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, 15 October 2020 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 17 September 2020		
3.	Carried Forward / Action List Items		
Presentation			
4.	The Christchurch Cancer Foundation	Professor Frank Frizelle *Chairman* *The Christchurch Cancer Foundation*	9.35-10.05am
Reports for Noting			
5.	Chair's Update (Oral)	Gabrielle Huria *Deputy Chair*	10.05-10.10am
6.	Chief Executive's Update	Dr Peter Bramley *Acting Chief Executive*	10.10-10.35am
7.	Finance Report	David Green *Acting Executive Director, Finance & Corporate Services*	10.35-10.45am
8.	Maori Population, Partnership, Health & Equity	Hector Matthews *Executive Director, Maori & Pacific Health*	10.45-11.15am
9.	Advice to Board: • HAC – 1 October 2020 – Draft Minutes	Andrew Dickerson *Chair, HAC*	11.15-11.20am
10.	Resolution to Exclude the Public		11.20am
ESTIMATED FINISH TIME – PUBLIC MEETING			**11.20am**

Morning tea will be held at the conclusion of the public meeting.

NEXT MEETING
Thursday, 19 November 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
Catherine Chu
Andrew Dickerson
James Gough
Jo Kane
Aaron Keown
Naomi Marshall
Ingrid Taylor

Executive Support

Dr Peter Bramley – *Acting Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
David Green – *Acting Executive Director, Finance & Corporate Services*
Becky Hickmott – *Acting Executive Director of Nursing*
Ralph La Salle – *Acting Executive Director, Planning Funding & Decision Support*
Paul Lamb – *Acting Chief People Officer*
Dr Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Hector Matthews – *Executive Director Maori & Pacific Health*
Dr Sue Nightingale – *Chief Medical Officer*
Dr Rob Ojala – *Executive Lead of Facilities*
Karalyn Van Deursen – *Executive Director of Communications*
Stella Ward – *Chief Digital Officer*

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	04/08/20	12/08/20	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	#	^	~	~	~	~	** 08/07/2020							
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**	**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*). **Rawa Hohepa Limited** – Director Family property company. **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 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.
Catherine Chu	**Christchurch City Council** – Councillor Local Territorial Authority **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. **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 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. **Christchurch City Council** – Chair of Disability Issues Group **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 in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 17 September 2020 commencing at 9.30am

BOARD MEMBERS
Sir John Hansen (Chair); Barry Bragg; Catherine Chu (via zoom); Andrew Dickerson (via zoom); James Gough (via zoom); Gabrielle Huria; Jo Kane; Aaron Keown; Naomi Marshall; and Ingrid Taylor.

BOARD CLINICAL ADVISOR
Dr Andrew Brant (via zoom).

APOLOGIES
An apology for absence was received and accepted from Dr Lester Levy.
An apology for early departure was received and accepted from Dr Andrew Brant (12.10pm).

EXECUTIVE SUPPORT
Dr Peter Bramley (Acting Chief Executive); Mary Gordon (Executive Director of Nursing); David Green (Acting Executive Director, Finance & Corporate Services); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Paul Lamb (Acting Chief People Officer); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Hector Matthews (Executive Director, Maori & Pacific Health); Dr Sue Nightingale (Chief Medical Officer); Karalyn van Deursen (Executive Director Communications); Stella Ward (Chief Digital Officer); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

IN ATTENDANCE
Matt Dean (Enterprise Architect, Information Services); Savita Devi (ICT Services Manager); Becky Hickmott (Nurse Manager, Nursing Workforce Development); and Melissa Macfarlane (Team Lead, Planning & Performance).

Hector Matthews, Executive Director, Maori & Pacific Health, opened the meeting with a special Karakia in acknowledgement of Maori Language week:

"Korihi mai ngā manu tīoriori	*The birds sing*
I te ata pūkohu e	*In the morning mist*
Te tōmairangi ki runga	*The dew rises*
Te tōmairangi ki raro	*The dew falls*
Ka ao, ka ao, ka awatea.	*It is dawn, it is daybreak, it is daylight*
Tihei mauri ora"	*Behold the breath of life*

Mr Matthews also acknowledged the passing of Sally Buck.

Sir John Hansen, Chair, acknowledged the passing of Sally Buck and commented that she had made a significant contribution to the DHB. He asked the meeting to observe a moments silence in remembrance.

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
Barry Bragg and Gabrielle Huria declared a conflict of interest in relation to car parking.

Perceived Conflicts of Interest
A perceived conflict of interest was raised regarding a conflict of interest for Catherine Chu; James Gough and Aaron Keown around the Bus Super Stop and Land Transfer. The members agreed that they would step back for that item.

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETINGS

Resolution (40/20)
(Moved: Sir John Hansen/seconded: Aaron Keown – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 20 August 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

There were no carried forward/action items.

4. CDHB RESEARCH (PRESENTATION)

Dr Sue Nightingale, Chief Medical Officer, introduced Dr Cameron Lacey, Clinical Director of Research, to present to the meeting on CDHB Research.

Dr Lacey introduced Dr Teddy Wu, Neurologist; Dr Gavin Harris, Anatomical Pathologist; Dr Martin Than, Medical Specialist ED; and Lynn Davis, Quality Improvement & Information Lead, Research Office.

Dr Lacey spoke about the New Zealand Health Research Strategy 2017-2027 and the Health Research Council. He advised that the Health Research Council have revamped one of their funding streams which is now the 2020 Health Delivery Research Investment Round and later this year we will look at governance arrangements and how we collaborate and approach Maori consultation.

Dr Than spoke regarding the impact of research on the health system and presented some Emergency Department research.

Dr Wu advised that his main interest is around acute interventional therapies for ischaemic stroke and he has been involved in publications in the New England Journal of Medicine in this area. Dr Wu has also been involved in: clinical research; international stroke trials; five multi-centre intervention trials; international collaborations; and registry based research and EXTEND-IA TNK trial which resulted in change to best practice guidelines.

Dr Harris spoke regarding Accelerating our Future through Research and in particular Anatomical Pathology, Digital Pathology and Computational Pathology.

Dr Lacey provided information regarding where we are going now around research. This included:

- investing and prioritising in research that focusses on equity across people and geography.
- acceleratung the development of pathways and policies that enable translation into practice.

- creating a vibrant research environment in Canterbury and the West Coast which attracts and retains staff.
- building staff capability/competence for health service implementation research.
- enhancing collaborations with health system partners across our region.
- embedding research into organisational practice and culture.
- advancing innovative ideas into commercial opportunities.

The Chair thanked the presenters for a fascinating and forward looking critical presentation.

Stella Ward, Chief Digital Officer, advised that there will be an update on our innovation activity at the next Board meeting.

The Board noted with interest the desire for a Clinical Trials Unit.

5. SCHEDULE OF MEETINGS 2021

David Green, Acting Executive Director, Finance & Corporate Services, presented the proposed schedule of meetings for 2021 which lay on the table from the previous meeting.

Andrew Dickerson, Chair, Hospital Advisory Committee, commented that the opportunity should be taken at some stage to discuss the frequency of the Hospital Advisory Committee. A similar comment was made regarding the Community & Public Health & Disability Support Advisory Committee.

Resolution (41/20)
(Moved: Aaron Keown/seconded: Sir John Hansen – carried)

"That the Board:

i. confirms support for the proposed schedule of meetings for 2021 (Appendix 1); and
ii. reconfirms the delegation of authority to the Chief Executive, in consultation with the Chair of the Board and/or relevant Committee Chairperson, to alter the date, time or venue of a meeting, or cancel a meeting, should circumstances require this."

6. BAD DEBT WRITE-OFF

Mr Green also presented this report which was taken as read and was recommended to the Board for approval by QFARC.

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

Resolution (42/20)
(Moved: Barry Bragg/seconded: Ingrid Taylor – carried)

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

i. approves the write off of approximately $161k being an invoice raised to a non-New Zealand resident inpatient; and
ii. notes that this request is made on the basis that Canterbury DHB has taken all reasonable steps to recover the debt and there is unlikely to be any payment on this invoice."

7. COMMITTEE VACANCIES

Sir John Hansen, Chair, presented this paper which was to fill the vacant Chair & Deputy Chair positions on Advisory Committees.

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

Resolution (43/20)
(Moved: Sir John Hansen/seconded: James Gough – carried)

"That the Board:

i. confirms the appointment of Aaron Keown as Chair of the Community & Public Health & Disability Support Advisory Committee;
ii. confirms the appointment of Naomi Marshall as Deputy Chair of the Community & Public Health & Disability Support Advisory Committee;
iii. confirms the appointment of Ingrid Taylor as Deputy Chair of the Quality, Finance, Audit & Risk Committee; and
iv. confirms the appointment of Naomi Marshall as Deputy Chair of the Hospital Advisory Committee."

8. CHAIR'S UPDATE

Sir John advised that a number of farewells had been held in the previous couple of weeks and he fully understands that this can be upsetting for staff. He commented that he wanted to publicly acknowledge that Business as Usual is still being delivered to the highest standard cross the health system. He added that he is also grateful to Dr Peter Bramley and the work he has been undertaking as Acting Chief Executive.

A query was made regarding the status of the EY report and it was agreed that this would be discussed later in the meeting.

The Chair's update was noted.

9. CHIEF EXECUTIVE'S UPDATE

Dr Peter Bramley, Acting Chief Executive, presented his report which was taken as read. Dr Bramley commented that it is a pleasure to be here and he feels very privileged to support the Canterbury DHB. He acknowledged that it is quite a different time for the organisation with people leaving and also acknowledged the great work those departing have undertaken during their time with the DHB. Dr Bramley also commented as follows:

- It has been an absolute privilege to connect with the teams here in Canterbury. I am impressed with the passion and commitment to care for the people of Canterbury. Many, as you know, are still working in damaged facilities.
- I want to acknowledge those stepping up into interim roles as we proceed.
- We are now getting close to a phenomenal new facility and I would like to honour Mary Gordon, Dr Rob Ojala and the rest of the facilities team for all of their hard work to make this happen. I also want to reassure the Board that the build is almost ready to hand over key and we will be double checking that everything is safe to occupy. The amount of work going into the migration is impressive and there will be a presentation to the next Hospital Advisory Committee around this.
- I want to acknowledge that behind the scenes we should not underestimate the amount of work taking place around COVID. A complete shout out to Labs who have just clocked up over 100,000 COVID tests.

Dr Sue Nightingale, Chief Medical Officer, advised that there is still a phenomenal amount of work being undertaken in Primary Care and around surveillance, with meetings three times per week, and also around COVID streams in the new hospital.

Dr Bramley also gave a shout out to all of the teams supporting the recovery of the health system post the COVID lockdown.

- We are still awaiting clarity from the Ministry of Health around how the COVID related costs will be funded.
- He acknowledged that this being Maori language week that there are more Te Reo speakers in the 18-25 year group than in 55+.

  Mr Matthews commented that for the first time in more than a century this data is available and we are seeing a shift in the demography of the Maori population and the speakers of Te Reo Maori which means the demands of these young people will be different and we need to be prepared as they come through.

- In regard to Oncology services, Dr Bramley advised that he had met with Dr David Gibbs, Clinical Chair for Oncology, and in reality they are 30 -40% down on staff due to personal leave, however, the team has rallied very well to deal with this.

A query was made regarding the risks around the Leave Care Plans. It was noted that it is a huge challenge and conflict for a lot of our senior staff to balance keeping the clinics full for catch up appointments and also to take leave. The Chair commented that there is more comprehensive reporting around this to QFARC.

Dr Bramley reassured the Board that the Executive Management Team and General Managers are making sure we are aligned and that the Programme Office is resourced and is capturing this information. Although there is not a lot of savings phased into the first two months, we are on track.

The Chief Executive's update was noted.

10. FINANCE REPORT

Mr Green presented the Finance Report which was taken as read. He advised that the result for July was favourable both before and after COVID costs. He added that savings have been achieved in the first month and a better resolution is expected around liquidity.

A query was made as to whether the Holidays Act compliance is now in the bottom line and it was noted that this has been treated the same as the previous year. We have an operating result and as part of the year end process we have looked at what our potential liability is and made an adjustment for Holidays Act compliance which is now reflected in the draft 2019/20 final result.

Resolution (44/20)
(Moved: Sir John Hansen/seconded: Barry Bragg – carried)

"That the Board:

i. notes the consolidated financial result for July 2020 is a net expense of $13.983M, being $0.086M favourable to the annual plan agreed by the Board on 20 August 2020;
ii. notes the operating result (before indirect items) for the month is favourable to plan by $0.156M;
iii. notes that net costs associated with the COVID-19 pandemic as included in the month of July results are $1.217M, therefore the underlying operating result (excl COVID) is $1.373 favourable;
iv. notes that budget phasing has not been finalised and adjustments may be required in August to the phasing for the remainder of the year; and
v. notes liquidity (cashflow) risk continues to be a significant concern without any sustainable long-term resolution."

11. ADVICE TO BOARD

Community & Public Health & Disability Support Advisory Committee (*CPH&DSAC*)
Aaron Keown, Deputy Chair (at the time), CPH&DSAC, provided the Board with an update on the Committee's public meeting held on 3 September 2020. He advised that there had been some good presentations at the meeting: the Community Languages Information Network Group; a Public Health Approach to Disabilities; and a COVID 19 update.

Resolution (45/20)
(Moved: Aaron Keown/Seconded: Naomi Marshall - carried)

"That the Board:

i. notes the draft minutes from CPH&DSAC's public meeting held on 3 September 2020."

Sir John expressed his thanks to Mary Gordon as this is her last meeting. I want to recognise her many many years of service to this Board, to the patients of Canterbury and even more to the nurses of Canterbury and throughout New Zealand.

12. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (46/20)
(Moved: Gabrielle Huria/seconded: Barry Bragg - carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 & 16 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 public excluded meetings – 20 August 2020	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (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.	Afternoon Staff Carpark – Public Consultation on Disposal of Land	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Bus Super Stop – Public Consultation on Disposal of Land	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Holidays Act Remediation Approach	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Selection of Recruitment Company	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Rangiora Health Hub – Family Health & Urgent Care Centre Lease	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Microsoft Licences Approval	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Equity Support for 2019/20 Deficit	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	Christchurch Campus Compliance Works Programme	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	Riverside Docks Relocation - Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
13.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
14.	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)
15.	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)

16.	Advice to Board: • QFARC Draft Minutes *01 September 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 11.05am.

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Sir John Hansen, Chairman Date of approval

BOARD MEETING 17 SEPTEMBER 2020 – MEETING NOTES

Clause No	Item	Action Points	Staff
	Apologies	• Dr Lester Levy – for absence • Dr Andrew Brant – early departure	Kay Jenkins
1.	Interest Register	• Gabrielle Huria and Barry Bragg – declared conflicts in relation to Carparking • Catherine Chu, James Gough and Aaron Keown – perceived conflict in relation to Bus Super Stop and Carparking	Kay Jenkins
2.	Confirmation of Minutes – 20 August 2020	Adopted: Sir John Hansen / Aaron Keown	Anna Craw
3.	Carried Forward/Action Items	Nil	
4.	CDHB Research - Presentation	Nil	
5.	Schedule of Meetings 2021	Adopted: Aaron Keown / Sir John Hansen	Anna Craw
6.	Bad Debt Write-Off	Adopted: Barry Bragg / Ingrid Taylor	Anna Craw
7.	Committee Vacancies	Adopted: Sir John Hansen / James Gough	Anna Craw
8.	Chairs Update	Nil	
9.	CEO Update	Nil	
10.	Finance Report	Nil	
11.	Advice to Board: • CPH&DSAC – 3 September 2020 - Draft Minutes	Noted: Aaron Keown / Naomi Marshall	Kay Jenkins
12.	Resolution to Exclude the Public	Adopted: Gabrielle Huria / Barry Bragg	Kay Jenkins
	Information	Meeting concluded at 11.05am. Morning tea from 11.05-11.20am	

Distribution List:
Kay Jenkins

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 15 OCTOBER 2020

DATE	ISSUE	REFERRED TO	STATUS

There are no carried forward items.

The Christchurch Cancer Foundation

Development Proposal

SOUTHERN COMPREHENSIVE CANCER CENTRE

www.christchurchcancerfoundation.nz
P O Box 1946, Christchurch 8140

The Christchurch Cancer Foundation

A SOUTHERN COMPREHENSIVE CANCER CENTRE

Proposal:

The Christchurch Cancer Foundation has developed this business case for a publicly funded Comprehensive Cancer Centre (CCC), supported by the University of Otago.

To address the increasing demand for cancer treatment in New Zealand and the increasing difficulty attracting the necessary cancer professionals as our population grows and ages, we have looked to solutions which have proven effective elsewhere. The Comprehensive Cancer Centre model has now been adopted in most developed countries with outstanding results, decreasing 12-month mortality rates in cancer patients substantially.

This proposal is for New Zealand's first Comprehensive Cancer Centre, to provide an equity-based, multidisciplinary, integrated approach to cancer research, education, and comprehensive clinical care for the two million people in central and southern New Zealand.

CANCER: AN INCREASING BURDEN

Cancer is the leading cause of death in New Zealand, and accounts for nearly one-third of all deaths. In New Zealand more people are developing cancer – mainly because the population is growing and getting older. In 2016, 24,086 New Zealanders were diagnosed with cancer; an increase of 21% since 2007.

Approximately 40% of men and women will be diagnosed with cancer at some point during their lifetimes, which means that we can all expect to be 'touched' by cancer to some extent at some stage.

By 2040, the number of diagnoses is predicted to double to around 52,000, or 142 people a day.

Internationally, survival trends for cancer are generally increasing. Until recently, New Zealand's five-year survival rates had been similar to those of the United States, Canada, Australia, Finland, Iceland, Norway and Sweden.

Now, however, our survival rates are falling behind. For example, Australia has shown significant improvements in overall cancer survival (6% in men, 3% in women) over ten years, while New Zealand over the same period had only a 1.8% increase in cancer survival in men and 1.3% in women.

In response to the increasing demand for cancer treatment, the Ministry of Health has developed the New Zealand Cancer Action Plan 2019-2029 to provide a pathway to improve cancer outcomes. On 1 December 2019, the Government launched the Cancer Control Agency (Te Aho o Te Kahu) to lead the implementation of this Action Plan, with the stated aim of improved outcomes in terms of survival and equity for patients with cancer.

ADDRESSING HEALTH INEQUITIES

In any community, cancer has a disproportionate effect on indigenous people and those on lower incomes. In New Zealand, Māori are 20% more likely to get cancer than non-Māori, and nearly twice as likely as non-Māori to die from cancer.

It is essential that we ensure the rights and meet the needs of Māori people. Given that Māori have the poorest overall health status in New Zealand, they have higher rates of most cancers and worse outcomes for most stages than others and are significantly disadvantaged in terms of health inequities.

Improved approaches to the delivery of cancer treatment need to be considered in a manner that encourages Māori involvement at all levels and improves Māori health outcomes. Integration of research and especially clinical trials into clinical practice in a manner that promotes Māori involvement at all levels is critical to improving the cancer outcomes for all New Zealanders.

A NEW, MULTIDISCIPLINARY APPROACH

Retaining the delivery of care under today's model will continue to grow the disparity in health outcomes. The present model has led us to today's declining outcomes, and a change, not just in philosophy (which we have seen) but in the model we use to deliver care, is required.

An integration of clinical practice and research, especially clinical trials, is well established as providing better outcomes across a range of outcome measures including survival, evidenced in the Comprehensive Cancer Centre (CCC) model now used across the world.

The CCC model, initially established by the US Government, was developed to improve cancer outcomes. The hallmarks of a Comprehensive Cancer Centre – comprehensive and multidisciplinary care – mean that specialists from different medical disciplines collaborate to plan, evaluate and deliver accurate cancer specific diagnosis and treatment, with integration of basic and clinical research pushing to improve outcomes.

The CCC model will allow New Zealand to deliver on the policy direction the government has so clearly defined, achieving the recommendations of its 2020 Health and Disability System Review.

This proposal, modelled on the Victorian Comprehensive Cancer Centre (Peter Mac) in Melbourne, has been researched and developed in consultation with leading cancer professionals and internationally recognised experts in CCC design and operation.

This proposal addresses:

- Patient comfort and psychological experience
- Equity-led outcomes
- Cancer treatment outcomes
- Cancer case twenty-year forecast
- Benefit for the recruitment of cancer professionals
- University of Otago Christchurch postgraduate cancer course opportunities
- Space creation at Christchurch Public Hospital
- Cancer-care cost efficiencies
- Valuable hospital redundancy
- Retention or return of New Zealand educated clinician scientists
- Leadership for the national cancer plan in prevention
- Provision of improved cancer screening by use of telemedicine
- Selective centralisation for complex cancer care
- Enabling New Zealand to participate in international clinical trials, with a research infrastructure
- Potential for international investment to support such trials.

RECOMMENDED CCC STRUCTURE

This proposal recommends the following structure:

- A National Cancer Institute-designated Comprehensive Cancer Centre
- A government-funded public hospital
- Potential for identification as a 'University Hospital'
- Its own Board and management structure answering directly to the Minister/Ministry of Health
- Operated independently of the District Health Boards of the regions
- Cancer services currently provided by the Canterbury District Health Board to be relocated to the CCC
- A globally recognised, university affiliated research program.

We propose that the CCC be a government-owned hospital institution, reliant on government for all basic funding. We anticipate that such an entity would attract significant external research programmes, providing indirect financial support to the CCC.

Our proposal is for the governance to include representation from the following bodies:

- The University of Otago
- The Canterbury District Health Board
- Te Rūnanga o Ngāi Tahu
- The Christchurch Cancer Foundation

PROPOSAL

A NCI accredited Comprehensive Cancer Centre

The CCC model, established by the US Government, is a centre of excellence for cancer and has now been adopted in most developed countries.

This proposal is for New Zealand's first (of two) Comprehensive Cancer Centre, to be located within the Christchurch Health Precinct and within the University of Otago Christchurch campus. It will provide an equity-based, multidisciplinary, integrated approach to cancer research, education and comprehensive clinical care.

Hub & spoke national cancer care structure

Our proposal is for this CCC to service southern and central New Zealand, including Manawatu and Hawkes Bay. The current population of this area is two million. If an Auckland based CCC was approved, it would cover those regions further north, serving a population of three million. These comprehensive facilities would provide the major clinical care, supported by the regional hospitals and clinics providing ongoing treatment such as scheduled radiation and chemotherapy.

The Christchurch Cancer Foundation

A government-funded public hospital

This proposal is for a publicly-funded Comprehensive Cancer Centre (CCC), which would stand outside the DHB network, but otherwise operate financially as a public hospital. All of the existing cancer services currently provided by Christchurch Hospital, with the exception of some very complex and acute cases, would be relocated to the CCC.

Its own Board and management structure

The fundamental premise behind this proposal for central and southern New Zealand, is that a Comprehensive Cancer Centre be developed, with governance to include representatives of the University of Otago, the Canterbury District Health Board, Te Rūnanga o Ngāi Tahu, and The Christchurch Cancer Foundation.

The institution would work collaboratively with the other cancer service providers throughout New Zealand, and consult continually with the ethnic, civil, and professional groups of the region. We believe this model will gain far greater benefits in both equity and patient outcomes, as an individual organisation.

Patient comfort and psychological considerations

This proposal has been developed with assistance from a London based consultant Catherine Zeliotis, who specialises in cancer centre design, and who has published the article *"Where to next for cancer centre design?"* [1]

Cancer treatment outcomes

There are many quality measures for cancer care, however over 70% are process related. A CCC by its nature has a more coordinated and integrated service and scores better when compared with other hospitals and institutions. In discussions about the added value of CCCs in terms of resources and processes, most relevant is whether it improves patient outcomes and equity.

Evidence from the United States, United Kingdom, Europe and Australia shows that patients treated in CCCs have better survival outcomes than those treated in other hospitals and institutions. For example Pfister et al. (2015)[2] showed that cancer patients treated in the 11 largest CCCs in the United States have a risk-adjusted probability of death 10% lower than among all cancer patients treated at United States community hospitals.

The survival at 12 months from diagnosis, is increased in CCCs compared to community hospitals, in patients with colorectal cancer by 50%, with prostate cancer by over 60%, lung cancer by over 70% and breast cancer by 100%. This pattern of improved survival persisted through five years of follow-up overall and within specific cancer categories.

CCCs are most important for vulnerable populations (underrepresented minorities) because sociodemographic factors are intrinsically linked to both health care delivery and quality, and this most impacts what a patient receives in cancer health care. CCCs can develop processes that correct for these sociodemographic factors and lead to better access, management, support and research for Māori and others who are presently poorly serviced by the cancer health care delivery systems. With the policy imperative that inequalities of care should be reduced, these indications are a major challenge to the thinking around organisation of care and integration of research which CCCs can, and do, address.

Cancer case twenty-year forecast

The Government predicts a 100% increase in cancer cases over the coming 20 years, consistent with predictions in other countries. This will require a 100% increase in clinicians (and other professional staff), as well as replacement of almost 100% of the existing clinicians who will retire during this period.

To meet the recruitment needs, Canterbury would need to recruit up to 180 clinicians over 20 years. This equates to one new clinician being recruited every 40-50 days for Canterbury, and one clinician every 8-10 days nationally - commencing immediately.

Benefits for the recruitment and retention of clinicians and other professionals

Some of the major strengths of this proposal are the very considerable benefit a CCC would provide in attracting cancer clinicians from other countries (all major English-speaking countries already have CCCs), and to have the University Medical School so closely associated with the CCC.

UOC postgraduate cancer course opportunities

This proposal provides a further substantial benefit toward the very challenging requirement for clinician (and other cancer professional) recruitment, through the increased opportunity the University of Otago Christchurch (UOC) would have to offer increased specialist cancer courses.

The possibility for the CCC to be identified as a 'University Hospital'

If the CCC was to become identified as a University Comprehensive Cancer Centre, or University Hospital, in which a university academic appointment was required, it would be the only such institution in Australasia, and would provide an added attraction to prospective medical recruits.

Public Hospital space creation

The relocation of the various cancer departments, together with the cancer related surgical and post-surgical inpatient requirements, will free an estimated 30-35% of the existing departmental net area of the Christchurch Hospital, thus providing the CDHB the valuable time necessary to plan the future expansion of the hospital, and benefit from developing technologies.

Valuable hospital redundancy

The addition of a fully equipped surgical hospital, which could be turned into an acute facility at short notice, would provide the CDHB with a very valuable level of redundancy in times of emergency, in a city susceptible to earthquakes and flooding.

Cancer care cost efficiencies

The operating accounts of the Peter Mac, show that the costs associated with the people employed and contracted by Peter Mac, represent approximately 50% of the total expenses, whereas the cost of the building (including interest and repaying the entire capital cost over 25 years) was just 12%. The interest content, based on current interest rates, would be approximately 3.5% of the total operating expense of the entire Comprehensive Cancer Centre.

If these were the ratios experienced in the proposed CCC, the inevitable cost efficiencies achievable, primarily in time saved, through the numerous benefits of a purpose-designed and built building, will clearly exceed the interest costs of financing the building, and contribute a significant amount toward the capital repayment. At Christchurch Hospital, where cancer surgery is combined with the acute services, elective cancer surgery lists are commonly cancelled during winter months on account of hospital bed shortages for post-surgery patients. The value of these lost operations is considerable.

SITE, BUILDING, AND FUNDING

This proposal is for a Comprehensive Cancer Centre of 40,000-45,000m^2 to be erected facing Hagley Park on the site of the existing Canterbury Laboratories buildings. The character of the building would be developed through the architectural approach now widely adopted overseas. We envisage the building being between eight and nine levels above ground, with two or more levels below.

To locate the building in this position would require the immediate re-planning of the block bounded by Hagley Ave, St Asaph St, Antigua St, and Tuam St. In particular, the recently announced new parking building would need to be relocated from its proposed location overlooking Hagley Park, to the more central location on the north east corner of the block. This location offers several advantages including being closer to the hospital, and the ability to provide a covered link (across Tuam St) to the Outpatients Building.

A revised plan of the block is attached, together with an architectural colour perspective of a possible building design, and a possible departmental floor stack diagram.

The Victoria State-owned VCCC facility was delivered as a 'turn key' PPP development including design, construction, project management, and funding, by the international developer Plenary Health. Such an arrangement could be available for this proposal. Another possibility, as an alternative to a fully government funded development, is for the base building to be developed and leased to the ministry, as are many other government buildings throughout the country. We would be willing to facilitate such an arrangement.

THE CHRISTCHURCH CANCER FOUNDATION

The Christchurch Cancer Foundation has been structured with a long-term outlook, to support the recruitment of cancer professionals to Christchurch.

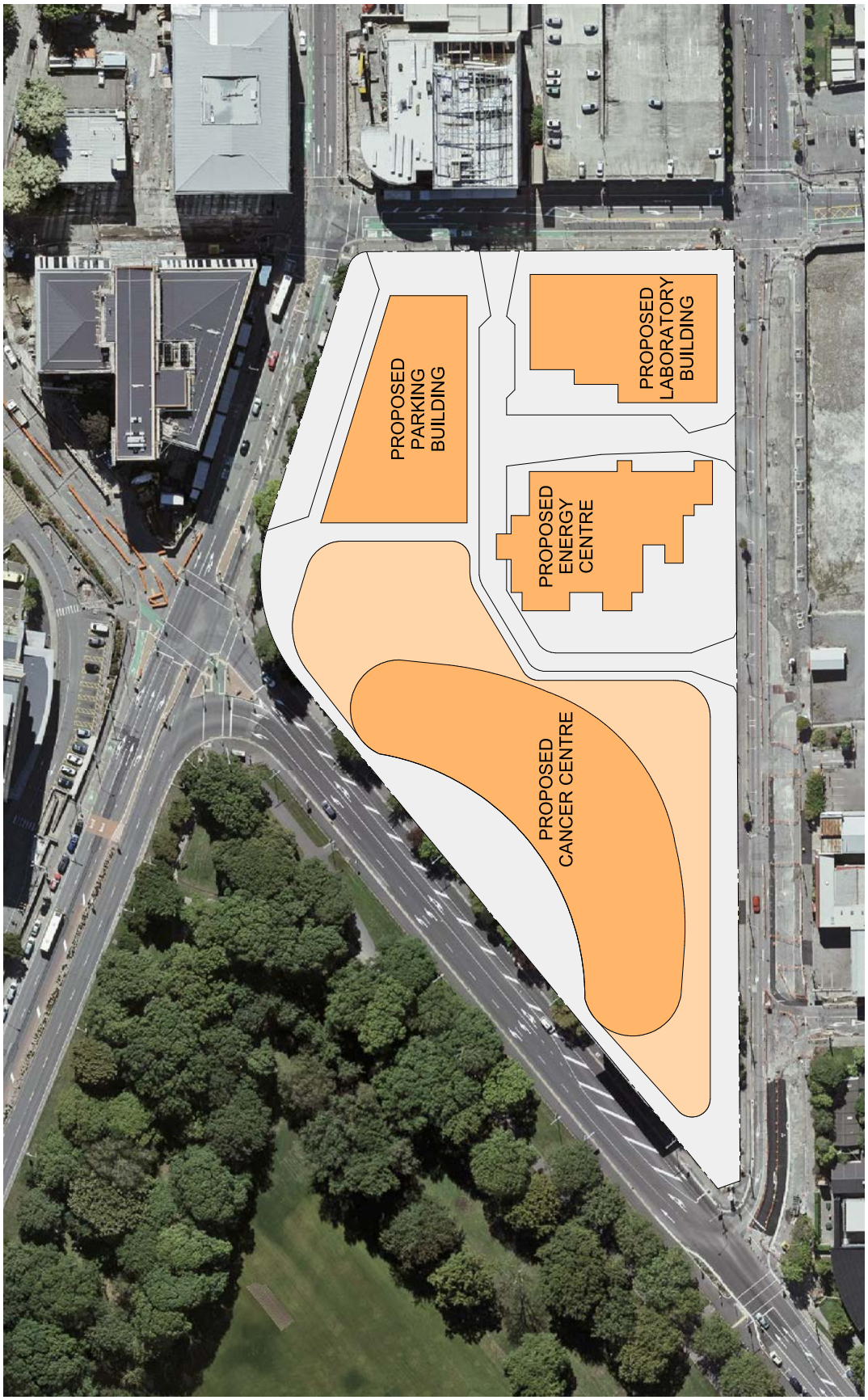
This proposal has been developed with the single-minded objective of improving outcomes for cancer patients from central and southern New Zealand, and to advance the region's ability to recruit and retain cancer clinicians. We appreciate that the model proposed may be regarded, by some, as disruptive.

We have posted several papers about cancer care and comprehensive cancer centres on our website, which we invite you to visit.

www.christchurchcancerfoundation.nz

1 www.ncbi.nlm.nih.gov/pmc/articles/PMC6502617/
2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6396367/#mol212442-bib-0009

The Christchurch Cancer Foundation

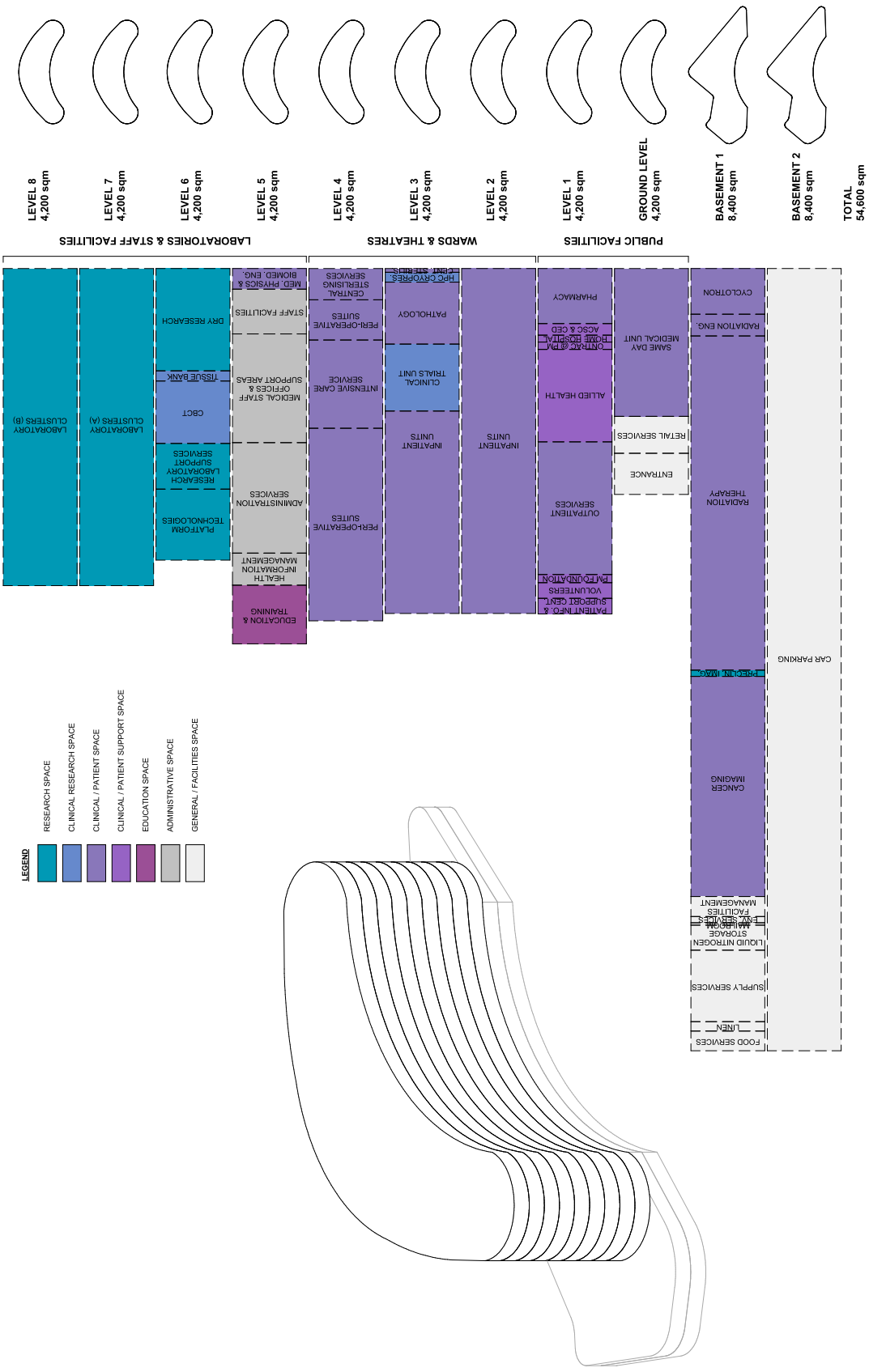


CHRISTCHURCH COMPREHENSIVE CANCER CENTRE

Wilson+HillArchitects

DATE / September 2020
SCALE / Not to scale (NTS)
Preliminary

The Christchurch Cancer Foundation



Wilson+HillArchitects

CHRISTCHURCH COMPREHENSIVE CANCER CENTRE

DATE / September 2020

SCALE / Not to scale (NTS)

Preliminary

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Could comprehensive cancer centres improve cancer outcomes and equity in New Zealand?

Frank Frizelle, Murray Brennan

In the midst of the present Covid pandemic it is easy to forget that we have an ongoing cancer pandemic that will not be ameliorated by a generic vaccine. Globally, based on 2013–2015 data approximately 40% of men and women will be diagnosed with cancer during their lifetime, meaning that most of us can be expected to be affected by cancer, either directly or indirectly.[1]

In New Zealand, cancer is now the leading cause of death, with cancer deaths making up 30.2% of all deaths, ischaemic heart disease 15.8% and cerebrovascular disease 7.8% in 2015.[2] More people are developing cancer in New Zealand, mainly because the population is growing and ageing. In 2016, 24,086 people in New Zealand were diagnosed with cancer; an increase of 21% since 2007.[3] By 2040, the number of cancer diagnoses is predicted to double to around 52,000, or 142 people a day.[4] The cancer burden is not evenly distributed in any community with a disproportioned effect on indigenous people and those on lower incomes. In New Zealand, Māori are 20% more likely to get cancer than non-Māori, and nearly twice as likely as non-Māori to die from cancer.[5]

Internationally, survival trends for cancer are generally improving, with New Zealand's five-year survival rates, similar to those of the US, Canada, Australia, Finland, Iceland, Norway and Sweden.[7] New Zealand does have a lower cancer survival compared to our neighbour Australia, and this difference is increasing.[8,9] For example, Australia showed significant improvements (6% in men, 3% in women) in comparing the periods 2000–05 and 2006–10, while New Zealand had only a 1.8% increase in cancer

Figure 1: Provisional New Zealand cancer mortality rates, 2016, selected cancers, Māori vs non-Māori, non-Pacific.[6]

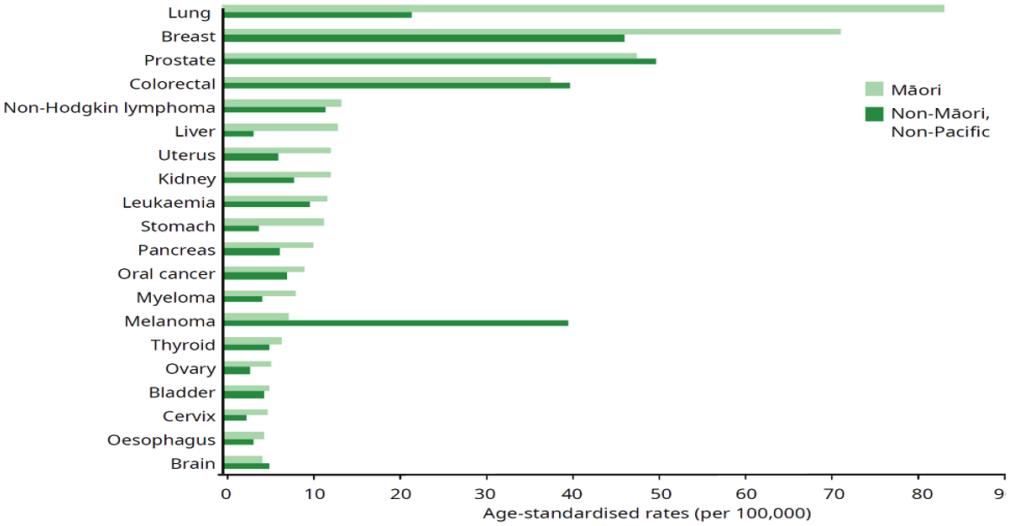
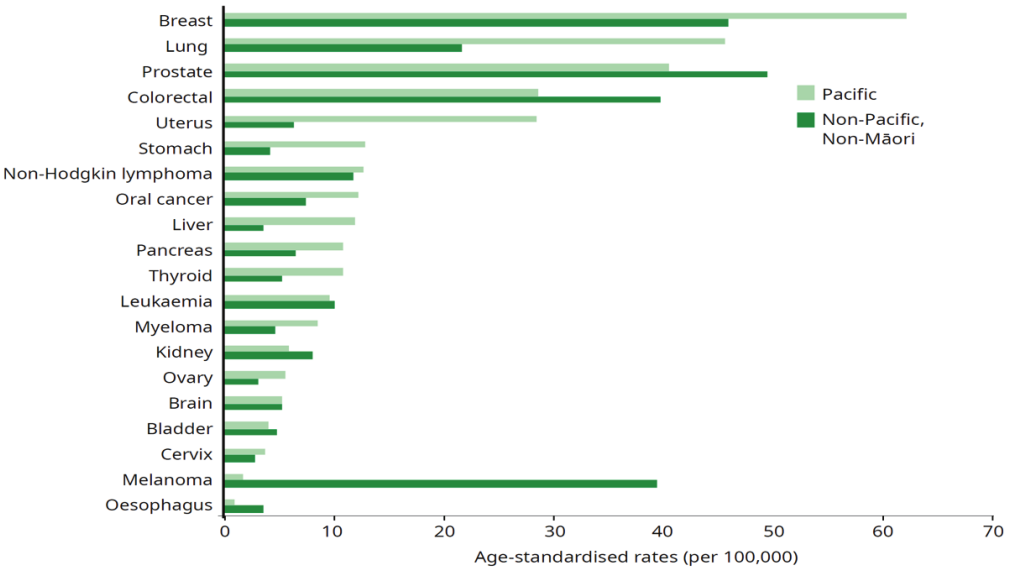
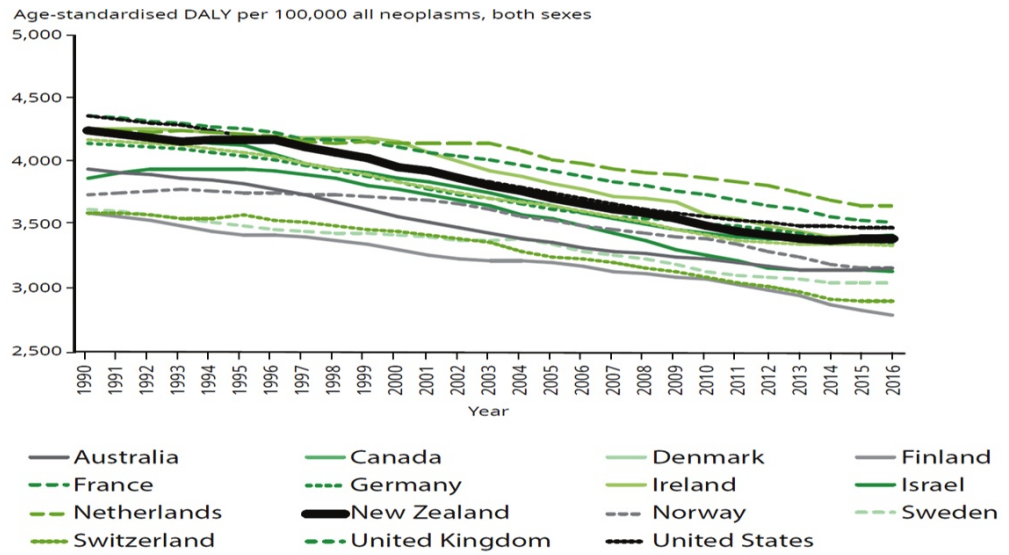


Figure 2: Provisional New Zealand cancer registration rates, 2017, selected cancers, Pacific vs non-Pacific, non-Māori.[7]



survival in men and 1.3% in women.[9] The five-year survival rates for these common cancers for Australia and New Zealand are, respectively: colorectal: 70.9% (Australia), 65% (New Zealand); lung: 19.4%, 15.3%; breast (women) 89.5%, 87.6%; prostate: 94.5%, 90.3% and melanoma: 92.9%, 91.8%, from 2000–05 to 2006–2010. Differences in cancer survival trends are thought most likely to, due to healthcare-related factors such as early diagnosis and optimum treatment.[9] This demonstrates that our survival rates from cancer are now falling behind those of our comparable countries and has not been improving at the same rate as elsewhere.[7–9] The impact as measured by disability adjusted life years lost by cancer is illustrated below.

Figure 3: Age-standardised disability-adjusted life years lost per 100,000, all neoplasms, both sexes, selected countries, 1990–2016.[6]



In response to the increasing demand for cancer treatment, the Ministry of Health has developed the New Zealand Cancer Action Plan 2019–2029 to provide a pathway to improve cancer outcomes.[6] On 1 December 2019, the Government launched the Cancer Control Agency (Te Aho o Te Kahu) to lead the implementation of this plan.[10] Key priorities for the agency include providing accountability, coordination of various agencies involved in cancer, and working to implement the Cancer Action Plan. Te Aho o Te Kahu has been charged with working closely with people impacted by cancer, including their whānau and healthcare professionals, as well as with Māori and Pacific leaders to ensure that they inform them on how best engage with them to meet their needs.

The New Zealand Cancer Action Plan 2019–2029 sets out the four main goals required over the next 10 years to ensure better cancer outcomes:[6]

- New Zealanders have a system that delivers consistent and modern cancer care
- New Zealanders experience equitable cancer outcomes
- New Zealanders have fewer cancers
- New Zealanders have better cancer survival, supportive care and end-of-life care.

This plan has a strong focus on achieving equity of outcomes and contributing to wellness for all, and recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. The plan states that it is guided by four overarching principles;

- Equity-led
- Knowledge-driven
- Outcomes-focused
- Person and whānau-centred.

Given that Māori have the poorest overall health status in New Zealand, have higher rates of most cancer and worse outcomes for most stages than others and are significantly disadvantaged in terms of health inequities, it is essential that we ensure the rights and meet the needs of Māori people; new approaches to the diagnosis and delivery of cancer care is needed to be considered with the integration of research and especially clinical trials into clinical practice in a manner that promotes support. Māori involvement at all levels is critical to improving the cancer outcomes for all New Zealanders.

The present model has led us to where we are today and continuing the delivery care in the same model will likely keep the disparity in outcomes growing. A change, not just in philosophy (which we have seen) but in the model we use to deliver care is required. The integration of clinical practice and research is well established as providing better outcomes across a range of outcome measures, including survival with comprehensive cancers centres across the world.

The Comprehensive Cancer Centre (CCC) model, initially established by the US Government was developed to improve cancer outcomes. A hallmark of a CCC—comprehensive and multidisciplinary care—means that specialists from different medical disciplines collaborate to plan, evaluate and deliver accurate cancer-specific diagnosis treatment, with integration of basic and clinic research pushing to improve outcomes. CCCs are places of excellence for cancer management and have now been adopted at least in part in most developed countries. In the UK The Maggie cancer centres have developed as a charity independent of the NHS, yet linked to the provision of care to provide the support and care needed to help patients with cancer. This culturally appropriate integration of comprehensive multidisciplinary clinical care, research and psychosocial support is a model that may meet the needs of New Zealand to achieve its cancer outcome goals and help close both the outcome and the equity gap.

Below, New Zealand's most famous cancer surgeon (Professor Sir Murray Brennan) tells his perspective of working in such a centre and how this might work in New Zealand.

From a New York perspective

I have spent almost 40 years at one of the most visible cancer centres in the world, Memorial Sloan Kettering Cancer Center in New York City. If I did not believe in the mission, the achievements and the relevance, I would never have stayed.

In the 1880s, J Marion Sims was the person who originally proposed the idea of a cancer centre in New York City: "…a cancer hospital (should be built) on its own foundation, wholly independent of all other hospitals… Its medical board ought to be men who go in to it with zeal, determined not only to give temporary relief to human suffering, but to do something toward discovering better methods for treatment…"

A visionary, Sims' interest grew from the difficulty of women with gynaecological cancer to be treated in general hospitals in the mid-to-late 19th century. No paragon, Sims was a controversial figure having left New York at the time of the American Civil War to avoid fighting for his home in the North or his birthplace in Alabama. Imminently successful in Europe, he returned to New York with zeal for his work. President of the American Medical Association, he was honored by his peers and a statue erected in his name in Central Park. This statue was recently removed as it represented a symbol of a man who performed surgery on African American slaves in the 1840s without consent and in the absence of anaesthesia—a conflicting story of competing ethics.

Sims died in 1883 aged 70, before the Memorial Hospital was opened in 1884 with benefaction from the rich and famous of the day, including John Jacob Astor III and his wife Charlotte, Elizabeth H Cullum, John E Parsons and other prominent New Yorkers.

But what has happened in the 136 years since the opening of what is now MSKCC? The buildings and the staff have proliferated across the upper East Side and on out to the suburbs, with a total staff approaching 20,000 with 1,000 volunteers, and an education programme that embraces almost 2,000 residents and clinical fellows, and an operating revenue which would have reached $5 billion in 2020 had not COVID-19 brought that to a halt or at least a slow walk.

Across the US there are 71 cancer centres, 51 comprehensive, 13 clinical and seven basic—a cancer centre for every 2.5 million people, a comprehensive centre for every six million people. Australia has an admirable institute built on clinical care—the Peter MacCallum Cancer Centre. Founded by Peter MacCallum, a Scottish-born oncologist raised in childhood by his New Zealand father in Christchurch! One might conjecture it was the relative ill health of Peter MacCallum from exposure to nitrogen mustard gas in 1918 that led him to a career in research and pathology. Ironically, it was nitrogen mustard that was the first cancer therapeutic used in the management of leukaemia and lymphoma because of its hematopoietic toxicity.

What are the real and potential benefits of such a disease-specific focus? The original mission of excellence in clinical care, research and education are embodied in the MSK logo—Research, Treatment, Education. For MSK this statement has been recently modified to read "To lead in the prevention, diagnosis, treatment, and cure of cancer through programs of excellence in research, education, outreach, and cost-effective patient care" to reflect and address the socioeconomic problems of healthcare in the US.

The pyramidal building of a cancer centre begins with integrated patient care, integrated from diagnosis to demise. Few appreciate how difficult it is to embrace the idea that cancer is not one but a myriad of diseases. When asked how many cancer types there are, I answer obliquely that "one day there will be as many different cancers as there are different people with cancer." With rapid evolution and characterisation of the human genome we know the genetic variation that calls us each a person. With molecular diagnosis we know, at least in part, the ever-evolving genetic definition of each cancer, and as we put your cancer into you, we have that unique identifier. But that demands a high degree of research which, you will say, belongs in the basic labs of any university or research facility. I would argue that that challenge can be admirably met by juxta-positioning the patient and the science in the one place. "Know then thyself, presume not God to scan; The proper study of mankind is man."[11]

Again, that is no reason for a cancer centre alone. Any competent clinical facility with a translational research arm can do that. In many places that is how an institution, clinic, hospital or university division begins and evolves into a designated cancer centre.

Outcomes for cancer patients treated at varying sites have been long studied.[12] A multitude of studies have demonstrated that for surgical outcomes, volume, especially for

complex cancers, improves with centralisation.[13,14] Not all cancer patients will benefit from referral centres; such a concentration is neither necessary nor realistic. We are in the process of deciding how many is enough for complex cancers to get results comparable to those best available.

But do cancer centres deliver better comprehensive cancer care, better long-term survival outcomes?

It is now clear that not only short-term but long-term survival can be improved if patients are treated from diagnosis at focused referral cancer centres.[15,16]

And what of the benefits in research and education? Research, both clinical and basic, are integral to any progress in the management of the cancer patient. Without a fundamental understanding of the etiology, initiation, progression and the metastatic process, ultimate control and cure is impossible.

New Zealand has a remarkable resource in their National Health Care data bases. The utilisation of such a data base is a potential rich source for identifying variations in the delivery of healthcare by variables such as site, race and ethnicity. As in other societies, the use of such data is often limited not by the value of the information but by the political ramifications of transparency.

The newly formed New Zealand National Cancer Programme is focused on "access to high quality screening and care". Without access to screening and early diagnosis for potential cure it is hard to improve cancer outcomes for all citizens. The focus by the New Zealand National Cancer Programme on regional networks would allow such screening programmes to translate to expedited timely care. While many cancer centres do focus on screening, the majority do not, as that is better left to the community with selective referral to regional centres, reserving complex and less common cancers to be referred to a comprehensive cancer centre. Despite not having the benefit of screening programmes, cancer centres do have better short- and long-term outcomes, corrected for all stages.

Cancer centres cannot survive only on integrated cancer care; they must provide innovation and progress. That cannot occur without sound basic and translational research and opportunities to educate the brightest and the best.

The rapid adoption of telemedicine brought about by the Covid-19 pandemic has opened a new opportunity for cancer centres. Clinical trials and clinical research are no longer necessarily confined to cancer centres. It is progressively clear that the former mandatory relocation to a centre to participate in a clinical trial may not be necessary. With telehealth, clinical trial oversight will allow trials to be extended with remote patient participation. That requires a centralised cancer centre infrastructure but could portent an option for New Zealand to participate and initiate clinical trials on a national and international platform.

Financing of all cancer centres is a challenge. The Peter MacCallum is Australia's only public hospital dedicated to cancer care. In the US, cancer centres rely predominately on revenue from patient care, albeit often private insurance rather than federal support by programmes such as Medicare and Medicaid. All centres rely on philanthropic and competitive grant support to advance their research mission. This is different from what I understand of the New Zealand health system; however, support from research grants and healthcare are not that different. When I look at our own financial base, with a $4.9 billion operating revenue, 80% is derived from patient care revenue, 7% from grants and contracts, 12% from contributions, investment income and royalties.

So, is it time for New Zealand to consider a national cancer centre? The building blocks of the new cancer programme would suggest that could be the next step. No doubt there are unique challenges in New Zealand that I have not appreciated. However, great the challenges, the benefits for the cancer patient, the physicians, the research scientists and the public are real.

Competing interests:
Nil.

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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 o Waitaha

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

PREPARED BY: **Dr Peter Bramley, Acting Chief Executive**

DATE: **15 October 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 provided by Operational General Managers, Programme Leads, and Executive Management Team members.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

3. DISCUSSION

COVID Catch-up: As at 24 September, at total of 1,139 admitting events had been cancelled across the DHB due to the COVID restrictions. Services have been working to provide the deferred events, which are being rebooked following clinical reprioritisation. All but 32 of these events have now been closed.

Planned Care Targets: Plans for 2020/21 incorporated the provision of 19,614 discharges following an operation – 432 more than the 2019/20 plan. As at 25 September (week 13), we have delivered 4,925 inpatient surgical discharges. This is just 32 behind the target of 4,957 for this period. We are well ahead of the target for minor procedures in hospital settings having delivered 613 as inpatients (275 ahead of target), 2,538 as outpatients (621 ahead of target) and 2,315 procedures in community settings (1,716 ahead of target). In all 5,466 minor procedures, 2,613 more than the year-to-date target of 2,853.

PUTTING THE PERSON FIRST – PATIENT SAFETY, QUALITY & IMPROVEMENT

Performance Highlights

Consumer Engagement Marker: The national Health Quality and Safety Commission's consumer engagement marker is being introduced in 2020/2021. The goal is to understand and promote what successful engagement looks like and how consumer engagement improves the quality and safety of services for consumers. As a pilot site for the marker Canterbury DHB was able to co-design ideal engagement during the marker development and following Maori and Pacific consumer feedback a local communication tool, Te Whare, was developed. A consumer and community engagement video has also been developed to show the journey so far. The DHB will report twice yearly on how consumer engagement takes place and will self-assess maturity levels. The first evidence is expected in March 2021.

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Covid-19 Managed Isolation Guest Survey: After wide consultation with partner organisations, the managed isolation guest survey, developed by Canterbury DHB's Quality & Patient Safety Team, has gone live. The questions are similar to patient experience questionnaires used for inpatient, outpatients and general practice, with specific service additions. The early response rate is 30% (110) with overall results for the domains being highlighted below. While the lowest rating question related to consistent information by staff (58%) overall feedback was that stay was well coordinated (90%).

LIVING WITHIN OUR MEANS

Performance Highlights

Year-to-Date (YTD) to August 2020 net expenses (excluding further Holidays Act compliance costs) are $8.605M, being $1.011M favourable to the annual plan agreed by the Board on 20 August 2020. The YTD result is $1.098M favourable to plan.

The net impact associated with the Covid-19 in August is a $1.922M surplus, therefore the underlying result (excluding Covid-19) is $0.912M unfavourable for August and $0.392M favourable YTD.

The following table provides the breakdown of the August result:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.098	0.000	0.098	0.136	0.000	0.136
Funder	(5.833)	(5.906)	0.073	(15.853)	(16.783)	0.930
DHB Provider	(2.870)	(3.710)	0.840	(6.871)	(6.902)	0.031
Canterbury DHB Group Result	**(8.605)**	**(9.616)**	**1.011**	**(22.588)**	**(23.685)**	**1.098**

MEDICAL / SURGICAL SERVICES

Performance Highlights

COVID Catch-up: 993 medical and surgical admitting events were cancelled due to the COVID19 lockdown. Medical and Surgical Services have been working to provide the deferred services, which are

being rebooked following clinical reprioritisation. As at 28 September all but 11 of these events have been closed and of those eight have an admission rebooked.

First Specialist Assessment Waiting Times: The DHB's improvement plan provides a weekly target for reducing the number of patients waiting longer than 120 days. As at 28 September Medical and Surgical services are meeting this objective for First Specialist Assessments with 1,061 people waiting for longer than 120 days against an overall target of 1,896 people. Four specialty areas within Med Surg have no patients waiting for longer than 120 days, 20 are meeting their recovery plan target and four are not.

Treatment Waiting Times: At a DHB level we are also now meeting our improvement plan waiting times for Treatment. At 28 September there are 875 patients waiting for longer than 120 days, against a target of 1,169. One specialty area has nobody waiting longer than 120 days, nine are meeting their recovery plan target and two are not. Campus clinicians and operational teams are optimising the provision of clinic and theatre activity and rigorously managing acceptance of referrals against HealthPathway criteria.

Production Levels: As at 25 September (week 13), we have delivered 4,925 inpatient surgical discharges, just 32 behind the target of 4,957 for this period. We are well ahead of the target for minor procedures in hospital settings having delivered 613 as inpatients (275 ahead of target) and 2,538 as outpatients (621 ahead of target).

Leave Care: The General Manager, nursing and service leaders continue to promote leave care. Activity reports covering across the Christchurch Campus indicate that 773 of 1,248 people with a red category annual leave balance (i.e. > 30 days) have received first level conversations with their managers. Based on leave bookings in Max 136 of these people will move out of the red zone by the end of January.

Preparations for the shift to Hagley: Migration plans are well developed. Onsite orientation for staff starts on 5 October and those that will lead the orientation are currently being trained. Most areas are stocked and prepared and fine detail of processes for the shift and ways of working in the new facility are being worked through

Accelerating Our Future

Remote Monitoring of Pacemakers: Patients with pacemakers need to have regular checks of their devices to ensure proper performance and monitoring of battery performance. Device technologists from Christchurch Hospital have worked with vendors to establish remote monitoring centres in Timaru, Ashburton, Westport, Greymouth, Kaikoura and the Chatham Islands. This service enables patients, assisted by local health staff, to transfer data to the device team at Christchurch Hospital for analysis but avoids the need for patients to spend time travelling and eliminates travel costs for the DHB. For patients from the Chatham Islands this avoids a cost of $4,000 per visit, saving $12,000 per patient in the first year with an estimated $56,000 savings over the ten-year life of each pacemaker.

Streamlining Practice: The Radiology service has implemented a multi-use contrast delivery system that improves productivity by streamlining CT contrast preparation practices, is safer for patients and has less handling required compared with connecting single-patient use tubing. It also reduces the wasted fluids and plastic waste associated with the existing single use system. Cost savings on consumables alone are estimated at $287,000 annually with an estimated saving of $227,000 in 2020/21.

Roster Changes: Plastic Surgery registrar roster changes are reducing the requirement for additional duties and cross cover charges. These changes will give us a compliant roster, as a result improving wellbeing, health and safety, whilst bolstering overnight cover.

Choosing Wisely: The introduction of generic intravenous Starter Kits for cannulation will reduce the cost of the items required by just over $1 per cannulation. This small product change is expected to save approximately $206,000 per annum.

Risk Management

Medical Oncology: The incidence of cancer in the community has continued to increase as our population ages and at the same time improved cancer management and detection, newly funded medications, and additional treatment options have improved the quality and length of life for cancer patients, meaning there has been an exponential rise in the workload for Medical Oncology services.

A significant level of unplanned leave, alongside the usual load of planned leave, has meant that our Medical Oncology service is operating below its usual capacity. This has severely reduced the department's ability to provide planned specialist assessments and follow up appointments and the service is in the process of deferring and rescheduling appointments based on clinical need. The service is working hard to minimise the impact for patients and keep waiting times as low as possible although patients will wait longer than usual for their appointments until full capacity is again available.

Actions urgently underway include: upskilling and redistributing trainees to cover expected increases in acute demand, urgent development of nurse specialist services to aid management of patients in 'active care', exploring outsourcing options, recruitment of additional SMOs and working with primary care to ensure patients receive the support and care they need.

Sick Leave: In the Med Surg division, for the 12-month period to the end of August, the proportion of staff in the sick leave green zone is 1.7% higher than the November 2019 baseline - reaching 71.7%. The division continues to work with People and Capability to implement the leave care programme.

WOMEN'S AND CHILDREN'S HEALTH SERVICES

Performance Highlights

COVID Catch-up: 158 Women's and Children's admitting events were cancelled due to the COVID19 lockdown. As at 23 September all but one of these events have been closed and the service is working with this one patient to find a mutually agreeable date for their planned admission.

ESPIs: As at 28 September Women's and Children's are meeting the ESPI improvement plan objectives for people waiting longer than 120 days for First Specialist Assessment in six speciality areas and not meeting them in seven. There is one area where no patients are waiting longer than 120 days. In relation to waiting times for Treatment one specialty area is meeting its improvement plan target and the other is not. Campus clinicians supported by operational teams are optimising the provision of clinic and theatre activity and rigorously managing acceptance of referrals against HealthPathways criteria.

Accelerating Our Future

Inductions Management: A high proportion of women (40%) being supported at Christchurch Women's Hospital receive an induction of labour. Of that group 40% go on to have an emergency caesarean section. The practice at Christchurch Women's Hospital has been to use Cerdavil pessaries to induce labour and following an extended period of review and planning, the team is changing to using oral Misoprostal from mid-October 2020. Other DHBs who do not use Cervidil have a lower level of emergency caesarean section. The team at Midcentral DHB moved to this method several years ago and their results and process documentation have been invaluable. MidCentral's emergency caesarean section rate has reduced to 1% and with our population we expect to reduce to 5%. This will have a huge impact

on the quality of life for women and their babies, it will also have a significant positive impact on the service. The change in medication alone is expected to create a cost saving of $120,000 annually and the reduction in emergency caesarean sections will be a significant modification in demand for the service.

Risk Management

Leave Care: Leave taken or cashed out during August has seen three people's leave annual leave balance move into the red category – with the total number of people in this category now sitting at 179. For the 12-month period to the end of August, the proportion of staff with sick leave in the green zone is 77.8%, 0.1% lower than the November baseline. Ongoing work is needed to make sustainable change.

OLDER PERSONS HEALTH & REHABILITATION | COMMUNITY DENTAL

Performance Highlights

Shared Goals of Care: As part of the Health Quality & Safety Commission's national patient deterioration programme Burwood Hospital has rolled out the Shared Goals of Care process. The Shared Goals of Care help to better incorporate patients and families wishes in relation to an episode of care and avoid unwanted or unwarranted treatments if the patient's condition deteriorates. The aim is to have the Shared Goals of Care plans completed within the first 24 hours of a person's admission. All members of the care team are encouraged to pick up cues from patient or their whanau on wishes for their care and relate these to a clinician to assist with conversations.

Training for Elder Abuse Awareness: Following on from a review of the DHB's Elder Abuse Policy in late 2019. The OPH & Rehabilitation Clinical Manager for Social work has developed a learning package for elder abuse and neglect. The package is designed to help staff to become more confident in recognising the signs of elder abuse and neglect and to support them to respond appropriately. The first training was delivered to staff in July 2020 and further sessions will be rolled out next year.

Floor Bed Trial: A floor bed trial which uses low level beds to reduce the need for close observation staffing was rolled out to two Wards within OPH Inpatient services and is showing positive early results. There has been no increase in falls or injuries for patients included in the trial and the cost savings have been estimated at $6.5k. The trial will continue until mid-October when an evaluation will be undertaken before a further rollout is considered. Discussions are also underway with the OPH / Mental Health team to determine the suitability of this model for their patient group.

Workforce Highlights

Former DHB staff member, Oral and Maxillofacial Surgeon Les Snape, has been recognised with a Distinguished Service Award by the Australian and New Zealand Association of Oral and Maxillofacial Surgeons (ANZAOMS). Les' impact on the specialty has been significant and his engagement with numerous agencies has helped raise the specialty's profile regionally and internationally.

SPECIALIST MENTAL HEALTH SERVICES (SMHS)

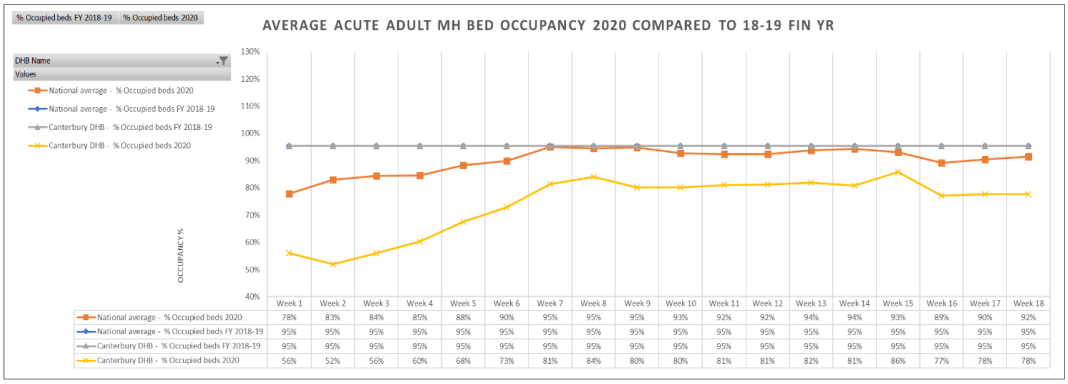
Performance Highlights

Adult Inpatient Occupancy: A number of steps were taken to reduce specialist mental health admissions and provide support in the community as part of a proactive approach to manage the potential impact of COVID-19, ensuring safe care could be provided in line with physical distancing guidelines and flexible capacity would be available to manage a potential increase in demand - including:

- Available bed numbers were reduced by 4 to create a 'red zone' isolation space for people with suspected or confirmed COVID-19
- Admission thresholds were reviewed, and community teams worked closely with inpatient units to support the reduced bed availability
- Crisis Admissions (a brief pro-active intervention to manage risk factors during an immediate crisis) were limited to a 24hr stay; a reduction from the previous standard of 48-72hrs
- The Community Intensive Pathway (resourced through FTE released using HomeCare Medical for triaging calls to Crisis Resolution) focused on supporting people to be discharged earlier.

DHBs were asked to report bed occupancy for adult acute services to the Ministry of Health as part of the COVID impact monitoring process. Optimal occupancy for mental health acute inpatient services is 85%. Canterbury DHB maintained lower levels of occupancy, in comparison to National and historical levels during this time (figure 1).

Figure 1.



	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Week 16	Week 17	Week 18
National average - % Occupied beds 2020	78%	83%	84%	85%	88%	90%	95%	95%	95%	93%	92%	92%	94%	94%	93%	89%	90%	92%
National average - % Occupied beds FY 2018-19	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Canterbury DHB - % Occupied beds FY 2018-19	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Canterbury DHB - % Occupied beds 2020	56%	52%	56%	60%	68%	73%	81%	84%	80%	80%	81%	81%	82%	81%	86%	77%	78%	78%

Note: Week 1 begins 4 May 2020 and data reflects acute Adult MH beds include C Ward (Eating Disorders and Mothers and Babies which have lower occupancy as well as Te Awakura).

Occupancy in Te Awakura (adult acute inpatient service) has historically sat above this figure resulting in use of sleepovers, leave and earlier discharge to manage flow (figure 2). COVID-19 provided the opportunity to review aspects of our model of care and this activity has enabled us to sustain a lower bed occupancy rate and support a more therapeutic environment. Our readmission rates remain stable (Figure 3) and there is some evidence that lower occupancy and adjustments in the model may also be supporting lower rates of seclusion and incidents, this is being monitored.

Figure 2.

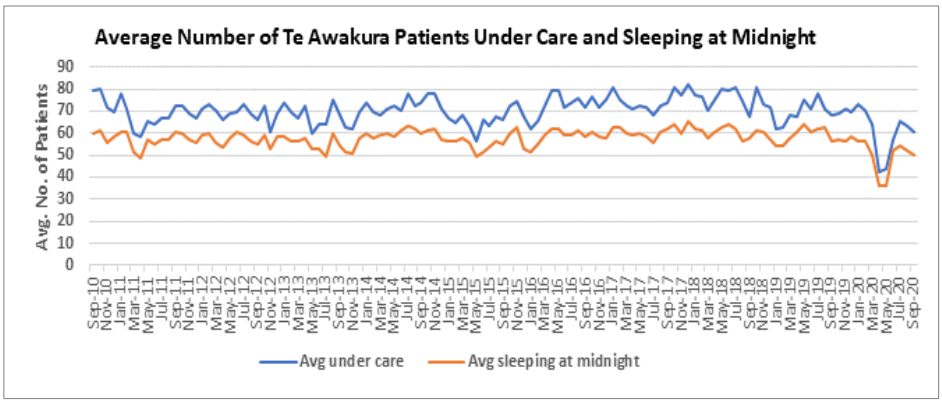


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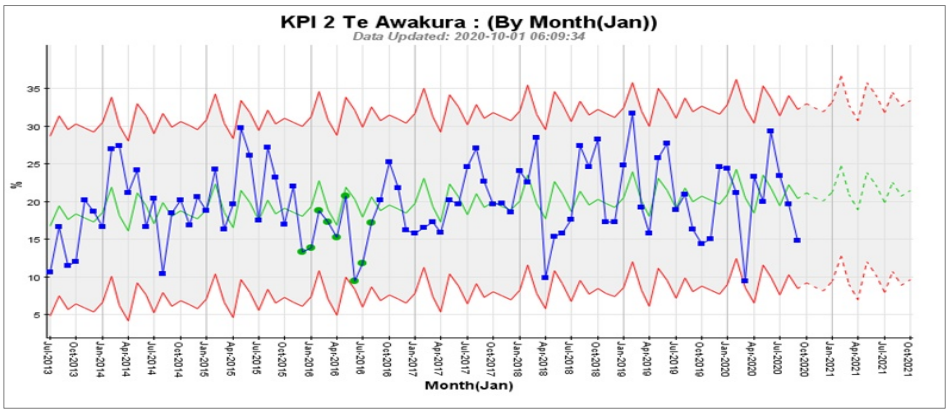
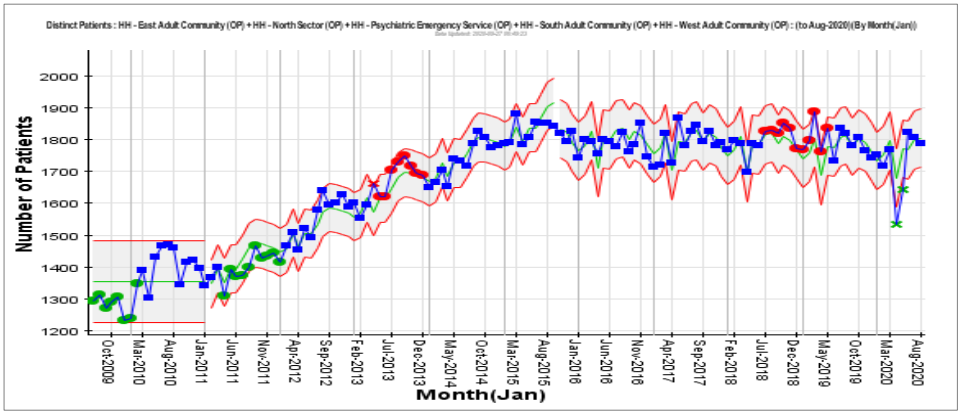
Figure 3.



Targeted Interventions: Alongside this work the Community teams have maintained a focus on providing targeted intervention for people under care, this has seen a stabilisation in the number of people who have had contact with the adult community teams with the number of clinical contacts remaining steady after a COVID-19 dip (figure 4).

Figure 4.



ASHBURTON RURAL HEALTH SERVICES

Performance Highlights

Single Rural Voice: The Rural Hospital Network, Rural General Practice Network and Rural Health Alliance Aotearoa have agreed to move towards a single voice/ single organisation for representation. This gives us an opportunity to align our own approach for rural health, bringing together the Service Level Alliances for Rural and Ashburton to focus on shared priorities. The three areas of focus for rural health nationally are sustainable funding, workforce development and digital connectivity these same themes are running through the local work.

Nursing Leadership Changes: Core work is underway to enhance the nursing leadership and operational structure for Ashburton Rural Health Services. The principles underpinning these changes include the development of a recognised generalist nursing model that can flex across multiple service delivery areas, building on the generalist medical model.

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Risk Management

Integrated services: The *"Caring for Communities Welfare Recovery Group"*, is a partnership of government, District Council, NGO and health services across the wider Ashburton District. Through this group, an application for philanthropic funding has enabled independent research report and recommendations to be pulled together to underpin a planned response to support the community and social sector through Covid-19 and beyond. It was acknowledged, that while Ashburton's social and community sector is relatively strong, there are opportunities to improve our partnerships and approach to co-ordinated service planning and delivery. Some deficits in health service provision identified in the report already have active responses underway however it evident that the work needs to be socialised wider to ensure the community are engaged and aware of the work that is happening. The findings from this report will be core to discussions for the Welfare Recovery Group and Ashburton Service Level Alliance.

LABORATORY SERVICES

Performance Highlights

MBIE Grant: The Virology team at Canterbury Health Laboratories received a $50,000 grant from the COVID Innovation Acceleration Fund (via MBIE) to support the development of a diagnostic assay to supplement and improve the clinical management of COVID-19 by assessing the level of infectiousness of positive patients. The current routine diagnostic tests cannot distinguish between alive or dead (infectious or non-infectious) SARS-CoV-2 virus without having to use culture-based methods. This enhanced testing pathway has critical advantages for individual patient care, wider public health management and the New Zealand economy. Initially, the enhanced testing pathway will be trialled within the Canterbury Health System, as a proof of concept, and then shared with other health care providers across the country.

Health Delivery Research Grant: Dr Gavin Harris, SMO in Anatomical Pathology, has been awarded a Health Delivery Research Investment Round Research Activation Grant of $30,000 for his work on understanding the correlation of digital image features of breast cancer nuclei with molecular data. This is part of an ongoing collaboration between the Department of Anatomical Pathology, Canterbury Health Laboratories and the Department of Computer Science and Software Engineering at the University of Canterbury. The grant will help develop Computational Pathology (the application of computer algorithms to understand and assess disease processes) and has the potential to improve and support future Anatomical Pathology service delivery.

Workforce Highlights

Emeritus Position: Scientific Officer, Dr Peter Elder has retired after forty-plus years of service with Canterbury Health Laboratories. Dr Elder has led work in producing monoclonal antibodies for routine diagnostics and for a range of groups within the Canterbury Health System including Haematology and Immunology. Peter has over 85 publications to his credit and will retain an emeritus position with the service where he will continue his research collaborations with the Christchurch Heart Institution.

Risk Management

COVID-19: We continue to work in partnership with a range of stakeholders both nationally and regionally to ensure resilience and have taken the learnings from the last surge of cases to refine our processes and to build on our state of continued preparedness.

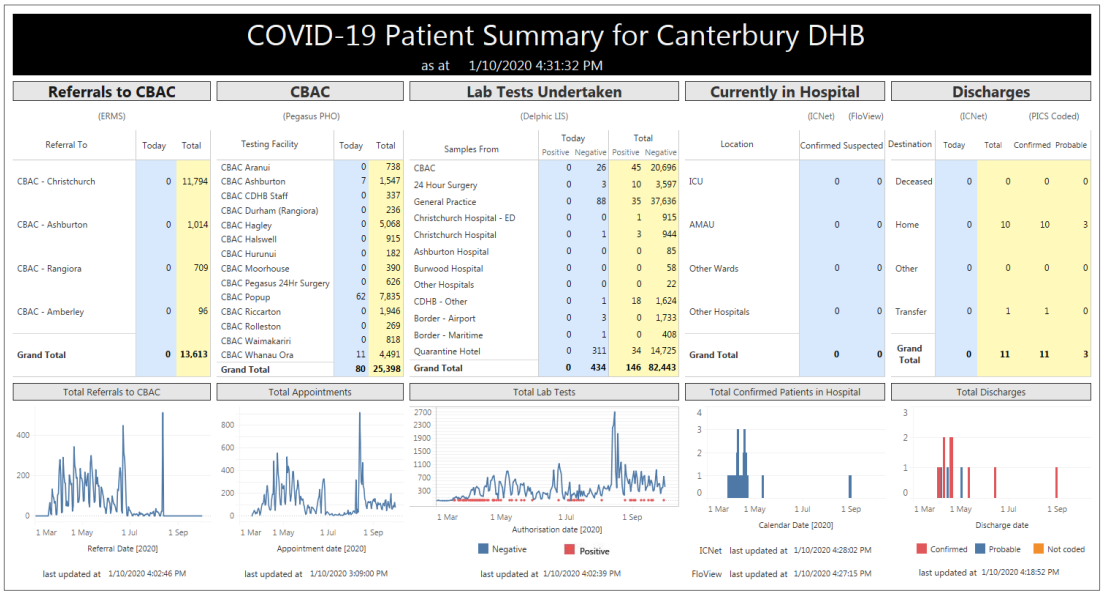
Workforce Pressures: We continue to experience continued pressures across our clinical workforce in microbiology, haematology chemical pathology and anatomical pathology with long lead times to recruit

into vacant positions. There are national and international shortages in these medical specialties and ongoing demand for this expertise, related particularly to COVID-19 and a growth in cancers, as well as regular requests for support from other DHB regions. Privatisation of pathology and laboratory services increases the challenge in recruitment. We continue to work with recruitment and commit to ongoing RMO training and support for our SMOs during this time.

PRIMARY AND COMMUNITY SERVICES

Performance Highlights

COVID-19 Testing: From 16 September mandatory COVID-19 testing came into effect for specific groups of workers at our air and maritime borders. While we had been testing at these locations for several weeks, testing was voluntary. These workforce groups will generally be required to have tests every two weeks. Testing teams have stepped up in both frequency and capacity at the airport terminal testing site and the Lyttleton Port sites, including testing of crew prior to shore leave. The DHB is reporting daily to the Ministry of Health on volumes of people tested and are providing weekly updates on the implementation of the Testing Strategy.



Measles Catch Up Programme: Canterbury's MMR (Measles, Mumps and Rubella) vaccine catch up campaign began with a soft start on 1 September. This programme is being delivered through general practice and community pharmacies and is aimed at people aged 15 – 30 years who have not had a recorded dose of the MMR vaccine. The soft start is due to delays in the production of the national campaign material, and COVID-19 restrictions making planning for mass vaccination clinics difficult.

National Immunisation Schedule Changes: The national immunisation schedule is undergoing its biggest change in a number of years. From 1 July Adults at 45 and 65 can now receive free Tdap (tetanus, diphtheria, and pertussis) booster immunisations, previously the vaccine was free, but people had to pay for administration. From the 1 Oct, MMR will be offered at 12 months and 15 months, instead of 15 months and 4 years. The final PCV (pneumococcal conjugate vaccine) will also be offered at 12 months of age. The DHB is working through the Immunisation Service Level Alliance to ensure people are fully informed of the changes to the schedule.

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Elective Services Funding: The government has allocated additional funds to help DHBs reduce Planned Care waiting lists caused by COVID-19 and implement planned care related service improvement initiatives. Canterbury submitted several funding bids, which are being considered by the Ministry. We expect to hear the outcome by mid-October.

Risk Management

Funded Family Care: Recent changes to legislation has resulted in a surge of interest from families and whānau who consider they may be eligible for Funded Family Care funding. A Funded Family Carer is a family member who is employed by a provider of Home and Community Support Services to undertake a support worker role, providing personal cares and/or domestic assistance to their family member (in effect, a one-off employee). Our Home and Community Support Services providers report that employing Funded Family Carers presents an administrative burden, a potential Health and Safety risk and complicates providers' obligations to existing staff around guaranteed hours. We have been advised that none of our existing providers are willing to employ new Funded Family Carers at this time. Providers are not contractually obliged to employ Funded Family Carers and this situation may remain until the new national Home and Community Support Services specification are released.

There is an inequity in that a disabled person may be able to access funding, under the national Disability Support Service for a Funded Family Carer, however an older person, or someone suffering from a long-term chronic health condition in the same circumstances won't be. The legislation change also means an increased financial risk for the DHB where we may be required to support Funded Family Carers via Individualised Funding Agreements, this was not anticipated in setting the Aged Care budget.

COVID-19 Testing: The DHB has had an agreement with Pegasus PHO to co-ordinate and deliver community testing across Canterbury. This includes the payment function for general practices carrying out swabbing, community-based assessment centres (CBACs), a mobile function and border testing. The Ministry provided $3.3m to deliver these services from 1 July to 30 September, and as previously reported this funding was fully expended before the end of the period. There are limited options available to the DHB or the PHO to address increased demand as a result of the increased public anxiety and with the prices for swabbing, testing and CBACs set at national rates we are reliant on monitoring utilisation closely and shifting capacity to match demand as much as possible to manage costs.

DHBs do not have further revenue agreements in place with the Ministry from 1 October 2020, although we understand a paper is due to be considered by cabinet on 6 October. The DHB's agreement with Pegasus expired on 31 August 2020 and as we must continue testing, the DHB has entered into another agreement to Pegasus for the continued delivery of these services to 31 December.

COMMUNITY & PUBLIC HEALTH SERVICES

Performance Highlights

COVID-19 Update: Community and Public Health continues to focus on the management of cases identified at the border and to ensure staff are fully trained in the necessary platforms for managing cases and contacts. We are devoting significant resource to meeting Ministry of Health's requirements that we be ready to support any surge in COVID-19 cases locally and nationally. Efforts to recruit staff (via redeployment) for case investigation and contact management continues along with training for identified staff and identification of additional work space. The Canterbury team has been delegated responsibility for local contacts with links to confirmed cases elsewhere in the country. This ensures staff retain familiarity with national systems and allows local processes to be well tested and embedded.

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Getting Through Together Campaign: The partnership with the Mental Health Foundation of NZ and Te Hiringa Hauora (Health Promotion Agency) has just completed its latest campaign inviting people to *'Reimagine Wellbeing Together, He Tirohanga Anamata'* as part of Mental Health Awareness week (21-27 September). Evaluation from early September demonstrates 33% awareness of the campaign at a population level and 86% of respondents believing the campaign valuable for their community. This extends to equity of impact, with Pasifika populations significantly likelier to take action as a result of the campaign, and Māori, Pasifika, and Asian populations more likely to find the campaign valuable for themselves personally and for their family, friends, and workmates. The campaign is funded until the end of September – a decision about future funding is awaited.

Risk Management

COVID-19: We continue to manage increasing demands at the border (both air and maritime ports), work with partner agencies to respond to cases in local Managed Isolation and Quarantine facilities and increase our readiness to rapidly upscale should case numbers significantly increase.

Drinking Water Assessment Functions: Responsibility for the Drinking Water Assessment function for the Christchurch City Council has been taken over by Wai Comply Limited who have also taken over Drinking Water Assessment functions for the Auckland, Wellington and Dunedin City supplies. The Ministry of Health has worked with Wai Comply Limited to define their delivery of services and this will come into effect on 1 September 2020.

EFFECTIVE INFORMATION SYSTEMS

Performance Highlights

Laboratory Information System Upgrade: The Laboratory Information System (LIS) upgrade (Delphic LIS v10) was successfully migrated into the Microsoft Azure Cloud environment on 24 September. Canterbury Health Laboratories host the shared LIS across the LabNet partnership which includes West Coast, Taranaki and Hawkes Bay DHBs and given its criticality the LIS is required to be available on a 24-hour basis. The application is now operating on the latest generation server and cloud infrastructure, and as part of the project delivery a successful Disaster Recovery Failover and Recovery test was performed that achieved agreed recovery timeframes (four-hour recovery).

This was a significant project driven by the Canterbury Health Laboratories and Information Services Group teams with laboratory, LIS and scientific and technical staff completing months of preparation and testing and maintaining all critical lab services throughout the upgrade, while also hosting IANZ for annual surveillance and peer review accreditation.

Risk Management

Paging Replacement System: Our paging system is end of life and requires replacement. Capital expenditure has been approved in principle and we are planning to approach the market for solutions due to the potential cost and the number of options available.

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Performance Highlights

Accelerating our Future: The communications team has worked with the Programme Office to develop and launched branding and a website which includes a mechanism for sharing cost-saving ideas. This has

included Q&As to help alleviate ongoing concerns expressed across the organisation and some confusion around the Equity Support Funding announcements this month.

Measles Catch-Up Campaign: Communications planning is underway to support the national measles catch up campaign which will target people aged between 15 and 30 years old, many of whom are under immunised. Communications will include local activities to complement and supplement the national campaign and will begin once the national branding is finalised, expected to be late September.

Maia Foundation First Flight: The arrival of the first official flight to the helipad was on 3 September, where we welcomed media, the rescue helicopter crew and a very special guest for a significant reunion. The Maia fundraising auction for the first flight was won by Willie Murney. Willie's Mum, Kate Murney, needed the service in 2013 when she was critically ill with septacaemia. Retired Clinical Leader of the Canterbury Air Retrieval Service, Dr David Bowie, treated Kate in ICU and was there to greet her on her arrival and was key in her treatment and recovery.

Terrace Fundraiser: The Communications Team is assisting with the fundraising for the Terrace Garden, a project that will see the terrace (the grey tiled space between the Hagley towers) landscaped to provide a garden environment for patients, whānau and staff. The fundraising campaign will kick off in October with a Garden Party at the Christchurch Art Gallery. The venue was kindly donated by a staff member and the fundraising committee has volunteered their time to raise the $500,000 required to create the Terrace Garden.

New Hagley Building: A new wall of information has been installed in the main campus with corflute signage highlighting areas of interest within the building. Communication for staff and the public will include flyers for visitors, patients and whānau, letters and advisories for patients, information for stakeholders and ancillary services, and large posters and banners for around campus. A new Sharepoint Online page will also be launched for staff and will feature a count-down clock. New videos are being produced to assist staff in familiarising themselves with the building and their specialty areas.

Mental Health Facilities: Te Huarahi Hou, a new journey has been launched as the brand for developments on the Hillmorton Campus. A new Prism Intranet page has been established as a single source of information for staff. It will be regularly updated to include plans, photos, renders and timetables for development.

Risk Management

Campus Compliance Communications: A communications plan is being developed to assist with communication of ongoing works around the hospital campus that will begin soon after the move into Hagley. The common theme to most of these works will be earthquake strengthening and ensuring passive fire systems are appropriate. Communications to staff, patients, whānau and the public will feature work requirements, effects on work and service areas, and planned mitigations to those effects.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

Media: September was a busy month for media, with the Communications Team responding to more than 130 enquiries. The month was dominated by queries regarding the DHB's deficit reduction programme 'Accelerating Our Future', the parts of Christchurch Hospital Hagley that will not open straight away when we migrate to the new facility, and changes to the Medical Oncology service because of unplanned and planned staff leave.

FINANCE REPORT 31 AUGUST 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **David Green, Acting Executive Director Finance & Corporate Services**

APPROVED BY: **Dr Peter Bramley, Acting Chief Executive**

DATE: **15 October 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 for the month of August 2020 is a net expense of $8.605M, being $1.011M favourable to the annual plan agreed by the Board on 20 August 2020. The YTD result is now $1.098M favourable to the annual plan;
ii. notes the operating result (before indirect items) for the month is favourable to plan by $0.959M (YTD $1.147M favourable);
iii. notes that the net impact associated with COVID-19 in August is a $1.922M surplus, therefore the underlying operating result (excl COVID) is $0.912M unfavourable (YTD $0.392M favourable); and
iv. notes liquidity (cashflow) risk has been alleviated by the recent receipt of $180M of equity support.

3. DISCUSSION

Overview of August 2020 Financial Result

Summary DHB Group Financial Result

The following table provides the breakdown of the August result:

	Appendix	MONTH			YEAR TO DATE		
		Actual	Budget	Variance	Actual	Budget	Variance
		$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate		(2.847)	(3.686)	0.839	(7.420)	(6.655)	(0.766)
Community & Public Health		(0.237)	(0.018)	(0.219)	(0.114)	(0.106)	(0.008)
Total In-House Provider excl Subsidiaries	**8**	**(3.084)**	**(3.704)**	**0.620**	**(7.535)**	**(6.761)**	**(0.774)**
Add: Funder & Governance							
Funder Revenue	6	158.775	156.748	2.027	315.778	313.496	2.281
External Provider Expense	6	(70.486)	(68.327)	(2.158)	(143.386)	(141.626)	(1.761)
Internal Provider Expense	6	(94.123)	(94.327)	0.204	(188.244)	(188.654)	0.410
Total Funder		**(5.833)**	**(5.906)**	**0.073**	**(15.853)**	**(16.783)**	**0.930**
Governance & Funder Admin	7	0.098	0.000	0.098	0.136	0.000	0.136
Total Canterbury DHB (Parent)		**(8.820)**	**(9.610)**	**0.791**	**(23.252)**	**(23.544)**	**0.292**
Add: Subsidiaries							
NZ Health Innovation Hub	9	0.012	(0.033)	0.045	0.000	(0.066)	0.066
Brackenridge Services Ltd	9	0.073	0.052	0.021	0.153	0.106	0.048
Canterbury Linen Services Ltd	9	0.129	(0.025)	0.154	0.510	(0.181)	0.691
Canterbury DHB Group Surplus / (Deficit)	**2**	**(8.605)**	**(9.616)**	**1.011**	**(22.588)**	**(23.685)**	**1.098**

4. KEY FINANCIAL RISKS

COVID-19 – the forecasted impact of COVID-19 on CDHB's performance is dependent on a number of uncertain parameters. The long-term impact will take some time to determine and will include factors such as elective revenue, IDF revenue, ACC revenue, and the costs associated with these (e.g. what level of outsourcing is required to catch up on lost throughput). On top of those considerations, CDHB is now managing six isolation hotels for the Canterbury Region. Refer Appendix 1 for costs to date.

Holidays Act Compliance – the workstream to determine CDHB's liability under the Holidays Act is continuing. We have accrued a liability based on the draft report from EY; there is risk the final amount differs significantly from this accrued amount. We are likely to have a qualified opinion on this issue in our annual report (as was done last year).

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 November 2020 has added stress points to the operating result of CDHB; this includes the delay in its handover which has both performance and financial downsides.

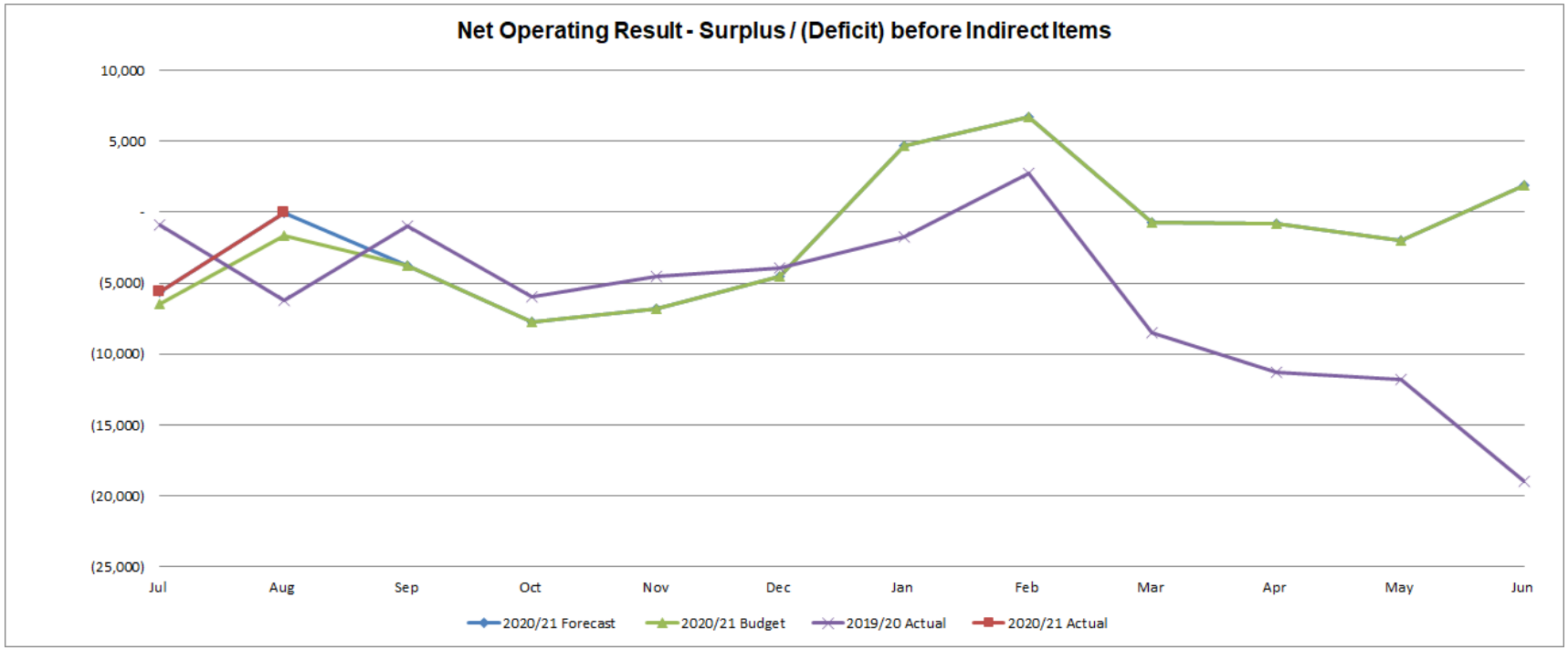
5. APPENDICES

Appendix 1: Financial Result
Appendix 2: CDHB Group Income Statement
Appendix 3: Statement of Financial Position
Appendix 4: Cashflow

APPENDIX 1: FINANCIAL RESULT (BEFORE INDIRECT ITEMS)

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 31 AUGUST 2020

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2019/20 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
Surplus/(Deficit) before Indirect items	(30)	(989)	959	-97% ✔	(5,614)	(6,761)	1,147	-17% ✔	(71,963)	(23,257)	(23,257)	-	0% ✔



NB: The actual results in the above graph exclude the one off Holiday Act compliance accrual made in June 2020.

KEY RISKS AND ISSUES

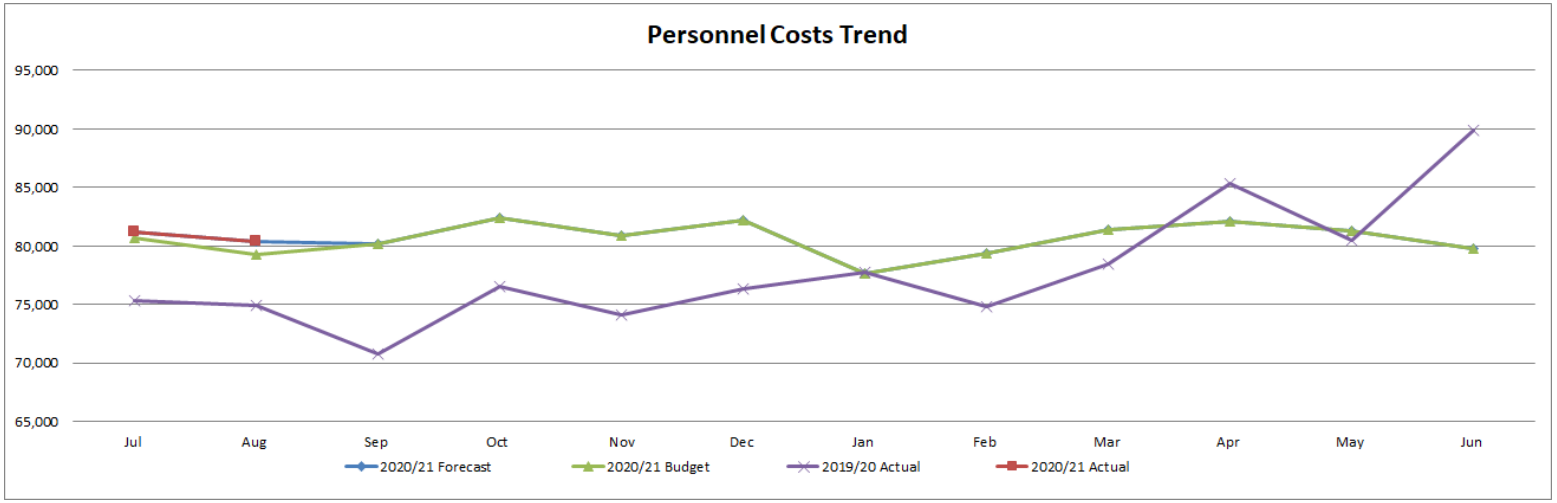
- This graph shows the operating result before indirect items such as depreciation, interest, donations, capital charge and the offsetting new capital charge funding.
- In August CDHB incurred a net $1.922M of COVID-19 pandemic related revenue. Adjusting for this revenue, our operating result would have been $0.912M favourable. YTD Covid-19 has had a net revenue impact of $0.705M, reducing our YTD favourable variance.

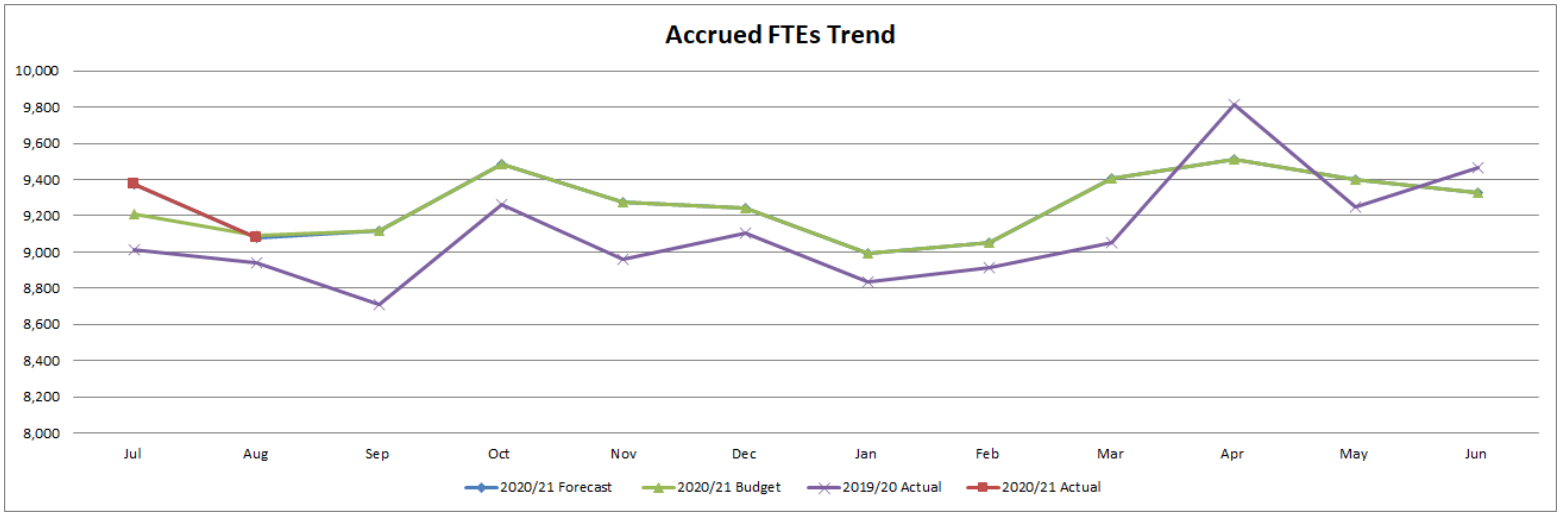
The following table shows the impact of COVID-19 for the month and YTD:

	Period to date $000						Year to date $000					
August 2020 Result	Month Actual	Month Budget	Month Variance Fav/(Unfav)	Covid-19	Excl Covid-19	Underlying Variance Fav/(Unfav)	YTD Actual	YTD Budget	YTD Variance Fav/(Unfav)	Covid-19	Excl Covid-19	Underlying Variance Fav/(Unfav)
MOH Revenue	(164,958)	(162,733)	2,225	(2,603)	(162,355)	(378)	(327,997)	(325,466)	2,531	(3,755)	(324,242)	(1,224)
Patient related revenue	(5,906)	(4,671)	1,235	(1,183)	(4,723)	52	(10,922)	(9,317)	1,605	(1,183)	(9,739)	422
Other Revenue	(5,341)	(3,291)	2,050	(1,950)	(3,391)	100	(9,016)	(6,782)	2,234	(2,427)	(6,589)	(193)
Total Operating Revenue	(176,205)	(170,695)	5,510	(5,736)	(170,469)	(226)	(347,935)	(341,565)	6,370	(7,365)	(340,570)	(995)
Employee expenses	78,805	77,638	(1,167)	678	78,127	(489)	157,710	156,762	(948)	1,422	156,288	474
Outsourced Personnel	1,591	1,614	23	-	1,591	23	3,876	3,228	(648)	-	3,876	(648)
Treatment Related costs	14,711	14,040	(671)	334	14,377	(337)	28,671	27,490	(1,181)	675	27,996	(506)
Other expenses	10,642	10,397	(245)	181	10,461	(65)	19,906	19,886	(19)	1,046	18,860	1,027
External Provider costs	70,486	67,995	(2,491)	2,621	67,865	131	143,386	140,960	(2,427)	3,518	139,868	1,091
Total Operating Expenditure	176,235	171,684	(4,551)	3,814	172,421	(737)	353,549	348,326	(5,223)	6,660	346,889	1,437
Operating result - (Surplus) / Deficit	30	989	959	(1,922)	1,952	(963)	5,614	6,761	1,147	(705)	6,319	442
Total Indirect revenue and expenditure	8,575	8,627	52	-	8,575	52	16,974	16,924	(50)	-	16,974	(50)
Total (Surplus) / Deficit	8,605	9,616	1,011	(1,922)	10,528	(912)	22,588	23,685	1,097	(705)	23,293	392

- **MoH revenue** covers most of the external provider costs incurred to date, which relate mainly to community surveillance and testing. In total, $7.3M of specific funding is available in 2020/21 for the Covid-19 response. This includes $5.3M of new funding, and $2.0M carried forward from the 2019/20 financial year for the Public Health Unit (PHU) and the Primary Mental Health Response. YTD August, $3.755M of this funding has been recognised as revenue.
- There is a risk of insufficient funding for Covid-19 surveillance and testing.
- **Patient related revenue** in August includes revenue for isolation hotels.
- **Other revenue** is from Covid-19 pathology tests processed by Canterbury Health Laboratories (CHL) for Canterbury and other regions. In August 2020 there was a significant increase in demand due to the Auckland region lockdown and increased testing requirements.
- **Unfunded costs** include:
  - lost revenue from laundry and café services
  - unfunded PPE, cleaning supplies, clinical supplies, minor equipment (including IT), etc
  - reduction in annual leave taken
  - sick and Covid-19 related leave

PERSONNEL COSTS/PERSONNEL ACCRUED FTE



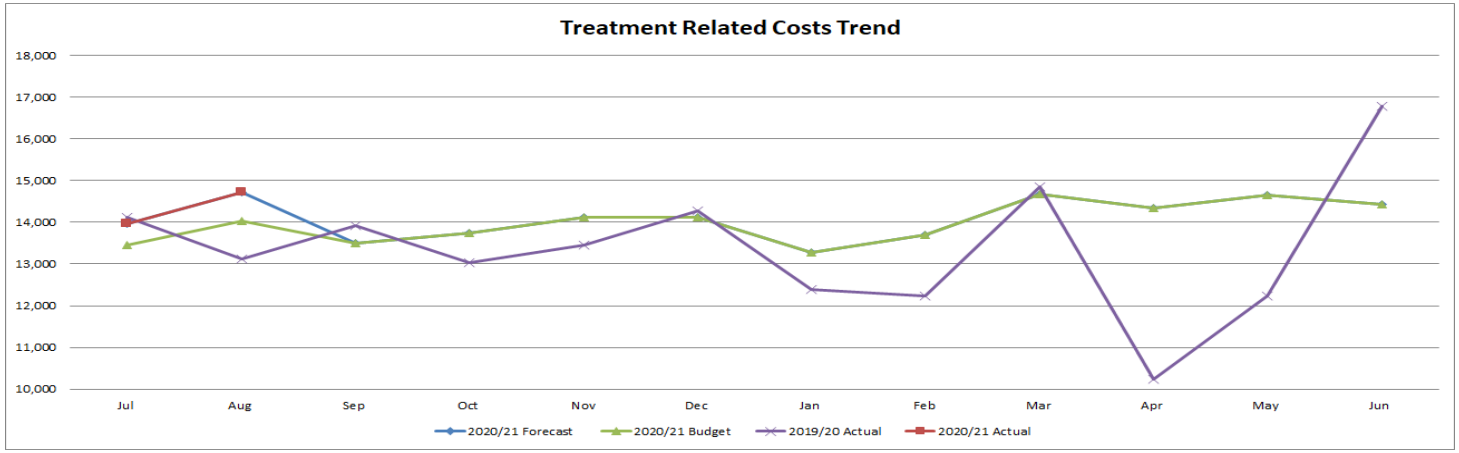


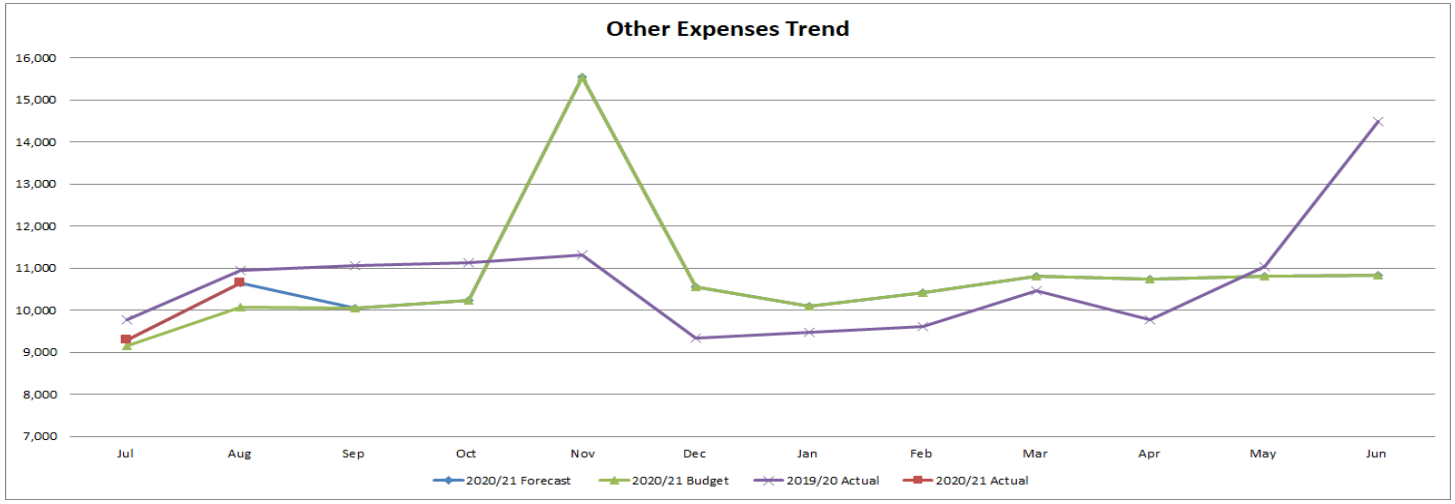
KEY RISKS AND ISSUES

- Excluding Covid-19 costs, YTD personnel costs are favourable. Covid-19 costs relate mainly to the running of the isolation hotels.

- YTD FTE includes 67 accrued FTE for isolation hotel staff that are not included in the plan. There are other Covid-19 related employee costs over and above this with FTE implications.
- 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 and Easter, Christmas and New Year periods), etc. The accrued FTE largely correlates with the trend in contracted FTE.

TREATMENT & OTHER EXPENSES RELATED COSTS





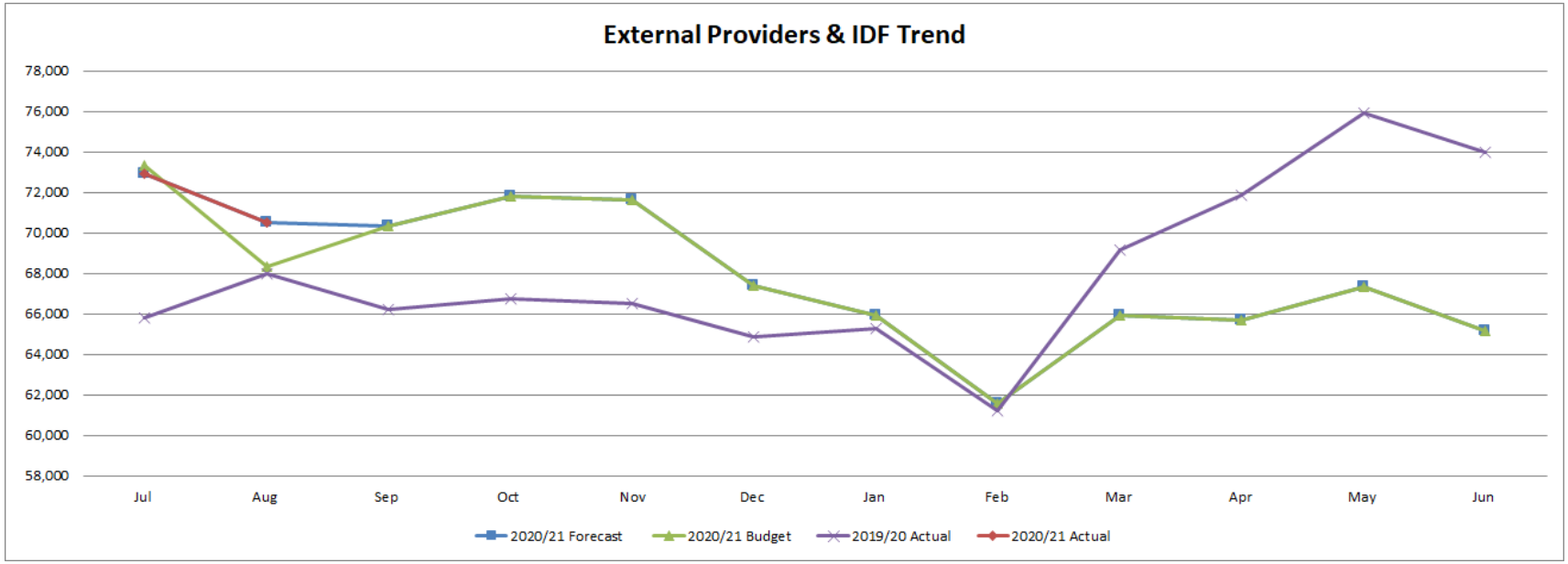
KEY RISKS AND ISSUES

- YTD Covid-19 Treatment Related Costs total $0.675M, reducing the underlying YTD variance to $0.506 unfavourable. Some of the unfavourable variance is related to setting up expense inventory locations in the new Hagley facility, these costs will be offset by closing expense inventory locations in the existing facility over the next few months.

- 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.
- YTD Covid-19 non treatment related costs total $1.046M reducing the underlying variance to $0.361M favourable.

EXTERNAL PROVIDER COSTS

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2019/20 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
External Provider Costs	70,486	68,327	(2,159)	-3% ✗	143,386	141,626	(1,761)	-1% ✗	810,046	814,341	814,341	-	0% ✓



- YTD Covid-19 costs total $3.518M. The underlying favourable variance is offset by lower MoH revenue.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000		YTD Actual $'000	YTD Budget $'000	Variance $'000	Year End 19/20 $'000
Equity	469,684	534,587	64,903	**Cash**	(33,503)	(36,082)	2,579	(6,966)

- Liquidity risk has been alleviated by the receipt of $180M of equity support in October. Based on current cashflow forecasts, we are unlikely to use our overdraft facility until June 2021. Note that this equity support does not impact the deficit reported for the 2019/20 financial year, and it will have minimal impact on the deficit planned for the 2020/21 financial year.
- We have commenced paying suppliers within 10 working days in late September and will continue to transition to a higher percentage of suppliers paid within this timeframe in October.

KEY RISKS AND ISSUES

- The equity variance to budget is due to the additional Holidays Act compliance provision made at 30 June 2020.
- As we move into the Hagley building we will be incurring high capital spend on Hagley FF&E (reimbursed by the MoH, but there is a timing delay to this reimbursement).
- Spend on the Mental Health facilities redevelopment continues and is expected to increase as construction activity increases (we have received an initial equity drawdown for the Mental Health project and have submitted a request for a further drawdown).

APPENDIX 2: CANTERBURY DHB GROUP INCOME STATEMENT

The Group financial results include Canterbury DHB and its subsidiaries
For the 2 months ending 31 August 2020

Month					Year to Date				Annual (Year End)			
20/21 Actual 000's	20/21 Budget 000's	19/20 Actual 000's	Variance to Budget 000's		20/21 Actual 000's	20/21 Budget 000's	19/20 Actual 000's	Variance to Budget 000's	20/21 Forecast 000's	20/21 Budget 000's	19/20 Actual 000's	Variance to Budget 000's
164,958	162,733	153,183	2,225 ✓	MoH Revenue	327,997	325,466	309,654	2,531 ✓	1,952,782	1,952,782	1,864,766	- ✓
5,906	4,671	4,310	1,235 ✓	Patient Related Revenue	10,922	9,317	8,511	1,605 ✓	55,498	55,498	53,364	- ✓
5,341	3,291	3,276	2,050 ✓	Other Revenue	9,016	6,782	6,548	2,234 ✓	47,534	47,534	48,770	- ✓
176,205	**170,695**	**160,769**	**5,510**	**Total Operating Revenue**	**347,935**	**341,565**	**324,713**	**6,370**	**2,055,814**	**2,055,814**	**1,966,900**	-
80,396	79,252	74,942	(1,144) ✗	Personnel Costs	161,586	159,990	150,242	(1,596) ✗	967,342	967,342	934,806	- ✓
14,711	14,040	13,111	(671) ✗	Treatment Related Costs	28,671	27,490	27,241	(1,181) ✗	168,059	168,059	160,676	- ✓
70,486	68,327	67,957	(2,159) ✗	External Service Providers	143,386	141,626	133,659	(1,761) ✗	814,341	814,341	810,046	- ✓
10,642	10,065	10,943	(577) ✗	Other Expenses	19,906	19,220	20,768	(685) ✗	129,329	129,329	133,335	- ✓
176,235	**171,684**	**166,953**	**(4,551)** ✗	**Total Operating Expenditure**	**353,549**	**348,326**	**331,910**	**(5,223)** ✗	**2,079,071**	**2,079,071**	**2,038,863**	- ✓
(30)	**(989)**	**(6,184)**	**959** ✓	**Total Surplus / (Deficit) Before Indirect Items**	**(5,614)**	**(6,761)**	**(7,197)**	**1,147** ✓	**(23,257)**	**(23,257)**	**(71,963)**	- ✓
61	48	59	13 ✓	Interest Revenue	120	96	129	24 ✓	577	577	695	- ✓
-	-	685	- ✓	Capital Charge Relief Funding	-	-	1,370	- ✓	10,170	10,170	8,220	-
17	23	308	(6) ✗	Donations	34	246	527	(212) ✗	2,674	2,674	3,674	- ✓
3	-	4	3 ✓	Profit on Sale of Assets	10	-	7	10 ✓	-	-	17	- ✓
81	**71**	**1,056**	**10** ✓	**Total Indirect Revenue**	**164**	**342**	**2,033**	**(178)** ✗	**13,421**	**13,421**	**12,606**	- ✓
2,437	2,437	2,961	- ✓	Capital Charge	4,874	4,874	5,922	- ✓	48,762	48,762	38,136	- ✓
6,153	6,153	5,916	- ✓	Depreciation	12,151	12,176	11,982	25 ✓	85,108	85,108	74,960	- ✓
64	108	32	44 ✓	Interest Expense & Forex Gains and Losses	111	216	14	105 ✓	1,300	1,300	315	- ✓
2	-	-	(2) ✗	Loss on Sale of Assets	2	-	5	(2) ✗	-	-	57	- ✓
8,656	**8,698**	**8,910**	**42** ✓	**Total Indirect Expenses**	**17,138**	**17,266**	**17,924**	**128** ✓	**135,170**	**135,170**	**113,468**	- ✓
(8,605)	**(9,616)**	**(14,038)**	**1,011** ✓	**Total Surplus / (Deficit)**	**(22,588)**	**(23,685)**	**(23,088)**	**1,098** ✓	**(145,006)**	**(145,006)**	**(172,826)**	- ✓

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 31 August 2020

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

Unaudited 30-Jun-20 $'000		Group Actual 31-Aug-20 $'000	Group Budget 31-Aug-20 $'000	Annual Group Budget 30-Jun-21 $'000
597,378	Opening Equity	492,272	558,272	558,272
136,588	Net Equity Injections / (Repayments) During Year	-	-	26,139
200	Other Movements (NZHIH)	-	-	719,355
(3,068)	Reserve Movement for Year	-	-	0
(238,826)	Operating Results for the Period	(22,588)	(23,685)	(145,006)
492,272	**TOTAL EQUITY**	469,684	534,587	1,158,760
	Represented By:			
	Current Assets			
4,066	Cash & Cash Equivalents	3,883	1,033	31,443
750	Short Term Investments	750	750	750
105,853	Trade and Other Receivables	97,529	103,253	103,253
5,649	Prepayments	11,373	5,649	5,649
14,549	Inventories	15,451	14,549	14,549
14,666	Restricted Assets	14,512	14,425	14,425
145,533	**Total Current Assets**	143,498	139,659	170,069
	Less Current Liabilities			
11,032	Overdraft	37,386	37,115	-
165,172	Trade and Other Payables	137,425	132,888	128,015
21,974	Income in advance	21,495	22,224	22,224
14,691	Restricted Funds	14,845	14,256	14,256
343,643	Employee Benefits	340,629	277,644	277,644
534,538	**Total Current Liabilities**	551,780	484,127	442,139
(389,005)	**Working Capital**	(408,282)	(344,468)	(272,069)
	Non Current Assets			
16	Restricted Funds	16	16	16
3,225	Investment in NZHPL	3,225	3,225	3,225
884,340	Fixed Assets	881,150	882,118	1,433,892
887,581	**Term Assets**	884,391	**885,359**	**1,437,133**
	Non Current Liablilties			
6,304	Employee Benefits	6,425	6,304	6,304
6,304	**Term Liabilities**	6,425	**6,304**	**6,304**
492,272	**NET ASSETS**	469,684	534,587	1,158,760

APPENDIX 4: CASHFLOW

Unaudited 30-Jun-20 $'000		Actual 31-Aug-20 $'000	Consol Adj $'000	Actual 31-Aug-20 $'000	YTD Budget 31-Aug-20 $'000	Budget 30-Jun-21 $'000
	CASHFLOW FROM OPERATING ACTIVITIES					
(52,680)	**Net Cash from Operating Activities**	(17,892)	(1,437)	(19,329)	(19,162)	(72,459)
	CASHFLOW FROM INVESTING ACTIVITIES					
(43,992)	**Net Cash from Investing Activities**	(8,645)	1,437	(7,208)	(9,954)	(109,917)
	CASHFLOW FROM FINANCING ACTIVITIES					
80,794	**Net Cash from Financing Activities**	-	-	-	-	220,785
(15,878)	Overall Increase/(Decrease) in Cash Held	(26,537)		(26,537)	(29,116)	38,409
(15,698)	Add Opening Cash Balance	(6,966)		(6,966)	(6,966)	(6,966)
(31,576)	**Closing Cash Balance**	(33,503)	-	(33,503)	(36,082)	31,443

MĀORI POPULATION, PARTNERSHIP, HEALTH AND EQUITY

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Hector Matthews, Executive Director, Māori & Pacific Health**

APPROVED BY: **Peter Bramley, Acting Chief Executive Officer**

DATE: **15 October 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The Acting Chief Executive has requested a Board paper on Māori based on request from a Board member.

This paper was to include what is working well and what is not, and to include partnerships, particularly the role of Manawhenua ki Waitaha, contracts with Māori providers, national targets, especially where improvements are needed, better ways of working together, and benchmarking against others DHBs.

2. RECOMMENDATION

That the Board:

i. notes the Maori Population, Partnership, Health and Equity report.

3. SUMMARY

The report is comprehensive and looks thoroughly at a range of issues that impact on our performance as a DHB with regard to our Māori population and Māori health equity.

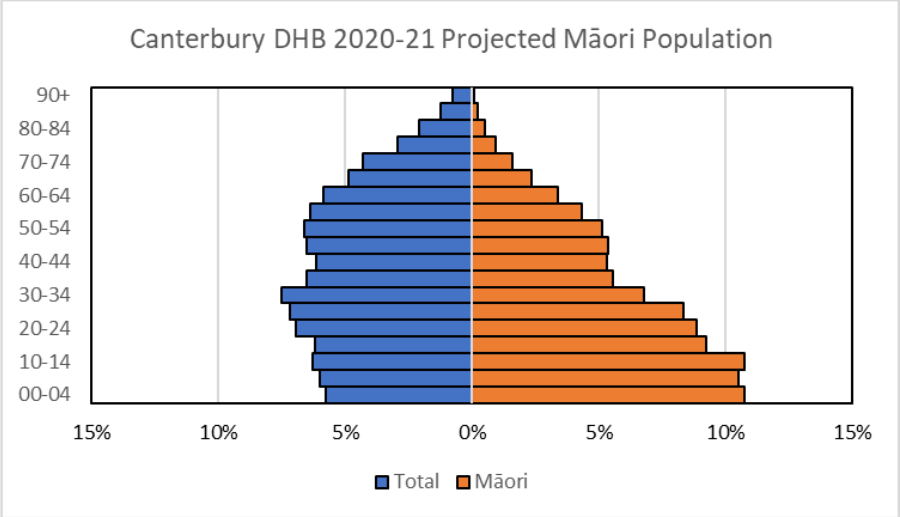
4. APPENDICES

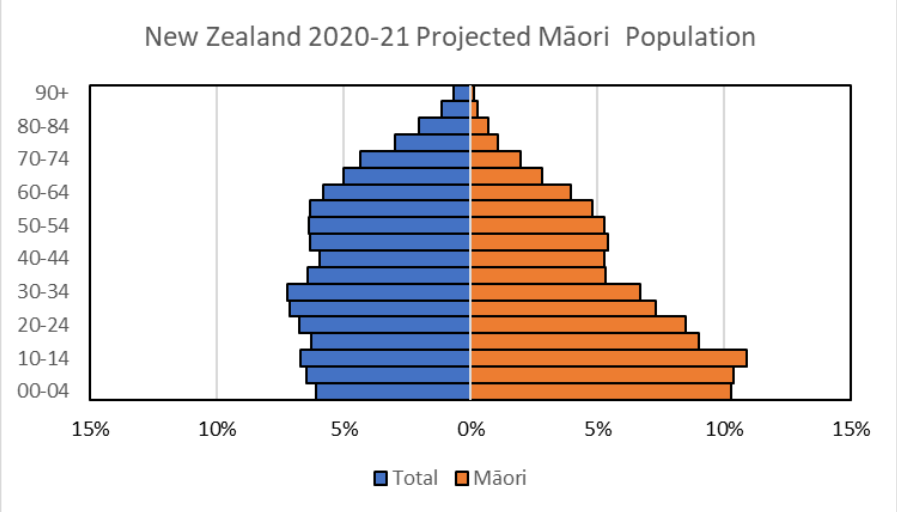
Appendix 1: Maori Population, Partnership, Health and Equity

Māori Population, Partnership, Health and Equity

Māori make up 10% of the Canterbury population with a population of 56,710. The age demography of our Māori population closely mirrors the national demography.

- 32% Under 15 years old, compared to 16% of non-Māori (excl. Pacific and Asian)
- lower life expectancy; less than 6% are over 65-years-old, compared to 18% of non-Māori (excl. Pacific and Asian).
- median age 24.4 years compared to 38.7 years overall population





In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

This definition of equity was signed-off by Director-General of Health, Dr Ashley Bloomfield, in March 2019.

Māori experience health inequities and poorer health outcomes, than the general population. This is long-standing and pervasive throughout the country and our health system, and Canterbury is no exception.

Māori receive[1]:

- fewer referrals
- fewer diagnostic tests
- less effective treatment plans than non-Māori
- are offered treatments at substantially decreased rates
- interviewed for less time
- prescribed fewer secondary services
- Māori encounter a different health system to non-Māori

The evidence for Māori receiving less access to and lower quality of health care services than other New Zealanders is now large and compelling:

Decades of Disparity 1999-2000[2]

- A series of three bulletins published by Ministry of Health on ethnic and socioeconomic inequalities in mortality in NZ, that analysed data from 1981 to 1999
- The ethnic disparity in life expectancy at birth increased from 6 - 7 years in the early 1980s to 8 - 9 years by 1999
- Throughout the 1980s and 1990s, the mortality rates between low-and-high-income groups increased over time
- Inequalities rooted in historical social processes that entrench the privileged position of dominant groups
- Māori and non-Māori inequalities in mortality persist within socioeconomic strata
- Widening inequalities between Māori and non-Māori during the 1980s and 1990s explain approximately half of the widening in the mortality disparity between these ethnic groups

WAI 2575 – Waitangi Tribunal Health Services and Outcomes Inquiry June 2019[3]

- The NZ health framework fails to consistently state a commitment to achieving equity of health outcomes for Māori

[1] Bacal, Jansen & Smith, NZ Family Physician, 2006

[2] https://www.moh.govt.nz/notebook/nbbooks.nsf/0/37A7ABB191191FB9CC256DDA00064211/$file/EthnicMortalityTrends.pdf

[3] https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

- The funding arrangements for primary health disadvantage Māori primary health organisations and providers
- The Crown has been aware of these failures for well over a decade but has failed to adequately amend or replace the current funding arrangements

New Zealand Health and Disability System Review June 2020[4]

- Māori experience of hospital services is characterised by poorer access, poorer outcomes and being exposed to institutional racism
- Hospital appointments are less accessible for Māori adults compared to non-Māori adults
- 16% of Māori adults DNA specialist appointments between 2011 and 2014 compared with 6% of non-Māori
- For Māori, deaths preventable by health care are 2.5 times as frequent as for non-Māori
- Specialist appointments happen less frequently for Māori
- Māori health outcomes are significantly worse than those for other New Zealanders; this represents a failure of the health system

Determinants of Health

Various factors have either negative or positive effects on health. Many root causes of ill-health lie beyond the span of control of individuals in their day-to-day lives, and beyond the health system.

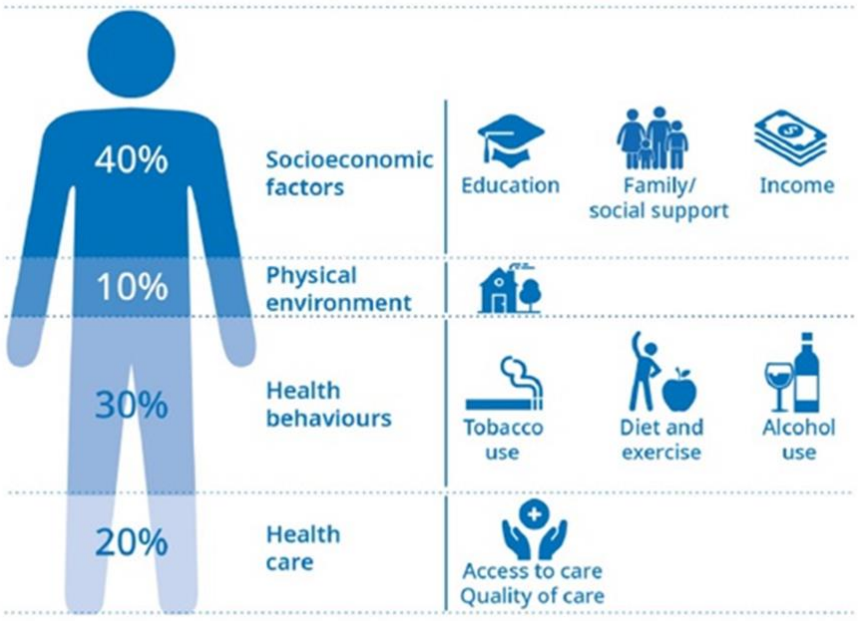
The factors affecting health are collectively known as the determinants of health. These can support or be barriers to good health and broader wellbeing. The determinants of health include:

- socioeconomic factors, such as employment, income and education
- physical environment, such as access to clean water and housing
- health behaviours, such as tobacco use, alcohol, diet and exercise
- access to and quality of health care

Socioeconomic factors (40 %) and the physical environment (10 %) constitute half of the factors that determine our health. Our health behaviours account for just under a third (30 %) and the health care environment is responsible for one fifth (20 %) – (*Institute for Clinical Systems Improvement 2014)*.

[4] *https://systemreview.health.govt.nz/final-report/download-the-final-report/*

The Determinants of Health and Their Relative Contribution to Health Outcomes



Source: Adapted from the Institute for Clinical Systems Improvement (2014).

It has become clear that the cumulative failures of our health system to respond appropriately to Māori, particularly in the access to and quality of health care, over many decades, are a significant factor in the failure to achieve Māori health equity. In short, our system is designed by non-Māori, for non-Māori and therefore frequently affords privilege to non-Māori in the system.

The Treaty of Waitangi and Our Treaty Relationship

The New Zealand Public Health and Disability Act 2000 in Part 1, Section 4 states that DHBs are required to "recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

Part 2, Section 21 states an objective of DHBs "to reduce health disparities by improving health outcomes for Māori".

Schedule 3 of the Act also obliges all board members to be familiar with "Māori health issues, Treaty of Waitangi issues, or Māori groups or organisations in the district of the DHB concerned; must fund and, to the extent practicable, ensure the member or members undertake and complete, training approved by the Minister relating to whichever of those matters the member or members are not familiar with." In addition, the "board must keep an up-to-date record of any familiarity each member of the board has at that date with the

obligations and duties of a member of a board, Māori health issues, Treaty of Waitangi issues, and Māori groups or organisations in the district of the DHB"

The Public Service Commission and the Office for Māori Crown Relations - Te Arawhiti, expect that the key instrument with which DHBs give effect to their Treaty obligations is through a relationship agreement with their Treaty partner(s).

When the CDHB was established, Ngāi Tahu was the sole iwi in our district boundaries, although we now have two other iwi on Rekohu/Wharekauri, the Chatham Islands. The CDHB approached Te Rūnanga o Ngāi Tahu in 2004 to negotiate a treaty partnership agreement. We were told that Te Rūnanga o Ngāi Tahu did not believe it was appropriate to have a treaty relationship with the CDHB because we were not the crown but an agent of the crown. Their treaty relationship was with the crown and they pointed us towards papatipu rūnanga as the appropriate place. At the time, Manawhenua Ki Waitaha was a fledgling entity, that comprised of membership from each of the seven Ngāi Tahu papatipu rūnanga in the Canterbury DHB boundaries, that had been mandated as the group responsible for health.

At that time, Te Rūnanga o Ngāi Tahu was still quite newly established and had created the Ngāi Tahu Development Corporation to support development of iwi, hapū and rūnanga. Ngāi Tahu Development Corporation had helped set up Manawhenua groups throughout the Ngāi Tahu takiwā (tribal area). For numerous reasons, Ngāi Tahu Development Corporation was later disestablished and many of the groups they were supporting, such as Manawhenua Ki Waitaha were required to fend for themselves.

Following that, Manawhenua had to find other methods to support their aims and continue to operate. The Ngāi Tahu Development Corporation had negotiated some funding support from the Ministry of Health before they disestablished, and this helped Manawhenua groups operate for a short time.

It was through the efforts at that time, of Dr. Matea Gillies, a Christchurch GP, the Rāpaki representative and chair on Manawhenua Ki Waitaha that significant steps were made by Manawhenua Ki Waitaha to formalise a relationship with the CDHB. He later became a ministerial appointment to the CDHB. Dr. Gillies led the push for a Treaty partnership agreement, which eventually led to the current Memorandum of Understanding (MoU) that the CDHB has with Manawhenua Ki Waitaha. That MoU was originally signed by the chairs of each papatipu rūnanga and the chair of the CDHB and represented a significant step forward for the CDHB and its Treaty partner. The signing also involved a gift of pounamu by Manawhenua Ki Waitaha to the CDHB. The pounamu has two pieces one held by each party to the MoU that were intended to symbolically come together when working in partnership. The CDHB pounamu is displayed at our corporate office reception.

The MoU has been reviewed a number of times over the years since signing and the latest version is attached as Appendix 1.

Manawhenua Ki Waitaha have done an exceptional job as a treaty partner, considering their limited resources and comparative size to the CDHB. Manawhenua Ki Waitaha, through the application of the MoU, have been engaged by the Canterbury health system at multiple points to provide a Māori perspective across many important decision and advisory groups. Where Manawhenua Ki Waitaha have not had the people or resources to support, they've been engaged to provide a Māori perspective from the wider Māori community. The Manawhenua Engagement graphic at Appendix 2, shows just how wide and deep the influence of Manawhenua Ki Waitaha is within our Canterbury health system.

It has taken more than a decade but over the years Manawhenua Ki Waitaha have been key partners in the development of our Māori Health Plans, alliances, CCN, PHOs, CDHB advisory committees and capital developments among many other things. At almost every part of our Canterbury health system, our leaders, committees, alliances and other groups are aware of the importance of equity and partnership with Manawhenua. However, the demands from a $1.5+ billion health system on a small organisation like Manawhenua Ki Waitaha are vast and can become overwhelming.

To support the demanding requests of the CDHB, Manawhenua Ki Waitaha became a charitable trust in 2015. This enabled the CDHB to demonstrate a fiscal commitment and supported Manawhenua Ki Waitaha to meet the many demands placed on it in partnering with the Canterbury health system.

Te Tiriti o Waitangi and the health and disability system

The Ministry of Health have expressed a framework for Te Tiriti o Waitangi in Whakamaua: Māori Health Action Plan 2020–2025[5], published in June 2020. The framework is attached at Appendix 3 and expresses Te Tiriti in terms of Mana. For practical purposes the framework describes how the principles of Te Tiriti o Waitangi apply to the health system.

The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal,[6] underpin the Ministry's commitment to Te Tiriti, and guide the actions outlined the action plan. The 2019 Hauora report4[7] recommends a series of principles be applied to the primary health care system.

These principles are applicable to wider health and disability system as a whole. The principles that apply to our work across the health and disability system are:

[5] https://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025

[6] *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641; *New Zealand Maori Council v Attorney-General* [1989] 2 NZLR 142; *New Zealand Maori Council v Attorney-General* [1991] WL 12012744; *New Zealand Maori Council v Attorney-General* [1992] 2 NZLR 576; *New Zealand Maori Council v Attorney-General* [2013] NZSC 6; *The Ngai Tahu report 1991* (Waitangi Tribunal 1991); *Report of the Waitangi Tribunal on the Orakei claim* (Waitangi Tribunal 1987); *Report of the Waitangi Tribunal on the Muriwhenua fishing claim* (Waitangi Tribunal 1988).

[7] *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal* 2019).

- **Tino rangatiratanga** - Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity** - Being committed to achieving equitable health outcomes for Māori.
- **Active protection** - Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options** - Providing for and properly resourcing kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership** - Working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the primary health system for Māori.

As a DHB, funder and provider of services, we should be authentically exploring how we're able to give effect to these principles as a pathway to support Māori equity and to improve health outcomes for Māori.

Kaupapa Māori (NGO) Services

A response of the health system to address poor Māori access to services, has been to create what has become known as kaupapa Māori services. These services tend to be far more successful at engaging with Māori and producing more equitable health outcomes for those Māori whanau that utilise them. But it is a mistake to think that this is a success for the whole health system. The quantum of vote health in NZ is more than $20 billion and kaupapa Māori investment is a fraction of 1% of this. The vast majority of investment in health goes to non-Māori services and the failure to achieve equity lies squarely at the feet of these services.

However, our Māori Health services, albeit humble in size, punch significantly above their weight in terms of equitable access and outcome for Māori. Our Kaupapa Māori (NGO) providers currently represent a total annual investment of $10,027,410 (less than 1% of CDHB funding), with the services we contract as follows:

Provider	Service
He Waka Tapu	MH Community Support Services
	Regional AOD Services
	AOD Community and Tāne ora/Whānau ora Services
	AOD Services for Offenders
	Senior AOD Clinician
	Whaiora Online

	Mana Ake Programme
	Te Tumu Waiora
	Stop Smoking Service
Purapura Whetu	MH Community Support Services
	MH Day programme activities and community clinic
	Youth MH&A
	Clinical position
	Muslim Services
	Mana Ake
	Stop Smoking Service
	Te Tumu Waiora
Te Puawaitanga ki Ōtautahi Trust	Tamariki Ora
	Mobile Disease State Management
	Workforce development support for Tamariki Ora nurse training
	Stop smoking service
	Pregnancy and parenting education
	Wahakura and weaving wananga
	SUDI Prevention Coordination
Te Whatu Manawa Māoritanga o Rehua	Community health services, including Kaumātua services
	Health hui
Te Kakakura Trust	MH Community Support and Residential Programme
Te Runanga O Nga Maata Waka Inc	Mother and Pēpi
Ha O Te O Wharekauri Trust	Community Health Access and Promotion
Te Tai O Marokura	Community Services for Māori in Kaikoura area

DHB Māori Services

The CDHB also has Māori services within its provider arm that have evolved over many years to support Māori patients and whānau that use our services. A total 51.7 FTE spread across our provider arm services:

Campus	**Service**	**FTE**	**Breakdown**
Christchurch	Hauora Māori	1.0	Team Leader
		0.5	Trainer/Educator
		5.0	Māori Heath Worker
		1.0	Māori Heath Worker at CWH
	Diabetes	1.0	Māori Diabetes CNS
		1.0	Māori Diabetes RN
	CRISS	2.0	Māori Heath Worker
SMHS	Te Korowai Atawhai	0.5	Pou Whirinaki
		0.4	Kaiārahi Matua

		22.3	Pūkenga Atawhai
		1.0	Consumer Advisor
		0.5	Whānau Advisor
Burwood/OPHS/Rehab	OPHS/Rehab	0.2	Pou Whirinaki
	Ranga Hauora	1.0	Kaiwhakahaere
		1.0	Kaiāwhina
	OPHS	1.0	Kaumatua Clinical Assessor (RN)
		1.0	Māori Heath Worker
Community and Public Health		1.0	Māori Relationship Manager
		3.0	Health Promotor
		4.0	Stop Smoking
		1.2	Stop Smoking (West Coast)
		1.3	Health Promotor (South Canterbury)
		0.8	Health Promotor (West Coast)
Community and Public Health also have Māori health FTE as part of their WCDHB and SCDHB responsibilities.			

In addition to these FTE, Planning and Funding have a Māori Portfolio Manager and EMT have the Executive Director, Māori and Pacific Health.

National Indicators

In 2010 the Ministry of Health created a set of National Indicators. Following on from this, Tumu Whakarae (the national collective of DHB Māori Health General Managers), set about creating an easily accessible repository of these indicators, comparing Māori with non-Māori.

Trendly is the resulting health performance monitoring website (https://trendly.co.nz/). The major transformative purpose of Trendly is monitor the health indicators and enable easily accessible comparisons between Māori and non-Māori by DHB. Monitoring the same health indicators by DHB and comparing the same indicators between Māori and non-Māori over a sustained period of time has given tremendous insight into the equity performance of the NZ system and individual DHBs.

Attached to this report are some key measurables that monitor and compare our performance against these national indicators:

- Appendix 4 - National Indicators Dashboard - Sep 20
- Appendix 5 - National Indicators Rank by DHB - Sep 20

Below is a snapshot from Trendly as at 25 Sep 20 comparing Canterbury non-Māori with Māori across the health indicators. In addition it shows the gap between Māori and non-

Māori for that target and the trend line. It then has the Māori data for the large metro DHBs which are a helpful comparison group for the CDHB.

Indicator	Target	Period	Canterbury (European /Other)	Canterbury (Maori)	Gap	Change	Trend	Waitemata (Maori)	Auckland (Maori)	Counties Manukau (Maori)	Waikato (Maori)	Capital & Coast (Maori)	Hutt Valley (Maori)	Southern (Maori)
PHO Enrolment	90	Jul-Sep 2020	95.5	84.4	11.1	0.4		83.4	82.1	88.8	86.7	88.6	88.0	81.8
ASH (0-4 yrs)	-	Sep 19	4726	7670	2944	1192		6758	6826	6053	10757	7236	10966	7762
ASH (45-64 yrs)	-	Sep 19	2306	5272	2966	302		8391	6804	9148	9799	6854	8203	5745
Breastfeeding (3 mths)	70	Jul-Dec 2018	63.0	50.0	13	-4		50.0	54.0	42.0	45.0	48.0	46.0	49.0
Breast Screening (50-69 yrs)	70	Oct-Dec 2019	75.1	70.8	4.3	0.4		66.1	58.9	65.2	58.4	67.8	68.6	69.6
Cervical Screening (25-69 yrs)	80	Jan-Mar 2020	72.9	69.0	3.9	-0.1		60.1	50.1	59.4	68.3	65.2	69.0	68.8
Immunisation (8 mths)	95	Apr-Jun 2020	95.9	90.8	5.1	0.2		83.6	83.1	82.2	81.6	84.7	88.7	90.0
Immunisation (Influenza)	75	Jan-Dec 2019	65.2	41.6	23.6	2.6		36.0	33.0	42.8	48.1	45.4	49.8	43.9
Mental Health	-	Year to Mar 2020	78	258	180	2		322	450	321	472	495	327	261
Oral Health	95	Jan-Dec 2018	92.7	41.5	51.2	-11.1		71.4	67.2	67.7	85.0	68.0	81.6	0.0
Rheumatic Fever	-	2018/19		0	0	-1.3		2.7	2.8	13.8	3.1		2.7	
SUDI	-	2012-2016 combined	0.63	0.92	0.29	-0.2			0.73	2.15	1.75	1.92	1.36	1.96

Trendly Promoting High Performance in Health

There is clearly an equity gap between Māori and non-Māori across these indicators and that has been the case since these indicators have been monitored. There have been gains over the years and the gap has closed but it is still there.

When we compare our Māori indicators with other large metro DHBs, it is clear we are a well performing DHB for our Māori population compared with these other DHBs in some areas but not all. For example we are the only large metro DHB that has achieved the breast screening for Māori women and we have consistently done well at this indicator for the past decade. We are 1% away from moving to yellow for cervical screening for Māori women and we are the best performing of the metro DHBs in this indicator. This is however a very new development. For 8 of the last 10 years the CDHB had languished as one of the poorer performing DHBs but in the past two years, Screen South, who also have responsibility for breast screening, have taken over responsibility for cervical screening. They have made huge improvements in engagement with wāhine Māori and significantly shrunk the existing equity gap. Given the performance of Screen South in breast screening, there is reason to be confident that this will improve over time.

Among the large metro DHBs we are also the best performer at childhood immunisation but Southern DHB and Hutt Valley are following closely. Influenza immunisation is a different story and all these DHBs traditionally do very poorly. In the aftermath of the COVID-19 pandemic, the MoH set aside equity funding for influenza immunisation using kaupapa Māori services. That has shown almost immediate success and points to what the evidence has often show; by Māori for Māori frequently is more successful than (so-called) mainstream services.

National Indicators Dashboard and by Rank

The snapshot of the National Indicators Dashboard at Appendix 4 shows that CDHB is one of the best performing DHBs in the country for its non-Māori population. But it also reiterates the body of evidence referred to earlier that Māori people receive different care and the results are stark. Despite some gains over the years, New Zealand has an equity gap for Māori people in their access to and the quality of health care they receive; and it's across almost every part of our health system.

Despite this equity gap between Māori and non-Māori for all DHBs, when comparing performance for Māori populations between DHBs, Canterbury is performing better than most for these indicators.

This is more clearly illustrated in the National Indicators Rank by DHB at Appendix 5. Of the 11 indicators ranking DHBs for their performance for their respective Māori populations, CDHB is in the top quartile for 5 of the indicators; ASH 45-64 years, breastfeeding at 3 months, breast screening, immunisation at 8 months and SUDI. CDHB is in the top half of DHBs for a further two indicators; ASH 0-4 years and mental health. We are in the third quartile of performers for PHO enrolment, cervical screening and influenza immunisation. There is a single indicator which we are among the worst in New Zealand for Māori, oral health.

Health Workforce

Diversity in the health workforce is an important factor in understanding and catering for the needs of a diverse population. Māori and Pacific peoples are currently under-represented.

The tables below, from the Health and Independence Report (Ministry of Health 2018) shows the proportion of Māori and Pacific peoples in the health workforce. Māori account for 16.5 percent of the population in 2018, and Pacific peoples account for 8.1 percent but they make up a much smaller proportion of the health workforce.

Health Workforce Statistics

Regulatory authority	Health profession and year	Proportion in the total workforce	
		Māori	Pacific
Dental Council (2017)	All oral health practitioners (includes dentists, dental specialists, dental therapists, dental hygienists, orthodontic auxiliaries, dental technicians and clinical dental technicians)	4%	2%
Medical Council of New Zealand (2017)	All doctors (resident medical officers and specialists, including general practitioners)	4%	2%

Midwifery Council of New Zealand (2018)	Midwives	9%	2%
Nursing Council of New Zealand (2019)	Nurses (includes enrolled nurses, registered nurses and nurse practitioners)	8%	4%
Pharmacy Council (2018)	Pharmacists and pharmacy interns	3%	2%
Physiotherapy Board (2018)	Physiotherapists	5%	2%
New Zealand Psychologists Board (2018)	All psychologists (includes clinical psychologists, counselling psychologists, educational psychologists, neuropsychologists, psychologists and trainee psychologists)	5%	1%

Notes: Health practitioners who identify as both Māori and Pacific are counted only as Māori in this table.
Data are based on workforce surveys by regulatory authorities of health practitioners with annual practising certificates. Source: Ministry of Health 2019

Domestic students completing qualifications by field of study and ethnic group, 2018

Fields of study*	**Proportion of Māori among 2018 New Zealand graduates**	**Proportion of Pacific peoples** among 2018 New Zealand graduates**
Dental Studies	12%	6%
Medical Studies	12%	5%
Nursing & Midwifery	14%	9%
Pharmacy	6%	4%
Rehabilitation Therapies	13%	5%
Behavioural Science	11%	6%

* Ministry of Education fields of study do not necessarily correspond exactly to clinical scopes of practice.
** Total response ethnicity data. People who identify as both Māori and Pacific are counted in both categories in this table (this differs from the previous table).
Source: Education Counts 2019

Māori Workforce Targets

A key national strategy to support a responsive health system for Māori is to grow our Māori workforce, so that it accurately reflects our society by ethnicity. Māori are 16.5% of our population but this proportion varies immensely around the country with DHBs like Tairawhiti at almost 50%, Waikato at approximately 25% and most in Te Waipounamu at 10%.

Given the wide variations in Māori population proportion, Te Tumu Whakarae developed a position paper on Māori workforce targets in early 2019 which, under the sponsorship of

the Workforce Strategy Group (WSG), was endorsed by the National DHB CE group in June 2019. The targets are designed to grow the Māori Workforce across occupational groupings and ensure the wider workforce can demonstrate cultural competence in their interactions with Māori patients and whanau. The targets are:

1. All DHBs will actively grow their Māori workforce to achieve a Māori workforce that reflects the proportionality for their Māori population.
   Target One:
   Each DHB will have 0% of employees who have their ethnicity recorded in their employee profile as "unknown" by 30 June 2020. ***Report quarterly.***

   This activity will be led by GMs HR/People and Capability and supported by training which conveys the importance of collection of staff ethnicity data as a component of improving the experience and outcomes of health care for Māori**.**

   Target Two:
   Each DHB will employ a Māori workforce that reflects the Māori population proportionality for their region by 2030. ***Report annually.***

   Target Three:
   Each DHB will employ a Māori workforce with occupational groupings that reflect the Māori population proportionality for their region *by 2040*. ***Report annually.***

2. All DHBs will set in place steps to significantly and meaningfully realise cultural competence for all clinical staff, the Board and other staff groups that have regular contact with patients and whānau.

   Target Four:
   All DHB staff (clinical and non-clinical) who have contact with patients and whānau, Board members and those in people management or leadership roles will demonstrate participation in cultural competence training by 2022.
   Report staff and Board member participation in cultural competence training as a percentage of these groups over the last 3 years by 30 June 2020 then monitor annually.

3. All DHBs will measure and report on the recruitment and retention of Māori staff in clinical and non-clinical occupations.

   Target Five:
   In each DHB 100% of Māori applicants who meet the minimum eligibility criteria for any role are shortlisted for interview. ***Report by October 2019, then monitor quarterly.***

   Target Six:
   In each DHB, turnover for Māori staff will be no greater than the DHB turnover for all staff.
   Report by October 2019, then monitor quarterly.

The target of employing a Māori clinical workforce that reflects the Māori population proportionality for each DHB region is very dependent on the training pipeline in addition to the actions of DHBs. We are therefore heavily reliant on the education sector if we are to

achieve these targets. Programmes such as Whakapiki Ake[8] (Auckland University), Mirror on Society[9] (Otago University), Kia Ora Hauora[10] (Ministry of Health and DHBs), among many others, grow the pipeline of Māori coming through to study health careers and eventually grow our health workforce.

To enable accurate reporting, it is necessary to reduce the number of employees whose ethnicity is unknown to 0% so that ethnicity information is reliable. Further targets will be developed when progress, supported by additional training and processes, has been demonstrated.

WSG agreed a critical enabler to support the development of cultural competence was the presence of an environment supportive to and which values cultural competence, as training on its own does not result in changes in behaviours and beliefs. This includes acknowledging and working to eliminate structures and processes which support institutional racism and the associated privileges they reinforce.

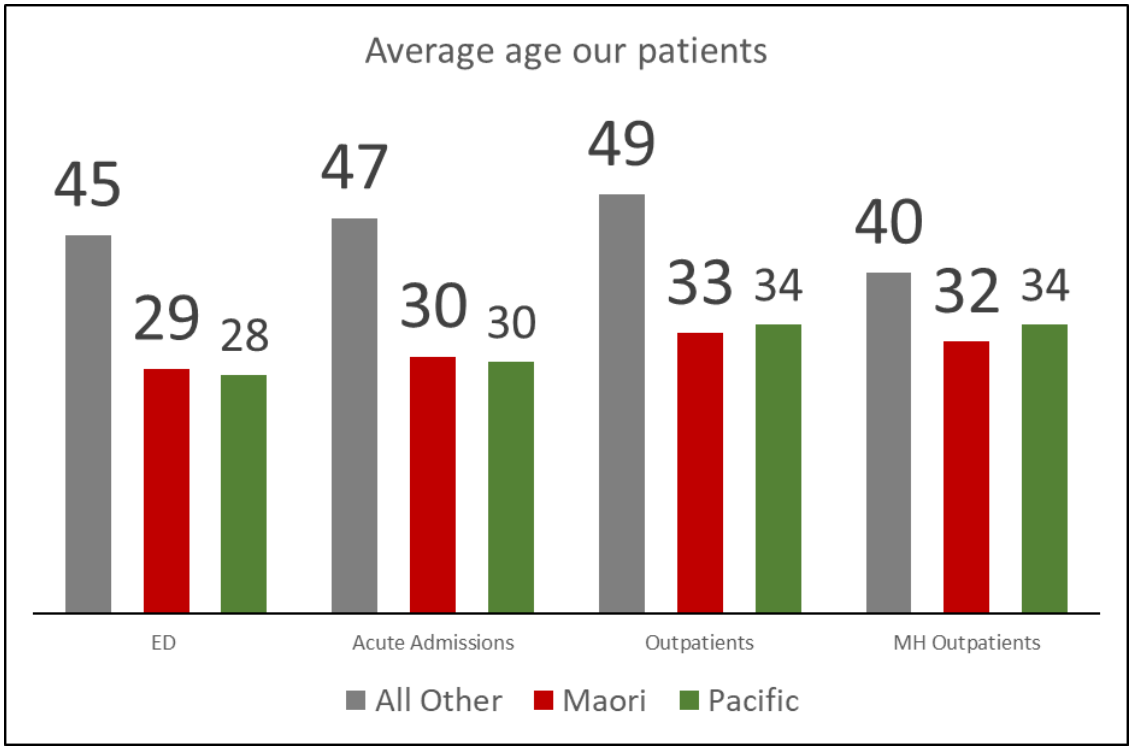
Appendix 6 - Māori Workforce Dashboard June 2020, was prepared by the central DHBs shared agency TAS, to monitor progress towards the agreed national Māori workforce targets. The COVID-19 lockdown has meant the pandemic response was prioritised so many of the target dates will need to be revisited.

The dashboard shows that the entire country is performing very poorly and as a country we have much work to do over many years, and probably decades. These targets are very aspirational.

Māori and Our Services Day to Day

On average, Māori attending ED, Acute Admissions or seen by Outpatients are nearly 15 years younger compared to non-Māori. This fits with the age demography of the Māori population in Canterbury where the median age for Māori is nearly 15 years younger than non-Māori.

[8] https://www.auckland.ac.nz/en/fmhs/study-with-us/vision-2020/whakapiki-ake-.html
[9] https://www.otago.ac.nz/healthsciences/students/professional/otago686979.html
[10] https://www.kiaorahauora.co.nz/



This has important implications for equity and access to services because it illustrates that for many episodic events as well as chronic conditions, Māori are becoming unwell at a much younger age, but our system tends to treat everyone the same by age.

For example, CDHB is currently rolling out the National Bowel Screening Programme (NBSP), which treats all ethnicities equally with a screening age of 60-74 years of age. At least half of Māori bowel cancer (60% female and 50% male) is diagnosed before the age of 60 years compared to less than a third (30%) of non-Māori bowel cancer (male and female). The NBSP screening age of 60-74 year age range will mean that most bowel cancer in Māori will not be diagnosed by this screening programme. Non-Māori bowel cancer mortality will fall as intended because the age range of the screening suits detection of bowel cancer in non-Māori and most cancers will be detected[11].

The decision by the Ministry of Health and the National Screening Unit to roll out a NBSP which knowingly exacerbates Māori health inequity and privileges Pākehā lives over Māori is deeply concerning.

Listed below are expert parties who are in support of lowering the age range for Māori, but who have to date, been ignored by the Ministry of Health and the National Screening Unit:

- Hei Āhuru Mōwai,
- Cancer Control Agency Advisory Board,

[11] https://teora.maori.nz/wp-content/uploads/2020/01/Position-Statement-Bowel-Screening.pdf

- Bowel Cancer NZ,
- National Screening Advisory Committee,
- RNZCGPs,
- General Practice NZ,
- National BCS Network,
- the National BC Working Group,
- Te Tumu Whakarae and various DHBs

Equity Responses in Primary Care

There is momentum both nationally and in Canterbury to refocus our health system to provide more equitable access to healthcare. The most recent Health and Disability Review highlights the need to change the driver of the health system to focus on population health through a collaborative and cohesive system which puts the intentions of Te Tiriti o Waitangi at the centre and enables equitable access and outcomes for all.

With this on mind, in September 2020, staff at Pegasus Health authored an Equity Strategy to help guide their future actions to achieve equity.

The Pegasus Health Equity Strategy will prioritise equity in every aspect of their work and will be embedded in the fabric of how they work.

The strategy is bold and innovative for a PHO and supports the findings of both the Wai 2575 Waitangi Tribunal Health Services Enquiry and the New Zealand Health and Disability Review. The Strategy is attached at Appendix 7.

Appendices

Appendix 1	MOU with Manawhenua - signed December 2015
Appendix 2	Manawhenua Engagement - September 2020
Appendix 3	Whakamaua Tiriti o Waitangi Framework – August 2020
Appendix 4	National Indicators Dashboard - September 2020
Appendix 5	National Indicators Rank by DHB - September 2020
Appendix 6	Māori Workforce Dashboard - June 2020
Appendix 7	Pegasus Health Equity Strategy - September 2020

December 2015

Te Poari Hauora Waitaha

Manawhenua Ki Waitaha

Memorandum of Understanding

between
Manawhenua Ki Waitaha Charitable Trust and Canterbury District Health Board

Parties

1. Manawhenua Ki Waitaha Charitable Trust

1.1 Manawhenua Ki Waitaha is a charitable trust mandated by the seven Papatipu Rūnanga of Waitaha, within whose takiwā Canterbury District Health Board ("CDHB") operates.

The Waitaha Rūnanga are;

Te Rūnanga o Kaikōura Incorporated
Te Ngāi Tūāhuriri Rūnanga Society Incorporated
Ōnuku Rūnanga Incorporated
Te Taumutu Rūnanga Incorporated
Te Hapū o Ngāti Wheke Incorporated

Te Rūnanga o Koukourārata Incorporated
Wairewa Rūnanga Incorporated

1.2 Manawhenua Ki Waitaha is the Ngāi Tahu and Rūnanga representative body in Canterbury for health issues.

1.3 Manawhenua Ki Waitaha and CDHB Board work collaboratively across the health system in Canterbury to facilitate the participation of Ngāi Tahu through its 7 Waitaha Papatipu Rūnanga.

2. Canterbury District Health Board (CDHB)

CDHB is established and constituted under the New Zealand Public Health and Disability Act 2000. The statutory role of CDHB is to improve the health outcomes for the people of its region. CDHB funds and provides health services in Canterbury.

3. Purpose

Manawhenua Ki Waitaha will take a proactive approach to the consolidation of a Treaty-based relationship, to assist CDHB in its responsibilities under the New Zealand Public Health and Disability Act 2000 with emphasis on equitable health outcomes for all Māori living in the Canterbury region, This MOU outlines agreed principles and guidelines for an enduring collaborative relationship between Manawhenua Ki Waitaha and CDHB.

4. Acknowledgements of parties

4.1 The parties acknowledge:

a. that Te Tiriti o Waitangi/The Treaty of Waitangi, is a founding document of Aotearoa/New Zealand, and lays an important foundation for the relationships between the Crown and Māori;

b. that the role of CDHB as defined by statute, benefits from the input of its relevant stakeholders, in this case, Manawhenua Ki Waitaha (Ngāi Tahu) in the Canterbury region;

c. that the relationship created by this MOU is not an exclusive one and that both parties reserve the right to create or maintain relationships with any

other group that may assist them in the furtherance of their respective objectives;

d. that this MOU does not alter or diminish CDHBs statutory powers and obligations under the New Zealand Public Health and Disability Act 2000; nor does it alter or diminish the statutory powers and obligations of Te Rūnanga o Ngāi Tahu, under the Te Rūnanga o Ngāi Tahu Act 1996, or any other statute in any way;

e. that the relationship developed in this MOU may also lead to the development of contracts for the provision of relevant services; but that this MOU is not developed in this expectation and such contracts;

f. that this MOU is not legally enforceable, but that this does not diminish the intention of the parties to comply with the terms and conditions of this MOU.

5. Agreement of parties

5.1 The parties agree on the following principles:

a. to work together to improve Ngāi Tahu and all Māori health outcomes in CDHB catchment;

b. to share information as it relates to both parties;

c. to mutually support the endeavours of the other; and

d. to act at all times in good faith and with good intent.

5.2 The parties further agree on the following operational undertakings:

a. to meet once a year to workshop the priorities around Māori health within the CDHB catchment and how these should be reported.

b. that the Chairperson of Manawhenua Ki Waitaha and the Chairperson, of CDHB will meet four times per annum; or as required by either party.

c. that the Chairperson of Manawhenua Ki Waitaha and the CEO of CDHB and Kāhui Kaumātua shall meet as required.

d. that a representative of CDHB shall attend Manawhenua Ki Waitaha meetings on a 6 monthly basis to report on progress.

e. that a representative of Manawhenua Ki Waitaha shall attend CDHB meetings on a 6 monthly basis to report on progress.

6. Manawhenua Ki Waitaha further agrees that it will:

6.1 mānaaki the Kāhui Kaumātua on matters of tikanga and kawa;

6.2 provide the human resource to:

a. sits on the selection panel for the CEO, Director of Māori Health and other important positions within the CDHB that impact directly on Ngāi Tahu and other Māori living in the Canterbury region.

b. advise on the development of the Māori Health directorate;

6.3 assist CDHB to identify problems with its policies and programmes related to all Māori in the Canterbury region and seek to provide CDHB with advice on developing solutions to these problems.

7. CDHB further agrees that it will:

7.1 take account of any information and advice provided by Manawhenua Ki Waitaha;

7.2 take a proactive approach to the consolidation of a Treaty-based relationship, and provide Manawhenua Ki Waitaha with opportunities to contribute to CDHBs decision-making processes and assist CDHB in satisfying its responsibilities under the New Zealand Public Health and Disability Act 2000;

7.3 keep Manawhenua Ki Waitaha informed about relevant policies and programmes, including the outcome of any decision-making process;

7.4 provide the necessary resources, (e.g. meeting facilities, food, administration support, meeting fees, etc.) to facilitate the functioning of this MOU and any activities or projects that arise from it; and

7.5 provide Manawhenua Ki Waitaha (via the Director of Māori Health and/or the Māori Health Directorate) quarterly reports on:

a. activities in relation to agreements within this MOU and

b. activities in relation to CDHB Māori Health plan.

8. Dispute Resolution

Both parties agree to resolve disputes informally.

9. Disclosure of Information

9.1 Any information exchanged under this MOU remains the property of the originating party and 'Will be kept confidential to the parties and only disclosed with the prior approval of the relevant party unless required by law.

9.2 The parties acknowledge the CDHB is limited in its ability to keep information confidential by the Official Information Act 1982.

10. Execution of memorandum

This MOU comes into effect on the date of signing.

11. Review of memorandum

This MOU will be reviewed two yearly from the date of execution.

12. Termination of memorandum

This MOU may be terminated by one party giving 60 days' notice to the other, or by mutual agreement at any time.

Signed this 17th day of December 2015

by:

Chair, Canterbury District Health Board

Signed this 17th day of December 2015

by:

Chair, Manawhenua Ki Waitaha

Glossary of Māori Terms

Kāhui Kaumātua	CDHB Kaumātua and Taua group that provides advice and support to CEO.
Kawa	Ceremonial rituals and protocol.
Mānaaki	Care for, help, support, show hospitality.
Papatipu Rūnanga	Traditional Ngāi Tahu council structure normally based on a hapū (sub-tribe) or a marae. All Ngāi Papatipu Rūnanga are defined and named in the Te Rūnanga o Ngāi Tahu Act.
Takiwā	Geographical area of traditional / customary authority
Tikanga	1. The correct way of doing things characterised by issues of principle, integrity of intent and correct processes being followed. 2, Values and respect.

Manawhenua ki Waitaha

PAPATIPU RŪNAKA X7
Koukourārata, Wairewa, Taumutu, Rāpaki, Ōnuku, Tūāhuriri, Kaikōura

MANAWHENUA KI WAITAHA CHARITABLE TRUST

MANAWHENUA KI WAITAHA RELATIONSHIP CHART
Septembert 2020

**MWKCT Board Appointed Rep*

CANTERBURY DISTRICT HEALTH BOARD
Ministerial Appointed Māori Reps x2
Gabrielle Huria & Barry Bragg

HOSPITAL ADVISORY COMMITTEE
Michelle Turrall*

CPHAC & DSAC COMMITTEE
Michelle Turrall*

CLINICAL BOARD
Michelle Turrall*

WOMEN'S HEALTH CONSUMER ADVISORY COUNCIL
Dominee Morgan
Tiriana Smith
CHILD HEALTH FAMILY ADVISORY COUNCIL
Toriana Hunt
CONSUMER COUNCIL
Henare Edwards
FACILITY DEVELOPMENT GROUP
Toriana Hunt*
DISABILITY STEERING GROUP
Waikura McGregor
PT ESCALATION PROJECT
Wikitoria Crofts
MATERNITY CO-DESIGN
Tumanako Stone-Howard*
QUALITY & SAFETY MARKER CONSUMER WORKSHOP
Tiriana Smith
Alcohol Strategy Group
Kereama Carmody *
Te Matou o Maui (NGO)
Wendy Dallas-Katoa*

PRIMARY HEALTH ORGANISATIONS

CHRISTCHURCH PHO
Ana Rolleston*
Michelle Turrall*
WAITAHA PHO
Toriana Hunt*
PEGASUS CHARITABLE TRUST BOARD
Jane Huria

TE KĀHUI O PAPAKI KĀ TAI MĀORI PRIMARY HEALTH ADVISORY GROUP
Wendy Dallas-Katoa*

REGIONAL

TE WAIPOUNAMU MANAWHENUA & DHB
Iwi Health Board (Nelson Marlborough), Māori Health Advisory Committee (South Canterbury), Tatau Pounamu Manawhenua Advisory Group (West Coast), Te Hauora o Murihiku me Araiteuru (Southern),Manawhenua Ki Waitaha (Canterbury)

NGĀI TAHU IWI ORANGA

ORANGA TAMARIKI
Amber Clarke
Michelle Turrall

TE PUTAHITANGA O TE WAIPOUNAMU
South Island Whānau Ora Commissioning Agency

SOUTH ISLAND ALLIANCE
SI MENTAL HEALTH SLA
Karaitiana Tickell
SI HOP SLA
Mere Wallace

TE HERENGA HAUORA
Hector Matthews

TE KAHUI O KAKAKURA ŌTAUTAHI RŪNANGA CHAIR
Puamiria Parata-Goodall
GREATER HEALTHY CHCH
Wendy Dallas-Katoa

TE WAIPOUNAMU MĀORI LEADERSHIP GROUP FOR CANCER
Wendy Dallas-Katoa

RELATIONSHIPS

MAORI WOMEN'S WELFARE LEAGUE

NZBA

Otago University of Canterbury, MIHI, Research Development Komiti

CANTERBURY CLINICAL NETWORK ALLIANCE LEADERSHIP TEAM
Wendy Dallas-Katoa

SYSTEM OUTCOMES STEERING GROUP
Renee Noble

ORAL HEALTH SDG
Ngaire Briggs, Gail McLaunchlan & Hector Matthews

PRIMARY CARE CAPABILITY SLA
Lovey Ratima-Rapson
Gail McLauchlan

URGENT CARE SLA
VACANT

POP HEALTH & ACCESS SLA
Wendy Dallas-Katoa

MANA AKE MENTAL SUPPORT IN SCHOOLS
Renee Noble

COMMUNITY SERVICES SLA
Irihapeti Bullmore

IMMUNISATION SLA
Dr Ramon Pink

HEALTH OF OLDER PEOPLE WS
Annette Finlay

RURAL HEALTH WS
Jaana Kahu

ASHBURTON SLA
Michelle Brett

MENTAL HEALTH WS
Karaitiana Tickell

PHARMACY SLA
Vicky Barr

INTEGRATED RESPIRATORY
Brendon McIntosh

OXFORD HEALTH SDG
Hutiika Crofts-Gibbs

LABORATORY SLA
Hector Matthews

CHILD & YOUTH WS
Renee Noble & Gail McLauchlan

FALLS & FRACTURES SLA
Kathy Simmons

INTEGRATED DIABETES
Debbie Rawiri

HURUNUI HEALTH SDG
Deidre Carrol

SELWYN HEALTH SDG
ON HOLD*

CCN MĀORI CAUCUS GROUP
Manawhenua Manuhiri

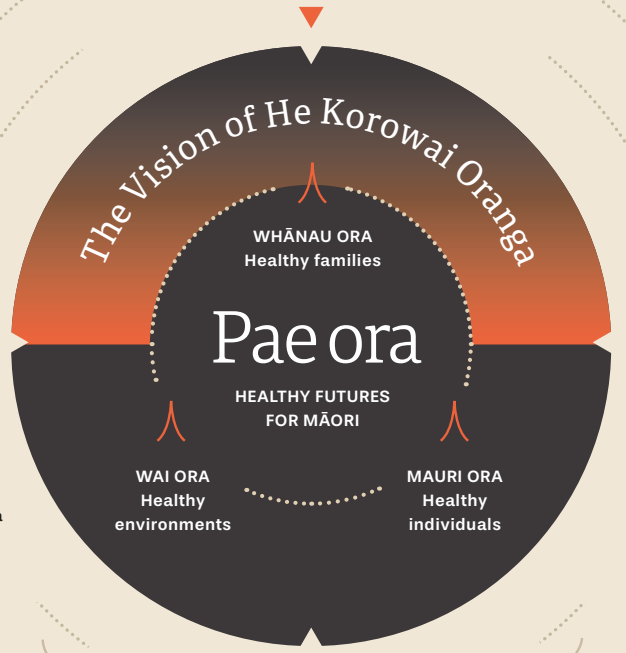
Te Tiriti o Waitangi and the health and disability system

MANATŪ HAUORA
MINISTRY OF HEALTH

He Mana tō Te Tiriti o Waitangi

Expressing Te Tiriti in mana terms

Mana Whakahaere	Mana Motuhake	Mana Tangata	Mana Māori
Good Government	Unique and indigenous	Fairness and Justice	Cultural identity and integrity
Article I	Article II	Article III	Declaration



Ngā Kupu o Te Tiriti o Waitangi

Preamble / Kupu Whakataki
Peace and good order

The Articles

Article I	Article II	Article III	Declaration
Ko te Tuatahi Kāwanatanga	Ko te Tuarua Tino Rangatiratanga	Ko te Tuatoru Ōritetanga	Whakapuakitanga Ritenga Māori

Principles of Te Tiriti o Waitangi

How we apply Te Tiriti in the modern world

Tino Rangatiratanga | Equity | Active protection | Partnership | Options

The Health and Disability Sector

How we express our kaitiakitanga

Stewardship	Iwi/Māori health development	Equity focus	Protect Mātauranga Māori
Article I	Article II	Article III	Declaration

Our Te Tiriti o Waitangi Framework

Te Tiriti o Waitangi

The text of Te Tiriti, including the preamble and the three articles, along with the Ritenga Māori declaration, are the enduring foundation of our approach. Based on these foundations, we will strive to achieve the following four goals, each expressed in terms of mana:

- **Mana whakahaere**

  Effective and appropriate stewardship or kaitiakitanga over the health and disability system. This goes beyond the management of assets or resources.

- **Mana motuhake**

  Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.

- **Mana tangata**

  Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.

- **Mana Māori**

  Enabling Ritenga Māori (Māori customary rituals) which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy and customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

The Treaty obligations are a foundation for achieving Māori health aspirations and equity for Māori and therefore delivering on He Korowai Oranga.

Principles of Te Tiriti o Waitangi

The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the framework for how we will meet our obligations under Te Tiriti in our day-to-day work. The 2019 *Hauora* report recommends the following principles for the primary health care system. These principles are applicable to wider health and disability system. The principles that apply to our work are:

- **Tino rangatiratanga**

  The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.

- **Equity**

  The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.

- **Active protection**

  The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

- **Options**

  The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

- **Partnership**

  The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

He Korowai Oranga

Meeting our obligations under Te Tiriti is necessary if we are to realise the overall aim of Pae Ora (healthy futures for Māori) under He Korowai Oranga (the Māori Health Strategy).

Along with the high-level outcomes for the Māori Health Action Plan:

- Iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing.
- The health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
- The health and disability system addresses racism and discrimination in all its forms.
- The inclusion and protection of mātauranga Māori throughout the health and disability system.

Equity lives within our Treaty framework

Equity is defined as 'In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.'

Equity is both inherent to Article 3 and an important Treaty principle.

National Indicators - Māori

September 2020

Indicator	Data Period	Target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	Mid Central	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui	Reached Target
PHO Enrolment	Jul-Sep 2020	90%	82.1%	90.6%	84.4%	88.6%	88.8%	91.7%	88.0%	88.5%	80.5%	83.8%	94.2%	81.7%	81.8%	93.5%	83.0%	86.7%	95.2%	83.4%	89.5%	91.7%	6
ASH (0-4 yrs)	Sep 19	-	6826	8812	7670	7236	6053	8495	10966	8672	7030	6464	8600	3387	7762	8307	10117	10757	5169	6758	8049	9235	0
ASH (45-64 yrs)	Sep 19	-	6804	8788	5272	6854	9148	9426	8203	9229	7395	5580	8634	4481	5745	6942	9400	9799	5776	8391	6092	11147	0
Breastfeeding (3 mths)	Jul-Dec 2018	70%	54.0%	52.0%	50.0%	48.0%	42.0%	43.0%	46.0%	46.0%	49.0%	53.0%	53.0%	42.0%	49.0%	36.0%	42.0%	45.0%	46.0%	50.0%	41.0%	50.0%	0
Breast Screening (50-69 yrs)	Oct-Dec 2019	70%	58.9%	67.5%	70.8%	67.8%	65.2%	70.0%	68.6%	67.1%	65.8%	74.9%	74.1%	61.6%	69.6%	68.3%	63.0%	58.4%	69.0%	66.1%	69.4%	74.1%	5
Cervical Screening (25-69 yrs)	Jan-Mar 2020	80%	50.1%	73.2%	69.0%	65.2%	59.4%	74.4%	69.0%	73.2%	64.9%	73.4%	70.1%	63.3%	68.8%	71.9%	73.2%	68.3%	74.9%	60.1%	69.7%	73.9%	0
Immunisation (8 mths)	Apr-Jun 2020	95%	83.1%	82.5%	90.8%	84.7%	82.2%	86.9%	88.7%	71.8%	76.5%	88.5%	83.0%	100.0%	90.0%	73.9%	77.6%	81.6%	86.0%	83.6%	85.0%	79.4%	1
Immunisation (Influenza)	Jan-Dec 2019	75%	33.0%	54.5%	41.6%	45.4%	42.8%	52.8%	49.8%	49.2%	41.7%	48.2%	40.2%	39.5%	43.9%	49.1%	38.9%	48.1%	53.2%	36.0%	42.6%	68.7%	0
Mental Health	Year to Mar 2020	-	450	218	258	495	321	439	327	242	301	231	512	146	261	220	281	472	354	322	250	256	0
Oral Health	Jan-Dec 2018	95%	67.2%	95.5%	41.5%	68.0%	67.7%	78.0%	81.6%	89.4%	51.7%	70.4%	82.3%	34.5%	0.0%	101.1%	78.1%	85.0%	87.4%	71.4%	90.0%	121.9%	3
SUDI	2012-2016 combined	-	0.73	0.61	0.92	1.92	2.15	1.54	1.36	1.18	1.49	-	1.03	-	1.96	2.37	1.55	1.75	-	-	-	2.97	0

National Indicators - non-Māori

September 2020

Indicator	Data Period	Target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	Mid Central	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui	Reached Target
PHO Enrolment	Jul-Sep 2020	90%	94.3%	97.2%	95.5%	94.7%	96.1%	96.7%	98.1%	97.4%	96.9%	97.7%	97.9%	97.7%	94.8%	106.5%	97.3%	97.8%	97.9%	97.1%	96.6%	97.1%	20
ASH (0-4 yrs)	Sep 19	-	5457	5977	4726	4867	4353	5336	6382	6096	5308	3664	5763	4429	5399	5299	7507	7418	4490	4632	5517	4551	-
ASH (45-64 yrs)	Sep 19	-	2630	2841	2306	2623	2740	3475	3894	3454	3915	2518	3232	3228	2769	3143	4482	3240	2936	3299	3259	5382	-
Breastfeeding (3 mths)	Jul-Dec 2018	70%	62.0%	68.0%	63.0%	66.0%	51.0%	66.0%	57.0%	58.0%	58.0%	63.0%	74.0%	63.0%	65.0%	62.0%	59.0%	61.0%	62.0%	65.0%	61.0%	52.0%	1
Breast Screening (50-69 yrs)	Oct-Dec 2019	70%	65.0%	76.8%	75.1%	72.0%	72.5%	74.1%	73.4%	72.7%	78.2%	78.5%	68.1%	77.3%	71.8%	73.7%	75.3%	70.5%	76.4%	65.9%	76.1%	81.0%	17
Cervical Screening (25-69 yrs)	Jan-Mar 2020	80%	61.6%	80.4%	72.9%	74.3%	65.9%	74.0%	74.2%	76.2%	74.4%	79.9%	72.5%	75.6%	75.2%	75.5%	79.0%	74.8%	73.7%	69.8%	74.1%	74.7%	1
Immunisation (8 mths)	Apr-Jun 2020	95%	95.7%	92.0%	95.9%	96.1%	90.2%	92.1%	94.9%	89.3%	91.7%	95.7%	82.5%	95.8%	97.3%	95.0%	87.1%	91.0%	89.9%	91.1%	95.1%	92.5%	8
Immunisation (Influenza)	Jan-Dec 2019	75%	51.5%	66.0%	65.2%	58.9%	51.2%	61.2%	55.6%	54.1%	60.2%	62.5%	53.0%	62.1%	54.9%	55.6%	59.7%	59.3%	69.4%	51.3%	59.9%	69.3%	0
Mental Health	Year to Mar 2020	-	123	56	78	145	82	119	112	88	90	102	159	91	89	65	92	108	68	91	109	100	-
Oral Health	Jan-Dec 2018	95%	94.2%	105.8%	92.7%	98.3%	84.6%	114.9%	100.2%	112.0%	125.4%	99.4%	82.2%	78.0%	0.0%	111.8%	116.7%	97.2%	94.6%	101.8%	104.6%	129.7%	13
SUDI	2012-2016 combined	-	-	-	0.63	-	-	-	0.51	-	-	-	-	-	0.3	-	0.6	0.46	-	0.11	-	-	-

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

PHO Enrolment

	To Jul-Sep 2020	%	90%	
1	Wairarapa	95.2%		-0.8
2	Northland	94.2%		0.2
3	Tairawhiti	93.5%		-0.5
4	Hawke's Bay	91.7%		-0.3
5	Whanganui	91.7%		-0.3
6	Bay of Plenty	90.6%		-0.4
7	West Coast	89.5%		0.5
8	Counties Manukau	88.8%		-0.2
9	Capital & Coast	88.6%		-0.4
10	Lakes	88.5%		-0.5
11	Hutt Valley	88.0%		0
12	Waikato	86.7%		-0.3
13	*Canterbury*	*84.4%*		*0.4*
14	Nelson Marlborough	83.8%		0.8
15	Waitemata	83.4%		-0.6
16	Taranaki	83.0%		0
17	Auckland	82.1%		0.1
18	Southern	81.8%		-0.2
19	South Canterbury	81.7%		-0.3
20	Mid Central	80.5%		0.5

ASH (0-4 yrs)

	To Sep 19		0	
1	South Canterbury	3387		-807
2	Wairarapa	5169		-4141
3	Counties Manukau	6053		-637
4	Nelson Marlborough	6464		1239
5	Waitemata	6758		232
6	Auckland	6826		210
7	Mid Central	7030		789
8	Capital & Coast	7236		-935
9	*Canterbury*	*7670*		*1192*
10	Southern	7762		325
11	West Coast	8049		-3658
12	Tairawhiti	8307		827
13	Hawke's Bay	8495		-170
14	Northland	8600		-768
15	Lakes	8672		-1579
16	Bay of Plenty	8812		654
17	Whanganui	9235		-561
18	Taranaki	10117		629
19	Waikato	10757		-1068
20	Hutt Valley	10966		272

ASH (45-64 yrs)

	To Sep 19		0	
1	South Canterbury	4481		251
2	*Canterbury*	*5272*		*302*
3	Nelson Marlborough	5580		580
4	Southern	5745		963
5	Wairarapa	5776		-1489
6	West Coast	6092		1484
7	Auckland	6804		-251
8	Capital & Coast	6854		784
9	Tairawhiti	6942		768
10	Mid Central	7395		228
11	Hutt Valley	8203		112
12	Waitemata	8391		722
13	Northland	8634		-42
14	Bay of Plenty	8788		1461
15	Counties Manukau	9148		-253
16	Lakes	9229		240
17	Taranaki	9400		-685
18	Hawke's Bay	9426		716
19	Waikato	9799		630
20	Whanganui	11147		-958

Breastfeeding (3 mths)

	To Jul-Dec 2018	%	70%	
1	Auckland	54.0%		4
2	Nelson Marlborough	53.0%		3
3	Northland	53.0%		-2
4	Bay of Plenty	52.0%		3
5	*Canterbury*	*50.0%*		*-4*
6	Waitemata	50.0%		-2
7	Whanganui	50.0%		9
8	Southern	49.0%		5
9	Mid Central	49.0%		6
10	Capital & Coast	48.0%		-2
11	Hutt Valley	46.0%		6
12	Lakes	46.0%		6
13	Wairarapa	46.0%		5
14	Waikato	45.0%		2
15	Hawke's Bay	43.0%		7
16	Counties Manukau	42.0%		-4
17	Taranaki	42.0%		-11
18	South Canterbury	42.0%		-10
19	West Coast	41.0%		-11
20	Tairawhiti	36.0%		-9

Breast Screening (50-69 yrs)

	To Oct-Dec 2019	%	70%	
1	Nelson Marlborough	74.9%		0.4
2	Northland	74.1%		-0.4
3	Whanganui	74.1%		-0.5
4	*Canterbury*	*70.8%*		*0.4*
5	Hawke's Bay	70.0%		-0.3
6	Southern	69.6%		0.5
7	West Coast	69.4%		-0.8
8	Wairarapa	69.0%		-1.4
9	Hutt Valley	68.6%		-0.2
10	Tairawhiti	68.3%		0.6
11	Capital & Coast	67.8%		0.9
12	Bay of Plenty	67.5%		1.1
13	Lakes	67.1%		1.2
14	Waitemata	66.1%		-0.4
15	Mid Central	65.8%		0.1
16	Counties Manukau	65.2%		0.1
17	Taranaki	63.0%		0.1
18	South Canterbury	61.6%		-1.1
19	Auckland	58.9%		0
20	Waikato	58.4%		0

Cervical Screening (25-69 yrs)

	To Jan-Mar 2020	%	80%	
1	Wairarapa	74.9%		0.9
2	Hawke's Bay	74.4%		-0.3
3	Whanganui	73.9%		0.2
4	Nelson Marlborough	73.4%		-0.3
5	Taranaki	73.2%		-0.6
6	Lakes	73.2%		-0.6
7	Bay of Plenty	73.2%		-0.3
8	Tairawhiti	71.9%		-1
9	Northland	70.1%		-0.7
10	West Coast	69.7%		-1.2
11	*Canterbury*	*69.0%*		*-0.1*
12	Hutt Valley	69.0%		-0.3
13	Southern	68.8%		-0.7
14	Waikato	68.3%		-1
15	Capital & Coast	65.2%		-1.1
16	Mid Central	64.9%		-0.9
17	South Canterbury	63.3%		-0.5
18	Waitemata	60.1%		-0.7
19	Counties Manukau	59.4%		-1
20	Auckland	50.1%		-1.3

Immunisation (8 mths)

	To Apr-Jun 2020	%	95%	
1	South Canterbury	100.0%		0
2	*Canterbury*	*90.8%*		*0.2*
3	Southern	90.0%		3.2
4	Hutt Valley	88.7%		7.1
5	Nelson Marlborough	88.5%		4.9
6	Hawke's Bay	86.9%		-4
7	Wairarapa	86.0%		-10.2
8	West Coast	85.0%		5
9	Capital & Coast	84.7%		-3.7
10	Waitemata	83.6%		-6.2
11	Auckland	83.1%		0.2
12	Northland	83.0%		2.3
13	Bay of Plenty	82.5%		-1.8
14	Counties Manukau	82.2%		-2
15	Waikato	81.6%		0.4
16	Whanganui	79.4%		0.7
17	Taranaki	77.5%		1.7
18	Mid Central	76.5%		-0.9
19	Tairawhiti	73.9%		-12.3
20	Lakes	71.8%		-12

Immunisation (Influenza)

	To Jan-Dec 2019	%	75%	
1	Whanganui	68.7%		-1.3
2	Bay of Plenty	54.5%		3.5
3	Wairarapa	53.2%		3.2
4	Hawke's Bay	52.8%		-0.2
5	Hutt Valley	49.8%		2.8
6	Lakes	49.2%		18.2
7	Tairawhiti	49.1%		-1.9
8	Nelson Marlborough	48.2%		-0.8
9	Waikato	48.1%		-0.9
10	Capital & Coast	45.4%		1.4
11	Southern	43.9%		-1.1
12	Counties Manukau	42.8%		-3.2
13	West Coast	42.6%		-7.4
14	Mid Central	41.7%		-0.3
15	*Canterbury*	*41.6%*		*2.6*
16	Northland	40.2%		-3.8
17	South Canterbury	39.5%		2.5
18	Taranaki	38.9%		-4.1
19	Waitemata	36.0%		-1
20	Auckland	33.0%		-2

Mental Health

	To Year to Mar 2020		0	
1	South Canterbury	146		-6
2	Bay of Plenty	218		-4
3	Tairawhiti	220		-24
4	Nelson Marlborough	231		-8
5	Lakes	242		-6
6	West Coast	250		19
7	Whanganui	256		7
8	*Canterbury*	*258*		*2*
9	Southern	261		-5
10	Taranaki	281		-9
11	Mid Central	301		-29
12	Counties Manukau	321		-13
13	Waitemata	322		-5
14	Hutt Valley	327		-11
15	Wairarapa	354		13
16	Hawke's Bay	439		0
17	Auckland	450		-24
18	Waikato	472		-2
19	Capital & Coast	495		10
20	Northland	512		-10

Oral Health

	To Jan-Dec 2018	%	95%	
1	Whanganui	121.9%		0.2
2	Tairawhiti	101.1%		-2.7
3	Bay of Plenty	95.5%		24.4
4	West Coast	90.0%		-5.7
5	Lakes	89.4%		5.7
6	Wairarapa	87.4%		3.8
7	Waikato	85.0%		26.5
8	Northland	82.3%		4.9
9	Hutt Valley	81.6%		3.9
10	Taranaki	78.1%		-0.6
11	Hawke's Bay	78.0%		1.9
12	Waitemata	71.4%		-1.4
13	Nelson Marlborough	70.4%		5.1
14	Capital & Coast	68.0%		1.5
15	Counties Manukau	67.7%		-2.8
16	Auckland	67.2%		-1.9
17	Mid Central	51.7%		-20.6
18	*Canterbury*	*41.5%*		*-11.1*
19	South Canterbury	34.5%		-8.1
20	Southern	0.0%		-67.6

SUDI

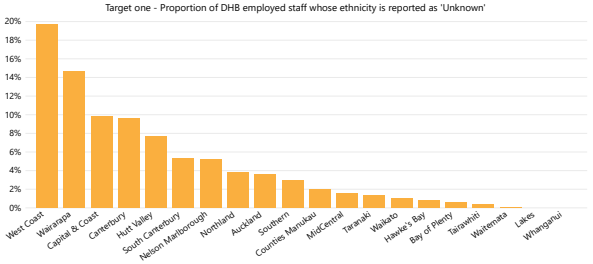
	To 2012-2016 combined		0	
1	Bay of Plenty	0.6		-0.9
2	Auckland	0.7		
3	*Canterbury*	*0.9*		*-0.2*
4	Northland	1		-0.29
5	Lakes	1.2		-0.91
6	Hutt Valley	1.4		0
7	Mid Central	1.5		0.03
8	Hawke's Bay	1.5		0.2
9	Taranaki	1.6		-0.36
10	Waikato	1.8		-0.01
11	Capital & Coast	1.9		0.05
12	Southern	2		-0.24
13	Counties Manukau	2.2		-0.23
14	Tairawhiti	2.4		-0.42
15	Whanganui	3		-0.07

Trendly Promoting High Performance in Health

Māori representation within DHB employed workforces as at 30 June 2020

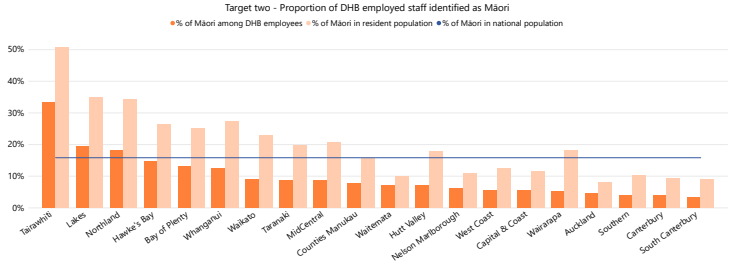
(Informing the Te Tumu Whakarae position statement and Workforce Strategy Group targets)

TAS
Kahui tuitui tangata

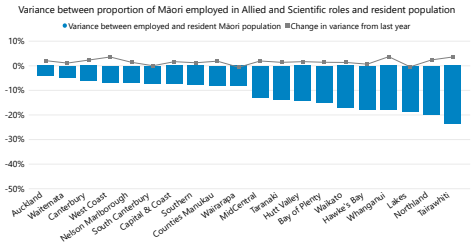


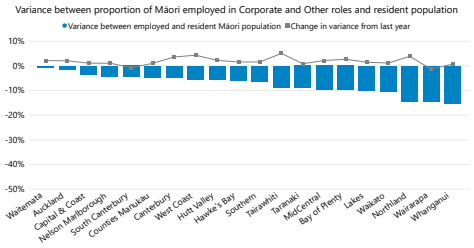
Compared to the March 2020 quarter, West Coast and Canterbury DHBs had the largest decrease in the proportion of employees reported with 'unknown' ethnicity, decreasing by 2.6 and 2.3 percentage points respectively. However, the 'unknowns' in Wairarapa increased by 2.8 percentage points from last quarter, and by more than 5 percentage points in the last year.

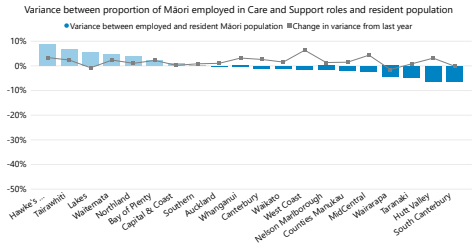
In terms of Māori representation in the workforce, all the DHBs have a lower proportion of people reported as Māori in their workforce than in their estimated resident populations. Compared to June 2019, West Coast had the largest increase in the proportion of their workforce who report as Māori, increasing by 2 percentage points. Four other DHBs had an increase of 1 percentage point or more in the proportion of Māori in their workforce: Tairāwhiti, Canterbury, Whanganui, and Northland (ordered from biggest to smallest change).

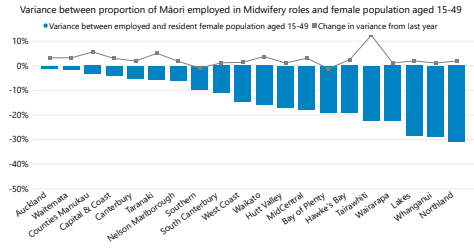


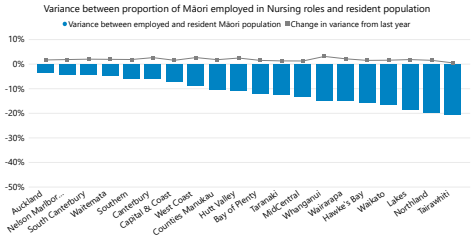
Target three - Differences between reported proportions of Māori within HWIP occupation groups and estimated proportions of Māori within resident population (including change from the same period 12 months ago)

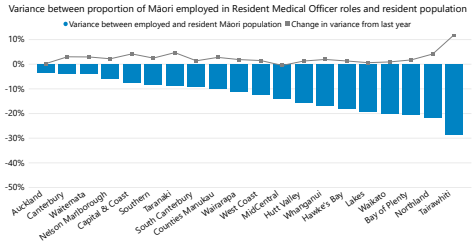


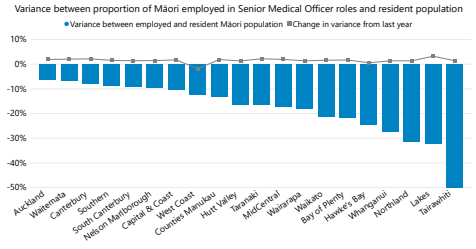












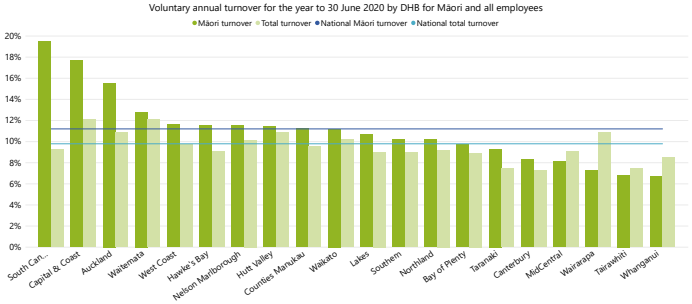
Across all occupation groups and DHBs, except Care and Support, the proportion of staff identified as Māori is lower than the estimated proportion of Māori within the resident populations.

The occupation groups with the largest Māori under-representation were Senior Medical Officers and Midwifery.

Tairāwhiti had some of the largest increases in Māori representation in the workforce between June 2019 and June 2020. In the Resident Medical Officer and Midwifery occupations groups, the gap between the proportion of Māori in the workforce and in the population reduced by about 10 percentage points.

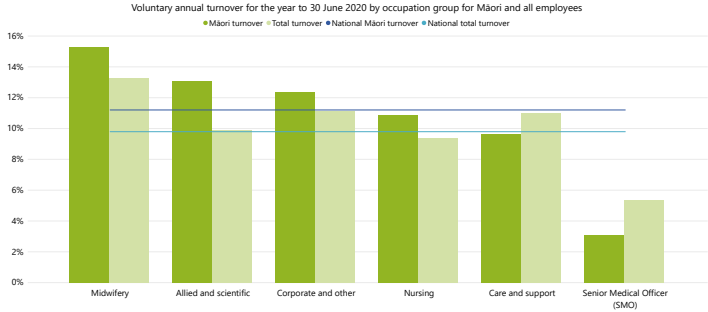
Overall, Auckland and Waitematā tended to have a smaller variance between the proportion of Māori in the workforce and their estimated resident population.

Target six - Comparison of annual voluntary turnover for Māori staff relative to all DHB employed staff



For most of the DHBs, voluntary annual turnover rates for Māori were higher than the rates for all employees. The biggest differences were in South Canterbury, Capital & Coast, and Auckland. Only four DHBs had Māori turnover rates lower than the total turnover.

When we look at turnover by occupation group the difference is smaller. However, four out of the six occupation groups had a higher turnover for Māori employees than for the total workforce.



Data extracted from the HWIP database on 2 September 2020. Data reflects people employed by the 20 DHBs as at 30 June 2020. Data excludes casuals, contractors, those on parental leave or on leave without pay. Resident population projections for DHBs have been supplied by Stats NZ. Voluntary turnover calculations exclude Resident Medical Officers (RMOs), people employed on a fixed term, as well as people who ceased employment due to restructure/redundancy, dismissal, death or for health reasons.

Pegasus Health Equity Strategy

Kia atawhai ki te tangata

2020 - 2030

Authors: Irihāpeti Mahuika, Melody Tuliau, Maria Pasene, Ester Vallero

Issued for Board Approval: September 2020

Pegasus™
partners in health
kia atawhai ki te tangata

1. Introduction

In Aotearoa and in Canterbury, Māori and Pasifika peoples disproportionately experience health inequities. People living with a disability, people with experience of mental health & addiction issues, people from low socio-economic backgrounds, culturally and linguistically diverse (CALD) people, and people who identify as lesbian bisexual gay transgender queer intersex (LGBTQI+), hereafter referred to as priority populations, also experience significant health inequities. To address these gaps, Pegasus Health has identified as a priority: "The reduction of disparities between the health of Māori and other identified groups within the population of Canterbury and the reduction of barriers to the timely access to appropriate health services".[1]

Our goal is to create an organisation that has equity in its veins to ensure we are able to provide highly effective and innovative services, operations, and collaboration across communities. Rangatiratanga (self-determination) must be at the heart of all we do, we must be fully informed and led by the very people we serve in our work. Our priority populations can be the solution to driving our work towards this strategy.

Pegasus Health has a commitment to ensure that we overtly, purposefully and strategically thread equity and Te Tiriti o Waitangi through all we do and how we operate. We will ensure equity is prioritised in our considerations, structures, decisions and processes so that we are able to improve the health outcomes of all of our people and communities in Canterbury.

2. Strategic Context

The Pegasus Health Equity Strategy will contribute to realising both our organisational and health system's strategies. There are some key strategic contexts this strategy aligns with:

2.1 Te Tiriti o Waitangi

Pegasus' strategic approach to equity is affirmed by the founding document of Aotearoa, New Zealand. Te Tiriti o Waitangi establishes Māori rights to health equity in particular through Article III (oritetanga). This ensures that Māori "have all the same rights and duties of citizenship as the people of England." What that means for us is that all people, including Māori, are entitled to equitable health outcomes.

Pegasus recognises that Māori rights are protected through Te Tiriti o Waitangi and it is the duty of the health sector as a whole to uphold these rights. We have an obligation to ensure that we are strategically planning for, measuring progress on and reporting about the following aspects of our work:

- Establishing and maintaining processes that enable Māori to participate in, and contribute to strategies for Māori health improvement.
- Fostering the development of Māori capacity for participating in the Primary Health sector and for providing for the needs of Māori in this context.
- Embedding the principles of He Korowai Oranga: New Zealand's Māori Health Strategy[2] as well as Whakamaua: Māori Health Action Plan 2020-2025.[3]

[1] Ministry of Health, 'Reducing inequalities in Health.' https://www.health.govt.nz/system/files/documents/publications/reducineqal.pdf

[2] Ministry of Health, "He korowai Oranga.' https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

[3] Whakamaua: Māori Health Action plan 2020-2025 (MOH) https://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025

It is through these lenses that we prioritise our Te Tiriti o Waitangi obligations in our Pegasus Health Equity Strategy. Ensuring that we are meeting our obligations under Te Tiriti o Waitangi must be prioritised. We will ensure that the following key messages from Te Tiriti o Waitangi are prioritised.

Article I

> The Ministry of Health, as the kaitiaki and steward of the health and disability system...

Article II

> ...has the responsibility to enable Māori to exercise authority over their health and wellbeing...

Article III

> ...and achieve equitable health outcomes for Māori...

Ritenga Māori Declaration

> ...in ways that enable Māori to live, thrive and flourish as Māori.

We will also connect our work to the following overview of He Mana tō Te Tiriti o Waitangi**4**, as outlined by the Whakamaua: the Māori Health Action Plan.

[4] Whakamaua: Māori Health Action plan 2020-2025 (MOH) https://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025

2.2 Equity in the health sector context

The Ministry of Health's definition of equity states that "in Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes". In addition to this, "Having a common understanding of equity is an essential foundation for coordinated and collaborative effort to achieve equity in health and wellness."[5]

There is considerable local and international evidence of significant inequities in health. These inequities are found within and for priority populations. In many countries, especially those with a colonial history, such as New Zealand, indigenous people have poorer health than non-indigenous people. The World Health Organization states that health is a fundamental human right. Therefore, we must be committed to reducing health inequities.[6] In addition, the New Zealand Health Strategy acknowledges the need to address health inequities as 'a major priority requiring ongoing commitment across the sector'.[7]

The Health Equity Assessment Tool (The HEAT tool)[8] promotes equity and offers us the opportunity to assess our systems, structures and ways of working against the key aspects of this tool. Pegasus will align their work with these national messages and utilise the HEAT tool to support the actualisation of this strategy.

2.3 Health sector strategy

Pegasus Health operates within the context of national direction for the health system outlined in the 'The New Zealand Health Strategy: Future Direction' and the strategic direction of the Canterbury Health System as led by the Canterbury Clinical Network (CCN), of which Pegasus is a founding member.

The Canterbury Health System's approach is patient-centred and whole of system to make health and social services integrated and sustainable; a focus on people; enabling clinically led service development and making the best use of our resources and capacity to achieve improved health outcomes for our population.

The strategic goals of the Canterbury Health System are:

1. People take greater responsibility for their own health. The development of services that support people / whānau to stay well and take greater responsibility for their own health and wellbeing.
2. People stay well in their own homes and communities. The development of primary care and community services to support people / whānau in a community based setting and provide a point of ongoing continuity, which for most people is general practice.
3. People receive timely and appropriate complex care. The freeing-up of hospital based specialist resources to be responsive to episodic events and the provision of complex care and support and specialist advice to primary care

[5] Ministry of Health, 'Achieving Equity'. https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity
[6] World Health Organisation, 'Equity'. https://www.who.int/healthsystems/topics/equity/en/
[7] Ministry of Health, 'New Zealand Health Strategy 2016'. https://www.health.govt.nz/publication/new-zealand-health-strategy-2016
[8] Ministry of Health, 'Health Equity Assessment Tool'. https://www.health.govt.nz/publication/health-equity-assessment-tool-users-guide

3. Pegasus' vision, mission and strategy and values

Pegasus Health is committed to improving the health outcomes for the people of Canterbury through innovation in service design and delivery, collaboration with partners and continuous improvement. Our vision is to support '**all** Cantabrians leading healthy lives', and our mission is to '**together** make Canterbury the best place to receive and provide Primary Health care'. Our values of **inclusive, connected, strive** and **integrity** underpinned by our guiding principle of Manaakitanga create the fabric of our ways of being as an organisation.

Our vision, mission, strategy and values drive everything we do. The whenu (strands) that are interwoven throughout our organisation will all have equity, with Te Tiriti o Waitangi and achieving equitable outcomes for all Cantabrians embedded throughout them.

In addition to this, the Pegasus Health Equity Strategy will support all of our charitable objectives. In particular:

- The reduction of disparities between the health of Māori and other identified groups within the population of Canterbury and the reduction of barriers to the timely access to appropriate health services;
- The greater participation of the population of Canterbury in health-related issues through proactive consultation and communication with Communities and in keeping with the spirit of the Treaty of Waitangi; and,
- The improvement of integration and liaison between healthcare providers and others in Canterbury to ensure that health care services are coordinated around the needs of the population of Canterbury.

4. Desired future state and outcomes

The Pegasus Health Equity Strategy will prioritise equity in every aspect of our work and will be embedded in the fabric of how we work. In order for the objectives of this strategy to be actualised, it is important that we grow and develop the capacity of our entire network. The specific work plan around this will include the growth, development and support of equity champions across the organisation. This concept grows leadership and sustainability of practice and expectations for how we do things in all areas of our organisation. We will work with teams and people leaders to identify and bring together equity champions from all of the aspects of our work.

In order to deliver this, the Strategy will deliver work in the following four priority outcome areas:

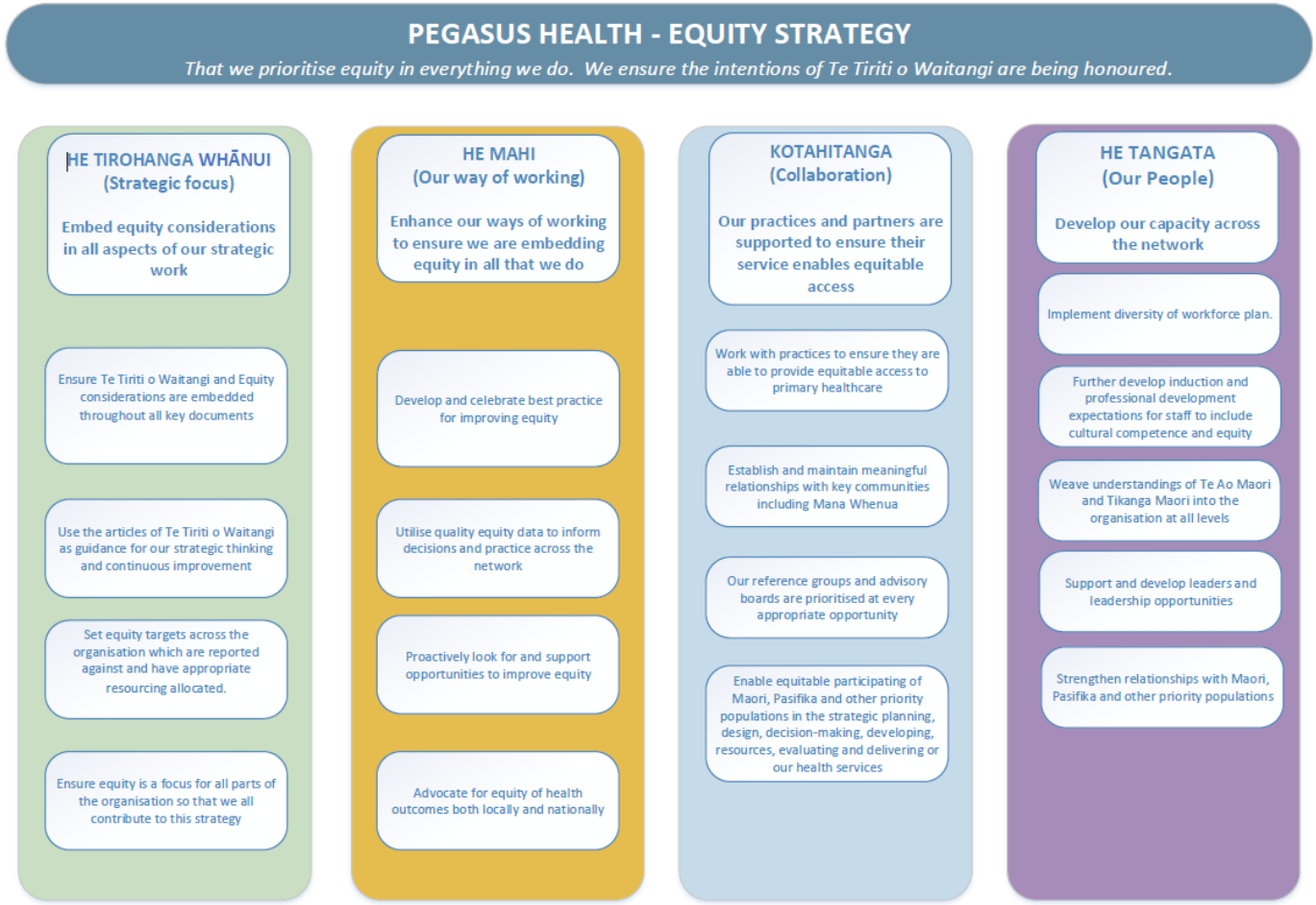
- **HE TIROHANGA WHĀNUI (Strategic focus)** embed equity considerations in all aspects of our strategic work.
- **HEI MAHI (Our way of working)** enhance our ways of working to ensure we are embedding equity in all that we do.
- **KOTAHITANGA (Collaboration)** our practices and partners are supported to ensure their service enables equitable access.
- **HE TANGATA (Our people)** develop our capacity across the network.

These outcomes are outlined in the framework for the Strategy (diagram below). Further operational detail with practical examples can be found in **Appendix A.** Details of potential advocacy channels/networks are detailed in **Appendix B** *(inclusive, but not an exhaustive list).*

As part of the operational implementation we will determine how best to measure these outcomes. These measures will be quantitative as well as qualitative, and will use The HEAT tool to guide this process.

Pegasus Equity Strategy

(High Level Outcomes and Anticipated Tactical Response)



5. Key linkages to other work

5.1 Pegasus 2025

Pegasus 2025 has been designed to bring together our challenges and opportunities in an integrated way that allows strategic thinking and resources to design change that delivers on our Vision and Mission. Pegasus 2025 is proposed to be made up of three strategic areas of focus:

People – understanding and connecting with our patients, populations and community.

Practices – strengthening our connection and growing our value proposition with our General Practices and primary care;

Potential – Unleashing the potential of our staff and the ways we work ensuring we are set up to better respond to the needs of the people of Canterbury, general practice and primary care teams.

An important consideration for Pegasus 2025 is how it effectively delivers change to operational areas. To support this critical fourth dimension a fourth strategic focus area is proposed:

Performance and Delivery - our systems and services.

This fourth focus area will adopt structures and processes that can receive and implement change resulting from the three Areas of Focus, improve delivery of our steady state work and respond to the business strategy needs of the organisation.

Equitable health outcomes are threaded throughout these different areas of work. There is an expectation that the different strategic work streams which contribute to Pegasus 2025 all have an equity focus.

5.2 System Level Measures

In the context of the wider Canterbury System Level Measures we have identified four focus areas where Pegasus and its general practice partners can positively contribute to the System Level Measures Improvement Plan, and from this, focus efforts to further improve health outcomes and equity of health outcomes.

The areas Pegasus has prioritised are:

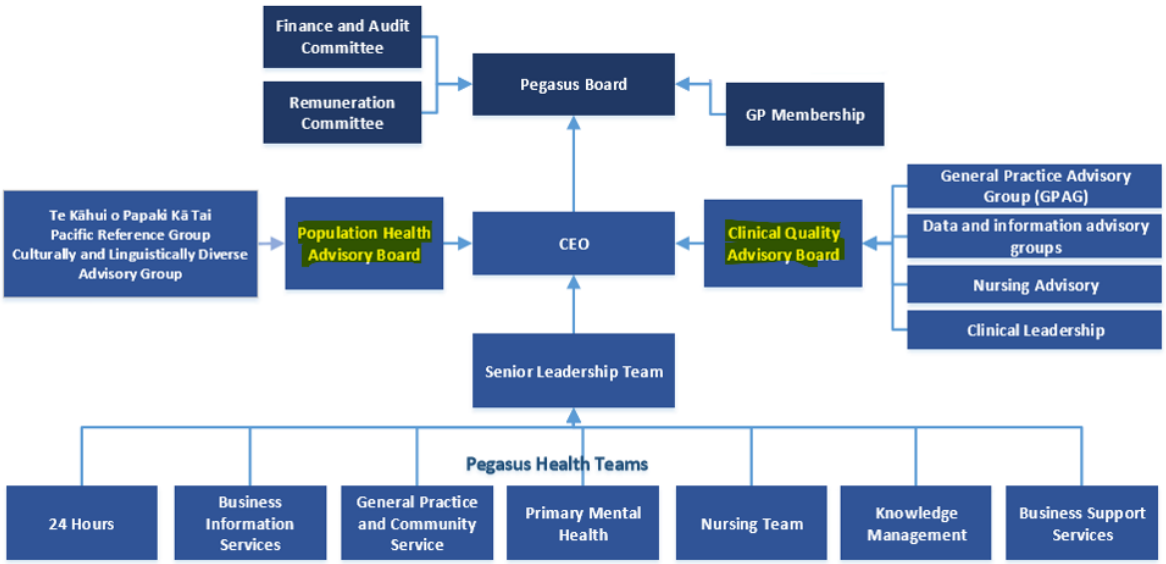
- **Cervical cancer prevention** (cervical screening and HPV immunisation): Cervical cancer is a preventable condition and could be virtually eliminated. Though there has been improvement in cervical screening rates, inequities persist. HPV immunisation remain low across the population
- **Equally well** (physical health outcomes for people experiencing serious mental illness & addiction (SMIA)): Physical health outcomes are poorer for people with SMIA compared with the general population.
- **Family violence**: family violence is prevalent in our community, primary care is in a unique position to identify and support people at risk of or experiencing family violence
- **Oral health**: though Pegasus and the GP network are not deliverers of oral health services, there is a role for promoting these services, particularly subsidised services to the enrolled population.

All of these priority areas will need a strong focus on equity to be able to make an impactful shift in the health outcomes of our people and communities. Specific equity outcome measures are required (will be developed) to monitor and assess progress in achieving equity in these four areas.

5.3 Reference Groups and Advisory Boards

Pegasus is privileged to be supported by some extremely talented, skilled and knowledgeable people through our Māori, Pasifika and Culturally and Linguistically Diverse reference groups. Te Kahui o Papaki ki Tai, the Pacific Reference Group and the CALD Health Advisory Group. The integration of the reference groups and the leadership opportunities they provide to this organisation are a vital component of the strategy.

In addition, the Clinical Quality and Population Health advisory boards offer more opportunity to thread equity throughout the fabric of how we work and what we do. Pegasus acknowledges these key opportunities to improve equitable outcomes across the Primary health network in Canterbury.



5.4 Foundation Standards

The Foundation Standard represents legal, professional and regulatory requirements that a general practice must meet as part of providing safe, effective and equitable care. The College has provided all New Zealand general practices with a consistent framework for showing their commitment to the safety of their patients and staff. Here are the Foundation Standards which specifically relate this this strategy:

"The practice has identified and understands the health needs of Māori. The practice collaborates with local Māori organisations, provider groups and whānau to deliver on these needs"

"The practice is knowledgeable about the diverse groups within its enrolled populations and plans and provides for their health care needs."

6. Governance structure

To support successful Strategy delivery it is essential that an appropriate level of governance is wrapped around the Strategy and its tactical and operational implementation. This will not only support clear, effective and timely decision-making but will also ensure an appropriate mechanism for change, resource allocation, risk and issue management and internal and external communication. An appropriate fit for purpose governance structure will also enable better awareness of internal and external dependencies.

The following outlines the current intended governance structure:

Governance Entity	
Strategy Governance	CEO and Senior Leadership Team (SLT)
SLT Sponsor	A nominated member of the Senior Leadership Team. This role is primarily concerned with ensuring that business outcomes (and therefore benefits) are delivered. The Sponsor also acts as the representative of the organisation and is an enabling role that can remove barriers. The SLT Sponsor will be the CEO supported by Director of Hauora Māori and Equity.
Advisory to CEO regarding the Plan (where applicable)	Clinical Quality Advisory Board (CQAB) Population Health Advisory Board (PHAB) Te Kahui o Papaki ki Tai (Māori health reference group: Canterbury Primary health wide) Pacific Reference Group (Canterbury Primary Health wide) Culturally and linguistically diverse advisory board (Canterbury Primary Health wide)
Operational Steering Group	Pegasus Health Managers Population Health specialists Clinical lead social work Representatives from each team across Pegasus
Chair of Operational Steering Group	To be decided by the steering group
Te Tiriti and Equity Group (CCN)	An opportunity to support and lead this work together

7. How will we operationalise our response?

The operationalisation of this strategy will be in alignment with the ways of working of Pegasus 2025. We will develop these 90-day cycles in consultation with our internal colleagues, ensuring that we review business areas and general practice capacity allowing us to collectively determine both internal and external priorities. This will align with an implementation plan which will have yearly, reviewable phases.

The implementation plan will be controlled and monitored through the Operational Steering Group. There should be consideration and allocation of appropriate resourcing in line with the PMO office and strategic work that is happening across the organisation.

8. Supporting documents and guidelines

In 2018, the Health Managers presented the paper 'Doing what is right, doing what is fair'. This outlined the need to strategically focus our attention on improving equity of access to primary healthcare through a deliberate and focussed shift across the organisation. This set the scene for this strategy, it is also supported by the messages and themes in some key documents and guidelines and are key parts of the New Zealand Health System. These can be found in **Appendix C.**

Appendix A: Practical examples of how we plan to deliver the Pegasus Equity Strategy

	Outcome	Goal	Description / Example(s)
PEGASUS HEALTH EQUITY STRATEGY *That we prioritise equity in everything we do. We ensure the intentions of Te Tiriti o Waitangi are being honoured.*	**TIROHANGA WHĀNUI (Strategic focus)** **Embed equity considerations in all aspects of our strategic work**	Ensure Te Tiriti o Waitangi and Equity considerations are embedded throughout all key documents	All key strategies, plans, reports and other key documents should ensure Te Tiriti o Waitangi and Equity are embedded into them.
		Use the articles of Te Tiriti o Waitangi as guidance for our strategic thinking and continuous improvement	Understanding is developed about how the articles of Te Tiriti o Waitangi can guide and underpin our strategic thinking. These can also inform our commitment and implementation of continuous improvement.
		Set equity targets across the organisation which are reported against and have appropriate resourcing allocated	Organisation wide Equity targets are set. People leaders are supported to set these targets within their teams and report progress of their teams towards our organisation equity targets. Appropriate resourcing is allocated.
		Ensure equity is a focus for all parts of the organisation so that we all contribute to this strategy	All of the different parts of the Pegasus organisation and network are able to articulate how they improve equity and contribute to this strategy.
	HEI MAHI (Our way of working) **Enhance our ways of working to ensure we are embedding equity in all that we do**	Develop and celebrate best practice for improving equity	Develop the capacity for everyone who works in the Pegasus network to improve their equitable practice. Celebrate and promote equitable practices through sharing these as best practice for equity. This will happen in all areas of our organisation.
		Utilise quality equity data to inform decisions and practice across the network	Consider our data with an equity lens. Use this to make decisions prioritising equity. Working with our knowledge management team to ensure that our data is able to be viewed with an equity lens.
		Proactively look for and support opportunities to improve equity	Support our people leaders to identify areas of development from an equity lens. Proactively look for opportunities to improve equity.
		Establish equity champions in the organisational structure of Pegasus	Working with teams to identify 'equity champions' who will come together and develop their skills and capacity to influence the people they work with. This will be a team which works across the organisation and interwoven into the existing organisation structure.
		Advocate for equity of health outcomes both locally and nationally	Advocacy opportunities are sought out and supported. These opportunities will include any opportunity to advocate for those who generally experience inequities in the health system. Advocacy opportunities exist at both a local and national level.
	KOTAHITANGA (Collaboration) **Our practices and partners are supported to ensure their service enables equitable access.**	Work with practices to ensure they are able to provide equitable access to primary healthcare	Planned, deliberate and collaborative opportunities to support practices in their journey of working towards equity. Foundation standard equity aspects are enhanced.
		Establish and maintain meaningful relationships with key communities including Mana Whenua.	Opportunities to further develop and nurture relationships between Pegasus and other key health professionals and communities who champion the work of ensuring equity. Kaupapa Māori organisations are known and relationships are supported.
		Our reference groups and advisory boards are prioritised in every appropriate opportunity	We work overtly and deliberately with our reference and advisory groups to whakamana their leadership and advice. These groups are supported and our organisation values their contribution to our mahi.
		Enable equitable participation of Māori, Pasifika and other priority populations in the strategic planning, design, decision making, developing, resourcing, evaluating and delivering of our health	Proactively seek opportunities to ensure participation of priority groups in all aspects of decision making and change. Celebrate these opportunities and use them as best practice.
	HE TANGATA (Our people) **Develop our capacity across the network**	Implement diversity of workforce plan	There is a detailed plan about developing a more diverse workforce at Pegasus health. The initial work sits with the recruitment processes and those who are involved in recruitment processes. In addition to this, proactively supporting any opportunity to
		Further develop induction and professional development expectations for staff to include cultural competence and equity.	Working with people leaders to ensure that all staff are developing their skills, knowledge and ways of working to improve equity and their commitment to Te Tiriti o Waitangi. Setting expectations of progress. Providing support and resources for staff
		Weave understandings of Te Ao Māori and Tikanga Māori into the organisation at all levels.	Every opportunity to sought and supported to weave Te Ao Māori and Tikanga Māori into our organisation. Examples include, Te Reo Māori, karakia, waiata learning opportunities, developing our cultural narrative and landscape and considering the
		Support and develop leaders and leadership opportunities.	Grow leadership capacity to be able to lead our people in their work to ensure it is equitable.
		Strengthen relationships with Māori, Pasifika and other priority populations	Ensure our relationships with Māori, Pasifika and other priority populations are prioritised, supported and mutually respectful.

Appendix B: List of potential support networks for equity advocacy

Network Name	Purpose and partnership
Manawhenua ki Waitaha	The Manawhenua Ki Waitaha Charitable Trust (MKWCT) board was established to ensure manawhenua have oversight and influence on the decision making of the Canterbury District Health Board (CDHB). • further development of relationships with Pegasus Health and Mana Whēnua • Enhancing and supporting the work Mana Whēnua ki Waitaha which align with Pegasus's work.
Te Kāhui o Papaki Kā Tai *Māori health reference group for Canterbury Primary Health*	Te Kāhui o Papaki Kā Tai is a Canterbury-wide Māori health reference group of primary care organisations, clinicians, community organisations, Manawhenua ki Waitaha (local iwi representation), Māori community providers and the Canterbury District Health Board including Community and Public Health, formed in 2009. • Opportunity to provide guidance and leadership from a Māori perspective in primary health. • Advice and guidance on policies and procedures that Māori Health.
Pacific Reference Group *Pacific health reference group for Canterbury Primary Health*	The Pacific Reference Group was formed in 2000 (known then as the Pacific Health Meeting), in recognition of the health inequalities of our Pasifika population. The Pacific Reference Group is a Canterbury-wide combined group of primary care organisations, clinicians, community organisations, Pasifika health providers, Government and District Health Board. • Opportunity to provide guidance and leadership from a Pacific perspective in primary health. • Advice and guidance on policies and procedures that affect Pacific Health.
CALD HEALTH Advisory Group *CALD health reference group for Canterbury Primary Health*	Culturally and linguistically diverse is a broad and inclusive umbrella term for communities with diverse language, ethnic background, nationality, dress, traditions, spiritual and religious beliefs and practices. The Culturally and Linguistically Diverse (CALD) Health Advisory Group is a Canterbury-wide health reference group, consisting of representatives of primary care organisations, clinicians, community members, and the Canterbury District Health Board. • Opportunity to provide guidance and leadership from a CALD perspective in primary health. • Advice and guidance on policies and procedures that affect the Health of those from the CALD communities.
Te Tiriti and equity Group. Canterbury Clinical Network Transforming Health Care. Whanau Ora ki Waitaha.	*CCN's reference group for Te Tiriti and Equity* A leadership group within the CCN network. The focus is on Te Tiriti o Waitangi and Equity in the work that CCN focuses on. • an opportunity to partner and follow leadership from across the Canterbury health sector. More information found here
MĀORI CAUCUS Rōpū taki Māori	The Māori Caucus brings together Māori members from across the Canterbury Clinical Network (CCN) to provide a coordinated focus on equitable health outcomes for Māori in Canterbury. • Partnering with Māori health sector leaders from across the network • An opportunity to seek advice and guidance from this leadership table.
Pacific Caucus	The Pacific Caucus brings together Pasifika members from across the Canterbury Clinical Network (CCN) to provide a coordinated focus on equitable health outcomes for Pasifika communities in Canterbury.

Maui Collective TE MATAU A MĀUI	The Maui Collective provides a platform to strengthen the capacity and influence of Māori and Pasifika providers who deliver services for the Canterbury DHB, and ensure Māori and Pasifika people in Canterbury have access to the best possible services. • Partnering with Māori and Pacific providers. • Seeking leadership and guidance about how we can work together
Maori Women's Welfare League TATAU TATAU	As the only National Maori Women's organisation, Te Ropu Wahine Maori Toko i te Ora (Maori Women's Welfare League Inc.) drive outcomes for wahine, whanau and tamariki. Our Constitution is our guiding document and our objects are the beacons which set the tasks for us to strive and achieve the well-being of wahine Maori and their whanau.
Te Hā – Waitaha STOP SMOKING CANTERBURY	Te Hā - Waitaha has a hub in Christchurch with Stop Smoking Practitioners based in Māori, Pasifika and rural community organisations across Canterbury. We run group clinics in various locations and also provide individual support. • An opportunity to learn about to focus on a different way of working (staff recruitment and development)
EDLG CHRISTCHURCH FOR EVERY BODY.	EDLG: Earthquake Disability Leadership Group: Christchurch has the opportunity to become one of the most accessible cities in the world and the Earthquake Disability Leadership Group was established to bring this vision to life. We are leading the way towards a universally accessible city that every person can enjoy.
Equally Well	Equally Well Primary care group. Equally Well is a group of people and organisations with the common goal of achieving physical health equity for people who experience mental health and addiction issues. People who access mental health and addiction services are at the centre of this work. • Considering equitable access to primary health care for those who experience mental health and addition issues.
Mana Tane Ora O Waitaha	Supporting Tane Maori in their aspirations to achieve well-being for themselves and their whanau in Canterbury. Tane Tu! Tane Kaha! Tane Ora! Tihei Mauriora! Mana Tane Ora O Waitaha are a group of men from all walks of life passionate about Maori mens health. Our aim is to connect with like minded organisations & whanau in the Canterbury region that support kaupapa enhancing the well-being of Tane Maori and their whanau.
cprg Canterbury Primary Response Group	Canterbury Primary Response Group (CPRG) has been in place for more than a decade to help ensure Canterbury primary care is ready for emergency and non-emergency events. They do this by working with the CDHB, Civil Defence, St John Ambulance, City Council and others throughout the year to network and plan.
better patient outcomes Canterbury Community Pharmacy Group	With an integrated, innovative approach, we are setting new standards for pharmacy care within our communities – working with our pharmacy members and patients directly to help reduce patient harm, improve patient outcomes and help people stay well and safe in their own homes and community.

Appendix C: List of key support resources and guidelines.

- Canterbury Māori Health Framework https://drive.google.com/file/d/1RFuwuOAlbvGRR7aLdsc0sH5wXQ-nEoFS/view?usp=sharing
- Canterbury Pacific Health Framework https://drive.google.com/file/d/1UpuVtQF1Tsfjiq-aM0sOnPgQXdus7gQE/view?usp=sharing
- Canterbury CALD responsiveness framework and workplan https://drive.google.com/file/d/1OLVl3OW_70b5Do1foxDn_mTdM0R41v2Z/view?usp=sharing
- Practice audit: Inclusive primary health care for gender diverse clients https://drive.google.com/file/d/1MR2g5kkle8ZYsWPhqQlf5DydK8u_QCvo/view?usp=sharing
- Health Equity Assessment (HEAT) Tool (MOH) https://www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf
- Achieving Equity in Health and Wellness: Equity Poster (MOH) https://www.health.govt.nz/system/files/documents/pages/hp7168-equity-poster-v5.pdf
- Achieving Equity (MOH) https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity
- Achieving Equity in Health Outcomes (MOH) https://www.health.govt.nz/system/files/documents/publications/achieving-equity-in-health-outcomes-important-paper-highlights-nov18_1.pdf
- Achieving Equity: Workplan 2019-2020 (MOH): https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity
- Achieving physical health equity for people with experience of mental health and addiction issues - evidence update. Equally Well. Te Pou. July 2020.
- Health Navigator: Equity https://www.healthnavigator.org.nz/clinicians/e/equity/
- HQSC: Quality improvement: No quality without equity?: https://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf
- IHI: How to increase the diversity of health care leadership Youtube https://www.youtube.com/watch?v=oQK5FcgnDLs
- International Journal for Equity in Health: Closing the health equity gap: evidence-based strategies for primary health care organizations: https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-11-59
- MCNZ: Best health outcomes for Māori: https://www.mcnz.org.nz/assets/MediaReleases/a4c0bf345a/2.-MCNZ-Achieving-Best-Health-Outcomes-for-Maori-a-Resource-consultation-May-2019.pdf
- MCNZ: Best health outcomes for Maori: Practice Implications: https://www.mcnz.org.nz/assets/standards/ed659af389/Best-health-outcomes-for-Maori-Practice-implications.pdf
- MCNZ: Best health outcomes for Pacific Peoples: practice implications: https://www.mcnz.org.nz/assets/standards/349b83865b/Best-health-outcomes-for-Pacific-Peoples.pdf
- MCNZ: He Ara Hauora Māori: A pathway to Māori health equity: https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga
- Medical Council of New Zealand He Ara Hauora Māori: A pathway to Māori Health Equity: https://www.mcnz.org.nz/assets/standards/6c2ece58e8/He-Ara-Hauora-Maori-A-Pathway-to-Maori-Health-Equity.pdf
- He Korowai Oranga: Māori Health Strategy: MOH:https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga
- NZ Nurses Organisation: Closing the Gap: How nurses can help achieve health access and equity: https://www.nzno.org.nz/LinkClick.aspx?fileticket=ZiCD_i0fsfY%3D&portalid=0
- 'Reducing inequalities in Health.' (MOH, 2002) https://www.health.govt.nz/system/files/documents/publications/reducineqal.pdf
- Royal New Zealand College of General Practitioners: Cornerstone: Equity Module:
    - Equity Module Guidance Transcript
    - Equity Module Guidance Webinar
- Sheridan, N.F., Kenealy, T.W., Connolly, M.J. *et al.* Health equity in the New Zealand health care system: a national survey. *Int J Equity Health* 10, 45 (2011). https://doi.org/10.1186/1475-9276-10-45
- Whakamaua: Māori Health Action plan 2020-2025 (MOH) https://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025

HAC – 1 OCTOBER 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **15 October 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 1 October 2020.

2. RECOMMENDATION

That the Board:

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

3. APPENDICES

Appendix 1: HAC Draft Minutes – 1 October 2020

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 1 October 2020, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Barry Bragg; Jan Edwards; James Gough; Naomi Marshall; Dr Rochelle Phipps; and Ingrid Taylor.

Via Zoom – Jo Kane.

APOLOGIES
An apology for absence was received and accepted from Sir John Hansen.

EXECUTIVE SUPPORT
Dr Peter Bramley (Acting Chief Executive); Becky Hickmott (Acting Executive Director of Nursing); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES
Dr Sue Nightingale (Chief Medical Officer); and Dr Rob Ojala (Executive Lead for Facilities) – absence.
Kirsten Beynon (General Manager, Laboratories) – lateness.

IN ATTENDANCE

Full Meeting
Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Dr Helen Skinner, General Manager, Older Persons Health & Rehabilitation
Dr Greg Hamilton, 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

Item 4
Lynne Johnson, Christchurch Campus Director of Nursing
Yvonne Williams, Hagley Operational Team Project Manager

Andrew Dickerson, Chair, HAC, opened the meeting. He acknowledged that Naomi Marshall has recently agreed to take on the role of HAC's Deputy Chair.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no 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 (13/20)
(Moved: James Gough/Seconded: Dr Rochelle Phipps – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 6 August 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. MIGRATION TO HAGLEY (PRESENTATION)

Pauline Clark, General Manager, Medical & Surgical; Women's & Children's Health, & Orthopaedics, introduced Lynne Johnson, Christchurch Campus Director of Nursing; and Yvonne Williams, Hagley Operational Team Project Manager, who presented on migration planning for the move to Hagley.

Ingrid Taylor joined the meeting at 9.07am.

The presentation highlighted:

- Facilities that Hagley will provide
- Detail of the migration planning
- Migration Governance structure
- Roles and responsibilities
- Overarching principles for migration
- Operational work underway
- Orientation and training
- Communication objectives with regards to the Hagley migration

There was a query around what work has been done, particularly in ED, to support staff to think differently regarding flow and removing duplicity. Ms Johnson advised there is an ED governance group looking at those issues.

A member queried from a risk matrix perspective what is likely to be problematic during the migration. What is the largest risk from an operational perspective and what steps are in place to mitigate the risk? The Committee was advised that everything has been planned around a worst-case scenario – all plans are geared towards that. It is also important to remember that we transport patients around the hospital every day in huge volumes. Reasonably confident with patient migration plans that we have planned to the nth degree. Ms Johnson noted a potential high risk is a patient having a medical event mid transfer – this has been planned for. The member queried whether there would be anything different done during the logistical phase. Ms Johnson advised there will be more staff on the day – to assist with transfers, check in points along the way, and at the destination area. In addition, it was also advised that for some areas (ED, AMAU, Children's Acute Admission Area) dual sites will be run for a period of time.

Ms Johnson noted another risk was if PCs did not work once shifted from one location to another. This is a critical thing, because we are dependent on electronic systems to function effectively. This ISG component is a high risk.

Ms Clark advised that at a General Manager level, highest risk is making sure other DHBs for whom we are the tertiary service, are aware and we are working together in that space. Also, that there is not another significant community event.

The Chair thanked Ms Johnson and Ms Williams for their attendance and wished them every success with the migration.

5. H&SS MONITORING REPORT

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

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

Older Persons Health & Rehabilitation Service – Dr Helen Skinner, General Manager
Highlighted ongoing work in the following areas:

- Older Persons Health Medication Management.
- Level of care assessments for rest home care.
- The bed loop replacement project.

A member noted concern that the Older Persons Health Medication Management work was as a result of an HDC complaint and had not been picked up internally. It was queried whether processes have been altered internally to try to detect these types of events prior to them happening. It was also queried whether this work was being spread around the hospital. Dr Skinner advised of doing continuous improvement on clinical governance and safety management. Previously have been reactive as opposed to going out and looking for things. Reporting has now changed to ensure that near misses are also reported. Much more proactive in trying to manage risk. There is whole process around what has been done and things have changed massively over the last three years. Dr Skinner confirmed that this does feed into the DHB as a whole.

Specialist Mental Health Services (*SMHS*) – Dr Greg Hamilton, General Manager
It was noted that previously the Committee had requested a deeper dive in the Child, Adolescent and Family Service (*CAF*), particularly around concerns of wait lists and the time that was taken for that particular group to be seen. Dr Hamilton noted a review of this was provided in the report, and further highlighted the following:

- We do not treat the list of people coming into our outpatient services as homogeneous. We have a very active triaging process and that triaging process puts into place supports along the way. Interestingly, only one third of people referred to our services get a therapeutic intervention from us. Have large numbers being referred not necessarily for a SMHS response. This is something we need to be dealing with in an intersectoral way, with our colleagues in Education and Oranga Tamariki. It is a collective problem. Need to be able to strengthen community response and work on this collectively. That will be an ongoing focus.
- Something that should give comfort is that when you look back at patient acuity, in terms of seriousness, the most serious cases are being seen quickly. If you are urgent, you will get a response from the team you are coming into either on the day or the next day, or are referred for an urgent response from our community teams.
- A 20% increase has been seen during Term 3 of the current school year. Teams have been working extra hours to provide the response to make sure we are not leaving people undifferentiated at the end of the day. Have had to put more resource into that, with more people and working some longer sessions. Dr Hamilton advised that Oranga Tamariki and NGO partners have agreed around a workshop with regards to managing this group who end up in crisis and distress.

Mr Dickerson noted that at its meeting on Tuesday, the Quality, Finance, Audit and Risk Committee (*QFARC*) considered the future of the CAF outpatient area with a recommendation to come through to the Board. Mr Dickerson was concerned that the paper was constructed around an engineering perspective and just because you can do something from an engineering perspective, is it desirable from a clinical perspective? Mr Dickerson hoped when the paper goes to the Board, the paper would include commentary as to the clinical desirability of the recommendation. Dr Hamilton advised that in terms of the clinical desirability, it is considered as a great option, putting teams into a purpose refitted facility. The role the Maia Health Foundation can play in this is absolutely fabulous, from turning this from a bricks and mortar response into a therapeutic space. Absolutely delighted with the direction.

There was a query around current presentation rates, this not being sustainable for staff and whether resourcing issues will be a barrier to service for this population. Dr Hamilton advised he believed the resourcing for this is an across entity issue. SMHS will probably never be the best solution for people with acute distress at any point in time, but we are relying on SMHS to pick that up because there is no-one else. It is a broader problem and if we address that then we will have a sustainable workforce.

In response to a query, Dr Hamilton advised initiatives are being developed for additional resources to come through which will assist in picking up mild and moderate distress and behavioural presentations. Work continues in this space.

A member noted it was useful to see in the report that telephone triaging is happening quite quickly. It would be useful to see what the waiting time is from referral to telephone triage, and seeing that high acuity are being seen within two days.

The member queried whether or not things are put in place for children who are waiting for months, or even a year for their first face to face. Have they been referred on? Do they have other points of contact? An assurance that children are not being lost in the system and that someone is monitoring/overseeing them.

The member spoke about the graph showing the "average waiting time from referral to first fact to face contact", and noted it would be useful to see this broken down into age groups, as previously there was disparity in the age groups, particularly the Under 12s. Dr Hamilton advised it is largely a same day response and if it is afterhours it then defaults to the Crisis Resolution Team.

A member noted that the Board is under pressure to reduce its deficit and there has been talk about services that are not fully funded. There are a couple of services here that CDHB funds over and above what would be targeted funding from the MoH. The member queried whether there was anything here at risk. Dr Hamilton advised that these are all services that contribute to our Operational Policy Framework responsibilities. Any options that you have in terms of how you could change them would have to be reconfigurations of what is provided currently.

There was a query whether the data being seen post lock down, was the same across the country or if it was also related to Christchurch's traumatic events. Dr Hamilton advised the MoH has been encouraged to answer this question around the country. Half way through a piece of work, but there are definitely some concerns about both young people and emergency presentations post lockdown.

There was a query around the definition of "phone triage" and why technology of Zoom or Teams is not being used. Dr Hamilton advised technology such as Zoom and Teams is used when doing some of the clinical work. Phone triage is done by phone. Phone triage is about

finding out what the situation is – talking to a number of people in quick succession. Have done over 100 referrals in a week. They are not a planned piece of work, they are reactive to what is coming through the door. Phone remains most appropriate for triage work.

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

- Clinical Director for Haematology, Dr Mark Smith, died unexpectedly last Wednesday. He will be greatly missed by all his colleagues.
- Have made an appointment for a Haematologist who will join CDHB reasonably quickly. This is not a replacement for Dr Smith, but for the retirement earlier in the year of Dr Ruth Spearing.
- In radiation oncology, are in the process of needing to do a replacement of one of the LINACs - T3.
- Medical Oncology continues to experience workforce challenges. In the process of recruiting for vacancies. Reasonably confident to have two medical oncologists joining CDHB by January 2021. At same time, working with remaining medical oncologists and with colleagues around NZ, relooking at our model of care, utilisation of other centres to help us, utilisation of nursing, and other opportunities to do a little more without overburdening our medical oncologists. At their request, we are undertaking additional, urgent clinics initially for a three week period while the impact is monitored on the medical oncologists and assisting staff. These will run from 12 October 2020.
- Had a series of meetings to ensure we are on track to bring back outplaced surgery. Migration period is for the two weeks starting 16 October 2020 and towards the end of the week we start to quietly bring back outplaced clients. All theatre lists will be slightly lighter than usual, just to allow everybody to settle into the new space and new ways of working.
- Everyone is focused on the migration, but are also very engaged in the Accelerating Our Future programme.
- Year to date production levels are ahead of where we said we would be. Also doing well on Faster Cancer Treatment times.
- Provision of annual leave being taken by people is statistically significantly more than it was for this time last year. In addition, have seen a reduction in the amount of sick leave being taken.

There was a query around Cancer Treatment targets, and whether in the next reporting period we will see a drop in the figures due to current workforce challenges. Ms Clark advised she did not believe so.

Mr Dickerson suggested it would be useful to have a presentation to a future HAC meeting or to the Board from the Medical Oncology team.

Hospital Laboratories – Kirsten Beynon, General Manager, Laboratories

- Had a weeklong visit from IANZ and peer reviewers for surveillance and peer review audits against a range of laboratory standards of which we hold accreditation for. This is significant in relation to resource commitment by our teams to prepare for and host the auditors. It is always an opportunity to show case the quality standards and assurance that the teams constantly work towards.
- The IANZ audit coincided with a major Laboratory System upgrade across our Lab net group that includes four DHB laboratories. It was a significant ask of teams to undertake the upgrade whilst testing is at high weekday volumes. This upgrade was essential to complete prior to the migration of Christchurch Hospital services into the new Hagley. A massive effort and long hours have been put in by ISG, LIS and laboratory teams in partnership with the vendor. The focus is now on optimising performance post upgrade and staff adjustments to the new system. Staff have fed back

that some of the improved functionality made available through the upgrade will make a big difference to processes.

- Acknowledged the passing of Dr Mark Smith. His contribution to Clinical and Laboratory Haematology within Canterbury and beyond has been significant and his passing is a great loss to NZ. We will continue to provide support in coming months to his clinical, nursing and laboratory colleagues as this will have a long lasting impact.
- Pleased to be working with our Maori and Pacifika colleagues Hector Matthews, Finau Heuifanga Leveni and Kiki Maoate, as well as primary and secondary care representatives re: labs equity dashboards - analysis of laboratory data and information to make visible equity gaps within our health system. This information shows lower uptake for Maori and Pacifika for testing and for the selected test groups we reviewed higher test abnormality rates for certain conditions. We look forward to working with our colleagues to fully review the lab data. Through this we hope to help identify specific initiatives/pilot projects that can help address the access issues identified and in turn improve outcomes for these ethnic groups.

Rural Health Services – Win McDonald, Transition Programme Manager

- Continuing to see an increase in end of life care across rural facilities. A few years ago it was one every three months, last year was averaging one every fortnight, and as at today have six people sitting across four facilities, with another eight sitting in the community. Finding that we have a change in the use of the community hospitals. People are being very well cared for in the primary sector – district nurses through Nurse Maude are doing a fantastic job with palliative care – usually find within the last three, two and one week of life, that is when stress comes onto the family and the individual becomes an inpatient. This is a heads up of what is coming our way. Still very early in meeting our large numbers of those aged over 85 coming through, so need to be thinking quite strategically about what we are going to do with this volume of people coming. We are getting referrals directly from Nurse Maude for us to pick up palliative care patients because they are already full and they cannot cope with the volumes. In remote rural it makes more sense to keep people as close to their homes as possible.
- In term of changes in service provision, have been working with general practice practitioners and have introduced Medimap in Oxford and Waikari Hospitals and are about to commence that into Ellesmere Hospital and one chart into Darfield. This will allow remote prescribing to happen from a GP in his/her home, for example, through a telephone consultation, which then takes it through to Pharmacy and then to Administration. Taking pressure off primary sector practitioners.
- On Chatham Islands, have seen significantly increased levels of anxiety in children as a result of COVID. The Chathams has been particularly hard hit by COVID, losing about 90% of its income since about January 2020. Been doing work with Oranga Tamariki to put in additional resourcing.
- Work is underway on a Darfield paper. There was a TAS audit nearly nine months ago which recommended we reduce or takeaway maternity services at Darfield Hospital. Have two beds there used for post-natal care. In the last 18 months we have not had any post-natal care patients. This has resulted from the midwives living in that area, now no longer living there, so they are no longer referring them through. CDHB cannot provide that level of midwifery care and service, so from a risk perspective it makes perfectly good sense to take those beds away and they will be put back into ARC and palliative care where there is huge demand.

There was a query whether a change in funding around end of life care was impacting the increase in end of life care across rural facilities. Ms McDonald advised no, it was to do with the share volume. She also noted that across all of rural there is a reducing workforce, an aging workforce, a different type of workforce in the younger workforce, which is putting more pressure again on people in their homes and caring for their elderly.

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

- Attended the rural hospital network meeting last week, a national forum where all rural hospitals are brought together. One of the core concerns nationally is afterhours care. Interesting to see mixed models. Need to keep an eye on and start looking at how we maintain a sustainable community model that ensures there is no reduction in equity of access, particularly for our high needs community.
- Acute demand cannot be looked at in isolation from community resilience. There is a lot of work happening in that space. Pleased to report that primary care workers and navigators are working well in Ashburton.
- Blessed with a philanthropic community. A recent community and social recovery research report was funded through Advance Ashburton. Has identified some core themes that are not uncommon to population health needs.
- Interested in what future opportunities there are around the Tier 2 modelling from the Heather Simpson report around integrated communities of care/integrated services. Clinical governance needs to be embedded and partnered into both the primary care clinical governance and PHO clinical governance. It cannot be looked at in isolation with a hospital lens only. Many of our services in the hospital are outreach services into the community.

The Committee noted the Hospital Advisory Committee Activity Report.

6. CLINICAL ADVISOR UPDATE – ALLIED HEALTH

Dr Jacqui Lunday Johnstone, Executive Director, Allied Health, Scientific & Technical, provided members with a copy of the CDHB/WCDHB Allied Health 2020–2025 Strategic Plan and suggested that given time constraints, it would be appropriate to provide a presentation to the next meeting on this document and other dimensions.

Dr Lunday Johnstone noted this is a group of professions which are probably less visible than our medical and nursing colleagues, and who have significant value to play across the system. Looking to build a more coherent vision about how to build some of the building blocks to support this workforce development and to mobilise their skills, capacity, capability and talent and service of system. Is about having more coherence and also how we support, in particular WCDHB, to avoid unnecessary variation and differences, but also to recognise where there are opportunities to involve the non-medical leadership, and also that inter professional approach that builds around the person at the centre. This is an exciting piece of work for Allied Health and also allows us to then develop an improvement and implementation plan that supports some of current strategic priorities.

A presentation will be scheduled for HAC's 3 December 2020 meeting.

A member queried the "Living Within Our Means" section of the H&SS Monitoring Report, noting HAC should be providing support to QFARC in this area. The member noted there is not a lot of narrative in this section of the report and requested that Mr Dickerson look at the best way for HAC to track some of the relevant pieces of work. Mr Dickerson undertook to discuss with Barry Bragg (QFARC Chair), and David Green (Acting Executive Director, Finance & Corporate Services).

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (14/20)
(Moved: Andrew Dickerson/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 6 August 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."

INFORMATION ITEMS

- 2021 Meeting Schedule
- 2020 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.40am.

Approved and adopted as a true and correct record:

Andrew Dickerson
Chairperson

Date of approval

HAC MEETING 1 OCTOBER 2020 – MEETING ACTION NOTES

Item No	Item	Action Points	Staff
	Apologies	Sir John Hansen – absence	Anna Craw
1.	Interest Register	Nil	
2.	Minutes – 6 August 2020	Adopted: James Gough / Dr Rochelle Phipps	Anna Craw
3.	Carried Forward Items	Nil	
4.	Migration to Hagley (Presentation)	Nil	
5.	H&SS Monitoring Report	• Provide commentary in Hillmorton Laundry / CAF Relocation paper around clinical desirability of the recommendations. **Board report - due to Anna Craw - Tuesday, 6 October 2020** • CAF – provide data on waiting time from referral to telephone triage, and data on high acuity being seen within two days. **Provide to 3 December 2020 HAC meeting.** • CAF – provide information on what is put in place for children who are waiting for months, or even a year for their first face to face. Have they been referred on? Do they have other points of contact? Provide an assurance that children are not being lost in the system and that someone is monitoring/overseeing them. **Provide to 3 December 2020 HAC meeting.**	Dr Greg Hamilton Dr Greg Hamilton Dr Greg Hamilton Dr Greg Hamilton

HAC MEETING 1 OCTOBER 2020 – MEETING ACTION NOTES

		• CAF - Graph showing "average waiting time from referral to first face to face contact" – provide this broken down into age groups. Wanting to ascertain if there is disparity in the age groups, particularly the Under 12s. **Provide to 3 December 2020 HAC meeting.** • Presentation to future HAC or Board meeting from Medical Oncology Team.	Pauline Clark / Anna Craw
6.	Clinical Advisor Update – Allied Health	Presentation to HAC's 3 December 2020 meeting on the Allied Health 2020-25 Strategic Plan. **Presentation material due to Anna Craw – 23 November 2020**	Dr Jacqui Lunday Johnstone
7.	Resolution PX	Adopted: Andrew Dickerson / Jan Edwards	Anna Craw
	General	"Living Within Our Means" section of the H&SS Monitoring report. Discussions to be held on developing this section of report.	Andrew Dickerson / David Green
	Info Items	Nil	

Distribution List:
Dr Greg Hamilton
Dr Jacqui Lunday Johnstone
Pauline Clark

CC: Sharryn Sunbeam; Jayne Stephenson; and Maree Millar

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **David Green, Acting Executive Director, Finance & Corporate Support**

DATE: **15 October 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, & 13 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 public excluded meetings – 17 September 2020	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (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.	Individual Employment Agreement Remuneration Strategy 2020/21	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)
5.	Hillmorton Programme Business Case – Reframing for Capital Investment Committee	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

6.	Repurposing & Strengthening of Hillmorton Laundry Building	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Parkside A&B – Passive Fire Protection Compliance Remediation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	New Zealand Health Innovation Hub – Progress Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Via Innovations	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Draft Annual Report 2019/20 Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	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)
12.	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)
13.	Advice to Board: • HAC Draft Minutes *01 October 2020* • QFARC Draft Minutes *29 September 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.