COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE

AGENDA

For the meeting of the Advisory Committee Members of Nelson Marlborough Health held on Tuesday 25 July 2017 at 11.00am

Seminar Center
Braemar Campus
Nelson Hospital

Section	Agenda Item	Time	Attached	Action
1	Welcome, Karakia, Apologies, Registration of Interests		Attached	Resolution
2	Confirmation of previous Meeting Minutes and Correspondence	**11.00am**	Attached	Resolution
2.1	Action Points		Attached	Resolution
3	GM Strategy Community & Primary Report		Attached	Resolution
3.1	Strategy Primary & Community Dashboard – A4		Attached	Note
4	**Update:** Youth Suicide		Attached	Note
	Presentation: Mental Health Directorate	**11.45am**	Verbal	
5	Glossary		Attached	Note
	Public Excluded	**12.25pm**		
	Meeting finish	**12.25pm**		

PUBLIC EXCLUDED MEETING 12.25pm
Resolution to exclude public

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

- ***Minutes of a meeting of CPHAC/DiSAC Committee Members held on 30 May 2017 (Clause 34(a) Schedule 4 of New Zealand Public Health & Disability Act 2000)***

WELCOME, KARAKIA AND APOLOGIES

Apologies

REGISTRATIONS OF INTEREST – CPHAC/DiSAC MEMBERS

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Jenny Black (Chair)	▪ Chair of South Island Alliance Board ▪ Chair of National Chairs ▪ Chair of West Coast DHB ▪ Member of West Coast Partnership Group			
Gerald Hope		▪ CE Marlborough Research Centre ▪ Director Maryport Investments Ltd ▪ CE at MRC landlord to Hill laboratory services Blenheim ▪ Councillor Marlborough District Council (Wairau Awatere Ward)	▪ Landlord to Hills Laboratory Services Blenheim	
Judy Crowe	▪ Co Convenor of Educate Don't Fluoridate	▪ Friend is owner of Electric Bike Hub NZ	Education in sound oral health and nutrition practices as an effective and risk free option for preventing dental caries ▪ Possible future purchasing ▪	▪ NMDHB has made enquiries and had demonstrations with electric bikes

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Patrick Smith	▪ Member of IHB	▪ Managing Director, Patrick Smith HR Ltd ▪ Member on Board of Nelson Tasman Chamber of Commerce	▪ Consultancy services • Contracts held	▪ Focus on primary sector and Maori Working with Maori Health Providers who hold contracts
Jenny Black (Marlborough)		▪ ACP Practitioner		
Brigid Forrest	▪ Doctor at Hospice Marlborough (employed by Salvation Army) ▪ Locum GP Marlborough (not a member of PHO) ▪ Member of SI Alliance Palliative Care Workstream ▪ Daughter's partner owns a house rented by DSS ▪ Daughter in Law employed by Nelson Bays Primary Health as a Community Dietitian	▪ Small Shareholder and director on the Board of Marlborough Vintners Hotel	▪ Functions and meetings held for NMDHB	
Dawn McConnell	▪ Te Atiawa representative and Chair of Iwi Health Board ▪ Director Te Hauora O Ngati Rarua	▪ Trustee, Waikawa Marae ▪ Regional Iwi representative, Internal Affairs	▪ MOH contract	

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Alan Hinton	▪ Nil	▪ Trustee, Richmond Rotary Charitable Trust ▪ Trustee, Natureland Wildlife Trust ▪ Trustee, Garin College Education Trust ▪ Trustee, Nelson Christian Trust ▪ Director, Solutions Plus Tasman Ltd ▪ General Manager, Azwood Ltd ▪ Secretary, McKee Charitable Trust	▪ Support of local worthy causes ▪ Education and support of endangered species ▪ Assisting students with financial assistance ▪ Local, national and international support ▪ Business consultancy ▪ Heating fuels and landscaping facilities ▪ Tertiary scholarships and general philanthropy	Supply of heating fuel to NMDHB
Allan Panting	▪ Chair Orthopaedic Prioritisation Working Group ▪ Chair General Surgery Prioritisation Working Group ▪ Chair Vascular Services Tier Two Specification Group ▪ Panel member to review Auckland DHB Orthopaedic Service	▪	▪	
Stephen Vallance	▪ Chairman, Marlborough Centre of the Cancer Society ▪ Chairman, Crossroads Trust Marlborough ▪ Chair Ophthalmology Service Improvement Advisory Group	▪	▪	

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Craig Dennis	▪ Trustee of Nelson Region Hospice Investment Trust	▪ Partner of CFO on Call ▪ Business consultancy Director of CD & Associates ▪ Business consultancy Director of Scott Syndicate Development Company Ltd ▪ Property Developer Director of 295 Trafalgar Street Ltd ▪ Director of KHC Dennis Enterprises Ltd ▪ Chair of Progress Nelson Tasman	▪ Property investor ▪ Property investor ▪ Unincorporated society	

As at 30 May 2017

MINUTES OF A PUBLIC MEETING OF CPHAC/DISAC COMMITTEES OF NELSON MARLBOROUGH HEALTH HELD IN SEMINAR ROOM 1, BRAEMAR CAMPUS, NELSON HOSPITAL ON TUESDAY 30 MAY 2017 AT 11.00AM

Present:
Patrick Smith (Chair), Judy Crowe, Jenny Black (Marlb), Brigid Forrest, Alan Hinton, Craig Dennis, Allan Panting, Stephen Vallance, Gerald Hope, Jenny Black (ex officio)

Apologies:
Dawn McConnell

In Attendance:
Peter Bramley (Chief Executive), Cathy O'Malley (GM Strategy Primary & Community), Nick Baker (Chief Medical Officer), Eric Sinclair (GM Finance & Performance), Pam Kiesanowski (DoNM & Acting GM Clinical Services), Hilary Exton (DAH), Jane Kinsey (GM Mental Health Addictions & DSS), Ditre Tamatea (GM Maori Health & Vulnerable Populations), Gaylene Corlett (Minute Secretary)

Karakia:
Patrick Smith

SECTION 1: APOLOGIES AND REGISTRATIONS OF INTEREST

Moved: Judy Crowe
Seconded: Craig Dennis

RECOMMENDATION:

THAT THE APOLOGIES AND REGISTRATIONS OF INTEREST BE ACCEPTED.

AGREED

SECTION 2: MINUTES OF PREVIOUS MEETING

2.1 Minutes of the CPHAC/DISAC Committee Meeting held on 28 March 2017
Check the statement on page 2, item 6, stating the ACP from Northland is used by NMH.

Moved: Alan Hinton
Seconded: Jenny Black (Marlb)

RECOMMENDATION:

THAT THE CPHAC/DISAC MINUTES OF THE MEETING 28 MARCH 2017 BE ADOPTED AS A TRUE AND CORRECT RECORD ONCE AMENDMENT MADE.

AGREED

2.2 Action Points

Item 1 – completed
Item 2 – this request has been passed to the developers to complete. Item closed
Item 3 – noted that this is due to service changes in the day hospital due to recruitment issues. The day hospital had to close for a while which increased admissions. The day hospital will reopen again next week. Readmissions over the period are being looked at to gain a better understanding as the majority are for clients who, as part of their care plan, are encouraged to be readmitted if they have an escalation so they can stay safe. The other group of patients are those who are clinically resistant to treatment and relapse despite the treatment. Consideration is being given to the readmission data on how to best present it to the Board to ensure there is meaning/understanding.
Item 4 – completed. Noted Seclusion had been removed from the dashboard, however the Board need to be alerted if the numbers change dramatically. It was noted that during the month of April the number of seclusion hours increased significantly, which involved two clients. The increase in hours was required for safety for staff and other patients. **It was agreed** that Seclusion be added back into the dashboard.

SECTION 3 GENERAL MANAGER'S REPORT

3.1 Performance Dashboard

Dashboard noted. **It was requested** that having best practice/benchmarking would be of value so we know what the numbers in the dashboard mean and what we are aiming for.

<u>Disability Support Services</u>
Discussion was held on DSS occupancy noting the average cost nationally for community & residential (DSS) is $25k and we pay $28k. **It was requested** that the GM Strategy Primary & Community look into the variance in the occupancy costs for DSS.

<u>Community Pharmaceuticals</u>
Noted nationally, pharmaceutical use is decreasing, except for NMDHB and Canterbury.

<u>PHO Enrolment</u>
Discussion held on the large disparity of Maori and Pacific enrolments into GP practices noting work is needed to get them enrolled which will ensure they pay lower GP fees, have access to cervical screening, and other health benefits. The barriers stopping people from enrolling need to be recognised, and ways to remove the barriers found.

Stop Smoking Service
The Pepi First quit smoking incentive programme for pregnant Maori mothers is now underway with encouraging results so far.

Sexual Health
Noted new money for sexual health including long term contraception has been allocated in the Budget. More detail will come to the next meeting.

Utilisation by Ethnicity
Noted this will be reported on each dashboard.

Moved: Brigid Forrest
Seconded: Jenny Black (Marlb)

RECOMMENDATION:

THAT THE GENERAL MANAGER'S REPORT BE RECEIVED.

AGREED

SECTION 4: PRESENTATION

Ditre Tamatea, GM Maori Health & Vulnerable Populations presented on Reducing Ambulatory Sensitive Hospitalisations (ASH) for Maori and vulnerable populations 0-4 year olds.

ASH are hospitalisations that could have been avoided. ASH is preventable through earlier treatment in primary care, supported by access to adequate resources and a healthy environment. So poverty, health literacy, healthy homes, welfare and education have a major impact on ASH rates.

Key areas of ASH for Tamariki 0-4 years:
- smoking (especially in pregnancy)
- respiratory conditions
- asthma
- gastro
- oral health for our children.

Reduce ASH smoking:
- Pepi First Quit Smoking Incentivisation – discussion held on sustainability of this project noting the pilot is for a two year period, and then it will be reviewed. Noted NMDHB is extending the incentivisation pilot to 12 weeks post natal.
- Pregnancy and parenting Hapu Wananga
- Safe Sleep
- Miraka Direct.

Harti Hauora
This project targets children in multiple child health priority areas and in multiple settings. Discussion held on oral heath noting this is an opportunity to get children enrolled in oral health services and engaged in oral health care. Multiple issues need to be addressed to increase the number of Maori children being enrolled.

Discussion was held on the possibility of having an incentive where the parent/caregiver was offered one free dental session when they bring in a child for oral heath care. It was noted the oral health hubs are only deigned/equipped for child oral health services not adults. Noted we have a large number of adults presenting at ED for urgent dental care who cannot afford to visit a dentist.

Hauora Direct
All age ranges (children, youth, adults, Kaumatua) with multiple health priority areas, across multiple settings. ALL top five ASH issues are addressed (smoking, gastro, respiratory, asthma, oral health).

Whare Ora
Creating safe, healthy, warm homes for Nelson Marlborough families. Discussion was held on the Whare-Ora stakeholders noting discussions are yet to he held with Marlborough District Council.

Whare ora is about addressing the symptoms of poverty and ASH. It is an upstream investment in keeping people well.

Discussion:
Discussion held on the ban on woodburners noting there are other alternatives like gas and pellet fires. Noted the heating devices for Whare ora are panel heaters.

Noted to make a difference in our community, oral health needs to get an extra 1,000 Maori children enrolled and using the service. For respiratory admissions there are 70 cases per annum (Maori children), and for Asthma there are 80 cases per annum (Maori children).

Discussion was held on support for young mothers around breastfeeding noting that whilst the lactation nurses do a good job, young mothers need someone they can relate to, who has breastfed and can answer their queries, provide encouragement and give advice (like a grandmother figure).

SECTION 5: GENERAL BUSINESS

Nil

MOVE INTO PUBLIC EXCLUDED

Moved: **Brigid Forrest**
Seconded: **Allan Panting**

RECOMMENDATION

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

- ***Minutes of a meeting of CPHAC/DiSAC Committee held on 28 March 2-17 Clause 34(a) Schedule 4 of New Zealand Public Health & Disability Act 2000)***
- ***Presentations – To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***

AGREED

Meeting closed at 12.20pm

ACTION POINTS – NMDHB – CPHAC / DiSAC Open Meeting Held on 30 May 2017						
Action Item #	**Action Discussed**	**Action Requested**	**Person Responsible**	**Meeting Raised In**	**Due Date**	**Status**
1	Action Items	It was agreed that Seclusion be added back into the dashboard	Cathy O'Malley	30 May 2017	25 July 2017	Completed
2	GM's Report	Look into the variance in the occupancy costs for DSS compared to the national average	Cathy O'Malley	30 May 2017	25 July 2017	Verbal

MEMO

Status
This report contains:
☐ **For decision**
✓ **Update**
✓ **Regular report**
☐ **For information**

To:	CPHAC/DISAC Members
From:	Cathy O'Malley, GM Strategy, Primary & Community
Date:	19 July 2017
Subject:	**General Manager's Report**

The dashboard for CPHAC/DiSAC is attached as item 3.1 showing performance for Mental Health, Disability Support Services, Pharmaceuticals, Community and Health of Older People.

A presentation will also be given at the meeting on Mental Health services.

Cathy O'Malley
General Manager Strategy, Primary & Community

RECOMMENDATION:

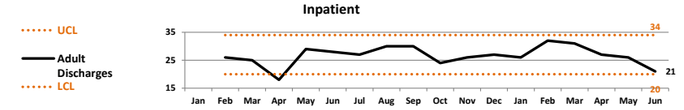
THAT THE GM STRATEGY PRIMARY & COMMUNITY REPORT IS RECEIVED.

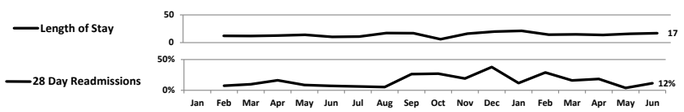
Community - Public Health - Disability Support Performance Bi-Monthly

June 2017

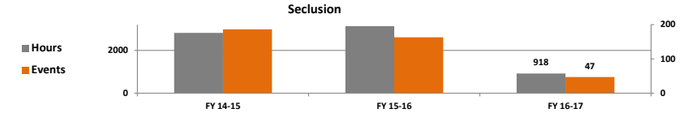
Mental Health

Inpatient

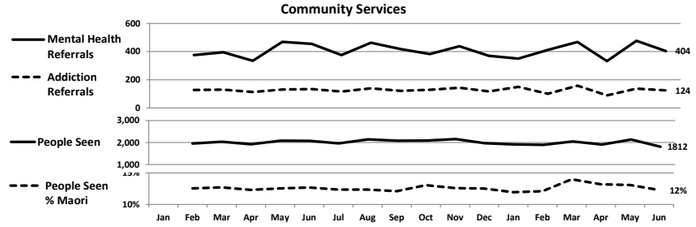




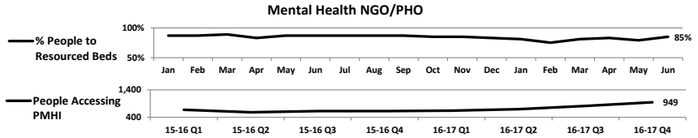
Seclusion



Community Services



Mental Health NGO/PHO



Disability Support Services

Occupancy

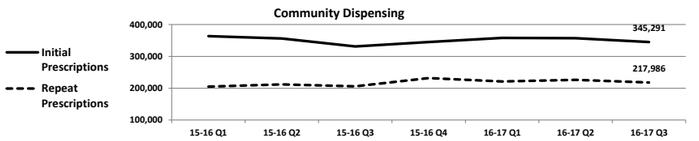
Avg Cost NMH Comm & Res Pkg	$28,594
Avg Cost National Comm & Res Pkg	$26,147

People With Current Lifestyle Plan

Supported by DHB DSS	215
In Residential Services	373
Supported in District	1338

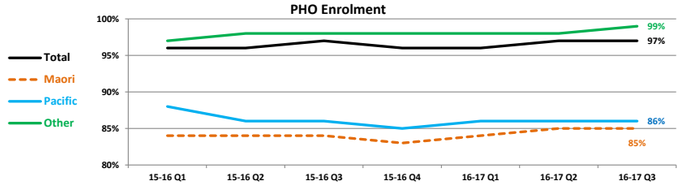
Pharmaceuticals

Community Dispensing

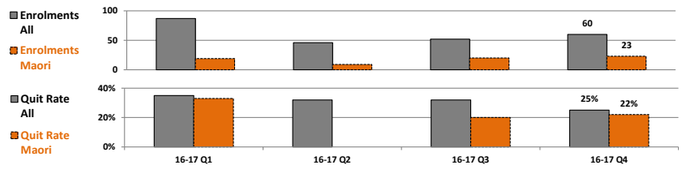


Community

PHO Enrolment

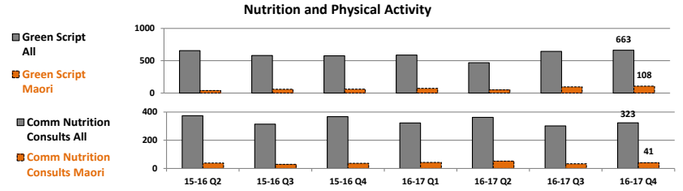


New Stop Smoking Service

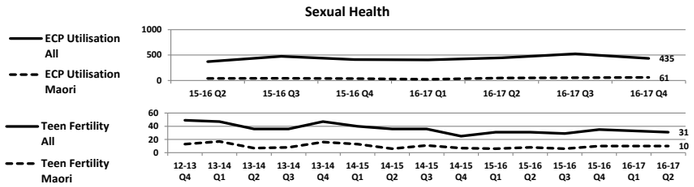


Quit Rate Pregnancy 60%

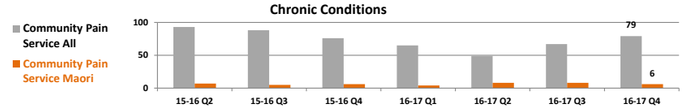
Nutrition and Physical Activity



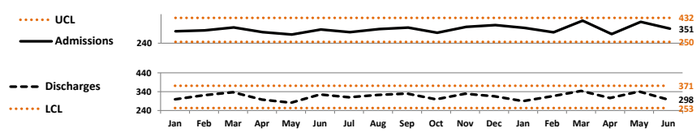
Sexual Health



Chronic Conditions

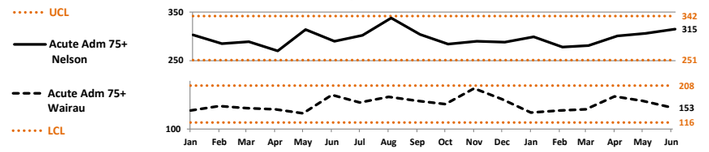


District Nursing

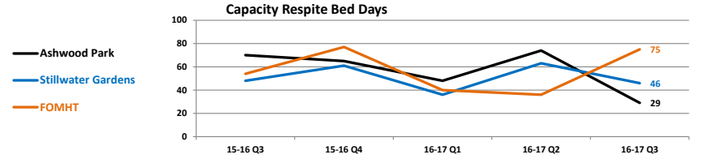


Health of Older People

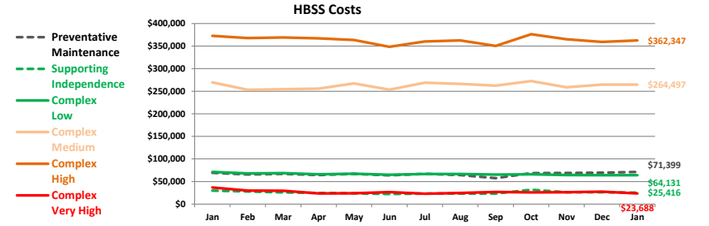
Acute Inpatients



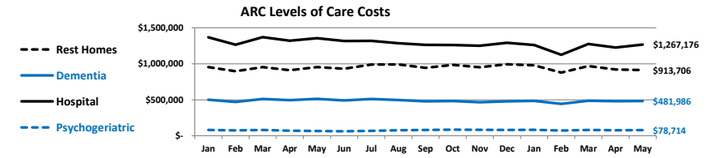
Capacity Respite Bed Days



HBSS Costs



ARC Levels of Care Costs



Bed Day Expenditure Per Capita Past 12 Months

Nelson Marlborough	$1,083
South Island	$1,427

Bed Day Volume Per Capita Past 12 Months

Nelson Marlborough	11.5
South Island	14.6

Utilisation by Ethnicity

Maori in HBSS	3%
Maori in ARC	1%
All Ethnicities in HBSS	8%
All Ethnicities in ARC	4%

Community - Public Health - Disability Support Performance Bi-Monthly Reporting Definitions

Mental Health

Monthly total of all adult discharges from Mental Health inpatient facilities

Monthly total of all youth discharges from Mental Health inpatient facilities

Monthly adult length of stay for Mental Health acute discharges

Monthly percentage of patients readmitted to any hospital department within 28 days of a prior discharge

Monthly total of new referrals to Community Mental Health teams where the patient was seen, or is planned to be seen.

Monthly total of new referrals to Community Addictions teams where the patient was seen, or is planned to be seen.

Monthly total of all people where one or more contacts/appointments occurred during the month

Monthly percentage of total people with one or more contacts/appointments during the month, Maori ethnicity

Year to date total count of seclusion events occurring at Wahi Oranga Mental Health Admission Unit

Year to date total count of hours of seclusion occurring at Wahi Oranga Mental Health Admission Unit

Monthly percentage of resourced NGO supported accommodation beds occupied on the last day of the month

Quarterly total of all people who accessed Primary Mental Health Initiative (PMHI) services

Disabilty Support Services

Monthly occupancy percentage of NMH Disability Support Services Residential Services facilities

Average cost of Community and Residential package of care in Nelson Marlborough district

Average cost of Community and Residential package of care in New Zealand
Monthly percentage of people with current Lifestyle Plan

Monthly total of people supported by NMH Disability Support Services

Monthly total of people in residential services across the District

Monthly total of people supported across the District

Pharmaceuticals

Quarterly total of number of items dispensed from a prescription for the first time

Quarterly total of number of items dispensed at a time subsequent to initial prescription dispensing

Community

The number of people enrolled with a PHO contracted general practice divided by the projected population, reported quarterly

Quarterly count of the number of people referred to the Stop Smoking Service where a face to face contact has been made, all ethnicities

Quarterly count of the number of people referred to the Stop Smoking Service where a face to face contact has been made, Maori ethnicity

Quarterly percentage of people reporting not having had a single cigarette puff 4 weeks after setting a quit date, all ethnicities

Quarterly percentage of people reporting not having had a single cigarette puff 4 weeks after setting a quit date, Maori ethnicity

Percentage of pregnant women reporting not having had a single cigarette puff 4 weeks after setting a quit date, all ethnicities

Quarterly count of the number of people enrolled with the Green Prescription service, all ethnicities

Quarterly count of the number of people enrolled with the Green Prescription service, Maori ethnicity
Quarterly count of the number of people enrolled with the community nutrition service, all ethnicities

Quarterly count of the number of people enrolled with the community nutrition service, Maori ethnicity

Quarterly count of the number of women who have received a funded emergency contraceptive from a community pharmacist or General Practice, all ethnicities

Quarterly count of the number of women who have received a funded emergency contraceptive from a community pharmacist or General Practice, Maori ethnicity

Quarterly count of inpatient events major diagnostic category 'Pregnancy, Childbirth and Puerperium', births and terminations, under age 20, all ethnicities

Quarterly count of inpatient events major diagnostic category 'Pregnancy, Childbirth and Puerperium', births and terminations, under age 20, Maori ethnicities

Quarterly count of people who have enrolled with a community pain service in Nelson Marlborough, all ethnicities

Quarterly count of people who have enrolled with a community pain service in Nelson Marlborough, Maori ethnicity

Monthly total of all District Nursing Service admissions and discharges

Health of Older People

Monthly total of acute admissions of patients age 75+ Nelson

Monthly total of acute admissions of patients age 75+ Wairau

Quarterly utilisation of NMH funded Respite Beds by bed days – Marlborough Ashwood Park

Quarterly utilisation of NMH funded Respite Beds by bed days – Nelson Stillwater Gardens

Quarterly utilisation of NMH funded Respite Beds by bed days – Motueka FOMHT

Monthly cost to NMH of Home Based Support Services at levels of support

Monthly total cost to NMH of Aged Related Residential Care at levels of care

Expenditure per Capita - Aged Related Residential Care all of South Island by bed day

Bed day use per Capita - Aged Related Residential Care all of South Island

Monthly access to Home Based Support Services by Maori compared to all Ethnicities

Points to Note This Report

Some of the graphs in this dashboard are in the form of control charts. This statistical calculation displays upper and lower control limits to enable recognition of usual-normal variation from unusual-special variation.

MEMO

Status
This report contains:
☐ **For decision**
✓ **Update**
☐ **Regular report**
✓ **For information**

To:	CPHAC/DISAC Members
From:	Nick Baker, Chief Medical Officer Jane Kinsey, GM Mental Health Addictions & DSS
Date:	19 July 2017
Subject:	**YOUTH SUICIDE AND HOSPITALISATION FOR SELF HARM IN NELSON MARLBOROUGH DISTRICT**

Contributors: Carla Lane and Eileen Varley, Addictions Service and Ryan Papps, Information and Performance Facilitator

Purpose
Response to the following action point from the June Board meeting:

"Prepare a paper on youth suicide statistics (including local data) for the July Board meeting".

Background

Youth suicide is a topic of concern for many New Zealanders and continues to be an area of specific focus and investment in health and social services within this country.

It is widely accepted that suicide, within any age group, is a complex phenomenon with multiple contributing factors, only one of which is the presence of mental health issues. Other factors may include biological, psychological or personality based issues, along with social, environmental and/or cultural factors.

One more of these issues can develop over the life of an individual before they may contribute to a person's decision to take their own life. While the presence of certain types of mental health disorder does increase the risk of suicide, it is not a definitive precursor. At times, suicide may occur impulsively in a moment of crisis when an individual lacks the ability to deal with acute or chronic stress.

University of Sydney psychiatry professor John Snowden has analysed New Zealand and Australian official statistics for suicide and reported that for many decades there have been persistently high rates of suicide amongst young New Zealanders.

Caution, however, should be noted when comparing standardised rates of suicide internationally, as the determination of *death by suicide* as a cause of death differs among many countries. For example, in the UK the cause of death will only be determined to be suicide if it meets the criminal definition of suicide. This requires proof beyond reasonable doubt (e.g. evidence of a suicide note). As such, the composition of suicide data for the UK differs from that of New Zealand, where deaths by suicide are determined following coronial inquiry, with a finding or 'intentionally self-inflicted'.

In New Zealand the standard of proof required for suicide is based on the "balance of probabilities" that is a more than fifty percent chance of suicide. The Ministry of Health recommends caution when comparing international suicide statistics because many factors affect the recording and classification of suicide in different countries, including the level of proof required for a verdict of suicide; the stigma associated with suicide; the religion, social class or occupation of suicide victims; and confidentiality. As a result, deaths classified as suicide in some countries may be classified as accidental or of undetermined intent in other.Discrepancies in data and reporting not-withstanding, each year there are a number of young people who choose to take their own lives. Every one of those deaths is undeniably a tragedy, not only for the individual and their families but also for the community.

The challenge for Government, health and social providers has been to learn from these deaths and to provide new pathways and opportunities to be more responsive to individuals experiencing distress in their lives. As such, a significant focus, particularly for youth, should include enabling and building resiliency and skills for coping with life stressors, and the associated emotions that often accompany these.

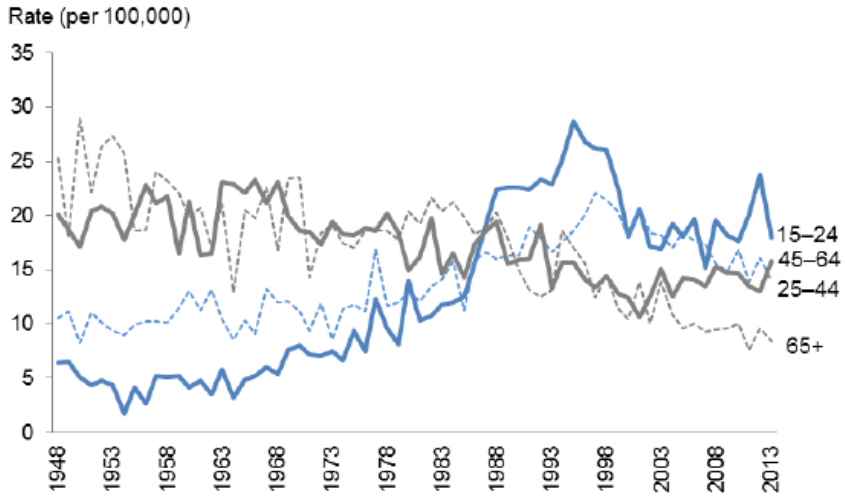
The *New Zealand Suicide Prevention Strategy 2006-2016* has contributed significantly to the monitoring, awareness and cross-agency approaches that have been implemented, specifically in the past 5 years. This initially saw the introduction of *Suicide Prevention Coordinator* roles within DHB catchment areas, facilitating and coordinating many of the suicide prevention and post-vention strategies.

One of the keys has been in recognising that this is not just an issue for health, but rather community wide. Therefore partnerships within the community across Primary and Secondary services, NGO's and other services working with vulnerable individuals such as MSD, justice, Police and indeed families themselves are all important. There are a number of cross-sector initiatives in place to identify people in vulnerable situations, such as the Children's Team in Wairau.

While there continue to be challenges in both identifying what is specifically contributing to the rate of youth suicides, as well as implementing solutions to reduce the frequency, there has been significant improvement over the past 20 years.

Nationally, since its peak in 1995, the youth suicide rate has reduced by nearly 40% (based on data available to the end of 2013).

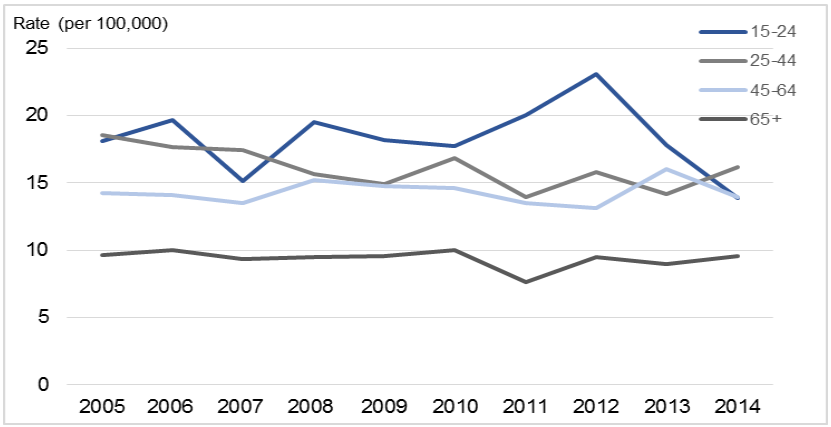
Figure 1: New Zealand age-specific suicide rate, by life-stage age group, 1948-2013



Source: Suicide Facts: Deaths and intentional self-harm hospitalisations 2013

Further, for the first time since 2007, the 2014 youth suicide rate dropped below the rate of suicide in the 25-44 year age group.

Figure 2: New Zealand age standardised suicide rates, by life-stage age group, 2005-2014



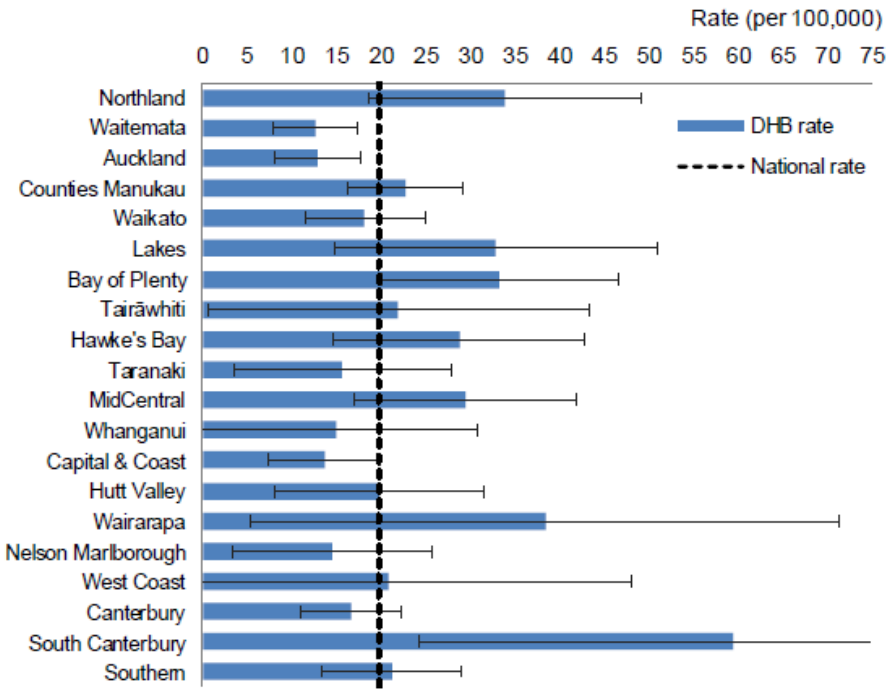
Source: Suicide Facts: Deaths and intentional self-harm hospitalisations 2014 data

While there is a challenge ahead in further reducing the frequency of youth suicide, we should also take time to reflect on the significant progess that has been made to date.

Nelson Marlborough District

Historically, the youth suicide rate in the Nelson Marlborough district has been comparatively low to other parts of New Zealand and below the national average.

Figure 3: Age-specific youth (15-24) suicide rates, by DHB regions, 2009-2013



Source: Suicide Facts: Deaths and intentional self-harm hospitalisations 2013

Between 2005 and 2014, there were 25 deaths in the Nelson Marlborough district that were determined to be from suicide.

Figure 4: Suicide mortality (number of deaths) prioritised by ethnic group and year of death, Nelson Marlborough, 2005-2014(n=25)

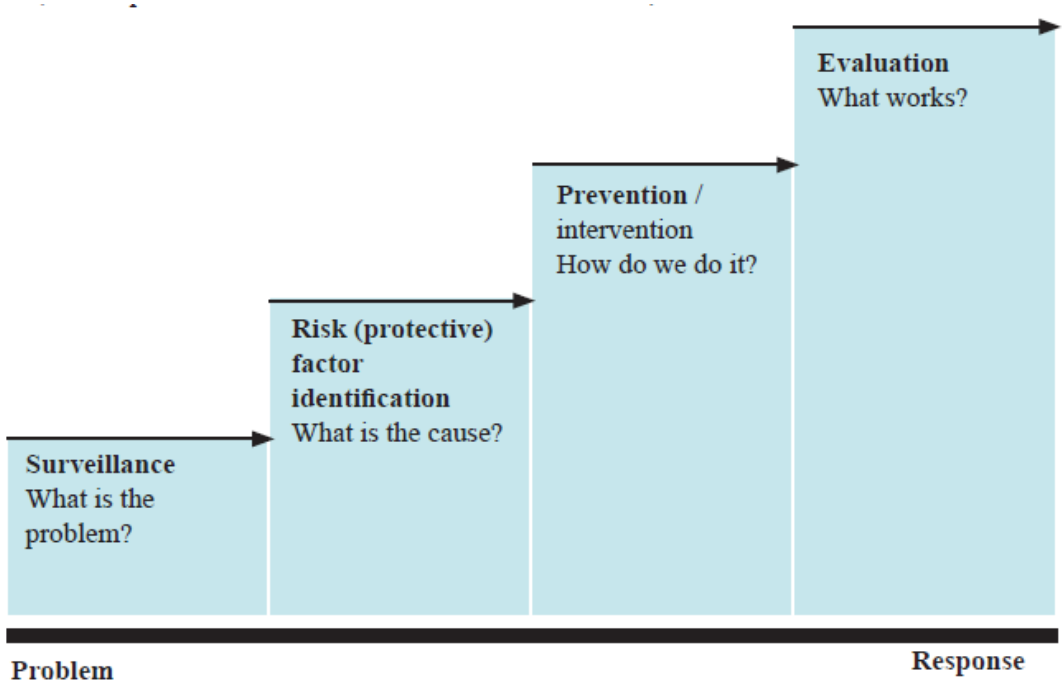
	Suicide deaths										
Ethnicity	**200**	**200**	**200**	**200**	**200**	**201**	**201**	**201**	**201**	**201**	**Total 2005–201**
Māori	<3	<3	<3	-	-	<3	-	-	-	<3	<11
Pacific peoples	-	-	<3	-	-	-	-	-	-	-	<3
European or other	<3	3	<3	4	<3	<3	<3	<3	<3	<3	19
Total	**3**	**<6**	**4**	**4**	<3	**<5**	<3	<3	<3	**<5**	**25**

Source: Mortality Review Database

The most recent (provisional) information available for 2015 and 2016 indicates that there were two youth suicides in 2015, and three in 2016. Most of these young people had no previous contact with Mental Health and Addictions Services at NMH.

Public Health Approach to Suicide Prevention

NMH has adopted a public health approach to suicide prevention. In contrast to other public health issues there is strong evidence that the wrong approach to prevention can increase the rate of suicide. For other public health topics e.g. injury prevention, infectious diseases and water safety increasing public awareness in almost any form is beneficial.



Suicide is just the very tip of the iceberg of need and risk so isolated focus on this aspect misses opportunities to address the majority of the numerically much more common problems. Also, while mental health services can help people with distress they are only a small part of the solution and response we need. Just as a pain clinic is only a small part of our communities overall way of managing physical pain.

Almost everyone suffers emotional and mental distress at some point in their lives. While far too common, suicide is very rare in comparison. Determining which person in distress is at risk of suicide is very difficult. Our focus should therefore be on preventing and managing distress.

We note that for many, but not all, suicide follows a life of accumulating adversity which often starts before their birth. It is then cemented in through experiences in the early years of life during which lifelong response patterns are learnt especially in the domains of emotional regulation, positive human interaction and ability to self-correct.

The absence of these skills casts long shadows on the years ahead. With low resilience and inability to self-correct and get back on track, people are at risk of adverse outcomes in most domains of life, employment, relationships, drugs and alcohol, risk taking behaviour, criminal actions as well as suicide. People in this group need support to grow resilience and increase supportive connections to others as early as possible in life.

Distress is in itself very unpleasant so we should make efforts at prevention, prepare people for it and develop pathways to help people suffering badly. For instance helping young people prepare for normal live events such as relationship break ups and know where they can get help if distressed. Linking all emotional and mental distress to suicide is not productive just as linking all physical pain to death or cancer is unproductive and distracts for management, prevention and treatment.

Coping with and managing distress needs a whole of community approach. We must all take expressions of distress seriously including those put on line and develop ways to reduce the suffering and harm. The harm and suffering can be reduced if people have resiliency factors and know where to go for help.

Key Community Responsibilities:

1. Do not ignore distress however it is expressed including online – listen and support people in finding a place to get help

2. Prepare in advance rehearse for the impact of traumatic events e.g. Relationship break ups

3. Keep linked to others, family, whanau and wider community and have a purpose. For young people parents should know how to contact your kids friends and their parents to share problems before they escalate – risk taking and personal distress

4. Help people new to our region settle in make new links for support and connect to the services they need locally e.g. a GP – a whole of community responsibility including schools, Oranga Tamariki, WINZ, and employers

5. Trusting relations with others who can help through listening and supporting balanced reflections to help self-correction. Everyone needs three people they can talk to when distressed – GPs are a place to consider for managing distress as well as physical illness

6. Know how to connect to professional support when distress risks spiralling out of control. For example a universal cause of distress is grief. It is normal to be sad and this only eases with time. However for some people there are unable to move on and abnormal grief reaction occurs so help is needed.

Key initiatives in the District:

- Mental Health & Addiction Services is looking to achieve a more integrated approach to urgent response to enable the services to respond more to the need and avoid multiple referrals between services
- Training has been identified for staff to provide specialist therapies such as dialectical behaviour therapy (DBT)
- Consider opportunities to flexibly respond to respite needs. There is a focus on the need to recognise the importance on taking respite to build resilience and support the access to planned respite with the aim to reduce the need for crisis respite
- A role of mental health nurse educator has been appointed to which identifies and provides training opportunities across mental health and addictions services. This will

of course include a focus of risk identification and risk management, but also serves to broaden the knowledge base and responsiveness in individual teams
- The implementation of a triage tool by MH services is currently underway which will assist focus on responding where it is most needed in a timely manner
- Improve access and entry to services to ensure it is well known and easily remembered and understood
- Development of community based education workshops
- Providing support to key stakeholders to support early intervention and, referral processes etc
- Development of navigator and clinical liaison roles for primary care to allow rapid access to specialist advice from Mental Health Services
- Support for ED staff and SMO's in identifying and responding to distressed individuals
- Education opportunities for staff in general practice and updating the mental health pathways to support primary health care workforce to be supported in the role of primary care management of mental health and addictions
- Regular cross agency meetings of Well Youth Forum and Suicide Prevention Network
- Post traumatic incident response well defined with clear communication to key stakeholders.

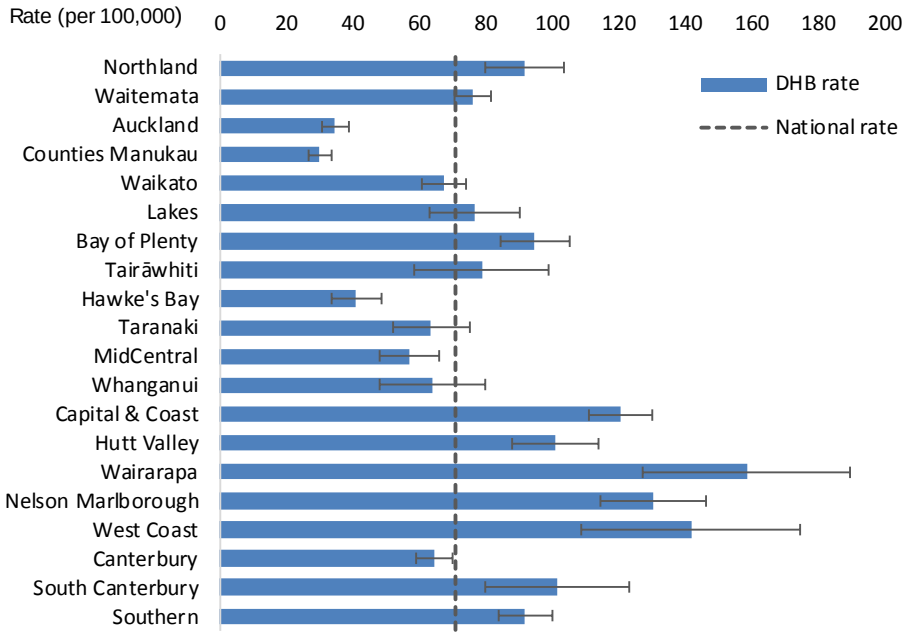
Hospitalisations for Self-Harm
The Ministry of Health publishes *hospitalisations for self-harm* in its annual *Suicide Facts* report. The data included in this report comprise coded inpatient discharge events, reported to the National Minimum Data Set (NMDS) by DHBs. Prior to 2013, the data excluded short stay ED events (treated only in ED), however from 2013 onwards, these events are now included in some parts of the report. In-scope data includes any event with one or more ICD-10-AM external cause codes in the range X60-X84, indicating intentional self-harm.

A key caveat around this information, as stated in the report, is that *"**it is important to recognise that the motivation for intentional self-harm varies, and therefore hospitalisation data for self-harm is not a measure of suicide attempts**".*

The issue of 'intent' is sometimes difficult to establish. It is classed as intent if there is clear evidence an individual deliberately undertook an activity with the intention to harm themselves. However, the associated outcome of self-harm or death may not always be intent of the action/activity.

In the most recent publication of *Suicide Facts*, covering data up to the end of the 2013 calendar year, Nelson Marlborough is shown to have the third highest rate (standardised per 100k of population) of hospitalisation for self-harm in New Zealand. Note, this does not include data for short stay ED events.

Figure 5: Age-standardised rate of intentional self-harm hospitalisations, by DHB, 2011-2013



Source: Suicide Facts: Deaths and intentional self-harm hospitalisations 2013
Note: Excludes short stay ED events

It is important to note that the report counts admission numbers, not individual patients. Unlike the data for suicides, these data are subject to a number of variables which demand a cautious approach when comparing different DHBs' data.

In looking at our local data for the calendar years between 2013 and 2016, there were 262 individuals, who between them had 313 admissions for intentional self-harm

NMDHB Hospitalisations for self-harm (all ages)					
	2013	**2014**	**2015**	**2016**	**Total 2015–2016**
People	79	79	69	58	262
Admissions	91	84	72	65	312

Of the 262 people, all but 2 had contact with NMH Mental Health and Addictions Services either before, during or subsequent to their hospitalisation(s). The primary mental health diagnoses associated with this group of individuals were Anxiety/Stress/Somatoform related diagnoses (39%), Personality/Behavioural disorders (26%) and Mood disorders (21%). 30% had either a primary or secondary Substance Use diagnosis (harmful use or dependence). 91% of admissions were related to self-poisoning/intentional ingestion (drugs and/or alcohol, or other substances).

We shouldn't look at hospitalisations for self-harm in isolation from presentations to ED, as the latter forms part of a wider picture around deliberate self-harm and other issues associated with intentional high use of health services. For context, the top 20 frequent ED presenters in NM district have had over 1300 ED presentations between them since Jan 2014. Of those 20 people, 17 are current or former clients of MH and/or Addictions services. All will be very well known, and most if not all will have plans in place to reduce the incidence of subsequent admission (depending of course on the severity of what they

are presenting with). Therefore, comparing a rate of presentations (1300) vs a rate of individuals presenting (20) is quite different.

A somewhat unique feature within the Nelson Marlborough district is the residential service (Te Whare Mahana in Golden Bay) for people with Borderline Personality Disorder – the only one of its kind in the country. This service works with individuals from all over New Zealand who often present with very challenging and complex issues, and commonly are pre-disposed to self-injurious behaviour. The programme duration is 12 months, and while individuals are at Te Whare Mahana, in some cases the DHB of origin will see a reduction in presentations to ED and admissions for self-harm. This may well contribute to issues with comparability between DHBs.

Looking Forward
In summary we recognise that youth suicide is a significant problem and are committed to working proactively to progress best practise. We need to continue to work closely with those services that are also faced with these challenges and work to overcome any barriers to most effective responses.

Identified strategies moving forward:
- Frequent ED presenters meeting
- Follow up with high/frequent attenders at ED
- Review our data to gain a better picture of what is occurring (presentations as well as outcomes) and work towards a local suicide death review committee
- Continue to encourage and support community based programmes that help develop resiliency in young people such as parenting programmes and to encourage development of skills such as emotional regulation
- Continue upskilling both community and staff in recognition and response to risk situations
- Continue to identify particular challenges within Golden Bay and Blenheim, Picton and plan for differential programmes depending on need
- Consider the re-establishment of a suicide prevention coordinator role for our health system which has a focus on developing community leadership and engagement, as well as supporting appropriate clinical and system response to issues as they present. A focus will also be on supporting the strengthening of resilience in our people and our communities.

GLOSSARY OF COMMONLY USED ACRONYMS, ABBREVIATIONS AND MAORI TRANSLATION

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
A&R	Audit & Risk Committee
ACC	Accident Compensation Corporation
ACMO	Associate Chief Medical Officer
ACNM -	Associate Charge Nurse Manager
ACU	Ambulatory Care Unit
ACP	Advanced Care Plan
ADR	Adverse Drug Reactions
ADM	Acute Demand Management
ADON	Associate Director of Nursing
AE	Alternative Education
AEP	Accredited Employer Programme
AIR	Agreed Information Repository
ALOS	Average Length of Stay
ALT	Alliance Leadership Team (short version of (TOSHALT)
AMP	Asset Management Plan
AOD	Alcohol and Drug
AOHS	Adolescent Oral Health Services
AP	Annual Plan with Statement of Intent
ARC	Aged Residential Care
ARF	Audit Risk and Finance
ARCC	Aged Residential Care Contract
ARRC	Aged Related Residential Care
ASD	Autism Spectrum Disorder
ASH	Ambulatory Sensitive Hospitalisation
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation
BSCQ	Balanced Score Card Quadrant
BA	Business Analyst
BAU	Business as Usual
BCP	Business Continuity Plan
BCTI	Buyer Created Tax Invoice
BFCI	Breast Feeding Community Initiative
BFCI	Baby Friendly Community Initiative
BHE	Blenheim
BOT	Board of Trustees
BS	Business Support
BSI	Blood Stream Infection
BSMC	Better, Sooner, More Convenient
CAR	Corrective Action Required
CaaG	Capacity at a Glance
CAMHS	Child and Adolescent Mental Health Services
CARES	Coordinated Access Response Electronic Service
CBAC	Community Based Assessment Centres
CBF	Capitation Based Funding
CBSD	Community Based Service Directorate
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)
CCDM	Care Capacity Demand Management
CCDP	Care Capacity Demand Planning

CCF	Chronic Conditions Framework
CCT	Continuing Care Team
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)
CeTas	Central Technical Advisory Support
CFA	Crown Funding Agreement or Crown Funding Agency
CFO	Chief Financial Officer
CGC	Clinical Governance Committee
CHFA	Crown Health Financing Agency
CHS	Community Health Services
CIMS	Coordinated Incident Management System
CIO	Chief Information Officer
CLAB	Central Line Associated Bacteraemia
CLAG	Clinical Laboratory Advisory Group
CME	Continuing Medical Education
CMI	Chronic Medical Illness
CMO	Chief Medical Officer
CMS	Contract Management System
CNM	Charge Nurse Manager
Concerto	IT system which provides clinician's interface to systems
COHS	Community Oral Health Service
COO	Chief Operating Officer
COPD	Chronic Obstructive Pulmonary Disease
COPMI	Children of Parents with Mental Illness
CPHAC	Community and Public Health Advisory Committee
CPIP	Community Pharmacy Intervention Project
CPNE	Continuing Practice Nurse Education
CP	Chief Pharmacist
CPO	Controlled Purchase Operations
CPSOG	Community Pharmacy Services Operational Group
CPU	Critical Purchase Units
CR	Computed Radiology
CRG	Christchurch Radiology Group
CRISP	Central Region Information Systems Plan
CSR	Contract Status Report
CSSD	Central Sterile Supply Department
CSSD	Clinical Services Support Directorate
CT	Computerised Tomography
CTA	Clinical Training Agency
CTC	Contributions to Cost
CTC	Computerised Tomography Colonography
CTANAG	Clinical Training Agency Nursing Advisory Group
CTU	Combined Trade Unions
CVD	Cardiovascular Disease
CVDRA	Cardiovascular/Diabetes Risk Assessment
CWD	Case Weighted Discharge
CYF	Child, Youth and Family
CYFS	Child, Youth and Family Service
DA	Dental Assistant
DAH	Director of Allied Health
DAP	District Annual Plan
DAR	Diabetes Annual Review
DBI	Diagnostic Breast Imaging
DBT	Dialectical Behaviour Training
DHB	District Health Board

DHBNZ	District Health Boards New Zealand
DHBRF	District Health Boards Research Fund
DIFS	District Immunisation Facilitation Services
DiSAC	Disability Support Advisory Committee
DGH	Director General of Health
DMH	Director of Maori Health
DNA	Did Not Attend
DONM	Director of Nursing and Midwifery
DR	Disaster Recovery
DR	Digital Radiology
DRG	Diagnostic Related Group
DSP	District Strategic Plan
DSS	Disability Support Services
DT	Dental Therapist
DWCSP	District Wide Clinical Services Plan
EAP	Employee Assistance Programme
EBID	Earnings Before Interest & Depreciation
ECP	Emergency Contraceptive Pill
ECWD	Equivalent Case Weighted Discharge
ED	Emergency Department
EDA	Economic Development Agency
EDaaG	ED at a Glance
EFI	Energy For Industry
ELT	Executive Leadership Team
EMPG	Emergency Management Planning Group
ENS	Ear Nurse Specialist
ENT	Ears, Nose and Throat
EOI	Expression of Interest
EPA	Enduring Power of Attorney
EQP	Earthquake Prone Building Policy
ERMS	ereferral Management System
ESA	Electronic Special Authority
ESOL	English Speakers of Other Languages
ESPI	Elective Services Patient Flow Indicators
ESR	Environmental Science & Research
ESU	Enrolled Service Unit
EVIDEM	Evidence and Value: Impact on Decision Making
FCT	Faster Cancer Treatment
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
FPSC	Finance Procurement and Supply Chain
FRC	Fee Review Committee
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
FUP	Follow Up
FVIP	Family Violence Intervention Programme
GM	General Manager
GMS	General Medical Subsidy
GP	General Practitioner
GRx	Green Prescription
hA	healthAlliance
HAC	Hospital Advisory Committee
HBI	Hospital Benchmarking Information

HBSS	Home Based Support Services
HBT	Home Based Treatment
H&DC / HDC	Health and Disability Commissioner
H&S	Health & Safety
HDSP	Health & Disability Services Plan Programme
HDU	High Dependency Unit
HEA	Health Education Assessments
He Kawenata	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
HNA	Health Needs Assessment
HODs	Heads of Department
HOP	Health of Older People
HP	Health Promotion
HPI	Health Practitioner Index
HPV	Human Papilloma Virus
HR	Human Resources
HR & OD	Human Resources and Organisational Development
HSP	Health Services Plan
HQSC	Health Quality & Safety Commission
IASS	Infrastructure as a Service
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
ILM	Investment Logic Mapping
IM	Information Management
InterRAI	Inter Residential Assessment Instrument
IoD	Institute of Directors New Zealand
IPAC	Independent Practitioner Association Council
IPC	Intensive Patient Care
IPC Units	Intensive Psychiatric Care Units
IPG	Immunisation Partnership Group
IPSAS	International Public Sector Accounting Standards
IPU	In-Patient Unit
IS	Information Systems
ISSP	Information Services Strategic Plan
IT	Information Technology
JAMHWSAP	Joint Action Maori Health & Wellness Strategic Action Plan
JOG	Joint Oversight Group
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 Caesarean Section
LTC	Long Term Care
LTIP	Long Term Investment Plan
LTCCP	Long Term Council Community Plan
LTO	Licence to Occupy
LTS-CHC	Long Term Supports – Chronic Health Condition
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)
MA	Medical Advisor
MAC(H)	Medicines Advisory Group (Hospital)
MCT	Mobile Community Team
MDC	Marlborough District Council
MDM	Multidisciplinary Meetings
MDO	Maori Development Organisation
MDS	Maori Development Service
MDT	Multi Disciplinary Team
MECA	Multi Employer Collective Agreement
MEND	Mind, Exercise, Nutrition, Do It
MHAU	Mental Health Admission Unit
MHC	Mental Health Commissioner
MHD	Maori Health Directorate
MHDSF	Maori Health and Disability Strategy Framework
MHFS	Maori Health Foundation Strategy
MHINC	Mental Health Information Network Collection
MHSD	Mental Health Service Directorate
MHWSF	Maori Health and Wellness Strategic Framework
MIC	Medical & Injury Centre
MMG	Medicines Management Group
MOE	Ministry of Education
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
MPDS	Maori Provider Development Scheme
MQ&S	Maternity Quality & Safety Programme
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist (or Technician)
MSD	Ministry of Social Development
MSD	Marlborough Services Directorate
MSSD	Medical Surgical Services Directorate
NPA	Nutrition and Physical Activity
NRAHDD	Nelson Region After Hours & Duty Doctor Limited
NRL	Nelson Radiology Ltd (Private Provider)
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
NETP	Nursing Entry to Practice
NGO	Non Government Organisation

NHCC	National Health Coordination Centre
NHI	National Health Index
NIR	National Immunisation Register
NM	Nelson Marlborough
NMDHB	Nelson Marlborough District Health Board
NMDS	National Minimum Dataset
NMH	Nelson Marlborough Health
NMIT	Nelson Marlborough Institute of Technology
NN	Nelson
NPA	Nutrition and Physical Activity (Programme)
NPV	Net Present Value
NRAHDD	Nelson Regional After Hours and Duty Doctor Ltd
NRSII	National Radiology Service Improvement Initiative
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
OAG	Office of the Auditor General
OECD	Organisation for Economic Co-operation and Development
OIA	Official Information Act
OIS	Outreach Immunisation Services
OPD	Outpatient Department
OPF	Operational Policy Framework
OPJ	Optimising the Patient Journey
ORL	Otorhinolaryngology (previously Ear, Nose and Throat)
OSH	Occupational Health and Safety
OT	Occupational Therapy
PACS	Picture Archiving Computer System
PAS	Patient Administration 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
PCBU	Person Conducting Business Unit
PCI	Percutaneous Coronary Intervention
PCO	Primary Care Organisation
PCT	Pharmaceutical Cancer Treatments
PDO	Principal Dental Officer
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
PICS	Patient Information Care System
PIP	Performance Improvement Plan
PN	Practice Nurse

PPE	Property, Plant & Equipment assets
PPP	PHO Performance Programme
PSAAP	PHO Service Agreement Amendment Protocol
PSR	Preschool Enrolled (Oral health)
PT	Patient
PTAC	Pharmacology and Therapeutics Committee
PRIMHD	Project for the Integration of Mental Health Data
PVS	Price Volume Schedule
Q&SGC	Quality & Safety Governance Committee
QA	Quality Assurance
QHNZ	Quality Health NZ
QIC	Quality Improvement Council
QIPPS	Quality Improvement Programme Planning System
RA	Radiology Assistant
Rangatiratanga	Autonomy, evidence of greatness (HW Williams Maori Dictionary pg 323)
RDA	Resident Doctors Association
RDA	Riding for Disabled
RIF	Rural Innovation Fund
RIS	Radiology Information System
RFI	Request for Information
RFP	Request for Proposal
RICF	Reducing Inequalities Contingency Funding
RIS	Radiology Information System
RM	Registered Midwife
RMO	Resident Medical Officer
RN	Registered Nurse
ROI	Registration of Interest
RSE	Recognised Seasonal Employer
RSL	Research and Sabbatical Leave
SAC1	Severity Assessment Code
SAC2	Severity Assessment Code
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
SI	South Island
SIA	Services to Improve Access
SIAPO	South Island Alliance Programme Office
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
SLA	Service Level Agreement
SLATs	Service Level Alliance Teams
SLH	SouthLink Health
SM	Service Manager
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SOI	Statement of Intent
SOPD	Surgical Outpatients Department
SOPH	School of Population Health
SPaIT	Strategy Planning and Integration Team
SPAS	Strategy Planning & Alliance Support
SPE	Statement of Performance Expectations
SSBs	Sugar Sweetened Beverages

SSE	Sentinel and Serious Events
SSP	Statement and Service Performance
TCR	Total Children Enrolled (Oral health)
TDC	Tasman District Council
TLA	Territorial Local Authority
TOW	Treaty of Waitangi
TOR	Terms of Reference
ToSHA	Top of the South Health Alliance
TPOT	The Productive Operating Theatre
TRTT	Te Roopu Tupu Tahi
UG	User Group
USS	Ultrasound Service
U/S	Ultrasound
VLCA	Very Low Cost Access
VRA	Vascular Risk Assessment
WAM	Wairau Accident & Medical Trust
WAVE (Project)	Working to Add Value through E-Information
WEll	Whanau Engagement, Innovation and Integration
WIP	Work in Progress
WR	Wairau
YOTS	Youth Offending Teams
YTD	Year to Date
YTS	Youth Transition Service

As at 19 July 2017