CANTERBURY DHB BOARD

Thursday, 21 June 2018
11:00am

Board Room
Level 1
32 Oxford Terrace
Christchurch

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 21 June 2018 commencing at 11:00am

			Approx. Times
ADMINISTRATION			**11.00am**
	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** *17 May 2018*		
3.	**Carried Forward/Action List Items**		
4.	**Patient Story**		
REPORTS			**11.05am**
5.	**Chair's Update (Oral)**	Dr John Wood *Chair, CDHB*	11.05-11.10am
6.	**Chief Executive's Update**	David Meates *Chief Executive*	11.10-11.40am
7.	**Finance Report**	Justine White *Executive Director, Finance & Corporate Services*	11.40-11.50am
8.	**Capital Charge Payment June 2018**	Justine White	11.50-12.00pm
9.	**Constitution of Brackenridge Services Limited**	Justine White	12.00-12.05pm
10.	**Annual Plan Approval – 2018/19**	Carolyn Gullery *Executive Director, Planning, Funding & Decision Support*	12.05-12.10pm
11.	**Committee Membership**	Dr John Wood	12.10-12.15pm
12.	**Advice to Board** • **HAC Draft Minutes** *31 May 2018*	Andrew Dickerson *Chair, HAC*	12.15-12.20pm
13.	**Resolution to Exclude the Public**	Justine White	12.20pm
INFORMATION ITEMS			
•	Nil		
ESTIMATED FINISH TIME – PUBLIC OPEN MEETING			**12.20pm**
NEXT MEETING: Thursday, 19 July 2018 at 9.00am			

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

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

Executive Support

David Meates – *Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
Michael Frampton – *Chief People Officer*
Mary Gordon – *Executive Director of Nursing*
Carolyn Gullery – *Executive Director Planning, Funding & Decision Support*
Hector Matthews – *Executive Director Maori & Pacific Health*
Sue Nightingale – *Chief Medical Officer*
Karalyn Van Deursen – *Executive Director of Communications*
Stella Ward – *Chief Digital Officer*
Justine White – *Executive Director Finance & Corporate Services*

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

Dr John Wood **Chair CDHB**	**Advisory Board NZ/US Council** – Member The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director. **Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice (as Chief Crown Treaty of Waitangi Negotiator)** – Ex-Officio Member The Office of Treaty Settlements, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Treaty Negotiator for Ngati Rangi** Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment. **Chief Crown Treaty Negotiator, Tongariro National Park** Engagement with Iwi collective begins July 2018. **Chief Crown Treaty Negotiator for the Whanganui River** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations** High level agreement in principle reached. Aiming for deed of settlement end of 2018. **Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA)** – Member ERIA is an international organisation that was established by an agreement of the leaders of 16 East Asia Summit member countries. Its main role is to conduct research and policy analysis to facilitate the ASEAN Economic Community building and to support wider regional community building. The governing board is the decision-making body of ERIA and consists of the Secretary General of ASEAN and representatives from each of the 16 member countries, all of whom have backgrounds in academia, business, and policymaking. **Kaikoura Business Recovery Grants Programme Independent Panel** – Member The Kaikoura Business Recovery Grants Programme was launched in May 2017 and is intended to support local businesses until State Highway One reopens by way of grants which can be applied for by eligible businesses. This programme is now closed.

	School of Social and Political Sciences, University of Canterbury – Adjunct Professor Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment. **Te Urewera Governance Board** –Member The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee. **University of Canterbury (*UC*)** – Chancellor The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation. **University of Canterbury Foundation** – Ex-officio Trustee The University of Canterbury Foundation, Te Tūāpapa Hononga o Te Whare Wānanga o Waitaha, is dedicated to ensuring that UC's tradition of excellence in higher education continues. From its earliest beginnings in 1873, philanthropic support and the generosity of donors and supporters has played a major part in making the university the respected institution it is today. The UC Foundation is dedicated to continuing that tradition. **Universities New Zealand** – Elected Chair, Chancellors' Group Universities New Zealand is the sector voice for all eight universities, representing their views nationally and internationally, championing the quality education they deliver, and the important contribution they make to New Zealand and New Zealanders.
Ta Mark Solomon **Deputy Chair CDHB**	**Claims Resolution Consultation – Senior Maori Leaders Group** – Member This is an Advisory Board to MSD looking at the claims process of those held under State care. **Deep South NSC (National Science Challenge) Governance Board** – Member The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities. **Greater Christchurch Partnership Group** – Member This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work). **He Toki ki te Rika / ki te Mahi** – Patron He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury.

Liquid Media Operations Limited – Shareholder
Liquid Media is a start-up company which has a water/sewage treatment technology.

Ngāti Ruanui Holdings – Director
Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki.

Oaro M Incorporation – Member
'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations.

Police Commissioners Māori Focus Forum – Member
The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation.

Pure Advantage – Trustee
Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth.

QuakeCoRE – Board Member
QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission.

Rangitane Holdings Limited & Rangitane Investments Limited - Chair/Director
The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members.

SEED NZ Charitable Trust – Chair and Trustee
SEED is a company that works with community groups developing strategic plans.

Sustainable Seas NSC (National Science Challenge) Governance Board – Member
This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement.

The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas

	NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding. **Te Ohu Kai Moana** – Director Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity.
Barry Bragg	**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. **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. **Farrell Construction Limited** - Chairman **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. **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.
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 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. **Rata Foundation** – Trustee Rātā Foundation, formerly The Canterbury Community Trust, was established in 1988 and is one of New Zealand's largest philanthropic organisations. The Foundation holds in trust for Canterbury, Nelson, Marlborough and the Chatham Islands an endowment, or putea, of over half a billion dollars. Investment returns on their capital base enables them to make millions of dollars in grants each year to community organisations across their funding region.

Dr Anna Crighton	**Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage **Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage **Heritage New Zealand –** Honorary Life Member CDHB owns buildings that may be considered to have historical significance.
Andrew Dickerson	**Accuro (Health Service Welfare Society)** - Director 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. **Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
Jo Kane	**HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Aaron Keown	**Christchurch City Council** – Councillor and Community Board Member Elected member and of the Fendalton/Waimairi/Harewood Community Board.
Chris Mene	**Canterbury Clinical Network** – Child & Youth Workstream Member **Core Education** – Director Has an interest in the interface between education and health.

	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. **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.
David Morrell Board Member	**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. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time. **Canon Emeritus - Christchurch Cathedral** The Cathedral congregation runs a food programme in association with CDHB staff. **Friends of the Chapel** - Member **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. **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. **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. **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.

MINUTES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held at 32 Oxford Terrace, Christchurch
on Thursday 17 May 2018 commencing at 11.00am

BOARD MEMBERS

Dr John Wood (Chair); Ta Mark Solomon (Deputy Chair); Barry Bragg; Sally Buck; Dr Anna Crighton; Andrew Dickerson; Jo Kane; Aaron Keown; and David Morrell.

APOLOGIES

Apologies were received and accepted from Chris Mene and Tracey Chambers.
An apology for lateness was received and accepted from Jo Kane (11.10am).
Apologies for early departure were received from Barry Bragg (2pm) and Aaron Keown (2pm).

EXECUTIVE SUPPORT

David Meates (Chief Executive); Carolyn Gullery (Executive Director Planning, Funding & Decision Support); Mary Gordon (Executive Director of Nursing); Hector Matthews (Executive Director, Maori & Pacific Health); Karalyn van Deursen (Executive Director, Communications); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

IN ATTENDANCE

Evon Currie (General Manager, Community & Public Health) - Items 9, 10 & 11.

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Ta Mark Solomon asked that Royal New Zealand Police College – Patron of Wing 312 be removed as this class has now graduated.

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

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

Perceived Conflicts of Interest
There were no perceived conflicts of interest

2. CONFIRMATION OF MINUTES OF THE PREVIOUS MEETING

Resolution (29/18)
(Moved: Sally Buck/seconded: Barry Bragg – carried)

"That the minutes of the meeting of the Canterbury District Health Board held at 32 Oxford Terrace on 19 April 2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

Maternity Strategy Update: noted that this is scheduled to come back to the Board, via the Hospital Advisory Committee, in August 2018.

The carried forward items were noted.

4. PATIENT STORY

The Patient Story was viewed.

Jo Kane joined the meeting at 11.10am

5. ORGAN DONATION & TRANSPLANTATION PRESENTATION

Nick Cross, Clinical Director, National Renal Transplant Service and Nephrologist provided a presentation on Organ Donation and Transplantation.

The presentation covered in particular: why transplant is best; progress nationally - deceased donation/live donation; deceased and live donation changes; and local issues.

The Chair thanked Nick Cross for his presentation and the work he is undertaking in this area.

6. CHAIR'S UPDATE

The Chair advised that the Chief Executives met in Wellington last week and the Minister took the opportunity to invite Chairs to Wellington to meet with him as a group and then meet individually (Chair & Chief Executive) with him and the Acting Director General. He commented that the message he took from the meeting was that health will receive more funding than the last financial year, however, nowhere near enough to cover the shortfall nationally. He added that the Minister appeared to accept Canterbury DHBs deficit and it became clear that there is a lot riding on the Truth & Reconciliation process. This process will be seriously underway with a visit by the Acting Director General and Facilitator next week.

A query was made as to whether in discussions with the Minister and Director General was there any discussion around changing the inequity in funding for Canterbury? Dr Wood advised that each DHB had only five minutes, so discussions did not go into any detail.

The Chair's update was noted.

7. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, took his report as read and highlighted the following:

- There has been an increase in the number of OIAs continuing to come to the DHB.
- The media coverage around mental health has caused some concerns due to the inaccuracy of the information, particularly around seclusion rates last weekend. He commented that seclusion is used very rarely and is normally for the protection of the patient. There was also a significant privacy issue around media wanting to photograph and film at Hillmorton.
- In regard to parking, he advised that discussions are continuing and solutions being looked at.

Discussion took place regarding traffic management around the hospital site.

A query was made regarding influenza vaccinations and it was noted that there had been 5,000 vaccinations to date. It was agreed that future reports would include information on the current status of influenza burden, as well as uptake by staff for the influenza vaccination.

Resolution (30/18)
(Moved: David Morrell/seconded: Ta Mark Solomon – carried)

"That the Board:

i. notes the Chief Executive's Update."

8. FINANCE REPORT

Justine White, Executive Director, Finance & Corporate Services, presented the Finance Report which was taken as read. The report showed that the consolidated Canterbury DHB financial result for the month of March 2018 was a deficit of $9.186M, which was $0.993M unfavourable against the draft annual plan deficit of $8.193M. The year to date position is $3.750M unfavourable to the draft annual plan.

Ms White commented that the March result showed a continuing unfavourable trend around Aged Residential Care, payroll costs and also the impact of outsourcing.

Resolution (31/18)
(Moved: Ta Mark Solomon/seconded: Aaron Keown – carried)

"That the Board:

i. notes the financial result and related matters for the period ended 31 March 2018."

9. DRAFT CDHB PUBLIC HEALTH PLAN

Evon Currie, General Manager, Community & Public Health, presented the draft Public Health Plan to the Board. She advised that this has been to the Community & Public Health and Disability Support Advisory Committee and planning documents have been received from the Ministry of Health that do not request any changes.

Resolution (32/18)
(Moved: Dr Anna Crighton/seconded: Andrew Dickerson – carried)

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

i. endorses the draft Canterbury DHB Public Health Plan, 2018-19."

A query was made as to whether the CDHB submitted on the recent Land Transport reduction in road toll submission. Ms Currie will check and provide advice to Anna Craw for circulation to Board members.

10. SUBMISSION – LOCAL GOVERNMENT (COMMUNITY & WELLBEING) AMENDMENT BILL

Evon Currie, General Manager, Community & Public Health, presented this submission. She advised that the DHB has already made a lot of progress in this area.

Resolution (33/18)
(Moved: David Morrell/seconded: Ta Mark Solomon – carried)

"That the Board:

i. approves CDHB's submission on the Local Government (Community Well-Being) Amendment Bill."

11. SUBMISSION – RESIDENTIAL TENANCIES (PROHIBITING LETTING FEES) AMENDMENT BILL

Evon Currie, General Manager, Community & Public Health, also presented this submission. There was no discussion.

Resolution (34/18)
(Moved: Sally Buck/seconded: David Morrell – carried)

"That the Board:

i. approves CDHB's submission on the Residential Tenancies (Prohibiting Letting Fees) Amendment Bill."

The meeting moved to Item 13.

13. DELEGATIONS FOR ANNUAL ACCOUNTS

Justine White, Executive Director, Finance & Corporate Services, presented this report which was taken as read. She advised that this is a standard delegation based on the timing of meetings.

Resolution (35/18)
(Moved: Ta Mark Solomon/seconded: Barry Bragg – carried)

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

i. authorises either the Quality, Finance, Audit and Risk Committee Chair and the Board Chair or, if one of these should not be available, one of these two and a Board member to approve the final audited accounts for 2017/18 on the Board's behalf if required, should the timetable not fit with a Board or Committee meeting;
ii. notes that if this delegated authority is exercised, the final accounts will be circulated to Committee and Board members; and
iii. notes that the Canterbury DHB Chair, Chief Executive and General Manager Finance and Corporate Services will sign the letter of representation required in respect to the 2017/18 Crown Financial Information System accounts which are required at the Ministry of Health in early August."

14. WRITE-OFF REPORT

Justine White, Executive Director, Finance & Corporate Services, presented this report which was taken as read. It was noted that the debt will still be referred for collection.

Resolution (36/18)
(Moved: Aaron Keown/seconded: Barry Bragg – carried)

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

i. approves the write off of $184,640, being the outstanding balance of a non-New Zealand resident inpatient charge."

15. DISPOSAL OF CDHB LAND AT 135 MADDISONS ROAD, TEMPLETON

(Aaron Keown and Sally Buck withdrew from discussion and abstained from voting.)

Justine White, Executive Director, Finance & Corporate Services, presented this report which was taken as read.

Resolution (37/18)
(Moved: David Morrell/seconded: Ta Mark Solomon – carried)

"That the Board:

i. notes receipt of, and takes into account, the views recorded in the public submissions; and
ii. declares the land surplus to DHB requirements and, subject to Ministerial approval, transfers it to Council in accordance with the New Zealand Public Health and Disability Act."

16. ADVICE TO BOARD

CPH&DSAC Draft Minutes
Dr Anna Crighton, Co-Chair, provided the Board with an update from the Committee's meeting held on 3 May 2018.

Resolution (38/18)
(Moved: Dr Anna Crighton/seconded: Jo Kane – carried)

"That the Board:

i. notes the draft minutes from CPH&DSAC's meeting on 3 May 2018."

The meeting returned to Item 12.

12. PRESENTATION OF CEMARS CERTIFICATE FOR CDHB ENVIRONMENTAL MANAGEMENT / CARBON EMISSIONS

Dr Belinda Mathers, General Manager, Enviro-Mark Solutions Limited presented Dr John Wood with a certificate stating that the Canterbury DHB meets the requirements of CEMARS certification, having measured its greenhouse gas emissions in accordance with ISO 14064-1:2006 and committing to managing and reducing its emissions in respect of the operational emissions of its organisation.

The meeting moved to Item 17.

17. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (39/18)
(Moved: David Morrell/Seconded: Barry Bragg – 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 and the information items contained in the report;
ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting of 19 April 2018	For the reasons set out in the previous Board agenda.	
2.	Chair & Chief Executive's Update on Emerging Issues – Oral Reports	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.	People Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4.	Parkside External Panels Restraint (North West Corner of Parkside)	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Statement of Intent Draft	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Deficit Support and Equity Drawdown	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Earthquake Settlement Proceeds – Equity Drawdown	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	2017/18 Year End Forecast	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	S9(2)(a) s9(2)(j) s9(2)(h)
10.	Advice to Board: • Facilities Committee (Oral) *17 May 2018* • QFARC Draft Minutes *01 May 2018*	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 12.35pm

_____ _____

Dr John Wood, Chair Date

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 21 JUNE 2018

DATE	ISSUE	REFERRED TO	STATUS
15 Mar 18	Maternity Strategy Update	Carolyn Gullery	Report to 16 August 2018 meeting.
17 May 18	Update to be provided on influenza vaccination uptake.	Michael Frampton	Today's agenda – Item 10PX
29 May 18 (QFARC)	Reconciliation of proposed 18/19 budget against current 17/18 forecast and numbers presented for the 18/19 year 12 months ago.	Justine White	Today's agenda – Item 8PX

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Chief Executive**

DATE: **21 June 2018**

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.

3. DISCUSSION

PUTTING THE PATIENT FIRST – PATIENT SAFETY

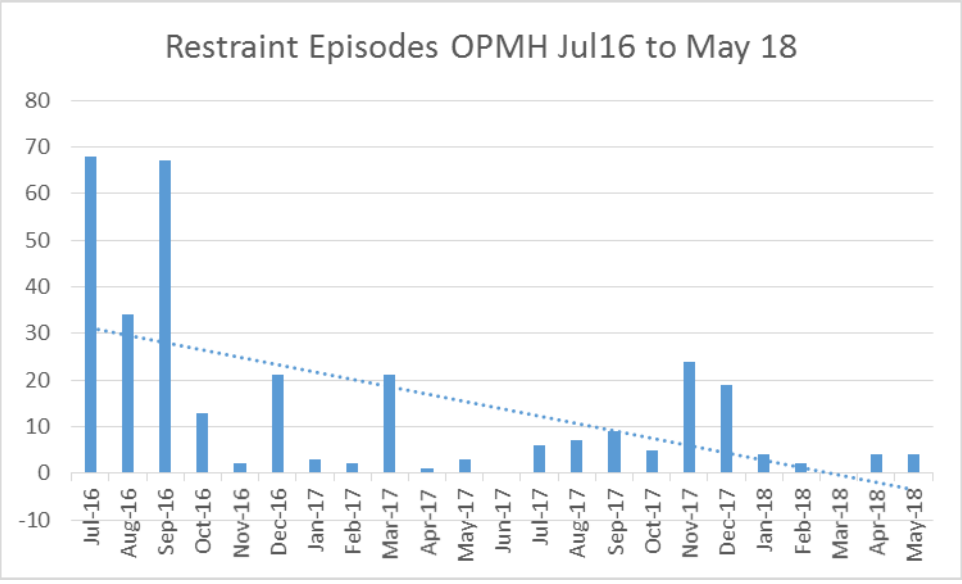
Patient Safety

- **Canterbury DHB MoH Certification Audit week - 18 June 2018:** Auditors will be on site for week of 18 June for the audit against the New Zealand Health and Disability Services Standards (NZS 8134.1:2008).
- **Hand Hygiene:** Hand Hygiene Focus for the Month of May was the WHO Theme – SAVE LIVES: Clean Your Hands – "It's In Your Hands – Prevent Sepsis in Healthcare".
- Several initiatives of heightened local activities and how these improved Hand Hygiene compliance were shared in the CEO update. From NICU's complex environment rethink on 'baby zones' to the Acute Medical Assessment Unit making use of visual aids and making Hand Hygiene part of the everyday clinical conversations and team updates. The Commonwealth Games inspired the hand hygiene going for gold initiative at Older Persons Health; a challenge to increase collection of the 5 moments of hand hygiene. Ashburton Hospital auditors discussed with clinical staff any 'missed moments' so they can be prevented in the future. Additionally resources were proudly displayed in public spaces to empower patients to ask staff to clean their hands - 'it's okay to ask me to clean my hands', to hand hygiene quizzes. The month concluded with a clinical presentation by Carl Hanger, Geriatrician on insights on HABSI from an Older Persons Health perspective.

- **Deteriorating Patient: Patient and Family/Whanau Escalation of Care (HQSC):** The mechanism for patients and families/whanau to use to escalate care if they have unresolved concerns has been co-designed with consumers. The initial two week test of the parent/family

information pamphlet and poster with prompts for staff in PHDU has finished. The feedback from parents and staff will be considered over the next few weeks. The next test phase will include the revised parent/family information as well as the agreed tiered escalation process.

- **NEW HQSC Quality & Safety Markers being introduced:**
- *Deteriorating Patient:* The majority of the data required for the new quality and safety measures is already captured electronically in Patientrack, and the existing standardised nursing early warning score audit tool has been modified to collect the other data. A delay in implementation of the revised EWS audit tool has meant that no data was collected in April. EWS auditing commenced in some areas during May with the remaining areas to commence in June.
- *Pressure Injuries*: The revised HQSC 'How to Guide' and data collection templates were released early April. Work has commenced on incorporating the measures into the standardised nursing Pressure Injury audit tool. The data collection is to commence from 1 July 2018.
- **Releasing Time to Care (RT2C):** Medication safety workshops have been completed at Burwood, Ashburton and Christchurch Women's Hospital. The focus was on medication safety at all stages of the administration process. Presentations were provided by Medical, Pharmacy, Maternity, RT2C, EMeds and Quality teams. Attendees discussed the role of Human Factors in medication incidents, and what staff could learn from the data collected from medication follows, staff surveys, Safety 1st incidents and patient engagement surveys. Burwood, Ashburton and Kaikoura hospitals are continuing to focus on standardisation, geographical/team nursing and bedside handover, incorporating the patient bedside boards. The rural hospitals received their bedside boards this month in time for certification. E-Handover training is underway in Burwood and Ashburton.
- **Older Persons Mental Health** (OPMH) has actively worked to meet the aims of the Restraint Minimisation and Safe Practice Standards (NZS 8134.2:2008). After a certification audit in 2015 the Canterbury DHB was given corrective actions regarding restraint and seclusion which have led to changes in practice and a significant reduction in the use of restraint.
- Consistent efforts to manage without restraint have proved successful. All forms of mechanical restraint have been removed from wards which is a great success and improvement from previous reporting.



- With the increase of the falls particularly across the Older Persons Health Wards, we are looking how we manage this differently and considering the Safe Recovery programme. What is different about this approach, compared to other previous falls prevention?
    - Focuses on the "end" goal ("safe" recovery/rehabilitation), not falls
    - Focuses on adult educational techniques, not pamphlets or information alone.
    - A proven multimedia approach is used
    - Personalises the issues for each patient (most people in a hospital setting underestimate their risk of falling) , giving them reasons to change behaviour
    - The success of the educators role in changing risk taking behaviour is dependent on reinforcement and support from ward staff
- Components of the Safe Recovery programme, includes:
    - The independent (from the ward team) educator undertakes 3 inter-related educational activities.
    - Educating patients about their (a) risk of falling and personalises this risk (b) motivate them to mitigate this risk and (c) get them involved in or engaged in their own falls prevention strategies. This is a multimedia educational approach, using DVD, patient workbook and 1:1 sessions with the patient
    - Staff training about the interventions and falls prevention, and how they can positively reinforce the messages with patients
    - Feedback from patients (fed back via the educator) to staff about perceived barriers. Patients also encouraged to speak up and proactively seek help from staff and encourage staff to carry out the prevention strategies
- The approach differs in that it is an educational programme targeted primarily at cognitively able patients, with components of staff education as well as feedback from patients to staff. The intervention (education) was applicable to approximately 50% of the admissions to their wards. The educators visit each ward 2-3 times per week, spend a median of 2 sessions per patient. It took a median of 45 minutes to educate each patient (IQR 35-55 minutes). The educator assists patient to formulate their own goals.
- **The Clinical Team Coordinator (CTC) Role Improves Patient Safety After Hours:** The CTC role was permanently introduced to Christchurch Hospital in early 2008. This was the primary recommendation from a review of patient care in the after-hours period that showed that there were serious deficiencies in leadership, the way that the various teams work together and task distribution during this time that resulted in negative effects on staff (particularly resident medical officers) and patients. In the 10 years since the role was introduced, it has expanded from a roster of three senior nurses covering the medical wards on nightshifts, to 11 covering both medical and surgical clusters in the afternoons, nightshifts and weekends. These after-hours periods cover 76% of the hospital week. In this time, the hospital has changed and so have the responsibilities of this role. Earthquake repairs have seen wards and departments relocated and overhauled. Also the increased ability to manage patients in the community, through systems and supports such as the Acute Demand Management Service and Health Pathways, has meant the typical inpatient is now of higher acuity.
- The current CTC role includes:

- Facilitating daily handover meetings between the afternoon and night RMO shifts that provide a valuable overview of patient activity and acuity, as well as medical workloads across the whole hospital;
- Coordinating duty house officer workloads by assessing and triaging tasks and requests from ward nursing staff;
- Assessing patients as part of the New Zealand Early Warning Score escalation pathway;
- Problem-solving clinical and logistical issues through good working relationships with ward nursing staff, Duty Nurse Managers, resident medical officers and Service Managers;
- Supporting and mentoring ward nurses through Post Graduate studies;
- Being members of the Clinical Emergency Team in the after-hours;
- Contributing to, many groups and committees within the hospital, including The Deteriorating Patient, Senior Nurse Review Steering Group, New Zealand Resuscitation Council, and Nursing Entry to Practice programme;
- Performing clinical procedures traditionally done by doctors, including IV cannulation, venepuncture, arterial blood gases, male urethral catheterisation and most recently, peripheral ultrasound guided cannulation.

- The main aim of the CTC role is to ensure effective teamwork in the after-hours period so that staff, particularly junior resident medical officers, can work in an environment where they are supported, have manageable workloads and their activity is prioritised so they can be with the right patient at the right time to enable good clinical decision-making and high-quality patient care. The shift is typically spent circulating the wards and other clinical areas, interacting with patients and staff. Team members typically walk around 9km in a shift.

- In a recent survey, respondents were asked what they found of most value from the role. Overwhelmingly both nurses and resident medical officers felt that being able to ask advice and having the support of a senior nurse in the after-hours was most valuable. When asked if they felt the role improved patient care and safety, 70% strongly agreed in 2018. When asked this same question in 2008, just 8% strongly agreed, suggesting that staff now place significant value in the role.

- To date, the CTC role is unique to the Canterbury DHB within New Zealand. No other district health boards have a position with this broad range of clinical and logistical scope. The move to the new Christchurch Hospital Hagley has offered the opportunity to review and reflect on the role and how it may develop in the future.

- **Diabetes:** In March an update was provided describing a project being carried out in partnership between Linwood Medical Centre and the specialist diabetes service to improve the care for people with diabetes in the community. Two recent developments in this work include:

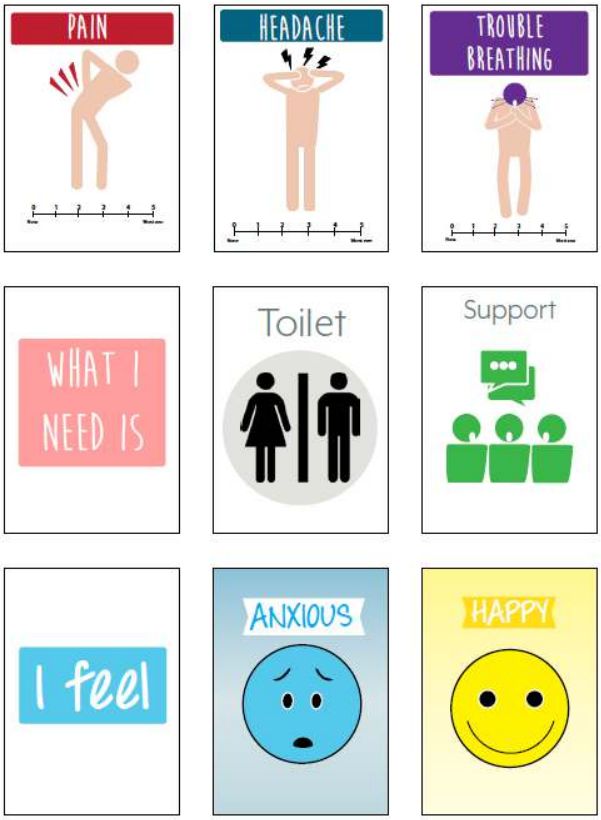
  - The Linwood specialist diabetes clinic, working to host a Sports Canterbury a Diabetes Be Active program pilot again. The original programme will be updated to provide key messages about diabetes self-management in a community setting. This material has previously been taught at specialist classes and it is exciting to see these being built into a community level program. Our aim is to achieve a sustainable diabetes specific program – via Green prescription (Sports Canterbury) with improved uptake within the Linwood locality. This will enable other primary care practices to also refer their patients into the Diabetes Be Active program. This means that patients will benefit from insights and information that will help them to manage their condition in the community without the need to visit a hospital service.
  - Alongside this we continue to focus on improving the uptake of retinal screening amongst patients with diabetes who attend the Linwood Medical Centre. Early analysis of retinal screening results has resulted in an urgent referral back to eye department, plus the need

for many to be re-referred. The Ophthalmology department is now working closely with us and supportive of a coordinated approach to improving the 30% retinal screen rates for Linwood Medical Centre diabetes patients.

- **PICC line improvements:** An update was provided in February describing the benefits demonstrated following implementation of a product called SecurAcath® that reduces the risk of these catheters migrating in or out of the vein. That update focussed on the reduction in reinsertions required and additional care not required due to a reduction in associated hospital acquired blood stream infections in a selection of wards. Since then a complete review of the number of blood stream infections associated with these catheters has been completed. This showed a reduction from 22 infections in 2015 to 10 in 2017, the infection rate reduced from 1.4% to 0.6%. This is a significant improvement for patients, avoiding much discomfort and time spent in hospital and avoids additional costs of $360,000 associated with treatment of blood stream infections each year.

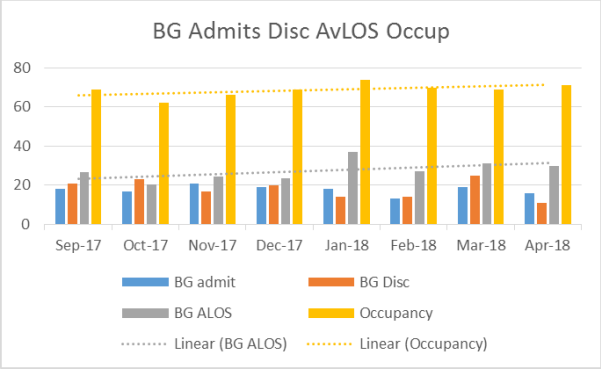
- **Changes in port locking protocols reducing risk of infection and saving materials and time:** Central venous access devices is a term used to cover a range of catheters that provide long term intravenous access. Historically the implanted ports have been "locked" with a solution of heparin in saline to ensure that they do not get clogged up with clots. When the line is not being used this lock solution has been refreshed on a monthly basis. However studies have found that using this solution can lead to development of a biofilm in the catheter that increases the risk of associated blood stream infection. It has been found that replacing the heparinised saline with plain saline eliminates the formation of a biofilm without increasing the incidence of clotting even when they are not used for weeks. Heparinised saline has now been replaced by saline for this purpose at Canterbury District Health Board. In addition to reducing the risk of blood stream infection this has reduced the expenditure on heparinised saline by over $13,000 a year. In addition to this a review of the literature has identified that reducing the frequency that refreshing the lock solution from monthly to three monthly does not increase the rate at which ports become occluded. Accordingly our practice is being changed so that adult patient's ports are locked every three months with saline. This saves patient and staff time and reduces the consumables required. This will be a positive impact, especially for adults with Cystic Fibrosis whose ports stay in place for many years. The impact of these changes on infection and occlusion rates will be monitored closely over the coming months.

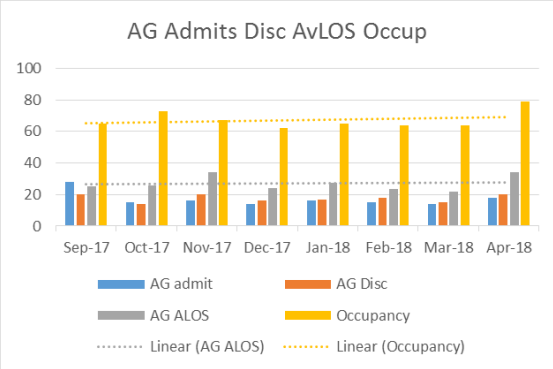
- **Cards help communication:** Finding it difficult to be understood and to understand what health staff were saying to them was the experience of three members of Canterbury DHB's Youth Advisory Council. One is deaf, one has a speech difficulty and the other was often unable to speak due to severe pain. In a small committee of 12 it was deemed significant that three people identified communication as difficult, especially when they were acutely unwell. While ward staff are very good at communicating it was decided that another tool would be a good resource for the patient at times when communication is difficult. The Committee assessed the communication cards that were already available and gathered information through a survey of 14-24 year olds who were inpatients in hospital. They found the existing cards did not cover all three vital aspects – the symptoms and how bad these were; what the person needed right now; and how the person was feeling about information, treatment, ongoing plans. The Committee then worked with Medical Illustration and a set of cards was created to encourage communication and allow the patient to have as much input as possible into an accurate assessment of their symptoms and ongoing treatment. Though designed for 14-24 year olds they can be used for any age group. Cards were delivered to paediatric and adult wards last Thursday and many wards have already identified patients who will benefit from this resource.



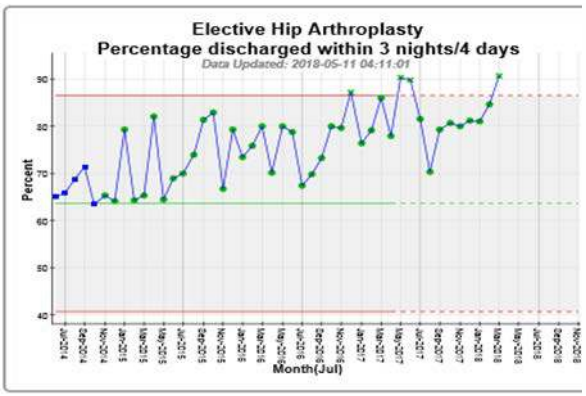
IMPROVING FLOW IN OUR HOSPITALS

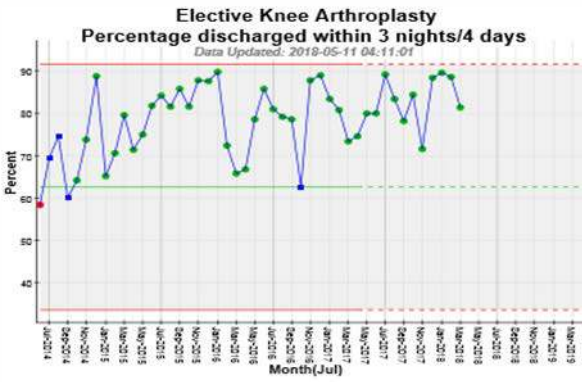
- **Improved pathway for people with soft food bolus impaction:** Around 60 people per year present to the Emergency Department with a soft food bolus impaction, a blockage of the oesophagus caused by a soft food bolus, usually meat. This is a distressing situation that results in discomfort and an inability to swallow fluids, including saliva. Treatment involves endoscopic removal of the food, followed by examination of the oesophagus to determine the underlying cause for the obstruction. Until recently people presenting in this situation typically waited for three hours in the Emergency Department before being admitted to a ward and then directed to the endoscopy suite for treatment. A new pathway has now been put in place where, instead of sending the patient on for full review in the Emergency Department, the triage nurse immediately refers patients with this condition to the gastroenterology registrar. They will then be sent directly to the endoscopy suite, and discharged home directly from there when appropriate. This will reduce waiting time for the patient – reducing the discomfort experienced by the patient. It will also reduce the time spent in hospital by this group of people and minimise the need for overnight stays for people that present during the day time. It will also reduce the number of call outs required to carry out endoscopies outside of normal hours.
- **Older Persons Mental Health (OPMH):** Across OPMH focus on our health pathways, models of care, lean methodology supports our service. A newly formed role of nurse consultant for OPMH in line with the roles in Specialist Mental Health will continue to support the clinical leadership and knowledge across the service. Improvements made to date around restraint, readmission will continue to be developed with this new role.





- **Older Persons Health & Rehabilitation (OPH&R) Surgical services**: our ERAS principles are well embedded. Consistency of our length of stay for elective joint surgery. A predicted change in the data for June is known as the joint target has been reached as planned. Focus on the non-joint surgery is currently underway.





- **Spinal Service**: There have been some difficulties in recruiting both EN and RN Nursing staff to the service over the last month to replace a number of resignations which has created challenges in providing adequate staffing for the service and in particular Ventilator patients.

REDUCING THE TIME PEOPLE SPEND WAITING

Medical & Surgical and Women's & Children's Services

- **Key Outcomes - Faster Cancer Treatment Targets: 62 Days Target:** For the three months this report covers (Feb-Apr 2018) Canterbury DHB submitted 156 records to the Ministry with 25 missing the 62 days target. Discounting 20 patients who missed the target through patient choice or clinical reasons left 135 patients eligible for inclusion in the target calculations. On this basis Canterbury DHB once again met the target of having at least 90% of patients receive their first treatment within 62 days of referral with 96.3% of eligible patients being treated within 62 days.
- **31 Day Performance Measure:** Canterbury DHB submitted 332 records towards the 31 day measure in the same three month period. This figure includes patients also eligible for the 62 days target. 88.3% of eligible patients met the 31 day measure. The threshold is still 85% so the Canterbury DHB continues to be compliant.
- **Elective Services Performance Indicator (ESPI) Target Outcomes:** Latest final reporting from the Ministry of Health shows that Canterbury DHB achieved a red result for elective services performance indicator two (covering first specialist assessment) at the end of April.

This is the third month that this indicator has shown as red. 18 of the 26 services that contribute to this measure had no patients waiting longer than 120 days, three services had eight or fewer and five services had more than ten.

- The same report shows that Canterbury District Health Board achieved a red result for elective services performance indicator five (covering waiting time for surgery) for the ninth month in a row. Four of the 13 services that contribute to this measure had no patients waiting longer than 120 days, seven services had less than ten patients and two services had more than ten patients waiting for longer than this. The Ministry of Health has provided Canterbury District Health Board with dispensation from financial penalties for Elective Services Performance Indicator achievement between January 2018 and June 2019 to recognise the pressures associated with facility limitations and issues associated with data transition. These measures will continue to be published and Canterbury DHB remains committed to working towards its goal that patients will not wait longer than 100 days for elective services they have been offered.

- **Community Infusion Service:** The Medical Day Unit at Christchurch Hospital provides a range of treatments to patients who have medical conditions or cancers. Patients attend the unit only for as long as is required for them to receive their treatment – this may be as short as one hour up to six hours. For most patients the treatment provided involves intravenous administration of drugs or blood products. This ambulatory model has become increasingly popular and this has resulted in an ongoing increase in demand for services from the Medical Day Unit and provides us with a risk that we will be unable to provide essential services in an appropriate setting. Within the group of patients who receive treatment in this unit there are cohorts of patients whose treatment does not need to be in a secondary hospital setting. Clinicians have worked with Planning and Funding to define infusion services that can safely be carried out in the community and a provider has been identified to carry this work out. From July this year lower complexity infusions will be provided from two general practices in Christchurch. This will provide a more convenient setting for many patients, avoiding a visit to Christchurch hospital and will release Medical Day Unit capacity to be used for other patients. The number of practices participating will increase over time as the service expands.

- **Celo the safe-snapping App:** Snapchat or WhatsApp are used widely in the community to enable people to communicate. However while these applications allow encrypted image sharing, there are issues with using them in the health system. Messages and images are stored on each phone and anyone who uses or steals the device can see them. This is not acceptable and so the benefits of these methods of communication have not been available to health professionals. In response to this, an App called Celo is being provided to Canterbury health professionals that lets medical staff confer or safely share a photo at the click of a button so that they can obtain a second opinion when they are in a hurry. Celo behaves more like a mobile banking app, where nothing is stored on the device and nobody can access information without the user's unique PIN code. All users on a Celo network are verified, so there is no chance of a user accidentally sending patient images to someone who does not work in healthcare.

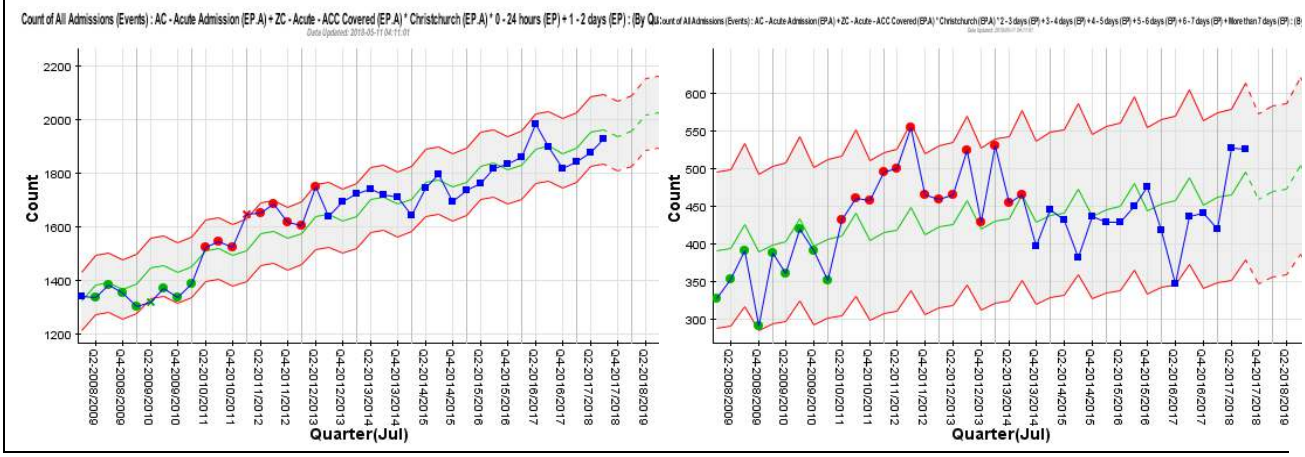
- Christchurch Hospital Paediatrician Dr John Garrett says the Celo App has been invaluable for his work. "I go to the Chatham Islands twice a year to see paediatric patients over there. One of my patients was also a patient in the plastic surgery service here." The patient's mother mentioned they were planning to fly to the Christchurch plastic surgery clinic for a follow-up appointment regarding a scar. The trip would have been a considerable inconvenience for the family involving three or four days of time off work for that parent, time off school for the child. Along with that travel costs can also add up, placing demand on an already stretched health budget. Using Celo, John was able to take a picture of the scar, send it straight to the plastic surgeon. Within five minutes she was able to communicate back that the scar looked fine and the patient was not required to travel to Christchurch. John has also found that the App is useful when he is on call. Registrars can share images with consultants instead of

describing conditions on the phone enabling better decisions to be made for the patient. Celo is the preferred method of communication in the Paediatrics department and John is looking forward to it being more widely used in the hospital. Celo will also soon be used in the West Coast DHB, where clinicians regularly confer with Canterbury DHB staff. Plans are being developed to extend Celo's use to primary care and also to enable the upload of images from Celo into Health Connect South so that they become a part of the patient's clinical record. Celo has been developed in partnership with Canterbury DHB as part of the Health Board's focus on using technology to improve healthcare for patients and staff.

- **Elective Health Target Delivery:** Ministry of Health reporting shows that following April 2018 Canterbury DHB was running 287 discharges (around 2%) behind its Elective Health Target. Internal reporting which is more up to date shows that the deficit was less than 220 at the end of that month. Within this reporting it is clear that in house delivery is above planned levels and outsourced discharges are running nearly 500 shy of target. However we know that catching up on delayed data entry along with some corrections being put in place will increase the outsourced count. Between this work, ongoing efforts to provide more outsourced work and work carried out within our own hospitals we are confident that we will meet the Elective Health Target at the end of June. Note, however that there is a mismatch between target and delivery in the various sub-categories (ie arranged versus elective and between specialties). For example as at the end of April we have provided over 260 more arranged discharges have occurred than planned. This represents good practice, as it ensures that patients receive surgery soon after an acute event, without having to be waitlisted. Canterbury DHB is working through these mismatches with the Ministry of Health.

- **Increase in Outplacing in order to enable more timely acute surgery:** Striking the right balance in allocation of theatre capacity between acute and elective duties and ensuring that capacity is provided to the right services requires ongoing attention from the Theatre Utilisation Workgroup. Over the past year it has been evident that acute theatre capacity was under increasing pressure. One indicator that provides evidence of this is that the number of people who have been admitted acutely to hospital who have waited less than two days for their first operation has been similar to the previous year whereas those waiting longer than that has increased over the past six months.

Acute admissions – waiting <2 days for first operation	*Acute admissions waiting ≥2 days for first operation*



- In response to this the Chief of Surgery and Service Manager for Anaesthesia have been working with surgical services to identify further surgical work that can be carried out on an outplaced basis – ie Canterbury DHB Surgeons and Anaesthetists operating at St Georges Hospital, Southern Cross Hospital or Christchurch Eye Surgery allowing additional theatre capacity for acute surgery. Our initial goal has been to identify six additional half day sessions each week that can be added to the acute allocation. So far we have identified an additional four half day

sessions. This will provide some additional capacity throughout the remainder of 2018 and will help bridge the gap until significant new acute capacity is brought on line with the opening of the Acute Services Building. The Theatre Utilisation Workgroup will continue to monitor requirements for theatres and make changes to optimise access.

- **Realistic, low-cost medical simulator developed by Christchurch team**: Simulation is an important component in preparing individuals and teams to manage complicated clinical situations that require rapid response. Some existing simulation tools are expensive or require off-site training limiting our ability to train all team members together. Most systems use mock monitors, designed to look like the real thing which means that the mock monitor and how it behaves is not the same as the ones actually used for clinical care – limiting the value of the simulation. Anaesthetic Specialist Dr Daniel Hartwell and Biomedical Engineer Michael Sheedy have worked together to develop a low cost approach. This involves a technique to use calibration devices to run simulations. These devices are used to check equipment, and can be used to make certain displays appear on medical monitors. Dan and Michael have developed software to allow someone to control the calibration device wirelessly from a tablet computer. The first module, called RESPIRECO2, is a device that generates carbon dioxide to imitate different human breathing patterns, which show up on real monitors. Daniel has conducted simulations for anaesthetics teams using partial and full mannequins, and actors. He has tested the simulator in surgical theatres, the intensive care unit, ambulances, and a medical transport helicopter. It has been used for training in Christchurch Hospital's Emergency Department, and further testing is being carried out at different hospitals around New Zealand and in Australia. The Hartwell Simulator has been developed in partnership with Canterbury DHB as part of a focus on using technology to improve healthcare for patients and staff.

- **ePharmacy Upgrade Update:** The Pharmacy Service in conjunction with ISG recently completed a major upgrade of its ePharmacy software and some associated hardware. Our previous ePharmacy version did not have the ability to talk with Medchart as they used different dictionaries of drug names. This meant that while charting occurred electronically in the wards pharmacy staff then manually transcribed the required information into the pharmacy system, printed off a dispensing request for the items required and dispensing was carried out on this basis. Implementing these two systems has occurred over several years and taken many hours of project manager, pharmacist and other clinician time. The upgrade means that the two systems will be able to be integrated later this year, once Medchart has undergone its next upgrade. This will enable Medchart to auto-populate the pharmacy system with dispensing requirements, avoiding manual transcription. Our aim is that it will also enable tracking of dispensing request status by nursing staff. It has also allowed the introduction of wireless, android bar-code scanners which enable real-time uploading of ward imprest stock requirements and more efficient processing of this data. This will impact most on nurse aide workflow as stock will be delivered sooner in the day. Integration will ensure transcription errors are avoided. Later this year, the new system will enable our dispensaries to go paperless for all inpatient dispensing transactions. Once again, releasing time to other tasks and reducing paper record transport and (commercial) storage costs.

Specialist Mental Health Services (SMHS)

- **Demand for Specialist Mental Health Services**: The SMHS divisional leadership team and Planning & Funding continue to closely monitor use of Mental Health Services. Demand for adult general services is continuing to grow. Our staff work exceptionally hard to provide the best care possible in some very challenging circumstances and we are continuously looking for ways to make the environment as safe as possible for consumers and staff. A range of initiatives are contributing 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. An interim environmental modification has seen a significant improvement in incidents related to a specific individual cared for in this environment, however there continues to be significant incident rates overall within this unit.

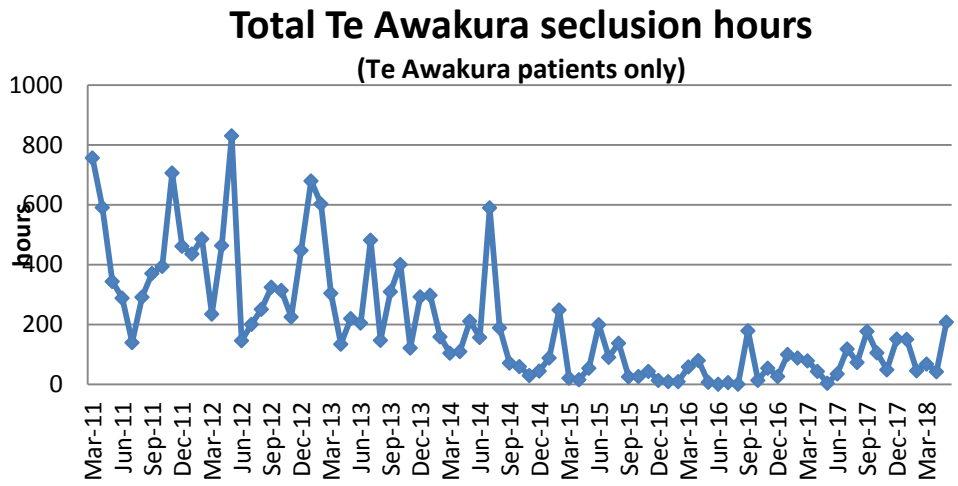
- Nurse Coaches were established within Te Awakura (the adult acute inpatient service) in late 2017. These roles were established to support practice for both registered and enrolled nurses in their first year of Mental Health practice. A formal 3-stage evaluation of the impact of the role is underway. Stage 1 has been completed with positive feedback.

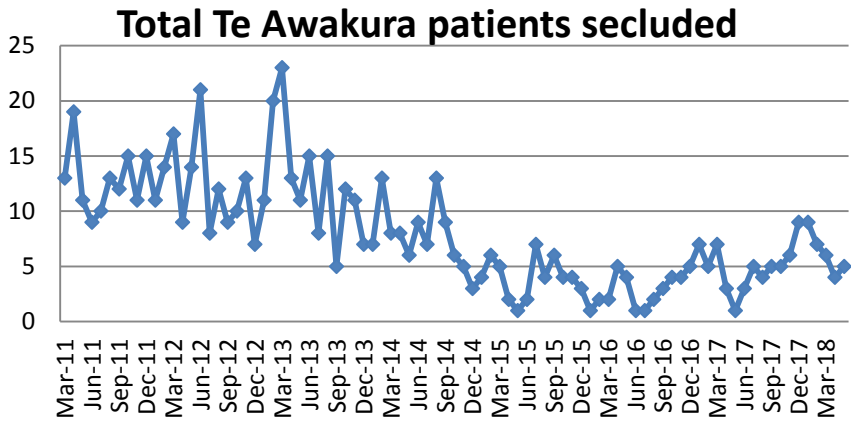
- There are currently several AT&R staff on ACC due to serious work related injuries. Strategies have been put in place to maintain staffing levels for the unit through using pool staff familiar with the area and a short term staff secondment to assist in continuity of care. Maintaining this level of staffing is an ongoing challenge.

- Occupancy of the **adult acute inpatient service** has been high at 98% in May 2018. Such high occupancy is unsustainable and does not allow for increased demand over time. Planning and Funding are leading the development of a community service that will provide an 8 bed alternative to an acute inpatient admission.

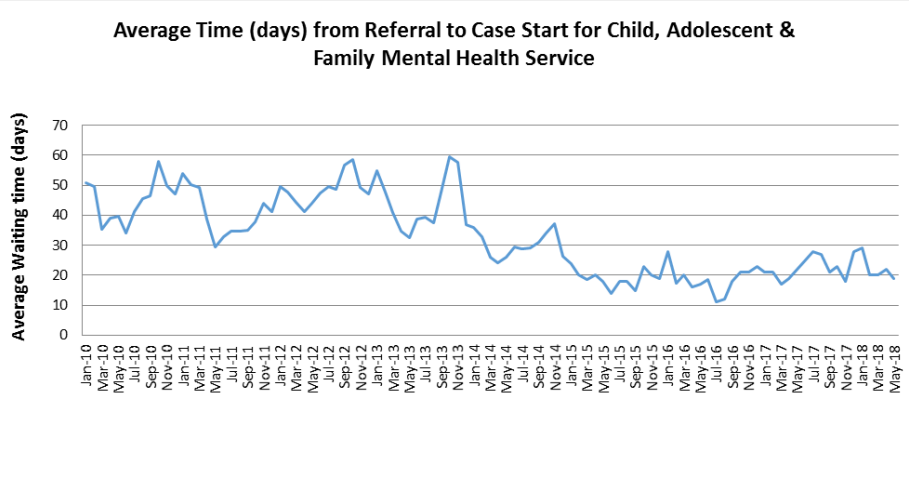
- **Demand for Adult Services** continues to increase. There were 221 new crisis case starts in May 2018. New crisis case starts require an assessment and response within a day of referral. The adult general service is exceeding national targets with respect to wait times for adult Specialist Mental Health Services. The wait time targets are 80% of people seen within 21 days and 95% within 56 days. In May 2018, 96% of people referred to the Adult Community Service were seen within 21 days and 99.7% were seen within 56 days. The percentages for May 2018 were 86% and 97% respectively when other adult services i.e. Specialty, Rehabilitation and Forensic were included.

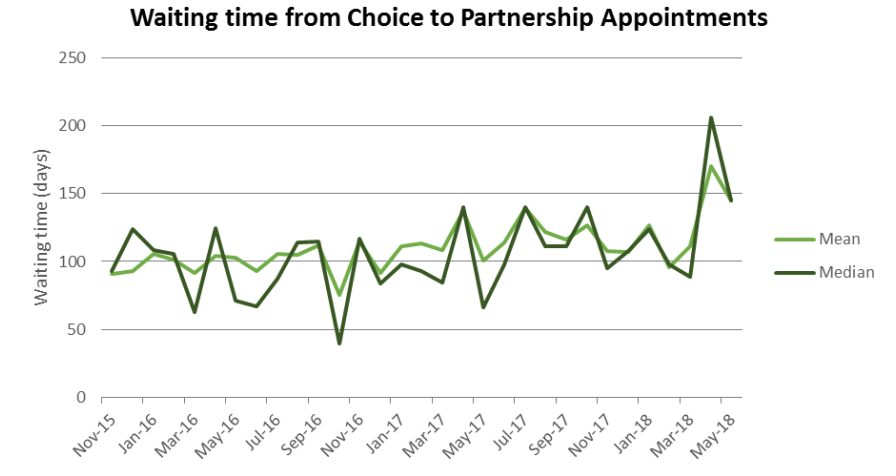
- Our focus on **least restrictive practice** continues. Within Te Awakura there were six seclusion events for May 2018 for a total of 208.5 hours. This was comprised of five unique individuals. The monthly average for the previous 12 months is currently 100.06 hours. Te Awakura continues to admit high numbers of acutely unwell consumers which is further compounded by an increase in Methamphetamine use. This has contributed towards to an increase in our seclusion rates over the last month. Staff are working extremely hard to continue to provide care for people in a least restrictive manner.





- **Child, Adolescent and Family (CAF):** Wait times for Child, Adolescent and Family services remains a concern. National targets require 80% of young people to be seen within 21 days and 95% within 56 days. Our results for April 2018 show that 68% of children and adolescents were seen within 21 days and 92% within 56 days. Child, Adolescent and Family Services had 264 new case starts in May 2018.





- Child, Adolescent and Family Services have applied a comprehensive approach to managing the waitlist. There have been multiple streams of clinician contact, with an increased capacity to take on new partnership appointments. This, combined with the provision of alternate treatment pathways for consumers has resulted in a marked increase in reported waiting time (as shown in the graph above for April 2018) but with a concurrent significant reduction of 100 people waiting to be seen.

- **Schools based Mental Health Team** continues to be approached by new schools across Canterbury requesting engagement. The team has continued to respond to the requests from schools, providing an individualised approach for all. Term two has proved to be a very busy term across Canterbury with lots of workshops and consultations being provided. As well as attending regular pastoral care meetings in many schools, the team also participates in Rock On meetings where attendance issues are discussed. Networking and fostering strong relationships across schools and with the Ministry of Education continues to play a major role. We have had some staff changes therefore creating greater pressure, but this will allow us to further align with the Communities of Learning | Kāhui Ako (school cluster).

Older Persons Health & Rehabilitation (OPH&R)

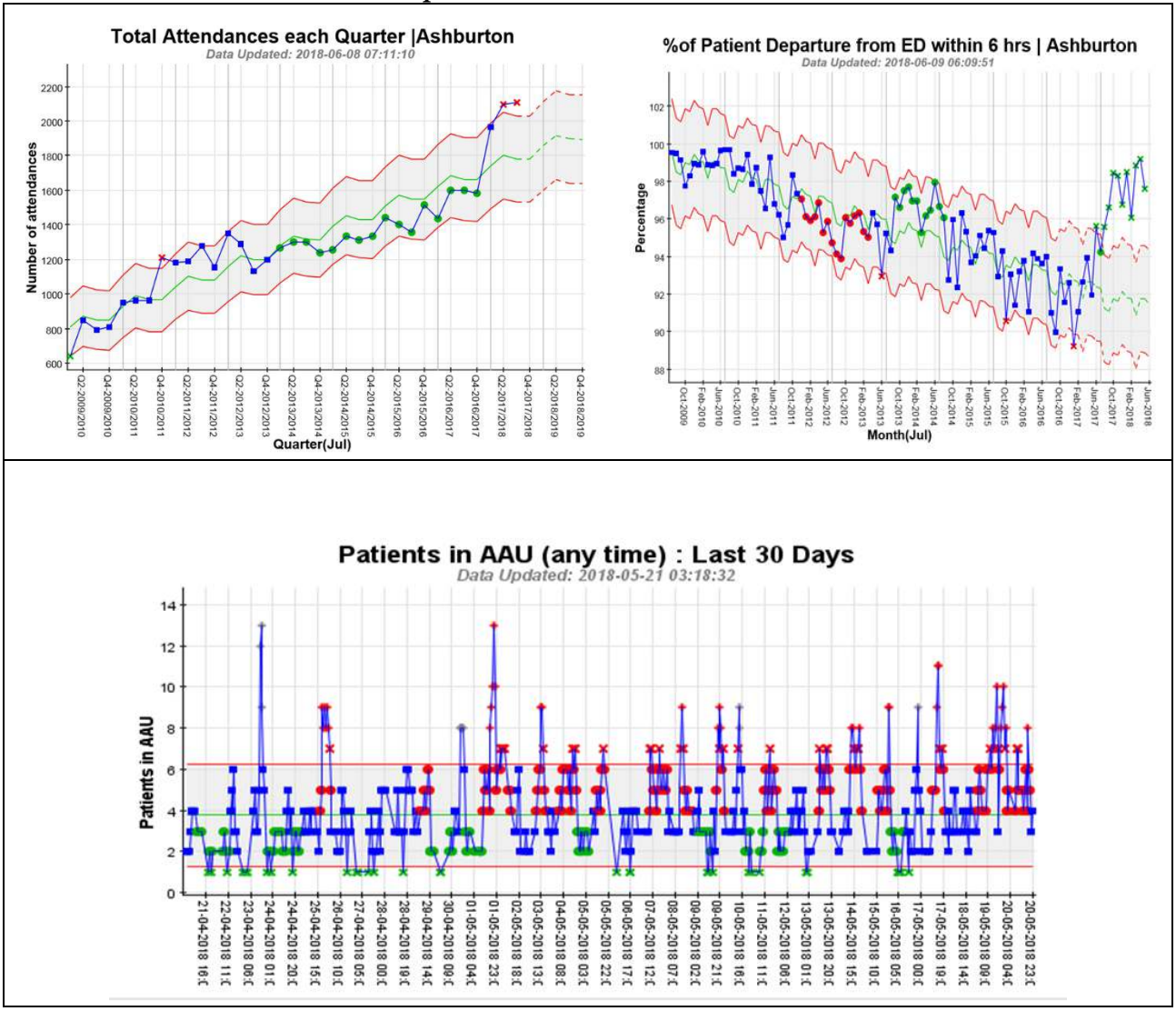
- **Winter Planning:** In preparation for forecast winter impacts we are continuing with the joint approach to winter planning. The lessons learnt around activity from 2017 continue with a number of the actions indicated in the Winter Review document now embedded as our new norm of activity. This includes our 0830 huddle, confirmation of the clinical nurse specialist liaison role at Christchurch Campus. A set of principles across the South Island DHBs have been agreed to winter planning and flow:
    - Patients will be treated as close to home as possible.
    - Pull rather than push.
    - Plan and do in parallel rather than sequentially.
    - Every patient needs a planned date of departure.
    - Handbacks to primary care need to be done well – reverse ERMS.
    - Specialists will manage the programme of care from available data via available technology and request tasks/roles of others in the system including surveillance.
    - Education/training/communications will be readily available to support the system continuum.
- A series of focus areas have formed part of an ongoing action plan for the combined campus and linking in with system partners such as Canterbury Clinical Network, Urgent Care Service Level Alliance (SLA) and primary care for influenza planning. The dashboard that made visible the data that was available during 2017 continues to be used and clinical leadership from the Chief of Medicine and Chief of Service for this activity. Within the Urgent Care SLA, focus areas cover:
    - Targeted messaging for the winter period including messaging through the chamber of commerce, schools and early childhood centres.
    - Hand sanitiser campaign and messaging for aged care facilities, general practice and pharmacy (this will be similar to the one implemented after the quakes).
    - Opportunities for pharmacy to take some of the acute load off general practice particularly during the winter period.
    - Looking at opportunities where pathways could be enhanced to improve flow through the system.
- The aim of the Urgent Care SLA is to ensure we:
    - Reduce demand from the community on ED and acute admissions
    - Use of shared information across the urgent care centres and ED

- Reinforcing communication about the community services available
- Improving frail elder pathway flows (ED to AMAU or home)
- Reinvigorating key messages to be delivered under the Care Around the Clock banner. The messaging will increase through the winter period with refreshed graphics.
- Communications plan is being developed which will identify system wide messages that are already in existence and identify gaps. The plan will help to ensure there is consistent winter messaging across the system.
- Exploring whether the Acute Demand criteria should be further flexed to cope with ACC

- Ongoing emphasis on Restorative care is the focus of our Older Persons Health (OPH) team. We are developing a **Making Time 4 Rehabilitation (MT4R)** module. Ensuring the visibility and awareness of this with both patient and whanau is a key step in ensuring we support the people we provide care for. An example of our promotional material to get moving and how each and every activity can be supportive of rehabilitation.

Ashburton Health Services

- **Acute Flow in Ashburton Hospital**



- Presentations to the Acute Assessment Unit (AAU) continue to trend around 2100 per month. Whilst the pattern of presentation cohorts at three distinct points during the day, around 10.30am, 3.00pm and 7.30pm, the variability total presentations per day provides less information for us to draw any distinct trends or drivers. We have noticed a drop in meeting optimum patient journey within six hours when reviewing the last quarter and have a small working group reviewing the flow, the objective is to identify where any distinct delay occurred and what can be implemented to address this before increased seasonal presentations.

- Our Service Improvement Co-ordinator has been working closely with the SFN project specialist to establish a regular set of trend information data sets that can be discussed with the AAU team at ward meetings and shared widely with the Ashburton Health Services team throughout hospital and community providers. What we learned from our SFN data covering the last 30 days:

    - 660 patients presented to our Acute Assessment Unit (AAU)
    - On average 4 patients attend per hour, the range is between 3 and 6 patients
    - 485 (73%) of patients are treated within AAU discharged home
    - 98.3% of these people left AAU within 6 hours

- 118 (18% of total presentations to the unit) were admitted and treated within the Short Stay Unit (SSU). 8 hours is the average time that patients spent in SSU before being discharged home.

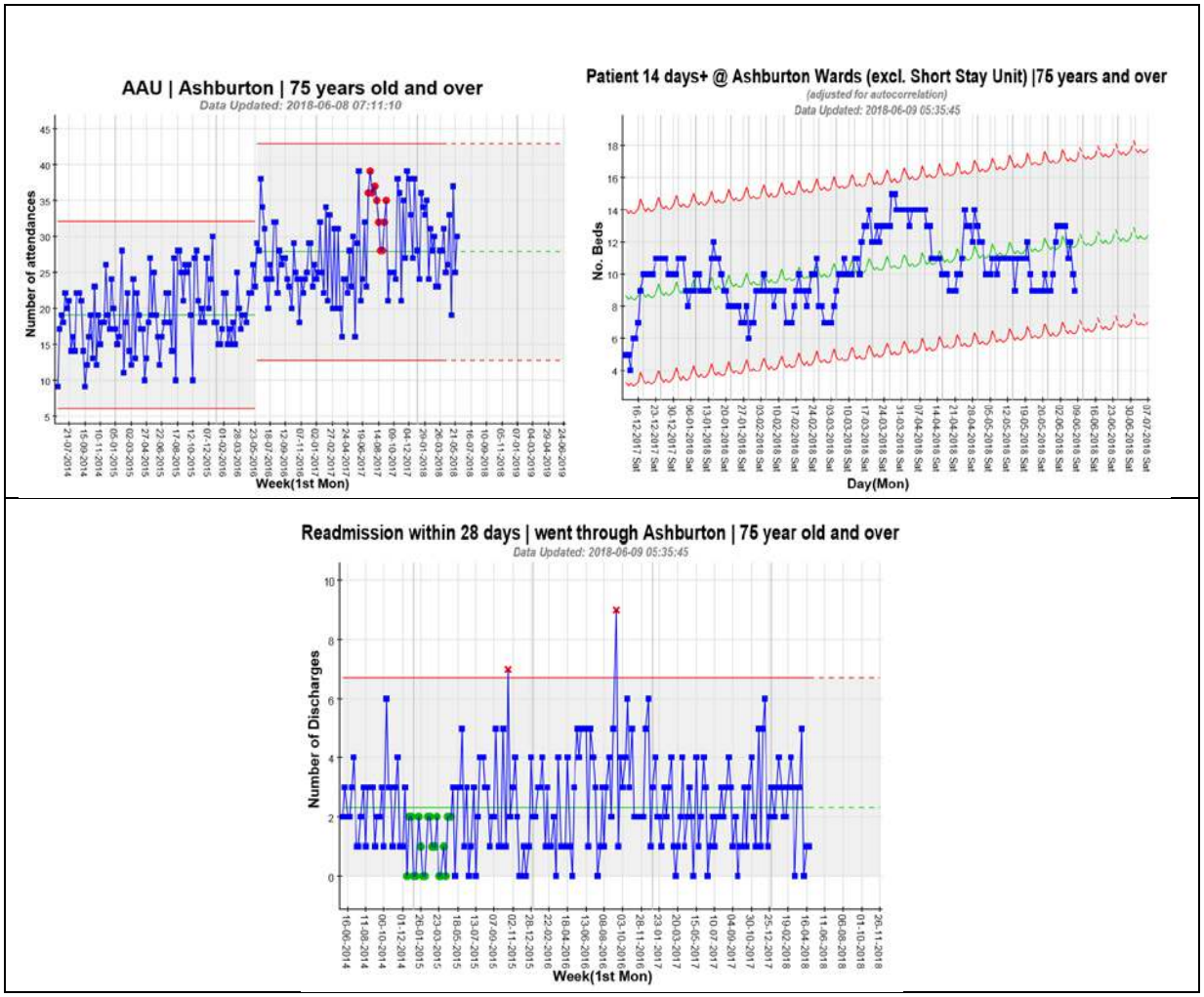
- The **Short Stay Unit (SSU)** is located within the AAU and is the same set of 8 beds that are used for acute assessment and treatment as the AAU. With space at a premium, we run a tight process to ensure we utilise the SSU process well. The cohort of patients that tend to be admitted to the SSU include patients we are waiting for diagnostic results, patients requiring observation to support medical decision to discharge or admit into inpatient ward and patients who require closer medical observation and response. After-Hours (evening and weekends) the hospital medical team cover reduces to one junior doctor and one SMO on-call covering the AAU, inpatient wards and Tuarangi. Duty Nurse Managers in consultation with the medical team and ward nursing staff will transfer a patient back to the SSU from an inpatient ward if they require closer observation. An "operations group" has been established on behalf of the Ashburton Service Level Alliance (ASLA) exploring more detailed opportunities to collaborate and respond to some of the challenges facing the system managing the demand for acute care. This group includes management from Pegasus and Rural Canterbury PHO, Dr Sue Fowlie as the nominated GP rep, the Service Improvement Co-ordinator and Health Services Manager from the Hospital. Key work under way includes the connecting the information of patients who have presented to the AAU over the previous three months and meeting with the local practices to explore what connections could be implemented that would support the patient experience. This is not an exercise to judge whether these patients "should not have come to the unit", it is an opportunity to look at a three month cohort with the detailed primary care knowledge about these patients. We have received a positive response to this plan and our goal is to action this in July. This is an adjunct to the Frail Elderly Patient Journey workshop held on 20 June.

- **Rural emergency training course:** For the second year running two three-day Rural Interdisciplinary Scenario-based (RISC) courses were run in the newly opened Rural Health Academic Centre in Ashburton from 23 May to 30 May, in partnership with the Rural Postgraduate Programme of the University of Otago and St John's. The courses brought together four teams of five participants, each comprising two to three doctors and two to three nurses from seven rural hospitals around New Zealand - Ashburton, Bay of Islands, Buller, Dunstan (two teams of 5), Kaikoura, Queenstown, and Taupo. The aim was to further develop their technical, communication and teamwork skills in management of severe trauma patients. This was done using scenario-based learning methods, debrief, skills training, and highly participatory discussion in small groups. Since human resources are generally scarce in rural hospitals the need to rely on small interdisciplinary teams is fundamental to rural trauma care, and a focus of the RiSC course.

- Steve Withington, Rural Hospital Specialist, and member of the course faculty notes that severe trauma is a low frequency, high impact event in rural hospitals, hence it is ideal to train for in simulation-based education. In this case that meant high-fidelity simulation training, which employs computerised mannequins and environments that try to replicate real-life situations as much as possible. "The key added value for participants was to be able to discuss and practice together as multidisciplinary teams, with colleagues who they normally work alongside, in a high fidelity simulated rural environment. Added to this was the chance to interact with and learn from other rural hospital teams, which is a rarity in isolated rural environments." The course was adapted from other University of Otago papers on trauma and emergencies in a rural setting, and facilitators were drawn from the University of Otago, Canterbury DHB – Ashburton and Christchurch, Southern DHB, and St John's. The feedback from participants has been overwhelmingly positive so far, with many requests from other rural hospitals for further courses in 2019. Clinical Nurse Specialist, Ashburton & Rural Health Services, and nursing member of the course faculty, Jane Wright reported " Observing the scenarios and

hearing the feedback it was wonderful to see the nurses really stepping up and their confidence growing with each scenario. The networking opportunities remain an integral part of the learning and it was also really heartening to see how supportive and collegial the participants were of each other."

- **Frail Elderly Pathway**



- As previously reported, we have been building interest and discussion for a whole of system approach to the Frail Elderly Patient Journey in Ashburton. The workshop will be held on 20 June and will include attendance from primary and community providers. The patient journey discussion will include presentations through to the AAU, through the hospital and discharge back to community and ongoing care, our intention is to have a robust discussion on where we can improve the journey for Ashburton Agnes and identify a work plan to implement any changes agreed.

- **Preparation for SI PICS:** A core focus for the administration and management team in May is site preparation for SI PICS. As a hospital and health service site, we cover all aspects of SI PICS utilisation and linkages as we administer patient care for emergency, inpatient, AT&R, outpatient – visiting specialists and community clinics, chemotherapy and primary birthing unit. The team have risen to the challenge and we have completed all nursing and administration training for both outpatient and inpatient modules.

- **Farewell and thank you for a combined 60 years of Nursing at Ashburton Hospital:** In June we said a heartfelt thankyou and farewell to two long standing members of our nursing community.

- Helen Hanranhan retired after 45 years at Ashburton Hospital. Helen commenced as a student in Ashburton Hospital in 1965 and graduated 1968 as a staff nurse. She worked in Ward One for a year and then had an eight year break. She returned to Ashburton Hospital in 1978 working solely night shifts in Ward 6 until her retirement.
- Marlene Officer worked with the Ward 1 team as Charge Nurse Manager for 16 years and is well recognised for her patient and staff advocacy. Marlene was committed to improving the patient experience and working through the ward moves and developments over the past years.

Laboratory Services

- **Dr Martin Sage – recognised to be a Companion of the Queen's Service Order, for services to forensic pathology:** Dr Martin Sage is a consultant forensic pathologist at Canterbury Health Laboratories (CHL), and for much of his career was the only full-time forensic pathologist residing in the South Island. Dr Sage has provided the coronial pathology service to the Christchurch region since 1991. For much of this time he has provided a 24/7 on-call forensic service for the whole of the South Island. He has conducted more than 10,000 autopsies for coroners in various parts of New Zealand and at various times has appeared at every High Court in the country to give evidence in many well-publicised homicide trials. He has been an expert forensic pathologist in some of New Zealand's most significant multi-fatality incidents including the Erebus aviation accident, Cave Creek viewing platform collapse, Christchurch earthquake, and Pike River mine disaster. He played a pivotal role in the creation of the National Forensic Pathology Service in 2005. For close to 10 years he campaigned with various government departments, Police and other agencies for the creation of a responsive national service to meet future demands. He continued his involvement in strategic and operational governance as an advisor to the Ministry of Justice and chief coroner for seven years. Dr Sage has played a significant part in the development of the speciality and the maintenance of standards through the Royal College of Pathologists of Australasia.

INTEGRATING THE CANTERBURY HEALTH SYSTEM

Acute Demand Management

- Winter planning in different parts of the system has been the focus for the last few months. Planning for the flu season led by the Primary Pandemic Group has been robust following significant issues in the northern hemisphere; to date there are relatively few cases.
- Acute Demand Management Services are being well utilised with a number of initiatives to ensure services are operating well. St John's continue to divert nearly 40% of their 111 calls away from ED to other community supports (largely general practice).
- The frail older person's pathway in ED will be supported by increased physiotherapist resource to conduct function reviews which will enable them to return home where appropriate.

SUPPORTING OUR VULNERABLE POPULATIONS

Older Persons' Health

- **Respite allocation:** The DHB has engaged with aged residential care providers and other DHB referrers on the principles of respite allocation to ensure appropriate use of the respite service. Generally respite is for carer relief and is designed to give carers a break or time off when a primary caregiver becomes unwell. The aim is to maintain health and wellbeing of carers so clients can return home. Respite allocation can be detrimental if allocated inappropriately.

Mental Health

- **Mana Ake – Stronger for Tomorrow** (School Based Mental Health Services): The team has now met with most of the pastoral support leads in schools across the two Kāhui Ako (communities of learning). The DHB has learned about the information and support needing to be provided to schools from two different environments, as we roll the initiative out more widely. The team is working on regular messaging for school clusters to help them prepare to implement Mana Ake collaboratively. The programme is on track to manage a prioritised phased roll-out over the next 12 months.

- A draft pathway for Leading Lights focusing on anxiety has been developed and shared with the first two Kāhui Ako and feedback has been positive. Leading lights is analogous to HealthPathways for schools. It helps school staff to manage their students and when required, request further help. The Leading Lights development will be progressed with the aim of having six topics available for the Phase 2 roll out in July. The NGO providers who will engage Mana Ake workers have been selected following an RFP process and will commence work with the next schools planned to engage in Mana Ake by 11 July.

- **Acute inpatient services:** The community based acute alternative framework for acute mental health needs has been agreed and an RFP is now open. Discussion continues about the role of a service for distressed people who can be supported by peers with clinical backup. A model being trialed in Auckland to embed mental health and addiction services in primary care teams, is attracting interest, with early indications of positive outcomes.

Primary Care

- **Pharmacy:** DHBs are working with the pharmacy agents and key stake-holder organisations to address issues raised in the consultation about on the Pharmacy Action Plan implementation proposal before finalising a new contract offer for community pharmacy services. In the interim DHBs have offered all pharmacies an extension of existing contracts to 30 September 2018.

- **Integrated Family Health Services and Community Health Hubs**

  Closer integration of health services is being pursued in several rural areas.

- **Hurunui** – Recommendations of the Hurunui Health Services Development Group (HHSDG) are the subject of a separate paper to the Board. The five general practices in the Hurunui are trialing new arrangements for rostered after-hours urgent care from July 2018. We are working with the practices to ensure appropriate supports are in place for the new model.

- **Oxford** – The Oxford and Surrounding Area Health Services Development Group (OSHSDG) is continuing to develop a proposal for improved access to health services. Feedback from the community will be sought in mid-2018. Key areas of focus are: transportation, 24 hour medical cover, telehealth for local access to specialist clinics, and restorative care in the community for people following hospital care.

- **Akaroa** – Construction of the new Health Centre is underway and expected to be completed in time for services to begin on site in June 2019. Akaroa Health Ltd general manager, Jenni Masters, is preparing an implementation plan for the Model of Care in consultation with the Akaroa Health Services Committee and DHB staff.

Maori and Pacific Health

- **New Pilot Help Line Service:** He Waka Tapu, one of our kaupapa Māori providers located in Aranui, have launched a new pilot help line service called Hey Bro. 0800 HEYBRO (439 276) is a new pilot for the Canterbury area, which launched on 5 June 2018. This number is

setup for men who feel they are going to harm a loved one or whānau member and are seeking help to prevent them from causing harm. The service aims to provide support 24/7 to listen and to help.

- **Trendly National Māori Health Indicators:** The website of National Māori Health Indicators was developed by the National Māori GMs group, Tumu Whakarae. This website is based on the National Māori Health Indicators that were set by the Ministry of Health over the past five to six years. With the change of government the Ministry of Health no longer requires DHBs to produce a Māori Health Plan to monitor these indicators, however the data is still collected and this website allows users to engage with and view the data.

- **Dashboard Report:** Attached as **Appendix 1** is a dashboard of all indicators for all DHBs for both Māori and non-Māori. As an indicator report the non-Māori dashboard shows that Canterbury typically performs very similar to other DHBs across all indicators for its non-Māori population. As an indicator report the Māori dashboard shows that Canterbury performs in the top half of DHBs across all indicators for its Māori population. However overall, there remains a significant difference across the country in the way Māori people experience the health system and the corresponding indicator data; ie in the non-Māori dashboard there is a proliferation of green and yellow (targets met or nearly met whereas with the Māori dashboard there is very little green at and lots of red (more than 20% away from the target). Note that these dashboards over time have shown that progress is being made (there is now much less red in the Māori dashboard than in previous years). However, there remains a gap and we have much progress yet to achieve.

- **Comparisons and Trends:** The Trendly website allows users to look at trends and make comparisons of the indicators. Attached as **Appendix 2** is also a report on the trends for these indicators in Canterbury with direct comparisons in the data between Māori and European (other). The trends show again that we are making progress but the gap, although shrinking, continues to persist. There are two separate comparison tables:
  - Comparisons with other South Island DHBs
  - Comparisons with similar sized (population) DHBs

- When comparing these indicators across the South Island, we see that the West Coast typically is the best performer for Māori but that Canterbury tends to outperform the other DHBs (except the WCDHB) across the indicators as a whole. When comparing these indicators across other similar sized DHBs (Waitemata, Counties-Manukau, Waikato, Hutt Valley, Capital and Coast) we see that Canterbury compares favourably in most indicators and tends to outperform the other DHBs. It should be noted that these reports are broad overviews and are intended to be indicative but can provide a useful insight into our progress but also how much work there is yet to do.

Promotion of Healthy Environments & Lifestyles

- ***All Right?* social marketing campaign update:**
  - **Kaikoura/Hurunui**: Research has been carried out by Opinions Market Research in order to understand the issues that the Kaikoura and Hurunui communities are facing, how they are perceived as affecting wellbeing, and to explore perceptions of recovery and ideas to improve wellbeing. In April 2018, the research company conducted three hundred phone interviews of people aged 15 years and over from Kaikoura and Hurunui (150 from each district). The phone interviews mostly consisted of closed questions with a small number of open response questions to gain more insight. Of those surveyed some key findings included:

- Although the majority of people in both districts felt their lives were the same as before the earthquakes and recent floods, almost a third (31%) of respondents from Kaikoura thought their lives were worse, as did 15% of respondents from Hurunui
- 22% of Kaikoura and 26% of Hurunui residents reported not knowing when their property claim would be settled
- 40% of respondents in Kaikoura were avoiding leaving the area in case they couldn't get back
- 95% of respondents in both districts were more aware of the need to take care of their wellbeing
- respondents in Kaikoura report a higher level of health issues than in Hurunui
- 59% of Kaikoura residents reported a sense of loss of kai moana
- 47% of respondents in Kaikoura and 24% in Hurunui report seeing the effect of the earthquakes on their children's wellbeing, and
- around half of all respondents reported feelings of concern or anger regarding loss of community control of decision making and independence.

- **Tangata Whaiora research:** The public health analyst who has carried out most of the campaign's process evaluation has been working on some research with Tangata Whaiora (mental health service users) to find out if the campaign has been useful or indeed unhelpful. A survey was sent to members of the Awareness group through the Mental Health Advocacy and Peer Support (MHAPS) group. There were 54 respondents 81% of whom were aware of the campaign. Of these respondents 88% indicated that the messages were helpful, and 72% indicated that they believed the campaign helped to reduce stigma associated with mental illness and that *All Right?* was one of the tools used to manage their wellbeing. In addition, 68% of those aware of the campaign, indicated that they had changed their behaviour as a result of the campaign messages. The report of the findings is currently being peer-reviewed and will be available on the *All Right?* website later in June.
- **Downtime in good time:** During May the focus for the Campaign has been on the benefits of downtime. The activator for this message is the downtime dice, a 12-sided dice with suggestions for downtime activities on each side. The rationale behind this resource is to promote the concept of downtime being "good time" as opposed to a waste of time. We know that small breaks can make a difference and the dice can help stimulate ideas about downtime activities. Each downtime activity has proven feel-good benefits - they are simple but they work. Dice are available free for individuals from a variety of pick up points around the city. Multiple dice can also be purchased for workplaces or large organisations, details are on the website www.allright.org.nz/dice

- **Healthy Greater Christchurch – seminar on Local Government (Community Well-being) Amendment Bill:** A seminar on the Local Government (Community Well-being) Amendment Bill was held by Healthy Greater Christchurch in mid-May. The seminar was organised in partnership with the Christchurch City Council and Environment Canterbury and was designed to provide participants with some context to local government legislation, some understanding of the proposed amendment, and information about how to make a submission on the Bill. More than thirty people/organisations attended and rated the workshop highly. After the workshop, several attendees remained to ask further questions of the presenters and reflected that not only would they be making a submission, but that the seminar had 'inspired' them to do so.

- **Pastoral care and pastoral care teams in schools:** Community and Public Health's Information team have recently published a review about pastoral care to inform policy and practice in schools. Although there is much talk about the importance of pastoral care and the work of pastoral care teams, there is limited guidance available to schools about pastoral care best practice – about how to actually do the work of pastoral care, in order to achieve the best possible outcomes for children and their families/whānau.

'Pastoral care is a planned, multi-faceted, whole-school approach to incorporating effective ways of caring for all students in a school setting. The approach supports the holistic development of students and is characterised by school policies and processes that clearly articulate the work of pastoral care - how the welfare, wellbeing and development of children and young people will be optimally supported.'

- This review was prepared in response to requests from schools who wanted to know more. It brings together the findings of a search of peer-reviewed literature, relevant websites and other grey literature, and also presents the findings of interviews conducted with teachers and other key professionals about their involvement in, and experience of, pastoral care teams in school settings. The review is presented in four sections and provides:

  - an overview of what is meant by pastoral care
  - a range of pastoral care frameworks and approaches
  - an analysis of the interview findings (with teachers and key professionals), and
  - a final section which summarises the findings, and invites the reader to reflect on next steps for pastoral care in their setting using the tools provided.

  '*Despite the ongoing complexity and myriad challenges existing for children and their families/whānau, interviewees expressed their belief that they were making a positive difference for these students through the pastoral care processes employed, and the focused, collaborative and caring efforts of the pastoral care team members.'*

- **South Island Tertiary Forum:** Building mental fitness on campus was the focus of the recent South Island Tertiary Forum held on 10 May. Almost 100 participants from seven tertiary institutions across the South Island attended the forum at the new Whareora health and wellbeing facility at Ara Institute of Canterbury. Presentations on mental fitness, workplace wellbeing, building relationships on campus, academic support for students and promoting mental fitness through digital media were given. Wellbeing activities such as breathing, stretching and meditation were taught to participants. Afternoon discussion groups helped participants to workshop ideas and practices to support the embedding of mental fitness on campus. The South Island Tertiary Forum has grown considerably since it started in 2010 as an initiative of the Tertiary Education Health Promoter in the Communities Team at Community and Public Health. Fora now have a broad wellbeing focus on topics chosen by participating campuses, invite people from tertiary campuses throughout the wider South Island and involve students in the running of the day. Post-forum evaluations continue to be very positive and are used to inform the content of future forums.

- **Staff Wellbeing Priority at Christchurch East School:** In February 2018, the Health Promoting Schools (HPS) team at Community and Public Health hosted a free workshop for school staff regarding staff wellbeing in schools. This event was facilitated by Ian Vickers, an ex-deputy principal who has been acknowledged nationally for his innovative work in actively promoting staff wellbeing in the school he worked in. While the event was well attended, the HPS team recognised that some people who would have liked to have attended were not able to do so. To mitigate this, presentation notes were uploaded onto the HPS website with Ian's permission.

- After reading through the presentation notes and discussing with her school's HPS facilitator, Deputy Principal (Sally Kent) of Christchurch East School, decided to initiate a staff wellbeing survey alongside their planned student wellbeing survey. Based on the results of this survey, Sally created a staff wellbeing resource similar to one used by Ian Vickers but adapted to her own school setting. Throughout term 2, staff at Christchurch East School are actively being encouraged to attend to their own wellbeing through behaviours such as drinking more water, taking time out for a break, and consciously making an effort to be kind to one-another. To support individual behaviours, the school management are also looking for ways to reduce

workload of staff and create a healthier, wellbeing-promoting work environment. For example the school will plan to host some fun staff events such as a games night or cooking competition. Staff at the school are also committing to exploring ways to integrate student inquiry focuses into staff culture. For example, if the school inquiry topic is 'Valuing Each Other', then not only will staff explore ways for the students to learn about this, but also ways in which the staff culture can be improved based on the focus of the wider inquiry. The expectation is that by taking on this multi-faceted approach to staff wellbeing, the benefits will be evident both in staff and student wellbeing experiences and outcomes.

SUPPORTING OUR TRANSFORMATION

Effective Information Systems

- **Acute Services Building**
  - Final marked up hardware plans are now in progress.
  - Validation of Application requirements ongoing and the team have met with the migration planner to understand the preferred approach for migration and analyse resourcing and BAU impacts with the ISG Leadership team.
  - There is a delay in the comms room readiness which is creating planning and resourcing difficulties. CDHB are working with the contractor on a workaround solution which adds complexity.
  - The project team are working with ISG leadership team to ensure there is effective comms and visibility on dependant projects to ASB.
  - The budget is tracking well. Key risks remain around several projects competing for the same resources and progress on interdependent digital projects.
- **Christchurch Outpatients**
  - The project team are awaiting the formal release of a revised programme to assist in effective planning.
  - The budget is tracking well and regular monitoring is in place to ensure scope and budget are adhered to.
  - The project team are working with the migration planner to understand the proposed approach and excellent progress has been made on the creation of a master IT document.
  - Risks continue to be monitored fortnightly by the project team and are escalated to the monthly ISG steering group. The key risk is ISG having multiple capital projects commissioning within a similar timeframe and competing for the same resources.
- **Cardiac Test Repository**
  - Regional delivery framework and Governance agreed and in place between all participating DHB's.
  - Network design, device audit and test plan development in progress, but slow. Discussions underway regarding next steps
- **Electronic Medicines**
  - The ePharmacy project went live on 1 May 2018 with no disruption to the hospital services.
  - The upgrade will make it easier to integrate MedChart and ePharmacy in the future.
- **Health Connect South**
  - Independent report into service improvements completed, and a plan to implement recommendations is being prepared.
  - A release to bring in new functionality was completed in May.

- **South Island Patient Information Care System (SIPICS)**
  - Preparations continue for the rollout of the software into the main Christchurch Hospital, although this has been delayed.
  - Work flows are being documented for each service that provide assistance for detailed planning.
- **Windows 10**
  - Business Case completed and will be presented to 21 June Board meeting.

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Communications and Engagement

- May was **Hand Hygiene** month, during which a number of stories from high performing areas were shared throughout the DHB through the CEO Update, modelling the factors that led to their success. The last piece publicised the latest hand hygiene performance statistics and highlighted areas for future focus.
- A new-look **WellNow** went to the printers in May and reached Canterbury mailboxes from 5 June. It features a refreshed way of presenting content, based on feedback we received late last year on the summer edition. People told us to lighten the content a bit, and to make it less corporate. They said they loved the people stories and to do more but to make them more visually appealing and with fewer big blocks of text. We have done our best to respond to this feedback.
- **Public influenza vaccination campaign**: The campaign launched in full this month with a new website – www.flufree.co.nz – to act as an information and resource hub, allowing people to download resources and promote messages about getting vaccinated to their own networks. The campaign also involves direct outreach to major employers, public-facing organisations, schools, Māori and Pasifika networks, the maternity community, over 65 interest groups, membership organisations, and Sport Canterbury; public relations; HealthTV promotion; and print, online and outdoor advertising.

Media

- May was a steady month for media inquiries, and again the media team also provided communications assistance to Community & Public Health, on such topics as the ongoing measles outbreak and reported health effects of chlorinated water.
- Some of the other issues media enquired about were:
  - Assaults on staff by patients at Hillmorton Hospital
  - Seclusion rates at the Child & Family Service in-patient facility at The Princess Margaret Hospital
  - The influenza vaccination programme, in particular staff uptake
- TV3's The Project interviewed Nick Cook, Imaging Scientist, on the 3D printed simulator developed at Christchurch Hospital. The simulator teaches doctors how to perform surgery on babies born with oesophageal atresia.
- A number of media releases were issued in conjunction with Techweek '18 on developments within and including Canterbury DHB, including the Hartwell Simulator, Celo, SI PICS, 3D Printing, SCoPe, data-driven health and virtual reality. Some of these media releases were accompanied by a short video and these have been posted on the CDHB website.

- Other media releases were issued on the measles outbreak; the *All Right?* downtime campaign, World Smoke-free Day, the lifting of a health warning for the Selwyn River and speakers attending the Lab Meeting in Christchurch & Wellington.
- Live radio interviews – Canterbury Mornings with Chris Lynch – featured Dr Edward Coughlan on sexual health, and Dr Ramon Pink and Viv Daley on World Smokefree Day.
- **NZNO industrial action:** Communications has been working with other DHBs and a Canterbury planning team on contingency planning and communications, should the proposed strikes go ahead.
- **Facilities Redevelopment**: Our regular communications channels have been kept up to date and a four page update was included in WellNow.
- Ongoing work communicating site activity related to the Acute Services and Outpatients builds, mostly via the daily global and weekly CEO updates.
- New video content has been created for the Christchurch Hospital TV screens and the next edition of the facilities newsletter is ready to be sent out. This content also appeared in the Well Now DHB publication.
- **Outpatients building:** Staff orientation work is underway including orientation manual and Healthlearn online orientation being drafted.
- **CEO Update stories**
    - Over 70 staff from the Radiology and Emergency departments turned out for the HiFIVE MasterChef Challenge competition. The evening enabled staff from the two departments to get together and working in teams, create a two course meal and compete for the MasterChef title. This team building the work environment improves the ability to work as a team in the workplace, leading to better patient care.
    - Canterbury DHB's Bio-Medical team have gone to "heroic efforts" to ensure hospital and home dialysis health care consumers are not harmed by the chlorination of Canterbury's water system. During dialysis large volumes of water are used and even tiny amounts of chlorine present in water entering the bloodstream can cause damage to red blood cells, which makes patients feel unwell. The dialysis service has worked hard over the past two months to install pre-filtration trolleys to their dialysis machines. All home haemodialysis patients now have protection against the effects of chlorine.
    - Events were held around the region to celebrate International Day of the Midwife on Saturday 5 May. Gifts and edible treats were handed out at birthing units in Canterbury, and units on the West Coast, Kaikoura, South Canterbury, and Ashburton marked the day with celebrations. At the Rangiora Maternity Unit a morning tea was held.
    - At Canterbury DHB this year we have the biggest group we've ever had of registered nurses commencing their new graduate Nurse Entry to Practice Programme and /or New Entry to Speciality Practice Mental Health and Addictions Programme. Excitement is building within the nursing education sector as primary, secondary and tertiary institutions are soon to collaborate in the new Health Research and Education Facility. Due to open in mid-July, it will provide the best practice and learning environment for all nurses.
    - A fun competition held to highlight falls awareness had over 200 entries from patients, visitors, whanau and staff. People had to guess how many autumn leaves were in a box, while the falls advocates took the opportunity to educate participants about the importance of falls and how to prevent them.

- It's been decades since Canterbury DHB orderlies got new style uniforms but a new uniform is being introduced consists of grey shirts with the Canterbury DHB logo on the sleeve and a choice of trousers, shorts or skirt. The new uniforms are fit for purpose, designed to support carrying "tools of the trade" such as radios. The new professional look reflects Canterbury DHB's values of supporting staff wellbeing in all areas and provides a consistent look for orderlies as one team.

- Canterbury prisoners who have the Hepatitis C virus are now getting liver scans in prison instead of travelling to hospital for this vital health check. The initiative is saving time and resources for both Canterbury DHB and the Department of Corrections, and benefiting the men and women in prison with this disease. Clinical Nurse Specialists (CNSs) from Christchurch Hospital's Gastroenterology and Infectious Diseases departments have been working closely with the Department of Corrections health teams to provide regular clinics at Christchurch Men's Prison, Christchurch Women's Prison and Rolleston Men's Prison. Additional resources such as a portable fibroscan is now allowing them to provide an enhanced service on site.

- Schoolchildren in Samoa are now sitting on chairs instead of the floor thanks to donated items from The Princess Margaret Hospital (TPMH) in Christchurch. The chairs are part of a donation to Manumalo Baptist School which was severely damaged by flooding from Cyclone Gita. The students were doing their school work while sitting on the floor. Now they can sit at a desk, and are much more productive.

FACILITIES REPAIR AND REDEVELOPMENT

General Earthquake repairs within Christchurch campus

- **Parkside Panels:** Detailed planning is continuing for disconnecting the Chemo Day Ward for Parkside. Pricing negotiations are ongoing with the ASB link main contractor.

- **Clinical Service Block roof strengthening above Nuclear Medicine:** Current delivery dates for the equipment are forecast for 1 Sep 2018. The equipment will be stored at Print Place. Design consultants are reviewing detailed user requirements. Engineering has brought the design within budget and has CLG approval. Design Team working towards consent / tender documents issue mid-July.

- **Lab Stair 3:** Three weeks behind programme for completion end of May.

- **Lab Stair 4:** Initial / scoping work has begun.

Christchurch Women's Hospital

- **Stair 2:** Awaiting review from fire engineer to enable planning as part of the overall Women's Risk analysis. This continues to be delayed due to the release of the master plan which is required to determine available space for decanting of clinical spaces.

- **Level 4:** Crack injection around core to be undertaken. Parent room, kitchen and toilet areas complete. Difficulties gaining access to area due to patient levels, but will endeavour to pick this up during Women's Passive Fire works.

- **Level 5:** Small amount of work to corridor unable to commence due to operational constraints (NICU). Working with teams to identify a suitable time, but will endeavour to pick this up during Women's Passive Fire works.

- **Level 3:** All areas complete except reception, which is to be done at same time as stair strengthening to minimise disruption.

Other Christchurch Campus Works

- **Passive Fire/Main Campus Fire Engineering**
    - Database designs complete and in use by Site Redevelopment on current passive work. Currently developing brief for digitalization of the passive fire system and database and within the digitalization programme the forms and documents will be updated to e-forms. Awaiting M&E senior management to approve / comment on draft policies.
    - Test rig complete and installer testing has commenced. RFP for materials complete, primary and secondary suppliers in final contract preparation stage.
    - Continue to identify more non-compliant areas as other projects open walls/ ceilings.
- **Christchurch Hospital Campus Energy Centre**: This is managed by the Ministry of Health (MoH)
    - Service Tunnel: Complete. Steam provided by coal boilers. Final connection for Outpatients and ASB still to be completed.
    - Energy Centre: ROI for boilers completed.
- **235 Antigua St and Boiler House (Demolition).** No work to be undertaken until new energy centre and new energy centre commissioned.
- **Parkside renovation project to accommodate clinical services, post ASB (managed by MoH):** Planning ongoing. 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. Draft master plans have been provided for review. The SRDU team are having regular meetings with the MoH project managers (Projex) to assist in their information gaps.
- **Back up VIE tank:** Proposed strengthening scheme has been approval by CDHB maintenance and currently under review by BOC. Work cannot commence until primary VIE tank becomes operational. This is currently affected by the Antigua Street exit widening works.
- **Antigua St Exit widening:** Work commenced on site 29 May. Due completion end June.
- **New Outpatient project (managed by MoH**): Facade 99% complete. Architectural / services fit out on all floors well underway. Completion programme issued. Certificate of Public Use (*CPU*) 31 Jul. Practical completion 27 Sep.
- **Avon Generator Switch Gear and Transformer** Relocation. Design work underway. Due to the small size and engineering component this is now being managed by M&E.
- **Otakaro/CCC Coordination.** Otakaro programme slipped – Antigua St open early Jun. Oxford Gap closed 7 Apr to Dec 2018. Land swap discussion still with LINZ.
- **Parkside Canopies:** Temporary repairs to plastic wrap have been made. Planning underway to replace the wrap at the main entry.
- **Hagley Outpatients 2 Storey demolition:** Demolition contractor ROI is currently on GETS.
- **New Outpatients Cafeteria:** Detail design nearing completion. Business case approved. Contract negotiation with Leighs construction underway and subject to QS review and approval of pricing. Aiming for completion of café on or before occupation.

Burwood Hospital Campus

- **Burwood New Build**: Defects are being addressed as they come to hand.

- **Burwood Admin old main entrance block:** Feasibility study complete and work to commence on repurposing building to accommodate community teams for TPMH. Project management resource available to start 4 Jul 2018.
- **Burwood Mini Health Precinct:** Internal project management resource has been identified to scope out options for detailed business case (new build vs relocatable). Programme is dependent on demolition of Birthing Unit.
- **Spinal Unit:** Construction is being tendered, which closes 13 Jun 2018, to be followed by the tender evaluation process. The Spinal Ward (HG) is to decant into ward FG to enable construction process.
- **Burwood Birthing/Brain Injury Demolition**: A preferred demolition contractor has been identified. Business case has been presented to Facilities Committee and to be approved / endorsed at Board meeting 21 Jun 2018. The demolition programme shows work will be completed in Dec 2018.
- **Burwood Tunnel Repairs:** Work is now largely complete.
- **2nd MRI Installation:** Design work and planning continues. MRI scanner temporarily relocated from Merivale to storage at Print Place. Faraday cage installation is being repriced by another provider. A new MRI has now been sourced with the original Merivale MRI traded in as part of the procurement process. Scope of works being finalised and costed with Siemens.
- **Decision making frame work**: Workshops have been completed. Planning and Funding to complete final report.

Hillmorton 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:** Previously completed strengthening schemes have been reviewed and concept cost estimates updated. Recommendation to strengthen to 67% IL2.
- **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. Design consultants RFP for new High Care Area at AT&R closes on 7 Jun 2018. Estimate one month to review submissions and provide evaluation report for appointment. Currently six weeks head of programme.
- **Decision making frame work:** Workshops have been completed. Planning and Funding to complete final report.

The Princess Margaret Hospital Campus

- **Older Persons Health (*OPH*) Community Team Relocation:** The Feasibility study is now complete and work is to commence shortly on repurposing the old Burwood Administration building to accommodate community teams.
- **Mental Health Services Relocation:** Indicative Business case approved by Ministers in September 2017. The next step is the development of Detailed Business Case which is planned for July 2018 for submission.

Ashburton Hospital & Rural Campus

- Stage 1 and 2 works are complete. Final claims have been agreed with the contractor. Final defects resolution and retention release expected to be resolved in next two months. Meeting mid-June to discuss.
- **Tuarangi Plant Room**: Concept drawing completed and safety consultant report received. Now looking to hand over to M&E to implement.
- **New Boiler and Boiler House**: Project process commenced. This is currently being managed by M&E.

Other Sites/Work

- **Decision Making Frame Work:** This work is now being led by Planning and Funding. SRU will continue to be heavily involved to ensure a streamlined process is achieved. Workshops have been completed and final report is currently being compiled.
- **Akaroa Health Hub:** Retaining walls and major earthworks are nearing completion. Building foundations to begin this month.
- **Kaikoura Integrated Family Health Centre:** Scoping of cosmetic damage due to November's earthquake is complete. Estimates provided to Corporate Finance. Driveway repair completed. Sound proofing underway. Beca working on repair strategy.
- **Rangiora Health Hub:** Value engineering has shown some area for cost saving. Minor work to the design of some elements taking place to realise possible savings. Main contractor ROI closed. Availability of Hagley Outpatients building has been set as 12 Nov 2018.
- **Home Dialysis:** Business case approved by Board. Detailed design commencing. Programme forecast completion in Feb 2019.
- **SRU:** Project Management Office manuals re-write and systems overview. Approximately 60% complete. Aligning with P3M3 process and documentation where appropriate.
- **Seismic Monitoring:** Business Case approved.
- **HREF:** SRU continues to be involved in providing construction and contract administration / interpretation advice to the HREF project. Completion expected in early June.
- **Annual Damage reviews:** Reviews have been completed on site. Some reports have been received, but not yet reviewed by SRU.

Project Programme Key Issues

- The recent notification of Fletcher Construction closing down their building and interiors division will have effects on current work programmes and pricing. SRDU continue to review outstanding work faces and projects to identify the risks and issues for delivery of these projects. Meetings held with Fletchers senior management.
- The lack of a detailed Master Plan for the Hillmorton campus is still affecting our ability to provide a comprehensive EQ decision making assessment. We continue to use the framework adopting a more granular approach to determine outcomes.
- Additional peer reviews of Parkside and Riverside structural assessments, being undertaken by the MoH, are now complete. Clarity on the direction of the Master Planning process is required to plan the next stage of the POW.

- Delays to the POW continue to add risk outside the current agreed Board time frames. Key high risk areas of Panel replacement are starting, as instructed by the Facilities Committee and CDHB Board.
- Access to NICU to undertake EQ repairs to floors continues to be pushed out due to access constraints. The urgent works undertaken to facilitate the MoH run link corridor works has further affected this. Restricted access has been given to one area.
- Passive fire wall repairs continue to be identified. 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, continue to put pressure on limited budgets and completion time frames.
- Passive fire issues are now being raised in the labs building. Work completed and in final review. Potential passive fire issues around comm floor 80 and use of all proof collars at outpatients, ASB and Burwood are currently under review and proposed solutions have been provided. We will work with contractors, designers and the MoH to ensure we get the appropriate systems installed.
- Impact of changes to the Building Act and Seismic assessment methodology continue to be assessed in relation to DHB buildings. Some buildings will be assessed at a higher % NBS than previously, but it is likely that more building will be deemed to be EQ prone than is currently the case. There are significant cost implications arising from these changes as strengthening schemes are likely to cost more and existing engineering reports are no longer valid as a basis for consentable strengthening work. SRDU have started work on assessing these items.
- Reconciliation of earthquake prone buildings with CCC has been completed.

LIVING WITHIN OUR FINANCIAL MEANS

Live Within our Financial Means

- The consolidated Canterbury DHB financial result for the month of April 2018 was a deficit of $7.176M, which was $0.731M unfavourable against the annual plan deficit of $6.445M. The year to date position is $4.481M unfavourable to the annual plan. The table below provides the breakdown of the April result.

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	(0.139)	-	**(0.139)**	(1.562)	-	(1.562)
Funder	(2.050)	(2.043)	**(0.007)**	(17.982)	(16.851)	(1.131)
DHB Provider	(4.987)	(4.402)	**(0.585)**	(22.556)	(20.769)	(1.787)
Canterbury DHB Group Result	**(7.176)**	**(6.445)**	**(0.731)**	**(42.101)**	**(37.620)**	**(4.481)**

4. APPENDICES

Appendix 1: Māori Health Indicators Full Dashboard 6 Jun 2018
Appendix 2: Māori Health Indicators Trends and Comparisons 6 Jun 2018

Report prepared by: David Meates, Chief Executive

DELIVERING AGAINST THE NATIONAL HEALTH TARGETS – PRELIMINARY RESULTS ONLY		Q1	Q2	Q3	Q4	Target	Status
 **Shorter Stays in ED** Patients admitted, discharged or transferred from an ED within 6 hours	Canterbury DHB met the health target in quarter three with 95% of patients admitted, discharged or transferred from ED within 6 hours The Acute Demand Management Service continues to play a critical role in keeping people well in the community and avoiding unnecessary presentations to ED. More than 7,806 acute demand packages of care were provided in quarter 3.	94%	95%	95%		95%	✓
 **Improved Access to Elective Surgery** Canterbury's volume of elective surgery	Canterbury missed target at 97%, or 15,341 elective surgeries, against the YTD target of 15,808. Quarter 4 continues to be adversely affected by coding delays, with these being worked through.	4,989 (90%)	10,344 (96%)	15,341 (97%)		21,330	✗
 **Increased Immunisation** Eight-month-olds fully immunised	Canterbury DHB achieved the health target with 95% of eligible children fully vaccinated at eight months. Only 2% (32 children) were not immunised on time (excluding declines and opt-offs of). Coverage was high across all population groups, meeting the health target for most ethnicities (96% Asian, 95% Pacific, and 96% New Zealand European). Māori coverage increased this quarter to 93%.	95%	95%	95%		95%	✓
 **Better Help for Smokers to Quit** Smokers enrolled in primary care receiving help and advice to quit	Canterbury DHB achieved the health target in quarter three with 91% of smokers enrolled with a PHO offered advice and help to quit smoking against the 90% target. Canterbury DHB's cessation support indicator is again the highest in the country at 56%. This indicator shows the percentage of current smokers who have taken the next step from brief advice and accepted an offer of cessation support services in the last 15 months.	91%	90%	91%		90%	✓
 **Faster Cancer Treatment** Patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer	Canterbury DHB achieved the target in quarter 3 with 91% of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer. This is the second quarter under the new target and definition.	95%	94%	91%		90%	✓
 **Raising Healthy Kids** Percent of children identified with obesity at their B4SC offered a referral for clinical assessment and healthy lifestyle intervention	Canterbury DHB achieved the health target in quarter 3 with 98% of four-year-olds identified as above the 98th centile for their BMI (height and weight measurement) referred for clinical assessment and healthy lifestyle intervention. This is a 2% increase on the previous quarter. 'Referrals declined' fell slightly to 26% this quarter.	93%	96%	98%		95%	✓

National Māori Health Indicators - June 2018

Non-Māori

Indicator	Data Period	Target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	Mid Central	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui
PHO Enrolment	Jan-Mar 2018	90%	81.0%	100.0%	93.0%	94.0%	92.0%	98.0%	100.0%	97.0%	95.0%	99.0%	101.0%	98.0%	93.0%	98.0%	96.0%	95.0%	102.0%	92.0%	94.0%	101.0%
ASH (0-4 yrs)	Yr to Sep 17	-	5308	6650	5905	5012	4447	4741	8143	8254	5868	3638	5747	3448	5615	5607	6303	7181	5824	4391	4625	7315
ASH (45-64 yrs)	Yr to Sep 17	-	2704	3059	2504	2530	2867	3313	3920	4222	4147	2356	3396	3758	2868	3007	4492	3426	3478	3489	2614	4988
Breastfeeding (6 wks)	Jan-Jun 2016	75%	75.2%	77.1%	65.1%	72.6%	65.8%	70.5%	65.2%	66.2%	60.3%	70.3%	73.6%	71.1%	68.0%	77.8%	66.7%	69.3%	70.6%	71.3%	80.4%	70.6%
Breastfeeding (3 mths)	Jan-Jun 2016	60%	67.1%	67.4%	58.9%	68.0%	57.2%	60.9%	56.7%	57.9%	51.4%	63.2%	73.4%	58.9%	58.1%	57.4%	59.2%	61.5%	60.4%	66.4%	55.2%	60.0%
Breastfeeding (6 mths)	Jan-Jun 2016	65%	78.8%	72.4%	67.2%	78.9%	66.3%	68.4%	69.5%	62.5%	58.3%	72.3%	77.1%	63.3%	64.9%	69.5%	68.0%	67.3%	72.1%	73.9%	62.0%	52.2%
Breast Screening (50-69 yrs)	Oct-Dec 2017	70%	63.3%	72.0%	76.5%	73.3%	70.9%	74.6%	74.5%	74.1%	78.2%	80.1%	72.6%	76.5%	75.0%	73.4%	77.0%	70.9%	78.3%	66.1%	76.1%	79.3%
Cervical Screening (25-69 yrs)	Jan-Mar 2018	80%	66.9%	83.4%	74.5%	78.9%	73.2%	77.9%	76.9%	79.0%	77.7%	82.2%	78.2%	78.1%	79.1%	81.7%	82.5%	78.6%	79.5%	73.8%	75.0%	79.4%
Immunisation (8 mths)	Oct-Dec 2017	95%	95.0%	89.5%	95.8%	94.5%	93.2%	92.7%	97.8%	92.9%	94.8%	91.0%	86.1%	90.7%	95.5%	86.1%	91.7%	92.1%	90.8%	92.1%	98.1%	89.0%
Immunisation (Influenza)	Mar-Aug 2017	75%	50.9%	58.2%	61.6%	57.3%	46.0%	59.0%	51.3%	37.5%	59.8%	60.5%	51.6%	59.9%	51.5%	53.4%	52.7%	52.7%	62.1%	45.7%	55.6%	55.5%
Mental Health	Year to Dec 2017	-	137	48	83	140	96	129	93	97	93	82	143	99	96	110	85	113	83	97	102	103
Oral Health	Jan-Dec 2016	95%	88.2%	114.6%	66.6%	106.9%	89.5%	107.0%	107.7%	127.3%	95.9%	88.4%	74.7%	95.4%	84.9%	113.2%	101.0%	72.1%	92.3%	99.6%	100.3%	106.4%
SUDI	2012-2016 combined	-	-	-	0.63	-	-	-	0.51	-	-	-	-	-	0.3	-	0.6	0.46	-	0.11	-	-

Target attained | Within 10% of target
10-20% away from target | More than 20% away from target

Māori

Indicator	Data Period	Target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	Mid Central	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui
PHO Enrolment	Jan-Mar 2018	90%	76.0%	96.0%	81.0%	85.0%	92.0%	97.0%	89.0%	100.0%	86.0%	86.0%	99.0%	78.0%	83.0%	100.0%	86.0%	93.0%	97.0%	81.0%	85.0%	97.0%
ASH (0-4 yrs)	Yr to Sep 17	-	6524	7426	5111	6573	6791	6434	9654	8292	6282	4171	8328	3387	5355	7960	8154	8841	11023	5827	4884	9442
ASH (45-64 yrs)	Yr to Sep 17	-	6638	7607	4952	6498	9182	8250	8297	8444	6924	4626	8401	4453	4550	6092	8747	9347	5420	7591	4276	8887
Breastfeeding (6 wks)	Jan-Jun 2016	75%	61.5%	64.0%	62.8%	53.1%	46.0%	59.3%	49.7%	51.7%	52.7%	54.8%	67.5%	51.4%	58.4%	59.7%	49.6%	56.3%	57.4%	58.2%	75.0%	56.3%
Breastfeeding (3 mths)	Jan-Jun 2016	60%	53.4%	44.5%	52.6%	42.6%	34.4%	38.8%	39.2%	41.4%	38.3%	43.2%	54.2%	41.3%	43.3%	38.2%	41.3%	41.4%	60.0%	50.2%	62.5%	42.8%
Breastfeeding (6 mths)	Jan-Jun 2016	65%	57.6%	53.6%	53.8%	54.9%	48.8%	50.2%	44.4%	57.7%	44.3%	62.3%	61.7%	37.5%	48.2%	55.4%	46.8%	49.1%	56.1%	61.5%	64.7%	57.1%
Breast Screening (50-69 yrs)	Oct-Dec 2017	70%	57.0%	59.9%	69.3%	66.9%	64.1%	68.0%	69.7%	64.2%	65.7%	75.2%	69.7%	68.9%	66.3%	68.4%	61.1%	58.6%	70.7%	62.6%	64.9%	70.2%
Cervical Screening (25-69 yrs)	Jan-Mar 2018	80%	54.5%	70.5%	60.3%	60.9%	65.1%	74.6%	67.0%	72.9%	62.2%	70.4%	68.1%	64.5%	66.1%	70.3%	75.6%	67.4%	69.5%	59.7%	65.7%	72.1%
Immunisation (8 mths)	Oct-Dec 2017	95%	78.3%	83.4%	92.2%	94.0%	85.7%	93.4%	90.7%	91.1%	93.0%	90.1%	90.3%	100.0%	93.8%	86.8%	85.7%	86.2%	93.5%	89.5%	83.3%	86.0%
Immunisation (Influenza)	Mar-Aug 2017	75%	33.1%	53.8%	41.9%	45.5%	40.0%	55.8%	46.4%	32.0%	47.9%	50.6%	50.2%	41.7%	43.9%	53.8%	42.1%	47.4%	50.9%	32.9%	48.9%	64.6%
Mental Health	Year to Dec 2017	-	540	176	210	509	388	398	212	392	214	148	443	159	252	304	190	455	257	288	203	217
Oral Health	Jan-Dec 2016	95%	65.3%	67.3%	43.7%	70.2%	73.5%	72.7%	81.1%	88.1%	94.6%	64.2%	70.5%	41.7%	65.4%	95.7%	81.4%	72.0%	67.7%	71.3%	88.1%	102.1%
SUDI	2012-2016 combined	-	0.73	0.61	0.92	1.92	2.15	1.54	1.36	1.18	1.49	-	1.03	-	1.96	2.37	1.55	1.75	-	-	-	2.97

Target attained | Within 10% of target
10-20% away from target | More than 20% away from target

- Target field is blank where there is either no target for the indicator assigned by the Ministry of Health, or where there are specific targets tailored to each DHB.
- Rheumatic fever is not displayed on this table as the Ministry of Health reports Total Population data, and data for South Island DHBs is aggregated.

Indicator Trends - Comparisons with South Island DHBs

Indicator	Target	Period	Canterbury (European /Other)	Canterbury (Maori)	Gap	Change	Trend	Nelson Marlborough (Maori)	West Coast (Maori)	Southern (Maori)	South Canterbury (Maori)
PHO Enrolment	90	Jan-Mar 2018	93.0	81.0	12	1		86.0	85.0	83.0	78.0
ASH (0-4 yrs)	-	Yr to Sep 17	5905	5111	-794	-543		4171	4884	5355	3387
ASH (45-64 yrs)	-	Yr to Sep 17	2504	4952	2448	1191		4626	4276	4550	4453
Breastfeeding (6 wks)	75	Jan-Jun 2016	65.1	62.8	2.3	3.6		54.8	75.0	58.4	51.4
Breastfeeding (3 mths)	60	Jan-Jun 2016	58.9	52.6	6.3	-0.2		43.2	62.5	43.3	41.3
Breastfeeding (6 mths)	65	Jan-Jun 2016	67.2	53.8	13.4	2.8		62.3	64.7	48.2	37.5
Breast Screening (50-69 yrs)	70	Oct-Dec 2017	76.5	69.3	7.2	-0.3		75.2	64.9	66.3	68.9
Cervical Screening (25-69 yrs)	80	Jan-Mar 2018	74.5	60.3	14.2	2.6		70.4	65.7	66.1	64.5
Immunisation (8 mths)	95	Oct-Dec 2017	95.8	92.2	3.6	1.2		90.1	83.3	93.8	100.0
Immunisation (Influenza)	75	Mar-Aug 2017	61.6	41.9	19.7	-1.1		50.6	48.9	43.9	41.7
Mental Health	-	Year to Dec 2017	83	210	127	2		148	203	252	159
Oral Health	95	Jan-Dec 2016	66.6	43.7	22.9	14.8		64.2	88.1	65.4	41.7
Rheumatic Fever	-	2016		0.7	0.7	-0.1			0		0
SUDI	-	2012-2016 combined	0.63	0.92	0.29	-0.2				1.96	

Indicator Trends - Comparisons with Similar Sized DHBs

Indicator	Target	Period	Canterbury (European /Other)	Canterbury (Maori)	Gap	Change	Trend	Waitemata (Maori)	Counties Manukau (Maori)	Waikato (Maori)	Hutt Valley (Maori)	Capital & Coast (Maori)
PHO Enrolment	90	Jan-Mar 2018	93.0	81.0	12	1		81.0	92.0	93.0	89.0	85.0
ASH (0-4 yrs)	-	Yr to Sep 17	5905	5111	-794	-543		5827	6791	8841	9654	6573
ASH (45-64 yrs)	-	Yr to Sep 17	2504	4952	2448	1191		7591	9182	9347	8297	6498
Breastfeeding (6 wks)	75	Jan-Jun 2016	65.1	62.8	2.3	3.6		58.2	46.0	56.3	49.7	53.1
Breastfeeding (3 mths)	60	Jan-Jun 2016	58.9	52.6	6.3	-0.2		50.2	34.4	41.4	39.2	42.6
Breastfeeding (6 mths)	65	Jan-Jun 2016	67.2	53.8	13.4	2.8		61.5	48.8	49.1	44.4	54.9
Breast Screening (50-69 yrs)	70	Oct-Dec 2017	76.5	69.3	7.2	-0.3		62.6	64.1	58.6	69.7	66.9
Cervical Screening (25-69 yrs)	80	Jan-Mar 2018	74.5	60.3	14.2	2.6		59.7	65.1	67.4	67.0	60.9
Immunisation (8 mths)	95	Oct-Dec 2017	95.8	92.2	3.6	1.2		89.5	85.7	86.2	90.7	94.0
Immunisation (Influenza)	75	Mar-Aug 2017	61.6	41.9	19.7	-1.1		32.9	40.0	47.4	46.4	45.5
Mental Health	-	Year to Dec 2017	83	210	127	2		288	388	455	212	509
Oral Health	95	Jan-Dec 2016	66.6	43.7	22.9	14.8		71.3	73.5	72.0	81.1	70.2
Rheumatic Fever	-	2016		0.7	0.7	-0.1		3.1	7.9	1	2.8	2.3
SUDI	-	2012-2016 combined	0.63	0.92	0.29	-0.2			2.15	1.75	1.36	1.92

FINANCE REPORT
AS AT 30 APRIL 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Finance**

DATE: **21 June 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the financial result for the period ended 30 April 2018.

3. DISCUSSION

Overview of April 2018 Financial Result

The consolidated Canterbury DHB financial result for the month of April 2018 was a deficit of $7.176M, which was $0.731M unfavourable against the annual plan deficit of $6.445M. The year to date position is $4.481M unfavourable to the annual plan. The table below provides the breakdown of the April result.

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate	(4.957)	(4.379)	**(0.578)**	(22.397)	(20.737)	(1.660)
Community & Public Health	(0.013)	0.004	**(0.017)**	(0.369)	(0.077)	(0.292)
Total In-House Provider excl Subsidiaries	**(4.970)**	**(4.375)**	**(0.595)**	**(22.766)**	**(20.814)**	**(1.952)**
Add: Funder & Governance						
Funder Revenue	131.974	132.403	(0.428)	1,319.847	1,323.900	(4.053)
External Provider Expense	(56.721)	(57.218)	0.497	(564.717)	(568.444)	3.728
Internal Provider Expense	(77.304)	(77.228)	(0.076)	(773.112)	(772.307)	(0.806)
Total Funder	**(2.050)**	**(2.043)**	**(0.007)**	**(17.982)**	**(16.851)**	**(1.131)**
Governance & Funder Admin	(0.139)	-	(0.139)	(1.562)	-	(1.562)
Total Canterbury DHB (Parent)	**(7.159)**	**(6.418)**	**(0.741)**	**(42.311)**	**(37.665)**	**(4.645)**
Add: Subsidiaries						
Brackenridge Estate Ltd	(0.017)	0.005	**(0.023)**	0.022	(0.014)	0.036
Canterbury Linen Services Ltd	0.001	(0.032)	**0.033**	0.188	0.059	0.129
Canterbury DHB Group Surplus / (Deficit)	**(7.176)**	**(6.445)**	**(0.731)**	**(42.101)**	**(37.620)**	**(4.481)**

4. APPENDICES

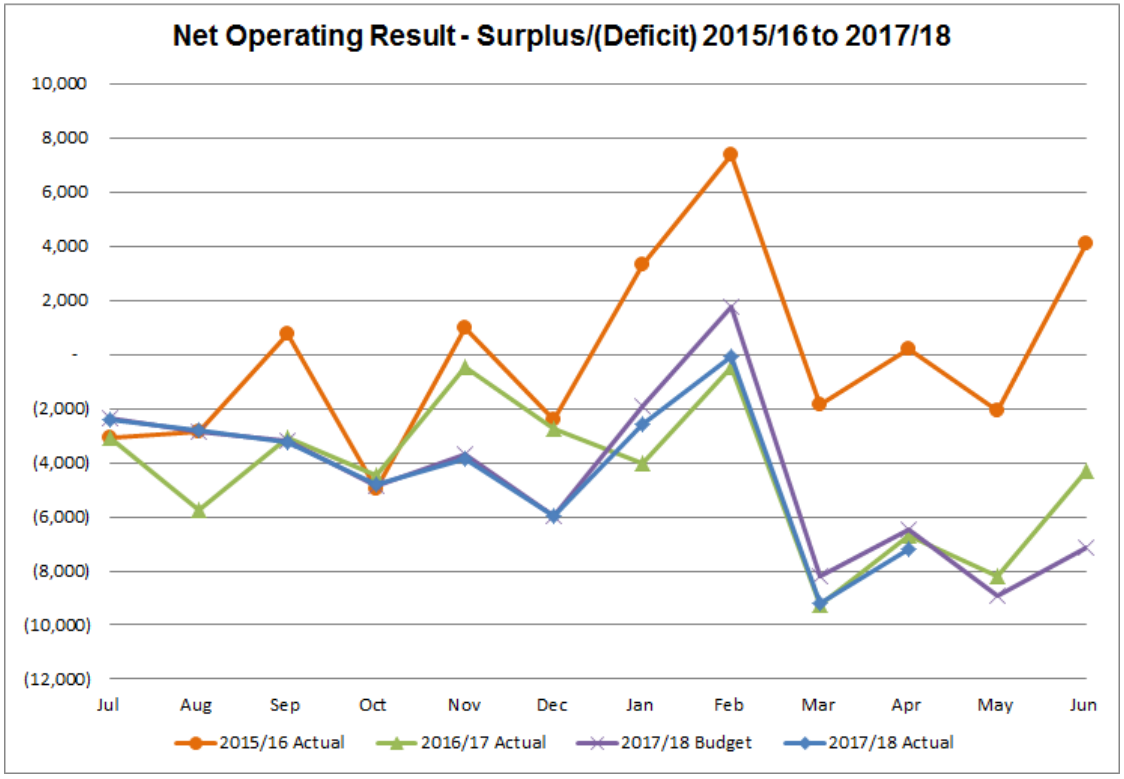
Appendix 1: Financial Result
Appendix 2: Statement of Comprehensive Revenue & Expense
Appendix 3: Statement of Financial Position
Appendix 4: Cashflow

Report prepared by: Justine White, Executive Director, Finance & Corporate Services

APPENDIX 1: FINANCIAL RESULT

FINANCIAL PERFORMANCE OVERVIEW – YTD APRIL 2018

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000	
Surplus/(Deficit)	(7,176)	(6,445)	(731)	11% ✗	(42,101)	(37,620)	(4,481)	12% ✗



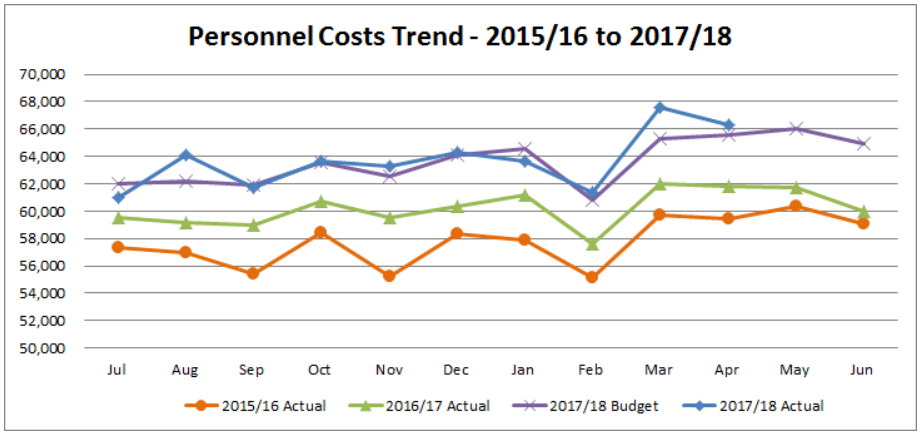
Our approved 17/18 Annual Plan is a deficit of $53.644M.

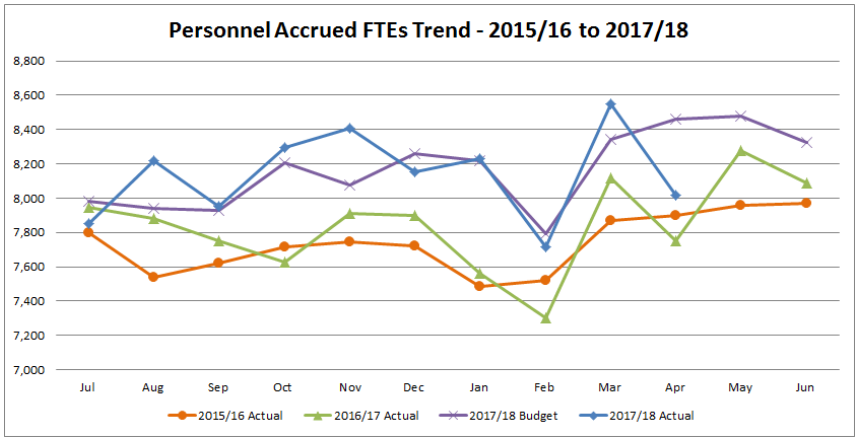
Our latest forecast is for a deficit of $59.839M, which is $1.2M higher than that forecast last month due to Board approved additional outsourcing.

KEY RISKS AND ISSUES

We 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 will be variability between the expected and actual timing of these costs.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE

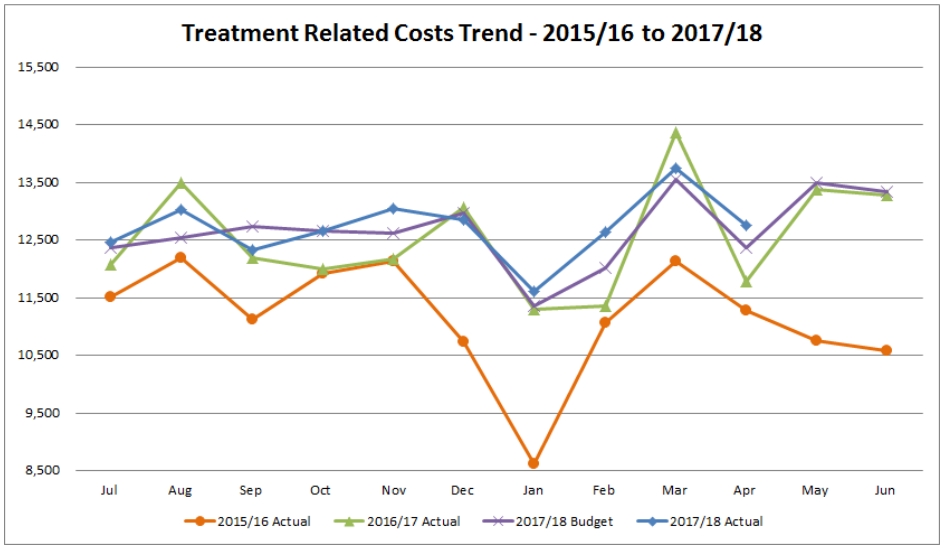


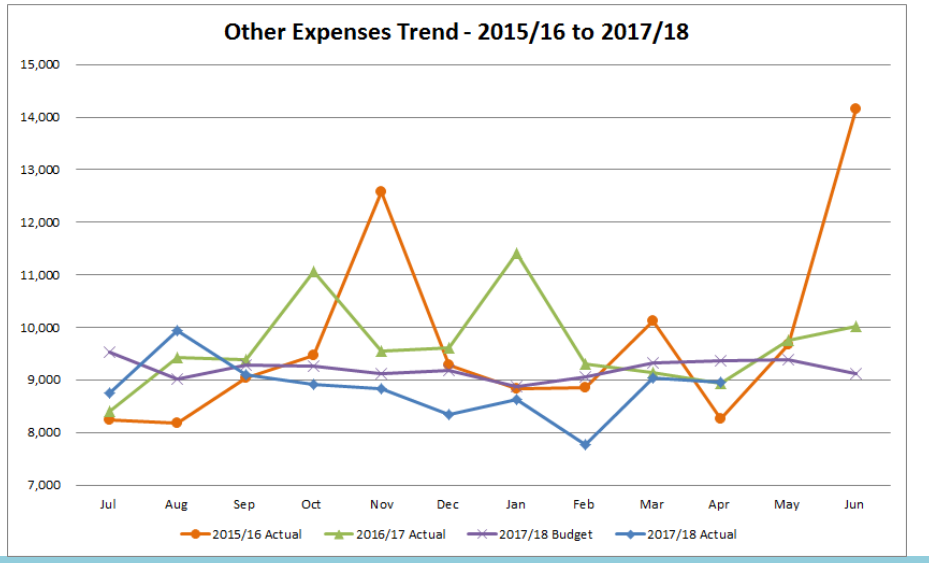


KEY RISKS AND ISSUES

Pressure will continue on personnel costs into the foreseeable future, as a result of settlements as well as additional resource required for the new ASB redevelopment.

TREATMENT & OTHER EXPENSES RELATED COSTS





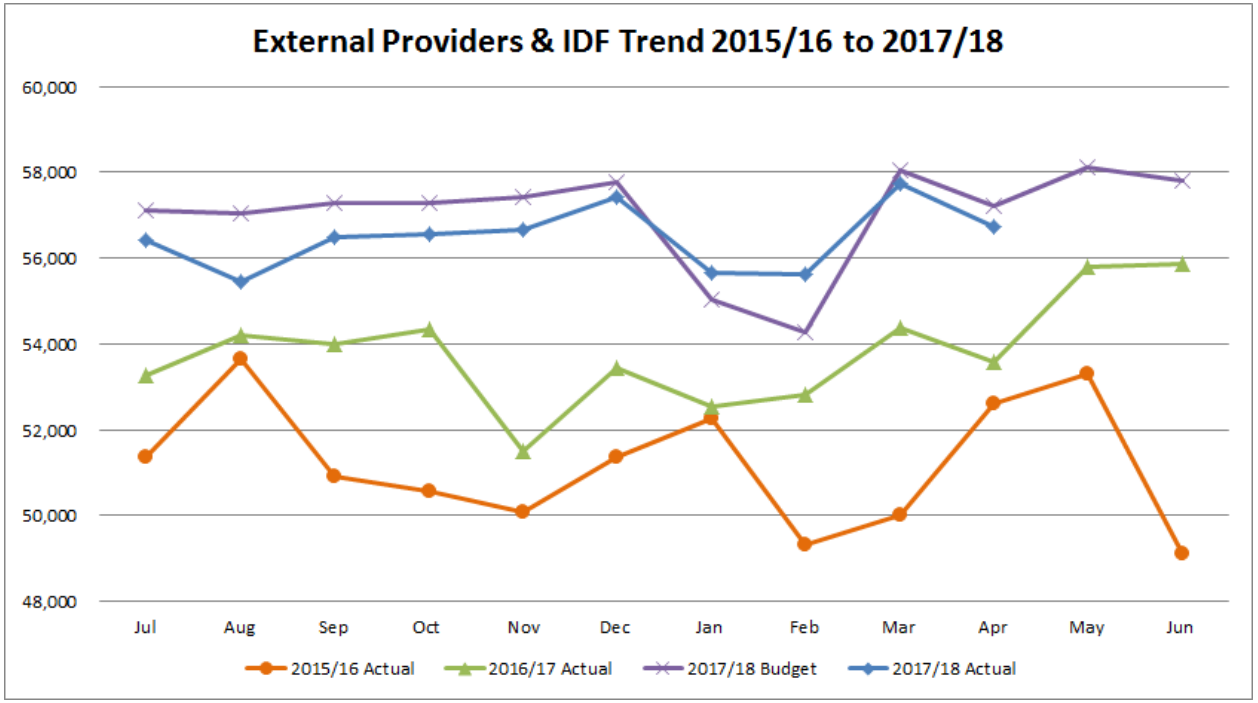
KEY RISKS AND ISSUES

Treatment related costs are influenced by activity volume, as well as complexity of patients.

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

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		
Pay Equity	1,805	2,073	268	13%	✓	17,073	21,006	3,933	19%	✓
IDF Expenditure	2,459	2,416	(43)	-2%	✗	24,071	24,162	91	0%	✓
Other External Provider Costs	52,456	52,729	272	1%	✓	523,572	523,277	(296)	0%	✗
Total External Provider Costs	56,721	57,218	497	1%	✓	564,717	568,444	3,728	1%	✓



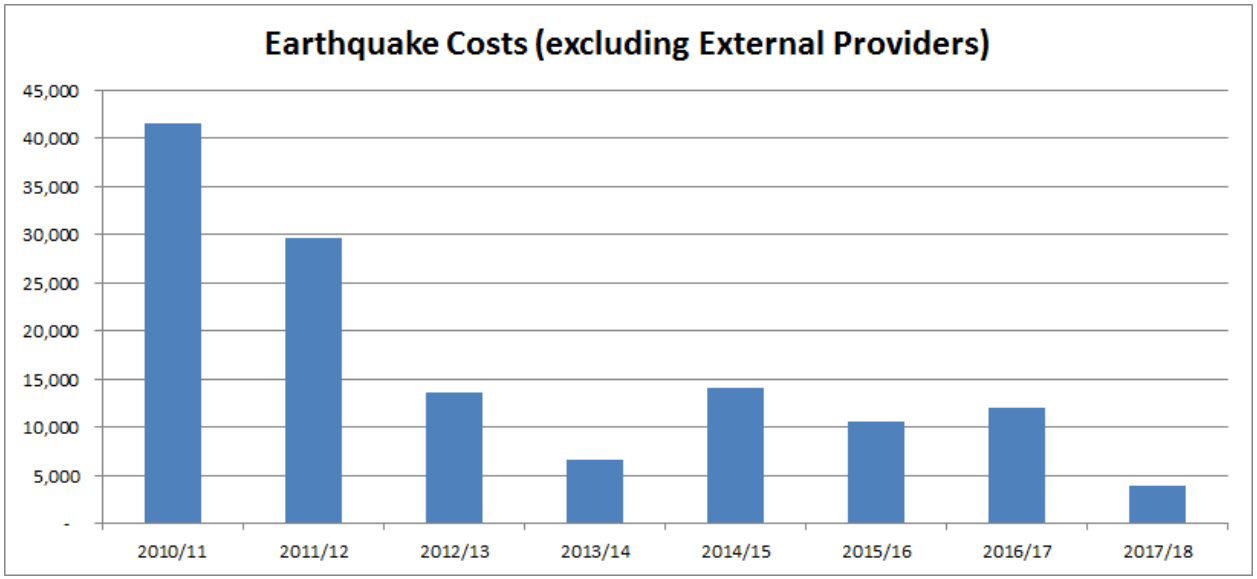
External provider expenditure is $3.728M favourable YTD (primarily pay equity expenditure).

KEY RISKS AND ISSUES

Any catchup on favourable expenditure areas will impact unfavourably on our overall result.

EARTHQUAKE

Data in this table excludes the Kaikoura earthquakes	Month Actual	Month Budget	Month Variance			YTD Actual	YTD Budget	YTD Variance		
	$'000	$'000	$'000			$'000	$'000	$'000		
Total Earthquake Revenue (Draw Down)	302	742	(440)	100%	✗	2,806	6,120	(3,314)	100%	✗
Earthquake Costs - Repairs	310	742	432	100%	✓	2,776	6,120	3,344	100%	✓
Earthquake Costs - External Provider	809	809	-	100%	✓	8,088	8,088	-	100%	✓
Earthquake Costs - Non Repairs	129	114	(15)	100%	✗	1,192	1,074	(118)	100%	✗
Total Earthquake Costs	**1,248**	**1,665**	**417**	**100%**	✓	**12,056**	**15,282**	**3,226**	**100%**	✓



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

EQ repair (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.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000		
Equity	484,991	543,046	(58,055)	-11%	✗
Cash	(9,256)	22,021	(31,277)	-142%	✗

The sweep account was overdrawn at the end of April with a balance of $11.931M. This reduced from the previous month due to the March GST not being payable until 7 May. There will be a double GST cashflow impact in the month of May.

Post month end (May 14) we received $35M for 16/17 deficit funding support; $15.8M less than planned.

Canterbury DHB is relying on 17/18 deficit funding to be received prior to calendar year end to enable supplier payments to be made on time.

Our closing overdraft forecast for June 2018 has increased due to the $15M difference in the 16/17 deficit funding support received.

KEY RISKS AND ISSUES

If future deficit funding is less than the expected amount, cash flows will be impacted, and the ability to service payments as and when they fall due will become a potential issue.

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 Services Ltd
For the 10 months ended 30 April 2018

Month					Year to Date				Annual
17/18 Actual	17/18 Budget	16/17 Actual	Variance to Budget		17/18 Actual	17/18 Budget	16/17 Actual	Variance to Budget	17/18 Budget
136,727	137,788	131,976	(1,061) ✗	MoH Revenue	1,369,703	1,377,873	1,307,388	(8,170) ✗	1,653,435
4,226	3,830	3,099	396 ✓	Patient Related Revenue	40,713	38,100	34,236	2,612 ✓	45,765
2,680	3,183	1,670	(503) ✗	Other Revenue	28,272	30,377	30,802	(2,105) ✗	36,947
143,634	**144,801**	**133,404**	**(1,167)**	**Total Operating Revenue**	**1,438,687**	**1,446,351**	**1,372,426**	**(7,663)**	**1,736,147**
66,316	65,592	61,845	(724) ✗	Personnel Costs	637,014	632,547	600,852	(4,467) ✗	763,497
12,752	12,365	11,182	(387) ✗	Treatment Related Costs	127,080	125,154	120,871	(1,926) ✗	151,996
56,721	57,218	57,218	497 ✓	External Service Providers	564,717	568,444	534,014	3,728 ✓	684,378
8,965	9,378	5,900	413 ✓	Other Expenses	88,343	91,961	99,210	3,618 ✓	110,657
144,754	**144,553**	**136,145**	**(201)** ✗	**Total Operating Expenditure**	**1,417,154**	**1,418,106**	**1,354,947**	**952** ✓	**1,710,528**
(1,121)	**248**	**(2,741)**	**(1,369)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**21,533**	**28,245**	**17,479**	**(6,712)** ✗	**25,619**
611	611	450	- ✓	Capital Charge Funding for Revaluation & Rate Change	6,113	6,113	2,700	- ✓	7,332
55	195	146	(140) ✗	Interest	1,148	1,178	1,717	(30) ✗	1,579
490	138	7	352 ✓	Donations	2,222	1,580	2,430	641 ✓	1,860
42	-	10	42 ✓	Profit / (Loss) on Sale of Assets	22	-	729	22 ✓	-
1,198	**944**	**613**	**254** ✓	**Total Indirect Revenue**	**9,504**	**8,871**	**7,577**	**633** ✓	**10,771**
2,470	2,487	781	17 ✓	Capital Charge	25,259	25,356	13,051	97 ✓	30,330
4,783	5,150	3,758	367 ✓	Depreciation	47,819	49,180	47,291	1,361 ✓	59,704
-	-	-	- ✓	Interest Expense	60	200	4,055	140 ✓	-
7,253	**7,637**	**4,540**	**384** ✓	**Total Indirect Expenses**	**73,138**	**74,736**	**64,397**	**1,598** ✓	**90,034**
(7,176)	**(6,445)**	**(6,667)**	**(731)** ✗	**Total Surplus / (Deficit)**	**(42,101)**	**(37,620)**	**(39,341)**	**(4,481)** ✗	**(53,644)**

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

As at 30 April 2018

Audited 30-Jun-17 $'000		Group Actual 30-Apr-18 $'000	YTD Group Budget 30-Apr-18 $'000	Annual Group Budget 30-Jun-18 $'000
199,933	Opening Equity	517,833	517,833	517,833
372,224	Net Equity Injections / (Repayments) During Year	9,259	62,833	114,618
(1,491)	Reserve Movement for Year	-	-	-
(52,833)	Operating Results for the Period	(42,101)	(37,620)	(53,644)
517,833	**TOTAL PUBLIC EQUITY**	484,991	543,046	578,807
	Represented By:			
	Current Assets			
1,985	Cash & Cash Equivalents	2,675	22,021	-
1,350	Short Term Investments	750	1,350	1,350
63,240	Trade and Other Receivables	75,580	63,238	116,882
9,629	Prepayments	8,281	9,411	9,411
9,119	Inventories	10,174	9,119	9,119
11,815	Restricted Assets	11,864	11,815	11,815
97,138	**Total Current Assets**	109,324	116,954	148,577
	Less Current Liabilities			
16,505	Overdraft	11,931	-	2,250
107,154	Trade and Other Payables	130,347	103,887	93,937
12,111	Restricted Funds	11,881	12,110	12,110
156,703	Employee Benefits	165,708	156,700	156,700
292,473	**Total Current Liabilities**	319,867	272,697	264,997
(195,335)	**Working Capital**	(210,542)	(155,743)	(116,420)
	Non Current Assets			
296	Restricted Funds	16	296	296
5,936	Investment in NZHPL	5,936	5,936	5,936
713,091	Fixed Assets	695,785	698,712	695,150
719,323	**Term Assets**	701,737	704,944	701,382
	Non Current Liablilties			
6,155	Employee Benefits	6,203	6,155	6,155
6,155	**Term Liabilities**	6,203	6,155	6,155
517,833	**NET ASSETS**	484,991	543,046	578,807

APPENDIX 4: CASHFLOW

Audited 30-Jun-17 *$'000*		Actual 30-Apr-18 *$'000*	YTD Budget 30-Apr-18 *$'000*	Budget 30-Jun-18 *$'000*
	CASHFLOW FROM OPERATING ACTIVITIES			
	Cash was provided from:			
15,897	**Net Cash from Operating Activities**	34,091	8,508	(6,940)
	CASHFLOW FROM INVESTING ACTIVITIES			
	Cash was provided from:			
(55,202)	**Net Cash from Investing Activities**	(38,086)	(34,800)	(41,762)
	CASHFLOW FROM FINANCING ACTIVITIES			
	Cash was provided from:			
11,239	**Net Cash from Financing Activities**	9,259	62,833	60,972
(14,520)	**Closing Cash Balance**	(9,256)	22,021	(2,250)

CAPITAL CHARGE PAYMENT JUNE 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Finance**

DATE: **21 June 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

All DHBs are required to pay a capital charge twice yearly (June and December). The amount and nature of the June 2018 payment is outside of our delegation framework, and approval from the Board is sought to make the payment.

2. RECOMMENDATION

That the Board:

i. approves payment of $14,914,800 to the Ministry of Health (*MoH*) as soon as practicable after the Board meeting.

3. DISCUSSION

The capital charge payable is governed by legislation. The invoice we have received from the MoH is calculated in accordance with the legislation, and is due for payment on 20 June 2018.

Our April cashflow forecast is for an overdraft of $82M as at 31 December 2018, compared to the maximum working capital limit of $89M (as defined in the Operational Policy Framework (*OPF*)). Note that the forecast is likely to be $4M - $5M+ short if the recent NZNO offer is accepted.

Our April cashflow forecast **excluding** 2017/18 deficit funding is for an overdraft of $133M as at 30 June 2019. (We are forecasting $60M of 2017/18 deficit funding to be received in January 2019 at this point.)

The OPF notes that equity injections will not be approved if any capital charge payments are overdue.

4. APPENDICES

Appendix 1: Capital charge invoice and calculation

Report prepared by: David Green, Financial Controller

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

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth St
PO Box 5013
Wellington
New Zealand
Phone (04) 496 2516
Fax (04) 816 3320
Contact: Joanna Quirke
E-mail: receivables@moh.govt.nz

TAX INVOICE

(GST No:60-463-727)

INVOICE TO:

CANTERBURY DISTRICT HEALTH BOARD
PO BOX 1600
CHRISTCHURCH

Invoice No: 254174
Invoice Date: 10-JUN-2018
Order No:
Customer Number: 1333
Page Number: 1 of 1

Attention: Justine White

Line	Description	Qty	Unit Cost (GST Excl)	Amount
1	Capital Charge - 1 January to 30 June 2018. Liable net assets as at 31 December 2017 as per attached calculation sheet.	1	14,914,800.00	14,914,800.00
			NET	14,914,800.00
			GST	0.00
		Balance Due By	20-JUN-2018	14,914,800.00

Please notify above contact by fax one day before payment.
Direct Credit to bank account 03 0049 0001805 29

Ministry of Health
PO Box 5013
Wellington
E-mail: receivables@moh.govt.nz

Please Check Details
CANTERBURY DISTRICT HEALTH BOARD
PO BOX 1600
CHRISTCHURCH

Customer No: 1333

Tax Invoice No: 254174

Invoice Total: $14,914,800.00

Primary Contact Number

Canterbury DHB
Capital Charge Calculation
For the six month period 1 January 2018 to 30 June 2018

Capital charge rate 6%

Crown Equity[1]	Donated Assets Net Book Value [1]	Liable net assets	6% of liable net assets	Six months capital charge due
$000's	$000's	$000's	$0's	$0's
A	B	C = A - B	D = 6% of C *1,000	E = D divided by 2
502,467	5,307	497,160	29,829,600	14,914,800

Note(s)
1 Data for these calculations were taken from financial templates for 31 December 2017 received by the Ministry of Health in January 2018

2. Invoice will follow by post and by email in June 2018

3. For addititional details and background on calculation please see the Crown Entities (Capital Charge) Regulations 2011.

http://www.legislation.govt.nz/regulation/public/2011/0135/latest/DLM3721830.html?search=ts_regulation_capital_resel&p=1&sr=1

http://www.treasury.govt.nz/publications/guidance/mgmt/capitalcharge

CONSTITUTION OF BRACKENRIDGE SERVICES LIMITED

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Brackenridge Services Limited**

DATE: **21 June 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

Brackenridge Services Limited is a subsidiary of the Canterbury DHB. A revised Constitution is presented to the Canterbury DHB Board for adoption. The Brackenridge Services Limited Constitution 2018 replaces the original one adopted in 1998.

2. RECOMMENDATION

That the Board:

i. adopts the Constitution of Brackenridge Services Ltd 2018.

3. SUMMARY

Brackenridge (Estate) Services Limited original Constitution was adopted in 1998. Its language and composition reflected the style and provision of disability services at that time. A nationwide transformation of the existing disability support system is under way. The current Constitution needs updating to use more contemporary language and allow for membership of a person with a lived experience of disability on the Brackenridge Services Ltd Board.

4. DISCUSSION

Brackenridge was established as a subsidiary of Healthlink South (a predecessor of the Canterbury DHB) in 1999, following the closure of the Templeton Centre. It initially provided support for 90 people to live in 14 homes on a site at Maddisons Rd, Templeton. Since then, the services have expanded into the community. Currently 190 people are supported by 340 staff across the Maddison site, Christchurch and Rolleston. Brackenridge also provides residential respite services, day and vocational services, and school holiday programme support. More recently, there has been an active involvement in the Enabling Good Lives movement and the organisation has recently become a provider of Flexible Disability Support Services. The organisation contracts to the Ministry of Health, Oranga Tamariki, and Ministry of Social Development. It has an annual turnover of $20 million.

The NZ Disability System is being actively transformed by Government and the disability community. The aim is to ensure disabled people and their families have greater choice and control in their lives. Enabling Good Lives is based on disabled people having greater choice and control. The principles of how disabled people would like to live their lives include self-determination, with the system investing early, being person-centred, being easy to use, supporting disabled people to live an everyday life like others at similar stages, able to access mainstream services, being mana enhancing, and building and strengthening relationships between disabled people, their whānau and community.

The Brackenridge Board reviewed the Constitution and determined its language and Board membership needed revising to reflect the NZ Disability Sector in 2018.

The 2018 Constitution (Appendix 1) uses more contemporary language while retaining the purpose of the organisation, its duties, its powers and relationship with the Canterbury DHB Board. It uses the new name of "Brackenridge Services Ltd" as agreed with the Board early in 2018.

The current Board has five Directors, all appointed by the Canterbury DHB Board. In light of sector transformation and the growth of the company it is proposed there are six Directors. The addition of a sixth Director would allow the appointment of a person with a lived experience of disability/intellectual disability.

The appointment to a governance role of a person with a lived experience of disability is considered best practice, consistent with the aims of the transformation of the disability sector, and common in this sector.

The cost of a sixth Director to Brackenridge is $10,933pa and would be covered by Brackenridge.

5. APPENDICES

Appendix 1 Constitution of Brackenridge Services Ltd 2018

Report prepared by: Jane Cartwright, Chair Brackenridge Services Ltd

Report approved for release by: David Meates, Chief Executive, Canterbury DHB

Dated 2018

CONSTITUTION OF

BRACKENRIDGE SERVICES LIMITED

CONTENTS

CONSTITUTION OF BRACKENRIDGE SERVICES LIMITED

PART I - PRELIMINARY

1. PRELIMINARY

1.1 Definitions

In this Constitution, unless the context otherwise requires:

Act means the Companies Act 1993.

CDHB means the Canterbury District Health Board.

Company means Brackenridge Services Limited.

Crown Entities Act means the Crown Entities Act 2004.

Director means a person appointed as a director of the Company in accordance with this Constitution.

Governmental Agency includes any state or government, local governmental, semi-governmental, judicial, statutory or regulatory entity, authority, body or agency or any person charged with the administration of any Law.

Law includes any rules of common law, statute, regulation, order in council, bylaw, ordinance or other subordinate or secondary legislation in force from time to time.

Public Health and Disability Act means the New Zealand Public Health and Disability Act 2000.

Publicly-Owned Health and Disability Organisation has the meaning given to it in the Public Health and Disability Act.

Share means a share in the Company.

Shareholder means a shareholder in the Company.

1.2 Interpretation

In this Constitution, unless the context requires otherwise:

(a) **capitalised words** or **expressions** have the same meaning as in the Act.

(b) references to:

(i) **clauses** and **Schedules** are to clauses of and Schedules to this Constitution; and

(ii) **paragraphs** in a Schedule are to the paragraphs in that Schedule;

(c) **derivations** of any defined word or term shall have a corresponding meaning;

(d) the **headings** to clauses are inserted for convenience only and shall be ignored in interpreting this Constitution;

(e) the word **including** and other similar words do not imply any limitation;

(f) a **person** includes any individual, company, corporation, firm, club, partnership, joint venture, association of persons (corporate or not), trust or Governmental Agency (in each case whether or not having separate legal personality);

(g) the **plural** includes the **singular** and vice versa; and

(h) a reference to a **statute** includes all regulations and other subordinate legislation made under that statute. A reference to a statute, regulation or other subordinate legislation includes that statute, regulation or subordinate legislation as amended or replaced from time to time.

PART II – STATUS AND POWERS

2. STATUS

2.1 **Status**: The Company is a wholly owned Crown entity subsidiary under the Crown Entities Act, and is a Crown entity in its own right.

2.2 **Auditor**: Under the Public Audit Act 2001, the Controller and Auditor General is to be the Auditor of the Company.

2.3 **Application of State Sector Act**: The Company is an employer for the purposes of sections 84 to 84B of the State Sector Act 1988.

3. CAPACITY AND POWERS

3.1 The Company must:

(a) not do anything that the CDHB does not have the power to do;

(b) act consistently with the CDHB's objectives and current statement of intent (to the extent they relate to the Company);

(c) exercise its powers only for the purpose of performing, or assisting the CDHB to perform, the CDHB's functions;

(d) perform its functions:

(i) efficiently and effectively;

(ii) in a manner consistent with the spirit of service to the public; and

(iii) in collaboration with other public entities (within the meaning of that term in the Public Audit Act 2001) where practicable;

(e) not contravene the Crown Entities Act, the Public Health and Disability Act or any other legislation applicable to the CDHB to the extent those Acts relate to the Company;

(f) comply with a direction given to the CDHB (to the extent it relates to the Company);

(g) pay remuneration to Directors of the Company only at a rate and of a kind determined by the CDHB in accordance with the fees framework or after consulting the Minister of Health;

(h) not pay Directors of the Company any compensation or other payment or benefit, on any basis, for ceasing for any reason to hold office;

(i) not perform any of the CDHB's statutorily independent functions;

(j) comply with the statutory requirements as to employees that apply to the CDHB. In particular, comply with the good employer requirements in section 118 of the Crown Entities Act;

(k) not appoint a member of Parliament as a Director; and

(l) comply with the requirements as to chief executives set out in section 117 of the Crown Entities Act in the same way as the CDHB must do (but for this purpose, references to the responsible Minister in section 117 must be read as references to the parent).

PART III - SHARES AND DIVIDENDS

4. ISSUE OF SHARES

4.1 Section 45 of the Act shall not apply. The issue of further Shares ranking equally with, or in priority to, existing Shares, whether as to voting rights or Distributions, is deemed not to be action affecting the rights attached to the existing Shares.

5. DISTRIBUTIONS TO SHAREHOLDERS

5.1 **Dividends**

A transfer of any Share does not pass the right to any Dividend authorised for payment in respect of that Share where the entitlement date for payment has passed before the date of registration of the transfer.

5.2 **Deductions**

The Board may deduct from any Distribution payable to the Shareholder monies payable by the Shareholder to the Company on account of:

(a) debts, liabilities or other obligations in respect of which the Company has a lien over specific Shares on which the Dividend or other Distribution is payable; and

(b) any amount it is required to deduct by law, including withholding and other taxes.

5.3 **Interest**

No Dividend shall bear interest against the Company.

5.4 **Manner of payment**

Any Distribution payable in cash may be paid in the manner directed by the person entitled to it. In any event, payment may be made by cheque posted:

(a) to the registered address of the Shareholder; or

(b) to the person or address as the Shareholder may direct,

and the Company will not be responsible for any loss arising from the mode of transmission.

5.5 **Unclaimed Distributions**

Any Distribution unclaimed for one year after the due date for payment may be:

(a) intermingled with other money of the Company;

(b) invested or otherwise made use of by the Board for the general benefit of the Company until claimed; and

(c) if unclaimed for five years from the due date for payment, forfeited by the Board for the benefit of the Company,

provided that at any time after forfeiture the Board may, subject to compliance with the Solvency Test, annul the forfeiture and pay the Distribution to any person producing evidence satisfactory to the Board that he or she is entitled to the amount claimed.

6. PURCHASE BY COMPANY OF ITS OWN SHARES AND TREASURY STOCK

6.1 **Acquisition of own Shares**

(a) The Company may acquire its own Shares in accordance with the Act.

(b) The Company may make an offer to the Shareholder to acquire Shares.

6.2 **Treasury stock**

The Company may hold its own Shares in accordance with the Act.

7. CALLS ON SHARES

7.1 **Directors powers to make calls**

(a) The Board may make calls upon the Shareholder in respect of any money that is:

(i) unpaid on their Shares; and

(ii) not made payable at a fixed time or times by the terms of issue of the Shares.

(b) Subject to receiving at least 10 Working Days notice specifying the time and place of payment, the Shareholder must pay to the Company the amount called on the Shareholder's Shares, in the manner specified in the notice.

(c) A call may be revoked or postponed.

(d) A call may be required to be paid by instalments.

(e) Unless the Board resolves to the contrary, a call will be deemed to have been made at the time the Board resolution authorising the call is passed.

7.2 **Interest**

If the call in respect of a Share is not paid when due, the person from whom the sum is due must pay interest on the sum from the due date for payment to actual payment, at a rate not exceeding

five percent above the Company's prime overdraft rate as certified by the Board. The Board may waive payment of all or part of that interest.

7.3 **Payment required by terms of issue of Shares**

If the terms of issue of a Share require a sum to be paid on issue or at any fixed date, for the purpose of this Constitution a call will be deemed to be duly made and the sum will become payable on the date specified in the terms of issue.

7.4 **Proof of liability**

The amount of any unpaid call or instalment may be recovered as a debt from the Shareholder at any time after the debt becomes payable. In any proceedings the proof of the following matters is conclusive evidence of the debt:

(a) the name of the Shareholder is entered on the Share Register as a holder of the Shares in respect of which the debt accrued;

(b) the resolution making the call is duly recorded in the minute book; and

(c) notice of the call was duly given to the Shareholder.

PART IV – SHAREHOLDER'S RIGHTS AND OBLIGATIONS

8. POWERS OF SHAREHOLDER

8.1 **Exercise of powers reserved to the Shareholder**

Unless otherwise specified in the Act or this Constitution, or the terms of issue of the relevant Shares, the powers reserved to the Shareholder of the Company by this Constitution, the Act or the terms of issue of the relevant Shares may be exercised only:

(a) at a meeting of the Shareholder pursuant to section 120 or section 121 of the Act; or

(b) by a resolution in lieu of a meeting pursuant to section 122 of the Act.

9. MEETINGS OF SHAREHOLDERS

9.1 **Proceedings at meetings of the Shareholder**

Schedule 2 applies to meetings of the Shareholder in addition to Schedule 1 of the Act.

PART V - DIRECTORS

10. DIRECTORS' DUTIES

10.1 **Director may act in the best interests of the CDHB**

A Director may (when exercising powers or performing duties as a Director), act in a manner which he or she believes is in the best interests of the CDHB, the Company's parent, even though it may not be the best interest of the Company.

11. APPOINTMENT AND REMOVAL OF DIRECTORS

11.1 **Number of Directors**: The minimum number of directors shall be one and the maximum number of directors shall be six.

11.2 **Appointment of Directors**

(a) Subject to sub-clauses (b), (c) and (d), the Directors are the persons appointed from time to time as Directors by a notice in writing signed by the holders of the majority of the ordinary Shares and who have not been removed or resigned or disqualified from office under:

(i) this Constitution;

(ii) Public Health and Disability Act;

(iii) the Crown Entities Act; or

(iv) the Act.

(b) The Shareholder will appoint at least one Director who has direct experience of disability (either being a person with a disability or as a family member of someone with a disability) provided that such person has the necessary skills to hold that office.

(c) A Director may be removed from office at any time by a notice in writing signed by the holders of the majority of the ordinary Shares.

(d) A notice given under sub-clauses (a) or (b) takes effect upon receipt of it at the registered office of the Company (including the receipt of a facsimile copy) unless the notice specifies a later time at which the notice will take effect. The notice may comprise one or more similar documents separately signed by Shareholders giving the notice.

(e) The Board may appoint any person to be a Director either to fill a casual vacancy or as an addition to the existing Directors.

(f) A resolution to appoint two or more Directors may be voted on as one resolution without each appointment being voted on individually.

11.3 **Director ceasing to hold office**

Without prejudice to section 157 of the Act, the office of Director is vacated if the person holding that office becomes permanently incapacitated and the remaining Directors resolve that he or she is no longer capable of carrying out his or her powers and duties as a Director by reason of that incapacity.

12. DIRECTOR'S REMUNERATION

12.1 **Board's power to authorise remuneration**

The Board may authorise the payment of remuneration or the provision of other benefits by the Company to a Director for services as a Director or in any other capacity:

(a) in accordance with the Cabinet Office Circular CO(12)6 ("Fees Framework for Members appointed to bodies in which the Crown has an interest") or any successor documents; and

(b) with prior approval by ordinary resolution of the Shareholder.

13. PROCEEDINGS OF BOARD

13.1 Meetings of the Board

Schedule 2 governs proceedings at meetings of the Board. Schedule 3 of the Act does not apply to the Company.

14. CONFLICTS OF INTEREST

14.1 Interests register

(a) A Director who is interested in a transaction of the Company must, as soon as practicable after the relevant facts have come to the Director's knowledge, disclose the nature of the interest to the Board.

(b) Where a Director discloses an interest under clause 14.1(a), this must be recorded in the minutes of the next meeting of the Board and entered in the Company's interests register.

14.2 Restrictions on voting

Without limiting sections 139 to 149 of the Act, a Director of the Company who is interested in a transaction entered into, or to be entered into, by the Company may not vote on a matter relating to the transaction; but may, if all the other Directors agree:

(a) attend a meeting of Directors at which a matter relating to the transaction arises, and be included among the Directors present at the meeting for the purpose of a quorum;

(b) take part in deliberations relating to the transaction;

(c) sign a document relating to the transaction on behalf of the Company; and

(d) do anything else as a Director in relation to the transaction,

as if he or she were not interested in the transaction.

14.3 Relaxation of restrictions

Where all other Directors agree that an Interested Director may do anything contemplated by clause 14.2(a) to 14.2(d), the Board must record in the minutes of its next meeting:

(a) the decision of the Directors and the reasons for the decision; and

(b) what the Member said during board deliberations or otherwise did in relation to the transaction concerned.

14.4 Meaning of "interested in a transaction"

For the purposes of this clause 14, a Director is interested in a transaction of the Company if, and only if, the Director:

(a) is a party to, or will derive a financial benefit from, the transaction;

(b) has a financial interest in another party to the transaction;

(c) is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is:

(i) the Crown;

(ii) a Publicly-Owned Health and Disability Organisation; or

(iii) a body that is wholly owned by one or more Publicly-Owned Health and Disability Organisations;

(d) is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or

(e) is otherwise directly or indirectly interested in the transaction.

14.5 **Exclusion from "interested in a transaction"**

A Director is not interested in a transaction for the purposes of clause 14.4:

(a) if his or her interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence him or her in carrying out his or her responsibilities under this Constitution, the Act, the Public Health and Disability Act or another Act; or

(b) because he or she receives remuneration or other benefits authorised under the Act, the Public Health and Disability Act or another Act.

15. INDEMNITY AND INSURANCE

15.1 **Indemnifying Directors and employees**

(a) The Company may indemnify a Director or employee of the Company or a Related Company for any costs incurred by him or her in any proceeding:

(i) that relates to liability for any act or omission in his or her capacity as a Director or employee; and

(ii) in which judgment is given in his or her favour, or in which he or she is acquitted, or which is discontinued.

(b) The Company may indemnify a Director or employee of the Company or a Related Company in respect of:

(i) liability to any person other than the Company or a Related Company for any act or omission in his or her capacity as a Director or employee; or

(ii) costs incurred by that Director or employee in defending or settling any claim or proceeding relating to any such liability,

not being criminal liability or liability in respect of a breach, in the case of a Director, of the duty specified in section 131 of the Act or, in the case of an employee, of any fiduciary duty owed to the Company or Related Company.

15.2 **Insurance**

(a) The Company may with the prior approval of the Board, effect insurance for a Director or employee of the Company or a Related Company in respect of:

(i) liability, not being criminal liability, for any act or omission in his or her capacity as a Director or employee;

(ii) costs incurred by that Director or employee in defending or settling any claim or proceeding relating to any such liability; or

(iii) costs incurred by that Director or employee in defending any criminal proceedings:

(1) that have been brought against the Director or employee in relation to any act or omission in his or her capacity as a Director or employee; and

(2) in which he or she is acquitted.

(b) The Directors who vote in favour of authorising the effecting of insurance under paragraph (a) of this clause must sign a certificate stating that, in their opinion, the cost of effecting the insurance is fair to the Company.

15.3 **Definitions**

In clauses 15.1 to 15.2:

Director includes a former Director;

effect insurance includes pay, whether directly or indirectly, the costs of the insurance;

employee includes a former employee;

indemnify includes relieve or excuse from liability, whether before or after the liability arises and **indemnity** has a corresponding meaning.

PART VI – ADMINISTRATION, FINANCIAL AND MISCELLANEOUS

16. CONTRACTING BY THE COMPANY

16.1 **Method of Contracting**

In addition to the other methods of contracting set out in section 180 of the Act, an obligation which, if entered into by a natural person would, by law, be required to be by deed, may be entered into on behalf of the Company in writing signed under the name of the Company by a director, or other person or class of persons whose signature or signatures must be witnessed.

PART VII – LIQUIDATION

17. LIQUIDATION

17.1 **Surplus Assets**

Subject to the terms of issue of any Shares, upon the liquidation of the Company the Surplus Assets of the Company (if any) must be distributed to the Shareholder.

17.2 **Vesting in trust**

With the approval of an Ordinary Resolution of the Shareholder, the liquidator of the Company may vest the whole or any part of any Surplus Assets of the Company in trustees upon trust for the benefit of the Shareholder. The liquidator may determine the terms of the trust.

18. REMOVAL FROM THE REGISTER

18.1 **Directors may remove the Company from the Register**

If the Company:

(a) has ceased to carry on business, has discharged in full its liabilities to all its known creditors and has distributed its Surplus Assets in accordance with this Constitution and the Act; or

(b) has no Surplus Assets after paying its debts in full or in part and no creditor has applied to the Court under section 241 of the Act for an order putting the Company into liquidation,

the Board may request the Registrar to remove the Company from the New Zealand Register.

SCHEDULE 1 - SHAREHOLDER MEETINGS

Chairperson

1. Subclause 1 of the First Schedule to the Act is deleted. There is no requirement for there to be a chairperson at shareholder meetings.

Proxies

2. A proxy must be appointed by notice in writing signed by, or in the case of electronic notice, sent by the Shareholder and the notice must state whether the appointment is for a particular meeting or a specified term. A proxy need not be a Shareholder of the Company.

3. A Shareholder may appoint more than 1 proxy for a particular meeting, provided that more than 1 proxy is not appointed to exercise the rights attached to a particular Share held by the Shareholder.

4. No proxy is effective in relation to a meeting unless a copy of the notice of appointment is sent to the Registered Office of the Company (or such other place within New Zealand that is specified for that purpose in the notice convening the meeting) at least 48 hours before the time for holding the meeting or adjourned meeting at which the person named in the notice proposes to vote. If the written notice appointing a proxy is signed under a power of attorney, a copy of the power of attorney and a signed certificate of non-revocation of the power of attorney must accompany the notice.

5. Where:

   (a) the Shareholder has died or become incapacitated;

   (b) the proxy, or the authority under which the proxy was executed, has been revoked; or

   (c) the Share in respect of which the notice of proxy is given has been transferred,

   before a meeting at which a proxy exercises a vote in terms of a notice of proxy but the Company does not receive written notice of that death, incapacity, revocation, or transfer before the start of the meeting, the vote of the proxy is valid.

Form of notice of proxy

6. A notice appointing a proxy is to be in the form set out in the Appendix to this Schedule or a form as near to it as circumstances allow, or in such other form as the Board may direct.

Postal votes not permitted

7. Postal votes are not permitted.

Shareholder participation by electronic means

8. For the purposes of this Schedule, a Shareholder, or the Shareholder's proxy or representative, may participate in a meeting by means of audio, audio and visual, or electronic communication if:

   (a) the Board approves of those means; and

(b) the Shareholder, proxy or representative complies with any conditions imposed by the Board in relation to the use of those means (including, for example, conditions relating to the identity of the Shareholder, proxy or representative and that person's approval or authentication (including electronic authentication) of the information communicated by electronic means).

9. To avoid doubt, participation in a meeting includes participation in any manner specified in Schedule 1 of the Act or permitted by this Constitution.

APPENDIX TO SCHEDULE 1 – PROXY FORM

SECTION 1: SHAREHOLDER DETAILS (please print clearly)

Full name:

Full address:

If Shares are held jointly, enter details of other joint holders:

Full name:

Full address:

Full name:

Full address:

SECTION 2: APPOINTMENT OF PROXY

(Please note that if the Shares are held jointly, the appointment made in this section is made on behalf of each joint holder).

I/We appoint

Full name(s):

Full address(es):

as my/our proxy to exercise my/our vote at the [annual/special] meeting of Shareholders of the Company to be held on [date], and at any adjournment of that meeting. If the person I/we have appointed is unable to be my proxy then I/we appoint

Full name:

Full address:

SECTION 3: VOTING INSTRUCTIONS

(Please note that if the Shares are held jointly, the voting instructions given in this section are given on behalf of each joint holder).

I/We direct my/our proxy to vote in the following manner:

(Tick the box that applies)

	For	*Against*
1.	☐	☐
2.	☐	☐
3.	☐	☐

Signed by each Shareholder named in Section 1

_____

_____

_____

Date:

NOTES

1. *As a Shareholder you may attend the meeting and vote, or you may appoint a proxy to attend the meeting and vote. A proxy need not be a Shareholder of the Company.*
2. *If you are joint holders of Shares each of you must sign this proxy form. If you are a company this proxy form must be signed on behalf of the company by a person acting under the company's express or implied authority.*
3. *For this proxy form to be valid, you must complete it and send it to [addressee] at [full postal address] so as to ensure that it is received by [time] on [day and date]. If it has been signed under a power of attorney please send a copy of the power of attorney and a signed certificate of non-revocation of the power of attorney with this proxy form.*
4. *If you return this form without directing the proxy how to vote on any particular matter, the proxy will vote as he or she thinks fit.*

SCHEDULE 2 - DIRECTORS' MEETINGS

Chairperson

1. The Shareholder may appoint one of the Directors to be chairperson of the Board.

2. The Director elected as chairperson holds that office until he or she dies or resigns or the Shareholder elects a chairperson in his or her place.

3. If no chairperson is elected, or if at a meeting of the Board the chairperson is not present within 5 minutes after the time appointed for the commencement of the meeting, the Directors present may choose one of their number to be chairperson of the meeting.

Notice of meeting

4. A Director or, if requested by a Director to do so, an employee of the Company, may convene a meeting of the Board by giving notice in accordance with this clause.

5. Subject to paragraph 1, not less than 2 days' notice of a meeting of the Board must be sent to every Director unless the Director is:

   (a) out of New Zealand; or

   (b) unable to attend the meeting because of a disability,

   unless the chairperson (or in the chairperson's absence, any other Director) believes it is necessary to convene a meeting of the Board as a matter of urgency, in which case shorter notice of the meeting of the Board may be given, so long as at least 2 hours' notice is given.

6. If a Director, who is for the time being out of New Zealand, supplies the Company with a facsimile number or address or electronic mail address to which notices are to be sent during his or her absence, then notice must be given to that Director.

7. The notice of meeting must:

   (a) be a written notice sent to the address or facsimile number, or an electronic mail message sent to an electronic mail address, which the Director provides to the Company for that purpose, or if an address or facsimile number or electronic mail address is not provided, then written notice to his or her last place of employment or residence or facsimile number known to the Company; and

   (b) include the date, time, and place of the meeting and an indication of the matters to be discussed in sufficient detail to enable a reasonable Director to appreciate the general import of those matters.

8. An irregularity in the notice of a meeting is waived if all Directors entitled to receive notice of the meeting attend the meeting without protest as to the irregularity or if all Directors entitled to receive notice of the meeting agree to the waiver.

Method of holding meetings

9. A meeting of the Board may be held either:

(a) by a number of the Directors who constitute a quorum, being assembled together at the place, date, and time appointed for the meeting; or

(b) by means of audio, or audio and visual, communication by which all Directors participating and constituting a quorum can simultaneously hear each other throughout the meeting.

Quorum

10. A quorum for a meeting of the Board is a majority of the Directors entitled to vote on the matters arising at the meeting.

11. No business may be transacted at a meeting of Directors if a quorum is not present.

Voting

12. Every Director has one vote.

13. The chairperson does not have a casting vote.

14. A resolution of the Board is passed if it is agreed to by all Directors present without dissent or if a majority of the votes cast on it are in favour of it.

15. A Director present at a meeting of the Board is presumed to have agreed to, and to have voted in favour of, a resolution of the Board unless he or she expressly abstains from or votes against the resolution at the meeting. A Director who abstains from voting will not be treated as having voted in favour of it for the purposes of the Act.

Minutes

16. The Board must ensure that minutes are kept of all proceedings at meetings of the Board and that a record is kept of written resolutions of the Directors. Minutes that have been signed correct by the chairperson of the meeting are prima facie evidence of the proceedings at the meeting.

Unanimous resolution

17. A resolution in writing, signed or assented to by all Directors then entitled to receive notice of a Board meeting, is as valid and effective as if it had been passed at a meeting of the Board duly convened and held.

18. Any such resolution may consist of several documents (including facsimile or other similar means of communication) in like form each signed or assented to by one or more Directors.

19. A copy of any such resolution must be entered in the minute book of Board proceedings.

Other proceedings

20. Except as provided in this Constitution, the Board may regulate its own procedure.

ANNUAL PLAN APPROVAL – 2018/19

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Planning and Funding**

DATE: **21 June 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This paper has been prepared to request that the Board delegate approval for submission of the first draft of the DHB's Annual Plan for 2018/19, due to the timing of the Board meeting and submission date for the draft Plan.

2. RECOMMENDATION

That the Board:

i. delegates to the Chair and Deputy Chair of the Board and the Chair of the Quality, Finance, Audit and Risk Committee (*QFARC*) sign-off of the first draft of the Annual Plan for submission to the Ministry of Health on 16 July 2018.

3. DISCUSSION

The first draft of the 2018/19 Annual Plan is being prepared for submission to the Ministry of Health (*MoH*) in accordance with the national timeframes. The draft is due for submission on 16 July 2018.

Due to the disconnect between the timing of the Board meeting and the submission date, a request is made that the Board delegates approval of the draft Plan (for submission) to the Chair and Deputy Chair of the Board and the Chair of QFARC.

A QFARC meeting is scheduled for 3 July and the team anticipates providing the draft Plan to that meeting for endorsement. However, the DHB is still waiting for confirmation of some national targets and there may be further edits and updates between the QFARC meeting and the submission date.

The draft would be presented to the Board at its next meeting on 19 July 2018. As with previous years any feedback from the Board would be incorporated into the final draft. The MoH will also provide feedback following the submission of the first draft.

The planning timetable is highlighted below:

10 May	Release of planning package and guidelines to DHBs
29 June	DHB to provide the final draft Statement of Performance Expectation (SPE)
2 July	DHBs to submit final draft System Level Measures Improvement Plan
16 July	DHBs to submit draft Annual Plans, updated SPE, Regional Plans and Public Health Plans
31 July	System Level Measures Improvement Plan approved
3 September	Ministry provides formal feedback on DHB's draft Plans
TBC	DHBs to submit final Annual Plans, Regional Service Plans and Public Health Plans

Report prepared by: Melissa Macfarlane, Team Leader, Planning & Performance

Report approved by: Carolyn Gullery, Executive Director Planning, Funding and Decision Support

COMMITTEE MEMBERSHIP

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

FROM: **Remuneration and Appointments Committee**

DATE: **21 June 2018**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This paper seeks the extension of the appointment of Bill Tate on the Board's Quality, Finance, Audit & Risk Committee (*QFARC*).

2. RECOMMENDATION

That the Board, as recommended by the Remuneration and Appointments Committee:

i. approves the extension of Bill Tate's membership on the Quality, Finance, Audit & Risk Committee until May 2020, noting that the Board has the right at any time within that term to review the membership of any Committee.

3. SUMMARY

In November 2017, the Board approved the roll-over of Bill Tate on QFARC until June 2018. This paper requests the extension of Mr Tate's membership through until May 2020, in line with other external appointments to QFARC.

Final approval for all Committee members rests with the Board.

Report prepared by: Dr John Wood
Chair, Remuneration & Appointments Committee

HAC – 31 MAY 2018

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Hospital Advisory Committee**

DATE: **21 June 2018**

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 31 May 2018.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from HAC's public meeting on 31 May 2018 (Appendix 1).

3. APPENDICES

Appendix 1: HAC Draft Minutes – 31 May 2018

Report prepared by: Anna Craw, Board Secretary

Report approved by: Andrew Dickerson, Chair, Hospital Advisory Committee

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 31 May 2018, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Sally Buck; Dr Anna Crighton; Jan Edwards; Dr Rochelle Phipps; Trevor Read; and Ana Rolleston.

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg; David Morrell; Ta Mark Solomon; and Dr John Wood.
Apologies for lateness were received and accepted from Ana Rolleston (9.45am).
An apology for early departure was received and accepted from Dr Anna Crighton (11.10am).

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Carolyn Gullery (Executive Director, Planning, Funding and Decision Support); Dr Sue Nightingale (Chief Medical Officer); Anna Craw (Board Secretariat); and Charlotte Evers (Assistant Board Secretariat).

IN ATTENDANCE

Item 4
Dan Coward – General Manager, Older Persons, Orthopaedics & Rehabilitation
Linda Wood – Service Manager, Older Persons Health
Jane Clarke – Nursing Director, Older Persons Health
Helen Skinner – Chief of Service
Martin Lee – Clinical Director, Community Dental Service
Colin Pebbles – Clinical Director, Older Persons Mental Health
Janice Lavelle – Service Manager, Older Persons Mental Health and Community Teams

Item 5
Dan Coward
Toni Gutschlag – General Manager, Specialist Mental Health Services
Berni Marra – Manager, Ashburton Health Services
Win McDonald – Transition Programme Manager, Rural Health Services
Pauline Clark – General Manager, Christchurch Hospital

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.

There was a request that Committee members provide a brief description of the organisations listed on the Interest Register, in order to make it consistent with other Committees and the CDHB Board Interest Registers.

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (08/18)
(Moved: Trevor Read/Seconded: Sally Buck – carried)

"That the minutes of the meeting of the Hospital Advisory Committee held on 29 March 2018 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

Item 2 Maternal Health Strategic Direction – there was discussion around why this has been pushed out for a further two months and whether this presents the organisation with any risks or problem areas. It was noted that co-design workshops are being held in early June and delivery of the strategy has been delayed until after that. The risks detailed at the time remain the same.

The Committee noted the carried forward items.

4. OLDER PERSONS HEALTH AND REHABILITATION SERVICES – PRESENTATION

Dan Coward, General Manager, Older Persons, Orthopaedics & Rehabilitation introduced Linda Wood, Service Manager, Older Persons Health; Jane Clarke, Nursing Director, Older Persons Health; Helen Skinner, Chief of Service; Martin Lee, Clinical Director, Community Dental Service; Colin Pebbles, Clinical Director, Older Persons Mental Health; and Janice Lavelle, Service Manager, Older Persons Mental Health and Community Teams, who presented to the Committee on Older Persons Health and Rehabilitation Services at Burwood Hospital.

The presentation provided an overview of the services, including:

- The range of specialities – Older Persons Health (*OPH*), Older Persons Mental Health (*OPMH*), Brain Injury Services (*BSU*), outpatients for many services including Christchurch Hospital; as well as community services covering dental, CREST and Stroke Rehabilitation Service.
- There are a number of stakeholders including the New Zealand Spinal Trust, The Champion Centre and Canterbury Orthopaedic Services.

<u>Spinal Unit – Dan Coward</u>

- The move into the new Spinal Unit at Burwood is underway, with spinal facilities decanting to the ward in June.
- There has been a reduction in traditional sports injuries presenting at the Spinal Unit.

<u>OPH – Linda Wood and Jane Clarke</u>

- OPH is over 65 years of age and over 50 years of age for Maori and Pacific Islanders.
- Smaller towns are becoming more sustainable, which means patients are able to return to their communities faster.
- 75% of patients in the service are from Christchurch Hospital, the remainder are from the wider community, including primary care.
- The service undertakes 2,000 admissions a year.
- 70% of patients return to where they came from on discharge; the remainder go to long-term hospital or rest home care.

- The mortality rate is 1.4% (200 deaths per year).
- The average age of patients is 83.
- Patients on the wards are encouraged to be self-managing (getting dressed in the morning, making their own breakfast etc).

There was a query around whether there is any correlation in advertising campaigns, such as stroke awareness, and functional improvement data. It was noted that Ms Clarke was not aware of any work being done to collect such data.

A query was raised whether Advance Care Planning has been introduced within the service. It was confirmed that it has.

There was discussion around the provision of seven day versus five day rehabilitation services. It was noted that rehabilitation continues through weekends, although not to the full extent as during the week. Mr Coward advised a range of initiatives are in place.

In response to a query from a member, Jane Clarke acknowledged that more work is required around falls prevention and that this remains a priority.

OPMH – Colin Pebbles and Janice Lavelle

- The service covers the area from Kaikoura to Arthurs Pass, Banks Peninsula and down to Rakaia.
- There are two Inpatient wards, an Outpatient Clinic, a Memory Assessment Clinic and a Day Clinic at Burwood Hospital, as well as consult/liaison services at Christchurch and Burwood Hospitals.
- The Interdisciplinary Community Team based at The Princess Margaret Hospital (*TPMH*) provides assessment, treatment and rehabilitation in the community and inpatient setting; is the acute emergency response service for over 65 year olds with mental health issues; and provides InterRAI assessments for the elderly.
- A highlight of the team's work has been the Walking in Others Shoes programme, which has recently been working with older people with Downs Syndrome, in conjunction with Hohepa Canterbury.
- There have been positive moves in dementia mapping.
- Repetitive Transcranial Magnetic Stimulation (*rTMS*) is an established new treatment for medication resistant depression, with other positive roles in aiding stroke rehabilitation/ predicting recovery. It is aimed to introduce this service at Burwood Hospital within the next 12 months, with involvement from the academic unit to evaluate local outcomes.

There was a query around what international data is available about rTMS and whether other DHBs are using it. It was noted that the treatment is FDA approved and can be effective when medication and ECT no longer work. At this time, no other DHB is using this treatment, however, other DHBs are looking at it.

In response to a question from a member, Ms Lavelle advised that a team is based in Rangiora, with 15/16 staff working from Rangiora at any one time.

Community Dental Service – Martin Lee

- Provide oral health services for children in Canterbury, South Canterbury and support the West Coast service.
- 89,000 children enrolled across 28 fixed and mobile clinics and 18 mobile clinics in schools.
- Improving access and availability of services through opening clinics in school holidays with volunteer staff, trialling call centre outbound calls in evenings, along with work underway with Unions to re-define hours of work in the MECA.

- A new clinical leadership structure has been established.
- The service is currently managing the effects of staffing shortages, early childhood caries and waiting times.

Ana Rolleston arrived at 9.45am.

Discussion took place on fluoridation of water, as well as the taxing of sugary drinks.

Mr Coward closed the presentation by acknowledging the team and their ability to work closely together. The Chair thanked Mr Coward and those in attendance for their presentation. It was noted that it is valuable to get feedback regarding facility improvements and how this can improve results for patients.

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

The Committee considered the Hospital and Specialist Services Monitoring Report for May 2018. The report was taken as read.

General Managers spoke to their areas as follows:

Hospital Laboratories – Dan Coward (for Kirsten Beynon, General Manager)

- Facilities: Awaiting feedback from Capital Investment Committee, which met 17 May 2018.
- Facilities Short-Term: Working on plan for short-term fixes to show continued commitment to IANZ, dependant on outpatients move to new facilities.
- Winter Planning: Staffing plans in place ready to meet workload demands.
- SMO Workforce: Working on a range of contingencies for Anatomical Pathologist shortages to maintain service delivery for cancer reporting. Workload and demand still high, with pathologists working hard to keep up both the scientific and technical histology staff managing the same demands.

Older Persons, Orthopaedics & Rehabilitation Service – Dan Coward, General Manager

- There is work being done around falls prevention, with a change in language in terms of recovery programmes to motivate and mitigate risk from a personal perspective.
- Restraint Events in OPMH: OPMH has experienced a significant and ongoing trend in reduction of restraint events. This is an excellent outcome and reflects changes in model of care, environment and staff practice. The team is very proud of its achievements in this area.
- Winter planning is well underway, with a focus on coordinating and connecting services as well as providing strong leadership, working closely with acute demand, CCN and primary care.

There was a query around data on falls that lead to morbidity. It was noted that this can be provided to the Committee.

There was discussion around the ability of GPs to pick up non-acute patients if there is demand on the system in winter. It was noted that currently there is not much flexibility in the system but there is the ability to divert some cases that would normally present in the Emergency Department (*ED*) to extended hours clinics such as the 24 Hour Surgery, Moorhouse Avenue and the Riccarton Clinic. Planning and Funding are also working with pharmacies to come up with strategies to manage some cases.

It was queried whether the elective orthopaedic ward will stay at Burwood once spinal facilities move out. They will stay where they currently are, but there are repairs to be done in the unit.

Specialist Mental Health Services (*SMHS*) – Toni Gutschlag, General Manager

- Te Awakura remains under pressure, but SMHS is committed to a programme of works agreed between NZNO, staff and managers. The environment itself is seen as the greatest challenge.
- There has been an increase in wait time to the Child and Family Service.
- Positive results are being seen through the ADHD pathway.
- Concerning trend of increased assaults in AT&R Unit. Work continues to support the team, including not accepting consumers from outside of Canterbury.
- Stu Bigwood has been seconded as a clinical member of the Facilities Leadership Team.
- Joan Taylor has been appointed as the Acting Director of Nursing.
- Sandy Clemett has been appointed as the Director of Allied Health.

There was a query around the KPI 18 data and whether a lack of follow-up in the community causes pressure in Te Awakura. It was noted while consumers have often been seen in the community, it can create pressure. The team is working to make improvements.

There was discussion around mental health in rural communities, particularly in areas affected by earthquakes and issues that may arise due to the Mycoplasma Bovis (*M. Bovis*) outbreak. It was noted that support is in place for rural communities, and preparations are underway for supporting people affected by M. Bovis. There was a request that David Meates contact the Mayors of Ashburton and Hurunui districts to discuss support being provided to rural communities.

There was discussion around the ongoing health and wellbeing of staff, and the importance of maintaining staff engagement over the coming years. It was noted that the impact on staff of working in poor facilities was becoming increasingly apparent, with it being equally apparent the resounding positive impact on staff at new facilities (eg, Ashburton, Burwood and Rangiora). It was noted that SMHS continues to take steps to ease pressures and is fortunate to have an exemplary team of staff, however, the toll on people has been and continues to be high.

The meeting adjourned for morning tea at 10.37am, reconvening at 10.54am.

Ashburton Health Services – Berni Marra, Manager Ashburton Health Services

- A frail elderly pathway workshop will be held in late June, with a good number of people indicating their attendance.
- There have been changes in staffing, which has provided a good opportunity to look at how the service operates.
- There is a positive operational group in the area, with many younger engaged GPs.
- Work is being done to ensure district nursing and primary care work together to tackle mental health issues and respond when required. This avoids patients going through the Acute Assessment Unit (*AAU*) or ED.

Rural Health Services - Win McDonald, Transition Programme Manager

- Two senior nurse positions in Kaikoura have been filled.
- It is anticipated that there will be an increase in registered nurses retiring in the next four years.
- The draft Hurunui Model of Care is scheduled to go to CPH&DSAC in July, and then onto the Board.

- The Chatham Islands stakeholder meeting is being held today. 40 different organisations are involved.
- The Oxford Model of Care is in draft form and will go out for public and health service consultation in the near future.

There was discussion around drug and alcohol issues in the Chatham Islands and how that compares with mainland Canterbury. It was noted that the issue is not as big as on the mainland, and community health providers are working with the Police and community networks to identify suppliers, with positive results. A campaign called "Stand Up" was recently launched.

There was a query around the retirement rates of registered nurses and what impact that will have. It was confirmed that there are strong numbers of graduate nurses coming through, with many completing their final placements in rural areas. Active planning to minimise the impact is underway.

Medical/Surgical & Women's & Children's Health – Pauline Clark, General Manager, Christchurch Hospital

- Traffic in Canterbury for Queen's Birthday weekend will be heavy, with several events occurring that will effect traffic flow. CDHB has made connections with Central Transport Control to minimise the effects on staff travelling to the hospital.
- Flu vaccination uptake for staff has been good.
- The Ministry of Health (*MoH*) accreditation survey visit will commence on 18 June.
- A changeover to the new Oracle finance/procurement system will occur on 1 July.
- Christchurch Campus is currently preparing for the SI PICS changeover.
- Planning can now get underway for the move into the Outpatients building, with the opening date confirmed.
- Work is continuing around re-presentation of cardio-thoracic patients in ED, with clinical nurse specialists working with their teams to increase confidence in clinical staff and consumers.
- Acknowledgement was made of Planning and Funding in their work sourcing over 50 filtration units for dialysis machines, after chlorination of the water supply.
- An acknowledgement was made of the clinical coding team and the work they do, with Ms Clark highlighting the clot retrieval service and how crucial coding is for this service.

Dr Anna Crighton retired from the meeting at 11.10am.

Acknowledgement was made by the Committee of the stroke pathway and the results this is achieving.

There was a query around whether CDHB will be moving to Snomed. It was confirmed that it is in use in ED.

An acknowledgement was made of the clot retrieval service. It was noted that it is the only service of its type in the South Island, which makes it a limited service as it uses a lot of resources and timing is crucial. There was discussion around whether there has been any research done on the efficacy of later clot removal. It was noted there has been some research. Other factors to consider are financial implications, as well as theatre/facility constraints.

It was acknowledged that without a lot of the improvements made in clinical services, such as clot retrieval, Enhanced Recovery After Surgery (*ERAS*) and FloView, the data would be very different. Committee members indicated they would like to thank and acknowledge the teams for their efforts. The Chair undertook to contact Dr John Fink, Clinical Director, to convey the Committee's appreciation.

ESPIs

- Still red, with Ms Clark indicating it is important to note the figure must be at zero to be anything other.
- Ms Clark is confident CDHB will make improvements in these figures.
- Financial dispensation has been given, due to theatre constraints and CDHB's moves through migration to SI PICS.

There was discussion around Faster Cancer Treatment and the data showing urology cancer waiting times exceeding targets. It was noted that this relates to one specific patient. The clinical team are aware and discussions have been held.

Resolution (09/18)
(Moved: Jan Edwards/Seconded: Sally Buck – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

6. 2018 WINTER PLANNING UPDATE

The report was taken as read. There was no discussion.

Resolution (10/18)
(Moved: Trevor Read/Seconded: Ana Rolleston – carried)

"That the Committee:

i. notes the 2018 Winter Planning Update."

7. CLINICAL ADVISOR UPDATE

Mary Gordon, Executive Director of Nursing, provided updates on the following:

- There is a focus on migration of staff to the new Outpatients and Acute Services Building (*Christchurch Hospital Hagley*). This is a significant piece of work as there is an extra ward component and 10 new theatres, requiring high intensity nursing. There is significant lead-in time required to train nurses in theatre environments.
- Dedicated Education Units (*DEU*) have been commissioned to begin operating theatre nurse training.
- There has been an increase in nurse graduates, with 25 in February this year, 25 earmarked in September and a further 40-45 in February 2019.
- Technical commissioning work by bio-engineers and maintenance staff is ongoing. Teams are under pressure but positive.
- Wards in Christchurch Hospital Hagley will be up to 32 beds, larger than existing wards. This will mean a new nursing structure, with a floating registered nurse on each shift. The role is in place now, with positive feedback that the role helps around peak workload times.
- The HREF building is on schedule, with first staff moving in in July. The nurse workforce team, currently located at Corporate, will be amongst those moving, and will be co-located with nursing lecturers and clinical teams from Ara and University of Canterbury.
- Nurse Manager and Nurse Specialist roles have been made permanent in Kaikoura, with Ms Gordon acknowledging the work done by interim staff.

- Ms Gordon gave the opening address at the recent 40th Annual Enrolled Nursing Workforce Conference, and noted positive reinforcement of CDHB's nursing scope from the keynote speaker.
- Certification process scheduled for June will include a team of 25 being on site for a full week. 15 patient traces will be undertaken.

In response to a question from a member, Ms Gordon confirmed that the certification process would include ambulatory care.

There was a query around whether the new theatres will be vastly different. It was confirmed that the environment will be different to current arrangements, with a centralised system for decontamination and moveable racks for equipment. Existing staff will need to be trained and there have been mock environments set up at the Design Lab for this.

There was discussion around how many Enrolled Nurses there are in Canterbury. There are approximately 700 with current practicing certificates, with many specialising in mental health, primary community care, rehabilitation and aged residential care.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (11/18)
(Moved: Sally Buck/Seconded: Jan Edwards – 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:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 29 March 2018.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	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	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

- Quality & Patient Safety Indicators Level of Complaints
  An update on clinical governance was requested for a future meeting.
- 2018 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.44am.

Confirmed as a true and correct record.

_____ _____

Andrew Dickerson Date
Chairperson

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Canterbury District Health Board

SOURCE: **Corporate Services**

DATE: **21 June 2018**

Report Status – For: **Decision** ☑ **Noting** ☐ **Information** ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATIONS

That the Board:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting of 17 May 2018	For the reasons set out in the previous Board agenda.	
2.	Chair & Chief Executive's Update on Emerging Issues – Oral Reports	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.	Statement of Intent Final Draft	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4.	NZ Health Partnerships' Statement of Performance Expectations 2018-19	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Windows 10	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Canterbury Linen Services Capital Expenditure	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Burwood Birthing Unit Demolition	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Forecast - Reconciliation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Insurance Briefing	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	People Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	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)
12.	Advice to Board: • Facilities Committee (Oral) *21 Jun 2018* • HAC PX Draft Minutes *31 May 2018* • QFARC Draft Minutes *29 May 2018*	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, Executive Director, Finance & Corporate Services