AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
to be held via Zoom
Thursday, 21 October 2021 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 16 September 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*	9.40-10.30am
Reports for Decision			
6.	Drug & Alcohol Policy	Mary Johnston *Chief People Officer*	10.30-10.40am
7.	Māia Funded Capital Expenditure	David Green *Acting Executive Director, Finance & Corporate Services*	10.40-10.45am
Reports for Noting			
8.	Finance Report	David Green	10.45-10.55am
9.	Care Capacity Demand Management	Becky Hickmott *Executive Director of Nursing*	10.55-11.05am
10.	Advice to Board: • HAC – 7 October 2021 – Draft Minutes	Andrew Dickerson *Chair, HAC*	11.05-11.10am
11.	Resolution to Exclude the Public		11.10am
ESTIMATED FINISH TIME – PUBLIC MEETING			**11.10am**

NEXT MEETING
Thursday, 18 November 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*
James Allison – *Chief Digital Officer*
David Green – *Acting Executive Director, Finance & Corporate Services*
Becky Hickmott – *Executive Director of Nursing*
Mary Johnston – *Chief People Officer*
Dr Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Tracey Maisey – *Executive Director, Planning, Funding & Decision Support*
Hector Matthews – *Executive Director Maori & Pacific Health*
Tanya McCall – *Interim Executive Director, Community & Public Health*
Dr Rob Ojala – *Executive Lead of Facilities*
Dr Helen Skinner – *Chief Medical Officer*
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	07/07/21 EM	15/07/21	19/08/21	16/09/21	21/10/21	18/11/21	16/12/21
Sir John Hansen (Chair)	√	√	√	√	√	√	√	√ (Zoom)	√ (Zoom)			
Gabrielle Huria (Deputy Chair)	#	√	√	√	√	√ (Zoom)	^	√ (Zoom)	√ (Zoom)			
Barry Bragg	√	√	√	√	√	^ (Zoom)	√	√ (Zoom)	√ (Zoom)			
Catherine Chu	√ (Zoom)	^ (Zoom)	#	^ (Zoom)	^ (Zoom)	√ (Zoom)	√ (Zoom)	√ (Zoom)	√ (Zoom)			
Andrew Dickerson	#	√	#	√ (Zoom)	#	#	√ (Zoom)	√ (Zoom)	√ (Zoom)			
James Gough	√ (Zoom)	√ (Zoom)	√	√	√	√ (Zoom)	#	√ (Zoom)	√ (Zoom)			
Jo Kane	^	√	√ (Zoom)	√	√ (Zoom)	√ (Zoom)	#	√ (Zoom)	√ (Zoom)			
Aaron Keown	√	√	√	√	√ (Zoom)	√ (Zoom)	√	√ (Zoom)	√ (Zoom)			
Naomi Marshall	√ (Zoom)	√	√	√	√	√ (Zoom)	√	√ (Zoom)	√ (Zoom)			
Fiona Pimm			* (16/04/21)	√	√	√ (Zoom)	√	√ (Zoom)	√ (Zoom)			
Ingrid Taylor	√ (Zoom)	√	√	√	√	√ (Zoom)	^	√ (Zoom)	√ (Zoom)			

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

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 and Daughter are Directors 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. **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 via zoom
on Thursday, 16 September 2021 commencing at 9.30am

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

CROWN MONITOR
Dr Lester Levy

CLINICAL ADVISOR
Dr Andrew Brant

APOLOGIES
Apologies for early departure were received and accepted from Dr Andrew Brant (12.00pm); and Dr Lester Levy (12.30pm).

EXECUTIVE SUPPORT
Dr Peter Bramley (Chief Executive); David Green (Acting Executive Director, Finance & Corporate Services); Becky Hickmott (Executive Director of Nursing); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Tanya McCall (Interim Executive Director, Community & Public Health); Tracey Maisey (Executive Director, Planning Funding & Decision Support); Hector Matthews (Executive Director Maori & Pacific Health); Dr Rob Ojala (Executive Director, Infrastructure); Dr Helen Skinner (Chief Medical Officer); Karalyn van Deursen (Executive Director, Communications); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support – Minute Taker).

APOLOGIES
Apologies were received from Mary Johnston (Chief People Officer); and James Allison (Chief Digital 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
Sir John asked if there were any declarations of interest apart from Ngai Tahu and Car Parking in respect of Barry Bragg and Gabrielle Huria. There were none.

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETINGS

Resolution (31/21)
(Moved: Sir John Hansen/seconded: Gabrielle Huria – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 19 August 2021 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

It was noted that all of the carried forward/actions items were included on today's agenda.

4. CHAIR'S UPDATE

Sir John Hansen, Chair CDHB, advised that he wished to speak about one matter around vaccinations. He commented that as Board members are aware there has been a lot of criticism in the media around Canterbury vaccination rates and whilst it is true that we developed our own plan it needs to be understood that it was based on modelling from the Ministry of Health and the Ministry of Health have approved our plan. He added that the pace of vaccinations has really thrown the plans out the window. It should be noted that over the last three weeks we have administered, as at yesterday, 170,772 vaccinations against a plan of 122,194, noting that this is over 50% more than plan and 40% above plan. He added that the other good news, which you will have read in the media is that there is a good and steady supply of vaccine so we can continue at that pace. Sir John commented that just to put it into context we have been doing a weekly average of 57,000 vaccinations per week and our plan had been that we hoped to get to 45,000 after an extended ramping up period as at the end of October.

Sir John commented that we owe a great debt to the teams here and in other DHBs for this outstanding achievement and he wished to publicly acknowledge this.

The Chair's update was noted.

5. CHIEF EXECUTIVE'S UPDATE

Dr Peter Bramley, Chief Executive, took his report as read. He highlighted the following:

- Maori Language Week - being Maori Language week, Dr Bramley advised that he had included in this CEO Update his Pepeha, as it is important that as an Executive Management Team and Board that we are growing in our cultural competency. He added Kia Ora to everyone and he encouraged the Executive and Board to keep growing in our journey towards a greater understanding and certainly greater participation.

- Vaccinations - he advised that every indication is that we will have undertaken 500,000 doses next week. We are ramping up capacity and there are plenty of bookings in place. Dr Bramley commented that a lot of thought is being given to how we reach those pockets in our community that are hard to get to and as you are no doubt hearing in the news media all of those solutions of taking the vaccine to those groups that are struggling to access vaccinations are key to "going to" with mobile settings, and our partnership with Iwi and Pacific People will particularly be crucial.

- Dr Bramley commented that our thoughts do go to Auckland who are still in the midst of lockdown and are also trying to manage a health system that does have COVID in its midst. We have been very fortunate that we have not had to deal with that, however, a huge amount of work went into making sure our health system was prepared and reset obviously to manage under various lockdown levels and the teams across the health system have done a stunning job.

He added that he was indebted to Emergency Operations Centre staff and controllers, Dr Helen Skinner and Tracey Maisey, for their outstanding work over the lock down and managing the various emergency responses. He commented that we learned a lot and thankfully we did not get COVID here, but it has gone a long way to building our resilience to making sure we are better prepared. We have considerably strengthened our ability to respond to a COVID insurgence should that happen.

- Planned Care – he commented that there has been some impact here. Back in July the system was hit by RSV (particularly child & youth) and we were overrun with presentations to ED and with high occupancy in the hospital. We had some deferment of planned care at that time and have had a similar impact with lockdown needing to defer some planned care activity. The system reset very fast and kicked back into gear quickly. Dr Bramley commended the clinical teams for continuing planned care and keeping everyone safe. He added that there has been some impact on numbers and teams are now booking to close that gap. It should be noted that there will be come changes to ESPIs as a result.

- Workforce – some of our challenge is currently in the workforce space, as well as the bed capacity space. This is in part to do with our borders being closed for so long in terms of accessing people with the right skills. This is putting pressure on the workforce across our systems.

- Demand and Pressure Across the System – Dr Bramley advised that one of the things he has been struck with in the last couple of weeks as we get back into the core delivery of health is the level of demand and pressure across the system and he would like to give huge credit to our Clinical Leaders who are doing an amazing job to ensure we utilise our people and configure care in the best possible way.

- Bowel Screening - there have been challenges in the delivery of bowel screening, even though we have done 1,100 more colonoscopies than the previous year. There is significant demand in this area and we met yesterday with the Clinical Lead for Cancer Services to discuss how we can support that team to meet this demand.

- Mental Health Post Lockdown - we did not see the drop off in presentations to Mental Health that we saw last time and the level of stress that sits in our community is different this time. As we have moved to level 2 there has been a significant rise in the numbers presenting to our mental health services.

- Dr Bramley invited Dr Helen Skinner, Chief Medical Officer, and Becky Hickmott, Executive Director of Nursing, to comment around the current challenges in our health system.

  Dr Skinner advised that she had taken over as the senior responsible officer for COVID and Health Emergency Planning and they have now redone the resurgence plan working across the system. She commented that this had been going to be a table top exercise but ended up actually being undertaken.

  Dr Skinner commented regarding models of care in Medical Oncology and Radiation and how we can use our LINACS in a different way, increasing our hours of use and giving us increased capacity quicker. In addition, there is combined work taking place with the clinical teams and Planning & Funding, particularly around Production Planning, looking at how we can do things differently but also predict demand.

  She commented that it is important we continue to work across the whole system with our Primary Care colleagues to ensure we are ready in terms of pathways around Primary Care.

Ms Hickmott commented that the vulnerability of our workforces across the nation is under huge discussion at the moment and we are putting pressure on, as much as we can, around bringing in people from overseas where possible. The government is trying to prioritise MIQ spaces, however, this is a long way off. There are a number of workforces, including Oncology, that this is impacting and the competition is quite a significant challenge. She advised that a number of challenges exist in Oncology and a number of organisations/ countries have been giving staff cash payments to stay in place. Ms Hickmott advised that there a number of workforces that we cannot recruit to, including mental health. She gave a shout out to Auckland who have shared a number of the lessons they have learnt from their current experiences.

- Dr Bramley advised the Board that our teams have been very active in supporting Auckland with Community & Public Health, ICU Nurses, Infection Control Nurses, IPC Nurses, Health Care Assistants, MIQ, and also a big shout out to Labs who have been supporting with the huge amount of testing.

- Dr Bramley added that the "making the system flow" piece of work is critical for us across our system in terms of improving our flow and access to services.

A query was made as to whether there is any information available from the Ministry of Health around an end goal for the vaccination target and what percentage we need to get to before we can open our borders. It was noted that most of the narrative is that we need to get as many people as we can vaccinated. We have not been given any information/advice around the re-opening of borders.

A query was made regarding cancer treatment services in relation to the Prime Minister's announcement around the intention to purchase new Linear Accelerators. Dr Bramley spoke again regarding the really good meeting yesterday with Cancer Services and the team is doing really well on meeting national targets, but they are signalling to us the growing demand in service provision and challenges around workforce. He added that we have some actions we are getting underway on to try and strengthen the resilience and capacity of those services. Dr Bramley commented that specifically yesterday they looked at Radiation Oncology and the proposal we are getting underway is on a virtual fit where we increase our staff which would increase the capacity with the bonus being this would help us meet demand, but it also buys us time while we get approval to put the new LINACs in place for the Canterbury region. It was noted that active discussions are taking place to secure funding to get on with the 5th & 6th LINAC, but in the interim we are adding virtual capacity.

A query was made as to what planning has been done around facilities for when COVID becomes endemic. It was noted that a huge amount of work has been undertaken looking at our readiness, not only around this, but also around other illnesses we could be facing.

Discussion took place regarding vaccinations in our vulnerable communities and also the pressure on Primary Care. An update will be provided at the next Board meeting around plans to vaccinate the remainder of our vulnerable communities and plans to assist and support primary care.

Dr Lester Levy, Crown Monitor, made a query thinking longer term around workforce. He commented that in the United States they regularly put out what are expected to be the most rapidly growing jobs in the next decade and whilst their system is different, just to draw some principals out if it, they expect the second highest growth to be in the Nurse Practitioner area; number 10 is Physician Assistant; and in between that there a lot of Physical Therapy Assistants and Health Assistants. Dr Levy added that you get the picture that they realise it is not going to be possible to deliver the professional workforce required without having a change, with nurses operating at higher level of scope and more independently, and more assistants in the medical and health area. He asked

if there is any progress here, as the Nurse Practitioner roles do not seem to have progressed as they could have and what about Physician Assistants - is this something we are looking at in New Zealand?

Ms Hickmott commented that she agreed that we have had some restraints around the Nurse Practitioner pathway as funding for this needs to be in place first. She added that there has been no change to the funding for this since 2009 and there is currently considerable pressure to address it. Ms Hickmott advised that locally we have increased our numbers considerably, particularly in ED and many other areas are also doing this now. In regard to Physician Assistants, Ms Hickmott commented that she has not had a lot to do with this as yet, however, discussions are commencing at Southern and also Nelson Marlborough DHBs, although we have not been involved as yet.

The Chief Executive's update was noted.

6. GREATER CHRISTCHURCH PARTNERSHIP MEMORANDUM OF UNDERSTANDING

Tanya McCall, Interim Executive Director, Community & Public Health, presented this paper which was taken as read. Ms McCall advised that the Greater Christchurch Partnership (the *GCP*) is updating its MOU with member organisations to recognise current work outputs and relationships, and it is also entering into a new MOU with Government to access resources and support through the Urban Growth Partnership.

Sir John commented that the GCP Group has been in existence for some time and focuses on urban growth, transport, climate change, and other matters, with a particular focus on Christchurch 2050 and it is timely to enter into a partnership with central government.

Sir John advised that he had been asked to remain as the appointed member of the GCP Committee and also become the appointed member on the Greater Christchurch Urban Growth Partnership Committee.

Resolution (32/21)
(Moved: Jo Kane/seconded: Naomi Marshall – carried)

"That the Board:

i. approves the Greater Christchurch Urban Growth Partnership Committee Memorandum of Agreement (Appendix 1) and updated Greater Christchurch Partnership Committee Memorandum of Agreement (Appendix 2);
ii. delegates responsibility to the Greater Christchurch Partnership Independent Chair to make any minor non-material amendments to the Agreements;
iii. delegates responsibility to the Chair to execute the Agreements;
iv. notes that officers are in discussions with mana whenua representatives on the potential of mana whenua Ngāi Tahu gifting a name for the Greater Christchurch Urban Growth Partnership Committee;
v. notes that Sir John Hansen remains the appointed member of the Greater Christchurch Partnership Committee;
vi. appoints Sir John Hansen as the appointed member of the Greater Christchurch Urban Growth Partnership Committee;
vii. resolves that the Greater Christchurch Partnership Committee and the Greater Christchurch Urban Growth Partnership Committee are not discharged following triennial general elections, in accordance with clause 5.6 of the Memorandum of Agreements; and
viii. delegates to the Greater Christchurch Urban Growth Partnership Committee the authority to adopt a new name."

7. FINANCE REPORT

David Green, Acting Executive Director, Finance & Corporate Services, presented the Finance Report for the month of July 2021. Mr Green advised that these July results were discussed in detail at the last QFARC meeting and showed an unfavourable variance to budget of $669k for the month. Mr Green added that this variance was due mainly to RSV treatment and Chatham Islands costs. It was noted that the August result is largely on track excluding the Chatham Islands and a couple of other issues.

There was no discussion.

Resolution (33/21)
(Moved: Sir John Hansen/seconded: Ingrid Taylor – carried)

"That the Board:

i. notes the consolidated financial result for the month excluding the impact of Covid-19, and Holidays Act compliance provision is unfavourable to plan by $0.803M;
ii. notes that the PTD impact of Covid-19 is an additional $0.140M net revenue;
iii. notes that the PTD impact of the Holidays Act Compliance is an additional $1.347M expense."

8. MAORI & PACIFIC HEALTH PROGRESS REPORT

Hector Matthews, Executive Director, Maori & Pacific Health, presented this report which was taken as read. He advised that this report was here with the Board due to lockdown and the cancellation of the Community & Public Health & Disability Support Advisory Committee meeting.

Mr Matthews commented that the COVID vaccinations have proved to be quite relentless for our staff and with borders closed it is difficult to get additional staff from overseas. He advised that some services have remained static (eg caries free @ 5yrs and breastfeeding), however, there has been an improvement in the enrolment of children. He added that these things are inevitably linked to deprivation and during lockdown this seems much worse than last time with many more food parcels being delivered.

Mr Matthews commented that worthy of note is that Ambulatory Sensitive Hospitalisation (*ASH*) rates for both Maori & Pacifica children have improved significantly and we have almost removed the inequity that existed between Maori & Pacific children and non-Maori and Pacific children in this area.

A query was made regarding the recording of immunisation rates for girls receiving HPV vaccinations who are Maori and why we are not collecting the data for boys for Maori. Mr Matthews will follow this up.

A comment was made regarding the B4School checks performance which is very good and a query was made regarding the model for this and how is it different to some of the other targets and how can we adopt this model. Mr Matthews provided some background around the model and added that the system is trying to replicate this model and take the services to the communities involved.

Discussion took place regarding the dissemination of information to Papatipu Runanga now that the new partnership agreement has been approved by the Board.

Discussion also took place regarding future reporting to measure progress against Annual Plan objectives.

The Māori & Pacific Health Progress Report was noted.

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (34/21)
(Moved: Sir John Hansen/seconded: Gabrielle Huria - 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 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 – 19 August 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.	2021/2022 Draft Annual Plan	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	COVID-19 Automated Testing Platform	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Service Change 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 *31 August 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 10.50am.

_____ _____

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 21 OCTOBER 2021

DATE	ISSUE	REFERRED TO	STATUS
16 Sep 2021	COVID-19 Update	Dr Peter Bramley	Today's Agenda – Item 5
16 Sep 2021	Personal Grievances	Mary Johnston	Today's Agenda – Item 9PX
16 Sep 2021	Sick Leave – Rural Hospitals	Mary Johnston	Today's Agenda – Item 9PX
05 Oct 2021 (QFARC)	CDHB's response to WorkSafe re: ED PIN	Greg Brogden	Today's Agenda – Item 10PX
05 Oct 2021 (QFARC)	Drug & Alcohol Policy – address issues raised at QFARC.	Mary Johnston	Today's Agenda – Item 6
05 Oct 2021 (QFARC)	CLS Loan – address issues raised at QFARC.	David Green	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: **21 October 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.

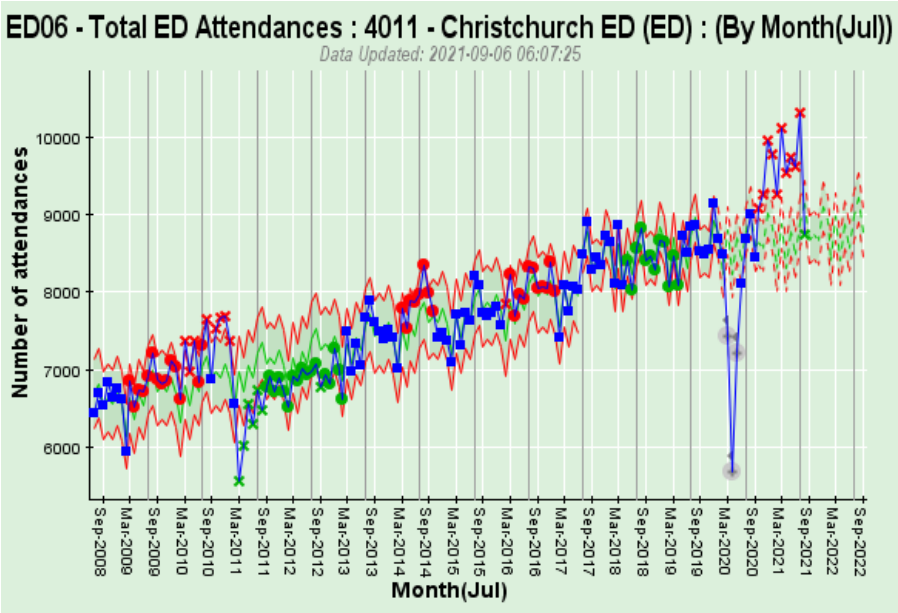
3. DISCUSSION

MEDICAL / SURGICAL SERVICES

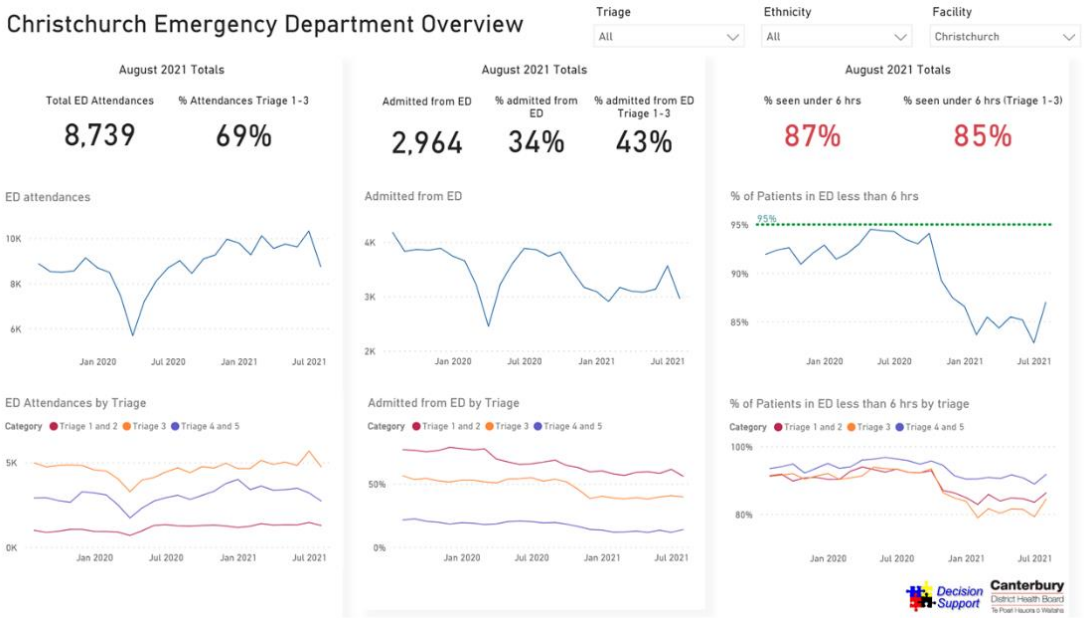
- The number of people provided with care by services based on the Christchurch Campus has been significantly affected by COVID-19 Alert Levels 3 and 4 that commenced on 17 August 2021.
- Throughout this period acute, non-deferrable and urgent planned care have been provided in line with the National Hospital Framework yellow status.
- This has resulted in a reduction in the overall volume of planned care provided by the system. In addition, acute presentations have reduced due to community behaviour being altered by the lockdown, leading to lower rates of trauma and other processes that lead to demand for urgent healthcare.

Service Delivery

- The number of attendances at the Emergency department reduced to 8,739 during August 2021 – significantly lower than the 9,200 to 10,300 seen per month since December 2020.
- The largest reduction was in triage 4 and 5 attendances where there was 77% (or 800) less attendances than the average monthly attendance count between December and July. Triage 3 attendances were at 95% and triage 1 and 2 at 98% of the average over the comparison period.



- 2,964 people were admitted to hospital from the Emergency Department, 375 less than forecast for the month.



- The Emergency Department has implemented the red zone pathway for patients with high index of suspicion for COVID-19. This has resulted in improved staff and patient safety.

Planned Care

- Canterbury District Health Board has agreed a phased schedule with the Ministry of Health for planned care delivery that will provide the target of 19,614 discharges (the same target as for 2020/21).
- At the end of week 10 (up to 3/9/2021) 2,800 planned care discharges have been provided – 958 less than the phased target. There are several events that have contributed to this deficit:
    - 100 cases were deferred because the response to respiratory syncytial virus constrained bed and nursing capacity, particularly for children.

  - A further 56 cases were deferred during the week ending 6 July due to bed constraints at Christchurch Hospital.
  - During the three weeks of COVID-19 lockdown (to 3/9/2021) 541 planned care discharges were provided against a target of 1,217, a deficit of 676
  - These together account for a deficit of 832 cases – 87% of the total deficit, some of which may be explained by wind-down in preparation for strike action.
- Anaesthetic Technician capacity continues to constrain theatre capacity. The constraint is being addressed in many ways including use of agencies to recruit international staff alongside work within the domestic market, use of casual capacity, , not automatically backfilling vacated lists and outplacing operating sessions to private hospital settings.
- At the end of 3 September 2021 CDHB is exceeding its target for minor procedures in hospital settings, having delivered 313 as inpatients (260 ahead of target) and 2,306 as outpatients (1,356 ahead of target).

The CDHB Improvement Action Plan

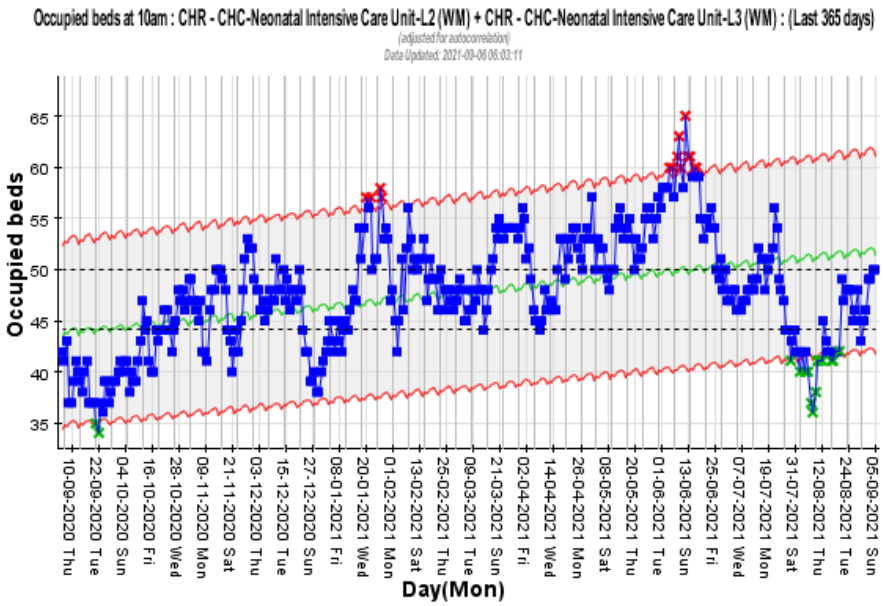
- 2,035 people were waiting for longer than 120 days for first specialist assessment at the end of August. This is an increase of 311 from the end of July. The limitations on practice in place due to the COVID-19 lockdown are the dominant contributor to this increase.
- The COVID-19 lockdown is also a contributor to the increase in patients waiting for surgery, from 1,359 at the end of July to 1,479 at the end of August.

ICU Occupancy

Measure	Number Jun-20 to Aug-20	Number Jun-21 to Aug-21
ICU 10am occupancy >21 (days)	5	21
ICU 10am occupancy >25 (days)	-	-

- Occupancy was high early in August. This resulted in the need to prioritise elective cases on several days. This occupancy was attributed to high acute activity into ICU (medical and trauma). Respiratory cases were high.
- During the 31 days of August there were 21 days on which 10am Occupancy exceeded 21 beds.

Neonatal Intensive Care Unit Occupancy



- It is thought that the reduction in NICU occupancy is, in part, reflective of the work of a newly instituted, regular, multidisciplinary, timing of birth assessment meeting (TOBA) that reviews and triages all high-risk inductions of labour.

Reducing Hospital Admissions and Improving Patient Flow for the Frail Elderly Patient

- Allied Health has successfully applied for Ministry of Health Sustainability Funding to provide three additional Allied Health Front of House roles; Occupational Therapist, Hauora Māori team member and an Allied Health Discharge Coordinator. These roles will be senior decision makers that will co-ordinate the interdisciplinary Allied Health team with the aim of avoiding admission from the Emergency Department and co-ordinating the discharge of the frail elderly patient via an extended seven-day service delivery model within General Medicine.

SPECIALIST MENTAL HEALTH SERVICES

- Staffing and Recruitment are the most pressing issues facing Specialist Mental Health Services. Our staff have taken on large amounts of overtime to ensure our consumers receive appropriate care and therapy.
- The transition from Covid Alert Level 3 to Alert Level 2 in early September has seen an upturn occupancy of in our Adult Acute and Child Adolescent and Family inpatient services. The 64-bed Te Awakura unit has had up to 82 people in care resulting in a significant increase in sleepovers away from the preferred therapeutic environment and an increased proportion of consumers on leave. On the weekend of 11/12 September there were 15 admissions with an unprecedented nine people having their first admission. This is likely to be an early indicator of mental health burden of illness associated with the COVID-19 outbreak and lockdown.

Service Delivery/Performance

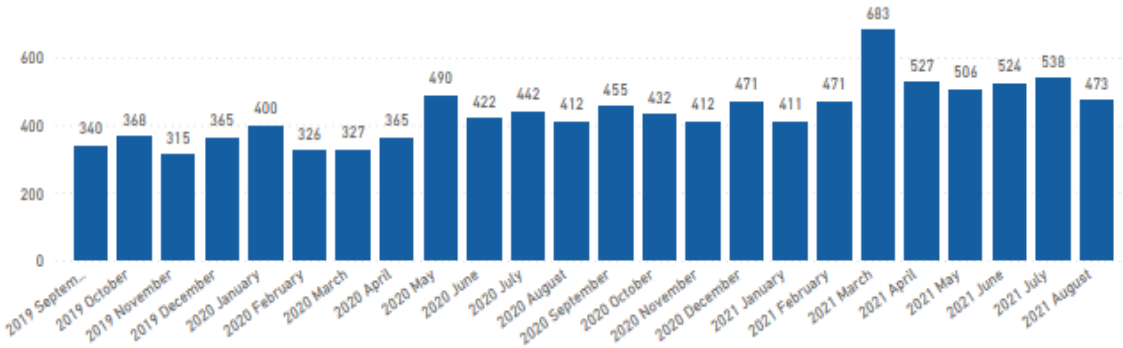
- In August there were 151 admissions to Specialist Mental Health Services and 17,035 contacts with 4,400 individuals.

Child Adolescent and Family

- There has been high occupancy within the inpatient wards and this has been combined with the highest acuity experienced. Parallel to adult services there has been a surge of demand as we moved back to COVID-19 Alert Level 2. Managing a number of young people with high acuity emphasises the shortcomings of our current facility.

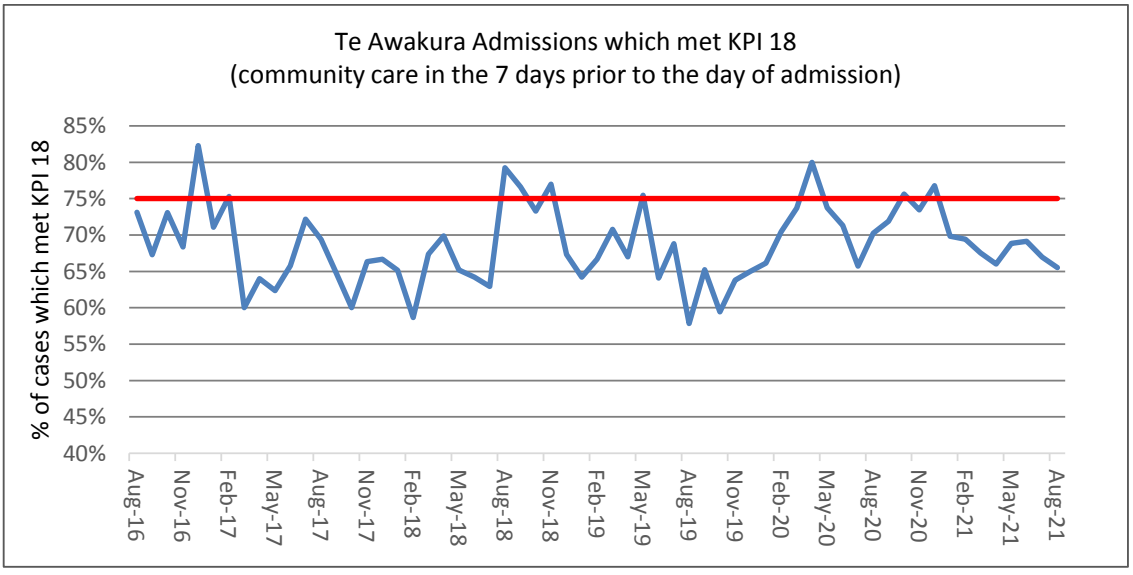
Forensic

- Our Forensic units have been running at full occupancy since before the COVID-19 outbreak. Admissions and discharges are represented below.

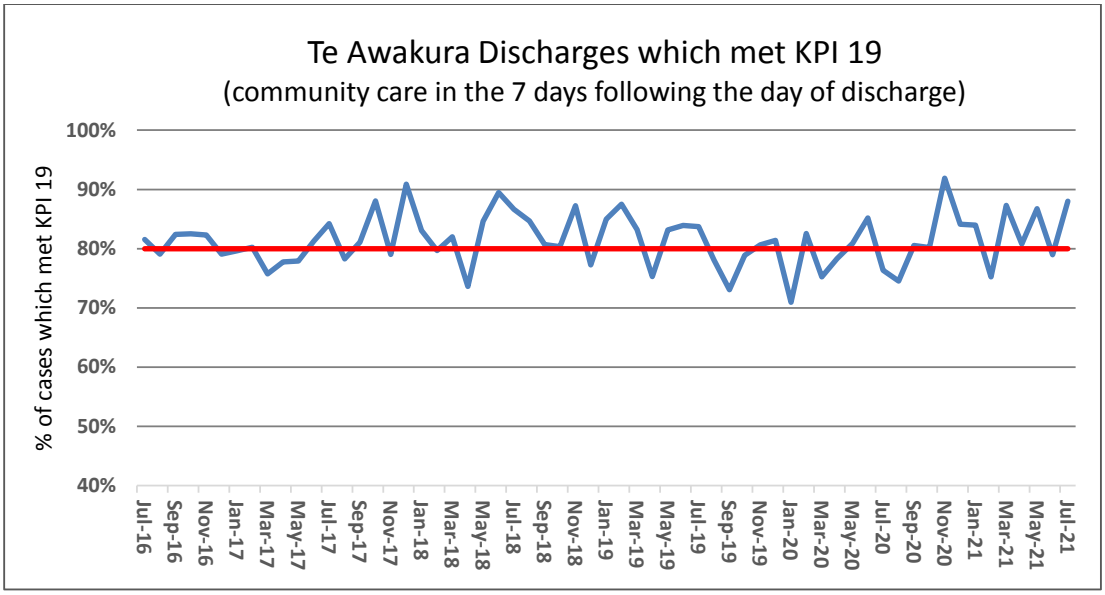


Quality and Safety

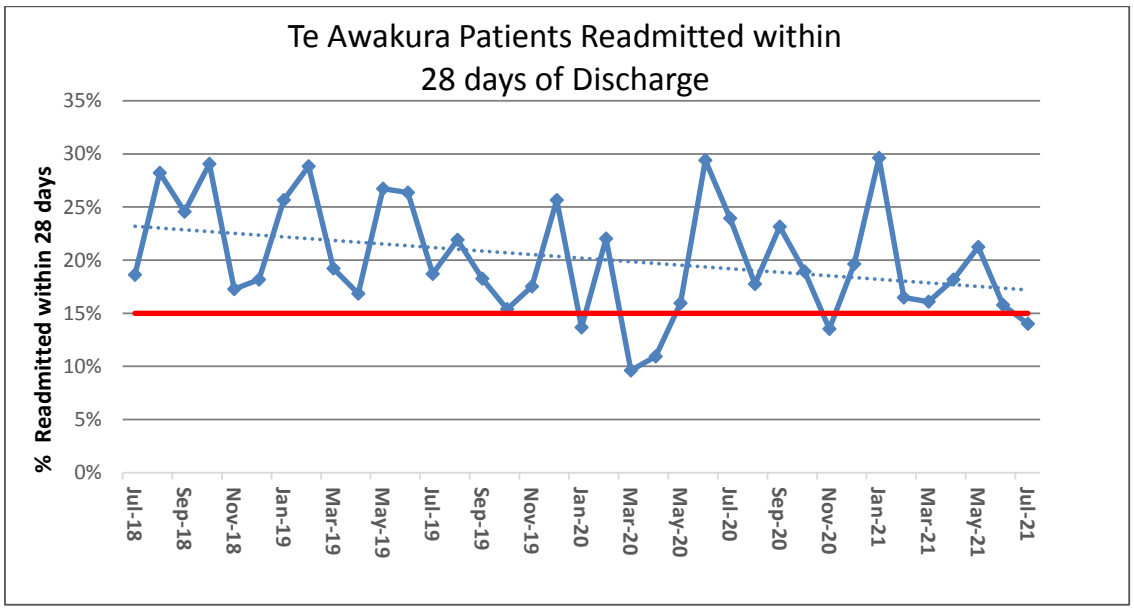
- The national Key Performance Indicator programme defines a number of measures of quality. 3 key indicators are illustrated below. Community care in the seven days prior to admission has been negatively affected by increases in the number of people receiving their first admission to mental health services.



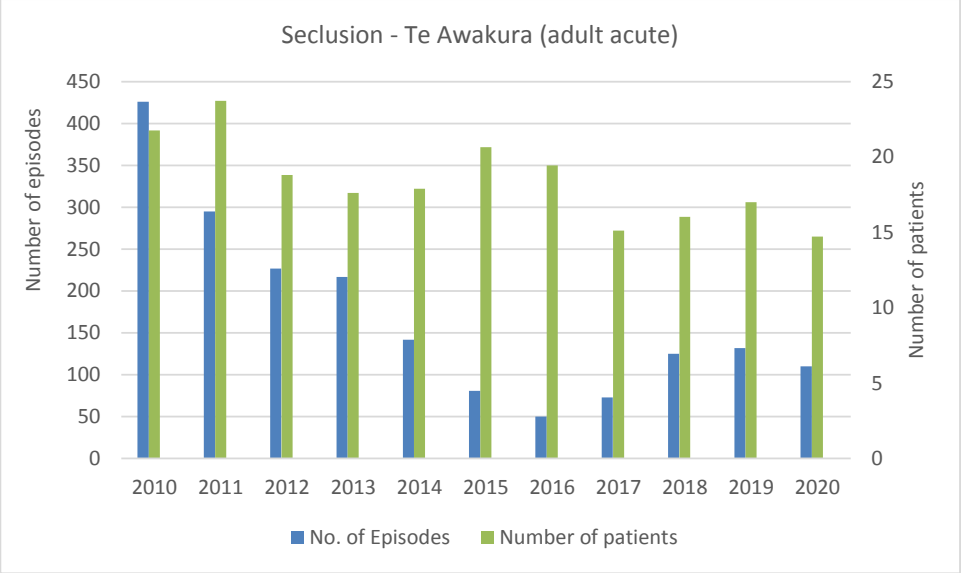
- We are seeing an increase in the number of people hospitalised on first contact.



- Canterbury performs well on this indicator (7% above national average). We have processes in place to review anyone not followed up within 7 days – usual reasons include decline follow-up, moved out of area.



- Occupancy levels often drive discharge rates, however early discharge may be linked to increased readmission rates.
- Reducing seclusion is a key focus for our restraint minimisation committee which aligns to the national Health Quality and Safety Commission campaign to reduce seclusion for inpatients. Ongoing work to improve documentation of the clinical rationale for seclusion is addressing the corrective action identified in the recent Certification audit. The overall focus of the programme is on developing our systems and culture to supports safe practice. Our facilities remain a significant barrier to supporting best practice with lack of space and ability to provide physical separation and de-escalation.



Equity

- Canterbury's Specialist Mental Health Services have a strong equity focus with Māori accessing community services 2.2 times higher and inpatient services 2.6 higher than the total population. This highlights the need for addressing the determinants of health and mental wellbeing for Māori early.
- Involvement of family/whānau is important for all mental health consumers, but particularly so for our Māori and Pacific consumers. The week following discharge from an inpatient unit can be a particularly risky time, as people transition back to their regular roles in the community. A project is underway to improve family/whānau involvement in discharge planning for consumers in Te Awakura.

PLANNING, FUNDING & DECISION SUPPORT

- **Additional Breastfeeding Support during Lockdown**: Breastfeeding support providers including community peer counsellors and lactation consultants were mindful of experiences in the last lockdown where māmā and pēpi had less time in DHB services, due to alert level restrictions and mothers preferring to get home quickly to whānau who were unable to visit. Aware of the risk to initiating/maintaining breastfeeding and our low breastfeeding rates against the national targets, the DHB funded additional support services including virtual peer counselling and community lactation support. This was highly valued. The Maternity Council provided this feedback: *"absolute tautoko to this korero, the incredible mahi that has been done to build & support the wāhine that provide this critical service is the stuff of passion & commitment. The taonga of the knowledge & skill that the wāhine are sharing goes far beyond that of BF, it's inspiring and so valuable".*

- **PHO Capitation Budget**: The latest PHO enrolment numbers indicate that the DHB's expenditure on capitation-based subsidies for PHO practices is currently expected to exceed the DHB's 2021-22 budget ($98.77m) by around $1.5 million. This is largely down to sustained growth in enrolments in PHO practices – currently running at around 2% per annum – even though more practices are reporting they are restricting or are closed to new enrolments. Enrolments of people 65 years and older, which make up 17% of Canterbury's enrolled population and receive the highest per-capita subsidies outside of 0-4-year olds, are growing at over 4% per annum. An increased level of enrolment

is a positive thing for our system, and we are supporting several initiatives to increase enrolments as a means of reducing acute demand through our Emergency Department.

- **Smokefree Programme Progress**: Following on from the July report about Smokefree cessation services and our increased focus on quit rates, a meeting was held with the three PHOs, Te Hā Waitaha providers, Community and Public Health and Planning & Funding in August to generate further momentum in this space.

  General practice in Canterbury currently fall well below the Ministry of Health performance target (78% against a 90% target) for providing ABC to their enrolled populations (Ask, Brief Advice and Cessation referral) and several opportunities were identified in this meeting where this performance can be improved. This meeting also identified the best investment opportunities for a small underspend in the Te Hā Waitaha programme.

  Examples of ideas to be explored included: Nurses or GP's offering brief advice during Cardiovascular Risk Assessments; Health Coaches offering brief advice as part of the Te Tumu Waiora service; utilising the 20-minute COVID-19 vaccination recovery time will education material available and adding Smokefree content to TV screens; linking with the Active Canterbury Network and providing Brief advice education to those NGO providers; and incentivising patients who reach certain quit milestones.

- **Managing Acute Demand**: Work is underway to support earlier intervention and reduce acute demand by identifying non-enrolled patients presenting to ED and those practices with a high number of their enrolled populations presenting to ED and understand what is driving these presentations. Māori and Pacific people have a higher ED attendance rate and a higher proportion of non-enrolled patients are Māori and Pacific. Our initial data review shows a very small number of general practices are associated with 28% of Pacific attendances and 18% of the Māori attendances. This presents an opportunity to target a small cohort of patients and general practices to understand how we might implement preventative initiatives to change presentation rates and improve health outcomes and this anaylsis has been shared with the Urgent Care SLA.

- **Youth Sexual Health Services**: Planning & Funding have been reviewing the provision of Youth Sexual Health Services in general practice service with a focus on equitable access and is redirecting some of the savings made in refocusing services into a new Ashburton service. Six months ago, a Youth One Stop Shop was set up in collaboration with the Ashburton community, called Hype. The Youth Health Centre is a free service for 10 to 24-year olds as well as parents and others seeking information about youth health issues, run by local providers and clinicians. With the withdrawal of NZ Family Planning from Ashburton and restricted enrolment in general practice a gap in services was identified for youth and with support from Waitaha PHO, Hype runs weekly clinics for high risk youth. The service has proven very successful with young people who state they would not go to their family GP for these issues and the DHB has agreed to provide some funding to ensure this valuable initiative is sustainable.

- **B4 Schools Checks Programme Delivery**: We are working with the public health nursing and COVID-19 vaccination teams to balance the need to quickly deliver the vaccination programme with the provision of the B4 Schools Checks programme for our under-fives. The public health nursing team delivers around 33% of the B4 School Checks. The B4 Schools Check programme is a key mechanism for ensuring early intervention for young children before they begin school including hearing and vision testing and other key health checks and is nationally driven and funded. Initial review of the programme suggests that coupled with the delay due to RSV illness amongst children in Canterbury in July, we will not make our national targets this year. As soon as we can secure a

return to BAU for the nurses they will focus on our population of highest need: children in quintile 5, Māori, Pacific and new migrant children. We will also work with the mobile team at Pegasus to support a catch-up for children not seen by 4 years-six months of age.

- **Response by General Practice and Pharmacy to COVID-19 Alert Level 4**: The response to COVID-19 in our community requires a health system response and all areas have risen to the changing needs of our population. General Practice continued to meet the demand for primary care services during the period of the Alert Level 4, re-organising themselves to ensure red and green streaming of patients and offering alternative virtual access to services where appropriate, by telephone and virtual consultations. For many general practices this was done while ramping up their contribution to the vaccination programme and meeting the demand for COVID-19 community testing.

  A massive effort was required from primary care (general practice and pharmacy) during the higher alert levels to increase the number of COVID-19 vaccination clinics onboarded and the number of vaccinations provided.

  The vaccination programme in Canterbury delivered 176,000 doses of COVID-19 vaccine through August - 126,000 of these (72% of the programme and 12% above what was planned) were delivered by primary care. The Vaccination Team onboarded 49 new clinics through August and there are now over 90 clinics operating across the vaccination programme.

COMMUNITY AND PUBLIC HEALTH (PUBLIC HEALTH DIVISION)

- **Supporting the Auckland August 2021 Community Outbreak:** On Tuesday 17 August the first case in the August 2021 Community Outbreak (SARS-CoV-2, Delta variant) was identified in Auckland and the country moved to COVID-19 Alert Level 4 at 2359hrs on 17 August. A public health risk assessment completed on 19 August deemed the public health risk for all of New Zealand to be high.

  Community and Public Health immediately instigated an Incident Management Team and introduced cohorting of our response teams. In addition, numbers working in the Christchurch office were reduced significantly with most staff, including members of the divisional leadership team, working remotely from home. These actions were taken in anticipation of ongoing and significant involvement in the Auckland response together with the likelihood of high numbers of close contacts within our region (including Canterbury, West Coast and South Canterbury DHBs) and the potential for emerging cases and clusters.

DRUG & ALCOHOL POLICY

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **People & Capability, Health & Safety Team, Unions**

APPROVED BY: **Mary Johnston, Chief People Officer**

DATE: **21 October 2021**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This report seeks to obtain approval for a Transalpine Drug and Alcohol Policy. The policy and associated documents have been approved by CDHB's Executive Management Team (*EMT*).

2. RECOMMENDATION

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

i. approves the Drug & Alcohol Policy;
ii. notes the Drug and Alcohol Testing Procedure; and
iii. notes the Rehabilitative Approach to Drug and Alcohol Related Issues.

3. DISCUSSION

The Health and Safety at Work Act 2015 (*HSWA*) requires persons conducting a business or undertaking (*PCBUs*) to take all reasonably practicable steps to eliminate or minimise risks to workers and others in the workplace. HSWA defines a hazard as including:

'a person's behaviour where that behaviour has the potential to cause death, injury, or illness to a person (whether or not that behaviour results from physical or mental fatigue, drugs, alcohol, traumatic shock, or another temporary condition that affects a person's behaviour)'.

As such, our people being under the influence of, or impaired by, any substance whilst at work is a health and safety risk that we are duty bound to appropriately manage. We are unable to do this effectively without an appropriate policy and supporting procedures.

The Policy recognises the safety risk to our people and to our patients and other members of the public. The fundamental provisions of the proposed Policy include:

- Our expectation that our people must not be under the influence of or impaired by any substance when performing their work. Note, this is not zero tolerance. This enables us to manage the actual risk of drug and alcohol use and subsequent effects on performance in our workplace.

- Inclusion of the right of the employer to test under certain circumstances:
  - Where there is reasonable cause.
  - Following a serious of potentially serious incident.
  - Where returning to work following a breach of the policy.

- Arrangements for rehabilitation support for our people.

The Drug and Alcohol Policy will be supported by the following:

- Drug and Alcohol Testing Procedures – we are unable to deploy the right to test without predetermined procedures. The testing procedure outlines roles and responsibilities, including when and how a worker must be stood down.
- Guidance on our Rehabilitative Approach to Drug and Alcohol Related Issues – as part of our restorative approach, this guide outlines our rehabilitative approach and commitment to supporting our people to overcome issues relating to drugs and alcohol that may be preventing them from reporting to work fit for duty.

Further Information Requested at 5 October QFARC Meeting
Clarification and additional information sought at QFARC's meeting on 5 October 2021 is provided in Appendix 4.

4. APPENDICES

Appendix 1:	Drug & Alcohol Policy
Appendix 2:	Drug & Alcohol Testing Procedure
Appendix 3:	Rehabilitative Approach to Drug & Alcohol Related Issues
Appendix 4:	Response to Questions Raised at 5 October QFARC Meeting

Drug and Alcohol Policy

Purpose

We recognise that being impaired by the effects of drugs or alcohol at work has the potential to:

- Pose a safety risk to our people,
- Pose a safety risk to the patients and/or visitors to our DHBs,
- Decrease performance ability and increase potential for mistakes.

We recognise that alcohol and substance abuse issues do occur and will do the best to support our people in resolving these issues.

This Policy sets out the Canterbury District Health Board and West Coast District Health Board (referred to as **"we", "our" and "us"**) expectations of our people regarding the use of drugs and alcohol in the workplace and use outside the workplace resulting in impairment at work; and provides the foundation for us to meet our obligations under the Health and Safety at Work Act 2015.

Scope

This Policy applies to all workers including our DHB's board members, employees, contracted individuals, volunteers, visiting health professionals and students (referred to as **our people**).

Policy

We are committed to the wellbeing of our people, patients and visitors by ensuring we take all reasonably practicable steps to maintain a drug and alcohol-free environment.

1. Our expectation for remaining free from drugs and alcohol

Our people must not be under the influence or impaired by any substance when performing their work. Substance impairment may include drug or alcohol use (whether legal or illegal) which could impair our people's performance or pose a risk to the health and safety of others

To promote the wellbeing of our people and our communities, we will not supply, and our people will not consume alcohol on our work premises. We strictly prohibit the use, making, supply or sale of drugs which have not been legally prescribed. Misappropriation of drugs will not be tolerated.

Those of our people who are concerned about their own or a colleague's drinking or drug use are expected to inform their people leader and seek support, while being assured a rehabilitative approach which supports wellbeing will be taken in accordance with our Rehabilitative Approach to Drug and Alcohol Related issues (Guideline).

Employees undertaking duties requiring an annual practising certificate do so with the additional responsibility of their professional and regulatory obligations.

Failing to be free from the effects of drugs and alcohol at work may amount to serious misconduct for which disciplinary action up to and including dismissal may be a possible consequence in line with our Code of Conduct and Disciplinary Policy.

2. Testing

We reserve the right to test our people for the presence of drugs or alcohol in the following circumstances:

- When there is Reasonable Cause,
- Post serious or potentially serious incident, and
- Returning to work following a breach of this policy.

(Refer to Drug and Alcohol Testing Procedure).

Reasonable cause testing

Substance testing may be necessary where there is reasonable cause to suspect a worker may be under the influence of drugs or alcohol (illegal or legal) at work.

Examples of "reasonable cause" for drug and/or alcohol testing include, but are not limited to, where the worker:

- produces an odour of drugs or alcohol.
- appears drowsy or inattentive at work without reasonable explanation.
- displays erratic behaviour at work without reasonable explanation.
- is unable to complete their work tasks and duties to the expected standard without reasonable explanation.
- is found in possession of drugs, drug paraphernalia or alcohol in the workplace.

Refer to our Drug and Alcohol Testing Procedure for further details on the circumstances in which testing may be carried out, and the process and procedure for doing so.

Post Incident testing

Substance testing may be necessary where there is reason to believe that a worker may be under the influence of or impaired by drugs or alcohol (illegal or legal) at work, and this is identified through the circumstances of a serious or potentially serious workplace incident.

Return to work testing following a breach of this policy

Substance testing may be required as part of returning to work following a breach of this policy. Regular testing may also continue for a reasonable period following a return to work as part of an agreed return to work | rehabilitative plan.

3. Rehabilitative approach

On a case by case basis we can provide support to our people to overcome their drug and alcohol related issues including the use of leave and/or support services. [Refer to our Rehabilitative Approach to Drug and Alcohol Related Issues for more information].

We may be obligated to advise a registration body appropriate to an individual working with an annual practising certificate.

4. Self-Disclosure

We encourage our employees to self-disclose and seek support if they are having any issues with alcohol or substance dependency.

Roles and Responsibilities

Our people must:

- Report to work fit for duty and free from the influence or impairment of drugs and alcohol, prescribed medication, or other substances.
- Perform assigned duties, including formal requirements such as on-call obligations, safely and acceptably without any limitations.
- Defer responsibility to an authorised delegate if unable to present for work free from the influence or impairment of drugs or alcohol when called upon in a crisis situation (if not a formal requirement of the role) and until no longer impaired.
- Immediately inform their people leader and/or clinical lead if they have taken any alcohol or drugs (prescription or otherwise) which may impair their work performance or pose a risk to the health and safety of themselves or others.
- Raise concerns with their people leader, clinical lead and/or People and Capability if they suspect a colleague is impaired by drugs or alcohol.
- Submit to testing procedures in accordance with this policy.
- Submit to testing procedures when working with third parties who may require our people to undergo drug or alcohol testing in line with their policies and procedures.
- Ensure drugs are prescribed within scope of practice and used in the way that they are prescribed for patient care.

Definitions

Drugs may include:

- "Controlled drugs" as defined under the Misuse of Drugs Act 1975, including cannabis, cocaine, ecstasy, methamphetamine and morphine.
- Synthetic or natural psychoactive substances including natural or synthetic cannabis or cannabis derivatives (illegal or legal) deliberately used or misused for the purpose of achieving an altered state of mind.
- Prescription and non-prescription (“over the counter”) medications that are known to impair mental or physical ability and/or that the user knows, or ought to know, does impair their ability to work safely.

Alcohol Free: For the purposes of this Policy, Alcohol Free is regarded as a test that returns less than 50mg of alcohol per 100ml of blood (0.05%) or equivalent breath alcohol of 100ug/L.

Policy measurement

We will record the number of substance tests, non-negative tests, confirmed positive tests, and rehabilitation support provided. This will be reported periodically and used to inform our efforts to reduce alcohol and drug related harm to our people. All data will be reported anonymously to preserve the privacy of our people.

Associated material

Including, but not limited to:

Our DHB's

- Drug and Alcohol Testing Procedure
- Rehabilitative Approach to Drug and Alcohol Related Issues (Guideline)
- Code of Conduct
- Disciplinary Policy
- Leave Policy

References

Including but not limited to:

- Health and Safety at Work Act 2015
- Health Practitioners Competence Assurance Act 2003

Drug and Alcohol Testing Procedure

Contents

1. Purpose

This Procedure operationalises our Drug and Alcohol Policy ("our Policy"). It ensures our people understand their individual roles and responsibilities when dealing with potential substance misuse in the workplace, particularly when determining when it is appropriate to initiate testing procedures.

2. Privacy and Confidentiality

We fully acknowledge the trust placed on the DHB to maintain the privacy and confidentiality of the people involved in substance testing.

All information shared or gathered as a result of addressing these issues is only to be used for the purpose of achieving the objectives of our Policy and this Guideline, and is subject to the Privacy Act.

A breach of privacy or confidentiality by any person will be regarded as a breach of the Code of Conduct for which disciplinary action may be a possible outcome.

3. Definitions

We have expanded on some words requiring clarity in the context of this Procedure below.

Term	Definition
Alcohol	Any substance that contains ethanol or methanol. It includes alcoholic drinks (including RTDs) and substances that could be used to ingest alcohol (e.g. methylated spirits, white spirits, lighter fluid).
Drugs	Any substances that are controlled and identified as illegal under the Misuse of Drugs Act 1975 and its amendments. Drugs may include: • "Controlled drugs" as defined under the Misuse of Drugs Act 1975, including cannabis, cocaine, ecstasy, methamphetamine and morphine. • Synthetic or natural psychoactive substances including natural or synthetic cannabis or cannabis derivatives (illegal or legal) deliberately used or misused for the purpose of achieving an altered state of mind. • Prescription and non-prescription ("over the counter") medications that are known to impair mental or physical ability and/or that the user knows, or ought to know, does impair their ability to work safely. It does not include:

Term	Definition
	• Prescribed medications, if the prescribing medical practitioner has ascertained that they are unlikely to impair mental or physical ability to work safely, and that medication is used in accordance with directions. • Pharmaceuticals or patient prescriptions being stored or supplied for legitimate healthcare purposes.
Impaired or impairment	Reduced ability to carry out some or all normal work tasks. Observable loss of function, unsatisfactory performance, or an adverse change in behaviour.
Negative	A specimen from a screening or confirmatory test result that shows no detectable drugs or alcohol or is below documented thresholds as defined by the relevant standard.
Non-negative	A specimen from a screening or confirmatory test result that is other than negative, indicating the possible presence of drugs or alcohol, but that has not been confirmed and quantitated by an accredited laboratory (in the case of a urine specimen for drug testing) or calibrated device (in the case of breath alcohol testing). Note: a 'non-negative' result is not a 'positive result', which can only be provided by an accredited laboratory following a urine specimen analysis collected and tested in accordance with AS/NZ 4308:2008 *Procedures for Specimen Collection and the Detection and Quantitation of Drugs of Abuse in Urine.*
Positive result	A specimen that has been referred to an accredited laboratory and has been confirmed to have drugs or alcohol detected that are above the confirmation cut-off levels.
Prescription medicines	Any medicine that has been prescribed by a medical practitioner.
Testee	The person being tested for drugs or alcohol.
Testing Agency	A person or organisation NZQA-certified to test under the relevant national standard for drug or alcohol testing.
Under the influence of drugs and/or alcohol	Under the influence of drugs - at a level higher than prescribed in AS/NZS4308:2008 *Procedures for specimen collection and the detection and quantitation of drugs of abuse in urine*.

Term	Definition
	Under the influence of alcohol - having a breath alcohol level higher than 100µg/L (100 micrograms per litre of breath).
Unfit for Duty	Impaired or under the influence to such an extent that the employee is unable to perform their duties to the required standard.
Work	Includes paid or unpaid work carried out for or on behalf of the DHB by any person to whom this Procedure applies.
Worker	An individual who carries out work in any capacity for a PCBU including work as – • An employee; or • A Board member; or • A contractor or subcontractor; or • An employee of a labour hire company who has been assigned to work in the business or undertaking; or • An outworker (including a homeworker); or • An apprentice or a trainee; or • A person gaining work experience or undertaking a work trial; or • A volunteer worker; or • A person of a prescribed class

4. Roles and Responsibilities

We are committed to the wellbeing of our people, patients and visitors by ensuring we take all reasonably practicable steps to maintain a drug and alcohol-free work environment. In order to achieve this, each party has a role to play:

Role	Responsibilities
Workers	• Report to work fit for duty and free from the influence or impairment of drugs and alcohol, prescribed medication, or other substances. • Perform assigned duties, including formal requirements such as on-call obligations, safely and acceptably without any limitations.

Role	Responsibilities
	• Defer responsibility to an authorised delegate if unable to present for work free from the influence or impairment of drugs or alcohol when called upon in a crisis situation (if not a formal requirement of the role) and until no longer impaired. • Immediately inform their people leader and/or clinical lead if they have taken any alcohol or drugs (prescription or otherwise) which may impair their work performance or pose a risk to the health and safety of themselves or others. • Raise concerns with their people leader, clinical lead and/or HR if they suspect a colleague is impaired by drugs or alcohol. • Submit to testing procedures in accordance with this policy. • Submit to testing procedures when working with third parties who may require our people to undergo drug or alcohol testing in line with their policies and procedures. • Ensure drugs are prescribed within scope of practice and used in the way that they are prescribed for patient care.

People Leaders	• Take action as prescribed in the drug and alcohol policy and procedures when:
	  ○ made aware that someone is suspected of being 'under the influence' or 'impaired' in the work environment.
	  ○ made aware that someone is suspected of being in possession of drugs or alcohol in the workplace
	  ○ when made aware that someone is suspected of taking drugs from the workplace.
	• Initiate testing procedures when deemed appropriate and maintain communication with those affected throughout the process.
	• Arrange for a DHB representative to accompany a worker for drug and/or alcohol testing to a Testing Agency.
	• Offer opportunities for workers to seek support and/or representation as appropriate.
	• Seek advice and guidance from HR Advisory as necessary including the potential consequences and support available to any of our people whose behaviour may fall short of their responsibilities set out in our Policies and Procedures.

Role	Responsibilities
DHB representative	• Accompany a worker for drug and/or alcohol testing to a Testing Agency when requested by a people leader/team leader to ensure their safety. • Maintain independence and neutrality during accompaniment.
Testing Agency	• Carry out substance testing on our behalf in accordance with New Zealand industry standards. • Communicate results with Wellbeing, Health and Safety team at the earliest opportunity.
HR Advisory	• Liaise with people leaders and Testing Agency as necessary to ensure testing procedures are undertaken at the earliest opportunity and in accordance with New Zealand standards. • Communicate results with relevant people leaders (where applicable) in a timely way while ensuring privacy and confidentiality is maintained. • Seek clinical review of test results and advice, as required e.g. Occupational Health physician
Health and Safety	• Provide advice and support to effectively manage associated health and safety risks.

5. Drug and Alcohol Testing

We trust that our people will comply with our Policy and the responsibilities outlined within it. However, there may be times when we are required to test workers for the presence of drugs or alcohol.

We reserve the right to test our people for the presence of drugs or alcohol in the following circumstances:

- When there is Reasonable Cause,
- Post serious or potentially serious incident, and
- Returning to work following a breach of this policy.

5.1 Reasonable cause

Substance testing may be necessary where there is reasonable cause to suspect a worker may be under the influence of drugs or alcohol (legal or illegal) at work. Whether reasonable

cause exists depends on the individual circumstances of each situation including the behaviour exhibited by the person we are concerned about.

Examples of "reasonable cause" for drug and/or alcohol testing include, but are not limited to, where the worker:

- produces an odour of drugs or alcohol.
- appears drowsy or inattentive at work without reasonable explanation.
- displays erratic behaviour at work without reasonable explanation.
- is unable to complete their work tasks and duties to the expected standard without reasonable explanation.
- is found in possession of drugs, drug paraphernalia or alcohol in the workplace.

Further examples are included in **Appendix A** attached.

A reasonable cause determination must be based on objective and observable physical signs and behaviours, rather than on a subjective view which can lead to bias. Before making a decision, a people leader should speak directly with the worker about their behaviour and ask for an explanation.

5.2 Post Incident testing

Substance testing may be necessary where there is reason to believe that a worker may be under the influence of or impaired by drugs or alcohol (illegal or legal) at work, and this is identified through the circumstances of a serious or potentially serious workplace incident.

5.3 Returning to work testing

As noted above, we also reserve the right to test for the presence of drugs or alcohol as part of a worker returning to work. This includes in advance of them returning to work as well as ongoing regular testing for a reasonable period as part of a return to work | rehabilitation plan.

These situations are reviewed on a case-by-case basis having regard to the individual circumstances of each situation.

6. Determining whether to test or stand down

Where a people leader becomes aware that a worker is suspected of being under the influence of, or impaired by, the possible effects of drugs or alcohol, they must take immediate steps to stop the individual from working and provide a supportive assessment before deciding whether to initiate substance testing.

The people leader should seek advice from HR Advisory at the earliest opportunity.

The main steps are captured in the **Flowchart attached** and summarised as follows:

6.1 Inform of concerns

The people leader must inform the worker that there are concerns in relation to the worker being under the influence or impaired by drugs oir alcohol. This will include providing reasons for the concerns.

At this point, the people leader must advise the worker that they will be seeking an explanation.

6.2 Offer Support

The people leader must:

- Tell the worker they may have a union delegate or other support person present, but arrangements to do so should not unreasonably delay the process.
- Tell the worker they may seek independent advice about our Policy or Procedures, but not so as to unreasonably delay the process.
- Inform the employee of their support options as outlined in the Rehabilitative Approach to Drug and Alcohol Related Issues guide.

6.3 Seek a Reasonable Explanation

We acknowledge there may be times when a worker may have a perfectly good reason for behaving in a certain way at work despite what appears to impairment from the presence of drugs or alcohol. In these situations, a people leader must determine whether there is a reasonable explanation for the behaviour.

A **reasonable explanation** is one that:

- is realistic, logical and sensible, considering all the circumstances of each situation;
- a fair and reasonable people leader would accept in the circumstances.

A people leader must genuinely consider a worker's explanation but does not have to accept it. If in doubt, we expect people leaders to seek advice from People and Capability.

6.4 Determine immediate actions

The people leader must consider the information they have and confirm whether there is reasonable cause to suspect the worker is under the influence or impaired by the effects of drugs or alcohol.

- If the worker **admits** that they are under the influence, the people leader stands them down and initiates substance testing.
- If the worker **denies** they are under the influence and gives another explanation, the people leader decides whether it is a reasonable explanation.
    - If the people leader decides the explanation is not reasonable, the people leader stands them down and initiates substance testing.

- If the people leader decides that the explanation is reasonable but cannot rule out the possibility of impairment, the people leader stands them down but does not initiate substance testing. The people leader may consider an Occupational Health referral for a fitness for work assessment.

6.5 Informing the worker

The people leader must inform the worker before testing is initiated that they would like them to submit to substance testing and seek their consent.

- The worker must be fully informed of the facts including the rationale for seeking a test in accordance with our Policy, the process for carrying out the testing, and the consequences that may follow from the failure to provide a test (see further details below).
- Where applicable, the people leader may explain that as part of our mandatory reporting obligations, we may be required to disclose testing results to their professional body.
- The people leader can remind and reassure the worker of our obligation to maintain privacy and confidentiality while engaged in a testing process.

6.6 Refusal to test

Where the worker refuses to test, the people leader will suspend the worker based on reasonable cause pending an investigation.

7. Testing Procedure

The people leader must contact the Testing Agency directly to arrange drug or alcohol testing of the worker.

The people leader must ensure the testee is accompanied by a DHB representative to the Testing Agency.

7.1 Alcohol Testing

Alcohol testing is carried out using a calibrated breathalyser that complies with industry standards (currently AS3547:1997 - Breath alcohol testing devices for personal use). Refer to FAQ on max for more information.

As outlined in the Policy, Alcohol Free is regarded as a test that returns less than 20mg of alcohol per 100ml of blood (0.02%) or equivalent breath alcohol of 100ug/L.

7.2 Drug Testing

Drug testing procedures must conform with industry standards, currently either:

- AS/NZS 4308:2008 - Procedures for specimen collection and the detection and quantitation of drugs of abuse in urine; or

- AS/NZS 4760:2019 Procedure for specimen collection and the detection and quantification of drugs in oral fluid)

Refer to max and FAQs for more information.

8. Results

All test results, whether positive or negative, are forwarded by the Testing Agency to Head of HR Advisory and Employee Relations who will:

- Liaise with Occupational Health Physician and Health and Safety Manager, as approporiate, to interpret test results and assess health and safety risks;
- Communicate with the relevant people leader and who then informs the individual concerned.

8.1 Response to test results

- A **negative** drug or alcohol test result is usually available within a few hours. It means the worker **can** resume their duties, subject to determining whether there are any other factors affecting their ability to perform their role (such as their health for instance).
- A **non-negative** result usually means the worker **cannot** resume their duties and may continue to be stood down pending confirmation of the result which may take up to 48 hours. While awaiting the confirmed result, the worker may be offered appropriate support and must not return to normal duties unless the worker and their people leader accept there is no ongoing health or safety risk to themselves or to any other person.
- A **confirmed positive** drug or alcohol test result means the worker **cannot** resume their duties until an investigation is undertaken by the people leader with support from HR Advisory. A worker is likely to be suspended without pay while this takes place.

8.2 Records Management

Results from drug tests will be held against your employee file and may be used to ensure that you are safe to perform your work, for employment processes, or for other related purposes.

For further information about confidentiality please see the confidentiality provisions.

9. Consequences

Being impaired due to drugs and alcohol at work may amount to serious misconduct for which disciplinary action (up to dismissal) may be a possible consequence in line with our Code of Conduct and Disciplinary Policy.

Where you are requested to undertake a drug and alcohol test, and you refuse to do so without a reasonable reason, we may consider all the circumstances in determining whether or not you are impaired. In some cases, this may mean assuming you are impaired. The

refusal to undertake a test may be considered if more formal employment processes are undertaken.

In alignment with our Rehabilitative Approach to Drug and Alcohol Related issues (Guideline), we may provide support to our people to overcome their drug and alcohol related issues including the use of leave and/or support services. Please refer to our Rehabilitative Approach to Alcohol and Drug Related Issues (Guideline) for more information on when such an avenue may be appropriate.

10. References

- Health and Safety at Work Act 2015
- Misuse of Drugs Act 1975
- Human Rights Act 1993
- Privacy Act 1993
- Employment Relations Act 2000
- Code of Conduct
- Drug and Alcohol Policy
- Fit for Work Policy
- Rehabilitative Approach to Drug and Alcohol Related Issues (Guideline)

Appendix A – Reasonable Cause indicators

- There are a range of physical signs or behaviours that may indicate potential impairment on the part of a worker. Some of these indicators are included but not limited to:

Lower confidence (more general indicators)	Higher confidence (more specific indicators)
Reduced ability to perform tasks requiring concentration and coordination.	An odour of drugs or alcohol.
Impaired memory, perception or judgement.	Bloodshot eyes, dilated or constricted pupils, horizontal gaze nystagmus, vertical gaze nystagmus or lack of convergence.
A sudden, unexplained drop in performance.	Slow or slurred speech, slow walking, lack of balance while walking in a straight line, swaying from heel to toe while standing still.
Intense anxiety, depression or panic attacks.	Acute reduction in level of consciousness or gross motor skills (seek medical advice).
Changes in appearance or personal hygiene.	Attention span difficulty, delayed comprehension of simple questions or compliance with straightforward directions.
Excessive sweating, flushed complexion, increased health problems or complaints about health.	Uncharacteristic violent or aggressive behaviour or outbursts / paranoia.
Frequent sickness or absences or 'emergencies' resulting in leaving work early.	A pattern of minor incidents involving decision-making, situational awareness or coordination.

Frequently Asked Questions

Question	Answer
How do I know the testing process is okay?	We follow nationally recognised standards when initiating any drug or alcohol testing at the DHB. This includes using an accredited person / agency to undertake testing on our behalf. If you feel these standards have been compromised, please get in touch with People and Capability.
What if I disagree with the result?	Any testee who disagrees with the result of a confirmation drug test can request that the first part of the sample (held by the Testing Agency) is also tested within 14 days of receiving the confirmation test result. This test determines any drugs at any level in the urine (it is not restricted to the cut-off levels). The outcome of this test is considered conclusive.
Who pays for the testing?	The DHB will pay for all costs associated with drug and alcohol testing, except where a testee has requested a second drug or alcohol confirmation test after a first confirmation test has been completed. If the second confirmation test is positive, the testee pays all costs associated with the second test.

Rehabilitative Approach to Drug and Alcohol Related Issues

Contents

1. Purpose

This Guideline describes the circumstances in which a rehabilitative approach may be considered when managing substance misuse in the workplace, including following a breach of our Drug and Alcohol Policy ("our Policy"). It ensures our people understand when this option may be available, the roles and responsibilities of those involved, and the process to follow.

2. Scope

This Guideline applies to DHB employees. It does not cover other groups such as contracted individuals, volunteers, visiting health professionals or students, unless we exercise our discretion to do so on a case-by-case basis.

3. Privacy and Confidentiality

We fully acknowledge the trust placed on us to maintain the privacy and confidentiality of employees who may be experiencing drug or alcohol related issues.

All information shared or gathered as a result of addressing these issues is only to be used for the purpose of achieving the objectives of our Policy and this Guideline, and is subject to the Privacy Act.

A breach of privacy or confidentiality by any person will be regarded as a breach of the Code of Conduct for which disciplinary action may be a possible outcome.

4. Definitions

We have expanded on some words requiring clarity in the context of this Guideline below.

Term	Definition
Alcohol	Any substance that contains ethanol or methanol. It includes alcoholic drinks (including RTDs) and substances that could be used to ingest alcohol (e.g. methylated spirits, white spirits, lighter fluid).
Drugs	Any substances that are controlled and identified as illegal under the Misuse of Drugs Act 1975 and its amendments. Drugs may include: • "Controlled drugs" as defined under the Misuse of Drugs Act 1975, including cannabis, cocaine, ecstasy, methamphetamine and morphine. • Synthetic or natural psychoactive substances including natural or synthetic cannabis or cannabis derivatives (illegal or legal) deliberately used or misused for the purpose of achieving an altered state of mind. • Prescription and non-prescription ("over the counter") medications that are known to impair mental or physical ability and/or that the

Term	Definition
	user knows, or ought to know, does impair their ability to work safely. It does not include: • Prescribed medications, if the prescribing medical practitioner has ascertained that they are unlikely to impair mental or physical ability to work safely, and that medication is used in accordance with directions. • Pharmaceuticals or patient prescriptions being stored or supplied for legitimate healthcare purposes.
Impaired or impairment	Reduced ability to carry out some or all normal work tasks. Observable loss of function, unsatisfactory performance, or an adverse change in behaviour.
Negative	A specimen from a screening or confirmatory test result that shows no detectable drugs or alcohol or is below documented thresholds as defined by the relevant standard.
Non-negative	A specimen from a screening or confirmatory test result that is other than negative, indicating the possible presence of drugs or alcohol, but that has not been confirmed and quantitated by an accredited laboratory (in the case of a urine specimen for drug testing) or calibrated device (in the case of breath alcohol testing). Note: a 'non-negative' result is not a 'positive result', which can only be provided by an accredited laboratory following a urine specimen analysis collected and tested in accordance with AS/NZ 4308:2008 *Procedures for Specimen Collection and the Detection and Quantitation of Drugs of Abuse in Urine.*
Positive result	A specimen that has been referred to an accredited laboratory and has been confirmed to have drugs or alcohol detected that are above the confirmation cut-off levels.
Prescription medicines	Any medicine that has been prescribed by a medical practitioner.
Testee	The person being tested for drugs or alcohol.
Testing Agency	A person or organisation NZQA-certified to test under the relevant national standard for drug or alcohol testing.
Under the influence of drugs and/or alcohol	Under the influence of drugs - at a level higher than prescribed in AS/NZS4308:2008 Procedures for specimen collection and the detection and quantitation of drugs of abuse in urine. Under the influence of alcohol - having a breath alcohol level higher than 100µg/L (100 micrograms per litre of breath).

Term	Definition
Unfit for Duty	Impaired or under the influence to such an extent that the employee is unable to perform their duties to the required standard.
Work	Includes paid or unpaid work carried out for or on behalf of the DHB by any person to whom this Procedure applies.

5. Rehabilitative Approach

As part of our restorative approach, we are committed to supporting our people to overcome any drug or alcohol related issues that may be preventing them from reporting to work fit for duty. We expect our people to fully engage in any rehabilitative process and be honest and transparent about the progress they are making towards returning to work free from the influence or impairment of drugs or alcohol.

6. When this approach works best

We need to take into account a number of factors when deciding whether it is appropriate to offer a rehabilitative approach to employees in certain situations.

1. **Engagement.** An employee acknowledges and accepts that they have a problem and they are willing to engage in the process of receiving support to overcome their issues. This means being committed to the process and working through any challenges that may present themselves even when it may be difficult.
2. **Likelihood of success**. There may be times when despite the best intentions of an employee and our best efforts to support them, they simply cannot make sufficient progress to enable them to return to work fit for duty within a reasonable period of time. In such situations, the likelihood of success may be so low that a rehabilitative approach is not, or is no longer, considered appropriate.
3. **Other factors**. There may be other factors that come into play when deciding whether a rehabilitative approach is the right way forward. This could include the severity of the issue giving rise to the issue in the first place, the position held by the person, including any professional responsibilities they need to meet, the ability of the service to support them from an operational perspective, and the timeframes for completion of a Rehabilitation Plan.

The employee's circumstances will be considered on an individual basis to determine whether a rehabilitative approach is appropriate, with any Rehabilitation Plan tailored to meet their needs.

7. Roles and Responsibilities

There are different roles and responsibilities involved when undertaking a rehabilitative approach, with the level of involvement dependent on the situation.

Role	Responsibilities
Employees	• Fully engage in the process and accept self-responsibility for returning to work fit for duty within a reasonable period of time. • Actively communicate with their people leader and/or HR Advisory contact and/or case manager about progress with rehabilitation. This may include providing evidence of treatment attendance and/or treatment progress reports, if requested. • Attend meetings with people leaders and/or HR Advisory / case manager as necessary to provide updates and monitor progress. • Follow the Rehabilitation Plan agreed to between the parties including submitting to ongoing substance testing if required and understand the consequences if the Rehabilitation Plan is unsuccessful. • Report immediately if they have failed to follow the Rehabilitation Plan or taken any alcohol or drugs which may impair their work performance or pose a risk to the health and safety of others.
People Leaders	• Maintain communication with employee, HR Advisory, case management and Health and Safety teams when managing a potential drug and alcohol related issue. • Seek advice and guidance from HR Advisory, case management and Health and Safety teams as necessary including the appropriate pathways for initiating a Rehabilitation Plan. • Consider all options available to support employees alongside or as part of a Rehabilitation Plan and fulfil those obligations in a timely manner such as arranging leave or providing cover. • Ensure communications are clear around expectations and timeframes for the successful completion of a Rehabilitation Plan including potential consequences if it is unsuccessful. • Monitor progress against the rehabilitation plan • Arrange substance testing of employee with Testing Agency if agreed to in Rehabilitation Plan as part of ongoing monitoring of employee.
People and Capability/ HR Advisory	• Work in partnership with the employee, people leader, case manager and Health and Safety team by providing sound advice and guidance when considering the different pathways for managing drug and alcohol related issues. • Maintain communications with those involved in fulfilling their obligations in the Rehabilitation Plan including advising on the consequences if it is unsuccessful.

Role	Responsibilities
Case Manager	• Work in partnership with the employee, people leader, health care provider and HR Advisory Team to develop a Rehabilitation / Return to Work Plan. • Work in partnership with the employee, people leader, health care provider and HR Advisory to facilitate connecting to appropriate care and provide advice regarding an employee's progress with a Rehabilitation Plan and their fitness to return to work. • Support people leader to arrange substance testing of employee with Testing Agency if agreed to in Rehabilitation Plan as part of ongoing monitoring of employee.

8. Referral Pathway

There are different pathways for initiating a rehabilitative approach when drug or alcohol related issues have arisen in the workplace. An employee may:

1. Make a referral through the Health and Wellbeing Referral Pathway.
2. Return a positive result from substance testing, whether as part of an investigation process or not.
3. Be found in possession of alcohol, drugs or drug paraphernalia in the workplace or found to be taking drugs from the workplace

In all situations the employee and people leader are expected to engage with HR Advisory, case management and where appropriate, the Health and Safety team, as needed.

9. Support Options

There are a range of options that may be considered in order to support an employee as part of a rehabilitative approach, from offering leave to programmes and courses offered by external agencies. The cost of any support options are to be discussed and agreed between the people leader and employee.

Examples of sources of support include the following:

- **General Practitioner**. As your key primary health provider, your General Practitioner is able to assess your physical and mental health needs and link you to care;
- **AOD Central Coordination Centre** (phone 03 338 4437). People are able to self-refer or be referred by the General Practitioner or by another agency. A broad range of services may be offered including offering brief intervention, self-help information, support/education groups and referrals to other agencies for individual or intensive treatment programmes, weekly meetings and information about resources for whanau;
- **www.alcohol.org.nz** This website provides up to date resources and information about services across New Zealand;

- **Alcohol and Drug Helpline** (free 24/7), phone 0800 787 797 or text 8681; Maori Alcohol and Drug Helpline 0800 787 798; Pacific Alcohol and Drug Helpline 0800 789 999;
- **Crisis Resolution** (Christchurch phone 0800 920 092; Ashburton phone 0800 222 955; West Coast phone 0800 757 678) provides free help for urgent mental health problems 24/7.
- **Support List** on Max

10. References

- Health and Safety at Work Act 2015
- Misuse of Drugs Act 1975
- Human Rights Act 1993
- Privacy Act 1993
- Employment Relations Act 2000
- Drug and Alcohol Policy
- Drug and Alcohol Testing Procedure

Appendix 4 – Responses to Questions Raised at 5 October QFARC Meeting

How does this align with other DHBs in terms of zero tolerance etc?

- Waitemata does not have drug and alcohol policy per se but has an Impairment at Work Policy. It does not include testing.
- Southern DHB have a Drug and Alcohol policy.
- South Canterbury have started to draft a policy, but it is still a work in progress.
- Auckland do not have a policy, but they are working on one. They do have an Illegal Substance policy. This policy covers topics relating to illegal substance use, supply or possession by patients or visitors on ADHB premises. It doesn't include testing.
    - The following DHBs do not have a confirmed policy:
        - ❖ Capital and Coast
        - ❖ Hutt Valley
        - ❖ Nelson Marlborough
        - ❖ Counties Manukau
        - ❖ Wairarapa

Where have we got our alcohol levels from and why not below any industry standards?

- The Australia /New Zealand Standard 4308/2008 has a stated positive cut off level for drug testing, but not for alcohol testing.
- The level chosen is the same as the NZ Driving legal limit

How are we treating activity outside of work?

- The policy covers employees at work. However, if they present impaired or under the influence we must deal with the consequences. We do not monitor employee usage outside of work hours.

Why have we not differentiated the classes of drugs and would we take into account the different classes in our decisions around consequences?

- We do not differentiate on illegal drugs and their categories. The focus is on our people not being under the influence, or impaired by any substance, when performing their work.

The policy assumes addiction. There could be recreational use or stealing of drugs for supply.

- We have included that the misappropriation of drugs will not be tolerated.
- We intentionally acknowledged under the purpose section that alcohol and drug use does occur and wanted to show that we will best support our people to get well regardless of circumstance.
- Under the Rehabilitative Approach Guidelines, we are committed to supporting our people to overcome any drug or alcohol related issues that may be preventing them from coming to work fit for duty.

What are the obligations to report incidents to other parties (Police, Medical Council and Nursing Council)?

- We do not report incidents involving alcohol use to the Police.

- However, the possession and / or supply of illegal substances is a criminal activity and Police will be notified.
- There is a strict process around reporting to professional bodies and they in turn have a detailed process in the handling these issues.

Why no random testing?

- Random testing is not undertaken as we do not have a zero-tolerance policy.

MĀIA FUNDED CAPITAL EXPENDITURE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Smit Bharati, Business Manager, Corporate Support**

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

DATE: **21 October 2021**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This paper has been generated to seek approval for the purchase of 29 sofa beds via the Māia Health Foundation. Board approval is required for capital expenditure >$50K from trust/donated funds.

2. RECOMMENDATION

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

i. notes that the Māia Health Foundation have fundraised $65,933 to purchase 29 sofa beds for Women's Health; and
ii. approves expenditure of trust/donated funds of $65,933.

3. SUMMARY

The Māia Health Foundation have fundraised $65,933 to purchase 29 sofa beds for various patient sleep areas in Christchurch Women's Health, Kaikoura Health Centre Maternity room and Ashburton Maternity.

There are consistent consumer complaints regarding support people having inadequate areas to rest while staying overnight to support a new family soon after birth. These sofa beds would address the need for support people to stay the night.

Women and babies remain on Birthing Suite and Maternity because of high levels of complexity, and having a loved one able to remain with them to give physical and emotional support is of huge importance at this very special time.

We also have unwell antenatal women who sometimes require a support person to stay with them during a worrying time in their pregnancy.

We support a person nominated by the mother to stay and they need to have the opportunity to have some rest as well. We currently ask support people to rest in an upright chair or on a thin mat on the floor. This is both uncomfortable and is a Health & Safety risk.

There is also a need for support people to stay the night with well women in our community units. Kaikoura and Ashburton Maternity facilities will benefit from the generosity of donors in their community who also understand this need.

FINANCE REPORT FOR THE PERIOD ENDED 31 AUGUST 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Gabrielle Gaynor, Corporate Finance Manager**

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

DATE: **21 October 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this paper is to provide a regular monthly report of the financial results of Canterbury DHB and other financial related matters.

2. RECOMMENDATION

That the Board:

i. notes the consolidated financial result for the month **excluding** the impact of Covid-19 and Holidays Act compliance provision is unfavourable to plan by $0.594M (YTD $1.396M unfavourable);
ii. notes that the YTD impact of Covid-19 is an additional $1.598M net revenue which is favourable to budget; and
iii. notes that the YTD impact of the Holidays Act Compliance is an additional $2.695M expense which is in line with budget.

3. FINANCIAL RESULTS EXECUTIVE SUMMARY

Summary DHB Group Financial Result excluding Covid-19, and Holidays Act Compliance:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.471	0.000	0.471	0.387	(0.000)	0.387
Funder	(9.668)	(7.970)	(1.698)	(17.674)	(15.370)	(2.304)
DHB Provider	(3.690)	(4.322)	0.633	(8.804)	(9.325)	0.521
Canterbury DHB Group BAU Result	**(12.887)**	**(12.293)**	**(0.594)**	**(26.091)**	**(24.695)**	**(1.396)**

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
Canterbury DHB Group BAU Result	**(12.887)**	**(12.293)**	**(0.594)**	**(26.091)**	**(24.695)**	**(1.396)**
Covid-19 & Holidays Act	(0.109)	1.352	(1.461)	1.097	2.691	(1.594)
Canterbury DHB Group Result	**(12.778)**	**(13.645)**	**0.867**	**(27.188)**	**(27.386)**	**0.198**

4. KEY FINANCIAL RISKS & EMERGING ISSUES

Liquidity - We are currently forecasting that we will not breach our overdraft limit until the second quarter of the 2022 calendar year. We will continue to require further equity support in the future whilst we are incurring deficits and we continue with our capital expenditure program.

Covid-19 - Use of Managed Isolation Quarantine Facilities (*MIQFs*) is back up to 100% with the closing of the trans-Tasman bubble. Vaccinations are being delivered via mass vaccination events and a drive through clinic has been setup. The biggest risk with vaccination is supply and staff shortage.

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 that the final amount differs significantly from this accrued amount.

MECA settlements - We continue to accrue for the anticipated one-off payments as part of the NZNO MECA settlement along with other MECA settlement accruals.

Recruitment - The transition to Health NZ as well as on going Covid-19 restrictions on international travel is creating some disruption to recruitment. The pool of potential employees that we can recruit from is currently very limited, and some positions are very hard to recruit to.

5. APPENDICES

Appendix 1	Financial Results
Appendix 2	Financial Result Before Indirect Revenue & Expenses **excluding** the impact of 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

The following table shows the financial results, the impact of Covid-19 and holidays act compliance accrued:

	Period to date									Year to date								
August 2021 Results	Month Actual $000	Actual Covid-19 $000	Actual Holidays Act $000	BAU Actual Result	Month Budget $000	Budget Covid-19 $000	Budget Holidays Act $000	BAU Budget Result	BAU Variance	YTD Actual $000	Actual Covid-19 $000	Actual Holidays Act $000	YTD BAU Actual Result	YTD Budget $000	Budget Covid-19 $000	Budget Holidays Act $000	YTD BAU Budget Result	BAU Variance
MOH Revenue	(183,406)	(11,710)		(171,696)	(168,395)	4,050		(172,445)	(750)	(360,827)	(15,545)		(345,282)	(347,371)	(2,370)		(345,001)	281
Patient related revenue	(6,507)	(1,609)		(4,898)	(6,395)	(1,230)		(5,165)	(267)	(12,465)	(2,610)		(9,855)	(12,802)	(2,469)		(10,333)	(478)
Other Revenue	(4,534)	(1,464)		(3,070)	(4,316)	(1,025)		(3,291)	(220)	(8,860)	(2,832)		(6,028)	(8,522)	(2,050)		(6,472)	(444)
Total Operating Revenue	(194,447)	(14,783)	-	(179,664)	(179,106)	1,795	-	(180,901)	(1,237)	(382,153)	(20,987)	-	(361,166)	(368,695)	(6,889)	-	(361,806)	(640)
Employee expenses	88,118	3,395	1,347	83,376	83,065	(1,067)	1,351	82,781	(595)	175,558	6,147	2,695	166,716	171,141	2,967	2,699	165,475	(1,240)
Treatment Related costs	17,915	1,021		16,894	18,096	678		17,418	524	35,699	1,309		34,390	36,529	1,397		35,132	742
External Provider costs	78,642	7,288		71,354	69,426	(1,355)		70,781	(574)	152,969	9,950		143,019	143,571	2,203		141,368	(1,651)
Other Expenses	11,286	1,619		9,667	10,637	(54)		10,691	1,025	22,095	1,974		20,121	21,500	305		21,195	1,074
Total Operating Expenditure	195,960	13,323	1,347	181,290	181,224	(1,798)	1,351	181,671	380	386,321	19,380	2,695	364,246	372,741	6,872	2,699	363,170	(1,075)
Operating result (Surplus) / Deficit	1,514	(1,460)	1,347	1,627	2,117	(3)	1,351	769	(857)	4,168	(1,607)	2,695	3,080	4,046	(17)	2,699	1,364	(1,715)
Total Indirect revenue and expenditure	11,264	4		11,260	11,527	4		11,523	263	23,021	9		23,012	23,340	9		23,331	319
Total - (Surplus) / Deficit	12,778	(1,456)	1,347	12,887	13,645	1	1,351	12,293	(594)	27,188	(1,598)	2,695	26,091	27,386	(8)	2,699	24,695	(1,396)

Covid-19 - Canterbury DHB's net result in relation to Covid-19 is a surplus of $1.456M for the month.

MoH Revenue includes community surveillance and testing, Maori health support and vaccinations, offset by external provider expenses, internal staffing and other costs.

Patient related revenue includes revenue for MIQFs. We are invoicing MoH based on the actual costs of services provided.

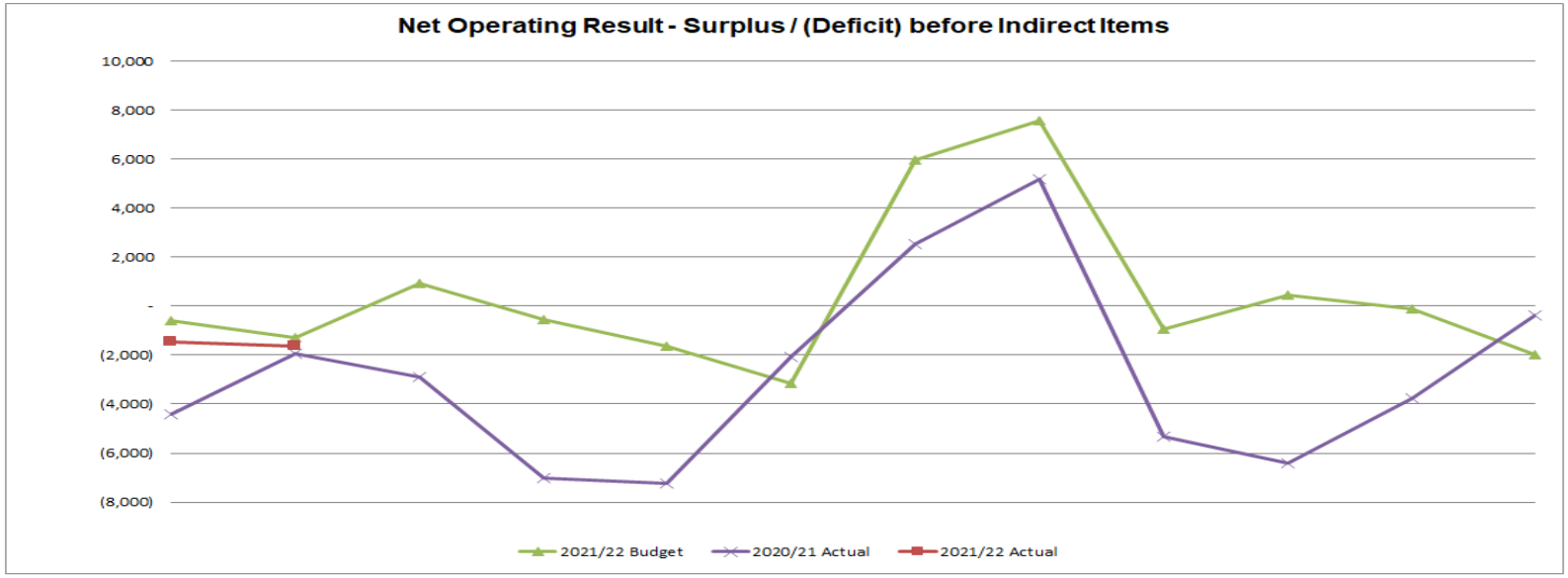
Other revenue is from Covid-19 pathology tests processed by Canterbury Health Laboratories (CHL) for Canterbury and other regions.

Variances to budget for Covid-19 are generally related to vaccination activity as this programme is not included in the budget as per MoH instruction. The favourable result in August is due in part to testing done on behalf of other regions like Auckland.

APPENDIX 2: FINANCIAL RESULT BEFORE INDIRECT REVENUE & EXPENSES (excludes Covid-19, and Holidays Act Compliance)

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED AUGUST 2021

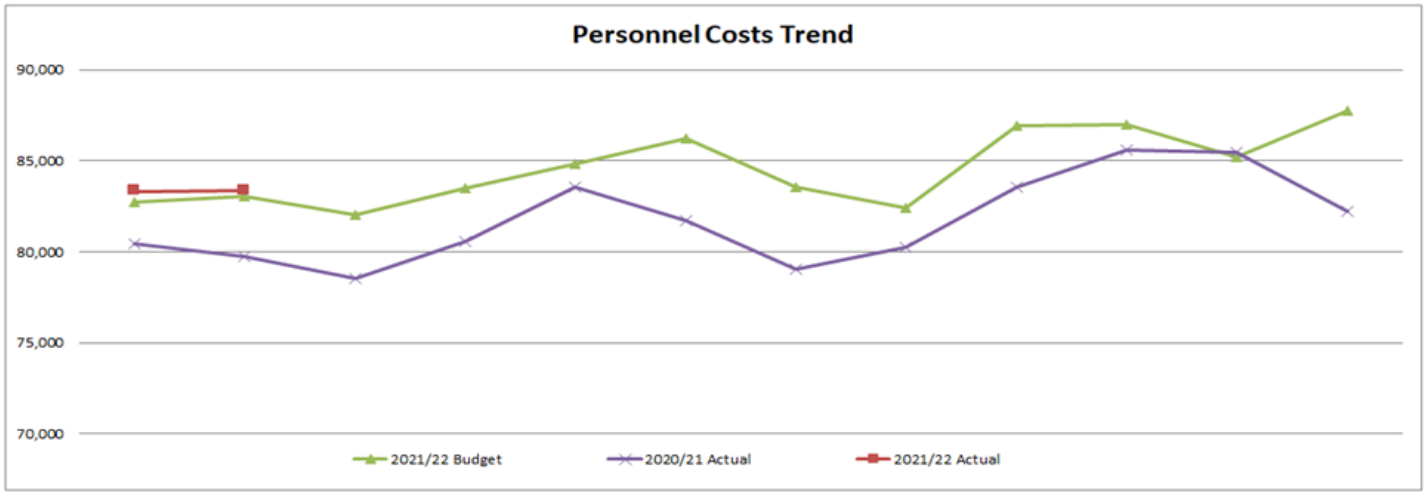
	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2020/21 Actual $'000	Yr End Budget $'000
Surplus/(Deficit) before Indirect items	(1,627)	(769)	(857)	111% ✗	(3,080)	(1,364)	(1,715)	126% ✗	(33,718)	4,649

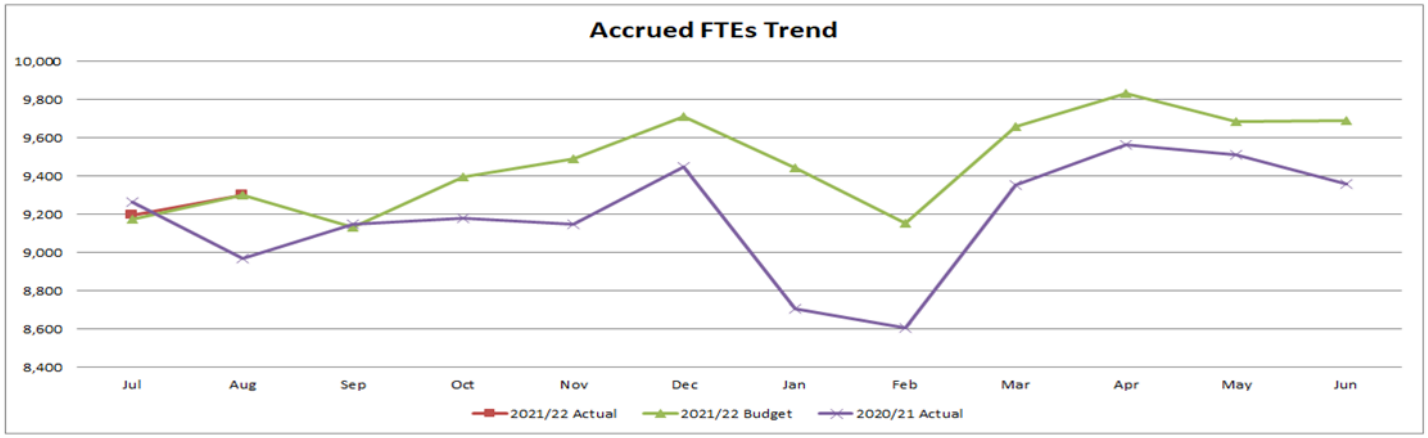


KEY POINTS

Our Business as Usual (BAU) result is $1.715M unfavourable to budget.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE (excluding Covid-19 and Holidays Act compliance and including outsourced personnel)



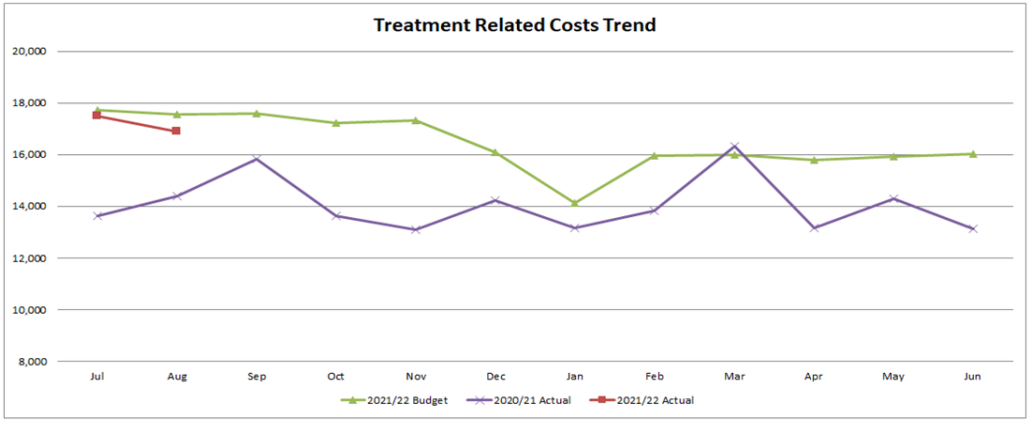


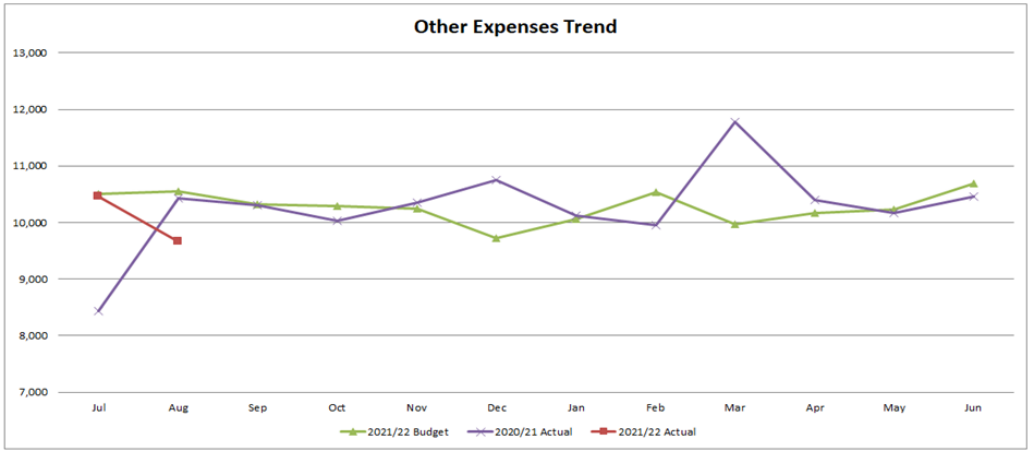
KEY POINTS

Personnel Costs are influenced by additional costs in relation to the RSV outbreak, including additional cleaning staff. Also included in personnel costs is outsourced staff to cover annual leave taken. Another factor affecting payroll costs is the high level of overtime required due to difficulty with recruitment of staff.

Accrued FTE largely correlates with the trend in contracted FTE.

TREATMENT RELATED & OTHER COSTS (excluding Covid-19)





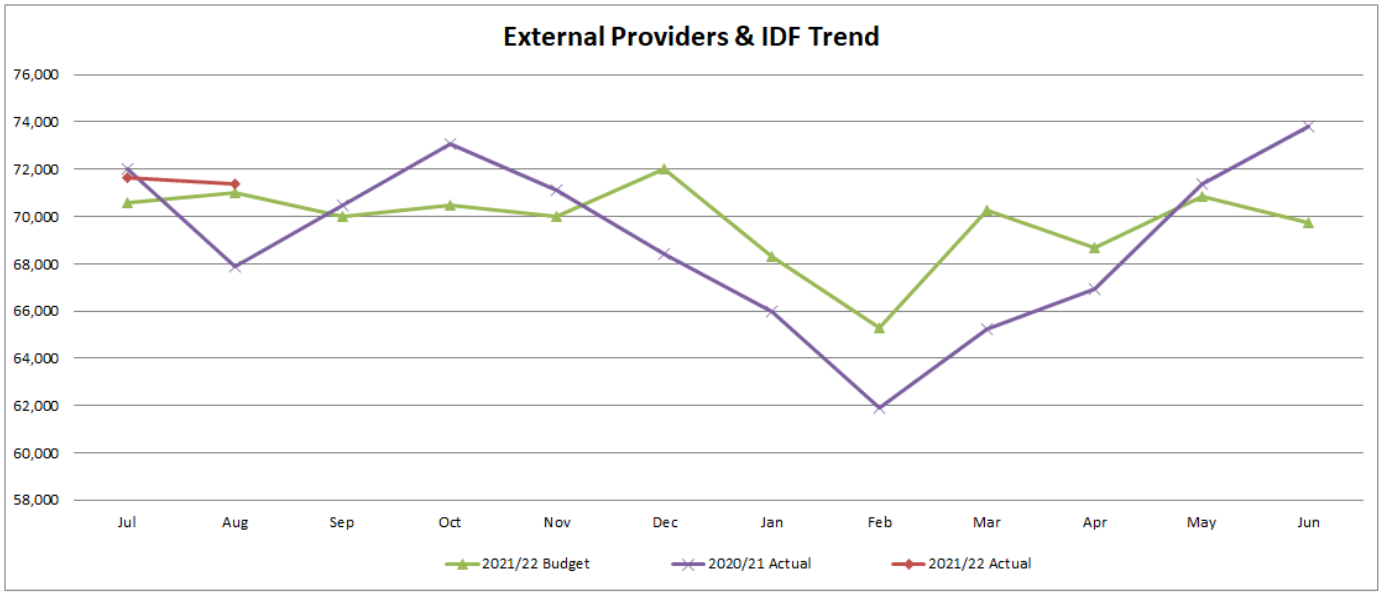
KEY POINTS

Treatment related costs are favourable to plan; this includes $0.4M favourable variance in outsourced clinical services due to a focused effort on delivering more clinical services in-house as part of the cost saving initiatives. August costs are also lower due to lower activity due to the Covid lockdown.

Other Expenses are tracking lower than expected. $500k of August variance was related to reclassification of Covid-19 expenses.

EXTERNAL PROVIDER COSTS (excluding Covid-19)

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000			2020/21 Actual $'000	Yr End Budget $'000
External Provider Costs	71,354	70,781	(574)	-1%	✗	143,019	141,368	(1,651)	-1%	✗	828,246	837,270



KEY POINTS

The unfavourable variance is largely offset by additional MoH subcontract revenue.

FINANCIAL POSITION – EQUITY & CASH

	YTD Actual $'000	YTD Budget $'000	Variance $'000		YTD Actual $'000	YTD Budget $'000	Variance $'000	Year End 20/21 $'000
Equity	1,108,130	1,107,940	(190)	Cash	21,348	40,854	(19,506)	50,775

KEY POINTS

Our cash position in August is lower than expected due to timing of receipts and payments.

APPENDIX 3: CANTERBURY DHB GROUP INCOME STATEMENT

The Group financial results include Canterbury DHB and its subsidiaries
For the 2 months ending 31 August 2021

Month					Year to Date					
21/22 Actual $000's	21/22 Budget $000's	20/21 Actual $000's	Variance to Budget $000's		21/22 Actual $000's	21/22 Budget $000's	20/21 Actual $000's	Variance to Budget $000's	21/22 Budget $000's	20/21 Actual $000's
183,406	168,395	164,958.08	15,010 ✓	MoH Revenue	360,827	347,371	327,997	13,456 ✓	2,086,388	1,991,657
6,507	6,395	5,906	112 ✓	Patient Related Revenue	12,465	12,802	10,922	(337) ✗	76,994	73,244
4,534	4,316	5,342	219 ✓	Other Revenue	8,860	8,522	9,017	338 ✓	58,295	48,140
194,447	**179,106**	**176,206**	**15,341**	**Total Operating Revenue**	**382,153**	**368,695**	**347,937**	**13,458**	**2,221,677**	**2,113,041**
88,118	83,065	80,396	(5,053) ✗	Personnel Costs	175,558	171,141	161,586	(4,416) ✗	1,049,643	1,018,854
17,915	18,096	14,711	181 ✓	Treatment Related Costs	35,699	36,529	28,671	830 ✓	204,873	177,141
78,642	69,426	70,486	(9,217) ✗	External Service Providers	152,969	143,571	143,386	(9,398) ✗	851,785	844,188
11,286	10,637	10,643	(648) ✗	Other Expenses	22,095	21,500	19,939	(595) ✗	125,943	122,152
195,960	**181,224**	**176,236**	**(14,737)** ✗	**Total Operating Expenditure**	**386,321**	**372,741**	**353,582**	**(13,579)** ✗	**2,232,245**	**2,162,334**
(1,514)	**(2,117)**	**(30)**	**604** ✓	**Total Surplus / (Deficit) Before Indirect Items**	**(4,168)**	**(4,046)**	**(5,645)**	**(121)** ✗	**(10,568)**	**(49,293)**
18	61	61	(42) ✗	Interest Revenue	68	81	120	(13) ✗	700	1,075
378	418	-	(40) ✗	Capital Charge Relief / Debt Equity Swap Funding	797	837	-	(40) ✗	5,020	8,940
631	429	17	202 ✓	Donations	832	694	34	138 ✓	5,010	2,384
-	-	3	- ✓	Profit on Sale of Assets	-	-	10	- ✓	-	1,653
-	-	-	-	Joint Venture Income	-	-	-	- ✓	-	25
1,028	**908**	**81**	**119** ✓	**Total Indirect Revenue**	**1,697**	**1,612**	**164**	**85** ✓	**10,730**	**14,078**
4,608	4,656	2,437	48 ✓	Capital Charge	9,296	9,332	4,874	36 ✓	53,949	39,871
7,511	7,538	6,153	27 ✓	Depreciation	15,017	15,049	12,151	32 ✓	92,104	94,651
231	236	-	5	Financing Component of Operating Leases	463	523	-	61	3,015	2,079
(58)	6	64	64 ✓	Interest Expense & Forex Gains and Losses	- 58	47	80	105 ✓	100	60
-	-	2	- ✓	Loss on Sale of Assets	-	-	2	- ✓	-	4,336
12,292	**12,436**	**8,656**	**144** ✓	**Total Indirect Expenses**	**24,718**	**24,952**	**17,107**	**234** ✓	**149,168**	**140,998**
(12,778)	**(13,645)**	**(8,606)**	**867** ✓	**Total Surplus / (Deficit)**	**(27,188)**	**(27,386)**	**(22,588)**	**198** ✓	**(149,006)**	**(176,213)**

This P&L includes all of the actual revenue and expenses related to Covid-19. As instructed by the MoH, we have removed the budget for the vaccination programme. Because we had a budget in July we have had to remove YTD budget figures in the month of August distorting the monthly budget numbers. This explains the large variances for Revenue, Payroll and External Provider costs. Overall the vaccination revenue and expenses net off to zero.

APPENDIX 4: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 31 August 2021

Un-audited 30-Jun-21 $'000		Group Actual 31-Aug-21 $'000	Group Budget 31-Aug-21 $'000	Annual Group Budget 30-Jun-22 $'000
490,730	Opening Equity	1,125,761	1,125,761	1,125,761
178,139	Net Equity Injections / (Repayments) During Year	9,557	9,557	151,139
537,624	Other Movements	-	-	97,357
95,481	Reserve Movement for Year	-	-	-
(176,213)	Operating Results for the Period	(27,188)	(27,379)	(149,006)
1,125,761	**TOTAL EQUITY**	1,108,130	1,107,939	1,225,251
-				
	Represented By:			
	Current Assets			
50,775	Cash & Cash Equivalents	21,348	40,854	120,487
750	Short Term Investments	750	750	750
107,157	Trade and Other Receivables	137,602	107,157	107,157
6,278	Prepayments	13,849	6,278	6,278
13,811	Inventories	14,495	13,811	13,811
15,095	Restricted Assets	14,914	15,094	15,094
193,866	**Total Current Assets**	202,958	183,944	263,577
	Less Current Liabilities			
1,682	Borrowings (Finance Leases Current)	1,682	1,682	1,682
158,379	Trade and Other Payables	164,166	164,552	155,219
15,111	Restricted Funds	14,919	15,111	15,111
381,697	Employee Benefits	397,597	381,696	381,696
556,869	**Total Current Liabilities**	578,364	563,041	553,708
(363,003)	**Working Capital**	(375,406)	(379,097)	(290,131)
	Non Current Assets			
16	Restricted Funds	16	16	16
4,253	Investment	4,193	4,253	4,253
1,541,081	Fixed Assets	1,535,637	1,539,353	1,567,699
1,545,350	**Term Assets**	1,539,846	1,543,622	1,571,968
	Non Current Liablilties			
7,544	Employee Benefits	7,591	7,544	7,544
49,042	Borrowings (Finance Leases Non Current)	48,718	49,042	49,042
56,586	**Term Liabilities**	56,310	56,586	56,586
1,125,761	**NET ASSETS**	1,108,130	1,107,939	1,225,251

Receivables are high this month due to Funder MoH accruals.

Insurance of $6M has been prepaid in August which has negatively impacted our cash balance.

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

Investment in the Non Current Assets include investment in NZHPL and Health One .

Borrowings in Current and Term Liabilities is the finance lease liability for the Manawa building, the CLS building and equipment. The lease costs of the buildings are also included in Fixed Assets.

APPENDIX 5: CANTERBURY DHB GROUP STATEMENT OF CASHFLOW

Un-audited 30-Jun-21 $'000		Actual 31-Aug-21 $'000	YTD Budget 31-Aug-21 $'000	Budget 30-Jun-22 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(46,875)	**Net Cash from Operating Activities**	(26,592)	(2,998)	(56,903)
	CASHFLOW FROM INVESTING ACTIVITIES			
(78,847)	**Net Cash from Investing Activities**	(12,067)	(16,480)	(121,881)
	CASHFLOW FROM FINANCING ACTIVITIES			
183,463	**Net Cash from Financing Activities**	9,233	9,557	248,496
57,741	Overall Increase/(Decrease) in Cash Held	(29,426)	(9,921)	69,712
(6,966)	Add Opening Cash Balance	50,775	50,775	50,775
50,775	**Closing Cash Balance**	21,349	40,854	120,487

CARE CAPACITY DEMAND MANAGEMENT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Janette Dallas, Nursing Director - Care Capacity Demand Management**

APPROVED BY: **Becky Hickmott, Executive Director of Nursing**

DATE: **21 October 2021**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report has been generated for the Board as a quarterly update on the Care Capacity Demand Management (*CCDM*) programme. The CCDM programme was approved by the Board for implementation in August 2019 to better match nursing and midwifery supply to patient care demand.

Part of the CCDM programme requirements is that "the Core Data Set is monitored, reported and actioned" and that the "DHB has a plan in place to advance reporting to EMT and to the Board on the Core Data Set measures and the improvements initiated as a result."

CCDM also requires that the "organisation annually reviews the relevance, frequency and effectiveness of the Core Data Set" and that the DHB provides a report to the Board that:

- Shows examples of improvements to a patient care process/system.
- Changes to workforce management/environment.
- Efficiencies across wards/units resulting from CCDM.

2. RECOMMENDATION

That the Board

i. notes the Care Capacity Demand Management report.

3. SUMMARY

The CCDM programme is progressing well, however, as reported previously we did not meet our June 2021 deadline for the Ministry of Health. Full implementation is dependent on the completion of all the FTE calculations and these calculations have now commenced within the CDHB and will be phased throughout this year. This report focusses in on the Core Data Set as part of the yearly reporting mechanism for CCDM.

4. DISCUSSION

The CCDM programme is working to a set of standards set out by the Safe Staffing Healthy Workplaces office of TAS. It has five major standards and we are progressing well against these.

Governance

The governance group meets monthly and contains membership of the Executive Management Team, senior nursing and midwifery leads and members of each union. Working groups as a subset as part of the CCDM requirements are also working well and we have moved to a business

as usual (*BAU*) model. Our partnership workshop has also now occurred which is part of the CCDM governance requirements.

TrendCare / Acuity Tool

TrendCare has been implemented in all inpatient areas apart from the Dialysis Unit and Oncology Day Unit. In addition, the perioperative area will be using TrendCare to support nursing allocation. We have been delayed in installing the latest version of TrendCare by the vendor, however, aim to have this installed by November.

Core Data Set

The Core Data Set measures how each area within the DHB is doing. It is a balanced set of measures placing equal priority on "quality patient care", "quality work environment" and "best use of health resources". It helps each ward/area to focus in on improvement and is now displayed on the intranet within "Seeing our System". We are currently monitoring 18 of 23 Core Data Set measures. The remaining 5 measures will be reported with the implementation of the variance response management system which is underway now. We have local data councils in place at Burwood, Specialist Mental Health, Ashburton, Christchurch Hospital, and Maternity. The core data set is also monitored by the CCDM Council. The data is visible for all DHB staff to view and can be drilled down to ward level or aggregated to division or DHB level.

Variance Response Management (*VRM*)

VRM is a safe staffing tool to provide early detection, rapid assessment and effective response to variance. We have completed escalation plans for each site and have an approved deployment policy. We have a Variance Indicator Scoring tool system and are underway with the installation. To be installed at Burwood and West Coast initially. The tool allows us to have visibility of when there is a clear variance of demand against capacity to ensure the coordination of resources to meet demand is visible and actions. Once this is installed at all sites we will have fully implemented this standard.

FTE Calculations

We have commenced the first round of FTE calculations (11) for the first tranche wards. Seven wards have had FTE approved by the CCDM Council and recruitment will commence shortly for these roles. We aim to have completed all wards by September 2022. The FTE calculations are annual for each clinical area, so we will be commencing our next year's round of FTE review in June 2022 for those first tranche wards.

The Safe Staffing Healthy Workplaces (*SSHW*) Governance Group will be evaluating the status of the implementation of the CCDM approach later in the year.

5. CONCLUSION

Our CCDM team are working at exceptional pace with the assistance of the team within the SSHW Unit during what can only be described as a challenging year. We are working very closely and in partnership with our unions and we are all deeply committed to ensuring safe patient care, a quality patient care environment and healthy workplaces are the outcome.

HAC – 7 OCTOBER 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: **Andrew Dickerson, Chair, Hospital Advisory Committee**

DATE: **21 October 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 Hospital Advisory Committee's (*HAC*) public meeting held on 7 October 2021.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from HAC's public meeting on 7 October 2021 (Appendix 1).

3. APPENDICES

Appendix 1: HAC Draft Minutes – 7 October 2021.

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held via Zoom
on Thursday, 7 October 2021, commencing at 9.00am

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

APOLOGIES
An apology for early departure was received and accepted from Catherine Chu (10.10am).

EXECUTIVE SUPPORT
Becky Hickmott (Executive Director of Nursing); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Dr Helen Skinner (Chief Medical Officer); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat – Minute Taker).

APOLOGIES
Dr Peter Bramley, Chief Executive – for absence.

IN ATTENDANCE
Kirsten Beynon, General Manager, Laboratories
Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Ralph La Salle, Team Leader & Operational Lead for Overall COVID Response, Planning & Funding
Kate Lopez, Acting General Manager, Older Persons Health & Rehabilitation
Berni Marra, Manager, Ashburton Health Services
Win McDonald, Transition Programme Manager

Item 4
David Green, Acting Executive Director, Finance & Corporate Services

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (08/21)
(Moved: Barry Bragg/Seconded: James Gough – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 5 August 2021 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. H&SS 2020 / 21 YEAR RESULTS

David Green, Acting Executive Director, Finance & Corporate Services, presented a financial update to the Committee. The presentation included:

- Last 12 months main financial impacts.
- Draft 2020/21 CDHB result.
- Examples of productivity movement. For example, Surgery – Christchurch Campus pre vs post Waipapa.
- Last three years actuals and 2021/22 plan.
- Achievements to date.
- Next 12 months – key challenges.

In response to queries, Mr Green advised:

- Audit NZ is currently undertaking it audit of CDHB for the 2020/21 financial year. This continues. There is normally a statutory deadline of 31 October for those signoffs, but unfortunately COVID is having an impact on the resourcing of some audit teams. Across the country, that deadline has been extended to 31 December. CDHB's audit will be delayed for these reasons, and finalisation is not expected until November/December 2021. This is not unique to CDHB.
- CDHB's 2021/22 budget is with the MoH at present. It is understood that this is supported and will be put through to the Minsters for signoff. Confirmation is awaited.

5. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for September 2021. The report was taken as read.

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

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

Planned Admissions Provided During Lockdown

- The need to defer surgery was driven by community isolation settings not by hospital capacity.
- CDHB continued to provide acute, non-deferrable and urgent elective surgery.
- Decisions about which cases met the criteria to proceed during the lockdown period were made according to an agreed prioritisation schedule based on acuity, and the likelihood of deterioration or loss of function associated with delays to surgery.
- The process has been closely overseen by the Chief of Surgery, consistent with local, regional and national guidelines including the National Hospital COVID-19 Escalation Framework.

Based on this way of working, during the period between 18 August and 7 September 2021:

- 713 planned operations were provided at Christchurch Hospital – this is 40 fewer operations than during matched days in 2020.
- 101 operations were provided at Burwood Hospital, this is approximately half of the normal volume.
- Operations for CDHB at the city's private hospitals was significantly curtailed with 29 discharges during this period.

Replacement Of Deferred Admissions – As At 6 October

456 inpatient admissions were deferred with "Pandemic" entered as the reason for deferral:

- 333 or 73% have been subsequently provided.
- Of the 123 still waiting care, 74 have replacement admissions booked. Mostly in October with 17 in November.
- 49 or 11% are yet to be booked.
- We are counting on bed capacity not being constrained due to COVID or other extraordinary demand and expect that all deferred planned inpatient admissions will be completed before the end of 2021.

5,150 outpatient appointments were deferred due to the COVID-19 pandemic since 18 August:

- 3,704 or 72% have already received their appointment or otherwise had the requirement for an appointment closed.
- Of the 1,446 appointments still to be replaced 1,000 are booked, with 873 booked in October, 112 in November and 15 in December.
- Bookings into November's clinics are gathering pace.
- People whose appointments were deferred will receive priority over those with similar clinical urgency who have been more recently referred.

Radiology

- With IPC Support Radiology resumed outpatient operations within 24 hours and continued to scan as much as it safely could during alert levels 3 & 4.
- 351 people had outpatient MRIs and 928 had outpatient CT scans at levels 3 & 4.
- 139 outpatient MRIs and 407 CT scans were deferred or patients did not attend during levels 3 & 4.
- CT has completed its catch-up.
- MRI has completed its catch up.
- Interventional Radiology has one patient to go.
- Ultrasound, X Ray and Nuclear Medicine have caught up. Waiting times are back to pre-COVID baselines.

Further Radiology Notes

- CT has completed its catch-up and in fact used the drop in demand coupled with the drop in MIT leave to reduce the CT waiting list to compliance with MoH targets. CT outpatient waiting times had been non-compliant and growing due to demand exceeding capacity. We have a request in to increase the resourced machine hours to address growth in ED, inpatient and outpatient volumes.
- MRI has completed its catch-up of cancelled patients, however, there has been an increase in its waiting times due to a combination of unplanned staff illness, leave and service days. Options are being looked at to address this.

Specialist Mental Health Services (*SMHS*) – Dr Greg Hamilton, General Manager

- It has been well documented that the events in Canterbury have meant we have a different mental health profile than perhaps some of the other, particularly larger, DHBs. In terms of the model we provide, it is a very integrated model, with a lot more of our consumers having contact with both NGO and DHB to manage their care over time than occurs elsewhere in the country. One of the results of this is that there are more people per capita in Canterbury receiving mental health care, compared with the larger DHBs, but at a hospital level, in terms of those who actually get admitted or come into Specialist Services, we are probably quite similar to the other DHBs. In other words, there is a greater proportion being looked after in a community setting, rather than a hospital setting. That means that those entering the hospital have higher acuity. This is a

measured phenomenon - we have a higher acuity on entry to inpatient services than other DHBs.

- Some key services have grown rapidly – the COVID effect is being seen. CAF, Eating Disorders, and Alcohol and Other Drug, have all seen large pieces of growth over time. The significant change in demand for these services is creating higher risk.
- Mental Health has always struggled with staffing. The position is significantly worse now with regards to under recruitment. For example, there are 21 gaps trying to be filled today due to staff absence and staff sickness. It is a major concern. August was a particularly bad month, where there were around 31 FTE of gaps and we filled up about 28FTE of that with overtime. That overtime rate is around four times higher than the rest of the DHB and is not sustainable for the workforce. The process in terms of recruiting is very difficult. We continue to view the makeup of staff – having gone largely from a registered nurse workforce to one that is registered nurse/enrolled nurse/health care assistant. An experienced registered nurse is gold, as they are responsible for running the system. We continue to look at the Allied Health workforce, which is really important for the therapeutic services provided.

Barry Bragg and Catherine Chu retired from the meeting at 10.10am.

Older Persons Health & Rehabilitation (*OPH&R*) Service – Kate Lopez, Acting General Manager

- Progress is being made with the flow between facilities piece of work. There are continued opportunities.
- To further support system flow and improving the patient journey, a Long Length of Stay Panel has been established, which met for the first time in August. This has been paying dividends in terms of bringing clinical leaders together, providing an escalation pathway, as well as building capability and confidence in the teams in the ward area.
- Community Dental Service. With respect to longitudinal data, particularly for school age children, we are now at a point of less children in arrears than pre-COVID last year.

Hospital Laboratories – Kirsten Beynon, General Manager, Laboratories

- Latest and Ongoing Surge Response. Canterbury Labs (CHL and CSCL) responded to local demands and played a support to the Auckland region as they built capacity and surged up. We did a split - with CSCL supporting labtests and CHL ADHB LabPlus - this worked well. CHL experienced a seven-day uplift in volumes and did not reach its capacity. Introduction of e-swab orders has made a difference in the distribution of swabs and processing, samples both referred directly for CHL and also between laboratories in NZ. CHL put in place a critical, fast-track, and routine testing stream for COVID testing pathway. This was based on a need to support the flow of patients and also supporting health care workers to return to work. The NZ laboratory network works well together and supports each other, there are some supplies that are prioritised to the greatest need regions as required.
- Resurgence. CHL continues to build on capacity and capability, and adaptability of test options for COVID testing as we move towards suppression phases and endemic in the future. We have a full complement of Microbiologists, with another SMO joining the team this week. Planning includes modelling of test options for other pathogens as well as COVID, particularly for flow and IP&C management in our hospitals and care facilities. We are conscious that we need to prioritise staffing requirements, ensure we do not run a service on adrenaline alone, and are modelling staffing requirements within our acute testing areas and the COVID team in preparation for patients in our hospitals and the community. Blood sciences and acute testing support will be essential when we have COVID and other patients who have high care needs.
- CHL commenced the removal of aged high-volume chemistry (testing and automated track analysers) only days before lock down. The lab is currently working off track with standalone instruments. The ongoing disruptions of COVID since commencement of

this project last year and the timing of the latest lock down and surge has added extra challenges for a busy team. Working on building extra business continuity and staff contingency due to potential further COVID impacts.

- CHL acknowledges the support of the CDHB and Board to invest in technology (robotics, staffing and automation, and e-swabs for COVID) and the difference the systems put in place have made. Colleagues around NZ are looking into automation and robotics and CHL will help them wherever they can with their learnings.

Rural Health Services – Win McDonald, Transition Programme Manager

- There has been a decrease in numbers coming through as a result of COVID.
- No cases of COVID on Chatham Islands. Currently at a 75% vaccination rate. Everyone on island has been telephoned.
- Had great support with putting a new x-ray machine onto the Chatham Islands. Infrastructure work around diesel generators, water and power are due to get underway later this month. Also doing work with ISG with regards to internet connections on the Chatham Islands.
- Staffing issues have settled down.

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

- A more recent focus has been partnering with primary care teams around the vaccine.
- Looking to have a "Vax for Life" on 16 October 2021.
- The Social Research Report from the Caring for Communities Partnership with the District Council has been released. Food, poverty, housing and considerable support for the Pasifika community has emerged as top of focus, which is of no surprise.

Committee members had the opportunity to discuss and ask questions.

The H&SS Monitoring report was noted.

6. CLINICAL ADVISOR UPDATE (ORAL)

Dr Jacqui Lunday-Johnstone, Executive Director of Allied Health, Scientific & Technical, provided the following updates on the implementation of the Allied Health Strategic Plan, and the shift into implementation and improvement: There is a focus on the following four priority areas: Flow, COVID Resurgence, Pae Ora, and Equity.

Flow

Have put in place an Associate Director of Allied Health whose focus is specifically on supporting the flow work. At the moment this is very much a focus on what can be done within the hospital setting, both in terms of supporting people to either avoid an avoidable admission, supporting people to have a shorter length of stay, to transit to another facility, or to support safe and early discharge. This includes some funding from the MoH to support an Allied Health flow coordinator.

COVID Resurgence

Issues for Allied Health are about how to support the community response, as well as BAU, patient flow, facilitating safe and early discharge, as well as avoidable admissions. A key priority is around prioritising community referrals and looking at how to instigate more of a rapid response approach that supports urgent care and acute demand, as well as patients in the community.

Pae Ora

Making good progress, despite challenges around lockdown. Have three tests of change within Mental Health, Older Persons Health & Rehabilitation, and the Community setting. Have established a governance group, working in partnership with our strategic partners Age Concern, Christchurch City Council, Sport Canterbury, some of our Māori and Pasifika providers,

Community and Public Health, Nurse Maude and University partners. This is very good foundational work and it is hoped to mainstream this in supporting us to reduce avoidable age related decline or frailty. It is very much about empowering people to stay well, stay active, and stay connected in the community.

Equity
Some exciting work in this space, including a dietitian led gestational diabetes pathway, working closely with LMCs and the team within maternity services. This approach has led to a dietitian led digitally enabled pathway, which avoids multiple attendances at hospital for these women. This is a condition that is very prevalent around our Asian, Indian, Māori and Pasifika communities and often it is very difficult for them to have multiple attendances. This new model, in a few months, has saved around 130 physician and obstetrician appointments (around 500 appointments per year) and with a savings of around $185K.

The Clinical Advisor Update was noted.

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (09/21)
(Moved: Jan Edwards/Seconded: Ingrid Taylor – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 5 August 2021	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

- 2022 Meeting Schedule
- 2021 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.45am.

Approved and adopted as a true and correct record:

_____	_____
Andrew Dickerson Chairperson	Date of approval

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: **21 October 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, 10 & 11 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 – 16 September 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.	Fit-Out of 12 ICU Beds in Shelled Space in Waipapa Building	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Christchurch Hospital Parkside Enhancement Tranche 2	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Contract Extension of Fire Maintenance Services	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Canterbury Linen Services – Loan to Repay Wage Subsidy	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Service Change Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	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)
10.	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)
11.	Advice to Board • HAC Draft Minutes *7 October 2021* • QFARC Draft Minutes *5 October 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.