AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 18 June 2020 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes - 21 May 2020		
3.	Carried Forward / Action List Items		
Reports for Decision			
4.	Delegations for Annual Accounts	Justine White *Executive Director, Finance & Corporate Services*	9.35-9.40am
Reports for Noting			
5.	Chair's Update (Oral)	Sir John Hansen *Chair*	9.40-9.45am
6.	Chief Executive's Update	David Meates *Chief Executive*	9.45-10.15am
7.	Finance Report	Justine White	10.15-10.25am
8.	Advice to Board: • HAC – 4 June 2020 – Draft Minutes	Andrew Dickerson *Chair, HAC*	10.25-10.30am
9.	Resolution to Exclude the Public		
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.30am**

NEXT MEETING
Thursday, 16 July 2020 at 9.30am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

Sir John Hansen (Chair)
Gabrielle Huria (Deputy Chair)
Barry Bragg
Sally Buck
Catherine Chu
Andrew Dickerson
James Gough
Jo Kane
Aaron Keown
Naomi Marshall
Ingrid Taylor

Executive Support

David Meates – *Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
Michael Frampton – *Chief People Officer*
Mary Gordon – *Executive Director of Nursing*
Carolyn Gullery – *Executive Director Planning, Funding & Decision Support*
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*

BOARD ATTENDANCE SCHEDULE – 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	25/02/20	19/03/20	16/04/20	01/05/20 SM	21/05/20	18/06/20	16/07/20	20/08/20	17/09/20	15/10/20	19/11/20	17/12/20
Sir John Hansen (Chair)	√	√	√	√	√							
Gabrielle Huria (Deputy Chair)	√	√	√	√	√							
Barry Bragg	^	√	√	√	√							
Sally Buck	#	^	~	~	~							
Catherine Chu	^	√	√	√	√							
Andrew Dickerson	√	√	√	√	√							
James Gough	√	√	√	√	√							
Jo Kane	√	√	√	√	√							
Aaron Keown	√	√	√	√	√							
Naomi Marshall	√	√	√	√	√							
Ingrid Taylor	√	√	√	√	√							

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

Sir John Hansen **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 **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.

Barry Bragg	**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. **Paenga Kupenga Limited** – Chair (effective 1 July 2020) Commercial arm of Ngai Tuahuriri Runanga **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	**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
Andrew Dickerson	**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.
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.
Jo Kane	**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.
Aaron Keown	**Christchurch City Council** – Councillor and Community Board Member Elected member and of the Fendalton/Waimairi/Harewood Community Board. **Grouse Entertainment Limited** – Director/Shareholder
Naomi Marshall	**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.
Ingrid Taylor	**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.

MINUTES

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held via Zoom
on Thursday, 21 May 2020 commencing at 9.30am

BOARD MEMBERS

Sir John Hansen (Chair); Barry Bragg; Catherine Chu; Andrew Dickerson; James Gough; Gabrielle Huria; Jo Kane (joined 9.55am); Aaron Keown; Naomi Marshall; and Ingrid Taylor.

BOARD CLINICAL ADVISOR

Dr Andrew Brant.

APOLOGIES

An apology for absence was received and accepted from Sally Buck and Lester Levy (Crown Monitor).
An apology for lateness was received and accepted from Jo Kane (9.55am).

EXECUTIVE SUPPORT

David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Michael Frampton (Chief People Officer); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Hector Matthews (Executive Director, Maori & Pacific Health); Dr Sue Nightingale (Chief Medical Officer); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services); Karalyn van Deursen (Executive Director Communications); and Susan Fitzmaurice (Executive Assistant to Chief Executive).

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETING

Resolution (14/20)
(Moved: Gabrielle Huria/seconded: Aaron Keown – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 16 April 2020 be approved and adopted as a true and correct record."

Resolution (15/20)
(Moved: Sir John Hansen/seconded: Gabrielle Huria – carried)

"That the minutes of the special meeting of the Canterbury District Health Board held on 1 May 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

- Selwyn Health Hub – made contact with Treasury and waiting on their response – leave as standing item.
- Equity Report – challenge is those involved have been diverted on the COVID-19 response – report back to 16 July 2020 meeting.

The carried forward / action list items were noted.

4. BAD DEBT WRITE-OFFS

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

It was noted that a change was made to the paper post the Quality, Finance, Audit and Risk Committee (*QFARC*) meeting around reviewing the insurance component and our ability to intervene in terms of insurance. A legal opinion has been provided that because CDHB is not a party to any policy, we are able to refer patients to Citizen Advice, Crown Community Law Centres etc, and can provide legal advice to patients to assist with their insurance claim, but CDHB is unable to do anything more in terms of intervening between an insured and insurer.

Resolution (16/20)
(Moved: Gabrielle Huria/seconded: Barry Bragg – carried)

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

i. notes that five ineligible patient debts over $50,000 totalling $304,680 have been written off,
ii. approves seven ineligible patient debts over $100,000 totalling $1,053,048 being written off,
iii. notes that these debts have been fully provided as doubtful in our results in accordance with our normal doubtful debt provision, therefore no further financial impact; and
iv. notes that this request is made on the basis that CDHB has taken all reasonable steps to recover the debts and there is unlikely to be further chance of getting any payment."

5. CHAIR'S UPDATE

Sir John Hansen, Chair, spoke of the amazing job done by management and clinicians through the different levels of the COVID-19 pandemic. He noted that we had "dodged a bullet", but was conscious that it could flare again at any time in New Zealand or when our borders eventually open unless we have a vaccine by that stage. He acknowledged the professionalism of everybody in setting this process up so quickly, and remarked that the generally good behaviour of the public has also been amazing. He spoke of the Rosewood cluster, noting the sympathetic and professional manner this was dealt with, which has attracted a great deal of acknowledgement from families and others for the work that has been done. The Board appreciates the enormous amount of work, skill and professionalism of the whole organisation in coping with the whole of the pandemic that we have just endured and will continue to endure the consequences of for some time.

The Chair's update was noted.

6. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, presented his report which was taken as read. Updates were provided as follows:

- The focus has very much been on the COVID-19 response over last few months and as the Chair has touched on, the ongoing response is going to continue for quite some time. While the country has been very successful in controlling and preventing community spread, again it is only one or two cases away from a significant challenge continuing to present for health.

- There are a number of parts of the organisation that will remain very much on a response footing, particularly Community & Public Health, and we are working through a range of choices and options at the moment in terms of their ongoing capacity for contact tracing out over the next two to three weeks and out over the next few months. This is a piece of work that is occurring at the moment.

- Mr Meates noted his appreciation of the Chair's acknowledgment of CDHB's response. The response across the Canterbury Health System has been stunning and again in terms of the very connected and joined up parts in terms of both the Aged Residential Care, the NGO sector, primary care, community pharmacies, and our own provider arms. Mental Health has operated under the radar screen and some of the actions within Specialist Mental Health Services (*SMHS*) have absolutely been remarkable and it is an area too where they have seen the same number of mental health patients as what they were doing before COVID-19. Most of that has been done through the use of Telehealth and a mixture of home visits supporting that as well.

- With regard to the Emergency Department, it was noted there had been a significant reduction in the presentation of aggressive and violent patients, as well as intoxicated patients over the lockdown period. It would be good to see this continue.

- The Rosewood patients managed through Burwood have been successfully transferred back to Rosewood and Rosewood has again taken over both the management and running of their facilities. We continue to provide both support to a range of different parts of the system that we will continue to do to ensure service provision remains.

- Mr Meates acknowledged Sue Nightingale, Chief Medical Officer, in terms of her role as lead of the Emergency Co-ordination Centre (*ECC*). The ECC is still functioning today, although in a much reduced capacity, but it does mean we are needing to be in a position to respond to any issues at a moment's notice.

- Approximately 400 people that were repatriated from India have been managed within the Canterbury health system. All of those individuals have now been discharged and are back home.

- We are continuing to ramp up surgical activity. As an example, yesterday we were back up doing 100 operations through the operating theatres. With the planned care with the private sector as well, we are on track with our planned delivery. We are anticipating delivering around 90-92% of our total elective performance by the end of the year, so again that is reflecting the significant step up in activity that has occurred.

- There have been significant changes with service delivery over the past 8-10 weeks. Many of those changes are being locked in and will continue to be provided in that way. What we will be making a lot more visible over the coming weeks is the extent of some of those changes that have actually occurred.

There was a query about child immunisations and it was noted that we have been good at keeping up with these and have no major gaps. It was also noted we have started discussions with the Ministry of Health to start rolling out the MMR catch-up and are in a good position to start immediately. We are ensuring to take a strong equity focus to ensure we capture the 15-29 year olds who are particularly at risk.

There was a query about Hand Hygiene and the compliance rates outlined in the report not being higher. It was noted that these are based on a national standard that relates to the five moments for hand hygiene which is used consistently around the country. This is different from the messaging relating to hand washing, but does encourage hand washing at every point of the process. Dr Andrew Brant, Clinical Advisor to the Board, commented that the national standard is a very high standard of hand hygiene to achieve and the measures may not give an accurate summation of what is occurring. Feedback has been given to the Ministry of Health on these standards.

There was a query regarding Whānau Ora and #manaaki20 and if separate from DHB (ie, is Whānau Ora funded through Te Pūtahitanga). It was noted the MoH announced early on in the COVID-19 crisis an allocation of $56M for Māori. This was distributed among providers including Whānau Ora commissioning agencies Te Pūtahitanga and Pasifika Futures to work with our providers. It is a South Island wide initiative which the DHB and providers supported.

There was a query in relation to lessons learned with COVID-19 and it was commented that we were two weeks too late establishing the Community Based Assessment Centre (*CBAC*) at Ngā Hau e Whā, which provided a broader service to the Māori and East Christchurch community. This was seen not just as a testing facility, but provided for welfare needs and facilitated a broader health assessment where appropriate.

There was discussion on how best to reach Maori and that this required a deep arm stretch into communities via Marae and smaller organisations that have that contact. It was requested that the DHB factor into its approach to equity those sorts of responses, as taking an institutional response does not necessarily work as well.

Jo Kane joined via phone at 9.55am.

Hector Matthews, Executive Director, Maori & Pacific Health, noted that a lot of things were learnt in the process of going into Level 4 and rolling out CBACs. The Canterbury Primary Response Group (*CPRG*) learnt that it would have been more sensible to have Māori voices involved early on in the piece. One of the things discussed was it is not just a check-up on COVID-19, as there are other issues that affect health. Also, as pointed out, our kaupapa Māori providers had networks into communities which is more difficult for our mainstream providers. It has been noticed nationally that many of our most economically deprived populations had significant economic stresses prior to going into COVID-19 and that was going to be a big risk. In the report that was included in the CEO's update this month, it showed that our responses were particularly targeted at that. It was noted that 5% of our Canterbury infections were Māori and is a significant issue in defeating equity at this first stage as Māori are 10% of our population. Pacifica were around about that as well and they are about 2.5% of our population - they had much higher rates of infection than their population proportion. Working with those providers who have those community networks is going to be a key issue moving forward.

The Chair noted to give some context, one of the critical things the National Chairs and CEOs have been asked to look at is the gains we have made and the lessons we have learnt from COVID-19 and to cement those gains into place. One of the critical ones is a cross sectorial Marae or other based approach to health in the populations where there are currently inequities. Critical is what we have learnt about how to deliver to our poorer communities and how do we improve the equity scale. The lessons learnt around access, in particular, and cross sectorial, have been grappled with in primary care for some time without actually getting it across the line and this is an opportunity to make sure we do that.

There was a query regarding a paper being tabled with CPRG and EMT to establish Māori Advisory Board to support the COVID-19 response. Mr Matthews advised there is not a Māori Advisory Board. One of the lessons learnt was there were insufficient Māori voices in the right places when things needed to be done. This occurred not just with health but all over Government agencies. Discussions have been held with the ECC Controller around what is required prior to the next emergency to ensure

that there are appropriate Māori voices at the table. It was also noted that it is key to understand who the community connectors are in both Māori and Pacific communities.

Mr Meates noted that this is part of the process of reviewing the response and is also linked up with the CPRG, which oversaw the CBAC strategy and implementation. Where and how if we are re-establishing CBACs, and what are some of the things we might think of slightly differently. There are a number of things we need to sit back as a system and fine tune and/or rethink.

There was discussion around surveillance testing, with it noted that some surveillance testing will continue on an on-going basis.

There was a query regarding increasing Acute Care Plans for COPD patients, the risk being in hospital poses to patients in the COVID-19 environment, and what is being done to keep these patients at home. It was noted that as part of the COVID-19 response, a virtual ward was developed to look after people who were unwell or potentially with COVID-19 in their own homes, with a constant check-up and review by a virtual ward round. Work continues on expanding this concept for these patients, and particularly those with respiratory disease, in order to support ongoing care in the patient's home.

The Chief Executive's update was noted.

7. FINANCE REPORT

Justine White, Executive Director, Finance & Corporate Services presented the Finance Report which was taken as read. Updates were provided as follows:

- The report showed that the consolidated Canterbury DHB financial result (before comprehensive income) for the month of March 2020 was a net expense of $15.755M, being $3.744M favourable to plan, and year to date $18.778M favourable to plan. The operating result (pre indirect items) for the month was unfavourable to plan by $341k, year to date $1.526M unfavourable to plan. This includes current COVID related costs; with it noted that net costs associated with the COVID-19 pandemic as included in the month of March results are $829k. It was also noted that costs associated with the Whakaari tragedy (excluding IDF) as included in the year to date operating result are in excess of $1M, with no associated funding.

- April result is a total surplus deficit which is positive by $3.0M and operating result which is unfavourable by $739K. COVID-19 related costs particularly in the month of April have increased dramatically and are sitting at a net $8.0M - net of revenue that was to provide for some of the community provision of COVID-19 related expenditure. The adjusted result would be a positive variance at an operating level of $7.3M and a positive variance at a total of $11.1M.

- Other key points to note include the liquidity issue. We did receive $130M of equity support which related largely to last year's operating deficit of 18/19. That operating deficit, including the Holidays Pay provision, was $177M and we received $130M to provide for that. What that means is the current forecasted inability to meet debts as they fall due is 1 September 2020. This does not account for MBIE's desire to move to a 10 day supplier payment. If we look at the 10 day supplier payment across sector services that brings that liquidity date back to July 2020. CDHB provides the Ministry of Health with weekly reports in terms of cashflow and is working with them around what that looks like.

- The scenarios on page 5 of the report around COVID-19 out term were noted. They are indicative and are evolving as we go. They provide an indicator of the low range to high range in terms of the out term.

- We understand there is a risk in terms of PHARMAC and last minute adjustments to the DPF. We are unsure of what that result will be but anticipate it impacting on our pharmaceutical expenditure this financial year. At this time we do not have enough information from PHARMAC to understand what that will look like.

- Have not yet received formal notification of our funding for next year. Using Treasury website appropriations as a guide, it looks like we are in the vicinity of a 4.35% increase. The highest of the increases appears to be about 8.75% in terms of PBF share across the nation, the low is 4.35%. We had anticipated a 4% increase which is $62M and going by Treasury appropriations 4.35% is $68M, so essentially we are about $5M higher than what we had anticipated in terms of next year's revenue. Until formal notification of those appropriations and the funding envelope are received, we cannot adjust, but we can start adjusting some of our assumptions based on that slightly increased revenue.

There was a query in relation to an update for Whakaari and additional funding. Ms White advised there has been ongoing discussions with ACC. Counties Manukau have taken the lead in negotiations with ACC for the country and we understand ACC are considering some form of payment. The next set of talks are scheduled for 22 May 2020 and we hope to see an outcome from that. Affected DHBs are Counties Manukau, Canterbury, Waikato, Bay of Plenty, Capital and Coast and Hutt, and negotiations with ACC are being done as a collective. There is acknowledgment there will be agreement reached, but unsure what that total figure will be and the timeframe around that.

A query was raised relating to seeking clarification from the Ministry of Health around how long the 10 day supplier payment term arrangement will last. Ms White advised it is a permanent change that has been suggested. It will involve a one off timing adjustment. There was discussion about the whole sector facing this problem and it was noted that the CFOs have collectively highlighted this with Ministry of Health, because essentially the entire sector runs out of cash in July with the movement to a 10 day cycle. The cashflow forecast sent to the Ministry of Health in the last two weeks has included a potential move to the 10 day cycle at an estimated level and conversations continue with the Ministry of Health's finance team. It was agreed to clarify how we will deal with that assumption at the next QFARC meeting.

There was a query whether there was any further update or movement on the capital charge given that the OCR is now 0.25%, the CPI is 2.5%, and the capital charge is still 6%. Ms White advised there has been no further update. One of the outcomes of QFARC was about raising at a national level the capital charge rate in light of the OCR. This has been raised with the Ministry of Health and will be raised with Treasury. There was also discussion on how new capital builds will be treated with capital charge and it was noted that this is something both the Ministry of Health and Treasury are working through. It was further noted that this is also part of the agenda of the operational meetings held with the Ministry of Health involving the Chair, Chair of QFARC, and the Crown Monitor.

The Finance report was noted.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (17/20)
(Moved: James Gough/Seconded: Naomi Marshall - carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14 and the information items contained in the report;

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meetings: • 16 April 2020 – ordinary meeting • 01 May 2020 – special meeting	For the reasons set out in the previous Board agenda.	
2.	Chair's Report (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
4.	Audit NZ – Audit Arrangements	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	ISG: End of Life Servers	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Hagley (ASB) Handover Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	External Committee Membership	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
8.	Aged Residential Care and Disability Support Services COVID-19 Readiness Assessment Update	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
9.	Support for Aged Related Residential Care Facilities	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
10.	Equity Support Letter – Minister of Health	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

11.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
13.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
14.	Advice to Board: • QFARC Draft Minutes *5 May 2020*	For the reasons set out in the previous Committee agendas.	

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

The Public meeting concluded at 10.26am.

_____ _____

Sir John Hansen, Chairman Date of approval

BOARD MEETING 21 MAY 2020 – MEETING NOTES

Clause No	Item	Action Points	Staff
	Apologies	Sally Buck – leave of absence Jo Kane – for lateness (9.55am) Lester Levy – absence for public meeting	Anna Craw
1.	Interest Register	Nil	
2.	Confirmation of Minutes • 16 April 2020 • 01 May 2020	Adopted *Gabrielle Huria / Aaron Keown* *Sir John Hansen / Gabrielle Huria*	Anna Craw
3.	Carried Forward/Action Items	Nil	
4.	Bad Debt Write-Offs	Adopted *Gabrielle Huria / Barry Bragg*	Anna Craw
5.	Chairs Update	Nil	
6.	CEO Update	Nil Jo Kane joined the meeting at 9.55am.	Anna Craw
7.	Finance Report	Provide clarification to next QFARC meeting on assumptions made in cashflow forecasting to the Ministry of Health with respect to 10 day supplier payment term arrangements. **Update to 2 June 2020 QFARC.**	Justine White
8.	Resolution to Exclude the Public	Adopted	
	Information	Nil Meeting concluded at 10.26am.	Anna Craw

Distribution List:

- Justine White (CC: Mary Howell)

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 18 JUNE 2020

DATE	ISSUE	REFERRED TO	STATUS
25/02/2020	Selwyn Health Hub – Treasury rules for fit-out	Justine White / Carolyn Gullery	Verbal update.
19/03/2020	Equity Report	Hector Matthews	Report to 16 July 2020 meeting.
19/03/2020	Primary Care Report	Carolyn Gullery	Today's agenda – Item 9, PX.
21/05/2020	Psychosocial Response to COVID-19	Evon Currie	Presentation to July Board meeting

DELEGATIONS FOR ANNUAL ACCOUNTS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **David Green, Financial Controller, Corporate Finance**

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

DATE: **18 June 2020**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to seek authorisation in respect to a delegation to approve the final audited accounts for the 2019/20 financial year on the Board's behalf if the timing of these does not fit with Board or Committee meetings.

2. RECOMMENDATION

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

i. authorises either the Quality, Finance, Audit and Risk Committee Chair and the Board Chair or, if one of these should not be available, one of these two and a Board member, to approve the final audited accounts for 2019/20 on the Board's behalf if required, should the timetable not fit with a Board or Committee meeting;
ii. notes that if this delegated authority is exercised, the final accounts will be circulated to Committee and Board members; and
iii. notes that the Canterbury DHB Chair, Chief Executive and Executive Director, Finance and Corporate Services, will sign the letter of representation required in respect to the 2019/20 Crown Financial Information System accounts which are required at the Ministry of Health in early August.

3. SUMMARY

The audited Crown Financial Information System (*CFIS*) accounts for the 2019/20 financial year are due with the Ministry of Health in early August to meet the Crown's financial reporting timetable. It should be noted that the Canterbury DHB Board's August meeting is on 20 August 2020.

The CFIS accounts for the 2019/20 financial year will be signed on behalf of the Board by the Canterbury DHB Chair, Chief Executive and Executive Director Finance and Corporate Services, and their letter of representation will accompany the accounts. Any change to the 'bottom line' result as reported to this Committee will be discussed with the Chair of the Quality, Finance, Audit and Risk Committee and/or the Canterbury DHB Chair; with Committee members to be updated via email of any change.

The audit process will begin in late July 2020 and is expected to be finished by early October 2020, with the final full audited accounts expected to be completed by mid October 2020. In the event that the timing of the completion of these does not fit the Board meeting schedule it is recommended the Board be asked to delegate approval of the final 2019/20 audited accounts as per the recommendations contained in this report.

CHAIR'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **David Meates, Chief Executive**

DATE: **18 June 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing the latest update and overview of key organisational activities and progress from the Chief Executive to the Board of the Canterbury DHB. Content is also provided by the Operational General Managers and relevant Executive Management Team members.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

3. DISCUSSION

PUTTING THE PERSON FIRST – PATIENT SAFETY, QUALITY AND IMPROVEMENT

Quality & Patient Safety

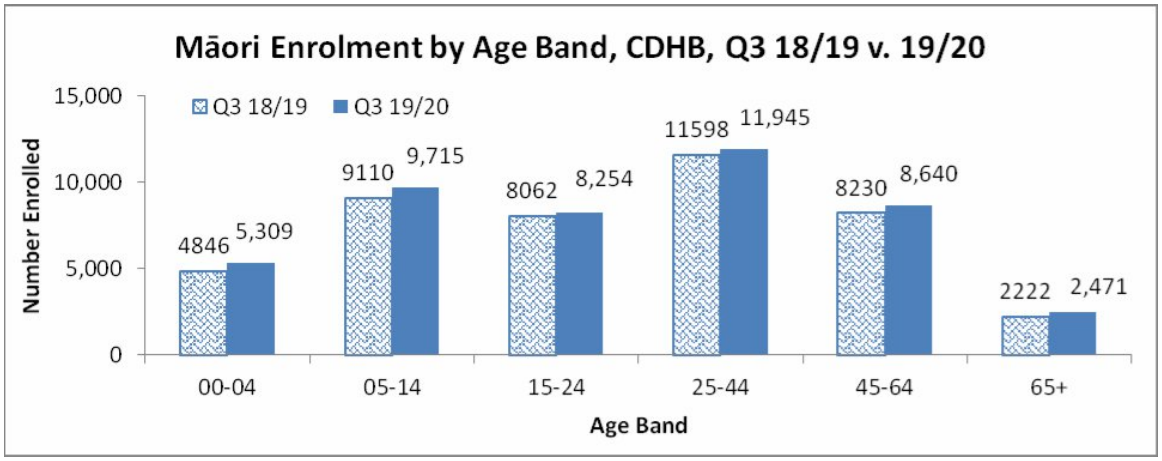
- **Patient Reported Experience in Hospital During Covid Alert Level 4:** Additional questions (from 31 March 2020 for those patients admitted in the week prior to the start of Level 4 - 25 March) were added to both the Inpatient and Outpatient Experience Surveys to assist monitoring patient experiences during the Covid-19 pandemic regarding their ability to contact family/whanau during admission (n=558: 89.6% Yes Always, 1.1% No), feeling safe while in Hospital (n= 558: 84.9 % Yes Always, 2.3% No) and staff cleaning hands when touching or examining (n=561: 87.3% Yes Always, 1.1% No).
- A snapshot of what some patients had to say as follows:
  - 'With access to internet, I was able to video chat with my family back in the States. This also allowed my wife to be involved in the consultations with doctors and staff. Thank you to them for their willingness to participate in the video chats. I had no reason to feel unsafe.' *Coronary Care Unit*
  - 'The staff inspired confidence and communicated what was going on very well.' *Ward 20*
  - 'I was informed all through my stay of what my recovery was at stage wise and what measures were been taken in regards to Corona.' *Ward GG*
  - 'All needs taken care of - often before I anticipated them. Constant checks on well-being by doctors, nurses and nurse aides.' *Ward GG*
  - 'Everyone was friendly, understanding and caring. Made me feel safe and looked after, especially in this crazy time we are all in'. *AMAU*
  - 'Would also like to say how wonderful all the NICU staff were with our child after I was discharged. At that point we had just gone into lockdown and were in uncharted territory. The staff were so calm and reassuring you wouldn't have known what was happening in the outside (except for the visitor allowance changes which did make things [hard] but were totally understandable for that time). We couldn't fault the doctors, nurses, support staff and physios who cared for our child and for us in NICU. Thank you.' *NICU*

MĀORI AND PASIFIKA HEALTH

- This report encompasses the Pūrongorongo Hauwhā (Quarterly Report) for quarter 3, January to March 2020, prepared from the data of our three PHOs (Pegasus, Waitaha and Christchurch) to their Māori Advisory group, Te Kāhui o Papaki Kā Tai which monitor Māori equity performance in three areas.
- **Raraunga Whakauru (PHO Enrolment):** Patient enrolment held under the National Enrolment Service (NES) is a measure of access and is an indicator of inequity if under-enrolment exists in some ethnicities. Trends across the PHOs and between Māori and non-Māori can be charted each quarter.
- A positive increase in Māori enrolment (+1.1%) this quarter, along with increases in enrolments of non-Māori (+0.4%). The graphs that follow compare the changes in enrolment by age band from Q3 2018/19 to Q3 2019/20 between Māori and non-Māori.

Pegasus Health PHO			
	Previous Quarter NES Oct 2019	Current Quarter NES Jan 2020	Variance
Māori	**39,325**	**39,772**	**+ 447**
Non-Māori	413,846	415,841	+ 1,995
Total Pop	453,171	455,613	+ 2,558
Waitaha PHO			
	Previous Quarter NES Oct 2019	Current Quarter NES Jan 2020	Variance
Māori	**3,783**	**3,827**	**+ 44**
Non-Māori	43,428	43,586	+ 158
Total Pop	47,211	47,413	+ 202
Christchurch PHO			
	Previous Quarter NES Oct 2019	Current Quarter NES Jan 2020	Variance
Māori	**2,731**	**2,735**	**+ 4**
Non-Māori	34,122	34,032	-90
Total Pop	36,853	36,767	-86
TOTAL MĀORI	**45,839**	**46,334**	**+495**

- **Figure 1:** The highest increase for Māori enrolments in absolute numbers is the 05-14 age band (+605) and the biggest % change is the 65+ age band (+11.2%)



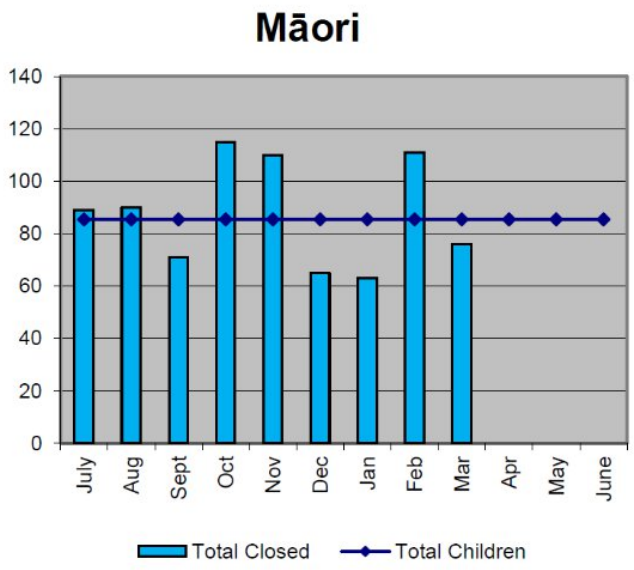
- **Arai mate (Immunisations):** The immunisations for this report include the National Childhood Schedule, Human Papiloma Virus (HPV) and the influenza vaccine for over 65 years.
- The Covid-19 lockdown has impacted with Outreach Immunisation Services (OIS) ceasing at the end of March. Without active OIS for six weeks our overall coverage has been impacted. Once the DHB moved to level 3, four OIS teams were put in place, one from Canterbury Immunisation and the other three built from DHB public health nurses. They have been focused on reaching the most at-risk, high needs families. There has been a positive from our community however we will need to monitor the progress of catch-up for some time to ensure we regain coverage. The DHB has submitted a proposal to the Ministry of Health for kaumātua influenza funding and are waiting to hear back on this proposal.

Measure	Previous Quarter Oct – Dec 2019	Quarter Jan – Mar 2020		Target Coverage (Māori)
	Coverage (Māori)	Coverage (Māori)	Coverage (Total)	
8 months fully immunised children	92%	91%	95%	95%
2 years fully immunised children	94%	90%	94%	95%
5 years	92%	93%	94%	95%
12 years	69%	66%	63%	
Influenza > 65 NES - 18 March – 10 May, MoH - Census projections	n/a	79% NES 46% MoH data	73% NES 69% MoH Data	**75%**

- **Tamariki ora e waru (Before School Check):** The Canterbury Before School Check (B4SC) programme comprises two parts; the nurse component, carried out by B4SC trained nurses in general practice and Public Health and the vision & hearing testing component by the CDHB. A good result for Māori this quarter, with 98% of the target population receiving the full (Nurse and VHT) B4SC.

Canterbury DHB Completed Checks (VHT & Nurse Component)

Māori			
Month	No Children	Target (90% of children)	Total Closed
July	85	77	89
Aug	85	77	90
Sept	85	77	71
Oct	85	77	115
Nov	85	77	110
Dec	85	77	65
Jan	85	77	63
Feb	85	77	111
Mar	85	77	76
Apr	85	77	
May	85	77	
June	85	77	
2019/20	1025	923	**790**



- **Pasifika Health Services:** During the COVID-19 lockdown period, our Pasifika providers (Tangata Atumotu and Etu Pasifika) have provided wrap-around support to their communities focusing on both clinical and a social services support.
- Etu provided support services to their community:
  - 1140 packages of support delivered
  - 1017 Pacific families made up of 6,065 individuals
  - 66 families have a member over 60 years old
  - 205 families have a disability or long term condition
- They continued their clinical roles with 593 GP consultations and 1,554 nurse consultations as well as:
  - Flu vaccinations administered outside and mostly in patient's vehicles to both enrolled and unenrolled patients (vaccination rate 50% of the total vulnerable population).
  - Urgent Care/Walk-in service – walk in service offered to anyone, whether enrolled or not.
  - Elderly – Matua services continued during COVID with regular over the phone contact and engagement with the group.
  - Mental Health services – this was also ongoing with follow-up referrals to counsellors and psychiatrist where needed.
  - Referrals were received from Canterbury Public Health to support COVID-19 positive Pacific families. This support included daily contact, provision of packages of support and assistance with tasks such as shopping. The work was intensive and required consultation and collaboration with a wide range of other agencies. 9 Public Health referrals were received impacting 45 family members.
  - COVID-19 has highlighted the access issues for Pacific families in the region, in particular in Ashburton. The team is currently in collaboration with a Pacific social services provider in Ashburton to deliver health services to Pacific families in their region. Fale Pasifika will organise families and communities to come together and we will provide an integrated health team to provide immunisations as well as other health checks. An additional registered nurse has been engaged to deliver this service.
- Tangata Atumotu supported our Pasifika community:
  - Undertook COVID-19 testing of asymptomatic Pasifika community in partnership with Pegasus Health and Community Public Health. Forty swabs taken on Sunday 25 May.
  - Delivering grocery vouchers to families with financial struggles (both patients of the service and community) and vouchers to tertiary students with financial struggles.
  - For their over 70s clients, Tangata Atumotu rolled out a nutritious food bag (fruit, vegetables and quality meat) that their four nurses delivered to homes under alert level 3. This was done as part of a holistic assessment of client wellbeing. Staff visited from outside the home and shared a hymn and prayer with families.
  - Worked in partnership with the Pegasus Health Pasifika PCWs (Partnership Community Workers) to organise food parcels, payment for rent and utility expenses, such as electricity.
  - Nursing team have been making up to 20 'holistic consultations' daily via phone to assess client's physical, emotional, and spiritual wellbeing, connectivity and financial status, and their understanding of COVID-19 protocols.
  - Working in partnership with Unichem Crisps Pharmacy (Bryndwr) and Eastern Pharmacy (Aranui) offering weekend free flu clinics to families of patients.

MEDICAL SURGICAL AND WOMENS AND CHILDRENS HEALTH

- **Adopting and adapting new ways of working:** Last month's update from Christchurch Hospital focussed on changes made and the amount of care provided whilst we were in levels 4 and 3.
- Forward planning enabled services to enter levels 3 and 2 with no delay in service provision. This included adapting the new ways of working and adopting them as components in our normal care

processes. The updates below provide a snapshot of some developments along with an indication of the volume of care being delivered.

- **Outpatient Care:** During the response period there was a significant uplift in outpatient services via non-face to face methods (including via phone calls, video, remote patient monitoring and correspondence). This emphasis on non-face-to-face methods has continued into May. Note that the outpatient volumes below relate to the entire month of April and the first 22 days of May as manual entry of telehealth information is currently required. The total volume of appointments provided on the campus sits at close to 80% of the volume provided in the analogous period in 2019.

	Comparison period – 2019		**2020**		**Proportional change**	
	April	**1-22 May**	**April**	**1 – 22 May**		
Number of working days	19	16	19	16		
Med Surg (excludes outsourced and outplaced volumes)						
Outpatient – face to face attendances	23,388	22,082	9,225	11,323	39%	51%
Outpatient – non face to face attendances	2,947	2,156	10,590	7,603	359%	353%
Outpatient – Total attendances	**26,335**	**24,238**	**19,815**	**18,926**	**75%**	**78%**
Women's and Children's (excludes outsourced and outplaced volumes)						
Outpatient – face to face attendances	3,363	3,069	1,241	1,455	37%	47%
Outpatient – non face to face attendances	354	302	1,902	1,410	537%	467%
Outpatient – Total attendances	**3,717**	**3,371**	**3,143**	**2,865**	**85%**	**85%**

- While the number of first specialist assessments in comparison with last year is lower than overall volumes, it has increased – sitting at 58% across the campus.

	Comparison period – 2019		**2020**		**Proportional change**	
	April	**1-22 May**	**April**	**1 – 22 May**		
Med Surg (excludes outsourced and outplaced volumes)						
First Specialist assessments	4,582	4,262	2,170	2,588	48%	61%
Women's and Children's						
First Specialist assessments	793	724	411	317	52%	44%

- The type of care provided by different services and requirements of the various patient cohorts varies, examples of changes in the way that we work that have been introduced include:
  - A new midwife and dietician led pathway for women with gestational diabetes. The midwives monitor the growth of the baby and blood glucose readings are shared with the dietitian through email and bluetooth meters. This has reduced the requirement for women to travel to Christchurch Women's Hospital and released obstetrician and physician capacity for other care.
  - Provision of telephone follow up the day after eye surgery and face to face review (at one month by an optometrist) has released 560 appointment slots a year for first specialist assessment.
  - Arranged maternity assessments are now operating from community units at Lincoln, Rangiora and Ashburton rather than women attending the busy Christchurch Women's Hospital.
  - Oncology clinics have been shifted from Christchurch Hospital to Christchurch Outpatients to meet social distancing requirements. This is in combination with phone and telehealth consultations.
  - Services having learned how to make better use of telehealth for the provision of outpatient services will continue using this approach for some groups of patients. Advantages include patients not required to travel, find a car park, less patients in the building assisting with appropriate distancing

between patients and, where patients for telehealth are carefully selected, being able to provide more patients with care during a clinic.

- The paediatric diabetes service is developing towards 50% Zoom and 50% in person consultations. Childhood enteral feeding is exploring providing families with a set of scales at home to enable weekly telehealth instead of face to face weighing and review at the hospital.
- The Otorhinolaryngology (ENT) team has created capacity by utilising telehealth and timely transfer of patients to their general practice.
- Improved equipment (including telephones, cameras and speakers) has been installed in clinic rooms throughout the campus to enable the increased reliance on technology.
- Consultants contacting patients by telephone in triaging referrals. This ensures a face to face appointment (if clinically required) is fine-tuned according to the individual patient. During lockdown some patients received their first specialist appointment at the time of triage, reducing waiting time to nil, ensuring they received immediate care and reducing the likelihood of acute presentation.
- Increased use is being made of remote monitoring capabilities of meters and implanted devices.
- Clinical services, Planning and Funding and General Practice have begun thinking together about how best to increase engagement between general practice and hospital specialists to enable general practice to provide care to patients that currently occurs via hospital outpatients.
- At least one service is exploring including evening and Saturday morning services via telehealth to accommodate patients' work schedules.
- The lockdown accelerated the transition of Natalizumab infusions to the community centre. This has freed up space in the Medical Day Unit (MDU) for other PHARMAC led treatments being made available. More treatments in MDU but appropriate for a community setting will be transitioned to the community infusion centre.
- Dental house officers developed a tool to help patients take adequate quality intraoral photographs to enable telehealth triage when facial swelling is present.
- The approach taken to the follow up of acute orthopaedics injury has been reviewed. This reduces the intensity of follow up and some patients are now reviewed by Registered Nurses rather than medical staff. Overall clinic scheduling has also been reviewed meaning patients spend less time waiting at clinic, the clinic is less crowded and Senior Medical Officer and Resident Medical Officer capacity has been released for other tasks that only they can perform.

- **Inpatient care:** During levels 4 and 3, social distancing and reduced busyness in our community led to an incredible reduction in demand for the acute care usually caused by trauma and infectious diseases.
- This contributed to a reduction in presentations to the Christchurch Emergency Department and acute admissions to Christchurch Hospital. Adult presentations remain lower than baseline but are increasing towards previous volumes. Children's presentations remain lower.

	Comparison period – 2019		**2020**		**Proportion of comparison period**	
	April	**May**	**April**	**May**	**April**	**May**
Emergency Department attendances	8,093	8,714	5,681	7,204	70%	83%
Med-Surg Acute Admissions	4,189	4,440	2,940	3,772	70%	85%
Women's Children's Acute Admissions	707	845	515	596	73%	71%

- In line with the National Hospital Response Framework clinicians carefully assessed each planned inpatient case to ensure that patients with non-deferrable requirements were provided with the care they required. Because a high proportion of the work carried out at Christchurch Hospital is non-deferrable, planned admissions to Christchurch Hospital continued at 70% of forecast volumes during the month of April.

- Prior to the transition to National Hospital Response Framework Yellow and Green Alert levels services worked to plan our approach as we entered each level. This included developing and agreeing prioritisation categories to ensure that planned cases are seen in an appropriate order in our own hospitals as well as in outplaced and outsourced settings. This preparation and implementation of changes has led in May to planned activity towards baseline.

Planned admissions Christchurch Hospital	**Comparison period – 2019**		**2020**		**Proportion of comparison period**	
	April	**May**	**April**	**May**	**April**	**May**
Med-Surg - planned admissions	2,010	2,485	1,226	1,867	60%	75%
Women's Children's - planned admissions	1,057	1,139	888	1,029	84%	90%

- Changes that are occurring to the way that we continue to work in the inpatient setting include:
  - Same day discharge pathways have been established for planned inpatient cardiology services such as electrophysiology, device battery changes and Percutaneous Coronary Intervention.
  - Physiotherapists are making greater use of electronic notes in Health Connect South, CORTEX has been adopted by more departments and the use of CORTEX for nursing and allied health notes has been accelerated. Prescriptions are now provided electronically to community pharmacists. The use of electronic clinical records ensures that information is immediately available wherever it is required throughout the system and reduce risk of viral transmission via paper clinical files.
  - The Emergency Department now has a negative pressure room which is used for patients with respiratory disease who require aerosol generating procedures while they are in the department.
  - Social Worker roster changes have expanded the hours Social Work are present on the campus and reduced overtime payments. It has also increased overall Social Work satisfaction with their role.
  - The Chest Pain Pathway has been reviewed and low yield diagnostic tests removed.
  - The Children's Haematology& Oncology (CHOC) service is retaining the purple card system that gave CHOC families quick access to the unit via the Emergency Department.
- **Physical distancing requirements and Christchurch Hospital Wards:** Ward spaces at Christchurch Hospital have been evaluated to determine whether appropriate physical distancing can be maintained. Six bedded rooms are widely used on the campus, none of them support appropriate distancing between inpatients and visitors. Reducing capacity in multi-bedded rooms to enable appropriate distancing if adopted would reduce the capacity in Christchurch Hospital by 83 beds.
- **Faster cancer treatment:** A recent Faster Cancer Treatment (FCT) report covering the three months to the end of April shows that despite being in lockdown for five weeks of the period, performance has not deteriorated. Canterbury achieved 96.6% exceeding MOH targets in the period January to March. The number of patients treated during the period is higher than the previous report period.
- **Theatre:** Because much of the surgery provided at Christchurch Hospital is acute or non-deferrable, provision of surgery in Christchurch Hospital's theatres continued at a high rate throughout the COVID response period. Surgery at Burwood hospital and our outplaced and outsourced settings was curtailed for a period. Outplaced operating was phased back in from the week of 20th April and outsourced work from early in May.
- In-house theatre volumes achieved >95% of forecast levels at Christchurch and Burwood Hospitals during the last two weeks of May. This is a remarkable achievement given new ways of working involving physical distancing and other restrictions mean that we are seeing a 13-15% reduction in theoretical efficiency volume compared with pre-COVID volumes.

	Comparison period – 2019		2020		Proportion of comparison period	
	April	**May**	**April**	**May**	**April**	**May**
Christchurch Hospital						
Theatre events - planned admissions	1,033	1,334	660	1077	64%	81%
Theatre events – acute admissions	702	697	575	716	82%	103%
Theatre events – Total Christchurch	1,735	2,031	1,235	1,793	71%	88%
Burwood Hospital						
Theatre events - planned admissions	241	335	30	171	12%	51%
Theatre events – acute admissions	5	1	5	2	100%	200%
Theatre events – Total Burwood	246	336	35	173	14%	51%

- During the first two weeks of May, despite Burwood theatres running at around 20% of the previous years' volume the system produced 94% of the volume seen in the same period during 2019. This was a result of outsourced and outplaced activity running significantly higher than last year and Christchurch theatres running at 91% despite the productivity loss associated with COVID precautions.
- Work is underway to forecast the effect of reduced theatre throughput associated with COVID-19 precautions, new theatre schedules required to improve the management of acute cases changes in the way that acute cases are managed, and new theatre schedules to be put in place once Hagley becomes available on the time that patients spend waiting for surgery.

OLDER PERSONS HEALTH & REHABILITATION | COMMUNITY DENTAL

- The transition to Alert Level One will mean that many services for Older people that have been suspended or rationalised during Alert levels 4 through 2 will be able to resume as normal. Home and Community Support Services (HCSS) have been rationalised during this period, with less complex clients having some inessential services reduced. At the beginning of Alert Level 4, analysis was carried out, examining individuals' interRAI Casemix scores to determine which clients could safely receive reduced services during the lockdown. This was necessitated by a reduction in the available staffing pool (where older workers, those with pre-existing conditions, and those with school-aged children were unable to work). A list of vulnerable people was compiled by Older Person's Health and Rehab, and by Older Person's Mental Health, with input from various NGO services, to identify those who might struggle over this period if services were reduced, and in these cases services were continued as usual, or in some cases, increased, with additional supports offered appropriately. Some people have struggled with the reduction in services, nonetheless, and there has been significant increase in pressure on informal carers in the community. HCSS will be back to normal as of 12 June. These are essential services for keeping people well at home, and will reduce the precarity of many who have found this period challenging.
- Services provided by NGOs in the Community, (for example, Day Support and Community Activity Programmes, Dementia and other disease-specific services, and services offered by Age Concern) will resume under Level 1. These services have been adapted over the Lockdown, with services keeping in touch via phone, Zoom with older people in an attempt to reduce isolation and Carer Stress, and the delivery of support packages, including activities and in some cases, meals.
- Community Strength and Balance classes, and Falls assessments, will also resume. Falls Champions have been working remotely to support people at home. The range of services in the Community to support older people create a network of supports; while there have been many creative solutions in place over

this period (which can be re-engaged later should the Alert Levels ramp up once again), return to normal services will help people living at home remain there more securely.

- Rosewood Rest Home has been cleared by Community and Public Health to admit people with dementia from 13 June. Rosewood has beds at both D3 (Dementia Rest Home) and D6 (Dementia Specialist Hospital, formerly Psychogeriatric) which are an invaluable part of our Dementia residential capacity in Canterbury. Rosewood has a good reputation in the community for care of elderly people with dementia. This will go some way to addressing an ongoing issue: Canterbury's capacity in Dementia beds, with a number of people currently in hospital awaiting rooms in Dementia care facilities.

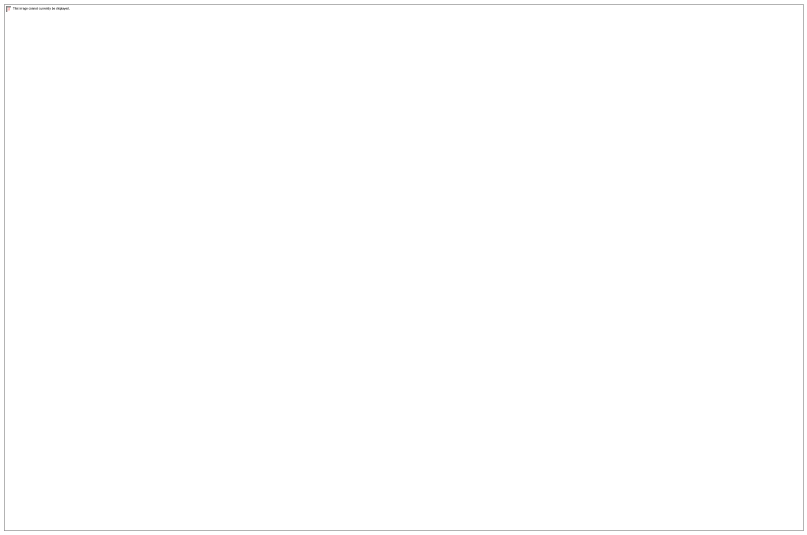
  Given that we anticipate an increased demand for Dementia residential care (and Dementia services more widely) in coming years, the ability of Rosewood to admit residents is welcomed, as are the additional beds which are expected to come on line from different providers in the next six months. Older Persons Mental Health will work with providers alongside the Walking in Another's Shoes programme to ensure that these providers of Dementia care are confident to provide person-centred care.

- A telehealth triage system was established for children's dental care, during alert levels 3 and 4 that allowed for a large proportion of patients to be managed without booking. Changes to staffing created a team of four dental therapists to review all incoming requests from families with children who have dental problems. It is intended to continue with this system.

  The data for triaging since the start of this process shows:
  - 33% of the incoming calls were booked for treatment, of the remainder:
  - 39% were managed over the phone with no follow up required,
  - 22% were non-urgent and visits deferred
  - 5% were on-referred to either Hospital Dental or Sedation

- Prior to the introduction of the triage system all 185 patients would have been booked for treatment, most as acute/semi acute, however the triaging has seen an average of 31 patients per day not needing booking – and their families not needing to make a visit to see our service. Ordinarily nearly eight staff would have been required to provide care for those avoided visits – four were rostered on the triage team.

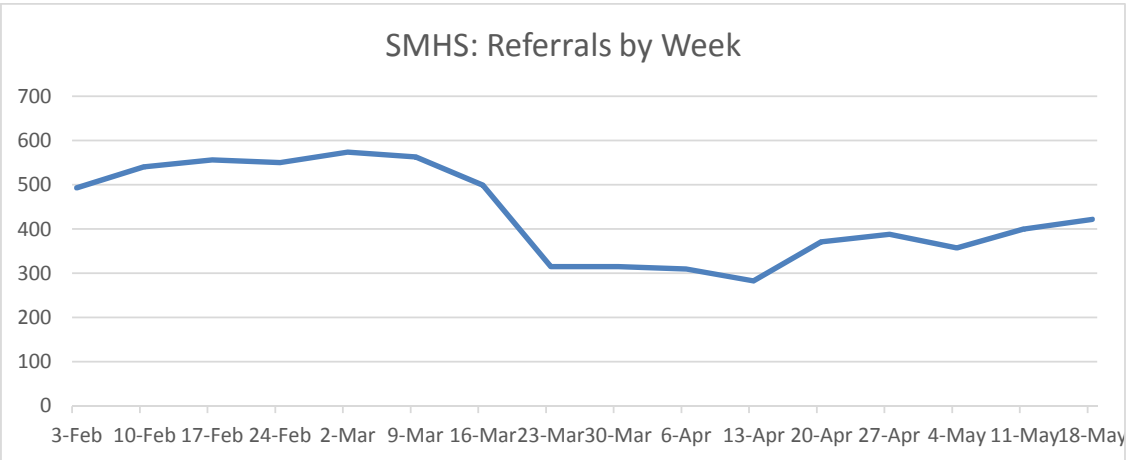
- **Incoming calls:** The single point of contact for Canterbury's adult emergency dental system (EDS) started on 30 March – one week following the implementation of restrictions on dental practice – and ran through to 13 May (the end of national alert level 3). The contact centre went to seven days per week operation from 18 April. Summary of call volumes during the 45 days the adult EDS ran for:
  - 1,852 incoming calls
  - 41 calls per day, on average
  - Highest number of calls – 113 on 28 April (Tuesday after ANZAC weekend and the first day after the transition from alert level 4 to level 3)
  - Lowest – 6 on 10 May (final Sunday before the end of alert level 3)



- **Triaging of callers:** Following an assessment of the patient's acute dental condition by phone, triaging dentists either managed the problem by providing advice/analgesia/antibiotics (AAA) or referred on for treatment to either the general dental practice (GDP) roster or the Hospital Dental Service (HDS). Data collection from the triaging team started on 7 April (8 days after the start of the scheme). For the 1,643 we have data for:
  - 49% were managed with AAA (range 24% to 73%),
  - 47% referred to GDPs and
  - 3% to HDS

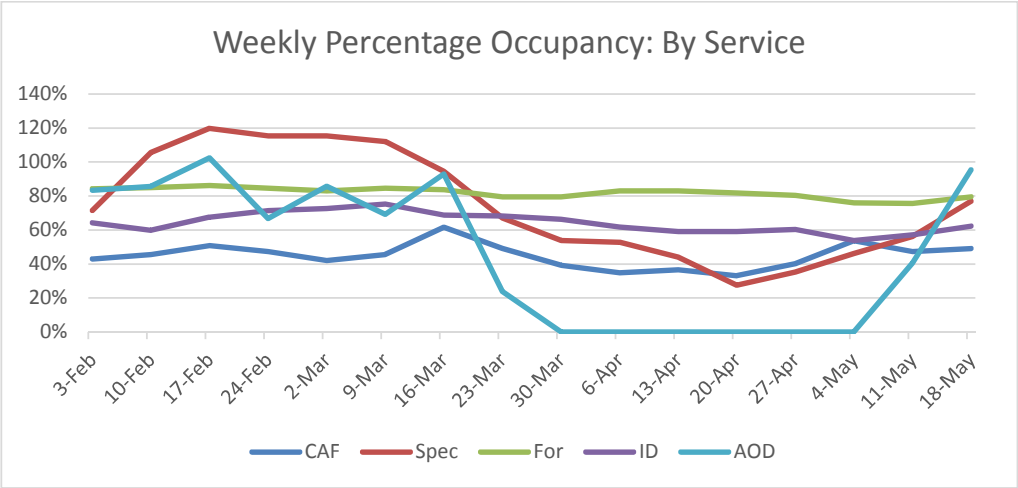
SPECIALIST MENTAL HEALTH SERVICES (SMHS)

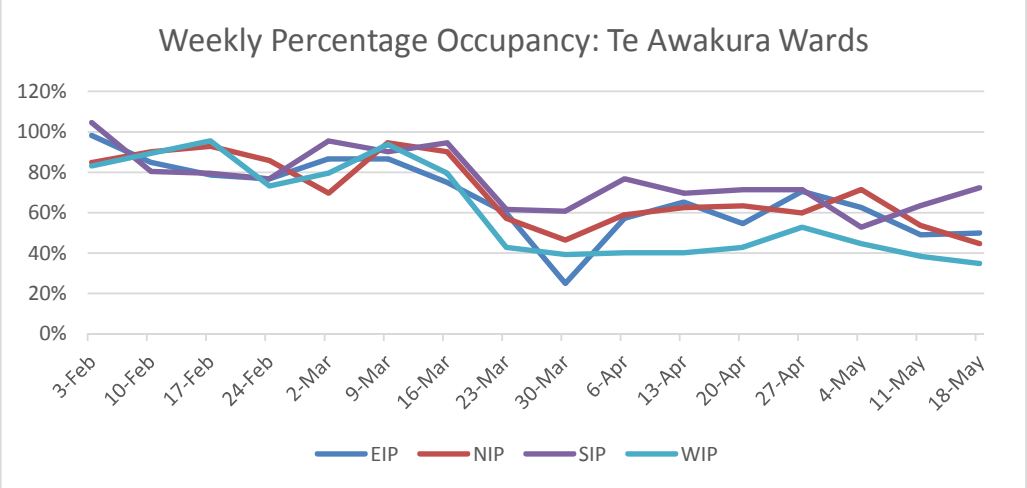
- **Demand and Waitlist Management**: With appropriate response plans in place for managing consumers that might present to SMHS with COVID-19, and with appropriate arrangements in place to support staff safety and wellbeing, the key focus during May was monitoring demand, ensuring core clinical activity continued and developing appropriate plans to manage deferred appointments and increasing waitlists.
- **Monitoring Demand:** Referrals decreased at the beginning of Level 4 but are beginning to return to the usual volumes. We anticipate seeing significant growth in demand as the psychosocial impacts of the pandemic and its ongoing impacts become more apparent.



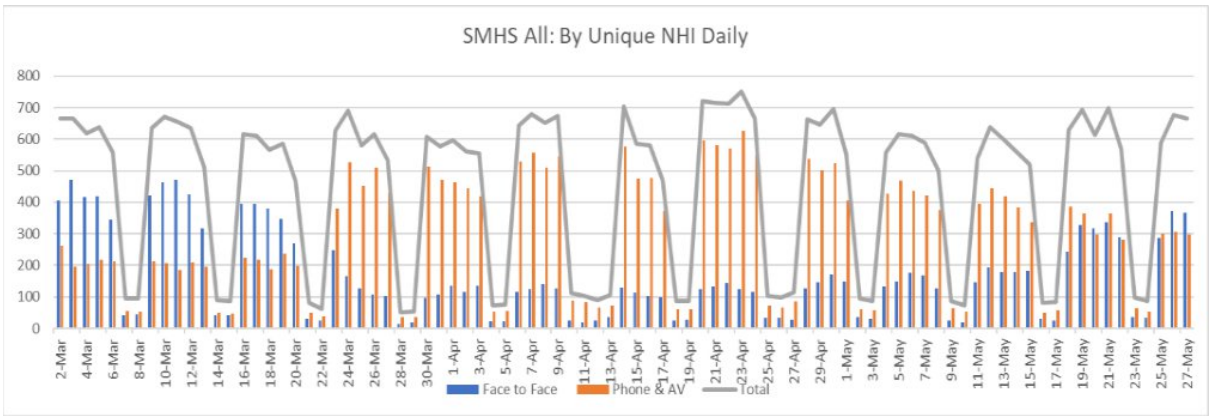
- After-hours community contacts reduced slightly initially, however remained relatively steady throughout and are returning to normal patterns.

- Inpatient occupancy was maintained in the longer stay units. The adult acute inpatient unit (Te Awakura) saw reduced occupancy in response to raised admission thresholds put in place as part of the COVID-19 response plan and has not yet returned to its typical occupancy pattern.

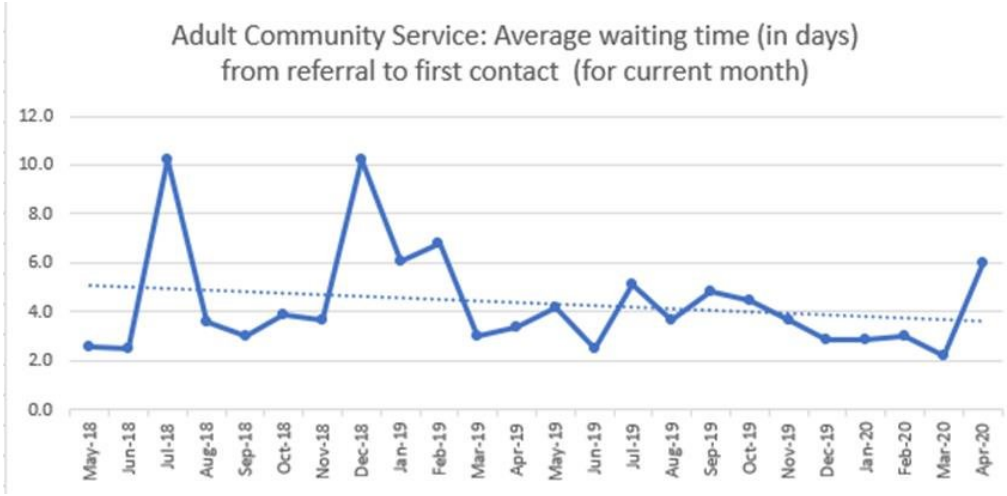


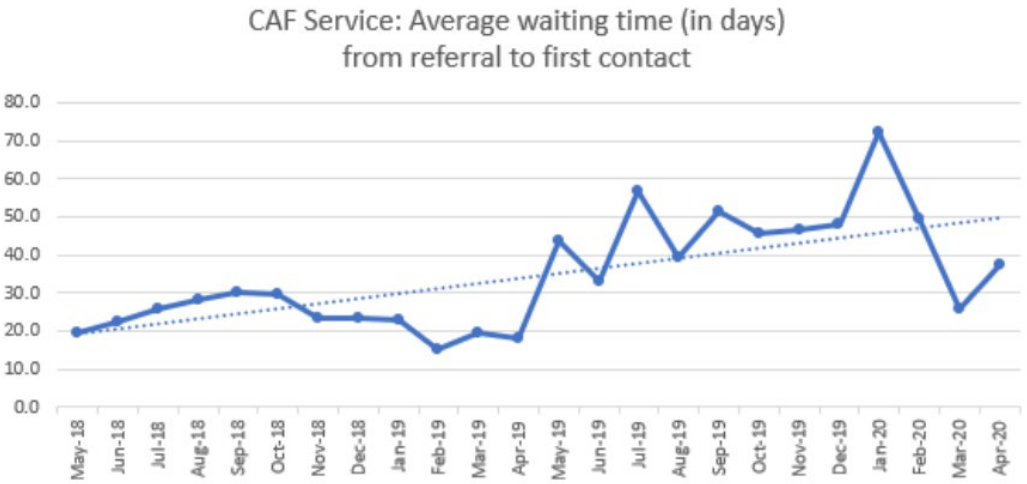


- **Maintaining core clinical activity:** The daily contact reports are showing a trend back to normal patterns of interaction with consumers in the community however there are still more non face to face contact recorded than prior to COVID-19.



- **Waitlist Management:** Waitlist recording and management (for the services that operate waitlists) will now be consistently recorded in Healthlinks. This improves tracking and visibility of the numbers of people waiting and any increase in demand or wait times across the system.
- Wait time in days to first face to face contact has seen an expected increase across both adult and CAF services due to the reduction in face to face contacts. There is often contact prior to the first face to face appointment as part of the triage and prioritisation process.





LABORATORY SERVICES

- Pathology and Labs COVID-19 response previously described in board reports achieved through collaboration at all levels. In Canterbury we adopted an integrated approach in partnership with primary care, community public health, IP&C, infectious diseases, ECC and other stakeholders to support identification of cases and the subsequent sentinel and asymptomatic screening to support the MOH response and decision making. This was achieved through the following goals and objectives set with the team at the start of the response.

Table one:

Overarching objective	***Provide data and information***	provide relevant testing activity information at a local, regional and national level to guide decisions and support the response
Goal one	***Support sustainable testing within NZ***	for all regions, bring together all the expertise, knowledge and capability from across our services to achieve this. Share all knowledge and intelligence we have with other laboratories to support their effort in a cohesive manner.
Goal two	***Build CHL testing and capacity***	build appropriate capability and capacity to deliver as much capacity as needed by the NZ Health System. Understanding our TATs to ensure these meet all the regions support needs. Model and review flow and process from end to end to remove bottle necks and ensure best use of our technical and scientific resource
Goal three	***Support Regionally***	support all our regional referral partners as needed (private and public, Taranaki, Hawkes Bay, West Coast, Med Lab Central/Mid Central) to build their own capability and services

		for covid19 testing within their regions within their hospital and community environments

Table two: Upscaling in SARS-CoV2 RNA testing Feb-May 2020 by CDHB_CHL. Levelling in growth April to May was due to regional labs stabilising and developing testing within their region (goal three).

performed by CHL per DHB	Feb	Mar	Apr	May	Total per DHB
Canterbury	25	1495	11568	12927	**26015**
West Coast	0	68	723	841	**1632**
South Canterbury	0	219	1430	1610	**3259**
Nelson Marlborough	0	294	2	1	**297**
Southern	10	73	24	6	**113**
Mid Central	3	381	1090	1	**1475**
Tairawhiti	*1*	160	352	0	**513**
Taranaki	0	289	1673	1419	**3381**
Hawkes Bay	2	548	3975	4898	**9423**
Auckland Regions	0	429	549	0	**978**
Wanganui	0	109	325	0	**434**
Total tests per month	**41**	**4065**	**21711**	**21703**	***47520***

Supporting acceleration of our Healthcare System and new ways of working

- Outpatients and primary care virtual consults - provision of paperless lab requests
  - Support ERMS (electronic referral management system) pilot for labs requests
  - 400 requests submitted for labs in first four days
- Canterbury Health System - data and information
  - Take learnings from COVID-19 test reporting and dashboards and utilisation of data from laboratory information system (LIS)
  - Use Lab information to target disease groups and high need populations to support focus on equity and equality as part of system acceleration (June 2020 selected test targets)
- Rural access to laboratory services - expansion of Point Of Care (POC) testing to rural sites and hubs
  - Kaikoura Hospital - full blood count analyser installed May 2020. Assists with the monitoring of side effects of therapeutic drugs e.g. chemotherapy and clozapine. Part of the wider CHL and Canterbury POC strategy.
- Labs programme of work remains on schedule - HVA and LIS
  - High Volume automation (HVA) replacement in 24/7 laboratory: Lab alternations have enabled improved layout and best use of limited floor plan for accommodation of any HVA solution. This project will enable improved capacity and throughput for testing and informatics
  - Laboratory information system (LIS) upgrade - Canterbury and DHB Labnet partners - user acceptance testing commenced in May for a go live August 2020
  - Both projects on schedule despite the disruption of COVID19

Risks

- Managing costs and prevention of wastage whilst maintaining capacity (staffing and supplies) for COVID-19 volumes in case of a second wave.
- Potential for continued supply chain disruption for COVID-19 and other testing supplies.

Focus	Mitigation
Staffing costs	• return staff to pre-COVID19 work areas • maintain staff competency by rotation through Virology for redeployment if increased staffing capacity required for a COVID19 resurgence • manage fixed term contracts and annual leave
Consumables and reagents costs and options	• keep stock on hand with close communication and monitoring with suppliers • maintain a range of validated in-house laboratory developed and proprietor methods
Technology (analysers and equipment) options	• robotics - interchangeable to reduce manual steps of current processes and enables an alternative platform for COVID-19 testing (nucleic acid extraction) using a range of reagents and consumables • spread COVID-19 testing over a range of platforms • non-COVID testing transferred to alternative and interchangeable platforms

ASHBURTON RURAL HEALTH SERVICES

- Reporting on work undertaken in May becomes a reflection on what we learnt in responding to COVID-19. As a generalist health service that combines hospital level acute and inpatient care, afterhours primary care, primary birthing and community service delivery within a campus of shared services, our challenge incorporated managing the patient risk, staff response, alongside our partnership with our primary health care providers. As primary care closed their physical space for patient access locally, implementing over 80% of patient contact and assessment via telemedicine, and we equally moved all our Allied Health, Needs Assessment, and Clinical Nurse Specialist support to digital platforms, our responsibility was to safeguard so that acute health care needs continued to be met. Whilst we physically "shut the front door", we needed to ensure we did not imply a sense of complete isolation to our community. We attempted to mitigate this through our involvement in welfare response with the Ashburton District Council and communication messages via the local radio networks. Our acute presentation trends remain lower than average, clinical feedback reflects the patients presenting have delayed their access and many are acutely unwell at the time of presentation.
- Feedback from our district nursing, home based support (which was limited to essential personal cares) voiced concerns from patients that they felt isolated and abandoned. Most of this cohort represents an older population group who are resilient to challenges faced in rural communities, the issues raised were not about supermarket access, but health care at end of life or a time of vulnerability.
- As we reflect that COVID-19 is a reminder that the future must be about breaking down boundaries, focusing on a collective goal of protecting and promoting health and protecting the most vulnerable, integration of service delivery both in shared data platforms and a commitment to shared resources remains our enabler.
- From a satellite campus lens, the expansion of the digital platform opens many opportunities for community access to specialist services and employee's participation in training, meetings and orientation previously only available within a Christchurch setting.

PRIMARY CARE AND COMMUNITY SERVICES

Mental Health

- Primary and community mental health and addiction services remained operational through lockdown via virtual services and are now providing face to face contact again for people who prefer this method of support. Providers are also considering lessons learned in terms of a mix of methods for service provision by phone or online which may contribute to improved access to mental health and addiction

support over time. Mental health and addiction services are participating in the wider psychosocial recovery planning alongside Community and Public Health.

- The roll out of Integrated Primary Mental Health and Addiction Services in general practice is progressing with a Registration of Interest now closed to create a pool of Health Coach and Support Workers. The CDHB is leading the implementation of a South Island regional hub and spoke model for alcohol and addiction withdrawal management. Post Mosque Attack Recovery continues with an increased provision of services amongst a range of providers.

Primary Care

- Influenza Programme – this year's Influenza vaccination season has seen over 160,000 people vaccinated within the Canterbury region for Influenza (up to 5 June 2020). This includes 105,000 people within general practice and 40,000 by community pharmacy and at least 15,000 by Occupational Health providers. 73% of those 65 years and older within the Canterbury region have been vaccinated, with all PHOs coverage over 70% for their enrolled eligible Māori populations and 69% for their enrolled eligible Pacific coverage. While there have been challenges this year with vaccine supply, this has largely been due to the early start in the season, the national strategy to secure coverage for funded patients and an increased demand for the vaccine.

- Measles Catch up Programme – planning has begun on the Measles (MMR) catch up programme, with a plan being drafted for the Ministry of Health. This programme will be implemented for 12 months from 1 July – 30 June 2021 and be focused on reaching those age 15 – 29 years old who have not been vaccinated. In the Canterbury region we have around 105,000 people in this age group but estimate that at around 50% have been vaccinated. Our proposal is to use General Practice and Community Pharmacy, as well as school based and occupational health services to reach this population. We are developing specific programmes to reach Māori and Pacific young adults who have not been vaccinated.

- New-born Enrollment – Canterbury DHBs newborn enrollment rate continue to improve. This quarter, 85% of 6-week olds and 96% of our 3-month olds were enrolled with general practice. This performance reflects the systems wide approach applied in Canterbury, with NIR, General Practice and PHOs playing a key role in identifying and supporting families to be enrolled with a general practice. More work is needed to improve equity, however performance is improving with 66% of Māori and 81% of Pacific at 6-weeks, and 79% of Māori and 98% of Pacific at 3-months.

- During Levels 3 and 4 of the lockdown, General Practice and Urgent Care providers adapted to new ways of working within days, to meet their enrolled populations primary care needs within the restrictions imposed during the COVID-19 response. Working virtually has many potential benefits in terms of building capacity through increased efficiency and for patients it overcomes many of the physical barriers to access experienced by those with disability and temporary impairments. New ways of working must be sustainable for General Practice. At Level 2 PHOs have canvased their affiliated Practices on future needs. There is appetite for PHOs to engage in an active programme of support to embed the new ways of working. For example the Pegasus PHO Board has signed off on a 'strengthening general practice' programme which focusses on the 9 fundamentals of modern general practice and will complement the work of the IFHS Programme with a more 'hands on' approach. Christchurch PHO and Waitaha PHO are following a similar approach. It is also anticipated that PHOs will work very closely with their Pharmacy colleagues to ensure the capacity of both systems is optimised and patients experience an integration response.

- In mid-March the Canterbury DHB received revenue agreements for the COVID-19 response in Primary Care. These were specifically for the Community Based Assessment Centres (CBAC) and the COVID-19 tests being done in General Practice. The response in Primary Care was co-ordinated by the Canterbury Primary Care Response Group in a close partnership with the Canterbury Initiative who ensured key information was available to General Practice on HealthPathways. As at June 8 the Canterbury system have completed 26,860 lab tests for COVID-19 with 110 positive results. Of these 13,588 tests have been taken in the 10 different CBAC sites and 9,629 tests have been taken in Canterbury General Practices. The volume of testing has reduced from a peak of 872 on 5 May to 292 on 5 June. A shift in testing requirements made after the revenue agreements were put in place pushed the volume of testing outside the funding envelope. Canterbury was funded $892K for GP Testing and

$3.65m initially for 6 weeks, the Ministry of Health have informed DHBs that there will be no more funding to 30 June 2020. The projected position at 30 June 2020 is that testing will exceed the funding by approximately $3.2 million. A bid for additional funding can be make after 1 July 2020.

COMMUNITY & PUBLIC HEALTH

- **COVID-19 – Uplift Plan:** A National Contact Tracing Preparedness Plan (Uplift Plan) was submitted by CPH to the Ministry of Health on 15 June, 2020. It outlined how CPH would increase its case management capacity to routinely manage 47 cases a day by the end of June, with plans in place to manage 67 cases a day within 3-4 days. The Ministry of Health has indicated the expectation that all public health units be prepared to support case and contact management across the country as required.
- An Uplift Implementation Plan has been drafted by CPH with sub-project areas include staffing, information systems, liaison, intelligence, quality, training, workflow and work location. CPH staff are currently focused on addressing the tasks identified in the plan, for each of the sub-project areas. This is a large and resource intensive undertaking involving extensive consultation across the wider Canterbury DHB.

Risk Management

- It is anticipated that case and contact identification and management will need to continue until a vaccine is available.
- Interim debriefs are being held for each CIMS team to inform the on-going response and the Uplift Implementation Plan.
- A letter from Ministry of Health was received early in the response clarifying BAU expectations. Staff are responding to Ministry of Health requests for specific tasks in relation to COVID-19-related drinking water safety. The annual Drinking Water Survey has received a 2-week extension from the Ministry. Other priority non-COVID work is increasing, including ECE inspections, HSNO work, non-COVID-19 communicable disease work, OIA requests and VTA permissions. Alert Level 2 also allows a greater range of work within our communities, as COVID-19 demands permit.

EFFECTIVE INFORMATION SYSTEMS

- Canterbury DHB has been working with St John to make information collected by the ambulance officers available to the hospital clinicians.
- An Ambulance Care Summary (ACS) is a compilation of the clinical notes made by an ambulance officer about a patient while they are being assessed and transported to hospital. Although the information was being collected electronically, it was being printed when the ambulance arrived in the Emergency Department (ED).
- St John's ambulance officers estimated that, per patient drop-off, they spent between three and five minutes manually printing and handing over ACSs (on paper) to ED clinicians. This was not a good use of anyone's time.
- Working with Orion Health and St John, we have been able to provide access to the Ambulance Care Summary from Health Connect South. Appropriate access controls are in place and the document access requests are made securely.
- Within the first 48 hours of being introduced more than 330 Ambulance Care Summaries had been viewed. It was piloted in Christchurch's ED and there has been plenty of positive feedback
  - *"As part of the delivery of care to patients, St John ambulance officers collect and document information that is very valuable, not just for the Emergency Department, but also for subsequent services who are part of the patient's journey. Thanks to collaboration between the CDHB, Orion Health and St John, we now have ready and persistent access to this information as part of our electronic medical record."* Dr Jacques Loubser, ED SMO
  - *"Absolutely essential and great that it has happened."* Dr Anthony (Swiss) Spencer, General Medicine SMO

- *"I love having the ambulance summaries on HCS. They're much easier to find, all the bits of paper are in order and the right way up and you know that it's for that patient, without having to hunt for a name halfway down the page.* Dr Claire Taylor, ED SMO

Risks/Issues

- **Paging Replacement System:** Our paging system is end of life and requires replacement. Clinical and non-clinical options have been identified with approval of capital expenditure required to proceed.
- **South Island Patient Information Care System (SIPICS):** Following the migration of our outdated Patient Administration Systems to a new regional platform, we are improving our national extract reporting, which includes the reconciliation of all extracts currently submitted for Canterbury DHB.

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Communications and Engagement

- The team's work throughout May continued to be dominated by COVID-19, as part of our role in the Canterbury Health System Emergency Coordination Centre and supporting the ten Emergency Operations Centres throughout Canterbury and the West Coast. This included providing:
  - 24/7 service with a designated Public Information Manager under the Coordinated Incident Management System.
  - Advice and support to Aged Residential Care providers, for example, Rosewood Rest Home when its residents returned from Burwood Hospital.
  - Resources to people staying in quarantine facilities.
- We continued to work closely with our public health team, including health promotion and hygiene messages for the public, responding to hundreds of media queries and issues management.
- We worked on internal and external communications to ensure staff and the general public were aware of key changes that affected them as we moved from Alert Level 3 to Alert Level 2. This included providing advice and information to assist staff transitioning back to the workplace after working from home and providing clear guidance for visitors to our various facilities.
- We profiled the important contribution of various teams across our health system to the pandemic response, including the GG ward at Burwood, Rosewood Rest Home and Hospital, Infection Prevention and Control, Community and Public Health, and Canterbury Health Laboratories teams, among others.
- We shared some of our stories with Canterbury Health System partners through Te Papa Hauora COVID-19 special newsletters, and prepared communications to support the launch of the NZ COVID Tracer App and the display of scannable QR codes at a number of our facilities. We also prepared communications to encourage people to attend outpatient and planned elective surgery appointments and advised of the additional measures we are taking to keep them safe during their visit.
- The Communications team has ddeveloped branding for Canterbury Health System Research and published stakeholder communications.
- Communications were provided to support the roll out of a new Do Not Attempt Cardiopulmonary Resuscitation form for all sites with communications cascade for all clinical areas

Media

- May was another busy month for media, with us responding to more than 130 enquiries. The month was dominated again by queries regarding COVID-19. The specific topics of media interest have included:
  - Visitor policy for DHB facilities at Alert Level 2
  - Compassionate exemptions to visitor policies
  - The use of 'COVID-19 wards' throughout the DHB's COVID-19 response
  - Facilities projects completed by the DHB as part of our COVID-19 response

- CBACs and sentinel testing
- The potential for COVID-19 transmission in Canterbury via Lyttleton Port
- The impact of COVID-19 on the DHB's mental health services
- The experiences of someone in one of our 'quarantine hotels'
- The Rosewood rest home cluster
- The George Manning COVID-19 cluster
- Disciplinary action taken against staff speaking to media during the pandemic
- Modelling done on hospital and Primary Care workloads as a result of COVID-19
- Changes to management remuneration made in response to COVID-19
- Data on PPE usage compared to this time last year
- The Living Earth workplace COVID-19 cluster
- Testing for COVID-19 in prisons
- Hospital services under Alert Level 2
- The DHB's policy on where staff were able to work after working in a 'COVID ward'
- Electives/outpatient capacity post Alert Level 3 – electives backlog

- Some of the other topics of media interest over the past month included:
  - Flu vaccine supply in Canterbury
  - The hospital shuttle service
  - An RFI for a national infection control surveillance system
  - Health impacts of dust from quarries
  - Christchurch Hospital Hagley building / Tower 3
  - Rheumatic Fever rates
  - Bowel Screening Programme roll out in Canterbury
  - Board Chair Sir John Hansen was interviewed by Radio NZ and The Press regarding the Board's decision to approve a reduced cost option for the construction of Tower 3 as part of the campus masterplan
  - Carolyn Gullery, Executive Director Planning, Funding and Decision Support, and Greg Hamilton, Team Leader, Intelligence and Transformation, were interviewed by NZ Doctor on the modelling Canterbury DHB is using to determine the impact of COVID/lockdown on hospital and primary care workloads.

LIVING WITHIN OUR FINANCIAL MEANS

- The YTD result to April continues to be favourable even after the COVID-19 impact, mainly due to a lower capital charge (relating to EQ insurance drawdowns excluded from CDHB's calculation of the payment due, as well as the June 2019 Holidays Act accrual), and depreciation (due to the delay with the Hagley transfer). Although the favourable depreciation variance is a non-operational expense, the delays in Hagley result in additional operational expense that partly offset this variance (eg, outsourced elective surgery).
- The following table provides the breakdown of the April result:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.007	(0.000)	0.007	(0.080)	(0.000)	(0.080)
Funder	(6.849)	(4.994)	(1.854)	(64.854)	(60.154)	(4.701)
DHB Provider	(12.046)	(16.942)	4.896	(51.103)	(77.705)	26.602
Canterbury DHB Group Result	**(18.888)**	**(21.936)**	**3.048**	**(116.037)**	**(137.862)**	**21.825**

4. APPENDICES

Appendix 1: Facilities Repair and Redevelopment
Appendix 2: Our People (CEO Update Stories)

FACILITIES REPAIR AND REDEVELOPMENT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

COVID–19 Response

- **Community Based Testing Centre (CBTC):** Several portacoms and other CDHB buildings were re-purposed to be test centres as part of COVID-19 response. The Aranui Community Dental Clinic test centre has subsequently been decommissioned. Decisions on the other test centres have yet to be made (Old Eyes Department adjacent to Christchurch Laboratory, Antigua/Tuam Street staff testing centre and the Christchurch Campus emergency department triaging portacoms).

General EQ Repairs within Christchurch Campus

- **Parkside Panels:** North West corner panels practical completion awarded 23 March 2020. North-East corner Request for Proposal (RFP) closed at the end of April 2020. Tenders are under review. Parkside South-East corner Registration of Interest (ROI) evaluation completed with shortlisted candidates approved. RFP documentation currently being finalised.
- **Lab Stair 4:** On hold due to COVID-19. The restart of the project will need to be coordinated with longer-term Government COVID-19 response due to the disruption that the construction work will have on the laboratories. The repurposing of the old Eyes Portacoms directly affects access for works and will need to be moved, once approvals have been received.
- **Riverside L7 Water Tank Relocation:** Maintenance and Engineering (M&E) is managing this project. Management has approved the design for tanks to be relocated to the basement of Parkside. Design has commenced.
- **Riverside Full Height Panel Strengthening:** Design is complete. The Business Case is to be submitted, for construction, to undertake this work in conjunction with the Parkside Panels project. Due to nature of work, construction work would preferably occur post staff migration to Christchurch Hagley.
- **Parkside Strengthening:** As part of the Parkside seismic strengthening works, consultants are progressing the revised Non-Linear Time History Analysis (NLTHA) on Parkside Block A. A Business Case is being prepared for Block B.

Christchurch Women's Hospital

- **Passive Fire Programme Stair 2:** The team has identified several potential passive fire targets for improvement. ROI and business case have been temporarily placed on hold due to master planning issues and re assessment of available budget allocations. The balance of fire analysis work is awaiting master plan sign off and migration dates for Hagley Christchurch before works can be programmed to complete proposed works.
- **Level 4:** Crack injection around core to be undertaken. Parent room, kitchen and toilet areas complete. Difficulties gaining access to area due to patient levels. Actively working with staff to look at options to commence the remedial and passive fire protection works.
- **Level 5:** Small amount of work to corridor unable to commence due to operational constraints - Neonatal Intensive Care Unit (NICU). Working with teams to identify a suitable time but will endeavour to pick this up during Women's Passive fire protection works and post Hagley Christchurch occupation.

- **Level 3:** All areas complete except reception, which is to be done at the same time as stair strengthening to minimise disruption.
- Remaining work for levels 3, 4 and 5 is unlikely to occur until after Hagley Christchurch occupation.

Christchurch Hagley Building

- **Ensuite Door Replacement:** Project on hold due to request from the Ministry of Health (MOH). Installation works can commence as soon as access to the building is authorised and the COVID-19 Level is reduced to a status that allows construction works to commence.
- **CT Installation:** Planning is underway to allow core drilling to proceed to allow machine to be installed – liaising with CPB/TTT for necessary permits and permissions. Equipment is on site.
- **Fluoroscopy:** Contractor, architect and subcontractors being engaged to complete enabling works for the room.
- **Emergency Department Radiology:** Scope and fit out works currently being confirmed. YSIO radiology equipment in Christchurch and stored at Fliways near the airport.

Other Christchurch Campus Works

- **Passive Fire/Main Campus Fire Engineering:** Individual Business Cases will be prepared to undertake works within specific areas of the Christchurch Campus buildings. The scope of work will require review by Fire and Emergency NZ (FENZ) and the Christchurch City Council (CCC).
  - Draft Business Case prepared for ChCh Women's Risers, requires FENZ and CCC agreement to scope of work. Procurement, Registration of interest and consent application documentation have been placed on hold due to master planning issues.
- **Christchurch Hospital Campus Energy Centre (managed by MOH):** Developed design complete with detail design now underway. Some delays have occurred due to co-ordination of design elements.
- **235 Antigua St and Boiler House (Demolition):** No work to be undertaken until the new energy centre is constructed and commissioned. This demolition project will be managed by the CDHB.
- **Parkside Renovation Project to Accommodate Clinical Services, Post Hagley (currently managed by MOH):** Planning ongoing. Still waiting on formal advice from management as to the outcome of master planning process and funding.
- **Backup VIE Tank:** This project is included as a separable portion to the Health Labs Stair 4 Project. Looking at options to add this project to panel works to enable earlier completion.
- **Seismic Monitoring System:** The Business Case for the installation phase is being circulated for sign-off. The Business Case is seeking funding for a 'mid-range' solution. RFP documents are being prepared.
- **Co-ordinated Campus Program:** Work is progressing on a co-ordinated programme to tie together the demolition of Riverside West, the relocation of clean and dirty loading docks, demolition of the Avon generator building, Parkside Panel replacement/repairs. Relocation of food services building and clinical support staff requirements in the lower ground floor (LGF) of The Hagley Christchurch are on hold as part of this tranche of

works due to uncertainties around funding. This will provide insight into timing, relocation requirements and potential sequencing issues. It is still subject to confirmation of who goes where and subsequent endorsement in relation to the MOH led campus master plan. It is also dependant on which components of work will be MOH or CDHB managed.

- **Avon Switch Gear and Transformer Relocation:** Design complete. Project is on hold as it is coordinated with Christchurch Hagley commissioning. This is being managed by the M&E team.
- **Avon Generator Building Demolition:** Business case for concept design has been approved. Building redundant once new Christchurch Hagley generators commissioned. The site will provide space for relocated loading docks. Work cannot commence until after go-live of Hagley Christchurch and bedding period for new generators.
- **Riverside Loading Docks:** User group meetings have been held during the month. Consultants are working remotely to develop concept design (sketches and layouts) for discussion and further development.
- **Cancer Centre Radiology:** A design and budgeting project has been completed for the proposed Cancer Centre to initially house two LINAC machines while considering longer term requirements. The investigation work has developed floor plans and provided an assessment of the feasibility of phased building construction to minimise initial CAPEX.

Canterbury Health Labs (CHL)

- **Anatomical Pathology (AP):** Initial planning of options for repatriating AP from School of Medicine has commenced. A design team has been engaged and briefed, and initial bulk and location options have been developed. Awaiting CHL management to discuss/select an option on which the business case for Concept Design can be progressed.
- **Core Lab (High Volume Automation) Upgrade:** Design team has been engaged and briefed. Initial advice provided to the CHL team in support of the equipment RFP process. This project is being managed by M&E due to its size and relatively straight forward process.

Burwood Hospital Campus

- **Older Persons Health (OPH) Community Team Relocation:** Repurposing of the old Burwood Administration area will need to be reassessed to accommodate community teams.
- **Mini Health Precinct:** The Artificial Limb Service (ALS) has withdrawn its proposal of building on the old maternity unit site. The project is currently being reassessed.
- **Earthquake Repairs:** Six buildings have outstanding earthquake repair work to be completed. Consultants have been approached to assist with initial scoping work, which will be coordinated with Maintenance. Initial consultant site visits (as part of the tender process) were held 19 May 2020.

Hillmorton Hospital Campus

- **Hillmorton SMHS:** Detailed design phase progressing. Green Star 4 funding approved and consultant engagement underway. The impact of Greenstar and COVID-19 on programme will need to be assessed and incorporated once more details are known. The Cultural Narrative is now being developed.
- **Laundry Repurposing:** Initial concept design to relocate the Design Lab is underway. The relocation of CAF Outpatients to the laundry is also being investigated.

- **Fergusson Upgrade:** Admin Relocation initial planning underway prior to Business Case submission. In the process of setting up User Group Meetings with Mental Health team.
- **Food Services Building:** The Engineer is working on updating the Detailed Seismic Assessment (DSA) of the building. Once completed a site visit will be undertaken to allow for physical assessment of the building. This has been held up as a result of COVID-19. ROI documentation for the main contractor has been completed awaiting internal CDHB sign-off prior to loading on GETS.
- **Cotter Trust:** On-going occupation being resolved as part of overall site plan requirements.
- **AT&R:** Construction work is back underway following Covid-19 restrictions. Costs of delay are being collated for scope change preparation. Full impact of delays and ongoing restrictions to construction programme are yet to be determined.
- **Masterplan:** Cost and programme review has been completed and the report submitted.

The Princess Margaret Hospital Campus

- **Child, Adolescent and Family (CAF) relocation:** Project is at the early feasibility stage to identify an alternative location for CAF Outpatients. Options to be assessed include lease, relocate to Hillmorton Laundry building and/or new build. Investigation is delayed because site visits to several potential locations could not progress due to COVID-19.

Ashburton Hospital & Rural Campus

- **New Boiler and Boiler House**: Project being managed by M&E.

Other Sites / Work

- **Central City Health (Endoscopy and Maternity):** Schedule of accommodation and RFP have been prepared and submitted for approval before issuing to the shortlisted respondents from the ROI process completed in December 2019.
- **Chatham Island Accommodation:** Business Case has been prepared and submitted. Price estimates for a range of building layouts have been provided to the Business Case author.
- **Rangiora Demolition:** Business case to demolish the old building and widen the existing driveway to make way for the new Community Health Centre has been submitted for approval. An ROI for a contractor has been prepared.
- **Selwyn Health Hub:** Project Management Plan being prepared. Consultants have been appointed. Preliminary Design about to start. An ROI for a main contractor is being prepared.

Project/Programme Key Issues

- COVID-19 is delaying/temporarily stopping some projects, however, many in the design phases have continued using remote networking. Actual time and cost impacts relating to this are still being quantified.
- Sign off on the direction of the Master Planning process is required to plan the next stage of the Programme of Works (POW), Passive Fire and Parkside Panel rectification works.
- Delays to the POW continue to add risk outside the current agreed Board time frames. Key high-risk areas of Panel replacement commenced, as instructed by CDHB Board.

- Access to NICU to undertake EQ repairs to floors continues to be pushed out due to access constraints. Work in these areas will not be possible until the Hagley Christchurch project is complete and space elsewhere on the campus becomes available.

OUR PEOPLE (CEO UPDATE STORIES)

Canterbury District Health Board
Te Poari Hauora ō Waitaha

- International Nurses' Day was marked with a story in the CEO Update featuring nurses speaking on: "I love my job…..", "Being a nurse means…." and "I chose nursing….". Nurses spoke enthusiastically about their career, saying they enjoy the variety of the role, that nursing for me will never be 'just a job', that it is satisfying knowing they are making a difference by improving people's health outcomes and that they have the best job in the world.

- Nurses Katie O'Byrne and Mereraina (Ashleigh) Porima are the successful recipients of this year's Kia Kaha scholarships. The scholarships were established last year by the College of Nurses Aotearoa for registered nurses or nurse practitioners involved at any stage of care following the mosque attacks on March 15. They consist of two $500 professional development scholarships. Katie, who is Charge Nurse Manager of Ward 10, Christchurch Hospital, will use the funds towards a project she is carrying out examining the level of sick leave after the Canterbury earthquakes and the Christchurch mosque attacks. Her aim is to evaluate the impact of these events on nurses' health and wellbeing. Nurse Educator, Mereraina, a former mental health nurse, is currently completing her Master's degree in Nursing at the University of Otago. The money will go towards her studies that will eventually provide evidence based research to understand some of the enablers and barriers for Maori accessing mental health services.

- During the COVID-19 situation a security guard on the Christchurch campus has been impressing with her fantastic people skills and dedication to her job. Security Guard Jeannie Te Poono, has been working at the Christchurch Women's Hospital front entrance, alongside the nurse team, screening all visitors and patients arriving, as well as staff coming and going. Jeannie's customer service approach and verbal de-escalation skills are exemplary, says Service Manager Women's Health Michele Pringle. Along with the screening and physical distancing tasks asked of her she also engages with parents, patient arrivals and parking issues with ease and confidence but in an empathetic way.

- May 31 was World Smokefree Day, and the occasion was marked in various ways around the country and the world. The focus in Canterbury was on promoting and celebrating smokefree pregnancies as the best way to protect pēpi (babies) from Sudden Unexplained Death in Infancy). Te Hā – Waitaha Smokefree Canterbury and Te Puawaitanga Ki Ōtautahi Trust teamed up to offer Cantabrians the chance to win a wahakura (woven harakeke bassinet) prize pack. There are currently no restrictions on where cigarettes can be sold in Aotearoa, even though they are R18 products. The Cancer Society had a poll on their Facebook page asking if cigarettes should only be sold in R18 Specialist Tobacco shops. People were invited to take part in the poll and share it to their social media pages.

Christchurch Hospital Hagley – facilities development communication

- COVID-19 activity has mostly disrupted facilities communications, however we were able to carry out and record a small blessing of sections of Hagley.

- As we look toward firmer dates for handover of the building, consideration is being given to requirements for orientation and migration collateral.

- To assist with training of staff in their new areas, a refreshed healthLearn package has been developed to include new or additional information that has been updated since release of the first package, and videos of training sessions will be provided to ensure staff and trainers will be able to refresh their knowledge prior to occupation.

- Additional videos are being produced to assist with orientation and familiarisation of the building. These videos feature footage and photographs from inside Hagley along with 3D renders and floor plans to illustrate the location of wards and services within the building.

The Blessing of areas of Christchurch Hospital Hagley

- **Maps and wayfinding:** The Communications Team is helping produce maps for transit routes for patient and staff migration and assisting with wayfinding strategies for patients, staff and visitors.

- **Website: Highlights – May/June 2020**
  - The CDHB public website continues to publicise frequent COVID-19 and health service related updates for people in Canterbury.
  - Public interest in this information peaked in mid-April with over 50% more visits than normal, however demand for information continues to be higher than normal.
  - To date, we have received more than 55,000 visits to our main COVID-19 information page.

  Of note:
  - For the first time the website has hosted a playable audio recording of a board meeting.
  - A multi-person change of contact details form has been developed to make this process more efficient for people.
  - The ability to schedule content changes at any time has been developed for easier publishing, particularly in periods out of normal office hours.

  Recent website feedback about what worked well for people…

• Information that I got from this page made all the difference. Thankyou
• It was easy to find and fill out the form for my inquiry, concise, well laid out and not complicated
• Easy access to the information I needed. thank you
• Knowing the circumstances of my home town re COVID-19…
• Knowing who to call if worried about something
• The opportunity to express my appreciation of my care the hardworking nursing staff in difficult circumstances.
• List of CBACs. Couldn't find that info when searching 10 days ago.
• Being able to express my appreciation of the care I received.
• Simple and easy way to provide feedback
• Ability to send suggestion to CDHB.

• All the information that I needed for my request was available and appropriate - thank you
• I could print out for work. Quick and efficient.
• Quite easy and straight forward to use
• Showing myself exactly where you are as requiring urgent blood test prior to a CT Scan.
• Seeing what dentists were available close to where we live.
• Simple, clear form; easy to follow. Convenient way to get in touch. Thank you.
• Access to email and other programmes and service desk…

FINANCE REPORT 30 APRIL 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **David Green, Financial Controller, Corporate Finance**

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

DATE: **18 June 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the consolidated financial result (before comprehensive income) for the month of April 2020 is a net expense of $18.888M, being $3.048M favourable to plan, and year to date $21.825M favourable to plan;
ii. notes the operating result (pre indirect items) for the month is unfavourable to plan by $738k, year to date $2.268M unfavourable to plan;
iii. notes that cost associated with the Whakaari tragedy (excluding IDF) as included in the year to date operating result is in excess of $1M, with no confirmed associated funding;
iv. notes that net costs associated with COVID-19 pandemic as included in the month of April results are $8.071M, and year to date $8.900M;
v. notes liquidity (cashflow) risk continues to be a significant concern without any sustainable long term resolution; and
vi. notes that we are awaiting a Ministry decision on our request for the exclusion of EQ insurance capital in excess of capital impairment from the standard capital charge calculation, the financial impact of which, if declined, is a $12.5M additional capital charge expense in the current financial year.

3. DISCUSSION

Overview of April 2020 Financial Result

Summary DHB Group Financial Result

The following table provides the breakdown of the April result:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate	(11.405)	(16.738)	5.333	(50.813)	(77.520)	26.707
Community & Public Health	(0.196)	(0.036)	(0.160)	(0.350)	(0.150)	(0.199)
Total In-House Provider excl Subsidiaries	**(11.601)**	**(16.774)**	**5.173**	**(51.163)**	**(77.670)**	**26.507**
Add: Funder & Governance						
Funder Revenue	153.917	147.639	6.278	1,489.036	1,472.656	16.380
External Provider Expense	(71.850)	(63.861)	(7.989)	(665.520)	(645.067)	(20.454)
Internal Provider Expense	(88.916)	(88.772)	(0.144)	(888.370)	(887.743)	(0.627)
Total Funder	**(6.849)**	**(4.994)**	**(1.854)**	**(64.854)**	**(60.154)**	**(4.701)**
Governance & Funder Admin	0.007	0.000	0.007	(0.080)	0.000	(0.080)
Total Canterbury DHB (Parent)	**(18.443)**	**(21.768)**	**3.325**	**(116.097)**	**(137.824)**	**21.727**
Add: Subsidiaries						
Brackenridge Services Ltd	(0.076)	(0.101)	0.024	0.194	0.018	0.176
Canterbury Linen Services Ltd	(0.368)	(0.067)	(0.302)	(0.133)	(0.055)	(0.078)
Canterbury DHB Group Surplus / (Deficit)	**(18.888)**	**(21.936)**	**3.048**	**(116.037)**	**(137.862)**	**21.825**

The YTD result to April continues to be favourable even after the COVID-19 impact, mainly due to a lower capital charge (relating to EQ insurance drawdowns excluded from CDHB's calculation of the payment due, as well as the June 2019 Holidays Act accrual), and depreciation (due to the delay with the Hagley transfer). Although the favourable depreciation variance is a non-operational expense, the delays in Hagley result in additional operational expense that partly offset this variance (eg, outsourced elective surgery).

4. KEY FINANCIAL RISKS

Liquidity risk continues to be a key issue. In April we received $130M additional equity that has alleviated our immediate liquidity issue. The risk will be brought forward by the move to 10 day payment cycles as endorsed by MBIE. Cashflow forecasts indicate we would breach our overdraft limit around the end of July 2020. The MoH have yet to formally confirm that DHBs are expected to move to a 10 working day payment cycle. Being a large organisation there are inevitably variations in the daily cashflow, so it is prudent to have a small tolerance to allow for payments that cannot be withheld without significant detrimental impacts on CDHB. We continue to actively manage and mitigate the issue, and continue to send weekly detailed cashflow forecasts to the MoH. We have also continued to raise the need for the MoH to be planning within the permitted mechanisms to mitigate the liquidity risk; at this stage no long term solutions have been clearly identified.

COVID-19 – the forecasted impact of COVID-19 on CDHB's performance is dependent on a number of uncertain parameters, and the long term impact will take some time to determine, and will include factors such as elective revenue, IDF revenue, and ACC revenue, and the costs associated with these (e.g. what level of outsourcing is required to

catch up on lost throughput). Refer Appendix 1 for estimated costs to date and forecasted full year costs.

Industrial Action -The industrial action taken earlier in the year impacts our YTD elective services and other key critical services such as radiology and cancer treatment. This has had a significant detrimental financial impact YTD.

Certain new **Ministry of Health initiatives** have cost implications for CDHB (eg, the national bowel screening programme, as noted in previous months).

The new **Hagley facility** becoming operational in 2020 will add stress points to the operating result of CDHB; this includes the continued delays and uncertainty in its scheduled handover which has both performance and financial downsides.

At this point no funding has been made available to cover the costs of the **Whakaari incident** incurred to date. The Whakaari incident has also impacted on the delivery of electives and IDF volumes. (Note that Counties-Manukau DHB have taken the lead and are discussing possible funding with ACC. We are awaiting a final outcome to these negotiations.)

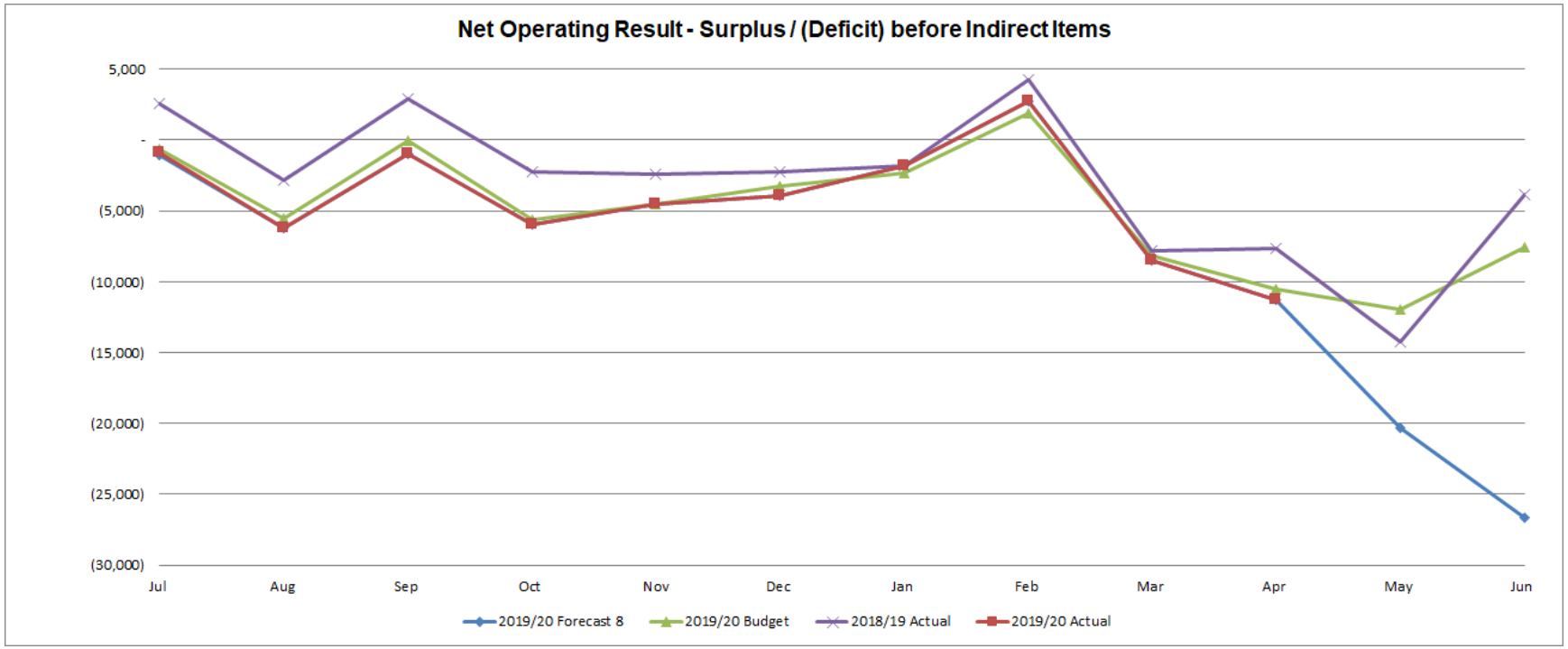
5. APPENDICES

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

APPENDIX 1: FINANCIAL RESULT (BEFORE INDIRECT ITEMS)

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 30 APRIL 2020

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2018/19 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
Surplus/(Deficit) before Indirect items	(11,287)	(10,549)	(738)	7% ✗	(41,105)	(38,837)	(2,268)	6% ✗	(100,335)	(88,217)	(58,337)	(29,880)	51% ✗



NB: The June 2019 result in the above graph excludes the one off Holiday Act compliance accrual for comparison purposes.

KEY RISKS AND ISSUES

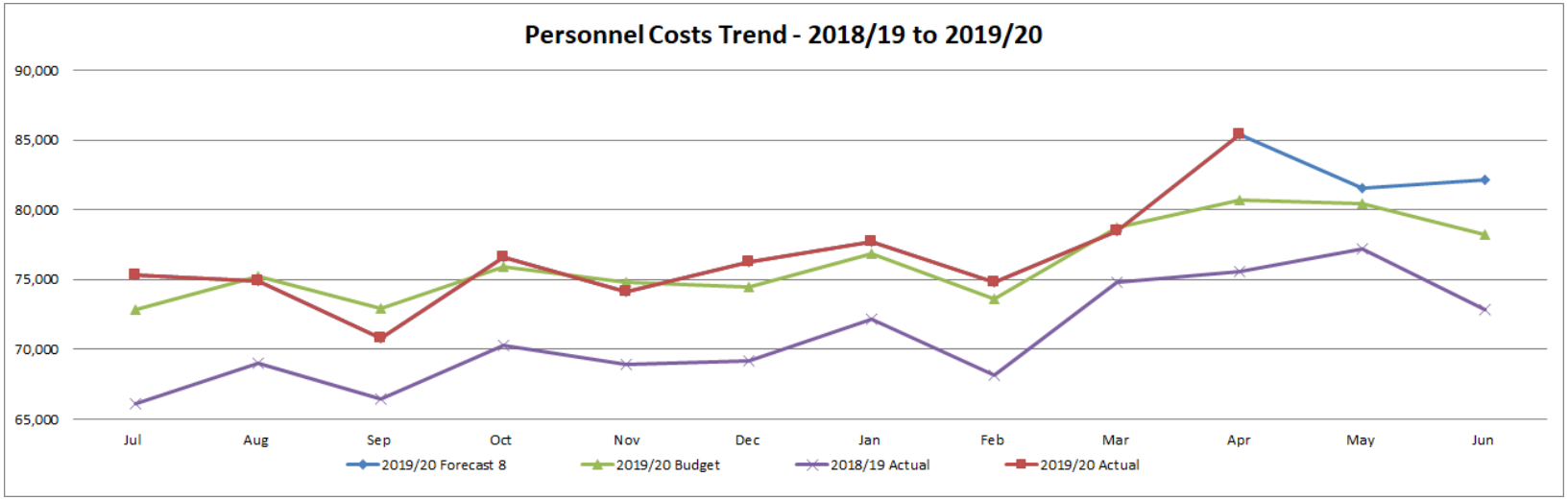
- This graph shows the operating result before indirect items such as depreciation, interest, donations, capital charge and the offsetting capital charge funding.
- In the month of April CDHB incurred a net $8.071M of COVID-19 pandemic related costs ($8.9M YTD). Adjusting for these costs, our result would have been $7.3M favourable for the month.

- The following table shows the impact of COVID-19 on the month, YTD, and full year forecast:

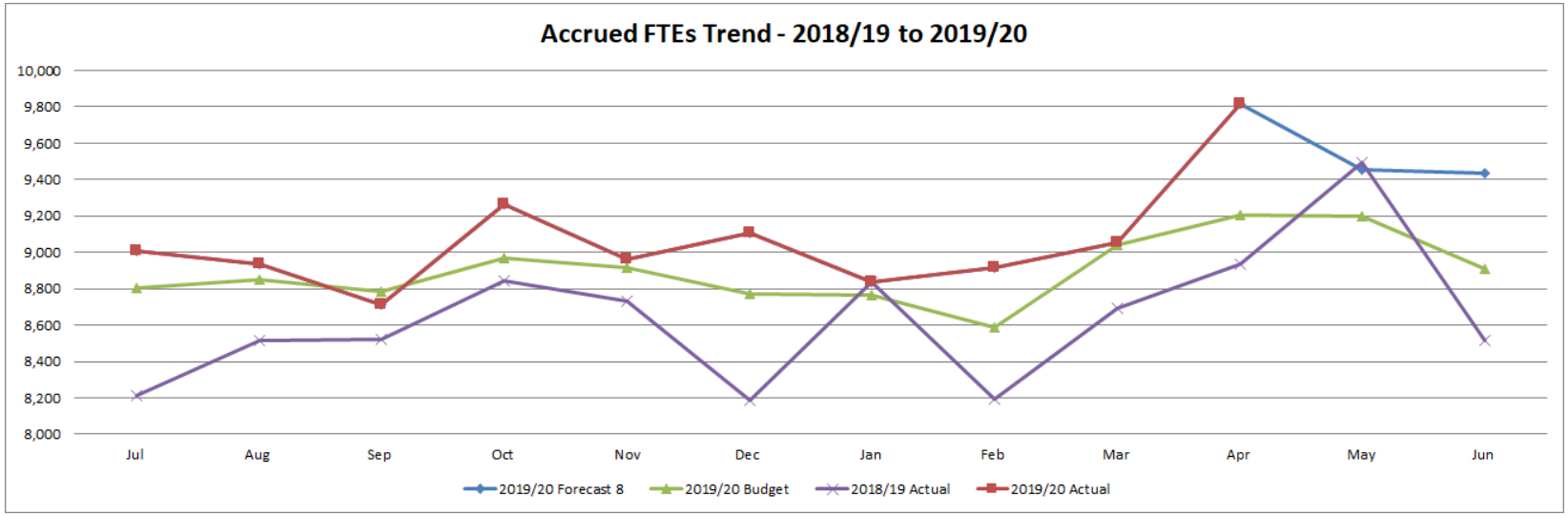
	Period to date							Year to date							Full Year						
April 2020 Result Snapshot	Month Actual $000	Month Budget $000	Month Variance F/(UF)	Covid-19 $000	Excl Covid-19 $000	Month Budget $000	Underlying Variance	YTD Actual $000	YTD Budget $000	YTD Variance F/(UF)	Covid-19 $000	Excl Covid-19 $000	YTD Budget $000	Underlying Variance	Full Year F'cast $000	Full Year Budget	Variance F/(UF)	Covid-19 $000	Excl Covid-19 $000	Full Year Budget	Underlying Variance
MOH Revenue	(159,134)	(152,346)	6,788	(6,549)	(152,585)	(152,346)	239	(1,544,179)	(1,524,642)	19,537	(9,149)	(1,535,030)	(1,524,642)	10,388	(1,856,064)	(1,829,389)	26,675	(8,962)	(1,847,102)	(1,829,389)	17,713
Patient related revenue	(3,766)	(4,091)	(325)	657	(4,423)	(4,091)	332	(43,564)	(40,898)	2,666	657	(44,221)	(40,898)	3,323	(51,385)	(49,121)	2,264	657	(52,042)	(49,121)	2,921
Other Revenue	(3,066)	(4,051)	(985)	821	(3,887)	(4,051)	(164)	(35,494)	(43,654)	(8,159)	821	(36,315)	(43,654)	(7,338)	(44,319)	(51,708)	(7,389)	4,524	(48,843)	(51,708)	(2,865)
Revenue	(165,966)	(160,488)	5,478	(5,071)	(160,895)	(160,488)	407	(1,623,237)	(1,609,194)	14,044	(7,671)	(1,615,566)	(1,609,194)	6,373	(1,951,768)	(1,930,218)	21,550	(3,781)	(1,947,987)	(1,930,218)	17,769
Employee expenses	85,386	80,738	(4,648)	3,588	81,798	80,738	(1,060)	764,453	756,304	(8,149)	3,783	760,670	756,304	(4,366)	928,210	915,003	(13,207)	6,711	921,499	915,003	(6,496)
Treatment Related costs	10,234	14,706	4,472	1,743	8,491	14,706	6,215	131,659	135,031	3,372	2,051	129,608	135,031	5,423	164,107	164,745	638	3,634	160,473	164,745	4,272
Other expenses	9,783	11,732	1,949	510	9,273	11,732	2,459	102,710	111,628	8,919	736	101,974	111,628	9,655	123,372	135,369	11,997	936	122,436	135,369	12,933
External Provider costs	71,850	63,861	(7,989)	7,301	64,549	63,861	(688)	665,520	645,067	(20,454)	10,001	655,519	645,067	(10,453)	814,870	773,439	(41,431)	16,943	797,927	773,439	(24,488)
Total expenditure	177,253	171,037	(6,216)	13,142	164,111	171,037	6,926	1,664,342	1,648,030	(16,312)	16,571	1,647,771	1,648,030	259	2,030,559	1,988,555	(42,004)	28,224	2,002,335	1,988,555	(13,780)
Operating result	11,287	10,549	(738)	8,071	3,216	10,549	7,333	41,105	38,837	(2,268)	8,900	32,205	38,837	6,632	78,791	58,337	(20,454)	24,443	54,348	58,337	3,989
Total Indirect revenue & expenditure	7,601	11,387	3,786	-	7,601	11,387	3,786	74,932	99,025	24,093	-	74,932	99,025	24,093	91,569	122,133	30,564	-	91,569	122,133	30,564
Total Surplus/Deficit	18,888	21,936	3,048	8,071	10,817	21,936	11,119	116,037	137,862	21,824	8,900	107,137	137,862	30,724	170,360	180,470	10,110	24,443	145,917	180,470	34,553

- We have received MoH funding to cover most of the expenditure to community providers, but there are some costs that have not been funded. Other direct costs of our Provider arm are being tracked, and we are submitting weekly reports as requested by the MoH. These additional costs include Public Health costs associated with border screening and, more lately, contact tracing. Our Laboratory also has additional workload and costs associated with testing. Outpatient volumes and all elective surgery volumes have been impacted from mid March. Whilst occupancy may be lower than expected, the pandemic situation has presented unique challenges for staffing and roster modelling to ensure both staff and patient safety, which has led to higher payroll costs. We had effectively removed elective throughput from our hospital facilities in anticipation of a potential large volume of COVID-19 patients. Payroll costs also include the impact on leave taken.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE



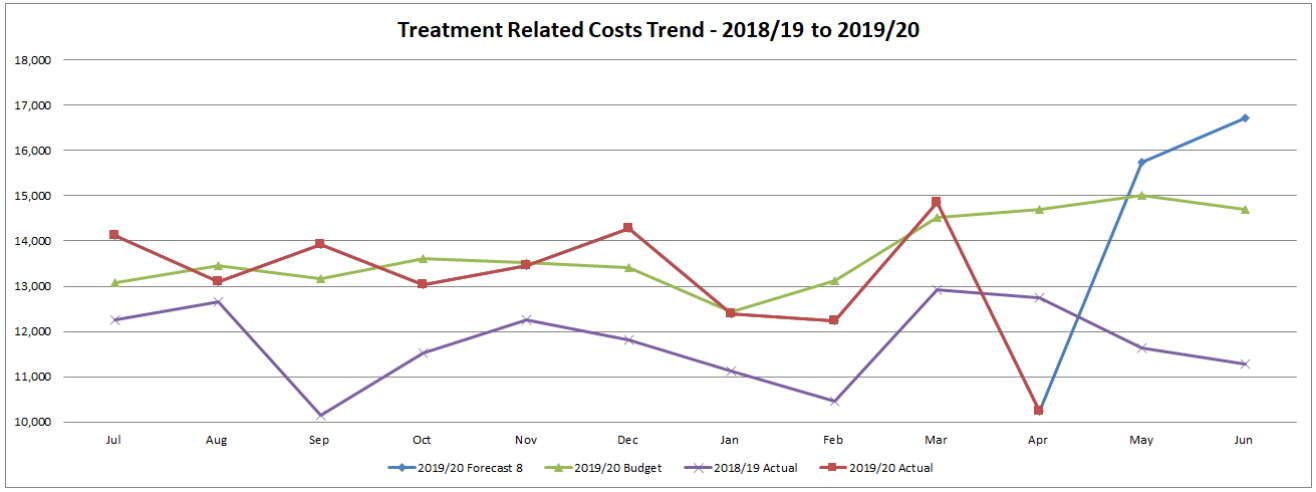
NB: June 2019 actual payroll costs in the Personnel Costs Trend graph exclude the one off Holiday Act compliance accrual of $65.260M for comparison purposes. December results reflect the first month of in-sourced cleaning services, a larger reduction in Non Treatment Related Costs has also been experienced

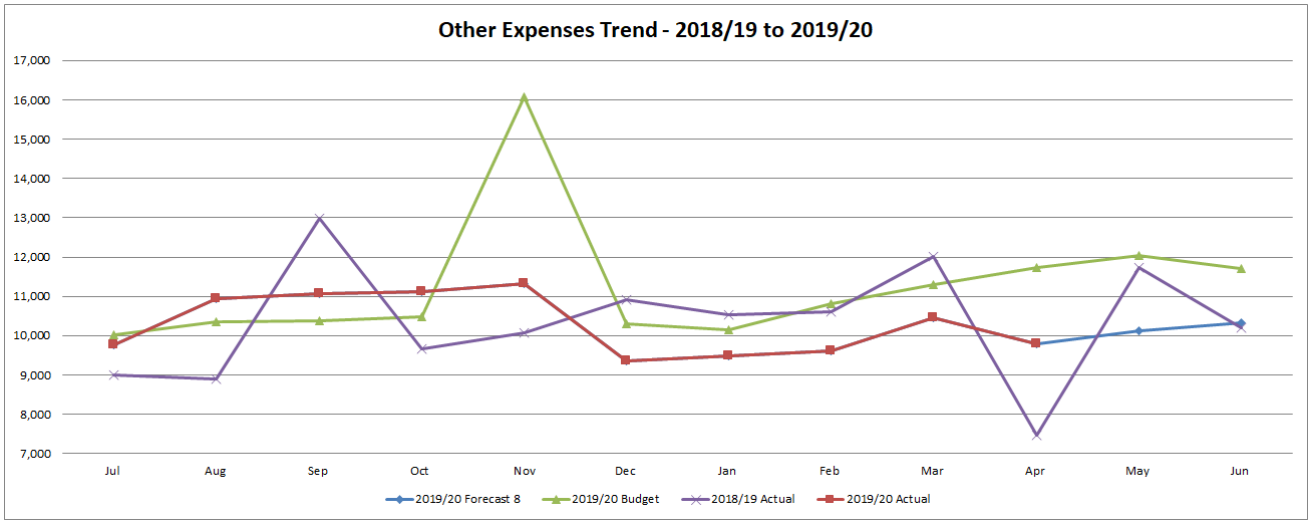


KEY RISKS AND ISSUES

- Although there continues to be a focus across the whole DHB on staff taking leave to ensure personnel costs remain on budget. Leave management initiatives have been severely disrupted with the COVID-19 issue. Senior Doctor CME leave has seen significant cancellations as well as other leave over Easter and the school holidays, in part due to the anticipation of COVID-19 cases. In addition there was FTE resource utilised for incident management of COVID-19. The Hagley delay also has impacted the results.
- We have transitioned cleaning services to an in-house model from 1 December; the payroll cost increase is estimated at $5M for the 7 months to June 2020; which is offset by an estimated $6M reduction in cleaning costs reported in Other Expenses. Cleaning staff accounted for $0.7M of the unfavourable variance for April, and $3.1M of the YTD variance; this will continue for the remainder of the year.
- Accrued FTE: The transition of cleaning from an outsourced provider to an in-house model has impacted of an additional 180 people from December 2019. FTE is higher than plan due to COVID-19. Note the FTE shown in this graph is an “accrued” FTE, and differs from contracted FTE. The methodology to calculate accrued FTE causes fluctuations on a month to month basis dependant on a number of factors such as working days (the range is 21-23 across the year), the accrual proportions, annual leave impacts (particularly school holidays, Easter, Christmas and New Year periods), etc. The accrued FTE largely correlates with the trend in contracted FTE.

TREATMENT & OTHER EXPENSES RELATED COSTS





KEY RISKS AND ISSUES

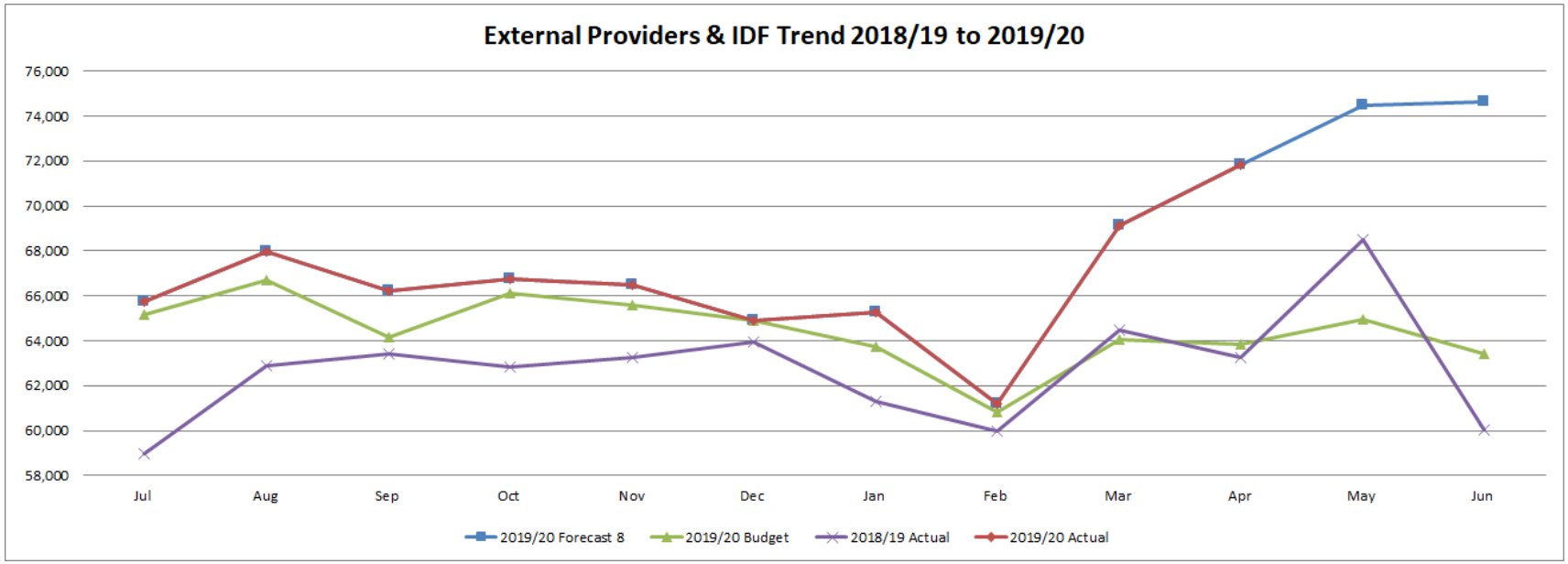
- The drop in clinical costs for the month of April is due to the disruption caused by COVID-19 with lost production. Additional costs for COVID-19 testing consumables has partially offset some of the reduced expenditure from planned activity. It is expected that these costs will come back to the previous expenditure trend quite quickly to

get through the backlog of work. Growth in pharmaceutical spend YTD is higher than planned but is being masked by an adjustment to PCT recovery costs where the budget sits in the Provider but the costs are being incurred in External Providers. Hospital pharmacy costs continue to increase, specifically immunosuppressants and cancer drugs.

- Note that the November budget for Other Expenses included $5M for the opex portion of the Tunnel handover (which will be offset by an equal earthquake programme of works drawdown). The forecast has been amended to reflect the delay in the Hagley handover to the 2020/21 financial year. YTD expenditure is $7.9M favourable due to earthquake expenditure – this is matched with an unfavourable variance in Operating Revenue.
- We have transitioned cleaning services to an in-house model from 1 December. The reduction in Other Expenses is $0.8M for April, and $4M YTD, partly offset by increased payroll costs, ie there is a savings component to this change in model.
- Security costs in our Specialised Mental Health division continue to be higher than planned. Additional facility costs continue to be incurred in relation to The Princess Margaret Hospital (TPMH) campus, including security, basic maintenance etc. Some of these additional costs are in relation to a number of mental health services that remain stranded at that site. Although we have Ministerial approval to progress a shift of services to Hillmorton, TPMH is still unlikely to be fully vacated until the 2022/23 financial year.

EXTERNAL PROVIDER COSTS

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2018/19 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
External Provider Costs	71,850	63,861	(7,989)	-13% ✗	665,520	645,067	(20,454)	-3% ✗	752,784	806,078	773,439	(32,639)	-4% ✗



KEY RISKS AND ISSUES

- External provider expenditure was $8M unfavourable - $7.3M of this relates to COVID-19 costs, but offset with $6.5M of additional MoH revenue to match.
- We were recently advised that our contribution to the national haemophilia costs has been increased by $1.6M for this financial year.
- Community pharmaceutical costs have been increasing in recent months, in line with the increase in the CPB. PCT continues to be impacted by the addition of the high cost non-PCT medicines which relate to conditions with a high prevalence in South Island populations.
- Note that part of the month, YTD and year end forecast variance relates to PCT drugs where the budget is in the Provider arm, but expenditure is being recognised in External Providers. This will be corrected in the 2020/21 financial year.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000	
Equity	617,334	1,171,470	554,135	47% ✔

	YTD Actual $'000	YTD Budget $'000	Variance $'000		2018/19 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
Cash	95,455	(5,649)	101,104	✔	(31,576)	(38,957)	(62,397)	23,440	-37.6% ✔

KEY RISKS AND ISSUES

- The equity variance to budget is due to the Holidays Act compliance provision made in June 2019 that impacted retained earnings, as well as the large increase anticipated in November 2019 related to the new Hagley facility handover which will now occur post 30 June 2020.
- We are experiencing higher cash outflows than predicted, partly due to higher capital spend on Hagley FF&E (reimbursed by the MoH, but there is a timing delay to this reimbursement), as well as on the Mental Health facilities redevelopment (we are working with the MoH to obtain equity drawdowns quarterly in advance to avoid timing issues with reimbursement).
- The sweep account was in funds at the end of April with a balance of $95M. In April we received a $130M equity injection, noting that we have an $80.5M cash advance to repay from our 4 June MoH funding. This has alleviated our liquidity issue in the short term but we will need a permanent solution over the next month or two. Taking into account the potential requirement[1] to pay suppliers within 10 working days, the date we will no longer be able to pay our debts as and when they fall due moves forward to late July 2020, and is subject to the final funding confirmation for the 2020/21 year.
- COVID-19 expenses have also added to our cashflow situation.
- We have factored in additional cash required for anticipated costs relating to the Hagley handover delay, costs to date of COVID-19, and made some allowance for potential COVID-19 costs through to 30 June 2020.
- A longer term resolution to this issue from the MoH and Treasury is urgently required to avoid CDHB defaulting on payments when they fall due.

[1] We are waiting for confirmation from the MoH to commence paying suppliers within this 10 day timeframe on a permanent basis

APPENDIX 2: CANTERBURY DHB GROUP STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

The Group financial results include Canterbury DHB and its subsidiaries, Canterbury Linen Services Ltd and Brackenridge Servies Ltd
For the 10 months ending 30 April 2020

Month					Year to Date				Annual (Year End)			
19/20 Actual 000's	19/20 Budget 000's	18/19 Actual 000's	Variance to Budget 000's		19/20 Actual 000's	19/20 Budget 000's	18/19 Actual 000's	Variance to Budget 000's	19/20 Forecast 000's	19/20 Budget 000's	18/19 Actual 000's	Variance to Budget 000's
159,134	152,346	143,066	6,788 ✓	MoH Revenue	1,544,179	1,524,642	1,449,747	19,537 ✓	1,852,157	1,829,389	1,740,486	22,768 ✓
3,766	4,091	4,789	(325) ✗	Patient Related Revenue	43,564	40,898	40,328	2,666 ✓	51,385	49,121	49,201	2,264 ✓
3,066	4,051	3,544	(985) ✗	Other Revenue	35,494	43,654	33,674	(8,159) ✗	38,601	51,708	39,747	(13,107) ✗
165,966	**160,488**	**151,398**	**5,478**	**Total Operating Revenue**	**1,623,237**	**1,609,194**	**1,523,749**	**14,044**	**1,942,143**	**1,930,218**	**1,829,434**	**11,925**
85,386	80,738	75,586	(4,648) ✗	Personnel Costs	764,453	756,304	700,641	(8,149) ✗	928,210	915,003	915,946	(13,207) ✗
10,234	14,706	12,734	4,472 ✓	Treatment Related Costs	131,659	135,031	117,872	3,372 ✓	164,107	164,745	140,795	638 ✓
71,850	63,861	63,310	(7,989) ✗	External Service Providers	665,520	645,067	624,717	(20,454) ✗	814,671	773,439	752,784	(41,232) ✗
9,783	11,732	7,411	1,949 ✓	Other Expenses	102,710	111,628	97,612	8,919 ✓	123,372	135,369	120,244	11,997 ✓
177,253	**171,037**	**159,041**	**(6,216)** ✗	**Total Operating Expenditure**	**1,664,342**	**1,648,030**	**1,540,842**	**(16,312)** ✗	**2,030,360**	**1,988,555**	**1,929,769**	**(41,805)** ✗
(11,287)	**(10,549)**	**(7,643)**	**(738)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**(41,105)**	**(38,837)**	**(17,093)**	**(2,268)** ✗	**(88,217)**	**(58,337)**	**(100,335)**	**(29,880)** ✗
36	93	60	(57) ✗	Interest Revenue	575	760	777	(185) ✗	720	939	627	(219) ✗
685	685	-	- ✓	MoH Revaluation Cap Charge funding	6,850	6,850	-	- ✓	8,220	8,220	-	-
-	748	-	(748) ✗	MoH Debt Equity Swap funding	-	2,244	-	(2,244) ✗	-	3,740	-	(3,740)
153	224	- 5	(71) ✗	Donations	3,385	2,236	3,565	1,149 ✓	3,731	2,586	4,067	1,145 ✓
-	1	1	(1) ✗	Profit on Sale of Assets	15	6	130	9 ✓	15	8	133	8 ✓
874	**1,751**	**56**	**(877)** ✗	**Total Indirect Revenue**	**10,825**	**12,096**	**4,472**	**(1,271)** ✗	**12,686**	**15,492**	**4,827**	**(2,806)** ✗
1,966	5,691	2,250	3,725 ✓	Capital Charge	21,678	42,480	20,966	20,802 ✓	25,611	53,864	24,241	28,253 ✓
6,493	7,397	4,760	904 ✓	Depreciation	63,641	68,141	45,060	4,500 ✓	78,166	83,161	54,407	4,995 ✓
13	50	47	37 ✓	Interest Expense	382	500	337	118 ✓	425	600	552	175 ✓
3	-	-	(3) ✗	Loss on Sale of Assets	56	-	6	(56) ✗	53	-	23	(53) ✗
8,475	**13,138**	**7,058**	**4,663** ✓	**Total Indirect Expenses**	**85,757**	**111,121**	**66,369**	**25,364** ✓	**104,255**	**137,625**	**79,223**	**33,370** ✓
(18,888)	**(21,936)**	**(14,645)**	**3,048** ✓	**Total Surplus / (Deficit)**	**(116,037)**	**(137,862)**	**(78,990)**	**21,825** ✓	**(179,786)**	**(180,470)**	**(174,731)**	**684** ✓

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 30 April 2020

Audited 30-Jun-19 $'000		Group Actual 30-Apr-20 $'000	Group Budget 30-Apr-20 $'000	Annual Group Budget 30-Jun-20 $'000
496,272	Opening Equity	597,378	662,639	662,639
141,600	Net Equity Injections / (Repayments) During Year	135,994	646,693	650,781
137,345	Reserve Movement for Year	(3,068)	-	-
(177,839)	Operating Results for the Period	(112,969)	(137,862)	(180,470)
597,378	**TOTAL EQUITY**	617,334	1,171,470	1,132,950
	Represented By:			
	Current Assets			
4,999	Cash & Cash Equivalents	95,455	627	627
750	Short Term Investments	750	750	750
91,010	Trade and Other Receivables	116,020	91,010	91,010
5,838	Prepayments	10,977	5,838	5,838
13,209	Inventories	15,154	13,209	13,209
14,510	Restricted Assets	14,490	14,685	14,685
130,315	**Total Current Assets**	252,846	126,119	126,119
	Less Current Liabilities			
36,575	Overdraft	-	6,276	63,024
123,935	Trade and Other Payables	162,606	133,408	123,936
14,760	Restricted Funds	14,605	14,760	14,760
245,602	Employee Benefits	250,347	180,342	180,342
420,872	**Total Current Liabilities**	520,453	348,078	382,062
(290,557)	**Working Capital**	(267,607)	(221,959)	(255,943)
	Non Current Assets			
16	Restricted Funds	16	16	16
3,225	Investment in NZHPL	3,225	3,225	3,225
890,595	Fixed Assets	887,822	1,396,090	1,391,554
893,837	**Term Assets**	891,063	1,399,331	1,394,795
	Non Current Liablilties			
5,902	Employee Benefits	6,122	5,902	5,902
5,902	**Term Liabilities**	6,122	5,902	5,902
597,378	**NET ASSETS**	617,334	1,171,470	1,132,950

Restricted Assets and Restricted Liabilities include funds held by Maia on behalf of CDHB.

APPENDIX 4: CASHFLOW

Audited 30-Jun-19 $'000		Actual 30-Apr-20 $'000	YTD Budget 30-Apr-20 $'000	Budget 30-Jun-20 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(52,680)	**Net Cash from Operating Activities**	48,824	(46,953)	(97,305)
	CASHFLOW FROM INVESTING ACTIVITIES			
(43,992)	**Net Cash from Investing Activities**	(57,786)	(60,428)	(70,913)
	CASHFLOW FROM FINANCING ACTIVITIES			
80,794	**Net Cash from Financing Activities**	135,994	133,483	137,572
(15,878)	Overall Increase/(Decrease) in Cash Held	127,032	26,102	(30,646)
(15,698)	Add Opening Cash Balance	(31,576)	(31,751)	(31,751)
(31,576)	**Closing Cash Balance**	95,455	(5,649)	(62,397)

HAC – 4 JUNE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Andrew Dickerson, Chair, Hospital Advisory Committee**

DATE: **18 June 2020**

Report Status – For:	Decision	☐	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Hospital Advisory Committee's (*HAC*) public meeting held on 4 June 2020.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from HAC's public meeting on 4 June 2020 (Appendix 1).

3. APPENDICES

Appendix 1: HAC Draft Minutes – 4 June 2020

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held via Zoom
on Thursday, 4 June 2020, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Barry Bragg; Catherine Chu; Jan Edwards; James Gough; Naomi Marshall; Dr Rochelle Phipps; Ingrid Taylor; Sir John Hansen (Ex-officio); and Gabrielle Huria (Ex-officio).

APOLOGIES
Apologies for absence were received and accepted from Sally Buck; and Andrew Brant (Board Clinical Advisor).

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

EXECUTIVE APOLOGIES
David Meates for lateness (9.17am).

IN ATTENDANCE
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
Ralph La Salle, Team Leader, Secondary Care

Andrew Dickerson, HAC Chair, opened the meeting. He welcomed new members to the Committee: Michelle Turrall as the new Manawhenua representative and two new Board members, Catherine Chu and James Gough. He noted the reappointment of external Committee members Jan Edwards and Dr Rochelle Phipps for a further three year term and took the opportunity to acknowledge the contribution of external Committee members whose terms concluded on 31 May 2020: Wendy Dallas-Katoa (Manawhenua representative) and Trevor Read.

Mr Dickerson acknowledged the contribution of everyone throughout what has been a public health emergency; across our hospital services, public health services, and laboratory services. He acknowledged that New Zealand's response has been comparatively very good and Canterbury's response has also been very good. He noted that it is not over yet and we cannot afford to be complacent.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Barry Bragg advised that he has been appointed as Chair of Paenga Kupenga Limited, the commercial arm of Ngai Tuahuriri Runanga, effective 1 July 2020.

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 (04/20)
(Moved: Barry Bragg/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 30 January 2020 be approved and adopted as a true and correct record, subject to correction of the BMI figure stated on page 5 of the minutes from '60+' to '40-45'."

3. CARRIED FORWARD / ACTION ITEMS

Item 3 – ED attendances for over 75s
Carolyn Gullery, Executive Director, Planning Funding & Decision Support, advised that analysis is being done around the over 75s. A new programme has been put in place for age residential care. She noted that we learnt during the COVID-19 response that access to afterhours general practice was variable in age residential care. From this we have built a new model platformed off the 24 hour surgery and our acute demand model, to provide better access both virtually and also through direct house calls for age residential care, to see if we can moderate back the over 75s presentations. Will be able to report back in a couple of months on the impact of the new model.

Ms Gullery further noted that during lockdown, we managed to accelerate rapidly our advance care planning. This was a targeted and focused approach for elderly people and also people with longstanding chronic conditions. Almost quadrupled the number of advance care plans and acute care plans that were undertaken or refreshed while general practice was in lockdown.

Item 4 – ESPI process, including prioritisation process and recovery plan
Ms Gullery noted that Ralph La Salle would be presenting to today's meeting on how we will deliver recovery for planned care. Further comment would be given during this item.

Item 5 – Bariatric Pathway
Status to be corrected to a report for the 6 August 2020 meeting.

The carried forward action items were noted.

The meeting moved to Item 5.

5. ELECTIVE SURGERY RECOVERY PLAN (PRESENTATION)

Ms Gullery introduced Ralph La Salle, Team Leader, Secondary Care, who is managing the elective surgery recovery plan.

Mr La Salle thanked the Committee for the opportunity to present and noted that he was presenting on behalf of everyone who had given him support and guidance while this plan was developed and was presenting on behalf of the front liners who brought all of this to life. Mr La Salle noted that whilst he walked alongside of these people during this journey he had been inspired by their ability to share their strength and unity of purpose, despite not always knowing what was going to come next. Mr La Salle shared a proverb with the Committee: "there is food

at the end of my hands" – referring to the ability to use the skills and resources we have to create success and be responsible for those resources and capabilities.

Mr La Salle's presentation covered the following:

- Managing clinical risk at restart
- Planned care:
  - Phased approach to surgery
  - Results
  - COVID capacity reduction
- Radiology restart:
  - Facility constraints
  - COVID constraints
- Oncology:
  - Medical oncology – pharmaceutical cancer treatments (*PCT*); clinics; facilities issues, MDMs; and inpatients
  - Radiation oncology – LINACs
  - Outreach
  - Wins & Learnings

Ms Gullery noted that as part of the whole recovery procedure, we are running through not only the new referrals into the system, but will be reviewing the referrals that got paused in the system and also looking at all of our long waits so we can make sure we get people back into the system with clinical priority. Addressing particularly issues of equity where the response of the system has not been appropriate. We have done some analysis to make sure that our Maori, Pacifica and Asian populations were not adversely affected any more than the whole population was affected by the pause. What we are seeing at the moment is that the reduction in access to our hospital based systems was similar across ethnicities, with the exception of Asian, which saw a significantly higher reduction, but the recovery has been slower for Maori and Pacifica. Will be addressing this directly through the work we are doing with primary care to ensure the right patients get back through the system faster. Ms Gullery advised it is about being deliberate about access, timing, transport and taking a proactive approach when people do not attend. There is a lot of work to go on in this space, but we are in a better position now than a year ago in terms of data analysis and also in terms of virtual models.

There was a query around cancer patients waiting for diagnostics. Ms Gullery advised that non-deferrable surgery went ahead. We are currently looking into issues around the diagnostic end, but it was noted that all radiology has been caught up on. Ms Gullery noted that the biggest concern, given the rate of cancer in Canterbury is higher than the rest of the country, is how many people did not present to their general practice. This is what we saw post the earthquakes – when people were identified with cancer they were further through, so were more complex and at a more invasive level because they had not stepped into the health system earlier. The 30 to 50% reduction in general practice attendance will be one of the biggest risks for us.

There was discussion around the impact of capacity reduction and what will occur when we shift to Level 1. Mr La Salle advised we are still working through what Level 1 will mean for us. Mr Meates advised that theatre throughput will struggle to get back to what it was pre-COVID-19 and that is simply due to physical issues, but it will reduce from the 13%. There are processes being worked through to remap and mitigate the impacts of that. He advised that the other issue is the six and five bedded rooms across Parkside and Riverside. Dealing with these, we will lose about 66 beds, not including another 15 that sit in the current ED component, where we cannot achieve a one metre separation on a good day. Clinical standards and protocols are being revisited in terms of how we manage complex respiratory cases in particular in very confined spaces that are contrary to what would be seen as good practice. Capacity issues will remain an ongoing part of our landscape.

In response to a query about theatre capacity nationally, Mr La Salle noted that theatre constraint has hit Canterbury more than other areas. For Canterbury we have indicated this will likely mean more outsourcing, at least until we get into Hagley where we will have more resource. Mr Meates advised that across all of the larger DHBs there are significant challenges with both catch-up and how that will be delivered out over the next 12-18 months. For smaller DHBs it is less of an issue purely and simply due to the type of cases they are doing and the capacity that sits in those areas. Ms Gullery advised that Canterbury has the advantage that due to our longstanding theatre capacity restraint our way of working with the private sector is well embedded. Work undertaken during the lockdown to cement that process means that we are better positioned than most other DHBs to use the private sector as part of our recovery.

The meeting moved to Item 4.

4. COVID-19 UPDATE

Sue Nightingale, Chief Medical Officer, presented the report which provided an update on CDHB's response to COVID-19. She also provided a presentation on the function of the Emergency Co-ordination Centre (*ECC*) and observations on the response.

Ms Nightingale noted that questions had been asked as to what we were doing when the hospitals were quiet during the COVID-19 response. She noted that just because we did not have a huge influx of COIVD-19 patients, this did not mean we could not plan for them. There was a phenomenal amount of organising that went on. We had to assume that we would be inundated with cases, as was seen in the United States for example, so that led to a wide range of activities for every single service in order to plan for care safely.

The ECC presentation covered the following:

- A brief overview of work as Incident Controller in the Emergency Coordination Centre and priorities through the COVID-19 response.
- Operational response plan objectives.
- Sites / Services
- How priorities are changing and will change as we transition to the new normal – accelerating the future.
- Key learnings and observations.
- Changes that have occurred through the COVID-19 response that if retained or adapted would accelerate the transformation of our system.

There was a query about concerns raised when it first became apparent that we may be looking at a global pandemic rather than an isolated incident in China, about intensive bed capacity across the country. Ms Nightingale noted there is a national group looking at ICU capacity. Locally, we were trying to move into Hagley early, but also had the ability to expand Wards 10 and 11. We have the ability to ramp up if we have to, but there remains the potential to be overwhelmed.

There was a comment that as a system there was a huge amount of planning, we were not really tested, and when it comes down to it it will be the public health system that will safeguard the hospitals from being overwhelmed.

Laboratory services were commended for their work during the COIVD-19 response. Ms Nightingale noted it was important to recognise that Labs work, in the same way as Community and Public Health's work, is not done with respect to the COIVD-19 response – this will be ongoing. Ms Nightingale also took the opportunity to acknowledge the work of

the Infection, Prevention and Control Team, who have been phenomenal in their advice and support to the whole of the health system, not just our hospitals.

There was acknowledgement of the people who pulled together the daily situation reports, both DHB and Ministry of Health staff. The information received was succinct, timely and useful.

There was a query around accelerating the future and what this will mean. Mr Meates advised that some of these elements are already emerging. A wide range of things have been identified through the ECC framework. We are looking to cohort into and leverage off existing infrastructures in the Canterbury health system – moving from emergency response to accelerating our future component. Some are simple and clear cut, whilst other elements need to be worked through to ensure we reach the right outcome. The challenge that all health systems have – there is a window of opportunity – the longer it goes on without embedding the changes, the likelihood of losing the opportunity gets higher.

The COIVD-19 Update report was noted.

The meeting moved to Item 6.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (05/20)
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 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."

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.30am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

HAC MEETING 4 JUNE 2020 – MEETING ACTION NOTES

Item No	Item	Action Points	Staff
	Apologies	Sally Buck and Andrew Brant – for absence David Meates for lateness	Anna Craw
1.	Interest Register	Barry Bragg – addition – Chair of Paenga Kupenga Limited	Anna Craw
2.	Minutes – 30 January 2020	Adopted – subject to clarifying correct BMI figure on page 5. *Barry Bragg / Jan Edwards*	Anna Craw
3.	Carried Forward Items	• ED attendances for over 75s – report to 6 Aug 20 meeting • Bariatric Pathway – correct status to a report for the 6 Aug 20 meeting	Carolyn Gullery Carolyn Gullery / Anna Craw
4.	COVID-19 Update	Nil	
5.	Elective Surgery Recovery Plan	Nil	
6.	Resolution PX	Adopted *Naomi Marshall / /Jan Edwards*	Anna Craw
	Info Items	Nil	

Distribution List:
Carolyn Gullery

CC: Regan Nolan

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Justine White, Executive Director, Finance & Corporate Support**

DATE: **18 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, Clauses 32 and 33, and the Canterbury DHB Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATIONS

That the Board:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting on 21 May 2020	For the reasons set out in the previous Board agenda.	
2.	Chair's Report (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
4.	Risk Appetite & Tolerance Results & Statement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Cancer Centre St Asaph Street Pre-Concept Investigation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

6.	New Zealand Health Innovation Hub Future Direction	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Child, Adolescent & Family Outpatients – Options Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	2020/21 Annual Plan Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Primary Care & CCN Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
11.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
12.	Advice to Board: • HAC Draft Minutes *4 June 2020* • QFARC Draft Minutes *2 June 2020*	For the reasons set out in the previous Committee agendas.	

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

(a) the general subject of each matter to be considered while the public is excluded; and

(b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on Clause 32(a) the particular interest or interests protected by section 6 or 7 or

section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and

(c) the grounds on which that resolution is based(being one or more of the grounds stated in Clause 32)

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