AGENDA – PUBLIC

CANTERBURY DISTRICT HEALTH BOARD MEETING
To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 17 August 2017 commencing at 9:00am

ADMINISTRATION 9.00am

Apologies

1. Conflict of Interest Register
   Update Board Conflict of Interest Register and Declaration of Interest on items to be covered during the meeting

2. Confirmation of the Minutes of Previous Meetings
   Public Meeting 20 July 2017

3. Carried Forward/Action List Items

4. Patient Story

REPORTS  9.10am

5. Chair's Update (Verbal)  Sir Mark Solomon  Acting Chair, CDHB  9.10-9.20am

6. Chief Executive's Update  David Meates  Chief Executive  9.20-9.45am

7. System Performance Presentation  Carolyn Gullery  GM, Planning & Funding  9.45-10.15am


MORNING TEA 10.30-10.45am

9. Chatham Islands Services – Financial Results  Carolyn Gullery  10.45-11.00am

10. Wellbeing Health & Safety Report  Michael Frampton  GM, People & Capability  11.00-11.15am


12. 2017/18 Elective Services Plan - Presentation  Carolyn Gullery  11.25-11.55am

13. Advice to Board
   • HAC – Draft Minutes  Andrew Dickerson  Chair, HAC  11.55-12.00pm
      3 Aug 2017

14. Resolution to Exclude the Public  Justine White  12.00pm

INFORMATION ITEMS

- Nil

ESTIMATED FINISH TIME – PUBLIC OPEN MEETING 12.00pm

NEXT MEETING: Thursday, 21 September 2017
CANTERBURY DISTRICT HEALTH BOARD MEMBERS

Dr John Wood (Chair)
Sir Mark Solomon (Deputy Chair)
Barry Bragg
Sally Buck
Tracey Chambers
Anna Crighton
Andrew Dickerson
Jo Kane
Aaron Keown
Chris Mene
David Morrell

Executive Support

David Meates (Chief Executive)
Mary Gordon (Executive Director of Nursing)
Sue Nightingale (Chief Medical Officer)
Stella Ward (Executive Director – Allied Health Scientific & Technical)
Carolyn Gullery (General Manager – Planning & Funding)
Hector Matthews (Executive Director -Maori & Pacific Health)
Michael Frampton (General Manager – People & Capability)
Justine White (General Manager – Finance & Corporate Services)
Kay Jenkins (Executive Assistant - Governance Support)
Anna Craw (Board Secretary)
CANTERBURY DISTRICT HEALTH BOARD
MEMBERS’ CONFLICTS OF INTERESTS
REGISTER

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

DR JOHN WOOD (CHAIR)

Advisory Board NZ/US Council – Member
Chief Crown Treaty Negotiator for Ngai Tuhoe
Chief Crown Treaty Negotiator for Ngati Rangi
Chief Crown Treaty Negotiator, Tongariro National Park
Chief Crown Treaty Negotiator for the Whanganui River
College of Arts – External Advisory Committee Member
Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA) – Member
Kaikoura Business Recovery Grants Programme Independent Panel – Member
School of Social and Political Sciences – Adjunct Professor
Te Urewera Governance Board – Inaugural Member
University of Canterbury - Chancellor
University of Canterbury Foundation – Ex-officio Trustee
Universities New Zealand – Chair, Chancellors’ Group

SIR MARK SOLOMON (DEPUTY CHAIR)

Te Waka o Maui – Independent Representative
Oaro M Incorporation - Member
Ngāti Ruanui Holdings - Director
Pure Advantage - Trustee
He Toki ki te Rika / ki te Mahi - Patron
Te Ohu Kai Moana - Director
Deep South NSC Governance Board - Member
Sustainable Seas NSC Governance Board - Member
Canterbury Recovery Learning & Legacy Sponsors Group - Member
Liquid Media Operations Limited - Shareholder
Urban Development Strategy Implementation Committee - Member
Police Commissioners Māori Focus Forum - Member
Post Settlement Advisory Group – Member
Primary Industries’ Earthquake Relief Fund Assessment Panel – Member
SEED NZ Charitable Trust – Chair and Trustee

BARRY BRAGG

Ngai Tahu Property Limited – Chairman
Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu.

Canterbury West Coast Air Rescue Trust – Trustee
The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.
New Zealand Flying Doctor Service Trust – Chairman
The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.

CRL Energy Limited – Managing Director
CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.

SALLY BUCK

Christchurch City Council (CCC) – Community Board Member
Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC.

Registered Resource Management Act Commissioner
From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time.

TRACEY CHAMBERS

Chambers Limited - Director
Arohanui Trust - Trustee
Rata Foundation - Trustee

Chambers Limited has clients and former clients that may mean a conflict or potential conflict arises. These will be discussed at the appropriate time if they arise.

ANNA CRIGHTON

Christchurch Heritage Trust – Chair - Governance of Christchurch Heritage
Christchurch Heritage Limited - Chair - Governance of Christchurch Heritage
Heritage New Zealand – Honorary Life Member

ANDREW DICKERSON

Accuro (Health Service Welfare Society) - Director (from 9 December 2016)
Is a not-for-profit, member owned co-operative society providing health insurance services to employees in the health sector and (more recently) members of the public. Accuro has many members who are employees of the CDHB.

Maia Health Foundation - Trustee
Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children’s wards at Christchurch Hospital.

Canterbury Health Care of the Elderly Education Trust - Chair
Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB.
Canterbury Medical Research Foundation - Member
Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB.

Heritage NZ - Member
Heritage NZ’s mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings.

No Conflicts of Interest are envisaged for the following interest, but should a conflict arise this will be discussed at the time.

NZ Association of Gerontology - Member
Professional association that promotes the interests of older people and an understanding of ageing.

JO KANE

Latimer Community Housing Trust – Project Manager
Delivers social housing in Christchurch for the vulnerable and elderly in the community.

Registered Resource Management Act (RMA) Commissioner
From time to time sits on RMA panels throughout Canterbury. If any conflicts of interest arise from this they will be advised.

NZ Royal Humane Society – Director
Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.

HurriKane Consulting – Project Management Partner/Consultant
A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised.

Key to Life Charitable Trust – Undertakes consultancy work for this trust.

AARON KEOWN

Christchurch City Council – Councillor and Community Board Member
Elected member and of the Fendalton/Waimairi/Harewood Community Board.

Grouse Entertainment Ltd – Director and Shareholder
Grouse Films Ltd – Director
O3 Productions – Writer/Director

No conflicts of interest are anticipated from these roles but will be discussed at the appropriate time should they arise.

CHRIS MENE

Canterbury Clinical Network – Child & Youth Workstream Member
**Core Education** – Director  
Has an interest in the interface between education and health.

**Wayne Francis Charitable Trust** - Board Member  
The Wayne Francis Charitable Trust is a philanthropic family organisation committed to making a positive and lasting contribution to the community. The Youth focussed Trust funds cancer research which embodies some of the Trust’s fundamental objectives – prevention, long-term change, and actions that strive to benefit the lives of many.

**Regenerate Christchurch** – General Manager, Partnerships and Engagement  
Regenerate Christchurch (RC) - established to lead regeneration activities across Christchurch. RC will work with strategic partners, including the Canterbury DHB, the community, iwi and other stakeholders to plan and drive development in key areas of the city.

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**DAVID MORRELL**

**British Honorary Consul**  
Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. In addition a conflict of interest may arise from time to time in respect to Coroners’ Inquest hearings involving British nationals.

**Nurses Memorial Chapel Trust** –Chair  
(CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.

**Heritage NZ – Subscribing Member**  
Heritage NZ’s mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance.

**Canon Emeritus - Christchurch Cathedral**  
The Cathedral congregation runs a food programme in association with CDHB staff.

**Great Christchurch Buildings Trust** – Trustee  
The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing.

**Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time.

**Friends of the Chapel** - Member
MINUTES

DRAFT

MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held at 32 Oxford Terrace, Christchurch
on Thursday 20 July commencing at 9.00am

BOARD MEMBERS
Sir Mark Solomon (Acting Chair); Barry Bragg; Sally Buck; Tracey Chambers; Anna Crighton; Andrew Dickerson; Jo Kane; Aaron Keown; Chris Mene; and David Morrell.

APOLOGIES
An apology for lateness was received from Tracey Chambers (9.55am).

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Acting Chief Executive); Carolyn Gullery (General Manager, Planning & Funding); Michael Frampton (General Manager, People & Capability); Hector Matthews (General Manager, Maori & Pacific Health); Sue Nightingale (Chief Medical Officer); Karalyn van Deursen (Strategic Communications Manager); Stella Ward (Executive Director, Allied Health); Justine White (General Manager, Finance & Corporate Services); Anna Craw (Board Secretary); and Kay Jenkins (Executive Assistant, Governance Support).

Hector Matthews acknowledged the passing of the Chief Executive’s mother and opened the meeting with a Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions or alterations to the Interest Register.

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

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

2. CONFIRMATION OF MINUTES OF THE PREVIOUS MEETINGS

Resolution (44/17)
(Moved Anna Crighton/seconded Barry Bragg – carried)

“That the minutes of the meeting of the Canterbury District Health Board held at 32 Oxford Terrace on 15 June 2017 be confirmed as a true and correct record.”

3. CARRIED FORWARD/ACTION LIST ITEMS

The carried forward items were noted.
A question was raised regarding the Primary Maternity Strategy and the Board noted that this would come back to the Board through the Hospital Advisory Committee in October.

4. PATIENT STORY

The Patient Story was viewed.

5. ACTING CHAIR’S UPDATE

Sir Mark Solomon, Acting Chair, advised that it had been a fairly busy month:

- Follow up letters have gone to the parties regarding the cross-agency meeting.
- He accompanied Minister Joyce on a tour of the new facilities.
- Some clarification is required around the completion date for the Acute Services Building.
- A $12m error has been acknowledged by PWC in their figures.
- He advised that he has accepted an invitation from the Ministry of Education to speak to them around his views around how they feed into the health sector.

The Chair’s verbal update was noted.

Resolution (45/17)
(Moved: Jo Kane/seconded: Aaron Keown – carried)

“That the Board:

i. moves a vote of confidence in the Acting Chair.”

6. CHIEF EXECUTIVE’S UPDATE

David Meates, Chief Executive, thanked the Board for their condolences on the passing of his mother. He also thanked the Executive Management Team for the role they undertook while he was on annual leave.

Mr Meates handed over to Mary Gordon to present the report which was taken as read.

Ms Gordon commented in particular on the winter workload which has hit the sector. She added that the hospital is running fairly well and that whilst ED has seen an increase in attendance this has been managed well. The Board noted that instead of a smooth flow of patients, people were all coming at once which can cause a backlog at times. It was also noted that Burwood Hospital is full, which is part of the strategy so was expected.

In regard to ESPIs, the Board noted that in ESPI5 yellow was maintained through May and June and at the end of June 19 people were awaiting surgery – this will drop to 13 after today. The Chair commented that 13 people out of 568,000 was quite an achievement. The comment was made that it is also important to recognise that the reason the DHB is outsourcing is due to there being no theatre capacity available.

Discussion took place regarding the Rangatahi Work Placement Programme and Hector Matthews, General Manager, Maori & Pacific Health, provided some background around this programme.
Resolution (46/17)
(Moved Jo Kane/seconded Anna Crighton – carried)

“That the Board:

i. notes the Chief Executive’s Update.”

Resolution (47/17)
(Moved: Jo Kane/seconded: Anna Crighton – carried)

That the Board

i. moves a vote of confidence in the Chief Executive and Acting Chief Executive, Executive Team, Clinicians, all staff, and the NGO Sector for the outstanding work and achievement over the last six years in particular.”

7. FINANCE REPORT

Justine White, General Manager, Finance & Corporate Services, presented the Finance Report which was taken as read.

The consolidated CDHB financial result for the month of May 2017 was a deficit of $8.218M which was $2.311M unfavourable against the revised budget deficit of $5.907M. The year to date position is $13.711M unfavourable to the revised budget.

For the month of June, Ms White advised that the provisional result (subject to audit) is a deficit of $51.8m, which is $2.4m higher than the revised forecast.

The Board noted that the impact of the Kaikoura earthquake and the $2m back to the Council was treated as an “equity injection” paper transaction which still shows on our books. The Ministry have been requested to reclassify this and if approved the result will become a deficit of $49.8m.

It was also noted that the underlying fiscal position of the DHB is really strong and robust, particularly with the impact of depreciation and capital spend when the DHB did not plan to have 44 buildings demolished.

It was also noted that the $8M spent on outsourcing was to avoid $24M in penalties for ESPI non-compliance.

The Board asked that when a request was made for deficit funding that the reasons for the over-run be outlined.

Tracey Chambers joined the meeting at 9.55am.

The Chair of the Hospital Advisory Committee, Andrew Dickerson, advised that this Committee had looked at Elective Services in detail and he acknowledged the work undertaken around the Elective Services Plan.
Resolution (48/17)
(Moved Jo Kane/seconded David Morrell – carried)

“That the Board:

i. notes the financial result for the period ended May 2017;
ii. notes the provisional (subject to audit) result for the period ended June 2017; and
iii. notes that future recommendations will include a timeline, exceptions and savings.”

8. WELLBEING HEALTH & SAFETY REPORT

Michael Frampton, General Manager, People & Capability, presented this report which was taken as read.

The Board noted that 63% of staff have now been vaccinated which is slightly behind last year.

In regard to injury management, Mr Frampton made reference to the work being undertaken around AT&R on the Hillmorton site. The Board noted that an independent Health & Safety review has been commissioned and as requested by the Board at an earlier meeting the Terms of Reference for this will be discussed with the Chair of the Hospital Advisory Committee for Governance input.

Mr Frampton highlighted that under “Key Milestones” in the report, the Board would note the status of the Wellbeing Strategy was showing as “red”. This is due to the belief that a “People” strategy is required as opposed to a “Wellbeing” strategy. This strategy will be stepped through with the General Manager’s Group and the Executive Management Team and will be presented back to the Board in September.

The Board noted that the biggest challenge we collectively face is that more than a third of our people are still dealing with earthquake issues.

Resolution (49/17)
(Moved Sir Mark Solomon/seconded Aaron Keown – carried)

“That the Board:

i. notes the Wellbeing Health & Safety Update.”

9. DELEGATIONS UPDATE

Justine White, General Manager, Finance & Corporate Services, presented this update which was taken as read.

There was no discussion on the update which was self-explanatory.

Resolution (50/17)
(Moved David Morrell/seconded Jo Kane – carried)

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

i. notes the “Delegation of Authority by the Board of the Canterbury DHB” Policy (Appendix 1);
ii. notes the Instrument of Delegation to the Chief Executive Officer (Appendix 2) is in place, based on delegations approved by the Board in September 2016; and

iii. notes that a comprehensive review process was undertaken of existing delegations across the CDHB and all Instruments of Delegation for the Organisation and Delegations Framework were updated in November 2016.”

10. ADVICE TO BOARD

Community & Public Health Advisory Committee
Anna Crighton, Chair, Community & Public Health Advisory Committee provided an update from the meeting held on 6 July 2017. She highlighted in particular the non-compliance of water within the Canterbury region and Sugary Drinks.

Resolution (51/17)
(Moved Sir Mark Solomon/seconded Chris Mene – carried)

“That the Board:

i. notes the draft minutes from the Community & Public Health Advisory Committee meeting held on 6 July 2017.”

Disability Support Advisory Committee
Tracey Chambers, Chair, Disability Support Advisory Committee provided an update from the meeting held on 6 July 2017. The Board noted that this had been an informal meeting.

The Committee Chair acknowledged the work undertaken around the Disability Action Plan and the commitment to this plan.

Resolution (52/17)
(Moved Sir Mark Solomon/seconded Aaron Keown – carried)

“That the Board:

i. notes the draft minutes from the Disability Support Advisory Committee meeting held on 6 July 2017.”

11. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (53/17)
(Moved: Sir Mark Solomon/Seconded: David Morrell – carried)

“That the Board:

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

ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:
<table>
<thead>
<tr>
<th>GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED</th>
<th>GROUND(S) FOR THE PASSING OF THIS RESOLUTION</th>
<th>REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)</th>
</tr>
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<tbody>
<tr>
<td>1. Confirmation of minutes of the public excluded meeting of 15 June 2017</td>
<td>For the reasons set out in the previous Board agenda.</td>
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</table>
| 2. Chief Executive’s Update on Emerging Issues – Verbal Report | Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). | S9(2)(a)  
S9(2)(j) |
| 3. Acute Services Building On-Grade Car Park | To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). | S9(2)(j) |
| 4. High Care Areas for the Assessment, Treatment and Rehabilitation Unit – Hillmorton Hospital Campus | To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). | S9(2)(j) |
| 5. 2017/18 Draft Annual Plan Update | To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). | S9(2)(j) |
| 6. Rangiora Health Hub – Stage 3 | To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). | S9(2)(j) |
| 7. Canterbury Linen Service Laundry | To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). | S9(2)(j) |
| 8. ADHB & CDHB Antenatal Downs Syndrome Tests New Contract Setup | To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). | S9(2)(j) |
| 9. 2017/18 Baseline Capital Allocation (Approved-In-Principle Capital) | To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). | S9(2)(j) |
| 10. Legal Report | Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege | S9(2)(a)  
S9(2)(j)  
S9(2)(h) |
| 11. Advice to Board:  
• Facilities Committee Draft Minutes 04 Jul 2017  
• QFARC Draft Minutes 04 Jul 2017 | For the reasons set out in the previous Committee agendas. | |

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.”
The Public meeting concluded at 11.15am

Sir Mark Solomon, Acting Chairman

Date
<table>
<thead>
<tr>
<th>DATE</th>
<th>ISSUE</th>
<th>REFERRED TO</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 Mar 17</td>
<td>Primary Maternity Strategy + primary/secondary birthing occupancy rates</td>
<td>Carolyn Gullery</td>
<td>Report to 19 October 2017 meeting.</td>
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</tbody>
</table>
CHIEF EXECUTIVE’S UPDATE

TO: Chair and Members
Canterbury District Health Board

SOURCE: Chief Executive

DATE: 17 August 2017

Report Status – For: Decision [ ] Noting [✓] Information [ ]

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing the latest update and overview of key organisational activities and progress from the Chief Executive to the Board of the Canterbury DHB.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive’s update.

PUTTING THE PATIENT FIRST – PATIENT SAFETY

Patient Safety

- **Patient Experience:** The Quarterly Public Patient Experience Report for the April to June 2017 period has been released. CDHB’s results for the quarter are consistent and displayed below, 4056 patients were invited to participate and 780 responded (response rate of 19%).

![Patient Experience Chart]

- **Quality Improvement & Innovation Awards 2017:** 15 written projects have been received from across Canterbury and the assessment process has commenced using the 3 categories as per the triple aim; Best Value for Public Health resources, Improved Quality, Safety and Experience of Care and Improved Health and Equity for all populations. The Quality Improvement and Innovation Awards Ceremony will be held on the 6 November 2017 as part of Patient Safety Week.
• **Hand Hygiene:** The national 2017 Hand Hygiene NZ Auditing Manual has been updated and released. HHNZ/HQSC Hand Hygiene Programme changes from 1 July 2017:

  - Focuses on monitoring spread across all inpatient areas, with data to be published in the next national Hand Hygiene Audit. All inpatient areas will require 300 moments to be audited annually. Locally as part of best practice and in preparation, all inpatient wards continue to be targeted for our Local Frontline Audit Programme.

  - Seeks to support engagement.

  - Recommends additional ways to validate auditing.

• **Deteriorating Patient Programme:** *Stream 1* - The changeover to the NZ Early Warning Scoring system is planned for 19 September 2017 across all hospital facilities inpatient services. 70 policies and procedures will be updated, the vital signs chart will be standardised to the New Zealand chart, all clinical staff will be retrained in the parameters, scoring and zones and staff will be responding to a new deteriorating patient pathway. Local change management planning workshops occur with clinical frontline leaders at the end of August. This will be followed by a two week countdown during which time the change leaders will implement their local plans.

  - **Current**

  - **New**

  ![Image of a chart showing changes in the New Zealand Early Warning Score]

• **Stream 2** - The Health Quality and Safety Commission recently announced the Canterbury District Health Board will be a pilot site for co-designing with consumers a patient, family and whānau escalation process as part of the national deteriorating patient programme. The aim is to co-design with consumers a means for patients/families to escalate care concerns if they feel they are not being listened to and their concerns have not resulted in action. Canterbury DHB is the South Island region’s lead site for a patient, family and whānau escalation design process.

• **Surgical Site Infection Prevention Programme:** To reduce the surgical site infection rate further in New Zealand, Canterbury DHB is participating in a collaborative to help design a standardised national pre-operative anti-staphylococcal bundle (care process) for orthopaedic surgery.

• **High-tech equipment will benefit children with respiratory conditions:** This month the Respiratory Physiology Laboratory has unveiled a new piece of technology that is designed to help children who have respiratory conditions with their breathing tests. Previously lung function could only be tested through spirometry which requires children to blow into a tube as hard as they can which can be a challenging task for this group. The new body plethysmograph, or body box, is the only one in New Zealand using the latest ultrasonic technology to measure a child’s lung performance. It allows for a fully integrated procedure that tests airway resistance and lung volumes. The body box is housed in a paediatric testing room.
within the laboratory that has recently been decorated in the same theme as the paediatric department.

- The machine can measure the size of a child’s lung, how well the lung can take in oxygen, and the resistance to airflow. It will also allow medical staff to measure the effect of medication given to help breathing. Having this new capability available specifically for children will enable us to set up paediatric clinics to ensure more children have better access to the appropriate testing and assessment of their respiratory function. In addition to the body box, the purchase of an Airwave Oscillometry System allows us to test children as young as three years old because minimal patient cooperation is needed. The $123,000 paediatric body plethysmograph was bought with funds from last year’s Countdown Kids Hospital Appeal which has helped raise more than $10.4 million over the last ten years.

**IMPROVING FLOW IN OUR HOSPITALS**

- **Older Persons Health and Rehabilitation (OPH&R):** Within Older Persons Health we have a number of activities that support and contribute to the patient journey. To ensure our focus on frail older persons we have our core functions of 4-Questions, Releasing Time to Care activities and making visible the expected date of discharge. Reviewing our data and developing our dashboards to bring to life further the data and how it shapes our conversations. As a result of this focus we are able to achieve a number of other activities that contribute to our frail older person’s pathway and the patient journey across OPH&R into the community.

- **eObs roll out across OPH&R:** The project team are completing the rollout through Burwood at the end of August. The surgical service and Spinal are transitioning between paper and electronic currently and a pilot using iPads, was carried out in one of the OPH wards.

- Strengthening of connections with Christchurch Hospital to ensure patients are taken as soon as possible to assist with patient flow in the acute environment has been a driver of the winter planning and will inform our usual approach to improving the transfer of care between services and sites. To support flow we have been flexing up to assist with the winter influx:
  - Wards B1, B2, C1, C2 have flexed their bed numbers up to 24
  - Ward D1 – has flexed their bed numbers up to 22
  - Ward DG – has remained steady at 20 beds

- Impact of increased beds has been around maintaining staffing numbers in both nursing and allied health in order to provide the level of rehabilitation care for the volume of patients. For some of our wards this has meant increased usage of pool and agency staff. This has resulted in rosters needing to be changed at times to ensure skills mix is appropriate, increased staff from other areas results in increase pressure on permanent staff. Flexing across our service has ensure flow maintained.

- Despite this additional capacity the increase in older patients requiring hospital care has meant that the number of patients awaiting transfer has remained consistently high (approximately 18-25) throughout winter. Other significant impacts has been the volume of winter illness for staff members - both nursing and allied health. We continue to look at ways to support wellbeing of the team during peak demand periods.
• The average time spent in AMAU for those patients transferring directly to Burwood is between 13 and 20 hours. There are around 3 – 4 OPH transfers per day for people who have been in AMAU at some point. LOS for those patients has dropped by about 4 days since February this year.

• On average this year 14 patients per week begin their hospital journey in AMAU, being provided with care by General Medicine then the Older Person’s Health Team and are discharged from the OPH wards at Burwood Hospital. Over the past three months this has increased to an average of 18 per week. As a result of changes being put in place this group of patients is spending two days less in Christchurch hospital this year compared with last year as shown in the graph below which details the entire time spent in Christchurch hospital for people admitted to AMAU, cared for by General Medicine and then transferred to and discharged from Burwood.

• Count of patients transferring directly from AMAU to Burwood.

• Length of stay this winter is reduced compared with last winter which, especially in the context of a higher number of admissions, lends weight to a conclusion that this year’s winter plan is working with the system managing increased demands more smoothly and with a slightly lower occupancy at Christchurch Hospital compared with last year.

• This result relies on continuing attention to the way that clinical tasks are carried out to ensure that people receive efficient care, reducing the effect of deconditioning while in hospital, preparing them to return home as well recovered as possible and support them to stay well in
their own home. One aspect of this has been to ensure that people are transferred from the acute hospital setting for assessment, treatment and rehabilitation at Burwood Hospital in a timely manner. An example of the improvements being put in place as a part of the Winter Plan is the Frailty Pilot commenced in April 2017 with a consultant geriatrician providing daily input into the Acute Medical Assessment Unit. This was designed to look at whether early intervention by a geriatrician allows improved flow to Older Person’s Health and whether this impacts overall length of stay. It is clear to see that direct transfer has been boosted in the last quarter and that length of stay for those patients has dropped by about four days since February this year.

- In order to maximise the ability to ensure that people will receive care in the right setting Burwood wards B1 and C1 are now resourced to 23 beds each – six more than normal. On top of this wards are flexing above standard occupancy during high demand periods. Planning occurs each day to flex as much as possible according to volume and acuity. When all services are considered, there are usually ten or more people transferring from Christchurch to Burwood Hospital each day and weekend transfers occurring at a level that matches discharges from Burwood.

- A transfer Clinical Nurse Specialist from Older Person’s Health has just been appointed, and based within Christchurch Hospital. The focus of this role is to ensure we are able to meet a timely approach to transferring and ensuring where possible early identification of frail older people are recognised and transferred.

- The shorter length of stay when compared with last autumn and winter and reduced occupancy at Christchurch Hospital in spite of increasing admissions is in line with the Winter Plan’s intention to improve flow, ensuring that care is provided at the best possible place. This encouraging result supports teams to continue working on the improvement efforts, as indicated by the number of people waiting to transfer from acute to rehabilitation areas. There is a sense around Christchurch Hospital that despite there being more admissions compared with last year we, as a system, are managing much more effectively and that the Winter Plan has been a part of this.

- **Cardiac Surgery and discharge to rural hospitals and the community:** Following discharge from Christchurch Hospital after Cardiac Surgery, patients continue to require support with wound care, problem solving and expected and unexpected complications. People living within Christchurch obtain this support within the community. Rural patients often receive this support during a short period spent in a rural hospital. Approximately 75 patients per year are discharged from the Cardiothoracic service to a rural hospital within Canterbury. A number of initiatives have been put in place to support effective care for people in these settings:
  - All patients are provided with educational support by one of the Service’s Clinical Nurse Specialist to ensure that they know what to expect and when to seek help. The Clinical Nurse Specialist provides her contact details so that immediate contact can be made if the patient is worried. She also makes telephone contact within two weeks of surgery so that any problems can be identified and dealt with without having to wait for a follow-up outpatients’ appointment.
  - A Registered Nurse working within the Department has compiled a set of easy to follow, detailed, guidelines about the care of dressings following cardiac surgery. This has meant far less confusion and unnecessary dressing changes.
  - A Cardiac Surgeon and Clinical Nurse Specialist have initiated regular visits to hospitals in other districts, rural hospitals and medical centres within Canterbury to speak with doctors and nurses about these topics ensuring they have the right information to confidently provide the support required by these patients.
• It is estimated that this work helps us to avoid five or six unnecessary readmissions to Christchurch Hospital per month in addition to enabling a lower length of stay in Hospital compared with other centres in New Zealand.

• **Rib Fixation:** Rib fractures are often extremely painful can lead to severe respiratory problems in some patients. They are often sustained as a result of a fall or motor vehicle accident.

• Providing rib-fixation surgery has been shown to be useful in defined groups of patients by reducing time spent in the Intensive Care Unit or on a ventilator, reducing incidence of pneumonia and speeding return to work and other normal functions.

• One of the cardiothoracic team’s surgeons has recently begun providing rib fixation operations for patients most likely to benefit. Patients requiring this surgery are identified and taken to theatre soon after their injury, this has led to less pain and quicker mobilisation for between six and ten patients per year, contributing to more timely recovery and shorter stays in hospital being required.

• **Heart Failure clinics:** Providing effective support to people with Heart Failure ensures that they remain as healthy as possible and able to participate in daily life as possible along with avoiding hospital stays. A part of this support is the provision of outpatient clinics and home visits to support people with heart failure. Monthly Clinical Nurse specialist clinics for people with heart failure commenced in Rangiora in March 2012. People soon expressed a preference to attend clinics at Rangiora and their frequency quickly increased to weekly to service the resulting demand, care is now provided to around 20 people a month. Since early 2017 two Clinical Nurse Specialists travel to Rangiora, one providing a clinic and one to conduct home visits for those too unwell to attend clinic.

• With this model in mind and having patients wanting to avoid attending the Christchurch Campus alongside a constraint on outpatient space existing a clinic commenced at Burwood Hospital’s outpatient department in March 2017. This too has proved positive, with people happy to attend that site from as far away as Prebbleton and Rangiora.

**REDUCING THE TIME PEOPLE SPEND WAITING**

**Medical & Surgical and Women’s & Children’s Services**

• **Elective Services Performance Indicator Target Outcomes:** Information provided by the Ministry of Health shows that Canterbury District Health Board achieved a yellow result for the Elective Services Performance Indicator 2 (first specialist assessment) at the end of June – the fourth month in a row. Of the services contributing to this measure 21 out of 27 have no patients waiting for longer than 120 days and all the remaining six services have four or less people waiting for an appointment for longer than this time.

• Elective Services Performance Indicator 5 (wait time for surgery) was yellow at the end of June, the third month in a row. This was achieved as projected in the recovery plan that was submitted to the Ministry of Health in late January. Internal reporting shows that we expect to also be yellow at the end of July.

• **Faster Cancer Treatment - 62 Day target:**
  • Canterbury DHB submitted 141 records to the Ministry for the three months of April, May and June 2017. In this period 85% of our eligible patients were treated within 62 days of their referral, meeting the Ministry of Health target of 85%.
• **31 Day Performance Measure**
  - Canterbury District Health Board submitted 377 records for March, April and May 2017. In this period 91% of eligible patients met the 31 day measure which, like the 62 days target, has a threshold of 85%.
  - The threshold for both targets will be increased to 90% from 1st July. At the same time eligibility criteria will be amended to exclude patients who choose to delay their treatment and also patients whose treatment is delayed for clinical reasons.

• **South Island cancer Multidisciplinary Meetings adopt Southern District Health Board solution:** Multidisciplinary meetings are used to bring together a range of specialists involved in diagnosing and treating cancer to make treatment or care plan recommendations. They are a key component of best clinical practice and patient management; providing continuity of care and reducing variation in access to treatment and improving outcomes for patients. Different systems have been used around the South Island to manage the information required at these meetings. However sometimes it can be weeks before all information is collated, finalised and available for everybody to view.

  A solution has been developed in the Southern District Health Board that supports these processes. The approach taken during development was to create an intuitive electronic form that could be easily completed to support and record decision making in the multidisciplinary meeting. One aim was to ensure there was consistency across the different tumour streams that use the system. As a part of expanding the use of this system across the South Island, it will be piloted by the Canterbury gynae-oncology and lung cancer multidisciplinary meetings for six weeks before being made available progressively to all remaining cancer multidisciplinary meetings hosted in the South Island. This system has provided a consistent platform across services at Southern District Health Board and its adoption across the South Island will bring additional benefits as a result of being a single, shared electronic multidisciplinary meeting system including:
  - alignment of processes and practice across the South Island;
  - quality and consistency of referral information;
  - improved timeliness of clinical documentation following the meetings;
  - increased visibility of patient care coordination and inter-district flow; and
  - better support for clinical audit and reporting requirements
• National standards for the provision of cancer services to adolescents and young adults:
  Until now standards for cancer care provided to adolescent and young adult people have not
  been described in a nationally accepted document. The Canterbury Adolescent and Young
  Adult Cancer Service has been chosen to pilot the new Adolescent and Young Adult Cancer
  Networks Standard of Care -Self Review Tool. The standards were launched by the Minister,
  Hon. Dr Jonathan Coleman, in May and provide a practical as well as educational and
  inspirational document. All the services who deal with patients with cancer between the ages
  of 12 to 24 have been invited to take part. Canterbury District Health Board will be assessed
  against the following six mandatory standards for the treatment of adolescents and young adults
  with cancer:
  • All will be offered the opportunity to enrol in available diagnostic and therapeutic clinical
    trials;
  • All will be informed prior to treatment about the potential risks of treatment related
    infertility, and, where appropriate, fertility preservation procedures will be completed;
  • All will be provided with access to psychological support from diagnosis;
  • Those patients with risk factors associated with increased non-adherence will be identified
    and prioritised for intensive case management;
  • Health care professionals and the supportive care workforce will be trained to deliver
    developmentally appropriate care
  • All will be treated in a health care environment that is developmentally appropriate

  • This new set of standards is enabling us to be clear about specific objectives for the care of this
    group and we can now ensure that we care for this group of patients in an appropriate manner.

• Standardised Booking work in General Surgery: General Surgery continues to make
  improvements that together help it to provide more care to the people of Canterbury. Because
  the number of patients able to be seen at each clinic changes over time as treatment pathways
  and other changes take effect, the templates used to book clinics require regular review. If this
  is not done we can either waste time that could be used provide care, or we overbook clinics
  thus increasing the time that patients wait. General Surgery has recently reviewed all Senior
  Medical Officer’s outpatient clinic templates to ensure they are set up in accordance with the
  Senior Medical Officer’s preference and departmental need.
  • Booking administrators are now booking into these templates according to urgency and
    longest wait. This ensures that the right patients are seen at the right times.
  • Senior Medical Officer’s annual leave bookings are provided with six weeks’ notice and all
    clinics are booked within the four to six weeks of their occurrence. This means that patients
    are not booked into clinics that will not run, thus we avoid inconveniencing patients by
    cancelling appointments and wasting administrative activity.
  • All clinics that become vacant due to leave or other reason are backfilled with General
    Surgery clinics where possible. If the service is not able to achieve this the clinic spot is
    returned to the Clinical Nurse Manager of Hagley Outpatients with good notice so that she
    can provide this capacity to another service.
  • The Breast Surgery team within General Surgery is working with the Choosing Wisely team
    to better understand its routine follow up workload.
  • Within General Surgery two outpatients appointments within each half day clinic have been
    dedicated to ‘new cancer’ cases. These appointment slots can only be booked into during
    the two weeks prior to the clinic to ensure that we are able to provide appointments for
people with cancer within two weeks, while avoiding disrupting the care of other booked patients. A paper based system has been put in place to provide Cancer Nurse Coordinators with visibility of these ‘new cancer’ slots. The Coordinators allocate these appointments to patients based on upcoming theatre availability and space remaining in clinics to optimise the entire patient journey.

- Reporting from the Ministry of Health indicates that CDHB has exceeded its Electives Health Target, having produced 21,456 elective and arranged discharges during 2016/17, 474 more than the target of 20,982.

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- Services and Planning and Funding have been working together to develop a phased plan for elective services delivery during 2017/18 that meet’s the Ministry of Health’s requirements and avoids the requirement to increase delivery significantly late in the year.

- **Avastin injection service – freeing theatre space and easing patient flow:** Avastin is a drug that is injected into people’s eyes to treat wet age-related macular degeneration. People with this condition will quickly go blind without Avastin treatment. In 2011-12 Canterbury District Health Board planned to provide around 750 Avastin injections. At that time these injections were provided in a theatre setting, this had a number of disadvantages. The theatre setting is not ideal for less complex tasks like this and only around twelve injections were able to be provided in a half-day session. These procedures were often scheduled at the end of operating lists, meaning that patients would often wait four hours for a fifteen minute procedure. Because of the costs associated with a theatre setting the unit cost rose to $1,500. This combination meant that we had inadequate capacity, unsafe practices, unacceptable waiting times, an unsatisfactory patient journey and costs were higher than they needed to be. The use of theatre sessions for this task was displacing other work that could only occur in theatres.

- Clinical staff in the Eye Clinic working with the CI team have redesigned the way that the service works. This has created a one stop shop Avastin clinic for assessment and injections in the Eye Clinic. Another first for the Canterbury District Health Board in New Zealand has been the use of a General Practitioner injector with Dr Leeanne O’Sullivan becoming accredited as an Avastin Injector in November 2014. By the middle of this year, she had done over 4,000 injections and trained our second General Practitioner injector, Dr Phil Hamilton. This redesign has enabled:
  - A 400 percent increase in the number of patients to 4,300 in 2016
  - A reduction in the unit cost of injections from $1,500 to $454.80. This is an effective saving of 75 percent on each treatment;
  - Elimination of waiting lists for Avastin injections;
  - The freeing up of two main theatre sessions per week for work that can only occur there;
  - Release of Senior Medical Officer time for tasks that only they can carry out;
  - Each single clinic can now be ‘scaled up’ with resources to perform between 18 and 48 injections;
  - Within clinic waiting time for the injection has reduced from four hours (waiting) to 30 minutes (turnaround), and is now saving an estimated 15,000+ hours of unnecessary patient waiting per year;
- Demonstration that similar treatment models can be used for the treatment of diabetic macular disease.

- **Electronic Blue Card system: supporting prompt care for our most vulnerable children:** The “Blue Card” system provides a fast track admission process for our most vulnerable children who have been identified by their paediatrician or surgeon as requiring frequent or rapid admission to hospital. A child with a blue card will have this flagged within the patient management system, alerting Emergency Department staff for the need for rapid assessment and referral onto the paediatric service. A paper based system has been replaced with an electronic template in Health Connect South which now provides better access to information about the likely presentation to hospital and management plans. There are currently over 770 children with active blue cards – the next step of this improvement is to review these, ensuring that all are still relevant and required.

- **Improved collaboration and information flow improving the care of children:** The Children’s Outreach Nursing Service provides health assessment, investigations, education and procedures for children aged 0-16yrs following referral from a paediatrician. They visit the family at home or preschool/school, at a time that suits the child and family. The aim is to reduce the amount of time away from school and normalise the diagnosis and treatment for the child and their family. To increase collaboration between the families and the health professionals involved the outreach team has introduced the following measures:
  - All notes are written in “Progress Notes” on Health Connect South so they are readily available through HealthONE and all health professionals can add to the patient notes;
  - Outreach nurses attend inpatient multidisciplinary ward handover meetings each weekday to discuss patients on admission and prior to discharge;
  - Contact is maintained with the General Practice team to provide updates, support and education;
  - Following consent from the family, a group email is set up for school and any other health professionals unable to access Health Connect South e.g. Starship team. Regular updates ensure that all aspects of the child’s care are included.

- The team has developed “Children’s Outreach Service Guidelines” to ensure that they continue to work in a collaborative way. This service is helping us to reduce hospital admissions, reduce the time children spend away from school for the child and away from work for parents.

- **Paperlite in General Surgery and Diabetes:** The implementation of paperlite outpatients’ clinics within General Surgery continues to make a significant difference in the workload and throughput of the Booking Administrators in the Department of General Surgery. All Senior Medical Officers have now transitioned to paperlite processes, with the final clinics transitioning in recent weeks. This includes that results and referrals are not printed with clinicians referring to the electronic record while in clinic. This saves 20-40 minutes of booking administrator time per clinic. Within General surgery there are 88 clinics every four weeks. This time saving is enabling an increase of 300 patient FSAs and surgeries to be organised each year with no additional clerical staff required.

- Likewise, within the Diabetes Service, using a mixed paper and electronic based system to support the operation of nursing and allied health clinics required the administration team to pick and file notes. This task was taking around two hours per day and was preventing the team from working on improvements required in the service. At the end of May the clinical teams within the diabetes service agreed to transition all allied health and nursing teams into a fully electronic clinical documentation system. The transition has occurred without any glitches with the team expressing that the electronic notes meet all clinical requirements. The ten hours per
week freed up within the administration team has been allocated to improving the way that other tasks are carried out and has avoided demand for more capacity within the team.

- **In house three dimensional modelling for surgery:** Planning of complex surgical operations can often benefit from use of a three dimensional model. These are especially useful when maxillo-facial surgeons are repairing fractures in the area around people’s eyes. Use of these models is beneficial to patient safety as it allows informed, hands on planning ahead of surgery. This means that surgeons are better placed than ever before to prepare for the operation, assess what surgical approach will offer the greatest chance of a safe, quick and successful procedure. Previously production of these models was outsourced at a cost of around $1,000 each and took two to three weeks to produce. Because of this it was reserved for the most complex cases – sometimes this resulted in other cases needing to return to theatre for repair of a poorly fitted plate.

- The Medical Physics and Bioengineering department, with its expertise in medical image processing, has developed a three dimensional printing service and now routinely provides this service to maxillo-facial surgeons. This service has also been extended to other areas of surgery when required. Models are now used routinely in every eye orbit repair case. Full skull models have been prepared for neurosurgeons to inform shaping of titanium plates and vascular surgeons have used hollow models of vessels for shaping stent implants and planning vascular surgeries. This has helped improve outcomes for patients, as well as saving costs and improving flow for surgical services:
  - Models are now available within three hours – rather than the two to three weeks provided under the previous arrangement;
  - The cost of models has dropped from $1,000 each to around $2;
  - The revision rate to repair poorly fitted plates in eye orbit surgery has fallen from around 30% to zero.
  - Cost savings are estimated at $150,000 per year.

- **Active management of service agreements pays off:** Over time Radiology has transitioned most of its x-ray rooms from a Computed Radiography system where images are captured by a cassette and subsequently digitised in a reader to a system that involves direct digital capture of images. The last room on Christchurch campus went live on digital technology on 31st of July this year. Following implementation of this change there is no longer a need for the readers which transfer information from cassettes to a digital format. As any equipment is retired from the fleet Service Contracts are reviewed. The cost of operational expenditure associated with service contracts for the readers reduced from $129k in 2014/15 to $68k at the end of 2016/17. Kit that is no longer required is relocated to other sites within Canterbury District Health Board (e.g. Kaikoura or the Chatham Islands) or gifted (e.g. Hanmer or Dunstan) where possible.

**Specialist Mental Health Services (SMHS)**

- **Demand for Specialist Mental Health Services:** The Specialist Mental Health Services divisional leadership team and Planning & Funding continue to closely monitor demand for Specialist Mental Health Services. Demand for adult general and child and adolescent services continue to increase. The specialist mental health service teams work exceptionally hard, to provide the best care possible in some very challenging circumstances. Management and clinicians are continuously looking for ways to make the environment as safe as possible for consumers and staff. A range of initiatives have contributed to ongoing improvements. These include:
• Plans are underway for a building modification designed to contain a high care area (HCA) to assist with addressing significant health and safety concerns that exist in the AT&R unit. This is the inpatient service for people with intellectual disability and challenging behaviour.

• Clinical leadership has been strengthened and expanded across the mental health division.

• Reviewing models of care (way of working) to ensure targeted and personalised interventions for consumers.

• Stabilising staff numbers in the AT&R (Assessment Treatment and Rehabilitation) unit to reduce the amount of agency use so that staff and consumers get to know each other better, resulting in greater awareness of individual consumer needs.

• Environmental changes have been made within most inpatient areas to create low stimulus areas and improved space for people to use when they are highly agitated.

• Reinforcement of induction and orientation procedures for new or returning staff to a unit.

• Use of our electronic incident recording system that allows real time incident review increasing our ability to learn from incidents and adapt our practice.

• We acknowledge the great work that current staff undertake and this is complemented by the NESP (new entry to specialist practice) group that commenced earlier this year. These new nurses, social workers and occupational therapists add much to the work that we do with their ongoing energy and expertise. Staff are committed to supporting and growing NESPs.

• We are experiencing an acute shortage of inpatient nursing staff with 45.73 FTE (full time equivalent) nursing vacancies from a full establishment of 537 FTE. Some of the reasons for the vacancies include retirements (linked to the demographics of our workforce), movement of staff within SMHS and out to non-DHB mental health services such as primary care and corrections. 23 of the vacancies are in Te Awakura (acute inpatient service), this is resulting in increased use of overtime and agency staff to ensure rosters are covered. Staff are working extremely hard to ensure services continue to be available for people. We have a range of activities underway to try to improve the situation. Including:
  • Increasing the number of Hospital Aids employed to free up nurses to provide acute care. 10 will be taking up positions mid-August.
  • Increasing number of Enrolled nurses. 12 have successfully completed initial interview process and we are currently undertaking referees and police checks.
  • An international recruitment campaign is underway focusing on UK and Australia, to date this has resulted in 82 applications (from a range of different health disciplines). 61 of these have been referred to the respective managers for consideration. These comprise nurses (24), Occupational Therapists (2), Physiotherapists (5) Psychologists (7) Social Workers (18) and Behavioural therapists (5). To date, these applications have not resulted in appointments. The Behavioural Therapist applications were from experienced primary mental health workers and have been forwarded to Pegasus Health.
  • We have increased the size of our internal nursing pool to cover roster gaps
  • We have established a volunteer system across SMHS where staff can elect to work extra shifts, which is having a positive impact.
  • We are expecting 25 graduate nurses to commence in SMHS in September and aim for another 25 in February.

• SMHS nursing turnover remains lower than other areas of CDHB. Staff turnover in that past 12 months:
• All CDHB 8.14%
• All Specialist Mental Health Service (SMHS) 7.95%
• SMHS Registered Nurses 8.59%
• Registered Nurses in all other areas of CDHB 9.06%

• Occupancy of the adult acute inpatient service remains high with 91% occupancy in July 2017. There were 25 sleepover nights required in July 2017, however, 21 of these nights were for consumers transitioning to Seager prior to admission. The workload associated with high numbers of patients under care is putting significant pressure on clinical staff and risks compromising quality.

• Demand for Crisis Resolution remains steady. There were 219 new crisis case starts in July 2017. New crisis case starts require an assessment and response within a day of referral. The service is exceeding national targets with respect to wait times for adult Specialist Mental Health Services. The targets are 80% of people seen within 21 days and 95% within 56 days. In July 2017, 97.0% of people referred to the Adult Community Service were seen within 21 days and 99.8% were seen within 56 days. The percentages for July 2017 were 92.8% and 97.8% respectively when other adult services i.e. Specialty, Rehabilitation and Forensic were included.

• Our focus on reduction of seclusion continues. Within Te Awakura (Acute Inpatient Service) there were five seclusion events for July 2017 for a total of 118 hours. This is a positive result considering the high acuity and occupancy challenges.
• **Child, Adolescent and Family (CAF):** Reducing wait times has been a key focus for Child, Adolescent and Family services. National targets require 80% of young people to be seen within 21 days and 95% within 56 days. Our results for July 2017 show that 56.0% of people were seen within 21 days and 89.1% within 56 days. Child, Adolescent and Family Services had 257 new case starts in July 2017. School holidays are always associated with a lesser take up of appointments. Therefore those who are referred within 1-2 weeks of the school holiday are less likely to be seen during the holiday period and have to be booked after the holiday. This impacts on the 3 week target.

![Average Time (days) from Referral to Case Start for Child, Adolescent & Family Mental Health Service](image)

- The average waiting time between Choice and Partnership appointments is calculated retrospectively and has increased this month. The increase is due to CAF staff targeting the 20 consumers who had been waiting the longest period of time.

- **The School Based Mental Health Team:** The team is working with 136 schools across Canterbury, as at end July 2017. More schools are now identifying the mental health support required for their population and the team is meeting those needs through workshops, pastoral care meetings, learning and development activities for staff, and liaison and engagement with other agencies. Additional mental health funding received from the Ministry last year is being utilised to provide direct service delivery to a number of schools. An increase in support required continues in Kaikoura schools in the wake of the 2016 earthquakes. The launch of the
“Sparklers” toolkit occurred in June and was received favourably, giving schools, children and parents more resources to enhance and build wellbeing.

Older Persons Health & Rehabilitation (OPH&R)

- **Burwood Outpatients Facility**: Outpatient Infusions – identified possible capacity at Burwood by improving the scheduling efficiency. Engaging with the Strategic Group which has agreed that the best option is for all iron infusions to go out to general practice and for Burwood to gear up to the provision of selected bisphosphonates, given the higher volumes and higher level of clinical complexity of bisphosphonates. The development of a decision tree for relocation of outpatient services has been discussed and tabled with GM’s. Continuing to engage with Christchurch Hospital exploring opportunities within the existing Outpatients Facility Schedule. Currently identified streams being explored
  - Midwifery/Obstetric Services are reviewing pathways that would fit with a relocation to BWD
  - Orthopaedic Outpatients Service MOC discussions continue

- **Allied Health Assistants Graduation Ceremony – Friday 4 August**: There will be a Graduation Ceremony for six Allied Health Assistants who have completed the Level 3 Health & Wellbeing qualification. Further cohorts planned and all new staff commence the course on appointment.

- **Enable Service Accreditation Process**: The CDHB has been re-accredited for a further three years via Enable to 30 June 2020. An appointment to the Service Accreditation Trainer/Co-ordination role is imminent – interest received from Primary Care and South Canterbury DHB to participate – the role is managed in the Community Service Team. Service accreditation will be in Calderdale format to meet various campus requirements and in line with South Island

- **Older Persons’ Health Spinal Unit**: The Canterbury earthquakes resulted in significant damage to the east end of the Burwood Spinal Unit (BSU) resulting in the decision to demolish rather than repair the single rooms as part of the repair strategy. This will require the service to decant from BSU during repairs with the plan to move to ward FG during this period for up to 12 months. The decant from the ward also provided an opportunity to enable some other enhancements to be made to the unit that will enable the delivery of a modern spinal service and extend the useful life of the ward.

  - The enhancements include adding ensuites to all the single rooms and isolation facilities to reduce cross infections and improve privacy and independence, standardising the bedheads in all the rooms, providing ceiling hoists to the clinical areas, designing staff bases that enable patient care using RT2C principles, repurposing equipment and storage areas, improving patient flow in the outpatient and urology areas and enhancing the kitchen/dining areas to encourage and enable independence during rehabilitation. The BSU facilities development project progresses in parallel with the decant planning process to move from HG to FG. Process to date has enabled wide consumer engagement which has ensured at the heart of the process and model of care our consumer current and past have been able to shape and support.

- **Gerontology Acceleration Programme**: The third cohort of the Gerontology Acceleration Programme is currently undertaking their first clinical rotation to each other’s clinical settings, supported for the first time by our newly established Nurse Coordinator – Nursing Workforce Development Age Residential Care (ARC) who sits within the Nursing Workforce Development Team and works closely with the Gerontology Nurse Specialists who support ARC. Early feedback is that the RNs involved are gaining invaluable insight into each other’s areas and the patient journey across the system. There continues to be a strong linkage between the GNS team and the OPH&R Infection Prevention & Control Clinical Nurse Specialist who
provides support and guidance to ARC within her role, this has been of real value in supporting the clinical management of vulnerable older people in ARC in the contexts of advice around evidence based practice around outbreak management etc.

- A series of **telehealth charters** are under development sponsored by Chief of Service Dr Helen Skinner – for the Adult Community Services, Wound Care support for the WCDHB and CDHB, Spinal Services and Pain Management. These are being completed in conjunction with Dr John Garrett, the Telehealth team, CDHB and WCDHB Telehealth special interest group and OPH&R Leadership.

- The first charter underway is with the Adult Community Services. This aims to reduce patient wait time for services and reduce travel times for patients; increase team connectedness, collegial support and reduced need to travel for staff; and increase the ability to work collaboratively with community secondary care services and primary health care services. A pilot trial is underway across the teams to support patients using a web based platform to virtually see patients at home for 1:1 or 2:1 visits. The Older Persons Mental Health community team recently launched a virtual daily IDT to link up clinicians across three sites, aiming to roll out to a fourth site shortly to support clinical connectivity in the Hub and Spoke model and ensure efficient workflow for staff working at various sites.

- **Ways of Working – Community teams**

  - Orion, Canterbury Clinical Network (CCN) and the Way We Work workstream from OPH&R have joined together in a smaller project team to help design and plan the requirements to address these issues as part of the personalise Care Plan (PCP) development led by CCN.

  - The PCP is due to go live for Canterbury in HCS on 6th September 2017. CREST have been piloting this for a year and show promising results in being able to reduce the time for document management tasks to be completed – more data and feedback from users is being gathered presently to evaluate the effectiveness. There is significant interest from the rest of the South Island DHBs.

**Laboratory Services**

- **Electronic laboratory test requests between Canterbury Health Laboratories and community laboratories reduces processing time and error rate:** The first step in
processing a laboratory test is the specimen registration (receipt and logging of information and 
assigning tests). Currently Canterbury Health Laboratories receives 190-220 patient specimens 
per day from Canterbury Southern Community Laboratory (CSCL) for specialist testing and 
from the 17 July these specimens have been referred to CHL using the new inter-laboratory 
ordering system. Prior to the introduction of digital ordering, patient information was manually 
entered separately into the CSCL and CHL LIS systems with no transfer of data between these 
systems. The new digital system has proven to be time efficient with a 46% reduction in the 
time taken to receipt a specimen into CHL for processing. The time saved has improved the 
flow of all patient specimens through the laboratory, as resource can be redirected to other 
manual specimen registration processes. In addition, more resource is available for performing 
auditing, a key quality performance indicator for the Registration service. Inter-laboratory 
ordering has also had a positive impact on the workload of the Registration evening shift where 
staffing is limited. Further improvements to the new system are ongoing such as making the 
process paper light by the introduction of electronic transportation documents and electronic 
request form images.

- **Research grant to expedite test development for cancer diagnosis:** Michelle Burns, 
technical lead of the Surface Markers laboratory at CHL, has been granted support from the 
Haematology Research Fund. This funding will be used to expedite the development, validation 
and implementation of 10-color flow cytometry panels for diagnosis and monitoring of 
treatment response in patients with acute leukaemia (blood cancer). The new panels are based 
on those used in highly-regarded international laboratories. They will allow for more sensitive 
screening for residual disease post-treatment, helping to identify patients who may be at higher 
risk of relapse and who therefore may benefit from a more aggressive treatment course.

- **Minimising the number of blood samples required from newborn babies:** After 
collaboration between the Neonatal Unit and Haematology laboratory at CHL, reticulocyte 
(immature blood cell) counts have now been added to the routine blood counts for all neonates. 
A reticulocyte test is used to help evaluate conditions such as anaemia or bone marrow 
disorders. With very small blood samples taken from the neonates, it is important to process 
all the required tests in the one sampling opportunity to avoid the need to retake another blood 
sample. Often reticulocytes were retrospectively requested which meant phone calls and impact 
on staff members time both in the Neonatal unit and laboratory. Reporting these routinely is a 
more efficient process all round - best for system: best for patient.

- **Scientific conference highlights the importance of research in improving patient care:** 
The New Zealand Hospital Scientific Officers’ Association (NZHSOA) held its annual scientific 
conference ‘Science in Medicine’ on the 21st of July 2017 at the Beaven Lecture Theatre at the 
University of Otago, Christchurch. The NZHSOA is primarily composed of CHL scientific 
officers and the meeting was organised by these staff and further financial support was provided 
by CHL for venue hire. There were 13 oral presentations of a high standard showcasing the 
variety of ways in which patient care is improving through scientific research being performed 
within CDHB, University of Otago and other national institutions. The meeting was well 
attended by scientific officers, clinicians, university researchers and medical laboratory scientists.

- The opening lecture was given by Prof David Murdoch, Dean of University of Otago, 
Christchurch who spoke about creating a culture of research in a clinical environment as 
envisioned in the NZ Health Research Strategy 2017-2027. Prof Murdoch pointed out the 
unique environment we have in Christchurch for working together across specialities and 
institutions and the importance of maintaining and strengthening that environment. The 
meeting continued with scientific presentations, demonstrating the depth and breadth of the 
scientific work undertaken by the scientific officers at Canterbury Health Laboratories and other 
NZ laboratories, often in collaboration with university researchers.
- **Registering blood samples onsite at Burwood Hospital counteracts transit time to the laboratory:** Following the relocation of Older Persons Health (OPH) from The Princess Margaret Hospital to the new Burwood site a review was undertaken on the turnaround time (TAT) of routine blood samples from Burwood Hospital. It was predicted the TAT had increased for the OPH samples due to the increase in distance to the laboratory and reduced frequency of shuttle transport times. The data showed this prediction to be true. To counteract the transit time, two new processes were trialled, phlebotomists (technicians who perform blood collection from patients) at Burwood Hospital registered the blood specimens onsite rather than the Registration team in the CHL and unregistered Burwood samples were specifically targeted on arrival at CHL. Registering a specimen within the system involves confirming patient information and logging test requirements within the laboratory information system. Although both trials reduced the TAT, registering at Burwood had the greatest impact showing a 48 minute reduction from time of blood draw to presenting the sample at an analyser. The improved turnaround times means that results are available to clinicians sooner and critical clinical decisions are not delayed.

![Percentage of Burwood blood samples registered onsite at Burwood during four week trial](image)

- All phlebotomy staff who rotate through Burwood are now trained in registration and as they become more proficient it is expected that the number of samples being registered onsite will increase. Within the first 4 weeks we have seen a steady climb to 41% of samples being registered at Burwood. The phlebotomy staff have gained greater skills in the use of technology which is crucial with the introduction of electronic ordering in the near future. This initiative is to be rolled out to our phlebotomy staff at Christchurch Women’s Hospital and Hagley Outpatients.

### Ashburton Health Services

- **Acute Flow:** We continue to focus on Acute Flow throughout the hospital facility with the objective of ensuring that patients identified for admission are settled into the ward without delay in the Acute Assessment Unit. Alongside this both wards utilise the assertive board rounds to support multidisciplinary engagement and focus on achieving a timely patient discharge.

- Ward One and Ward Six are working together to distribute patients and staff, enabling us to manage an increase in occupancy in July and manage workforce constraints. Our goal to increase our capacity to accept transfers from Christchurch and Burwood hospitals during week and weekends continues, with a key focus of preparation for this as we enter into each weekend. The balance of Health Care Assistants and Nursing rostering as a collective hospital (as opposed to individual ward areas) is being explored as we juggle the pressure of staff required for inter hospital transfers and additional support for patients who are identified at risk of falling.
• In July we completed the RT2C Service Delivery Workshop, the focus of this workshop was to review models that:
  • Reduce unnecessary delays
  • Eliminate unnecessary duplication
  • Reduce frustration and anxiety of staff
  • Maximise the effectiveness of the process
  • Improving the experience for patients and their families

• The wards are starting to embed bedside handovers and geographic nursing in each area from this workshop. In addition to this the teams are preparing for Patient Trak with the intention to implement end of August in time for the role out of NEWS (NZ Early Warning Score)

• In addition to hospital level improvement, we are using the service improvement framework to progress the work with our Ashburton Service Level Alliance partners. The objective is to have four or five key meetings with representation from local primary care and pharmacy and hospitals/community team members, where they define the problem and propose local solutions. First off the rank is a project supporting patients who present in AAU reconnect quickly with their primary care provider.

• **Faster Cancer Treatment:** Medical Day Stay has relocated into the refurbished area previously occupied by the old Acute Assessment Unit. The new location is very spacious and provides a more comfortable environment for the provision of chemotherapy clinics and associated therapies. Oncology Clinical Nurse Specialist Jane Wright provides the local leadership for this service delivery, Jane also holds the 0.2 Nursing Research and Teaching position in the Rural Health Academic Centre (RHACA). Through this role, Jane is exploring research opportunities comparing the outcomes of patients receiving treatments in a rural setting versus an urban setting throughout NZ.

• **Primary Birthing Unit:** The Ashburton primary birthing unit has undergone recent leadership changes in one of the busiest times of the year.

  Bronwyn Torrance has been a great support for the unit as Acting Charge Midwife Manager over the past month and has been able to pull together LMC and DHB employed midwives from across the area to cover our roster during this challenging time. We are pleased to announce that Julie Dockrill has been appointed to the Charge Midwifery Manager role in Ashburton. Julie is a midwife with over 17 years’ experience in a variety of midwifery practice settings. The last 5 years she has been the Clinical Midwifery Manager in a Secondary Care
Hospital but this role has also included managing continuity of care midwives working in primary care. Julie will be starting her role with us in Ashburton on Monday 28th of August.

INTEGRATING THE CANTERBURY HEALTH SYSTEM

Acute Demand Management

- Referrals to the Acute Demand Management Service have increased with the onset of winter conditions and associated sickness. There were 8366 referrals in quarter 4 of 2016/17. Referral patterns are consistent with previous years', although chest X-rays have increased. We continue to work with the revised Acute Demand dataset to evaluate the utilisation and effectiveness of each pathway in terms of hospital avoidance.

- Winter planning across the system has resulted in greater visibility and closer monitoring of operational flows. This has been supported by a viewer in SFN that makes the plan and key measures visible to stakeholders throughout the system.

SUPPORTING OUR VULNERABLE POPULATIONS

Older Persons’ Health

- **Pay Equity:** The National pay equity settlement was implemented on 1 July 2017. There has been minimal financial disruption to the sector due to the three month front-funding provided. The front funding revenue received from the Ministry aligns with expected expenditure by providers. New contracting clauses need to be added to future service specifications to ensure increases to offset pay equity are received by the employees.

- There is continued risk for services which are provided outside of the settlement process with other unions having filed claims for equity. There is a national process underway to assess these pay equity claims. During this period there will be increased cost pressures on some providers. There have been increased requests for funding, as well as movement of staff between employers and sectors.

- The risk of staff movement from DHB to external providers remains. There has been a number of staff who have reduced their hours as a result of the additional income.

- There is currently an oversupply of approximately 980 ARC beds throughout Canterbury. The continuation of post-earthquake infrastructure rebuilds and capital expansion will see this number grow. There is concern for the viability of some smaller facilities due to low occupancy. The DHB is working to identify facilities most affected to ensure plans are in place to support the residents and the local population appropriately.

Mental Health

- The mental health system continues to respond to sustained demand, workforce, and facility challenges, in a constrained environment.

- Workforce challenges are leading to high levels of overtime in specialist mental health (SMHS) services. All options are being considered to free up nursing staff for areas of acute need.

- There is a high degree of collaboration across SMHS and NGOs to provide the best possible pathway and outcome for service users. However, the DHB is aware of the risk of increasing capacity in specialist mental health services by attracting staff from another part of the system. This is being avoided as much as possible.
• The Alcohol and Other Drug (AOD) System is working with regional partners on planning for the South Island implementation of the new Substance Addiction Compulsory Assessment and Treatment (SACAT) in February 2018. The Ministry are providing a series of information and training workshops in the coming months.

• Specialist Mental Health Services – Child and family services (CAFS) and planning and funding are in discussion with a provider regarding community-based support options for children (under 13) and families. The team is building options to sit alongside CAFS for children and families to address their needs in a timely way and to improve access to specialist services. This has been identified as a high need, given current demand for community services for this age group.

• A working group with a combined membership from the Canterbury Clinical Network Child and Youth Workstream and Mental Health Workstream is being established to focus on the needs of children.

Child and Youth Health

• Vulnerable children and young people: Work continues on a number of themes around vulnerable children and young people.

• The Children’s Team Governance Group (CTGG) held a workshop in July to review the effectiveness of the Children’s Team in Canterbury now that it has been operating for 18 months. The workshop identified a need to reduce the emphasis on procedural and transactional requirements in favour of freeing up lead professional time to care for children and families. A roadmap to guide future service delivery is in development. It should be noted that Canterbury has the largest implementation of the Children’s Team in terms of volumes (691 since inception) and geographical coverage having deliberately extended services to North Canterbury and Ashburton.

• Funding has been provided to appoint a regional coordinator to assist DHBs to reduce sudden death in infancy (SUDI) rates. The new position will be based in the South Island Alliance Programme Office (SIAPO) and will assist Canterbury and the other four South Island DHBs to develop interventions.

• A new Child and Youth Health Workstream project group has been established to explore ways in which health education, understanding and provision of services to transgender children and young people can be improved.

• A joint initiative between the DHB and Te Pūtahitanga has been put in place to support Maori mothers under the age of 19 receiving Whanau Ora support. This work is linking into collaboration with the Canterbury Police who have identified the importance of collective work and social interventions to improve outcomes for the most at risk populations.

Primary Care

• Smoking Cessation: Te Ha Waitaha is experiencing a rapid increase in referrals to the service from the wider health sector now that the service is fully established. When the service started with a small compliment of staff, it received around 80 referrals per month. Current indications are that the service received over 450 referrals for the past two months. Analysis of this will take place during the quarter 4 reporting for 2016/17 later this month.

• As part of the variation for the Community Pharmacy Services Agreement (CPSA) for 2017/18, some community pharmacies will soon be motivating smokers to attempt quitting then referring these people for ongoing help with Te Hā - Waitaha’s stop smoking practitioners.
• At a national level PHARMAC is now consulting on a proposal to allow pharmacists to supply funded nicotine replacement therapy (lozenges, gum, patches) without prescription. This would improve access for smokers, especially those on low incomes, making quitting attempts easier and hopefully more successful.

• System Level Measures Framework: At quarter four 2016/17, Canterbury DHB met three of the four agreed milestones outlined in the 2016/17 Improvement Plan. While the 0-4 year old Ambulatory Sensitive Hospitalisation (ASH) rate milestone was not met, Canterbury’s rate remains significantly lower than the national average and continues to trend downwards.

• The final draft 2017/18 SLM Improvement Plan submitted to the Ministry of Health on 30 June following its endorsement by the CCN Alliance Leadership Team.

• In response to feedback received from the Ministry, changes to the Babies in Smokefree Homes Measure are being finalised and were resubmitted on 4th August. The relevant alliance workstreams have worked alongside the Systems Outcomes Steering group in response to this feedback.

• A co-creation workshop was conducted with Pasifika Futures (the whanau ora funder for Pasifika), E-Tu, Pasifika people, and stakeholders in late July. The focus was on developing new models for collective impact on the wellbeing of Pacific populations in Canterbury. Integrated approaches were at the heart of this workshop with models to be further developed. The proposed outcome will be a co-funded integrated whanau ora and health service delivery model

• Continued progress has been made with the ABC primary care health target. Although we are awaiting confirmation, initial results indicate general practice has reached the 90% target for the first time.

Integrated Family Health Services and Community Health Hubs

• The ‘principles of integration’ are guiding discussions on health service delivery in rural areas where locally led service reconfiguration is being implemented.

• Akaroa: The Trustees of the Akaroa Community Trust have been appointed along with the Directors for the intended provider, Akaroa Health Hub Ltd (AHHL). Resource consents for the new facility have been lodged. If consents are approved, the full design is expected to be finalised by the end of July with building consent lodged shortly after. It is anticipated construction tenders will be awarded before the end of the year. This requires the current facilities to be removed from site and the Akaroa Health Centre to be temporarily relocated while construction takes place.

• Kaikoura: The next stage of integrating the DHB service with the general practice is to review the nursing roles across the site. The new Health Services Manager and Charge Nurse Manager have continued to develop an integrated team. New leadership arrangements are being developed.

• Hurunui: The Hurunui Health Services Development Group continues to prepare their vision for services in the region. It is anticipated the high level Model of Care will be presented to ALT in September, prior to full consultation. The Model of Care includes a recommendation to establish an observation service in Amberley to reduce patient flow and transfer into Christchurch Hospital. After-hours district nursing and other alliancing arrangements are being developed.

• Oxford: The group has actively identified opportunities, challenges and enablers where service improvements can occur. Focus is currently on the patient journey and the development of pathways for youth and mental health patients. As Waimakariri has health services in both Oxford and Rangiora, consideration is being given to how decisions may affect the wider
Waimakariri health service, including the Rangiora Health Hub, telemedicine, and after-hours projects.

Maori and Pacific Health

- **Penina O Le Pasifika**: Penina o le Pasifika (Pearls of the Pacific) promotes the Like Minds Like Mine philosophy, targets Pacific Youth in Christchurch to reduce stigma and discrimination associated with mental illness. Penina o le Pasifika delivered by our Pasifika provider, Tangata Atumotu and supports a number of activities and events while delivering this service.

- **Music Video Production**: A two-year workshop series with Pasifika Year 9 and 10 students at Catholic Cathedral College culminates with a music video production this school term. The students draw from what they have learned about mental health and the stigma and discrimination associated with mental distress, and express it in the form of a music video. The students have written an original song, Blazing Roses, with the help of a music mentor from the Ara Music Arts programme (formerly known as the New Zealand Jazz School). The objective of this project is to give authentic voice to Pasifika youth in raising mental health awareness; to create a mental health promotion resource, which is meaningful to Pasifika peoples; and provide a platform for our young people to develop their natural talents in performing and visual arts. The video will be published widely on social media and used as an educational resource in the community. Its public release is scheduled for the Pasifika Community Event (see below).

- **Pasifika Community Event**: At the end of October, Tangata Atumotu Trust presents You and Me, a Penina o le Pasifika mental health event at the Haeata Auditorium. The evening will bring Pasifika youth, their families and communities together to hear inspirational stories from people with lived experience of mental distress in a culturally appropriate and safe setting. You and Me promotes the idea that social inclusion and positive attitudinal and behavioural change towards those living with mental distress, starts by reaching out with compassion to just one person. Live entertainment and multi-media presentations will also relate to the theme. The finale of the evening will be the public release of the Blazing Roses music video by Catholic Cathedral College students (see above).

- **Community Radio**: Tangata Atumotu Trust recognises the large Samoan audience tuned in to the various Samoan programmes on Plains FM 96.9 and seeks to not only capitalise on this as a communication medium, but to expand to a pan-Pasifika audience through its show, *Nesia Now*. A resident segment on *Nesia Now* is Penina o le Pasifika which facilitates interviews and panel discussions on mental health-related issues. Local Pasifika people share their own lived experiences of mental distress on-air, and discussions that question and challenge beliefs, and expert knowledge is shared by an executive member of the NZ Association of Counsellors.

- **Sound to Screen Production**: A four-episode radio drama was devised for broadcast on *Nesia Now* (and before that, Hamo at Heart) on Plains FM 96.9. The bilingual story centres on a Samoan family coming to terms with their son’s diagnosis of depression and addresses mental health issues from the individual perspectives of each character – the traditional parents, their NZ-born children and a palagi friend who also lives with mental distress. Funding has been approved in principle to adapt the radio drama to film and pre-production is currently underway with filming scheduled for January 2018. Local Samoan actors will be cast in the film. It is hoped the film will be considered for the Like Minds Like Mine nationwide campaign and broadcast on television.

- **Supporting Pasifika Youth Initiatives for Mental Wellbeing**: Tangata Atumotu Trust recognises the creative arts as a powerful outlet and vehicle to healing and wellbeing, for people who live with mental distress. Pasifika youth in Canterbury have very limited access to professional development in the arts. In July, Penina o le Pasifika sponsored a Youth
Scriptwriting and Performing Arts workshop for Maori and Pasifika, led by two of New Zealand’s top practitioners, Victor Rodger (playwright and Shortland Street writer) and Anapela Polataivao (New Zealand’s theatre director of the year 2016). The event was organised by the Centre of Contemporary Art and local Pasifika writers’ collective, FIKA Writers. The other sponsors were Creative NZ and the Tautai Trust.

- **Waitaha Suicide Symposium:** The Waitaha Suicide Prevention Action (WSPA) Group brings to you their 3rd Annual World Suicide Prevention Day Symposium in September. The symposium will be led by our Māori provider He Waka Tapu. This symposium is for all people, to inform and equip workers, managers, whānau, friends, neighbours, business owners and colleagues with the right information on dealing with suicide related issues.

- **Te Puna Oranga Kaumātua Event:** Te Puna Oranga is a community social service provider in Christchurch. At a recent kaumātua lunch event in July a health check and vaccination service was provided. It was challenging to organise with 13 kaumātua vaccinated for influenza and more than 20 blood pressure checks completed. Most people who hadn’t had the influenza vaccination either said they couldn’t afford the doctor’s visit or that they thought the vaccination would give them the flu. So we took the opportunity to inform/educate kaumātua about how the flu jab works and the importance of having it. A few high blood pressure readings were referred to their general practice. Taking the blood pressures was also a good opportunity to talk about the importance of diet and exercise.

- **Promotion of Healthy Environments & Lifestyles**
  - **All Right? social marketing campaign update: All Right? Parenting Portal**

The new All Right? Parenting Portal (web-based) brings together useful tips and tools for surviving the ups and downs of parenting. The Parenting toolkit includes information about nearly 70 free Canterbury parenting courses, provides downloadable ‘routine’ charts, and offers many school holiday activities suggested by parents, along with numerous fun, wellbeing boosters for the whole whānau.

Parenting guides have also been developed on some of the issues parents often ask about, such as helping children to be grateful and kind, manage their worries and keep calm. Guides to support parent wellbeing are also available. The Parenting portal is available at: [https://www.allright.org.nz/tools/parents/](https://www.allright.org.nz/tools/parents/)
• **Reducing Alcohol-related harm:** On 7 July the tri-partite (Christchurch City Council, Police and Canterbury District Health Board) Christchurch Alcohol Action Plan working group coordinated a breakfast and workshop to present the draft Alcohol Action Plan. The day also featured Dr Taisia Huckle, of the Shore and Whariki Research Centre at Massey University, who spoke on alcohol availability and social supply. The day was primarily coordinated by the CPH working group members with the assistance of HPA (as funder). The breakfast and workshop were well attended by a range of individuals and organisations from across the local alcohol sector, including some councillors, Canterbury District Health Board senior managers and senior members of the Police, together with treatment providers and organisations who have identified alcohol as contributing significantly to harm (e.g. The Cancer Society, and those working in the area of family violence). Positive feedback has been received from those in attendance. The collated feedback on the draft plan will be used to inform the revision of the draft prior to circulation of a final draft Alcohol Action Plan.

• On 14 July CPH Health in All Policies Advisor Bronwyn Larsen presented the draft Health System Strategy to Reduce Alcohol-related Harm at the Canterbury District Health Board’s Grand Round. This presentation included information regarding the harm alcohol causes nationally and within the Canterbury health system, and addressed the need for the strategy to engage the whole health system in collectively reducing harm from alcohol through utilising different approaches. The presentation also encouraged each clinician, through their everyday efforts, to contribute to change through knowing the facts about the impact of alcohol and engaging with their patients about the issue.

• **The Integrated Assessment of the Red Zone regeneration Plan:** Community and Public Health staff have been part of the core team working alongside Regenerate Christchurch to prepare and deliver the Integrated Assessment on the Red Zone Regeneration plan for the Avon corridor. At the first workshop invited members identified criteria against which to assess the outcomes of the final plan. This included such things as accessibility, connections to existing and wider communities, being financially accessible, meeting high ecological standards and delivering a positive experience. A second workshop was recently held to consider the early drafts of three design plans and to assess them against the initial criteria. The outcome of this process was strong feedback for the designers to incorporate in the plans prior to their being released for community input at the end of August. Community and Public Health staff have helped to ensure a Health in All Policies approach through the process. In addition, the contribution by CPH staff (including facilitation skills and community knowledge) has been acknowledged by Regenerate Christchurch as having contributed positively to the Integrated Assessment process.

• **Drinking Water – Havelock Inquiry:** In September 2016, the Government established an Inquiry into Havelock North Drinking Water under the Inquiries Act 2013 after an outbreak of gastroenteritis in Havelock North (August 2016). The Inquiry has proceeded in two stages. Stage 1 of the Inquiry focused on identifying what happened, what caused the outbreak, and assessing the conduct of those responsible for providing safe drinking water to Havelock North. Stage 2 of the Inquiry will address lessons learned for the future and steps to be implemented to reduce the likelihood of such an outbreak occurring again. The Inquiry has produced an extensive list of issues that may be considered as part of Stage 2 of the Inquiry and has invited submissions from interested parties. The CDHB made a submission on Stage 2 which was well received and the work has been complimented by the Inquiry. The CDHB submission was also shared with other District Health Boards who made reference to our submission in their submissions. Our submission was a technical submission compiled by the Protection Team at Community and Public Health. It was written by Drinking Water Assessors (DWAs), Health Protection Officers and Medical Officers of Health whose responsibilities include ensuring that the drinking water provisions of the Health Act are complied with.
• The CDHB submission covers a wide range of topics specific to the management of drinking water across the system. The key recommendations made in the submission include:
  • That all water suppliers should employ a risk-based multi barrier approach to managing water supplies which prioritises the risk to public health.
  • Support for retaining the role of the DWA within the Public Health Unit / District Health Board environment.
  • Recommending specific changes to improve the enforceability of Water Safety Plans
  • Recommending that the robustness of the drinking water system could be improved by the development of a national enforcement strategy.
  • Recommending the inclusion of an emergency response section to each WSP that outlines the response measures specific to the supply and that this be linked to a wider organisation-level Emergency Response Plan.

• Drinking Water – Canterbury Drinking Water Reference Group: Following the drinking water contamination incident in Havelock North and the subsequent Government Inquiry, Canterbury local authority Chief Executives formed a Canterbury Drinking Water Reference Group. The group comprises representatives from all Canterbury territorial authorities, Environment Canterbury and the Canterbury District Health Board including Community and Public Health’s Drinking Water Assessors and a Medical Officer of Health. This group made a joint submission on Stage 2 of the Havelock North Inquiry. Positive comments were made by the Inquiry regarding the formation of this joint working group.

SUPPORTING OUR TRANSFORMATION

Effective Information Systems

• HealthONE
  • HealthONE went live in Nelson Marlborough DHB – resulting in Primary, Secondary and Community information now being available in the form of a single Electronic Health Record across the entire South Island. The system holds records for nearly a million people. The South Island is the first region in New Zealand to have this functionality.

• South Island Patient Information Care System (SIPICS)
  • The SI PICS software in patient module went live on 22nd July at Older Persons Health and Rehabilitation division surgical and spinal services.

• Electronic Medicines
  • Med Chart is being implemented into Rangiora and Lincoln Maternity units
  • Planning continues for the upgrade to ePharmacy
  • An upgrade to MedChart is being planned with the vendor

• SIP (Operation Switch)
  • 2500 mobile connections now completed migration to Vodafone. Remaining users on Spark are being contacted and working through any barriers to them migrating to Vodafone.
  • Outbound calling for fixed lines has been cutover to Vodafone circuits for all main hospital sites. Christchurch Hospital was cutover on 22 June.
COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Internal/ external Communications Projects

- During the first week of July small celebration events were held with the new Canterbury DHB WellFood staff at Burwood, Christchurch, Hillmorton and Ashburton where GMs welcomed them to the DHB and thanked them for their work which resulted in a smooth transition from Compass Medirest to Canterbury DHB management.

- Work continues on developing an internal communications strategy, developing new guidelines for Canterbury DHB’s various online and social media channels, and supporting quality improvement initiatives such as the new Early Warning Score framework being introduced next month.

- Weather events saw the communications team step up internal communications to keep staff informed of planning for the snow which hit Canterbury in July, this was followed the following week by the floods. There was significant internal and external communications involved during and after the floods.

- Media: A large number of complex queries were received and these have required considerable research and collation. In total more than we responded to more than 130 media requests. We also worked with reporters from The Press and The Listener setting up interviews and providing information on features on our mental health services and funding. There was considerable media interest following the release of OIA documents about Canterbury DHB by the Treasury and this also triggered a number of requests for information and interviews. The focus was on the relationship between the Ministry of Health and the Canterbury DHB and the intricacies of funding.

- Several proactive/positive media releases were issued which resulted in two ‘good news’ stories on TV3 (the new paediatric respiratory box and the launch of WellFood), the NZ Herald picked up our patient story promoting head and neck cancer awareness and this resulted in numerous positive local story appearances in print and radio media. We also issued a media release on how Canterbury people can access health advice from their favourite chair by calling their own general practice team phone number 24/7 for #carearoundtheclock. After-hours calls are answered by a nurse who can provide free health advice. If a person needs to be seen urgently, the nurse will advise on what to do and where to go.

- Other media queries were received on several common themes:
  - Mental health staff vacancies, funding and stranded services at The Princess Margaret Hospital
  - Passive fire protection within our Canterbury DHB buildings
  - Wait times for a number of different elective services/specialities, including bowel screening programmes, MRI scans for people with multiple sclerosis.
  - Parking and shuttles for staff and patients
  - Regular appearances on the Chris Lynch/Newstalk ZB have included Alistair Humphrey on sexual health, staying well this winter/influenza immunisation, how to clean up after the floods.

- Facilities Redevelopment – our regular communications channels have been kept up to date.

- Acute Services building (ASB):
  - Communications developed for a trial staff Park & Ride service – launched on July 10 and updated with a new timetable at the end of the month following staff feedback.
• Ongoing work with Christchurch Campus staff to communicate changes and forthcoming works on the ASB site including new timelapse videos of the site.
• Ongoing work communicating other site activity related to the ASB build, including temporary boilers and tunnel work, mostly via the daily global comms update.
• The Minister of Finance, Steven Joyce visited the site to check on progress.

• Christchurch Outpatients:
  • Development of communications material for the Christchurch Outpatients Paperlite workstream, including CEO update pieces. Paperlite is the main focus of the Outpatients communications for August 2017.
  • Assistance provided with Canterbury DHB’s submission on the roading layout around Hospital Corner, currently under public consultation by Otakaro.
  • Beginning process to assemble and create staff orientation materials for the new facilities in conjunction with Health Educator team.
  • Video clips were produced to assist staff with Dump the Junk/Five S processes in preparation for migration to new facilities.

• CEO Update stories:
  • Fifteen probable new cases of leprosy were found at a skin clinic in Kiribati attended by two Christchurch clinicians. University of Otago and Canterbury DHB Infectious Diseases specialist, Stephen Chambers, Dermatology Registrar Emma Trowbridge, and Older Persons Health Clinical Assessor, Jude Baker, along with two other New Zealand doctors were part of a group of medical practitioners who travelled to Kiribati to participate in a skin clinic organised by the Pacific Leprosy Foundation (PLF).
  • The Burn Support Group Charitable Trust has donated two large recliner chairs to Ward 20 to provide some extra comfort to patients and their families going through the intensive treatment and rehabilitation from burn injury. Ward 20 is the Regional Burn Unit for the South Island, except for patients at Nelson and Marlborough DHB.
  • Four departments at Christchurch Hospital have welcomed new clinical directors (CDs) this year. David Richards is the new CD of the Emergency Department. Ashley Padayachee started as CD of the Anaesthesia service on June 6. The Urology Service welcomed Sharon English as its new clinical director on June 12. Tim Beresford is the new CD of Vascular Surgery, he started in the role in January.
  • Christchurch Hospital Mail Room Clerk Katie Morris has been selected for the New Zealand 21 and Under Indoor Cricket team to play at the prestigious World Cup 2017 in Dubai.
  • Improving the care of frail older people is the aim of a joint University of Otago and Canterbury DHB project starting in January next year to be funded by the Health Research Council. Called ‘Using the InterRAI to improve identification and management of frailty’, it will be led by the University of Otago in collaboration with Canterbury DHB. Senior Lecturer in Medicine at the University of Otago and Consultant, Older Persons Health, Hamish Jamieson, is behind the Health Research Council funded $1.2 million project, on which General Manager, Planning and Funding, Carolyn Gullery is a named investigator.
  • New Orderly Supervisor Leeann Johnson is the first orderly to have received a promotion to supervisor position since new orderly qualifications were introduced. Leanne has qualified as an orderly supervisor after passing the New Zealand Health and Wellness for Orderlies Level 3 Careerforce certificate. She began working as an orderly in May last year and started the course in August, finishing it in just two months – most people take nine. She started her supervisor training at Christchurch Hospital in February this year and officially took up the new role on Thursday 6 July.
• Physiotherapy Liaison with the Canterbury Initiative, Graeme Nuttridge, made a significant contribution to health in New Zealand. Sadly he passed away recently after a short illness. He was 57. Graeme joined the Canterbury Initiative team in 2012.
• Mark Leggett is the new South Island Alliance General Manager. His career spans 30 years of clinical and executive management including time as General Manager of Christchurch Hospital.
• Te Panui Runaka – Ngai Tahu Magazine: Canterbury DHB has a regular feature/ad in each issue of Te Panui Runaka. A recent story focused on the Whānau Wellbeing Collaborative. Over the past two years a group of passionate kaimahi have worked closely together to celebrate the power of family and the everyday magic that happens within whānau. The Whānau Wellbeing Collaborative is made up of representatives of All Right?, Pegasus Health, the School Based Mental Health Service, and Community & Public Health, have worked together to develop and promote resources designed to boost whānau wellbeing. Previous focus groups, work alongside tamariki and feedback from whānau has guided the collaborative to develop a range of activities for the home, schools, and other places where families live, work and play. Matariki calendar.
• All Right?’s popular Whānau Effect activity cards, Sparklers, which consists of 36 activities that teachers can use to help their Year 1-8 students feel calmer, happier, and more ready to learn, and All Right Parenting has been developed. The online toolkit contains useful tips and tools for surviving the ups and downs of parenting.

PEOPLE AT THE HEART OF ALL WE DO

• The People and Capability team is focused on ensuring people are at the heart of all we do. Our programme of work (below) supports this goal and ensures we continue:
  • Doing the basics brilliantly.
  • Growing individual and team capability.
  • Enabling the wellbeing of our people.
  • Supporting the delivery of care.
• The current summary work programme is detailed below.

Wellbeing, Health and Safety

<table>
<thead>
<tr>
<th>Key initiatives</th>
<th>Due</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance our Health and Safety system</td>
<td>2017: Q4</td>
<td></td>
</tr>
<tr>
<td>Develop a People Strategy</td>
<td>2018: Q1</td>
<td></td>
</tr>
<tr>
<td>Enhance Occupational Health and Injury Management Services</td>
<td>2017: Q4</td>
<td></td>
</tr>
</tbody>
</table>

• The health and safety policy framework is about to be released for consultation, with the alignment, review, migration of documentation underway. Detailed work in terms of contractor management will commence shortly. A process continues to be developed to confirm designated work areas and the roles and responsibilities within these.
• As discussed and confirmed at the June Board meeting, the General Manager People and Capability will work with the Executive Management Team and other key stakeholders to
develop an organisational People Strategy that is broader and more ambitious than the previously signalled Wellbeing Strategy.

- The People Strategy is expected to be completed in Quarter 3 [July – September 2017], followed by the development of a work programme and metrics in Quarter 4 [October – December 2017].

- Phase one of the Occupational Health and Injury Management project has been completed. This included:
  - Establishing the Steering Group
  - Gathering relevant national and international literature in relation to Occupational Health Services
  - Gathering relevant information related to the existing work programme of the Wellbeing, Health and Safety team
  - Gathering relevant workforce data – both locally and nationally
  - Linking with the People Lifecycle Review.

**People and Capability Services**

<table>
<thead>
<tr>
<th>Key initiatives</th>
<th>Due</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redesign the employee lifecycle</td>
<td>2017: Q2</td>
<td>●</td>
</tr>
</tbody>
</table>

- Implementation planning continues, which includes the prioritisation of over 1,000 business requirements and the mobilisation of the next phase.

**People and Capability Operations**

<table>
<thead>
<tr>
<th>Key initiatives</th>
<th>Due</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design a policy framework and renew People and Capability policies</td>
<td>2017: Q2</td>
<td>○</td>
</tr>
</tbody>
</table>

- Planning for the development of our three people foundation policies has begun. A draft engagement framework has been developed and will be piloted during August prior to finalisation.

**Organisational Development**

<table>
<thead>
<tr>
<th>Key initiatives</th>
<th>Due</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and deploy leadership and talent framework</td>
<td>2017: Q4</td>
<td>●</td>
</tr>
</tbody>
</table>

- An 18 month plan to deliver our commitment to grow widely distributed clinical and operational leadership is being developed. This includes:
  - Investing in, and driving, capability development for line managers:
    - Management essentials; Leadership essentials; and Xcelr8 refresh
    - Online access to information, resources and tools; supported by content on HealthLearn and regular ‘People Academy’ sessions; and with specific development provided internally or by external providers
  - Building leadership capability on the job while targeting support for major change:
○ Initial areas of focus will be the Christchurch Campus [due to the largescale change on the horizon]; Specialist Mental Health Services – given the range of issues and pressures]; and ISG [given their role as a critical enabler of much that we do].

○ Implement an organisational approach to identify and share talent, and develop leadership, that is available to everyone

○ Common platform for leadership development; shared approach and tools for identifying and developing talent; and agreed mechanisms for enabling talent to move to where it makes greatest impact

FACILITIES REPAIR AND REDEVELOPMENT

General Earthquake repairs within Christchurch campus

○ Injection grouting of floors and walls. As new work commences additional grouting is being identified. This will be addressed accordingly.

○ A business case to develop a design solution for EQ prone Parkside Panels has been approved. The work has some urgency as some panels must be removed prior to construction of the ASB Western Link Bridge.

○ Repairs of seismic joints throughout the Christchurch site largely complete.

○ The final Parkside stair (No.4) has been completed.

○ Clinical Service Block roof strengthening above Nuclear Medicine: The business case has been approved and a Project Manager has been identified.

○ Clinical Service Block: Ground floor fire wall to corridor outside Pharmacy from north end to south. Work to protect ducting on Bone Shop side has commenced with completion of these complicated services nearing completion. This work has been held up due to the requirement for the work to be done at night. This work is currently 90% complete. Fire protection around server room is currently being rectified.

○ Design and planning underway for Labs Stair 3 (south-west corner). Business case for remaining work to stair 3, stair 4 and panels has been submitted.

○ Concept Design for strengthening of Parkside link to CSB is complete and is currently being priced by the Quantity Surveyor.

Christchurch Women’s Hospital

○ Stair 1 repairs: works continue to track well. Expected completion of this stair is the end of July 2017. Minor painting and cosmetic works nearing completion.

○ Stair 2: Planning and risk assessment completed with an additional review by Fire Engineers as part of Passive Fire Programme underway.

○ Level 5: Small amount of work to corridor unable to commence due to operational constraints (NICU). Working with teams to identify a suitable time.

○ Level 3: Essential slab repairs has commenced. Clinical restrictions continue to make access difficult. Meeting with staff to work through the issues.

○ Survey of windows: Planning for rectification has been hampered by competing projects and multiple work faces. Once final costings have been finalised a business case will be required for approval to proceed.
Other Christchurch Campus Works

- **Main Campus Fire Engineering.** Stage 1 investigation work complete; Stage 2A “Stop the Rot” programme has been approved by the Facilities Committee and Board; 2B risk analysis work has commenced on Christchurch Woman’s Hospital. Stage 2A works commenced, which includes contractor RFP and accreditation requirements. The final design of the contractor competency test rig has been completed and is currently being priced prior to construction at the Design Lab.

- **Christchurch Hospital Campus Energy Centre:** This is managed by the Ministry of Health (MoH). Tunnel works contract awarded to Dominion Constructors. Construction has commenced. Programme is extremely tight. Concept plan for the new energy centre is nearing completion. Delivery dates are yet to be advised by the MoH.

- **235 Antigua St and Boiler House.** No work to be undertaken until boiler requirements have been resolved for the new energy centre.

- **Parkside renovation project to accommodate clinical services, post ASB (managed by MoH):** Health planners appointed and planning underway. This project is being managed by the MoH with close stakeholder involvement from the CDHB. Still waiting on advice from MoH as to outcome of master planning process.

- **New Outpatient project (managed by MoH).** Structural steel 95% erected. Concrete floors being progressively poured. First fix services commenced. Final report on safety incident issued to MoH.

- **Avon Generator Switch Gear and Transformer relocation.** Feasibility work underway. Awaiting confirmation form GM that reallocation of space in LGF Parkside is acceptable.

- **Christchurch Hospital campus flood mitigation and lateral spread requirements:** Practical completion has occurred. New stairs for the ED carpark are undergoing final adjustment. Landscaping partially complete with balance to occur in early spring once Lyttelton Engineering vacate site. Adjustment to kerb line to accommodate larger BOC oxygen tanker currently in design stage. Final account for cost allocation to MoH still to be agreed.

- **3rd Feeder.** DHB campus works complete. Orion street works complete. Changeover delayed by Maintenance and Engineering as they did not want to reconfigure the network during the Orion control period months. This delay has added approximately $10K to the cost. Work scheduled for September/October.

- **Otakaro / CCC Coordination.** Otakaro works on Avon River Precinct (ARP) to start end August on Oxford Terrace/Montreal/Antigua St. An Accessible City works on Tuam St/St Asaph St to start August. Oxford Terrace (gap) between OPD/Hospital design recommenced.

**Burwood Hospital Campus**

- **Burwood New Build:** Handover from MoH to Site Redevelopment to manage defects liability period has commenced. Practical completion and code compliance have both been achieved. Currently awaiting outcome of passive fire review.

- **Burwood Admin old main entrance block:** Additional damage following Kaikoura Earthquake has occurred. Further structural and QS advice suggests the building is no longer economic to upgrade. This may affect decision making on the future of this building. Master Planning review with key stakeholders was undertaken on 9 June. Feasibility of minimally invasive ground improvement is currently being investigated. Options for new build for Mini Health precinct also being developed.
• **Tapper & Milner Units**: Documentation issued to Council for removal of EQ prone notice received 11 July 2017. Both have now been removed from EQ list held by CCC.

• **Drainage repairs**: 90% complete. Contractor has remobilised on site and commenced work. Expected completion is December 2017.

• **Spinal Unit**: Design and user group process continues. Detailed design commenced.

• **Burwood Birthing/Brain Injury Demolition**: Methodology to be agreed. Reviewing work required to demolish building whilst maintaining a service duct located under the building. Existing switch board, servicing other parts of the campus, will need to be relocated and/or re-routed to allow demolition to commence. Price being received from market with diversion work to start shortly.

• **2nd MRI Installation**: Design work and planning underway. Equipment being ordered to relocate MRI scanner from Merivale to the 2nd scanner room in Radiology in Burwood. Serious issues are being experienced due to subcontractor performance around the Faraday cage installation and the general building works required for installation of the MRI.

Hillmerton Hospital Campus

• **Earthquake works**: No earthquake works currently taking place. This will be reviewed once the outcome of the TPMH mental health business case has been advised.

• **Food Services building**: A review will be commencing shortly to identify the requirements and scope the project.

• **Cotter Trust** on-going occupation being resolved as part of overall site plan requirements.

• **Mental Health Services** – Review of all Forensic services including PSAID, AT&R, Roko being completed, including refurbishment verses rebuild cost and logistic process. Awaiting results of clinical review. Roko/Manaaki High Care Unit on hold until master planning has been agreed.

The Princess Margaret Hospital Campus

• **West Spoke for Older Persons Health (OPH) community team relocation** – options still being investigated by the service.

• Mental Health Services relocation –Canterbury DHB is continuing to refine the options and re-review the Indicative Business Case (IBC) as a result of a request for further information from the MoH.

Ashburton Hospital & Rural Campus

• **Stage 2**: Building works are complete. Final claim to be received from builder.

• **Stage 1**: The building is completed and operational. With final claim for this separable portion submitted for approval.

• **Tuarangi Plant Room**: upgrade of access and egress systems. Discussion with specialist Health and Safety consultant has revealed that further analysis is required around the concerns of M&E personnel. Once completed a design can then be drawn up and costs calculated.

Other Sites/Work

• **Akaroa Health Hub**: Detail design is progressing. Resource consent has been lodged with CCC.

• **Kaikoura Integrated Family Health Centre**: Code compliance received. Scoping of cosmetic damage due to November’s Earthquake is complete. Estimates provided to Corporate
Finance. Final design works for remedials to adjoining neighbours drives have now started. These had been stalled due to EQ issues in the area.

- **Rangiora Health Hub**: Stage 3, which involves the relocation of the single story outpatient’s facility to Rangiora, was approved at the July 2017 Board meeting. Planning is underway. Commencement dates are subject to confirmation from MoH regarding the completion of the new Outpatients building. At this time, the Hagley building is required to be off the Christchurch Hospital Campus before 31 March 2018 to meet MoH ASB project time frames. However, this cannot happen until St Andrews Outpatients is complete and occupied.

- **Former Christchurch Women's Site**: Evaluation of Park and Ride options complete. No other work currently being undertaken.

- **Home Dialysis**: Concept design being undertaken to enable pricing and subsequent business case for approval. Mock up complete at the Design Lab. Concept plan now with Fire and Mechanical Engineers for comment before going to QS.

- **SRDU**: Project Management Office manuals re-write and systems overview. Approximately 25% complete.

- **Seismic Monitoring**: RFP documentation being developed.

**Project Programme Key Issues**

- Additional peer reviews of Parkside and Riverside structural assessments are being undertaken by the MoH. This is further pushing out the already protracted master planning process. This continues to push out the programme for work generally, which continues to add risk outside the current agreed Board time frames.

- Access to NICU to undertake EQ repairs to floor continues to push out due to access constraints.

- Passive fire wall repairs continue to be identified as EQ work is being carried out. Repairs to these items are being completed before the areas are being closed up, but the budget for this has not been formalised. On-going repairs of these items, while essential, continues to put pressure on limited EQ budgets and completion time frames.

- General consultant performance for structural assessment and design is slow and is being affected by recent earthquakes in other regions. SRDU are actively chasing consultants to improve performance.

- Uncertainty of delivery of MoH projects is affecting our ability to programme projects and allocate resources efficiently. Rangiora is one example in this space.

- Proposed ASB Western Link – a number of constraints and issues have been identified by CDHB and these are being worked through with assistance from SRDU. The requirements of additional decant space, the responsibility for undertaking the work and payment of costs is still to be addressed by the MoH as they are an ASB related project work face.

- **Burwood 2nd MRI**: Looking at alternative suppliers to complete this work due to poor performance from current sub-contractor. The use of an alternative contractor will create additional budget pressure due to existing agreements. The recovery of costs from the Faraday cage in the CSB needs to be considered with any new subcontract proposal.
DELIVERY AGAINST THE NATIONAL HEALTH TARGETS

Quarter four 2016-17. These results are preliminary and may change.

<table>
<thead>
<tr>
<th>Target</th>
<th>Status</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shorter Stays in ED</td>
<td>×</td>
<td>Canterbury just missed out on achieving the Shorter Stays in ED health target in June, with 94.4% of patients admitted, transferred and discharged from our emergency departments within six hours against the 95% target.</td>
</tr>
<tr>
<td>Improved Access to Elective Surgery</td>
<td>✓</td>
<td>Canterbury achieved the Improved Access to Elective Surgery health target, delivering 21,456 electives discharges. The DHB achieved yellow status for both ESPI 2 and ESPI 5 in June.</td>
</tr>
<tr>
<td>Immunisation</td>
<td>✓</td>
<td>Canterbury achieved the Immunisation health target with 95% of eight-month-old babies fully immunised. Coverage for Māori children increased to 92.2%. Canterbury was again among the highest performing DHBs.</td>
</tr>
<tr>
<td>Better Help for Smokers to Quit – Primary Care</td>
<td>✓</td>
<td>Canterbury met the Better Help for Smokers to Quit – Primary Care health target with 90% of PHO enrolled patients who smoke having been offered help to quit within the last 15 months.</td>
</tr>
<tr>
<td>Faster Cancer Treatment</td>
<td>✓</td>
<td>Canterbury met the Faster Cancer Treatment health target with 85.5% of eligible patients receiving their first cancer treatment within 62 days of being referred with a high suspicion of cancer. Target was also met for the 31 day measure with 87.1% of eligible patients receiving their first cancer treatment within 31 days of agreeing a treatment plan with their clinician. From 1st July, both targets increased to 90% and will now exclude patients who choose to delay their treatment or whose treatment is delayed for clinical reasons.</td>
</tr>
<tr>
<td>Raising Healthy Kids</td>
<td>✓</td>
<td>Canterbury met the Raising Healthy Kids health target with 95% of four year olds in or above the 98th percentile for their weight referred for healthy lifestyle advice/intervention. Uptake of one of the support options, Active Families, has seen the target exceeded by 28% this year.</td>
</tr>
</tbody>
</table>
LIVING WITHIN OUR FINANCIAL MEANS

Live Within our Financial Means

- The consolidated Canterbury DHB financial result for the month of June 2017 was a deficit of $4.274M (before impairment) which was $0.373M favourable against the revised budget deficit of $4.648M. The year to date position is $13.337M (before impairment) unfavourable to the revised budget. The table below provides the breakdown of the June result.

<table>
<thead>
<tr>
<th></th>
<th>MONTH</th>
<th>YEAR TO DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Forecast</td>
</tr>
<tr>
<td>Governance</td>
<td>$0.453</td>
<td>-</td>
</tr>
<tr>
<td>Funder</td>
<td>$(1.789)</td>
<td>(1.286)</td>
</tr>
<tr>
<td>DHB Provider</td>
<td>$(2.938)</td>
<td>(3.362)</td>
</tr>
<tr>
<td>Canterbury DHB Group Result</td>
<td>$(4.274)</td>
<td>(4.648)</td>
</tr>
</tbody>
</table>

Report prepared by:  David Meates, Chief Executive
1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the financial result for the period ended 30 June 2017.

3. DISCUSSION

Overview of June 2017 Financial Result

The consolidated Canterbury DHB financial result for the month of June 2017 was a deficit of $4.274M (before impairment) which was $0.373M favourable against the revised budget deficit of $4.648M. The year to date position is $13.337M (before impairment) unfavourable to the revised budget. The table below provides the breakdown of the June result.

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital &amp; Specialist Service and Corporate</td>
<td>$3.018</td>
<td>$3.410</td>
<td>$0.392</td>
<td>$38.655</td>
<td>$33.160</td>
<td>$(5.095)</td>
</tr>
<tr>
<td>Community &amp; Public Health</td>
<td>0.015</td>
<td>0.008</td>
<td>$0.007</td>
<td>(0.043)</td>
<td>(0.050)</td>
<td>0.007</td>
</tr>
<tr>
<td>Total In-House Provider excl Subsidiaries</td>
<td>$3.003</td>
<td>$3.402</td>
<td>$0.399</td>
<td>$38.698</td>
<td>$33.666</td>
<td>$(5.032)</td>
</tr>
<tr>
<td>Add: Funder &amp; Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funder Revenue</td>
<td>127.273</td>
<td>124.393</td>
<td>$2.880</td>
<td>1,507.548</td>
<td>1,495.908</td>
<td>11.640</td>
</tr>
<tr>
<td>External Provider Expense</td>
<td>55.858</td>
<td>53.018</td>
<td>$2.841</td>
<td>645.682</td>
<td>629.034</td>
<td>16.648</td>
</tr>
<tr>
<td>Internal Provider Expense</td>
<td>73.204</td>
<td>72.651</td>
<td>$(0.543)</td>
<td>874.747</td>
<td>872.488</td>
<td>2.261</td>
</tr>
<tr>
<td>Total Funder</td>
<td>(1.789)</td>
<td>(1.286)</td>
<td>$(0.503)</td>
<td>(12.882)</td>
<td>(5.612)</td>
<td>(7.270)</td>
</tr>
<tr>
<td>Add: Governance &amp; Funder Admin</td>
<td>0.482</td>
<td>-</td>
<td>0.482</td>
<td>(0.432)</td>
<td>-</td>
<td>(0.432)</td>
</tr>
<tr>
<td>Total Canterbury DHB (Parent)</td>
<td>(4.310)</td>
<td>(4.688)</td>
<td>0.377</td>
<td>(52.011)</td>
<td>(39.278)</td>
<td>(12.733)</td>
</tr>
<tr>
<td>Add: Subsidiaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brackenridge Estate Ltd</td>
<td>0.047</td>
<td>0.084</td>
<td>$(0.037)</td>
<td>(0.108)</td>
<td>0.550</td>
<td>(0.658)</td>
</tr>
<tr>
<td>Canterbury Linen Services Ltd</td>
<td>(0.011)</td>
<td>(0.044)</td>
<td>0.033</td>
<td>0.286</td>
<td>0.232</td>
<td>0.054</td>
</tr>
<tr>
<td>Canterbury DHB Group Surplus / Deficit</td>
<td>(4.275)</td>
<td>(4.648)</td>
<td>0.373</td>
<td>(51.833)</td>
<td>(38.496)</td>
<td>(13.337)</td>
</tr>
</tbody>
</table>
### Key Drivers for 16/17 Variance to Plan

<table>
<thead>
<tr>
<th>Key Drivers</th>
<th>Comment</th>
<th>$M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaikoura District Council</td>
<td>Donation returned to community - reimbursed by MoH as equity not revenue</td>
<td>2.0</td>
</tr>
<tr>
<td>Kaikoura earthquake costs</td>
<td>Costs incurred to date over &amp; above MoH funding</td>
<td>1.3</td>
</tr>
<tr>
<td>Community pharmaceutical expenditure &amp; rebates</td>
<td>Includes rebates redirected to new PHARMAC programmes such as Hepatitis C</td>
<td>3.0</td>
</tr>
<tr>
<td>Surgical outsourcing</td>
<td>ESPI electives recovery plan</td>
<td>7.7</td>
</tr>
<tr>
<td>In-between travel (IBT), palliative care,</td>
<td>IBT is partially offset with additional revenue; other areas are an increase in demand driven services</td>
<td>4.7</td>
</tr>
<tr>
<td>residential care, primary care, etc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashburton Hospital donation</td>
<td>Donation received from Advance Ashburton</td>
<td>(1.1)</td>
</tr>
<tr>
<td>Other increased expenditure</td>
<td>Various</td>
<td>1.6</td>
</tr>
<tr>
<td>Additional clinical staff costs</td>
<td>Staff costs related to increased volume via weekend surgeries, IDF etc</td>
<td>4.0</td>
</tr>
<tr>
<td>RDA strikes</td>
<td>Allowances paid for strike cover</td>
<td>1.8</td>
</tr>
<tr>
<td>Personnel costs</td>
<td>Avoided growth across staff categories</td>
<td>(1.5)</td>
</tr>
<tr>
<td>Procurement savings</td>
<td>Local and regional initiatives</td>
<td>(0.4)</td>
</tr>
<tr>
<td>Other external provider costs</td>
<td>Various</td>
<td>1.0</td>
</tr>
<tr>
<td>E initiatives</td>
<td>PICS, Paperlite, Cortex, Emeds etc</td>
<td>(1.4)</td>
</tr>
<tr>
<td>Additional provider arm treatment costs</td>
<td>Includes increased cancer treatment and implant costs, weekend theatre usage, etc</td>
<td>1.0</td>
</tr>
<tr>
<td>ACC revenue</td>
<td>Reduced number of spinal cases</td>
<td>0.5</td>
</tr>
<tr>
<td>IDF revenue</td>
<td>Additional revenue from higher volumes from other DHBs</td>
<td>(3.3)</td>
</tr>
<tr>
<td>Depreciation reduced cost</td>
<td>Review of asset useful lives</td>
<td>(2.0)</td>
</tr>
<tr>
<td>Bad debts &amp; doubtful debts provision</td>
<td>Higher level of debt write off and provisioning than expected</td>
<td>0.4</td>
</tr>
<tr>
<td>Mental health activity DHB wide</td>
<td>Includes increased acute presentations</td>
<td>2.4</td>
</tr>
<tr>
<td>Increased Ministry of Health revenue</td>
<td>Additional funding for a variety of programmes &amp; initiatives</td>
<td>(6.4)</td>
</tr>
<tr>
<td><strong>Full year variance to plan</strong></td>
<td></td>
<td>13.3</td>
</tr>
</tbody>
</table>

#### 4. APPENDICES

- Appendix 1: Financial Result
- Appendix 2: Statement of Comprehensive Revenue & Expense
- Appendix 3: Statement of Financial Position
- Appendix 4: Cashflow and Bank

Report prepared by: Justine White, General Manager Finance & Corporate Services
APPENDIX 1: FINANCIAL RESULT

Note that the Appendix 1 tables compare actual against the recently revised annual plan full year deficit budget of $38.496M.

FINANCIAL PERFORMANCE OVERVIEW – YTD JUNE 2017

The final result recognises the effect of the Kaikoura earthquakes, the two RDA strikes and the ongoing effect of their resolution, external provider expenditure pressures, additional costs required to deliver the ESPI electives recovery plan, and the MoH reimbursement for CDHB’s repayment to the Kaikoura District Council received as an equity injection. If the $2M for Kaikoura had been treated as revenue we would have had a result of $49.833M, similar to the final forecast submitted at the end of May.

We have incorporated as many of the year end adjustments as we can in this June management result, and there are no variations from this result to the draft CFIS templates submitted on 24 July. However, the audit of these accounts is yet to be completed.

The year to date earthquake related costs (excluding the Kaikoura earthquake costs) total $28.727M, offset by insurance revenue drawdown from the MoH of $10.712M.

KEY RISKS AND ISSUES

We continue to actively monitor expenditure trends, including earthquake related costs, and expect to continue to incur earthquake related repair and maintenance expenditure and the depreciation impacts of quake related capital spend for a significant number of years into the future. There is expected to be variability between the expected and actual timing of these costs.
PERSONNEL COSTS/PERSONNEL ACCRUED FTE

KEY RISKS AND ISSUES
TREATMENT & NON TREATMENT RELATED COSTS

KEY RISKS AND ISSUES

Additional facility costs continue to be incurred in relation to The Princess Margaret Hospital campus. Some of these additional costs are in relation to a number of mental health services that remain stranded at that site.
EXTERNAL PROVIDER COSTS

Refer to the Planning and Funding section of the report for further information on the total external provider costs.

KEY RISKS AND ISSUES
Earthquake (EQ) operating costs include EQ repair works and other non-repair related costs such as additional security and building leases.

EQ repairs (integral part of the DHB EQ Programme of Works) costs are offset by an equivalent amount of insurance revenue that will be progressively drawn down to minimise the impact of EQ repair costs on the net result. The insurance revenue relates to the portion of earthquake insurance settlement amount that was repaid to the Crown in 2013/14 for future draw down by the DHB as and when appropriate to fund the earthquake repairs and programme of works.

Note: ‘Quake’ costs associated with additional funder activity such as increased outsourced surgery are captured under external provider costs.

### Key Risks and Issues

The variability and uncertainty of these costs will continue to put pressure on meeting our monthly budgets in future periods.

**Kaikoura Earthquakes**

In January we received additional MoH funding of $845k to offset the financial impact of the November Kaikoura/Culverden earthquakes. All of this revenue was recognised in the January YTD result. A further $150k funding was received in June for GP visits, giving a total of $995k additional funding received. Costs continue to come through related to these earthquakes, mainly for continuing support required for the community. The YTD costs total approximately $2M, noting that some costs – particularly employee costs – may not be recorded as earthquake in our ledger, so not captured in the following breakdown:

<table>
<thead>
<tr>
<th>Expenditure category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee expenses</td>
<td>237,406</td>
</tr>
<tr>
<td>External providers</td>
<td>653,647</td>
</tr>
<tr>
<td>Other expenses</td>
<td>438,057</td>
</tr>
<tr>
<td>Outsourced services</td>
<td>307,522</td>
</tr>
<tr>
<td>Treatment related costs</td>
<td>341,989</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,978,621</strong></td>
</tr>
</tbody>
</table>
FINANCIAL POSITION

<table>
<thead>
<tr>
<th></th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td>518,332</td>
<td>575,059</td>
<td>-10%</td>
</tr>
<tr>
<td>Cash</td>
<td>(14,520)</td>
<td>(11,505)</td>
<td>26%</td>
</tr>
</tbody>
</table>

CDHB swapped $231M of debt for equity in February relating to the Crown’s directive to swap Crown debt with equity. Our net cash position includes a $16.5M overdraft position with NZ Health Partnerships Ltd. In June we paid $17M to the MoH (mainly for the Burwood boiler), which explains the drop in our cash balance from previous months.

We anticipate costs of earthquake repairs and related expenses to continue to impact our cash balances that were otherwise being accumulated for our facilities redevelopment.

As previously noted, a significant portion of the repairs and maintenance that we are undertaking (and will continue to undertake in the future) to place our buildings and infrastructure back to a pre earthquake condition is being capitalised and depreciated, resulting in the amortisation of costs over a number of years. We continue to review and close off earthquake related projects, accounting for the increase in building asset cost, and, as noted above, facilities costs.

Appendix 4 shows the breakdown of our funds exposure to different financial institutions.

CDHB relies on deficit funding for future cash flows, and a formal application for 16/17 deficit funding has been made to the MoH. The application is on hold waiting for our revised 17/18 annual plan to be submitted, which includes a cash forecast that the MoH will review to ensure our application is in line with OPF criteria.

KEY RISKS AND ISSUES

16/17 deficit funding will be dependent on our cash requirements over the 17/18 year, and our application for deficit funding may not be fully approved. Additionally, earthquake costs continue to be difficult to predict with certainty, including the impact on the valuation of our facilities.
## APPENDIX 2: CANTERBURY DHB GROUP STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

The Group financial results include Canterbury DHB and its subsidiaries, Canterbury Linen Services Ltd and Brackenridge Estate Ltd.

For the 12 Months Ended 30 June 2017

<table>
<thead>
<tr>
<th>Mth</th>
<th>16/17 Actual</th>
<th>16/17 Budget</th>
<th>15/16 Actual</th>
<th>15/16 Budget</th>
<th>Variance to Budget</th>
<th>YTD</th>
<th>Annual Actual</th>
<th>16/17 Actual</th>
<th>16/17 Budget</th>
<th>15/16 Actual</th>
<th>15/16 Budget</th>
<th>Variance to Budget</th>
<th>Annual Budget</th>
<th>Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>130,492</td>
<td>126,994</td>
<td>134,951</td>
<td>2,499</td>
<td></td>
<td>1,646,499</td>
<td>1,641,969</td>
<td>1,616,057</td>
<td>4,530</td>
<td>1,643,014</td>
<td>1,646,200</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues</td>
<td>131,790</td>
<td>128,343</td>
<td>129,366</td>
<td>3,355</td>
<td>Meht Revenue</td>
<td>1,563,309</td>
<td>1,543,048</td>
<td>1,522,994</td>
<td>9,901</td>
<td>1,544,475</td>
<td>1,547,661</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6,592</td>
<td>4,988</td>
<td>4,951</td>
<td>1,041</td>
<td>Patient Related Revenue</td>
<td>58,950</td>
<td>58,521</td>
<td>52,017</td>
<td>6,239</td>
<td>59,730</td>
<td>58,599</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1,291</td>
<td>3,761</td>
<td>034</td>
<td>(2,567)</td>
<td>Other Revenue</td>
<td>34,330</td>
<td>39,340</td>
<td>41,126</td>
<td>(5,180)</td>
<td>39,540</td>
<td>39,540</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>59,983</td>
<td>60,325</td>
<td>59,164</td>
<td>342</td>
<td>Personnel Costs</td>
<td>722,528</td>
<td>717,943</td>
<td>693,369</td>
<td>(488)</td>
<td>717,621</td>
<td>726,413</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12,778</td>
<td>12,776</td>
<td>11,406</td>
<td>(469)</td>
<td>Treatment Related Costs</td>
<td>140,468</td>
<td>149,362</td>
<td>142,198</td>
<td>(1,694)</td>
<td>149,362</td>
<td>146,996</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>55,801</td>
<td>53,018</td>
<td>41,375</td>
<td>(2,643)</td>
<td>External Service Providers</td>
<td>646,062</td>
<td>629,834</td>
<td>696,747</td>
<td>(66,804)</td>
<td>629,634</td>
<td>643,291</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10,036</td>
<td>9,543</td>
<td>13,992</td>
<td>(493)</td>
<td>Other Expenses</td>
<td>116,953</td>
<td>114,380</td>
<td>111,611</td>
<td>(1,773)</td>
<td>114,462</td>
<td>111,281</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect</td>
<td>139,152</td>
<td>135,662</td>
<td>125,509</td>
<td>(3,451)</td>
<td>Total Expenditure</td>
<td>1,634,728</td>
<td>1,610,409</td>
<td>1,553,925</td>
<td>(4,484)</td>
<td>1,616,469</td>
<td>1,626,581</td>
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<td></td>
<td></td>
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<tr>
<td>Surplus</td>
<td>341</td>
<td>1,332</td>
<td>9,012</td>
<td>(992)</td>
<td>Total Surplus / (Deficit) Before Indirect Items</td>
<td>11,771</td>
<td>31,560</td>
<td>62,132</td>
<td>(19,789)</td>
<td>32,685</td>
<td>19,220</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>611</td>
<td>611</td>
<td>-</td>
<td>-</td>
<td>Capital Charge Funding for Revaluation &amp; Rate Change</td>
<td>7,335</td>
<td>7,335</td>
<td>-</td>
<td>-</td>
<td>6,290</td>
<td>6,290</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td>255</td>
<td>249</td>
<td>254</td>
<td>15</td>
<td></td>
<td>2,113</td>
<td>2,830</td>
<td>2,663</td>
<td>(77)</td>
<td>2,851</td>
<td>2,851</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donations</td>
<td>216</td>
<td>126</td>
<td>279</td>
<td>90</td>
<td></td>
<td>2,740</td>
<td>1,500</td>
<td>3,994</td>
<td>1,210</td>
<td>1,546</td>
<td>1,546</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Profit</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>Profit (Loss) on Sale of Assets</td>
<td>728</td>
<td>-</td>
<td>(22)</td>
<td>728</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,081</td>
<td>976</td>
<td>575</td>
<td>105</td>
<td>Total Indirect Revenue</td>
<td>12,896</td>
<td>11,726</td>
<td>6,435</td>
<td>1,160</td>
<td>10,681</td>
<td>10,681</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Charges</td>
<td>1,563</td>
<td>1,875</td>
<td>479</td>
<td>312</td>
<td>Capital Charge</td>
<td>16,177</td>
<td>18,231</td>
<td>5,726</td>
<td>2,054</td>
<td>18,231</td>
<td>18,231</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deprecation</td>
<td>4,133</td>
<td>5,081</td>
<td>4,124</td>
<td>948</td>
<td></td>
<td>56,250</td>
<td>59,151</td>
<td>57,739</td>
<td>2,083</td>
<td>59,151</td>
<td>59,151</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td>-</td>
<td>-</td>
<td>457</td>
<td>-</td>
<td>Interest Expense</td>
<td>4,955</td>
<td>4,400</td>
<td>5,575</td>
<td>345</td>
<td>4,400</td>
<td>4,400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5,696</td>
<td>6,956</td>
<td>5,060</td>
<td>1,260</td>
<td>Total Indirect Expenses</td>
<td>76,490</td>
<td>81,782</td>
<td>69,040</td>
<td>2,742</td>
<td>81,782</td>
<td>81,782</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus</td>
<td>(4,273)</td>
<td>(4,648)</td>
<td>4,527</td>
<td>373</td>
<td>Total Surplus / (Deficit)</td>
<td>(51,633)</td>
<td>(38,496)</td>
<td>(473)</td>
<td>(13,337)</td>
<td>(38,496)</td>
<td>(51,881)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairment</td>
<td>(1,791)</td>
<td>(1,791)</td>
<td>-</td>
<td>-</td>
<td></td>
<td>(1,791)</td>
<td>-</td>
<td>-</td>
<td>(1,791)</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revaluation Reserve Release</td>
<td>300</td>
<td>-</td>
<td>-</td>
<td>300</td>
<td></td>
<td>300</td>
<td>-</td>
<td>-</td>
<td>300</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>(6,065)</td>
<td>(4,648)</td>
<td>4,527</td>
<td>(1,418)</td>
<td>Total Comprehensive Revenue and Expense</td>
<td>(53,328)</td>
<td>(38,496)</td>
<td>(473)</td>
<td>(14,820)</td>
<td>(38,496)</td>
<td>(51,881)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

As at 30 June 2017

<table>
<thead>
<tr>
<th></th>
<th>Group Actual</th>
<th>Group Annual Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30-Jun-17</td>
<td>30-Jun-17</td>
</tr>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td><strong>Opening Equity</strong></td>
<td>77,014</td>
<td>199,933</td>
</tr>
<tr>
<td><strong>Net Equity Injections / (Repayments) During Year</strong></td>
<td>31,639</td>
<td>413,622</td>
</tr>
<tr>
<td><strong>Reserve Movement for Year</strong></td>
<td>91,753</td>
<td>-</td>
</tr>
<tr>
<td><strong>Operating Results for the Period</strong></td>
<td>(473)</td>
<td>(38,496)</td>
</tr>
<tr>
<td><strong>TOTAL PUBLIC EQUITY</strong></td>
<td>199,933</td>
<td>518,833</td>
</tr>
<tr>
<td>Represented By:</td>
<td></td>
<td>575,059</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents</strong></td>
<td>13,546</td>
<td>-</td>
</tr>
<tr>
<td><strong>Short Term Investments</strong></td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td><strong>Trade and Other Receivables</strong></td>
<td>64,710</td>
<td>103,207</td>
</tr>
<tr>
<td><strong>Prepayments</strong></td>
<td>4,639</td>
<td>4,639</td>
</tr>
<tr>
<td><strong>Inventories</strong></td>
<td>9,432</td>
<td>9,432</td>
</tr>
<tr>
<td><strong>Restricted Assets</strong></td>
<td>8,060</td>
<td>8,060</td>
</tr>
<tr>
<td><strong>Assets Held for Sale</strong></td>
<td>540</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>101,927</td>
<td>98,138</td>
</tr>
<tr>
<td></td>
<td></td>
<td>126,338</td>
</tr>
<tr>
<td><strong>Overdraft</strong></td>
<td>16,505</td>
<td>11,505</td>
</tr>
<tr>
<td><strong>Trade and Other Payables</strong></td>
<td>100,886</td>
<td>106,895</td>
</tr>
<tr>
<td><strong>Restricted Funds</strong></td>
<td>14,297</td>
<td>14,297</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td>154,321</td>
<td>154,321</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>269,503</td>
<td>287,008</td>
</tr>
<tr>
<td><strong>Working Capital</strong></td>
<td>(167,576)</td>
<td>(154,334)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(160,670)</td>
</tr>
<tr>
<td><strong>Restricted Funds</strong></td>
<td>6,237</td>
<td>6,237</td>
</tr>
<tr>
<td><strong>Investment in NZHPL</strong></td>
<td>5,935</td>
<td>5,935</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td>607,684</td>
<td>728,919</td>
</tr>
<tr>
<td><strong>Total Non Current Assets</strong></td>
<td>519,856</td>
<td>742,011</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td>6,362</td>
<td>6,362</td>
</tr>
<tr>
<td><strong>Term Loans</strong></td>
<td>145,985</td>
<td>-</td>
</tr>
<tr>
<td><strong>Term Liabilities</strong></td>
<td>152,347</td>
<td>6,362</td>
</tr>
<tr>
<td><strong>NET ASSETS</strong></td>
<td>199,933</td>
<td>518,833</td>
</tr>
<tr>
<td></td>
<td></td>
<td>575,059</td>
</tr>
</tbody>
</table>
APPENDIX 4: CASHFLOW & BANK

<table>
<thead>
<tr>
<th></th>
<th>Audited 30-Jun-16 $000</th>
<th>Actual 30-Jun-17 $000</th>
<th>Budget 30-Jun-17 $000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Month</strong></td>
<td><strong>Previous Month</strong></td>
<td><strong>Net Cash from Operating Activities</strong></td>
<td><strong>Net Cash from Investing Activities</strong></td>
</tr>
<tr>
<td>NZ Health Partnerships shared treasury function</td>
<td>(16.5)</td>
<td>10.5</td>
<td></td>
</tr>
<tr>
<td>Westpac</td>
<td>2.9</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>BNZ</td>
<td>10.6</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>ANZ</td>
<td>1.3</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41,623</td>
<td>15,987</td>
<td>26,655</td>
</tr>
<tr>
<td>(66,578)</td>
<td>(55,292)</td>
<td>(65,845)</td>
<td></td>
</tr>
<tr>
<td>Closing Cash Balance</td>
<td>13,546</td>
<td>(14,520)</td>
<td>(11,505)</td>
</tr>
</tbody>
</table>

At the end of June, the total exposure to our banking partners (including Brackenridge and our trust funds) for on call, term deposits, and bonds was:
CHATHAM ISLANDS SERVICES – FINANCIAL RESULTS

TO: Chair and Members
Canterbury District Health Board

SOURCE: Planning and Funding

DATE: 17 August 2017

Report Status – For: Decision ☐ Noting ✔ Information ☐

1. ORIGIN OF THE REPORT

The report is a periodic update on the financial result for the Chatham Island population and follows up from the February 2017 report, highlighting the level of funding provided by the Ministry of Health (MoH).

2. RECOMMENDATION

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

i. notes the report; and

ii. notes that despite funding challenges, CDHB has implemented a model of service resulting in significant gains for the Chatham Islands community.

3. SUMMARY

Summary from the previous reports, dated 1 March 2016 and 28 February 2017:

“Following a MoH led consultation process; the responsibility for the provision of health services to the Chatham Islands was transferred from the Hawkes Bay DHB (HBDHB) to Canterbury DHB. At the same time, an order in council was utilised to transfer the ownership of the physical building assets on the Chathams to Canterbury DHB (valued $1.655m). The provision of services to this small community is costly due to a number of unique features related to population demographics, access and small population volumes.

The operational cost of delivering health services to the Chatham Islands was conservatively estimated for 2015/16 at $4.2m, based on information provided by HBDHB. Despite providing information to the MoH to support the expected expenditure, the MoH only agreed to provide $4.03m additional funding for the Chatham’s for the 2015-16 financial years.”

The cost of health services for the population of Chatham Islands can be distinguished in three major categories, - operational cost of community health centre on the island, service provision and delivery costs at Canterbury DHB facilities and non-Canterbury DHB events (IDFs). The Planning and Funding and Ashburton & Rural Health divisions have been recording and monitoring all the operational and health services provision expenditures.

Table 1 summarises the 2016-17 FY actual result, with the last financial year result (2015-16) for a comparison reference. The operational expenditure for 2016-17 FY dropped by around 7%, with the net expenditure of $3.90m compared to last year’s net result of $4.21m. The earlier report presented at the February 2017 QFARC meeting reported an end of year forecast of $3.95m (net result) based on the first seven months financial results, the actual outturn posted a $0.05m favourable result.
The reduction in operational expenditures was mainly driven by reduction in transport costs and inpatient IDF events as a result of efficient and effective health services delivery combined with sustainable provision of the critical equipment (i.e. telehealth, radiology equipment, server upgrade).

Total expenditure does not include any overhead allocation, depreciation or provision for building repairs and maintenance costs, as referred in the earlier reports. The physical assets at Chatham Islands are in a dire state and in critical need of significant capital investment to minimise the disruptions and remove any barriers to quality clinical service delivery.

Table 1 – Financial Results for the Chatham Island Population

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Actual $000</th>
<th>2015-16 Actual $000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MoH Operational Revenue</td>
<td>-</td>
<td>4.03</td>
</tr>
<tr>
<td>MoH Other Revenue</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Inter DHB Revenue (Patient Transfer)</td>
<td>0.01</td>
<td>0.04</td>
</tr>
<tr>
<td>ACC Revenue</td>
<td>0.06</td>
<td>0.03</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>0.01</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>0.12</td>
<td>4.14</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ORACLE Finance System</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Expenses</td>
<td>1.01</td>
<td>0.98</td>
</tr>
<tr>
<td>Other Employee Expenses</td>
<td>0.12</td>
<td>0.13</td>
</tr>
<tr>
<td>Transport Expenses</td>
<td>0.83</td>
<td>0.97</td>
</tr>
<tr>
<td>Treatment Related Expenses</td>
<td>0.56</td>
<td>0.57</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>0.30</td>
<td>0.25</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>2.82</td>
<td>2.90</td>
</tr>
<tr>
<td><strong>CDHB Hospital Events</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients (including Mental Health)</td>
<td>1.03</td>
<td>1.05</td>
</tr>
<tr>
<td>Outpatients &amp; ED</td>
<td>0.10</td>
<td>0.12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1.13</td>
<td>1.17</td>
</tr>
<tr>
<td>**Non-CDHB Hospital Events (IDFs) ***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatients</td>
<td>0.05</td>
<td>0.23</td>
</tr>
<tr>
<td>Outpatient &amp; ED</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.07</td>
<td>0.25</td>
</tr>
<tr>
<td><strong>Net Result</strong></td>
<td>-3.90</td>
<td>-0.19</td>
</tr>
</tbody>
</table>

* The IDF cost may shift further post final wash-up in August/September.
4. **DISCUSSION**

**Revenue**
The MoH Operation Revenue for the 2016-17 FY has been devolved to PBFF, 2015-16 FY actual $4.03mn.

**Oracle Financial System**
Expenditure directly attributable to providing services to the Chatham Islands population includes:

- Services provided from the DHB-owned Chatham Island Health Centre (e.g. General Practice consultations and inpatient beds).
- Specialist clinics delivered on the island from Canterbury Hospital and Specialist Services (excluding payroll costs).
- Community services delivered on the island by contracted NGO providers. These services include Maori Health, Pharmacy, Community Laboratory and Midwifery.
- Patient travel to Christchurch for specialist referrals including diagnostics.
- Air retrievals for acute episodes.

Expenditure excludes any operational overheads incurred by the DHB, including Planning and Funding, Ashburton and Rural Health Services, Corporate, Support Services and M&E division for overseeing the Health Centre, and any costs for future repairs and maintenance or capital expenditure.

**Canterbury DHB Hospital Events**
Expenditure attributable to Provider Arm specialist services delivered in Christchurch to this particular population is not identifiable in our financial systems. These are expenses incurred when Chatham Islands residents use ED, hospital inpatient services, outpatient consultations and radiology.

Decision Support identified patients with an NHI address in the Chathams and provided an estimate of the service cost based on the person’s Discharge Related Group (DRG). Events have costs attributed through a costing system called “Power Performance Manager” which identifies the treatment costs plus a recovery for the DHB’s overheads.

In order to check the reasonableness of the cost data, a comparison was made to those events with a valid MoH data dictionary purchase unit and national IDF prices.

**Non-Canterbury DHB Hospital Events (Inter District Flows)**
Both inpatient and outpatient health events were extracted from the National Collections for patients recorded with a Chatham Islands domicile code. The national IDF price was applied to determine these costs.

**High-Cost Outliers**
Recorded event with cost exceeding $100k.

- $286,517 – General Surgery (Canterbury DHB)

**Building Repairs and Maintenance**
The recommendations by the Canterbury DHB Board, following the paper presented on 17 November 2016, are being further developed which include a business case to the MoH seeking additional funding towards deferred maintenance and capital improvement.
As previously mentioned, funding from the MoH has not addressed capital expenditure and annual depreciation. The actual repairs and maintenance charges incurred by Canterbury DHB to date are minimal, and there has been no depreciation expense recognised (as the assets are effectively recorded at nil value). If an allowance was made for a regular repairs and maintenance programme, and we had a reasonable depreciation charge, the total expenditure would be much higher than the funding received.

As there is no excess of funding over operational expenses, Canterbury DHB has not been able to accumulate any funds to upgrade the buildings, nor is there any likelihood of being able to accumulate funds in the future. This creates issues given the anticipated need to upgrade the facilities in the short term.

We are continuing to prioritise equipment replacement and building repairs and maintenance with the priority on essential medical equipment and patient and staff safety. Asbestos has been removed where there was potential staff exposure and measures taken to meet the standards for minimising exposure to asbestos. The x-ray equipment has been replaced, significantly improving imaging, orthopaedic assessments and reducing the need for patients to fly to Canterbury.

In addition to the buildings and infrastructure requirements, a number of essential pieces of equipment will need to be replaced in the coming year including the autoclave, patient beds and pressure-reducing mattresses.

An emergency backup power supply and new server will be installed in August 2017. The new server will improve connectivity and access to the online programmes and enable the 2002 Medtech software to be updated.

Business cases for two vehicle replacements have been approved, as both vehicles failed warrant of fitness tests. The cars are the First responder vehicles for the PRIME contract.

The Community Dental Clinic based at Te One School requires significant upgrade of both the facility and equipment to meet compliance standards. Work is underway to cost this project.

**A Summary of Service Delivery from July 2016 to January 2017**

There has been significant increase in service utilisation on the Chatham Islands as a result of sustainable staffing provision resulting in ease of access and continuity of care. The overall uptake in clinical consultations, both at the Chatham Islands Health Centre and in the community, suggests early intervention and improved health outcomes for the community. The below table summarises the major changes in the service utilisation.

<table>
<thead>
<tr>
<th></th>
<th>2016-17 FY</th>
<th>2015-16 FY</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Consults</td>
<td>3,497</td>
<td>2,255</td>
</tr>
<tr>
<td>Nurse Consults</td>
<td>2,650</td>
<td>2,968</td>
</tr>
<tr>
<td>Home visits</td>
<td>1,069</td>
<td>149</td>
</tr>
<tr>
<td>Midwife</td>
<td>99</td>
<td>75</td>
</tr>
<tr>
<td>Nurse escorts for commercial flight</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Bed nights</td>
<td>112</td>
<td>127</td>
</tr>
<tr>
<td>Life flights</td>
<td>13</td>
<td>36</td>
</tr>
<tr>
<td>Tele Health</td>
<td>21</td>
<td>39</td>
</tr>
</tbody>
</table>

There is a significant increase in both personal cares and support care being delivered in the home. This is being driven by an ageing population and improved community InterRai assessments identifying service needs early. As a result, fewer residents are leaving the island for long term residential care placement in other parts of New Zealand, fewer inpatient bed nights and a significant reduction in emergency life flights.
In addition to the services listed in the above table, over 1,180 specialist appointments were delivered for the Chatham Island residents in the 2016-17 FY. The range of specialist clinical services delivered to the local communities included Paediatrics, Orthopaedics, Well-Child, Radiology, Community Mental Health, Obstetrics and Gynaecology, Occupational and Physiotherapy, Older Person’s Needs Assessment, Radiology, Podiatrist and Diabetes Nursing. Visits were coordinated with a visiting ACC team working closely with the Occupational and Physiotherapy staff, with ACC sharing the cost of this service delivery.

The orthopaedic team visited the Chatham Islands in September 2016 and May 2017. During the second visit, a number of patients who had already received surgery were seen and discharged. During the two day May clinic, 55 patients were seen and six minor surgeries performed. Following assessment, 24 patients remain under Orthopaedic care and 31 patients were discharged.

New contracts were put in place with a visiting podiatrist and on-island physiotherapist and the LMC contract was renewed. Dental services were provided by a private dentist in February, this was the second clinic and again the service was fully booked for 14 days.

In June, Rural Canterbury PHO appointed a Primary Mental Health Nurse/Registered Counsellor to deliver independent counselling services.

Sixty-three of the 112 eligible women took part in the biennial breast screening clinics run by BreastScreen South in Christchurch. For those who were unable to attend, planning is underway for a further clinic in May 2018.

The Health Centre and Ha O Te Ora O Wharekauri Trust are working more closely together to coordinate visits to the health centre with other needs like shopping, as well as arranging the follow-up support in the community.

Report prepared by:  Krunal Shukla, Finance Manager, Rural Health Services
Win McDonald, Transitional Manager Rural Hospitals

Report approved for release by:  Carolyn Gullery, General Manager, Planning & Funding
1. **ORIGIN OF THE REPORT**

This report provides an update on employee wellbeing, health and safety activities including a high level dashboard.

2. **RECOMMENDATION**

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

i. notes the Wellbeing Health and Safety Report.

3. **SUMMARY**

**General**

A range of wellbeing, health and safety activities continue to progress. These are outlined below.

**Wellbeing**

- All of the Wellbeing Workshops are now being managed through the Canterbury DHB e-learning platform HealthLearn. Enrolments have been very good for all courses.
- The online ‘Building Resilience’ module is in development. The module will be peer reviewed prior to being launched.
- Response to the financial seminars has been excellent. Seminars are planned weekly during July, August and September.

**Health and Safety**

- Gathering of evidence in preparation for the annual audit for the ACC Accredited Employer Programme has been completed.
- Due to the unprecedented quantum of ongoing construction activity, there has been a heightened requirement to consult, coordinate and collaborate between Canterbury DHB and main contractors to ensure a safe and healthy workplace. Ongoing interface meetings continue to occur for the projects where there is a need for joint PCBU interaction.
- The construction risk register for the Christchurch Hospital campus has been updated to reflect the commencement of new contracts.

**Occupational Health**

- Influenza Vaccination remains available to staff. Staff continue to be encouraged to access Authorised Vaccinators in their work area. 63% of our people have been vaccinated against flu to date. The programme continues to be actively promoted.
- Contact tracing has been carried out for staff in the Emergency Department who nursed a patient with potential meningococcal disease. All staff were assessed following consultation with Infectious Diseases.
Injury Management

- There were 72 new claims registered in June, with 19 staff experiencing time off as a result.
- Planning is well advanced for the annual Accredited Employer Programme audit scheduled for August. This includes the completion of a self-assessment and the collation of the appropriate claim information requested by ACC.

Safety 1st Incident Reporting

Amendments to the employee incident recording form have been agreed across the South Island and approved by the Control Group. The goal of the project is to provide more accurate and timely health and safety incident data across South Island DHBs to inform improved ways of working that reduce harm to our people. Cycle 1 of system testing is complete with eight defects identified and a number of suggested improvements to the form. Vendor RL Solutions has made the changes to the form and cycle 2 of system testing is underway. Test plan and a communications plan is complete and signed off, and work is underway to develop communications material. User acceptance testing is due to commence from Monday 24 July with test scenarios and surveys currently being developed.

Canterbury DHB People Strategy

As discussed and confirmed at the June QFARC meeting, the General Manager People and Capability is working with the Executive Management Team and other key stakeholders to develop a People Strategy for CDHB that will be more broadly based than the previously signalled Wellbeing Strategy.

The People Strategy will be based on all the intelligence gathered through all engagements with our people. The strategy acknowledges that to put patients at the centre, we must continue to create a culture in which everyone:

(a) **Understands their contribution.** A culture of connectedness, engagement and communication.
(b) **Knows how to get stuff done.** People and team-friendly systems, processes and ways of working.
(c) **Is supported to make it better.** Service improvement and innovation through co-design.
(d) **Is enabled to take the lead.** Widely distributed clinical and operational leadership.
(e) **Is supported to thrive.** Continuous team and individual capability development.

Focusing our collective efforts around these five pillars will be central if we are going to deliver on our commitment to our people.

The following key is applicable to all tables below.

<table>
<thead>
<tr>
<th>Performing to plan</th>
<th>At risk but not an issue</th>
<th>Needs immediate attention</th>
<th>Not scheduled to commence</th>
<th>Complete</th>
</tr>
</thead>
</table>

**Key Milestones: Wellbeing Survey and Strategy**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Due</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm People Strategy</td>
<td>Q3</td>
<td></td>
</tr>
<tr>
<td>Develop decision making framework and metrics</td>
<td>Q3</td>
<td></td>
</tr>
<tr>
<td>Develop work programme and pilot metrics</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>Implement and monitor the People Strategy</td>
<td>Q1</td>
<td></td>
</tr>
</tbody>
</table>

**Health and Safety System Review**

The health and safety policy framework is about to be released for consultation, with the alignment, review, migration of documentation underway. Detailed work in terms of contractor...
management will commence shortly. A process is being developed to confirm designated work areas and the roles and responsibilities within these. This work will inform the ways in which ‘workers’ (employee, contractor, student, visitor) will be engaged and participate in health and safety. This includes, but is not limited, to Health and Safety Representatives and Health and Safety Committee structures. Designated work areas and roles and responsibilities will also inform the risk register and incident management procedures. Health and Safety processes were mapped as part of the People Lifecycle Review, including Contractor Management, and will be confirmed by the end July 17.

<table>
<thead>
<tr>
<th>Key Milestones: Health and Safety System Review</th>
<th>Due</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work programme commenced [phase one]</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>Phase 1 continues</td>
<td>Q1</td>
<td></td>
</tr>
<tr>
<td>Work programme commenced [phase two]</td>
<td>Q2</td>
<td></td>
</tr>
<tr>
<td>Phase 2 continues</td>
<td>Q3</td>
<td></td>
</tr>
</tbody>
</table>

**Occupational Health Service Improvement Project**

Phase one of the project has been completed, which included:

- Establishing the Steering Group - membership, terms of reference, roles and responsibilities.
- Gathering relevant international and national literature that outlines the current context and best practise in terms of workforce health and wellbeing, including the provision of Occupational Health Services.
- Gathering relevant information related to the existing Wellbeing, Health and Safety team programme of work with a focus on Occupational Health Service activities, outputs and outcomes.
- Gathering relevant workforce data with respect to our people, Canterbury and New Zealand.
- Liaising with and be responsive to the People Lifecycle Review "Wellbeing and Staying Safe" workstream.

The first Steering Group meeting is scheduled for late in July and will be chaired by Terry Buckenham. Terry currently leads a team of Occupational Health Nurses and Rehabilitation Advisors across Fonterra’s operations in New Zealand. He has previously led successful health and safety teams in areas as diverse as consulting, finance and insurance, and tertiary education.

<table>
<thead>
<tr>
<th>Key Milestones: Occupational Health and Injury Management Service Review</th>
<th>Due</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Planning</td>
<td>Q2</td>
<td></td>
</tr>
<tr>
<td>Project Implementation</td>
<td>Q3</td>
<td></td>
</tr>
<tr>
<td>Future state design</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>Review recommendations</td>
<td>Q4</td>
<td></td>
</tr>
</tbody>
</table>

4. **APPENDICES**

Appendix 1: Wellbeing, Health and Safety Dashboard

Report prepared by: Mark Lewis, Manager Wellbeing Health and Safety

Report approved by: Michael Frampton, General Manger People and Capability
Wellbeing, Health and Safety Dashboard: Organisational Overview (June 2017)

Days Lost Due to Work Injury - Monthly

Lost Time Injury Frequency [LTIFR] - Total

Combined Injury Frequency [CIFR] - Total

Mechanism of Harm: Work Injuries - Monthly

Worksafe Notifiable Events - Monthly

Paid Leave Compared to Accrued Leave - Quarterly

Sick Leave Compared to Hours Worked - Quarterly

Workplace Support Contacts ≥ 30 Minutes

Employee Assistance Programme Clients - Quarterly

Prepared by: Mark Lewis, Manager Wellbeing Health and Safety
Approved by: Michael Frampton, General Manager People and Capability
<table>
<thead>
<tr>
<th>Days Lost Due to Work Injury (monthly)</th>
<th>Lost Time Injury Frequency (monthly)</th>
<th>Combined Injury Frequency (monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> Average days lost per loss time injury.</td>
<td><strong>Description:</strong> Lost time injury frequency rates are based on the number of lost time injuries per million hours worked. The lost time injury frequency is compared to the ACC Healthcare Levy Risk Group Average of 10 (standard).</td>
<td><strong>Description:</strong> Combined injury frequency is a ratio based on the number of all ACC accepted medical treatment claims per million hours worked.</td>
</tr>
<tr>
<td><strong>Comment:</strong> Average days lost due to injury continue to decline.</td>
<td><strong>Comment:</strong> Injuries resulting in lost time continue to increase, mainly driven by claims in May and August in 2016.</td>
<td><strong>Comment:</strong> The total number of ACC accepted claims continue to decline over the 5 year period.</td>
</tr>
<tr>
<td><strong>Focus:</strong> Continuing to focus on face to face proactive return to work meetings with both staff and management. Establishing meaningful rehabilitation plans in conjunction with external allied health providers.</td>
<td><strong>Focus:</strong> Work continues in identifying key trend locations and providing data to key stakeholders along with appropriate support.</td>
<td><strong>Focus:</strong> Safety Advisors continue to work with line management to complete risk assessments and implement appropriate action plans.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mechanism of Harm: Work Injuries (monthly)</th>
<th>Worksafe Notifiable Events (monthly)</th>
<th>Paid Leave (quarterly)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> Number of injuries in the last 12 month period compared to the previous 12 months.</td>
<td><strong>Description:</strong> Events reported and confirmed by WorkSafe that meet the legislative definition of notifiable.</td>
<td><strong>Description:</strong> Annual leave taken relative to entitlement.</td>
</tr>
<tr>
<td><strong>Comment:</strong> Patient and manual handling remain the key area involving injuries.</td>
<td><strong>Comment:</strong> Steel erection incident Outpatients Project, St Andrew’s Triangle 07/06/17. While lifting a steel H frame a single soft sling failed.</td>
<td><strong>Comment:</strong> We continue to see a slight decrease in the amount of annual leave taken relative to entitlement.</td>
</tr>
<tr>
<td><strong>Focus:</strong> Work continues in identifying these trends in relation to locations and putting in place appropriate support and advice.</td>
<td><strong>Focus:</strong> Actions arising from the notifiable event on the Outpatients Project 07/06/17 will be tracked till completion.</td>
<td><strong>Focus:</strong> People and Capability will monitor this over the next quarter. If this trend continues, People and Capability will work with Operational Leadership to identify how people can be supported to use their leave entitlement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sick Leave (quarterly)</th>
<th>Workplace Support (quarterly)</th>
<th>Employee Assistance Programme (quarterly)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong> Sick leave taken compared to hours worked.</td>
<td><strong>Description:</strong> Number of contacts in relation to organisational headcount.</td>
<td><strong>Description:</strong> Number of contacts in relation to organisational headcount.</td>
</tr>
<tr>
<td><strong>Comment:</strong> We are continuing to see a slight increase in sick leave taken compared to hours worked.</td>
<td><strong>Comment:</strong> There has been a decrease in the number of Workplace Support contacts relative to CDHB headcount. This is after a peak in contacts after the 2015 Valentine earthquake.</td>
<td><strong>Comment:</strong> There has been a decrease in the number of Employee Assistance Programme contacts relative to CDHB headcount. This is after a peak in contacts after the 2015 Valentine earthquake.</td>
</tr>
<tr>
<td><strong>Focus:</strong> People and Capability will continue to monitor the situation over the next quarter and work with Operational Leadership to support our people to stay well and healthy at work.</td>
<td><strong>Focus:</strong> People and Capability will continue to monitor the situation over the next quarter and work with Operational Leadership to support our people to stay well and healthy at work.</td>
<td><strong>Focus:</strong> People and Capability will continue to monitor the situation over the next quarter and work with Operational Leadership to support our people to stay well and healthy at work.</td>
</tr>
</tbody>
</table>
WRITE-OFF REPORT

TO: Chair and Members
Canterbury District Health Board

SOURCE: Finance

DATE: 17 August 2017

Report Status – For: Decision ☑ Noting ☐ Information ☐

1. ORIGIN OF THE REPORT

This report is to request the write-off of $200,902.43 healthcare charges levied by the Canterbury DHB. This request is made on the basis that there is no chance the Canterbury DHB will recover the debt. All reasonable steps have already been taken and there is no chance that it will be collected.

Write-offs over $50,000 must be notified to the Quality, Finance, Audit and Risk Committee and write-offs over $100,000 require Board approval.

2. RECOMMENDATION

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

i. approves the write off of $200,902.43 being non eligible patient healthcare charges.

3. DISCUSSION

The patient was in New Zealand without a valid visa and had been so since 2004. She was admitted acutely unwell to Kew Hospital in Invercargill and was subsequently transferred to Dunedin Hospital. She was transferred to Christchurch Hospital in August 2016 where she was sent to theatre immediately and was admitted to the Intensive Care Unit. The patient recovered in Christchurch Hospital before being transferred to the Burwood Brain Injury Unit where she received rehabilitation until her discharge from acute care in October 2016.

The patient and her Social Work supports were aware that she was not eligible for publicly funded healthcare in New Zealand. The patient was invoiced a total of $201,522.43 by the Canterbury DHB for healthcare services provided at Christchurch and Burwood Hospitals. As the admission was an acute admission, the DHB is required to provide healthcare regardless of the patient’s ability to pay.

The patient did not have any form of insurance and there were no immigration sponsors. The patient’s parents flew to New Zealand to support her when they were advised of her admission. Both parents were very clear they would not offer any financial support for the account. The British Honorary Consul was involved and advised that the UK Government is not in a position to contribute to any of these costs.

Following unsuccessful attempts to be able to remain in New Zealand, the patient was given 60 days to get her affairs in order as she would not qualify for a work visa due to her current medical condition. She left New Zealand in December 2016.
To try to stop any further recovery action while in New Zealand, the patient made payments totalling $620 between November 2016 and February 2017; no further payments have been made. The Christchurch Campus Finance department issued a reminder in January 2017 and a final demand in April 2017. There is no forwarding address for the patient, nor do we have any family members’ contact numbers or addresses.

Canterbury DHB has fulfilled all responsibilities for acute care for this patient. As required under the Code of Health and Disability Services Consumer Rights, the patient was informed as soon as practical after admission that there would be a cost for the health services.

Canterbury DHB is only able to write off an account when all reasonable steps have failed, or it is not cost effective to recover the debt. All reasonable steps have been completed in this case.

Report prepared by: Antoanette du Preez and Andrew Meier,
Christchurch Campus Finance

Report approved for release by: Justine White, GM Finance & Corporate Services
HAC – 3 AUGUST 2017

TO: Chair and Members
    Canterbury District Health Board

SOURCE: Hospital Advisory Committee

DATE: 17 August 2017

Report Status – For: Decision ☐ Noting ☑ Information ☐

1. ORIGIN OF THE REPORT

   The purpose of this report is to provide the Board with an overview of the Hospital Advisory Committee’s (HAC) public meeting held on 3 August 2017.

2. RECOMMENDATION

   That the Board:

   i. notes the draft minutes from HAC’s public meeting on 3 August 2017 (Appendix 1).

3. APPENDICES

   Appendix 1: HAC Draft Minutes – 3 August 2017

   Report prepared by: Anna Craw, Board Secretary

   Report approved by: Andrew Dickerson, Chair, Hospital Advisory Committee
PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Barry Bragg; Sally Buck; Anna Crighton; David Morrell; Jan Edwards; Trevor Read; and Sir Mark Solomon.

APOLOGIES
Apologies for early departure were received and accepted from Sally Buck (12.08pm).

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Carolyn Gullery (General Manager, Planning & Funding); Dr Sue Nightingale (Chief Medical Officer); Karalyn Van Deursen (Strategic Communications Manager); Justine White (General Manager, Finance & Corporate Services); Jan van der Heyden (Business Manager); and Anna Craw (Board Secretary).

IN ATTENDANCE

Item 4
Dan Coward – General Manager, Older Persons, Orthopaedics & Rehabilitation.
Toni Gutschlag – General Manager, Specialist Mental Health Services.
Kirsten Beynon – General Manager, Hospital Laboratories.
Berni Marra & Win McDonald – Rural Health Services.
Pauline Clark – General Manager, Medical/Surgical and Women’s & Children’s Health.

Item 5
Berni Marra – Manager, Ashburton Health Services.

Item 7
Dr Melissa Kerdemelidis, Public Health Physician, Planning & Funding.

Item 8
Ralph La Salle – Team Leader, Secondary Care, Planning and Funding.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions/alterations to the Interest Register.

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

Perceived Conflicts of Interest
There were no perceived conflicts of interest.
2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (12/17)
(Moved: Trevor Read/Seconded: Jan Edwards – carried)

“That the minutes of the meeting of the Hospital Advisory Committee held on 1 June 2017 be confirmed as a true and correct record.”

3. CARRIED FORWARD/ACTION ITEMS

The Committee noted the carried forward items.

4. HOSPITAL AND SPECIALIST SERVICES (H&SS) MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for July 2017. The report was taken as read.

General Managers spoke to their areas as follows:

**Older Persons, Orthopaedics & Rehabilitation Service – Dan Coward, General Manager**
- The Enhanced Recovery After Surgery (ERAS) programme is now embedded as a business as usual approach.
- Average length of stay continues to drop.
- Winter planning – focus continues on monthly meetings sharing updates on implementation plans and further developments. There has been a considerable focus by a lot of people to keep patient flow moving despite massive demand. At this point, CDHB has remained under the peak demand expected. A review is scheduled to commence shortly into this year’s planning, with winter planning for 2018 scheduled to commence next month.
- Burwood Spinal Unit Business Case. This is being finalised and will go to EMT, Facilities Committee and the Board for approval in the near future.

There was a query around Spinal Unit repairs and demolition of the Burwood Maternity Unit. The Committee was advised that the Spinal Unit will decant to the Orthopaedic Unit, which is currently undergoing earthquake repairs and remedial work in preparation for the Spinal Unit moving in. With respect to demolition of the Burwood Maternity Unit, this is being worked through by the Site Redevelopment Unit, with the demolition process complicated by the complexity of service issues involved.

Discussion took place around bed capacity at Burwood Hospital. It was noted that from the Indicative Business Case (IBC) to the Detailed Business Case (DBC), CDHB proposed reducing the number of beds for Older Persons Health at Burwood by 48 (two wards) based on its commitment to reducing the amount of time frail older people spent in a bed and its ability to support rehabilitation in people’s homes. It was further noted that in reality, CDHB has further reduced bed days as it is now using the equivalent of 38 less beds (at 85% occupancy), than forecast in the DBC and 19 less beds than it was using in 2012. Effectively, CDHB has saved a ward since 2012 which is $8 million per annum, as well as saving the Government the cost of building 48 beds. At this stage, because Christchurch Hospital is running so tight, CDHB is using Burwood to relieve pressure on the acute hospital, which is also running 45 beds below DBC forecast despite population growth being five years ahead. The DBC forecast that CDHB would be out of beds until the Acute Services Block is built.
and then would need more beds in 2022, however, CDHB currently has the same population that was forecast for 2022.

There was a request for all data to be provided in the ESPI Target Outcomes update on page 25 of the report, to ensure a complete picture is provided and data is taken in perspective.

There was a further request for consideration to be given to future reporting, to include a summary of efficiency gains and savings on a single page which sat at the front of the report.

**Hospital Laboratories – Kirsten Beynon, General Manager**

- Dr Anja Werno has been appointed to the position of Acting Chief of Pathology for Canterbury Health Laboratories, commencing July 2017. This role will be a 12 month fixed term position.
- Ongoing initiatives to reduce wastage and ensure wise spending. One such initiative is the rationalisation of the usage of national courier networks.
- Feedback from South Island Cancer multidisciplinary meetings (MDM), indicates that Christchurch Pathologist input is a significant contributor and has been well received.
- Inter-lab orders between Southern Community Laboratories and CHL went live a month ago. Proving to be very successful and well received, with a reduction in errors and an increase in patient throughput.

There was discussion on workforce planning. This is viewed as an ongoing issue, with increasing demand sitting in tertiary centres.

**Rural Health Services - Win McDonald, Transition Programme Manager**

- High staff turnover is being experienced, with approximately 80% attributable to retirement.
- Rural hospitals are running at approximately 80% occupancy, with the exception of Kaikoura which is running at 100%. This is largely due to the additional workforce which has come into the Kaikoura region.
- Chatham Islands efficiency gains have been seen from the increase in both personal cares and support care being delivered in the home. This is being driven by an ageing population and improved community assessments, identifying service needs earlier. As a result, fewer residents are leaving the island for long term residential care placement, there have been fewer inpatient bed nights, as well as a significant reduction in emergency life flights.

There was a query around the impact on Kaikoura health services from the presence of an increased workforce. The Committee was advised that clinics have been set up where staff go out to the workforce. No additional funding has been received for these patients. Workers are invariably not covered by Population Based Funding (PBF), as most remain enrolled in their home regions.

There was discussion around anecdotal drug and alcohol issues on the Chatham Islands.

Discussion took place around funding for Chatham Islands going forward and how this has been devolved to PBF.

**Specialist Mental Health Services – Toni Gutschlag, General Manager**

- AT&R Unit was recently audited by the Ministry of Health (MoH). Whilst the report has yet to be received, the verbal report was very complimentary with no findings reported.
- There have been ongoing recruitment issues, but 21 nurses are scheduled to start in September.
There was discussion around the dedicated overseas recruitment campaign, with a focus on the UK and Australia. This has generated a number of inquiries, which could benefit both CDHB and primary health.

Discussion took place around Child and Youth, and the wait time experienced between initial assessment and first treatment. The Committee was advised that there is a considerable amount of work underway in an attempt to address this and whilst noticeable improvements have yet to be seen, there is optimism that they will occur. Balancing demand with resources is difficult where resources are constrained.

The Committee commented that staff should be assured that the Board is hugely appreciative of their efforts in dealing with unrelenting demand and that as far as possible staff continue to work to minimise the impact.

**Medical/Surgical & Women’s & Children’s Health – Pauline Clark, General Manager**

- Importance and success of the 8.30am 10 minute stand up meetings.
- Recent success of resident medical staff in Australian examinations.
- South Island DHB and lower North Island DHB patient flow issues, and using CDHB for overflow. Discussions continue to ensure that CDHB is not disadvantaged.
- Faster Cancer Treatment – a joint project is underway with Nelson Marlborough DHB around the head and neck pathway.
- The appointment of Norma Campbell as Director of Midwifery. Ms Campbell’s breadth of knowledge, contacts, credibility and mana will be huge asset to the organisation.
- Ongoing difficulties and challenges with physical environment.

**ESPIs - Pauline Clark**

The Committee was advised that CDHB achieved yellow status for ESPI 5 for the months of April, May and June, meeting MoH expectations. This was achieved as a result of amazing efforts by all teams involved.

**Resolution (13/17)**

(Moved: Jo Kane/Seconded: Andrew Dickerson - carried)

“That the Committee:

i. notes the Hospital Advisory Committee Activity Report;
ii. notes the efficiency gains highlighted throughout the report;
iii. notes that pressure remains in Specialist Mental Health Services, particularly with regards to Child and Youth treatment times;
iv. notes the pressure on Burwood Hospital bed numbers; and
v. notes winter planning and capacity issues.”

Andrew Dickerson, Chair, asked Sir Mark Solomon, Acting Deputy Chair, CDHB, if he would like to address the Committee in relation to recent developments.

Sir Mark advised that he had received a phone call from the Minister of Health the previous evening, advising that Dr John Wood had been appointed as the new Chair, CDHB. Sir Mark further advised that he would remain as Deputy Chair.

*The meeting moved to Item 6.*
6. **H&SS 2016/17 YEAR RESULTS - PRESENTATION**

Justine White, GM Finance and Corporate Services, provided a presentation detailing financial results for the 2016/2017 year.

The year end result for Canterbury DHB was a $13.337M negative variance to budget, this represents an expenditure variance of less than 1% (0.88%). Results show the actual deficit for the year was $51.8M as compared to the budgeted deficit of $38.5M and reforecast deficit (including additional outsourcing costs for ESPI compliance from February) of $49.4M. This deterioration was largely as expected, although a little higher than anticipated. In terms of the unexpected portion, this is approximately $2M different from reforecast. The main contributors were additional outsourcing incurred for ESPI compliance, additional internal costs for ESPI compliance (staff time, Saturday surgeries etc), and costs over and above what was funded for the North Canterbury earthquakes (eg, free GP visits, moving staff up to Kaikoura and Huruni to perform clinics as opposed to bringing patients down to Christchurch when roads were closed). Another contributor was the refunded donation to the Kaikoura District Council (KDC) of their $2M contribution towards their new facility – this donation was received from the MoH as an equity appropriation, but the funding was remitted to the KDC as expenditure, resulting in an immediate $2M deficit to CDHB. Other large component parts were around pharmaceutical cost increases; in between travel (difference between funding and actual costs); and additional payments made to ensure cover was in place during the RDA strikes in November and January. The RDA strikes were also a large contributor to the ESPI compliance issue.

There was discussion around the expected ability of a DHB to absorb these ups and downs. Under “normal” circumstances it is reasonable to assume that this would be the case, however, for CDHB specifically, after six years of heightened efficiency objectives in our post disaster conditions, it has become increasingly difficult to find any spare “give” to enable absorption of these types of additional costs, that has not already been taken advantage of or eliminated, hence the direct impact on the net operating results.

The 2017/18 draft annual plan has recently been submitted and is yet to be approved. It assumes a forecast deficit of $53.6M.

There was a request for an information paper to the Board on the CDHB’s 9% discretionary funding and what this is allocated to.

*The meeting adjourned for morning tea from 10.36 to 10.50am.*

*The meeting moved to Item 5.*

5. **ASHBURTON HEALTH SERVICES - PRESENTATION**

Berni Marra, Manager, Ashburton Health Services presented to the Committee, noting the late apology from Dr John Lyons, Clinical Director, for his non-attendance. The presentation included the following:

- History of Ashburton services.
- Key Developments.
- Successes to Date.
- Rural Hospitals and what they are.
- Ashburton Public Hospital and its classification as a Level 3 Rural Hospital.
- Overview of Ashburton health services.
• Work in progress.
• Opportunities in terms of research, education and service delivery.

The Committee thanked Ms Marra for her presentation.

The meeting moved to Item 7.

7. DO NOT ATTENDS (DNA) - PRESENTATION

Dr Melissa Kerdemelidis, Public Health Physician, Planning & Funding, presented on Outpatient Did Not Attends (DNA). The presentation included the following:

• What a DNA is.
• The importance of addressing DNAs.
• National and local DNA rates.
• Estimate of costs and pricing for DNAs in Canterbury.
• DNAs by ethnicity, age and gender.
• Initiatives and activities underway at both a DHB level, as well as department level, to reduce DNA rates, acknowledging there is not one single strategy which will address the issues.

The Committee thanked Dr Kerdemelidis for her presentation.

8. 2017/18 ELECTIVE SERVICES - PRESENTATION

Ralph La Salle, Team Leader, Secondary Care, Planning and Funding, presented on the 2017/18 Elective Services Plan. The presentation included:

• 2016/17 ESPI Recovery Plan – how CDHB went.
• 2017/18 Health Target – what it is and how it is determined.
• How CDHB plans to achieve the Health Target.
• Funding – what CDHB gets and how we manage it.
• Where CDHB’s previous investments have been successful and where to next – successes, challenges and opportunities.

The Committee thanked Mr La Salle for the comprehensive presentation.

Sally Buck retired from the meeting at 12.08pm.

9. CLINICAL ADVISOR UPDATE – VERBAL REPORT

This item was deferred to the Committee’s 5 October 2017 meeting.

10. SOCIAL WORK AFTER HOURS ON-CALL SERVICE

This item was deferred to the Committee’s 5 October 2017 meeting.
11. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (15/17)
(Moved: Anna Crighton/Seconded: David Morrell - carried)

“That the Committee:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1 and 2;

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

<table>
<thead>
<tr>
<th>GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED</th>
<th>GROUND(S) FOR THE PASSING OF THIS RESOLUTION</th>
<th>REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Confirmation of the minutes of the public excluded meeting of 1 June 2017.</td>
<td>For the reasons set out in the previous Committee agenda.</td>
<td></td>
</tr>
<tr>
<td>2. CEO Update <em>(If required)</em></td>
<td>Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege</td>
<td>s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)</td>
</tr>
</tbody>
</table>

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

INFORMATION ITEMS

- Pressure Injuries Prevention Briefing – July 2017
- 2017 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 12.15pm.

Confirmed as a true and correct record.

__________________________ ____________________
Andrew Dickerson Date
Chairperson
RESOLUTION TO EXCLUDE THE PUBLIC

TO: Chair and Members
   Canterbury District Health Board

SOURCE: Corporate Services

DATE: 17 August 2017

Report Status – For: Decision ☑ Noting ☐ Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATIONS

That the Board:

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

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

<table>
<thead>
<tr>
<th>GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED</th>
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<th>REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Confirmation of minutes of the public excluded meeting of 20 July 2017</td>
<td>For the reasons set out in the previous Board agenda.</td>
<td></td>
</tr>
<tr>
<td>2. Coronal Support Services Ministry of Justice RFP</td>
<td>To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).</td>
<td>s9(2)(j)</td>
</tr>
<tr>
<td>3. Investor Confidence Rating Improvement Initiative</td>
<td>To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).</td>
<td>S9(2)(j)</td>
</tr>
<tr>
<td>4. Chief Executive’s Update on Emerging Issues – Verbal Report</td>
<td>Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).</td>
<td>S9(2)(a) s9(2)(j)</td>
</tr>
<tr>
<td>5. Programme of Works Reprioritisation Framework Update</td>
<td>To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).</td>
<td>s9(2)(j)</td>
</tr>
</tbody>
</table>
6. **Legal Report**

- Protect the privacy of natural persons.
- To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).
- Maintain legal professional privilege

| S9(2)(a) | s9(2)(j) | s9(2)(h) |

7. **Advice to Board:**

- Facilities Committee Draft Minutes 1 Aug 2017
- HAC PX Draft Minutes 3 Aug 2017
- QFARC Draft Minutes 1 Aug 2017

For the reasons set out in the previous Committee agendas.

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

3. **SUMMARY**

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

(a) the general subject of each matter to be considered while the public is excluded; and
(b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on Clause 32(a) the particular interest or interests protected by section 6 or 7 or section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and
(c) the grounds on which that resolution is based(being one or more of the grounds stated in Clause 32)

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

Approved for release by: Justine White, GM Finance & Corporate Services