AGENDA

Canterbury District Health Board
Te Poari Hauora o Waitaha

COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING

To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 29 August 2019 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 4 July 2019		
3.	Carried Forward / Action List Items		
4.	Community & Public Health Update Report	Evon Currie	9.05-9.15am
5.	Environmentally Sustainable Health Care: Position Statement	Evon Currie	9.15-9.25am
6.	Communicable Disease (Presentation)	Kerry Marshall Dr Ramon Pink	9.25-9.55am
7.	Planning & Funding Update Report	Carolyn Gullery	9.55-10.05am
8.	InterRAI (Presentation)	Mardi Postill Andrea Davidson	10.05-10.30am
MORNING TEA			**10.30-10.45am**
9.	Workforce Diversity, Inclusion & Belonging	Jacqui Lunday-Johnston	10.45-11.00am
10.	Step Up Programme Update	Kathy O'Neill	11.00-11.15am
11.	Community & Public Health Update – Disability Sector (Presentation)	Allison Nichols-Dunsmuir	11.15-11.40am
ESTIMATED FINISH TIME			**11.40am**

AGENDA

Canterbury District Health Board
Te Poari Hauora o Waitaha

	Information Items • CDHB Public Health Report: January – June 2019 • Board Minutes Excerpt – 18 July 2019 – Maori Health Strategy Proposal • Extracts from Chief Executive's Report to Board - 18 July 2019 • Influenza – Pharmac Approvals (CPH&DSAC - 7 March 2019) • Disability Steering Group Minutes (21 June 2019 and 26 July 2019) • Canterbury & West Coast Health Disability Action Plan • 2020 Tentative Meeting Schedule • 2019 Workplan		

NEXT MEETING: Thursday, 31 October 2019 at 9.00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

Dr Anna Crighton (Chair)
David Morrell (Deputy Chair)
Sally Buck
Tracey Chambers
Jo Kane
Chris Mene
Wendy Dallas-Katoa
Rochelle Faimalo
Dr Susan Foster-Cohen
Yvonne Palmer
Dr John Wood (ex-officio)
Ta Mark Solomon (ex-officio)

DISABILITY SUPPORT ADVISORY COMMITTEE

Tracey Chambers (Chair)
Chris Mene (Deputy Chair)
Sally Buck
Dr Anna Crighton
Tom Callanan
Dr Olive Webb
Hans Wouters
Dr John Wood (ex-officio)
Ta Mark Solomon (ex-officio)

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*
Kay Jenkins – *Executive Assistant, Governance Support*

COMMITTEE ATTENDANCE SCHEDULE 2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	07/03/19	09/05/19	04/07/19	29/08/19	31/10/19
Dr Anna Crighton (Chair, CPHAC)	√	~	√		
Tracey Chambers (Chair, DSAC)	√	√	#		
David Morrell (Deputy Chair, CPHAC)	#	√	^		
Chris Mene (Deputy Chair, DSAC)	√	#	#		
Sally Buck	√	√	√		
Jo Kane	√	√	√		
Tom Callanan	√	√	√		
Wendy Dallas-Katoa	√	√	√		
Rochelle Faimolo	#	√	#		
Dr Susan Foster Cohen	#	√	#		
Yvonne Palmer	#	√	#		
Dr Olive Webb	√	√	√		
Hans Wouters	√	√	√		
Dr John Wood (ex-officio)	√	#	#		
Ta Mark Solomon (ex-officio)	√	^	√		

√ Attended
x Absent
Absent with apology
^ Attended part of meeting
~ Leave of absence
* Appointed effective
** No longer on the Committee effective

CONFLICTS OF INTEREST REGISTER COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE (*CPH&DSAC*)

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 Anna Crighton **Chair - CPHAC** Board Member	**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. **The Art Registry Company Limited** – Shareholder **Theatre Royal Charitable Foundation** - Director
Tracey Chambers **Chair - DSAC** Board Member	**Chambers Public Relations Limited** – Director/Shareholder 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. (NB: in resignation process)
David Morrell **Deputy Chair - CPHAC** 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.

Chris Mene **Deputy Chair – DSAC** Board Member	**Canterbury Clinical Network** – Child & Youth Workstream Member **Core Education** – Director Has an interest in the interface between education and health. **Muslim Community Reference Group** – Independent Facilitator Advising Royal Commission of Inquiry into the Attack on Christchurch Mosques on 15 March 2019 (the Royal Commission). **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.
Sally Buck Board Member	**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.
Tom Callanan	**CCS Disability Action** – Services Manager, Canterbury Service provider within disability sector in New Zealand, including advocacy and information sharing. **Disability Sector System Transformation, Regional Leadership Group** – Member. **Project Search Canterbury** – Steering Group Member Representing CCS Disability Action as a partner. CDHB current host business.
Wendy Dallas-Katoa Manawhenua	**Greater Healthy Christchurch** – Runanga Representative **IHI Research –** Social Change and Innovation Researcher **Manawhenua Ki Waitaha** – Chair, Representative of Onuku Runanga Manawhenua Ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the CDHB area. There is a memorandum of understanding between Manawhenua and the CDHB. **NZBA** – Maori Advisory Group **Population Health Alliance SLA** – MKW Representative **RANZCOG** – Cultural Advisor, He Hono (Wahine Maori Collective of Obstetrics and Gynaecologists) **Te Kahui o Papaki ka Tai** – Mana Whenua Representative (Cultural Advisor) Maori Advisory Group to Pegasus Health/PHO

	Victoria University – Women's Health Representative
Rochelle Faimalo	**Canterbury Youth Workers Collective** – Committee Member **Faimalo Limited** – Director & Shareholder **Hurunui District Council** – Community Team Leader
Dr Susan Foster-Cohen	**Director Champion Centre** Receives funding from both the MoH and CDHB. **Dyspraxia Support Group** – Patron Parent Support Group for families/children with dyspraxia. **Early Intervention Association of Aotearoa New Zealand** – Chair Professional association that aims to support early intervention professionals through professional development and information sharing. Has representation on ECAC and Early Childhood Federation. **New Zealand Institute of Language Brain and Behaviour** – Member Researcher with NZILBB through Champion Centre partnership. **New Zealand Speech Therapy Association** – Associate Member Professional body for Speech and Language therapists. **University of Canterbury** – Adjunct Associate Professor Researcher and graduate student supervisor in Linguistics and in Communication Disorders. (Lecturer on short term contracts as needed.)
Jo Kane Board Member	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **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.
Yvonne Palmer	**Age Concern Canterbury** – Project Coordinator Staff member responsible for education courses and events. **Canterbury Community Justice Panels** – Facilitator/Panel Member/ Member Steering Group **Canterbury Justice of the Peace Association Incorporated** – Elected Councillor

	Safer Waimakariri Advisory Group – Member **Styx Living Laboratory Charitable Trust** – Trustee
Ta Mark Solomon **Ex Officio–CPH&DSAC** 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. **Governance Board (General Partnership Limited) Te Putahitanga o Te Waipounamu** – Chair Te Putahitanga o Te Waipounamu is a commissioning entity that works on behalf of the iwi in the South Island to support and enable whanau to create sustained social impact by developing and investing in ideas and initiatives to improve outcomes for Māori, underpinned by whānau-centred principles and strategies, these include emergency preparedness and disaster recovery. Te Pūtahitanga o Te Waipounamu also invests in Navigator roles to support and build whānau capability. **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. **Interim Te Ropu** – Member An Interim Ropu has been established to work in partnership with the Crown, Ministers, and the joint venture to help develop and shape initial work on a national strategy to prevent and reduce family violence, sexual violence and violence within whānau. The interim Te Rōpū has been appointed by the Minister of Māori Development and the Lead Minister in consultation with the Minister of Māori/Crown Relations. It comprises up to ten members who bring appropriate skills and expertise and who can reflect communities, rangatahi and whānau, urban and regional Māori and wāhine Māori. The group will help inform the terms of reference of the permanent Te Rōpū, with advice due by April 2019. **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 Corporation Limited – 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. **Taranaki Capital Partners Limited** – Director Not for profit company looking after share portfolios for Nga Rauru & Ngati Ruanui. **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 Ohu Kai Moana Portfolio Management Services Limited** – Director Sub-committee of Te Ohu Kai Moana **Te Ohu Kai Moana Trustee Limited** – Director & Trustee Charitable Trust of Te Ohu Kai Moana. **Te Putea Whakatupu Trustee Limited** – Shareholder Standalone Trust affiliated to Te Ohu Kai Moana. **Te Wai Maori Trustee Limited** – Shareholder Standalone Trust affiliated to Te Ohu Kai Moana. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity.
Dr Olive Webb	**Canterbury Plains Water Trust** – Trustee **Greater Canterbury Forum** - Member **Private Consulting Business** Sometimes works with CDHB patients and services. Frequently involved in legal proceedings alleging breaches of human rights of people with disabilities in Ministry of Health and District Health Board services.
Dr John Wood **Ex Officio–CPH&DSAC** 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. **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 2019. **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 Arawhiti, Office for Maori Crown Relations** **Member Chief Crown Negotiators Forum** Te Arawhiti, are responsible for monitoring and enhancing relations between Maori and the Crown, 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. **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.
Hans Wouters	**New Zealand Spinal Trust** – Chief Executive Provides support services to patients of the Burwood Spinal Unit during and after admission. NZST receives regular funding from CDHB and MoH as a contribution towards services rendered.

MINUTES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 4 July 2019 commencing at 9.00am

PRESENT

Dr Anna Crighton (Chair, CPHAC); Sally Buck; Tom Callanan; Wendy Dallas-Katoa; Jo Kane; David Morrell; Ta Mark Solomon (ex-officio); Dr Olive Webb; and Hans Wouters.

APOLOGIES

Apologies for absence were received and accepted from Tracey Chambers (Chair, DSAC); Rochelle Faimalo; Susan Foster-Cohen; Chris Mene; Yvonne Palmer; and Dr John Wood.
An apology for lateness was received and accepted from David Morrell (9.40am).

EXECUTIVE SUPPORT

David Meates (Chief Executive); Evon Currie (General Manager, Community & Public Health); Carolyn Gullery (Executive Director, Planning Funding and Decision Support); Jacqui Lunday-Johnstone (Director of Allied Health, Scientific & Technical); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES

There were no Executive apologies.

IN ATTENDANCE

Item 4
Hector Matthews, Executive Director, Māori & Pacific Health

Item 6
Neil Brosnahan, Manager, Community & Public Health (*CPH*)
Chris Ambrose, Development Specialist, CPH

Item 7
Kerry Marshall, Public Health Manager, CPH

Item 9
Gordon Boxall, Chair, Disability Steering Group (*DSG*)

Item 10
Kathy O'Neill, Team Leader, Planning & Funding (*P&F*)

Item 11
Michael Frampton, Chief People Officer
Maureen Love, Strategic HR Business Partner

Item 12
Michael Frampton
Maureen Love
Linda Leishman – Project Search Facilitator
Ricky Reeves – Project Search Intern

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
Tom Callanan – Item 12 - Project Search Steering Group member.

There were no other declarations of interest for items on today's agenda.

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

2. MINUTES OF THE PREVIOUS MEETING

Resolution (10/19)
(Moved: Tom Callanan/Seconded: Sally Buck – carried)

"That the minutes of the meeting of the Community & Public Health and Disability Support Advisory Committee held on 9 May 2019 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

It was noted that CDHB's Fluoridation Position Statement is currently under review and will come before the Committee for consideration in due course.

The carried forward action list was noted.

The meeting moved to Item 8.

8. TRANSGENDER HEALTH / GENDER AFFIRMING HEALTHCARE

Carolyn Gullery, Executive Director, Planning Funding & Decision Support presented the report, noting it was a follow-up to the Ko Awatea Transgender Health Working Group presentation received at the Committee's 9 May 2019 meeting.

Ms Gullery advised that a Steering Committee has been established to progress work already underway in this area to enable better access to the right services. A key gap identified has been access to appropriate psychologists, and this is to be an initial focus. Data collection issues will also be a focus moving forward.

The Steering Committee will be critical for maintaining momentum in this space and for this reason the CDHB has committed to funding it for an initial two year period.

The Committee expressed its congratulations for an excellent piece of work.

Resolution (11/19)
(Moved: Ta Mark Solomon/Seconded: Tom Callanan – carried)

"That the Committee:

i. notes the Transgender Health / Gender Affirming Healthcare report."

The meeting moved to Item 4.

4. MAORI HEALTH STRATEGY PROPOSAL

Hector Matthews, Executive Director Maori & Pacific Health, presented the report which looked at options for a Maori Health Strategy/Plan for the DHB moving forward. Mr Matthews gave details of the proposal to develop a co-design process to develop a longer-term Strategy for improving Māori health outcomes and reducing Māori health inequity.

Discussion took place around aspects of the Waitangi Tribunal's recent statements regarding health inequities for Maori.

There was discussion around the need for better quantitative and qualitative data by region in order to better inform.

Resolution (12/19)
(Moved: Dr Anna Crighton/Seconded: Ta Mark Solomon – carried)

"The Committee recommends that the Board:

i. approves the proposal to develop a co-design process to develop a longer-term Strategy for improving Māori health outcomes and reducing Māori health inequity."

5. COMMUNITY & PUBLIC HEALTH UPDATE REPORT

Evon Currie, General Manager, Community & Public Health, presented the report which was taken as read. Discussion took place on the following:

- Syphilis project
- Peace train memorial bike ride
- Canterbury Wellbeing Survey

David Morrell joined the meeting at 9.40am.

Resolution (13/19)
(Moved: Wendy Dallas-Katoa/Seconded: Sally Buck – carried)

"That the Committee:

i. notes the Community and Public Health Update Report."

6. HEALTHSCAPE (PRESENTATION)

Neil Brosnahan, Manager, CPH; and Chris Ambrose, Development Specialist, CPH, presented to the Committee on Healthscape – a structured information management and accountability tool specifically designed for population and public health requirements.

The Chair thanked Messrs Brosnahan and Ambrose for the informative presentation.

7. WORK IN SCHOOLS (PRESENTATION)

Kerry Marshall, Public Health Manager, CPH, presented to the Committee on CPH's Work in Schools. The presentation highlighted:

- Early Childhood Health Promotion – an oral health toolkit, established through collaboration between CDHB Dental Services and CPH.
- Health Promoting Schools – ways of working and priorities; a move towards working with Kahui Ake; and health sector partnerships.
- All Right? Sparklers – outlining its history and focus; activities; and links with Mana Ake.
- Kakano - an online support programme for parents of 5-12 year olds, to help them manage their kids "BIG emotions". The programme was piloted last year and is now undergoing a randomised control programme, with 300 families trying the app. Results are due at the end of 2019 and it is hopeful that the app will be launched publicly next year.

The Chair thanked Ms Marshall for the presentation.

The meeting adjourned for morning tea from 10.30 to 10.50am.
The meeting moved to Item 9.

9. DISABILITY STEERING GROUP UPDATE (ORAL)

Gordan Boxall, Chair, DSG, provided an update on DSG activities. He noted that Canterbury is at the leading edge in many areas, which creates both opportunities and challenges. Three areas highlighted by Mr Boxall were: Hillmorton Hospital facilities; the Accessibility Charter; and Employment.

There was discussion around:

- Disability Sector Transformation
- Disability funding
- Employment opportunities for people with a disability
- Winston Churchill Memorial Trust Fellowship
- Synergy between the DSG and CPH&DSAC. Mssrs Callanan and Wouters expressed an interest in attending DSG meetings.
- Whanau Ora funding

The Chair thanked Mr Boxall for his update.

The meeting returned to Item 4.

4. MAORI HEALTH STRATEGY PROPOSAL

Following discussions under Item 9, Mr Matthews was recalled to the meeting for a discussion about Whanau Ora and its incorporation in the proposed Maori Health Strategy (Item 4). In addition to the recommendation passed earlier in the meeting, the Committee passed a second recommendation.

The Committee requested an update on Whanau Ora to a future meeting.

Resolution (14/19)
(Moved: Dr Anna Crighton/Seconded: Wendy Dallas-Katoa – carried)

"The Committee recommends that the Board:

i. formalises the incorporation of Whanau Ora into the proposed Maori Health Strategy."

The meeting moved to Item 10.

10. TRANSALPINE STRATEGIC DISABILITY ACTION PLAN – PRIORITY ACTIONS - REFRESH

Kathy O'Neill, Team Leader, Planning & Funding, presented the report which was taken as read. An update was provided on forums and other avenues for feedback where attendance at forums is not possible.

Discussion took place around the limited response received from a previously used electronic survey which sought feedback on progress against the priority actions to the sector and where CDHB should be focusing its efforts in the coming two years.

There was also discussion about capturing the knowledge and experiences of current DSG members who would not be renewing their terms.

There was a request for the Canterbury and West Coast Health Disability Action Plan to be attached as an information item for the Committee's 29 August 2019 meeting.

Resolution (15/19)
(Moved: Ta Mark Solomon/Seconded: David Morrell – carried)

"That the Committee:

i. notes the processes for refreshing the priority actions of the Disability Action Plan; and
ii. notes the process for the seeking of new disability community members of the Disability Steering Group."

11. CDHB WORKFORCE UPDATE

Michael Frampton, Chief People Officer, presented the report which was taken as read. Also in attendance, was Maureen Love, Strategic HR Business Partner.

There was discussion on a Radio New Zealand interview about supported employment in Washington State, and how over 80 percent of people with intellectual and developmental disability are in paid employment, compared to 15 percent in New Zealand. A link to the interview will be circulated to Committee members.

Resolution (16/19)
(Moved: Dr Anna Crighton/Seconded: Ta Mark Solomon – carried)

"That the Committee:

i. notes the Canterbury Workforce Update."

12. PROJECT SEARCH (PRESENTATION)

Mr Frampton introduced Linda Leishman, Project Search Tutor; and Ricky Reeves, Project Search Intern. The presentation provided an update on:

- Background to the Project Search programme
- Progress to date
- The establishment of a business advisory group

- An introduction to the "Class of 2019"

Mr Reeves spoke to the Committee about his experiences and learnings from being a part of the "Class of 2019".

The presentation was enthusiastically received by the Committee, with members extending their congratulations on CDHB's participation in the Project Search Programme, which was proving to be a stunning piece of work.

INFORMATION ITEMS

- Disability Steering Group Minutes
  (3 May 2019 & 24 May 2019)
- CCN Q3 2018/19
- 2019 Workplan

There being no further business the meeting concluded at 12.15pm.

Confirmed as a true and correct record:

_____ _____

Dr Anna Crighton
Chair, CPHAC

Date of approval

_____ _____

Tracey Chambers
Chair, DSAC

Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

COMMUNITY AND PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE
CARRIED FORWARD / ACTION ITEMS / POSITION STATEMENTS
AS AT 29 AUGUST 2019

	DATE	ACTION	REFERRED TO	STATUS
1.	07 Mar 19	Presentation on "Vaping to Quit" Health Promotion Agency (HPA) campaign, launching in July 19	Vivien Daley	31 October 2019 meeting
2.	07 Mar 19	Report on focus on people with disabilities throughout the DHB system	Jacqui Lunday-Johnstone	Today's agenda – Item 9
3.	09 May 19	Update on InterRAI assessment wait times and associated work	Carolyn Gullery	Today's agenda – Item 8
4.	04 Jul 19	Whanau Ora Update	Hector Matthews	Report to 31 October 2019 meeting

CDHB POSITION STATEMENTS

STATEMENT	DATE ADOPTED	STATUS
Alcohol Position Statement	Jul 2012	
Canterbury Water Management Strategy	Oct 2011	
Fluoridation Position Statement	Jul 2003	Due to be reviewed.
Gambling Position Statement	Nov 2006	
Housing, Home Heating and Air Quality	Apr 2012	
South Island Smokefree Position Statement	Nov 2012	
Unflued Gas Heaters Position Statement	Jul 2015	
Sugar-Sweetened Beverages Position Statement	Nov 2018	
Environmentally Sustainable Health Care: Position Statement		Under development

COMMUNITY AND PUBLIC HEALTH – UPDATE REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Community & Public Health and Disability Support Advisory Committee

SOURCE: **Community and Public Health**

DATE: **29 August 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing exception reporting against the Canterbury DHB's Strategic Directions and Key Priorities as set out in the District Annual Plan and the Core Directions.

2. RECOMMENDATION

That the Committee:

i. notes the Community and Public Health Update Report.

3. DISCUSSION

All Right? Social Marketing Campaign – An Update

At the request of the Ministry of Health, *All Right?* has prepared an action plan for the next 12 months which will work towards supporting the psychosocial wellbeing of Cantabrians, the national population, including the NZ Muslim population. The rapid expansion of a wellbeing campaign built on local research to a much larger and more diverse population has significant challenges. However, the *All Right?* team has built up considerable expertise over the last six and a half years and with fine-tuning the existing tools and resources have the potential to benefit wellbeing for those beyond Canterbury.

The National focus of the plan is reflected in the Ministry of Health's document: "Supporting People Affected by the Christchurch Mosque Attacks" National Response and Recovery Plan to 15 March 2020. *All Right's* role is to promote public wellbeing and mental health literacy though identifying key stakeholders in the Muslim community and reorienting existing tools and resources to reach the Muslim community, promoting wellbeing campaigns both locally and nationally, and enhancing community cohesion by promoting positive diversity messages.

This emphasis on population wellbeing supports the direction of He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, which identifies the important role wellbeing promotion can play in getting ahead of problems before they arise.

He Waka Eke Noa (we are all in this together) is the name of the campaign launched a month after the Mosque attacks. The resources associated with this campaign have been translated into seven languages (Arabic, Somali, Dari, Urdu, Hindi Nepali and Tigrinya), and have been distributed to a range of organisations in Canterbury. Early anecdotal feedback has been extremely positive. Additional languages

will be added to this suite of resources following conversations with stakeholders in different parts of the country.

Sparklers and the Prime Minister. Sparklers was singled out in Prime Minister Jacinda Ardern's Budget Day speech as an initiative that "is about helping educators to improve children's emotional and mental health at school". The Prime Minister went on to say: "We know these resources make a difference to children's mental health, and that's why from now on they will be **available to every school across New** Zealand as a result of this Budget". We are currently exploring opportunities associated with this announcement. https://sparklers.org.nz/

Every Life Matters, the Draft Suicide Prevention Strategy and Plan 2020-2030 *All Right?* is identified in the "promoting wellbeing" section of the draft suicide prevention strategy which takes an holistic and multi-pronged approach to suicide prevention.

Early Childhood Settings Health Promotion – Oral Health

Partnering with Community Dental Service, and with guidance from Early Childhood Education settings leaders, Community and Public Health (*C&PH*) has developed "Menemene Mai" (Smile), an online oral health toolkit for Early Childhood kaiako in Waitaha.

"Menemene Mai" is the first online guide of its kind in the South Island, and includes a "Teeth Tools"' kit which can be borrowed from C&PH. The online kit is now available on the CDHB website: https://www.cdhb.health.nz/health-services/menemene-mai/

Health Promoting Schools (*HPS*)

In the past year C&PH health promoters facilitated Health Promoting Schools engagement, inquiry, planning, action and evaluation with 75 schools (including four kura) and nine Kāhui Ako across the Canterbury and West Coast DHB region. Examples of work progressed includes:

- Supporting development and trialling of a student wellbeing journal called RAD (reflective answers daily) at Chisnallwood Intermediate as a curriculum resource for the Ōtākaro Kāhui Ako. Students reported positive engagement and wellbeing benefits.
- Te Kura Whakapūmau is now running mau rākau and traditional Māori games as part of its physical activity curriculum with our Māori health promoter having successfully transitioned the kura into being able to lead this activity for themselves.

Food Resilience Network

C&PH has an advisor role in the Food Resilience Network. This year we have been contributing towards the revision of the Network's strategic plan to increase access to healthy locally grown kai in Waitaha. C&PH's Communities Team has played a key role in supporting the Network's activities including the Edible School Gardening hui and distribution of heritage fruit trees for the development of school and community orchards. Our new food security and nutrition focused health promoter will be able to add considerable time and energy to progressing the Network's action plan over the coming year.

The Ōtākaro Orchard eco-building project that includes a café and community meeting rooms is now under construction. C&PH organised for Medical Illustrations to film the launch event on Friday 25 May 2019, capturing the vision and hopes of stakeholders and supporters for this collaborative initiative. The video will be up on the new Edible Canterbury website shortly: https://ediblecanterbury.org.nz/. The Orchard will become a great teaching space, community facility and public café, acting as a hub for promoting locally grown healthy food and sustainability – key determinants of health.

The First 1000 Days

We are pleased to report that *The First 1000 Days* report prepared by C&PH, is being used by the Hauora Alliance and the South Island Child Health SLA to inform the South Island Alliance's "First 1000 Days" priority. The First 1000 Days: A South Island report for the Hauora Alliance

Recent years have seen numerous calls to action on early childhood both in New Zealand and overseas. A growing body of evidence confirms that experiences during the first 1000 days – the period from conception until a child's second birthday – have a far-reaching impact on health, educational and social outcomes, and on health equity. The purpose of this report is to inform inter-sectoral planning, action and monitoring, to support the best start in life for every child in the South Island / Te Waipounamu. View a summary of The First 1000 Days report View the appendices for The First 1000 Days report.

The Canterbury Wellbeing Index

The Canterbury Wellbeing Index was launched online in November 2018. Subsequently, the Index team has been working through a rolling schedule of content updates as new data become available. The Canterbury Wellbeing Survey is a major data source for the Index. The survey questionnaire has been reviewed by the interagency working group and the 2019 survey is currently in the field. There will be a substantial update of the Index once the survey data become available in late July. The Index has had 6,464 page views between 1 January and 31 May, representing 1,303 individual users.

The Index continues to be positively received, with presentations made in the last six months to a Selwyn District wellbeing forum, University of Canterbury staff development day, Healthy Greater Christchurch hui, Pegasus Health Population Health and Community Engagement Team, and the Ngāi Tahu Data Stakeholders Group. The Index was also presented as a case study of Treaty partnership at a partnerships day at the University of Otago, Wellington Public Health Summer School, via a ten-minute video made together with representatives from Te Rūnanga o Ngāi Tahu and Te Pūtahitanga o Te Waipounamu. Index team members have recently been invited to provide feedback on the pilot website for the Statistics New Zealand Indicators Aotearoa New Zealand (*IANZ*) project. The Index is available at: www.canterburywellbeing.org.nz

The Integrated Planning Guide (*IPG*)

The Integrated Planning Guide for a healthy, sustainable and resilient future - Version 3 of the Guide is designed to help us:

- plan in ways that build stronger more sustainable social, environmental and economic outcomes;
- promote the health of all; and
- keep sight of the shared vision for stronger, healthier and more resilient communities.

The IPG builds on existing work of the Canterbury District Health Board and the Christchurch City Council — Health Promotion and Sustainability Through Environmental Design: A Guide for Planning (*HPSTED*) and the Integrated Recovery Planning Guide Version 2.0 (*IRPG*). Designed by the Health in All Polices team to be used for policy projects, community projects and all built environment projects, this new version recognises the need for a streamlined tool where the focus is broader than recovery.

Staff from across several organisations provided input and expertise into the development of this version: Canterbury District Health Board, Christchurch City Council, Environment Canterbury, Greater Christchurch Partnership, and Regenerate Christchurch.

The IPG has recently been endorsed by the Greater Christchurch Partnership Chief Executive Group and is in the process of being printed.

Wellbeing Opuke Project

C&PH's Ashburton based health promoter, Pup Chamberlain, has been supporting this community-led initiative that has the agreed aim of improving personal wellbeing and resilience in the Methven community and wider Mid-Canterbury.

Mount Hutt College and the Opuke Kāhui Ako, they are a member of, recognised that suicide events over the past year were not just a symptom of issues affecting the school community but something for the wider community to address collectively.

A diverse range of organisations and community groups is represented and engaged in developing the project. They have sought input from health services but the community is taking ownership for leading the initiative. With Pup's input they have agreed to use the 'Five Ways to Wellbeing' as the model guiding their activities. Key measures of the project's success have been decided by the community as follows:

- Suicide statistics improve (other health data is yet to be identified).
- General discussions about mental health are "normalised"; no stigma.
- Wellbeing is part of daily life – organisations have a wellbeing aspect to their roles.
- People know where to go for information/what to do if they need help.

Canterbury DHB Submission On Planned Quarry At Templeton (Roydon Quarry)

C&PH made a submission on an application for resource consent by Fulton Hogan to establish a quarry at Templeton, known as Roydon quarry.

A number of health considerations related to the proposed quarry development and operation were highlighted in the submission which included, air quality (PM_{10}, $PM_{2.5}$ and Respirable Crystalline Silica), noise and vibration, and general wellbeing considerations for nearby residents and the local community.

C&PH consulted experts in the field of air quality and noise to assist in technical aspects of the submission, using a Ministry of Health fund available to Public Health Units when requiring scientific expertise.

It is expected that a hearing will be held in early 2020. C&PH has stated a wish to be heard, in order to present mitigation measures for consideration should the proposal go ahead.

Recent Measles Cases

There have been no further measles cases identified in Christchurch since the two recent cases notified in July. The initial Christchurch case, an 11 month-old baby, was infected in Auckland. Her household and health care contacts were followed up by C&PH staff and susceptible contacts were asked to remain in quarantine for their potential incubation period.

The second case, a 25 year-old family member of the initial case but from a different household, had been identified as a susceptible contact, and had remained in quarantine throughout her infectious period as requested.

The usual measles incubation period for contacts of both these cases has now passed, and although a number of suspected cases have been notified, none has tested positive for measles. C&PH's outbreak response team has now stood down.

The Auckland outbreak that our cases were a part of is ongoing, with over 300 cases to date. There is an ongoing risk for further cases in Canterbury associated with the Auckland outbreak, or with travel to a number of overseas countries currently experiencing measles outbreaks, and health professionals are encouraged to continue notifying cases of measles on suspicion.

Report prepared by: Nicola Laurie, Public Health Analyst

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

ENVIRONMENTALLY SUSTAINABLE HEALTH CARE: POSITION STATEMENT

Canterbury District Health Board
Te Poari Hauora o Waitaha

TO: **Chair and Members**
Community & Public Health and Disability Support Advisory Committee

SOURCE: **Community & Public Health**

DATE: **29 August 2019**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The South Island Public Health Partnership has created a Sustainability Position Statement. This Position Statement is being presented to each South Island Board for approval.

2. RECOMMENDATION

The Committee recommends that the Board:

i. approves the draft Environmentally Sustainable Health Care: Position Statement.

3. SUMMARY

The purpose of this position statement is to describe the commitment of the Canterbury District Health Board to achieving an environmentally sustainable health system and the actions needed to accomplish this. This position statement builds on the South Island District Health Boards' current environmental sustainability commitments and actions, and sets out our approach to managing environmental impacts, reporting on our sustainability performance, and delivering environmentally sustainable patient-centred health care services – to 2050.

4. DISCUSSION

The position statement and accompanying actions enable South Island District Health Boards to work both collaboratively and independently to ensure an appropriate focus and response to sustainability.

5. APPENDICES

Appendix 1:	Draft Environmentally Sustainable Health Care: Position Statement

Report prepared by: South Island Public Health Partnership

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

Environmentally Sustainable Health Care: Position Statement

2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

SOUTH ISLAND ALLIANCE

Contents

POSITION STATEMENT

Purpose

The purpose of this position statement is to describe the commitment of the XXXX District Health Board to achieving an environmentally sustainable health system and the actions needed to accomplish this. This position statement builds on the South Island District Health Boards' current environmental sustainability commitments and actions and sets out our approach to managing environmental impacts, reporting on our sustainability performance, and delivering environmentally sustainable patient-centred health care services – to 2050.

Definition

The World Health Organization (WHO) defines an environmentally sustainable health system as:

> '*A health system that improves, maintains or restores health, while minimizing negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and well-being of current and future generations*' (WHO, 2017, p. IV).

Scope

The focus of this position statement and background paper is on human-caused global warming[1] and the resultant global climate change, because human-caused global warming has been identified as *the* most pressing environmental change currently occurring [1-3].

Position

Note: (page numbers) refer to the corresponding sections of the Background Paper

At the 2015 Paris Climate Conference (COP 21), the New Zealand Government affirmed New Zealand's commitment to limiting the increase in global average temperature to well below 2°C above pre-industrial levels (page 10) [4,5]. XXX District Health Board acknowledges New Zealand's commitment to the 2015 Paris agreement and:

1.1. recognises the impending impacts of global climate change on human health as *the* most pressing environmental issue in the immediate future (alongside other aspects of environmental protection such as resource use, waste, and water) (page 10 & 11)

1.2. recognises that significant ill-health effects will result from ongoing unchecked climate change, and other environmental impacts, and as the burden of this harm will likely be carried disproportionately by some population groups, special attention to equity and Treaty of Waitangi issues is required (pages 11–12)

1.3. acknowledges that the health sector has the ability and the responsibility to advocate for public health by communicating the threats and opportunities to the public and policy makers and ensuring that climate change is understood as a central issue for human wellbeing (page 13)

[1] In this Position Statement, the term *global warming* refers to a gradual increase in average global surface temperature (as one of the consequences of anthropogenic emissions) and the term *climate change* describes the resultant amplification of natural climate variability (i.e., the portion of climatic variability that is attributable to human activities).

... continued

1.4. acknowledges that health care systems' contributions to New Zealand's total greenhouse gas emissions are significant, and environmental sustainability within health care involves ensuring the efficient management of all physical, financial, and human resources within the sector, including upstream inputs of goods and services and downstream clinical and non-clinical waste, (pages 14–17) and

1.5. recognises that health systems can benefit directly (e.g., improved efficiency) and indirectly (e.g., via a healthier population) from implementing environmentally sustainable actions as business-as-usual (pages 18–21, & Appendix).

Actions

XXX District Health Board will:

2.1. advocate for health by demonstrating sustainability leadership in the community, and by communicating the threats and opportunities to the public and policy makers to ensure that climate change is understood as a central issue for human wellbeing (page 13)

2.2. develop the system-wide resource capacity and capability to effect change; including the establishment of a South Island network, group, or entity with the means to work collaboratively to develop, embed and promote environmentally sustainable health systems (page 13 & Appendix)

2.3. participate in a regional project to measure the total carbon footprint of the South Island District Health Boards, and identify the main areas that could be improved (emission *hot-spots*). In order to achieve this, the South Island District Health Boards commit to expanding the scope of measurement previously applied under the Carbon Emission Measurement and Reduction Scheme (CEMARS) to include the embedded carbon inherent in procurement, travel, food and catering, and other indirect emissions sources (pages 14–19 & Appendix), and

2.4. develop and implement a local and/or South Island-wide environmental sustainability plan to guide the reduction of the District Health Board's environmental burdens, across the full range of activities, in order to be environmentally sensitive and carbon-neutral by 2050. The plan will include mitigation measures and an adaptation strategy that anticipates service change (pages 19–24).

About this Position Statement

This Statement was developed for the South Island District Health Boards by the Information Team, Community and Public Health, a division of the Canterbury District Health Board, with the guidance of the South Island Public Health Partnership Management Group.

BACKGROUND PAPER

Abstract

The purpose of this Background Paper is to inform the commitment, statements, and actions of the South Island District Health Boards in their efforts to achieve an environmentally sustainable health system. The most rapid environmental change currently occurring, on a global scale, is human-induced global warming and the resultant global climate change [1-3]. Increased emissions of fossil CO_2 since the mid-18th century have amplified the natural greenhouse effect causing the Earth's average surface temperature to rise [1,6,7]. The effects of ongoing global warming and global climate change now threaten to undermine many of the social, economic, and environmental drivers of health and wellbeing that have contributed greatly to human progress [1,3]. Trends in climate change impacts, exposures, and vulnerabilities indicate high levels of risk for the current and future health and wellbeing of all populations in New Zealand [8]. Our failure to reduce emissions and to build adaptive capacity threatens human health and wellbeing and the viability of health infrastructure and services.

Most organisations and businesses still apply a fragmented, reactive approach to climate change mitigation, rather than embedding sustainability as a core principle. However, in the health sector, there are a number of exemplar organisations around the world that have made substantial progress towards sustainable health systems. Many health systems have achieved substantial improvements in resource efficiency in areas such as energy, waste, water, and use of raw materials, along with financial savings, positive environmental impacts, and direct benefits to health.

While some progress has been made, the most recent Intergovernmental Panel on Climate Change report (IPCC, 2018) clearly demonstrates that the increasing rate of global warming is greatly outweighing the scale and urgency of the response, not only in health but across all sectors. The Intergovernmental Panel on Climate Change concludes that *unprecedented* rapid and far-reaching transitions in energy, land use, infrastructure, and industrial systems are required to limit the worst effects of global warming [6]. Within the health sector, substantial investment in sustainable infrastructure and systems will be required to ensure the sustainable, equitable delivery of health services, in the face of increased demand. Future climate-resilient development within health care will require a mix of mitigation and adaptation measures consistent with profound societal and systems transformations [6]. Ambitious mitigation actions are crucial to limiting future warming. Significant adaptation actions will also be needed to manage already inevitable impacts of climate change – by reducing vulnerability and exposure to its harmful effects [6].

This Background Paper provides a brief, practical overview of relevant issues and challenges, and the resultant risks to human health and wellbeing. The Background Paper also outlines current and potential health-sector actions (New Zealand and international) that aim to prevent and/or manage these risks to human health, as well as describing the potential health co-benefits that can accrue from well-designed policies that support climate-resilient development.

Key definitions relevant to this position statement

SUSTAINABILITY

"a dynamic process that guarantees the persistence of natural and human systems in an equitable manner"

Source: The Intergovernmental Panel on Climate Change (IPCC) Working Group II: Impacts, Adaptation and Vulnerability, Annex II, 2014

HEALTH SYSTEM

"all the activities whose primary purpose is to promote, restore or maintain health"

Source: The world health report (2000). Health systems: improving performance. Geneva, World Health Organization, 2000, p.5

HEALTH

"A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"

Source: World Health Organization (1946): Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference; New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

ENVIRONMENTALLY SUSTAINABLE HEALTH SYSTEM

'A health system that improves, maintains or restores health, while minimizing negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and well-being of current and future generations'

The World Health Organization (2017). Environmentally sustainable health systems: a strategic document WHO Regional Office for Europe (p. IV)

Introduction

Background

Global warming[2] and subsequent global climate change are consequences of anthropogenic emissions, mainly from fossil fuel–based power generation and transport, agriculture, and industry, which increase the heat-retaining capacity of the lower atmosphere[3] [9,10] . Global warming is part of a larger set of human-induced global environmental changes which include land degradation, ocean acidification, depletions of the ozone layer, reduced soil fertility and fresh-water resources, and disruptions to biodiversity stocks and ecosystem functioning [9].

The global scale and economic intensity of contemporary human activity are unprecedented [11,12]. Increasingly, interrelated and widespread environmental impacts are resulting from population growth, intensive economic activities, urbanisation, and consumerism [12-14]. These global changes fundamentally influence patterns of human health and health care activities [7,9,12,15-21]. Human-induced global warming has already caused multiple observed changes in climate systems [2,10,22].

Human activities are estimated to have already caused approximately 1.0°C of global warming above pre-industrial levels (likely range of 0.8°C to 1.2°C) [3,6]. Global warming is likely to reach 1.5°C between 2030 and 2050 if emissions continue to increase at the current rate (BOX 1) [6]. Pathways limiting global warming to 1.5°C will require rapid and far-reaching transitions in energy, land use, urban infrastructure, and industrial systems (including transport and buildings) [6]. Limiting global warming to 1.5°C will also require future large-scale deployment of carbon dioxide removal technologies (CDR) [23] and can only be achieved if global CO_2 emissions start to decline well before 2030 [6]. Without these global actions, the world will exceed its carbon budget and may experience high levels of warming (4- 6°C) by 2100 [6]. Warming in the range of 4–6°C will result in many populated areas of the world being unable to support human health and wellbeing.

BOX 1

Why the 1.5°C threshold?

At the 2015 Paris Climate Conference, 195 nations agreed to curb greenhouse gas emissions sufficiently to limit global warming to "well below" 2 degrees Celsius above pre-industrial levels. However, many nations called for the goal of '*pursuing efforts to limit'* global temperature rise to 1.5°C above pre-industrial levels (the 1.5 degrees target having first been proposed within UN Climate Change documents in 2010, or earlier). Subsequently, the 1.5 degrees target has been adopted as the lower temperature value in climate modelling scenarios. Current modelling highlights stark environmental differences between the two warming targets (i.e., 1.5°C vs. 2°C) [22].

However, the 2018 IPCC's analysis now predicts that the 1.5° C temperature threshold will be exceeded around 2050. The IPCC state that "negative emissions" will be required to bring the temperatures back down after overshooting 1.5° C mid-century. However, the technologies required, such as carbon capture and storage, are not yet commercially viable [6,22].

The scale of future risks to human health and wellbeing generally depend on numerous interactions between specific hazards, exposures, and vulnerability. Climate-related risks for natural and human

[2] In this Background Paper, the term *global warming* refers to a gradual increase in average global surface temperature (as one of the consequences of anthropogenic emissions) and the term *climate change* describes the resultant amplification of natural climate variability.

[3] This list only includes emissions, however, deforestation also increases the net carbon dioxide (CO_2) in the atmosphere by reducing the amount of natural carbon dioxide removal.

systems depend largely on the future magnitude and rate of warming, geographic location, levels of development, and ultimately on the choices and implementation of mitigation and adaptation options [10,22]. The effects of climate change are being felt today, and have been described as representing an 'unacceptably high and potentially catastrophic risk to human health' [2, p.1861] which 'threaten[s] to undermine the past 50 years of gains in public health' [1, p.581].

Climate change in New Zealand

The IPCC [Australasia] report concludes that increased atmospheric warming is 'almost certain' for New Zealand as the 21st century progresses [24]. Projected overall changes for New Zealand have been calculated using a regional climate model developed by the National Institute of Water and Atmospheric Research (NIWA) and the New Zealand Ministry for the Environment [8]. The model estimated that mean temperature will increase for New Zealand (relative to the 1986-2005 period) by 1.6°C by 2110. In New Zealand, annual average temperatures have already risen 0.92°C, over the period 1909 to 2015, and coastal sea levels show an average increase of 1.7 mm per year between 1900 and 2013 [25]. Both temperature and sea level are expected to continue to rise.

These changes in average temperature will have large effects on the likelihood and frequency of future extreme weather events [24] and local and regional differences in the type and extent of the consequences are expected [20]. In New Zealand, populations living in different social, economic, and physical conditions will be affected differently by climate changes. Low-income and remote populations are more vulnerable to physical hazards, undernutrition, infectious diseases, and the health consequences of displacement [18]. The list below summarises the health risks that are related to climate change, by category, sourced from both New Zealand specific and global analyses [1,2,6,8,17,18,20,26,27].

Primary health effects/risks include death, injury, and/or loss of public welfare that may result directly from:

- drought
- heat waves
- wildfire
- wind and storms
- heavy rainfall
- flooding
- landslides
- sea level rise
- coastal inundation
- increased ultraviolet radiation
- decreased air quality.

Secondary health effects/risks that are related to changes in biophysically and ecologically based processes and systems include:

- emerging/re-emerging infectious disease
- changes to infectious-disease vectors
- changes to intermediate-host ecology
- increases in toxin-producing organisms
- increases in antimicrobial resistant bacteria
- health effects related to cancer, cardiovascular disease, stroke and nutritional risk factors
- undernutrition related to disruption of food production and water supply (including access to drinking and irrigation water).

Tertiary health effects/risks include:

- social change and population displacement/migration to New Zealand
- social and economic disruptions (diverse health consequences of livelihood loss)
- child development and life-course/adult health
- mental health and stress-related disorders, and neurological diseases and disorders
- health effects related to food security and safety
- effects on occupational health
- consequences of tension and conflict (domestic and international) owing to climate change-related declines in basic resources
- poverty and disadvantage increased effects of aesthetic and cultural impoverishment.

Towards environmentally sustainable health care

Approaches to environmental sustainability within private and public organisations have evolved significantly over the past 50 years, from a basic compliance approach to an environmental stewardship approach [18,28,29]. During the era of *compliance* (1970s-2000s), most organisations applied a fragmented, often minimal, reactive approach in order to comply with regulations or to deal with emergencies [30]. For the health sector, the *stewardship* approach involves the efficient management of all physical, financial, and human resources, including upstream inputs of goods and services and downstream clinical and non-clinical waste. Current approaches to stewardship (or sustainable development) in health care anticipate change and are based on the relationships between human health, wellbeing, and the environment. The World Health Organization defines an environmentally sustainable health system as a health system that:

> 'improves, maintains or restores health, while minimizing negative impacts on the environment and leveraging opportunities to restore and improve it, to the benefit of the health and well-being of current and future generations' [29, p. IV].

Through stewardship, innovation can arise from a recognition of the synergies that exist between health and the environment, and of the need to address modifiable upstream determinants of health. This means a strong focus on actively identifying win–win solutions (co-benefits) whereby environmental sustainability actions reinforce core service delivery. Co-benefits provide an important framework for public health action on climate change [18,28,29,31]. The WHO definition of an environmentally sustainable health system also highlights the focus on social equity (BOX 2), the fair access to resources, and the fair distribution of costs and benefits across and between generations. Financial sustainability, environmental sustainability, and improving the quality of care (including equity) can be framed and operationalised as complementary goals.

BOX 2

Equity

The principle of equity is central to issues of environmental sustainability – recognising that many of the impacts of global warming, and some potential impacts of the mitigation actions required, fall disproportionately on the poor and vulnerable [6,38].

Māori health and equity

Climate change will result in different exposures and degrees of impact for different population groups; depending on geographic location, age, ethnicity, health status, socioeconomic circumstances, and other pre-existing vulnerabilities [32,33]. Māori, Pacific people, the elderly, and low-income groups in New Zealand are at greater risk of many of the adverse health impacts of climate change, compared with the general population [34,35].[4] A disproportionately high number of Māori and Pacific people in New Zealand live in deprived circumstances, and deprivation is a significant driver of poor health outcomes [36-38]. Māori may also experience unique impacts related to indigenous relationships with the environment and/or cultural impoverishment [38].

Exposures related to climate change can be expected to exacerbate pre-established and disproportionate burdens and susceptibilities to disease for Māori, across many health conditions

[4] Many equity issues for Māori may also be experienced by Pacific Peoples living in New Zealand and by low income New Zealanders.

[38]. These effects will act most strongly on the more climate-sensitive conditions, such as water/food/vector-borne diseases, direct injuries due to extreme weather events, respiratory diseases, heat stress, and mental health conditions [1,2,20,39]. Further, reduced agricultural production could lead to higher unemployment, and wide-ranging economic and social impacts, including impacts on income distribution, attitudes and health behaviours, and these impacts may be disproportionately severe for Māori [40]. Overall, climate change will increasingly exert an influence on and through the broader social determinants of health in New Zealand and globally, and progress on adaptation will require the health sector to increasingly engage with the multiple sectors outside health, in areas such as trade, agriculture, employment, and education [41,42].

Advocacy

Attention to the related health effects of climate change, and the necessary responses, is growing both in the media and in academic publications [1]. Contributions from within the health professions are increasingly seen as essential in driving sustained progress on reducing emissions, and realising the local and global health benefits of climate action [1]. The need for advocacy in public health is not new. The 1986 Ottawa Charter [43] has long highlighted advocacy as a fundamental strategy for advancing health as a major resource for social, economic and personal development, and an important dimension of quality of life. Most definitions of public health reinforce that public health is future–orientated and depends on 'the organised efforts of society'[5] [44,45]. The World Health Organization continues to highlight the need for the health sector to 'advocate social change as a means for sustainable improvement of population health' [37, p.175]. Moreover, the principle of moral equality[6] provides strong ethical grounds for the health community in particular, to advocate for climate change action on behalf of current and future generations [45]. Advocacy is required to raise attention and sustain support for climate change actions and this requires the development and implementation of a health sector strategy for high-level strategic communication [1,2,37].

[5] Adapted from the 'Acheson Report', the *Report of the Committee of Inquiry into the Future Development of the Public Health Function*. London, 1988.

[6] The principle that no one individual is intrinsically superior to, or worth more than, another.

Mitigation

Carbon accounting

The first step towards system-wide emission reductions for an organisation is to measure its carbon footprint; or the *total* (direct and indirect) greenhouse gas emissions[7] of the organisation occurring over a given time frame or event. Carbon accounting can produce a detailed breakdown or profile of the relative contributions across the different sources of emissions (called scopes) [46-50]. The emission profile can then be used to inform planning and mitigation actions. There are three defined groupings or Scopes of emissions as set out in the *Greenhouse Gas Protocol*, the internationally adopted guidebook on carbon accounting methods [50]. Table 1 provides an example overview of the greenhouse gas Scopes 1, 2 and 3 as applied to a health system in a developed country (in this example, the NHS England, 2015) [51].

Table 1: Summary of Greenhouse Gas Protocol Scopes 1, 2 and 3, applied to a health care system

Scope	Description	Summary	Contribution[A]	
1	Scope 1 emissions are the *direct* emissions emitted from the burning of fossil fuels to generate heat and electricity, on-site.[B] Plus the direct emissions from health-organisation owned vehicles such as fleet and patient transport services, other incinerators or combustion processes, and emissions from chemical production where the equipment is owned and operated by the health-organisation/entity. Scope 1 emissions account for approximately 20% of the total CO_2e emissions in this example.	Direct, by-products of combustion (for heat, power, and transport: on-site.	≈20%	
2	Scope 2 emissions are those *indirect* CO_2e emissions attributable to the generation of electricity off-site[C] that is purchased and consumed on-site. Scope 2 emissions account for approximately 20% of the total CO_2e emissions in this example.	Indirect by-products of electricity generation: off-site.	≈20%	
3	Scope 3 emissions are those *indirect* CO_2e emissions attributable to the production of materials used for buildings and health care infrastructure, the procurement of goods and services used in the delivery of health services, and patient, visitor and staff travel.[D] Scope 3 emissions account for approximately 60% of the total CO_2e emissions in this example.	Indirect, everything else: off-site.	≈60%	

[A] The relative contributions from each scope are likely to be country/organisation/time-specific. A country's electricity generation profile will influence the relative contributions (the table should be considered as an example only).
[B] Direct CO_2 emissions from the combustion of biomass (e.g., in a wood-fired boiler) are reported separately.
[C] Scope 2 emissions physically occur at the power station where electricity is generated.
[D] These emissions occur as a consequence of the activities of a health-organisation, but occur from sources not owned or controlled by the health-organisation (e.g., pharmaceuticals and medical devices; transportation of purchased fuels and other goods; employee business travel, employees commuting, transportation of waste, and emissions generated during the production of electricity that is consumed/lost in a transmission and distribution system).

[7] Climate change is largely attributable to emissions of carbon dioxide (CO_2), hence other greenhouse gasses are equivalised to CO_2's warming potential.

The Scopes 1, 2, and 3 cover three fundamental categories of emissions: emissions generated by the production of heat and electricity (on-site), emissions attributable to the generation of grid electricity (off-site), and 'everything else'. These broad categories can be further broken down into numerous sub-categories, such as heating, lighting, travel to-and-from health care sites by patients and visitors, staff commuting and business travel, and notably, embedded carbon emissions associated with the procurement of goods and services used in health care delivery.

Scope 1 and Scope 2 emissions are relatively easy to identify and quantify as they relate to energy consumption activities that occur within an organisation's operational boundary. These energy-related emissions may account for approximately 40% of a health system's total carbon footprint (depending on a country's electricity generation profile or 'percent renewable' and the influence this has on Scope 1 and Scope 2 emissions). Scope 3 emissions have been shown to account for approximately 60% of a developed country's health system's total CO_2e emissions, based on a number of carbon footprinting studies [46,51-54]. In particular, procured pharmaceuticals, single-use medical devices, and medical equipment typically contribute the most within the Scope 3 category [55], as well as non-medical goods (e.g., food) and building/construction [52]. Health systems also procure substantial volumes of services from external contractors, and these procured services also contribute to Scope 3 emissions. The Appendix extends Table 1 and provides a detailed example of the application of carbon accounting principles to an entire health system. International research in the US, Australia and the UK[8] [46,51,56-59] has shown that it is necessary to pursue carbon reductions across all categories, because no one category has the potential for the scale of savings necessary to meet current global emission targets [47,56].

Applying carbon accounting to prioritisation and decision-making processes

As already outlined, the primary purpose of carbon accounting is to produce an emissions profile that is sufficiently detailed to inform planning and decision-making about future mitigation initiatives. The challenge for decision-makers, in this regard, is to effectively prioritise and implement a complementary selection of mitigation initiatives that together result in the most economically-efficient carbon reductions, taking into account the cradle-to-grave [60] environmental costs of service delivery and other practicalities (BOX 3) [12,31,61,62]. In selecting mitigation initiatives (particularly for energy-emissions), it is necessary to take account of interactions and overlaps between initiatives. Interactions concern situations where the potential carbon savings from one initiative are reduced because another technology or approach has already been implemented.

In practice, prioritising abatement measures involves simultaneously considering different initiatives that broadly fit within two main approaches: (1) energy generation/efficiency and (2) non-energy emissions. The energy-generation approach typically involves energy infrastructure projects such as converting coal-fuelled boilers to biomass-fuelled boilers (e.g., wood chip) or installing combined-heat-and-power plants in hospital settings (i.e., targeting Scope 1 emissions). The energy efficiency

[8] Sustainable Development Unit NHS carbon footprint publications relating to 2004, 2007, 2010, 2012, and 2015, are available at: http://www.sdu.nhs.uk/corporate-requirements/measuring-carbon-footprint/nhs-carbon-footprint.aspx

approach focuses on Scope 2 emission reduction projects such as lighting upgrades, insulation, and/or other energy saving initiatives within hospitals and other facilities [48,50]. While fundamentally important, the abatement potential of energy projects is to some extent limited, because their total contribution to a health system's carbon footprint is likely to be less than 30% (see Appendix).

The non-energy initiatives focus on Scope 3 emissions.[9] This broad category of emissions includes all emissions that occur as a consequence of the activities of a health-organisation, but occur from sources not owned or controlled by the health-organisation.

Most health systems in developed countries have yet to start the transition to upstream carbon accounting that substantively includes Scope 3 emissions. To date, most measurement and mitigation projects have been focused on energy-related emissions. However, informative work has been undertaken by the UK National Health Service over the last ten years [47,51,56,57] and by other health systems including the US [58] and more recently Australia [46].

One consistent rule-of-thumb that *has* been demonstrated [12,31,63] is that it is ideal to pursue the most economically-efficient carbon reductions first, to their maximum potential. This principle applies even when upfront capital costs may be relatively high, or when implementation is perceived as difficult, because failing to do so may lead to the overall cost of mitigation and adaptation measures being considerably higher over the longer term [12,31,63]. By applying knowledge of the emission scopes and the best available carbon abatement initiatives, planners and decision-makers can weigh the relevant practical, operational, clinical, and economic factors, alongside current and future projected health burdens, and the cost of any essential social safeguards [64].

BOX 3

Cradle-to-grave analysis of the environmental costs of goods and services

Life Cycle Assessment (LCA) is the 'cradle-to-grave' analysis of the environmental costs associated with a given product or service (covering manufacture, use and disposal) and LCA can be applied to examine the environmental effects of an entire supply chain in health care [60,61]. Impacts are all-inclusive, covering resource consumption, release of greenhouse gases, and generation of solid waste. LCAs use economic input–output carbon accounting methods to provide a comprehensive picture by ensuring that both the direct and indirect effects are captured [67].

[9] Note: Scope 3 is not entirely non-energy because it also includes fuel consumed for staff, patient, and visitor travel, and lifetime emissions from all medical products used by patients in home-care settings.

Procurement emissions: hot-spots, and possible solutions

The hot-spots approach to reducing procurement emissions initially involves identifying those high-carbon aspects of service delivery that are also the most amenable to optimisation. Then, low carbon procurement seeks to work with suppliers, and to procure goods, services, works, and utilities with a reduced carbon footprint, throughout their life cycle. Identifying goods and services that produce high levels of greenhouse gas emissions may also highlight areas where potential cost savings can be made. Low carbon procurement can lead to substantial reductions to the organisation's overall carbon footprint [65] and this is particularly relevant to clinical settings because many of the consumables used, such as pharmaceuticals and anaesthetic gasses, contain particularly high levels of embedded carbon. Low carbon procurement strategies can be applied across all settings, including primary care, hospitals and other facilities, as well as patients' homes [48].

Because detailed information is needed to calculate the environmental impacts of each individual product of service used by a provider, spend-based models and industry averages, using pharmaceutical and medical device guidelines [66], are now available and are often used to calculate an organisation's procurement emissions [47,48,50,65]. For products or services not covered by existing guidelines, a standardised approach to calculating these emissions has been developed, and detailed guidance is available from the *Publicly Available Specification for assessing the life cycle GHG emissions of goods and services* (BOX 4) [67].

BOX 4

The PAS 2050

The PAS 2050 [67] is a publicly available specification providing a method for assessing the life cycle greenhouse gas emissions of goods and services (jointly referred to as "products").

Originally published in 2008, the 2011 revision is now parent to an expanding family of specifications, providing tailored guidance for individual sectors to enable the most effective application of carbon footprinting and supply chain management.

Procurement patterns reflect a health system's decisions about the design of specific care pathways and/or the state of optimisation across existing services [68]. Optimisation strategies can include, for example, investing in prevention early in care pathways, opting for e-solutions that strengthen self-care, and/or delivering care at patients' homes, and all of these approaches can act to influence the size and type of demand for goods and services, and therefore contribute to improved environmental, health, and wellbeing outcomes [68].

Optimisation can initially focus on obvious product substitutions; guided by a substantial body of research that has now identified and short-listed the pharmaceuticals and other procured items that are the most greenhouse intensive. Top-20 lists have been compiled for pharmaceuticals as well as a range of medical items (based on aggregating the ranking for cost, quantity and greenhouse gas estimates). The published lists prioritise items for further investigation and provide a starting point for a systematic approach to reducing procurement emissions. Lower impact product alternatives may be immediately available for full or partial substitution or small changes to a care pathway may enable additional pharmaceutical choices and/or waste reductions [48,49,53]. When lower impact product alternatives are not readily available, working with suppliers to reduce the carbon intensity of the supply chain, via modifications to product specifications, can bring about some of the larger reductions in emissions, over the longer term.

In summary, accounting for and acting on Scope 3 emissions is not without complexity, and there remain significant gaps in the evidence base on procurement, as it relates to health system

sustainability. Further assessments of environmental impacts are needed, both at the level of individual care facilities and at the system level [52]. However, despite these knowledge gaps, a large amount of easily accessible information is now available to inform sustainable procurement planning and action. A useful starting point is to apply cradle-to-grave [69] assessments to a small number of selected business-as-usual care pathways, using product guidelines and product hot-spot lists. Incrementally, this approach can progress to applying environmental and social/ethical criteria to all tendering processes [48,50,67].

Future opportunities within the New Zealand health sector

There is considerable scope to improve environmental sustainability practices within the New Zealand health sector, with large potential for operational cost savings [70-73].[8] However, as yet, there is no legislation, national framework, or mandate to support this work, despite sufficient international expertise [50,67,74]. Nevertheless, noteworthy regional-level work has been undertaken by select District Health Boards via the Carbon Emission Measurement and Reduction Scheme (CEMARS).[10] In these accreditations/assessments, comprehensive data have been collected across Scope 1 and Scope 2 emission inventories to meet or exceed the mandatory reporting standard. However, the reporting standard for Scope 3 emissions allows for considerable discretion, and to date, Scope 3 emissions have not been extensively reported in New Zealand. For example, Table 2 shows the coverage of Scope 3 emissions for Canterbury and Counties Manukau District Health Boards via the CEMARS programme for 2017; compared with the full range of possible Scope 3 items/categories as specified in the Greenhouse Gas Protocol (the international standard with which CEMARS conforms). The table shows that the Scope 3 emissions reported by the two District Health Boards' examples do not include the major categories of pharmaceuticals and medical instruments/devices, commissioned health services from outside system, or food and catering. A standardised and expanded approach to Scope 3 reporting in New Zealand would provide broader, and more in-depth information to guide future health sector emission reduction initiatives [1].

[10] CEMARS® a wholly owned subsidiary of Landcare Research and 100% owned by the New Zealand Government.

Without comprehensive Scope 3 data, service providers lack much of the information needed to be able to understand and effectively manage their future sustainability.

Table 2: Comparison of included Scope 3 emissions for the Canterbury District Health Board CEMARS programme and Counties Manukau CEMARS programme, compared with the full range of Greenhouse Gas Protocol Scope 3 emissions, 2017

The Greenhouse Gas Protocol Scope – 3 emissions*	CEMARS programme	
GHG protocol Scope 3 sources (non-exhaustive) ranked by contribution	Canterbury	Counties Manukau
Pharmaceuticals		
Commissioned health services from outside system		
Medical Instruments/devices		
Food and catering		
Freight transport		
Meter-Dose inhalers		
Air travel - domestic and international		
Transport – private car for work-related transport		
Taxi		
Other staff transport (shuttle bus)		
Staff commuting to and from work		
Construction		
Paper products (office paper)		
Waste products and recycling		
Anaesthetic gases		
Other products		
Other services (e.g. linen services)		
Home use of medical devices (e.g., electricity used to run CPAP machine)		
ITC technologies		
Water and sanitation		

= included = not included

* Scope 3 emissions have been estimated to account for the majority of a health system's total GHG emissions (the balance being energy-related emissions – in one form or another). The exact proportions will differ from country to country based on different energy generation profiles and other factors.

Climate change threats to health also highlight the vital requirement for improved leadership, and population-based planning. Anticipatory action is necessary [75] because the ability to mount responses in any future circumstance might be limited by the degradation of infrastructure and by the economic stressors that climate change brings [15]. Health systems need to maintain a platform for the delivery of clinical services but they also need to provide the foundation for an effective public health response to the many climate-induced threats to health [1,2,15]. Therefore, at national and subnational levels, long-term strategies and investments will continue to be needed to develop the clinical, management, and human capacity of health systems [15].

Whole-of-system planning will be most effective when focused on organisational change – to embed sustainability principles and practices in all policies, operations and technologies, across the health system. As a starting point, planning might be based on WHO best practice guidelines [21]; including a focus on energy efficiency, environmentally sensitive building design, alternative energy generation, transportation (staff, patient and community), and limiting embedded carbon emissions from procured goods and services [49].

Co-benefits

Further opportunities lie in the leveraging of health co-benefits. There is growing recognition that the implementation of low-carbon policies can have substantial near-term health co-benefits through multiple overlapping pathways [31] (see Box 5 for examples). Co-benefits are the positive effects that a carbon reduction policy or measure might have on other objectives. Co-benefits and their related cost savings are often not taken into account in decision making processes[11] [76] but the economic co-benefits of climate change mitigation policies *can* be put forward as a forceful argument for policy makers to take action [76]. Initiatives that effectively leverage co-benefits to reduce greenhouse gas emissions can bring about strong positive welfare effects [31].

Common pathways to health co-benefits include promoting and facilitating low-carbon transport such as walking, cycling, and public transport; which in turn can improve physical activity levels, therefore lowering the incidence of heart disease, cancer, obesity, musculoskeletal disease, Type 2 diabetes, and some mental health conditions. Active transport also reduces air pollution (and hence respiratory disease) and road traffic injuries [77,78]. Electronic health interventions (eHealth) are another group of interventions that can generate important co-benefits. A range of e-health interventions have been shown to reduce carbon emissions *and* improve access to care, reduce demand for care, improve health outcomes, and reduce out-of-pocket expenses through reduced need for patients to travel [79]. Other health benefits can accrue via socioeconomic pathways, for example, the reduction of out-of-pocket health expenses for households can improve the affordability of good nutrition and other health promoting activities [2,31]. Even so, compensatory and/or redistributive measures may be required in some circumstances [40].

Overall, health and equity co-benefits associated with climate change mitigation have the potential to significantly reduce the burdens (costs) on health care systems [1,21,32]. Analyses [80] using data from the Global Burden of Disease Study 2015 [81] show that the health co-benefits of meeting commitments under the Paris Agreement are 'potentially immense', reducing the burden of disease for many of the greatest health challenges today and in the future [1, P.601]. Projected climate change effects will impact human health mainly by exacerbating health problems that already exist (at least until mid-century) [10]. Therefore, mitigation and adaptation mechanisms are likely to be most efficient and cost-effective when they recognise locally relevant scenarios of future change (i.e., continue to work on well-understood historical health problems) and when they seek to exploit co-benefits to maximum effect [10].

[11] Likely because they are not easy to capture and some potential wellbeing impacts and/or cultural value(s) cannot be fully monetarised.

BOX 5

Examples of carbon reduction measures applicable to health systems, the overlapping pathways, and a range of health co-benefits

Mitigation measures

- Develop infrastructure for renewable energy generation, distribution, and use
- Improve the energy-efficiency of buildings/ increase heating and cooling efficiency (includes insulation)
- Reduce emissions associated with procured goods and services
- Decrease distances between service providers and service users
- Decrease air travel
- Promote telecommuting/working remotely, telemedicine, and low-carbon models of care
- Promote active transport
- Use of lower emission vehicles
- Use locally produced fruit and vegetables and less food from animal sources (e.g., within hospital kitchens)

Overlapping pathways

- Reduced costs
- Lower CO_2 emissions
- Improved air quality
- Reduced indoor humidity and more comfortable temperature
- Increased physical activity
- Less noise from transport
- Reduced exposure to motor vehicles
- Less livestock production and associated deforestation and less methane emissions
- Improved nutrition and social capital from locally grown food

Health benefits

- Fewer deaths and injuries from extreme weather events
- Reduced susceptibility to heat-related illnesses due to decrease in heat island effects
- Reduced levels of respiratory illnesses
- Reduced likelihood of heart disease, cancer, obesity, musculoskeletal disease, and Type 2 diabetes
- Reduced motor vehicle injuries and fatalities
- Improved mental health
- Reduced spread of vector-borne diseases to new areas

Adapted from: Frumkin et al. (2008); Iacobucci (2016); Watts, et al. (2015); Younger et al. (2008)

Adaptation

Adaptation in this context means 'adjustment in natural or human systems in response to actual or expected climate stimuli or their effects, which moderates harm or exploits beneficial opportunities' [82, p.1758]. Mitigation will not be sufficient as the need for adaptation is already locked in [6,17]. Therefore, there is a need for the health sector to plan for the inevitable health impacts of climate change in coming decades [22,71]. Adaptation to climate change can reduce existing and near-term risks. However, a number of potential barriers to public health adaptation to climate change have been identified; including, uncertainty about future socioeconomic and climatic conditions as well as a range of financial, institutional, and skills/knowledge gaps within health institutions [83]. These barriers can constrain the recognition of climate change effects and the actions required [83].

Suggested approaches for health sector institutions include; placing a high priority on research aimed at clarifying the potential health impacts of climate change, including scenario-based projections of local-level health impacts, identifying and clarifying the health co-benefits of potential mitigation strategies, and evaluating the cost-effectiveness of potential options [83]. While some of these approaches build on conventional health sector activities, others (for example, local-level scenario-based projections of climate change health impacts) will require health agencies to develop new skills, methods and tools, and broader collaborative relationships within other sectors. These collaborative relationships will become essential as the adaptive capacity of the health sector alone will have a limited impact, partly because the environmental determinants of health are complex and are largely outside the direct influence of the health system [42,64].

There is a strong argument for strengthening public health services' climate change planning and response capability. As one example approach, the US Centers for Disease Control and Prevention (CDC) has proposed a 5-step climate change adaptation framework "Building Resilience Against Climate Effects" (BRACE) to facilitate climate readiness in public health agencies [84]. The BRACE framework steps are:

- forecasting climate impacts and assessing vulnerabilities
- projecting the disease burden
- assessing public health interventions
- developing and implementing a climate and health adaptation plan, and
- evaluating impact and improving the quality of activities [84].

As a further example, Table 3 provides a brief list of potentially relevant climate change actions (selected examples only). These actions build on and extend conventional public health activities. A comprehensive response will involve adapting all of the 'building blocks' broadly common to all health systems, including leadership and governance, health workforce, health information systems, infrastructure, essential medical products and technologies, and service delivery [42]. Within the health sector, substantial investment in sustainable infrastructure and systems will be required to limit the economic and health impacts of climate change and to ensure the sustainable delivery of health services, in the face of increased demand.

Table 3: Examples of climate change adaptation activities relevant to New Zealand health care settings

Secondary prevention *(Adaptation)*

- Tracking of diseases and trends related to climate change.
- Program assessment of various preparedness efforts.
- Research on the local-level health effects of climate change, including innovative techniques such as scenario-based modelling, and research on optimal adaptation strategies.
- Training of health care providers on health aspects of climate change.
- Public health partnerships with industry, other professional groups, and others, to craft and implement solutions.
- Promote written heat response plans to reduce heat-related morbidity and mortality.
- Preparing for and responding to climate change-related public health emergencies, such drought, heat waves, wildfire, wind and storms, heavy rainfall, flooding, landslides, coastal inundation.
- Enforce laws and regulations that protect health and ensure safety (although probably little role for public health).
- Develop a coordinated adaptation plan
- Build capability and capacity in climate change adaptation across public health units/DHBs. Adaptation must be recognised as an essential part of the climate change agenda now (alongside the legislative attention being given to climate change mitigation) because all of New Zealand will be impacted by the changing climate.
- Engage in broader collaboration with other sectors.
- Strengthen all public health programmes.
- Support vulnerable communities.
- Advocacy.

Source: adapted from The Climate Change Adaptation Technical Working Group (2018). Adapting to Climate Change in New Zealand; Frumkin et al. (2008). Climate change: the public health response; and McMichael (2013). Globalization, climate change, and human health [17,31,75].

Conclusion

The health sector is increasingly considering and responding to the health effects of climate change [1]. Future climate-resilient development within health care will require a mix of mitigation and adaptation measures consistent with profound societal and systems transformations [6]. Ambitious mitigation actions are crucial to limiting future warming [6]. Significant adaptation actions will be needed to manage the impacts of climate change over the long term; primarily by reducing vulnerabilities and exposure to its harmful effects. The health system has important roles to play in achieving longer-term sustainable development, including advocacy, building resilience, and enhancing human capacities to adapt, all while paying close attention to equity and wellbeing for all [6].

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Appendix

International example: the National Health Service (England)

Work completed by the National Health Service (NHS) in England provides perhaps the best international example of the development of an environmentally sustainable health system. In response to the (United Kingdom) Climate Change Act 2008 [85][12] the NHS has made significant progress towards environmental sustainability. A dedicated Sustainable Development Unit (SDU) was established to develop and enact an approach to environmental sustainability across the NHS. Two key achievements of the SDU have been the development of (1) a detailed *carbon footprint* which covers the entire NHS, public health and social care sector and (2) a *marginal abatement cost curve* (MACC) that provides an estimate of the potential of all technological greenhouse gas abatement measures, and their relative cost-effectiveness.

The SDU

The Sustainable Development Unit is a government agency with the sole purpose of embedding the principals of sustainable development across the health and social care system in England. The SDU had undertaken extensive work, through carbon accounting, to inform and facilitate a reduction in the NHS's environmental impact. This approach has incentivised models of care that favour prevention, self-care and 'lean' pathways; which in turn have driven low carbon procurement, energy-efficiency, and other environmentally sustainable practices.

The footprint

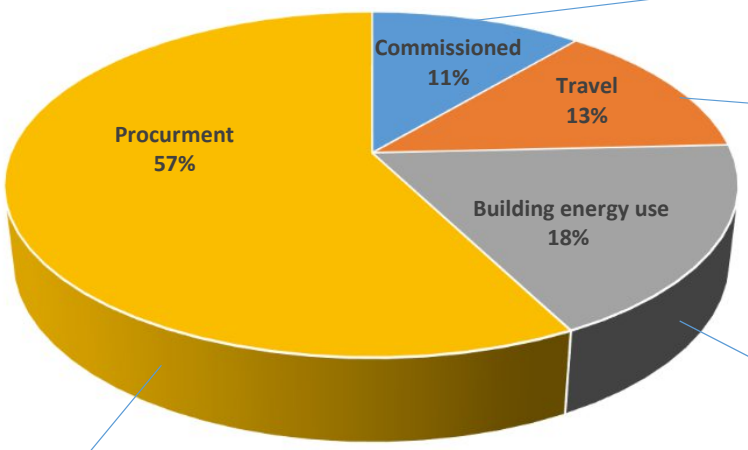
Using the best available carbon accounting methods, a series of updated footprints have been published[13] for 2004, 2007, 2010, 2012, and 2015. The current carbon footprint provides a detailed breakdown of emissions across four broad categories: building energy use and direct emissions, travel, commissioned health and care services from outside the NHS system, and procurement of goods and services. These four main categories are further broken down into 21 sub-categories.

The NHS consumption carbon footprint (Figure 1) clearly shows that the main sources are embedded carbon within procured goods and services, and this category of emissions accounted for approximately 57% of all emissions in 2015. The balance was due to: heating, lighting and providing power for NHS sites (18%); travel to and from NHS sites by patients, visitors, and staff, and business travel (13%); and health services commissioned from outside the NHS (11%) [47]. The NHS's carbon footprint has fallen by 12% between 1990 and 2015, within the context of an 18% increase in inpatient admissions over the same period [57]. The NHS's carbon footprint is predicted to fall by a further 15% by 2020 and 20% by 2050 [47,56].

[12] The Climate Change Act 2008 specifies that the net UK carbon account for all six Kyoto greenhouse gases for the year 2050 is to be at least 80% lower than the 1990 baseline.

[13] Sustainable Development Unit NHS carbon footprint publications, available at: http://www.sdu.nhs.uk/corporate-requirements/measuring-carbon-footprint/nhs-carbon-footprint.aspx

Figure 1: Consumption carbon footprint breakdown by categories for the NHS, in 2015



Commissioned health services		Proportion
Health services		11%

Travel		Proportion
Patient		6%
Visitor		2%
Staff commute		2%
Business		3%
Total travel	Total	13%

Building energy use and direct emissions		Proportion
Electricity		8%
Fossil fuels (Gas, Coal and Oil)		8%
Total building energy	Total	18%

Procurement of goods and services		Proportion
Pharmaceuticals (excluding Meter Dose Inhalers)		11%
Business services		11%
Medical Instruments /equipment		10%
Food and catering		5%
Freight transport		3%
Meter Dose Inhalers		3%
Construction		2%
Manufactured fuels, chemicals and gases		2%
Paper products		2%
Waste products and recycling		2%
Anaesthetic gases		2%
Other manufactured products		2%
Information and communication technologies		2%
Water and sanitation		1%
Total Procurement	Total	57%

Notes

– Metered Dose Inhalers use Hydrofluorocarbons gases as aerosol propellants. The gases used have over 1000 times the impact on global warming compared with the same weight of carbon dioxide gas. The majority of the emissions are released during the 'in use' phase and occur mostly outside health care premises.

– Anaesthetic gases (including Nitrous Oxide) are potent greenhouse gases with between 130 to 2000 times the impact on global warming compared with the same weight of carbon dioxide gas.

Summarised from: Sustainable Development Unit and UK National Health Service data (2016) *Carbon footprint update for the NHS in England 2015*

The Cost Curve

Marginal Abatement Cost (MAC) reflects the cost of one additional unit or ton of pollution that is abated, or not emitted. A marginal abatement cost curve (MACC) is a data visualisation tool that allows the user to compare emission reduction options both in terms of cost-effectiveness and their potential for CO_2 reductions (Figure 2). Marginal abatement cost curves highlight the win-wins where carbon cutting measures can save money and the abatement information also puts into perspective those measures where the investment costs cannot be recouped.

A marginal abatement cost curve can help decision makers to plan and prioritise a number of options into a strategic package of mitigation measures. However, MACCs cannot produce a definitive and generalisable set of initiatives, because local and country-level characteristics vary greatly. In addition, it is necessary to take account of interactions and overlaps between interventions, where the potential carbon savings from one initiative are reduced because another technology has already been installed.

Figure 2: A hypothetical example of a Marginal Abatement Cost Curve (MACC) applied to a health care system (indicative only)

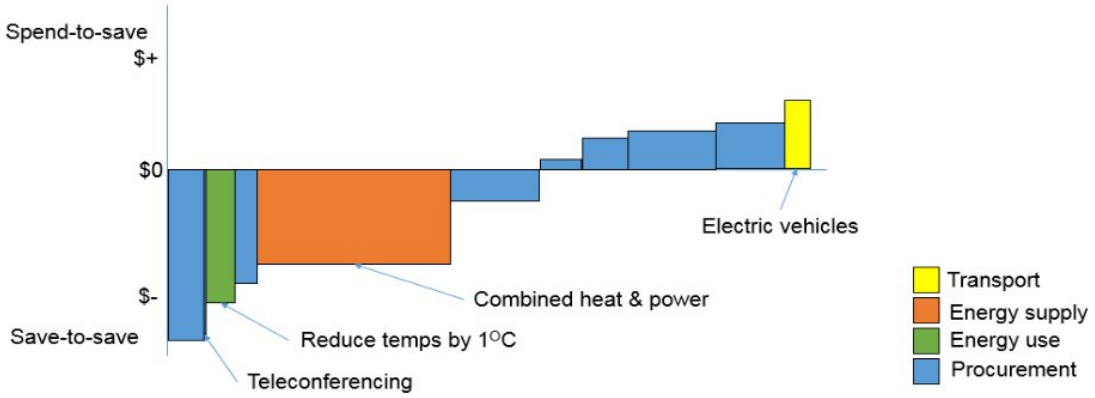


Figure 2 shows a generalised example of a health system's Marginal Abatement Cost Curve (MACC). Each block represents a different technology or intervention. In this example, each technology is colour-coded into four categories: transport, energy supply, energy use and procurement. A block that is projecting downwards indicates that the technology has the potential to generate financial savings (i.e., negative costs indicate a net financial benefit to the health system over the lifecycle of the abatement opportunity) and a block that projects above the zero line indicates that the particular technology is not cost-effective (i.e., positive costs imply that capturing the opportunity would incur incremental costs compared to business-as-usual or 'do nothing'). The relative height or depth of each block represents the degree to which the intervention is cost-saving. The options presented in a MACC are always placed in decreasing order of cost-effectiveness so that the reader can easily identify how options compare with each other on both cost-effectiveness and abatement potential. The horizontal axis (x-axis) shows the annual carbon savings that would result from the full implementation of a particular technology. The cumulative annual savings, shown by the full width of all of the blocks side-by-side on the MACC, gives an indication of the maximum potential for system-wide carbon savings in a particular assessment year. The abatement potential can be compared with the baseline year and/or any future targets set for an organisation.

Source: drawn from the principles and methodology developed by McKinsey & Company and informed by findings from the Marginal Abatement Cost Curve for NHS England (2015).

Marginal abatement cost information can also be displayed in table format. Table 4 shows marginal abatement cost information for the NHS England for 2015 [56]. The table lists a range of energy-efficiency interventions that have been identified as suitable for implementation within health care facilities. The list is presented in descending order of cost-effectiveness (not considering interactions and overlaps between measures). The right-hand column shows the potential CO_2 savings that could be made in one-year if the technology was fully implemented. The table shows that the top-five technologies/interventions are (1) combined-heat-and-power, equal with biomass boiler (2) energy awareness campaigns (3) travel planning (4) lighting controls, and (5) reduce heating by 1 degree Celsius (based on potential CO_2 saving as shown in bold in Table 3). The table also shows that the cost-effectiveness of these examples differs considerably. For example, combined-heat-and-power and biomass boilers offer similar potential CO_2 saving, but combined-heat-and-power is significantly more cost-effective than a biomass boiler conversion (ranked 6th compared with 24th in the example list).

Table 4: List of CO_2 reduction measures related to energy supply and use, not considering interactions and overlaps (non-energy related measures for procurement of pharmaceuticals and medical devices are not shown)

	CO_2 reduction measures (options)	*£/tCO_2	CO_2 savings (tCO_2)
1	Teleconferencing	-2051	6,827
2	Introduce hibernation system for stations	-120	1,255
3	Improve the efficiency of chillers	-110	9,133
4	Voltage optimisation	-110	16,828
5	1 degree C	-110	**32,763**
6	CHP installation	-98	**173,975**
7	Improve lighting controls	-94	**34,286**
8	Variable speed drives	-90	3,083
9	Energy awareness campaign	-89	**90,265**
10	Building management system optimisation	-86	11,521
11	Improve insulation to pipe work, boiler house	-79	10,264
12	Decentralisation of hot water boilers	-77	10,612
13	Improve heating controls	-72	17,219
14	Roof insulation	-71	22,869
15	Improve efficiency of steam or hot water boiler	-71	6,367
16	Wall insulation	-70	24,624
17	Energy efficient lighting	-67	22,290
18	Upgrade garage and workshop heating	-60	214
19	Install high efficiency lighting and controls	-45	3,745
20	Wind turbine	-42	10,722
21	Double insulation window and draught proofing	-27	11,831
22	Improve building insulation levels (U-levels)	-19	951
23	Boiler replacement/optimisation HQ/control	-15	171
24	Biomass boiler	-6	**172,724**
25	Travel planning	1	**81,524**
26	Office electrical equipment improvements	17	15,900
27	Solar hot water	49	0
28	Electric vehicles	49	36,96

* NHS data: presented as published, in British pounds [47]


Canterbury
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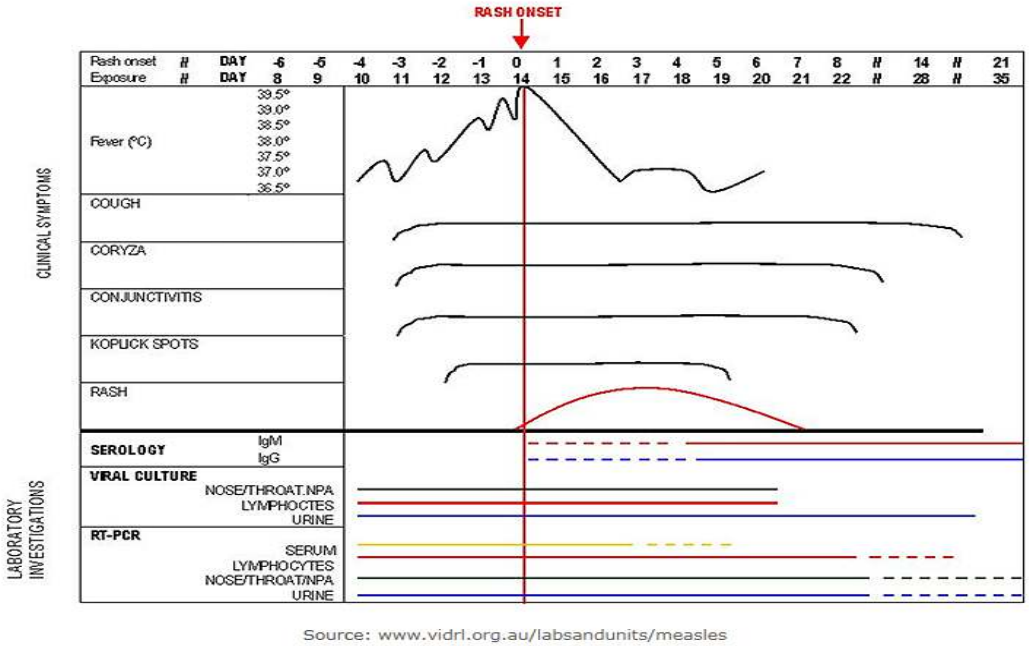
SOUTH ISLAND
ALLIANCE

Communicable Disease CPHAC Presentation

Canterbury District Health Board
Te Poari Hauora ō Waitaha



Source: www.vidrl.org.au/labsandunits/measles

Kerry Marshall (C&PH Communicable Disease Manager)
Dr Ramon Pink (C&PH Clinical Director)

August 29th 2019

Communicable Disease Control

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Purpose

preventing and reducing spread of communicable diseases

Outcomes

Outbreaks rapidly identified and controlled
Reduced spread of communicable diseases
Improved immunisation rates

February 2019 Measles Outbreak

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Key Features

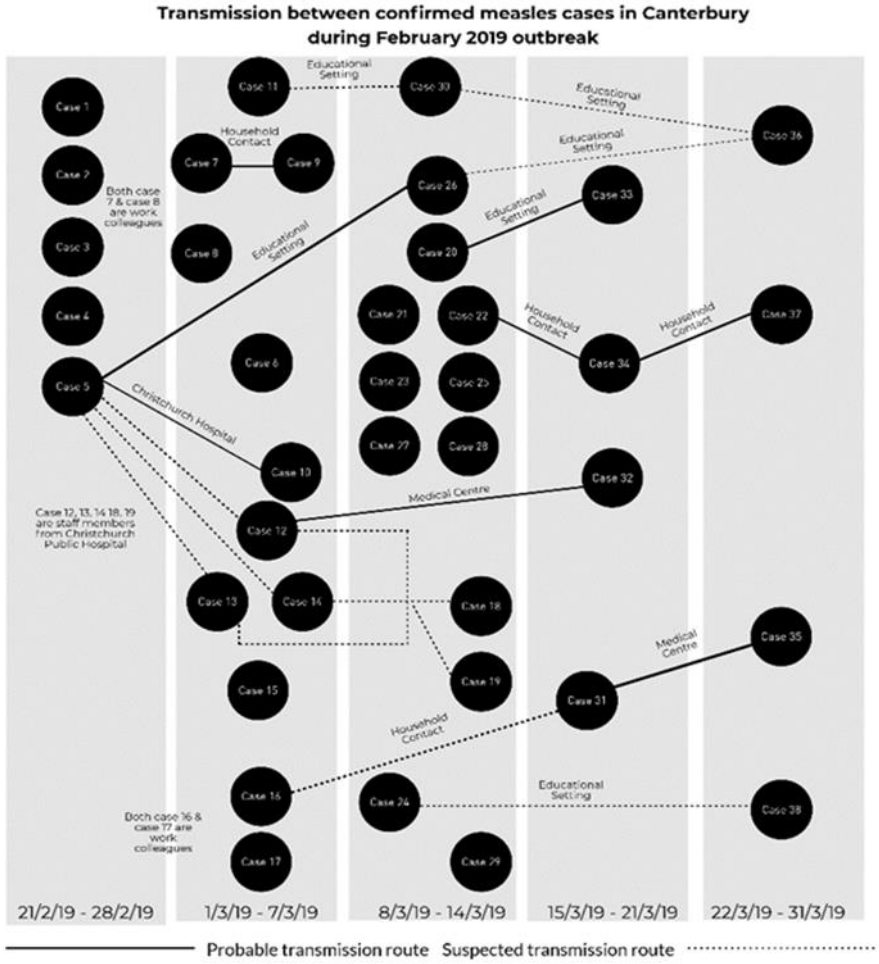
- 38 confirmed cases
- CIMS structure in place during this time
- Over 30 staff from 6 different C&PH Teams involved
- 236 notifications and investigations
- 1,021 contacts followed up
- 27,000 MMR vaccinations delivered by CDHB/Primary Care
- CDHB, Primary Care, Ministry of Health and PHARMAC involvement
- Outbreak declared over May 16th 2019

February 2019 Measles Distribution

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Measles Transmission

Canterbury District Health Board
Te Poari Hauora ō Waitaha



Vaccination Campaign

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Key Features

- Canterbury 2 and 4 years olds 93% MMR vaccination rate
- Concern for vulnerable community members ie: too young for first MMR
- Vaccination priorities developed by Immunisation Programme Team (CPH, Ministry of Health, and Canterbury DHB Planning and Funding, who worked closely with PHARMAC and the Canterbury Primary Response Group).

Measles Outbreak July 2019

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Key Features

- 2 confirmed cases (11 month old baby infected in Auckland and 25 year old family member)
- Household and health care contacts were followed up by Community and Public Health staff and susceptible contacts were asked to remain in quarantine for their potential incubation period.
- Contact tracing of 98 contacts and isolation required for 36 people.
- Health and welfare support for quarantined households from C&PH, MSD and Primary Care providers.

Discussion

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Ongoing Challenge

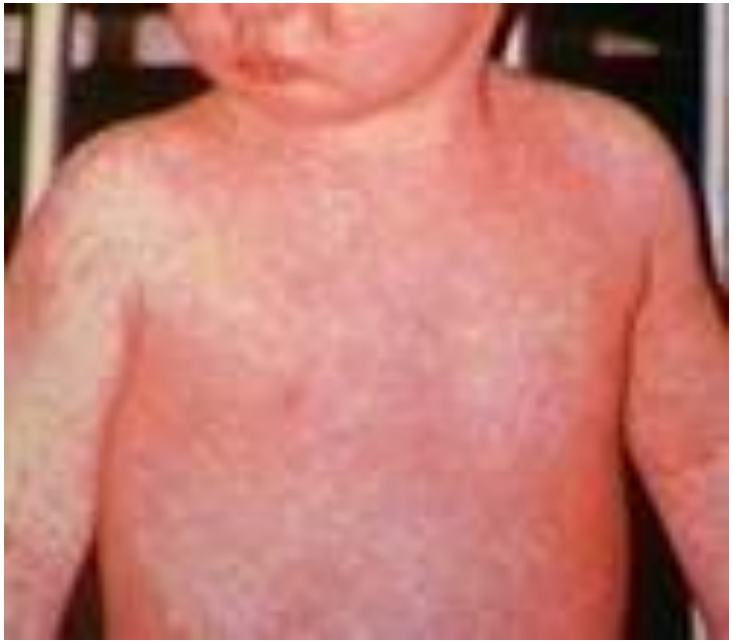
- Ongoing risk of importation
- Importance of MMR vaccination
- Burden of isolation and quarantine
- Health Care workers vaccination
- Liaison between CDHB, Primary Care and Ministry of Health
- Importance of communications (including social media)

Measures to prevent the introduction of Communicable Disease

Canterbury District Health Board
Te Poari Hauora ō Waitaha

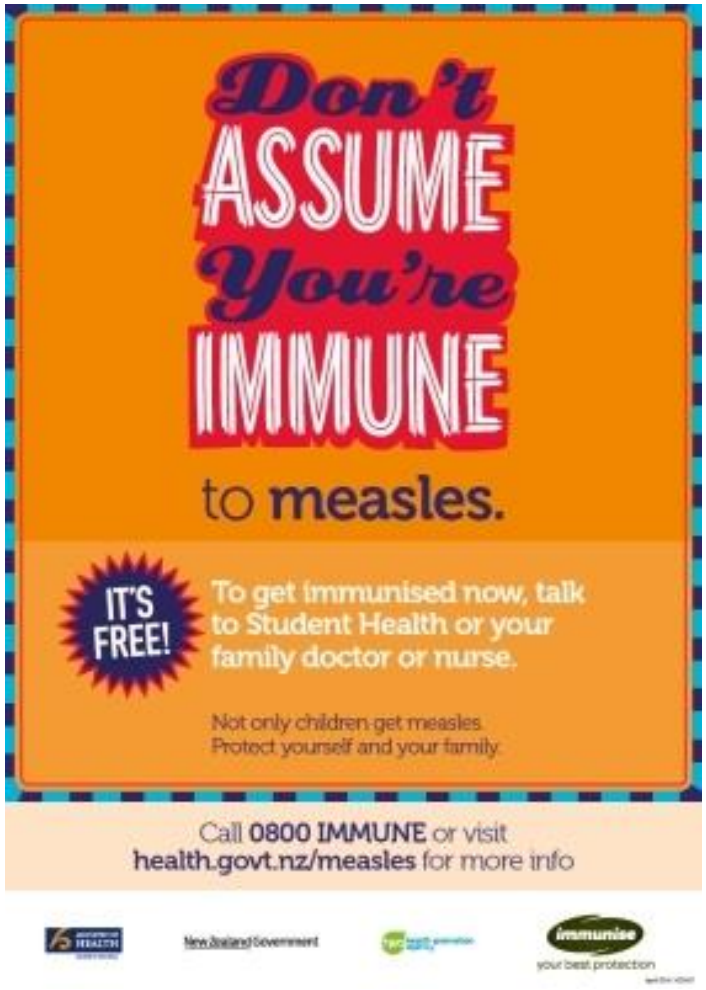
Surveillance, Prevention

- Weekly review local, regional and national notifiable disease data
- Response to disease notification
- Firmly established relationships and integrated response planning with Border Agencies
- Combined exercises to test response capability



Immunisation

Canterbury District Health Board
Te Poari Hauora ō Waitaha

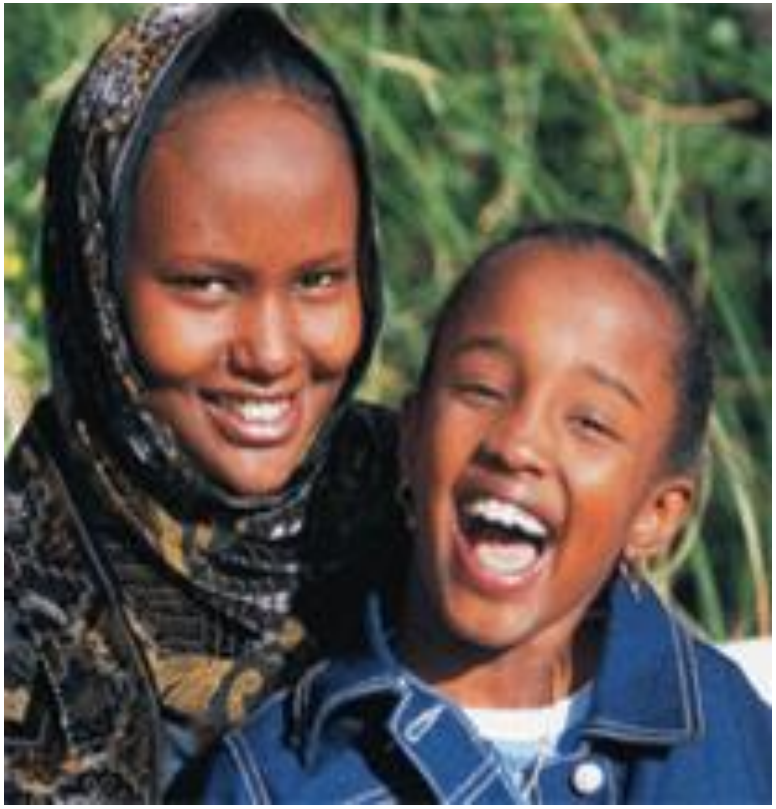


Refugee and Migrant Health

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Key points:

- Christchurch now receiving quota refugees
- Family reunification following mosque attacks
- Free health screening
- First doctors visit
- Collaboration between Pegasus Health and C&PH Communicable Disease Nurses



Canterbury District Health Board
Te Poari Hauora ō Waitaha

Any questions?

PLANNING AND FUNDING UPDATE REPORT

Canterbury District Health Board
Te Poari Hauora o Waitaha

TO: **Chair and Members**
Community & Public Health and Disability Support Advisory Committee

SOURCE: **Planning & Funding**

DATE: **29 August 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The attached report (Appendix 1) has been prepared to provide the Committee with an update on progress against the initiatives, actions and targets highlighted in the DHB's Annual Plan for 2018/19.

2. RECOMMENDATION

That the Committee:

i. notes the update on progress to the end of quarter four (Apr - Jun) 2018/19.

3. SUMMARY

The attached quarterly report has been prepared to highlight progress being made against the commitments set out in Canterbury DHB's Annual Plan for 2018/19.

The quarter four report shows the full year performance in many service areas. Overall, good progress was made across most focus areas with most quarter four milestones completed or to be completed early in 2019/20. However, disruption following the extraordinary events of 2019, including Measles and the March 15th events, have increased demand in a number of service areas and this is reflected in performance against targets, particularly across mental health, primary care, emergency and planned services such as electives.

Key Points to Note

- The Mana Ake service has delivered against all commitments set in 2018/19 with over 2,400 children and families accessing the service in its first year.
- Performance in child immunisation remained strong in quarter four across all ethnicities which speaks to the embedded nature of the Canterbury immunisation model.
- 96% of all children received their B4 Schools Check in quarter four and 100% of children identified as overweight were referred to a health professional for advice and support.
- A pilot programme is underway automatically referring people post discharge from hospital with a fractured Humerus or neck of femur (NOF) to the in-home falls prevention service. Engagement with the falls prevention programme remains high with 2,127 referrals made to the service over the last year and over 33,000 places made available at strengths and balance classes - almost three-times the target set for the service.
- The DHB has also shown leadership across the newer priority areas being the first DHB to achieve a Gold Energy-Mark certificate and being a ""Top 20" CEMARS carbon reducer.

4. APPENDICES

Appendix 1: Annual Plan Report Quarter Four

Report prepared by:	Ross Meade, Accountability Co-ordinator, Planning & Funding Melissa Macfarlane, Team Lead, Planning & Performance
Report approved for release by:	Carolyn Gullery, Executive Director, Planning Funding & Decision Support

Canterbury DHB Annual Plan 2018/19

Delivery of National Priorities & Targets

Status Report Quarter 4
April - June 2019

Status Key:

✓	Completed As Planned
↺	Underway (but not yet completed)
✖	Delayed / At Risk

Mental Health Services

Population Mental Health Services

NZ Health Strategy link - One Team

Status Report for 2018/19

Performance Reporting Link – PP43

Key Actions from the Annual Plan	Milestones	Status	Comment
Continue to invest in the delivery of Brief Intervention Counselling in primary care to provide earlier intervention and therapeutic support to youth and adults. Continue to invest in extended GP consults to support young people aged 13-24 with mental health, alcohol or other drug issues. Continue to invest in the Equally Well programme to promote the physical health of people with mental health conditions.	Q1: Quarterly monitoring of BIC and extended consult access rates by demographic.	✓	Quarterly monitoring of BICs by age, gender and ethnicity are in place. Funding for Equally Well consults is now allocated to practices on a capitation basis and individual practice uptake is not tracked. A refreshed focus on Equally Well is underway in Specialist Mental Health Services. Primary mental health teams have implemented effective triaging with greater clarity regarding eligibility. Training is also occurring to trial embedding additional mental health expertise into primary care teams.
	Q2: Quarterly monitoring of Equally Well programme uptake established.	×	
	Q3: Opportunities to reduce BIC wait times identified and implemented.	✓	
Invest in the development of a community-based acute residential service to provide alternative options for people experiencing an acute episode of mental health illness.	Q1: Service provider identified.	✓	The new service has been operational from 8 April.
	Q3: Community-based Acute Residential Service operational.	✓	
Complete development of a whole-of-system performance Dashboard highlighting service and outcome performance by demographic. Use the Dashboard to identify opportunities to reduce equity gaps. (EOA)	Q2: Dashboard operational.	✓	The dashboard is operational and is being presented to stakeholders in late July. Work to identify opportunities for addressing equity gaps will continue in the next quarter.
	Q3: Opportunities to reduce equity gaps presented to the CCN Mental Health Workstream.	↺	
Establish a cross-sector Suicide Prevention Governance Committee to support a collective response to suicide prevention. Update the Suicide Prevention Action Plan. Ensure a strong Māori and Pacific voice (as priority groups) in the consultation on the refreshed Action Plan and on the Governance Group. (EOA)	Q1: Suicide Prevention Governance Committee established.	✓	Governance Group established with membership from Ngāi Tahu. Canterbury DHB suicide action plan is in place with reporting against actions underway. The whole of system suicide prevention plan is delayed awaiting the new NZ National Suicide Prevention Strategy in order to align the documents.
	Q2: Ngāi Tahu representation on the Governance Committee.	✓	
	Q2: Cross-sector consultation undertaken.	✓	
	Q3: Refreshed Action Plan released.	↺	
Review progress in implementing the national Supporting Parents Healthy Children guidelines and confirm priority actions.	Q2: Review completed.	✓	A steering group is overseeing workplan activities for the identified priority actions: • Family/whanau champions • Family care plans • Workforce training to support family inclusion
	Q3: Priority actions identified.	✓	
Coordinate Inquiry Panel visit to provide opportunities for agencies to be heard. Publish submission and feedback dates to ensure people opportunity to participate.	Q1: Agencies given opportunity to be represented.	✓	There was good engagement with the Inquiry panel in Christchurch. Meetings included clinicians, service users, Māori, families, Canterbury DHB, and Alliance Leaders.
	Q1: DHB actively participates in Mental Health Inquiry and provides feedback to the Panel.	✓	

Key Performance Measures	Result	Comment
>500 Young people (0-19) accessing brief intervention counselling in primary care.	552	The DHB continues to work through a number of changes to support a more integrated approach and reduced wait times across the system this includes, strengthening of programmes delivered by NGOs and in primary care with specialist support through consult/liaison.
>4,500 Adults (20+) accessing brief intervention counselling in primary care.	6,353	
80% of people referred to specialist mental health services are seen within 3 weeks.	71%	
95% of people referred to specialist mental health services are seen within 8 weeks.	88%	

Mental Health Improvement Activities

NZHS Link - One Team

Status Report for 2018/19			Performance Reporting Link – PP7
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comment**
Participate in regionally-based learning opportunities and co-design workshops related to seclusion reduction and improving transitions. Complete an evaluation of consumer, Whānau and staff experience of seclusion Support a strong focus on ensuring culturally safe approaches for Māori/Pacific mental health consumers and their whānau.	Q2: Focus groups/interviews of consumers, whānau, and staff to understand their experience.	✓	Consumer/whanau interviews have been completed and further interviews are being arranged in order to gather more information.
	Q3: Thematic evaluation complete and ideas for testing, identified.	✓	Testing of ideas and themes that have come through the evaluation process is ongoing as part of a continuous improvement programme within specialist mental health services.
	Q3: Ideas tested in the clinical environment and evaluated for effectiveness.	✓	
	Q4: Balancing metrics captured and reported to HQSC– use of seclusion, use of restraint, use of sedatives.	✓	
Develop programme of improvement for youth to adult transitions Improve consistency of discharge planning documentation. Develop tool for auditing wellness / transition plans.	Q2: Project plan for improving youth to adult transitions agreed.	✓	A review has identified the development work required to improve the functionality of the electronic platform which contains our treatment and discharge documents, this work is underway. Improving the standardisation of how transition plans are documented remains a key focus and work on defining qualitative criteria is ongoing. Specialist Mental Health Services are working through a process for upgrading guidance for clinicians on effective treatment and discharge planning.
	Q3: Discharge plans consistently identified and recorded to support accurate measurement.	↺	
	Q4: Audit tool developed, tested and implemented.	✖	
Key Performance Measures		**Result**	**Comment**
95% of clients discharged have a transition or wellness plan in place.		78%	The work outlined above will help to improve these rates.
95% of audited files meet accepted good practice.		n/a	Work is ongoing to define the criteria for these audits, which will begin once this is completed.

Addictions Services

NZHS Link - Value & High Performance

Status Report for 2018/19		Performance Reporting Link – PP8	
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comment**
Continue to work through the CCN Mental Health Workstream to support the development of whole of system pathways for people with addiction issues.	Q1: Quarterly monitoring of wait times and ongoing improvements to data collection.	✓	Wait times are monitored quarterly.
Work with He Waka Tapu to roll out access to their online support service (Whaiora Online) to other service providers, to support people's health and wellbeing and recovery after treatment. (EOA)	Q2: Increase in the number of users accessing Whaiora online.	✓	He Waka Tapu has increased client engagement and are working with other AOD providers to implement Whaiora online for their client.
Investigate options to further develop community-based withdrawal management support.	Q2: Additional community-based withdrawal management support options identified.	↺	The Specialist Mental Health Services proposal for change feedback has resulted in a closer look at withdrawal activity and patient acuity with a determination that at this stage the service needs to remain with the DHB.
	Q4: Increased community-based withdrawal management capacity available.	↺	
Key Performance Measures		**Result**	**Comment**
80% of people referred to specialist addiction services are seen within 3 weeks.		65%	Addiction services are providing immediate access to a range of non-specialist options, including formal and informal peer support which is not reflected in treatment services wait times. There were 889 people referred and seen within 3 weeks in the period. This data currently reflects inclusion of people not available for treatment. We are working to clarify this impact on the results.
95% of people referred to specialist addiction services are seen within 8 weeks.		85%	

Mental Health Support in Schools

NZHS Link – Closer to Home

Status Report for 2018/19			Performance Reporting Link – PP42
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comment**
Support the cross-sector CCN Mana Ake Service Level Alliance to oversee the design and delivery of the initiative in Canterbury. Continue the rollout, focusing the first clusters on school in areas of highest need. (EOA)	Q1: Mana Ake rolled out to 3 more school clusters.	✓	Mana Ake now has more than 80 kaimahi (workers) operating in all 219 schools with students in years 1-8 across Canterbury. The programme team were able to quickly respond to the March events and provide additional support in schools to children and their families following the terrorist event.
	Q4: Mana Ake rolled out to all eligible primary schools in Canterbury (Year 1-8 children).	✓	
Work in partnership with providers to identify Kaimahi (staff) to support the rollout. Use school rolls to identify optimal allocation of Kaimahi to ensure children and whānau have access to culturally appropriate support. (EOA)	Q4: 80 Mana Ake Kaimahi in place.	✓	
Invest in the development of Leading Lights (web-based tool) to clarify support pathways for children and young people and provide schools with reliable, consistent information.	Q2: 10 topics available on the Leading Lights website, to schools with the Mana Ake initiative.	✓	Leading Lights is now available in all schools with 70 pathways and support pages.
	Q4: Leading Lights available to all primary schools in Canterbury.	✓	
Implement the agreed evaluation approach, focusing on four outcome domains: children, whānau, school and system to inform opportunities for ongoing improvement.	Q1: Evaluation approach agreed.	✓	The draft evaluation report was tabled at the Mana Ake Service Level Alliance meeting in June.
	Q4: Evaluation report on impact of Mana Ake completed.	✓	
Key Performance Measures		**Result**	**Comment**
Number of children and families accessing services.		2,037	1,147 seen as individuals, 890 in groups as at May 2019.
Number of visits to Leading Lights pages. (Page views)		39,094	2,217 new users as at May 2019. 27% of views are from returning visitors.
Positive impact demonstrated across four domains: children, whānau, school and system.		✓	On track with positive feedback coming from schools, whānau and system partners – update included in the Evaluation Report

Primary Care Services

Service Access

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Through the Primary Care Under 13's Working Group, complete the review of the current model for Zero Fees (after hours) for children under 13 years. Analyse after-hours access patterns to ensure free after-hours provision accounts for geographic and demographic factors that are potential barriers to access. (EOA) Agree with PHOs the access and funding arrangements for extending zero fees for children from under 13 to children under 14 from 1 December. Work with PHOs, to keep general practice informed about the details of the community services card policy as they are released, and identify processes that will lead practice to choose to offer reduced consultation fees. Work with the three Canterbury PHOs to ensure practices update their public websites showing details of their zero-fee arrangements.	Q2: Consultation and review completed.	✓	Canterbury has 100% uptake of zero fees for children under 14 from Canterbury general practices, who enrol families. This covers approximately 95% of the Canterbury 0-14 population at current enrolment rates.
	Q2: Proposed new model communicated and agreed with general Practice.	✓	
	Q2-Q3: Implementation of zero fees model for children <14 (both in and after- hours).	✓	
	Q4: General practice websites are confirmed as updated.	✓	
	Q4: Monitor access patterns for all under 14s in-hours and after-hours.	✓	
	Q4: 95% of children <14 have zero fee access to general practice services and prescriptions.	✓	

System Integration

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to invest in the CCN District Alliance as a mechanism for leading service and system improvements. Monitor system performance against Canterbury's Outcomes Framework and the national System Level Measures to identify areas for improvement and focus. Embed the four new service level alliances: Primary Care Capability, Population Health & Access, Oral Health and Mana Ake. (EOA) Extend Alliance partnerships, with a focus on engaging with ACC.	Q1: Work plans for four new alliance groups endorsed by the Leadership Team.	✓	Work plans for the Primary Care Capability, the Population Health & Access SLA and the Oral Health Service Development Group and Mana Ake Service Level Alliance are all on track and regularly reported to the Alliance Leadership Team. The majority of 2018/19 SLM Plan actions have been delivered. A small number (<5) remain outstanding due to competing priorities for staff time, an action that requires change at a national level and, for one, data is yet to be made available to the DHB to complete analysis. Canterbury's 2019/20 System Level Measures Plan was approved by the Ministry in June and outstanding actions will continue to be implemented as planned.
	Q2: ACC endorsed as members of at least two alliance groups.	✓	
	Q4: Delivery of the actions agreed in the CCN work plans for 2018/19.	✓	
	Q4: Delivery of the actions agreed in the 2018/19 System Level Measures (SLM) Improvement Plan.	✓	
Working through the joint SLM Alliance Steering Group, refresh and refine the SLM Improvement Plan outlining collective activity to improve performance against the national measures.	Q1: Implementation of agreed Improvement Plan underway.	✓	
	Q1: Quarterly review of progress against the Improvement Plan.	✓	
Investigate nurse practitioner internships for rural nurses in Canterbury. Develop a training initiative to assist the support care workforce who have trained overseas to integrate into workplaces that may be different than where they trained.	Q2: Nurse practitioner internships scoped and recommendations made.	✗	Canterbury registered their interest in the Health Workforce New Zealand (HWNZ) Development Fund in quarter one. We are still awaiting a formal response from HWNZ. Work is ongoing on strategies for education on Carer Support. This continues to be an action item in the work plan for the Health of Older People Workstream for 2019/20.
	Q4: Support care worker training initiatives scoped and recommendations made.	✓	

CVD and Diabetes Service Improvement

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – PP20

Key Actions from the Annual Plan	Milestones	Status	Comments
Support PHO clinical and executive teams to identify and support practice level champions and follow up with practices with below average performance.	Q1: Quarterly performance reporting by general practices.	✓	Quarterly reporting against targets by ethnicity is in place.
	Q1: Quarterly performance reporting by ethnicity.	✓	
Support PHOs to maximise the capability of IT audit, dashboard and new algorithm tools to prompt the delivery of a CVD risk assessment and streamline the recording of this activity.	Q4: Pegasus rollout of the Sirius PMS system (with enhanced dashboard tool) complete.	↺	Due to delays in PHOs receiving the national data dictionary to support this work, implementation of the PMS and dashboard tool will continue into quarter one.
Support PHOs to implement initiatives targeting high-need Māori and Pacific populations through collaboration with local organisations that have high reach into these populations. (EOA)	Q1: Quarterly reporting of existing and upcoming initiatives.	✓	As part of the new CVD Improvement Plan PHOs are supporting the 2019 Aranui AFFIRM festival to promote and improve access to primary care. Whanau Ora Navigators are working with Te Puawaitanga to support communities and General Practice with outreach services. We also continue to promote "Health Heart" messages in the Tutupu Pacifica Churches project.
Progress a redesign of the patient education model to improve engagement with services and increase the health literacy of our high-need Pacific populations. (EOA)	Q1: IDSDG sub-group set up to progress the redesign.	✓	Work to redesign the patient education model was delayed due to staff capacity. Work is now being completed with education being the first focus which will be followed by nursing integration. An Integrated Diabetes Services Group sub-group has been set up to progress the four key priorities from the Diabetes Review. An oversight group has been established under the IDSG to look at access to dietetic and nutrition services. The first of a series of workshops on diabetes education have been held and a work plan to implement the agreed model will be progressed in quarter one of 2019/20. An initial workshop has been held to look at integrating the diabetes nursing workforce and key stakeholders have been identified. Work is scheduled to continue in quarter one of 2019/20.
	Q4: Draft model developed.	↺	
Further integrate the diabetes nursing workforce to support service delivery closer to communities of need, and maintain consistent clinical oversight and equity of access (regardless of the complexity of people's diabetes). (EOA)	Q3: Workshop held to develop roadmap and identify quick wins.	✓	
	Q4: Implementation plan for the reorientation of diabetes services completed and agreed.	↺	
Explore opportunities for increasing access to dietetic and nutrition services in the community and aligning the workforce to the location of service delivery.	Q2: Working group formed to identify barriers to access.	✓	
	Q4: Change proposal developed.	↺	

Key Performance Measures	Total Results	Māori Results	Pacific Results	Comments
90% of the eligible population have had a CVD risk assessment in the last 5 years.	67%	62%	61%	A CVD Improvement Plan has been developed with clinical input from the three PHOs and has been submitted to the Ministry. The improvement plan outlines actions which will support implementation of the new national guidelines and improve update of CVD Risk Assessments in 2019/20.
90% of eligible Maori men (35-44) have had a CVD risk assessment in the last 5 years.		46%		
90% of the population identified with diabetes have had an annual HbA1c test.	90%	88%	85%	Results are to December 2018. Some Pegasus PHO reporting is being impacted by data issues arising from the move to a new patient management system in some practices.

Newborn Enrolment

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – SI18

Key Actions from the Annual Plan	Milestones	Status	Comments
Invest in the LinKIDS coordination function to support the multiple enrolment process, connect children to available health services and better inform parents. (EOA) Work with PHOs to refresh the multiple enrolment process chart and support general practice to engage with the process. Align the National Immunisation Register and LinKIDs process to reduce the number of children with an unknown provider. Provide feedback to LMCs when they notify LinKIDS of a birth with no nominated or identified general practice.	Q1: Expansion of the LinKIDS programme.	✓	A LinKIDS programme coordinator was appointed in December and a refreshed process chart was distributed in January. LinkKIDSs and NIR process are aligned and linking up children with no nominated provider on the NIR or whose NIR nomination is declined at general practice.
	Q2: Refreshed process chart circulated to general practice.	✓	
	Q3: NIR and LinKIDS processes aligned.	✓	
	Q4: >95% of children have a known provider.	✓	

Key Performance Measures	Total Results	Māori Results	Pacific Results	Comments
85% of newborns are enrolled with general practice by 3 months of age.	97%	85%	97%	A change in how this indicator is calculated nationally (to align it with the six week old indicator) means Canterbury is now meeting the national target across all ethnicities. Results are no longer comparable with previously reported results.

Pharmacy Action Plan

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link – PP22

Key Actions from the Annual Plan	Milestones	Status	Comments
Work with local pharmacies and the Canterbury Community Pharmacy Group to implement the new agreement locally.	Q1: All pharmacies in Canterbury sign the new service agreement.	✓	All 127 pharmacies in Canterbury have new evergreen Integrated Community Pharmacy Service Agreement in place with the DHB. The DHB is on track to meet national expectations.
	Q4: 120 pharmacies have new 'evergreen' pharmacy service agreements in place.	✓	
Support pharmacists to provide medication management reviews (MURs) and medication therapy assessments (MTAs) for people on high risk/multiple medicines. Analyse polypharmacy patterns by demographics to increase GP visibility of enrolled patients on multiple mediations and guide refinement of actions to improve performance. (EOA)	Q2: Analysis of polypharmacy patterns circulated.	✓	Pegasus Health's GPView clinical support portal includes a tool highlighting for GPs their patients at-risk from polypharmacy. Uptake of MURs and MTAs has increased but the latter more slowly than planned (see below).
	Q4: Increased uptake of MURs and MTAs by high need populations.	✓	
Invest in a pharmacy outreach programme for Māori, promoting health literacy and self-management of medicines. (EOA)	Q3: Kaupapa Māori mobile clinics launched.	✓	A Maori pharmacist has been engaged part-time providing outreach education and medicines use reviews for Maori.
Engage pharmacists in protecting our community against influenza by vaccinating pregnant women and people aged 65+.	Q4: >80 Pharmacies providing free influenza vaccinations.	✓	91 of 130 pharmacies are providing free influenza vaccinations in Canterbury.

Key Performance Measures	Results	Comments
>1,000 people receive a Medication Use Reviews (MUR).	1,289	
>250 people receive a Medication Therapy Assessments (MTA).	145	Slower than expected GP referrals for the new MTA services have impacted this result. Referral numbers are slowly increasing.

Support to Quit Smoking

NZHS Link - One Team

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Monitor the DHB's Tobacco Control Plan to support an integrated approach to achieving Smokefree Aotearoa 2025. Review the current Plan to ensure smokefree efforts are focused on communities, whānau and groups with a higher smoking prevalence (Māori, Pacific and people living in more deprived circumstances). (EOA)	Q1: Continued delivery against the Tobacco Control Plan.	✓	The Ministry of Health has altered the deadline for this plan and are looking to push it back to quarter two 19/20. The DHB is on track to meet national expectations.
	Q3: Plan reviewed and updated for resubmission in May 2019.	✓	
Continue to support the rollout of the Motivational Conversations Programme, to support health professionals to have difficult conversation with patients about risk behaviours and adopting healthier lifestyles.	Q1: Ongoing uptake of motivational training.	✓	23 trainings have been delivered. Training sessions were postponed due to staff capacity following the events of March 15 and the measles outbreak. Despite this, 235 health professionals attended the training exceeding the 200 participant target.
	Q4: 25 training events delivered.	✓	
Support the continued development of our Stop Smoking Service (Te Hā Waitaha). Monitor enrolments by referrer and ethnicity to identify opportunities for improvement and to ensure uptake by Māori, Pacific and high need population groups. (EOA)	Q1: Quarterly monitoring of referrals and enrolments.	✓	Enrolment rates with Te Hā Waitaha are impacted by regular fluctuations throughout the year. Despite this has there has been an overall increase of enrolments.
	Q4: Increased enrolment rates amongst Māori, Pacific and high need population groups.	✓	
As an integral part of Te Hā Waitaha, continue to invest in a programme that incentivises pregnant women to stop smoking. Complete an evaluation of the incentivised programme to identify successes and opportunities for improvement.	Q1-4: Increased enrolments rates for pregnant women.	✓	
	Q4: Evaluation completed and circulated to Alliance partners.	✓	

Key Performance Measures	Total Results	Māori Results	Pacific Results	Comment
90% of PHO enrolled patients who smoke are offered brief advice/support to quit.	82%	79%	77%	The fall in performance is related to the extraordinary combination of adverse events in Canterbury in 2019 and introduction of a new patient management systems in several practices with some data incomplete. Canterbury's cessation support rates were the highest in the country at 61%, well above the national average of 33%.
90% of pregnant women who identify as smokers upon registration with an LMC are offered brief advice and support to quit smoking.	89%	79%		Total population results remain just below target in quarter four. The Māori rate represents just four women who were not offered brief advice, this can be for a number of reasons including complexity of the patient and mental health concerns.
95% of hospitalised smokers are offered brief advice and support to quit smoking.	90%	89%	93%	The DHB has moved to an electronic discharge form which has changed the way inpatient smoking data is gathered, work is underway to resolve this with performance expected to improve in the coming months. A Coding backlog at year end has also contributed to these results.

Child Health Services

Maternal Mental Health Services

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP44

Key Actions from the Annual Plan	Milestones	Status	Comments
Develop a system-wide Maternity Strategy to support the realignment of our maternity system and improved health of mothers and babies. Ensure a targeted focus on Māori and Pacific, women living in lower decile areas and younger mothers as populations of higher need. (EOA)	Q1: Feedback from co-design workshops used to inform the development of the Strategy.	✓	The proposed strategy was presented to the DHB Board in quarter two. Feedback on the Maternity Strategy was received in quarter three and taken into account for the current draft. A draft is currently available for consultation among maternity stakeholders.
	Q2: Strategy presented to DHB Board.	✓	
	Q3: Implementation Plan agreed.	✓	
Identify all community-based DHB funded services and initiatives currently in place to support maternal mental health. Identify the number of women being supported.	Q2: Stocktake report completed.	✓	The completed stocktake and access report has been shared with the Ministry of Health.
	Q4: Access report provided to the Ministry of Health.	✓	

Child Wellbeing

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP27

Key Actions from the Annual Plan	Milestones	Status	Comments
Establish a cross-system Oral Health Service Development Group under the CCN Alliance. Develop a 'whole of life' oral health communication/education strategy to raise awareness of the importance of good oral health and motivate behaviour change. Include the Community Dental Service in the multiple enrolment process to capture children in the database at birth. (EOA)[1] Use the LinKIDS coordination function to support the Community Dental Service to connect with children lost to recall. (EOA) Use focus groups to determine factors impacting adolescent engagement with dental services with a focus on Māori and Pacific youth. (EOA)	Q1: Terms of reference and work plan for Oral Health SDG endorsed by the Alliance Leadership Team.	✓	Youth focus groups have been completed. Development of the communication plan and key messages is now underway. This work will align with and build on national messages but include a local considerations, particularly around how the messages are communicated.
	Q2: Oral Health Strategy agreed.	✓	
	Q3: Adolescent focus groups held.	✓	
	Q4: Whole-of-Life communications plan and key messages developed to support improved oral health at any stage in life.	↺	It is anticipated that this will be launched in quarter one of 2019/20.
Undertake further research on why Pacific children are more likely to end up admitted to hospital with an avoidable condition. (EOA) Work with Whānau Ora providers to strengthen referral pathways for children admitted to hospital services acutely. Increase general practice visibility of their enrolled 0-4-year olds who are admitted to hospital with an avoidable condition.	Q1: Quarterly monitoring of Avoidable Hospital Admissions.	✓	Quarterly monitoring is part of the System Level Measures monitoring.
	Q3: Referral pathways strengthened in two key areas.	✓	A referral pathway for 0-4-year olds admitted to ED and/or Children's Acute Assessment (CAA) has been implemented.
	Q3: Avoidable admissions of enrolled 0-4-year olds identifiable to each general practice.	✓	Avoidable admissions are now identifiable by general practice where patients are enrolled. Consultation is now underway to determine the best way to share this data with practices.
	Q4: Further research identifies opportunities for focus.	✓	2018 ambulatory sensitive hospitalisation data has helped to inform key priorities for the joint 2019/20 SLM Improvement Plan approved by the Ministry in June.
Continue to invest in the Violence Intervention Programme (VIP) and activity to support a reduction in harm and adverse health outcomes.	Q1: VIP training sessions ongoing.	✓	550 staff attended training in the past year, compared to 448 the previous year. The VIP results are reported each calendar year, the 2018 result was 80 out of a possible 100.
	Q4: VIP audit results >70/100.	✓	

Key Performance Measures	Results	Comments
95% of children (0-4) are enrolled with Community Dental Services.	83%	After several years of underperforming oral health results we are now seeing stabilisation and improvement in several areas as the Oral Health Service Development Group addresses service issues. While enrolment and examination rates have not met targets this is a clear improvement on previous years. The LinKIDS programme and the changes to enrolment process have improved preschool enrolment rates by 25% since 2016. We anticipate continued improved performance over the 2019/20 year.
90% of enrolled children (0-12) are examined according to plan.	88%	
>85% of adolescents (13-17) are accessing DHB-funded oral health services.	66%	

[1] *A higher proportion of Māori and Pacific children are 'lost to recall' when they cannot be contacted and are made inactive on the Community Dental Service database.*

Supporting Health in Schools

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP39

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to support the Health Promoting Schools framework in decile 1-4 schools and schools with a high proportion of Māori and Pacific students. (EOA) Continue to support interschool forums and deliver professional development and training workshops for schools. Identify all actions and initiatives currently underway to support health in primary and secondary schools in Canterbury. Develop action plans with each priority school engaged in the HPS framework.	Q2: Interschool forum held.	✓	The stocktake was completed and includes those services that are unique to Canterbury (such as Specialist Mental Health Services in Schools and Mana Ake).
	Q2: Professional development workshop held.	✓	
	Q2: Stocktake report completed.	✓	
	Q4: >50 schools have action plans.	✓	

School-Based Health Services (SBHS)

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Undertake a stocktake of all school-based health services (SBHS) currently provided in public secondary schools in Canterbury. Work with decile 1-4 schools to identify and reduce barriers to participation in routine health assessments, with particular focus on Māori and Pacific participation. (EOA) Work with Te Pa o Rakaihautu School to identify an appropriate model or approach to school-based nursing support in a kaupapa Māori environment. (EOA) Work with schools and providers to roll out SBHS to all decile 4 schools and develop an implementation plan for expanding SBHS to all public secondary schools in Canterbury.	Q2: Stocktake report completed.	✓	The stocktake was completed and includes those services that are unique to Canterbury (such as Specialist Mental Health Services in Schools and Mana Ake).
	Q3: Kaupapa Māori model/approach identified and supported.	✓	Te Te Pa o Rakaihautu School is receiving culturally appropriate school-based nursing services through Nurse Maude.
	Q4: SBHS in place in all 1-4 decile schools in Canterbury.	✓	As at the end of June 2019, all decile 1-4 schools have a SBHS agreement in place.
	Q4: Implementation plan for expanding SBHS to all schools completed and provided to the Ministry of Health.	✓	An implementation plan has been forwarded to the Ministry as required.
	Q4: 95% of year nine children receive a HEEADSSS assessment.	✓	100% of eligible year 9 children assessed.

Immunisation

NZHS Link – One Team

Status Report for 2018/19

Performance Reporting Link – PP21

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to invest in the outpatients' vaccination programme to reach women and children who are not vaccinated. (EOA) Continue to support practices with catch-up schedules and overseas vaccination history for children new to living in Canterbury. Refresh the immunisation process chart and include tips and prompts for having difficult immunisation conversations. Engage with alliance partners to better understand Māori and Pacific five-year-old declines rates and work with practices to reduce declines for these high need populations. (EOA)	Q1: Quarterly review of immunisation and decline rates by ethnicity.	✓	The process chart has been refreshed and printed and distributed to general practice teams.
	Q1: LMC focus group held to identify barriers to promoting immunisation.	✓	
	Q2: Refreshed process chart issued to general practice.	✓	
	Q3: Options for difficult conversation training for practice nurses explored.	✓	A programme has been developed to target practices with high incidence of declines. We are currently working out how best to deliver this programme. Rollout will be confirmed in quarter one 2019/20.
	Q4: Opportunities to reduce decline rates captured.	↺	

Key Performance Measures	Total Results	Māori Results	Pacific Results	Comments
50% of pregnant women vaccinated for Pertussis.	63%			
95% of 8-month-olds fully immunised.	95%	90%	99%	Canterbury continues to meet immunisation targets for eight month olds and has met the target for two year olds this quarter. Immunisation rates for Māori were slightly below the rest of the population in quarter four – but this reflects small numbers with just 25 eight month old, 24 two year old, and 24 five year old children not immunised on time.
95% of 2-year-olds fully immunised.	95%	91%	97%	
95% of 5-year-olds fully immunised.	92%	89%	96%	

Responding to Childhood Obesity

NZHS Link – Value and High Performance

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Monitor the delivery of B4 School Checks (B4SC) and referrals to the Healthy Lifestyle Coordination Service, by ethnicity and deprivation, to ensure all children are being appropriately assessed and referred for support where needed. (EOA) Investigate reasons why families don't take up and/or complete family-based nutrition, activity and lifestyle interventions.	Q1-Q4: Quarterly monitoring of assessments, referrals and programme uptake.	✓	Rates are monitored quarterly by the Child & Youth Workstream.
	Q3: Audit to identify reasons for those declining referrals.	✓	A research/evaluation programme was instigated through the regional Healthy Weight in Childhood Clinical Advisory Group to follow up on children and families who declined to participate in the healthy lifestyle programmes.
	Q3-Q4: Provision of 'difficult conversation' training for staff assessing and referring families.	✓	Training has been delivered to Well Child/Tamariki Ora nurses. Further training is available through the Pegasus education programme.
Expand the range of nutrition, activity and lifestyle interventions available, to provide general practice teams with multiple referral options when referring overweight children and their families. Explore the development of services tailored specifically to meet the needs of Māori and Pacific children, and children living in high deprivation areas. (EOA)	Q3: Identify models and service interventions that are succeeding elsewhere in NZ.	✓	Alternative models of service delivery have been explored.
	Q4: Identify a pathway for the development and/or implementation of additional programmes in Canterbury.	↺	A Proposal is being developed to trial the Te Whanau Pakari model operating in Taranaki. This will be further explored in quarter one 2019/20.

Key Performance Measures	Total Results	Māori Results	Pacific Results	Comments
95% of children identified as obese at their B4 School Check are offered a referral to a health professional for clinical assessment and family-based lifestyle intervention.	100%	100%	100%	Data issues from the Ministry mean the June result is not available, the December to May result is shown.

Older Person's Health Services

Healthy Ageing

NZHS Link – Closer to Home

Status Report for 2018/19

Performance Reporting Link – PP23

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to work with partner organisations through the CCN Falls and Fractures SLA to enhance and integrate falls and fracture prevention services. Support Sport Canterbury to accredit community strength and balance classes targeted towards Māori and Pacific people. (EOA) Engage with other existing DHB funded rehabilitation and education programs to bring in a strength and balance component. Embed the fracture pathway to ensure people with a fractured Neck-of-Femur (NOF) are referred to the in-home Falls Prevention programme.	Q1: ACC endorsed as a member of the Falls and Fractures SLA.	✓	A connection with Te Puawaitanga was developed through the delivery of an 8-week exercise programme, creating the opportunity for ongoing community classes to meet the needs of Māori participants. Unfortunately, staff capacity and relocation issues have meant both the Māori and Pacific Strength and Balance classes have not happened. Sports Canterbury is working on alternative options to resume these classes. Further development of classes for culturally and linguistically diverse population such as the Kaumatua of Tuahiwi Marae, E Tu Pasifika, Muslim women and the Indian community are under way. We are now piloting auto referrals post discharge from hospital with a fractured Humerus or neck of femur (NOF) to the falls champion service in order to capture those most at risk of serious harm from a fall.
	Q2: Māori and Pacific focused community strength and balance classes accredited.	✓	
	Q2: Falls Prevention Pathway reviewed and updated.	✓	
	Q4: DHB funded rehabilitation or education programmes accredited to provide community strength and balance components.	✓	
	Q4: 150 community strength and balance places in place, targeted towards Māori and Pacific.	✗	
Review the Community Services Operations Manual to further support and embed the restorative approach across the system. Establish a reporting framework to raise the focus on the rate by which Māori and Pacific people (50+) are having their needs assessed using the InterRai tool. (EOA) Work with partner DHBs on the InterRAI Visualisation Project to develop a single dashboard view of people's assessments and make this available to the health professionals involved in their care. Design a new community services referral process to streamline service referrals.	Q2: Community Services Operations Manual updated.	↺	The updating of the Community Services Operations Manual has taken longer than expected. A workgroup has been established to look at a number of sections within the Manual and as new processes are agreed, the manual will be updated.
	Q2: InterRAI reporting framework in place, and assessment rates tracked by ethnicity.	✓	
	Q4: Prototype InterRAI dashboards available to general practice via HealthOne.	✗	It was anticipated the development we required would be in the latest InterRAI software update, but unfortunately this has not happened. We remain focused on this outcome and issues are being worked through with Central TAS. The new referral form has been formulated and is currently being trialled in paper form. Work on the electronic referral system is due to start and a working group has been established to help with the process.
	Q4: New electronic community services referral forms operational and HealthPathway updated.	↺	
Work with our partners in the CCN Urgent Care Workstream, to review and target the Acute Demand Management Service to reduce avoidable ED presentations. Invest in GP visit vouchers for people seen at risk of re-presentation to ED following discharge with a focus on high need people aged 50+. (EOA) Analyse the 65+ cohort with repeat acute admissions and investigate potential interventions. (EOA)	Q1: Quarterly monitoring of uptake of the ADMS by age and ethnicity.	✓	The post-discharge voucher program was implemented last winter. An evaluation of the trial although showing no noticeable reduction in readmission rates received positive clinical feedback. An identified strategy focused on frail elderly (led by the Canterbury Initiative team) is in place for this winter to support primary care to identity those most at risk of admission early.
	Q1: Launch of the post-discharge voucher program (over winter).	✓	
	Q2: Strategies for repeat admissions cohort identified.	✓	
	Q3: Review uptake of post-discharge vouchers.	✓	
	Q4: Alternative pathways and/or interventions introduced.	✓	

Key Performance Measures	Results	Comments
12,000 places available at accredited strengths and balance classes.	33,201	Changes to service delivery in coordination with ACC this year have resulted in increased referrals. Direct referrals to the service are now made for eligible people with fractured NOF whose treatment has been covered ACC. We are also
1,200 referrals made to the Falls Prevention Service.	2,127	

		proactively identifying older people who would benefit from the service.
2,100 people supported by the Fracture Liaison Service.	667	The Fracture Liaison Service reviews the treatment of patients presenting to hospital with a fracture. This service is not always face to face and not always recorded; hence the target number has not been reached. The FLS Nurse is also responsible for the promotion of the service throughout secondary care, reporting to the Hip Fracture Registry and maintaining key contacts with ACC and primary care.
95% of long-term Home-Based Support Services clients have had an InterRAI assessment and have a completed care plan in place.	91%	An InterRAI is a comprehensive geriatric assessment primarily for older persons 65+. Not all people who receive long term home based supports are 65 plus.
<25 days median wait time for an interRAI Assessment.	41	The percentage of people 65+ living in their own homes is increasing as out population ages, meaning more InterRAI assessments are needed. Home Based Support services and a care plan are put in place whilst a person waits for their assessment.
Baseline established for the rate of InterRAI assessments per 1,000 population.	✓	11.84 per thousand people

Disability Support Services

NZHS Link - One Team

Status Report for 2018/19			Performance Reporting Link – SI14
Key Actions from the Annual Plan	**Milestones**	**Status**	**Comments**
Form a transalpine West Coast/Canterbury DHB Diversity Training Group to develop a diversity education framework. Engage the Disability Steering Group and Māori and Pacific leads to ensure content is consumer focused and culturally appropriate. (EOA) Engage subject matter experts to develop disability training modules, building on the e-learning work completed in 2017/18. Track uptake and feedback on modules as a means of evaluation.	Q1: Diversity Training Group established.	↺	There have been initial delays with this work but a number of enablers are now in place or underway: the appointment of the Care Starts Here Programme Manager, the initiation of the Diversity Inclusion and Belonging Policy, and the coming together of members from the Disability Steering Group to discuss 'what change looks like'. This provides the basis for a diversity learning framework and there is more clarity on the scope of training linked to the intended behaviour change. This work has been reprioritised for 2019/20.
	Q2: Diversity education framework approved.	✘	
	Q2: Development of training modules complete.	✘	
	Q3: Disability training modules launched on HealthLearn.	✘	
	Q4: Report on uptake of training modules.	✘	
Key Performance Measures		**Result**	**Comment**
Percentage of staff completing disability training modules.		13%	There is an online training module available through HealthLearn with 1,423 completions.
Percentage of staff rating content positively.		✘	The current online module does not provide for evaluation.

Improving System Settings

Strengthened Delivery of Public Health Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – SI16

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to invest in the Integrated Family Health Services (IFHS) Programme to support new ways of working in general practice.	Q3: Review of investment in healthy lifestyle programmes to maximise opportunities for impact.	↺	Work to establish what is currently delivered by the DHB in the Healthy Lifestyles is underway.
Continue to invest in models that enhance care and enable self-management for patients with long-term conditions.	Q3: New subsidised procedures investigated.	✓	New pathways for community infusion of bisphosphonates and infliximab are in development.
Continue to invest in subsidised procedures to enable the delivery of services in general practice rather than hospital settings.	Q4: Increased uptake of shared electronic individualised care plans across general practice.	✓	
Partner with Pasifika Futures to identify and establish priority areas to improve health outcomes for our Pacific population. (EOA)	Q1: Joint portfolio role established.	✓	A joint Pasifika Portfolio Manager is now in place and the DHB and Pasifika Futures have agreed on focus areas.
	Q1: Areas of focus identified.	✓	
Engage with our pacific community to better understand and improve the experience of Pacific service users. (EOA)	Q1: Pacific health outcome indicators established	✓	A contract is under development to enhance Integrated Family Health Services (IFHS) for Pasifika, which will include a capacity focus.
Invest in the design and development of innovative service models to better enable and support our Pacific population. (EOA)	Q2: Opportunities for enhancing Etu Pasifika IFHS model identified.	✓	This will incorporate a personalised wellness plan approach and use of patient experience surveys. This work will continue in 2019/20.
Identify opportunities to increase the cultural capacity and capability of DHB staff working within priority services. (EOA)	Q2: Capacity building approach agreed.	✓	
	Q3: Pacific service users targeted with patient experience survey.	↺	
Continue to support the Rural Sustainability Programme to develop sustainable rural health service models and improve service access for people in rural settings. (EOA)	Q1: Rural Supported Discharge Service co-design workshop held.	✓	Rural Supported Discharge Service workshops have been held in the Hurunui and Oxford regions. These have identified opportunities to strengthen the delivery of services in the rural areas. This work will continue in 2019-20
Invest in the development of rural-based restorative models of care to support older people living in rural areas. (EOA)	Q1: Trial of new after-hours model underway in Hurunui.	✓	
Invest in the development of telehealth and telemedicine in rural settings to reduce unnecessary travel. (EOA)	Q3: Trial of new observation service underway in Hurunui.	↺	Two workshops have been held with clinicians from both Rangiora, Hurunui and Oxford districts to develop a clinical pathway and work is now progressing to implement these pathways into the local areas.
	Q3: Rural Supported Discharge Service model agreed.	↺	Delayed pending completion of the work outlined above this will be completed in 2019/20.
	Q4: Akaroa Health Centre open.	✓	The new Akaroa Health Centre was blessed in July ahead of the formal opening 7th September.

Key Performance Measures	Result	Comment
> 500 people have Personalised Care Plans in place.	✓	2,112 Personalised Care Plans in place
>2,500 people have Acute Plans in place.	✓	3,215 Acute Plans in place.
>30,000 urgent care packages provided in the community.	✓	35,089 Urgent care packages provided in the community
>10,000 subsidised procedures delivered in primary care settings.	✓	12,225 Subsidised procedures delivered in primary care settings.

Shorter Stays in Emergency Departments

NZHS Link – Value and High Performance

Status Report for 2018/19

Performance Reporting Link - TBC

Key Actions from the Annual Plan	Milestones	Status	Comments
Working through the Urgent Care SLA, refine the Acute Demand Management Programme to better target the rural population who can be looked after in the community. (EOA)	Q2: Rural stabilisation supports implemented to manage patient flows closer to home.	✓	New rural stabilisation funding was made available in December for remote rural practices to enable observation of patients while they wait for transfer to hospital. There has been modest uptake however general practice have provided positive feedback of the benefit to patients at high risk.
	Q4: Uptake assessed and supports modified as required.	✓	
Ensure timely patient flows from ED to ED Observation and the Acute Medical Admission Unit (AMAU).	Q1: Monitoring of ED Observation and Acute Medical Admission Unit volumes and ED length of stay.	✓	Volumes in ED Observation and AMAU have remained stable over 2018/19. The ED Observation and AMAU average lengths of stay were 4.6 hours and 15.1 hours respectively, with 87% of ED Obs patients being discharged home. The post-discharge voucher has not been continued with the Urgent Care Service Level Alliance replacing this with a general practice-led assessment and care planning process being trialled through winter of 2019. There is also a focus on supporting return to ARC (from ED) pathways.
	Q3: Frail older person's pathway updated to maximise flow, including review of uptake of post-discharge vouchers.	✓	
	Q4: Alternative pathways and/or interventions introduced.	✓	
Continue to develop capabilities and processes in preparation for shifting to the Acute Services Building early 2019/20.	Q2: Mapping of processes for each treatment area.	✓	ED processes for each treatment area continue to be reviewed with a focus on future service configuration. The business case for staffing configuration in the new Hagley building is in draft with further work to be completed.
	Q4: Complete staffing profile for shift.	↺	

Key Performance Measures	Total Result	Māori Result	Pacific Result	Comment
95% of patients are admitted, discharged, or transferred from ED within six hours.	90%	92%	94%	Canterbury DHB has implemented a new patient management system (SIPICS) over the last 12 months including the introduction of EdaaG in October 2018. The transition to EDaaGs is still bedding in with some time stamps not capturing the underlying clinical processes. Education to ensure best use of the PMS is ongoing. Internal data shows performance is closer to 92%.
<15% of patients admitted from ED observation to inpatient wards (nat. guidelines <20%).	14%			

Cancer Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP30

Key Actions from the Annual Plan	Milestones	Status	Comments
Continue to use data/intelligence systems to support discussion with specialties who are missing wait time targets and identify opportunities to reduce process delays. Complete the head and neck cancer patient pathways review, a joint DHB project between Nelson Marlborough and Canterbury.	Q1: Quarterly monitoring of cancer wait times.	✓	Improvement work to reduce progress delays is ongoing. A review of written and online information has been undertaken by the Patient Information Group and the Patient Diary has been updated to include more Maori & Pacifica information.
	Q1: Head & Neck Review report published and circulated.	✓	
	Q2: Improvements identified and implementation underway.	✓	
Engage locally in the regional Te Waipounamu Māori Cancer Pathway Project to support improved outcomes for West Coast Māori. (EOA) Appoint a Māori Pathways Haematology Nurse to support service improvements for Māori and Pacific patients. (EOA) Work with the Māori Pathways Haematology Nurse to identify opportunities to reduce treatment delays. (EOA)	Q1: Māori Pathways Haematology Nurse in place.	✓	A Māori Haematology Nurse is in place and has identified areas where she can make a difference including enhancing cultural responsiveness and building community links. The Māori Haematology Nurse is working with other departments to identify and promote better ways of working.
	Q1: Review of current issues and opportunities completed.	✓	
	Q2: Opportunities of the new role identified and disseminated to other pathway areas.	✓	
Incorporate references and links to Kupe (the national prostate cancer decision support tool) to support men and their families to understand the risks and benefits of treatment before having a prostate cancer check, so that they can make informed decisions.	Q2: Kupe link on HealthPathways to support GP/patient conversations.	✓	Links to the KUPE tool are loaded on HealthPathways and HealthInfo. https://kupe.net.nz/en/taking-action
	Q2: Kupe link on HealthInfo to support patients and their families to make informed decisions.	✓	
Engage with the Southern Cancer Network, Cancer Society and others to develop a national Cancer Survivorship Consensus Statement.	Q1: Feedback provided on the national Survivorship Consensus Statement.	✓	

Key Performance Measures	Result	Comment
90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks.	96%	
85% of patients receive their first cancer treatment (or other management) within 31 days of date of a decision-to-treat.	90%	

Elective Services

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP45

Key Actions from the Annual Plan	Milestones	Status	Comments
Review production and capacity plans and determine outsourcing needs for the 2018/19 year, in order to meet Electives Targets and Elective Services Patient Flow Indicator (ESPI) expectations.	Q1: Production and capacity planning completed and elective funding schedule agreed.	✓	Several factors have impacted on elective services delivery over the past year, including: ongoing delays with the completion of the Acute Services Building, effects of industrial action, and the impact of the March 15 event. The DHB has advised the Ministry of Health that we will not meet elective targets this year. Production planning has been completed for 2019/20, however repatriation of outsourcing is dependent on the actual 'Go Live' date for services moving to the ASB.
	Q1: Outsourcing contracts in place.	✓	
	Q4: Production and capacity planning for 2019/20 includes repatriation of outsourcing.	✓	
	Q4: Services on track to meet ESPI expectations.	×	
Build on the experience and research of the Māori Pathways Haematology Nurse as a model to improve awareness of factors that impinge on equity within elective service streams. (EOA)	Q2: Work undertaken with services to identify barriers and ways to raise cultural awareness within teams.	✓	Strategies are in place to enhance the cultural responsiveness of the haematology team so that information for patients is delivered in a way that supports Māori health. Information has been reviewed and lessons shared with other departments.
	Q3: Information for patients reviewed and refined to reflect different needs and health literacy levels.	✓	
	Q3: Services linked into Did Not Attend (DNA) and Improving Accuracy of Ethnicity Data projects.	✓	DNA rates are now visible via a dashboard on the CDHB intranet. A spike in DNA rates occurred when South Island PICS was introduced but this has been resolved by re-enabling the ability to send text reminders and the DNA rate has subsequently returned to the pre-SI PICS rate.
Develop a plan for transitioning outpatient appointments to the new Outpatients Building for November 2018. Develop an online scheduling tool to support the smooth flow of 800+ outpatient appointments a day from across the Christchurch Hospital campus to the new Building.	Q1: Population and demand profile reviewed to confirm use of space in the new Building.	✓	Outpatient Move Complete. The Orange Book has been updated and reviewed. The online scheduling tool has been developed and implementation is underway with the tool is being piloted prior to full roll-out.
	Q1: Elective Services Guidelines (Orange Book) updated to include new standardised ways of working.	✓	
	Q1: Online scheduling tool developed.	✓	
	Q2: Online tool implemented.	↺	
Define levels of service to be provided in the public system in Canterbury for people with gender dysphoria, in line with national expectations. (EOA)	Q1: Clinically-led group established to oversee pathway development.	✓	Pathways to support service delivery have been developed and are awaiting implementation. A steering group has been established to support the implementation of the pathway which will be live in quarter one.
	Q2-Q3: Pathway to support service delivery developed.	✓	
	Q4: Pathway in place.	↺	

Key Performance Measures	Result	Comment
21,782 elective surgeries delivered.	21,267	Despite a significant amount of work going into elective surgery, both in output and coding; Canterbury did not meet the year-end target. The implementation of the new patient management system as well as the events of March 15 contributed to this result. Work continues to ensure appropriate capture of waiting times for Elective Services Patient Flow Indicators (ESPI 2 and 5) following the implementation of PICS in October.
Average elective length of hospital stay at or below 1.54 days.	1.56	

Service Quality

NZHS Link - Value & High Performance

Status Report for 2018/19 | Performance Reporting Link – SI17

Key Actions from the Annual Plan	Milestones	Status	Comments
Build understanding of asthma's contribution to avoidable admissions for Pacific children 0-4 years. (EOA) Work with CCN to increase general practice visibility of their enrolled 0-4-year olds who are admitted to hospital with asthma.	Q3: Avoidable admissions (including contribution of asthma) of enrolled 0-4-year olds identifiable to each general practice.	✓	Avoidable admissions are identifiable by general practice where patients are enrolled. Consultation is now underway to determine the best way to share this data with practices.
Work with consumers and staff to co-design and articulate the role of a 'nominated or preferred' contact person. Work with consumers to develop material describing and clarifying the role. Develop an organisational change process, including training and materials for staff who collect patient details, to ensure that a patient's nominated or preferred person is identified in the early stages of admission.	Q1: Terminology agreed.	✓	While there have been initial delays with this work due to staff capacity, progress has been made in the last quarter. The procedure and patient and family information has been developed and is currently being consulted on. Work will continue in 2019/20.
	Q2: Procedure for contact details collection updated to include nominated contact person.	↺	
	Q3: Organisational change process confirmed and tested.	↺	
	Q4: Change process approved and implemented.	×	
	Q4: >57% of inpatients felt 'staff included their family/whānau or someone close to them in discussion about their care'.	↺	Results to May 2019 show that 50% of respondents felt 'staff included their family/whānau or someone close to them in discussion about their care'.

Waste Disposal

NZHS Link - Value & High Performance

Status Report for 2018/19 | Performance Reporting Link – PP41

Key Actions from the Annual Plan	Milestones	Status	Comments
Distribute materials to pharmacies for educating patients about returning unused and expired medicines and used sharps.	Q1: Educational materials distributed to pharmacies.	✓	
Commence PVC recycling with the collection of oxygen tubing and masks from theatres, the post anaesthetic care unit and surgical wards.	Q3: PVC recycling materials developed and circulated.	✓	PVC recycling has commenced in Theatre, Post-Anaesthetic Care Unit (PACU) and two surgical wards.
	Q4: PVC recycling commenced.	✓	
Launch the peritoneal dialysis (at home) recycling scheme for solution bags and pouches.	Q4: Peritoneal dialysis recycling scheme launched.	✓	
Undertake a stocktake on current disposal processes for each category of waste to identify opportunities for improving waste disposal.	Q2: Stocktake report completed and submitted to the Ministry.	✓	Stocktake shared with the Ministry.

Climate Change

NZHS Link - Value & High Performance

Status Report for 2018/19

Performance Reporting Link – PP40

Key Actions from the Annual Plan	Milestones	Status	Comments
Establish a Sustainability Governance Group to develop and implement a DHB wide Environmental Sustainability Strategy. Maintain CEMARS certification and work towards achieving a Gold Energy Mark by identifying further opportunities to reduce energy use, costs and emission.	Q1: Sustainability Group in place.	✓	The Sustainability Governance Group (SGG) is in place with a Chair and Executive sponsor identified. The sustainability position statement has been reviewed by the SGG and supported. It is waiting for the Regional CEO group at SIAPO to review.
	Q2: DHB Environmental Sustainability Position Statement developed.	↺	
Validate alignment of current initiatives with position statement and operation policy to identify priority focus areas.	Q2: Stocktake of current actions completed.	✓	Stocktake complete and submitted to the Ministry of Health. First order priorities are still being worked through.
	Q4: First order priorities identified.	✗	
Replace Christchurch and Ashburton Hospital coal boilers with carbon neutral biomass boilers to reduce emissions.	Q4: Replacement of Boilers is planned for 2020/21.	↺	This work continues.
Develop a travel demand management plan to support Christchurch Hospital staff to get to work in healthy and sustainable ways.	Q1: Travel demand management pilot launched in ICC.	✓	The ICU pilot was a success. A travel demand management plan has been rolled out to Christchurch campus and on-line.
	Q2: Travel demand management plan fully actioned.	✓	
Engage with the Christchurch City Council to share their electric fleet, reducing the reliance on fossil fuel/LPG.	Q2: Corporate users using CCC Fleet for appropriate journeys.	✓	Corporate users are using the CCC fleet and Lime scooters for travel across town to meeting.

Key Performance Measures	Result	Comment
CEMARS certification maintained.	✓	CDHB was a 'Top 20' reducer in NZ CEMARs certified organisations.
Gold Energy-Mark certification achieved.	✓	CDHB is the first DHB to achieve Gold certification.
Energy consumption per square metre.	✓	Total energy use is rising due to increased building size but per square metre consumption is stable.
Continued reduction of CDHB carbon emissions.	✓	Our emissions profile continues to improve. SMOs can now use their CME funding for offsetting travel related to CME.

InterRAI

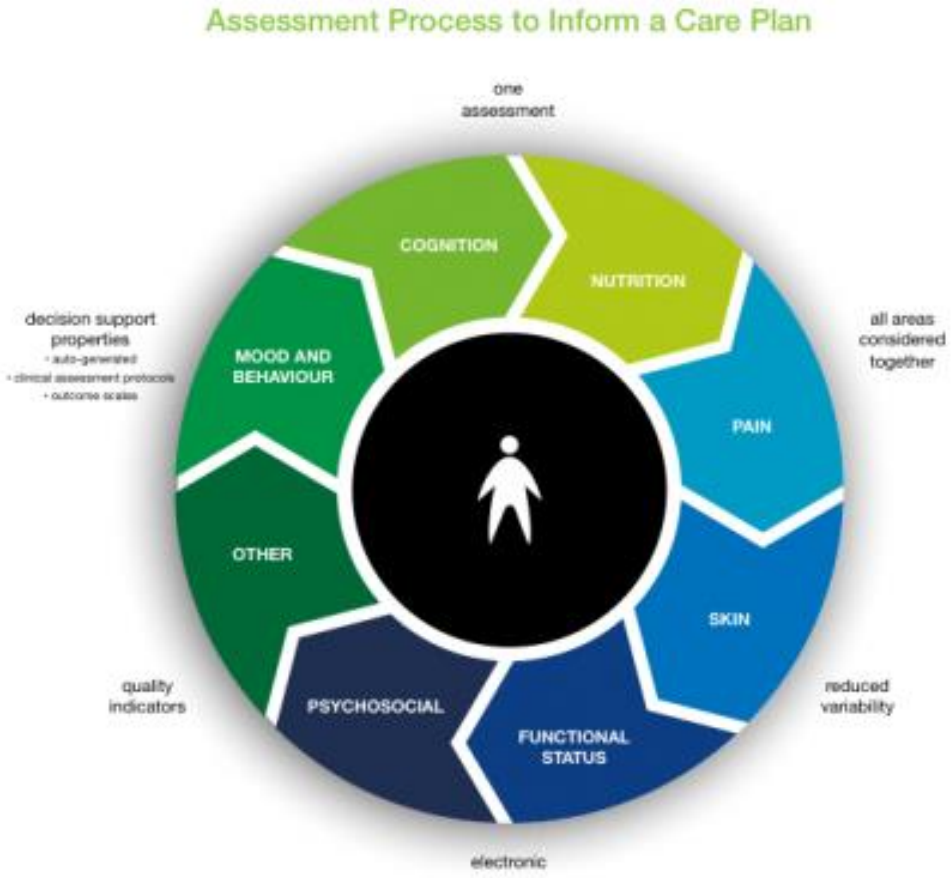
Mardi Postill, OPH Team Leader, Planning and Funding

Andrea Davidson, Portfolio Manager, Planning and Funding

What is InterRAI?

- A suite of assessment tools, developed by International Experts

- Supports clinical decision making and care planning, indicates opportunities for improvement and highlights potential areas of decline



- Standardised assessment and mandatory in New Zealand for those receiving HBSS >6 weeks or prior to entry to ARC

- Produces quality data which can be used by Healthcare Professionals and Policy Makers to develop better health services and target resources according to need across the wider community

How do we use InterRAI in Canterbury?

CA (Contact) Assessment

- Home & community Based Settings
- Initial screener that captures information to support the homecare intake process
- Non-complex casemix outcomes
- Completed by HBSS Providers with a Nursing qualification
- Up to 1hr to Complete

HC-MDS (Homecare) Assessment

- Home & community Based Settings
- Frail Elderly or persons with disabilities or chronic needs for care
- Complex casemix outcomes
- Completed by a NASC Clinical Assessor
- Up to 3hrs to Complete

LTCF (Long Term Care Facility) Assessment

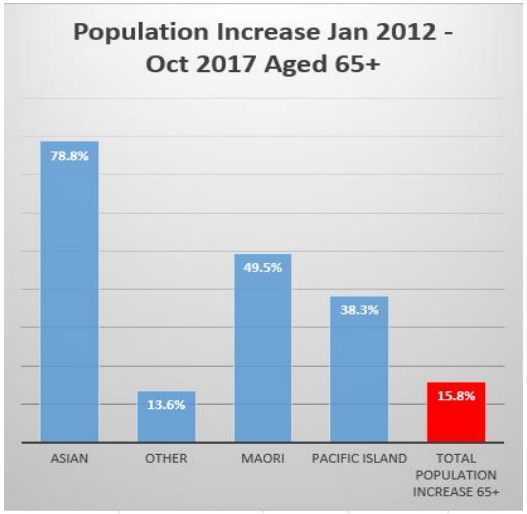
- Aged Residential Care Settings
- Frail Elderly or persons with disabilities or chronic needs for care
- Informs initial intake care plan and repeated at 230 days
- Completed by a Registered Nurse at the Facility
- Up to 3hrs to Complete

Potential Risk Areas

We have an Ageing Population

Wait time for an InterRAI Assessment in Q4 2018/19 was a median of 54.5 days

We have 1 DHB Community InterRAI Assessor per 900 of the 65+ Population

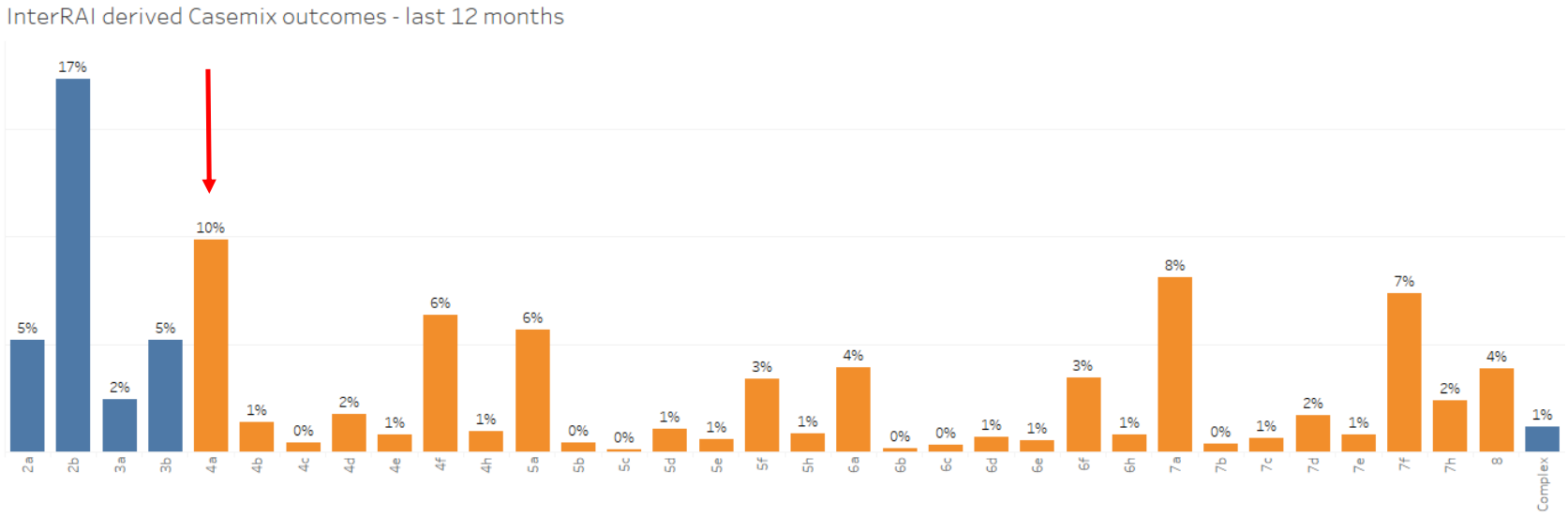


Month-Year	Total 1st HC Assessment	Average WT (days)	Median WT (days)	New InterRAI Assessment	New InterRAI Reassessment
Qtr-3 2018/19	358	59	48	605	204
01-2019	135	53	40.5	207	65
02-2019	110	58	48	201	59
03-2019	113	66	55	197	80
Qtr-4 2018/19	271	65	54.5	544	186
04-2019	95	68	58.5	171	67
05-2019	145	64	55	239	69
06-2019	31	64	40.5	134	50

Note: wait time for an InterRAI is not an indication of HBSS wait time – services are put in place upon referral

Investigating the data

- Data using the outputs from the InterRAI assessment (casemix) showed that we had a higher percentage of 4a clients as opposed to any other complex casemix group



- A deep dive of the 4a clients showed that a high percentage of these clients could have been assessed in the community by our NGO provider Registered Health Professionals using the InterRAI CA (non-complex tool)

How we have mitigated the risk

- It was identified that a Service Allocation Tool (SAT) used by our secondary care and community teams was overly identifying clients as complex and therefore increasing the number of referrals to the DHB Clinical Assessors
- A clinical workgroup was established to amend the SAT to reflect true complexity

YES	Support Allocation Tool (SAT)	NO
☐ Complex Client	Does the client have a cognitive impairment (decreased ability to think, concentrate, formulate ideas or remember, that impacts on everyday life)	☐ Continue Screening
☐ Complex Client	Does the client have a progressive neurological condition (conditions that get worse as time goes on e.g. Parkinson's Disease, Multiple Sclerosis, Motor Neurone Disease, Huntington's Disease	☐ Continue Screening
☐ Complex Client	Is the client's carer unable to continue caring for the client or feeling overwhelmed or distressed	☐ Continue Screening
☐ Complex Client	Does the client require ***ongoing / long term*** physical assistance with daily dressing of their ***lower body*** (does not include application or removal of compression hosiery)	☐ Continue Screening
☐ Complex Client	Does the client require ***ongoing / long term*** verbal or physical assistance in managing their own medications	☐ Continue Screening
☐ Complex Client	Does the client have anxiety, low mood or other mental health condition that significantly impacts on daily living	☐ Continue Screening

Outcome

- Clients triaged using the SAT will receive an assessment that is more appropriate to their complexity
- It is anticipated that the wait time for a HC assessment will now reduce as the numbers referred for an assessment will reduce – wait times will continue to be monitored
- All clients referred for an InterRAI assessment will continue to receive services whilst they are waiting for an assessment to be completed

WORKFORCE DIVERSITY, INCLUSION AND BELONGING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Community and Public Health & Disability Support Advisory Committee

SOURCE: **People and Capability**

DATE: **29 August 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report has been written at the request of Jacqui Lunday Johnstone, Executive Director of Allied Health to inform the Committee about People and Capability's current approach and activities as they relate to improving diversity, inclusion and belonging in our workforce.

2. RECOMMENDATION

That the Committee:

i. notes the Workforce Diversity, Inclusion and Belonging report.

3. SUMMARY

People and Capability is currently developing and implementing a programme of work focused on Diversity, Inclusion and Belonging in the Canterbury DHB and West Coast DHB workforces. We are taking an equity approach where we recognise that there are some groups which are more likely than others to be underrepresented and experience prejudice or discrimination.

Our current work programme is focused on creating a foundational policy and strategy as well as making specific headway for Māori, Pasifika and those who live with disabilities. This work builds off success from Project SEARCH which is catalysing change in how our organisation views issues related to equity and employment of people who live with disabilities.

4. DISCUSSION

People and Capability currently supports the Diversity, Inclusion and Belonging (*DIB*) work programme with the Programme Manager of Care Starts Here and a Project Specialist focused on Diversity, Inclusion and Belonging. Care Starts Here is a programme focused on our organisational culture as underpinned by three core behaviours: doing the right thing, being and staying well and valuing everyone. This programme has been active for five months since the appointment of Tyler Brummer as the Programme Manager.

Recent Progress

a. Appointed dedicated project specialist to lead DIB work.
b. Drafted a policy focused on workforce Diversity and Inclusion that is currently out for limited consultation and will go to EMT within the next month.
c. Hosted an employment forum to develop a set of strategic recommendations on how we can increase the number of people with disabilities we employ (see Appendix 1).
d. Held initial meetings with Ministry of Social Development to discuss partnering to employ more people with disabilities (as a result of the employment forum).
e. Began an audit of our recruitment and placement processes as they related to our equity groups (i.e. Māori, Pasifika and people that live with disabilities).

Future Direction

a. Develop a DIB Strategy that is co-designed with people who face inequity in the workplace.
b. Improve our capture of diversity data so we can measure current state and progress towards some of our KPIs (e.g. improved representation of Māori and people with disabilities in the workforce).
c. Continue to redesign our recruitment and placement processes where they are or may be biased.
d. Raise the awareness and knowledge of our hiring managers around unconscious bias, and why diversity is critical to us delivering better health services.
e. Develop a strategy to tell the stories of Canterbury DHB and West Coast DHB staff who are diverse (including Project SEARCH) to help shift mind sets and effectively market our DHBs as places that embrace all people.
f. Further advance partnerships and strategies to increase representation of underrepresented groups (with a specific initial focus on Maori, Pasifika and people who live with disabilities).

5. APPENDICES

Appendix 1: Strategic Recommendations from Disability Employment Forum to be Further Developed

Report prepared by: Tyler Brummer, Programme Manager, People and Capability

Report approved for release by: Michael Frampton, Chief People Officer

APPENDIX 1

Strategic Recommendations from Disability Employment Forum to be Further Developed

Recommendation	Key Benefits
Identify individuals with lived experience at the CDHB and capture & communicate their stories	-Change managers and staff perception / bias around disability -Attract more applicants that see CDHB as a potential employer -Improve inclusion and belonging for existing staff
Implement unconscious bias and disability awareness training (include myth busting around the fears of hiring managers)	-Hiring managers minds should be open to employing people with disabilities -Work environment becomes more inclusive of people with disabilities, increasing belonging
Incorporate a strengths based approach to employing people with disabilities and clearly articulate the case for employing people with disabilities	-Create positive culture around employing people with disabilities -Increase organisational understanding of why this matters, creating more champions
Review and improve our recruitment and placement processes to make them more inclusive (including upskilling of our recruitment team and anonymising CVs)	-Increase the number of applicants and success rate of applicants who live with disabilities
Partner with agencies and organisations that can provide applicants with disabilities and supports once employed (e.g. Workbridge & MSD)	-Increase the number of applicants and support our DHBs to better support successful applicants
Improve our job adverts and advertising methods to attract more applicants with disabilities	-Increase the number of applicants
Develop a multi-approach attraction strategy for people with disabilities	-Increase the number of applicants
Provide support for people during the onboarding process to prepare their workplace and teams for their arrival	-Improve the belonging and retention of people with disabilities. -Create champions within the organisation
Implement best practise for inclusive recruitment practise (e.g. diverse hiring panels,)	-Increase success rate of applicants with disabilities
Identify services in the DHB that are willing to be early supporters (e.g. Clinical Record)	-Quick wins help break down barriers and tell stories to the rest of the organisation
Develop an employee advisory group for employees with disabilities to provide feedback and advice to P&C	-Co-design initiatives to improve employee experience to increase belonging and retention
Creating a safe environment for disabled people to talk about their personal needs and the support they require to do their job effectively.	-Improve employee experience to improve inclusion, belonging and retention
Incorporate the concept of recruiting disabled people on the basis of potential, rather than just experience.	-Improve the likelihood of successful appointment of people who live with disabilities into roles

STEP UP PROGRAMME UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Community & Public Health and Disability Support Advisory Committee

SOURCE: **Planning and Funding**

DATE: **29 August 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide an update on the Step Up Programme, noting that the last update was provided in March 2019.

2. RECOMMENDATION

That the Committee:

i. notes the Step Up Programme update.

3. BACKGROUND

In February 2017, the Step Up service was established in the Canterbury region. Step Up is a joint initiative between the Ministry of Social Development (*MSD*), the Canterbury DHB, Pegasus Health (Charitable) Limited (*Pegasus Health*), and the Volunteer Army (previously *MyCare)*, to provide integrated health and employment support to clients with a health condition, injury or disability.

Step Up applies a general practice-based response co-ordinating support to clients who receive a main benefit and who have a health condition impacting on their capacity to seek employment. The service aims to achieve improved health, employment, training and education outcomes for participants.

The prototype period was longer than anticipated and ended on 31 October 2018. During the period of the prototype the initial target of 40 clients had increased to 100 and the number of participating General Practices was expanded from four Practices to 11 Practices.

From 1 November 2018, Step Up moved into a one year Trial with increased capacity with an expectation it would expand across urban Christchurch practices, broadened eligibility criteria and increasing flexibility to respond to individual need.

4. DISCUSSION

Structure

Pegasus Health, via a contract with the Canterbury DHB, employs six Health Navigators & a Team Lead who support the engagement of the client and General Practice, and facilitates access to health, social support and employment. The programme is made up of two stages, including a three month intensive phase. Clients continue to receive support for up to 12 months, which may include on the job support once employment is found.

General Practice identifies potential work ready clients for Step Up at the time of signing their medical certificates. If the client agrees, the General Practice refers to Step Up for Health Navigation support. Engagement in the service entitles the client to free consultations with General Practice to enable the underlying health condition to be comprehensively addressed. The

complexity of combined health and social issues requires support to ensure a positive outcome. Navigators work holistically to support the clients to work through these challenges. Navigators maintain a close connection with Work and Income, the case manager and jointly attend meetings.

During the Prototype it was identified that engagement with young people in Step Up was low after referral. The Volunteer Army deliver the Live Life Programme - a programme designed for 18-35 year olds and works with clients to build confidence, overcome barriers and foster a supportive community, by providing community work opportunities to improve their employability skills. A unique feature of the programme is inter-generational mentoring, where clients build strong positive relationships with their mentors which go beyond the period of the programme.

The Step Up Trial has had a challenging start with events in Christchurch resulting in General Practice needing to focus on priorities relating to the events of 15 March 2019 and the measles outbreak. Consequently, referral numbers were low during this period and may mean the target of 180 client enrolments required by MSD by the end of this agreement at 31 October 2019 will not be achieved. Pegasus responded by rolling the service out to all urban practices instead of the planned staged approach, this resulted in increased referrals. In the week of 5 August, Pegasus reported that they had enrolled a total of 100 clients in the pilot. With 52 referrals in June and 42 referrals in July, and a 60 % enrolment rate the target of 180 clients by 31 October 2019 looks possible. It is worth noting that once the clients are enrolled in the service, there is a 12 month period to achieve the outcomes specified above.

Step Up is seen as a highly valued service by General Practices. Participating clients report increased levels of wellbeing as evidenced by increasing WHOQAL scores, a measure of quality of life. This far exceeds the "off benefit" outcomes. WHOQAL assessments have been an addition to the Trial to capture the health outcomes not previously captured in the prototype and are assessed several times throughout the programme. Family members are also reporting benefits from the increased motivation and skills of the family member, and report decreased stress in the home environment.

During the duration of Step Up inclusive of the prototype and Trial period, 199 people have been referred, 129 have enrolled and 66 people have been supported into work or study. The programme is measured on work related outcomes including entering work, study or increased workability as indicated on the medical certificate.

Trial Referrals

Target of 180 enrolments

Month	Referrals	Enrolled in Step Up
November	12	4
December	8	6
January	12	5
February	22	11
March	24	14
April	8	9
May	38	10
June	50	20
July	53	20

Outcomes

The clients have 12 months from enrolment into the programme to achieve the employment related outcomes and we expect the number achieving positive outcomes to increase from those shown below.

Of the 82 enrolments in the Trial:

- Two were supported into fulltime work (30+ hours).
- Two were supported into part time work.
- Four were supported into voluntary work.
- One was supported into full time study.
- All participants have been supported to connect with and access various support, including health and social services.

Evaluation approach

MSD have commissioned an independent evaluation of the Step Up Trial which is currently underway. The process undertaken by Malatest includes interviews with Canterbury DHB, Pegasus Health, Live Life staff, clients and General Practice. The evaluation will help all the key stakeholders understand how the Trial is working in practice and how it is contributing to client outcomes.

5. CONCLUSION

Although the Trial got off to a slow start, referrals in June and July have seen a significant increase. The Canterbury DHB has had assurances from MSD that the programme will continue to be funded for a further two years in Canterbury. The contracting process for this is underway.

The Trial included expanded reporting which will be monitored and evaluated against agreed targets. We look forward to the evaluation of the service, due in draft at the end of the month. We will continue to seek feedback and share the impact of the programme as illustrated by the client's stories (examples provided in Appendix 1).

6. APPENDICES

Appendix 1: Client Stories / Case Studies

Report prepared by:	Kathy O'Neill, Team Leader, Planning and Funding Rachel Thomas, Service Development Manager, Planning & Funding
Report approved for release by:	Carolyn Gullery, Executive Director, Planning Funding & Decision Support

Appendix One

CLIENT STORIES

(NB: Permission has been given by the individuals, but some details have been changed to ensure anonymity)

Case Study 1

Mike is a 26 year old young man who told us last week that "the LLP course is exactly what I need right now." Mike has, however, been experiencing very low moods, but finds having the requirement of turning up to the LLP three times per week has really helped.

Mike has been able to meet with his Step Up Health Navigator in the Live Life office. This has removed the hassle for the client of meeting in another location, and enabled the Live Life Coordinator to contribute to each meeting.

Mike is very enthusiastic about the voluntary opportunity we have at a local High School. The project is potting native seedlings that are bound for the Red Zone. The seeds have been collected from the Wet Land at Travis Road and they have been chosen to particularly attract bird life back into the city. Mike really enjoyed hearing the story behind the project and can't wait to return. He is keen to meet up with his mentor next week.

Case Study 2

Di is a 26 year old who is motivated, gregarious and determined to work. She has been working as a kitchen hand since she was 13.

She has worked in various restaurants around Christchurch until a contact eczema health issue on her hands and fingers put a premature end to this. At the time of referral, she also presented with anxiety and depression, and is currently taking citalopram on a treatment plan to deal with this. She is also dyslexic.

ACC declined workplace compensation and neither public nor private specialist dermatology appointments were an option. A request to the Regional Health Advisor (MSD) to fund private specialist treatment was also declined. Private treatments including a patch test would stretch to over $2000. Her GP put in place an intervention plan - latex gloves, creams, etc. but nothing worked.

Despite numerous attempts to find work, without understanding the cause of the allergy the possibility of sustainable work was limited. A collaborative funding model was developed with MSD and Pegasus Health - both contributed to the cost of specialist consults.

An initial consult provided new treatment, including cream which has had such an amazing result that Di is considering a return to the food sector in a limited capacity. She has also undertaken further investigations, with results pending.

Di is currently working as a volunteer in a community organisation, tutoring elderly people with computers. She has applied at UC to undertake a writer's course, and has completed the Live Life programme.

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- Allison Nichols-Dunsmuir – Health in All Policies Advisor
- A public health approach to disability
- Community & Public Health update highlights – out and around

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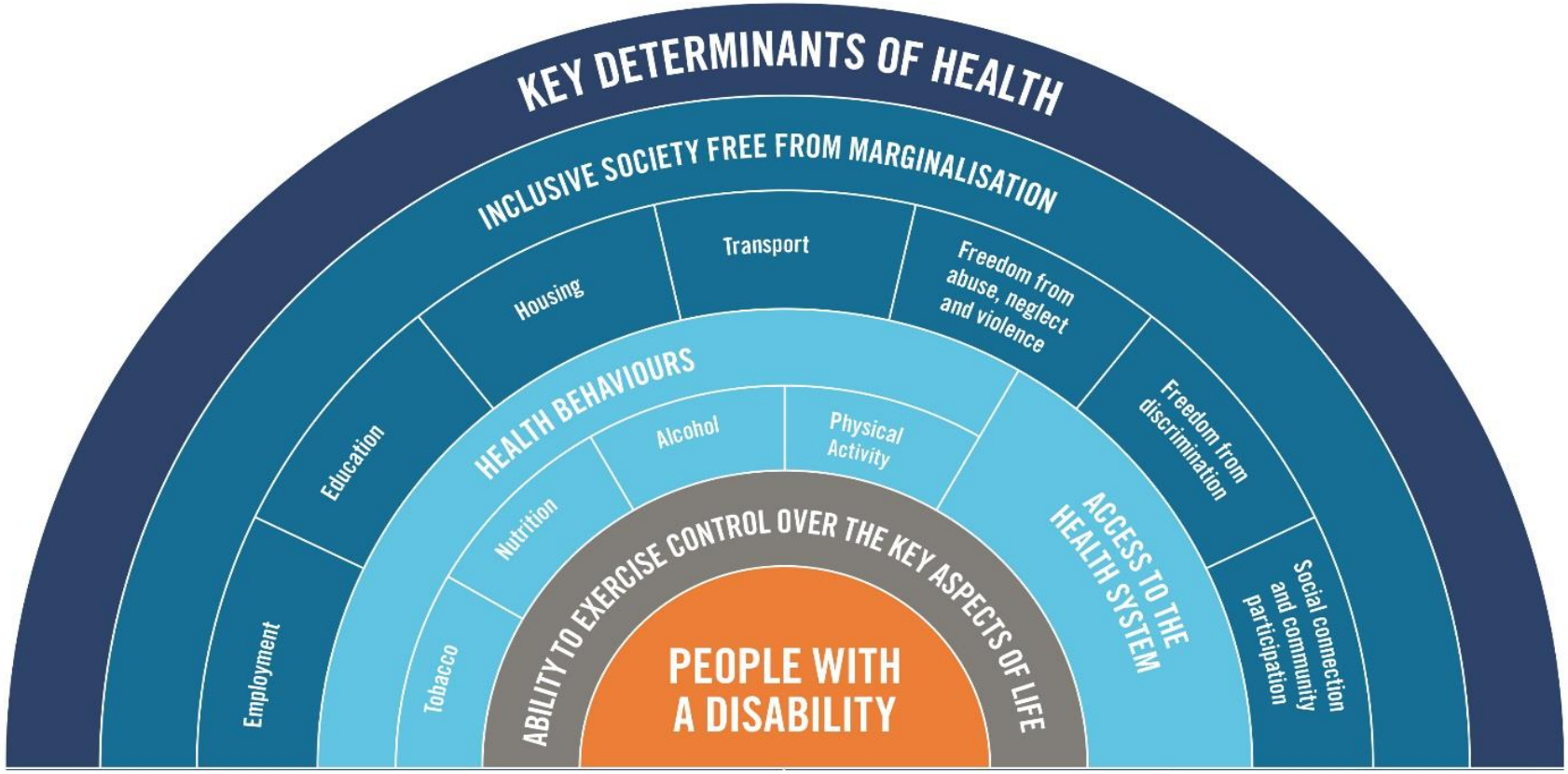

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CDHB will incorporate the perspectives and needs of people with disabilities in our work to:

- Promote the health and wellbeing of the population
- Address inequalities

This give us the mandate to:

- Advocate for inclusion and better built environments
- Improve our own buildings, sites and services

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Approaches

- Health in All Policies – Social Determinants of Health
- Social model of disability
- New Zealand Disability Strategy
- UN Convention on the Rights of Persons with Disabilities
- Mainstream services and supports are inclusive of, and accessible to, disabled people
- Services and supports that are specific to disabled people are also available

Barriers to access are barriers to wellbeing

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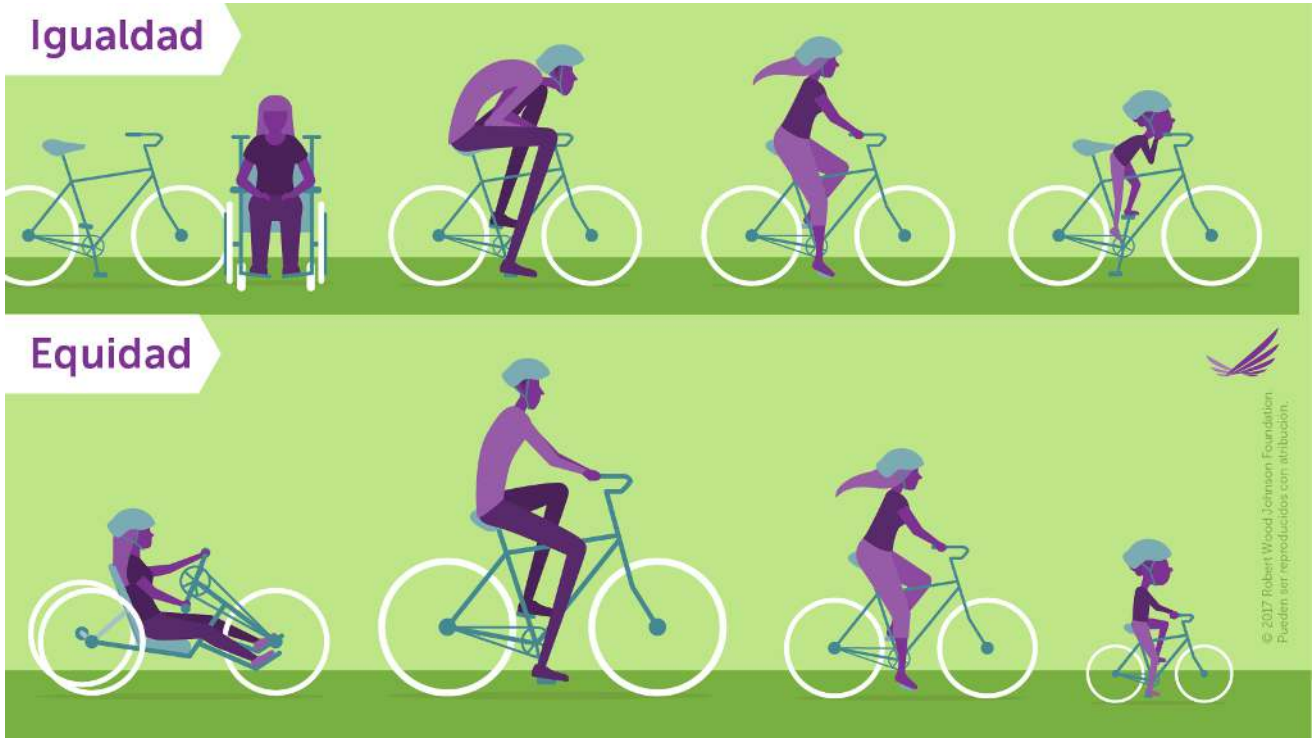

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Of interest nationally

New Disability Strategy Action Plan – to Cabinet Sept

Information Accessibility Charter

Access Alliance for Accessibility Legislation

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Update of Activity since September 2018

- CPH 'out and around'
- Partnerships, advice, projects, submissions

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Partnerships and Projects

- Advise CCC Disability Advisory Group
- Earthquake Disability Leadership Trust
- Hagley Park Reference Group
- Attend the CCC Disability Issues Working Group (!) – Taiora/QEII, St Albans Community Centre, Changing Places
- Town Hall – Focus on lessons learned

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Transport

- Joint Work Plan with ECAN
- Known issues for travel to Chch hospital campus
- Option for some to travel by bus
- Brochure to encourage/explain from a whole population perspective
- Article in HiAP newsletter https://mailchi.mp/cdhb/health-in-all-policies-newsletter-1351509?e=312104f029
- Ongoing work around Superstop and wayfinding in the vicinity

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Partnerships and Projects

- Invited by Council Heritage staff and Matapopore to advise on making the cultural trail accessible
- Organised for Arts Centre to be assisted with mobility signage
- Advised ODI on Action Plan, and MSD on accessibility legislation
- DPMC on accessibility for Earthquake Symposium

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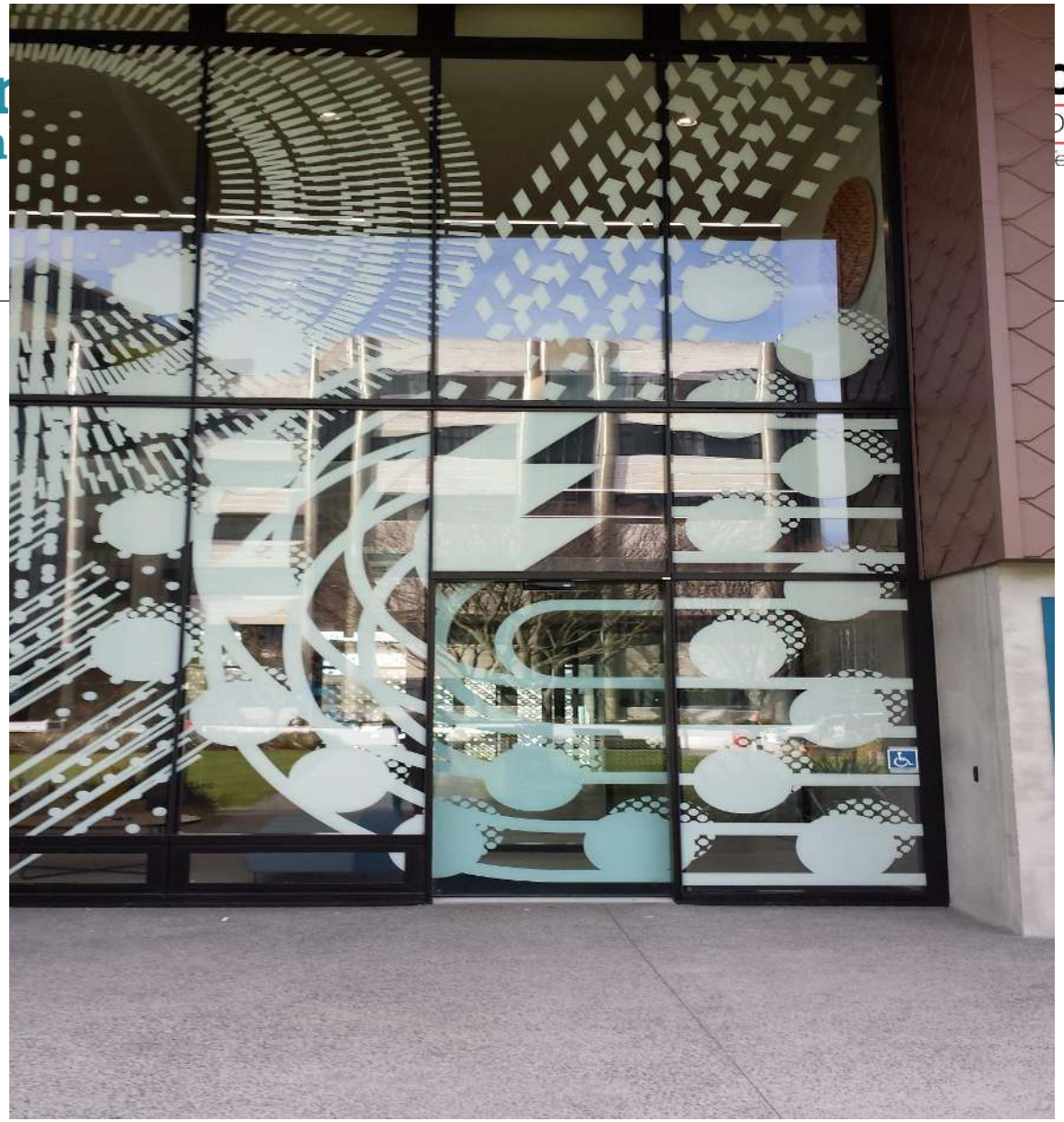

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Canterbury District Health Board Public Health Report January-June 2019

Community and Public Health

Christchurch Office
353617/04 Public Health Service

1. INTRODUCTION

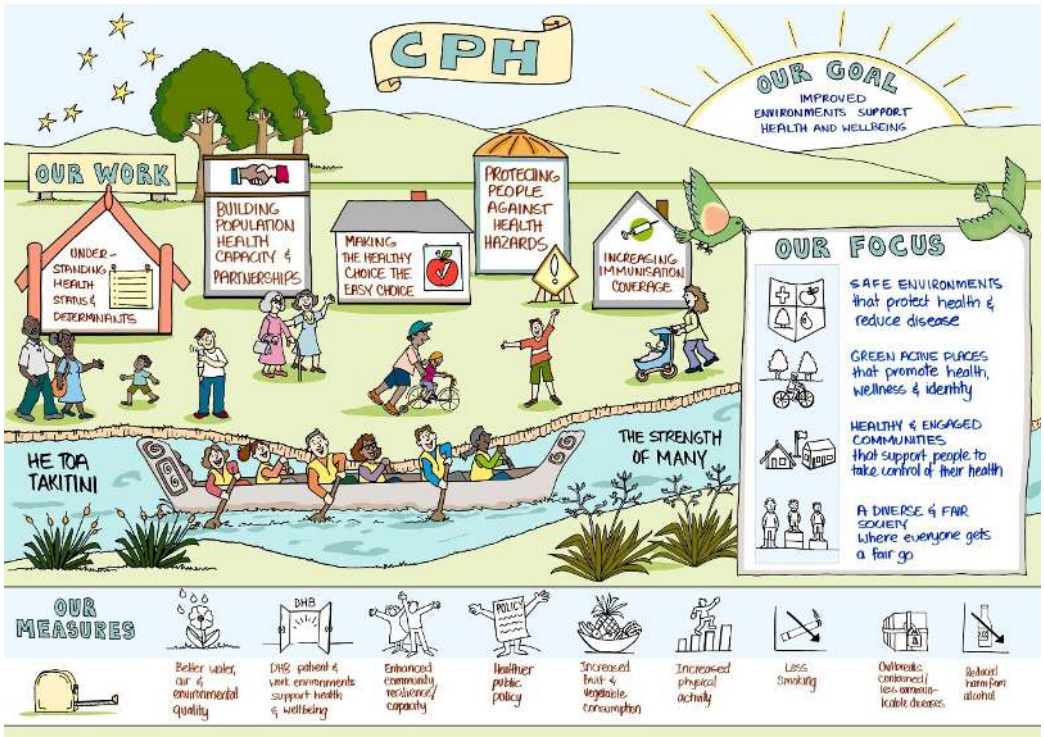
Public health is the part of our health system that works to keep our people well. Our goal is to improve, promote and protect the health and wellbeing of populations and to reduce inequities. Our key strategies are based on the five core public health functions[1]:

1. Information: sharing evidence about our people's health & wellbeing (and how to improve it)
2. Capacity-building: helping agencies to work together for health
3. Health promotion: working with communities to make healthy choices easier
4. Health protection: organising to protect people's health, including via use of legislation
5. Supporting preventive care: supporting our health system to provide preventive care to everyone who needs it (e.g. immunisation, stop smoking).

The principles of public health work are: focusing on the health of **communities** rather than individuals; influencing **health determinants**; prioritising improvements in **Māori health**; reducing **health disparities**; basing practice on the best available **evidence**; building effective **partnerships** across the health sector and other sectors; and remaining **responsive** to new and emerging health threats.

Public health takes a life course perspective, noting that action to meet our goal must begin before birth and continue over the life span.

This report describes progress against the outcomes and priorities in our 2018-19 annual plan.



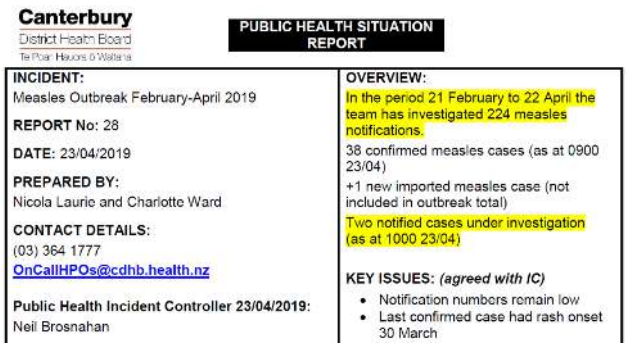
[1] Williams D, Garbut B, Peters J. Core Public Health Functions for New Zealand. NZMJ 128 (1418) 2015. https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vo-128-no-1418-24-july-2015/6592

2. SURVEILLANCE / MONITORING

"Tracking and sharing data to inform public health action"

Our key surveillance/monitoring priorities for 2018-19 are:

- To monitor and report communicable disease trends and outbreaks.
- Development and publication of the Canterbury Wellbeing Survey report 2018 and Canterbury Wellbeing Index 2018
- Development of the inaugural South Island Population Health Report, in collaboration with other South Island public health units



Canterbury District Health Board
Te Poari Hauora o Waitaha

PUBLIC HEALTH SITUATION REPORT

INCIDENT:
Measles Outbreak February-April 2019

REPORT No: 28

DATE: 23/04/2019

PREPARED BY:
Nicola Laurie and Charlotte Ward

CONTACT DETAILS:
(03) 364 1777
OnCallHPOs@cdhb.health.nz

Public Health Incident Controller 23/04/2019:
Neil Brosnahan

OVERVIEW:
In the period 21 February to 22 April the team has investigated 224 measles notifications.
38 confirmed measles cases (as at 0900 23/04)
+1 new imported measles case (not included in outbreak total)
Two notified cases under investigation (as at 1000 23/04)

KEY ISSUES: *(agreed with IC)*
- Notification numbers remain low
- Last confirmed case had rash onset 30 March

- A review of our monitoring / surveillance processes and products (excluding the Canterbury Wellbeing Index and Survey, which were reviewed in 2017).

The Surveillance Team continues to produce **weekly and monthly reports of notifiable diseases in the South Island.** From time to time this includes special requests for data: in this period this has included graphing of influenza-like illness and meningococcal disease.

Sentinel practices for this year's influenza surveillance were recruited in South Canterbury, Canterbury and the West Coast, and Community and Public Health's weekly Canterbury and South Island DHBs reporting commenced on 6 June. Numbers of patients presenting with influenza-like illness in general practice, and at Christchurch Hospital's Emergency Department, are higher than usual for this time of year as is the number of laboratory confirmed influenza results.

The final edition of the printed Public Health Information Quarterly was distributed in January, and in response to survey feedback **we are moving to electronic communications**, with an **updated Health Professionals website and electronic alerts and updates to health professionals**, both due to be launched in August.

The Surveillance Team supported the **Canterbury measles outbreak** by providing **regular situation reports to the wider health sector**, incorporating updates regarding MMR vaccination uptake. In addition, the team assembled **Incident Action Plans** that clearly articulated, across multiple domains, the agreed next steps for Community and Public Health staff, and is supporting development of the outbreak report.

The ***First 1000 Days*** **report, released in October 2018, is being used by the Hauora Alliance and the South Island Child Health SLA** to inform the South Island Alliance's "First 1000 Days" priority.

The **Canterbury Wellbeing Index** was launched in November 2018. Subsequently, the Index team has been working through a **rolling schedule of content updates as new data become available**. The Canterbury Wellbeing Survey is a major data source for the Index. The survey questionnaire has been reviewed by the interagency working group and the 2019 survey is currently in the field. There will be a substantial update of the Index once the survey data become available in late July.
The Index has had 6,464 page views between 1 January and 31 May, representing 1,303 individual users.

The Index **continues to be positively received**, with presentations made in the last six months to a Selwyn District wellbeing forum, University of Canterbury staff development day, Healthy Greater Christchurch hui, Pegasus Health Population Health and Community Engagement Team, and the Ngāi Tahu Data Stakeholders Group. The Index was also **presented as a case study of Treaty partnership at a partnerships day** at the University of Otago, Wellington Public Health Summer School, via a ten-minute video made together with representatives from Te Rūnanga o Ngāi Tahu and Te Pūtahitanga o Te Waipounamu. Index team members have recently been **invited to provide feedback on the pilot website for the Statistics New Zealand Indicators Aotearoa New Zealand (IANZ) project**. The Index is available at www.canterburywellbeing.org.nz

3. EVIDENCE / RESEARCH / EVALUATION

"Providing evidence and evaluation for public health action"

Our key evidence/research/evaluation priorities for 2018-19 are:

- To conduct and support evaluation of public health-focused initiatives.
- To provide evidence reviews and synthesis (both on a request basis and self-initiated) to support the work of other programmes and other public health focused work.
- To collect / access, analyse and present data to inform public health action.


Hanmer Springs town centre first in NZ to become smoke and vapefree

Emma Dangerfield - 05:00, Feb 13 2019

The Hanmer Springs town centre is the first in the country to go completely smokefree and vapefree with a six-month trial starting this Valentines Day.

Our 2015 literature reviews on **Configuration of Public Health Services** and **Investing in Public Health** have been updated to provide the most up-to-date evidence to inform the Health and Disability System Review panel as it considers "the role of public health and prevention in supporting health and wellness". While there is little in the literature to suggest one "ideal" configuration for a public health system, there is some evidence and much reflection on aspects that can enhance or inhibit public health's effectiveness. Public Health Service Configurations: A brief literature review (2019 update); Investing in Public Health: An update (2019)

The **evaluation** of the Community Engagement with Alcohol Licensing Project identified a number of **success factors for the project** including: increased community participation in objecting to higher risk alcohol licensing applications; increased community knowledge of alcohol licensing applications; increased community knowledge of how to successfully object to alcohol licensing applications; and success at hearings including both the withdrawal of an application by an applicant prior to the DLC hearing, and applications being declined. The evaluation proposed a number of **recommendations which are under consideration**.

The **evaluation** of the WAVE (Wellbeing and Vitality in Education) programme 2018, demonstrated that WAVE continues to be valued by education settings for its central role in collaborative partnerships between health and education in South Canterbury. Success factors for WAVE included that **facilitators were viewed as a credible, trusted and responsive source of information and advice**; that WAVE provided support to education settings for planning around health; and that WAVE provided access to resources. Education settings' overall level of **satisfaction with WAVE was high, and the programme was perceived as having an impact on both health and education outcomes.**

A **Sustainability Position Statement and background paper prepared for the South Island Public Health Partnership have been well-received**. The Position Statement **will progress through a SIAPO-led process towards acceptance** by all South Island DHBs.

Surveys developed and hosted to inform the next steps of other programme areas/regional offices included: **Canteen Providers** (for canteen staff and others associated with canteens in Christchurch Health Promoting Schools), **pre- and post-surveys** exploring the experiences of staff and parents participating in South Canterbury's ECE-based **Kai Kōrero Programme**, South Canterbury's **professional development sessions on Vaping & Smokefree policies** and **an evaluation of the Little Lungs workshop**, survey support for the **Mackenzie Fresh Air Project,** and a **School Travel survey.** In addition, a **survey of Service Level Alliances/workstream members** was hosted and asked respondents to describe actions within their plans focused on reducing alcohol-related harm.

In addition, surveys have been developed as part of the CPH-led **evaluation of the Hanmer Springs Vapefree and Smokefree Zone** which is currently being undertaken in collaboration with the Cancer Society – these include face-to-face interviews, online surveys, and feedback cards placed in accommodation venues.

4. HEALTHY PUBLIC POLICY

"Supporting development of health-promoting policies and approaches in other agencies"

Our key healthy public policy priorities for 2018-19 are:

- To build capacity in the CDHB and beyond in terms of understanding of the role of the social determinants of health and disease and developing Health in All Policies (HiAP) skills.
- To continue to build and manage relationships, recognising that professional relationship are essential for a successful HiAP approach.

  To undertake collaborative project work with partner organisations to positively impact the social determinants of health.

The Policy team **supports individuals and organisations within and beyond our region with best practice Health in All Policies (HiAP) approaches**. This is carried out in many ways including the delivery of the Broadly Speaking Programme, which continues to have high numbers of attendees from diverse settings; sharing our experiences at conferences in New Zealand and, by invitation, overseas; receiving regular requests from other PHUs and recently from an Australian health agency wanting to learn how we implement HiAP in Canterbury.

The resources, presentations and skills we share are **highly valued and we receive positive feedback**. Distribution of the Canterbury **HiAP newsletter continues to grow, with an immediate distribution list of 649 subscribers**. The content is wide and varied contributing to its appeal. "*Thanks for the newsletter-once again; a great reference, barometer and indicator for moving forwards with our mahi*" - Taranaki PHU https://www.cph.co.nz/your-health/health-in-all-policies-newsletter/

Developing and maintaining relationships is a key component of our work and reaps many benefits as opportunities arise to engage with our partners. Waka Toa Ora (formally Healthy Christchurch) provides an opportunity for partners to meet regularly and identify projects in common.

A video of key people involved in Healthy Christchurch's history has been produced: https://vimeo.com/327837629.

Waka Toa Ora Annual Hui. 12 March 2019

A recent focus is **supporting Climate Strategy development**. This occurs in a number of ways, including through submission writing. **Submissions are often the result of strong engagement with partners prior** to the submission's development. Input is therefore often supportive of the direction taken, or provides evidence to support changes already discussed. All submissions provide opportunities to raise disability issues and highlight that any identified barriers to access, are barriers to wellbeing.

CPH staff are working on over 30 joint initiatives with the Christchurch City Council (CCC) and 24 with Environment Canterbury (ECan). A recent example of the value of relationships formed with these two partners was the development of a brochure and information campaign to encourage bus use to Christchurch Hospital and Outpatients. CCC, ECan and CPH developed a map emphasising the ways bus travel can work well for everyone, including people with mobility challenges.

CPH input to the Greater Christchurch Partnership hearings on the Our Space draft planning **framework was well received**. In contrast with other submissions **almost all CPH's suggestions presented using a HiAP framework were accepted in the final hearings report**.

Our strong and ongoing relationship with ECan resulted in ECan's input into an Inquiry by Design process using our Toolkit Guide to assist in a public transport review for the Waimakariri District. Whilst initially hesitant, **ECan staff were enthusiastic about the value the workshop added to the review** and are **looking forward to utilising the approach as other opportunities arise**.

5. HEALTH PROMOTING HEALTH SYSTEM

"Supporting development of health-promoting policies and approaches across our health system"

Our key health-promoting health system priorities for 2018-19 are:

- To define Health Promoting Health Systems, from literature review and examples of case studies.
- To undertake a stocktake of activities, in Canterbury DHB and primary care, that support the working definition.
- To develop a story or narrative, that promotes Health Promoting Health Systems as a way of engendering wellbeing as a focus across the system.
- To link actively with the Sustainability programme where appropriate, seeking synergies between the two programmes.

The Health Promoting Health System continues to be a focus that involves not only community and Public Health but also the broader Health system. While from a Public Health division perspective we continue to focus on the areas we are best able to contribute on e.g. Health in All Policies (HiAP), Sustainability opportunities (e.g. CEMARS) and the development of position statements, we also recognise the role of other areas in influencing this component. This has resulted in our close connection with the Canterbury Clinical Network Population Health Alliance. Through the alliance we have promoted our Alcohol Harm reduction strategy, our Smokefree approach and the broader concept of sustainability.

There is a continuing focus on the involvement of CDHB within the Greater Christchurch Partnership (GCP) and the recent adoption by the GCP of the Integrated Planning Guide (authored by C&PH PHS Anna Stevenson and the Policy Team) is a very positive achievement in this area. The Integrated Planning Guide is based on a HiAP approach and it is very positive to see the increasing adoption of this approach in TA's planning processes.

We continue to provide Public Health input into a variety of CCN, and SI Alliances workgroups (45 such groups at this time).

6. SUPPORTING COMMUNITY ACTION

"Supporting communities to improve their health"

Our key supporting community action priorities for 2018-19 are:

- To support communities to access health information resources.
- To partner with Marae, churches and priority Māori and Pacific settings to deliver culturally appropriate health promotion initiatives.
- To support under-served communities to identify and address their health priorities e.g. workplaces, active transport, food security, sexual health.
- To deliver Smokefree Enforcement requirements.
- To develop partnership initiatives to enable social housing residents and priority renters to address their health needs, including housing affordability.
- To support Healthy (Greater) Christchurch signatory groups to develop and deliver health promotion partnership initiatives.

Communities accessed +135,000 pieces of information, mental health leading demand (70,597), 38,433 for nutrition, 23,531 for drugs, alcohol and safety. Health Information stands stocked and refilled at sites across 14 priority areas.

CPH is pleased to note the **handover to Rapaki Marae of all the initiatives developed.** These included **healthy kai and wai, smokefree policies** and connection with strong relations and support from health providers. Now **working to replicate the 'Health Hubs' concept** with other Papatipu Rūnanga and underserved communities. Tane Māori in Christchurch prisons **self-reported consistent percentage change in Wairuatanga, Whanaugatanga, Manaakitanga and Rangatiratanga** following CPH's **collaborative project** with Te Ihu Waka, and Jade Associates.

Ongoing discussion result in the partnership with Tangata Atumotu Trust to **deliver health promotion project Tutupu project** in **Pacifika Churches**.

The **Learn2Ride pilot for immigrants and migrant women was well attended**. There are **plans to restart in spring and to link with the BuyCycles programme**, which has distributed 68 bikes to high needs mental health clients this year.

Nutrition health promoter working with Food Resilience Network influencing clear direction, clear implemented strategy and encouraging collaboration with the community. **Supporting CCC** to implement **Healthy Food and Beverage policy** across council venues and events.

CPH is contributing to the Canterbury Syphilis working group and **leading Health Promotion and Prevention of Syphilis**. A plan is underway to **increase low uptake of HPV vaccination with Māori and Pacific rangatahi**. CPH is working with the **Healthy Families** team to work collaboratively on **wai, kai and wellbeing initiatives**. **Nine new workplaces** are working towards **Work Well accreditation.**

Evaluation is in progress for the **Hanmer Springs Smokefree and Vapefree Precinct Pilot** in conjunction with the Cancer Society and CPH's Information Team. Partnered with Cancer Society and UC Masters student to scope Economic Modelling Project for Diaries to go tobacco free. This scoping will inform development of smokefree dairies projects. Completed 100 Compliance checks, 3 Controlled Purchase Operations with 3 sales. Follow up on 6 complaints and 5 enquiries into the Smokefree Enforcement Act.

Connecting organisations for ongoing housing issues **to access services for priority renters and social housing residents**. **Led inaugural Intentional Housing Networking meeting,** participants indicated the need to organise ongoing meetings.

Te Waka Toa Ora's (formerly Healthy Christchurch) Annual hui, **'Being Unbreakable'** followed the 15 March mosque attacks. **Actions,** including a **follow-up seminar,** and **The Peace Train Ride**, were identified by attendees. Of the several hundred participants 14 inter-faith centres participated. Muslim community members have advocated for the **'Peace Train' Ride** be taken up nationally.

7. EDUCATION SETTINGS

"Supporting our children and young people to learn well and be well"

Our key supporting education setting priorities for 2018-19 are:

- To continue delivery of the Health Promoting Schools initiative in low decile schools, kura kaupapa Māori, and priority Kāhui Ako.
- To support student-led school health and wellbeing leadership forums.
- Prioritisation and delivery of health promotion initiatives in early childhood settings.
- To develop, promote and evaluate wellbeing promotion resources for education settings, e.g. Sparklers.
- To continue development of the South Island Tertiary Forum and related activities.

Health Promoting Schools engagement, inquiry, planning, action and evaluation facilitated in **75 schools** (including four kura) and nine Kāhui Ako across the Canterbury and West Coast DHB regions. Highlights have included: supporting development and successful **trial of a student wellbeing journal** - RAD (reflective answers daily) at Chisnallwood Intermediate as **a curriculum resource for the Ōtākaro Kāhui Ako**; Te Kura Whakapūmau now runs **mau rākau and traditional Maori games** as part of its physical activity curriculum (our Māori health promoter has **successfully supported the kura** to the point where they now lead this themselves); Van Asch Deaf Education Centre and Spreydon School **linked to** Kid Power Teen Power Full Power Trust to run Mates & Dates and Kidpower workshops, **enabling both schools to address relationship and sexuality education** as identified wellbeing priorities; student voice in wellbeing was supported with Hornby School's **student wellbeing team holding a mini-health forum for their school** and Yaldhurst School's **student council presenting their wellbeing inquiry to parents**; supporting Department of Conservation initiated Collaborative Community Education Model project to restore health of the Ōpāwaho/Heathcote River catchment; **strengthening learning environments for promoting healthy sustainable kai, by partnering with the Food Resiliency Network** to organise regular, well attended regional Edible Canterbury School Gardening hui.

Partnering with Community Dental Service, with guidance from Early Childhood Education setting leaders, developed 'Menemene Mai' (Smile), the first online oral health toolkit for **Early Childhood** kaiako in Waitaha (includes a 'Teeth Tools' kit which can be borrowed).

Sparklers – continuing to support the *All Right?* team to develop new Sparklers activities focused on the cultural wellbeing of Māori and Pacific tamariki, building friendship skills and respecting diversity. **Sparklers was singled out in Prime Minister Jacinda Arden's Wellbeing Budget Day speech as an initiative that helps educators improve children's emotional and mental health**. The Prime Minister went on to say, 'We know these resources make a difference to children's mental health, **and that's why from now on they will be available to every school across New Zealand** as a result of this Budget'. We are currently exploring opportunities associated with this announcement. https://sparklers.org.nz/

Provided **appropriate wellbeing messages to schools** in response to the Mosque Attacks. The HPS team is active in a CDHB-led mental health services workgroup providing advice and support to assist community recovery; participated in **orientation programme for Mana Ake** workers and facilitated **the engagement of Mana Ake workers** with Canterbury schools and **Kāhui Ako.** Supported mental health suicide post-vention responses with local mid-Canterbury schools.

Responding to consultation on Ministry of Health 'Healthy food and drink policy' guidelines for schools drawing on experience of implementing such policies in schools and resources we developed previously e.g. Healthy Events and Fundraisers Guidelines and Canterbury Water Only Policy Guide.

CPH's Tertiary Settings Health Promoter is co-chairing the Tertiary Wellbeing Aotearoa NZ network; **refining an online toolkit to address sexual violence on campus**; presentations made in Rotorua and Vancouver; and is **currently developing wellbeing strategies** with Ara Institute and the University of Canterbury.

8. COMMUNICABLE DISEASE CONTROL

"Preventing and reducing spread of communicable diseases"

Our key communicable disease control priorities for 2018-19 are:

- Notifiable disease follow-up (with protocol review for high-volume).
- Outbreak detection and control.
- Promotion of immunisation.
- To develop a communication plan on infection prevention / control and immunisation in various community settings.
- To span national, regional and local approaches and issues.

Measles Outbreak Operations Room

The Canterbury **measles outbreak was declared over on 16 May**. A multidisciplinary incident management team, of Community and Public Health staff was responsible for **implementing and supporting effective public health action to limit and stop the spread of measles** in the community. In the period 21 February to 16 May staff investigated 236 measles notifications. Of these notifications, 38 (+1 case not related to the outbreak) were confirmed as measles cases. Case management included following up 1021 contacts and recommending suitable public health interventions (including vaccination & isolation). As part of the outbreak strategy approximately 27,000 MMR vaccinations were administered in general practice in an effort to prevent community spread. Limiting the outbreak to 38 cases is seen as a major achievement and illustrates the effectiveness of sound incident management, investigation (of cases and contacts), and judicious application of isolation requirements. It **also highlights the benefits of an all of health system approach which encouraged and achieved significant community cooperation and increased MMR vaccination rates**.

C&PH staff developed a poster, website and Facebook campaign aimed at **raising awareness of the potential spread of serious enteric illnesses within Swimming Pools**. The poster is displayed at pools across Canterbury.

Worksafe and CCC with CPH have agreed on **strategic progress toward a cooling tower registration and surveillance/investigation**. CPH, CCC and Worksafe are producing a list of cooling towers (with interactive map and ability to add comment) which will be finalised by August 2019. The working group will sample (when issues are found), with WorkSafe taking the lead for any non-compliance follow-up.

Articles placed in the Health Promoting Schools magazine this year have **focused on school groups travelling internationally and the need for health planning to be undertaken** (protection from vector borne diseases, poor sanitation, unsafe food and water) as well as addressing vaccination (including seasonal influenza).

Hand sanitiser stations and health promotion have been **provided/promoted at a number of Agricultural and Pastoral (A&P) shows** during summer and autumn **to reduce the incidence of zoonotic transmission**.

The first quota refugees (since 2010) have come to Canterbury, as well as refugees from other categories. A National Refugee Networking day was organised by CPH and well attended by cross sector workers. With family members arriving to support victims and families of the mosque shooting it is likely that the capacity of our Communicable Diseases nurses will be stretched.

CPH have partnered with ESR in support of a Health Research Council application called 'Unravelling the mysteries of Yersiniosis' **designed to identify sources of Yersiniosis** using hypothesis testing questionnaires, and whole genome sequencing of isolates from cases, food, animal and environmental sources, **and to quantify the impact of the disease** (burden and severity). It is anticipated that the findings of this planned research **would inform interventions to reduce the impact of the disease**.

9. HEALTHY PHYSICAL ENVIRONMENT

"Supporting communities to improve their health"

Our key physical environment priorities for 2018-19 are:

- Effective risk assessment, management and communication of identified public health environmental issues.
- To undertake regulatory functions required under the Health Act 1956 including drinking water.
- To maintain Border Health surveillance and core capacity programmes
- To implement the Hazardous Substance Action Plan and regular requirements under the Hazardous Substance legislation.
- To collaborate with external agencies including ECan, Territorial Authorities and Drinking Water suppliers.

CPH has conducted assessments for a number of quarry applications in Canterbury. The most notable in terms of public concern, is the proposed Roydon Quarry near Templeton. **The primary public health considerations relate to air quality, noise, and psychosocial impacts**. These concerns have been raised in our submission; the hearing where CPH will appear is imminent.

Mega Survey Sampling

Health Act - Drinking Water: **CPH has been working closely with the Kaikoura DC following a serious *E.coli* transgression in March 2019**, which was linked to contamination in their main reservoir. **A mandatory boil water notice was issued and a full investigation of the supply integrity was initiated** by Kaikoura DC. This investigation concluded that **significant remedial works were required to the supply - these have now been completed.**

Drinking Water Assessors have started to receive Water Safety Plans under the new Ministry of Health framework. **This has required up-skilling and a significant increase in workload associated with the assessment of plans and the provision of advice to water suppliers regarding the interpretation** of the framework. **Potentially non-compliant** drinking water supplies **are more regularly being brought to the attention of the Designated Officer**. Non-compliances have been investigated and warning letters issued as required. Investigations are ongoing in relation to a number of other suppliers.

The **Mega Survey to identify existing and potential mosquito breeding sites** was carried out in February at Christchurch Airport and Lyttelton Port. Mosquito larvae found in drain sumps at the airport were identified as non-exotic species Culex pervigilans and Culex quinquefasciatus. Culex quinquefasciatus larvae were also found at Naval Point during the survey of Lyttelton Port. **The Port and Airport authorities have been sent reports with recommendations to treat the mosquito breeding sites and potential breeding sites** highlighted during the summer period, and **to ensure good housekeeping practices are in place to prevent pooling of water**.

CPH's HSNO Officer resourcing is **currently shared across all three regions to ensure that the high number of VTA applications received are effectively managed**. The overall numbers of hazardous substances injury notifications (HSDIRT) are mainly related to lead exposure although four carbon monoxide poisoning incidents have been investigated with three believed to be from the same source. The **HSDIRT area of work is expected to increase** if the Ministry of Health's **proposal to reduce the whole blood lead level at which lead absorption must be notified** is introduced.

There has **been collaboration with CCC and EQC regarding a project which hopes to address the leakage from private wastewater laterals following the earthquakes, and as a result of incomplete or inadequate repairs**.

10. EMERGENCY PREPAREDNESS

"Minimising the public health impact of any emergency"

Our key emergency preparedness priorities for 2018-19 are:

- To review our Emergency Response plans to ensure alignment with DHB Health Emergency Plans.
- To ensure all staff have appropriate emergency response training.
- To participate in local and national emergency response exercises.
- To support improvements in community emergency response capacity and resilience.
- To work with Ngāi Tahu to support emergency response capacity of iwi Māori.

Following significant revision, version 3 of **CPH's Health Emergency Management Plan was signed off** by our Clinical Director on 10 April 2019. This version has **moved away from a generic all-hazards approach, to a risk-based comprehensive management approach**. An additional section 'Emergency Management Approach' has been added to the plan, and the 'Risk Reduction' section has been substantially extended. The Readiness, Recovery, Wellbeing and Health and Safety sections have been revised. Much of the Response Section has been removed from the plan and inserted into a new EOC Manual which is currently in draft form.

The Emergency Preparedness Coordinator (EPC), assisted by two colleagues**, presented a one day CIMS in Health training course** on 27 May. **Designated personnel participated for refresher training purposes**, while two new administration staff and two key CDHB staff (from Infection Control and Occupational Health) attended for the first time. The EPC also recently accepted an invitation from Captain Naomi Gough, Medical Officer at Burnham Military Camp, **to provide CIMS in Health training for defence health staff later in the year**.

In the absence of any exercises so far this year (due to ongoing operational responses such as the measles outbreak) the EPC took the opportunity to attend a two day exercise writing course run by CDEM in Christchurch on 26 and 27 March. **He intends to use this training to prepare a table-top exercise in the near future**. The EPC also **provided information on the public health aspects of multi-agency responses to tsunami events** to Canterbury Region Civil Defence and Christchurch City Council, who are both in the process of writing tsunami response plans.

The EPC **facilitated CPH's Canterbury measles outbreak debrief** and has **prepared a report**. Once this has been peer-reviewed it will be shared with the Ministry of Health and the other parts of the Canterbury health system involved in the response.

The Emergency Planning Manager/Māori Relations Manager meets regularly with Robyn Wallace, Te Rūnanga o Ngāi Tahu, and **Hector Matthews, Director of Māori and Pacific Health, Canterbury DHB**. Both she and the EPC are familiar with Te Rūnanga o Ngāi Tahu's 'Emergency Response Framework' **and liaise with Ngāi Tahu to support public health aspects of the iwi's emergency response capacity**.

11. SUSTAINABILITY

"Increasing environmental sustainability practices"

Our key sustainability priorities for 2018-19 are:

- To work to develop a Sustainability Governance Committee to oversee recommendations from the Health Promoting Health Systems paper endorsed by EMT and the Clinical Board in 2017.
- To continue to support the Canterbury DHB Energy Manager with CEMARs and Enviro-mark work.
- To maintain and build the Zero Heroes sustainability group at CPH.
- To re-build and nurture the Sustainable Health 4 Canterbury staff advocacy group.
- To maintain links with the National green hospitals group and with Ora Taio – NZ Climate and Health Council.
- To link actively with the Health Promoting Health system programme where appropriate, seeking synergies between the two programmes.

The **Transalpine Environmental Sustainability Governance Group** (formally the Sustainability Governance Committee) **meets regularly as of February**. Membership includes services from both WC and Canterbury DHBs. The Group is currently considering the South Island Alliance's Environmentally Sustainable Healthcare: Position Statement for adoption. Minister Genter's visit to the CDHB to discuss sustainability was delayed as result of the 15 March Mosque Attacks, this will be now be held in July.

The **CDHB has now achieved Energy-mark gold status**. We are not aware of any other DHBs who have yet achieved this.

Zero Heroes Sustainability Group at CPH - Zero Heroes has grown in membership and continues to meet monthly. In February **the group led an 'all-staff meeting' which was an opportunity to speak to issues of Climate Change and the Sustainable Development Goals**. Staff were encouraged to commit to one small action (using postcards of CPH staff 'loving their planet' as per the photo below) showing our commitment to embed a culture of environmental sustainability across CPH.

With the establishment of the Transalpine Environmental Sustainability Governance Group, **we are receiving more requests from CDHB staff to rebuild this network to support sustainability initiatives**. Developing and coordinating this will be a priority going forward. The **challenge remains adequate resourcing** given the CDHB no longer has a sustainability officer.

CPH continues to maintain links via the Sustainable Health Sector National Network and Ora Taio. Their Sustainability Forum held in May was video-streamed to both the CPH office and a location at Manawa for wider CDHB staff.

12. WELLBEING AND MENTAL HEALTH PROMOTION

"Improving mental health and wellbeing"

Our key wellbeing and mental health promotion priorities for 2018-19 are:

- Ongoing development and delivery of the All Right? campaign, including a new strategic plan and funding strategy.
- Continued evaluation and publication of All Right? campaign impact.
- Ongoing development and maintenance of psychosocial recovery bodies (Greater Christchurch Psychosocial Committee and Governance Group).
- Delivery of the Canterbury Parenting Resource Project.
- Development and delivery of initiatives which increase capacity for mental health promotion.

'All Right?' strategic planning for the first six months of 2019 outlined some of the work currently under way; **strategic planning was reconfigured in mid-March** to respond to the 15-March terror attacks and emerging needs in Christchurch, Canterbury, and throughout New Zealand. The campaign team rapidly developed *He waka eke noa*, a **campaign to respond to the mosque shootings** in partnership with the Mental Health Foundation. ***He waka eke noa*** draws on the skills and knowledge the Canterbury community built up following the earthquakes and the team's extensive network of champions and contacts throughout the city. The campaign also builds on the outpouring of kindness and compassion that has been on display in the city since March 15. Requests have come from the Muslim communities for resource translations into seven languages, and that process is underway. There is also a Te Reo Māori version.

Many of the other *'All Right?'* planned activities are still progressing. The '**Moments that Matter**' summer campaign is now complete. The 'He Waka Ora' **disaster recovery website is now live** and awaiting a launch with the Ministry of Health to share the tool nationwide. The **annual survey** measuring the reach and impact of the campaign has been piloted and is now in the field. As part of the Te Waioratanga stream of the campaign, **work is progressing on a Maramataka project** to encourage people to learn the key phases of the Māori Lunar calendar, and to understand how tipuna incorporated this knowledge into their lives to support their wellbeing. Workshops about how to use this knowledge in the workplace are launching soon, and an online lunar calendar which will be launched at Matariki this year.

The campaign collaborated with the Mental Health Foundation for **Pink Shirt Day,** developing several activities now hosted on Sparklers. The activities were popular, with website visits reaching nearly 3,000; Pink Shirt Day activities held the top-ten spots for most visited. The report about *'All Right?'* **research into Rainbow Communities** is due to be released. With *'All Right?'* funding to continue for the next 12 months, the campaign will consider how to respond to the research. The campaign is planning to release a resource for parents and children about 'big emotions' in August 2019. The Psychosocial Committee has contributed to the **Public Inquiry into the Earthquake Commission.** The full Committee met with Dame Silvia Cartwright and some of the Inquiry team, and a smaller subcommittee will participate in a more focused meeting.

The **parenting app**, Kākano, has been successfully proto-tested and has now received ethics approval to move to a large randomised control trial to measure effectiveness and acceptability. The trial will run through Term 3, 2019, in partnership with the Mana Ake service.

Internally, CPH is continuing to identify the current understanding of and capacity for mental health promotion across teams. Work is under way to grow this capacity across external partner organisations through a **Mental Wellbeing Impact Assessment** workshop planned for later in the year.

13. ALCOHOL HARM REDUCTION

"Reducing alcohol-related harm"

Our key alcohol priorities for 2018-19 are:

- Ongoing development of health promotion initiatives that support alcohol harm reduction.
- Alignment with South Island priorities that address alcohol-related harm.
- To support priority communities to access appropriate information and resources that address alcohol-related harm.
- Ongoing development and implementation of policy initiatives that address alcohol-related harm.
- To undertake appropriate regulatory functions required under the Sale and Supply of Alcohol Act 2012.
- To span national, regional and local approaches and issues.

Alcohol Health Promotion has **focused on *strengthening community voice in DLC hearings* and *evaluating* this process with recent local decisions appearing to increasingly listen to communities**; **rugby league games now come under the City Council alcohol ban areas**; a **sports and alcohol workshop with Canterbury Cricket,** and providing a **new lanyard to assist club bar staff**; a **new co-creation social supply project with students and staff at Haeata Community College**; and **an expanded website for the Good One Party Register to cover Dunedin**.

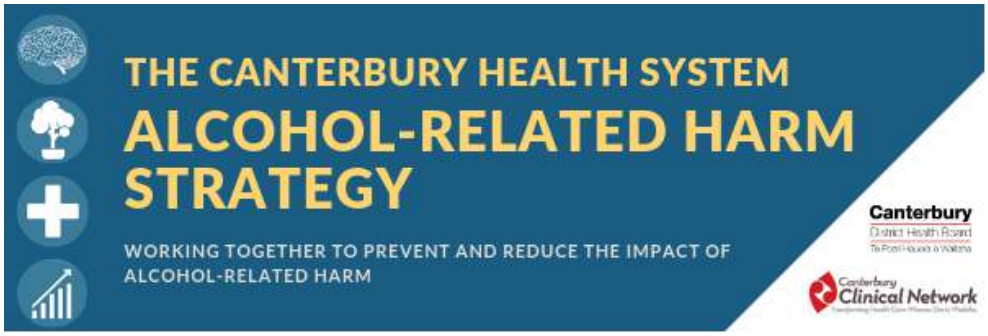
Alignment with South Island priorities include chairing of the *South Island Alcohol Working Group*. **Regional alcohol forums promote consistent good practice**.

Informing and upskilling priority communities to have a say in local alcohol licensing decisions remains a focus, in collaboration with Community Law and CAYAD. **The funding of our local approach at a national level is a highlight**. A current focus is working with Māori communities.

Policy work has **recently seen the formal launch of *the Canterbury Health System Alcohol-Harm Reduction Strategy***. The **working group continues to engage with various service level alliances to implement this strategy**. The *Christchurch Alcohol Action Plan (CAAP)* **working group is having constructive discussions to secure funding for a CAAP coordinator to assist implementation of the plan**.

Regulatory work has seen **improved management** of high workload volumes, **assisted by streamlined recording and specials processes**. **Targeted monitoring** of high risk premises and special events is taking place**. CPOs continue to be challenging with Police staffing shortages and changes**. DLC and ALRA **hearings are more complex and legalistic**, requiring detailed preparation, with applicants and Council increasingly represented by legal counsel.

National, regional and local issues include the ongoing **high rates of hazardous drinking** in some population groups; and the **relationship between alcohol and mental health, suicide, family violence, crime, injuries and illness**. **Efforts to promote consistent good practice** across the country, **regionally and locally are promising**, while implementation of the '5+ solution' has yet to be realised.

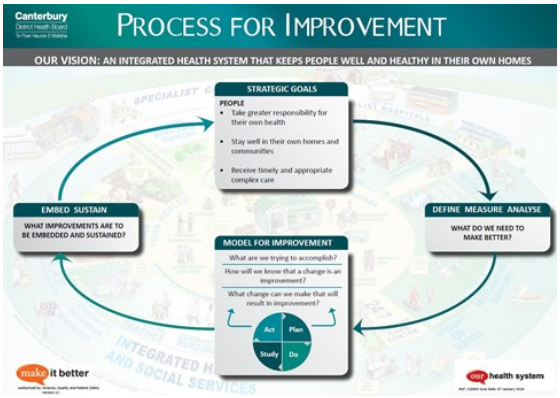


14. TUAIWI

Although not a formal part of our annual plan, our Tuaiwi ("backbone") programme provides infrastructure and support for all our other programmes.

Our key Tuaiwi priorities for 2018-19 are:

- The continued roll-out and embedding the revised Healthscape throughout CPH and other organisations using Healthscape
- A highly accessible and well-utilised CPH website
- Effective IT use by CPH staff
- To support and co-ordinate the 2018-19 Operational Quality Improvement Plan
- To support and coordinate the 2018-19 Workforce Development Plan
- Effective reporting and profiling of CPH's work with Ministry and DHBs



The 2018 Healthscape upgrade in use by CPH staff, has been rolled out to Hawkes Bay DHB, and successfully installed as part of a new implementation of Healthscape at Waikato DHB. **Healthscape is now in use in 7 PHUs covering 12 DHBs, and installation has just been completed in an eighth PHU**.

SIPHAN, CPH's secure online information-sharing and collaboration tool, **is now in active use around the country by Ministry of Health *Healthy Homes Initiative* providers**.

Support continues for the CDHB MyMedicines site, including translation of information sheets into te reo Māori for the 40 medicines mostly commonly used by Māori patients.

CPH has 312 documents logged in the CDHB Electronic Document Management System (EDMS), which is a library used to maintain policies, procedures, protocols and other associated quality documentation. Document reviews are carried out three yearly; 11 of 312 remain outstanding to 30 June 2019. **CPH is proud to hold a document currency of 96%**.

The **viewership of the CPH website went to new highs with 20,319 page views and 11,989 sessions in March 2019**. This is likely due to the popularity of information published on the Measles outbreak in Canterbury, and doubling of the page views of mental health and illness information – in the wake of the 15 March terror event. Page views to the Mental Illness page accounted for 11% of the total views to the website from 1 March to 31 May 2019.

The Healthy Christchurch website received 34,622 page views and 21,680 sessions from 1 January to 31 May 2019 – a small increase on the same period last year (6.9 and 10% increases respectively). **Older content on the website continues to be well used such as issues papers from the 2011 City Health Profile, alongside more recent popular news items** such as the Ministry of Health Long Term Conditions Conference, Waka Toa Ora - Healthy Greater Christchurch events (forums and lunchtime seminars), and updates on cases of measles in Canterbury.

The content on the **Stop Smoking Canterbury website has been recently reviewed and updated** in collaboration with the Te Ha – Waitaha team. Further work was recently completed to make mihi/ personal statements available for all Stop Smoking Practitioners and Support team members.

Eight audits of our Common Filing Structure (CFS) have been conducted from January to May 2019 including folders from the regional offices. **The CFS Moving Tool application has also been used to safely transfer files internally** – including the recent re-distribution of files associated with the Psychosocial Recovery and Monitoring (PRAM) project.

Each CPH team is progressing its quality improvement project for this year, and in June all our managers, public health specialists, and team leaders/programme co-ordinators **attended a special workshop on CDHB's quality improvement tools (Elev8) as part of our process for agreeing improvement priorities** for the 2019-20 year.

CPH's new-format six-month reports for the first half of this year were well-received by our DHBs, and our 2019-20 annual plans have been accepted by our respective DHBs and the Ministry of Health. CPH continues to support a common approach to planning and reporting across the three South Island public health units.

CANTERBURY DISTRICT HEALTH BOARD

Canterbury District Health Board
Te Poari Hauora ō Waitaha

EXCERPT FROM PUBLIC BOARD MEETING MINUTES
18 July 2019

Item 8
Maori Health Strategy Proposal

Resolution (XX/19)
(Moved: Dr Anna Crighton/seconded: Ta Mark Solomon – carried)

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

i. approves the proposal to develop a co-design process to develop a longer-term Strategy for improving Māori health outcomes and reducing Māori health inequity; and
ii. formalises the incorporation of Whanau Ora into the proposed Maori Health Strategy.

Further, the Board:

iii. notes that the targeted implementation date is 1 July 2020, with progress reporting back to the Board."

Extracts from Chief Executive's Report to Board - 18 July 2019

Making It Better - System Improvement

Canterbury Initiative

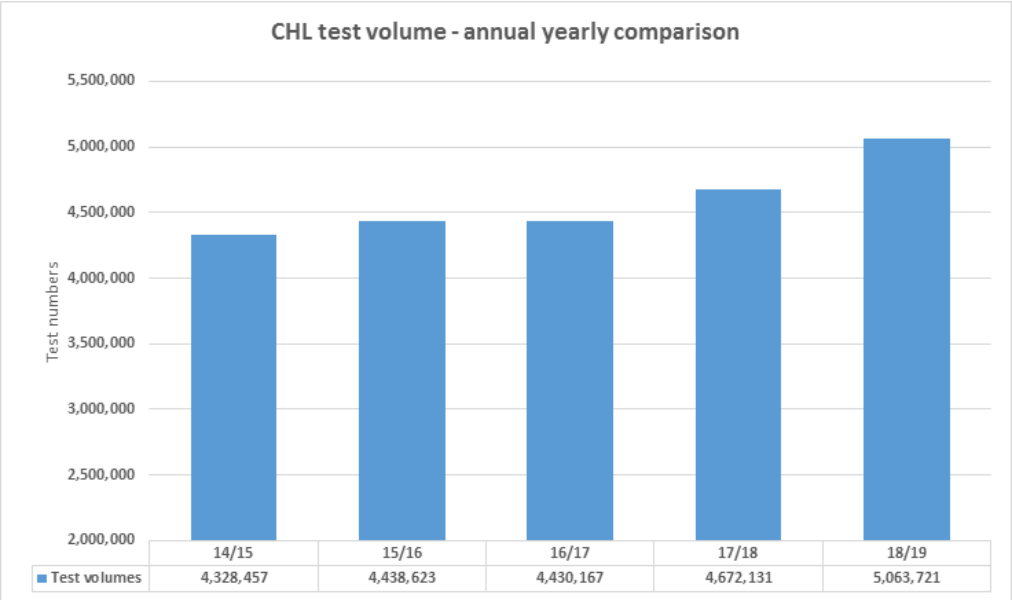
- **TamiFlu for High Risk Patients:** With the high rates of influenza in Canterbury, funded oseltamivir (TamiFlu) is available through General Practice via Acute Demand for influenza A in adult high-risk patients. High risk patients are pregnant women, people with severe respiratory or cardiac disease and immunosuppression.

Impact of Influenza

Laboratory Services

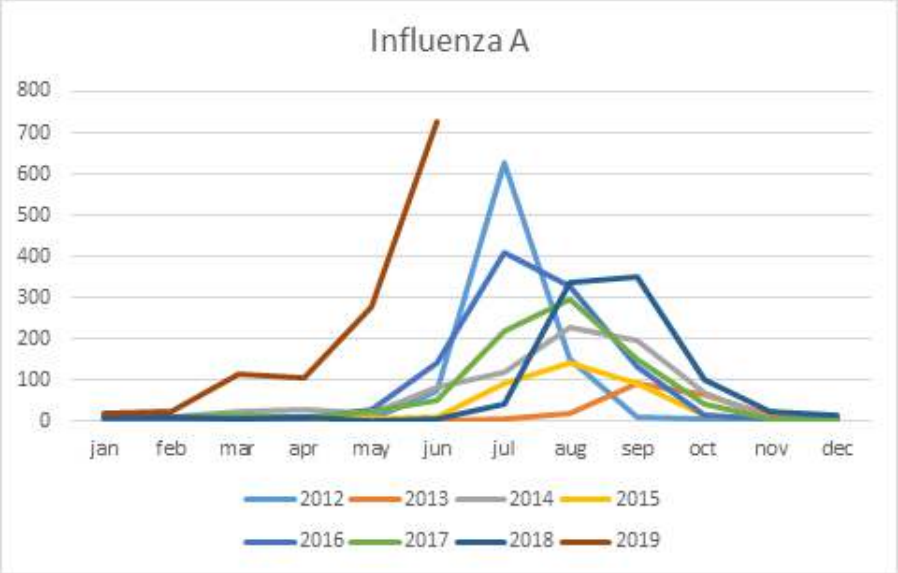
- **CHL volume activity reports:** Activity year to date (12 months July-June) demonstrates growth in demand for laboratory services over previous years:

	Historical comparisons of 12 months (July-June) demand				
F/Y	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Test volumes	4,328,457	4,438,623	4,430,167	4,672,131	5,063,721
Percent change		2.55%	-0.19%	5.46%	8.38%



- Final year end test volumes are in line with the forecasts previously predicted through to end of 18/19 with an 8.34% growth in demand against the 17/18 year. Testing in 18/19 exceeded 5 million.

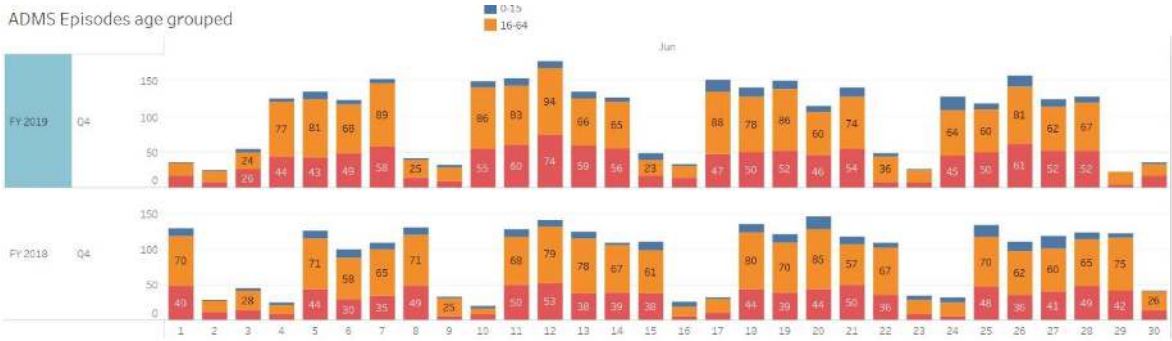
- CHL continues to work with the regional alliance partner and internal referrers on ways to manage this growth and opportunities for any appropriate mitigations in service demand.
- **Winter planning**: Rapid testing for FluA/FluB/RSV for all CDHB inpatients as well as specimens from local GP's (excluding surveillance samples) is now offered 24/7. The results are automatically be available in HCS and ICNet. Samples from critical wards like BMTU, NICU and CHOC, which test negative for the rapid FluA/FluB/RSV test, are automatically be reflex tested with a wider respiratory panel batched once daily as well as all surveillance samples and all other samples on specific request for the full respiratory panel.
- **Influenza in Canterbury:** Influenza A activity in Canterbury started very early this year and is well above previous comparative years. The majority of cases are attributed to subtype H3N2. The now offered rapid FluA/FluB/RSV testing 24/7 is alleviating the workload on laboratory staff and offers quicker turn-around-times and shows a positive impact on patient management.



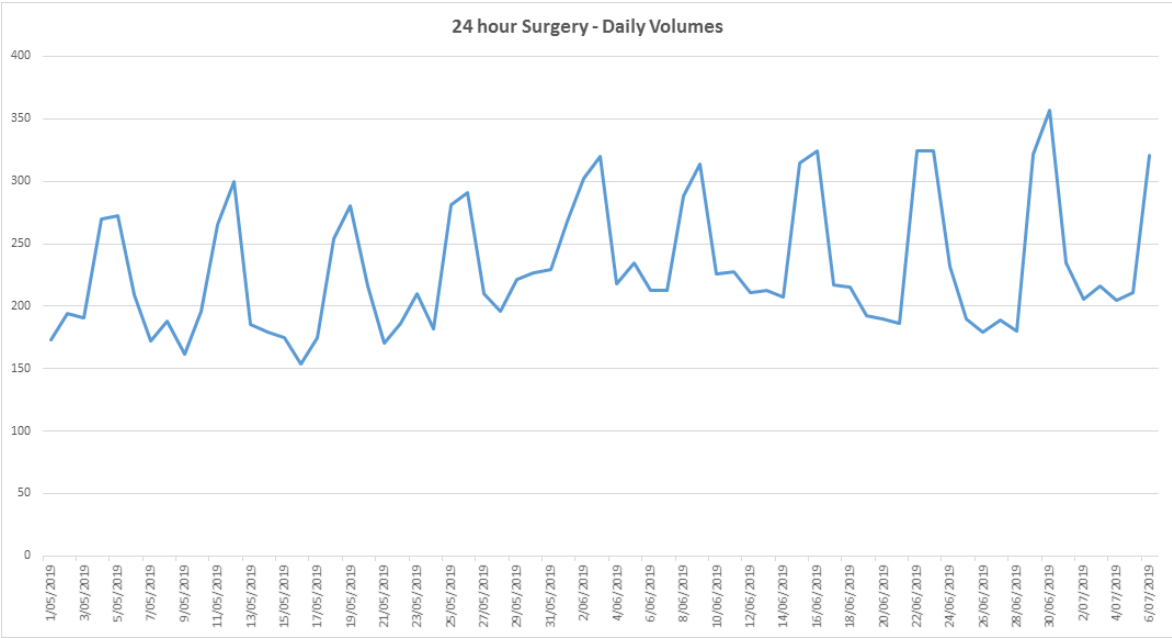
- Influenza B activity is now increasing in parallel:

Acute Demand Management

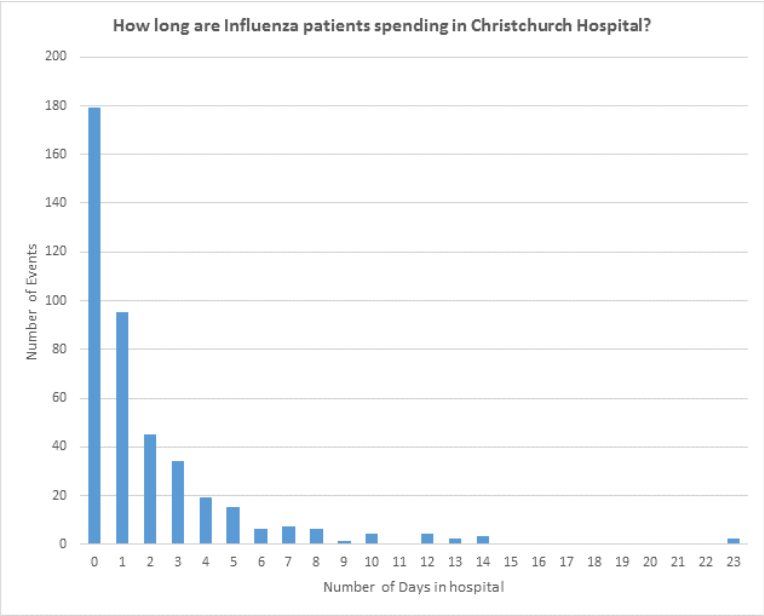
- This winter has seen an early arrival of influenza following similar reports in Australia. Over 60 beds have been required for people with flu but this has fallen slightly. The decrease follows forecast patterns with a higher peak of 450-500 admissions expected in one week in August. A whole of system response is key to avoiding system failure. Our community partners report high volumes but are coping with demand. A number of new initiatives are being trialled to help us through this winter until we have more capacity. These include increasing senior decision making at the front door of ED, proactive assessment and management of higher risk people in primary care.
- Our Acute Demand Management Service (ADMS) has seen a 10% increase in activity comparing this June with June 2018. On average 100 people per day were cared for by the service in 2019 but this varied from less than 50 per day on the weekends to as high as 178 during the week when General Practice is adding to the capacity . The following graphic breaks cases down by age band and compares June 2018 with June 2019. Red is 65 plus



- The 24 Hour Surgery has also seen significant activity. With its highest volumes taking place in the weekend. We do not have that activity coded by reason for attendance.



- Christchurch Hospital has experienced episodes of peak occupancy with many days over its available bed numbers. General medicine has ranged between 40 and 70 beds over its bed foot-print and patients have been located in Gynaecology ward, DOSA and parts of ED to manage the volume of activity. Current forecasts predict that August will be worse with the entire campus being 60 beds short. Burwood Older Persons has also been running at 100% occupancy to support patient flow and the community based teams (Acute Demand, CREST and Community Services) have been in the hospital each day facilitating discharge.
- The following graphic identifies the number of in-patients by length of stay in Christchurch Hospital with influenza. It should be noted that this will be less than the total number as not all coding is complete and some patients are yet to be discharged.



INFLUENZA – PHARMAC APPROVALS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Community & Public Health and Disability Support Advisory Committee

SOURCE: **Planning and Funding**

DATE: **7 March 2019**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report has been prepared at the request of the Committee, from its 1 November 2018 meeting.

2. RECOMMENDATION

That the Committee:

i. notes a population–wide influenza vaccination campaign is not supported by Pharmac.

3. SUMMARY

Acute hospital bed capacity across our health system will come under significant pressure this winter and a number of winter planning strategies are being prepared. In the initial years post-quake we implemented a programme to immunise children and adolescents for influenza in order to reduce winter illness and the impact on our hospitals (see Appendix 1). It is questionable that we achieved sufficient coverage to have a population impact, which was difficult to measure partially due to there being low influenza incidence in these years.

It is not recommended that Canterbury pursues a population-wide influenza campaign this year. Our influenza programme will continue to target high rates of vaccination across older people and those with medical conditions that benefit from individual protection from influenza.

Currently, influenza vaccination for children or the general public is not provided by Pharmac. This would require a special approval; which we sought for the post-quake child vaccination programme.

A population-based approach would require approximately 40% (although this figure is more focused on young people) of our population to be vaccinated to achieve a population effect. This equates to over 220,000 people; significantly more than we currently achieve with our current programme (approximately 60,000). With general practice teams reporting capacity issues, such a target appears unachievable.

4. APPENDICES

Appendix 1: Influenza Vaccination in Children / Young People

Report prepared by: Greg Hamilton, Team Leader Intelligence & Transformation, Planning & Funding

Report approved by: Carolyn Gullery, Executive Director, Planning Funding & Decision Support

APPENDIX ONE

Influenza Vaccination in Children / Young People

Background

After the Canterbury earthquakes of 2010/11, between 2011 and 2014, Canterbury DHB provided free influenza vaccine for all children 6 months to 18 years living in Canterbury, with the aim of reducing demand on the health system, both by reducing the burden of disease in the targeted age group, but also through the indirect effect of reducing transmission to the whole population.
A mixed model of delivery through primary care and through schools was used that varied from year to year.

- In 2011, vaccination was done through primary care, as the staff were trained and had systems in place to deliver vaccination to their enrolled population.
- In 2012, school-based vaccination was also included, in addition to primary care delivery, as a targeted approach within two school clusters (primary/intermediate (10) and secondary (3) schools), selected by location (eastern Christchurch), size and ability to support delivery.
- In 2013, primary care delivery continued, with the school-based programme offered through high schools across all of Christchurch, rather than primary schools as in the previous year.
- In 2014, the school-based programme was offered through high schools across all of Christchurch, as in 2013, but delivered earlier in the year and over a shorter period of time (March and April) than previously.

Evaluation

Canterbury DHB evaluated each of the years that the influenza vaccination programme was delivered. The focus of evaluation was on the approach to vaccination each year, uptake by age, ethnicity, and deprivation quintile, and not on the impact that the programme had on incidence of influenza-like illness (ILI) in Canterbury for those years.
General observations drawn from evaluations after each year's vaccination programme:

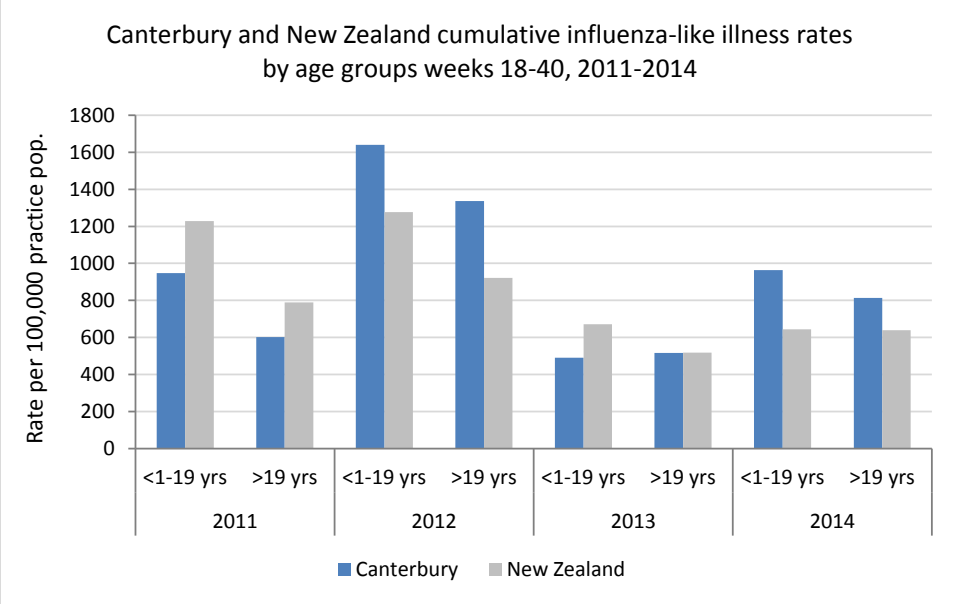
1. To have full effect on the population beyond the target group it was hypothesised that 40% of the under 18 population would need to be vaccinated. Coverage of the under 18 year old age group was approximately:
    - 21% in 2011
    - 19% in 2012
    - 33% in 2013
    - 25% in 2014
2. Of the school programmes, uptake was greater in high schools overall than primary schools, although there was considerable variation in uptake between schools.
3. There was more equitable uptake of the vaccine by ethnicity in the school programme compared to primary care.
4. Primary care achieved greater uptake in the least deprived quintiles than the school programme.
5. Administration including the consenting process, scheduling of the programmes, and recording the event were resource intensive.
6. A cost benefit analysis of the programme was not undertaken.

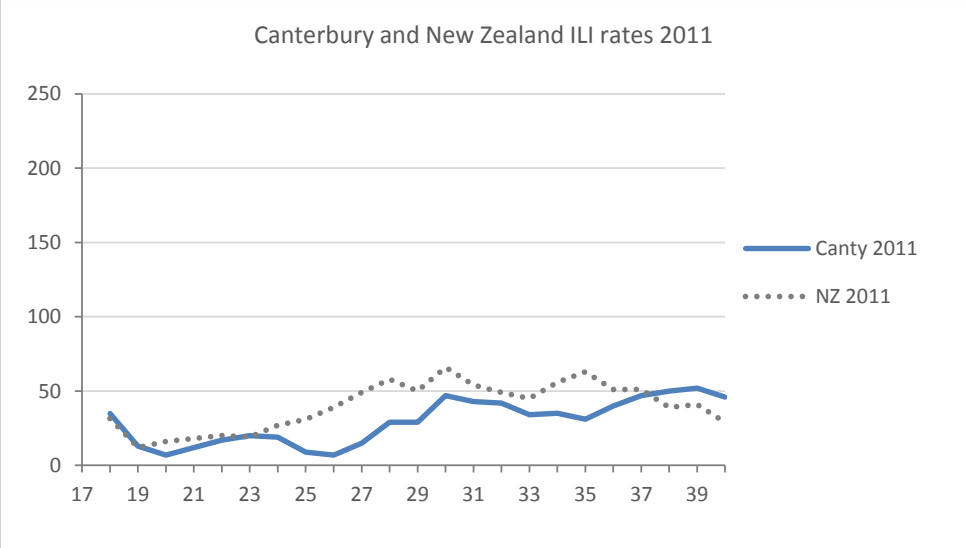
The evaluation in 2013 also reviewed recent literature on uptake of influenza vaccine in children, which may be useful for planning or as the basis of an updated literature review.

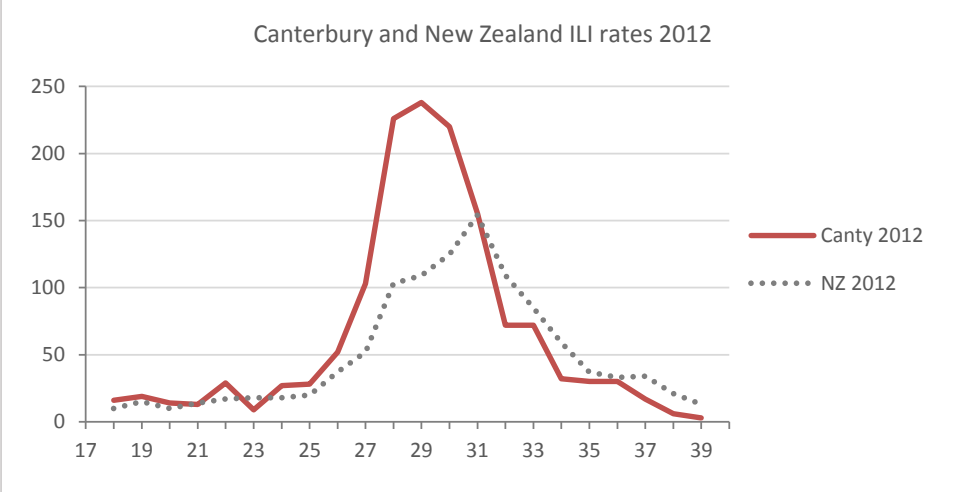
Incidence

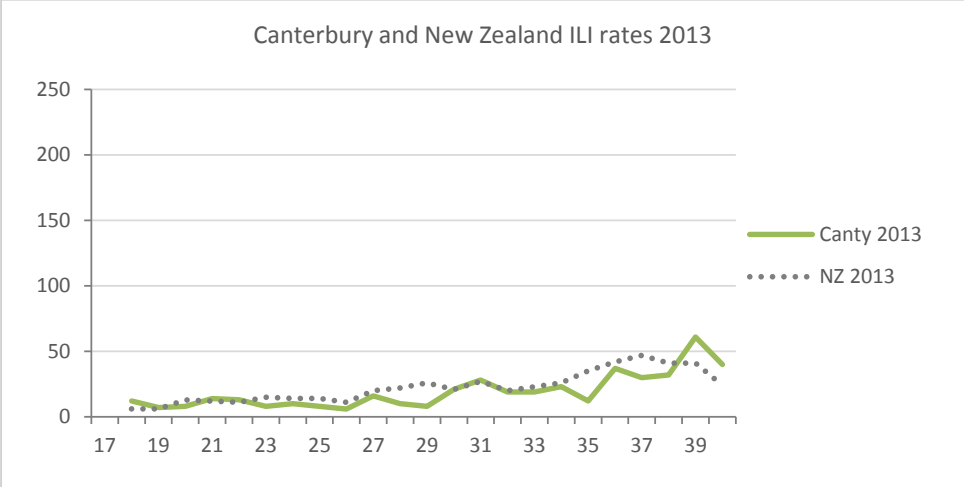
Incidence of ILI in Canterbury and nationally, has been analysed retrospectively (see below). Incidence of ILI is affected by many factors beyond coverage, including social and environmental conditions, vaccine effectiveness, and antigenic match for each season, which limits comparison between years and between geographic areas. It should not be assumed that variation in incidence of ILI is necessarily due, or not due, to the influenza vaccination programme.
Coverage of under 18 influenza vaccination was highest in 2013, which coincided with the lowest ILI rates for the four years in Canterbury for both under and over 19 year olds. However, there was also a low ILI rate nationally for that year.

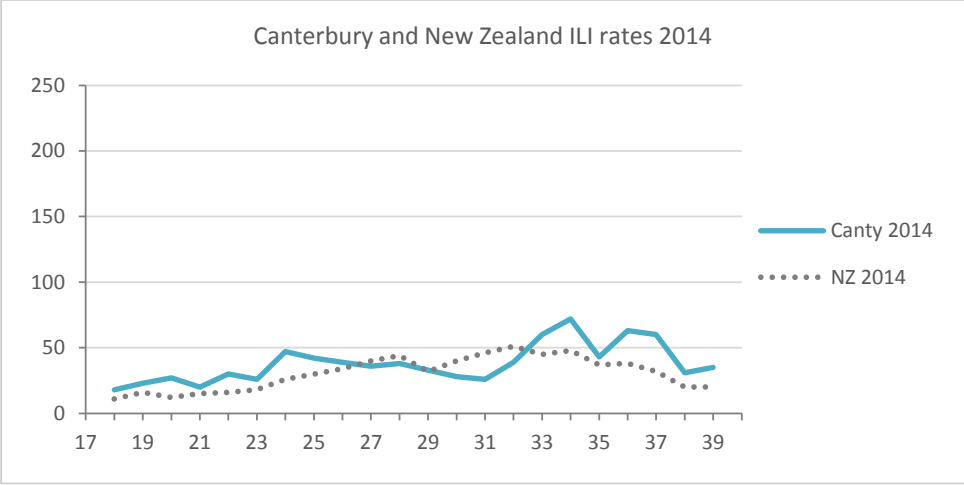
Conversely, coverage of under 18 vaccination was lowest for 2012, which coincided with the highest ILI rates in Canterbury for both age groups. Again however, there were high rates of ILI nationally for that year, although not as high as Canterbury and with a later peak.
A rate of 36 ILI consultations per 100,000 population per week is considered the threshold over which ILI exceeds the baseline level. Only 2012 was a significant influenza season, reaching above high normal season activity.











Note: Data for New Zealand ILI rates does not include Auckland and Counties Manukau DHBs as they were part of the SHIVERS study.

Other programmatic considerations

1. The largest burden of disease is in <5 year olds, but interruption of transmission in the community appears to be best achieved by targeting early school aged children, in the 5-10 year old age group. These children would be most easily reached in a primary school delivery model. Public Health England have found a vaccination programme delivered in primary schools using live-attenuated influenza vaccine as a nasal spray resulted in significant reductions in ILI presentations, ED

attendance, and hospital admission in programme areas in the targeted age group (5–10 years) compared with non-pilot areas. There were also effects on non-targeted age groups, e.g. ILI presentations in the over 17 year old age group.

2. The influenza vaccination programme was delivered in schools between 2012 and 2014. The HPV catch up programme for girls was introduced as a pilot into secondary schools in Canterbury in 2014. It is now delivered in primary care with catch up in primary/intermediate schools for girls and boys. First line delivery of tetanus-diphtheria-pertussis booster vaccination (Tdap) is in primary care. In 2018, Tdap vaccination is also being added to the school programme, to reinforce the linkage of Tdap to the HPV vaccine that exists in primary care. This is going to be introduced nationally, in 2019. These factors have implications for the availability of staff and resources to deliver any additional school-based programme in 2018 and beyond.
3. The influenza vaccine is now entered onto the National Immunisation Register. This was not the case when the programme was introduced into Canterbury schools in 2011, but will mean that coverage data will be more comprehensive.

Canterbury District Health Board Te Poari Hauora o Waitaha	Minutes – Friday 21 June 2019 Canterbury DHB Disability Steering Group (DSG)

Attendees: Gordon Boxall (Chair), Allison Nichols-Dunsmuir, Kay Boone, Paul Barclay, Prudence Walker, Simon Templeton, Kathy O'Neill, Dave Nicholl, Jane Hughes, Tyler Brummer, Catherine Swan, Jacqui Lunday Johnstone, Sekisipia Tangi, Ngaire Button, Kathryn Jones, Lara Williams (Administrator)
Guests: Bella Bartley, Ester Vallero
Apologies: Maureen Love, George Schwass, Mick O'Donnell, Waikura McGregor, Susan Wood

	Agenda Item	Summary of Discussion	Action/Who
1	Karakia Timatanga	Gordon welcomed the group. Prudence gave a Karakia.	
2	Apologies above Previous minutes, matters arising and any conflicts of interest for today's agenda items	Welcome to Bella Bartley, Pacific Lead and Contract Relationship Manager, Disability Directorate; Ministry of Health Conflicts of interest, none. Matters Arising – none. May 24th minutes passed as correct record.	
3	Focus on the needs of Pacific people.	Bella Bartley Pacific Lead and Contract Relationship Manager Disability Directorate; Ministry of Health. Bella spoke of improving outcomes for Pacific families, meeting their needs, and encouraging people and families to engage with providers. All providers must be welcoming and have an understanding of Pacific cultures. There are few Pacific providers in the South Island. Sekisipia Tangi has previously highlighted the gap that exists of people engaging with the providers. There is a hesitancy on the part of Pacific disabled people. Le Va, based in Auckland offers cultural competencies training around NZ by arrangement. https://www.leva.co.nz/training-education/engaging-pasifika Le Va has developed disability service information in Pacific languages. Bella suggested sending the link out to the PHO's and asking them to print out some copies for display for their clients. www.leva.co.nz/resources/words-matter-disability Bella discussed the National Pasifika Disability Plan Faiva Ora and confirmed that ACC figures aren't included in the Plan. DSG asked what is working well in other places? One approach that is working is connectors in the community and DSG explained the navigator situation in Canterbury. Bella will ensure disability is represented in Pacific community innovation	***Action point:*** *Kathy to organise MoH resources to be circulated to DSG*

	Agenda Item	Summary of Discussion	Action/Who
		grants. Applications invited from Canterbury communities looking for funding opportunities. Workforce development funding and training grants coming up in July. System transformation is open to Pasifika communities. Bella encouraged DSG to email her to give feedback on policies being developed by the CDHB. She encouraged CDHB take the initiative, for example, to investigate what our system has in place for rehabilitation of Pasifika people with a disability, caused, for example by stroke or a heart condition, before discharge to home. If we could develop this pathway, it could make a real difference to peoples' lives and is an achievable target. Bella and her team can be available by video conference to continue the conversation with DSG.	
4	Issues for people with disabilities from CALD, Refugee and Migrant backgrounds.	Welcome to Ester Vallero, CALD Health Manager, Pegasus Health. CALD stands for Culturally and Linguistically Diverse. The CALD Health Advisory Group advises on issues of health and equity. This includes access to translation and interpreter services, workforce cultural awareness, and improving the diversity of the workforce. It is important to have CALD representation on working groups. Eg diabetes working group. Ester can help with sourcing CALD representative if we are looking for someone. There is a CALD Framework that should be used in initiatives. CDHB should be looking at CALD issues in their Health Pathways work, as there could be a risk of putting people all in the same box when their needs are very different. CALD, Pathways and Individual Care Plans are an area that CDHB could explore. Work is being done to improve translation and interpreter services and systems. For example, more and better health resources; interpreter standards. Video is being tested as a resource. Booking appointments is a big challenge for CALD people. Accessing the health system is predominantly by phone for many services, and can be a barrier to good outcomes. The recent Mosque attacks highlighted the importance of service providers collaborating and reaching out to support people in ways that suit their individual circumstances. Ester invited a DSG member to attend the CALD Health Advisory Group, so disability issues could be raised as appropriate.	**Action point**: CALD Health Frameworks will be circulated with minutes **Action point**: Those interested in attending CALD HAG to contact Kathy for Ester's details.
5	General Business Accessibility Charter	Rebecca Price, Ministry of Education Accessibility Advisor attended today's ACWG meeting. Rebecca is an Occupational Therapist within the MoE's South Island property team, advising on all stages of new builds and refurbishing school properties. The aim is to meet current and future needs for accessibility, and she is present when all decisions are made. Over 13 years,	

	Agenda Item	Summary of Discussion	Action/Who
	Working Group Update	Rebecca has built up extensive expertise and become an integral part of the design and build process, arguably saving the Ministry money from avoidance of expensive rebuilding, and providing suitable learning environments. Rebecca gave an example of a school that used a contractor instead of her, and had to rebuild 80 doorways and add colour contrast to all stairs. The ACWG knows that the CDHB lacks technical accessibility expertise, and is considering whether to have that in-house or contracted (or both). It also needs to consider the economic case for the impact of health environments that help people get well quicker etc. The ACWG is in discussion with the project to move Specialist MH services from PMH, and refurbish a high needs facility at Hillmorton. There are also ongoing concerns about PSAID and AT&R facilities. A site visit for Jacqui and Gordon will be arranged.	
6	Update on the refresh of the Action Plan What should our priorities be for next 3-5 years	In refreshing the Action Plan we need to document what actions have been achieved, where we have changed focus, what has become a higher priority under each objective. For instance, aids to daily living has been progressed. Before this is taken off the list, it would be nice to speak to the team involved. We should get project updates on agendas for the next couple of months. To gain input from the disability community, Prudence will work with Kathy on roadshow, to include three forums in Canterbury, two forums on West Coast. August forums. The refresh at objectives level needs to consider an equity focus and have language reviewed.	**Action Point:** Invite groups to speak on successful projects implemented.
7	Outpatients Experience Survey	The CDHB Outpatients Experience Survey was reviewed recently and there are no questions about accessibility or inclusion. It is suggested that a demographic question be added using the Washington Group Short set of questions (adding a free text 'other' to acknowledge not all disabilities are captured.) This would result in useful information if we could analyse the surveys by disabled/not disabled, and also to know more about which category of disabilities affect our outpatients.	**Action Point** Allison to follow up with Quality and Safety, conveying DSG ideas
8	Given our priorities who would we like to hear from?	Health Pathways' approach to disability and other equity issues.	**Action Point:** Erin from HealthPathways to speak with us
9	What's made a difference to a disabled person's life	Congratulations offered to Prudence on her appointment as Chief Executive for Disabled Persons Assembly (DPA) NZ. Prudence was thanked for her considerable contribution to DSG. Prudence closed the meeting with a suitable Karakia.	

	Agenda Item	Summary of Discussion	Action/Who
10	Next Meeting	**Next meeting Friday 26 July 2019** **11am-1pm** **32 Oxford Terrace**	

Canterbury District Health Board
Te Poari Hauora o Waitaha

Minutes – Friday 26 July 2019
Canterbury DHB Disability Steering Group (DSG)

Attendees: Gordon Boxall (Chair), Allison Nichols-Dunsmuir, Simon Templeton, Kathy O'Neill, Dave Nicholl, Tyler Brummer, Jacqui Lunday Johnstone, Sekisipia Tangi, George Schwass, Mick O'Donnell, Waikura McGregor, Lara Williams (Administrator)

Guests: Disability Support Advisory Committee (DSAC) members - Hans Wouters, Thomas Callanan
Erin Wilmshurst, Hannah Gordon (The Canterbury Initiative)
Matt Elliott, CDHB Webmaster

Apologies: Susan Wood, Jane Hughes, Kay Boone, Catherine Swan, Ngaire Button, Paul Barclay, Maureen Love, Kathryn Jones

	Agenda Item	Summary of Discussion	Action/Who
1	Karakia Timatanga	Gordon welcomed the group and Waikura provided a karakia	
2	Apologies above Previous minutes, matters arising and any conflicts of interest for today's agenda items	Welcome to Hans Wouters and Thomas Callanan, DSAC members. Conflicts of interest - none. Matters Arising – none. June minutes passed as correct record.	
3	Discussion on how to strengthen the interface between DSG and DSAC	DSG acknowledged the need to strengthen link to DSAC; relating to discussions, activities, priorities. Noting the DSAC strategic and advocacy roles, DSG analysis and action roles Suggested consideration for DSAC members to attend DSG meetings. Either an ongoing member or revolving members to attend when they are able.	***Action point:*** DSAC to be invited to DAG hosted events. ***Action point:*** Kathy to follow up with DSAC re members attending DSG meetings
4	Transition from Paediatric to Adult Service. Presentation of Project Recommendations	Nikki Scott gave an overview of journey so far that has led to their recommendations. The aim is for uninterrupted healthcare for 16 year olds from Paediatrics into adult services, with roles and responsibilities known and accepted. DSG members and group as a whole are available to assist with the Transition project as needed.	***Action point:*** Presentation circulated with these minutes. ***Action point:*** Nikki and Erin will discuss potential for Canterbury Initiative work to assist Transition project.
5	Health Pathways and HealthInfo	Erin Wilmshurst explained the web based information used in the CDHB and Primary Care by clinicians (Hospital	***Action point:***

	Agenda Item	Summary of Discussion	Action/Who
		HealthPathways, Community HealthPathways and AlliedHealthways). Discussion canvased suggestions to improve the disability content integrated into on HealthPathways as this is an important source of information for clinicians. DSG advised that disability relevant information needed be linked to sources already used by clinicians. The information needs to be developed with lived experience input 'nothing about us without us'. Case studies and clinical information are both important, as is the language used. Health Pathways has great potential in improving disability awareness among clinicians. Hannah Gordon provided overview of HealthInfo, information developed for public use. Suggestions that reading level of this material be reviewed, with a view that some information could be put in 'Easy read' format.	Erin's presentation to be circulated with minutes. **Action point**: Erin to consider the development of Health Pathways disability content, with a process that is inclusive. **Action point**: Erin to provide DSG feedback to Canterbury Initiative action team. **Action point**: Kathy will note this discussion for the Disability Action Plan refresh.
6	Request for endorsement of Vision Australia link for all CDHB windows users	Matt Elliott – CDHB Webmaster presented https://www.visionaustralia.org/services/digital-access/document-accessibility-toolbar This is a free tool to help us create/amend documents that meet accessibility standards (eg able to be read by screen readers, etc). Endorsement sought to sponsor this so ISG can implement this software to Windows users. Discussion of benefits including providing information that is accessible to everyone. Agreed to take this forward and to involve Paul Barclay. DSG supportive but could use more information before endorsing. It.	***Action Point:*** DSG will ask Paul Barclay to assess this software
7	Information Accessibility Charter	There is a national Accessibility Charter relating to information in the state services. This has caused some confusion re the Canterbury Accessibility Charter that addresses the built environment. The tool above could be useful in helping CDHB to improve accessibility of its documents.	***Action Point:*** Kathy and Mick have been asked to check on whether CDHB has signed Information Accessibility Charter, and ensuing work plan
8	General Business Accessibility Working Group Update	Allison gave AWG update.	

	Agenda Item	Summary of Discussion	Action/Who
	Follow up on Employment Forum held 5 July Update on the refresh of the Action Plan	AWG will meet Project team members for HIllmorton on 14th August, re fully integrating accessibility into design and build processes. National surveys – inpatient and primary care Patient Experience Surveys will include disability status questions. CDHB will also include disability questions in their outpatient surveys. We will then have information on any disparities in experience related to disability, useful to identify priorities and assess progress. Tyler is writing up a summary of recommendations of this very successful forum. His team so far has identified that we need to focus on: changing people's perceptions: using a strengths based approach; capturing people's experience; partnering with agencies and organisations, including MSD; supporting hiring manager to address unconscious bias and myths; reviewing the application form; reviewing the information provided to hiring managers. P&C are considering setting up an employee advisory group and are looking at psychometric testing. P&C will work with any managers who believe they may have roles that may be suitable for people with disabilities. Plans under way for refresh of DSG membership, noting especially that we now have diminished voice of lived experience after Prudence and Hayley's membership ending. Recruitment and selection are planned over the next 5 months.	
9	Anything that's different in a disabled person's life since we last met.	Nothing added.	
10	Next Meeting	**Next meeting Friday 23 August 2019** **11am-1pm** **32 Oxford Terrace**	

CANTERBURY AND WEST COAST HEALTH DISABILITY ACTION PLAN

A plan for improving the health system for people with disabilities and their family/whānau

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

Foreword

The Canterbury and West Coast Health Disability Action Plan has been developed with people with disabilities, their family/whānau, providers of disability services and our Alliance partners from across the health system. The Plan will be implemented with the ongoing engagement of all these key stakeholders using existing processes, and through developing new ways of working together.

Contents

Developing our Disability Action Plan 2016 - 2026

In 2016 we began the development of a Canterbury and West Coast Health Disability Action Plan for 2016 - 2026.

The draft document, approved for wider consultation, was developed in line with the New Zealand Disability Strategy 2001 and the United Nations Convention on the Rights of People with Disability.

Disabled People Organisations are those recognised by the New Zealand Office of Disability Issues as representing the collective voice of people with disabilities. All such recognised groups have received and been invited to provide feedback on the draft Plan and the priority actions for 2016 - 2017.

Feedback was received via attendance at face to face meetings, forums and network meetings, and through written feedback. This feedback has been incorporated into the final Plan.

Development of the Plan included the review and incorporation of the key elements of core New Zealand documents relating to people with disabilities. Those core documents can be found in Appendix A.

The importance of the United Nations Convention on the Rights of Persons with Disability was consistently referred to by people with disabilities and their supports. These guiding principles are included as Appendix B.

For the purposes of this Plan, disability is defined according to the United Nations Convention on the Rights of People with Disability. It describes disability as resulting 'from the interaction between persons with impairments

and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'
(UN General Assembly 2007).

This definition distinguishes the impairment or health condition from the restrictions on participation in society (e.g. unemployment due to discriminatory recruitment practices). These restrictions are not an inevitable consequence of the impairment; they are a result of unfair and avoidable barriers which results in many of the differences in health status between people with a disability and people without a disability. Using this definition the Plan is applicable to all people with disabilities regardless of age or the type of impairment.

The principles of partnership, participation and protection have been central to the development of the strategic objectives and priority actions in this Plan. These principles are consistent with the Treaty of Waitangi and demonstrate our commitment to working with Māori as treaty partners. This is especially important because Māori have higher rates of disability and poorer health outcomes than non-Māori. While there is a specific objective to achieve equitable outcomes for Māori within the Plan, each of the identified priority actions will have identified actions that are inclusive and culturally appropriate.

The Plan includes a Canterbury and West Coast position statement which addresses the critical issues relating to human and civil rights, treatment, and services and programmes for people with disabilities and their family/whānau. This statement is to inform our population and other agencies of the prevailing organisational view on key issues for people with disabilities.

Progress on achieving the stated objectives and priority actions in this Plan will be reported back to the disability community through a range of tactics including forums, electronic information and written communication. The Plan will be refreshed at least annually and priority actions will be developed and amended as necessary to ensure we continue to strengthen our engagement and inclusion of disabled people in the transformation of our health system. *Refer to Appendix C for a summary of the consultation process and feedback.

Position Statement

Promoting the health and wellbeing of people with disabilities

Purpose

This position statement summarises our commitment to actions aimed at improving the lives of people with disabilities in Canterbury and on the West Coast. It will be used in making governance, planning, funding, and operational decisions. The Plan reflects this position statement and provides details of how it will be implemented.

Key points

We recognise that a significant proportion of the New Zealand population experience impairments, which may result in disability and disadvantage. In addition, the population is aging which will increase the number of people experiencing impairment. Accessibility and inclusion are rights to be protected. They are also catalysts for new ideas and innovation that can lead to better services and outcomes.

We make the following commitments to people with disabilities, their families and whānau, to:

1. Collect their feedback about the services we deliver
2. Understand their perspectives and needs
3. Deliver appropriate specialist, general and public health services, in a way that suits them
4. Uphold the rights of people with disabilities, and counter stigma and discrimination
5. Equip and upskill staff to meet their needs.

We will also incorporate the perspectives and needs of people with disabilities when we:

1. Contract other organisations to deliver services
2. Employ people with disabilities
3. Design and build our facilities
4. Monitor and report on how well we are doing, and plan for improvements
5. Partner with our communities to improve population health and wellbeing.

CANTERBURY AND WEST COAST HEALTH DISABILITY ACTION PLAN 2016 - 2026

Vision

The Canterbury and West Coast strategic vision for people with disabilites is of a society that highly values lives and continually enhances their full participation. Through this strategic vision, we will ensure that all people with disabilities experience a responsive and inclusive health system that supports them to reach their full potential by providing equitable access to services that focus on keeping people safe and well in their homes and communities.

Safety and Autonomy

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I am safe in my home, community and work environment. I feel safe to speak up or complain and I am heard. Those assisting me (professionals and others) have high awareness and I do not experience abuse or neglect.

Our Strategic Focus

People with disabilities and their family/whānau/carers are listened to carefully by health professionals and their opinions are valued and respected. Individuals are included in plans that may affect them and encouraged to make suggestions or voice any concerns by highly aware staff.

We will...

1. ***Integrate services for people of all ages with a disability***

   Work with people with disabilities and their family/whānau/carers to identify opportunities for achieving an integrated and co-ordinated approach between cross government services and local providers, so that infants/children and youth with impairments and adults with a disability, including those with age related conditions, can live lives to their full potential. (8, 10, 11 – These numbers relate to objectives in The NZ Disability Strategy 2001, see Appendix D).

2. *Improve health literacy*

Improve access to health information in a form that works for them. This includes access to their personal health information. Support is provided when required so that the individual/family/whānau can use information to manage their own health, share in decision making, provide informed consent, and make choices and decisions that are right for them and their family/whānau. (3, 8, 10, 11, 12)

3. *Offer appropriate treatment*

Offer interventions with individuals and their family/whānau which are evidence-based best practice, such as restorative, recovery focused approaches. (6, 7, 10, 11)

4. *Monitor quality*

Develop and use a range of new and existing quality measures for specific groups and services that we provide for people with disabilities, and develop systems and processes to respond to unmet needs e.g. consumer survey. (6, 10, 13, 14)

Wellbeing

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I feel dignity and cultural identity through a balance of family/community, mental, physical and spiritual wellbeing.

Our Strategic Focus

The wellbeing of people with disabilities is improved and protected by recognising the importance of their cultural identity. Health practitioners understand the contribution of the social determinants of health.

We will...

5. Measure and progress

Develop measures and identify data sources that will provide baseline information about people with disabilities who are accessing the health system. Using the Health System Outcomes Framework for each strategic goal, use data analysis to understand the population and evaluate progress towards improving health outcomes for people with disabilities. (1, 8, 13)

6. Improve access to personal information

Enable people with disabilities to have increased autonomy in making decisions that relate to their own health by developing processes that enhance communication e.g. access to their medical records through patient portals. People with disabilities will be given support to do this if they are unable to do this on their own. (2, 14)

7. Work towards equitable outcomes for Māori

Work with Māori people with a disability, whānau and the Kaupapa Māori providers to progress the aspirations of Māori people as specified in He Korowai Oranga, Māori Health Strategy. Apply our Māori Health Framework to all the objectives of this action plan in order to achieve equitable population outcomes for Māori with a disability and their whānau. (11, 13, 15)

8. Implement a Pasifika disability plan

Work with Pasifika people, their families and Pasifika providers to action the Ministry of Health National Pasifika Disability Plan 2014 - 2016 which identifies nine specific objectives for Pasifika people with a disability and ‘Ala Mo’ui: Pathway to Pacific Health and Wellbeing 2014 - 2018 which is aimed at improving culturally appropriate service provision with

emphasis on improved access to Primary Care. Canterbury Pasifika Health Framework 2015 - 2018 will also be used as a core document to inform the work required. (12, 13, 15)

9. Develop better approaches for refugee, migrant and culturally and linguistically diverse groups

Work with people with disabilities and their families who are from different refugee, migrant and other culturally and linguistically diverse groups to identify and implement responsive processes and practices. This includes information being appropriately translated and an awareness by staff of how disability is viewed from different cultural perspectives. (9, 13)

Self Determination

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I make my decisions myself, based on my aspirations. I have access to information and support so that my decisions are informed.

Our Strategic Focus

People with disabilities contribute to their own health outcomes as they and their family/whānau receive the information and support which enables them to participate and influence at all levels of society.

We will...

10. Provide accessible information and communication

Promote and provide communication methods that improve access and engagement with people with disabilities, such as using plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology, and expanding the use of sign language. (1)

11. Develop leadership of people with disabilities who have a role in the health system

Identify and support opportunities for leadership development and training for people with disabilities within the health system. This includes further development of peer support as a model of care for people with long term conditions. (5)

Community

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

I feel respected for my views and my contribution is received on an equal basis with others.

Our Strategic Focus

People with disabilities experience equal workplace opportunities. The health system supports access, equity and inclusion for those living with impairments, their family/whānau, carers and staff.

We will...

12. Be an equal opportunity employer

Increase the numbers of people with disabilities being employed and supported in their role within the Canterbury and West Coast health system. (4) Develop and implement an appropriate quality tool for current employees who identify as having a disability, that can inform and identify opportunities to improve staff wellbeing. (2, 4, 10)

13. Increase staff disability awareness, knowledge and skills

Develop and implement orientation and training packages that enhance disability awareness of all staff, in partnership with the disability sector e.g. people with disabilities, their family/whānau/carers, disability training providers and disability services. (1)

14. Services and facilities are designed and built to be fully accessible

Services and facilities will be developed and reviewed in consultation with people with disabilities and full accessibility will be enhanced when these two components work together to ensure people with disabilities experience an inclusive health system that is built to deliver waiora/ healthy environments. (6)

Representation

The New Zealand Disability Action Plan 2014 - 2018 Strategic Focus

Disabled People's Organisations (DPO) represent collective issues that have meaning for me (based on lived experience) in a way that has influence.

Our Strategic Focus

The collective issues that emerge from people with disabilities' lived experience of the health system are actively sought and used to influence the current and future Canterbury and West Coast health system.

We will...

15. Implement the plan in partnership

Work with the Canterbury and West Coast Consumer Councils to ensure a network of disability-focused consumer groups who are empowered to actively engage with health service providers and be partners in health service improvement and redesign. This network will support the implementation and evaluation of the Canterbury and West Coast Health Disability Action Plan. (1)

16. Promote the health, wellbeing and inclusion of people of all ages and abilities

Actively promote and influence at all levels of society, to address stigma and discrimination, increase universal design for public spaces, and advocate for a fully inclusive society. (1, 4, 13)

Priority Actions 2016 - 2017

Key

Will be progressed in 2016 - 2017

Will be progressed in the future as opportunities emerge

Safety and Autonomy

1. Integrate services for people with a disability of all ages

Objective

Work with people with disabilities and their family/whānau/carers to identify opportunities for achieving an integrated and co-ordinated approach between cross government services and local providers so that infants/children and youth with impairments and adults with a disability, including those in related to age related conditions, can live lives to their full potential.

Priority Actions

1.1 Map the pathway for people with disabilities and long term chronic health conditions (LT - CHC) to available services, and work with Disability Support Services and the Needs Assessment and Service Co-ordination Services to improve processes as people transition between health and disability services.

1.2 Work with other providers of services for children and youth to address the gap in service provision for respite for 0-19 year olds with complex needs and for those living in rural communities.

1.3 The agreed pathways across funders and service providers will be placed on HealthPathways.

1.4 Where gaps in service provision are identified, engage with the key stakeholders to identify opportunities and actions that can be progressed.

Outcomes

- Increased planned care and decreased acute care
- Decreased wait times
- Decreased institutionalisation rates.

2. Improve Health Literacy

Objective

Improve access to health information in a form that works for people with disabilities. This includes access to their personal health information. Support is provided when required so that the individual/family/whānau can use information to manage their own health, share in decision making, provide informed consent, and make choices and decisions that are right for them and their family/whānau.

Priority Actions

2.1 People will better understand their health status through the development of the electronic patient portal in collaboration with people with disabilities and relevant experts to ensure that when the electronic patient portal is implemented it is accessible to people with disabilities, including those who use communication devices.

2.2 With the involvement of people with disabilities and their family/whānau, explore the potential for HealthOne as the electronic shared record between primary and secondary care, as the repository for information that people with disabilities want communicated about how best to support them when they are accessing a health or disability service. Evaluate the potential effectiveness of this with the disability community.

Outcomes

- Improved environments support health and wellbeing
- Increased planned care and decreased acute care.

3. Offer appropriate treatment

Objective

Offer interventions with individuals and their family/whānau which are evidence based best practice and that these restorative, recovery focused approaches will result in people living lives to their full potential.

Priority Actions

3.1 Explore opportunities and identify how to support a timely response for people with disabilities and their families/whānau who require

- Aids to daily living
- Housing modifications
- Driving assessments.

Outcome

- Improved environments support health and wellbeing.

4. Monitor Quality

Objective

Develop and use a range of new and existing quality measures for specific groups and services that we provide for people with disabilities, and develop systems and processes to respond to unmet need e.g. consumer surveying.

Priority Actions

4.1 Trial the use of feedback at the time of treatment within an identified service and explore whether this can include asking people if they have a long term impairment.

4.2 The quality of life for people with disabilities while in Canterbury and West Coast long term treatment facilities is measured and monitored and that actions occur to address any identified areas of improvement quality actions occur.

4.3 Ensure people with disabilities and their family/whānau know about and understand the Canterbury and West Coast DHBs' complaints and compliments process by describing the process in Easy Read format, placed alongside existing signage within wards and reception areas.

Outcomes

- No wasted resource
- The right care, in the right place, at the right time, delivered by the right person.

Wellbeing

5. Measure and Progress

Objective

Develop measures and identify data sources that will provide baseline information about people with disabilities who are accessing the health system. Using the Health System Outcomes Framework for each strategic goal, analyse data to understand the population and evaluate progress towards improving health outcomes for people with disabilities. (1, 8, 13)

Priority Actions

5.1 The disability population will be identified by developing an inventory of available data and potential data sources that can be used to better understand those with disability who access the health system.

5.2 Identify additional data collection required to inform further service improvement and ensure that baseline data are developed and used as measures of success. (These processes are inclusive of the actions specified for Māori and Pasifika in 7.1 and 8.1 of this plan).

6. Improve access to personal information

Objective

Enable people with disabilities to have increased autonomy in making decisions that relate to their own health by developing processes that enhance communication e.g. access to their medical records through patient portals. People with disabilities will be given support to do this if they are unable to do this on their own.

Priority Actions

6.1 The process for identifying the solution for a patient portal in primary care includes how the needs of people with disabilities will be met.

7. Work towards equitable outcomes for Māori

Objective

Work with Māori people with a disability, whānau and the Kaupapa Māori provider to progress the aspirations of Māori people as specified in He Korowai Oranga, Māori Health Strategy. Apply our Māori Health Framework to all the objectives of this Plan in order to achieve equitable outcomes for Māori with a disability.

Priority Actions

7.1 Develop high quality ethnicity data sets by having processes in place that enable all data collected and collated to capture information specific to the Māori population with a disability.

7.2 All the priority actions of this plan are to include culturally appropriate actions for Māori with a disability and their whānau, and that this promotes and supports whānau ora and rangatiritanga.

Outcome

- Delayed/avoided burden of disease and long term conditions.

8. Implement a Pasifika Disability Plan

Objective

Work with Pasifika people, their families and Pasifika providers to action the Ministry of Health National Pasifika Disability Plan 2014 - 2016 and ‘Ala Mo’ui: Pathway to Pacific Health and Wellbeing 2014 - 2018 which are aimed at improving culturally appropriate service provision with an emphasis on improved access to primary care. Canterbury Pasifika Health Framework 2015 - 2018 will also be used as a core document to inform the work required.

Priority Actions

8.1 Develop high quality ethnicity data sets by having processes in place that enable all data collected and collated to capture information specific to the Pasifika people with a disability. To develop and implement local responses appropriate to Canterbury and the West Coast.

8.2 Strengthen the culturally appropriate service responses, as Canterbury is one of the target DHBs working to achieve the four priority outcomes* of ‘Ala Mo’ui, and transfer strategies.

*1. Systems and services meet the needs of Pasifika people
2. More services are delivered locally in the community and in primary care
3. Pasifika people are better supported to be healthy
4. Pasifika people experience improved broader health determinants of health.

West Coast only: The West Coast will engage with Canterbury to identify and strengthen its service responses in line with 'Ala Mo' ui.

Outcome

Delayed/avoided burden of disease and long term conditions.

9. Develop better approaches for refugee, migrant and culturally and liguistically diverse (CALD) groups

Objective

Work with people with disabilities and their families who are from different refugee, migrant and other culturally and linguistically diverse groups to identify and implement responsive processes and practices. This includes information being appropriately translated and an awareness by staff of how disability is viewed from different cultural perspectives.

Priority Actions

9.1 Engage with the Migrant Centre and CALD Co-ordinator Resettlement Service to explore opportunities for including the needs of CALD people with disabilities in the way we communicate.

9.2 Use the local Canterbury and West Coast networks to establish communication processes to disseminate health and disability-related information and advice to CALD communities. There will be a focus on Asian communities.

Outcome

- Delayed/avoided burden of disease and long term conditions.

10. Provide accessible information and communication

Objective

Promote and provide communication methods that improve access and engagement with people with disabilities e.g. use of plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology. Expand the use of sign language.

Priority Actions

10.1 Engage with Canterbury and West Coast communications staff to review health system websites and identify any parts of them which are not fully accessible for people who use communication devices.

10.2 Build on the partnership with the disability sector by having the Disability Strategy and a version of this Plan made available in Easy Read format.

10.3 Work with communications staff to identify which key communications will be made available in plain language and circulated to a network of disability organisations and key contacts.

10.4 Develop a Canterbury and West Coast policy on the use of sign language and access to interpreters.

10.5 Undertake a stocktake within the Divisions of the DHBs, which will be aimed at identifying where people with lived experience are providing peer support to service users, and recommend areas for further development.

Outcome

- Improved environments support health and wellbeing.

11. Develop leadership of people with disabilites who have a role in the health system

Objective

Identify and support opportunities for leadership development and training for people with disabilities within the health system. This includes further development of peer support as a model of care for people with long term conditions.

Priority Actions

11.1 Engage workforce development training providers from the disability sector to identify opportunities to support people with disabilities and their family/whānau who are providing a voice for people with disabilities within the health system. This will include exploring options for appropriate leadership training.

Outcome

- Improved environments support health and wellbeing.

Community

12. Be an equal opportunity employer

Objective

- The number of people with disabilities being employed and supported in their role within Canterbury and West Coast health will increase.
- Develop and implement an appropriate quality tool for current employees who identify as having a disability, which can inform and identify opportunities to improve staff wellbeing.

Priority Actions

12.1 Work with Work and Income NZ and the Ministry of Social Development in achieving employment of people with disabilities

12.2 Develop and implement an affirmative action plan that will result in more people with disabilities being employed in the Canterbury and West Coast health system.

12.3 Explore how to use the Staff Wellbeing Survey to ask staff how Canterbury and the West Coast DHBs can continuously improve their support of people with disabilities employed in either DHB.

Outcome

- Understanding health status and determinants.

13. Increase staff disability awareness, knowledge and skills

Objective

Develop and implement orientation and training packages that enhance disability awareness among staff, in partnership with the disability sector e.g. people with disabilities, their family/whānau/carers, disability training providers and disability services.

Priority Actions

13.1 Identify Disability Champions across our health systems. These champions will form a network that will disseminate disability-related information and resources and be an essential part of implementing the priority actions.

13.2 Work with the Learning and Development Unit and professional leaders to identify relevant education programmes that are already developed and offered by disability-focused workforce development organisations e.g. Te Pou.

13.3 Work with the Learning and Development Unit and professional leaders to progress the development of an eLearning tool that can then be placed on the healthLearn website and promoted for staff.
West Coast only: The West Coast will work with Canterbury to ensure applicability to the West Coast.

13.4 Training packages are developed and implemented in partnership with Māori people with disabilities and their whānau, to ensure cultural competency is inclusive of any training delivered.

Outcomes

- Delayed/avoided burden of disease and long term conditions
- Access to improved care.

14. Services and facilities are designed and built to be fully accessible

Objective

Services and facilities will be developed and reviewed in consultation with people with disabilities and full accessibility will be enhanced when these two components work together to ensure people with disabilities experience an inclusive health system.

Priority Actions

14.1 Site Redevelopment and Communications will work together to develop a communication plan for the disability community to receive quarterly updates on the development of Canterbury and West Coast health facilities. This will be in formats that are user-friendly for those with disabilities.

14.2 The communication plan will include information on how people with disabilities and their family/whānau can provide feedback and input when they have or potentially will experience barriers to access.

14.3 We will engage experts at key stages of the design, build and fit out of the building or rebuild of facilities, e.g. barrier-free and dementia-friendly.

Outcomes

- Delayed/avoided burden of disease and long term conditions
- Community capacity enhanced
- Access to care improved.

Representation

15. Implement the Action Plan in partnership

Objective

Work with our Consumer Councils to ensure a network of disability focused consumer groups who are empowered to actively engage with health service providers and be partners in health service improvement and re-design. This network will support the implementation and evaluation of the Canterbury and West Coast Health Disability Action Plan.

Priority Actions

15.1 Establish a Disability Steering Group that has members from the disability community who will provide leadership in the implementation of the plan.

15.2 A communication plan is developed and actioned, and this includes regular engagement with the disability sector including people with disabilities, their family/whānau and Disabled Peoples Organisations.

15.3 Monitor progress against the priority actions to be undertaken quarterly and communicated to the sector as a key part of the communication plan.

15.4 The priority actions will be refreshed annually within the health system and the disability sector with engagement and input from the people with disabilities, family/whānau and the wider disability sector.

Outcome

- Building population health, capacity and partnerships.

16. Promote the health, wellbeing and inclusion of people of all ages and abilities

Objective

Actively, promote and influence at all levels of society, to address stigma and discrimination, increase universal design for public spaces, and advocate for a fully inclusive society.

Priority Actions

16.1 Community and Public Health for both DHBs continues to co-ordinate submissions on behalf of Canterbury and West Coast DHBs. However, they will use the Plan's underpinning principles to inform their submissions.

16.2 In conjunction with Disabled Peoples Organisations, Disability Support Services, the Ministry of Social Development and the Ministry of Education, set an annual seminar which presents new developments and initiatives for people with disabilities.

Outcomes

- Improved environments support health and wellbeing
- Access to improve care.

APPENDICES

Appendices

APPENDIX A

CORE DOCUMENTS

The core documents referenced in the development of this Plan include:

- New Zealand Disability Strategy 2001
- New Zealand Disability Action Plan 2014 - 2018
- New Zealand Disability Action Plan 2014 - 2018. Updated December 2015
- He Korowai Oranga, Māori Health Strategy 2014 - 2018
- Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Service 2012 - 2017
- Faiva Ora National Pasifika Disability Plan 2014 - 2016
- Ala Mo'ui: Pathway to Pacific Health and Wellbeing 2014 - 2018
- United Nations Convention on the Rights of People with Disabilities (ratified by New Zealand 2007)
- Second Report of Independent Monitoring Mechanism of the Convention of the Rights of Disabilities, August 2014
- United Nations Convention on the Rights of the Child (ratified by New Zealand 2008)
- Human Rights Act 1993

APPENDIX B

GUIDING PRINCIPLES OF THE CONVENTION

There are eight guiding principles that underpin the Convention:

1. Respect for inherent dignity and individual autonomy, including the freedom to make one's own choices and be independent
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of a diverse population
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities, and respect for the right of children with disabilities to preserve their identities.

APPENDIX C

CONSULTATION PROCESS AND SUMMARY OF FEEDBACK

Recommended amendments to the Draft Canterbury and West Coast Health Disability Action Plan

All feedback received to date, both written and verbal, has endorsed the vision and objectives of the Plan with some recommended amendments. The respondents stated that the principles of the New Zealand Disability Strategy 2001 of participation, partnership and protection of the rights of people with disabilities were present throughout the document.

Respondents unanimously commended the development of a Disability Action Plan and the process undertaken to seek the opinions of people with disabilities, their family/whānau and other key stakeholders on the Plan and the priorities for implementation over the next two years.

The consultation process has resulted in a number of recommendations on how the draft Plan could be strengthened in terms of the language used, and by broadening the scope of some of its stated goals.

These include:

1. The New Zealand Disability Strategy 2001 is considered an important landmark document but it is fourteen years old and requires updating. It is recommended that, in addition to identifying the alignment with the New Zealand Disability Strategy, each objective should also be aligned with the Articles of the United Nations Convention on the Rights of People with Disabilities and that the language used is consistent with the relevant articles.
2. Include with the dissemination of the Plan the definition of disability we used, and the Position Statement.

3. The draft Plan is primarily adult-focused and it is recommended that the United Nations Convention on the Rights of the Child (UNCROC) be included as a core document to inform the development of the final Plan and the priorities for action.
4. The Plan needs to place more direct emphasis on addressing the health disparities for people with disabilities compared with those people without a disability. It is recommended that the need to have a targeted approach to addressing the barriers of access to healthcare is explicitly stated.
5. Feedback from Māori Advisory Groups both in Canterbury and on the West Coast was that for each of the strategic goals there needs to be inclusion of what would be an appropriate objective for Māori.
6. Wherever possible the language is amended to ensure it is explicit that the objectives are inclusive of all people with disabilities. This will require careful consideration, as feedback has also complimented the Plan on recognising the diversity of the people with disabilities by identifying the different population groups. There was consistent feedback that the Plan needed to reference Asian people specifically.
7. Outcomes need to be identified for each objective including how their achievement will be measured. Measures will form part of the work plans that are developed.
8. Amend the vision statement to include a statement about supporting people with disabilities to reach their full potential.
9. Amend the draft Objective 4 so that the goal positively promotes the use of only appropriate treatments rather than a goal that is more about stopping inappropriate treatments.
10. An additional objective needs to be added under the heading of an Equal Opportunity Employer which states health system employers will take affirmative action to increase the number of people with disabilities employed within the organisations.

11. Add into the Strategic Goal for Safety and Autonomy the commitment to addressing stigma and discrimination.
12. To include families/whānau as a central part of the Plan, including the identification of needs, gaps in services and how to implement and monitor progress.
13. Amend draft Objective 14 that accessibility is more than just buildings and facilities, so that this objective reads as accessible services and buildings.
14. Significant concern was expressed at the number of high level strategic objectives contained in the Plan, but it is less clear how these will be achieved. There was support for identifying the priorities for action and concentrating on progressing a limited number of objectives to avoid the risk of spreading resources too thinly.
15. Feedback on the consultation process showed appreciation for the plain language version being available electronically to networks within the disability community. It has been recommended that the final approved version also be made available in other formats such as large print and on CD.
16. There was concern that those individuals who don't belong to any specific disability groups did not have the opportunity to comment. Those within the disability sector recognise that reaching people with disabilities is one of the significant challenges within the sector, as they are often an invisible part of the community due to the very barriers this Plan has been developed to address. Further planning and ongoing engagement about how to reach this group is required.
17. It is recommended that a process for amending the Plan should be put in place to ensure opportunities for improving the Plan or priorities for action that have not yet emerged, can be added at a later date.
18. The Plan requires ongoing engagement with people with disabilities and their supports on the emerging issues for them. As a minimum, an

annual refresh of the priority actions and any amendment to the overall strategy would occur.

Identifying the Priorities for Action

The key themes and opportunities for priority action

The following areas have been consistently raised by those providing feedback on the priority areas for action:

1. Accessibility of buildings and facilities

- Increasing engagement – providing regular updates in the form of a newsletter, written in a way that is accessible for people with disabilities.
- Identifying and promoting the process for people with disabilities to provide feedback and input when accessibility is impacted e.g. parking, after hours security, etc.
- Designing above code – having experts audit and make recommendations at key stages of the design and fit-out of new buildings and rebuilds e.g. barrier-free, dementia-friendly.

2. Promoting disability awareness

- Develop a network of Disability Champions at a service level across the Canterbury and West Coast health systems. These people will be the conduit for disseminating disability-related information and resources available to staff when working with people with disabilities.
- Work with the Learning and Development Unit and professional leaders of the Canterbury and West Coast health system to identify appropriate and relevant education programmes that are already developed and offered by disability-focused workforce development organisations e.g. Te Pou. This is initially envisaged as an e-learning tool available on healthLearn. Any education tool developed will have input from people with disabilities and their family/whānau.

3. *Communication*

- The use of plain language, Easy Read and formats such as large print will be promoted and expanded for all forms of health information available across the health system.
- Appropriate formats are used when disseminating information to the Canterbury and West Coast population so that it is readable by communication devices.
- Health Passports are a mechanism where people with disabilities can have their individual needs specified. Identify, within the growing suite of information technologies, the best way this information can be included and made available when people with disabilities are accessing any part of the health system e.g. through HealthOne.
- The Patient Portal is being developed in a format that meets the needs of people with disabilities.
- Making information available in different languages, including increased use of sign language interpreters, is also a priority.

4. *The Canterbury and West Coast health system as employers of people with disabilities*

- Under the heading of an Equal Opportunity Employer state that the Canterbury and West Coast health system employers will increase the numbers of people with disabilities being employed and supported in their role within Canterbury and West Coast health.

5. *Specific feedback which related to particular population groups*

- Ensure timely access to equipment that is necessary to enable people to live lives to their full potential.
- Work together with Disability Support Services to develop improved access to appropriate respite options for children with complex conditions.
- Understand and improve the experience of health services for people with learning disabilities

- Work to achieve equitable outcomes for Māori.
- Work with Pacifika people, their families and Pacifika providers to improve engagement.

6. Other Opportunities

- Establish a Disability Action Group that has a membership of people with disabilities and their family/whānau who can contribute to progressing the identified actions.

APPENDIX D

OBJECTIVES FROM THE NEW ZEALAND DISABILITY STRATEGY 2001

The objectives are to:

1. Encourage and educate for a non-disabling society
2. Ensure rights for disabled people
3. Provide the best education for disabled
4. Provide opportunities in employment and economic development for disabled people
5. Foster leadership by disabled people
6. Foster an aware and responsive public service
7. Create long-term support systems centred on the individual
8. Support quality living in the community for disabled people
9. Support lifestyle choices, recreation and culture for disabled people
10. Collect and use relevant information about disabled people and disability issues
11. Promote participation of disabled Māori
12. Promote participation of disabled Pacific peoples
13. Enable disabled children and youth to lead full and active lives
14. Promote participation of disabled women in order to improve their quality of life, value families, whānau and people providing ongoing support.

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

CANTERBURY DISTRICT HEALTH BOARD

Canterbury District Health Board
Te Poari Hauora ō Waitaha

EXCERPT FROM PUBLIC BOARD MEETING MINUTES
15 August 2019

Item 9
2020 Meeting Schedule

Resolution (XX/19)
(Moved: Dr Anna Crighton/seconded: Tracey Chambers – carried)

"That the Board:

i. confirms support for the proposed schedule of meetings for 2020 (Appendix 1);
ii. notes that in terms of the Canterbury DHB Standing Orders (Clause 1.6.1) a formal resolution will be required from the incoming Board in December 2020 to adopt a meeting schedule for 2020;
iii. notes that for planning purposes, the assumption has been made that the Community and Public Health Advisory Committee (*CPHAC*) and Disability Support Advisory Committee (*DSAC*) will continue as one committee (the Community & Public Health and Disability Support Advisory Committee (*CPH&DSAC*)) through 2020, however, should they revert back to two separate committees following review by the incoming Board, CPHAC and DSAC meetings will take place on the scheduled CPH&DSAC dates, with CPHAC meetings starting at 9:00am and DSAC meetings starting at 1.00pm; and
iv. reconfirms the delegation of authority to the Chief Executive, in consultation with the Chair of the Board and/or relevant Committee Chairperson, to alter the date, time or venue of a meeting, or cancel a meeting, should circumstances require this."

	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon
January 2020				NEW YEARS DAY 1	PUBLIC HOLIDAY 2	3	4/5	6	7	8	9	10	11/12	13
February	1/2	3	4	5	WAITANGI DAY 6	7	8/9	10	11	12	13	14	15/16	17
March	1	2	QFARC 9AM 3	4	CPH&DSAC 9AM 5	6	7/8	9	10	11	12	13	14/15	16
April				1	HAC 9AM 2	3	4/5	6	7	8	9	GOOD FRIDAY 10	11/12	EASTER MONDAY 13
May						1	2/3	4	QFARC 9AM 5	6	CPH&DSAC 9AM 7	8	9/10	11
June		QUEEN'S BIRTHDAY 1	QFARC 9AM 2	3	HAC 9AM 4	5	6/7	8	9	10	11	12	13/14	15
July				1	CPH&DSAC 9AM 2	3	4/5	6	7	8	9	10	11/12	13
August	1/2	3	QFARC 9AM 4	5	HAC 9AM 6	7	8/9	10	11	12	13	14	15/16	17
September			QFARC 9AM 1	2	CPH&DSAC 9AM 3	4	5/6	7	8	9	10	11	12/13	14
October					HAC 9AM 1	2	3/4	5	6	7	8	9	10/11	12
November	1	2	QFARC 9AM 3	4	CPHAC/DSAC 9AM 5	6	7/8	9	10	11	12	CANTERBURY ANNIVERSARY DAY 13	14/15	16
December			QFARC 9AM 1	2	HAC 9AM 3	4	5/6	7	8	9	10	11	12/13	14

Tues	Wed
14	15
18	19
17	18
14	15
12	13
16	17
14	15
18	19
15	16
13	14
17	18
15	16

Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S
16	17	18/19	20	21	22	23	24	25/26	27	QFARC 9AM 28	29	HAC 9AM 30	31	
CDHB BOARD 9AM 20	21	22/23	24	25	26	27	28	29						
CDHB BOARD 9AM 19	20	21/22	23	24	25	26	27	28/29	30	QFARC 9AM 31				
CDHB BOARD 9AM 16	17	18/19	20	21	22	23	24	25/26	ANZAC DAY OBSERVED 27	28	29	30		
14	15	16/17	18	19	20	CDHB BOARD 9AM 21	22	23/24	25	26	27	28	29	30/31
CDHB BOARD 9AM 18	19	20/21	22	23	24	25	26	27/28	29	QFARC 9AM 30				
CDHB BOARD 9AM 16	17	18/19	20	21	22	23	24	25/26	27	28	29	30	31	
CDHB BOARD 9AM 20	21	22/23	24	25	26	27	28	29/30	31					
CDHB BOARD 9AM 17	18	19/20	21	22	23	24	25	26/27	28	QFARC 9AM 29	30			
CDHB BOARD 9AM 15	16	17/18	19	20	21	22	23	24/25	LABOUR DAY 26	27	28	29	30	31
CDHB BOARD 9AM 19	20	21/22	23	24	25	26	27	28/29	30					
CDHB BOARD 9AM 17	18	19/20	21	22	23	24	CHRISTMAS DAY 25	26/27	BOXING DAY OBSERVED 28	29	30	31		

January 2020
February
March
April
May
June
July
August
September
October
November
December

WORKPLAN FOR CPH&DSAC 2019 *(WORKING DOCUMENT)*

	7 March 2019	9 May 2019	4 July 2019	29 August 2019	31 October 2019
Standing Items	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standard Monitoring Reports	Planning and Funding Update Report Community and Public Health Update Report Maori and Pacific Health Progress Report	Planning and Funding Update Report Community and Public Health Update Report	Community and Public Health Update Report	Planning and Funding Update Report Community and Public Health Update Report	Planning and Funding Update Report Community and Public Health Update Report Maori and Pacific Health Progress Report (to include progress update on implementation of co-design process to develop a longer-term strategy for Maori)
Planned Items	Draft CDHB Public Health Plan 2019-20 Influenza – Pharmac Approvals Te Ha – Waitaha Stop Smoking Programme Update Step-Up Programme Update CDHB Workforce Update	AllRight? – Presentation Public Health Clinical Network (*PHCN*) – Presentation South Island Public Health Partnership (*SIPHP*) - Presentation Ko Awatea Transgender Health Working Group - Presentation Canterbury Accessibility Charter – Accessibility Working Group Update Equally Well Programme Update	Maori Health Strategy Proposal Work in Schools – Presentation Healthscape - Presentation Transgender Health / Gender Affirming Healthcare Disability Steering Group Update Transalpine Strategic Disability Action Plan – Priority Actions - Refresh CDHB Workforce Update Project Search	Environmentally Sustainable Health Care: Position Statement Communicable Diseases - Presentation InterRAI Assessment & Wait Times Workforce Diversity, Inclusion & Belonging Community & Public Health Update – Disability Sector Step-Up Programme Update	Wellbeing Index Update – Presentation Hauora Alliance – Presentation Greater ChCh Partnership - Presentation Vaping To Quit Health Promotion Agency Campaign Whanau Ora Update Broadly Speaking (HIAP Training Program) - Presentation CDHB Workforce Update Disability Steering Group Update Canterbury Accessibility Charter – Accessibility Working Group Update Equally Well Programme Update Transalpine Strategic Disability Action Plan Refresh
Governance and Secretariat Issues	Draft 2019 Workplan				
Information only items	Disability Steering Group Minutes CCN Q2 2018/19 CPH 6 Month Report to MoH	CPH&DSAC Terms of Reference – Amended Process for the Review of CDHB Background Papers & Position Statements Food Resilience Network Rural Health Promotion Disability Steering Group Minutes 2019 Workplan	CCN Q3 2018/19 Disability Steering Group Minutes 2019 Workplan	CDHB Public Health Report: Jan-Jun 19 Board Minutes Excerpt – 18 Jul 19 – Maori Health Strategy Proposal Extracts from Chief Executive's Report to Board -18 Jul 19 Influenza – Pharmac Approvals (CPH&DSAC – 7 Mar 19) Disability Steering Group Minutes Canterbury & West Coast Health Disability Action Plan 2020 Tentative Meeting Schedule 2019 Workplan	CCN Q4 2018/19 Disability Steering Group Minutes 2019 Workplan