AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
Board Room, Level 1, 32 Oxford Terrace, Christchurch | Zoom
Thursday, 16 June 2022 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 19 May 2022		
3.	Carried Forward / Action List Items		
Overview			
4.	Chair's Update (Oral)	Sir John Hansen *Chair*	9.35-9.45am
5.	Chief Executive's Update	Dr Peter Bramley *Chief Executive*	9.45-10.10am
Reports for Noting			
6.	Finance Report	David Green *Acting Executive Director, Finance & Corporate Services*	10.10-10.15am
7.	Care Capacity Demand Management	Becky Hickmott *Executive Director of Nursing*	10.15-10.25am
8.	Advice to Board: • HAC – 2 June 2022 – Draft Minutes	Andrew Dickerson *Chair, HAC*	10.25-10.30am
9.	Resolution to Exclude the Public		10.30am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.30am**

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

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

Executive Support

Dr Peter Bramley – *Chief Executive*
James Allison – *Chief Digital Officer*
Norma Campbell – *Executive Director Midwifery & Maternity Services*
Jo Domigan – *Interim Chief People Officer*
David Green – *Acting Executive Director, Finance & Corporate Services*
Becky Hickmott – *Executive Director of Nursing*
Dr Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Tracey Maisey – *Executive Director, Planning, Funding & Decision Support*
Hector Matthews – *Executive Director Maori & Pacific Health*
Tanya McCall – *Interim Executive Director, Community & Public Health*
Dr Rob Ojala – *Executive Lead of Facilities*
Dr Helen Skinner – *Chief Medical Officer*
Karalyn Van Deursen – *Executive Director of Communications*

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

BOARD ATTENDANCE SCHEDULE – 2022

NAME	17/02/22 (Zoom)	17/03/22 (Zoom)	21/04/22 (Zoom)	19/05/22	16/06/22
Sir John Hansen (Chair)	#	√	√	√	
Gabrielle Huria (Deputy Chair)	√	√	^	^	
Barry Bragg	√	√	√	^	
Catherine Chu	√	#	√	√ (Zoom)	
Andrew Dickerson	√	√	√	√ (Zoom)	
James Gough	^	√	#	√ (Zoom)	
Jo Kane	√	√	#	√ (Zoom)	
Aaron Keown	√	√	√	√ (Zoom)	
Naomi Marshall	√	√	√	~	
Fiona Pimm	√	√	^	^	
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 **Brackenridge Services Limited** - Director **Canterbury Cricket Trust** - Member **Christchurch Casino Charitable Trust** - Trustee **Court of Appeal, Solomon Islands, Samoa and Vanuatu** **Dot Kiwi** – Director and Shareholder **Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member The JCA is an independent statutory authority constituted under the Racing Act. The JCA ensures that judicial and appeal proceedings in thoroughbred and harness racing are heard and decided fairly, professionally, efficiently and in a consistent and cost effective manner. **Rulings Panel Gas Industry Co Ltd** **Sir John and Ann Hansen's Family Trust** – Ingrid Taylor sits as independent Trustee; and provides legal services to the Trust and to Sir John and Ann Hansen.
Gabrielle Huria **Deputy Chair CDHB**	**Pegasus Health Limited** – Sister and Daughter are Directors Primary Health Organisation (*PHO*). **Rawa Hohepa Limited** – Director Family property company. **Sumner Health Centre** – Daughter is a General Practitioner (*GP*) Doctor's clinic. **Te Kura Taka Pini Limited** – General Manager **The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs. **Three Waters Governance Working Party** – Member A Crown appointed taskforce of Mayors and iwi representatives to recommend a governance framework for the four proposed new Water Services Entities. **Upoko Rawiri Te Maire Tau of Ngai Tuahuriri** - Husband
Barry Bragg	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term

	air ambulance contract with the CDHB. **CMUA Project Delivery Limited** - Chair 100% owned by the Christchurch City Council and is responsible for the delivery of the Canterbury Multi-Use Arena project within agreed parameters. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Paenga Kupenga Limited** – Chair Commercial arm of Ngai Tuahuriri Runanga **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Venues Ōtautahi** - Advisor A Christchurch City Council controlled organisation. Venues Ōtautahi is responsible for attracting, planning and delivering events for the Christchurch venues it owns, operates and manages. **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 Education and Research Trust for the Health of Older Persons** - Trustee Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB.

	Heritage NZ - Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
James Gough	**Amyes Road Limited** – Shareholder Formally Gough Group/Gough Holdings Limited. Currently liquidating. **Christchurch City Council** – Councillor Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board **Christchurch City Holdings Limited (*CCHL*)** – Director Holds and manages the Council's commercial interest in subsidiary companies. **Civic Building Limited** – Chairman Council Property Interests, JV with Ngai Tahu Property Limited. **Gough Corporation Holdings Limited** – Director/Shareholder Holdings company. **Gough Property Corporation Limited** – Director/Shareholder Manages property interests. **Medical Kiwi Limited** – Independent Director Research and distribution company of medicinal cannabis and other health related products. **The Antony Gough Trust** – Trustee Trust for Antony Thomas Gough **The Russley Village Limited** – Shareholder Retirement Village. Via the Antony Gough Trust **The Terrace Car Park Limited** – (Alternate) Director Property company – manages The Terrace car park **The Terrace Christchurch Limited** – Director Property company – manages The Terrace **The Terrace On Avon Limited** – (Alternate) Director Property company – manages The Terrace on Avon

Jo Kane	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Aaron Keown	**Christchurch City Council** – Councillor and Community Board Member Elected member and of the Fendalton/Waimairi/Harewood Community Board. **Christchurch City Council** – Chair of Disability Issues Group **Grouse Entertainment Limited** – Director/Shareholder
Naomi Marshall	**College of Nurses Aotearoa NZ** – Member **Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Fiona Pimm	**Careerforce Industry Training Organisation** – Chair Provides training to kaiawhina workforce in health and disability sector, social services sector and building contractors sector (cleaners). **Fiona Pimm Whānau Trustee Company Limited** – Director Private family trust. **Interim Māori Health Authority** – Board Member **Kia Tika Limited** – Director & Employee **NZ Blood and Organ Donation Services** – Board Member Statutory organisation responsible for national supply of all blood products and management of organ donation services. **NZ Parole Board** – Board Member Statutory organisation responsible for determining prisoners' readiness for release on Parole. **Restorative Elective Surgical Services** – Chair Joint venture project piloting ACC funded Escalated Care Pathways with a collective of clinicians and private hospitals. **Te Runanga o Arowhenua Incorporated Society** – Chair Governance entity for Arowhenua affiliated whānau.

	Te Runanga o Ngāi Tahu – Director Governance entity of Ngāi Tahu iwi. **Whai Rawa Fund Limited** – Chair Ngāi Tahu investment and savings scheme for tribal members.
Ingrid Taylor	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee. **Taylor Shaw** – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. **The Youth Hub** – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.

MINUTES

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held via zoom
on Thursday, 19 May 2022 commencing at 10.45am

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

CLINICAL ADVISOR
Dr Andrew Brant (via zoom)

APOLOGIES
An apology for absence was received from Dr Lester Levy.
Apologies for lateness were received from Barry Bragg; Gabrielle Huria; and Fiona Pimm (11.05am)
It was noted that Naomi Marshall was on leave of absence.

EXECUTIVE SUPPORT
Dr Peter Bramley (Chief Executive); Norma Campbell (Executive Director, Midwifery & Maternity Services); Jo Domigan (Interim Chief People Officer); David Green (Acting Executive Director, Finance & Corporate Services); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Tracey Maisey (Executive Director, Planning Funding & Decision Support); Tanya McCall (Interim Executive Director, Community & Public Health); Hector Matthews (Executive Director, Maori & Pacific Health); Julia Goode (Communications); Dr Rob Ojala (Executive Director, Infrastructure); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support – Minute Taker).

APOLOGIES
Apologies for absence were received from: James Allison (Chief Digital Officer); Becky Hickmott (Executive Director of Nursing); Helen Skinner (Chief Medical Officer); and Karalyn van Deursen (Executive Director, Communications).

Hector Matthews opened the meeting with a Karakia.

The meeting acknowledged the passing of Richard Webb, a former Chief Executive of Canterbury Health and the Canterbury District Health Board and Gordon Davies a former Chief Executive of the Canterbury District Health Board from 2005 – 2008.

1. INTEREST REGISTER

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

Declarations of Interest for Items on Today's Agenda
Sir John asked if there were any declarations of interest apart from Ngai Tahu and Car Parking in respect of Barry Bragg and Gabrielle Huria and Christchurch City Council in respect of Catherine Chu, James Gough and Aaron Keown.

Andrew Dickerson declared an interest it Item 4 of the Public Excluded meeting – "Maia Health Foundation – Trust Deed". He also advised that Gabrielle Huria, Dr Peter Bramley and Becky Hickmott (if she joined the meeting) also had an interest in this item.

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETINGS

Resolution (10/22)
(Moved: Sir John Hansen/seconded: Ingrid Taylor – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 21 April 2022 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

The carried forward/actions item were noted.

4. CHAIR'S UPDATE

Sir John Hansen, Chairman, commented that other than to repeat from earlier meetings the tremendous pressure the health system is under from COVID he had nothing to report.

The Chair's update was noted.

5. CHIEF EXECUTIVE'S UPDATE

Dr Peter Bramley, Chief Executive, Apologised for the shorter Board meeting today as it had coincided with a visit to Canterbury by the Chief Executives from Health New Zealand, Margie Apa, and the Maori Health Authority, Riana Manuel, who are meeting with Iwi Leads at the moment and then our Primary & Secondary Clinical Leads across the health system. They will connect in with the both the Board and Executive Team later in the day.

He took his report as read and highlighted:

- It was wonderful to be able to host the Minister of Health at the new ICU Pods and once again congratulations to the facilities team – it took only 75 days to complete that fit-out which is just exceptional in the midst of COVID and they supply chain issues. The Minister was really impressed by this so a fantastic win for the Canterbury Health System and having 12 more ICU beds in terms of tertiary care provision.

- We also got to visit one of the Mental Health Acute Residential Homes for those with Acute mental health distress. This was a wonderful facility run by Pathways whom we contract to undertake this service. Our mental health teams are fully integrated in supporting that service. While there the Minister made some of the pre-budget announcements around Mental Health funding.

- As Sir John has highlighted we are still in the midst of COVID with 1300 new cases in our community today, so those numbers are staying high around 1,000. These are of course those that we know of from those who have chosen to test and enter the result into the system. There are still high numbers of people presenting acutely unwell to various settings. ED for instance had 357 people present in the last 24 hours and in the weekend we had our second highest ever number of ED presentations. We are yet to see any influenza in our community however there are significant numbers emerging in Dunedin.

- Dr Bramley asked that members encourage all of their networks to get their COVID booster if they do not already have it and also their flu vaccination.

- Inpatients are running with 54 people with COVID so the numbers are up there. About 50% of those people in our hospitals with COVID are there because of COVID the other 50% have been admitted for another reason but also have COVID.

- Dr Bramley commented that we have moved from an ECC to an Operations Centre approach supporting both COVID and Winter, Becky Hickmott is our lead in the Winter space with Norma Campbell picking up the lead of the vaccination space and Tracey Maisey is providing the leadership in the Community Hub where he commented that he believes there is room for phenomenal transformation and it is a place where we integrate our health response with our welfare response and a place where we can be responsive out into our community and the cross agency area.

- Dr Bramley publicly acknowledged that Dr Helen Skinner, Chief Medical Officer, has only one week to go before she picks up her new role as Chief Medical Officer in one of the NHS Trusts in Cornwall and we are indebted to her leadership and amazing energy. She has served this health system incredibly well. He added that Helen, along with Tracey have led the ECC response and we probably underestimate how demanding it has been for our leaders supporting the COVID response and safe care for our community.

- In regard to planned care, Dr Bramley advised that we are struggling to get this back up and running and it can be seen in the report that we are sitting at over 3,000 planned care discharges and we are behind where we would have expected to be. Up until the last month Canterbury has done remarkably well and teams have been very flexible in terms of delivering planned care and have probably out performed many other parts of New Zealand but the reality of significant staff sickness and the need to redeploy staff has curtailed our planned care throughput over the last 4 – 6 weeks which is starting to have a significant impact.

  Dr Bramley commented that there is the National Planned Care Taskforce which hopefully will see additional funding from the Budget announcements today which will help DHBs and the health system recover, however the reality is that the health system is still very stretched. Next week we will start to increase our throughput for planned care at Burwood Hospital but we are still constrained around what we can do given workforce challenges.

- The other area impacted with COVID is around our Rural Hospitals and we are committed to reopening these but at the moment given staff constraints and the number of residents we are committed to opening Oxford Hospital mid-June but the others at this stage are on hold and the further community and staff engagement about how we can support the best rural health services are continuing.

- In the midst of this we still have a number of strike actions pending and ongoing with our Allied Health Workforce as well as our Medical Physicists which all have a huge impact.

- There has been a settlement in pay equity area for our clinical administration staff which recognises that this workforce has been underpaid and will suitably remunerate them going forward. There are still lots of issues to be addressed around pay equity and pay parity.

Barry Bragg, Fiona Pimm & Gabrielle Huria joined the meeting at 11.05pm

- Dr Bramley acknowledged the Mana Taurite team from People and Capability who have launched a new Emerging Maori Leaders Development Programme which will initially have 20 places.

- Another highlight was the blessing of the Selwyn Primary Birthing Centre which will open at the end of May.

- We are in the most difficult phase of the transition to Health New Zealand and at the moment there are still lots of gaps in terms of understanding what this will look like particularly in the Regional and District level which is creating a lot of uncertainty for our staff and unfortunately some are choosing to leave health as they want to make sure their future is certain and others are being poached by other industries.

- The new Public Health Service under Health New Zealand is well progressed so this will be transitioned on 1 July and some reporting lines will change through this.

- There is only 5 weeks to go as a DHB Board and we are doing all that we can and are desperately keen to finish well as a DHB. We are keeping the momentum going in the various facilities projects with fantastic progress being made and similarly financially we want to finish well. We are bringing our forecast which had gone out to $161m back towards our budget and this sits at $155m with another 2 months to run.

- In regard to planned care, Tracey Maisey advised that with the CEO's approval we have negotiated additional outplaced sessions with our private providers from the beginning of May until the end of June and hopefully this will cover 350 cases.

- In regard to the Operations Centre Norma Campbell advised that we have about 180 staff off with COVID today. This Centre is really important as we head into winter.

A query was made regarding rural hospitals and whether only one will be reopening before Health New Zealand takes over. It was noted that this is the case however Bernie Mara has been in contact with all of the "friends" and "mayors" and had conversations with them about service model options. We certainly have not said that the facilities will be closed however it is hard to speak for Health New Zealand.

The Chair advised that we are preparing a report for the next Board meeting as a handover and our commitment to the reopening of Rural Hospitals is on that list.

Discussion took place regarding the modelling around COVID.

The Chief Executive's update was noted.

6. BAD DEBT WRITE-OFFS

David Green, Acting Executive Director, Finance & Corporate Services, presented this report which was recommended to the Board for approval by QFARC. There was no discussion on the item.

Resolution (11/22)
(Moved: Ingrid Taylor/seconded: Jo Kane – carried)

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

i. approves the write-off of two ineligible patient debts totalling $330,808 (excluding GST);
ii. notes that the debts have been fully provided for as doubtful in our accounts, so there is no further financial impact to our results; and

iii. notes that this request is made on the basis that Canterbury DHB has taken all reasonable steps to recover the debt and there is unlikely to be any payment on these accounts.

7. FINANCE REPORT

David Green, Acting Executive Director, Finance & Corporate Services, presented the Finance Report for the month of March 2022 and commented that this was discussed in detail at the QFARC meeting.

It was noted that there have been additional costs with the impact of COVID and also some statutory holidays during this period.

Resolution (12/22)
(Moved: Barry Bragg/seconded: Ingrid Taylor – carried)

That the Board:

i. notes the consolidated financial result YTD is favourable to plan by $1.923M;
ii. notes that the YTD impact of Covid-19 is $2.440M favourable to budget;
iii. notes that the YTD impact of the Holidays Act Compliance is an additional $12.150M expense which is in line with budget; and
iv. notes that excluding HAP and Covid-19, the YTD result is $0.537M unfavourable to budget.

8. ADVICE TO THE BOARD – CPH&DSAC – VERBAL UPDATE

Aaron Keown, Chair, Community & Public Health & Disability Support Advisory Committee, provided an update of the Committee meeting held on 5 May 2022.

Mr Keown advised that this had been an unusual meeting with no quorum so we continued as an informal meeting. He highlighted updates on COVID Recovery; Maori & Pacific Health progress report; Disability Steering Group update; and Te Tumu Waiora.

Sir John thanked those who have contributed to this committee over the years and in particular Dr Olive Webb who has been involved for over 20 years.

The draft minutes were noted

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (13/22)
(Moved: Sir John Hansen/seconded: Ingrid Taylor - 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 and the information items contained in the report;
ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION

			ACT 1982 (Section 9)
1.	Confirmation of minutes of public excluded meetings – 21 April 2022	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(a) s9(2)(j)
4.	Maia Health Foundation – Trust Deed	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Audit NZ – Audit Arrangements	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Advice to Board • QFARC Draft Minutes *3 May 2022*	For the reasons set out in the previous Committee agenda.	

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 11.45am.

_____ _____

Sir John Hansen, Chair Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 16 JUNE 2022

DATE	ISSUE	REFERRED TO	STATUS
21 Apr 22	Fee for Service Contracts	Jo Domigan	Today's Agenda – Item 16PX

CHAIR'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Dr Peter Bramley, Chief Executive**

DATE: **16 June 2022**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the Chief Executive's update.

3. DISCUSSION

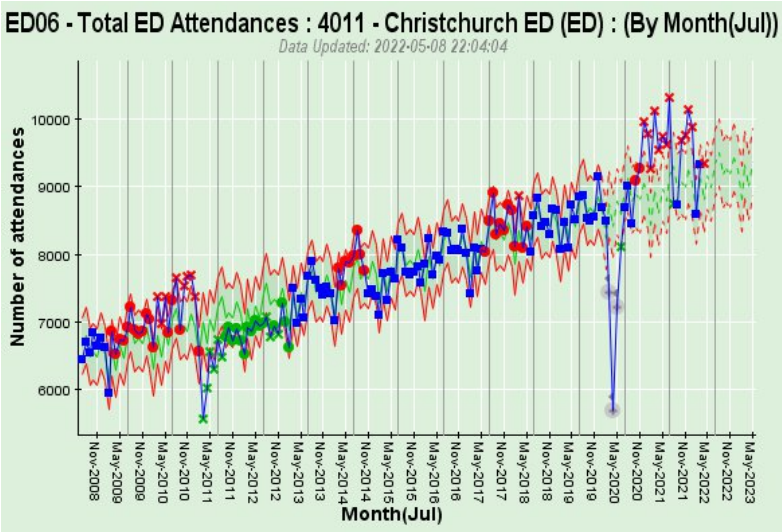
This is the last CEO Board report for Canterbury DHB. As the final CEO, I would like to acknowledge our Boards (current and previous), previous Chief Executives, leadership teams both clinical and non-clinical and all our wonderful staff for everything that has been achieved during the past 21 years. You will find attached (Appendix 1) a reflection on some of those achievements and events that have been part of our history since beginning in 2001 as Canterbury DHB.

MEDICAL / SURGICAL SERVICES

- Our surgical teams have worked flexibly to optimise the provision of acute and non-deferrable surgery during the period of restricted capacity because of COVID-19 settings.
- The use of Telehealth has increased to ensure that people continue to receive outpatient care while reducing the number of people on campus and freeing staff to be deployed to other care tasks.

Emergency Department

- There were 9,342 attendances at the Christchurch Hospital Emergency Department during April 2022, around 500 more than forecast.
- When compared with April 2021 triage 1 and 2 attendances have increased by 18% to 1,542, triage 3 attendances are steady at 4,891 and triage 4 and 5 attendances have decreased by 13% to 2,909.



- 3,121 people were admitted to hospital from the Emergency Department – similar to April 2021.
- 80% of people attending the Emergency Department left the department within six hours. This is the lowest value reported yet and is well short of the 95% target.
- The department has weathered the challenges created by the Omicron outbreak well. Compliments have increased, and complaints decreased.
- Preparations are underway to open the Children's Emergency Care late in June, prior to peak Winter demand.

Outpatient Attendances

- During March 2022 more than 11,830 non-face to face appointments were provided. This is the third highest volume ever recorded and only slightly lower than in April and May 2020.
- There were 1,093 less outpatient visits provided in March than during the same month in 2021 – incorporating 1,673 fewer new patient appointments due to COVID-19 restrictions.

Planned Care

- Total delivery versus phased target gives an indication of progress towards the phased target. 13,294 planned care discharges have been delivered at the end of April – 2,682 less than the phased target.
- Neither internal nor outsourced planned volumes have been delivered at the rates planned in the planned care dashboard.
- At the end of April, Canterbury DHB was exceeding targets for minor procedures in hospital settings, having delivered 1,871 as inpatients (633 ahead of target) and 10,823 as outpatients (4,466 ahead of target).

Use of Theatre Capacity

- Fewer acute and planned operations were provided at Christchurch Hospital in April 2022 than April 2021, with a total of 1,668 theatre events – this is 18% lower than in April 2021. During April 2022 there were 1,109 acute and 559 planned operations (vs 1,080 and 965 respectively in April 2021).
- The volume of operating at Burwood was 79% lower than in April 2021, with 55 operations provided during April 2022 and 266 in April 2021. During April 2022 there were no acute and 55 planned operations (vs 27 and 239 respectively in April 2021).
- When all operations provided by or for Canterbury District Health Board (including in house, outsourced and outplaced) 1,860 operations were provided during April 2022 – 28% less than during April 2021 - due to COVID-19 restrictions.

The CDHB Improvement Action Plan

- 3,407 people were waiting for longer than 120 days for first specialist assessment at the end of April. This is an increase of 282 from the end of March.

SPECIALIST MENTAL HEALTH SERVICES

- The demands of the Omicron surge have abated to some degree, however there is still a significant number of staff off work who are COVID-19positive (now 37, peak 65). Our teams have demonstrated flexibility to support key functions with services operating well in trying times. The number of COVID-19 positive consumers has been low and well managed.
- Staffing and Recruitment remain the most pressing issues facing Specialist Mental Health Services. Addressing deficits in staffing to ensure we have an experienced and skilled workforce will remain a focus through the next year.

Adult Acute Inpatients

- The slight reduction in the bed occupancy of Te Awakura (adult acute inpatient) and fewer consumers under the care of inpatient teams due to Omicron has not lasted and we are now experiencing high occupancy, especially over the past two holiday weekends. This is accompanied by reports of high acuity across services. The temporary merging of PSAID and Tupuna wards has now been reversed with both wards back to normal pre-Omicron operations. Both wards are tight on staffing for rosters but are coping and SMHS staff continue to demonstrate flexibility in moving units to support consumer needs.

INFORMATION SERVICES GROUP AND INNOVATION

- The additional team members in the Service Desk are contributing to a great improvement in call closure and abandonment statistics. Their short-term recruitment has also enabled the extension of service hours.
- Recruitment of our first Incident & Problem Manager is a really positive move toward active and consistent management of major service impacting events (P1), understanding the root cause, and identifying permanent corrective actions.
- Restarting our Data & Digital Governance framework development is underway.
- Completing our de-escalation plan and getting our people back into Walker Street is a priority. We need to rekindle our culture before embarking on whatever new remote working is appropriate under the new policy once ratified.
- Resolving our VDI replacement is our #1 production issue which will require an urgent scope change and further funding.
- Completing the firewall replacement project is a critical infrastructure project which addresses technical debt but also enables improved security and systems performance. This is the first step of several to progressively improve our core network.
- Completing our MedChart upgrade is similarly our #1 health domain project.

MIDWIFERY AND MATERNITY

- All community units (except St Georges) have had births with women who were COVID-19 positive and have managed well.
- Christchurch Women's Hospital had on average 3 women per day during March birthing with COVID-19.

- Sickness levels, both COVID-19 and unrelated, are still very high in maternity.
- 20FTE vacancies by end of March with no pipeline of midwives coming.
- We are working on the model of care for the Central City Primary Birthing Unit supported by NZCOM- region and nationally, Maori midwives roopu and international evidence.
- We plan to recruit a Midwife Manager Community Birthing later in the year to oversee all community units.

4. APPENDICES

Appendix 1 Canterbury DHB 2001 to 2022

APPENDIX 1

Canterbury DHB – 2001 to 2022

To mark the last meeting of the Canterbury District Health Board, I wanted to reflect on some of the milestones that our Board has seen in the past 21 years.

The years have seen four chief executives, Jean O'Callaghan, Gordon Davies, David Meates and myself and eight boards. The chairs over the years were Syd Bradley, Alister James, Bruce Matheson, Murray Cleverley, Ta Mark Solomon, Dr John Wood and Sir John Hansen.

I would like to thank each and every one of you for your service to the people of Canterbury to make sure their health needs are met, and in particular I want to acknowledge Jo Kane and Andrew Dickerson who are our longest serving current Board members.

We now serve a population of 589,930 stretching from Ashburton in the south to Kekerengu (north of Kaikoura), along with the Chatham Islands (which we took over responsibility for in 2015).

Our communities are as diverse as are our staff. Over the past 21 years we've grown from a team of 7,500 staff to more than 11,000 now. They work across our facilities from Te Hā o Te Ora in Kaikoura to the Christchurch Campus, Burwood, Hillmorton to Ashburton Hospital and the Chatham Islands Health Centre. Our newest facility is the Oromairaki Birthing Unit in the Toka Hāpai Selwyn Health Hub. There's a total of 23,500 health staff in our wider health system which covers everyone working in Aged Residential Care facilities, NGOs primary care and privately owned hospitals and health providers.

Our objectives, outlined when the DHBs were formed in 2001, include:

- improving, promoting and protecting the health of people and communities;
- promoting the integration of health services, especially primary and secondary care services;
- seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs; and
- promoting effective care or support of those in need of personal health services or disability support.

I think we can all be very proud of what has been achieved during the past 21 years.

Canterbury has been through a lot since the District Health Boards were established. We've had more than our fair share of disasters and challenges with the Canterbury earthquakes, Kaikoura earthquakes, Port Hills fire and the Christchurch terrorist attacks, as well as supporting the response to Whakaari/White Island, but we have also been incredibly progressive and many of our milestones are positive.

For example, the 'Improving the Patient Journey' initiative that has been part of our DHB since 2004 epitomises what Canterbury DHB has tried to achieve, that the patient is the person whose time is most valuable. This work has evolved into a way of working that has achieved significant change in how health is being delivered across Canterbury.

APPENDIX 1

The South Island Alliance has enabled the South Island region's five District Health Boards (DHBs) to work collaboratively to develop more innovative and efficient health services than could be achieved independently.

On 7 March 2008, the DHB signed a Memorandum of Understanding with Manawhenua ki Waitaha which was in place until 2021 when a Partnership Agreement was signed. This partnership has been invaluable in working to improve health outcomes for Māori and this will set us up well for the future with the Māori Health Authority.

We've done a huge amount of work to improve the health infrastructure of our region.

At its 10 August 2001 meeting, Board members were presented with an Executive Summary of the Business Case for the new Christchurch Women's Hospital and Day Surgery Unit. This construction commenced on 25 November 2002, was project managed by the DHB's Site Redevelopment Unit and was completed on time and under budget with the move into Christchurch Women's Hospital and Day Surgery Unit taking place in March 2005.

Other significant building achievements were the $215 million Burwood Hospital build which was officially opened in August 2016 by the then Prime Minister, John Key. Waipapa Hospital then followed, opening in 2020 and is the South Island's largest hospital building.

The work that is currently being progressed at the Hillmorton campus will see many of its buildings and facilities improved, modernised and transformed as part of a Masterplan to ensure the campus will meet the needs of our population and across the region for some specialist services. In addition, we continue to work on our earthquake remediation programme to repair earthquake damage and strengthen buildings.

Our woody biomass boiler at Burwood has contributed hugely to a reduction in our carbon emissions and the new Christchurch Campus boiler is set to further reduce emissions.

Our technology has also come a long way; the creation of Community HealthPathways (now in 47 health systems) and Hospital HealthPathways; the use of electronic systems such as ERMS, Cortex, Patient Track, HealthOne/Health Connect South, SIPICS and Max.

We now operate a system in Canterbury that has a single source of data truth and is run with real time data and information that enables active 24/7 patient flow. Every discussion and decision about services is immersed in data and how to 'make it better.'

In 2013, the Canterbury Health System was internationally recognised by The King's Fund – a highly regarded British health authority, as one of the high-performing health systems in the world. We've also received many awards over the years for our cutting-edge work and research. I am constantly in awe of our clinicians leading in world class best practice here in Canterbury. It is amazing to see their work being recognised globally and producing measurably better outcomes for patients because of the research we do here.

APPENDIX 1

In 2015 Canterbury won a number of awards in the IPANZ awards, including the prestigious Prime Minister's Award for Public Sector Excellence which recognised the important work of the Canterbury Clinical Network and the results of our alliancing approach to improve health outcomes.

And from 2020, the work we have done to prepare and then manage the COVID-19 outbreak in Canterbury has been phenomenal. Our Community and Public Health Unit has been outstanding coordinating the contact tracing system and caring for those with COVID-19 when we had small numbers in the community. We have also been recognised for the quality support we provided for the Managed Isolation and Quarantine programme helping to keep COVID-19 at bay for a long time.

Our COVID-19 Vaccination Programme has seen 99 percent of our community vaccinated while we continue to distribute boosters, and our Canterbury Hauora Coordination Hub, a cross-agency collaboration dedicated to the Canterbury region's COVID-19 response, has supported our primary care teams to manage people's health and wellbeing issues.

With more than 155,000 COVID-19 cases now recorded in Canterbury, I take my hat off every day to our people working to care for those with COVID-19 on top of an already high workload.

I am pleased to be taking on the role of *Interim Regional Director* for Te Waipounamu/the South Island from 1 July, when Health NZ is our new employer. I will also be the *Interim District Director* for Canterbury, which will provide continuity for our health system. We operate as an integrated health system in Canterbury and I believe that the relationships we have with our primary care, private, community and NGO colleagues, as well as the South Island Health Alliance, will help set the model for Health NZ nationally as we move forward.

APPENDIX 1

Appendix – Canterbury Health System Events

Canterbury and West Coast DHBs have been through a lot over the past ten years and the people of the Canterbury and West Coast Health Systems have had to respond in extraordinary ways.

4 September 2010	Mag 7.1 earthquake
19 November 2010	Pike River Mining Disaster
22 February 2011	Mag 6.3 earthquake
13 June 2011	Mag 6.4 earthquake
23 December 2011	Mag 6.0 earthquake
2013 and 2014	Several serious floods
2015	NZ's first suspected Ebola Case admitted to Christchurch Hospital
14 February 2016	Mag 5.7 earthquake
14 November 2016	Mag 7.8 earthquake
13 February 2017	Port Hills fire
February – May 2019	Significant measles outbreak in Canterbury
15 March 2019	Terrorist attack on mosques
29 March 2019	New Outpatient facility flooded with 15,000 outpatient appointments cancelled & rescheduled
11 December 2019	Whakaari/White Island
February 2020 onwards	COVID-19

FINANCE REPORT FOR THE PERIOD ENDED 30 APRIL 2022

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **16 June 2022**

Report Status – For: Decision ☐ Noting ☑ Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the consolidated financial result YTD is unfavourable to plan by $4.578M;
ii. notes that the YTD impact of Covid-19 is $2.271M favourable to budget;
iii. notes that the YTD impact of the Holidays Act Provision (HAP) is an additional $13.477M expense which is in line with budget; and
iv. notes that excluding HAP and Covid-19, the YTD result is $6.873M unfavourable to budget.

3. FINANCIAL RESULTS EXECUTIVE SUMMARY

Summary DHB Group Financial Result – April 2022:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate	(4.358)	(6.855)	2.496	(36.018)	(58.541)	22.523
Community & Public Health	(0.029)	0.017	(0.046)	0.489	0.028	0.461
Total In-House Provider excl Subsidiaries	**(4.387)**	**(6.838)**	**2.450**	**(35.529)**	**(58.513)**	**22.984**
Add: Funder & Governance						
Funder Revenue	175.591	169.512	6.079	1,779.424	1,686.221	93.203
External Provider Expense	(81.667)	(70.070)	(11.597)	(787.022)	(708.375)	(78.646)
Internal Provider Expense	(107.371)	(103.881)	(3.490)	(1,082.478)	(1,038.819)	(43.659)
Total Funder	**(13.447)**	**(4.439)**	**(9.008)**	**(90.076)**	**(60.974)**	**(29.102)**
Governance & Funder Admin	(0.139)	(0.186)	0.047	(0.212)	(1.921)	1.709
Total Canterbury DHB (Parent)	**(17.974)**	**(11.463)**	**(6.511)**	**(125.817)**	**(121.408)**	**(4.409)**
Add: Subsidiaries						
NZ Health Innovation Hub	(0.028)	0.081	(0.109)	0.013	0.030	(0.017)
Brackenridge Services Ltd	0.124	(0.108)	0.232	0.417	0.108	0.309
Canterbury Linen Services Ltd	(0.332)	(0.219)	(0.113)	(0.881)	(0.420)	(0.461)
Canterbury DHB Group Surplus / (Deficit)	**(18.211)**	**(11.710)**	**(6.501)**	**(126.268)**	**(121.690)**	**(4.578)**

4. KEY FINANCIAL RISKS & EMERGING ISSUES

Covid-19 continues to have both a direct and indirect impact on our financial result and our ability to undertake business as usual activities.

The activities of Canterbury Linen Services Ltd (*CLS*) continue to be significantly impacted with revenue from customers continuing to be below volumes pre Covid-19.

Planned care revenue is below budget due to Covid-19. Surgical activity has been reduced to a minimum; this will continue to impact the results until activity returns to more normal levels.

Holidays Act Compliance - we are accruing a liability based on an assessment from EY (prepared when the programme was started); there is risk that the final amount differs significantly from this accrued amount. Additional Crown funding is expected, but we do not know the quantum on this funding.

Staffing - The transition to Health NZ as well as ongoing Covid-19 restrictions on international travel are creating disruptions to recruitment. The pool of potential employees that we can recruit from is currently very limited, and some positions continue to be difficult to recruit to. This is adversely impacting on personnel costs as it increases overtime, additional duty payments, and locum costs.

5. APPENDICES

Appendix 1	Financial Results
Appendix 2	Financial Result Before Indirect Revenue & Expenses
Appendix 3	Group Income Statement
Appendix 4	Group Statement of Financial Position
Appendix 5	Group Statement of Cashflow

APPENDIX 1: FINANCIAL RESULTS

The following table shows the financial results, the impact of Covid-19 and Holidays Act Provision (HAP) accrued:

	Period to date									Year to date								
April 2022 Results	Month Actual $000	Actual Covid-19 $000	Actual Holidays Act $000	BAU Actual $000	Month Budget $000	Budget Covid-19 $000	Budget Holidays Act $000	BAU Budget	BAU Variance	YTD Actual $000	Actual Covid-19 $000	Actual Holidays Act $000	YTD BAU Actual $000	YTD Budget $000	Budget Covid-19 $000	Budget Holidays Act $000	YTD BAU Budget	Underlying Variance
MOH Revenue	189,681	18,593		171,088	173,855	1,401		172,454	(1,366)	1,879,175	127,154		1,752,021	1,738,375	12,722		1,725,653	26,369
Patient related revenue	5,879	1,246		4,633	6,565	1,388		5,177	(544)	75,416	14,144		61,272	64,038	12,694		51,344	9,928
Other Revenue	2,604	(616)		3,220	5,528	1,025		4,503	(1,284)	50,539	18,168		32,371	47,391	10,249		37,142	(4,770)
Total Operating Revenue	198,164	19,223	-	178,941	185,949	3,814	-	182,135	(3,193)	2,005,131	159,466	-	1,845,665	1,849,804	35,665	-	1,814,139	31,526
Employee expenses	96,514	7,249	1,347	87,918	89,654	1,643	1,351	86,660	(1,258)	935,270	44,395	13,477	877,398	870,754	15,232	13,501	842,021	(35,378)
Treatment Related costs	14,394	257		14,137	16,092	699		15,393	1,257	175,246	10,548		164,698	172,292	6,984		165,308	610
External Provider costs	81,667	10,469		71,198	70,070	1,318		68,752	(2,446)	787,022	83,909		703,113	708,375	11,879		696,496	(6,616)
Other Expenses	11,966	730		11,236	10,394	152		10,242	(994)	117,082	15,833		101,249	104,580	1,516		103,064	1,815
Total Operating Expenditure	204,540	18,705	1,347	184,488	186,210	3,812	1,351	181,047	(3,441)	2,014,621	154,685	13,477	1,846,459	1,856,001	35,611	13,501	1,806,889	(39,570)
Operating result Surplus / (Deficit)	(6,376)	518	(1,347)	(5,547)	(261)	2	(1,351)	1,088	(6,635)	(9,490)	4,781	(13,477)	(794)	(6,197)	54	(13,501)	7,250	(8,044)
Total Indirect revenue and expenditure	(11,835)	(695)		(11,140)	(11,448)	(11)		(11,437)	298	(116,778)	(2,539)		(114,239)	(115,493)	(83)		(115,410)	1,171
Total - Surplus / (Deficit)	(18,211)	(177)	(1,347)	(16,687)	(11,710)	(9)	(1,351)	(10,350)	(6,337)	(126,268)	2,242	(13,477)	(115,033)	(121,690)	(29)	(13,501)	(108,160)	(6,873)

Covid-19 - Canterbury DHB's net result in relation to Covid-19 is a YTD surplus of $2.242M.

Covid-19 MoH revenue includes community surveillance and testing, Maori health support and vaccinations.

Covid-19 Patient related revenue includes revenue for MIQFs.

Covid-19 Other revenue is mainly generated by Canterbury Health Laboratories (CHL).

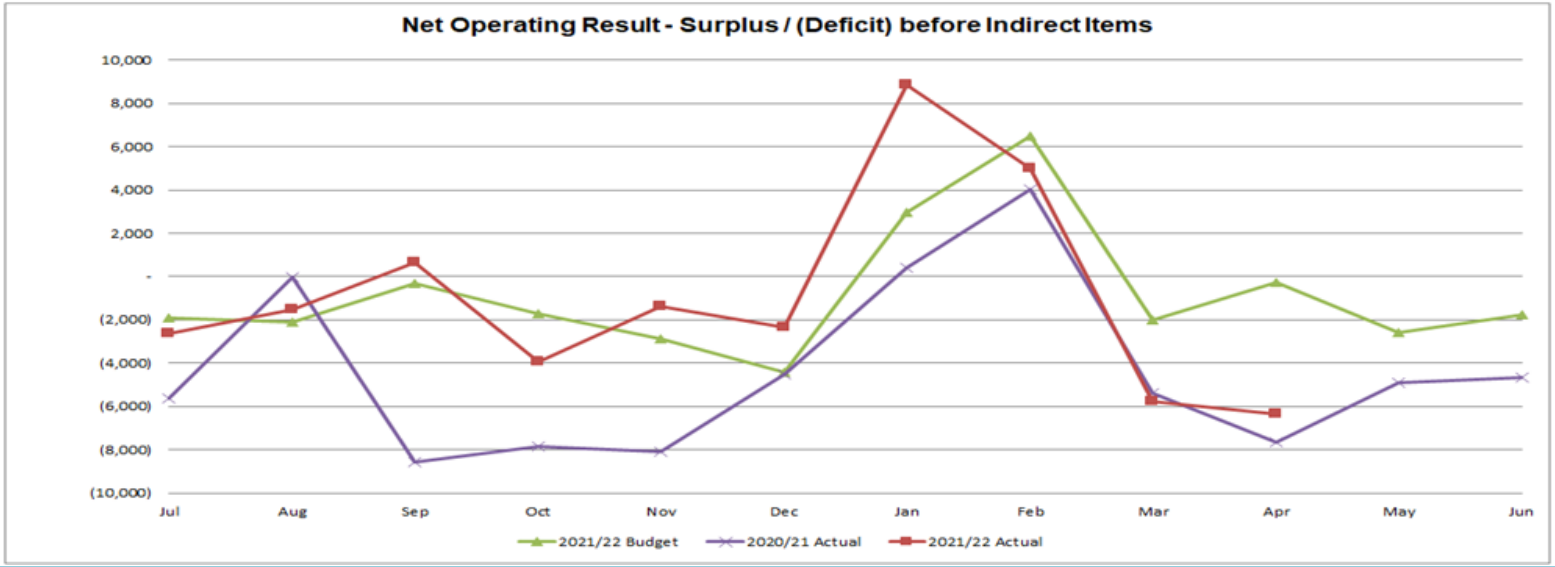
Variances to budget for Covid-19 are generally related to vaccination activity as this programme is not included in the budget (as per MoH instruction).

Our **savings initiatives** for the full year total $42.2M, with $29.5M phased April YTD. Our result excluding Covid-19 and HAP is a deficit of $6.873M, explainable by additional ACC revenue, offset by lower planned care revenue as a result of Covid-19, Chatham's underfunding, RSV, etc. Savings initiative activity has been disrupted by the impact of the Covid-19 outbreaks and lock-downs., thus we are not expecting to achieve the total $42.2M of savings that we had built into the budget, noting that $12.7M of savings are phased in the remaining months of the year.

APPENDIX 2: FINANCIAL RESULT BEFORE INDIRECT REVENUE & EXPENSES

FINANCIAL PERFORMANCE OVERVIEW BEFORE INDIRECT REVENUE & EXPENSES – PERIOD ENDED FEBRUARY 2022

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2020/21 Actual $'000	Yr End Budget $'000
Surplus/(Deficit) before Indirect items	(6,376)	(261)	(6,115)	2340% ✗	(9,490)	(6,197)	(3,293)	53% ✗	(50,211)	(10,568)

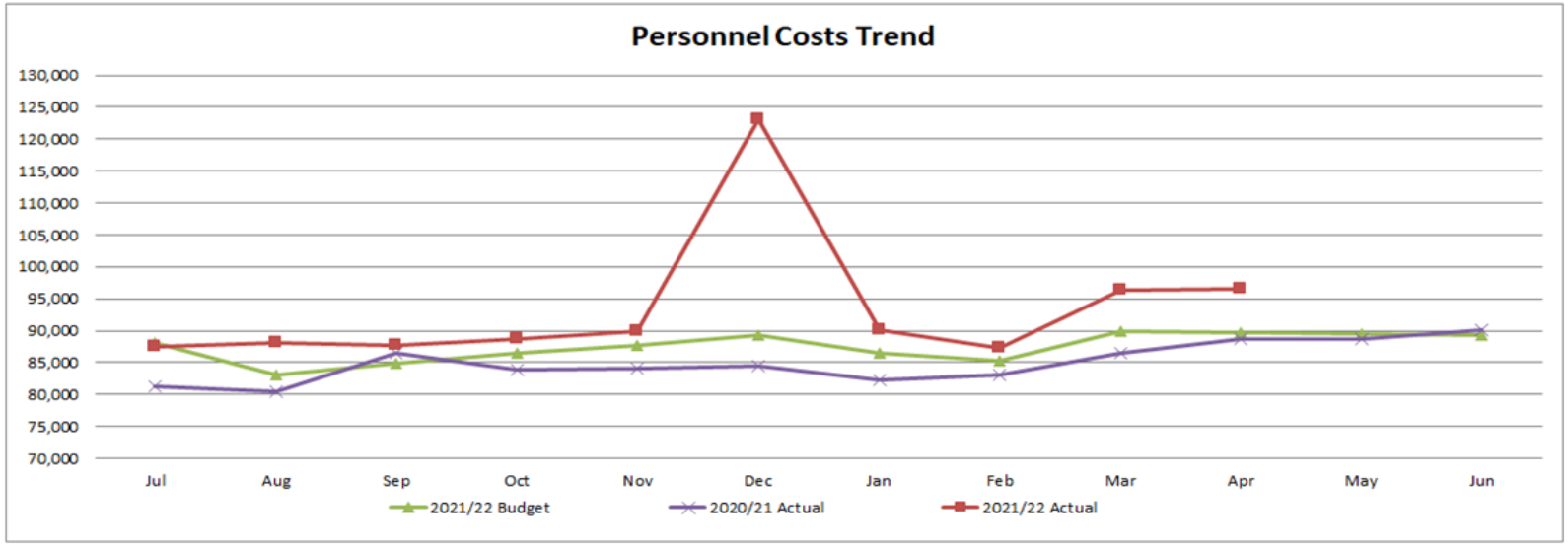


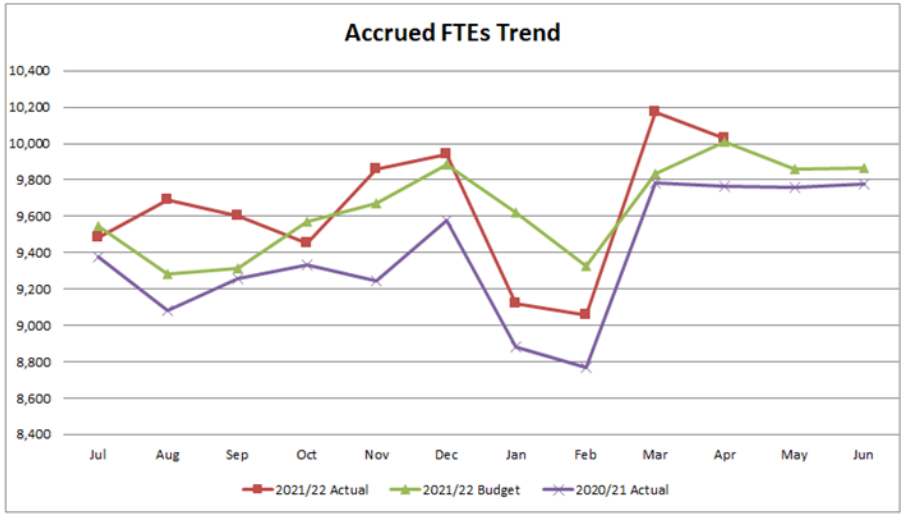
KEY POINTS

Our YTD result before indirect items is $3.293M unfavourable to budget. The renegotiated ACC contract has contributed favourably to our result. The main factors offsetting this unfavourable result include:

- Planned care revenue based on lower activity, due to the impact of Covid-19 (noting recent advice that planned care revenue will be paid on planned rather than actual activity).
- Chatham Islands funding shortfall - $1.8M YTD, and $2.1M full year.
- RSV treatment costs ($0.5M in July), which increased staff costs, including cleaning resources.
- Treatment related costs, both price and volume.
- Capitation and additional After Hours costs.
- Savings activity disrupted by the impact of the Covid-19 outbreaks and lockdowns.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE



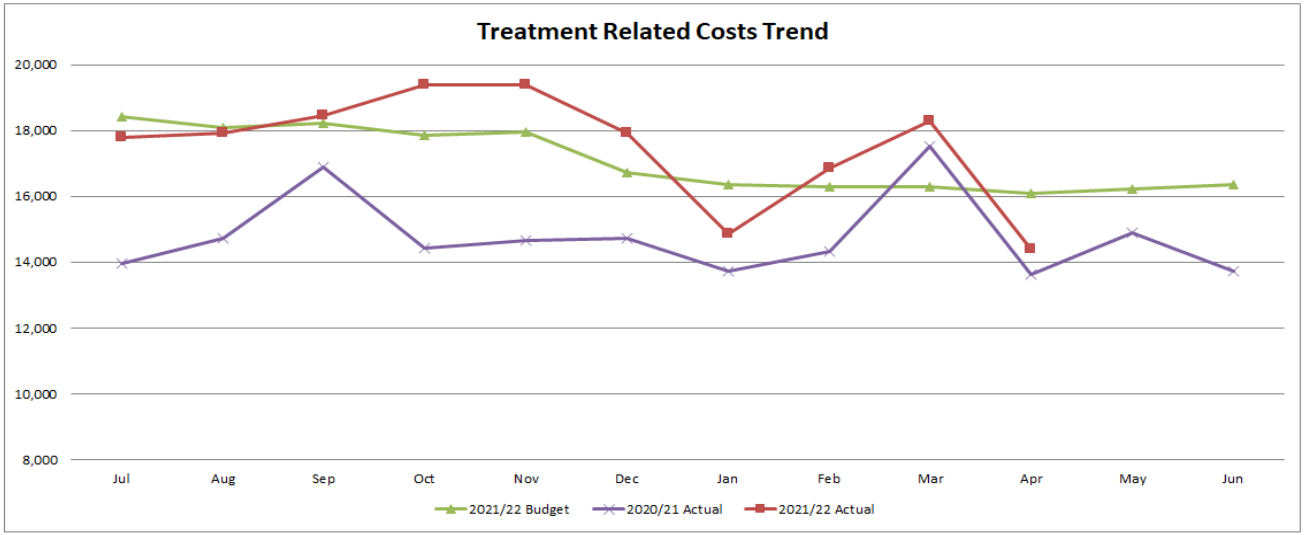


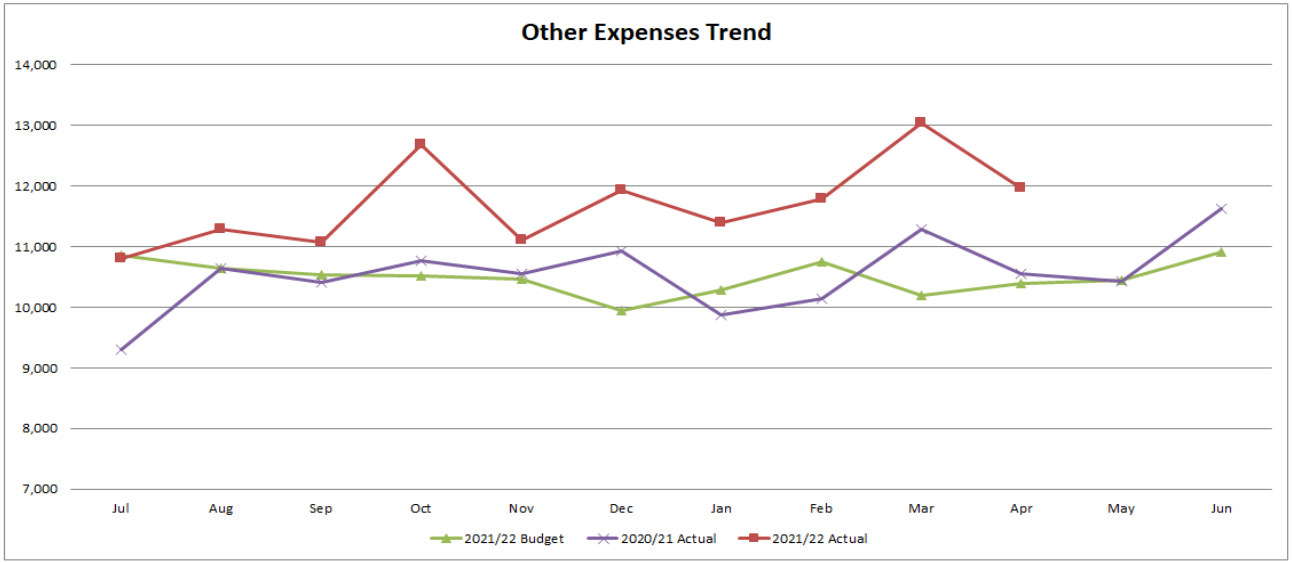
KEY POINTS

Personnel Costs are $64.517M unfavourable to plan YTD. $29.163M is related to Covid-19 (vaccination costs were not included in the budget as instructed by the MoH) and are offset by additional revenue. Covid-19 had an adverse impact on sick leave and special leave in April. We are unable to claim additional funding for this, and additional costs have been incurred in backfilling these and other vacant positions across the whole organisation. The December variance relates to the interim pay equity settlement for Nurses and Midwives, which is offset by additional revenue.

Accrued FTE are unfavourable to plan, primarily due to vaccination FTEs that are not included in the budget.

TREATMENT RELATED & OTHER COSTS (excluding Covid-19)





KEY POINTS

Treatment related costs include $10.548M YTD of Covid-19 related costs offset by Covid revenue; the YTD BAU variance is $0.610M favourable.

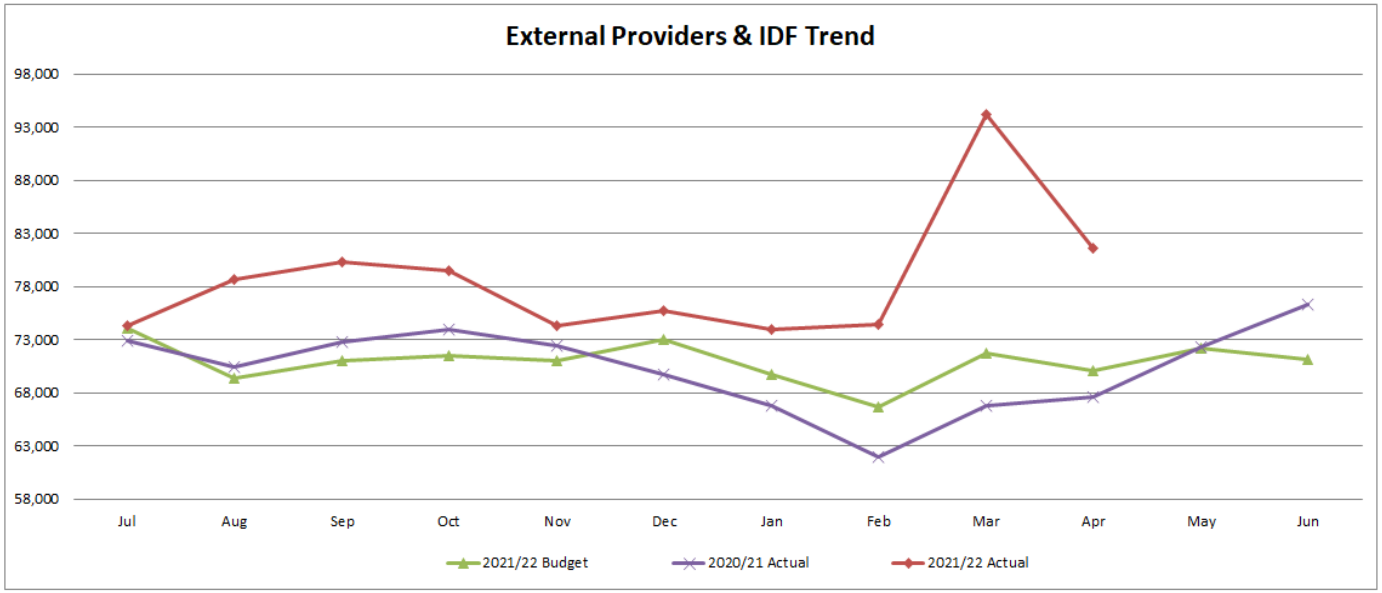
Supply and procurement are coming under continued pressure with sourcing product and price increases.

Outsourced clinical services are favourable YTD due in part to a focused effort on delivering more clinical services in-house as part of the cost saving initiatives and the impact of Covid on planned care. However, this favourable variance is expected to reduce in June with savings targets unlikely to be met due to the impact of Covid-19.

Other Expenses are $12.502M unfavourable to budget YTD; of this $15.833M relates to Covid-19 which is offset by additional revenue.

EXTERNAL PROVIDER COSTS (excluding Covid-19)

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2020/21 Actual $'000	Yr End Budget $'000
External Provider Costs	81,667	70,070	(11,597)	-17% ✗	787,022	708,375	(78,646)	-11% ✗	844,188	851,785



KEY POINTS

The unfavourable variance is largely offset by additional MoH revenue and relates to Covid-19.

FINANCIAL POSITION – EQUITY & CASH

	YTD Actual $'000	YTD Budget $'000	Variance $'000		YTD Actual $'000	YTD Budget $'000	Variance $'000	Year End 20/21 $'000
Equity	1,135,983	1,216,633	80,650	Cash	84,695	139,031	(54,336)	50,775

APPENDIX 3: CANTERBURY DHB GROUP INCOME STATEMENT

The Group financial results include Canterbury DHB and its subsidiaries
For the 10 months ending 30 April 2022

Month					Year to Date					
21/22 Actual $000's	21/22 Budget $000's	20/21 Actual $000's	Variance to Budget $000's		21/22 Actual $000's	21/22 Budget $000's	20/21 Actual $000's	Variance to Budget $000's	21/22 Budget $000's	20/21 Actual $000's
189,681	173,855	162,335.84	15,826 ✓	MoH Revenue	1,879,175	1,738,375	1,649,783	140,801 ✓	2,086,388	1,991,657
5,879	6,565	7,822	(686) ✗	Patient Related Revenue	75,416	64,038	60,457	11,378 ✓	76,994	73,244
2,604	5,528	1,811	(2,925) ✗	Other Revenue	50,539	47,391	39,844	3,149 ✓	58,295	48,140
198,164	**185,949**	**171,968**	**12,216**	**Total Operating Revenue**	**2,005,131**	**1,849,804**	**1,750,084**	**155,327**	**2,221,677**	**2,113,041**
96,514	89,654	88,793	(6,860) ✗	Personnel Costs	935,270	870,754	840,961	(64,517) ✗	1,049,643	1,019,771
14,394	16,092	13,611	1,699 ✓	Treatment Related Costs	175,246	172,292	148,540	(2,954) ✗	204,873	177,141
81,667	70,070	67,664	(11,597) ✗	External Service Providers	787,022	708,375	695,515	(78,646) ✗	851,785	844,188
11,966	10,394	10,550	(1,572) ✗	Other Expenses	117,082	104,580	100,182	(12,502) ✗	125,943	122,152
204,540	**186,210**	**180,617**	**(18,330)** ✗	**Total Operating Expenditure**	**2,014,621**	**1,856,001**	**1,785,197**	**(158,620)** ✗	**2,232,245**	**2,163,252**
(6,376)	**(261)**	**(8,649)**	**(6,115)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**(9,490)**	**(6,197)**	**(35,113)**	**(3,293)** ✗	**(10,568)**	**(50,211)**
191	60	124	132 ✓	Interest Revenue	1,005	561	1,213	444 ✓	700	1,075
381	418	502	(37) ✗	Capital Charge Relief / Debt Equity Swap Funding	3,812	4,183	-	(371) ✗	5,020	8,940
639	430	532	209 ✓	Donations	4,243	4,134	2,044	110 ✓	5,010	2,384
3	-	-	3 ✓	Profit on Sale of Assets	13	-	1,762	13 ✓	-	1,653
-	-	-	-	Joint Venture Income	-	-	-	- ✓	-	25
1,215	**908**	**1,158**	**307** ✓	**Total Indirect Revenue**	**9,074**	**8,878**	**5,020**	**195** ✓	**10,730**	**14,078**
4,341	4,332	4,627	(9) ✗	Capital Charge	45,345	45,284	30,654	(61) ✗	53,949	39,871
8,502	7,743	7,828	(759) ✗	Depreciation	78,072	76,457	77,547	(1,615) ✗	92,104	94,651
240	277	235	37	Financing Component of Operating Leases	2,448	2,543	1,617	95	3,015	2,079
(41)	5	54	46 ✓	Interest Expense & Forex Gains and Losses	(45)	87	480	132 ✓	100	60
8	-	-	(8) ✗	Loss on Sale of Assets	32	-	4,272	(32) ✗	-	4,336
13,050	**12,356**	**12,744**	**(693)** ✗	**Total Indirect Expenses**	**125,852**	**124,371**	**114,570**	**(1,481)** ✗	**149,168**	**140,998**
(18,211)	**(11,710)**	**(20,234)**	**(6,501)** ✗	**Total Surplus / (Deficit)**	**(126,268)**	**(121,690)**	**(144,663)**	**(4,578)** ✗	**(149,006)**	**(177,131)**

As instructed by the MoH, we have not budgeted for the vaccination programme.

Overall the vaccination revenue and expenses offset.

APPENDIX 4: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 30 April 2022

Audited 30-Jun-21 $'000		Group Actual 30-Apr-22 $'000	Group Budget 30-Apr-22 $'000	Annual Group Budget 30-Jun-22 $'000
490,730	Opening Equity	1,124,844	1,124,844	1,125,762
178,139	Net Equity Injections / (Repayments) During Year	137,373	212,557	151,139
537,624	Other Movements	-	-	97,357
95,482	Reserve Movement for Year	34	-	-
(177,131)	Operating Results for the Period	(126,268)	(121,686)	(149,006)
1,124,844	**TOTAL EQUITY**	1,135,983	1,215,715	1,225,252
	Represented By:			
	Current Assets			
50,775	Cash & Cash Equivalents	84,695	139,031	120,487
750	Short Term Investments	2,609	750	750
107,157	Trade and Other Receivables	157,507	107,157	107,157
6,278	Prepayments	10,542	6,278	6,278
13,811	Inventories	14,646	13,811	13,811
15,095	Restricted Assets	12,997	15,094	15,094
193,866	**Total Current Assets**	282,995	282,121	263,577
	Less Current Liabilities			
1,682	Borrowings (Finance Leases Current)	1,693	1,682	1,682
159,296	Trade and Other Payables	193,574	173,465	155,218
15,111	Restricted Funds	14,581	15,111	15,111
381,697	Employee Benefits	426,838	381,696	381,696
557,786	**Total Current Liabilities**	636,687	571,954	553,707
(363,920)	**Working Capital**	(353,692)	(289,833)	(290,130)
	Non Current Assets			
16	Restricted Funds	16	16	16
4,253	Investment	3,953	4,253	4,253
1,541,081	Fixed Assets	1,541,352	1,557,865	1,567,699
1,545,350	**Term Assets**	1,545,321	1,562,134	1,571,968
	Non Current Liablilties			
7,544	Employee Benefits	7,850	7,544	7,544
49,042	Borrowings (Finance Leases Non Current)	47,796	49,042	49,042
56,586	**Term Liabilities**	55,646	56,586	56,586
1,124,844	**NET ASSETS**	1,135,983	1,215,715	1,225,252

Restricted Assets and Restricted Funds include funds held by the Māia Foundation on behalf of CDHB. We are in the process of transferring all trust funds to Māia by year end.

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

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

APPENDIX 7: CANTERBURY DHB GROUP STATEMENT OF CASHFLOW

Audited 30-Jun-21 *$'000*		Actual 30-Apr-22 *$'000*	YTD Budget 30-Apr-22 *$'000*	Budget 30-Jun-22 *$'000*
	CASHFLOW FROM OPERATING ACTIVITIES			
(46,875)	**Net Cash from Operating Activities**	(26,080)	(27,901)	(56,903)
	CASHFLOW FROM INVESTING ACTIVITIES			
(78,847)	**Net Cash from Investing Activities**	(77,138)	(96,400)	(121,881)
	CASHFLOW FROM FINANCING ACTIVITIES			
183,463	**Net Cash from Financing Activities**	137,138	212,557	248,496
57,741	Overall Increase/(Decrease) in Cash Held	33,920	88,256	69,712
(6,966)	Add Opening Cash Balance	50,775	50,775	50,775
50,775	**Closing Cash Balance**	84,695	139,031	120,487

CARE CAPACITY DEMAND MANAGEMENT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Carol-Ann Todd, Acting Nursing Director, Care Capacity Demand Management**

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

DATE: **16 June 2022**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report has been generated for the Board as a quarterly update on the Care Capacity Demand Management (*CCDM*) programme. The CCDM programme was approved by the Board for implementation in August 2019 to better match nursing and midwifery supply to patient care demand. Trendcare, the acuity tool, was purchased but full implementation was delayed during the first COVID outbreak. CCDM was subsequently fully commenced late June 2021.

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

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

- examples of improvements to a patient care process/system;
- changes to workforce management/environment; and
- efficiencies across wards/units resulting from CCDM.

2. RECOMMENDATION

That the Board:

i. notes the Care Capacity Demand Management report.

3. SUMMARY

The CCDM programme is progressing well. Full implementation is dependent on completion of all the FTE calculations and these calculations have now recommenced following delays due to COVID.

4. DISCUSSION

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

Governance

The governance group meets monthly and contains membership of the Executive Management Team, Senior Nursing, Allied Health and Midwifery Leads, as well as members of each union.

Working groups as a subset as part of the CCDM requirements are also working well and we have moved to a business as usual (*BAU*) model. The meetings have been disrupted due to COVID.

TrendCare / Acuity Tool

TrendCare has been implemented in all inpatient areas apart from the Dialysis Unit and Oncology Day Unit. The upgraded version of the TrendCare acuity tool is due to be installed on 8 June. This version includes enhancements for patient isolation and also new patient types for many specialties. TrendCare data is visible within the core data set display allowing us to monitor that we are meeting the vendor gold standards.

Core Data Set

The Core Data Set measures how each area within the DHB is doing. It is a balanced set of measures placing equal priority on "quality patient care", "quality work environment" and "best use of health resources". It helps each ward/area to focus on improvement and is displayed on the intranet within "Seeing our System". We are currently monitoring 19 of 23 Core Data Set measures. The remaining measures will be reported once the FTE calculations have been completed and the end of shift survey recommendations from TAS have been published. We have local data councils in place at Burwood, Specialist Mental Health, Ashburton, Christchurch Hospital, Woman's and Children's and Maternity. The core data set is also monitored by the CCDM Council. The data is visible for all DHB staff to view and can be drilled down to ward level or aggregated to division or DHB level.

The Safe Staffing Healthy Workplaces (*SSHW*) unit is undertaking a national dashboard development project. Phase one focuses on identifying metrics collected consistently within DHB's documenting sources and developing provisional permissions structure of the national core data set (*CDS*). Phase one completion will allow a whole of system view of key health indicators in relation to nursing, midwifery and allied health workforce, quality and safety of care and best use of resources.

Variance Response Management (*VRM*)

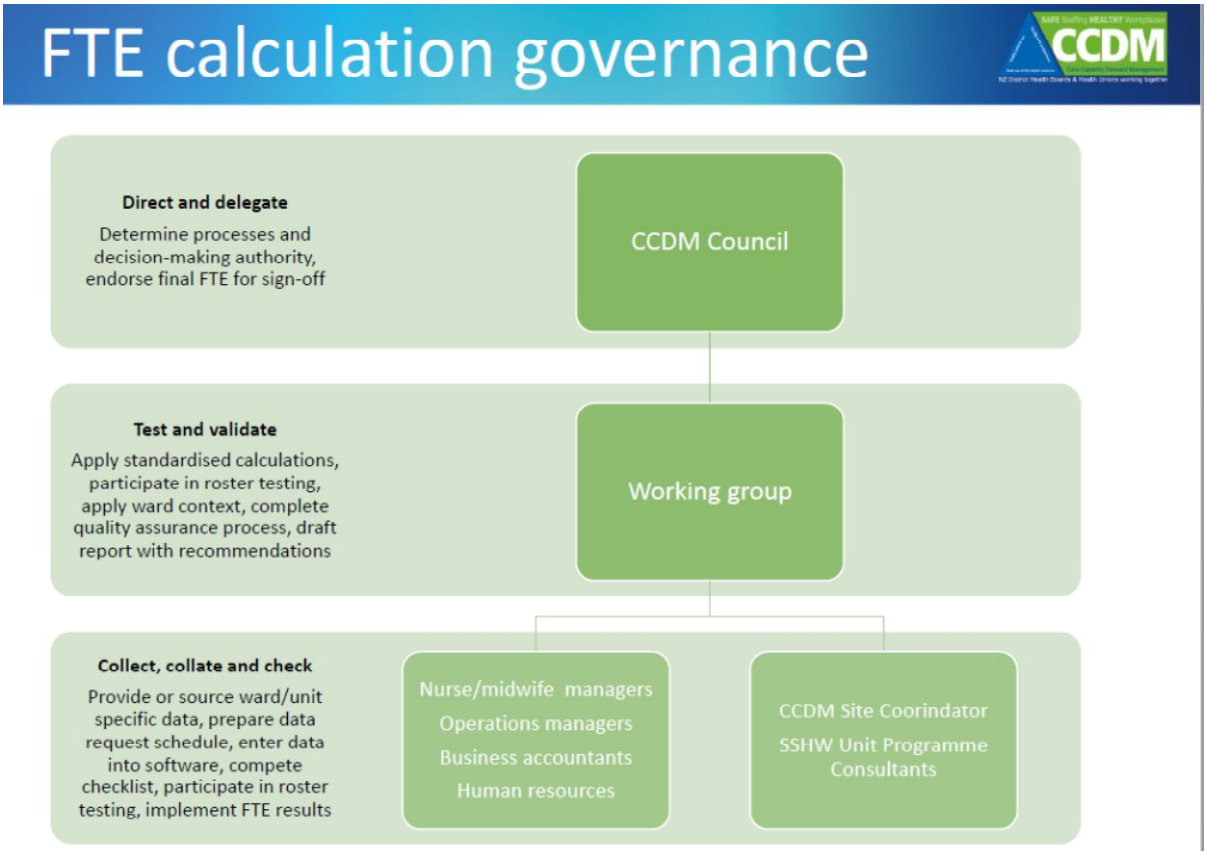
VRM is a safe staffing tool to provide early detection, rapid assessment and effective response to variance. We have completed escalation plans for each site and have an approved deployment policy. We have a Variance Indicator Scoring tool and this is displayed on the Capacity at a Glance (*CaaG*) screens. The CaaG screen is now live for Christchurch, Burwood, Specialist Mental health and Ashburton Campus. The tool allows us to have visibility of when there is a clear variance of demand against capacity to ensure the coordination of resources to meet demand is visible and actions have been taken. This has now been operationalised at all sites. The corresponding status colour is now visible on the Hospital at a Glance screen (*HaaG*) at Christchurch Hospital and other hospitals will eventually have this as well. We have now fully implemented this standard.

FTE Calculations

We are continuing the first round of FTE calculations for all areas. FTE calculations meetings are currently being held for the remaining Burwood Hospital wards and are scheduled for the Paediatric and Gynaecology wards in June and July.

Twenty-one wards (29%) have had FTE approved by the CCDM Council and recruitment has commenced. We aim to have completed all wards by May 2023. The FTE calculations are annual for each clinical area, so we will be commencing our next year's round of FTE review in August 2022 for those first tranche wards.

The Governance for how FTE Calculations are determined is outlined in the SSHWU slide with one key difference is that we have our Directors of Nursing present for each step of the way as this is our first FTE calculation process:



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

5. CONCLUSION

Our CCDM team continue to work at pace with the assistance of the team within the SSHW Unit. We are working very closely and in partnership with our unions and are all deeply committed to ensuring safe patient care, a quality patient care environment and healthy workplaces are the outcome.

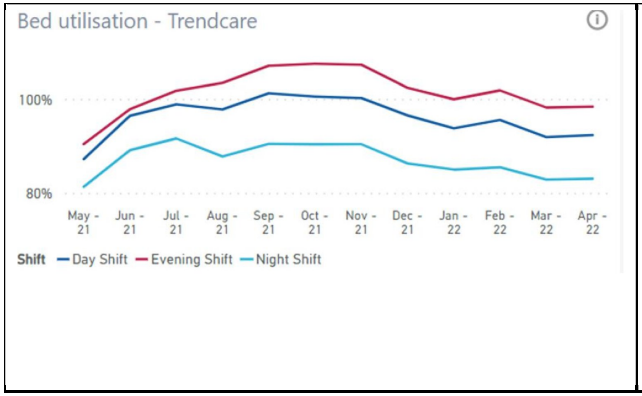
We continue to support West Coast DHB with their CCDM progress as able.

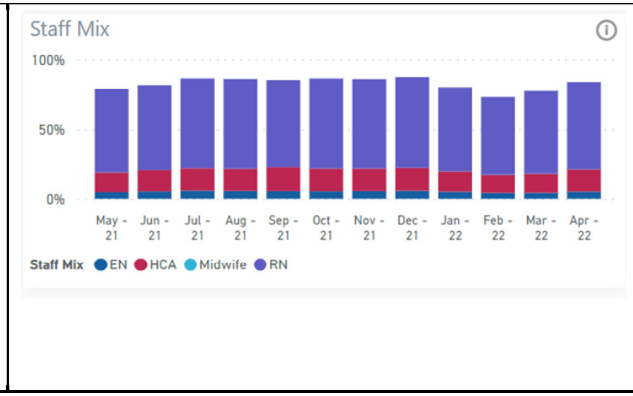
It is with regret that we have to announce that Janette Dallas, who so successfully led the CCDM Programme for Canterbury DHB, has resigned to take up new opportunities in Queenstown. We thank her for her outstanding work and wish her all the best for her new life ahead.

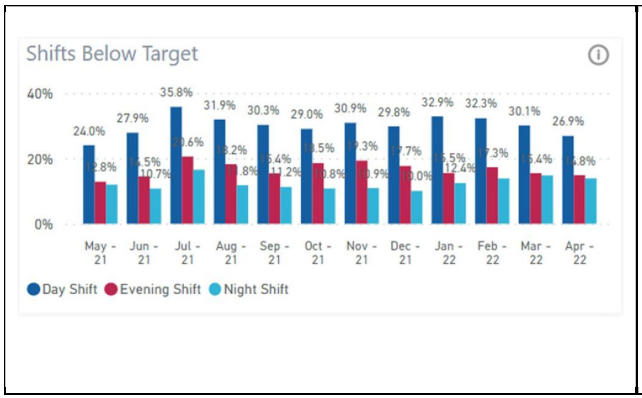
6. APPENDICES

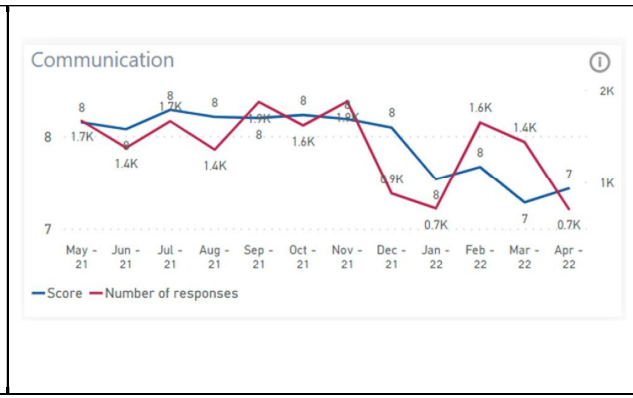
Appendix 1: Christchurch Campus, Ashburton, Burwood & SMHS Data
Appendix 2: Midwifery Data
Appendix 3: CCDM Implementation Overall Progression – Q3

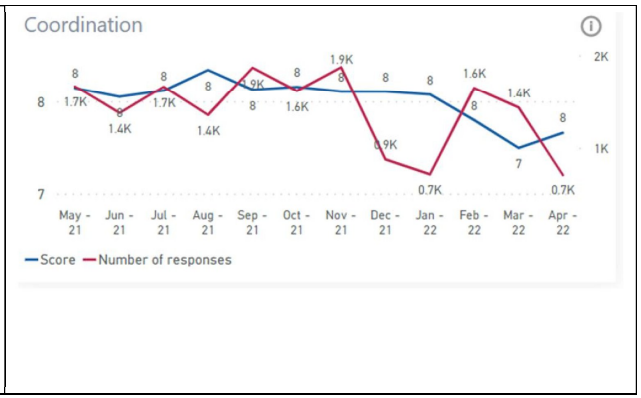
Christchurch campus, Ashburton Burwood and SMHS,

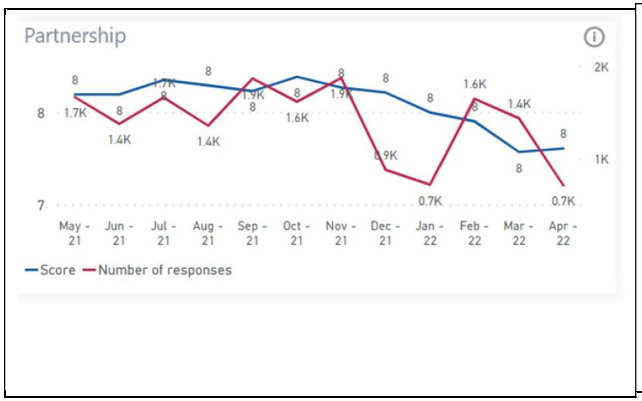


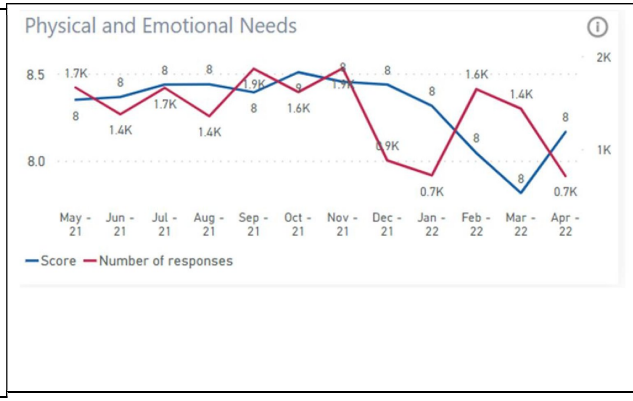












Christchurch campus, Ashburton Burwood and SMHS,

Bed Utilisation (Monthly)

Bed utilisation reflects the throughput of patients during a calendar day – accounting for all discharges, deceased patients, admissions and transfers for the shift on which the patient received care. By shift AM, PM, N.
Source: TrendCare

Staff mix (Monthly)

The number of regulated staff (RN, RM and EN) that worked, compared with all staff that worked expressed as a percentage for AM, PM and N shift.

Higher levels of RNs have been associated with better patient outcomes (2). Higher RN levels are associated with lower mortality rates (31, 35, 39) and failure to rescue (5). The majority of patient care requires RNs (2). RNs also contribute to the provision of coherent, quality nursing services through supervision, patient flow, team organisation and delegation (2). Monitoring the percentage of regulated nurses (RN, RM and EN) is a logical step towards ensuring the delivery of quality patient care.

Patient incidents (Monthly)

The number of patient incidents in this month. A patient incident is any event that could have or did cause harm to a patient (adverse event, near miss, reportable event).
Source: https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf)
Examples include: falls, pressure injury, hospital acquired infection, patient collapse/777, medication error etc.)

Shifts Below Target (Monthly)

The number or percentage of shifts by AM, PM, N where the difference in the care hours provided and the care hours required was greater than negative 8.5% (or 40 minutes per FTE). Red is the number of shifts and blue is the percentage of total shifts below target.
Worked example: If there are 30 days in the month (or 90 shifts in total) and 25 shifts had more than negative 8.5% difference in hours between required and supplied, then the percentage of shifts below target = 25 / 90 x 100 = 27%.

Patient mortality increases with exposure to increased number of shifts below target (4, 10). Shifts below target is the companion measure to nursing hours variance. Nursing hours variance may be 400 hours for the month on PM shifts. However 9 of the 30 shifts may have had a negative variance of greater than 8.5% (or 40 minutes per FTE). Once 40 minutes per FTE has been breached there is increasing risk to patient safety, staff meal breaks, working overtime etc.

Communication (quarterly)

Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

Note: This cannot be drilled down to a ward level - reported by DHB only.
Patient experience is an indicator of the quality of care provided to patients. There is evidence that quality work environments and higher levels of registered nurses are associated with higher patient satisfaction. There is a significant association between positive nursing leadership styles, behaviours and practices, and increased patient satisfaction.

Coordination (quarterly)

Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

Example:
Did you have enough information about how to manage your condition or recovery after you left hospital?

Partnership (quarterly)

Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

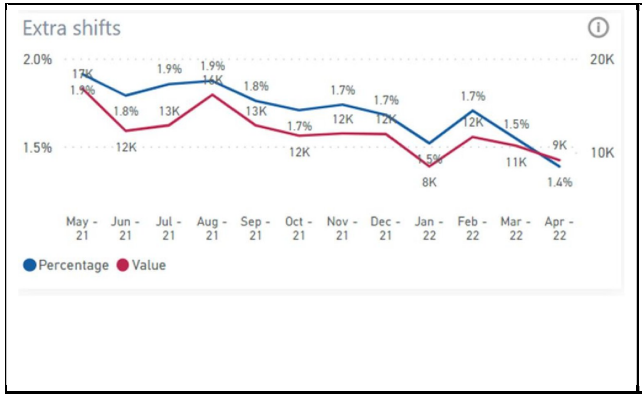
Example
Were you involved as much as you wanted to be in making decisions about your treatment and care
Did hospital staff include your family/whānau or someone close to you in discussions about the care you received during your stay?

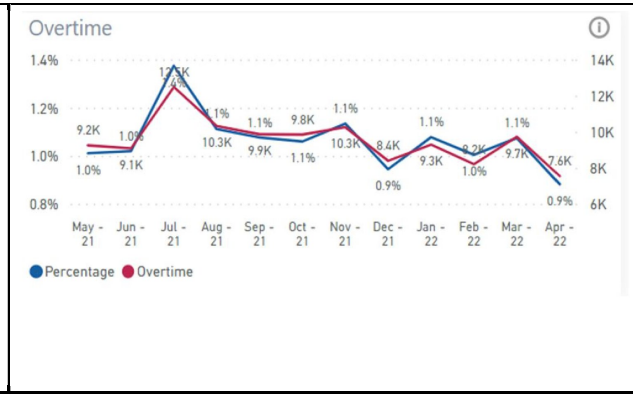
Physical and emotional needs. (quarterly)

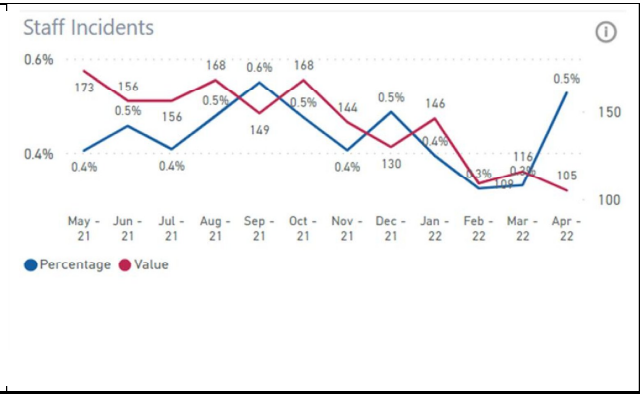
Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

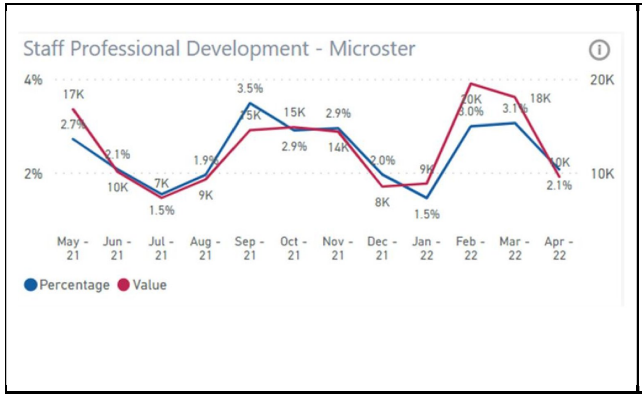
Example
Did the hospital treat you with kindness and understanding while you were in the hospital?
Did the hospital treat you with respect?
Did hospital staff help you to get to the bathroom or to use a bedpan as soon as you wanted?

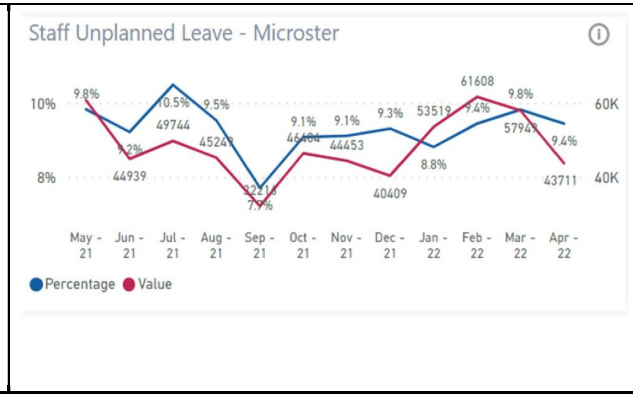
Christchurch campus, Ashburton Burwood and SMHS,

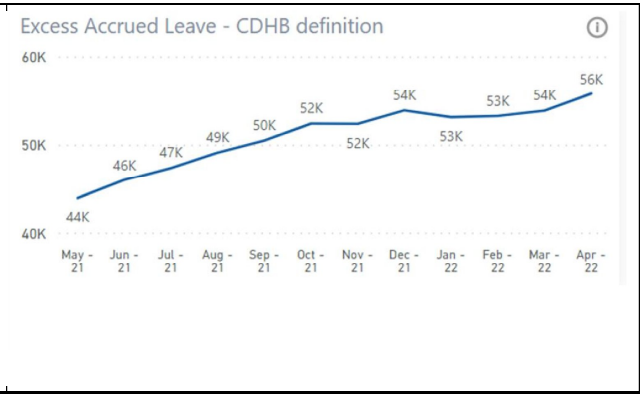




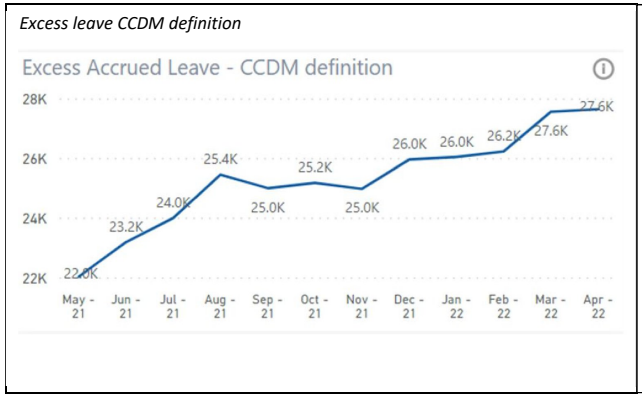


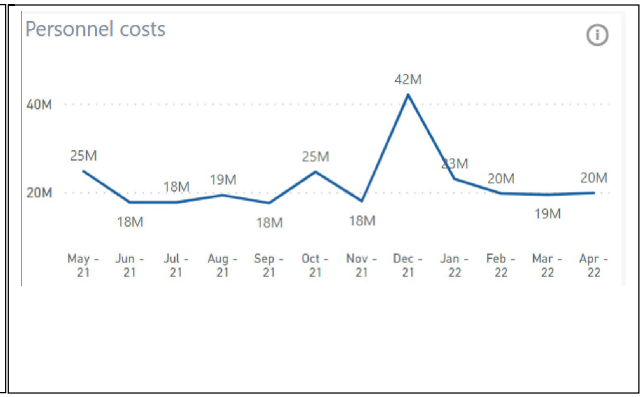






Excess leave CCDM definition





Christchurch campus, Ashburton Burwood and SMHS,

Extra Shifts (Monthly)

Displayed in red for actual hours and in blue as the percentage of worked hours

All staff hours worked that are additional to their normal contracted hours of work. This applies to part time staff only.
Example: a nurse may be contracted to work 24 hours per week but actually works 32 hours.
Note: This differs from the NZNO definition of overtime as the nurse may not exceed 8 hours per day or 80 hours per fortnight, but is still working additional hours to contract.
Source: Microster and PSE

Overtime (Monthly)

Displayed in red for actual hours and in blue as the percentage of worked hours

Overtime includes any extra paid hours that a nurse is required to work beyond their contracted hours at either end of their shift (2).
Overtime is defined as per the MECA. Includes payment for missed meal breaks.
Example from NZNO: *Overtime is time worked in excess of*
(i) eight hours per day or the rostered duty whichever is greater or
(ii) 80 hours per two week period
Source: Microster

Staff Incidents (Monthly)

Displayed in red for actual incidents and in blue as the percentage of worked hours

A staff incident is any reported event that could have or did cause harm to a staff member (adverse event, near miss, reportable event). Examples include accidents, needle sticks, back injuries, slips, verbal abuse etc.
Source: Safety first

Staff Professional Development (Monthly)

Displayed in red for actual hours and in blue as the percentage of worked hours

All paid hours for staff to attend professional development activities which are additional to mandatory training and hospital training.
Source: Microster

This should be around 1.5 % of worked hours for the ward. 32hrs /2086 1 fte hours

Unplanned Leave (Monthly)

Displayed in red for actual hours and in blue as the percentage of worked hours

The total unplanned or short notice leave hours taken by staff e.g. sick, domestic, bereavement, ACC. This includes sick leave hours paid, unpaid or paid as annual leave. Includes staff on permanent contracts only.
Source: Microster

Rationale
Sick leave is one indicator of the health of the workplace. Burnout and job stress increase staff absenteeism due to sickness (19).

Excess Accrued leave/ CDHB

Actual number of annual leave hours remaining above 30 hours

Rationale

A healthy work environment has the health and wellbeing of the person as its primary objective (1). Annual leave entitlements exist to support staff take adequate breaks from work. Excess annual leave indicates staff are not taking or unable to take their annual leave. Excess annual leave is a financial liability for the DHB.

Excess Accrued leave/ CCDM

Actual number of annual leave hours owing over two FTE entitlement.

Rationale

A healthy work environment has the health and wellbeing of the person as its primary objective (1). Annual leave entitlements exist to support staff take adequate breaks from work. Excess annual leave indicates staff are not taking or unable to take their annual leave. Excess annual leave is a financial liability for the DHB.

Total Leave Accrued.

Total hours of leave accrued.

Source: HRIS leave data

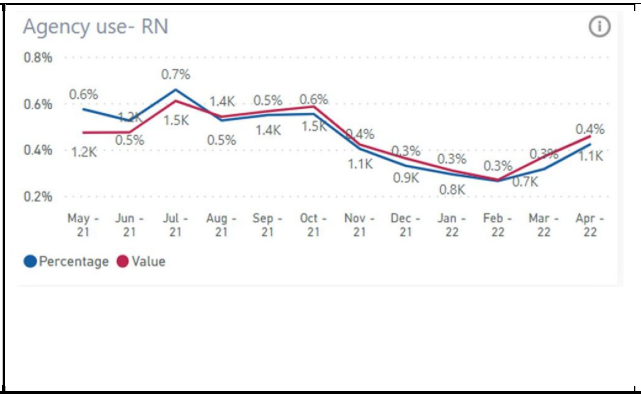
Personal Costs (Monthly)

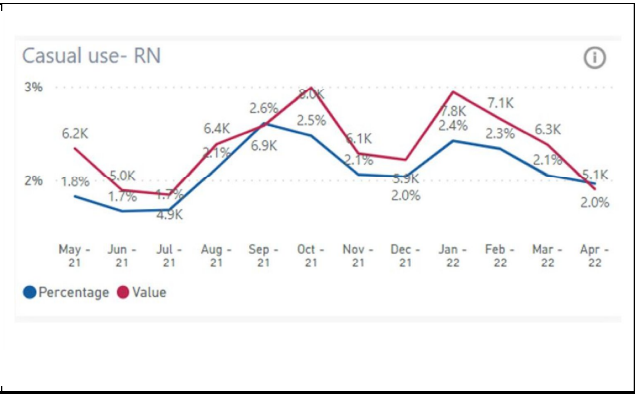
The dollar amount spent per month on personnel costs (e.g. nursing, HCA). Includes personnel costs for casual staff. The peaks are when there are more than two pay periods in one month.

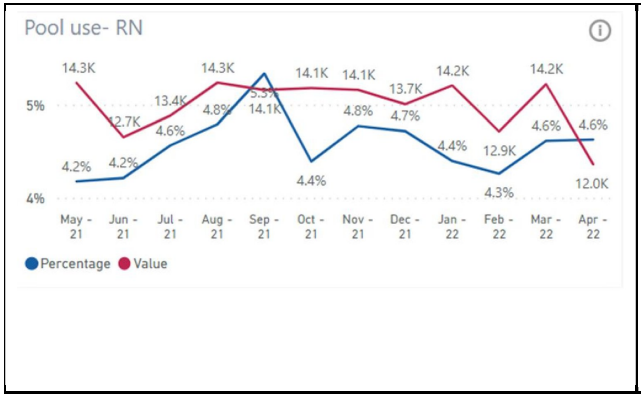
Rationale

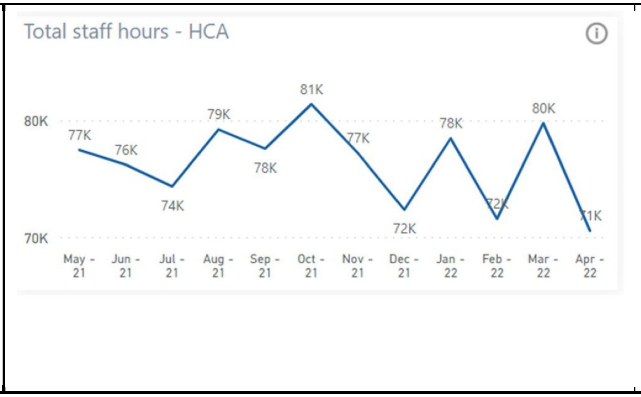
Nursing is the largest workforce and therefore one of the biggest investments in providing healthcare services. DHBs are responsible for best value for public health system resources. A logical step in achieving this is to monitor the spend on nursing personnel costs. Some studies suggest higher staff costs are offset by better patient or system outcomes. Higher staffing levels are associated with lower hospital use in terms of length of stay and re-admission.

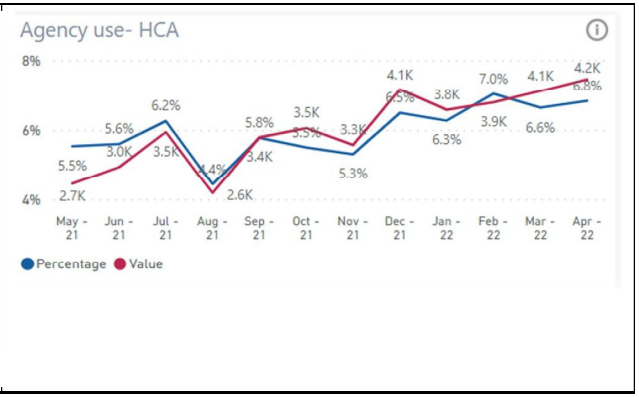
Christchurch campus, Ashburton Burwood and SMHS,

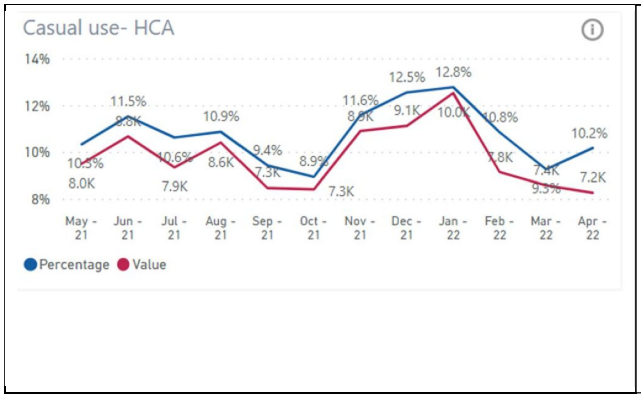


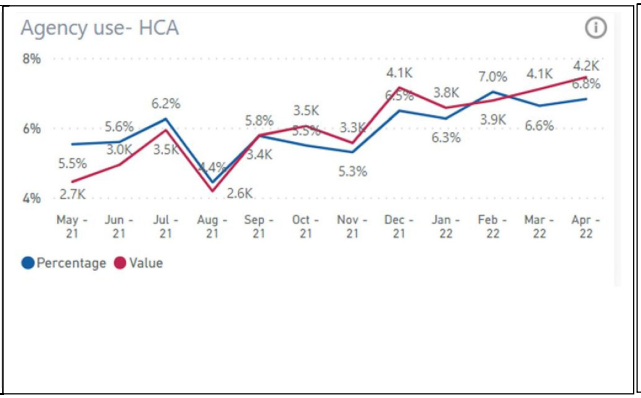


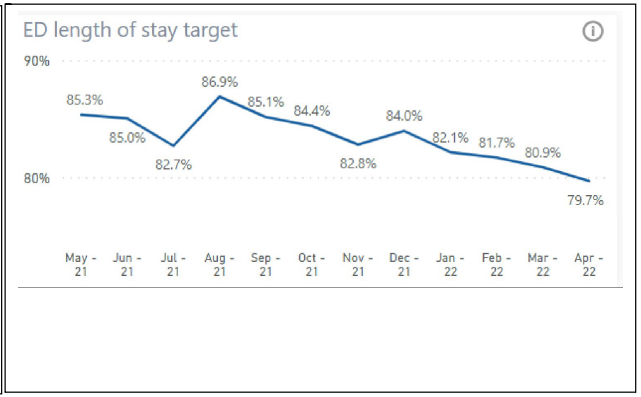












Christchurch campus, Ashburton Burwood and SMHS,

Total staff hours Registered Nurse

Displayed in red for percentage of worked hours and in blue as the actual hours

The total hours includes all productive (clinical and other productive hours) and non-productive (annual, sick, bereavement) hours, includes casual staff.

Rationale

It is important to see the total hours so that the dollar spend can be accounted for in terms of productive and non-productive hours.

Nursing hours have a significant impact on patient outcomes such as morbidity, mortality and incidents.

Agency use Registered Nurse

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to agency staff working in inpatient areas compared with total hours worked by staff CDHB.

Casual Registered nurse (casual pool)

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to staff working in inpatient areas on casual contract compared with total hours worked by staff on permanent contracts. As percentage of total hours of care.

Rationale
Casual staff play an important role in the hospitals variance response management system. However, increasing or persistently high casual use is of concern for several reasons. Casual staff may not be familiar with the environment or have the same skill set as the staff they are replacing. Team function can be altered by high levels of casual staff. Casual labour may also directly and indirectly cost more.

Casual Registered nurse use (from permanent pool)

Displayed in red for percentage of worked hours and in blue as the actual hours

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to staff working in inpatient areas on casual contract compared with total hours worked by staff on permanent contracts. As percentage of total hours of care.
Rationale
Casual staff play an important role in the hospitals variance response management system. However, increasing or persistently high casual use is of concern for several reasons. Casual staff may not be familiar with the environment or have the same skill set as the staff they are replacing. Team function can be altered by high levels of casual staff. Casual labour may also

Total staff hours HCA

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to staff working in inpatient areas on casual contract compared with total hours worked by staff on permanent contracts. As percentage of total hours of care.

Rationale
Casual staff play an important role in the hospitals variance response management system. However, increasing or persistently high casual use is of concern for several reasons. Casual staff may not be familiar with the environment or have the same skill set as the staff they are replacing. Team function can be altered by high levels of casual staff. Casual labour may also directly and indirectly cost more.

Agency use HCA

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to agency staff working in inpatient areas compared with total hours worked by staff CDHB.

Casual HCA (casual pool)

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to staff working in inpatient areas on casual contract compared with total hours worked by staff on permanent contracts. As percentage of total hours of care.

Rationale
Casual staff play an important role in the hospitals variance response management system. However, increasing or persistently high casual use is of concern for several reasons. Casual staff may not be familiar with the environment or have the same skill set as the staff they are replacing. Team function can be altered by high levels of casual staff. Casual labour may also directly and indirectly cost more.

Casual HCA (from permanent pool)

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to staff working in inpatient areas on casual contract compared with total hours worked by staff on permanent contracts. As percentage of total hours of care.

Rationale
Casual staff play an important role in the hospitals variance response management system. However, increasing or persistently high casual use is of concern for several reasons. Casual staff may not be familiar with the environment or have the same skill set as the staff they are replacing. Team

ED length of stay target

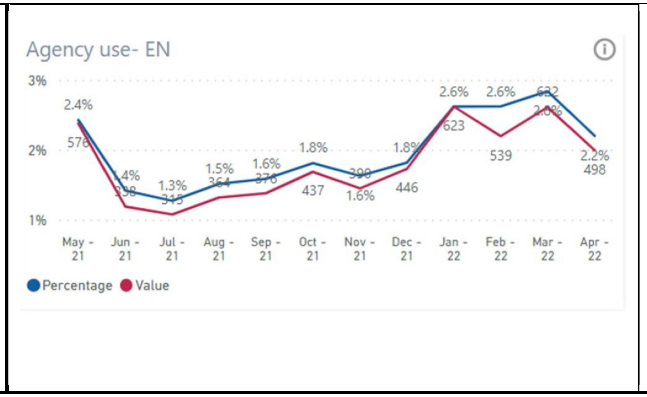
Sum of patients admitted, discharged, or transferred from ED within six hours / total number patients seen x 100.

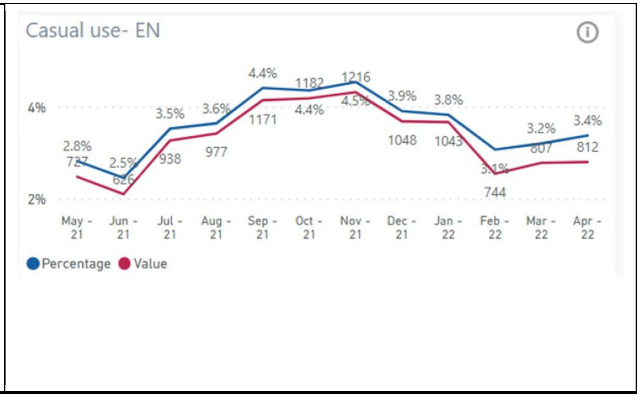
We moved into Waipapa on the 18th November and the ED observation unit was closed.

Rationale

This is a national DHB performance measure. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals and home again.

Christchurch campus, Ashburton Burwood and SMHS,





Christchurch campus, Ashburton Burwood and SMHS,

Total staff hours enrolled nurse

Displayed in red for percentage of worked hours and in blue as the actual hours

The total hours includes all productive (clinical and other productive hours) and non-productive (annual, sick, bereavement) hours, includes casual staff.

Rationale

It is important to see the total hours so that the dollar spend can be accounted for in terms of productive and non-productive hours.

Nursing hours have a significant impact on patient outcomes such as morbidity, mortality and incidents.

Agency use enrolled nurse

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to agency staff working in inpatient areas compared with total hours worked by staff CDHB.

Casual enrolled nurse (casual pool)

Displayed in red for percentage of worked hours and in blue as the actual hours

Hours paid to staff working in inpatient areas on casual contract compared with total hours worked by staff on permanent contracts. As percentage of total hours of care.

Rationale
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Casual enrolled nurse use (from permanent pool)

Displayed in red for percentage of worked hours and in blue as the actual hours

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Hours paid to staff working in inpatient areas on casual contract compared with total hours worked by staff on permanent contracts. As percentage of total hours of care.
Rationale
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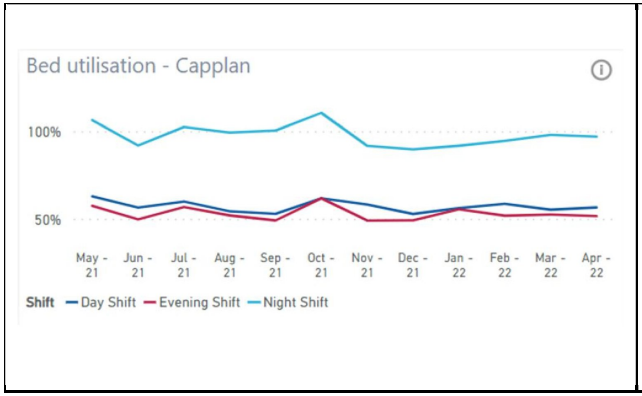
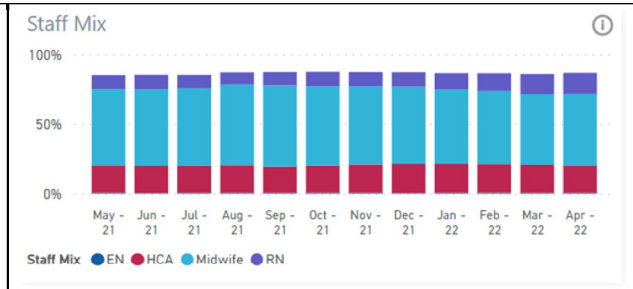
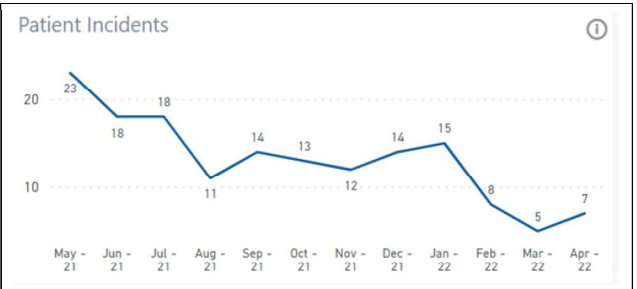
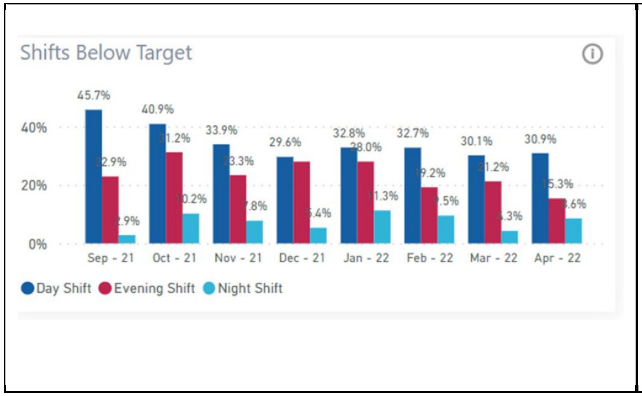
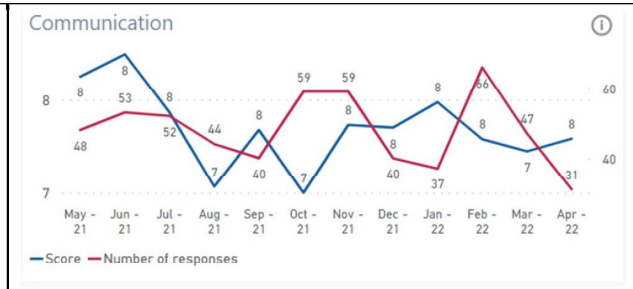
Midwifery

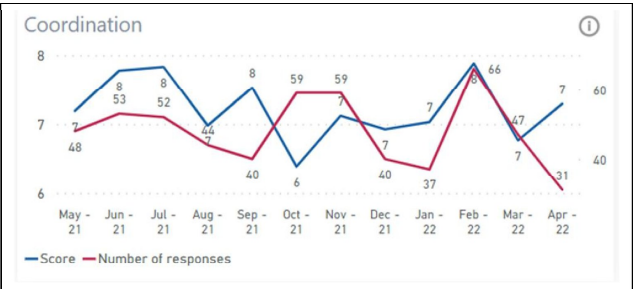


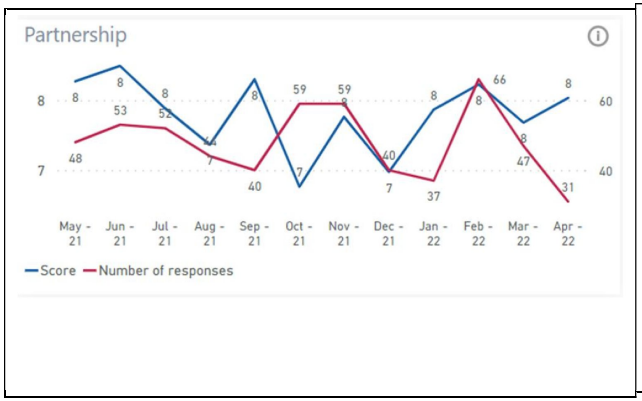


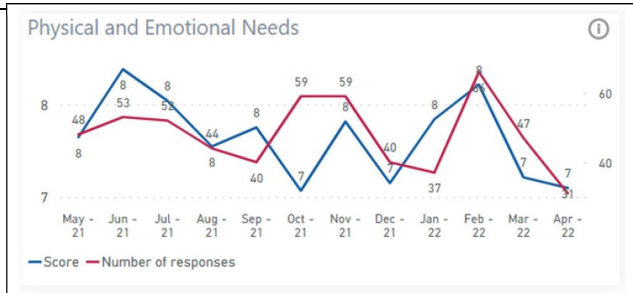




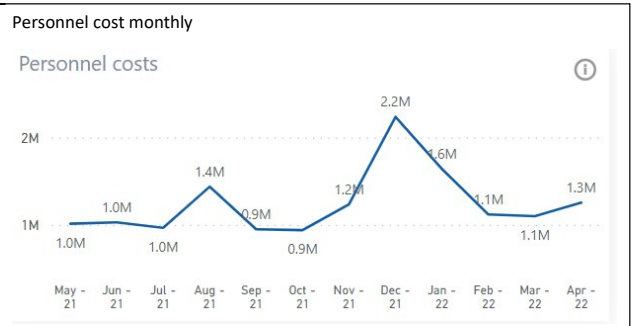








Personnel cost monthly



Midwifery

Bed Utilisation (Monthly)

Bed utilisation reflects the throughput of patients during a calendar day – accounting for all discharges, deceased patients, admissions and transfers for the shift on which the patient received care. By shift AM, PM, N.
Source: TrendCare or Capplan for those areas that use it

Staff mix (Monthly)

The number of regulated staff (RN, RM and EN) that worked, compared with all staff that worked expressed as a percentage for AM, PM and N shift.

Higher levels of RNs have been associated with better patient outcomes (2). Higher RN levels are associated with lower mortality rates (31, 35, 39) and failure to rescue (5). The majority of patient care requires RNs (2). RNs also contribute to the provision of coherent, quality nursing services through supervision, patient flow, team organisation and delegation (2). Monitoring the percentage of regulated nurses (RN, RM and EN) is a logical step towards ensuring the delivery of quality patient care.

Patient incidents (Monthly)

The number of patient incidents in this month. A patient incident is any event that could have or did cause harm to a patient (adverse event, near miss, reportable event).
Source: https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Reportable-Events-Policy-Final-Jan-2013.pdf)
Examples include: falls, pressure injury, hospital acquired infection, patient collapse/777, medication error etc.)

Shifts Below Target (Monthly

The number of shifts by AM, PM, N where the difference in the care hours provided and the care hours required was greater than negative 8.5% (or 40 minutes per FTE).
Worked example: If there are 30 days in the month (or 90 shifts in total) and 25 shifts had more than negative 8.5% difference in hours between required and supplied, then the percentage of shifts below target = 25 / 90 x 100 = 27%.

Patient mortality increases with exposure to increased number of shifts below target (4, 10). Shifts below target is the companion measure to nursing hours variance. Nursing hours variance may be 400 hours for the month on PM shifts. However 9 of the 30 shifts may have had a negative variance of greater than 8.5% (or 40 minutes per FTE). Once 40 minutes per FTE has been breached there is increasing risk to patient safety, staff meal breaks, working overtime etc.

Communication (quarterly)

Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

Note: This cannot be drilled down to a ward level - reported by DHB only.
Patient experience is an indicator of the quality of care provided to patients. There is evidence that quality work environments and higher levels of registered nurses are associated with higher patient satisfaction. There is a significant association between positive nursing leadership styles, behaviours and practices, and increased patient satisfaction.

Coordination (quarterly)

Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

Example:
Did you have enough information about how to manage your condition or recovery after you left hospital?

Partnership (quarterly)

Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

Example
Were you involved as much as you wanted to be in making decisions about your treatment and care
Did hospital staff include your family/whānau or someone close to you in discussions about the care you received during your stay?

Physical and emotional needs. (quarterly)

Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

Example
Did the hospital treat you with kindness and understanding while you were in the hospital?
Did the hospital treat you with respect?
Did hospital staff help you to get to the bathroom or to use a bedpan as soon as you wanted?

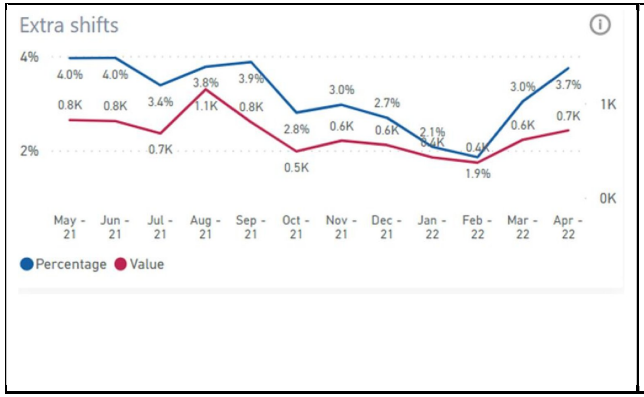
Personal Costs (Monthly)

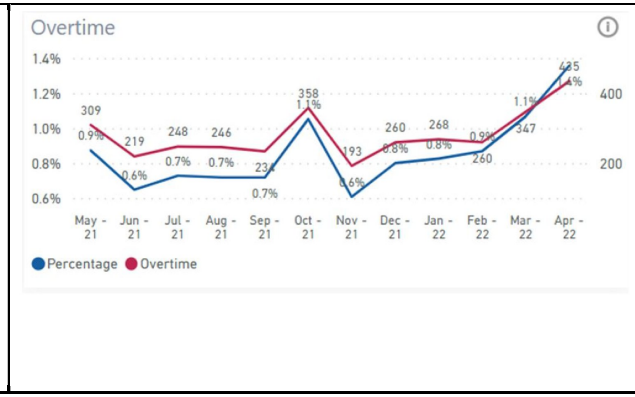
The dollar amount spent per month on personnel costs (e.g. nursing, HCA). Includes personnel costs for casual staff. The peaks are when there are more than two pay periods in one month.

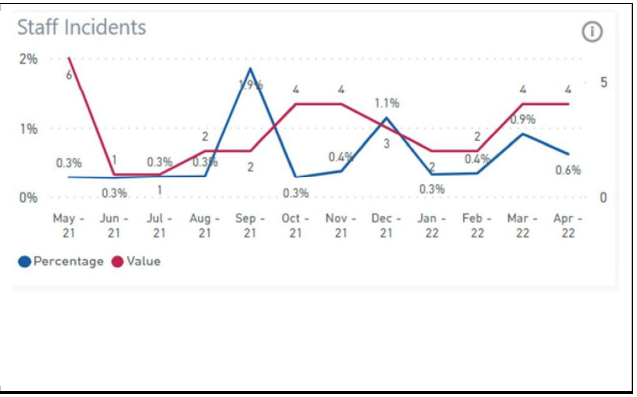
Rationale

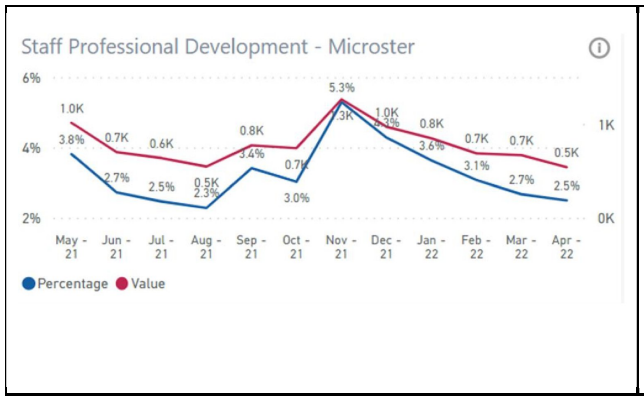
Nursing is the largest workforce and therefore one of the biggest investments in providing healthcare services. DHBs are responsible for best value for public health system resources. A logical step in achieving this is to monitor the spend on nursing personnel costs. Some studies suggest higher staff costs are offset by better patient or system outcomes. Higher staffing levels are associated with lower hospital use in terms of length of stay and re-admission.

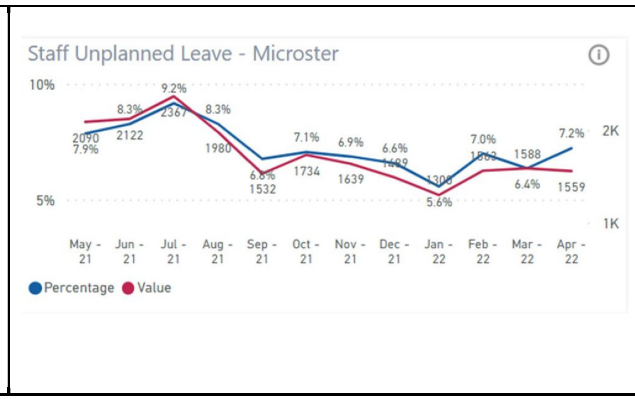
Midwifery


Extra shifts
Percentage
Value

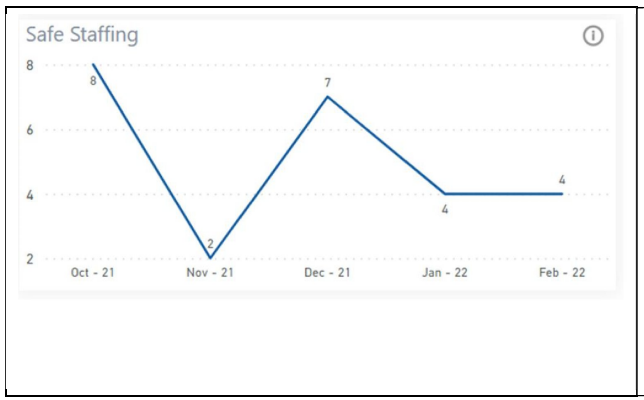

Overtime
Percentage
Overtime


Staff Incidents
Percentage
Value

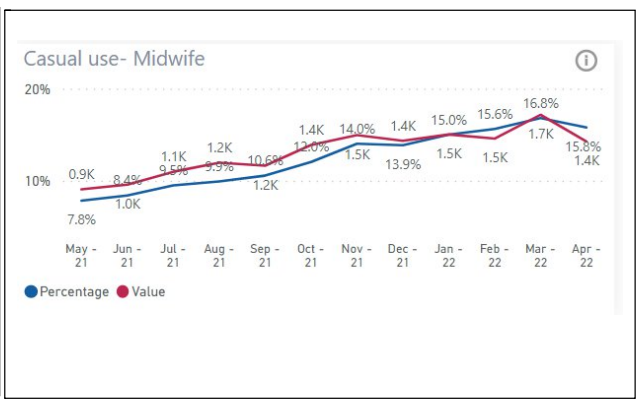

Staff Professional Development - Microster
Percentage
Value


Staff Unplanned Leave - Microster
Percentage
Value


Excess Accrued Leave - CDHB definition


Safe Staffing
Oct - 21
Nov - 21
Dec - 21
Jan - 22
Feb - 22


Total leave accrued


Casual use- Midwife
Percentage
Value

Midwifery

Extra Shifts (Monthly)

Displayed in red for actual hours and in blue as the percentage of worked hours

All staff hours worked that are additional to their normal contracted hours of work. This applies to part time staff only.
Example: a nurse may be contracted to work 24 hours per week but actually works 32 hours.
Note: This differs from the NZNO definition of overtime as the nurse may not exceed 8 hours per day or 80 hours per fortnight, but is still working additional hours to contract.
Source: Microster and PSE

Overtime (Monthly)

Displayed in red for actual hours and in blue as the percentage of worked hours

Overtime includes any extra paid hours that a nurse is required to work beyond their contracted hours at either end of their shift (2).
Overtime is defined as per the MECA. Includes payment for missed meal breaks.
Example from NZNO: *Overtime is time worked in excess of*
(i) eight hours per day or the rostered duty whichever is greater or
(ii) 80 hours per two week period
Source: Microster

Staff Incidents (Monthly)

Displayed in red for actual incidents and in blue as the percentage of worked hours

A staff incident is any reported event that could have or did cause harm to a staff member (adverse event, near miss, reportable event). Examples include accidents, needle sticks, back injuries, slips, verbal abuse etc.
Source: Safety first

Staff Professional Development (Monthly)

Displayed in red for actual hours and in blue as the percentage of worked hours

All paid hours for staff to attend professional development activities which are additional to mandatory training and hospital training.
Source: Microster

This should be around 1.5 % of worked hours for the ward. 32hrs /2086 1 fte hours

Unplanned Leave (Monthly)

Displayed in red for actual hours and in blue as the percentage of worked hours

The total unplanned or short notice leave hours taken by staff e.g. sick, domestic, bereavement, ACC. This includes sick leave hours paid, unpaid or paid as annual leave. Includes staff on permanent contracts only.
Source: Microster

Rationale
Sick leave is one indicator of the health of the workplace. Burnout and job stress increase staff absenteeism due to sickness (19).

Excess Accrued leave

Actual number of annual leave hours remaining above 30 hours

Rationale

A healthy work environment has the health and wellbeing of the person as its primary objective (1). Annual leave entitlements exist to support staff take adequate breaks from work. Excess annual leave indicates staff are not taking or unable to take their annual leave. Excess annual leave is a financial liability for the DHB.

Safe Staffing (reporting commenced October 21**)**

Monthly sum of all acute staffing shortage incidents reported by staff working in inpatient wards/units.

When a nurse considers they have reached the limits of safe practice (NZNO MECA Clause 6.0). This includes short staffing, inappropriate staff mix, influx of patients and/or unexpected increase patient acuity.

Reporting of acute staffing shortages is a MECA requirement. In these circumstances emphasis is placed on professional judgement. Poor perceptions of staffing adequacy and perceived psychological strain are linked to increased patient mortality, falls, medication errors and missed care.

Total Leave Accrued.

Total hours of leave accrued.

Source: HRIS leave data

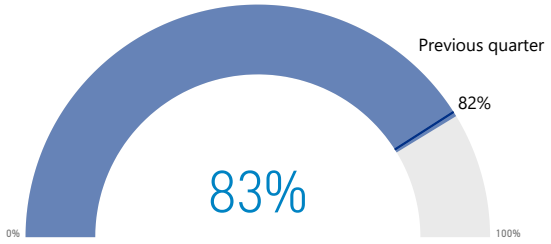
Casual Use Midwife

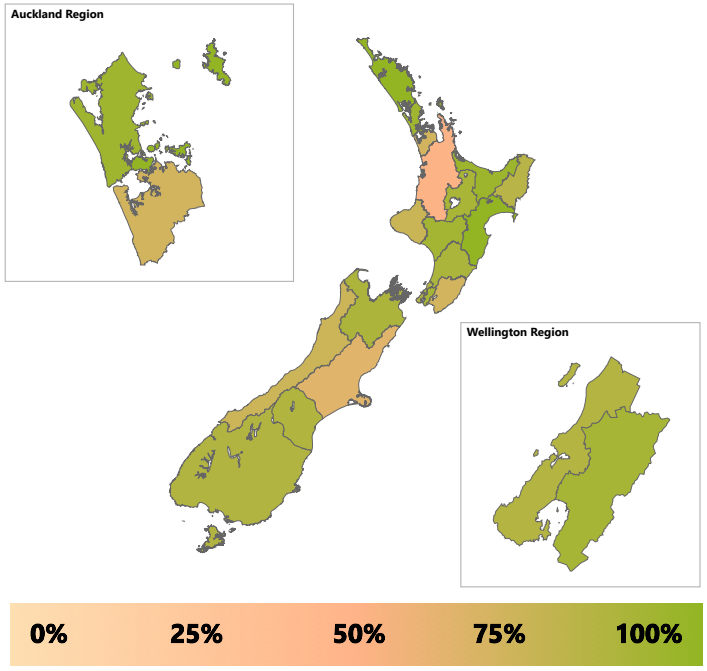
Displayed in red for the percentage of worked hours as casual contract and in blue as number of actual hours of worked hours

Care Capacity Demand Management (CCDM) implementation overall progression

Rolling four quarters from 1 April 2021 to 31 March 2022

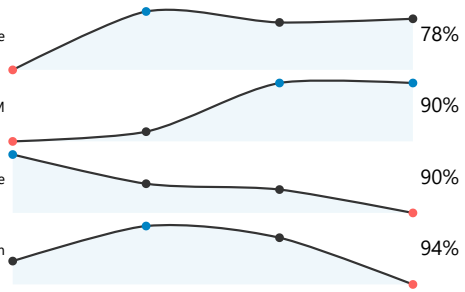
1. Overall implementation as at quarter 3 2021-22



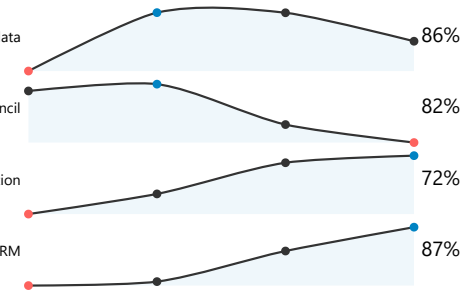


3. Progress against all milestones

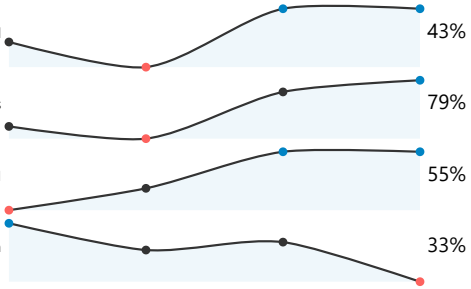
Site milestones progression as at quarter 3



Ward milestones progression as at quarter 3

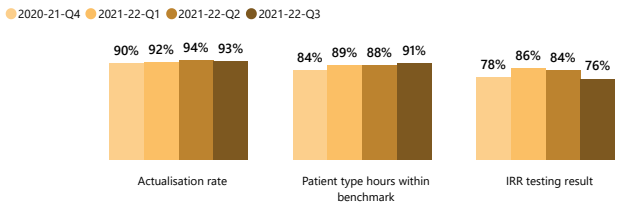


Team milestones progression as at quarter 3

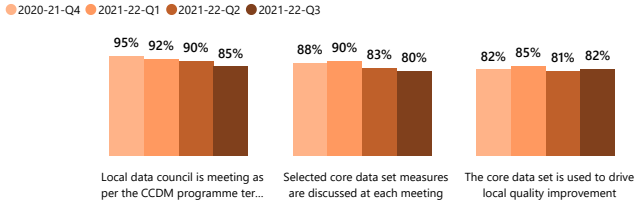


4. Breakdown of ward milestones

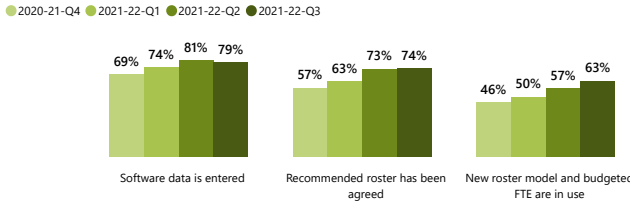
Accurate Trendcare Data



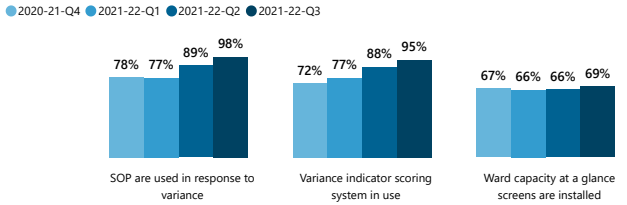
Operational Local Data Council



Completed Annual FTE Calculation



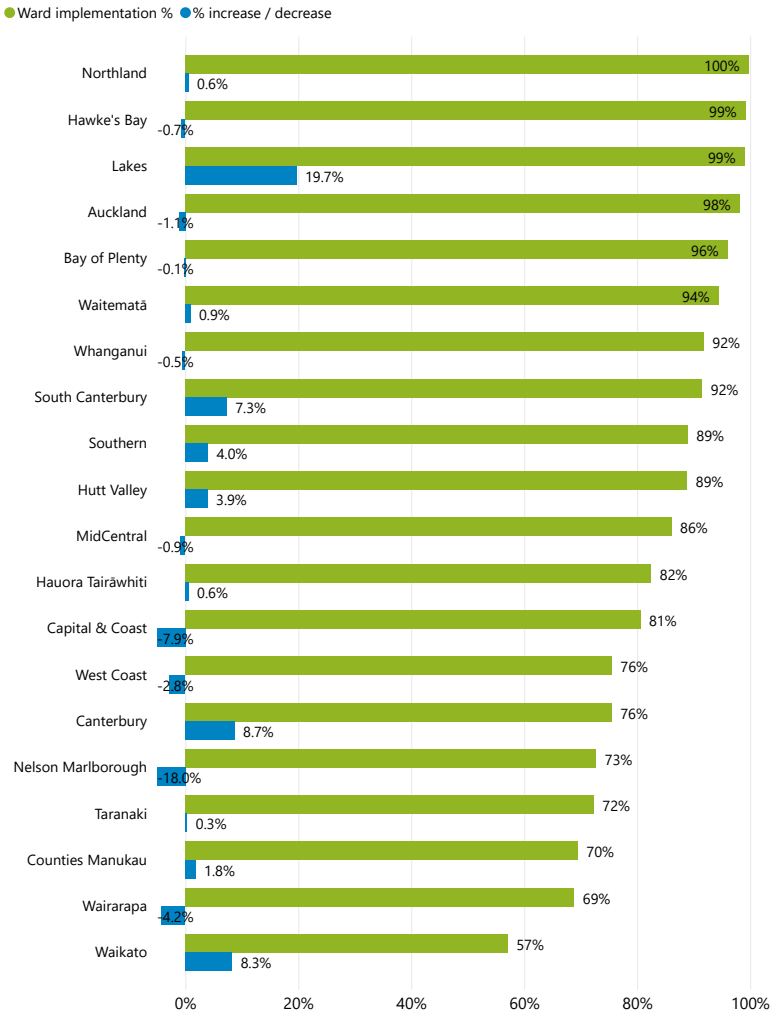
Effective Ward VRM



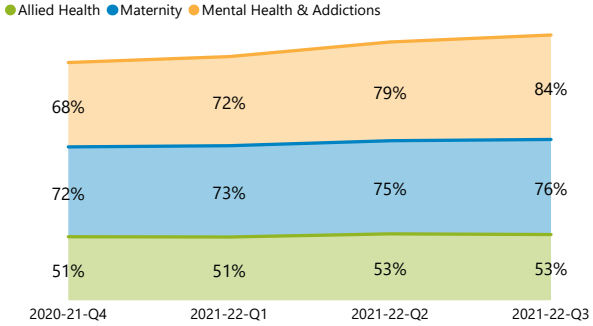
Care Capacity Demand Management (CCDM) progress by DHB

Rolling four quarters from 1 April 2021 to 31 March 2022

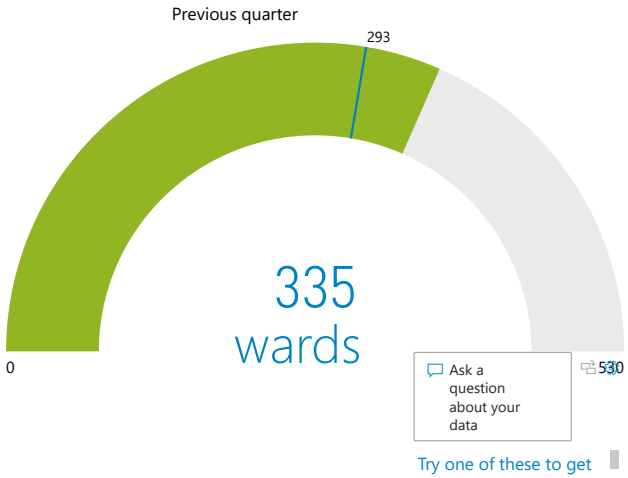
5. DHB implementation rate quarter 3 2021-22



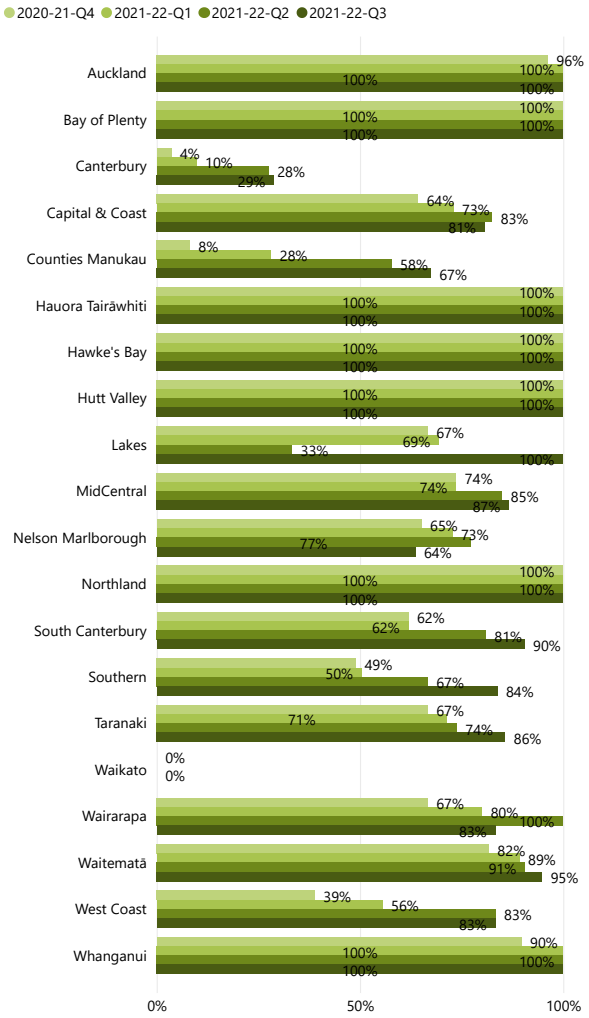
6. Progress in Allied Health, Maternity and Mental Health services



7. Count of total wards completed FTE calculations

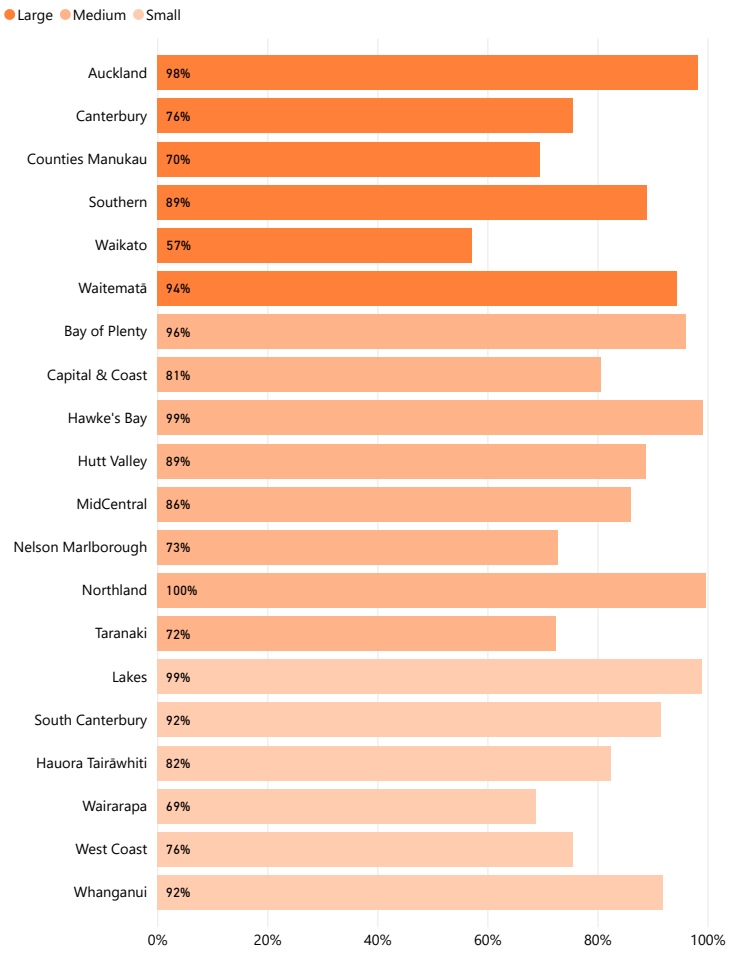


8. Progress with annual FTE calculation as at quarter 3 2021-22



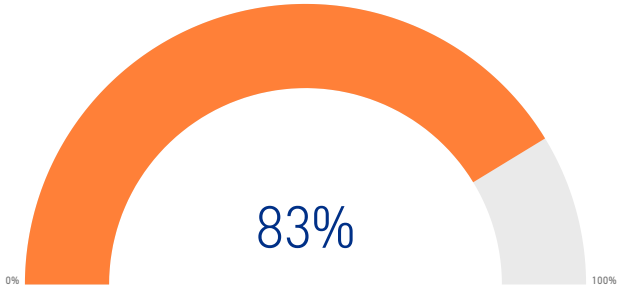
Care Capacity Demand Management (CCDM) Implementation January to March 2022 - Quarter 3

1. DHB implmentation varies by DHB size

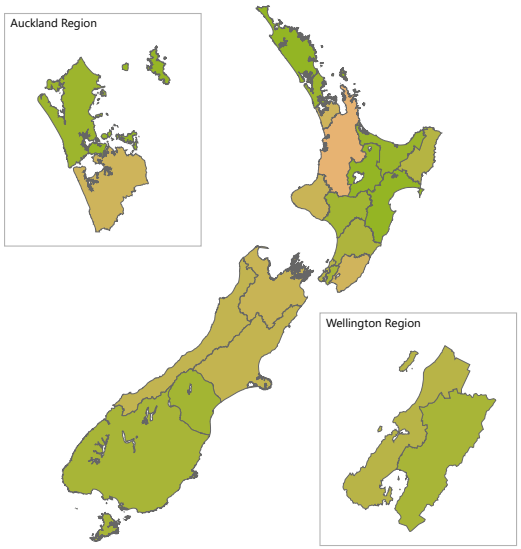


-Results approved for submission by each DHBs' CCDM Council.
-Allied Health team milestones are excluded from the overall implementation rate.
-Updated 11 May 2022.

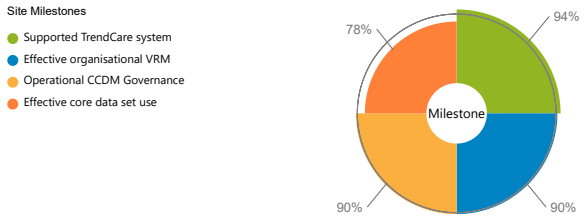
2. National implementation rate



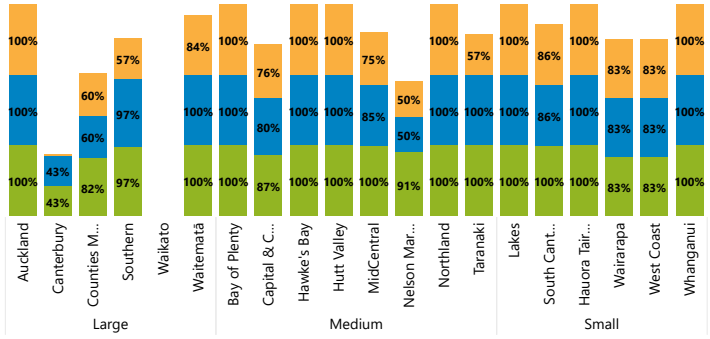
3. Implementation heat map by DHB



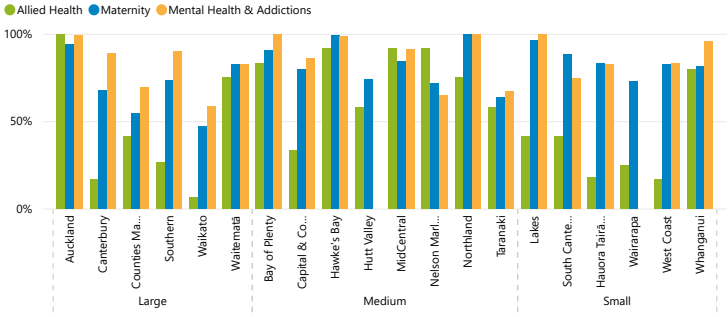
4. Milestone progression for Sites



5. DHB progress with annual FTE calculations

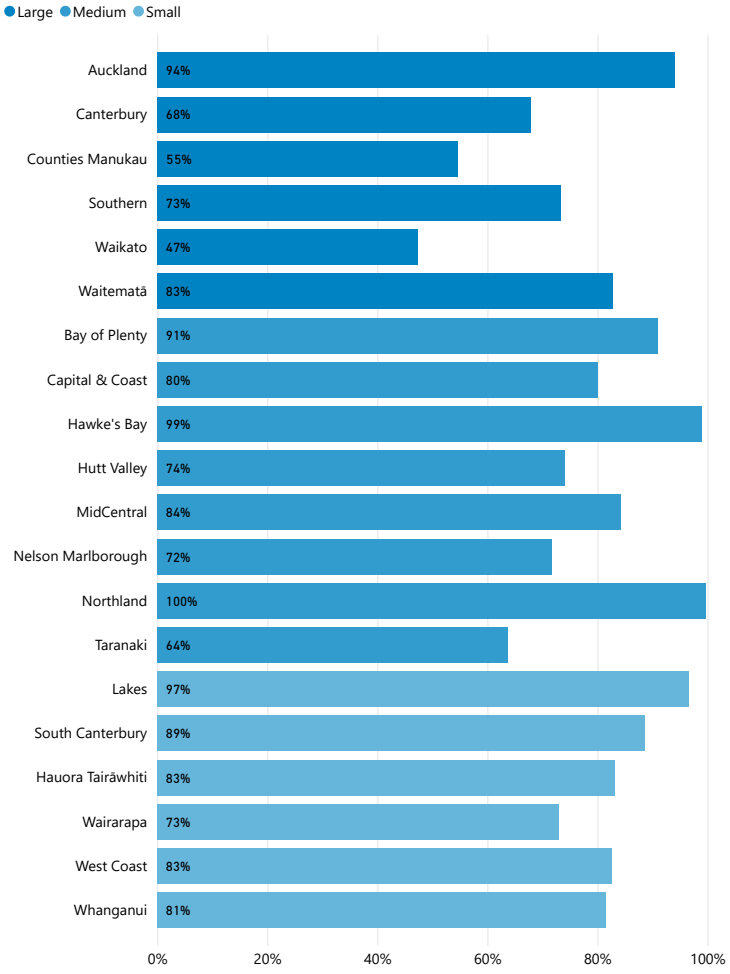


6. Allied health, Maternity and Mental health services are making varied progress across DHBs



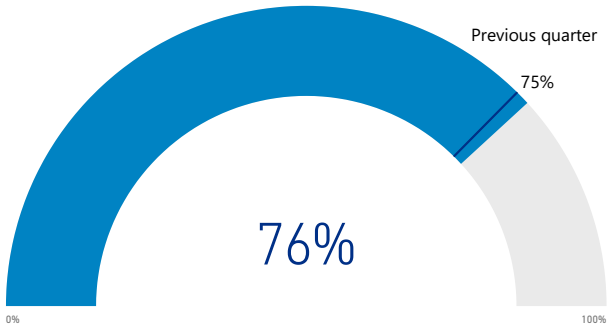
Maternity CCDM Implementation January to March 2022 - Quarter 3

1. DHB implmentation varies by DHB size

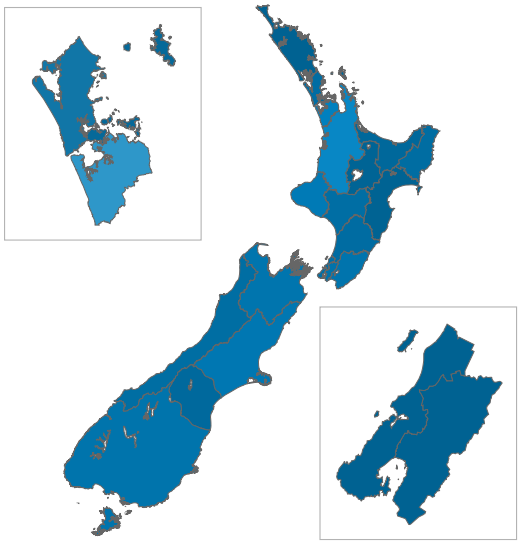


-Results approved for submission by each DHBs' CCDM Council.
-Updated 11 May 2022.

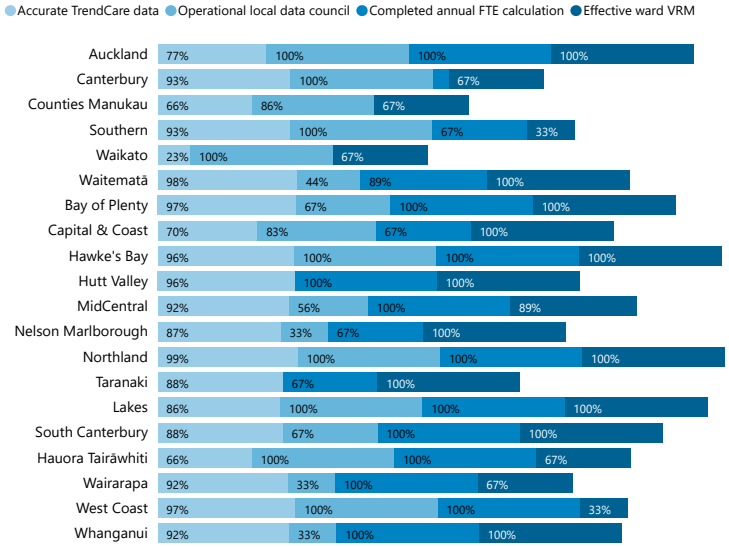
2. National implementation rate



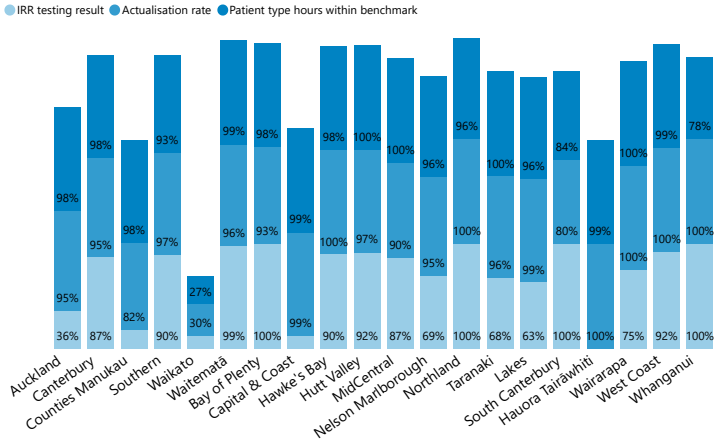
3. Implementation heat map by DHB



4. Milestone progression for all DHBs

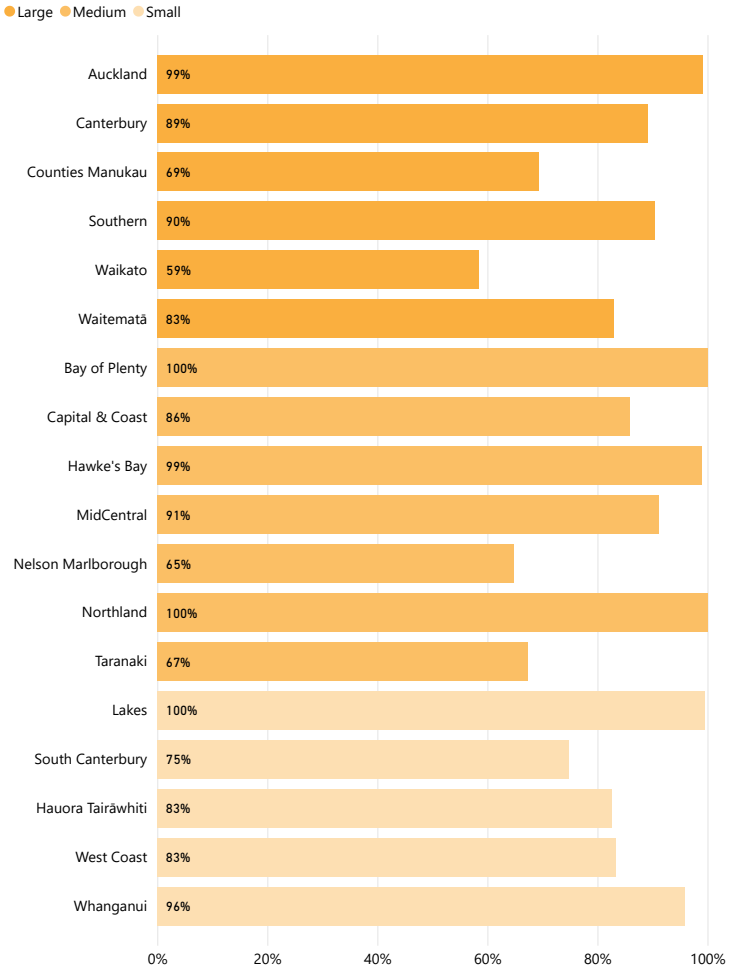


5. Accurate TrendCare Data milestone progression for all DHBs



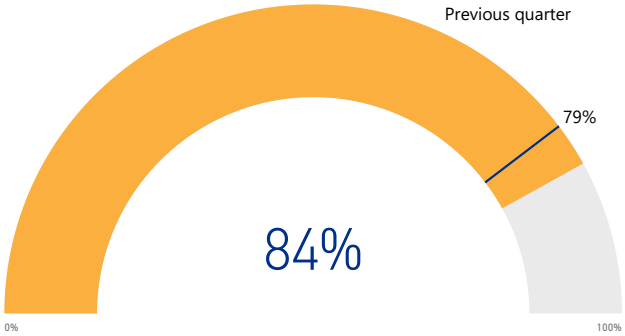
Mental Health & Addictions CCDM Implementation January to March 2022 - Quarter 3

1. DHB implmentation varies by DHB size

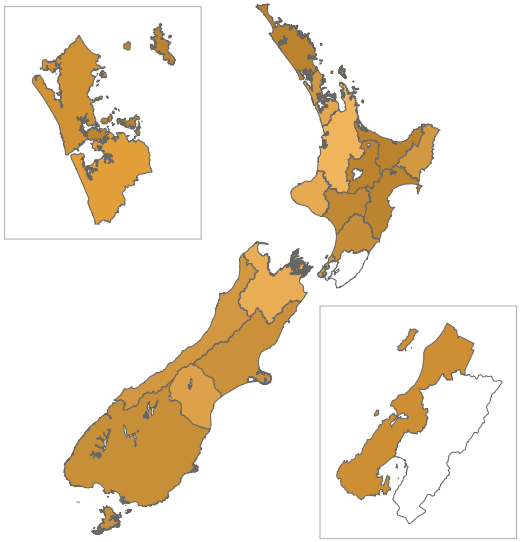


-Results approved for submission by each DHBs' CCDM Council.
-The maximum number of DHBs with mental health and addiction services is 18.
-Updated 11 May 2022.

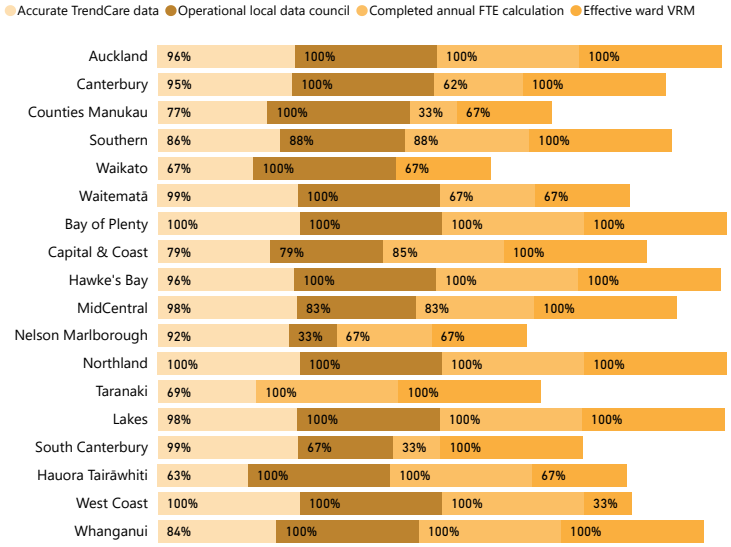
2. National implementation rate



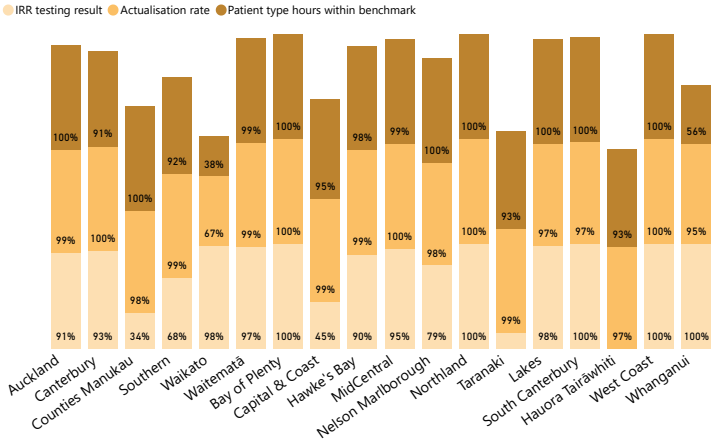
3. Implementation heat map by DHB



4. Milestone progression for all DHBs

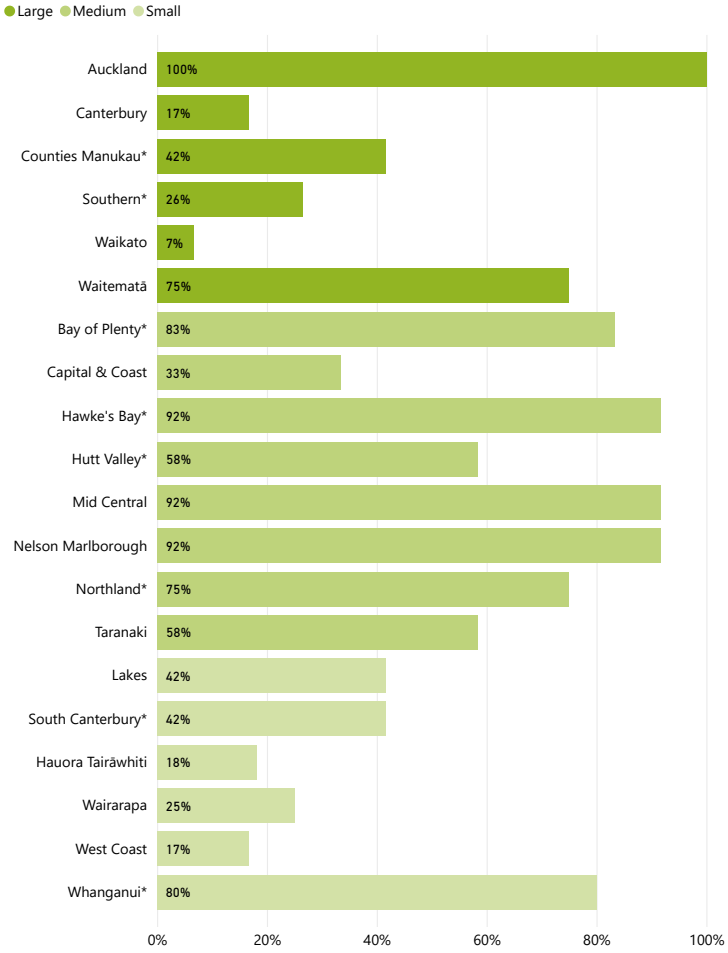


5. 17 DHBs making progress with Accurate TrendCare data

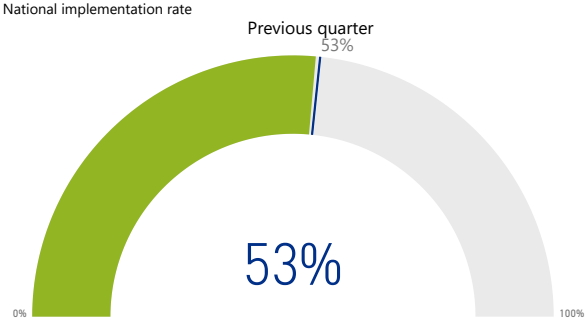


Allied Health CCDM Implementation January to March 2022 - Quarter 3

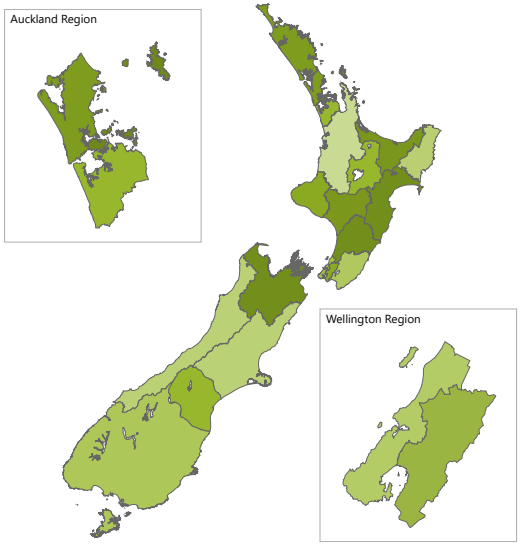
1. DHB implmentation varies by DHB size



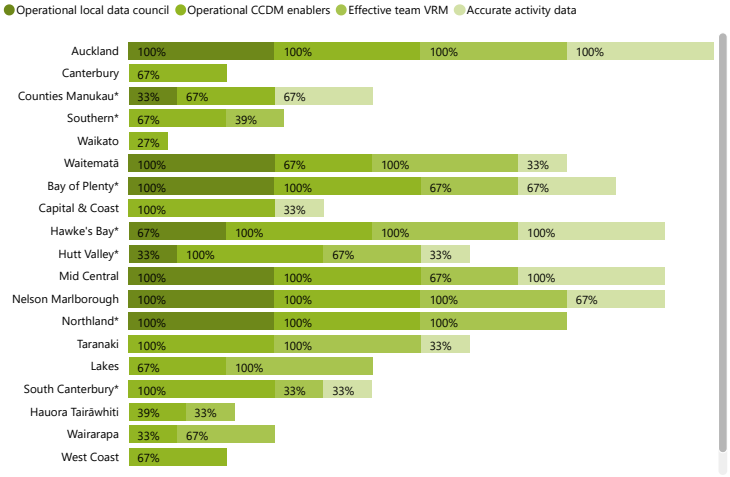
2. National implementation rate



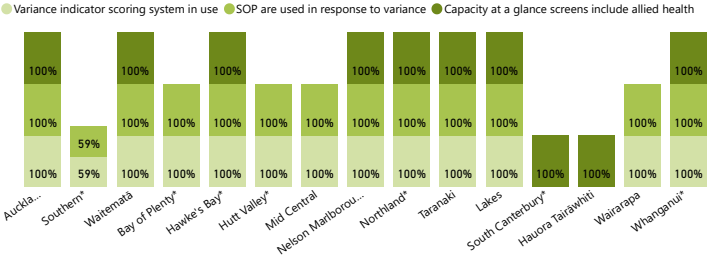
3. Implementation heat map by DHB



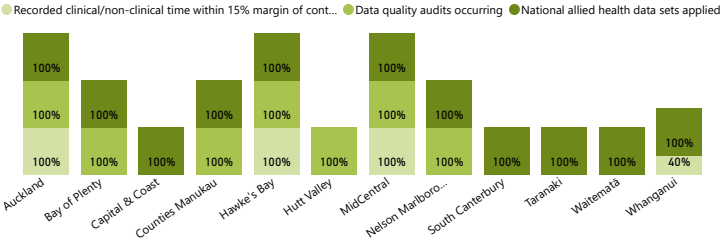
4. Milestone progression for all DHBs



5. 13 DHBs are making progress with Effective Team VRM



6. 13 DHBs are making progress with Accurate Activity Data



-Results approved for submission by each DHBs' CCDM Council.
-19 of 20 DHBs submitted team milestones data for the quarter.
-Allied Health team milestones are excluded from the overall implementation rate.
-Updated 11 May 2022.

HAC – 2 JUNE 2022

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Andrew Dickerson, Chair, Hospital Advisory Committee**

DATE: **16 June 2022**

Report Status – For:	Decision	☐	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Hospital Advisory Committee's (*HAC*) public meeting held on 2 June 2022.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from HAC's public meeting on 2 June 2022 (Appendix 1).

3. APPENDICES

Appendix 1: HAC Draft Minutes – 2 June 2022.

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held via Zoom
on Thursday, 2 June 2022, commencing at 9.00am

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

APOLOGIES
An apology for lateness was received and accepted from Ingrid Taylor (9.20am).
An apology for early departure was received and accepted from Jo Kane (9.50am).
Naomi Marshall was noted as being on a leave of absence.

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

APOLOGIES
Dr Peter Bramley (Chief Executive); Norma Campbell (Executive Director, Midwifery & Maternity Services); Pauline Clark (General Manager, Medical/Surgical; Women's & Children's Health); and Kate Lopez (Acting General Manager, Older Persons Health & Rehabilitation).

IN ATTENDANCE
Gloria Crossley, Interim General Manager, Laboratories
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Ralph La Salle, Senior Manager, Specialist Services & Non-Clinical Support
Berni Marra, General Manager, Rural Health Services
Diane Pizzato, Acting Finance Manager, Older Persons Health & Rehabilitation
Keith Wright, Programme Director, Surgical Services

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (03/22)
(Moved: Jan Edwards/Seconded: Jo Kane – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 3 February 2022 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

There were no carried forward / action items.

4. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for May 2022. The report was taken as read.

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

Rural Health Services – Berni Marra, General Manager

Ashburton Hospital

- Focus for the last couple of months has been around the management of staffing and Omicron. Ward 2 was reopened yesterday.

Rural Community Hospitals

- There is a plan underway to open Oxford with Aged Residential Care (*ARC*) beds towards the middle of June 2022. Also exploring the opportunity to provide some urgent respite for the rest of the system by looking after patients short-term under a general medical practitioner in Oxford. This would include people who may need to be discharged from Christchurch and/or Burwood, but require further support prior to being discharged to the home environment.
- Friends of Ellesmere Hospital AGM last night. There is great excitement as well as opportunities to look at rural areas differently, as well as stand up the hospitals. Whilst there is no detail of what that could look like yet, it is heartening that the friends of the hospitals have reached out, are engaged and committed to walking alongside us as we look to see how we can expand what we do and what we can deliver.

Medical/Surgical; & Women's & Children's Health; & Orthopaedics – Keith Wright, Programme Director, Surgical Services

- Very busy campus. The entire system, including primary care, is experiencing record demand at the moment.
- Staff and families are experiencing COVID and winter illness, which is compounding issues.
- Occupancy yesterday sat at 106% - more patients than resourced beds.
- 60 elective surgical cases were cancelled / deferred on 31 May 2022. 25 surgeries went ahead yesterday.

Discussion took place on the following:

- Resourced beds. Sitting at approximately 93% resourced bed occupancy right now. The issue is a significant staffing issue. Across the DHB, we are down around 200 FTE, with around 100 of those FTE sitting within the Christchurch campus alone. Hence why resourced bed occupancy is low and changes on a daily basis. Resourced bed occupancy going up and down is purely to do with what staffing we have available on the day.
- Outsourced theatre capacity. Private hospitals are experiencing in some cases a 2nd wave of COVID and are having problems with short notice cancellations to their own lists as well. We need to get through the hump in the system now, both in public and private. As soon as primary care starts to see people again and we start to get the flow come in on referrals there will probably be another hump to work through. Outsourcing will be an integral part to the overall solution, but what that looks like is still to be seen.

- Planning for winter months. The biggest challenge will be staffing issues and a System Wide Operations Centre (*SWOC*) has been set up to assist with this. Currently, the greatest need is within Christchurch Campus and Aged Residential Care (*ARC*). A second piece of work underway is around training up the Kaiawhina workforce to help support and augment the workforce to provide safety and support within the clinical area.
- Working closely with primary care, who are under huge pressure at the moment – seeing extraordinary numbers. Meeting with CEOs and clinical leads weekly. Healthline has added to its numbers and support. Effective communication with the community is critical.
- Risk management over the next few years and national discussions that are underway.

Ingrid Taylor joined the meeting at 9.20am.

Older Persons Health & Rehabilitation (*OPH&R*) Service – Diane Pizzato, Acting Finance Manager, OPH&R

- Dental – extended hours clinics have been rolled out. This new model has been well received by parents, with every minute being fully utilised. On target to significantly reduce screening arrears.
- Continue to have workforce pressures across the system. Sickness peaked at the tail end of April. Now seeing around 3-6% of sickness rates for staff. Compounding this are staff vacancies:
  - Allied – 9% vacancy rate - 29FTE
  - Nursing – 3% vacancy rate - 14FTE
  - SMOs – 5% vacancy rate - 3FTE
- There is a huge focus on flow and supporting Christchurch Campus.

In response to a query around patients booked to go to Burwood from Christchurch Hospital, Ms Pizzato advised that there are currently 16 on a waiting list as of today. Burwood has nine planned discharges today, so it is hoped to take the bulk of the 16 over the next couple of days.

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

- Mental Health sits in the position of having previously had staffing deficits. It has been pretty tight over the past few months with Omicron.
- Last month the Service was around 45FTE under budget. However, the total number of gaps in the Service is hidden by staff having high rates of overtime, which is double paid. That said, staff have delivered services consistently throughout the period and teams have worked well to ensure we got through.
- COVID has increased Child & Adolescent, Eating Disorders, and Alcohol and Other Drug presentations. Adult services were relatively stable across the Omicron period, but the last couple of weeks has seen a significant increase in acuity and volume.
- Yesterday, 33 staff were off with either Omicron or winter sickness.
- The focus is on how to create capacity to do the work. Looking at configurations and smart work with community partners.

Discussion took place around workforce sustainability, along with plans and strategies to address this.

In response to a query about interest from the UK and NHS staff wanting to come to New Zealand, Dr Hamilton advised there has been none. He added that there has not really been any overseas movement, with only two overseas nurses recruited since March 2020.

Dr Jacqui Lunday-Johnstone, Executive Director, Allied Health, Scientific and Technology, commented that we need to evolve our home-grown solutions. We are overly reliant on the

overseas workforce. She noted that there is a lot of work to do, but there are also some great opportunities.

Hospital Laboratories – Gloria Crossley, Interim General Manager

- Staffing is reasonable. There are some vacancies in management, which are being worked through.

The H&SS Monitoring report was noted.

Jo Kane departed the meeting at 9.50am.

5. OFFICE OF THE CLINICAL EXECUTIVE UPDATE

Becky Hickmott, Executive Director of Nursing; and Dr Jacqui Lunday-Johnstone, Executive Director, Allied Health, Scientific & Technical, presented the report, which was taken as read.

The following points were noted:

- There is a strong focus on workforce development. This is critical for planned care, urgent care, COVID and the winter response.
- Partnering across the system with our colleagues in primary care, the Hub, and the vaccination programme – making sure we are keeping a watching brief on quality data.
- Looking to partner with Health NZ to engage across the system as to how we strengthen the consumer engagement partnership and co-production.

Discussion took place around the anaesthetic technician workforce and work being undertaken to evolve a sustainable model.

The Clinical Advisor Update was noted.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (04/22)
(Moved: Barry Bragg/Seconded: Jan Edwards – carried)

"That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 3 February 2022	For the reasons set out in the previous Committee agenda.	

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

INFORMATION ITEMS

- Quality & Patient Safety Indicators – Level of Complaints
- 2022 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.00am.

Approved and adopted as a true and correct record:

_____	_____
Andrew Dickerson	Date of approval
Chairperson	

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **16 June 2022**

Report Status – For: **Decision** ☑ **Noting** ☐ **Information** ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATIONS

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 & 18 and the information items contained in the report;

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of public excluded meetings – 19 May 2022	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(a) s9(2)(j)
4.	Health NZ Annual Account Requirements & Delegations	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Audit NZ Fraud Risk Assessment	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

6.	Service Change Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	MedChart Upgrade Scope Change	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Health One Request for Working Capital Draw Down	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Waipapa Tower 3 – Fit Out of Residual 3 Shelled Wards Business Case	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Hillmorton Mobile Duress System – Phase 2	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	Capital Projects Funding Requests	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	885 Colombo Street	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
13.	35 James Street, Lincoln	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
14.	Going Concern Assessment - Year Ended 30 June 2022	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
15.	Revaluation & Impairment for the Year Ended 30 June 2022	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
16.	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)
17.	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)
18.	Advice to Board • HAC Draft Minutes *2 June 2022* • QFARC Draft Minutes *31 May 2022*	For the reasons set out in the previous Committee agenda.	

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.