

## NOTICE OF MEETING

### OPEN MEETING

A meeting of the Board Members of  
Nelson Marlborough Health to be  
held on Tuesday 24 September 2019 at 1.00pm

Seminar Centre Room 1, Braemar Campus, Nelson Hospital

Section	Agenda Item	Time	Attached	Action
	<i>PUBLIC FORUM</i>	<b>1.00pm</b>		
1	Welcome, Karakia, Apologies, Registration of Interests	<b>1.10pm</b>	Attached	Resolution
2	Confirmation of previous Meeting Minutes	<b>1.15pm</b>	Attached	Resolution
2.1	Action Points			
2.2	Correspondence		Attached	Note
3	Chair's Report		Attached	Resolution
4	<b>Decision:</b> Position Statement Environmentally Sustainable Health Care		Attached	Resolution
4.1	Position Paper – Environmentally Sustainable Health Care		Attached	Note
5	<b>Update:</b> Models of Care Programme		Attached	Note
5.1	MOC Update		Attached	Note
6	Chief Executive's Report	<b>1.30pm</b>	Attached	Resolution
6.1	DSS Annual Priorities		Attached	
6.2	Mental Health & Addictions Priorities		Attached	
6.3	Maori Mental Health & Addiction Strategic Plan		Attached	
7	Consumer Council Chair's Report		Attached	Resolution
8	Finance Report		Attached	Resolution
9	Clinical Governance Report		Attached	Resolution
10	For Information		Attached	Note
11	Glossary		Attached	Note
	<i>Resolution to Exclude Public</i>	<b>2.00pm</b>	As below	Resolution

**PUBLIC EXCLUDED MEETING**

2.00pm

Resolution to exclude public

#### **RECOMMENDATION**

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

## Open Board Agenda

- ***Minutes of a meeting of Board Members held on 27 August 2019 (Clause 32(a) Third Schedule NZ Public Health & Disability Act 2000)***
- ***Decision Items – To protect information that is subject to negotiation (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***
- ***DHB Chief Executive’s Report - To protect information that is subject to negotiation (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***

## WELCOME, KARAKIA AND APOLOGIES

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### Apologies

## REGISTRATIONS OF INTEREST – BOARD MEMBERS

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Jenny Black (Chair)	<ul style="list-style-type: none"> <li>▪ Chair of South Island Alliance Board</li> <li>▪ Chair of National Chairs</li> <li>▪ Chair of West Coast DHB</li> <li>▪ Member of West Coast Partnership Group</li> <li>▪ Member Health Promotion Agency (HPA)</li> </ul>			
Alan Hinton (Deputy Chair)	<ul style="list-style-type: none"> <li>▪ Nil</li> </ul>	<ul style="list-style-type: none"> <li>▪ Trustee, Richmond Rotary Charitable Trust</li> <li>▪ Trustee, Natureland Wildlife Trust</li> <li>▪ Trustee, Nelson Christian Trust</li> <li>▪ Director, Solutions Plus Tasman Ltd</li> <li>▪ Consultant, Azwood Ltd</li> <li>▪ Secretary, McKee Charitable Trust</li> </ul>	<ul style="list-style-type: none"> <li>▪ Support of local worthy causes</li> <li>▪ Education and support of endangered species</li> <li>▪ Local, national and international support</li> <li>▪ Business consultancy</li> <li>▪ Heating fuels and landscaping facilities</li> <li>▪ Tertiary scholarships and general philanthropy</li> </ul>	Supply of heating fuel to NMDHB

## Open Board Agenda

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Gerald Hope		<ul style="list-style-type: none"> <li>▪ CE Marlborough Research Centre</li> <li>▪ Director Maryport Investments Ltd</li> <li>▪ CE at MRC landlord to Hill laboratory services Blenheim</li> <li>▪ Councillor Marlborough District Council (Wairau Awatere Ward)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Landlord to Hills Laboratory Services Blenheim</li> </ul>	
Judy Crowe		<ul style="list-style-type: none"> <li>▪ Daughter is senior HR Consultant at Oranga Tamariki in Wellington</li> </ul>		
Patrick Smith	<ul style="list-style-type: none"> <li>▪ Member of IHB</li> </ul>	<ul style="list-style-type: none"> <li>▪ Managing Director, Patrick Smith HR Ltd</li> </ul>	<ul style="list-style-type: none"> <li>▪ Consultancy services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Focus on primary sector and Maori Working with Maori Health Providers who hold contracts</li> </ul>
Jenny Black (Marlborough)		<ul style="list-style-type: none"> <li>▪ ACP Practitioner</li> </ul>	End of life care	
Brigid Forrest	<ul style="list-style-type: none"> <li>▪ Doctor at Hospice Marlborough (employed by Salvation Army)</li> <li>▪ Locum GP Marlborough (not a member of PHO)</li> <li>▪ Daughter in Law employed by Nelson Bays Primary Health as a Community Dietitian</li> </ul>	<ul style="list-style-type: none"> <li>▪ Small Shareholder and director on the Board of Marlborough Vintners Hotel</li> <li>▪ Joint owner of Forrest Wines Ltd</li> </ul>	<ul style="list-style-type: none"> <li>▪ Functions and meetings held for NMDHB</li> </ul>	

## Open Board Agenda

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Dawn McConnell	<ul style="list-style-type: none"> <li>▪ Te Atiawa representative and Chair of Iwi Health Board</li> <li>▪ Director Te Hauora O Ngati Rarua</li> </ul>	<ul style="list-style-type: none"> <li>▪ Trustee, Waikawa Marae</li> <li>▪ Regional Iwi representative, Internal Affairs</li> </ul>	<ul style="list-style-type: none"> <li>▪ MOH contract</li> </ul>	
Allan Panting	<ul style="list-style-type: none"> <li>▪ Chair Orthopaedic Prioritisation Working Group</li> <li>▪ Chair General Surgery Prioritisation Working Group</li> <li>▪ Chair Ophthalmology Service Improvement Advisory Group</li> <li>▪ Chair Maternal Foetal Medicine Service Improvement Advisory Group</li> <li>▪ Chair National Orthopaedic Sector Group</li> </ul>			
Stephen Vallance	<ul style="list-style-type: none"> <li>▪ Chairman, Marlborough Centre of the Cancer Society</li> <li>▪ Chairman, Crossroads Trust Marlborough</li> </ul>			
Craig Dennis	<ul style="list-style-type: none"> <li>▪ Trustee of Nelson Region Hospice Investment Trust</li> </ul>	<ul style="list-style-type: none"> <li>▪ Director of CD &amp; Associates</li> <li>▪ Director of Scott Syndicate Development Company Ltd</li> <li>▪ Director of 295 Trafalgar Street Ltd</li> <li>▪ Director of KHC Dennis Enterprises Ltd</li> <li>▪ Director, Taylors Contracting Co Ltd</li> </ul>		

*As at July 2019*

**REGISTRATIONS OF INTEREST – EXECUTIVE LEADERSHIP TEAM MEMBERS  
REGISTRATIONS OF INTEREST – EXECUTIVE LEADERSHIP TEAM MEMBERS**

Name	Title	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
<b>CLINICAL SERVICES</b>					
Lexie O’Shea	GM Clinical Services	Nil			
Pam Kiesanowski	Director of Nursing & Midwifery	<ul style="list-style-type: none"> <li>▪ Chair SI NENZ Group</li> </ul>			
Elizabeth Wood, Dr	Clinical Director Community / Chair Clinical Governance Committee	<ul style="list-style-type: none"> <li>▪ General Practitioner Mapua Health Centre</li> <li>▪ Chair NMDHB Clinical Governance Committee</li> <li>▪ MCNZ Performance Assessment Committee Member</li> </ul>			
Nick Baker, Dr	Chief Medical Officer	<ul style="list-style-type: none"> <li>▪ Senior Clinical Lecturer, Community Child Health, University of Otago Wellington School of Medicine</li> <li>▪ Member Steering Group NZ Child and Youth Epidemiology Service (previously Chair of and co-founder of the service)</li> <li>▪ Member of Paediatric Society of NZ</li> <li>▪ Fellow Royal Australasian College of Physicians</li> <li>▪ Workforce Taskforce – Health Work Force NZ</li> <li>▪ Occasional Expert Witness Work – Ministry of Justice</li> <li>▪ Technical Expert DHB Accreditation – MOH</li> <li>▪ Occasional external contractor work for SI Health Alliance teaching on safe</li> </ul>	<ul style="list-style-type: none"> <li>▪ Wife is a graphic artist who does some health related work</li> </ul>		

Name	Title	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
		<ul style="list-style-type: none"> <li>sleep</li> <li>▪ Chair National CMO Group</li> <li>▪ Co-ordinator SI CMO Group</li> <li>▪ Member SI Quality Alliance Group - SIAPO</li> <li>▪ External Clinical Incident Review Governance Group - ACC</li> </ul>			
Hilary Exton	Director of Allied Health	<ul style="list-style-type: none"> <li>▪ Member of the Nelson Marlborough Cardiology Trust</li> <li>▪ Member of the South Island Strategic Planning and Integration Team</li> <li>▪ Member of Physiotherapy New Zealand</li> <li>▪ Member of the New Zealand DHB Physiotherapy Leaders group</li> <li>▪ Member of the New Zealand Paediatric Group</li> <li>▪ Chair of South Island Directors of Allied Health</li> <li>▪ President of the Nelson Marlborough Physiotherapy Branch</li> <li>▪ Deputy Chair National Directors of Allied Health</li> </ul>			
<b>MENTAL HEALTH SERVICES</b>					
Jane Kinsey	GM Mental Health Addictions & DSS	<ul style="list-style-type: none"> <li>▪ Husband works for NMDHB in AT&amp;R as a Physiotherapist.</li> <li>▪ Son employed on a short term contract doing data entry</li> </ul>	<ul style="list-style-type: none"> <li>▪ Board member Distance Running Academy</li> </ul>		



Name	Title	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
<b>CORPORATE SUPPORT</b>					
Trish Casey	GM People & Capability	<ul style="list-style-type: none"> <li>Husband is shift manager for St John Ambulance</li> </ul>	<ul style="list-style-type: none"> <li>Trustee of the Empowerment Trust</li> </ul>		
Kirsty Martin	GM IT				
Eric Sinclair	GM Finance Performance & Facilities	<ul style="list-style-type: none"> <li>Trustee of Golden Bay Community Health Trust</li> <li>Member of National Food Services Agreement Contract Management Group for Health Partnerships</li> <li>Wife is a Registered Nurse working for Tahunanui Medical Centre and Richmond Health Centre on a casual basis</li> </ul>			
Cathy O'Malley	GM Strategy Primary & Community	<ul style="list-style-type: none"> <li>Daughter employed by Pharmacy Department in the casual pool</li> <li>Sister is employed by Marlborough PHO as Healthcare Home Facilitator</li> </ul>	<ul style="list-style-type: none"> <li>Daughter is involved in sustainability matters</li> </ul>		
Ditre Tamatea	GM Maori Health & Vulnerable Populations	<ul style="list-style-type: none"> <li>Te Herenga Hauora (GM Maori Health South Island)</li> <li>Member of Te Tumu Whakarae (GM Maori Health National Collective)</li> <li>Partner is a Doctor obstetric and gynaecological consultant</li> <li>Member of the South Island Child Health Alliance Te Herenga Hauora representative to the South Island Programme Alliance Integration Team (SPAIT)</li> </ul>	<ul style="list-style-type: none"> <li>Both myself and my partner own shares in various Maori land incorporations</li> </ul>		

Name	Title	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
<b>CHIEF EXECUTIVE'S OFFICE</b>					
Peter Bramley, Dr	Chief Executive	<ul style="list-style-type: none"> <li>▪ Brother has been engaged by NMDHB to explore options for NMHCT</li> <li>▪ Daughter employed as RN for NDHB</li> <li>▪ DHB representative on the PHARMAC Board</li> <li>▪ Lead CE for Joint Procurement Agency</li> <li>▪ Member of Health Roundtable Board</li> </ul>	<ul style="list-style-type: none"> <li>▪ Son-in-law employed by Duncan Cotterill</li> </ul>		
Gaylene Corlett	EA to CE	<ul style="list-style-type: none"> <li>• Brother works at NMDHB in the Transport Department</li> </ul>			

*As at June 2019*

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**MINUTES OF A PUBLIC MEETING OF BOARD MEMBERS OF NELSON MARLBOROUGH HEALTH HELD IN SEMINAR CENTRE ROOM 1, BRAEMAR CAMPUS, NELSON HOSPITAL ON 27 AUGUST 2019 AT 1.00PM****Present:**

Jenny Black (Chair), Alan Hinton (Deputy Chair), Stephen Vallance, Patrick Smith, Jenny Black (Marlb), Dawn McConnell, Judy Crowe, Allan Panting, Brigid Forrest, Craig Dennis, Gerald Hope

**In Attendance:**

Peter Bramley (Chief Executive), Eric Sinclair (GM Finance Performance & Facilities), Jane Kinsey (GM Mental Health Addictions & DSS), Nick Baker (Chief Medical Officer), Ditre Tamatea (GM Maori Health & Vulnerable Populations), Lexie O'Shea (GM Clinical Services), Stephanie Gray (Communications Manager), Judith Holmes (Chair Consumer Council), Gaylene Corlett (Board Secretary)

**Apologies:**

Nil

**Karakia:**

Patrick Smith

**SECTION 1: PUBLIC FORUM / ANNOUNCEMENTS**

Samantha Gee, Nelson Mail

Paul Matheson, member of public (Board candidate)

Ian Pirie, member of public (Board candidate)

Lew Solomon, member of public, spoke about Nitrate levels in the Nelson Marlborough water supply. Noted two private bores in the TDC area have high nitrate levels. It is believed that many residents who have private bores will be drinking unsafe water. Data to be sent to Public Health.

**SECTION 2: APOLOGIES AND REGISTRATIONS OF INTEREST**

Noted.

**Moved: Stephen Vallance**

**Seconded: Alan Hinton**

**RECOMMENDATION:**

**THAT APOLOGIES AND REGISTRATIONS OF INTEREST BE NOTED.**

**AGREED**

**SECTION 3: MINUTES OF PREVIOUS MEETING**

**Moved: Stephen Vallance**

**Seconded: Alan Hinton**

**THAT THE MINUTES OF THE MEETING HELD ON 23 JULY 2019 BE ADOPTED AS A TRUE AND CORRECT RECORD.**

**AGREED**

### **Matters Arising**

Noted in the CE's report in the previous minutes, the Board member who raised issues on 5G and HPV to be identified as Judy Crowe. **It was requested that** the Board Secretary ascertain if Board members had received an email from Judy Crowe about immunisation and the response from MOH.

### **3.1 Action Points**

- Item 1 – H&S Dashboard: To be discussed further in CE report. Completed
- Item 2 – Medlab South Collection Point: Due in September
- Item 3 – Review of Consumer Council. Removed
- Item 4 – Care Foundation Update: Provided in CE report. Completed
- Item 5 – Primary Falls in HQSC Measures: Provided in CE report. Completed
- Item 6 – Tumour streams. Noted the rates for tumours are actively monitored. As we are a small service, we are impacted at times if there is staff sickness or extended leave, which means we may miss the target by a few days. Noted all DHBs are struggling with capacity at the moment.
- Item 7 – 5G network: Completed

### **3.2 Correspondence**

Nil.

## **SECTION 4: CHAIR'S REPORT**

The Chair provided an update on recent meetings attended.

## **SECTION 5: DECISION**

### **5.1 FY18/19 Year End**

Paper noted and endorsed.

**Moved: Judy Crowe**  
**Seconded: Craig Dennis**

### **RECOMMENDATIONS:**

- 1 THAT THE BOARD NOTES THE REVISED 2018/19 FINANCIAL RESULTS**
- 2 APPROVES THE CHAIR SIGN A LETTER REQUESTING A LETTER OF COMFORT FROM THE MINISTER OF HEALTH AND THE MINISTER OF FINANCE.**

**AGREED**

## SECTION 6: UPDATE

### 6.1 MOC Programme

Discussion held on the Health Intelligence initiative. It was noted that an Analyst supporting the MOC programme has been employed, and that the Health Intelligence business case has been put on hold whilst we develop our own analytics. Should extra support be needed, the business case will be presented to the Board for approval.

## SECTION 7: CHIEF EXECUTIVE'S REPORT

### Mental Health

Discussion held on the high number of vacant mental health positions across the country, noting that we are lucky in NMH as we do manage to fill our positions.

### Shorter Stays in ED

Discussion held on ED performance and meeting the shorter stay health target. It was noted now that MAPU is open 24/7, and we are heading out of winter, we should see an increase in meeting the health target in October/November.

### Oral Health

Discussion held on progress around education on prevention of tooth decay by encouraging tooth brushing etc. **It was requested that** the GM Strategy Primary & Community ascertain if tooth brushing education is provided in schools.

### Care Foundation

The update on funds raised and distributed by the Care Foundation was noted. The Foundation will begin fundraising. Noted funds raised, and bequests received will be used for the benefit of the health system, rather than specific trusts (as occurred in the past). Discussion held on the opportunity to reach out to communities for the new hospital build noting any funds raised will be kept in the Care Foundation rather than DHB accounts.

**Moved: Allan Panting**  
**Seconded: Dawn McConnell**

### **RECOMMENDATIONS:**

**THAT THE BOARD RECEIVES THE CHIEF EXECUTIVE'S REPORT.**

**AGREED**

## SECTION 8: CONSUMER COUNCIL CHAIR'S REPORT

*Judith Holmes, Chair of Consumer Council attended for this item*

The Consumer Council Chair thanked those Board members who have given long service, especially those who are standing down this year.

The Chair spoke of progress made by the Consumer Council.

## **SECTION 9: FINANCIAL REPORT**

The result for the first month of the 2019/20 year shows a deficit of \$764k. The 2019/20 financial budget is still to be agreed with MOH.

Discussion held on accruals for the Holidays Act.

**Moved:** Alan Hinton  
**Seconded:** Brigid Forrest

### **RECOMMENDATIONS:**

**THAT THE BOARD RECEIVES THE FINANCIAL REPORT.**

**AGREED**

## **SECTION 10: CLINICAL GOVERNANCE REPORT**

Noted.

## **SECTION 11: GENERAL BUSINESS**

Nil.

### ***Public Excluded***

**Moved:** Dawn McConnell  
**Seconded:** Patrick Smith

### **RECOMMENDATION:**

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

- ***Minutes of a meeting of Board Members held on 23 July 2019 (Clause 32(a) Third Schedule NZ Public Health & Disability Act 2000)***
- ***DHB Chair's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***
- ***DHB Chief Executive's Report - To protect information that is subject to a delegation of confidence (Clauses 32(a) and (b) Third Schedule NZ Public Health & Disability Act 2000)***

**Resolutions from the Public Excluded Meeting:**

The Board approved the following resolutions in the Public Excluded section of the Board meeting:

- Minutes of Previous Meeting – APPROVED
- Chair's Report – RECEIVED
- Decision – Contract Variations – APPROVED
- Decision – NZ Health Partnerships – APPROVED
- Decision – Financial Policies – APPROVED
- Decision – Mental Health Procurement – NOT APPROVED
- Decision – Holidays Act – APPROVED
- CE's Report – RECEIVED
- Update – Indicative Business Case – RECEIVED
- H&S Report – RECEIVED

**Meeting closed at 2.06pm.**

**ACTION POINTS - NMH – Board Open Meeting  
held on 27 August 2019**

<b>Action Item #</b>	<b>Action Discussed</b>	<b>Action Requested</b>	<b>Person Responsible</b>	<b>Meeting Raised In</b>	<b>Due Date</b>	<b>Status</b>
1	Public Forum	Update on investigate options for a Medlab collection point in Stoke	Lexie O'Shea	26 February 2019	24 September 2019	
2	Matters Arising	Ascertain if Board members received an email from Judy Crowe regarding immunisation and the response from MOH	Gaylene Corlett	27 August 2019	24 September 2019	Completed by Chair
3	CE's Report: Oral Health	Ascertain if tooth brushing education is provided in schools	Cathy O'Malley	27 August 2019	24 September 2019	CE report



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# MEMO

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**To:** Board Members  
**From:** Peter Bramley, Chief Executive  
**Date:** 18 September 2019  
**Subject:** **Correspondence Received for August**

*Status*

This report contains:

- For decision
- Update
- Regular report
- For information

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Date Received	From	Title
23/08/2019	State Services Commission	Positive and Safe Workplaces

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# MEMO

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**To:** Board Members  
**From:** Jenny Black, Chair  
**Date:** 18 September 2019  
**Subject:** **Chair's Report**

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*Status*

This report contains:

- For decision
- Update
- Regular report
- For information

A verbal update will be provided at the meeting.

Jenny Black  
**Chair**

**RECOMMENDATIONS:**

**THAT THE BOARD RECEIVE THE CHAIR'S REPORT.**

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# MEMO

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**To:** Board Members  
**From:** Daniel Lister and Peter Burton  
**Date:** 18 September 2019  
**Subject:** **Decision: Environmentally Sustainable Health Care Position Statement**

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## *Status*

This report contains:

- ✓ For decision
- ✓ Update
- Regular report
- For information

You will all have heard of Greta Thunberg, the young climate activist from Sweden who started the School Strike 4 Climate movement as well as the #FridaysForFuture and #Climatestrike campaigns which have quickly moved around the world and seen students leave classes for their concerns to be heard. This included Blenheim in March and Nelson in May. A recent quote from Greta's TEDx talk reads "What we do or don't do right now will affect my entire life and the lives of my children and grandchildren. What we do or don't do now, me and my generation can't undo in the future." – Greta Thunberg, (TEDx Stockholm).

The Position Statement: *Environmentally Sustainable Health Care* (attached as item 4.1) has been developed through the South Island Alliance by the South Island Public Health Partnership. The intention is that all South Island DHBs will approve the Statement with the proviso that local terms and conditions may be applied.

The Position Statement was considered by the Executive Leadership Team on 3 May and approved on 4 July 2019. The comments that came from the May meeting were considered by the South Island Public Health Partnership on 19 June 2019 and are reflected in the amended draft. This includes renaming of what was the actions section to become a policy statement, denoting the course of action proposed by NMH for the foreseeable future.

The Position Statement is in two parts. The first two pages are the Position Statement itself. The remaining twenty five pages are a Background Paper designed to inform the commitment, statements, policy and actions of the South Island District Health Boards in their efforts to achieve an environmentally sustainable health system.

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.

Of interest, Southern District Health Commissioners have endorsed the Position Statement as has the Canterbury District Health Board Executive Team. A similar process is in place for SCDHB and WCDHB.

A key concern of the NMH ELT was that a Position Statement turn quickly into actions. To this end a Sustainability Action Plan has been drafted which builds on the policy

direction identified in the proposed Position Statement and is inclusive of the draft NMH Annual Plan commitments for 2019/20.

The Plan also includes an organisational structure for the leadership of the environmentally sustainable health care agenda within NMH. That is: ELT will have leadership and oversight; a Sustainability Leadership Group comprising three members of ELT and; a Sustainability Steering Group comprising the Leadership Group and some members of the Green Team. Importantly it was noted that NMH staff members have the opportunity to work on sustainability actions as part of their primary day-to-day roles.

Should the Board approve this Position Statement then it would form part of a triad of founding documents for NMH. The other two are “*Sustainability and the health sector – a guide to getting started*”, MoH 2019 and “*Government Procurement Rules – rules for sustainable and inclusive procurement*”, MBIE 2019.

## **RECOMMENDATIONS:**

### **THAT THE BOARD:**

- 1 APPROVE THE POSITION STATEMENT: ENVIRONMENTALLY SUSTAINABLE HEALTH CARE.**
- 2 NOTE THAT THE POSITION STATEMENT WAS APPROVED BY THE ELT ON 4 JULY AND REQUESTED THAT IT BE FORWARDED TO THE BOARD FOR APPROVAL.**

# Environmentally Sustainable Health Care: Position Statement

2019

DRAFT

*DRAFT 18 September 2019*



DRAFT

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# POSITION STATEMENT

## Purpose

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

## Definition

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

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

## Scope

The focus of this position statement and background paper is on human-caused global warming<sup>1</sup> 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

**N**elson Marlborough Health acknowledges New Zealand's commitment to the 2015 Paris agreement. 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]. As such Nelson Marlborough Health:

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

... continued

- 1.4. acknowledges that health care systems' contributions to New Zealand's total greenhouse gas emissions are significant, and environmental sustainability within health care involves ensuring the efficient management of all physical, financial, and human resources within the sector, including upstream inputs of goods and services and downstream clinical and non-clinical waste, ([pages 14–17](#)) and
- 1.5. recognises that health systems can benefit directly (e.g., improved efficiency) and indirectly (e.g., via a healthier population) from implementing environmentally sustainable actions as business-as-usual ([pages 18–21](#), & [Appendix](#)).

## Policy

Nelson Marlborough Health will:

- 2.1. advocate for health by demonstrating sustainability leadership in the community, and by communicating the threats and opportunities to the public and policy makers to ensure that climate change is understood as a central issue for human wellbeing ([page 13](#))
- 2.2. develop the system-wide resource capacity and capability to effect change; including the establishment of a South Island network, group, or entity with the means to work collaboratively to develop, embed and promote environmentally sustainable health systems ([page 13](#) & [Appendix](#))
- 2.3. participate in a regional project to measure the total carbon footprint of the South Island District Health Boards, and identify the main areas that could be improved (emission *hot-spots*). In order to achieve this, the South Island District Health Boards commit to expanding the scope of measurement previously applied under the Carbon Emission Measurement and Reduction Scheme (CEMARS) to include the embedded carbon inherent in procurement, travel, food and catering, and other indirect emissions sources ([pages 14–19](#) & [Appendix](#)), and
- 2.4. develop and implement a local and/or South Island-wide environmental sustainability plan to guide the reduction of the District Health Board's environmental burdens, across the full range of activities, in order to be environmentally sensitive and carbon-neutral by 2050. The plan will include mitigation measures and an adaptation strategy that anticipates service change ([pages 19–24](#)).

### About this Position Statement

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

# BACKGROUND PAPER

DRAFT

## Abstract

The purpose of this Background Paper is to inform the commitment, statements, policy and actions of the South Island District Health Boards in their efforts to achieve an environmentally sustainable health system. The most rapid environmental change currently occurring, on a global scale, is human-induced global warming and the resultant global climate change [1-3]. Increased emissions of fossil CO<sub>2</sub> 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

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

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

### HEALTH SYSTEM

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

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

### ENVIRONMENTALLY SUSTAINABLE HEALTH SYSTEM

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

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

## Introduction

### Background

Global warming<sup>2</sup> 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<sup>3</sup> [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<sub>2</sub> 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

## BOX 1

### Why the 1.5°C threshold?

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

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

<sup>2</sup> 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.

<sup>3</sup> This list only includes emissions, however, deforestation also increases the net carbon dioxide (CO<sub>2</sub>) in the atmosphere by reducing the amount of natural carbon dioxide removal.

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

## Climate change in New Zealand

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

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

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

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

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

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

Tertiary health effects/risks include:

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

## Towards environmentally sustainable health care

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

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

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

### BOX 2

#### Equity

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

## Māori health and equity

Climate change will result in different exposures and degrees of impact for different population groups; depending on geographic location, age, ethnicity, health status, socioeconomic circumstances, and other pre-existing vulnerabilities [32,33]. Māori, Pacific people, the elderly, and low-income groups in New Zealand are at greater risk of many of the adverse health impacts of climate change, compared with the general population [34,35].<sup>4</sup> 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

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<sup>4</sup> Many equity issues for Māori may also be experienced by Pacific Peoples living in New Zealand and by low income New Zealanders.



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

## Advocacy

Attention to the related health effects of climate change, and the necessary responses, is growing both in the media and in academic publications [1]. Contributions from within the health professions are increasingly seen as essential in driving sustained progress on reducing emissions, and realising the local and global health benefits of climate action [1]. The need for advocacy in public health is not new. The 1986 Ottawa Charter [43] has long highlighted advocacy as a fundamental strategy for advancing health as a major resource for social, economic and personal development, and an important dimension of quality of life. Most definitions of public health reinforce that public health is future-orientated and depends on 'the organised efforts of society'<sup>5</sup> [44,45]. The World Health Organization continues to highlight the need for the health sector to 'advocate social change as a means for sustainable improvement of population health' [37, p.175]. Moreover, the principle of moral equality<sup>6</sup> 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].

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<sup>5</sup> Adapted from the 'Acheson Report', the *Report of the Committee of Inquiry into the Future Development of the Public Health Function*. London, 1988.




<sup>6</sup> 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<sup>7</sup> of the organisation occurring over a given time frame or event. Carbon accounting can produce a detailed breakdown or profile of the relative contributions across the different sources of emissions (called scopes) [46-50]. The emission profile can then be used to inform planning and mitigation actions. There are three defined groupings or Scopes of emissions as set out in the *Greenhouse Gas Protocol*, the internationally adopted guidebook on carbon accounting methods [50]. Table 1 provides an example overview of the greenhouse gas Scopes 1, 2 and 3 as applied to a health system in a developed country (in this example, the NHS England, 2015) [51].

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

Scope	Description	Summary	Contribution <sup>A</sup>
1	Scope 1 emissions are the <i>direct</i> emissions emitted from the burning of fossil fuels to generate heat and electricity, on-site. <sup>B</sup> 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 <sub>2</sub> e emissions in this example.	Direct, by-products of combustion (for heat, power, and transport: on-site.	≈20% 
2	Scope 2 emissions are those <i>indirect</i> CO <sub>2</sub> e emissions attributable to the generation of electricity off-site <sup>C</sup> that is purchased and consumed on-site. Scope 2 emissions account for approximately 20% of the total CO <sub>2</sub> e emissions in this example.	Indirect by-products of electricity generation: off-site.	≈20% 
3	Scope 3 emissions are those <i>indirect</i> CO <sub>2</sub> 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. <sup>D</sup> Scope 3 emissions account for approximately 60% of the total CO <sub>2</sub> e emissions in this example.	Indirect, everything else: off-site.	≈60% 

<sup>A</sup> 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).

<sup>B</sup> Direct CO<sub>2</sub> emissions from the combustion of biomass (e.g., in a wood-fired boiler) are reported separately.

<sup>C</sup> Scope 2 emissions physically occur at the power station where electricity is generated.

<sup>D</sup> 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).

<sup>7</sup> Climate change is largely attributable to emissions of carbon dioxide (CO<sub>2</sub>), hence other greenhouse gasses are equalised to CO<sub>2</sub>'s warming potential.

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

Scope 1 and Scope 2 emissions are relatively easy to identify and quantify as they relate to energy consumption activities that occur within an organisation's operational boundary. These energy-related emissions may account for approximately 40% of a health system's total carbon footprint (depending on a country's electricity generation profile or 'percent renewable' and the influence this has on Scope 1 and Scope 2 emissions). Scope 3 emissions have been shown to account for approximately 60% of a developed country's health system's total CO<sub>2</sub>e emissions, based on a number of carbon footprinting studies [46,51-54]. In particular, procured pharmaceuticals, single-use medical devices, and medical equipment typically contribute the most within the Scope 3 category [55], as well as non-medical goods (e.g., food) and building/construction [52]. Health systems also procure substantial volumes of services from external contractors, and these procured services also contribute to Scope 3 emissions. The Appendix extends Table 1 and provides a detailed example of the application of carbon accounting principles to an entire health system. International research in the US, Australia and the UK<sup>8</sup> [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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<sup>8</sup> Sustainable Development Unit NHS carbon footprint publications relating to 2004, 2007, 2010, 2012, and 2015, are available at: <http://www.sdu.nhs.uk/corporate-requirements/measuring-carbon-footprint/nhs-carbon-footprint.aspx>

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

The non-energy initiatives focus on Scope 3 emissions.<sup>9</sup> 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].

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<sup>9</sup> 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

### BOX 4

#### The PAS 2050

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

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

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].<sup>8</sup> 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).<sup>10</sup> 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].

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<sup>10</sup> CEMARS® a wholly owned subsidiary of Landcare Research and 100% owned by the New Zealand Government.

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

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

The Greenhouse Gas Protocol Scope – 3 emissions*	CEMARS programme	
	Canterbury	Counties Manukau
GHG protocol Scope 3 sources (non-exhaustive) ranked by contribution		
Pharmaceuticals	Not included	Not included
Commissioned health services from outside system	Not included	Not included
Medical Instruments/devices	Not included	Not included
Food and catering	Not included	Not included
Freight transport	Not included	Not included
Meter-Dose inhalers	Not included	Not included
Air travel - domestic and international	Included	Included
Transport – private car for work-related transport	Not included	Not included
Taxi	Not included	Included
Other staff transport (shuttle bus)	Not included	Not included
Staff commuting to and from work	Not included	Not included
Construction	Not included	Not included
Paper products (office paper)	Not included	Included
Waste products and recycling	Included	Included
Anaesthetic gases	Not included	Not included
Other products	Not included	Not included
Other services (e.g. linen services)	Not included	Not included
Home use of medical devices (e.g., electricity used to run CPAP machine)	Not included	Not included
ITC technologies	Not included	Not included
Water and sanitation	Not included	Not included

Legend: ■ = included ■ = not included

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

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

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

## Co-benefits

Further opportunities lie in the leveraging of health co-benefits. There is growing recognition that the implementation of low-carbon policies can have substantial near-term health co-benefits through multiple overlapping pathways [31] (see Box 5 for examples). Co-benefits are the positive effects that a carbon reduction policy or measure might have on other objectives. Co-benefits and their related cost savings are often not taken into account in decision making processes<sup>11</sup> [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].

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<sup>11</sup> 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



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

## Adaptation

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

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

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

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

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

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

**Secondary prevention (*Adaptation*)**

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

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

## Conclusion

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

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## Appendix

### International example: the National Health Service (England)

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

#### The SDU

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

#### The footprint

Using the best available carbon accounting methods, a series of updated footprints have been published<sup>13</sup> 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].

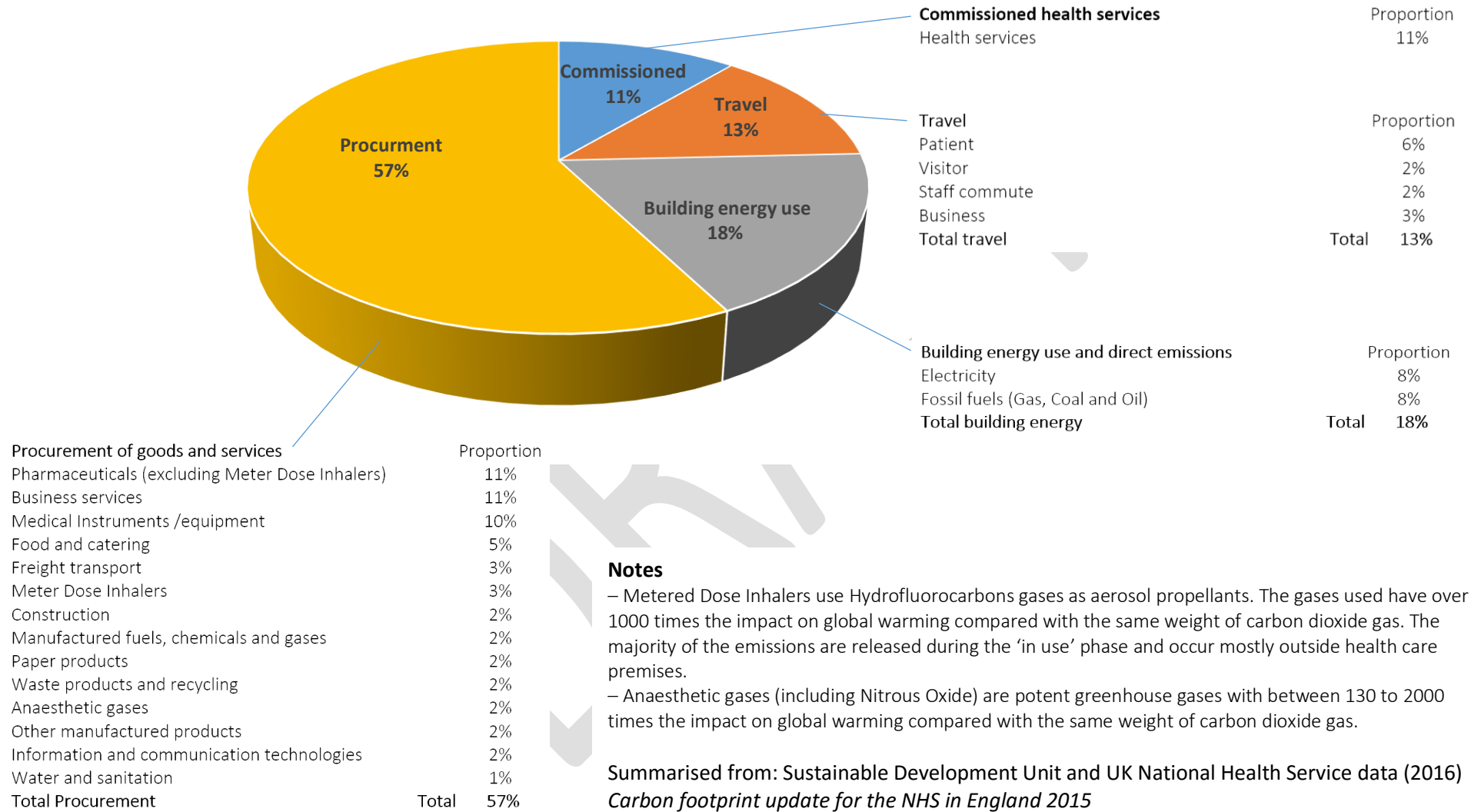
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<sup>12</sup> The Climate Change Act 2008 specifies that the net UK carbon account for all six Kyoto greenhouse gases for the year 2050 is to be at least 80% lower than the 1990 baseline.

<sup>13</sup> Sustainable Development Unit NHS carbon footprint publications, available at:

<http://www.sdu.nhs.uk/corporate-requirements/measuring-carbon-footprint/nhs-carbon-footprint.aspx>

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



## The Cost Curve

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

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

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

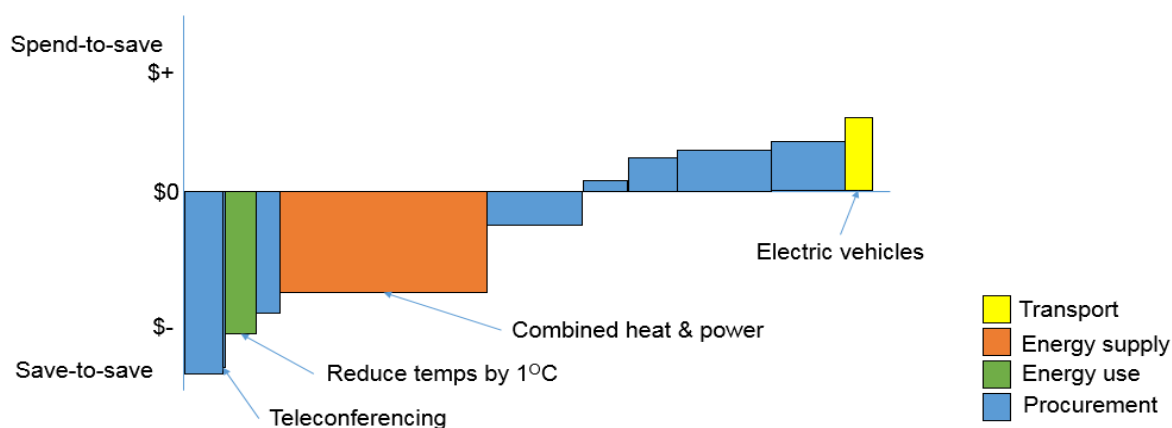


Figure 2 shows a generalised example of a health system's Marginal Abatement Cost Curve (MACC). Each block represents a different technology or intervention. In this example, each technology is colour-coded into four categories: transport, energy supply, energy use and procurement. A block that is projecting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

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

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

Table 4: List of CO<sub>2</sub> reduction measures related to energy supply and use, not considering interactions and overlaps (non-energy related measures for procurement of pharmaceuticals and medical devices are not shown)

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

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

DRAFT

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# MEMO

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**To:** Board Members  
**From:** Cathy O'Malley, Models of Care Programme Sponsor  
**Date:** 18 September 2019  
**Subject:** **UPDATE: Models of Care Programme**

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## *Status*

This report contains:

- For decision
- Update
- Regular report
- For information

Attached as item 5.1 is the update from the Models of Care programme.

### Summary

#### Programme Update

- The Indicative Business Case review recommended an update of the Clinical Services Plan to provide more detail about the impact of changing models for acute and secondary services on demand management, and the refinement of data modelling to capture the impact of changes to the models of care.
- During August Ernst & Young held the first stakeholder workshop to update the Clinical Services Plan and define in more detail the future flow of patients within Nelson hospital for planned, acute and outpatients care; More workshops will be held during September.
- The MOC programme team is working with Clinical Services and Ernst & Young to support the work and ensure alignment with MOC programme activities and principles.
- The priority activity for the MOC programme team is quantifying the impact each identified programme benefit will have on volume of demand and finances.

#### Implementation Project Highlights

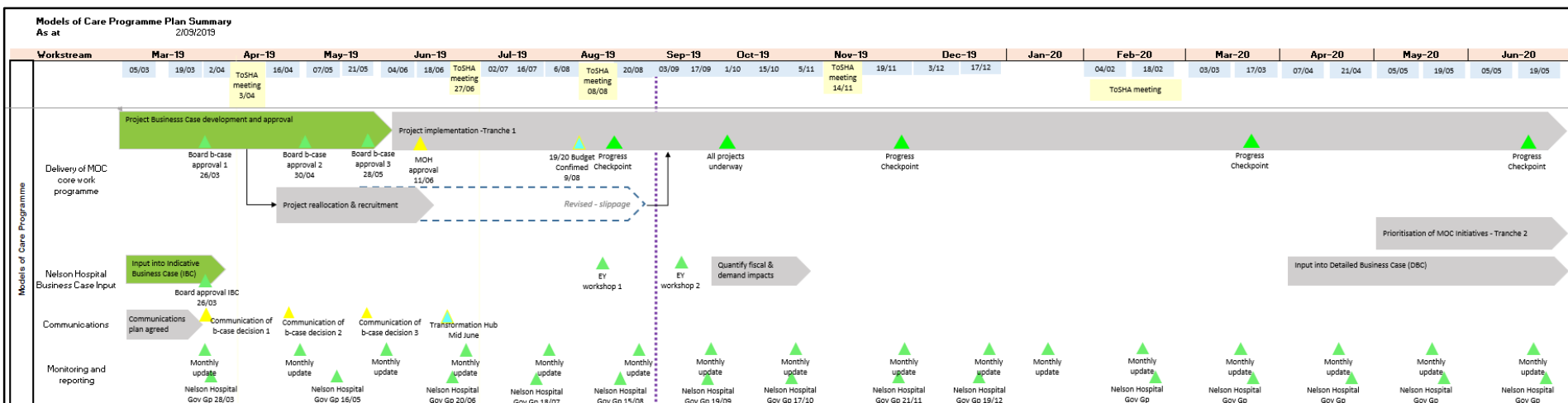
##### Care Anywhere - Virtual Health

- Pilots currently being evaluated with surveys of patients and clinicians. Early indications are that the use of video consultations has been well received by both groups.
- Patient comments
  - Would have been happy to use at home in future, happy to use data from home.
  - Just like being in the room, interested in in home consultation, having the medical professional was beneficial.
  - no major issues
  - Excellent for country people as not everyone can afford to go in, sometimes its good to go to Nelson so having the opportunity to decide how the appointment is done would be good.
  - no issues, would be happy to do it from home or clinic
  - More that you can get patients to use it the better.

What did you like the most about your Telehealth consultation?				
	Counts	Percents	Percents	
			0	100
Time saved on travel	6	100.0%		
Money saved on travel	6	100.0%		
The ease with which the Telehealth consultation was conducted	5	83.3%		
Local support throughout the Telehealth consultation	4	66.7%		
Conducted at local clinic with familiar health professionals	3	50.0%		
Personal interaction with the specialist	3	50.0%		
Ability to have family support/carers at consultation	0	0.0%		
Continuity of care and follow up	0	0.0%		
Other	0	0.0%		
Totals	*	*		



# Programme Plan Tracking



Programme Workstream	Status	Commentary/progress since last report
Delivery of MOC work core programme	In Progress	All projects will have commenced by the end of September 2019. The Health Intelligence business case is on hold as the outcomes sought are being addressed through internal NMH activities.
Nelson Hospital Business Case input	On Track	Workshops are underway to update the Clinical Services Plan and define in more detail the future flow of patients within Nelson hospital for planned, acute and outpatients care.
Communications	On Track	Models of Care programme information on the DHB public site; Stakeholder & Communications Hub established on level 2 of Nelson Hospital with 'pop-up' MOC sessions planned for Wairau Hospital and the Health Hubs; Key messaging document regularly sent to ELT.
Monitoring and reporting	On Track	MOC summary report sent monthly to ELT, CWG, ToSHA partners, clinical governance groups at NMH and both PHOs; Monthly progress report to Nelson Hospital Governance Group.

# Project and Workstream Tracking

## Implementation Projects

Project	Status	Key activities this month	Key activities next month
Health Care Home	On Track	Four Tranche two practices have completed their establishment stage and are working on their year one implementation plans. Tranche one practices are re-scoping the gap and preparing their year 2 implementation plans.	Supporting the implementation of the Strengthening Coordinated Care initiative in Marlborough with a Stakeholder meeting to co-design the locality based Interdisciplinary approach to coordinated care. On boarding NBPH practice to DataCraft to enable data collection and reporting.
Acute Demand : Medical Admissions & Planning Unit (MAPU)	On track	MAPU operational for 7 days per week from 1 <sup>st</sup> July; Full team recruited; Currently working on developing metrics and a Dashboard.	Develop 5 Virtual Beds in SIPICs for overflow patients.
Contribution to the First 1,000 Days	On Track	Project plan and Terms of Reference for Project Group developed. 10 workstream areas identified, concept plans for 3 of these have been drafted. Home Visiting Service Model with focus on the Parent:Infant relationship in development. Draft First 1000 Days Position Statement developed.	Develop workstream area plans for all 10 areas identified. Develop project communications plan. Connect with the Health Promotion Agency around National direction for First 1000 Days. Socialise draft position statement.
Strengthening Coordinated Care	On Track	Steering Group convened and initial meeting held. Planning for first pilot in Marlborough. Benefits realisation plan developed. Draft project schedule completed	Stakeholder session in Marlborough.
Care Anywhere: Making Virtual Health Happen	On Track	Awatere connectivity testing completed successfully. Pilot consumer and clinicians surveys completed. Follow-up appointments after an IDF consultation are being analysed. Early analysis suggests that each 10% increase in virtual consults has a potential fiscal reduction of approximately \$90k.	Transfer from workstream group to broader project steering group. Complete evaluation report and recommendations of next steps. User guide resources developed.
Workforce Development: People Powered Care	On Track	Resourcing options under consideration.	Agree preferred resourcing option. Convene project group.
On the Same Page: Shared Information Platform	In progress	Assigned project manager (part FTE) to focus on PCP trial, although overlap in current projects nearing completion will have some impact. Orion Personalised Care Plan (PCP) made available to NMH HCS users as part of release 53.2	Draft overview of activities for PCP trial, including resources required. Identify primary based resource to focus on maximising use of H1 in the community and to assist with Care Plans roll-out.
One Team: Transforming Timely Advice	On Track	Implementation Steering Group convened, 9 areas for potential improvement within existing systems identified. Developed Benefits Realisation Plan.	Scope the potential areas for improvement identified at the steering group meeting. Establish implementation plan. Identify appropriate resources for implementation.
Towards Equity: Extension of Hauora Direct	On Track	Transferred to Business As Usual.	N/A – regular report to be provided to the MOC Programme.

## Workstreams

Current Workstreams	Status	Comment
Departmental Deep Dive	S	The Detailed Business Case (DBC) requires a comprehensive examination of every hospital department; The approach for this work will be agreed by the IBC and MOC Sponsors.
Planned Care	S	Scope to be agreed with consideration of Elective Services Framework changes and IBC/DBC requirements.
Ambulatory Care / Outpatient Services	S	Scope to be agreed.
Population Health Social Movement	S	Resource identified; Initial discussions planned.
Clinical Engagement	S	Project group convened; Culture Diagnostic tool tested

Stage	
S	Starting phase – key resources identified, data collection, scoping
P	Planning underway, next steps being developed
I	Implementation
U	Pilot / activity underway
E	Evaluation

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# MEMO

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**To:** Board Members  
**From:** Peter Bramley, Chief Executive  
**Date:** 18 September 2019  
**Subject:** Chief Executive's Report

## Status

This report contains:

- For decision
- Update
- Regular report
- For information

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## 1. INTRODUCTORY COMMENTS

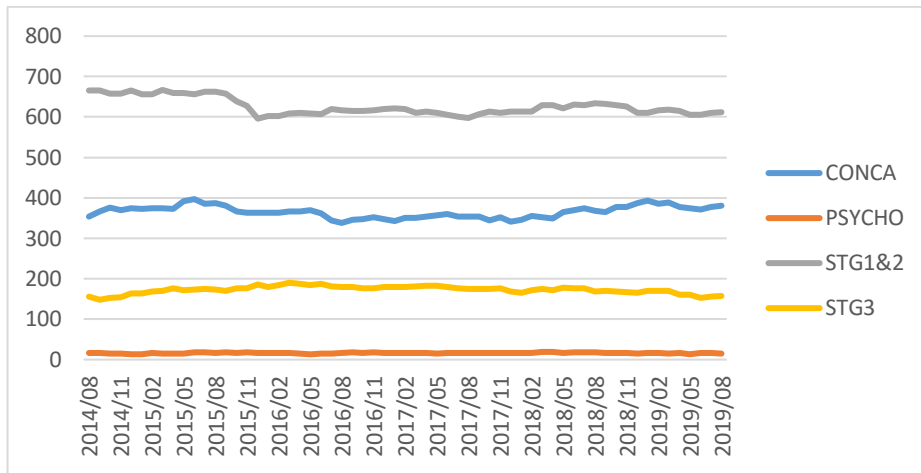
I had the privilege of visiting some twenty residences in our community (we have a total of fifty three across Nelson Marlborough) that are the homes of people who have significant disabilities. This was part of an organisation wide delivery of muffins and fruit to our staff to hopefully bring a bit of spring cheer, and to say a HUGE THANK YOU for the work they do in supporting our community to live healthy lives.

I was so impressed with the positivity and commitment that our disability support staff exhibited on my brief visits with them. They kindly introduced me to the residents who then showed me around their home. They are nice homes, situated amongst our community, but what is most stunning is the kindness and support that our staff provide, sometimes in the midst of some pretty challenging behaviours. I loved meeting three staff who collectively have given 100+ years of service to the DHB, and who obviously love what they do. I loved the young people working in the houses who showed such kindness and humour in the way they engaged with the people in their homes. I was offered cups of tea, invited to the next session of indoor bowls, asked to ride a motorbike, and proudly shown pictures of family, interests and new birthday gifts. Our staff demonstrate every day what it means to live out compassionate care. My visit to our Disability Services homes reminded me afresh that the care we provide as a DHB is not limited to hospital wards, but extends across our community in a 100 different settings – all a crucial part of living out our vision of helping people to live well, get well and stay well.

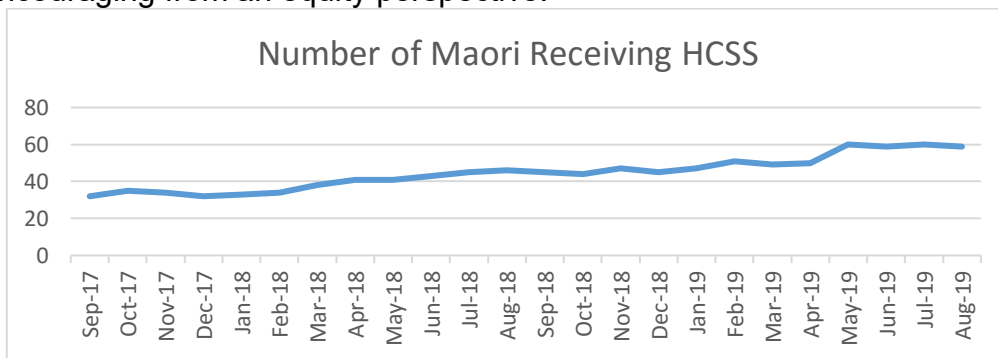
## 2. PRIMARY & COMMUNITY

- A Health Promoter, with three Marlborough School Principals, attended a Refugee Symposium held at Mangere Refugee Centre. Marlborough is one of the new intake areas set by the Government for refugees beginning in 2020, and this Symposium was an opportunity to see first-hand the challenges and support required. The Principals who went intend to discuss their findings with all Marlborough Principals.
- There is Aged Residential Care availability at all levels of care across the region, except for dementia level care in Motueka. Utilisation of aged residential care services has begun to increase post winter, with 14 additional residents in situ at the end of August compared with July.
- Aged Residential Care and Home & Community Support Service allocation has increased this month, although it is following a similar seasonal trend to previous years.

The following graph illustrates relatively flat utilisation in ARC.



- Uptake of Homebased Support Services by Māori is increasing, which is encouraging from an equity perspective.



- An operational management meeting was held this month with HCSS providers with a focus to discuss service delivery, further embed restorative practice, and respond to and collaborate with HCSS providers on emerging items.
- Arrears across the Community Oral Health Service have increased by 1% to 23% with Blenheim and Motueka driving the increase. A Saturday clinic has been introduced to Blenheim as well as referring out Year 8 children to community dentists. The mobile is on hold for the later part of this year and early next year, as the mobile is on 7% arrears with most areas up to date. The team are presenting at the Auckland and Otago graduation days to attract new Therapists for 2020.
- New Zealand has seen its largest measles outbreak since the 1990s with many people admitted to hospital. While Nelson Marlborough has seen several suspected cases that have been managed, as yet, we have been fortunate in not having a confirmed local case in this outbreak. Areas that are not part of the outbreak need to continue with the existing “stamp it out” strategy, while maximizing the MMR coverage.
- The Ministry of Health’s final feedback on the Annual Plan 2019/20 was received on 26 August with most sections approved or approved with minor changes. For non-financial performance reporting the Ministry of Health has requested DHBs create five templates, one for each of the priority areas, to report on the status of annual plan activities.
- The Ministry of Health have approved our System Level Measures Improvement Plan 2019/20. The development of a Health Literacy Action Plan 2019/20, which draws together our key quality improvement activities, is underway.
- Smokefree quit rates (59%) were the highest the service has achieved in the last eight quarters.

- A total of 90 referrals were received by the Stop Smoking Service in August with Blenheim receiving 25 (2 Pēpi First) and Nelson receiving 65 (5 Pēpi First).
- Smokefree group support is going well with the successful completion of the seven-week programme at a local business in Blenheim.
- ‘The Plan’ was presented to staff at Nelson City Council during a lunch time session. A total of 17 parents turned up and the positive evaluations showed once again that parents appreciate the opportunity to discuss the issue of alcohol and their teens.
- Health Promoters have been focusing on Foetal Alcohol Syndrome Disorder (FASD) and have been linking with Paediatrics and external agencies to raise awareness and promote prevention of the condition throughout September as part of a national campaign.
- The Public Health Service are supporting Te Kura Kaupapa Māori o Tuia Te Matangi to establish their He kura wai Māori anake tō mātou kura (water only policy).
- Asthma Marlborough was supported by the Public Health Service to present to Ward School staff. All teaching staff attended and an asthma kit was supplied to the school.
- A meeting was held with the Principal and School Coordinator of Redwoodtown to discuss the whanui hub that has been set up at the school. It has been developed to create a school community for parents, who meet once a week. People are invited to discuss topics that are of concern. A Public Health Nurse will attend to talk about bed wetting and is also going to discuss with CAMHS support for teachers around student anxiety issues.
- Three Marlborough Suicide Prevention sessions, facilitated by the NMH Suicide Prevention Coordinator, were held with 48 people attending from a variety of community agencies.
- HealthPathways website was used by 1,431 users with 7,849 sessions (an average of approximately 5 sessions per user). The most accessed pathway remains the Antibiotic Guidelines for Primary Care.
- The Nelson District Nursing team has continued to be very busy with similar numbers of patient visits this month to previous months. Referrals into the service have decreased this month which was much needed to catch up on the backlog of accumulated patients. It has been 6 months since discharges outweighed admissions.
- In response to a query on tooth brushing education in schools, we provide customised tooth brushing advice to all school children as part of their dental examinations in the Community Oral Health Service. Specifically they, and their accompanying caregiver, are taught the following across NMDHB:

*Tooth brushing*

*Give some advice on tooth brushing at every recall appointment:*

- *Brush with at least 1000ppm fluoride toothpaste for 2 minutes twice a day.*
- *Recommend 1450ppm toothpaste for all children living in non-fluoridated communities. For children under 6 years at Woodburn Airforce Base recommend 1000ppm toothpaste.*
- *Toothpaste should not be eaten due to the risk of fluorosis. Young children should not be dispensing their own toothpaste to minimise this risk.*
- *Under 6 years use a smear of toothpaste.*
- *From aged 6 use a pea-sized amount.*
- *Help children under 7 years old and supervise older children brushing.*
- *After brushing just spit, don't rinse. Children who spit out and don't rinse after brushing show an extra 10% reduction in caries compared with those who rinse their mouth out with water.*
- *If parents choose to use a non-fluoride toothpaste emphasise the need for a strict, very low sugar diet.*

### 3. MENTAL HEALTH, ADDICTIONS AND DSS

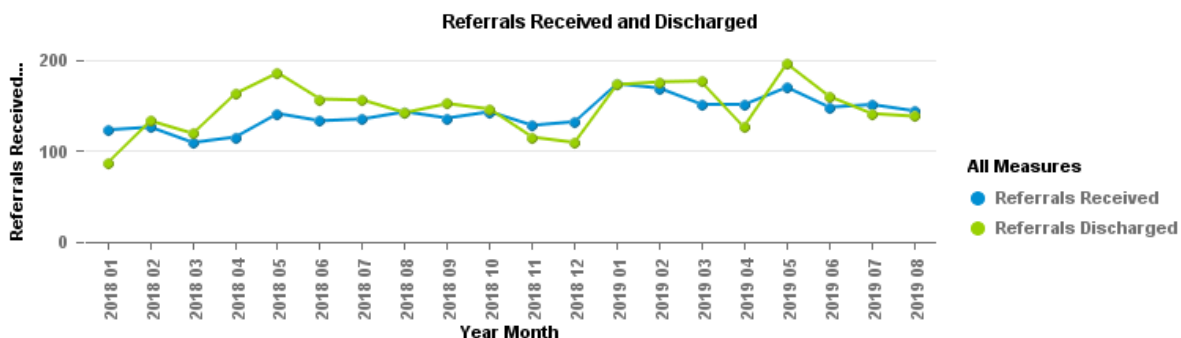
#### 3.1 Mental Health

- Government released the national Suicide prevention plan this month.
- The Wellbeing Practitioner role in Motueka has begun, and is being well accepted by the General Practice teams. Marlborough are also progressing a similar role, due to begin next month. The aim of these are to deliver a small amount of targeted, brief interventions to a large number of people, as well as connecting social services with strong connection with specialist support across the continuum of care. This trial mainly focusses on the people presenting with mental health conditions of “moderate to severe” presentations – what is coined ‘the missing middle’, in the inquiry review recently commissioned by the Government.
- The annual priorities for the MHA&DSS services have been finalised. These are attached as follows:
  - Item 6.1 – DSS Annual Priorities
  - Item 6.2 – Mental Health & Addictions Priorities
  - Item 6.3 – Māori Mental Health & Addictions Strategic Plan.

#### 3.2 Addictions Service

##### District-wide Referrals

##### Addictions



We have identified an opportunity to move our stable Opioid Substitution Treatment (OST) clients to primary care. Our GP liaison person has had three stable clients declined this month from different GPs, which has prompted specialists to offer training and education with GPs in order to utilise their setting of care.

#### 3.3 Older Persons Community

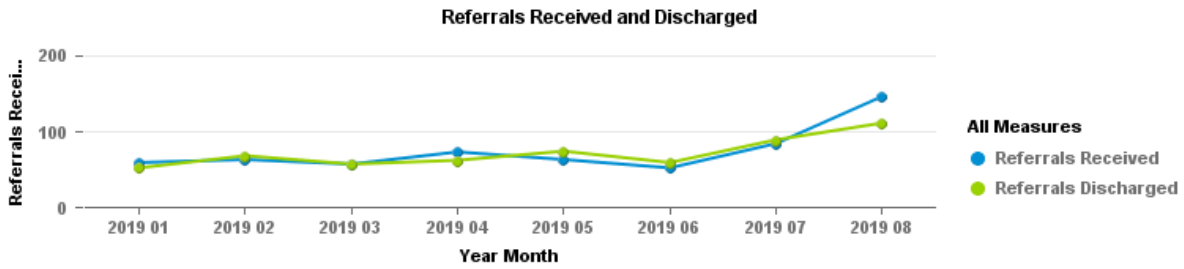
##### Alexandra Hospital

75% with no days at over 100% utilisation. This combined with relatively low acuity and less admissions/discharges has meant that baseline staffing was adequate.

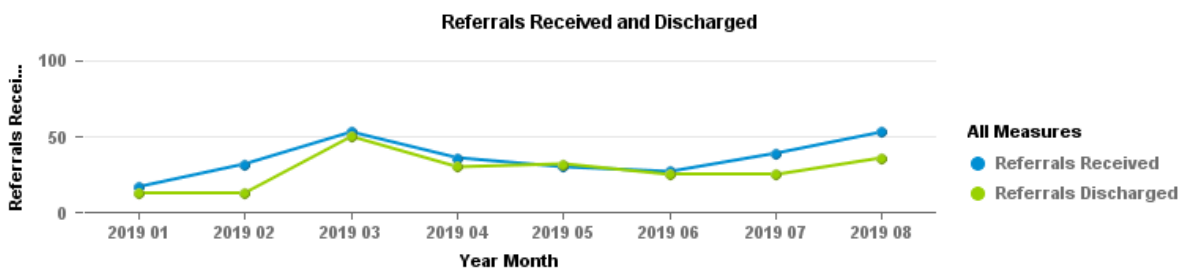
	June	July	August
Bed Occupancy	84%	102%	75%
Admissions	8	9	4
Discharges	6	11	5
# Waiting for D6 Beds (dementia)	1	1	0

### 3.4 Community Teams

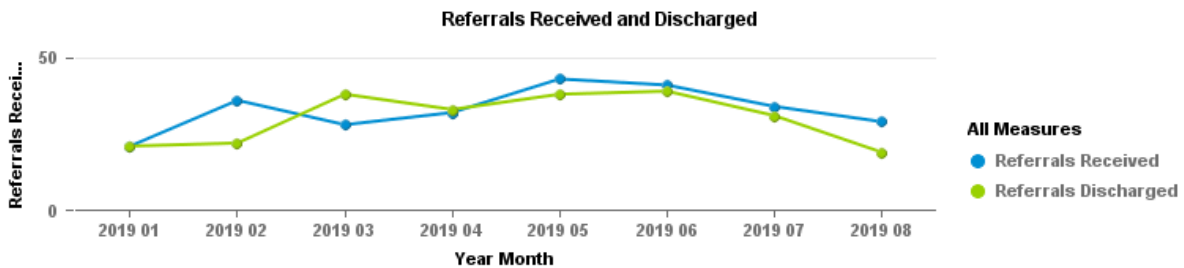
#### Community Assessment Team (CAT)



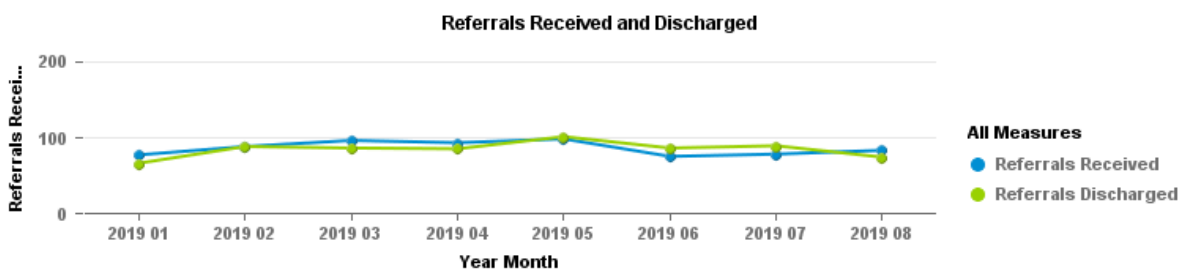
#### Adult Mental Health Nelson



#### Adult Mental Health Tasman

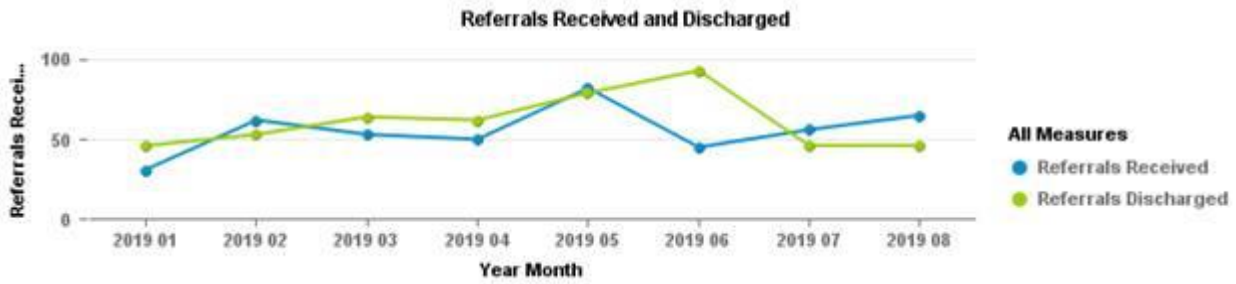


#### Marlborough Adult Mental Health

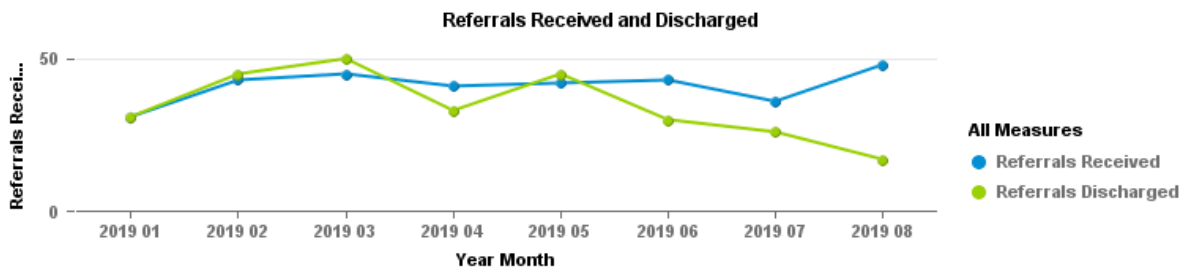


### 3.5 Child and Adolescent Mental Health Service (CAMHS)

#### Nelson

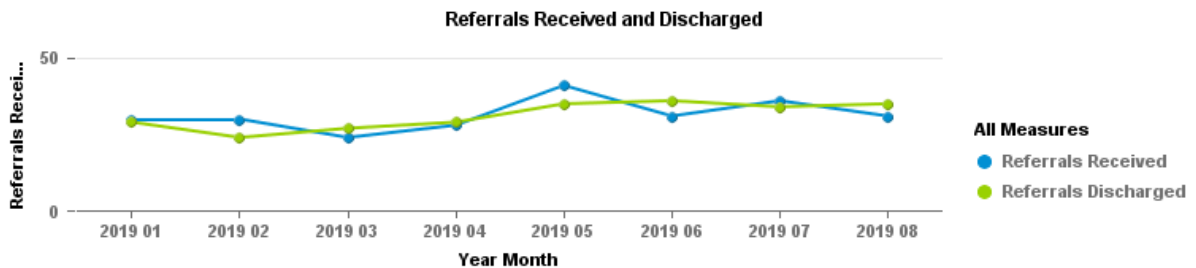


#### Wairau



### 3.6 Mental Health Admissions Unit (Wahi Oranga)

- A busy month with over 30 admissions/discharges, although slightly less compared to previous months.
- Some nights seclusion not used for Complex patient with use of Health Care Assistants.



	June	July	August
Seclusion: Episodes	40	40	9
Number of Patients	8	8	2

### 3.7 Disability Support Services

#### Client Story

When DSS uploaded medi map an old photo appeared from the system of Client S when they were living at Alexandra Hospital. It was like looking at a different person. This was shown to Client S by the Team Leader as a reminder of how far they had come.

When Client S came to live at DSS they were still drinking, having seizures and prone to violence. Despite this, staff supported Client S to the best of their ability. The team got the client's father on board with reducing the amount of money Client S was able



*to have at any given time, without someone accompanying them, to only \$5. The aim was to limit their ability to access alcohol. The team successfully encouraged Client S to engage with addictions services, which the client had in the past been extremely reluctant to do.*

*Client S was supported and encouraged to get out in the community and take care of the gardens at their home. Client S's drinking started to reduce dramatically, although they did have the odd slip up (which was to be expected), but Client S was improving. Client S had also previously been abusing their PRN medication. The RN worked with the GP to reduce this by addressing the client's pain issues through accessing physio and reducing the amount of medication the client was given. The team used positive behaviour support strategies – not saying “NO” to the client and phrasing responses in a way that worked for them.*

*As the client's health and wellbeing improved and they stopped using alcohol, staff advocated for them to have more opportunities to be independent. This was achieved by slowly increasing the amount of money they had unsupported and also by transitioning the client into a flat where they could live an independent life with oversight more than staff supervision.*

*Staff continued to support and advocate for the client as they demonstrated their resolve to abstain from alcohol and, as time passed, the more independence and control over their life the client gained, including managing their own finances.*

*Client S has remained alcohol free for over 12 months now and has managed to continue their sobriety through some really hard times, including their father passing away.*

*Client S has insight to talk to staff when they are struggling with depression and feeling they might drink, and the team has supported them with this. Next steps for Client S is to gain paid employment. DSS are trying to work through this currently as the big goal for Client S is to return to living independently in the community again.*

Disability Support Services (DSS)		Current July 2019				YTD July 2019	Current August 2019				YTD August 2019
<i>Contracted Services</i>		ID	PD	LTCH	Total	YTD Total	ID	PD	LTCH	Total	YTD Total
Current Moh Contract	As per Contracts at month end	163	17		180		163	19		182	
Beds – Moh Individual contracts	As per Contracts at month end	8	0		8		8	0		8	
Beds – S&P- Chronic Health Conditions	As per Contracts at month end	1	0	8	9		1	0	8	9	
Beds – Individual contracts with ACC	As per Contracts at month end	1	1		2		1	1		2	
Beds – Others - CY&F & Mental Health		2	2		4		2	2		4	
	Residential contracts - Actual at month end	175	20	8	203		175	22	8	205	
<i>Number of people supported</i>											
Total number of people supported	Residential service users - Actual at month end	175	20	8	203	increase 1	175	22	8	205	increase 2
	Respite service users - Actual at month end	4	3		7	increase 2	4	2		6	redn 1
	Child Respite service users - Actual at month end	33			33	increase 1	34			34	increase 1
	Personal cares/SIL service users - Actual at month end	0	0		0		0	0		0	
	Private Support in own home	0	0		0		0	0		0	
	Total number of people supported	212	23	8	243	increase 4	213	24	8	245	increase 2
		ALL		Residential	Child Respite		ALL		Residential	Child Respite	
<i>Occupancy Statistics</i>		Current		Current		Current		Current	YTD	Current	YTD
Total Available Beds - Service wide	Count of ALL bedrooms	230		222		8		230		222	
	Total available bed days	7,130		6,882		248		7,130	14,260	6,882	13,764
Total Occupied Bed days	Actual for full month - includes respite	6,447		6,301		146		6,506	12,953	6,364	12,665
Total Occupied Beds	Based on actual bed days for full month (includes respite volumes)	90.4%		91.6%		58.9%		91.2%	90.8%	92.5%	92.0%
		Last month	Current month	Variance				Last month	Current month	Variance	
	Total number of people supported	239	243	4				243	245	2	
Referrals	Total long term residential referrals	16	7					7	8		
Referrals - Child Respite	Child Respite referrals	9	5					5	6		
	Adult Respite referrals		3					3	3		
	New Referrals in the month	4	4					4	3		
Of above total referrals	Transitioning to service	-	1					1	-		
	On Waiting List	16	14					14	17		
Vacant Beds at End of month		17	17					17	13		
	Less people transitioning to service	-	1					1	-		
	Vacant Beds	17	16					16	13		

#### 4. INFORMATION TECHNOLOGY

##### Project Status

Name	Description	Status	Original Due date	Revised due date	
<b>PaperLite and New</b>					
<b>Shifts</b>	A mobile app utilising Microsoft Teams which allows managers to create, update, and manage shift schedules	Pilot in Wairau with RMOs starting Nov. Within scope of this pilot is all activities related to the management of shifts including view shifts online, shift swap, sick leave notification, and shift replacement	Feb 2020		●
<b>eTriage</b>	Electronic triage of referrals delivered via ERMS	Tranche 3 – all medicine – live on 14/8 and 2/9 (Cardiology). Now an estimated 86% of referrals centre volume managed with eTriage. Next tranche to go live mid October including the rest of core allied health and dermatology taking us to 94% of referral volume (estimated at 47k presenting referrals per year). On track to complete original project scope by 12/2019.	May 19	Dec 19	●
<b>eRadiology</b>	Regional project for online ordering and sign-off for Radiology tests and results.	NMH project commencing UAT. Targeting 18 <sup>th</sup> Sep for technical activation, as significant resource constraints after this date. Subsequent roll out will be gradual and phased by department.	Mar 18	Sep 19	●
<b>eObservations (Patientrack)</b>	Mobile Nursing tool to record EWS, assessments, & provide active alerts.	Nelson roll out has gone well with 8 Adult wards now live. Next steps to move into Maternity, Paediatrics and SCBU this will involve version upgrade and form development which is all within current capex.	July 18	Oct 18 for pilot.	●
<b>Virtual Health PoC</b>	Establishing small local Proof of Concepts to implement Virtual Health, as part of a step programme.	Continued work on POC groups for virtual health, with small and steady steps forward. Pilot group identified with Cardiology and Greenwood Medical Centre for all PCI follow ups.	n/a		●
<b>ePharmacy: Upgrade from WinDOSE</b>	ePharmacy is a dispensing and stock management system which will allow reporting of medication usage.	Key User and Super User training completed. Operational BAU Workshop for Pharmacy stakeholders and suppliers in Christchurch on July 9 <sup>th</sup> with the objective of undertaking a deeper dive into the roles and responsibilities for support across the regional teams.	Dev 19	Mar 20	●

Name	Description	Status	Original Due date	Revised due date	
<b>SI PICS - Foundation</b>	Patient Administration System (PAS) replacement for Ora*Care	Training of midwives is progressing, with over 750 users now on SI PICS. Testing and impact analysis is underway for the upcoming functionality release 19.2 in November. Capture of current Theatre system use is underway.	Release 19.2: Nov 19		●
<b>ICT</b>					
<b>Office 365 Implementation</b>	Utilisation of new M365 licensing to bring organisation up to date for Microsoft software / Cloud adoption	NMH Active Directory Users now being synced to our O365 Cloud Tenant. Fantastic kickoff of the Regional O365 working group in CHCH on the 20/08/19	Various		●
<b>Titanium upgrade</b>	Dental Software used by DHB and Community Oral Health	Successful implementation 2/3 <sup>rd</sup> August. No significant issues, majority of raised issues now resolved. Working with vendor to address last reporting issues.	Q1-2019	LIVE	●
<b>Server 2008 Replacement</b>	Decommissioning or upgrade of all Servers that are going out of support in January 2020	CCL presented a comprehensive proposal to work in together with the NMH IT group in order to hit this deadline. Questions of affordability.	Jan 2020		●
<b>Zoom Room</b>	Zoom is an easy to use, widely available VC alternative to Vivid. Trial use of Zoom enterprise level Video conference capability	PoC (Proof of Concept) has been successful and consolidation is underway with 10 licences organisation wide. Roadmap for Zoom integration currently being worked on. Free POC demo has been extended for a month in August.			●
<b>Development</b>					
<b>Hauora Direct</b>	A project aimed at improving enrolments in health programmes for vulnerable populations.	Business case and capex approved. Requirements and process flow development nearing completion. Agile development planning under way for delivery of Phase 1 Solution by 30 Nov. Datacom providing solution design and development resource.	Jun 19	Dec 19	●
<b>Capex form online</b>	Create an online form and workflow to replace the paper capex form.	Development work is progressing well and targeting September for pilot roll-out.	Aug 17	Sep 19	●
<b>Gastro Booking Viewer</b>	Web based viewer for gastro bookings.	Initial meeting with vendor – solution options agreed. Targeting November.	Nov 19		●
<b>Winscribe Text Implementation</b>	Replace the Electronic Patient Letter Management	Contract negotiation ongoing with Sound Business Solutions (SBS).	May 19	Mar 20	●

Name	Description	Status	Original Due date	Revised due date	
<b>(EPLMS Replacement)</b>	Systems (EPLMS) with Winscribe Text.	Project implementation planning to start in September.			
<b>EDaaG</b>	Emergency Department at a Glance developed in-house enhancements	Prioritisation meetings happening monthly to agree development activity for each month alongside support of SI PICS releases. SNOMED changes, and SIPICS interface Phase 2 current priority.	Various	ACC: Oct 19 EDaaG Dev WP Jun20	●
<b>ACC Claims and Invoicing – API implementation</b>	ACC are replacing legacy electronic claims and invoicing with a new suite of web services APIs in early 2019.	Development work has been completed, final testing and compliance with ACC required. Now targeting November for implementation.	Apr 19	Nov 19	●
<b>Care Plans</b>	Acute and Advance Care Plans (built on Clinical Pathways in HCS) to be implemented for NMH.	Advance Care Plan is available now. Acute Care Plan implementation planning including EDaaG integration (Care Plan status indicators) and HCS windowlet config is underway. As CDHB ED also require the Care Plan indicator for their EDaaG, Orion have started working on an API to provide the care plan flag for EDaaG.	Jun 19	Nov 19	●

## 5. CLINICAL SERVICES

- Clinics via Zoom are now being investigated by the Nelson Paediatric team. It is envisioned that this will be very helpful for children who live a significant distance from the hospital, eg Golden Bay, and also those children where the nature of their condition or family circumstance make it difficult for them to attend an appointment on site.
- The Child Development Services Team Leader is working with other South Island Child Development Services (CDS) groups to develop a plan for the additional Government funding being provided to target more face to face client contacts.

### 5.1 Health Targets

Year to date, as at the end of August 2019, 1,232 discharges were completed against a plan of 1,248 (98.7%). This is under plan by 16 discharges.

Year to date as at August 2019 NMDHB has delivered 4,062 caseweight discharges (CWDs) against a plan of 3,744 (108%).

Elective CWD delivery was 569 against a plan of 592 (96%) for August. Acute CWD delivery was 1,479 against a plan of 1,287 (115%) for August.

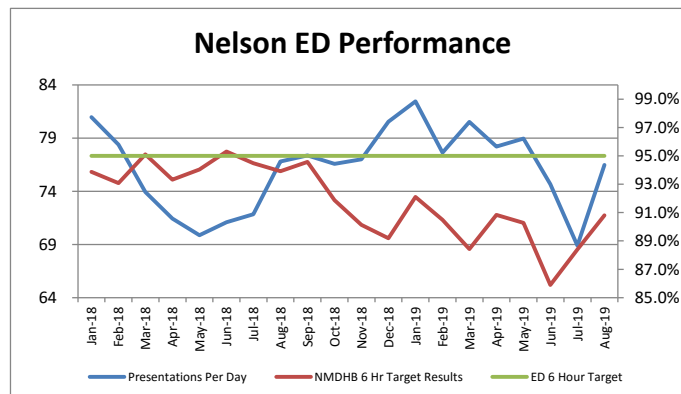
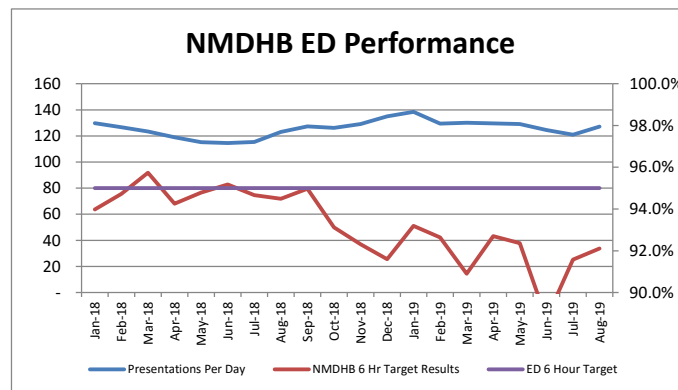
Year to date delivery to end of August for orthopaedic interventions was 93 joints against a plan of 92, over plan by 1.

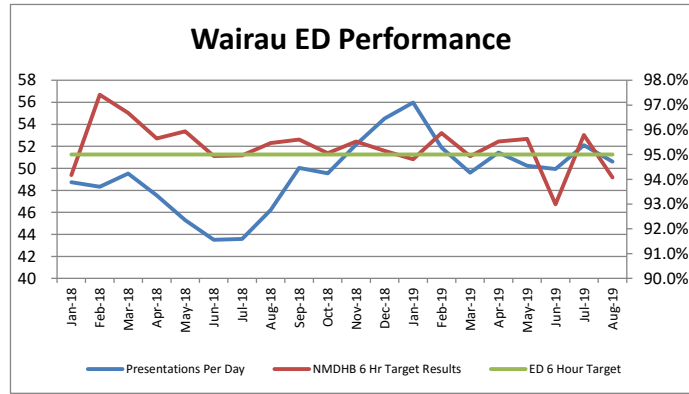
Year to date delivery to end of August for cataracts was 92 against a plan of 96, under plan by 4.

### 5.2 Elective / Acute Arranged Services

- ESPI 2 was Red for the month of August with 129 patients not being seen within 120 days of referral acceptance.
- ESPI 5 was Red for the month of August with 67 patients not being treated within 120 days of being given certainty.
- General Surgery, Neurology and Orthopaedics are still the main areas of focus with ESPI compliance.
- The following specialties require compliance for FSA:
  - Orthopaedics by April 2019 – achieved
  - Ophthalmology by June 2019 – achieved
  - General Medicine by June 2019 – achieved
  - Gynaecology by July 2019 – not achieved
  - ENT by August 2019 – achieved
  - Gastroenterology by August 2019 – achieved
  - General Surgery and Vascular by August 2019 – not achieved
  - Neurology and all services by October 2019.
- The following specialties require compliance for surgical treatment:
  - Ophthalmology by May 2019 – achieved
  - ENT by June 2019 – achieved
  - Orthopaedics by August 2019 – not achieved
  - General Surgery and Gynaecology by September 2019.

### 5.3 Shorter Stays in Emergency Department



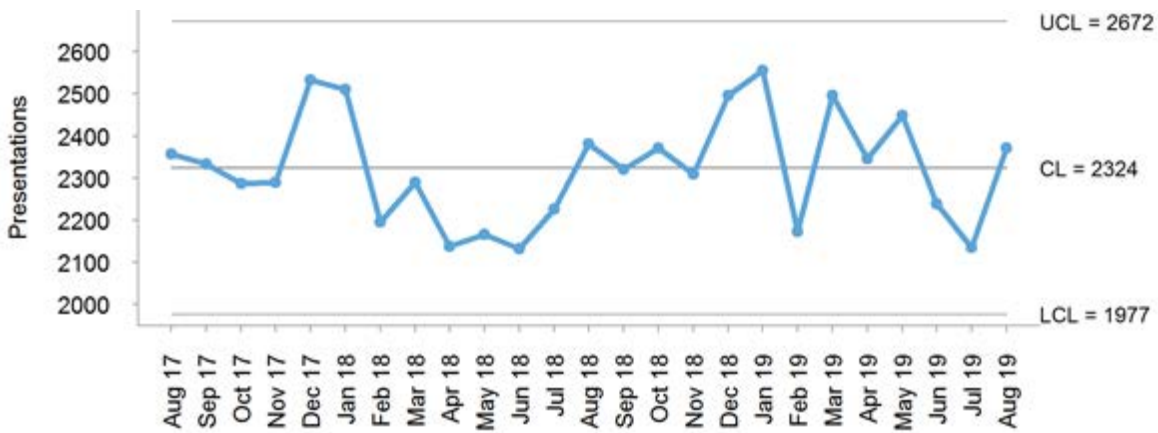


Length of stay target for past 3 months

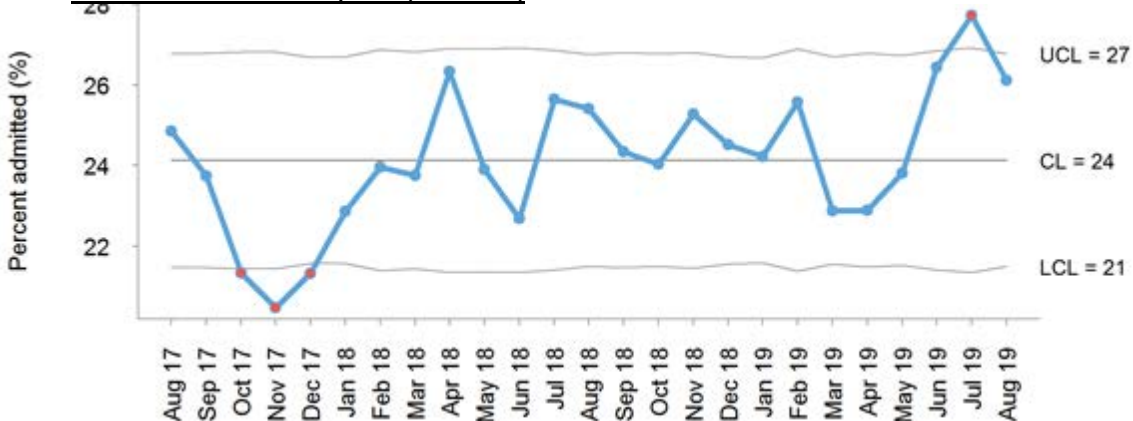
	June 2019		July 2019		August 2019	
	Total	<6hrs	Total	<6hrs	Total	<6hrs
<b>Nelson</b>	2,239	1,924 86%	2,136	1,888 88.4%	2,371	2,153 92%
<b>Wairau</b>	1,497	1,393 93%	1,615	1,547 95.8%	1,569	1,476 94%

Number of Presentations in Nelson ED

Nelson 91.8% discharged or admitted within 6 hours of presentation to ED.

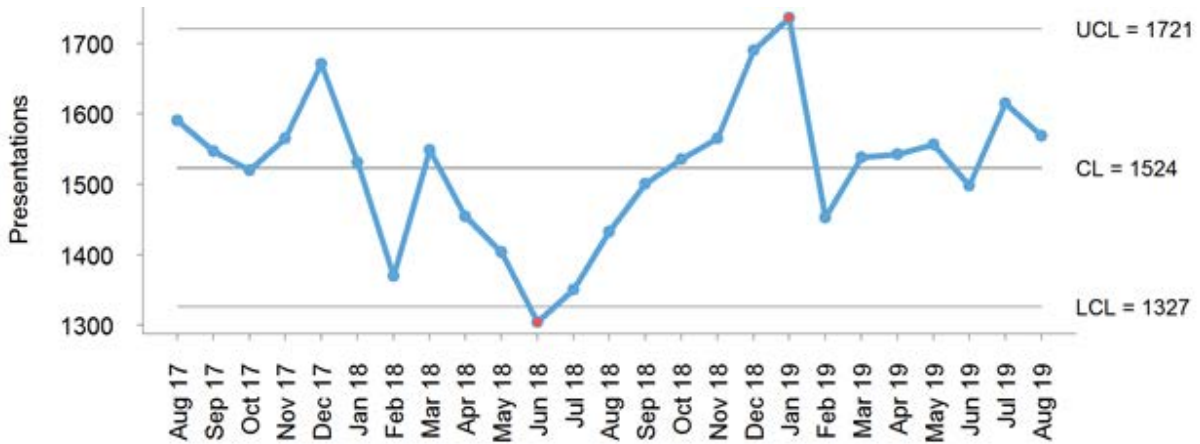


Admissions to Hospital (Nelson)

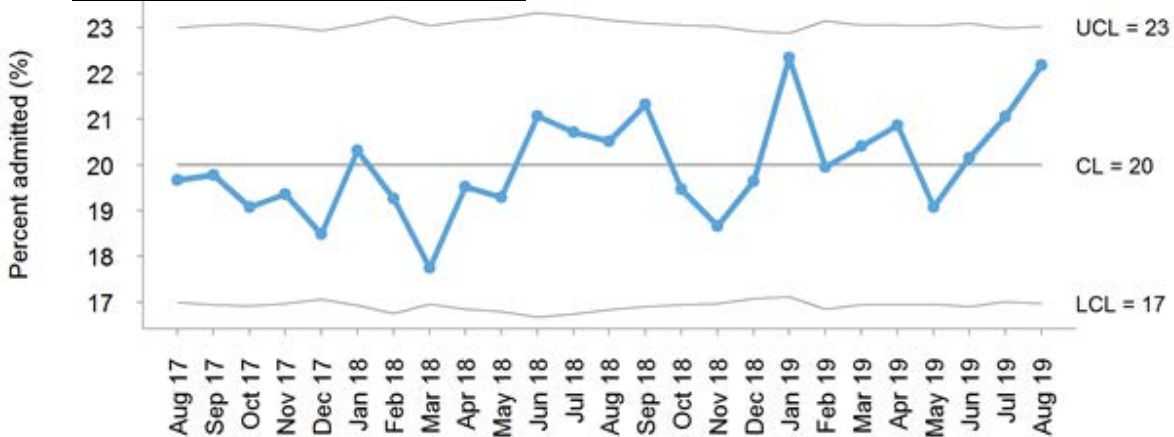


Number of Presentations in Wairau ED

Wairau 94.1% discharged or admitted within 6 hours of presentation to ED.



Admissions to Hospital (Wairau)



Occupancy Nelson and Wairau Hospitals

Hospital Occupancy 22 July – 18 August 2019	Adult in Patients	Hospital total inc Paeds & Maternity
Nelson	92%	82%
Wairau	86%	76%

- Adult inpatient occupancy exceeded 100% capacity in Nelson x 3 days
- Adult inpatient occupancy exceeded 100% capacity in Wairau x 4 days
- Both sites at, or over, 100% capacity at the same time x 1 day.

**5.4 Enhanced Access to Diagnostics**

- MRI numbers are 396 patients scanned in Nelson, and 96 scanned in Wairau (a total of 492 for August).
- MOH MRI target shows 92% of referrals accepted are scanned within 42 days (target is 90%). Machine capacity has increased and we expect to have the waitlist reduced by the end of September. Overall waitlist for MRI is 577, however of those 469 are planned scans that are scheduled over the next three to four years.
- MOH CT target shows 75% of referrals accepted are scanned within 42 days (target is 95%).



- Overall the waitlist for CT is 429, however of those 341 are planned scans that are scheduled over the next two to three years.
- The eRadiology ordering and sign off project continues, however the implementation date has been delayed until mid September.
- Shortage of radiologists is now having a serious impact on the service in terms of outsource costs and management of interventional lists.

### 5.5 Improving Waiting Times – Colonoscopy

At the end of August, there were 223 overdue colonoscopies, down from 241 at the end of July. Increased colonoscopy sessions have been taking place whilst we reduce the backlog of colonoscopies.

### 5.6 Faster Cancer Treatment – Oncology

FCT Monthly Report - August 2019											Reporting Month: July 2019 - Quarter 1 - 2019-2020						
											As at 28/08/2019						
62 Day Indicator Records																	
<b>TARGET SUMMARY (90%)</b>		<b>Completed Records</b>															
		Aug 19 (in progress)		Jul-19		Jun-19		Quarter 1 (in progress)		Quarter 4		Quarter 1 (2018-2019)		Rolling 12 Months Aug 18-Jul 19			
<b>Numbers as Reported by MOH (Capacity Constraint delay only)</b>		Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days		
		88%	12%	96%	4%	92%	8%	93%	7%	95%	5%	89%	11%	92%	8%		
<b>Number of Records</b>		15	2	23	1	24	2	38	3	69	4	66	8	273	25		
<b>Total Number of Records</b>		17		24		26		41		73		74		298			
<b>Numbers Including all Delay Codes</b>		75%	25%	77%	23%	86%	14%	76%	24%	80%	20%	73%	27%	77%	23%		
<b>Number of Records</b>		15	5	23	7	24	4	38	12	69	17	66	24	273	81		
<b>Total Number of Records</b>		20		30		28		50		86		90		354			
<b>90% of patients had their 1st treatment within: # days</b>		93		94		64		94		76		91		85			
<b>62 Day Delay Code Break Down</b>		Aug 19 (in progress)		Jul-19		Jun-19		Quarter 1 (in progress)		Quarter 4		Quarter 1 (2018-2019)		Rolling 12 Months Aug 18-Jul 19			
01 - Patient Reason (chosen to delay)		0		2		0		2		2		5		12			
02 - Clinical Cons. (co-morbidities)		3		4		2		7		11		11		48			
03 - Capacity Constraints		2		1		2		3		4		8		29			
<b>All BREACHES</b>																	
<b>TUMOUR STREAM (all breach codes)</b>						<b>ETHNICITY (all breach codes)</b>											
<b>Rolling 12 Months (Aug 18-Jul 19)</b>						<b>Rolling 12 Months (Aug 18-Jul 19)</b>						Within 62 Days	Within 62 Days	Exceeded 62 Days	Exceeded 62 Days	Total Records	
Brain/CNS	100%	3	0%	0	3	Asian not further defined	100%	1	0%	0	1	Chinese	100%	1	0%	0	1
Breast	95%	72	5%	4	76	European nfd	100%	15	0%	0	15	Maori	76%	16	24%	5	21
Gynaecological	93%	13	7%	1	14	New Zealand European	75%	208	25%	70	278	Not Stated	100%	1	0%	0	1
Haematological	74%	17	26%	6	23	Other Asian	100%	1	0%	0	1	Other Ethnicity	100%	5	0%	0	5
Head & Neck	50%	9	50%	9	18	Other European	74%	17	26%	6	23	Other Pacific Peoples			0%	0	0
Lower Gastrointestinal	60%	35	40%	23	58	Response Unidentifiable	100%	2	0%	0	2	Samoan	100%	2	0%	0	2
Lung	67%	32	33%	16	48	Southeast Asian	100%	4	0%	0	4	Grand Total	77%	273	23%	81	354
Other	38%	3	63%	5	8												
Sarcoma	67%	2	33%	1	3												
Skin	90%	52	10%	6	58												
Upper Gastrointestinal	71%	10	29%	4	14												
Urological	81%	25	19%	6	31												
Grand Total	77%	273	23%	81	354												

## **6. MĀORI HEALTH**

### **6.1 Whare Ora Health Homes**

Whare Ora is focused on reducing hospitalisations for those of our tamariki whom have respiratory problems which are the result of living in cold, damp unhealthy homes.

Home assessments for Whare Ora are underway, with products being purchased as needed.

Currently we have completed 32 homes which has brought a benefit to 151 whanau members. Of the 32 households assessed, 74% were tenants and 26% were home owners. Of the 151 people whom have benefited from the initiative, some 81 were aged 0-14 years, and 67 were aged between 15-49 years. Of those whom have benefited so far, 62% identified as Māori and 25% as Pasifika, and 13 % identified as being from other ethnic groups, the largest of which were Pakeha.

### **6.2 Hauora Direct**

The current focus of Hauora Direct is to make the assessment tool electronic and to move, as much as possible, the assessment tool to a day to day intervention by nurses working with whanau in the community and potentially in the hospital. An electronic version of the tool will be piloted in November of this year.

### **6.3 Hapū Wānanga**

Our latest Hapū Wānanga was held in Motueka at Te Awhina Marae. The newly appointed Portfolio Manager for Child & Maternal Health for Te Waka Hauora, who comes from a Charge Midwife Manager background, took the lead of the Hapū Wānanga which had eight whanau in attendance.

Ten Hapū Wānanga have been held to date (4 in Wairau, 3 in Whakatū and 3 in Motueka).

Just over 80% of Wānanga participants have identified themselves as Māori, and close to 80 whanau have been through the programme. It is likely that we will have over 100 whanau having participated in the Hapū Wānanga by the end of this year.

### **6.4 Māori Mental Health**

Work continues to progress with Māori Mental Health and AOD staff. Several hui have been held, and a plan of action has been developed which aligns to Poutama the Māori Mental Health & Addictions integrated Model of Care and its associated Action Plan. Signage has now been finalised and forwarded to management for action, training sessions in regards to tikanga, te reo and Treaty of Waitangi have been held and will continue in 2020. The last Treaty workshop held in Nelson had approximately 50 participants.

### **7.5 Pacific and Refugees Cross Sector Action Plan**

Key outcomes for health has been a significant investment of funding for interpreters via Interpreting NZ, with some funding to be used for cultural competency training for staff employed by health to gain a greater understanding of Pasifika and refugee communities. Also a Nurse and Navigator position have been funded by the DHB within the Nelson Pasifika Trust, and also a Nurse position has been funded to drive Hauora Direct in the Victory Community Centre which serves a diverse ethnic community.

## 7. CLINICAL GOVERNANCE

### 7.1 Service User Complaints

We received 21 new complaints in August compared to 69 the previous month. Sixty-six complaints remain open and active.

### 7.2 HDC Complaints

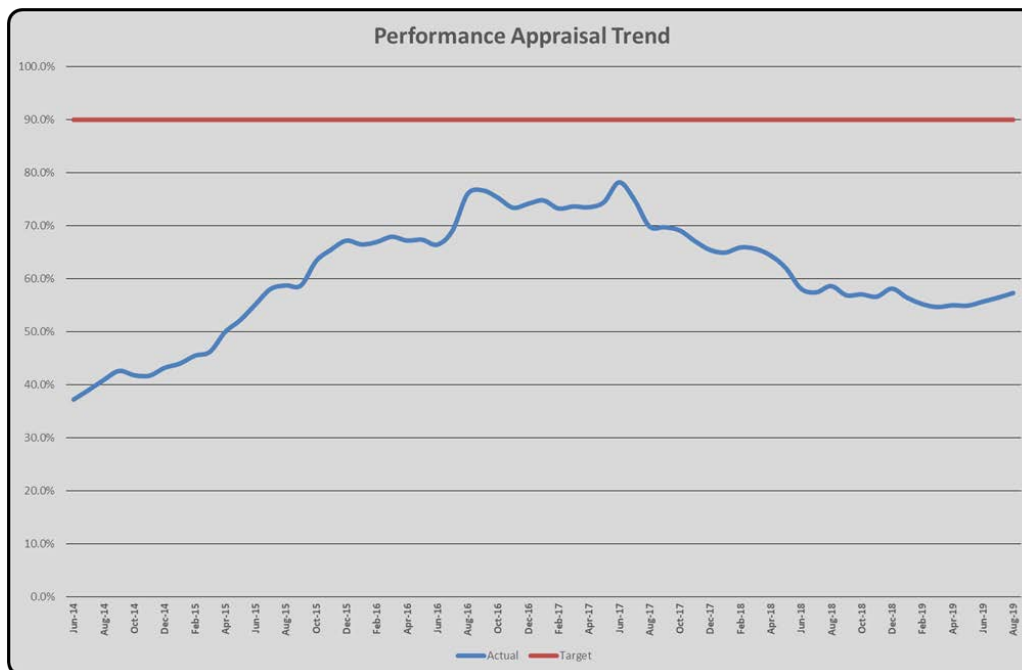
We received two new HDC complaints in August. We have a total of six HDC complaints open, with one complaint reopened and awaiting further information, and five complaints awaiting a decision from HDC. One complaint was closed.

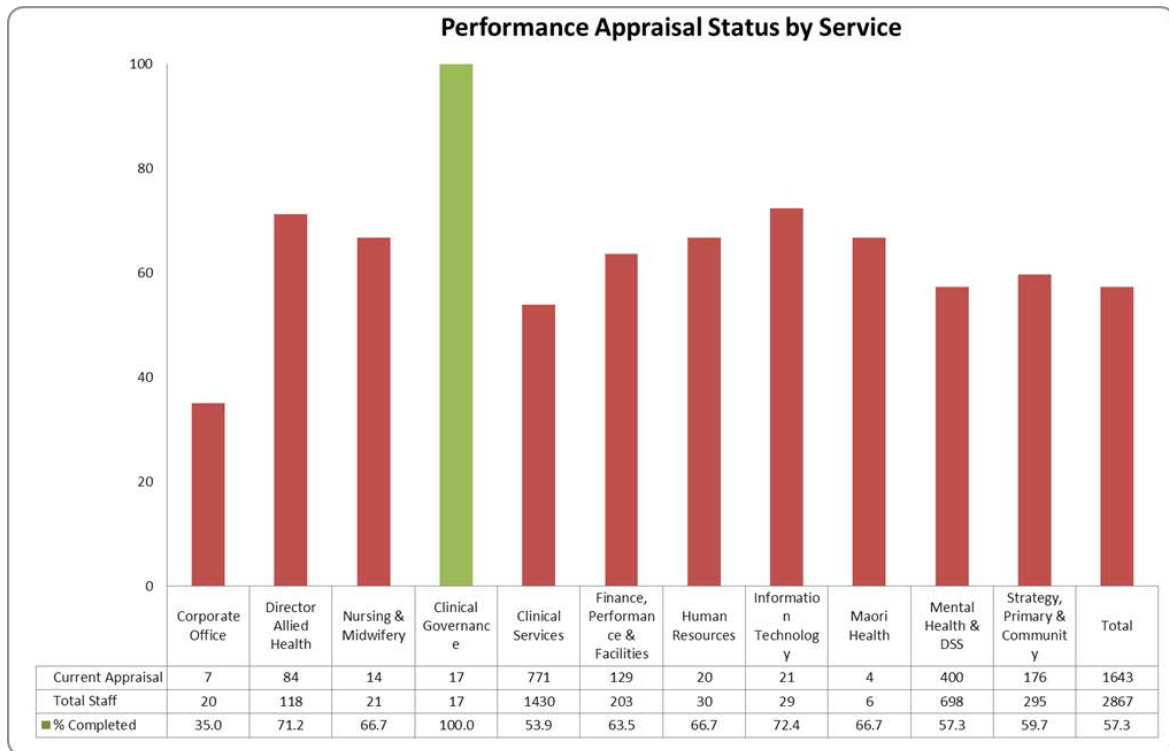
### 7.3 Official Information (OIA) Requests

During August eight OIAs were completed, with three extensions of time requested. All were completed within the legislated timeframe.

## 8. PERFORMANCE APPRAISALS

To date we are at 57.3% of staff with a current appraisal.





Peter Bramley  
**CHIEF EXECUTIVE**

**RECOMMENDATION:**

**THAT THE CHIEF EXECUTIVE’S REPORT BE RECEIVED**

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# MEMO

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**To:** Board Members  
**From:** Judith Holmes, Consumer Council Chair  
**Date:** 18 September 2019  
**Subject:** **Consumer Council Report**

## *Status*

This report contains:

- For decision
- Update
- Regular report
- For information

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The Consumer Council met in Nelson on Monday 16 September 2019.

Further discussion on considerations regarding Virtual Health was held with the Models of Care team. The Consumer Council would like to see Virtual Health consultations succeed for many reasons; economies of both clinical and consumer time and travel being paramount. Discussion revolved around criteria for in-person appointments right through to the necessity to ensure that there is what we will call ‘touchless warmth’ in virtual interactions. The Council also considers that the word ‘virtual’ may have negative connotations. Other terms, such as mixed mode / blended / multimedia may require consideration in order to interest consumers in such “technologically rich” consultations. Some work reflecting the considerable advantages in ‘virtual’ consultations (such as the hugely magnified camera visuals of certain dermatological applications) will need to be explained to “sell” the use of virtual consultations to increase enthusiasm and uptake of this increasingly relevant form of consultation.

The Council met with the Choosing Wisely Committee facilitator, who gave an overview of the progress of Choosing Wisely at Nelson Marlborough Health. This included the setting up of the Choosing Wisely Committee, and their intended approach to consult the Consumer Council on relevant and proposed initiatives.

There was also discussion on the progress on the Choosing Wisely four questions initiative:

1. Do I really need this test or procedure?
2. What are the risks?
3. Are there simpler, safer options?
4. What happens if I don't do anything?

The Council were positive about the questions, but wanted to ensure that not only were consumers encouraged to ask the questions, but that health professions were educated about being receptive to being asked the questions and giving honest answers. The Council also felt these questions were particularly relevant in a primary health setting although their relevance spans the whole patient journey.

The Chief Medical Officer from Southern DHB attended the Consumer Council meeting and explained the intricacies involved in Access to Patient Information in the South Island. He intends to speak to all Consumer/Community Councils across the South Island increasing awareness of the systems used. He was seeking initial feedback on how information is currently shared. He will be seeking further consultation both by email and in person as discussion on the issue is progressed. An overview was given of the systems of information sharing within the South Island, including the use of privacy controls and audits within patient information sharing systems currently in use. The Council is

supportive of patient information being shared across providers. The obvious advantage to treating clinicians having access to patient history, medications and treatment when patients are away from their usual providers are clear. It is surprising that information is not routinely shared between North and South Island providers. Discussion centred around the need for information sharing being patient centred rather than provider centred.

Judith Holmes  
**Consumer Council Chair**

**RECOMMENDATION:**

**THAT THE BOARD RECEIVES THE CONSUMER COUNCIL REPORT.**

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# MEMO

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**To:** Board Members  
**From:** Eric Sinclair  
GM Finance, Performance & Facilities  
**Date:** 18 September 2019  
**Subject:** **Financial Report for August 2019**

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## *Status*

**This report contains:**

- ✓ For decision
- Update
- ✓ Regular report
- For information

The result for the first two months of the 2019/20 year shows a deficit of \$1.2M which is \$0.7M adverse to the current planned deficit. The 2019/20 financial budget is still to be agreed with the MOH, however any changes to the current position, as shown on the following page, would not affect the budget for the two months – any budget changes would be rephrased across whatever months remain once the budgets are agreed.

The balance sheet and cash flow statements have been included with budgets aligned to the current \$6.0M deficit position, however these are subject to change depending on the final position agreed with the MOH. This does not affect the actuals presented for the month in both these statements.

The adverse result for the first month is driven mainly from higher activity within the hospital. The major drivers for the variances within the monthly result are:

- Orthopaedic and cardiology volumes have been higher than expected for the two month driving clinical supplies costs higher. At this point we expect this is largely a timing issue as both services are expected to deliver to planned volume levels. Some of the cardiology volumes will attract inter district flow revenue as some support is being provided to central region DHBs. Further work is underway to determine whether this support will continue. Adverse variances in patient meals and laundry corroborate the higher hospital activity.
- Intragam volumes are also higher than planned given the current cohort of patients. As we have seen intragam volumes can fluctuate significantly from month to month and we will continue to monitor the volumes over the next few months.
- Medical locum costs have tracked higher than the favourable variance from employed medical staff. It remains a challenge to recruit medical staff and we expect this will remain a fiscal challenge throughout the year.
- Non-clinical supply costs are tracking higher than planned which reflects the adverse variances in patient meals and laundry. A number of facilities compliance costs have been incurred where the budget has been phased across the year resulting in some timing variances that will correct over the year.
- Provider payments are adverse but are largely offset by additional revenue received including in between travel and payments to the PHOs.
- The Model of Care business case programme costs have been accrued to budget level except for the Health Care Home initiative where the first tranche of costs have been incurred. This creates a timing issue that will correct as the year progresses.

Eric Sinclair  
**GM Finance and Performance**

## **RECOMMENDATION:**

**THAT THE BOARD RECEIVES THE FINANCIAL REPORT.**

Operating Statement for the period ending August 2019

Month \$000s				YTD \$000s				Full Year \$000s	
Actual	Budget	Variance	Last Yr	Actual	Budget	Variance	Last Yr	Budget	Last Yr
40,114	39,979	135	42,634						
1,894	1,890	4	1,943						
423	485	-62	554						
821	812	9	881						
1,306	926	380	1,139						
<b>44,558</b>	<b>44,092</b>	<b>466</b>	<b>47,151</b>						
16,054	16,616	562	18,035						
747	153	-594	461						
16,801	16,769	-32	18,496						
1,557	1,461	-96	1,490						
2,370	2,078	-292	2,605						
3,971	3,971	0	4,192						
321	295	-26	292						
2,633	2,204	-429	3,099						
11,122	11,166	44	10,602						
3,948	3,949	1	3,894						
<b>42,723</b>	<b>41,893</b>	<b>-830</b>	<b>44,670</b>						
<b>1,835</b>	<b>2,199</b>	<b>-364</b>	<b>2,481</b>						
27	27	0	28						
1,112	1,271	159	1,126						
821	872	51	910						
<b>1,960</b>	<b>2,170</b>	<b>210</b>	<b>2,064</b>						
<b>-125</b>	<b>29</b>	<b>-154</b>	<b>417</b>						
<b>-233</b>	<b>-125</b>	<b>-108</b>	<b>0</b>						
0	0	0	0						
0	0	0	0						
0	0	0	0						
0	0	0	0						
<b>-358</b>	<b>-96</b>	<b>-262</b>	<b>417</b>						
<b>Revenue</b>				<b>YTD \$000s</b>				<b>Full Year \$000s</b>	
				Actual	Budget	Variance	Last Yr	Budget	Last Yr
MOH devolved funding				79,674	79,559	115	78,899	498,953	469,551
MOH non-devolved funding				3,920	3,883	37	3,995	24,029	26,512
ACC revenue				1,079	1,008	71	909	6,213	5,909
Other government & DHBs				1,653	1,623	30	1,739	9,807	10,354
Other income				2,254	1,879	375	2,144	12,181	13,621
<b>Total Revenue</b>				<b>88,580</b>	<b>87,952</b>	<b>628</b>	<b>87,686</b>	<b>551,183</b>	<b>525,947</b>
<b>Expenses</b>				<b>YTD \$000s</b>				<b>Full Year \$000s</b>	
				Actual	Budget	Variance	Last Yr	Budget	Last Yr
Employed workforce				32,271	33,194	923	32,380	220,723	197,407
Outsourced workforce				1,342	308	-1,034	830	2,004	6,264
<b>Total Workforce</b>				<b>33,613</b>	<b>33,502</b>	<b>-111</b>	<b>33,210</b>	<b>222,727</b>	<b>203,671</b>
Outsourced services				3,141	2,921	-220	2,876	18,004	18,047
Clinical supplies				4,848	4,173	-675	4,575	26,421	28,454
Pharmaceuticals				7,816	7,816	0	7,918	48,207	52,267
Air Ambulance				613	591	-22	575	3,839	4,134
Non-clinical supplies				5,194	4,704	-490	5,670	29,029	29,596
External provider payments				22,431	22,234	-197	21,177	134,233	127,293
Inter District Flows				7,897	7,898	1	7,809	47,390	46,977
<b>Total Expenses before IDCC</b>				<b>85,553</b>	<b>83,839</b>	<b>-1,714</b>	<b>83,810</b>	<b>529,850</b>	<b>510,439</b>
<b>Surplus/(Deficit) before IDCC</b>				<b>3,027</b>	<b>4,113</b>	<b>-1,086</b>	<b>3,876</b>	<b>21,333</b>	<b>15,508</b>
Interest expenses				54	54	0	56	352	332
Depreciation				2,220	2,541	321	2,218	15,056	13,041
Capital charge				1,642	1,743	101	1,638	10,460	11,072
<b>Total IDCC</b>				<b>3,916</b>	<b>4,338</b>	<b>422</b>	<b>3,912</b>	<b>25,868</b>	<b>24,445</b>
<b>Operating Surplus/(Deficit)</b>				<b>-889</b>	<b>-225</b>	<b>-664</b>	<b>-36</b>	<b>-4,535</b>	<b>-8,937</b>
MOC Business Case costs				-358	-250	-108	0	-1,502	0
MECA related costs				0	0	0	0	0	-3,111
Holidays Act compliance				0	0	0	0	0	-7,155
Other one-off cost implications				0	0	0	0	0	-1,060
Impairment of NOS asset				0	0	0	0	0	-302
<b>Net Surplus/(Deficit)</b>				<b>-1,247</b>	<b>-475</b>	<b>-772</b>	<b>-36</b>	<b>-6,037</b>	<b>-20,565</b>



**CONSOLIDATED STATEMENT OF FINANCIAL POSITION**  
**AS AT 31 AUGUST 2019**

	<b>Budget</b>	<b>Actual</b>	<b>Actual</b>
	<b>Aug-19</b>	<b>Aug-19</b>	<b>Jun-19</b>
	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
<b>Assets</b>			
<b>Current assets</b>			
Cash and cash equivalents	7,649	9,966	6,315
Other cash deposits	21,284	21,284	21,284
Receivables	19,222	19,032	19,222
Inventories	2,742	2,811	2,742
Prepayments	1,188	1,724	1,188
Non-current assets held for sale	465	465	465
<b>Total current assets</b>	<b>52,550</b>	<b>55,281</b>	<b>51,215</b>
<b>Non-current assets</b>			
Prepayments	36	29	36
Other financial assets	1,715	1,655	1,715
Property, plant and equipment	196,103	199,148	197,681
Intangible assets	11,345	11,288	11,509
<b>Total non-current assets</b>	<b>209,199</b>	<b>212,120</b>	<b>210,941</b>
<b>Total assets</b>	<b>261,749</b>	<b>267,401</b>	<b>262,156</b>
<b>Liabilities</b>			
<b>Current liabilities</b>			
Payables	33,340	37,546	31,127
Borrowings	501	501	501
Employee entitlements	44,441	46,764	46,585
<b>Total current liabilities</b>	<b>78,282</b>	<b>84,810</b>	<b>78,213</b>
<b>Non-current liabilities</b>			
Borrowings	7,664	7,578	7,664
Employee entitlements	9,870	9,870	9,870
<b>Total non-current liabilities</b>	<b>17,534</b>	<b>17,448</b>	<b>17,534</b>
<b>Total Liabilities</b>	<b>95,816</b>	<b>102,258</b>	<b>95,747</b>
<b>Net assets</b>	<b>165,933</b>	<b>165,143</b>	<b>166,409</b>
<b>Equity</b>			
Crown equity	81,920	81,920	81,920
Other reserves	86,476	86,456	86,476
Accumulated comprehensive revenue and expense	(2,463)	(3,233)	(1,987)
<b>Total equity</b>	<b>165,933</b>	<b>165,143</b>	<b>166,409</b>

**CONSOLIDATED STATEMENT OF CASH FLOWS**  
**FOR THE PERIOD ENDED 31 AUGUST 2019**

	Budget Aug-19 \$000	Actual Aug-19 \$000	Budget 2019/20 \$000
<b>Cash flows from operating activities</b>			
Receipts from the Ministry of Health and patients	87,951	91,465	551,177
Interest received	262	210	1,700
Payments to employees	(33,194)	(32,094)	(217,396)
Payments to suppliers	(52,831)	(52,308)	(316,429)
Capital charge	-	-	(10,460)
Interest paid	-	-	-
GST (net)	-	-	-
<b>Net cash flow from operating activities</b>	<b>2,188</b>	<b>7,273</b>	<b>8,592</b>
<b>Cash flows from investing activities</b>			
Receipts from sale of property, plant and equipment	-	4	-
Receipts from maturity of investments	-	-	-
Purchase of property, plant and equipment	(650)	(3,508)	(6,500)
Purchase of intangible assets	(150)	22	(1,000)
Acquisition of investments	-	-	-
<b>Net cash flow from investing activities</b>	<b>(800)</b>	<b>(3,482)</b>	<b>(7,500)</b>
<b>Cash flows from financing activities</b>			
Repayment of capital	-	-	(547)
Repayment of borrowings	(54)	(140)	(352)
<b>Net cash flow from financing activities</b>	<b>(54)</b>	<b>(140)</b>	<b>(899)</b>
<b>Net increase/(decrease) in cash and cash equivalents</b>	<b>1,334</b>	<b>3,651</b>	<b>193</b>
Cash and cash equivalents at the beginning of the year	6,315	6,315	6,315
<b>Cash and cash equivalents at the end of the year</b>	<b>7,649</b>	<b>9,966</b>	<b>6,508</b>

Consolidated 12 Month Rolling Statement of Cash Flows \$000s	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020
	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
<b>Operating Cash Flow</b>												
<b>Receipts</b>												
Government & Crown Agency Received	42,957	47,046	44,549	47,209	45,104	43,524	43,363	47,740	43,749	47,686	42,475	42,475
Interest Received	131	163	131	163	131	131	131	163	131	163	143	143
Other Revenue Received	927	1,134	917	1,132	997	1,006	1,000	1,152	918	1,116	948	948
<b>Total Receipts</b>	<b>44,015</b>	<b>48,343</b>	<b>45,597</b>	<b>48,504</b>	<b>46,232</b>	<b>44,661</b>	<b>44,494</b>	<b>49,055</b>	<b>44,798</b>	<b>48,965</b>	<b>43,566</b>	<b>43,566</b>
<b>Payments</b>												
Personnel	16,559	20,798	16,675	20,662	18,737	17,515	16,583	21,103	17,486	18,083	17,534	17,534
Payments to Suppliers and Providers	26,261	28,403	27,265	22,942	26,137	25,907	25,857	27,860	26,433	26,535	24,350	24,350
Capital Charge	-	-	-	5,230	-	-	-	-	-	5,230	-	-
Interest Paid	-	-	-	-	-	-	-	-	-	-	-	-
Payments to Other DHBs and Providers	-	-	-	-	-	-	-	-	-	-	-	-
<b>Total Payments</b>	<b>42,820</b>	<b>49,201</b>	<b>43,940</b>	<b>48,834</b>	<b>44,874</b>	<b>43,422</b>	<b>42,440</b>	<b>48,963</b>	<b>43,919</b>	<b>49,848</b>	<b>41,884</b>	<b>41,884</b>
<b>Net Cash Inflow/(Outflow) from Operating Activities</b>	<b>1,195</b>	<b>(858)</b>	<b>1,657</b>	<b>(330)</b>	<b>1,358</b>	<b>1,239</b>	<b>2,054</b>	<b>92</b>	<b>879</b>	<b>(883)</b>	<b>1,682</b>	<b>1,682</b>
<b>Cash Flow from Investing Activities</b>												
<b>Receipts</b>												
Sale of Fixed Assets	-	-	-	-	-	-	-	-	-	-	-	-
<b>Total Receipts</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>Payments</b>												
Capital Expenditure	250	500	250	450	1,100	750	900	500	1,050	950	625	625
Increase in Investments	-	-	-	-	-	-	-	-	-	-	-	-
<b>Total Payments</b>	<b>250</b>	<b>500</b>	<b>250</b>	<b>450</b>	<b>1,100</b>	<b>750</b>	<b>900</b>	<b>500</b>	<b>1,050</b>	<b>950</b>	<b>625</b>	<b>625</b>
<b>Net Cash Inflow/(Outflow) from Investing Activities</b>	<b>(250)</b>	<b>(500)</b>	<b>(250)</b>	<b>(450)</b>	<b>(1,100)</b>	<b>(750)</b>	<b>(900)</b>	<b>(500)</b>	<b>(1,050)</b>	<b>(950)</b>	<b>(625)</b>	<b>(625)</b>
<b>Net Cash Inflow/(Outflow) from Financing Activities</b>	<b>(27)</b>	<b>(34)</b>	<b>(27)</b>	<b>(34)</b>	<b>(27)</b>	<b>(27)</b>	<b>(27)</b>	<b>(34)</b>	<b>(27)</b>	<b>(581)</b>	<b>(115)</b>	<b>(115)</b>
Net Increase/(Decrease) in Cash Held	918	(1,392)	1,380	(814)	231	462	1,127	(442)	(198)	(2,414)	942	942
Plus Opening Balance	9,966	10,884	9,492	10,872	10,058	10,289	10,751	11,878	11,436	11,238	8,824	9,766
<b>Closing Balance</b>	<b>10,884</b>	<b>9,492</b>	<b>10,872</b>	<b>10,058</b>	<b>10,289</b>	<b>10,751</b>	<b>11,878</b>	<b>11,436</b>	<b>11,238</b>	<b>8,824</b>	<b>9,766</b>	<b>10,709</b>

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# MEMO

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**To:** Board Members  
**From:** Elizabeth Wood, Chair of Clinical Governance Committee  
**Date:** 18 September 2019  
**Subject:** Clinical Governance Report

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## Status

This report contains:

- For decision
- Update
- Regular report
- For information

Key messages from the NMH Clinical Governance Committee (CGC) meeting held on 6 September 2019 are as follows:

### DHB CGC endorsed:

- **Use of email to communicate patient information external to the DHB with patient consent** – The issue of implicit or explicit consent between clinicians is yet to be fully clarified. As part of the Models of Care Programme, the safe use of email to assist rapid communication between clinicians on behalf of patients has been identified as a critical enabler to nearly all the initiatives. In June 2019 the Ministry of Health, in conjunction with ACC, issued a set of updated guidelines to assist health agencies to address the security of email and fax communications (noted here <https://www.health.govt.nz/system/files/documents/publications/joint-acc-moh-advice-on-securing-email-and-fax-jun2019.pdf>)

The Information and Communications Technology (NMDHB ICT) group have recommended the following criteria, some of which are in addition to those mentioned in the MoH guideline, be adopted to ensure safe and appropriate use of email in this context.

- Use of a Domain (e.g. Greenwoodhealth.co.nz) that uses the TLS (Transport Layer Security) as outlined by the MOH guidelines. This would exclude Gmail and the like.
- Gaining explicit and documented patient consent (see \*\*\* below)
- Keeping to one to one AND carefully checking the recipient (no copying the email to multiple others)
- Copying the responses / conversation to the patient record
- Only using the NHI as identifier.

\*\*\* The issue of explicit patient consent was thought to need more consideration since other forms of communication such as telephone, letter and conversations face to face do not currently require the patients to provide explicit consent for their use. This question will be further considered and in the meantime the above criteria should be adopted.

### DHB CGG noted:

- **The recent publication from HQSC- He Matapihi Ki Te Kounga O Ngā Manaakitanga Ā-Hauora O Aotearoa 2019 (A Window on the Quality of Aotearoa New Zealand's Health Care 2019 – a view on Māori health equity)**  
<https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3721/>

This excellent document makes for sobering reading. The forward written by Professor Sir Mason Durie starts with this summary:

*He mana taurite  
Hei oranga tangata*

*Good health for everyone demands a society that is fair and just, committed to equal*

*opportunities as well as equal outcomes, and ready to shift the focus if that is needed. A window on the Quality of Aotearoa New Zealand's Health Care 2019 – a view on Māori health equity makes it clear that shifting the focus is sorely needed.*

Elizabeth Wood  
**Chair Clinical Governance Committee**

**RECOMMENDATION:**

**THAT THE BOARD RECEIVE THE CLINICAL GOVERNANCE REPORT.**

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# MEMO

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**To:** Board Members  
**From:** Peter Bramley, Chief Executive Officer  
**Date:** 18 September 2019  
**Subject:** **FOR INFORMATION**

## *Status*

This report contains:

- For decision
- Update
- Regular report
- For information

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In response to a query regarding nitrate levels in our water supply, the Public Health Service responds as follows:

Thank you for your submission and supporting material on nitrate in drinking water that you presented to the two Nelson Marlborough District Health Board meetings recently. This information was forwarded to the Public Health Service (PHS) by the Board Secretary. The PHS notes the points you make and advises that it is the role of the Public Health Service to assess drinking water supplier's compliance with the current drinking water standards (Drinking Water Standards for New Zealand 2005 (Revised 2018)). A Drinking Water Assessor in the Public Health Service has advised that the Richmond supply currently complies with the chemical criteria for nitrates. The PHS is also aware that Tasman District Council conducts monitoring of private bore water supplies and provides information to the consumers of those supplies that contain Nitrate in excess of the current Maximum Acceptable Value.

Following your query, one of our two Medical Officers of Health, Dr Stephen Bridgman, has been in touch with Ministry of Health colleagues about the paper you kindly shared with the Board and its possible implications for New Zealand. Ministry colleagues have advised Dr Bridgman "New Zealand's drinking-water standards follow international best practice and advice from the World Health Organisation. Ministry of Health officials also monitor any changes [in] standards adopted by countries including Australia, Canada, the United States and Europe. Health officials have asked the Drinking-water Advisory Committee to review the Drinking-water Standards for New Zealand. A specialist Water Chemistry Working Group has [reviewed] the chemical MAVs but has not recommended any change to the maximum acceptable level of nitrate. Health officials do not consider it appropriate to change the standards on the basis of this one (cancer registry) study and in the absence of advice and recommendations from the World Health Organisation. The maximum acceptable value for nitrate in Danish water supplies is the same level as in New Zealand, and as the World Health Organisation recommends".

**GLOSSARY OF COMMONLY USED ACRONYMS, ABBREVIATIONS AND MAORI TRANSLATION**

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ABC	Ask about their smoking status; brief advice to quit; cessation
A4HC	Action for Healthy Children
A&D / AOD	Alcohol and Drug / Alcohol and Other Drugs
A&R	Audit & Risk Committee
ACC	Accident Compensation Corporation
ACMO	Associate Chief Medical Officer
ACNM -	Associate Charge Nurse Manager
ACU	Ambulatory Care Unit
ACP	Advanced Care Plan
ADR	Adverse Drug Reactions
ADM	Acute Demand Management
ADON	Associate Director of Nursing
AE	Alternative Education
AEP	Accredited Employer Programme
AIR	Agreed Information Repository
ALOS	Average Length of Stay
ALT	Alliance Leadership Team (short version of (TOSHALT))
AMP	Asset Management Plan
AOD	Alcohol and Other Drug
AOHS	Adolescent Oral Health Services
AP	Annual Plan with Statement of Intent
ARC	Aged Residential Care
ARF	Audit Risk and Finance
ARCC	Aged Residential Care Contract
ARRC	Aged Related Residential Care
ASD	Autism Spectrum Disorder
ASH	Ambulatory Sensitive Hospitalisation
ASMS	Association of Salaried Medical Specialists
AT&R	Assessment, Treatment & Rehabilitation
BSCQ	Balanced Score Card Quadrant
BA	Business Analyst
BAFO	Best and Final Offer
BAU	Business as Usual
BCP	Business Continuity Plan
BCTI	Buyer Created Tax Invoice
BFCI	Breast Feeding Community Initiative
BFCI	Baby Friendly Community Initiative
BHE	Blenheim
BOT	Board of Trustees
BS	Business Support
BSI	Blood Stream Infection
BSMC	Better, Sooner, More Convenient
CaaG	Capacity at a Glance
CAMHS	Child and Adolescent Mental Health Services
CAPEX	Capital operating costs
CAR	Corrective Action Required
CARES	Coordinated Access Response Electronic Service
CAT	Mental Health Community Assessment Team
CBAC	Community Based Assessment Centres
CBF	Capitation Based Funding
CBSD	Community Based Service Directorate
CE (CEO)	Chief Executive (Chief Executive Officer)

CEA	Collective Employee Agreement
CDHB	Canterbury District Health Board
CCDHB	Capital & Coast District Health Board (also called C & C)
CCDM	Care Capacity Demand Management
CCDP	Care Capacity Demand Planning
CCF	Chronic Conditions Framework
CCT	Continuing Care Team
CCU	Coronary Care Unit
CD	Clinical Director
CDEM	Civil Defence Emergency Management
CDHB	Canterbury District Health Board
CDM	Chronic Disease Management
CEG	Coordinating Executive Group (for emergency management)
CeTas	Central Technical Advisory Support
CFA	Crown Funding Agreement <u>or</u> Crown Funding Agency
CFO	Chief Financial Officer
CGC	Clinical Governance Committee
CHFA	Crown Health Financing Agency
CHS	Community Health Services
CIMS	Coordinated Incident Management System
CIO	Chief Information Officer
CLAB	Central Line Associated Bacteraemia
CLABSI	Central Line Associated Bloodstream Infection
CLAG	Clinical Laboratory Advisory Group
CME	Continuing Medical Education
CMI	Chronic Medical Illness
CMO	Chief Medical Officer
CMS	Contract Management System
CNM	Charge Nurse Manager
CNS	Charge Nurse Specialist
COAG	Clinical Operations Advisory Group
Concerto	IT system which provides clinician's interface to systems
COHS	Community Oral Health Service
COO	Chief Operating Officer
COPD	Chronic Obstructive Pulmonary Disease
COPMI	Children of Parents with Mental Illness
CPHAC	Community and Public Health Advisory Committee
CPIP	Community Pharmacy Intervention Project
CPNE	Continuing Practice Nurse Education
CP	Chief Pharmacist
CPO	Controlled Purchase Operations
CPSOG	Community Pharmacy Services Operational Group
CPU	Critical Purchase Units
CR	Computed Radiology
CRG	Christchurch Radiology Group
CRISP	Central Region Information Systems Plan
CSR	Contract Status Report
CSSD	Central Sterile Supply Department
CSSD	Clinical Services Support Directorate
CT	Computerised Tomography
CTA	Clinical Training Agency
CTC	Contributions to Cost
CTC	Computerised Tomography Colonography
CTANAG	Clinical Training Agency Nursing Advisory Group
CTU	Combined Trade Unions
CVD	Cardiovascular Disease
CVDRA	Cardiovascular/Diabetes Risk Assessment
CWD	Case Weighted Discharge

CYF	Child, Youth and Family
CYFS	Child, Youth and Family Service
DA	Dental Assistant
DAH	Director of Allied Health
DAP	District Annual Plan
DAR	Diabetes Annual Review
DBI	Diagnostic Breast Imaging
DBT	Dialectical Behaviour Therapy
DHB	District Health Board
DHBRF	District Health Boards Research Fund
DIFS	District Immunisation Facilitation Services
DiSAC	Disability Support Advisory Committee
DGH	Director General of Health
DMH	Director of Maori Health
DNA	Did Not Attend
DONM	Director of Nursing and Midwifery
DR	Disaster Recovery
DR	Digital Radiology
DRG	Diagnostic Related Group
DSA	Detailed Seismic Assessment
DSP	District Strategic Plan
DSS	Disability Support Services
DT	Dental Therapist
DWCSP	District Wide Clinical Services Plan
EAP	Employee Assistance Programme
EBID	Earnings Before Interest & Depreciation
EBITDA	Earnings Before Interest, Tax Depreciation and Amortisation
ECP	Emergency Contraceptive Pill
ECWD	Equivalent Case Weighted Discharge
ED	Emergency Department
EDA	Economic Development Agency
EDaaG	ED at a Glance
EFI	Energy For Industry
ELT	Executive Leadership Team
EMPG	Emergency Management Planning Group
ENS	Ear Nurse Specialist
ENT	Ears, Nose and Throat
EOI	Expression of Interest
EPA	Enduring Power of Attorney
EQP	Earthquake Prone Building Policy
ERMS	ereferral Management System
ESA	Electronic Special Authority
ESOL	English Speakers of Other Languages
ESPI	Elective Services Patient Flow Indicators
ESR	Environmental Science & Research
ESU	Enrolled Service Unit
EVIDEM	Evidence and Value: Impact on Decision Making
FCT	Faster Cancer Treatment
FF&E	Furniture, Fixtures and Equipment
FFP	Flexible Funding Pool
FFT	Future Funding Track
FMIS	Financial Management Information System
FOMHT	Friends of Motueka Hospital Trust
FOUND	Found Directory is an up-to-date listing of community groups and organisations in Nelson/Tasman



FPSC	Finance Procurement and Supply Chain
FRC	Fee Review Committee
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
FVIP	Family Violence Intervention Programme
GM	General Manager
GMS	General Medical Subsidy
GP	General Practitioner
GRx	Green Prescription
hA	healthAlliance
HAC	Hospital Advisory Committee
H&DC / HDC	Health and Disability Commissioner
H&S	Health & Safety
HBI	Hospital Benchmarking Information
HBSS	Home Based Support Services
HBT	Home Based Treatment
HCS	Health Connect South
HCSS	Home and Community Support Services
HDSP	Health & Disability Services Plan Programme
HDU	High Dependency Unit
HEA	Health Education Assessments
HEAL	Healthy Eating Active Lifestyles
He Kawenata	Covenant, agreement, treaty, testament (PM Ryan Maori Dictionary pg 104)
HEeADSSS	Psychosocial tool – Home, Education, eating, Activities, Drugs and Alcohol, Sexuality, Suicidality (mood), Safety
HEHA	Healthy Eating Healthy Action
HEP	Hospital Emergency Plan
HESDJ	Ministries of Health, Education, Social Development, Justice
HFA	Health Funding Authority
HHS	Hospital and Health Services
HIA	Health Impact Assessment
HM	Household Management
HMS	Health Management System
HNA	Health Needs Assessment
HOD	Head of Department
HOP	Health of Older People
HP	Health Promotion
HPI	Health Practitioner Index
HPV	Human Papilloma Virus
HR	Human Resources
HR & OD	Human Resources and Organisational Development
HSP	Health Services Plan
HQSC	Health Quality & Safety Commission
laaS	Infrastructure as a Service
IANZ	International Accreditation New Zealand
IBA	Information Builders of Australia
IBC	Indicative Business Case
ICU	Intensive Care Unit
IDF	Inter District Flow
IDSS	Intellectual Disability Support Services
IFRS	International Financial Reporting Standards
IHB	Iwi Health Board
ILM	Investment Logic Mapping
IM	Information Management

IMCU	Immediate Care Unit
InterRAI	Inter Residential Assessment Instrument
IoD	Institute of Directors New Zealand
IPAC	Independent Practitioner Association Council
IPC	Intensive Patient Care
IPC Units	Intensive Psychiatric Care Units
IPG	Immunisation Partnership Group
IPS	Individual Placement Support
IPSAS	International Public Sector Accounting Standards
IPU	In-Patient Unit
IS	Information Systems
ISBAR	Introduction, Situation, Background, Assessment, Recommendation
ISSP	Information Services Strategic Plan
IT	Information Technology
JAMHWSAP	Joint Action Maori Health & Wellness Strategic Action Plan
JOG	Joint Oversight Group
KIM	Knowledge and Information Management
Kotahitanga	Unity, accord, coalition, solidarity (PM Ryan Maori Dictionary pg 127)
KPI	Key Performance Indicator
KHW	Kimi Hauora Wairau (Marlborough PHO)
LA	Local Authority
LCN	Local Cancer Network
LIS	Laboratory Information Systems
LMC	Lead Maternity Carer
LOS	Length of Stay
LSCS	Lower Segment Caesarean Section
LTC	Long Term Care
LTI	Lost Time Injury
LTIP	Long Term Investment Plan
LTCCP	Long Term Council Community Plan
LTO	Licence to Occupy
LTS-CHC	Long Term Supports – Chronic Health Condition
LTSFSG	Long Term Service Framework Steering Group
Manaakitanga	Goodwill, show respect, or kindness to ((PM Ryan Maori Dictionary pg 172)
Manawhenua	Power, prestige, authority over land (HW Williams Maori Dictionary pg 172)
Manawhenua O Te	Tau Ihu O Te Waka A Maui – Referring to the eight iwi who hold tribal authority over the top of the South Island (no reference)
MA	Medical Advisor
MAC(H)	Medicines Advisory Group (Hospital)
MAPA	Management of Actual and Potential Aggression
MAPU	Medical Admission & Planning Unit
MCT	Mobile Community Team
MDC	Marlborough District Council
MDM	Multidisciplinary Meetings
MDM	Multiple Device Management
MDO	Maori Development Organisation
MDS	Maori Development Service
MDT	Multi Disciplinary Team
MECA	Multi Employer Collective Agreement
MEND	Mind, Exercise, Nutrition, Do It
MH&A	Mental Health & Addiction Service
MHAU	Mental Health Admission Unit
MHC	Mental Health Commissioner
MHD	Maori Health Directorate

MHDSF	Maori Health and Disability Strategy Framework
MHFS	Maori Health Foundation Strategy
MHINC	Mental Health Information Network Collection
MHSD	Mental Health Service Directorate
MHWSF	Maori Health and Wellness Strategic Framework
MI	Minor Injury
MIC	Medical Injury Centre
MMG	Medicines Management Group
MOC	Models of Care
MOE	Ministry of Education
MOH	Ministry of Health
MOH	Medical Officer of Health
MOA	Memorandum of Agreement
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding
MOW	Meals on Wheels
MPDS	Maori Provider Development Scheme
MQ&S	Maternity Quality & Safety Programme
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MRT	Medical Radiation Technologist (or Technician)
MSD	Ministry of Social Development
MTI	Minor Treatment Injury
NMH	Nelson Marlborough Health (NMDHB)
NP	Nurse Practitioner
NPA	Nutrition and Physical Activity
NRAHDD	Nelson Region After Hours & Duty Doctor Limited
NRL	Nelson Radiology Ltd (Private Provider)
NRT	Nicotine Replacement Therapy
NHBIT	National Health Board IT
NASC	Needs Assessment Service Coordination
NBPH	Nelson Bays Primary Health
NCC	National Capital Committee
NCC	Nelson City Council
NCSP	National Cervical Screening Programme
NESP	Nurse Entry to Specialist Practice
NETP	Nurse Entry to Practice
NGO	Non Government Organisation
NHCC	National Health Coordination Centre
NHI	National Health Index
NIR	National Immunisation Register
NM	Nelson Marlborough
NMDHB	Nelson Marlborough District Health Board
NMDS	National Minimum Dataset
NMH	Nelson Marlborough Health
NMIT	Nelson Marlborough Institute of Technology
NN	Nelson
NOF	Neck of Femur
NOS	National Oracle Solution
NP	Nurse Practitioner
NPA	Nutrition and Physical Activity (Programme)
NPV	Net Present Value
NRAHDD	Nelson Regional After Hours and Duty Doctor Ltd
NRSII	National Radiology Service Improvement Initiative
NSU	National Screening Unit
NTOS	National Terms of Settlement
NZHIS	NZ Health Information Services

NZISM	New Zealand Information Security Manual
NZMA	New Zealand Medical Association
NZNO	NZ Nurses Organisation
NZPH&D Act	NZ Public Health and Disability Act 2000
OAG	Office of the Auditor General
OECD	Organisation for Economic Co-operation and Development
OIA	Official Information Act
OIS	Outreach Immunisation Services
OPD	Outpatient Department
OPEX	Operating costs
OPF	Operational Policy Framework
OPJ	Optimising the Patient Journey
OPMH	Older Persons Mental Health
OST	Opioid Substitution Treatment
ORL	Otorhinolaryngology (previously Ear, Nose and Throat)
OSH	Occupational Health and Safety
OT	Occupational Therapy
PACS	Picture Archiving Computer System
PAS	Patient Administration System
P&F	Planning and Funding
P&L	Profit and Loss Statements
PANT	Physical Activity and Nutrition Team
PBF(F)	Population Based Funding (Formula)
PC	Personal Cares
P&C	Primary & Community
PCBU	Person Conducting Business Undertaking
PCI	Percutaneous Coronary Intervention
PCO	Primary Care Organisation
PCT	Pharmaceutical Cancer Treatments
PDO	Principal Dental Officer
PDR	Performance Development Review
PDRP	Professional Development and Recognition Programme
PDSA	Plan, Do, Study, Act
PFG	Performance Framework Group (formerly known as Services Framework Group)
PHS	Public Health Service
PHCS	Primary Health Care Strategy
PHI	Public Health Intelligence
PHO	Primary Health Organisation
PHOA	PHO Alliance
PHONZ	PHO New Zealand
PHS	Public Health Service
PHU	Public Health Unit
PIA	Performance Improvement Actions
PICS	Patient Information Care System
PIP	Performance Improvement Plan
PN	Practice Nurse
POCT	Point of Care Testing
PPE	Property, Plant & Equipment assets
PPP	PHO Performance Programme
PRIME	Primary Response in Medical Emergency
PSAAP	PHO Service Agreement Amendment Protocol
PSR	Preschool Enrolled (Oral health)
PT	Patient
PTAC	Pharmacology and Therapeutics Committee
PTCH	Potential To Cause Harm

PRG	Pacific Radiology Group
PRIMHD	Project for the Integration of Mental Health Data
PVS	Price Volume Schedule
Q&SGC	Quality & Safety Governance Committee
QA	Quality Assurance
QHNZ	Quality Health NZ
QIC	Quality Improvement Council
QIPPS	Quality Improvement Programme Planning System
QSM	Quality Safety Measures
RA	Radiology Assistant
Rangatiratanga	Autonomy, evidence of greatness (HW Williams Maori Dictionary pg 323)
RCGPs	Royal College of General Practitioners
RDA	Resident Doctors Association
RDA	Riding for Disabled
RIF	Rural Innovation Fund
RIS	Radiology Information System
RFI	Request for Information
RFP	Request for Proposal
RICF	Reducing Inequalities Contingency Funding
RIS	Radiology Information System
RM	Registered Midwife
RMO	Resident Medical Officer
RN	Registered Nurse
ROI	Registration of Interest
RSE	Recognised Seasonal Employer
RSL	Research and Sabbatical Leave
RTLB	Resource Teacher: Learning & Behaviour
SAC1	Severity Assessment Code
SAC2	Severity Assessment Code
SAN	Storage Area Network
SCBU	Special Care Baby Unit
SCL	Southern Community Laboratories
SCN	Southern Cancer Network
SDB	Special Dental Benefit Services
SHSOP	Specialist Health Services for Older People
SI	South Island
SIA	Services to Improve Access
SIAPO	South Island Alliance Programme Office
SICF	South Island Chairs Forum
SICSP	South Island Clinical Services Plan
SI HSP	South Island Health Services Plan
SI-PICS	South Island Patient Information Care System
SIRCC	South Island Regional Capital Committee
SISSAL	South Island Shared Service Agency
SLA	Service Level Agreement
SLATs	Service Level Alliance Teams
SLH	SouthLink Health
SM	Service Manager
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SOI	Statement of Intent
SOPD	Surgical Outpatients Department
SOPH	School of Population Health
SPaIT	Strategy Planning and Integration Team
SPAS	Strategy Planning & Alliance Support

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

As at April 2019

# Nelson Marlborough Disability Support Services Annual Priorities 2019-2020

(August 2019)

**Vision: Supporting people to live well.**

**Aim:** We support people and whānau in our community who live with disabilities to maximise their health, wellbeing, community participation and inclusion. We do this in alignment with **'Enabling Good Lives'** by developing strong connections with our community by a team that supports people to be the key decision makers on anything that impact on their lives.

## DSS guiding principles



**People's choice** – People are supported to make decisions everyday about how they live their lives; the person is in the driver's seat; usual life outcomes; **'Enabling Good Lives'**



**Partnerships & collaboration** – building relationships right across the organisation and work as one team; strengthen collaboration with other providers and services



**Focus on equity** – improved access; reduce inequity; maximise health and wellbeing; promote and celebrate diversity



**Communications** – people, whanau and the workforce are well connected; our teams are IT confident and competent



**Quality** – valued workforce; shared learning; evidence based; funding fit – affordable and sustainable



**Culture** – Appreciate diversity and culture; ensure the service is people and whanau friendly with a customer service orientation

### Engagement with Whānau Priorities

1. Ensure tangata whaiora and whānau participation in care and support planning across all services
2. Develop the Family Partnership Model for DSS
3. Strengthen methods and increase opportunities for communicating with whānau

### Priorities for People We Support

1. Support engagement of people we support in decision making processes
2. People are active participants in daily choices, care and support planning, community connections and social and recreational activities
3. People we support live without fear and take a zero tolerance approach to abuse or neglect
4. Develop and facilitate regular feedback from our clients

### Māori Health Priorities

1. Ensure equity of access for tangata whaiora & whanau
2. Support to have a culturally responsive service
3. Continue to develop kaupapa Māori residential service options
4. Increase % Māori in the workforce and promote diversity

### Health Promotion Priorities

1. Look to develop a NM autism strategy
2. Work with local authorities and government agencies to support access across the board for people with disabilities

### Service Operations Priorities

1. Recruitment and orientation process refreshed and modified
2. On-call processes reviewed to support improved access to information, reduced reliance on on-call during afterhours and increased number of people on the roster.
3. Improve processes and documentation for people transitioning into service
4. Minimise vacancies in the service
5. Focus on recruitment and retention of team members, increase the casual pool and minimise vacancies
6. Review access to transport needs for people across the services
7. Maintain a sustainable financial position
8. Increased opportunity for Supported Living to be offered

### Partnerships Priorities

1. Increase access to Respite for adults and children
2. Strengthen relationships and responses with other sectors
3. Culture & Connection - Providing culturally appropriate support and re-establishing lost connections between families, whanau and friends.
4. Strengthen interface with key agencies e.g. NASC, Explore, ACC, MSD, Housing NZ, and MH&A.

### Quality Priorities

1. High engagement in quality improvement processes
2. Review and support pathway for those with complex needs
3. Ensure policies and procedures are current
4. Increase knowledge and confidence in reviewing incidents and events

### Workforce development Priorities

1. Support and grow leadership within teams
2. Support access to cultural support and development
3. Support team wellbeing and foster positive attitude - "why we're here" – support kindness, compassion and joy at work
4. Ongoing focus on positive behaviour support and person centred thinking
5. Ensure ongoing support for people to attain level 4 qualification and beyond
6. Trial apprenticeship models of training

### Health & Wellbeing Priorities

1. Improvement on medication compliance
2. Improve uptake of population immunisation programmes e.g. flu
3. Strengthen interface between registered nurses and the District nursing services
4. Focus on high uptake of Advance Care Plans (ACP)

### Health and Safety Priorities

1. Enhance wellbeing, preparedness for work and safety for all
2. Increase engagement in H&S processes and systems
3. Improve uptake of flu immunisation by teams
4. Ensure compliant with all H&S reporting and processes
5. Support teams to be work fit and work ready

### Day Services Priorities

1. Identify how to support access to day activities for all people in our services
2. Work to provide day service and programme opportunities to maximise people's potential

### Facilities Priorities

1. Work to ensure residential service placements best meet the changing needs of people we support
2. Work to ensure facility design and arrangement maximise people's potential for independence
3. Address facilities to support team and client safety & wellbeing
4. Improve access to healthy, sustainable housing solutions

### IT Priorities

1. Trial an electronic system for personal plans, house management, rostering, timesheets and incident reporting
2. Increase IT literacy across the teams and service
3. Improve utilisation of IT functions to increase whanau engagement

### Child Respite Priorities

1. Establish a home agreement process for children and whānau
2. Further develop a network of connections with other providers and sectors e.g. OT (Oranga Tamariki), MOE (Ministry of Education), ECC (Early Childhood Centres)
3. Develop a child respite facility in Blenheim and grow the service in Nelson to better meet demand

**“Kare te Rito E Taea Te Tu o ia Anake”  
The centre of the flax does not stand alone**

**Nelson Marlborough Mental Health and Addictions Priorities 2019-2020**

(August 2019)

*Vision: Working together for mental wellbeing*

*Aim: Working with people of our community to promote, encourage and enable their health, wellbeing and independence by providing flexible, responsive, integrated mental health and addictions services*

**MH&A system-wide integration priorities**



Achieve **Equity** and strengthen the **Equally Well** commitment by supporting district-wide access to safe and effective person centred care to reduce inequity and maximise wellbeing. **People and whānau** are essential members of the care team



We take a **whole of person** approach by ensuring strong intra and inter sectoral relationships to ensure people access the range of support available to achieve recovery and optimal outcomes.



We work as **one team** with person centred plan, assisted by appropriate sharing of information and innovative technology solutions.



We support a diverse workforce that is recovery focussed, fosters independence, and is well connected, to ensure we **build trust**, respect and confidence.



Supporting and monitoring our services to be integrated, flexible and responsive and a **high performing** network of people and agencies.

**Quality Priorities**

1. Fully in quality improvement processes and HQSC programmes
2. Improve data collation analytical processes to inform service quality
3. Support clinical teams to measure & report on outcomes
4. Up to date with complaints and event reviews

**Person & Whānau Priorities**

1. Embed Supporting Parents Healthy Children practice
2. Medication information accessible and understandable – in line with Choosing Wisely campaign
3. Ensure tangata whaiora and whānau participation in care plan across all services
4. Improve access to healthy, sustainable housing to maximise independence

**Māori Health Priorities**

1. Ensure equity of access for tangata whaiora & whanau
2. Support a culturally responsive service
3. Continue to implement Poutama MOC
4. Increase Maori in the workforce and promote diversity
5. Support Maori involvement at triage and intake

**Health Promotion Priorities**

1. Expand Equally Well initiatives
2. Promote 5 ways to wellbeing
3. Suicide Prevention strategy
4. Increase community awareness of ACEs

**MH&A Service Priorities**

1. The Right number of people with the Right skills, in the Right place, at the Right time, with the Right attitude, doing the Right work, at the Right cost with the Right work output
2. Refresh stepped care model and implement
3. Strengthen our approach to enhance team wellbeing
4. Review and support pathway for those with complex needs
5. Enhance orientation, preparedness for work with safety for all focus
6. Implement the agreed processes for serious event review processes, including support for restorative processes
7. Implement ERMS and e-triage for all system wide referrals

**NGO Priorities**

1. Increase access to Respite for adults and children
2. Develop the peer and community support workforce, with a focus on Maori health
3. Reduce access barriers to care e.g. cost, entry to services
4. Strengthen one team approach to meeting the needs of clients
5. Support new provider of residential and community support

**Primary Health Priorities**

1. Frist 1000 days implementation
2. Wellbeing practitioner trial in three sites
3. Expand the credentialing programme
4. ACE and trauma informed workforce development
5. Equally well initiatives

**Adult MH Community Priorities**

1. Enhance the interface between ED and MHA
2. Review and improve MDT processes to support across the system
3. Embed sustainable IPS evidence based practice for employment
4. Develop early intervention maternity pathways for infant MH

**Nursing Priorities**

1. Increase opportunities for senior roles
2. Strengthen Top of Scope focus and support stratified workforce
3. Support workforce in MH and wider system e.g. NESP, CCDM
4. Support and grow leadership

**Allied Health Priorities**

1. Improve access to allied health input e.g. brief psych in CAT
2. Further develop group sessions in line with stepped care model
3. Increase student and look to introduce Allied NESP opportunities
4. Strengthen top of scope approach
5. Increase people trained in de-brief and event reviews

**Inpatient Service Priorities**

1. Address ongoing high occupancy issues to improve flow
2. Continue to focus on seclusion reduction and minimisation
3. Improve integrated approach to admission, discharge and MDT
4. Ensure facility upgrades assist with client & team safety & wellbeing
5. Improve transitions of care on admission and discharge

**Medical Priorities**

1. Recruit to all vacancies
2. Strengthen service response to clients with complex and or co-existing presentations
3. Facilitate access to ECT
4. Strengthen relationships with regional services e.g. forensic
5. Strengthen response to paper light stratev

**Child and Youth Service Priorities**

1. Further develop integration focus for eating disorders, infant mental health and behaviour, community options if not for CAMHS
2. Focus on reducing wait time for access to services
3. Strengthen our reputation and responsiveness to the needs of young people by an integrated cross agency response in multiple settings
4. Further develop the duty role, allocation and triage processes

**Addictions Service Priorities**

1. Implement meth treatment model
2. Enhance Primary and Community addictions services
3. Focus on enhancing youth services
4. Reduce wait times to access support
5. Expand wider workforce training







**Specialist MH Older Persons Service Priorities**

1. Upskill wider system; workforce and facility design for older people with complex issues
2. Increase liaison capacity for primary, community and hospital

**IT Priorities**

1. Compliance with reporting
2. Improve tools service wide
3. Build ability to provide virtual care
4. Wellbeing and risk forms finalised



Purpose	Key priorities and Objectives	Benefits
<p><i>“Kete Ritoi E Taea Te Tu o ia Anake” - The Centre of the flax does not stand alone</i></p> <p><b>Our Vision:</b> <i>Working together for Mental Wellbeing</i></p> <p><b>NMH Values:</b></p> <ul style="list-style-type: none"> <li>• Integrity</li> <li>• Respect</li> <li>• Teamwork</li> <li>• Innovation</li> </ul> <p><b>Guiding Principles:</b></p> <ul style="list-style-type: none"> <li> Achieve <b>Equity</b> and strengthen the <b>Equally Well</b> commitment</li> <li> <b>People and whānau</b> are essential members of the care team</li> <li> We take a <b>whole of person</b> approach to achieve recovery and optimal outcomes.</li> <li> We work as <b>one team</b> with person centred plan.</li> <li> We support a <b>diverse workforce</b> to ensure we build trust, respect and confidence.</li> <li> Supporting and monitoring our services to be integrated, flexible and responsive and a <b>high performing</b> network of people and agencies.</li> </ul>	<p><b>1: Increase diversity in the workforce</b></p> <ul style="list-style-type: none"> <li>• Recruitment</li> <li>• Stepped career pathways</li> <li>• Dedicated roles</li> </ul> <p><b>2: Workforce development</b></p> <ul style="list-style-type: none"> <li>• Cultural competency</li> <li>• Cultural bus tour</li> </ul> <p><b>3: Cultural assessments and supports</b></p> <ul style="list-style-type: none"> <li>• Support pathways</li> </ul> <p><b>4: Communication and resources</b></p> <ul style="list-style-type: none"> <li>• Bicultural signage</li> <li>• Tikanga practices adopted</li> </ul> <p><b>5: Holistic health approaches</b></p> <ul style="list-style-type: none"> <li>• Hauora Direct</li> <li>• Immunisation</li> <li>• Advance Directives</li> <li>• Whanau ora approach</li> </ul> <p><b>6: Intervention options</b></p> <ul style="list-style-type: none"> <li>• Community options</li> <li>• Targeted activities in Wāhi Oranga</li> <li>• Welcome process into Wāhi Oranga</li> </ul>	<p><b>The Key Priority by Objective:</b></p> <p><b>1: Increase diversity in the workforce</b></p> <ul style="list-style-type: none"> <li>• Ethnicity of staff understood # staff</li> <li>• Recruitment processes documented and support Maori</li> <li>• % services with a dedicated role</li> <li>• Stepped career pathways documented and supported</li> </ul> <p><b>2: Workforce development</b></p> <ul style="list-style-type: none"> <li>• Te Reo # sessions</li> <li>• Tikanga practice followed in meetings</li> <li>• Treaty training #sessions</li> </ul> <p><b>3. Cultural assessments and supports</b></p> <ul style="list-style-type: none"> <li>• Cultural assessment tool utilised</li> <li>• Tool available on HCS</li> <li>• Pathways to access supports available and utilised</li> </ul> <p><b>4: Communication and resources</b></p> <ul style="list-style-type: none"> <li>• % Services with bicultural signage</li> </ul> <p><b>5. Holistic health approaches</b></p> <ul style="list-style-type: none"> <li>• Adoption of Hauora direct</li> <li>• Targeted immunisation programme % coverage</li> <li>• Advance directives policy and guideline sin place</li> <li>• Number of advance directives produced</li> </ul> <p><b>6: Intervention options</b></p> <ul style="list-style-type: none"> <li>• Maori activities available</li> <li>• Powhiri process adopted by Wāhi Oranga</li> </ul>