Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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5 August 2020

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[redacted]

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RE Official information request CDHB 10373

I refer to your email dated 31 July 2020 requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

- **Any communications between the Canterbury DHB clinicians and board over the last six months. This should also cover any correspondence or reports in relation to clinicians and the board over that same period**.

Please find attached as **Appendix 1.**

I trust this satisfies your interest in this matter.

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

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Canterbury
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18th June 2020

Dear Members of the CDHB Board

Yesterday we held a workshop with representation from your Board and advisers, the Ministry of Health, the CDHB executive along with clinical representation including myself.

The purpose of the meeting was to determine next steps in seeking funding for the redevelopment of the Christchurch Campus. In particular to address requirements in relation to compliance work for existing facilities.
We also needed to consider the impacts of delays for funding new facilities [full T3, CT4 etc] and the prospect of occupying Parkside (and indeed Riverside) for periods likely exceeding the next 15 years for inpatient care and the clinical fitness of those facilities.

As you are aware we are awaiting the determination of the Board's request for $154m from the Crown for the partial development of Tower 3 (T3) facility.
The indication from this meeting yesterday is that any recommendation in regard to the T3 funding is curiously linked to the request for existing facilities compliance funding. In addition, urgency would be advisable in order not to undermine the original request. Unsurprisingly, there is a view that Crown capital appears to be scarce and that any requests would be less vulnerable if they were entirely constrained.

As you may also be aware the Ministry has also released its National Asset Management Program (NAMP) last week. Within that assessment the Parkside theatres rated the worst in New Zealand. They represent nearly half our capacity on the campus in the foreseeable future.

The NAMP also rated the Riverside Ward facility as one of the worst in New Zealand [and the worst of the tertiary DHBs] and Parkside only slightly better - improved by non-facility measures. These facilities will represent almost half of our bed capacity post-Hagley occupation.

In terms of amenity – with the exception of two wards - Only 7% of rooms meet basic isolation standards and have an ensuite toilet (the current MOH-accepted guidelines specify 21 ensuites for 28 patients). There a *no* accessible showers in Parkside or Riverside wards ; most toilets are only 970mm wide precluding safe handling of patients. Most wards have only 3 showers to 28 patients.

We are the last major DHB to house 6 acute patients in one bedroom – which precludes appropriate separation and any practical use of hoists to move patients, in clear contravention of the DHB's 'no lifting' policy for staff.

In the post-COVID context these facilities grossly inadequate and infection control has only been partially mitigated by the application of FTE -contributing no doubt to our deficit.

The DHB has had 74 outbreaks of norovirus gastroenteritis over a five year period affecting 526 patients and more than 200 staff in our older amenities. The 9 new Burwood wards have had just 6 small outbreaks over 4 years. The new Burwood wards have also recorded a 30% reduction in patient falls compared with previous amenities. These, and many other shortcomings, are clear indictments of our older facilities and should be red flags to our health and safety obligations to both patients and staff. They help explain our bottom scoring in the NAMP document.

While the Board is clearly mindful on its statutory obligations, the issues above highlight clear health and safety requirements to consider along with its objective of improving, promoting and protecting the health of Canterbury people and communities. In that context, and with the spectre of occupying these facilities for a further 15+years, it should be noted that there is currently no identified request for funding for any clinical upgrade to these existing ward amenities or to these operating theatres in lieu of new amenities. There is also no identified funding path to meet our agreed capacity requirements.

I suggest the Board has a responsibility to the people of Canterbury to be explicit about the appropriate requirements for funding in order to safely deliver the patient care that the Ministry requires of it.

In turn it is the Ministry's responsibility to recommend a decision on funding allocation to the Ministers, and to Treasury; being fully informed of the implications of any shortfall that might exist with its impact on the delivery of care. I urge the Board to carefully consider the distinction.

Yours sincerely

Dr Rob Ojala
Clinical lead,
CDHB Facilities Redevelopment.

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3rd July 2020

The Right Honorable Jacinda Ardern

Prime Minister of New Zealand

Parliament Buildings

Dear Prime Minister

We are writing to you in our capacity as the Clinical Leaders of the Canterbury District Health Board. We are taking the unusual step of writing directly to you because the circumstances of the last six months have left us with no confidence that we have a viable path to meet the current and future health needs of our Canterbury community. Our acknowledged inadequate facilities, coupled with our contentious fiscal position*, present us with bleak options in terms of sustaining service delivery.

Over the last decade we engaged constructively and in a measured fashion to face the multiple issues and develop solutions to the challenge of a deteriorating healthcare trajectory. Our views and concerns however were repeatedly disregarded by central agencies and this rejection appeared to have persisted despite clear and compelling evidence presented to them by our management team. At that time it had become clear that the relationship between the Canterbury DHB and the Ministry of Health (Ministry) under the previous Government, was a core issue and was in need of reconciliation.

We welcomed the new Government's commitment to addressing the issues and concerns with actions such as investing in Mana Ake and appointing an independent person (Gary Wilson) to seek to understand and address this concerning disconnect. We took heart when his report reflected the issues we could see and committed ourselves to developing a shared masterplan with the Ministry and an agreed fiscal pathway back to sustainability.

It was apparent however that these efforts failed to achieve the necessary reset. This was despite our best efforts and those of the executive management team- in whom we continue to have confidence.

For many of us this led to questions around the part the Ministry played as a stakeholder in developing a renewed plan. They supported a minimal and mutually agreed facilities option, then inexplicably rejected this without providing any viable alternative.

We now find ourselves with an inadequate Board-supported outcome to the Master-planning process. This sees us with no clear facilities path to meet agreed capacity needs for beds, theatres and support services for our patients. There appears to be a perception that the new Hagley facility will address these issues; but it will not. Hagley occupation will see almost half of our most complex acute patients remaining in old facilities for 15+ years. Facilities, that independent clinical reviews and health planners have slammed as not fit for purpose 10 years ago and re-emphasized recently by the Ministry's own National Asset Management (NAMP) report.

It should be noted that refurbishing/repairing these facilities have been repeatedly and independently assessed as a poor investment and representing very limited clinical benefit and with significantly increased operational impact. Meanwhile we have to remain in quake-damaged facilities that no other Governmental department or organisation in New Zealand will permit for their staff. We have little choice but to endure these amenities in order to deliver care for our community despite the safety of both our staff and patients being continually compromised.

In our attempts to find a way forward, there seems to be a view that Canterbury has dominated the capital allocations nationally and that we have 'had our share'. In reality the crown has funded just $51M towards amenities prior to Hagley over the last 10 years. This is despite the loss of 40+ buildings post-quake and many others recognized nationally as very poor.

From a fiscal perspective, having delivered on the current year's saving plan and incorporating the further delay to Hagley and unfunded COVID 19 costs, the Board is requiring further accelerated savings to address a deficit that is largely structural rather than operational. While additional savings of $47M were planned, it was dependent on two outcomes:

- Timely Hagley occupation to enable the return of surgery from the private sector (currently 8-10 theatres of activity);
- Being excused capital charge on the earthquake repairs to end-of-life buildings which were funded by insurance proceeds, and not Crown monies.

The combined impact of those two issues alone is an additional $27M burden that is outside the organisation's control.

In short, the organisation is now being asked by the Board to cut $47M+ or the equivalent of more than 500 staff and community-based services to compensate for the MoH delay in the delivery of Hagley and the decision to impose capital charge on insurance funded repairs.
These same services that have enabled Canterbury to continue to deliver care to a population that has grown nearly 100,000 with fewer beds than we had in 2007. There appears to be a lack of understanding that cutting services and staff will only increase the pressure on our currently over-stretched organisation.
When the Board has been made aware of these issues by our executive team they repeatedly inform us, through our representatives, that the cuts are required by the government. We note the presence of the Crown Monitor on our Board, and we would expect that the Ministry and the Minister has accordingly been well informed of Board decisions and concerns.

Reluctantly therefore we, as clinicians, have reached a point of no confidence in both the Board and Ministry to adequately recognize what is happening, or indeed to respond effectively to this situation. We feel we can no longer continue to support this direction without becoming complicit in this.

Hence, we are now communicating directly to you. We feel it is important that you are aware of the unintended and serious consequences of the current approach for the population of Canterbury and beyond. It is important that both the Board and the Government understand the complexities of our challenge and the potential that exists for catastrophic breakdown of the health response. Indeed, we believe it has now reached a stage that it would be irresponsible for us not to inform you of these circumstances.

You saw the way in which our DHB functioned in the tragic aftermath of the Mosque shootings. The exemplary care that every patient received was a lauded globally. We also absorbed the largest number of Whakaari/White Island victims as part of our broader national role. Our system likewise responded magnificently to the earthquakes and continues to deal with the impacts of these. The capability to cope with such events does not evolve by accident. It reflects a high-functioning, well integrated system staffed by fantastic people. It is therefore distressing to witness what appears to be an avoidable degeneration of an organisation recognized internationally for its efficiency and innovation.

Prime Minister, we are asking for your intervention. After a decade of inadequate action and failure to address basic issues post-disaster we need a fundamental reset in how the Canterbury health system is supported by central Government. Further, the approach the Ministry has taken to addressing the infrastructure issues locally and indeed on a national level is piecemeal and completely inadequate. It will leave clinicians high and dry in their efforts to deliver appropriate contemporary care.

We are at a crossroads – the path we must take is for a Canterbury health system that is sustained by adequate investment and a partnership of truly committed stakeholders.

We hope you can assist us to find a constructive solution.

Yours sincerely,

Rob Ojala
Chair, Clinical Leaders Group

David Smyth
Chief of Medicine

Lynne Johnson
Director of Nursing, Medical and Surgical

Richard French
Clinical Director, Service Improvement

Greg Robertson
Chief of Surgery

Sharyn MacDonald
Chief of Radiology

Nicky Topp
Nursing Director, Daily Operations

Clare Doocey
Chief of Child Health

David Gibbs
Chair, Haematology & Oncology Cluster

David Richards
Clinical Director – Emergency Medicine

Richard Scrase
Nursing Director Older Persons Health

Joan Taylor
DON, Mental Health

Sandy Clemett
Director of Allied Health

Anja Werno
Chief of Pathology & Laboratories

Peri Renison
Chief of Psychiatry

Emma Jackson
Clinical Director, O&G

Mark Jeffery
Clinical Director - Medical Capability Development

Paul Tudor Kelly
Scientific/Technical Lead

Ashley Padayachee
Clinical Director - Anaesthetics

Mark Crawford
Nursing Director Facilities

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Contextual notes

Appended to letter to the Prime Minister dated 3rd July 2020 from the Clinical Leaders at Canterbury District Health Board.

- We have continued to deliver services in the worst infrastructure in New Zealand (according to the recently released National Asset Management Program Report (NAMP)) and damaged by the earthquakes, because it was the right thing to do for our population.

- We have endured through three years of MoH failure to deliver the new Hagley facility. This includes the fiscal and operational consequences of having to deliver our planned surgery across seven sites (including the private sector) to maintain access for our population.

- We have seen our share of population funding decline each year despite a growing population that carries the largest burden of mental health issues (according to Ministry data) and cancer (according to Ministry data) in New Zealand, as well as having to extend our services to many regions including all the way to the Chatham Islands.

- The Ministry's own benchmarking supports that we are at the leading edge of efficiency compared to our peers and our benchmarking with international peer organisations supports this as well.

- The previous Government chose to 'deficit fund' Canterbury for the additional costs of the earthquakes which distorts Treasury's analysis of the DHB's historical performance.

- With the exception of Hagley – all of the capital expenditure in Canterbury has been funded out of Canterbury's carefully conserved reserves and insurance proceeds. The Crown in the last decade has funded $51M (until Hagley is transferred) despite officials stating otherwise.

- We have battled with the unusual fiscal impacts on depreciation and capital charge that are a direct result of the earthquakes that account for most of the deficit.
    - The changes to the capital charge approach will reduce the impact of Hagley on our fiscal position but are not retrospective so we will continue to have to pay $10.6M p.a. as a result of New Zealand's largest natural disaster
    - Canterbury takes a conservative approach to depreciation of assets – this can be confirmed by Audit New Zealand - but because of the earthquakes and the need to repair and replace infrastructure we now have depreciation of $83M. This is $50M *more* than similar-sized assets at Waitemata, and a core reason for the deficit.

- The quake insurance revenue
    - Was capped and therefore inadequate to repair the damage to Canterbury's infrastructure.
    - The MoH has chosen instead to use much of these monies to fund budget over-runs and an energy Centre that wasn't included in the Hagley Business Case.
    - Accordingly there is not enough left to even meet the obligated repairs which means that key buildings on the Christchurch Campus will only be insured for indemnity. This was pointed out in Gary Wilson's* report as a risk to the Crown.
- The Cabinet approved Business Case for Hagley recognised that it would take two years post-commissioning for Canterbury to get out of deficit. We do not yet have Hagley and we have no certainty as to when it will arrive.

From: John Hansen
Sent: Monday, 13 July 2020 3:45 PM
To: Rob Ojala
Cc: Anna Craw
Subject: Your letter to the Board

Dear Rob
I have been remiss in not replying to your letter.
The Board considered it. There was little if anything they took issue with.
Firstly, the Board also would have liked a better outcome from the application to CIC. Separately that was something conveyed to both CIC and MOH by myself and the Crown Monitor without effecting any change. I have reviewed the master plan and the detailed business case for the T3 project. It was of course created and submitted before my time. However, it seems to me to be an extremely detailed document. I'm unclear whether something else should have been included in that submission to CIC. If you believe something was omitted from the submission I would be happy to discuss that with you.Further if you believe something more should have been done by the Board at the time of submission to CIC again I would be happy to understand what that was and to discuss it with you.
Secondly, the only funding advised to the Board was the 150 million you are aware of. You are also aware of the added comments of the Acting Chair of the CIC. The intercession made did not alter that sum.Again if you expected something more I'd be happy to discuss.
Thirdly, the Board agrees this is a less than optimal outcome. The Board is very conscious of the state of much of the Hospital Campus and the considerable legal and clinical risks associated with those buildings. Indeed having read copious pages I'm concerned with a number of the risk assessments and the need for compliance. But the reality of the CIC decision is that facilities may have to be used for longer than was envisaged by the CDHB. In those circumstances It would be remiss not to address the legal compliance issues and the clinical risks associated with those facilities. Even for that work there is less money than was apparently thought. Again I'm happy to discuss those constraints with you and any possible solutions. But in my view the reality is the Board will be left balancing two areas of high risk.
The whole situation is made worse by the obvious capital constraints following the pandemic. Again if you have any ideas how we might solve that issue I'd be happy to discuss.

Don't hesitate to contact me as no solutions will be forthcoming unless we work together.

John Hansen

Sent from my iPad