ADVISORY COMMITTEE

AGENDA

For the meeting of the Advisory Committee Members of Nelson Marlborough Health held on Tuesday 24 September 2019 at 10.30am

Seminar Centre Room 1, Braemar Campus Nelson Hospital

Section	Agenda Item	Time	Attached	Action
1	Welcome, Karakia, Apologies, Registration of Interests	**10.30am**	Attached	Resolution
2	Confirmation of previous Meeting Minutes		Attached	Resolution
2.1	Action Points		Attached	Note
3	GM Report	**10.35am**	Attached	Resolution
3.1	Dashboard		Attached	Note
4	**For Information:** Submissions		Attached	Note
5	**Presentation:** Equity	**11.00am**	Verbal	
6	Glossary		Attached	Note
	Meeting finish	**12.30pm**		

THERE IS NO PUBLIC EXCLUDED MEETING

WELCOME, KARAKIA AND APOLOGIES

Apologies

REGISTRATIONS OF INTEREST – BOARD MEMBERS

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Gerald Hope (Chair)		▪ CE Marlborough Research Centre ▪ Director Maryport Investments Ltd ▪ CE at MRC landlord to Hill laboratory services Blenheim ▪ Councillor Marlborough District Council (Wairau Awatere Ward)	▪ Landlord to Hills Laboratory Services Blenheim	
Jenny Black	▪ Chair of South Island Alliance Board ▪ Chair of National Chairs ▪ Chair of West Coast DHB ▪ Member of West Coast Partnership Group ▪ Member of Health Promotion Agency (HPA)			

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Alan Hinton	▪ Nil	▪ Trustee, Richmond Rotary Charitable Trust ▪ Trustee, Natureland Wildlife Trust ▪ Trustee, Nelson Christian Trust ▪ Director, Solutions Plus Tasman Ltd ▪ Consultant, Azwood Ltd ▪ Secretary, McKee Charitable Trust	▪ Support of local worthy causes ▪ Education and support of endangered species ▪ Local, national and international support ▪ Business consultancy ▪ Heating fuels and landscaping facilities ▪ Tertiary scholarships and general philanthropy	Supply of heating fuel to NMDHB
Judy Crowe		▪ Daughter is senior HR Consultant at Oranga Tamariki in Wellington		
Patrick Smith	▪ Member of IHB	▪ Managing Director, Patrick Smith HR Ltd	▪ Consultancy services	▪ Focus on primary sector and Maori Working with Maori Health Providers who hold contracts
Jenny Black (Marlborough)		▪ ACP Practitioner	▪ End of life care	

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Brigid Forrest	▪ Doctor at Hospice Marlborough (employed by Salvation Army) ▪ Locum GP Marlborough (not a member of PHO) ▪ Daughter in Law employed by Nelson Bays Primary Health as a Community Dietitian	▪ Small Shareholder and director on the Board of Marlborough Vintners Hotel ▪ Joint Owner of Forrest Wines Ltd	▪ Functions and meetings held for NMDHB	
Dawn McConnell	▪ Te Atiawa representative and Chair of Iwi Health Board ▪ Director Te Hauora O Ngati Rarua	▪ Trustee, Waikawa Marae ▪ Regional Iwi representative, Internal Affairs	▪ MOH contract	
Allan Panting	▪ Chair Orthopaedic Prioritisation Working Group ▪ Chair General Surgery Prioritisation Working Group ▪ Panel member to review Auckland DHB Orthopaedic Service ▪ Chair Ophthalmology Service Improvement Advisory Group ▪ Chair Maternal Foetal Medicine Service Improvement Advisory Group			
Stephen Vallance	▪ Chairman, Marlborough Centre of the Cancer Society ▪ Chairman, Crossroads Trust Marlborough			

Name	Existing – Health	Existing – Other	Interest Relates To	Possible Future Conflicts
Craig Dennis	▪ Trustee of Nelson Region Hospice Investment Trust	▪ Director of CD & Associates ▪ Director of Scott Syndicate Development Company Ltd ▪ Director of 295 Trafalgar Street Ltd ▪ Director of KHC Dennis Enterprises Ltd ▪ Director, Taylors Contracting Co Ltd		

As at July 2019

MINUTES OF MEETING

MINUTES OF A MEETING OF THE ADVISORY COMMITTEE OF NELSON MARLBOROUGH HEALTH HELD IN SEMINAR CENTRE ROOM 1, BRAEMAR CAMPUS, NELSON HOSPITAL ON TUESDAY 27 AUGUST 2019 AT 10.30AM

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

In Attendance:
Peter Bramley (CEO), Lexie O'Shea (GM Clinical Services), Jane Kinsey (GM Mental Health Addictions & DSS), Eric Sinclair (GM Finance Performance & Facilities), Ditre Tamatea (GM Maori Health & Vulnerable Populations), Nick Baker (Chief Medical Officer), Linda Ryan (proxy for Director of Nursing & Midwifery), Gaylene Corlett (Board Secretary)

Apologies:
Cathy O'Malley (GM Strategy Primary & Community), Pam Kiesanowski (Director of Nursing & Midwifery), Hilary Exton (Director of Allied Health), Patrick Smith for lateness

Karakia:
Ditre Tamatea

SECTION 1: APOLOGIES AND REGISTRATIONS OF INTEREST

Moved: **Craig Dennis**
Seconded: **Allan Panting**

RECOMMENDATION:

THAT THE APOLOGIES AND REGISTRATIONS OF INTEREST BE NOTED.

AGREED

SECTION 2: MINUTES OF PREVIOUS MEETING AND CORRESPONDENCE

2.1 Minutes of Previous Meeting

Moved: **Craig Dennis**
Seconded: **Allan Panting**

RECOMMENDATION:

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

AGREED

SECTION 3: ACTION POINTS

Item 1 – Discussion on Medications: Ongoing. May be the topic for the September meeting
Item 2 – Dental Amalgam: Noted in GM report. Completed
Item 3 – Improving equity and coverage of oral health care: GM report. Paper to come to Board

Matters Arising
In relation to oral health for elderly, it was noted a dentist in Picton has a holistic approach to oral health, and specialises in elderly oral health.

SECTION 4: GM REPORT

The GM's report and dashboard were discussed.

Noted Brian Dolan will be presenting to DHB staff looking at patient flow (Brian is a renowned international speaker with expertise in patient flow). This follows on from ideas for improvement gathered from a recent MOH visit. Those projects are forming the basis of the workshop with Brian Dolan. **It was agreed** that the list of projects will be presented at the October meeting.

Dashboard
Discussion held on bed occupancy noting this is tracking up. It was noted that for this time of year this will be our new normal as we are admitting more patients. Once we get through the winter season bed occupancy should drop to around 88-90%. Noted Wairau has had significant challenges around patient flow. We are looking to hold a workshop with primary care, the community and St John on how to better understand patient flow. We are collecting data on those being admitted to see if we can prevent the deterioration of the patient so they do not need admitting (especially the elderly).

Discussion held on readmission rates and the plans in place to support patients when they are discharged.

It was suggested as part of Advanced Care Plans that people think of who their supports are and have them included in their plan, eg church, activity groups, and sports clubs etc rather than just medical notes.

Discussion held on the ED health target of being seen within 6 hours, noting the challenge with dashboards is that it only gives you a snapshot. Noted if a person comes into ED and gets discharged from there we meet the target, however we are currently missing the target if the person needs to move to a bed.

Moved: **Stephen Vallance**
Seconded: **Patrick Smith**

RECOMMENDATION:

THAT THE GENERAL MANAGER'S REPORT BE RECEIVED.

AGREED

SECTION 5: PRESENTATION – PUBLIC HEALTH

Public Health Nursing
Jill Clendon (ADON & Ops Manager Ambulatory Care), Mary Strang (Public Health Nurse Wairau), Rebekah Blease (Public Health Nurse) attended for this item

Presentation provided on the Wairau Public Health Nursing team.

The Wairau Public Health Nursing team consists of four nurses. Mary and Rebekah work with the Children's Team and vulnerable children. They advocate for children and young people from 4-18 years old and family/whanau. This includes health assessment, advice, follow up and referrals as appropriate, school and pre-school liaison, immunisation programmes, communicable disease follow up, and B4School checks.

The Children's Team began through the Vulnerable Children Act 2014 to provide support services to children to ensure they thrive, achieve and belong. The Blenheim Children's Team started in 2016 and it was voluntary for families. There are 18 lead professionals in Blenheim providing support from a number of agencies. The only other Children's Team in the South Island is Christchurch.

Referrals come from a wide source, eg GPs, schools. Referrals go to a central office in Auckland and then to a local panel who looks at each cases to determine who the best lead professional is.

Two case stories were given.

Strengths include everyone is around the table (accountability), sharing of information, joint plans, coordinated admin support, more chance of a positive outcome. The barriers include lack of family support, time consuming, addiction and mental health issues, failure to engage, lack of resources and wait times, escalation of concerns.

Health Promotion
Lauren Ensor (Health Promotions Manager Nelson), Kelly Atkinson (Team Leader Smokefree Service), Karen Petrie (Smoking Cessation/Quit Coach), Sonia Hepi-Treanor (Stop Smoking TPO) attended for this item

There are 22 staff in health promotion (includes alcohol and smokefree) who offer a wide range of services.

Stop Smoking Service
Smokefree Aotearoa 2025 is about taking action so that by 2025 fewer than 5% of New Zealanders will be smokers. This will be achieved by:

- Providing the best possible support for quitting
- Protecting children from exposure to tobacco marketing and promotion
- Reducing the supply of, and demand for tobacco.

Smoking rates continue to reduce, with **13% of adults smoking daily** (this has dropped from 25% in 1996/97). Of note:

- Māori are 2.6 times more likely to be smokers than non-Māori

- The smoking rate for Māori adults is 34%
- Māori men – 30%, Māori women – 37%
- Māori smokers are the youngest to start smoking, at just over 14-years-old on average
- Smoking rates are higher in areas of higher deprivation
- Smoking rates amongst people with mental illness are higher than the general population, particularly in Mental Health inpatients.

In Nelson Marlborough:

- 16,000+ smokers
- Smoking rates are higher for Māori compared to non-Māori and in high deprivation areas
- Smoking prevalence is highest in the young 20s to early 30s age groups.

Focus is on supporting Māori, Pacific and refugee communities; high deprivation communities; pregnant women/hapū māmā; mental health consumers and youth.

The Stop Smoking Service and Pepi First launched on 31 May 2017. The partnership project (between NMH, TPO and PHOs) is a free service available to everyone who smokes in the Nelson Marlborough region. Benefits include:

- Intensive one-on-one support with a 'quit coach'
- Workplace support and community clinics
- Nicotine replacement therapy
- Information about other quit smoking products and services
- A complementary approach to the Quitline service that offers 24/7 support.

Pēpi First is free for all pregnant women in the Nelson Marlborough region. Benefits include:

- Vouchers to reward progress
- Intensive one-on-one support with a 'quit coach'
- Home visits, workplace support and community clinics
- Nicotine replacement therapy
- Information about other quit smoking products and services
- A complementary approach to the Quitline service that offers 24/7 support.

Referrals are received from primary and secondary care, other health care providers, and self-referral. Our target is to have 856 smokers enrolled.

- Over the last two years, we have had 1,963 referrals and 1,206 enrolments – Referral to enrolment rate of 61%
- Work with colleagues within the DHB and PHOs to strengthen Smokefree messages, education and referrals
- We have seen a healthy increase in referrals and enrolments in those aged 17-18 and 18-19
- We are offering more community-based clinics (Victory, Tahunanui, Motueka, Picton and soon Havelock), also working with local colleges.

Over the last two years:

- The client quit rate has been just over 50% (self-reported and CO-validated)
- In this most recent quarter (Q4 18-19, we had a CO-validated quit rate of 59%)
- Cost per quitter has decreased significantly.

Enrolments by ethnicity shows a higher proportion of Māori than in the Nelson Marlborough population 9.1% (Stats NZ 2013)

- 32% Māori (49% of Maori clients are self-reported and 39% are CO-validated quit).

Other enrolment stats:
- 37% male, 63% female
- Largest group is 30 to 39 year olds (24%)
- Have worked with nearly 130 hapū māmā (51% are self-reported quit and 46% are CO-validated quit).

The Smokefree Quit Coaches gave a brief outline of the roles they undertake. One Quit Coach works with Māori, Pacific Island, migrants and refugees. She goes into client homes and builds a relationship with them.

One Quit Coach is focussed on community centres (Victory Community Centre, Tahuna Centre, and Jack Inglis Hospital in Motueka), and recently started working with secondary schools. In the community setting the target group is European aged 39-65 years. Many of them have often tried quitting before unsuccessfully.

Noted vaping is now used as a quit smoking tool rather than nicotine patches (it is 95% safer than smoking). The cost of vaping is a huge reduction for clients. Clients are told that nicotine based vaping is short term and not a replacement for smoking. For those quitting the Quit Coaches look at trigger moments, eg if clients get stressed they can go to vape whereas with patches if they get stressed they revert back to cigarettes. For clients the first step is not buying cigarettes, and this is a big move, then they move to vaping, and then move to quitting altogether. Noted many of the older group are not interested in trying vaping.

Discussion held on whether young people are starting to vape without being cigarette smokers, and whether they become cigarette smokers. It is believed that it is often social pressure for young people to start vaping if they are non-smokers.

Smokefree Environments
NMH Health Protection Officers, Health Promoters, Health in All Policies Advisor, Communications team and community partners:
- Enforcement of Smokefree Environments Act
- Education, support, advocacy
- Collaborative Smokefree work with NCC, TDC, MDC.

Challenges, innovations, next steps:
- Supporting smokers who reside outside of main centres
- Increasingly complex clients
- Raising profile of the Stop Smoking Service
- Vaping.

Position on vaping from MOH, Health Promotion Agency and other organisations:
1. The best thing for your health is to be Smokefree + vape free.
2. Vaping is not for children or young people.
3. Vaping can help some people quit smoking.
4. Vaping is not harmless (but less harmful than smoking).
5. Vaping is not for non-smokers.

SECTION 6: FOR INFORMATION

Submissions noted.

THERE WAS NO PUBLIC EXCLUDED MEETING

Meeting closed at: 12.18pm

Karakia:
Ditre Tamatea

ACTION POINTS – NMDHB – ADVISORY COMMITTEE Open Meeting

Held on 27 August 2019

Action Item #	Action Discussed	Action Requested	Person Responsible	Meeting Raised In	Due Date	Status
1	Dashboard: Pharmaceuticals	Suggested to have medications (across all services) as a discussion topic at a future CPHAC meeting	Cathy O'Malley/ Peter Bramley	22 May 2018	22 October 2019	Paper to come to Board in October
2	GM's Report	Provide the list of projects on improving patient flow (ideas gathered from MOH visit)	Lexie O'Shea	27 August 2019	22 October 2019	

MEMO

Status
This report contains:
- ☐ **For decision**
- ✓ **Update**
- ✓ **Regular report**
- ☐ **For information**

To:	Advisory Committee Members
From:	Cathy O'Malley, GM Strategy Primary & Community
Date:	18 September 2019
Subject:	**General Manager's Report**

Dashboard
The dashboard is attached as item 3.1

Presentation
A presentation will be provided on Equity.

Cathy O'Malley
General Manager Strategy, Primary & Community

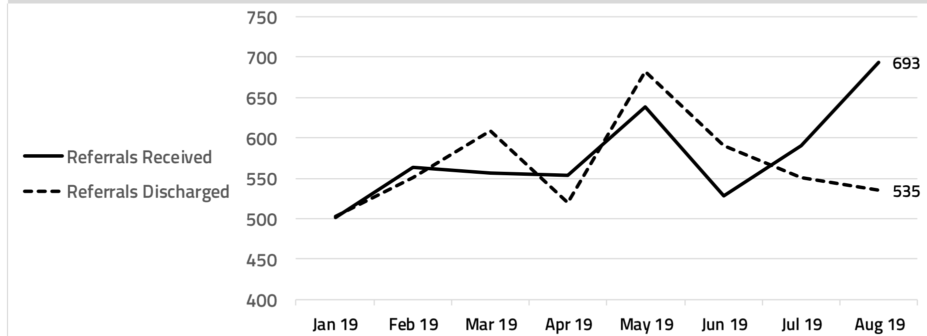
RECOMMENDATION:

THAT THE ADVISORY COMMITTEE RECEIVE THE GM REPORT.

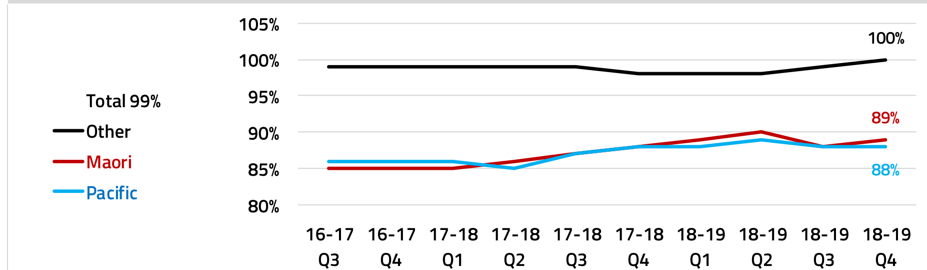
CPHAC-DISAC Dashboard

August 2019

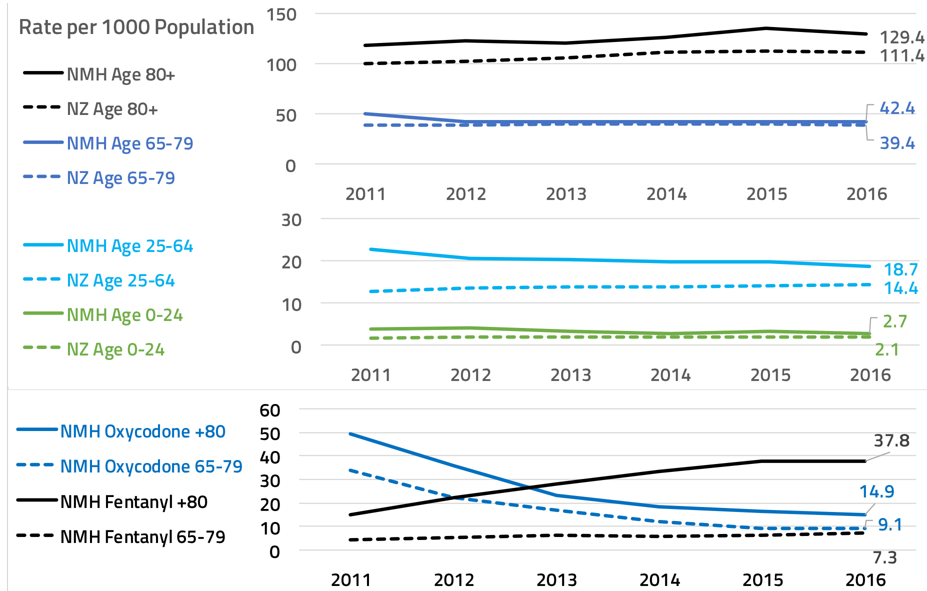
Community, Addictions, & Older Persons Mental Health



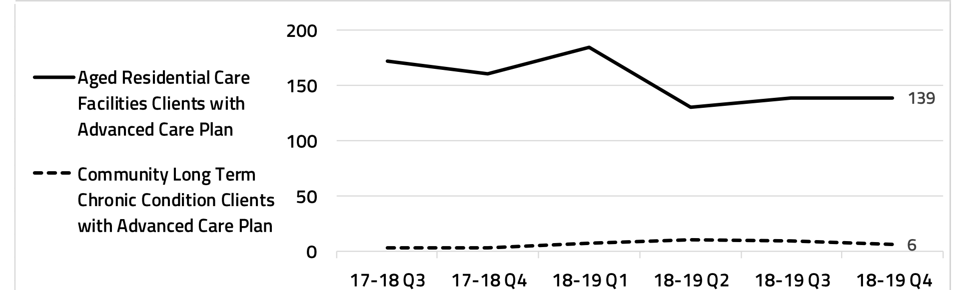
NBPH and MPHO Enrolment



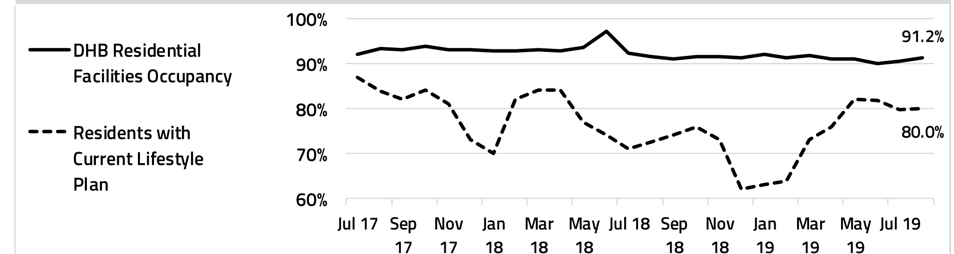
Pharmaceuticals - Strong Opioid Dispensing



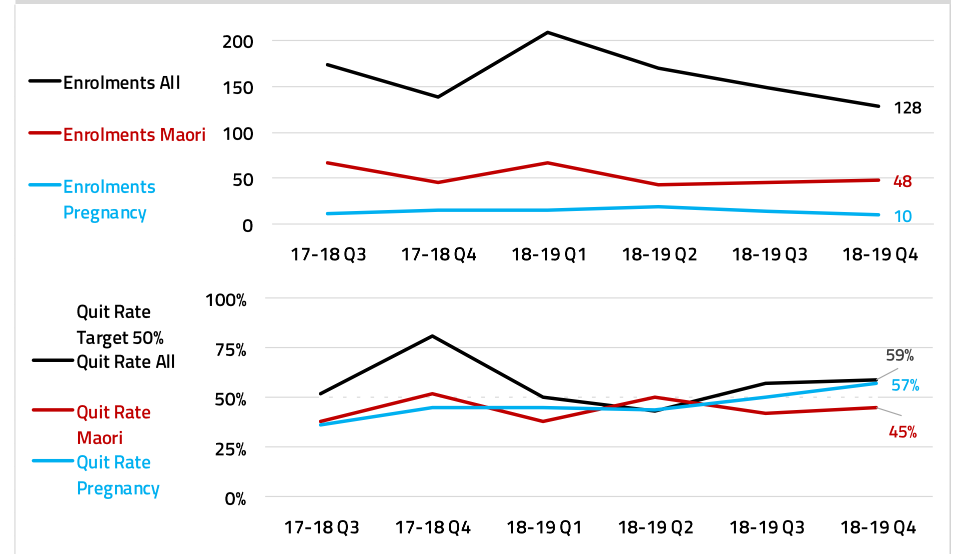
Aged Residential Care



Disability Support Services



Stop Smoking Activity



MEMO

Status
This report contains:
- ☐ **For decision**
- ☐ **Update**
- ☐ **Regular report**
- ✓ **For information**

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

NMH have submitted a number of submissions recently. Submissions include:

4.1 **Advertising Standards Authority (ASA) – Code for Advertising and Promotion of Alcohol**
The ASA is calling for submissions on the Alcohol Advertising and Promotion Code. This Code is designed to ensure that alcohol advertising and promotion is consistent with the need for responsibility and moderation in merchandising and consumption, and does not encourage consumption by minors. Particular care is also required in the advertising and promotion of products likely to have strong appeal to young adults over the legal purchase age.

Submission contents:
1. NMH recommends that statutory regulations are developed rather than relying on an industry voluntary self-regulation.
2. Regulation that restricts alcohol marketing was recommended by the Law Commission Review, and Ministerial Forum on Alcohol Advertising, and the Mental Health Inquiry.
3. NMH recommends that regulation that restricts alcohol marketing applies to all age groups, in particular content is limited to objective product information only (origin, composition and production); cultural icons should not be used in advertising.
4. Alcohol advertising is banned where 10% or more of audience is younger than 18 years.
5. NMH recommends that no child should appear in any alcohol advertisements.
6. NMH recommends that non-restricted areas including public transport, movie theatres should not be venues for alcohol advertising nor any other public places accessible to young people.
7. Alcohol advertising should be restricted on all media between 5.00am to 9.30pm.
8. NMH advocate that it should be compulsory to include warnings in alcohol advertisements about the harms of alcohol.
9. NMH recommends that a penalty system be introduced for breaches of the code.

4.2 **Environmental Protection Authority – Modified Reassessment of Methyl Bromide**
Methyl bromide is used as a fumigant in the quarantine and pre-shipment treatment of logs, produce, flowers and other goods. It is also used for the treatment of potato wart.

We are processing this application as a modified reassessment. This means that the reassessment will only consider specific aspects of the approval, such as the required controls. The approval to import or manufacture methyl bromide cannot be revoked in this type of reassessment.

STIMBR has asked us to consider:

- proposed new controls regarding the definition of recapture
- the time that such recapture would have to be used when fumigating ship holds with methyl bromide.

<u>Submission Details</u>

1. NMH does not support an extended period of 10 years given the effects of exposure on human health.
2. NMH supports urgent further work on other fumigant option that would greatly reduce methyl bromide use.
3. NMH **opposes** changing the recapture technology definition and also **opposes** increasing the concentration on the grounds that it will not reduce or minimise the risk to human health and the environment.

4.3 **TDC – Gambling Venues Policy Review 2019**

The draft Policy intends to control gaming machine numbers with a sinking lid policy.

In practice, the draft Policy prohibits the gaming societies that own and operate the gaming machines, from increasing the number of gaming machines they are licensed to operate.

The policy also continues the prohibition on transferring of any class 4 venue licence within the District.

<u>Submission Details</u>

We are in support of the revised policy. TDC attempted to revise the policy to a sinking lid policy in 2010 and it was quashed. It is hoped that this time the policy will go through.

4.4 **TDC – Coastal Management Feedback**

We need to better prepare our communities for the effects of ongoing changes to weather patterns and rising sea levels. We are starting the conversation with our communities on coastal management.

At this early stage, the focus of the programme is on raising awareness, developing a common understanding of the information we have and gathering your feedback.

<u>Submission Details</u>

1. NMH considers the number one sea level rise and coastal storm inundation concern is the impact on lifeline utilities infrastructure.
2. Consideration should be given to ensuring that potentially toxic and/or biologically contaminative facilities meet stringent design and maintenance requirements intended to seal potential contaminants within sea water–proof buildings and containers when storms occur.
3. The protection of homes is another key concern for NMH. Sea level rise and inundation will have a major effect on people in coastal areas. NMH notes that some European countries have dedicated national funding for household-level protection measures and funds of investment in risk reduction. This may be something that TDC would like to advocate for.

4.5 **Pharmac – Access to Meningococcal Vaccine**

Pharmac's proposal: to widen access to funded meningococcal ACWY vaccine (Menactra) for people aged 13 to 25 years in close-living situations from 1 December 2019.

<u>Submission Details</u>

NMH supports the proposal and recommends that access to meningococcal b vaccine is also widened. Meningococcal disease occurs more commonly for children under 10 therefore NMH recommends that meningococcal vaccines (ACWY and B) are added to the National Immunisation schedule.

Advertising Standards Authority's Code for Advertising and Promotion of Alcohol

23rd August 2019

For more information please contact:
Jane Murray
NMH Public Health Service
Email: jane.murray@nmdhb.govt.nz
Phone: (03) 543 7805

Introduction

1. Nelson Marlborough Health (Nelson Marlborough District Health Board) (NMH) is a key organisation involved in the health and wellbeing of the people within Te Tau Ihu. NMH appreciates the opportunity to comment from a public health perspective on the Code for Advertising and Promotion of Alcohol.
2. NMH makes this submission in recognition of its responsibilities to improve, promote and protect the health of people and communities under the New Zealand Public Health and Disability Act 2000 and the Health Act 1956.

Question 1: Any inconsistencies between the draft code and current legislation?

3. This consultation on the standards for Advertising and the Promotion of Alcohol has limited itself to a review of the current ASA codes. These codes have been developed by an industry body and they are voluntary. Voluntary codes have been shown to be ineffective at restricting alcohol marketing.[1] Regulation that restricts alcohol marketing has been recommended by the Law Commission Review of the Regulatory Framework for the Sale and Supply of Liquor in 2010[2] and the Ministerial Forum on Alcohol Advertising and Sponsorship.[3] This Forum was tasked with assessing the appropriateness of introducing new restrictions for regulating alcohol advertising and sponsorship. It considered existing measures under the Sale and Supply of Alcohol Act 2012 (the Act) and the codes and complaints processes managed by the Advertising Standards Authority.

4. NMH recommends that robust statutory regulations be developed rather than relying on industry voluntary self-regulation to protect our communities from harmful alcohol advertising and sponsorship.

5. The Government Inquiry into Mental Health and Addiction in 2019[4] also recommended the adoption of regulation to restrict alcohol marketing. This

[1] (Noel, J. K., & Babor, T. F. (2017a). Does industry self-regulation protect young people from exposure to alcohol marketing? A review of compliance and complaint studies: Self-regulation complaint process. *Addiction*, *112*, 51–56. https://doi.org/10.1111/add.13432).

[2] NZLC R114

[3] 3 Ministerial Forum on Alcohol Advertising and Sponsorship: Recommendations on alcohol advertising and sponsorship. Wellington: Ministry of Health October 2014

[4] 4 He Ara Oranga : Report of the Government Inquiry into Mental Health and Addiction Nov 2018

recommendation is also strongly promoted by the United Nations as a cost-effective policy to reduce alcohol harm[5]

6. The ASA code states that it has a particular emphasis on protecting children and young people and other vulnerable audiences. However both alcohol and advertising industries have a strong conflict of interest in their self-regulatory role.

7. It is our submission that the most effective way to provide these protections is to adhere to the recommendation of the forums, inquiries and reviews referenced above which all recommend Regulation that restricts alcohol marketing rather than continuing with the self-regulatory system and attempting to amend the current code.

Question 2: Do you agree with the wording of the draft code?

Rule 1 (a) Targeting adults: The content and placement of alcohol advertisements and promotions must target adult audiences.

8. The alcohol industries in New Zealand rely on heavy drinking for profits. Almost half (48%) of alcohol in New Zealand is consumed in heavy drinking occasions as defined by the World Health Organisation. Harm from alcohol is therefore not just confined to children under 18 years.[6]

9. NMH recommends that regulation that restricts alcohol marketing applies to all age groups. In order to protect the community, NMH recommends that alcohol advertising content be limited to objective product information only (origin, composition, production).

10. NMH recommends that Rule 1a is rewritten as "The content and placement of alcohol advertisements and promotions must protect the public from its glamorising and normalising impacts. Any advertisements must in particular not target children under 18 years"

Rule 1 (a): Guidelines

11. In relation to this Rule and in particular harm to children, the draft ASA guidelines would still allow marketing intended to make alcohol more appealing and palatable for anyone under 18years. The inclusion of the wording in the guideline

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[5] World Health Organization (Ed.). (2010). Global strategy to reduce the harmful use of alcohol. Retrieved from http://www.who.int/substance_abuse/activities/gsrhua/en/

[6] Law Commission. (2009) *Alcohol in our lives: An issues paper on the reform of New Zealand's liquor laws*. Issues Paper 15.

"Sweet, colourful, mild-tasting products that may appear to be for children or young people or products that may cause confusion with confectionery or soft drinks" suggests that the harm from alcohol advertising only comes from children or young people confusing alcohol with a soft drink. It does not acknowledge that the harm comes from the promotion of alcohol itself.

12. NMH recommend that the draft Guidelines 1 and 2 for Rule 1a are replaced with

    The extent to which an advertisement or promotion content and placement does or does not target adults is determined by having regard to context and the following criteria:

    a. Alcohol advertising content should be limited to objective product information only (origin, composition, production).
    b. No product that is designed to be attractive to anyone under 18 years old shall be allowed.
    c. Cultural icons, sporting heroes (individuals or teams), social media influencers, popular or easily recognisable celebrities, children or young people should under no circumstances appear or be used in any alcohol advertisements, promotions, or alcohol sponsorship advertisements.

Rule 1 (a) Guideline 3: The expected average audience at the time or place the advertisement appears is predominantly adults

13. Harm from alcohol is not just confined to children under 18 years. Almost half (48%) of alcohol in New Zealand is consumed in heavy drinking occasions at levels likely to cause harm.[7] There is also increasing and sufficient evidence that alcohol causes cancer.[8] Alcoholic beverages are classified by the International Agency for Research on Cancer (IARC) as a Group 1 carcinogen (carcinogenic to humans). Regulation that restricts alcohol marketing must apply to all age groups to protect the public from its glamorising and normalising impacts.

14. NMH supports the recommendation of the Ministerial Forum on Alcohol Advertising and Sponsorship[3] that alcohol advertising is banned where 10% or more of the audience is younger than 18 years and that the onus of proving the audience composition rests with the media buyers.

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[7] Ibid

[8] Conner J, et al., (2016) *Alcohol Attributable cancer deaths under 80 years of age in NZ Drug & Alcohol Review* (2

15. The Forum noted that the estimated current population in NZ under 18 years is 25%. Therefore taking care to ensure that advertisements target adults by assessing whether 25% or fewer of the expected audience will be under 18, imposes no limitation on the proportion of the expected audience.

16. NMH recommends that guideline 3 (page 11) is rewritten as

    Advertisers need to demonstrate that care is taken when evaluating the expected impact prior to the placement of alcohol advertisements and promotions to ensure they target adults and protect the public from its glamorising and normalising impacts

    Measures to determine if children or young people are likely to be a 'significant proportion' of the expected average audience may include one or a combination of the following;

    a. Where 10% or more of the expected audience will be children and / or young people;

    b. Content with significant appeal to children and / or young people such programmes, artists, playlists, video, movies, and magazines;

    c. Locations/events where children and / or young people gather.

    The onus of proving the audience composition rests with the media buyers.

Guideline (page 12, bullet point 1): Children or Young People may appear in alcohol advertising and promotion but only in situations where they would naturally be found, for example, a family meal, provided there is no direct or implied suggestion they will consume the alcohol.

17. Research indicates harm from consumption of alcohol by adults in the presence of children. A systematic review of parenting and adolescent alcohol use published in the Australian and New Zealand Journal of Psychiatry in 2010 clearly showed, that drinking any amount of alcohol in front of your children, no matter how "responsibly" consumed, leads to earlier onset of alcohol consumption in those children, and heavier consumption of alcohol by those children[9].

[9] Ryan, S., Jorm, A., & Lubman, D. (2010). Parenting factors associated with reduced adolescent alcohol use: a systematic review of longitudinal studies. Aust NZ J Psychiatry, 44(9): 774-783.

18. A Scottish report[10] specifically looked at the effect of non-addicted adults on their children's' alcohol consumption and found that negative impacts on children were found at all levels of parental alcohol consumption. The report concluded that "such impacts can begin from relatively low levels of parental alcohol consumption."

19. NMH recommends that no child should appear in any alcohol advertisements incidentally or otherwise.

Guideline (page 12, bullet point 4) Current cultural icons, sporting heroes (individuals or teams) or celebrities that are easily recognisable and / or popular with children and young people may only be used in alcohol advertisements and promotions placed in age-restricted environments

20. Regulation is needed to ensure that advertisers do not use sports stars, cultural icons and celebrities that appeal to anyone under 18 years to avoid the normalising of alcohol. In reality this voluntary code has been ineffectual in limiting the amount of alcohol advertising associated with sporting teams and events, music festivals. This type of promotion is prominent in advertising in retail outlets, roadside signage, television, radio and social media platforms.

21. NMH submits that no current cultural icons, sporting heroes (individuals or teams) or celebrities that are easily recognisable and / or popular with children and young people may be used in alcohol advertisements and promotions in any environments, not just age restricted ones.

22. In addition, NMH recommends that non-restricted areas including public transport, movie theatres, sporting events/venues, cultural events/venues, and the exterior of alcohol outlets, should not be venues for alcohol advertising, nor should be any other public places accessible to young people within 500 metres of any school.

Guideline (page 12, bullet point 5): Broadcasted alcohol advertisements on linear television and on radio must not appear to dominate the viewing or listening period.

23. NMH support the recommendation of the Forum[3] that alcohol advertisements including alcohol sponsorship should be excluded from 5.00 am to 9.30 pm and that this restriction should also apply to free to air, on demand, subscription (live and repeat) services and advertising placed on social media.

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[10] Institute of Alcohol Studies (2017) *Like sugar for adults - the effect of non-dependent parental drinking on children & families* October 2017

24. NMH consider that 9.30 pm to be a conservative estimate of the time of evening when youth up to 18 years will watch media, many will continue later than 9.30 pm.

25. The Forum[3] noted that "research indicates that the volume and frequency of exposure to alcohol advertising is important" and they recommended that additional controls should be introduced. Further, the findings indicate that exposure may be equally if not more important than content. Research found a cumulative effect of exposure meaning that the more times young children are exposed to alcohol advertising and sponsorship the greater the impact it is likely to have on their initiation to consumption and patterns of drinking.[11,12]

26. NMH recommend that to protect children and young people and other vulnerable audiences, the guidelines should reduce exposure to all audiences by reducing the length and frequency of alcohol advertisements.

Rule 1 (b) Alcohol Consumption Guidelines (page 13): Alcohol advertisements and promotions must demonstrate responsibility and moderation in alcohol consumption. Alcohol advertisements and promotions must not portray or represent as irresponsible, harmful or excessive the amount of alcohol consumed or the way drinking is portrayed. For example;

   a. *Rapid or frequent consumption*
   b. *Peer pressure to consume*
   c. *Refusal of alcohol is portrayed as a weakness*

27. NMH recommend that this guideline includes restrictions on advertisements portraying alcohol being consumed in the presence of children under 18 years as evidence indicates harm from consumption of alcohol by adults in the presence of children[4,5]

28. NMH also submit that this guideline should reflect the increased risk of cancers associated with consuming even low rates of alcohol. The portrayal of alcohol being used to relax or unwind implies that this activity carries no risk because of the proviso added that it is consumed in moderation. There is increasing evidence that for some cancers there is no safe level of alcohol consumption.

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[11] Gordon, R., Harris, F. Mackintosh, A. M, & Moodie, C. (2011). *Assessing the cumulative impact of alcohol marketing on young people's drinking: Cross-sectional data findings.* Addiction Research and Theory, 19(1), 66-75;

[12] Lin, E., Caswell, S., You, R. & Huckle, T. (2012). *Engagement with alcohol marketing and early brand allegiance in relation to early years of drinking.* Addiction Research & Theory, 20(4), 329-338

29. NMH recommends that this guideline also includes criteria that is reflective of the risks associated with even moderate amounts of alcohol.

30. NMH advocate that it should be compulsory to include warnings in alcohol advertisements of the harm of alcohol especially in regards to there being no safe limit for alcohol in pregnancy.

Principal 3 Alcohol Sponsorship Advertisements (page 16)

31. Alcohol sponsorship advertisements must clearly and primarily promote the sponsored party

32. The forum[3] focused on issues associated with advertising and sponsorship. NMH recommends that their eleven recommendations to reduce youth exposure through sponsorship and advertising are adopted,

Reducing Youth Exposure Through Sponsorship

a. Ban alcohol sponsorship of all streamed and broadcast sports

b. Ban alcohol sponsorship of sports [long-term]

c. Ban alcohol sponsorship (naming rights) at all venues

d. Ban alcohol sponsorship of cultural and music events where 10% or more of participants and audiences are younger than 18

e. Introduce a sponsorship replacement funding programme

f. Introduce a targeted programme to reduce reliance on alcohol sponsorship funding

Reducing Youth Exposure Through Advertising

g. Ban alcohol advertising during streamed and broadcast sporting events

h. Ban alcohol advertising where 10% or more of the audience is younger than 18

i. Further restrict the hours for alcohol advertising on broadcast media

j. Continue to offset remaining alcohol advertising by funding positive messaging across all media

k. Introduce additional restrictions on external advertising on licensed venues and outlets

33. In addition, the Forum's three recommendations to strengthen the current system of co regulation should also be adopted. Voluntary codes have been shown to be ineffective at restricting alcohol marketing[1]

Strengthening The Current System Of Co-Regulation

a. Establish an independent authority to monitor and initiate complaints about alcohol advertising and sponsorship

b. Establish a mechanism to identify and act on serious or persistent breaches of advertising standards

c. Establish a multi-stakeholder committee to periodically review and assess Advertising Standards Complaints Board decisions and pre-vetted advertising

Question 3: Are there any aspects of alcohol advertising and promotion standards that are not captured in this draft code?

34. According to the Advertising Standards Complaints Board there is a maximum six-week turn-around period for the complaint procedure. There is no requirement for the advertisement to be withheld during this time therefore by the time the complaints procedure and sometimes the appeal procedure is undertaken, the advertisement has usually finished. This effectively means that any advertiser in breach of the code receives no penalty.

35. NMH recommend that complaint processes are amended to allow for 1) quicker assessment of breaches of the codes and 2) withdrawal of advertisements whilst complaint and appeals processes are undertaken. Until the time that alcohol sponsorship is prohibited, we recommend that alcohol sponsorship advertisements in breach of Code requirements be immediately removed rather than reconsidered as alcohol advertisements.

36. NMH recommend that a penalty system be introduced for breaches of the current codes. Advertisers and media found to breach the Code must face significant financial penalties as well as a meaningful suspension period during which the advertiser is not permitted to be place new advertisements.

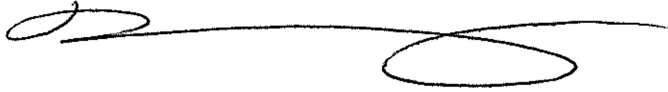
Conclusion

37. In summary we have made recommendations on the draft voluntary code but to best protect communities our recommendation is that voluntary industry self-

regulation of alcohol advertising is abandoned and replaced by robust statutory regulations.

38. NMH thanks the Advertising Standards Authority for the opportunity to comment on Code for Advertising and Promotion of Alcohol.

Yours sincerely



Peter Bramley
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TE WAIORA Nelson Marlborough Health

Environmental Protection Authority

Modified Reassessment of Methyl Bromide

29 August 2019

For more information please contact:
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Phone: (03) 543 7805

Submitter details

1. Nelson Marlborough Health (Nelson Marlborough District Health Board) (NMH) is a key organisation involved in the health and wellbeing of the people within Te Tau Ihu. NMH appreciates the opportunity to comment from a public health perspective on the Environmental Protection Authority's Modified Reassessment of Methyl Bromide.

2. NMH makes this submission in recognition of its responsibilities to improve, promote and protect the health of people and communities under the New Zealand Public Health and Disability Act 2000 and the Health Act 1956.

3. This submission sets out particular matters of interest and concern to NMH.

Background

4. NMH employs Statutory Officers of the Ministry of Health (Medical Officers of Health and Health Protection Officers). Some of these Officers are also Enforcement Officers under the Hazardous Substances and New Organisms (HSNO) Act 1996.

5. In May 2010 the Public Health Service (PHS) of Nelson Marlborough Health made a submission and then subsequently presented a further submission to the ERMANZ (now EPA) Decision Making Committee on the full reassessment of methyl bromide.

6. The PHS has a role to protect public health. In making this submission the PHS is mindful of the purpose of the HSNO Act (Section 4) to protect the environment, and the health and safety of people and communities, its recognition of the precautionary approach (Section 7) and the duty (Section 97) imposed on the Ministry of Health to ensure that the provisions of the Act are enforced where it is necessary to protect public health.

7. At high exposures methyl bromide can be fatal and cause irreversible neurological damage. At lower levels of exposure, there remains significant gaps in knowledge about the overall effects on humans, therefore a precautionary approach should be taken.

8. NMH notes that methyl bromide is a known ozone-depleting substance, and under the Montreal Protocol New Zealand has an obligation to phase out its use, and where it is used to maximise its recapture during phase-out.

9. In our 2010 submission the PHS supported the following:

   (i) Continued work on up scaling the recapture technology for log fumigations.

(ii) Supported efforts to minimise release of methyl bromide to the atmosphere particularly given its effects on the ozone layer and consequent health effects resulting from increased solar UV exposure.

And recommended that:

(i) An end point (5 years) for the release of methyl bromide to the atmosphere.

10. NMH again raises the above issues in this submission as it appears to NMH that progress has been slow around these matters, which are addressed below.

Specific Comments

I. An end point (5 years) for the release of methyl bromide to the atmosphere

11. NMH notes that "*Grounds to reassess were granted based on data that evidenced New Zealand's use of the fumigant has increased from over 400 tonnes a year in 2010, to more than 600 tonnes in 2016*".

12. NMH's 2010 recommendation for a 5 year end point to phase out methyl bromide was not accepted and rather 10 years was agreed by the EPA. NMH is very concerned that New Zealand, rather than reducing the use of methyl bromide, has seen a large and continuing increase in the quantity of methyl bromide used since 2010.

13. NMH **does not support** an extended period of 10 years. In effect this would be a total of 20 years for the phase out if the original period is included. Given the health effects of exposure, NMH **recommends** there is no further extension.

II. Supports efforts to minimise release of methyl bromide to the atmosphere

14. The application provides other options for QPS, and to protect human health. NMH **supports** urgent further work on other options, especially Ethanedinitrile (EDN) as a phytosanitary fumigant with the potential to greatly reduce methyl bromide use.

15. The applicant proposes the definition of recapture technology be revised to reflect the highest practical level of recapture, such as: "*Recapture technology is a system that mitigates methyl bromide emissions from fumigation enclosures such that the*

residual level of methyl bromide in the enclosed space is at least 80% less than that at the end of the fumigation period."

16. Furthermore the applicant has proposed that fumigation companies should no longer be required to achieve a 5ppm concentration of methyl bromide in the head-space of the covers before venting the gas to the atmosphere.

17. NMH **opposes** changing the recapture technology definition and also **opposes** increasing the concentration on the grounds that it will not reduce or minimise the risk to human health and the environment.

18. In addition to the issues being considered, the application states that lower concentrations of methyl bromide can achieve the QPS outcomes just as effectively as higher concentrations of the fumigant which would lead to major reduction of the pollution of methyl bromide released in the atmosphere.

III. Continued work on upscaling the recapture technology for log fumigations

19. The applicant states that there is currently no technology or infrastructure available to undertake recapture when fumigation takes place in a ship's hold.

20. The applicant also states that as the current recapture requirements will not be achievable by the date at which they come into effect, there will be a significant impact on the ability to fumigate imports and exports and that there will therefore be a significant cost to the associated industries.

21. In addition the applicant proposes *"the deadline for recapture technology be limited to on-port and container fumigations only, and a new deadline of a further 10 years be imposed on ship-hold fumigations"*.

22. If approved, the above proposal would mean recapture of methyl bromide in ship-holds would take effect 20 years after the date of this approval, and 10 years after the date of this approval for all other fumigations.

23. Given the industry has had 10 years to address the capture of methyl bromide, NMH **opposes** any further delay in meeting the original conditions due to the risk on human health and the environment.

Conclusion

1. NMH thanks the Environmental Protection Authority for the opportunity to comment on the Modified Reassessment of Methyl Bromide.
2. NMH **does not wish to be heard** in support of its submission.

Yours sincerely

Peter Bramley
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TE WAIORA Nelson Marlborough Health

Tasman District Council's Gambling Venues Policy Review 2019

13 September 2019

For more information please contact:
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Submitter details

1. Nelson Marlborough Health (Nelson Marlborough District Health Board) (NMH) is a key organisation involved in the health and wellbeing of the people within Te Tau Ihu. NMH appreciates the opportunity to comment from a public health perspective on the Tasman District Council's Gambling Venues Policy Review 2019.
2. NMH makes this submission in recognition of its responsibilities to improve, promote and protect the health of people and communities under the New Zealand Public Health and Disability Act 2000 and the Health Act 1956.
3. This submission sets out particular matters of interest and concern to NMH.

General Comments

4. NMH welcomes this review of the Council's Gambling Venue Policy. NMH commends TDC on proposing to introduce a sinking lid for the number of gaming machines in the area. Gambling is a public health concern: Gambling harms includes depression, suicide, emotional and psychological distress, job losses, bankruptcy, reduced work or educational performance, relationship breakdowns and crime including theft from family members, theft from businesses and theft from communities[1]. Harm from problem gambling affects many people other than the gambler in particular children who may be exposed to crime, household stress and poverty. Gambling has a major impact on the wellbeing of children and young people. The impact of indebtedness, criminality, poor physical and mental health, family violence, and household stress all have a significant and lasting impact on children. The harm done to the children of problem gamblers can be severe and long-lasting.
5. Ministry of Health research shows that 50% of problem gamblers experience family violence.[2] Based on the figures shown in the Council report[3] on Gambling Venues, there are potentially 260 problem gamblers in Tasman, therefore there could be 130 families at risk of family violence as a result of gambling and related compounding factors. In order reduce family violence and child abuse, we need to

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[1] Ministry of Health (2015) Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19

[2] Ministry of Health (2017) Problem Gambling and Family Violence in Health-Seeking Populations: Co-occurrence, impact and coping

[3] https://www.tasman.govt.nz/document/serve/EP_06092018_AGN_AT.pdf?path=/EDMS/Public/Meetings/EnvironmentPlanningCommittee/2018/2018-09-06/000000877530

address the drivers for the abuse and address child poverty and this includes looking at the correlation between gambling, poverty and children.

6. Research shows that increased availability and accessibility to gaming machines leads to an increase in problem gambling. Studies have found that although there are fewer gaming machines than there had been historically, they are still concentrated in more deprived areas.[4,5,6]
7. Across New Zealand, gaming machines tend to be more concentrated in socially deprived areas[7]. The resulting harm disproportionately affects Maori, Pacific, people who are separated, divorced and those from single-person households as well as lower income families and communities. The Council report[8] states that Tapawera (deprivation index 5) has 1 machine per 74 people compared with Wakefield (deprivation index 1) has 1 machine per 273 people. In addition, the number of machines has increased in Tapawera in recent years.
8. There is no guarantee that the grants benefit the communities who have put their money in these machines. The return from these machines therefore does little to reduce the social impact of gambling in this already deprived communities.

Specific Comments

9. NMH strongly supports the introduction of a sinking lid policy: a district wide ban on any new gambling venues or machines and gaming machines cannot be transferred to a new pub or owner if the venue closes. A sinking lid policy would reduce the number of venues over time but would not affect existing venues or current community funding in the short term.
10. This approach supports the first objective of the TDC policy to minimise the harm caused by gambling to the community and is consistent with the Tasman's Community Outcome 4 as identified in the 2018-2028 Long Term Plan, particularly: *Our communities are healthy, safe, inclusive and resilient.*

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[4] Ministry of Health 2015 Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19

[5] Orme, C. (2008). *Problem Gambling: The Hidden Disorder.* Mindnet: Mental Health Foundation of New Zealand. http://www.mentalhealth.org.nz/newsletters/view/article/4/33

[6] Abbott, M. (2001). *What Do We Know About Gambling and Problem Gambling in New Zealand?* The Department of Internal Affairs: Wellington

[7] Rook, H. & Rippon R., (2018) *Gambling Harm Reduction Needs Assessment* Ministry of Health https://www.health.govt.nz/system/files/documents/publications/gambling-harm-reduction-needs-assessment-aug18.pdf

[8] https://www.tasman.govt.nz/document/serve/EP_06092018_AGN_AT.pdf?path=/EDMS/Public/Meetings/EnvironmentPlanningCommittee/2018/2018-09-06/000000877530

11. From an administrative perspective, sinking lid policies are also favourable for Councils. Introducing a sinking lid results in natural attrition therefore it reduces the need for extensive reviews of gambling policies every few years to ensure that cap is appropriate.

Conclusion

1. NMH thanks the Tasman District Council for the opportunity to comment on the Gambling Venues Policy Review 2019.
2. NMH wishes to be heard on its submission.

Yours sincerely

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TE WAIORA Nelson Marlborough Health

Tasman District Council

Coastal Management Feedback

13 September 2019

For more information please contact:
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Phone: (03) 543 7805

Submitter details

1. Nelson Marlborough Health (Nelson Marlborough District Health Board) (NMH) is a key organisation involved in the health and wellbeing of the people within Te Tau Ihu. NMH appreciates the opportunity to comment from a public health perspective on the Tasman District Council's Coastal Management Feedback.
2. NMH makes this submission in recognition of its responsibilities to improve, promote and protect the health of people and communities under the New Zealand Public Health and Disability Act 2000 and the Health Act 1956.
3. This submission sets out particular matters of interest and concern to NMH.

Specific Comments

4. NMH congratulates Tasman District Council on requesting feedback on the future coastal management. Sea level rise and erosion will impact the health of our environment and communities.
5. NMH considers the number one sea level rise and coastal storm inundation concern is the impact on *lifeline utilities infrastructure*. From a public health perspective, salt-water intrusion into aquifiers in a major concern. In Tasman, there are a range of drinking water supplies (both Council and privately owned) drawing water for human consumption which are located near the coast.
6. In addition there are a number of key transport routes which are very close to the coast and are vulnerable to sea level rise.
7. As new information emerges, TDC needs to have the ability to react to the extent and speed of sea level rise. NMH advocates for a comprehensive assessment of vulnerable public infrastructure along the coastlines. It is critical that plans and funding for adaptive strategies are available in order to secure lifeline infrastructure.
8. Consideration should be given to ensuring that potentially toxic and/or biologically contaminative facilities e.g. sewage treatment plans, solid and hazardous waste disposal facilities, chemical manufacturers (past and present), power plants meet stringent design and maintenance requirements intended to seal potential contaminants within sea water–proof buildings and containers when storms occur[1]. This is especially important given the recent problems with erosion at the

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[1] https://www.researchgate.net/publication/228322085_A_Public_Health_Perspective_on_Sea-Level_Rise_Starting_Points_for_Climate_Change_Adaptation

old Fox Glacier landfill site[2]. Any new facility must be required to be sited away from vulnerable coastlines.

9. The protection of homes is another key concern for NMH. Homes are often the most significant material and financial possession people have. Sea level rise and inundation will have a major effect on people in coastal areas. Inundation can result in loss of possessions, damage to homes, disruptions to home life which can affect mental health. In addition, the inability for some coastal homes to get insurance in the future could affect both new and existing developments[3].

10. Steps need to be taken to help homeowners prepare for sea level rise, erosion and coastal inundation. NMH was pleased to see that the Future Development Strategy has sited growth areas outside of coastal areas. Information needs to be given to home owners within affected areas about options to protect property in terms of elevating buildings or reinforcing structures[4] as well as information about evacuation procedures. NMH notes that some European countries have dedicated national funding for household-level protection measures and funds of investment in risk reduction. This may be something that TDC would like to advocate for.[5]

Conclusion

11. NMH thanks the Tasman District Council for the opportunity to comment on the Coastal Management Feedback.

Yours sincerely

Peter Bramley
Chief Executive
peter.bramley@nmhs.govt.nz

[2] https://www.stuff.co.nz/national/111835637/volunteers-in-tears-as-full-scale-of-westland-landfill-flood-disaster-becomes-clear

[3] http://www.level.org.nz/site-analysis/hazards/rising-sea-levels/

[4] https://www.civildefence.govt.nz/assets/Uploads/publications/consistent-messages-part-B-coastal-inundation.pdf

[5] http://www.oecd.org/environment/cc/policy-highlights-responding-to-rising-seas.pdf

Gaylene Corlett

From: Jane Murray
Sent: Tuesday, 10 September 2019 9:15 AM
To: Gaylene Corlett
Cc: Cathy O'Malley; Peter Burton
Subject: Signature Required: Coastal Management Feedback
Attachments: SubmissionCoastalManagementv2.docx

Hi Gaylene,

Please find attached a copy of the Coastal Management Feedback submission.

Background to the consultation:
We need to better prepare our communities for the effects of ongoing changes to weather patterns and rising sea levels. We're starting the conversation with our communities on coastal management.
At this early stage, the focus of the programme is on raising awareness, developing a common understanding of the information we have and gathering your feedback.

Key points in our submission:

1. NMH considers the number one sea level rise and coastal storm inundation concern is the impact on lifeline utilities infrastructure.
2. Consideration should be given to ensuring that potentially toxic and/or biologically contaminative facilities meet stringent design and maintenance requirements intended to seal potential contaminants within sea water–proof buildings and containers when storms occur.
3. The protection of homes is another key concern for NMH. Sea level rise and inundation will have a major effect on people in coastal areas. NMH notes that some European countries have dedicated national funding for household-level protection measures and funds of investment in risk reduction. This may be something that TDC would like to advocate for.

This submission has had input from Health Protection officers Geoff Cameron and Evan McKenzie, Peter Burton.

This submission is due on Friday the 13 September.

Kind regards

Jane

Jane Murray
Health In All Policies Advisor / Public Health Service / Nelson Marlborough District Health Board
PO Box 647, Nelson / 281 Queen Street, Richmond / jane.murray@nmdhb.govt.nz / Phone: 03-543 7805
*We value : **Respect** - Integrity - **Teamwork** - Innovation*

My hours of work are Monday - Thursday 8.45 - 2.45

TE WAIORA

Nelson Marlborough Health

Submission on Pharmac's Proposal to widen access to meningococcal ACWY vaccine for people in close-living situations

16 September 2019

For more information please contact:
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Introduction

1. Nelson Marlborough Health (Nelson Marlborough District Health Board) (NMH) is a key organisation involved in the health and wellbeing of the people within Te Tau Ihu. NMH appreciates the opportunity to comment on Pharmac's proposal to widen access to meningococcal ACWY vaccine for people in close-living situations.

2. NMH makes this submission in recognition of its responsibilities to improve, promote and protect the health of people and communities under the New Zealand Public Health and Disability Act 2000 and the Health Act 1956.

General Comments

3. NMH commends Pharmac's proposal to widen access to meningococcal ACWY vaccine for people aged 13 to 25 years in close-living situations.

4. NMH recommends that access to meningococcal b vaccine is also widened as it is the most prevalent strain of meningococcal cases in New Zealand[1].

Table 5. Meningococcal disease cases by group by year, 2016–2019*

Group	Year			
	2016	2017	2018	2019*
B	47	70	51	41
C	8	11	10	5
W	5	12	33	24
Y	7	11	16	8
X	0	0	1	0
E	0	0	0	1
Group unknown[1]	3	5	6	9
Not lab-confirmed	5	3	3	3
Total	**75**	**112**	**120**	**91**

[1] Includes non-groupable, DNA laboratory-confirmed by PCR and laboratory-confirmed isolates not received by ESR.
*data to 31 August only.

5. Meningococcal disease occurs more commonly for children under 10 therefore NMH recommends that meningococcal vaccines (ACWY and B) are added to the National Immunisation schedule.

[1] https://surv.esr.cri.nz/PDF_surveillance/MeningococcalDisease/2019/Aug2019_MeningoReport.pdf

Table 1. Number of meningococcal disease cases for August 2019 and cumulative number of cases and deaths for 2019* by age group

Age group	August 2019	Cumulative total 2019*	Number of deaths 2019*
<1	5	20	2
1 to 4	3	15	0
5 to 9	1	11	0
10 to 14	0	2	0
15 to 19	1	7	0
20 to 29	2	12	1
30 to 39	0	2	0
40 to 49	0	3	0
50 to 59	0	6	1
60 to 69	1	8	1
70+	1	5	1
Total	**14**	**91**	**6**

*data from January to August 2019.

6. NMH notes that the consultation period was set at two weeks. This timeframe is quite tight for organisations to prepare and authorise submissions. The communicable disease teams in public and primary health units are currently responding to the measles outbreak therefore it would have been advantageous to have a longer consultation period in order to make a more detailed response.

Conclusion

7. NMH thanks Pharmac for the opportunity to comment on the proposal to widen access to widen access to meningococcal ACWY vaccine for people in close-living situations.

Yours sincerely

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GLOSSARY OF COMMONLY USED ACRONYMS, ABBREVIATIONS AND MAORI TRANSLATION

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
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 Training
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
IaaS	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	Intermediate 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
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 Admissions 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 Techer: 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 August 2019