AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 20 May 2021 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 15 April 2021		
3.	Carried Forward / Action List Items		
Overview			
4.	Chair's Update (Oral)	Sir John Hansen *Chair*	9.35-9.40am
5.	Chief Executive's Update	Dr Peter Bramley *Chief Executive*	9.40-10.10am
Reports for Decision			
6.	Transalpine Health Disability Action Plan 2020-2030	Dr Jacqui Lunday-Johnstone *Executive Director, Allied Health, Scientific & Technical*	10.10-10.20am
7.	CDHB Submission: Mental Health (Compulsory Assessment and Treatment) Amendment Bill	Dr Peter Bramley	10.20-10.25am
Reports for Noting			
8.	Finance Report	David Green *Acting Executive Director, Finance & Corporate Services*	10.25-10.35am
9.	Māori & Pacific Health Progress Report	Janice Donaldson *Portfolio Manager, Māori Health, Planning & Funding*	10.35-10.45am
10.	Advice to Board: • CPH&DSAC – 6 May 2021 – Draft Minutes	Aaron Keown *Chair, CPH&DSAC*	10.45-10.50am
11.	Resolution to Exclude the Public		10.50am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.50am**

NEXT MEETING
Thursday, 17 June 2021 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
Fiona Pimm
Ingrid Taylor

Executive Support

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

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

BOARD ATTENDANCE SCHEDULE – 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

√ 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 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. **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**	**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 Kura Taka Pini Limited** – General Manager **The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs. **Upoko Rawiri Te Maire Tau of Ngai Tuahuriri** - Husband
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. **CMUA Project Delivery Limited** - Director 100% owned by the Christchurch City Council and is responsible for the delivery of the Canterbury Multi-Use Arena project within agreed parameters.

	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. **Medical Kiwi Limited** – Independent Director Research and distribution company of medicinal cannabis and other health related products. In process of listing on NZX. **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 **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	**College of Nurses Aotearoa NZ** – Member **Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Fiona Pimm	**Careerforce Industry Training Organisation** – Chair Provides training to kaiawhina workforce in health and disability sector, social services sector and building contractors sector (cleaners). **Fiona Pimm Whānau Trustee Company Limited** – Director Private family trust. **Kia Tika Limited** – Director & Employee **NZ Blood and Organ Donation Services** – Board Member Statutory organisation responsible for national supply of all blood products and management of organ donation services. **NZ Council for Education Research** – Chair Statutory organisation responsible for independent research in the education sector. **NZ Parole Board** – Board Member Statutory organisation responsible for determining prisoners' readiness for release on Parole. **Restorative Elective Surgical Services** – Chair Joint venture project piloting ACC funded Escalated Care Pathways with a collective of clinicians and private hospitals. **Te Runanga o Arowhenua Incorporated Society** – Deputy Chair Governance entity for Arowhenua affiliated whānau. **Te Runanga o Ngāi Tahu** – Director Governance entity of Ngāi Tahu iwi. **Whai Rawa Fund Limited** – Chair Ngāi Tahu investment and savings scheme for tribal members.
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, 15 April 2021 commencing at 9.30am

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

CROWN MONITOR
Dr Lester Levy.

BOARD CLINICAL ADVISOR
Dr Andrew Brant (via zoom).

APOLOGIES
Apologies for absence were received and accepted from Catherine Chu; and Andrew Dickerson.

EXECUTIVE SUPPORT
Dr Peter Bramley (Chief Executive); Savita Devi (Acting Chief Digital Officer); David Green (Acting Executive Director, Finance & Corporate Services); Becky Hickmott (Executive Director of Nursing); Mary Johnston (Chief People Officer); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Hector Matthews (Executive Director, Maori & Pacific Health); Dr Rob Ojala (Executive Lead Facilities); Karalyn van Deursen (Executive Director Communications); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

EXECUTIVE APOLOGIES
An apology for absence was received from Dr Richard French (Acting Chief Medical Officer).

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETINGS

Resolution (07/21)
(Moved: Aaron Keown/seconded: Naomi Marshall – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 18 March 2021 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

The carried forward item was noted. It was noted that a meeting with Ngai Tahu leadership is being arranged with a view to resetting a strong partnership relationship with our Iwi partners.

4. CHAIR'S UPDATE

Sir John Hansen, Chair, advised that his most pressing item is the vaccination programme. He commented that quite understandably the government's priority for the rest of the year and part of next year is this.

Sir John added that we are expected to undertake 35,000 shots per week in Canterbury at the peak and the target across New Zealand will be 50,000. He commented that we have made a very good start around this and we will have to consider the necessity from time to time of taking our foot off the accelerator on some of our other priorities.

The update was noted.

5. CHIEF EXECUTIVE'S UPDATE

Dr Peter Bramley, Chief Executive, provided an update around the COVID response. He commented that there are a number of strands to the programme to ensure that we keep our community safe. Testing at our Boarders continues and we are preparing for quarantine free travel. He advised that he had met with the Chief Executive of Christchurch Airport and they are happy with the partnership with health and what we are doing together to ensure the safe arrival of people with the airport being set up into "Red" and "Green" zones.

Dr Bramley advised that the managed isolation facilities are still stood up. Numbers have reduced slightly as people have cancelled out of managed isolation given the Trans-Tasman bubble.

He advised that he has visited the coordination centre for managed isolation, which is a great illustration of cross-agency teams managing huge complexities. They have just clicked over one year in operation, with about 30,000 people being provided with both safe care and support as they come into the country. We owe these people a great vote of thanks for the work they have been doing and continue to do.

He advised that he had also met with the team at Chateau on the Park and had the COVID swab. These people are exceptional in their commitment to infection prevention and control, and we need to look after them as there is a certain amount of stigma associated with working in a managed isolation facility.

Dr Bramley commented that vaccination is the number one game in town and he thanked the teams that did an amazing job over the weekend, ensuring that there was no vaccine wastage.

He advised that he has stood up the Emergency Coordination Centre, primarily to ensure that we are giving this the right resource, focus and discipline. He added that the two people coordinating this are Kim Sinclair-Morris and Becky Hickmott, with Dr Ramon Pink providing clinical leadership. We are also ensuring we have the equity agenda right.

The Board noted that there are cemented plans with the Ministry of Health through to June and have committed to 92,000 doses to be delivered by the end of June. He added that we have robust plans to get there. This is whole of system response, utilising our Primary Care partners including GP and pharmacy settings, with lots of different locations where we can maximise the opportunity to deliver the vaccine.

He added that the other very present challenge is the national booking system and the CDHB will be trialling this.

He commented that this is the most important thing on our agenda, but not the only thing as we are also delivering many other important services and safe care to our community.

Dr Bramley took his report as read. He advised that Tracey Maisey has been appointed as the Executive Director, Planning Funding & Decision Support. He thanked Ralph La Salle for acting in this role over the last months. Ms Maisey, who has previously held the role of Chief Executive at Wairarapa DHB and has huge experience in the health system, will commence with us from 7 June.

He advised that he had the privilege, along with the Ministry of Health, of attending the launch the bowel screening programme for Canterbury, which for many people will improve health outcomes and will literally save lives. Already we have had 18,000+ kits go out and 400 positive tests have been further investigated. Of those that have been followed up, 20 cancers have been identified.

Dr Bramley advised that there is going to be an announcement by the Ministry of Health next Wednesday regarding the Health & Disability System Review.

Discussion took place in regard to the cumulative vaccinations table in the report. A request was made for future reports to provide a per capita breakdown.

Lester Levy departed the meeting at 9.55am.

A query was made as to whether travellers are being vaccinated before they leave the country. It was noted that they can make an application to the Ministry of Health for a special vaccination.

It was noted that everyone entering New Zealand has to have a swab and they are also required to wear masks while travelling.

Discussion took place regarding the high occupancy levels in NICU. It was noted that there are ongoing national issues around this. It was noted that a possible transitional facility is being considered as part of this solution.

Discussion also took place regarding Waipapa flows and a report will go to the 3 June HAC meeting around this.

The Chief Executive's update was noted.

6. FINANCE REPORT

David Green, Acting Executive Director, Finance & Corporate Services, presented the Finance Report for the month of February, which he advised had been discussed in detail at the last QFARC meeting. He advised that the consolidated financial result for February, excluding the impact of Covid-19, Holidays Act compliance, and loss on sale of the carpark, was favourable to plan by $106k with the year to date result being $2.458m favourable to plan.

A query was made regarding the $10m attributed to next month under external provider. It was noted that this is the amount of outsourced surgery which needs to take place before the end of June. The Chief Executive highlighted that the "outplaced" surgery has come back "in-house", however, the "outsourced" is still taking place. It was noted that the catch-up programme is included in this.

Resolution (08/21)
(Moved: Sir John Hansen/seconded: Barry Bragg – carried)

"That the Board:

i. notes the consolidated financial result for February **excluding** the impact of Covid-19, Holidays Act compliance, and loss on sale of the carpark is favourable to plan by $106k (YTD $2.458M favourable);
ii. notes that the YTD impact of Covid-19 is an additional $1.143M net cost;
iii. notes that the YTD impact of the Holidays Act compliance is an additional $11.801M expense, and the full year impact is estimated to be $18.470M; and
iv. notes the loss on sale of the carpark is $4.235M."

7. ADVICE TO THE BOARD

Hospital Advisory Committee (*HAC*)
Naomi Marshall, Deputy Chair, HAC, provided an update to the Board on the Committee meeting held on 1 April 2021. She advised that presentations were received around Mental Health, as well as Allied Health.

The draft minutes were noted.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (09/21)
(Moved: Gabrielle Huria/seconded: Ingrid Taylor - carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, & 10 and the information items contained in the report;
ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of public excluded meetings – 18 March 2021	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.	Insurance Renewal Strategy 2021/22	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Radiology Xray Machine Replacements	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

6.	Burwood Spinal Hostel/ Transitional Rehabilitation Facility Strengthening	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Holidays Act Remediation Approach	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	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)
9.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
10.	Advice to Board • QFARC Draft Minutes *30 March 2021*	For the reasons set out in the previous Committee agendas.	

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

The Public meeting concluded at 10.05am

_____ _____

Sir John Hansen, Chair Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 20 MAY 2021

DATE	ISSUE	REFERRED TO	STATUS
15 Oct 20	Review of CDHB/Manawhenua MOU	Dr Peter Bramley	Under action.
15 Apr 20	Holidays Act Remediation – confirmation of national payment approach.	Mary Johnston	Today's Agenda – Item 7PX

CHAIR'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

DATE: **20 May 2021**

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 performance from the Chief Executive to the Board of the Canterbury DHB. Content is provided by Operational General Managers, Programme Leads, and the Executive Management Team.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

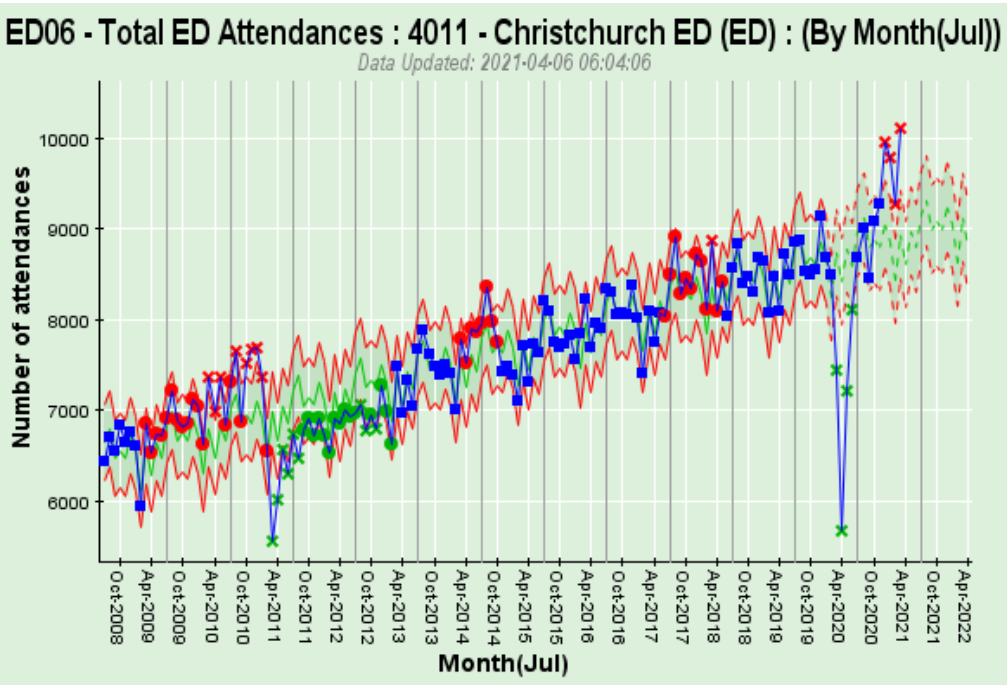
3. DISCUSSION

MEDICAL / SURGICAL SERVICES

Service Delivery/Performance

The **Emergency Department** is the front door of the Hospital System in Christchurch for most acute patients.

- The uplift in Emergency Department presentations that began in October 2020 continues with more than 10,100 presentations in March 2021 – the first time this count has been greater than 10,000. The most significant uplift has been in triage 4 and 5 presentations.



- The number of people being admitted to hospital from the Emergency Department has grown slightly, however does not come close to matching the increase in presentations to the Emergency department, indicating that most of the growth is being managed within the confines of the department.

Measure	Number Jan-20 to Mar-20	Number Jan-21 to Mar-21	Change (%)
Emergency Department Presentations	24,611	29,161	18%
Triage 1 and 2 presentations	2,752	3,786	38%
Triage 3 presentations	13,082	14,388	10%
Triage 4 and 5 presentations	8,777	10,987	25%
Admissions from ED	8,507	9,159	8%
Proportion of ED presentations admitted	35%	31%	
Proportion in ED >6 hr	92.1	85.3	

- Unfortunately this has been associated with a reduction in the proportion of patients leaving the ED within six hours of arrival.

Outpatient Attendances

- Focussing solely on the March 2021 results – there were more than 38,800 outpatient events, 3,300 more than in March 2020 – this number will grow further as records are processed. Looking at New Patient appointments alone, there were 8,172 events in March 2021, 1,316 more than in March 2020 – a 19% uplift.
- At the end of March CDHB is exceeding target for minor procedures in hospital settings having delivered 1,782 as inpatients (319 ahead of target) and 8,763 as outpatients (1,207 ahead of target).

Planned Care.

- At the end of March CDHB was 220 planned surgical discharges behind the phased target, having provided 14,016 against a target of 14,145 after having been 10 behind target at the end of February.

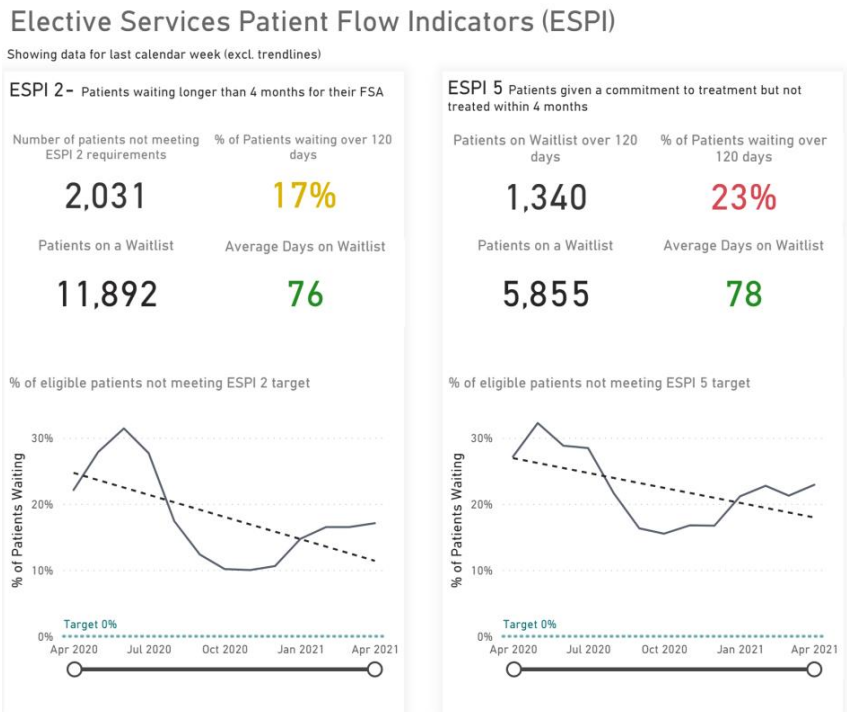
Use of Theatre Capacity

Measure	Number Jan-20 to Mar-20	Number Jan-21 to Mar-21	Change (%)
Theatre - Christchurch campus planned (arranged/ elective)	3,095	3,786	22%
Theatre - Burwood planned (arranged/elective)	693	712	3%
In house planned (i.e Christchurch and Burwood, arranged and elective)	3,788	4,498	19%
Theatre Outsourced/Outplaced planned (arranged/ elective)	1,127	465	-59%
Subtotal planned	4,915	4,963	1%
Theatre - Christchurch campus acute	2,096	2,354	12%
Theatre - Burwood acute	3	4	33%
Subtotal acute	2,099	2,358	12%
Total in house theatre events	5,887	6,856	16%
Total Theatre events	**7,014**	**7,321**	4%

- Outplaced operating ceased from 7 December (except for Dental which continued until 25 February) and outsourced operating has reduced.

The CDHB Improvement Action Plan 2020/21

- Provides a weekly target for the number of patients waiting longer than 120 days. For **First Specialist Assessment** there are 2,031 people waiting longer than 120 days against an overall target of 756. This is an increase from 1,968 at the end of February. Services are aware of and committed to meeting the plan's ultimate target and there are a multitude of actions now occurring.
- A similar pattern applies to ESPI 5 – which relates to waiting time for surgery or other treatment.



NICU Occupancy

Measure	Number Jan-20 to Mar-20	Number Jan-21 to Mar-21
NICU 10am occupancy >44	27	79
NICU 10am occupancy >50	5	36

- There has been high occupancy and acuity within all areas including intensive care, requiring high dependency babies to be cared for in the special care area.
- Women's and Children's leadership is assessing the care of this group of patients and the risks and any safety concerns.

Examples of Innovation and Improvement

- Ophthalmology is focusing on reviewing its models of care to see which areas virtual appointments may be appropriate.
- Improved utilisation of endoscopy lists through introduction of nurse-led telephone pre-assessment for all colonoscopy procedures.
- The Resident Medical Officer electronic leave form is now ready for trial. This is a significant milestone.
- Patients with **Hereditary Angioedema**, a rare genetic disease, have been taught to self-administer subcutaneous medicines in order to manage attacks, which when they involve laryngeal swelling may lead to fatal asphyxiation. For some patients this is not sufficient and intravenous administration of a blood product is required. These patients are being offered training so that they can cannulate and administer this treatment to themselves at home.
- **Tocilizumab Infusions**. Since 2019 select patients having intravenous immunoglobulins (9 patients) and rheumatology patients having Infliximab (29 patients) have been referred to the Community Infusion Service from Medical Day Unit for ongoing infusions. The feedback from patients has been overwhelmingly positive.

Patient Safety - Hand Hygiene

In the period November 2019 to February 2021 the Hand Hygiene audit staff have observed (audited) 119,000 times in Christchurch Hospital when the 5 moments of hand hygiene should have occurred.

- Improvements have been observed in all moments over this time except for moment 5 which remains at below the national target of 80%.

Compliance Rate as a percentage of times staff have been observed to complete hand hygiene correctly – total moments observed 119,000				
	Feb 2020	June 2020	Oct 2020	Feb 2021
Overall %	79%	84%	84%	83%
Before Touching a Patient	77%	85.7%	81.8%	82.5%
Before a Procedure	83.2%	89.8%	89.3%	87.8%
After a Procedure or Body Fluid Exposure Risk	83.1%	84.1%	87.8%	87.5%
After Touching a Patient	81.5%	88.1%	86.5%	87.2%
After Touching a Patient's Surroundings	72.2%	72.2%	76.7%	72%

Allied Health

- Project Search is a programme for people with disabilities to have an internship with CDHB in the Child Development Service. This is due to start on 3 May with mentoring commenced.

SPECIALIST MENTAL HEALTH SERVICES (SMHS)

Service Delivery/Performance

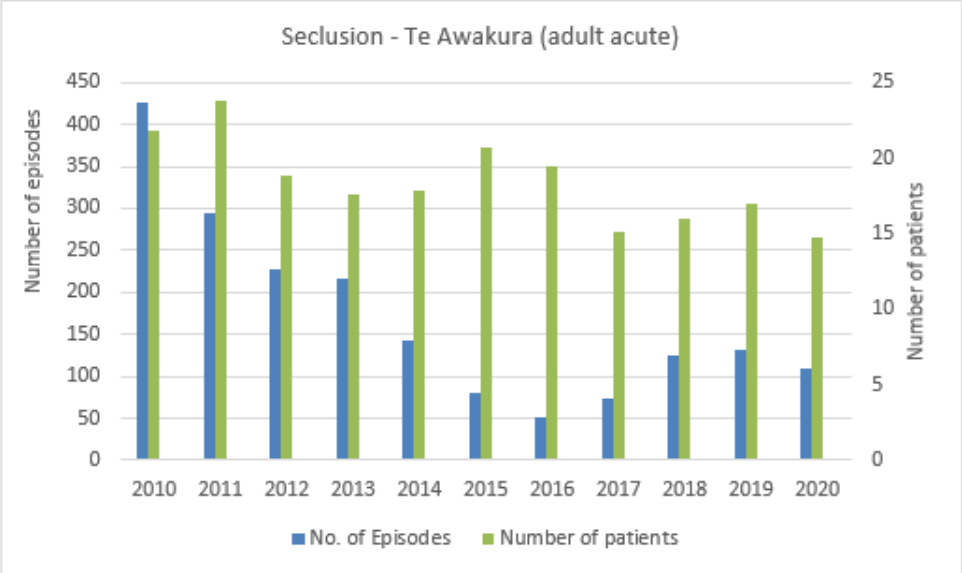
In March there were 200 admissions to Specialist Mental Health Services and 18,331 contacts with 4,719 individuals.

Adult Acute: Occupancy of adult services remains relatively high, however some Covid-related gains have been embedded with a decrease in occupancy due to better integration with community services, allowing greater therapeutic time with those on the wards.

Quality and Safety

The number of serious assaults has decreased over the last three years, and we aim to further reduce these numbers.

There is a national campaign supported by the Health Quality and Safety Commission to reduce the amount of seclusion for inpatients. While there have been significant reductions in seclusion, the nature of our facilities does not support best practice with lack of space and ability to provide physical separation.



Our People

There has been a slight increase in vacancies across mental health recently. While recruitment has been steady some problem areas have emerged; intellectual disability (especially AT&R) has been particularly difficult.

The voice of people with *lived experience* is important to delivery of mental health services. While there is strong consumer and family/whanau engagement in the provision of mental health services, this voice has not been at the leadership table for many years. The recommendations from *He Ara Oranga*

(the Government Inquiry into Mental Health and Addiction) mean we need to ensure the people with *lived experience* should be part of Divisional leadership and proposals are being developed to enable this.

OLDER PERSON'S HEALTH & REHABILITATION (OPH&R)

Service Delivery/Performance
OPH&R continue to focus on improving patient flow within Burwood Hospital. There has been an improvement in wait time from transfer from Christchurch Hospital to Burwood Hospital in February with an average wait of 1.3 days. This worsened in March with increased referrals to 2.14 days.

Rethinking-rehab has been focussing on improvements we can make to enhance the rehabilitation and restorative journeys for our patients and whanau in our **Older Persons' Health inpatient wards**.

A goal setting workstream was established to streamline our approach to engaging patients and whanau in their recovery and journey through OPH services.

PLANNING, FUNDING & DECISION SUPPORT

Service Delivery/Performance
Participation in the National Bowel Screening Programme – The participation targets for the National Bowel Screening Programme are 60% for all population groups. The Canterbury Programme went live on 29 October 2020. Participation rates are looking positive with 58% of the total eligible Canterbury population already having participated in the Programme. As of 7 April, Maori participation rates are currently sitting at 49% and continuing to rise. Rates for our Pacific population are lower at 32.5%, although this is also gradually improving. These population groups are the focus for the next few months. Marketing will be focused directly on our priority populations with ongoing face to face education and support being driven through a range of formats including, websites, community meetings and general practice contact. As of 7 April, we have had 405 positive kits out of the 8,455 returned, 141 colonoscopies have been undertaken which have identified 20 cancers and 54 significant findings.

Rural Emergency and After-Hours Care - In March 2021 access to emergency and urgent care improved significantly in north Canterbury with both Cheviot and Waikari Community Health Centres introducing a new 24/7 nurse-led on-call response, alongside St John and Fire & Emergency NZ volunteers, and St John significantly increasing paramedic staff numbers at its Amberley, Culverden and Kaikoura stations. Amberley St John is receiving a huge boost in personnel, with six paid staff joining the volunteer base. Culverden-based Amuri St John and Kaikoura St John are also getting extra fulltime, paid staff to enable the provision of a seven-day- a-week paramedic coverage across these regions, and to support double-crewing of ambulances. Both these initiatives are a culmination of collaborative work with the local providers, Waitaha PHO and Planning & Funding and will improve equity of access to emergency and after-hours care for our rural communities.

Emerging Priorities – Areas of Focus
MMR Vaccination Campaign – The national focus on vaccinating 15 – 30-year-olds for Measles through the Measles, Mumps, Rubella vaccination programme continues. Canterbury's programme was launched in December 2020 and we have been in full swing since, including promotion at community events across the district and targeted campaigns through tertiary education providers. Despite the significant impact the establishment of the COVID-19 vaccination programme has had on

focus, with staff seconded to help in this space, March coverage results indicated that Canterbury DHB delivered 776 MMR vaccines in the month, which was the highest number across the country.

Other Areas of Interest

Virtual Consultation for Aged Residential Care – In 2020, a review was undertaken by the Canterbury Initiative of a cohort of patients presenting to the Emergency Department from Aged Residential Care (ARC), to explore potential opportunities for the patient to have remained at their facility. It was found that a significant proportion of those presenting had not seen a general practitioner in the previous 24 hours and that the presenting condition could have been managed within the ARC facility if the general practice team had been engaged. A project was established to support a service operating out of the 24-hour Surgery, offering virtual consultations for urgent care to ARC when the usual ARC general practice was not available. The project commenced in June 2020. The service is working well and on average 60 virtual consultations are delivered per month, with a spike in December and January of 105 and 92 respectively. The plan for the coming year is to work more actively with Ashburton ARC and to consider expanding the services to support disability residential providers.

PEOPLE & CAPABILITY

Quality and Safety

Injury Prevention Programme: The Wellbeing, Health and Safety Team have been working with key stakeholders to design a Safe Moving and Handling Programme, to address the high levels of harm resulting from manual handling and musculoskeletal injuries. In the last five years, 1799 ACC claims have been made relating to manual handling or musculoskeletal injuries which has cost a total of **$6.7million in ACC costs and an estimated further $9.7 million** in backfill costs.

TRANSALPINE HEALTH DISABILITY ACTION PLAN 2020 - 2030

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

PREPARED BY: **Kathy O'Neill, Team Leader, Primary Care, Planning & Funding**

APPROVED BY: **Dr Jacqui Lunday Johnstone, Executive Director of Allied Health, Scientific and Technical**

DATE: **20 May 2021**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to seek formal endorsement of the refresh of the Transalpine Health Disability Action Plan 2020 – 2030. The updating of the plan is a required process embedded in the 2016-2026 Disability Action Plan.

2. RECOMMENDATION

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

i. formally endorses the Transalpine Health Disability Action Plan 2020-2030; and
ii. notes the actions being undertaken in the Work Plan for 2020 – 2021.

3. SUMMARY

The refreshed Action Plan with Work Plan was developed within the Disability Steering Group (*DSG*) to identify priority actions that will be completed in the next 12 months against the 41 new and revised priorities actions. These actions have been identified following the consultation process with disabled people, their whanau undertaken in the second half of 2019 and disabled peoples organisations and providers, which is regular and ongoing.

4. DISCUSSION

The Plan is aligned with the principles of Enabling Good Lives (identified and approved by disabled people) and of Whanau Ora. Disabled members and the Manawhenua members of DSG required that this alignment be made more explicit and a table has been added into the forward of the Plan to meet this requirement. The Chair and members of DSG have also engaged with Te Matau a Maui who have requested DSG assist them to ensure the update of the Māori Action Plan is inclusive of the needs of disabled Māori and their whanau.

The following changes have been made to the Plan following engagement and feedback:

- Has an increased focus on intervening early with disabled children.
- Reducing the need for disabled people to have to repeat their story through increased shared records and plans.
- Increases disabled peoples' self-determination by giving them more control of their information, through patient portals and knowing what is being communicated about them.
- Plans to employ more disabled people with a target of having the health workforce more reflective of the population, including employing more Māori and Pacific people.
- In the most part disabled people and their whanau have fed back that our communication has not improved over the last few years. In response, the Canterbury DHB has signed up to the

Accessible Information Charter and a Work Group has formed with a separate Work Plan in development.

- Intellectually disabled people have the poorest health outcomes; therefore, actions need to be prioritised to include this population group.
- Raising disability responsiveness through focused training for staff.

The Work Plan has been developed to provide an increased structure to implementation of the Action Plan. While the Work Plan specifies that it is for the next 12 months, this is a living document and is used to monitor progress and to capture new work undertaken. For example, we are developing new actions with Vaka Tautua (Pacific Disability Provider) in relation to meeting the needs of disabled Pasifika people, following the passing of Lemalu Te Pou who was leading this work for DSG. We are also engaged with the Multicultural Society and are developing actions with them around what are the important priority areas from their perspective. Both areas will be added to the Work Plan by the end of September 2021.

5. CONCLUSION

Evaluation will be through the Disability Steering Group and its progress measured in the Work Plan which will continue to update the DSAC/CPHAC at least 6 monthly.

6. APPENDICES

Appendix 1: Canterbury and West Coast Disability Action Plan 2020-2030
Appendix 2: CDHB Disability Action Plan – Priority Actions 2020-2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast – District Health Board –
Te Poari Hauora a Rohe o Tai Poutini

Canterbury and West Coast Health

Disability Action Plan 2020 – 2030

A plan for improving the health system for disabled people and their family/whānau

Contents

Implementing and refreshing our Disability Action Plan: 2016 - 2026

The Canterbury and West Coast Health System Disability Action Plan (the Plan) was launched in July 2016. It was developed after wide consultation with the disability community, including disabled people, their families/whānau, providers of disability services and our Alliance partners from across the health system. The Plan is being implemented with the ongoing engagement of all these key stakeholders using existing processes, and through developing new ways of working together.

The Canterbury DHB Disability Steering Group (DSG) provides a way to deliver outcomes against the identified priority actions. In Canterbury, the DSG now has 22 staff and community members, and includes links with the Canterbury Clinical Network. On the West Coast, the Alliance Leadership Team and the Board's Disability Support Advisory Committee provide governance. The Divisions with transalpine responsibilities e.g. People and Capability, Communications and Quality Safety and Risk, are leading the implementation. It is important to note that the within the updated priority actions there is a plan to include the development of a West Coast Disability Steering Group to support the implementation on the West Coast.

Progress has been made towards the original 16 Priority Actions of the Plan especially in key areas such as:

- highlighting the importance of addressing issues of accessibility
- employing more disabled people in the DHB
- capturing disabled peoples experience of the health system
- having user friendly information through a re-designed web site
- and establishing a foundation for the on-going engagement with the disability community

To revisit the Plan for 2020 -2030 the original priority actions have been reviewed and have been amended or removed as appropriate. New priority actions have been added to incorporate feedback from forums held in August 2019 with the disability community including people with lived experience and that received from other key stakeholder groups. This information is summarized in Appendix A.

We also updated the core documents which influence our obligations (Appendix B). The importance of the United Nations Convention on the Rights of Persons with Disability (UNCRPD) was consistently referred to in the consultation forums, and these remain the underlying core principles (Appendix C).

For the purposes of this Plan, disability is defined according to the UNCRPD. It describes disability as resulting 'from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others' (UN General Assembly 2007).

This definition distinguishes the impairment or health condition from the restrictions on participation in society (e.g. unemployment due to discriminatory recruitment practices). These restrictions are not an inevitable consequence of the impairment; they are a result of unfair and avoidable barriers which results in many of the differences in health status between disabled people and people without a disability. Using this definition the Plan is applicable to all disabled people regardless of age or the type of impairment.

This Plan supports the position taken in the New Zealand Disability Strategy 2016 – 2026. 'For some of us, the term 'disabled people' is a source of pride, identity and recognition that disabling barriers exist within society and not with us as individuals. For others, the term 'people with disability' has the same meaning and is important to those who want to be recognised as a person before their disability'.

This document uses the term disabled people. We do recognize the importance of listening to how disabled people refer to themselves e.g. People First prefer disabled people and people from the Deaf community often identify as Deaf first rather than disabled.

The principles of partnership, participation and protection have been central to the development of the strategic objectives and priority actions in this Plan. These principles are consistent with the Treaty of Waitangi and demonstrate our commitment to working with Māori as treaty partners. This is especially important because Māori have higher rates of disability and poorer health outcomes than non-Māori. While there is a specific objective to achieve equitable outcomes for Māori within the Plan, each of the identified priority actions will have identified actions that are inclusive and culturally appropriate. In addition Phase 2 of the Plan links the strategic objectives to the principles of Whānau ora and Enabling Good Lives as a recognition of the need to move away from a medical model of seeking transformational change to adopting a principled approach that empowers disabled people and whānau.

The Plan is structured around the eight strategic outcomes in the 2016 -2026 NZ Disability Strategy. As District Health Boards, we emphasise the Health and Wellbeing strategic outcome, but also have a wider role, consistent with our Position Statement.

This statement is to inform our population and other agencies of the prevailing organisational view on key issues for disabled people.

The Canterbury DHB Disability Steering Group the West Coast and Canterbury Alliance Leadership Teams and the Advisory Committees to the DHB Boards have the responsibility and the role for ensuring the Plan is implemented consistent with the priorities identified by disabled people and their family/whānau, the following systemic priorities will be assessed by all members of these groups, but is a particular role of the disability community members on these groups, and their networks, as the priority actions are progressed:

- disabled people will have input into design of new or transformed services and processes ('nothing about us without us')
- appropriate communication methods are developed and used to inform and engage the disability community at key points of the implementation process
- the rights of disabled people to have increasing choice and control over the services they receive.

In addition to this, the groups are committed to improving all aspects of the health system and with the governance of the District Health Boards Advisory Committees, we will apply a 'disability in all policies' approach as we endeavor to achieve the inclusion of disability related issues in all aspects of the system as business as usual approach.

Progress on achieving the stated objectives and priority actions in this Plan will be reported back at regular intervals to the disability community through forums, electronic information and written communication.

The key partners in the Canterbury and West Coast health system would like to thank the disability community members who have contributed, and will continue to provide input, in the development, implementation and refresh of the Plan. Without your input there can be no transformational change at the level and degree we need to make our health system truly inclusive and achieve equitable outcomes for all.

Back row from left: Lara Williams (Administrator), Jane Hughes, Sekisipia Tangi, Rāwā Karetai, Rose Laing, Paul Barclay, Kathy O'Neill, Tyler Brummer, Kay Boone, WaikuraTau-McGregor, Maureen Love, Lemalu Lepou Suia Tuula

Front row from left: Joyce Stokell, Thomas Callanan, Grant Cleland (Chair), Allison Nichols-Dunsmuir, Shane McInroe, Harpreet Kaur, Mick O'Donnell

Absent: Simon Templeton, Jacqui Lunday-Johnstone, Catherine Swan, George Schwass, Dave Nicholls, Susan Wood

Position Statement – Promoting the health and wellbeing of disabled people

Purpose

This position statement summarises our commitment to actions aimed at improving the lives of disabled people in Canterbury and on the West Coast. It will be used in making governance, planning, funding, and operational decisions. The Plan reflects this position statement and provides details of how it will be implemented.

Key points

We recognise that a significant proportion of the New Zealand population experience impairments, which may result in disability and disadvantage. In addition, the population is aging which will increase the number of people experiencing impairment. Accessibility and inclusion are rights to be protected. They are also catalysts for new ideas and innovation that can lead to better services and outcomes.

We make the following commitments to disabled people, their families and whānau, to:

1. Collect their feedback about the services we deliver
2. Understand their perspectives and needs
3. Deliver appropriate specialist, general and public health services, in a way that suits them
4. Uphold the rights of disabled people, and counter stigma and discrimination
5. Equip and upskill staff to meet their needs

We will also incorporate the perspectives and needs of disabled people when we:

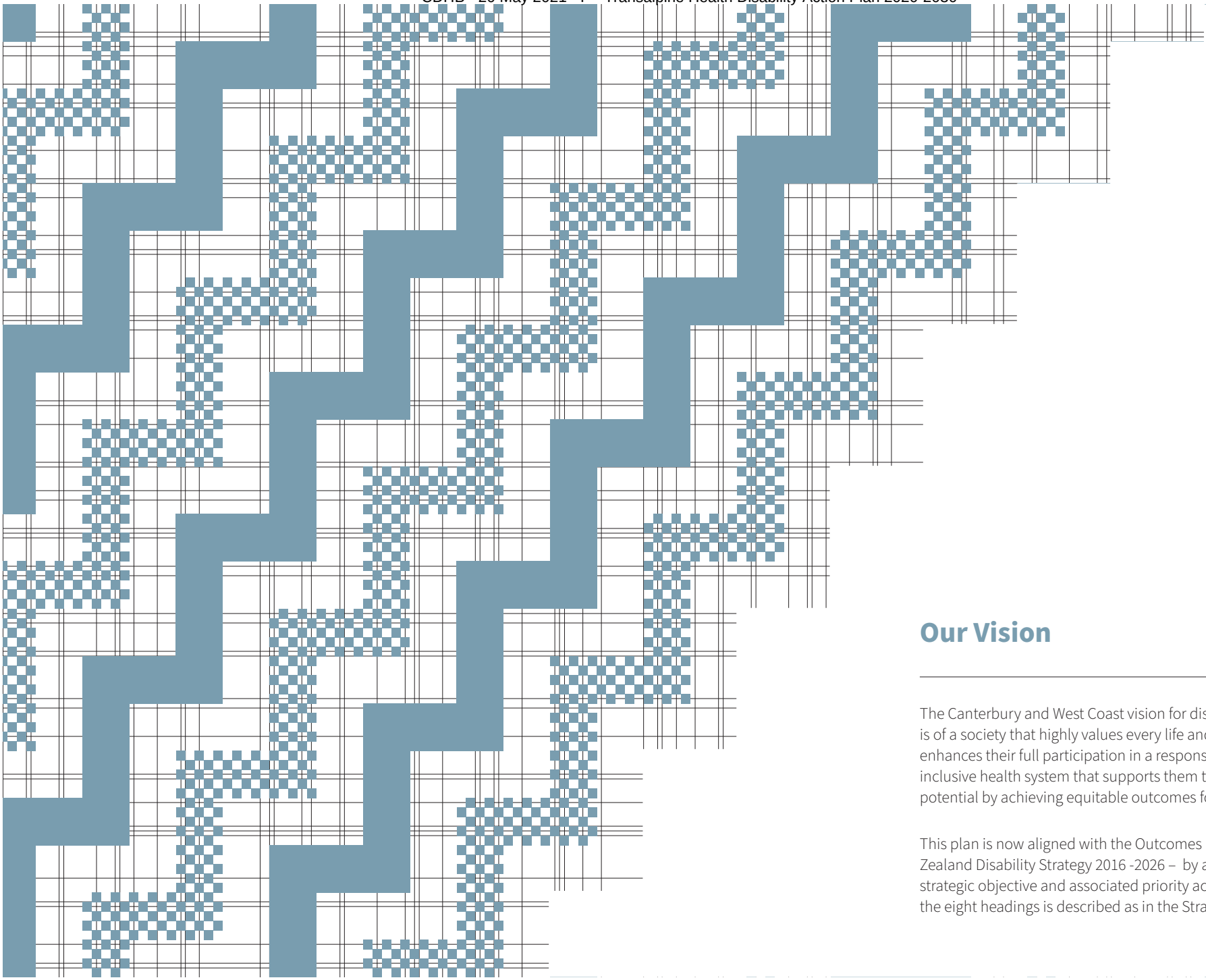
1. Employ disabled people
2. Design and build our facilities
3. Contract other organisations to deliver services
4. Partner with our communities to improve population health and wellbeing
5. Monitor and report on how well we are doing, and plan for improvements

Alignment with Core Principles and Philosophies

The philosophies of whānau ora and Enabling Good Lives (EGL) are compatible with each other, with a mutual emphasis on building whānau capacity, collective leadership, whānau planning and kaitūhono.

The whānau ora outcome goals and EGL principles are outlined in the following table and are shown to be aligned with the UNCRPD Articles and the strategic objectives of this Action Plan:

Whānau Ora outcome goals	Enabling Good Lives principles	UNCRPD Articles	Transalpine Health Disability Action Plan 2020 -2030
Whānau are self-managing	Self-determination	• Self-direction • Clauses N and O in the Preamble	• Improve Health Literacy • Improve access to personal information
Whānau are living healthy lifestyles	Beginning Early	• Health, Article 25 • Habitation, Article 26	• Offer appropriate treatments • Monitor Quality
Whānau are participating fully in society	Person Centred	• Awareness raising Article 8 • Living independently and being involved in the community Article 19 • General obligations – human rights and fundamental freedoms	• Implement a Pasifika disability plan • Develop better approaches for refugee, migrant and culturally and linguistically diverse groups
Whānau are confidently participating in Te Ao Māori	Ordinary life outcomes		• Work towards equitable health outcomes for Māori
Whānau are economically secure and successfully involved in wealth creation	Mainstream first		• Be an equal opportunity employer
Whānau are cohesive, resilient and nurturing	Mana enhancing	• Article 17 - Liberty of movement and nationality • Article 18 - Respect for home and family • Article 23 - Protecting the integrity of the person	• Provide accessible information and communication • Increase staff disability awareness, knowledge and skills • Develop leadership of people with disabilities who have a role in the health system
Whānau are responsible stewards of their living and natural environment	Easy to use	• Accessibility Article 9	• Integrate services for people of all ages with a disability • Services and facilities are designed and built to be fully accessible
	Relationship building	• Living independently and being involved in the community Article 19	• Implement the plan in partnership



Our Vision

The Canterbury and West Coast vision for disabled people is of a society that highly values every life and continually enhances their full participation in a responsive and inclusive health system that supports them to reach their full potential by achieving equitable outcomes for all.

This plan is now aligned with the Outcomes in the New Zealand Disability Strategy 2016 -2026 – by attaching the strategic objective and associated priority actions to each of the eight headings is described as in the Strategy.

Outcomes, Strategic Focus and Priority Actions

1. Education (NZ Disability Strategy 2016-2026)

We get an excellent education and achieve our potential throughout our lives.

Our Strategic Focus and Outcome Sought – Improve health literacy

Improve access to health information in a form that works for disabled people. This includes access to their personal health information. Support is provided when required so that the individual/family/whānau can use information to manage their own health, share in decision making, provide informed consent, and make choices and decisions that are right for them and their family/whānau. Disabled people contribute to their own health outcomes as they and their family/whānau receive the information and support which enables them to participate and influence at all levels of society.

Priority Actions:

With the involvement of disabled people and their family/ whānau and further explore the potential for electronic shared plans as the repository for information that disabled people want communicated about how best to support them when they are accessing a health or disability service.

1. In Canterbury this includes expanding the current shared plan pilot at New Brighton Health Centre and New Zealand Care to other large residential disability providers. Evaluate the potential effectiveness of this with the disability community.
2. In the West Coast work with the Co-ordinated Care Team of the Canterbury Clinical network to explore these opportunities on the West Coast.

2. Employment and Economic Security (NZ Disability Strategy)

We have security in our economic situation and can achieve our full potential.

Our Strategic Focus and Outcome Sought – Be an equal opportunity employer

Disabled people experience equitable workplace opportunities. The health system supports access, equity and inclusion for those living with impairments, their family/whānau, carers and staff.

Priority Actions:

3. Increase the numbers of disabled people being employed and supported in their role within the Canterbury and West Coast health system.
4. Develop and implement an appropriate quality tool for current employees who identify as having a disability, that can inform and identify opportunities to improve staff wellbeing.
5. Work with Work and Income NZ and the Ministry of Social Development in achieving employment of people with disabilities
6. Develop and implement affirmative action initiatives that will result in more people with disabilities being employed in the Canterbury and West Coast health system. We will work towards achieving a percentage people employed in the workforce as having a disability that is reflective of the districts population e.g. 24% as identified in the 2013 NZ Disability Survey.
7. Explore and implement ways to engage staff living with disabilities to help identify and inform how Canterbury and the West Coast DHBs can continuously support their wellbeing at work.

8. Utilise updated workforce data to track progress

9. Explore the development, with support from external agencies, of pathways that support people living with disabilities into leadership positions.

10. Undertake an environmental scan of a pilot site within our workplace to assess inclusivity and subtle messages in our environment - with a focus on accessibility.

3. Health and Wellbeing (NZ Disability Strategy)

We have the highest attainable standards of health and wellbeing.

Our Strategic Focus and Outcome Sought – Integrate services for people of all ages with a disability

Disabled people and their family/whānau/carers are listened to carefully by health professionals and their opinions are valued and respected. Individuals are included in plans that may affect them and encouraged to make suggestions or voice any concerns by highly responsive staff.

Priority Actions:

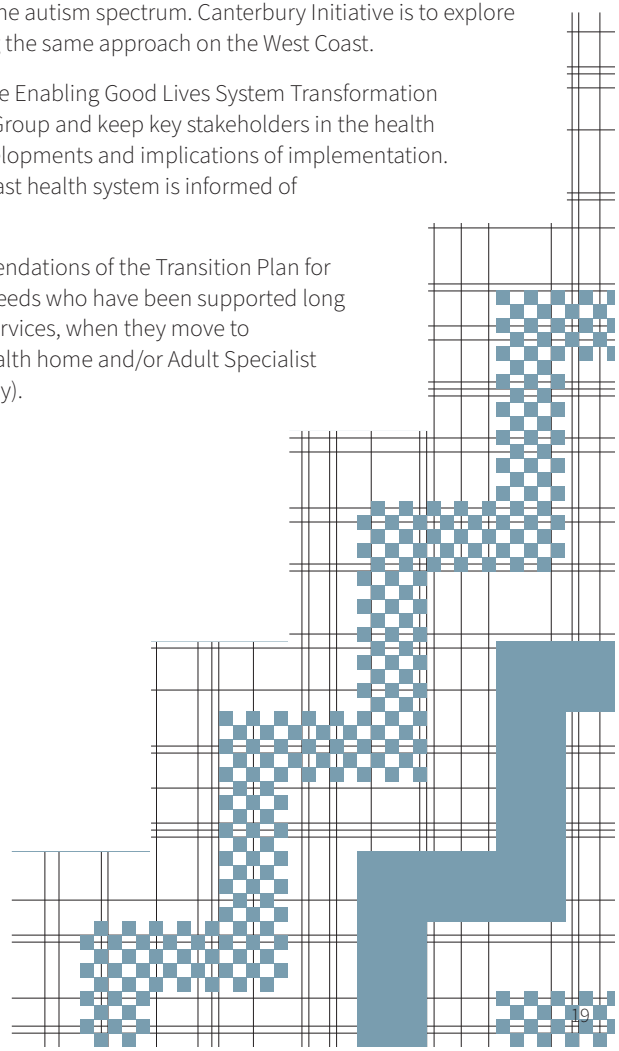
11. Work with disabled people and their family/whānau/carers to identify opportunities for achieving an integrated and co-ordinated approach between cross government services and local providers, so that infants/children and youth with impairments and adults with a disability, including those with age related conditions, can live lives to their full potential.

12. Ensure Funded Family Care is implemented equitably across the Canterbury and West Coast health system.

13. Integration of the Mental Health, Pediatric and Child Development Services through a Health Pathways approach as developed in full engagement of these clinical services, the Child and Youth Workstream and Canterbury Initiative. Note that the pathway needs to ensure it has inclusive and equitable responses for those on the autism spectrum. Canterbury Initiative is to explore the applicability of using the same approach on the West Coast.

14. Remain engaged with the Enabling Good Lives System Transformation Canterbury Leadership Group and keep key stakeholders in the health system informed of developments and implications of implementation. Ensure that the West Coast health system is informed of key developments.

15. Implement the recommendations of the Transition Plan for children with complex needs who have been supported long term in the Paediatric Services, when they move to Primary Care as their health home and/or Adult Specialist Services (Canterbury only).



Our Strategic Focus and Outcome Sought – Offer appropriate treatment

Offer interventions with individuals and their family/whānau which are evidence based best practice and that these restorative, recovery focused approaches will result in disabled people living lives to their full potential.

Priority Actions:

16. Explore opportunities and identify how to support a timely response for disabled people and their families/whānau who require:
    - Aids to daily living
    - Housing modifications
    - Driving assessments
17. The geographical equity across NZ of the provision of hearing aids will be explored and options considered.
18. Work with Specialist Mental Health Services and the disability sector to identify how to build capacity and capability across the system in an evidence-informed way for those accessing the Intellectually Disabled Persons Health inpatient services. Explore what is needed to ensure progress can be made based on the Enabling Good Lives 'Try, Learn, Adjust' approach
19. Work with Primary Care and General Practice to adapt the Mental Health Equally Well approach to be able to be implemented for those with an intellectual disability and other disabilities at highest risk of poor health outcomes.

Our Strategic Focus and Outcome Sought – Implement a Pasifika disability plan

Work with Pasifika people, their families and Pasifika providers to action the Ministry of Health National Pasifika Disability Plan Faiva Ora 2016 – 2021, – Pacific Health Action Plan (currently under development) and the Canterbury Pasifika Strategy (currently under development) will also be used as a core document to inform the work required.

Priority Actions:

20. As part of the development of a longer-term collective strategy for improving Pasifika health ensure each part of the co-design process is inclusive of those with lived experience of disability and their whānau, the core national documents and that their needs are captured in the Canterbury strategy. Ensure that all the actions of this Plan is inclusive of that strategy.

Our Strategic Focus and Outcome Sought – Develop better approaches for refugee, migrant and culturally and linguistically diverse groups

Work with disabled people and their families who are from different refugee, migrant and other culturally and linguistically diverse groups to identify and implement responsive processes and practices. This includes information being appropriately translated and an awareness by staff of how disability is viewed from different cultural perspectives.

Priority Actions:

21. Engage with key service providers, established groups and the CALD communities to explore opportunities for including the needs of CALD disabled people in the way we communicate. Use these local Canterbury and West Coast networks to establish communication processes to disseminate health and disability-related information and advice to CALD communities.

Our Strategic Focus and Outcome Sought – Monitor quality

Develop and use a range of new and existing quality measures for specific groups and services that we provide for disabled people, and develop systems and processes to respond to unmet needs e.g. consumer survey.

Priority Actions:

22. Develop measures and identify data sources that will provide baseline information about disabled people who are accessing the health system. Using the Health System Outcomes Framework for each strategic goal, use data analysis to understand the population and evaluate progress towards improving health outcomes for disabled people.

23. The quality of life for disabled people while in Canterbury and West Coast long term treatment facilities is measured and monitored and that actions occur to address any identified areas of improvement quality actions occur.

24. Regular reporting occurs to the Disability Steering Group on the analysis of the Patient Experience Surveys response from people identified as having a disability. Where possible this information will be used to target quality initiatives that will improve the experience of the health system for disabled people.

4. Rights Protection and Justice (NZ Disability Strategy)

Our rights are protected, we feel safe, understood and are treated fairly and equitably by the justice system.

Our Strategic Focus and Outcome Sought – Work towards equitable health outcomes for Māori

Work with Māori disabled people, whānau and the Kaupapa Māori providers to progress the aspirations of Māori people as specified in He Korowai Oranga, Māori Health Strategy. Apply our Māori Health Framework to all the objectives of this action plan in order to achieve equitable population outcomes for Māori with a disability and their whānau.

Priority Actions:

25. All the priority actions of this plan are to include culturally appropriate actions tāngata whaikaha* and their whānau, and that this promotes and supports whānau ora and rangatiritanga.

26. Equity is a key consideration in planning and carrying out all priority actions, including making use of the Health Equity Assessment Tool where indicated.

27. As part of the development of a longer-term collective strategy for improving Māori health ensure each part of the co-design process is inclusive of those and tāngata whaikaha their whānau and that their needs are captured in the strategy. Conversely that the actions of this Plan is inclusive of the strategy.

*(tāngata whaikaha is a strength based description that, as defined by Maaka means ‘ striving for enlightenment/striving for enablement)

5. Accessibility (NZ Disability Strategy)

We access all places, services and information with ease and dignity.

Our Strategic Focus and Outcome Sought – Services and facilities are designed and built to be fully accessible

Services and facilities will be developed and reviewed in consultation with disabled people and full accessibility will be enhanced when these two components work together to ensure disabled people experience an inclusive health system that is built to deliver waiora/healthy environments.

Priority Actions:

28. The Canterbury DHB Accessibility Working Group scope is expanded to include the West Coast DHB. And includes engagement with the West Coast Accessibility Coalition and the implementation of the West Coast Accessibility Strategy.
29. Technical accessibility experts will be engaged at key stages of the design and or rebuild, and involve disabled people to remove physical barriers.
30. Information will be sought about accessibility of our services and facilities from patients, family/whānau, and staff. The information gathered will be used to plan services and facilities improvements.

Our Strategic Focus and Outcome Sought – Provide accessible information and communication

Promote and provide communication methods that improve access and engagement with disabled people e.g. use of plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology. Expand the use of sign language.

Priority Actions:

31. Establish Executive Management and Board approval for the national Accessible Information Charter endorsed by all the Public Sector Directors General.
32. Establish an Accessible Transalpine Information Working Group accountable to the implementation groups, to identify and progress actions necessary to meet the objectives of the Accessible Information Charter (endorsed by all Public Service Chief Executives).
33. Upskill DHB Communications Team members in producing easy read documents and as a priority have this Plan made available in Easy Read format.

6. Attitudes (NZ Disability Strategy)

We are treated with dignity and respect.

Our Strategic Focus and Outcome Sought – Increase staff disability responsiveness, knowledge and skills

Develop and implement orientation and training packages that enhance disability responsiveness of all staff, in partnership with the disability sector e.g. disabled people, their family/whānau/carers, disability training providers and disability services. The wellbeing of disabled people is improved and protected by recognising the importance of their cultural identity. Health practitioners understand the contribution of the social determinants of health.

Priority Actions:

34. Support the development of an employee network group for staff living with disabilities to create a sense of community and amplify voices range of employee networks

35. Work with Talent, Leadership and Capability and professional leaders to identify relevant education programmes that are already developed and offered by disability-focused workforce development organisations e.g. Te Pou.

36. Work with the Talent, Leadership and Capability, professional leaders and people with lived experience to progress the development of targeted responsiveness trainings

37. Deliver and evaluate a targeted disability equity training programme including telling stories of our workforce who live with disabilities

38. Review and update the Corporate Orientation Package

39. Work with the Maori and Pacific Reference Group who are providing guidance to People and Capability on building a diverse workforce that in turn increases systems capability to meet the diverse needs of our community.

7. Choice and control (NZ Disability Strategy)

We have choice and control over our lives.

Our Strategic Focus and Outcome Sought – Improve access to personal information

Priority Actions:

40. Enable disabled people to have increased autonomy in making decisions that relate to their own health by developing processes that enhance communication e.g. access to their medical records through patient portals. Disabled people will be given support to do this if they are unable to do this on their own.

8. Leadership (NZ Disability Strategy)

We have great opportunities to demonstrate our leadership.

Our Strategic Focus and Outcome Sought – Develop leadership of people with disabilities who have a role in the health system

Priority Actions:

41. Identify and support opportunities for leadership development and training for disabled people within the health system. This includes further development of peer support as a model of care for people with long term conditions.

42. Engage workforce development training providers from the disability sector to identify opportunities to support disabled people and their family/whānau who are providing a voice for disabled people within the health system. This will include exploring options for appropriate leadership training e.g. Be Leadership.

Our Strategic Focus and Outcome Sought – Implement the plan in partnership

The collective issues that emerge from disabled people' lived experience of the health system are actively sought and used to influence the current and future Canterbury and West Coast health system.

Priority Actions:

43. Work with the Canterbury and West Coast Consumer Councils to ensure a network of disability-focused consumer groups who are empowered to actively engage with health service providers and be partners in health service improvement and redesign. This network will support the implementation and evaluation of the Canterbury and West Coast Health Disability Action Plan.

44. A West Coast DHB Disability Leaders Working Group is formed consisting of Transalpine Divisional Leads and members for the Consumer Council who identify as having lived experience of disability or as a family/whānau member. The purpose of the group is to progress the priority actions where their division holds the responsibility. The West Coast DHB Disability Leaders Working Group is accountable to the West Coast Alliance Leadership Team. (West Coast only)

45. Monitor progress against the priority actions to be undertaken annually, a report written and endorsed by the responsible implementation groups and communicated to the sector as a key part of the communication plan.

46. The priority actions will be refreshed at a minimum of 3 yearly through engagement with the health system and the disability sector and input from the disabled people, family/whānau and the wider disability sector.

Our Strategic Focus and Outcome Sought – Promote the health, wellbeing and inclusion of people of all ages and abilities

Actively promote and influence at all levels of society, to address stigma and discrimination, increase universal design for public spaces, and advocate for a fully inclusive society.

Priority Actions:

47. Community and Public Health for both DHBs continues to co-ordinate submissions on behalf of Canterbury and West Coast DHBs. They will use the Plan's underpinning principles to inform their submissions.

48. The Canterbury and West Coast health system hosts, in partnership with the DPOs, a bi-annual forum to show case developments and initiatives to improve the experience of the health system for disabled people and their family/ whānau.

Appendix A

CORE DOCUMENTS

The core documents referenced in the development of this Plan include:

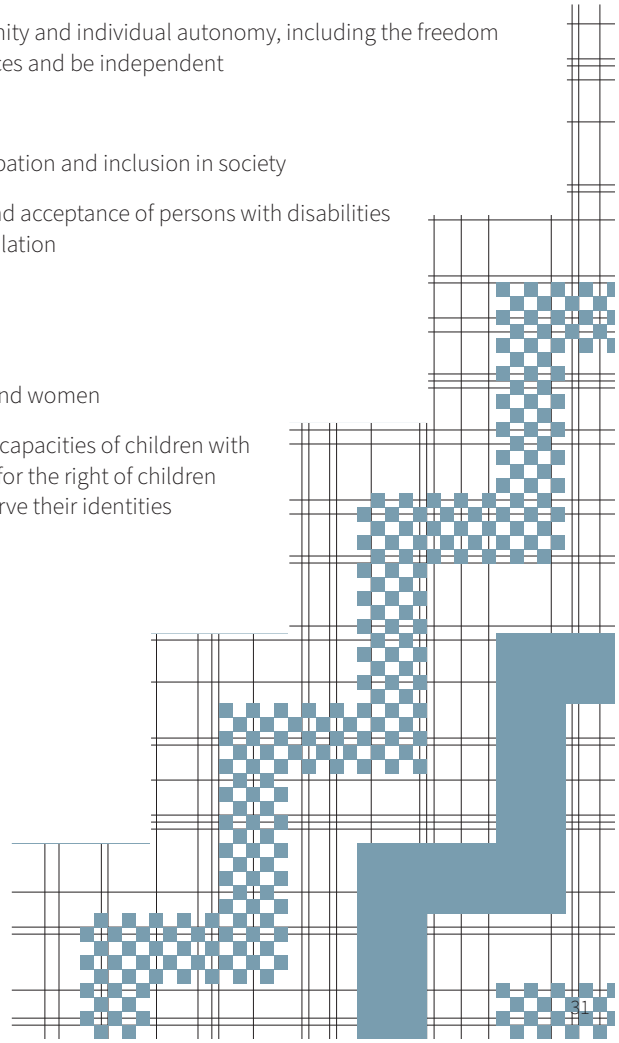
- New Zealand Disability Strategy 2016 - 2026
- New Zealand Disability Action Plan 2019 - 2023
- He Korowai Oranga, Māori Health Strategy
- Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Service 2018 - 2022
- Faiva Ora National Pasifika Disability Plan 2016 - 2021
- Ala Mo'ui: Pathway to Pacific Health and Wellbeing –(currently being updated)
- United Nations Convention on the Rights of Persons with Disability (ratified by New Zealand 2007)
- Second Report of Independent Monitoring Mechanism of the Convention of the Rights of Disabilities, August 2014
- United Nations Convention on the Rights of the Child (ratified by New Zealand 2008)
- Human Rights Act 1993

Appendix B

GUIDING PRINCIPLES OF THE CONVENTION

There are eight guiding principles that underpin the Convention:

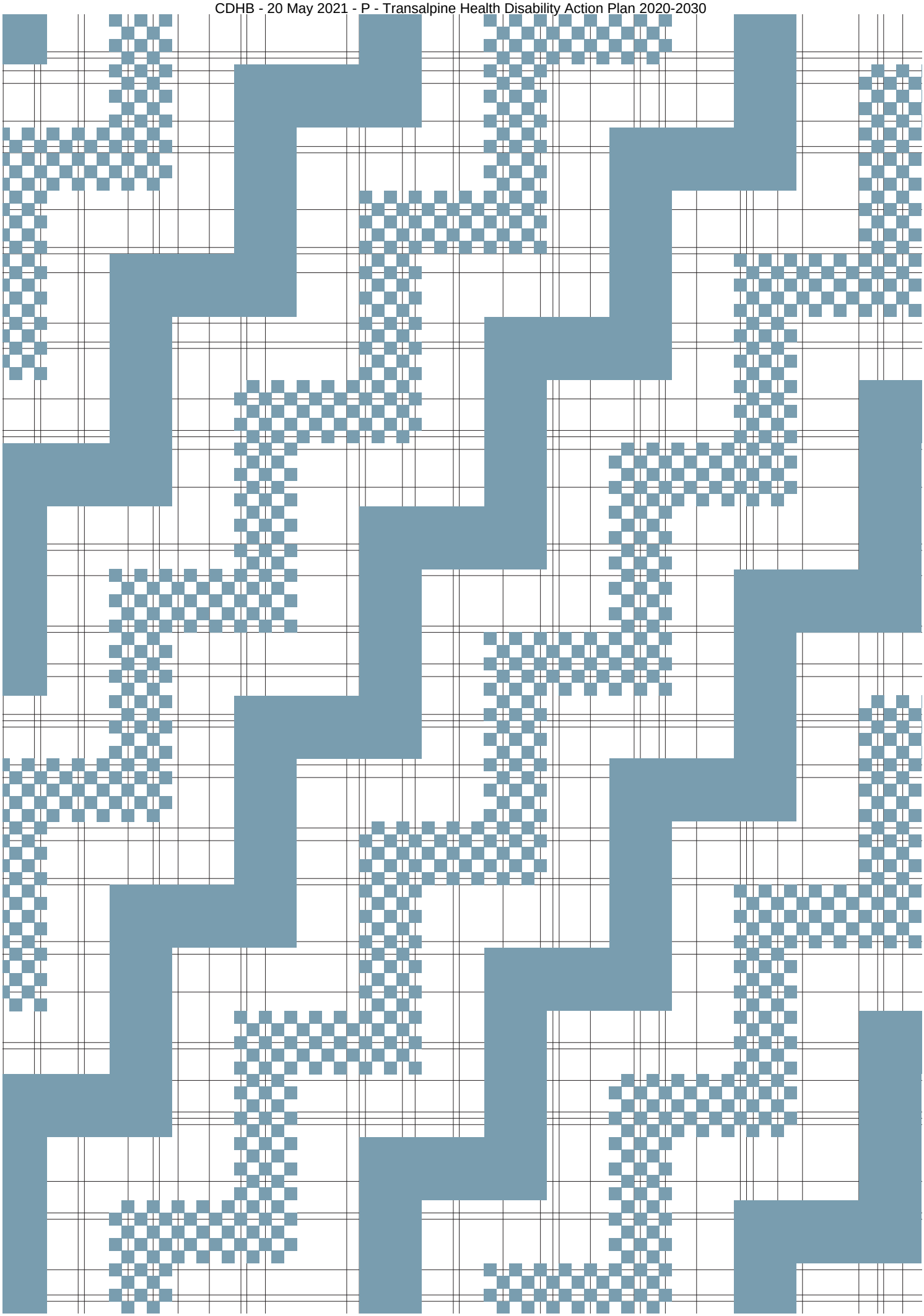
1. Respect for inherent dignity and individual autonomy, including the freedom to make one's own choices and be independent
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of a diverse population
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities, and respect for the right of children with disabilities to preserve their identities



Appendix C

KEY THEMES FROM THE 2019 CONSULTATION

1. The importance building capacity and services to intervene early.
   - Child Development Service is under-resourced, and is especially hard for those with Autism Spectrum Disorder to access. Autism and ADHD repeatedly came up as under-resourced.
   - There are not enough psychology services, there are gaps in key roles, services need to be integrated and have co-ordinated approaches between agencies.
   - Transition of child to adult secondary care services needs to improve, and needs to include the transfer from specialist to general practice care.
2. There is not enough about learning(intellectual) disability in the Plan. It seems to be more weighted to physical or sensory disability.
3. Disabled people are still expressing their frustration about re-telling their story and what they need when accessing health services. Disabled people want their voice involved in treatment. When described in the forums it was agreed that HealthOne as the electronic shared health record between General Practice and Secondary Care, on its own, doesn't seem to be changing the experience of disabled people and their family/whānau of the health system. Electronic Shared Plans were suggested as a suitable electronic alternative to Health Passport and attendees at the forums saw this as an opportunity that would be crucial to improving experience of health services.
4. A recurring theme is people wanting to have control of their information. This is seen as a key to their self determination. People wanted access to their records through patient portal. They also want to know what is being communicated about them.
5. There was significantly more feedback about General Practice this time compared to the first consultation round in 2015. Specifically, frustration was expressed about cost, not getting timely appointments, GP rooms poorly equipped and often no accessible toilets etc. There were questions about why appointments have to be at the Practice rooms - what about skype or zoom appointments? This was seen as working well for people where physically getting to appointments is challenging or there is a lack of accessibility at the facility.
6. While employing more disabled people in the DHB was still a high priority people communicated what disabled people wanted to see happen is slightly differently this time. People wanted the workforce to reflect the community. Feedback included employing more Maori and Pacific people – 'whānau just know what is needed'. This approach is seen as improving awareness, enhancing equity and shifting the culture of health services to being more responsive and inclusive of diversity more generally.
7. Disabled people repeatedly stated that effective communication at every level was essential in engaging with them and their family/whānau. It was highlighted that the Canterbury DHB is still not using plain language or Easy Read. Deaf Aotearoa also gave useful feedback about having TV's with captions and the increasing the use of technology such as iPads.
8. Every forum raised the challenge of finding what they needed in a complex system. Suggestions were made that a person or a place where they could go to assist them to navigate them to what they needed was necessary. People said that they often don't even know what's out there or what to ask for. Specific suggestions is for a central place that people could go to, within the health system for disability information and/or a dedicated role that could provide advice to people and staff. Alliance type structures between health, disability and social services was seen as crucial in unlocking services and stopping people bouncing from service to service.
9. Issues with getting transport to appointments and parking came up every forum.
10. There is a lack of confidence that new builds were getting people with lived experience of having a disability involved in planning layout and fit out early enough or at all. This was a theme on the West Coast and Canterbury.
11. General feedback that access to equipment had improved but there could still be unacceptable delays.
12. Older People make up the highest proportion of the population with a disability but the current Plan does not seem to recognize this.



CDHB Disability Action Plan - Priority Actions 2020 -2021: Report for Monitoring Progress towards Outcomes

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
Accessibility (NZ Disability Strategy)					
1. Provide accessible information and communication	1.1 Establish Working Group and gain Executive Management Team and Board approval for the National Accessible Information Charter endorsed by all the Public Sector Directors General.	Board endorsed Accessible Information Charter.	Comms Mick O'Donnell, People and Capability Elyse Gagnon, Planning & Funding Kathy O'Neill	Completed May 2021	Accessible Information Charter approved by EMT and Board –November 2020. EMT Sponsors to sign the Charter at event 28 May 2021.
	1.2 Develop accessible information work plan	Work plan completed.	Comms Mick O'Donnell, People and Capability Elyse Gagnon, Planning & Funding Kathy O'Neill	June 2021	Draft Work Plan completed by May 2021
	1.3 Upskill DHB Communications Team to produce easy read documents and as a priority have this plan in Easy Read format	Number of documents/public notices produced in easy read and other accessible formats reported	Comms Mick O'Donnell, People and Capability Elyse Gagnon, Planning & Funding Kathy O'Neill	June 2021	Communications Team has completed some internal training and key staff across CDHB attended MSD Accessible Information Training in November 2020 Producing Easy Read documents

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
	1.4 In conjunction with the Accessible Information Working Group and Quality Team develop a policy that identifies the expected components of accessible information	Policy developed and approved by EMT	Quality and Patient Safety Susan Wood	September 2021	
	1.5 CCN to submit Accessibility Charter to ALT for endorsement	Policy signed by CCN	CCN Elly Edwards	September 2021	
	1.6 Work with DHB Emergency Coordination Committee (ECC) to establish a Disability Reference Group who will ensure communication to and from the disability community is effective. (In line with feedback from the disability community following 2020 COVID lockdown).	Group established Key contacts identified and included in ECC structure Communicate structure to DSS/MOH to ensure who is communicating what at national and local levels	Planning and Funding Kathy O'Neill	June 2021	Lead in Service Continuity Team identified. Disability Community members to be engaged from DSG. May 2021
2. Services and facilities are designed and built to be fully accessible	2.1 Accessibility Charter Working Group (ACWG) paper approved by EMT, setting out the process for physical access audits at design and rebuild stages.	Process approved and \ implementation steps in place.	The ACWG	EMT approved July 2020	EMT approved 'Three Pillars' model that sets out expectation that all building design work will include technical expertise, lived experience, and in-house resourcing to oversee. Implementation continues in 2021.
	2.2 The Canterbury DHB Accessibility Working Group scope is expanded to include the West Coast DHB.	West Coast engaged	Planning and Funding Kathy O'Neill and the ACWG	Ongoing	Communication of work being done out of Christchurch made available to West Coast via DSG minutes. More to do to expand.
	2.3 Technical accessibility experts will be engaged at key stages of design and/or rebuild, and	Report on Technical expert activity prepared six-monthly to DSG	The ACWG	Ongoing	DSG regularly advised on progress. Two new build projects have engaged accessibility auditors – Hillmorton and

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
	involve disabled people to remove physical barriers.				Rolleston projects. The Outpatients accessible toilet rooms were audited; issues identified are being addressed. DSG toured Waipapa February 2021. Report being prepared
	2.4 Information will be sought about accessibility of our services and facilities from patients, family/whānau, and staff. The information gathered will be used to plan services and facilities improvements. See also 9.7.	Process for information collection is identified and ready for implementation	CPH Allison Nichols-Dunsmuir, the ACWG and Quality and Patient Safety Susan Wood.	Ongoing	More integrated work is planned for 2021; information is collected but needs better collation and reporting.
Employment and economic security (NZ Disability Strategy)					
3. Be an equal opportunity employer	3.1 Work towards achieving a percentage of disabled people employed in the workforce reflective of the district's population and track progress using workforce data.	Identify and implement how we measure numbers of disabled staff	People and Capability – Elyse Gagnon	February 2020	As of October 2020, 3.7% of our CDHB workforce and 3.0% of our WCDHB workforce identified as having a disability.
	3.2 Develop and implement a quality tool for current disabled staff, to inform and identify opportunities to improve staff wellbeing.	Tool developed	People and Capability – Elyse Gagnon	August 2020	In partnership with University of Canterbury a diversity survey focussing on disability, was sent out to CDHB staff and was open for two weeks. The data will inform a report produced by end of May 2021 which will inform our learning and development as well as help us prioritise our initiatives.

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
	3.3 Develop & implement affirmative action initiatives that result in more disabled people employed by CDHB.	Affirmative actions identified. Implementation Plan developed with timeline for implementation	People and Capability – Elyse Gagnon	May 2021	
	3.4 Explore & implement ways to engage disabled staff to identify/inform how to continuously support their wellbeing at work.	Establish an engagement plan	People and Capability – Elyse Gagnon	August 2021	
	3.5 Explore support from external agencies, to support disabled people into leadership/jobs.	Produce a report on external agencies engaged and how they will provide support	People and Capability – Elyse Gagnon	October 2021	
Attitudes (NZ Disability Strategy)					
4. Increase staff disability responsiveness, knowledge and skills	4.1 Support the development of an employee network group for disabled staff	Group Established	People and Capability – Elyse Gagnon	August 2021	
	4.2 Work with Talent, Leadership and Capability professional leaders and disabled people to progress targeted disability responsiveness staff training/s, including disabled staff telling their stories.	Plan developed and training implemented	People and Capability – Elyse Gagnon		In collaboration with the Chair of the Disability Steering Group, the Learning and Design team have created a piece of learning entitled “adapting your communication style” for our people to learn ways they can meet the diverse communication needs of our workplace. Additional training is needed to keep increasing staff disability responsiveness, knowledge and skills

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
	4.3 Deliver and evaluate this staff training	Training evaluation	People and Capability – Elyse Gagnon	May 2021	Training has been developed (01/02/2020) but additional information needed
	4.4 Review and update the corporate orientation Package	Updated orientation package	People and Capability – Elyse Gagnon	September 2021	
	4.5 Work with the Māori and Pacific Reference Group to build a diverse workforce.	Increased diversity in the workforce	People and Capability – Elyse Gagnon	Ongoing	We are working with our Māori and Pacific partners and supporting each other in our efforts to build a diverse workforce. We have a new recruitment policy which now allows us more freedom to implement affirmative action initiatives.
Rights protection and justice (NZ Disability Strategy)					
5. Work towards equitable health outcomes for Māori	5.1 All the priority actions of this plan are to include culturally appropriate actions for Māori with a disability and their whānau, that promote and support whānau ora and rangatiritanga.	Engage with mana whenua, Māori provider network Establish and agree a mutual plan which is aligned with the Māori Health Improvement Plan	Network - Waikura McGregor, Rawa Karetai	May 2021	Met with Māori and Pacific Provider Network November 2020. Plan to meet again in March 2021 to ensure alignment between Action Plans Māori members of DSG have provided input into the development of the Canterbury Māori Health Improvement Plan. Attending April provider meeting to progress this.

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
6. Implement a Pasifika disability plan	6.1 Implement a Pasifika disability plan as part of the longer-term collective strategy for improving Pasifika health.	Form an alliance with CCLN Pacific Reference Group Disability is included in the Pacific Health Strategy	Community member Sekisipia Tangi	March 2021 June 2021	Recruit new member to DSG. Join Pacific Reference Group Seki are developing specific actions that will be worked on through DSG for Pasifika people Engage with Pacifika Futures who agree there is a current gap in their strategy.
7. Develop better approaches for refugee, migrant culturally/ linguistic diverse groups	7.1 Engage with key service providers, established groups and the CALD communities to explore opportunities to include the needs of CALD disabled people in the way we communicate.	Meet with the Multicultural Society Establish specific goals that fit within the Accessible information Strategy	Community member Harpreet Kaur	March 2021 June 2021	Met with Multicultural Council 9 March 2021. MC are to provide recommendations for specific actions by end of Q3
Health and wellbeing (NZ Disability Strategy)					
8. Integrate services for people of all ages with a disability	8.1 Integration of the Mental Health, Paediatric and Child Development Services through a Health Pathways approach.	Health Pathway for ADHD completed	Catherine Swan, Jane Hughes, Kay Boone	September 2021	Being progressed by Bruce Penny, Health Pathways. Progress Update provided to DSG in October 2020 Health Pathway for Autism completed December 2020 The Health pathways for Child Development Therapy services has been reviewed and updated in December 2020

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
9. Achieve a more integrated & coordinated approach to improve early intervention services: **Offer appropriate treatment** **Improve health literacy**	9.1 (Aligns with accessible information policy development)		Catherine Swan, Jane Hughes, Kay Boone		
	9.2 Implement recommendations of the Transition Plan for children with complex needs, when they move to Primary Care.	Health Pathways live	Catherine Swan, Jane Hughes, Kay Boone	June 2022	**(Canterbury)** Monthly planning meetings on hold. New virtual ways of working in General Practice and Specialist services need to be explored and implemented as they offer the potential for warm handovers. **(West Coast)** Plans to be progressed within the Child and Youth Work Stream as identified for 2020-22. This is aligned with the rural early years work. Child Development Staff from Canterbury are working with West Coast services to standardise referral pathways , triage and develop health pathways for referrers for children with delayed development and disabilities so they can get support
	9.3 Explore opportunities and identify how to support a timely response for disabled people and	Improved pathway live	EMT member Jacqui Lunday Johnstone	December 2021	An allied health lead has been identified in Canterbury and the West Coast who will explore how to appropriately support improved access and response times for disabled people to these daily living aids.

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
	their families/whānau who require: – Aids to daily living – Housing modifications – Driving assessments				Review and amend Allied Health Ways in line with identified improvements. CDS Canterbury is working with West Coast for Child with developmental needs to ensure whanau have access to housing – ramps , wet area bathrooms, safety things and complex equipment – wheelchairs , mobility equipment etc
	9.4 The geographical equity across NZ of the provision of hearing aids will be explored and options considered.	Access to hearing aids is improved	Planning and Funding Kathy O'Neill	July 2021	An options paper will be presented to Planning and Funding based on the findings of the exploration. Next steps will be reliant on the recommendations made as a result of the options paper.
	9.5 Expanding the current shared plan pilot at New Brighton Health Centre and New Zealand Care to other large residential disability providers by: Specific disability field added to Acute Plan template where patient where clinicians can add details about client needs and risks Work with Health Care Home team to integrate electronic shared care planning into the work flow and standards of the primary care teams they are working with Guideline with a strong disability and equity focus shared with primary care outlining which	Increased planned care and decreased acute care	Canterbury Clinical Network – Rose Laing	Review progress quarterly	Primary care teams continue to be encouraged and supported to create care plans with their most vulnerable patients. Patient cantered care plan brochures have been distributed to primary care, public health and some NGOs.

Objectives	Priority Actions	Measure	Lead Responsibility	Completion Date Target	Progress Updates against measure (any other activity reported here)
	patients could benefit from a shared care plan Evaluate the potential effectiveness of this with the disability community.				
	9.6 Regular reporting occurs to the Disability Steering Group on the analysis of the Patient Experience Surveys response from disabled people. See also 2.4.	Improved environments support health and wellbeing	Quality and Patient Safety – Susan Wood	March 2021	First report to DSG meeting March 2021. Measures and quality improvements that are identified will be added to this Work Plan
Leadership (NZ Disability Strategy)					
10. Develop leadership of people with disabilities who have a role in the health system	10.1 A West Coast DHB Disability Leaders Working Group is formed and local Work Plan developed	Improved environments support health and wellbeing	Planning and Funding Kathy O'Neill	June 2021 October 2021	First call for EOI for members concluded September 2021. Only 2 members found. Re-circulate March 2021
11. Monitor quality	11.1 Develop measures and identify data sources that will provide baseline information about disabled people who are accessing the health system.	No wasted resource (Right care, in the right place, at the right time, delivered by the right person) Improved environments support health and wellbeing	Planning and Funding – Kathy O'Neill	June 2021	Kathy has engaged with Decision Support who will take this to South Island Information Services Alliance for the approval that the Alert button in SI Patient Information System (SIPICS) is used to identify type of impairment and needs.
	The CPHAC/DSAC Board Committee monitor progress against the priority actions.		DSG	Ongoing	Regular reports presented to DSAC

CDHB SUBMISSION: MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) AMENDMENT BILL

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

PREPARED BY: **Emma Kenagy, Community & Public Health**

APPROVED BY: **Executive Management Team**

DATE: **20 May 2021**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

Approval is sought for the attached submission to the Health Committee on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill. The submission has been approved by the Executive Management Team (*EMT*).

As per the CDHB Submissions Procedure, any submissions to a Select Committee must be approved by EMT, the Board and the Minister's Office.

2. RECOMMENDATION

That the Board:

i. approves CDHB's submission to the Health Committee on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill.

3. SUMMARY

Content in the submission was written and reviewed by relevant Specialist Mental Health Service (*SMHS*) Senior Medical Officers (*SMOs*) and the General Manager of SMHS.

The full Mental Health (Compulsory Assessment and Treatment) Amendment Bill and more information about the consultation can be found here: https://www.parliament.nz/en/pb/sc/make-a-submission/document/53SCHE_SCF_BILL_109428/mental-health-compulsory-assessment-and-treatment-amendment

The submission is due with the Health Committee on Friday, 21 May 2021.

4. APPENDICES

Appendix 1: Draft CDHB Submission on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Submission on Mental Health (Compulsory Assessment and Treatment) Amendment Bill

To: Canterbury District Health Board

Submitter: Canterbury District Health Board

Attn: Emma Kenagy
Community and Public Health
C/- Canterbury District Health Board
PO Box 1475
Christchurch 8140

Proposal: The Health Committee is calling for public submissions on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill. The bill seeks to improve the protection of individual rights and the safety of patients and the public. It also aims to enable the Mental Health (Compulsory Assessment and Treatment) Act 1992 to be applied more effectively.

SUBMISSION ON MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) AMENDMENT BILL

Details of submitter

1. Canterbury District Health Board (CDHB).

2. The submitter is responsible for promoting the reduction of adverse environmental effects on the health of people and communities and to improve, promote and protect their health pursuant to the New Zealand Public Health and Disability Act 2000 and the Health Act 1956. These statutory obligations are the responsibility of the Ministry of Health and, in the Canterbury District, are carried out under contract by Community and Public Health under Crown funding agreements on behalf of the Canterbury District Health Board.

Details of submission

3. Thank you for the opportunity to comment on the Mental Health (Compulsory Assessment and Treatment) Amendment Bill (the Bill).

4. The CDHB welcomes the amendments proposed and agrees with the explanatory note of the Bill. The changes are consistent with the protection of individual rights under the principal Act and will improve this process for many.

5. The CDHB supports the proposal and has provided a number of specific comments for consideration below.

Specific comments

6. The elimination of indefinite treatment orders carries an increase in clinical, administration and judicial input. To put this in context, there are close to 300 cases in the CDHB which fall into this category. The CDHB recommends that adequate administration and clinician funding is provided by the Ministry of Health for District Health Boards to meet these additional requirements.

7. The amendments do allow for some flexibility by *dispensing with examination and hearing* when consent from an individual is provided in writing with advice from an

independent party, such as a solicitor, but this might well be the case in a limited number only.

8. The CDHB supports the amendment that provides the opportunity for family or caregiver to be present via audio or visual link at the section 9 explanation to proposed patient. This is a difficult process for individuals and having support from family or caregivers, when they cannot be physically present due to geographical or other issues, will be of added benefit.

9. The CDHB supports the changes with regards to transport of special patients, as this provides for safe movement to different settings of care. This is an improvement to an issue that has been the subject of great concern for services and clinicians.

10. The CDHB supports the measures and safeguards put in place by requiring prior approval from the Director of Mental Health. This is a sound process, that follows on from others for patients under part 4 of the principal Act.

11. Amendments related to the COVID-19 Response are a prudent solution to the sunset clauses. The deadline for the changes is October 2021 and it is therefore important to have these imbedded before they expire.

Conclusion

12. The CDHB does not wish to be heard in support of this submission.

13. Thank you for the opportunity to submit on Mental Health (Compulsory Assessment and Treatment) Amendment Bill.

Person making the submission

Signature

Name Date: Click here to enter a date

Position

Contact details

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For and on behalf of
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FINANCE REPORT 31 MARCH 2021

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, Chief Executive**

DATE: **20 May 2021**

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 March **excluding** the impact of Covid-19, Holidays Act compliance, and gain on sale of the Bus Super Stop is unfavourable to plan by $3.092M (YTD $0.636M unfavourable);
ii. notes that the YTD impact of Covid-19 is an additional $0.976M net cost;
iii. notes that the YTD impact of the Holidays Act compliance is an additional $13.275M expense, and the full year impact is estimated to be approximately $18M; and
iv. notes the one-offs comprise the $4.2M loss on sale relating to the carpark land, offset by a $1.2M gain on sale of land for the council's Bus Super Stop.

3. FINANCIAL RESULTS EXECUTIVE SUMMARY

Summary DHB Group Financial Result excluding Covid-19, Holidays Act Compliance and net loss on Land Sales:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	(0.151)	(0.000)	(0.151)	(0.018)	(0.000)	(0.018)
Funder	(0.075)	(2.416)	2.341	(41.269)	(47.946)	6.677
DHB Provider	(16.036)	(10.753)	(5.283)	(65.879)	(58.584)	(7.295)
Canterbury DHB Group BAU Result	**(16.261)**	**(13.169)**	**(3.092)**	**(107.166)**	**(106.530)**	**(0.636)**
Covid-19 & Holidays Act & One-off	0.087	0.000	0.087	17.263	0.000	17.263
Canterbury DHB Group Result	**(16.348)**	**(13.169)**	**(3.179)**	**(124.429)**	**(106.530)**	**(17.899)**

4. KEY FINANCIAL RISKS

Savings plans – The savings plans were phased to increase significantly from January 2021, and $26.9M are phased in the final quarter. Actual savings have not reached the level expected and it is likely that we will not substantively achieve these savings. Note also that the 2019/20 savings plan had a Year 2 component totalling $17.2M, largely phased evenly over the full year ($12.7M phased up to March 2021).

Liquidity - We are forecasting that we will not need to use our overdraft facility until the third quarter of the 2021/22 financial year. As we will continue to incur deficits, we will require further equity support in the future.

Covid-19 – the forecasted impact of Covid-19 on CDHB's performance is dependent on several uncertain parameters. The forecast is based on current available information and does not include provision for additional revenue and costs that could result from a community outbreak, changes in Covid Alert Levels or the vaccination programme.

CDHB is managing six Managed Isolation Quarantine Facilities (*MIQFs*) and also providing support for contact tracing, laboratory testing, supporting the trans-Tasman travel bubble and managing the vaccination programme. Rolling out vaccinations to all frontline staff is in progress, and we are currently actively recruiting appropriate resources to deliver the programme.

Holidays Act Compliance – the workstream to determine CDHB's liability under the Holidays Act is continuing. We have accrued a liability based on an assessment from EY; there is risk the final amount differs significantly from this accrued amount.

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

5. APPENDICES

Appendix 1: Financial Results **including** the impact of Covid-19 and Holidays Act compliance
Appendix 2: Financial Result before indirect revenue & expenses **excluding** Covid-19 and Holidays Act compliance
Appendix 3: Group Income Statement
Appendix 4: Group Statement of Financial Position
Appendix 5: Group Statement of Cashflow

APPENDIX 1: FINANCIAL RESULTS INCLUDING THE IMPACT OF COVID-19 AND HOLIDAYS ACT COMPLIANCE

The following table shows the financial results, including the impact of Covid-19, Holidays Act compliance and other one off transactions for the month and year to date:

	Period to date								Year to date							
March 2021 Results	Month Actual $000	Month Budget $000	Month Variance F/(UF)	Covid-19 $000	Holidays Act $000	Other One Off	BAU Actual Result	Underlying Variance	YTD Actual $000	YTD Budget $000	YTD Variance F/(UF)	Covid-19 $000	Holidays Act $000	Other One Off	YTD BAU Actual Result	Underlying Variance
MOH Revenue	(165,000)	(162,732)	2,268	(1,424)			(163,576)	844	(1,480,733)	(1,464,592)	16,141	(10,496)			(1,470,237)	5,645
Patient related revenue	(5,545)	(4,716)	828	(1,143)			(4,402)	(314)	(52,635)	(41,427)	11,208	(10,283)			(42,352)	925
Other Revenue	(4,782)	(3,616)	1,166	(1,229)			(3,553)	(63)	(38,033)	(36,673)	1,360	(10,088)			(27,945)	(8,728)
Total Operating Revenue	(175,327)	(171,064)	4,263	(3,796)	-	-	(171,531)	466	(1,571,402)	(1,542,692)	28,710	(30,867)	-	-	(1,540,535)	(2,157)
Employee expenses	86,406	81,426	(4,980)	1,395	1,475		83,536	(2,110)	752,168	724,212	(27,956)	11,521	13,275		727,372	(3,160)
Treatment Related costs	17,507	14,665	(2,842)	1,180			16,328	(1,663)	134,929	124,635	(10,294)	6,836			128,093	(3,458)
External Provider costs	66,759	65,891	(868)	1,537			65,222	669	627,851	616,207	(11,644)	11,721			616,130	77
Other Expenses	11,287	10,832	(455)	(488)			11,775	(943)	93,904	96,882	2,978	1,758			92,146	4,736
Total Operating Expenditure	181,960	172,814	(9,145)	3,624	1,475	-	176,861	(4,047)	1,608,852	1,561,936	(46,916)	31,836	13,275	-	1,563,741	(1,805)
Operating result (Surplus) / Deficit	6,633	1,750	(4,883)	(173)	1,475	-	5,330	(3,580)	37,450	19,244	(18,207)	969	13,275	-	23,206	(3,963)
Total Indirect revenue and expenditure	9,715	11,419	1,704	7		(1,223)	10,931	488	86,979	87,286	307	7		3,012	83,960	3,326
Total - (Surplus) / Deficit	16,348	13,169	(3,179)	(166)	1,475	(1,223)	16,261	(3,092)	124,429	106,530	(17,899)	976	13,275	3,012	107,166	(636)

CDHB's result **excluding** the impact of Covid-19, Holidays Act compliance, and net loss on land sales (one-offs) is unfavourable both for the month and YTD.

Covid-19:

MoH revenue: In total, $14.86M of specific funding is available in 2020/21 for the Covid-19 response.

MOH revenue does not cover all of the external provider costs incurred to date, which relate mainly to community surveillance and testing. $10.5M has been recognised as revenue against expenditure of $13.6M YTD March. The shortfall of $3.1M is primarily driven by Covid-19 surveillance and testing. We expect to receive further funding before the end of the financial year.

Patient related revenue includes revenue for MIQFs. This funding covers our incremental costs provided our occupancy remains high, although there is a risk with the trans-Tasman bubble that occupancy rates will reduce.

Other revenue is from Covid-19 pathology tests processed by Canterbury Health Laboratories (CHL) for Canterbury and other regions.

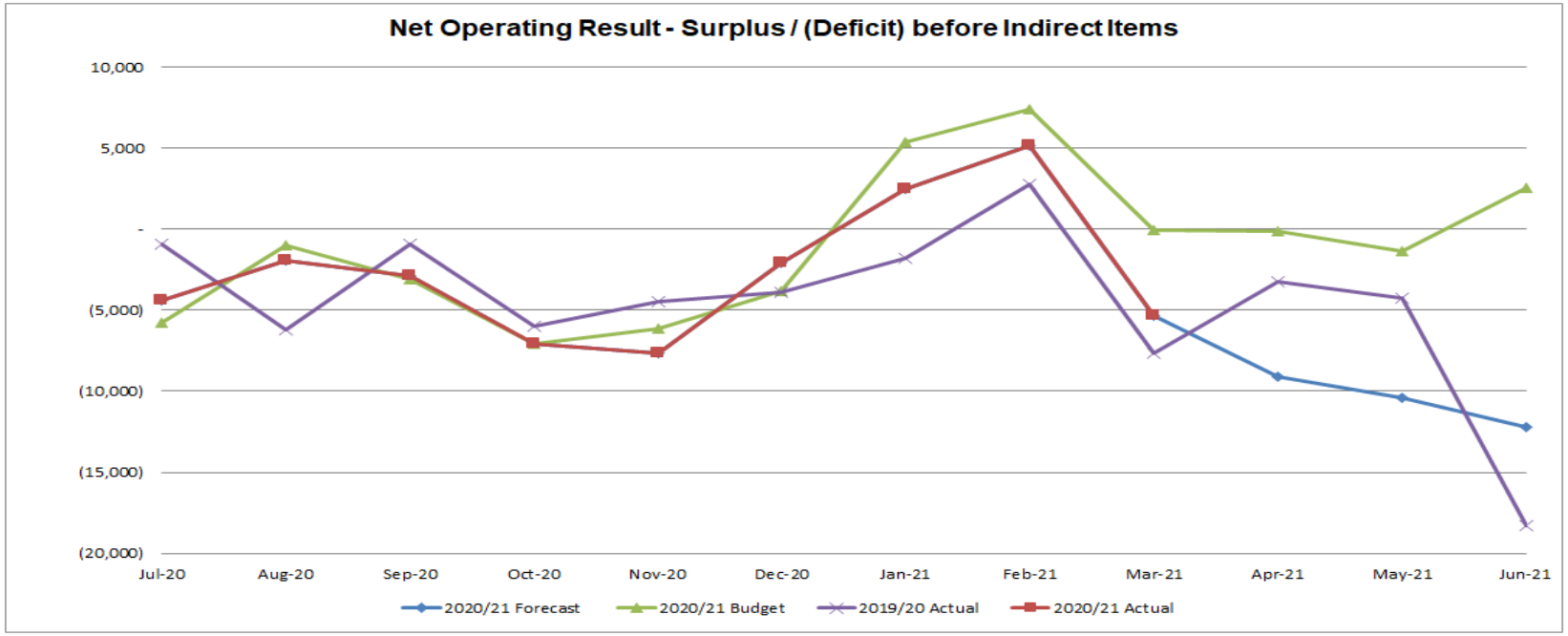
Personnel costs for Covid-19 mainly relate to the running of the MIQFs as well as lab testing.

Covid-19 vaccination programme: Rolling out the vaccinations to all frontline staff is in progress, and we are currently recruiting resources to deliver the rest of the programme. There is an assumption that these costs will be fully funded by the MoH.

APPENDIX 2: FINANCIAL RESULT BEFORE INDIRECT REVENUE & EXPENSES (excluding Covid-19, Holidays Act Compliance and net loss on sale of the staff carpark and Bus Super Stop land)

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 31 MARCH 2021

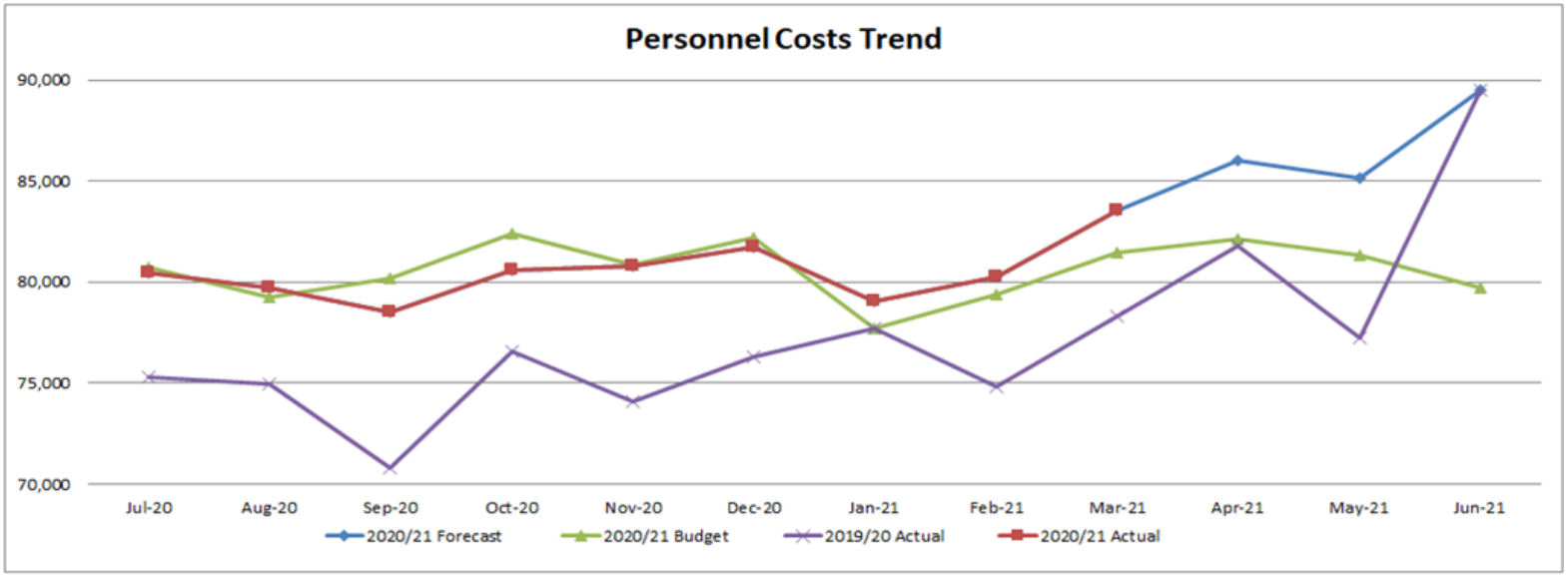
	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2019/20 Actual $'000	Yr End Budget $'000
Surplus/(Deficit) before Indirect items	(5,330)	(1,750)	(3,580)	205% ✗	(23,206)	(19,244)	(3,963)	21% ✗	(51,601)	(23,257)

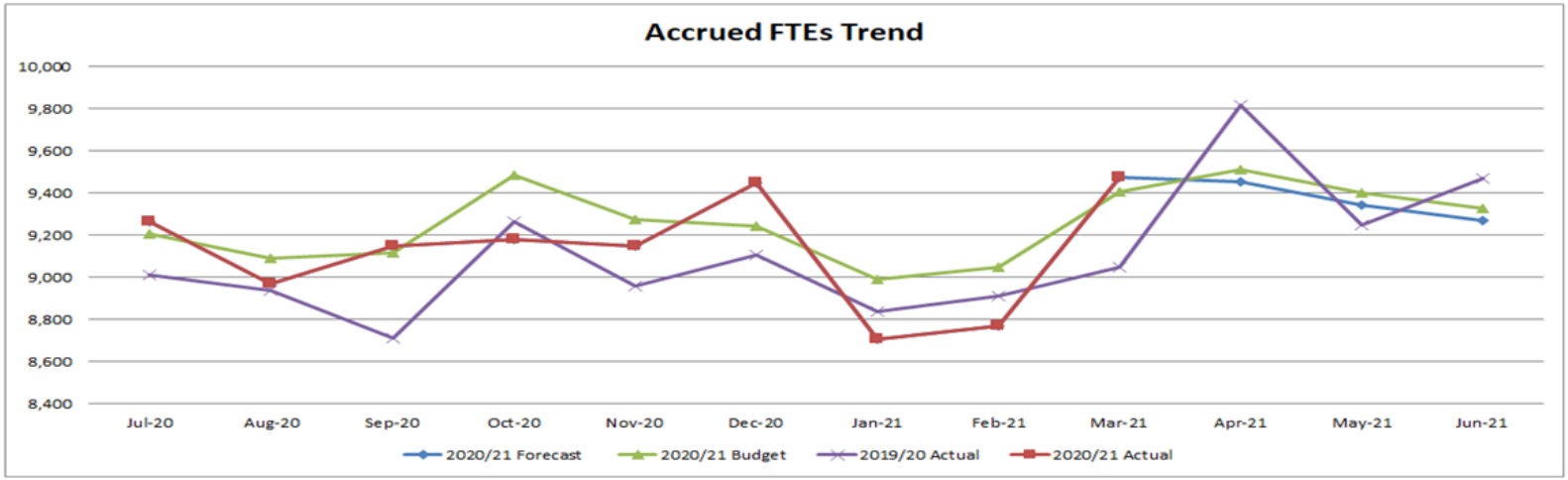


KEY RISKS AND ISSUES

Our YTD Business as Usual (BAU) result is $3.963M unfavourable to budget, and reflects savings that have not been fully realised; continuing this trend will see our YTD position deteriorate for the remainder of the year.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE



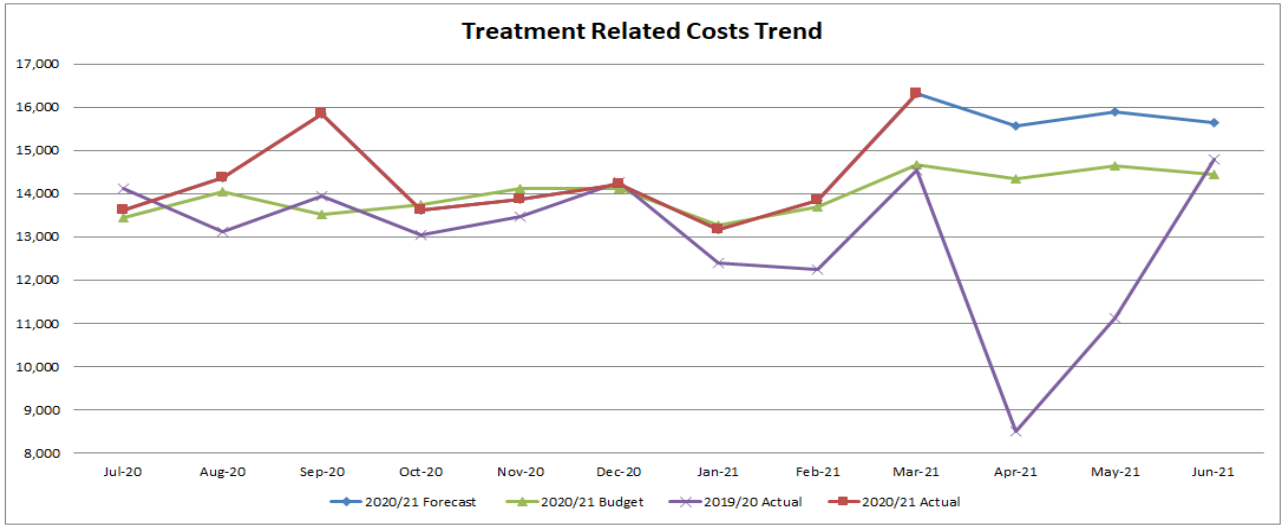


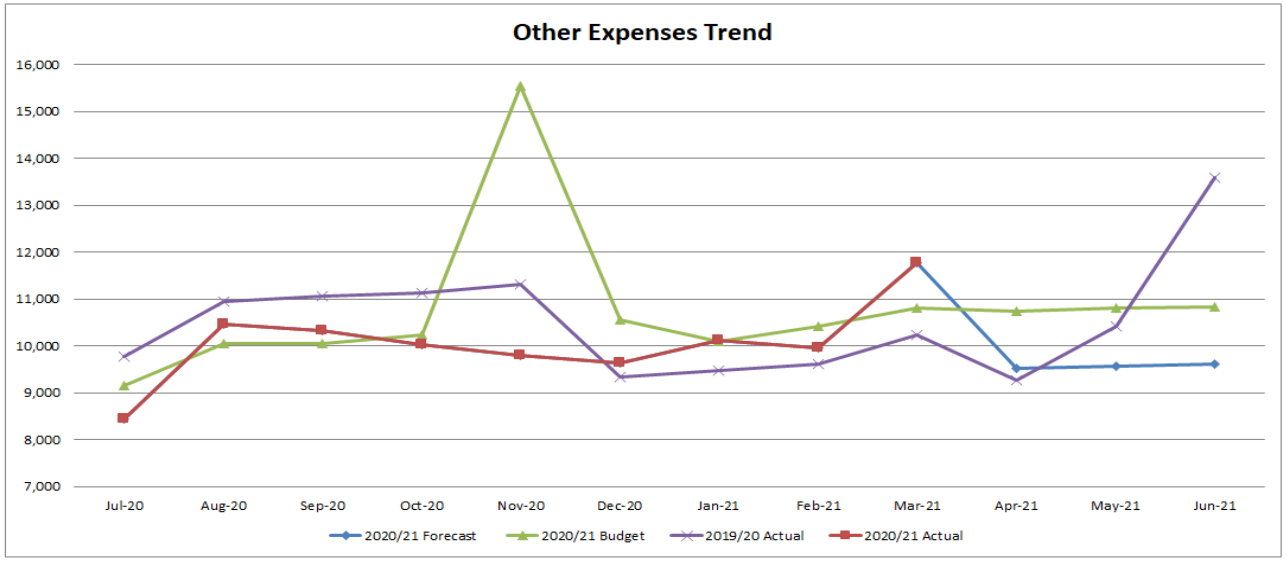
KEY RISKS AND ISSUES

Personal Costs Trend – YTD BAU personnel costs are unfavourable to budget partly due to not having reached our savings targets in this area, as well as high patient activity which contributed to additional expenditure for penal, overtime, and sick leave costs.

Accrued FTE is largely on track to plan.

TREATMENT & OTHER EXPENSES RELATED COSTS





KEY RISKS AND ISSUES

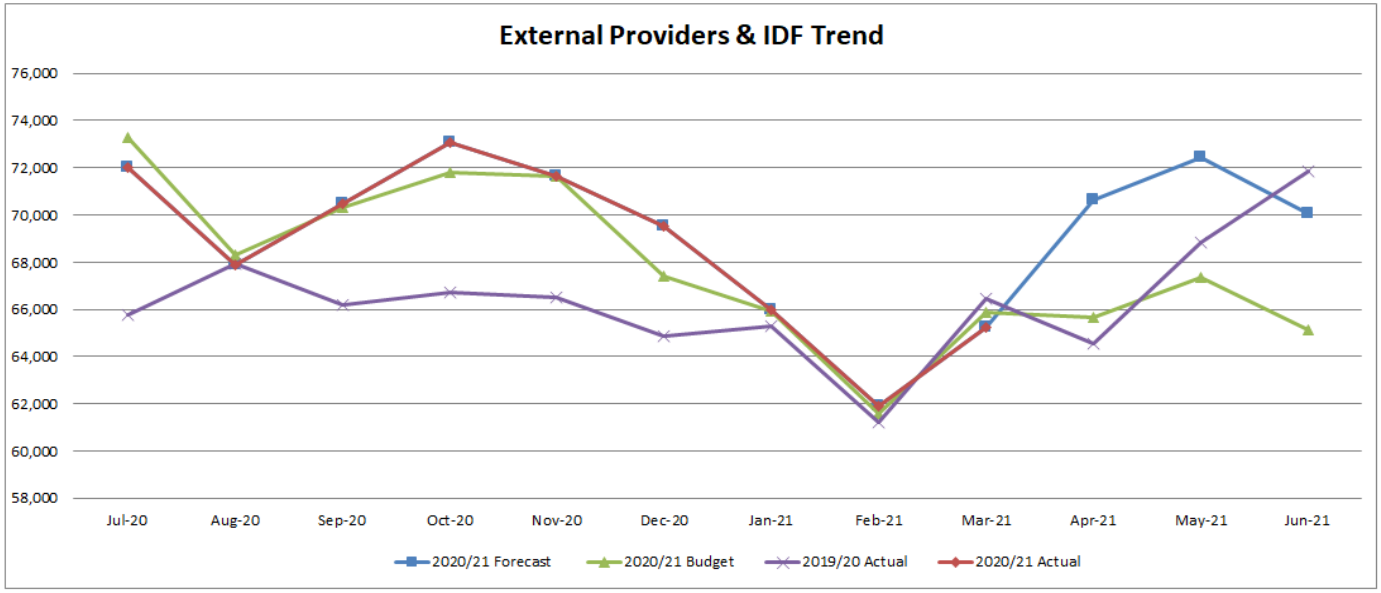
Treatment related costs:
YTD BAU treatment related costs are unfavourable to budget. The Emergency Department had its busiest month with ED attendances exceeding 10,000 presentations for the first time. The ED impact together with higher bed occupancy and outpatient activities has resulted in higher clinical costs for the month.

Note the BAU treatment related costs decrease in April 2020 primarily related to lower patient activity during the Covid-19 pandemic lock-down period.

Other expenses:
Earthquake repair expenditure is favourable to plan, and is equally offset by reduced revenue. The budget increase in November relates to the tunnel project and is equally offset by revenue; this was accrued in June 2020 and is therefore not in our year end forecast for the current year.

EXTERNAL PROVIDER COSTS EXCLUDING COVID-19

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2019/20 Actual $'000	Yr End Budget $'000
External Provider Costs	65,222	65,891	669	1% ✔	616,130	616,207	77	0% ✔	790,838	814,341



Community pharmacy costs are unfavourable to plan but this is offset by additional revenue. ARRC expenditure growth trend is continuing to be higher than plan.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000		YTD Actual $'000	YTD Budget $'000	Variance $'000	Year End 19/20 $'000
Equity	1,083,902	1,167,347	83,445	Cash	107,598	69,536	38,062	(6,966)

KEY RISKS AND ISSUES

Equity

We received equity support of $180M in October 2020 ($145M was budgeted in November and a further $41M in January 2021). This is offset by an opening unfavourable variance in July due to the additional Holidays Act compliance provision made at 30 June 2020.

We also had a large equity increase in November 2020 relating to the handover of the Waipapa facility.

Cash

Spend on the Mental Health facilities redevelopment continues and is expected to increase now construction has started. We are progressively drawing down equity from the Crown to cover the redevelopment costs.

APPENDIX 3: CANTERBURY DHB GROUP INCOME STATEMENT

The Group financial results include Canterbury DHB and its subsidiaries
For the 9 months ending 31 March 2021

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
165,000	162,732	156,734	2,268 ✓	MoH Revenue	1,480,733	1,464,592	1,391,210	16,141 ✓	1,980,426	1,952,782	1,864,766
5,545	4,716	4,837	828 ✓	Patient Related Revenue	52,635	41,427	39,798	11,208 ✓	69,518	55,498	53,364
4,782	3,616	3,591	1,166 ✓	Other Revenue	38,033	36,673	32,431	1,360 ✓	56,591	47,534	48,770
175,327	**171,064**	**165,162**	**4,263**	**Total Operating Revenue**	**1,571,402**	**1,542,692**	**1,463,439**	**28,710**	**2,106,535**	**2,055,814**	**1,966,900**
86,406	81,426	78,500	(4,980) ✗	Personnel Costs	752,168	724,212	679,067	(27,956) ✗	1,018,263	967,342	1,000,806
17,507	14,665	14,850	(2,842) ✗	Treatment Related Costs	134,929	124,635	121,424	(10,294) ✗	187,498	168,059	160,676
66,759	65,891	69,151	(868) ✗	External Service Providers	627,851	616,207	593,670	(11,644) ✗	847,764	814,341	810,046
11,287	10,832	10,467	(455) ✗	Other Expenses	93,904	96,882	93,042	2,978 ✓	123,952	129,329	130,109
181,960	**172,814**	**172,969**	**(9,145)** ✗	**Total Operating Expenditure**	**1,608,852**	**1,561,936**	**1,487,203**	**(46,916)** ✗	**2,177,476**	**2,079,071**	**2,101,637**
(6,633)	**(1,750)**	**(7,807)**	**(4,883)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**(37,450)**	**(19,244)**	**(23,764)**	**(18,207)** ✗	**(70,941)**	**(23,257)**	**(134,737)**
140	48	48	91 ✓	Interest Revenue	1,089	433	538	656 ✓	1,053	577	695
2,219	1,695	-	524 ✓	Capital Charge Relief / Debt Equity Swap Funding	6,212	5,085	-	1,127 ✓	11,150	10,170	8,220
238	243	1,013	(5) ✗	Donations	1,512	1,947	3,231	(435) ✗	2,674	2,674	3,674
1,235	-	0	1,235 ✓	Profit on Sale of Assets	1,762	-	15	1,762 ✓	1,762	-	17
3,831	**1,986**	**1,061**	**1,844** ✓	**Total Indirect Revenue**	**10,576**	**7,465**	**3,784**	**3,111** ✓	**16,639**	**13,421**	**12,606**
4,627	5,690	1,966	1,063 ✓	Capital Charge	26,027	31,692	19,712	5,665 ✓	40,146	48,762	38,136
8,698	7,607	7,014	(1,091) ✗	Depreciation	65,447	62,087	54,080	(3,360) ✗	89,902	85,108	79,829
234	-	-	(234)	Financing Component of Operating Leases	1,382	-	-	(1,382)	1,900	-	2,967
(13)	108	29	121 ✓	Interest Expense & Forex Gains and Losses	426	972	255	546 ✓	600	1,300	315
-	-	-	- ✓	Loss on Sale of Assets	4,272	-	53	(4,272) ✗	4,290	-	57
13,546	**13,405**	**9,010**	**(141)** ✗	**Total Indirect Expenses**	**97,555**	**94,751**	**74,100**	**(2,804)** ✗	**136,838**	**135,170**	**121,304**
(16,348)	**(13,169)**	**(15,755)**	**(3,179)** ✗	**Total Surplus / (Deficit)**	**(124,429)**	**(106,530)**	**(94,080)**	**(17,899)** ✗	**(191,139)**	**(145,006)**	**(243,436)**

APPENDIX 4: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 31 March 2021

Audited 30-Jun-20 $'000		Group Actual 31-Mar-21 $'000	Group Budget 31-Mar-21 $'000	Annual Group Budget 30-Jun-21 $'000
597,378	Opening Equity	490,730	558,272	558,272
136,588	Net Equity Injections / (Repayments) During Year	182,901	14,650	26,139
200	Other Movements	534,700	700,955	719,355
-	Reserve Movement for Year	(0)	-	-
(243,436)	Operating Results for the Period	(124,429)	(106,530)	(145,006)
490,730	**TOTAL EQUITY**	1,083,902	1,167,347	1,158,760
	Represented By:			
	Current Assets			
4,066	Cash & Cash Equivalents	107,598	69,536	31,443
750	Short Term Investments	750	750	750
105,853	Trade and Other Receivables	82,674	103,253	103,253
5,649	Prepayments	10,372	5,649	5,649
14,549	Inventories	15,189	14,549	14,549
14,666	Restricted Assets	14,576	14,425	14,425
145,533	**Total Current Assets**	231,159	208,162	170,069
	Less Current Liabilities			
11,032	Overdraft	-	-	-
205	Borrowings	1,392	-	-
165,170	Trade and Other Payables	171,301	167,308	150,239
14,693	Restricted Funds	14,869	14,256	14,256
343,643	Employee Benefits	362,549	277,644	277,644
534,743	**Total Current Liabilities**	550,112	459,208	442,139
(389,209)	**Working Capital**	(318,952)	(251,046)	(272,070)
	Non Current Assets			
16	Restricted Funds	16	16	16
3,225	Investment in NZHPL	3,064	3,225	3,225
909,554	Fixed Assets	1,455,044	1,421,456	1,433,893
912,795	**Term Assets**	1,458,123	1,424,697	1,437,134
	Non Current Liablilties			
6,304	Employee Benefits	6,679	6,304	6,304
26,552	Borrowings	48,591	-	-
32,856	**Term Liabilities**	55,270	6,304	6,304
490,730	**NET ASSETS**	1,083,902	1,167,347	1,158,760

Restricted Assets and Restricted Liabilities include funds held by the Māia Foundation on behalf of CDHB.

The Holidays Act compliance provision is shown under Employee Benefits, and was not included in the budget.

Borrowings in current and term liabilities is the finance lease liability for the Manawa and CLS buildings. The lease cost of the buildings is also included in Fixed Assets.

APPENDIX 5: CASHFLOW

Audited 30-Jun-20 $'000		Actual 31-Mar-21 $'000	YTD Budget 31-Mar-21 $'000	Budget 30-Jun-21 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(48,135)	**Net Cash from Operating Activities**	(22,268)	(39,900)	(72,459)
	CASHFLOW FROM INVESTING ACTIVITIES			
(63,551)	**Net Cash from Investing Activities**	(45,431)	(74,493)	(109,917)
	CASHFLOW FROM FINANCING ACTIVITIES			
136,529	**Net Cash from Financing Activities**	182,263	190,895	220,785
24,843	Overall Increase/(Decrease) in Cash Held	114,564	76,502	38,409
(31,809)	Add Opening Cash Balance	(6,966)	(6,966)	(6,966)
(6,966)	**Closing Cash Balance**	107,598	69,536	31,443

MĀORI AND PACIFIC HEALTH PROGRESS REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **20 May 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report provides an update on progress and activities pertaining to Māori and Pacific Health.

2. RECOMMENDATION

That the Board:

i. notes the Māori and Pacific Health Progress Report.

3. DISCUSSION

Māori Health Dashboard

Green – the target has been met for Māori

- Early intervention; ASH children aged 0-4 years, rate per 100,000.
- B4 School Check; children receiving B4SC by age 4 years.
- B4 School Check; children with a BMI > 98th percentile are referred to a health specialist.
- Cancer; women aged 50-69 years who had a breast screen in the previous two years.

Orange – the target has not been met for Māori, however, performance is improving

- Breastfeeding; babies exclusively/fully breastfed at 3 months old.
- Oral health; pre-school children (aged 0-4 years) enrolled with school and community dental services.
- Oral health; children caries free (no holes or fillings) at age 5 years.
- Immunisation; eligible girls receiving final dose of the HPV vaccination.
- Smokefree; women smokefree at two weeks postnatal.
- Cancer; women aged 25-69 years who had a cervical screen in the previous three years.
- Early intervention; ASH adults (aged 45-64), rate per 100 000 people.
- Immunisation - influenza; people aged over 65 who have had a seasonal influenza vaccination.

Red – the target has not been met for Māori and performance is declining

- Breastfeeding; babies exclusively/fully breastfed at LMC discharge.
- Immunisation; eight-month-old children fully vaccinated.
- Mental health; rate of Community Treatment Orders.
- Engagement; population enrolled with a PHO.

The Māori health dashboards continue to show strong performance from B4 school checks and early intervention; Ambulatory Sensitive Hospitalisations for children aged 0-4 years.

Ambulatory sensitive hospitalisations (*ASH*) are mostly acute admissions that are considered potentially reducible through interventions deliverable in a primary care setting. ASH rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

Breast screening has also been a consistent high performing target.

Alternatively, there are areas where we have not performed well recently.

Babies exclusively/fully breastfed at LMC discharge is an area that has remained at a similar level for many years. Throughout NZ this indicator has been a consistently poor performer, likely due the external economic pressures on women to return to work rather than stay at home to continue breastfeed.

Immunisation; eight-month-old children fully vaccinated has been low this reporting period and normally we are able to catch this up before the child turns one, however, the COVID-19 vaccination roll out may impact further on this indicator. This is a disappointing result because in past years Canterbury has often led the country in this indicator.

PHO enrolment has improved in the past decade, but there is still much work to do.

Mental health - rate of Community Treatment Orders is another consistently poor result.

There are a number of targets that have not been met for Māori, however, performance is showing promise and improvement. Of particular note is the steady improvement in cervical screening rates and the commensurate slow reduction in the equity gap between Māori and non-Māori. Credit must go to Screen South, who have consistently performed well in breast screening and are now the service provider for cervical screen, using a similar delivery model to breast screening.

There has also been steady improvement in the oral health target for pre-school children (aged 0-4 years) enrolled with school and community dental services and children that are caries free (no holes or fillings) at age 5 years.

In immunisation services there has been improvement for eligible girls receiving final dose of the HPV vaccination alongside influenza for people aged over 65 who have had a seasonal influenza vaccination. The influenza vaccination improvement can be credited to Kaupapa Māori providers who received funding last year to improve influenza vaccination because of the COVID-19 threat.

It is equally pleasing to see improvement in smokefree rates of women at two weeks postnatal and the ASH rates for Māori adults (aged 45-64).

Pasifika Health Dashboard

Green – the target has been met for Pasifika

- Early intervention; ASH children aged 0-4 years, rate per 100,000.
- Early intervention; ASH adults aged 44-64 years, rate per 100,000.
- B4 School Check; children receiving B4SC by age 4 years.
- B4 School Check; children with a BMI > 98th percentile are referred to a health specialist.
- Smoking; women who are smokefree at two weeks postnatal.

Orange – the target has not been met for Pasifika however performance is improving

- Breastfeeding; babies exclusively/fully breastfed at 3 months old.
- Oral health; pre-school children (aged 0-4 years) enrolled with school and community dental services.
- Oral health; children caries free (no holes or fillings) at age 5 years.
- Immunisation - influenza; people aged over 65 who have had a seasonal influenza vaccination.
- Cancer; women aged 50-69 years who had a breast screen in the previous two years.

Red – the target has not been met for Pasifika and performance is declining

- Breastfeeding; babies exclusively/fully breastfed at LMC discharge.
- Immunisation; eligible girls receiving final dose of the HPV vaccination.
- Immunisation; eight month old children fully vaccinated.
- Cancer; women aged 25-69 years who had a cervical screen in the previous three years.
- Engagement; population enrolled with a PHO.

There are some very pleasing results for our Pasifika targets in this reporting period. Like our Māori population dashboards, they continue to show strong performance from B4 school checks and early intervention; Ambulatory Sensitive Hospitalisations for Pasifika children (aged 0-4 years) and Pasifika adults (aged 44-64 years) are both pleasing results alongside the target for smoking reduction; women who are smokefree at two weeks postnatal.

There are similarities between both Māori and Pasifika in both the orange and red indicators. It is disappointing to see the drop in PHO enrolment, especially given that in previous reporting periods we frequently exceeded that target. There is also much work to do in Pasifika childhood and HPV immunisation as well as cervical screening.

HQSC Māori Health Equity Report

Also attached to this update (Appendix 3) is an HQSC Māori Health Equity Report from their online tool.

4. APPENDICES

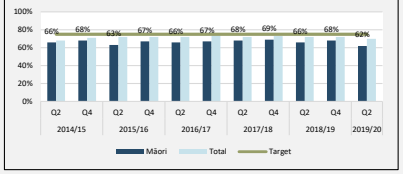
Appendix 1: Māori Health Dashboard April 2021
Appendix 2: Pasifika Health Dashboard April 2021
Appendix 3: HQSC Māori Health Equity Report for CDHB April 2021

Canterbury DHB Māori Health Dashboard
April 2021

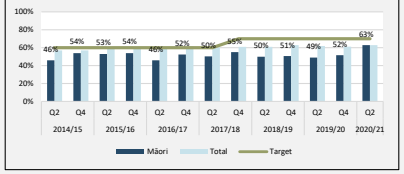
The target is met for Māori
The target has not been met for Māori however performance is improving
The target has not been met and performance is declining

Tamariki Health and Wellbeing

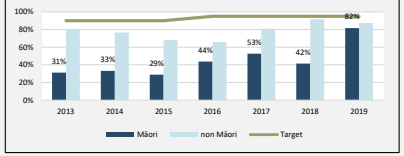
BREASTFEEDING
Babies exclusively / fully breastfed at LMC discharge



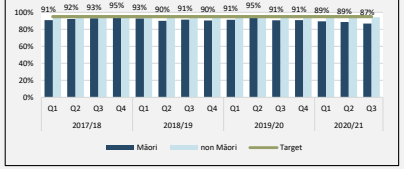
BREASTFEEDING
Babies exclusively / fully breastfed at 3 months old



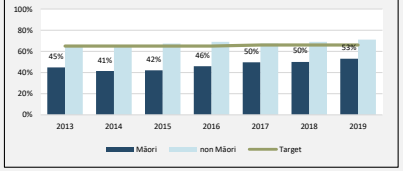
ORAL HEALTH
Pre-school children (aged 0-4 years) enrolled with school and community dental services



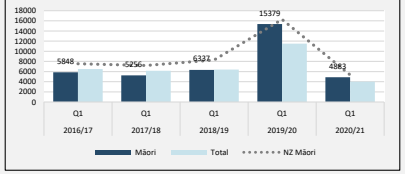
IMMUNISATION
Eight month old children fully vaccinated



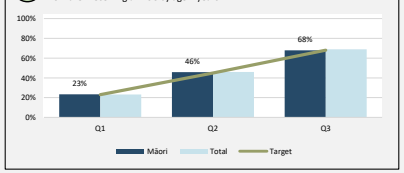
ORAL HEALTH
Children caries free (no holes or fillings) at age 5 years



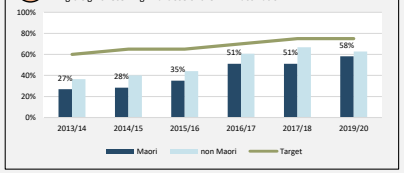
EARLY INTERVENTION
ASH children (aged 0-4), rate per 100 000 people



B4SCHOOL CHECK
Children receiving a B4SC by age 4 years

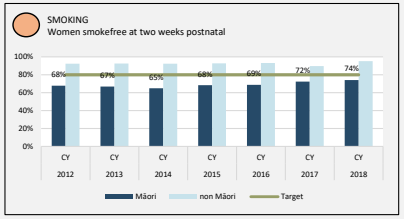


IMMUNISATON
Eligible girls receiving final dose of the HPV vaccination

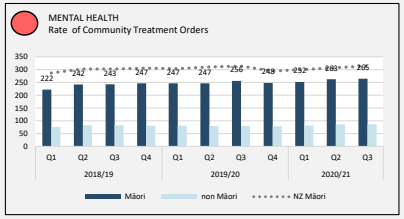


Adult Health and Wellbeing

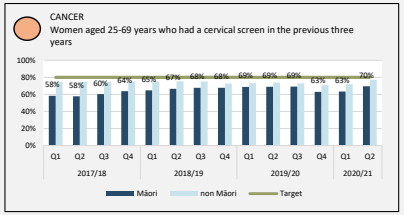
SMOKING
Women smokefree at two weeks postnatal



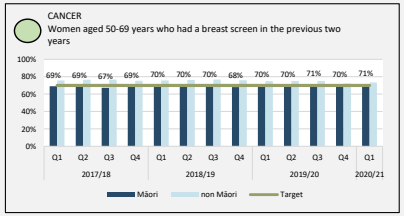
MENTAL HEALTH
Rate of Community Treatment Orders



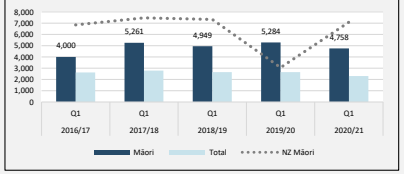
CANCER
Women aged 25-69 years who had a cervical screen in the previous three years



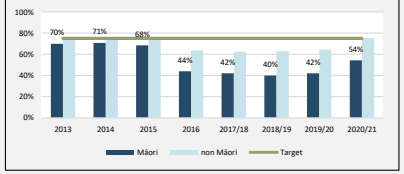
CANCER
Women aged 50-69 years who had a breast screen in the previous two years



EARLY INTERVENTION
ASH adults (aged 45-64), rate per 100 000 people

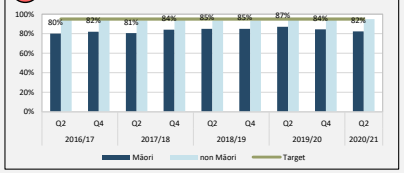


IMMUNISATION - INFLUENZA
People aged over 65 who have had a seasonal influenza vaccination

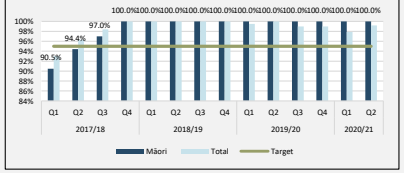


Enablers to support Improved Health and Wellbeing

ENGAGEMENT
Population enrolled with a PHO



B4 SCHOOL CHECK
Children with a BMI >98th percentile are referred to a health specialist

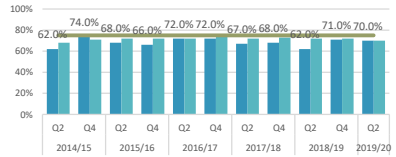


Kia whakakotahi te hoe o te waka
WE PADDLE OUR WAKA AS ONE

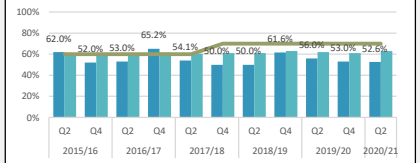
Canterbury DHB Pacific Health Dashboard
April 2021

- The target is met for Pacific
- The target has not been met for Pacific however the trend is improving
- The target has not been met for Pacific and performance is decreasing or there is significant inequity

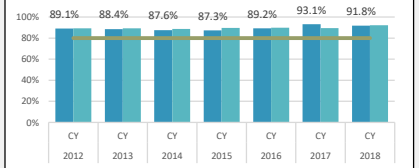
BREASTFEEDING
Babies exclusively / fully breastfed at LMC discharge



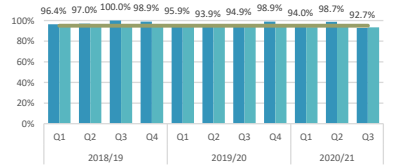
BREASTFEEDING
Babies exclusively and fully breastfed at 3 months



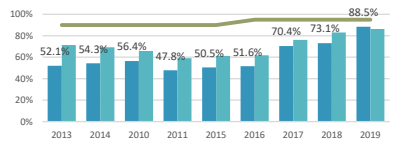
SMOKING
Women who are smokefree at two weeks postnatal



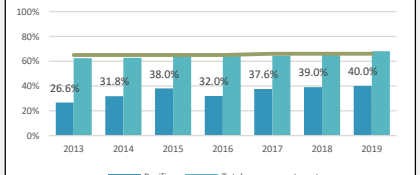
IMMUNISATION
Infants fully immunised by eight months of age



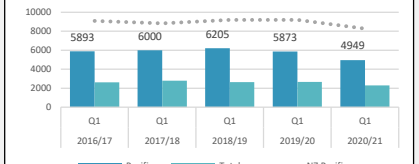
ORAL HEALTH
Children aged under 5 enrolled in DHB community oral health service



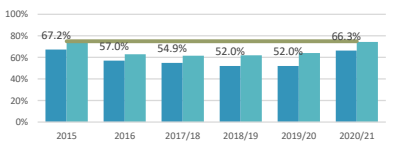
ORAL HEALTH
Children carries-free (no holes or fillings) at age 5



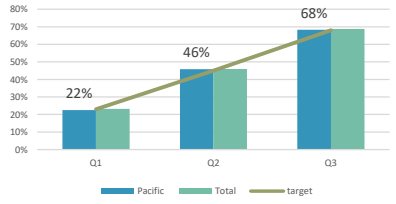
EARLY INTERVENTION
ASH rate for adults 45-64 years old, per 100,000 population



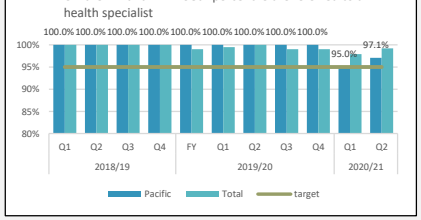
IMMUNISATION
People aged over 65 years who have had a seasonal influenza vaccination



Percentage of children receiving a B4SC by age 4 years

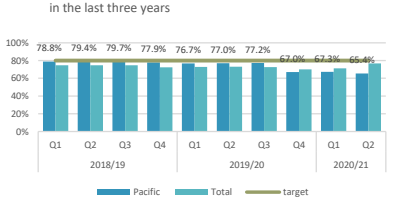


EARLY INTERVENTION
Children with a BMI >98th percentile are referred to a health specialist

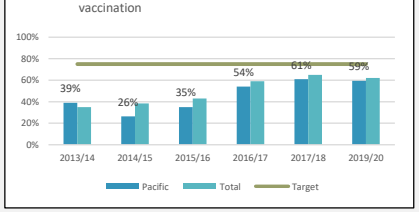


CANCER
Women aged 50-69, who have had a breastscreen once in the last two years

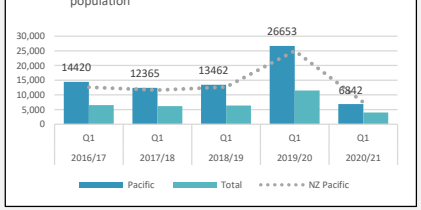
CANCER
Women aged 25-69, who have had a cervical smear once in the last three years



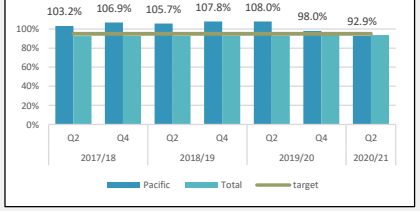
IMMUNISATION
Eligible children receiving final dose of the HPV vaccination



EARLY INTERVENTION
ASH rate for children 0-4 years old, per 100,000 population



ENGAGEMENT
Population enrolled with a PHO

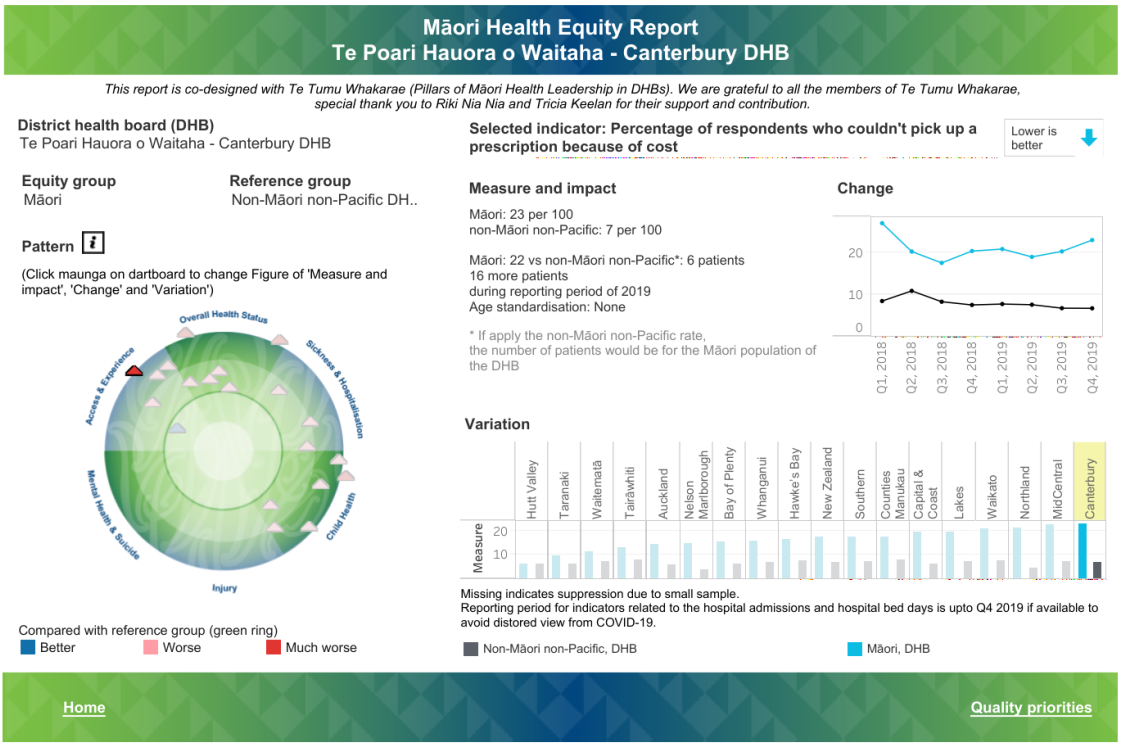


HQSC Māori Health Equity Report

This report is an online tool that enables an insight into equity indicators throughout NZ and by DHB. Below are snapshots of a range of these indicators showing, like all DHBs, there is wide variation in performance. I some areas, CDHB is one of the leading DHBs and in others we have mediocre or poor performance.

The value of such a tool is monitoring progress and providing data to target areas of poor performance. The link to the report is below. It is well worth visiting and exploring the data contained within.

(https://public.tableau.com/profile/hqi2803#!/vizhome/Healthsystemqualitydashboard12Feb2021/1_Home)



Māori Health Equity Report
Te Poari Hauora o Waitaha - Canterbury DHB

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District health board (DHB)
Te Poari Hauora o Waitaha - Canterbury DHB

Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Percentage of respondents who couldn't visit a GP or nurse because of cost

Lower is better

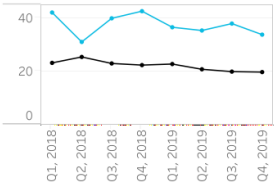
Measure and impact

Māori: 34 per 100
non-Māori non-Pacific: 20 per 100

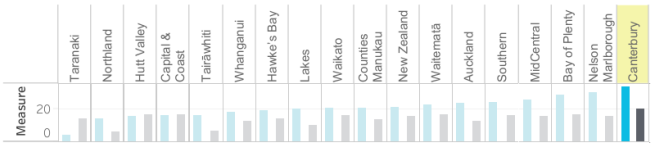
Māori: 43 vs non-Māori non-Pacific*: 25 patients
18 more patients
during reporting period of 2019
Age standardisation: None

* If apply the non-Māori non-Pacific rate, the number of patients would be for the Māori population of the DHB

Change



Variation



Missing indicates suppression due to small sample.
Reporting period for indicators related to the hospital admissions and hospital bed days is upto Q4 2019 if available to avoid distored view from COVID-19.

Non-Māori non-Pacific, DHB Māori, DHB

Home Quality priorities

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District health board (DHB)
Te Poari Hauora o Waitaha - Canterbury DHB

Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Percentage of respondents who couldn't get health care from a GP or nurse

Lower is better

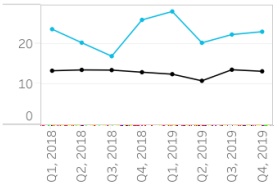
Measure and impact

Māori: 23 per 100
non-Māori non-Pacific: 13 per 100

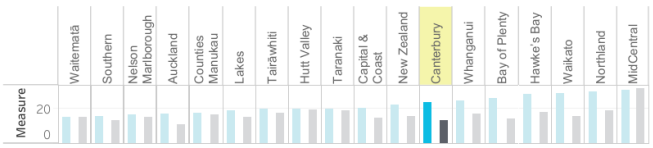
Māori: 29 vs non-Māori non-Pacific*: 17 patients
12 more patients
during reporting period of 2019
Age standardisation: None

* If apply the non-Māori non-Pacific rate, the number of patients would be for the Māori population of the DHB

Change



Variation



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Non-Māori non-Pacific, DHB Māori, DHB

Home Quality priorities

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District health board (DHB)
Te Poari Hauora o Waitaha - Canterbury DHB

Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Percentage of respondents who felt involved in decisions about their care and treatment

Higher is better

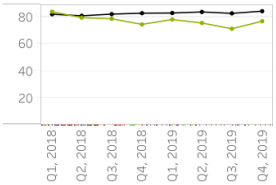
Measure and impact

Māori: 77 per 100
non-Māori non-Pacific: 85 per 100

Māori: 94 vs non-Māori non-Pacific*: 103 patients
9 fewer patients
during reporting period of 2019
Age standardisation: None

* If apply the non-Māori non-Pacific rate, the number of patients would be for the Māori population of the DHB

Change



Variation

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Non-Māori non-Pacific, DHB Māori, DHB

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District health board (DHB)
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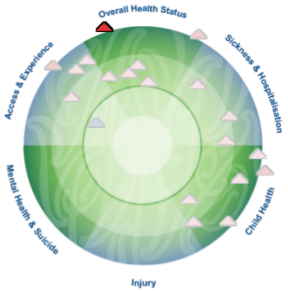
Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')



Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Heart failure hospitalisation, 35 plus years, rate per 100,000 population

Lower is better

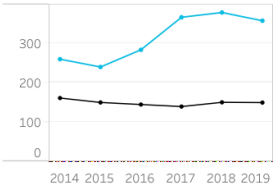
Measure and impact

Māori: 356 per 100000
non-Māori non-Pacific: 148 per 100000

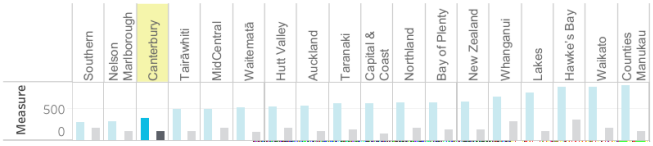
Māori: 67 vs non-Māori non-Pacific*: 28 hospitalisations
39 more hospitalisations
during reporting period of 2019
Age standardisation: Māori population 2013

* If apply the non-Māori non-Pacific rate, the number of hospitalisations would be for the Māori population of the DHB

Change



Variation



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Non-Māori non-Pacific, DHB Māori, DHB

Home Quality priorities

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Te Poari Hauora o Waitaha - Canterbury DHB

Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Age standardised amenable mortality rate per 100,000 population

Lower is better

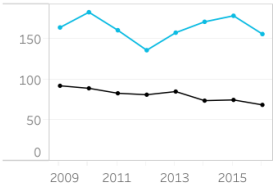
Measure and impact

Māori: 156 per 100000
non-Māori non-Pacific: 69 per 100000

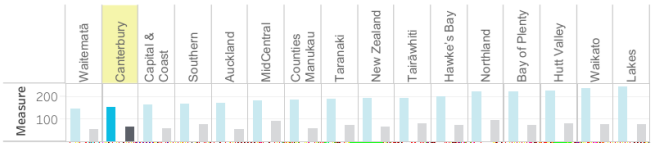
Māori: 62 vs non-Māori non-Pacific*: 27 death
35 more death
during reporting period of 2016
Age standardisation: WHO population

* If apply the non-Māori non-Pacific rate, the number of death would be for the Māori population of the DHB

Change



Variation



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Non-Māori non-Pacific, DHB Māori, DHB

Home Quality priorities

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District health board (DHB)
Te Poari Hauora o Waitaha - Canterbury DHB

Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Life expectancy at birth 2012

Higher is better

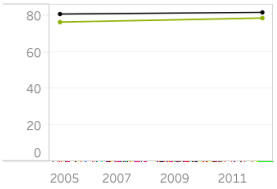
Measure and impact

Māori: 79
non-Māori: 82

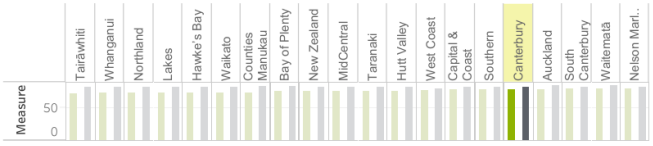
Māori: 79 vs non-Māori*: 82 years
3 fewer years
during reporting period of 2012
Age standardisation: None

* If apply the non-Māori rate, the number of years would be for the Māori population of the DHB

Change



Variation



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Non-Māori non-Pacific, DHB Māori, DHB

Home Quality priorities

Māori Health Equity Report
Te Poari Hauora o Waitaha - Canterbury DHB

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District health board (DHB)
Te Poari Hauora o Waitaha - Canterbury DHB

Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Total cardiovascular disease mortality rates, 35 plus years, rate per 100,000 population

Lower is better

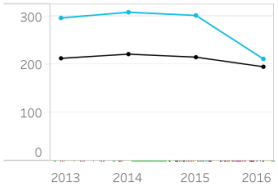
Measure and impact

Māori: 211 per 100000
non-Māori non-Pacific: 195 per 100000

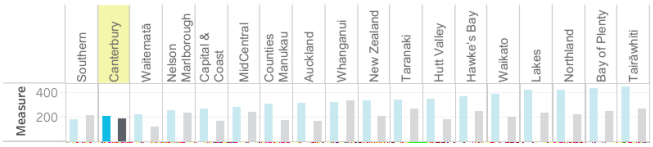
Māori: 36 vs non-Māori non-Pacific*: 33 death
3 more death
during reporting period of 2016
Age standardisation: Māori population 2013

* If apply the non-Māori non-Pacific rate, the number of death would be for the Māori population of the DHB

Change



Variation



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Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Average number of decayed, missing and filled teeth per child of 5 years old of areas with water fluoridation

Lower is better

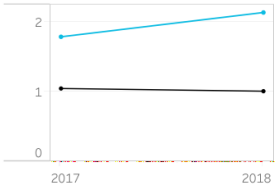
Measure and impact

Māori: 2
non-Māori non-Pacific: 1

Māori: 17 vs non-Māori non-Pacific*: 8 teeth
9 more teeth
during reporting period of 2018
Age standardisation: None

* If apply the non-Māori non-Pacific rate, the number of teeth would be for the Māori population of the DHB

Change



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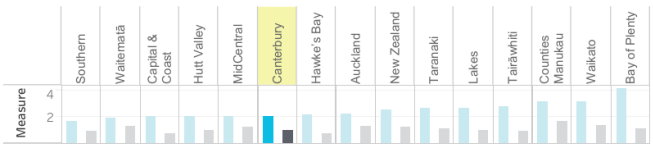

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Equity group
Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Immunisation rate per 100 eligible children at age 2

Higher is better

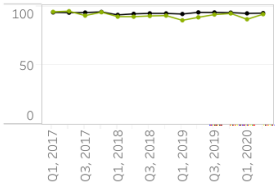
Measure and impact

Māori: 94 per 100
non-Māori: 95 per 100

Māori: 241 vs non-Māori*: 243 children
2 fewer children
during reporting period of quarter 2, 2020
Age standardisation: None

* If apply the non-Māori rate, the number of children would be for the Māori population of the DHB

Change



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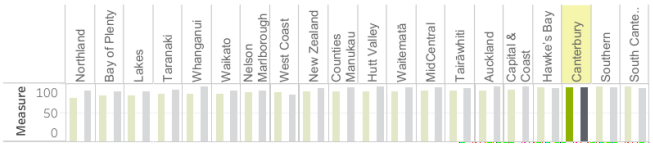

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Māori

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Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Ambulatory sensitive hospitalisation (ASH) 0–4-year old admissions per 100,000 population

Lower is better

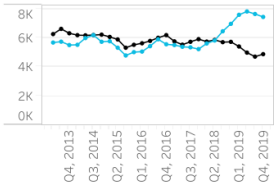
Measure and impact

Māori: 7,466 per 100000
non-Māori non-Pacific: 4,898 per 100000

Māori: 442 vs non-Māori non-Pacific*: 290 hospitalisations
152 more hospitalisations
during reporting period of year end quarter 4, 2019
Age standardisation: None

* If apply the non-Māori non-Pacific rate, the number of hospitalisations would be for the Māori population of the DHB

Change



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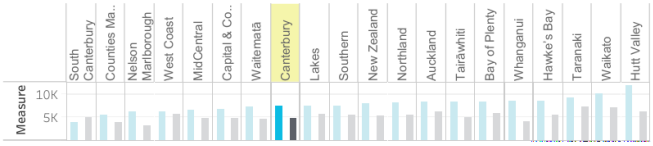

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Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Percentage of children aged 5 years with caries free of areas with non-fluoridated water

Higher is better

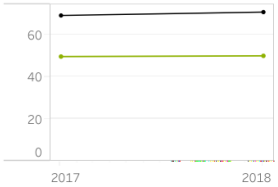
Measure and impact

Māori: 50 per 100
non-Māori non-Pacific: 71 per 100

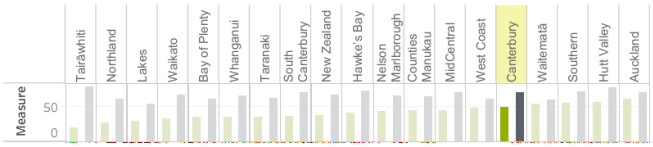
Māori: 404 vs non-Māori non-Pacific*: 573 children
169 fewer children
during reporting period of 2018
Age standardisation: None

* If apply the non-Māori non-Pacific rate, the number of children would be for the Māori population of the DHB

Change



Variation



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Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

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Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Diabetes prevalence rate per 100 population

Lower is better

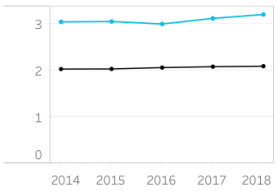
Measure and impact

Māori: 3 per 100
non-Māori non-Pacific: 2 per 100

Māori: 1,643 vs non-Māori non-Pacific*: 1,071 patients
571 more patients
during reporting period of 2018
Age standardisation: Māori population 2013

* If apply the non-Māori non-Pacific rate, the number of patients would be for the Māori population of the DHB

Change



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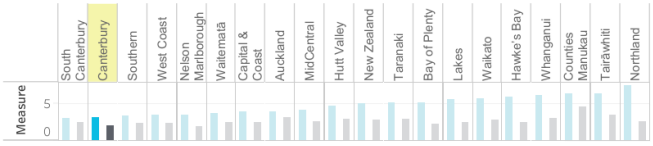

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Reference group
Non-Māori non-Pacific DH..

Pattern

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Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Age standardised amenable mortality rate per 100,000 population

Lower is better

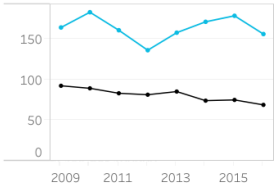
Measure and impact

Māori: 156 per 100000
non-Māori non-Pacific: 69 per 100000

Māori: 62 vs non-Māori non-Pacific*: 27 death
35 more death
during reporting period of 2016
Age standardisation: WHO population

* If apply the non-Māori non-Pacific rate, the number of death would be for the Māori population of the DHB

Change



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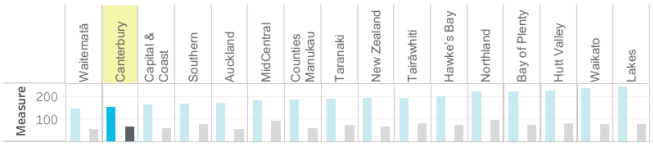

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Māori, DHB

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Māori

Reference group
Non-Māori non-Pacific DH..

Pattern

(Click maunga on dartboard to change Figure of 'Measure and impact', 'Change' and 'Variation')

Compared with reference group (green ring)
Better Worse Much worse

Selected indicator: Total cardiovascular disease mortality rates, 35 plus years, rate per 100,000 population

Lower is better

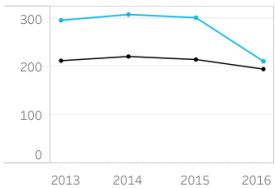
Measure and impact

Māori: 211 per 100000
non-Māori non-Pacific: 195 per 100000

Māori: 36 vs non-Māori non-Pacific*: 33 death
3 more death
during reporting period of 2016
Age standardisation: Māori population 2013

* If apply the non-Māori non-Pacific rate, the number of death would be for the Māori population of the DHB

Change



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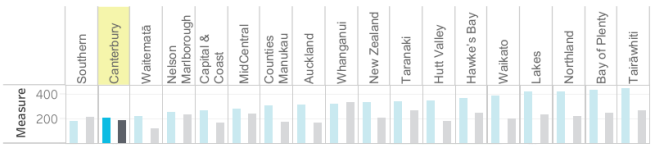

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Non-Māori non-Pacific, DHB
Māori, DHB

Home Quality priorities

CPH&DSAC – 6 MAY 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Aaron Keown, Chair, Community & Public Health & Disability Support Advisory Committee**

DATE: **20 May 2021**

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 Community & Public Health and Disability Support Advisory Committee's (*CPH&DSAC*) meeting held on 6 May 2021.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from CPH&DSAC's meeting on 6 May 2021 (Appendix 1).

3. APPENDICES

Appendix 1: CPH&DSAC Draft Minutes – 6 May 2021.

MINUTES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 6 May 2021 commencing at 1.00pm

PRESENT

Aaron Keown (Chair); Tom Callanan; Catherine Chu; Rochelle Faimalo; Jo Kane; Naomi Marshall; and Yvonne Palmer.

Attending via Zoom: Gordon Boxall; Rawa Karetai; and Olive Webb.

APOLOGIES

An apology for absence was received and accepted from Sir John Hansen (Ex-officio).
An apology for late arrival (1.35pm) and early departure (2.40pm) was received and accepted from Gordon Boxall.

EXECUTIVE SUPPORT

Evon Currie (General Manager, Community & Public Health); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Dr Jacqui Lunday-Johnstone (Director of Allied Health, Scientific & Technical); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES

Apologies for absence were received from Dr Peter Bramley, Chief Executive; and Hector Matthews, Executive Director of Māori & Pacific Health.

IN ATTENDANCE

Full Meeting

Kathy O'Neill, Team Leader, Primary Care, Planning & Funding

Items 6 & 7

Grant Cleland, Chair, Disability Steering Group

Item 8

Janice Donaldson, Portfolio Manager, Māori Health, Planning & Funding

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
There were no additions/alterations to the interest register.

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

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

2. CONFIRMATION OF MINUTES

Resolution (03/21)
(Moved: Aaron Keown/Seconded: Yvonne Palmer – carried)

"That the minutes of the meeting of the Community & Public Health and Disability Support Advisory Committee held on 4 March 2021 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

Item 1: Lessons Learnt from the Audit of Outpatients Toilet Rooms. Dr Jacqui Lunday-Johnstone advised that an audit was undertaken following a complaint from a disability perspective. Work is underway with the Facilities team around remediation.

There was discussion around the design of the Waipapa showers.

Dr Lunday-Johnstone noted that the differential between code and what people actually need is problematic for us. The code is the minimum and it does not really meet either our expectations as a provider or those of the people who use our services. Dr Lunday-Johnstone commented that she has raised this issue with the Deputy Director General of Disability, reflecting that it would be very helpful if the Ministry of Health (*MoH*) could take a stronger line around the use of the Australasian standards for hospital settings, because they would be significantly closer to our aspirations to provide an environment that is actually fit for purpose. It is important to get the balance right.

Item 2: DSG Waipapa Visit. Dr Lunday-Johnstone provided an update on issues raised following DSG's Waipapa visit. She noted that some issues are easy fixes, while others are not (eg, shifting the location of a disability toilet). The Accessibility team is working with the Facilities team on these.

There was a query about signage and the reasons why it is not all a mix of Te Reo and English.

Ms Lunday-Johnstone undertook to provide a paper to the next meeting picking up on the various issues raised, as well as revisiting the outcomes of the visit to Waipapa.

Item 3: Covid-19 – Older Population Not Receiving Their Cares – Poor Communication. Raise with Canterbury Provider Network and Older Persons Health Team. Tom Callanan advised that he had raised this at the Canterbury Provider Network forum, noting there was not any significant feedback. He will continue to raise this at future meetings.

Kathy O'Neill, Team Leader, Primary Care, Planning & Funding, advised she took this up with Mardi Postil, Team Leader, Older Person's Health. Ms Postil provided feedback around the three community support providers that we have contracted with the CDHB to provide these home support services. The providers support 6,000 clients across the Canterbury region. While they endeavour to get to all scheduled appointments on time, there are some occasions where events happen out of their control (eg, a client being unwell, or they arrive and the client is injured), which then delays them in getting to their next appointment. However, if there are ongoing issues it is recommended that the person involved or their family make a complaint, as this then identifies if it is a systemic issue or an individual issue.

The carried forward action list was noted.

4. PUBLIC HEALTH ROLES / FUNCTIONS

Evon Currie, General Manager, Community & Public Health (*CPH*) provided a presentation on Public Health Roles and Functions. The presentation highlighted the following:

- Goal, Structure and Principles
- Core Public Health functions
- Key considerations, challenges and priorities
- CPH programmes
- Non-COVID priorities
- COVID programme
- COVID priorities
- Working in Partnership

In addition to the presentation, Ms Currie provided members with individual reading packs and spoke to the following:

- Community and Public Health 2020/21 Workplan
- Canterbury Wellbeing Index
- Broadly Speaking
- Collaborating for Health
- Healthscape
- All Right?

There was discussion around the All Right? campaign and the "Getting Through Together" campaign (which was created by the All Right? team). Ms Currie noted that the All Right? campaign was a health promotion response to the earthquakes. What it morphed to over time was being able to be used in different environments for different purposes. Inevitably, a decade later, it is not going to continue to be funded by the MoH, so All Right? will be ceasing. "Getting Through Together" – we need to look at what it means to try to continue that campaign with an incredibly reduced budget.

There was a query as to how positive programmes will be carried through to the new health system. Ms Currie noted that for the past decade CDHB has been involved in the South Island Public Health Partnership, working closely with Nelson/Marlborough and Southern DHBs. The three public health units work very closely together. The South Island Public Health Partnership has recognised as a strength that it is already a unified, South Island, public health provider – know each other, trust each other, and work well together. We have been given an opportunity to strengthen that and we want to make sure that our voice, about our experience and expertise, is part of the conversation that happens at a national level. Dr Daniel Williams, CDHB Public Health Specialist, is now pulling together the outline of the project that will be undertaken South Island wide to help form the kind of way public health services can be provided in the South Island. We are very active in this space.

Gordon Boxall joined the meeting at 1.35pm.

5. LIFE CURVE

Dr Lunday-Johnstone provided a presentation on LifeCurve: A Model of Accelerated Function Decline. The presentation highlighted the following:

- LifeCurve is an easy-to-use app for your phone.
- Measures how you are ageing by looking at your ability to do everyday tasks.
- Compares your ability to others your age.
- Gives useful advice and empowers you to age well.

In response to queries, Dr Lunday-Johnstone advised:

- You can choose whether your anonymised data is shared for research purposes or not.
- By using the app you get an individualised plan. Someone in a care home may need significantly more support, but this can be achieved through the care assistants.
- This is an age-related tool. It was not designed with disability in mind. We are trying to illustrate how a targeted intervention, particularly for people in their mid 50-60s, can prevent them from becoming on the life curve.

6. TRANSALPINE HEALTH DISABILITY ACTION PLAN 2020-2030

Ms O'Neill presented the refreshed plan on behalf of the Disability Steering Group (*DSG*). She advised that this is the work that DSG is wanting to undertake to build on the foundation that has been created from the original plan. DSG is very strong, with membership from all of the disabled persons organisations. It also remains strongly linked with the Enabling Good Lives and System Transformation Leadership Group.

Ms O'Neill advised of other gains since the original plan came into play. These include:

- Structures in place around the accessible built environment.
- Policy around adversity and inclusion for recruitment.
- Beginnings of a way of surveying staff to understand the mix of our staffing group, including disability.
- Project Search.
- Canvassing nationally on the patient satisfaction survey that comes out from the Safety and Quality Commission. This now includes questions around disability.

Ms O'Neill commented that the new plan continues to focus on the above areas. In addition, there has been feedback from disability community members and the Chair of DSG, strongly advocating for accessible information. We now have the signing of the Accessible Information Charter which will provide a platform for tackling a mass of opportunities that exist in this space.

The other area to highlight is work in partnership with other communities. For example, meeting with the Manawhenua Provider Network and having input into the Māori Improvement Health Plan from a disability perspective.

A member commented that there is an alignment being drawn with Māori and Pasifika health, and the health of people with disabilities. This may be seen as a natural alignment, as the health profiles and the number of issues faced are particularly similar. Concern was expressed that if the national development of a separate Māori Health Authority goes forward, then disability could once again slide into the middle. We need to be more deliberate in specifying the issues for people with disabilities and noting the alignment with Māori and Pasifika. Ms O'Neill

commented that the DSG is cognisant of those concerns. Grant Cleland, Chair, DSG, added that one of the ways is to ensure that the Disability Action Plan is at the forefront of what we see as key issues for the disability community and making sure that in the changes in health that they do not get lost. We must continue to advocate for action plans going forward; and for them to be clearly monitored.

A member congratulated those involved in this piece of work. A strong platform was laid in past times and the DSG has taken this work forward. It shows how important those foundations are to build on and adapt. Whatever happens structurally to the organisation going forward, this work is well set to continue.

In response to a query, Dr Lunday-Johnstone advised that Mr Cleland also Chairs the Accessibility Working Group, which she sits on along with a range of Facilities Team employees. The timing of things like audits etc are often problematic. For example, the Outpatient toilet – the audit of that part of the building was done before the building had been completed, so none of the work relevant to the complaint was actually looked at because it had not been done. There are issues and challenges around building in these elements around the considerations of accessibility etc – the environment, what would be appropriate and suitable for the needs of a whole variety of people, including disability specifically. We are building that into the processes that the Facilities Team use.

In response to a query, Ms O'Neill advised that there was a Pasifika action in the workplan, but it was linked to Lemalu Lepou Suia Tu'ulua who sadly passed away in March 2021. This section has since been removed as the action needs to be refreshed. Ms O'Neill further commented that a meeting was held in March with the Multi-Cultural Society with a follow-up arranged to go back to them to get what we need to focus on from their perspective. The plan is very much a living document. It was requested that commentary to this effect be added to the paper going to the Board's meeting on 20 April 2021.

Resolution (04/21)
(Moved: Jo Kane/Seconded: Yvonne Palmer – carried)

"The Committee recommends that the Board:

i. formally endorses the Transalpine Health Disability Action Plan 2020-2030; and
ii. notes the actions being undertaken in the Work Plan for 2020 – 2021."

7. DISABILITY STEERING GROUP UPDATE (ORAL)

Mr Cleland reintroduced himself, reminding members that he Chairs the DSG, as well as the Accessibility Working Group and the Accessible Information Working Group. Mr Cleland wished to acknowledge the recent passing of Lemalu Lepou Suia Tu'ulua.

Mr Cleland provided updates as follows:

- Development of the monitoring reporting is important, as this identifies what is seen as the key projects. Quarterly reporting is required.
- Conversations about data and information required by DSG in order to be able to determine the needs of the community and how staff are responding etc.
- Work around a disability alert.
- Tackling key issues at a systemic level.
- DSG's recent visit to Waipapa and being able to provide advice/feedback from a disability perspective.

- Dr Peter Bramley, Chief Executive, CDHB, signed the Accessible Information Charter this morning. This is critical. Information and communication access is as important, if not more important, to the disability community, but is often forgotten about.

  There is a team that has been working on this since 2019. The team has put together some strategic objectives that relate to developing an Accessible Information Policy (the guiding document); the implementation plan relating to that; developing accessible information standards and requirements; and thinking about what the coordination needs to be going forward and the structure for that to ensure that the greatest value is gained from the Accessible Information Charter. A stock take is required of existing tools, as well as what staff require in terms of awareness and training. What will be critical going forward with implementation is making sure that staff know "why" this is so important and what the simple things are that can make communication and information more accessible.

  Mr Cleland commented that with the proposed changes to the health system, it is critical that this work does not get lost or derailed, because issues for the disability community will still be there.

The Chair thanked Mr Cleland for his attendance.

Gordon Boxall retired from the meeting at 2.40pm.

8. MAORI & PACIFIC HEALTH PROGRESS UPDATE

Janice Donaldson, Portfolio Manager, Māori Health, Planning & Funding, presented the report which was taken as read. The following points were highlighted:

- Immunisation. Because there has been so much positive attention paid to immunisation for children, we can see why and how this has been declining post COVID-19. There is a plan in place, COVID- 19 willing, for this to increase again. The performance in immunisation is an example in this DHB of when we monitor what is happening for Māori and Pacific health we can make improvements.
- Some other indicators on the dashboard languish year on year on year and we have to ask whether we are satisfied with that. These things are important.
- Oral health may change if we get fluoridation. This will make a huge difference to the oral health of the children in New Zealand. Currently, for the Māori and Pacific indicators, they languish and this has a life long impact on people. Things that start off as babies, as children, where a lot of these indicators focus and where we are not performing well, have a life course.

There was discussion on the following:

- If you keep doing the same, you will get the same result. There are ways of engaging people that have been shown to be successful that we can borrow from.
- Access to general practice is a big issue.
- The group less likely to pick up the smokefree message are Māori women who are pregnant. This has been a constant for 25 years or more.
- The number of Māori Health workers.
- Primary birthing units and the importance of a women friendly culture; accepting of women and their whānau.
- Resources and targets. Where will resources add the most value to improve the statistics.

The Māori & Pacific Health Progress Update report was noted.

9. COMMUNITY & PUBLIC HEALTH UPDATE

Ms Currie presented the report which was taken as read.

There was discussion and concern expressed about funding cuts to various campaigns (All Right?; The Getting Through Campaign). A member requested that this be highlighted to the Board.

There was a query around the ongoing prolonged implications of COVID-19. The Committee was advised that the term for this is Long COVID. Ralph La Salle, Acting Executive Director, Planning Funding & Decision Support, undertook to provide an update to the Board meeting on numbers and issues involved.

Mr Keown noted the pending retirement of Ms Currie. He acknowledged her significant contribution to health and the health of others. He thanked her for her leadership, her passion and belief in her work, and spoke of the loss that she will be to the DHB.

The Committee noted the Community & Public Health Update report.

10. PLANNING & FUNDING UPDATE

Mr La Salle, presented the report which was taken as read. There was no discussion.

The Planning & Funding Update report was noted.

INFORMATION ITEMS

The following information items were received:

- CCN Q2 2020/21
- Disability Steering Group Minutes: 22 January 2021
- 2021 Workplan

There being no further business the meeting concluded at 3.10pm.

Confirmed as a true and correct record:

_____ _____

Aaron Keown Date of approval
Chair

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: **20 May 2021**

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 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 – 15 April 2021	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.	MoH Quarterly Financial Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	2021 / 22 Annual Planning Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	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)
8.	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)
9.	Advice to Board • QFARC Draft Minutes *3 May 2021*	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.