AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING

To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 13 December 2018 commencing at 9.00am

	Karakia		9.00am
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 15 November 2018		
3.	Carried Forward / Action List Items		
4.	Patient Story		
5.	Chair's Update - Oral		9.05-9.10am
6.	Chief Executive's Update	Mary Gordon *(Acting)*	9.10-9.40am
7.	Finance Report	Justine White	9.40-9.55am
8.	Health (Drinking Water) Amendment Bill – Draft Submission	Evon Currie	9.55-10.10am
9.	Canterbury Health System Alcohol-Related Harm Reduction Strategy	Evon Currie	10.10-10.25am
10.	Advice to Board: HAC – 29 November 2018 – Draft Minutes	Andrew Dickerson	10.25-10.30am
11.	Resolution to Exclude the Public		10.30am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.30am**

NEXT MEETING: Thursday, 21 February 2019 at 9.00am

Morning tea will be held at the conclusion of the public meeting

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

Dr John Wood (Chair)
Ta Mark Solomon (Deputy Chair)
Barry Bragg
Sally Buck
Tracey Chambers
Dr Anna Crighton
Andrew Dickerson
Jo Kane
Aaron Keown
Chris Mene
David Morrell

Executive Support

David Meates – *Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
Michael Frampton – *Chief People Officer*
Mary Gordon – *Executive Director of Nursing*
Carolyn Gullery – *Executive Director Planning, Funding & Decision Support*
Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Hector Matthews – *Executive Director Maori & Pacific Health*
Sue Nightingale – *Chief Medical Officer*
Karalyn Van Deursen – *Executive Director of Communications*
Stella Ward – *Chief Digital Officer*
Justine White – *Executive Director Finance & Corporate Services*

Anna Craw – *Board Secretariat*
Charlotte Evers – *Assistant Board Secretariat*
Kay Jenkins – *Executive Assistant, Governance Support*

CONFLICTS OF INTEREST REGISTER CANTERBURY DISTRICT HEALTH BOARD (*CDHB*)

Canterbury District Health Board
Te Poari Hauora ō Waitaha

(As disclosed on appointment to the Board/Committee and updated from time-to-time, as necessary)

Dr John Wood **Chair CDHB**	**Advisory Board NZ/US Council** – Member The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director. **Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice (as Chief Crown Treaty of Waitangi Negotiator)** – Ex-Officio Member The Office of Treaty Settlements, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Treaty Negotiator for Ngati Rangi** Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment. **Chief Crown Treaty Negotiator, Tongariro National Park** Engagement with Iwi collective begins July 2018. **Chief Crown Treaty Negotiator for the Whanganui River** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations** High level agreement in principle reached. Aiming for deed of settlement end of 2018. **Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA)** – Member ERIA is an international organisation that was established by an agreement of the leaders of 16 East Asia Summit member countries. Its main role is to conduct research and policy analysis to facilitate the ASEAN Economic Community building and to support wider regional community building. The governing board is the decision-making body of ERIA and consists of the Secretary General of ASEAN and representatives from each of the 16 member countries, all of whom have backgrounds in academia, business, and policymaking. **Kaikoura Business Recovery Grants Programme Independent Panel** – Member The Kaikoura Business Recovery Grants Programme was launched in May 2017 and is intended to support local businesses until State Highway One reopens by way of grants which can be applied for by eligible businesses. This programme is now closed.

	School of Social and Political Sciences, University of Canterbury – Adjunct Professor Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment. **Te Urewera Governance Board** –Member The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee. **University of Canterbury (*UC*)** – Chancellor The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation. **University of Canterbury Foundation** – Ex-officio Trustee The University of Canterbury Foundation, Te Tūāpapa Hononga o Te Whare Wānanga o Waitaha, is dedicated to ensuring that UC's tradition of excellence in higher education continues. From its earliest beginnings in 1873, philanthropic support and the generosity of donors and supporters has played a major part in making the university the respected institution it is today. The UC Foundation is dedicated to continuing that tradition. **Universities New Zealand** – Elected Chair, Chancellors' Group Universities New Zealand is the sector voice for all eight universities, representing their views nationally and internationally, championing the quality education they deliver, and the important contribution they make to New Zealand and New Zealanders.
Ta Mark Solomon **Deputy Chair CDHB**	**Claims Resolution Consultation – Senior Maori Leaders Group** – Member This is an Advisory Board to MSD looking at the claims process of those held under State care. **Deep South NSC (National Science Challenge) Governance Board** – Member The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities. **Greater Christchurch Partnership Group** – Member This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work). **He Toki ki te Rika / ki te Mahi** – Patron He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury.

	Liquid Media Operations Limited – Shareholder Liquid Media is a start-up company which has a water/sewage treatment technology. **Maori Carbon Foundation Limited** – Chairman The Maori Carbon Foundation has been established to deliver environmental, social and economic benefits through the planting of permanent carbon forestry, to Maori and New Zealand landowners throughout the country. **Ngāti Ruanui Holdings** – Director Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki. **NZCF Carbon Planting Advisory Limited** – Director NZCF Carbon Planting Advisory Limited is a company that carries out the obligations in respect of planting and upskilling relating to the Maori Carbon Foundation Limited. **Oaro M Incorporation** – Member 'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations. **Police Commissioners Māori Focus Forum** – Member The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation. **Pure Advantage** – Trustee Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth. **QuakeCoRE** – Board Member QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission. **Rangitane Holdings Limited & Rangitane Investments Limited** - Chair The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members. **SEED NZ Charitable Trust** – Chair and Trustee SEED is a company that works with community groups developing strategic plans.

	Sustainable Seas NSC (National Science Challenge) Governance Board – Member This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement. The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding. **Te Ohu Kai Moana** – Director Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity.
Barry Bragg	**Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **CRL Energy Limited** – Managing Director CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB. **Farrell Construction Limited** - Chairman Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Chairman The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Property Limited** – Chairman Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu.
Sally Buck	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.

Tracey Chambers	**Chambers Limited** – Director Chambers Limited has clients and former clients that may mean a conflict or potential conflict arises. These will be discussed at the appropriate time if they arise. **Rata Foundation** – Trustee Rātā Foundation, formerly The Canterbury Community Trust, was established in 1988 and is one of New Zealand's largest philanthropic organisations. The Foundation holds in trust for Canterbury, Nelson, Marlborough and the Chatham Islands an endowment, or putea, of over half a billion dollars. Investment returns on their capital base enables them to make millions of dollars in grants each year to community organisations across their funding region.
Dr Anna Crighton	**Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage **Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage **Heritage New Zealand –** Honorary Life Member CDHB owns buildings that may be considered to have historical significance.
Andrew Dickerson	**Accuro (Health Service Welfare Society)** - Director Is a not-for-profit, member owned co-operative society providing health insurance services to employees in the health sector and (more recently) members of the public. Accuro has many members who are employees of the CDHB. **Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
Jo Kane	**HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised.

	Latimer Community Housing Trust – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Aaron Keown	**Christchurch City Council** – Councillor and Community Board Member Elected member and of the Fendalton/Waimairi/Harewood Community Board.
Chris Mene	**Canterbury Clinical Network** – Child & Youth Workstream Member **Core Education** – Director Has an interest in the interface between education and health. **Wayne Francis Charitable Trust** - Board Member The Wayne Francis Charitable Trust is a philanthropic family organisation committed to making a positive and lasting contribution to the community. The Youth focussed Trust funds cancer research which embodies some of the Trust's fundamental objectives – prevention, long-term change, and actions that strive to benefit the lives of many.
David Morrell Board Member	**British Honorary Consul** Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time. **Canon Emeritus - Christchurch Cathedral** The Cathedral congregation runs a food programme in association with CDHB staff. **Friends of the Chapel** - Member **Great Christchurch Buildings Trust** – Trustee The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing. **Heritage NZ –** Subscribing Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have heritage significance. **Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time. **Nurses Memorial Chapel Trust** – Member (CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.

MINUTES

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held at 32 Oxford Terrace, Christchurch
on Thursday 15 November 2018 commencing at 9.00am

BOARD MEMBERS

Dr John Wood (Chair); Ta Mark Solomon (Deputy Chair); Sally Buck; Tracey Chambers; Dr Anna Crighton; Andrew Dickerson; Jo Kane; Aaron Keown; Chris Mene; and David Morrell.

APOLOGIES

An apology for absence was received and accepted from Barry Bragg.
An apology for lateness was received from Dr Anna Crighton (9.05am).
Apologies for early departure were received and accepted from Sally Buck (1.20pm) and Chris Mene (2.00pm).

EXECUTIVE SUPPORT

David Meates (Chief Executive); Michael Frampton (Chief People Officer); Carolyn Gullery (Executive Director, Planning, Funding & Decision Support); Mary Gordon (Executive Director, Nursing); Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Hector Matthews (Executive Director, Maori & Pacific Health); Karalyn van Deursen (Executive Director, Communications); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions or alterations to the Interest Register.

Declarations of Interest for Items on Today's Agenda
There were no declarations of interest for items on today's agenda.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. CONFIRMATION OF MINUTES OF THE PREVIOUS MEETINGS

Resolution (75/18)
(Moved: Sally Buck/seconded: Aaron Keown – carried)

"That the minutes of the meeting of the Canterbury District Health Board held at 32 Oxford Terrace on 18 October 2018, and the Special Meeting held on 30 October 2018, be approved and adopted as true and correct records."

3. CARRIED FORWARD/ACTION LIST ITEMS

The carried forward items were noted.

4. PATIENT STORY

The Patient Story was viewed.

Dr Anna Crighton and Jo Kane joined the meeting at 9.05am.

5. APPOINTMENT OF ELECTORAL OFFICER

Justine White, Executive Director, Finance & Corporate Services, introduced Anthony Morton who was present to answer any questions Board members had.

Discussion took place regarding the possibility of on-line voting for the 2019 elections, with it noted that nationally nine Territorial Local Authorities are considering this option. A decision around this is expected to be made by Christmas.

A view was expressed that the Selwyn District Council should not make a decision on on-line voting without consulting with CDHB. Ms White advised that Selwyn District Council has had discussions with CDHB, however, it has no obligation to formally consult.

Resolution (76/18)
(Moved: Sally Buck/seconded: Aaron Keown - carried)

"That the Board:

i. confirms the continued appointment of Anthony Morton as the Canterbury DHB Electoral Officer, in accordance with the Local Electoral Act 2001; and
ii. adopts "random" as the order of candidates' names on Canterbury DHB voting documents, as permitted under Clause 31(1) of the Local Electoral Regulations 2001."

6. SUGAR SWEETENED BEVERAGES POSITION PAPER

Dr Ramon Pink, Public Health Physician/Medical Officer of Health, presented this paper which was taken as read.

Dr Anna Crighton, CPHAC Chair, asked that it be noted that this is a "position paper" and not a "strategy", and that this was discussed at length at the Committee meeting.

Resolution (77/18)
(Moved: Chris Mene/seconded: Dr Anna Crighton - carried)

"That the Board , as recommended by the Community & Public Health and Disability Support Advisory Committee:

i. endorses the South Island District Health Boards' position statement on sugar-sweetened beverages."

7. CHAIR'S UPDATE

Dr Wood commented that we are at that time of the year where there are a number of strategic issues we should take the time to discuss in the Public Excluded section of the meeting.

He advised that in terms of the Truth & Reconciliation process, progress has been made and a meeting was held with the Minister, Director General, CDHB and the Independent Facilitator to present the findings. It is expected that there will be a joint media statement in the near future.

Dr Wood commented that partly as a result of the Truth & Reconciliation Process there has also been progress with the Christchurch Hospital Master Plan, and the Annual Planning process is continuing.

The update was noted.

8. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, introduced Jacqui Lunday-Johnstone, the new Executive Director of Allied Health, Scientific & Technical, to the Board.

Mr Meates took his report as read and updated the Board as follows:

- The Quality Accounts have been included in the Well Now which is currently being delivered into letter boxes. Copies of Well Now were available for Board members at the meeting.
- The CDHB Website has been upgraded, as has the West Coast DHB website.
- A number of interventions around Restorative Care are progressing well and these interventions, some of which are listed in the report, are proven to reduce time spent in hospital and also reduce problems associated with deconditioning and loss of physical and mental function.
- Midwifery support remains a challenge over the Christmas period as this is when more midwives are keen to take time off on leave.
- Attention is strongly focused on next year, and forecasted volumes show that our system will be under immense pressure.
- Mental Health remains an unrelenting challenge:
  - Occupancy of the adult acute inpatient service was 95% in October 2018. There have been periods of extreme pressure this month when the Te Awakura unit was 100% full with further admissions pending. High occupancy is unsustainable and does not allow for increased demand over time. Our staff are doing an incredible job in very challenging circumstances.
  - Demand for Adult Services continues to be high with 236 new crisis case starts in October 2018.
  - Wait times for Child, Adolescent and Family services remain a concern. National targets require 80% of young people to be seen within 21 days and 95% within 56 days. Our results for October 2018 show that 57.5% of children and adolescents were seen within 21 days and 85.8% within 56 days. Child, Adolescent and Family Services had 233 new case starts in October 2018.
- SIPICS has gone live on the Christchurch Campus and in Ashburton. The system is stable, however, there is still a way to go to get the system to optimal use.
- HealthOne - we have progressed into the first stage of rolling HealthOne out into Aged Residential Care facilities. Ryman Healthcare is in the process of setting up the required secure connections to HealthOne. Once this has been completed, virtual testing will be progressing in mid-December. This work will provide those working in residential care the same access to the clinical records of their residents as others across the health system.
- Mana Ake - Phase 3 workers were welcomed at the start of October for a two week induction, supported by a range of stakeholders. The workers commenced in schools on 15 October, bringing the total number of schools to 98 and the total number of workers to 40.
- The new Outpatients Building move has been completed with the response from both Clinicians and the public being very positive.
- Health Targets - CDHB was the only DHB to deliver five of the six health targets, which is a real testament to all of the different services to achieve this.
- There will be a book launch for the "Rising from the Rubble" book next Thursday at the University of Canterbury.

Discussion took place regarding a completion date for the Acute Services Building and it was noted that this is a hugely complex migration which is expected to take around three months to complete.

Discussion also took place regarding car parking at the Litchfield Street Car Park and the DHBs continued use of this facility. It was noted that with the lead up to Christmas, pressure on the car parks capacity may be experienced.

It was noted that the DHB has facilitated a meeting next month with all interested parties around car parking.

Resolution (78/18)
(Moved: Chris Mene/seconded: Ta Mark Solomon - carried)

"That the Board:

i. notes the Chief Executive's Update."

Tracey Chambers departed the meeting at 10.00am.
The meeting agreed to take Items 10, 11 & 12, reverting to Item 9 after morning tea.

10. FINANCE REPORT

Justine White, Executive Director, Finance & Corporate Services, presented the Finance Report which was taken as read. The report stated that the consolidated CDHB financial result for the month of September 2018 was a deficit of $2.691M, which was $3.479M unfavourable against the draft annual plan surplus of $0.788M.

Ms White advised that a revised Annual Plan has been submitted taking into account the reduced revenue resulting from pharmaceutical costs budgeted in the Provider arm coming through as external provider costs due to a change in the accounting treatment from 1 July. It was noted that essentially the same pressures continue in Treatment Related Costs.

Resolution (79/18)
(Moved: Aaron Keown/seconded: Ta Mark Solomon – carried)

"That the Board:

i. notes the financial result for the period ended 30 September 2018."

11. MAORI AND PACIFIC HEALTH PROGRESS REPORT

Hector Matthews, Executive Director, Maori & Pacific Health, presented the report which was taken as read. Mr Matthews highlighted the data around Oral Health and Cervical Screening, commenting that he was cautiously optimistic that this may be a trend.

Resolution (80/18)
(Moved: Dr John Wood/seconded: Ta Mark Solomon – carried)

"That the Board:

i. notes the Māori and Pacific Health Progress Report; and
ii. commends progress made in oral health and cervical screening."

12. CPHAC&DSAC DRAFT MINUTES

Dr Anna Crighton, provided the Board with an update from the Community & Public Health and Disability support Advisory Committee meeting which took place on 1 November 2018. She highlighted the arrival of a first tranche of refugees in Canterbury early next year. She also advised that a question was raised at the meeting regarding a Maori Health Plan.

Dr Crighton advised members that a Canterbury Well Being Index Update is to be held between 12.00pm and 1.00pm on Wednesday 28 November 2018.

Resolution (81/18)
(Moved: Dr Anna Crighton/seconded: Jo Kane – carried)

"That the Board:

i. notes the draft minutes from CPH&DSAC's meeting on 1 November 2018."

The meeting adjourned for morning tea from 10.25am to 10.45am.
The meeting reverted back to Item 9.

9. SEEING OUR SYSTEM – PRESENTATION

Tracey Chambers rejoined the meeting at 10.47am.

Carolyn Gullery, Executive Director, Planning Funding & Decision Support, provided the Board with a presentation: "Seeing Our System".

The Chair thanked Ms Gullery for the presentation.

The meeting moved to Item 13.

13. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (82/18)
(Moved: Ta Mark Solomon/Seconded: Jo Kane – carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14 & 15 and the information items contained in the report;

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of public excluded meetings: • 18 October 2018 • 30 October 2018	For the reasons set out in the previous Board agenda.	

2.	Individual Employment Agreement (*IEA*) Remuneration Strategy 2018/19	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
3.	Proposed Benefits & Opportunities Programme	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4.	IP Cross-Licencing Arrangements with Streamliners NZ Limited	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	HealthOne Limited Partnership Formation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	IT Disaster Recovery	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Chair & Chief Executive's Update on Emerging Issues – Oral Reports	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
8.	Christchurch Hospital Review: Indicative Business Case & Site Review	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Specialist Mental Health Services Detailed Business Case	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Energy Centre – Approval to Award, Design, Manufacture & Installation of Boilers	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	Annual Plan Update 2018/19	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
13.	People Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
14.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
15.	Advice to Board: • QFARC Draft Minutes *30 Oct 2018*	For the reasons set out in the previous Committee agendas.	

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982."

The Public meeting concluded at 11.25am.

Approved and adopted as a true and correct record:

_____ _____

Dr John Wood, Chairman Date of Approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 13 DECEMBER 2018

DATE	ISSUE	REFERRED TO	STATUS
20 Sep 18	Presentation on IT systems; continual enhancement & ongoing use of data throughout the health system.	Stella Ward	Scheduled for 21 February 2019
20 Sep 18	Following on from Water NZ Conference & Expo 2018 - water issues update once direction of travel and legislation becomes clear.	Evon Currie	Today's Agenda – Item 8 + Verbal Update

CHAIR'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Chief Executive**

DATE: **13 December 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing the latest update and overview of key organisational activities and progress from the Chief Executive to the Board of the Canterbury DHB.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

3. DISCUSSION

PUTTING THE PATIENT FIRST – PATIENT SAFETY

Quality & Patient Safety

- **Canterbury Health System Quality Improvement Showcase:** The Canterbury Health System Quality Improvement and Innovation Awards Showcase was held on 6 December. Submissions were assessed on their contribution to the system as well as on how well they meet specific improvement science criteria: identifying the need; having an aim; using the reflective problem solving cycle of the PDSA (Plan, Do, Study, Act) to test change ideas; processes used for making improvements and embedding the change s it is sustained. The submission posters were on display in Corporate throughout November.

- **Canterbury DHB Serious Adverse Event Report 2017/2018:** The Canterbury DHB National Serious Adverse Event Report 17/18 was published on 7 December (exclusive of SMHS events). For the 17/18 year, there were 82 serious adverse events reported out of the total of 14,353 incidents reported by the Canterbury DHB in the year from 1 July 2017 to 30 June 2018. Of the total serious adverse events reported, 50 were inpatient falls and 14 were Hospital-Acquired pressure injuries. The HQSC have released a national aggregated report on their website however unlike previous years, they will not be linking to DHB websites. Aim is to take the emphasis away from the numbers and comparisons between DHBs and focus on the learnings in the report.

- **Health Round Table New Zealand:** The NZ Chapter Collaborative was held on 21 November 2018 and focussed on collaboration to reduce hospital acquired complications. The 2017/2018 benchmarking data has been released for use by District Health Boards and the Health Round Table staff are able to assist in linking up to leaders in the various aspects. The benchmarking report was also discussed recently at the Canterbury DHB Clinical Governance

Committee and will be a focus for improvement effort in 2019. We have local dashboards and SfN to monitor effects from improvement work.

- **ICNet ACC Expansion Programme:** As part of our contractual requirements with ACC for the national ICNet expansion Programme, Canterbury DHB held the national User Group meeting in Auckland in November. The focus was on how Canterbury DHB would support the seven Laboratories and the 13 New Zealand District Health Boards to adopt the ICNet. The day was attended by nearly all DHBs. Following on from this, Canterbury DHB attended Waikato to meet with their ICNet implementation team. The Midland region is working collectively to come on to the system with Lakes DHB likely to be first.

Christchurch Campus

- **Developments in the treatment of obstructive sleep apnoea:** Attendance at this year's European Respiratory Society Conference, along with 22,000 other delegates, has enabled us to keep up to date with key developments in areas which have a significant impact on the health of our population. An area of particular interest is phenotyping obstructive sleep apnoea in order to choose the most appropriate treatment. Obstructive sleep apnoea is a common treatable condition that is a major public health issue in New Zealand. Untreated it is associated with increased morbidity and mortality and an increased risk of driving related accidents. The most common clinical treatment for obstructive sleep apnoea is continuous positive airway pressure. Each year 900 people are provided with a trial of this treatment by Canterbury DHB. Around 70% of these patients gain significant benefit from this treatment and continue using it. However, 30% are unable to tolerate this therapy as their obstructive sleep apnoea may be more complex and not completely related to an anatomical constraint of the airway. A team working in Australia has identified methods that enable the accurate phenotyping of this disorder. The Christchurch Sleep Service will continue to monitor development of these methods closely, as these techniques could help identify patients where a trial of continuous positive airways pressure may not be appropriate first line therapy, and instead may be able to be directed towards other methods of treatment. This would free up more capacity to be used on those patients that would benefit from the current first line treatment.

Older Persons Health & Rehabilitation (OPH&R)

- We are trialling new sensor mats for a chair in two wards across Older Persons Health that connects to the bell system. Initial feedback is positive. Patients are being admitted to the pod where the night staff sit so that new patients can be monitored more closely on their first night within the service where a falls risk is identified. There are now three meal break times allocated in each ward resulting in only two staff away at any one time, leaving more staff on the ward to supervise and help patients.
- Intentional Rounding education has been completed in all wards. All wards are now embedding this into their practice on all shifts.
- Increased focus on Pressure Injuries forms part of the intentional ward rounds process. This is asking patients about their positioning and levels of comfort, with the plan to see a reduction in pressure injuries. Initial indications are that this is having an impact.
- The Safe Recovery Program has been extended until the end of November. The pilot of the Safe Recovery program has been ongoing at Burwood Hospital for three months on four of the Older Persons' Health Rehabilitation wards. The goal of this evidence based intervention is to reduce the rate of patient falls during their rehabilitation and their subsequent injuries. The program is currently delivered to patients that are over 65 years of age, are mobile and have intact cognition suitable for the education. They are shown a video on an iPad, go

through a written booklet and guided through a discussion to identify patient-centred goals they can follow to reduce their risk. We have four retired nursing volunteers who are also providing the education, hoping to draw on some of their clinical and personal experiences as well as peer support for our patients. At the time of writing, there have been 203 unique patients provided with the education of which half has been given by the volunteers.

IMPROVING FLOW IN OUR HOSPITALS

Christchurch Campus

- **General Medicine continuing to improve the way it provides care:** The number of patients cared for in hospital by the General Medicine service continues to grow with close to 15,200 patients in the 12 months to the end of October 2018. As a result the number of patients in hospital at any one time continues to challenge the service, with maximum occupancy regularly reaching over 160 patients during the winter. Despite this, the length of patient stay has been slightly lower than in the previous year, which has allowed the service to accommodate the higher level of activity. The service is working with nursing leaders to plan for appropriate beds following the opening of Christchurch Hospital Hagley.
- A restorative model of care is being rolled out across medical wards following a trial in Ward 23. This will help people sustain and regain as much of their function as possible, with an aim of a quicker return to previous functional levels and a quicker discharge from medical care. An Ambulatory care pathway has been instigated, this allows for urgent, intensive investigation and care for a cohort of patients in the Acute Medical Assessment Unit without any requirement for hospital admission.
- **Streamlining the Vascular Ward Round - A Time-Out Structure:** Ward rounds enable clinicians to gather information, sharing it with one another and the patient. The way that surgical ward rounds are conducted can impact patient outcomes as well as patient and staff satisfaction. Introduction of a formalised routine has been trialled recently for vascular ward rounds in order to improve workflow, hand hygiene, and communication, ensuring the patient has a voice while not increasing administrative time. The model developed is loosely based on the World Health Organisation Surgical Safety Checklist and has had input from nursing staff, consultants, Resident Medical Officer, and Multidisciplinary Team members. Use of the new routine continues, based on encouraging results from audit of the trial. Improvements in hand hygiene and staff satisfaction provide a strong argument for its continued utilisation.
- **Community Infusion Centres releasing Medical Day Unit capacity:** An update in mid-2018 provided information about the launch of a community based infusion service, carrying out tasks previously occurred in the Medical Day Unit at Christchurch Hospital. Demand in this area will continue to increase, driven by improved clinical capability, a growing population and decisions made to fund drugs that require infusion services some of which are complex in nature. Community based infusions are being provided from Helios Integrative Medical Centre in Opawa and the Linwood Medical Centre. The first group of 15 people benefitting from this model require regular blood transfusions, and are otherwise medically stable. The referral process is now documented in Hospital Health Pathways. The Clinical Nurse Specialist in Haematology makes the necessary arrangements including arranging for the transfusion to be prescribed, seeking a scheduled time at the infusion centre and sending the appointment out. Work towards providing General Practitioner requested transfusions at the community infusion centres is ongoing. This change alone has released around 35 hours per month worth of capacity for other patients in the Medical Day Unit.

- The next area of work under development sees the Medical Day Unit, Infusion Centres, Neurology and Immunology working together so that people receiving regular, usually monthly, infusion of Intragam P will receive this service at the Infusion Centres. The initial cohort of six patients will soon begin receiving their services in the infusion centre, releasing a total of around 24 hours a month for other services in the Medical Day Unit. Our aims is to continue to develop this service for infusions that can safely be provided in the community, releasing time for the increases in demand faced by the Medical Day Unit. Patients report appreciating the new service, finding that they receive the care they would have in the hospital but it is in a quiet environment with easy access to transport routes and easy parking.

Older Persons Health & Rehabilitation (OPH&R)

- Older Persons Health have been reviewing the data from the clinical nurse specialist (CNS) role based at Christchurch campus. Since its pilot and subsequent confirmation of the importance and contribution to flow we have seen changes in the way in which we ensure timely transfer of care between the two sites. The role's key function is to ensure timely assessment with referral and pulling of patients into the Older Person's service. Since this began in July 2017 3028 patients have been through this service. Of this 1,772 general medicine (and associated speciality) patients 327 were seen solely by a consultant (some of these patients were assigned to teams with a geriatrician in 2017). In 2018 81.5% of consults are now seen by the CNS role. The benefits are both a reduction in the time for assessment following referral and a reduction in the time on the waiting list once accepted for transfer. The average length of time on the waitlist has reduced from 2 days in 2017, to 1.59 days in 2018.
- Other benefits seen include:
  - other patients being identified before formal referral therefore reducing waste in referral
  - single point of contact for staff at Christchurch – particularly junior medical staff
  - improved communication between sites
  - updated information for Christchurch about likely date of transfer through updates made on Floview
  - thorough assessment of patients prior to transfer
  - reduction in patients transferring when not well enough
  - reduction in patients transferring who don't need inpatient rehabilitation
  - monitoring of patients while on waitlist and assessed for alternative pathways if condition changes
  - early review of patients well known to OPH and discussion with OPH teams about appropriateness of another inpatient rehab stay
  - early information for Burwood wards about patients with particular requirements
  - released SMO time

REDUCING THE TIME PEOPLE SPEND WAITING

Christchurch Campus

- **Faster Cancer Treatment Targets: 62 Day Target:** For the three months of August, September and October 2018 Canterbury District Health Board submitted 163 records to the Ministry with 23 missing the 62 days target. Of these 18 missed the target through patient choice or clinical reasons meaning five of the remaining 145 patients missed the target due to capacity or scheduling issues. Canterbury District Health Board once again met the target of

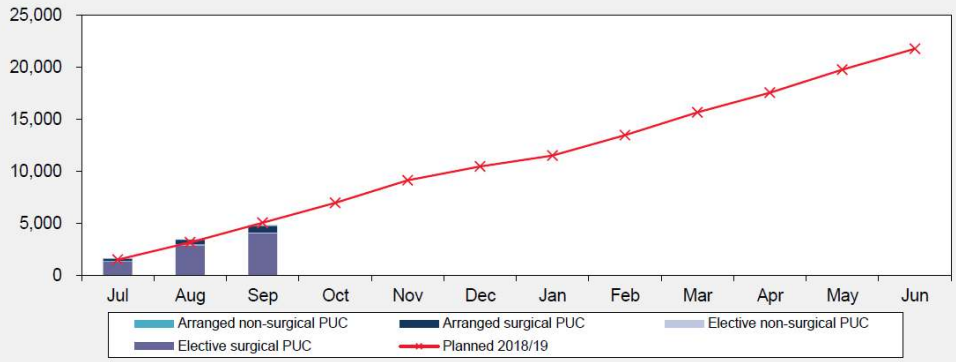
having at least 90% of patients receive their first treatment within 62 days of referral with 96.6 % of eligible patients being treated within 62 days.

- **31 Day Performance Measure:** CDHB submitted 387 records towards the 31 day measure in the same three-month period. Unlike the 62 days target all reasons for missing the target are included: there are no exceptions made for patient choice or clinical considerations but the threshold remains at 85%. 345 eligible patients (89.1%) received their first treatment within 31 days from a decision to treat, meeting the 85% target.

- **Elective Services Discharges**

Elective Surgical Discharges ▼ 95.5%

	2018						2019					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	1,520	3,182	5,065	6,985	9,132	10,470	11,532	13,474	15,676	17,548	19,773	21,782
Actual	1,616	3,463	4,837									
Variance	96	281	-228									
%Achievement	106%	109%	95%									



- A phased plan for provision of the 21,782 elective surgical discharges to be delivered in 2018/19 has been agreed with the Ministry of Health. Increased volumes will generally be achieved through increases in outsourced and outplaced operating and are focussed on Ear, Nose and Throat and Plastic Surgery. The increase in Ear, Nose and Throat outplaced theatre capacity is a part of its transition towards the capacity that will be available when the new theatre capacity within Christchurch Hospital Hagley opens.

- **Improved collaborative care model for children with complex needs:** An earlier update covered the initial development of a collaborative care approach by the children's outreach and Daystay nurses. This has now been adopted as the usual way of working in the Paediatric Outpatient Department, for children who have complex care requirements. Children with the most complex healthcare needs often need to visit many healthcare and educational professionals on a regular basis. This is disruptive for them and their whānau, making it difficult to develop a routine that supports their ongoing development and education. Initially this approach involved developing an "ecomap" using the Whare Tapa Wha model of health to assess the whānau environment, strengths, stressors, sources of support and social, cultural and spiritual reality. The Outreach or Daystay nurse then worked together with the whānau, schools, health care professionals and other support agencies to "collate" their appointments and improve communication and documentation between services. This enables the whānau and the wider team to think together about solutions to the challenges being faced, thus minimising the number of appointments and disruptions to the whānau routine.

- The patient's support networks are mapped to ensure that there is a good understanding of the social environment around the patient. A whānau care plan is generated, providing an integrated snapshot of decisions agreed at a meeting between the whānau and wider

healthcare and education team and other support agencies. This approach has made a huge improvement for patients and their whanau. This approach continues to develop. Over the past year the group of providers involved in this work has expanded, and has begun taking a collaborative approach, similar to that seen in Service Level Alliances, to design the way that we serve our patients. Primary care, schools, adult services, hospital and community allied health, nursing and senior medical officers from secondary care, Māori support worker, primary care workers, Youth Advisory and Child Health Advisory Council reps, have been involved. This allows a broad based approach with the entire team committed to thinking together about the way to best support our children and whānau. A structured approach is taken to make positive changes in areas that will make a difference for whanau. This year's focus has been on the way we support patients to shift from children's to adult services, which often involves a transition from Secondary to Primary based services. This is resulting in better communication between health providers and also between health providers, patients and whānau. General Practice will now be engaged throughout the transition process. The approach that has been developed sets people and providers up to have the best chance at successful transition.

- **The way we work in the new Outpatients' building:** The Outpatients' building had been designed with a focus on having a "long life, loose fit" so that the range of health services provided from it can change over time without compromising those services. Merely shifting into this space, continuing to do things the way that we always had would have squandered the opportunities provided by the building's design. Deliberate choices were made to agree changes that would impact on multiple services in order to deliver the right outcomes. Care has been taken to ensure that teams are allocated space on the floors in a way that makes for the best clinical and operational workflows. A collaborative approach has been taken, this was initiated through a series of five workshops at the design lab, followed by a series of working groups considering various aspects of the way that we work. Principles were developed collaboratively by the Campus Outpatient and Ambulatory Services Team (COAST) that have subsequently directed plans about how we would work together. For example we no longer have any pure receptionist roles in the Outpatients' building. We now have a generic Administrator roles that encompass reception and booking duties. This approach highly values the customer service requirements inherent in all administrative tasks and enables provision of additional value at the front desk as every enquiry is addressed by somebody that can make bookings. This provides a productive, responsive environment that is patient centric. Lessons have been learned from this planning work that will inform our transition to Christchurch Hospital Hagley. Work continues to occur in specific areas that patient and clinician experience can be improved.

- **Collaboration produces highly effective x-ray simulation panel:** Manawa, the health research and education facility, is a collaboration between Christchurch's health and tertiary education sectors, bringing together the Canterbury District Health Board (Canterbury DHB), Ara and University of Canterbury (UC) to help create and train the health workforce. The simulation floor at Manawa enables large-scale simulations in real world healthcare environments and access to advanced clinical equipment that students would normally only see during placements. The Medical Imaging area needed a fully functioning X-ray control panel. The Bioengineering department at Christchurch Hospital, in collaboration with staff from Ara Institute of Canterbury (Ara) to develop a simulated X-ray control panel that looks and acts like the real thing at a fraction of the price. This is now used by radiology students to practice their X-ray technique in a safe, radiation-free environment. This simulator was created from an Android tablet, some skilled wood carving, grey paint, an old bedside hospital locker, and a good dose of clever software engineering.

Real X-ray control panel

Simulated X-ray control panel

- **Blood Borne Virus and STI screening at Christchurch Men's:** In 2018 the Christchurch Prison's Health Service has been supported to conduct a site wide screen for blood borne viruses and sexually transmitted infections. Specialist staff from the Sexual Health Service and Infectious Diseases Department have had two highly successful visits already, with fantastic uptake by prisoners and support from Department of Corrections' staff. These clinics provide an opportunity to carry out screening for Hepatitis B and C, HIV and Syphilis, and other diseases. The focus has been on education and prevention as well as detection and treatment in this vulnerable population. This has required the services to work together closely to explore and resolve numerous operational and logistical issues with a shared goal of improving the health of this group of men along with those that they have contact with both while imprisoned and when they return to the community. The Corrections Health Service has noted its appreciation of the efforts made to run this busy clinic specifically noting the team's personal qualities, combined clinical strengths and ability to engage with the men with openness and unfailing good humour.

- **Bronchoscopy emergencies training:** Bronchoscopy is an endoscopic technique used to visualise the inside of the airways. Procedural risks are small, but include major bleeding, pneumothorax and respiratory depression. There is evidence that simulation is an effective training method for emergency situations that may arise during bronchoscopy. In Christchurch Hospital we had no routine training for emergency situations that may arise during bronchoscopy. This was identified by the as a significant clinical risk and there was broad support from medical and nursing staff within the department for training to occur. Three clinical scenarios were created and run covering hypoxia, bleeding and pneumothorax.

- A number of changes were made to our processes as a result of the simulation sessions, including standardising emergency equipment and purchasing a longer 'bronchial blocker' to assist with controlling major bleeding. These sessions will continue to be run and have contributed to the ongoing provision of safe care to people being undergoing this procedure.

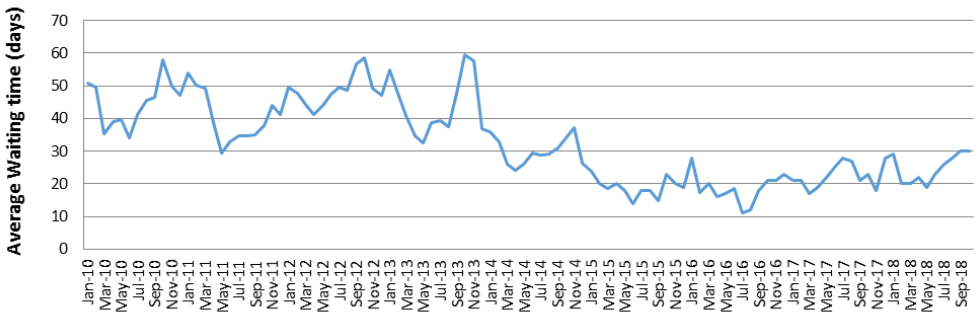
- **Christchurch Hospital involved in the worldwide launch of a new cannula:** Peripheral intravenous cannulae are, at first view, an apparently simple piece of technology used to provide administration of intravenous fluids, medication and blood products. They are the most prevalent medical device used in the healthcare setting. It is estimated that over half of all patients admitted to hospital have a cannula inserted. A new product, the Cathena™ safety IV Cannula, has been designed by Becton Dickinson and builds on existing improvements that make it easier to locate the cannula in a vein through the triple flash system increasing placement success. Additional technology ensures healthcare practitioners are protected from needle-stick injuries and occupational blood exposure through a unique multiguard technology that contains blood spill on insertion and access into a vein. The cannula has power injection capabilities which is essential for acute care settings.

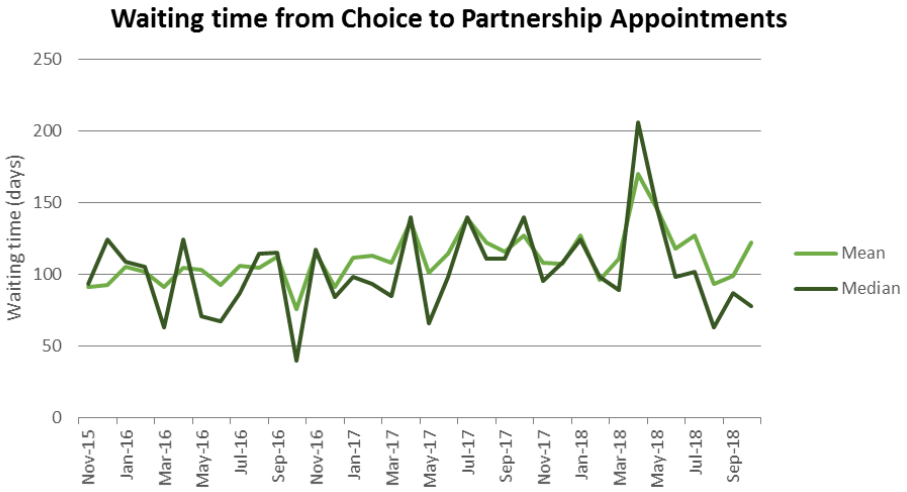
- Canterbury has been a pilot site for the rollout of this new cannula, and our feedback has been used to improve the product further. The trial was so successful that we are rolling out this cannula across Canterbury District Health Board over the coming months. In addition Southern District Health Board has also decided to use this cannula based on our trial feedback. Becton Dickinson is supporting the training we are putting in place for our staff through the provision of free cannulae and use of a simulator arm. Not only is this cannula better, making the process more comfortable for patients and safer for staff, but it saves us money. Canterbury District Health Board uses 203,000 cannulae a year. We are paying $5 less per box of 50 compared with the old product, a saving of over $20,000 per year.

Specialist Mental Health Services (SMHS)

- **Demand for Specialist Mental Health Services**: We continue to closely monitor use of Mental Health Services. Our staff are working exceptionally hard to provide the best care possible in some very challenging circumstances and we are continuously looking for ways to make the environment as safe as possible for consumers and staff.
- Data for the full month of November 2018 is not yet available, but occupancy of the **adult acute inpatient service** to 26 November was 97% High occupancy is unsustainable and increases risks of harm to patients and staff. The Te Awakura building poses a number of challenges that limit our ability to care for acutely unwell people in a contemporary way. Our staff are doing an incredible job in very challenging circumstances. Planning and Funding are leading the development of a community service that will provide an 8 bed alternative to an acute inpatient admission which is anticipated to open early to mid-2019.
- **Least restrictive practice** Seclusion use in Te Awakura for November is projected to be less than recent months. As at 26 November 2018, four consumers had been secluded for a total of 138 hours.
- **Child, Adolescent and Family (CAF):** Data for November 2018 is not yet available. There are ongoing challenges with reducing the wait times while at the same time continuing to receive high numbers of referrals (averaging 63 per week). We are working on improving health pathways and responsiveness to young people with Attention Deficit Hyperactivity Disorder (ADHD).

Average Time (days) from Referral to Case Start for Child, Adolescent & Family Mental Health Service

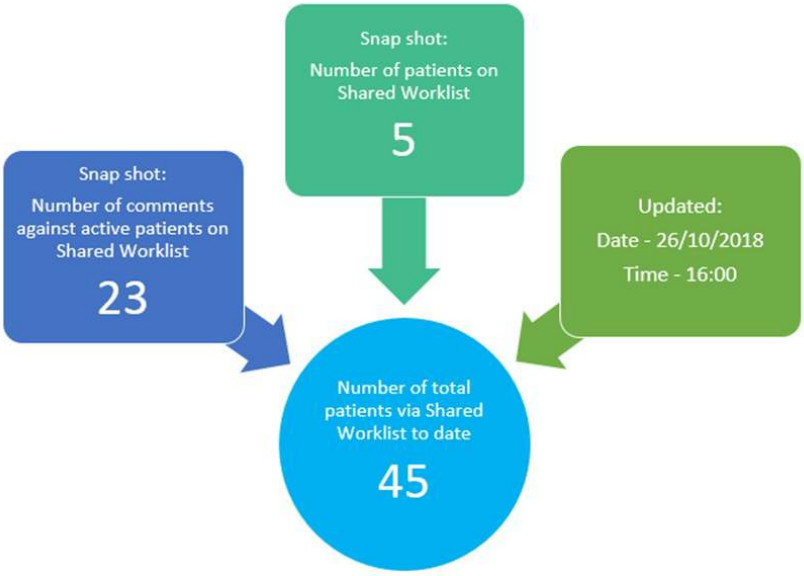




- Child, Adolescent and Family Services have applied a comprehensive approach to managing the waitlist. There have been multiple streams of clinician contact, with an increased capacity to take on new partnership appointments. This, combined with the provision of alternate treatment pathways for consumers has resulted in a marked increase in reported waiting time (as shown in the graph above) for partnership appointments.
- **The Schools based mental health team** continues to be approached by new schools across Canterbury requesting engagement. The team responds to each request and provides an individualised approach for each school. The team is currently engaged with 166 schools across the region with 2 additional schools in the early stages of engagement. The team continues to attend regular pastoral care meetings in many schools, and participates in Rock On meetings at which attendance issues are discussed. Networking and fostering strong relationships across schools and with the Ministry of Education remains a major function.
- **Mana Ake** - The SBMHT Clinical Manager has met with the Clinical lead and 3 of the Team leads from Mana Ake. A further meeting has been scheduled for December with SBMHT staff to discuss how the two services can work more collaboratively to support schools in the region. Individual staff continue to build and develop relationships with the various Mana Ake workers in their respective schools.

Older Persons Health & Rehabilitation (OPH&R)

- **Adult Rehabilitation project:** Transition of care work stream – we have commenced the use of the Collaborate shared work lists between two wards at Christchurch Hospital and Ward CG – Brain Injury service. This is used to provide an electronic record of transfer of care discussion for patients between the two services. This ensures that there is transparency of information which can be easily updated by each service. The Clinical teams are finding it extremely useful to have the transfer information all in one place and the history of conversations maintained. We are currently assessing which additional services and areas will move onto this platform next.
- Transfer of Care meetings have also commenced to support referrals on the adult rehab pathway – focusing on the complex patients. There are clinical representatives from the services based at Burwood Hospital – Older Persons Health, Brain Injury, Spinal, and other services as required to facilitate transfers to the most appropriate Ward/ Service based on the clinical requirements of the patient. This provides a point of entry into rehabilitation services and reduces the multiple referrals which have happened historically. It also provides wider Clinical support for these complex patients who often require input across multiple services.



- **Older Persons Health Inpatient Wards:** Two Wards have commenced a trial of the Purpose T Clinical Pathway. This Clinical pathway aims to enable earlier detection of pressure risk patients and improve our management of these patients to reduce pressure injuries. The trial was successful and the pathway will be rolled out to the other Older Persons Health Wards in the coming weeks.
- **Outpatients:** There has been a focused piece of work on Outpatients for Older Persons Health. This has resulted in consistency of process for all patients across the service and reduced waiting times with all patients now being seen within triage category recommended timeframes.
- **Community Dental Service:** As part of national oral health day (2 November 2018) we asked everyone to swap their sugary drinks and give water a go for 30 days in November. Supported by a New Zealand Pole Vaulter a significant emphasis was placed this year to increase awareness of the impact of sugar. The service has completed an Engagement: Survey of schools with a 60% response rate. The survey has provided some positive feedback for the Service but also some areas for improvement which will be developed into an action plan for 2019.

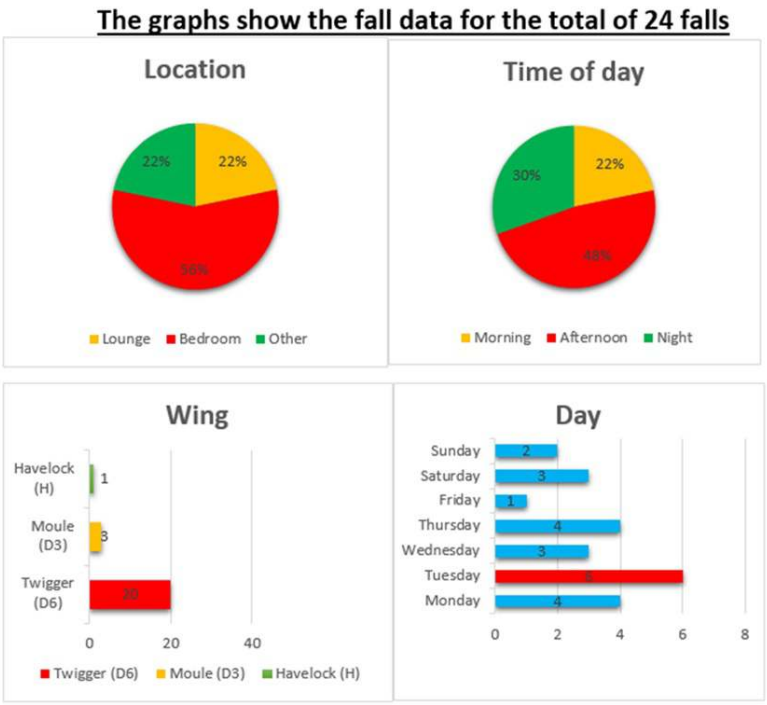
Ashburton Health Services

- **Ward 2 physical move complete – model of care work new focus:** Ward 2 (previously known as Ward 6) is settling into their refurbished physical space. Whilst the ward layout is not significantly different from the previous area, the various spaces designated for rehabilitation do require some changes in the way the teams are working. After the physical move we have partnered with the Releasing Time to Care team to explore further opportunities to work as a team with the nursing, hospital aid and allied health workforce involved in the ward. Janette Balfe, Clinical Manager Allied Health and Diana Kerr, Charge Nurse manager are partnering to lead the team into developing a new sustainable model of care, working with the local ward team and looking towards opportunities of improved partnership across the hospital.
- **Older Persons Health Meeting in Ashburton:** The group agreed the following key areas to start focusing our Service Improvement Project:
  - Overall, seeing more patients at an earlier stage rather than waiting until they are at a high risk stage is the priority.

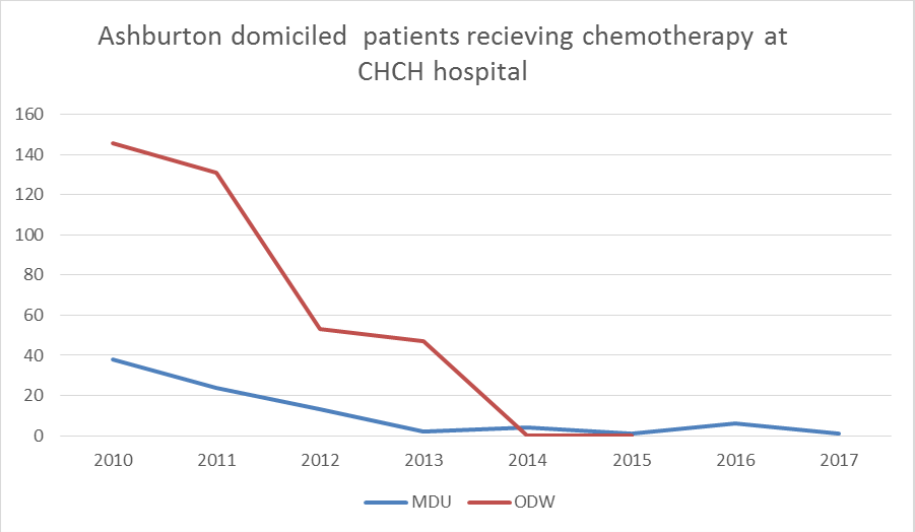
- Establish an Interdisciplinary Team Meeting with all stakeholder present is a priority. This group will undertake case reviews, taking a holistic approach to integrate all services rather than just thinking hospital based. Alongside individual case reviews the group will be supported to develop a work plan of key activities, noting that a key priority is reviewing/establishing localised health pathways for primary care
- A key principle that will guide our work is "localising without isolating". It is important to focus on an improved connection to specialist and acute services in Christchurch.
- We do not limited rehabilitation to bed capacity in Ward 2, we can start in Ward one and manage the beds collectively as a hospital
- Overall filling knowledge gaps where possible by working as a shared team.
- Look for opportunities to build local knowledge and response, especially local support for ARC facilities that can occur more frequently.

- Of equal attention for frail elderly in Ashburton is the prevention and response to falls. The Ashburton Event Review Committee (ERC) meeting in October discussed in detail the increasing falls rate in Tuarangi facility. As an aged residential care facility, the cohort of residents provides a different challenge for ongoing care provision than an acute medical or Assessment, treatment and rehabilitation ward. Tabled below is the review of falls for the month of October, as we seek to find the key drivers for falls. The outcome and recommendation from this recent work is the notable gap in medication reviews for our residents. Work has been immediately put in place to support the pharmacy team undertake medication reviews for these residents, evidence from other areas in New Zealand has indicated this action can drop falls dramatically. The Canterbury DHB Falls Committee has an excellent programme of work for the inpatient setting, however we are exploring the opportunity to connect with our local Aged Residential Care Facilities (ARC) and implement a falls committee focused specifically in this environment. The shared learning of medication reviews or other work can be built into our Frail Elderly patient journey with primary care and pharmacy support.

- **Tuarangi Aged Residential Care Falls Rate – October 2018**



- **Ashburton Hospital Oncology Service Delivery**: In September Jane Wright, Clinical Nurse Specialist (CNS) and Professor Bridget Robinson, Medical Oncologist completed a service review and clinical audit of services provided through Ashburton Hospital. This report has highlighted opportunities for service in Ashburton to connect with the services in Christchurch further, building on the model currently delivered for Endoscopy where nursing staff regularly participate in service delivery and developments with their Tertiary Service colleagues. The graph below shows a steady decline in Ashburton patients travelling to Christchurch for chemotherapy. The data source was provided by decision support reviewing appointments from the CONDW and CONMJ code.



- Ashburton Hospital is now able to offer a wide range of chemotherapy treatments. Treatments are given in a dedicated medical day stay (MDS) suite comprising of six chairs and two beds on Tues/Wed/Thurs 08.30-1700 each week. There are currently five registered nurses who are chemotherapy certified who also work in other areas of the hospital. These services are given in conjunction with other medical day stay procedures e.g. trial of voids, blood transfusions, bisphosphonate therapy, iron infusions and biotherapy for other disorders.

- There are many strengths to the current service model and opportunities to explore further expansion. Patients continue to express a high level of satisfaction of care and remain grateful for the opportunity to have their care provided locally, ie chemotherapy, imaging, follow up. The decrease in numbers of patients requiring care at Christchurch Hospital enables less disruption for patients, greater opportunities for whanau involvement and decreased costs associated with travel and time away from employment.

- There are a number of detailed recommendations to investigate further, including how Ashburton Health services can expand the nursing workforce delivering specialist services in the unit and work in partnership with primary care regarding the administration of other products ie bisphosphonates and iron infusions, thus releasing capacity in the hospital team. The general recommendation from this review is that with adequate resources patient's residing south of Rolleston and Darfield South could be offered the option of receiving treatment at Ashburton Hospital. Benefits of this would be parking and reduce numbers attending a stretched oncology day ward.

Laboratory Services

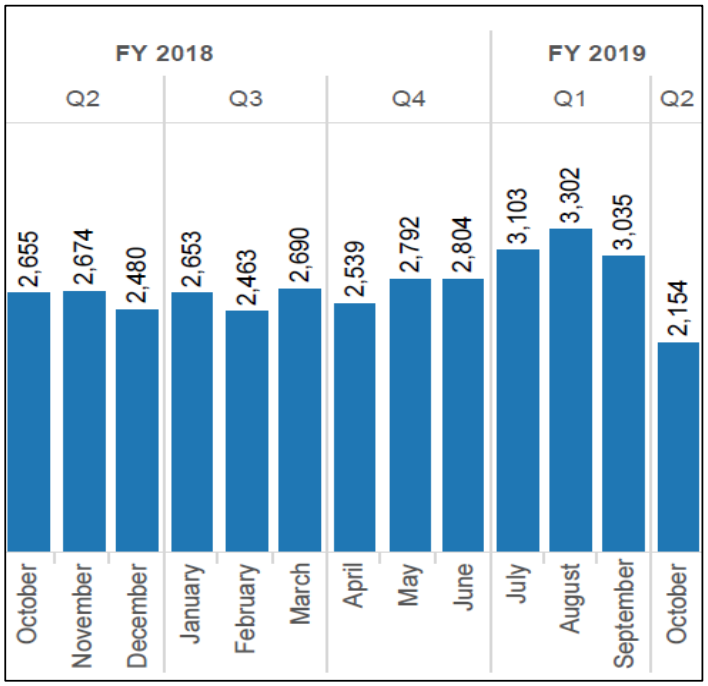
- **World Health Organisation Joint External Evaluation visit**: The NZ Ministry of Health has agreed to undergo a Joint External Evaluation by a WHO team. This process is voluntary for WHO member states and is part of the work on implementing the International Health Regulations and establishing national public health capacities. The aim of this evaluation was to determine if participating countries have core public health capacities and abilities to detect, assess, notify and report promptly and effectively to public health risks and public health emergencies of international concern. There are 19 technical domains in the evaluation covering areas such as border control, emergency response, surveillance and laboratory capacity. The evaluation team was visiting NZ for one week in November. CHL is the WHO accredited National Measles and Rubella Laboratory and therefore a delegation of eight WHO representatives from the Netherlands, from the WHO Western Pacific Office in Manila/Philippines, from the Fiji Department of Health and from Western Australia as well as two observers (the head of the Emergency Preparedness for Jamaica and the Health Protection Manager from Cook Islands Department of Health) plus three officials from the NZ Ministry of Health visited the laboratory on the 27th of November. The team also had a chance to visit our PC3 laboratory, which is currently used for Tuberculosis multidrug resistance testing, but can also be utilized for any high-risk outbreak diagnostic purpose. The evaluation team was impressed by the technical diagnostic capacities of the National Measles and Rubella Laboratory and CHL and the visit to the PC3 lab. They also commented positively on the good collaboration of our lab with public health, other NZ labs and national surveillance institutions. The final evaluation report will be presented to the NZ Ministry of Health in the New Year.

- **Appointment of Dr Leslie Anderson:** An offer of employment to the position of Medical Specialist, Forensic Pathology and Coronial Service, Canterbury Health Laboratories, Canterbury District Health Board has been accepted by Dr Leslie Anderson effective from 10 June 2019. Dr Anderson had been accepted for a Forensic Pathology Fellowship at the San Diego Medical Examiner's Office which she will complete in June 2019. Dr Anderson completed her Anatomical Pathology Residency at the University of Manitoba June 2018 and completed her Medical Council of Canada Qualifying Examinations in October 2014. Dr Anderson will be moving to New Zealand with her husband and young son.

- **Exam Success:** Canterbury Health Laboratories would like to congratulate our two Anatomical Pathology Registrars and Microbiology Senior Registrar on their recent success in their Part II oral exams. Dr Julia Howard will have completed her training time by the end of 2018, ready to become a fellow of the RCPA. Dr Teresa Bailey is now eligible for Fellowship and Dr Annie Jo will complete her training within the next few months, ready for Fellowship.

INTEGRATING THE CANTERBURY HEALTH SYSTEM

Acute Demand Management



Transition to South Island PICs continues to provide data issues, however these are being worked through and some near real-time dashboards are live again. The winter peak was very close to our forecasts, however the environment remains dynamic. A number of plans appear to have worked and we will continue to refine these. For example the general practice voucher for people being discharged has been successful but a number of improvements will be incorporated into future initiatives. The Acute Demand Management Service continues to provide the backbone of our efforts to keep people well and in their own homes. The winter peak has fallen since the arrival of warmer weather.

SUPPORTING OUR VULNERABLE POPULATIONS

Older Persons' Health

- **Carer support:** There have been some interesting developments nationwide in the area of Carer Support. Carer Support payments are made where the informal or family carer of a person is experiencing Carer Stress – the objective is that this money can be used to allow the carer to take a break. Traditionally, the rules around this payment have been onerous, resulting in the Canterbury DHB spending under budget, and people being allocated this expenditure finding it difficult to use. While this in the first instance represents a saving, it means that the use of Carer Support has not fulfilled its optimal purpose, which is to provide carer relief, and reduce premature entry into Aged Residential Care.
- The Ministry of Health will be implementing significant changes to the delivery of Carer Support packages for people with disabilities from 2019. The new "I Choose" or "flexible respite budget" system will allow once or twice yearly cash payments to be made into the bank account of families, to purchase any respite or support services desired. This represents a significant change towards flexibility and ease of uptake. The Ministry is encouraging DHBs to similarly review the ways in which Carer Support is allocated and implemented for older people and people with long term conditions. The Health of Older People workstream has brought together a working group to review the way our Carer Support is allocated and administered, with the expectation of writing a paper with recommendations to leadership. A more flexible approach to Carer Support may be a very valuable development in supporting people who care for their loved ones and help keep those people at home for longer.

Mental Health

- **Mental Health Inquiry:** The mental health inquiry report was made available on Tuesday 4th December. The Minister has a signaled a response to the recommendations by March. It is a 200 page report but initial assessment reinforces much of our direction of strengthening primary and community responsiveness to provide more early intervention and prevent the development of serious mental illness and addiction. Early in 2019 the Mental Health Workstream will consider the implications of the report and prioritise actions for 2019.
- **Child, Adolescent and Family Services (CAFS):** Integration is a key focus for Child Adolescent and Family Services. Centralised pathways are being developed to streamline access to the right response and reduce wait times. Community based services for children needing intensive intervention are being expanded to provide more options, particularly in rural areas.
- **Suicide Prevention:** A newly developed governance structure has been established to include participation wider than just health. This participation includes the Ministry of Education, NZ Police, the Department of Corrections, Oranga Tamariki, the Ministry of Social Development, and others. This will support a whole of system coordinated approach to prevention and postvention activities.
- **Mana Ake – Stronger for Tomorrow:** Mana Ake currently has more than 40 kaimahi (workers) operating in 98 schools in 12 clusters from North Canterbury to Selwyn. The team is currently focused on preparing for the induction of the next phase of Kaimahi due to commence on 21 January, for 20 new FTE. More than 500 tamariki have engaged with the kaimahi. As well as this work we are:
  - developing an approach for induction of Cluster Leads (Kaiarahi);
  - organising a forum scheduled for 18 December for kaimahi, providers, and the SLA to engage with, inform and learn from each other;
  - Building our reporting capacity from our Client Management System (Paua);
  - Ensuring Leading Lights will be available for all schools in Canterbury from the end of December; and
  - Developing a strategy to support teachers to engage with Leading Lights.

Primary Care

- **Free care for under 14s:** All children under 14 years in Canterbury now have access to free primary care with their regular general practice, and after-hours at certain urgent care clinics. Prescription medicines for children under 14 years are also free of the normal $5 co-payment at the pharmacy. This is an extension of free access to 13 years olds that has been available for 5 years.
- Also, 77% of Canterbury's general practices have agreed to charge lower fees for seeing a doctor or nurse for patients enrolled with the practice and who hold a Community Services Card (no more than $12.50 for 14-17 year olds, and no more than $18.50 for people 18 years and older). More practices are expected to join this extended access programme from April. Awareness of these changes is being promoted by practices and by the DHB through its website and social media.

Maori and Pacific Health

- **Registered Nurse from Tangata Atumotu Trust scholarship recipient:** Our Pasifika provider, Tangata Atumotu Trust is very excited and proud of one of their nurses, Lisa Suapopo, who has recently been granted an Aniva Scholarship to advance her nursing studies to Postgraduate level. Aniva is a leadership programme for Pacific health and disability

professionals. The programme offers a Pacific-tailored postgraduate qualification up to Masters-level. The Aniva programme will equip Suapopo with the qualifications, skills and knowledge to take up leadership roles within the health sector and further advocate on behalf of Pasifika communities.

- Tangata Atumotu Trust is a small Pasifika Provider where Suapopo works providing mobile nursing services to the Pasifika community.
- **Kaupapa Māori & Pacific NGO Collective (The Māui Collective):** The Māui Collective, comprising of Māori and Pasifika health providers within Canterbury DHB have been growing their own skills and knowledge through their inaugural "Te Matau a Māui" Workforce Series. The series of workforce development days has been supported by the Canterbury DHB with funding and run by our local providers supported by Manawhenua Ki Waitaha. The Te Matau o Māui, Māori Workforce Development Wānanga have been an enormous success. The series is currently still in the middle of the three individual days. There are three specific skill areas identified by the Māui Collective to focus on and develop both collectively and individually:
  - cultural competency
  - supervision (developing the skills as well as receiving the support)
  - evaluation
- 150 whānau attended the first two days. It is hoped to make this an annual event.

Promotion of Healthy Environments & Lifestyles

- ***All Right?*** **social marketing campaign update**
- **Research with Rainbow communities** - research currently in the field is focused on the LGBTQIA+ (Rainbow) communities of Otautahi. Five focus groups have been held with the outcomes from these are being used to identify questions for a quantitative survey which will be launched in mid-November. Very little research has been carried out with these communities in Aotearoa so we hope that this work will contribute to the national wellbeing picture of this highly diverse community. The aims of this research, as with previous research, are to take the pulse of Rainbow communities and gather some information about the usefulness of the Campaign for Rainbow community members. The survey will be in the field for three weeks after which it will be analysed, with a final report comprising the qualitative and quantitative research completed by mid-January.
- **Summer Campaign** - December and January will see the roll out of our summer campaign which will focus on the celebration of 'moments that matter'. The imagery will again be photography-based and will appear on posters, bus backs and corflutes around the city. The rationale for the campaign lies in the pressures and stress experienced by many people at Christmas time. To help mitigate this our campaign will focus on whanau friends and the fact that when we reminisce, it's not the fancy gifts or expensive holiday we remember, but the ordinary times with our friends and family.
- **Workplace Wellbeing** - we have continued our focus on workplace wellbeing which includes running workshops, and continuing to add information and resources including case studies and evidence based material about the benefits of a mental health promoting workplace, to the *All Right?* at Work web page. Posters for workplaces have been produced to support this work. These will be available through CPH's resource centre once printed (see examples below).

- The campaign presented a poster at the recent Earthquake Recovery Symposium. We continue to have conversations with officials from the Ministries of Health and Education about the future development of the campaign as a whole, and Sparklers in particular.

- **Canterbury Wellbeing Index for 2018 launched:** The Canterbury Wellbeing Index for 2018 was officially launched at a Healthy Greater Christchurch seminar on 28 November 2018. The Index brings together high-quality information about community wellbeing in Christchurch City, Selwyn District and Waimakariri District in a new on-line format. As well as drawing from the data of many different local and national agencies, the Index incorporates information from the 2018 Canterbury Wellbeing Survey which was completed by nearly 3,000 randomly selected greater Christchurch residents in April and May 2018. There are three parts to the Index:
  - 'Our Wellbeing' has 56 indicators covering a diverse range of domains including subjective wellbeing, education, housing, health and employment
  - 'He Tohu Ora' is a set of 19 Māori-focused wellbeing indicators informed by a Māori worldview that has been developed in consultation with Ngāi Tahu and Te Pūtahitanga
  - 'Our Population' describes the population of greater Christchurch in ten indicators.
- The online Index enables users to extract the information they are interested in. It is available at www.canterburywellbeing.org.nz. The Index was signed off by the Greater Christchurch Psychosocial Governance Group and the Canterbury District Health Board Executive Management Team and key content has also been shared with the Greater Christchurch Partnership and the Greater Christchurch Psychosocial Committee. Local decision-makers are being encouraged to explore the data and use it to inform and focus their activities to positively influence the wellbeing of the local population. The eleventh Canterbury Wellbeing

Survey was released at the same time as the Index and is available on the Community and Public Health website.

- **Sun safety health promotion in Early Childhood Education settings:** Earlier this year Community and Public Health's Early Childhood Health Promoter and staff from the Cancer Society teamed up to talk with 26 Early Childhood Education teachers about their sun protection practices – to establish what was working well and what support they would value. 'Equity-funded' preschools were prioritised, together with a selection of others.

- All settings had sun protection policies, all spoke of providing spare hats, 96% used a broad spectrum SPF 30+ sunscreen and ECE managers self-reported that 96% of staff model sun protective behaviour very well. Affordability of resources was highlighted by these educators who believed that the expense of sunscreen was a barrier to many families. All participating settings were provided with a 'sun protection information resource pack' (including bilingual resources), a large story book, stickers, and information snippets. A report of this work is being finalised, and communications will likely include a call for funding support for access to sunscreen, hats, and shade cloth. New Zealand, along with Australia, have the highest rates of melanoma in the world, and there is a need to further raise awareness of the need for sun protection amongst the public.

- **Workplaces Health Promotion:** One of Community and Public Health's two Ashburton-based Health Promoters has focused on supporting workplaces to sign-up to, and implement, the WorkWell programme. Ashburton Contracting Ltd (ACL*) a major employer in the Ashburton district has become the first company in Ashburton to achieve the WorkWell Bronze Accreditation award through creating a happier, healthier and more productive workplace. The WorkWell programme provided ACL with the tools to assist in ensuring a healthy working environment for staff. ACL have already completed a smokefree challenge; supporting staff to quit smoking and supplying prizes for those who did. One staff member who quit smoking and is still smokefree was awarded a weekend in Hanmer Springs. ACL's first three priority areas are Healthy Eating, Smokefree and Mental Health. Mike King visited and spoke to staff (staff found the session thought-provoking) during Mental Health Awareness week in October. ACL will continue an organisational focus on Mental Health and plans to address Healthy Eating in the new year.

- *ACL specialise in civil contracting and construction; drainage and plumbing services; geotechnical drilling; quarry and landscaping supplies; ready mix concrete; rural contracting; surfacing; utility management; and workshop services and employ around 130 people.

SUPPORTING OUR TRANSFORMATION

Effective Information Systems

- **Projects, including facilities and redevelopment**
  - **Acute Services Building**: Progress is steady. We are working with the contractor to resolve issues with patching cables to ensure they meet the required standards in network performance. Wireless design has been peer reviewed and opportunities for improvement are being investigated.
  - **Christchurch Outpatients**: IT work largely completed to support the move. Updates to the configuration management database are underway. Kiosks are in place awaiting the South Island Patient Information Care System 18.2 upgrade.

- **Digital Transformation**
  - **Cardiac Test Repository:** Pilot in development.

- **End of Bed Chart (Clinical Cockpit)**: Project to collate information from a number of systems on a hand-held device, including Medchart, Patientrack and Éclair results. A preferred vendor has been selected, and the Business case is in progress.
- **Cortex:** Digital progress notes across Nursing, Allied Health and Doctors which will be accessible from point-of-care devices (iPads) so that the care team has immediate access to accurate information about our patients. Cortex, created by Sense Medical and co-developed by Canterbury DHB received the New Zealand Health IT Solution Innovation Award in November. This application has been trialled in Christchurch Hospital since mid-2017 and a Business Case is currently in development for broader rollout.
- **Health Connect South:** An important release was successfully delivered for the region in November which will improve the quality of service and the ability to upgrade Health Connect South in the future. It also provided improved functionality for the clinical teams across the South Island.
- **South Island Patient Information Care System (SIPICS):** Christchurch Campus and Ashburton Hospital went live on 6 October 2018. Software changes are planned for early December to enhance the end user experience and improve data quality. .

Integrated Family Health Services and Community Health Hubs

- Improving access and closer integration of health services is being pursued in several rural areas.
- **Hurunui –** Implementing recommended changes endorsed by the Board at its meeting in July is underway, including a six month trial of new collaborative urgent care after-hours arrangements by Hurunui practices and St John. Case load and management is being regularly reviewed.
- **Oxford –** the Oxford and Surrounding Area Health Services Development Group is now finalising its recommendations for the Board to consider early next year

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Communications and Engagement

- Canterbury DHB Communications have worked with a multi-disciplinary team during November to produce and distribute communications concerning the MERAS midwives' strike.
- The latest Quality Accounts edition of WellNow has now been distributed. As well as to every mailbox, it also goes to a list of around 800 stakeholders and providers and to all DHB waiting rooms.

Media

- During November there was significant interest in mental health services. We had multiple enquiries on the relocation of specialist mental health services including the detailed business case for the relocation and the current demand for services. In addition, we also responded to enquiries regarding Child, Adolescent and Family mental health and the wait times for these services.
- Some of the other topics of media interest included:
  - Synthetic drug use
  - Lime Scooter accidents

- The financials in the 2018/19 annual plan
- AT&R Unit
- Diabetes Christchurch's move out of 550 Hagley Ave
- Roll out of SI PICS
- Whooping cough cases in the Ashburton District
- Board meetings and procedures for public-excluded sessions
- Land swap for Metro Sports Facility and judicial review
- The agreement between the DHB and CCC re the Lichfield St Car Park
- Maternity Quality and Safety Programme and action plan
- Nitrate levels in Canterbury water

- Star Media filmed Clare Shepherd of the Mana Ake programme as part of a series of video stories on mental health in Canterbury.
- Radio NZ interviewed Bronwyn Dixon, Neonatal Paediatrician, about the frenotomy (tongue-tie) procedure and the work Canterbury DHB has done to significantly reduce the number of procedures performed and the benefits of this.
- The Press interviewed Dr Erik Monasterio, Clinical Director and Consultant in Forensic Psychiatry, Specialist Mental Health Services about synthetic cannabinoids and their impact on Canterbury's mental health services.
- Newstalk ZB interviewed Evon Currie, in her capacity as chair of the greater Christchurch Psychosocial Governance Group, on the latest Canterbury Wellbeing Index.
- Live radio interviews – Canterbury Mornings with Chris Lynch featured:
  - Kathy Davenport, Service Manager General Surgery and Outpatients, gave a brief overview of the new Outpatients building and an update on how the move into the new facilities was going.
  - Dr Mike Ardagh, on the Rising from the Rubble book and the health system's response to the 2011 earthquakes.

Facilities Redevelopment

- **Christchurch Outpatients**
  - Weekly videos and infosheets were produced until November 12 for staff as part of the staged moves into the building. Various follow-up messages e.g. about the correct defect reporting process were disseminated after this point.
  - Planning has begun for the building's official opening ceremony scheduled for 31 January 2019.
- **Acute Services building**
  - Work is ongoing communicating site activity related to the Acute Services build, mostly via the daily global and weekly CEO updates.
- **CEO Update stories**
  - The Medical Physics and Bioengineering department at Christchurch Hospital, in collaboration with staff from Ara Institute of Canterbury, have created a simulated X-ray control panel that students can use to practice their X-ray technique in a safe, radiation-free environment in the Manawa Simulation Centre. They made the ingenious item out of a cheap Android tablet, wood, grey paint, an old bedside hospital locker, and some clever software engineering. Manawa, the health research and education facility, is a collaboration between Christchurch's health and tertiary education sectors, bringing

together the Canterbury District Health Board (Canterbury DHB), Ara and University of Canterbury (UC). The simulation floor at Manawa enables large-scale simulations in real world healthcare environments and access to advanced clinical equipment that students would normally only see during placements. This enables students to get the full experience before they use them on clinical placement.

- Medical Photographer Tara Gibb, who joined Medical Illustrations in July from the United Kingdom (UK) has received four Bronze Awards for medical photographs she entered into the 50th Annual Conference of the Institute of Medical Illustrators (IMI) held in Harrogate, UK recently. The awards are coveted in the UK and Europe and are a great opportunity for a photographer to enter the best medical images they have taken throughout the year and receive recognition for the high quality of their work.
- The Clinical Engineering department at Christchurch Hospital has been awarded ISO 9001:2015 accreditation. This is not just recertification but certification to the new quality management standard. ISO 9001 is the international standard that specifies requirements for a quality management system. Organisations use the standard to demonstrate the ability to consistently provide products and services that meet customer and regulatory requirements. Achieving this is a huge accomplishment facilitated and managed by Charge Technician Quality and Systems, Michael Stackhouse. The department's ongoing vision is to provide a centre of excellence for a Clinical Engineering service to Canterbury DHB, and other health providers, and in so doing assist with effective delivery of patient treatment and diagnosis.
- Canterbury DHB staff assembled at Manawa to welcome Catherine Hughes to her first day as Clinical Manager of Social Work. Catherine joins Canterbury DHB after working at Unitec Institute of Technology in Auckland for a number of years where she was associate professor and head of department. As a testament of their high regard for her and with the support of the Unitec kaumātua, Haare Paniora, a large contingent of colleagues and family travelled to Christchurch to 'hand' her over to her new team. Catherine and her party received a karanga (call) of welcome, before whaikōrero / speeches from Māori Health Kaiārahi (Team Leader) Eru Waiti and Director of Allied Health Garth Munro.
- Workplace Support remind staff to look after themselves in the lead up to Christmas and remember to look back on what you have learnt over the year, which would have had a variety of celebrations, change and challenges. It is timely to think of plans we can all put into place to help us arrive at the end of the year in a healthy state rather than feeling frazzled and worn out by all the demands. If we look after ourselves with a balance of regular exercise, healthy diet, adequate rest, time-out and fun we will in turn have more energy when caring for others. Christmas can be a difficult time for some of our colleagues and friends, for various reasons. Being sensitive to other people's needs is an important aspect of the season.

- **Te Panui Runaka:** Welcome to the new Christchurch Outpatients. The building has been blessed, the equipment has been installed and staff from 27 different Outpatient services have set up in their purpose-built space. Canterbury District Health Board outpatient services have been brought back under one roof after being dispersed widely across the hospital campus and the city since the 2011 earthquakes. The Christchurch Outpatients is five storeys high and provides 10,500m2 of state-of-the-art facilities for 27 different services.

FACILITIES REPAIR AND REDEVELOPMENT

General Earthquake repairs within Christchurch campus

- **Parkside Panels:** Cost estimate and programme for restraint of all panels on Parkside have been prepared. Final contractual items are being resolved for removal of panels above ASB Link. Work is expected to start on site prior to Christmas.
- **Clinical Service Block Roof Strengthening Above Nuclear Medicine:** Equipment has now been received and stored at Print Place. Contractor selected and work is due to start 12 November.
- **Lab Stair 4:** EOI issued. Programme start date to be in 2nd quarter 2019 following completion of Diabetes building demolition. Relocation of Labs staff and other associated planning underway.

Christchurch Women's Hospital

- **Stair 2:** Draft review completed by fire engineer as part of the overall Women's risk analysis. Strategic assessment process has been finalised and presented to facilities committee and for endorsement by board. The balance of fire analysis work is awaiting master plan before works can be programmed to complete strengthening works.
- **Level 4:** Crack injection around core to be undertaken. Parent room, kitchen and toilet areas complete. Difficulties gaining access to area due to patient levels, actively working with staff to look at options to commence the remedial and Passive fire protection works.
- **Level 5:** Small amount of work to corridor unable to commence due to operational constraints (NICU). Working with teams to identify a suitable time, but will endeavour to pick this up during Women's Passive fire protection works.
- **Level 3:** All areas complete except reception, which is to be done at same time as stair strengthening to minimise disruption.

Other Christchurch Campus Works

- **Passive Fire/Main Campus Fire Engineering**
  - Database designs are complete, additional information added as test data received and in use by Site Redevelopment on current project / passive work. Currently developing the process for digitalization of the passive fire system and database. The forms and documents will be updated to e-forms and will be part of the digitalization programme. Continue discussion with Maintenance & Engineering on management of the passive fire programme.
  - Test rig being used weekly by CDHB and Engineers for training and evaluations. Materials supply is well established with savings being made.
  - Continue to identify non-compliant areas as other projects open walls / ceilings.
  - Second Stage RFP for installer fixed costs is in final stage of procurement progressing.
  - Passive program continues to receive positive support from wider industry representatives. Recently presented to Christchurch City Council building inspection team who fully support the process and accreditation.
  - Risk analysis and recommendation progressing slowly due to delay in releasing the master plan details. Works may need to be stopped until information is available.
- **Christchurch Hospital Campus Energy Centre**: This is managed by the Ministry of Health (*MoH*).
  - Service Tunnel: Complete. Steam provided by coal boilers to Outpatients and Hospital. Final connection for ASB still to be completed.
  - Energy Centre: ROI for boilers completed. Preferred Boiler supplier identified and to be advised shortly.

- **235 Antigua St and Boiler House (Demolition).** No work to be undertaken until new Energy Centre constructed and commissioned.
- **Temporary Accommodations on Antigua/Tuam St.** Construction started. Completion due early 2019.
- **Parkside Renovation Project to Accommodate Clinical Services, post ASB (managed by MoH):** Planning ongoing. This project is being managed by the MoH with close stakeholder involvement from the CDHB. Still waiting on advice from MoH as to outcome of master planning process. Draft master plans currently being peer reviewed by Ernst and Young.
- **Back up VIE Tank:** Initial proposed strengthening scheme has been approved by BOC. Quantity Surveyor has completed estimate. Business case to be presented shortly. Primary VIE tank is operational.
- **Antigua St Exit widening:** CDHB work completed in advance of Otakaro requirements.
- **New Outpatient Project (managed by MoH):** 1st and 2nd migration shift completed with only the hospital dental to come.
- **Avon Switch Gear and Transformer Relocation**. Design complete. Business case to be submitted for approval. Project is being managed by M&E.
- **Otakaro/CCC Coordination.** Oxford Gap closed to mid-December 2018. Regular Wednesday meetings are continuing with key stake holders. Crossing from main campus to Outpatients complete.
- **Hagley Outpatients 2 Storey demolition:** Business case approved. Contractor appointed. Working plan and programme complete. Work on site began 12 Nov 2018 following the Outpatients department relocation to the new building.
- **New Outpatients Cafeteria:** Business case approved. Main Contractor awarded. Fitout commenced. Completion forecast December 2018.
- **Diabetes Demolition**: Demolition to occur after Home Dialysis Training Centre has relocated to refurbished leased facility. Business case for additional funding submitted.
- **Canterbury Health Labs**
  - **Anatomical Pathology:** Initial planning on options for repatriating AP from School of Medicine has commenced. Business case for pre-concept has been approved.
  - **Core Lab (High Volume Automation)** Upgrade: SRU to commence procurement of design consultants to develop scope for required building of infrastructure changes. Business case for seed funding underway.
  - SRU is assisting CHL with strategy and planning on best use of the former Eye Outpatient facility.

Burwood Hospital Campus

- **Burwood New Build**: Defects are being addressed as they come to hand.
- **Burwood Admin Old Main Entrance Block:** Meeting held onsite to review the area. Meeting with community team leaders on 8 November to discuss requirements and numbers to be accommodated.
- **Burwood Mini Health Precinct:** User groups have been engaged with to identify space needs and expectations. Project delivery options, funding options and lease agreements are currently being discussed and need to be resolved before the project can proceed any further.

- **Spinal Unit:** Good progress being made. Foundation work to extension underway. 1st fix of services to existing areas has commenced.
- **Burwood Birthing/Brain Injury Demolition**: Work continues. Target completion date of 20 December 2018.
- **2nd MRI Installation:** MRI 2 works complete and fully operational.

Hillmorton Hospital Campus

- **Mental Health Services:** New High Care Area for AT&R is in design development stage with all consultants working well. Resource consent to be lodged. Currently working on development for building 1 and 2 and temporary High Care Area for building 3. These include options for additional space in the PSAID area and opportunity's for a low stimulus area retrofitted into existing spaces.

- **The Princess Margaret Hospital Campus**
  - **Older Persons Health (*OPH*) Community Team Relocation:** The feasibility study is now complete and work is to commence shortly on the options for repurposing the old Burwood Administration building to accommodate community teams.
  - **Mental Health Services Relocation:** Indicative Business case approved by Ministers in September 2017. The Detailed Business Case is awaiting Ministry of Health and Capital Investment Committee approval.

  Ashburton Hospital & Rural Campus
  - **Stage 1 and 2 Works are Complete.** Final claims have been agreed with the contractor. Final defects resolution and retention release is protracted and expected to require several more months to resolve.
  - **Tuarangi Plant Room**: Concept drawing completed and safety consultant report received. Now looking to hand over to Maintenance & Engineering to implement.
  - **New Boiler and Boiler House**: Consultants engaged and concept design complete. Will go out to the market shortly. Currently being managed by Maintenance & Engineering.

  Other Sites/Work
  - **Akaroa Health Hub:** In construction. Roof cladding is currently underway and it is targeted to complete first fix by the end of November. Programme remains at previous delay due to winter weather. Anticipating completion approx. mid May 2019
  - **Kaikoura Integrated Family Health Centre:** Repair strategy received from Beca. Minor repairs to be undertaken by Maintenance & Engineering.
  - **Rangiora Health Hub:** Main contractor appointed. Work to begin at Christchurch on 12 November and has started at Rangiora.
  - **Home Dialysis Relocation:** Business case approved by Board. Programme forecast completion March 2019. Contract awarded and work has started on site.
  - **SRU:** Project Management Office manuals re-write and systems overview. Scope has increased as understanding of documentation required has been realised to approximately 3 times original size. Main documentation is now 96% complete and is in use daily by the SRU team. Aligning with P3M3 process and documentation where appropriate.
  - **Seismic Monitoring:** Fee proposals received from engineer. Business case submitted.

  Project/Programme Key Issues
  - The lack of a detailed Master Plan for the Hillmorton campus is still affecting our ability to provide a comprehensive EQ decision making assessment. We continue to use the framework adopting a more granular approach to determine outcomes.

- Additional peer reviews of Parkside and Riverside structural assessments, being undertaken by the MoH, are now complete. Clarity on the direction of the Master Planning process is required to plan the next stage of the POW.
- Delays to the POW continue to add risk outside the current agreed Board time frames. Key high risk areas of Panel replacement are starting, as instructed by the Facilities Committee and CDHB Board.
- Access to NICU to undertake EQ repairs to floors continues to be pushed out due to access constraints. SRU is looking at options to decant teams to adjacent spaces to allow works to commence. This will, however, not be possible until the ASB project is complete and space in Parkside becomes available.
- Impact of changes to the Building Act and Seismic assessment methodology continue to be assessed in relation to DHB buildings. Some buildings will be assessed at a higher % NBS than previously, but it is likely that more buildings will be deemed to be EQ prone than is currently the case. There are significant cost implications arising from these changes as strengthening schemes are likely to cost more and existing engineering reports are no longer valid as a basis for consentable strengthening work. The programme of works and business as usual projects are currently being reviewed in conjunction with the approved revised decision making framework in an attempt to identify tranches of work for commencement. This process is still largely dependent on master planning. Guidance from the Board will be required as to the timing and suitability of any proposed projects to mitigate ongoing risks to the CDHB.

LIVING WITHIN OUR FINANCIAL MEANS

Live Within our Financial Means

- The consolidated Canterbury DHB financial result for the month of October 2018 was a net operating expense of $7.176M, which was $3.496M favourable against the draft annual plan net operating expense of $10.672M. The October result includes recent adjustments to the annual plan, so the YTD result is the more appropriate result to review. The table below provides the breakdown of the October result.

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.258	(0.00)	**0.258**	0.466	(0.00)	0.469
Funder	(2.859)	(8.408)	**5.549**	(17.712)	(15.801)	(1.911)
DHB Provider	(4.575)	(2.263)	**(2.311)**	(6.421)	(7.783)	1.362
Canterbury DHB Group Result	**(7.176)**	**(10.672)**	**3.496**	**(23.667)**	**(23.587)**	**(0.080)**

Report prepared by: David Meates, Chief Executive

Canterbury DHB national performance measures report

Quarter 1: July - September 2018/19

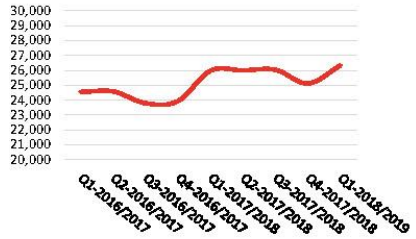
What are the national performance measures?

This report presents current performance against the national performance measures formerly referred to as national health targets. A new set of high-level measures are being developed, however these have not yet been released.

These measures still reflect Canterbury's performance in areas of significant public and government interest and continue to be tracked by the Ministry as part of the DHB's quarterly performance reporting suite. The targets remain in place . Three of the measures focus on patient access and three focus on prevention.

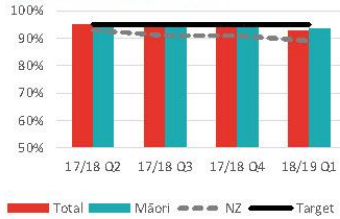
Supplementary indicators

The number of people presenting to Ashburton and Christchurch



Shorter stays in ED — 93%

*Patients admitted, discharged or transferred ED within six hours. Target: **95%***

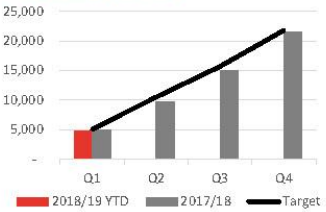


Canterbury DHB did not achieve the ED target in quarter one with 93% of patients admitted, discharged or transferred from ED within 6 hours. The number of people presenting to ED continues to grow.

More than 9,440 acute demand packages of care were also provided in the community in quarter one.

Improved access to elective surgery — 95%

*Patients receiving planned surgery Year-end target: **21,782***

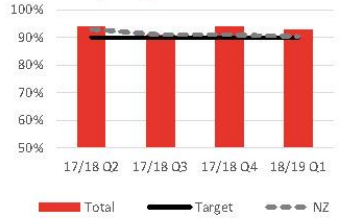


Canterbury did not meet the quarter one elective surgery target with 4,837 of 5,065 planned elective surgeries delivered.

The development and roll out of the new patient management system (South Island PICS) has resulted in a number of significant coding delays across the health system including elective discharges.

Faster cancer treatment — 93%

*Patients getting their first cancer treatment within 62 days. Target: **90%***



Canterbury DHB achieved the cancer target in quarter one with 93% of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer.

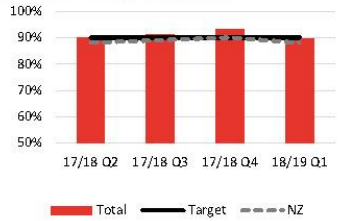
Increased immunisation — 95%

*Eight-month-olds fully immunised Target: **95%***

Canterbury DHB achieved the increased immunisation target with 95% of eligible children fully vaccinated at eight months. The target was reached for New Zealand European (96%) Asian (99%) and Pacific (96%) groups. The target was just missed for Maori, with 93% of infants fully immunised at eight months.

Better help for smokers to quit — 90%

*Patients in the community who smoke are offered help to quit Target: **90%***

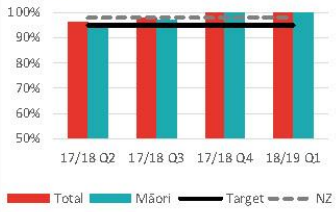


Canterbury DHB achieved the smoking target in quarter one with 90% of smokers enrolled with a PHO offered advice and help to quit smoking.

Canterbury DHB's cessation support indicator (the percentage of current smokers who have been given or referred to cessation support services in the last 15 months) is again the highest in the country at 56%.

Raising healthy kids — 100%

*Children with obesity referred for support Target: **95%***



In Canterbury, 100% of children, identified as obese at their Before School Check (B4SC), were offered a referral to a health professional in quarter one. The number of referrals declined' by families increased slightly to 24% this quarter.

Produced by Canterbury and West Coast DHB Planning and Performance team.

Canterbury

make it better

FINANCE REPORT 31 OCTOBER 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Finance**

DATE: **13 December 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This is a regular report and standing agenda item providing an update on the latest financial results and other relevant financial matters to the Board of the Canterbury DHB. A more detailed report is presented to and reviewed by the Quality, Finance, Audit and Risk Committee monthly, prior to this report being prepared.

2. RECOMMENDATION

That the Board:

i. notes the financial result for the period ended 31 October 2018.

3. DISCUSSION

Overview of October 2018 Financial Result

The consolidated Canterbury DHB financial result for the month of October 2018 was a net operating expense of $7.176M, which was $3.496M favourable against the draft annual plan net operating expense of $10.672M. The October result includes recent adjustments to the annual plan, so the YTD result is the more appropriate result to review. The table below provides the breakdown of the October result.

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate	(4.474)	(2.227)	**(2.247)**	(6.528)	(7.862)	1.334
Community & Public Health	(0.053)	(0.034)	**(0.019)**	(0.047)	(0.066)	0.020
Total In-House Provider excl Subsidiaries	**(4.526)**	**(2.261)**	**(2.267)**	**(6.575)**	**(7.929)**	**1.354**
Add: Funder & Governance						
Funder Revenue	138.487	134.630	3.857	552.193	552.034	0.159
External Provider Expense	(62.863)	(64.580)	1.717	(248.270)	(246.299)	(1.971)
Internal Provider Expense	(78.483)	(78.458)	(0.025)	(321.636)	(321.536)	(0.100)
Total Funder	**(2.859)**	**(8.408)**	**5.549**	**(17.712)**	**(15.801)**	**(1.911)**
Governance & Funder Admin	0.258	(0.001)	0.258	0.466	(0.003)	0.469
Total Canterbury DHB (Parent)	**(7.128)**	**(10.670)**	**3.540**	**(23.821)**	**(23.733)**	**(0.088)**
Add: Subsidiaries						
Brackenridge Estate Ltd	(0.022)	0.003	**(0.025)**	0.078	0.131	(0.053)
Canterbury Linen Services Ltd	(0.026)	(0.005)	**(0.021)**	0.077	0.015	0.062
Canterbury DHB Group Surplus / (Deficit)	**(7.176)**	**(10.672)**	**3.496**	**(23.667)**	**(23.587)**	**(0.080)**

4. APPENDICES

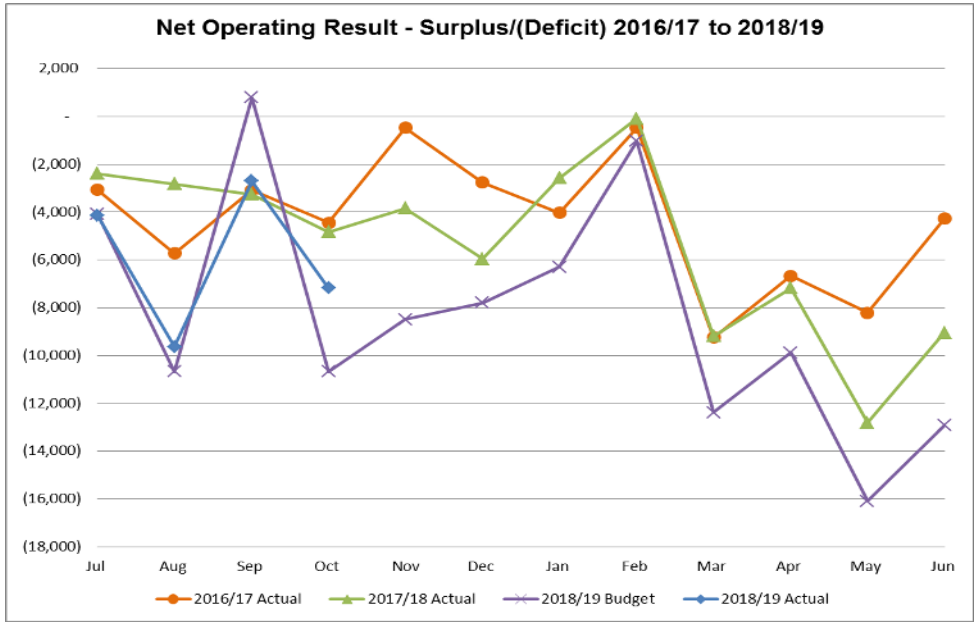
Appendix 1: Financial Result
Appendix 2: Statement of Comprehensive Revenue & Expense
Appendix 3: Statement of Financial Position
Appendix 4: Cashflow

Report prepared by: Justine White, Executive Director, Finance & Corporate Services

APPENDIX 1: FINANCIAL RESULT

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 31 OCTOBER 2018

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Surplus/(Deficit)	(7,176)	(10,672)	3,496	-33% ✓	(23,667)	(23,587)	(80)	0% ✗



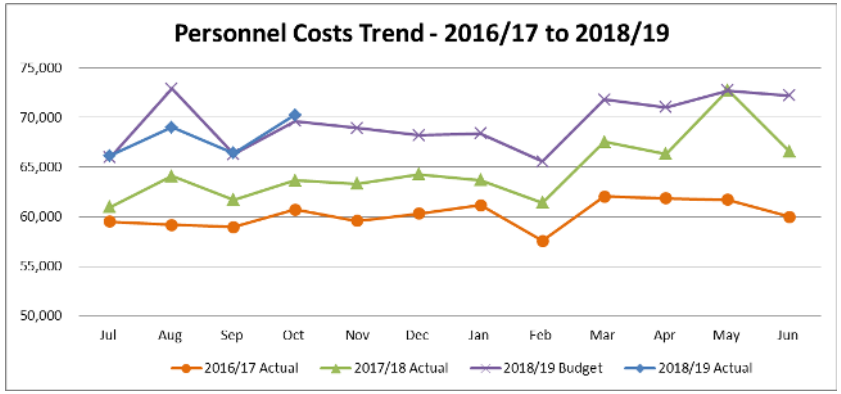
Our revised draft 18/19 Annual Plan is a net operating expense position of $98.475M, and was submitted to the MoH in November. The significant changes include a reduction in the nursing MECA funding; a reduction to the annual capital charge; and a change to our depreciation rates on assets.

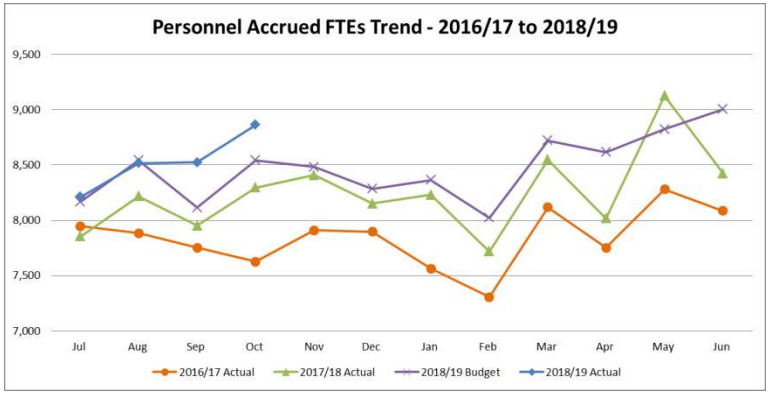
The YTD budget has been adjusted to pick up these changes.

KEY RISKS AND ISSUES

We expect to continue to incur earthquake related repair and maintenance expenditure and the depreciation impacts of quake related capital spend for a significant number of years into the future. There will be variability between the expected and actual timing of these costs. New facilities coming on stream will attract additional capital charge and depreciation expense.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE





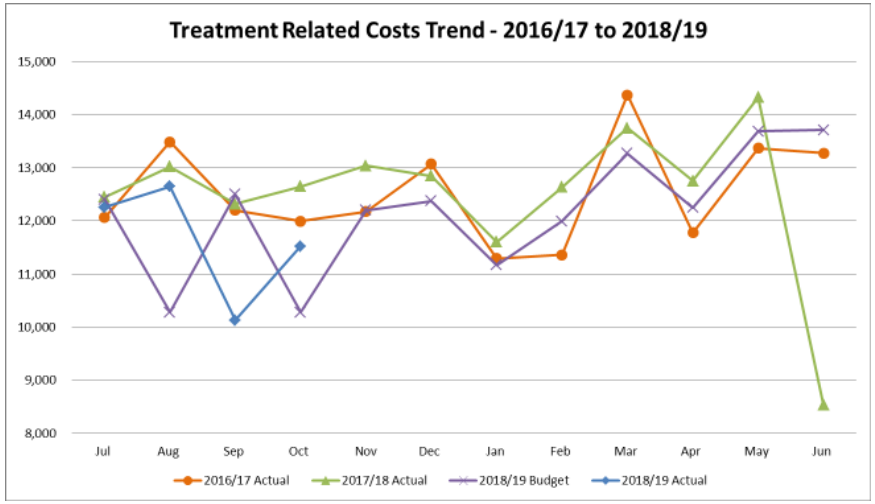
KEY RISKS AND ISSUES

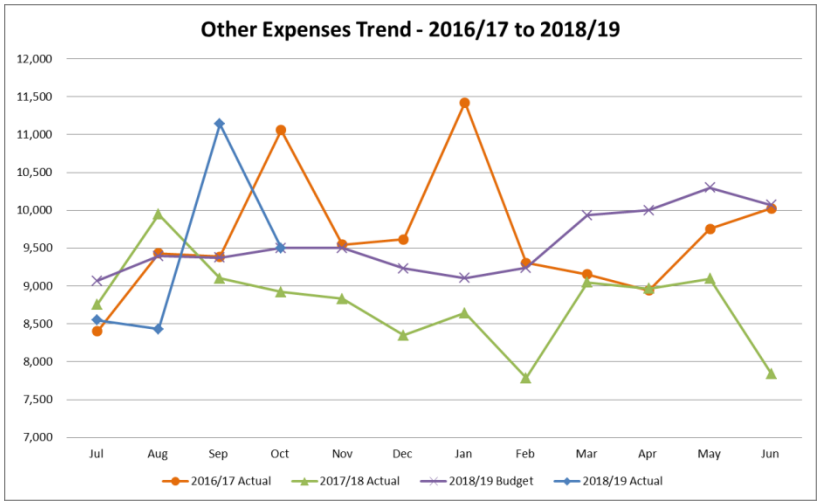
Pressure will continue on personnel costs into the foreseeable future, as a result of settlements as well as additional resource required for the new ASB redevelopment.

The full implication of potential minimum wage increments, including the timing that is proposed for these, and the relativity impacts that this will create on other workforce groups that are not otherwise directly impacted, continue to be a financial risk.

We have not made any provision for Holidays Act compliance issues that the Sector is currently working through. The impact for CDHB is at this stage unquantifiable, given the complexity of the current interpretation in regard to the sector.

TREATMENT & OTHER EXPENSES RELATED COSTS





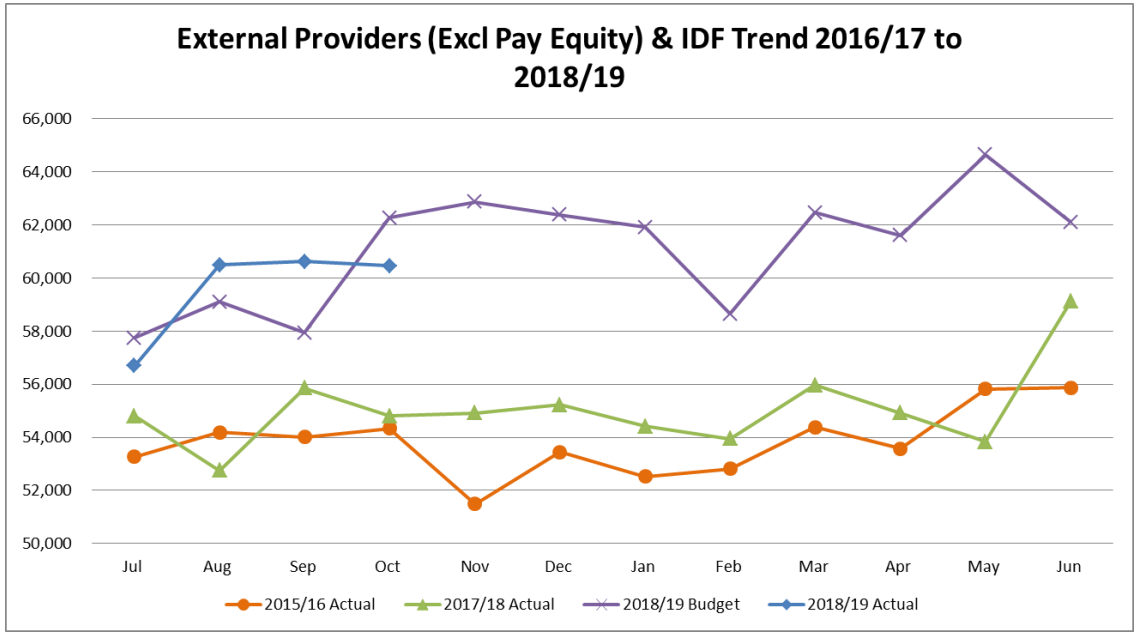
KEY RISKS AND ISSUES

Treatment related costs are influenced by activity volume, as well as complexity of patients.

Additional facility costs continue to be incurred in relation to The Princess Margaret Hospital campus. Some of these additional costs are in relation to a number of mental health services that remain stranded at that site. Earthquake expenditure is lower than planned due to the timing of the repairs, and the split between capex and opex repairs.

EXTERNAL PROVIDER COSTS

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Total External Provider Costs	62,863	64,580	1,717	3%	✓	248,270	246,299	(1,971)	-1%	✗
Pay Equity	2,828	2,313	(515)	-22%	✗	10,034	9,250	(784)	-8%	✗
External Provider costs excl Pay Equity	60,035	62,268	2,232	4%	✓	238,236	237,049	(1,187)	-1%	✗



YTD pharmaceutical spend in relation to PCT costs is reflected in external provider costs this year, as we have changed our accounting treatment from 1 July.

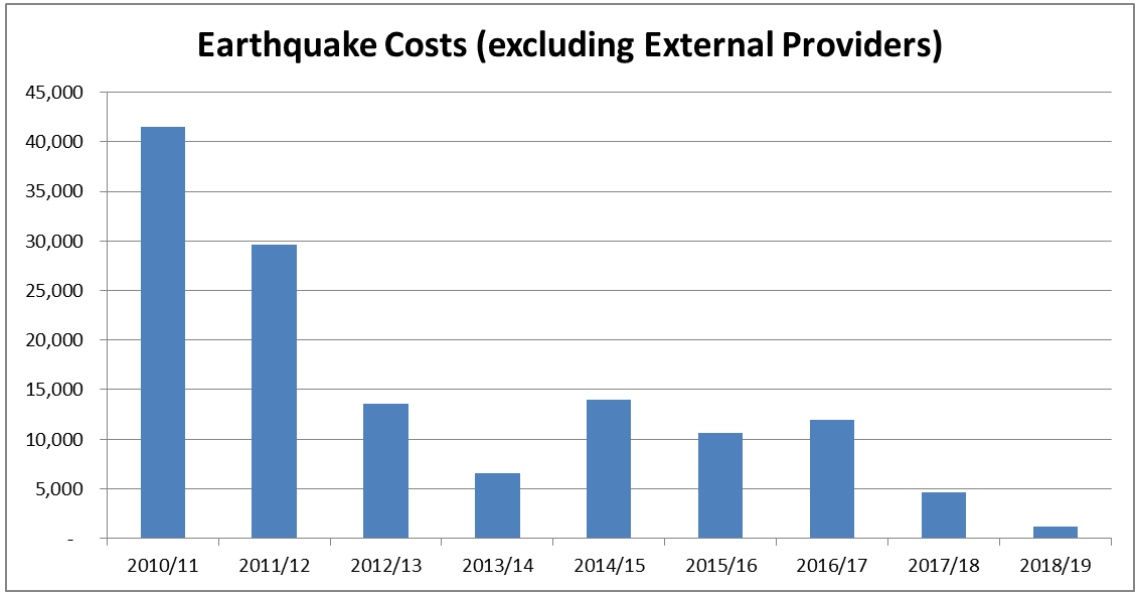
Additionally, the reimbursement of hospital pharmaceutical spend from the combined pharmaceutical budget rebate pool has result in an unfavourable variance in external provider costs.

KEY RISKS AND ISSUES

Additional outsourcing to meet electives targets may be required. Additionally, there is uncertainty on the impact on community rebates as a result of recent PHARMAC changes.

EARTHQUAKE

Data in this table excludes the Kaikoura earthquakes	Month Actual	Month Budget	Month Variance			YTD Actual	YTD Budget	YTD Variance		
	$'000	$'000	$'000			$'000	$'000	$'000		
Total Earthquake Revenue (Draw Down)	**136**	**400**	**(264)**	**100%**	✗	**669**	**1,300**	**(631)**	**100%**	✗
Earthquake Costs - Repairs	65	400	335	100%	✓	666	1,300	634	100%	✓
Earthquake Costs - External Provider	1,431	1,431	-	100%	✓	5,724	5,724	-	100%	✓
Earthquake Costs - Non Repairs	131	131	-	100%	✓	527	527	-	100%	✓
Total Earthquake Costs	**1,627**	**1,962**	**335**	**100%**	✓	**6,917**	**7,551**	**634**	**100%**	✓



Earthquake (EQ) operating costs include EQ repair works and other non-repair related costs such as additional security and building leases.

EQ repair (integral part of the DHB EQ Programme of Works) costs are offset by an equivalent amount of insurance revenue that will be progressively drawn down to minimise the impact of EQ repair costs on the net result. The insurance revenue relates to the portion of earthquake insurance settlement amount that was repaid to the Crown in 2013/14 for future draw down by the DHB as and when appropriate to fund the earthquake repairs and programme of works.

Note: 'Quake' costs associated with additional funder activity such as increased outsourced surgery are captured under external provider costs.

KEY RISKS AND ISSUES

The variability and uncertainty of these costs will continue to put pressure on meeting our monthly budgets in future periods.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000		
Equity	472,606	493,685	(21,079)	-4%	X
Cash	(25,774)	(17,482)	(8,292)	47%	X

KEY RISKS AND ISSUES

If future deficit funding is less than the expected amount, cash flows will be impacted, and the ability to service payments as and when they fall due will become a potential issue.

APPENDIX 2: CANTERBURY DHB GROUP STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

The Group financial results include Canterbury DHB and its subsidiaries, Canterbury Linen Services Ltd and Brackenridge Services Ltd
For the month of October 2018

Month					Year to Date				Annual
18/19 Actual	18/19 Budget	17/18 Actual	Variance to Budget		18/19 Actual	18/19 Budget	17/18 Actual	Variance to Budget	18/19 Budget
144,452	140,412	137,511	4,040 ✓	MoH Revenue	576,583	575,162	550,108	1,421 ✓	1,726,350
3,936	3,198	3,996	738 ✓	Patient Related Revenue	15,550	12,642	16,407	2,908 ✓	37,172
3,571	4,360	2,717	(789) ✗	Other Revenue	12,733	17,000	11,494	(4,267) ✗	52,497
151,959	**147,970**	**144,224**	**3,989**	**Total Operating Revenue**	**604,865**	**604,804**	**578,009**	**61**	**1,816,019**
70,260	69,637	63,645	(623) ✗	Personnel Costs	271,852	271,374	250,432	(478) ✗	830,258
11,527	10,284	12,652	(1,243) ✗	Treatment Related Costs	46,569	48,437	50,482	1,868 ✓	149,097
62,863	64,580	58,252	1,717 ✓	External Service Providers	248,270	246,299	224,906	(1,971) ✗	742,871
9,505	9,503	7,267	(2) ✗	Other Expenses	37,629	37,339	36,694	(290) ✗	114,720
154,156	**154,004**	**141,816**	**(152)** ✗	**Total Operating Expenditure**	**604,320**	**603,449**	**562,514**	**(871)** ✗	**1,836,946**
(2,197)	**(6,034)**	**2,408**	**3,837** ✓	**Total Surplus / (Deficit) Before Indirect Items**	**545**	**1,355**	**15,494**	**(810)** ✗	**(20,927)**
114	148	320	(34) ✗	Interest	405	592	527	(187) ✗	1,778
15	290	44	(275) ✗	Donations	2,059	1,205	285	854 ✓	4,027
-	-	0	- ✓	Profit / (Loss) on Sale of Assets	5	-	(8)	5 ✓	-
129	**438**	**365**	**(309)** ✗	**Total Indirect Revenue**	**2,469**	**1,797**	**803**	**672** ✓	**5,805**
954	953	2,568	(1) ✗	Capital Charge	8,319	8,318	10,272	(1) ✗	24,994
4,143	4,085	5,027	(58) ✗	Depreciation	18,309	18,269	19,257	(40) ✗	57,909
10	38	-	28 ✓	Interest Expense	54	152	48	98 ✓	450
5,108	**5,076**	**7,595**	**(31)** ✗	**Total Indirect Expenses**	**26,681**	**26,739**	**29,578**	**58** ✓	**83,353**
(7,176)	**(10,672)**	**(4,823)**	**3,496** ✓	**Total Surplus / (Deficit)**	**(23,667)**	**(23,587)**	**(13,280)**	**(80)** ✗	**(98,475)**

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

As at 31 October 2018

Audited 30-Jun-18 $'000		Group Actual 31-Oct-18 $'000	YTD Group Budget 31-Oct-18 $'000	Annual Group Budget 30-Jun-19 $'000
517,833	Opening Equity	496,272	496,272	496,272
42,398	Net Equity Injections / (Repayments) During Year	-	21,000	149,098
(63,959)	Operating Results for the Period	(23,667)	(23,588)	(98,475)
496,272	**TOTAL PUBLIC EQUITY**	472,605	493,684	546,895
	Represented By:			
	Current Assets			
1,677	Cash & Cash Equivalents	3,673	-	-
750	Short Term Investments	750	750	750
87,165	Trade and Other Receivables	71,734	85,839	85,839
4,554	Prepayments	10,679	4,554	4,554
11,171	Inventories	11,540	11,171	11,171
10,561	Restricted Assets	12,699	14,576	14,577
115,878	**Total Current Assets**	111,075	116,890	116,891
	Less Current Liabilities			
17,376	Overdraft	29,448	17,482	48,920
111,189	Trade and Other Payables	121,827	119,510	111,192
10,577	Restricted Funds	12,848	14,591	14,591
172,699	Employee Benefits	163,261	163,361	163,361
311,841	**Total Current Liabilities**	327,384	314,944	338,064
(195,963)	**Working Capital**	(216,309)	(198,054)	(221,173)
	Non Current Assets			
16	Restricted Funds	16	16	16
5,186	Investment in NZHPL	6,333	5,186	5,186
693,197	Fixed Assets	688,691	692,713	769,043
698,399	**Term Assets**	695,040	697,915	774,245
	Non Current Liablilties			
6,164	Employee Benefits	6,127	6,177	6,177
6,164	**Term Liabilities**	6,127	6,177	6,177
496,272	**NET ASSETS**	472,605	493,684	546,895

APPENDIX 4: CASHFLOW

Audited 30-Jun-18 $'000		Actual 31-Oct-18 $'000	YTD Budget 31-Oct-18 $'000	Budget 30-Jun-19 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
	Cash was provided from:			
(5,124)	**Net Cash from Operating Activities**	2,371	(4,999)	(48,565)
	CASHFLOW FROM INVESTING ACTIVITIES			
	Cash was provided from:			
(38,453)	**Net Cash from Investing Activities**	(12,446)	(17,784)	(61,754)
	CASHFLOW FROM FINANCING ACTIVITIES			
	Cash was provided from:			
42,398	**Net Cash from Financing Activities**	-	21,000	77,098
(1,179)	Overall Increase/(Decrease) in Cash Held	(10,075)	(1,783)	(33,221)
(14,520)	Add Opening Cash Balance	(15,699)	(15,699)	(15,699)
(15,699)	**Closing Cash Balance**	(25,774)	(17,482)	(48,920)

HEALTH (DRINKING WATER) AMENDMENT BILL

Canterbury District Health Board
Te Poari Hauora o Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Community and Public Health**

DATE: **13 December 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

Approval is sought for the attached draft submission on the Health (Drinking Water) Amendment Bill.

As per the CDHB Submissions Procedure, any submissions to a Select Committee must be approved by EMT, the Board and the Minister's Office.

2. RECOMMENDATION

That the Board:

i. approves the draft submission on the Health (Drinking Water) Amendment Bill.

3. SUMMARY

The Health (Drinking Water) Amendment Bill proposes amendments to Part 2A of the Health Act 1956 to improve the effectiveness and efficiency of provisions regulating the supply of drinking-water.

Following the Havelock North Drinking Water Inquiry, a number of recommendations have been made. This Bill includes some of the less complex, administration changes recommended which can be implemented without materially affecting any party or imposing new or additional costs.

This Bill does not deal with matters such as water treatment which is not included in Part 2A of the Health Act and will likely form part of a new regulatory regime in the future.

4. DISCUSSION

This submission has been developed by members of the Health Protection Team, namely the Drinking Water Assessors and the Medical Officer of Health at Community & Public Health.

The recommendations made are mainly supportive in nature, as the proposed changes to the Act are technical and intended to enable processes for water suppliers and Drinking Water Assessors to better respond to changes in the water sector and mitigate against risk to public health.

5. APPENDICES

Appendix 1: Draft CDHB Submission on Health (Drinking Water) Amendment Bill

Report prepared by: Community & Public Health
Report approved for release by: Evon Currie, General Manager, Community & Public Health

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Submission on Health (Drinking Water) Amendment Bill

To: Health Select Committee

Submitter: Canterbury District Health Board

Attn: Alizon Paterson
Community and Public Health
C/- Canterbury District Health Board
PO Box 1475
Christchurch 8140

Proposal: The policy objectives of this bill are to improve the effectiveness and efficiency of Part 2A of the Health Act 1956 without materially affecting any party or imposing new or additional costs.

SUBMISSION ON HEALTH (DRINKING WATER) AMENDMENT BILL

Details of submitter

1. Canterbury District Health Board (CDHB).

2. The submitter is responsible for promoting the reduction of adverse environmental effects on the health of people and communities and to improve, promote and protect their health pursuant to the New Zealand Public Health and Disability Act 2000 and the Health Act 1956. These statutory obligations are the responsibility of the Ministry of Health and, in the Canterbury District, are carried out under contract by Community and Public Health under Crown funding agreements on behalf of the Canterbury District Health Board. It should be noted that the CDHB employs a number of Drinking Water Assessors (DWAs) appointed under the Health Act 1956.

3. The Ministry of Health requires the submitter to reduce potential health risks by such means as submissions to ensure the public health significance of potential adverse effects are adequately considered during policy development.

Details of submission

4. We welcome the opportunity to comment on the Health (Drinking Water) Amendment Bill . The future health of our populations is not just reliant on hospitals, but on a responsive environment where all sectors work collaboratively.

Comments

Item	Recommendation and Rationale
Part 1 cl 4 *Sec 69C amended*	**Recommendation 1:** The CDHB supports the amendment to section 69C of the principal Act, which relates to the application of sections 69S to 69ZC of that Act. 5. The majority of designated port or airports are on networked

	supplies and therefore the water supply is already covered by a Water Safety Plan under the Health Act 1956. The International Health Regulations 2005 also require these designated sites to have a water management plan to control risks within the port boundary.

Part 1 cl 5 *Section 69P amended*	**Recommendation 2:** The CDHB supports the amendment to section 69P of the principal Act, which requires the Minister of Health to consult before issuing, adopting, or amending drinking-water standards. 6. Both the risks to drinking-water and the technology involved in the treatment and monitoring of drinking water evolve quickly and it is therefore important in order to protect the public's health that the Drinking-water Standards can be amended and new requirements implemented quickly. The current requirement of a 3 year consultation does not meet this need. 7. The CDHB considers the drinking-water sector to be well-established and relatively easy to consult with therefore a reduced consultation period will still allow a range of stakeholders to contribute as appropriate to proposed changes.

Part 1 cl 6 *Sec 69R replaced*	**Recommendation 3:** The CDHB supports the replacement of section 69R of the principal Act, which relates to the commencement of drinking-water standards. 8. As stated in point 7 above, the CDHB considers the drinking-water sector to be well-established and relatively easy to consult with therefore a reduced consultation period will still allow a range of stakeholders to contribute as appropriate to proposed changes.

Part 1 cl 7 *Sec 69U amended*	**Recommendation 4:** The CDHB supports the repeal of section 69U(4) of the principal Act, which sets out examples of reasonable steps that contribute to the protection of the source of drinking water. 9. It was unusual that the legislation gives examples for how a drinking-water supplier could meet this duty. Strategies to assist with the protection of source water have progressed significantly since Part 2A of the Health Act was written, with collaborative regional programmes now leading the way in terms of source protection. It is important that amendments to the Health Act does not limit the recognition of innovative approaches (which it possibly does by providing the proposed examples). It is the outcome of effective source protection that the legislation should seek rather than prescribing how this should occur.

Part 1 cl 8 *Sec 69Z amended*	**Recommendation 5:** The CDHB supports the amendments to section 69Z of the principal Act, which requires drinking-water suppliers to prepare and implement a water safety plan. However CDHB seeks to have the amendment strengthened to include the management and control of critical points identified in the water safety plan. 10. The amendment provides more clarity and strength to the current provision, which has caused difficulties in terms of compliance/ enforcement. Under the current section 69Z wording it is difficult to take action against a drinking water supplier who is partially implementing their water safety plan, whilst ignoring improvements in the plan that have a critical impact on the public health risks associated with that supply. 11. CDHB consider that section 69Z would be strengthened by

	requiring all current critical points (as currently defined in the Act) are identified in the water safety plan and that their control/management is effectively implemented. The current proposed amendment in the Bill only ensures adequate implementation of controls/actions that are identified in the water safety plan timetable , but does not cover a situation where deficiencies in implementation occur with controls / mechanisms that a drinking water supplier indicates are already in place. In practice, for the majority of drinking water supplies, the controls associated with bacterial protection are already in place (not covered by the water safety plan timetable), so it is therefore important that the Act allows for effective enforcement where identified existing controls are deficient, or possibly, not in place at all. **Recommendation 6:** The CDHB, in reference to the above rationale seeks the following wording change to the addition to 69Z*:* *"(c) take all reasonable steps to comply with the timetable set out in the supplier's water safety plan in accordance with subsection (2)(a)(v) and (b)(iv) and all reasonable steps to comply with the management and control of the current critical points identified in the water safety plan."*

Part 1 cl 9 *Sec 69ZK amended*	**Recommendation 7:** The CDHB supports the amendment of section 69ZK of the principal Act, which removes the requirement that individual assessors and any agency that employs them be internationally accredited. 12. The CDHB does not agree that such a requirement should be enforced via legislation and any requirements for international accreditation should remain at policy level. We note that the Havelock North Inquiry found that international accreditation was a barrier to attracting new DWAs. The CDHB encourages

	the Ministry of Health to retain a quality system which includes an external, technical peer review of DWAs.
Part 1 cl 10 *Sec 69ZP amended*	**Recommendation 8:** The CDHB supports the amendment to section 69ZP of the principal Act, which sets out the powers of drinking-water assessors and designated officers and makes the exercise of those powers subject to sections 69ZR (which restricts the exercise of powers) and 69ZS (which requires a warrant to enter a dwelling/house). 13. Streamlining use of powers will reduce delays in responding to public health issues associated with drinking water.

Conclusion

14. The CDHB does wish to be heard in support of this submission.

15. Thank you for the opportunity to submit on the Health (Drinking Water) Amendment Bill.

Person making the submission

Signature

Evon Currie Date: Click here to enter a date

General Manager, Community & Public Health

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CANTERBURY HEALTH SYSTEM ALCOHOL-RELATED HARM REDUCTION STRATEGY

Canterbury District Health Board
Te Poari Hauora o Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Community and Public Health**

DATE: **13 December 2018**

Report Status – For:	Decision	✓	Noting	Information	☐

1. ORIGIN OF THE REPORT

Attached (Appendix 1) is the final version of the Canterbury Health System Alcohol-related Harm Reduction Strategy which is ready for publication following Board endorsement.

The Strategy was developed using expertise from across the Canterbury DHB and wider Canterbury Clinical Network partners during 2016-2018. It was endorsed by the Executive Management Team (*EMT*) in January 2018, where adoption and implementation via the Canterbury Clinical Network structure was recommended. The Canterbury Clinical Network Alliance Leadership Team considered and formally endorsed the strategy in March 2018. The Strategy has since been presented to CPH&DSAC in August 2018.

2. RECOMMENDATION

That the Board:

i. endorses the Canterbury Health System Alcohol-Related Harm Reduction Strategy.

3. SUMMARY

In 2012, Canterbury DHB's Alcohol Position Statement (Appendix 2) created a mandate to develop a strategy to reduce alcohol-related harm.

Significant consultation and development has taken place since this time and in 2018 the Canterbury Heath System Alcohol-Related Harm Reduction Strategy was finalised.

The scope of this Strategy not only includes the Canterbury DHB, but our partners across the Canterbury Clinical Network, in recognition that alcohol harm requires a multi-agency, collaborative response from all of the health system.

4. DISCUSSION

The Canterbury Clinical Network has taken ownership of the Strategy, which now sits within the newly formed Population Health and Access Service Level Alliance. This implementation structure is the preference of the Canterbury DHB EMT, Alliance Leadership Team and primary care, all whom are eager to partner in this work.

The Strategy provides a framework for alcohol harm reduction work across the Health System. It takes a population health approach, recognises current strengths, and through its implementation aims to coordinate activities to achieve the vision of the strategy which is *"reduced harm from alcohol"*. It aligns with the vision and objectives of the Christchurch Alcohol Action Plan, with which it has been co-developed to ensure local government, non-governmental agencies, local communities and health partners are all working together to reduce harm from alcohol.

The strategy framework clusters objectives within four focus areas:

- Influence social norms and behaviour change;
- Promote healthy environments;
- Coordinate prevention, identification, treatment and support, and;
- Measure harm and monitor performance

The strategy and implementation which will follow are founded on a number of principles or "ways of working" which are considered essential in effectively reducing harm at a population level. These are equity considerations, collaboration across the system, framing alcohol within a life-course approach, having a strong evidence-base behind activities, best use of resources across the health system and supporting rangatiratanga within our Māori communities.

There are seven recommendations as to the next steps required, three of which relate to setting up governance and reporting structures and have already been achieved.

The Alcohol Strategy Working Group which is a sub-group of the Population Health and Access SLA was set up in May 2018 to begin planning implementation of the strategy across CCN partners. It meets six weekly and has made significant gains as to ensuring there are links and connections across the various service level alliances and work streams.

The Alcohol Strategy Working Group has the purpose of achieving the four outstanding recommendations of the strategy. These include:

- developing an **implementation plan** to accompany the Strategy which will include specific actions to be undertaken across the health system;
- **prioritising these actions via selection criteria** which the Working Group is also developing;
- developing an **evaluation and monitoring framework** for the Strategy; and
- developing a **communications plan** for health messaging which is a key component of this plan.

We are currently working with medical illustrations on a design proof for the Strategy which could be published on the Canterbury DHB and CCN websites. The publication of the strategy is an important step towards engaging partners across the health system in the action-based implementation plan which is to follow.

5. APPENDICES

Appendix 1: Canterbury Health System Alcohol-Related Harm Reduction Strategy
Appendix 2: CDHB Position Statement on Alcohol (July 2012)

Report prepared by: Community & Public Health

Report approved for release by: Evon Currie, General Manager, Community & Public Health

Canterbury Health System

Alcohol-related Harm Reduction Strategy

2018-2023

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

(Example cover design proof- not intended to be final design option)

Canterbury Health System

Alcohol-related Harm Reduction Strategy

2018- 2023

Contents

Acknowledgements

Community and Public Health would like to acknowledge the significant contribution of the working group involved in the development of this strategy:

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Dr Dominic Fleischer, CDHB, Emergency Medicine
Dr Lynley Cook, Pegasus Health
Rosemarie Eyres, CDHB, Social Work Services, Christchurch Campus
Selina Elkington and Toni Tinirau, He Waka Tapu
Steve Jones, Christchurch Central Service- AOD Coordination
Sandy McLean, CDHB, Planning & Funding
Dr Anna Stevenson, Dr Anna Thorpe, Bronwyn Larsen, Emma Kenagy and Chantal Lauzon, CDHB, Community & Public Health

This final draft was collated by the Health in All Policies Team at Community and Public Health and reflects careful consideration of all feedback received throughout the development process.

1. Overview

1.1 Background

Alcohol is a major public health issue because of the harm it causes to individuals and communities. Despite wide acceptance that drinking alcohol can lead to a number of health and social problems it remains the most commonly used recreational drug in New Zealand[1].

Alcohol-related harm is the term used to explain the wide range of negative effects from alcohol use. It includes acute harm such as intoxication or injury; chronic harm through over 200 diseases that have been associated with alcohol use; and indirect harm via alcohol-related social issues such as family violence, crime, financial hardship and lost productivity.

In New Zealand, alcohol is estimated to contribute to 800 deaths a year, of which nearly half are injuries, almost one third are from cancer and over a quarter are from other diseases[2].

Our health system absorbs significant costs due to alcohol-related harm. In 2011 the wider cost of alcohol-related harm to the Canterbury health system was estimated at $62.8 million[3].

1.2 Rationale for Strategy Development

In July 2012, the Canterbury District Health Board (CDHB) as part of the South Island Alliance committed to developing an alcohol harm reduction strategy within their alcohol position statement.[4] The Canterbury Health System Alcohol-related Harm Reduction Strategy (the Strategy) is the realisation of this commitment.

A number of activities to reduce alcohol-related harm already occur within the Canterbury health system such as; health promotion, community and GP-based assessment and treatment services, specialist services, alcohol licensing and compliance and inter-agency action groups (see Figure 1). Strategy development has identified opportunities to improve integration of these activities across the health system.

The CDHB remains a strong advocate for further national alcohol law reform in line with the 5+ Solution to reduce the availability and accessibility, as detailed in the Law Commissions' Report[5]. International evidence tells us this is the key driver in reducing alcohol-related harm to our population. Whilst opportunities to continue to engage in this national debate are key components of the strategy, the intention goes beyond this to identify a number of local opportunities to develop a health system that is collectively engaged in reducing alcohol-related harm in Canterbury. The Strategy intends to ensure the Canterbury health system's local approach to alcohol-related harm is streamlined, effective and patient-centred.

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[1] Ministry of Health. (2015). *Alcohol Use 2012/13: New Zealand Health Survey*. Wellington: Ministry of Health.
[2] Connor, J., Kydd, R., Shield, K. et al. (2015). The burden of disease and injury attributable to alcohol in New Zealanders under 80 years of age: marked disparities by ethnicity and sex. *New Zealand Medical Journal*, 128 (1409), 15-28.
[3] Slack, A. & Nana, G. (2012). *Costs of Harmful Alcohol Use in Canterbury DHB*. Wellington: BERL.
[4] Canterbury District Health Board. (2012). *Position Statement on Alcohol*. Christchurch: South Island Alliance.
[5] New Zealand Law Commission. (2010*). Alcohol in Our Lives: Curbing the Harm – A report on the review of regulatory framework for the sale and supply of liquor*. Wellington: Law Commission.

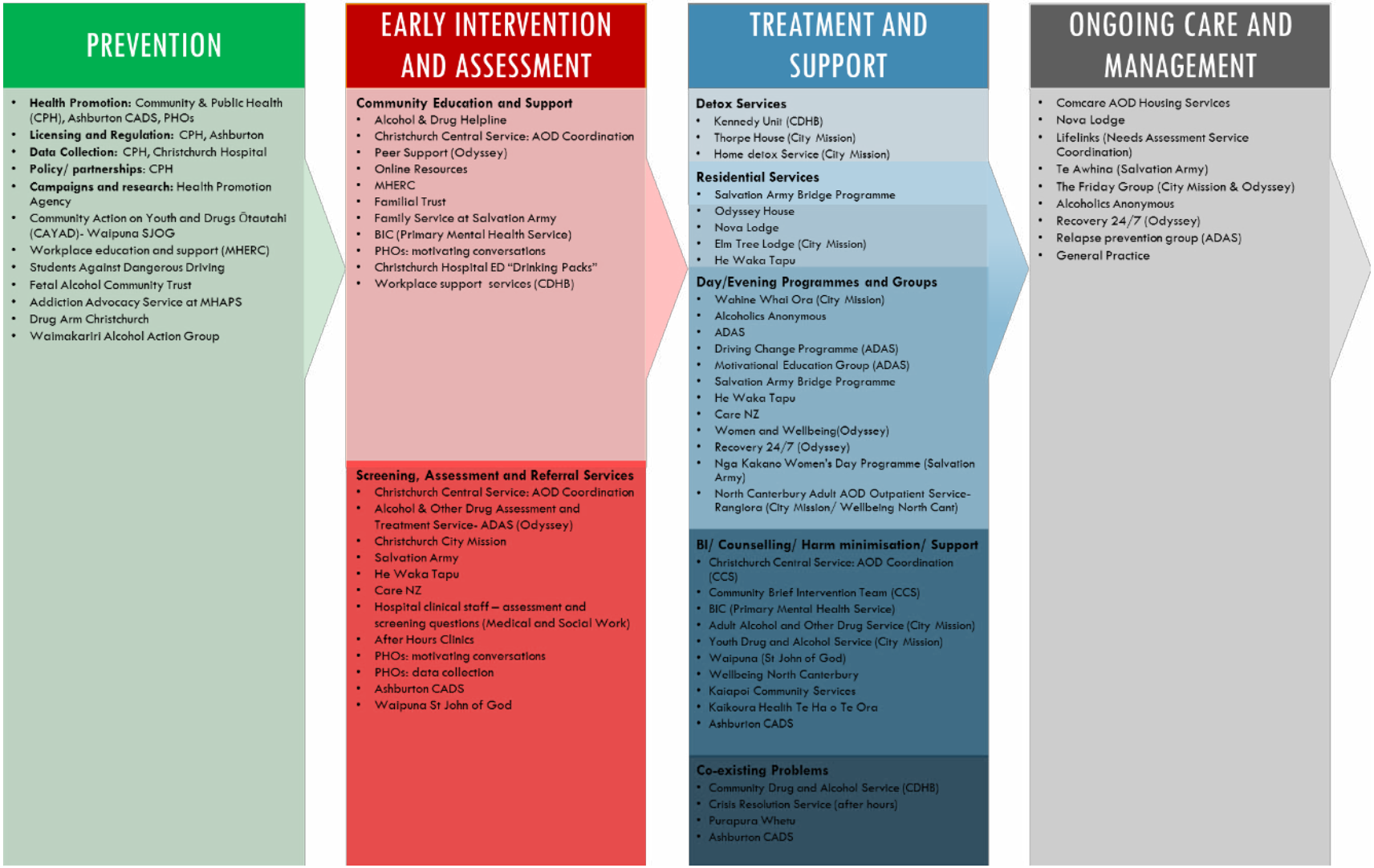

Figure 1. Representation of Alcohol-harm Reduction Activities and Services across the Canterbury Health System

Please note that the information in this list is intended to illustrate the wide-scope of activity related to alcohol already occurring in the Canterbury health system and although every effort was made to be accurate at the time of writing it may contain errors and omissions.

1.3 Vision

Reduced Harm from Alcohol: A Canterbury Health System working together to prevent and reduce the impact of alcohol-related harm in our community.

1.4 Scope and alignment with the Christchurch Alcohol Action Plan

The Canterbury health system incorporates a number of CDHB services, primary care, and local health and social services that provide education and treatment under contract. Geographically, the Canterbury health system incorporates not only Christchurch City but the surrounding regions of: Ashburton, Banks Peninsula, Selwyn, Hurunui, Waimakariri and Kaikoura. This Strategy covers all these regions.

The Canterbury Clinical Network is a collective alliance of healthcare leaders which provides a partnership framework, enabling components of the health system to come together, agree priorities and collaboratively achieve outcomes.

"Reduced Harm from Alcohol" is recognised as a key population level outcome within the Canterbury Health System Outcomes Framework[6]. This Strategy aligns directly to this outcome.

Concurrently, the Christchurch Alcohol Action Plan (CAAP) has been developed by Christchurch City Council, NZ Police and the CDHB and has been endorsed by Safer Christchurch[7]. This plan identifies cross-sector opportunities to achieve a safe, vibrant, healthy Christchurch free from alcohol-related harm. This Strategy demonstrates the health system's contribution to achieving the objectives of the CAAP and ensures that the link to activities occurring outside of the health system is strong.

1.5 Strategy development

The Strategy was originally a collaborative vision between CDHB Planning and Funding and Community & Public Health, however, the consultation process made apparent that a whole of health system approach is necessary to effectively reduce the impact of alcohol-related harm.

Initial consultation included a series of local stakeholder events, the most recent being a workshop held in 2015. Attendees communicated a clear collective aspiration to reduce alcohol-related harm and change societal attitudes towards alcohol.

A background review of national and international alcohol strategy, evidence-based measures to reduce harm and local data to inform how alcohol impacts the population of Canterbury was completed in late 2016.

The review process also encompassed a stocktake of alcohol-related harm reduction activities already occurring across the Canterbury health system (see Figure 1).

[6] Canterbury District Health Board. (2014). *Canterbury Health System Outcomes Framework.* Christchurch: Canterbury Clinical Network. Retrieved from: http://ccn.health.nz/Resources/OutcomesFramework.aspx

[7] Christchurch City Council, Christchurch Police & Canterbury District Health Board. (2017). *Christchurch Alcohol Action Plan*. Christchurch: Christchurch City Council. Available at: https://www.ccc.govt.nz/culture-and-community/community-safety/alcoholactionplan

Engagement meetings with partners across the health system were held in late 2016 and early 2017, from which a strategy development Working Group was established, with membership from:

- Planning & Funding
- Community & Public Health
- Mental Health
- Allied Health (specifically Social Work Services)
- Emergency Medicine
- Primary Health Organisations
- Christchurch Central Service- AOD Coordination
- Māori Health Provider

The Working Group agreed a vision, focus areas and objectives for the strategy through a series of scoping activities and discussions. The outcome of this work is a concise strategic framework which defines four focus areas with a number of underlying objectives and recommendations.

2. Strategic Framework

2.1 Strategy Diagram

The Strategy builds on the Canterbury Health System Outcomes Framework model which already includes the outcome "Reduced Harm from Alcohol".

This Strategy is an expansion of this system-wide objective and has been visually depicted to reflect the relationship to a system-wide approach.

The Strategy framework (Figure 2.) reflects the Strategy vision within a central circle, mirroring the Canterbury Health Systems Outcomes Framework objective described above. The vision is surrounded by an inner circle of fundamental ways of working, which are then surrounded by the four focus areas from which the Strategy objectives are built upon.

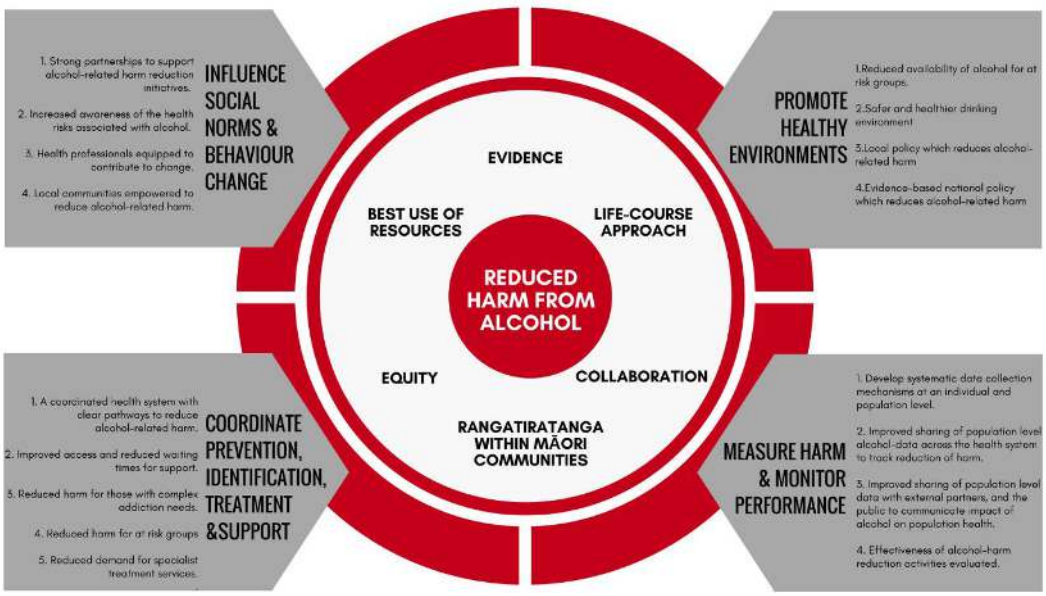

Figure 2. Framework for the Canterbury Health System Alcohol-Related Harm Reduction Strategy

2.2 Values and Ways of Working

The values of this Strategy align with CDHB strategic goals, with respect to alcohol use:

- that people take greater responsibility for their own health;
- people stay well in their own homes and communities; and
- that people receive timely and appropriately complex care.

The following ways of working have been identified during strategy development as an important foundation for all alcohol-related harm reduction efforts in Canterbury:

1. Equity

Alcohol-related harm impacts on certain groups disproportionally. Actions should be a mix of universal and targeted measures to ensure that inequalities around who experiences alcohol-related harm are reduced and not increased.

2. Collaboration

Reducing the harm caused by alcohol requires coherent, collaborative working across the health sector and beyond. This strategy provides an opportunity to demonstrate the potential of primary, secondary and tertiary care, and non-governmental organisations (NGOs) to work together to collectively reduce alcohol-related harm. This strategy also provides an opportunity for others to adopt the CDHB position statement on alcohol.

3. Life-course approach

Alcohol-related harm impacts differently across a lifespan. While youth have traditionally been singled out as the target group for alcohol harm reduction activities and still form an important part of this strategy, the impact of alcohol across life-stages is emphasised; for example acute harm experienced by young adults, chronic illnesses which become apparent during middle-age and the vulnerability of older people who drink. Opportunities to influence different life-stages include targeting pregnant women to reduce rates of Foetal Alcohol Spectrum Disorder or parents who model harmful drinking behaviour to their children.

4. Rangatiratanga within our Māori Communities

This strategy acknowledges the success of local providers who use Māori and bicultural models of health to engage those who identify as Māori in reducing harmful alcohol use. This strategy also acknowledges the important role Mana whenua and tangata whenua has in supporting the health and wellbeing of their communities and the CDHB's commitment to working in partnership with Ngāi Tahu and Papatipu Rūnanga. The strategy should enable iwi, hapū, whānau and local marae to identify and lead their own activities to reduce alcohol-related harm, and support initiatives across various focus areas.

5. Evidence-based

This strategy is built on a strong evidence-base, incorporating both the local impact of alcohol-related harm and effective measures to reduce this harm. This strategy acknowledges that the most effective way to reduce harm caused by alcohol at a population level is through national law change which reflects the 5+ Solution. There is significant evidence-base to show this legislative change is a

very effective method to alter the environment where choices about drinking are made[8]. At the local level, a number of other evidence-based activities can also be carried out.

6. Best use of resources

This strategy includes a stocktake of current activities and services in the alcohol sector to improve visibility of services, and raise awareness for professionals and the public as to what is available. It is important that the health sector works together to ensure a system where the *right care is provided, in the right place, at the right time, by the right person*[9]. A strategic, coordinated approach to alcohol-related harm reduction will prevent duplication, and reduce the demand on specialist services in the long-term through investment in innovative, preventative approaches.

2.3 Focus Areas

Four focus areas with specific objectives provide direction and measurable outcomes for the Strategy. These focus areas cover prevention, treatment and evidence gathering activities.

1. Influence behaviour change and social norms

   The way in which individuals drink alcohol is in part influenced by the way alcohol is portrayed in wider society. Many people do not appreciate the health risks associated with their own drinking behaviour. This focus area of the strategy aims to increase understanding of the risk from alcohol to health. Alcohol is not an ordinary commodity[10]. Action needs to be taken to counter normative drinking attitudes and behaviour on both a national and local level. Social norms around drinking alcohol can be changed; as illustrated by the shift in attitudes to drink driving.

2. Promote Healthy Environments

   Health is influenced by a wide range of factors beyond the health sector. Examples include how alcohol is regulated and how built environments impact upon drinking behaviour. This focus area links strongly with the Christchurch Alcohol Action Plan's objective "Create Safer Spaces" which also promotes strong relationships with decision makers outside of health to consider how the rebuild of Canterbury will impact upon drinking behaviour.

   The Strategy also strongly supports work undertaken by CDHB in assisting its partners, the Police and Christchurch City Council to effectively regulate and enforce the Sale and Supply of Alcohol Act 2012 and Local Alcohol Policies.

3. Coordinate prevention, identification, treatment and support

   Many activities occur across the Canterbury health system to identify and intervene around harmful alcohol use; for example, specialist addiction services, treatment of alcohol-related injuries and health promotion work on and around tertiary campuses. Any level of drinking may carry some risk. Coordination of activities to reduce harm is important for ensuring that alcohol-related harm is identified early, and that right type of support is accessible in a timely manner for individuals, families and communities experiencing alcohol-related harm.

[8] Casswell, S. & Maxwell, A. (2005). What Works to Reduce Alcohol-Related Harm and why aren't The Policies More Popular? *Social Policy Journal of New Zealand Te Puna Whakaaro*, 25, 118-141

[9] Canterbury Clinical Network. (2017). *Our Health System*. Christchurch: Canterbury Clinical Network. Retrieved from: http://ccn.health.nz/OurHealthSystem.aspx

[10] Babor, T. (2010). Alcohol: No ordinary commodity: research and public policy. Oxford: Oxford University Press.

4. Measure harm and monitor performance

Collection of alcohol-related data will help inform and evaluate strategy actions and effectiveness. Understanding the evidence behind alcohol-related harm in Canterbury will help focus activities in the most effective areas. The Strategy aims to expand upon current data collection methods and identify additional data sources to help build a better understanding of how alcohol-related harm impacts our community. This data will be shared across the health system and beyond.

2.4 Objectives

The following objectives aim to achieve the overarching outcomes of each related focus area. The objectives under focus areas 1 and 2 aim to achieve change at a population level, consequently reducing the load on the health system from preventable alcohol-related admissions. Focus area 3 objectives aim to ensure that treatment services are as efficient and patient-centred as possible. Focus area 4 objectives link to development of a solid evidence base and provides direction for monitoring the implementation and impact of the Strategy.

Strategy development has identified where activities are already occurring, but also areas for which future opportunities exist. The table below includes examples of what is currently meeting the specific objective, and an example of the types of activities identified as future opportunities. Each would require assessment as to their feasibility via a proposed selection criteria prior to any form of implementation.

FOCUS AREA 1	OBJECTIVE	
Influence Social Norms and Behaviour Change	1. Strong partnerships to support alcohol-related harm reduction initiatives.	**Health services have an important role in actively working with each other and external organisations to ensure there is a collaborative approach to reducing alcohol-related harm in Canterbury.** E.g. Currently CDHB is collaborating with partners in the implementation of the Christchurch Alcohol Action Plan. **Future opportunities** could be developed between Ngāi Tahu and Papatipu Rūnanga and the health system to support priorities and approaches for reducing alcohol-related harm within Māori communities.

	2. Increased awareness of the health risks associated with alcohol.	**Health services have a responsibility to consistently communicate the evidence-based health risks associated with alcohol. Such messages should be aligned with the Health Promotion Agency, the governmental lead for health messaging**. E.g. Currently Community & Public Health are piloting the "Game On" programme with sports clubs to raise awareness of the health risks associated with alcohol within the sports sector. **Future opportunities** could be developed through promoting every patient interaction within the Health System as an opportunity to positively influence attitudes around alcohol use.
	3. Health professionals equipped to contribute to change.	**Health professionals should have access to training or information which enables them to confidently identify, screen and refer to address harmful drinking.** E.g. Primary Care have been developing their skill-base to provide early intervention to patients through the use of "Motivating Conversations" training module. **Future Opportunities** for the health system could be to engage CDHB People & Capability and equivalent HR resources across the Health Sector in sensitively supporting staff to address their own harmful drinking.

	4. Local communities empowered to reduce alcohol-related harm.	**Local communities should have the ability to access health information which support their own initiatives to reduce alcohol-related harm. Enablers such as community groups, residents associations and Papatipu Rūnanga can be supported to initiate their own harm reduction measures through provision of evidence-based, local information.** E.g. Presently, the Community & Public Health identify alcohol licence applications within high risk communities and ensure the community is informed. HPA has also partnered with Community Law to ensure high risk communities have access to information regarding application and objection processes. **Future Opportunities** within this objective could be to produce a quarterly newsletter for local communities, providing information about latest alcohol research and examples of community-based initiatives to reduce harm.

FOCUS AREA 2	OBJECTIVE	
Promote Healthy Environments	1. Reduced availability of alcohol for at risk groups.	**Health services should continue to participate in initiatives which monitor and reduce the availability of alcohol under the Sale and Supply of Alcohol Act 2012, particularly for communities who experience disproportionate harm.** E.g. Community and Public Health will continue routine Control Purchase Operations (CPOs) to ensure compliance of licensees. **Future Opportunities** may be to expand the Good One Party register to other at risk populations.

	2. Safer and healthier drinking environments.	**Health services should continue to support partners to understand that urban design and planning processes are influential factors in shaping the drinking environment and promote collaboration with building safer, healthier spaces.** E.g. Health Organisations will continue to participate in planning processes with local government to ensure the health implications of planning decisions are considered. **Future Opportunities** exist in fostering relationships with Ngāi Tahu and Papatipu Rūnanga during development planning phases to encourage use of alcohol-harm reduction measures in the built environment.
	3. Local policy which reduces alcohol-related harm.	**Health services should support evidence-based policy at both organisational and community level to reduce alcohol-related harm.** E.g. The CDHB continues to support implementation and review of Local Alcohol Policies across Canterbury. **Future Opportunities** could be to support organisations across the health sector and beyond to develop and implement individual workplace alcohol policies.
	4. Evidence-based national policy which reduces alcohol-related harm.	**Health services should take opportunities to advocate for national policy changes (such as the 5+ solution) which will reduce population level harm, and are supported by strong evidence.** E.g. The CDHB and other health organisations continue to influence local alcohol policy through submissions. **Future Opportunities** exist in possible advocating opportunities as a collective health system for national legislation reform which adopts the 5+ solution.

FOCUS AREA 3	OBJECTIVE	
Coordinate prevention, identification, treatment and support	1. A coordinated health system with clear pathways to reduce alcohol-related harm.	**People should be able to access the level of assessment, treatment and support required to meet their needs to reduce alcohol-related harm.** E.g. The Christchurch Central Service – AOD Coordination provides a centralised access point to all services with processes for ongoing monitoring and review. There is also direct access to kaupapa Māori services for those who seek this approach. **Future opportunities** exist around improving access for rural communities and culturally and linguistically diverse communities.
	2. Improved access and reduced waiting times for support.	**The health system should incorporate activities to ensure opportunities for identification/screening are available in a range of settings**. E.g. Primary care, ED and other health services can access resources (online and hard copy) to provide education/information as part of motivational conversations about alcohol use. **Future opportunities** include broadening training and support to increase opportunistic screening and brief intervention and improving access for non-AOD staff to specialist advice.

	3. Reduced harm for those with complex addiction needs.	**People with complex needs may not respond to standard treatment approaches, they should be able to access a range of support to reduce the impact of alcohol-related harm.** E.g. Community Alcohol and Drug Service (CADS) is the specialist Co-existing Problems (CEP) service and provides input into all treatment planning through a centralised approach. **Future opportunities** may be to explore options that can provide long-term care and support for people with poor mental health and enduring alcohol use disorders who do not wish to cease alcohol use.
	4. Reduced harm for at risk groups.	**There are a number of at risk groups disproportionally affected by alcohol-related harm. It is important these groups are identified and approaches for engagement tailored accordingly.** E.g. Currently a number of services provide targeted support to at risk populations, such as the Alcohol & Other Drug Assessment & Treatment Service (ADAS) for offenders, 65 Alive for older persons, and the Community Youth Mental Health Service (CYMHS). **Future Opportunities** exist around working with young women who are pregnant, and establishing stronger links with Integrated Safety Response and Family Violence agencies given the strong relationship between alcohol and family violence.

	5. Reduced demand for specialist treatment services.	**The health system should work together to reduce the development of severe and enduring alcohol use disorders by supporting prevention, early intervention and options for self-management.** E.g. Early intervention and self-management services are currently available through the Alcohol & Drug Helpline, Health Promotion Agency resources, upskilling primary care, MHERC training with non-health workforces, primary mental health teams undertaking Assessment and Brief Intervention (ABI), dedicated ABI in the Christchurch Central Service- AOD Coordination. **Future Opportunities** exist around increasing awareness of and access to resources, education, training, specialist advice and support.

FOCUS AREA 4	OBJECTIVE	
Measure harm and monitor performance	1. Develop systematic data collection mechanisms at an individual and population level.	**Accurate information on alcohol-related harm will help inform partners and identify groups which may require targeted intervention or selective prevention. Such information should provide an evidence-base which informs where future resources and efforts should be concentrated.** E.g. ED data collection on alcohol related presentations. **Future opportunities** exist around targeted screening in general practice and recording when at risk drinking patterns are identified.

	2. Improved sharing of population level alcohol-data across the health system to track reduction of harm.	**Enabling the development of tools such as a "viewer" supports the desire for organisations across the health system to share information so that they better understand the overall impact of alcohol-related harm on the health system.** **Future Opportunities** exist around developing platforms to share summary data such as rate of hospital admissions, primary care presentations, referrals to providers and successful treatment outcomes.
	3. Improved sharing of population level data with external partners, and the public to communicate impact of alcohol on population health.	**Population level data regarding the impact of alcohol-related harm on the health system provides evidence-base to the health risk narrative associated with this Strategy. Such information should be shared with partners and the public to support collaborative actions to reduce harm.** **Future Opportunities** exist around developing infographics which summarise alcohol health system data for dissemination via existing partnerships such as Healthy Greater Christchurch.
	4. Effectiveness of alcohol-harm reduction activities evaluated.	**A whole of system reporting framework to track indicators and report on agreed measures should be developed to monitor objectives and evaluate the impact of the Strategy as a whole.** **Future opportunities** could include seeking qualitative feedback from consumers, police and other partners.

3. Recommendations for Strategy Implementation

The purpose of the Strategy is to provide direction for future alcohol harm reduction work. Although many potential activities have been identified during development, the Strategy is not intended to specify project detail regarding implementation.

The following are recommendations of how the Strategy could be implemented in order to achieve its objectives in a collaborative, coordinated and efficient way.

1. Establish an advisory group or service level alliance

To achieve coordinated implementation of the Strategy, a group which holds a governance role in relation to achieving Strategy objectives is required. Membership of such a group requires representation from across the health system (including primary care and community services) and should include clinical experts. Use of the Canterbury Clinical Network model may be appropriate to ensure that once implementation of the Strategy is under way, individual members of the group drive agreed activities that relate to their respective services with support from the facilitator.

2. Develop reporting arrangements that ensure wider accountability

It is recommended that the Strategy maintains lines of accountability to both the Canterbury Clinical Network, Alliance Leadership Team and the CDHB Executive Management Team (EMT). This would be via annual reporting on objectives and review of the implementation plan. The General Manager for the service under which the facilitator role would be managed, may also provide periodic updates as to progress to EMT, the Community and Public Health Advisory Committee (CPHAC), Manawhenua ki Waitaha and the board as appropriate.

3. Establish links with the Christchurch Alcohol Action Plan

Established links between the Strategy and the Christchurch Alcohol Action Plan should be maintained via regular liaison between the project leads responsible for implementation of each plan. This would involve co-membership on the respective working groups given the number of cross-over activities. The Christchurch Alcohol Action Plan and the Strategy have been designed to complement one another rather than replicating activities to ensure that all sectors work together to achieve the shared vision of reduced alcohol-related harm for Christchurch.

4. Develop an implementation plan

It is recommended that implementation of the Strategy is managed via an accompanying implementation plan. This should detail specific activities required to achieve the objectives, set targets, timeframes and name relevant responsible leads for each activity across the health services. The implementation plan should be reviewed annually and activities formally evaluated.

5. Develop assessment criteria to select and prioritise implementation activities

From scoping already completed, there is likely to be over 60 implementation activities associated with achieving the Strategy objectives. A robust criteria for selecting and prioritising these activities is proposed and should be included in the implementation plan.

6. Develop a communications plan

It is recommended that a Communications and Engagement Plan accompanies the Strategy to ensure a coordinated release of information, consistent with the key messages of the Strategy, and

to identify the communication tools to be used. Key messages should be consistent with the CDHB position statement on alcohol, the National Drug Policy 2015 to 2020[11] and the Health Promotion Agency's Statement of Intent[12] and draft Alcohol Programme Strategic Plan 2017-2021, and the Christchurch Alcohol Action Plan 2017-2021.

7. Undertake evaluation and monitoring

The Work plan Portal, an online project management portal developed by Community & Public Health, is recommended as an appropriate tool to house the Strategy implementation plan and monitor implementation progress. A key strength of the Portal design is that it is internet-based and accessible to registered users from any web browser.

[11] Ministry of Health. (2015). *National Drug Policy 2015-2020*. Wellington: Ministry of Health. Retrieved from: http://www.health.govt.nz/publication/national-drug-policy-2015-2020

[12] Health Promotion Agency. (2014). *Statement of Intent 2014 – 2018*. Wellington: Health Promotion Agency. Retrieved from: http://www.hpa.org.nz/sites/default/files/documents/SOI%202014-2018.pdf

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Canterbury District Health Board's

POSITION STATEMENT ON ALCOHOL

This position statement is consistent with the position statements of Nelson Marlborough, West Coast, Canterbury, South Canterbury, and Southern District Health Boards[1] and should be read in conjunction with the evidence-based background paper on alcohol.[2] Both documents have been developed collaboratively by the South Island Public Health Units and represent the South Island DHBs working together to address alcohol-related harm.

The Canterbury District Health Board acknowledges the wide range of alcohol-related harm that is experienced by people within the Canterbury district and that the burden of this harm is carried disproportionately by some population groups. It recognises that alcohol use is a major risk factor for numerous health conditions, injuries and social problems. Additionally, alcohol-related harm costs the health sector significant money, time and resources.

CANTERBURY DHB POSITION:

The Canterbury District Health Board will reduce the alcohol-related harm experienced by people within the Canterbury district by developing an Alcohol Harm Reduction Strategy. This strategy will set out the actions Canterbury District Health Board will undertake to reduce alcohol-related harm, including a communication plan.

The Canterbury District Health Board will identify and record alcohol-related presentations within the Canterbury district in a consistent manner.

The Canterbury District Health Board will support and assist Territorial Authorities to develop local alcohol plans that seek to reduce alcohol-related harm by providing information on alcohol-related presentations to emergency departments, and other information pertaining to the burden of alcohol. It will provide further evidence-based advice to assist with these plans.

EVIDENCE BASED SOLUTIONS:

The Canterbury District Health Board will advocate for the following evidence-based solutions to reduce the alcohol-related harm experienced by New Zealanders[3]:

[1] Individual DHBs: delete own DHB from this list as appropriate.
[2] A summary of evidence from the paper is attached as an appendix. Full references are in the background paper.
[3] These recommendations align with the CDHB's Submission to The Law Commission's Issues Paper on the Reform of New Zealand's Liquor Laws (2009), and with those contained in a recent Commentary from the Injury Prevention Research Unit: Kypri, K., Maclennan, B., Langley, J.D., and Connor, J.L. 2011. 'The *Alcohol Reform Bill*: More tinkering than reform in response to the New Zealand public's demand for better laws'. *Drug and Alcohol Review* 30, 428-433.

Raise alcohol prices

- Increase levels of excise tax on alcohol by at least 50%
- Adjust excise tax so that alcohol products taxed directly on level of ethanol
- Use revenue from increase in excise tax to reduce harm amongst high-risk consumers
- Set minimum retail price for alcohol (per alcohol unit)

Raise the alcohol purchase age

- Restore alcohol purchase age to 20 years for both on-licences and off-licences
- Ensure enforcement of minimum purchase age
- Additionally, make it an offence for an adult other than a parent/guardian to supply alcohol to a child; and require parents/guardians who supply alcohol to their child to supervise the consumption of that alcohol

Reduce alcohol accessibility

- Restrict on-licences from selling alcohol after 2am
- Restrict off-licences to selling alcohol between 8am and 10pm
- Restrict convenience stores / dairies from selling alcohol
- Tighten law on granting of liquor licences – provide further grounds to refuse licences (e.g. detrimental social impact to community)
- Tighten restrictions on numbers of outlets in a given area

Reduce marketing and advertising of alcohol

- Ban alcohol sponsorship of sporting and cultural events
- Ban advertising of alcohol from television and cinema
- Advertising of alcohol to convey only basic information about the product
- Put health warning labels on alcohol products
- Ensure alcoholic beverages are labelled with ingredient and nutritional information
- Prohibit marketing of alcohol to youth

Reduce legal blood-alcohol limits for drivers

- Lower the legal blood alcohol (BAC) limit from 80mg/100ml blood to 50mg/100ml blood

Canterbury
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APPENDIX: Summary of Evidence

Alcohol Related Harm:

Alcohol use is a major risk factor for numerous health conditions, injuries and social problems, causing approximately 4% of deaths worldwide and (in 2000) 3.9% of all deaths in New Zealand. Much acute harm results from intoxication and includes: road traffic injuries and fatalities, burns, falls, drowning, poisoning, foetal alcohol spectrum disorder, assault, self-inflicted injury, suicide and homicide.

Biological effects of alcohol
Alcohol affects the brain. It alters the mood and impairs memory and psychomotor function. People who consume alcohol are less inhibited and therefore more likely to take risks and behave aggressively, leading to motor vehicle accidents and other injuries. Alcohol use is linked to a wide range of major diseases, including: heart disease, cancer, psychiatric and neurological conditions, gastrointestinal disease, and birth defects including foetal alcohol syndrome. It also contributes to diabetes, sleep disorders, and infectious diseases such as pneumonia and tuberculosis.

Unborn children and adolescents are particularly vulnerable to the effects of alcohol. Unborn children exposed to alcohol are at high risk of problems with memory, language, attention, learning, Visio-spatial ability, fine and gross motor skills, and social and adaptive functioning. Adolescent brains are still developing and therefore vulnerable to alcohol toxicity, addictive problems and psychiatric disorders.

Alcohol-related harm
Alcohol contributes to crime in New Zealand. Nearly half of all homicides in New Zealand between 1999 and 2008 involved alcohol. A third of all offenders in the year 2007/08 had consumed alcohol. Drink driving causes substantial harm - 27% of drivers in all fatal crashes between 2007 and 2009 were reported as having consumed alcohol.

Social harm results from alcohol: reportedly 12.2% of adults experienced harmful effects on friendships, social life, home life, work/study/employment opportunities, financial position, and legal problems or difficulty learning from their own drinking in the past year.

The economic cost of alcohol-related harm in New Zealand is significant. Harmful alcohol use in 2005/06 alone cost New Zealand an estimated $4,794 million of diverted resources and lost welfare.

Alcohol-related harm and population groups
Alcohol-related harm is experienced variably throughout the population. Men have a higher rate of alcohol-related mortality than women and Māori have a higher rate than non-Māori. Evidence clearly demonstrates that Māori suffer disproportionately from a wide range of alcohol-related harms compared to non-Māori. New Zealanders with lower socioeconomic status also bear a disproportionate burden of alcohol-related harm. Children are particularly vulnerable to alcohol-related harm caused by the drinking of other people and can suffer from increased susceptibility to child abuse, neglect and witnessing family violence if caregivers have an alcohol problem.

Cost of alcohol-related harm to the health sector
Alcohol-related harm in New Zealand costs the health sector significant money, time and resources. Intoxicated patients also impact negatively on staff and other patients. An estimated 35% of injury-based emergency department presentations are alcohol-related. From 1 November 2010 to 29 October 2011 892 patients were seen in Dunedin Hospital Emergency Department for alcohol-related presentations. The average length of stay for these patients was 4.5 hours, with an average cost to Southern District Health Board of $1,000 per person.

NZ Drinking Pattern:

Alcohol is widely available in NZ
Alcohol is easily accessible from a wide variety of outlets and to anyone over the age of 18. It can be purchased 24 hours a day, 7 days a week and on most days of the year. Alcohol can be consumed either on the premises (on-licences) in bars, restaurants, cafes, hotels, pubs and individual clubs or at special functions; or off the premises (off-licences) when purchased from liquor stores, supermarkets, grocery stores or dairies. Alcohol is more widely available now than in the past: in 2010 the number of places which held liquor licences was 14,424; this has increased from 6,295 in 1990. It is inexpensive: reportedly, in 2010, 3 litres of cask wine could be purchased (on special) for as little as $16.99.

Drinking patterns in NZ
According to recent surveys, most New Zealanders (85%) drink at least some alcohol. At least two-thirds of those surveyed in 2007/08 drank once a week. Of people surveyed, nearly two-thirds of all people drank to excess at least once a year and one in ten did so at least once a week. Harmful drinking is more common amongst Māori, Pacific and young people. New Zealanders tolerate excess drinking – less than half surveyed agreed that "It is never O.K. to get drunk" and over one quarter agreed that it is "O.K. to get drunk as long as it's not everyday". A third of those surveyed started drinking at around the age of 14.

How the current law impacts upon these drinking patterns
The Sale of Liquor Act (1989) has liberalised the sale of alcohol, allowing it to be sold widely, including from supermarkets and over a 24 hour period. Since 1999 (with an amendment to the Act), the purchase age has dropped to 18 (from 20 years), beer has become available in supermarkets and alcohol can be purchased on Sundays. District Licensing Authorities (DLAs) in each local area grant and renew licenses and stipulate opening times. Licensing Inspectors check that premises within their area comply with regulations (e.g. not selling to those who are already intoxicated). The Resource Management Act (1991) legislates how local communities manage the use of land, which requires that a District Plan be put into place and complied with. The Local Government Amendment Act 2001 allows local authorities to impose liquor bans, banning alcohol in public places at certain times. The Land Transport Amendment Act (2011) has lowered the blood alcohol concentration (BAC) limit for drivers under 20 years to zero. The limit for drivers over 20 years is 80mg per 100ml blood.

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Evidence Based Strategies to Reduce Harm:

Raise prices
Evidence shows that when alcohol prices go up, consumption goes down. One of the best ways to influence the consumption of alcohol is through pricing. Alcohol prices are subject to excise tax, which in New Zealand is set at a particular rate depending on which band of alcohol strength the product falls into (e.g. alcoholic beverages between 9-14% alcohol are taxed at 10%). Currently excise tax rates are lower than that of other countries; they are also not adjusted for inflation. In New Zealand there is often a price differential between on and off-licences, which encourages 'pre-loading' (loading up on cheap alcohol before frequenting on-licences).

Raise the purchase age
Research shows that the legal purchase age affects how much youth drink. A lower purchase age has been associated with increased harm (including traffic crashes). In order for a higher purchase age to be effective, it needs to be combined with adequate enforcement. A higher purchase age acknowledges that the effect of alcohol and its harms is much greater on the adolescent brain as it is still developing.

Reduce alcohol accessibility
It is scientifically and economically effective to restrict the physical availability of alcohol in order to reduce harm. Limiting the physical availability of alcohol can be achieved through limiting the hours and days of sale, and controlling outlet density. Currently alcohol is too easily purchased and facilitates pre-loading. There are often too many alcohol outlets within an area – high densities of alcohol outlets have been shown to be associated with increased harm, including traffic crashes.

Reduce marketing and advertising
Advertising of alcohol has increased in many countries over recent decades, including New Zealand. Prior to the 1980s alcohol advertising in New Zealand was mostly non-existent, due to legislation controlling the advertising of alcohol – now alcohol advertising is left to the self-regulation of the industry. Since 1992, advertising of alcohol has been allowed on both television and radio – albeit at restricted times (9pm-6am) for television. Since 1987 alcohol companies have been allowed to sponsor sports and advertise corporately. Alcohol advertisements often sell the image that drinking is attractive, glamorous and fun; and these messages are particularly appealing to young people. Alcohol advertising not only leads to greater consumption of alcohol, but also colours people's perceptions of the drinking habits of others.

Reduce legal blood alcohol limits for drivers
With increasing levels of alcohol in the blood, driving performance declines. Currently (as of 2011), there is zero tolerance for drivers under 20 years with any alcohol at all in their blood. Drivers over 20 are legally entitled to drive after drinking with no more than 80mg per 100ml of alcohol in the blood. In 2009 in New Zealand, 138 deaths resulted from traffic accidents where alcohol (and/or drug use) was a contributing factor. Research has shown that the risk of traffic crashes goes up proportionate to the level of alcohol in the blood: the risk doubles for those with 0.05% BAC compared to those with none; there is ten times the risk for those with 0.08% BAC; and one hundred times the risk for those with 0.15% BAC or higher.

HAC – 29 NOVEMBER 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Hospital Advisory Committee**

DATE: **13 December 2018**

Report Status – For:	Decision	☐	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Hospital Advisory Committee's (*HAC*) public meeting held on 29 November 2018.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from HAC's public meeting on 29 November 2018 (Appendix 1).

3. APPENDICES

Appendix 1: HAC Draft Minutes – 29 November 2018

Report prepared by: Anna Craw, Board Secretariat

Report approved by: Andrew Dickerson, Chair, Hospital Advisory Committee

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 29 November 2018, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Barry Bragg; Sally Buck; Dr Anna Crighton; Jan Edwards; David Morrell; and Dr Rochelle Phipps.

APOLOGIES
Apologies for absence were received and accepted from Trevor Read; Ta Mark Solomon; and Dr John Wood.

EXECUTIVE SUPPORT
Mary Gordon (Executive Director of Nursing); Dr Greg Hamilton (Team Leader, Intelligence & Transformation, Planning & Funding); Jacqui Lunday-Johnstone (Executive Director of Allied Health, Scientific & Technical); Dr Sue Nightingale (Chief Medical Officer); Anna Craw (Board Secretariat); Charlotte Evers (Assistant Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

IN ATTENDANCE

Item 4
Dan Coward – General Manager, Older Persons, Orthopaedics & Rehabilitation Service, Burwood Hospital
Heather Gray – Director of Nursing, Christchurch Campus
Dr Peri Renison – Chief of Psychiatry, Specialist Mental Health Services (*SMHS*)
Bernice Marra – Manager, Ashburton Health Services

Item 5
Ralph La Salle, Team Leader, Secondary Care, Planning & Funding

Andrew Dickerson, Chair, welcomed Jacqui Lunday-Johnstone to her first meeting of the Committee, and asked her to introduce herself as the newly appointed Executive Director of Allied Health, Scientific & Technical.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions/alterations to the Interest Register.

Declarations of Interest for Items on Today's Agenda
There were no declarations of interest for items on today's agenda.

Perceived Conflicts of Interest
There were no perceived conflicts of interest.

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (19/18)
(Moved: Sally Buck/Seconded: Dr Rochelle Phipps – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 4 October 2018 be approved and adopted as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

Item 1, AT&R Unit Update: remove from carried forward list.

The Committee noted the remaining carried forward items.

4. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for October 2018. The report was taken as read.

General Managers spoke to their areas as follows:

Ashburton Health Services – Bernice Marra, Manager Ashburton Health Services
Ms Marra highlighted the Signal for Noise (*SFN*) graph on inpatient occupancy and the continuing focus on the frail elderly pathway. A workshop was held recently on re-focusing this service, with a new model for falls in rural hospitals underway.

There is ongoing research in chemotherapy delivery in the oncology unit, including expanding treatment to five days a week.

A new Director of Nursing starts in December.

Jo Kane joined the meeting at 9.10am.

There was discussion around the upcoming change in GP fee structure and the impacts on GP service. Work is underway with Service Level Alliance (*SLA*) operations groups to utilise opportunities in acute demand and with nurse practitioners. Recruitment is continuing for more nurse practitioners.

The chemotherapy service was discussed, with questions around whether it is for only adults and if patients stay in the unit overnight. Ms Marra confirmed children travel to Christchurch for treatment. How a patient's treatment is handled depends on the regime, with patients attending weekly or monthly. It is a day stay unit.

Discussion was held around recent media coverage of job vacancies in Ashburton and the impact on health services. This is largely due to population growth and diversity. Work is ongoing on a 10-15 year health plan, in conjunction with the Ashburton District Council.

Medical/Surgical & Women's & Children's Health – Heather Gray, Director of Nursing, Christchurch Campus (for Pauline Clark)
Ms Gray highlighted the recent successful rollout of the South Island Patient Information Care System (*SIPICS*). Operational matters are currently being worked through.

The move to the Outpatients building was also highlighted, with Ms Gray commenting on its success. A daily meeting is held regarding service issues. The defect process is underway. Access to the building has been better than expected, and staff and patients are enjoying the new facilities.

A Committee member queried what measures had been taken towards sustainability. Discussions were held around natural light, air flow and energy sources, with the model of care re-designed before migration to look at what equipment was surplus to requirements. A Sustainability Committee works across all services to develop long-term strategies for efficient, sustainable facilities.

Discussion was held around migration planning for the Acute Services Building (*ASB*). The governance group has been re-set to allow broader representation. Agile movement practices were learned from earthquake moves.

Specialist Mental Health Services (*SMHS*) – Dr Peri Renison, Chief of Psychiatry (for Toni Gutschlag)

Dr Renison discussed the level of assaults in the in-patient unit. Staff are working on finding solutions.

The planned shift from The Princess Margaret Hospital (*TPMH*) was discussed. Planning work is underway, with teams working on detail in anticipation of a move. Staff engagement in this is high, and staff morale has lifted.

Discussion was held around growth in adult community cases and the source of these. The main route is GP referrals. A Committee member queried how many of these patients are likely to be undergoing earthquake related stress. Dr Renison commented it is difficult to know the exact number, but commented it is an ongoing issue.

Discussion was held around the inquiry into Mental Health and Addiction, with it noted that a report is due for release before the end of the parliamentary year.

Older Persons, Orthopaedics & Rehabilitation Service – Dan Coward, General Manager

Mr Coward highlighted the falls and introduction of the Safe Recovery Programme at Burwood Hospital. This has involved a three month pilot and has included patient surveys in order to shape tools and resources. Data from the pilot will be included in the Committee's January 2019 report. This will be an ongoing programme.

Specialist gerontology statistics have shown a decrease in patients seen by consultants, now being seen by Clinical Nurse Specialists. This allows for better interaction between services and a reduction in waiting times.

A query was raised on the redevelopment of the Spinal Unit. Mr Coward advised that the demolition component is complete, and strip out is nearly complete. The project is on track.

Discussion was held around the artificial limb centre. Mr Coward confirmed that the New Zealand Artificial Limb Centre is undertaking a nationwide review of facilities and are in the early stages of re-thinking their Canterbury operations. Burwood will continue to support the current arrangement.

Mary Gordon, Director of Nursing, commented on the recent Gateway Review of the Burwood Hospital redevelopment. A group of four independent reviewers visited the campus last week, undertaking patient and staff interviews. Early findings show that the benefits of the redevelopment were achieved, with outstanding patient outcomes. It was requested that formal recognition of staff be made by the Board.

Resolution (20/18)
(Moved: David Morrell/Seconded: Jan Edwards – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

5. PLANNING & FUNDING ELECTIVES UPDATE

Ralph La Salle, Team Leader, Secondary Care, Planning & Funding, presented the report.

2019 will be a challenging year, due to population increases and the continued use of operating theatres at Christchurch Hospital in acute surgical cases. Outsourcing/placing of surgeries will remain high, with complex and complicated cases driving a new standard for care.

Discussion was held around intervention rates and how they drive volume. There are complexities in outsourcing surgical care, particularly spinal, which is a nationwide issue. There is a strategy around recruitment, but this will remain challenging.

A Committee member put a question to Dr Sue Nightingale, Chief Medical Officer, on the level of risk. While it is a tenuous position, daily work is ongoing in finding alternatives and creating rosters that have flow-on effects in other areas.

A query was made around what further electives planning has been done beyond 2018/19, particularly when ASB is open. Mr La Salle confirmed conversations are ongoing, but there are still decisions to be made around the order of services to be brought back in-house.

Resolution (21/18)
(Moved: Jo Kane/Seconded: David Morrell – carried)

"That the Committee:

i. notes the Planning & Funding Electives Plan for 2018/19."

6. 2018 WINTER PLANNING REVIEW – PRESENTATION

Dr Greg Hamilton, Team Leader, Intelligence and Transformation, Planning & Funding presented the review, highlighting the following:

- Growth in population is driving Emergency Department (*ED*) attendances.
- Higher ACC attendances as a result of accidents.
- Increase in re-admission rate to Acute Medical Admitting Unit (*AMAU*) and ED.
- Higher volume of pneumonia care in over 75 year olds.
- High pressure in ICU July to September.
- ED demand is in line with projections, with summer spikes driven by various factors.
- Inpatient admissions, total occupied beds and patients over 75 are in line with projections.

Planning for winter 2019 is underway.

A Committee member queried whether a second 24 hour clinic would help decrease demand. Due to the concentrated workforce in the current 24 hour clinic, a second one would split resources and would be of no benefit.

Dr Anna Crighton, Co-Chair, Community & Public Health and Disability Support Committee (*CPH&DSAC*), asked what work had been done in extending free flu jabs to the wider population. Dr Hamilton commented that special authority is needed from Pharmac for this, as well as a review of the literature on how effective it would be. Dr Hamilton undertook to present a report to the next CPH&DSAC meeting in March 2019.

Discussion was held around what drove the summer peak. In October 2017, private radiology practices raised their ACC co-payments, which was then withdrawn in December. ACC presentations also increased. However there were no obvious trends. It was queried whether summer planning is needed, but Dr Hamilton confirmed this comes under daily planning, whereas winter planning needs complex and additional resources.

7. CLINICAL ADVISOR UPDATE – MEDICAL – ORAL

Dr Sue Nightingale, Chief Medical Officer, provided her clinical advisor update. There was no discussion.

8. DRAFT 2019 WORKPLAN

The Committee received the Draft Workplan for 2019. The Chair welcomed suggestions from the Committee.

It was requested that the Quality & Patient Safety Indicators – Level of Complaints report be included as a standing agenda item, rather than an information item. The Chair undertook to consider this.

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (22/18)
(Moved: Dr Anna Crighton/Seconded: David Morrell – carried)

"That the Committee:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1 and 2;

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 4 October 2018.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to

result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982."

INFORMATION ITEMS

- Quality & Patient Safety Indicators – Level of Complaints
- 2018 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.59am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson Date
Chairperson

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Corporate Services**

DATE: **13 December 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The following agenda items for the meeting are to be held with the public excluded. This section contains items for discussion that require the public to be excluded for the reasons set out below. The New Zealand Public Health and Disability Act 2000 (the *Act*), Schedule 3, Clauses 32 and 33, and the Canterbury DHB Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATIONS

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and the information items contained in the report;

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting on 15 November 2018	For the reasons set out in the previous Board agenda.	
2.	Christchurch Hospital – Avon Switchgear & Transformers	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
3.	Land Swap with the Crown	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4.	Approval of Trust Fund Expenditure	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	IT Disaster Recovery	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Chair & Chief Executive's Update on Emerging Issues – Oral Reports	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)

7.	People Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
9.	Advice to Board: • FAC Draft Notes & Email Resolution *21 Nov 2018* • QFARC Draft Minutes *27 Nov 2018* • HAC Draft Minutes *29 Nov 2018*	For the reasons set out in the previous Committee agendas.	
10.	Board Only Time	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

"A Board may by resolution exclude the public from the whole or any part of any meeting of the Board on the grounds that:

(a) the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982.

In addition Clauses (b) (c) (d) and (e) of Clause 32 provide further grounds on which a Board may exclude members of the public from a meeting, which are not considered relevant in this instance.

Clause 33 of the Act also further provides:

(1) Every resolution to exclude the public from any meeting of a Board must state:

(a) the general subject of each matter to be considered while the public is excluded; and

(b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on Clause 32(a) the particular interest or interests protected by section 6 or 7 or section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and

(c) the grounds on which that resolution is based(being one or more of the grounds stated in Clause 32)

(2) Every resolution to exclude the public must be put at a time when the meeting is open to the public, and the text of that resolution must be available to any member of the public who is present and form part of the minutes of the Board.

Approved for release by: Justine White, Executive Director, Finance & Corporate Services