Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

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25 March 2022

9(2)(a) [redacted]

RE Official Information Act request CDHB 10830

I refer to your email dated 14 March 2022 requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

- **I request a transcript of all CDHB meetings with regards to the closure of rural hospitals in the Canterbury District. (Noting** clarification received 14/3/2022 that you are referring to CDHB Board meetings in the last month).

There was a briefing to the Canterbury DHB Board and members via zoom on 28 February 2022 to provide the Board with an overview of the resilience levels across our rural hospitals and community services. **Note;** this was a 'briefing' only (not a formal meeting), and as such no minutes were taken and no decision was required from the Board. (Please find attached as **Appendix 1** a copy of the Briefing Paper.
We have redacted information pursuant to section 9(2)(a) of the Official Information Act to protect individual privacy.

I trust that this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

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

Yours sincerely

Ralph La Salle
Senior Manager, OIAs
Canterbury DHB & West Coast DHB

APPENDIX 1

RURAL HOSPITALS RESILIENCE PLANNING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Bernice Mara, General Manager, Rural Hospitals**

APPROVED BY: **Tracey Maisey, Executive Director, Planning Funding & Decision Support**
Becky Hickmott, Executive Director of Nursing

DATE: **28 February 2022**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This paper has been prepared to provide the Board with an overview of the resilience levels across our rural hospitals and community services, and to outline the proposal to mitigate the risks identified as part of our Omicron planning by temporarily relocating people being supported in our smallest rural hospitals until the community outbreak and risk has passed.

2. RECOMMENDATION

That the Board:

i. notes the resilience challenges across our rural hospitals and community services;
ii. notes that the proposal will support a more sustainable clinical response to Omicron;
iii. notes the health risk inherent in temporarily relocating people but understands the immediate risk to patient safety posed by the community outbreak;
iv. notes the proposal includes the temporary redeployment of DHB staff to other service areas to support the health system's response and ensure continuity of care for the most vulnerable in our community during the Omicron outbreak;
v. notes the proposal to temporarily relocate people currently being supported in our rural hospitals to ensure continuity of care and patient safety during the Omicron outbreak;

3. SUMMARY

The DHB is currently preparing our local response to the Omicron outbreak which is expected to flow through our community over the next several months.

In working on our community response with providers, we have identified workforce risks across our aged residential care, district nursing and home-based support services, particularly in rural locations. Aged Residential Care (ARC), district nursing and home-based support service workforce attrition and vacancy levels are already high driven by several factors including: fewer overseas staff coming into the country, MECA settlements making other roles more attractive, and resignations related to vaccination mandates. With forecasts for the community outbreak suggesting health services can expect 8-15% of staff will be off sick at any one time, we are concerned about the ability of our community providers to maintain service levels throughout the outbreak. Staff with geriatric residential care, district nursing and palliative care experience are scarce and will be in high demand.

We are likewise looking at the impact of sick leave on continuity of service provision across our own DHB service teams, particularly those with high vacancy levels and those with smaller staffing numbers that might be person dependant. Our rural health services have been identified as a vulnerable service area and we are working through our COVID response planning to identify how we might mitigate some of the challenges we expect to face.

Part of our response planning is focused on consolidating service teams and identifying staff who can be temporarily redeployed to other services areas within the DHB, and across the health system, to support our response to the outbreak and ensure continuity of care for the most vulnerable in our community. This will not be directive but in consultation with individual staff and their managers and could include the redeployment of some DHB staff to external providers to ensure appropriate care can continue to be provided during the outbreak, rather than having a community provider fall over and needing to transfer people into our hospitals.

The DHB is currently operating four rural hospitals with a small number of people being supported in each facility for a mix of geriatric residential care, general observation, end-of-life and respite care. These facilities are supported 24/7 by a small team at each site, with little resilience should staff be sick or need to isolate. Transferring these people into the Ashburton or Christchurch Hospitals is not a good option. Secondary and tertiary resources will be stretched responding to the most acute and complex cases during the outbreak. Also, our experience with the urgent transfer of people in ARC during earthquakes or flooding is that it is resource intensive and stressful for residents, their families and staff. It is not something we would want to be doing during the Omicron outbreak.

The most clinically sustainable solution is to temporarily relocate people in our smaller rural hospitals into alternative private ARC facilities or back into the community and to support ARC, district nursing and home-based service providers with redeployment or the use of our COVID surge workforce. This solution would provide more assurance of continuity of care for those people in our care during the coming months and provide additional resilience for our community providers.

There is a clear process to be following in relocating people, and we would step through that process even though this relocation is temporary. We would also step through a process with our staff at these facilities engaging and consulting around temporary redeployment to support our response to the outbreak or backfilling other staff who will assist with redeployment. We plan to begin immediately to ensure a well-paced move is possible rather than risk the kind of urgent transfer that is likely to be needed if we leave things to the middle of the outbreak when we are without the staff to support people in our rural facilities.

4. DISCUSSION

The Omicron variant is already circulating in the community and numbers will pick up exponentially over the coming month, with a peak expected in March/April. Currently modelling suggests almost 4,000 cases a day during the height of the outbreak. We can also expect 8-15% of our workforce to be on sick leave at any time and this same level of absence can be expected by other health services across the region. Community providers are signalling significant staffing pressures and concerns about the impact of the predicted sick leave levels on their ability to respond to demand.

Calls have gone out across our workforce for people available for redeployment, particularly clinical staff currently working in non-clinical roles who could support vulnerable services. We are also pulling together a student and volunteer workforce pool and offering fixed-term positions to people with much needed clinical skills not currently working in our system. Understanding the clear pressures on our ARC, district nursing and home-based support service providers we have a temporary moratorium on recruiting staff from these community providers.

The pressure on rural areas is heightened with workforce shortages, smaller person dependant teams and isolation from the larger services available in urbans areas.

DHB Rural Hospital Facilities

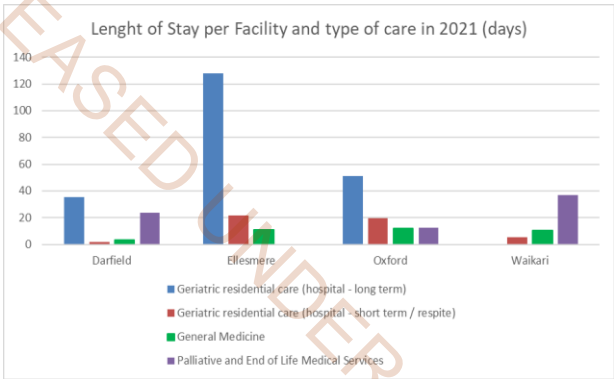
The DHB is operating rural hospitals in Darfield, Oxford, Waikari and Ellesmere, with very small numbers of people being supported in each facility – currently 23 people in total. General medicine/observation admissions (directed and supported by general practice) are minimal. The

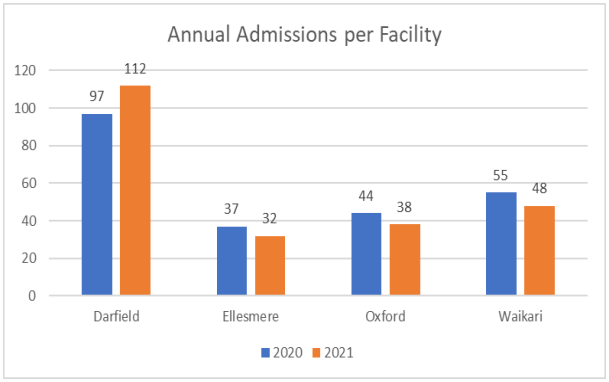
majority of care across these facilities is standard geriatric residential care, respite, or End-of-Life care, provided elsewhere in ARC or through home-based care in the community.

Current Occupancy:[1]

	Geriatric Residential Care	End-of-Life	Respite	**Total**	Empty Beds
Darfield	6			**6**	4
Oxford	7			**7**	7
Waikari	3			**3**	5
Ellesmere	7			**7**	3
Total	**23**			**23**	**19**

Annual Occupancy:





An initial review suggests all but 2 of the 23 people currently being supported for geriatric residential care have already been assessed as needing aged residential care and are eligible for subsidies.

DHB Rural Hospital Workforce

The rostered workforce for each of the four facilities operates 24/7 with the minimum cover of one Registered Nurse per 8-hour shift. Darfield, Ellesmere and Waikari incorporate the Nurse Manager position into the Register Nursing roster, to enable a stable roster deployment and in the last six months a stand-alone Nurse Manager position has been employed in Oxford to provide some cover and system leadership for the other facilities - however all four facilities are vulnerable to sick leave cover. The teams have employed casual contracts to draw in staff to cover planned and unplanned leave, however this is not always successful, and staff have had to been deployed from Ashburton or Burwood to provide cover.

In total 44 Registered Nurses and 44 Health Care Assistants are employed across the four sites. This relates to 19.4 FTE Registered Nurses and 18.9 FTE Health Care Assistants.

Current Workforce Type - Headcount (FTE)[1]

	Registered Nurses	Health Care Assistants
Darfield	12 (5.4)	9 (3.5)
Ellesmere	11 (4.4)	9 (3.9)
Waikari	11 (4.4)	9 (3.5)
Oxford	10 (5.2)	17 (8.0)
Total	**44 (19.4)**	**44 (18.9)**

The Health Care Assistants provide a range of personal cares and this workforce includes cooks who provide daily meals for residents and local meals on wheels. Like ARC facilities, this creates a fragile structure with residents and community clients dependent on the cooks with little or no ability to address the impact of sick leave.

[1] These numbers are a snapshot in time and will be worked through specifically for each site.

Temporary Relocation Proposal

While staffing levels are at minimum levels for covering 24/7 service in our rural hospitals, this is a reasonable sized workforce if people were available for redeployment across other service areas. The small stand-alone teams are at significant risk when faced with the possibility of 8-15% of their staff on sick leave or isolating and even in normal circumstances are looking to Ashburton and Burwood for cover.

Canterbury is fortunate to have a sizable number of vacant ARC beds across our region. Patient safety and continuity of care would be supported by a pro-active move to temporarily relocate people into alternative ARC facilities or back into the community. This would not only support the people in our facilities, but significant resilience will be added to the system by consolidating services and staffing during the outbreak.

We have experience in temporarily relocating people from ARC facilities, during the earthquakes and most recently in preparation for the flooding on the West Coast, where the residents and staff of the rest home in Westport were relocated to two ARC facilities in Christchurch. Relocating frail older people in their last months of life is not something we would normally contemplate. We know that the relocation process can impact on people's health status and after the earthquakes some of the residents who were temporarily relocated did not return to their previous facilities, either because of mortality, or reluctance to move again. However, taking a proactive planned approach is preferred rather than waiting until there is a staffing crisis at one or more of the facilities and having to respond by shifting people urgently.

We expect that there will be media and community interest in this move and will prepare clear communications as to the rationale and the distress that this might cause if it needed to happen under urgency during the peak of the outbreak. This is a difficult situation and national workforce shortages, particularly in rural areas, have meant that we need to take steps to ensure continuity of care during the community outbreak. Continuing to rely on staff from Burwood or Ashburton to cover sick leave for all four facilities is not sustainable over this period. Ashburton Health Services are already under pressure with vacancies and deploying a response plan to maintain acute and inpatient services and we need to consider how we can best support our community providers to maintain services during this period.

Early discussions have already commenced regarding alternative options for Meals on Wheels cover as part of our Omicron response planning, considering similar models to those used in Lincoln, Rangiora and Rakaia where the meals are prepared by a cafe or in an alternate food preparation facility. We would look to redeploy the Cooks for the period of the outbreak.

5. NEXT STEPS

There are established protocols to be following in transferring people in emergencies or when facilities close, including consultation with the individuals and their families, needs assessment by clinical teams, negotiations with the private providers and notifying of other funders. Although this is only a temporary move we would still step through this same process: assessing need and engaging with people and their families. We are aware in such small isolated areas (and at short notice) it might not be possible for everyone to have their first choice in terms of ARC facilities and established protocols for prioritisation of ARC beds would also be applied. We would also consider where some people might be appropriately managed in the community.

We plan to begin the work to confirm the needs of each person and the alternative accommodation options available right away and to work with the individuals and their whanau to begin the relocation as soon as possible.

Alongside this work we will engage appropriately with our staff impacted by this proposal (and their unions) to discuss temporary redeployment to other service areas within the DHB, and across the

health system, to support our response to the community outbreak and ensure continuity of care for the most vulnerable in our community over this period.

6. APPENDICES

Appendix 1: Process to Reallocate Multiple Residents
Appendix 2: Timeline for Proposal

Appendix 1: Process to Reallocate Multiple Residents

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Planning and Funding

Process Where Proposal to Close ARC or Relocate Multiple Residents

A decision of the intention to close a facility or relocate residents will be made in conjunction with the DHB Planning and Funding Team and Provider. Once a decision to close or relocate residents has been made the following will occur:

1. Planning and Funding will notify the DHB OPH&R or CCCN "the Clinical Team" of the impending closure/intention to relocate residents and the proposed timeframes.

2. The Provider will notify other funders (DSS, ACC) if they have residents subject to these Contracts in their care.

3. Planning and Funding will notify HealthCERT of the impending closure/intention to relocate residents and proposed process.

4. The Provider Management Team will provide written and verbal communication to resident of the intention to close/relocate residents. This will include:
- The reason for the move/relocation
- The proposed time frame
- Information about the involvement of the DHB in the process, including the role of both the Planning and Funding and the Clinical Team.

5. The Clinical and/or Planning and Funding Team may be involved in the meetings with the residents/families. The degree to which the DHB will be involved in the process will be decided jointly between the DHB and the Provider.

6. The Clinical Team will evaluate the need to review the residents in the Facility to confirm the level of care required and work with the family/whanau to identify the appropriate Facility to relocate to.

7. If the required number of beds exceeds demand in a particular area, the prioritisation tool to be used.

8. Once the Facility has closed, the Contract will be terminated. Where residents subject to Individualised Contracts are moved, the Contract will move with the resident.

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Phone: (03) 364 4150, Facsimile: (03) 364 4165

Appendix 2 – Timeline for Rural Hospital Temporary Relocation

RURAL HOSPITALS

Project Start: Monday, 28 February 2022

Display Week: 1

TASK	ASSIGNED TO	START	END
RURAL HOSPITALS			
STAFF	9(2)(a)		
Change proposal drafted for P&C		24/2/22	24/2/22
ECC Controller to formally instruct EOC about the decision		24/2/22	24/2/22
Mardi Postill to contact Janice		24/2/22	24/2/22
Verbal briefing to NZNO, PSA, E-tu Unions		28/2/22	28/2/22
All of ECC meeting		25/2/22	25/2/22
Briefing to Board		28/2/22	28/2/22
Board Chair to Call Mayors		28/02/2022 pm	28/2/22
Meeting with Nurse Managers confirmed		1/3/22	1/3/22
Meeting with Staff		1/3/22	1/3/22
Advise PHOs to inform their GP practices		1/3/22	1/3/22
Advise CCN		1/3/22	1/3/22
Press Release		1/3/22	1/3/22
Residents			
Confirm NOK details		25/2/22	25/2/22
Contact families and invite to re-assessment meetings with residents		1/3/22	1/3/22
Contact nurse managers to offer support as appropriate once they have been told		1/3/22	1/3/22
Nurse managers and/or OPH staff to inform residents following staff meeting		1/3/22	1/3/22
Team on site to support residents (TBC)		1/3/22	1/3/22
Contact with Age Concern & Grey Power		1/3/22	1/3/22
Assisted dying relocation conversation with Norma		2/3/22	2/3/22
Information to Residents and Families re ARC options		2/3/22	3/3/22
Re-assessment of Residents		2/3/22	4/3/22
Residents Moving		5/3/22	15/3/22