SOUTH CANTERBURY DISTRICT HEALTH BOARD

COMMUNITY & PUBLIC HEALTH ADVISORY COMMITTEE

FRIDAY, 25 OCTOBER 2019 8.30 AM

KAURI ROOM
TALBOT PARK 156 OTIPUA ROAD TIMARU
<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
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<tbody>
<tr>
<td><strong>KARAKIA</strong></td>
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</tr>
<tr>
<td>1. APOLOGIES</td>
<td>Receive</td>
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<tr>
<td>Joseph Tyro</td>
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<tr>
<td>2. DECLARATIONS OF INTEREST</td>
<td>Note</td>
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<tr>
<td>Attached</td>
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<tr>
<td>3. CONFIRMATION OF MINUTES OF PREVIOUS MEETING</td>
<td>Receive</td>
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<tr>
<td>4. MATTERS ARISING</td>
<td>Receive</td>
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<tr>
<td>Items not covered elsewhere in agenda</td>
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<tr>
<td>5. ACTION PLAN</td>
<td>Receive</td>
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<td>Attached</td>
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<td>6. FINANCIAL REPORT</td>
<td>Receive</td>
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<td>Attached</td>
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<tr>
<td>7. PROPOSAL INTERGRATED PRIMARY MENTAL HEALTH AND ADDICTION: FUNDING</td>
<td>Endorse</td>
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<td>Attached</td>
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<tr>
<td>8. CLINICAL BOARD UPDATE</td>
<td>Verbal</td>
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<td>9. IMMUNISATION REPORT</td>
<td>Receive</td>
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<td>Attached</td>
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<td>10. PRIMARY HEALTH REPORT</td>
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<td>Attached</td>
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<tr>
<td>11. DRAFT: SUSTAINABILITY POSITION STATEMENT</td>
<td>Receive</td>
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<tr>
<td>12. HEALTH PROMOTION MATRIX: 6MTH REPORT</td>
<td>Receive</td>
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<td>Attached</td>
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<tr>
<td>13. BREAST FEEDING ACTION PLAN</td>
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<td>14. PUBLIC EXCLUDED RESOLUTION</td>
<td>Resolution</td>
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<tr>
<td>15. INTERGRATED COMMUNITY PHARMACY AGREEMENT VARIATION</td>
<td>Receive</td>
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<td>16. RESOLUTION TO RESUME OPEN MEETING</td>
<td>Resolution</td>
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<td>GLOSSARY</td>
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<td><strong>KARAKIA</strong></td>
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Community & Public Health Advisory Committee
Member Interest Register
25 October 2019

Paul Annear
- SCDHB Board – Elected member
- Physiotherapist in Private Practice (Timaru & Ashburton)
- FAIM Holdings (Family Company) – Shareholder & Director
- Timaru Holdings – Shareholder & Director
- McLeod Building, Invercargill – Director
- Kiwispan Invercargill Limited - Shareholder
- Westhills Forestry Ltd – Shareholder/Director
- Daughter: Employed by SCDHB as a NASC Assessor

Peter Binns
- SCDHB Board - Elected member
- MB, BChir, FRCS
- Member of Disability Support Advisory Committee (DSAC)
- Retired medical practitioner
- Timaru Grey Power – Committee member
- Trustee – Line Trust SC

Murray Cleverley
- SCDHB Board – Elected Member – Chair of CPHAC
- Trust Aoraki – Director
- Business Class Ltd – Managing Director
- Cleverley Holdings Partnership – Director
- Silver Fin Capital Ltd – Director
- Pacific Seaweed Ltd – Managing Director
- Timaru Eye Ltd – Director
- Sister: Employed at SCDHB as a Registered Nurse

Rene Crawford
- SCDHB Board - Elected member
- Employed by SCDHB as Associate Director Allied Health, Scientific & Technical
- Brother employed by SCDHB as a Consultant Orthopaedic Surgeon
- Physiotherapy New Zealand South Canterbury and Canterbury Branch Member
- NZ Physiotherapy Board – Professional Conduct Committee member
- Health and Disability Commissioner Physiotherapy Expert Advisor
- Trustee – Temford Family Trust
- Board of Trustees Member – Craighead Diocesan School

Raeleen de Joux
- SCDHB Board - Elected member
- Timaru Māori Women’s Welfare League – Secretary
- Ara Institute of Canterbury, Department of Nursing Midwifery & Allied Health - Tutor
- Te Aitarakihi Trust – Chairperson
- Parents Centre New Zealand - Board Member
- Aoraki Development - Board of Directors
Suzanne Eddington
- Maori Health Advisory Committee Member – Representative on CPHAC
- Te Rūnaka of Waihao – Executive Vice Chair
- Lower Waitaki & South Coastal Streams Zone – Committee member
- Te Paiherangi – Waihao representative
- Te Roopu Tuia Vice Chair – Waihao representative
- Aoraki National Park Plan Review – Waihao representative
- Waihao/Wainono Augmentation Working Party
- Clinical Governance Board – Community representative
- Orari Temuka Opihi Pareora (OTPO) Zone Committee – Member
- Daughter: Employed by Timaru Mental Health Support Trust and Waihao representative of Māori Health Advisory Committee and MHAC representative on Hospital Advisory Committee (HAC)

Gareth Ford
- Community Representative of CPHAC
- Multiple Sclerosis South Canterbury – Member
- Fiancée: Employee of Presbyterian Support Services SC

Ronal (Ron) Luxton
- SCDHB Board - Elected member, Chair of Board
- Ex-officio member of CPHAC, DSAC, HAC, MHAC, Audit & Assurance Committee
- Aoraki MRI Charitable Trust – Chair
- Justice of the Peace
- Green-gables Trust – Trustee
- Temuka Lions Club – Member
- Ward Family Trust – Trustee
- New Zealand Health Partnerships Ltd – Director
- South Canterbury Eye Clinic - Director

Kari Mohoao (AJ)
- Māori Health Advisory Committee Member – Representative on CPHAC

Ngaire Whytock
- Community Representative of CPHAC
- Alzheimer’s Society SC Inc. – Member

Joseph Tyro
- Director of Maori Health

Committee members are reminded that they are responsible for notifying the Committee Chair through the Secretary of any changes in interests, as soon as any changes occur. The disclosure must provide adequate information to enable a determination of the extent of the nature of the interest and to assess actions that may need to be taken to manage any conflicts that arise.
CPHAC MINUTES

MINUTES OF A MEETING OF THE COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE
HELD ON FRIDAY, 30 AUGUST 2019 IN BOARD ROOM, LEVEL 6 GARDENS BLOCK, SOUTH CANTERBURY DISTRICT HEALTH BOARD AT 8.30AM.

PRESENT
Mr M Cleverley, Chair, Board Member, Mr R Luxton, Chair of SCDHB, Ms R Crawford, Board Member, Board Member, Mr G Ford, Community Member, Mr P Binns, Ms N Whytock, Community Member, Ms R de Joux, Board Member (late).

IN ATTENDANCE
Mr N Trainor, Chief Executive Officer, Mr J Power, Director Corporate Services, Carol Murphy, Primary Health Manager, Dr B Small, Chief Primary Care Medical Officer, Joseph Tyro, Director of Maori Health and Mrs Tracey Bown (minute taker)

WELCOME AND KARAKIA
The Chair – Murray Cleverley declared the meeting open at 8.30am.
This was followed by a karakia led by Joseph Tyro.

1. APOLOGIES
Mr K Mohoao, Community Member (MHAC Representative), Ms S Eddington, Community Member (MHAC Representative), and Mr P Anear.

2. DECLARATIONS OF INTEREST
The declaration of interest register was noted.

3. CONFIRMATION OF MINUTES OF PREVIOUS MEETING
The minutes of the meeting held on 28 June 2019 were confirmed.
It was agreed as a true and correct record of the meeting,

4. MATTERS ARISING FROM PREVIOUS MINUTES
Ngaire Whytock corrected that she was indeed at the 3 May and 28 June 2019. This has been confirmed.

5. ACTION PLAN
Report was taken as read.

6. FINANCIAL REPORT
Report was taken as read.
The Committee received the report.

7. ADDITIONAL FUNDING MENTAL HEALTH AND ADDICTION SERVICES
The Committee received the presentation.
Cecilia Hamel-Smith attended a workshop on how the extra funding will look like. There is a new dedicated team to manage and deliver the package to the nation. There is $455 million for Access and Choice across 4 years – the key features: Free access to primary care Mental Health and Addictions Services, No entry criteria, Choice of settings, Easy access, What do you need now and for how long? Move away from prescribed number of sessions, Designed for individuals / whanau / groups, all age groups, National consistency with local flavour, ‘coordination and collaboration’. 
The first year will receive $25mil for expansion of existing pilot programmes – increase staffing and resources. The priorities are Maori, Youth, and Pacific, services for rural and remote communities and a focus of people with lived experience.

Substance and gambling harm will focus on supporting services already in place and funding to DHB’s on a regional basis with expectation that this will support NGO contracts. Gambling will include piloting new services, peer support and residential care.

Mental Health Act 1992 is up for Reform and will be a huge piece of work which has already started. The main focus of the workshop was access and choice and primary initiatives. At the moment we are putting together a proposal for the “one stop” for health, within primary care like AWS that have the smoke free co-ordinator, mental health nurse and primary care nurse. That model is very good and would be great to have a hub like that in Timaru – get the care when the care is needed – integrated health centre.

8. CLINICAL BOARD UPDATE
The Committee received the verbal report.

The Clinical has met twice - 23 July - Credentialling of the Ophthalmology Service was looked at. The service is doing really well and reaching targets, looking at rescheduling of surgery days, staff training due to an aging workforce and communication to general practise. There was a report on Hospice Carers Support Programme went well and will run again. Aoraki Maternity went live on 1 July, doing well so far. A snapshot of our health services 2018/19 shows our ED is doing well at the top of ED’s across Australasia. It was noted that 110 refugees arriving next year. ICATT team launched 1 July this is single point of entry integrated health for community services based up at Woolcombe Street and seems to be going well so far.

27 August – there was a presentation on Mental Health – HQS Zero Seclusion – realistically there will be no Zero Seclusion though reduction is what they are working towards. There needs to be a balance between protecting the staff and the patient. There is a separate isolation area being used before, to reduce the number of seclusions. Child dental health is a big issue and looking at ways to improve the low enrolments numbers. There was analysis of complaints and we had David Templeton attend to discuss the recommendations from the Orthopaedic Credentialling which was done May 2018.

9. IMMUNISATION REPORT/PRESENTATION
The Report was taken as Read.

There is now a category in the report “missed” and Sarah has provided information on HPV. The outbreak of measles was discuss and in South Canterbury we have not had one confirmed case of the 800 cases. Nationally they are thinking to lower the immunisation from 15mth to 12mths. Those born after 1969 to 1999 should have a second shot MMR to boost their immunity.

Wairarapa area doing well with HPV.

The Committee received the report.

10. PRIMARY HEALTH REPORT
Report was taken as read.

The only update is that we have another general practise sitting across the line of Foundation Standards. Murray complimented Carol on the full report. Originally the thought of holding telehealth clinics in Waimate with our Mental Health Service but there was already had an outreach service. There was a trial telehealth clinic done with Twizel patients, this was met with resistance as patients wanted to come to Timaru for the day. Oncology is using this service successfully.

The Committee received the report.
11. **REFUGEE 2020**
   The Committee received the report.
   There is 110 refugees arriving next year in South Canterbury commencing April 2020, after 6-8 weeks at a refugee resettlement centre. 50% are from Asia Pacific region and the main reason is protection. The quota is 50% of the refugees are 18 years or under. When they arrive they have resident status. They will stay in Auckland until accommodation can be found for the families. Each family has a case officer and plan for resettlement. The biggest challenge will be interpreters in the health industry.
   We also have 100 Pacifica men arriving in January 2020 – they will be on 9 months visa so will not be entitled to free hospital care.
   The Committee received the report.

12. **COMMUNITY AND PUBLIC HEALTH 6 MONTH REPORT**
    Report was taken as read.
    Rose Orr attended and Neil Brosnahan phoned in to present. The report is structured around the priority areas. Rose covered the health promotion areas with mentioning feedback from Sneeze Safe, noting that South Canterbury DHB is the programme’s most significant, supportive and loyal community partner, 17 of 19 schools accepting the offer of a session in term 2 and the other two remaining schools would next term. The Voice Youth Art Project has taken place in this period, and are in partnership with Ara Polytechnic, YMCA and Community College, there were 159 entries which was an increase of 30 from last year. There was a School Travel Survey with parents of a primary school, the findings will be used by the Working group. Five ways to Wellbeing promoted in ECE was suggested to reach other sectors.
    Health prevention was presented by Neil starting with the measles outbreak and how providing effective information and proactive work being done to reduced the risk of measles spreading. Measures have been put in place for more effective communication in regards to recreational water such as Caroline Bay. It was suggested to have a flow chart to be implemented with who is responsible for what and who to go to next, and get everyone to sign off on it. Work continues to progress with Alcohol Harm Reduction with monitoring of high risk events with maintaining good communication with all parties involved.
    The Committee received the report.

13. **COMMUNITY AND PUBLIC HEALTH 12 MONTH REPORT**
    Report was taken as read.
    This is a 12 month report for oral health home visits. A majority of the referrals came from medium to high deprivation. The most referrals came from the hospital dental service, community dental service, AWS, and public health nurse. The first 2 months of this financial year we have received 32 referrals all ready. There has been a review of the process with Lynley Cook – Public Health Specialist, to make the process clear and there is more communication with the GP now. This is the highest number of Maori being referred in this time period compared to previous reports, and we will continue to keep well engaged with referring agencies.
    The Committee received the report.

14. **PLANNED CARE APPROACH**
    Report was taken as read.
    New strategic 3 year plan approach is yet to be discussed with all parties, however it is looking at possibility of moving some minor procedures (lumps and bumps) into primary care to reduce the pressure on hospitals. The drivers are the aging population and increased expectations of service users and funding restraints. It about ensuring that services are delivered as close to home as possible and to reduce the gaps between services in a timely manner by reducing demand on hospital services and intervening at the most appropriate time.

15. **PUBLIC EXCLUDED RESOLUTION**
16. RESOLUTION TO RESUME OPEN MEETING

CLOSING
Bruce Small was acknowledged for his contribution to CPHAC and will be missed as he has resigned from his position of Clinical Director for AT&R and CMO for Primary Care.
The Chair thanked everyone for their attendance.
The meeting was closed with a karakia by Joseph Tyro.

There being no further business, the meeting concluded at 10.20am.

Chair: ..............................................................  Date: 3 May 2019
# CPHAC ACTION PLAN

30 August 2019

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<th>Completion Due</th>
<th>Status</th>
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<tr>
<td>1</td>
<td>Kathryn Robinson – management response and a plan in place (Mental Health Services).</td>
<td>Kathryn Robinson</td>
<td>22 February 2019</td>
<td>Mental Health and Addictions Alliance TOR on Agenda</td>
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## Standing Items

<table>
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<tr>
<th>Standing Items</th>
<th>Frequency</th>
<th>Months to be Included in Agenda</th>
<th>Status</th>
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<tbody>
<tr>
<td>1. Community &amp; Public Health Report</td>
<td>Six-monthly</td>
<td>February, August</td>
<td>Ongoing</td>
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<td>2. Health Promotion Matrix</td>
<td>Six-monthly</td>
<td>April, October</td>
<td>Ongoing</td>
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To: Community & Public Health Advisory Committee
From: Grant Keene – Finance Manager
Date: 17 October 2019
Re: Financial Reports – September 2019

Financial Performance Summary

Funder
The Funder is unfavourable to budget by $40k for the month and unfavourable YTD September 2019 by $73k; this is driven by:

Favourable to budget revenue variance $1,522k
Disability Support $416k driven by unbudgeted In Between travel $327k and, Pay Equity funding $101k,

GPs $663k driven by unbudgeted CSC Community Card access funding $473k, Primary Careplus $24k, Very Low Cost Access to Under 14s $34k, GP System Level capability $101k, MOH CPC one off funding $22k

Personal Other Health Services $407k mainly driven by additional unbudgeted Elective funding $274k, ACC Falls Prevention $53k, Tobacco control $45k, Bowel Screening $22k

Unfavourable to budget expenditure variance $1,595k
The main contributor to this unfavourable variance:

- Disability Support services ($587k);
  The unfavourable variance is driven by demand for Home Based Support ($819k) - partially driven by In Between Travel expenditure – ($630k), offset by Residential Care Services $193k, Carer Support $68k.

- Personal health ($876k)
  The unfavourable variance is made up of demand for Pharmaceuticals ($536k) driven by PCT drugs, Primary Practise ($456k) - driven by Community service card expenditure, Travel & Accommodation $65, Minor Expenditure $43k

- Public Health ($22k)

- Maori Health ($12k)

- IDF ($99k)
Governance

*Governance is $137k favourable to budget YTD September 2019*

The Governance favourable variance is driven by the under budget expenditure in Capital Charge of $123k due to the provision of $14mill for the Holiday Act in 2018/19

Recommendation

That the Committee

- Receives this report.

Grant Keene
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<td>Actual</td>
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<td>Variance</td>
<td>YTD Act</td>
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<td>Variance</td>
<td>Forecast</td>
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<td>September 2019</td>
<td>Month</td>
<td>Month</td>
<td>Month</td>
<td>YTD</td>
<td>YTD</td>
<td>YTD</td>
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<td>MOH Funding</td>
<td>17,346</td>
<td>16,753</td>
<td>593 ✓</td>
<td>51,781</td>
<td>50,259</td>
<td>1,522 ✓</td>
<td>204,021</td>
<td>201,035</td>
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<td>Other Non Government income</td>
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<td>IDF Inflow Income</td>
<td>334</td>
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<td>1,001</td>
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<td>4,004</td>
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<td>Total Revenue</td>
<td>17,680</td>
<td>17,087</td>
<td>593 ✓</td>
<td>52,783</td>
<td>51,261</td>
<td>1,522 ✓</td>
<td>208,031</td>
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**Payments to**

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<td>Personal Health Providers</td>
<td>9,669</td>
<td>9,440</td>
<td>(229) ✓</td>
<td>29,199</td>
<td>28,323</td>
<td>(876) ✓</td>
<td>112,181</td>
<td>110,695</td>
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<td>Mental Health Providers</td>
<td>1,021</td>
<td>935</td>
<td>(86) ✓</td>
<td>2,810</td>
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<td>11,141</td>
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<td>Disability Support Providers</td>
<td>3,158</td>
<td>2,889</td>
<td>(269) ✓</td>
<td>9,313</td>
<td>8,726</td>
<td>(587) ✓</td>
<td>35,884</td>
<td>34,286</td>
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<td>43</td>
<td>34</td>
<td>(9) ✓</td>
<td>123</td>
<td>101</td>
<td>(22) ✓</td>
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<td>Maori Health Providers</td>
<td>65</td>
<td>59</td>
<td>(6) ✓</td>
<td>189</td>
<td>177</td>
<td>(12) ✓</td>
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<td>DHB Governance</td>
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<td>1</td>
<td>3,609</td>
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<td>IDF Outflow Expenditure</td>
<td>2,595</td>
<td>2,561</td>
<td>(34) ✓</td>
<td>7,783</td>
<td>7,684</td>
<td>(99) ✓</td>
<td>31,389</td>
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<td>Total Expenditure</td>
<td>16,852</td>
<td>16,219</td>
<td>(633) ✓</td>
<td>50,319</td>
<td>48,724</td>
<td>(1,595) ✓</td>
<td>195,297</td>
<td>192,213</td>
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Net Result (Deficit)/Surplus | 828     | 868     | (40) ✓  | 2,464   | 2,537   | (73) ✓  | 12,734  | 12,832  |
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<td>September 2019</td>
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<tr>
<td><strong>Total Revenue</strong></td>
<td>301</td>
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<td>902</td>
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<td>Outsourced Services</td>
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<td>Infrastructure &amp; Non-Clinical Supplies</td>
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<td>688</td>
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<td>137</td>
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<td><strong>Net Result (Deficit)/Surplus</strong></td>
<td>83</td>
<td>24</td>
<td>59</td>
<td>214</td>
<td>77</td>
<td>137</td>
<td>863</td>
</tr>
</tbody>
</table>
In response to He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addiction, Budget 2019 provided an investment to increase access to, and choice, of primary mental health and addiction services as a critical first step in transforming our mental health and addiction services. The aim of these services is to increase access and equity of access; increase choice in addressing people’s holistic needs; reduce wait times and improve outcomes and equity of outcomes.

Mental health and addiction support funded through the access and choice initiative will encompass all aspects of people’s lives so that when people are in distress, they know there is appropriate support available that is easily accessible. Greater access to services and more choice about the kinds of support available are a core part of this work. Choices will include dedicated services for priority groups: Maori, Pacific peoples and youth, services for people living in rural settings and services integrated with general practices.

An invitation has now been issued to submit a Request for Proposal (RFP) for Integrated Primary Mental Health & Addiction Services accessed through General Practice and represents the first module of the Access and Choice initiative. These general services need to prioritise the groups listed above. The Ministry of Health is seeking evidence of collaboration among PHOS, DHBs and NGOs in developing proposals and has indicated the following evaluation criteria weightings: Focus on equity and priority populations – 15%; collaborative service development and delivery – 20%; service provision capability – 30%; workforce development – 20%; project management – 15%.

There are two tranches of funding: one for services commencing between January and June 2020 and one for services commencing between July 2020 and June 2021. There will be a further RFP opportunity in 2020 for those who wish to commence implementation in late 2021. Funding for the services will be equitably distributed by the Ministry of Health based on population characteristics.

A decision has been made by the Mental Health & Addictions Alliance to submit an RFP for tranche 1 to expand capacity in the current Mental Health Brief Intervention Service and increase the scope and reach of the Arawhenua Whanau Service Outreach Clinic. The rationale for this was that there was strong messaging from the Ministry that funding allocation for the current financial year would to focus on either the expansion of or further
roll out of current initiatives that are known to be effective. Both of these services are held in high regard by both general practice and our community. The following briefly outlines the service scope and proposal to increase FTE through additional funding.

Mental Health Brief Intervention (MHBIS) is a team which provides support to adults aged 18-90+ years with mild to moderate mental health issues. Most of the people seen are experiencing life stressors: alcohol and substance use they or someone else feels are problematic; grief; trauma; relationship stressors such as separation, family court processes; work stress including bullying. All of these has an associated impact on emotional wellbeing.

Referrals are primarily received from general practices and where room allows clients are seen at the general practice. There is also back up capacity at the Community Health Hub at Talbot Park and community centres in the rural areas where space in the general practices is an issue. The service covers the whole of the South Canterbury district with weekly clinics to Geraldine, Temuka and Waimate and fortnightly to Fairlie and Twizel. Where required home visits are made.

A range of intervention modalities are used including: acceptance & commitment therapy; cognitive behaviour therapy; mindfulness, solution focused and trauma informed care. The service currently offers 4-6 sessions that can be used flexibly for a year from the date of referral, however this criterion would need to be relaxed in the spirit of the RFP guidance.

The team FTE is currently 4.4 FTE which is insufficient to meet the increasing demand in referrals. Whilst clients are contacted within three working days from referral the waiting time for the first consultation is 2–3 weeks, often exacerbated during periods of planned and unplanned leave.

The RFP is to increase the FTE to 6.4. This would allow 0.5 FTE clinical lead non-contact time for liaison with general practices and service development (the team is currently remotely directly managed by the Primary Health Manager), and an additional 1.5 FTE to absorb increasing demand and provide leave cover. This would allow capacity to consider initiatives to remove barriers to access such as running evening clinics.

The role of the Arowhenua Whanau Services Mental Health Team is to provide community-based support and education in the home, in the community or at their service bases, whilst walking alongside those people who have identified a need to utilize this service on their journey to well-being.

Arowhenua Whanau Services currently provide nurse led outreach clinics across the district; daily in Temuka as well as an evening clinic on a Wednesday, weekly in Waimate and Timaru and monthly in Twizel. This is a free and confidential service supporting whanau who face challenges in relation to their mental well-being. Referral can be either self-referral or via GP or other community professional. Intervention includes an initial Mental Health Assessment, goals development and navigation and support. The number of sessions is unlimited.

As part of this clinic the current mental health team consists of a 0.4 FTE youth mental health registered nurse, 1.2 FTE adult mental health registered nurse and 1.0 FTE community support worker with ‘lived experience’. The team collectively works with people with mild to moderate mental illness and addictions.
The RFP is to increase the overall FTE by 1.3FTE clinicians and an additional 2.0 FTE peer support ‘lived experience’. This would increase resourcing for youth, a priority group, to 1.3 FTE and a modest increase of 0.4FTE in adult would provide capacity for a 0.3FTE clinical team leader to ensure supervision of the un-regulated workforce, cultural leadership and ongoing service development. The additional peer support will fulfil the critical navigation function and will be able to be accessed by the mental health brief intervention team and general practice in general.

The deadline for submission is the 25 October 2019.

**Recommendation**

CPHAC endorses this proposal.
Memo
To: Community and Public Health Advisory Committee
From: Sarah Greensmith
Date: 16 October 2019
Re: IMMUNISATION UPDATE

Measles

It is recommended that the Immunisation Advisory Centre is the first port of call for everyone seeking the most up to date information about measles in New Zealand. As the Committee would be aware, there is a shortage of measles vaccine and the Ministry of Health and Pharmac have charged all DHBs with keeping and distributing vaccine stocks to Primary Care. This situation is likely to be in place until at least the end of 2019. For South Canterbury, Sarah Greensmith (sgreensmith@scdhb.health.nz) is the single point of contact for measles vaccine.

At the time of writing this report, there has been one confirmed case of measles in the South Canterbury area, and this is being managed through Community and Public Health.

Immunisation 8 Months

<table>
<thead>
<tr>
<th>South Canterbury DHB</th>
<th>Summary of results: Immunisation coverage at age 8 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 95%</td>
<td>Total</td>
</tr>
<tr>
<td>Q1 2019/20</td>
<td>91%</td>
</tr>
<tr>
<td>Q2 2019/20</td>
<td></td>
</tr>
<tr>
<td>Q3 2019/20</td>
<td></td>
</tr>
<tr>
<td>Q4 2019/20</td>
<td></td>
</tr>
</tbody>
</table>

In the three-month period July-September 2019, 91% of our 8 months of age population were fully immunised. For comparison, national coverage was 91% as well.

Out of the 158 eligible children in the 8 month cohort, 144 were fully immunised and 14 were not fully immunised on time. Of the 14 not fully immunised, 6 were of NZ European, 3 of Maori and 5 of other ethnicities. There were:
- 8 declines
- 2 opt off
- 4 missed – for 1 we are awaiting overseas records, and the other 3 are known to immunisation outreach (1 family is delaying immunisation because the baby has been unwell, 1 family is just delaying immunisation, and 1 family is avoiding contact).

**Immunisations 2 years**

For July – September 2019, 94% of our 2 year olds were fully immunised for age, compared with a national average of 91%.

This quarter, 100% of Pacific and 97% of Maori children were immunised on time. Of the 11 children not fully immunised, 6 were New Zealand European, 1 Maori and 3 other ethnicities. There were:
- 7 decline
- 1 opt off
- 3 missed – 1 child is on an overseas catch up schedule and 2 are now being followed up by the immunisation outreach team. Through preparing this report we noticed that follow-ups and referrals to outreach from a particular area needed some work, which we have now commenced.

**Immunisations 5 years**

For July – September 2019, 95% of our 5 year olds were fully immunised for age, compared with a national average of 88%.

Of the 8 children not fully immunised on time, 6 were New Zealand European, 1 Maori and 1 other ethnicities. There were:
- 7 decline
- 0 opt off
- 1 missed – this child is on an overseas catch up schedule which is almost completed.

_For this report, data was extracted from the National Immunisation Register 09 October 2019. The data covers quarter 1 2019/20 which is 1 July-30 September 2019._

**School Based Immunisation Programme**

The school based immunisation programme is complete for 2019. In the first round of the programme in March, the team delivered 175 Boostrix vaccinations to Year 7s and 277 HPV9 vaccinations to Year 8s. The second dose of HPV9 was delivered to the Year 8’s in September.

The participation rate of Year 8s in HPV immunisation here remains low compared with other areas of New Zealand. However early indications are that we will see an improvement in coverage for the 2006 cohort when we report on this in July 2020 – our baseline is 40% coverage for the recently reported 2005 cohort, and we are aiming for 50% (at least) for the 2006 cohort in July 2020.

The Committee asked me to follow-up with colleagues in Wairarapa DHB to see what they may be doing differently to be getting high HPV coverage. My colleagues in Wairarapa were pleased to be asked, but stated that the school based programme is deemed Business as Usual, and does not rely on any special communications or campaigns.

For the 2020 School Based Immunisation Programme, we are discussing with schools the possibility of delivering the Year 7 Boostrix vaccinations with the second round of HPV9 in September, rather than with the first round in March. This is because first term is particularly busy for schools with sports and camps, and getting two year groups sorted for vaccinations is challenging for both schools and the nursing team. Schools so far are happy with shifting the Year 7 vaccinations to September.

**HPV Official Information Act Request**
For the Committee’s interest a journalist from TVNZ made an Official Information Act request to the Ministry of Health for data about HPV immunisation, and the request was partially transferred to all DHBs for their response. The three questions that we were required to respond to were:

1. The number of schools offering the vaccine over the past ten years
2. The number of women who received the vaccine in schools over the past ten years
3. The number of women who received the vaccine outside of schools over the past ten years

### OIA Request: HPV Vaccine South Canterbury

<table>
<thead>
<tr>
<th>Year</th>
<th>girls vaccinated at school</th>
<th>girls vaccinated outside of school</th>
<th>total girls vaccinated</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>952</td>
<td>445</td>
<td>1397</td>
<td>29 schools - HPV immunisation offered to all girls year 8-13. Gardasil 4 vaccine, three dose regime for all.</td>
</tr>
<tr>
<td>2010</td>
<td>0</td>
<td>122</td>
<td>122</td>
<td>HPV immunisation offered through primary care only</td>
</tr>
<tr>
<td>2011</td>
<td>0</td>
<td>130</td>
<td>130</td>
<td>HPV immunisation offered through primary care only</td>
</tr>
<tr>
<td>2012</td>
<td>dose 1 only at schools n=107, dose 2 and 3 outside of school</td>
<td>141</td>
<td>248</td>
<td>32 schools = routine all schools with year 8 girls, plus offer to high schools for catch up programme. This mixed school/primary care initiative was intended to encourage more families to begin, and continue with, the immunisation process.</td>
</tr>
<tr>
<td>2013</td>
<td>123</td>
<td>156</td>
<td>279</td>
<td>32 schools = routine all schools with year 8 girls, plus offer to high schools for catch up programme. All 3 doses completed at schools moving forwards.</td>
</tr>
<tr>
<td>2014</td>
<td>126</td>
<td>62</td>
<td>188</td>
<td>32 schools = routine all schools with year 8 girls, plus offer to high schools for catch up programme</td>
</tr>
<tr>
<td>2015</td>
<td>155</td>
<td>85</td>
<td>240</td>
<td>32 schools = routine all schools with year 8 girls</td>
</tr>
<tr>
<td>2016</td>
<td>115</td>
<td>49</td>
<td>164</td>
<td>32 schools = routine all schools with year 8 girls</td>
</tr>
<tr>
<td>2017</td>
<td>131</td>
<td>47</td>
<td>178</td>
<td>32 schools (plus 1 more school boys only). 2017 was when boys were first eligible, and were included in the year 8 school based programme. School based programme shifted to Gardisal 9 and 2 dose regime for under 15 year olds.</td>
</tr>
<tr>
<td>2018</td>
<td>111</td>
<td>116</td>
<td>227</td>
<td>31 schools (plus 1 more school boys only). School programme now routinely includes all students in year 8, 2 doses of Gardisal 9.</td>
</tr>
<tr>
<td>totals</td>
<td>1820</td>
<td>1353</td>
<td>3173</td>
<td>These data were sourced from the National Immunisation Register 2 and 3 October 2019, using “vaccination list report” per year, and our school based system.</td>
</tr>
</tbody>
</table>
Memo

To: CPHAC Members
From: Carol Murphy, Primary Health Manager
Date: 8 October 2019
Re: Primary Health Report

Primary Health Support

Another busy period for Primary Care relating to *MMR immunisation* activity including, public inquiries, vaccine level stock takes and changes to stock acquisition process for general practices. With the rationing of MMR vaccine across the country in support of the Auckland outbreak, all stock is now controlled through a central DHB stock control manager. This situation is expected to remain in place in the foreseeable future. Clear criteria for vaccination priority groups has now been received from the Ministry and advised to general practices. Regular national updates continue to be received. South Canterbury has not had a reported case of measles (one child in Starship Hospital Auckland did have a South Canterbury address which has been captured in the national data set).

Notification has been received that **McSherry Medical Ltd will own Highfield Medical Centre** as of the 15 November. Highfield Medical Centre will operate as a satellite clinic of Parkside Medical Centre as of the 18 November 2019. This will reduce the number of local general practices to 20.

The following outlines activity related to requests for a GP.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of New GP requests</td>
<td>41</td>
</tr>
<tr>
<td>Number of New GP requests closed</td>
<td>34</td>
</tr>
<tr>
<td>Number of Change requests</td>
<td>19</td>
</tr>
<tr>
<td>Number of Change requests closed</td>
<td>10</td>
</tr>
<tr>
<td>Number of people left on NP list</td>
<td>15</td>
</tr>
<tr>
<td>Number of people left on change list</td>
<td>38</td>
</tr>
</tbody>
</table>

During November 17 Samoan men will arrive at the Silverfern freezing works, as NZ residents. Early in the New Year their wives and family will join them. We are expecting that this quota will be around 100 residents to enrol with GPs. A further 29 workers arrive before Christmas on a 1-year visa. These workers are not eligible for public health care funding (to enrol with a GP) so will put pressure on our duty Drs.
Discussions continue over the status of the current Aoraki HealthPathways. As reported previously a significant number HealthPathways are either yet to be localised or reviewed. This appears to be a multi-factorial issue which includes clinician engagement in addition to resourcing. We have been advised by Streamliners that in 6 months’ time there will be 415 reviews overdue which is, 83% of our localised pages. They are suggesting that initially this be brought down to 30% overdue as a good target. This means we would need to complete 265 reviews. Streamliners has requested a corrective action plan to resolve this issue. A plan to address this was devised on the 8 October 2019.

Recruitment for a replacement CMO Primary Care continues.

The after-hours roster for Temuka/Geraldine has been developed for 2019/20. Temuka/Geraldine afterhours and has now also been set up on Healthpoint as HML no longer do this. This will be an additional ongoing administrative task for the Primary Health Support Office.

Work continues on trying to attract a replacement locum, with no success. This is now becoming critical as the current locum’s contract finishes in November. Work on reviewing the true cost recovery for this support service is currently underway and practices will be advised of the new rates (which will be dependent on whether an agency is used or not) shortly. This work is required to ensure the future sustainability of this well-regarded service. Administration costs relating to the coordination of this service will continue to be covered by the Primary Health Support Office and as such will be a cost saving for practices.

Attendance at GP peer group meeting provided an opportunity to engage a large number of GPs and provide updates on new Ministry funding and access criteria. As an aid to GP/NPs a quick reference sheet with all current available programmes, access criteria and payment schedules has been put together as a memory aid for use during consultations. This is being finalised and will be sent out in October.

Performance Monitoring

Work has commenced on developing a Balanced Score Card for Primary Care. This will have six domains: Population Screening; Immunisation Coverage; Patient Experience; Contract Monitoring; Flexible Funding Programme Monitoring; and Quality Monitoring. The intent is to provide a comprehensive monitoring report that brings all current activity together into one report for reporting to SLT, Primary Care Alliance and CPHAC. This will be produced quarterly with the first report expected for Q1 2019/20.

The latest Patient Experience Survey has been completed. This was for the survey week in August 2019. There was a response rate of 27% which is comparable to last year. 4% of those invited to participate were Maori. 29% of those Maori invited completed the survey.

Some feedback

- 56.3% can get either a same day or next day appointment (36.5% nationally)
- 10.2% report the time they wait at the practice for their appointment is unacceptable
- 7.5% report they couldn’t get healthcare when they needed it (15.8% nationally)
Responsive – 62.7% (national 62.9%) get same day response for important matters.

12.4% say cost is a barrier – there has been a significant drop in this statistic (Due to the CSC subsidy)

There were 427 comments from survey week in August:

Overall comments were extremely positive. Some areas of interest included lack of continuity of care, length of time to see specialist, lack of explanations of medication side effects, wait time of up to 2 hours to be seen by the Dr, issues around mental health/understanding of practitioners.

National & Regional Activity

The Primary Care Caucus pre-PSAAP meeting was attended on the 22 August and followed in the afternoon with a Primary Care Combined Strategic Workshop facilitated by the Ministry. A framework, setting the direction for Primary Care was worked up further to identify priorities for PSSAP budget bids for 2020/21 and to inform the PSAAP Work Plan for 2020/21. These priorities were confirmed at the PSAAP meeting held on the 27 August 2021. SC Primary & Community Services will be part of the working group on Immunisation Schedule Review Group. Other agenda items included Planned Care Approach and Foundation Standard. Dr David Clarke briefly attended the meeting and provided an update on the status of the Health & Disability Review. The progress report is currently with him and is expected to be released shortly.

A PSAAP Working Group Primary Care Caucus approach meeting was held on the 13 September 2019. The meeting focused on clarifying the scope of each of the four working groups.

The SCDHB portfolio manager is also to be part of the PHO Services Agreement ‘back to back’ template working group. Whilst in the absence of a PHO SCDHB doesn’t utilise such a template it was considered to be a useful learning opportunity relating to contract management.

The Community Pharmacy Portfolio Managers meet on the 26 August to discuss the Integrated Community Pharmacy Services contract variations and signing process.

Local Activity

Attendance at the Refugee Re-settlement Hui provided an introductory session to the planned intake of 110 refugees to Timaru commencing April – June 2020. Each family has a case worker and a re-settlement plan. A further hui is planned for November, at which time we will know the origin of the cohort and the Service Provider coordinating the local resettlement. Access to translation services is likely to be one of the biggest issues for healthcare provision.

Participation in the DHB Emergency Response Exercise, whilst not directly impacting on Primary Care did identify the lack of a telephone cascade system within South Canterbury general practices. This has been added to the Primary Health Supports work plan.

The Primary Care Alliance meet on the 20 August 2019.
1. Quarterly Accountability & Contract Monitoring Reports – Alliance to take a greater role in monitoring performance across general practices.
2. Primary Care Education Approach – very poor attendance at forums which would indicate current approach is not meeting need. Group to be convened to review education calendar.
5. Planned Care Approach – presentation and to remain a standing item.
6. Mental Health & Addictions Additional Funding – presentation and MH&A Alliance and Health & Wellbeing Working Group updates to be a standing item.
7. Community Nurse Prescribing – presentation and to be a standing item.
9. PPIG Contract – not renewed (see contract Management section for further information).
10. Practice Manager representation – request for expressions of interest.

The Primary Care Alliance meet on the 17 September 2019.

1. Access to diagnostics - clarification relating to access to CT and MRI to be included in Healthmatters newsletter.
2. Response to CVDRA funding - to be targeted at ‘hard to reach’ and Maori. AWS to be invited to present a proposal on a CVDRA Outreach service at the October meeting.
3. PCMO Recruitment Update – interview panel to include a GP representative. PCA chair to provide clinical advice to Primary Care in the interim.
4. Maternity Early Warning Score – Hospital version to be modified for use in Primary Care for consideration by the Alliance.
5. Discussion on what Excellence looks like in Primary Care – workshop to be held in November 2019.
6. Planned Care Approach Update – meeting with business owners before year end.
7. Mental Health & Addictions Funding - RFP open for Integrated Mental Health & Addictions Services. Proposal being worked up to expand existing MHBIS and AWS mobile community health hub.
8. Community Nurse Prescribing – interest from one ARRC facility and one general practice
9. Selection Practice Manager Representative – Michelle Baldwin, Timaru Medical Centre
10. Suggested Improvements to HealthOne – safety of platform i.e. privacy breaches and inconsistency of access to radiology results
11. Vaccine Stock Control Manager – all MMR stock for general practice to be ordered through designated stock control manager for SCDHB, Sarah Greensmith.

The Rural Health Alliance met on the 13 August. Discussions centred on rural funding streams and rural ranking scores. Follow up letters have been sent to providers with a request to meet individually to discuss draft Rural Ranking Scores. Clarification is being sought from the Ministry regarding designated rural practice status and interpretation to the Rural Ranking Score Worksheet. This will inform follow up discussions.

Primary Care is participating in the Mental Health & Addictions Alliance and is part of both the Review document working group and taking the lead on preparing the RFP for tranche 1 of the Integrated Mental Health & Addictions Ministry funding. These is a significant piece of work and will focus on expanding both the MHBIS and the AWS Outreach Clinic. In doing so
we hope to meet the requirement to target a number of the high priority groups i.e. Maori, Youth and rural.

Primary Care attended the Ministry of Health Diabetes Services Review Meeting. A way forward has been identified in meeting Ministry reporting requirements around Annual Diabetes Reviews. The Virtual Diabetes Register for South Canterbury has been requested from the Ministry for data matching against the labs warehouse.

The Joint Forum on the 21 August focused on a number of topics: Fala Pacifica O Aoraki Health Homes and Mother & Pepe Programme; Whanau Support Pathway and the Hep C Pathway.

The GP/NP Forum on the 11 September 2019 was delivered by Southern Community Laboratories and provided an opportunity for discussion on a number of clinical topics.

The PN Forum on the 18 September 2019 included the Nurse Practitioner Pathway – lived experience as well as a professional nursing update and a combined session delivered by the Surgical CNS team covering, wound care, pain management and adverse reaction to metal and debris (joint replacement).

The first education forum review meeting is scheduled for the 16 October 2019. A tentative date for the 2020 Primary Health Symposium has been set for the 28 March 2019.

**Contract Management**

The review of the Primary Care Services Agreement is progressing with both the main document and local variations with the review team for comment. A meeting will be scheduled for later in October 2019.

**Performance payments** for practices as per the Primary Care Services Agreement are currently being calculated for the 2018/19 year and will be paid in November.

All local Community Pharmacy Owners have sign Variation 1 of the Integrated Community Pharmacy Services Agreement. In relation to local commissioning a decision was made to transfer those monies previously allotted to smoking cessation, and not utilised to the workforce development funding component of the local commissioning funding. This is for the 2019/20 year only. Once training is delivered on local commissioning, expected from the Ministry soon, discussions will occur as to how this $8K could be utilised going forward to reduce inequities in health outcomes for priority groups.

We are exploring the option of getting an institutional subscription for Up to Date to have this available for all Primary Care clinicians. We are awaiting a quote and a meeting is scheduled for the 15 October 2019.

Despite permission to access our pharmaceutical data from the Ministry being provided there has been a delay on the Ministry’s behalf in releasing this information. We hope to receive our first suite of dashboards from AirMed shortly.
A decision has been made not to renew the **PPIG programme** contract due to the associated increased costs. A similar programme will be developed and run by the Community Physiotherapy Team. This will allow an increased volume and no co-payment to the participant. A physiotherapist who will oversee this new programme (yet un-named) has already been appointed. As this FTE is largely funded from the Primary Care Ring Fence funding, quarterly activity and outcome monitoring reports will be submitted to the Primary Care Alliance. This position is contracted for two years and will be reviewed by the Alliance at that time.

The subcontract from CDHB for the provision of ‘**Integrated Hepatitis C Assessment & Treatment Services in South Canterbury**’ has now been signed. Public health messaging continues with posters having been distributed to general practices and community pharmacies.

An update to the contract held with ACC for **Sexual Abuse Assessment & Treatment Team** has been received and updates with revised rates distributed to contracted providers for sign off. One of our long-standing clinicians will exit the service in November. A replacement GP is currently in training.

A further contract has been issued for **Nerve Conduction Studies**. The volume has now been capped and the timeframe set till June 2020 only. This is to allow the orthopaedic service time to establish access criteria and the funding source to be reviewed.

We have now received a contract for a further three years to support **More Heart & Diabetes Checks**. This money will be utilised to establish a CVDRA Outreach Service focused on Maori and hard to reach populations. AWS have been requested to present a proposal to the Primary Care Alliance on how this could be delivered in October.

**Population Health**

**Health Promotion & Prevention Steering Group**

The first meeting of the **Health Promotion & Prevention Steering Group** was held on the 8 October 2019. The priority of an Alcohol Harm Reduction Plan aligned to the DHB Position Statement on Alcohol is on the next Primary Care Alliance agenda. $10k of Primary Care flexible funding has been allocated to support health promotion in relation to this plan.

**Cervical & Breast Screening**

Additional priorities relating to breast and cervical screening have been worked up for inclusion in the **DHB Annual Plan**. Initial discussions have occurred with Fale Pacifica in relation to improving screening rates for this cohort and will be progressed once Fale Pacifica staff available. A meeting was held with the team from ScreenSouth and AWS on the 6 August. This has help cement relationships and set the foundations for our partnership moving forward.

**Smokefree Team**

The SmokeFree team are continuing to rebuild our public profile in the community. A full presentation was delivered to the Community Sector Forum, updating them on our full
services, products with a display table offering referral forms and promotional material. Approximately 50 people representing various government, non-government and community organisations attended and many took our referral forms for themselves, clients and family members. We have been promoting the Stomp out the Butts Promotion for September by visiting and distributing fliers and posters to general practices, pharmacies, opticians, dentists, hospital and community. This is being promoted on the radio and involves incentives and spot prizes to set a quit date, and an incentive to those who have stopped smoking for four weeks in September. This is also promoted on the radio and Healthbeat.

Fale Pasifika had a pacific parenting programme that the Stop Smoking Service (SSS) were asked to participate in, however no-one enrolled. Fale Pasifika have found that they must provide a service in the home with small groups, and will include the SSS service.

A weekly trial clinic has commenced at Community College, with one young person already enrolled.

SSS received educational training from the National General Manager for Vaporium (Maia Waters) regarding their new referral pathway for our clients who choose to stop smoking using vaping as a cessation tool. This may suit those who live in rural areas but also those working during our work hours.

We are working with the communication manager on a good news story about a 26-year-old, Timaru woman with four children, who improved her health and family life to stop smoking using our service. This will be shared with professionals to communicate how this reduced her stress and to not to give up on smokers because it took her several attempts to stop smoking.

All hospital CNM have been offered in-service training for staff after receiving ABC Smoking reports and training was delivered to the hospital midwives including vaping, prescribing NRT, pregnancy incentive programme and Carbon Monoxide monitor training.

An evaluation form on the pregnancy incentive has been delivered to clients which has been running for 18 months.

A shared presentation to the Timaru Boys High school boarders was given alongside Community Public Health to educate on drugs, alcohol, smoking and vaping. Over 40 boys attended with 90 per cent indicating they have tried vaping. Very few are smoking, and they are well aware of the nicotine in some vaping juices/salts. Their preference is to use products with nicotine.

New quit packs have been created, and delivered to the community which contain various relevant SmokeFree information to educate and promote our service.

The SmokeFree team had some short-dated product of Nicotine Replacement Therapy (NRT), which we were distributed to priority and rural practices. We are encouraging practices to offer patients these products to sample, with an information book describing how to use the products correctly, and our contact details for further support. We hope that this increase the uptake of our services. We have also started a trial to supply NRT sample packs to inpatients who are smokers and wish to stop smoking on discharge. This will be done with full consultation with medical staff.
Mental Health Brief Intervention Service

Attendance at the Waimate Resource Trust 25th anniversary provided a good networking opportunity with community and government departments. Other networking opportunities have included the connecting with the Multi-Conditions Group in Waimate and the Primary Health Joint Forum.

Reporting from our new Halcyon reporting software is now available. During September 89 new referrals were accepted. 250 consultations were delivered to 172 clients. It is expected that the suite of reports will be expanded over time. Two client satisfaction surveys have been distributed. Enhancements to the Halcyon system continue. Referral numbers continue to climb. Some additional resourcing approved to cover leave.

ICATT

Throughout the quarter iCATT referrals have reached a total of approx. 1734 (Average 28 per day which is not evenly distributed across the week) hence the triage time in the am meeting fluctuates often governed by the information contained on the referral forms. ICATT Coordinator will touch base with CNM’s in the next month to support improvements in documentation. The iCATT HPS process is to be implemented in October which will allow more accurate recording and streamlining of paper-based referrals which aims to reduce duplication in particular for referrals to Allied Health that occur across the team will no longer need to be paper-based.

NASC

NASC have seen a drop in hospital referrals July-65, August-51 and September-27. Wards anecdotally are delaying discharges following completion of NASC assessments and coordination tasks. To monitor reasons for this to identify if changes to process are required. A stocktake occurred identifying there are 164 Annual NASC reviews that are overdue. Priority list and plan in place to address these over the next two months. Home Based Providers 3 and 6 monthly reviews are also behind schedule and they been requested to complete with urgency. It is predicted that by completion of these reviews it will avoid potential hospital admissions.

Social Work Service:

The Paeds/Maternity Social Worker has been busy networking in September for the new Pepe and Whanau Service. They also held their first meeting which was very successful. This is a multi-agency approach to supporting vulnerable whanau/families during the maternity care period (antenatal to 6 weeks post-partum), by working in partnership with these whanau/families. The purpose of the group is to support and strengthen whanau/families who are expecting a baby and face challenges that may impact on their parenting or wellbeing of the children.
Memo

To: CPHAC Members
From: Carol Murphy, Primary Health Manager
Date: 8 October 2019
Re: Draft Environmentally Sustainable Healthcare Position Statement

The attached draft Environmentally Sustainable Healthcare Position Statement has been created by the South Island Public Health Partnership and is presented to the SCDHB CPHAC for endorsement prior to being presented to the Board for approval. This position statement has already been approved by NMDHB, CDHB and WCDHB Boards and accepted by the SDHB Commissioners.

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

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

Recommendation:

That CPHAC endorses this position statement.
Environmentally Sustainable Health Care: Position Statement

2019
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POSITION STATEMENT

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

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

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

Scope
The focus of this position statement and background paper is on human-caused global warming1 and the resultant global climate change, because human-caused global warming has been identified as the most pressing environmental change currently occurring [1-3].

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

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

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

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

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

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1 In this Position Statement, the term global warming refers to a gradual increase in average global surface temperature (as one of the consequences of anthropogenic emissions) and the term climate change describes the resultant amplification of natural climate variability (i.e., the portion of climatic variability that is attributable to human activities).
1.4. acknowledges that health care systems’ contributions to New Zealand’s total greenhouse gas emissions are significant, and environmental sustainability within health care involves ensuring the efficient management of all physical, financial, and human resources within the sector, including upstream inputs of goods and services and downstream clinical and non-clinical waste, (pages 14–17) and

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

Actions
South Canterbury District Health Board will:

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

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

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

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

Abstract

The purpose of this Background Paper is to inform the commitment, statements, and actions of the South Island District Health Boards in their efforts to achieve an environmentally sustainable health system. The most rapid environmental change currently occurring, on a global scale, is human-induced global warming and the resultant global climate change [1-3]. Increased emissions of fossil CO₂ since the mid-18th century have amplified the natural greenhouse effect causing the Earth’s average surface temperature to rise [1,6,7]. The effects of ongoing global warming and global climate change now threaten to undermine many of the social, economic, and environmental drivers of health and wellbeing that have contributed greatly to human progress [1,3]. Trends in climate change impacts, exposures, and vulnerabilities indicate high levels of risk for the current and future health and wellbeing of all populations in New Zealand [8]. Our failure to reduce emissions and to build adaptive capacity threatens human health and wellbeing and the viability of health infrastructure and services.

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

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

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

SUSTAINABILITY

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

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

HEALTH SYSTEM

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


HEALTH

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


ENVIRONMENTALLY SUSTAINABLE HEALTH SYSTEM

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

Introduction

Background

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

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

Human activities are estimated to have already caused approximately 1.0°C of global warming above pre-industrial levels (likely range of 0.8°C to 1.2°C) \[3,6\]. Global warming is likely to reach 1.5°C between 2030 and 2050 if emissions continue to increase at the current rate (BOX 1) \[6\]. Pathways limiting global warming to 1.5°C will require rapid and far-reaching transitions in energy, land use, urban infrastructure, and industrial systems (including transport and buildings) \[6\]. Limiting global warming to 1.5°C will also require future large-scale deployment of carbon dioxide removal technologies (CDR) \[23\] and can only be achieved if global CO\(_2\) emissions start to decline well before 2030 \[6\]. Without these global actions, the world will exceed its carbon budget and may experience high levels of warming (4–6°C) by 2100 \[6\]. Warming in the range of 4–6°C will result in many populated areas of the world being unable to support human health and wellbeing.

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

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

\(^3\) This list only includes emissions, however, deforestation also increases the net carbon dioxide (CO\(_2\)) in the atmosphere by reducing the amount of natural carbon dioxide removal.
systems depend largely on the future magnitude and rate of warming, geographic location, levels of
development, and ultimately on the choices and implementation of mitigation and adaptation
options [10,22]. The effects of climate change are being felt today, and have been described as
representing an ‘unacceptably high and potentially catastrophic risk to human health’ [2, p.1861]
which ‘threaten[s] to undermine the past 50 years of gains in public health’ [1, p.581].

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

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

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

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

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

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

Tertiary health effects/risks include:

- social change and population
displacement/migration to New Zealand
- social and economic disruptions (diverse health
consequences of livelihood loss)
- child development and life-course/adult health
- mental health and stress-related disorders, and
neurological diseases and disorders
- health effects related to food security and
safety
- effects on occupational health

- consequences of tension and conflict (domestic
and international) owing to climate change-
related declines in basic resources
- poverty and disadvantage increased
effects of aesthetic and cultural
impoverishment.
Towards environmentally sustainable health care

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

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

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

Māori health and equity

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

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

BOX 2

Equity

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

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

Advocacy
Attention to the related health effects of climate change, and the necessary responses, is growing both in the media and in academic publications [1]. Contributions from within the health professions are increasingly seen as essential in driving sustained progress on reducing emissions, and realising the local and global health benefits of climate action [1]. The need for advocacy in public health is not new. The 1986 Ottawa Charter [43] has long highlighted advocacy as a fundamental strategy for advancing health as a major resource for social, economic and personal development, and an important dimension of quality of life. Most definitions of public health reinforce that public health is future–orientated and depends on “the organised efforts of society”5 [44,45]. The World Health Organization continues to highlight the need for the health sector to ‘advocate social change as a means for sustainable improvement of population health’ [37, p.175]. Moreover, the principle of moral equality6 provides strong ethical grounds for the health community in particular, to advocate for climate change action on behalf of current and future generations [45]. Advocacy is required to raise attention and sustain support for climate change actions and this requires the development and implementation of a health sector strategy for high-level strategic communication [1,2,37].

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

Carbon accounting

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

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

<table>
<thead>
<tr>
<th>Scope</th>
<th>Description</th>
<th>Summary</th>
<th>Contribution(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Scope 1 emissions are the <em>direct</em> emissions emitted from the burning of fossil fuels to generate heat and electricity, on-site.(^b) Plus the direct emissions from health-organisation owned vehicles such as fleet and patient transport services, other incinerators or combustion processes, and emissions from chemical production where the equipment is owned and operated by the health-organisation/entity. Scope 1 emissions account for approximately 20% of the total CO(_2)e emissions in this example.</td>
<td>Direct, by-products of combustion (for heat, power, and transport: on-site.</td>
<td>≈20%</td>
</tr>
<tr>
<td>2</td>
<td>Scope 2 emissions are those <em>indirect</em> CO(_2)e emissions attributable to the generation of electricity off-site(^c) that is purchased and consumed on-site. Scope 2 emissions account for approximately 20% of the total CO(_2)e emissions in this example.</td>
<td>Indirect by-products of electricity generation: off-site.</td>
<td>≈20%</td>
</tr>
<tr>
<td>3</td>
<td>Scope 3 emissions are those <em>indirect</em> CO(_2)e emissions attributable to the production of materials used for buildings and health care infrastructure, the procurement of goods and services used in the delivery of health services, and patient, visitor and staff travel.(^d) Scope 3 emissions account for approximately 60% of the total CO(_2)e emissions in this example.</td>
<td>Indirect, everything else: off-site.</td>
<td>≈60%</td>
</tr>
</tbody>
</table>

\(^a\) The relative contributions from each scope are likely to be country/organisation/time-specific. A country’s electricity generation profile will influence the relative contributions (the table should be considered as an example only).

\(^b\) Direct CO\(_2\) emissions from the combustion of biomass (e.g., in a wood-fired boiler) are reported separately.

\(^c\) Scope 2 emissions physically occur at the power station where electricity is generated.

\(^d\) These emissions occur as a consequence of the activities of a health-organisation, but occur from sources not owned or controlled by the health-organisation (e.g., pharmaceuticals and medical devices; transportation of purchased fuels and other goods; employee business travel, employees commuting, transportation of waste, and emissions generated during the production of electricity that is consumed/lost in a transmission and distribution system).

---

\(^7\) Climate change is largely attributable to emissions of carbon dioxide (CO\(_2\)), hence other greenhouse gasses are equivalised to CO\(_2\)’s warming potential.
The Scopes 1, 2, and 3 cover three fundamental categories of emissions: emissions generated by the production of heat and electricity (on-site), emissions attributable to the generation of grid electricity (off-site), and ‘everything else’. These broad categories can be further broken down into numerous sub-categories, such as heating, lighting, travel to-and-from health care sites by patients and visitors, staff commuting and business travel, and notably, embedded carbon emissions associated with the procurement of goods and services used in health care delivery.

Scope 1 and Scope 2 emissions are relatively easy to identify and quantify as they relate to energy consumption activities that occur within an organisation’s operational boundary. These energy-related emissions may account for approximately 40% of a health system’s total carbon footprint (depending on a country’s electricity generation profile or ‘percent renewable’ and the influence this has on Scope 1 and Scope 2 emissions). Scope 3 emissions have been shown to account for approximately 60% of a developed country’s health system’s total CO₂e emissions, based on a number of carbon footprinting studies [46,51-54]. In particular, procured pharmaceuticals, single-use medical devices, and medical equipment typically contribute the most within the Scope 3 category [55], as well as non-medical goods (e.g., food) and building/construction [52]. Health systems also procure substantial volumes of services from external contractors, and these procured services also contribute to Scope 3 emissions. The Appendix extends Table 1 and provides a detailed example of the application of carbon accounting principles to an entire health system. International research in the US, Australia and the UK⁸ [46,51,56-59] has shown that it is necessary to pursue carbon reductions across all categories, because no one category has the potential for the scale of savings necessary to meet current global emission targets [47,56].

**Applying carbon accounting to prioritisation and decision-making processes**

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

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

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

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

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

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

BOX 3
Cradle-to-grave analysis of the environmental costs of goods and services

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

---

9 Note: Scope 3 is not entirely non-energy because it also includes fuel consumed for staff, patient, and visitor travel, and lifetime emissions from all medical products used by patients in home-care settings.
Procurement emissions: hot-spots, and possible solutions
The hot-spots approach to reducing procurement emissions initially involves identifying those high-carbon aspects of service delivery that are also the most amenable to optimisation. Then, low carbon procurement seeks to work with suppliers, and to procure goods, services, works, and utilities with a reduced carbon footprint, throughout their life cycle. Identifying goods and services that produce high levels of greenhouse gas emissions may also highlight areas where potential cost savings can be made. Low carbon procurement can lead to substantial reductions to the organisation’s overall carbon footprint [65] and this is particularly relevant to clinical settings because many of the consumables used, such as pharmaceuticals and anaesthetic gasses, contain particularly high levels of embedded carbon. Low carbon procurement strategies can be applied across all settings, including primary care, hospitals and other facilities, as well as patients’ homes [48].

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

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

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

In summary, accounting for and acting on Scope 3 emissions is not without complexity, and there remain significant gaps in the evidence base on procurement, as it relates to health system...
sustainability. Further assessments of environmental impacts are needed, both at the level of individual care facilities and at the system level [52]. However, despite these knowledge gaps, a large amount of easily accessible information is now available to inform sustainable procurement planning and action. A useful starting point is to apply cradle-to-grave [69] assessments to a small number of selected business-as-usual care pathways, using product guidelines and product hot-spot lists. Incrementally, this approach can progress to applying environmental and social/ethical criteria to all tendering processes [48,50,67].

Future opportunities within the New Zealand health sector

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

10 CEMARS® a wholly owned subsidiary of Landcare Research and 100% owned by the New Zealand Government.
Without comprehensive Scope 3 data, service providers lack much of the information needed to be able to understand and effectively manage their future sustainability.

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

<table>
<thead>
<tr>
<th>The Greenhouse Gas Protocol Scope – 3 emissions*</th>
<th>CEMARS programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHG protocol Scope 3 sources (non-exhaustive) ranked by contribution</td>
<td>Canterbury</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td></td>
</tr>
<tr>
<td>Commissioned health services from outside system</td>
<td></td>
</tr>
<tr>
<td>Medical Instruments/devices</td>
<td></td>
</tr>
<tr>
<td>Food and catering</td>
<td></td>
</tr>
<tr>
<td>Freight transport</td>
<td></td>
</tr>
<tr>
<td>Meter-Dose inhalers</td>
<td></td>
</tr>
<tr>
<td>Air travel - domestic and international</td>
<td></td>
</tr>
<tr>
<td>Transport – private car for work-related transport</td>
<td></td>
</tr>
<tr>
<td>Taxi</td>
<td></td>
</tr>
<tr>
<td>Other staff transport (shuttle bus)</td>
<td></td>
</tr>
<tr>
<td>Staff commuting to and from work</td>
<td></td>
</tr>
<tr>
<td>Construction</td>
<td></td>
</tr>
<tr>
<td>Paper products (office paper)</td>
<td></td>
</tr>
<tr>
<td>Waste products and recycling</td>
<td></td>
</tr>
<tr>
<td>Anaesthetic gases</td>
<td></td>
</tr>
<tr>
<td>Other products</td>
<td></td>
</tr>
<tr>
<td>Other services (e.g. linen services)</td>
<td></td>
</tr>
<tr>
<td>Home use of medical devices (e.g., electricity used to run CPAP machine)</td>
<td></td>
</tr>
<tr>
<td>ITC technologies</td>
<td></td>
</tr>
<tr>
<td>Water and sanitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>included</td>
</tr>
</tbody>
</table>
| * Scope 3 emissions have been estimated to account for the majority of a health system’s total GHG emissions (the balance being energy-related emissions – in one form or another). The exact proportions will differ from country to country based on different energy generation profiles and other factors.

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

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

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

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

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

\(^{11}\) Likely because they are not easy to capture and some potential wellbeing impacts and/or cultural value(s) cannot be fully monetarised.
BOX 5

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

Mitigation measures

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

Overlapping pathways

- Reduced costs
- Lower CO\(_2\) emissions
- Improved air quality
- Reduced indoor humidity and more comfortable temperature
- Increased physical activity
- Less noise from transport
- Reduced exposure to motor vehicles
- Less livestock production and associated deforestation and less methane emissions
- Improved nutrition and social capital from locally grown food

Health benefits

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

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

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

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

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

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

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

#### Secondary prevention (Adaptation)

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

Conclusion

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


22. IPCC (2018) *IPCC special report on global warming of 1.5ºC, summary for policymakers*. 48th Session of the IPCC. Incheon, South Korea: IPCC.


64. WHO (2017) *Regional action on achieving the Sustainable Development Goals in the Western Pacific.* Manila: WHO Regional Office for the Western Pacific.


Appendix

International example: the National Health Service (England)

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

The SDU

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

The footprint

Using the best available carbon accounting methods, a series of updated footprints have been published13 for 2004, 2007, 2010, 2012, and 2015. The current carbon footprint provides a detailed breakdown of emissions across four broad categories: building energy use and direct emissions, travel, commissioned health and care services from outside the NHS system, and procurement of goods and services. These four main categories are further broken down into 21 sub-categories.

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

12 The Climate Change Act 2008 specifies that the net UK carbon account for all six Kyoto greenhouse gases for the year 2050 is to be at least 80% lower than the 1990 baseline.
Figure 1: Consumption carbon footprint breakdown by categories for the NHS, in 2015

Commissioned health services
- Health services: 11%
- Patient: 6%
- Visitor: 2%
- Staff commute: 2%
- Business: 3%
- Total travel: 13%

Procurement
- 57%

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

Notes
- Metered Dose Inhalers use Hydrofluorocarbons gases as aerosol propellants. The gases used have over 1000 times the impact on global warming compared with the same weight of carbon dioxide gas. The majority of the emissions are released during the ‘in use’ phase and occur mostly outside health care premises.
- Anaesthetic gases (including Nitrous Oxide) are potent greenhouse gases with between 130 to 2000 times the impact on global warming compared with the same weight of carbon dioxide gas.

Summarised from: Sustainable Development Unit and UK National Health Service data (2016)

Carbon footprint update for the NHS in England 2015
The Cost Curve

Marginal Abatement Cost (MAC) reflects the cost of one additional unit or ton of pollution that is abated, or not emitted. A marginal abatement cost curve (MACC) is a data visualisation tool that allows the user to compare emission reduction options both in terms of cost-effectiveness and their potential for CO2 reductions (Figure 2). Marginal abatement cost curves highlight the win-wins where carbon cutting measures can save money and the abatement information also puts into perspective those measures where the investment costs cannot be recouped.

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

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

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

Marginal abatement cost information can also be displayed in table format. Table 4 shows marginal abatement cost information for the NHS England for 2015 [56]. The table lists a range of energy-efficiency interventions that have been identified as suitable for implementation within health care facilities. The list is presented in descending order of cost-effectiveness (not considering interactions and overlaps between measures). The right-hand column shows the potential CO₂ savings that could be made in one-year if the technology was fully implemented. The table shows that the top-five technologies/interventions are (1) combined-heat-and-power, equal with biomass boiler (2) energy awareness campaigns (3) travel planning (4) lighting controls, and (5) reduce heating by 1 degree Celsius (based on potential CO₂ saving as shown in bold in Table 3). The table also shows that the cost-effectiveness of these examples differs considerably. For example, combined-heat-and-power and biomass boilers offer similar potential CO₂ saving, but combined-heat-and-power is significantly more cost-effective than a biomass boiler conversion (ranked 6th compared with 24th in the example list).

Table 4: List of CO₂ reduction measures related to energy supply and use, not considering interactions and overlaps (non-energy related measures for procurement of pharmaceuticals and medical devices are not shown)

<table>
<thead>
<tr>
<th>CO₂ reduction measures (options)</th>
<th>*£/tCO₂</th>
<th>CO₂ savings (tCO₂)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Teleconferencing</td>
<td>-2051</td>
<td>6,827</td>
</tr>
<tr>
<td>2 Introduce hibernation system for stations</td>
<td>-120</td>
<td>1,255</td>
</tr>
<tr>
<td>3 Improve the efficiency of chillers</td>
<td>-110</td>
<td>9,133</td>
</tr>
<tr>
<td>4 Voltage optimisation</td>
<td>-110</td>
<td>16,828</td>
</tr>
<tr>
<td>5 1 degree C</td>
<td>-110</td>
<td>32,763</td>
</tr>
<tr>
<td>6 CHP installation</td>
<td>-98</td>
<td>173,975</td>
</tr>
<tr>
<td>7 Improve lighting controls</td>
<td>-94</td>
<td>34,286</td>
</tr>
<tr>
<td>8 Variable speed drives</td>
<td>-90</td>
<td>3,083</td>
</tr>
<tr>
<td>9 Energy awareness campaign</td>
<td>-89</td>
<td>90,265</td>
</tr>
<tr>
<td>10 Building management system optimisation</td>
<td>-86</td>
<td>11,521</td>
</tr>
<tr>
<td>11 Improve insulation to pipe work, boiler house</td>
<td>-79</td>
<td>10,264</td>
</tr>
<tr>
<td>12 Decentralisation of hot water boilers</td>
<td>-77</td>
<td>10,612</td>
</tr>
<tr>
<td>13 Improve heating controls</td>
<td>-72</td>
<td>17,219</td>
</tr>
<tr>
<td>14 Roof insulation</td>
<td>-71</td>
<td>22,869</td>
</tr>
<tr>
<td>15 Improve efficiency of steam or hot water boiler</td>
<td>-71</td>
<td>6,367</td>
</tr>
<tr>
<td>16 Wall insulation</td>
<td>-70</td>
<td>24,624</td>
</tr>
<tr>
<td>17 Energy efficient lighting</td>
<td>-67</td>
<td>22,290</td>
</tr>
<tr>
<td>18 Upgrade garage and workshop heating</td>
<td>-60</td>
<td>214</td>
</tr>
<tr>
<td>19 Install high efficiency lighting and controls</td>
<td>-45</td>
<td>3,745</td>
</tr>
<tr>
<td>20 Wind turbine</td>
<td>-42</td>
<td>10,722</td>
</tr>
<tr>
<td>21 Double insulation window and draught proofing</td>
<td>-27</td>
<td>11,831</td>
</tr>
<tr>
<td>22 Improve building insulation levels (U-levels)</td>
<td>-19</td>
<td>951</td>
</tr>
<tr>
<td>23 Boiler replacement/optimisation HQ/control</td>
<td>-15</td>
<td>171</td>
</tr>
<tr>
<td>24 Biomass boiler</td>
<td>-6</td>
<td>172,724</td>
</tr>
<tr>
<td>25 Travel planning</td>
<td>1</td>
<td>81,524</td>
</tr>
<tr>
<td>26 Office electrical equipment improvements</td>
<td>17</td>
<td>15,900</td>
</tr>
<tr>
<td>27 Solar hot water</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>28 Electric vehicles</td>
<td>49</td>
<td>36,96</td>
</tr>
</tbody>
</table>

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

To: CPHAC Members
From: Carol Murphy, Primary Health Manager
Date: 8 October 2019
Re: Health Promotion Matrix 6 Month Report

Please find attached the latest Health Promotion Matrix reporting for the period January – June 2019. This report has been reviewed by the Health Promotion & Prevention Steering Group when they met on the 8 October 2019. Overview of this monitoring is a key role of this group.

Where target has not been met comment has been included either providing context to result or outlining corrective action planned. Colour coding has been utilised for ease of reference.

Recommendation:

That CPHAC receives this report.
## South Canterbury DHB Prevention/Early Detection/Intervention Performance Targets 2018/19

<table>
<thead>
<tr>
<th>Rating</th>
<th>Abbrev</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding performer</td>
<td>O</td>
<td>1. This rating indicates a level of performance considerably better than the agreed expectations.</td>
</tr>
</tbody>
</table>
| Achieved                    | A      | 1. Deliverable demonstrates targets / expectations have been met in full.  
2. In the case of deliverables with multiple requirements, all requirements are met.                                                                                           |
| Partial achievement         | P      | 1. Target/expectation not fully met, but the resolution plan indicates progress is on track to compliance.  
2. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of requirements have been achieved.                                           |
| Not achieved – escalation required | N | 1. The deliverable is not met.  
2. There is no resolution plan for-compliance.  
3. There are significant gaps in delivery.                                                                                                                                                                                                                                  |

### Nutrition & Physical Activity

<table>
<thead>
<tr>
<th>Resp</th>
<th>Community</th>
<th>Progress rating 1/7/18 to 31/12/18</th>
<th>Comment / Reason for Variance/For any deliverables not on track include mitigation strategies and new timeframes for delivery</th>
<th>Progress rating 1/1/19 to 30/6/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCDHB/SC</td>
<td>Nutrition &amp; physical activity</td>
<td>6 sessions / week averaging 20 students / SC Kiwisport Non participating Youth (Dec 2018)</td>
<td>The YMCA has been providing a range of activities that secondary school students of both Mountainview, TGHS and the alternate education programme have been participating in. They have far exceeded this target. They have again applied for Kiwisport in 2020 with a decision pending, the programme will expand the services to include play as a key part of physical activity.</td>
<td>A</td>
</tr>
<tr>
<td>CPH</td>
<td>All SFEA complaints processed in specified times</td>
<td>A</td>
<td>3 Complaints received which were dealt with in required timeframes</td>
<td>A</td>
</tr>
<tr>
<td>CPH</td>
<td>3 tobacco CPOs completed</td>
<td>P</td>
<td>Three CPOs completed in this period, no sales were made</td>
<td>A</td>
</tr>
<tr>
<td>CPH</td>
<td>At least 1 presentation held to communicate Smokefree 2025 to key leaders/sectors/orgs</td>
<td>A</td>
<td>Smokefree 2025 included in the Little Lungs workshop with an ECE and in the presentation to Mackenzie District Council about the Fresh Air pilot project.</td>
<td>O</td>
</tr>
</tbody>
</table>

### Tobacco

<table>
<thead>
<tr>
<th>Resp</th>
<th>Community</th>
<th>Progress rating 1/7/18 to 31/12/18</th>
<th>Comment / Reason for Variance/For any deliverables not on track include mitigation strategies and new timeframes for delivery</th>
<th>Progress rating 1/1/19 to 30/6/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCDHB/AWS</td>
<td>Tobacco</td>
<td>6Stop Smoking Services enrol 400 clients All referrals contacted within 3 working days</td>
<td>429 clients enrolled during the 2018/19 year</td>
<td>A</td>
</tr>
<tr>
<td>CPH</td>
<td>4 events, settings or initiatives where young people, Māori and 18-35 age group frequent are supported with a smokefree/Auahi Kore message</td>
<td>A</td>
<td>World Smokefree Day celebrated at John Street Kindergarten, including the presentation of the WAVE smokefree award and media coverage in the Courier. Smokefree promoted at the VOICE Youth Art Awards, including the awards night. A kindergarden and a secondary school have both updated their smokefree policies to include vapefree.</td>
<td>A</td>
</tr>
<tr>
<td>CPH</td>
<td>All SFEA complaints processed in specified times</td>
<td>A</td>
<td>3 Complaints received which were dealt with in required timeframes</td>
<td>A</td>
</tr>
<tr>
<td>CPH</td>
<td>3 tobacco CPOs completed</td>
<td>P</td>
<td>Three CPOs completed in this period, no sales were made</td>
<td>A</td>
</tr>
<tr>
<td>CPH</td>
<td>At least 1 presentation held to communicate Smokefree 2025 to key leaders/sectors/orgs</td>
<td>A</td>
<td>Smokefree 2025 included in the Little Lungs workshop with an ECE and in the presentation to Mackenzie District Council about the Fresh Air pilot project.</td>
<td>O</td>
</tr>
</tbody>
</table>

### Alcohol

<table>
<thead>
<tr>
<th>Resp</th>
<th>Community</th>
<th>Progress rating 1/7/18 to 31/12/18</th>
<th>Comment / Reason for Variance/For any deliverables not on track include mitigation strategies and new timeframes for delivery</th>
<th>Progress rating 1/1/19 to 30/6/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPH</td>
<td>2 community alcohol accord agreements are maintained</td>
<td>P</td>
<td>We have three alcohol accords in our area, meeting regularly.</td>
<td>O</td>
</tr>
<tr>
<td>CPH</td>
<td>Inter-agency monitoring of high-risk premises and events as appropriate 3 alcohol CPOs completed</td>
<td>P</td>
<td>3 alcohol CPO’s took place in South Canterbury, with two sales to minors and two sales without food being supplied. Interagency monitoring occurs regularly.</td>
<td>A</td>
</tr>
<tr>
<td>Resp</td>
<td>Community</td>
<td>Progress rating 1/7/18 to 31/12/18</td>
<td>Comment / Reason for Variance/For any deliverables not on track include mitigation strategies and new timeframes for delivery</td>
<td>Progress rating 1/1/19 to 30/6/19</td>
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</tr>
<tr>
<td><strong>Skin cancer prevention</strong></td>
<td>CANZ</td>
<td>P</td>
<td>Relay for Life Timaru and community shade loan programme run from CS Centre. Data collection on number of events supported by CS and attended by CS introduced as part of the CS National Minimum Data Set</td>
<td>A</td>
</tr>
<tr>
<td><strong>Oral Health</strong></td>
<td>CPH</td>
<td>A</td>
<td>44 referrals received from 1 January – 30 June 2019 from the Hospital Dental Service, Community Dental Service, Arowhenua Whānau Services, Public Health Nurse and an ECE. Referrals are followed up within one week with an average contact time of 5.6 days.</td>
<td>A</td>
</tr>
<tr>
<td><strong>Breastfeeding</strong></td>
<td>SCDHB/BFAG</td>
<td>P</td>
<td>Removed from next annual plan as not achievable.</td>
<td>N</td>
</tr>
<tr>
<td><strong>Communicable diseases</strong></td>
<td>SCDHB/BFAG</td>
<td>A</td>
<td>Maintained well.</td>
<td>A</td>
</tr>
<tr>
<td><strong>Fall prevention</strong></td>
<td>SC</td>
<td>A</td>
<td>08 (total for year – 154)</td>
<td>A</td>
</tr>
<tr>
<td><strong>Physical environment</strong></td>
<td>CPH</td>
<td>A</td>
<td>Maintained connections with referring organisations including Arowhenua Whānau Services, Public Health Nurses, Community Dental Service, Plunket (this included providing oral health sessions at five Pepe talks), and the Timaru Hospital Dental Service. Provided relevant oral health resources to agencies including Midwives. Presented at CDS and Hospital Dental Service staff meetings, and supported AWS and Public Health Nurses to source toothbrushes to use with their clients.</td>
<td>A</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>PHNS / PCS</td>
<td>A</td>
<td>The team are providing B4SCs to above the target level across ethnicities, the decline rate is less than 2% which is below national average, and the team achieved 97% of checks within the target age band.</td>
<td>A</td>
</tr>
<tr>
<td><strong>General</strong></td>
<td>CPH</td>
<td>A</td>
<td>The Accredo database continues to be used, stock maintained and requests actioned as required for the resources held at CPH. The Authorised Provider ordered 15,480 items to restock compared with 12,930 in the previous six month period.</td>
<td>A</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>CPH/SCDHB</td>
<td>A</td>
<td>WAVE team members are part of the Ka Toi Māori o Aoraki Incorporated Society, with the Team Leader and two staff also members of the Executive along with representatives from Arowhenua Whānau Services, Arowhenua Marae, and Te Rūnanga o Ngai Tahu. WAVE team members have contributed to funding applications and planning requirements. Information has been sent to all ECE, schools and tertiary settings inviting participation in the 2019 festivals with registrations closing in August and September.</td>
<td>A</td>
</tr>
<tr>
<td><strong>SCDHB</strong></td>
<td>Organise local World Suicide Prevention Day (Sept 10) event each year, with local media coverage</td>
<td>N</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>RESP</td>
<td>EDUCATION</td>
<td>PROGRESS</td>
<td>COMMENT / REASON FOR VARIANCE/ FOR ANY DELIVERABLES NOT ON TRACK INCLUDE MITIGATION STRATEGIES AND NEW TIMEFRAMES FOR DELIVERY</td>
<td>CODE OF COMPLIANCE</td>
</tr>
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</tr>
<tr>
<td><strong>NUTRITION &amp; PHYSICAL ACTIVITY</strong></td>
<td>CPH</td>
<td>95% of all settings have active WAVE settings plans</td>
<td>A</td>
<td>98% of settings have a setting plan.</td>
</tr>
<tr>
<td></td>
<td>CPH</td>
<td>2 new settings develop school travel plans</td>
<td>A</td>
<td>Two new schools are undertaking the school travel process and information provided to an additional two schools to consider committing to the school travel plan process</td>
</tr>
<tr>
<td></td>
<td>CPH</td>
<td>6 schools supported to sustain travel plans</td>
<td>P</td>
<td>Ongoing support provided to two schools to sustain their travel plans, and three schools participated in a NZTA curriculum resources workshop organised by the School Travel Planner to support teachers to integrate active travel into their teaching programmes.</td>
</tr>
<tr>
<td><strong>SC</strong></td>
<td>13 primary schools engaged from targeted communities</td>
<td>A</td>
<td>9/13 schools engaged from Jan - June 2019. Year to date 13/13</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>17 primary schools engaged in supported communities</td>
<td>A</td>
<td>16/16 primary schools engaged from Jan - June 2019</td>
<td>A</td>
</tr>
<tr>
<td><strong>TOBACCO</strong></td>
<td>CPH</td>
<td>Smokefree reflected in 5 settings plans</td>
<td>O</td>
<td>16 settings have smokefree as a focus in their settings plan.</td>
</tr>
<tr>
<td><strong>SKIN CANCER PREVENTION</strong></td>
<td>CSNZ</td>
<td>100% of all primary schools SunSmart Accredited by June 2019</td>
<td>O</td>
<td>100% of primary schools due for reaccreditation in 2018/19 have process completed by June 2019.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% of all 41 schools [33] are now SSAP schools, with 1 in the process of being accredited and 1 not applied. Of the remaining 6, 1 is an area school and the others are years 7 - 13, which means full coverage of SSAP is not feasible, e.g. high schools do not make hat wearing compulsory, which is mandatory for SSAP status. Adjusting for this means that 33 of 35 primary schools or 97% are SSAP schools.</td>
<td>P</td>
<td>Reaccreditation - 13 schools due reaccreditation in period - 5 completed (38%)</td>
</tr>
<tr>
<td><strong>ORAL HEALTH</strong></td>
<td>CPH</td>
<td>5 ECE settings engaged in oral health promotion activities / initiatives</td>
<td>O</td>
<td>Four ECE have undertaken Kai Kōrero which includes a planning session with staff, a weekly session over four weeks with staff and whānau, culminating in a celebration with healthy food. Follow-up meetings with two ECE have taken place so far. Pre and post surveys are undertaken with staff and whānau. Two WAVE ECE 5 + A Day Challenges were provided in this period with a focus on healthy eating and oral health with a total of 15 entries from 7 ECE received across the two challenges. Teachers report that the 5 + A Day Challenges encourage healthy eating activities that are easy to implement and sustainable, which whānau readily engage with.</td>
</tr>
<tr>
<td><strong>COMMUNICABLE DISEASES</strong></td>
<td>CPH</td>
<td>Infection control procedures reviewed in 10 ECE</td>
<td>P</td>
<td>Infection prevention control procedures in 10 ECE</td>
</tr>
<tr>
<td></td>
<td>CPH</td>
<td>Sneezesafe delivered to 18 education settings in Autumn 2019</td>
<td>P</td>
<td>Delivery of an ECE SneezeSafe kit to all 44 ECE, and a SneezeSafe session at schools was undertaken in Term 2 with 17 out of 19 schools accepting the offer of a session by a PHN and WAVE. The remaining two schools wish to have the session in Term 3.</td>
</tr>
<tr>
<td><strong>SCREENING</strong></td>
<td>PCS</td>
<td>95% of students eligible for a routine Health Assessment receive one in the calendar year</td>
<td>P</td>
<td>57.0%</td>
</tr>
<tr>
<td><strong>GENERAL</strong></td>
<td>CPH</td>
<td>WAVE Facebook page 'likes' increased from 17/18 year</td>
<td>A</td>
<td>The WAVE facebook 'page likes' has increased to 743 compared to 666 in the previous six month period.</td>
</tr>
<tr>
<td></td>
<td>CPH</td>
<td>WAVE Resource Centre usage increases</td>
<td>P</td>
<td>555 resources booked by 56 settings (compared with 478 resources booked by 46 settings 1 January – 31 May 2018).</td>
</tr>
<tr>
<td></td>
<td>CPH</td>
<td>25 professional development Health workshops for teachers across the district</td>
<td>A</td>
<td>10 workshops provided during this period (a total of 36 during the 12-month period).</td>
</tr>
<tr>
<td></td>
<td>PCS/AWS</td>
<td>Minimum 8 Hauora Education Hui</td>
<td>A</td>
<td>Over the last 12 months we have completed 15 Wananga for Health Education: Smoke Free, Smears and breast care, Breast is best, gout, Welcome to spring, Melanoma, Living with chronic illness, MH awareness which included gout, mindfulness, smoke free, Raising awareness of diabetes, Gallstones, Getting ready for winter, CVD Risk assessments</td>
</tr>
<tr>
<td>Resp</td>
<td>Workplaces</td>
<td>Progress</td>
<td>Comment / Reason for Variance/For any deliverables not on track include mitigation strategies and new timeframes for delivery</td>
<td>Progress</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td>BFAG</td>
<td>Expand ‘Welcome Here Project’ to workplace settings</td>
<td>N/A</td>
<td>On going promotion</td>
<td>A</td>
</tr>
<tr>
<td>B</td>
<td>Continue to maintain staff Breastfeeding Room at Timaru Hospital</td>
<td>A</td>
<td></td>
<td>A</td>
</tr>
<tr>
<td>SC</td>
<td>557 patients referred to Green Prescription</td>
<td>P</td>
<td>479 referrals for 2018-2019 year</td>
<td>P</td>
</tr>
<tr>
<td>SC</td>
<td>123% GFR referrals Diabetes related</td>
<td>A</td>
<td>123% (103) of total referrals for 2018-2019 were diabetes related</td>
<td>A</td>
</tr>
<tr>
<td>SC</td>
<td>8 Wellness programmes delivered to 120 patients</td>
<td>P</td>
<td>6 8ie Active programmes were delivered to 82 patients. 2 other programmes were planned and promoted but did not go ahead due to low registration numbers. Staffing changes also contributed. Moving forward 2 programmes will continue to be planned and held each quarter.</td>
<td>A</td>
</tr>
<tr>
<td>SC</td>
<td>2 Face to Face clinics catering for 140 GFRx patients</td>
<td>A</td>
<td>166 clients received Face to face consultations.</td>
<td>A</td>
</tr>
<tr>
<td>PCS</td>
<td>95% obese children identified in 84 School Check offered referral for clinical assessment &amp; family based nutrition, activity &amp; lifestyle interventions.</td>
<td>P</td>
<td>100% achieved for 6 months Dec18-May19</td>
<td>A</td>
</tr>
<tr>
<td>SC</td>
<td>19% patients referred to BFAG</td>
<td>P</td>
<td>19% of total referrals for 2018-2019 were BFAG related.</td>
<td>A</td>
</tr>
<tr>
<td>SC</td>
<td>80% of PHO enrolled patients who smoke offered help to quit</td>
<td>N</td>
<td>80.6%. Continue to work with targeted practices to improve brief advice and associated coding.</td>
<td>N</td>
</tr>
<tr>
<td>SC</td>
<td>90% Māori, Pacific &amp; pregnant women receive ABC in primary care</td>
<td>N</td>
<td>Māori - 82.6%, Pacific 79.4%, Other 80%. Whilst target not meet there is no equitable difference across the ethnicities.</td>
<td>N</td>
</tr>
<tr>
<td>SC</td>
<td>95% children (Māori &amp; Total) aged 0-4yrs are enrolled with dental services</td>
<td>N/A</td>
<td>Total 69.6% and Māori 34.5%</td>
<td>N</td>
</tr>
<tr>
<td>PCS</td>
<td>270 patients referred to falls prevention (FP) programmes</td>
<td>A</td>
<td>199 (total for year – 379)</td>
<td>O</td>
</tr>
<tr>
<td>SC</td>
<td>90 FP patients receive Face to Face support with Health Professional</td>
<td>A</td>
<td>56 completed, 44 active (total completed for year – 103)</td>
<td>A</td>
</tr>
<tr>
<td>PCS</td>
<td>75% of eligible girls are fully immunised with HPV vaccine</td>
<td>N/A</td>
<td>40% We believe there may be a few messaging issues from Primary Care through to the NIR, due to the change in vaccine/schedule, however these would not be significant enough to change the overall poor coverage. We continue to promote positive immunisation messages, and use the HPV resources on social media during the school-based campaign times.</td>
<td>N</td>
</tr>
<tr>
<td>PCS</td>
<td>95% 8 month old and &gt;95% 2 year olds are fully immunised.</td>
<td>P</td>
<td>8 months - Total 95%, Māori 100% and 2 years - Total 95%, Māori 96%</td>
<td>A</td>
</tr>
<tr>
<td>PCS</td>
<td>95% 4yr olds fully immunised by age 5yrs</td>
<td>P</td>
<td>5 years - Total 93%, Māori 84%. The outreach immunisation service continues to focus on hard to reach families and has strong professional relationships with Primary Care.</td>
<td>A</td>
</tr>
<tr>
<td>PCS</td>
<td>≥75% of 65+ years population receive the flu vaccine</td>
<td>P</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>PCS</td>
<td>540 doses of Boostrix are administered 2018/19</td>
<td>A</td>
<td>We have administered 393 doses of Boostrix for the first six calander months of 2019.</td>
<td>A</td>
</tr>
<tr>
<td>PCS</td>
<td>≥ 300 of &gt;65yrs immunised for pneumonia.</td>
<td>P</td>
<td>217 pneumovax administered between Jan - June 2019.</td>
<td>A</td>
</tr>
<tr>
<td>PCS</td>
<td>Cervical screening target ≥80% of eligible women within 3 years</td>
<td>P</td>
<td>Māori - 62.4%, Total 73.8%. ScreenSouth working with practices with large high needs populations to recall patients. Importance of cervical screening continues to be promoted through Wananga. Outreach cervical smear taking in the home offered by AWS.</td>
<td>N</td>
</tr>
<tr>
<td>PCS</td>
<td>Breast screening target ≥70% seen 50-69yrs by ethnicity</td>
<td>P</td>
<td>Māori - 62.6%, Total 75.8%. Importance of breast screening continues to be promoted through Wananga delivered by AWS.</td>
<td>N</td>
</tr>
<tr>
<td>PCS</td>
<td>CVD screening target for eligible population ≥90%</td>
<td>P</td>
<td>75.4%. A proposal to utilize More Heart &amp; Diabetes Checks funding to establish a CVDRA Outreach Service delivered by AWS is under development.</td>
<td>P</td>
</tr>
<tr>
<td>PCS</td>
<td>CVD screening target eligible Māori men in PHO 35-44 yrs ≥90%</td>
<td>P</td>
<td>48.6%. Primary Care flexible funding of $10K is being utilised via AWS to engage Māori men in the workplace to improve CVDRA uptake.</td>
<td>N</td>
</tr>
<tr>
<td>Resp</td>
<td>Secondary Care</td>
<td>Progress</td>
<td>Comment / Reason for Variance/For any deliverables not on track include mitigation strategies and new timeframes for delivery</td>
<td></td>
</tr>
<tr>
<td>------</td>
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<td>-----------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition &amp; physical</strong></td>
<td>SC/SS</td>
<td>A</td>
<td>23 new referrals received from secondary care. Referrals slowed considerably in second half of year.</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td>SS</td>
<td>A</td>
<td>95.5% average for year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DS</td>
<td>A</td>
<td>100% achieved.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SS</td>
<td>A</td>
<td>Māori - 94.5%, Pacific 80.8%, Other 96%. Small numbers particularly for Pacific has a big impact on achievement rates.</td>
<td></td>
</tr>
<tr>
<td><strong>Fall prevention</strong></td>
<td>SS</td>
<td>A</td>
<td>90% for Q4 2018/19</td>
<td></td>
</tr>
<tr>
<td><strong>Breastfeeding</strong></td>
<td>SS</td>
<td>A</td>
<td>Maternity Unit maintains BFHI accreditation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SS</td>
<td>A</td>
<td>“BF welcome here” certification for SCDHB Secondary Service(included in BFHI)</td>
<td></td>
</tr>
<tr>
<td><strong>Communicable diseases</strong></td>
<td>SS</td>
<td>A</td>
<td>Staff influenza vaccination target - 2017 total of immunisations delivered to SCDHB staff</td>
<td></td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>SS</td>
<td>A</td>
<td>Universal Newborn Hearing Screening offered to 100% eligible babies</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td></td>
<td></td>
<td>PHO data indicates that there were 1.7% more current smokers identified in January 2019 as there were at the same time the previous year.</td>
<td></td>
</tr>
<tr>
<td><strong>Oral health</strong></td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Breastfeeding</strong></td>
<td>BFAG</td>
<td></td>
<td>Māori - 66%, Total - 73% (Jan-June 2018)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BFAG</td>
<td></td>
<td>Māori - 42%, Total - 59% (Jul-Dec 2018)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BFAG</td>
<td></td>
<td>Data not available</td>
<td></td>
</tr>
</tbody>
</table>
Memo

To: CPHAC Members
From: Carol Murphy, Primary Health Manager
Date: 14 October 2019
Re: Breast Feeding Action Plan

Please find attached the annual South Canterbury Breast Feeding Plan which is submitted by the Breast-Feeding Action Group.

Recommendation:

That CPHAC receives this plan
South Canterbury District Breastfeeding Action Plan

2019/2020 Promoting – Protecting – Supporting Breastfeeding across South Canterbury

The following Breastfeeding Plan aligns with relevant Breastfeeding sections as stated in the SCDHB Prevention/early Detection/Intervention Performance Targets for 2019 /20.

(Shown Red below in ‘Measured by’ column)

Introduction
Breastfeeding helps lay the foundation of a healthy life for a baby and also makes a positive contribution to the health and wider wellbeing of mothers and whanau/families. Exclusive breastfeeding is recommended until babies are around six months.

National Strategic Plan of Action
The National Strategic Plan of Action for breastfeeding (the plan) is the advice of the National Breastfeeding Advisory Committee to the Director-General of Health. The Ministry of Health asked the Committee to develop a strategic framework with the aim of improving breastfeeding rates in New Zealand. It is set in the context of existing work and emerging programmes, and established the health sector as the leader in the protection, promotion and support of breastfeeding in this country. The Plan centres on four key settings:

- Government;
- family and community;
- health services; and
- workplace, childcare and early childhood education.
The MOH wishes to increase the proportion of infants being exclusively breastfed to six months and the proportion of infants partially breastfed beyond 6 months (this is consistent with World Health Organization breastfeeding recommendations). The indicator for this target is increasing the proportion of infants who are exclusively or fully breastfed at:

- six weeks to 75% or greater;
- three months to 70% or greater; and

Three settings have been identified as areas of intervention; health system, family/whānau, and communities including workplaces. Māori and Pacific peoples have been identified as the key priority groups for the campaign, although it is also envisaged that generic elements of the campaign will reach high-need groups of all ethnicities.

The overarching goal is to increase environmental support to initiate and maintain breastfeeding, especially for Māori and Pacific people. Therefore, an important part of measuring the success of the campaign will be to measure increases in the level of support.

**Health Sector Service and Strategies to Support Breastfeeding**

- **Baby Friendly Hospital Initiative (BFHI) and the Baby Friendly Community Initiative (BFCl) and the New Zealand Breastfeeding Alliance** - the BFHI and BFCl are implemented in New Zealand by the New Zealand Breastfeeding Alliance under contract to the Ministry of Health.
- **Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand** - New Zealand is a signatory of the International Code which aims to contribute to providing safe and adequate nutrition for infants by protecting and promoting breastfeeding.
- **Ministry of Health NZ Health Strategy** – this document links with the Ministry’s specific health indicator of increasing the proportion of infants being exclusively and fully breastfed in the first six months of life.
- **Breastfeeding policy statements from health sector organisations** – includes statements from New Zealand, Australia and international Sectors.
- **Well Child** services are aimed at supporting women to continue to breastfeed, and keeping infants, toddlers and pre-schoolers (under five years old) well, growing and developing to their fullest potential.
- **Maternity** – Maternity services are aimed at improving health outcomes and reducing inequalities.

**South Canterbury**

Around 600 babies are born in South Canterbury each year. The LMC providers in South Canterbury are 10-14 Midwives. Part of these number is a team employed as case loading LMCs by South Canterbury District Health Board.

South Canterbury DHB’s Jean Todd Maternity Unit is currently gold accredited under the Baby Friendly Hospital Initiative meaning a four year accreditation cycle.

**Breastfeeding support and promotion**

- Ante-natal and post-natal (to 4-6 weeks) breastfeeding information, promotion and support is provided by the midwives.
- The South Canterbury DHB funds 1.0FTE Breastfeeding Advisor position, which is a job share position with two 0.5 FTE Lactation Consultants.
- A free SCDHB breastfeeding class is facilitated once a month by the SCDHB Breastfeeding Advisors
- The South Canterbury DHB Breastfeeding Advisor has a target group of rural women and Maori & Pasifika women.
- Ante-natal breastfeeding information is provided via ante-natal classes run through the Timaru Parents Centre and Timaru Hospital Maternity Unit and at the Waimate Parenting Hub and private providers.
- Post-natal breastfeeding support is provided through midwives, Breastfeeding Advisors and Well Child Providers (Tamariki Ora Nurse and Plunket Nurses).
- La Leche League run monthly breastfeeding support meetings in Timaru and also provides voluntary phone support.
Plunket are funded by the South Canterbury DHB to implement a Peer Support Programme across South Canterbury, targeting low income, Māori, Pacific and rural women. Forty one counsellors and the Peer Counsellor Administrator (PCA) have been trained to support women who make contact with breastfeeding issues. A new PCA in has just been appointed.

Breastfeeding Peer Support Groups are facilitated in Timaru and Waimate regularly by peer counsellors. Also Peer counsellors attend other community groups e.g. the multiple birth group and provide breastfeeding support there. Training of Peer Counsellors occurs on a regular basis as able to be recruited.

Peer Counsellors facilitate rural ‘Big Latch On’ events as part of World Breastfeeding Week in August.

The SCDHB funds Breastfeeding Health promotion through the implementation of strategies included in the Breastfeeding Action Plan. These funds are under the management of the South Canterbury Breastfeeding Action Group (BFAG).

**South Canterbury Breastfeeding Statistics**

<table>
<thead>
<tr>
<th>Exclusive and full breastfeeding rates</th>
<th>2014/2015</th>
<th>20153/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding at 2 weeks (Total)</td>
<td>77%</td>
<td>75%</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td>Breastfeeding at 6 weeks (Total)</td>
<td>67%</td>
<td>74%</td>
<td>73%</td>
<td>71%</td>
</tr>
<tr>
<td>Breastfeeding at 3 months (Total)</td>
<td>58%</td>
<td>59%</td>
<td>60%</td>
<td>63%</td>
</tr>
</tbody>
</table>

**South Canterbury Annual Plan Targets for 2018 – 19**

<table>
<thead>
<tr>
<th>Exclusive and full breastfeeding rates</th>
<th>Māori</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding at 2 weeks (Total)</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Breastfeeding at 6 weeks (Total)</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Breastfeeding at 3 months (Total)</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Breastfeeding at 6 months (Total)</td>
<td>21%</td>
<td>26%</td>
</tr>
</tbody>
</table>

The S.C. Breastfeeding Action Group (BFAG)

The S.C. Breastfeeding Action Group undertakes collaborative work and ongoing planning, implementation and monitoring of the South Canterbury District Breastfeeding Plan.

The objectives of this group are:

- Work collectively, in collaboration with other providers and promoters of breastfeeding, to improve breastfeeding rates, including a reduction in inequalities of breastfeeding rates across the South Canterbury population
- To identify the barriers to establishing and maintaining breastfeeding in South Canterbury and investigate strategies to overcome these barriers
- Support the BFHI and BFCI initiatives
- Support the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly Resolutions
- To provide half yearly education forums and opportunities for liaison for all persons with an associated interest to Breastfeeding and better health outcomes for babies and children. Share relevant information and research and act as a forum to ensure that women are provided with consistent research based information and support.

**Membership**

South Canterbury Clinical Leader (Plunket), Clinical Midwife Manager (SCDHB), Breastfeeding Advisor (SCDHB), Peer Counsellor/Consumer (Plunket), Tamariki Ora/Well Child Nurse (Arowhenua Whanau Services (AWS)), LMC midwife and Mother to Mother Counsellor (La Leche League).

Main focus areas for 2019/2020

- Equity for Maori, Pasifika and other ethnic minority groups
- Resources in non-English languages
- Updating Breastfeeding Handbook to reflect different cultures
- Try to engage AWS to gauge the needs of the health providers working in their service (with largely Maori women/whanau)

**Professional Development**

- The BFAG will facilitate half yearly Professional Development for all health professionals and support persons whose work is linked to Breastfeeding.
- In the July – December 2019 half year this will be linked to World Breastfeeding Week in the first week of August. Speaker yet to be organised for the workshop
- In the January – June 2020 half year the second workshop is planned to be held.

**South Canterbury Breastfeeding Handbook**

- Members of the BFAG will action the formatting of a S.C. Breastfeeding Handbook. This handbook has been produced since 2015 and is a valuable ‘tool’ for new parents – approximately 700 printed per year.

**Breastfeeding 'Welcome Here Programme'**

- The BFAG will action all process around the extension of the programme with the support of the Peer Counsellors.

**2019 Latch On**

- The BFAG will support the organising of all rural Latch On events and the Timaru Latch On.
- Breastfeeding promotion material will be provided for all attendees.
- Encourage a Latch on event at Te Aitarakihi Multicultural Centre.
### Goal: More breastfeeding mothers making attempts with breastfeeding.

#### Promotion - Protection - Supporting

<table>
<thead>
<tr>
<th>2016/17 Areas of focus</th>
<th>Key planning approaches</th>
<th>Actions to deliver improved performance (specific and tangible)</th>
<th>Measured by (Specific measurable outputs – it is expected baselines or dates of delivery will be included for all measures)</th>
<th>High level systems outcomes (Delivery of actions will contribute to achievements of this/these outcomes)</th>
<th>Area of Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion of Breastfeeding</td>
<td>Breastfeeding is <strong>promoted</strong> in a range of ways which includes social marketing campaigns, health promotion programmes, as well as health education via midwives, lead maternity carers and other health professionals who have interaction with pregnant woman and their family/whanau</td>
<td>SCDHB maintains the requirements for the Baby Friendly Hospital Initiative. (BFHI)</td>
<td>-Monthly monitoring of practice by Jean Todd Maternity unit staff against BFHI.</td>
<td>Promotion of breastfeeding to expectant mothers and whanau through a wide range of forums will increase the chances of mother’s breastfeeding.</td>
<td>SCDHB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Local radio, newspaper communications are part of World Breastfeeding Week in August 2019 promoting Breastfeeding.</td>
<td>-Evaluation of WBW activities by S.C. Breastfeeding Action Group (BFAG) post World Breastfeeding Week.</td>
<td></td>
<td>BFAG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-‘Big Latch On’ events throughout South Canterbury.</td>
<td>-5 rural and 1 urban Big Latch On are held.</td>
<td></td>
<td>BFAG Breastfeeding Works Peer Counsellors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Media coverage of Breastfeeding issues is actioned throughout the year.</td>
<td>-Increased attendance by 5% from 2018.</td>
<td></td>
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<td></td>
<td></td>
<td>-The Early Childhood Community has the resources to provide appropriate and accessible environments for Breastfeeding.</td>
<td>-An advertising feature is organised in WBW</td>
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<td></td>
<td></td>
<td>-Actioned through liaison with WAVE Programme Early Childhood Facilitator.</td>
<td>Breastfeeding articles on BFAG Facebook page and member organisations pages.</td>
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<td></td>
<td></td>
<td>South Canterbury BFAG includes national breastfeeding promotions from MOH, NZBA, and other organisations in its core business. Distribution of resources including the Breastfeeding Handbook, printed breastfeeding resources, breastfeeding posters for display in public places including Plunket Centres, medical practices and Early Childhood Centres, and breastfeeding support contact details.</td>
<td>Media coverage as above. Increased visual promotion and breastfeeding resources in Early Childhood Centres, including contact details for breastfeeding support.</td>
<td></td>
<td>BFAG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify needs and engage with Maori/Pacific communities to reduce barriers to breastfeeding</td>
<td>Re-invite AWS Tamariki Ora Nurse to attend BFAG meetings. Make contact with SCDHB Directors of Maori Health and see how we can work together to promote breastfeeding.</td>
<td></td>
<td>BFAG AWS FP</td>
</tr>
<tr>
<td>Year</td>
<td>Areas of focus</td>
<td>Key planning approaches</td>
<td>Actions to deliver improved performance (specific and tangible)</td>
<td>Measured by (Specific measurable outputs – it is expected baselines or dates of delivery will be included for all measures)</td>
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</tr>
<tr>
<td>2016/17</td>
<td>Protection of Breastfeeding</td>
<td>Breastfeeding in South Canterbury will be protected through implementation of approaches that include legislative and policy approaches and the subsequent practices that give practical effect to the intent of the legislation.</td>
<td>A suitable area is available at Timaru Hospital, Woolcombe Street Primary and Community Services campus and Talbot Park for staff who are breastfeeding their children, including facilities for expressing and storing breast milk.</td>
<td>Half yearly report on availability of these facilities to BFAG.</td>
<td>The provision of relevant documentation will ensure that mothers and whanau are protected by the relevant legislation after child birth.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Achieve the provisions supporting breastfeeding in the workplace as contained in the Employment Relations (Rest Breaks, Infant Feeding and Other Matters) Amendment Act passed by Parliament in September 2008.</td>
<td>Half yearly ensure at SCDHB Health &amp; Safety meetings to be included in agenda for discussion.</td>
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<td></td>
<td></td>
<td></td>
<td>‘Support’ workplaces to support breastfeeding in their workplace, with information about becoming a breastfeeding friendly environment.</td>
<td>Include as an agenda item on monthly meetings of BFAG. Make contact with one workplace (e.g. Presbyterian Support Services) and see how we can support them to make it a breastfeeding friendly environment for their staff.</td>
<td></td>
</tr>
</tbody>
</table>

2016/17 | Areas of focus | Key planning approaches | Actions to deliver improved performance (specific and tangible) | Measured by (Specific measurable outputs – it is expected baselines or dates of delivery will be included for all measures) | High level systems outcomes (Delivery of actions will contribute to achievements of this/these outcomes) | Area of Responsibility |
|------|----------------|-------------------------|---------------------------------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------|
**Support of Breastfeeding**

Breastfeeding support within South Canterbury is accessible and appropriate to breastfeeding mothers and family/whanau and includes programmes that foster and encourage supportive environments for breastfeeding in healthcare facilities, and in the paid workforce.

- SCDHB participation in the South Canterbury ‘Breastfeeding Welcome Here’ programme and ongoing maintenance of certification requirements.
- Updates on progress of ‘Breastfeeding Welcome Here’ programme in May and November BFAG meetings.
- Review process for re-certification.
- The provision of breastfeeding support is shown to increase the chances of mothers successfully breastfeeding.

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with Well Child providers (Plunket, Tamariki Ora)</td>
<td>To gain full breastfeeding statistics for South Canterbury population.</td>
</tr>
<tr>
<td>Members of the BFAG promote the Breastfeeding Peer Support Programme</td>
<td>To health professionals i.e. primary care providers, midwives, ante-natal educators, early childhood centres and clients.</td>
</tr>
<tr>
<td>Liaise with social and other relevant agencies recruiting peer counsellors</td>
<td>To work from within their organisations to support clients / breastfeeding women.</td>
</tr>
<tr>
<td>Communities positively support breastfeeding in public places</td>
<td>As the established norm.</td>
</tr>
<tr>
<td>All members of the BFAG</td>
<td>Deliver breastfeeding support and guidance in a culturally appropriate manner.</td>
</tr>
<tr>
<td>Half yearly reports</td>
<td>In February &amp; August on discharge from midwife and at 6 weeks &amp; 3 months from Plunket and AWS.</td>
</tr>
<tr>
<td>5% increase in referrals</td>
<td>Made to the Peer Support Programme.</td>
</tr>
<tr>
<td>Included in half-yearly report</td>
<td>On Peer Support Programme.</td>
</tr>
<tr>
<td>Increase in Peer counsellors of Maori, Pasifika and other ethnicities.</td>
<td></td>
</tr>
<tr>
<td>5 new businesses and community facilities engaged</td>
<td>To take part in the ‘Breastfeeding Welcome Here Project’.</td>
</tr>
<tr>
<td>Biennial education session</td>
<td>On culturally appropriate breastfeeding support.</td>
</tr>
</tbody>
</table>

**Definitions/Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWS</td>
<td>Arowhenua Whanau Services</td>
</tr>
<tr>
<td>BFAG</td>
<td>Breastfeeding Action Group</td>
</tr>
<tr>
<td>BFCI</td>
<td>Baby Friendly Community Initiative</td>
</tr>
<tr>
<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
</tr>
<tr>
<td>SCDHB</td>
<td>South Canterbury District Health Board</td>
</tr>
<tr>
<td>BFAG</td>
<td>Breastfeeding Action Group</td>
</tr>
<tr>
<td>Plunket</td>
<td>Plunket</td>
</tr>
<tr>
<td>BFWX PC</td>
<td>Breastfeeding Welcome Here Programme</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>---------</td>
<td>--------------------------------------------------</td>
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<tr>
<td>C&amp;PH</td>
<td>Community &amp; Public Health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>P&amp;CS</td>
<td>Primary and Community Services</td>
</tr>
<tr>
<td>WAVE</td>
<td>Wellbeing and Vitality in Education</td>
</tr>
<tr>
<td>PC</td>
<td>Peer Counsellor</td>
</tr>
</tbody>
</table>
RESOLUTION EXCLUDING PUBLIC

The Committee resolves that in accordance with the provisions of clause 32 of the 3rd schedule of the New Zealand Public Health and Disability Act 2000 ("the Act") that the public be excluded from the following part of this meeting in order that the Committee may consider:

1. SCDHB Service Reviews

The reason for passing this resolution in relation to

- SCDHB Service Reviews

is that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under the Official Information Act 1982, being -

(a) Information that would enable the Committee to carry out, without prejudice or disadvantage, commercial activities (S. 9 (2) (i) Official Information Act 1982).

The grounds on which this resolution is based are those contained in clause 32 (a) 3rd schedule of the Act.
RESOLUTION TO RESUME OPEN MEETING

The Committee resolves to resume in open meeting and actions taken with the public excluded are confirmed by the Committee.