AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
to be held via Zoom
Thursday, 21 May 2020 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes • 16 April 2020 – Ordinary Meeting • 1 May 2020 – Special Meeting		
3.	Carried Forward / Action List Items		
Reports for Decision			
4.	Bad Debt Write-Offs		9.40-9.50am
Reports for Noting			
5.	Chair's Update (Oral)	Sir John Hansen *Chair*	9.50-10.00am
6.	Chief Executive's Update	David Meates *Chief Executive*	10.00-10.30am
7.	Finance Report	Justine White *Executive Director, Finance & Corporate Services*	10.30-10.40am
8.	Resolution to Exclude the Public		
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.40am**

NEXT MEETING
Thursday, 18 June 2020 at 9.30am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

Sir John Hansen (Chair)
Gabrielle Huria (Deputy Chair)
Barry Bragg
Sally Buck
Catherine Chu
Andrew Dickerson
James Gough
Jo Kane
Aaron Keown
Naomi Marshall
Ingrid Taylor

Executive Support

David Meates – *Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
Michael Frampton – *Chief People Officer*
Mary Gordon – *Executive Director of Nursing*
Carolyn Gullery – *Executive Director Planning, Funding & Decision Support*
Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Hector Matthews – *Executive Director Maori & Pacific Health*
Sue Nightingale – *Chief Medical Officer*
Karalyn Van Deursen – *Executive Director of Communications*
Stella Ward – *Chief Digital Officer*
Justine White – *Executive Director Finance & Corporate Services*

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

BOARD ATTENDANCE SCHEDULE – 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	25/02/20	19/03/20	16/04/20	01/05/20 SM	21/05/20	18/06/20	16/07/20	20/08/20	17/09/20	15/10/20	19/11/20	17/12/20
Sir John Hansen (Chair)	√	√	√	√								
Gabrielle Huria (Deputy Chair)	√	√	√	√								
Barry Bragg	^	√	√	√								
Sally Buck	#	^	~	~								
Catherine Chu	^	√	√	√								
Andrew Dickerson	√	√	√	√								
James Gough	√	√	√	√								
Jo Kane	√	√	√	√								
Aaron Keown	√	√	√	√								
Naomi Marshall	√	√	√	√								
Ingrid Taylor	√	√	√	√								

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

CONFLICTS OF INTEREST REGISTER CANTERBURY DISTRICT HEALTH BOARD (*CDHB*)

Canterbury District Health Board
Te Poari Hauora ō Waitaha

(As disclosed on appointment to the Board/Committee and updated from time-to-time, as necessary)

Sir John Hansen **Chair CDHB**	**Bone Marrow Cancer Trust** – Trustee **Canterbury Clinical Network Alliance Leadership Team** - Chair **Canterbury Clinical Network Oxford and Surrounding Area Health Services Development Group** - Member **Canterbury Cricket Trust** - Member **Christchurch Casino Charitable Trust** - Trustee **Court of Appeal, Solomon Islands, Samoa and Vanuatu** **Dot Kiwi** – Director and Shareholder **Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member The JCA is an independent statutory authority constituted under the Racing Act. The JCA ensures that judicial and appeal proceedings in thoroughbred and harness racing are heard and decided fairly, professionally, efficiently and in a consistent and cost effective manner. **Ministry Primary Industries, Costs Review Independent Panel** **Rulings Panel Gas Industry Co Ltd** **Sir John and Ann Hansen's Family Trust** – Ingrid Taylor sits as independent Trustee; and provides legal services to the Trust and to Sir John and Ann Hansen.
Gabrielle Huria **Deputy Chair CDHB**	**Kawa Hohepa Limited** – Director Family property company. **Nitrates in Drinking Water Working Group** – Member A discussion forum on nitrate contamination of drinking water. **Pegasus Health Limited** – Sister is a Director Primary Health Organisation (*PHO*). **Sumner Health Centre** – Daughter is a General Practitioner (*GP*) Doctor's clinic. **Te Runanga o Ngai Tahu** – General Manager Tribal Entity. **The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs.

Barry Bragg	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **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.
Sally Buck	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.
Catherine Chu	**Bank of New Zealand** – Private Banking Manager Christchurch Partners Centre **Christchurch City Council** – Councillor Local Territorial Authority **Keep Christchurch Beautiful** – Executive Member **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. **Countrywide Residential (2018) Limited** – Director/Shareholder Residential Property Development **Gough Corporation Holdings Limited** – Director/Shareholder Holdings company. **Gough Property Corporation Limited** – Director/Shareholder Manages property interests. **The Antony Gough Trust** – Trustee Trust for Antony Thomas Gough **The McLean Institute Trust** – Trustee Trust for the McLean Institute

	The Russley Village Limited – Shareholder Retirement Village. Via the Antony Gough Trust **The Terrace Car Park Limited** – (Alternate) Director Property company – manages The Terrace car park (under construction) **The Terrace On Avon Limited** – (Alternate) Director Property company – manages The Terrace.
Jo Kane	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Aaron Keown	**Christchurch City Council** – Councillor and Community Board Member Elected member and of the Fendalton/Waimairi/Harewood Community Board. **Grouse Entertainment Limited** – Director/Shareholder
Naomi Marshall	**Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Ingrid Taylor	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee. **Taylor Shaw** – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • I / Taylor Shaw have acted as solicitor for Bill Tate and family.

	The Youth Hub – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.

MINUTES

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held via Zoom
on Thursday, 16 April 2020 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; and Ingrid Taylor.

CROWN MONITOR
Dr Lester Levy.

BOARD CLINICAL ADVISOR
Dr Andrew Brant (from 10.30am)

APOLOGIES
An apology was received and accepted from Sally Buck. The Chair advised that he had granted Sally leave of absence for a period of time.

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Michael Frampton (Chief People Officer); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Hector Matthews (Executive Director, Maori & Pacific Health); Dr Richard French (Acting Chief Medical Officer); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services) Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

EXECUTIVE APOLOGIES
Dr Sue Nightingale (Chief Medical Officer); and Karalyn van Deursen (Executive Director, Communications).

Private Board only time 9.30am – 10.30am.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETING

Resolution (09/20)
(Moved: Sir John Hansen/seconded: Barry Bragg – carried)

"That the minutes of the meeting of the Canterbury District Health Board held at 32 Oxford Terrace on 19 March 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD/ACTION LIST ITEMS

Selwyn Health Hub – Treasury rules for fit out. Item to remain on carried forward list, with update to be provided to Board when available.

4. COMMITTEE MEMBERSHIP

The Chair spoke to this paper on Committee Membership. There was no discussion.

Resolution (10/20)
(Moved: Sir John Hansen/seconded: James Gough – carried)

"That the Board:

i. confirms the appointment of Board member James Gough to the Quality, Finance, Audit and Risk Committee, and Hospital Advisory Committee;
ii. confirms the appointment of Board member Catherine Chu to the Hospital Advisory Committee, and Community and Public Health and Disability Support Advisory Committee; and
iii. confirms that the term of such appointments is until December 2022 (while they remain members of the Board)."

5. HAC – TERMS OF REFERENCE

Justine White, Executive Director, Finance & Corporate Services, presented these Terms of Reference which were taken as read. Andrew Dickerson, Chair, Hospital Advisory Committee, spoke in support of the Terms of Reference.

Resolution (11/20)
(Moved: Andrew Dickerson/seconded: Barry Bragg – carried)

"That the Board:

i. adopts the HAC Terms of Reference."

6. CHAIR'S UPDATE

The Chair commented that we have been through some challenging times and congratulated the Chief Executive on how the organisation has performed. He noted with sadness the COVID-19 cluster at Rosewood and added that this was something that the Chief Executive had warned about earlier on.

He advised that the Board would need to make an urgent decision around Tower 3 today or, as discussed in Board only time, there could be a risk that the funding for the project is lost.

The Chair's update was noted.

7. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, advised that he has asked Dr Alan Pithie, Consultant Physician, Infectious Diseases and General Medicine, to speak to the Board about PPE which has caused a lot of speculation across the country and around which there is a lot of mis-information.

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Mr Meates acknowledged the six Rosewood residents who have passed away who were from a very vulnerable part of our community with high end psycho geriatric and underlying conditions. He added that feedback from the families has been that the care of these residents has been exemplary.

Mr Meates commented that there are currently 23 possible COVID-19patients in Christchurch Hospital, however, all patients are treated as positive until proved otherwise.

He also acknowledged the work from the Community & Public Health teams with contact tracing, Christchurch Hospital and Mental Health Services.

Mr Meates introduced Dr Alan Pithie, who provided the Board with an overview around PPE. Dr Pithie advised that PPE is only part of the solution around COVID-19 and it is only as effective as how it is used. He added that there has been a lot of emotion around this and there is not a limitless supply available. He commented that the DHB has followed Ministry of Health guidelines and also followed the guidance of infection control.

The detailed update and discussion can be heard on the CDHB website as part of the Public Board meeting.

A query was made regarding Outpatient appointments and how the back log of these will be met. Mr Meates commented that this is the right concern to have and this has been foremost in our thinking. He added that in regard to surgical activity every specialty has been stratified into less than two weeks and more than two weeks. We have been undertaking a lot of operating on non-deferrable cases over the last few weeks, however, the challenge is that some of the deferrable cases will now become non-deferrable. This is assessed daily by a Clinical Review Team.

Mr Meates commented that there have also been a significant number of virtual consults (1500 - 1600) and also a number of telephone consults. In addition, a lot of work has taken place between Primary Care and Secondary Care around referrals.

A lot of work is also taking place around how our facilities will operate around Green/Orange/Red to help support the re-establishment of services across the country.

In regard to Hagley, Mr Meates advised that work is continuing with CPB to have the three ICU pods established and set up. At this point this is still about a week away.

He advised that he had spent some time in Christchurch Hospital last week and the COVID-19 procedures and protocols are adding about three to three and a half hours per operation. Dr Richard French commented that the patients are also unpredictable as they quite often answer questions and then after thinking further say they may have had contact with a COVID-19 positive person. This then means that everyone who has had contact with this person needs to be treated in a different way.

The Chief Executive's Update was noted.

8. FINANCE REPORT

Justine White, Executive Director, Finance & Corporate Services presented the Finance Report which was taken as read. The report showed that the consolidated Canterbury DHB financial result for the month of February 2020 was a net expense of $5.264M, which was $4.199M favourable against the draft annual plan net expense of $9.463M. YTD the result is $15.034M favourable.

The net operating result for the month (ie before indirect revenue and expenses) was a favourable variance of $882k, reducing the YTD unfavourable variance to $1.183M. Noting that we have costs associated with Whakaari in excess of $1M (excluding the impacts on IDF outflows), and that we

have not recorded any additional revenue at this point in relation to this event, our YTD operating result would have been breakeven.

The report went on to say that the current draft annual plan is for a full year deficit result of $180.470M. This includes savings initiatives from our five key taskforces.

Ms White commented that the trends are the same as previously advised with a slight ease up around liquidity issues with the receipt of $10M from the Ministry of Health. She added that there is less pressure around industrial action and COVID-19 costs are being captured under separate coding for both capital and operational costs.

It was noted that in regard to electives revenue the entire country is in the same position and there has been no confirmation from the Ministry of Health how this will be dealt with.

A query was made regarding deficit funding and it was noted that we have received $10M of this and no formal letter had been received regarding the balance.

The Finance Report was noted.

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (12/20)
(Moved: Ingrid Taylor/Seconded: Naomi Marshall – carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 & 11 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 the public excluded meeting on 19 March 2020	For the reasons set out in the previous Board agenda.	
2.	Chief Executive - Emerging Issues (Oral 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)
3.	Predictive Dynamic Demand Modelling – Presentation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
4.	Christchurch Hospital Campus Master Plan – Tower 3 and Compliance Costs	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Parkside South-East External Concrete Wall Panels	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Canterbury Health Laboratories High Volume Automated Laboratory	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	2020/21 Annual Plan Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	New High Care Area for SMHS AT&R – Scope Change	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: • QFARC Draft Minutes *31 March 2020*	For the reasons set out in the previous Committee agendas.	

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

The Public meeting concluded at 11.55am.

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Sir John Hansen, Chairman Date of approval

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BOARD MEETING 16 APRIL 2020 – MEETING ACTION NOTES
PUBLIC

Clause No	Item	Action Points	Staff
	Apologies	*Meeting commenced at 10.30am.* Sally Buck – leave of absence until further notice for health reasons	Kay Jenkins / Anna Craw
1.	Interest Register	Nil	
2.	Confirmation of Minutes – 19 March 2020	Adopted – John Hansen/Barry Bragg	Anna Craw
3.	Carried Forward/Action Items	Selwyn Health Hub – Treasury rules for fit out. Item to remain on carried forward list, with update to be provided to Board when available.	Anna Craw / Justine White
4.	Committee Membership	Adopted – John Hansen/Jamie Gough	Anna Craw
5.	HAC – Terms of Reference Review	Adopted – Andrew Dickerson/Barry Bragg	Anna Craw
6.	Chairs Update	Nil	
7.	CEO Update	Nil	
8.	Finance Report	Nil	
9.	Resolution to Exclude the Public	Adopted – Ingrid Taylor/Naomi Campbell	Anna Craw
	Information	Nil *Meeting concluded at 11.55am.*	

Distribution List:
Justine White
Kay Jenkins

CC: Mary Howell

MINUTES – SPECIAL MEETING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD SPECIAL MEETING
held via Zoom
on Friday, 1 May 2020 commencing at 11.30am

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

CROWN MONITOR
Dr Lester Levy (via teleconference).

APOLOGIES
Sally Buck

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Hector Matthews (Executive Director Maori & Pacific Health); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services); Rob Ojala (Chair, CDHB Clinical Leader's Group); Richard French (Clinical Leader's Group); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

APOLOGIES
Michael Frampton (Chief People Officer); Sue Nightingale (Chief Medical Officer); and Karalyn van Deursen (Executive Director of Communications).

1. INTEREST REGISTER

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

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

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

2. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (13/20)
(Moved Ingrid Taylor/seconded Barry Bragg - carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely item 1;
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.	Christchurch Hospital Campus Master Plan – Tower 3 and Compliance Costs	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

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."

There being no further business the public meeting closed at 11.35pm.

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Sir John Hansen, Chair Date of approval

SPECIAL BOARD MEETING 01 MAY 2020 – MEETING ACTION NOTES
PUBLIC

Clause No	Item	Action Points	Staff
	Apologies	Sally Buck – leave of absence	Anna Craw
1.	Interest Register	Nil	
2.	Resolution to Exclude the Public	Adopted – Ingrid Taylor/Barry Bragg *Meeting concluded 11.35am.*	Kay Jenkins

Distribution List:

- Kay Jenkins

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 21 MAY 2020

DATE	ISSUE	REFERRED TO	STATUS
25/02/2020	Selwyn Health Hub – Treasury rules for fit-out	Justine White	Verbal update.
19/03/2020	Equity Report	Hector Matthews	Report to 16 July 2020 meeting.

BAD DEBT WRITE-OFFS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **David Green, Financial Controller, Corporate Finance**

APPROVED BY: **Justine White, Executive Director, Finance & Corporate Services**

DATE: **21 May 2020**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

This paper is to advise of bad debt write offs over $50,000 per item, and to request the approval of write-offs over $100,000, as per our delegations of authority.

2. RECOMMENDATION

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

i. notes that five ineligible patient debts over $50,000 totalling $304,680 have been written off,
ii. approves seven ineligible patient debts over $100,000 totalling $1,053,048 being written off,
iii. notes that these debts have been fully provided as doubtful in our results in accordance with our normal doubtful debt provision, therefore no further financial impact; and
iv. notes that this request is made on the basis that CDHB has taken all reasonable steps to recover the debts and there is unlikely to be further chance of getting any payment.

3. DISCUSSION

The CDHB Bad Debt Write-offs Procedure/Policy specifies that: "A debt should be written off as 'uncollectable' when there is no chance of collecting it, or the likelihood of recovery is very low."

In preparation for our year end accounts, we have reviewed our outstanding debtors as at 31 March 2020 and have identified the following debts where the likelihood of collection is low. It should be noted that this is an accounting formality only, as the debts have been fully provided for as doubtful in our accounts to 30 April 2020, so there will be no further financial impact to our results.

Table A: Patients 1 to 5 over $50,000 total $304,680 and have been written off.

Table B: Patients 6 to 12 over $100,000 total $1,053,048, and we are requesting approval to write off.

In writing these debts off the CDHB can claim back $204K in GST. We have or will list certain debts with a debt collection agency where we consider some or all of the amounts owing may be collectable through external collection procedures. It should be noted that we continue to list debts with external debt collection agencies regardless of the Covid-19 impact on the community.

Some patients have insurance policies that they may be able to claim against for medical costs. Where possible, CDHB provides information to the insurance companies to assist them to determine what amounts if any they will pay under the patient's policy. However, we are unable to advocate on behalf of any patient, due to the DHB not being a party to the policy, but we will refer patients to agencies such as the Community Law Centre, Citizens Advice and the Insurance Ombudsman, where appropriate. We cannot provide legal advice to patients on debts they owe to us. Therefore, from a legal perspective, there is little more that CDHB can do to collect the debts due.

Table A

Patient ID	Amount (including GST)	Comment
Patient 1	72,689.90	Reminder and final demand letters sent to parents of patient; phone numbers are not active.
Patient 2	72,437.23	Reminder & final demand; debtor has refused to engage with collector when contacted by phone
Patient 3	56,878.42	Patient now deceased. Daughter paid for funeral and there does not appear to be any funds in the estate, and we do not hold alternative sponsor details.
Patient 4	53,684.54	Patient deceased. We corresponded with sponsor and received correspondence from sponsor's legal representative advising that their client was disputing sponsorship status.
Patient 5	94,692.18	Letter received from daughter noting inability to pay.
Total	$350,382.27	GST component $45,702; net write off $304,680

Table B

Patient ID	Amount (including GST)	Comment
Patient 6	199,902.14	We continue to follow through with insurance company as to the possibility of collecting this debt, and we need to get further internal medical advice on this (the insurance company is declining on the basis of a pre-existing condition). The family are making a minimal payment of $50 per week in the meantime as a sign of good faith, but the likelihood of collecting this debt in its entirety is low. Regardless of the write off, we would expect to try and maintain the regular weekly payment as long as possible.
Patient 7	146,418.99	Patient is GNA (gone, no address). We have discovered details of an insurance company in Germany whom we have had correspondence with, but to date no payment has been forthcoming.
Patient 8	123,459.23	Settlement offer of $10k received but not accepted. We have not been able to agree an acceptable settlement.

Patient 9	121,953.39	Patient is GNA and no contact details available. We have already received a part payment from an insurance company (the maximum entitlement under the patient's policy).
Patient 10	121,218.58	Patient deceased. Have also tried to obtain payment from a sponsor.
Patient 11	326,577.19	Family are paying approximately $300 per fortnight and appear to have little means to pay more. Possible insurance claim that the family is investigating.
Patient 12	171,175.52	No payment likely to be forthcoming after correspondence with debtor.
Total	$1,211,005.04	GST component $157,957; net write off $1,053,048

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 and Members, Canterbury District Health Board**

PREPARED BY: **David Meates, Chief Executive**

DATE: **21 May 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing the latest update and overview of key organisational activities and progress from the Chief Executive to the Board of the Canterbury DHB. Content is also provided by the Operational General Managers and relevant Executive Management Team members.

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

3. DISCUSSION

PUTTING THE PERSON FIRST – PATIENT SAFETY, QUALITY AND IMPROVEMENT

Quality & Patient Safety

- **Hand Hygiene:** There is a high continued effort on Hand Hygiene practice keeping our patients and staff safe. Focus is also on enabling our patients to self-manage by ensure that we provide them hand hygiene opportunities while in our care by ensuring that they have access to soap and water or have the Alcohol Based Hand Rub (ABHR) within the bed space. Staff are reminded to ensure that ABHR is both available and accessible at each point of care.
- Since 1 March 2020, 1144 moments were observed with a result of 86.4%.

Compliance Rate by Moment

Name	Correct Moments	Total Moments	Compliance Rate
1 - Before Touching A Patient	286	321	89.1%
2 - Before Procedure	77	92	83.7%
3 - After a Procedure or Body Fluid Exposure Risk	114	130	87.7%
4 - After Touching a Patient	361	399	90.5%
5 - After Touching A Patient's Surroundings	150	202	74.3%

- **Patient Reported Experience in Hospital During COVID Alert Level 4:** Additional questions (31 March 2020 for those patients admitted in the prior week at the start of Level 4 - 25 March) were added to both the Inpatient and Outpatient Experience Survey to assist monitoring patient experiences during the COVID-19 pandemic regarding ability to contact family/ whānau during admission (n=558: 89.6% Yes Always), feeling safe while in Hospital (n= 558: 84.9 % Yes Always) and staff cleaning hands when touching or examining (n=561: 87.3% Yes Always).

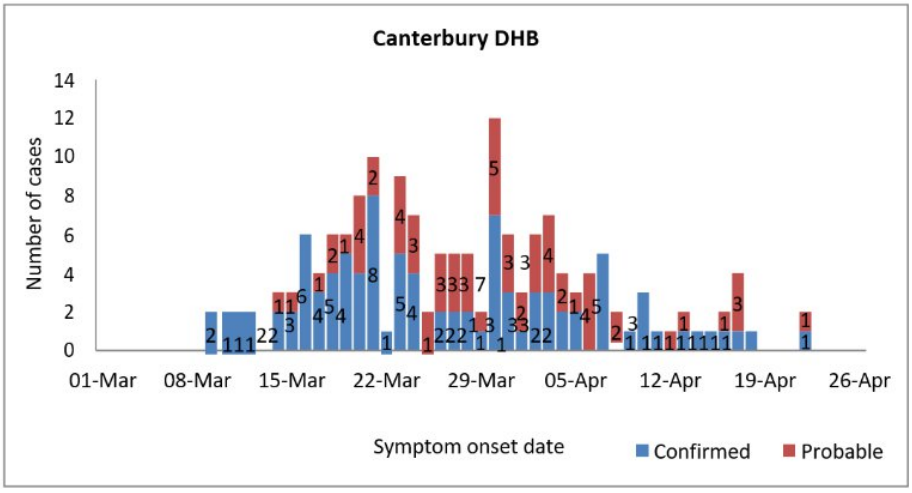
MĀORI AND PASIFIKA HEALTH

- **COVID-19 Equity Report as at 30 April 2020:** Equity for Māori and Pasifika peoples have been a priority for the Canterbury DHB long before the COVID-19 pandemic. However, this pandemic has brought equity into sharp focus and tested our equity responses. The data we collect helps us to examine the effectiveness of our equity response for Māori and Pasifika peoples during the current COVID-19 crisis. The small number of COVID infections mean interpreting ethnicity analyses should be treated with caution, however Māori have remained consistently around 4% of confirmed COVID-19 infections, less than half of proportion of Māori in the Canterbury population.
- Pacific have remained consistently around 5% of confirmed COVID-19 infections, almost double the proportion of Pacific peoples in the Canterbury population.
- Pacific peoples rates have primarily occurred from infection of a staff member in an aged residential care facility becoming infected and then others in their family becoming infected. This was picked up by our Pasifika provider, Etu Pasifika, and followed up quickly and carefully.
- It appears at this stage, end of April 2020, there is little inequity for Māori which was the biggest equity risk in early-mid March.
- **Whānau Ora and #manaaki20:** Alongside our health and social services, Te Pūtahitanga and Pasifika Futures (Whānau Ora Commissioning agencies) have been supporting Māori and Pasifika communities with a particular emphasis on our most disadvantaged. Whānau Ora Commissioning agencies received funding to support their mahi (work) and have done a tremendous job at supporting our most disadvantaged populations.
- The efforts of Te Pūtahitanga using their #manaaki20 campaign have supported the efforts of health and social services to aid in mitigating the risks to these vulnerable communities. Employing Whānau Ora navigators, distributing hygiene packs and supporting whānau with kai (food) have helped reduce the risk of many other health and social difficulties as we move forward.
- **Total Case numbers – Confirmed and Probable*,:** [data to week ending 26/04/2020] Numbers from last week [week ending 19/04/2020] in parentheses

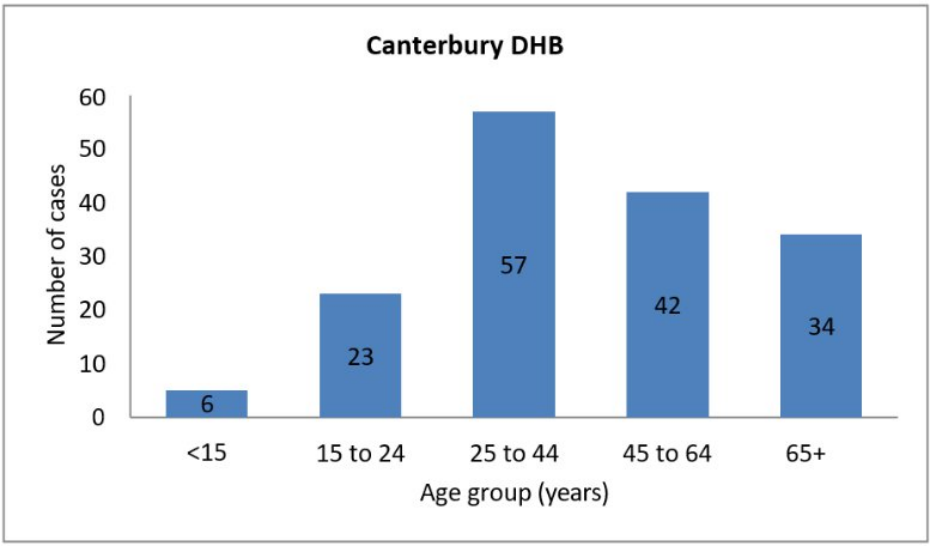
	Canterbury DHB
TOTAL confirmed cases	96 (92)
TOTAL probable cases	66 (61)
TOTAL cases	162(153)

*a probable case is a symptomatic close contact of a confirmed case OR a case that meets the clinical criteria where other known aetiologies that fully explain the clinical presentation have been excluded and either has laboratory suggestive evidence or for whom testing for SARS-CoV-2 is inconclusive.

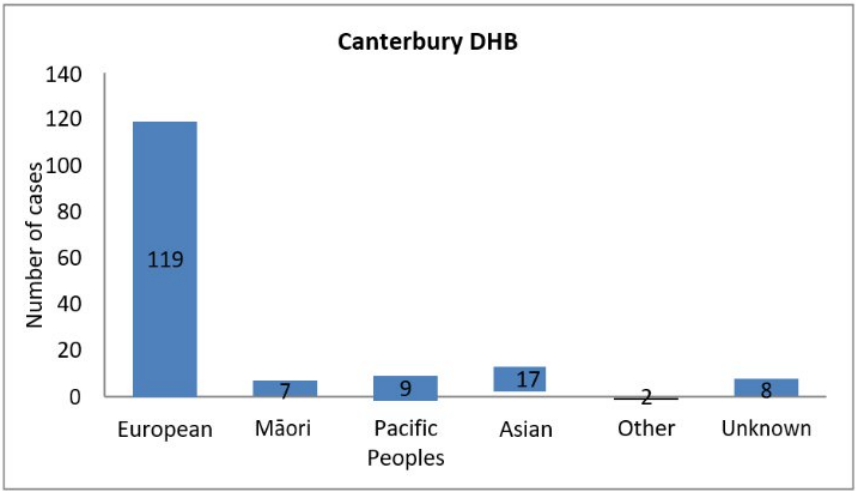
- **Epidemic curve – case numbers (by onset date), over time:** [data to week ending 26/04/2020]



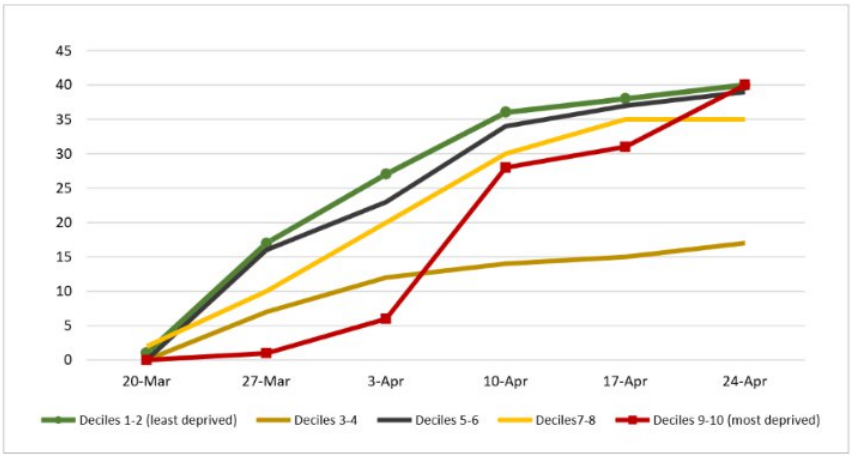
- **Total case numbers by age group:** [data to week ending 26/04/2020]



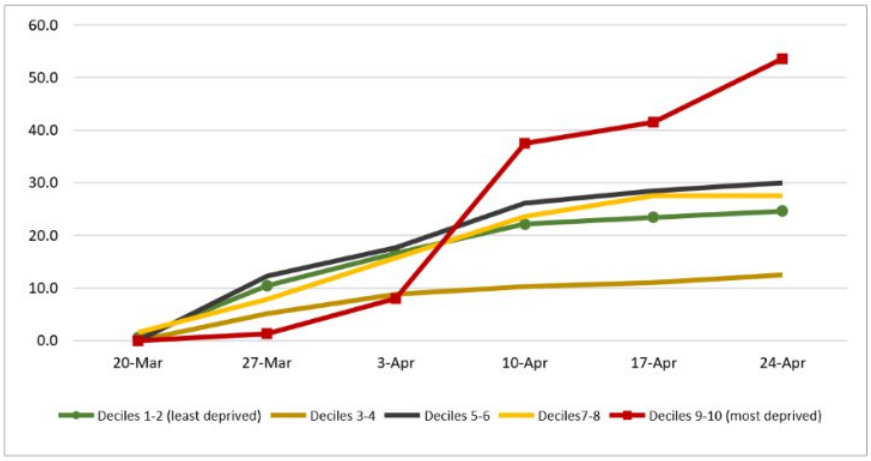
- **Total case numbers by ethnicity (prioritised):** [data to week ending 26/04/2020]



- **Cumulative notified case counts in CPH region (Canterbury, South Canterbury, West Coast) by NZDep 2018, over time** [data to 24/04/2020]



- **Cumulative notified case rates (per 100,000) in CPH region by NZDep 2018, over time**: [data to 24/04/2020]



- The number of new confirmed and probable cases in the CPH region has fallen over the last week of April.
- The majority of cases continue to be associated with overseas travel (in the 14 days prior to illness onset) or known contact with a confirmed or probable case of COVID-19.
- Until the fourth week of the outbreak, COVID-19 rates were relatively similar across deprivation deciles. The disparity noted at week four between those living in the most deprived areas (deciles 9 and 10) is higher compared with other deciles.
- **Psychosocial Response:** Psychosocial support is one of nine welfare functions under Civil Defence legislation. It is led by Ministry of Health nationally, and DHBs at the regional level. Our Canterbury DHB Psychosocial Response Plan for COVID-19: Phase 1 (1 April 2020) was quick to ensure equity and Te Tiriti were included. A key principle in the plan is to promote human rights and equity and ensure that Te Tiriti and equity inform all psychosocial work undertaken.
- The steering group set up to guide this plan has identified key issues with regard to Māori and equity:
  - There is long and ongoing history in NZ of failing to provide health services and policies which serve Māori well.
  - Involve Māori at the start and throughout all decision-making processes (recognising Māori are not homogenous in voices and perspectives).
  - Include Papatipu Rūnanga.
  - Collect accurate ethnicity data.
  - Be courageous in allocating resources and enable Māori to control the narrative.
  - Make sure we as leaders, and those who lead us, are held accountable for our delivery to Māori.
- **Moving Forward to Alert Level 3 and Beyond:** We are in unknown territory and data is limited. Our Māori and Pasifika providers are reporting a great deal economic insecurity, job uncertainty, and food shortages in our most deprived and vulnerable communities. They have also seen elevated levels of anxiety and the associated risks that this brings, across many in the community.
- Our provider network (Māui Collective) of which Manawhenua Ki Waitaha is a member and our primary care advisory group (Te Kāhui o Papaki Kā Tai), where Manawhenua also sits, have also reported similar accounts and suggests there are risks to equity, moving in to level 3 and into the future. To this end they have collaborated to develop a Māori response plan for level 3 and beyond.
- If we are able to continue to control community transmission, then our principal equity risks over the coming weeks will be supporting whānau to recover from the economic, employment and social costs of alert level 4. Food, housing, employment are far more significant issues in communities whose relative deprivation pre-dated the pandemic. Both Māori and Pasifika peoples were already disproportionately represented in (NZDep 2018) deciles 9 and 10 so the risks are elevated for the most economically disadvantaged parts of our community.

- **Tumu Whakarae and National Efforts to Support Equity:** Throughout alert level 4 the Deputy Director General Māori and Tumu Whakarae (national DHBs Māori GMs group) have met frequently to respond quickly to issues of equity. Much of the guidance documentation from Ministry of Health regarding Māori has transpired because of this close collaboration. In particular it has facilitated financial support to Māori providers, extra funding to DHBs to support increasing flu vaccination for Māori and the development tangihanga guidelines in level 4 and level 3. This has led to the Ministry promulgating a Māori Response Plan beyond level 3, which TKOP has collaborated to develop a Canterbury specific response.
- Tumu Whakarae have also collaborated to produce COVID-19 Guiding Principles (Appendix 1) to support health services to ensure Māori equity is at the forefront of our responses.
- Default responses in our health system tend not to think about things such as te reo Māori, aroha, manaaki, mana motuhake, mana Māori, mana whakahaere or mana tangata. Rather they have focused on infection control, PPE, virtual consultations, testing and contact tracing. All of these are important. But in the rush to avert crisis, systemic and cultural norms largely ignore Māori needs, instead believing these needs are the same as everyone else. While the needs are indeed often very similar, the risks, particularly the socio-economic risks, and therefore the cultural needs, differ vastly. When this crisis began, some approaches did not engage broadly and Māori and Pasifika voices were absent. The principle of partnership was implemented variously and inconsistently in different parts of the system. The rush to protect all, often led to little or no-consideration for the nuances of inequity.
- **Waiho i te toipoto, kaua i te toiroa (Let us keep close together not far apart):** Metaphorically speaking, as whānau, hapū, iwi, community, city, province, region and country; if we aspire to stay close together, look after our vulnerable, then we will come out of this stronger.

MEDICAL SURGICAL

- **Preparations for a Pandemic:** Early projections of COVID – 19 predicted a significant response was needed by the Canterbury health system. Christchurch Hospital, Christchurch Women's and Maternity, as well as Burwood Hospital all underwent significant preparations to develop a pandemic response plan. Changes were made to enable social distancing in the workplace, determination of work zones, identification of vulnerable staff, setting up of multiple teams for infection control and well as considerable time learning and practising the use of personal protective equipment (PPE). In addition, staff were required to learn new ways to minimise virus transmission by managing care of patients requiring aerosol creating procedures. While some of this work was done within our normal work practices, deferrable planned work had to be postponed at the Ministry's recommendation.
- **Outpatient Care**: To minimise harm going into the pandemic event, clinicians reviewed each patient on our wait lists and prioritised them so any requiring an acute or urgent intervention received that care even during Alert Level 4. The re-prioritisation effort then also meant that our clinicians could change visits from face to face to telephone or telehealth. By changing delivery method, we were able to see more people during the lockdown period than if we simply rebooked appointments. During the lockdown period, 11,418 outpatient visits were cancelled but approximately 4000 of these cancellations have been seen by alternative methods during the same period.
- New ways of working will be embedded in the system restart. More telephone and telehealth appointments will be completed particularly for follow up appointments where face to face meetings are not required. New models including utilising telehealth to support general practice directly with specialist advice are emerging and ways of including patients in those conversations are being tested.
- While the clinical side of this work is highlighted above, the administrative effort required to cancel, update, reschedule, rebook and update wait lists has been extensive and our administrators have played a vital part in making new ways of working work.
- **Inpatient Care**: A COVID-19 Medical Team was put in place, made up of members of the Infectious Diseases, General Medicine and Respiratory Services. A COVID-19 Assessment Unit was also set up using half of the Acute Medical Assessment Unit. Patients without potential COVID-19 disease were cared for by staff that had no contact with staff working in the COVID-19 area. This required separation

of nursing and medical rosters and allocation of areas for clinical and non-clinical activities for the two groups. This was a huge logistical undertaking to achieve quickly.

- Many surgical services also created separate teams so that potential COVID and non-COVID patients could receive appropriate care. This entailed senior surgeon input into planning and provision of care for acute patients from the start of their journeys and required significant reworking of rosters and schedules to make it work.
- Patients normally cared for in the Gynaecology Unit were shifted to the Urology Unit, freeing the Gynaecology Unit to serve as an overflow area for the COVID-19 Assessment Unit if required. Some physical changes were made to the Gynaecology Unit to prepare it for use as a COVID-19 overflow area. Caring for Gynaecology patients in the Urology Unit required a re-working of processes to recognise the different environment.
- **Planned Care**: A significant volume of non-deferrable planned care has continued through the COVID-19 response period. Innovative ways of working in the surgical area emerged during this period. Brought together by our Chief of Surgery and our Planning and Funding Team**.** The DHB combined with all private hospitals in the area to form a working group that sought to ensure all hospitals were in a state of readiness for any pandemic event. The group formed and adopted combined theatre policies, case definitions for urgent, non-deferrable and deferrable surgical cases and made plans on how we could share resources including both workforce and facilities if needed during the response period. The group developed and adopted a Framework for Planned Care Services for the Canterbury Health System which has been shared nationally.
- Once the pandemic concerns lessened, the Combined DHB and Private Hospital Surgical Group refocused its efforts on how to restart the delivery of surgery. Using the combined agreement, we have planned for a rapid restart of the system which not only includes work done in DHB hospitals but also outplaced and outsourced work in private hospitals. In addition, several previously internally supplied services were moved to community provision for a period within local hospitals or health care providers space. The group plans include getting up to 85% of pre-COVID capacity within a four-week period from 27 April 2020. Halfway through we are well on the way – the week of 4 May all planned surgical volumes in the 'step-up' plan were delivered.
- The Mobile Surgical Bus and the lithotripsy bus are also included in the group's plans with the MSS Bus being in Rangiora for two weeks and the lithotripsy bus undertaking a two day stay in Christchurch during the week of 11 May.
- **Communication and planning**
  - As there is not a reliable postal service, a General Clinical Communications External Form has been created. This enables important brief communications in electronic form from hospital clinicians to General Practice.
  - Electronic prescriptions vis ERMS are now being used by Christchurch Hospital clinicians for medicines being supplied by community pharmacies.
  - Services have worked with the Canterbury Initiative Team to update and capture guidance across the system in HealthPathways as appropriate. This has formed part of the backbone of the national HealthPathways response supported by the Ministry of Health.
  - Significant time has also been invested in planning and implementing the provision of service (as Alert Levels allow), ensuring patients are treated in order of clinical priority and provided with safe care.
- **Nursing**
  - 5.7 FTE were re-deployed from Day Surgery Unit to the staff swab testing centre.
  - A COVID-19 theatre pathway has been developed. It requires two additional nursing staff and has been achieved by the reconfiguration of afternoon and night rosters.
  - Perioperative nursing staff have been trained in Intensive Care skills, including rotation through the intensive care unit, as part of preparation of Intensive Care surge capacity potentially required for COVID-19. This has required training Day Surgery staff to take the place of Post Anaesthetic Care Unit staff in case they are required in the Intensive Care Unit.

- Orientation of NETp nurses in theatre has been condensed to enable our new employees to be available for limited clinical duties sooner if required.
- A range of operations on the respiratory system are provided that require COVID-19 precautions (including Maxillo Facial, Dental and Ear, Nose and Throat cases). This has lengthened the operating time required per patient and increased the number of staff involved.
- Taking advantage of a time when the flow of theatre consumables was at a lower level than normal, stocktaking of bar-coded stock in theatre has been completed ahead of year end with assistance from Finance system.
- Staff have been supportive in responding to the extraordinary demands and new ways of working listed above. Some staff have been unable to work at their usual duties due to pregnancy, age or medical conditions:
  - Registered Nurses – 54 FTE zoned for 3-4 only – a small number has been redeployed but the remainder are on special leave
  - Healthcare Assistants - 10.5 FTE
  - Ward clerks 2.3 FTE

- **Nursing Bank/Pool**
  - Casual Health Care Assistants have been re-deployed to:
    - Aged Residential Care (27 shifts)
    - Christchurch Hospital (237 shifts)
  - Nursing staff have been redeployed to manage screening at entrances from 24th March – 23 April 2020.
    - Casual pool Registered Nurses: 120 - shifts
    - Permanent pool Registered Nurses: 153 shifts
    - Registered Nurses from wards: 71 shifts
    - This role required consistency so generally a specific pool of nurses used rather than redeployment from wards.

- **Orderlies**
  - 7 FTE have been on special leave due to work zone limits

- **Radiology**
  - As it became clear that the anticipated worst-case scenario was not occurring, we quickly identified that we had additional capacity. This was countered by ceasing use of outsourced reporting and purchase of additional reporting sessions (with the exception of the overseas reporters who provide overnight cover). Annual leave was also offered to staff.
  - The Radiologists who have been working have been:
    - reporting (the reporting backlog is now at an all-time low)
    - holding clinical meetings
    - triaging, cancer pathway work
    - carrying out non-clinical work on the understanding they are catching up on their non-clinical now as the rosters going forward are set to 100% clinical time.
  - From Tuesday, 28 April 2020, radiology will be operating a four-week recovery plan to provide imaging and interventions to patients who have previously been deferred. This will include operating our Burwood unit on a seven day per week basis for four weeks.
  - We continued to provide care to the people of our district and region. As a result of our teams being keen to adopt new ways of working, a significant volume of planned services was delivered during this period.

WOMENS AND CHILDRENS HEALTH

- **Christchurch Women's/Maternity**
  - Following occupational health assessments nine staff were stood down. Following review of the assessment framework all except two are now returning to work.
  - All clinical staff received training in donning and doffing of personal protective equipment early in the response period. With the cancelation of group education, the midwifery educators were able to be used in a clinical capacity supporting staff.
  - One of the midwifery educators was also released to support personal protective equipment training in Aged Residential Care.
  - Substantial changes have been made to the operation of antenatal clinics at Christchurch Women's Hospital with an increase in virtual clinics. These have generally been well received, especially following resolution of teething problems. There is an intention to continue this way of working where it is applicable.
  - The Day Assessment Unit was moved to the Maternity Assessment space to enable social distancing. We have now reviewed the use of the Day Assessment Unit. Women who live close to Lincoln, Rangiora or Ashburton will be provided with their assessments at those units with support from Christchurch Women's Hospital when this is required. Women that need a scan and a review by an obstetrician will still be provided with this service at Christchurch Women's, plans are in place to continue to review this.
  - The Gestational Diabetes pathway was in the process of being reviewed – our response to COVID-19 has hastened this work. Women are now attending clinics less with follow-up from Christchurch Women's Hospital virtually instead and utilising dieticians alongside midwives for women who are stable enough not to require input from a physician and obstetrician.
- **Child Health and Neonatal Intensive Care Unit**
  - The COVID-19 response period came at a time that the neonatal intensive care unit was experiencing very high occupancy. Staff capacity has been maintained, despite several staff members being unable to work following assessment. Options for caring for babies at other centres were explored, but limitations on travel meant this was not viable.
  - As per other areas in the hospital, red and green areas were defined in the Children's Assessment Area and paediatric wards. This enabled appropriate and safe care for patients with and without infectious respiratory disease. Staff with risk factors were able to work exclusively in green areas.
  - Significant time was required to re-plan models of care to ensure that all children continued to receive appropriate care.
  - Due to social distancing and other limits on societal activity, demand created by infectious disease and trauma was reduced but continued at normal levels for other areas of demand.
  - This reduction in demand released enough time to provide for the increased use of personal protective equipment when caring for patients with potential COVID-19 disease.
  - Outreach nurses and medical staff checked in regularly with our most vulnerable children to ensure that they were able to be cared for at home and reduce the requirement to present at hospital. This involved regular phone calls and zoom meetings. Families are able to call the Children's Assessment Unit at any time. Teams are keen to formalise this way of working and ensure that it continues to be used wherever this is appropriate.
  - Nurses, medical, technical and administrative staff demonstrated a high level of flexibility and collaborative creativity throughout this period. This enabled rapid adaptation to the demands of the period.

OLDER PERSONS HEALTH & REHABILITATION | COMMUNITY DENTAL

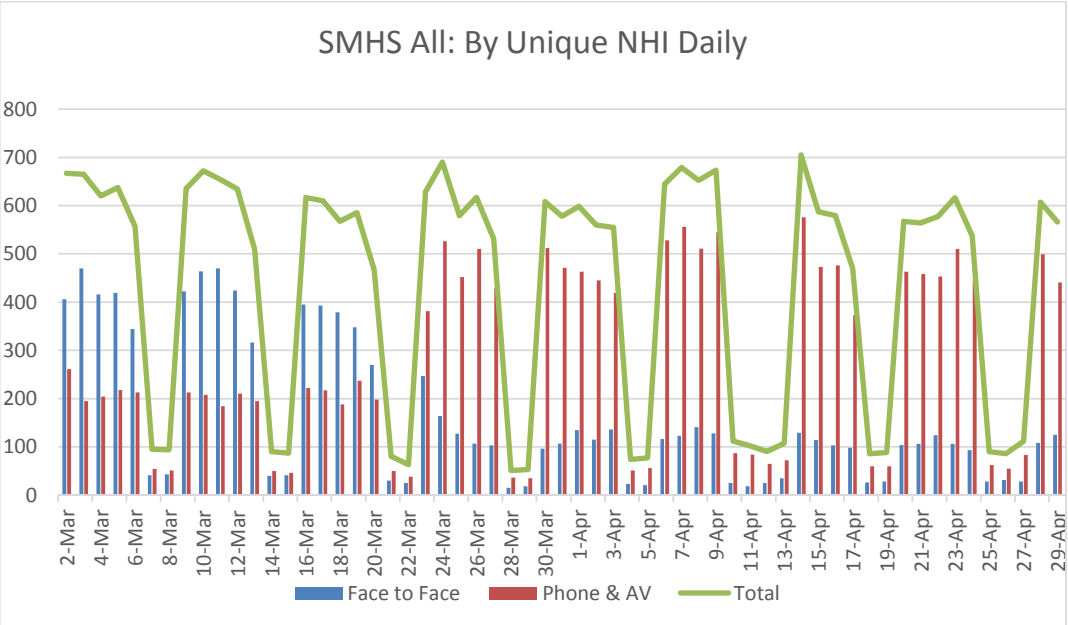
- The focus for Older Persons Health & Rehabilitation (OPH&R) for the month was the response to the COVID-19 Rosewood Cluster along with the challenges of ARC facilities not taking patients from Burwood Hospital when they were ready for transfer.
- There was a COVID-19 positive resident at Rosewood Rest Home which resulted in Rosewood staff being stood down for isolation. This left the residents from the Hospital Level Care Dementia wing with very few staff to care for them. Following discussion by the Canterbury DHB Emergency Control Centre (ECC) a decision was made on Sunday 5 April to move these 20 residents to Burwood Hospital. A plan was developed by the OPH&R team to bring these patients into Burwood Hospital and locate them in a Surgical Ward. The plan was developed in a very short timeframe in conjunction with the ECC, Burwood EOC, Infection Prevention and Control, Planning and Funding, Burwood services – food, cleaning, laundry and the GP with medical responsibility of these patients. The residents were transferred across to Burwood Hospital on Monday 6 April. Many of these residents arrived onto the Ward with existing and underlying medical conditions. The Rosewood Residents were treated as a COVID-19 Cohort and staff were required in full PPE, with a challenging group of patients who were very unwell. The staff were from the surgical Ward, Older Persons Mental Health, Operating Theatres and the Nursing Pool. 34 staff worked 470 shifts across the month of April. OPH&R staff also supported ECC Staffing to staff the Rosewood Rest Home Facility.
- The OPH Community team members worked over the Easter weekend with the Planning and Funding team and Rosewood resident whanau to support the potential transfer of a second group of Rosewood Residents from Hospital level care to other ARC Facilities, this was due to on-going challenges staffing the facility. There were four patients re-located as part of this process. This process did not continue due to resistance from other ARC Facilities to take these patients.
- The Community team referrals were 668 for the month of April a 50% of our normal referral activity for a month. Referrals are steadily increasing for May with 169 received in the first week. The teams have been working through the lockdown doing welfare checks on vulnerable patients which were identified and undertaking virtual assessments where possible.
- Recommencing elective surgery and deferrable outpatients at Burwood Hospital planning is underway. Elective Surgery will recommence the week of the 11 May following the Rosewood repatriation and the staff become available following stand-down associated with working with the Rosewood cohort and Rosewood Rest Home. Due to the MoH guidelines for COVID-19 testing and many ARC facilities not accepting patients without a swab we had longer stays for several OPH and OPMH inpatients during April. We had between 14 to 19 patients waiting for transfer to ARC during April. This also impacted on OPMH patients in the community awaiting transfer to ARC with up to 10 patients waiting for a transfer to ARC. With some limited testing approved the OPH Inpatients patients were moved early May. There is now a MoH solution to support this issue.
- The Allied Health Team were required to transfer 100% of their outpatient activity to telephone or telehealth consultations within 24 hours of the Level 4 restrictions being implemented to ensure that patients were still able to progress with their treatments and felt connected to their clinician. This has been very successful in completing patient pathways and has allowed us to work through our wait list throughout this time. The team furthered this by transferring their usual group education sessions to a telehealth session using the Logitech Group equipment held within the department to increase access to our service. Within the inpatient area, Zoom has been used to facilitate: family meetings, specialist outreach rehab and support and even to assess patient's homes to avoid the need for staff and patients to travel. In our community settings, Zoom and telephone consultations have been used successfully to manage patient needs to allow them to progress their treatment journey and also prevent care needs escalating.
- Going forward we will be continuing to provide Telehealth consultations as often as appropriate after feedback from our patient groups which suggest that this is a positive enhancement to service delivery, increases accessibility and provides more patient choice as to time to receive a service. We expect to be able to reduce the number of face to face appointments required on a sustainable basis. This has been of significant value when the use of a translator is required as this has been easy to include this input in

to consultations. Our ability to provide interdisciplinary care to patients has also increased with the use of Telehealth due to the ease of being able to 'dial in' and we hope to expand this further by working with other services to reduce duplication and ensure earlier intervention for our patients.

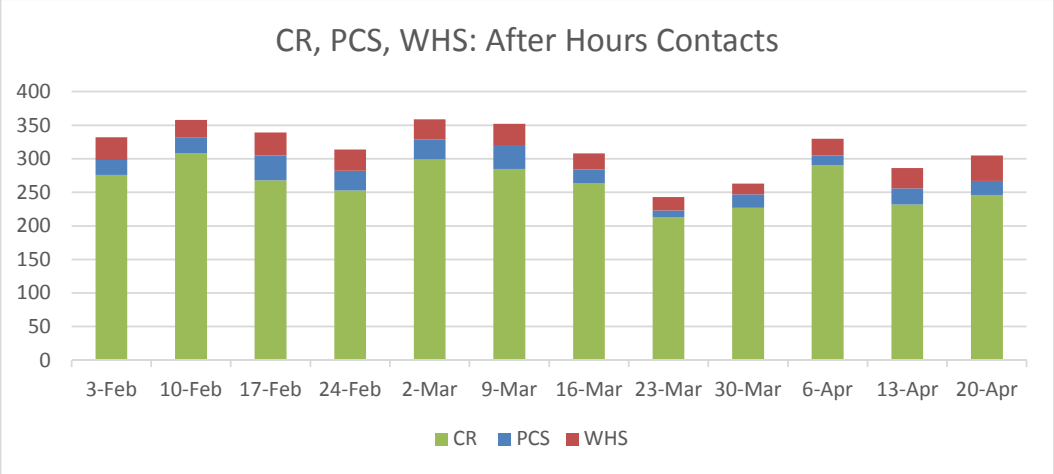
- The acute spinal destination policy remained in place for acute trauma as per MOH advice at the beginning of lockdown, however, low volumes correlating to low movement/activity over lockdown. All were admitted via Christchurch Hospital. The Spinal Unit had three acute transfers out to Burwood during April, two of these had accidents prior to lockdown and one after that was local. There are currently two patients at Christchurch Hospital not ready to come over, one from Hawkes Bay and one from Invercargill. Inter-regional non-traumatic spinal patients were/are held in domicile hospital wherever possible with support from Burwood Spinal Unit team, we admitted two cases one from Wellington hospital (domicile Blenheim) and one from Nelson via ward 28. Urology Theatre and consults for inpatients continued, outpatients, outreach, reassessments patients were all seen via Telehealth.

SPECIALIST MENTAL HEALTH SERVICES (SMHS)

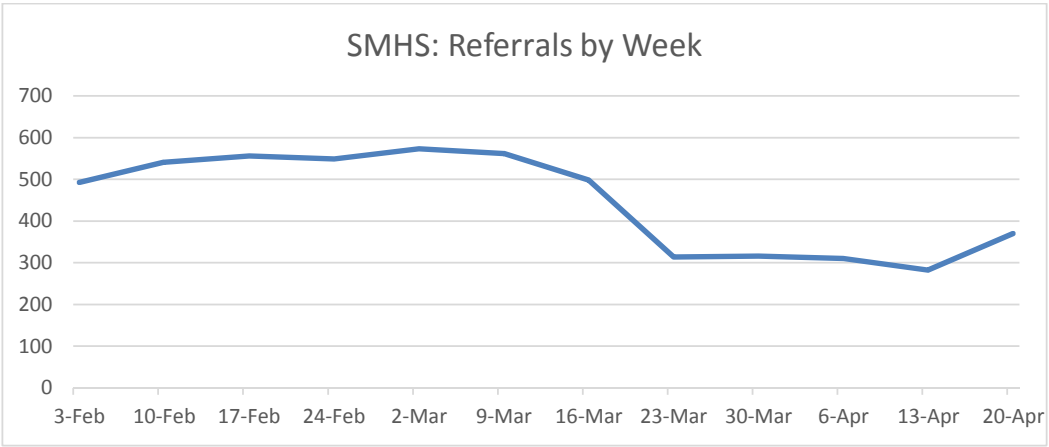
- **COVID-19 Response**: The focus for the past month has been developing our plans to a) manage the risk of COVID-19 in our services and b) maintain activity under Level 3 and 4 alerts and the National Hospital Framework.
- The mental health population present with significant vulnerabilities to COVID-19, due to challenges with maintaining self-isolation and the risk to health due to co-morbid presentations.
- Managing exposure risks is very difficult in acute mental health inpatient settings, so plans were focused on minimising movement, minimising admissions, screening all presentations and developing plans to isolate any person presenting as suspected or confirmed COVID-19+. Service delivery, in line with alert levels 3 and 4 and the Hospital Framework, has been focused on providing acute and urgent care, or care that was required to prevent significant deterioration in a person's mental health. Because deferred care and increased waiting times was anticipated as an outcome of our approach, careful monitoring has been put in place to support effective decision-making, as the pandemic progressed. Waiting lists are actively reviewed, including contact made with those waiting and the referrers.
- The Adult Mental Health Service made significant efforts to continue to see some people face to face within the boundaries of the COVID-19 restrictions. Community based contacts have moved to predominantly telephone and telehealth contacts.

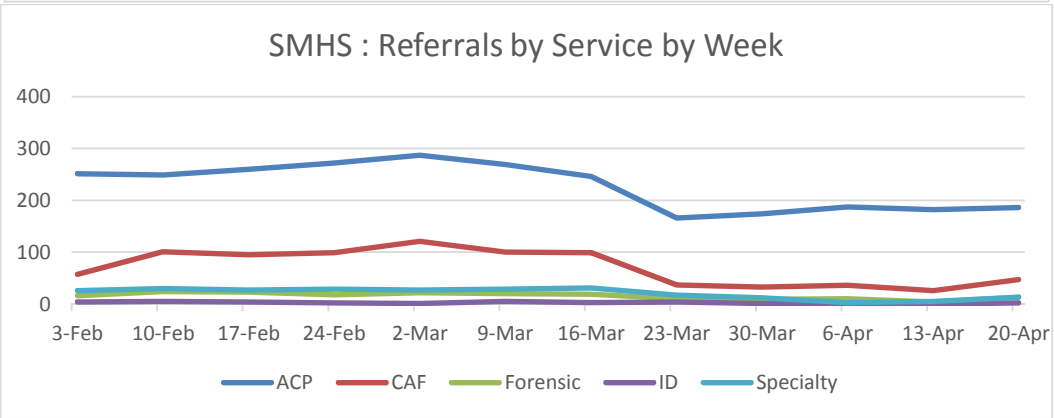


- After-hours community contacts reduced slightly initially. Service delivery changes included increasing the number of people seen after hours at Hillmorton Hospital, rather than in the Emergency Department, to reduce the numbers presenting there.

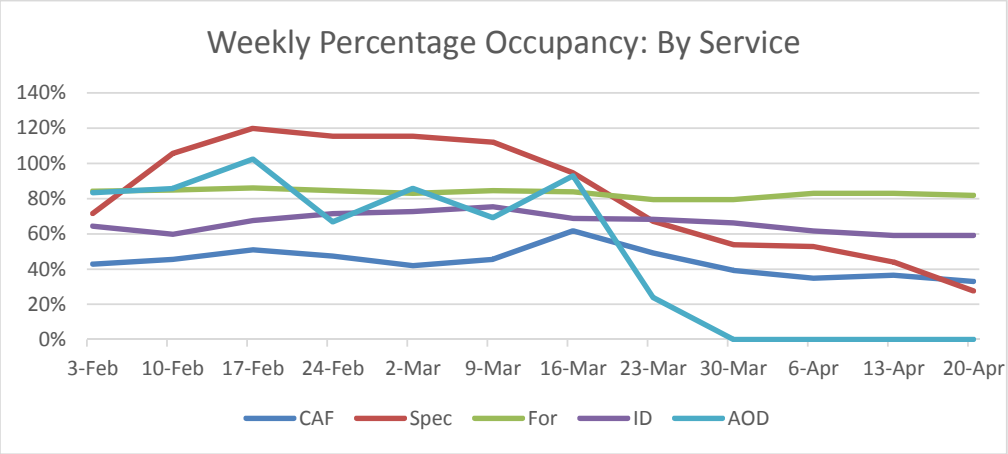


- Referrals decreased at the beginning of Level 4 but are now returning to the usual volumes. We anticipate seeing significant growth in demand as the psychosocial impacts of the pandemic become more apparent.





- Longer stay units have maintained their occupancy levels, maintaining a static population to meet level 4 requirements and to minimise the impact on community-based support providers who moved to predominantly virtual contacts. Te Awakura, the acute adult inpatient unit, raised the threshold for admission and the Kennedy ward was repurposed to enable flexibility and capacity as part of infection prevention and control measures. While Kennedy is repurposed, alternatives for both medical detox and opioid substitution establishment pathways have been in place.



LABORATORY SERVICES

SARS-CoV-2 RNA tests performed at CHL (as of 1500h 6 May 2020):

	Total	Positive Results
Total numbers all regions	29, 971	256
CDHB region	15, 683	103

SARS-CoV-2 RNA patients tested by CHL (some patients repeat tested)

	Total	Positive Patients
Total numbers all regions	28,954	242
CDHB region	15,129	98

702% increase in workload for Virology Lab with the equivalent demand on logistics team

- **Background:** Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the virus strain that causes coronavirus disease 2019 (COVID-19). CHL is one of twelve labs in NZ now undertaking testing for SARS-CoV-2. CHL was the first laboratory to have testing available for SARS-CoV-2 in NZ, with both ESR and LabPlus the other tertiary level labs having assays set up within days following this. The first patient tested at CHL was on 31 January 2020.
- CHL rapidly set up a local EOC in recognition of the emerging pandemic. It was imperative early action was taken to identify reagent, analyser and sample collection supply chain constraints, emerging raw material supply issues, testing logistics and capacity constraints and creating contingencies for all these challenges.
- We recognised these challenges were greater than Canterbury and we needed to be contributing to a national response in the interest of all NZ. If testing in NZ and other regions was struggling, then we were all at risk as a country of not getting COVID-19 under control.
- At the commencement of the pandemic CHL was providing testing for Canterbury & West Coast, Nelson Marlborough, South Canterbury, Mid Central, Hawkes Bay, Tairawhiti, Taranaki and Whanganui for all tests. Lower respiratory tract samples from Southern DHB continue to be referred. We picked up overflow from other regions who had laboratories operational but were in the process of scaling up their capacity and stabilising supply chains, on several occasions we have been on standby for laboratories awaiting supplies to be delivered. As regional laboratories implemented testing or their parent laboratory increased capacity and stabilised supply chains COVID-19 testing transitioned to them to support local responses and increasing capacity across New Zealand.
- **The CHL Pathology and Laboratory Response:** With the early establishment of the CHL EOC, the labs have ensured strong collaboration within its clinical, scientific, technical, administration and management teams. We have ensured connections were established early on nationally at a clinical and operational level. Our Microbiologists (Clinical Pathologists) provide significant contribution to all

aspects of the response from IP&C, Occupational Health, Laboratory diagnostics and research at a local and national level.

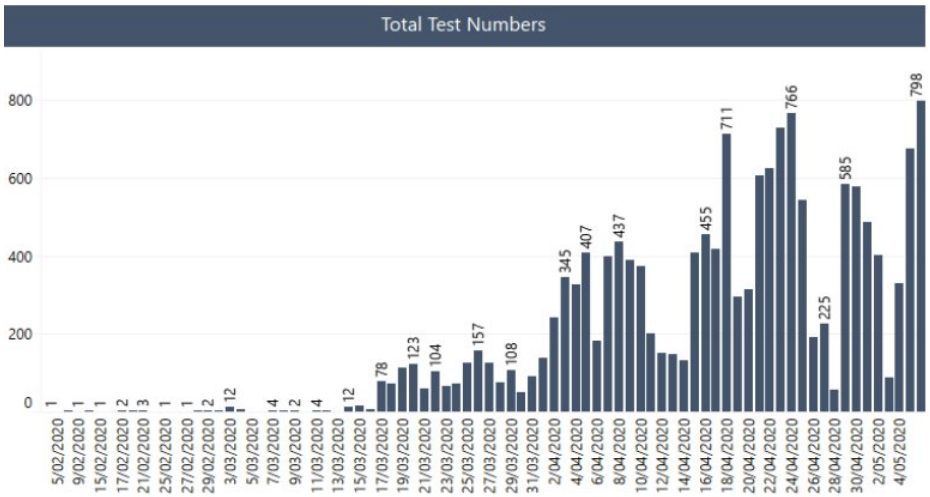
- It was recognised our team needed to bring together our own scientific and management expertise from across labs to support the Virology response. We also needed to share scientific know how and knowledge to support other laboratories – particularly the scientific and technical teams in test development, trouble shooting, provision of consumables and controls to ensure testing capacity was stabilised around the country to meet the demands. CHL has made an on-going contribution to the validation or alternative supplies and reagents for use around the country.
- **Supply Chain:** As a result of the focused response CHL was well positioned, relationships with our established supply partners (suppliers) were able to support our forward ordering of materials to meet increased testing demands and expectations in relation to capacity. This was at the same time as the rest of the world were seeking these same materials from the same suppliers and transport networks closed. While this was not without issues and challenges. A significant commitment was required, and long hours worked by the team to achieve this. The supply chain requires very close and constant monitoring. CHL should remain well placed with its forecasting and forward ordering practices.
- CHL has been able to assist suppliers redirecting orders, swabs, reagents and analysers to other labs around NZ rather than to CHL to support regions establishing or continuing their own testing. This has not been without compromise and we recognise we have to flex for the whole country.
- CHL was also in a position to expedite the Molecular Microbiology analyser tender processes that were already well advanced in order to expedite further testing capacity and flexibility between platforms to optimise throughput and reagent utilisation.
- **Alternative Testing Options and Methods:** An extraction process has been developed by a scientist at the University of Otago that has been refined for use for SARS-CoV-2 RNA extraction in partnership with CHL scientific officers. Further collaboration and work is being undertaken to refine this extraction process to enable it to be scalable and automated on to analytical platforms to provide further testing contingency if there was a period of reduced availability of commercially produced kits which all labs in NZ are currently reliant on from a range of vendors. There are several other tests and options being explored as contingencies.
- **Data and Information:** As with all public health responses, fast and accurate information is essential. During the first couple of weeks for the response CHL (in partnership with Decision Support) developed reports and dashboards to be presented to ESR, the MoH, our DHB and referrers on laboratory testing for COVID19. This included ethnicity reporting for our Canterbury population and supporting national reporting.
- CHL have been able to openly and transparently respond within hours to any request that the MOH, Parliamentary Select Committee or the media has of us in relation to testing activity, trends and turnaround times as a total service or by region. This has been achieved by having the expertise on the ground and advance planning as to what is essential to inform those caring and contact tracing patients and for all decision makers at local, regional and national levels.
- The COVID-19 response has again reinforced strong relationships between Labs and the wider health system both hospital and primary care. We have worked in a partnership with CPRG, Pegasus and other providers with timely response to logistics to support CBAC set up, general practice response for patients meeting the wide case definition and targeted sentinel surveillance. All this testing contributes to informing the national lockdown level decisions.
- **Sentinel Screening:** This screening is critical to inform decision making, as the various agencies work thorough what information is required to assist with decision making at to take NZ to another level there is often little notice for DHBs to respond. This has required a very collaborative effort between CPRG, Pegasus and many health care facilities.
- One example of this is the test information from the sentinel testing at PAK'nSAVE Moorhouse Ave was time critical for the Cabinet meeting where movement from level 4 to 3 approval was discussed. CHL and Pegasus worked together to meet a very tight turnaround, setting up the testing location, sample

collection, processing and reporting of 350 results to inform the Canterbury situation as part of national decision making. In parallel CHL tested for five other DHBs in their efforts.

- This week there has been another collaborative effort across the system for further sentinel surveillance to hit a target of swabbing 1500 asymptomatic staff from ARC, hospitals, laboratory and police within Canterbury within five days to help inform the level 3 to level 2 decision making. Primary care and hospital services have worked in partnership with labs to balance the testing load across the week. CHL are also supporting COVID-19 testing for five other DHBs who have similar targets.
- **Regional Laboratory Support:** A CHL objective early in the response was for CHL to support setting up our regional laboratory referral partners to have COVID-19 testing capability within their own labs and DHB regions to support timely responses for urgent COVID-19 and symptomatic testing. CHL has provided advice and materials to the private laboratory Medlab Central (who supports MidCentral, Whanganui, Lakes and Tairawhiti DHBs) to take testing in house for COVID-19 with a non-medical provider. We are assisting Hawkes Bay DHB secure a medium throughput COVID-19 platform to support set up of testing in their region and have also supplied a rapid throughput platform for them. This will still take a few weeks to have them set up.
- Early in the response CHL was able to support the Auckland region on several occasions when staff required a reprieve during a period of high testing demands and whilst they stabilised their consumable supply and built their capacity across the region. CHL has also been able to lead a piece of work to ensure coordination of a consistent and transparent costing framework for DHBs to submit to the MOH for COVID-19 tests costs.
- CHL has received notes of thanks from Hawkes Bay DHB, Tairawhiti DHB, Whanganui DHB, Southern DHB, South Canterbury DHB, West Coast DHB and the Auckland Region DHBs acknowledging our teams testing services and provision of support for their responses. We have many acknowledgements of thanks for our support from scientific, technical and logistics staff from our private and public laboratory partners across the county for the expert advice that has been provided by our scientific officers and the sharing of materials and supplies to help them develop and validated assays. CHL scientific officers have validated a range of kits, platforms and reagents for use nationally and have shared protocols on request.
- **People:** Early in the response CHL moved to a complex system of rosters separating pods of staff within most laboratories. This was established to reduce pressure on communal spaces within the facility. These pod rosters also retained some capacity in each laboratory should there have been a reason to stand one pod down through an exposure or risk of exposure. Close contact has been maintained with the union partners and staff throughout. Staff in the team have gone above and beyond for the local, regional and national DHBs and patients.
- **Summary:** The quality of the CHL response to the COVID-19 requirements have been driven by forward planning, data analysis, technical expertise and a constant drive for operational efficiency. CHL has been well placed to pull on the resources and skills from across the laboratory service to deliver a nationally leading response and one that has again proven the relationships and commitment of CHL to a high quality national, regional and local response. Thankfully many of the contingency plans put in place for managing increases in hospital and community deceased have not been required but again the planning for this has proven the relationships established with police and civil defence through both the Earthquakes and the Mosque shootings have been invaluable in ensuring efficient communications and planning.

CHL COVID-19 Dashboard and summary of testing to date for Canterbury Region (as of 1500h 6 May 2020)

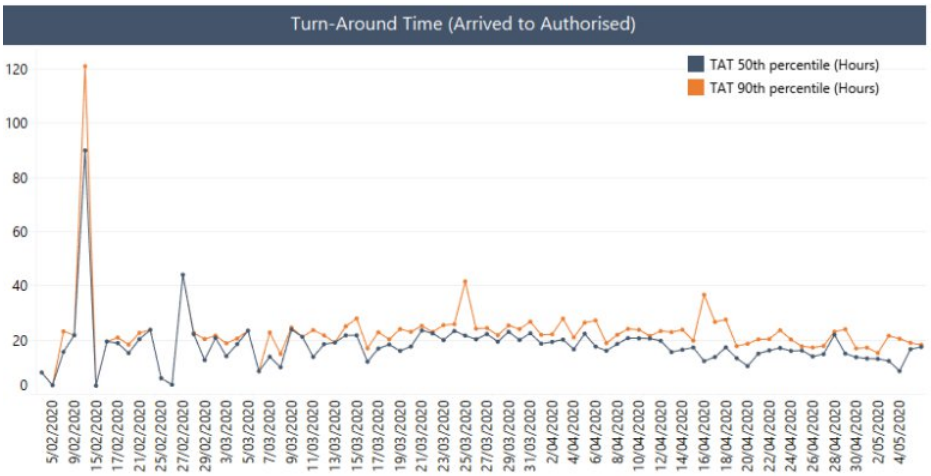
1. **Total COVID-19 testing completed by CHL for Canterbury Region.**



NB: Peak in results to some retrospective test add of COVID PCR test from samples receive for full respiratory viral PCR screens

These volumes are approximately 50% of the total COVID-19 tests performed by CHL.

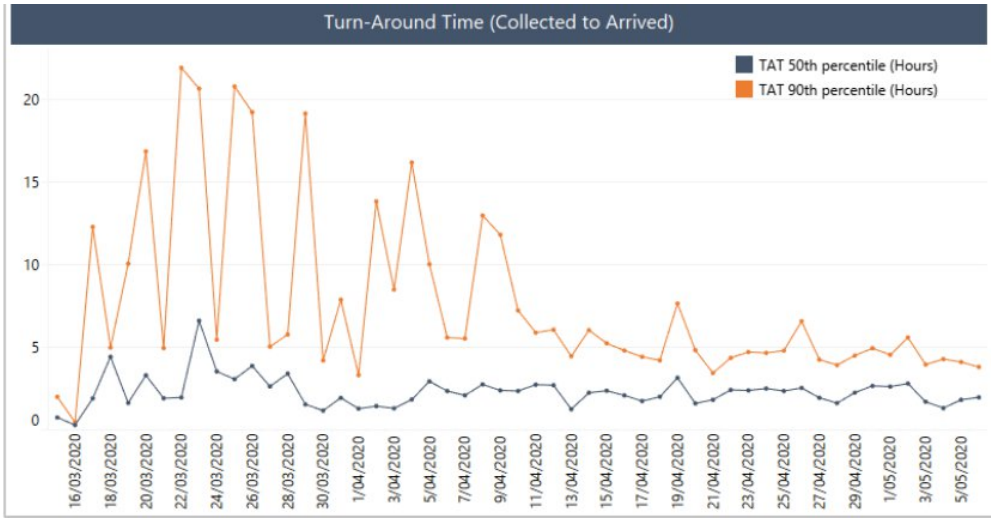
2. **Turn Around Time (TAT) for Canterbury referrals - Arrival at CHL to Result Authorised (laboratory processing time once received)**



NB: Peak in TAT in (9 Feb 2020) was due to some retrospective test add of COVID PCR test from samples receive for full respiratory viral PCR screens

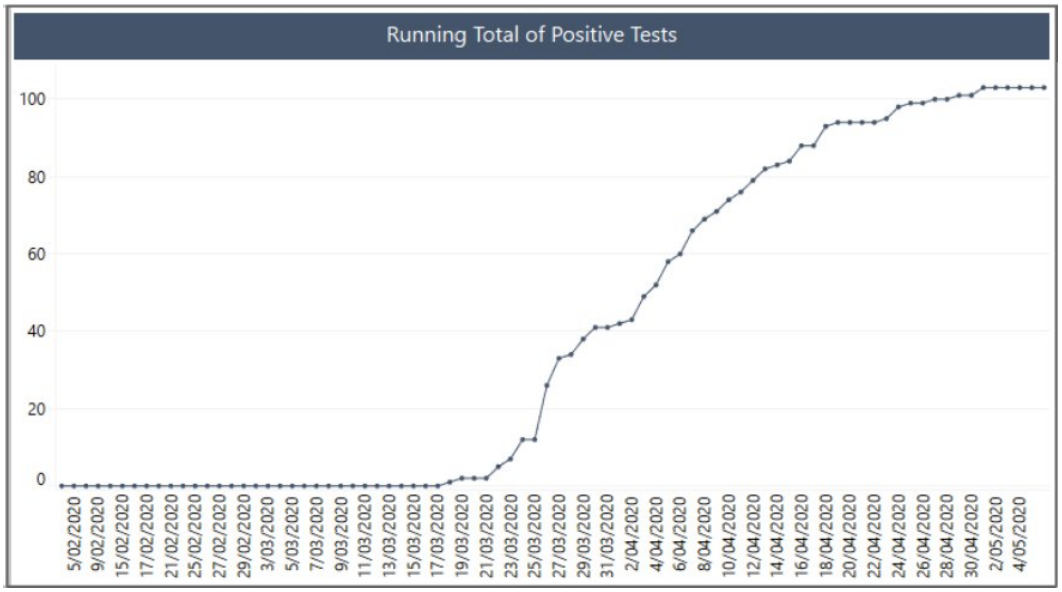
- The slight improvement in TATs are due to the team constantly reviewing and refining process to balance the workload whilst managing a significant increase in total volumes referred for testing from Canterbury and beyond.

3. TAT for Canterbury referrals – Collected to arrival at CHL (transport and couriers)



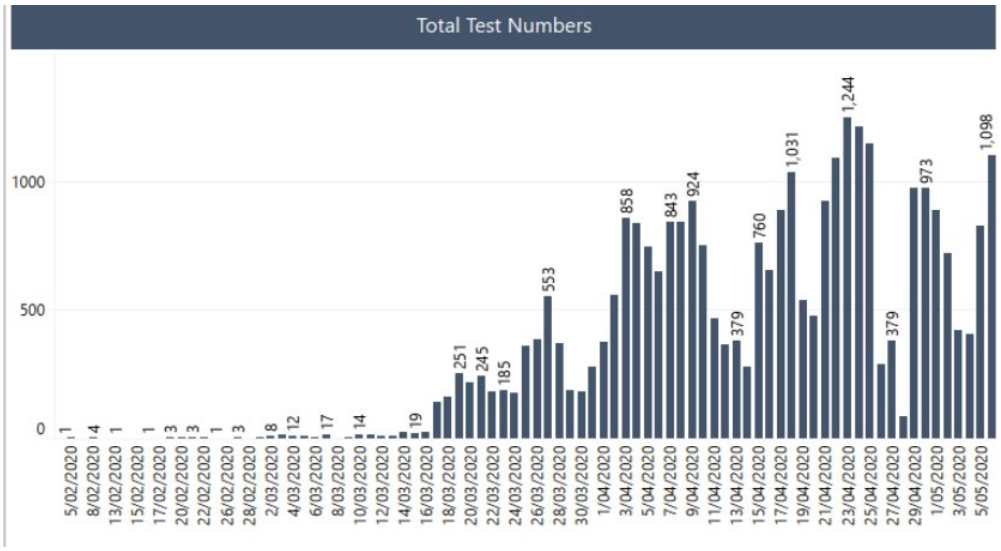
- The introduction of a dedicated courier system in partnership with Pegasus to ensure direct delivery of COVID-19 samples to CHL has made a significant improvement in getting samples to the laboratory on the day taken. This has enable maintaining of TATs whilst managing the increase in volumes.

4. Positivity rate SARS-CoV-2 RNA - total 103 positive results for 98 patients in Canterbury



- These results are critical to contact tracing for all confirmed positive COVID-19 patients and the community and public health response. The combined national testing response has been vital to ensuring the current successes that NZ has achieved as a country towards elimination of COVID-19.

5. Total tests performed by CHL



ASHBURTON RURAL HEALTH SERVICES

- The focus for Ashburton Health Services is building on the opportunities from changed practice implemented through our COVID-19 response plan. The administration team are leading change with a "love it or list it" theme, designing a more efficient model of service cover across the campus to correspond with new "norm". Within existing resources, the new model can increase admin into the AAU to 7 days per week and providing pre-screening calls with appointment reminders for all planned appointments, community or hospital based.
- Alongside this, our Needs Assessment and Care-co-ordination (NASC) team have integrated with our home support response, providing 220 overdue reviews of existing care plans. Through this we have been able to bring forward our implementation of the case mix model and national guidelines supporting a refocus of care provision for older people with complex care requirements and re-connect community members to existing support structures if domestic support only is no longer providing a restorative approach. Domestic only services were removed during the COVID-19 response in Alert level 4, this opportunity has enabled us to provide engage with our clients and assess their progress and will provide an excellent database for further personalised care plan implementation. This also aligns to our resource optimisation work, ensuring our Home-Based Support Services are rostered within a sustainable delivery model.

PRIMARY CARE AND COMMUNITY SERVICES

Mental Health

- Primary and community mental health and addiction services remained operational through lockdown albeit with most contact by phone or online. Residential services focused on keeping existing service users safe while remaining open to limited new admissions. Assessments of the services' readiness to deal with a pandemic have been completed with no immediate actions required. Mental health and addiction services are participating in the wider psychosocial recovery planning alongside Community and Public Health and a wide variety of agencies and organisations.
- The roll out of Integrated Primary Mental Health and Addiction Services in general practice is progressing with an anticipated 56,000 enrolled patients able to access these services by 30 June and 170,000 by 30 June 2021.

Primary Care

- The primary care system in Canterbury has adapted to the rapidly changed environment with General Practice teams mobilised quickly to undertake the essential component of assessing and testing for COVID19 against the Ministry of Health case definition, complementing the national advice to contact Healthline who also was charged with providing the virtual assessment function. People had to be assessed as symptomatic before testing was approved along with contact history (this strict requirement has eased to anyone symptomatic of cold and/or flu symptoms).
  - General Practice adapted by using telephone or other forms of virtual consultations to complete the assessment. By the 11th May 2020, 6,839 COVID tests had been undertaken directly in General Practice. Funding for these assessments and tests is via a revenue agreement with the Ministry of Health and the Canterbury DHB has contracted with Pegasus PHO to distribute these funds on behalf of the system when a claim is made from any General Practice. Not all General Practice assessments result in a test and General Practice can also claim for assessments at a lesser rate, against the same revenue agreement.
  - Reporting on these assessments and tests has been crucial in tracking the amount of Ministry funding against actual utilisation and reporting this back to the Ministry. Pegasus PHO has provided Planning and Funding with forecasting for this General Practice activity and the 10 Ministry funded Community Based Assessment Centres (CBAC) also co-ordinated via a Canterbury DHB contract with Pegasus PHO. (CBACs have undertaken 8,835 tests as at 11 May 2020 and are a core component of the Canterbury COVID response).
- The Canterbury Initiative in conjunction with Streamliners created a Community HealthPathways site for the only DHB without HealthPathways (Hawke's Bay) so HealthPathways now provides a nationwide platform for localised primary care clinical guidance. The Canterbury team facilitated collaboration between all 11 New Zealand regional HealthPathways teams to adapt international and national COVID-19 guidance to work for their local DHB environment. All New Zealand sites have been upgraded to mobile-friendly (app-like) format. The success of the national platform for the response is evidenced by the COVID-19 guidance rising to 15% of total page views on Community HealthPathways.
- In response to Covid-19 the Collaborative Care Team of the Canterbury Clinical Network have provided targeted promotion of the Acute Plan over the last two months including engagement with general practices with 950 COPD patients that are regular attendees at ED, and the adaption of the Acute Plan to capture medical guidance and patient preferences. This is work critical for the support of the most vulnerable in our population. As a result of this work there has been a substantial increase in the number of Acute Plans that have been created or amended. In April there was a total of 662 claims made by general practice for the creation of new acute plans and the amendment of existing plans, up from an average of 100 per month for the previous six months.

COMMUNITY & PUBLIC HEALTH

- Over the previous month Community and Public Health's (CPH) efforts have continued to be focused on leading the public health response to COVID-19 in the CPH region (Canterbury, West Coast, and South Canterbury District Health Boards).
- As of 4 May we are entering week 15 of our response to this ongoing situation – CPH's Emergency Operations Centre/Incident Management Team has been operating since late January when staff began to provide a health presence at the border, and to prepare for the arrival of the virus in New Zealand. A summary of key COVID-19 related work is as follows:
  - CPH makes the first call to all contacts - including non-household contacts. When there are large numbers of non-household close contacts these can be passed on to NCCS (National Close Contact Service). There are few, if any, of these at present due to the recent Level 4 status, but it is anticipated that this may change during Level 3 and below.
  - Case and contact tracing and management, particularly in relation to Aged Residential Care clusters, has been substantial and ongoing. Cluster management teams are in place, with cluster management documented, and cluster meetings held as required.

- A follow-up dashboard and calling module for CPH's existing contact tracing system was also rapidly prototyped and put into production, which has supported, to date, 8,000+ daily follow up calls to people who are COVID cases and their close household contacts.
- A small team of CPH staff have been actively participating in development and roll-out of the Ministry of Health's NCTS (National Contact Tracing Solution) providing feedback, testing and real-world advice back to the NCTS team. We are one of small number of PHUs to have piloted the system, running concurrently with our long-established regional system for case management and contact tracing. We are currently preparing for a staged transition to the NCTS, which includes careful consideration of change/risk management and training issues.
- CPH submits regular data updates to the Ministry's data and analytics team, and is also contributing to development of a nationally held repository of all case and contact management information gathered since the beginning of NZ's Public Health COVID response.
- The COVID-19 protocol is reviewed and updated as required (currently version 14) – this involves extensive contact with the wider health sector – primary care and hospital and community HealthPathways. A common Electronic Request Management System (ERMS) form and fax form has been implemented across CDHB, SCDHB and WCDHB (updated as necessary to reflect new case definition and other changing factors).
- A Medical Officer of Health connects with secondary care via the Infection Prevention and Control Executive Committee (IPCEC) and the Covid Leadership Team, including providing a public health overview.
- Within Christchurch Hospital, clinicians can now use Cortex to send notifications to CPH from iPads, as emails. The Emergency Department continue to notify CPH using fax.
- In the last month the The Mental Health Foundation/CDHB (All Right?) national COVID-19 wellbeing promotion campaign – Getting Through Together has rolled out on TV, radio and multiple social media channels. There has been high uptake.
- CPH is working closely with Te Rūnanga o Ngāi Tahu, Te Pūtahitanga and Te Puni Kōkiri to prioritise Te Tiriti, and an equity lens, across all psychosocial activity.
- The Regional Psychosocial Steering Group for South Canterbury, West Coast, Canterbury and the Chatham Islands is convened and working on aligning overarching principles for future work. The Canterbury Psychosocial Committee met the first time on 30/04; will meet weekly from now on. Dr Caroline Bell gave an overview on the best evidence on psychosocial issues in this pandemic to both the Regional Steering group and the Canterbury Psychosocial Committee.
- The national DHB Psychosocial Coordinators networks meets fortnightly and the National Psychosocial Recovery Plan is regularly updated. The Transalpine Psychosocial Plan will be amended to keep alignment with the national plan.
- Staff are connecting families associated with clusters to welfare support as necessary; a case and contact welfare coordinator has been added to CPH's CIMS structure.
- Regular CPH Intel outputs at present are as follows:
  - a weekly Incident Action Plan, shared with ECCs, NHCC and all CPH staff
  - a weekly intelligence summary report, shared with ECCs and all CPH staff.
  - Daily case numbers and information update to CDHB ECC, WCDHB, SCDHB and CPRG EOCs, all CPH staff (CDHB only), and CDHB, WCDHB and SCDHB Comms.
  - Daily case numbers by TA to CDHB, WCDHB and SCDHB Comms.

Risk Management

- **Case and Contact Management**
  - It is expected that at Alert Level 3 (and below), case numbers may rise and that each case may have more contacts due to larger bubbles, some workplaces being open, some hospitality being open, and a small number of children attending ECE and schools.
  - CPH expects to need to be able to rapidly increase capacity for case and contact management and is planning accordingly. Consequently, additional CPH staff are being trained to join CPH's Case

and Contact Management Team in order to provide the necessary surge capacity for any increase in cases.

- An App may be identified by the government to support contact tracing - this is most likely to use Bluetooth, as seen with the Australian example (which is voluntary, with an opt-in component to protect privacy). Regardless, it is anticipated that case and contact identification and management will need to continue until a vaccine is available.

- **Psychosocial impact and response**
  - Contact tracers report that there is considerable ongoing stress, stigma and fear among those who are isolated at home with COVID-19, or as close contacts of those with COVID-19.
  - There is ongoing concern and stress for all involved with ARC facilities around use of PPE, stigma for staff working with those with COVID, concern for families of ARC residents around what safety protocols are in place for their relatives.
  - The Canterbury DHB Psychosocial Response Plan for COVID-19: Phase 1 is in place.
  - The Regional Psychosocial Steering Group has met. This group has significant Māori membership, and also includes Ministry of Pacific Peoples. Some local groups for each DHB have met.
  - The Psychosocial Committee of the CDEM Welfare Co-ordinating Group is established.

- **Māori Health:** The Hauora Māori response in the overall response to COVID-19 has CPH participation in several key ways:
  - Paper being tabled with Canterbury Primary Response Group and EMT to establish Māori Advisory Board, to support the COVID-19 response.
  - CPH worked with Pegasus as CPRG to implement reach agreement to establish a Community Based Assessment Centre (CBAC) at Ngā Hau e Whā providing a broader service to the Māori and East Christchurch community. It is not just a testing facility but provides for welfare needs, and facilitates a broader health assessment where this is appropriate.

- **Education**
  - A Governance Group for education settings will be convened with representation from CPH, Public Health Nurses s, MoE, and Māori and Pacifica communities. A plan for education settings will be developed with a flow chart to capture the process should a case be identified in a school/ECE.

- **Civil Defence, NGOs**
  - There is a referral system in place for welfare assistance for cases and contacts.
  - CPH staff are regularly in touch with the local CDEM, including attendance at the Welfare Co-ordinating Group.
  - CPH has made a formal response to the Caring for Communities welfare structure policy drafted by Civil Defence.

- **Greater Christchurch 2050**
  - CPH continues to engage and be directly involved in the development of the Greater Christchurch 2050 plan via the Greater Christchurch Partnership (GCP). Our input provides a focus on wellbeing and HiAP as fundamental to the review of the plan whilst also reflecting COVID-19 implications. Continuing to have a focus on the key risk factors for COVID-19 such as obesity, hypertension and diabetes aligns with the same intermediate risk factors resulting from inadequate attention to the social determinants of health, the focus of a HiAP approach.

EFFECTIVE INFORMATION SYSTEMS

- ISG have led, enabled and supported the accelerated deployment of IT devices, services and solutions in response to COVID-19, to help keep our staff and communities healthy and connected.
- ERMS (Pegasus and DHB owned electronic referral management system) rapidly provided a solution for electronic prescribing to support virtual general practice and hospital for two-way communication with community pharmacy which has managed more than 17000 scripts since implementation.

- Online connectivity, communication and collaboration have become part of our everyday lives as we unite against COVID-19. We have experienced a rapid increase in the use of secure platforms such as Microsoft Teams and Zoom with over 10,000 meetings occurring to date. Our staff are reporting that these tools are intuitive, easy to use and time saving.
- ISG have also deployed many mobile devices with 83% of this year's total issued during the months of March and April. These devices meant our staff were able to keep connected and work in different environments such as the Emergency Coordination Centre, Isolation and Quarantine locations, and from home.
- Our Service Desk also experienced unprecedented volumes with a 30% increase in calls when compared to March. The team also resolved 25% more enquiries with over 1,400 received in one week. This level of activity was managed when many of the team were working remotely to ensure physical distancing.
- ISG also supported the accelerated deployment of Cortex to nursing services within the Christchurch campus and a further two services - Respiratory and Cardiothoracic. Prior to this deployment approximately 11,000 clinical notes were made per week and post deployment this number has now risen to 26,000 clinical notes per week. It is expected that this number will continue to grow significantly as the hospital begins to return to pre-COVID-19 levels.

Risks/Issues

- **Paging Replacement System:** The paging system is end of life and requires replacement. Clinical and non-clinical options have been identified with approval of capital expenditure required to proceed.
- **South Island Patient Information Care System (SIPICS):** Following the migration of our outdated Patient Administration Systems to a new regional platform, we are improving our national extract reporting, which includes the reconciliation of all extracts currently submitted for Canterbury DHB.

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Communications and Engagement

- The team's work has been dominated by COVID-19 for some months now. We have been part of the Canterbury Health System Emergency Coordination Centre (ECC) and in addition supporting the 10 Emergency Operations Centres throughout Canterbury and the West Coast. We have continued to provide a 24/7 service with a designated Public Information Manager under the Coordinated Incident Management System. This has required the team to engage a number of contractors to assist with the increased workload for internal and external communications and engagement.
- We have provided advice and practical assistance to Canterbury DHB staff to communicate the numerous changes to the way we work, and the way people can access services. A significant amount of our time has been spent working with our Older Persons Health team supporting Aged Residential Care providers, and in some instances providing direct support to facilities involved.
- The COVID-19 pages created on our public website and on Prism, our staff intranet, have been updated regularly and the intranet content has been well utilised by staff, with educational videos and collateral such as posters on donning and doffing PPE proving to be the most popular content for staff. Q&A videos with our infectious diseases specialists have also been incredibly popular and a useful way to alleviate staff concerns.
- We have been working closely with our public health team for the past three months. This included health promotion and hygiene messages for the public to daily updates on cases, clusters, hundreds of media queries and issues management.
- The Communications team has also worked closely with our counterparts at the Ministry of Health as we managed the communications around the first COVID-19 death in New Zealand on the West Coast, and the largest cluster in New Zealand at the Rosewood Rest Home & Hospital. The team also managed communications and family liaison for each resident who died as part of the Rosewood cluster. We

hosted one of the Director-General's daily media stand ups in Canterbury and liaised with a range of other government agencies to share key public health messaging.

- Other work during April included supporting one of our subsidiaries, Brackenridge, to enable them to provide appropriate COVID-19 advice and messages to their staff, the people they support and to their families.
- We are working on a series of articles to celebrate the often unseen work by teams across our health system in the context of our COVID-19 response. This includes the GG ward at Burwood and our Infection Prevention and Control teams, our labs, the work at Community Based Assessment Centres (CBACs), the COVID and Acute Medical Assessment Unit (AMAU) wards, extraordinary work in pharmacy and general practice, our procurement and supply chain – and many more.
- We worked with graphic designers at the DHB's in-house medical illustrations team to produce a significant volume of resources for our own facilities, general practices, pharmacies and private hospitals along with printed pull up banners for every Aged Residential Care facility. Hundreds of handouts, posters promoting various public health and hygiene messages, various levels of alerts and symptoms were created, and we also created some popular resources to promote physical distancing: The 'two metre Peter' campaign proved to be a relatable way for staff to check their physical distancing.
- Peter is Pete Dooley, a well-known Charge MRI Technologist, whose 'wing-span' and height are both exactly two metres. The measuring strips are also exactly two metres.

Media

- March and April were incredibly busy months for media, with us responding to more than 450 enquiries. The two months have been dominated by queries regarding the DHB's response to COVID-19. The specific topics of media interest have included:
  - The preparedness and hospital capacity for COVID-19 cases
  - Management of COVID-19 cases in Canterbury
  - The contact tracing work of our Community and Public Health teams
  - Precautions being taken to minimise the risk of transmission in our facilities
  - Information on specific cases
  - The DHB's visitor policies throughout the various phases of the pandemic
  - Case data broken down by territorial local authority area
  - Remuneration and leave arrangements for staff who have to self-isolate or for vulnerable staff members who are unable to work
  - Protection of vulnerable staff members
  - Travel restrictions for staff in the early days of the pandemic
  - Childcare arrangements for staff
  - Public health measures at the border, pre-Alert Level Four
  - Elective surgeries that went ahead in Alert Level Four
  - Theft of PPE and hand sanitiser from our hospitals
  - Acute presentations to hospital throughout COVID-19 Alert Level Four
  - The distribution and supply of PPE in the region
  - PPE supplies for DHB staff and home care support workers
  - Testing for COVID-19, including testing volumes in Canterbury
  - CBACs and sentinel testing
  - The Rosewood Rest Home & Hospital cluster
  - The George Manning Rest Home cluster
  - Responses to comments made by staff in the media regarding PPE
  - Advice given to funeral homes throughout the pandemic
  - The Primary Care response to COVID-19
  - Delays and postponements of elective surgeries as a result of COVID-19
  - Electives/outpatient capacity post Alert Level Four
  - David Meates, and the DHB's two Incident Controllers, Dr Sue Nightingale and Dan Coward, have each done numerous interviews over the past two months traversing various topics listed above.
- Some of the other topics of media interest over the past two months included:
  - Flu vaccine supply
  - Hospital parking and comments made by a Christchurch City Councillor
  - A staff member who was hit by a falling tree in the car park of The Princess Margaret Hospital
  - One year anniversary of the mosque attacks
  - Our staff were interviewed by a range of media outlets for their coverage of the one year anniversary of the 15 March mosque attacks:
    - Dr Dominic Fleischer, Emergency Specialist, Nikki Ford, ICU Nurse Manager and Nicky Graham, Surgical Nursing Director were interviewed by One News about their experiences on the day of the Mosque attacks, reflecting on this one year later.
    - Dr Fleischer was also interviewed by The Project, giving the same account from a personal perspective, specifically reflecting on the events in ED on 15 March 2019 and how staff are doing one year on.

- Dr Adib (Eddie) Khanafer was interviewed by Newshub and The Press about the one year anniversary as well.

- Dr Erik Monasterio was interviewed by the Press for a piece on the Rights for Victims of Insane Offenders Bill that was recently introduced to Parliament.

LIVING WITHIN OUR FINANCIAL MEANS

- The YTD result to March is favourable mainly due to a lower capital charge (relating to EQ insurance drawdowns excluded from CDHB's calculation of the payment due, as well as the June 2019 Holidays Act accrual), and depreciation (due to the delay with the Hagley transfer). Although the favourable depreciation variance is a non-operational expense, the delays in Hagley result in additional operational expense that partly offset this variance (eg outsourced elective surgery.
- The current draft annual plan is for a full year deficit result of $180.470M. This includes savings initiatives from our five key taskforces. COVID-19 is impacting on both revenues and expenses, and will affect our forecasted result including taskforce savings initiatives; the full impact is yet to be quantified.
- The following table provides the breakdown of the March result:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	(0.062)	0.000	(0.062)	(0.087)	(0.000)	(0.087)
Funder	(7.621)	(5.161)	(2.461)	(58.005)	(55.159)	(2.846)
DHB Provider	(8.072)	(14.338)	6.266	(39.057)	(60.765)	21.708
Canterbury DHB Group Result	**(15.755)**	**(19.499)**	**3.743**	**(97.149)**	**(115.928)**	**18.778**

4. APPENDICES

Appendix 1: Tumu Whakarae COVID-19 Priorities Framework
Appendix 2: Facilities Repair and Redevelopment
Appendix 3: Our People (CEO Update Stories)

Tumu Whakarae COVID-19 Guiding Principles

Ngā Mātāpono Mate Korona o Tumu Whakarae

1. Arahinatia, kia kore tētahi Māori e hinga
2. Kia mataara, i ngā wā katoa, ahakoa te Pae Mataara
3. Hononga - hono atu, hono mai
4. Whakamana i ngā whānau i roto i ō tātou whāinga
5. Ko te aroha ki ō tātou whānau e noho mātāmua ana
6. Ahakoa te Pae Mataara, kei konā ngā āheinga e marumaru ai te Iwi

Ngā Mātāpono o Wai2575

- Tino Rangatiratanga
- Equity
- Active Protection
- Options
- Partnership

Prepared for Tumu Whakarae by the NRHCC Covid-19 Māori Response Team 24/04/20

TUMU WHAKARAE

Tumu Whakarae COVID-19 Guiding Framework

Ngā Pae Mataara	Ngā whāinga	Ngā whakaarotau	Ngā hua e whāia ana
Pae Whā: Lockdown **Pae Toru:** Restrict /Recover **Pae Rua:** Reduce /Recover **Pae Tahi:** Prepare/Recover	**E hāngai ana ngā mātāpono ki ngā Pae Mataara katoa**		• Whānau are engaged & informed at every level of the Pandemic • Māori Health Equity expectations & measures applied to the Pandemic response e.g. Funding • Whānau Ora pathways of care are in place at every level of the Pandemic • Whānau can access Primary Care at every level of the Pandemic • Hospital services are responsive to Whānau at every level of the Pandemic • Intelligence and data is available to inform the Māori health response at every level of the Pandemic
	WHAKAMARU	*Protecting our whānau from COVID-19 in all alert levels* 1. Champion COVID-19 testing and surveillance of the Māori population, including Māori led case & contact management 2. Whānau Ora pathway of care for whānau who test positive for COVID-19 3. Champion Māori led COVID-19 communication & engagement strategy for whānau 4. Ensure whānau support services in Hospitals (including virtual options) 5. Champion the influenza vaccination of whānau	
	WHAKAKAHA	*Enabling our whānau to stay well in all alert levels* 1. Champion Whānau Ora pathways of care for whānau 2. Champion removing barriers to Primary Care access for whānau 3. Champion hospital services to address unmet whānau need 4. Champion the implementation of a Māori intelligence & data team for COVID-19 5. Champion a system-wide approach with partners to address the social and economic barriers to health equity for whānau	
	WHAKAORA	*Accelerating whānau recovery in all alert levels* 1. Champion Māori Health Provider led innovation and Māori Health Provider sustainability 2. Champion Iwi led innovation and COVID-19 recovery strategies 3. Implement a Māori health COVID-19 learning stream to capture, advance and shape the new normal 4. Champion Māori Health Equity measures and priorities for accelerated post pandemic recovery 5. Champion Māori Health Equity expectations & measures for all new COVID-19 funding allocations	

FACILITIES REPAIR AND REDEVELOPMENT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

COVID–19 Response

- **Community Based Testing Centre (CBTC):** Several portacoms and other Canterbury DHB buildings have been re-purposed to be test centres as part of COVID-19 response. Site Redevelopment Unit (SRDU) directly involved in CBTCs at the old eyes department adjacent to Christchurch Laboratory, Aranui Community Dental Clinic conversion, Moorhouse Avenue Pak and Save car park testing centre, Antigua/Tuam Street staff testing centre and the Christchurch Campus emergency department triaging portacoms.

General EQ Repairs within Christchurch Campus

- **Parkside Panels:** North West corner panels are physically complete with practical completion awarded 23 March 2020. North-East corner Request for Proposal (RFP) due to close at the end of April 2020. Parkside South-East corner Registration of Interest (ROI) evaluation completed with a shortlisted candidates approved. RFP documentation currently being prepared.
- **Lab Stair 4:** On hold due to COVID-19. The restart of the project will need to be coordinated with longer-term Government COVID-19 response due to the disruption that the construction work will have on the laboratories.
- **Riverside L7 Water Tank Relocation:** Maintenance and Engineering (M&E) is managing this project. Management has approved the design for tanks to be relocated to the basement of Parkside. Design has commenced.
- **Riverside Full Height Panel Strengthening:** Design is complete. The Business Case to be submitted for construction to undertake this work in conjunction with the Parkside Panels project. Currently waiting on updated financials.
- **Parkside Strengthening:** As part of the Parkside strengthening works, consultants have been engaged and have started the revised Non-Linear Time History Analysis (NLTHA) on Parkside Block A. A Business Case is being prepared for Block B.

Christchurch Women's Hospital

- **Passive Fire Programme Stair 2:** The team has identified several potential passive fire targets for improvement and are currently working through design and engineering before the formal submission of the ROI and business case. The Architect has completed a concept design to enable budgets to be completed. The balance of fire analysis work is awaiting master plan sign off and migration dates for Hagley Christchurch before works can be programmed to complete proposed works.
- **Level 4:** Crack injection around core to be undertaken. Parent room, kitchen and toilet areas complete. Difficulties gaining access to area due to patient levels. Actively working with staff to look at options to commence the remedial and passive fire protection works.
- **Level 5:** Small amount of work to corridor unable to commence due to operational constraints - Neonatal Intensive Care Unit (NICU). Working with teams to identify a suitable time but will endeavour to pick this up during Women's Passive fire protection works and post Hagley Christchurch occupation.
- **Level 3:** All areas complete except reception, which is to be done at the same time as stair strengthening to minimise disruption.

- Remaining work for levels 3, 4 and 5 is unlikely to occur until after Hagley Christchurch occupation.

Christchurch Hagley Building

- **Ensuite Door Replacement:** Project on hold due to request from the Ministry of Health (MOH). Installation works can commence as soon as access to the building is authorised and the COVID-19 Level is reduced to a status that allows construction works to commence.
- **CT Installation:** Planning is underway to allow core drilling to proceed to allow machine to be installed – liaising with CPB/TTT for necessary permits and permissions. Equipment is on site.
- **Fluoroscopy:** Contractor, architect and subcontractors being engaged to complete enabling works for the room.
- **Emergency Department Radiology:** Scope and fit out works currently being confirmed. YSIO radiology equipment in Christchurch and stored at Fliways near the airport.

Other Christchurch Campus Works

- **Passive Fire/Main Campus Fire Engineering:**
  - Individual Business Cases will be prepared to undertake works within specific areas of the Christchurch Campus buildings. Planning work for the risers in Christchurch Women's is continuing. The scope of work will require review by Fire and Emergency NZ and the Christchurch City Council (CCC).
  - Business Case is being prepared for ChCh Women's Risers. Procurement, Registration of interest and consent application documentation being prepared. Progress delayed due to COVID-19
- **Christchurch Hospital Campus Energy Centre (managed by MOH):** Developed design complete with detail design now underway. Some delays have occurred due to co-ordination of design elements.
- **235 Antigua St and Boiler House (Demolition):** No work to be undertaken until the new energy centre constructed and commissioned. This demolition project will be managed by the CDHB.
- **Parkside Renovation Project to Accommodate Clinical Services, Post Hagley (managed by MOH):** Planning ongoing. This project is being managed by the MOH with close stakeholder involvement from the CDHB. Still waiting on formal advice from management as to the outcome of master planning process and funding.
- **Backup VIE Tank:** On hold due to COVID-19. This project is included as a separable portion to the Health Labs Stair 4 Project. Looking at options to add this project to panel works to enable earlier completion.
- **Avon Switch Gear and Transformer Relocation:** Design complete. Project is delayed as it is coordinated with Christchurch Hagley commissioning.
- **Co-ordinated Campus Program:** Work is progressing on a co-ordinated programme to tie together the demolition of Riverside West, the relocation of clean and dirty loading docks, demolition of the Avon generator building, Parkside Panel replacement/repairs, relocation of food services building and clinical support staff requirements in the lower ground floor (LGF) of The Hagley Christchurch. This will provide insight into timing, relocation requirements and potential sequencing issues. It is still subject to confirmation of who goes where and subsequent endorsement in relation to the MOH led campus

master plan. It is also dependant on which components of work will be MOH or CDHB managed.

- **Seismic Monitoring System:** The Business Case for the installation phase has been submitted to Corporate Support. The Business Case is seeking funding for a 'mid-range' solution and is based on price estimates from three local consultants. Procurement Plan and RFP documents are being prepared.
- **Avon Generator Building Demolition:** Business case for concept design has been approved. Building redundant once new Christchurch Hagley generators commissioned. The site will provide space for relocated loading docks. Work cannot commence until after go live of Hagley Christchurch and bedding period for new generators.
- **Riverside Loading Docks:** User group meetings have been held during the month. Consultants are working remotely to develop sketches and layouts for discussion and further development.
- **Cancer Centre Radiology:** A design project is underway to progress the investigations for the proposed Cancer Centre to initially house two LINAC machines. The investigation work will develop floor plans and assess the feasibility of phased building construction to minimise initial CAPEX.

Canterbury Health Labs (CHL)

- **Anatomical Pathology (AP):** Initial planning on options for repatriating AP from School of Medicine has commenced. A design team has been engaged and briefed, and initial bulk and location options have been developed. Awaiting CHL management to discuss/select an option on which the business case for Concept Design can be progressed.
- **Core Lab (High Volume Automation) Upgrade:** Design team has been engaged and briefed. Initial advice provided to the CHL team in support of the equipment RFP process. This work has now been transferred to M&E due to its size and relatively straight forward process.

Burwood Hospital Campus

- **Older Persons Health (OPH) Community Team Relocation:** Repurposing of the old Burwood Administration area will need to be reassessed to accommodate community teams.
- **Mini Health Precinct:** The Artificial Limb Service (ALS) has withdrawn its proposal of building on the old maternity unit site. The project is currently being reassessed.
- **Earthquake Repairs:** Six buildings have outstanding earthquake repair work to be completed. Consultants have been approached to assist with initial scoping work, which will be coordinated with Maintenance. The project is on hold due to COVID-19 preventing site visits. Architects and engineers advised of restriction on access to buildings.

Hillmorton Hospital Campus

- **Hillmorton SMHS:** Detailed design phase has commenced. MOH has confirmed they will fund a Green Star 4 and consultants are now underway. The impact of Greenstar and COVID-19 on Programme will need to be assessed and incorporated once more details are known. The Cultural Narrative is now being developed.
- **Laundry Repurposing:** Initial concept design to relocate the Design Lab is underway.
- **Earthquake Works:** No earthquake works currently taking place.

- **Fergusson Upgrade:** Admin Relocation initial planning underway prior to Business Case submission. In the process of setting up User Group Meeting with Rebecca Webster regarding Consideration of Masterplan.
- **Food Services Building:** Design work has been progressing with M&E input. Four proposals in relation to the EQ strengthening works have been received. A preferred Engineer has been chosen and contract sign off is underway. Until the COVID-19 restrictions are lifted and a site visit is undertaken no design will be completed. ROI documentation for the main contractor has been completed awaiting internal CDHB sign-off prior to loading on GETS.
- **Cotter Trust:** On-going occupation being resolved as part of overall site plan requirements.
- **AT&R:** Construction work on hold due to COVID-19. Third lift of blockwork had been in progress at the time when work was stopped. Planning under way to recommence works including inspections by the Architect and Structural Engineer.
- **Masterplan:** Cost and programme review is underway to finalise the report for presentation to EMT.

The Princess Margaret Hospital Campus

- **Child, Adolescent and Family (CAF) relocation:** Investigation is delayed because site visits to several potential locations cannot progress due to COVID-19. Project is at the early feasibility stage to identify an alternative location for CAF. Options to be assessed include lease and/or new build.

Ashburton Hospital & Rural Campus

- **New Boiler and Boiler House**: Project being managed by M&E.

Other Sites / Work

- **Central City Health (Endoscopy and Maternity):** Schedule of accommodation and RFP being prepared to identify potential options from shortlisting ROI process completed in December 2019.
- **Chatham Island Accommodation:** Business case has been prepared and submitted. Price estimates for a range of building layouts are being sought from potential suppliers.
- **Rangiora Demolition:** Business case to demolish the old building and widen the existing driveway to make way for the new Community Health Centre is complete. An ROI for a contractor is being prepared.
- **Selwyn Health Hub:** Project Management Plan being prepared, and consultant contracts are with consultants for pricing. An ROI for a main contractor is being prepared.

Project/Programme Key Issues

- COVID-19 is delaying/temporarily stopping some projects, however, many in the design phases can continue using remote networking.
- Sign off on the direction of the Master Planning process is required to plan the next stage of the Programme of Works (POW), Passive Fire and Parkside Panel rectification works.
- Delays to the POW continue to add risk outside the current agreed Board time frames. Key high-risk areas of Panel replacement commenced, as instructed by CDHB Board.

- Access to NICU to undertake EQ repairs to floors continues to be pushed out due to access constraints. Work in these areas will not be possible until the Hagley Christchurch project is complete and space elsewhere on the campus becomes available.

OUR PEOPLE (CEO UPDATE STORIES)

Canterbury District Health Board
Te Poari Hauora ō Waitaha

- CEO Update stories were done on Personal Protective Equipment (PPE), the facts; on ePrescribing through the Electronic Request Management System (ERMS) enabling mainly general practices to avoid passing over another piece of paper to patients and then on to pharmacy staff – this was repurposed into a media release to specialist media and was picked up by New Zealand Doctor, Pharmacy Today and the Healthinformatics NZ eNewsletter.

- The Canterbury Eye Service has gratefully received a generous donation of $50,000 worth of new eye testing equipment thanks to the hard work of Christchurch Hospital volunteers. The items purchased were:
  - Two Nidek Tonoref III machines which do four different measurements in one.
  - A Lensmeter which allows staff to test the prescription of patients' glasses.

- Canterbury Eye Service Charge Nurse Manager Jody Allen says having these additional pieces of equipment has enabled the staff to move patients through testing faster as they are not waiting for long periods of time for shared equipment to become available and patients don't have to be moved around the department to different testing spaces. Volunteer Co-ordinator Louise Hoban-Watson says the donation was made possible by funds raised through the Christchurch Hospital gift shop and the ward trolley which volunteers sell items from.

- Waitaha Stop Smoking Aukati Kaipaipa Practitioners Maraea Peawini and Christine Solomon who are based at Community and Public Health visited the Chatham Islands Rēkohu/Wharekauri to assist with smoking cessation activities on the remote islands where smoking rates are high. They built rapport and relationships. They say discussions flowed well and they gained insight into the culture which will be valuable for stop smoking strategies going forward. Maraea says the Rēkohu/Wharekauri people are amazing and work hard to maintain their autonomy and authenticity "so whatever we do has to build on that". One of the Chathams' kuia said the visit had given them hope.

- Brain Week in March was a chance to raise awareness of delirium, dementia, and other neurological conditions and the role we can all have in supporting brain health. Burwood Hospital staff celebrated with a range of activities. The theme was "Let's stop delirium before it starts". Delirium is sudden confusion which develops over hours to days. People with a delirium have trouble thinking clearly, focusing their thoughts, and paying attention. It is different from dementia which is a progressive cognitive decline that develops and progresses over time. Delirium is under-recognised but is surprisingly common, particularly among older people who are hospitalised, says Lead Researcher, Psychiatry of Old Age, Susan Gee. It can have lasting and grave consequences for a patient's recovery, with an increased risk of staying in hospital longer, having more complications, being discharged to long-term care, and dying.

- In March Christchurch Hospital's Paediatric Diabetes team began offering young people with Type 1 diabetes web-based appointments to protect them from possible COVID-19 contact. Paediatric Endocrinologist Martin de Bock says Zoom meetings are a creative and easy way to get around face to face consultations. For young patients and their families, it's simple and convenient, there are no parking issues, saving their time, and it is socially responsible given the current pandemic. During a web-based consultation the team can still provide prescriptions, adjust insulin, and trouble-shoot as normal.

- Christchurch Hospital Pharmacist Jenny Lin was unable to attend her PhD graduation at the University of Sydney in March as the ceremony was cancelled due to COVID-19 so her colleagues decided to surprise her with an impromptu morning tea and presentation to acknowledge her outstanding achievement. Pharmacy Clinical Supervisor Clare Greasley ensured the team's superior baking skills were in evidence and that everyone was able to join in the celebration of

Jenny's hard work and dedication. Jenny's PhD was on the use of computer-aided drug design in small molecule drug discovery. Molecular modelling software was used to simulate a protein receptor involved in causing a particular disease. Protein models had all been validated prior to any simulation, following this virtual screening work commenced to search for optimal compounds that will bind to the active binding site on the protein, that will hopefully inhibit the protein (to induce bacterial division). The selected compounds hopefully will have the potential to become possible lead compounds to be developed into a novel antibacterial agent.

- Careful measures were put in place to ensure COVID-19 stays out of the small community of the Chatham Islands. Several protocols were created in advance to prevent COVID 19 getting to Chathams, says Transition Programme Manager Win McDonald. All crew on the Chatham Islands observe strict hand washing before and after handling cargo so that there is minimal handling of goods. Crews don't mix with loading staff in New Zealand and no one is at work if they have any signs of being unwell. Shops and other distribution agencies have been advised about washing hands before and after handling all packages, and products being delivered to vulnerable people are left at the gate so there is no physical contact. Chatham Islands Health Centre Manager Sally Lanauze says there is PPE on the Chathams and all staff are trained in its use. There are two emergency houses set up if needed, to isolate suspected or confirmed cases of COVID-19.
- The Medical Physics and Bioengineering Department met the needs of staff by making 50 mobile personal protective equipment (PPE) stands. They were designed by the team. Team Leader Bioengineering Chris Morison says it was a huge job for the small team who worked flat out in their workshop to get them assembled. Intensive Care Unit Registered Nurse Julie Burgess says the stands make life easier as they are a single point for Personal Protective Equipment (PPE), helping keep it all tidy and orderly and easy to see when it needs restocking which helps to reduce waste. Being mobile means they are easy to take to where they are needed to ensure staff have access to the PPE they need, she says.

- A free wellbeing toolkit originally designed for classroom use has been adapted so parents can use it at home. Sparklers is an online toolkit full of fun activities that support the mental health and wellbeing of primary and intermediate students. Sparklers Content Creator Anna Mowat says Sparklers at Home was designed to support parents in a very different-looking school term during level 4 lockdown and beyond. The website is full of wellbeing activities that parents can do with their children in their living room or on their lawn. Sparklers started out as a resource for schools in post-quake Canterbury and is now used by teachers all over New Zealand. Sparklers is part of

the All Right? wellbeing campaign. Sparklers at Home has been funded by the Ministry of Health as part of the Getting Through Together mental health and wellbeing package.

- **Facilities Redevelopment- Communication**
- **Christchurch Hospital Hagley**
- COVID-19 activity has mostly disrupted facilities communications, however we were able to carry out and record a small blessing of sections of Hagley.
- As we look toward firmer dates for handover of the building, consideration is being given to requirements for orientation and migration collateral.
- To assist with training of staff in their new areas, a refreshed healthLearn package has been developed to include new or additional information that has been updated since release of the first package, and videos of training sessions will be provided to ensure staff and trainers will be able to refresh their knowledge prior to occupation.
- Additional videos are being produced to assist with orientation and familiarisation of the building. These videos feature footage and photographs from inside Hagley along with 3D renders and floor plans to illustrate the location of wards and services within the building.

The Blessing of Christchurch Hospital Hagley

- **Maps and wayfinding:** The Communications Team is helping produce maps for transit routes for patient and staff migration and assisting with wayfinding strategies for patients, staff and visitors.
- **Specialist Mental Health Services support:** Communications is working with the Mental Health facilities team to ensure staff and stakeholders are kept up to date with developments on the Hillmorton site. A communications plan is being developed to identify key dates and milestones and ensure communication around the build is timely, effective and relevant.
- **Website:** The website has facilitated frequent COVID-19 related updates for the general public. While public interest peaked in mid-April, demand for information continues to be high. The website has had 200,000 visitors in the past 60 days, a +51% increase on normal use for the same period. There have been more than 50,000 visits to our main COVID-19 page over this period.
- **During the week 30 April to 5 May 2020 the COVID-19 information of most interest has been:**
  - Current COVID-19 case numbers in Canterbury
  - COVID-19 Case numbers for Christchurch

- Elective surgery and outpatient appointments resuming
- Hospital visitor restrictions
- How to get COVID-19 tests

- **Recent website feedback about what worked well for people includes the following**

Information that I got from this page made all the difference. Thank you
It was easy to find and fill out the form for my inquiry, concise, well laid out and not complicated
Easy access to the information I needed. thank you
Knowing the circumstances of my home town re COVID-19…
Knowing who to call if worried about something
The opportunity to express my appreciation of my care the hardworking nursing staff in difficult circumstances.
List of CBACs. Couldn't find that info when searching 10 days ago.
Being able to express my appreciation of the care I received.
Simple and easy way to provide feedback
Ability to send suggestion to CDHB.
All the information that I needed for my request was available and appropriate – thank you
I could print out for work. Quick and efficient.
Quite easy and straight forward to use
Showing myself exactly where you are as requiring urgent blood test prior to a CT Scan.
Seeing what dentists were available close to where we live.
Simple, clear form; easy to follow. Convenient way to get in touch. Thank you.
Access to email and other programmes and service desk…

- **Flu campaign nets communications award in global competition:** In April, the Communications Team was recognised with an international communications Award for their 2018 flu vaccination campaign. The International Association of Business Communicators (IABC) Gold Quill Awards celebrates excellence in strategic communication worldwide and has run for more than 40 years. A panel of international judges reviewed over 550 entries from across the world. Canterbury DHB's entry "Keeping Canterbury flu-free" was one of three to receive an excellence award in the Governmental Communication category and the only entry from New Zealand to be recognised across all categories. Judges said of Canterbury DHB's entry, "This is a very strong blueprint for strategic planning and execution. A well-explained and thorough approach to setting strategic goals leading to excellent results… This was an extraordinary example of connecting to the community audience in a meaningful and memorable way that impacted the community positively." The campaign was led by Senior Communications Advisor Renee Parsons and Executive Director Communications Karalyn van Deursen.

FINANCE REPORT 31 MARCH 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **David Green, Financial Controller, Corporate Finance**

APPROVED BY: **Justine White, Executive Director, Finance & Corporate Services**

DATE: **21 May 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This is a regular report and standing agenda item providing an update on the latest financial results and other relevant financial matters to the Board of the Canterbury DHB. A more detailed report is presented to and reviewed by the Quality, Finance, Audit and Risk Committee monthly, prior to this report being prepared.

2. RECOMMENDATION

That the Board:

i. notes the consolidated financial result (before comprehensive income) for the month of March 2020 is a net expense of $15.755M, being $3.744M favourable to plan, and year to date $18.778M favourable to plan;
ii. notes the operating result (pre indirect items) for the month is unfavourable to plan by $341k, year to date $1.526M unfavourable to plan. This includes current COVID related costs;
iii. notes that costs associated with the Whakaari tragedy (excluding IDF) as included in the year to date operating result is in excess of $1M, with no associated funding;
iv. notes that net costs associated with COVID-19 pandemic as included in the month of March results are $829k;
v. notes liquidity (cashflow) risk continues to be a significant concern without any sustainable long term resolution; and
vi. notes that we are awaiting a Ministry decision on our request for the exclusion of EQ insurance capital in excess of capital impairment from the capital charge calculation, the financial impact of which, if declined, is a $12.5M additional capital charge expense.

3. DISCUSSION

Overview of March 2020 Financial Result

Summary DHB Group Financial Result

The following table provides the breakdown of the March result:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate	(8.157)	(14.435)	6.278	(39.409)	(60.784)	21.376
Community & Public Health	0.060	(0.034)	0.094	(0.153)	(0.114)	(0.039)
Total In-House Provider excl Subsidiaries	**(8.097)**	**(14.469)**	**6.372**	**(39.562)**	**(60.898)**	**21.336**
Add: Funder & Governance						
Funder Revenue	150.445	147.639	2.806	1,335.118	1,325.017	10.101
External Provider Expense	(69.151)	(64.028)	(5.123)	(593.670)	(581.205)	(12.465)
Internal Provider Expense	(88.915)	(88.772)	(0.143)	(799.454)	(798.971)	(0.483)
Total Funder	**(7.621)**	**(5.161)**	**(2.461)**	**(58.005)**	**(55.159)**	**(2.846)**
Governance & Funder Admin	(0.062)	0.000	(0.062)	(0.087)	0.000	(0.087)
Total Canterbury DHB (Parent)	**(15.780)**	**(19.630)**	**3.849**	**(97.654)**	**(116.058)**	**18.403**
Add: Subsidiaries						
Brackenridge Services Ltd	0.038	0.049	(0.011)	0.270	0.118	0.152
Canterbury Linen Services Ltd	(0.013)	0.082	(0.095)	0.235	0.012	0.223
Canterbury DHB Group Surplus / (Deficit)	**(15.755)**	**(19.499)**	**3.743**	**(97.149)**	**(115.928)**	**18.778**

The YTD result to March is favourable mainly due to a lower capital charge (relating to EQ insurance drawdowns excluded from CDHB's calculation of the payment due, as well as the June 2019 Holidays Act accrual), and depreciation (due to the delay with the Hagley transfer). Although the favourable depreciation variance is a non-operational expense, the delays in Hagley result in additional operational expense that partly offset this variance (eg, outsourced elective surgery).

The current draft annual plan is for a full year deficit result of $180.470M. This includes savings initiatives from our five key taskforces.

4. KEY FINANCIAL RISKS

The **liquidity issue** continues to be a key issue. In April we received $130M additional equity that has alleviated our immediate liquidity issue. However, the current forecasted inability to clear our financial obligations as they fall due has only moved to 1 September 2020, this date excludes the one-off impact of a move to payment to suppliers within 10 days as endorsed by MBIE. Being a large organisation there are inevitably variations in the daily cashflow, so it is prudent to have a small tolerance to allow for payments that cannot be withheld without significant detrimental impacts on CDHB. We continue to actively manage and mitigate the issue, and continue to send weekly detailed cashflow forecasts to the MoH.

Note that an increase in equity prior to 30 June 2020 (compared to an increase in funding or advance funding) will result in additional capital charge expense over that currently forecast for the 2020/21 financial year of approximately $4.2M.

COVID-19 – the forecasted impact of COVID-19 on CDHB's performance is evolving. The long-term impact will take some time to determine, and will include factors such as elective revenue, IDF revenue, and ACC revenue, and the costs associated with these (eg what level of outsourcing is required to catch up on lost throughput). We have estimated the impact of COVID-19 on the full year result and presented these in low, mid, and high impact scenarios, including the estimated year end closing cash balance[1].

Direct expenditure to community providers has been reimbursed. Other direct costs of the Provider are being tracked, and we are submitting weekly reports as requested by the MoH. These additional costs include Public Health costs associated with border screening and, more lately, contact tracing. Our Laboratory also has additional workload and costs associated with testing. Outpatient volumes and all elective surgery volumes have been impacted from mid-March. Whilst occupancy may be lower than expected, the pandemic situation has presented unique challenges for staffing and roster modelling to ensure both staff and patient safety.

Included within the operating result for the month are net costs of $829k relating to the COVID-19 pandemic (these are costs that CDHB has not otherwise been reimbursed for).

Industrial Action -The industrial action taken earlier in the year impacts our YTD elective services and other key critical services such as radiology and cancer treatment. This has had a significant detrimental financial impact YTD.

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

The new **Hagley facility** becoming operational in 2020 will add stress points to the operating result of CDHB; this includes the continued delays and uncertainty in its scheduled handover which has both performance and financial downsides.

At this point no funding has been made available to cover the costs of the **Whakaari incident** incurred to date. The Whakaari incident has also impacted on the delivery of electives and IDF volumes.

5. APPENDICES

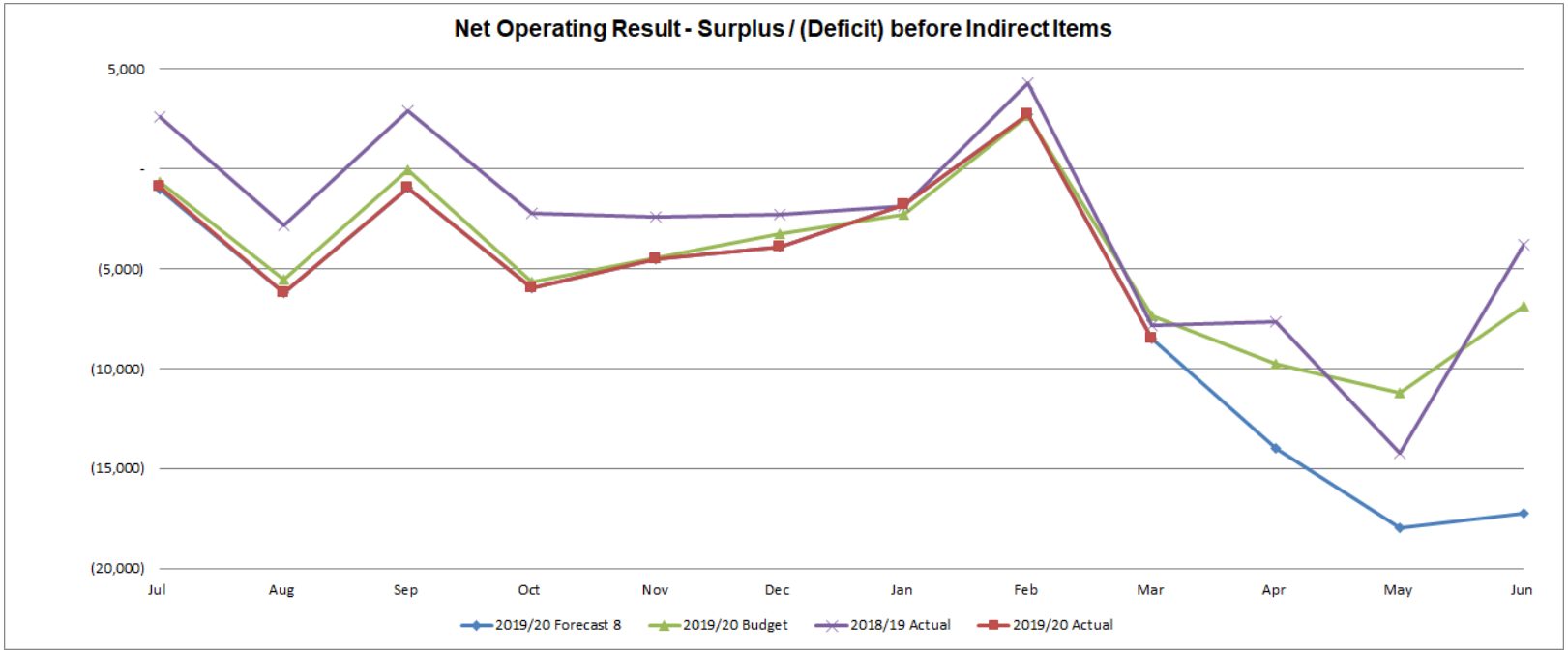
Appendix 1: Financial Result
Appendix 2: Statement of Comprehensive Revenue & Expense
Appendix 3: Statement of Financial Position
Appendix 4: Cashflow
Appendix 5: COVID-19 indicative forecasts

[1] This cash balance is updated as at 14 May 2020.

APPENDIX 1: FINANCIAL RESULT (BEFORE INDIRECT ITEMS)

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 31 MARCH 2020

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2018/19 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
Surplus/(Deficit) before Indirect items	(8,484)	(8,143)	(341)	4% ✕	(29,816)	(28,290)	(1,526)	5% ✕	(100,335)	(83,980)	(58,337)	(25,643)	44% ✕

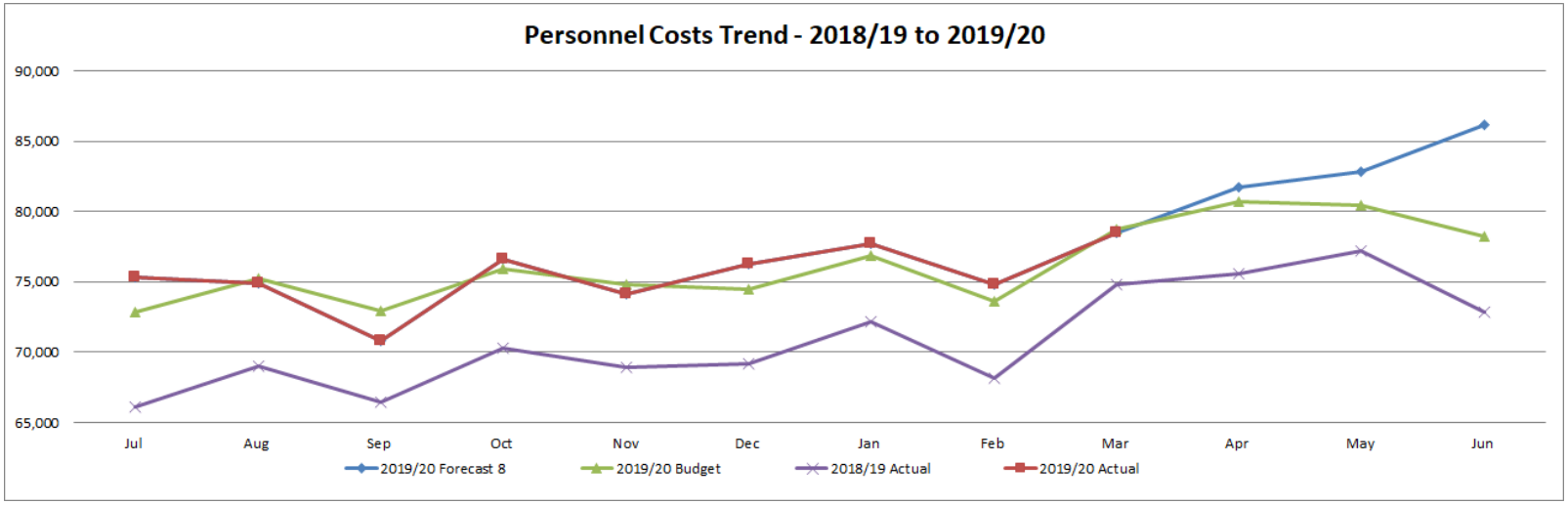


NB: The June 2019 result in the above graph excludes the one off Holiday Act compliance accrual for comparison purposes.

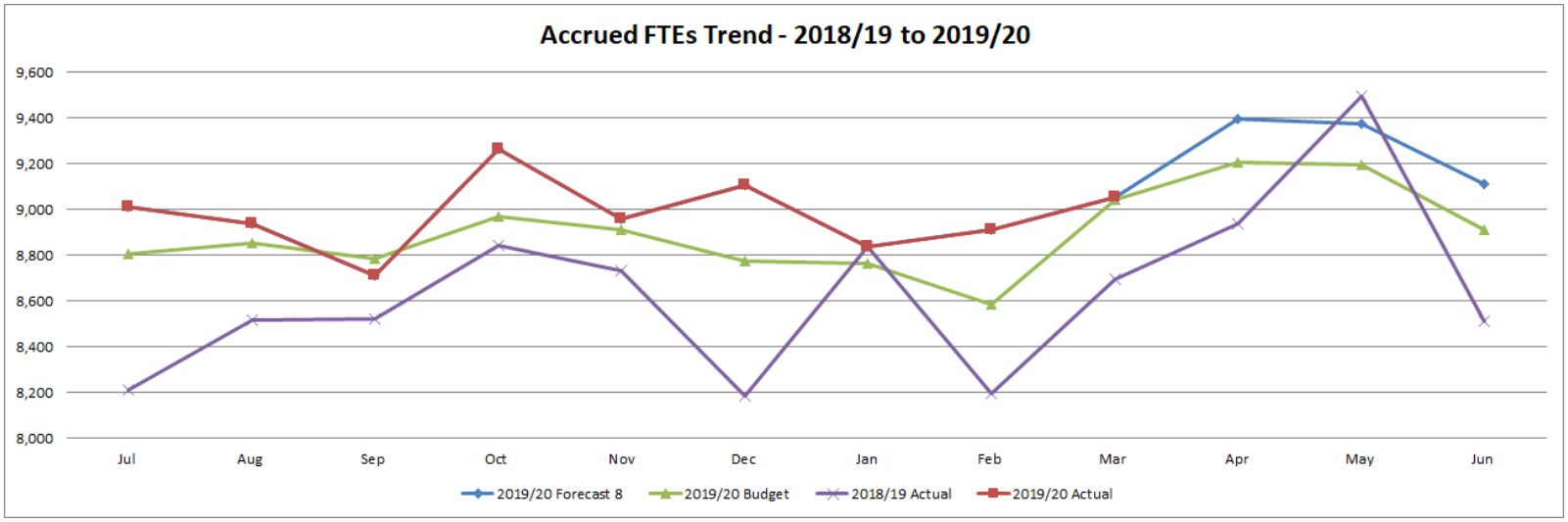
KEY RISKS AND ISSUES

- This graph shows the operating result before indirect items such as depreciation, interest, donations, capital charge and the offsetting capital charge funding.
- In the month of March CDHB incurred $829k of COVID-19 pandemic related costs; our result would be $489k favourable for the month if these costs were excluded.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE



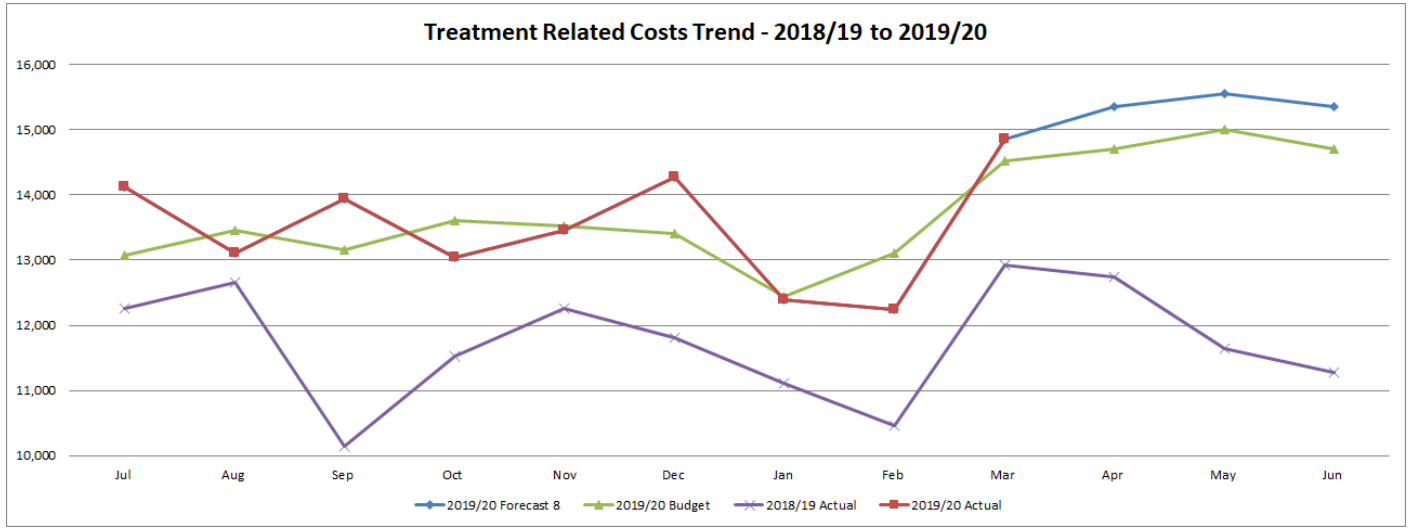
NB: June 2019 actual payroll costs in the Personnel Costs Trend graph exclude the one off Holiday Act compliance accrual of $65.260M for comparison purposes. December results reflect the first month of in-sourced cleaning services, a larger reduction in Non Treatment Related Costs has also been experienced

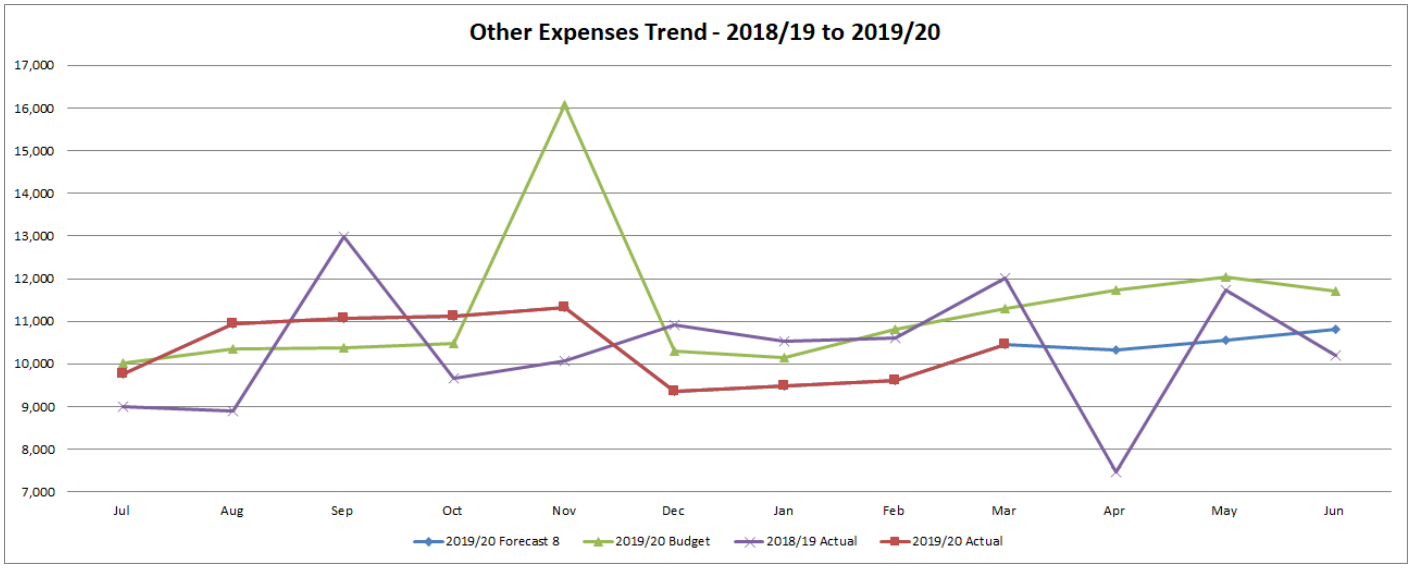


KEY RISKS AND ISSUES

- Although there continues to be a focus across the whole DHB on staff taking leave to ensure personnel costs remain on budget. Leave management initiatives have been severely disrupted with the COVID-19 issue. Senior Doctor CME leave has seen significant cancellations.
- We have transitioned cleaning services to an in-house model from 1 December; the payroll cost increase is estimated at $5M for the 7 months to June 2020; which is offset by an estimated $6M reduction in cleaning costs reported in Other Expenses. Cleaning staff accounted for $0.6M of the unfavourable variance for March, and $2.5M of the YTD variance; this will continue for the remainder of the year.
- Accrued FTE: The transition of cleaning from an outsourced provider to an in-house model has impacted of an additional 180 people from December 2019. The FTE shown in this graph is an "accrued" FTE, and differs from contracted FTE. The methodology to calculate accrued FTE causes fluctuations on a month to month basis dependant on a number of factors such as working days (the range is 21-23 across the year), the accrual proportions, annual leave impacts (particularly school holidays, Easter, Christmas and New Year periods), etc. The accrued FTE largely correlates with the trend in contracted FTE.

TREATMENT & OTHER EXPENSES RELATED COSTS



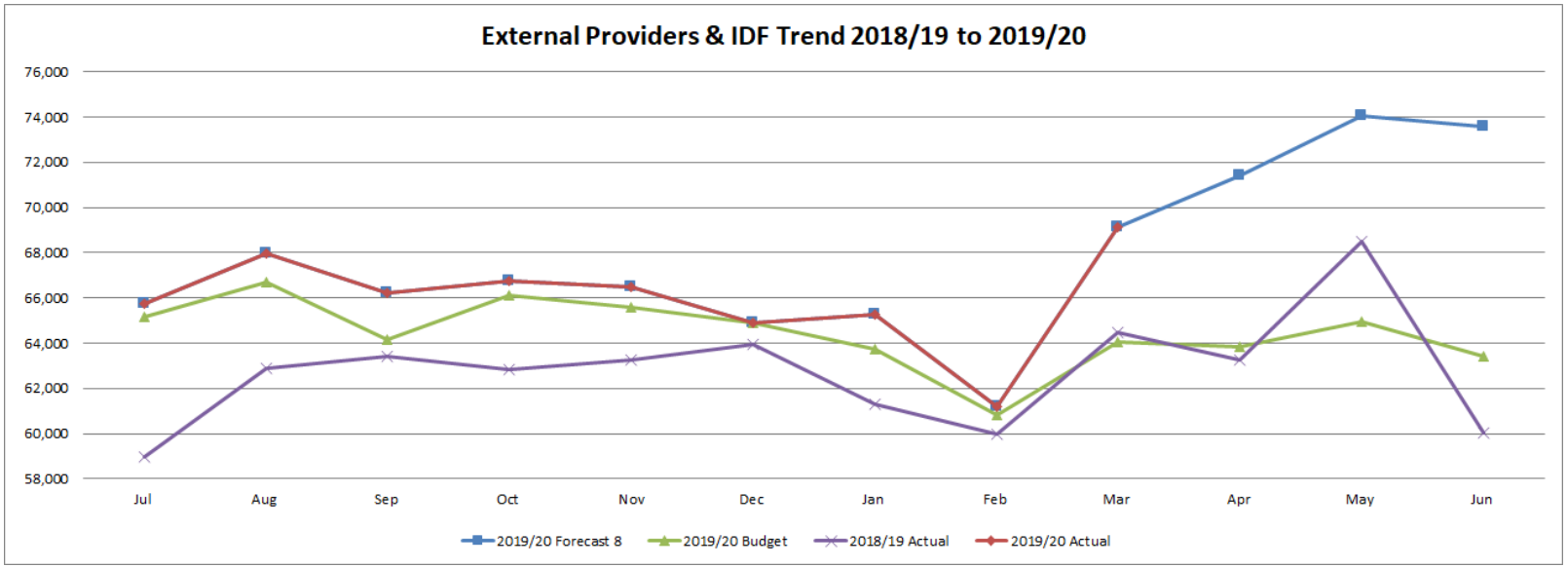


KEY RISKS AND ISSUES

- The variance for the month includes $308k of COVID-19 costs, so the result is largely on budget. However growth in pharmaceutical spend YTD is higher than planned but is being masked by an adjustment to PCT recovery costs where the budget sits in the Provider but the costs are being incurred in External Providers. Hospital pharmacy costs continue to increase, specifically immunosuppressants and cancer drugs.
- Treatment related costs are influenced by activity volume, as well as complexity of patients.
- Note that the November budget for Other Expenses included $5M for the opex portion of the Tunnel handover (which will be offset by an equal earthquake programme of works drawdown). The forecast has been amended to reflect the delay in the Hagley handover to the 2020/21 financial year. YTD expenditure is $7.6M favourable due to earthquake expenditure – this is matched with an unfavourable variance in Operating Revenue.
- We have transitioned cleaning services to an in-house model from 1 December. The reduction in Other Expenses is $0.9M for March, and $3.2M YTD, partly offset by increased payroll costs, ie there is a savings component to this change in model.
- Security costs in our Specialised Mental Health division continue to be higher than planned. Additional facility costs continue to be incurred in relation to The Princess Margaret Hospital (TPMH) campus, including security, basic maintenance etc. Some of these additional costs are in relation to a number of mental health services that remain stranded at that site. Although we have Ministerial approval to progress a shift of services to Hillmorton, TPMH is still unlikely to be fully vacated until the 2022/23 financial year.

EXTERNAL PROVIDER COSTS

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000			2018/19 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000		
External Provider Costs	69,151	64,028	(5,123)	-8%	✗	593,670	581,205	(12,465)	-2%	✗	752,784	812,371	773,439	(38,932)	-5%	✗



KEY RISKS AND ISSUES

- External provider expenditure was $2.7M unfavourable due to pandemic costs, but offset with $2.6M of additional MoH revenue to match.
- We were recently advised that our contribution to the national haemophilia costs has been increased by $1.6M for this financial year. We have recognised $1.2M of this in March.
- Community pharmaceutical costs have been increasing in recent months, in line with the increase in the CPB. PCT continues to be impacted by the addition of the high cost non-PCT medicines which relate to conditions with a high prevalence in South Island populations.
- Note that part of the month, YTD and year end forecast variance relates to PCT drugs where the budget is in the Provider arm, but expenditure is being recognised in External Providers. This will be corrected in the 2020/21 financial year.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000	
Equity	506,222	1,193,406	687,183	58% ✓

	YTD Actual $'000	YTD Budget $'000	Variance $'000		2018/19 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
Cash	(29,005)	8,430	(37,435)	-444% ✗	(31,576)	(28,396)	(62,397)	34,001	-54.5% ✓

KEY RISKS AND ISSUES

- The equity variance to budget is due to the Holidays Act compliance provision made in June 2019 that impacted retained earnings, as well as the large increase anticipated in November 2019 related to the new Hagley facility handover which will now occur post 30 June 2020..
- We are experiencing higher cash outflows than predicted, partly due to higher capital spend on Hagley FF&E (reimbursed by the MoH, but there is a timing delay to this reimbursement), as well as on the Mental Health facilities redevelopment (we are working with the MoH to obtain equity drawdowns quarterly in advance to avoid timing issues with reimbursement).
- The sweep account was overdrawn at the end of March with a balance of $30.8M (against our facility of $89M). In April we have received a $130M equity injection.. This has alleviated the problem in the short term but will need a permanent solution over the next month or two.
- COVID-19 expenses have also added to our cashflow situation. The incremental unfunded costs we have recorded for COVID-19 to 26 April are $3.9M.
- We have factored in additional cash required for anticipated costs relating to the Hagley handover delay, but the impact of COVID-19 has not been factored in.
- A longer term resolution to this issue from the MoH and Treasury is urgently required.
- The Crown, via MBIE has also indicated that Government agencies will need to pay suppliers within 10 working days from July 2020. We would require a change in the timing of our funding for CDHB to be able to pay our suppliers within these terms. We have not had any formal notification on this issue from the MoH.

APPENDIX 2: CANTERBURY DHB GROUP STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

The Group financial results include Canterbury DHB and its subsidiaries, Canterbury Linen Services Ltd and Brackenridge Services Ltd
For the nine months ended 31 March 2020

Month					Year to Date				Annual (Year End)			
19/20 Actual 000's	19/20 Budget 000's	18/19 Actual 000's	Variance to Budget 000's		19/20 Actual 000's	19/20 Budget 000's	18/19 Actual 000's	Variance to Budget 000's	19/20 Forecast 000's	19/20 Budget 000's	18/19 Actual 000's	Variance to Budget 000's
156,049	152,367	148,808	3,682 ✓	MoH Revenue	1,385,045	1,372,296	1,306,681	12,749 ✓	1,854,308	1,829,389	1,740,486	24,919 ✓
4,837	4,185	4,096	652 ✓	Patient Related Revenue	39,798	36,808	35,539	2,990 ✓	52,193	49,121	49,201	3,072 ✓
3,591	3,934	3,507	(343) ✗	Other Revenue	32,430	39,603	30,130	(7,172) ✗	42,415.81	51,708	39,747	(9,292) ✗
164,477	**160,486**	**156,411**	**3,991**	**Total Operating Revenue**	**1,457,273**	**1,448,707**	**1,372,350**	**8,567**	**1,948,917**	**1,930,218**	**1,829,434**	**18,699**
78,500	78,778	74,843	278 ✓	Personnel Costs	679,067	675,566	625,055	(3,501) ✗	926,653	915,003	915,946	(11,650) ✗
14,850	14,524	12,933	(326) ✗	Treatment Related Costs	121,424	120,325	105,138	(1,099) ✗	167,686	164,745	140,795	(2,941) ✗
69,151	64,028	64,498	(5,123) ✗	External Service Providers	593,670	581,205	561,407	(12,465) ✗	812,371	773,439	752,784	(38,932) ✗
10,460	11,299	11,947	839 ✓	Other Expenses	92,928	99,900	90,200	6,972 ✓	126,186	135,369	120,244	9,183 ✓
172,961	**168,629**	**164,221**	**(4,332)** ✗	**Total Operating Expenditure**	**1,487,089**	**1,476,996**	**1,381,800**	**(10,093)** ✗	**2,032,896**	**1,988,555**	**1,929,769**	**(44,341)** ✗
(8,484)	**(8,143)**	**(7,809)**	**(341)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**(29,816)**	**(28,290)**	**(9,450)**	**(1,526)** ✗	**(83,979)**	**(58,337)**	**(100,335)**	**(25,642)** ✗
48	94	56	(46) ✗	Interest Revenue	538	666	717	(128) ✗	720	939	627	(219) ✗
685	685	-	- ✓	MoH Revaluation Cap Charge funding	6,165	6,165	-	- ✓	8,220	8,220	-	-
-	748	-	(748) ✗	MoH Debt Equity Swap funding	-	1,496	-	(1,496) ✗	-	3,740	-	(3,740)
1,013	224	210	789 ✓	Donations	3,231	2,012	3,570	1,219 ✓	3,731	2,586	4,067	1,145 ✓
-	1	1	(1) ✗	Profit on Sale of Assets	15	6	130	9 ✓	15	8	133	8 ✓
1,746	**1,752**	**267**	**(6)** ✗	**Total Indirect Revenue**	**9,949**	**10,345**	**4,417**	**(396)** ✗	**12,686**	**15,492**	**4,827**	**(2,806)** ✗
1,966	5,691	2,079	3,725 ✓	Capital Charge	19,712	36,789	18,715	17,077 ✓	25,611	53,864	24,241	28,253 ✓
7,014	7,367	4,741	353 ✓	Depreciation	57,148	60,744	40,300	3,596 ✓	78,166	83,161	54,407	4,995 ✓
37	50	63	13 ✓	Interest Expense	369	450	290	81 ✓	425	600	552	175 ✓
-	-	2	- ✓	Loss on Sale of Assets	53	-	6	(53) ✗	53	-	23	(53) ✗
9,017	**13,108**	**6,884**	**4,091** ✓	**Total Indirect Expenses**	**77,282**	**97,983**	**59,311**	**20,701** ✓	**104,255**	**137,625**	**79,223**	**33,370** ✓
(15,755)	**(19,499)**	**(14,426)**	**3,744** ✓	**Total Surplus / (Deficit)**	**(97,149)**	**(115,928)**	**(64,345)**	**18,778** ✓	**(175,548)**	**(180,470)**	**(174,731)**	**4,922** ✓

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 31 March 2020

Audited 30-Jun-19 $'000		Group Actual 31-Mar-20 $'000	Group Budget 31-Mar-20 $'000	Annual Group Budget 30-Jun-20 $'000
496,272	Opening Equity	597,378	662,639	662,639
141,600	Net Equity Injections / (Repayments) During Year	5,994	646,693	650,781
137,345	Reserve Movement for Year	(3,068)	-	-
(177,839)	Operating Results for the Period	(94,081)	(115,926)	(180,470)
597,378	**TOTAL EQUITY**	506,222	1,193,406	1,132,950
	Represented By:			
	Current Assets			
4,999	Cash & Cash Equivalents	1,814	8,430	627
750	Short Term Investments	750	750	750
91,010	Trade and Other Receivables	91,473	91,010	91,010
5,838	Prepayments	12,183	5,838	5,838
13,209	Inventories	14,227	13,209	13,209
14,510	Restricted Assets	14,477	14,685	14,685
130,315	**Total Current Assets**	134,924	133,922	126,119
	Less Current Liabilities			
36,575	Overdraft	30,819	-	63,024
123,935	Trade and Other Payables	132,673	127,717	123,936
14,760	Restricted Funds	14,592	14,760	14,760
245,602	Employee Benefits	250,893	180,342	180,342
420,872	**Total Current Liabilities**	514,435	336,111	382,062
(290,557)	**Working Capital**	(379,511)	(202,189)	(255,943)
	Non Current Assets			
16	Restricted Funds	16	16	16
3,225	Investment in NZHPL	3,225	3,225	3,225
890,595	Fixed Assets	888,761	1,398,256	1,391,554
893,837	**Term Assets**	892,002	1,401,497	1,394,795
	Non Current Liablilties			
5,902	Employee Benefits	6,269	5,902	5,902
5,902	**Term Liabilities**	6,269	5,902	5,902
597,378	**NET ASSETS**	506,222	1,193,406	1,132,950

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

APPENDIX 4: CASHFLOW

Audited 30-Jun-19 $'000		Actual 31-Mar-20 $'000	YTD Budget 31-Mar-20 $'000	Budget 30-Jun-20 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(52,680)	**Net Cash from Operating Activities**	49,549	(38,106)	(97,305)
	CASHFLOW FROM INVESTING ACTIVITIES			
(43,992)	**Net Cash from Investing Activities**	(52,971)	(55,196)	(70,913)
	CASHFLOW FROM FINANCING ACTIVITIES			
80,794	**Net Cash from Financing Activities**	5,994	133,483	137,572
(15,878)	Overall Increase/(Decrease) in Cash Held	2,572	40,181	(30,646)
(15,698)	Add Opening Cash Balance	(31,576)	(31,751)	(31,751)
(31,576)	**Closing Cash Balance**	(29,005)	8,430	(62,397)

APPENDIX 5: COVID-19 INDICATIVE FORECASTS

	Full Year Forecast incl COVID 19		
	Low impact	Mid Impact	High Impact
	000's	000's	000's
MoH Revenue	1,851,898	1,850,694	1,847,079
Patient Related Revenue	50,441	50,206	48,418
Other Revenue	40,001	40,700	39,307
Total Operating Revenue	**1,942,340**	**1,941,600**	**1,934,804**
Personnel Costs	928,604	929,581	930,370
Treatment Related Costs	169,155	169,269	170,157
External Service Providers	802,130	806,078	812,183
Other Expenses	124,722	124,888	125,135
Total Operating Expenditure	**2,024,611**	**2,029,816**	**2,037,845**
Total Surplus / (Deficit) Before Indirect Items	**(82,271)**	**(88,216)**	**(103,041)**
Interest Revenue	720	720	720
MoH Revaluation Cap Charge funding	8,220	8,220	8,220
MoH Debt Equity Swap funding	-	-	-
Donations	3,731	3,731	3,731
Profit on Sale of Assets	15	15	15
Total Indirect Revenue	**12,686**	**12,686**	**12,686**
Capital Charge	25,611	25,611	25,611
Depreciation	78,166	78,166	78,166
Interest Expense	425	425	425
Loss on Sale of Assets	53	53	53
Total Indirect Expenses	**104,255**	**104,255**	**104,255**
Total Surplus / (Deficit)	**(173,840)**	**(179,785)**	**(194,610)**
Estimated ending cash balance 30 June 2020	**(36,983)**	**(42,928)**	**(57,753)**

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Justine White, Executive Director, Finance & Corporate Support**

DATE: **21 May 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The following agenda items for the meeting are to be held with the public excluded. This section contains items for discussion that require the public to be excluded for the reasons set out below. The New Zealand Public Health and Disability Act 2000 (the *Act*), Schedule 3, Clauses 32 and 33, and the Canterbury DHB Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATIONS

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14 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 the public excluded meetings: • 16 April 2020 – ordinary meeting • 01 May 2020 – special meeting	For the reasons set out in the previous Board agenda.	
2.	Chair's Report (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.	Audit NZ – Audit Arrangements	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

5.	ISG: End of Life Servers	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Hagley (ASB) Handover Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	External Committee Membership	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.	Aged Residential Care and Disability Support Services COVID-19 Readiness Assessment Update	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
9.	Support for Aged Related Residential Care Facilities	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.	Equity Support Letter – Minister of Health	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	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)
13.	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)
14.	Advice to Board: • QFARC Draft Minutes *5 May 2020*	For the reasons set out in the previous Committee agendas.	

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

"A Board may by resolution exclude the public from the whole or any part of any meeting of the Board on the grounds that:

(a) the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982.

In addition Clauses (b) (c) (d) and (e) of Clause 32 provide further grounds on which a Board may exclude members of the public from a meeting, which are not considered relevant in this instance.

Clause 33 of the Act also further provides:

(1) Every resolution to exclude the public from any meeting of a Board must state:

(a) the general subject of each matter to be considered while the public is excluded; and

(b) the reason for the passing of that resolution in relation to that matter, including, where that resolution is passed in reliance on Clause 32(a) the particular interest or interests protected by section 6 or 7 or section 9 of the Official Information Act 1982 which would be prejudiced by the holding of the whole or the relevant part of the meeting in public; and

(c) the grounds on which that resolution is based(being one or more of the grounds stated in Clause 32)

(2) Every resolution to exclude the public must be put at a time when the meeting is open to the public, and the text of that resolution must be available to any member of the public who is present and form part of the minutes of the Board.