Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
carolyn.gullery@cdhb.health.nz

17 December 2019

9(2)(a) [redacted]

RE Official Information Act request CDHB 10227

I refer to your email, dated 18 November 2019, requesting information under the Official Information Act from Canterbury DHB in relation to the Detailed Business Case and Programme Business Case for the redevelopment of the Christchurch Hospital Campus as mentioned in the CEO update dated 18 November 2019. Specifically:

1. **All correspondence from the Clinical Leaders Group, or any correspondence from individual clinicians on behalf of the group, to CDHB management regarding the redevelopment of the Christchurch Hospital campus and the two business cases in 2019 up to the submission of the business cases.**

Please refer to **Appendix 1** (attached) for correspondence from the Clinical Leaders Group to Canterbury DHB Management and the Board regarding the redevelopment of the Christchurch Hospital Campus and the two business cases in 2019 up to the submission of the business cases.

Note: We have redacted information pursuant to section 9(2)(a) of the Official Information Act i.e. *"…to protect the privacy of natural persons, including those deceased".*
We have also not included correspondence previously released to Cate Broughton at the Press, CDHB 10139 at the end of July this year, which is available on our website: https://www.cdhb.health.nz/about-us/document-library/?_sft_document_type=official-information-act-response and which you will find relevant to your request.

I trust that this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Kathleen Smitheram

From:	Rob Ojala
Sent:	Thursday, 11 July 2019 6:31 p.m.
To:	David Meates; Mark Solomon
Cc:	9(2)(a) [redacted]@xtra.co.nz
Subject:	FW: Follow-up letter, meeting notes and appendices from meeting between the Minister of Health and Canterbury DHB's CLG
Attachments:	Post-meeting letter, meeting notes [and Appendicies 1 & 2] from meeting between Minister of Health and CLG 04-07-19.pdf; Pres for Minister fo Health meeting July 2019 Final.pdf

Kia Ora Te Mark and David,
[and John by CC as I believe you are on leave]

We had a constructive meeting with the Minister of Health on the 4th July 2019. This letter and additional information is a follow up to that meeting.

Kind regards,

Rob Ojala
Chair CLG

From: Rob Ojala
Sent: Thursday, 11 July 2019 6:28 p.m.
To: 'david.clark@parliament.govt.nz' <david.clark@parliament.govt.nz>
Cc: 9(2)(a) [redacted]@parliament.govt.nz>
Subject: Follow-up letter, meeting notes and appendices from meeting between the Minister of Health and Canterbury DHB's CLG

Dear Dr Clark,

Please find enclosed a letter from CLG following our meeting with you on the 4th July 2019. I have included some meeting notes [although these are not exhaustive]and associated appendices as a reflection on that meeting – and some additional information to provide further context.
Also included is a copy of the presentation.

Yours sincerely

Rob Ojala
Chair,
CDHB Clinical Leaders Group

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

The Honorable Dr David Clark
Minister of Health
Parliament Buildings
Wellington 6160

11th July 2019

Dear Minister

Follow-up to your meeting with the Canterbury Clinical Leaders Group

Thank you for taking the time to travel to Christchurch last week to meet with the Clinical Leaders Group.

We are acutely aware of the current pressures and challenges faced by the New Zealand heath system. However there is no other DHB in New Zealand that continues to work in earthquake damaged, not fit-for-purpose facilities with staff enduring the ongoing impacts of our country's largest natural disaster and recent terror event.

As a group of some of your most senior clinical leaders in NZ, we have built strong and trusted relationships with management and the executive team. Further, we have developed a deep engagement with clinical groups across primary and tertiary services. These partnerships are how we have managed to keep services operating in Canterbury for the past 8 years when services in any normal system would have disintegrated. The level of innovation, discretionary effort and use of data to manage patient flow by the hour in our hospitals and our communities is unparalleled. This has been driven by our collective desire over the past 8 years to ensure that the people of Canterbury and the wider regions we serve would *not* have access to their care compromised.

The lack of understanding and engagement over a number of years by central agencies including the Ministry of Health regarding the health and social impacts on populations following large and ongoing disasters is incomprehensible. It has compromised funding; delayed critical facility decisions; placed every clinical and support team in this DHB under extreme and unrelenting pressure; and has left us continuously picking up the consequences and the consequential insinuations. In truth, it is astounding that 8 years on we still have no pathway forward with the Ministry of Health to deal with earthquake-damaged facilities and to deliver the physical capacity that is required just to sustain services. Regardless of what decisions are now made regarding facilities, service failure is almost inevitable.

The Canterbury Health system is only just continuing to work because of goodwill and enduring relationships that exist in Canterbury.

Minister, we acknowledge that you have inherited a health sector that has been chronically underfunded and many competing capital pressures. However it is clear that the longstanding criticality of Canterbury in the national context seems not to have been fully understood and broader implications of impairment missed. Canterbury has not been the same as every other DHB for over 8 years. This DHB and us, as clinical leaders, have gone to extraordinary lengths to just keep functioning and there has been a total lack of urgency and understanding from the agencies responsible for briefing government. Since we first wrote to you about this issue on 20th July 2018 little about that appears to have changed.

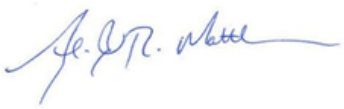
We need urgent and fast-tracked decisions regarding our facilities and an acknowledgement that Canterbury will not be business-as-usual for many years. Without this, it is important that you understand that Canterbury DHB will inevitably and dramatically be placed at risk of serious failure. Given the broad dependencies on our services by other DHBs this will have significant impact on services across the New Zealand health system. We, as clinicians, are not prepared to stand silently by while this happens.

Yours sincerely

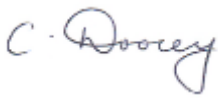
Rob Ojala
Chair, CLG

Richard French
Vice Chair, CLG

Greg Robertson
Chief of Surgery



Hector Matthews
Executive Director
Maori and Pacific Health

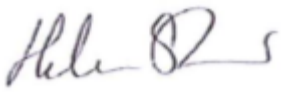


Clare Doocey
Chief of Child Health

David Gibbs
Chair of
Haematology/Oncology
Cluster

Heather Gray
DON, Medical & Surgical

David Smyth
Chief of Medicine



Helen Skinner
Chief of Older Persons Health
and Rehabilitation

Nicky Topp
Nursing Director

Joan Taylor
DON, Mental Health

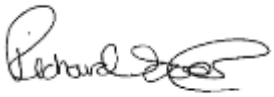
Peri Renison
Chief of Psychiatry

Emma Jackson
Clinical Director, O&G

Diana Gunn
DON, Older Persons Health & Burwood Hospital

Stu Bigwood
Clinical Lead, Mental Health

Sharyn MacDonald
Chief of Radiology

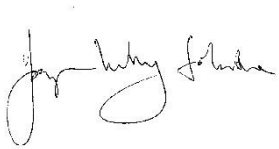


Richard Scrase
Nursing Director
Older Persons Health

Paul Tudor Kelly
Scientific/Technical Lead

Mark Jeffery
Acting Chief Medical Officer

Mary Gordon
Exec Director of Nursing



Jacqui Lunday Johnstone
Exec Director of Allied Health

Appendix 1 – Summary notes of meeting held in Christchurch on Thursday 4 July 9, 2019

The Minister of Health, Dr David Clark; Director General of Health, Dr Ashley Bloomfield; Chair of HRPG and CIC Evan Davies and the Clinical Leaders Group [CLG], Canterbury DHB met in on Thursday 4 July.

Key points:

The Clinical Leaders Group acknowledged there was pressure nationally in terms of demand on capital and signals of capacity constraint. With everyone signaling needs what makes this DHB any different?

We have an impending capacity crisis – other centres with capacity issues continue to have *options* – we have run out of capacity with no flex in the system and no room to move.

- We have managed demand on the hospital different to all other DHBs
    - This is reflected in the lowest rates of ED attendance and admission
    - If we were functioning at the national average we would admit an additional 13,000 patients annually
        - We would need at least 3 more wards now to match this number of patients.
        - Compared with similar DHBs such as Waitemata and Auckland we would need considerably more than 3 wards due to their higher admission rates.
- We have gone to exceptional lengths to optimise capacity and flow
    - This is reflected in our length of stay [note LOS has AT&R data removed as this is an acute campus]
    - We currently run an extraordinary 183 patients through each bed every year – this was 140 patients just four years ago
- We are managing with fewer buildings
    - 40 buildings have been demolished post-quakes and many staff work in Portacoms
    - Eight buildings on the main campus remain quake-*damaged* – noting, that other centres are quake-*prone* – our buildings are damaged.
- Our population has already reached the levels predicted 2024
    - We are 50,000 ahead of government projections
    - Our Maori population is the sixth largest and second fastest growing in NZ.
    - *[Not discussed at the meeting but included for information – refer appendix 2]*
        - We have the fastest growing paediatric population
        - Our Asian population has increased by 64% [to 62,320 people] – that's more than the entire population of Napier.
        - Our Pacifica population has also increased by 31% [to 14,460 people] more than the entire population of the Grey District.

- <u>We fail – New Zealand fails.</u>
  We provide care for people from the lower half of North Island and all of the South Island for a number of services.
    - We are the busiest trauma centre in New Zealand and the 5th largest in Australasia.
    - We are the second biggest provider of acute surgery and elective surgery in the country;

- Second biggest provider of oncology services
- One of only two providers of pediatric oncology, burns, spinal injury services, certain specialist mental health services, paediatric surgery, certain gynecological cancers and a tertiary provider of transplant services, stroke clot retrieval.

The Canterbury Health System has continued to operate because of

- The extraordinary *discretionary and ultimately unsustainable* efforts of staff
- The strong relationship based on trust and respect between clinicians, management and the executive team
- The strong relationships between primary, secondary and tertiary care providers
- A culture enabling of innovation which has allowed us to respond to the extraordinary challenges in ways that keep the system running to ensure people receive the treatment and care they need.
- Clinicians have an in depth knowledge of the data, the performance of the entire system including where the pressure points are and where the opportunities lie [and indeed visibility of other centres performance]. Importantly we have a culture of no secrets.
- Hospital avoidance processes have resulted in 34,000 acute attendances being avoided, with people receiving specialised care in a primary care setting [often their own home].

The system

- The system is now brittle – there is no flex or buffer zone.
- We contend that a system facing these challenges would have imploded had it not been for the goodwill and enduring relationships within our health system.
- Our DHB now has the highest sick leave rates after having the lowest only a few years ago.
- 23% of sick leave is unpaid as staff have used all their entitlement but still need to take time off to recover.
- The community are increasingly wanting answers
- Changing plans and services due to delays etc is disruptive and a massive undertaking
- Head room/fat in the system is so wafer thin that any small degradation in service will have a disproportionate impact.
- Clinical leads are very aware of the challenges –and have managed this – but we are now deeply concerned by what we see
- Even with fast track approvals the build programme demonstrates a clear gap between new capacity and demand.
- System failure is inevitable – the degree of failure depends in part on the urgent provision of further capacity as our mitigating measures are exhausted.

Facilities

- Timelines for new facilities are already too late to match demand
- Only one option [O*ption 1*] for the fast track of Towers 3 and 4 is seen as viable

- Decanting options to address quake repairs under the elongated '*Options 2 and 3'* etc are not seen as viable from an operational perspective and will create an even greater capacity shortfall.
- *Proposals for renovation* – Concern, shared by the independent health planners, that renovating existing wards would yield poor results due to the need for a new seismic shear wall and other compliance issues. The result would be
  - Lower bed numbers than current wards, which would be operationally inefficient
  - Low number of single rooms <25%
  - Low number of ensuites
  - Poor 'line of sight' and other clinical safety issues i.e. result not fit for purpose.
  - Clinical support space squeezed out of the ward
- Important to remember that the Acute Services Building [Christchurch Hospital, Hagley] was not a response to the quakes but was in train years prior to replace the outdated Riverside Building
- The perception that Canterbury DHB has 'had its share'– The reality is the new Christchurch Outpatients building, Burwood Hospital and Energy centre have all been funded by the DHB from reserves and insurance proceeds.
- The Monro-Kellie Doctrine* – where patients with increasing brain pressure [eg head injury] remain relatively well as the body goes to extraordinary lengths to compensate – but once these mechanisms are overwhelmed, the patient very rapidly deteriorates. They have minutes to live if pressure is not relieved by neurosurgery.
  *This concept was highlighted as a metaphor for the current clinical circumstance – seemingly performing well but with the compensatory mechanisms overwhelmed. The signs of system failure are apparent and will progress far more rapidly than in a system that has options.

Poor facilities are negatively and drastically impacting patient care

The current situation is not sustainable as clinical staff make do in not fit for purpose facilities. Clinicians described a number of clinical situation to illustrate the dire state of amenities:

- Infected dialysis patients side-by-side,
- Patients arresting in narrow toilet cubicles who unable to be extracted for resuscitation.
- Cardiac patients funnelling through our cath lab where other DHBs have 4-7 –[and apparently more announced shortly]
- Patients in infectious isolation in six-bedded multi-rooms with only a curtain to segregate them
- Ablutions opening into ward food preparation areas
- The fluent response to the Terrorist event of March 15 was only possible because the DHB is a high performing organisation – but the pressure from other centres to resume normal IDF activities shortly after, was a clear reflection of the impact capacity issues in this DHB have in respect to the national context.

Unsatisfactory communication & bureaucratic obfuscation

- Uncertainty remains about the congruence of the advice to the Minister coming from the DHB relative to other sources
- Extreme frustrations around the protracted campus planning process and the time and money lost in this respect. Importantly the opportunity cost is the quality of patient care which is negatively impacted due to delays. Tower 3 was originally projected at $75m but was deferred as concern about loss of competitive tension with the contractor might result in a $1m penalty – that facility is now thought to cost $150m+
- Lack of sharing information in the campus planning and Business case development– Sapere Demand Report and PWC business case given as examples – the former obtained only after it was released to the news media under the OIA
- A perception that the processes elsewhere have not required the same degree of scrutiny as the process in Canterbury, noting this process has lasted more than 3 years and well in excess of 300 meetings and 5 independent reviews of demand. The cost of clinicians and project team members attending so many meetings – almost one every 3 days with no tangible result is a gross waste of resources.

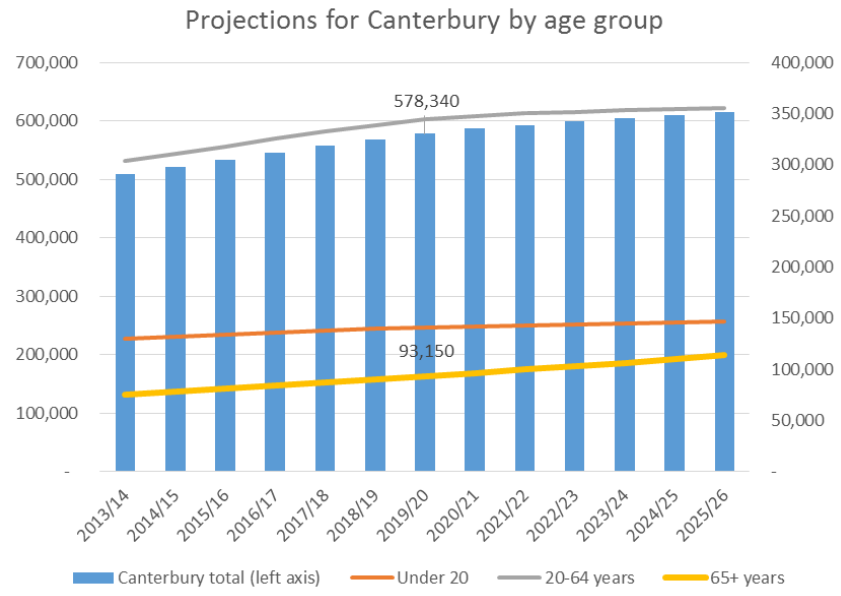
Appendix 2 – Canterbury's population

Canterbury 2019 – not Canterbury 2009

- Canterbury was historically less diverse than much of New Zealand, characterised by a well-off, European population
- This historical perception continues to exist among some people: Canterbury's population remains like it was in 2009. The earthquakes, rebuild and opportunities here have dramatically transformed our physical and socio-cultural environment into a dynamic and diverse place to live. The population is now significantly more diverse in terms of ethnicity, deprivation and health need.

The Population

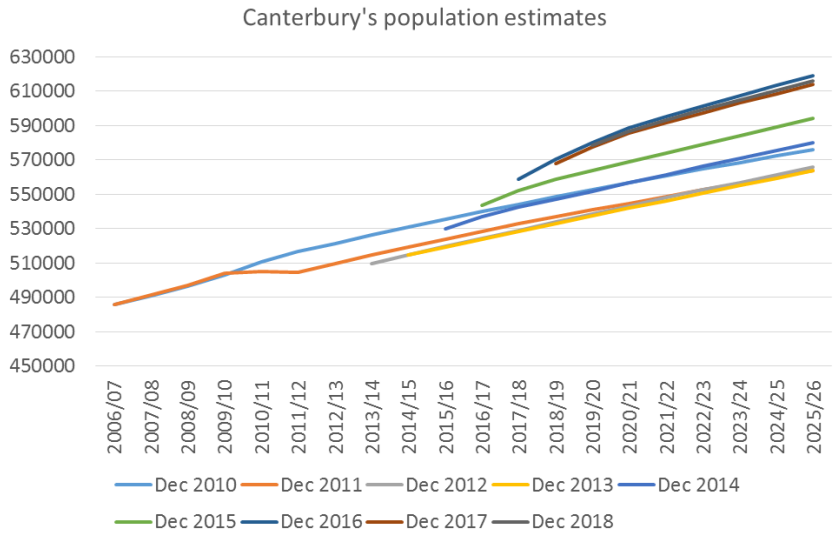
- Over the past 10 years, Canterbury's population has grown by 14%, however our population composition has changed considerably
- Our Maori population has increased by 31% (to 53,300)
- Our Pacifica population has increased by 31% (to 14,460)
- Our Asian population has increased by 64% (to 62,320)
- These populations have come with new challenges



Canterbury's population is growing faster than expected post-quakes

Over the past five years (compared with national)

- 21% faster growth in total population
- 58% faster growth in Maori
- 63% faster growth in Pacifica



DHB funded population, Stats NZ--- 2014/15 to 2018/19

Perception: Canterbury is largely European

- Facts: Canterbury has the second fastest growing Maori population by rate and by number
- Our non-Maori/Pacifica/Asian population is now 78% of the total (down from 82%)
- Our Maori population is the 6th largest nationally – larger than Maori populations in Auckland, Hawkes Bay, Lakes, Capital and Coast and Tairawhiti.

Perception: Canterbury has fewer children

- Facts: Our child population is the fastest growing in New Zealand – Under 15s are up 8% over 10 years; but Maori have increased by 23%, Pacifica by 35% and Asian are up 88%
- Canterbury has the fastest growing Maori child population by rate and second fastest by number

Deprivation

- Perception: NZDep shows Canterbury has 29% of least deprived (quintile 1) and 9% of the most deprived (quintile 5) people in New Zealand
- Facts: Proportionately, Canterbury people have the median proportion of CSC as comparator DHBs – below Waikato, Counties Manukau and Southern, but over 10% more than Auckland, Waitemata and Capital and Coast DHBs.
- Our children (0-14 years) are second most likely to have a CSC (5% fewer than Waikato and around 50% more than Waitemata and Auckland)
- Canterbury's median household income is 2% ($1,761) above the national average ($90,800)
- Our median household income is 10.6% ($9,600) lower than greater Auckland and 25% ($23,000) lower than Capital and Coast

NZDep has failed to capture the key elements of deprivation in a post-earthquake, forced migration environment.

CLG meeting with Minister of Health

4th July 2019

Common Issues in Health Systems

- “Demand is overwhelming us”
- “We are at 95% occupancy”
- “Our facilities aren’t fit for purpose”
- “We have Seismic prone buildings”

Overview

- Demand
- Capacity
- Facilities - disabling and enabling
- Current state

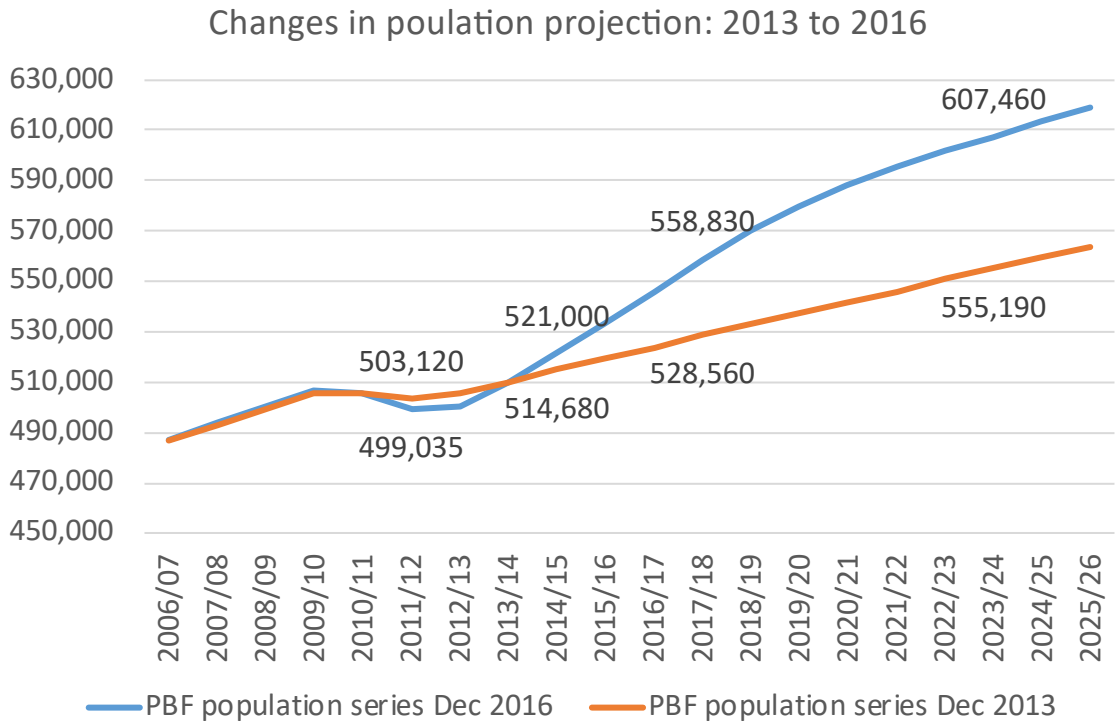
Why is CDHB any different?

Our Demand

Demand

Our population

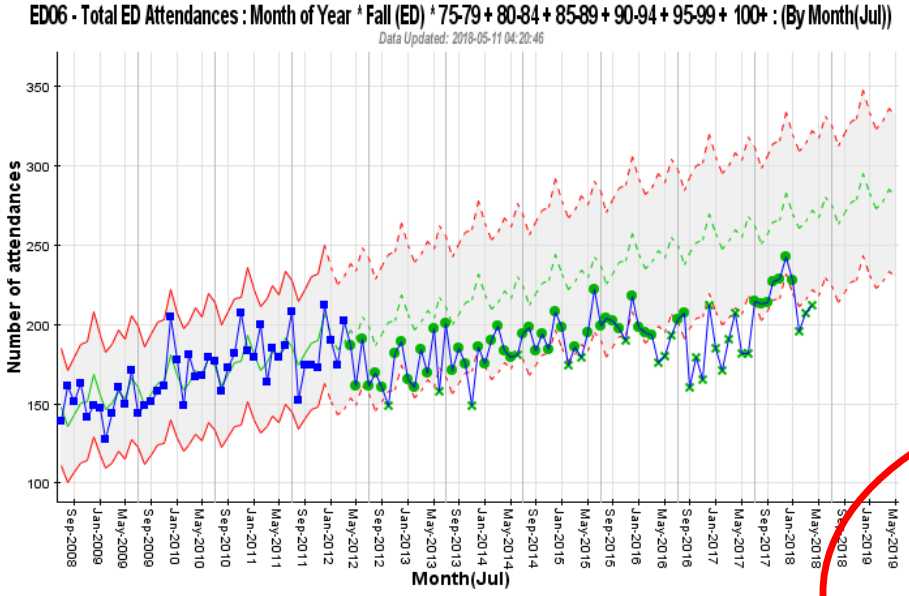
- Out population today is where it was projected for 2024



How are we reducing pressure on the Hospital?

- Examples
  - 34,000 managed via acute demand
  - COPD patients via COPD pathway – 150 fewer admissions PA
  - St John Nurse practitioners reviewing patients in home
    - Transport to hospital is 62% [lowest in NZ metros]
    - 30% of COPD patients NOT taken to hospital
  - “Outsourced/outplaced surgery”
  - Elderly advanced care directives

Demand



Fewer ED attendances for a fall (75+)

COMMUNITY FALLS PREVENTION

In six years, compared with expected (75+ years):

2,621 fewer ED attendances

766 fewer fractured NOFs

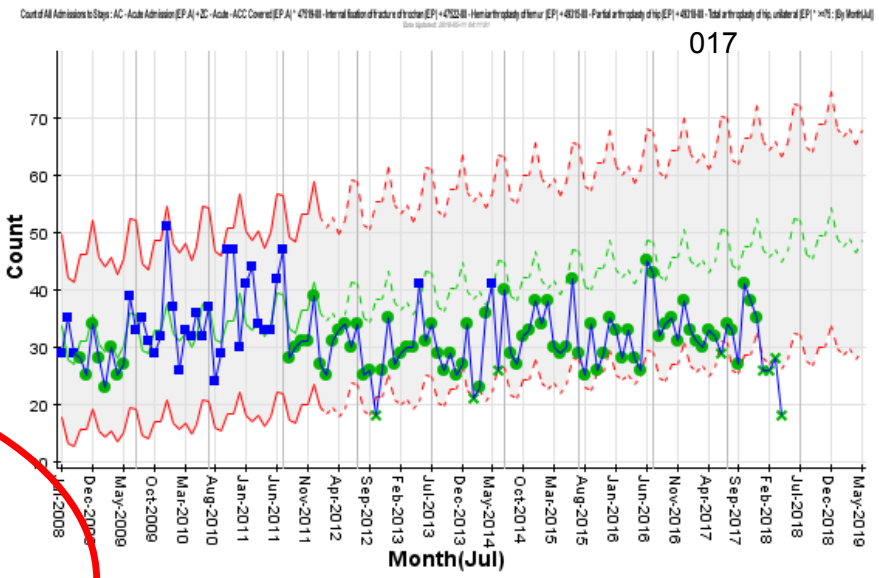
50,926 fewer NOF bed days

269 fewer deaths at 180 days

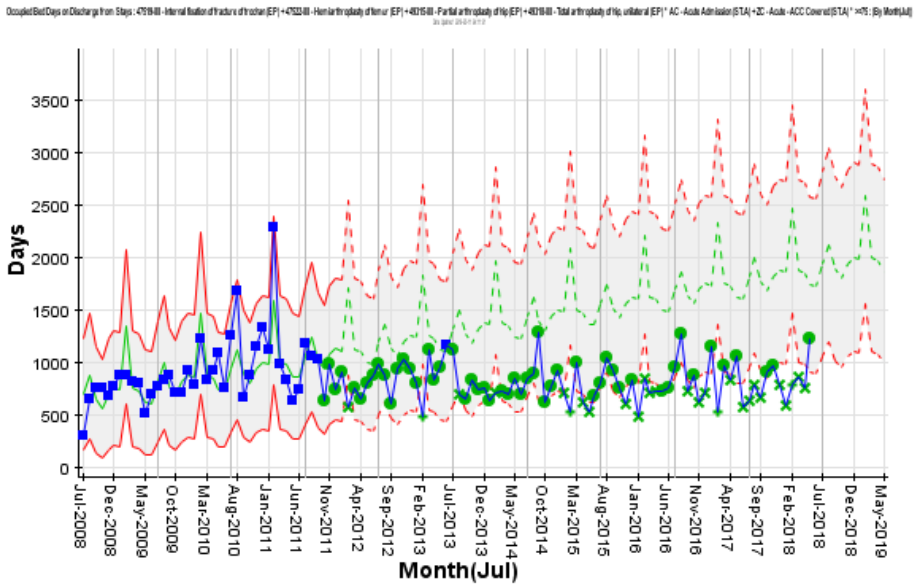
Agreed price (IDF) $815 per rehab bed day

$10.213M costs foregone in last 12 months

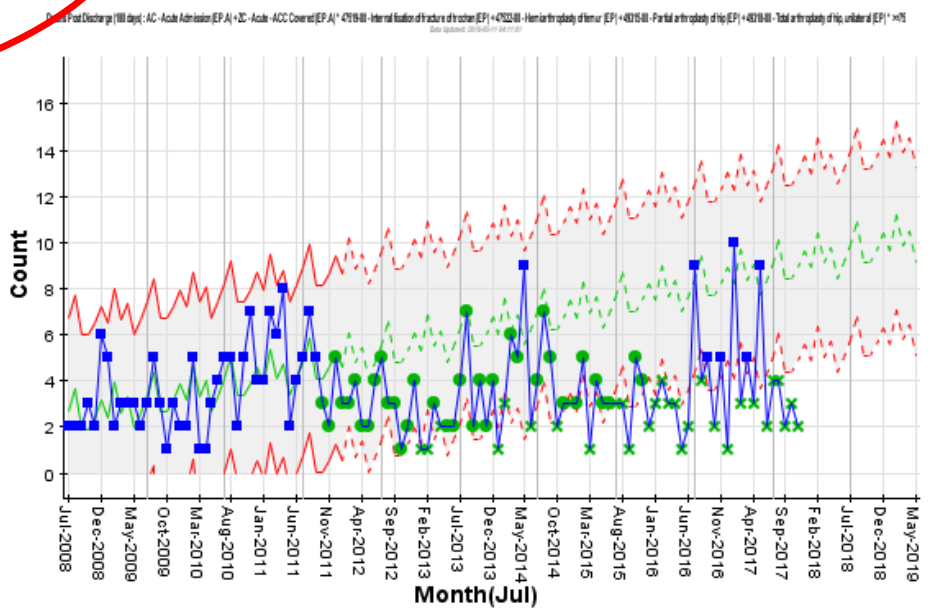
Cost: 7 FTE falls champion ($700k pa)



Fewer admissions for # NOF



Fewer bed days for # NOF



Fewer deaths at 180 days post # NOF

Admission avoidance – keeping people at home

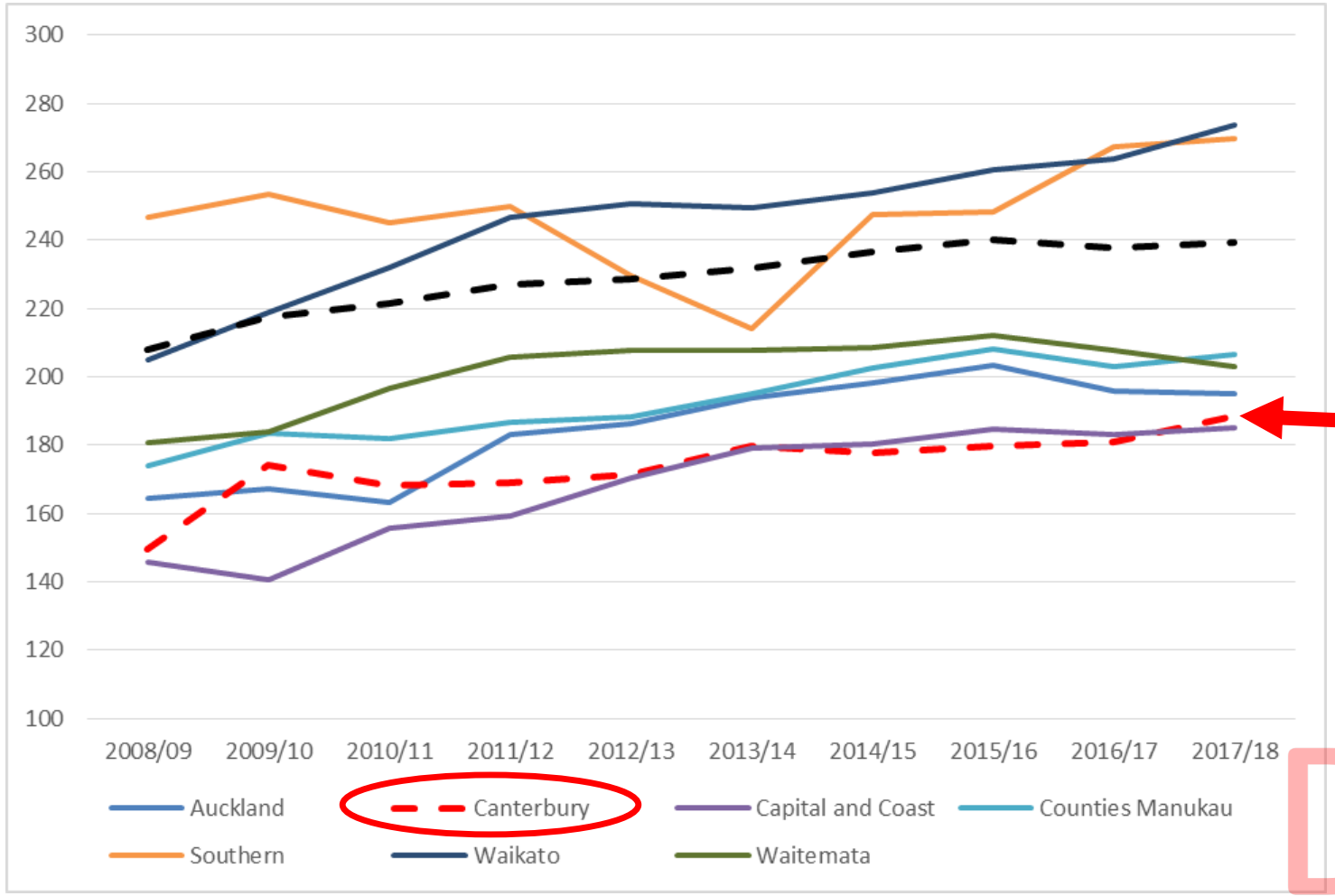
Canterbury's acute admission avoidance program enables specialist services, general practice, urgent and emergency services to support people to stay well and healthy in their own homes

If Canterbury performed at the *national average*:

- 13,000 more people would have required an acute medical hospital admission

ED presentations
Comparator DHBs (>300,000)

Age standardised per 100,000 (WHO Standard population)

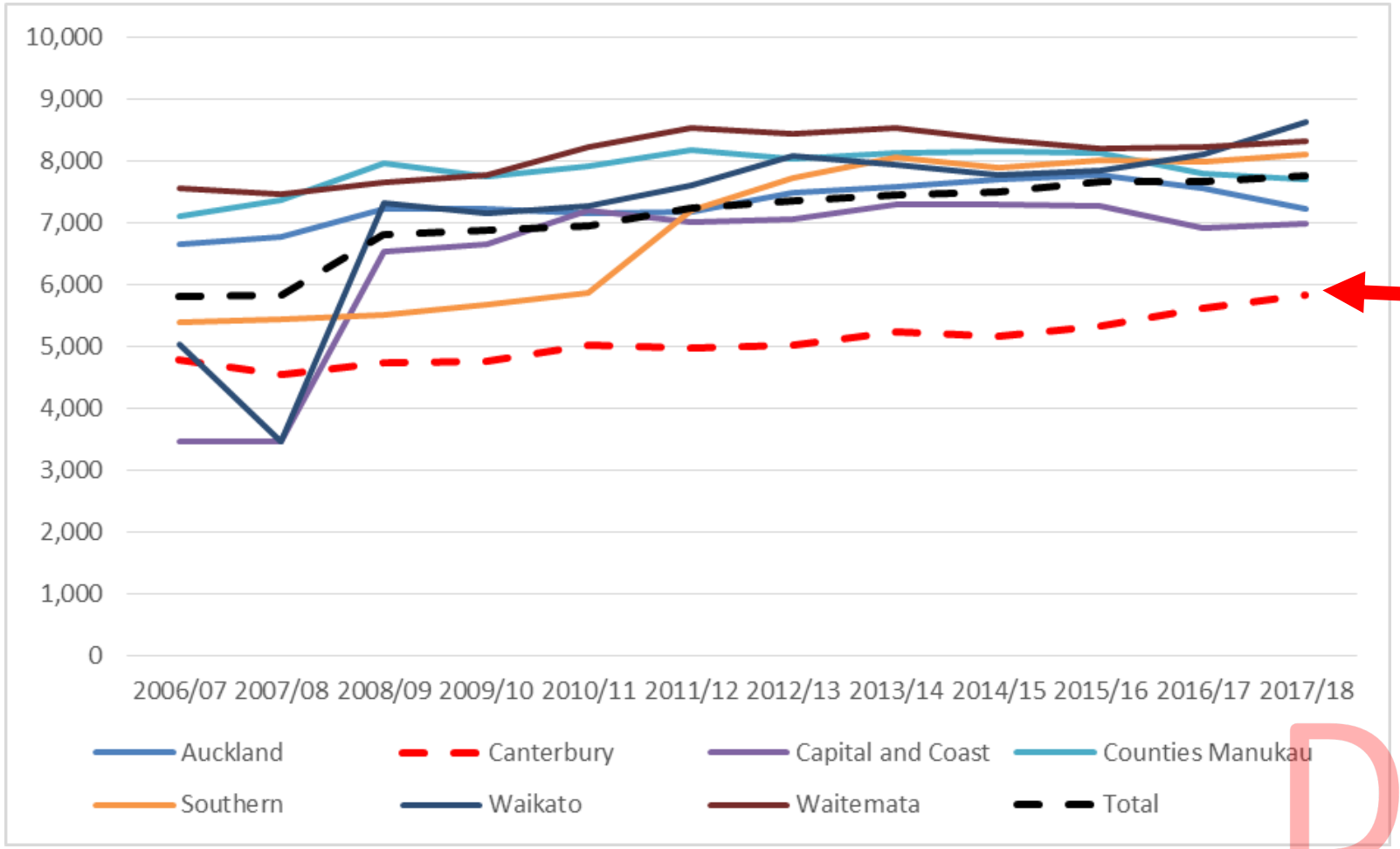


Demand

Source: NNPAC,
Stat NZ pop projections (to MOH)

Acute Medical Discharge Rate – all admissions Comparator DHBs (>300,000)

Including 0 days stay, age standardised per 100,000 (WHO Standard population)



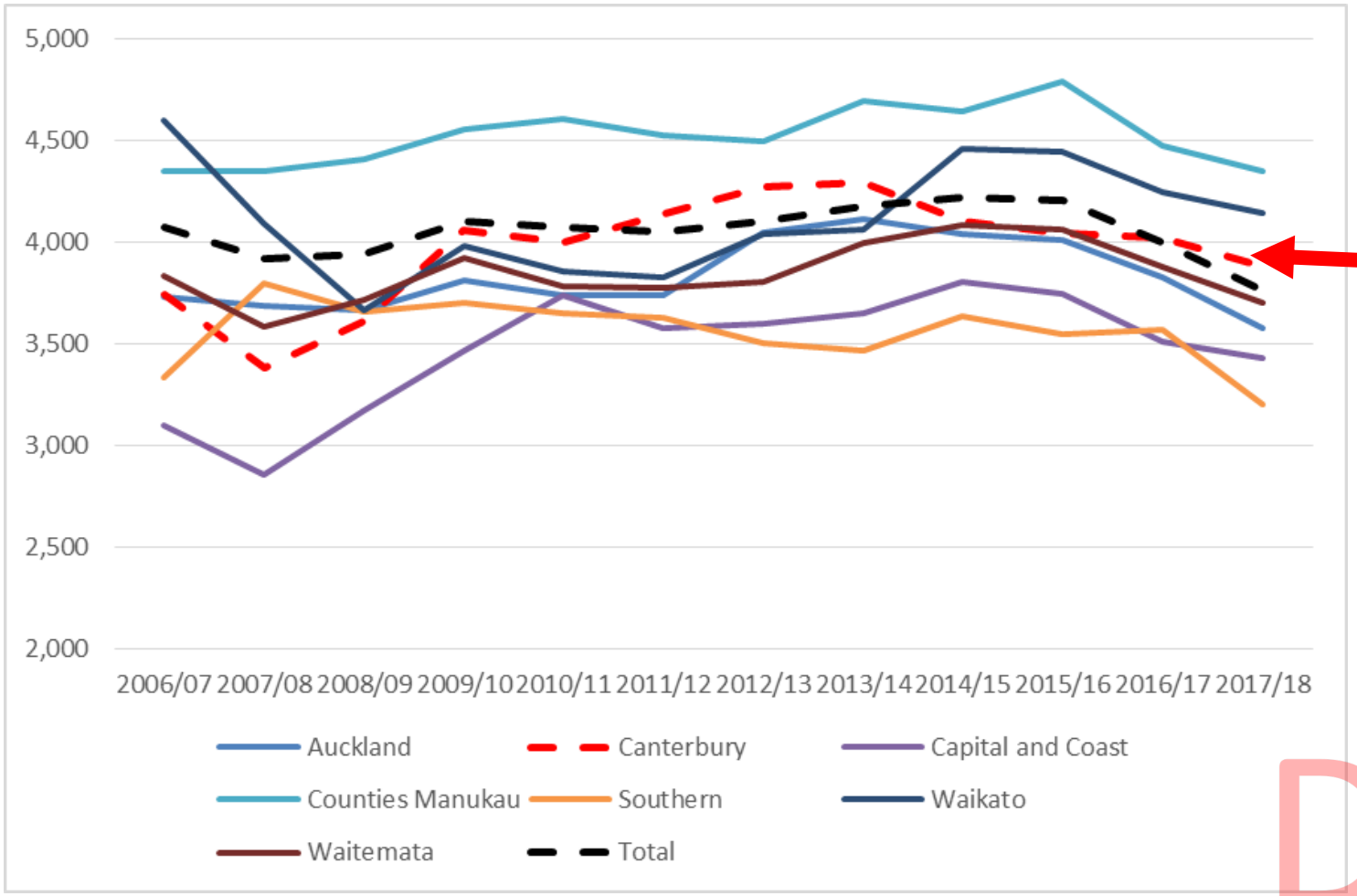
Note: includes 0 days stays which may distort the data due to the 3 hour rule

Demand

Source: NMDS,
Stat NZ pop projections (to MOH)

Acute Surgical Discharge Rate Large DHBs (>300,000)

Age standardised per 100,000 (WHO Standard population)



Demand

Source: NMDS,
Stat NZ pop projections (to MOH)

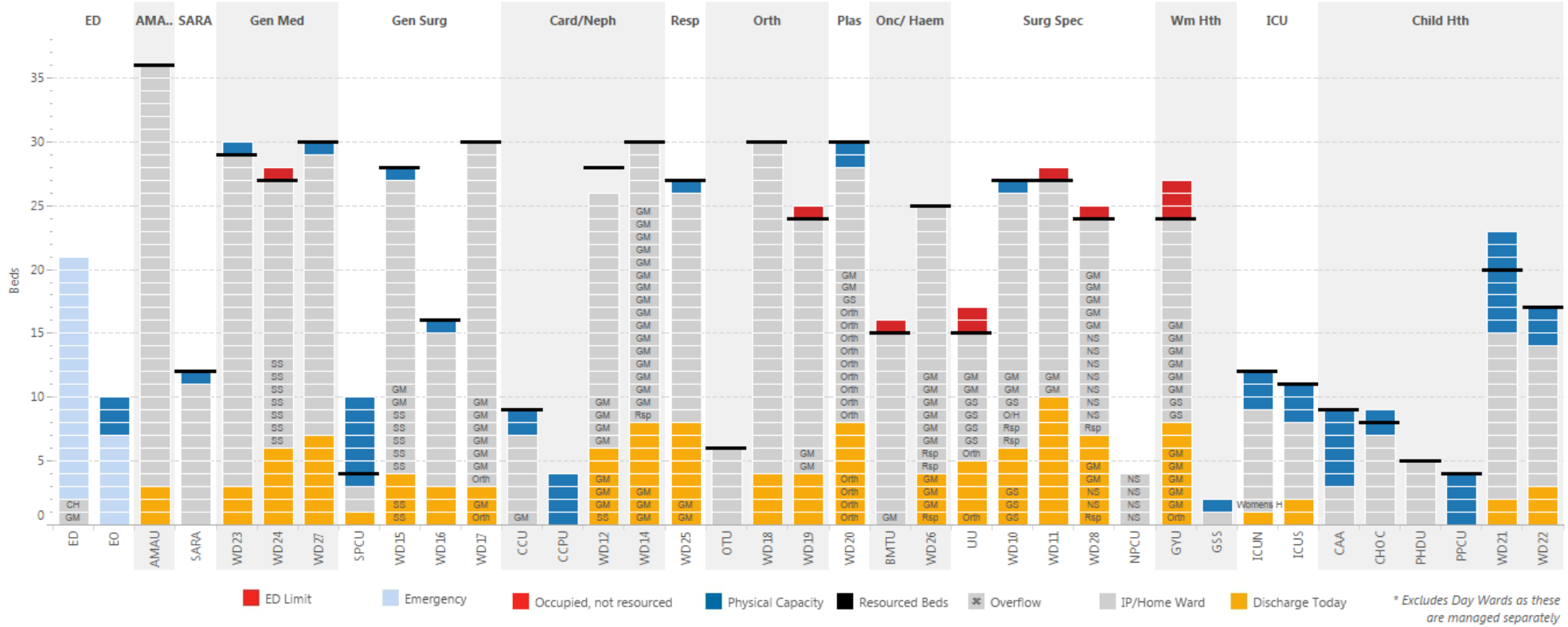
Capacity

Capacity

Decision Support

Christchurch Hospital Inpatient Wards at a Glance at 10:04 am

260 / 202	30	527	100%	93%	16 / 2
Forecast ED Arrivals 12am to 12am / now to 12am	ED Overload Score: No Overload	Occupied Beds (ex. Childrens, ED, ICU, & GYU)	Resourced Bed Occupancy (ex. Childrens, ED, ICU, & GYU)	Physical Bed Occupancy	Admissions / Discharges (since 7am)



Monitored Alerts

	ED	EO	AMAU	SARA	WD23	WD24	WD27	SPCU	WD15	WD16	WD17	CCU	CCPU	WD12	WD14	WD25	OTU	WD18	WD19	WD20	BMTU	WD26	UU	WD10	WD11	WD28	NPCU	GYU	GSS	ICUN	ICUS	CAA	CHOC	PHDU	PPCU	WD21	WD22	
Influenza like illness	8	0	11	4	9	0	0	0	0	1	0	1	3	4	0	0	1	6	1	1	0	0	0	1	0	1	0	1	0	1	2	0	0	0	1	57
Norovirus like infection	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

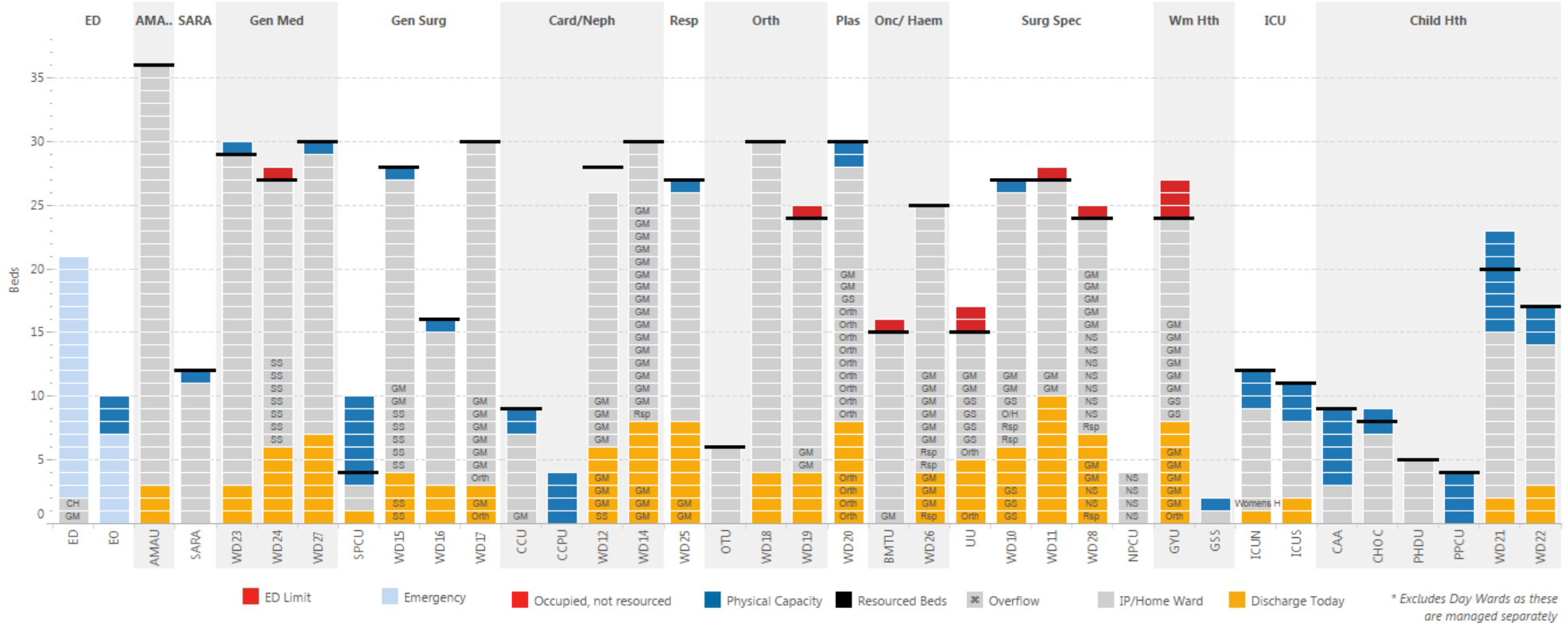
Expected Discharges

	ED	EO	AMAU	SARA	WD23	WD24	WD27	SPCU	WD15	WD16	WD17	CCU	CCPU	WD12	WD14	WD25	OTU	WD18	WD19	WD20	BMTU	WD26	UU	WD10	WD11	WD28	NPCU	GYU	GSS	ICUN	ICUS	CAA	CHOC	PHDU	PPCU	WD21	WD22	
Today	3	0	3	7	7	1	4	3	3	0	0	6	8	8	0	4	5	8	0	4	6	6	11	7	0	8	0	1	2	0	0	0	2	3	0	120

Decision Support

Christchurch Hospital Inpatient Wards at a Glance at 10:04 am

260 / 202	30	527	100%	93%	16 / 2
Forecast ED Arrivals 12am to 12am / now to 12am	ED Overload Score: No Overload	Occupied Beds (ex. Childrens, ED, ICU, & GYU)	Resourced Bed Occupancy (ex. Childrens, ED, ICU, & GYU)	Physical Bed Occupancy	Admissions / Discharges (since 7am)



Monitored Alerts

	ED	EO	AMAU	SARA	WD23	WD24	WD27	SPCU	WD15	WD16	WD17	CCU	CCPU	WD12	WD14	WD25	OTU	WD18	WD19	WD20	BMTU	WD26	UU	WD10	WD11	WD28	NPCU	GYU	GSS	ICUN	ICUS	CAA	CHOC	PHDU	PPCU	WD21	WD22	
Influenza like illness	8	0	11	4	9	0	0	0	0	1	0	1	3	4	0	0	1	6	1	1	0	0	0	1	0	1	0	1	0	1	2	0	0	0	1	57
Norovirus like infection	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Expected Discharges

	ED	EO	AMAU	SARA	WD23	WD24	WD27	SPCU	WD15	WD16	WD17	CCU	CCPU	WD12	WD14	WD25	OTU	WD18	WD19	WD20	BMTU	WD26	UU	WD10	WD11	WD28	NPCU	GYU	GSS	ICUN	ICUS	CAA	CHOC	PHDU	PPCU	WD21	WD22	
Today	3	0	3	7	7	1	4	3	3	0	0	6	8	8	0	4	5	8	0	4	6	6	11	7	0	8	0	1	2	0	0	0	2	3	0	120

How do we manage 95% occupancy?

- Not by cancelling surgery
- Not by diversion
- Not by keeping patients in ED
- Not by calling a crisis

Capacity

How do we manage 95% occupancy?

- Admission avoidance
- By aggressively managing flow in the hospital

Capacity

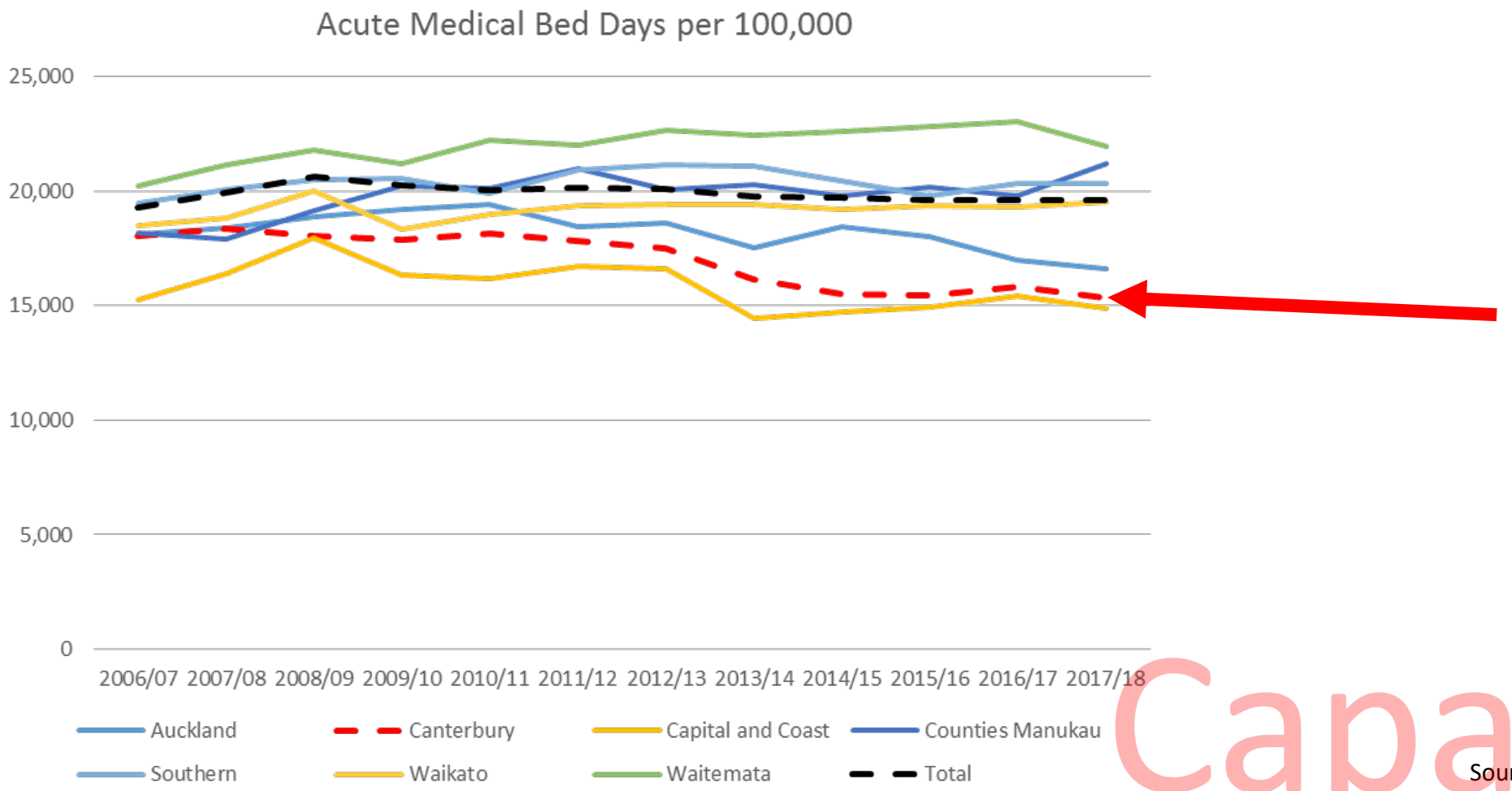
Our hospital flow

- Focus on planning discharges – all patients have an EDD
- 24/7 live dashboards showing capacity, resourcing and the tension between acute, elective and discharge activity so we can manage flow proactively avoiding bottlenecks
- Increased ward rounding by medical teams [eg twice daily]
- Expectation that we are all responsible for patient flow
- Board rounds in the morning by the multidisciplinary teams planning co-ordinated care
- Prioritise production inputs e.g Radiology for discharges

Capacity

Acute Medical Bed Days – unstandardised Comparator DHBs (>300,000)

Crude rate per 100,000



Source: NMDS,
Stat NZ pop projections (to MOH)

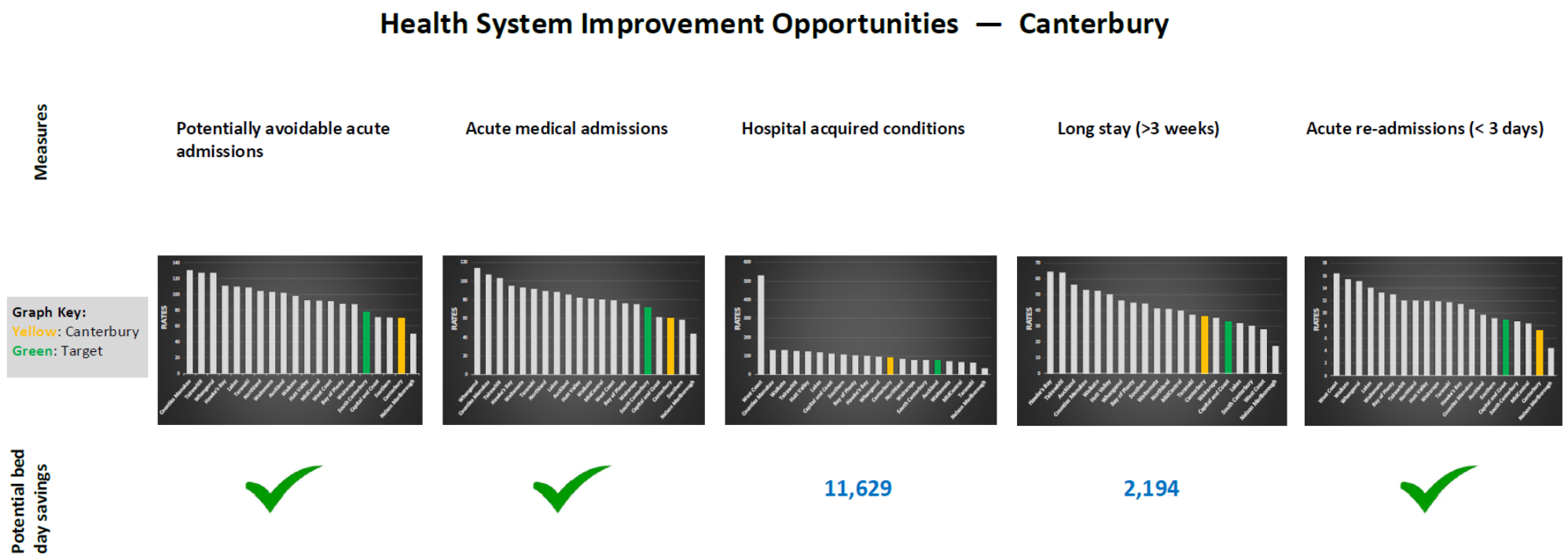
Flow – how many patients through a bed in one year?

- 140 [2014]
- 180 [current]
- National average for large DHBs

Capacity

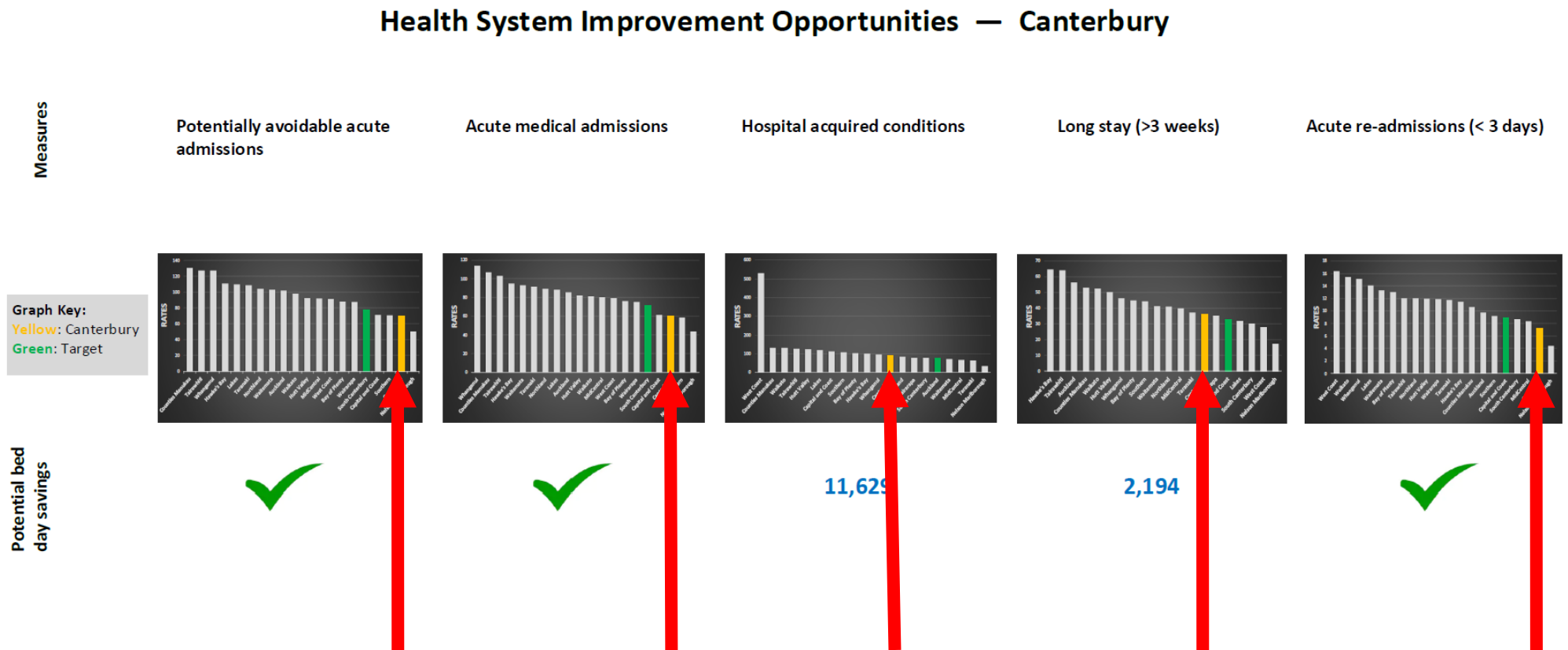
Our performance is reflected in national analyses

Central TAS *Addressing Acute Demand Pressures* indicates strong performance against key national metrics



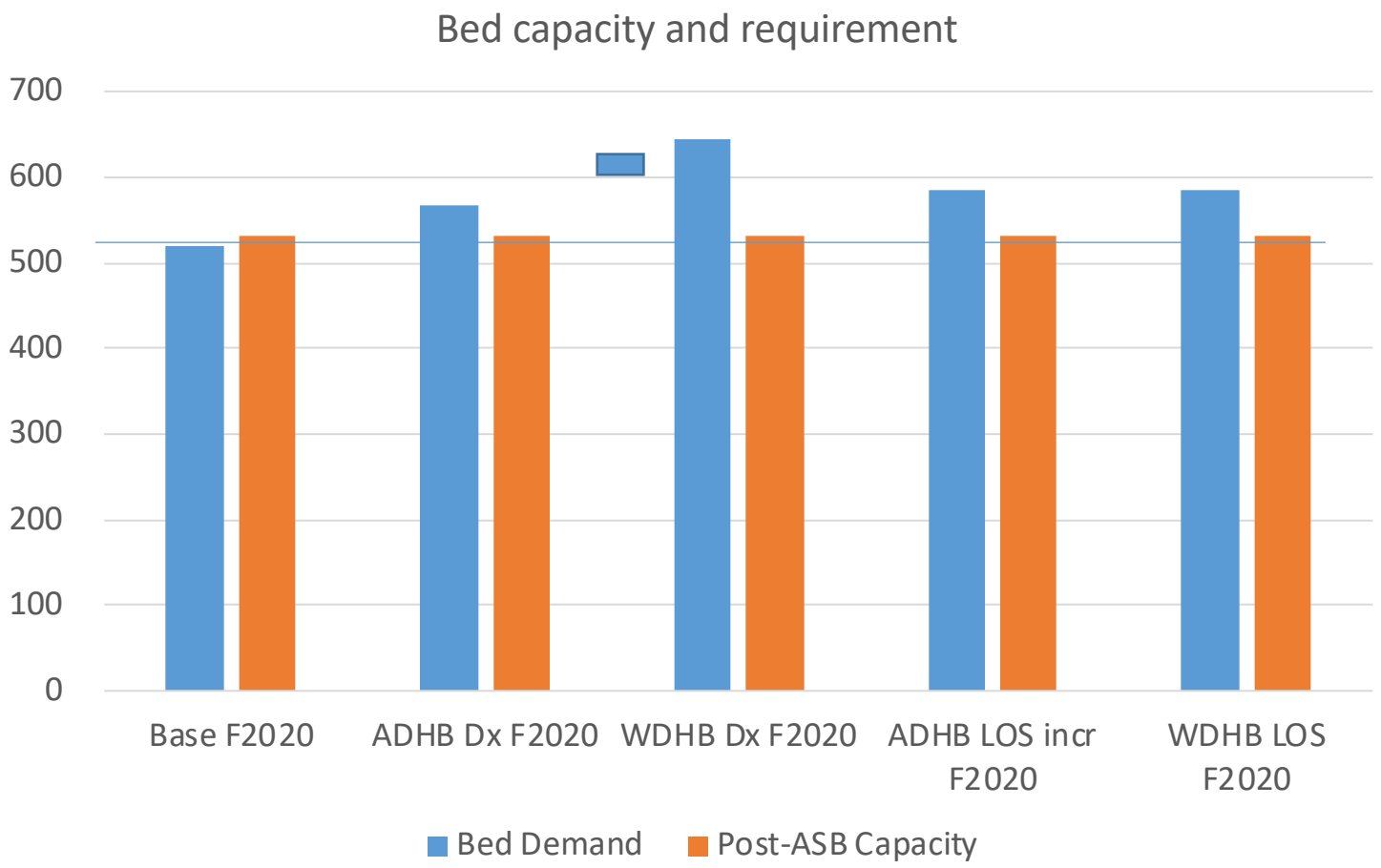
Our performance is reflected in national analyses

Central TAS *Addressing Acute Demand Pressures* indicates strong performance against key national metrics



Out of Scope

F2020 - Scenarios of performance



Base – post Hagley

Medical Discharge Rates @ Auckland DHB

Medical Discharge Rates @ Waitemata DHB

LOS @ Auckland DHB

LOS @ Waitemata DHB

Facilities -disablers and enablers

Facilities – disabling

- 40+ buildings demolished or being demolished
- Eight major facilities on CHCH campus that are
  - Earthquake damaged
  - Earthquake prone
- More than half of chch campus unrepaired.
- Large number of staff in portacoms
- No other governmental agency in such damaged facilities

Facilities – enabling or disabling

- Limiting investment in older damaged facilities

Facilities


DO NOT ENTER
EVACUATION PLAN | RIVERSIDE 5TH FLOOR WEST INTERNAL
Follow the instructions of the Floor Warden
They can be identified by
EMERGENCY ASSEMBLY
Canterbury

Facilities

Facilities

Out of Scope

Out of Scope


Out of Scope

Out of Scope

Out of Scope

Out of Scope

Out of Scope

Out of Scope

Out of Scope

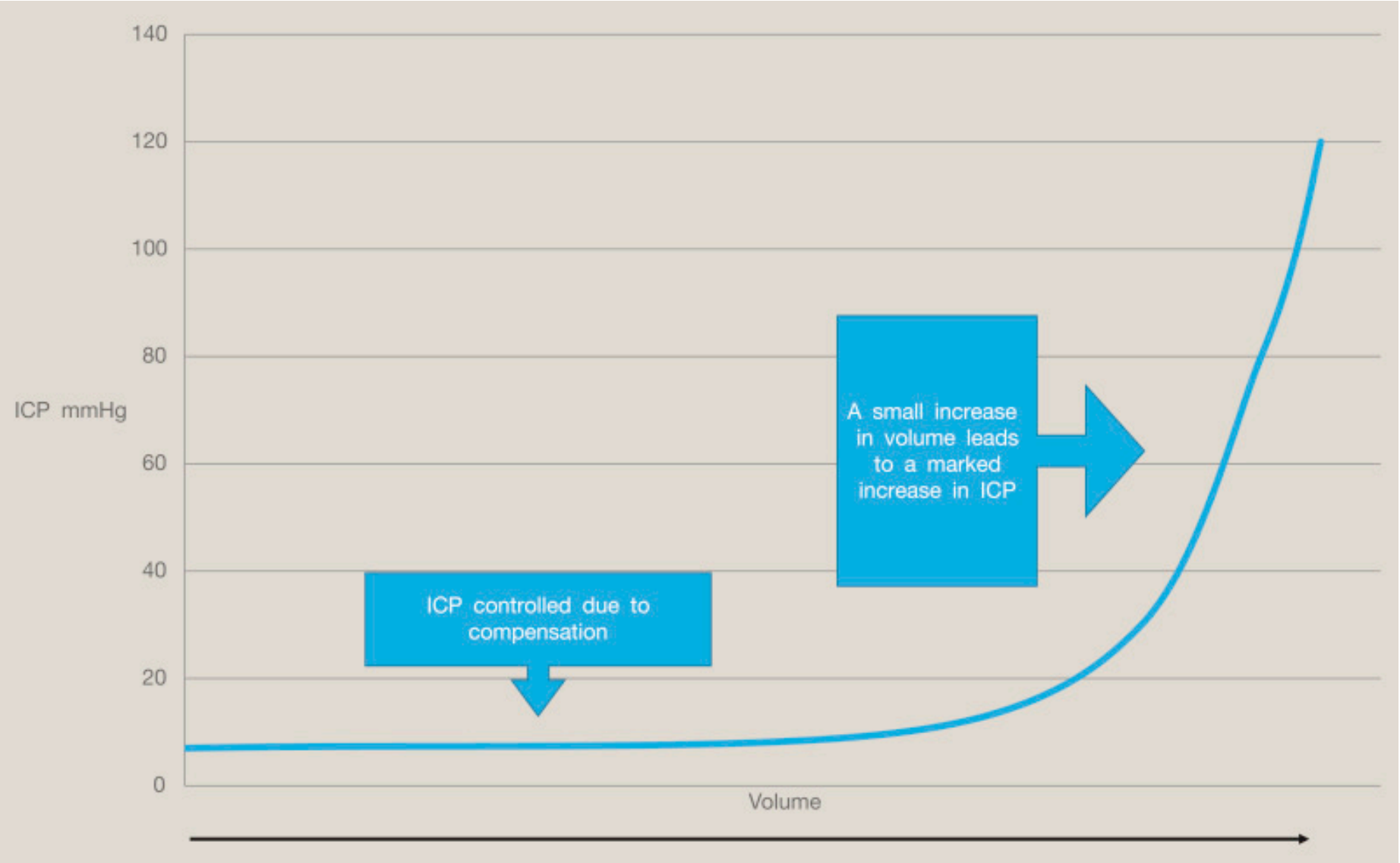
Out of Scope

Options - delay

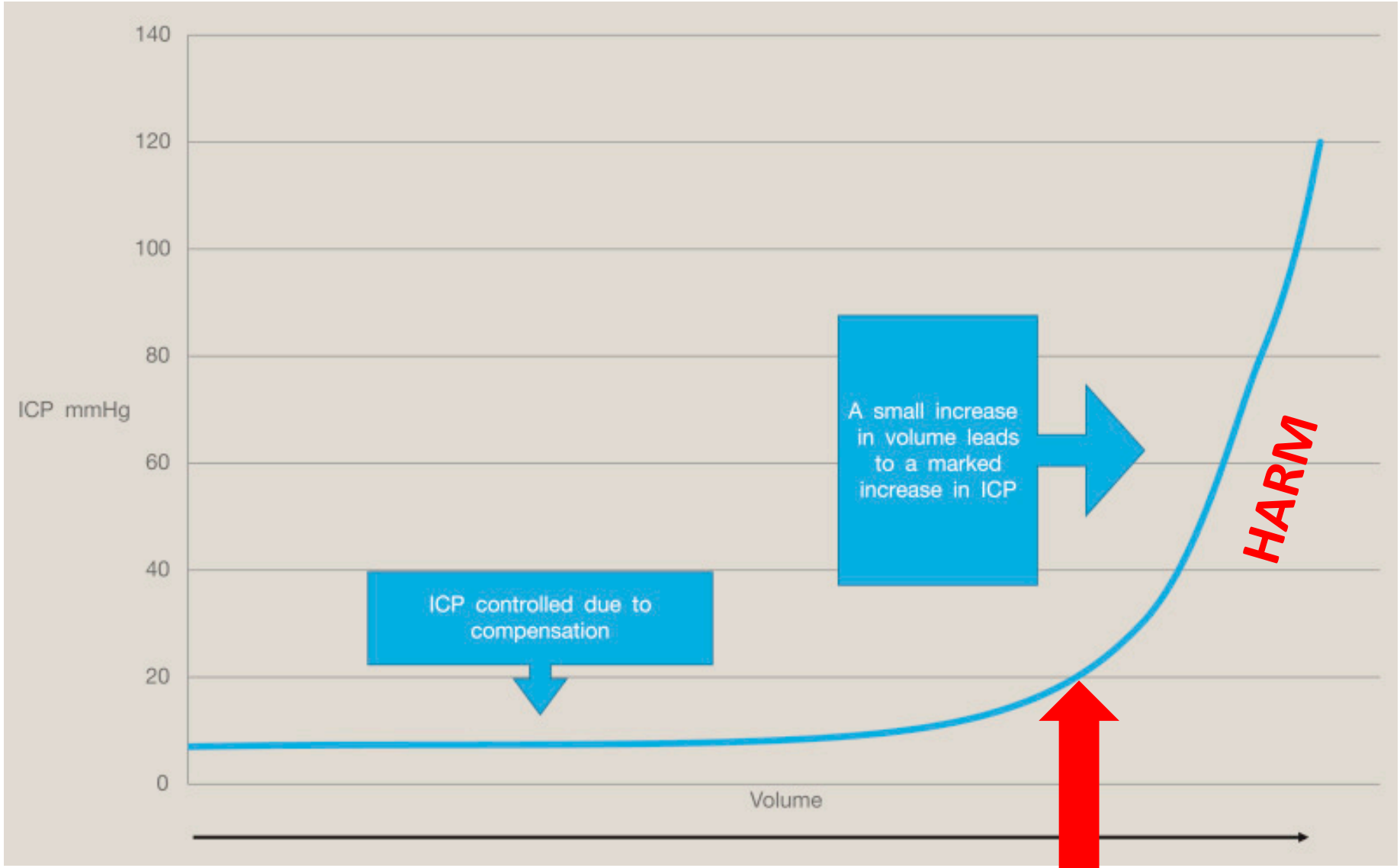
- Examining the feasibility of delaying CT4 by refurbishing Parkside et al
  - No agreed path to achieve this
  - Decanting steps to enable this is highly implausible
  - Meaningful degradation of service unavoidable.

Current State

Monro-Kellie Doctrine – Critical Brain pressure



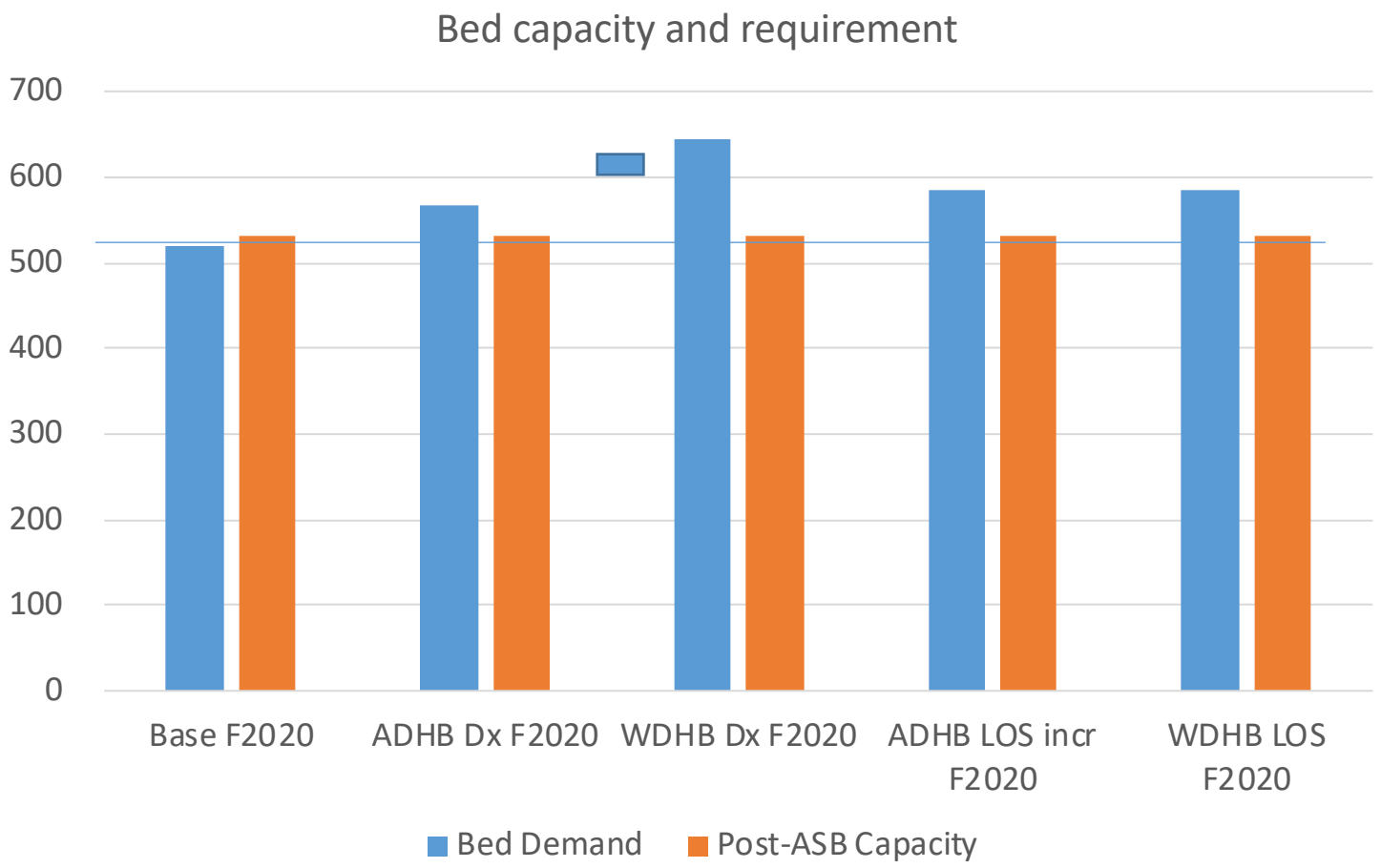
Monro-Kellie Doctrine- Critical Brain pressure



Clinical safety

- Aggressively managed by engaged staff
- Discretionary efforts
- Sick leave
  - From lowest sick leave DHB to the worst in just a few years
  - 23% of all sick leave is unpaid.

F2020 - Scenarios of performance



Base – post Hagley

Medical Discharge Rates @ Auckland DHB

Medical Discharge Rates @ Waitemata DHB

LOS @ Auckland DHB

LOS @ Waitemata DHB

Managing Clinical safety

–the Bases are loaded

- Minimised demand ✓
- Minimised LOS ✓
- Maximised use of space ✓
- **But in context of -**
- Loss of amenity ✗
- Quake repairs ✗
- Improbable decanting ✗
- Growth ✗
- Unsustainable Discretionary Efforts ✗
- Facilities redevelopments are too late to address this

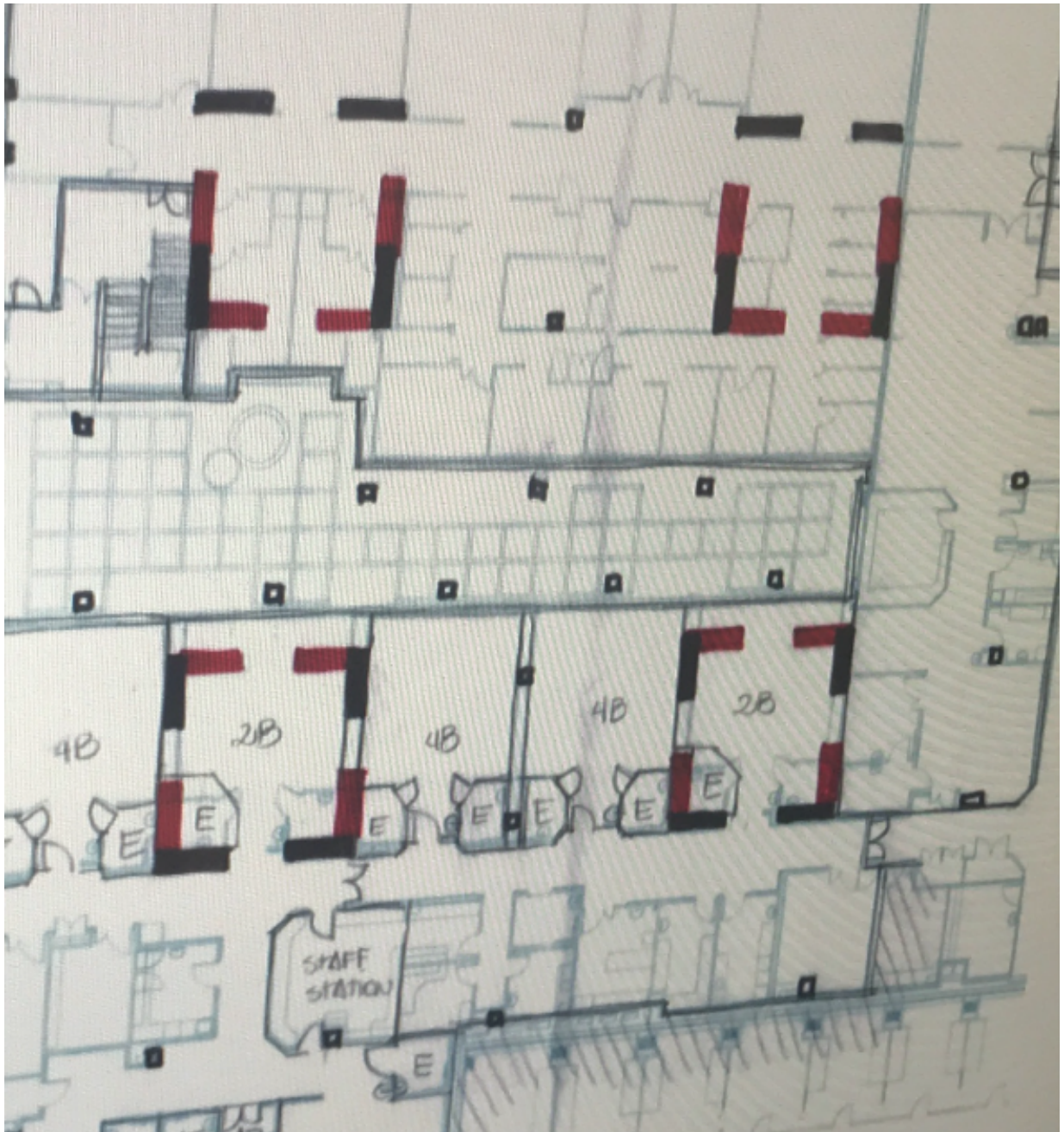
Summary

- We are facing system failure
  - even with the approvals
- The compensatory mechanisms are fully engaged and obscure the risks.
- Our confidence in the process to deliver our facilities is low.
- We can no longer manage clinical risk with any confidence

Can we use parkside to provide capacity?

Can Parkside deliver capacity?

- Full refurb
- Massively disruptive to change hydraulics etc
- Decanting solution not apparent


4B
2B
4B
4B
2B
E
E
E
E
E
E
E
E
STAFF
STATION
E

EY report

Working in a building that is being refurbished is not desirable. To reaffix the Parkside exterior concrete panels from the inside and adding shear walls will require long periods of concrete drilling. Many staff have been working in these circumstances for many years, and will need to continue to do so for several more years

Can Parkside deliver capacity?

- 22 beds [operationally poor – need higher nursing FTE]
- 4 single rooms [18%] with ensuites
- Higher numbers can be achieved but
  - The spaces around the beds poor
  - Reduced ablutions
  - Reduced support space
  - Reduced storage etc

Arrival Method

Self	Ambulance	Police	Other
23	20	0	0

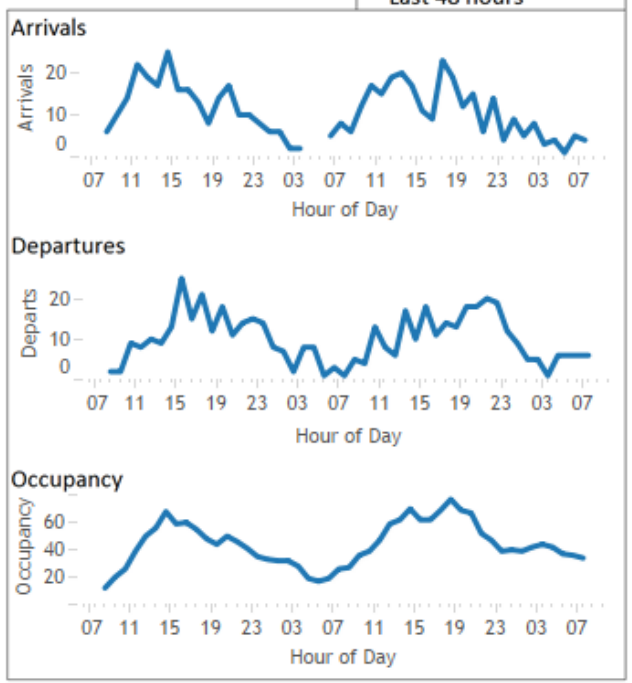
Midnight Occupancy: 39

New Arrivals: 43

Referral Source

GP	0		
Accident/Urgent Medical Centre	2	Outpatients	0
Rest Home	1	Other Facility / DHB	0
Other External Health Provider	1	Police / Justice	0
ED	1	Self / Relative	38
Adult comm. Mental Health	0	Overseas	0

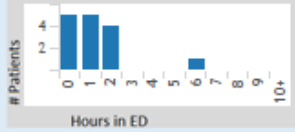
Last 48 hours



Current

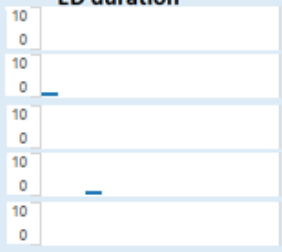
Occupancy: 15

ED duration



Waiting for:	
3	Waiting for First ED Doctor
1	Waiting for Specialty Doctor
0	Waiting for Bed Allocation
1	Waiting for Transfer to Ward
9	Care in progress

ED duration



Departed

Non Admitted

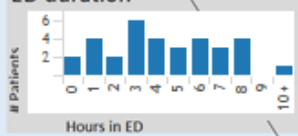
34 (51%)

ED duration

Admitted

33 (49%)

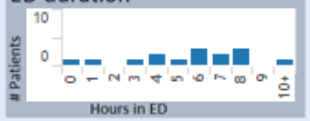
ED duration



Admitted Medical

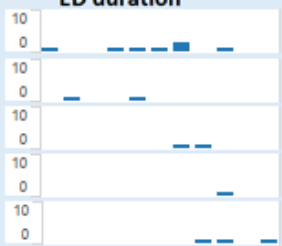
15

ED duration



Ward:	
7	CHC-AMAU
2	CHC-Coronary Care Unit
2	CHC-Ward 25
1	CHC-Ward 26
3	Other

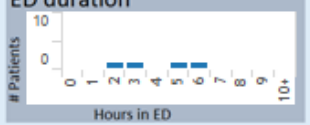
ED duration



Admitted Surgical

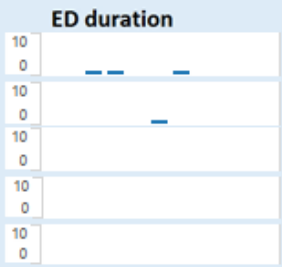
4

ED duration



Ward:	
3	CHC-SARA
1	CHC-Ward 19
0	Other
0	
0	

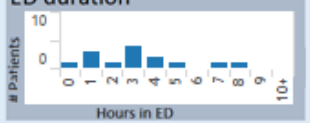
ED duration



Admitted Other

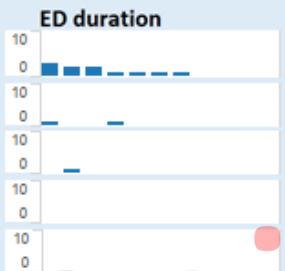
14

ED duration



Ward:	
11	CHC-Emergency Observation Unit
2	CHC-Child Acute Assessment Unit
1	ICU - Intensive Care Unit
0	Other
0	

ED duration



Dashboard Last Refreshed : 27-06-2019 08:42

Last Data Received : 27-06-2019 08:38

Capacity

Decision Support

ED – time from bed request to allocation

14 minutes

- The Minister of Health through the Ministry of Health is responsible for ensuring that DHBs carry out their duties. The risk carried by the Canterbury DHB Board is equally carried by the Minister and MOH.
- The Board cannot demand a faster solution to the problem than is possible physically to do. However, looking at the 2025 finish of the current IBC it does seem a long way from 2011.

Kathleen Smitheram

From: Anne Scott
Sent: Monday, 15 October 2018 10:01 a.m.
To: David Meates
Subject: FW: david meates - icu status
Attachments: Scan-to-Me from hos1014mfd2.cdhb.local 2018-10-15 101317.pdf

From: Anne.Scott@cdhb.health.nz [mailto:Anne.Scott@cdhb.health.nz]
Sent: Monday, 15 October 2018 10:14 a.m.
To: Anne Scott <Anne.Scott@cdhb.health.nz>
Subject: david meates - icu status

As attached

Anne Scott
Supervisor / Secretarial Team Leader
Department of Surgery / 1st Floor / Hagley Outpatients
Christchurch Hospital
9(2)(a) [redacted]

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Greg Robertson
Chief of Surgery
Department of General Surgery
Level 1, Hagley Outpatients

Christchurch Hospital
9(2)(a) [redacted]

15th October 2018

Mr David Meates
CEO
Christchurch Hospital

Dear David,

I write to express my increasing concerns around the inability of ICU to support the necessary Urgent/ Non-deferrable elective /Elective Surgery requirements of Canterbury and often our regional neighbours due to significant facility constraints which reached a crisis last week and led to previously unheard of request by senior clinicians to divert IDF acute patient care away from ICU in Christchurch for a period of 10 days. This short term action has highlighted the necessity of an agreed threshold to prompt such a response, but more specifically the need for a medium term plan to bridge the gap between now and when we get new capacity as the current situation is clinically unacceptable.

Canterbury clinicians have accepted that on occasions our ICU will not have sufficient capacity to meet both the acute needs and the demands of planned surgical patients. Increasing the physical capacity of our ICU was a core driver of the new hospital building and it is recognised that as the second largest tertiary hospital in New Zealand which undertakes a range of complex surgery not undertaken elsewhere, we currently have an under-sized ICU which we have managed through some increases in bed numbers in recent times, the adoption of an "out-reach" model and having a higher threshold for access to ICU than is customary in other hospitals.

However with the ongoing delays to delivery of our new facilities, our population increasing much more quickly than anticipated and the implementation of Destination Policies (Spinal) or Hub and spoke models (vascular) we have reached a point of service failure where we cannot complete this month the surgical activity that clinically needs to be completed this month specifically because of the lack of physical capacity in ICU.

Whilst this might have occurred transiently in the past this has been problematic since May 2018 when a significant change has become apparent, with regular requirement for prioritising cases and often cancellations at the last minute which is distressing for patients , their families and for staff . The types of surgery that have been delayed/cancelled on the day include patients admitted acutely with cardiac problems, others with cancer on specific treatment timeline windows around radiotherapy or chemotherapy, others requiring major excisional and reconstructive procedures as well as a significant paediatric case load in Neurosurgery, Plastic Surgery and ORL .

Bed demand in ICU has regularly been above the physical bed space with patients being managed in PACU which, due to its dislocation from ICU, is a sub-optimal solution with inherent clinical risk.

While this is particularly challenging for those patients who have their surgery cancelled at the last minute, it is also having a significant effect on those providing the care with surgeons struggling to replan

a time for procedures to be undertaken/ rearrange the often multidisciplinary teams involved/or rearrange their future planned lists (often already booked well in advance with other patients with cancers etc).

Surgeons have expressed difficulty coping with the last minute cancellations, and have deferred early to avoid the tensions associated with preparing themselves to undertake complex procedures, only to have it cancelled at the last minute, or uncertainty as to whether it will occur that day. These same surgeons and their teams, have robustly helped the organisation as a whole, maintain a range of services, over the last 7 years, by operating across multiple sites (utilising both public and private operating facilities), balancing complexity, increased population and increasing regional flows, to deliver surgical care.

Compounding all of these issues is the continued uncertainty around the completion date for the Christchurch Hospital Hagley building, with HRPG advising that there is a 50/50 chance of earliest predicted delivery in October 2019 (now over 18 months later than planned). A paper to CDHB Board in February 2017 highlighted the increased fragility of services, the impact of facility delays on service delivery and the increased risk of service failure.

Just sustaining current service levels over this next 12 month period due to facility delays is going to be challenging in the extreme and will require some alternative actions to occur to avoid a repeat of last week's situation when we had 15 patients facing multiple cancellations and an ICU operating well beyond capacity.

The recommendations from the Christchurch clinicians staffing, and caring for patients needing ICU level care are:

1) Action is taken earlier when there is a build-up of delayed cases. The only options currently available are diversion of acute cases to other tertiary level DHB's, refusal to accept new complex IDF cases and transfer of patients if clinically possible
2) The DHB enables the development of a bridging service by agreeing to the CDHB staffing 4 beds of St George's ICU capacity which is currently only used intermittently for cardiac surgery.
3) The DHB notes that getting additional capacity at St George's functional may take some months as staffing is also a constraint however given the increasing demand and the uncertainty of the delivery of the Hagley Building we think taking action now is essential.
4) The DHB notes that we will still need to develop some other solutions to carry the DHB through between now and additional capacity becoming available.
5) The DHB accepts responsibility for clinicians managing patients in situations that are not optimal, or have by necessity changed to provide ongoing service within the constraints of our present environment.

The current circumstance is demonstrating that we are no longer able to absorb escalating demand without either some alternative structure in place or reduction of clinical service provision to our populations as well as the populations of our regional colleagues.

Yours sincerely

Greg Robertson
Chief of Surgery CDHB

Kathleen Smitheram

From:	Rob Ojala
Sent:	Thursday, 24 October 2019 1:20 p.m.
To:	David Meates; 9(2)(a) [redacted]@xtra.co.nz; Mary Gordon (Executive Director of Nursing); Sue Nightingale
Cc:	Pauline Clark; Angela Mills; Andy Savin; Kay Jenkins; Anna Craw
Subject:	2019 Campus Redevelopment BC Options Assessment - Decision form CLG
Attachments:	Memo CLG 2019 Campus Redevelopment Business Case Options Assessment Decision October 2019.pdf

Dear All,

Please find enclosed the decision to endorse, with caveats, an option proposed in the campus redevelopment business case.

Regards,

Rob Ojala
Chair,
CDHB Clinical Leaders Group

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CDHB Clinical Leaders Group
Corporate Office, 32 Oxford Terrace
Private Bag 4710
CHRISTCHURCH

M E M O

To: **CDHB Board -** ***Dr John Wood (Chair), Ta Mark Solomon (Deputy Chair), Barry Bragg, Sally Buck Tracey Chambers, Dr Anna Crighton, Andrew Dickerson, Jo Kane, Aaron Keown, Chris Mene, David Morrell.*** **David Meates, Mary Gordon, Sue Nightingale.**

C.C.: **Pauline Clark, Angela Mills, Andy Savin.**

From: **CDHB Clinical Leaders Group**

Date: **24 October 2019**

SUBJECT: **2019 Campus Redevelopment Business Case Options Assessment -CLG Decision**

1. The tranche one Christchurch Hospital campus redevelopment business case options have been assessed by the CDHB Clinical Leaders Group.
2. CLG acknowledge that the extensive damage to CDHB facilities in the 2010/11 earthquakes has created demand for out-of-cycle capital investment.
3. CLG note that the previous draft business cases (2016) and MOH advice about capital intentions all signalled that CDHB need for out-of-cycle was going to be significant.
4. CLG note that the 2012 DBC approved by cabinet signalled the need for further infrastructure requirement by 2022 to meet demand which has been superseded by significantly more rapid population growth, significantly greater earthquake related infrastructure damage (including 44 buildings that have been demolished) and legislative changes about building capacity.
5. CLG note that CDHB continues to be the only DHB in the country where critical health services are continuing to be provided out of both earthquake-damaged and earthquake-prone facilities and that it is now 8 years post the 2011 earthquakes.
6. CLG note the previous advice provided to Board, MOH and HRPG about the critical impacts that the ongoing delays around capital decision making is and will continue to have on the DHB's ability to sustain service levels (including service failure)
7. CLG note the DHB's preferred option (option1) is now fiscally and sequentially challenging, and is an inevitable outcome of the unnecessarily protracted process that surrounds this business case's development.

<u>In this context:</u>
The Clinical Leaders Group have endorsed, with caveats, 1b as the only pragmatic and viable option to deliver appropriate bed and theatre capacity for the site. This includes the design of T4 and Central podium and enabling works.

<u>The caveats are:</u>
1. The explicit understanding that the new central podium and fourth tower (CT4) must be fast-tracked as part of tranche two in order to meet agreed demand.
2. The compromises in delaying repair and repurposing of Parkside, Clinical Services Block and the residual of Riverside are agreed contingent on capital approvals being achieved for Tranche two by 2021 at the latest. This would otherwise precipitate a need for additional capital into the above facilities to meet compliance and clinical requirements.