AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
to be held via Zoom
Thursday, 4 June 2020 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 30 January 2020		
3.	Carried Forward / Action List Items		
4.	COVID-19 Update	Sue Nightingale *Chief Medical Officer*	9.05-9.40am
5.	Elective Surgery Recovery Plan (Presentation)	Carolyn Gullery *Executive Director, Planning Funding & Decision Support*	9.40-10.15am
6.	Resolution to Exclude the Public		10.15am
Estimated Finish Time			**10.15am**
	Information Items: • HAC Terms of Reference – amended April 2020 • 2020 Workplan		

NEXT MEETING: Thursday, 6 August 2020 at 9:00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

Andrew Dickerson (Chair)
Jo Kane (Deputy Chair)
Barry Bragg
Sally Buck
Catherine Chu
James Gough
Naomi Marshall
Ingrid Taylor
Jan Edwards
Dr Rochelle Phipps
Michelle Turrall
Sir John Hansen (Ex-officio)
Gabrielle Huria (Ex-officio)

Executive Support

(as required as per agenda)

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*
Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
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*
Kay Jenkins – *Executive Assistant, Governance Support*

COMMITTEE ATTENDANCE SCHEDULE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	30/01/20	02/04/20 Meeting Cancelled	04/06/20	06/08/20	01/10/20	03/12/20
Andrew Dickerson (Chair)	√					
Jo Kane (Deputy Chair)	√					
Barry Bragg	√					
Sally Buck	√					
Catherine Chu		* 16/04/20				
James Gough		* 16/04/20				
Naomi Marshall	* 25/02/20					
Ingrid Taylor	* 25/02/20					
Wendy Dallas-Katoa	√	** 01/06/2020				
Jan Edwards	√					
Dr Rochelle Phipps	√					
Trevor Read	√	** 01/06/2020				
Michelle Turrall		* 01/06/20				
Sir John Hansen (ex-officio)	√					
Gabrielle Huria (ex-officio)	x					

√ Attended
x Absent
Absent with apology
^ Attended part of meeting
~ Leave of absence
* Appointed effective
** No longer on the Committee effective

CONFLICTS OF INTEREST REGISTER HOSPITAL ADVISORY COMMITTEE (*HAC*)

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)

Andrew Dickerson **Chair – HAC** Board Member	**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 **Deputy Chair – HAC** Board Member	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **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.
Barry Bragg Board Member	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **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. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee 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 Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Verum Group Limited** – Director Verum Group Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.
Sally Buck Board Member	**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. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.
Catherine Chu	**Bank of New Zealand** – Private Banking Manager Christchurch Partners Centre **Christchurch City Council** – Councillor Local Territorial Authority **Keep Christchurch Beautiful** – Executive Member **Riccarton Rotary Club** – Member **The Canterbury Club** – Member
Jan Edwards	No conflicts at this time.
James Gough	**Amyes Road Limited** – Shareholder Formally Gough Group/Gough Holdings Limited. Currently liquidating. **Christchurch City Council** – Councillor

	Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board **Christchurch City Holdings Limited (*CCHL*)** – Director Holds and manages the Council's commercial interest in subsidiary companies. **Civic Building Limited** – Chairman Council Property Interests, JV with Ngai Tahu Property Limited. **Countrywide Residential (2018) Limited** – Director/Shareholder Residential Property Development **Gough Corporation Holdings Limited** – Director/Shareholder Holdings company. **Gough Property Corporation Limited** – Director/Shareholder Manages property interests. **The Antony Gough Trust** – Trustee Trust for Antony Thomas Gough **The McLean Institute Trust** – Trustee Trust for the McLean Institute **The Russley Village Limited** – Shareholder Retirement Village. Via the Antony Gough Trust **The Terrace Car Park Limited** – (Alternate) Director Property company – manages The Terrace car park (under construction) **The Terrace On Avon Limited** – (Alternate) Director Property company – manages The Terrace.
Naomi Marshall Board Member	**Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Dr Rochelle Phipps	**Accident Compensation Corporation** – Medical Advisor ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers. **OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive) The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with: • the negative impacts of climate change on health; • the health gains possible through strong, health-centred climate action; • highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and • reducing the health sector's contribution to climate change. **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member The RNZCGP is the professional body and postgraduate educational institute

	for general practitioners.
Ingrid Taylor Board Member	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee. **Taylor Shaw** – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • I / Taylor Shaw have acted as solicitor for Bill Tate and family. **The Youth Hub** – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.
Michelle Turrall Manawhenua	**To be advised.**
Sir John Hansen **Ex-Officio – HAC** Chair CDHB	**Bone Marrow Cancer Trust** – Trustee **Canterbury Clinical Network Alliance Leadership Team** - Chair **Canterbury Clinical Network Oxford and Surrounding Area Health Services Development Group** - Member **Canterbury Cricket Trust** - Member **Christchurch Casino Charitable Trust** - Trustee **Court of Appeal, Solomon Islands, Samoa and Vanuatu** **Dot Kiwi** – Director and Shareholder **Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member The JCA is an independent statutory authority constituted under the Racing Act. The JCA ensures that judicial and appeal proceedings in thoroughbred and harness racing are heard and decided fairly, professionally, efficiently and in a consistent and cost effective manner. **Ministry Primary Industries, Costs Review Independent Panel** **Rulings Panel Gas Industry Co Ltd** **Sir John and Ann Hansen's Family Trust** – Ingrid Taylor sits as independent Trustee; and provides legal services to the Trust and to Sir John and Ann Hansen.

Gabrielle Huria **Ex-Officio – HAC** Deputy Chair, CDHB	**Kawa Hohepa Limited** – Director Family property company **Nitrates in Drinking Water Working Group** – Member A discussion forum on nitrate contamination of drinking water. **Pegasus Health Limited** – Sister is a Director Primary Health Organisation (*PHO*). **Sumner Health Centre** – Daughter is a General Practitioner (*GP*) Doctor's clinic. **Te Runanga o Ngai Tahu** – General Manager Tribal Entity. **The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs.

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, 30 January 2020, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Barry Bragg; Sally Buck; Wendy Dallas-Katoa; Jan Edwards; Dr Rochelle Phipps; Trevor Read; Sir John Hansen (Ex-officio); and Naomi Marshall (Observer).

APOLOGIES
There were no apologies.

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordan (Executive Director of Nursing); Dr Greg Hamilton (Team Leader, Intelligence & Transformation, Planning & Funding); Dr Sue Nightingale (Chief Medical Officer); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES
Carolyn Gullery for absence.
Dr Sue Nightingale for lateness (10.00am).

IN ATTENDANCE

Item 4
Dr Ashley Padayachee, Clinical Director, Department of Anaesthesia
Carole Stuart, Service Manager, Department of Anaesthesia

Item 6
Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health
Dan Coward, General Manager, Older Persons, Orthopaedics and Rehabilitation
Barbara Wilson, Acting General Manager, Specialist Mental Health Services
Kirsten Beynon, General Manager, Laboratories
Win McDonald, Transition Programme Manager Rural Health Services
Berni Marra, Manager, Ashburton Health Services

Andrew Dickerson, HAC Chair, opened the meeting welcoming Sir John Hansen as CDHB Chair. Naomi Marshall, new Board member, was also welcomed, attending today's meeting in an observer role.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Wendy Dallas-Katoa advised she has additions to her interest register which she will send through to the Board Secretariat for inclusion.

There were no other additions/alterations.

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (01/20)
(Moved: Trevor Read/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 5 December 2019 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. DEPARTMENT OF ANAESTHESIA (PRESENTATION)

Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health, introduced Dr Ashley Padayachee, Clinical Director; and Carole Stuart, Service Manager; from the Department of Anaesthesia. The Committee received a presentation on the Department of Anaesthesia which covered the following:

- Workforce
- What an Anaesthetist does
- What it does outside of the theatre environment
- Some of the ways it contributes to the CDHB
- How it fares as a department
- Challenges

Discussion took place on the following:

- The future role of anaesthetists, trends for anaesthesia and technical advancements. Dr Padayachee advised he saw the role increasing not decreasing.
- Strong relationship between public and private sectors in Christchurch. With a workforce of 70 SMOs, CDHB has 60 SMOs who work across both sectors. CDHB insists that the primary practice for these SMOs is with CDHB, with the smaller portion of their practice being in private. Dr Padayachee stressed the importance of keeping SMOs engaged to ensure they remain in the public sector.
- The standardisation of anaesthetic equipment across both public and private sectors and the benefits this provides.
- Challenges from a clinical governance perspective, specifically staff resourcing constraints. The Department sees thing from a lot of subspecialty perspectives, but with limited resources must weigh participation against service requirements.
- Growth in FTEs, largely contributable to requirements to meet increased theatre capacity following migration to the Hagley facility.

Mr Dickerson thanked Dr Padayachee and Ms Stuart for the informative presentation.

5. CLINICAL ADVISOR UPDATE – NURSING (ORAL)

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

- Standardisation is also occurring with nursing across the public and private sectors. This can be evidenced through standardised online health education across the South Island. One set of education learning can be accessed, ensuring consistency.

- Late 2019 the Care Capacity Demand Management (*CCDM*) programme was rolled out to the first cohort - Hillmorton, Ashburton, and some Christchurch Hospital wards. "Prediction – Workload – Actualisation" is the process and with the short amount of time that the programme has be in place results are pleasing, with 95% prediction compliance and 86% actualisation compliance. The next focus will be on reliability to ensure there is no "over" or "under" reporting.
  Rollout of the programme to the second cohort is progressing. This was to have been to surgical wards at Christchurch Hospital, but due to delays in migrating to Hagley, the rollout will now occur at Burwood.
- Post graduate nurses: the number of applicants continues to rise, with funding outstripped and a wait list in place. The biggest increase is in the number of nurses applying for prescribing, as nurse practitioners.
- A number of overseas qualified nurses are applying for the Nursing Competency Assessment Programme. February's intake for the April programme is closed with 70 applicants. Several of these programmes are held throughout the year.
- World Health Organisation (*WHO*) has named the focus of 2020 as "The Year of the Nurse and Midwife". Two programmes around this are:
  - Nursing Now; and
  - Nursing Challenge (encouraging DHBs to prioritise young (under 35 years) nurses for leadership advancement).
- Acknowledged the resignation and significant contribution of Heather Gray as Director of Nursing for Christchurch Hospital. Ms Gray leaves the role on 14 February 2020.

Mr Dickerson advised he would contact Ms Gray on behalf of the Committee and thank her for her contribution as Director of Nursing. Mr Dickerson took the opportunity to also note that since the last meeting, he had contacted Dr Anna Crighton and Ta Mark Solomon (outgoing Board members) to thank them for their contribution to the Hospital Advisory Committee during their terms of appointment.

6. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for January 2020. The report was taken as read.

General Managers introduced their respective divisions and spoke to their areas as follows:

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

- Over the two weeks of Christmas/New Year between 23 December and 5 January:
  - A high number of people presented at the Christchurch Hospital Emergency Department (*ED*). There were 4,062 presentations over the two weeks. This is 290 people per day on average. On the busiest day (Friday 27th) 326 people arrived at ED. It is the second highest volume of people ever seen at the ED over the Christmas period, second only to last year.
  - The Acute Medical Assessment Unit (*AMAU*) area also had a busy period. Volumes were similar to last year and higher than earlier years. There was an average of 41 admissions and transfers into AMAU each day. This was generally in line with the expected volume.
  - The Surgical Assessment area was slightly down on past years with an average of 16 admissions and transfers in each day compared with 18 in the past few years.
  - Theatre capacity was in high demand over the period. 673 hours of theatre work were generated by admissions over 15 days around Christmas and New Year. This is higher than ever seen before. Planned daytime theatre capacity sat at about the same level. A total of 775 hours theatre activity was provided over the

period – reflecting the work done outside of daytime hours along with capacity added in reactively throughout the period.

- Continuing with migration planning & team work in support of occupying Hagley.
- Continuing with efforts to date re encouraging staff to take a period of leave in summer. Have had a positive uptake and leave taken is running higher than previous years. Staff are returning refreshed and are being encouraged to consider further periods of leave and booking it in.
- April planning is well underway: With Easter, ANZAC and school holidays it is a popular time of the year for staff to take leave. Christchurch campus is working with other campuses and primary health to ensure all are aligned across services to support the predicted level of patient demand in April. The focus is on achieving timely patient flow, providing the appropriate teams and ensuring no one group and / or service is planning in isolation. This planning leads into Winter 2020 planning.
- There is an ever-increasing demand for surgery, especially acute surgery. The plan to address this predicted change had been the opening of the additional theatres in Hagley. With occupation delayed we are constrained. We already outsource and outplace to the limit available in the private sector those patients who are deemed clinically suitable to have their procedure on a site other than Christchurch Hospital.
- Failure to occupy additional theatres is resulting in acute surgery putting pressure on planned surgery to the extent that some planned surgery patients are having their planned procedure delayed and re-scheduled. ESPI compliance will not be achieved whilst we cannot occupy Hagley and the re-work involved in re-planning theatre schedules and rescheduling patients and theatres teams is enormous.

There was discussion around migration planning, with Ms Gordon noting that part of the orientation process will be familiarising staff with the extra space. Initially, this may be quite disorientating. There will be a strong emphasis on education, orientation and simulation training prior to migration. All scenarios will be practiced, including a mass tragedy simulation. There is a significant amount of work being undertaken on a daily basis to manage this process, with work and rework having to be undertaken as migration dates shift.

There was a query around why total ED attendances of people over 75 has increased at a significantly higher rate than the established trend, with more patients seen in the past six and 12-month periods than in any other preceding. Management is to look into this and report back to the next meeting.

There was discussion around ESPIs, with it noted that CDHB has an agreed exemption from the Ministry of Health. As a result of the mosque attack, Outpatients flooding, and subsequent rescheduling issues, the MoH has agreed that CDHB will not be subject to a fiscal penalty due to ESPI non-compliance. A recovery plan is in place, which is reported on. It is anticipated that ESPI 5 compliance will start to resolve following migration to Hagley, with ESPI 2 compliance resolving later in the year.

It was agreed for the next meeting that management will provide an overview of the ESPI process from the perspective of one speciality area. This is to include the prioritisation process for ESPI 2 and 5 patients. The ESPI recovery plan is also to be provided to the Committee.

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

- Focus on quality measures. There has been success in falls and by rethinking rehabilitation, however, focus remains on pressure injuries and medication errors which are known to contribute to both cost, time for reviews and further care. A clinically lead process is in place with targets that will result in supporting length of stay for long stay patients, reduce costs, and ultimately improve the quality of care and reduce the risk of death in care.

- Focusing on changes seen with targets for length of stay for hip and knee replacements. A multi-factorial approach is being taken that recognises new contemporary practices where surgery is being undertaken with patients who have a BMI of 60+ (previously not undertaken), coupled with an increase in 80+ years receiving either revision or joint replacement. It is known from a process perspective there is a need to alter weekend discharges, with risk aversion influenced by Thursday being a heavy joint day. In recognition that every move increases a patient's length of stay, patients are now spending their entire stay in the surgical ward, with full wrap around services provided.

There was a query around development of clinical criteria for new contemporary practices. It was noted that this is a clinically led process.

There was a discussion around bariatric treatment provided by CDHB and whether it is looking to do more in the future. It was noted there is a South Island bariatric pathway, with surgery based on greatest need. The Committee requested further detail around the bariatric pathway, including the process and implications of undertaking bariatric treatment.

Specialist Mental Health Services (*SMHS*) – Barbara Wilson, Acting General Manager

- A sustained increase in adult inpatient admissions has seen increased demand in both inpatient and outpatient adult services. Data also shows there is an increase in the number of people being admitted on their first day of contact with the service.
- Demand for the Adult Community Service continues to increase. One initiative to improve efficiency of the service is that CDHB contracts the Homecare Medical After-Hours telephone triage service. This has released mental health staff clinical time to focus on those already under care.
- Sustained Child and Youth Outpatient Services demand has resulted in a longer time for the child or young person to be seen. The Child and Youth Services (*CAF*) Access Team, which includes their Emergency Team, redesigned all of its processes last year and as a result, any child or young person being referred and needing to be seen more promptly is prioritised.
- SMHS has 60 FTE vacancies. These vacancies mean that current staff need to work extra shifts to ensure wards are safety staffed. Future work will include reviewing if a workforce response to ongoing extra shifts impacts on the use of sick leave.
- Despite a national and international shortage of mental health nurses, the People and Capability recruitment team is working actively with Nursing Leadership to recruit staff. Twenty nine (29) new entry to specialist mental health practice registered nurses are starting in early February.
- The detailed design of the Integrated Family Services Centre is due to commence.
- The CDHB Board has approved the Hillmorton Campus masterplan.
- The AT&R pods are progressing and are due for completion in September 2020.
- There has been a reduction in assaults as a result of a multi-faceted approach. This has included environmental improvements, additional leadership on the wards, and the presence of safety officers.

There was a request for reporting to revert back to splitting age groups for the CAF data.

There was a request for a future report on how children are being managed, where the gaps are, and how these are being addressed.

Hospital Laboratories – Kirsten Beynon, General Manager, Laboratories

- There were record numbers of anatomical pathology / histology cases between 23 and 27 December 2019. Despite reducing annual leave liability during this period, the heavy workload was managed and currently turnaround targets are being exceeded for

Anatomical Pathology. This is part of an ongoing programme of work focussed on turnaround times for Histology Lab and Anatomical Pathologists.

- There has been a 10% increase in volumes compared to last year. High volume services include Microbiology, Haematology, Biochemistry, Coagulation and Genetics. A complex mix of patients and cases are presenting to Christchurch Hospital, as well as the 24 Hour Surgery.
- Anatomical Pathology and Genetics have worked with Oncology on the development of an algorithm / test pathway for lung cancer biopsies. This supports best use of testing and expensive Pharmac approved drugs for the right patient.
- Industrial action resulted in the withdrawal of labour between two public holidays and weekends over the Christmas period. This had a large impact. Mitigation and contingency plans were in place for all departments and worked well.

There was discussion around the Coronavirus, diagnosis of it, and CDHB's preparedness. It was noted that diagnosis is by a respiratory swab. Dr Sue Nightingale, Chief Medical Officer, advised that a readiness group has been formed and from a hospital perspective CDHB is prepared. At this point one of the main focuses is communication and containing panic levels.

Rural Health Services – Win McDonald, Transition Programme Manager

- There has been an increase in demand for carer support.
- Work continues with general practice to identify vulnerable patients, in order to develop care plans to keep patients within their communities.
- Chatham Islands residents have recently benefited from the visit of a dentist to the Island. In addition, the Ophthalmology department is looking to provide a screening programme on the Islands in the near future.
- Upcoming hospital anniversaries include:
  - Ellesmere Hospital 95 years on 8 February 2020
  - Oxford Hospital 100 years on 29 March 2020
  - Waikari Hospital 100 years on 5 September 2020.

A report is to be provided to a future meeting on the Chatham Islands health services – where they have come from and where they are at today.

Rural Health Services – Berni Marra, Manager, Ashburton Health Services

- A short-term project in underway to increase the application of careplans in Ashburton. The goal is to ensure care plans are implemented, reviewed and updated when patients connect with any member of the local hospital or community team. The updated plans are then visible in primary care.
- There is ongoing work to implement a single roster for nursing and health care assistants to ensure resources are deployed to occupancy as the team follow the patient load and reduces the pressure to roster additional staff in local wards.
- Ongoing challenges working with primary care colleagues around community enrolments. This is proving problematic, with the right model yet to be reached. This issue continues to be worked on through the Service Level Alliance.

Resolution (02/20)
(Moved: Jo Kane/Seconded: Jan Edwards – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

7. 2020 DRAFT WORKPLAN

The Committee received the 2020 draft workplan. It was noted that this is a working document.

There was a request for a presentation on the Emergency Department's transfer and change in model come migration to the new Hagley facility.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (03/20)
(Moved: Trevor Read/Seconded: Dr Rochelle Phipps – 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 5 December 2019.	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."

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.45am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

HAC MEETING 30 JANUARY 2020 – MEETING ACTION NOTES

Item No	Item	Action Points	Staff
	Apologies	Nil	
1.	Interest Register	Nil	
2.	Minutes – 5 December 2019	Adopted	Anna Craw
3.	Carried Forward Items	Nil	
4.	Department of Anaesthesia - Presentation	Nil	
5.	Clinical Advisor Update – Nursing	Nil	
6.	H&SS Monitoring Report	• Total ED attendances of people over 75 has increased at a significantly higher rate than the established trend, with more patients seen in the past six and 12-month periods than in any other preceding. Provide report on why this is happening and steps being taken to address it (to 2 April 2020 meeting) • Provide an overview of the ESPI process from the perspective of one speciality area. To include the prioritisation process for ESPI 2 and 5 patients (to 2 April 2020 meeting). • ESPI recovery plan also to be provided to the Committee (to 2 April 2020 meeting). • A report on the bariatric pathway, including the process and implications of undertaking bariatric treatment (to 2 April 2020 meeting). • SMHS reporting - reporting to revert back to splitting age groups for the CAF data (2 April 2020 meeting onwards).	Carolyn Gullery Carolyn Gullery Carolyn Gullery Carolyn Gullery Barbara Wilson / Jan van der Heyden

HAC MEETING 30 JANUARY 2020 – MEETING ACTION NOTES

		• SMHS – provide report on how children are being managed, where the gaps are, and how these are being addressed (to 2 April 2020 meeting). • A report on the Chatham Islands – where it has come from and where it is at today (to 2 April 2020 meeting).	Barbara Wilson Carolyn Gullery
7.	2020 Draft Workplan	• Presentation on the Emergency Department's transfer and change in model come migration to the new Hagley facility (Pauline to confirm to Anna which HAC meeting this presentation will be to).	Pauline Clark
8.	Resolution PX	Adopted	Anna Craw
	Info Items	Nil	
1PX	Minutes PX – 5 December 2019	Adopted	Anna Craw
2PX	CEO Update	Nil	

Distribution List:
Carolyn Gullery
Barbara Wilson
Pauline Clark
Jan van der Heyden

Copy: Regan Nolan, Maree Millar, Sharryn Sunbeam

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 4 JUNE 2020

DATE RAISED		ACTION	REFERRED TO	STATUS
1.	01 Oct 2019 (QFARC)	Strategic Paper on Maternity / NICU Services, following completion of national piece of work.	Carolyn Gullery	Awaiting completion of national piece of work.
2.	5 Dec 2019	Cancer Treatment - analysis of 62-day pathway	Carolyn Gullery	Report to 6 August 2020 meeting.
3.	30 Jan 2020	ED attendances for over 75s - increased at significantly higher rate than established trend.	Carolyn Gullery	Verbal Update.
4.	30 Jan 2020	ESPI process, including prioritisation process and recovery plan.	Carolyn Gullery	Verbal Update.
5.	30 Jan 2020	Bariatric pathway.	Carolyn Gullery	Report to 6 April 2020 meeting.
6.	30 Jan 2020	SMHS – management of children and addressing gaps	Barbara Wilson	Report to 6 August 2020 meeting.
7.	30 Jan 2020	Chatham Islands	Carolyn Gullery	Report to 6 August 2020 meeting.
8.	30 Jan 2020	Emergency Department Presentation – Hagley migration transfer and change of model.	Pauline Clark	TBA

COVID-19 UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members, Hospital Advisory Committee**

PREPARED BY: **Sue Nightingale, Chief Medical Officer**

DATE: **4 June 2020**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report was prepared in response to a request from the Chair of the Hospital Advisory Committee (*HAC*) to provide an update on our response to Covid-19.

It will be accompanied by a brief presentation on the functions of the ECC and observations on the response.

2. RECOMMENDATION

That the Committee:

i. notes the COVID-19 update report.

3. SUMMARY

During an Emergency all agencies work within the Co-ordinated Incident Management System (*CIMS*) structure. In Canterbury we set up an Emergency Co-ordination Centre (*ECC*) with 10 supporting EOCs, a Technical Advisory Group and other supporting groups such as People and Capability, including Occupational Health. We were also required to provide a health response to the quarantine and isolation facilities. This report outlines the activities of the ECC and the contributing EOCs and expert teams.

4. DISCUSSION

Now that our system is no longer at risk of being overwhelmed by Covid-19 patients we need to be, and are, planning for "Accelerating the Future", how we can continue to do the things that have improved our workflow and patient experience and how to be embedding new ways of working whilst returning to providing the level of care that we need to.

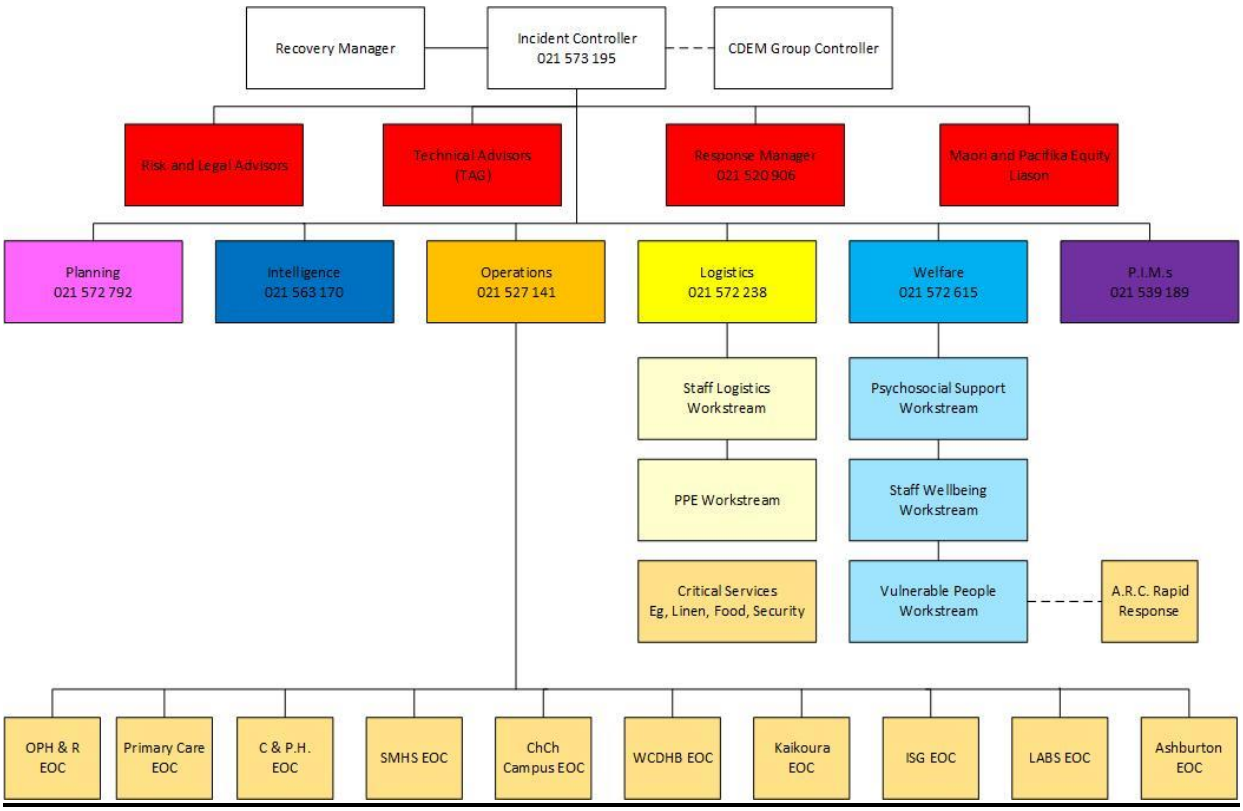
4.1 ECC Controller Notes

Understanding what we saw was happening in China, I set up a Technical Advisory Group with the first meeting on 31 January to prepare for a Pandemic. This comprised: Infection Prevention and Control, Infectious Diseases, Community and Public Health, Primary Care, St John and Emergency Planning. The focus at that stage was the "keep it out" phase of planning and preparing – supporting Community and Public Health who were responsible for boarder management, investigating PPE stocks and preparedness and assessing our facilities for suitability.

Timeline

12 Jan	WHO confirmed Wuhan cluster
31 Jan	CDHB TAG group and 'keep it out' preparedness
28 Jan	MJCC response – notifiable disease order from 30 Jan
28 Feb	NZ first case identified
02 Mar	Limited 'virtual' ECC established
18 Mar	Full ECC established – 2 teams 7 days per week. 2nd Controller – Dan Coward joined 23 March
21 Mar	Alert level 2
23 Mar	Alert level 3
25 Mar	Alert level 4
28 Apr	Alert level 3
07 May	Full ECC – reduced – still operating on limited basis
14 May	Alert level 2

ECC Structure



4.2 Infection Prevention & Control

Governance

- Proactive collaboration with Supply Chain Manager to streamline decision-making and secure critical stock items is turbulent environment i.e PPE, cleaning and disinfection products and waste management supplies.
- IPC representatives on CDHB Technical Advisory Group.
- Close collaboration with Community and Public Health and Occupational Health (especially around contact tracing e.g. Ward 28, GG x2).
- IPC representatives on Christchurch Health Campus COVID-19 Response group.
- Guideline and policy and procedure development e.g. Enhanced Droplet and Contact precautions resources, Care of the deceased (COVID-19), IPC COVID-19 Guidelines for Patient Management.

Surveillance

- Reviewing COVID-19 results in the electronic surveillance system (ICNet) on a daily basis.
- Advising clinical staff and other key stakeholders on appropriate containment measures and infection prevention and control precautions.

Education

COVID-19 Preparedness/PPE training

- 192 COVID-19 education and preparedness sessions, which included PPE donning and doffing between Jan 22 and April 4.
- Over 4,195 CDHB staff (across all work groups and divisions) attendees. Additionally, a range of other external groups in collaboration with C&PH (eg land and air transport agencies).

Online resources

- COVID-19 Healthlearn Module (accessed by 7817 and completed by 7234 nationally and includes ARA students).
- PPE training videos.

Environment Management

- Assessment of all clinical wards for COVID-19 readiness and PPE stocks.
- Technical advice on stand-up of AMAU as COVID-19 Assessment Unit, CBACs, staff testing clinic and quarantine hotels.
- Technical advice on cleaning and disinfection (heightened interest in staff laundering of uniforms and footwear management).

Community Outreach

COVID-19 ARC Outbreak Management

- Extensive support for two ARC facilities in Canterbury with COVID-19 outbreaks (on-going).
- Stand up and on-going support of GG Ward with Rosewood residents.

COVID-19 readiness assessments (MOH directive)

- Independent ARC facilities (n=30) in Canterbury.
- Group ARC facilities (n=60) were a mixture of virtual and site visits. Some Group ARC facilities (n=25) chose site visits from the IPC Service, others requested an alternative process nationally which was agreed by the MOH.

Disability Sector

- MOH identified a sample of 43 small group home facilities covering 20 providers. Assessments were undertaken for DSS facilities (n=19) that chose site visits from the IPC Service.

4.3 Older Persons Health and Rehabilitation

EOC – OPH&R / Burwood Hospital EOC was established early March to respond to the COVID-19 pandemic including both Operational and Clinical Leadership representatives. This was initially virtually but was soon after expanded and based on level 2 Burwood Hospital. A backup EOC was also established with other Leadership team members working at other locations as this group remained separated for the period of lockdown. The team provided cover 24/7 supported by the usual after-hours Managers on-call.

The focus of the EOC was providing operational support to Burwood Hospital and the wider OPH&R Division. Activities included securing of the Burwood site, Visitor policy development and management, approval of service plans for COVID-19 responses and recovery plans,

collation of staff available for redeployment, IS requests, responding to media queries in conjunction with the communication team, supporting managers and staff with HR questions. Daily zoom meetings were held with the wider leadership team and other services based at Burwood Hospital to communicate the EOC actions and current focuses and collate issues as well as regular email updates to managers and staff.

A major focus of the EOC became supporting the Rosewood Rest Home residents. There was a Covid-19 positive resident at Rosewood Rest home which resulted in Rosewood staff being stood down for isolation. This left the residents from the Hospital Level Care Dementia wing with very few staff to care for them. Following discussion by the CDHB Emergency Control Centre (ECC) a decision was made on Sunday 5th April to move these twenty residents to Burwood Hospital. A plan was developed by the OPH&R team to bring these patients into Burwood Hospital and locate them in Ward GG, the Surgical Ward. The plan was developed in a very short timeframe in conjunction with the ECC, Burwood EOC, Infection Prevention and Control, Planning and Funding, Burwood services – food, cleaning, laundry and the GP with medical responsibility of these patients. The residents were transferred across to Ward GG at Burwood Hospital on Monday 6th April. Many of these residents arrived onto Ward GG with existing and underlying medical conditions. The Rosewood Residents were treated as a COVID-19 Cohort and staff were required to full in full PPE, with a challenging group of patients who were very unwell. The staff were from the surgical Ward, OPMH, Operating Theatres and the Nursing Pool. Thirty-four staff worked 470 shifts across the month of April. We returned 11 of the original 20 Residents to Rosewood on Monday 4th May. Following this the Occupational Health team worked with the staff who had worked with Ward GG to support as needed, most of these staff were stood down for 14 days and most have since returned to normal duties.

The Burwood / OPH&R EOC also undertook the initial contact tracing for several staff who became COVID positive as a result of their work with both the Rosewood Rest Home and Ward GG. This information was passed on to Community and Public Health and then Occupational Health to support their on-going isolation.

A number of OPH&R staff also supported ECC Staffing to staff the Rosewood Rest Home Facility as well as members of the Community Dental team being PPE champions to support good PPE practice for ARC. The OPH Community team members worked over the Easter weekend with the planning and funding team and Rosewood resident whanau to support the potential transfer of a second group of Rosewood Residents from Hospital level Care to other Rest Homes, this was due to on-going challenges staffing the facility. There were 4 patients re-located as part of this process. This process didn't continue due to resistance from other ARC Facilities to take these patients.

The Allied Health Team were required to transfer 100% of their outpatient activity to telephone or telehealth consultations within 24 hours of the level 4 restrictions being implemented to ensure that patients were still able to progress with their treatments and felt connected to their clinician.

This has been very successful in completing patient pathways and has allowed us to work through our wait list throughout this time. The team furthered this by transferring their usual group education sessions to a telehealth session using the Logitech Group equipment held within the department to increase access to our service. Within the inpatient area, zoom has been used to facilitate family meetings, specialist outreach rehab and support and even to assess patient's homes to avoid the need for staff and patients to travel. In our community settings, zoom and telephone consultations have been used successfully to manage patient needs to allow them to progress their treatment journey and also prevent care needs escalating.

4.4 CPRG – Canterbury's Community-Based Assessment Centres (*CBACS*)

To support the assessment and testing of suspect COVID-19 patients in the community, novel community-based assessment centres (CBACs) have been established and special arrangements (e.g., capacity contracts) for designated testing clinics have been undertaken with some general practices teams in both urban and rural settings. CBACs provided rapid primary care capacity especially when the risk of undetected cases of COVID-19 in the community was identified. Mobile units have also been established with clinical staff to support testing elsewhere in the community.

CBACs are staffed by doctors, nurses and administration staff and provide clinical assessment, testing, advice, triage, and referrals to other services. They do not provide inpatient or observation services or operate as field hospitals.

The CBACs follow the testing guidelines as established by the Ministry of Health. CBACs have been established in: Ashburton, Rolleston, Halswell, Riccarton, Central Christchurch, Aranui/Wainoni, Rangiora, Amberley and Kaikoura. CDHB Staff and aged residential care staff can also be tested at the Staff CBAC.

The mobile units are deployed to assess and test patients who are unable to attend their general practice or a CBAC. They also provide a mobile testing service to provide capacity in special areas of concern, as directed by the Ministry or Community & Public Health. This includes sentinel, or asymptomatic testing. Mobile teams have performed testing at pop-up clinics[1] at: supermarkets, rest homes, Police and Fire stations and hotels. Further asymptomatic testing is expected to be done over the coming weeks.

To facilitate referrals to the CBACs and mobile clinics, a telephone triage team was established. General Practice teams can refer patients to a CBAC via ERMS. Healthline can direct callers into the triage team who assess the patients and book appointments into CBAC clinics. The Whānau Ora CBAC at Nga Hau e Wha is a walk-in CBAC and requires no appointments.

Data is compiled from the CBACs and pop-up clinics to indicate volume of tests being done as well as the demographics of people being tested. Between 18 March and 18 May, 11,884 people have been tested in CBACs or by a mobile unit. 9.7% of people tested were Māori, 8.2% Asian, and 2.8% Pasifika.

The plan is to maintain flexibility and scalability while reducing the number of novel facilities to align with demand and prepare for the redeployment of clinical staff back to their primary roles in the healthcare system. The Aranui CBAC clinic at Haeata Community Dental Clinic has recently closed and the 24 Hour Surgery has just begun operating as a CBAC. The Rangiora CBAC is expected to move onsite to a local general practice facility within the month.

4.5 Community and Public Health

On 11 May 2020, the Ministry of Health released its National Contact Tracing Preparedness Plan to enable the public health system to effectively manage up to 1,000 cases of COVID-

[1] Specifically: Pak 'N Save on Moorhouse Avenue, Bainlea Rest Home, Rosewood Rest Home, Ashburton Rugby Club, NZ Police, Ashburton Marae, FENZ, Rakaia, Lakewood Rest Home, Burwood Hospital, Diana Isaac Rest Home, Summerset Rest Home, Margaret Stoddart Rest Home, Rosecourt Rest Home, Wesley Care Rest Home, Essie Summers Rest Home, Parklands Rest Home, Parklane Rest Home, Parkstone Rest Home, Anthony Wilding Rest Home, Chateau on the Park Hotel, Novotel Hotel, Countdown Supermarket, Crown Plaza Hotel, Rydges Hotel, New World Supermarket, George Manning Rest Home and other locations.

19 daily. This plan is PHU-centric, recognising that contact tracing skills, expertise, and local knowledge sit within PHUs. The target capacity across all New Zealand Public Health Units (*PHUs*) is 500 new cases per day. PHUs needs to be able to routinely manage 350 cases per day by 30 June with the ability to scale up to 500 cases within 3-4 days if required. Each PHU has a target number of cases to manage, based on the proportion of the national population they support applied to the 350/500 cases per day. This work will be supported by the National Close Contact Service (*NCCS*) and the National Contact Tracing System (*NCTS*) (a cloud-based platform). If case numbers in any district exceed its PHU's capacity, cases are expected to use the NCTS to delegate those cases to other PHUs and/or the NCCS.

Community and Public Health (*CPH*) are required to have capacity to routinely manage 47 COVID-19 cases daily by 30 June 2020 with a robust plan in place to scale up to manage 67 cases daily within 3-4 days if required.

Throughout the COVID-19 response, CPH has maintained several critical functions in addition to case and contact management, including a psychosocial response and border control. This work will continue alongside the Uplift Project and will be managed within the Incident Action Plan (IAP). The Uplift Project supports a specific focus on increasing case and contact management capacity, and the work required will be included within the COVID-19 IAP to ensure coordination between this project and other critical and ongoing CPH work. The Uplift Project will be a major part of the IAP until the end of June.

The past four months of CPH's COVID-19 response has operated within a full CIMS structure, including case investigation and management and contact management across Canterbury, South Canterbury, and the West Coast. CPH are responsible for the investigation and management of all cases, their household contacts, and clusters within our region. Some non-household close contacts not related to a cluster or complex case have been delegated to NCCS for management and follow-up.

The current CIMS structure includes an Incident Controller overseeing these core functions:

- Operations
- Planning and Intelligence
- Quality
- Logistics
- Public Information Management
- Psychosocial response

Until mid-May, CPH has been operating on a seven-day roster, with separately-managed case investigation and contact management teams. The case investigation team includes a team leader, responsible for the immediate oversight of up to 24 case investigators (depending on case volume), and 1-3 persons providing data entry and admin support. Case investigators are primarily experienced Health Protections Officers (*HPOs*), although a small number of Public Health Nurses (*PHNs*) and Environmental Health Officers (*EHOs*) were seconded to CPH and undertook case investigation when case volumes were high. The contact management team includes a team leader and approximately 14 staff carrying out case and contact daily follow-up. Daily callers are current CPH staff (e.g. health promoters) who received training in contact management. Medical Officers of Health (*MOoH*) have provided clinical oversight to daily operations and oversight of other key functions such as communications, quality, intelligence, planning, and critical non-COVID-19 work.

Operational work is supported by other functions within the CIMS structure. The quality management system is incorporated into the IAP, encompassing document control (e.g.

consistent review and distribution of the COVID-19 protocol), auditing, and records (e.g. file structures in CFS and management of various databases). The quality management system is led by the Quality Coordinator and is supported by Public Health Specialists (PHS). Planning and Intel also supports internal operations and external requirements by producing various outputs. Currently this team includes a planning and intel manager, up to five analysts and clinical oversight by a MOoH. All intel outputs present equity-focused breakdowns (ethnicity, deprivations, geographic) where feasible (sufficient numbers and high-quality data available).

The current planning and intel outputs include:

- Daily updates
- Weekly Intelligence summary
- Daily case numbers by TA
- Weekly case numbers by TA
- Literature scanning
- Weekly Incident Action Plan
- CPH 2-page overview plan

Throughout the response, CPH staff have responded to various information requests, including: Official Information Act (*OIA*), Ministry of Health data requests, Parliamentary Questions, and media requests. To date, these have been undertaken by Information Systems and operational staff, with support from CDHB Communications for media enquiries. All requests require sign-off by a MOoH and/or Manager and have taken considerable resources.

Logistics manage the rostering and workplace locations of staff; currently key operational teams are working primarily on site, with physical distancing and hygiene measures in place. While other CPH staff are working remotely (including some daily callers). This team also provides resources to staff (e.g. IT equipment) and deliver staff wellbeing initiatives.

Under the current CIMS and operating model, CPH has the capacity and resources to manage up to 21 cases daily.

4.6 Specialist Mental Health Services (*SMHS*)

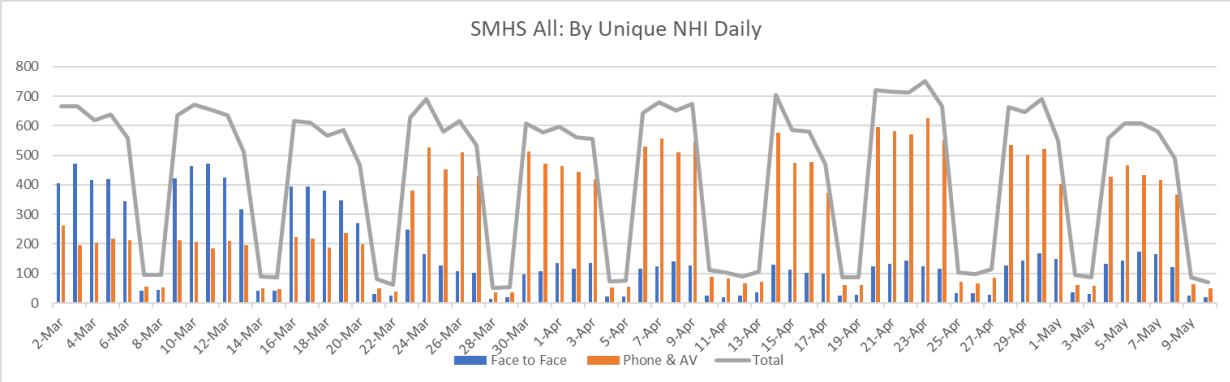
SMHS COVID-19 activity centred on preparedness for managing consumers who may be suspected or confirmed COVID-19 cases. Those challenges included managing consumers who were mentally unwell and the vulnerabilities that exist for many of them and the inpatient environmental constraints.

The Mental Health EOC was fully operational with a daily Teams meeting with the services leadership teams, H&S and P&C staff. The response included working closely with IP&C and the Infectious Diseases team to establish COVID isolation areas for both inpatient adults and children and assessment areas for outpatient consumers. This required development of supporting IP&C processes, processes for managing restraint in confirmed COVID cases and providing guidance and education for staff on infection control and use of PPE.

To ensure the inpatient system had the flexibility to maintain services if staff were significantly impacted, we raised the admission threshold and discharged all inpatients from the Kennedy unit to reserve space for any surge and the need for physical distancing. Te Awakura (adult acute inpatient unit) occupancy averaged 57% between 23 March – 4 May. The AoD service developed alternative pathways to ensure that medical detox and OST establishment could continue, if needed.

An announced OPCAT COVID -19 inspection by the Office Ombudsman occurred on 6 May 2020. The purpose of the inspection was to ensure that people are treated humanely, and their human rights are being protected during the COVID-19 pandemic. The provisional report has no recommendations. The final report is due at the end of May.

Most consumers in the SMHS live in the community. The outpatient focus was on maintaining acute and urgent care as well as care that would prevent significant deterioration. All community teams moved to split teams to enable physical distancing in their workplace. Half the team worked on site and half worked remotely. This was rotated weekly. Contact with consumers was by phone consultation or telehealth through Zoom. Good daily contact levels were maintained as demonstrated in the graph below. This information was extracted from contacts in SAP.



4.7 Christchurch Campus

Projections of potential significant illness in our community led health systems throughout New Zealand to change the way that they worked.

- Patient pathways were put in place to provide separate streaming of patients who did and did not meet the definition for COVID-19 in the Emergency Department, Acute Medical Assessment Area, Intensive Care Unit Children's Acute Assessment unit and wards, Neonatal Intensive Care Unit, and Maternity.
- Christchurch Hospital's larger services split their teams – enabling the segregation of patients and staff so that patients without acute respiratory symptoms were kept safe
- Significant time was spent on designing and adopting new pathways and guidelines, teaching and learning the use of personal protective equipment, simulation to provide familiarity, additional time taken when working with potential COVID-19 patients and making and re-making arrangements for planned patients. These tasks were carried out alongside existing workloads
- Patient and visitor screening was carried out on the point of entry into hospital and outpatient buildings. For walk in patients at the Emergency Department this screening occurred at a rapidly set up portacom outside of the main emergency department doors.
- Members of the General Medicine, Respiratory and Infectious Diseases services formed a COVID-19 team. Half of the Acute Medical Assessment Area, including its negative pressure rooms, was set aside for the care of patients with potential or confirmed COVID-19 disease.
- The Gynaecology Ward was set aside as an overflow COVID-19 unit should it be required. This required combination of other clinical areas. Plans for further COVID-19 capacity were developed and involved further combination of existing clinical areas to release space.

- Intensive Care Unit equipment purchases were bought forward and medical and nursing staff were trained to provide intensive care services should expansion in capacity be required.
- Social distancing and the associated shut down led to an incredible reduction in demand for the acute care usually caused by trauma and infectious diseases.
- This led to a reduction in presentations to the Christchurch Emergency Department and acute admissions to Christchurch Hospital. During April there were 5,681 presentations at the Christchurch Hospital Emergency department - 71% of forecast and 3,460 acute admissions 71% percent of forecast. During the first 12 days of May the number of patients presenting has increased and is close to 80% of the same period in 2019.
- While only non-deferrable services were able to be provided face to face, use of telephone and video consultation enabled Christchurch Hospital to provide a high volume of outpatient appointments 22,571 during April – 75% of the previous April.
- Volume of deferrable work is rebuilding during May. For example during the first 14 days of May planned surgery volumes are close to 90% of those in the same days of 2019.
- During lockdown approximately 500 births were facilitated by both Lead Maternity Carers and the employed teams who had to be alert to screening for COVID-19 and appropriately donned in personal protective equipment. The level of precautions taken was different to what is usually done due to increased risk.
- Work is underway to adopt changes to models of care for enduring use. This will see ongoing use of use of telephone and video consultation for outpatient activity where this is relevant, increased day stay services for procedures requiring hospital admission and increased provision of services in the community.
- Many staff were unable to work in their usual settings following occupational health assessment. Many were also deployed to areas they would not normally work. For example screening of people entering Christchurch Hospital consumed around 21 nursing FTE at its peak and the staff testing centre used nearly 6FTE of peri-operative nursing capacity.

4.8 ISG

ISG staff, especially our Service Desk and Technicians have managed a high volume of requests with a 30 per cent increase in calls and many bulk requests for hardware, including mobile devices, headsets and cameras. We also provided services and hardware to many critical temporary facilities including CBACs and Quarantine / Isolation hotels.

We also found that many Covid-19 related requests were already in the pipeline and we responded with an accelerated delivery of the planned solution. Some key activities lead, enabled and supported by ISG include:

- Fast-tracking the completion of IT work to support Hagley ICU & Radiology. This included the deployment of Cortex at pace.
- Setting up a Drop and Clean Zone for device repairs near CHCH hospital to manage the health and safety of our staff and contractors.
- Managing the large volume of requests for remote access with a Prioritisation Framework and process put in place to give staff supporting critical services priority.
- Fast tracking key components of our virtual desktop infrastructure expansion strategy to support the increasing number of staff working remotely due to Covid-19. This includes the phased rollout of new short- and long-term remote access options, in tandem with the harvesting of existing VDI licenses.

- Progressing at pace an increased number of Health Connect South, MedChart and Patientrack COVID-19 requests, to support the business.
- Supporting increased demand/use of Microsoft Teams (3,505 users) and Zoom (902 active users) to keep our staff productive and connected.
- Improving Public Wi-Fi performance at Burwood and delivering extra mobile coverage for Christchurch Campus and Hospital Hagley to improve services for patients and staff.
- Fast-tracking the deployment of Microsoft One Drive to support the flexible working needs of the organization by giving staff the ability to access documents from their Mobile Device, as well as their PC.
- The delivery of an Electro Clave device (UV disinfection of devices) for Christchurch Campus.
- The implementation of a visitor contact tracing app, which needs to have bespoke requirements, specific to the secondary care environment. We are also deploying a solution for visitors who do not have a cell-phone.

While our staff have been stretched responding to Covid-19 related matters, the effective operation of our EOC has seen Covid tasks managed efficiently. As part of our Covid-19 response ISG has rapidly embraced the use of Microsoft Teams – a secure online platform that all staff have access to as part of our Office 365 license. Microsoft Teams provided ISG with one simple, secure solution that includes chat, video, voice and other tools all in one place. ISG utilized the additional functionality in Microsoft Teams to track and action all Covid-19 related activities, so all staff had access to and could update tasks in one place. This platform complemented our flexible working environment with more staff working remotely to support the wellbeing of our people. We were able to ensure service continuity in this flexible environment and demonstrated that the business can be supported effectively from a business continuity perspective.

4.9 Pathology and Laboratories

Quick Facts

SARS-CoV-2 RNA tests performed at CHL (as of 1500h 6 May 2020):

	Total	**Positive results**
Total numbers all regions	29, 971	256
CDHB region	15, 683	103

SARS-CoV-2 RNA patients tested by CHL (some patients repeat tested)

	Total	**Positive patients**
Total numbers all regions	28,954	242
CDHB region	15,129	98

702% increase in workload for Virology Lab with the equivalent demand on logistics team.

Background

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the virus strain that causes coronavirus disease 2019 (COVID-19). CHL is one of twelve labs in NZ now undertaking testing for SARS-CoV-2. CHL was the first laboratory to have testing available for SARS-CoV-2 in NZ, with both ESR and LabPlus the other tertiary level labs in having assays set up within days of this. The first patient tested at CHL was on 31 January 2020.

CHL rapidly set up a local EOC in recognition of the emerging pandemic. It was imperative early action was taken to identify reagent, analyser and sample collection supply chain constraints,

emerging raw material supply issues, testing logistics and capacity constraints and creating contingencies for all these challenges.

We recognised these challenges were greater than Canterbury and we needed to be contributing to a national response in the interest of all NZ. If testing in NZ and other regions was struggling, then we were all at risk as a country to get COVID under control.

The CHL Pathology and Laboratory Response

With the early establishment of the CHL EOC, the labs have ensured strong collaboration within its clinical, scientific, technical, administration and management teams. We have ensured connections were established early on nationally at a clinical and operational level. Our Microbiologists (Clinical Pathologists) provide significant contribution to all aspects of the response from IP&C, Occupational Health, Laboratory diagnostics and research at a local and national level. With the share workload and demands on their expertise the Microbiologist have all taken a lead on different aspects of our response from a clinical perspective supported by operational and scientific leaders.

It was recognised our team needed to bring together our own scientific and management expertise from across labs to support the Virology response. We also needed to share scientific know how and knowledge to support other laboratories – particularly their scientific and technical teams in test development, trouble shooting, provision of consumables and controls to ensure testing capacity was stabilised around the country to meet the demands. CHL has made a significant contribution to the validation or alternative supplies and reagents for use around the country.

Supply Chain

As a result of the focused response CHL was well positioned, relationships with our established supply partners (suppliers) were able to support our forward ordering of materials to meet increased testing demands and expectations in relation to capacity. This was at the same time as the rest of the world were seeking these same materials from the same suppliers and transport networks closed. While this was not without issues and challenges. A significant commitment was required, and long hours worked by the team to achieve this. The supply chain requires very close and constant monitoring. CHL should remain well placed with its forecasting and forward ordering practices.

CHL has been able to assist suppliers redirecting orders some swabs, reagents and analysers to other labs around NZ rather than to CHL to support regions establishing or continuing their own testing. This has not been without compromise and we recognise we have to flex for the whole country.

CHL was also in a position to expediate the Molecular Microbiology analyser tender processes that were already well advanced in order to expediate further testing capacity and flexibility between platforms to optimise throughput and reagent utilisation.

Alternative Testing Options and Methods

An extraction process has been developed by a scientist at the University of Otago that has been refined for use for SARS-CoV-2 RNA extraction in partnership with CHL scientific officers. Further collaboration and work is being undertaken to refine this extraction process to enable it to be scalable and automated on to analytical platforms to provide further testing contingency if there was a period of reduced availability of commercially produced kits which all labs in NZ are currently reliant on from a range of vendors.

There are several other tests and options being explored as contingencies.

Data and Information

As with all public health responses, fast and accurate information is essential. During the first couple of weeks for the response CHL (in partnership with Decision Support) developed reports and dashboards be presented to ESR, the MoH, our DHB and referrers on laboratory testing for COVID19. This included ethnicity reporting for our Canterbury population and supporting national reporting.

CHL have been able to openly and transparently respond within hours to any request that the MOH, parliamentary select committee or the media has of us in relation to testing activity, trends and turnaround times as a total service or by region. This has been achieved by having the expertise on the ground and advance planning as to what is essential to inform those caring and contact tracing patients and for all decision makers at local, regional and national levels.

The Covid-19 response has again reinforced strong relationships between Labs and the wider health system both hospital and primary care. We have worked in a partnership with CPRG, Pegasus and other providers with timely response to logistics to support CBAC set up, GP practice response for patients meeting the wide case definition and targeted sentinel surveillance. All this testing contributes to informing the national lockdown level decisions.

Sentinel Screening

This screening is critical to inform decision making, as the various agencies work thorough what information is required to assist with decision making at to take NZ to another level there is often little notice for DHBs to respond. This has required a very collaborative effort between CPRG, Pegasus and many health care facilities.

One example of this is the test information from the sentinel testing at PAK'nSAVE Moorhouse Ave was time critical for the Cabinet meeting where movement from level 4 to 3 approval was discussed. CHL and Pegasus worked together to meet a very tight turnaround, setting up the testing location, sample collection, processing and reporting of 350 results to inform the Canterbury situation as part of national decision making. In parallel CHL tested for five other DHBs in their efforts.

This week there has been another collaborative effort across the system for further sentinel surveillance to hit a target of swabbing 1500 asymptomatic staff from ARC, hospitals, laboratory and police within Canterbury within five days to help inform the level 3 to level 2 decision making. Primary care and hospital services have worked in partnership with labs to balance the testing load across the week. CHL are also supporting COVID testing for five other DHBs who have similar targets.

Regional Laboratory Support

A CHL objective early in the response was for CHL to support setting up our regional laboratory referral partners to have COVID testing capability within their own labs and DHB regions to support timely responses for urgent COVID and symptomatic testing.

CHL has provided advice and materials to the private laboratory Medlab Central (who supports MidCentral, Whanganui, Lakes and Tairawhiti DHBs to take testing in house for COVID with a non-medical provider.

We are assisting HBDHB secure a medium throughput COVID platform to support set up of testing in their region and have also supplied a rapid throughput platform for them. This will still take a few weeks to have them set up.

Early in the response CHL was able to support the Auckland region on several occasions when staff required a reprieve during a period of high testing demands and whilst they stabilised their consumable supply and built their capacity across the region.

CHL has also been able to lead a piece of work to ensure coordination of a consistent and transparent costing framework for DHBs to submit to the MOH for COVID tests costs.

CHL has received notes of thanks from HBDHB, TDHB, Whanganui DHB, SDHB, SCDHB, WCDHB and the Auckland Region DHBs acknowledging our teams testing services and provision of support for their responses. We have many acknowledgements of thanks for our support from scientific, technical and logistics staff from our private and public laboratory partners across the county for the expert advice that has been provided by our scientific officers and the sharing of materials and supplies to help them develop and validated assays. CHL scientific officers have validated a range of kits, platforms and reagents for use nationally and have shared protocols on request.

People

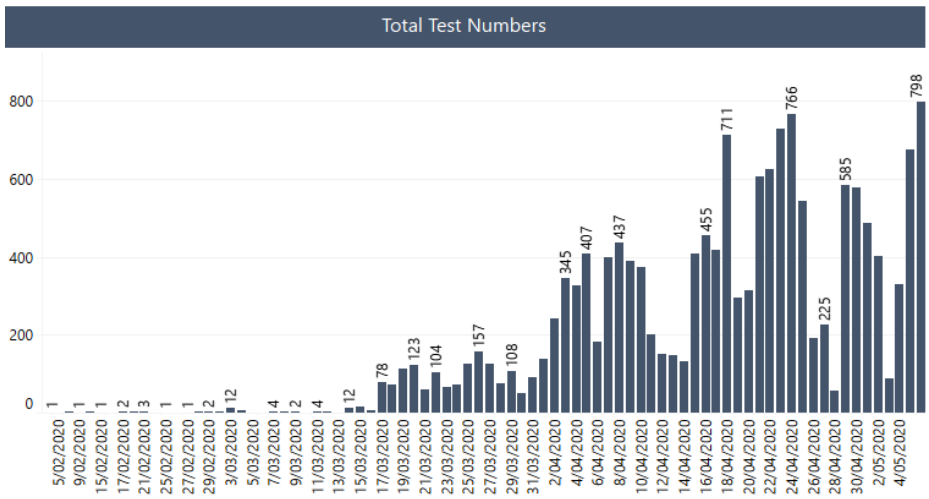
Early in the response CHL moved to a complex system of rosters separating pods of staff within most laboratories. This was established to reduce pressure on communal spaces within the facility. These pod rosters also retained some capacity in each laboratory should there have been a reason to stand one pod down through an exposure or risk of exposure. Close contact has been maintained with the union partners and staff throughout. Staff in the team have gone above and beyond for the local, regional and national DHBs and patients.

Summary

The quality of the CHL response to the Covid-19 requirements have been driven by forward planning, data analysis, technical expertise and a constant drive for operational efficiency. CHL has been well placed to pull on the resources and skills from across the laboratory service to deliver a nationally leading response and one that has again proven the relationships and commitment of CHL to a high quality national, regional and local response. Thankfully many of the contingency plans put in place for managing increases in hospital and community deceased have not been required but again the planning for this has proven the relationships established with police and civil defence through both the Earthquakes and the Mosque shootings have been invaluable in ensuring efficient communications and planning.

CHL COVID Dashboard and summary of testing to date for Canterbury Region (as of 1500h 6 May 2020)

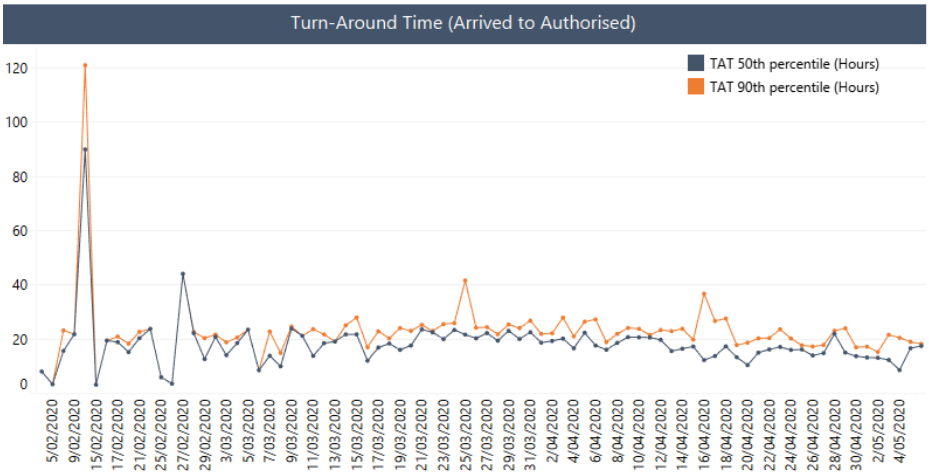
A. Total COVID 19 testing completed by CHL for Canterbury Region



NB: Peak in results to some retrospective test add of COVID PCR test from samples receive for full respiratory viral PCR screens

These volumes are approximately 50% of the total COVID19 tests performed by CHL.

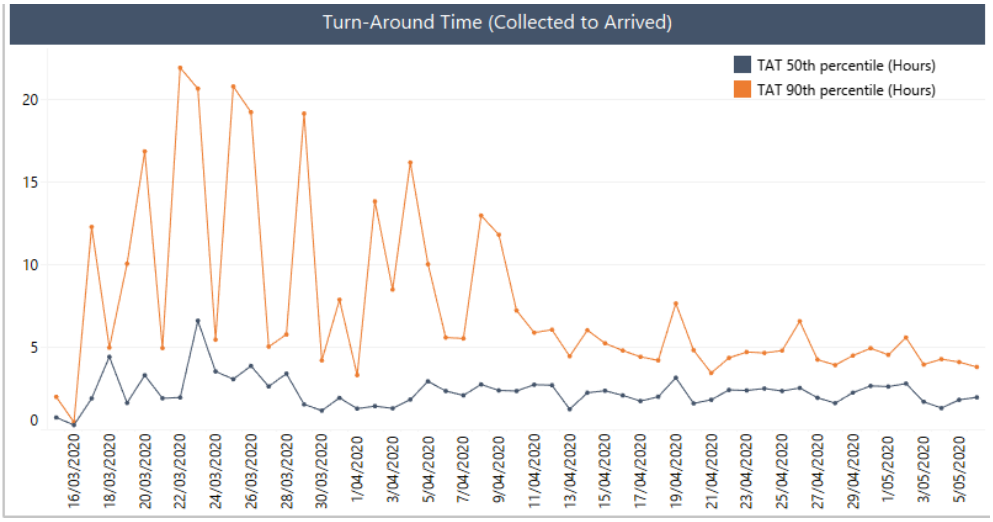
B. TAT for Canterbury referrals - Arrived at CHL to Authorised (laboratory processing time once received)



NB: Peak in TAT in (9 Feb 2020) was due to some retrospective test add of COVID PCR test from samples receive for full respiratory viral PCR screens

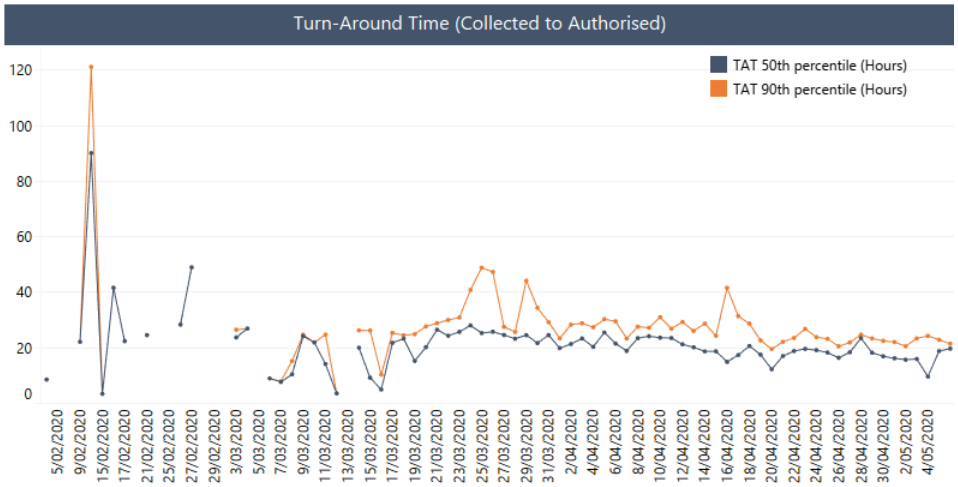
The slight improvement in TATs are credit to a team that are constantly reviewing and refining process to balance the workload whilst managing a significant increase in total volumes referred for testing from Canterbury and beyond.

C. TAT for Canterbury referrals – Collected to arrival at CHL (transport and couriers)



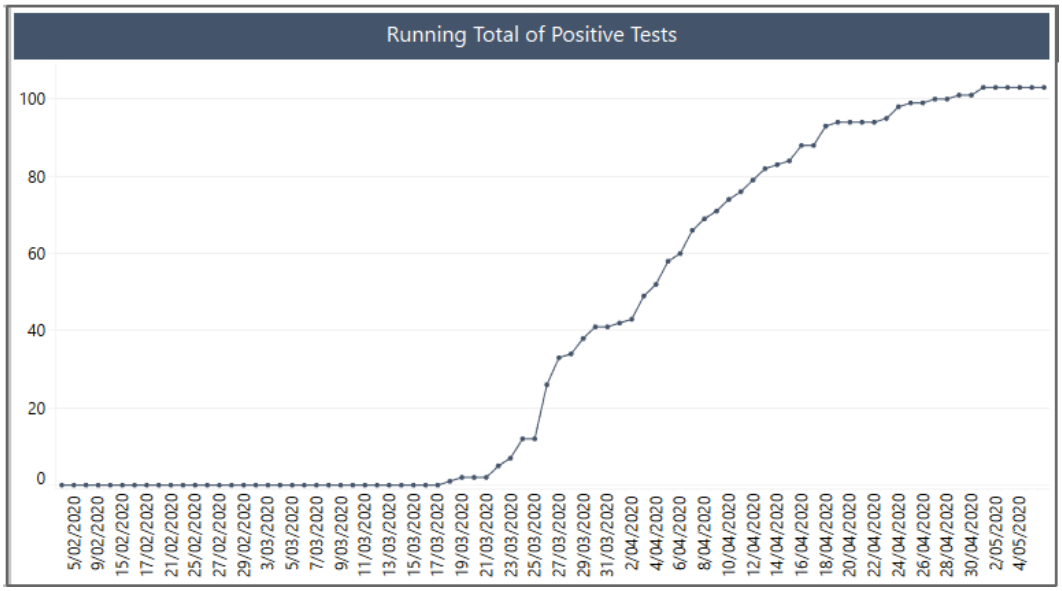
The introduction of a dedicated courier system in partnership with Pegasus to ensure direct delivery of COVID samples to CHL has made a significant improvement in getting samples to the laboratory on the day taken. This has enable maintaining of TATs whilst managing the increase in volumes.

D. TAT for Canterbury referrals - Collected to Authorised by CHL (the patient and referrer wait time for result release by CHL)



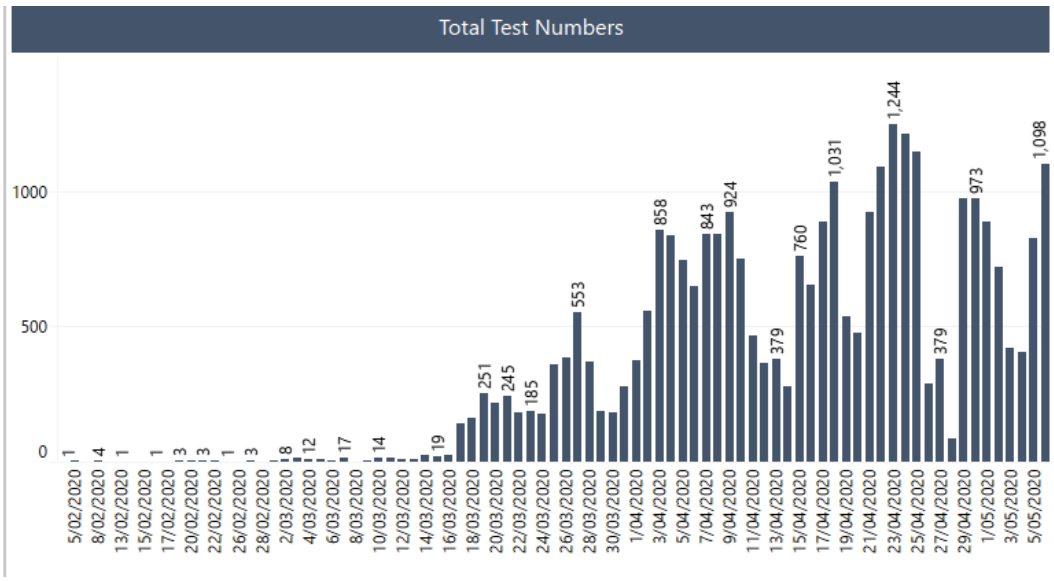
NB: Gaps in graph relate to where collection times were not recorded by the referrer
NB: Peak in TAT in (9 Feb 2020) was due to some retrospective test add of COVID PCR test from samples receive for full respiratory viral PCR screens

E. Positivity rate SARS-CoV-2 RNA - total 103 positive results for 98 patients in Canterbury



These results are critical to contact tracing for all confirmed positive COVID19 patients and the community and public health response. The combined national testing response has been vital to ensuring the current successes that NZ has achieved as a country towards elimination of COVID19.

F. Total tests performed by CHL



4.10 Ashburton, Rural and Chatham Islands

Co-ordinating the collective response across Ashburton Hospital and community services, DHB operated Aged Residential Care (ARC) Facilities and the Chatham Island's primary medical care team was a rewarding, if at times challenging, exercise in taking the leadership from the centre and applying the direction to the "generalist" service delivery context.

With the advantage of recently participating in an Emergency Operations Centre (EOC) exercise, we setup our EOC space and roles with confidence. Early in the response we invited Kaikoura EOC to join our daily EOC meeting, enabling a connected approach to manage the vulnerable community of ARC residents within our system.

Requiring a comprehensive plan that covered the diversity of acute and inpatient, primary birthing, ARCs, district nursing, home support and older persons planned care appointments and day care, we quickly defined our options where essential face to face care was required and designed alternate models with telecommunication resources.

Allied Health, Clinical Nurse Specialists, Needs Assessment Co-ordinators implemented telemedicine clinics, the diversional therapy team for day care developed care packs and activities to client's homes, whom they phoned daily to connect in and provide support. Working with COVID-19 medical team, Dr Steve Withington held the portfolio lead on site working closely with the CD, DON and IP&C to guide our acute responses. Early adaptive practice utilising the theatre in negative pressure as a dedicated space for COVID resus and options for supporting CPAP had us the envy of many rural centres.

The advantages of the single service multiple site approach with I P&C model enabled us to connect quickly and confidently with the system response and training available, in all aspects of service delivery. Connecting with the clinical team and EOC in the Chatham's enabled us to address issues raised and provide confidence in supply and resources. Partnering into our response was the implementation of community-based assessment centres in Ashburton and Kaikoura.

The strength in connecting primary care with CPRG and the systems involved minimised duplication and enabled us to respond with logistics support from within the EOC campus. As a service within a community, we had a strong connection with our local council and the welfare response co-ordination.

The swift implementation on ZOOM and Microsoft Teams was a welcomed for platform for both operational and clinical service delivery. As increased planned care is the focus of the system, the review of which visiting specialist clinics are required on campus and our opportunity to create integrated community teams with our CNS and Allied Health workforce, maximising technology, is our priority.

The early work we have undertaken with Rural Health Academic Centre for ongoing teaching provides a strong platform for expanding hospital wide and community training utilising technology.

As we build partnerships with the professional specialities located in our tertiary hospitals, the acceptance and ease in which we can connect expertise with the generalist setting is ready for implementation.

4.11 P&C Including OCC Health

People and Capability's response to COVID-19 has focused in three key areas: supporting staff through our occupational health service; supporting staffing requirements through our workforce stream; and managing employment relations issues alongside union engagement.

The occupational health response focused on keeping staff with underlying vulnerabilities to staff safe, case managing staff who had been exposed to COVID-19 (including contact tracing, isolation support), providing welfare support to those involved in the response (e.g. the Rosewood Cluster and Burwood GG unit). The occupational health response was up resourced with occupational physicians support and physicians and nurses to support assessing staff vulnerability. Over 9,500 vulnerability assessments were completed with 2,500 occupational health assessments completed by our occupational health clinicians. Currently, with the de-escalation of COVID-19, these services are being integrated into our typical business processes. One outstanding deliverable we are working on with ID, IPC and Microbiology relates to mask fit testing. People and Capability also drove the national occupational health response so that there was a 20 DHB approach to vulnerable staff.

We established a workforce service to urgently recruit, screen and deploy people to support our COVID-19 response is now moving to business-as-usual. To date, the Workforce Hub has:

- Received 590 applications for Clinical roles and 752 applications for Non-Clinical via an Expression of Interest.
- Offered casual contracts to 93 candidates. Of the 93 offers, 84 were accepted and 47 candidates were placed into external aged residential care facilities.
- Fast-tracked development of a new appointment service within max., to facilitate onboarding new staff.
- Received 326 notifications from employees volunteering for redeployment via max.
- Commenced Candidate Management strategy to manage and maintain talent pools created during the Covid-19 response. Applicants are being engaged by our operational recruitment team and identified for current and future opportunities.

Michael Frampton led the national union engagement to proactively address all employment related issues as a result of COVID-19 and we met up to three times a week with all regional

union representatives to collaboratively and proactively deal with employment related issues that arose.

4.12 Aged Residential Care (*ARC*)

Over the past eight weeks, the Planning and Funding Health of Older People Team have worked in a number of areas as the aged care sector has adapted to the challenges of COVID-19.

Aged Residential Care (*ARC*)

- Communicated daily with ARC via Eldernet platform to update with Ministry of Health guidelines and best practice supports for lockdown.
- Provided guidance and support for planning via two forums: one on infection prevention and the appropriate use of Personal Protective Equipment (*PPE*), and one on Business Continuity Planning (ensuring ARC facilities had crisis plans).
- Worked with Health Pathways team to update Aged Residential Care Pathways around COVID-19 (as well as for Home and Community Support Services) including rules around admissions, use of PPE, visitors, etc.
- Worked with clinical teams and ECC to manage the Rosewood Resthome outbreak, including:
  - Practical on-the-ground assistance with management of the facility and care of residents after the staff had been stood down for self-isolation.
  - Other administrative and contractual tasks to manage this situation, including ongoing communication with next-of-kin.
  - Continuing work with Rosewood to allow residents to return and enable an appropriate return to business-as-usual.
- Developed and circulated to ARC facilities a hardcopy information booklet that included a range of useful COVID-19 resources in one package.
- Worked with clinicians on guidelines for the provision of additional support to enable people with dementia to be admitted to ARC and supported to self-isolate.
- Met with national bodies to establish protocols around delivery of services to older people during the pandemic including around best guidelines for testing and admission to Aged Care.
- Worked with General Practice on after-hours protocols to support ARC during COVID-19.
- Worked with Infection Prevention and Control to ensure all residential facilities (including those for younger people) were evaluated according to pandemic readiness criteria subsequently developed by the Ministry of Health.

Home and Community Support Services and other Community Based services

- Worked with HCSS providers to ensure their pandemic planning was current and fit-for-purpose.
- Identified areas where services could be safely rationalised or reconfigured over the lockdown period by determining client need via analysis of Case Mix and working on communications to clients to manage expectations over this period.
- Worked nationally on developing Case-mix-based bulk-funding models to support other districts to move away from fee-for-service delivery during the pandemic.
- Supported providers of group programmes (for example Community Activity Programmes) to work with clients via telephone contact, Zoom-based meetings, and other activities.
- Identified vulnerable clients, ensuring that appropriate supports were put in place.
- Ensuring providers were appropriately provided with PPE.

Personal Protective Equipment (*PPE*)

- Ensured all ARC facilities had the required 48 hours of PPE in stock.
- Liaised with Ministry of Health to ascertain current guidelines for PPE use (these have changed frequently).
- Collated information from community organisations providing essential services – ARC; NGOs, non-funded community organisations.
- Undertook modelling to identify likely future need.
- Worked with Supply Dept and ECC Logistics to ensure PPE was distributed in line with MoH guidelines.

4.13 Managed Isolation & Quarantine

Implementation and operational management of Managed Isolation & Quarantine Facilities for Canterbury was a collaborative effort between Canterbury District Health Board and Civil Defence Emergency Management (*CDEM*), a team consisting of members of Civil Defence, New Zealand Defence Force (*NZDF*), NZ Police and Aviation Security, along with local hotels and their frontline staff.

The two Managed Isolation & Quarantine Facilities were stood up at short notice to care for approximately 480 repatriation guests aboard two flights from India, who would be isolated in either facility for a 14-day cycle, in place to prevent the spread of COVID-19 within New Zealand.

Guests were monitored on a 24/7 basis, including regular health checks and wellbeing sessions as well as being provided with education and information resources to keep them informed and up to date and all food requirements were provided by the hotels.

At the end of the 14 day cycles all guests from both flights were able to leave the facilities with the knowledge they are clear of infection.

4.14 Residual Work

There are several 'residual' pieces of work specific to the response that require ongoing support. The National Health Coordination Centre (NHCC) has recognised this and transitioned to the COVID-19 hub to manage ongoing activity.

Personal Protective Equipment (*PPE*)

CDHB management and distribution of PPE across the health sector is expected to continue until such time as 'usual' distribution channels are resumed. The use of PPE to limit the spread of COVID-19 for the foreseeable future requires additional logistical support and incurs additional expense for the DHB and the provider. National oversight is in place and the Chief Financial Officer leads this work.

Testing, Quarantine and Isolation

Testing (of symptomatic and asymptomatic people) is a 'new BAU' activity for Canterbury Health Laboratories and discussed separately in this document. Community Based Assessment Centres (CBACs) are now being systematically withdrawn with a corresponding increase in testing capacity in general practice.

COVID positive people and close contacts requiring quarantine and isolation (*QI*) will be managed by the Community and Public Health team as part of their infectious disease management process. As during the response period is its expected that a small number of these people will require provision of accommodation and support which is new activity and can at

times require nursing intervention. This is consistent with the MoH expectations outlined during the quarantine and isolation of people entering NZ on repatriation flights. Further direction from the MoH on the scope and requirement for provision of QI support by DHBs is expected in the next 4-6 weeks. An interim model has been established until this advice is received.

Scalability

As experienced with the outbreak at Rosewood and with the establishment of repatriation QI facilities the ability to rapidly scale up the response is required. To support this the ECC team is currently working with C & PH to support planning for increased contact tracing and management of QI facilities.

A casual nursing workforce has been identified and retained with a view to supporting community providers if required.

Psychosocial Support Planning

Psychosocial support planning now comes into its own and is expected to be in place for some time to come (years). This work is led by Community and Public health using a regional plan and coordinates a range of activity by multiple providers.

Emergency Co-ordination Centre

Priorities, Learning, Transition

HAC

June 2020

Sue Nightingale CMO CDH

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our health syst

Brief

A brief overview of your work as Incident Controller in the Emergency Coordination Centre and your priorities through the COVID response

How these priorities are changing or will change as we transition to the new normal – Accelerating the Future

Key learnings and observations

What changes have occurred through the COVID response that if retained or adapted would accelerate the transformation of our system

A brief overview of your work as Incident Controller in the Emergency Coordination Centre and your priorities through the COVID response

Operational Response Plan Objectives:

Workforce able to meet demand

Protect and support wellbeing of health workforce

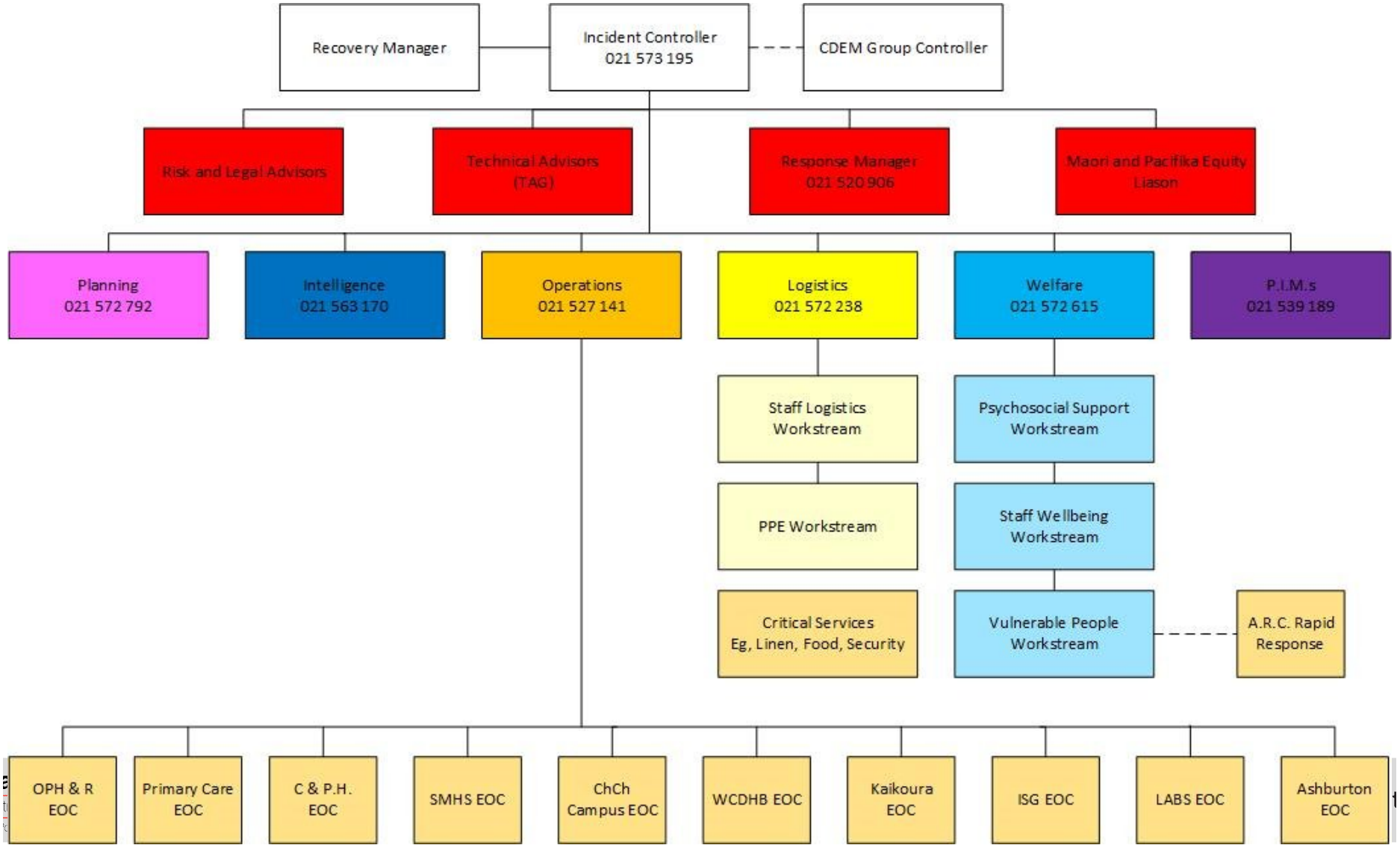
Maintain provision of essential clinical service deliver

Facility Access and Security

Maintenance of Essential Services

Support vulnerable people

Reduce physical, psychological and social consequences of a pandemic


Recovery Manager
Incident Controller
021 573 195
CDEM Group Controller
Risk and Legal Advisors
Technical Advisors
(TAG)
Response Manager
021 520 906
Maori and Pacifika Equity
Liason
Planning
021 572 792
Intelligence
021 563 170
Operations
021 527 141
Logistics
021 572 238
Welfare
021 572 615
P.I.M.s
021 539 189
Staff Logistics
Workstream
Psychosocial Support
Workstream
PPE Workstream
Staff Wellbeing
Workstream
Critical Services
Eg, Linen, Food, Security
Vulnerable People
Workstream
A.R.C. Rapid
Response
OPH & R
EOC
Primary Care
EOC
C & P.H.
EOC
SMHS EOC
ChCh
Campus EOC
WCDHB EOC
Kaikoura
EOC
ISG EOC
LABS EOC
Ashburton
EOC

Operational Response Plan Objectives:

- Workforce able to meet demand
- Protect and support wellbeing of health workforce
- Maintain provision of essential clinical service delivery
- Facility Access and Security
- Maintenance of Essential Services
- Support vulnerable people
- Reduce physical, psychological and social consequences of a pandemic
- Surveillance and detection of Covid-19
- Essential Supplies meet demand
- Manage physical surge capacity

Sites/Services

- Community and Public Health
- Christchurch Health Laboratories, incl. community & mortuary
- Primary care – CPRG
- Christchurch Campus
- DPH&R
- Vulnerable populations
- ARC
- Psychosocial
- MHS
- Ashburton
- Rural, Chatham Islands, Kaikoura
- ISG
- P&C
- Clinical Technologies
- Maintenance
- Procurement
- Support Services
- Recovery Planning (transition co-ordination)

How these priorities are changing or will change as we transition to the new normal – **Accelerating the Future**

The focus continues to need to be Public Health

The ever increasing importance of whole of system co-operation

The needs of our most vulnerable people

The importance of looking after our staff

Supporting people to look after themselves

Key learnings and observations

Relationships, relationships, relationships

Importance of business continuity planning

Equity – not just in response but especially in planning

Primary care can be done very differently – efficiency, empowerment

Telehealth

Follow up not always needed

Business efficiency with use of Zoom/Teams – but

Importance of social contact

What changes have occurred through the COVID response that if retained or adapted would accelerate the transformation of our system

Clinical use of technology – virtual clinics, MDMs etc

Efficient use of GP time

Types of and need for follow up

Business efficiency with use of technology

Increased awareness of public health messaging – hygiene!

(Even) better co-operation across health and disability sector

Occupational Health and caring for staff

Re-starting the Canterbury Health System

Hospital Advisory Committee - 04 Jun 2020

Prepared by: Ralph La Salle

Approved By: Carolyn Gullery

Managing Clinical Risk at Restart

- CDHB Planned Care system has five key elements to restart from COVID:
  - Consistent process to identify and classify for assessing a patient's need for the procedure, and ranking that patient's priority against others – **Case Definitions agreed by all public and private hospitals**
  - Consistent policy and process for work in theatres – **CHCH Operating Theatres policy adopted by all public and private hospitals**
  - Agreement from all providers to work as a system – **Framework for Planned Care Service Delivery – COVID 19**
  - An equity lens with focus on Maori and Pasifika patients to identify barriers to access and ensure access is at an appropriate level
  - Ability to switch back to COVID response if required

Planned Care Restart

Manage Clinical Risk Aim

- **Maintain one theatre for COVID use during period**
- **Physical and social distancing requirements enacted per IP&C**
- **Treat patients in order of urgency first and long wait second**
- **Review patients on wait list to ensure any change is situation is noted**
- **Align private and private provision to case definitions agreed**

We'll do this by

- **Operating in line with MOH: COVID 19 – Increasing and Improving Planned Care Final V1 21/04**
- **Implementation of a phased approach to surgery initially focussed on <6 week non-deferrable cases moving to deferrable cases (Acute, urgent and <2 week non-deferrable cases have been done during level 4)**
- **Internal and Outplaced and Outsource provision**
- **Moving some services to community locations (BOPU / Eye Clinics)**

Planned Care – Phased Approach - Surgery

- Week of 20 April
  - Internal – remaining at 3 COVID theatres –work going on in Theatre 22 and 23 to install negative pressure systems – Burwood theatres closed
  - External – the following outplaced lists will occur
    - **Southern Cross – 6 Sessions**
    - **St Georges – 3 Sessions**
    - **Christchurch Eye Surgery – 2 Sessions**
  - BOPU relocates to St Georges for up to a 12 week period
  - Avastin clinics continue to work at Southern Eye Services for the second week

Planned Care – Phased Approach - Surgery

- Week of 27 April through 18 May

Week	Internal Cases per day	External Cases per day	Total
27 Apr	30	30	240
04 May	35	35	350
11 May	40	40	400
18 May	45	45	450
Total for four weeks			1,440

  - Achieves 85% of pre-covid capacity by end of four weeks
  - First week outplaced cases only
  - Outsourced cases start 04 May
  - One COVID theatre held in reserve

- Burwood Theatres closed to 11 May
  - week of 11 May open 2 theatres
  - week of 18 May increase to 3 theatres to facilitate COS work
- COS restarts 18 May
- MSS Bus at Rangiora for 04 & 11 May weeks
- Lithotripsy bus at CHCH for 13 & 14 May
- Dental surgery starts at level 2
- BOPU continues at St Georges
- Eye Clinics continue at Southern Eye

Planned Care – Results

- Week of 27 April through 18 May
  - Achieved 96.6% of target
  - 82% of pre-COVID capacity
  - Expectations that post-COVID capacity will reduce by 13-15% due to physical distancing
  - Supported by all local private hospitals

Week	Internal Cases per day	External Cases per day	Forecast Target	Actual
27-Apr	30	30	240	177
4-May	35	35	350	350
11-May	40	40	400	443
18-May	45	45	450	421
Total for four weeks			1,440	1,391

Planned Care – Phased Approach - Surgery

- Week of 25 May through 30 June
  - Plan for additional 1600 cases – split agreed
  - Outplaced and Outsourced cases continue in private
  - Burwood theatres open
  - One COVID theatre maintained in reserve
  - Dental Surgery started at level 2
  - BOPU returns to Burwood

- Key Points
  - 3440 planned surgeries from 27 April through 30 June

Planned Care – Surgery

Plan

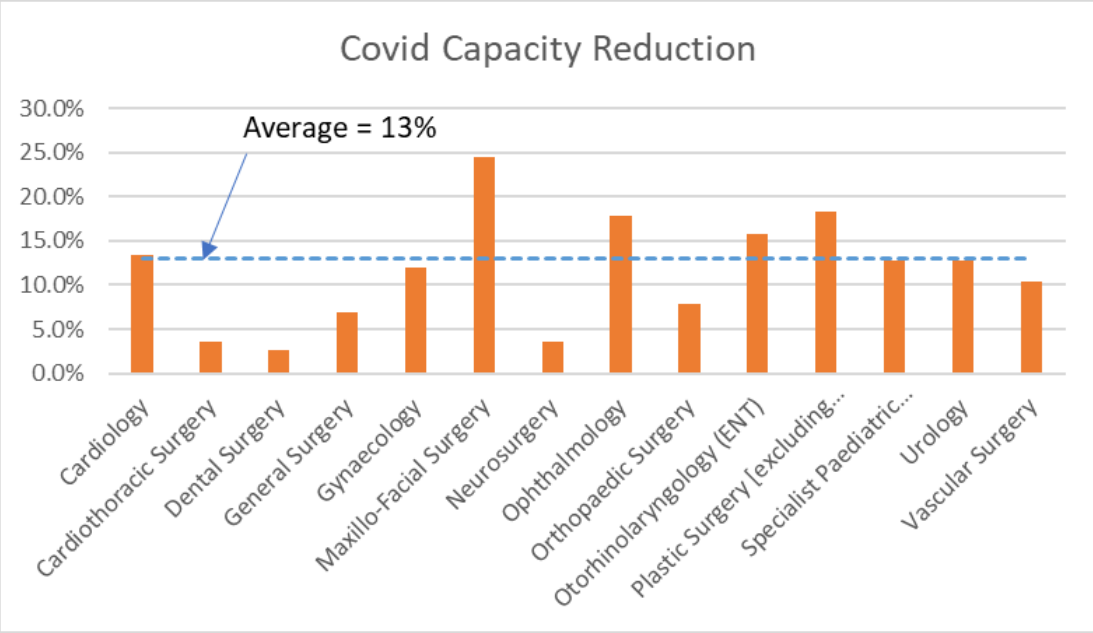
- Inpatient Surgical Discharges = 19,182
- Minor Surgical Procedures = 11,385
- Non-Surgical Interventions = 108

Actual

- Inpatient Surgical Discharges = 17,327 – **90.3%** of total
- Minor Surgical Procedures = 11,385 - **100%** of total
- Non-Surgical Interventions = 54 - **50%** of total

Planned Care – COVID Capacity Reduction

- 100% of sessions used
- Reduction based on session throughput
- Sessions with 3 or less patients – no reduction
- Sessions with 4 or more patients – reduction of 25%*
- Affects high volume departments more



*Caused by physical distancing requirements in facilities resulting in staggering patient arrivals – anaethestist is required to now go to see each new patient sequentially after the previous surgery is done. This has been tested both in pubic and private and is having the effect of capacity reduction. In Urology for example a number of their sessions were able to have four patients within the four hours. Now, they are only able to do three patients in the same time period. In ENT, there were lists of up to 10 patients which can no longer be completed within the four hour session time – calculated from actual service delivery over the period from 01 March 2019 through 29 Feb 2020

Planned Care – Surgery

Further Constraints

- Physical & social distancing, COVID practices will reduce throughput by 13% based on pre-COVID volumes even though 100% of sessions will be utilised
- One theatre internal capacity reduction due to COVID requirements

New Practices

- More clinics will be done by telehealth and telephone
- New referral delivery model will reduce patient wait times
- Combined private and public hospital weekly meetings to confirm theatre allocations
- New practices planned for Hagley opening in 20/21

Radiology Restart

Manage Clinical Risk Aim

- **Get back to pre-covid 19 wait lists within a 4 -6 week period**

We'll do this by

- **Operating in line with MOH: Advice on radiology services during national level 4 COVID-19 response 29/3/2020**
- **Commenced deferrable imaging week of 27 April**
- **Extended hours weekdays and weekend at CDHB sites with plan to take advantage of lower IP volumes for the first two weeks to recover OP volumes before clinics restart**
- **Outsource 300 MRI, 1560 x-ray, 55 fluoroscopy in place week of 21 April**
- **Ensuring focus on Maori and Pasifika patients to identify barriers to access and ensure access is at an appropriate level**

Radiology Restart

- Facility Constraints
  - **Many modalities were operating at max capacity before COVID and**
  - **Additional machine capacity required to meet current demand is located in Hagley i.e. not accessible**
- COVID Constraints
  - **Working on workflow redesign (for example to avoid congestion in waiting areas, many of which are small) and what the impact will be**
  - **High throughput modalities are likely to be impacted the most**
  - **We are aiming to minimise the impact on actual scanning capacity but there will be a reduction in capacity for physical distancing and staggering patient flow**

Oncology Planning

Manage Clinical Risk Aim

- **Work within National guidance of NZ Stem Cell Transplant Programme, MOWG, ROWG and HWG**
- **Physical and social distancing requirements enacted per IP&C**
- **Treat all patients where possible and if not stratify where a pause can be made**
- **Review patients to ensure any change in situation is noted**

We'll do this by

- **Internal and outsource service provision**
- **Moving some services to community locations**
- **Relocating services within CHCH campus**
- **Changing service delivery provisions using technology and phone platforms**
- **Ensuring focus on Maori and Pasifika patients to identify barriers to access and ensure access is at an appropriate level**

Oncology – Medical Oncology – Pharmaceutical Cancer Treatments (PCT)

Plan

- Implemented patient cascade to determine which patients could be paused
- Facilities
  - MDU and Day ward – inappropriate for physical distancing
    - Removed treatment chairs and beds
    - Separated patients to queues
    - Outsourced patients to community infusion services

Outcomes

- Patient cascade was not used – all patient treatments continued
- Facility concerns with patient physical distancing requirement remain
  - Need to continue outsourcing

Oncology – Medical Oncology - Clinics

Plan

- New Patients – Face to face continues and increased use of telehealth/zoom
- Follow up – Active Treatment – moved to telephone
- Follow Up – Normal – moved to telephone
- See all patients

Outcomes

- Practice changes to embed
  - New Patients – first appts, change of treatment appts, change to palliative care appts will all be done face to face – others by virtual apps/phones
  - Follow up appointments will be done by phone with treatment exceptions noted above
- All patients seen during level 4 with transition to phone appts – no backlog generated
- Patient acceptance of move to phone appointments confirmed by previous Joint CDHB Oncology & SCN Patient Survey 14 Feb 20

Oncology – Medical Oncology – Facilities Issues

Plan

- Separate 6 palliative care physicians from one office – split up team and sacrifice the only meeting room
- Separate 14 registrars working in one office – reduce to 5 and other 9 were scattered throughout Oncology campus
- 3 SMOs sharing one office not achieving physical spacing – separate into clinic rooms
- Divide department into two zones

Outcomes

- No meeting facilities in the department if palliative care remains separated
- Use of clinic rooms for offices to support physical distancing was okay during lockdown but clinic rooms will be needed for face to face appts
- Even with 2 SMOs in one office the phone and Teams – electronic feedback is too much
- Current facilities do not allow for even 1 metre of separation within shared offices

New ways of working do not fit within the current physical space available

Oncology – Medical Oncology – MDMs

Plan

- Move to Microsoft Teams (Teams) Environment
- Complete all MDMs
- Close Lecture Theatre

Outcomes

- MDMs working in Teams – evaluating on-going use of Teams
- Working on space requirement to re-open lecture theatre
- Most MDMs continued – remaining will restart over next 4 weeks

Oncology – Medical Oncology - Inpatients

Plan

- Move assessment area from Ground Floor Oncology building to old ENDO Lab area
  - Required for physical distancing
  - Best placement for patients

Outcomes

- Shifted assessment area
  - Relieves ED usage from patients under active treatment who become unwell
  - Direct dial to registrar for admitting

Oncology – Radiation Oncology - LINACs

Plan

- Patient classification undertaken
  - Pt referred but not started
  - Pt referred and CT planning done
  - Pt in active treatment
- LINACs
  - Planning for staffing changes and move to 3 operational LINACs
  - Investigate outsourcing of some patients
  - Meet physical distancing requirements

Outcomes

- At one point, 52 pts were paused – now down to 12 and expect to be caught up in 4 weeks
- Non-COVID related breakdown of 2 LINACs and 1 limping LINAC exposed extended delays of overseas parts delivery and internal travel delay of repair personnel
- Physical space issues remain – expect to be at 85% capacity – will continue to outsource
- Return of vulnerable staff to work is an issue under Level 3 and 2

Oncology – Outreach

Plan

- Move appts to phone
- Established contingency plans with SCDHB
- Continue chemo at NMDHB, WCDHB, SCDHB
- Continue chemo at Ashburton
- Weekly Teams conference with outreach areas – working as a region if one DHB went down with COVID

Outcomes

- Practice Changes
  - Continue with phone appts where possible
    - Saves SMO domestic and now extended travel
    - With extended travel comes loss of capacity for home DHB issues
- Physical space issues remain as described above – exacerbated because more SMOs in office requires more space
- Vulnerable staffing at outreach locations is noticeable and may prevent new ways of working
- Shuttle Services for outreach patients in CHCH were stopped and specialised transport needed to be arranged

Oncology – Wins & Learnings

Wins

- All patients seen for chemotherapy during level 4 – no backlog generated – chemo provision supported in outreach areas
- All radiation therapy backlog will be completed within 4 weeks
- Major shift in service provision from face to face appointments to IT platform or phone
- A bone marrow transplant was completed with a donor from Rarotonga
- First chemo occurring on Chatham Islands

Learnings

- New ways of working do not fit within the current physical space
- Physical distancing requirement will result in 15% capacity reduction in radiation treatments – means extended internal work or outsourcing
- Physical distancing requirements expose capacity problems within department facilities
- Breakdown and repairs will require extended delays
- SMO travel for outreach will require extended time limiting service provision to home DHB
- Overseas availability of stem cell retrieval limits our ability for treatment

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members, Hospital Advisory Committee**

PREPARED BY: **Anna Craw, Board Secretariat**

APPROVIED BY: **Justine White, Executive Director, Finance & Corporate Services**

DATE: **4 June 2020**

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, Clause 32 and 33, and the Canterbury District Health Board (*CDHB*) Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATION

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 30 January 2020	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.

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"

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TERMS OF REFERENCE
HOSPITAL ADVISORY COMMITTEE

INTRODUCTION

The Hospital Advisory Committee is a Statutory Committee of the Board of the Canterbury District Health Board (*CDHB*) established in terms of Section 36 of the New Zealand Public Health and Disability Act 2000 (the *Act*). These Terms of Reference are supplementary to the provisions of the Act, Schedule 4 to the Act and the Standing Orders of the CDHB. These Terms of Reference will apply from 16 April 2020.

FUNCTIONS

The functions of the Hospital Advisory Committee (as per Schedule 4 of the NZ Health & Disability Act 2000) are to:

- *"monitor the financial and operational performance of the hospital and specialist services of the Canterbury DHB; and*
- *assess strategic issues relating to the provision of hospital and specialist services by the Canterbury DHB; and*
- *give the Board advice and recommendations on that monitoring and that assessment."*

The Hospital Advisory Committee's advice to the Board must be consistent with the priorities identified in the New Zealand Health Strategy and with the strategic direction and objectives of the CDHB.

ACCOUNTABILITY

The Hospital Advisory Committee is a Statutory Committee of the Board and as such its members are accountable to the Board and will report regularly to the Board.

- Members of the Hospital Advisory Committee are to carry out an assessment role but are not to be advocates of any one health sector group. They are to act in an impartial and objective evidence based manner for the overall aims of the Committee.
- Legislative requirements for dealing with conflicts of interest will apply to all Hospital Advisory Committee members and members will abide by the CDHB's Media Policy; its Conflict of Interest and Disclosure of Interest Policy; Gift, Sponsorship, Donations and Corporate Hospitality Policy; and with its Standing Orders.
- The Committee Chair will annually review the performance of the Hospital Advisory Committee and members.

WELLBEING HEALTH AND SAFETY

Support, promote and monitor the continuance of a culture of wellbeing health and safety at the CDHB and ensure that the wellbeing health and safety risks faced by the Board are appropriately understood, mitigated and monitored, and ensure that the Board receives regular reports in regard to meeting its wellbeing health and safety obligations.

LIMITS ON AUTHORITY

The Hospital Advisory Committee must operate in accordance with directions from the Board and, unless the Board delegates decision making power to the Committee, it has no delegated authority except to make recommendations or provide advice to the Board.

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TERMS OF REFERENCE
HOSPITAL ADVISORY COMMITTEE

- The Hospital Advisory Committee provides advice to the Board by assessing and endorsing recommendations on the reports and material submitted to it.
- Requests by the Hospital Advisory Committee for work to be done by management or external advisors should be made by the Chair and directed to the Chief Executive or their delegate (the Principal Administrative Officer).
- There will be no alternates or proxy voting of Committee members.

RELATIONSHIPS

The Hospital Advisory Committee is to be cognisant of the work being undertaken by the other committees of the CDHB to ensure a cohesive approach to health and disability planning and delivery, and as such will be required to develop relationships with:

- The Board
- Consumer groups
- Management of the CDHB
- Clinical staff of the CDHB
- Manawhenua Ki Waitaha (*MKW*)
- The community of the CDHB
- Other Committees of the CDHB

TERM

These Terms of Reference shall apply until April 2023, at which time they will be reviewed by the newly elected Board of the CDHB who will also review the membership of the Committee to ensure an appropriate skills-mix.

MEMBERSHIP OF THE COMMITTEE

The Chair of the Hospital Advisory Committee will be a member of the Board and will be appointed by the Board. The Board may also appoint a Deputy Chair to the Committee. Other members of the Hospital Advisory Committee will be appointed by the Board and may be both CDHB Board members and external members who will supplement the skills, knowledge and experience of Board members. The Board will comply with the requirements of the Act and provide for Maori representation on the Committee by appointing a representative nominated by MKW in addition to other external appointments in accordance with policy adopted by the Board in December 2012.

The Chair and Deputy Chair of the Board will be ex-officio members of the Committee (if not appointed to the Committee by the Board), and will have full speaking and voting rights at all meetings of the Committee.

- Board members who are not members of the Committee will receive copies of agendas and minutes of all meetings electronically, and may attend any meetings of the Committee with speaking rights for those meetings that they attend.
- The Board will not appoint to the Hospital Advisory Committee any member who is likely to regularly advise on matters relating to transactions in which that member is specifically interested. All members of the Hospital Advisory Committee must make appropriate disclosures of interest.
- The Chair, Deputy Chair and members of the Hospital Advisory Committee will continue in office for the period specified by the Board, or until such time as:
  - the Chair, Deputy Chair or member resigns; or

  - the Chair, Deputy Chair or member ceases to be a member of the Hospital Advisory Committee in accordance with clause 9 of Schedule 4 of the Act; or
  - the Chair, Deputy Chair or member is removed from office by notice in writing from the Board.
- All Hospital Advisory Committee members must comply with the provisions of Schedule 4 of the Act, relating in the main to:
  - the term of members not exceeding three years;
  - a conflict of interest statement being required prior to nomination;
  - remuneration; and
  - resignation, vacation and removal from office.

MEETINGS

The Hospital Advisory Committee will meet as determined by the Board in accordance with the Act, with the frequency/timing taking into account the times and dates of the other committee meetings and the Board meetings.

- Subject to the exceptions outlined in the Act, the date and time of the Committee meetings shall be publicly notified and be open to the public. The agenda, any reports to be considered by the Committee, and the minutes of the Committee meeting will be made available to the public as required under the Act.
- Meetings shall be held in accordance with Schedule 4 of the Act and with CDHB's Standing Orders.
- In addition to formal meetings, Committee members may be required to attend workshops or forums for briefings and information sharing.

REPORTING FROM MANAGEMENT

Management will provide exception reporting to the Hospital Advisory Committee to allow measurement against the financial and operational performance indicators of the Hospital and Specialist Service of the CDHB.

MANAGEMENT SUPPORT

In accordance with best practice and the delineation between governance and management, key support for the Hospital Advisory Committee will be from staff designated by the Chief Executive Officer from time to time who will assist in the preparation of agendas, reports and provision of information to the Committee in liaison with the Chair of the Committee.

- The Hospital Advisory Committee will also be supported by clinical staff and other staff as required.
- The Board may appoint advisors to the Hospital Advisory Committee from time to time, for specific periods, to assist the work of that Committee. The Committee may also, through management, request input from advisors to assist with their work.

REMUNERATION OF COMMITTEE MEMBERS

In accordance with Cabinet Guidelines and the CDHB's Fees and Expenses Policy, members of the Hospital Advisory Committee will be remunerated for attendance at meetings at the rate of $250.00 per meeting, up to a maximum of ten meetings per annum, total payment per annum $2,500.00. The Committee Chair will be remunerated for attendance at meetings at the rate of $312.50 per meeting, again up to a maximum of ten meetings per annum, total payment per annum of $3,125.00. Ex officio members are not remunerated. These payments may be reviewed by Ministerial direction from time to time and will be revised to comply with any Cabinet/Ministerial amendments.

- These payments are made for attendance at public meetings and do not include workshops.
- Any officer or elected representative of an organisation who attends committee meetings which their organisation would expect their officer or elected representative to attend as a normal part of their duties, and who is paid by them for that attendance, should not receive remuneration.
- The Fees Framework for Crown Bodies includes the underlying principle that any employees of Crown Bodies should not receive remuneration for attendance at committee meetings whilst being paid by their employer.
- Reasonable attendance expenses (ie., reasonable travel-related costs) for Committee members may be paid. Members should adhere to the CDHB's travel and reimbursement policies.

Adopted by Board: 18 February 2011.

Amended by Board: 16 February 2012.
Amended by Board: 17 April 2014.
Amended by Board: 20 April 2017.
Amended by Board: 16 April 2020.

WORKPLAN FOR HAC 2020 *(WORKING DOCUMENT)*

9am start	30 Jan 20	02 Apr 20	04 Jun 20	06 Aug 20	01 Oct 20	03 Dec 20
Standing Items	Interest Register Confirmation of Minutes	Meeting Cancelled	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report			H&SS Monitoring Report	H&SS Monitoring Report Care Capacity Demand Management Update	H&SS Monitoring Report
Planned Items	Clinical Advisor Update – Nursing		COVID-19 Update	Clinical Advisor Update - Nursing H&SS 19/20 Year Results	Clinical Advisor Update – Allied Health People & Capability Report	Clinical Advisor Update – Medical 2020 Winter Planning Review
Presentations	Department of Anaesthesia		Elective Surgery Recovery Plan	TBC: Christchurch Hospital	TBC: Rural Hospitals	TBC: Labs
Governance and Secretariat Issues	2020 Workplan					
Information Items			HAC Terms of Reference - Amended 2020 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2020 Workplan	2021 Meeting Schedule 2020 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2020 Workplan
Public Excluded Items	CEO Update (as required)		CEO Update(as required)	CEO Update (as required)	CEO Update (as required)	CEO Update (as required)