emergency Services	(147)	(147)			(1,175)	(1,173)	(2) U		(1,760)
Minor Personal Health Expenditure	(31)	(75)	44 F	58%	(144)	(599)	455 F	76%	(898)
Price adjusters and Premium	(66)	(72)	6 F	(8%)	(520)	(574)	54 F	(9%)	(861)
Travel & Accomodation	(283)	(359)	77 F	21%	(2,922)	(2,875)	(47) U	(2%)	(4,313)
Inter District Flow Personal Health	(1,834)	(2,115)	281 F	13%	(17,717)	(16,918)	(800) U	(5%)	(25,376)
Personal Health Total	**(18,284)**	**(18,584)**	**300 F**	**2%**	**(154,315)**	**(155,633)**	**1,318 F**	**1%**	**(234,526)**
Mental Health									
Mental Health to allocate	-	-			-	-			-
Acute Mental Health Inpatients	-	-			-	-			-
Sub-Acute & Long Term Mental Health	-	-			-	-			-
Crisis Respite	(9)	(18)	8 F	47%	(75)	(141)	66 F	47%	(212)
Alcohol & Other Drugs - General	(72)	(81)	9 F	11%	(542)	(643)	101 F	16%	(966)
Alcohol & Other Drugs - Child & Youth	(39)	(98)	59 F	61%	(499)	(779)	280 F	36%	(1,171)
Methadone	-	-			-	-			-
Dual Diagnosis - Alcohol & Other Drugs	(10)	(7)	(3) U	(48%)	(65)	(55)	(10) U	(18%)	(83)
Dual Diagnosis - MH/ID	-	-			-	-			-
Eating Disorder	(14)	(14)			(111)	(112)			(168)
Child & Youth Mental Health Services	(301)	(214)	(87) U	(41%)	(1,922)	(1,707)	(215) U	(13%)	(2,562)
Forensic Services	-	-			-	-			-
Kaupapa Maori Mental Health Services	-	-			-	-			-
Kaupapa Maori Mental Health - Residentual	(12)	(29)	17 F	57%	(121)	(230)	109 F	47%	(345)
Kaupapa Maori Mental Health - Inpati	-	-			-	-			-
Mental Health Community Services	(118)	(106)	(11) U	(11%)	(854)	(850)	(4) U		(1,276)
Prison/Court Liaison	-	-			-	-			-
Mental Health Workforce Development	(1)	(1)	1 F	45%	(5)	(9)	4 F	45%	(14)
Day Activity & Work Rehabilitation S	(127)	(140)	13 F	10%	(1,047)	(1,123)	76 F	7%	(1,687)
Mental Health Funded Services for Older People	-	-			-	-			-
Advocacy / Peer Support - Consumer	(23)	(25)	2 F	10%	(180)	(200)	20 F	10%	(301)
Other Home Based Residential Support	(349)	(265)	(84) U	(32%)	(2,183)	(2,121)	(62) U	(3%)	(3,182)
Advocacy / Peer Support - Families	(59)	(50)	(9) U	(17%)	(401)	(404)	3 F	1%	(607)
Community Residential Beds & Service	(400)	(471)	71 F	15%	(3,459)	(3,761)	301 F	8%	(5,650)
Minor Mental Health Expenditure	(81)	(27)	(54) U	(199%)	(339)	(215)	(123) U	(57%)	(323)
Inter District Flow Mental Health	(489)	(489)			(3,909)	(3,909)			(5,864)
Mental Health Total	**(2,102)**	**(2,035)**	**(66) U**	**(3%)**	**(15,713)**	**(16,259)**	**547 F**	**3%**	**(24,411)**

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Southern District Health Board

Feb-12

	Current Month				Year to Date				Annual
	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance	Budget
	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%	$(000)
Public Health									
Alcohol & Drug	-	-			-	-			-
Communicable Diseases	-	-			-	-			-
Injury Prevention	-	-			-	-			-
Mental Health	-	-			-	-			-
Screening Programmes	-	(12)	12 F		-	(96)	96 F		(144)
Nutrition and Physical Activity	-	(2)	2 F		7	(14)	21 F	149%	(21)
Physical Environment	-	-			-	-			-
Public Health Infrastructure	-	-			-	-			-
Sexual Health	(1)	-	(1) U		(6)	-	(6) U		-
Social Environments	-	-			(4)	-	(4) U		-
Tobacco Control	-	-			-	-			-
Well Child Promotion	-	-			-	-			-
Meningococcal	-	-			-	-			-
Public Health Total	**(1)**	**(14)**	**13 F**	**92%**	**(3)**	**(110)**	**107 F**	**97%**	**(165)**
Disability Support Services									
AT & R (Assessment, Treatment and Re	(308)	(321)	13 F	4%	(2,460)	(2,566)	105 F	4%	(3,849)
Information and Advisory	(1)	(1)		3%	(4)	(4)			(6)
Needs Assessment	(24)	(20)	(4) U	(22%)	(184)	(156)	(28) U	(18%)	(234)
Service Co-ordination	(3)	(3)			(27)	(27)			(40)
Home Support	(1,066)	(1,157)	91 F	8%	(8,686)	(9,258)	572 F	6%	(13,888)
Carer Support	(170)	(168)	(1) U	(1%)	(1,185)	(1,346)	161 F	12%	(2,019)
Residential Care: Rest Homes	(2,986)	(2,830)	(155) U	(5%)	(23,975)	(23,109)	(866) U	(4%)	(34,170)
Residential Care: Loans Adjustment	15	23	(8) U	(35%)	211	181	30 F	17%	271
Long Term Chronic Conditions	37	-	37 F		(735)	-	(735) U		-
Residential Care: Hospitals	(3,238)	(3,266)	28 F	1%	(26,919)	(26,126)	(793) U	(3%)	(39,189)
Ageing in Place	(109)	(112)	2 F	2%	(873)	(892)	19 F	2%	(1,338)
Environmental Support Services	(96)	(98)	2 F	2%	(770)	(784)	14 F	2%	(1,179)
Day Programmes	(10)	(41)	31 F	75%	(197)	(257)	60 F	23%	(459)
Expenditure to Attend Treatment ETAT	-	-			-	-			-
Respite Care	(103)	(75)	(28) U	(38%)	(558)	(599)	42 F	7%	(899)
Community Health Services & Support	(95)	(139)	44 F	32%	(733)	(951)	218 F	23%	(1,600)
Inter District Flow Disability Support	(375)	(352)	(23) U	(6%)	(2,792)	(2,815)	23 F	1%	(4,223)
Disability Support Other	-	-			-	-			-
Disability Support Services Total	**(8,532)**	**(8,560)**	**28 F**		**(69,887)**	**(68,711)**	**(1,176) U**	**(2%)**	**(102,822)**
Maori Health									
Maori Service Development	(22)	(22)		1%	(176)	(179)	3 F	1%	(268)
Minor Maori Health Expenditure	(9)	(12)	3 F	26%	(71)	(96)	25 F	26%	(144)
Whanau Ora Services	(109)	(109)			(861)	(868)	7 F	1%	(1,304)
Maori Health Total	**(140)**	**(143)**	**3 F**	**2%**	**(1,108)**	**(1,142)**	**34 F**	**3%**	**(1,716)**
Total Expenses	**(29,059)**	**(29,336)**	**278**	**(1)**	**(241,026)**	**(241,855)**	**830**	**(1)**	**(363,640)**