

TE WAI ORA



**Nelson Marlborough
District Health Board**

NOTICE OF MEETING

OPEN MEETING

**A meeting of the
Community and Public Health Advisory Committee
of the Nelson Marlborough District Health Board
will be held on 31 August 2010 at 12.30 p.m. in the
Support Services Room 1
Wairau Hospital
Blenheim**

Note: Videoconferencing available from the DHB Seminar Centre Room 1,
Braemar Campus, Waimea Road, Nelson

AGENDA**12:00 CPHAC Lunch (public excluded)****PUBLIC FORUM – 12:30 p.m.****OPEN SECTION – 12:40 p.m.**

12:40 p.m.	Karakia (Lorraine McMath) and welcome (Chair)	
	SECTION 1:	Apologies
	SECTION 2:	Registrations of Interest
12:45 p.m.	SECTION 3:	Minutes
		<ul style="list-style-type: none"> • From previous meeting • Matters Arising
	SECTION 4:	Correspondence
1:00 p.m.	SECTION 5:	Monitoring Reports
		<ul style="list-style-type: none"> • Chair • Te Roopu Tupu Tahi • GM Planning and Funding • Director of Māori Health • GM Primary and Community • Members' Reports • Members' Issues
1:30 p.m.	SECTION 6:	Government Priorities:
		No new items
1:30 p.m.	SECTION 7:	Presentation 1:
		Health Promotion Plan
2.00 p.m		Public Excluded Meeting

RECOMMENDATION

THAT the committee resolve itself into a committee of the whole and that in terms of the NZ Public Health and Disability Act 2000, the public be excluded while the following items are considered:

- **Minutes of a meeting of committee members held on 17 February 2009 (Clause 34 (a) Fourth Schedule NZ Public Health and Disability Act 2000)**
- **South Island Health Services Planning – To protect information that is subject to negotiation (Clauses 34 (a) and (b) Fourth Schedule NZ Public Health and Disability Act 2000)**
- **Statement of Services Performance – To protect information that is subject to audit and negotiation (Clauses 34 (a) and (b) Fourth Schedule NZ Public Health and Disability Act 2000)**
- **Business Case: Accommodation for After Hours Service in Nelson – To protect information that is subject to negotiation (Clauses 34 (a) and (b) Fourth Schedule NZ Public Health and Disability Act 2000).**

3:30 p.m.

Closing Karakia

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1 APOLOGIES

Nil received

2 REGISTRATIONS OF INTEREST

1) Committee Members

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
John Moore	<ul style="list-style-type: none"> Nil 	<ul style="list-style-type: none"> Member Nelson Regional Land Transport Committee Trustee Top of the South Athletics Charitable Trust. 		
Liz Richards	<ul style="list-style-type: none"> Chair of the Upper South A Regional Ethics Committee 	<ul style="list-style-type: none"> Member of Nelson Labour Electorate Committee. Appointed as Trustee Tasman Bay Heritage Trust. 	<ul style="list-style-type: none"> Health Research. 	
Jenny Black	<ul style="list-style-type: none"> Life member of Diabetes NZ. 			
Judy Crowe	<ul style="list-style-type: none"> Chairperson of Nelson Marlborough Hospitals' Charitable Trust. 	<ul style="list-style-type: none"> Member of the Gladys Amelia Pascoe Trust 	<ul style="list-style-type: none"> Provision of trust funds towards equipment, training and patient support. 	
Judith Holmes	<ul style="list-style-type: none"> Partner works for Child and Adolescent Mental Health Services (CAMHS). NMDHB representative on the Mapua, Ruby Bay and Moutere District Health Centre Inc Board 			
Lorraine McMath	<ul style="list-style-type: none"> Director of Wellbeing Works Ltd. 	<ul style="list-style-type: none"> NMDHB representative on Marlborough Regional Land Transport Committee 		<ul style="list-style-type: none"> Husband is Director of Construction Coatings and has been contracted for work with Wairau Hospital redevelopment.
Sonny Alesana	<ul style="list-style-type: none"> Nil 			

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Suzanne Win (ex- officio)	<ul style="list-style-type: none"> ▪ Director of Split Ridge Associates Ltd that provides consultancy services to health & disability organisations ▪ Trustee of Gracelands Group ▪ Member of DHBNZ Chairs Executive with lead responsibility for workforce and participant on Tripartite Forum ▪ Partner is a part-time employee of NMDHB Provider Division. 		<ul style="list-style-type: none"> ▪ Provision of consultancy services to health and disability organisations for DHBs or Ministry of Health. 	<p style="text-align: center;">Partner is</p> <ul style="list-style-type: none"> ▪ Member on PHO Alliance Executive ▪ Chair of West Coast PHO ▪ contracted to MOH to coordinate the implementation of the Cardiac Network ▪ Chair of the Board of Access Home Health Ltd ▪ Director on Management Board of Jack Inglis Friendship Hospital.

As at 17 August 2010

2) Strategic Leadership Team Members

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Denise Hutchins	<ul style="list-style-type: none"> ▪ Member DHBNZ Workforce Group ▪ Surveyor/Team Leader Quality Health NZ. 		<ul style="list-style-type: none"> ▪ Certification/Accreditation. 	
Heather McPherson (Acting CMA)	Nil		<ul style="list-style-type: none"> ▪ 	
Harold Wereta	<ul style="list-style-type: none"> ▪ Ngati Toarangatira Connections 		<ul style="list-style-type: none"> ▪ Tribal Interest 	
John Peters	<ul style="list-style-type: none"> ▪ Director of SISSAL ▪ Trustee of Nelson Marlborough Hospitals' Charitable Trust ▪ Trustee Churchill Trust. 	<ul style="list-style-type: none"> ▪ Director of Management and Industrial Services Ltd. 	<ul style="list-style-type: none"> ▪ Shared services provision, administration of trust funds for health purposes & provision of private health services at Wairau Hospital ▪ MIS Ltd previously provided consultant services to other DHBs. 	
Keith Rusholme	<ul style="list-style-type: none"> ▪ Wife provides first aid training and confidential help services. 		<ul style="list-style-type: none"> ▪ Provision of services to DHB staff or contracted providers. 	<ul style="list-style-type: none"> ▪ Sister works for IDSS.
Mike Cummins	Nil			
Peter Burton	Nil	<ul style="list-style-type: none"> ▪ NMDHB Representative on Tasman Council's Regional Land Transport Committee. 		
Robyn Henderson	Nil	<ul style="list-style-type: none"> ▪ 		

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Sharon Kletchko	<ul style="list-style-type: none"> ▪ Member Exceptional Circumstances Panel – PHARMAC ▪ Treasurer, International Society for Health Care Priorities ▪ Member St John Northern Region South Island Trust Board ▪ Member RACP NZ Policy and Advocacy Committee. ▪ South Island Representative on RACP NZ Joint Executive. ▪ Member of the Medicine’s Review Committee (Medicine’s Act) MEDSAFE. 	<ul style="list-style-type: none"> ▪ Deputy Chair of the New Zealand Standards Council. 		

As at 17 August 2010

3 MINUTES

MINUTES OF THE OPEN MEETING OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE (CPHAC) OF NELSON MARLBOROUGH DISTRICT HEALTH BOARD			
Date	22 June 2010	Time	9.30
Where	Nelson Seminar Centre Room 1	Previous meeting date	27 April 2010
Present	John Moore (Chair), Judy Crowe, Sonny Alesana, Judith Holmes, Suzanne Win, Jenny Black		
In attendance	John Peters, Sharon Kletchko, Peter Burton, Bruce Moorhead, Jasmin Brandt (minutes), Harold Wereta, Andrew Swanson-Dobbs, Christine Smith, Rennie Dix, Lorraine Eade		
Apologies	Liz Richards, Lorraine McMath, Suzanne Win for leaving early		
Mihi/Intro	Jenny Black		

Item	Discussion	Action	Who	When
Public Section	<p>Member of the public Cynthia McConville spoke on the need for mental fitness and raised the following questions:</p> <ol style="list-style-type: none"> 1. What percentage of the mental health budget is committed to the prevention of mental illness? 2. How is this money spent? 3. Is there any recognition of the worth of mindfulness based programmes within the NMDHB? 4. Has NMDHB funded attendance of the ‘Happiness and Its Causes Conference’, and do we know the outcomes for the community? <p>Member of the public Dan McGuire alerted the meeting to a resource consent that will be launched by the Council seeking to increase the level of noise acceptable at outdoor</p>	Provide responses	GM P&F	

Item	Discussion	Action	Who	When
	<p>events. He noted that the proposed levels exceed WHO recommendations. Question posed to CPHAC:</p> <ol style="list-style-type: none"> 1. Can CPHAC ask Public Health to take this matter up with the Council before it is too late? 	<p>Public Health to contact Council</p>	<p>GM P&C</p>	
<p>Apologies</p>	<p>Received:</p> <ul style="list-style-type: none"> • Liz Richards • Lorraine McMath • Suzanne Win for leaving early 	<p>Moved: Judith Holmes Seconded: Judy Crowe THAT THE APOLOGY RECEIVED BE ACKNOWLEDGED. AGREED</p>		
<p>Registrations of Interest</p>		<p>Moved: Suzanne Win Seconded: Judith Holmes THAT THE REGISTRATIONS OF INTEREST BE NOTED. AGREED</p>		
<p>Minutes</p>	<p>Matters Arising</p> <p>The Chair noted commended the Secretary on the quality of the minutes.</p>	<p>Moved: Judy Crowe Seconded: Jenny Black THAT THE MINUTES OF THE MEETING ON 27 APRIL BE ADOPTED AS A TRUE AND CORRECT RECORD. AGREED</p>		
<p>Correspondence</p>	<p>Nil</p>			
<p>Reports</p>	<p>Committee Chair</p> <p>The Chair’s verbal report mentioned attendance at the opening of the new rooms of the NICHE Trust. This Trust administers the needle exchange programme funded by Government. Hepatitis C rates are falling slowly to about 60% in the user group.</p>	<p>Moved: John Moore Seconded: Judy Crowe THAT CHAIR' S REPORT BE RECEIVED. AGREED</p>		

Item	Discussion	Action	Who	When
	<p>Preliminary reporting is being made on the Nelson Arterial Road Study, a Health Impact Assessment will be made on the options. The DHB position from 2008 is that new roading should be delayed until the effects of traffic management measures and public transport are apparent. This position supports the Nelson Regional Land Transport Strategy of 2009.</p> <p>The Chair informed CPHAC members that he had publicly and politically presented a view that drug use is a health issue and that the present position of making it a criminal issue is ineffective at every level. This supports a WHO position. The Chair noted that he had taken care not to involve or implicate the DHB in this argument.</p> <p><i>Suzanne Win leaves the meeting</i></p>			
	<p>Te Roopu Tupu Tahī</p> <p>The report was taken as read.</p> <p>The question was raised whether the number of sessions mentioned for the PHO anxiety workshops were deemed sufficient to adequately treat such conditions?</p> <p>The committee noted the concern expressed around cessation of Ministry funding for the Mental Health Advisory Coalition. The General Manager Planning and Funding commented that Ministry is currently revising funding in a number of areas and that DHB will be expected to pick up the liaising role for between NGOs and the Ministry.</p> <p>Terms of Reference (TOR) - Feedback re meeting frequency:</p>	<p>Moved: John Moore Seconded: Judy Crowe THAT REPORT FROM TE ROOPU TUPU TAHI BE RECEIVED. AGREED</p> <p>Contact TRTT facilitator regarding ToR feedback.</p>	<p>Chair</p>	

Item	Discussion	Action	Who	When
	<p>Earlier this year CPHAC along with the other Board advisory committees to the Board had changed its meeting frequency to bi-monthly meetings. CPHAC wonders if it would be more convenient for TRTT from a reporting perspective if they aligned their meeting frequency to that of CPHAC? After discussion it was agreed that a fixed meeting schedule in TRTT'S TOR was not required by CPHAC.</p>			
	<p>Director of Maori Health</p> <p>Report taken as read.</p> <p><u>Whanau Ora</u> Noted that some providers insist on putting in singular Expression of Interests (EOI). DHBs position is that this needs to be a joint effort. Closing date for the Whanau Ora EOI is end of the year. Applications from providers who would like to be involved in a regional EOI are invited for prior consideration through the DHB by 7 July 2010.</p> <p><u>Pacific Community</u> Meeting held 21 June with PHOs facilitated by GM Planning and Funding to progress implementation of MOUs between PHOs and Pacific Community. Sonny Alesana noted that the discussions had been necessary and were heading in the right direction.</p> <p>Page 22: Chair asked for clarification as to which Board Chairs are being referred to? Provider Board Chairs.</p>	<p>Moved: Judy Crowe Seconded: Judith Holmes THAT THE REPORT FROM THE DIRECTOR OF MAORI HEALTH BE RECEIVED. AGREED</p>		
	<p>GM Planning and Funding</p> <p>Report taken as read</p>	<p>Moved: Jenny Black Seconded: Judy Crowe • THAT THE REPORT</p>		

Item	Discussion	Action	Who	When
	<p><i>Christine Smith, Rennie Dix, Lorraine Eade join the meeting by videoconference</i></p> <p><u>Smoking Cessation/ Tobacco Control</u> At what point do you expect to see a reduction in cost? Internationally there is no single level initiative that shows this achievement. That eventually society will make a social shift towards seeing smoking as something negative. Noted that due to New Zealand's current legislation the tar and nicotine content of tobacco is higher here than in other countries. Also of relevance are the chemicals that are being added which increase the intake of nicotine.</p> <p><i>Andrew Swanson-Dobbs joins the meeting</i></p> <p>The committee suggested that Public Health makes a recommendation to CPHAC to support a request for legislative change to see New Zealand align with other countries in regards to tar/ nicotine content.</p> <p><u>Pharmaceutical Expenditure</u> Question around Nelson Marlborough's rise in these costs: where is the budget problem coming from? GM Planning and Funding noted that there are three groups of prescribers under non-NGO, namely SMOs employed by the DHB; community prescribers not employed by DHB including midwives and dentists; and junior doctors). The spending of these groups is currently being looked at with the Chief Medical Advisor to gain a better understanding of the issues. Once outcomes become available, they will be reported back to CPHAC.</p>	<p>FROM THE GENERAL MANAGER PLANNING AND FUNDING BE RECEIVED.</p> <ul style="list-style-type: none"> • THAT THE FINANCIAL REPORT BE ADOPTED. • AGREED <p>Prepare recommendation for CPHAC re legislative change regarding tar and nicotine content in tobacco</p>	<p>GM P&C</p>	<p>Mid-August</p>

Item	Discussion	Action	Who	When
	<p>GM Primary and Community</p> <p>Report taken as read.</p> <p><u>After Hours Report</u> Page 35: Rushed composition of report noted with various errors in grammar and punctuation.</p> <p><u>Health Promotion Plan</u> Noted that CPHAC is hugely interested in this plan and would have liked to be involved before the draft plan is presented to the Ministry.</p> <p><u>Adolescent Oral Health</u> Question raised as to why we are under budget even though we are far exceeding the 2009 DAP target? How does it relate? Is there no demand? Noted that Nayland School now set up to provide this service. Students attending have been shown to need less intervention than expected. Moving to national contract this year.</p>	<p>Moved: Jenny Black Seconded: Judith Holmes THAT THE REPORT FROM THE GENERAL MANAGER PRIMARY AND COMMUNITY BE RECEIVED. AGREED</p> <p>Seek CPHAC feedback</p>	<p>GM P&C</p>	
<p>Members Issues</p>	<p>Rationale and process regarding the funding cuts in mental health</p> <p><u>General feedback on paper received</u> Chair noted that the language of the paper could have been less bureaucratic.</p> <p>Judith Holmes noted that she had raised this item as a member's issue following an article in the newspaper. Whilst the article was highly sensationalised it had raised concerns in the community, e.g. fear of increased crime. Noted that such mental health/ public safety concerns are mainly driven by dual diagnosis issues. Member thanked GM Planning</p>			

Item	Discussion	Action	Who	When
	<p>and Funding for the informative paper, as it clarifies the issue and enables an informed response to queries from the public.</p> <p>Noted that in future management will endeavour to get the information to the right people at the right time; challenges noted around community representatives not receiving closed Board papers.</p> <p><u>Addiction Services Support House</u> Agenda page 44 (bottom table): Noted that this was not a service that NMDHB originally contracted for but was a provider initiative aimed at being a self sustainable service. It is used as a step down support house for those service users being discharged from the AOD residential programme. It assists with transition back into the community. Located next door to the residential programme, service users pay weekly board payments. NMDHB provided initial support to get the service up and running.</p> <p><u>How do the cuts affect the provision of mental health services to Maori and other ethnic communities?</u> Noted that in terms of the Community Support Worker position, the impact is minimal as there was capacity to increase the number of service users within the existing caseloads. Pasifika numbers are serviced across the sector but predominantly by Maori Health Providers. The number of Pasifika people is lower across services.</p> <p>Where there have been lower than expected staff to service user ratios, some of these services have been trimmed.</p>			

Item	Discussion	Action	Who	When
	<p>The next challenge is the reduction of the number of Day Activity programmes from six to four.</p> <p>The aim is to have a holistic approach in a collaborative manner (Alliance approach) so we can capture everyone more effectively.</p> <p>Currently working with providers around service agreements to be more prescriptive around inputs/ outputs and outcomes, therefore providing more clarity around demonstrating best value for each health dollar invested.</p>			
<p>Presentations/ Discussions</p>	<p>Transforming Care for People with Long Term Conditions</p> <p><u>The GM Planning and Funding, Dr Sharon Kletchko, spoke to her Powerpoint presentation slides</u></p> <p>It was explained that due to the way health/ illness functioned in the 20th century, i.e. acute infections and injury caused most of the burden of disease and death, the focus in health was on single conditions/ episodes.</p> <p>Today, however, 85% of health problems are chronic diseases, and there is a fundamental mismatch between how we operate our health system and what is actually going on.</p> <p>Noted that all age groups are affected by the chronic diseases.</p> <p>Multiple long-term conditions frequently manifest in the same individual as those on the list of premature deaths. Huge impact of comorbidity on cost. If we could affect change for this group, then we would see considerable cost</p>			

Item	Discussion	Action	Who	When
	<p>savings.</p> <p>Suggested that we learn from what we know about combinations, i.e. if cancer survivors have a higher rate of vascular problems, these should be monitored proactively.</p> <p><u>General comments/ discussion</u></p> <ul style="list-style-type: none"> • KHW CEO thanked GM Planning and Funding for the valuable information provided in the presentation. • What about the people who are not captured at all? Can we use VRA Programme as the way in? • Noted that the ultimate responsibility for people’s health lies with the individual but need to support people to get there. Noted that this is part of Whanau Ora, which goes beyond health issues. • Is the attitude change we need going as fast as it could? Noted that money speaks loudest, so if funding changes this can be used as an incentive. Going from model where GPs provided 95% of all care to a different model, how do keep the GPs involved and supportive? The majority of practices is fine, as they are interested in their patients getting the best care. Importance of feedback of information to GP noted however. Sonny noted that the strategy behind the promotion of services to the community is taking place – not one promotional strategy works for all the communities, however. KHW CEO noted that they are working on this. • NMDHB Chief Executive explained the new ELT structure and pointed out that this new structure is part of future proofing how we can respond to these challenges. 			

Item	Discussion	Action	Who	When
	<p>The General Manager Planning and Funding introduced the concept of 'ecological model' for long-term conditions. This model explains the spheres of influence on such conditions by relating them to the way a lake feeds water into a river which feeds into the sea, and how different factors, e.g. high rainfall, can have lead-on effects, but exemplifying at the same time that successful interventions can be made at each level of the 'ecological system'.</p> <p>Such interventions can be packaged into six packages, which span across the continuum of care and all populations with increasing need for care:</p> <ol style="list-style-type: none"> 1. Public Health Package of Care 2. Primary/ Secondary Chronic Care Coordination Package 3. Secondary/ Tertiary Health Promotion and Early Detection Package 4. Chronic Care Management Package 5. Rehabilitation and Supportive/ Respite Care Package 6. Palliative Care Package. <p>These packages could encompass the 180 individual services we currently have in place.</p> <p>Noted that with Jumbo we have put more effort on maintaining wellbeing but that we need to move away from episodic treatment to focusing on the chronic care areas.</p> <p>Prioritisation Funnel and integrated family health system as key to care-managed people.</p>			

Item	Discussion	Action	Who	When
	<p><u>General comments/ discussion</u></p> <ul style="list-style-type: none"> • GM P&C noted Golden Bay as example where one system with over-all care model rather than competing elements is what we aim for. Will enable to identify the cohort of affected people as joint effort, with commitment to the 'how' of managing those patients • NBPH CEO commented that the primary secondary interface is being expanded, i.e. he had met with Dr Nick Baker and gone through local immunisation data. Noted the PHO has robust clinical governance group in place, feels they have made great progress, i.e. achieved buy-in to Cornerstone by all practices. IT has improved vastly, so they can bring about change for practices within 24 hours. Nearly got 10,000 EQ-5D questionnaires. Noted that NBPH are excited to move to new way of doing 'package' funding with one overarching contract versus twenty individual funding lines. Sees it as great opportunity to leap forward with diabetes/ chronic conditions. Ready to go now. 			
	Meeting closed 12.45			

RECOMMENDATION

THAT THE MINUTES OF THE MEETING HELD ON 22 JUNE 2010 BE ADOPTED AS A TRUE AND CORRECT RECORD OF THE MEETING

MATTERS ARISING

- Responses to public section enquiries (were provided; see correspondence)
- CPHAC's Feedback on Terms of Reference to be communicated to Te Roopu Tupu Tahī
- Legislative change re: tar and nicotine content in tobacco
- Health Promotion Plan (see presentations)

4 CORRESPONDENCE

Outgoing

Date	Recipient	Organisation	Regarding
05/07/10	Cynthia McConville	N/A	Acknowledgment of enquiry made at CPHAC meeting on 22/06/10 regarding mental fitness
08/07/10	Cynthia McConville	N/A	Response provided to mental fitness enquiry (see appendix 1)
05/07/10	Dan McGuire	N/A	Acknowledgment of enquiry made to CPHAC on 22/06/10 re: Council resource consent for noise levels at outdoor events

Incoming

Date	Sender	Organisation	Regarding
26/5/10	Bronwyn White	Settling In – Health Sector Group	Health Sector Group and refugee mental health needs (see appendix 1)

5 MONITORING REPORTS

5.1 CHAIR'S REPORT

As we are all aware, there is a great deal of change in our health services and the way they are being mandated at a national level in particular. Much of this has to do with service integration and rationalisation. CPHAC and NMDHB have been already working in this direction for some years so we can hope the changes will advance progress, especially for the Long Term Conditions Strategy. If we can stay ahead of the game we should be able to ensure that the national process retains a flavour that reflects our local needs.

At this meeting we look forward to hearing about integrated health promotion planning and can make recommendations and comment on this.

Late additions to the agenda include the Nelson urban After Hours service provision proposal for recommendation to the Board and an update on the provision of services in Murchison.

As chair of CPHAC, I have participated in a survey by the Auckland School of Population Health on aspects of our NPA project. I have attended meetings with our committee managers, Nelson Bays Primary Health, Sustainability Forum meetings and some meetings with Nelson City Council governance.

Finally, you will recollect that the Board, at the request of CPHAC, hosted a joint DHB and Local Authority governance meeting after the last local elections. It was an excellent catalyst for establishing relationships and joint planning initiatives. It may be a good time to recommend a repeat of this exercise early next year.

John Moore.

RECOMMENDATION

THAT THE CHAIR'S REPORT BE RECEIVED.

5.2 REPORT FROM TE ROOPU TUPU TAHI

Te Roopu Tupu Tahī met in Nelson on 20th July with 18 members in attendance. The agenda included:

Presentation by John Peters: John had been invited to give a presentation to TRTT on the proposed Management Structure for the DHB. He gave a very informative talk, with explanation on the reasons for the restructure, detail on the principles embodied in the new Executive Leadership Team, and information on the proposed reporting relationships, partnership agreements and service delivery configuration.

NGO Activities: Some recent activities and issues for NGOs have included: **SF Nelson** held a successful mid-winter “Christmas” dinner for about 40 people – service users and family members. **Health Action Trust** conducted a four-day advocacy training course for support workers and volunteers. First Aid training for Mental Health workers is also being made available through **MH101** in both Nelson and Marlborough, funded by MoH. Information on a Literacy and Numeracy Support programme for mental health service users run by **Wellcare Education** was provided. This free programme is offered via the DHB’s Learning and Development Unit. **Motueka Mental Health Network** met at the end of June and worked on rewriting the terms of reference for the group and discussed using information from the Nelson Bays PHO Health Directory specific to Motueka and Mental Health to produce a brochure for Motueka residents and visitors. The group is also intending to co-ordinate some activities for Mental Health Awareness Week in October. **Te Whare Mahana** has lost employment support worker funding (0.5FTE) for its Helping Hands community employment service as a result of the Rutherford deliberations, and they are now looking at ways of turning the service into a self-sustaining community enterprise to enable it to continue its good work. A similar downsizing has taken place at **Te Ara Mahi** (supported employment service) which has closed their offices in Motueka and Richmond. Merrill Brunt, the Consumer Advisor for the DHB’s Mental Health Service, retired at the end of June and we wish her well for her future.

Mental Health Planning and Funding: The TRTT **Annual Work Plan** for the forthcoming financial year was discussed. This will be finalised at the next meeting.

The Mental Health Commission is developing a set of **systemic recovery indicators** that can be used by DHBs and DHB funded mental health and addiction services to monitor recovery practice within their organisations. Systemic indicators measure high level statistics, trends, strategies and policies rather than day-to-day procedures, behaviour, attitudes or

experiences. The Commission will ask to see the results of the self-monitoring as part of its monitoring of DHBs. The systemic recovery indicators need to:

- Be brief and easy for DHBs to administer
- Assess DHB planning and funding as well as DHB funded mental health and addictions services
- Focus on the system at a high level
- Allow for comparisons between DHBs
- Be inclusive of families/whanau.
-

The MHC discussion paper and survey questionnaire was tabled with the suggestion that a TRTT response be submitted, but it was decided that it would be better for individuals and NGOs to complete it separately. There was a lively discussion on the term “recovery” and its interpretation.

It had been intended also to look at **websites relevant to mental health** at this meeting but we ran out of time, so this item has been deferred to the next meeting, which will held at the end of August in Blenheim.

Carol Gowan
Facilitator, Te Roopu Tupu Tahī

RECOMMENDATION

THAT THE REPORT FROM TE ROOPU TUPU TAHI BE RECEIVED.

5.3 REPORT FROM GM PLANNING AND FUNDING

5.3.1 Alliance Developments

- 28/07/10: Members of the Alliance Stewardship Group as well as Board members from NMDHB and local PHOs attended a videoconference with John Macaskill-Smith. The Director of Turanganui, Pinnacle Taranaki and Lake Taupo PHOs answered questions from NM and provided informal lessons learned information regarding alliance processes in the mid central region.
- 10/08/10: Canterbury DHB put on a workshop to inform interested parties about their Canterbury Initiative, Health Pathways and Alliance Contracting. This workshop was attended by a delegation from NMDHB, Nelson Bays Primary Health and Kimi Hauora Wairau.
- 23/08/10: GM Planning and Funding met with PHO CEOs to progress work on the alliance charter for Nelson Marlborough.

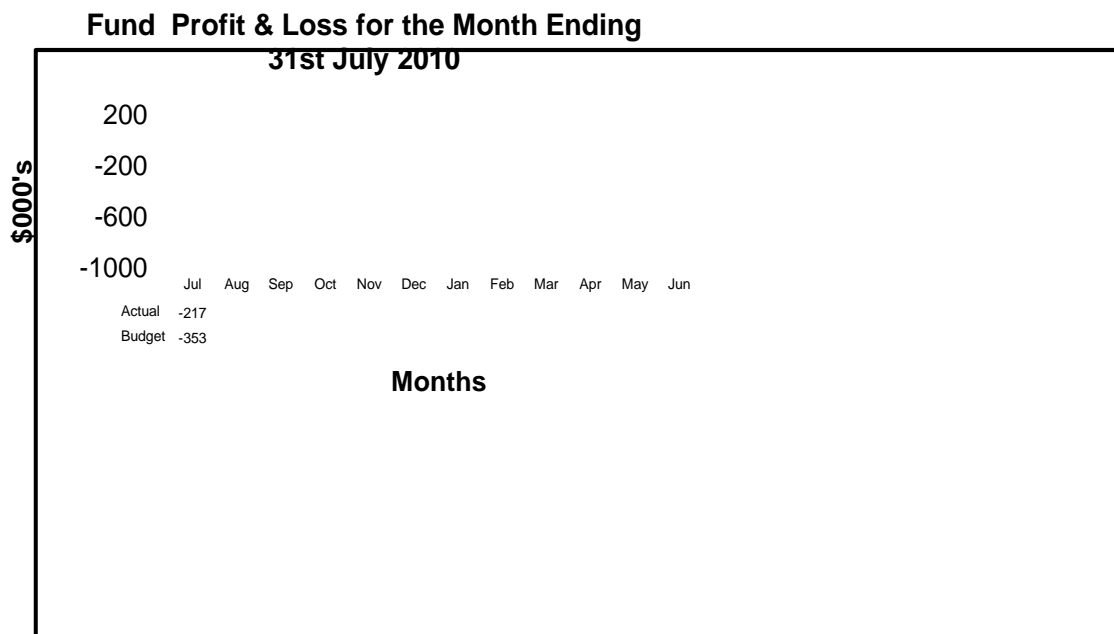
5.3.2 Financial Report

Operating Result NMDHB Fund Division

Statement of Financial Performance for the Month 31st July 2010

\$000's	Jul-10				Year to date			Annual	Annual	Forecast
	Budget	Actual	Variance		Budget	Actual	Variance	Budget	Forecast	Variance
REVENUE										
PBF Vote Health - Mental Health Ringfence	2,978	2,988	10	1	2,978	2,988	10	35,733	35,851	118
PBF Vote Health - Other	24,704	24,704	(0)		24,704	24,704	(0)	296,447	296,447	(0)
PBF Adjustments	-	66	66	1	-	66	66	-	792	792
MOH - Funding Subcontracts	1,105	1,125	20		1,105	1,125	20	15,112	15,809	697
IDFs - Mental Health Services	65	56	(9)	2	65	56	(9)	786	668	(118)
IDFs - All Other (excluding Mental Health)	525	576	51	3	525	576	51	6,306	6,857	551
Interest	60	89	29	4	60	89	29	716	716	-
REVENUE TOTAL	29,437	29,603	166		29,437	29,603	166	355,100	357,140	2,040
EXPENSES										
Governance & Admin	459	458	1		459	458	1	5,501	5,501	-
Personal Health	21,500	21,609	(109)		21,500	21,609	(109)	258,560	260,542	(1,982)
Mental Health	3,043	3,025	18		3,043	3,025	18	36,519	36,519	(0)
Maori Health	227	228	(1)		227	228	(1)	2,732	2,732	0
Disability Support	4,561	4,500	61		4,561	4,500	61	54,566	54,592	(26)
EXPENSES TOTAL	29,790	29,820	(30)		29,790	29,820	(30)	357,878	359,886	(2,008)
Net Result Mental Health Ringfence	0	19	18		-	19	19	-	0	0
Net Result - All other services	(353)	(235)	118		(353)	(235)	118	(2,778)	(2,746)	32
Net Result - All Services	(353)	(217)	136		(353)	(217)	136	(2,778)	(2,746)	32

The Fund has a deficit of \$217K against a budget deficit of \$353K at the end of July 2010. This is an overall positive variance of \$136K.



Revenue:

The total Fund revenue (excluding interest received) is above budget by \$137K at the end of July. The main variances are:

- PBF adjustment - \$66K net funding for Herceptin costs
- MoH Subcontract revenue - \$20K favourable is offset by additional expenditure. This is made up of \$35K revenue accrued to offset expenditure on MoH funded PHO programmes plus an unfavourable variance in Interim Funding Pool revenue (related to disability support care for people who are assessed for this need under the age of 65 with long term chronic health conditions) offset by reduced expenditure in the Aged Residential Care service.
- IDF revenue (excluding Mental Health) – favourable variance of \$51K is the estimated inflow revenue relating to the PBF adjustment for Herceptin costs from 1st July. This will be offset by increased expenditure.

4 Interest Received

Favourable variance of \$29K. Total cash is close to DAP assumptions but deposits made early in the month that mature before the end of the month have generated significant interest (\$24K). These deposits are not quantified in the DAP model

Expenditure:

Overall Provider payments are \$30K over budget

Provider Payments

\$000's	Jul-10				Year to date			Annual	Annual	Forecast
	Budget	Actual	Variance		Budget	Actual	Variance	Budget	Forecast	Variance
Personal health										
Child and Youth	130	130	(0)	5	130	130	(0)	1,564	1,564	(0)
Laboratory	450	451	(1)		450	451	(1)	5,406	5,407	(1)
Maternity	869	862	7		869	862	7	10,434	10,434	-
Sexual Health	62	61	1		62	61	1	741	741	-
Dental	665	664	1		665	664	1	7,954	7,952	2
Pharmaceuticals	2,851	2,877	(26)		2,851	2,877	(26)	33,560	33,586	(26)
Pharmaceutical Cancer Treatment	153	163	(10)		153	163	(10)	1,830	2,407	(577)
PHO and GP Services	2,028	2,047	(19)		2,028	2,047	(19)	24,295	24,748	(453)
Rural Bonus	371	368	3		371	368	3	4,450	4,447	3
Immunisation	28	64	(36)		28	64	(36)	819	875	(56)
Radiology	196	197	(1)		196	197	(1)	2,352	2,353	(1)
Palliative Care	321	317	4		321	317	4	3,850	3,850	-
Other Community Based Services	630	603	27		630	603	27	7,558	7,557	1
Chronic Disease Management	99	99	0		99	99	0	1,185	1,185	0
Medical/Surgical	8,464	8,464	0		8,464	8,464	0	101,568	101,568	0
Emergency Services	686	686	0		686	686	0	8,226	8,226	0
Miscellaneous Services	142	144	(2)		142	144	(2)	1,711	1,711	-
Price Adjusters	38	42	(4)		38	42	(4)	1,258	1,258	-
Patient Travel & Accommodation	387	375	12		387	375	12	4,643	4,643	-
Pacific Peoples Health	-	-	-		-	-	-	-	-	-
Nutrition and Physical activity	153	153	0	153	153	0	1,833	1,833	0	
Tobacco Control	29	24	5	29	24	5	351	351	-	
HPV Programme	46	42	4	46	42	4	548	544	4	
Vision hearing Screening	9	9	(0)	9	9	(0)	113	113	(0)	
Inter District Flows	2,693	2,766	(73)	6	2,693	2,766	(73)	32,311	33,189	(878)
TOTAL PAYMENTS - PERSONAL HEALTH	21,500	21,609	(109)		21,500	21,609	(109)	258,560	260,542	(1,982)
Maori Health										
Whanau Ora	132	133	(1)		132	133	(1)	1,590	1,590	-
Workforce and Service development	95	95	0		95	95	0	1,142	1,142	0
Other Maori Health	-	-	-		-	-	-	-	-	-
TOTAL PAYMENTS - MAORI HEALTH	227	228	(1)		227	228	(1)	2,732	2,732	0
Mental Health										
Acute Mental Conditions	448	448	0		448	448	0	5,375	5,375	0
Sub-Acute & Long Term Mental Conditions	159	159	0		159	159	0	1,906	1,906	0
Respite	82	82	0		82	82	0	987	987	0
Alcohol & Drug	320	309	11		320	309	11	3,835	3,867	(32)
Child & Youth Mental Services	371	371	0		371	371	0	4,451	4,451	0
Forensic Services	32	33	(1)		32	33	(1)	393	394	(1)
Kaupapa Maori Services	34	35	(1)		34	35	(1)	414	414	-
Mental Health Team Services	813	819	(6)		813	819	(6)	9,756	9,762	(6)
Prison/Court Liaison	11	11	(0)		11	11	(0)	138	138	(0)
Mental Health Workforce Development	3	4	(1)		3	4	(1)	38	38	-
Day Activity & Rehab Services	102	102	0		102	102	0	1,221	1,221	0
Consumer and Carer/Family Support	48	47	1		48	47	1	569	569	0
Home Based Support	37	32	5		37	32	5	446	446	-
Community Residential Beds & Services	352	346	6		352	346	6	4,227	4,221	6
Mental Health – Other	13	12	1		13	12	1	151	150	1
Inter District Flows	218	215	3		218	215	3	2,612	2,580	32
TOTAL PAYMENTS - MENTAL HEALTH	3,043	3,025	18		3,043	3,025	18	36,519	36,519	(0)
DHB Governance & Administration	459	458	1		459	458	1	5,501	5,501	-

Provider payment variances from budget >\$30K are as follows:

Personal Health

Total payments for Personal and Public Health services are \$109K above budget.

Unfavourable

- 5 Immunisation (\$36K). This is a demand driven service. Expenditure on vaccinations has been higher than expected in June and July but related to the Ministry of Health widening access to free influenza (including H1N1) vaccinations.
- 6 Inter District Flows (\$73K) is the estimated outflow expenditure relating to the PBF adjustment for Herceptin costs from 1st July IDF (this is partially balanced by additional revenue).

Māori Health

Expenditure is tracking to budget

Mental Health

Total payments for Mental Health services are \$18K favourable to budget
This is due to minor variances across all Mental Health service lines.

Governance and Administration expenditure is tracking to budget.

Year-end Forecast

At this stage, the Fund is forecast to end the year with a small favourable variance (\$32K) to budget.

The following assumptions have been made

- Net effect of increased expenditure on Herceptin – drug cost (\$577K) and net IDF flow (\$224K) is equal to PBF share of Herceptin funding (\$801K) for 2010/11
- Community Pharmaceutical expenditure will track to budget for the remaining eleven months and overspend will remain at \$26K
- Expenditure on MoH funded PHO programmes will be \$370K higher than budget. This is offset by increased revenue.
- Growth in PHO enrolled population will be higher than budget resulting in \$83K overspend on PHO capitation expenditure by the end of the year.
- We have not as yet factored in changes to Murchison Health Services related to not as yet realised Ministry of Health revenue (Care Plus, SIA, HP, under sixes free access) and expected costs.

RECOMMENDATION

THAT THE REPORT FROM THE GENERAL MANAGER PLANNING AND FUNDING BE RECEIVED.

5.4 REPORT FROM DIRECTOR OF MĀORI HEALTH

5.4.1 Whanau Ora Expression of Interest (EOI) Update

Applications for both the first and second wave of the Whanau Ora EOI process have closed. In regards to the first wave of applications, due diligence was completed on three local Maori health providers who had joined He Oranga Pounamu, a Maori Development Organisation based in Christchurch. Nelson Marlborough is part of the Wellington Regional Leadership Group which was established to review applications. The regional boundaries are based on Te Puni Kokiri Regional Office advice.

Applications for the first round have now been completed and the Regional Leadership Groups nationally have now made recommendations to the Governance Group overseeing the Whanau Ora EOI. This group which includes Sir Mason Durie, Rob Cooper (Chair), Nancy Tuaine, Director-General of Health (Vacant), Peter Hughes (CE, Ministry of Social Development) and Leith Comer (CE, Te Puni Kokiri) will make the final recommendation to the Government.

The second wave of applications closed on 2 August 2010. The DHB has received a request to complete a due diligence on two providers who are Non-Maori. This information has been submitted to the Ministry of Health for processing. The same process as described above will be followed for regional selection.

For the first and second wave a total of 40 providers nationally may be selected. The Government is looking for providers who have the capacity and capability to deliver on the activities for Whanau Ora.

Impacts on future services

The Whanau Ora EOI process concerns new money that was approved by the Government in the May 2010 Budget. However, the DHB is still awaiting advice on what the impacts might be on local services the DHB currently contracts for. Te Puni Kokiri advises that through Whanau Ora the

Government wants to free up health and social service providers from the dozens of separate contracts for services that currently tie them up. Whanau Ora providers will have streamlined contracts that will be focused on results. They will be funded to work with whanau rather than just individuals.

A key Government shift will be towards integrated contracts. However, for the three Maori health providers who have joined He Oranga Pounamu, we need to wait and see what the outcome will be for this application and what impacts it will have on current services and its funding in Te Tau Ihu.

5.4.2 DHB Whanau Ora Programme

For the past three years, the DHB has been developing its Whanau Ora implementation programme. The key focus of this activity has been towards four core projects, which are Whanau Ora modelling; Whanau Ora services development; Maori health provider coalition; and measurement/ performance review.

Whanau Ora Modelling

A review of the current service model is now underway at NMDHB. This follows the Government's announcement on Whanau Ora and what they are envisaging in terms of future service development. The DHB, working with the principles set in the National Taskforce Report and more recently the Whanau Ora EOI document, is drafting a discussion paper that can support this approach going forward.

The proposed approach for the DHB is to work with the sector to develop a Whanau Ora model that can be implemented across a number of different settings (GP, Maori health provider, mental health) within the health sector and wider social service setting.

Whanau Ora Service Development

The DHB has in place four relatively new services which have been established for a period of 16 months. They include Tane Ora, Kaumatua Ora, Palliative Care and Pathfinder (Cancer). The services emerged out of a desire by Maori health providers to develop models and processes that work to the best advantage of whanau. The services have now been reviewed and a number of issues have come forward. These are challenges in providing a district-wide service; availability of limited funds; coordination and the need to improve this with partner providers. Once the reports are finalised, changes will be made to improve service delivery and outcomes.

Measurement and Performance Review

A key component to the implementation of the four new services was the need to improve the measurement and monitoring of these services. The contracts now include an electronic reporting template for providers to complete. There has been training with Maori health providers on the need to collect accurate and good data.

Reports are now being generated where providers are measured on performance by quarters. Trends are provided if there is sufficient data available for this to happen. Over time, the DHB hopes to be able to measure performance over a number of different financial years.

5.4.3 Maori Health Provider Coalition Update

Work continues to be made towards the Maori health provider coalition ('Coalition'). There have been two important meetings of the Maori health provider managers to progress this activity. On 12 July 2010, a small group of five providers were present. This group agreed to a set of values, principles and a proposed structure that will see the group transition into the 'Coalition.' The transition group will be made up of the Maori health provider managers. In time, this group will be changed and a new governance will emerge which will have representation from each of the Maori health provider boards.

The second important meeting was held on 12 August 2010 where all eight providers were in attendance. A review on past decisions (12 July) was completed and a session on truth and honesty took place. Since the release of the Whanau Ora EOI process, behaviours have emerged that have been inconsistent with the principles and values that underpin the 'Coalition.' The session ensured that each provider had their say and that there was challenge and counter-challenge. What emerged was a better understanding and unity for the 'Coalition' to proceed forward. The group also started the discussion on the development of a Memorandum of Agreement.

A further session is planned for October 2010. At this session, Maori health provider managers will workshop the contents to the MOU or MOA. On 30 October 2010, NMDHB will also hold a one-day seminar hosted jointly by IHB. All Maori health provider boards will be asked to attend. The day will include presentations from the Board Chair, NMDHB CE, Hayden Wano (or his representative) on Tui Ora Ltd and Pinnacle Health Collaboration and a summary on the Maori health provider managers progress/ decision points.

RECOMMENDATION

THAT THE REPORT FROM THE DIRECTOR OF MĀORI HEALTH BE RECEIVED.

5.5 REPORT FROM GM PRIMARY AND COMMUNITY

August 2010

5.5.1 Health Protection and Health Promotion

(H1N1) Outbreak Seddon School An outbreak of illness at Seddon School was shown to be swine flu (Influenza AH1N1) - the predominant flu strain this year and the first cases in Nelson Marlborough this winter.

Health Impact Assessment (HIA) Arterial Flow study – this Nelson City Council project has begun. It will be conducted in two stages: an abbreviated HIA assessing the four short-listed options and a more comprehensive HIA on the preferred option that the decision-making team will select in September.

Smoking Cessation – ABC system

The ABC system in hospitals is now into its third month. New monthly auditing systems have been introduced to help provide us with a picture of activity and to help identify lapses in the system. It is hoped each month we will see a steady progression towards the 80% target. Work is under way to set up the ABC system with non-government organisations. This includes facilitation of quit coach and cessation support training.

Ask every patient about his or her smoking status; give **B**rief advice to stop smoking to all smokers; provide evidence-based **C**essation support for those who wish to stop smoking

Health Promotion Planning. Attached as Appendix 2 is an update on health promotion planning in the Primary and Community Division. A presentation on this will be made at today's CPHAC meeting.

5.5.2 Nutrition and Physical Activity Programme

The Nutrition and Physical Activity Programme (NPA) has funded the delivery of the district-wide Community Nutrition Service pilot since 2007.

The delivery contracts with Nelson Bays Primary Health and Kimi Hauora Wairau Primary Health Organisation were due to expire in June 2009.

Through an internal re-prioritisation process and the supportive evidence supplied through the Auckland University evaluation of the pilot, NPA has been able to confirm with both PHOs that funding will now be available until the 30th June 2012. This will also be the conclusion of the funding for the 5-year NPA programme.

NPA are now working with the PHOs and the hospital based Dietetics Service to define the service continuum for nutrition/ dietetic support across the district and

refine the referral pathways. The outcome of these discussions will define the contract Service Specifications for the next two years' delivery.

Future funding options post NPA are still being explored.

5.5.3 Primary Health Care

Golden Bay

St John has agreed, in principle, to join the integrated project. Work will need to be undertaken to determine how their needs can best be accommodated. Work is under way to obtain the necessary resource consents for the upgrade and extension of the Community Hospital to accommodate the integrated services. Work is also continuing on gaining Ministerial approvals as substantive progress cannot be made with fundraising until such time as a registered charitable trust as a vehicle for fundraising is created which is dependent on the approval; approaching philanthropic organisations as part of a broader fundraising plan to seek funds; and, working with the Crown Health Financing Authority for loan financing.

The IMG are also in communication with Wanganui DHB on their lessons learnt as a partner in O Taihape Integrated Health Services. This service, which has significant parallels to that intended for Golden Bay, has had a \$1M loss in the last two years.

5.5.4 Financial, Primary and Community Division

By Business Line, July 2010:

Totals ,000	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Annual Forecast	Variance
Revenue						
PHS	475	480	5	5,703	5,681	(22)
NPA	153	172	19	1,833	1,912	79
Development	98	99	1	1,177	1,179	2
Total Revenue	726	751	25	8,713	8,772	59
Costs						
PHS	390	318	72	4,682	4,401	281
NPA	145	63	82	1,742	1,722	20
Development	94	82	12	1,132	1,072	60
Total costs	630	463	167	7,556	7,195	361
Surplus (Deficit)						
PHS	85	162	77	1,021	1,280	259
NPA	8	109	101	91	190	99
Development	4	17	13	45	107	62
Total Surplus	96	288	192	1,157	1,577	420

RECOMMENDATION

THAT THE REPORT FROM THE GENERAL MANAGER PRIMARY AND COMMUNITY BE RECEIVED.

5.6 MEMBERS' REPORTS

Nil received

5.7 MEMBERS' ISSUES

5.7.1 Community dieticians

Member noted disquiet about losing this service in Marlborough, and has received several concerns from both the public and providers.

Response provided as part of the report from GM Primary and Community.

5.7.2 DHB promotion of PHO involvement in Primary Care delivery in Murchison

Response from GM Primary and Community below:

18 August 2010

These notes outline the current position of the DHB in relation to health services delivery in Murchison.

Murchison Hospital and Health Centre

At a public meeting in Murchison on 16 August, NMDHB announced that the Hospital and Health Centre will remain open. At the same time residents will now have to pay for GP visits. This comes after half a century of being a 'special area' where GP visits were provided free-of-charge to residents. This designation was removed in 1993 when the Government revoked all 'special area' status. While there may still be a deficit for the facility built in 2007, the DHB will continue to support the community of Murchison through meeting the shortfall. The facility serves a dual purpose of providing continuing care beds for elderly people and being the base for first response for emergencies.

The payment for GP visits will contribute an additional \$60,000 per year and go some way towards addressing the deficit incurred. The charges have been

estimated based on the amounts being paid in other GP practices throughout the district which, depending on a patient’s age and whether they have a Community Services card, range from \$25 - \$45, with children under 6 years of age free.

The DHB recommended that a Nurse Practitioner be appointed to provide additional Primary Care cover for the community. This position will be developed to work in conjunction with GP services of the area.

Nelson Bays Primary Health has expressed an interest in the management of this facility.

6 GOVERNMENT PRIORITIES

No updates at present

7 PRESENTATIONS

Time	Topic	Presenter
1:30 – 2:00	Health Promotion Plan	GM Primary and Community, Peter Burton

See appendix 2 for more information

8 APPENDIX 1: CORRESPONDENCE

Settling In - Health Sector Group

C/- Bronwyn White
Public Health Service
P.O.Box 647
NELSON
DDI (03) 546 1265
bronwyn.white@nmdhb.govt.nz

Dr John Moore
Chair, Community & Public Health Advisory Committee (CPHAC)
Nelson Marlborough DHB

May 26th, 2010

RE: Settling In - Health Sector Group and Refugee mental health needs

Dear Dr Moore,

I am currently convening the Settling In – Health Sector Group and ask that you please accept this letter as chair of CPHAC from me on behalf of the Settling In – Health Sector Group. The purpose of this letter is two fold. First, is to inform CPHAC about Settling In – Health Sector Group. The second is to highlight to CPHAC an area of concern that this group has identified.

Settling In - Health Sector Group

This group meets approximately six weekly and currently comprising representatives from Nelson Multicultural Council, Ministry of Social Development, Refugee Services, NMDHB (Public Health/Planning & Funding), Nelson City Council, Victory Community Health, Nelson Bays PHO, and NZ Police. The purpose is to share and identify issues which relate to the health needs of the Nelson Tasman migrant and refugee population and undertake projects to address priority needs.

This group was first established in 2005 as a result of a needs assessment with migrant and refugee communities. The membership of the group changes depending on the priorities that are identified and the projects that are current. Some examples of projects this group has completed are a handbook “*Useful*

Tips for Migrants” and a more recent project was *“Healthy Living in NZ – Nutrition and Oral Health” DVD*, developed for Chin refugee.

Current priority need: Refugee mental health

Late last year Refugee Services and NZ Police presented their increasing concerns regarding new and long term refugee community members with severe alcohol intake to the Settling In – Health Sector Group. Particularly noted was alcohol related incidents attended by police. Refugee Services and NZ Police have worked closely and collaboratively with the refugee community to put in place interventions to minimise harm in the most extreme cases with some success; however there remains major gaps in the interventions to address underlying mental health issues.

To this end, Settling In - Health Sector group decided to hold a wider interagency/inter sector session led by Refugee services, with the purpose of defining the mental health needs of our refugee community. Please refer to the summary notes of this session which is attached to this letter.

Outcomes

Mental Health and Alcohol issues delay the development of English language skills leading to isolation, lack of integration, and are a barrier to gaining employment. Long-term refugees with mental health and alcohol issues are increasingly appearing in the Nelson justice system.

To summarise, the defined needs identified on the day were:

- Increased Support for Interpreters
- Training and cultural knowledge for service providers working with refugees
- A holistic approach inclusive of all ages.

As a result a working group was formed to progress this further and are currently engaged in preparing a combined agency business case. We are all committed to looking where we can combine our existing resources to meet the needs of our refugee community to ensure successful resettlement. The working group to date is made of up representatives from Refugee Services, Ministry of Social Development, Nelson Marlborough DHB, Nelson Bays PHO, Ministry of Education, and Nelson City Council.

To conclude, it is becoming clear that while pre migration trauma and torture experiences do present a barrier to successful resettlement for some people, it is what is experienced post migration, which can determine whether a person successfully resettles or not. We require a holistic multiple agency response to address the immediate needs of our refugee community, as well making sure we have the right systems and services connectivity in place. We would welcome support from CPHAC to progress this.

Please let me know if you require further information on refugee and migrant communities in Nelson and Tasman regions, or if you would like us to present at a future CPHAC meeting on issues facing our refugee community.

Yours Sincerely,

Bronwyn White
On behalf of Settling In –Health Sector group

REFUGEE MENTAL HEALTH: DEFINING THE NEED – MEETING NOTES*

March 12, 2010 at the Meeting Room, Victory Community Centre

Facilitator: Claire Nichols

Present:

Gabrielle Humphreys (Refugee Services-
Nelson Co-ordinator)

Claire Nichols (Newcomers Network)

Jeff Thomas (Refugees as Survivors)

Di Russell (Social Worker- Victory and
Nelson Intermediate Schools)

Rita Van Iddekinge (NMDHB-Unit
Manager Mental Health)

Martin Kane (NBPHO- Mental Health Co-
ordinator)

Hilary Genet (NMDHB- Public Health)

Barb Whitaker (Refugee Services- Social
Worker)

Jackie Moulton (NBPHO- Brief
Intervention Co-ordinator)

Claire Mckenzie (NMDHB- Planning &
Funding)

Les Milligan (NMDHB- Public Health)

Bronwyn White (NMDHB- Public Health)

Malcolm Drummond (NZ Police)

Sonny Alesena (NCC-Settlement Support)

A visitor to the Victory Primary school from
Porirua

Mark Brown (Victory School- Principal)

Penny Molnar (Victory Community Health)

Anne-Marie Reynolds (Refugee Services-
Regional Manager)

Brigid Ryan (Ministry of Social
Development- Family & Community
Services)

Evey McAuliffe (MultiCultural Council Co-
ordinator)

Dr Terry Gavin (General Practitioner)

Alison Lewin (Health Action Trust-
Manger)

Dr Joseph Hassan (General Practitioner)

David Hough (NMDHB- Planning &
Funding)

Paul Baird (Health Action Trust-Compass
co-ordinator)

Apologies

Martha Rice (NMDHB- Public Health), Lorraine Eade (NMDHB- Planning & Funding)

*Discussion from the meeting has been recorded under topic headings

New Zealand Quota- refugee program

The New Zealand policy on refugee intake is to take in those with high and complex needs. The quota programme, led by the Department of Immigration, requires cross sector cooperation to meet the needs of this group. At a national level this includes, Education, NZ Police, MSD, Health and Housing. The government has an obligation to meet the needs of the refugees that their representatives select to come for a better life.

Refugees as Survivors Trust

Jeff Thomas - described Refugees as Survivors (RAS) service.

RAS is a mental health service for those refugees specifically on the quota. A multi disciplinary service is provided comprising psychiatrist, psychologists, psychotherapists, counsellors and social workers who see adults, children/families. RAS is part of a network of related services. Most referrals come from GPs, sometimes directly from Mangare and some from the Refugee Services.

The RAS service provided in Wellington is funded by the DHBs for the following:

- Provide a one on one service to individuals
- Build capacity of other professionals across the sector to meet the needs of refugees. This includes secondary services, interpretation services. RAS can provide a three day training to develop cultural competency
- Train own staff.
- Advocacy
- Community development - Jeff gave some examples of providing opportunities for and developing community connectedness and identity such as Ethiopian youth being provided with the skills to write stories about their life and have produced a quality publication.

Local Perspectives**Refugee services**

Barbara Whitaker - Described her three roles as social worker with Refugee Services.

1. She meets with Nelson based clients from Mangare and works intensively with them in Nelson for the next six months.
2. Client advocacy
3. Community Development

Issues she has identified are:

- Poor mental health with alcohol and drug use/abuse. Services dealing with these issues are siloed. The Burmese refugees demonstrate high levels of alcohol abuse leading to involvement with police.
- Family violence and family re unification issues were described.
- Lack of parenting skills
- Previous intake of 'boy' soldiers who didn't settle and displayed high levels of poor mental health
- Language barriers which require interpreters
- Health care workers require professional development specific to the needs of refugees and the appropriate use of interpreters
- Can take up to three years for mental health issues to emerge.

Barbara thanked the Primary Health Organisation (PHO) for funding a cross cultural worker 10 hours a week to provide limited interpreting for clients. It has made a positive difference to her clients and her workload.

General Practitioner

Dr Gavin

- The mental health services do a good job for patients at the extreme end. He has some cases waiting to be seen by the mental health services
- The Chin families have good contact with their GPs and are generally good and caring families/parents who present for reassurance as any good parent would. They often present with practical, physical problems
- The 'boy' soldiers exhibited high use of alcohol.
- Very limited translation services for the Chin community. Younger family members sometimes interpret as they have a better command of the English language. This is not always appropriate and can be a barrier to services
- Interpreting and translation is the biggest issue in general practice. Some concerns were raised relating to accurate interpretation, translation and confidentiality of cross cultural worker.
- Nelson has done well with existing resources to help the refugee community (for example, smoking cessation) and we could do better

NZ Police

Mal Drummond – on behalf of Multi Ethnic community constable David Coggar

NZ Police aim to minimize the number of incidents in which refugees come to Police attention as offenders or victims. Issues noted:

- Under reporting of crimes and victimisation in the refugee community
- Previous experience of police leaves them feeling distrustful of the police in NZ.
- Accurate translation is legally required once there is involvement with justice. i.e translation of victim/offender statements
- There is alcohol and drug abuse/use associated with poor mental health.
- Drink driving is a problem
- Many refugees present with mental health issues while in custody

Refugee Mental health

One third of the Wellington refugee quota experience poor mental health resulting from trauma and torture which requires intervention by RAS. Not much psychosis mainly Drug and Alcohol, Post traumatic Stress disorder, depression. All are traumatised.

Point of difference

- New Zealand has plenty of training around trauma but not around torture.
- All work is undertaken with trained interpreters

Interpreters require special training and support therefore are hard to come by. In Australia where 13,000 refugees arrive every year, telephone translation is used effectively.

Nelson Perspective

Nelson receives 60 refugees with each quota (annually). About 10/60 have immediate mental health, with another 10/60 emerging in the longer term. Involving the clients in accessing support services is sometimes difficult.

- Ministry of Health only fund the DHB services to work with the top 3% of those with poor mental health.
- PHO provides brief early intervention services with 80 options available on the list. It was strongly suggested that only professionals such as clinical/registered psychologists should work with refugees.
- A psychiatric nurse visits the police cells every morning at 8am

Outcomes

Mental Health and Alcohol issues delay the development of English language skills leading to isolation, lack of integration, and are a barrier to gaining employment. Long-term refugees with mental health and alcohol issues are increasingly appearing in the Nelson justice system.

THE NEED DEFINED

Interpreter support

Build capacity of staff that work with refugees by providing training and cultural knowledge.

Inclusive of refugees of all ages

NEXT STEPS

Establish a working group to develop a strategy.

Expressions of interest for members to this group were:

Gabrielle Humphreys

Claire McKenzie

Martin Kane

Brigid Ryan

Sonny Alesena

Bronwyn White

Bronwyn to organise a meeting date.



Nelson Marlborough District Health Board

*Planning & Funding
DHB Office*

Fax: (03) 5461747
Phone: (03) 5461587

Private Bag 18
Nelson 7042, New Zealand

8 July 2010

Cynthia McConville
95 Halifax Street East
The Wood
Nelson 7010

Dear Cynthia

Re: Mental Fitness enquiry made at CPHAC meeting on 22 June 2010

Thank you for raising a number of issues in relation to mental health and addiction services. In response to your four questions, we can advise that:

1. What percentage of the mental health budget is committed to the prevention of mental illness?

Mental Health Promotion/ Prevention service agreements are funded by the Ministry of Health, and not NMDHB, therefore it is not part of our mental health and addiction budget.

2. How is this money spent?

NMDHB is aware of several promotion/ prevention programmes funded through the Ministry and these include:

- (a) District wide Suicide Prevention Co-ordinator 1.0 FTE (Full time equivalent)*
- (b) District wide Public Health Mental Health Promoter 1.0 FTE (Full time equivalent)*
- (c) Child and Youth Alcohol and Drugs Promoter 1.0 FTE (Full time equivalent Nelson/Tasman)*
- (d) District-wide Maori Like Minds Like Mine 1.0 FTE (Full time equivalent)*

3. Is there any recognition of the worth of mindfulness based programmes within the NMDHB?

NMDHB has been supporting the sector with the implementation of Dialectical Behaviour Therapy (DBT), which combines standard cognitive-behavioural techniques for emotion regulation and reality testing with concepts of mindful awareness, distress tolerance and acceptance. Nelson Marlborough has the only DBT residential service in New Zealand, alongside DBT training of both the community and specialist mental health sectors.

4. Has NMDHB funded attendance of the "Happiness and Its Causes Conference' and do we know the outcomes for the community?

No, NMDHB has not funded staff to attend this conference.

If you have any further enquiries, please contact Lorraine Eade on Lorraine.Eade@nmdhb.govt.nz or phone Lorraine on (03) 5209860.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'SKletchko', with a large, sweeping flourish above the letters.

Dr Sharon Kletchko
GM Planning and Funding
sharon.kletchko@nmhs.govt.nz

9 APPENDIX 2: HEALTH PROMOTION PLAN UPDATE

*Primary and Community
Division*



Nelson Marlborough
District Health Board

PRIMARY AND COMMUNITY – HEALTH PROMOTION PLAN UPDATE TO CPHAC – AUGUST 2010

Rationale for new approach to health promotion planning

1. Need for an integrated plan (NMDHB DAP 10/11).
2. Prioritisation of resources required a refocusing of work.
3. Renewed focus on national health targets and local health needs.
4. Team work and collaboration needed to be supported and grown.
5. Reduction in work load (reduced FTE of health promotion staff in Public health Service [PHS] and Nutrition and Physical Activity Programme [NPA]).
6. Status of Health Promotion Development Project (HPDP) – pending its placement on hold by CEO awaiting Rutherford Initiative decisions on primary and community services and ELT restructure – needed to pursue in terms of the South Island planning process, and requirement for this element in terms of a vision for our health promotion delivery.

Key aspects

This new approach better reflects the current environment, yet enables full delivery on the current contractual requirements for the PHS and NPA programme. This development begins moving us away from a traditional broad-brush, silo-ed delivery of health promotion activity where individual staff work in specific isolated areas, towards a targeted and collaborative way of working, both internally and with the community.

1. Under this new framework all components of the PHS's *Public Health Services Service Specification* and the NPA Programme Plans will remain addressed – the key change here is in reallocation of resources to focus on areas of biggest gain and the greatest health needs.
2. We have developed 5 '**Focus Areas**' where our resources and energy will be prioritised. They are:
 - 1) Child and Youth.
 - 2) Nutrition.
 - 3) Physical Activity.
 - 4) Tobacco.
 - 5) Alcohol.These areas address: national 'Health Targets' which are a key priority for 10/11 for the Ministry; local Health Needs Assessment for the District (Twitchen, 2008); the Ministry's SOI for 2010-2013; and, the local Child and Youth Health Determinants.
3. To support these we identified 4 '**Contributing Areas**' of activity:
 - 1) Sexual Health.
 - 2) Injury Prevention.

3) Mental Health.

4) Health Promoting Schools.

Activities under these areas will be carried out under one of the *Focus Areas*, in association with staff in that *Focus Area*. That is, any current activities in these areas, that lie outside of the *Focus Areas* will cease as we need to better target our resources on the areas of greatest needs.

Exceptions will be made to activities that have been evaluated as successful in terms of contributing positive outcomes to identified health needs. This point also applies to Healthy Communities activities, which is not included in the Service Specifications as a separate area; it will be delivered under a *Themes* stream.

4. In addition, we have identified another aspect to the framework, that of supporting **'Themes'**. These serve to unite staff working on various activities to come together and develop their knowledge, skills, and work programme around unifying themes. The Themes are:

1) Public Health Leadership.

2) Public Policy.

3) Health Literacy.

4) Intersectoral action.

We felt it was essential to highlight these areas as essential for assuring that new health promotion activity was delivered in the most comprehensive and professional manner possible.

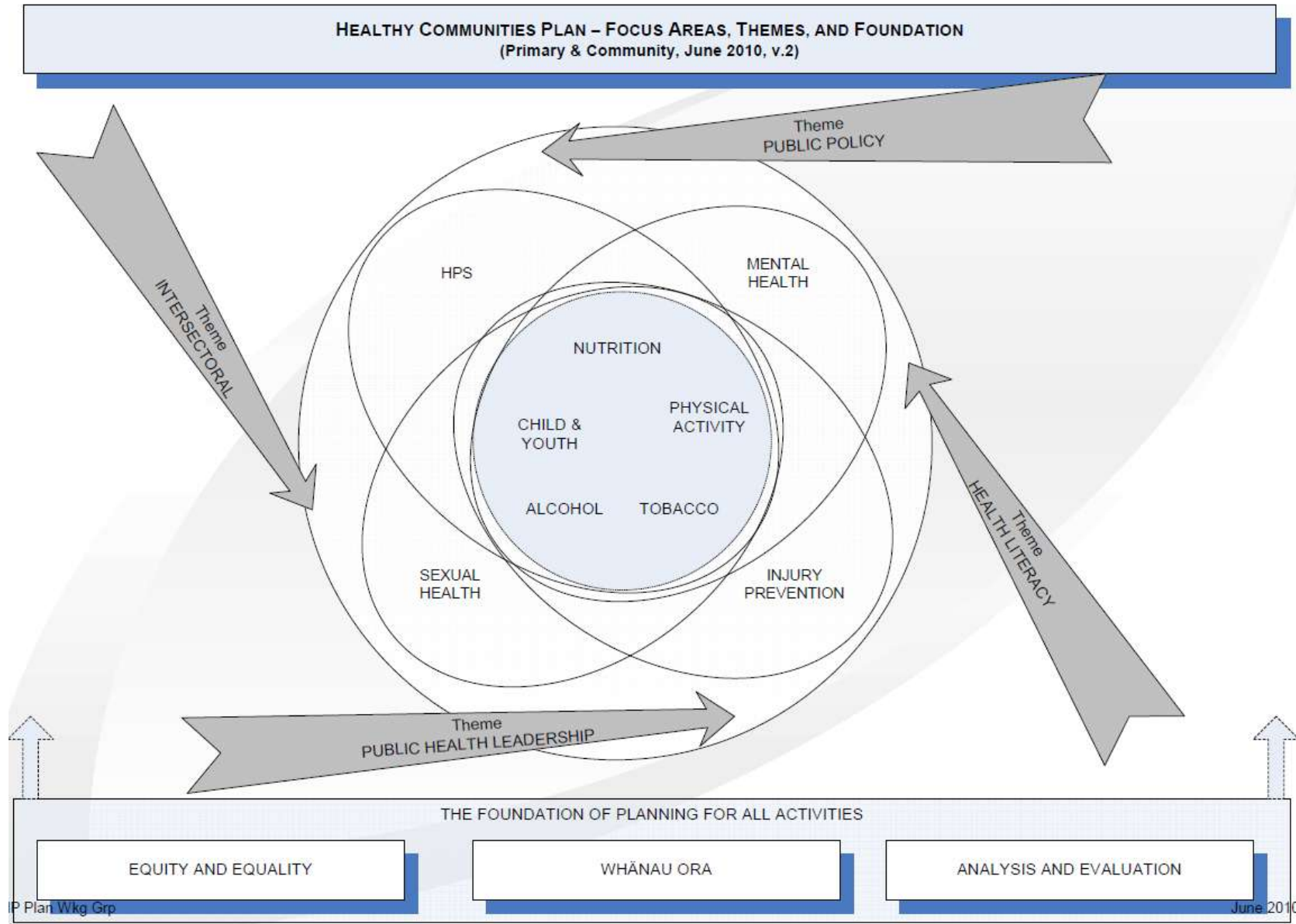
These themes will be championed and overseen by dedicated staff with specific skills in each of these areas, who will ensure that staff with activities in these are working together to develop and strengthen core skills for the unit.

5. Finally, we incorporated the three **'Foundation Areas'** of:
Whānau Ora (using the Ministry's Toolkit);
Equity and Equality;
Analysis and Evaluation.

These areas are the only non-negotiable parts of the framework that will be incorporated in all health promotion planning at every level. They form the basis of a solid foundation for all developmental work and activity execution.

To date

- The Division has worked together to create a new Framework (see accompanying diagram).
- As the first stage in implementing this approach (until HPDP Business Case is implemented) the Themes and Focus Areas have been presented to the Ministry of Health as our new way forward, and this approach has been accepted.
- The PHS Annual Plan for 2010-2011 has now been redesigned to include the Focus Areas and Themes, with staff now creating activities and implementation plans within this framework.



10 GLOSSARY OF TERMS

ABC	Ask about their smoking status; brief advice to quit; cessation
A4HC	Action for Healthy Children
A&D / AOD	Alcohol and Drug / Alcohol and Other Drugs
ACC	Accident Compensation Corporation
ACNM -	Associate Charge Nurse Manager
ACU	Ambulatory Care Unit
AE	Alternative Education
AEP	Accredited Employer Programme
AIR	Agreed Information Repository
ALOS	Average Length of Stay
AOD	Alcohol and Drug
AOHS	Adolescent Oral Health Services
ARC	Aged Residential Care
ARF	Audit Risk and Finance
ARCC	Aged Residential Care Contract
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation
BSCQ	Balanced Score Card Quadrant
BA	Business Analyst
BCTI	Buyer Created Tax Invoice
BFCI	Breast Feeding Community Initiative
BFCI	Baby Friendly Community Initiative
BS	Business Support
BSI	Blood Stream Infection
CAMHS	Child and Adolescent Mental Health Services
CBAC	Community Based Assessment Centres
CBF	Capitation Based Funding
CE (CEO)	Chief Executive (Chief Executive Officer)
CEA	Collective Employee Agreement
CDHB	Canterbury District Health Board
CCDHB	Capital & Coast District Health Board (also called C & C)
CCF	Chronic Conditions Framework
CCU	Coronary Care Unit
CDEM	Civil Defence Emergency Management
CDHB	Canterbury District Health Board
CDM	Chronic Disease Management
CEG	Coordinating Executive Group (for emergency management)
CFA	Crown Funding Agreement <u>or</u> Crown Funding Agency
CFO	Chief Financial Officer
CHFA	Crown Health Financing Agency
CHS	Community Health Services
CIMS	Coordinated Incident Management System
CIO	Chief Information Officer
CME	Continuing Medical Education
CMI	Chronic Medical Illness
CMS	Contract Management System
CNM	Charge Nurse Manager
COO	Chief Operating Officer

COPMI	Children of Parents with Mental Illness
CPHAC	Community and Public Health Advisory Committee
CPIP	Community Pharmacy Intervention Project
CPNE	Continuing Practice Nurse Education
CPU	Critical Purchase Units
CSR	Contract Status Report
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CTC	Contributions to Cost
CTANAG	Clinical Training Agency Nursing Advisory Group
CTU	Combined Trade Unions
CVD	Cardiovascular Disease
CVDRA	Cardiovascular/Diabetes Risk Assessment
CWD	Case Weighted Discharge
CYAERG	Child Youth Advisory & Expert Reference Group.
CYF	Child, Youth and Family
CYFS	Child, Youth and Family Service
DAP	District Annual Plan
DAR	Diabetes Annual Review
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
DHBRF	District Health Boards Research Fund
DiSAC	Disability Support Advisory Committee
DMH	Director of Maori Health
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSP	District Strategic Plan
DSS	Disability Support Services
DWCSP	District Wide Clinical Services Plan
EAP	Employee Assistance Programme
EBID	Earnings Before Interest & Depreciation
ECWD	Equivalent Case Weighted Discharge
ED	Emergency Department
EDA	Economic Development Agency
EFI	Energy For Industry
ELT	Executive Leadership Team
EOI	Expression of Interest
ENT	Ears, Nose and Throat
ESA	Electronic Special Authority
ESOL	English Speakers of Other Languages
ESPI	Elective Services Patient Flow Indicators
ESR	Environmental Science & Research
ESU	Enrolled Service Unit
FF&E	Furniture, Fixtures and Equipment
FFT	Future Funding Track
FMIS	Financial Management Information System
FOMHT	Friends of Motueka Hospital Trust
FOUND	Found Directory is an up-to-date listing of community groups and organisations in Nelson/Tasman
FRC	Fee Review Committee
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
FVIP	Family Violence Intervention Programme

GM	General Manager
GMS	General Medical Subsidy
GP	General Practitioner
GRx	Green Prescription
HAC	Hospital Advisory Committee
H&DC / HDC	Health and Disability Commissioner
HBI	Hospital Benchmarking Information
HBSS	Home Based Support Services
HBT	Home Based Treatment
HDSP	Health & Disability Services Plan Programme
HDU	High Dependency Unit
He Kawenata 104)	Covenant, agreement, treaty, testament (PM Ryan Maori Dictionary pg 104)
HEeADSSS	Psychosocial tool – Home, Education, eating, Activities, Drugs and Alcohol, Sexuality, Suicidality (mood), Safety
HEHA	Healthy Eating Healthy Action
HEP	Hospital Emergency Plan
HESDJ	Ministries of Health, Education, Social Development, Justice
HFA	Health Funding Authority
HHS	Hospital and Health Services
HIA	Health Impact Assessment
HM	Household Management
HMS	Health Management System
HODs	Heads of Department
HOP	Health of Older People
HPI	Health Practitioner Index
HPV	Human Papilloma Virus
HR	Human Resources
HR & OD	Human Resources and Organisational Development
IANZ	International Accreditation New Zealand
IBA	Information Builders of Australia
IDF	Inter District Flow
IDSS	Intellectual Disability Support Services
IFRS	International Financial Reporting Standards
IHB	Iwi Health Board
IM	Information Management
InterRAI	Inter Residential Assessment Instrument
IPAC	Independent Practitioner Association Council
IPC	Intensive Patient Care
IPC Units	Intensive Psychiatric Care Units
IPG	Immunisation Partnership Group
IPU	In-Patient Unit
IS	Information Systems
ISSP	Information Services Strategic Plan
IT	Information Technology
JAMHWSAP	Joint Action Maori Health & Wellness Strategic Action Plan
KIM	Knowledge and Information Management
Kotahitanga	Unity, accord, coalition, solidarity (PM Ryan Maori Dictionary pg 127)
KPI	Key Performance Indicator
KHW	Kimi Hauora Wairau (Marlborough PHO)
LA	Local Authority
LCN	Local Cancer Network
LIS	Laboratory Information Systems
LOS	Length of Stay

LSCS	Lower Segment Caesarian Section
LTC	Long Term Care
LTCCP	Long Term Council Community Plan
LTSFSG	Long Term Service Framework Steering Group
Manaakitanga	Goodwill, show respect, or kindness to ((PM Ryan Maori Dictionary pg 172)
Manawhenua	Power, prestige, authority over land (HW Williams Maori Dictionary pg 172)
Manawhenua O Te Tau Ihu O Te Waka A Maui	Referring to the eight iwi who hold tribal authority over the top of the South Island (no reference)
MHDSF	Maori Health and Disability Strategy Framework
MHFS	Maori Health Foundation Strategy
MPDS	Maori Provider Development Scheme
MA	Medical Advisor
MCT	Mobile Community Team
MDC	Marlborough District Council
MDO	Maori Development Organisation
MDS	Maori Development Service
MDT	Multi Disciplinary Team
MECA	Multi Employer Collective Agreement
MHAU	Mental Health Admission Unit
MHC	Mental Health Commissioner
MHD	Maori Health Directorate
MHINC	Mental Health Information Network Collection
MHWSF	Maori Health and Wellness Strategic Framework
MOH	Ministry of Health
MOH	Medical Officer of Health
MOA	Memorandum of Agreement
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding
MOW	Meals on Wheels
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist (or Technician)
MSD	Ministry of Social Development
NPA	Nutrition and Physical Activity
NRAHDD	Nelson Region After Hours & Duty Doctor Limited
NRT	Nicotine Replacement Therapy
MRSA	Methicillin Resistant Staphylococcus Aureus
NHBIT	National Health Board IT
NASC	Needs Assessment Service Coordination
NBPH	Nelson Bays Primary Health
NCC	National Capital Committee
NCC	Nelson City Council
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHI	National Health Index
NIR	National Immunisation Register
NMDHB	Nelson Marlborough District Health Board
NMDS	National Minimum Dataset
NMIT	Nelson Marlborough Institute of Technology
NPA	Nutrition and Physical Activity (Programme)
NPV	Net Present Value

NRAHDD	Nelson Regional After Hours and Duty Doctor Ltd
NSU	National Screening Unit
NTOS	National Terms of Settlement
NZHIS	NZ Health Information Services
NZMA	New Zealand Medical Association
NZNO	NZ Nurses Organisation
NZPH&D Act	NZ Public Health and Disability Act 2000
OIA	Official Information Act
OIS	Outreach Immunisation Services
OPD	Outpatient Department
OPF	Operational Policy Framework
OPJ	Optimising the Patient Journey
OSH	Occupational Health and Safety
OT	Occupational Therapy
PACS	Picture Archiving Computer System
P&F	Planning and Funding
PANT	Physical Activity and Nutrition Team
PBF(F)	Population Based Funding (Formula)
PC	Personal Cares
P&C	Primary & Community
PCI	Percutaneous Coronary Intervention
PCO	Primary Care Organisation
PCT	Pharmaceutical Cancer Treatments
PDR	Performance Development Review
PDRP	Professional Development and Recognition Programme
PDSA	Plan, Do, Study, Act
PFG	Performance Framework Group (formerly known as Services Framework Group)
PHS	Public Health Service
PHCS	Primary Health Care Strategy
PHI	Public Health Intelligence
PHO	Primary Health Organisation
PHOA	PHO Alliance
PHONZ	PHO New Zealand
PHS	Public Health Service
PHU	Public Health Unit
PIA	Performance Improvement Actions
PN	Practice Nurse
PPP	PHO Performance Programme
PSAAP	PHO Service Agreement Amendment Protocol
PT	Patient
PTAC	Pharmacology and Therapeutics Committee
PRIMHD	Project for the Integration of Mental Health Data
PVS	Price Volume Schedule
QA	Quality Assurance
QHNZ	Quality Health NZ
QIC	Quality Improvement Council
Rangatiratanga	Autonomy, evidence of greatness (HW Williams Maori Dictionary pg 323)
RDA	Resident Doctors Association
RDA	Riding for Disabled
RIF	Rural Innovation Fund
RFI	Request for Information
RFP	Request for Proposal
RICF	Reducing Inequalities Contingency Funding

RM	Registered Midwife
RMO	Resident Medical Officer
RN	Registered Nurse
ROI	Registration of Interest
RSE	Recognised Seasonal Employer
RSL	Research and Sabbatical Leave
SAN	Storage Area Network
SCBU	Special Care Baby Unit
SCN	Southern Cancer Network
SDB	Special Dental Benefit Services
SHSOP	Specialist Health Services for Older People
SICF	South Island Chairs Forum
SICSP	South Island Clinical Services Plan
SI HSP	South Island Health Services Plan
SIRCC	South Island Regional Capital Committee
SISSAL	South Island Shared Service Agency
SLH	SouthLink Health
SLT	Strategic Leadership Team
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SOI	Statement of Intent
SOPD	Surgical Outpatients Department
SOPH	School of Population Health
TDC	Tasman District Council
TLA	Territorial Local Authority
TOW	Treaty of Waitangi
TOR	Terms of Reference
TRTT	Te Roopu Tupu Tahī
UG	User Group
VLCA	Very Low Cost Access
VRA	Vascular Risk Assessment
WAM	Wairau Accident & Medical Trust
WAVE (Project)	Working to Add Value through E-Information
YTD	Year to Date
YTS	Youth Transition Service

August 2010