AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 16 July 2020 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 18 June 2020		
3.	Carried Forward / Action List Items		
Presentation			
4.	COVID-19: Population Wellbeing Update	Evon Currie *General Manager, Community & Public Health*	9.35-10.00am
Reports for Decision			
5.	Submission: Inquiry into Student Accommodation	Evon Currie	10.00-10.10am
6.	Approval of Trust / Donated Funds	Justine White *Executive Director, Finance & Corporate Services*	10.10-10.15am
Reports for Noting			
7.	Chair's Update (Oral)	Sir John Hansen *Chair*	10.15-10.20am
8.	Chief Executive's Update	David Meates *Chief Executive*	10.20-10.50am
9.	Finance Report	Justine White	10.50-11.00am
MORNING TEA			**11.00-11.15am**
10.	Maori & Pacific Equity Report June 2020	Hector Matthews *Executive Director, Maori & Pacific Health*	11.15-11.45am
11.	Advice to Board: • CPH&DSAC – 2 July 2020 – Draft Minutes	Jo Kane *Chair, CPH&DSAC*	11.45-11.50am

12.	Resolution to Exclude the Public		
ESTIMATED FINISH TIME – PUBLIC MEETING			**11.50am**

NEXT MEETING
Thursday, 20 August 2020 at 9.30am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

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

Executive Support

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	#	^	~	~	~	~	** 08/07/2020					
Catherine Chu	^	√	√	√	√	√						
Andrew Dickerson	√	√	√	√	√	√						
James Gough	√	√	√	√	√	√						
Jo Kane	√	√	√	√	√	√						
Aaron Keown	√	√	√	√	√	√						
Naomi Marshall	√	√	√	√	√	√						
Ingrid Taylor	√	√	√	√	√	√						

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

Barry Bragg	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Paenga Kupenga Limited** – Chair Commercial arm of Ngai Tuahuriri Runanga **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Verum Group Limited** – Director Verum Group Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.
Catherine Chu	**Christchurch City Council** – Councillor Local Territorial Authority **Riccarton Rotary Club** – Member **The Canterbury Club** – Member
Andrew Dickerson	**Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation

	and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
James Gough	**Amyes Road Limited** – Shareholder Formally Gough Group/Gough Holdings Limited. Currently liquidating. **Christchurch City Council** – Councillor Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board **Christchurch City Holdings Limited (*CCHL*)** – Director Holds and manages the Council's commercial interest in subsidiary companies. **Civic Building Limited** – Chairman Council Property Interests, JV with Ngai Tahu Property Limited. **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. **Christchurch City Council** – Chair of Disability Issues Group **Grouse Entertainment Limited** – Director/Shareholder
Naomi Marshall	**Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Ingrid Taylor	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee. **Taylor Shaw** – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • I / Taylor Shaw have acted as solicitor for Bill Tate and family. **The Youth Hub** – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.

MINUTES

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 18 June 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.

APOLOGIES
An apology for absence was received and accepted from Sally Buck.

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 Sue Nightingale (Chief Medical Officer); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services); Karalyn van Deursen (Executive Director Communications); Susan Fitzmaurice (Executive Assistant to Chief Executive); and Anna Craw (Board Secretariat).

Hector Matthews opened the meeting with a Karakia.

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
Item 6PX – NZHIH Future Direction – Stella Ward advised she is a Director of NZHIH.

Item 7PX – Child, Adolescent & Family Outpatients – Options Update – Andrew Dickerson advised he is a Trustee of the Maia Health Foundation.

Item 8PX – 2020/21 Annual Plan Update – Barry Bragg advised he is Trustee of the New Zealand Flying Doctor Service Trust.

There were no other declarations of interest for items on today's agenda.

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETING

Resolution (18/20)
(Moved: Aaron Keown/seconded: Barry Bragg – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 21 May 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

- Selwyn Health Hub – has been referred to Treasury and a response is awaited. The Board expressed its concerns with the time it was taking for this matter to be addressed and requested that this be communicated to Treasury in future correspondence on the matter.

The carried forward / action list items were noted.

4. DELEGATIONS FOR ANNUAL ACCOUNTS

Justine White, Executive Director, Finance & Corporate Services, presented the report which was taken as read. There was no discussion.

Resolution (19/20)
(Moved: Sir John Hansen/seconded: Barry Bragg – carried)

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

i. authorises either the Quality, Finance, Audit and Risk Committee Chair and the Board Chair or, if one of these should not be available, one of these two and a Board member, to approve the final audited accounts for 2019/20 on the Board's behalf if required, should the timetable not fit with a Board or Committee meeting;
ii. notes that if this delegated authority is exercised, the final accounts will be circulated to Committee and Board members; and
iii. notes that the Canterbury DHB Chair, Chief Executive and Executive Director, Finance and Corporate Services, will sign the letter of representation required in respect to the 2019/20 Crown Financial Information System accounts which are required at the Ministry of Health in early August."

5. CHAIR'S UPDATE

Sir John Hansen, Chair, referred to the outstanding work that was done through COVID-19, noting that we had started to assume it was over, but clearly it is not. Whilst we hope it does not come back, we know that if it does we will be ready to go as always.

The Chair's update was noted.

6. CHIEF EXECUTIVE'S UPDATE

David Meates, Chief Executive, presented his report which was taken as read. Updates were provided as follows:

- Through the COVID-19 process we had further questions for consumers/users of services to make sure we were capturing experiences (both the good and the bad). It is interesting that people provide feedback, as often it takes quite a lot for them to do so. This reflected the very positive nature of the experiences of those who were being managed under care.

- Significant shifts and changes that have already occurred in the way that services are being provided. A significant shift to digital in terms of virtual consults.

- Significant increase in the connection and rollout of cortex, which is the fundamental technology that sits underneath the services that are going into Hagley. Also being rolled out to Burwood. Not another framework like it in the world.

- Faster cancer treatment. During this period of time, we have continued to exceed the targets despite COIVD-19. In terms of non-deferrable surgery, this is largely cancer surgery. Anticipate ending this financial year with approximately 90-93% of elective volumes being delivered. Given the disruption, this is an extraordinary effort.

- Radical change in the way that community dental care is being provided. Again, the use of technology – both telephone and video conferencing to deal with dental cases both for children and adults.

- Rosewood Resthome. Reinforced that Rosewood was a good operator before COVID-19, and is now back operating again and retaking admissions. This is an important part of the recovery, not only for Rosewood, but also the health system in terms of dementia care.

- Labs and the breakdown of testing done for a number of DHBs on the basis that Canterbury Health Laboratory is one of two tertiary labs in the country. It was also noted we are starting to mitigate the significantly restrained physical capacity of the laboratory through the use of new technology and automation.

There was a query around physical distancing requirements in Christchurch Hospital. Mr Meates advised there is an intent with physical distancing, but it is challenging in the constrained environment. The impact of taking six bedded rooms down to four bedded rooms achieves additional distancing, but not the ideal distancing, and has the impact of taking out approximately 88 beds. We do not have the capacity to take this number of beds out. There are a range of very deliberate clinical criteria in place to mitigate the risks as much as possible. Sue Nightingale, Chief Medical Officer, further advised that we have had to continue to limit patients to one visitor, to further mitigate the risk. Ms Nightingale advised that we are managing the risk as best we can, but are not comfortable with it. Mary Gordon, Executive Director of Nursing, advised that we breach the physical distancing requirements every day. Mr Meates advised we are in the business of managing risk. This is another part of the risk component that we are needing to balance and the trade off is clearly we provide care or we do not.

There was discussion on current occupancy rates at Christchurch Hospital.

There was a query around 2nd wave planning for COIVD-19. Mr Meates advised that with the ongoing impact of COIVD-19 we will not be back to "business as usual". There are already some fundamental changes of flow that have resulted. Our planned capacity impact on that is around about a 13% reduction in flow – surgical flow. Looking to mitigate that through other changes – either through extended hours and/or where surgery is being provided. As of today, we are using the equivalent of eight operating theatres in the private sector.

Mr Meates advised that in terms of 2nd wave planning, we have areas like ED and AMAU that already use and continue to have streaming processes in place to manage with appropriate flows, testing and PPE.

In terms of the quarantine framework, we have teams stood up to provide ongoing health input to quarantine facilities. This is tying up a considerable amount of resource at the moment. A bigger issue is the continual standing up of contact tracing, with several hundred individuals going through the process of being trained for contact tracing to be stood up almost immediately.

In terms of the costs of 2nd wave planning and preparation, there was a query around whether there was a clear understanding of costs being covered by the Government. Mr Meates advised that this was not black and white. CDHB has been clear on the quarantine component, that we will not do it unless there is alignment on the funding. In terms of contact tracing, that is still being worked through. Much of 2nd wave costs for planning and preparation are being considered as part of the normal activity of the DHB.

Mr Meates advised there is a requirement for all DHBs to report to the MoH weekly COVID-19 associated costs based on MoH criteria. It was noted that reporting of costs was not a guarantee of reimbursement nor was it all COVID-19 related costs. As an example, Ms Nightingale noted that CBAC funding was stopped when CBACs were stopped, but we have had to step up a CBAC today due to community anxiety. This cost will not be reimbursed.

There was discussion around Christchurch quarantine facilities. It was noted there is a further flight tomorrow. Ms Nightingale advised that we cannot make people have the test, but we can detain them in theory. However, she noted to date there has been 100% agreement to testing. She further noted that whilst happy with our processes and flights coming directly into Christchurch, we are unhappy with processes around flights from Auckland to Christchurch.

There was a query around delays with the ensuite doors in the Hagley building. Mr Meates advised that this is a contractual issue. Work is scheduled to commence once practical completion has been received.

There was comment that it was good to see the increase in enrolments in PHOs. There was a request that future reporting provide % of the population, in addition to the raw numbers.

The Chief Executive's update was noted.

7. FINANCE REPORT

Justine White, Executive Director, Finance & Corporate Services presented the Finance Report which was taken as read. Updates were provided as follows:

- The report showed that the consolidated financial result (before comprehensive income) for the month of April 2020 was a net expense of $18.888M, being $3.048M favourable to plan, and year to date $21.825M favourable to plan. The operating result (pre indirect items) for the month was unfavourable to plan by $738k, year to date $2.268M unfavourable to plan. It was noted that the net costs associated with the COVID-19 pandemic as included in the month of April results were $8.071M, and year to date $8.900M. Further, costs associated with the Whakaari tragedy (excluding IDF) as included in the year to date operating result are in excess of $1M, with no confirmed associated funding.

- May result is a favourable result of $200K for the month and year to date $2.1M unfavourable. This includes COIVD-19 costs to date of $16M to the end of May. This is a net COIVD-19 figure, the difference between what we are funded for COIVD-19 and the total we are expending on COIVD-19.

- Looking at the out-turn for the year, a total COVID-19 result net for the year is estimated at $24.4M; a total result of $170M deficit against a budget of $180M deficit – a $10M favourable variance (including the COIVD-19 costs), and a $34M favourable variance if we exclude the COIVD-19 net costs.

- The liquidity risk was highlighted. It was noted we are working with the MoH on this and understand they are looking at resources they have to mitigate some of the liquidity risk that the Board faces.

- The MoH have verbally advised of the decision to decline CDHB's 2019 request for outstanding earthquake insurance proceeds to be exempt from the capital charge levy on the basis that they are not Crown Funds. Written confirmation of this decision has been requested.

There was discussion around COVID-19 costs.

There was a request for PPE and re-agent costs to be provided to Gabrielle Huria.

There was discussion on the MoH's decision to deny the request for omission of insurance proceeds to capital charge. Ms White advised that we put together a position paper in January 2019 based on prior conversations with the Board and Minister, which was provided to the MoH. This essentially walked through the Public Finance Act and the Operating Policy Framework setting out our belief that these funds should not be considered Crown Funds, they are over and above any impairment to the Crown Funds and therefore should not be treated as subject to capital charge. Effectively, these are surplus funds that have come from other sources and should be treated as such. At the time when we put our position to the MoH and Treasury, via the MoH, the Board's decision was that it would be treated as though accepted, so therefore we have been paying a reduced capital charge from that point. Now, with the decision that the insurance funds should be treated as Crown Funds, they are therefore subject to the 6% capital charge levy, which equates to $12M in this financial year.

A member queried whether Dr Lester Levy, Crown Monitor, had canvassed this particular issue with the Minister. Dr Levy advised this was raised with him recently. According to the MoH, he advised there is no agreement or has never been any agreement that there would not be a charge on this. Effectively, the DHB is wishing this to be treated as a gift when it is regarded as not. There was meant to be some work done between the MoH and Treasury around a policy statement, but that has not happened.

Ms White advised the MoH and Treasury have been working around capital charge, but they have been working around normal circumstances with capital charge, whereas the insurance proceeds component to this is a very unusual situation in the history of New Zealand where previously the largest insurance pay out was somewhere in the region of $20-30M, as opposed to CDHB's $290M. This was never contemplated as part of the policy work between the MoH and Treasury to Ms White's understanding.

Ms White confirmed that the matter had been referred to Michelle Arrowsmith at the MoH in December 2018, who at the last MoH/CDHB Operation meeting advised the request was declined. Ms White advised she would assume Ms Arrowsmith has discussed the matter with Treasury, but cannot guarantee this. The position that was put to the MoH at the time, was not to go back and recalculate the capital charge, but just to remove it from that point forward. We have been treating it on that basis, as agreed by the Board, until we received an answer (18 months after the initial request).

Dr Levy asked whether this has been accrued in the accounts. Ms White advised it has not and this is why the matter sits on QFARC's report as a risk, because it has not been accrued in the accounts.

The Finance report was noted.

8. ADVICE TO BOARD

Hospital Advisory Committee (*HAC*)
Andrew Dickerson, Chair, HAC, provided the Board with an update on the Committee's public meeting held on 4 June 2020.

Resolution (20/20)
(Moved: Andrew Dickerson/Seconded: Barry Bragg - carried)

"That the Board:

i. notes the draft minutes from HAC's public meeting on 4 June 2020 (Appendix 1)."

9. RESOLUTION TO EXCLUDE THE PUBLIC

There was a request to add items 13, 14 and an Information Item to the public excluded resolution as detailed below:

Resolution (21/20)
(Moved: Jo Kane/Seconded: Barry Bragg - carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14 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 21 May 2020	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.	Risk Appetite & Tolerance Results & Statement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Cancer Centre St Asaph Street Pre-Concept Investigation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	New Zealand Health Innovation Hub Future Direction	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Child, Adolescent & Family Outpatients – Options Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	2020/21 Annual Plan Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Primary Care & CCN Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	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)
11.	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)
12.	Advice to Board: • HAC Draft Minutes *4 June 2020* • QFARC Draft Minutes *2 June 2020*	For the reasons set out in the previous Committee agendas.	
13.	EY Assignment	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
14.	Change to Financial Delegations	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
15.	Information Item • Letter from Clinical Lead, CDHB Facilities Redevelopment	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."

The Public meeting concluded at 11.35am.

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Sir John Hansen, Chairman Date of approval

BOARD MEETING 18 JUNE 2020 – MEETING NOTES

Clause No	Item	Action Points	Staff
	Apologies	Sally Buck – absence	Anna Craw
1.	Interest Register	• Item 6PX – NZHIH Future Direction – Stella Ward advised she is a Director of NZHIH. • Item 7PX – Child, Adolescent & Family Outpatients – Options Update – Andrew Dickerson advised he is a Trustee of the Maia Health Foundation. • Item 8PX – 2020/21 Annual Plan Update – Barry Bragg advised he is Trustee of the New Zealand Flying Doctor service Trust.	Anna Craw
2.	Confirmation of Minutes – 21 May 2020	Adopted – *Aaron Keown / Barry Bragg*	Anna Craw
3.	Carried Forward/Action Items	Selwyn Health Hub – Treasury rules for fitout. Advise Treasury of the Board's concern with the delay in responding to CDHB's query.	Tim Lester / David Green
4.	Delegations for Annual Accounts	Adopted – *Sir John Hansen / Barry Bragg*	Anna Craw
5.	Chairs Update	Nil	
6.	CEO Update	Future reporting on PHO enrolments – provide % of population, in addition to the raw numbers.	Carolyn Gullery
7.	Finance Report	PPE and re-agent costs to be provided to Gabrielle Huria.	Justine White / Anna Craw
8.	Advice to Board • HAC – 4 June 2020 – Draft Minutes	Nil	
9.	Resolution to Exclude the Public	Add items 13, 14 & Information Item Adopted – *Jo Kane / Barry Bragg* Meeting closed: 11.35am.	Anna Craw Anna Craw

Distribution List:
Justine White
Carolyn Gullery
Tim Lester
David Green

CC: Mary Howell, and Regan Nolan

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 16 JULY 2020

DATE	ISSUE	REFERRED TO	STATUS
25/02/2020	Selwyn Health Hub – Treasury rules for fit-out	Justine White / Carolyn Gullery	Verbal update.
19/03/2020	Equity Report	Hector Matthews	Today's Agenda – Item 10 – Public Agenda.
21/05/2020	Psychosocial Response to COVID-19	Evon Currie	Today's Agenda – Item 4 – Public Agenda.

COVID-19 : Population wellbeing update

Sue Turner
Manager, All Right? Campaign

Sara Epperson
Coordinator, Wellbeing and Mental Health Promotion Programme

Community and Public Health

Canterbury District Health Board

National CDEM Plan Welfare sub-functions

(Welfare services support individuals, families and whānau, and communities in being ready for, responding to, and recovering from emergencies, which includes the following welfare services sub-functions:

(a) registration:

(b) needs assessment:

(c) inquiry:

(d) care and protection services for children and young people:

(e) psychosocial support: Led by Ministry of Health nationally and DHBs locally

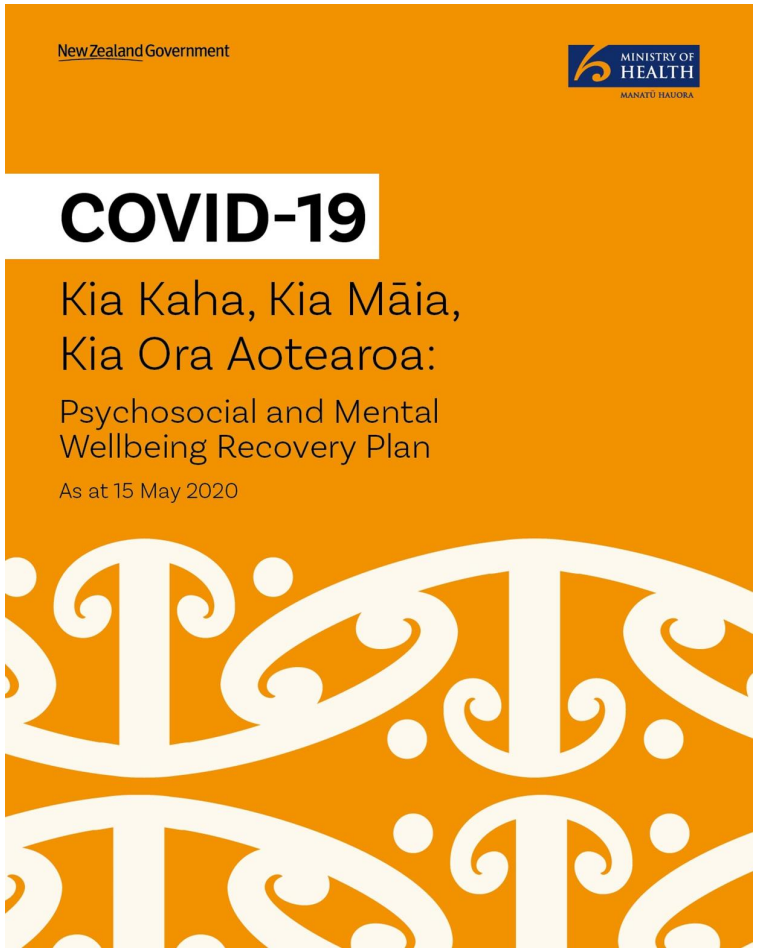
(f) household goods and services:

(g) shelter and accommodation:

(h) financial assistance:

(i) animal welfare.

https://www.civildefence.govt.nz/assets/Welfare-Services-in-an-Emergency/Welfare-Services-in-an-Emergency-Directors-Guideline.pdf

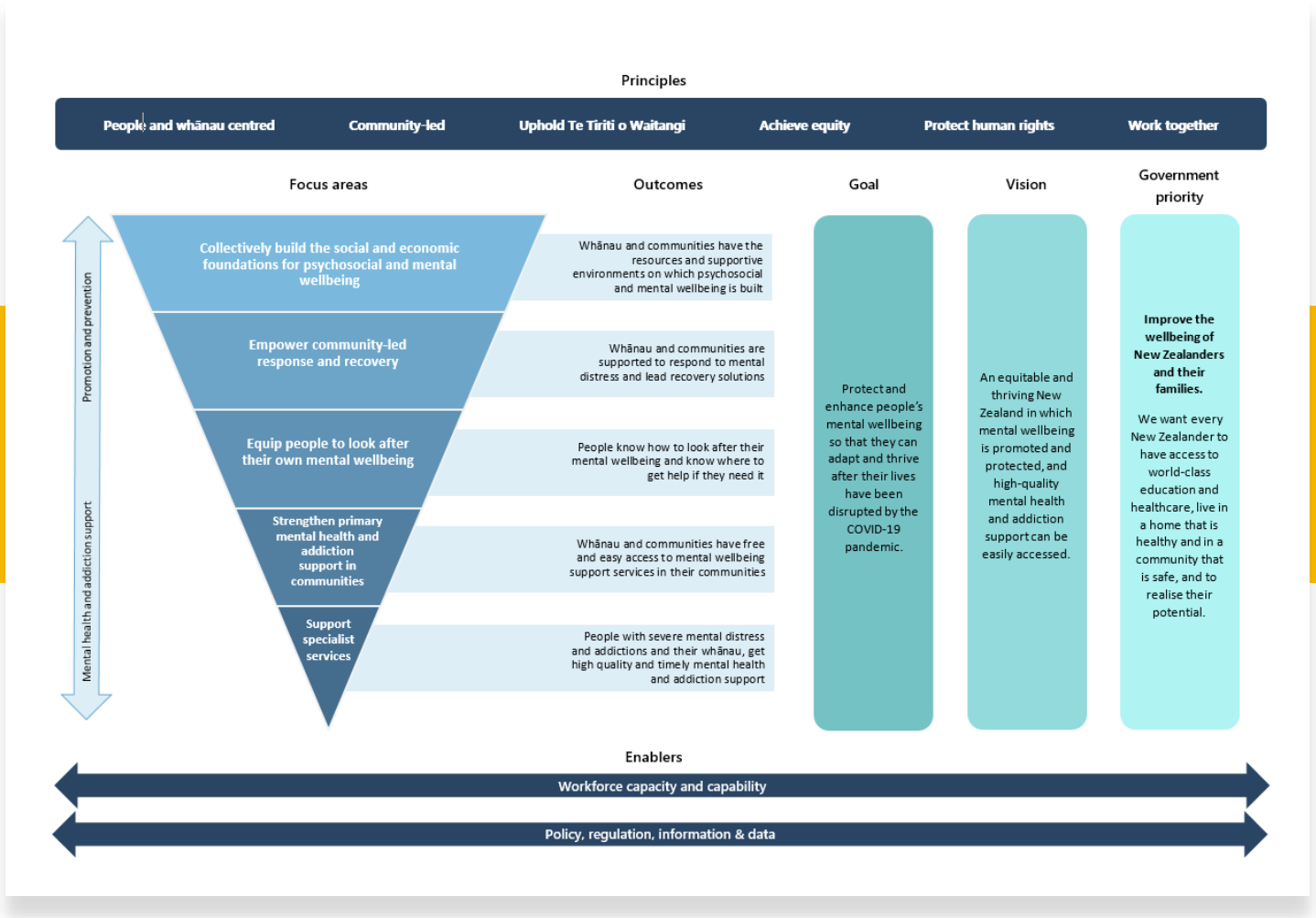


National Psychosocial Plan

Psychosocial support

- focuses on ensuring that the mental and social wellbeing needs of whānau and communities are met, and **they are supported to recover, adapt and thrive despite challenges and disruption**.
- **spans a wide range of both mental health and social interventions:** from …clear information, basic needs and community connection… to delivering specialist mental health and addiction services.
- The goal of the recovery framework is **to protect and enhance people's mental wellbeing so that they can adapt and thrive** after their lives have been disrupted by the COVID-19 pandemic

https://www.health.govt.nz/publication/covid-19-psychosocial-and-mental-wellbeing-recovery-plan



COVID-19 Psychosocial and Mental Wellbeing Recovery Framework

Conditions for mental wellbeing

- ***Safety***
- ***Self-efficacy and community empowerment***
- ***Sense of connection***
- ***Calm***
- ***Hope***

"What matters … is not how individuals actually cope but rather how they perceive their capacities to cope and control outcomes. The perception that one is capable of managing the specific demands related to the disaster has been strongly predictive of good psychological outcomes."

(Norris et al., 2002)

"The universal experience of living through a great shock is the feeling of being completely powerless [...]. The best way to recover from helplessness turns out to be helping – having the right to be part of a communal recovery."

(Woolf, 2007)

https://www.centreformentalhealth.org.uk/sites/default/files/2020-05/CentreforMentalHealth_Briefing56_Trauma_MH_Coronavirus_2.pdf

Pae Ora framework (incorporates waiora, whānau ora and mauri ora)

Values/Principles

- Kotahitanga - alignment with purpose
- Te Kāinga - localised solutions (also recognises interdependence between individual and community)
- Manaakitanga - deep ethic of care for those effected
- Mana Orite - Equity

Objectives: How individuals and communities will feel/know

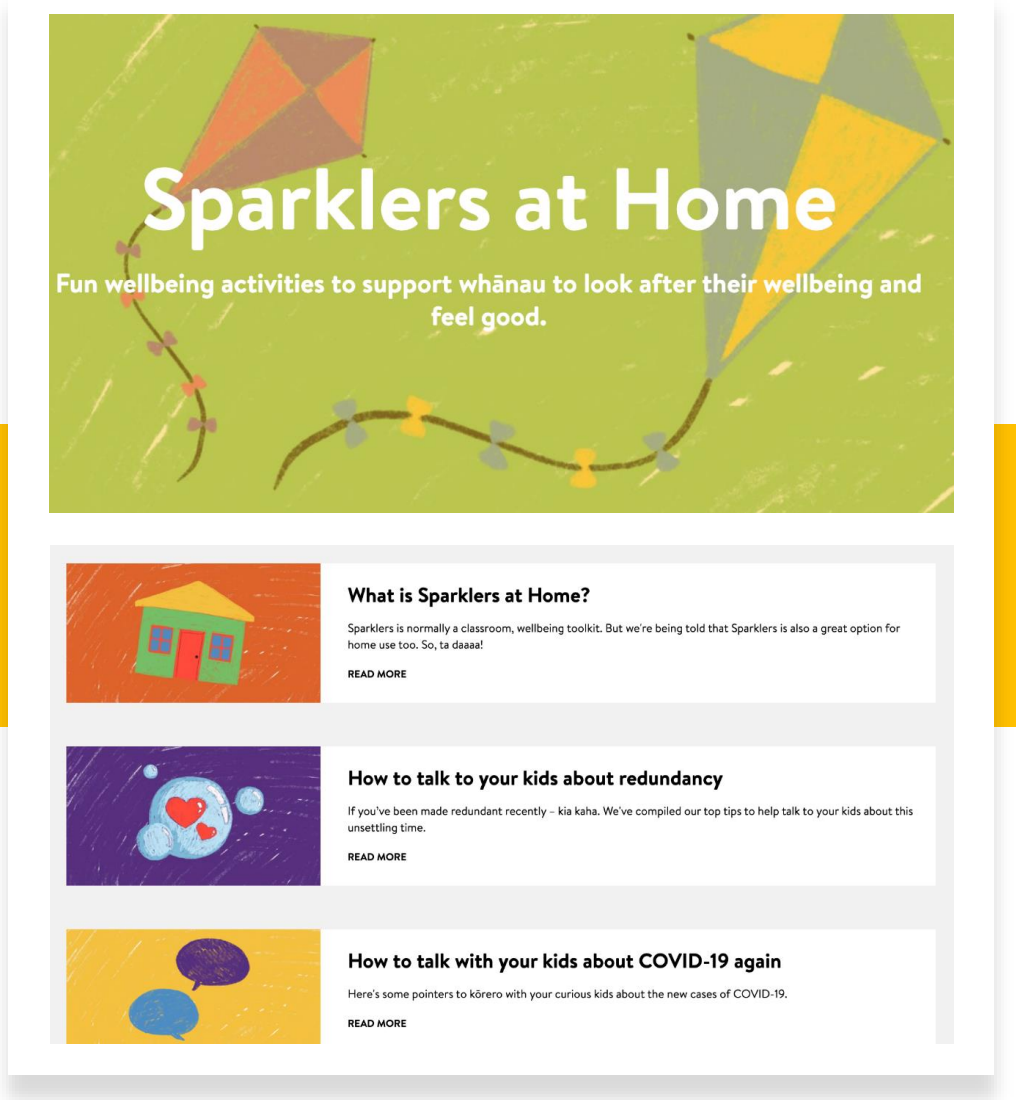
- Mana Tuku Iho (Identity and belonging)
- Mana Āheinga (Aspiration and Capacity)
- Mana Tauutuutu (Community belonging and Cohesion)
- Mana Whanake (Future prospects / resource)

Local initiatives gone national!

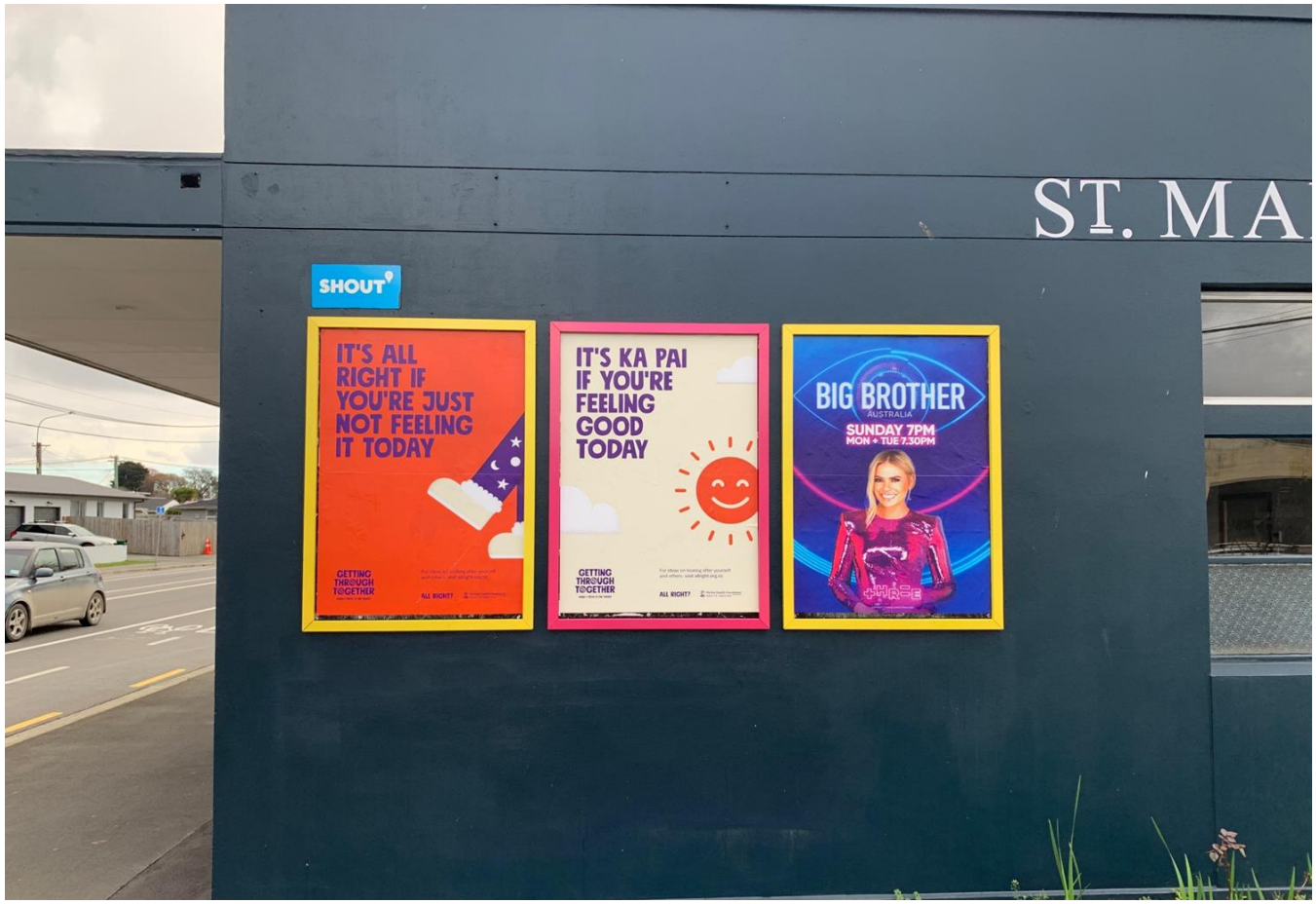
Getting through together
Whāia e tātou te pae tawhiti

Campaign objectives

- Recognition, validation and reassurance of psychological impacts (feeling heard/seen)
- Maintaining a sense of agency (focusing on what we can control/influence – self-efficacy/determination)
- Maintaining a sense of social connectedness (despite physical distancing)
- Maintaining community and practicing kindness (maintaining social capital)
- Collective responsibility/action (purpose and meaning during uncertain, troubling times)
- Brokering optimism – fostering a sense of safety and hope



Sparklers at home


ST. MA
SHOUT
IT'S ALL RIGHT IF YOU'RE JUST NOT FEELING IT TODAY
GETTING THROUGH TOGETHER
ALL RIGHT?
IT'S KA PAI IF YOU'RE FEELING GOOD TODAY
GETTING THROUGH TOGETHER
ALL RIGHT?
BIG BROTHER
AUSTRALIA
SUNDAY 7PM
MON + TUE 7.30PM

Questions???

Activity to date

- Transalpine Psychosocial steering group convened
- Interagency Committees convened for Canterbury, South Canterbury and West Coast DHBs
- Preparation to create an interagency Shared Programme of Action
- Canterbury Comittee membership includes
    - Ngāi Tahu, Te Pūtahitanga, Ngā Hau E Whā,
- Ministries (Education, Oranga Tamariki, Social Development, Primary industries, Pacific Peoples, Te Puni Kōkiri),
- NGOs – MHAPS, MHERC, SEWN,
- Networks – EDLG, Interchurch Network
- Pegasus Health, Specialist MH Services, Waitaha health

SUBMISSION ON INQUIRY INTO STUDENT ACCOMMODATION

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

PREPARED BY: **Silas Thielmann, Policy Advisor, Community & Public Health**

APPROVED BY: **Evon Currie, General Manager, Community & Public Health**

DATE: **16 July 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

Approval is sought for a submission on the inquiry into student accommodation (Appendix 1).

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

2. RECOMMENDATION

That the Board:

i. approves the submission on the inquiry into student accommodation.

3. DISCUSSION

The Education and Workforce Committee is calling for submissions on an inquiry into student accommodation. The inquiry covers three broad areas:

- Consumer Protection: Student accommodation is marketed as providing greater care but strips students of consumer protections under the Residential Tenancies Act.
- Pastoral Care: The inquiry seeks to inform a permanent Pastoral Care Code and identify adequate resourcing to meet the expectations of both institutions and students.
- Viral and Disease Prevention: The inquiry explores higher education provider's accommodation response to coronavirus and explores the proposed accommodation response for returning international students.

The Canterbury DHB supports the Education and Workforce Committee's inquiry into student accommodation because of the identified lack of support, under regulation and unfit for purpose accommodation.

The submission supports greater student tenancy protection, as students do not have the same protections other tenants do, even though they pay more than other tenants and are often more vulnerable.

The submission also supports the establishment of a permanent Pastoral Care Code and highlights wellbeing considerations that should be included, such as performance pressure, mental health, wellbeing and suicide, alcohol policies, sexual harm and risk taking, healthy food and beverage policies, and the need for consistencies in different areas.

As a Government inquiry, this submission requires Board approval. The Education and Workforce Committee has granted the Canterbury DHB an extension until 20 July 2020, to allow consideration by the Board at today's meeting.

4. APPENDICES

Appendix 1: Submission on Inquiry into Student Accommodation.

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Submission on Inquiry into student accommodation

To: Education and Workforce Committee

Submitter: Canterbury District Health Board

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

Proposal: The inquiry into student accommodation was launched after the sector was deemed as under-regulated and unfit for purpose. The enquiry covers three broad areas: 1) **Consumer protection:** Student accommodation is marketed as providing greater care but strips students of consumer protections under the Residential Tenancies Act. 2) **Pastoral Care:** The inquiry seeks to inform a permanent Pastoral Care Code and identify adequate resourcing to meet the expectations of both institutions and students. 3) **Viral and disease prevention**: The inquiry explores higher education provider's accommodation response to coronavirus explore the proposed accommodation response for returning international students.

SUBMISSION ON THE INQUIRY INTO STUDENT ACCOMMODATION

Details of submitter

1. Canterbury District Health Board (CDHB).

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

3. The Ministry of Health requires the submitter to reduce potential health risks by such means as submissions to ensure the public health significance of potential adverse effects are adequately considered during policy development.

Details of submission

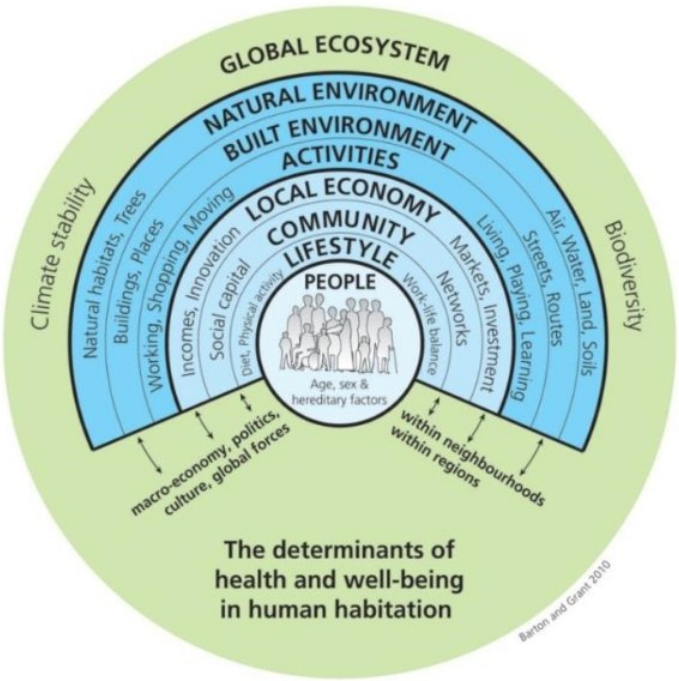
4. We welcome the opportunity to comment on the inquiry into student accommodation. The future health of our populations is not just reliant on hospitals, but on a responsive environment where all sectors work collaboratively.

5. While health care services are an important determinant of health, health is also influenced by a wide range of factors beyond the health sector. Health care services manage disease and trauma and are an important determinant of health outcomes. However health creation and wellbeing (overall quality of life) is influenced by a wide range of factors beyond the health sector.

6. These influences can be described as the conditions in which people are born, grow, live, work and age, and are impacted by environmental, social and behavioural factors. They are often referred to as the 'social determinants of health[1]. The diagram[2] below shows how the various influences on health are complex and interlinked.

7. The most effective way to maximise people's wellbeing is to take these factors into account as early as possible during decision making and strategy development. Initiatives to improve health outcomes and overall quality of life must involve organisations and groups beyond the health sector, such as local government if they are to have a reasonable impact[3].

[1] *Public Health Advisory Committee. 2004. The Health of People and Communities. A Way Forward: Public Policy and the Economic Determinants of Health. Public Health Advisory Committee: Wellington.*
[2] Barton, H and Grant, M. (2006) A health map for the local human habitat. The Journal of the Royal Society for the Promotion of Health 126 (6), pp 252-253. http://www.bne.uwe.ac.uk/who/healthmap/default.asp
3 McGinni s JM, Williams-Russo P, Knickman JR. 2002. The case for more active policy attention to health promotion. Health Affairs, 21(2): 78 - 93.



General Comments:

8. The Canterbury DHB supports the Education and Workforce Committee's enquiry into student accommodation because of the identified lack of support, under regulation and unfit for purpose of the accommodation. We would like to acknowledge the changes that tertiary providers have already begun to implement as a result of the interim pastoral care code. We also recognise the work that has been done by many to increase equity for disadvantaged groups that has seen many students who are the first in their families to enter higher education.

Specific comments:

Student tenancy protection:

9. Students are a vulnerable, high risk group. Entering student accommodation is often at a time of critical transitions including the young person's first time away from home and parental support and other informal support networks[4]. Moving into student accommodation is also associated with a lot of other life changes that are known to increase stress, for example increased isolation, fear of failure, difficulties feeling like they belong, making friends and transitioning out of the home environment.

10. In the case of international students, their living in a different culture is exacerbating vulnerability and stress further[5]. Student accommodation providers should have cultural competency and systems in place to connect students with external supports such as Resettlement Services.

[4] Browne, Munro, & Cass, 2017; Kene, 2015; McAuliffe, et al. 2012; Mewett & Sawyer, 2016; Munro, 2017; Gharibi, 2018
[5] Mewett & Sawyer, 2016

11. Tertiary education providers have a duty of care. Student accommodation is more expensive than general accommodation and is marketed as providing a higher level of care. Student 'experience' of the protections, and consequently the rights and availability of recourse, should be greater than for other tenants under the Residential Tenancies Act 1986. It is concerning that at present students are stripped of consumer protections.
12. During to the Covid-19 lockdown communication from halls was inconsistent. Some students were effectively evicted from their accommodation to make space in the accommodation, but were continued to be charged by providers. Many students also lost their employment because of the lockdown and the consequential economic downturn. The stress these events caused negative impacts on the wellbeing of many students during an already very challenging time.
13. The Canterbury DHB recommends that student accommodation providers be required to meet at least the same requirements other accommodation providers under the Residential Tenancies Act 1986. Clear responsibilities under the Residential Tenancies Act could have prevented inconsistencies among education providers.
14. The Canterbury DHB strongly recommends that the government require accommodation providers to ensure equity in access for disabled people. The rental market is a known barrier for the disability community and accommodation should not be a barrier to academic opportunities.

Pastoral Care Code for student accommodation providers:

15. The Canterbury DHB strongly supports the development of a permanent Pastoral Care Code for student accommodation providers. Important considerations include that codes are not rigidly prescriptive and deficit-focused, as the current interim code has been criticised in these areas.
16. The Canterbury DHB recommends that more work is done to prepare students for university life especially in the first two months of the first year when many students move into accommodation. Students are often not set up well enough to succeed and need a proper induction and orientation which actively supports students. Actively developing wellbeing skills, managing alcohol and preventing sexual harm should be priorities. In addition, accommodation providers should continue to offer a wide range of events and activities throughout the year to build a sense of belonging on campus for all kinds of people.
17. **Residential Assistants [RAs]:** The number of RAs supporting students in the accommodation needs to be adequate to meet the range of student needs. Ideally RAs need to have a maximum ratio of 1:30 students. RAs need to be provided with Psychological First Aid and Bystander training. RAs need time to follow up with each student weekly, have office space and weekly supervision available.

18. **Service Providers:** Student support needs to be provided by well trained, registered practitioners who are aware of appropriate referral pathways to meet different needs in a timely manner[6]. Qualified interventions are more likely to minimise the risk of exacerbated harm. All practitioners must be competent to work Te Tiriti based with tangata whenua, as well as cross-culturally with international students from different backgrounds. Student needs are complex and support must be varied dependant on the individual's needs. Referral pathways must be in place for different accommodation providers and skilled practitioners available to make appropriate referrals in partnership with community providers[7].

19. There are some key student needs that the Canterbury DHB believes should be considered in the Permanent Pastoral Care Code:

20. **Performance pressure:** Performance pressure impacts on many students, especially international students who need to get used to different academic frameworks[8] and often language. Not all international students come from the stereotypical wealthy, well-educated families but come from families who rely on their success for their financial future. Many international students are forced to seek additional employment as they lack the funds to survive[9].

21. **Mental health, wellbeing and suicide:** Mental wellbeing is a critical component of a pastoral care code. Tertiary students have higher numbers of mental health problems than the general population[10]. Mental health problems among international students are higher than with domestic students[11]. Many students are reluctant to seek support with mental health problems[12] and the sense of shame felt by international students can delay help-seeking when the problem is at crisis point[13]. There are not always standardised screening and assessment tools[14]. Educators often lack the knowledge of support pathways if students do disclose mental illness[15]. Universities need to respond to students' mental health issues[16].

22. **Alcohol policies:** The Canterbury DHB recommends that all student accommodation providers be required to have alcohol policies for student residences that ensure that alcohol consumption is managed and safe. The Canterbury DHB also recommends the establishment of curfews for drinking in halls and the provision of some alcohol-free halls.

[6] Munro, 2017
[7] Munro, 2017
[8] Mewett & Sawyer, 2016
[9] Mewett & Sawyer, 2016
[10] McAuliffe, et al., 2012
[11] Mewett & Sawyer, 2016
[12] Gharibil, 2018; McAuliffe, et al. 2012
[13] Mewett & Sawyer, 2016
[14] Mewett & Sawyer, 2016
[15] McAuliffe, et al. 2012
[16] Munro, 2017

23. New Zealand tertiary student's excessive alcohol consumption is a public health concern that needs to be managed[17]. Tertiary student drinking causes direct and indirect harm to themselves and others[18]. Presently there is wide inconsistency in alcohol policies between different providers.

24. A third of undergraduate students are hazardous drinkers: it is known that excessive alcohol consumption is a direct cause of personal injury and health issues, public disorder, physical and emotional harm[19]. Excessive alcohol consumption has also been associated with negative educational outcomes because of missed lectures, decreased concentration and learning and grades[20].

25. Tertiary education culture may inadvertently promote drinking among students, as it can be considered intrinsic to student culture, directly promoted to students, seen as a sign of masculinity and adulthood and more accessible[21]. Indirect alcohol related harm has disproportionately greater negative consequences on minority and disadvantaged groups[22], increasing inequity.

26. Alcohol policies and an environment that does not actively promote alcohol consumption may lead to decrease in alcohol consumption and alcohol related harm[23].

27. **Sexual harm and risk taking:** The Canterbury DHB recommends that appropriate referral pathways for disclosure and support for students who experience sexual harm in student accommodation be developed. Services must have the ability to cater for all students, regardless of culture or sexual orientation.

28. The Canterbury DHB also recommends that accommodation providers reserve some female only floors and apartments to minimise risk to women, who are disproportionately affected by sexual harm.

29. There is a high risk of sexual harm associated with student accommodation that has negative impacts on personal and social wellbeing as well as academic achievement[24]. Students are particularly vulnerable when and alcohol and other drugs are involved. High alcohol use among university age students is associated with significant sexual harm, including negative sexual health and wellbeing, regretted sex and significantly higher odds of sexually transmitted infections due to failure to use contraception or condoms[25]. Alcohol can cause perpetrators to have less restraint and survivors to be less likely to identify warning signs and resist advances[26].

[17] ALAC, 2004
[18] ALAC, 2004; Hallett, et al., 2014
[19] Cousins, Connor & Kypri, 2010; Hallett, et al. 2012, 2014
[20] Hallett, et al., 2014
[21] ALAC, 2004; Keene, 2015
[22] ALAC, 2004
[23] Hallett, et al., 2014; Kypri, et al, 2018
[24] Keene, 2015
[25] Connor, Kydd, & Dickson, 2015; Kene, 2015
[26] Keene, 2015

30. Women, rainbow students, disabled students and Māori and Pasifika students are overrepresented in sexual harm statistics. International students who can come from more conservative backgrounds may not be used to spending time with potential partners and this may lead to sexual encounters they are not prepared for[27] or misinterpret.

31. **Healthy food and beverage policies:** It is important that food provided as part of student accommodation is nutritious and at least meets the Ministry of Health Eating and Activity Guidelines for Adults. Considerations should include culturally appropriate options such as halal and vegetarian options, as well as the service providers' ability to safely provide for common allergies such as gluten and fish/seafood.

32. Student accommodation services should be encouraged to write specific food and nutrition policies, or at least implement as a minimum a policy such as the Healthy Food and Drink Policy for Organisations which is designed to align with the MoH guidelines.

33. **Code alignment:** Due to these concerns the Canterbury DHB recommends that the codes of conduct at the different student accommodation providers are aligned. Codes should be applicable regardless of whether the providers are privatised, contracted out, commercialised; for-profit or not for profit.

Viral and disease prevention:

34. Given that the world is experiencing a Covid-19 pandemic, the Canterbury DHB supports the establishment of preventative public health measures as the close proximity of people in student accommodation increases the risk of viral spread.

35. The Canterbury DHB recommends considering of the following to be included:
    - Exodus plans in case of emergencies such as Covid-19. In these times students are reliant of support and must not be left to fend for themselves.
    - Hygiene protocol that can be scaled as needed such as in the case of epidemics.
    - Capacity to follow physical distancing.
    - Capacity to accommodate isolation if required.

Conclusion:

36. Thank you for this opportunity to have input into the Inquiry into student accommodation. The Canterbury DHB considers a permanent code of pastoral care for student accommodation to be an important and positive step that will improve the health and wellbeing of students in campus accommodation.

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[27] Mewett & Sawyer, 2016

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Person making the submission

Signature

Name Date: Click here to enter a date

Position

Contact details

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APPROVAL OF TRUST/DONATED FUNDS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Melanie Bryant, Corporate Support**

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

DATE: **16 July 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

This report has been generated to seek approval of the capital investment of simulation training equipment for Child Health services, to be funded from Trust/Donated funds, as required by the Delegation of Authority where expenditure is in excess of $50,000.

2. RECOMMENDATION

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

i. approves the investment of trust/donated funds from Buddle Findlay Child Health Foundation Trust and Paediatric Trust Funds of $76,000 for the purchase of a SimBaby manikin, as training equipment for Christchurch Hospital Child Health Services.

3. DISCUSSION

Simulation training is considered an essential technique for training staff in life-like scenarios to support improved staff confidence in responding to clinical emergencies and managing acutely unwell patients, to provide for improved patient outcomes.

The Child Health services currently have a child sized manikin and a baby simulator would support wider simulation training of clinical emergencies with babies. The SimBaby is a life-like 9-month old baby and will be utilised in the regular scenario training undertaken on a weekly basis by the Child Health services.

A contribution of $70,000 has been approved by the Trustees of the Buddle Findlay Child Health Foundation via the Maia Foundation, and the balance of $6,000 is to be funded from the Paediatric Trust Funds.

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: **16 July 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

- **Clinical Monitoring and Health Quality and Safety Commission (HQSC) Markers:** Work is underway to improve and automate the collection and entry of health quality and safety data into DHB systems. New Business Intelligence tools and the DHBs data management system (PRISM) are being used to distribute audits and digitise the data collection for audit and the Health Quality and Safety Commission markers e.g. New Zealand Early Warning Score. The results are displayed in the DHBs intranet-based data viewer 'Seeing Our System'. In the future it is envisaged Cortex data will be used to populate these audits alongside the vital signs and assessment data, leaving manually entry to observed data.
- Results from the monthly Pressure Injury & Fall Prevention audits and HQSC markers are now on the DHB intranet in the 'Reports and Interactive Analytics' section under 'Clinical Observations'. The reports are interactive and able to be displayed for all hospitals, by hospital and at ward level. These process measures (reflective of the steps in the process leading to the outcome) are supported by the existing ICD coding cohort dashboard which is inclusive of pressure injuries reported outcomes (impact of care).
- A similar process has been set for the early warning scores and dashboard display for all staff will be available soon.

MEDICAL SURGICAL AND WOMENS AND CHILDRENS HEALTH

- Christchurch Campus is focussing on ensuring the Canterbury Health System restarts as effectively and efficiently as possible, while finding and making use of cost savings opportunities and ensuring leave is being used appropriately.

- **Production volumes**
  - Since the beginning of June, Outpatient volumes have increased from 65% of forecast in April to forecast levels made prior to the COVID lockdown period.
  - Focus is being maintained to deliver the rate of telehealth consultation higher than it was prior to our COVID response. This work is clinically led. It has implications for both clinical and administrative workflows.
  - Emergency Department daily attendances have come back to within forecast ranges since 1 June with attendances in the week of 15th June reaching the same level as the corresponding week in 2019.
  - The number of events in Christchurch and Burwood theatres is back at forecast levels and has been since early and mid-May respectively. The number of operations carried out for CDHB patients in private hospitals has been at forecast levels since early May.
  - Since early June elective admissions into Christchurch Hospital have reached previously forecast volumes. Acute admissions, whilst lower than forecast, are trending upwards.
  - May 2020 Medical and Radiation Oncology clinic volumes exceeded May 2019
  - Radiology has utilised extended hours (four weeks of 7 day per week imaging) and some outsourcing to complete the backlog of deferred referrals. This ensures that radiology is not a constraint to the recovery plans of other services.
- **Appointments cancelled during COVID-19 lockdown**
  - Of the 1159 admissions cancelled 871 (80%) have now either been admitted or managed in another way, a further 113 booked, leaving 106 yet to be booked.
  - Of the 11,454 cancelled outpatient bookings 78% are either closed or rebooked, plans for the remaining 22% are in train.
  - Analysis shows progress is being made on this list daily. Administrators and clinicians continue to work through the waitlist on a line by line basis to ensure the right actions are put in place.
- **Cost saving work**
  - Improvements have been put in place to the controls around administration team overtime. This has resulted in a reduction from $261k in the 11 months to May 2019 to $125k in the 11 months to May 2020, a saving of $136k – i.e. greater than 50% savings.
  - A focus on reducing nursing agency costs across the campus has resulted in a decreased spend of $54K during the six months to May 2020. This is 17% of the expenditure during the same period in 2019 – a reduction of $271K.
  - Perioperative nursing resource that was employed in anticipation of Hagley theatres coming on line is being allocated to other areas. Approximately 17 FTE are providing support at the quarantine hotels and other nurses are working in the private sector 3-4 sessions per week on outplaced elective surgery. The opportunity for increased levels of annual leave being taken by perioperative staff is also being pursued.
  - The operation of the Maternity Assessment Unit, established in August 2019, has been continually fine-tuned and requires fewer staff to run than planned for while still providing the desired benefits.
  - Maternity services are in the process of replacing Cervidil, used in the induction of labour, with Misoprostil. The current product costs between $100 and $300 per patient, with the monthly budget of $10,000 per month frequently overrun. The new product will cost $10 per patient.
  - Introducing a Day of Surgery admission pathway for Transcatheter Aortic Valve Implantation (TAVI) procedures with one-night stay will increase the service capacity with the same number of staff.
  - The Eye Service has introduced a new diagnostic clinic for patients following retinal screening. These clinics are run by nurses who take a range of measurements – followed by virtual review of the patient by a Senior Medical Officer. This increases the service's capacity with the same number of SMOs, reducing the demand for more of this scarce and valuable resource. In addition, two nurse

injectors have been trained and are supporting SMOs in providing this regular vision saving treatment to patients with macular degeneration.

- Stock management in the Radiology Department has been progressively improved over recent years because of an increasingly strong partnership between the Supply and Radiology departments. Over this time the Supply Department has taken up responsibility for management of many more stock items. The systematic discipline used has contributed significantly to effective stock management. Alongside this, a Hospital Aide has been dedicated to stock management and the stock requirements of Interventional Radiology are reviewed monthly to ensure that the regularly changing requirements of clinical practice are recognised in stock levels. These changes have meant that while $2,000,000 of consignment and DHB stock items were held at the 2019/20 stock take, only $856 worth of items needed to be written off (0.04% of total holdings).

- **Optimising revenue**
  - Review of charges to other District Health Boards for activity not covered by inter-district flow has identified that another District Health Board has not been invoiced for stem cell search expenses. To date we have invoiced an additional $84k revenue.

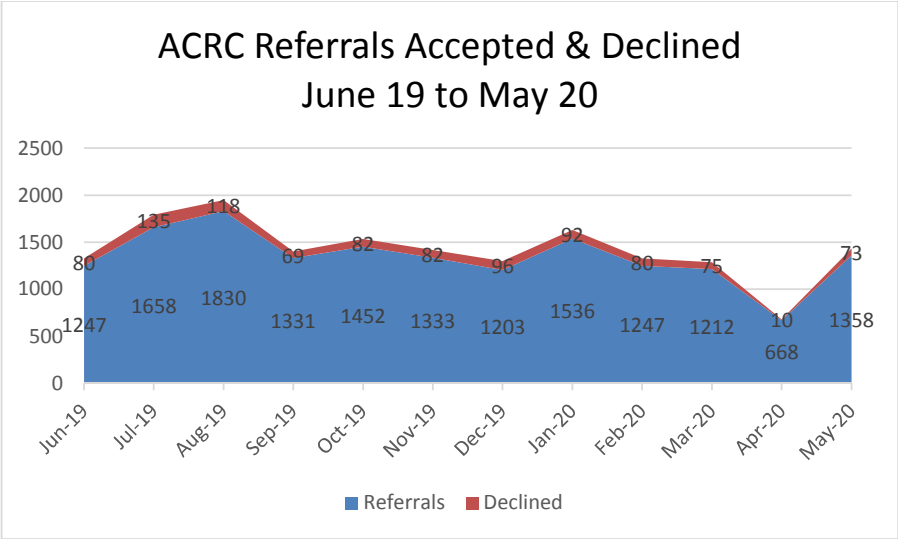
- **Our new technology/ECRI process has created savings from changes to the choice of consumables used**
  - The ECRI Institute (founded in 1968 as the Emergency Care Research Institute) provides tools that are supporting us to make evidence-based decisions on the adoption of new technology and review of existing technology.
  - A change in supplier and introduction of new generation vaginal support pessaries has led to avoided costs of $8k per year within Women's Health.
  - Routine use of filter needles will be discontinued from December 2020. Savings on the Christchurch Campus by early adopters have totalled $31k over the past five months.
  - Use of thigh high compression stockings is being replaced with knee high stockings. It is estimated this will save $44k per year, over the past quarter demonstrated savings of $10k have been made.
  - Replacement of medicine cups with paper ones – estimated savings of $10k per year, demonstrated savings of $5k in six months.
  - Elimination of anti-slip socks as there is no evidence that they prevent falls. Saving $84k annually.

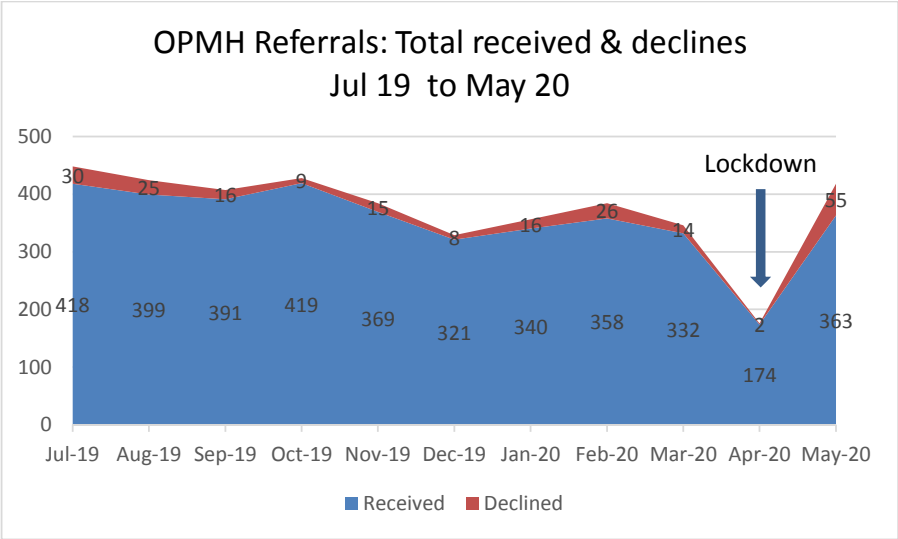
- **Leave Care Programme work is progressing on the campus**
  - All people leaders working on the campus are working with employees with long leave balances to significantly reduce these balances by 31 January 2021. A clear process has been developed and communicated and tools provided. Accountabilities for process and achievement targets have been clearly set.
  - Nurses at Christchurch Hospital took a total of 101,120 hours of leave during April and May 2020. This is the equivalent of 12,640 eight hours shifts and is a 31% increase from the same months the previous year. In the 11 months to May the increase is only 6.6% on last year – demonstrating the huge effort being put into addressing this in the latter months. There was no increase in sick leave in April and May compared with the same periods last year.

OLDER PERSONS HEALTH & REHABILITATION | COMMUNITY DENTAL

- A significant drop in Older Persons Mental Health and Community team referrals occurred during lockdown. Community patients and those who would have attended the Burwood Day Clinic were contacted by telephone and via Zoom over this period. May saw a significant spring back as people visited primary care or relatives became concerned for their whanau.
- Welfare checks/service reviews were completed for over 1,600 people with open cases. This was well received by clients and families and resulted in a variety of interventions including organising support from other agencies, urgent medical intervention and sourcing food and heating.

- Our Community Services providers reported a 63% reduction in the number of people receiving long-term home-based supports during lockdown. Non-essential services were re-introduced at alert level 2 on a bi-weekly basis to allow for vulnerable employees to return from COVID leave.
- During lockdown, the services of several student nurses from The Southern Institute of Technology and Massey University, were used to complete 1,870 InterRAI contact assessments over the phone, ensuring that our vulnerable population who were not receiving services were reviewed during this period. Urgent InterRAI assessments were also completed using Zoom. This worked well, and we are exploring this utility further as there could be benefits in reducing travel and allowing relatives who live at a distance to support the assessment.





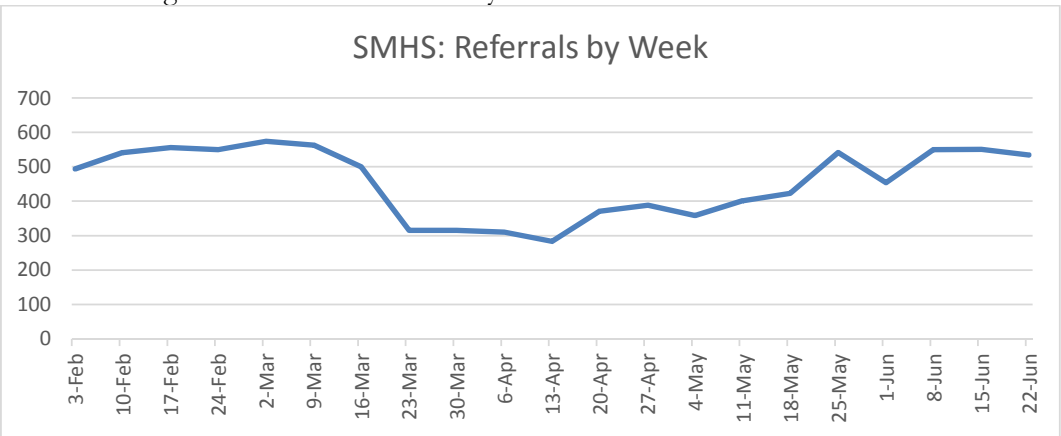
- Burwood dementia wards AG and BG were busy across the lockdown. The major issue related to an inability to discharge particularly to Aged Residential care facilities because of lockdown restrictions. This, in turn, limited admissions. At one point the waiting list was over 15 which is extraordinary. This has since resolved.
- **Community Dental service:** Experience during the COVID-19 lockdown period showed that dental/oral health therapists could effectively manage a large proportion of the non-acute dental problems using phone consultations supported with photographs taken by whānau. Further work has taken place to embed a phone triaging system in the Service's new-normal way of working. A group of 10 therapists have been trained and supported to undertake phone triaging—this involves both new graduates and experienced therapists. Rostering has been refined to ensure the right number of triagers are 'on-deck' during the incoming call surge periods of the day and week.

Early results show a 26% reduction in the number of appointments being booked for unplanned care – down from average of 117 per week in May/June 2019 to 87 per week for June 2020.

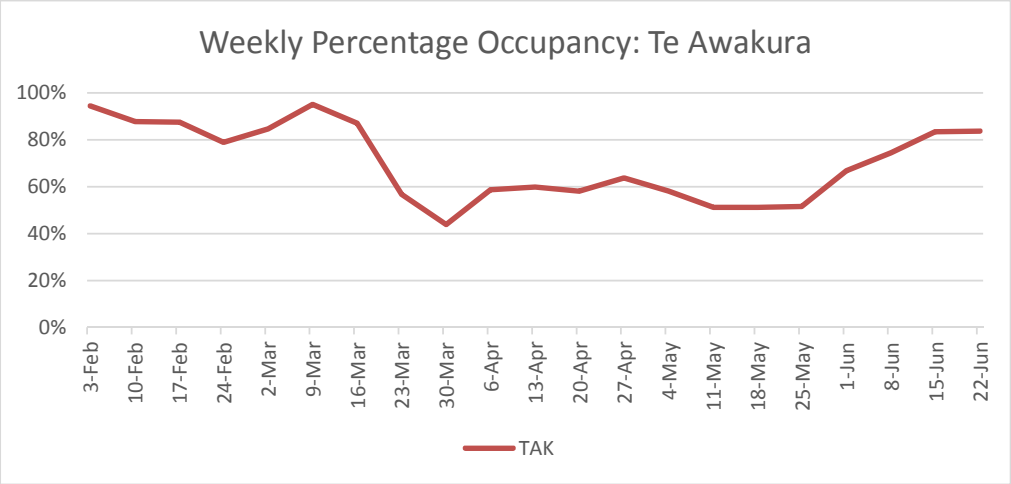
- **New after-hours support for aged residential care facilities:** A new after-hours medical support service is now available for residents in aged residential care facilities. With after-hour support for aged care residents identified as being more important than ever, the DHB and Canterbury Initiative have worked with the 24-hour surgery to establish a process to provide guidance to facilities and care-givers if their usual after-hours provider is not available. The new service also enables residents to stay supported and well cared for in their home, when that is appropriate, reducing the risk of infection for residents and facilities. Support can be provided both by way of actual and virtual visits, building on the significant use of virtual consultations during the COVID-19 lock-down period.

SPECIALIST MENTAL HEALTH SERVICES (SMHS)

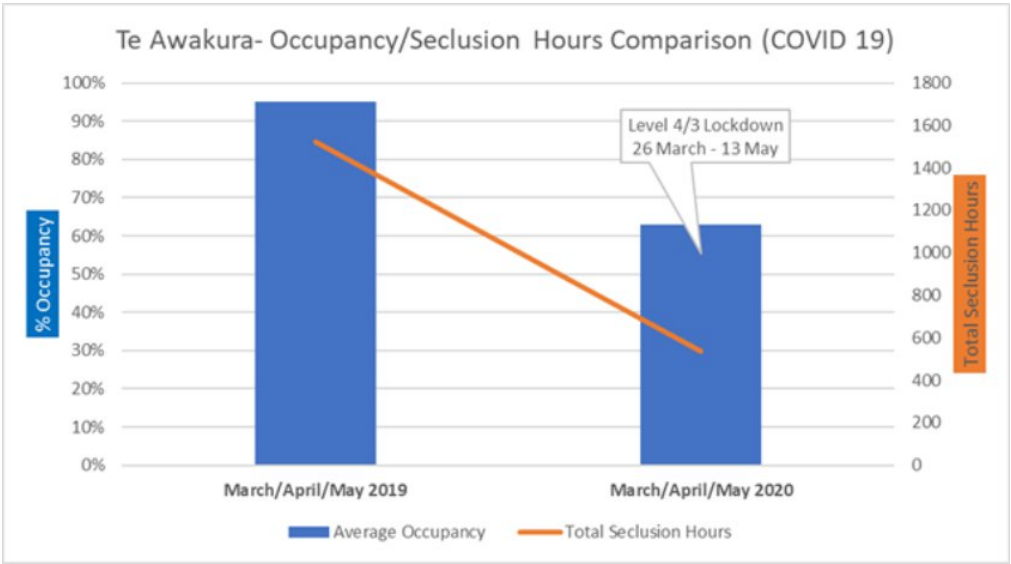
- **Facilities**: There has been significant activity over the past month to progress the multiple SMHS facilities programmes that are currently underway:
  - The Programme Business Case (PBC) is under development in line with the Masterplan for Hillmorton Campus. The focus is Acute and Forensic services and enabling works required as part of the site redevelopments.
  - The end detailed design phase for the new builds, Integrated Family Services Centre and High and Complex Needs, is progressing well and on schedule. Furniture, fittings and equipment process work has commenced with user groups.
  - AT&R high care (pod extension) is expected to complete in October 2020. Operational planning with the service leadership is underway.
  - Approval in principle received for the mobile duress solution. Progressing with procurement process. This will enable a single site wide solution which includes AT&R extension, new builds and existing services.
- **Monitoring Demand and Wait-times:** Monitoring demand remains a key metric to evaluating impact of the COVID-19 pandemic on community wellbeing, subsequent demand on SMHS and any ongoing issues in moving back to full service delivery. **Referrals** continue to return to usual volumes.

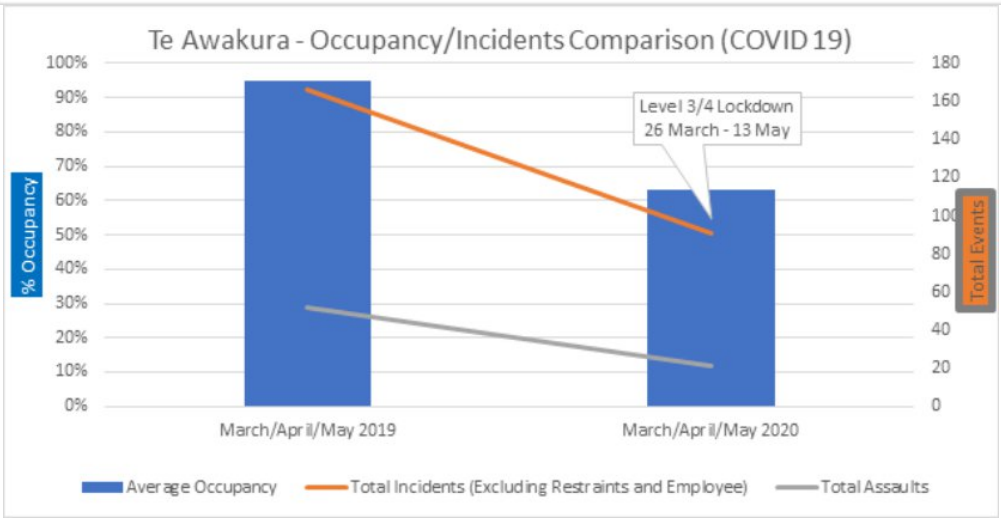


- **Occupancy** within the adult acute inpatient unit (Te Awakura) reduced in response to raised admission thresholds put in place as part of the COVID-19 response plan, however we are seeing a return to a more typical occupancy pattern.



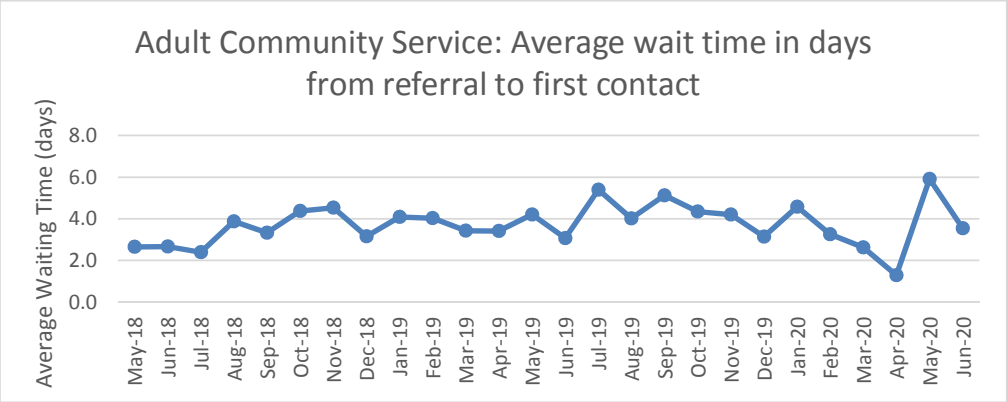
- As part of a review of the impact of reduced occupancy, the use of seclusion and the number of incidents and assaults has been captured. Whilst there was an expectation of a reduction, given the lower occupancy, the degree of reduction is significant. Early analysis is being undertaken to understand the drivers for this change.



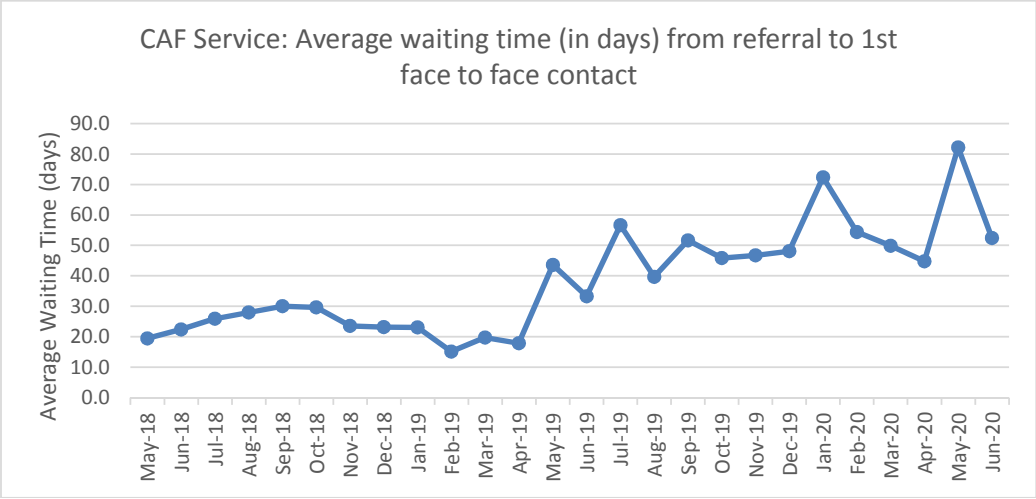


March/April/May 2019	March/April/May 2020	Variance
Average Occupancy		
95%	63%	-32%
Total Seclusion Hours		
1525	536	-65%
Total Incidents (excluding restraint and employee)		
166	91	-45%
Total Assaults		
52	21	-60%

- **Wait times** within both Adult and Child, Adolescent and Family Community Services (CAF) outpatient services saw an expected increase during COVID-19 and it is encouraging to see a reduction in both with a return to full service delivery.



- Given the extended wait-time for first face-to-face contact in CAF services, a comprehensive telephone triage process is in place to prioritise acute and urgent cases, and to ensure that people who do not need our services are signposted to the correct services in a timely way.



LABORATORY SERVICES

- **COVID-19 still represents the biggest risk to Lab Services in Canterbury, this includes:** Service disruption, workforce and financial impacts.

Service continuity: Business continuity plans have been developed for all alert levels to ensure:

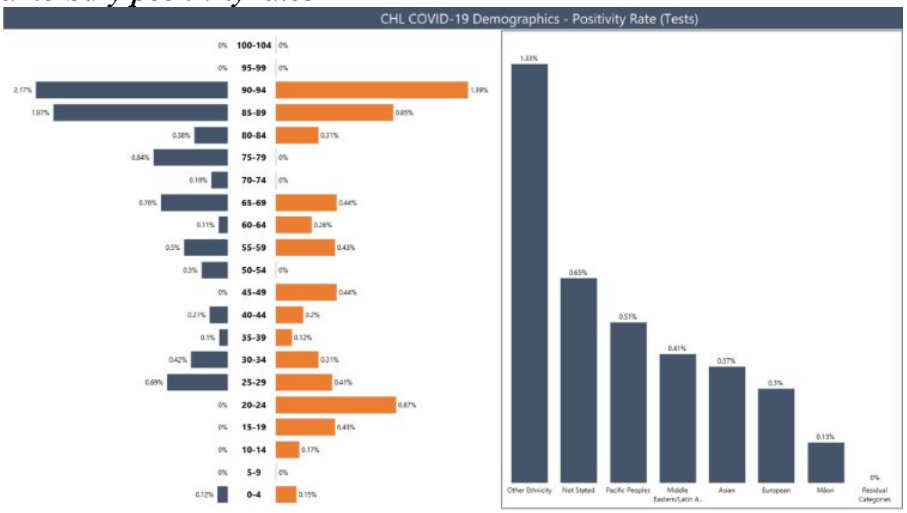
- continuity of critical services lab services;
- employee safety and wellbeing through all alert levels.

Financial:

- Significant cost for consumables and reagents for testing;
- Additional staffing costs;
- Monitoring and tracking all costs and activities – working closely with the Ministry and quarantine facilities, and primary care to anticipate testing load.

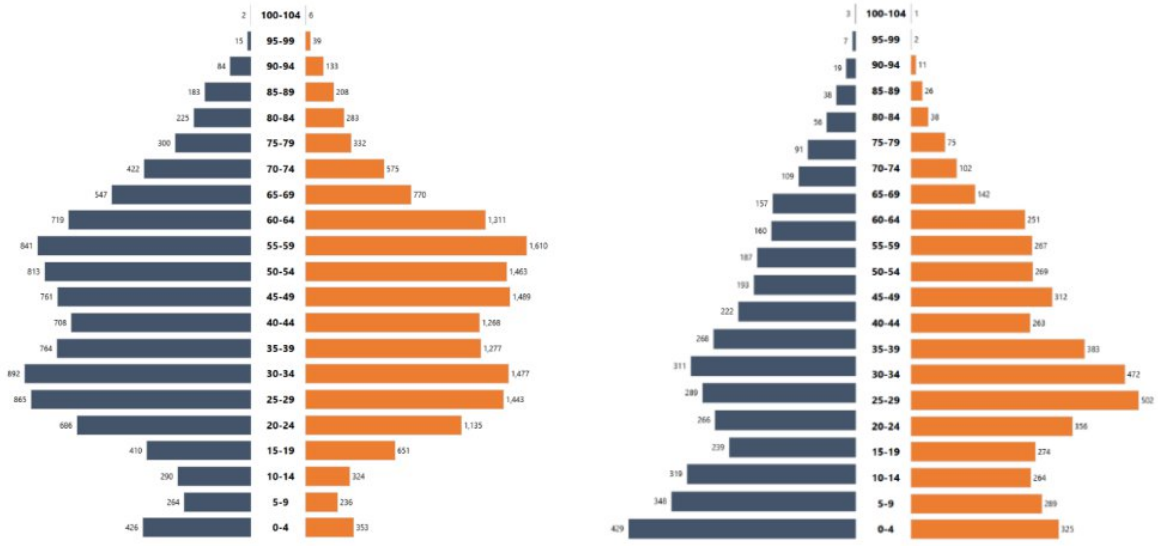
- **Financial Health - Cost Saving Initiatives - $1 million:** Lab services have submitted a range of cost saving initiatives to ensure the correct use of resource and testing to support the deficit reduction (to the value of approximately $1m) – These initiatives include new consumable contract negotiations, appropriate test utilisation, and a reduction in waste.
- **Canterbury Health System – lab data and information:** We continue to build on our capability and use of data to make activity visible and the opportunities to improve equity of access and improved patient outcomes – e.g. Canterbury COVID-19 demographics (positivity rates) and shift in demographics.

Canterbury positivity rates



Shift in patient demographics CHL COVID-19 Test referrals

Lock Down ***Post Lock Down***



- **Improving Patient Outcomes - Cancer Treatment:** Surface Markers have developed an MRD (minimal residual disease) test for B-ALL (B-cell acute lymphoblastic leukaemia), in partnership with Clinical Haematology. Surface Markers have developed a flow cytometry test to monitor patients that are being treated for leukaemia. It allows them to detect very low levels of abnormal cells. If the abnormal cells are present after initial treatment it is an indication that the therapy is unlikely to be successfully, so a different treatment can be initiated straight away rather than waiting to see if the patient relapses. This enables timely testing and response for patients.
- **Improving Patient Outcomes – Specialist Service:** Toxicology have enhanced their ability to test new-borns meconium in instances where the use of a drug in the months prior needs to be identified. This allows a more targeted response to treatment for both the mother and her baby.
- **Improving Patient Outcomes – Genetics Service:** Genetics has over the last few months introduced a new testing panel which utilises Next Generation Sequencing (NGS). The panel has enabled the consolidation of a range of tests into one process. This has enabled efficiency gains within the lab, the ability to detect more genetic changes relating to specific diseases (e.g. cystic fibrosis and hereditary pancreatitis). This test change has provided improved turnaround times for results and the provision of more information on each targeted condition to support patient care.
- **COVID-19 response - Clinical Microbiologists (SMOs):** Canterbury Health Laboratories has been holding a vacancy for a Clinical Microbiologist for two years. This is putting significant pressure on the existing small SMO (Senior Medical Officer) team in relation to workload and leave taking. There has been a reduction in pathology training positions in New Zealand over the years through contracting out and cost saving measures. This is further compounded by process to obtain New Zealand Medical Council (NZMC) registration of applicants at such a critical time for New Zealand.

  COVID-19 has stretched the microbiologist workforce further as their expertise is relied upon at a national, regional and local level in response to COVID-19. These SMOs also provide continued support and advice for all non-COVID-19 related microbiology clinical advice 24/7 and are internal to the Infection Prevention and Control response.

  We continue to work with recruitment, and we are grateful for the continued support of a locum Microbiologist who has delayed her retirement to support the Canterbury Health System at this time.

ASHBURTON RURAL HEALTH SERVICES

- **Ashburton Health Services redesign:** Ashburton Health Services are engaging with staff, seeking feedback and ideas on the opportunity of redesigning our nursing leadership and operational structure. The delivery of health services in Ashburton is founded on principles of integration and sustainable models of care led by rural generalist expertise. We provide a core partnership and support for local primary and community care, providing acute episodic care with a commitment to engaging patients back to their home and primary care providers. Alongside this we work in partnership with the specialist services across the Canterbury health system, connecting to the individual models of care with a localised generalist lens.

  The information shared with our local staff and integration stakeholders proposes to establish a new nursing management structure to achieve a clinically led, nursing operational management delivery model. This will support the development of a generalist rural nursing workforce in Ashburton Health Services. In our current model there are limited resources and cover for planned leave, and unplanned leave places an additional burden on existing staff and resources.

  The realignment of community and specialist services is aimed at enhancing the integration of service delivery that best utilises specialist nursing services within this rural generalist foundational model. The recent learnings in COVID and increasing focus on digital service delivery provides multiple opportunities for specialist services to consider how they engage and deliver care outside of the centralised Christchurch campus.

  In recognition of the DHBs commitment to reducing health inequities for Māori and in increasing our Māori workforce, our proposal also considers tikanga Māori and identifies an alignment to certain elements that would be evident throughout the ongoing development and delivery of services and

workforce planning for Ashburton Health Services. It is intended that these elements are intrinsically woven throughout all areas of service development and delivery.

- Rangatiratanga – empowering and upholding people (patients, whānau/families and staff).
- Whānaungatanga – building and maintaining respectful and caring relationships.
- Manaakitanga – compassionate care, guidance and support, sustainability
- Kotahitanga – working collaboratively

These collective pieces of work contribute to our ongoing mitigation of developing a sustainable generalist workforce and health delivery models to manage care service delivery closer to home in rural communities.

PRIMARY CARE AND COMMUNITY SERVICES

Primary Care

- **COVID-19 Testing and Surveillance:** On 25 June the Ministry of Health announced a change to the COVID case definition related to eligibility for testing. A person with symptoms is no longer a suspect case unless they meet criteria for a higher index of suspicion.

  The testing strategy advises that anyone presenting to primary or secondary care who has clinical symptoms consistent with COVID-19 can be tested as part of community surveillance with priority to be given to those who meet the new high index of suspicion (HIS) criteria. While we are being asked to maintain a level of community surveillance, what that level is has not been specified. The Ministry of Health are looking to DHBs to make sure they keep up with surveillance testing and maintaining equitable access.

  To date the change in case definition appears to be reducing the volume of testing referred on a daily basis from the spike that occurred in mid-June. There was an expected increase in seasonal flu which has COVID-19 like symptoms, and public concern about the management of isolation at our border led to concern these symptoms could be COVID-19. This spike has further impacted on the overspend now calculated to be $3.3m above revenue. Additional revenue of $3.3m has been received for the 3-month period of quarter 1 2020/21.

- **Canterbury influenza immunisation rates for older people (65+):** The 2020 influenza immunisation programme began early, from 18 March, as part of the Ministry of Health's preparation for the potential impact of COVID-19 and to reduce the additional pressure of the flu on our health system. Vaccinations were prioritised for people at greatest risk of serious illness from influenza including: people aged 65 and over, pregnant women, people with certain chronic conditions, and young children with a history of severe respiratory illness.

  The Canterbury system responded well with the vaccination programme and public health messaging resulting in 10,000 more vaccinations being delivered to people in Canterbury, over the age of 65, compared with the 2019 year. Currently 74% of Over 65-year olds are vaccinated, this compares to 64% in 2019.

  The vaccination rates for Canterbury's Primary Health Organisations increased across all ethnicities, as well as across our highest deprivation (9-10) populations, compared with the 2019 year.

  Please be aware there is a difference between DHB and PHO coverage when looking at ethnicity. This is due to PHO coverage being based on PHO enrolment rates, therefore a true reflection of their population. DHB coverage is based on population projections. We have also noticed a difference between vaccines given by ethnicities – which has highlighted the need to work with PHOs around patients' ethnicities on the national immunisation register.

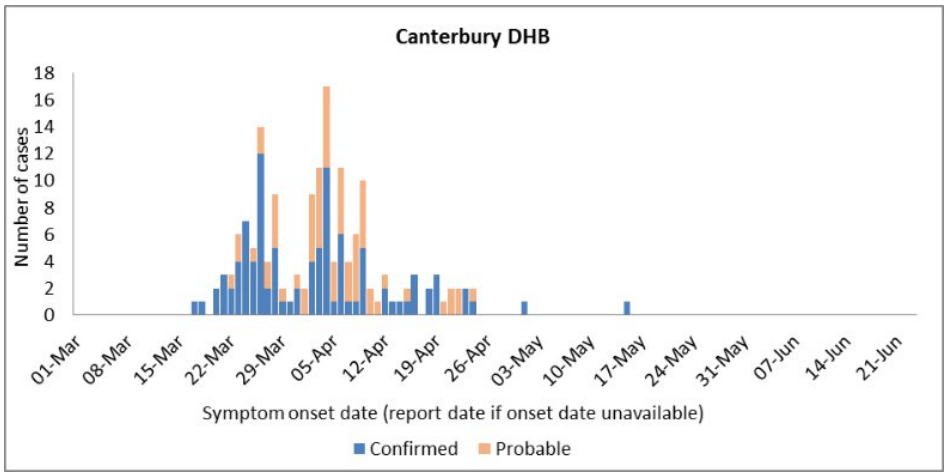
Canterbury influenza immunisation rates for older people (65+)

	Māori		Pacific		Asian		Deprivation 9-10	Total	Total
	2019	2020	2019	2020	2019	2020	2020	2019	2020
Christchurch PHO	59%	77%	66%	74%	50%	57%	72%	59%	70%
Waitaha PHO	65%	73%	39%	71%	53%	66%	88%	72%	81%
Pegasus PHO	62%	80%	56%	59%	59%	51%	75%	69%	78%
Canterbury DHB	42%	50%	61%	65%	44%	46%	58%	63%	74%

- **Portfolio Manager Māori Health vacancy:** Planning and Funding are in the process of recruiting a Portfolio Manager – Māori Health. Twenty two high calibre candidates have applied for the role. The Māori Health portfolio manager will work with various service areas to to drive health outcomes and improve collaboration and engagement with Māori. This is an integral role that will work across multiple portfolio areas., with initial interviews scheduled for week commencing 13 July.

COMMUNITY & PUBLIC HEALTH

- **COVID-19 Update:** Canterbury DHB confirmed and probable cases to week ending 23 June 2020 (Note - this excludes cases identified whilst in managed isolation)



- **COVID-19 – Uplift Plan:** Community and Public Health has continued to devote significant resource to meeting the Ministry of Health's requirements to be ready to manage case investigation and contact monitoring for 47 COVID-19 cases daily by mid-July (with the ability to surge to 67 cases daily within 3-4 days if required).

  Modelling has been carried out to ascertain the resources required to meet this 'Uplift' requirement for various scenarios from best to worst case (this recognises the resourcing implications associated with particularly complex cases). It has been agreed with the Ministry of Health that they will take responsibility for following up non-household contacts. This allows Community and Public Health to focus its resources on case investigation. All Community and Public Health staff have been allocated to roles in the 'Uplift' response – including leadership, case investigation, contact monitoring and support roles. Staff are being trained as required – training opportunities include undertaking leadership training, on-line modules in case investigation and face-to-face training in the use and application of the National Contact Tracing Solution. Training of staff is planned for completion by 12 July.

  To manage 47 cases daily (in line with mid case scenario modelling) and to surge to 67 cases if required, additional staff beyond those currently employed will be required. Work is underway to identify and secure a workforce who can be trained and available at short notice. It is anticipated that the ability to respond to surges in case numbers will continue to be necessary over the next 12-18 months.

- **COVID-19 – Psychosocial Update:** Under Civil Defence Welfare legislation, the Ministry and DHBs are required to lead the Psychosocial Support sub-function. Canterbury DHB has therefore stood up a Regional Psychosocial Steering Group to coordinate psychosocial support across South Canterbury, West Coast and Canterbury, and has also convened a Canterbury Psychosocial Committee, made up of representatives from Iwi, Ministries, NGOs and key social networks. Canterbury DHB, in conjunction with Christchurch City Council, has also submitted on the draft national COVID Mental Wellbeing and Psychosocial Recovery Plan.

  The regional and Canterbury groups have met regularly since April over Zoom, and are now moving to monthly meetings, with the Canterbury Committee meeting in person.

  Psychosocial recovery is predicated on supporting people and communities to feel safe, calm, hopeful, connected with a sense of agency. Emotional literacy and social solidarity are crucial to the wellbeing of any community. Since 2013, the *All Right?* campaign has proved successful in improving people's sense of wellbeing, and in March, the *All Right?* team were commissioned by the Ministry of Health to partner with Mental Health Foundation and Te Hiringa Hauora on a national social marketing campaign. **Getting Through Together** is funded for six months and is proving popular, with a significant increase in social media activity, and orders of collateral.

  The most recent evaluation of the reach and impact of the All Right? campaign in Greater Christchurch shows a 90% awareness rate, with 40% of these respondents recalling taking action as a result of seeing the campaign.

- **Risk Management – Canterbury Health System Alcohol-Related Harm Reduction Strategy:** The Canterbury Health System Alcohol-related Harm Reduction Strategy was endorsed by the Canterbury DHB Executive Management Team in early 2018. The Alcohol Strategy Working Group, developed in July 2018, is a working group of the Canterbury Clinical Network Population Health and Access Service Level Alliance that oversees and monitors the Strategy's implementation. The working group has evolved over its period of operation and has identified the need to introduce additional expert perspectives and links to People and Capability, ACC, and St John, and to guide how to better engage with Youth and Māori communities on alcohol harm.

  Priority actions for the coming year are to: develop and implement a communications plan to increase awareness of the health risks associated with alcohol; improve understanding of individual and population level alcohol data across the health system to build a multi-dimensional picture of the impact of alcohol; and, promote healthy environments. At their meeting on Monday 15 June the Alliance Leadership Team:

  - Noted the progress to date and deliverables planned for the next 12 months.
  - Endorsed the membership/perspective changes for the Alcohol Strategic Working Group and associated financial implications.
  - Endorsed the revised Terms of Reference.

EFFECTIVE INFORMATION SYSTEMS

- **Kotahi interRAI consolidation project:** This project went live in the Azure Cloud environment on 15 June. Canterbury DHB is now the national provider of InterRAI to users from other DHBs and Long-Term Care Facilities nationwide. Prior to this, InterRAI was hosted by Canterbury for users in the South Island and Auckland North, while the rest of the North Island was hosted by Taranaki DHB.

  The project was delivered by the Canterbury DHB on behalf of the Central Region Technical Advisory Services (Central TAS), who have the contract to manage InterRAI for the Ministry of Health. Project Sponsor Terry Huntley, Service Manager at TAS, said "We are very pleased with the outcome of the project, which ran very smoothly. The consolidation of these two hosts is something the InterRAI Board have been looking to achieve for a long time, and the benefits in administration time saved by only having to log into one system have been well received."

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Communications and Engagement

- The Communications Team continues to support Canterbury's COVID-19 response at the Border by providing a range of communications support to our teams working in the Managed Isolation and Quarantine facilities. Communications activities have included communications for guests, collateral (posters/information notices) FAQs and media liaison.
- Communications planning is underway to support Canterbury's anticipated addition to the National Bowel Screen Programme, subject to the outcome of our readiness assessment in early August.
- Entries to the HealthTech Supernode Challenge are now being invited to encourage the creators of the next great health tech innovations to come forward with their ideas and solution to solve real world health technology issues, helping confirm Canterbury as a centre of health technology excellence. We have been working with The Ministry of Awesome, Via Innovations, the University of Canterbury's Centre for Entrepreneurship, ChristchurchNZ, KiwiNet, and Ryman Healthcare to help publicise this great initiative and encourage the highest possible standard of entries.
- Communications helped promote National Volunteer Week by acknowledging the contribution of our volunteers and welcoming them back to their roles across the DHB as they returned from staying home and staying safe during COVID-19.

Media

- June was another busy month for media, with us responding to more than 130 enquiries. The month was dominated again by queries regarding COVID-19. The specific topics of media interest have included:
  - Visitor policy for DHB facilities at Alert Level 1
  - The DHB's use of the National Contact Tracing Solution Software
  - The Rosewood cluster
  - PPE supply during the pandemic
  - The potential for a 'lockdown baby boom'

- Electives/outpatient capacity post Alert Level 3 – catch-up strategy
- Demand for COVID-19 and delays to testing results
- The operation of CBACs in Canterbury and the West Coast
- Managed isolation facilities in Canterbury
- A group of people released from a quarantine facility to attend a burial
- The circumstances of compassionate exemptions given to people in managed isolation
- The financial impact of COVID-19 on the Board's financial position
- The flu season and vaccine supply in Canterbury
- Prioritisation of Maori and Pasifika patients for elective surgeries
- Christchurch Hospital Hagley building / Tower 3
- The National Asset Management Report
- The government's Health and Disability System Review
- The redevelopment of the Hillmorton Hospital campus
- A proposal for a new nursing management structure at Ashburton Hospital
- The Board's financial position
- Car parking and the future of the 'park and ride' service
- The future of the Riverside building
- David Meates was interviewed by The Press regarding the National Asset Management Plan report and the Christchurch Hospital campus facilities projects currently underway.
- Ralph La Salle, Team Leader – Secondary Care, was interviewed by The Press on the DHB's electives catch up strategy post Alert Levels 4 and 3.

LIVING WITHIN OUR FINANCIAL MEANS

- The YTD result to May continues to be favourable after the COVID-19 impact, mainly due to a lower capital charge (relating to EQ insurance drawdowns excluded from the DHB'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 following table provides the breakdown of the May result:

		MONTH			YEAR TO DATE		
		Actual	Budget	Variance	Actual	Budget	Variance
		$M	$M	$M	$M	$M	$M
Governance		(0.000)	(0.000)	(0.000)	(0.080)	(0.000)	(0.080)
Funder		(10.412)	(6.085)	(4.327)	(75.266)	(66.239)	(9.027)
DHB Provider		(21.579)	(17.316)	(4.263)	(72.683)	(95.024)	22.341
Canterbury DHB Group Result		**(31.992)**	**(23.401)**	**(8.591)**	**(148.030)**	**(161.263)**	**13.235**

4. APPENDICES

Appendix 1: Facilities Repair and Redevelopment
Appendix 2: Our People (CEO Update Stories)

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 CDHB buildings were re-purposed to be test centres as part of COVID-19 response. These were closed in early June, however, following the two new COVID-19 cases being detected in the North Island in mid-June, the test centres may be reopened. The old repurposed eyes Portacoms have been re-opened as part of this response requirement.

General EQ Repairs within Christchurch Campus

- **Parkside Panels:** North West corner panels practical completion awarded 23 March 2020. North-East corner Request for Proposal (RFP) closed at the end of April 2020. Tenders are under review with a result expected in early July. Parkside South-East corner Registration of Interest (ROI) evaluation completed with shortlisted candidates approved. RFP documentation currently being finalised.
- **Lab Stair 4:** The restart of the project will need to be co-ordinated with longer-term Government COVID-19 response due to the disruption that the construction work will have on the laboratories. The repurposing of the old Eyes Portacoms directly affects access for works. We are currently looking at other options to allow us to undertake this work. All alternatives will have time and cost implications.
- **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 is to be submitted, for construction, to undertake this work in conjunction with the Parkside Panels project. The work to be completed will form part of the Parkside panels project. We are currently awaiting budget estimates from the quantity surveyors which will help to inform this Business Case.
- **Parkside Strengthening:** As part of the Parkside seismic strengthening works, consultants are progressing the revised Non-Linear Time History Analysis (NLTHA) on Parkside Block A. RLB are providing a high-level cost estimate for the options being developed. A Business Case has been approved for Block B and the contract is now being finalised.

Christchurch Women's Hospital

- **Passive Fire Programme Stair 2:** The team has identified several potential passive fire targets for improvement. ROI and Business Case have been temporarily placed on hold due to master planning issues and reassessment of available budget allocations. 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 a request from the Ministry of Health (MoH). Installation works can commence as soon as access to the building is authorised.
- **CT Installation:** Permission granted to proceed with work by CPB. Core drilling for fixing of equipment is now complete. Installation of the CT machine is awaiting completion of HVAC works by CPB. No more work can continue in this area until CPB have completed their work. Access to the area is expected to be early July 2020.
- **Fluoroscopy:** CPB is working in this area at present and do not expect to be finished until early August. Works cannot start until the area is handed over.
- **Emergency Department (ED) Radiology:** Scope and fit out works currently being confirmed. YSIO radiology equipment is in Christchurch and stored at Fliways near the airport. Waiting on approval to proceed from MoH.
- **ED X-Ray Room G228:** Siemens contractor has commenced installation of Ysio X-Ray equipment on the 15 June. The contractor is expected to have completed work in mid-July.

Other Christchurch Campus Works

- **Passive Fire/Main Campus Fire Engineering:** Site Redevelopment has been requested to make a change to the investigation approach by completing assessments of all 85+ fire cells upfront. Previously, this work had been planned to progress over several years to be able to incorporate lessons learnt into the process. Individual Business Cases will continue to be prepared to undertake works within specific areas of the Christchurch Campus buildings, and the scope of work for each fire cell will still require review by Fire and Emergency NZ (FENZ) and the Christchurch City Council (CCC).
    - Draft Business Case prepared for Christchurch Women's Risers, requires FENZ and CCC agreement to scope of work. Procurement, Registration of interest and consent application documentation have been placed on hold due to master planning changes.
- **Christchurch Hospital Campus Energy Centre (managed by MoH):** Developed design complete with detail design now underway. Some delays have occurred due to coordination of design elements.
- **235 Antigua St and Boiler House (Demolition):** No work to be undertaken until the new energy centre is constructed and commissioned. This demolition project will be managed by the CDHB.
- **Parkside Renovation Project to Accommodate Clinical Services, Post Hagley (currently managed by MoH):** Planning ongoing. Still waiting on formal advice from management as to the outcome of master planning process and funding.

- **Backup VIE Tank:** This project is included as a separable portion to the Health Labs Stair 4 Project. This work is now going to be undertaken as a separate item as soon as is practicable.
- **Seismic Monitoring System:** The Facilities EMT Subcommittee have made a recommendation to the Board that this project is progressed as part of Master Plan development work. The timeframe for it to continue is unknown.
- **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, strengthening and passive fire remediation works. This will provide insight into timing, relocation requirements and potential sequencing options and 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 dependent on which components of work will be MoH or CDHB managed.
- **Avon Switch Gear and Transformer Relocation:** Design complete. Project is on hold as it is co-ordinated with Christchurch Hagley commissioning. This is being managed by the M&E team.
- **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 a 3-month bedding in period for new generators.
- **Riverside Loading Docks:** Concept designs have been prepared and are currently being costed. It is intended to have the Business Case for the next stage of design submitted for approval by the end of June.
- **Cancer Centre Radiology:** A design and budgeting project has been completed for the proposed Cancer Centre to initially house two LINAC machines while considering longer-term requirements. The investigation-stage project is now closed. NO more work will be undertaken until guidance has been received from MoH.

Canterbury Health Labs (CHL)

- **Anatomical Pathology (AP):** Initial planning of 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 project is being managed by 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 co-ordinated with Maintenance. Following delays due to COVID-19, tenders for consultants to help with initial scope development have been pushed out and are now due at the end of June.

Hillmorton Hospital Campus

- **Hillmorton SMHS:** Detailed design phase is nearing completion. Finishes have been presented to the Facilities Development Governance Group (FDGG). ROI for the main construction contractor is out to market and closes on 23 June 2020. The project is continuing to programme and on budget.
- **Laundry Repurposing:** Initial concept design to relocate the Design Lab is underway. The relocation of CAF Outpatients and O/T equipment to the laundry is also being investigated.
- **Fergusson Upgrade:** Admin Relocation initial planning underway before Business Case submission. Preliminary works to-date have included reviewing the space in the Fergusson building to establish its suitability, developing some concept costings, and developing a preliminary schedule of accommodation.
- **Food Services Building:** The Engineer has completed a site visit and some options for the structural strengthening are due for presentation on 19 June. The ROI documentation for the main contractor has been loaded on GETS with a closing date of 01 July 2020.
- **Cotter Trust:** On-going occupation being resolved as part of overall site plan requirements.
- **AT&R:** Construction work is back underway following COVID-19 restrictions. Costs of delay are being collated for scope change preparation. An updated programme that reflects the impact of delays to the construction works has been received and accepted by the project team.
- **Masterplan:** Cost and programme review has been completed and the report submitted. Programme Business Case being developed by Sapere, with report delivery time for the July Board Meeting.

The Princess Margaret Hospital Campus

- **Child, Adolescent and Family (CAF) relocation:** Project is at the early feasibility stage to identify an alternative location for CAF Outpatients. Options assessed include lease, relocate to Hillmorton Laundry building and/or new build. Options paper to be prepared with cost estimates.

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 have been prepared. RFP was released on GETS 15 June 2020.
- **Chatham Island Accommodation:** Business Case has been prepared and submitted. Price estimates for a range of building layouts have been provided to the Business Case author.
- **Rangiora Demolition:** Business Case to demolish the old building and widen the existing driveway to make way for the new Community Health Centre has been submitted for approval. An ROI for a contractor has been prepared.

- **Selwyn Health Hub:** Project Management Plan being prepared. Consultants have been appointed. Preliminary Design is progressing. An ROI for the main contractor is being prepared.

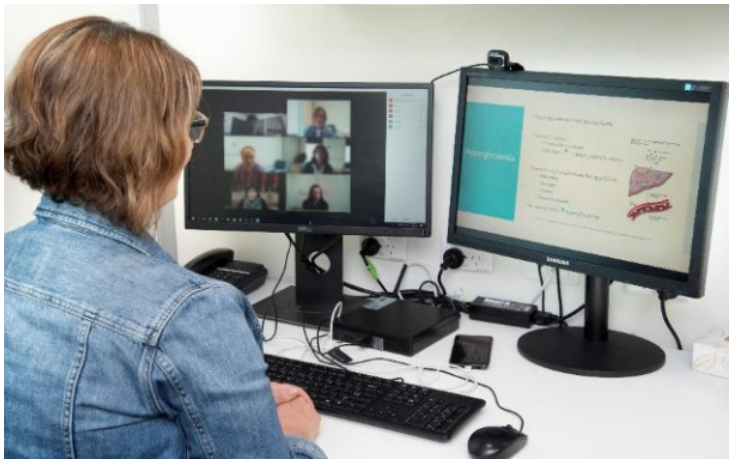
Project/Programme Key Issues

- 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.
- Confirmation on way forward for the Cancer Centre is urgently required to ensure replacement requirements for new linear accelerators are achieved.

OUR PEOPLE (CEO UPDATE STORIES)

Canterbury District Health Board
Te Poari Hauora ō Waitaha

- The Christchurch Hospital Dental Service, the Community Dental Service, and private dental practices in Canterbury, supported by the local branch of the New Zealand Dental Association (NZDA), joined forces to create an efficient process to assess, give advice and provide dental care during the Level 4 lockdown. An 0800 number was set up through the Community Dental Service call centre as a single point of contact for all people in Canterbury and West Coast with acute dental problems. Patients were assessed in free Telehealth consultations. In Christchurch, in a single day, up to 118 calls were made to the 0800 number and the total number of calls during lockdown reached almost 2000. Dental Specialist Juliet Gray says the speed that it was set up is completely unprecedented and many of the clinical pathways they developed for safe provision of dental triage and care were adopted locally and nationally.
- First year House Surgeon at Christchurch Hospital, David Nair, won the Pasifika Medical Association's Papali'i Dr Semisi Ma'ia'i University of Otago Scholarship. The 26 year-old graduated from the University of Otago School of Medicine last year with a Bachelor of Medicine and a Bachelor of Surgery (MBChB). David used the scholarship to return home to Fiji to work in hospitals there as part of his elective.
- The provision of care to people with diabetes during lockdown period of Levels 4 and 3 has enabled trials of several initiatives to further explore their use of Telehealth technology. Using Zoom, staff were able to teach people how to use their insulin pump and to download glucose management results from their devices through links to their smart phone. Diabetes Clinical Nurse Specialist Cate Fleckney says the team have noticed that patients who were reluctant in the past have gained confidence in downloading their technologies having now discovered how surprisingly easy it can be. This is a positive step towards reaching diabetes self-care goals.



Christchurch Hospital Hagley – Facilities Development Communication

- As we anticipate confirmed dates for handover of the building, detailed communications planning is underway. A refreshed healthLearn package is being fine-tuned to provide individual services access to the information most relevant to their specialty, ensuring the courses are tailored and timely for staff.

- 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.
- **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.
- **New Mental Health Facilities:** The team is assisting with communications for facilities development on the Hillmorton campus. Staff, public and patient communications are being planned for the impending Assessment Treatment & Rehabilitation facility, Integrated Family Services Centre and High and Complex Needs units. Plans include static displays in and around campus, community information/updates for the neighbours and regular staff updates.

FINANCE REPORT 31 MAY 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: **16 July 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 May 2020 is a net expense of $31.992M, being $8.591M favourable to plan, and year to date $13.235M favourable to plan;
ii. notes the operating result (pre indirect items) for the month is favourable to plan by $172k, year to date $2.096M unfavourable to plan;
iii. notes that costs associated with the Whakaari tragedy (excluding IDF) as included in the year to date operating result are in excess of $1M;
iv. notes that net costs associated with COVID-19 pandemic as included in the month of May results are $7.570M, and year to date $16.470M;
v. notes the operating result (pre indirect) excluding COVID-19 costs, is favourable to plan by $7.742M for the month, YTD $14.374M;
vi. notes liquidity (cashflow) risk continues to be a significant concern without any sustainable long term resolution; and
vii. notes that the Ministry has declined our request for the exclusion of EQ insurance capital in excess of capital impairment from the capital charge calculation, the impact of this has been included in our full year forecast.

3. DISCUSSION

Overview of May 2020 Financial Result

Summary DHB Group Financial Result

The following table provides the breakdown of the May result:

	Appendix	MONTH			YEAR TO DATE		
		Actual	Budget	Variance	Actual	Budget	Variance
		$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate		(24.683)	(17.421)	(7.262)	(75.496)	(94.941)	19.445
Community & Public Health		(0.015)	0.001	(0.016)	(0.365)	(0.149)	(0.216)
Total In-House Provider excl Subsidiaries	**8**	**(24.698)**	**(17.419)**	**(7.278)**	**(75.861)**	**(95.090)**	**19.229**
Add: Funder & Governance							
Funder Revenue	6	154.851	147.640	7.211	1,643.887	1,620.296	23.591
External Provider Expense	6	(75.934)	(64.953)	(10.981)	(741.454)	(710.020)	(31.435)
Internal Provider Expense	6	(89.329)	(88.772)	(0.557)	(977.699)	(976.515)	(1.184)
Total Funder		**(10.412)**	**(6.085)**	**(4.327)**	**(75.266)**	**(66.239)**	**(9.027)**
Governance & Funder Admin	7	(0.000)	0.000	(0.000)	(0.080)	0.000	(0.080)
Total Canterbury DHB (Parent)		**(35.110)**	**(23.504)**	**(11.605)**	**(151.207)**	**(161.328)**	**10.121**
Add: Subsidiaries							
NZ Health Innovation Hub	9	0.065	0.000	0.065	0.065	0.000	0.065
Brackenridge Services Ltd	9	0.071	0.048	0.023	0.264	0.065	0.199
Canterbury Linen Services Ltd	9	2.982	0.056	2.926	2.849	0.000	2.848
Canterbury DHB Group Surplus / (Deficit)	**2**	**(31.992)**	**(23.401)**	**(8.591)**	**(148.029)**	**(161.263)**	**13.235**

The May result is impacted by an additional $11.8M capital charge accrual in relation to EQ insurance revenue, which is reflected in the Hospital & Specialist Service and Corporate line above.

The YTD result continues to be favourable including the COVID-19 impact due to:

- Capital charge on the $65M Holidays Act accrual at 30 June 2019, and
- Capital charge on the Hagley facility transfer planned for November 2019, and
- Depreciation expense on the Hagley facility, less
- Additional operational expenses that partly offset this variance (eg, outsourced elective surgery).

4. KEY FINANCIAL RISKS

Liquidity risk continues to be a key issue.

We had previously received $80.5M advance funding that has now been deducted from our 4 June MoH bulk funding.

The capital charge payable in June 2020 has increased by $11.8M to $24.3M due to the change as mentioned above.

Our liquidity risk has been brought forward by the request to move to 10 day payment term as endorsed by MBIE and now confirmed by the MoH. The impact of this move will not be fully known until we actually make the transition. The impact on our current cashflow forecast would move our current forecasted inability to clear our financial obligations as they fall due forward by approximately 4-5 weeks. Being a large organisation

there are inevitably variations in the daily cashflow, so it is prudent to have a small buffer 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 cashflow forecasts to the MoH. We have also continued to raise the need for the MoH to be planning within the permitted mechanisms to mitigate the liquidity risk, at this stage no long term solutions have been clearly identified.

COVID-19 – the forecasted impact of COVID-19 on CDHB's performance is dependent on a number of uncertain parameters, and 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 (e.g. what level of outsourcing is required to catch up on lost throughput). Refer Appendix 1 for estimated costs to date and forecasted full year costs.

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.

The Whakaari incident has impacted on the delivery of electives and IDF volumes. Counties-Manukau DHB have led the discussion on possible funding with ACC; we have just been advised that funding of $1M will be received for this incident.

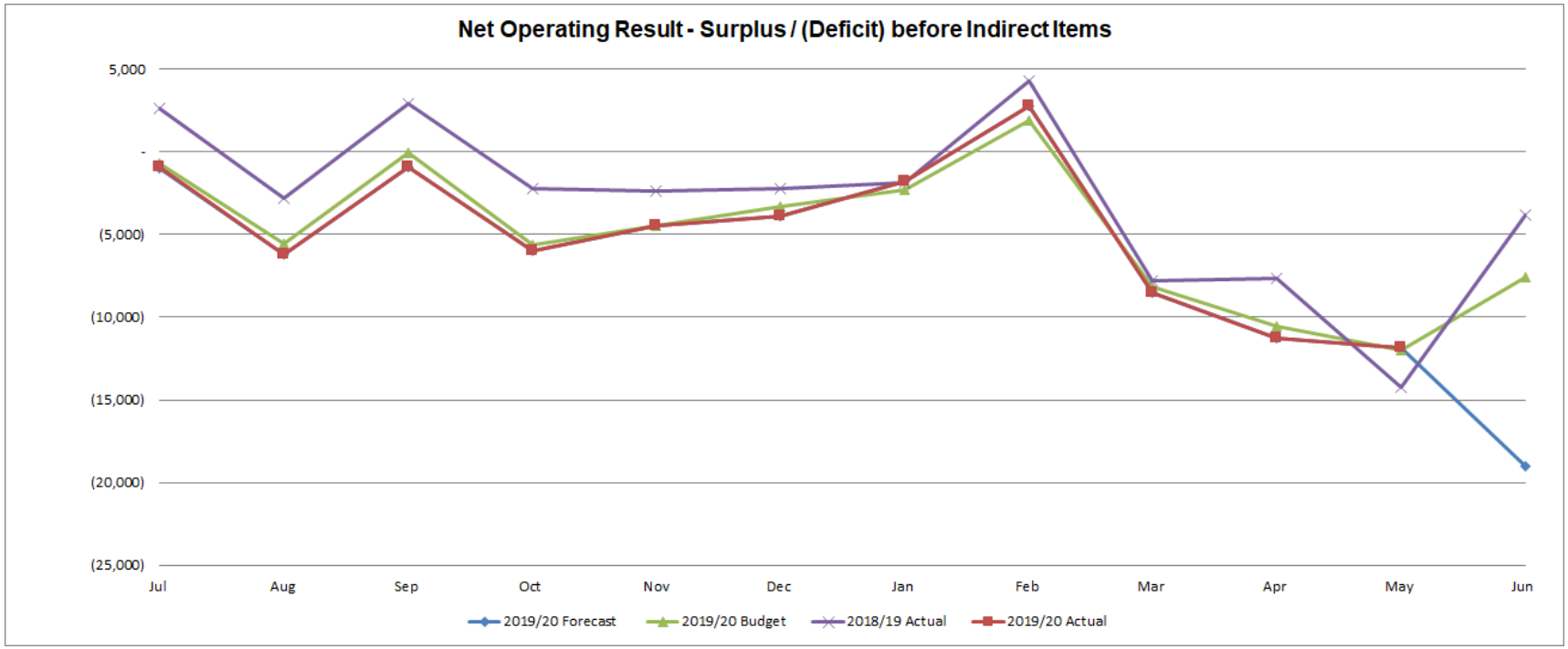
5. APPENDICES

Appendix 1: Financial Result
Appendix 2: Statement of Comprehensive Revenue & Expense
Appendix 3: Statement of Financial Position
Appendix 4: Cashflow

APPENDIX 1: FINANCIAL RESULT (BEFORE INDIRECT ITEMS)

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 31 MAY 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	(11,822)	(11,995)	173	-1% ✓	(52,924)	(50,829)	(2,095)	4% ✗	(100,335)	(73,225)	(58,337)	(14,887)	26% ✗



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

KEY RISKS AND ISSUES

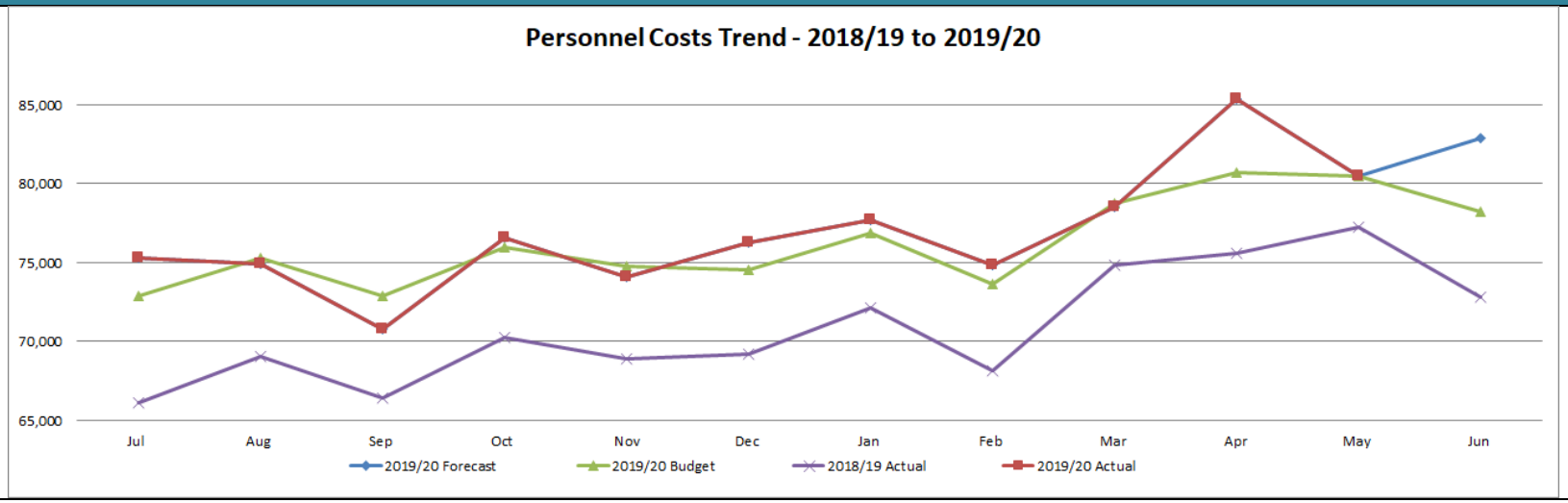
- This graph shows the operating result before indirect items such as depreciation, interest, donations, capital charge and the offsetting new capital charge funding.
- In the month of May CDHB incurred a net $7.6M of COVID-19 pandemic related costs ($16.5M YTD). Adjusting for these costs, our result would have been favourable for the month as well as YTD.

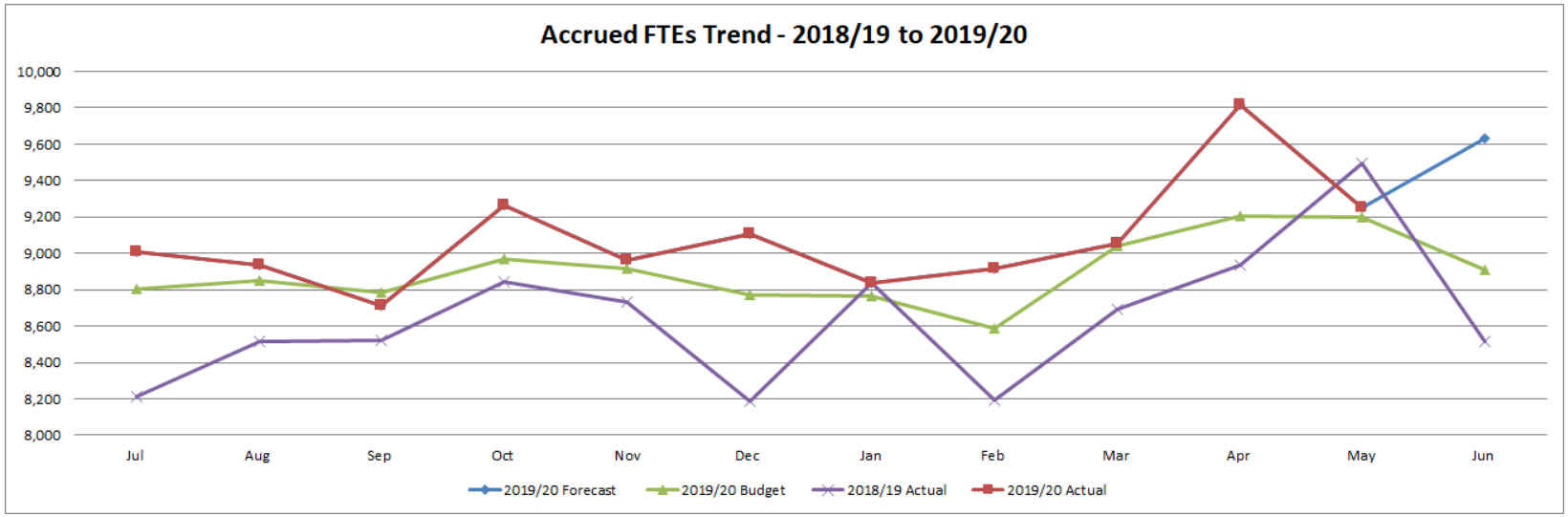
- The following table shows the impact of COVID-19 on the month, YTD, and full year forecast:

	Period to date							Year to date							Full Year						
May 2020 Result Snapshot	Month Actual $000	Month Budget $000	Month Variance F/(UF)	Covid-19 $000	Excl Covid-19 $000	Month Budget $000	Underlying Variance	YTD Actual $000	YTD Budget $000	YTD Variance F/(UF)	Covid-19 $000	Excl Covid-19 $000	YTD Budget $000	Underlying Variance	Full Year F'cast $000	Full Year Budget	Variance F/(UF)	Covid-19 $000	Excl Covid-19 $000	Full Year Budget	Underlying Variance
MOH Revenue	(160,826)	(152,420)	8,406	(5,414)	(155,412)	(152,420)	2,992	(1,705,006)	(1,677,061)	27,945	(14,563)	(1,690,443)	(1,677,061)	13,382	(1,849,426)	(1,829,389)	20,037	(15,791)	(1,833,635)	(1,829,389)	4,246
Patient related revenue	(4,672)	(4,125)	547	-	(4,672)	(4,125)	547	(48,236)	(45,024)	3,212	657	(48,893)	(45,024)	3,869	(51,385)	(49,121)	2,264	657	(52,042)	(49,121)	2,921
Other Revenue	(2,369)	(3,941)	(1,572)	914	(3,283)	(3,941)	(658)	(37,864)	(47,597)	(9,732)	1,735	(39,599)	(47,597)	(7,997)	(51,973)	(51,708)	265	2,524	(54,497)	(51,708)	2,789
Revenue	(167,867)	(160,486)	7,381	(4,500)	(163,367)	(160,486)	2,881	(1,791,106)	(1,769,682)	21,425	(12,171)	(1,778,935)	(1,769,682)	9,254	(1,952,784)	(1,930,218)	22,566	(12,610)	(1,940,174)	(1,930,218)	9,956
Employee expenses	80,475	80,491	16	3,244	77,231	80,491	3,260	844,928	836,794	(8,134)	7,031	837,897	836,794	(1,103)	927,827	915,003	(12,824)	8,431	919,396	915,003	(4,393)
Treatment Related costs	12,236	15,005	2,769	1,115	11,121	15,005	3,884	143,895	150,036	6,141	3,162	140,733	150,036	9,303	159,648	164,745	5,097	3,162	156,486	164,745	8,259
Other expenses	11,044	12,031	987	626	10,418	12,031	1,613	113,753	123,659	9,907	1,362	112,391	123,659	11,269	126,169	135,369	9,199	1,362	124,807	135,369	10,561
External Provider costs	75,934	64,953	(10,981)	7,085	68,849	64,953	(3,896)	741,454	710,020	(31,435)	17,086	724,368	710,020	(14,349)	814,671	773,439	(41,232)	20,072	794,599	773,439	(21,160)
Total expenditure	179,689	172,480	(7,209)	12,070	167,619	172,480	4,861	1,844,030	1,820,509	(23,521)	28,641	1,815,389	1,820,509	5,120	2,028,315	1,988,555	(39,760)	33,027	1,995,288	1,988,555	(6,733)
Operating result	11,822	11,994	172	7,570	4,252	11,994	7,742	52,924	50,828	(2,096)	16,470	36,454	50,828	14,374	75,531	58,337	(17,194)	20,417	55,114	58,337	3,223
Total Indirect revenue and expenditure	20,170	11,407	(8,763)	-	20,170	11,407	(8,763)	95,105	110,435	15,330	-	95,105	110,435	15,330	103,455	122,133	18,678	-	103,455	122,133	18,678
Total Surplus/Deficit	31,992	23,401	(8,591)	7,570	24,422	23,401	(1,021)	148,029	161,263	13,234	16,470	131,559	161,263	29,704	178,986	180,470	1,484	20,417	158,569	180,470	21,901

- We have received MoH funding to cover some of the expenditure to community providers, however there remain some costs that have not been funded. Other direct costs, which we believe may not all be specifically funded, in our Provider arm 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 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. The pandemic situation has presented unique challenges for staffing and roster modelling to ensure both staff and patient safety, which has led to higher payroll costs. Payroll costs also include the impact on leave taken.
- The overall forecast operating result, net of the Covid-19 costs is a favourable variance to budget of $3.2M.
- In May we have started to prepare for the provision of isolation facilities. The costs and reimbursement from the MoH associated with these facilities are currently being worked through.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE

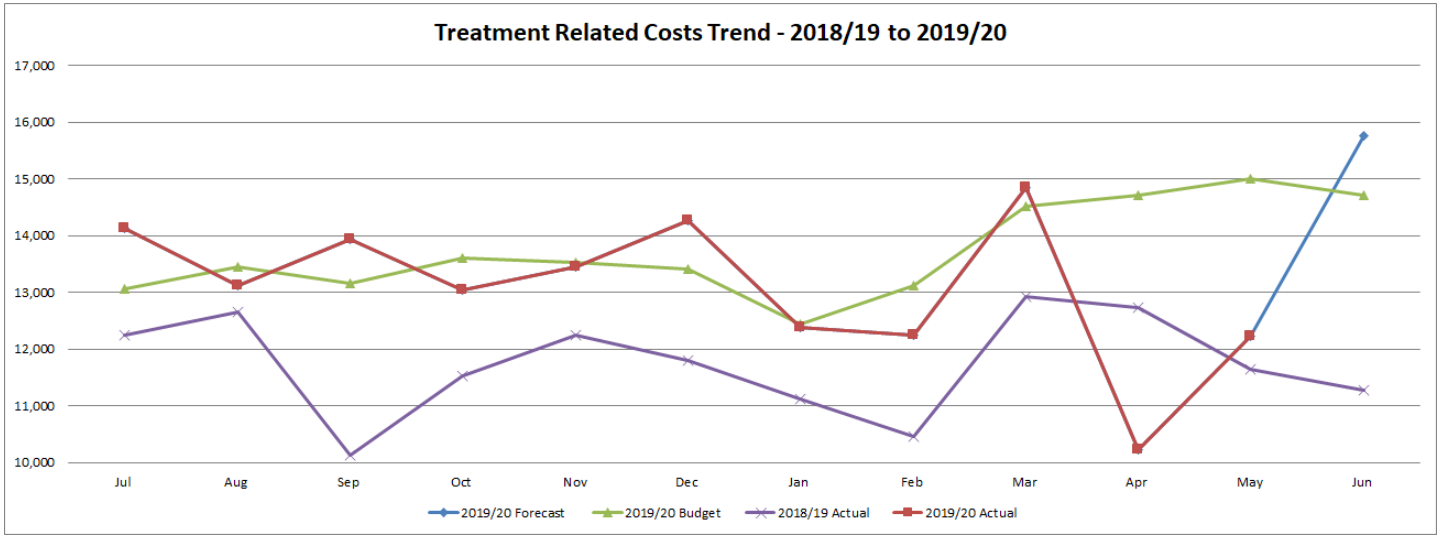


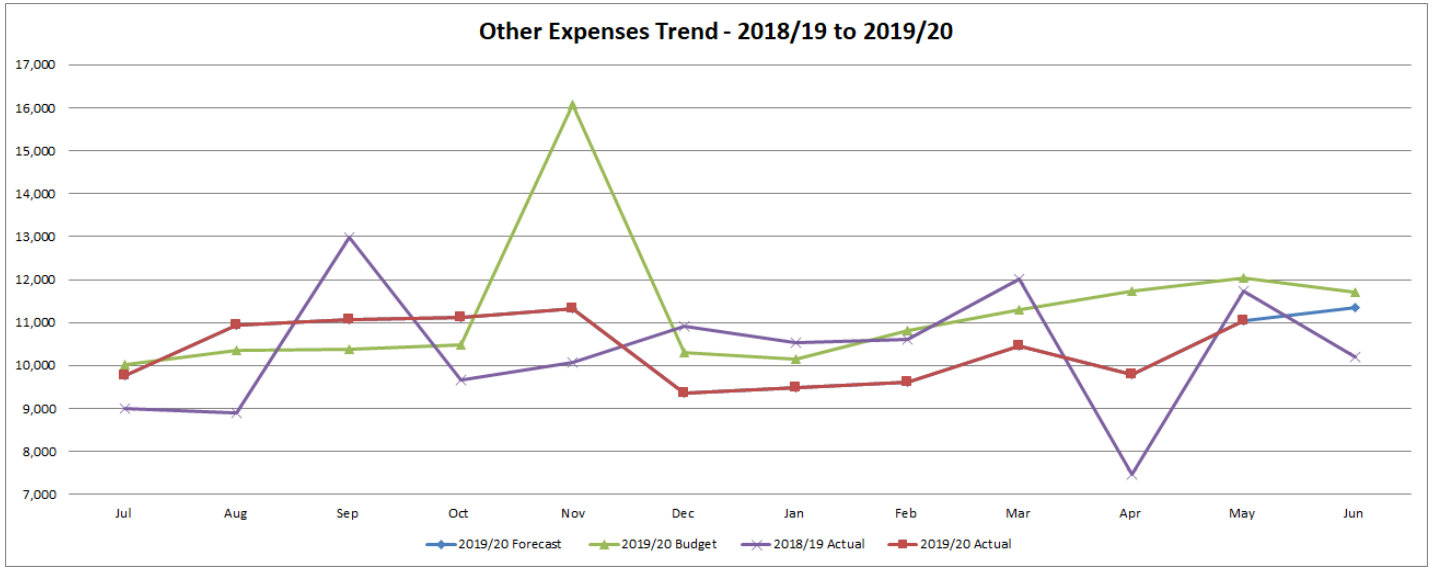


KEY RISKS AND ISSUES

- 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, eg Senior Doctor CME leave has seen significant cancellations. In addition there was FTE resource utilised for incident management of COVID-19. The Hagley delay has also impacted the results.
- 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 $0.7M of the unfavourable variance for May, and $3.8M 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. FTE is higher than plan due to COVID-19. Note the FTE shown in this graph is an "accrued" FTE, and differs from contracted FTE. The methodology to calculate accrued FTE causes fluctuations on a month to month basis dependant on a number of factors such as working days (the range is 21-23 across the year), the accrual proportions, annual leave impacts (particularly school holidays, Easter, Christmas and New Year periods), etc. The accrued FTE largely correlates with the trend in contracted FTE.

TREATMENT & OTHER EXPENSES RELATED COSTS



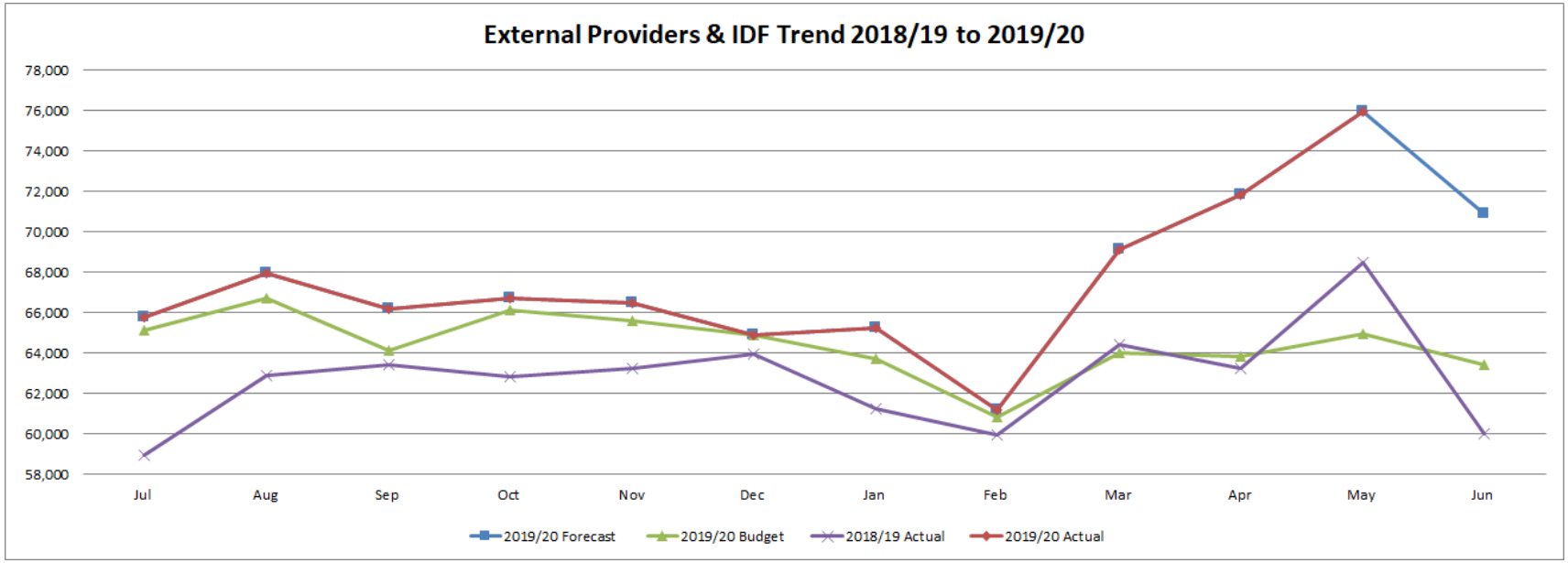


KEY RISKS AND ISSUES

- The drop in clinical costs for the month of May is due to the disruption caused by COVID-19 with lost production. Additional costs for COVID-19 testing consumables has partially offset some of the reduced expenditure from planned activity. As expected these costs are coming back to previous expenditure levels and are expected to increase again in June. 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.
- 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 $8.4M 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 $0.8M for April, and $4.8M 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	75,934	64,953	(10,981)	-17% ✗	741,454	710,020	(31,435)	-4% ✗	752,784	812,364	773,439	(38,925)	-5% ✗



KEY RISKS AND ISSUES

- External provider expenditure was $10.98M unfavourable - $7.1M of this relates to COVID-19 costs, but offset with $5.4M 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.
- 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	587,998	1,151,069	563,071	49%

	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	77,919	(18,172)	96,091		(31,576)	(16,050)	(62,397)	46,347	-74.3%

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.
- The sweep account was in funds at the end of May with a balance of $73M. In April we received a $130M equity injection, noting that then $80.5M cash advance was repaid from our 4 June MoH funding. This has alleviated our liquidity issue in the short term. Depending upon when we transition to paying suppliers within 10 working days, the date we will no longer be able to pay our debts as and when they fall due is within the first quarter of the new financial year.
- COVID-19 expenses have also added to our cashflow situation.
- We have factored in additional cash required for anticipated costs relating to the Hagley handover delay, costs to date of COVID-19, and made some allowance for potential COVID-19 costs through to 30 June 2020.
- A longer term resolution to our liquidity issue from the MoH and Treasury is urgently required to avoid CDHB defaulting on payments when they fall due.

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

The Group financial results include Canterbury DHB and its subsidiaries
For the 11 months ending 31 May 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
160,826	152,420	147,618	8,406 ✓	MoH Revenue	1,705,006	1,677,061	1,597,365	27,945 ✓	1,849,426	1,829,389	1,740,486	20,037 ✓
4,672	4,125	4,583	547 ✓	Patient Related Revenue	48,236	45,024	44,911	3,212 ✓	51,385	49,121	49,201	2,264 ✓
2,369	3,941	2,658	(1,572) ✗	Other Revenue	37,864	47,597	36,332	(9,732) ✗	51,973	51,708	39,747	265 ✓
167,867	**160,486**	**154,859**	**7,381**	**Total Operating Revenue**	**1,791,106**	**1,769,682**	**1,678,608**	**21,425**	**1,952,784**	**1,930,218**	**1,829,434**	**22,566**
80,475	80,491	77,230	16 ✓	Personnel Costs	844,928	836,794	777,871	(8,134) ✗	927,827	915,003	915,946	(12,824) ✗
12,236	15,005	11,642	2,769 ✓	Treatment Related Costs	143,895	150,036	129,514	6,141 ✓	159,648	164,745	140,795	5,097 ✓
75,934	64,953	68,535	(10,981) ✗	External Service Providers	741,454	710,020	693,252	(31,435) ✗	812,364	773,439	752,784	(38,925) ✗
11,044	12,031	11,661	987 ✓	Other Expenses	113,753	123,659	109,273	9,907 ✓	126,169	135,369	120,244	9,199 ✓
179,689	**172,480**	**169,068**	**(7,209)** ✗	**Total Operating Expenditure**	**1,844,030**	**1,820,509**	**1,709,909**	**(23,521)** ✗	**2,026,008**	**1,988,555**	**1,929,769**	**(37,454)** ✗
(11,822)	**(11,994)**	**(14,208)**	**172** ✓	**Total Surplus / (Deficit) Before Indirect Items**	**(52,924)**	**(50,828)**	**(31,301)**	**(2,096)** ✗	**(73,225)**	**(58,337)**	**(100,335)**	**(14,887)** ✗
89	94	45	(5) ✗	Interest Revenue	663	853	822	(190) ✗	720	939	627	(219) ✗
685	685	-	- ✓	MoH Revaluation Cap Charge funding	7,535	7,535	-	- ✓	8,220	8,220	-	-
-	748	-	(748) ✗	MoH Debt Equity Swap funding	-	2,992	-	(2,992) ✗	-	3,740	-	(3,740)
48	224	188	(176) ✗	Donations	3,432	2,459	3,753	973 ✓	3,731	2,586	4,067	1,145 ✓
2	1	2	1 ✓	Profit on Sale of Assets	17	7	133	10 ✓	15	8	133	8 ✓
824	**1,752**	**235**	**(928)** ✗	**Total Indirect Revenue**	**11,647**	**13,846**	**4,707**	**(2,199)** ✗	**12,686**	**15,492**	**4,827**	**(2,806)** ✗
13,802	5,691	2,079	(8,111) ✗	Capital Charge	35,480	48,171	23,045	12,691 ✓	37,480	53,864	24,241	16,384 ✓
7,179	7,418	4,690	239 ✓	Depreciation	70,820	75,560	49,750	4,740 ✓	78,166	83,161	57,515	4,995 ✓
-	50	59	50 ✓	Interest Expense	382	550	396	168 ✓	425	600	552	175 ✓
13	-	3	(13) ✗	Loss on Sale of Assets	70	-	9	(70) ✗	70	-	23	(70) ✗
20,994	**13,159**	**6,831**	**(7,835)** ✗	**Total Indirect Expenses**	**106,752**	**124,281**	**73,201**	**17,529** ✓	**116,141**	**137,625**	**82,331**	**21,484** ✓
(31,992)	**(23,401)**	**(20,805)**	**(8,591)** ✗	**Total Surplus / (Deficit)**	**(148,029)**	**(161,263)**	**(99,794)**	**13,235** ✓	**(176,679)**	**(180,470)**	**(177,839)**	**3,791** ✓

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 31 May2020

Audited 30-Jun-19 $'000		Group Actual 31-May-20 $'000	Group Budget 31-May-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	138,449	649,693	650,781
	Other Movements (NZHIH)	200	-	-
137,345	Reserve Movement for Year	(3,068)	-	-
(177,839)	Operating Results for the Period	(144,961)	(161,263)	(180,470)
597,378	**TOTAL EQUITY**	587,998	1,151,069	1,132,950
	Represented By:			
	Current Assets			
4,999	Cash & Cash Equivalents	77,919	627	627
750	Short Term Investments	750	750	750
91,010	Trade and Other Receivables	116,493	91,010	91,010
5,838	Prepayments	7,778	5,838	5,838
13,209	Inventories	16,812	13,209	13,209
14,510	Restricted Assets	14,568	14,685	14,685
130,315	**Total Current Assets**	234,320	126,119	126,119
	Less Current Liabilities			
36,575	Overdraft	-	18,799	63,024
123,935	Trade and Other Payables	165,697	139,099	123,936
14,760	Restricted Funds	14,652	14,760	14,760
245,602	Employee Benefits	258,436	180,342	180,342
420,872	**Total Current Liabilities**	532,400	366,292	382,062
(290,557)	**Working Capital**	(298,080)	(240,173)	(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	888,998	1,393,903	1,391,554
893,837	**Term Assets**	892,239	1,397,144	1,394,795
	Non Current Liablilties			
5,902	Employee Benefits	6,161	5,902	5,902
5,902	**Term Liabilities**	6,161	5,902	5,902
597,378	**NET ASSETS**	587,998	1,151,069	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-May-20 $'000	YTD Budget 31-May-20 $'000	Budget 30-Jun-20 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(52,680)	**Net Cash from Operating Activities**	32,624	(57,244)	(97,305)
	CASHFLOW FROM INVESTING ACTIVITIES			
(43,992)	**Net Cash from Investing Activities**	(61,578)	(65,660)	(70,913)
	CASHFLOW FROM FINANCING ACTIVITIES			
80,794	**Net Cash from Financing Activities**	138,449	136,483	137,572
(15,878)	Overall Increase/(Decrease) in Cash Held	109,495	13,579	(30,646)
(15,698)	Add Opening Cash Balance	(31,576)	(31,751)	(31,751)
(31,576)	**Closing Cash Balance**	77,919	(18,172)	(62,397)

MĀORI AND PACIFIC EQUITY REPORT JUNE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

DATE: **16 July 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report provides an overview of Health equity pertaining to our Māori and Pacific Health populations.

2. RECOMMENDATION

That the Board:

i. notes the Māori and Pacific Health Equity Report; and
ii. provides guidance for subsequent equity reporting.

3. DISCUSSION

What is Health Equity / Inequity?

Equity and inequity are frequently misunderstood and often mistakenly interchanged with equality and inequality. Other terms such as disparities and gaps also appear in both literature and vernacular. It is essential to appreciate the distinctions between such terms to fully understand what it is we mean in health and the DHB when we seek equity.

Disparities in health status between different groups within a population are found worldwide. These include disparities by age, gender, socioeconomic position, ethnicity, impairment and geographical region. In Aotearoa, ethnic inequalities between Māori and non-Māori are the most consistent and compelling inequities in health (Ajwani et al 2003; Ministry of Health and University of Otago 2006).

Health inequalities, or more correctly health inequities, are defined as "differences which are unnecessary and avoidable, but in addition are considered unfair and unjust" (Whitehead 1992, p. 431). The word 'inequities' is preferred as not all inequalities are unexpected or unfair. For example, men get prostate cancer, but women cannot, and women get cervical cancer and men cannot. These are inequalities (differences) but not inequities (unfair). Equity, like fairness, is an ethical concept based in a model of justice where distribution of resources ensures everyone has at least their minimum requirements. It does not necessarily mean that resources are equally shared; rather, it acknowledges that sometimes different resourcing is needed in order that different groups enjoy equitable health outcomes.

Health equity is defined as 'the absence of systematic disparities in health (or in the determinants of health) between different social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy' (Braveman and Gruskin 2003, p. 254). This concept of health equity focuses attention away from the individual and her/his health. Instead it monitors how resources, including health services, are distributed to the community. This includes evaluating the processes that determine how resources are shared and the underlying values of society.

The word 'inequalities' in this country is widely used to mean inequities, as are the terms disparities and gaps.

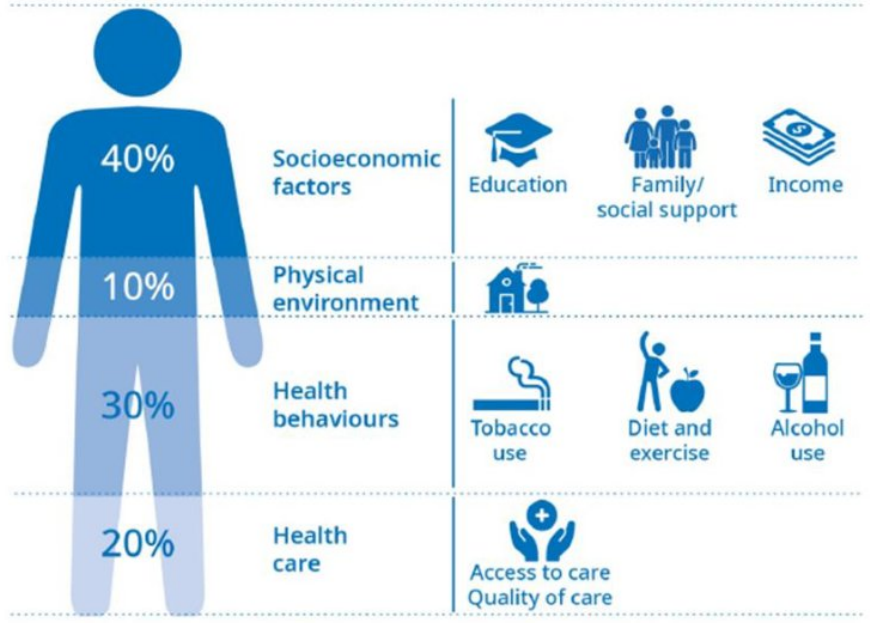
The Ministry of Health definition of equity: "In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes". (https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity#:~:text=The%20definition,to%20get%20equitable%20health%20outcomes)

Health inequalities and health disparities are differences in health; access, quality, status, outcome etc. Health inequities are also differences, but importantly they are differences that are both avoidable and unfair.

The Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. (https://www.who.int/social_determinants/sdh_definition/en/).

Figure 4: The determinants of health and their relative contribution to our health outcomes



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

However, there are factors within our control that the health system is responsible for that can impact on equity and contribute to reducing inequity. These are the factors we must genuinely interrogate and transform when required, to bring about equity.

Equity and Inequity is Complex

"We are too much accustomed to attribute to a single cause that which is the product of several, and the majority of our controversies come from that." (Marcus Aurelius; Roman emperor 161 to 180).

Inequity is complex and does not have a single cause; consequently, there is not a single solution or indeed a simple answer. The complexities of the social determinants of health, combined with systems created through centuries of social and cultural conditioning make it incredibly difficult to

unravel causation, remove barriers and create solutions. Over-simplifying equity invariably leads to limited or no success.

Clearly understanding the 20% that we as a health system can control, particularly access to and quality of care, has the greatest potential to reduce inequity.

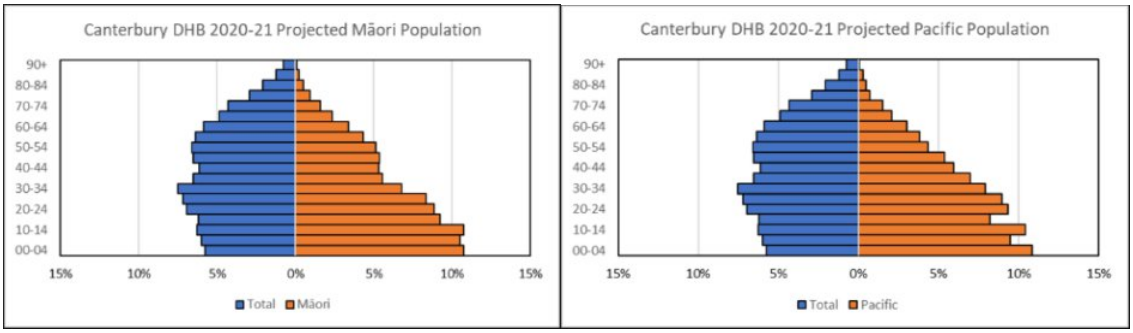
Indicators of Health

The size and complexity of our health system makes in incredibly difficult to ascertain total system performance without using snapshots of data that provide a reasonable indication of performance. For equity performance, indicators of health at significant measurable points in the system, allow us to gain a reasonable overview of how we are progressing towards equity. These indicators are a tool that provide governance and managers with pointers towards how the system is likely to be performing and we illustrate these in our Dashboards of Māori and Pacific Health.

The indicators in the dashboard provide a tool that permits an overview of various parts of the system. They cannot tell us everything about our overall performance towards equity, but they are able to provide an indication. Indicators such as ASH (ambulatory sensitive hospitalisations), oral health, breastfeeding, smoking and immunisation are chosen because they often provide "red flags" to deeper issues which impact on equity.

The Board asked for an Equity report which would first give an overview of progress towards equity using our existing data and dashboards and then looking deeper into two of the indicators to see more thoroughly how well or poorly we are doing with reducing inequity in these two chosen indicators.

In this equity report we will get a look at the Canterbury Māori and the Canterbury Pacific, Health Dashboard Reports as at May 2020 and look more intensely into two indictors, oral health and immunisation. Importantly, both of these are indicators of child health because both Māori and Pacific have much larger proportions of children than all other ethnicities (see CDHB population projections below).



Canterbury Māori Health Dashboard Report

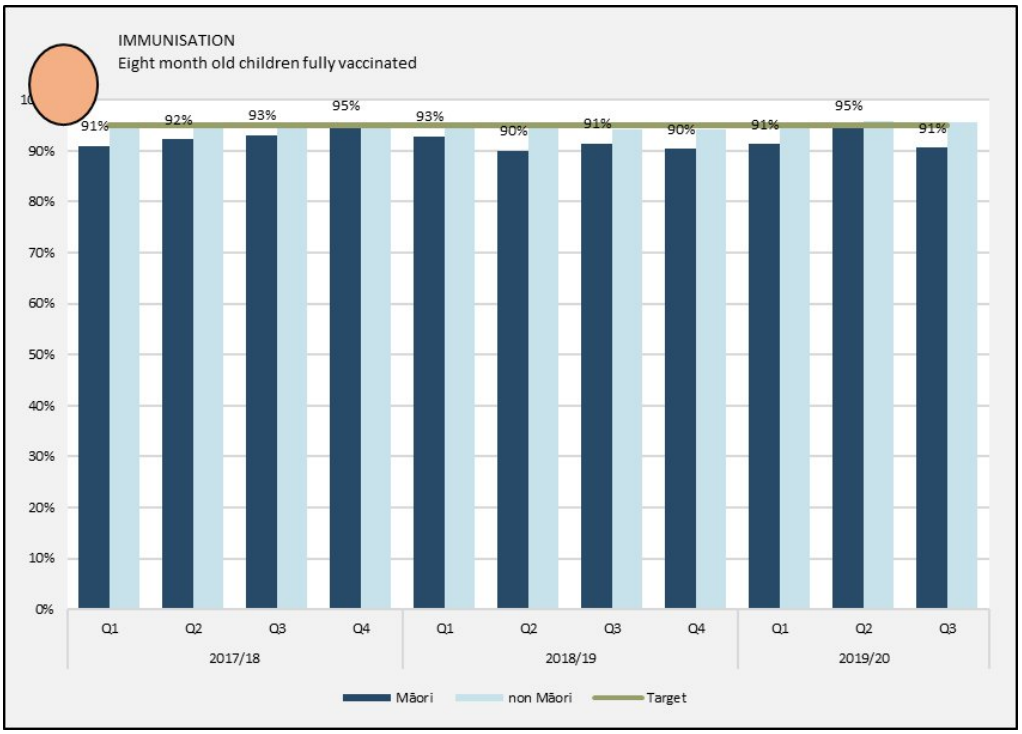
The Canterbury Māori Health Dashboard Report shows that for the majority of the indicators we have not hit the targets that have been set. We have achieved the targets for the two Before Schools Checks indicators and breast screening for Māori woman.

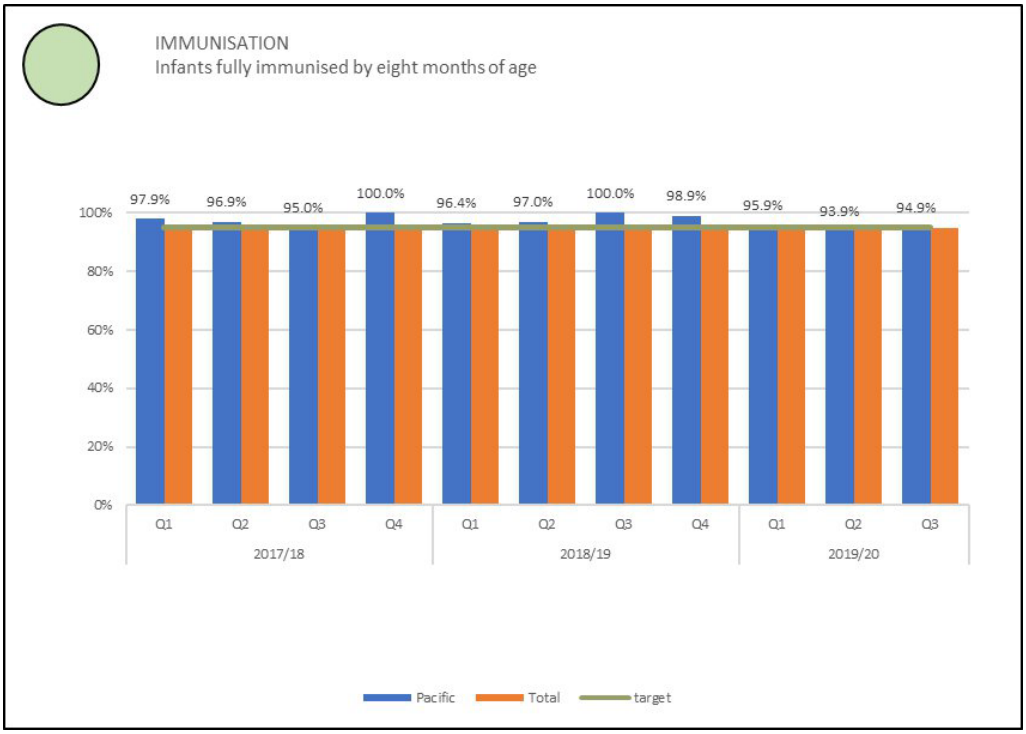
The remainder of the targets have either not been met or show significant inequity for Māori. However, despite not meeting the targets for many, the data does show reducing inequity and gains in areas such as cervical screening, HPV vaccination and PHO enrolment. It is vital that we are able to demonstrate progress towards the target and reducing inequity over a sustained period of time because it establishes that our changes at service and system level are making an impact on inequity. Alternatively, if data is unable to demonstrate a reduction in inequity over time, it is a signal to reassess and change.

Canterbury Pacific Health Dashboard Report, May 2020

Like the Māori dashboard, the Pacific dashboard shows that most of the targets have not been achieved but similarly we have achieved the targets for Before Schools Checks and PHO enrolment and additionally the targets for childhood immunisation and breastfeeding, smokefree two weeks post-natal have also been achieved. There are some interesting data trends in the Pacific dashboard. For example, the breast screening inequity has been slowly decreasing over time and despite not hitting the cervical screening target, there is no Pacific inequity; i.e. the rate of Pacific women being screened is actually higher than the total rate.

CDHB Children Immunised At Age 8 Months – May 2020





We have achieved this target with our Pacific children and there is no inequity at this stage for our Pacific children compared with the rest of the population. We have not achieved the immunisation target with our Māori children and there is inequity in immunisation rates, but it is very small, and we are very close to achieving equity and the target.

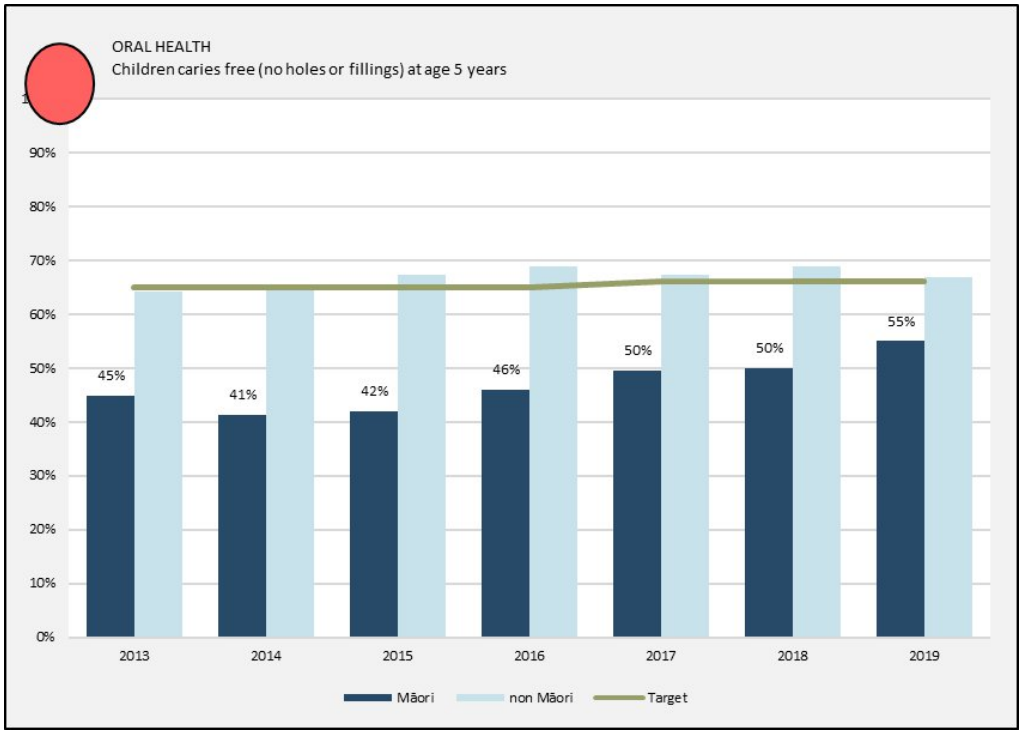
Our health system has developed an innovative new-born enrolment process. New-borns are now enrolled at birth with local child health services including Tamariki Ora, Well Child providers and general practice.

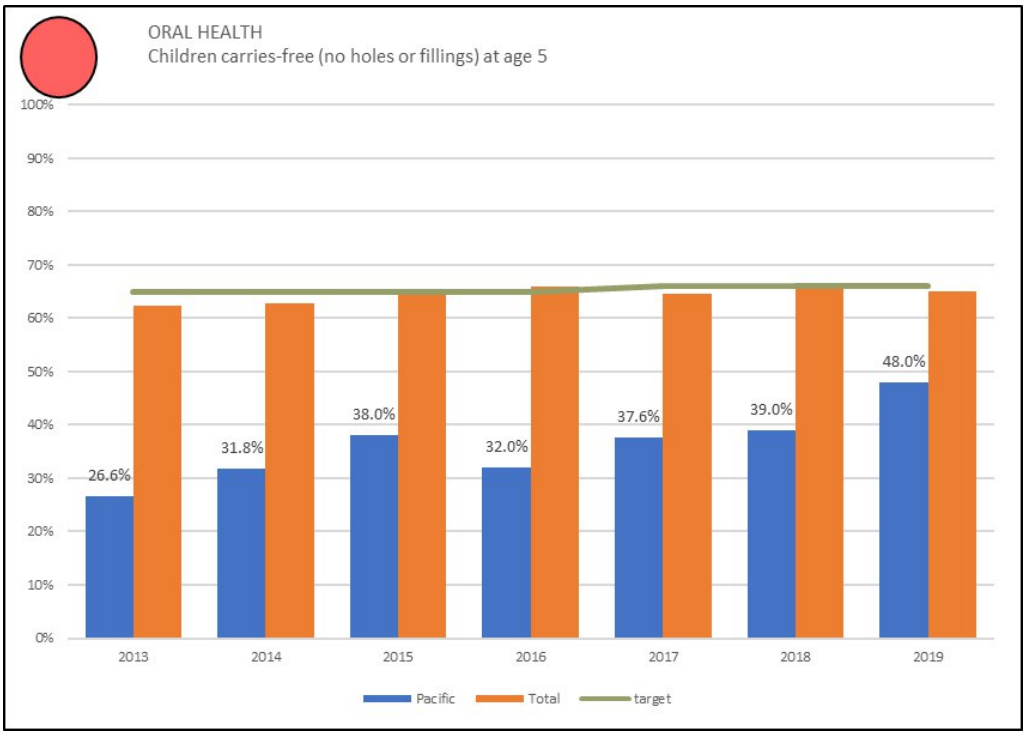
Our system has also developed a second innovation in this space, LinKIDs data sharing. LinKIDs brings together our data linking and tracking functions which enable follow-up of late attenders to routine immunisation services and allows us to liaise with whānau to help overcome barriers they may be experiencing. More info: https://www.cdhb.health.nz/health-services/linkids/

Outreach immunisation service can also go into homes if needed to support whānau and reduce barriers to immunisation.

We are doing reasonably well in childhood immunisation but because the cohort of children is continually changing, our system has to remain flexible to ensure we can maintain this level of performance.

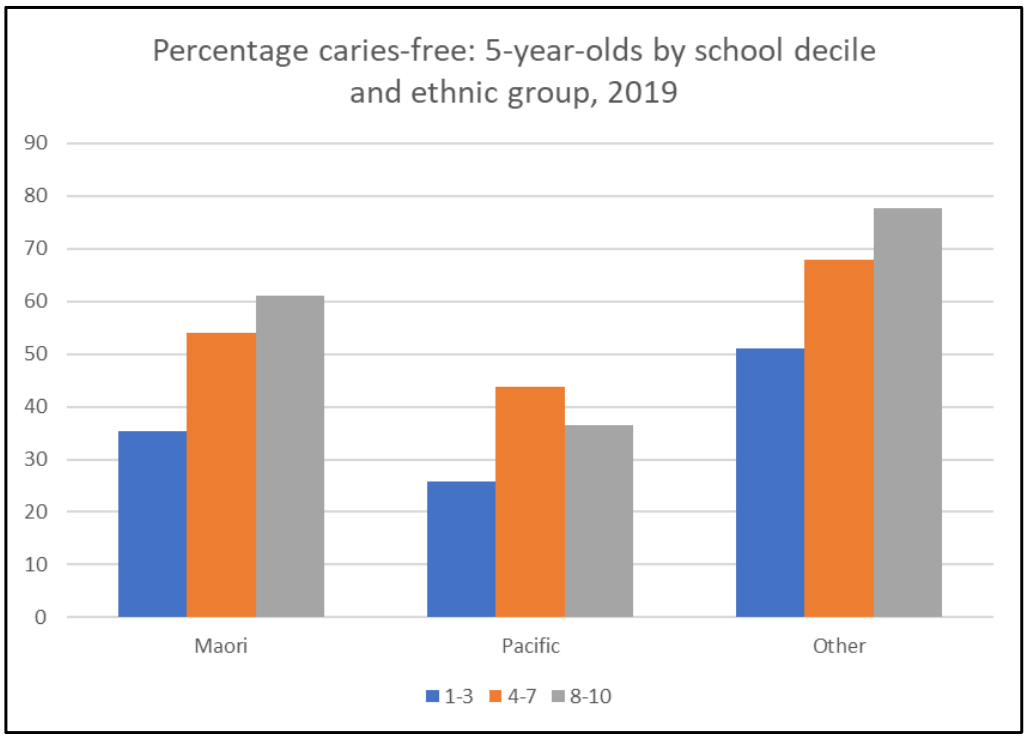
CDHB Children With Caries Free Teeth At Age 5 Years





This is an area where there is significant and prolonged inequity. Many of the things that impact on this measure are out of the control of the health system such as cost of and quality of food and drink that children consume. However, we can do better and need to find ways to address this persistent inequity for both Māori and Pacific Children.

On the optimistic side, there has been reduction in the inequity gap (10% for Māori and more than 20% for Pacific) since 2013 so we are making progress, but we have much work to do.



The graph above shows the profound impact that economic deprivation has on oral health. CDHB children in the lowest socioeconomic school deciles (poorest) had the most caries. Pacific children

had the most caries in teeth, followed by Māori (Caries = decayed teeth/ or decayed teeth treated with fillings).

The graph shows that the poorest children in the non-Māori, non-Pacific cohort still had fewer caries than all Pacific children and most Māori, regardless of decile.

What Are We Doing Well? Local Innovations

DHB community dental call centre hours have been increased to improve access for those that found normal hours a barrier.

Community Dental services have been progressively working on the cultural upskilling of oral health staff; e.g. increasing use of te reo Māori.

Improving ethnicity data quality by rechecking ethnicity as well as contact details, at routine appointments.

LinKIDs service for child health is helping to link new-born and child data with our oral health services so we can identify whānau that may have challenges in accessing services.

Issues Out Of Our Control

Lack of fluoride in local water supply. Fluoridation is the most effective way to reduce oral health inequities, especially for the most economically deprived. Fluoridation is safe and effective at usual water treatment dosages. There is currently a bill before parliament, which, if passed, would give the DHB boards power to determine fluoridation.

Fluoridation of water supply is the most effective way to reduce inequity. The science and the evidence for fluoridation continues to demonstrate over many decades the safety and efficacy of fluoridation. The data has been rigorously and independently reviewed and repeated in multiple countries throughout the world and locations with NZ, and the results repeatedly validate that fluoridation is safe and effective.

The data below summarises the differences between Māori and non-Māori with fluoridated and non-fluoridated water. Time and again, the evidence shows that Māori with non-fluoridated water (i.e. CDHB) have the greatest inequity and the worst outcomes. Fluoridation leads to approximately 40% reduction in tooth decay for children and the greatest impact is on the most economically deprived populations.

Fluoridation is effective and safe:

- Review by NZ Royal Society - colourless, tasteless, safe at usual water supply dosages (less than 1 part per million). https://www.health.govt.nz/our-work/preventative-health-wellness/fluoride-and-oral-health/water-fluoridation/effective-and-safe
- Sapere research independent review 2015 of fluoride: protects and remineralises early cavities; & is cost-effective, reducing hospitalisations & ED presentations (children, above table, from p 38 Sapere). https://www.health.govt.nz/system/files/documents/publications/review-benefits-costs-water-fluoridation-new-zealand-apr16.pdf
- Health (Fluoridation of Drinking Water) Amendment bill –would give fluoridation power to DHBs, status is stalled, before/ prior to a second reading in parliament. https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/00DBHOH_BILL71741_1/health-fluoridation-of-drinking-water-amendment-bill

The bottom line is that the single most effective tool we have for reducing inequity in oral health is to fluoridate our drinking water. The evidence says that this will also reduce hospital admissions and lead to significant savings.

Ethnic Inequalities In Oral Health By Fluoridation Of Water Supply: 5-Year-Old Māori Compared To Non-Māori

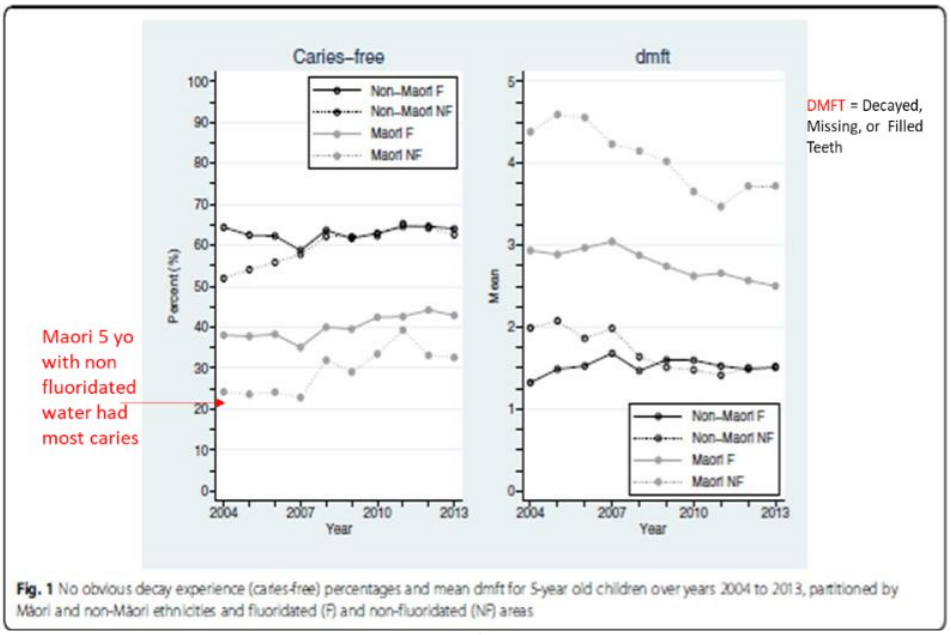
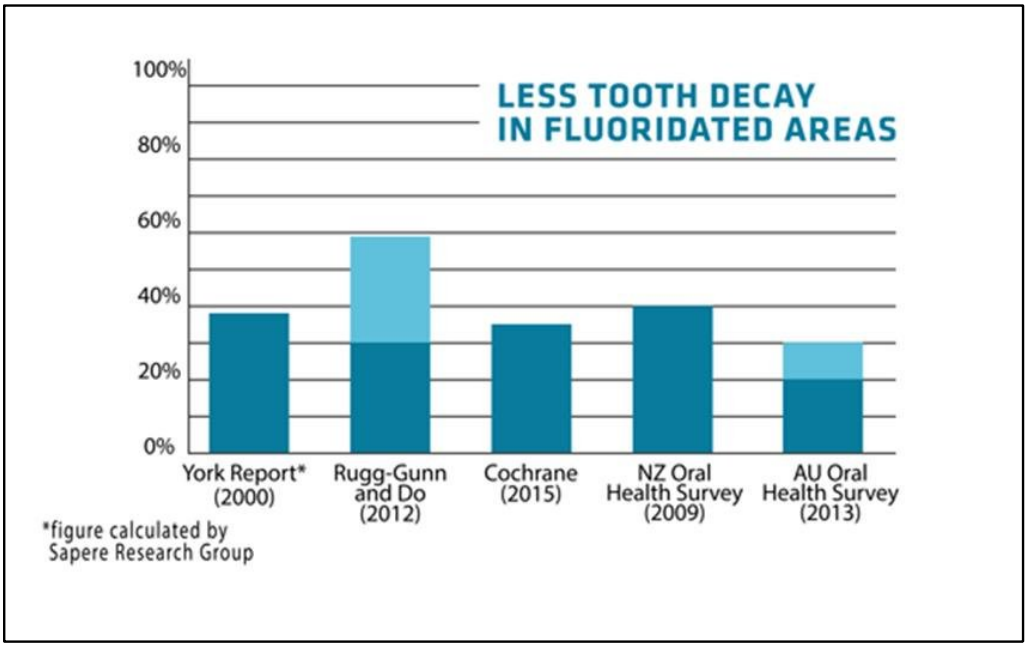


Fig. 1 No obvious decay experience (caries-free) percentages and mean dmft for 5-year old children over years 2004 to 2013, partitioned by Māori and non-Māori ethnicities and fluoridated (F) and non-fluoridated (NF) areas

Schluter and Lee BMC Oral Health (2016) 16:21 DOI 10.1186/s12903-016-0180-5



Sapere Research Group. (2015). Review of the Benefits and Costs of Water Fluoridation in New Zealand. Wellington: Ministry of Health. https://www.health.govt.nz/publication/review-benefits-and-costs-water-fluoridation-new-zealand

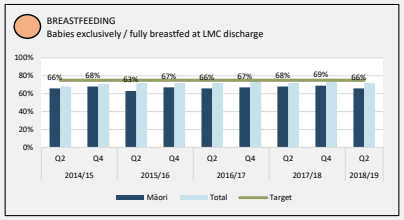
4. APPENDICES

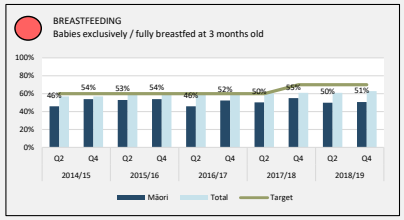
Appendix 1: Canterbury Māori Health Dashboard Report, May 2020.
Appendix 2: Canterbury Pacific Health Dashboard Report, May 2020.
Appendix 3: Equity Report PowerPoint Presentation – June 2020.

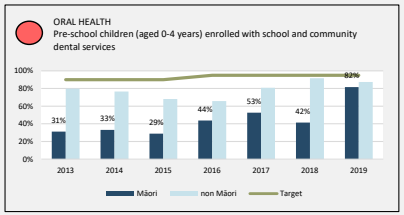
Canterbury DHB Māori Health Dashboard
May 2020

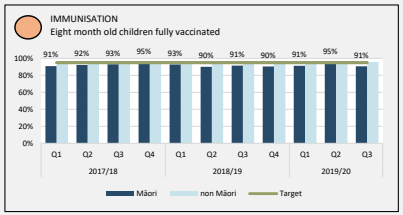
The target is met for Māori
The target has not been met for Māori
There is significant inequality between Māori and non-Māori / target health performance (greater than 10%)

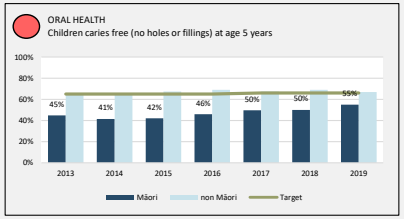
Tamariki Health and Wellbeing

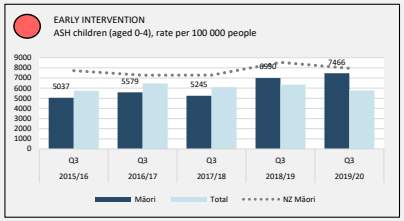


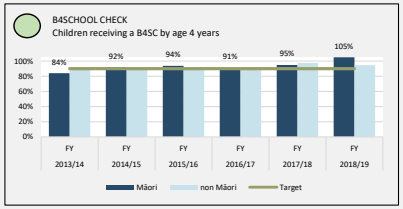


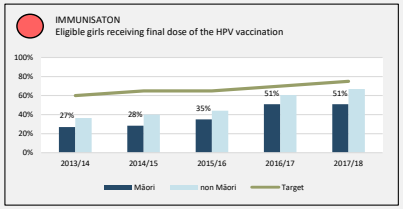




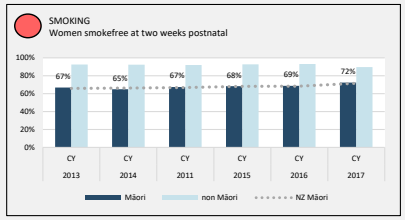


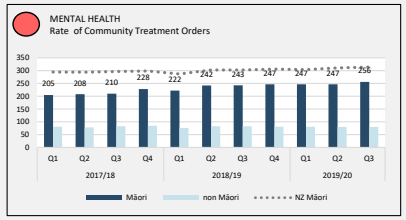


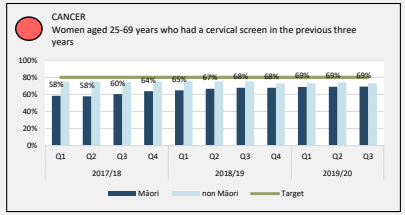


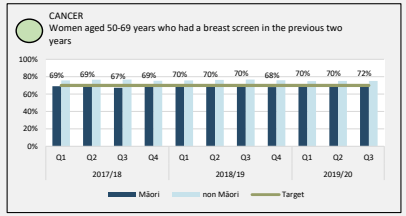


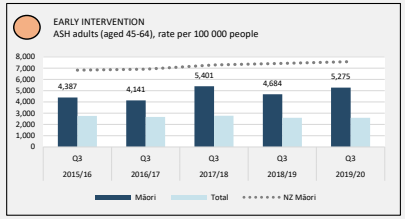
Adult Health and Wellbeing

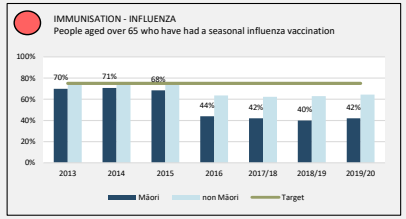




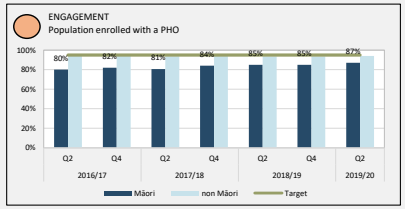


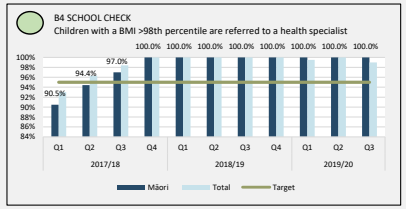






Enablers to support Improved Health and Wellbeing





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

Indicator Full Name	Data Source	Data Notes	Additional Notes
Infants are exclusively or fully breastfed at discharge from LMC	National Maternity Collection (MAT)	Data may be incomplete, LMC data is usually delayed. This may exclude data where records have no status	
Infants are exclusively or fully breastfed at three months	Well Child Tamariki Ora (WCTO) National Dataset	Well Child data for the latest period has been delayed by the Ministry.	
Percentage of Infants fully vaccinated at eight months	National Immunisation Register		
Children aged 0-4 years are enrolled with the Community Oral Health Service	Canterbury DHB Community Oral Health Service database "Titanium"	Results are provided annually in line with the school year. The next release is expected in March 2021	Due a change in calculation method Māori Oral health results for the 2018 year are not directly comparable with prior years. Results have been included as they are the nationally reported result.
ASH rates per 100,000 Children 0-4 years old	National Minimum Dataset (NMDS)		
B4SCs are started before children are 4½ years	B4 School Check		
Percentage of children caries-free for 5 years	Canterbury DHB Community Oral Health Service database "Titanium"	Results are provided annually in line with the school year. The next release is expected in March 2021	Due a change in calculation method Māori Oral health results for the 2018 year are not directly comparable with prior years. Results have been included as they are the nationally reported result.
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Percentage of Women Smokefree at two weeks postnatal	National Maternity Collection (MAT)	MAT data can take up to two years to show all events which may explain deviation between reports	
Population under Mental Health Act: section 29 Community Treatment Orders, rate per 100 000 population	Project for the Integration of Mental Health Data (PRIMHD)	Data is provided 3 months in arrears for each reporting quarter	
Women aged 25-69, who have had a cervical smear once in the last three years	National Screening Unit	Screening data has been recalculated retrospectively by the National Screening Unit, taking into account changes in ethnicity. We have elected at this time to maintain the results as reported at the time.	
Women aged 50-69, who have had a breast screen once in the last two years	National Screening Unit		
ASH rates per 100,000 Adults 45-64 years old	National Minimum Dataset (NMDS)		The result for ASH 45-64 has been given an orange rating as performance is significantly better than the national rate. Our expectation is to close the gap between Māori and non-Māori over time.
Percentage of population (65+years) who have had a seasonal influenza vaccination	National Immunisation Register	This measure has changed from using PHO enrolled population data to census population data. The reporting dates have changed from 2016, the reporting period now covers Mar- Sep where previously this was Jan-Dec. Results are not directly comparable between 2017 and previous years.	
Percentage of the population enrolled with a PHO	Canterbury DHB data Q2 onwards PHO Enrolment Collection		
Children with a BMI >98th percentile are referred to a health specialist	B4 School Check		

Canterbury DHB Pacific Health Dashboard
May 2020

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The target has not been met for Pacific
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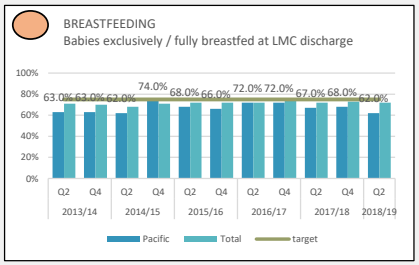

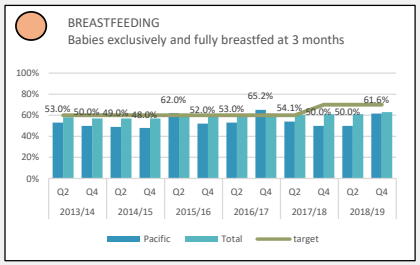

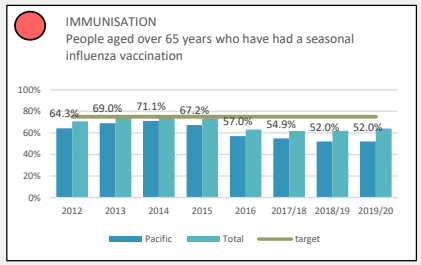

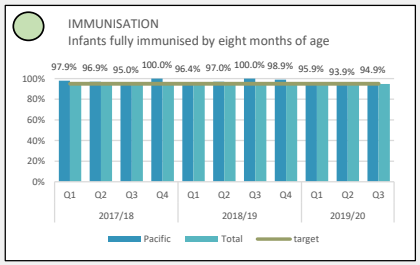

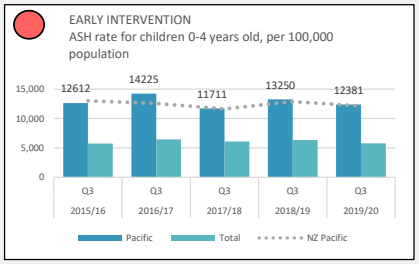

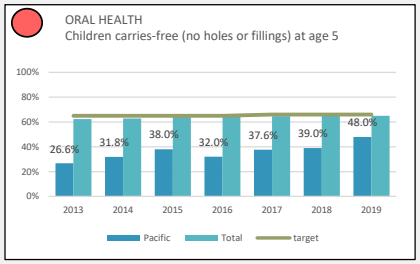

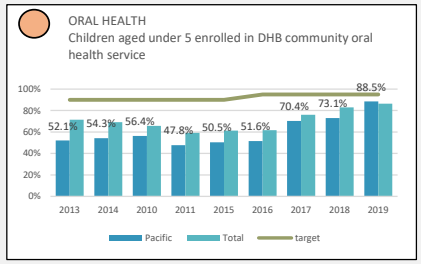

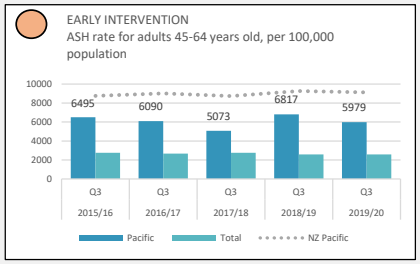

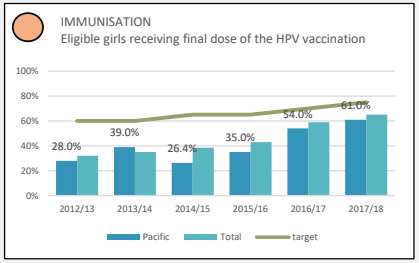

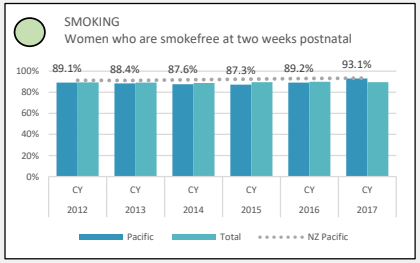

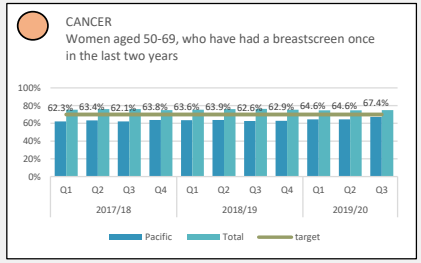

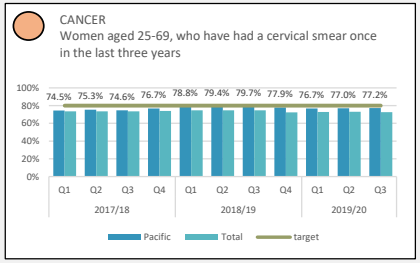

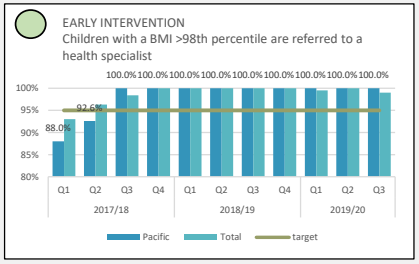

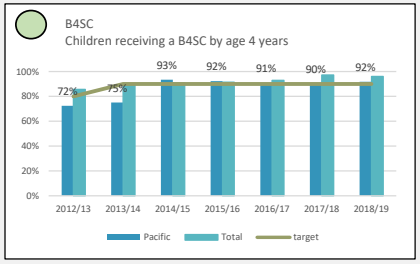

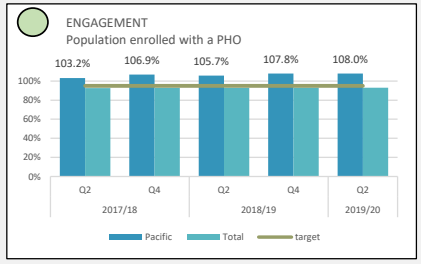

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Canterbury DHB
Māori & Pacific Health
Equity Report
June 2020
Hector Matthews

WHAT IS HEALTH EQUITY / INEQUITY ?

Ministry of Health's definition of equity

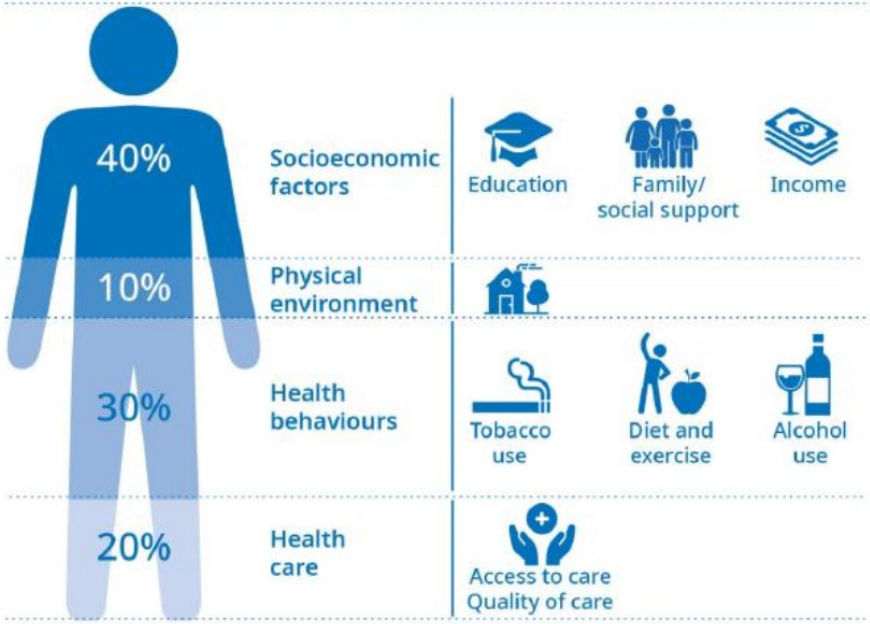
"In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes"

Health inequities = avoidable health inequalities or differences in health outcomes

HEALTH IS IMPACTED BY DETERMINANTS

SOME ARE FROM OUTSIDE THE HEALTH SYSTEM

Figure 4: The determinants of health and their relative contribution to our health outcomes



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

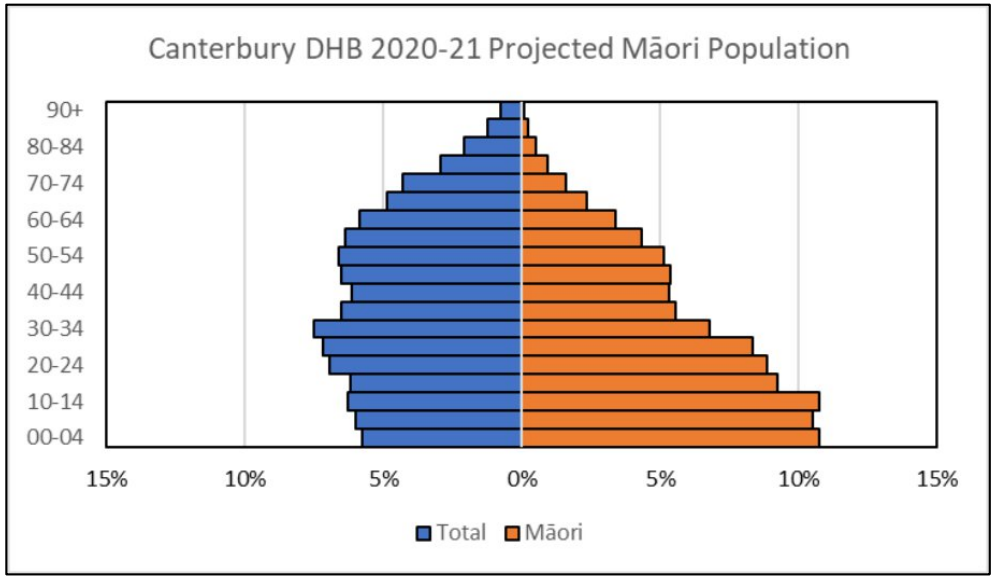
Ministry of Health. (2020). Health and Independence Report 2018. Wellington: Ministry of Health

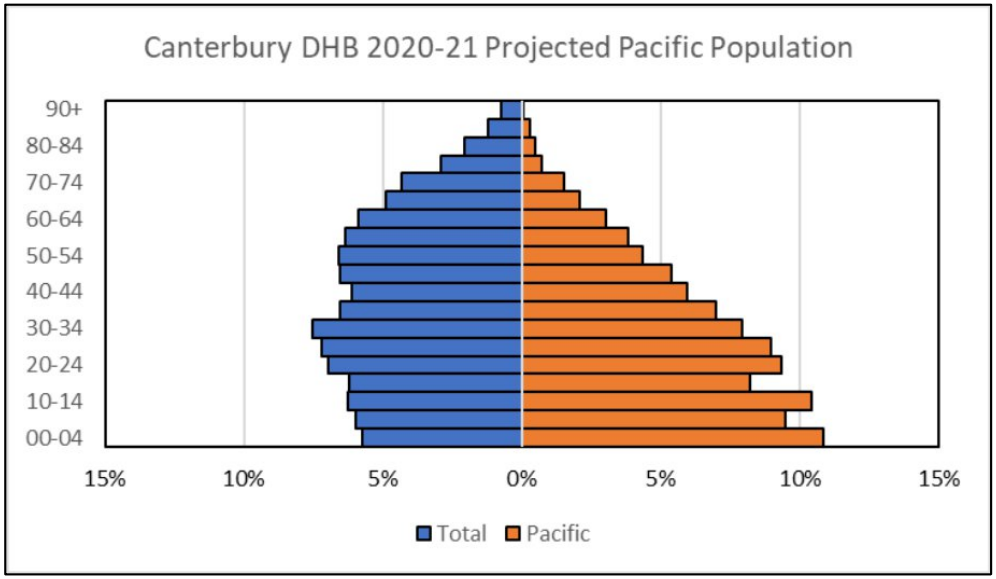
The factors affecting health are collectively known as the determinants of health. These can support or be barriers to good health and broader wellbeing

As shown in Figure 4, the determinants of health include

- Socioeconomic factors, such as income
- Physical environment, such as access to clean water
- Health behaviours, such as tobacco use
- Access to health care

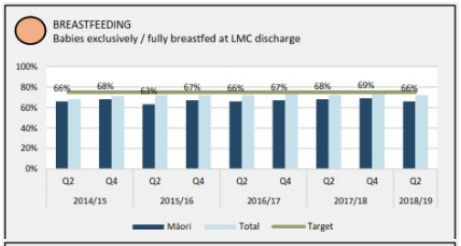
CDHB POPULATION PROJECTIONS 2020 - 2021

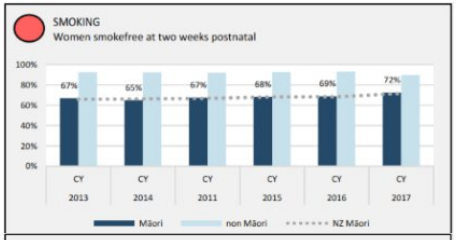


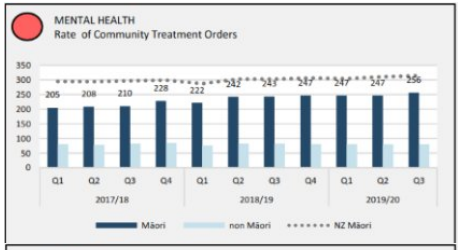


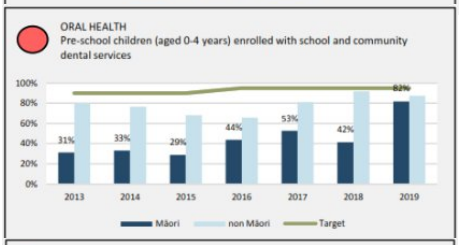
CANTERBURY DHB MĀORI HEALTH DASHBOARD

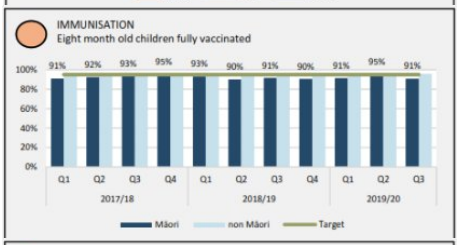
MAY 2020

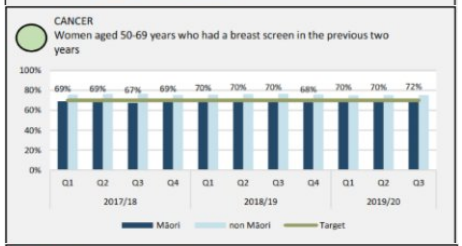


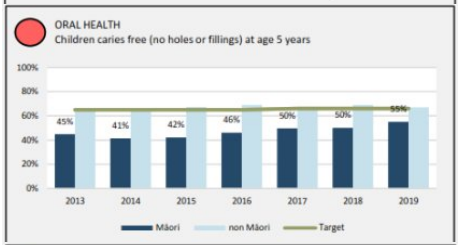


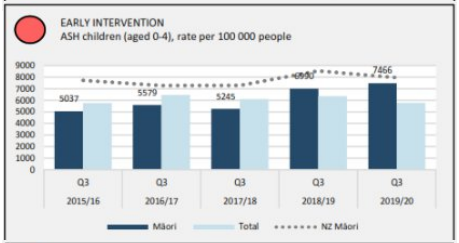


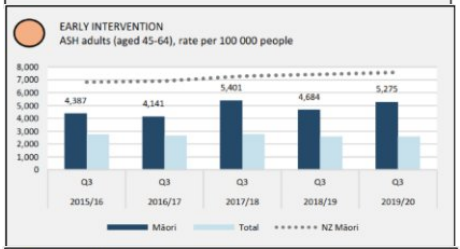


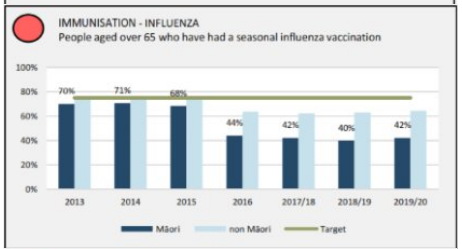


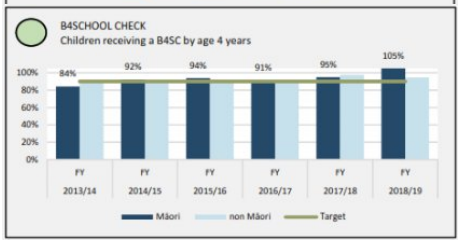


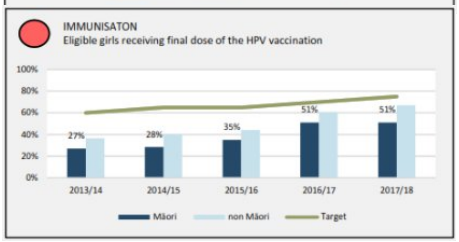


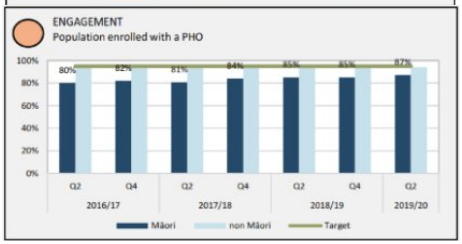


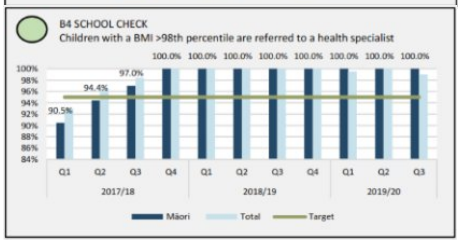












CANTERBURY DHB MĀORI HEALTH DASHBOARD
MAY 2020

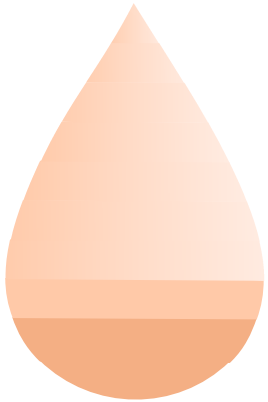
19%
Target met

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

2 B4 SCHOOL CHECK
Children receiving a B4SC by age 4 years

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

25%
Target not met



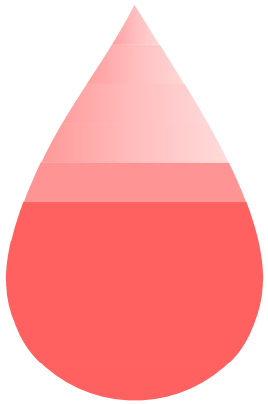
1 BREASTFEEDING
Babies exclusively / fully breastfed at LMC discharge

2 IMMUNISATION
Eight month old children fully vaccinated

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

4 ENGAGEMENT
Population enrolled with a PHO

56%
Significant inequality



8 MENTAL HEALTH
Rate of Community Treatment Orders

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

1 BREASTFEEDING
Babies exclusively / fully breastfed at 3 months old

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

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

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

5 IMMUNISATION
Eligible girls receiving final dose of the HPV vaccination

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

7 SMOKING
Women Smokefree at two weeks postnatal

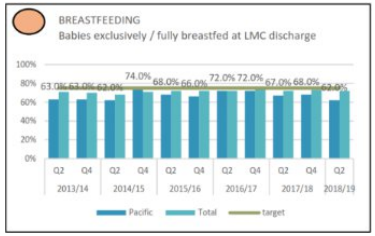
The target is met for Māori

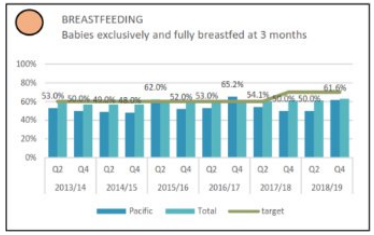
The target has not been met for Māori

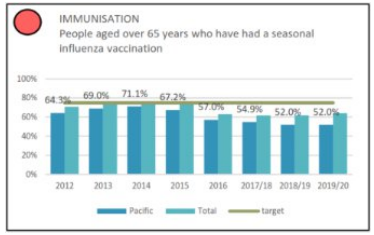
There is significant inequality between Māori & non-Māori / target health performance (greater than 10%)

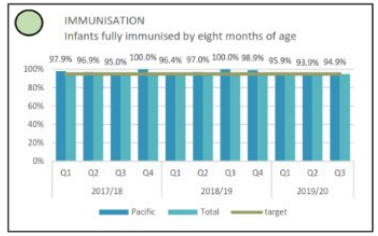
CANTERBURY DHB PACIFIC HEALTH DASHBOARD

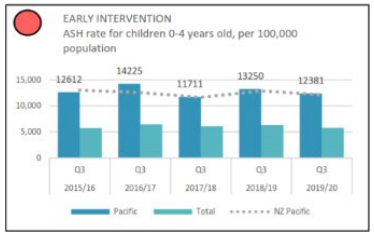
MAY 2020

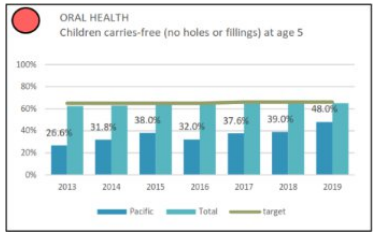


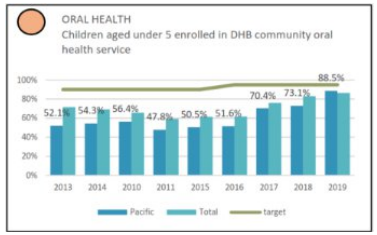


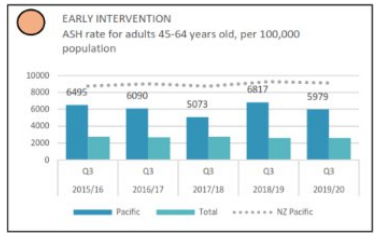


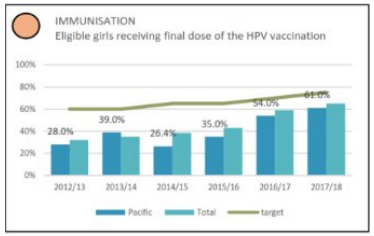


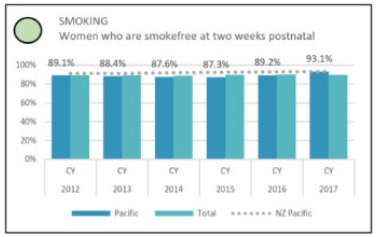


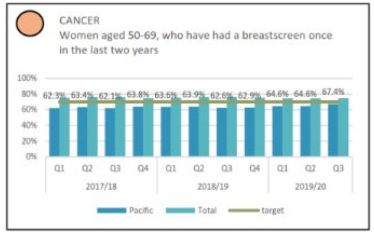


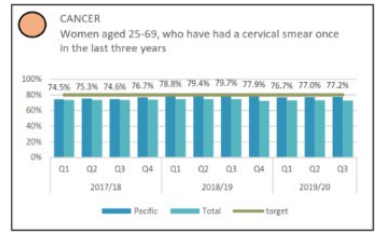


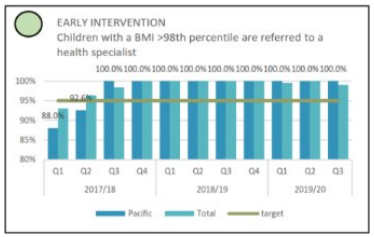


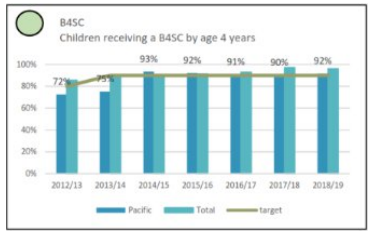


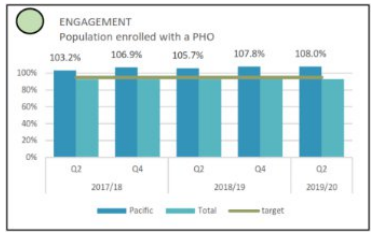












CANTERBURY DHB PACIFIC HEALTH DASHBOARD
MAY 2020

33%

Target met

1 IMMUNISATION
Infants fully immunised by eight months of age

2 SMOKING
Women Smokefree at two weeks postnatal

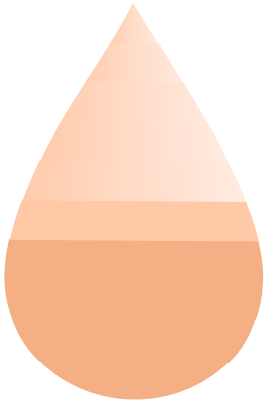
3 B4 SCHOOL CHECK
Children with a BMI >98th percentile are referred to a health specialist

4 B4 SCHOOL CHECK
Children receiving a B4SC by age 4 years

5 ENGAGEMENT
Population enrolled with a PHO

47%

Target not met



1 BREASTFEEDING
Babies exclusively / fully breastfed at LMC discharge

2 BREASTFEEDING
Babies exclusively / fully breastfed at 3 months old

3 IMMUNISATION
Eligible girls receiving final dose of the HPV vaccination

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

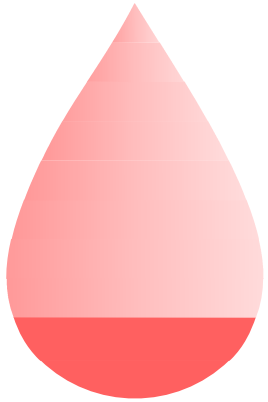
5 CANCER
Women aged 50-69 years who had a breast screen in the previous two years

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

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

20%

Significant inequality



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

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

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

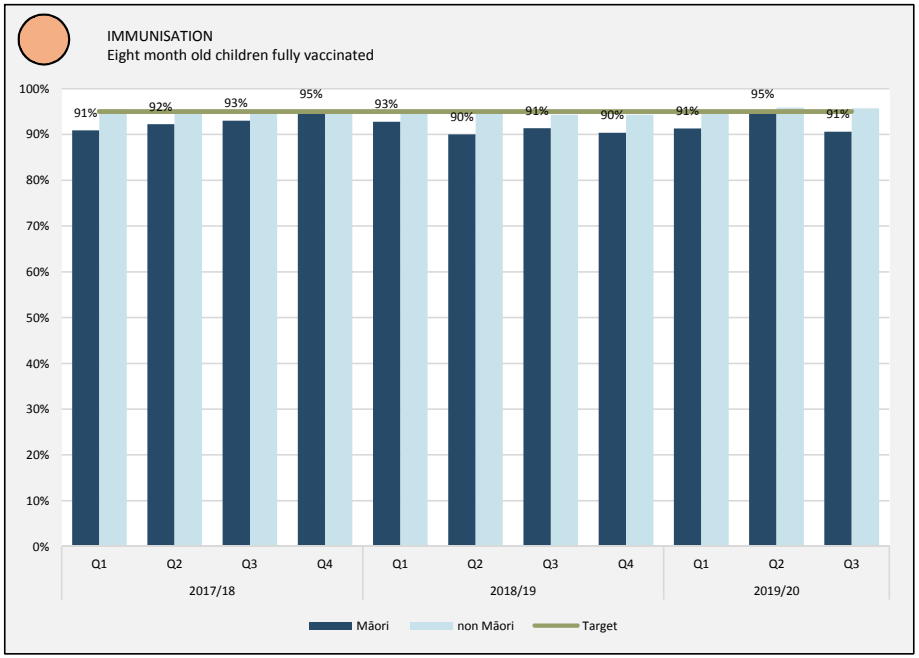
The target is met for Pacific

The target has not been met for Pacific

There is significant inequality between Pacific & non-Pacific / target health performance (greater than 10%)

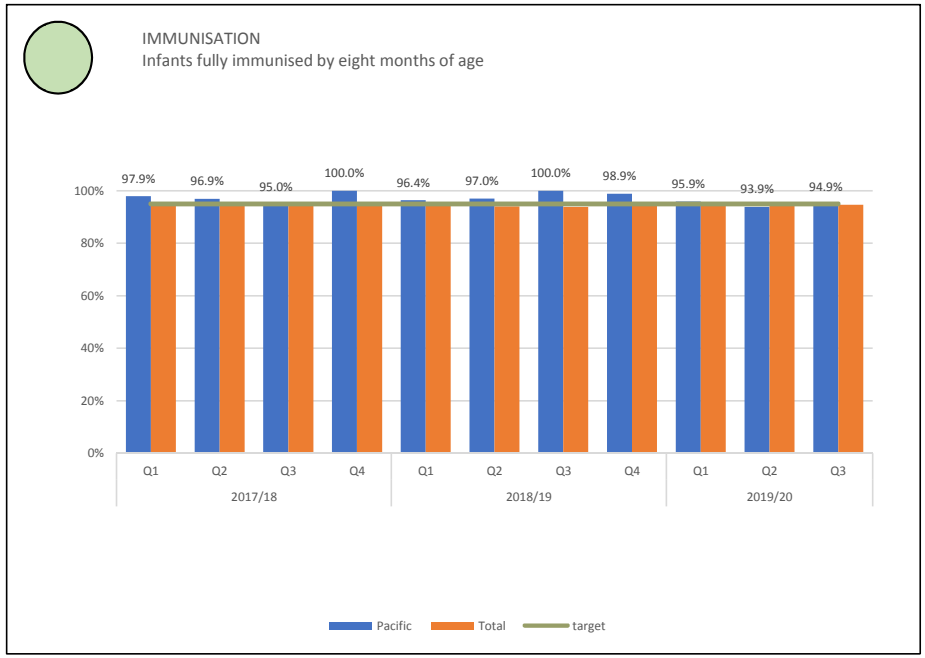
CDHB CHILDREN IMMUNISED AT AGE 8 MONTHS
MAY 2020

Māori children



The target has not been met for Māori

Pacific children



The target is met for Pacific

CDHB CHILD IMMUNISATION

Our health system has developed innovative processes

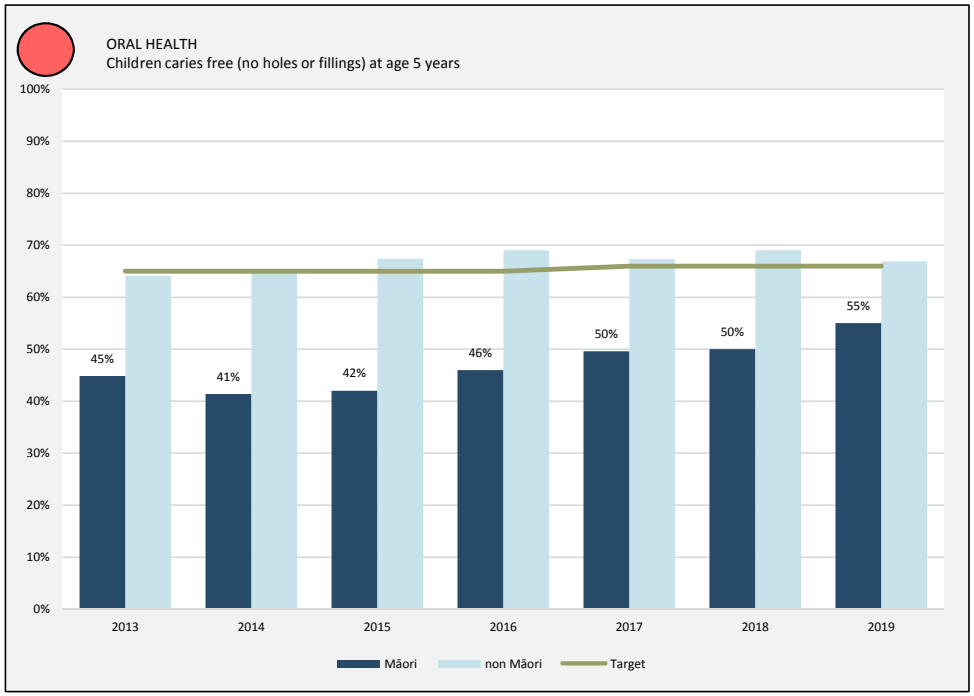
New-borns are now enrolled at birth with local child health services including Tamariki Ora, Well Child providers and General Practice

LinKIDS helps connect families to health services in Canterbury and enables data sharing and tracking functions to follow up late attenders to routine immunisation services and to liaise with whānau to overcome barriers

Outreach immunisation services that can go into homes to support whānau and reduce barriers to immunisation

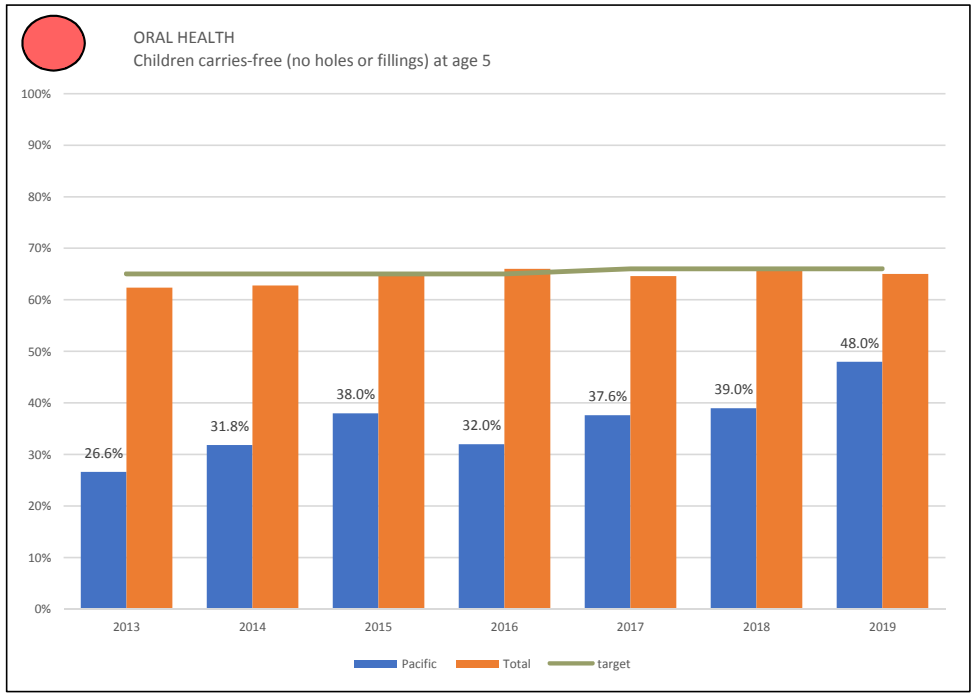
CDHB CHILDREN WITH CARIES FREE TEETH
AT AGE 5 YEARS

Māori children



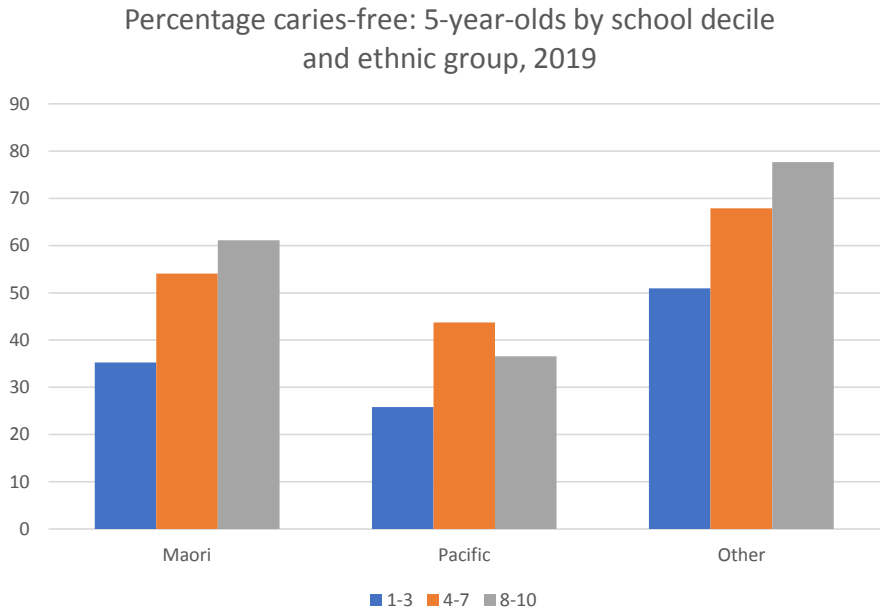
There is significant inequality between Māori and non-Māori / target health performance (greater than 10%)

Pacific children



There is significant inequality between Pacific and non-Pacific / target health performance (greater than 10%)

5 YEAR OLDS' CARIES-FREE STATUS IN CDHB
BY SCHOOL DECILE



Data: Dr M Lee

CDHB children in the lowest socioeconomic school deciles (poorest) had the most caries

Pacific children had the most caries in teeth, followed by Māori

The graph shows that the poorest children in the non-Māori, non-Pacific cohort still had fewer caries than all Pacific children and most Māori, regardless of decile

Caries = decayed teeth or decayed teeth treated with filings

CDHB CHILD ORAL HEALTH

What are we doing well – local innovations

- DHB community dental call centre hours increased
- Cultural upskilling of oral health staff
- Rechecking ethnicity at routine appointments to ensure accurate data
- LinKIDS linkage service for child health

Issues / barriers – within our control

- Capturing correct ethnicity data
- Opening hours of oral health services – trying to increase

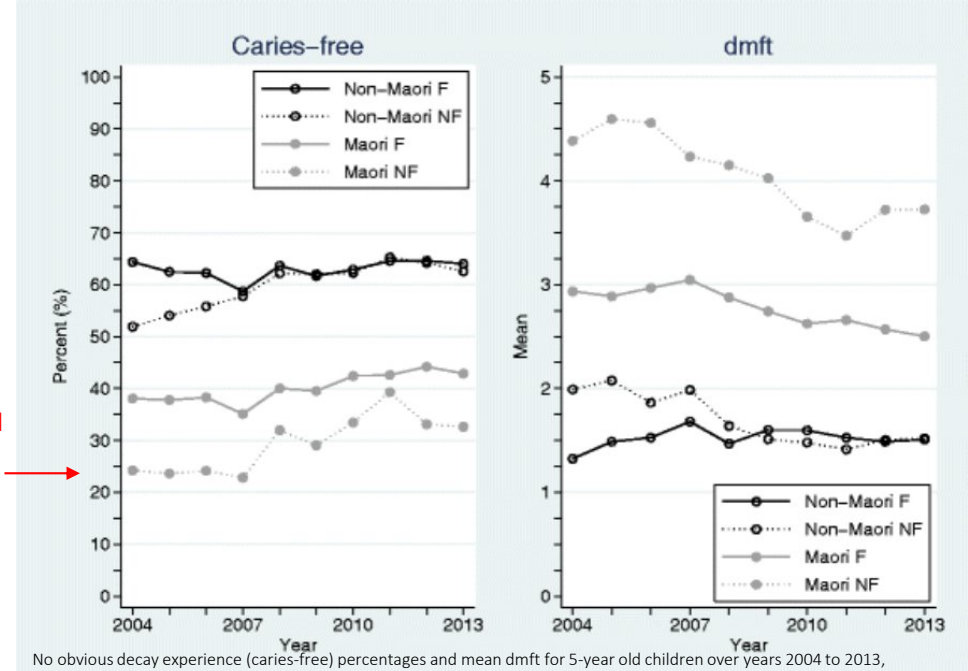
Issues out of our control

- Lack in fluoride in local water supply. Fluoridation is the most effective way to reduce oral health inequities, especially for our most socioeconomically deprived
- Fluoridation is totally safe at usual water treatment dosages
- Bill is before parliament – this would give the DHB board's power to determine fluoridation

BENEFITS OF FLUORIDATION

Ethnic inequalities in oral health by fluoridation of water supply
5 year old Māori compared to non-Māori

Māori 5 years with non fluoridated water had the most caries



No obvious decay experience (caries-free) percentages and mean dmft for 5-year old children over years 2004 to 2013, partitioned by Māori and non-Māori ethnicities and fluoridated (F) and non-fluoridated (NF) areas

Schluter and Lee BMC Oral Health (2016) 16:21
DOI 10.1186/s12903-016-0180-5

DMFT – Decayed, Missing, or Filled Teeth

Fluoridation leads to approx 40% reduction in tooth decay for children

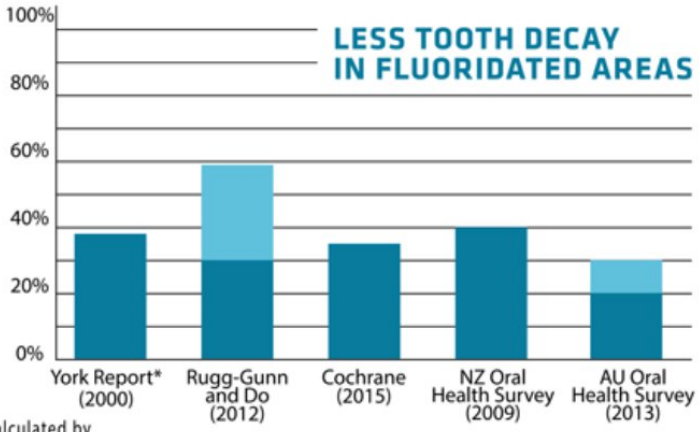


*figure calculated by Sapere Research Group

Sapere Research Group (2015). Review of the Benefits and Costs of Water Fluoridation in New Zealand. Wellington: Ministry of Health

FLUORIDATION IS EFFECTIVE AND SAFE

Review by NZ Royal Society

Colourless, tasteless, safe at usual water supply dosages (less than 1 part per million)

Sapere research independent review 2015 of fluoride

Protects and remineralisers early cavities & is cost-effective, reducing hospitalisations & ED presentations (children, table attached, from p 38 Sapere)

Health (Fluoridation of Drinking Water) Amendment bill

Would give fluoridation power to DHBs, status is stalled, before/prior to second reading in parliament

	Without fluoridation	With fluoridation	Difference
Admissions	3,800	2,000	1,800
Costs	$7.4m	$3.8m	$3.6m

Estimated annual impact of water fluoridation on hospitalisation to treat dental decay in tamariki aged 0 to 4

He pātai

Any questions

Nā Hector Matthews

CPH&DSAC – 2 JULY 2020

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: **Jo Kane, Chair, Community & Public Health and Disability Support Advisory Committee**

DATE: **16 July 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Community & Public Health and Disability Support Advisory Committee's (*CPH&DSAC*) meeting held on 2 July 2020.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from CPH&DSAC's meeting on 2 July 2020 (Appendix 1).

3. APPENDICES

Appendix 1: CPH&DSAC Draft Minutes – 2 July 2020.

MINUTES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 2 July 2020 commencing at 1.00pm

PRESENT

Jo Kane (Chair); Aaron Keown (Deputy Chair); Catherine Chu; Naomi Marshall; Gordon Boxall; Tom Callanan; Yvonne Palmer; and Sir John Hansen (Ex-officio).

APOLOGIES

Apologies for absence were received and accepted from Sally Buck; Rochelle Faimalo; and Gabrielle Huria.
An apology for early departure was received and accepted from Sir John Hansen (2.00pm).

EXECUTIVE SUPPORT

Evon Currie (General Manager, Community & Public Health); Jacqui Lunday Johnstone (Director of Allied Health, Scientific & Technical); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES

David Meates and Carolyn Gullery

IN ATTENDANCE

Full Meeting
Allison Nichols-Dunsmuir, Health In All Policies Advisor
Kathy O'Neill, Team Leader, Primary Care

Item 4
Lucy D'aeth, Public Health Specialist
Sue Turner, Public Health Manager

Item 5
Dr Ramon Pink, Medical Officer of Health

Items 6 & 7
Grant Cleland, Chair, Disability Steering Group

Jo Kane, Chair, opened the meeting welcoming all present.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register

Catherine Chu:	Bank of New Zealand – delete
	Keep Christchurch Beautiful - delete
Aaron Keown:	Christchurch City Council, Chair of the Disability Issues Group – addition.
Yvonne Palmer:	Canterbury Community Justice Panels - delete
	Canterbury Justice of the Peace Association Incorporated – delete
	Styx Living Laboratory Charitable Trust - delete

There were no other additions/alterations to the interest register.

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

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

2. CARRIED FORWARD / ACTION LIST ITEMS

The carried forward action list was noted.

3. UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES AND THE CANTERBURY DISTRICT HEALTH BOARD

Allison Nichols-Dunsmuir, Health In All Policies Advisor, presented to the Committee on the UN Convention on the Rights of Persons with Disabilities (*UN Convention*) and the CDHB. The presentation highlighted the following:

- The Convention
- Article 1 - Purpose of the Convention
- What is Disability
- The Convention and the CDHB
- Article 25 – Health
- Article 26 – Habilitation and Rehabilitation
- Article 9 – Accessibility
- NZ Health & Disability Sector

Discussion took place on the following:

- The difference between habilitation and rehabilitation
- Differing standards country to country
- Building Code versus best practice Building Code
- Employment and equity in society
- Need for greater consultation to ensure all people have access to equipment and facilities
- Greater education for primary care facilities

A member noted that the UN Convention is the benchmark that we need to meet so anything we can contribute is important. The refreshed action plan will be built up against the UN Convention. It will be interesting to see the result of New Zealand's assessment due to be held later in the year, and whether the independent monitoring mechanism is as supportive as it has been in the past.

Ms Jacqui Lunday Johnstone, Executive Director, Allied Health, Scientific & Technical, advised that the UN Convention is a good guide for CDHB, but is not a directive - there is no requirement for countries to do things specifically. We are well aware of the differentials between building to code, what we are required to do, and what actually makes a difference for people with a variety of disabilities. There are competing challenges. There are all sorts of tensions hidden in what we are required to do as opposed to what we might like to do. Some of those are financial. Where we have facilities that are less than optimal by modern standards what we might need to do to them may be prohibitive financially. The Accessibility Group is working through a process to be proactive and upstream in the co-design component when commissioning projects, before they start, or with any future fitout of a new facility. The requirement to be involved at the earliest possible stage in the project is important. Another

important component is the involvement of people with lived experience of disability in helping to influence why we have to do things in a particular way.

Ms Lunday Johnstone further noted that as a public sector, we should be an exemplar of employing people with disability. Project Search whilst great, is one project. People & Capability are starting to look at the learnings taken from Project Search and how this can be moved forward into the business, along with removing unintentional barriers to employment.

The Committee requested an update from People & Capability on progress against the CDHB's Diversity, Inclusion and Belonging Policy, to include what is working well and where there are gaps.

4. COVID-19: POPULATION WELLBEING UPDATE

Lucy D'aeth, Public Health Specialist; and Sue Turner, Public Health Manager, presented the COVID-19 Population Wellbeing Update. The presentation highlighted the following:

- Statutory requirement under the Civil Defence Legislation to lead psychosocial recovery. There are nine sub-functions of welfare, of which psychosocial support is one. The Ministry of Health leads it nationally, and DHBs lead locally.
- National Psychosocial Plan
- COVID-19 Psychosocial and Mental Wellbeing Recovery Framework
- Conditions for mental wellbeing
- Pae Ora Framework
- Local initiatives gone national – Getting Through Together; Sparklers At Home; and Reconnect

Sir John Hansen retired from the meeting at 2.00pm.

There was discussion on the following:

- Importance of language and messaging
- Accessible messaging for the young, old, and rural sector
- Vulnerability of middle-aged men and identity issues
- The role of social media and TV
- Measuring success of the recovery plan

It was noted that the psychosocial plan is being designed for an 18 month period. At this stage, funding for the campaign is in place until the end of September 2020.

The Committee acknowledged the work being undertaken. A member noted that some families are having earthquakes every week and some families are having COVID-19 (or the equivalent) every week. Any support to a trauma informed way of practicing, teaching or parenting has to be a good thing.

There was discussion around why society waits for major events to occur before we start to talk to people about how we can become stronger emotionally and how we can be more resilient. Such discussions need to be normalised.

5. FUTURE OPERATIONAL PLAN

Evon Currie, General Manager, Community & Public Health, referenced a document that Mayor, Lianne Dalziel presented to the Christchurch City Council (*CCC*) at its meeting on 25 June 2020. The paper was about leading Christchurch COVID-19 recovery. CDHB has strong linkages and partnerships with CCC. CCC and CDHB are both partners in the Greater Christchurch Partnership. The Greater Christchurch Partnership is Environment Canterbury, CCC, Waimakariri, Selwyn, CDHB, Ngai Tahu, and the NZ Transport Agency. The paper talked a lot about the Greater Christchurch Partnership. It talked an incredible amount about Public Health approaches – breaking down silos within our organisations and between them; the repositioning of our city; the four wellbeing pillars (social, economic, environmental and cultural); promoting equity, valuing diversity and fostering inclusion. Talked a lot about collaboration, employment, home ownership, education, enabling communities and enterprises to be self-sufficient and adaptive.

Ms Currie noted that the Council is a member of the Canterbury Psychosocial Committee, an interagency group that came into existence in September 2010 to plan, coordinate, promote and monitor the psychosocial recovery and wellbeing of the population of greater Christchurch. The Committee focuses on identifying emerging or ongoing wellbeing issues and how to address them. The Committee is convened by Community & Public Health (*CPH*) and includes the Mental Health Education Centre, MSD, MOE, Red Cross, Te Puni Kokiri, Ministry of Pacific Peoples, and the University of Canterbury. It is important to draw on the expertise, capability and resource of the Committee and its members organisations.

Ms Currie advised that it is very encouraging that our Council is so connected to what is fundamentally public health ways of operating and thinking. Sometimes we can almost forget that the promotion and protection of health is also the mandate for the DHB. We often become so overwhelmed by the demands of the public health service delivery model that we can forget the bigger picture. The world in which our communities are born, live, work and play are accountable for the wellbeing of our communities. Ms Curried noted that we are working in a very good manner with our partners and we should always be encouraging those linkages and strengthening them.

In terms of the Future Pathway for CPH, Ms Currie advised that we have not got that sorted yet as it is not the right time to sort it. We need to be on a journey – a journey with our local authorities, with all state sector enterprises, working together. Our future will be dictated by that type of collaborative and overarching health determinants approach.

COVID-19 has given us the chance to stop and think and relook at what is needed. In terms of the day to day reality of what we are involved in, that is very operational and very busy. We are not doing much about future planning. We are really focused on creating the response (Uplift Plan) for a potential second wave outbreak of COVID-19.

Dr Ramon Pink, Medical Officer of Health, addressed the Committee providing an update on work underway in relation to being prepared should a second wave eventuate. Three areas being focused on are the border; managed isolation and quarantine facilities; and the Uplift Plan as referenced by Ms Currie.

The border includes Air and Port. With Air we are looking at different types of flights:

- International flights that are either charter or commercial.

- Bridging flights, where passengers arrive in Auckland, go through boarder processes and a health check, then come down to Christchurch. Christchurch is the second biggest catcher of inbound travellers from overseas.

Operational functions include being there for bridging flights, looking at PPE and the like. For the international flights we have to do the health checks and then assist travellers to managed facilities.

Management of isolation and quarantine facilities involves a multi-agency response - Defence, DHB, Public Health, Primary Care - working together with very short notice to get things organised.

Dr Pink spoke about the Uplift Plan. Planning has been underway for a while now for a second wave of up to 1,000 cases per day. This modelling was done three months ago. It requires all Public Health Units around the country to be able to case investigate and contact trace a number of cases as reported to the population we serve. For CPH this is three regions – West Coast, South Canterbury, and Canterbury. This requires the ability to case investigate up to 67 new cases per day and the associated contacts that have been identified with those, which could be anywhere between 20 and 40 contacts per case. This is a significant challenge. Resourcing of this is very challenging and we are working closely with People & Capability to assist in identifying people to do that. It is not easy to try and engage people with something that might not happen.

Dr Pink advised that the Port is a challenging area. There have been changes to requirements for those travelling to New Zealand by vessel. They must now be in New Zealand waters for 14 days before they can leave their vessel. This is going to create some challenges, which are being worked through with the MoH.

In response to a query around testing, Dr Pink advised that currently all travellers who come into our facilities get tested at Day 3 and Day 12. Further, for those close contacts, in addition to Day 3 and Day 12 testing, they also receive testing on Day 6.

There was a query on the potential strain on hotels and infrastructure to support people, given the number of returning travellers to New Zealand. Dr Pink advised that this process is going to be happening for the next 18 months to two years at least. A lot of the folk coming in are on chartered flights and it is important to ensure that the numbers coming in are able to be managed in quarantine. This will be closely monitored.

The meeting moved to Item 7.

7. COVID-19: ISSUES AND ACTIONS IDENTIFIED BY MEMBERS OF THE DISABILITY STEERING GROUP

Ms Kane welcomed Grant Cleland, Chair, Disability Steering Group (*DSG*).

Kathy O'Neill, Team Leader, Primary Care, advised it was the DSG itself, which after standing down for two meetings, wanted to focus on capturing issues that they had known about or experienced themselves during the COVID-19 Levels 2-4 period. The diversity of the group became the opportunity to understand the impact within the DHB. In response to the issues raised, proposed actions have been identified. Ms O'Neill noted the intention for the issues raised to be circulated wider.

Mr Cleland highlighted issues raised in the paper, both positives and negatives.

There was discussion around the importance of telling it as it is and the need to be open about it. It was also noted that responsibility does not just sit with the DHB, the community has a role to play as well. How we use this community, which has such diversity and expertise in the room, to be able to channel that energy and effort, and communicate it in a way through that single point of contact seems to be one of the key things coming through.

The Committee noted the content of the paper as a record of the issues raised by DSG members about the experience of disabled people during the period of COVID-19 Levels 2 -4; and noted that CPH&DSAC will receive updates on progress against the proposed actions via DSG.

The meeting moved to Item 6.

6. TRANSALPINE HEALTH DISABILITY ACTION PLAN

Ms Lunday-Johnstone introduced this report noting that it is the next step in consolidating the DHBs approach. The Transalpine Health Disability Acton Plan (the *Plan*) is in the process of being refreshed and this is being done in partnership with the DSG.

Kathy O'Neill, Team Leader, Primary Care, advised new members that this is the next phase. We have been building a foundation over the last few years on all of the actions and objectives contained within the Plan. The workplan is an addition under the Plan, to make it more transparent and more accountable in terms of what we are working on and achieving at any point in time. It also identifies which area in the DHB holds responsibility for progressing each of the actions. It is a big piece of work and cannot sit with one particular area – it is across both DHBs. Whilst we have reported on the Plan before in a similar way, we have not had such a specific workplan that is a living part of the document.

Ms O'Neill highlighted the addition of aligning the Plan with Whanau Ora. Enabling Good Lives and our commitment to equity and the Treaty is at the front of the Plan. This is an important and valuable addition that shows how we have moved in the last three years.

Gordon Boxall retired from the meeting at 3.15pm.

The Committee noted this was a good piece of work. Implementation will be key. Ms O'Neill advised that the workplan will come back to the Committee regularly as actions are progressed.

A member raised the point that babies/antenatal – early life focus – was not well represented in the Plan. Ms O'Neill undertook to give further consideration to this area.

Ms O'Neill highlighted that an Accessible Information Working Group has been started. A paper will be coming to a future meeting seeking endorsement of the Accessibility Information Charter, a national document.

The Committee noted the report.

INFORMATION ITEMS

- Notes from Informal Meeting – 5 March 2020
- CPH&DSAC Terms of Reference
- Disability Steering Group Minutes - 28 February 2020
- 2020 Workplan

GENERAL BUSINESS

There was a request for a report on End of Life Care – an overview, access to funding, and impacts of any changes.

There being no further business the meeting concluded at 3.30pm.

Confirmed as a true and correct record:

_____ _____

Jo Kane
Chair

Date of approval

CPH&DSAC MEETING 2 JULY 2020
ACTION NOTES

Clause No		Action Points	Staff
	Apologies	Sally Buck; Rochelle Faimalo; and Gabrielle Huria – for absence. Sir John Hansen – for early departure (2.00pm)	Anna Craw
1.	Interest Register	Catherine Chu • Bank of New Zealand – delete • Keep Christchurch Beautiful - delete Aaron Keown • Christchurch City Council, Chair of the Disability Issues Group – addition. Yvonne Palmer • Canterbury Community Justice Panels - delete • Canterbury Justice of the Peace Association Incorporated – delete • Styx Living Laboratory Charitable Trust - delete	Anna Craw
2.	Carried Forward Items	Nil	
3.	UN Convention on the Rights of Persons with Disabilities and the CDHB	People & Capability to report on progress against the CDHB's Diversity, Inclusion and Belonging Policy, to include what is working well and where there are gaps. Also learnings from Project Search and how these are being moved into the business, as well as work around the removal of unintentional barriers to employment. **Report to 3 September 2020 meeting – report due to Anna Craw on 24 August 2020.**	Tyler Brummer / Michael Frampton
4.	COVID-19: Population Wellbeing Update	Nil	

5.	Future Operational Plan	Nil	
6.	Transalpine Health Disability Action Plan	Further consideration be given to "early life focus" in the Plan (ie, antenatal/babies).	Kathy O'Neill
7.	COVID-19: Issues and Actions Identified by Members of the Disability Steering Group	Nil	
	Info Items	Nil	
	General Business	Report on End of Life Care – overview, access to funding, and impacts of any changes. **Report to 3 September 2020 meeting – report due to Anna Craw on 24 August 2020.**	Kathy O'Neill

Distribution List:
Michael Frampton
Tyler Brummer
Kathy O'Neill

CC. Sarah Connell

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: **16 July 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 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 18 June 2020	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues (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)
4.	Seismic Monitoring System, Christchurch Hospital Campus	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	2020/21 Planning Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	2020/21 Capital Intention	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
9.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
10.	Advice to Board: • QFARC Draft Minutes *30 June 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.