AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 18 March 2021 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 18 February 2021		
3.	Carried Forward / Action List Items		
Overview			
4.	Chair's Update (Oral)	Sir John Hansen *Chair*	9.35-9.40am
5.	Chief Executive's Update	Dr Peter Bramley *Chief Executive*	9.40-10.00am
Presentation			
6.	Allied Health	Dr Jacqui Lunday-Johnstone *Executive Director, Allied Health, Scientific & Technical*	10.00-10.30am
Reports for Decision			
7.	Community Water Fluoridation Position Statement	Evon Currie *General Manager, Community & Public Health*	10.30-10.45am
8.	Waipapa L3 Terrace Garden	Dr Rob Ojala *Executive Director for Facilities*	10.45-10.55am
Reports for Noting			
9.	Finance Report	David Green *Acting Executive Director, Finance & Corporate Services*	10.55-11.05am
10.	Advice to Board: • CPH&DSAC – 4 March 2021 – Draft Minutes	Aaron Keown *Chair, CPH&DSAC*	11.05-11.10am
11.	Resolution to Exclude the Public		11.10am
ESTIMATED FINISH TIME – PUBLIC MEETING			**11.10am**

NEXT MEETING
Thursday, 15 April 2021 at 9.30am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

Sir John Hansen (Chair)
Gabrielle Huria (Deputy Chair)
Barry Bragg
Catherine Chu
Andrew Dickerson
James Gough
Jo Kane
Aaron Keown
Naomi Marshall
Ingrid Taylor

Executive Support

Dr Peter Bramley – *Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
Savita Devi – *Acting Chief Digital Officer*
Dr Richard French – *Acting Chief Medical Officer*
David Green – *Acting Executive Director, Finance & Corporate Services*
Becky Hickmott – *Acting Executive Director of Nursing*
Mary Johnston – *Chief People Officer*
Ralph La Salle – *Acting Executive Director, Planning Funding & Decision Support*
Dr Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Hector Matthews – *Executive Director Maori & Pacific Health*
Dr Rob Ojala – *Executive Lead of Facilities*
Karalyn Van Deursen – *Executive Director of Communications*

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

BOARD ATTENDANCE SCHEDULE – 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	18/02/21	18/03/21	15/04/21	20/05/21	17/06/21	15/07/21	19/08/21	16/09/21	21/10/21	18/11/21	16/12/21
Sir John Hansen (Chair)	√										
Gabrielle Huria (Deputy Chair)	#										
Barry Bragg	√										
Catherine Chu	√ (Zoom)										
Andrew Dickerson	#										
James Gough	√ (Zoom)										
Jo Kane	^										
Aaron Keown	√										
Naomi Marshall	√ (Zoom)										
Ingrid Taylor	√ (Zoom)										

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

Sir John Hansen **Chair CDHB**	**Bone Marrow Cancer Trust** – Trustee **Canterbury Cricket Trust** - Member **Christchurch Casino Charitable Trust** - Trustee **Court of Appeal, Solomon Islands, Samoa and Vanuatu** **Dot Kiwi** – Director and Shareholder **Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member The JCA is an independent statutory authority constituted under the Racing Act. The JCA ensures that judicial and appeal proceedings in thoroughbred and harness racing are heard and decided fairly, professionally, efficiently and in a consistent and cost effective manner. **Ministry Primary Industries, Costs Review Independent Panel** **Rulings Panel Gas Industry Co Ltd** **Sir John and Ann Hansen's Family Trust** – Ingrid Taylor sits as independent Trustee; and provides legal services to the Trust and to Sir John and Ann Hansen.
Gabrielle Huria **Deputy Chair CDHB**	**Nitrates in Drinking Water Working Group** – Member A discussion forum on nitrate contamination of drinking water. **Pegasus Health Limited** – Sister is a Director Primary Health Organisation (*PHO*). **Rawa Hohepa Limited** – Director Family property company. **Sumner Health Centre** – Daughter is a General Practitioner (*GP*) Doctor's clinic. **Te Kura Taka Pini Limited** – General Manager **The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs. **Upoko Rawiri Te Maire Tau of Ngai Tuahuriri** - Husband
Barry Bragg	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.

	Farrell Construction Limited - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Paenga Kupenga Limited** – Chair Commercial arm of Ngai Tuahuriri Runanga **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Verum Group Limited** – Director Verum Group Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.
Catherine Chu	**Christchurch City Council** – Councillor Local Territorial Authority **Riccarton Rotary Club** – Member **The Canterbury Club** – Member
Andrew Dickerson	**Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital.

	NZ Association of Gerontology - Member Professional association that promotes the interests of older people and an understanding of ageing.
James Gough	**Amyes Road Limited** – Shareholder Formally Gough Group/Gough Holdings Limited. Currently liquidating. **Christchurch City Council** – Councillor Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board **Christchurch City Holdings Limited (*CCHL*)** – Director Holds and manages the Council's commercial interest in subsidiary companies. **Civic Building Limited** – Chairman Council Property Interests, JV with Ngai Tahu Property Limited. **Gough Corporation Holdings Limited** – Director/Shareholder Holdings company. **Gough Property Corporation Limited** – Director/Shareholder Manages property interests. **Medical Kiwi Limited** – Independent Director Research and distribution company of medicinal cannabis and other health related products. In process of listing on NZX. **The Antony Gough Trust** – Trustee Trust for Antony Thomas Gough **The Russley Village Limited** – Shareholder Retirement Village. Via the Antony Gough Trust **The Terrace Car Park Limited** – (Alternate) Director Property company – manages The Terrace car park (under construction) **The Terrace On Avon Limited** – (Alternate) Director Property company – manages The Terrace.
Jo Kane	**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.

Aaron Keown	**Christchurch City Council** – Councillor and Community Board Member Elected member and of the Fendalton/Waimairi/Harewood Community Board. **Christchurch City Council** – Chair of Disability Issues Group **Grouse Entertainment Limited** – Director/Shareholder
Naomi Marshall	**College of Nurses Aotearoa NZ** – Member **Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Ingrid Taylor	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee. **Taylor Shaw** – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • I / Taylor Shaw have acted as solicitor for Bill Tate and family. **The Youth Hub** – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.

MINUTES

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 18 February 2021 commencing at 9.30am

BOARD MEMBERS

Sir John Hansen (Chair); Barry Bragg; Catherine Chu (via zoom); James Gough (via zoom); Jo Kane; Aaron Keown; Naomi Marshall (via zoom); and Ingrid Taylor (via zoom).

APOLOGIES

Apologies for absence were received and accepted from Andrew Dickerson, Gabrielle Huria; and Dr Lester Levy (Crown Monitor).
An apology for early departure was received and accepted from Jo Kane (10.35am).

EXECUTIVE SUPPORT

Dr Peter Bramley (Chief Executive)(via zoom); Savita Devi (Acting Chief Digital Officer); David Green (Acting Executive Director, Finance & Corporate Services); Becky Hickmott (Acting Executive Director of Nursing); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Paul Lamb (Acting Chief People Officer); Dr Jacqui Lunday-Johnstone (via zoom) (Executive Director, Allied Health, Scientific & Technical); Hector Matthews (Executive Director, Maori & Pacific Health); Dr Rob Ojala (Executive Director for Facilities); Karalyn van Deursen (Executive Director Communications); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

APOLOGIES

Apologies were received from Dr Richard French (Acting Chief Medical Officer); and Greg Brogden (Senior Corporate Solicitor).
An apology for early departure was received from Dr Peter Bramley (11.00am).

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
James Gough advised he had a change to his interests which he would e-mail through.

There were no other additions/alternations to the Interest Register.

Declarations of Interest for Items on Today's Agenda
Barry Bragg advised that he had a conflict of interest in regard to Item 5 in public excluded and would leave the room for this item.

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. CONFIRMATION OF MINUTES OF PREVIOUS MEETINGS

Resolution (01/21)
(Moved: Sir John Hansen/seconded: Barry Bragg – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 17 December 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

The carried forward item was noted.

4. CHAIR'S UPDATE

Sir John Hansen, Chair, congratulated Board member Naomi Marshall on successfully completing the Ministry of Health "Enhancing Governance Programme" and advised that he had a certificate for her.

Sir John spoke about the upcoming vaccination programme and commented that he is very conscious that this will be a challenge for DHBs throughout New Zealand and also on our staff and on Primary Care as this is rolled out. We need to give them all the support we possibly can.

He commented to the new Chief Executive, Dr Peter Bramley, that we had welcomed him formally on Monday morning and welcomed him to his first Board meeting as Chief Executive. He thanked Dr Andrew Brant for his contribution as Acting Chief Executive. Sir John also thanked the staff who have stepped up over the past few months and a number of people around this table who have stepped into interim positions and supported us through this difficult period.

The update was noted.

5. CHIEF EXECUTIVE'S UPDATE

Dr Peter Bramley, Chief Executive, thanked everyone for the welcome extended to him and echoed the Chair's comments regarding Dr Andrew Brant who has done a superb job of supporting the team and the organisation over the last few months.

Dr Bramley took the report as read and noted that this had been pulled together by Dr Brant.

He commented that it is good news that we are back to Level 1 in regard to COVID. He acknowledged that the health system did an amazing job just getting prepared again. In some ways this has been a reminder for us to refresh and get re-prepared. There is a lot of work taking place behind the scenes, with people putting in some long hours to ensure we are prepared.

In regard to vaccine planning, this is largely being led by the Ministry but hugely supported locally and requires local delivery. This is a huge logistics planning exercise. Tranche 1 gets underway on 24 February. This tranche is all about border and MIQ workers and their close contacts.

We are ramping up the catch-up measles programme which is also of high importance to us in terms of protecting our population, and also flu vaccinations.

In regard to other key pieces of work, the team is well underway on budget preparation and we have budget review meetings for 2021/21 scheduled in our diaries. We will be going back to QFARC and here to the Board with updates on progress and at some point in time approval for the 2021/22 budget.

Annual Planning for 2021/222 – you will have seen the Minister's Letter of Expectation outlining Minister Little's priorities. There are no real surprises in that, although there is the expectation on all DHBs that they will finish 2021/22 in a breakeven position. We will obviously have to have a significant discussion with the Ministry and get the Minister's approval to plan a deficit track towards a breakeven position as this will not be realistic within the 21/22 year. We have already begun these discussions with the Ministry.

I am working to progress the recruitment of the Executive team and I thank the team for their patience in their acting roles. I am very conscious of the Health & Disability System review sitting on the horizon and that we need to make sure we get some clarity and certainty at our Executive Leadership to ensure that we can strengthen our team work and make sure we are delivering a safe and supportive health system for our community.

Dr Bramley apologised for his early departure at 11am.

A query was made regarding the vaccine rollout as to when the PR campaign would commence. Board member Aaron Keown expressed concern about some comments he received on facebook when he was promoting the vaccination. Dr Bramley commented that there is no question that the government is aware of the scale of the task required in delivering this to all of our population but they are also very aware that we are going to have to provide very proactively information to inform and educate and reassure the public around the safety of the vaccine and also education around why everyone picking up the vaccine is crucial for the overall health of the population. There are plenty of myths and fears floating around the internet, so we need to work really hard to ensure that the correct information is being communicated and we are providing reassurance to people. We have good evidential assessment around the safety of the vaccine.

Sir John commented that this had also been raised at the recent National Chair's & CE's meeting.

Karalyn van Deursen, Executive Director of Communications, advised that the public campaign commenced this weekend, led by the Ministry and All of Government COVID Campaign. She also advised that there is a separate Iwi campaign nationally and locally.

A query was made regarding our vulnerable population and Dr Bramley advised that prioritisation is being led centrally and will be very much evidence based. He added that our commitment is to get to all of our population and obviously the most vulnerable will be targeted first.

Ralph La Salle, Acting Executive Director, Planning Funding & Decision Support, commented that this sequence is happening in low or no community transmission and if we do have community transmission things will change very rapidly and we will move to a different sequence.

A query was made regarding a comment that even once the whole country is vaccinated New Zealanders will still not be able to travel. Dr Bramley commented that it is probably too early to have this discussion and he is sure that these are the issues being thought through to ensure the ongoing safety of the population while also promoting travel and business and much greater freedom globally. This will also be dependent on the extent to which COVID-19 is reducing its impact globally and also the extent to which the vaccine is going to provide coverage.

The Chief Executive's update was noted.

6. FINANCE REPORT

David Green, Acting Executive Director, Finance & Corporate Services, presented the Finance Report for the month of December which was taken as read. He referred the Board to Appendix 1 which detailed the financial results including the impact of COVID-19 and Holiday's Act Compliance which tend to cloud the position. He advised that the December result showed a small

favourable variance once COVID and Holiday's Act costs were taken out. He added that the January result is a very similar result.

Mr Green advised that Holiday's Act compliance is ongoing and the COVID costs are largely covered by revenue. He commented on the sale of land on St Asaph Street used by CDHB as a carpark which was sold to the Crown for the use of the new Christchurch Sports Facility, and advised that the compensation for this will be by way of an equity contribution for the extension of the CDHB staff carpark on Antigua Street. He added that the impact of this transaction in December was a loss on sale of the asset of $1.253M and that the final accounting treatment for this transaction has not yet been determined and may change at a later date.

In regard to the $8.73M unfavourable result a request was made for some information around what the drivers of this are. The Chair of QFARC commented that the $8.73m variance is mainly made up of COVID and Holiday's Act costs.

A query was made as to whether the $1.235M would go directly to the bottom line. It was confirmed that this is the case.

A query was made as to whether we are still working to the August 2020 Annual Plan that was approved by the Board. The Chair commented that it is important to get this into context as the Board approved the annual plan in August 2020 "subject to validation." It was noted that we continue to work with the Ministry around the budget, but at this stage there is no update from the August 2020 budget.

The Finance Report was noted.

7. ADVICE TO THE BOARD

Hospital Advisory Committee (*HAC*)
Naomi Marshall, Deputy Chair, HAC, provided an update to the Board on HAC's meeting held on 28 January 2021. She highlighted the higher numbers of presentations at the hospital since last reporting and also the discussions that took place around rural health.

The draft minutes were noted.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (02/21)
(Moved: Barry Bragg/seconded: Aaron Keown - carried)

"That the Board:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of public excluded meetings – 17 December 2020	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
4.	2021/22 Planning Expectations	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Central City Primary Birthing Unit	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Ministry of Health Quarterly Financial Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	CT (Computed Tomography) Scanner Replacement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Greenstar Requirements for SMHS Relocation to Hillmorton	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Biomass Fuel Supply Tender	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Carparking	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	CDHB Controlled Coordinated Campus Planning Works Approvals & Updates	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	CDHB Capital Intention - Updated	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
13.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
14.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)

15.	Advice to Board • HAC Draft Minutes *28 January 2021* • QFARC Draft Minutes *26 January 2021*	For the reasons set out in the previous Committee agendas.	

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

The Public meeting concluded at 10.05am

_____ _____

Sir John Hansen, Chair Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 18 MARCH 2021

DATE	ISSUE	REFERRED TO	STATUS
15 Oct 20	Review of CDHB/Manawhenua MOU	Dr Peter Bramley	Under action.

CHAIR'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

TO: **Chair & Members, Canterbury District Health Board**

PREPARED BY: **Dr Peter, Bramley Chief Executive**

DATE: **18 March 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing the latest update and overview of key organisational activities and performance from the Chief Executive to the Board of the Canterbury DHB. Content is provided by Operational General Managers, Programme Leads, and the Executive Management Team.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

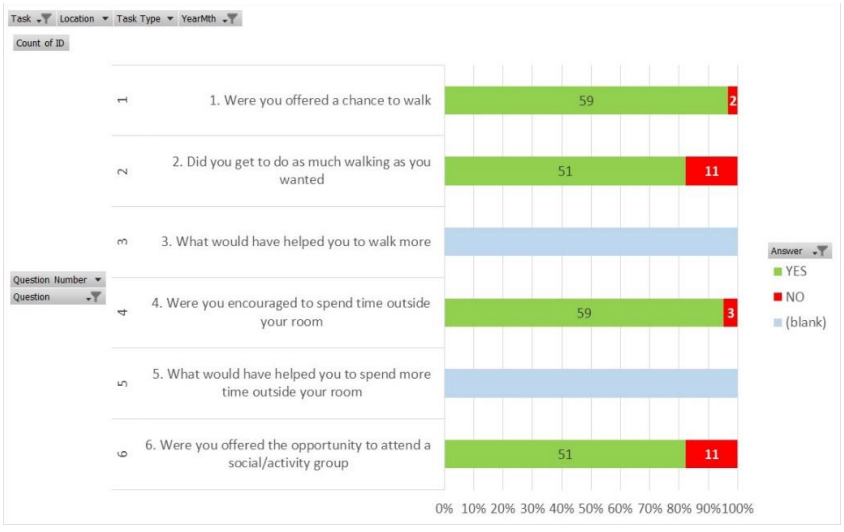
3. DISCUSSION

MAKING A DIFFERENCE FOR OUR POPULATION

Rethinking Rehab: In June 2019, Older Person's Health and Rehabilitation held a series of workshops and presentations to generate ideas and actions aimed at increasing the levels of activity across our Older Persons Health inpatient wards, to support strength and balance and restorative care. Three key working groups were set up to take forward these ideas:

- How we can provide our patients with more rehabilitation focused activities.
- How we can make the most of our purpose-built facility – especially the social spaces.
- How can our volunteers be involved in group or one-on-one activities.

A follow up audit has found that significant improvements had been made across all of these areas with over 80% of patients reporting that they had been offered opportunities to mobilise, spend time in shared spaces and participate in activities on the ward.



CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

COVID UPDATE

The latest national announcement on the rollout of the wider vaccination programme has seen our teams step up their planning to another level. The national programme expectations are:

- Tier 1 - Border and MIQ workers, their household contacts and the people they live with. This started last month, the vast bulk will be completed this month, with at least one dose administered.
- Tier 2 - Frontline workers and people living in high-risk settings. Starting with healthcare workers on community frontlines, and then moving through to healthcare workers protecting our most vulnerable and some priority populations. This started in February and will continue through to May.
- Tier 3 - Priority populations who are at higher risk if they catch COVID-19, planned to start in May.
- Tier 4 - The remainder of the general population – starting from July.

Canterbury DHB continues to progress the first phase of the COVID-19 vaccine rollout in our region. To 8 March 1,853 Tier 1 (MIQF and boarder workers) vaccinations have been delivered, with clinics operating at each of the six MIQF sites, the Port and the Orchard Road (airport) testing site.

We expect to begin vaccinating household contacts of our border workers from the week beginning 24 March, starting from a single clinic location and then expanding further. We are establishing three fixed clinic locations across Christchurch which will be supported by several pop-up clinics at locations chosen based on where we know household contacts live, enabling us to move rapidly to reach this group. We are also in the process of designing a more flexible mobile clinic to ensure we're able to reach our most vulnerable household contacts.

The training to deliver COVID-19 vaccinations is a complex and multi-step process coordinated by the DHB and the Ministry of Health. We have approximately 25 nurses trained to vaccinate, with a further 41 recovery/administration staff trained to support the wider rollout. We are currently recruiting to bolster our vaccination teams' resources and hope to recruit approximately 30 more vaccinators and 30 support staff. The vaccination rollout programme has been timed to ensure we can train enough staff to start household vaccinations the week of 24 March.

Equity for our most vulnerable populations is foremost in our planning and we continue to work with our Māori and Pacific partners to ensure there is an equity lens across our vaccine rollout.

MĀORI AND PACIFIC HEALTH

Performance Highlights

New Service Supporting Youth: On 19 February 2021, Odyssey House, Purapura Whetu Trust and several other non-government organisations were joined by Minister Andrew Little to launch Manu Ka Rere as part of the national expansion of mental health and addiction services. The service's name 'Manu Ka Rere' is derived from the whakatauki "mā te huruhuru, ka rere te manu," which means that adorned with features the bird is able to fly. This new nationally funded service targets 13-24-year olds with mild-moderate mental health and addiction needs and is expected to benefit an additional 1,000 rangatahi or young people in Canterbury over the next four years.

Whānau Whakapuawai (Supporting Whānau to Blossom): This new Kaupapa Māori maternal mental health service is being developed and offered by Te Puawaitanga ki Ōtautahi Trust. Funded by Te Ao Auahatanga Hauora Māori (Ministry of Health, Māori Innovation Fund), this pilot service offers both clinical and cultural pathways to wellbeing for māmā, pēpi and their whānau. Māmā and hapū māmā who

are experiencing mild to moderate mental health distress can be referred to the service via their Tamariki Ora/Well Child Nurse or the Whānau Mai/Kaupapa Māori Antenatal Education programme. The focus is on developing and supporting connection, self-determination and building community.

PUBLIC HEALTH SERVICES

Performance Highlights

Getting Through Together: The Getting Through Together campaign contract has just been extended to the end of June 2021. This will enable the partnership with the Mental Health Foundation of NZ and Te Hiringa Hauora (Health Promotion Agency), to extend the summer campaign from December through to mid-March - reminding people that even when times are tough, it's the simple things that bring us joy, and see us through – ahakoa he iti, he pounamu. Campaign research from the start of February shows that the campaign's effectiveness is strong, although reach seems to have decreased due to reduced media expenditure. The research shows the campaign performs especially well with Maori.

Health in All Policies (HiAP) Annual Report: The 2020 Health in All Policies Annual Report highlights the wide variety of ways the HiAP approach has been implemented in Canterbury during the last year, and the many projects and adjustments that have positive benefits for health, the environment and the climate. The Health in All Policies (HiAP) team at Community and Public Health wants to express sincere gratitude to all our partners, community organisations, and other changemakers in the region. The adaptations needed to face the challenges of the past year have created some positive and hopefully sustainable changes to priorities and the way we all work to create healthier places and improve the wellbeing of people in Canterbury.

PRIMARY AND COMMUNITY SERVICES

Performance Highlights

Working Towards a Smokefree Canterbury: The delivery of core health programmes in primary care settings has been challenged over the past 12-18 months by COVID-19 testing, measles vaccination programmes, changes in physical restrictions and a move to a new patient management system in general practice. We have noticed a drop in the delivery of ABC for smokers in primary care – the Ask, give Brief advice and offer Cessation support approach helps to encourage smokers to quit.

Canterbury's three Primary Health Organisations (PHOs) are working to improve performance in this space by refocusing support teams and identifying Māori and Pasifika stop smoking champions in key practices. In quarter two all three PHOs improved their performance against the national measure – the percentage of the population enrolled in PHOs being offered ABC.

	Quarter one	Quarter two	Change
Waitaha Primary Health	85.9%	88.1%	+ 2.2%
Christchurch PHO Limited	71.7%	73.3%	+1.7%
Pegasus Health (Charitable) Limited	65.0%	68.5%	+3.5%
Canterbury DHB	68.0%	71.2%	+3.2%

In addition, Canterbury's stop smoking service Te Hā – Waitaha has targeted programmes for our priority populations running alongside its general quit service. The pregnancy incentivisation programme provides free medications (NRT products and Quickmist) and behavioural support for people to develop

and maintain strategies and coping mechanisms and support positive outcomes. Sessions are provided to individuals and groups and this has been widely adopted by community providers. There have been 281 enrolments of pregnant women in Te Hā - Waitaha in the past 12 months, of those 132 people (47%) became smoke free (carbon monoxide-validated at 4 weeks).

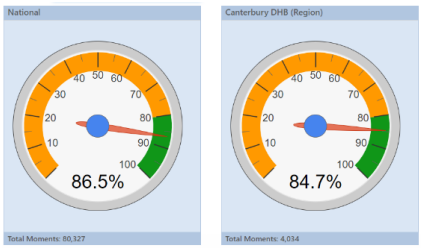
Equity Initiative

Equity Focus Introduced to HealthPathways: Working closely with Clinical Lead for Māori Health in Planning & Funding, the HealthPathways team are developing a toolkit to ensure that equity for Māori is applied to all HealthPathways developments and reviews. A new Māori Health Services page outlining all the different Hauora Māori services available in Canterbury is in development and an increasing number of these service providers have been set up with the electronic referral management service (ERMS) so they can receive direct referrals. The goal is to promote awareness of the availability of these services to general practice to help reduce barriers to referral and promote choice for Māori service users.

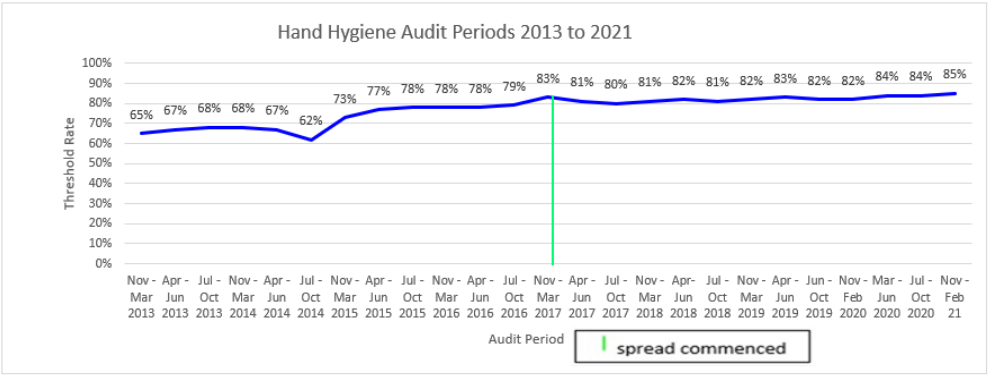
At a national level, the Canterbury HealthPathways team are members of the Aotearoa HealthPathways Support for Health Equity Group. Formed from all HealthPathways regions throughout New Zealand, the Group has a shared goal of improving Māori Health outcomes through a collaborative approach to identifying and implementing improvements in HealthPathways.

PATIENT SAFETY, QUALITY & IMPROVEMENT

Performance Highlights



Hand Hygiene Results Positive: There is a continued focus on Hand Hygiene across Canterbury DHB with raised awareness due to the COVID-19 virus. For the thirteenth consecutive audit period the 80% hand hygiene threshold has been exceeded with 84.7% compliance with good hand hygiene practice (5,263 moments) for the audit period 1 November 2020 – 28 February 2021. Spreading the hand hygiene programme across the organisation continues and is now inclusive of Specialist Mental Health Services, Operating Theatres, Christchurch Campus and additional areas undertaking invasive procedures. Services are encouraged to investigate why moments are being missed and identify targeted actions.

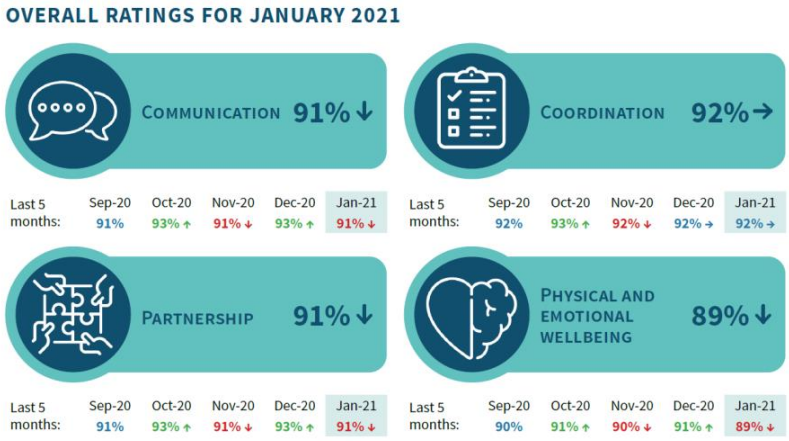


The COVID-19 Managed Isolation Facilities Survey: The consumer survey is now in its fifth month. The questions are similar to the DHB's patient experience questionnaires used for inpatient, outpatients and general practice, with specific service additions. Understanding how people experience their stay in managed isolation gives us valuable insight and an opportunity to celebrate our success, do more of what

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

we are doing well and to consider how we can do better. The Canterbury DHB is undertaking this survey on behalf of all the agencies that contribute to the guests' stay in managed isolation. In January 2021, 425 surveys were completed with a response rate of 32%. The high results achieved show a small amount of variation month to month.



LIVING WITHIN OUR MEANS

Performance Highlights

The consolidated financial result for the month of January 2021 is a net expense of $9.638M, being $1.982M unfavourable to the Annual Plan agreed by the Board in August 2020. This result includes the impacts of COVID-19 ($0.778M unfavourable) and Holidays Act compliance ($1.475M unfavourable). The YTD result is $10.703M unfavourable to the Plan. The following table provides the breakdown of the January result:

		MONTH			YEAR TO DATE		
		Actual	Budget	Variance	Actual	Budget	Variance
		$M	$M	$M	$M	$M	$M
Governance		0.175	(0.000)	0.175	0.141	(0.000)	0.141
Funder		(2.943)	(1.798)	(1.145)	(49.285)	(47.622)	(1.663)
DHB Provider		(6.870)	(5.858)	(1.012)	(49.236)	(40.055)	(9.181)
Canterbury DHB Group Result		**(9.638)**	**(7.656)**	**(1.982)**	**(98.380)**	**(87.677)**	**(10.703)**

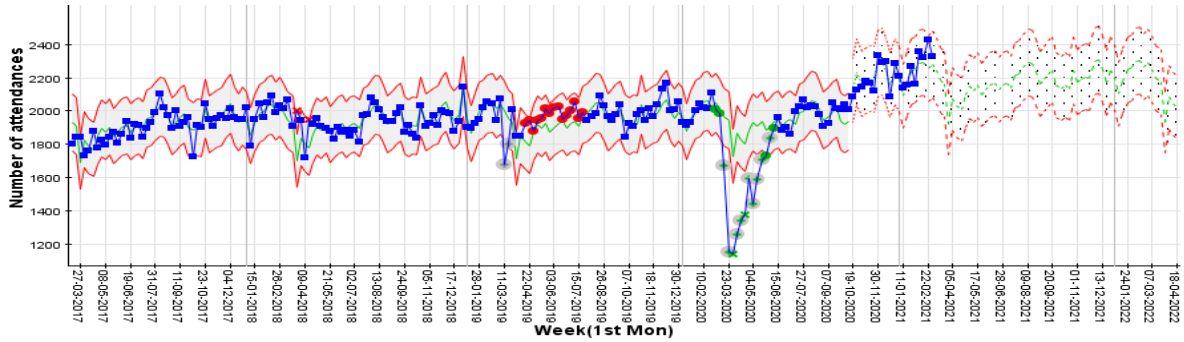
MEDICAL / SURGICAL SERVICES

Performance Highlights

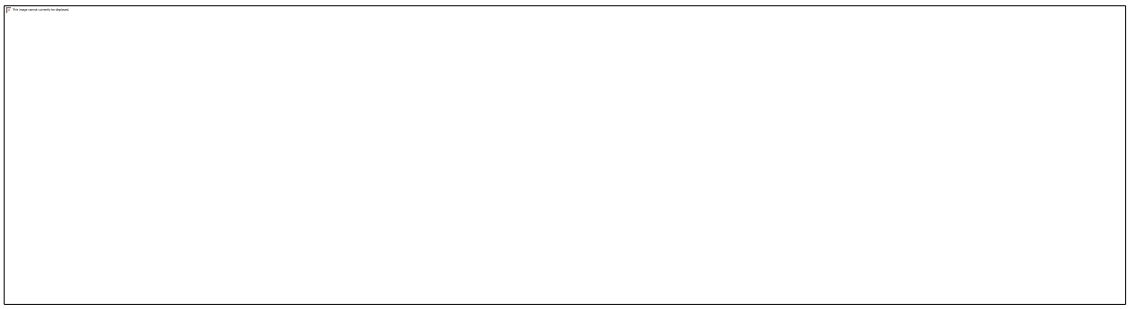
Sustained Demand in Christchurch Hospital Emergency Department (ED): The increased number of people presenting to ED remains a significant challenge. There were 9,200 presentations to the Christchurch Hospital ED during February 2021, 9% growth compared to the previous year. Analysis shows the increase in demand continues to incorporate an increase in self-referrals and an increase in Triage 4 and 5 presentations where people could be appropriately seen in a primary care setting.

A collaborative project, 'Making Waipapa Flow', involving the ED and Canterbury Initiative teams is examining opportunities to improve patient care and flow. One initial focus is on identifying cohorts of patients who are best managed outside of ED and working with referrers (including Lead Maternity Carers, general practitioners and others) to make them aware of HealthPathways and other management options. The Urgent Care Service Level Alliance and Acute Demand Management Service are also

working to ensure people are accessing appropriate services in the community and that community HealthPathways are up-to-date and socialised.



Access to Planned Care: As at the end of February (end of week 36), we have delivered 28,303 Planned Care interventions, 7,186 over plan. This is largely driven by exceeding our planned targets for minor procedures delivered in the hospital and community by 8,017 procedures. Inpatient surgical discharges are behind schedule by 681 discharges, largely driven by decreased activity over the Christmas and New Year holiday period with delivery expected to get back on track in the coming months.



As part of the DHB's Planned Care Improvement Plan a weekly target is in place for the number of patients waiting longer than 120 days for First Specialist Assessment. There are currently 1,956 people waiting for longer than 120 days against an overall target of 930. A similar pattern applies to waiting time for surgery or other treatment. Services are aware of and committed to meeting the plan's ultimate target and a multitude of actions now occurring to address these long waits.

Bariatric Surgery Services Returning: It has long been planned to repatriate this surgery and the associated dietetic care back in-house as part of the return of outsourced and outplaced services. Recent national Planned Care Improvement and Sustainability funding has provided an opportunity to begin the process and the opportunity to develop improved internal processes and competency in delivery of the services associated with bariatric surgery. We are seeking to improve both patient experience and outcomes for our population.

Equity Initiative

Shorting Hospital Stays: Bronchiectasis hospitalisations is an area of inequity for our priority populations with Pacific people six times more likely to be hospitalised compared with Pākehā and Māori three times more likely. The length of stay in hospital was also significant longer for both Pacific and Māori patients at 6 and 5.8 bed days compared to 4 for non-Māori patients. A re-designed bronchiectasis clinic has been in place for 12 months and is achieving its aim of improving treatment for these priority group, making the process more acceptable for patients and enabling them to return home sooner. Improvements have meant the length of stay for Māori has dropped from 6 bed days to 4.5 bed days.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

Workforce Highlight

Leave Care: Between between July 2020 and February 2021, 650,387 hours of annual leave were taken by staff across the Medical/Surgical division, an increase of over 60,000 hours on the same period last year. The number of people in the division with annual leave balances >100 days has reduced to 16 people. Work on reducing the high leave balances amongst of staff will improve overall health and wellbeing and it is anticipated will impact on sick leave rates which are high across the DHB.

Accelerating Our Future Update

Recycling Good for the Environment and the Budget: Pillows sent to Canterbury Linen Services were previously being discarded. Christchurch Hospital and Canterbury Linen Services have worked together to improve process so that some pillows are able to be cleaned and returned to use. This initiative has saved over $8,000 since July 2020 and is forecast to save nearly $12,000 this financial year.

Changes in Social Work Model: Changes have been made to the after-hours model for social workers, which previously relied on call backs and overtime, to one that relies on a shift system and ensures that social workers are available on-site afterhours. The social workers involved report increased job satisfaction with less on-call and overtime associated with their roles. The change is also forecast to save over $225k in overtime and on-call costs by the end of the financial year.

Risk Management Update

Occupancy at Christchurch Hospital is currently at levels not previously experienced during Summer. Population based acute (surgical and medical) demand forecasts combined with the planned theatre generated bed occupancy indicate that there could be several weeks during the year that demand could exceed resourced beds and the physical capacity of wards. General Medicine in particular is operating outside of its current footprint, which means general medicine patients are distributed across many wards. This impacts on the time it takes to complete rounds and on the length of stay for general medicine patients and other patients in the wards where the wider multi-disciplinary teams are drawn off the care of their normal cohort to support the general medicine patients.

Campus clinicians, managers and planners are working together to review the allocation of resourced beds and service models to minimise the impact of this demand. A renewed focus is also being placed on improving utilisation of operating theatres by focussing on optimising processes to ensure the first case starts on time. This work will help to mitigate increases in demand for increased theatre capacity.

Anaesthetic Technician Capacity: There is currently a shortfall of anaesthetic technicians that will increase between now and the end of May. Recruitment attempts within New Zealand have failed to identify any suitable applicants, but two new employees are expected from the UK in April. A specialist recruitment agency has been engaged to support this work and anaesthetic technician overtime and casuals are being used as appropriate to support continued service delivery.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

OLDER PERSONS HEALTH & REHABILITATION | COMMUNITY DENTAL

Te Ara Whakapiri/Care in the Last Days of Life: Te Ara Whakapiri is an evidence-based programme, developed by the Ministry of Health to help deliver quality care at the end of people's lives. It was implemented throughout the DHB in 2017. A recent audit was carried out on the use of this pathway at Burwood Hospital, with the main findings showing good uptake of Te Ara Whakapiri, with our staff supporting patients and whanau to discuss these options. The audit results for levels of anticipatory prescribing indicate there is widespread knowledge regarding the importance of this aspect of end of life care. A repeat audit has been scheduled in 2022.

- 22 of 23 (96%) patients commenced on the Te Ara Whakapiri pathway prior to their passing.
- A DNACPR order was in place for 22/23 (96%) patients.
- Anticipatory prescribing was evident in Medchart in 17/23 (74%) patients and non-essential medications were discontinued in 17/23 (74%) patients.

Equity Initiative

Project Search: Older Person's Health and Rehabilitation welcomed the third intake of Project Search interns to the site in February with an event held at Burwood Hospital on 3 February for the 2021 interns and their whanau. Project Search is a business-led internship for high school leavers aged 18-21 years old who have learning disabilities, and who want to enter the workforce. Eight interns per year work in rotating placements across Burwood Hospital for 10 weeks each time, alongside a DHB mentor and Project Search skills trainer. The division is proud to be the first place in New Zealand to have supported this programme and continues to seek new opportunities for our interns to gain workplace skills and experience. The Project Search Steering Committee also works alongside previous interns to help find them paid employment. Several of the staff who have supported the interns were invited to speak at Christchurch City Council Holdings Limited in January, an opportunity to encourage more business to offer placements and employment.

Workforce Highlight

Support Safe Staffing: Inpatient areas are progressing well with implementation of the Care Capacity Demand Management Programme for nursing, meeting the standard for inter-rater reliability for the TrendCare platform during January, which allows us to now consider the data live. TrendCare will help to inform nursing resource decisions balancing staffing levels with patient acuity and will support our obligations for safe staffing and a healthy workplace. The Canterbury DHB has been commended by Central Region Technical Advisory Services for the speed with which our teams have implemented the use of TrendCare into their daily workflow and the quality of data at this early stage of implementation.

Risk Management Update

Fit-testing: The division is currently expediting a fit testing programme to ensure that staff are correctly fit tested (for masks) in line with guidance. This is a particular area of focus within our Older Persons' Mental Health acute admission pathway as there could be a requirement to directly admit a patient from managed isolation facilities or respond into MIQF for acute assessments. One member of staff is already fully trained and undertaking fit testing and plans are in place to train another two fit testers in March.

CHIEF EXECUTIVE'S UPDATE

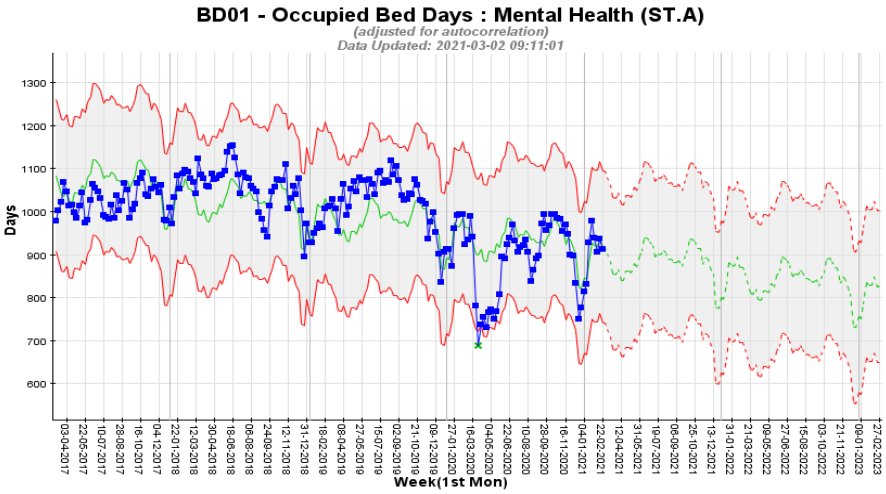
Canterbury District Health Board
Te Poari Hauora o Waitaha

SPECIALIST MENTAL HEALTH SERVICES (SMHS)

Performance Update

Shorter Wait times: Demand for child and adolescent services has eased from the peak seen in the latter half of 2020; this has resulted in a reduction in waiting times. We are monitoring this situation closely.

Occupancy of our inpatient units is also lower than much of New Zealand. We speculate this may be due to our integrated model of care and that Cantabrians building a degree of resiliency from their experience of the Canterbury earthquakes, Port Hills fire and Mosque attacks.

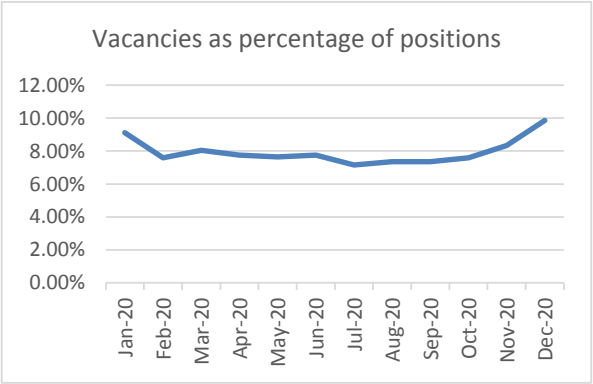


Facilities Work Progresses: The extension to the Whaikaha (AT&R) building is nearing completion. While there will be no increase in overall bed numbers, this extension will enable the unit to offer a more therapeutic environment and space for some of our most complex consumers. Expected occupation is the week after Easter, dependent on the installation of the mobile duress system.

Work has begun on the new buildings on the Hillmorton Campus which will house the Child and Youth Inpatient unit, Mothers and Babies and Eating Disorders Inpatient Unit, and Mothers and Babies and Eating Disorders Outpatients. The excavation and ground work necessary for the building is well underway. Work has also started on excavating and compacting the site for the building that will replace Princess Margaret Hospital's Seager Unit.

Risk Management Update

Staffing: There are still several vacancies across services within Specialist Mental Health Services and the Intellectual Disability Service is currently under resourced. We are also reviewing baseline clinical FTE due to an increase in acuity and complexity of the people we are caring for. Staff with the necessary experience and skillset are often not available in New Zealand and need to be sourced from overseas. This is proving challenging given the current border restrictions. Active recruitment is underway to ensure robust rosters are maintained.



CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

ASHBURTON RURAL HEALTH SERVICES

Performance Highlights

Development of Balanced Score Card: To support the operational performance and accountability of the wide-ranging services provided through Ashburton Health services, the division has developed a collective balanced score card framework identifying core system measures that contribute to overall performance. Four quadrants of performance will be measured: Quality and Safety; Service Delivery, Financial Performance and Workforce to help the team to move away from traditional volume measures and think of performance with a multi-faceted lens. Each service cluster is supported to complete an annual service plan with associated balanced score card. This work will enable the clinical, operational and senior management team to consolidate information on performance and address external and internal barriers for success.

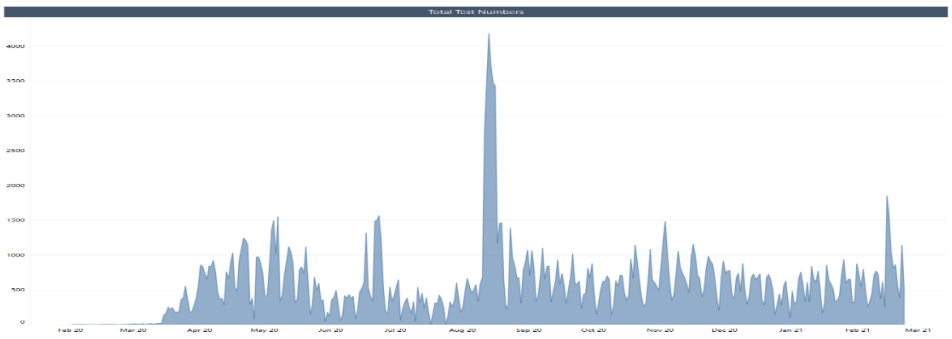
Workforce Highlights

Adopting a Learning Framework for Leaders: The Ashburton Health division have partnered with People and Capability to enable the delivery of Te Huarahi Hautū over the next six months. Te Huarahi Hautū is about equipping our leaders with the right tools to enable them to reach their full potential. The programme will provide an understanding of everyday processes like financial management, time and attendance and employee relations. This work will bring together the wider campus and we aim to share our journey and visioning with our colleagues also operating smaller teams and generalist/broad scope of practice models. We are exploring suitable opportunities for primary care leadership to join components of the workshops.

LABORATORY SERVICES

Performance Highlights

COVID Testing: During February, the COVID response team have managed surges of testing volumes due to the community cases in Auckland (approximately 5000 tests between 16-20 Feb). The team has also performed a technical and clinical verification of saliva testing following the Ministry of Health directive on daily saliva testing of MIQ staff and are investigating alternative rapid, automated methods for saliva testing. COVID e-orders from MIQ facilities is progressing and will make a significant difference to flow of samples into the laboratory. The electronic registration of COVID test requests by MIQ staff will mean less duplication and manual transcription when the patient sample reaches the laboratory. CHL is also focussing on increasing robotics within the COVID testing process to minimise repetitive strain injuries from de-capping and recapping sample tubes. A review of facilities in relation to employee health and safety and optimal COVID testing workflow is ongoing.



CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

EFFECTIVE INFORMATION SYSTEMS

Performance Highlight

Enabling Digital Connectivity: The DHB's Information Services Group is enabling the local digital response for the COVID-19 Vaccination Programme. This includes building laptops and deploying mobile phones for team members and establishing vaccination site Wi-Fi coverage and connectivity, so vaccinators can access the Ministry's COVID-19 Immunisation registry. Our Technicians and Service Desk Teams are providing ongoing support and we have had our staff onsite to troubleshoot connection issues. We are anticipating further demand for digital services and support as the vaccination programme is rolled out.

Workforce Highlight

COVID MIQ Facilities Software Training: The DHB's Information Services Group is engaged with the Ministry of Health to lead the local rollout of the Border Clinical Management System in Christchurch MIQ sites. This electronic practice management system will be used to record clinical details of guests, in terms of the mandatory testing and daily check-in processes, and other clinical needs of guests during their stay in MIQ sites. We have connected with the rollout team in Auckland to understand and learn from their plan and approach. Approximately 110 staff working in MIQ hotels will need training and different option for delivering the training will be considered as a group setting is not viable.

Accelerating our Future Update

Electronic Delivery of Outpatient Clinic Letters: We are continuing to send clinical letters electronically from general surgery to general practice. The electronic process is running in parallel with the manual process, so we can thoroughly test, investigate and address any issues. We are currently working through one remaining issue and once this is resolved we will stop sending general surgery letters by post and begin working with another specialty to include this new process into their workflows.

Risk Management Update

Paging Replacement System: Our paging system is end of life and requires replacement. We are currently engaging with key areas of the organisation to define our business and integration requirements and specifications, and understand the users, roles and numbers that will be impacted.

Cyber Security: Canterbury DHB continues to make inroads to increasing our maturity to mitigate the risk of cybersecurity threats. This includes updating policies, delivering security awareness and phishing training, penetration testing and remediation and improving security solutions such as email, web and end point security. We have recently installed an improved End Point Protection solution onto our VMWare and Citrix VDI environments, and the majority of our servers and desktops. With this tool we have greater visibility of our security posture. We are examining our resourcing needs, so we have the capacity to monitor and respond to current and emerging threats in a timely manner.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Performance Highlights

MMR Vaccination Campaign Rollout: The rollout of the 'Guardians of our Future' MMR (Measles, Mumps & Rubella) campaign is continuing.

COVID19 Vaccination Programme: We are receiving large volumes of media requests in relation to the vaccination programme. Our first vaccinations were delivered to vaccinators on Wednesday 24 February 2021, with our first MIQ and Border workers vaccinated the following day. Together with the Ministry of Health we coordinated a media event to promote the start of border worker vaccinations. A media briefing was held at Christchurch International Airport and focused on Health Protection Officers Debbie Smith and Jimmy Wong and Cherry an airport cleaner employed by OCS, who all received vaccinations and spoke to media about their experience and why they felt compelled to get vaccinated. Clinical nurse specialist John Hewitt, a DHB clinical adviser for COVID-19 vaccination, also spoke to media about the rollout of the vaccination programme in Canterbury.

We continue to promote the COVID-19 key messages with staff and in our external communications, and are working on a campaign to encourage all staff to scan in at work, every day, using the government's COVID-19 tracer app, and have Bluetooth turned on within the app. This is particularly important for those who work shifts and move between facilities. In the event of staff being exposed to a case within any of our facilities, being sent a 'push notification' via the app by the Ministry of Health means people who have been potentially exposed can be notified and isolate sooner.

DHB Website Use High: While the Unite Against COVID-19 website www.covid19.govt.nz and the Ministry of Health website www.health.govt.nz provide the most up to date and accurate information available for the public, particularly around locations of interest, Canterbury DHB's website is the source of truth for local information regarding visiting hours and testing centres. Visits to the Canterbury DHB website have increased to over 4,000 visits a day (compared to 3,000 visits a day when at Alert Level 1.) In addition, there's been a 220% increase in the number of visits to our COVID-19 information webpages as a result of the Alert Level changes. The most visited areas of the page include COVID-19 community testing locations and visitor information for Christchurch Hospital.

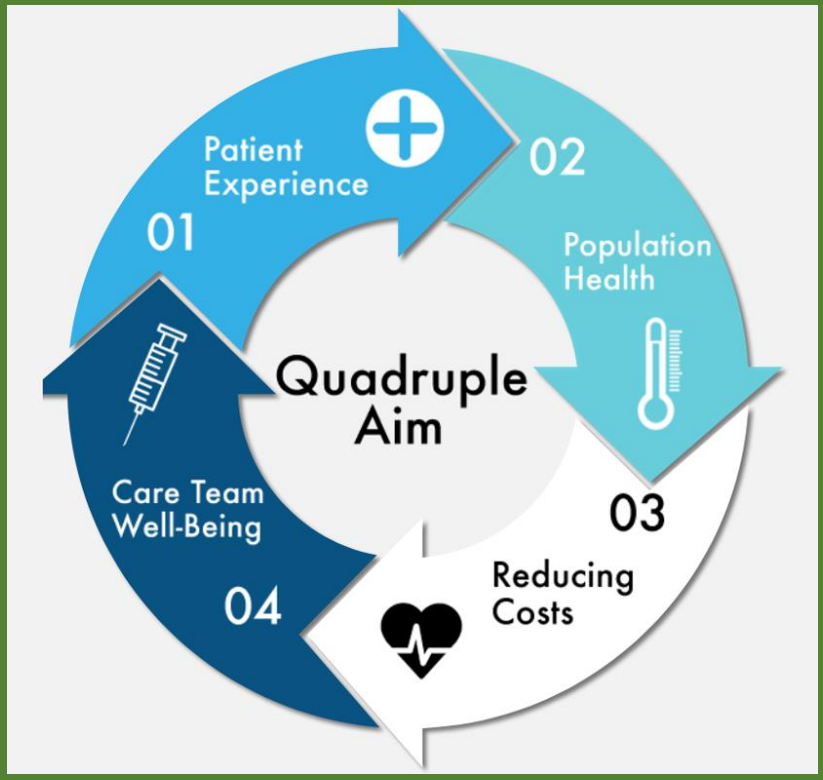
Allied Health: The Value Proposition in 21st Century Health & Disability System

Strategic Plan: Our Aims

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

Institute of Health Care Improvement Quadruple Aim



Canterbury District Health Board
Te Poari Hauora o Waitaha

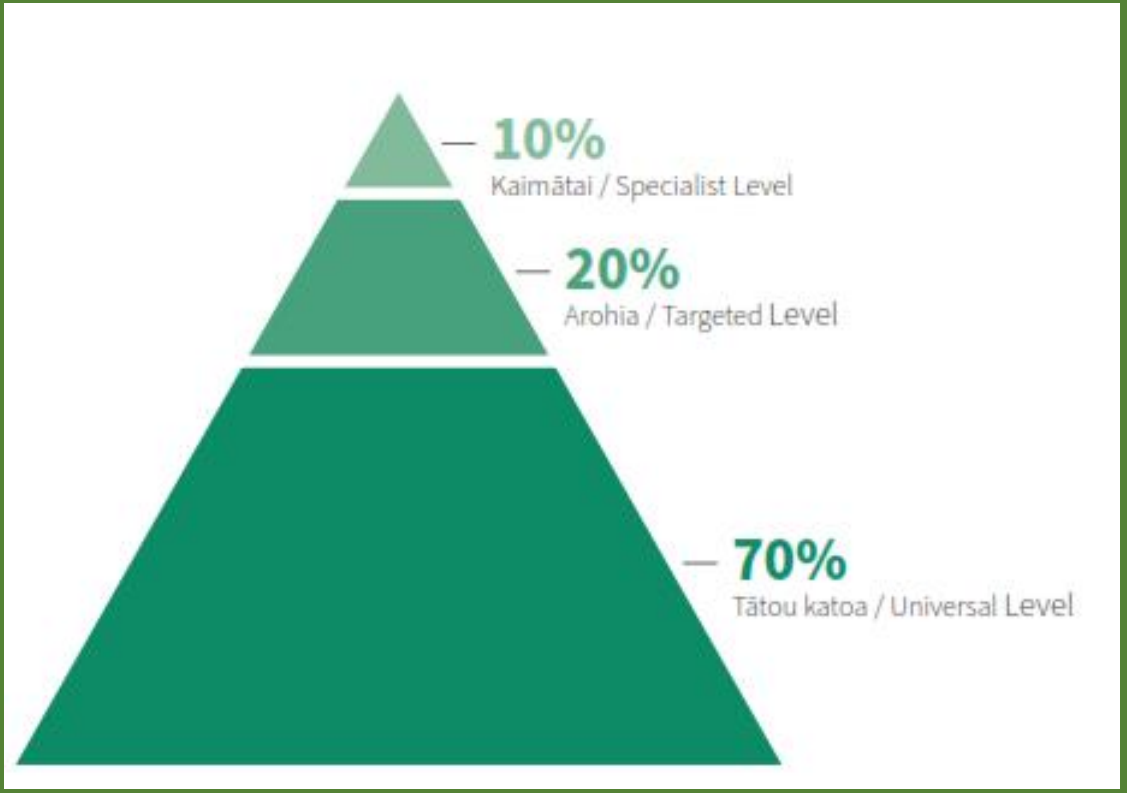
West Coast District Health Board

Stepped Model of Care

Individual

People Focus

Population



High

Resource Intensive

Low

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

Why Does It Matter?

A **fair** health system prioritises **equity**

Definition of equity

In Aotearoa New Zealand, people have **differences** in health that are not only **avoidable** but **unfair** and **unjust**.

Equity recognises different people with different levels of advantage **require different approaches and resources** to get equitable health outcomes.

Rights

Upholds the rights of people, especially under Te Tiriti o Waitangi

&

Needs

Addresses unfair differences between population groups

- Whānau-centred services
- Competent workforce
- Systems
- Tools
- Funding

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

Why Does It Matter?

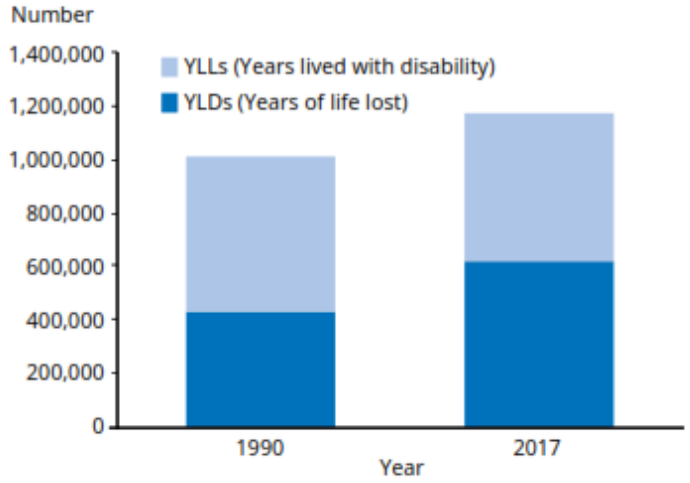
- Global Burden of Disease NZ 2020
- Inequitable Outcomes
- Population Changes
- Public Expectations
- Value Based Care:
    i. Prevention
    ii. Early Intervention
    iii. Enablement

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

2020 Global Burden of Disease NZ

Figure 21: Number of years of life lost and years lived with disability, 1990 and 2017



YLD Ranking	
1	Low back pain
2	Falls
3	Headache disorders
4	Anxiety disorders
5	Depressive disorders

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

2020 Global Burden of Disease NZ

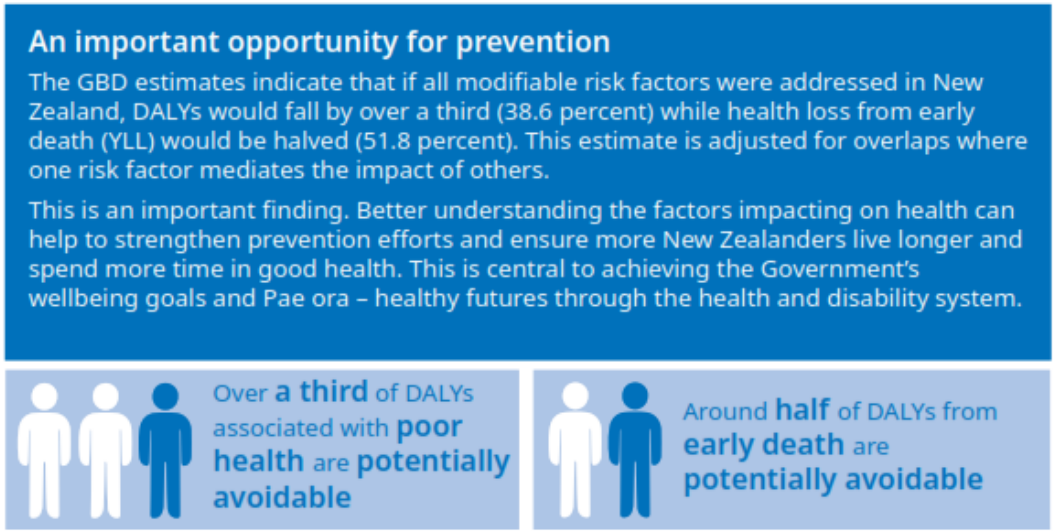
- People are living longer but, at the same time, life expectancy has increased at a faster pace than healthy life expectancy which means we are also spending more years in poor health.
- Māori and Pasifika tend to develop a range of non-communicable diseases or long term conditions at an earlier age, live more years with disability and have a higher mortality rate than other non- Māori, non-Pasifika counterparts

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

2020 Global Burden of Disease NZ

Figure 33: The attributable burden of risk factors



Note: The GBD estimates the **attributable burden** – the burden of health loss that is due to exposure to risk factors in a given year in the past. In contrast, **avoidable burden** estimates how changes in current and future exposure to risk factors can change our future level of health. However, the attributable burden is likely to be highly correlated with avoidable burden. In this report, we use the term **potentially avoidable** as attributable burden. In addition, we calculate population attributable fraction (PAF) for each outcome from each risk. The counterfactual level exposure is the theoretical minimum risk exposure level (TMREL). TMREL is the maximal proportion; in real life it is not always possible to reach this low-risk exposure level (for example, no smoking at all).

3 of the Top 6 Modifiable Risks

1. Child & Maternal Malnutrition
2. Low Physical Activity
3. Poor Diet

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

2020 Global Burden of Disease NZ

- Allied Health Practitioner subject matter experts
- Nutritional support, advice and treatment
- Exercise/physical activity
- Rehabilitation and restorative care and supported self management
- Clinically effective and cost effective across all care groups and conditions
- Need to evolve our strengths based community delivered approach in partnership with the people, whanau and communities we serve.

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

Allied Health Led Pathways

Sustainability/Planned Care Initiatives

- Physiotherapy led pathway for urinary incontinence – conservative management approach including pelvic floor muscle training.
- Physiotherapy led pathway for respiratory patients to reduce bronchiectasis, reduce admissions and support self-management in the community.
- Dietician led pathway for gastroenterology – conservative management of gastric problems for category 2 patients.
- Dietician led pathway for gestational diabetes (GD) to support enhanced equity outcomes and enable more women with GD to be able to birth naturally.

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

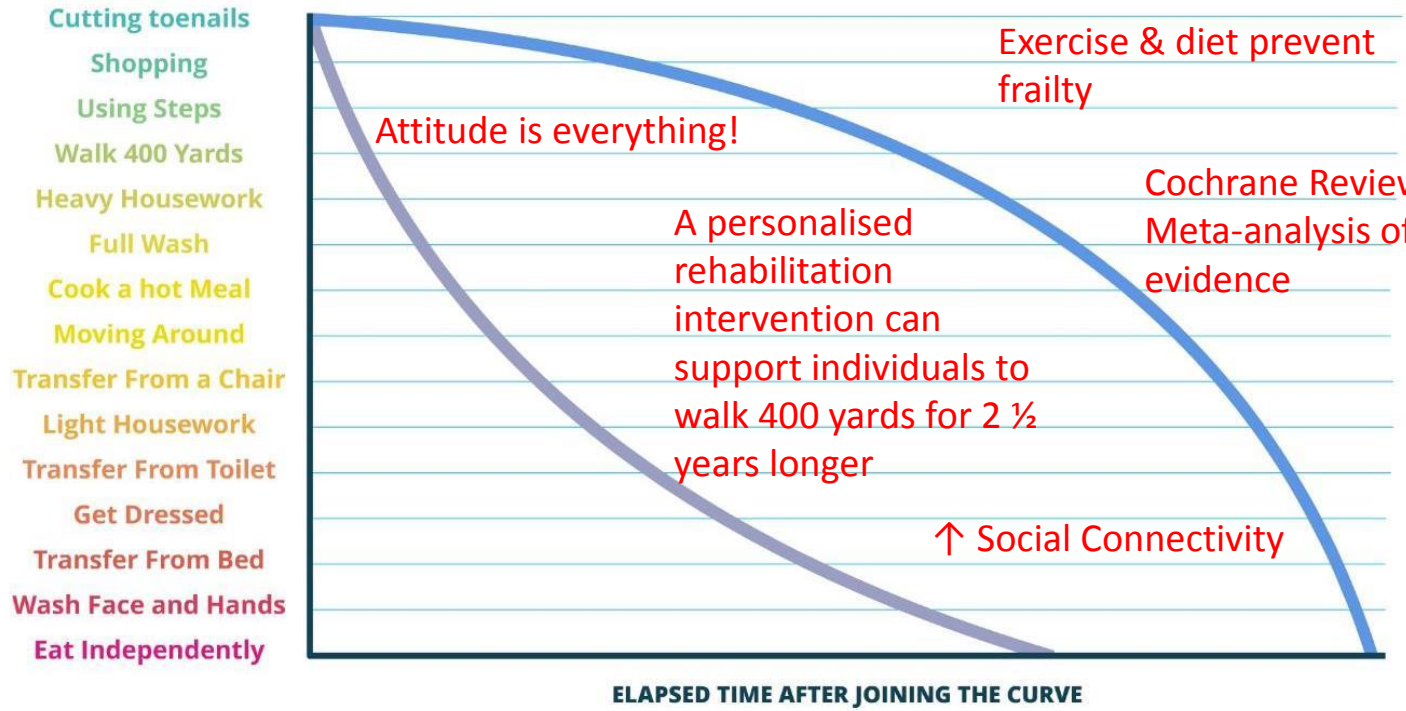
Physical Activity Facts

- 40% of Kiwis are physically inactive (80% of teenagers)
- 30% of Kiwis are classified as obese (ethnicity variables - 30%, 48%, 63%)
- Low cardio-respiratory fitness is the consequence

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board

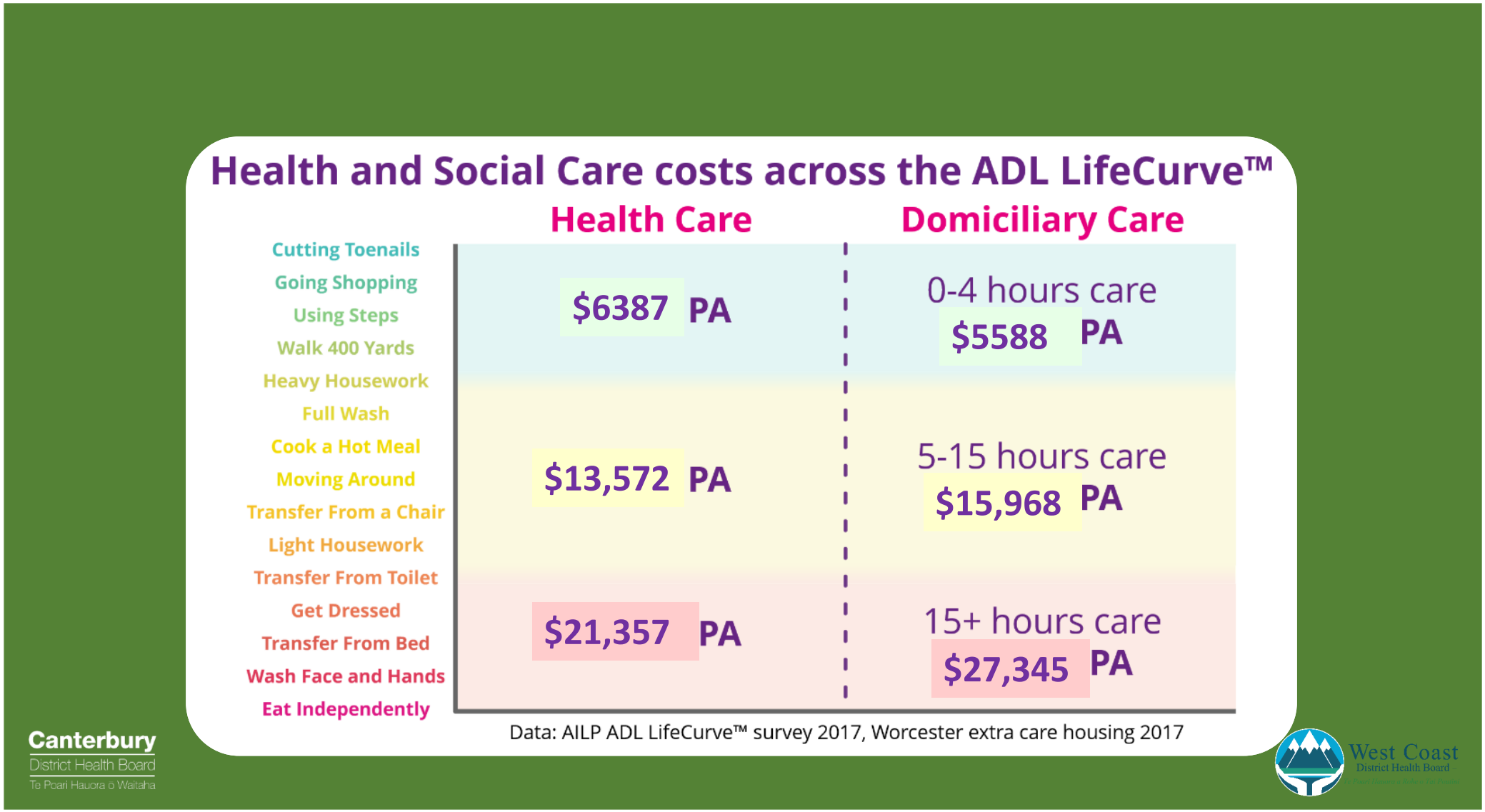
The LifeCurve: A Model of Accelerated Function Decline



Frailty is not inevitable, but it is predictable

Canterbury District Health Board
Te Poari Hauora o Waitaha

West Coast District Health Board


Health and Social Care costs across the ADL LifeCurve™
Health Care
Domiciliary Care
Cutting Toenails
Going Shopping
Using Steps
Walk 400 Yards
Heavy Housework
Full Wash
Cook a Hot Meal
Moving Around
Transfer From a Chair
Light Housework
Transfer From Toilet
Get Dressed
Transfer From Bed
Wash Face and Hands
Eat Independently
$6387 PA
$13,572 PA
$21,357 PA
0-4 hours care
$5588 PA
5-15 hours care
$15,968 PA
15+ hours care
$27,345 PA
Data: AILP ADL LifeCurve™ survey 2017, Worcester extra care housing 2017
Canterbury
District Health Board
Te Poari Hauora o Waitaha
West Coast
District Health Board

Eat Walk Engage - RCT, Queensland

A comprehensive restorative care programme that improves outcomes for older adults in hospital.

Problem Identified

- 32% of people in hospital are under-nourished
- Up to 5% muscle mass per day can be lost from lying in bed
- ↓ 5% bodyweight impact on pressure care

Outcomes

- ↓ 42% reduction in likelihood of delirium
- ↑ 46 % in likelihood of discharge home
- ↓ length of stay
- 4-1 return on investment

Canterbury District Health Board
Te Poari Hauora o Waitaha

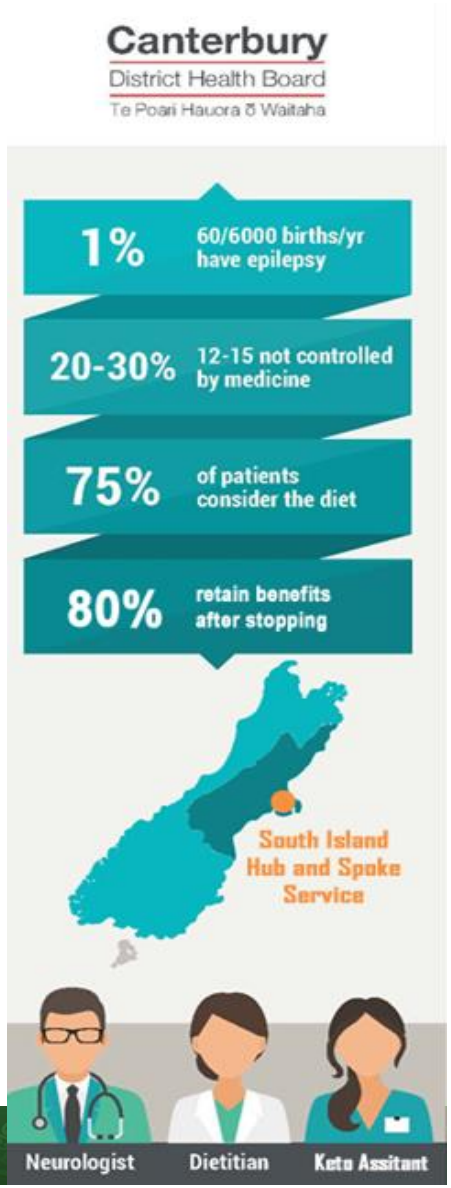
West Coast District Health Board

South Island Ketogenic Dietary Therapy (KDT) Service

Children with refractory epilepsy

- Hundreds of seizures per day
- Don’t respond to drugs
- Life limiting - disability, death
- When drugs don’t work, Ketogenic therapy is the last resort

- Introduction of Ketogenic Dietary Therapy Service 2016
- Achieving significant outcomes for Māori and non-Māori
- After 2 years diet weaned and benefits retained



What is Ketogenic Dietary Therapy?

- Not to be confused with popular weight loss programs
- An evidence based treatment using Medicalised Ketogenic Therapy
- High Fat (90%), Low Carbohydrate (10g carbs) per day
- The brain uses fat (ketones) instead of carbohydrates (sugar) for energy
- Dietitian Led = Consultant

We're Doing it Differently

Canterbury District Health Board
Te Poari Hauora ō Waitaha

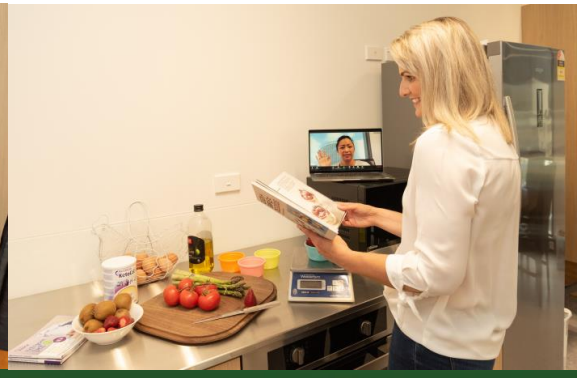
Kotahi te aho ka whati;
ki te kāpuia e kore e whati

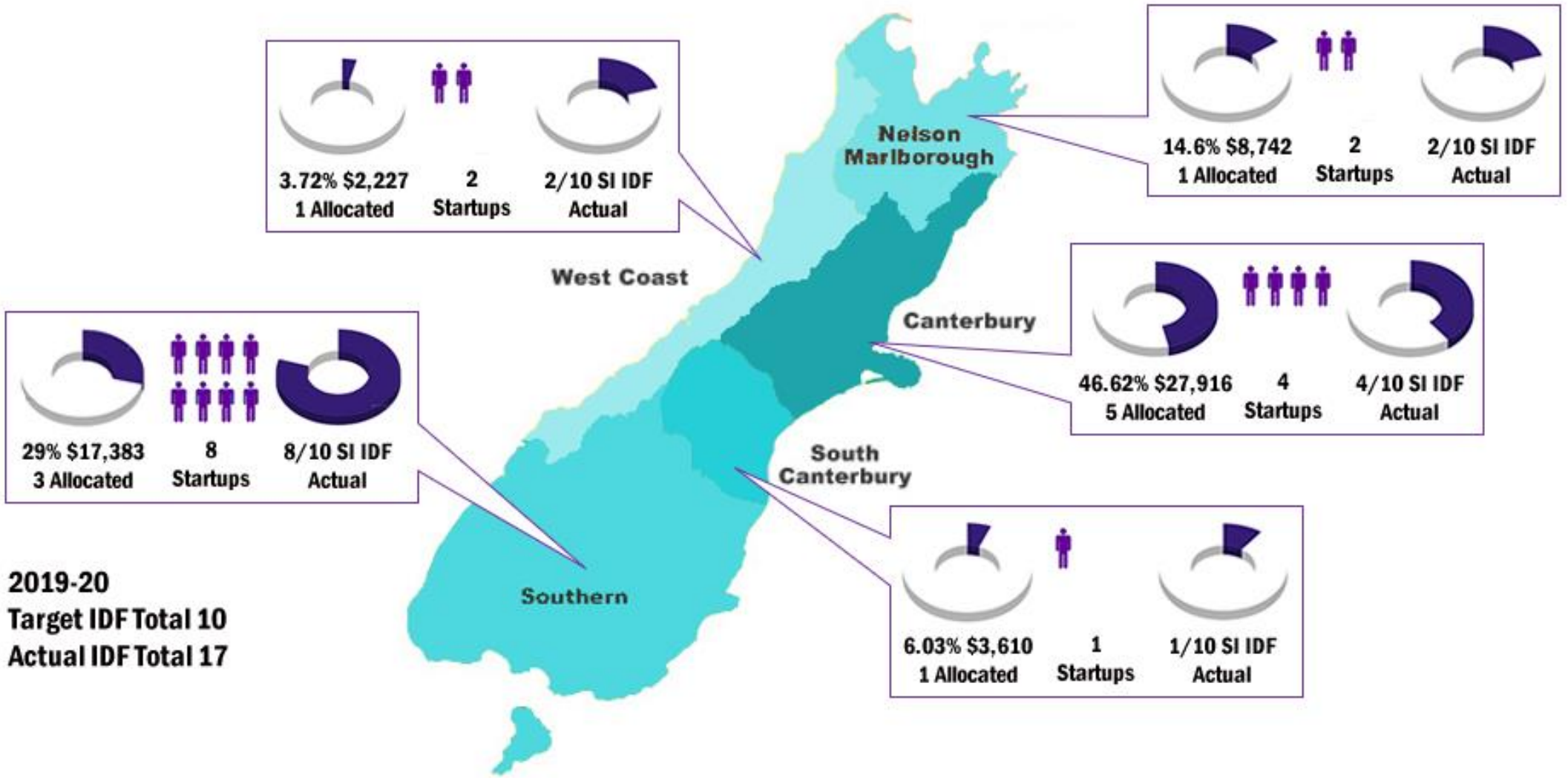
One strand of flax is easy to break,
but many strands together will stand strong.

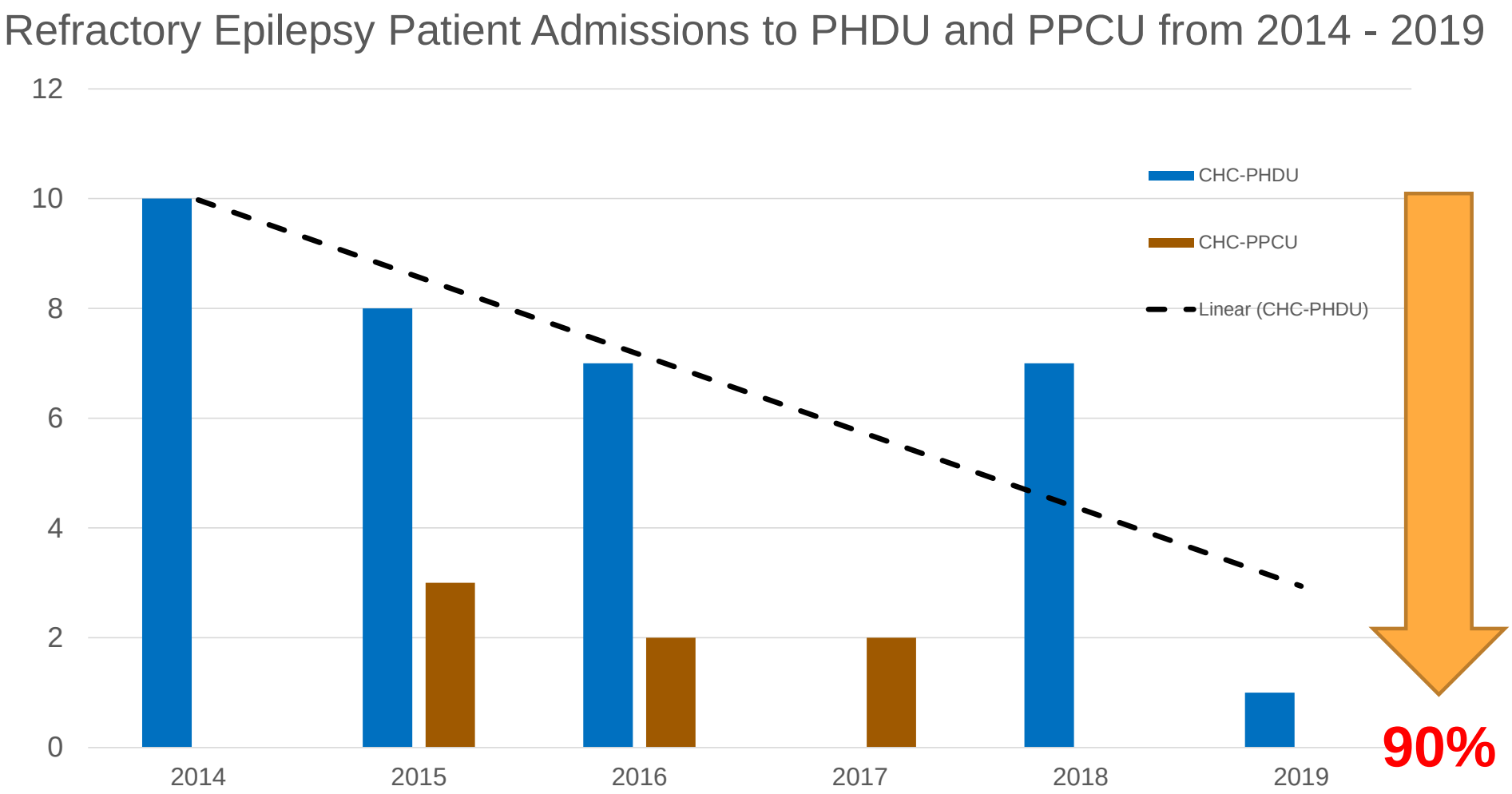
PEOPLE

PROCESS

TECHNOLOGY




3.72% $2,227
1 Allocated
2
Startups
2/10 SI IDF
Actual
Nelson
Marlborough
14.6% $8,742
1 Allocated
2
Startups
2/10 SI IDF
Actual
West Coast
Canterbury
46.62% $27,916
5 Allocated
4
Startups
4/10 SI IDF
Actual
29% $17,383
3 Allocated
8
Startups
8/10 SI IDF
Actual
South
Canterbury
Southern
6.03% $3,610
1 Allocated
1
Startups
1/10 SI IDF
Actual
2019-20
Target IDF Total 10
Actual IDF Total 17



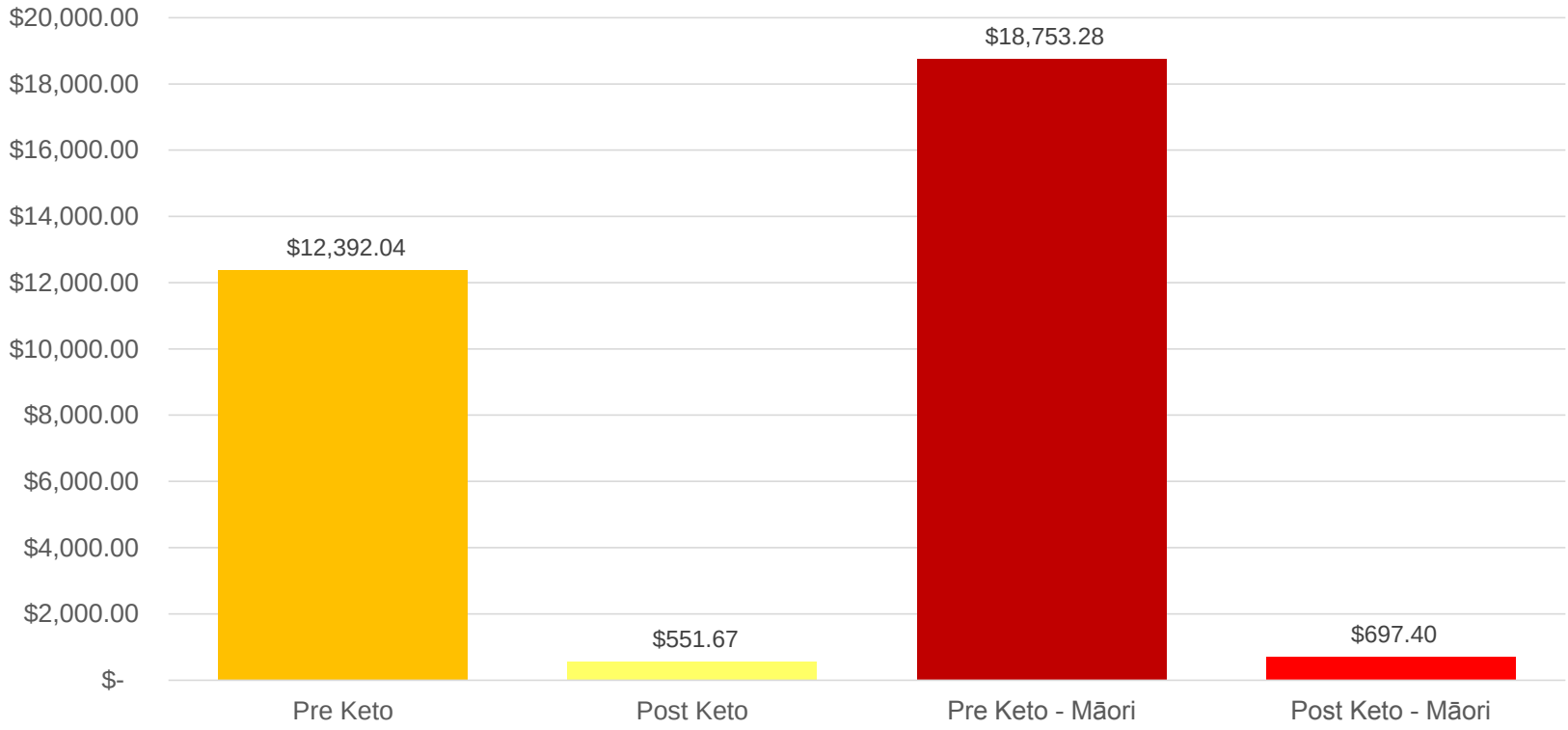
Epilepsy admissions to Paed High Dependency Unit (PHDU) & Paed Progressive Care Unit (PPCU) have **decreased** since establishment of KDT Service

Equity of Access, Care, and Outcomes for Māori

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Average Seizure-related Cost* per Patient per Annum

As at Oct 2020



* Cost not including ED, ICU, medical intervention & investigations, medication etc.

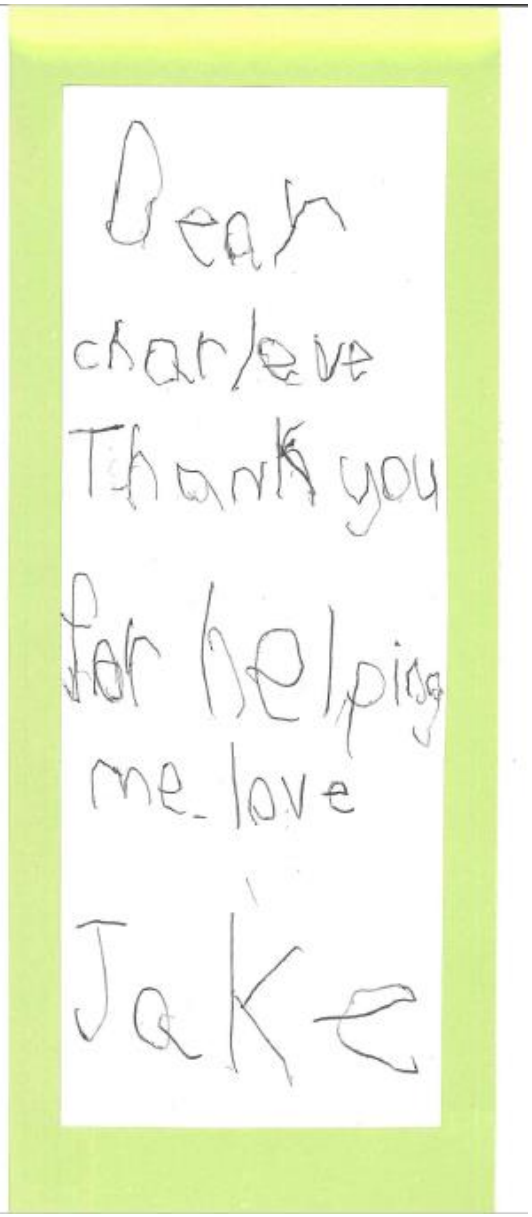
Jake
3 years old

- 100+ seizures per day
- Cluster of 10+ every 5-10 mins
- Constant hospital admissions
- Paralysed right side

- Started acutely KDT August 2016

Seizure free & enjoying life from December 2016

“The ski trip (2020) was our first time away with Jake not on a medical diet. Was so lovely for him to be able to eat what he wanted and go out for dinner with our friends. Amazing for me to not doing all that measuring - can’t say I miss it! 😊” – mum (Jen)



Jake
7
years
old

Jan 2021

Allied Health Strategic Plan

Future Opportunities…

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

COMMUNITY WATER FLUORIDATION POSITION STATEMENT

Canterbury District Health Board
Te Poari Hauora o Waitaha

TO: **Chair & Members, Canterbury District Health Board**

PREPARED BY: **Information Team, Community and Public Health**

APPROVED BY: **Evon Currie, General Manager, Community & Public Health**

DATE: **18 March 2021**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

This Statement was developed for the Canterbury District Health Board by the Information Team, Community and Public Health (*C&PH*), a division of the Canterbury District Health Board.

C&PH carries out scheduled reviews of existing CDHB position statements. This updated background paper and position statement on Community Fluoridation are the result of this process.

2. RECOMMENDATION

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

i. adopts the reviewed Position Statement on Community Water Fluoridation.

3. DISCUSSION

Background

- New Zealand water supplies generally have naturally low concentrations of fluoride, typically within the range of ~0.1-0.2 mg/L.
- Community water fluoridation at concentrations in the range 0.7 and 1.0 mg/L provides additional caries protection by favourably shifting the de-/remineralisation balance in the oral cavity, and fluoride is most effective when provided at multiple times during the day.
- Community water fluoridation is safe and effective in preventing tooth decay.
- Community water fluoridation is a passive fluoride delivery method, and individuals in all social strata benefit. The greatest benefits are seen in those with most disease.
- Water fluoridation provides benefits across the life-span.
- Support for community water fluoridation as a public health measure is unreserved among scientific experts and major health organisations.

Position Statement

Purpose

The purpose of this document is to outline the Canterbury District Health Board's support for community water fluoridation as a safe and effective way of improving oral health and reducing oral health inequities.

Definitions

Community water fluoridation is the controlled addition of fluoridating agents into municipal water supplies. Community water fluoridation adjusts the level of naturally-occurring fluoride in drinking water to an optimal level for protection against tooth decay (0.7-1.0 mg/L).

Scope

The focus of this position statement and background paper is on the safety and effectiveness of community water fluoridation. A brief discussion of relevant legal and ethical considerations is also included.

Position

The Canterbury District Health Board:

- recognises that dental caries is caused by a range of socio-behavioural risk factors and the burden of tooth decay in Canterbury is substantial (page 9);
- recognises that persistent oral health inequalities exist for some vulnerable groups, including those who experience socioeconomic disadvantage (page 9);
- recognises that Māori in Canterbury carry an enduring and disproportionate oral health burden compared with non-Māori, and that community water fluoridation is pro-equity and consistent with Māori values (page 12);
- accepts the extensive scientific evidence that community water fluoridation is a safe, effective and socially equitable public health strategy for the prevention of tooth decay for whole populations (page 10, 12, 13); and
- supports fluoridating community water supplies to the level recommended by the Ministry of Health.

4. APPENDICES

Appendix 1: Community Water Fluoridation Position Statement

Community Water Fluoridation: Position Statement

June 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Suggested citation

CDHB (2021). Community Water Fluoridation: Position Statement. Christchurch: Canterbury District Health Board.

Community and Public Health

310 Manchester Street, Christchurch

PO Box 1475, Christchurch 8140

New Zealand

Phone: +64 3 364 1777

www.cph.co.nz

About this Position Statement

This Statement was developed for the Canterbury District Health Board by the Information Team, Community and Public Health, a division of the Canterbury District Health Board.

This document has been prepared by a member(s) of the Information Team, Community and Public Health and has been through a process of internal Public Health Specialist review.

Te Pae Māhutonga graphics courtesy of Healthy Christchurch.

Contents

Position statement

Purpose

The purpose of this document is to outline the Canterbury District Health Board's support for community water fluoridation as a safe and effective way of improving oral health and reducing oral health inequities.

Definition

Community water fluoridation is the controlled addition of fluoridating agents into municipal water supplies. Community water fluoridation adjusts the level of naturally-occurring fluoride in drinking water to an optimal level for protection against tooth decay (0.7-1.0 mg/L).

Scope

The focus of this position statement and background paper is on the safety and effectiveness of community water fluoridation. A brief discussion of relevant legal and ethical considerations is also included.

Position

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

The Canterbury District Health Board:

1. recognises that dental caries is caused by a range of socio-behavioural risk factors and the burden of tooth decay in Canterbury is substantial *(page 9)*
2. recognises that persistent oral health inequalities exist for some vulnerable groups, including those who experience socioeconomic disadvantage *(page 9)*
3. recognises that Māori in Canterbury carry an enduring and disproportionate oral health burden compared with non-Māori, and that community water fluoridation is pro-equity and consistent with Māori values *(page 12)*
4. accepts the extensive scientific evidence that community water fluoridation is a safe, effective and socially equitable public health strategy for the prevention of tooth decay for whole populations *(page 10, 12, 13)*
5. supports fluoridating community water supplies to the level recommended by the Ministry of Health, and
6. believes that decision-making for community water fluoridation should be a single national process rather than a series of local decisions.

Background paper

In brief

- New Zealand water supplies generally have naturally low concentrations of fluoride, typically within the range of 0.1-0.2 mg/L.
- Community water fluoridation at concentrations in the range 0.7 and 1.0 mg/L. provides additional caries protection by favourably shifting the de-/remineralisation balance in the oral cavity, and fluoride is most effective when provided at multiple times during the day.
- Community water fluoridation is safe and effective in preventing tooth decay.
- Community water fluoridation is a passive fluoride delivery method, and individuals in all social strata benefit. The greatest benefits are seen in those with most disease.
- Water fluoridation provides benefits across the life-span.
- Support for community water fluoridation as a public health measure is unreserved among scientific experts and major health organisations.

Key considerations

Background

Community water fluoridation is a common method of population-level fluoride delivery[a] (Box 1). Water can be fluoridated through the controlled addition of a fluoride compound to a public water supply [1] with the optimum level considered to be 0.7 – 1.0 mg/L [2]. Fluorides are widespread in the earth's crust and are naturally present in water with varying concentrations from less than 0.5 parts per million (ppm) to 25ppm [3]. When fluoride is continually present in saliva it is adsorbed strongly to the surface enamel mineral, and this reduces the acid solubility of the enamel [4]. Therefore, fluoride is most effective in preventing and slowing the progression of dental caries when it is frequently available at low concentration. Community water fluoridation provides an optimal system of delivery [3,5,6]. Community water fluoridation does not affect the appearance, taste, or smell of drinking water.

Currently, more than 30 countries and over 250 million people participate in water fluoridation programs in countries that include the USA[b], Canada, the UK, Ireland, Brazil, Australia and New Zealand[c][7].

Water fluoridation coverage in New Zealand is incomplete. Currently, just over half of the total population receive fluoridated water. In 2016, approximately 2.27 million people across New Zealand were supplied with fluoridated water, with the potential for a 1.45 million increase in coverage if all drinking-water supplies servicing over 1000 people were fluoridated [8]. The cities of Auckland[d], Wellington and Dunedin comprise the greatest populations with fluoridated water.

Box 1

Origins/history

Community water fluoridation has its origins in Trendley Dean's studies of naturally occurring fluoridated water in the US in the 1930s. Dean and colleagues published a series of epidemiological studies describing the relationship between the different levels of fluoride naturally present in public drinking water supplies and the prevalence and severity of dental fluorosis and dental caries [18].

In 1942, Dean demonstrated a clear curvilinear relationship between dental caries rates and the natural fluoride content of the public water supply. On the basis of these findings, the first community water fluoridation programme was initiated in Grand Rapids Michigan in 1945, along with a 15-year trial of the effects.

[a] Other fluoride delivery methods include delivery via milk or salt or supplements, via toothpaste, mouth-rinses, gels, and varnishes.
[b] Two-thirds of the US population received fluoridated drinking water from water fluoridation schemes in 2014 (≈211 million) (CDC, 2014).
[c] Community water fluoridation has been implemented in many regions in New Zealand for over 60 years.
[d] Auckland (Super City) accounts for two thirds of the population that has fluoridated water.

Importance of oral health

Dental caries is a chronic and progressive disease of the mineralised tissues of the teeth, caused by interactions over time between tooth substance and acid produced by certain micro-organisms when they metabolise dietary carbohydrates. New Zealand's oral health statistics compare unfavourably with similar countries such as Australia and the United Kingdom. There are also persistent differences in child and adult oral health across different ethnic, socioeconomic, and other population groups [9-12]. Dental caries is associated with pain, infection, tooth loss (Box 2), reduced quality of life, and, for school children, lost school time and restricted activity days, as well as problems in eating, speaking and learning [13,14]. The carious process can progress to serious destructive disease resulting in hospitalisations among children, and the cost of treatment under general anaesthetic is substantial. For many adults, the formation of new cavities continues unabated throughout the lifespan in a linear relationship (Box 3) [12,15,16]. By Age 65, an estimated three-quarters of the New Zealand adult population has had one or more teeth removed due to decay, an abscess, infection or gum disease [12].

Box 2

Burden of disease: destructive tooth decay in New Zealand, 2019/20

"An estimated **32,000 children** aged 0-14 years and an estimated **274,000 adults** had one or more of their teeth removed in the past 12 months, due to decay, an abscess or infection in 2019/20" [12].

Poor oral health and oral health inequities

By five years of age, 41 percent of New Zealand children have already experienced tooth decay (2019) [17]. There are statistically significant differences within the population by ethnicity and deprivation [12]. In 2019, 58.9 percent of Māori children and 65.9 percent of Pacific children experienced dental decay in their lifetime (at 5 years) compared with approximately 40 percent of the total population and 30 percent of 'other' (at 5 years, mean dmft[e] Māori =2.9; mean dmft Pacific =3.5; mean dmft total population =1.9; and mean dmft 'other' =1.3)[f][17]. Further, approximately 15 percent of Māori and Pacific children (0-14 years) had experienced at least one tooth extraction due to decay in their lifetime, compared with approximately 10 percent of European/Other children (2019/20) [12].

For all adults aged 15+ years in 2019/20, 45.1 percent reported that at least one tooth had been removed because of tooth decay, an abscess, infection or gum disease in their lifetime and for Māori adults the proportion was over half (52.0%) [12].[g]

Box 3

The Dunedin Study

The Dunedin Study [15] remains the only dental study to have followed a group of individuals from birth to adulthood [36]. The study demonstrated that the rate of increase in caries-affected teeth (surfaces) was linear, with no apparent drop-off in the rate of increase in disease with increasing age. The study shows that childhood and adolescence are *not* periods of *special* risk for dental caries, rather, caries-preventive measures are necessary at all stages of the life-course.

[e] The dmft/DMFT index is one of the most common methods for assessing dental caries prevalence. The lower-case notation 'dmft' refers to decayed, missing, or filled deciduous ("baby") teeth while the upper-case notation DMFT refers to permanent teeth. Missing teeth (M/m) are teeth that have been extracted due to decay.
[f] Not adjusted for socio-economic status.
[g] After adjusting for differences in gender and age.

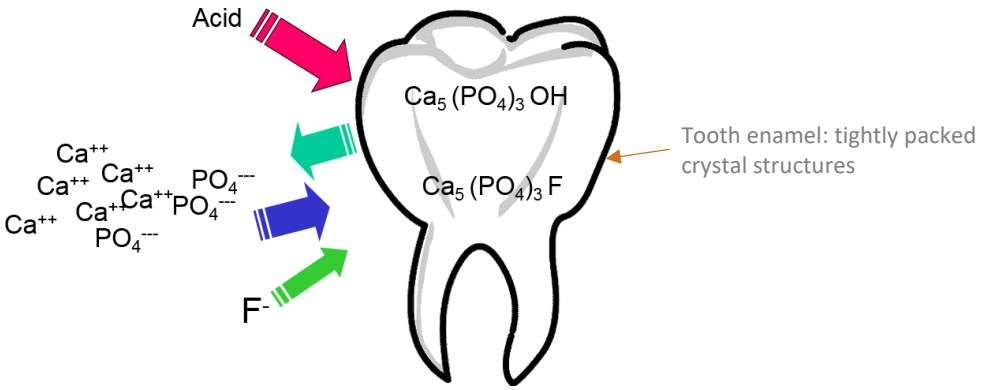
Contribution of fluoridation

International and New Zealand studies show that community water fluoridation is associated with fewer decayed, missing, and filled teeth, and a greater proportion of children remaining caries-free [9,18-24]. The greatest benefits from community water fluoridation are experienced within lower socio-economic status communities as these communities typically have higher rates of tooth decay [9,11,25,26]. A comprehensive approach to controlling dental caries in high-risk populations may include reducing exposure to sugary food and drinks, ensuring the use of fluoride toothpaste and other forms of individual-level fluoride delivery, implementing passive fluoride delivery via community water supplies, and configuring oral health services to include easy access. Community water fluoridation is considered international best-practice and is recommended by the World Health Organization as one of the most effective public health measures for prevention of dental decay [27]. The benefits of community water fluoridation accrue in addition to other approaches [28].

Mechanism of action and delivery methods

The principle actions of fluoride in reducing caries are its effects on demineralisation (the loss of calcium and phosphate) and subsequent remineralisation of enamel during caries initiation and progression [14] (Figure 1). The beneficial effects of fluoride predominantly rely on continued and frequent topical interactions with the tooth surface [6,29]. A constant low level of fluoride ion in saliva and plaque fluid reduces the rates of enamel demineralisation during the caries process and promotes the remineralisation of early caries lesions [6,14,29].

Figure 1: The role of fluoride in the demineralisation and remineralisation of tooth enamel



The figure shows that fluoride forms an acid resistant $Ca_5(PO_4)_3F$ 'fluorapatite-like' reinforcement of the enamel matrix. Bacteria feed on fermentable carbohydrates and produce the acids that dissolve tooth mineral (demineralisation). Demineralisation leads to the release of mineral ions into the solution and a loss of tooth enamel (calcium and phosphate). When fluoride is present in the biofilm fluid, the net demineralisation is reduced. Remineralisation occurs after the exposure to sugars has ceased, and acids in the biofilm are cleared by saliva and converted to salts. If the biofilm still contains fluoride, then the calcium or phosphorus that has leached out of enamel can be recovered more efficiently [30]. Fluoride inhibits demineralisation and enhances remineralisation [29].

Adapted from: Featherstone JD (1999) Prevention and reversal of dental caries: role of low-level fluoride. Community Dent Oral Epidemiol 27: 31-40.

Operationally, community water fluoridation involves three main processes: (1) delivery of the fluoridating agent to the treatment plant or point-of-supply (2) the metered dosing of the water supply, and (3) real-time monitoring of the concentration of fluoride in the community supply.

Effectiveness

Community water fluoridation provides protection against tooth decay across the lifespan when used at the concentration recommended by the New Zealand Ministry of Health [27]. In reaching this conclusion, the review panel of the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor (RSNZ/OPMCSA) [27] considered a large body of epidemiological evidence spanning 60 years, including a number of systematic reviews and numerous New Zealand and international studies. The evidence summarised in the RSNZ/OPMCSA report includes the five most commonly cited systematic reviews published since 2000[h]: specifically, the York review/NHS England (2000), and the reviews conducted by the NHMRC Australia (2007), Health Canada (2010), and Rugg-Gunn and Do, (2012).

The RSNZ/OPMCSA report concluded that:

> 'There is compelling evidence that fluoridation of water at the established and recommended levels produces broad benefits for the dental health of New Zealanders' (reference p. IV).

The most recent review of community water fluoridation by the Cochrane Collaboration (2015) was published subsequent to the RSNZ/OPMCSA report. Together, these publications include over 150 studies of community water fluoridation. The reviews [19,20,24,31,32] summarise individual studies reporting reductions in the incidence of decayed, missing, and filled deciduous teeth (dmft) in the range of 14-68% with water fluoridation compared with no fluoridation, and reductions in the incidence of decayed, missing, and filled permanent teeth (DMFT) in the range of 0-85% with water fluoridation compared with no fluoridation.

Overall, the pooled results from the child and adolescent caries severity data indicate that the initiation of community water fluoridation results in reductions in *dmft* of approximately 35% and reductions in *DMFT* of approximately 26%, compared to the median control group mean values [20]. These data also indicate absolute increases in the proportion of *caries-free* children in fluoridated areas of approximately 15%.

Fewer studies have estimated the effectiveness of community water fluoridation in preventing dental caries for adults [15,19,33-36]. However, Griffin et al. (2007) analysed 20 comparisons of community water fluoridation versus no water fluoridation among adults (aged 20+ and aged 40+ years) and derived a prevented fraction of 27% (absolute difference in annual caries increment) [19]. Table 1 summarises the available findings for dmft, DMFT, and % caries-free, for children, adolescents, and adults.

Table 1: Summary of effectiveness, fluoridation vs, no fluoridation

Group	Age	Measure	Caries reduction	Source
Children	≈0-11	dmft	35%	Iheozor-Ejiofo, 2015
Adolescents	≈11+	DMFT	26%	Iheozor-Ejiofo, 2015
Adults	20+ & 40+	DMFT	27%	Griffin, 2007
Children	≈0-11	% caries-free deciduous	Δ% caries-free = +15$_{pp}$	Iheozor-Ejiofo, 2015
Adolescents	≈11+	% caries-free permanent	Δ% caries-free = +14$_{pp}$	Iheozor-Ejiofo, 2015

pp = percentage points

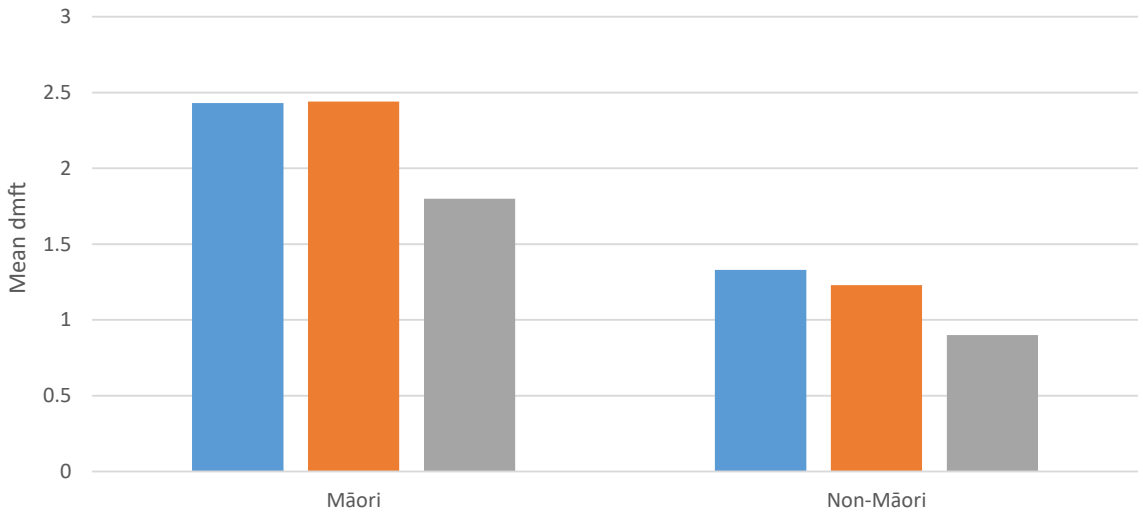
[h] Most studies of community water fluoridation have focused on children because the data are more readily available.

Impact on inequities

Tooth decay is strongly associated with social deprivation [10,25,26,28,37]. As community water fluoridation is a passive fluoride delivery method, individuals in all social strata benefit from its effects. It has also been suggested that there should be focused effort to fluoridate water supplies in rural, remote and indigenous communities to ensure that that those people with the potential to benefit most receive the intervention equally [38].

In the New Zealand context, Māori children continue to carry a disproportionate oral health burden when compared to non-Māori children [9-11]. Figure 2 shows the comparison between levels of tooth decay (dmft) for Māori and non-Māori five-year-olds living in both Canterbury and Southern District Health Board areas, with and without fluoridation, in 2017. The Figure shows that the mean dmft values for Māori children were considerably higher than non-Māori children and that mean dmft was also related to fluoridated area status [39].

Figure 2: Mean dmft for Māori and non-Māori five-year-olds, Canterbury and Southern District Health Board areas, with and without fluoridation, 2017



	Māori	Non-Māori
Canterbury DHB (non-fluoridated)	2.43	1.33
Southern DHB (non-fluoridated)	2.44	1.23
Southern DHB (fluoridated)	1.8	0.9

Source: Ministry of Health (2017)

A similar pattern is seen nationally (data not shown)[i]. Routine child oral health service dental examination data show that water fluoridation is effective but 'not a panacea' [11, p.9]. However, there can be little argument that population-level interventions such as community water fluoridation can provide a valuable contribution to addressing disparities in oral health outcomes in Canterbury.

[i] Data for the whole of New Zealand and for regions within New Zealand are not always directly comparable because the population distribution may be different– for example there are a greater proportion of low-income Māori in rural North Island (non-fluoridated) areas, compared with Canterbury.

Safety

Objections to community water fluoridation have been raised since its inception and often centre on safety. A large number of systematic reviews of water fluoridation attest to its safety, with dental fluorosis identified as the only potential adverse outcome [40]. A recent review of community water fluoridation's effectiveness and safety was conducted by the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor (RSNZ/OPMCSA) [27]. With respect to safety, the report concluded as follows:

> "From a medical and public health perspective, water fluoridation at the levels used in New Zealand poses no significant health risks" … and,
>
> 'the prevalence of fluorosis of aesthetic concern is minimal in New Zealand, and is not different between fluoridated and non-fluoridated communities' [27, p.10].

The RSNZ/OPMCSA review also determined that the weight of evidence does not support a link between exposure to fluoride in drinking water (at the recommended levels) and any adverse health effects, including skeletal fluorosis, cancer, cardiovascular or metabolic conditions, reproductive and related effects, immunotoxicity, and/or developmental effects – and that no subset of the population is at risk because of fluoridation [27].

Cost effectiveness/Cost benefit

Economic analyses seek to answer broad questions about value: essentially "Is the effect worth its costs to individuals and/or society"? To answer this question, the Ministry of Health commissioned an updated review of the costs and benefits of community water fluoridation in the New Zealand context (updating Wright et al. 1999) [41]. The review, by the Sapere Research Group [42], focused on the cost-effectiveness (patient outcomes)[j] and cost-benefit (monetary outcomes)[k] of community water fluoridation.

The analyses demonstrated that community water fluoridation is on average cost-saving for water treatment plants serving populations over 500 (i.e., with existing water treatment plant infrastructure).[l] The report also noted the strong evidence that water fluoridation reduces dental decay regardless of ethnicity, socioeconomic status and age. From an equity perspective, this provides a rationale for extending coverage to include smaller more remote communities despite less favourable cost-effectiveness. Wright et al. (1999) previously summarised that where the community has a substantial proportion of Māori, a socio-economic status lower than average, or a high proportion of children and young people (aged 1-20 years) then the economic argument is particularly persuasive.

A supplementary report by the Sapere Research Group [43] provides DHB-level analysis [42]. The analysis found fluoridation to be cost-saving in all DHBs when adding fluoridation to existing water treatment plants serving populations of more than 500 people, using a 20 year time horizon. The Canterbury District Health Board results are summarised in Table 2.

Table 2: Benefits and costs of fluoridation for Canterbury DHB: 20 year time horizon, providing water fluoridation to plants supplying populations over 500

DHB	Cost per person p.a.	Cost of Fluoridation ($ million)	Cost saving dental decay ($ millions)	Net saving ($ millions)	Net QALYs
Canterbury	$1.7 - $5.0	$15 - $46	$106 - $318	$60 - $303	592 - 2,764

Source: Moore & Poynton/Sapere Research Group (2016), DHB-level analysis, p. 13.

[j] Measured by natural units (e.g., dental decay experience, and quality adjusted life years).
[k] Where the benefit is measure by monetary units.
[l] The report notes that small community settings may require further economic evaluation (on a case-by-case basis) as the cost-benefit ratio is sensitive to the type/configuration of existing infrastructure.

Fluoridation: a polarising issue

Support for community water fluoridation as a public health measure is unreserved among scientific experts and major health organisations. However, progress towards increasing fluoridation coverage in developed countries is often disrupted by anti-fluoridation groups. The strongest reason for community water fluoridation's suitability as a public health measure, its passive nature, also appears to be the main reason for its lack of acceptance. Opposition appears to originate from the perception of restricted freedom of choice, and from individualised differences in perceptions of risk and benefits.

Community water fluoridation has been the subject of many referenda regarding both introducing and removing fluoridation (e.g., in the US, over 1000 since 1980) and historically, approximately two-thirds of referenda 'vote down' community water fluoridation at the ballot box [44].[m] Theory suggests that voters will vote in their own best interest, which fluoridation fulfils. However, this assumes that voters have complete information and are able to compare expected advantages with and without fluoridation. In reality, voters face incomplete or conflicting information and this conflicting information can alter what voters understand to be their best interest. In the case of new proposals to fluoridate, this confusion (i.e., low health literacy with respect to fluoridation) can prompt voters to simply maintain the status quo to avoid perceived risk [45,46].

Two recent High Court challenges have been brought against New Zealand local authorities that have adopted water fluoridation.[n] These cases [8] tested the claim that community water fluoridation programmes are an unjustified breach of the right to refuse medical treatment under section 11 of the New Zealand Bill of Rights Act and that the Council had failed to meet the obligations under Section 5 of the Act to ensure that any curtailment of human rights is demonstrably justified in a free and democratic society. In rejecting both claims, the High Court found that fluoridation is not a medical treatment for the purposes of the Act and that a council's power to fluoridate water is justified because the benefits of fluoridation far outweigh its risks. Although the High Court found in favour of the local authorities in each of these cases, none of the Court's decisions rule out further challenges and councils continue to face the prospect of having to undertake further public consultations and to revisit decisions to fluoridate [8].

The ethics of community water fluoridation have also been tested internationally. The London-based Nuffield Council on Bioethics review found that community water fluoridation contributed to the central goals of public health stewardship by reducing inequities, reducing disease through environmental measures, and benefiting child health [47]. The review recommended that the effects and ethics of both fluoridating and not fluoridating community water supplies be considered when local decisions are made, in a similar way to decisions about water chlorination [46,47]. Community water fluoridation sets no precedent [46]. Adding fluoride to water is just one of many instances where a chemical or nutrient is added to a food or beverage for public health benefits.

[m] Note: The Health Select Committee recommends inserting section 69ZJD in clause 8 if the Health (Fluoridation of Drinking Water) Amendment Bill to make it clear that local authorities would not be required to consult their communities about a DHB's direction to fluoridate or its invitation to comment because the DHB would have the ultimate decision-making power about fluoridation.

[n] Notably: *New Health New Zealand Inc. vs. South Taranaki District Council [2014] NZHC 395, and* Safe *Water Alternative New Zealand Inc. vs. Hamilton City Council [2014] NZHC 1463.*

The Ministry of Health's position on fluoridation

The Ministry of Health recommends community water fluoridation where technically feasible as a safe and effective means of improving oral health [48]. Recently, the Ministry of Health has commissioned a number of reports which update the evidence relating to the effectiveness, safety, and economics of community water fluoridation. These reports include the Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor's evidence review of the health effects of water fluoridation [27], and the Sapere Research Group's economic evaluations of the benefits and costs of water fluoridation in the New Zealand setting [42,43]. In addition, the Code of Practice for Fluoridation of Drinking-water Supplies in New Zealand was released in December 2014 by Water New Zealand (with input and endorsement from the Ministry of Health)[49,50].[o] This publication provides up-to-date technical guidance for treatment plant designers, operators and asset managers. The Ministry of Health has also been instrumental in the drafting of the Health (Fluoridation of Drinking Water) Amendment Bill (see below) and in the preparation of the final report of the Health Committee (May 2017).

District Health Boards' role

Under current New Zealand law (New Zealand Public Health and Disability Act 2000) [51], District Health Boards are responsible for protecting the health of their populations. However, the decision-making processes and implementation of community water fluoridation are currently the responsibility of individual territorial authorities (for water supplies owned by the local authority). The Health (Fluoridation of Drinking Water) Amendment Bill (referred to the committee on 6 December 2016) would amend Part 2A of the Health Act 1956 by inserting a *power* for District Health Boards to make decisions and give directions about the fluoridation of local government-owned drinking water supplies in their areas (i.e. it *transfers* decision-making from Territorial Authorities to District Health Boards). The stated aim of the Bill is to achieve more consistency in the implementation of community water fluoridation across New Zealand. For water supplies which are already fluoridated, the Bill would require water fluoridation to continue unless directed otherwise by the DHB.

[o] These reports can be accessed via the government's community water fluoridation webpage at https://www.fluoridefacts.govt.nz/ or via the Ministry of Health's website at https://www.health.govt.nz/your-health/healthy-living/teeth-and-gums/fluoride

References

1. NZWWA (2014) *Code of practice for fluoridation of drinking-water supplies in New Zealand*. Wellington: The New Zealand Water and Waste Association (Water New Zealand)
2. WHO (2011) *World Health Organization (WHO). Guidelines for Drinking-Water Quality*. Geneva: World Health Organization.
3. ten Cate JM (2013) Contemporary perspective on the use of fluoride products in caries prevention. *Br Dent J* 214: 161-167.
4. Featherstone JD (1999) Prevention and reversal of dental caries: role of low level fluoride. *Community Dent Oral Epidemiol* 27: 31-40.
5. Fejerskov O, Manji F (1990) Risk assessment in dental caries. In: Bader J, editor. Risk assessment in dentistry. Chapel Hill, NC: University of North Carolina Dental Ecology.
6. Fejerskov O, Thylstrup A, Larsen MJ (1981) Rational use of fluoride in caries prevention: A concept based on various cariostatic mechanisms. *Acta Odontol Scand* 39: 241-249.
7. Centers for Disease Control and Prevention (2014) Populations Receiving Optimally Fluoridated Public Drinking Water — United States.
8. Ministry of Health (2016) Regulatory Impact Statement: Transferring decision-making on the fluoridation of drinking-water from local authorities to district health boards. Wellington: Ministry of Health.
9. Lee M, Dennison PJ (2004) Water fluoridation and dental caries in 5- and 12-year-old children from Canterbury and Wellington. *N Z Dent J* 100: 10-15.
10. Ministry of Health (2010) *Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey*. Wellington: Ministry of Health.
11. Schluter PJ, Lee M (2016) Water fluoridation and ethnic inequities in dental caries profiles of New Zealand children aged 5 and 12-13 years: analysis of national cross-sectional registry databases for the decade 2004-2013. *BMC Oral Health* 16: 21.
12. Ministry of Health (2020) Annual Data Explorer 2019/20: New Zealand Health Survey [Data File]. . Wellington.
13. Jackson SL, Vann WF, Kotch JB, Pahel BT, Lee JY (2011) Impact of Poor Oral Health on Children's School Attendance and Performance. *American Journal of Public Health* 101.
14. Fejerskov O, Ekstrand J, Burt BA (1996) *Fluoride in dentistry*. Copenhagen: Munksgaard.
15. Broadbent JM, Thomson WM, Poulton R (2008) Trajectory patterns of dental caries experience in the permanent dentition to the fourth decade of life. *J Dent Res* 87: 69-72.
16. Ministry of Health (2017) Annual Update of Key Results 2016/17: New Zealand Health Survey. Wellington.
17. Ministry of Health (2020) Age 5 and year 8 oral health data from the community oral health service. Wellington: NZ: Ministry of Health.
18. Dean HT, Arnold FA, Elvove E (1942) Domestic water and dental caries. Additional studies of the relation of fluoride domestic waters to dental caries experience in 4,425 white children aged 12-14 years of 13 cities in 4 states. *Public Health Rep.* 57: 1155-1179.
19. Griffin SO, Regnier E, Griffin PM, Huntley V (2007) Effectiveness of Fluoride in Preventing Caries in Adults. *Journal of Dental Research* 86: 410-415.
20. Iheozor-Ejiofor Z, Worthington HV, Walsh T, O'Malley L, Clarkson JE, et al. (2015) Water fluoridation for the prevention of dental caries. *Cochrane Database Syst Rev*: Cd010856.
21. Kanagaratnam S, Schluter P, Durward C, Mahood R, Mackay T (2009) Enamel defects and dental caries in 9-year-old children living in fluoridated and nonfluoridated areas of Auckland, New Zealand. *Community Dent Oral Epidemiol* 37: 250-259.
22. Mackay TD, Thomson WM (2005) Enamel defects and dental caries among Southland children. *N Z Dent J* 101: 35-43.
23. McDonagh MS, Whiting PF, Wilson PM, Sutton AJ, Chestnutt I, et al. (2000) Systematic review of water fluoridation. *BMJ* 321: 855-859.
24. Rugg-Gunn AJ, Do L (2012) Effectiveness of water fluoridation in caries prevention. *Community Dent Oral Epidemiol* 40 Suppl 2: 55-64.
25. Hobbs M, Wade A, Jones P, Marek L, Tomintz M, et al. (2020) Area-level deprivation, childhood dental ambulatory sensitive hospitalizations and community water fluoridation: evidence from New Zealand. *Int J Epidemiol* 49: 908-916.
26. Schluter PJ, Hobbs M, Atkins H, Mattingley B, Lee M (2020) Association Between Community Water Fluoridation and Severe Dental Caries Experience in 4-Year-Old New Zealand Children. *JAMA Pediatr.* 174: 969-976. doi: 910.1001/jamapediatrics.2020.2201.

27. Royal Society of New Zealand and the Office of the Prime Minister's Chief Science Advisor (2014) *Health effects of water fluoridation: A review of the scientific evidence*. Wellington and Auckland: PMCSA and RSNZ.
28. Fejerskov O, Kidd E, Nyvad B, Baelum V, editors (2008) Dental caries: the disease and its clinical management. Oxford: UK: Blackwell Publishing
29. Featherstone JD (1999) Prevention and reversal of dental caries: role of low level fluoride. *Community Dent Oral Epidemiol* 27: 31-40.
30. Buzalaf MA, Pessan JP, Honorio HM, ten Cate JM (2011) Mechanisms of action of fluoride for caries control. *Monogr Oral Sci* 22: 97-114.
31. Health Canada (2010) *Guidelines for Canadian Drinking Water Quality: Guideline Technical Document - Fluoride, 2010*. Ottawa: Water, Air and Climate Change Bureau, Healthy Environments and Consumer Safety Branch.
32. McDonagh M, Whiting P, Bradley M (2000) *A systematic review of public water fluoridation*. York: University of York National Health Service Centre for Reviews and Dissemination.
33. Bernabe E, Sheiham A (2014) Extent of differences in dental caries in permanent teeth between childhood and adulthood in 26 countries. *Int Dent J* 64: 241-245.
34. Grembowski D, Fiset L, Spadafora A (1992) How fluoridation affects adult dental caries. *J Am Dent Assoc* 123: 49-54.
35. Slade GD, Sanders AE, Do L, Roberts-Thomson K, Spencer AJ (2013) Effects of fluoridated drinking water on dental caries in Australian adults. *J Dent Res* 92: 376-382.
36. Poulton R, Moffitt TE, Silva PA (2015) The Dunedin Multidisciplinary Health and Development Study: overview of the first 40 years, with an eye to the future. *Social psychiatry and psychiatric epidemiology* 50: 679-693.
37. Jones CM, Worthington H (2000) Water fluoridation, poverty and tooth decay in 12-year-old children. *J Dent* 28: 389-393.
38. Armfield JM (2010) Community effectiveness of public water fluoridation in reducing children's dental disease. *Public Health Rep* 125: 655-664.
39. Ministry of Health (2017) *Age 5 and year 8 oral health data from the community oral health service*. Wellington: NZ: Ministry of Health.
40. Harding MA, O'Mullane DM (2013) Water fluoridation and oral health. *2013* 42.
41. Wright JC, Bates MN, Cutress T, Lee M (1999) *The cost-effectiveness of fluoridating water supplies in New Zealand*. Wellington: Institute of Environmental Sciences and Research.
42. Sapere Research Group (2015) *Review of the benefits and costs of water fluoridation in New Zealand: Report prepared for the Ministry of Health*; Moore D, Poynton M, editors. Wellington: Sapere Research Group.
43. Moore D, Poynton M (2016) *The benefits and costs of water fluoridation - a summary for DHBs*. Wellington: Sapere research group.
44. Christoffel T (1985) Fluorides, facts and fanatics: public health advocacy shouldn't stop at the courthouse door. *Am J Public Health* 75.
45. Curiel JA, Slade GD, Christian T-ML, Lafferty-Hess S, Carsey TM, et al. (2019) Referendum opposition to fluoridation and health literacy: a cross-sectional analysis conducted in three large US cities. *BMJ Open* 9: e022580.
46. Jiang Y, Foster Page LA, McMillan J, Lyons K, Broadbent J, et al. (2014) Is New Zealand water fluoridation justified? *N Z Med J* 127: 80-86.
47. Nuffield Council on Bioethics (2007) *Public Health Ethical Issues. Chapter 7 – fluoridation of water*. London: Nuffield Council on Bioethics.
48. Ministry of Health (2018) Fluoride. Wellington: Ministry of Health.
49. Water New Zeland (2014) *Water New Zealand Code of Practice: Fluoridation of Drinking-Water Supplies in New Zealand*. Wellington: Water New Zealand.
50. Ministry of Health (2008) *Drinking-water Standards for New Zealand 2005. revised 2008*. Wellington: Ministry of Health.
51. (2000) New Zealand Public Health and Disability Act 2000.

WAIPAPA L3 TERRACE GARDEN

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair & Members, Canterbury District Health Board**

PREPARED BY: **Angela Mills, Programme Manager, Facilities Development**
Dr Sharyn MacDonald, Chief of Radiology

APPROVED BY: **Dr Rob Ojala, Executive Director for Facilities**

DATE: **18 March 2021**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The Executive Management Team has endorsed the proposal to fit out Waipapa Level 3 Terrace as a Terrace Garden for patients, whanāu/family and staff funded by donation revenue from the Māia Health Foundation (*Māia*). Therefore, in line with the delegation of authority in relation to donated funds, this report is to seek approval from the Board.

2. RECOMMENDATION

That the Board, as recommended by the Quality, Finance, Audit & Risk Committee:

i. approves the use of up to $150,000 donated funds to commence Waipapa Level 3 Terrace Garden stage 1 works, including placement of privacy and tree planters, noting that Māia have already raised these funds;
ii. approves the use of a further $150,000 donated funds to commence Waipapa Level 3 Terrace Gardens stage 2 works, noting that stage 2 will only proceed when the funds are available from Maia;
iii. notes the funding source will be donations from Māia and of time and/or services; and
iv. notes that no work will commence until funding is confirmed and suitable contracts for pro bono services are in place.

3. SUMMARY

This is a community fundraising project with assistance from Māia to fit out the terrace on L3 of Waipapa into a patient, whanāu and staff space.

4. DISCUSSION

The scope of the Terrace on L3 of Waipapa as per the Ministry of Health (*MoH*) project was as a tiled surface with glass barrier only.

CDHB clinicians have undertaken with approval and in conjunction with Māia, a fundraising campaign to fund the design and fit out of a garden for patients, whanāu and staff, as a little relief from the overwhelming clinical environment.

The Terrace design has seen pro bono input from the project architects, structural engineers, and Quantity Surveyor, alongside pro bono input from Landscape architect Tony Milne from Rough Milne.

The fundraising has seen time, skill, products, services and funds gifted from the community to enable this garden to come to life. These donations include Smiths Cranes and Fulton Hogan to name a few. Fundraising has been supported by Māia and donations have been via Māia.

With endorsement the project is looking to:

- Commence an initial four week fitout of stage 1 of the garden on 1 May 2021.
- Stage 1 includes placing privacy planters alongside the bedroom walls to offer privacy to patients and alternatively a view out to a garden and tree planters more centrally along with planting. As much building work that is possible is aimed for this stage 1, whilst the machinery and personnel are available.
- Stage 2, which includes the grassy mound and decking, will not commence until further funds have been secured.
- Soft fit out of planting and furniture can occur either in stage 2 or in an ongoing basis as funds are available and via normal DHB access processes.
- Fitout will be supported by CDHB Maintenance & Engineering Department &/or Site Redevelopment Unit staff in terms of project management and internal liaison for permits.

The initial fit out is planned to assist in privacy for inpatients in the wards adjacent to the Terrace which has halted access and use of the space to date.

5. CONCLUSION

The Waipapa L3 Terrace has been endorsed in principle by CDHB Executive Management Team to proceed with design initially and then to complete the fit out via fundraising. The fundraising campaign to date has resulted in $150,000 of donations held by Māia, which along with gifts of services in kind such as crane lift, is sufficient to complete Stage 1 of the Terrace Garden fitout.

This space is seen as invaluable for patients, whanāu/family and staff as an area of external relief from an overwhelming clinical environment within proximity of the clinical areas.

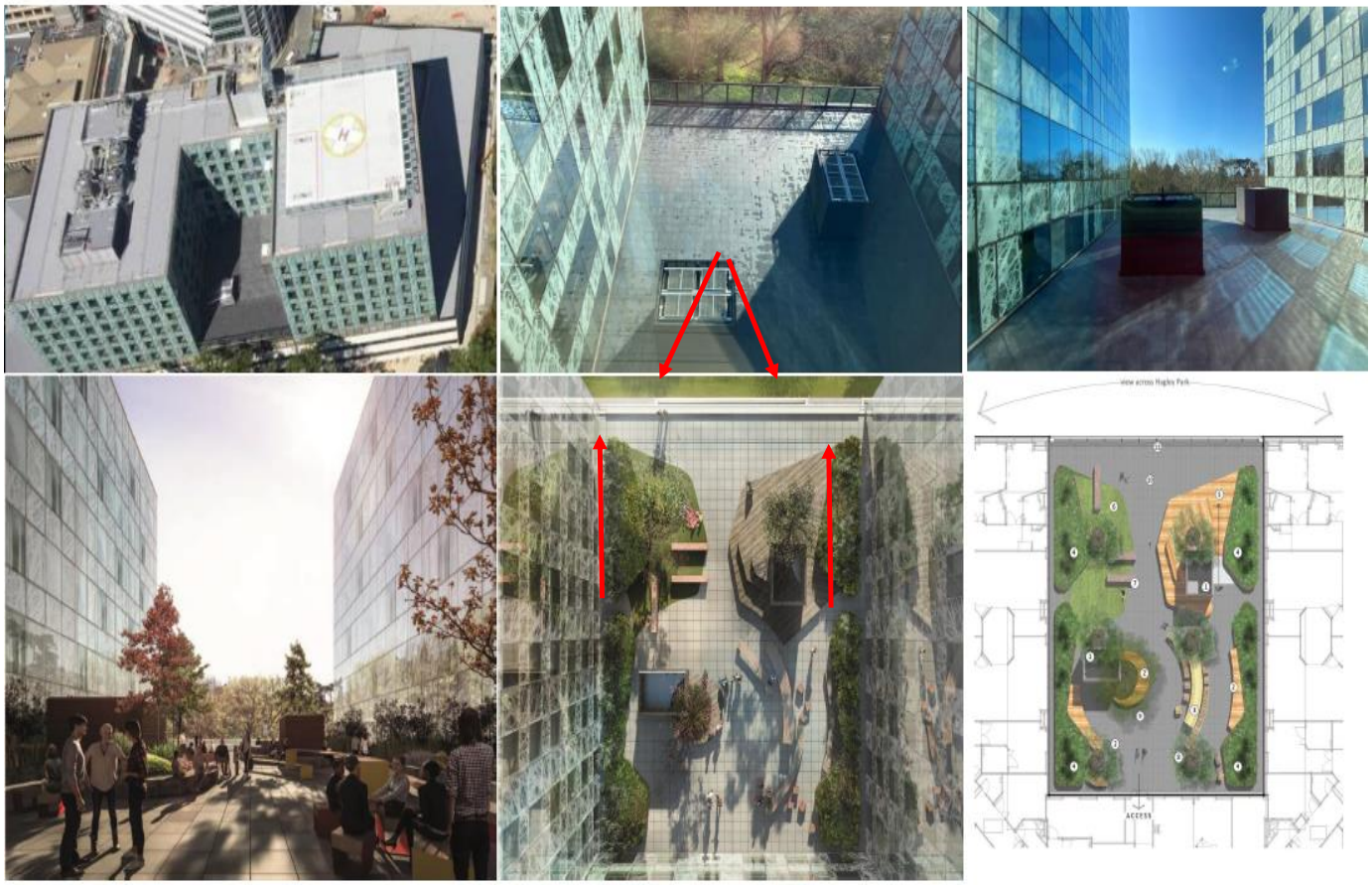
6. APPENDICES

Appendix 1: Pictorial of Waipapa L3 Terrace

Appendix 1

Waipapa L3 Terrace

Red arrows indicate the areas included in stage 1 with provision of planters along the window edge and planter-based trees centrally



FINANCE REPORT 31 JANUARY 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair & Members, Canterbury District Health Board**

PREPARED BY: **David Green, Acting Executive Director, Finance & Corporate Services**

APPROVED BY: **Dr Peter Bramley, Chief Executive**

DATE: **18 March 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the consolidated financial result for the month of January 2021, including the impacts of Covid-19 and Holidays Act compliance, was a net expense of $9.638M, being $1.982M unfavourable to the annual plan agreed by the Board on 20 August 2020. The YTD result is now $10.703M unfavourable to the annual plan;
ii. notes the consolidated financial result for the month, excluding the impact of Covid-19 and the Holidays Act compliance provision, was favourable to plan by $0.272M (YTD $1.099M favourable); and
iii. notes that the full year impact of the Holidays Act Compliance is estimated to be $17.701M.

3. FINANCIAL RESULTS EXECUTIVE SUMMARY

Summary DHB Group Financial Result

The table below shows the net January result excluding Covid-19 and Holidays Act Compliance:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.175	(0.000)	0.175	0.141	(0.000)	0.141
Funder	(3.938)	(1.798)	(2.140)	(56.155)	(47.622)	(8.533)
DHB Provider	(3.621)	(5.858)	2.237	(30.564)	(40.055)	9.491
Canterbury DHB Group Result	**(7.384)**	**(7.656)**	**0.272**	**(86.578)**	**(87.677)**	**1.099**

4. KEY FINANCIAL RISKS

Savings plans – Although we are progressing well with our phased savings plans to date, it is likely that we do not substantively achieve these savings, as the savings plans are heavily phased in the later part of the financial year.

Liquidity - We are forecasting that we will not need to use our overdraft facility until the first quarter of the 2021/22 financial year. As we will continue to incur deficits, we will require further equity support in the future.

Covid-19 – the forecasted impact of Covid-19 on CDHB's performance is dependent on a number of uncertain parameters. The forecast is based on current available information and does not include provision for additional revenue and costs that could result from a community outbreak or the recent change in Covid Alert Levels.

CDHB is managing six Managed Isolation Quarantine Facilities (*MIQFs*) and also providing support for contract tracing and testing.

Holidays Act Compliance – the workstream to determine CDHB's liability under the Holidays Act is continuing. We have accrued a liability based on an assessment from EY; there is risk the final amount differs significantly from this accrued amount.

Certain new **Ministry of Health initiatives** have cost implications for CDHB (eg, the impact of the national bowel screening programme, as noted in previous months, will crystallise this year).

5. APPENDICES

Appendix 1: Financial Results **including** the impact of Covid-19 and Holidays Act compliance
Appendix 2: Financial Result before indirect revenue & expenses **excluding** Covid-19 and Holidays Act compliance
Appendix 3: Group Income Statement
Appendix 4: Group Statement of Financial Position
Appendix 5: Group Statement of Cashflow

APPENDIX 1: FINANCIAL RESULTS INCLUDING THE IMPACT OF COVID-19 AND HOLIDAYS ACT COMPLIANCE

The following table shows the impact of Covid-19 and the Holidays Act compliance for the month and year to date:

	Period to date							Year to date						
January 2021 Results	Month Actual $000	Month Budget $000	Month Variance F/(UF)	Covid-19 $000	Holidays Act $000	Excl Covid-19 & Hols Act $000	Underlying Variance	YTD Actual $000	YTD Budget $000	YTD Variance F/(UF)	Covid-19 $000	Holidays Act $000	Excl Covid-19 & Hols Act $000	Underlying Variance
MOH Revenue	(163,999)	(162,733)	1,266	(744)		(163,254)	521	(1,152,268)	(1,139,128)	13,140	(8,932)		(1,143,336)	4,208
Patient related revenue	(5,737)	(4,471)	1,265	(1,054)		(4,683)	212	(41,076)	(32,164)	8,911	(8,001)		(33,075)	910
Other Revenue	(3,168)	(3,491)	(323)	(246)		(2,922)	(569)	(29,231)	(29,536)	(305)	(7,733)		(21,498)	(8,039)
Total Operating Revenue	(172,903)	(170,695)	2,208	(2,044)	-	(170,859)	164	(1,222,575)	(1,200,829)	21,746	(24,666)	-	(1,197,909)	(2,920)
Employee expenses	82,231	77,684	(4,547)	1,698	1,475	79,058	(1,374)	582,710	563,425	(19,285)	8,776	10,326	563,608	(183)
Treatment Related costs	13,727	13,275	(452)	565		13,162	113	103,085	96,265	(6,820)	5,161		97,924	(1,659)
External Provider costs	66,812	65,921	(891)	810		66,002	(81)	499,142	488,722	(10,420)	10,144		488,998	(276)
Other Expenses	9,866	10,117	251	(251)		10,117	(0)	72,482	75,603	3,122	2,061		70,420	5,183
Total Operating Expenditure	172,636	166,997	(5,639)	2,822	1,475	168,339	(1,341)	1,257,419	1,224,015	(33,403)	26,142	10,326	1,220,951	3,064
Operating result - (Surplus) - Deficit	(267)	(3,698)	(3,431)	778	1,475	(2,520)	(1,178)	34,844	23,187	(11,657)	1,476	10,326	23,042	144
Total Indirect revenue and expenditure	9,905	11,354	1,449	-		9,905	1,449	63,536	64,490	955	-		63,536	955
Total - (Surplus) / Deficit	9,638	7,656	(1,982)	778	1,475	7,384	272	98,380	87,677	(10,703)	1,476	10,326	86,578	1,099

Covid-19

MoH revenue covers most of the external provider costs incurred to date, which relate mainly to community surveillance and testing. In total, $13.6M of specific funding is available in 2020/21 for the Covid-19 response. This includes $8.1M of funding for External Provider expenditure, and $4.8M for the Public Health Unit (PHU) and the Primary Mental Health Response.

YTD January, $8.9M of this funding has been recognised as revenue.

There is risk that there will be insufficient funding to cover Covid-19 additional costs.

Patient related revenue includes revenue for MIQFs. The testing requirements have recently changed from two tests per guest to three tests over the two week stay.

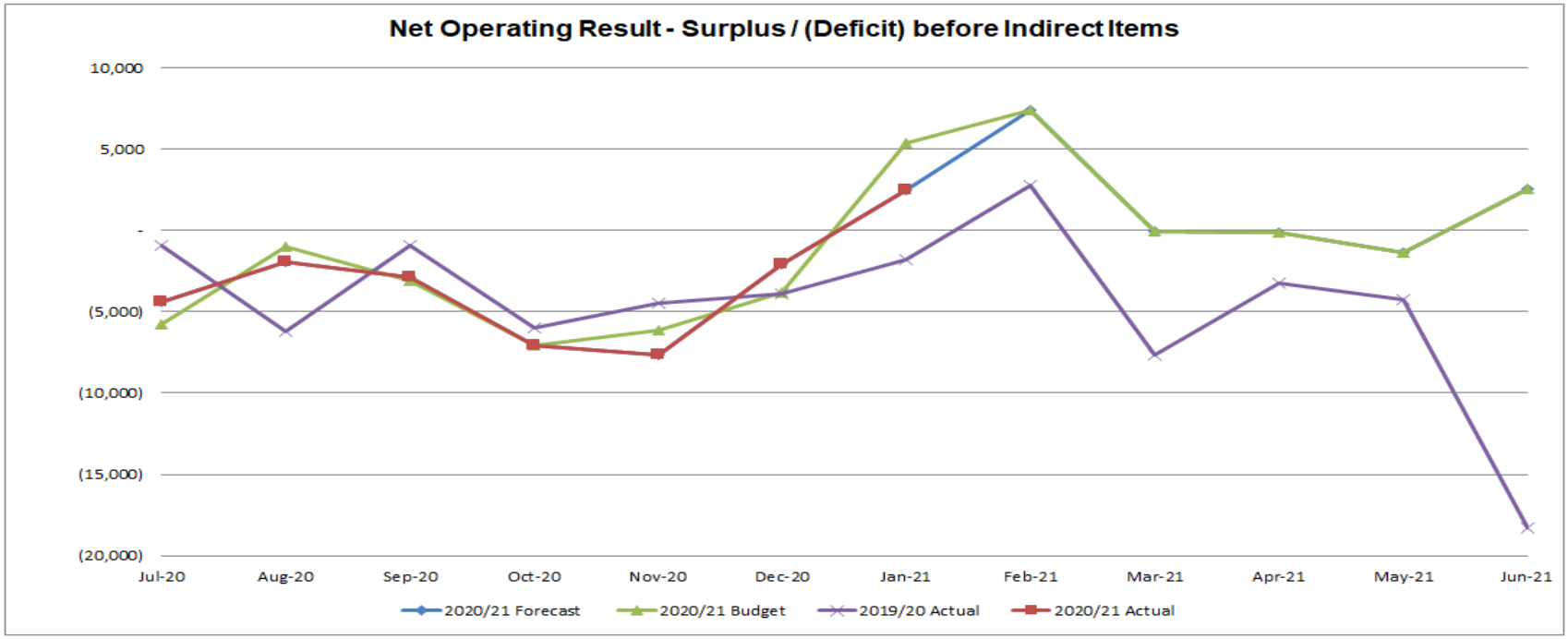
Other revenue is from Covid-19 pathology tests processed by Canterbury Health Laboratories (CHL) for Canterbury and other regions.

Personnel costs for Covid-19 mainly relate to the running of the MIQFs as well as lab testing.

APPENDIX 2: FINANCIAL RESULT BEFORE INDIRECT REVENUE & EXPENSES (EXCLUDING COVID-19 / HOLIDAYS ACT COMPLIANCE)

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 31 JANUARY 2021

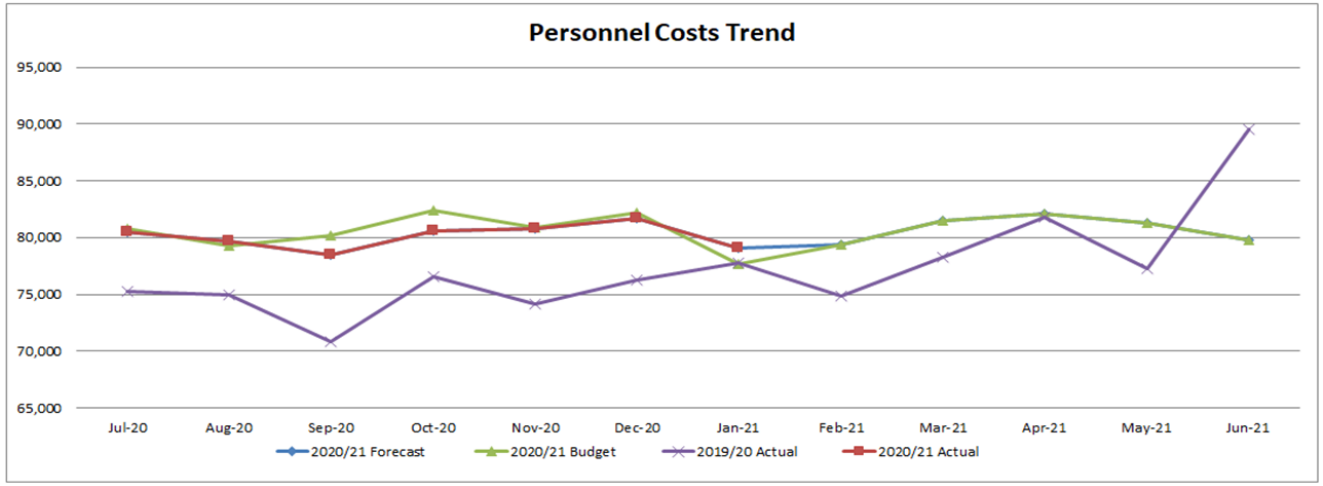
	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2019/20 Actual $'000	Yr End Budget $'000
Surplus/(Deficit) before Indirect items	2,520	3,698	(1,178)	-32% ✗	(23,042)	(23,187)	144	-1% ✓	(51,601)	(23,257)

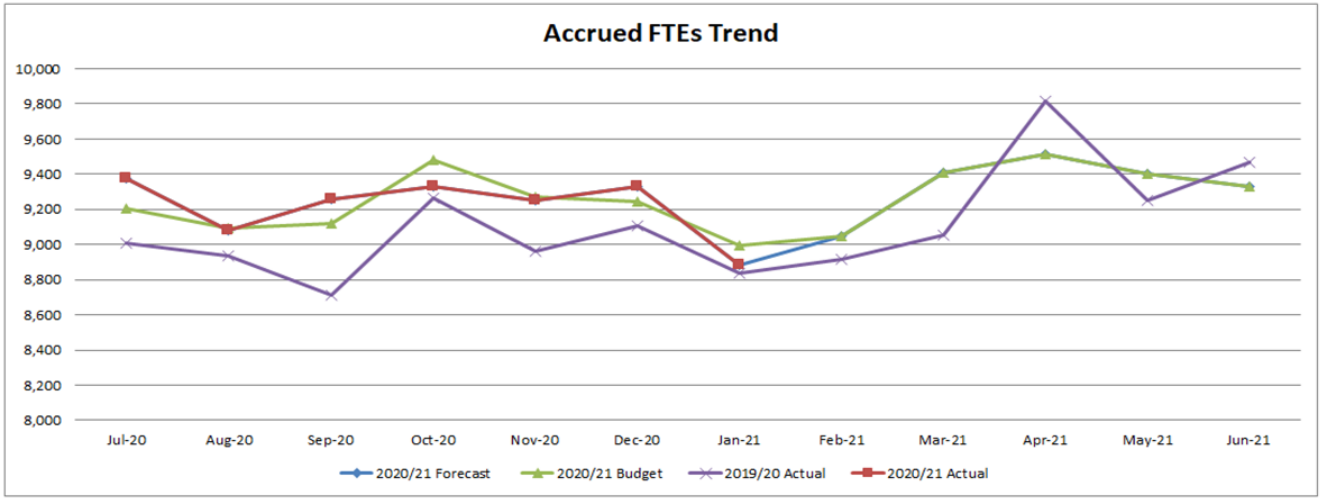


KEY RISKS AND ISSUES

Our YTD Business as Usual (BAU) result is favourable to budget, however the full year savings plan is heavily weighted in the last two quarters of the year.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE



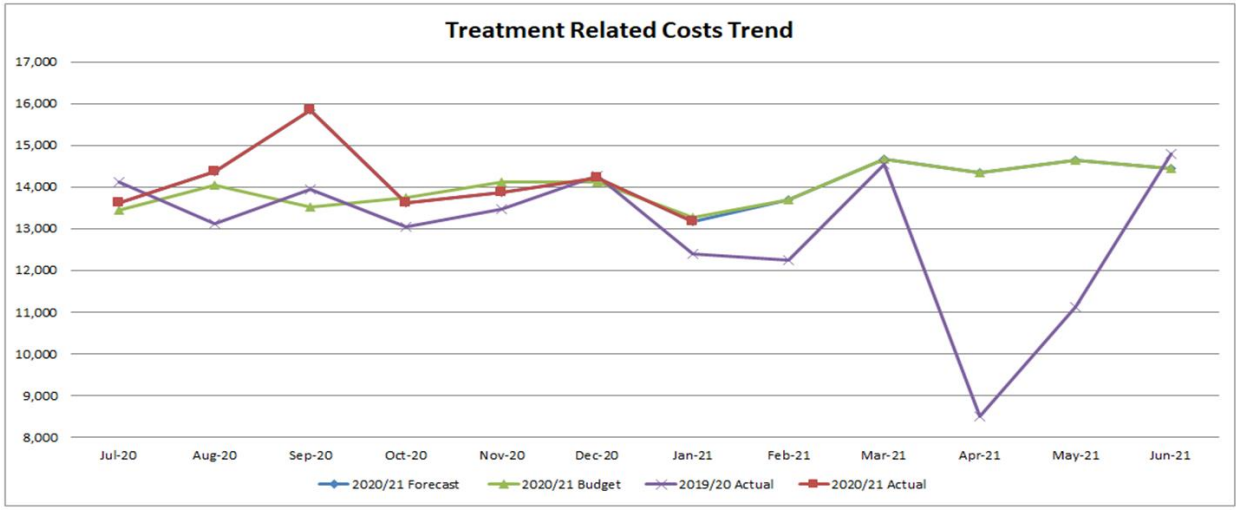


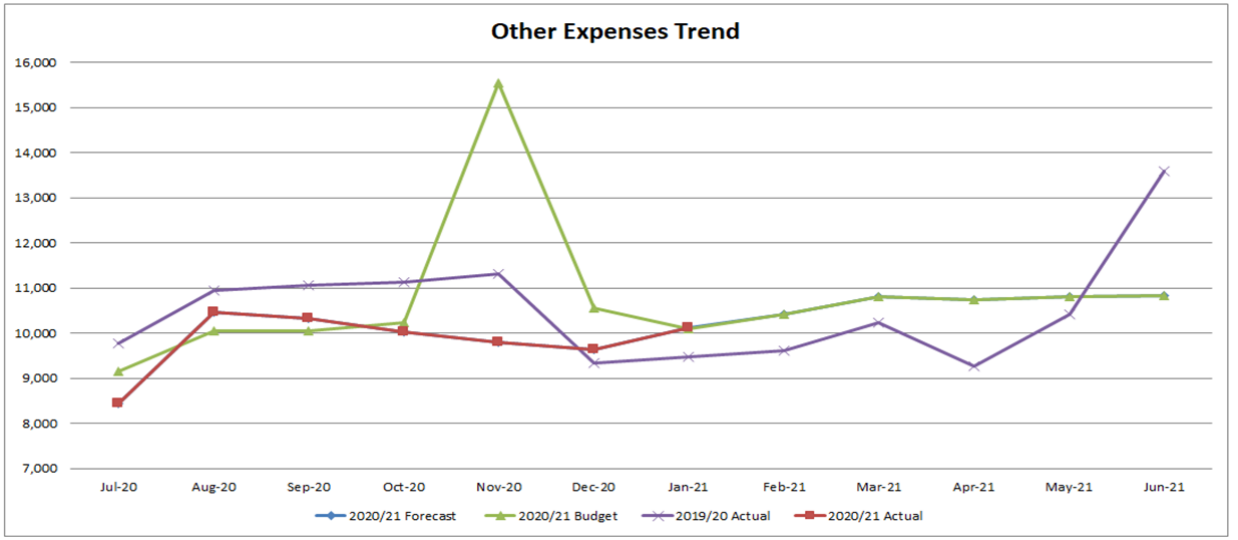
KEY RISKS AND ISSUES

Personal Costs Trend – YTD BAU personnel costs are largely on track, and FTE is slightly favourable to plan.

Accrued FTE Trend - Note the FTE shown in this graph is an "accrued" FTE, and differs from contracted FTE. The methodology to calculate accrued FTE causes fluctuations on a month to month basis dependant on a number of factors such as working days (the range is 21-23 across the year), the accrual proportions, annual leave impacts (particularly school holidays and Easter, Christmas and New Year periods), etc. The accrued FTE largely correlates with the trend in contracted FTE.

TREATMENT & OTHER EXPENSES RELATED COSTS





KEY RISKS AND ISSUES

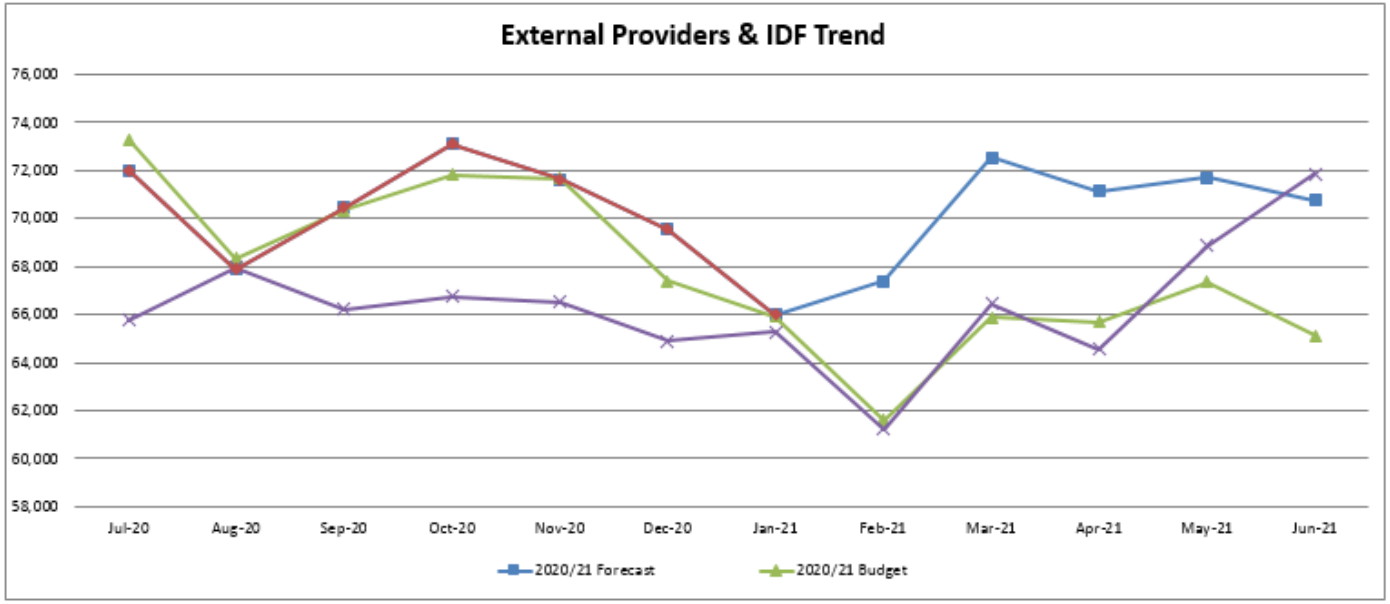
YTD BAU treatment related costs are unfavourable to budget. The January month was favourable due in part to lower outsourced clinical services. The pressure on the Emergency Department continued in the January month and ED attendances were 13% higher compared to the same month last year (5% YTD).

Note the BAU treatment related costs decrease in April 20 primarily related to lower patient activity during the Covid-19 pandemic lock-down period.

The budget increase in November relates to the tunnel project and is equally offset by revenue; this was accrued in June 2020 and is therefore not in our year end forecast for the current year.

EXTERNAL PROVIDER COSTS EXCLUDING COVID-19

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000			2019/20 Actual $'000	Yr End Budget $'000
External Provider Costs	66,002	65,921	(81)	0%	×	488,998	488,722	(276)	0%	×	790,838	814,341



Community pharmacy costs are unfavourable to plan but this is offset by additional revenue. Some MoH contract spend has been delayed, which is a timing issue only.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000		YTD Actual $'000	YTD Budget $'000	Variance $'000	Year End 19/20 $'000
Equity	1,107,082	1,186,200	79,118	**Cash**	108,091	83,291	24,800	(6,966)

KEY RISKS AND ISSUES

Equity –

We received equity support of $180M in October 2020 ($145M was budgeted in November and a further $41M in January 2021).

This is offset by an opening unfavourable variance in July due to the additional Holidays Act compliance provision made at 30 June 2020.

We also had a large equity increase in November 2020 relating to the Waipapa handover.

Cash -

Spend on the Mental Health facilities redevelopment continues and is expected to increase as construction starts in January 2021 (we have received an initial equity drawdown for the Mental Health project and a further drawdown of $1.434M was received on 8 October, with a further drawdown requested in February 2021).

APPENDIX 3: CANTERBURY DHB GROUP INCOME STATEMENT

The Group financial results include Canterbury DHB and its subsidiaries
For the 7 months ending 31 January 2021

Month					Year to Date				Annual (Year End)		
20/21 Actual $000's	20/21 Budget $000's	19/20 Actual $000's	Variance to Budget $000's		20/21 Actual $000's	20/21 Budget $000's	19/20 Actual $000's	Variance to Budget $000's	20/21 Forecast $000's	20/21 Budget $000's	19/20 Actual $000's
163,999	162,733	155,412	1,266 ✓	MoH Revenue	1,152,268	1,139,128	1,080,869	13,140 ✓	1,971,451	1,952,782	1,864,766
5,737	4,471	4,923	1,265 ✓	Patient Related Revenue	41,076	32,164	30,506	8,911 ✓	55,498	55,498	53,364
3,168	3,491	3,435	(323) ✗	Other Revenue	29,231	29,536	25,565	(305) ✗	80,378	47,534	48,770
172,903	**170,695**	**163,770**	**2,208**	**Total Operating Revenue**	**1,222,575**	**1,200,829**	**1,136,940**	**21,746**	**2,107,327**	**2,055,814**	**1,966,900**
82,231	77,684	77,719	(4,547) ✗	Personnel Costs	582,710	563,425	525,743	(19,285) ✗	1,006,506	967,342	1,000,806
13,727	13,275	12,386	(452) ✗	Treatment Related Costs	103,085	96,265	94,332	(6,820) ✗	177,691	168,059	160,676
66,812	65,921	65,275	(891) ✗	External Service Providers	499,142	488,722	463,299	(10,420) ✗	843,515	814,341	810,046
9,866	10,117	9,481	251 ✓	Other Expenses	72,482	75,603	72,963	3,122 ✓	129,020	129,329	130,109
172,636	**166,997**	**164,861**	**(5,639)** ✗	**Total Operating Expenditure**	**1,257,419**	**1,224,015**	**1,156,337**	**(33,403)** ✗	**2,156,733**	**2,079,071**	**2,101,637**
267	**3,698**	**(1,091)**	**(3,431)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**(34,844)**	**(23,187)**	**(19,397)**	**(11,657)** ✗	**(49,406)**	**(23,257)**	**(134,737)**
178	48	72	130 ✓	Interest Revenue	847	337	392	510 ✓	577	577	695
475	1,695	-	(1,220) ✗	Capital Charge Relief / Debt Equity Swap Fund	(199)	1,695	-	(1,894) ✗	10,170	10,170	8,220
132	243	665	(111) ✗	Donations	1,147	1,461	2,139	(314) ✗	2,674	2,674	3,674
115	-	2	115 ✓	Profit on Sale of Assets	528	-	14	528 ✓	-	-	17
900	**1,986**	**738**	**(1,086)** ✗	**Total Indirect Revenue**	**2,323**	**3,493**	**2,545**	**(1,170)** ✗	**13,421**	**13,421**	**12,606**
2,769	5,690	1,966	2,921 ✓	Capital Charge	14,915	20,312	15,779	5,397 ✓	50,112	48,762	38,136
7,928	7,542	3,360	(386) ✗	Depreciation	48,503	46,915	40,185	(1,588) ✗	85,489	85,108	79,829
123	-	-	(123)	Financing Component of Operating Leases	858	-	-	(858)	1,472	-	2,967
(14)	108	15	122 ✓	Interest Expense & Forex Gains and Losses	292	756	192	464 ✓	1,300	1,300	315
-	-	-	- ✓	Loss on Sale of Assets	1,290	-	53	(1,290) ✗	-	-	57
10,805	**13,340**	**5,340**	**2,535** ✓	**Total Indirect Expenses**	**65,858**	**67,983**	**56,210**	**2,125** ✓	**138,373**	**135,170**	**121,304**
(9,638)	**(7,656)**	**(5,693)**	**(1,982)** ✗	**Total Surplus / (Deficit)**	**(98,380)**	**(87,677)**	**(73,062)**	**(10,703)** ✗	**(174,358)**	**(145,006)**	**(243,436)**

APPENDIX 4: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 31 January 2021

Audited 30-Jun-20 $'000		Group Actual 31-Jan-21 $'000	Group Budget 31-Jan-21 $'000	Annual Group Budget 30-Jun-21 $'000
597,378	Opening Equity	490,730	558,272	558,272
136,588	Net Equity Injections / (Repayments) During Year	182,901	14,650	26,139
200	Other Movements	534,700	700,955	719,355
-	Reserve Movement for Year	(2,870)	-	-
(243,436)	Operating Results for the Period	(98,380)	(87,677)	(145,006)
490,730	**TOTAL EQUITY**	1,107,082	1,186,200	1,158,760
	Represented By:			
	Current Assets			
4,066	Cash & Cash Equivalents	108,091	83,291	31,443
750	Short Term Investments	750	750	750
105,853	Trade and Other Receivables	86,885	103,253	103,253
5,649	Prepayments	12,224	5,649	5,649
14,549	Inventories	17,055	14,549	14,549
14,666	Restricted Assets	14,821	14,425	14,425
145,533	**Total Current Assets**	239,826	221,917	170,069
	Less Current Liabilities			
11,032	Overdraft	-	-	-
205	Borrowings	1,392	-	-
165,170	Trade and Other Payables	174,700	133,704	128,015
14,693	Restricted Funds	14,875	14,256	14,256
343,643	Employee Benefits	355,697	277,644	277,644
534,743	**Total Current Liabilities**	546,665	447,828	442,139
(389,209)	**Working Capital**	(306,839)	(225,911)	(272,070)
	Non Current Assets			
16	Restricted Funds	16	16	16
3,225	Investment in NZHPL	3,100	3,225	3,225
909,554	Fixed Assets	1,465,684	1,415,174	1,433,893
912,795	**Term Assets**	1,468,799	1,418,415	1,437,134
	Non Current Liablilties			
6,304	Employee Benefits	6,421	6,304	6,304
26,552	Borrowings	48,458	-	-
32,856	**Term Liabilities**	54,879	6,304	6,304
490,730	**NET ASSETS**	1,107,082	1,186,200	1,158,760

Restricted Assets and Restricted Liabilities include funds held by the Māia Foundation on behalf of CDHB.

The Holidays Act compliance provision is shown under Employee Benefits, and was not included in the budget.

Borrowings in current and term liabilities is the finance lease liability for the Manawa Building. The lease cost of the building is also included in Fixed Assets.

APPENDIX 5: CASHFLOW

Audited 30-Jun-20 $'000		Actual 31-Jan-21 $'000	YTD Budget 31-Jan-21 $'000	Budget 30-Jun-21 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(48,135)	**Net Cash from Operating Activities**	(24,337)	(47,599)	(72,459)
	CASHFLOW FROM INVESTING ACTIVITIES			
(63,551)	**Net Cash from Investing Activities**	(42,921)	(53,039)	(109,917)
	CASHFLOW FROM FINANCING ACTIVITIES			
136,529	**Net Cash from Financing Activities**	182,315	190,895	220,785
24,843	Overall Increase/(Decrease) in Cash Held	115,057	90,257	38,409
(31,809)	Add Opening Cash Balance	(6,966)	(6,966)	(6,966)
(6,966)	**Closing Cash Balance**	108,091	83,291	31,443

CPH&DSAC – 4 MARCH 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair & Members, Canterbury District Health Board**

PREPARED BY: **Anna Craw, Board Secretariat**

APPROVED BY: **Aaron Keown, Chair, Community & Public Health & Disability Support Advisory Committee**

DATE: **18 March 2021**

Report Status – For:	Decision	☐	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Community & Public Health and Disability Support Advisory Committee's (*CPH&DSAC*) meeting held on 4 March 2021.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from CPH&DSAC's meeting on 4 March 2021 (Appendix 1).

3. APPENDICES

Appendix 1: CPH&DSAC Draft Minutes – 4 March 2021.

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 March 2021 commencing at 1.00pm

PRESENT

Aaron Keown (Chair); Tom Callanan; Rochelle Faimalo; Naomi Marshall; and Yvonne Palmer.

Attending via Zoom: Catherine Chu; Jo Kane; Rawa Karetai; Olive Webb; and Sir John Hansen (Ex-Officio).

APOLOGIES

An apology for absence was received and accepted from Gordon Boxall.
An apology for early departure was received and accepted from Sir John Hansen (2.30pm).

EXECUTIVE SUPPORT

Dr Peter Bramley (Chief Executive); Evon Currie (General Manager, Community & Public Health); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Dr Jacqui Lunday-Johnstone (Director of Allied Health, Scientific & Technical); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES

Dr Peter Bramley – for lateness and early departure.
Ralph La Salle; and Dr Jacqui Lunday-Johnstone – for early departure.

IN ATTENDANCE

Full Meeting

Kathy O'Neill, Team Leader, Primary Care

Item 4

Dr Daniel Williams, Public Health Physician
Dr Martin Lee, Clinical Director, Community Dental Service

Item 5

Dr Ramon Pink, Public Health Physician / Medical Officer of Health
Dr Hannah Gordon, Primary Care GP

Item 6

Dr Kiki Maoate ONZM, FRACS Chairperson Pasifika Medical Association/Pasifika Futures Whanau Ora Commissioning Agency
Mrs Debbie Sorensen, CEO, CCT. Pasifika Medical Association/Pasifika Futures Ltd
Mr Amanaki Misa, General Manager, Pasifika Futures Ltd
Mr Hector Matthews, Executive Director, Maori & Pacific, CDHB
Dr Greg Hamilton, General Manager, Specialist Mental Health Services, CDHB
Ms Sandy McLean, Team Lead, Mental Health, Planning and Funding, CDHB
Mrs Finau Heuifanga Leveni, Pacific Portfolio Manager, Planning and Funding, CDHB

Aaron Keown, Chair, opened the meeting welcoming those in attendance. Mr Keown acknowledged the recent passing of Lemalu Lepou Suia Tu'ulua, noting she was an integral part of the pacific community especially here in Christchurch and Canterbury. She had done an incredible amount of work for her community over the years. Our thoughts go out to her family.

Kathy O'Neill, Team Leader, Primary Care, advised she attended Lemalu's funeral and noted that the family spoke at the service specifically about how proud she was to be involved with the Disability Steering Group and CDHB.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Yvonne Palmer – Safer Waimakariri Advisory Group – delete.

There were no other additions/alterations to the interest register.

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

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

2. CONFIRMATION OF MINUTES

Resolution (01/21)
(Moved: Aaron Keown/Seconded: Naomi Marshall – carried)

"That the minutes of the meeting of the Community & Public Health and Disability Support Advisory Committee held on 5 November 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

An update on the Disability Steering Group's visit to Waipapa will be provided to the Committee's May meeting.

The carried forward action list was noted.

4. COMMUNITY WATER FLUORIDATION POSITION STATEMENT

Evon Currie, General Manager, Community & Public Health introduced the paper. Dr Daniel Williams, Public Health Physician; and Dr Martin Lee, Clinical Director, Community Dental Service; were in attendance.

Ms Currie advised that a request had previously been made to revisit CDHB position statements to ensure they continue to reflect best evidence. Review of the evidence reinforces that the original position statement is as powerful today as it was then. It is presented for endorsement by the Board.

Discussion took place around:

- Statistics around tooth decay, abscesses and removal, and whether these have been separated out between ACC related cases versus decay or carries related removals.

- Data analysis between CDHB and other DHBs.
- Reluctance of Ashburton data standing up on its own. Ashburton is relatively small. In addition, when looking at child oral health data, fluoridation status is related to the school the child attends, not where they live.
- Benefits and costs. Expectations as to who will pay – the government or the ratepayer? At the moment the costs of fluoridation sit with Territorial Local Authorities.
- Ashburton and Methven fluoridation experiences.
- How to get the science across to the population.
- Bill before Parliament to amend the Health Act.

Ms Currie advised that when faced with clear evidence of what is the best health outcome for our populations, we must take that stand. We know this is the right thing and it is our role to say it.

Dr Williams noted that fluoridation is an issue that lends itself to misinformation. It is important for people to have good information and to understand the benefits that their children and the people who are least well off in their communities can achieve from community water fluoridation.

Dr Williams noted the final point in the position statement itself, which states the "CDHB supports fluoridating community water supplies to the level recommended by the Ministry of Health". This paper is not asking the Committee to make a call about politically how that should happen, or where the costs should be borne. It is asking members, as a health committee, to say this is an important health issue for our region, for our people, for our least well-off people, and we support the MoH's recommendation that community water fluoridation will help with that.

In response to a query about helping to inform the public, Ms Currie commented that one of the ways to do that is by having a District Health Board that has a position statement saying fluoridation is the appropriate thing to protect the wellbeing of our children's teeth. Dr Williams added that the other component is investment. The messages are simple – there is nothing mysterious about fluoride. It is a natural mineral. It is present in everything we eat and drink. In a glass of water there are 0.1 parts per million. All we are talking about is adjusting that to 0.8 parts per million. This requires some national level investment to get the message clearly to people.

The Committee requested the following addition to the position statement: "CDHB believes fluoridation should be NZ wide".

Resolution (02/21)
(Moved: Aaron Keown/Seconded: Naomi Marshall – carried)

"The Committee recommends that the Board:

i. adopts the reviewed Position Statement on Community Water Fluoridation."

5. COVID-19 UPDATE (ORAL)

Ms Currie introduced Dr Ramon Pink, Public Health Physician / Medical Officer of Health; and Dr Hannah Gordon, Primary Care GP.

Dr Pink provided the following updates:

MIQs

- There are six MIQs in Canterbury – the only ones in the South Island. Guests are received both internationally, and also those who have come through Auckland.
- Since facilities began last year, there is a change in cases. With spread of the virus globally, we are seeing a lot more travellers coming in who have had historic infections. Therefore, the way we manage those cases that test positive has changed. That has meant some changes to the way we do our testing and the way we do our management of cases when identified.
- From a public health perspective, we work alongside a team of stakeholders. Facilities are under the auspices of the Ministry of Business, Innovation and Employment. NZ Defence Forces manage the sites. CDHB has the critical role of providing infection prevention advice and direction.
- From a public health point of view, for any cases identified in those facilities, we take responsibility for how those cases are managed.
- We know the transmissibility has increased in the virus. It is critical that infection control measures are very tightly controlled.
- We need to be very cautious and clear about what impacts ventilation has with the rooms - for staff servicing rooms, nursing staff, defence force – how this gets managed. Makes it a very multi-faceted challenge.
- The stigmatisation of front-line workers. This is depleting our workforces and redlining the numbers of staff who work in these places. This needs to change.
- Sports teams. International sports teams come to Christchurch. We tailor make how we respond to them.

Borders – Maritime and Airport

- We meet anywhere between six and 14 flights per week. This varies depending on alert levels in New Zealand, Australia, as well as capacity in hotels. We also respond to private flights, medivacs, and Antarctica flights. It is a very busy area. Staff have been working on this since January 2020 and are very grateful to have been able to develop and enhance airport relationships.
- Boats come in day and night, which is more difficult. Boats are coming from all over the world. The on-signing and off-signing of crew poses challenges. We now have significant legislative tools to manage these mariners as they come in and as they leave, but it does pose challenges for us and certainly for testing teams when they come in at strange hours.
- Relationships are vital. Everything is a fast moving river. The only constants are the relationships that we build. We need to maintain those, work with those, make sure we water those relationships, because they are critical to achieving our goal of protecting our nation from the entry of this virus.

Getting Through Together

- A campaign in partnership with the Mental Health Foundation and the Health Promotion Agency. The All Right? campaign team have been intimately involved with Getting Through Together. The programme has extended from the focus of the summer, in responding in particular to the stress and anxiety we see in our community for many reasons caused by this pandemic. Our public health involvement in that has been significant from its inception and from its ongoing work.

Dr Gordon provided the following updates:

Testing

- Seen a significant uptake in testing at the port.
- Testing at the border has been stable.

- Good relationships have been built.
- Community testing has seen a maturing of processes.
- This week has seen an increase in testing by six-fold, with relatively little disruption to any other aspects of the health system.
- Working with communication teams about improving communication into our more diverse communities. Front footing this and being proactive has resulted in good engagement in the testing space.

Vaccinations

- Starting with border workers. Next phase is rolling out to their household contacts. As part of that, this will include some high-risk healthcare workers. Beyond that is group 2 – healthcare workers; and then moving onto group 3 – which is the community, which will have specific areas in it.
- A lot of planning is continuing in this space, lots of movement, and very complicated.

In response to a query about feedback from the disability sector, Kathy O'Neill, Team Leader, Primary Care, advised the Disability Steering Group (*DSG*) have had a major focus on hearing from the disability community and using disability community representatives to bring the issues they are hearing from their networks to DSG. A workplan has been developed. One of key areas is around communication.

Ms O'Neill further advised that in the Emergency Response Centre, there are two communities that have sub groups we can go to to enquire about how to reach those communities, how to communicate with them. They are Maori and Pacific. We are now in the process of setting up a Disability Group that we will be able to do the same thing with.

A member noted that communication around the disability sector has much improved. People are feeling connected and better prepared. A number of support services have got to the stage of finding alternative ways of delivering and those have gone into action this year a lot smoother. The member was not sensing as much disruption for people.

Another member commented that there is confidence that disabled voices area being heard right across the board.

A member commented about the older population with disabilities who have not been receiving their cares and this is not being communicated to them. It will be raised as a point of concern at the Canterbury Provider Network meeting scheduled for the end of March. Ms O'Neill undertook to take the issue to the Older Persons Health Team as well.

There was a query about media communications for the COVID-19 vaccine. Dr Gordon advised that a communications campaign has been promised. This will be a proactive campaign coming out from the Centre. Locally, feedback has been received that within the Maori and Pacific communities there is a lot of distrust of the vaccine, so we are working with the CDHB comms team to undertake some targeted comms into those communities. Ms Currie also noted it is a relationship issue and building trust in the system itself.

Dr Pink noted that hesitancy is not new. There will be misinformation. It is important to find a positive and proactive way through.

The Chair thanked Dr Pink and Dr Gordon for their attendance.

6. CDHB PACIFIC HEALTH STRATEGY - IMPLEMENTATION PLAN – TARGETS & INDICATORS

Hector Matthews, Executive Director, Maori & Pacific Health introduced the paper and those in attendance:

- Dr Kiki Maoate ONZM, FRACS Chairperson Pasifika Medical Association/Pasifika Futures Whanau Ora Commissioning Agency
- Mrs Debbie Sorensen, CEO, CCT. Pasifika Medical Association/Pasifika Futures Ltd
- Mr Amanaki Misa, General Manager, Pasifika Futures Ltd
- Mr Hector Matthews, Executive Director, Maori & Pacific, CDHB
- Dr Greg Hamilton, General Manager, Specialist Mental Health Services, CDHB
- Ms Sandy McLean, Team Lead, Mental Health, Planning and Funding, CDHB
- Mrs Finau Heuifanga Leveni, Pacific Portfolio Manager, Planning and Funding, CDHB

Mrs Sorensen provided a presentation to the Committee which highlighted the following:

- Pacific population.
- Vision – Prosperous and healthy Pacific families in Canterbury.
- Values – Families; Shared Responsibility; Integrity; Relationships; and Strengths Based.
- Strategic Priorities.
- Focus Areas – Service Priorities; Workforce Development; Pacific Leadership; Innovation; Partnerships; Research, Data and Evidence.
- Short-term outcomes over the next 18 to 24 months for the focus areas.
- Progress so far.

Mrs Sorensen acknowledged the work of Mr Matthews, noting that the two of them had been partnering for 25 years around this plan and it was indeed a privilege to put the plan in front of the Committee today. She thanked Mr Matthews for championing their cause.

There was a query whether a disability lens had been put across this work. Mrs Sorensen advised that a piece of work is due to commence looking in depth at disability issues and also child poverty issues in their community. She expects to be able to report back more comprehensively in the future. This is in progress.

In response to a query about COVID-19, Mrs Sorensen advised that for the last 12 months a very comprehensive COVID-19 response has been delivered. In the last two weeks, support has been provided in Auckland for the lockdown for nearly 5,000 families. Also, the point of contact for the national contact tracing centre and all Pacific referrals through the contact tracing centre come to the organisation and team, and then are referred out to our partners. We have 52 partners up and down the country, including several partners in Canterbury. Should we have an outbreak here, we have very sophisticated systems and support levels, including funding for packages of care, support for payments of utilities, and support for people who may be in quarantine or self-isolating. We believe we are comprehensively well set up to support any outbreak in Canterbury.

In response to a query around funding, Dr Maoate advised that this is a partnership model in funding. We need to be clear in our minds that if we set our strategies and programmes, that there are two partners in the room who will actually fund it. If the DHB has difficulty funding it, then we will look to provide the resource to add to the DHB value. We would expect that vice versa in other ways, that the DHB would provide resources, not necessarily money, to support the cause. The intent is not about the money. If we focus on the money, it will not work.

Dr Peter Bramley, Chief Executive, thanked those in attendance. He looked forward to strengthening the partnership and expected CDHB will be looking to continue its investment and prioritising its investment for Pasifika health.

Sir John Hansen retired from the meeting at 2.30pm.

7. COMMUNITY & PUBLIC HEALTH UPDATE

Ms Currie presented the report which was taken as read. She drew attention to commentary in the report about Waka Toa Ora, which was previously known as Healthy Christchurch, then Healthy Greater Christchurch. It has over 200 signatory organisations participating and is very active. The Greater Christchurch Partnership is another area hugely important for the DHB to be participating in, and is going incredibly well, including a secondment of one of the Public Health staff into the development of Greater Christchurch 2050.

In response to a query about funding for the All Right? campaign, Ms Currie advised it is a tricky space. We have just received notification that funding will continue until February 2022. The evaluations that come through show that it is absolutely successful. It resonates with the Maori community, with people using particularly Mental Health Services – it is getting great results, which will speak for itself.

There was a query whether the Medical Officer of Health very often opposes an alcohol license for an established premises. Ms Currie advised this does happen, but is not a common occurrence. At the moment there seems to be an upswell in communities to have a voice in this space, which is positive. When the Medical Officer of Health is objecting, it is because there are very good reasons for that.

The Committee noted the Community & Public Health Update report.

8. PLANNING & FUNDING UPDATE

Kathy O'Neill, Team Leader, Primary Care, presented the report which was taken as read.

There was discussion about red status items, noting these are often influenced by positioning and timing. Ms O'Neill advised that from advice she received there is nothing to cause alarm. All of the reds have a reason for being red – a national policy that has been delayed; diversion because of COVID-19 for a number of community and public health initiatives; or a reprioritisation due to either of those things, resulting in dates shifting - rather than this year it will be next. Justifications are provided throughout the report.

Discussion took place around the following immunisation planning priorities:

- Refresh of the current immunisation service model; and
- Develop a process to identify women who have not been vaccinated during pregnancy. The Committee queried how CDHB compared to the rest of the country on this.

The Planning & Funding Update report was noted.

9. 2021 WORKPLAN

There was discussion about the role of the Committee.

The Committee received the 2021 Workplan, noting that this is a working document.

INFORMATION ITEMS

- Remembering a Pacific Community Hero
- CPH 6 Month Report to MoH
- CCN Q1 2020/21
- Disability Steering Group Minutes:
  - 25 September 2020
  - 23 October 2020
  - 27 November 2020

There being no further business the meeting concluded at 2.55pm.

Confirmed as a true and correct record:

_____ _____

Aaron Keown
Chair

Date of approval

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair & Members, Canterbury District Health Board**

PREPARED BY: **Anna Craw, Board Secretariat**

APPROVED BY: **David Green, Acting Executive Director, Finance & Corporate Support**

DATE: **18 March 2021**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATIONS

That the Board:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of public excluded meetings – 18 February 2021	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
4.	2021/22 First Draft Annual Plan	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Cardiac Cath Lab 2 Replacement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	CDHB Asbestos Management Survey & Remediation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
9.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
10.	Advice to Board • QFARC Draft Minutes *2 March 2021*	For the reasons set out in the previous Committee agendas.	

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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