AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 19 November 2020 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 15 October 2020		
3.	Carried Forward / Action List Items		
Reports for Decision			
4.	Gifting of Name for New Hospital Building (ratification of resolution)	Sir John Hansen *Chair*	9.35-9.40am
5.	Delegations	David Green *Acting Executive Director, Finance & Corporate Services*	9.40-9.50am
6.	COVID-19 Health System Response: Ventilator & Respiratory Equipment	David Green	9.50-10.00am
7.	Accessible Information Charter	Dr Jacqui Lunday-Johnstone *Executive Director, Allied Health, Scientific & Technical*	10.00-10.10am
Reports for Noting			
8.	Chair's Update (Oral)	Sir John Hansen	10.10-10.15am
9.	Chief Executive's Update	Dr Andrew Brant *Acting Chief Executive*	10.15-10.45am
MORNING TEA			**10.45-11.00am**
10.	Finance Report	David Green	11.00-11.10am
11.	COVID-19 Testing (Oral)	Evon Currie *General Manager, Community & Public Health*	11.10-11.40am
12.	Advice to Board: • CPH&DSAC – 5 November 2020 – Draft Minutes	Aaron Keown *Chair, CPH&DSAC*	11.40-11.45am

13.	Resolution to Exclude the Public		11.45am
ESTIMATED FINISH TIME – PUBLIC MEETING			**11.45am**

NEXT MEETING
Thursday, 17 December 2020 at 9.30am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

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

Executive Support

Dr Andrew Brant – *Acting Chief Executive*
Evon Currie – *General Manager, Community & Public Health*
David Green – *Acting Executive Director, Finance & Corporate Services*
Becky Hickmott – *Acting Executive Director of Nursing*
Ralph La Salle – *Acting Executive Director, Planning Funding & Decision Support*
Paul Lamb – *Acting Chief People Officer*
Dr Jacqui Lunday-Johnstone – *Executive Director of Allied Health, Scientific & Technical*
Hector Matthews – *Executive Director Maori & Pacific Health*
Dr Sue Nightingale – *Chief Medical Officer*
Dr Rob Ojala – *Executive Lead of Facilities*
Karalyn Van Deursen – *Executive Director of Communications*
Savita Devi – *Acting Chief Digital Officer*

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

BOARD ATTENDANCE SCHEDULE – 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	25/02/20	19/03/20	16/04/20	01/05/20 SM	21/05/20	18/06/20	16/07/20	04/08/20	12/08/20	20/08/20	17/09/20	15/10/20	19/11/20	17/12/20
Sir John Hansen (Chair)	√	√	√	√	√	√	√	√	√	√	√	^		
Gabrielle Huria (Deputy Chair)	√	√	√	√	√	√	^	√	√	√	√	√		
Barry Bragg	^	√	√	√	√	√	√	√	√	√	√	√		
Sally Buck	#	^	~	~	~	~	** 08/07/2020							
Catherine Chu	^	√	√	√	√	√	^	√	√	√	√	x		
Andrew Dickerson	√	√	√	√	√	√	√	√	√	√	√	√		
James Gough	√	√	√	√	√	√	√	√	√	√	√	√		
Jo Kane	√	√	√	√	√	√	√	√	√	√	√	√		
Aaron Keown	√	√	√	√	√	√	√	√	√	√	√	√		
Naomi Marshall	√	√	√	√	√	√	√	√	√	√	√	√		
Ingrid Taylor	√	√	√	√	√	√	√	√	√	√	√	√		

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

	Farrell Construction Limited - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Paenga Kupenga Limited** – Chair Commercial arm of Ngai Tuahuriri Runanga **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Verum Group Limited** – Director Verum Group Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.
Catherine Chu	**Christchurch City Council** – Councillor Local Territorial Authority **Riccarton Rotary Club** – Member **The Canterbury Club** – Member
Andrew Dickerson	**Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital.

	NZ Association of Gerontology - Member Professional association that promotes the interests of older people and an understanding of ageing.
James Gough	**Amyes Road Limited** – Shareholder Formally Gough Group/Gough Holdings Limited. Currently liquidating. **Christchurch City Council** – Councillor Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board **Christchurch City Holdings Limited (*CCHL*)** – Director Holds and manages the Council's commercial interest in subsidiary companies. **Civic Building Limited** – Chairman Council Property Interests, JV with Ngai Tahu Property Limited. **Gough Corporation Holdings Limited** – Director/Shareholder Holdings company. **Gough Property Corporation Limited** – Director/Shareholder Manages property interests. **The Antony Gough Trust** – Trustee Trust for Antony Thomas Gough **The Russley Village Limited** – Shareholder Retirement Village. Via the Antony Gough Trust **The Terrace Car Park Limited** – (Alternate) Director Property company – manages The Terrace car park (under construction) **The Terrace On Avon Limited** – (Alternate) Director Property company – manages The Terrace.
Jo Kane	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Aaron Keown	**Christchurch City Council** – Councillor and Community Board Member Elected member and of the Fendalton/Waimairi/Harewood Community Board. **Christchurch City Council** – Chair of Disability Issues Group

	Grouse Entertainment Limited – Director/Shareholder
Naomi Marshall	**Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Ingrid Taylor	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee. **Taylor Shaw** – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • I / Taylor Shaw have acted as solicitor for Bill Tate and family. **The Youth Hub** – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.

MINUTES

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 15 October 2020 commencing at 9.30am

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

BOARD CROWN MONITOR
Dr Lester Levy (via zoom).

BOARD CLINICAL ADVISOR
Dr Andrew Brant.

APOLOGIES
An apology for early departure was received and accepted from Sir John Hansen (1.15pm).

ABSENT
Catherine Chu.

EXECUTIVE SUPPORT
Dr Peter Bramley (Acting Chief Executive); Evon Currie (General Manager, Community & Public Health); David Green (Acting Executive Director, Finance & Corporate Services); Becky Hickmott (Acting Executive Director of Nursing); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Paul Lamb (Acting Chief People Officer); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Melissa Macfarlane (Team Lead, Planning & Performance); Hector Matthews (Executive Director, Maori & Pacific Health); Dr Rob Ojala (Executive Lead Facilities); Karalyn van Deursen (Executive Director Communications); Stella Ward (Chief Digital Officer); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

EXECUTIVE APOLOGIES
Dr Sue Nightingale (Chief Medical Officer)

IN ATTENDANCE
Full Meeting
Savita Devi (ICT Services Manager).

Hector Matthews opened the meeting with a Karakia.

1. INTEREST REGISTER

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

Declarations of Interest for Items on Today's Agenda
Stella Ward declared an interest regarding Item 8 in the Public Excluded part of the meeting (NZHIH).
Barry Bragg and Gabrielle Huria declared a conflict of interest in relation to car parking.

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETINGS

Resolution (47/20)
(Moved: Aaron Keown/seconded: Ingrid Taylor – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 17 September 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

There were no carried forward/action items.

4. PRESENTATION – THE CHRISTCHURCH CANCER FOUNDATION

Brian Pearson, Trustee, Christchurch Cancer Foundation, thanked the Board for the opportunity to present and introduced their Chair, Professor Frank Frizelle, and Founder and Trustee and also Benefactor, Ernest Henshaw.

Mr Pearson advised that their proposal for a comprehensive Cancer Centre serving the people of Southern and Central New Zealand which is a population of approximately two million is included in today's Board papers and was taken as read. He added that there is also a lot of information and links to cancer organisations on the Foundation's website and Professor Frank Frizelle has had a perspective piece published in The Press on Tuesday.

Mr Pearson commented that the purpose of them being here today was to discuss the proposal, answer questions and seek the Board's support to work together with other key stakeholders including government, the University of Otago and Ngai Tahu to promote this compelling proposal. More specifically they seek the Board's support to immediately consider the Master Plan for the block of land bordered by Tuam, Antigua, St Asaph Streets and Hagley Avenue including the relocation of the recently approved parking building to the more patient accessible north east corner of that site.

Professor Frizelle spoke regarding cancer being the number one cause of death in New Zealand with the burden of cancer being shared disproportionally in the community by some groups, particularly Maori with 20% more cancer and twice the mortality from cancer.

Professor Frizelle also spoke about the New Zealand Cancer Action Plan 2021-29 which sets out four main goals for cancer over the next 10 years to ensure better outcomes:

- New Zealanders have a system that delivers consistent and modern cancer care;
- New Zealanders experience equitable cancer outcomes;
- New Zealanders have fewer cancers; and
- New Zealanders have better cancer survival, supportive care and end-of-life care.

Professor Frizelle asked how we turn policy into action and outlined the role of a Southern Comprehensive Cancer Centre. He commented that what would be expected from this was:

- Better cancer outcomes - survival and quality of care;
- Better equity of outcomes and care;
- Better research;
- A beacon to attach staff;
- Better training and education; and
- A place of hope.

Professor Frizelle commented that what we currently have is little bits of treatment all around the place and what we need to do is bring these together in a coordinated way which will lead to better outcomes.

Mr Henshaw advised that this proposal had been nine months in the making and the model has gone backwards and forwards and around the place and has come back essentially to follow the path of Peter Mac in Melbourne which is probably the most pertinent model in the world right now and is only four years old. He reiterated Professor Frizelle's comments around the strategy for this project. He commented that one of the outcomes proposed is "a specialised facility with a dedicated management and governance", however, we do realise that political and other interests will probably influence the structure and we ask that you note our suggestions are merely that at this point in time. Mr Henshaw commented that they see this as a world standard centre of excellence for cancer, a government funded public hospital that would incorporate advanced training programmes provided by the University of Otago. It would incorporate research programmes and clinical trial programmes which would attract funding from the commercial sector.

Mr Pearson summarised by commenting that the proposition is clear and compelling and without a comprehensive cancer centre, cancer survival rates will fall further behind and we will lose out in the global talent war.

Questions posed by members and responses were:

Attracting & Remunerating Clinicians
How is it intended to attract and retain talent in light of the remuneration offered here?
Professor Frizelle responded that attracting people to come to New Zealand is not about money. People want to work in recognised places and a Centre of Excellence would provide that. It should be noted that we are not in a unique position here, most of the world is in the same position.

Carparking
How do you see this integrating in terms of what has been recently signed off between Ngai Tahu and the Crown?
With the relocation of the carpark how many parks are now proposed?
What will happen with Carparking in the interim?
Mr Henshaw responded that the carpark could go ahead immediately at the other location. As to the number of parks, whilst we have not seen the specifications for the carpark the footprint appears to be the same. The next stage would require the new lab building to be completed and occupied and the park frontage protected.

Dr Rob Ojala, Executive Lead for Facilities, commented that from a Master Plan perspective options around Carparking were looked at closely and with the Super Stop now in place at the frontage, the options would need to again be carefully considered.

IL Rating
A query was made regarding what the IL rating of the building would be.
Mr Henshaw responded that they would expect the building to be bullet proof, particularly in light of recent disasters. He added that the intention would be for the building to be a backup for the main hospital in a disaster.

Governance Structure
You mentioned that the governance structure would sit outside the DHB network (perhaps with a CDHB representative on the Board), but will be publicly funded. What thought has been given to the connection between the DHB management of health and a separately operated structure?
Mr Pearson responded that there is a lot of water to go under that bridge, but we were mindful of the H&D Review and also that a comprehensive Cancer Centre will service central and southern New Zealand, so there is a much broader range of stakeholders than simply the local DHB. In that respect, we thought it would be necessary to develop a different governance model and operating structure, which is not an area of our expertise.

Accommodation Component
Does this come with an accommodation option?
Professor Frizelle responded that they are not planning to treat everyone with cancer in the South Island. This would be more of a hub and spoke model.

Sir John Hansen commented that there are already accommodation providers here such as Ronald McDonald House, the Cancer Society and the Bone Marrow Cancer Trust that own Ranui Apartments (Sir John declared an interest regarding this as he sits on the Board) and have shovel ready funding for a further 42 apartments. Sir John thought with that additional stock, accommodation would be pretty much taken care of.

Commuting from Outside Christchurch
How would patients commuting from somewhere like Waiarapa, who have to commute to Wellington and then catch a plane, be accommodated given that access might be a big issue for them?
Professor Frizelle agreed about the access and commented that an improvement is needed on the way it is now.

Separate Service
If cancer care is separated out how will the seamless care currently provided continue?
Mr Henshaw responded that the background to this sits around the Peter Mac in Melbourne where 10 organisations were involved in putting together this model and it is a state owned hospital.

Clinical Input
Interested in hearing some clinical input. Would like a follow up report that engages the stakeholders, treaty partners etc.

What level of Engagement has taken place already?
It has been difficult with the elections coming up so not a lot at this stage.

Sir John commented that whilst this departs from the Master Plan we need to be looking to the future and if this is a better outcome for patients, he would support further investigation.

Funding Model
Has any work been done around how the funding model might work in the context of PBFF? Obviously the DHB does not have enough money to make ends meet. We would like to understand how far your thinking has gone around both Capital and Operational funding.
Mr Henshaw responded that they propose this to be a government funded public hospital so it is left to the government to make a decision around whether they fund it or don't fund it. The cost of not funding it would be greater than building the hospital in the first place.

Sir John Hansen commented that this is not a Christchurch facility but a South Island/Central New Zealand facility and would suggest that this presentation be made to the South Island Alliance.

Dr Lester Levy, Crown Monitor, commented that he is quite familiar with these kind of institutions around the world. A couple of things to think about - should there only be one centre of this type in NZ? Also, the impact on CDHB will be very interesting as one of the big difficulties about shifting services and funding is overheads and the DHB would be left with unallocated overheads which is something for QFARC to talk about. Also, the move to specialisation is not just around cancer, but seems to be the way we are going.

The Acting Chair thanked the group for giving up their time to come and present and said that we would be in touch after the relevant groups had a chance to discuss further.

5. CHAIR'S UPDATE

Gabrielle Huria, Acting Chair, welcomed Dr Andrew Brant to the meeting and thanked him for coming to Act as our Chief Executive.

She also thanked Sir John Hansen, Barry Bragg and Dr Lester Levy for the incredible amount of work undertaken to secure the $180m equity support for the DHB.

Barry Bragg, Chair, QFARC advised that the monthly meeting with the Ministry of Health has a focus to get the Annual Plan approved.

The update was noted.

6. CHIEF EXECUTIVE'S UPDATE

Dr Peter Bramley, Acting Chief Executive, presented his report which was taken as read. Dr Bramley updated the Board as follows:

- We are heading positively towards being able to receive the new Hagley building. He acknowledged the suburb work undertaken by the teams in preparation for this as orientation takes place for many getting ready to receive patients.

- He highlighted the work of those stepping up into acting management positions and encouraged the Board as governors to give these people all their support. He added that we need to ensure we keep delivering quality care and moving down the path of financial sustainability. He added that he was pleased to see the way that everyone is engaging in "Accelerating Our Future".

- Dr Bramley commented that although his short time here has been exhausting, it has been a privilege and pleasure to come and support the team here and the Nelson/Marlborough DHB will do everything to support the Canterbury DHB during this time.

Discussion took place regarding disability accessible toilets in the Hagley building and it was noted that the DHB has an accessibility group who are very aware of this. It was also noted that this is more of a challenge in existing facilities.

Discussion also took place regarding current COVID testing statistics at borders and this information is to be provided to the Board. The Acting Chief Executive advised there is a regular programme to test staff at both airport borders as well as ports.

In regard to funding for COVID costs, a query was made regarding the Cabinet Paper of 6 October 2020 and it was noted that DHBs are not yet aware of the contents of this. The Acting Chief Executive commented that every DHB is pushing these costs through very transparently and there is every indication that the centre will support DHBs and they certainly understand the position of the DHBs. He added that this is not just about funding, but about the importance of doing this work well.

Board member Jo Kane raised the matter of an OIA released by Treasury and asked if anyone had been aware of this release.

The acting Chair acknowledged this question and other questions provided the previous evening via e-mail and asked that Ms Kane give management some time to provide answers to these questions. Ms Kane commented that the Board's reputation is taking a beating from unsubstantiated reports. Her questions will be provided to other Board members.

The Chief Executive's update was noted.

7. FINANCE REPORT

David Green, Acting Executive Director, Finance & Corporate Services, presented the Finance Report which was taken as read.

Mr Green noted the result for August and advised that the year to date result is on target after an adjustment for COVID costs.

He advised that the DHB is very thankful for the $180M equity funding. He noted this does not change the deficit at all, but does provides us with some cash reserves. It was noted that this money has now been received.

The Acting Chief Executive endorsed Mr Green's comments, noting that this money is to pay the bills, it is not for further investment. He added that the letter from the Minister was no different from letters received in previous years and no different from letters received by other DHBs. He reiterated the importance, for the sake of New Zealand Health and the future of health that we need to be financially sustainable and live within our means. He highlighted that the level of funding is a government decision and that we need to: watch cost growth; watch our people costs; and check that we are getting value for money from suppliers and providers, and ensure the right levels of controls in these areas.

Resolution (48/20)
(Moved: Barry Bragg/seconded: Aaron Keown – carried)

"That the Board:

i. notes the consolidated financial result for the month of August 2020 is a net expense of $8.605M, being $1.011M favourable to the annual plan agreed by the Board on 20 August 2020. The YTD result is now $1.098M favourable to the annual plan;
ii. notes the operating result (before indirect items) for the month is favourable to plan by $0.959M (YTD $1.147M favourable);
iii. notes that the net impact associated with COVID-19 in August is a $1.922M surplus, therefore the underlying operating result (excl COVID) is $0.912M unfavourable (YTD $0.392M favourable); and
iv. notes liquidity (cashflow) risk has been alleviated by the recent receipt of $180M of equity support."

8. MAORI POPULATION, PARTNERSHIP, HEALTH & EQUITY

Hector Matthews, Executive Director, Maori & Pacific Health, presented this report which had been requested by the Board. Ms Huria thanked Mr Matthews for the report.

Mr Matthews commented that equity is not about dollars in these types of conversations. He added that most people do not understand what has happened with our population here in Canterbury and throughout New Zealand.

He spoke about the incidence of cancer and some of the things that can be done to reduce this.

Discussion took place regarding the Bowel Cancer Programme and around this being racist. It was noted that the College of Surgeons have written to the Minister of Health and Mr Matthews advised he had spoken to the Minister about rolling out a cancer screening programme that in its current form will miss the majority of Maori. The majority of Maori in the risk group are in their 50's. Multiple organisations have advised the Ministry of this and there is a level of ambivalence around it.

Mr Matthews also raised the DHB's partnership with Manawhenua ki Waitaha and the Board's relationship, responsibility and knowledge around treaty obligations and also knowledge of Maori services provided.

Resolution (49/20)
(Moved: Gabrielle Huria/seconded: Barry Bragg – carried)

"That the Board:

i. notes the Maori Population, Partnership, Health and Equity report; and
ii. agrees that the Memorandum of Understanding between Manawhenua ki Waitaha and the CDHB needs to be reviewed".

9. ADVICE TO BOARD

Hospital Advisory Committee (*HAC*)
Andrew Dickerson, Chair , HAC, provided the Board with an update on the Committee's public meeting held on 1 October 2020. He advised the meeting had been shorter than normal to allow members time to visit the new Hagley Building. He highlighted the following:

- the move to the new Hagley building;
- the recent passing of Dr Mark Smith and his enormous contribution to Christchurch Hospital;
- discussion around medical oncology; outplaced surgery; Laboratory Audit; increase in end-of-life care; and the effect of COVID on the Chatham Islands.

Resolution (50/20)
(Moved: Andrew Dickerson/Seconded: Naomi Marshall - carried)

"That the Board:

i. notes the draft minutes from HAC's public meeting held on 1 October 2020."

Ms Huria, Acting Chair, made a presentation to Dr Peter Bramley on behalf of Sir John and the Board to thank him for everything he had done while in the position of Acting Chief Executive.

10. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (51/20)
(Moved: Barry Bragg/seconded: Aaron Keown - carried)

"That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, & 13 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 – 17 September 2020	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues	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.	Individual Employment Agreement Remuneration Strategy 2020/21	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)
5.	Hillmorton Programme Business Case – Reframing for Capital Investment Committee	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Repurposing & Strengthening of Hillmorton Laundry Building	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Parkside A&B – Passive Fire Protection Compliance Remediation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	New Zealand Health Innovation Hub – Progress Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Via Innovations	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Draft Annual Report 2019/20 Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	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)

12.	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)
13.	Advice to Board: • HAC Draft Minutes *01 October 2020* • QFARC Draft Minutes *29 September 2020*	For the reasons set out in the previous Committee agendas.	

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

The Public meeting concluded at 11.35am

_____ _____

Sir John Hansen, Chair Date of approval

BOARD MEETING 15 OCTOBER 2020 – MEETING NOTES

Clause No	Item	Action Points	Staff
	Apologies	Dr Sue Nightingale – for absence Sir John Hansen – for early departures (1.15pm)	Kay Jenkins
1.	Interest Register	• Gabrielle Huria and Barry Bragg – carparking. • Stella Ward – Item 8 PX – NZ Health Innovation Hub – Progress Update.	Kay Jenkins
2.	Confirmation of Minutes – 17 September 2020	Adopted: Aaron Keown / Ingrid Taylor	Anna Craw
3.	Carried Forward/Action Items	Nil	
4.	The Christchurch Cancer Foundation	Questions raised by Board members to be collated and forwarded through to Foundation members.	Kay Jenkins
5.	Chair's Update	Nil	
6.	Chief Executive's Update	• COVID-19 – current testing statistics for staff at borders – to be provided to Board members. • Jo Kane's questions to Acting CEOs to be circulated to Board members.	Evon Currie Kay Jenkins
7.	Finance Report	Nil	
8.	Maori Population, Partnership, Health & Equity	Review of CDHB/Manawhenua MOU	Kay Jenkins
9.	Advice to Board: • HAC– 1 October 2020 - Draft Minutes	Nil	
10.	Resolution to Exclude the Public	Adopted: Barry Bragg / Aaron Keown	Anna Craw
	Information	Nil Meeting closed at 11.35am Morning tea from 11.35 to 11.50am	

Distribution List:
Evon Currie
Kay Jenkins
CC: Julie Jones

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 19 NOVEMBER 2020

DATE	ISSUE	REFERRED TO	STATUS
15 Oct 20	Hillmorton Laundry Building Fitout	Dr Rob Ojala	Today's agenda – Item 4PX
	Review of CDHB/Manawhenua MOU	Kay Jenkins	Under action.

GIFTING OF NAME FOR NEW HOSPITAL BUILDING

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

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

APPROVED BY: **Dr Andrew Brant, Acting Chief Executive Officer**

DATE: **19 November 2020**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to seek the Board's endorsement to use the name "Waipapa" for the new hospital building currently known as "Hagley".

2. RECOMMENDATION

That the Board:

i. acknowledges the gift of the name "Waipapa" for the new hospital building, currently known as Hagley; and
ii. accepts and endorses the use of the name "Waipapa" for the new hospital building, currently known as Hagley.

3. DISCUSSION

Te Reo Māori Name for New Christchurch Hospital Building

Historically, the Canterbury DHB and its predecessor organisations have rarely opted for naming major facilities in te reo Māori. However, post the 2010 and 2011 earthquakes in Canterbury, there has been a steady increase in the number of major facilities in Canterbury having te reo Māori names given to them by iwi and Māori. Examples of these are Tūranga (Christchurch Library) and Ngā Puna Wai (Canterbury multi-sport facility). In health services we have seen our health centre in Kaikōura given the name Te Hā o Te Ora by the Takahanga rūnanga in Kaikōura, and our Akaroa health centre given the name Te Hauora o Rākaihautū by the Ōnuku rūnanga in Akaroa.

Following on from this, it seems appropriate to have a te reo Māori name for Christchurch Hospital's newest building. The papatipu rūnanga who has mana in the Christchurch area and therefore best placed to give a te reo Māori name is Te Ngāi Tūāhuriri Rūnanga.

Te Ngāi Tūāhuriri Rūnanga

Te Ngāi Tūāhuriri Rūnanga, based at Tuahiwi marae, is one of seven Ngāi Tahu papatipu rūnanga in the CDHB region and is a member of Manawhenua Ki Waitaha, our Treaty partner.

Tuahiwi, the home of Ngāi Tūāhuriri, has played a vital role in Ngāi Tahu history. The takiwā (district) of Te Ngāi Tūāhuriri Rūnanga centres on Tuahiwi and extends from the Hurunui to the Hakatere river and inland to the Main Divide and includes Christchurch city.

The Ūpopko (head) of Ngāi Tūāhuriri, Te Maire Tau, has gifted the name "Waipapa" for our new hospital building, currently known as Hagley.

Waipapa is broadly known as the area near or around Hagley Park. It also appears in the Māori names of a number of other places in or near Hagley Park such as Hagley College (Te Puna Wai o Waipapa) and the Christchurch Botanic Gardens (Te Māra Huaota o Waipapa).

The cultural design strategy for Cathedral Square (on page 9), prepared by the Ngāi Tahu group Matapopore, has a description of the original name of Waipapa: (https://www.regeneratechristchurch.nz/assets/Uploads/CSSB12-Cultural-Design-Strategy.pdf):

> "Waipapa/Little Hagley Park is a pocket park located by Carlton Mill Bridge, it was set aside in 1862 for Māori to use as a meeting or resting place when they visited Ōtautahi. In 1868 150 Māori camped in the area while they argued their claims in the Native Land Court for the banks of the Ōtākaro/Avon river between Barbadoes and Madras Streets."

Te Maire Tau has been generous and pragmatic in the gifting of this name. The use of a te reo Māori name for this new building, from Te Ūpoko o Ngāi Tūāhuriri, has been strongly supported by Manawhenua Ki Waitaha as well as the wider Māori community because it acknowledges the mana of Ngāi Tūāhuriri.

Our Treaty partner, Manawhenua Ki Waitaha, has written to the board supporting the gift of this name by Ngāi Tūāhuriri (Appendix 1). It is also believed that this name will get broad support from staff and community because it is closely connected to local history, iwi and community.

The use of a te reo Māori name for this new building is also a tangible demonstration of the CDHB working in partnership with Manawhenua by acknowledging the mana of Ngāi Tūāhuriri on the land that the new building sits.

Potential Challenges

Given that this new facility has been called Hagley for quite some time, there may well be some challenges from a timing point of view and the CDHB will need to manage communication and timing of introduction of the te reo Māori name. There may be other logistical challenges such as signage and already existing documentation and systems that do not currently have the te reo Māori name. It is suggested that these challenges not be viewed as an impediment because all planned migration and associated work can continue. The gifting of Waipapa can be viewed as a welcome addition to the building, migration and transition to new facilities. We will make changes where practicable and transition to Waipapa, while not overtly changing any existing migration planning.

A suggested position for the Board could reflect that we are delighted with the gift of a te reo Māori name from Te Ūpoko o Ngāi Tūāhuriri and the strong connection to location and community that Waipapa has in Christchurch and Canterbury. We are grateful for this name and look forward to seeing it displayed and used in our new facility. Ngā mihi mīharo.

4. APPENDICES

Appendix 1: Manawhenua ki Waitaha letter dated 23 October 2020.

IN-CONFIDENCE

Manawhenua ki Waitaha

23 October 2020

Tēnā kōutou nga Rangatira, Sir John raua ko Andrew me ngā mema o te Poari Hauora ō Waitaha.

Manawhenua ki Waitaha Chair and Board members would like to express their tautoko for the naming of Hagley Hospital as Waipapa.

As the Chair of MKWCT I was present at the meeting between the Ūpoko of Te Ngāi Tūāhuriri and the previous Chair where we discussed and agreed upon the naming of Hagley Hospital, as Waipapa. We thank and congratulate the Board and CEO in honouring the gesture in which Ngāi Tūāhuriri Ūpoko Te Maire Tau, together with the Rūnanga gifted this name.

Manawhenua ki Waitaha Board Chair and members tautoko the generosity and mana that Waipapa brings for all Waitaha community to rest, endure and heal within.

Manawhenua ki Waitaha Board Tumuaki and Members envisage a new beginning - Te Whakaohooho, the awakening of a new partnership between Manawhenua ki Waitaha and Canterbury District Health Board.

Tēnā koutou Ngāi Tūāhuriri for leading us all on a path of new discovery, new visions, and new beginnings.

Nga mihi mahana tēnā koutou katoa,

Manawhenua ki Waitaha Tumuaki
Michelle Turrall Chair Manawhenua ki Waitaha - Ngāi Tūāhuriri Rūnanga

Jaana Kahu – Kaikōura Rūnanga – Deputy Chair

Wendy Dallas - Katoa – Ōnuku Rūnanga

Ana Rolleston – Wairewa Runanga

Toriana Hunt – Te Taumutu Runanga

Tumanako Stone – Howard – Te Hapū ō Ngāti Wheke – Rāpaki

Ngaire Briggs – Te Rūnanga ō Koukourarata

DELEGATIONS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Dr Andrew Brant, Acting Chief Executive Officer**

DATE: **19 November 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

This report has been generated in relation to the Delegations policy. The policy for the "Delegation of Authority by the Board of the Canterbury DHB", requires the policy to be reviewed within six months following each Board election. A paper was submitted for the 5 May 2020 meeting but was withdrawn by the Chair. A further paper was submitted to the 29 September 2020 meeting and deferred to the 3 November 2020 meeting to address points raised in a letter from the Minister of Health, and the Ernst Young report.

2. RECOMMENDATION

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

i. notes that existing delegations and enhanced processes are in place to support the points raised by the Minister of Health in relation to new personnel, community provider contracts, and approval of capital plans;
ii. notes the delegations as identified in the EY report have been reviewed, noting capital delegation levels have been set in relation to the proportion and composition of investments CDHB makes, and payroll related expenses enable approval of rosters for line managers;
iii. approves the existing "Delegation of Authority by the Board of the Canterbury DHB" policy (Appendix 1) remaining in place, unchanged;
iv. notes the "Delegation of Authority to Staff" policy (Appendix 2) which is supported by a Delegations Guidance that provides the framework and definitions of delegations; and
v. approves the Instrument of Delegation to the Acting Chief Executive Officer (Appendix 3), noting a change in delegation for Capital Expenditure reduced from $1M to $500K, to be reviewed in 12 months time (November 2021).

3. SUMMARY

Delegation Policies

Delegations at CDHB are guided by two policies:

- Delegation by the Board of the Canterbury DHB policy (Appendix 1); and
- Delegation of Authority to Staff policy (Appendix 2).

The Delegation of Authority by the Board of the Canterbury DHB policy, is jointly approved by the Minister of Health and the CDHB Board. In accordance with the New Zealand Public Health and Disability Act 2000 section 39, any change or update to this policy requires approval from the CDHB Board and the Minister of Health. This policy provides the principles of

delegation, as well as compliance, conflicts of interest declarations, and Board retained delegations. Every exercise of a power of delegation must comply with this policy. The policy also identifies the process to be used by the CEO to further delegate, which is established as the Delegation of Authority to Staff policy issued and authorised by the CEO.

Compliance to the policy is periodically reviewed by the CDHB Risk and Assurance team to ascertain compliance with delegated authorities and associated policies.

All delegations are governed by the requirement of managers to ensure that spending of public money is subject to the standards of probity and financial prudence, as expected from a public entity.

Delegations Guidance

The Delegations Guidance provides the framework and detail to support the delegation policies. These provide the required processes and procedures to support ensuring all relevant staff hold written Instrument of Delegations, clarity of definitions for what the delegation allows, sub-delegation, and ensuring consistency of delegation levels across the organisation. These delegation levels are aligned to the National Oracle System (*NOS*) agreed Delegated Financial Authority (*DFA*) schedules.

The NOS supports the control of the approval processes for requisitions and purchase orders through the Oracle system by establishing workflows that ensure appropriate approvals are achieved based on the DFA of all signed Instruments of Delegation. A requisition cannot proceed until the appropriate manager with the correct level of delegation has approved. This in some cases requires a requisition to be approved by multiple levels of management before reaching the appropriate delegated level.

Delegations are also supported by operational processes and procedural requirements in relation to specific delegations to ensure checks and controls are in place to assist managers in decision making.

Minister of Health Delegation Request

Three key delegated authorities were identified by the Minister of Health requiring the Board to ensure approval remains the responsibility of the Chief Executive. These were:

Recruitment of New Personnel

The existing delegations currently provides for only the Chief Executive and the Executive Director of Finance & Corporate Services to holding the delegation to recruit new personnel.

The existing operational process ensures all requests for new personnel are approved by the CEO. The process is established within the *max.* software system which requires all requests for new and replacement FTE to be submitted electronically with supporting information. The system has set approval workflows that ensures the requests progress through appropriate approvals, and all new positions require CEO approval prior to any recruitment process commencement.

This delegation is identified as *Recruitment of Additional Staff* in the Instruments of Delegation, with all other Instruments of Delegation throughout the organisation clearly indicating this delegation authority with 'No Delegation'.

Increases in Community Provider Contracts
A process has been established to collate a schedule of all provider contract changes on a weekly basis and seek CEO approval of all increases in community provider.

Approval of Capital Expenditure Plans
The existing process ensures the annual capital plans are submitted to the CEO and Executive Management Team (*EMT*) for approval.

The development of the Approved In Principle (*AIP*) baseline capital investments planned for the financial year are established by the Baseline Capital Committee, comprised of representatives across the organisation. The baseline AIP encompasses capital investment required to maintain service delivery and meet the current and forecast needs of the population.

The operational divisions assess their capital requirements with the use of a scoring tool which encompasses the asset status, impact of investment/non-investment on service delivery and likelihood of failure or timeframe for benefit realisation. The baseline capital committee reviews the divisional prioritised submissions as a consolidated CDHB wide view and determine the prioritised list of AIP within the allocated funding available.

The AIP capital investments recommended by the committee are submitted to EMT for approval every financial year. Following that, the Capital Intention is submitted to the Board.

EY Observations

Level of Capital Expenditure Delegation
The current level of delegation for capital investments require all business cases greater than $1M to seek Board approval. It is noted that other DHBs operate with a lower level of delegation for the CEO, and therefore this level is proposed to be adjusted to align with other DHB delegation levels, with the level proposed in the Acting CEO Instrument of Delegation reduced to $500K.

Payroll and Payroll Related Expenditure
The delegation for Payroll related expenditure on the Instrument of Delegation is provided to ensure managers have a delegation that enables the management of staff under their reporting lines and the payroll costs related to those staff members.

This delegation is defined within the Delegations Guidance as:

Authority	Definition/ Responsibilities	What this authority means e.g. "you have the authority to…"
Approve Payroll Expenses	To confirm and approve the amount of hours worked for an employee/s with a direct reporting line **Includes** approval via Microster or off any electronic system, including manual Exception sheets. **Excludes** work related expenses or staff reimbursements refer delegation *Purchase of Goods and Services* Note: this is **NOT** the same delegation as "Approve **CDHB** Payroll and Related Expenses" under the Treasury category.	Approve a roster for payroll (Microster, Exception sheets) for staff with a direct reporting line.

4. APPENDICES

Appendix 1: Delegation of Authority by the Board Policy
Appendix 2: Delegation of Authority to Staff Policy
Appendix 3: Instrument of Delegation to the Acting CEO

Delegation of Authority by the Board of the Canterbury DHB

Contents

Purpose

In accordance with Section 25 of the Crown Entities Act 2004 (CE Act) the Board is the governing body of the Canterbury DHB, with the authority, in the name of the Canterbury DHB, to exercise the powers and perform the functions of the Canterbury DHB.

All decisions relating to the operation of the Canterbury DHB must be made by, or under the authority of, the Board in accordance with the CE Act and the Act.

Under Section 26 of the Act the Board of a DHB must delegate to the Chief Executive the power to make decisions on management matters relating to the DHB. Such delegation may be on terms and conditions the Board think fit.

This policy establishes the framework for the delegation of authority to the Chief Executive and the exercise of that delegated authority, to ensure the efficient and effective management of the DHB.

Policy

This Policy contains the following parts:

The Policy statement, principles, processes and associated information as approved by the Board of the Canterbury DHB (Board) and the Minister of Health, in accordance with the New Zealand Public Health and Disability Act 2000 (the Act). This includes delegation categories showing those delegations that the Board has retained.

The Board's delegation to the Chief Executive Officer (CEO) pursuant to the Policy of the power to make decisions on management matters relating to the DHB and the terms and conditions of such delegation (see Appendix 1)

The process to be used by the CEO to further delegate authorities is covered in a separate policy authorised by the CEO. That policy and its associated principles, processes and information may be amended from time to time by the CEO, provided it is not inconsistent with this Policy approved by the Board.

Definitions

Capital Disposals

The disposal of capital assets belonging to the CDHB, including selling, trading-in, exchanging, or gifting the asset or the right to use the asset.

Capital Expenditure

Expenditure on assets that have a useful life in excess of 12 months and which cost or have a value in excess of $2,000 per item. The limit is the full value, excluding trade-ins or use of donated funds, and irrespective of the financing method.

Collective Employment Agreement

An employment agreement covering a number of staff. This includes the national MECA's (Multi-Employer Collective Agreements).

Contract for Service for Consultants and Contractors

A contract with any external individual or organisation to provide services such as professional or legal advice and/or tradesmen, where the individual(s) does not meet the IRD/ERA criteria of an employee. Consultants and contractors for capital expenditure projects are covered under Capital Expenditure. Bureau staff and locums are covered under Contract Temporary Staff.

Contract Temporary Staff

A contract for service to provide labour-only services, such as bureau nurses and locums, to cover for short-term staff shortages.

Financial Write-offs

The process of removing assets from the Financial Accounts because they do not have any value. This could be because they no longer exist, are obsolete, or the debt is uncollectible.

Funding Contract

A contract (service agreement) to fund an external organisation to provide health and/or disability services on behalf of the Canterbury DHB.

All funding contracts are the responsibility of Planning and Funding.

Individual Employment Agreement

An employment agreement covering one staff person.

Procurement

Procurement is the acquisition (buying) of goods and/or services from an external organisation on behalf of the CDHB. Procurement usually involves a signed contract.

Procurement Contract

A contract to purchase goods and/or services, but excluding capital expenditure. Procurement contracts for services include utilities such as maintenance, power, communications, etc. but excludes service contracts for contract staff.

Purchase of Goods and Services

The ordering of goods and services that are required during the ordinary course of business, ie. operational expenditure. Orders are usually made via a CDHB electronic ordering system or direct with a CDHB approved supplier under the terms of a CDHB procurement contract.

Sub-delegated authorities may allocate reduced limits for some types of discretionary expenditure, such as travel, training, entertainment, etc.

Recruitment of Additional Permanent FTE Staff

The recruitment of staff (FTE) to additional (new) permanent positions in order to fulfil the DHB's requirements.

Staff Restructuring

The costs associated with any restructuring of the organisation, including any redundancy payments and the cost of any support services provided to affected staff.

Revenue Contract

A contract for the DHB to earn income from an external organisation by providing services. This includes the Ministry of Health, ACC, and the Clinical Training Agency.

Note:
For more details refer to the relevant policies, eg. Capital Disposals, Capital Expenditure, Volume 3 Human Resources, Funding Contracts, Procurement and Tender, Purchasing and Revenue Contracts Policies.

Policy statement

Every exercise of a power of delegation must comply with this Policy.

Pursuant to clause 39(5) of Schedule 3 of the Act every delegation of any function, duty or power of the Canterbury DHB (Board) must be in writing.

Pursuant to Clause 39(6) of Schedule 3 of the Act delegation of a function, duty or power is revocable and does not prevent the Board or the DHB from performing the function or duty, or exercising the power. Any revocation must be recorded in writing.

All persons have an obligation to ensure that they do not perform a function, duty or power beyond the scope of their delegated authority.

This delegation policy and any changes to it must be approved by the Board and the Minister of Health.

The CEO can sub-delegate his or her power and authorities unless specifically not permitted to do so by the Board.

If a management decision is required urgently on a matter not covered by the delegated authority to the CEO, the Chairperson of the Board has the Board's delegated authority to make decisions in such circumstances. The Chairperson must subsequently report any such decisions to the Board.

Pursuant to clause 39(8) of Schedule 3 of the Act any person who considers that they have or will have a conflict of interest with the Canterbury DHB in the exercise of any delegation given by the Board must immediately disclose such conflict to the Board. Such a person who has been delegated authority from the Board, who is interested in a transaction of the Canterbury DHB may not perform a function or duty, or exercise a power that relates to the transaction, except with the prior written consent of the Board.

Failure to comply with this Policy (and related policies and procedures of the Canterbury DHB) may result in disciplinary action, up to and including termination of employment.

Review of Policy

This Policy can be reviewed at any time and must be reviewed within six months following each District Health Board election.

No delegation made prior to any review of this Policy is invalidated solely because of a review of the Policy. Any changes required to an existing delegation to comply with an amended policy must be notified in writing, and existing delegations remain in effect until such notification.

1 Principles, Processes and Associated Information

Authority must Exist

A person shall not commit the Canterbury DHB to any obligation or incur any liability included in this Policy unless:

- They are one of the people authorised to do so in accordance with an actual delegation; or
- They have the required authority properly sub-delegated to them by a person so authorised; or

The Board or the CEO specifically authorises the person in writing to make the commitment or incur the liability.

Revocation or Termination of Authority

Every delegation shall remain in force until it is revoked. The revocation must be in writing.

All delegations of authority are automatically revoked in respect of an individual upon the termination of employment of that person. The termination of employment will not affect the authority of those people who have been sub-delegated authority by that person.

All delegations of authority may be revoked in whole or in part at any time by the Board.

Where the CEO's employment terminates, the delegations will pass unchanged to the "Acting CEO" or the new CEO, unless otherwise resolved by the Board. That person will execute a new Instrument of Delegation.

Compliance with Canterbury DHB Policies and Procedures

All delegated authorities are exercised on the Board's behalf and shall be exercised in accordance with other relevant policies and procedures set by the Canterbury DHB from time to time.

Compliance with Legislation and other Requirements

All delegated authorities shall be exercised in accordance with all applicable legislation and other binding directions upon the Board and the Canterbury DHB. These include the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000, the Operating Policy Framework and Cabinet direction.

Sub-delegation

Sub-delegation is the ability to delegate (pass on) a delegated authority, in whole or in part, to individuals or holders of specified positions.

A sub-delegation may only be further sub-delegated, wholly or in part, where specific authority to sub-delegate has been given (unless with the prior written approval of the Board).

These sub-delegations may be permanent to a person whilst holding the specified position or temporary for the duration of a specific event or period.

Notwithstanding any sub-delegation the delegator shall remain accountable for the exercise of the sub-delegated authority.

Where any delegation is revoked or amended (in whole or in part) the revocation or amendment shall specify the effect of that revocation or amendment on sub-delegations already in place.

Actions Exceeding Authority or Where in Doubt

Any proposed action that either exceeds the delegated authority limits specified in an instrument of delegation or is in areas outside the scope of the delegation, must be approved by a person with the necessary authority to approve that action.

Authority shall revert to the next higher level in cases of unplanned absence of the person given the sub-delegation.

Should there be any doubt as to authority to make the commitment the matter shall be referred to the Board (or if the matter is urgent, the Chairperson) for action.

Expenditure of Public Money

All expenditure by a public entity (i.e. the Canterbury DHB) is the spending of public money. Consequently, the expenditure should be:

- Subject to the standards of probity and financial prudence that are to be expected of a public entity (including “value for money”); and
- Able to withstand Parliamentary and public scrutiny.

Guidance is provided in the statements of good practice issued by the Controller and Auditor-General, for example “Procurement” and “Controlling Sensitive Expenditure: Guidelines for public entities”.

Access to Instruments of Delegation

Copies of the Instruments of Delegation approved by the Board and any revocations or amendments, shall be retained on behalf of the Board by the Chairperson. Copies of sub-delegated authority shall be retained by the person authorising the sub-delegation and by the person receiving the sub-delegation. Copies shall be retained in a manner to enable ready access for audit purposes.

Conflicts of Interest – Where Delegations are Given Directly by the Board to a Person

As required by the Act, a person (under this policy usually the Chief Executive or the Chairperson of the Board) who on any day is to perform a function, or duty, or exercise a power, delegated by the Board under the Act:

- Must, before performing the function or duty or exercising the power, consider whether or not he or she has (or, as the case requires, will have) on that day any conflicts of interest with the DHB; and
- If the person has (or will have) any such conflicts of interest, must give the Board a statement completed by the person in good faith that discloses those conflicts of interest, together with any such conflicts of interest the person believes are likely to arise in future; and
- If the person has (or will have) no such conflicts of interest, must be treated as if he or she had given the Board a statement completed by the person in good faith that states that the person has (or will have) no such conflicts of interest on that day.

Such a person (who has been delegated authority by the Board), who has completed a statement must inform the Board in writing of any relevant change in the delegate's circumstances affecting a matter disclosed in that statement, as soon as practicable after the change occurs.

Such a person (who has been delegated authority by the Board), who is interested in a transaction of the Canterbury DHB may not perform a function or duty, or exercise a power that relates to the transaction, except with the prior written consent of the Board.

Powers, Duties and Functions Retained by the Board

The Canterbury DHB operates in accordance with the principles of good governance. This means that irrespective of delegations properly made there will be occasions when a matter should be referred to the Board that might otherwise be dealt with under delegated authority.

The following clauses refer to the functions, duties and powers the Board wishes to retain and the situations in which a matter otherwise delegated may be referred to the Board. The Board may from time to time retain such further functions, duties or powers as it so determines.

The Board will reserve the functions, duties and powers to itself as set out in the following table.

1.1 Board's Functions, Duties and Powers Reserved

Authority not to be delegated	Comment
Change the delegated authority policy issued by the Board of the Canterbury DHB	The policy approved by the Board can be changed by the Board only. The Minister of Health's approval of any changes is required (clause 39(2) of Schedule 3 of the Act).
Entry into of Co-operative Agreements or Arrangements	Approval of Minister required in the circumstances stated (refer section 24 of the Act)
New Section 88 notices – Arrangements relating to payments	Approval of the Board is required. Copies are provided to Parliament by the Minister of Health and the Ministers consent may be required in certain circumstances (refer sections 88 and 89 of the Act).
Hold any shares or interests in a body corporate or partnership, joint venture or other association of persons.	Approval of the Board and the Minister of Health required (refer Section 28 of the Act).
Settle, or be, or appoint a trustee of a trust	Approval of the Board and the Minister of Health required (refer Section 28 of the Act).
Sell, exchange, mortgage or charge land	Approval of the Board and the Minister of Health required (refer clause 43 of Schedule 3 of the Act).
Grant a lease or licence for land for a term of more than 5 years (including renewal periods)	Approval of the Board and the Minister of Health required (refer clause 43 of Schedule 3 of the Act).
Raise a loan for the Board other than as authorised by the Board	Any loans must be raised in accordance with regulations made under the Act or with consent of the Minister of Finance (refer clause 45 of Schedule 3 of the Act).
Invest money not immediately required other than within the constraints of the Board's delegated authority schedules and Clause 46 of Schedule 3 of the Act.	Clause 46 of Schedule 3 of the Act sets out a limited range of investment options. The delegated authority schedules authorise investment in a sub-set of this limited range.
Approve expenditure or asset disposals above the limits delegated by the Board to the Chief Executive from time to time.	The Chief Executive must seek Board approval for expenditure or asset approvals in excess of the limits of the Board's delegation.

Signing Documents on Behalf of the Canterbury DHB

All contracts entered into by the Canterbury DHB with external parties must be signed by a person who has the delegated authority to approve the commitments within the contract, except as provided below:

- Some documents known as “deeds” must be signed in accordance with strict legal requirements. Deeds must be signed by two Board members, or one Board member and an authorised signatory. All deeds must be referred to the Canterbury DHB legal department for review prior to signature.
- Where the Canterbury DHB is required to demonstrate duly authorised signatories approved by the Board, in the absence of any other specific authority from the Board, these are:
  - Chief Executive
  - General Manager Corporate Services
  - General Manager Finance
  - General Manager Planning & Funding
  - Director of Strategic Projects and Business Development Unit
  - General Manager Population and Public Health

The Chief Executive shall determine any terms and conditions applicable to the signing of contracts (including deeds) by those duly authorised signatories, other than for those powers, duties and functions retained by the Board.

Instruments of Delegation

Delegations of Authority pursuant to this policy shall be in writing, in the form set out below:

CDHB Instrument of Delegation

From: Canterbury District Health Board **To:** Chief Executive of CDHB

As per Board Resolution number _____ Dated _____

This instrument grants you as Chief Executive the power to make decisions on management matters relating to the Canterbury DHB, and in accordance with the Canterbury DHB policies. This instrument also sets out the limits (exclusive of GST) for various authorities. Outside the scope of your authority or above these limits, the Board must approve such items (where it is stated there is "no $ limit", the expenditure must be within the Canterbury DHB's budget).

Authority Type	Authority Limit	Ability to Sub-delegate
Capital Disposals	Up to $1,000,000 per asset/event.	Yes
Capital Expenditure	Up to $1,000,000 per asset/event.	Yes
Human Resources Collective Employment Agreement Individual Employee Agreement Contract Temporary Staff Recruitment of additional permanent Full-time equivalent staff Staff Restructuring	 No $ limit if within CDHB budget for current and future years. Up to CEO salary level. Up to CEO salary level. No $ limit per FTE if within CDHB budget for current and future years. Up to $500,000 per event.	Yes
Consultants and Contractors	Up to $300,000 per event.	Yes
Other Operating Expenditure Procurement Contract Purchase of Goods and Services	No $ limit, up to 3 year term. Up to $1,000,000 per transaction.	Yes
Revenue Contract	No $ limit, up to 3 year term.	Yes
Funding Contract	No $ limit, up to 3 year term.	Yes
Financial Write-offs (per item) *The Chief Executive is required to report write-offs over $50,000 per item to the Finance, Audit and Risk Committee.*	Bad debts – up to $100,000 Stock – up to $100,000 Lost cash - up to $2,500 Fixed Asset – up to $100,000	Yes

Authorised on behalf of the Board: _____ Date _____ Chair of CDHB	I acknowledge receipt of this Instrument, and confirm that if I have at any time any actual or potential conflict of interest in a transaction the subject of any delegation, I will immediately disclose this in writing to the Board. _____ Date _____ _____ *(Name)* Chief Executive of CDHB

Delegation of Authority to Staff Policy

Contents

Introduction

Under Section 26 of the New Zealand Public Health and Disability Act 2000 (the Act) the Board of a District Health Board must delegate to its Chief Executive Officer (CEO) the power to make decisions on management matters relating to the DHB. Such delegation may be on terms and conditions the Board thinks fit.

The Board of the Canterbury DHB has delegated power to make decisions on management matters. These delegations have limits, and the Board has retained certain matters for itself (refer to the "Delegation of Authority by the Board of the Canterbury DHB" policy approved by the Board and Minister of Health).

In accordance with his/her authority the CEO has approved this Delegation of Authority to Staff policy. This Policy also contains the form Instrument of Delegation to be used when issuing sub-delegations. This form and its principles, processes and associated information within this Policy may be amended from time to time by the CEO, provided it is not inconsistent with *the Delegation of Authority by the Board of the Canterbury DHB* policy.

Purpose

This policy establishes the expectations for the creation and use of delegation of authority within the DHB and the exercise of that delegated authority, to ensure the efficient and effective management of the DHB based on:

- *Section 25 of the Crown Entities Act 2004 (CE Act):*
  The Board is the governing body of the Canterbury DHB, with the authority, in the name of the Canterbury DHB, to exercise the powers and perform the functions of the Canterbury DHB.
- *Section 26 of New Zealand Public Health and Disability Act 2000 :*
  The Board of a DHB must delegate to the CEO the power to make decisions on management matters relating to the DHB. Such delegation may be on terms and conditions the Board think fit. The Board has delegated such power to the CEO.

All decisions relating to the operation of the Canterbury DHB must be made by, or under the authority of, the Board in accordance with the Crown Entities Act and the New Zealand Public Health and Disability Act.

Policy Statement

Every exercise of a power of delegation must comply with this Policy.

Every delegation of any function, duty or power of the Canterbury DHB must be in writing.

Delegation of a function, duty or power is revocable and does not prevent the Board or any person who grants such a delegation, from performing the function or duty, or exercising the power. Any revocation must be recorded in writing.

All persons have an obligation to ensure that they do not perform a function, duty or power beyond the scope of their delegated authority.

A person can only sub-delegate his or her authorities if they are specifically permitted to do so in their Instrument of Delegation.

If a management decision is required urgently on a matter not covered by the delegated authority to the CEO, the Chairperson of the Board has the Board's delegated authority to make decisions in such circumstances. The Chairperson must subsequently report any such decisions to the Board.

Any person who considers that they have or will have a conflict of interest with the Canterbury DHB in the exercise of any delegation must immediately disclose the conflict. Any person that has a conflict of interest cannot authorise/exercise a power or be involved in the relevant transaction/s related to that conflict. A person may not perform any function, duty or exercise any power, where they have any conflict of interest unless they are specifically authorised in writing to do so.

A central repository of Instruments of Delegation will be held to maintain transparency of existing delegations to appropriate staff.

Failure to comply with this Policy (and related policies and procedures of the Canterbury DHB) may result in disciplinary action, up to and including termination of employment.

This policy should be read in conjunction with Delegations Guidance.

All delegated authorities are exercised on behalf of the CDHB and shall be exercised in accordance with other relevant policies and procedures set by the CDHB.

Authority Not Delegated

The Board has reserved some functions, duties and powers for itself. For a full list please refer to the '*Delegation of Authority by the Board of Canterbury DHB'* policy.

Review of Policy

This Policy can be reviewed at any time and must be reviewed every three years, or within six months following each District Health Board election.

No delegation made prior to any review of this Policy is invalidated solely because of a review of the Policy. Any changes required to an existing delegation to comply with an amended policy must be notified in writing, and existing delegations remain in effect until such notification.

Scope

This policy applies to all CDHB staff and any person who has been delegated authority by the CEO.

Definitions

Delegation
The assignment of responsibility or authority to another person to carry out specific activities.

Instrument of Delegation
Document that gives a person, in a specified role, authority to make decisions for their area of responsibility.

Master Copy
The signed hardcopy *Instrument of Delegation* form

Sub Delegation
Sub-delegation is the ability to delegate (pass on) a delegated authority, in whole or in part.

Central Repository
Centralised location holding a scanned version of the Master Copy

Associated documents

- Delegation of Authority by the Board of the Canterbury DHB
- Delegation Guidance (including sub-delegation templates)
- Purchasing and Authorities Volume 4
- Procurement Policy
- People and Capability policies

**The latest version of this document is available on the CDHB intranet/website only.
Printed copies may not reflect the most recent updates.**

- Major Incident and Emergency Plan
- Ministry of Health Operational Policy Framework

Exercising A Delegation

Authority must exist

A person shall not commit the Canterbury DHB to any obligation or incur any liability included in this Policy unless:

- They are one of the people authorised to do so in accordance with an actual delegation; or
- They have the required authority properly sub-delegated to them by a person so authorised; or
- The CEO specifically authorises the person in writing to make the commitment or incur the liability.

The CEO reserves the right to be the sole person authorised to commit the "Canterbury District Health Board" as an organisation unless they have specifically authorised the person in writing to do so.

No authority to commit the Canterbury DHB to any obligation or incur any liability with an external party exists for persons who are not employees, unless that person (or class of persons) has been duly authorised under the authority of the CEO.

Sub-delegation is allowed

A sub-delegation may only be further sub-delegated where specific authority to sub-delegate has been given (or otherwise with the prior written approval of the CEO).

Sub-delegations may be permanent whilst holding the specified position or temporary for a specified period.

The delegator shall remain accountable

In all cases the delegator will be accountable for the exercise of the sub-delegated authority.

Where the position holder is absent the default decision maker is the delegator unless alternative arrangements have been agreed and notified prior.

Any proposed action that either exceeds the delegated authority limits specified in an instrument of delegation or is in areas outside the scope of the delegation must be approved by a person with the necessary authority to approve that action.

In cases of unplanned absence, whereby a temporary delegation has not been authorised, the authority shall revert to the next higher level of the person who was given the sub-delegation.

Should there be any doubt as to authority to make the commitment the matter shall be referred to a Finance Manager or General Manager Finance and Corporate Support.

Compliance is mandatory

All delegated authorities are exercised on the DHB's behalf and shall be exercised in accordance with other relevant policies and procedures set by the Canterbury DHB.

Additionally all delegated authorities shall be exercised in accordance with all applicable legislation and other binding directions upon the Board and the Canterbury DHB. These include the Crown Entities Act 2004, the New Zealand Public Health and Disability Act 2000, the Operating Policy Framework and Cabinet direction.

Expenditure of Public Money should be able to withstand scrutiny

All expenditure by a public entity (i.e. the Canterbury DHB) is the spending of public money. Consequently, the expenditure should be:

- Subject to the standards of probity and financial prudence that are to be expected of a public entity (including "value for money" and the requirement for another person to approve transactions); and
- Able to withstand Parliamentary and public scrutiny.

Guidance is provided in the CDHB Purchasing and Authorities Policy, and statements of good practice issued by the Controller and Auditor-General, for example "Procurement" and "Controlling Sensitive Expenditure: Guidelines for public entities".

Conflicts of Interest should be declared

A person who on any day is to perform a function, duty or exercise a power, that is delegated in accordance with the policy:

- Must, before performing the function or duty or exercising the power, consider whether or not he or she has (or, as the case requires, will have) any conflicts of interest with the DHB; and
- If the person has (or will have) any such conflicts of interest these must be declared, refer to the guidance provided by the Conflict of Interest, Probity and Gift policy.
- All persons involved in procurement transactions/decisions are required to comply with the conflict of interest requirements in the Procurement and Tender Policies in addition to the requirements in this policy.

A central register for Instruments of Delegation will be maintained

Master Instruments of Delegations and sub-delegations will be retained by Finance Managers. A scanned copy of all Instruments of Delegations and sub-delegations must be uploaded to the central repository to enable ready access for audit purposes. Finance Managers are responsible for updating delegations.

Every delegation shall remain in force until it is revoked

All delegations of authority may be revoked or amended at any time by the person who has given the delegation, or by a person who otherwise has the authority to revoke the delegation. Where any delegation is revoked or amended (in whole or in part) the revocation/amendment shall specify the effect of that revocation or amendment on sub-delegations already in place. For example, the revocation or amendment of delegations may occur when budgets have been overspent, or as otherwise specified.

Revocations must be in writing except for automatic revocations.

All delegations of authority are automatically revoked in respect of an individual upon the termination of employment of that person or if the person transfers to another role. The termination or change of employment will not affect the authority of those people who have been sub-delegated authority by that person.

Urgent and emergency response

If a management decision is required urgently on a matter not covered by the delegated authority to the CEO, the Chairperson of the Board has the Board's delegated authority to make decisions in such circumstances. The Chairperson must subsequently report any such decisions to the Board.

In the event of an 'emergency or major event' i.e. Major Incident or emergency situation the Co-ordinated Incident Management System (CIMS) will be activated. CIMS Controllers are authorised to manage all aspects of emergency events including actions as required to urgently care for patients, to protect public health and safety, and may be required to incur expenditure outside of delegations. The CEO will subsequently report the expenditure to the board.

Please refer to the Major Incident and Emergency Plan.

Signing Documents on behalf of the Canterbury DHB

This policy primarily deals with authority to approve items such as contracts for funding, revenue and expenditure.

In addition this policy also specifies certain authorised signatories (see below). The authority to "sign" a document is not the same as the authority to "approve" the relevant expenditure. The signing of a contract can only occur if the required CDHB processes for review and approval are completed.

All contracts entered into by the Canterbury DHB with external parties must be signed by a person who has the delegated authority to approve the commitments within the contract, except as provided below:

- Some documents known as "deeds" must be signed in accordance with strict legal requirements. Deeds must be signed by two Board members, or one Board member and an authorised signatory. **All deeds must be referred to the Canterbury DHB Legal department for review prior to signature.**
- Where the Canterbury DHB is required to demonstrate duly authorised signatories approved by the Board, these are:
  - Chief Executive Officer
  - General Manager Finance and Corporate Support
  - General Manager Planning & Funding (for Funding and relevant Revenue contracts only)

Instruments of Delegation

Delegations of Authority pursuant to this policy will be in writing in accordance with the Delegation Guidance and on the appropriate template. All staff receiving delegations will be provided with a copy of this policy.

Copies of the Instruments of Delegation and any revocations or amendments shall be retained by the person authorising the sub-delegation and by the person receiving the sub-delegation.

Exercising a delegation

Adherence to authority limits specified on an Instrument of Delegation, is the responsibility of the person with the delegation, this includes any electronic transactions.

Additional internal processes may be required before or as part of an approval within any delegated level. For assistance when using the Instrument of Delegation, best practice and procedures please refer to the Delegation Guidance document.

Compliance with Policy

Finance Managers are responsible for preparing the Instrument of Delegation and ensuring alignment with Authorities, Authority Limits and Sub delegations. Corporate Support may undertake reviews of Instruments of delegations. Finance Systems match the requested Oracle System delegated level to the appropriate Instrument of Delegation.

Periodic reviews will be conducted by the Canterbury DHB's internal audit function, Risk and Assurance, (as a part of their internal audit plan), to ascertain the level of compliance with the delegated authorities and associated policies. The DHB expects complete co-operation by all persons with this work.

Measurement or evaluation

A central repository will hold a scanned version of the master copy of all delegations to maintain transparency of existing delegations to appropriate staff. Any alterations, updates or new delegations will be reviewed by Corporate Support in line with delegator approval limits to ensure sub-delegations are appropriate. Check of additional delegations in line with position based levels of authorities schedule for consistency across the organisation. Requirement for update of the Oracle System will require the Instrument of Delegation to be provided in conjunction to the request.

Ongoing review of the Delegation Guidance will be undertaken every three years or prior as required.

Risk and Assurance review of adherence to policy to be undertaken periodically.

This policy will be measured by evidence supporting compliance with the policy and associated operational procedures, including any reports to management and the Quality, Finance, Audit and Risk Committee where appropriate.

Policy Owner	General Manager Finance and Corporate Support
Policy Authoriser	Chief Executive Officer
Date of Authorisation	27 September 2016

CDHB Instrument of Delegation

From: [Manager] (*Name*)
Chair, Canterbury DHB (*Title*)

To: Andrew Brant (*Name*)
Acting Chief Executive – Canterbury DHB (*Title*)

This instrument establishes the authority you may exercise in your role, for the budgets under your control, and in accordance with CDHB policies and procedures. Outside the scope of your role or above the limits specified, a person with the delegated authority must approve.

Authority	Authority Limit	Authority to sub-delegate
Procurement		
Purchase of Goods and Services	Up to $3,000,000 per transaction	Yes
Procurement Contract	No $ limit, up to 7 year term	Yes
Capital		
Approve Capital Expenditure	Up to $500,000 per asset/event	Yes
Approve Capital Expenditure from trust/donated funds	Up to $50,000 per asset/event	Yes
Approve Capital Disposals	Up to $1,000,000 per asset/event	Yes
Trusts		
Approve Operational Expenditure from Trust/Donated funds	Up to $100,000 per transaction	Yes
People		
Approve Payroll Expenses	Full Authority	Yes
Sign Collective Employment Agreement	Full Authority	Yes
Sign Individual Employee Agreement	Up to $500,000, at any % of grade	Yes
Approve Temporary Operational staff	Full Authority	Yes
Sign contracts for Consultants and Contractors	Up to $300,000 per event	Yes
Recruitment of Additional Staff	No $ limit	Yes
Proposal for Change	Up to $500,000 per event	Yes
Staff Management and Leave Approval	Full Authority	Yes
Revenue and Funding		
Revenue Contract	No $ limit, Up to 7 year term	Yes
Approve Research Agreements/Memorandum of Understanding	No $ limit, Up to 10 year term	Yes
Funding Contract	No $ limit, up to 7 year term	Yes
Finance		
Financial Write offs -Bad Debts	Up to $100,000	Yes
Financial Write offs –Stock	Up to $100,000	Yes
Financial Write offs -Lost Cash	Up to $5,000	Yes
Financial Write offs -Fixed Asset	Up to $100,000	Yes
Issue Credit Notes	No $ limit	Yes
Treasury		
Treasury Management	No $ limit	Yes
Any previous sub delegations given by Andrew Brant must be reviewed in relation to this Instrument of Delegation.		

I confirm I have an Instrument of Delegation that gives me the authority to grant the delegations shown above. These delegations granted are permanent until the staff member transfers to a new role or on termination of employment. I have provided the 'Delegation of Authority to Staff' policy to the receiver of the above delegations.	I acknowledge receipt of this Instrument and confirm that if I have at any time any actual or potential conflict of interest in the exercise of any delegation, I will immediately disclose this in writing to my Manager and General Manager. I confirm **I have received and read** the accompanying Delegation of Authority to Staff policy and Delegations Guidance.
Signature	*Signature*
[Manager]	Andrew Brant
Name	*Name*
Chair, Canterbury DHB	Acting Chief Executive – Canterbury DHB
Title	*Title*
Date	*Date*
This delegation has been prepared by a Finance Manager: Name: David Green Signature:	

Once signed, send a copy to the central CDHB register via delegations.corpfinance@cdhb.health.nz

Notes:

- Dollar value limits are exclusive of GST and are a maximum.
- For any delegations not listed, assume no delegation has been granted.
- All other relevant CDHB policies and procedures must be adhered to
- The delegator shall remain accountable for the exercise of the sub-delegated authority

COVID-19 HEALTH SYSTEM RESPONSE: VENTILATOR AND RESPIRATORY EQUIPMENT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Jan van der Heyden, Business Manager, Corporate Support**

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

DATE: **19 November 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

This report seeks approval to accept equity funding provided for additional ventilators and respiratory equipment to improve hospital resilience as part of Covid-19 preparedness.

2. RECOMMENDATION

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

i. notes that Cabinet has agreed to supply additional ventilators and respiratory equipment to DHBs, free of capital charge;
ii. notes the equipment allocated to CDHB totals $1,741,442;
iii. notes that CDHB can only clinically support $1,466,042 worth of equipment, with the remaining $275,400 being equipment either not currently used or not appropriate for use without increased clinical risk for the CDHB;
iv. endorses the acceptance of $1,466,042 of equipment and return of $275,400 of equipment;
v. notes that additional time and effort will be required to operationalise the new equipment in terms of staff training and commissioning;
vi. notes that CDHB was already well prepared in advance for the Covid-19 pandemic and had bought forward capital requests for ventilators; and
vii. accepts equity funding of $1,466,042.

3. SUMMARY

Cabinet has agreed to additional funding for additional ventilators and respiratory equipment to improve New Zealand hospital resilience. The Ministry is coordinating the additional supply of ventilator and respiratory equipment for use in a possible COVID-19 surge (Appendix 1). The equipment sourced was worked up through national respiratory and ICU clinical networks, so included CDHB clinical input.

CDHB is expected to acknowledge acceptance of the equipment and is responsible for all acceptance testing, regulatory requirements and take responsibility for managing all ongoing costs for the equipment allocated to them, including servicing and maintenance, depreciation and replacement based on the equipment's list price and its manufacturers service life.

The list of capital items being allocated totals $1,741,442 (248 units), but it is noted that out of the allocation, CDHB can only clinically support $1,466,042 worth of equipment, with the remaining $275,400 being equipment either not currently used or not appropriate for use without increased clinical risk for the CDHB. We have attempted to swap this equipment with other DHBs, but have not been successful.

All DHBs will receive their respective allocated equipment in return for an equity injection. The MoH have confirmed that the equipment is to be treated as a "donated asset" and will not attract a capital charge. DHBs will need to maintain the equipment, and will need to depreciate the equipment. Using a 10% depreciation rate, depreciation would account for $147k for a full year.

Equipment not supported by CDHB Respiratory and Intensive Care Specialists and to be returned ($275,400):

Lowenstein Prisma 30c and 50c (45 units)

These devices are inferior devices for provision of safe non-invasive ventilation (NIV) in a COVID population and within the current infrastructure of CDHB. NIV for hypoxemic respiratory failure is primarily managed within Christchurch ICU and delivered by high-tech ICU ventilators (Hamilton C6 and Drager C500). Planned expansion of this service to accommodate a COVID surge relies exclusively on our incumbent Phillips V60 range from within ED and the respiratory department. Whilst the Lowenstein Prisma 30c and 50c can provide NIV, they are inferior to the V60. These devices would not have been purchased on merit, they introduce unnecessary practice variation with inherent risk and will result in a training burden to a system that by definition will be under pressure during a COVID upsurge.

The terms of reference defined in accepting these devices includes a requirement for managing ongoing costs including maintenance, depreciation and replacement. Accepting these devices therefore exposes patients to unnecessary risk and exposes CDHB to unnecessary costs.

We therefore would like to respectfully decline these devices and acknowledge that this will result in these devices either being redistributed to other DHBs or being held centrally by the MoH.

Alaris Syringe Pumps (60 units)

The Fresenius Kabi syringe pump system has recently been installed in all acute areas CDHB-wide. This instalment was after appraisal of multiple devices including the Alaris system. It therefore seems illogical to expose patients to the risk of an unfamiliar and inferior device during a COVID pandemic. The defined commitment to managing ongoing costs and replacement of this large number of devices makes it strategically illogical to accept these devices as part of the MoH Covid response.

We therefore would like to respectfully decline the Alaris syringe pumps.

Equipment supported by CDHB Respiratory and Intensive Care Specialists and to be retained but not placed in current operational use ($655,720):

Mindray SV800 (10 units)

Clinicians consider these to be good units, but would need training on their use, and, before using, *"… would need to demonstrate some additional benefit before we disadvantaged patients with using unfamiliar and potentially inferior equipment to our incumbent fleet."* We will retain these units to be used in a Covid-19 surge.

Procurement and Clinical Engineering in conjunction with the clinical ICU and Respiratory teams have sought to swap equipment with other DHBs but there has been no appetite from the other DHBs for this. At the National Clinical Engineers forum no one was willing to swap, as most DHBs particularly did not want the Mindray ventilators nor the Prisma non-invasive ventilators.

Clinical leaders including Respiratory, Intensive Care and General Medicine all believe that CDHB are already in a healthy state equipment wise to meet a Covid-19 surge. These clinicians have endorsed the acceptance of $1,466,042 worth of ventilation and respiratory equipment.

MoH COVID-19 devices								
Category	Model	Quantity	Cost per unit	Fair value	Supllier name	Estimated delivery date	Clinically supported	Clinical comments
CAPA and HFNO	F&P Airvo	40	1,850	$ 74,000	F&P Healthcare	September	YES	Could help with COVID
CAPA and HFNO	Lowenstein Prisma 30c	40	2,585	$ 103,400	USL	October	NO	Change to Philips V60 devices
ICU Vents	Mindray SV800	10	65,572	$ 655,720	Connected Healthcare Systems Ltd		NO	CDHB Use Hamilton C6 devices Happy to see them and be trained up them as long as there is no commitment to be obligated to use them
Monitors	Intelliview MX450	10	10,362	$ 103,620	Phillips	August	YES	Will need to have correct cables provided with kit approx $750 extr each device
NIV	Lowenstein Prisma 50c	5	12,000	$ 60,000	USL	August	NO	CDHB use Philips V60 devices
NIV	Philips V60+ respirators	14	30,703	$ 429,842	Phillips	August/September	YES	Preferred device
Syringe pumps	Alaris CC Plus with Guardrails syring	19	2,000	$ 38,000	BD	August/ September	NO	CDHB Use Fresenius devices
Syringe pumps	Alaris GH Syringe Pump	21	2,000	$ 42,000	BD	August	NO	CDHB Use Fresenius devices
Syringe pumps	Alaris GP Plus pump with Guardrails	20	1,600	$ 32,000	BD	August	NO	CDHB Use Fresenius devices
Humidifiers	F&P 950	69	2,940	$ 202,860	F&P Healthcare	September	YES	Can be used in many clinical areas.
Respiratory consumables	To be advised	TBA			TBA	TBA by Aug 21st	YES	Care to be taken on possibly doubling up on stock and servicing costs for multiple vendor devices
	TOTAL			**$ 1,741,442**				
	Clincially Supported			**$ 1,466,042**				
	Clinically not spported			$ 275,400				
	TOTAL			$ 1,741,442				

4. APPENDICES

Appendix 1: Memo to DHB Executives received 16 August 2020

MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

DHB Chief Executives

COVID-19 HEALTH SYSTEM RESPONSE: VENTILATOR AND RESPIRATORY EQUIPMENT

Purpose

As part of COVID-19 response and recovery, Cabinet has agreed to additional funding for additional ventilators and NIV respiratory equipment to improve hospital resilience.

The Ministry is coordinating the additional supply of ventilator and respiratory equipment for use in a possible COVID-19 surge. The Hospital Response Group (HRG), which includes three DHB CEs, a COO and Ministry staff, has been overseeing this work.

The next step is for DHBs to agree how this equipment can best be deployed to improve New Zealand's ICU and respiratory capacity to manage any future COVID-19 surges.

It is not intended that the additional ventilators result in DHBs increasing their normal operating ventilated bed capacity. Where additional ventilated bed capacity and use of NIV equipment is required to be commissioned for COVID-19, all additional costs should be added to the COVID-19 cost tracker. Where DHBs choose to commission any of the new NIV equipment, any additional costs must be absorbed under existing funding and not contribute to a deterioration in your DHBs financial position.

Background

Ventilators

On the advice of a national ICU clinical group led by Dr Andrew Stapleton (HVDHB) and working through New Zealand Health Partnerships Ltd (NZHP) and other sources, the Ministry has procured ICU-capable ventilators and related equipment (monitors, pumps and consumables).

Some ventilators have already arrived in the country and are being held in a store managed by NZHP. The remainder are expected to arrive in the country between now and the end of the year. I am also aware that some DHBs have ordered ventilators directly, for delivery over a similar period.

The national ICU Clinical Group, in collaboration with DHB ICU specialists, has developed a draft plan as outlined in Appendix A for allocating the bulk of these units to DHBs. The allocation plan builds on the current DHB fleet using modelled DHB ICU demand in a Covid-19 pandemic. It also takes DHB experience with the new equipment into account where possible.

Some machines will be retained centrally as a mobile resource should they be needed to support a location as part of the pandemic response.

Respiratory equipment

On the advice of a working group of respiratory physicians led by Dr Andrew Brant (WDHB) and working through NZHP, the Ministry is procuring a range of non-invasive ventilation (NIV), continuous positive airway pressure (CPAP) and high flow nasal oxygen (HFNO) equipment and related equipment (humidifiers, masks, helmets, valves, filters and tubes). Some units have already arrived in the country and are being held in a store managed by NZHP. The remainder is expected to arrive in the country between now and the end of the year.

Dr Brant and fellow clinicians have developed a plan, see Appendix B, for allocating these to DHBs like that developed for the additional ventilators. Some machines will be retained centrally as a mobile resource should they be needed to support a particular location.

Distribution of Equipment

It is intended that this equipment is provided to DHBs based on the developed distribution plans based on the following conditions:

1. Your acknowledgment that your DHB will be allocated the equipment listed in Appendix A and B.
2. The equipment is being made available free of capital cost delivered to each receiving DHB.
3. NZHP will arrange for the equipment to be delivered as soon as practicable.
4. Each DHB is responsible for managing acceptance testing and ensuring regulatory compliance of all equipment allocated to them.
5. All equipment will be available for operation if required to manage Covid-19 patients.
6. DHBs will not allow the additional ventilators to increase their resourced ventilated bed capacity, unless this has been agreed as a planned Service Change with the Ministry.
7. If DHBs choose to commission any of the new NIV equipment, other than for COVID-19, any increase in operational cost must be within budget.
8. Each DHB will assume responsibility for managing all ongoing costs for the equipment allocated to them, including servicing and maintenance, depreciation and replacement based on the equipment's list price and its manufacturers service life.
9. Each DHB will ensure that their staff are appropriately trained to use the equipment.
10. In the unlikely event that a DHB does not require some of the equipment specified, it will continue to be held centrally.
11. The Ministry will bear no responsibility for any costs in relation to equipment that has been ordered directly by DHBs.
12. The Ministry will work with DHBs and suppliers to ensure that warranties are transferred to DHBs.

Training

Care has been taken to match ventilators with equipment that is already being used by DHBs to minimise the need for further training. The exception is Mindray equipment which

is not currently used in New Zealand. The Mindray distributor in New Zealand has offered to provide training to the DHBs concerned.

The respiratory working group has developed a potential training programme to support the use of the respiratory equipment, see Appendix C. Each DHB is responsible for ensuring appropriate training is undertaken and maintained.

National Reserve

Some ventilators and respiratory equipment will be held in a national reserve to support a flexible Covid-19 response. The cost of operating this reserve will be met by the Ministry.

To enable an equipment rotation policy, DHBs are expected to purchase any additional or replacement ventilator or respiratory equipment they need from the Ministry's national reserve in the first instance. Reasons not to do this will need to be agreed with the Ministry.

The Ministry and DHBs will undertake further work to determine the need for retaining a national stock in the longer term, and if deemed necessary, how that would be managed.

Next Steps

The Ministry wishes to start allocating available equipment as soon as possible, followed by ordered equipment as it comes into stock.

Can you please acknowledge your understanding that your DHB will be receiving the equipment outlined in Appendices A and B at no capital cost but subject to the conditions set out above.

While there will be operational costs to DHBs, the equipment will allow them to be better equipped for both Covid-19 and supporting patients with respiratory needs.

Please address your response and any questions to the programme lead, Roger Perkins - roger.perkins@health.govt.nz. Roger will be contacting you soon to arrange delivery schedules.

Yours sincerely

Michelle Arrowsmith
Deputy Director-General
DHB Performance, Support and Infrastructure

Appendix A

Proposed ventilator allocation plan

	DHB allocation from MoH national supply	Model	Estimated delivery month
ADHB	18	Draeger Evita V800	Aug/Sep
		Hamilton C6 (3)	Aug/Sep
		Hamilton T1 (2)	Aug/Sep
Northland	7	Draeger Oxylog (2)	Oct/Nov
Waitemata	0		
Counties Manukau	15	GE Carescape	Jul/Aug
Bay of Plenty	1	Hamilton C6	Aug/Sep
Waikato	2	Hamilton T1	Aug/Sep
Tairawhiti	3	Hamilton C6	Aug/Sep
		Draeger Evita V800(6)	Aug/Sep
		Hamilton T1 (1)	Aug/Sep
Lakes	9	Draeger Oxylog (2)	Oct/Nov
Taranaki	0		
		Hamilton C6 (3)	Aug/Sep
Hawke's Bay	5	Mindray SV800 (2)	Aug/Sep
		PB840(3)	Jul/Aug
Whanganui	4	Hamilton T1 (1)	Aug/Sep
MidCentral	6	Hamilton C6	Jul/Aug
Wairarapa	0		
		Hamilton C6 (3)	Aug/Sep
		Hamilton T1 (1)	Aug/Sep
Hutt	6	GE Carescape (2)	Aug/Sep
Capital & Coast	25	Mindray SV800	Jul/Aug
		Mindray SV800 (4)	Jul/Aug
Nelson Marlborough	7	Hamilton C6 (3)	Aug/Sep
West Coast	0		
Canterbury	10	Mindray SV800	Jul/Aug
South Canterbury	3	Draeger Evita V800	Aug/Sep
Southern DHB - Dunedin + Invercargill	19	Mindray SV800	Jul/Aug
		Mindray SV800(44)	
		Mindray SV600 (25)	
		Draeger Evita V800(3)	
		Hamilton T1 (34)	
		Draeger Oxylog (46)	
National Inventory (MoH)	156	GE Carescape (4)	

Appendix B

Proposed respiratory equipment allocation plan

	NIV			CPAP			HFNO		
	DHB allocation from MoH national supply	Model	Estimated delivery month	DHB allocation from MoH national supply	Model	Estimated delivery month	DHB allocation from MoH national supply	Model	Estimated delivery month
ADHB	22	Philips V60+ (16) USL Prisma 50C (6)	Jul/Aug Jul/Aug	38	USL Prisma 30C	Sep	5	F&P Airvo	Aug/Sep
Northland	5	Philips Trilogy EVO	Sep/Oct	13	USL Prisma 30C	Sep	8	F&P Airvo	Aug/Sep
Waitemata	26	Philips V60+ (18) USL Prisma 50C (8)	Jul/Aug Jul/Aug	44	USL Prisma 30C	Sep	23	F&P Airvo	Aug/Sep
Counties Manukau	19	Philips V60+ (14) USL Prisma 50 C (5)	Jul/Aug Jul/Aug	40	USL Prisma 30C	Sep	15	F&P Airvo	Aug/Sep
Bay of Plenty	9	Philips V60+ (6) USL Prisma 50 C (3)	Sep/Oct Jul/Aug	17	USL Prisma 30C	Sep	5	F&P Airvo	Aug/Sep
Waikato	13	Philips V60+ (10) USL Prisma 50 C (3)	Sep/Oct Jul/Aug	30	USL Prisma 30C	Sep	16	F&P Airvo	Aug/Sep
Tairawhiti	2	Philips Trilogy EVO	Sep/Oct	3	USL Prisma 30C	Sep	0		
Lakes	4	Philips Trilogy EVO	Sep/Oct	8	USL Prisma 30C	Sep	3	F&P Airvo	Aug/Sep
Taranaki	5	Philips Trilogy EVO	Sep/Oct	8	USL Prisma 30C	Sep	4	F&P Airvo	Aug/Sep
Hawke's Bay	7	Philips Trilogy EVO (5) USL Prisma 50C (2)	Sep/Oct Jul/Aug	12	USL Prisma 30C	Sep	6	F&P Airvo	Aug/Sep
Whanganui	3	Philips Trilogy EVO	Sep/Oct	5	USL Prisma 30C	Sep	5	F&P Airvo	Aug/Sep
MidCentral	7	Philips V60+ (5) USL Prisma 50C (2)	Sep/Oct Jul/Aug	13	USL Prisma 30C	Sep	10	F&P Airvo	Aug/Sep
Wairarapa	2	Philips Trilogy EVO	Sep/Oct	3	USL Prisma 30C	Sep	2	F&P Airvo	Aug/Sep
Hutt	6	Philips V60+ (4) USL Prisma 50C (2)	Sep/Oct Jul/Aug	11	USL Prisma 30C	Sep	8	F&P Airvo	Aug/Sep
Capital & Coast	13	Philips V60+ (9) USL Prisma 50C (4)	Sep/Oct Jul/Aug	22	USL Prisma 30C	Sep	17	F&P Airvo	Aug/Sep
Nelson Marlborough	6	Philips Trilogy EVO (4) USL Prisma 50C (2)	Sep/Oct Jul/Aug	11	USL Prisma 30C	Sep	7	F&P Airvo	Aug/Sep
West Coast	1	Philips Trilogy EVO	Sep/Oct	2	USL Prisma 30C	Sep	2	F&P Airvo	Aug/Sep
Canterbury	19	Philips V60+ (14) USL Prisma 50C (5)	Sep/Oct Jul/Aug	40	USL Prisma 30C	Sep	40	F&P Airvo	Aug/Sep
South Canterbury	2	Philips Trilogy EVO	Sep/Oct	4	USL Prisma 30C	Sep	4	F&P Airvo	Aug/Sep
Southern DHB - Dunedin + Invercargill	12	Philips V60+ (9) USL Prisma 50 C (3)	Sep/Oct Jul/Aug	23	USL Prisma 30C	Sep	22	F&P Airvo	Aug/Sep
National Inventory (MoH)	91	USL Prisma 50C	Jul/Aug	173	USL Prisma 30C Philips (113) Dreamstation (60)	Sep	101	F&P Airvo	Aug/Sep

Appendix C

Possible training programme for respiratory equipment (including, but not only, in relation to COVID 19 resurgence preparedness).

Respiratory therapy is usually administered in a hierarchical fashion with NIV being the most complex, followed in order by CPAP, HFNO and wall oxygen.

Given the number of staff to be trained in using this equipment, it would be pragmatic to train two cohorts, one to be able to deliver NIV/CPAP, and by default the lower specification HFNO and wall oxygen, and the other to deliver HFNO and wall oxygen only. The former group is anticipated to account for 41% of patients with respiratory failure and the latter 59%.

This following course outline is for training the higher complexity cohort and is illustrative only.

Covid-19 preparations: NIV/CPAP/HFNO

Staff training requirements

(Nurses, doctors, physios and others not normally administering these therapies or caring for patients with acute respiratory failure)

- Initial training required with quarterly refresher training. One course for all.
- Initial training requirements likely 1.5 – 2.0 days (former with pre-reading)
- Refresher training 1 day every 3 months.
- Ideally manual, YouTube videos and workbook

Suggested course content for discussion:

Day 1

90-120 mins anatomy and physiology

- Anatomy, dead-space, cilia and humidification
- Respiratory mechanics and change of these with posture (for proning)
- Respiratory failure, V/Q matching, work of breathing, PIFR vs gas supply flow rate, compliance, resistance and benefits of CPAP/PEEP, rebreathing

120 mins machine familiarisation - 3 machines used in the organisation x 40 mins each

240 mins lectures and practicals

- Hoods – putting on and off, safety anti-asphyxiation valve, flows and rebreathing, vomiting, viral filters on expiratory ports, wetting out of filters, pressure area care
- Masks – vented and unvented, optimal fit, adjustment, pressure areas, NGTs, putting them on and off and staff risks
- Circuits – single limb with vented masks, dual limb with non-vented masks, heated and cold, humidified and dry

- Humidification – set up, water, wetting out, loss of CPAP/PEEP on refilling on some models plus dangers of aerosolization and back flow during change
- Interface – trouble shooting everything between machine and lungs
- Proning – why, how, pressure areas, challenges e.g. obese, stomach compression etc
- Monitoring and work of breathing:
- Are patients improving or deteriorating?
- How do you know and what do you do?
- CO2 (ET and occasional ABG if extreme), FiO2, SpO2, NIBP, Heart rate
- Patient comfort – anxiolysis, analgesia, sedation
- Escalation of therapy
- De-escalation of therapy
- When to call for help
- Troubleshooting

What goes wrong and how to fix it:

- Disconnections
- Leaks,
- Pressure areas
- Vomiting and reflux
- Gastric/bowel distension
- Communication areas
- Managing delirious patient
- Gas supply failure
- Machine failure
- Worsening respiratory failure:
  - Equipment issues from machine/gas supply to patient
  - Covid-19
  - PTE
  - Pneumothorax
  - Superadded infection

<u>Day 2</u>

Workshops:

- Setting up
- Trouble shooting
- Monitoring and documentation
- Review session - What do you do if multiple scenarios occur?
- Simulation of scenarios

Questions and clarifications

Feedback

ACCESSIBLE INFORMATION CHARTER

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Kathy O'Neill, Team Leader, Planning & Funding**

APPROVED BY: **Dr Jacqui Lunday Johnstone, Executive Director of Allied Health, Scientific and Technical**

DATE: **19 November 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to propose actions that will align with Objective 10 of the Canterbury and West Coast Disability Action Plan.

2. RECOMMENDATION

That the Board, as recommended by the Community & Public Health & Disability Support Advisory Committee:

i. endorses the New Zealand Government Accessible Information Charter (the *Charter*);
ii. approves a signed copy of the Charter being forwarded to the Office of Disability Issues and the Charter's founder within the Ministry of Social Development to recognise CDHB's commitment;
iii. notes the Terms of Reference for the Accessible Information Working Group;
iv. notes that six monthly updates will be provided to CPH&DSAC on actions undertaken to meet the objectives of the New Zealand Government Accessible Information Charter; and
v. looks at innovative ways and opportunities to source new monies to help support the budgets in this area.

3. DISCUSSION

Background

Objective 10 of the Transalpine Health System Disability Action Plan states that the Canterbury and West Coast DHB's will provide accessible information and communication by ***'promoting and providing communication methods that improve access and engagement with people with disabilities e.g. use of plain language and Easy Read, ensuring all computer systems and websites are fully accessible'***

While the Canterbury and the West Coasts DHB's have demonstrated their commitment to delivering against this objective by undertaking an accessibility audit on the public facing website and rebuilding the website to comply with the audit recommendations, this is only one component of the intent and scope of this objective. There would not appear to be any other DHB in New Zealand who is ahead of CDHB in this journey. Most DHBs are similarly considering how their work can be more inclusive and responsive to those with communication difficulties, sensory impairments or other disabilities which make getting the information they need more challenging. Our biggest risk is in failing to address these needs, in that disabled people may miss out on receiving the services they need or have bad experiences because they did not receive the information they needed to know where to go, what to expect and what will happen next.

To identify what the approach needed to be, a group of interested CDHB staff have been meeting monthly to explore the scope of this objective and what the next steps needed to be. They have

developed a draft Terms of Reference for an Accessible Information Working Group and the group have identified potential actions they would undertake in the 12-month work plan described below.

Proposal

a. The Board formally endorses the New Zealand Government Accessible Information Charter (Appendix 1). Public Service Chief Executives have already signed the Accessible Information Charter and it is anticipated that getting the Board's approval to sign up to the Charter is an important step in demonstrating the DHB's commitment to actions that will deliver on Objective 10 of our Disability Action Plan.

b. Formalise the Establishment of an Accessible Information Working Group. An initial group of invested CDHB staff have met monthly since December 2019 (except from February to June 2020) with the objective of identifying opportunities within their work areas that would achieve improvements in providing accessible health information to the public and to staff. Note the membership in the Terms of Reference, noting that all those present have transalpine responsibilities and it is the intent that actions that are to be developed and implemented will be as a transalpine approach. The working group will operate as a subgroup of the Disability Steering Group and as such will have Dr Jacqui Lunday Johnstone as Executive Sponsor. There will also be strong connection with the Diversity Inclusion and Belonging Steering Group for Maori and Pacific hosted by People and Capability.

c. Potential Areas of focus within a Work Plan to be developed by the Accessible Information Working Group.

d. To ensure the standards of accessible information are aligned with best practice recommendations, the Ministry of Social Development (*MSD*), sponsor of the Accessible Information Charter, is scheduled to deliver free accessible information training to 25 staff from within the CDHB on 5 November 2020. This is deliberately scheduled to coincide with the CPH&DSAC meeting where the MSD sponsor is on the agenda and will be available to speak to the Advisory Committee about Accessible Information. It is hoped they will support the endorsement of the Charter by the CDHB Board.

To support this paper the draft Terms of Reference for the Accessible Information Working Group are attached (Appendix 2). Note the input for all areas of work being actioned in the Work Plan will secure input from disabled people, drawn from the Disability Steering Group community members and their networks.

Budget Implication

Signing the Charter does not commit the DHBs to meeting all the strategic goals of the Charter from day one. Rather it communicates our positive intent to the disability community in striving towards inclusive and accessible communication with all our service users.

Initially we would expect the work programme to prioritise those elements which can be incorporated through existing work streams within the system, such as the programme to support evolution of digital correspondence for both GPs and Patients. Any ongoing work, and the resources required, would then be prioritised in the context of other programmes across the system (ie. Accelerating our Future). Any future proposal that has budget implications outside of existing divisional resources will be considered on a case by case basis.

4. CONCLUSION

This Accessible Information Charter was tabled at EMT's meeting held on 21 October 2020. This approach was endorsed in principle and the report has also been updated to reflect the discussion regarding aspects of risk to the organisation and potential financial impact.

5. APPENDICES

Appendix 1: Accessibility Charter
Appendix 2: Terms of Reference, Accessible Information Working Group

APPENDIX 1

Accessibility Charter

Our organisation is committed to working progressively over the next five years towards ensuring that all information intended for the public is accessible to everyone and that everyone can interact with our services in a way that meets their individual needs and promotes their independence and dignity.

Accessibility is a high priority for all our work.

This means:

- meeting the New Zealand Government Web Accessibility Standard and the Web Usability Standard, as already agreed, by 1 July 2017
- ensuring that our forms, correspondence, pamphlets, brochures and other means of interacting with the public are available in a range of accessible formats including electronic, New Zealand Sign Language, Easy Read, braille, large print, audio, captioned and audio described videos, transcripts, and tools such as the Telephone Information Service
- having compliance with accessibility standards and requirements as a high priority deliverable from vendors we deal with
- responding positively when our customers draw our attention to instances of inaccessibility in our information and processes and working to resolve the situation
- adopting a flexible approach to interacting with the public where an individual may not otherwise be able to carry out their business with full independence and dignity.

Our organisation will continue to actively champion accessibility within our leadership teams so that providing accessible information to the public is considered business as usual.

Chief Executive	Manager Communications	Manager IT

Date _____

New Zealand Government

Appendix 2

Canterbury District Health Board Te Poari Hauora o Waitaha	**TERMS OF REFERENCE** Accessible Information Working Group, Canterbury DHB
Scope	The Accessible Information Working Group of the Canterbury DHB is to action and influence the priorities of the Accessibility Charter, (New Zealand Government) of which the Canterbury DHB will be a signatory. Members of the Working Group are tasked with working within their divisions and areas of influence on specific projects and actions identified within the group that will deliver on the Charters specific objectives.
Purpose	By delivering on the Charters Specific objectives the health system will achieve the strategic objective of the Transalpine Disability Action Plan 2016-2026 **Strategic Objective 10: Provide accessible information and communication** which states the following: *Promote and provide communication methods that improve access and engagement with people with disabilities, such as using plain language and Easy Read, ensuring all computer systems and websites are fully accessible to those who use adaptive technology, and expanding the use of sign language*
Objectives	• Development, implementation and evaluate an annual work plan which will identify the priorities to be delivered on for that period • Facilitate linkages and information sharing to clinical, operational and professional groups of the Canterbury DHB to ensure having accessible information is universally adopted across the organisation • Research best practice and where to source resources required to facilitate accessible information and seek organisational approval whenever required • Effectively link to the disability community to ensure disabled people are involved in the development and review of the core elements of accessible information as described in the Charter.
Accountability	The Accessible Information Working Group is accountable to the Canterbury DHB Disability Steering Group who will endorse the annual Work Plan and receive regular updates on progress.
Membership	Communications Quality and Patient Safety People and Capability Health Info Information Services Group Planning and Funding Community and Public Health Canterbury Clinical Network 2 Community Members of Disability Steering Group (including 1 Māori member)

Chairperson	Chair of Disability Steering Group
Quorum	50% membership
Meetings	Monthly (11 per year)
Agenda	Approved by the chair and circulated 1 week prior to the scheduled meeting date
Minutes	Minutes will be circulated within 5 working days following the meeting

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 o Waitaha

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

PREPARED BY: **Dr Andrew Brant, Acting Chief Executive**

DATE: **19 November 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, providing the latest update and overview of key organisational activities and 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

COVID Update

Cases in international mariners: A charter Singapore Airlines flight carrying 249 people (235 passengers, 14 air crew) arrived in Christchurch on 16 October 2020. The flight had departed from Moscow, transiting via Singapore. All passengers were transported via charter bus to the Sudima Airport Hotel to commence 14 days of managed quarantine. In total 31 mariners from Russia and the Ukraine were identified as positive cases. Genome sequencing suggests several separate initial infections with subsequent spread of one main lineage within the group. Following the identification of a case in a worker, the departure of the mariners ready for release was delayed. An exit plan was agreed; most mariners departed the MIQF on 7 November 2020. All mariners are due to have departed by 12 November 2020.

Cases in workers at the Sudima Airport Hotel (MIQF)
Case 1: Following the onset of minor symptoms a worker at the hotel sought a test on Sunday 1 November – this was reported as a positive test on Monday 2 November. The case's close (household) contact received a negative test result on Monday evening 2 November. The case had tested negative at routine testing on 29 October.

Case 2: A further hotel worker tested positive on 3 November. This person was tested as a workplace contact of Case 1. They were asymptomatic and had tested negative on routine testing on 29 October. Their two household contacts tested negative on 3 November.

Public health follow-up of the two staff cases and their contacts is ongoing. All staff working at the Sudima Airport Hotel from 23 October have been tested; to date no further positive cases have been identified in this worker group.

Genotyping for the two staff cases has been completed. Their genotypes are different, linking them to different individuals among the mariners group.

An investigation into source of hotel worker cases by senior staff from IPC, Labs, and CPH has been completed - a report with recommendations was provided to the Ministry of Health on 9 November.

CHIEF EXECUTIVE'S UPDATE

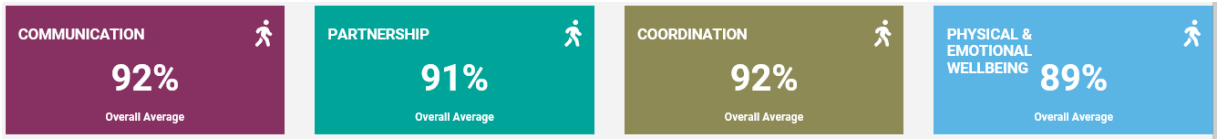
Canterbury District Health Board
Te Poari Hauora o Waitaha

PUTTING THE PERSON FIRST – PATIENT SAFETY, QUALITY & IMPROVEMENT

Performance Highlights

COVID-19 Survey Showing Positive Results: The Canterbury Covid-19 Managed Isolation Facilities Survey is now in its second month. The questions are similar to the DHB's patient experience questionnaires used for inpatient, outpatient and general practice, with specific service additions. Understanding how people experience their stay gives us valuable insight into what is working well and what could be done better. The DHB is undertaking this survey on behalf of all agencies that contribute to the Managed Isolation stay.

The overall results for the domains in the past month were positive: 1,580 surveys have been sent via email, 404 have been completed with 1,430 comments – a response rate of 26%.



Highest rated questions	
Overall did you feel staff treated you with respect and dignity while you were in isolation	96%
Overall, did you feel staff treated you with kindness and understanding while you were in isolation?	96%
Did you feel the staff were supportive of your needs while in isolation?	95%

Lowest rated questions	
Was religious, cultural or spiritual support available when you needed it?	82%
Did staff support you to remain virtually connected with friends, family/whanau when you wanted to while you were in isolation?	81%
Do you feel you were given consistent information by staff members?	58%

Initiative Helps Manage the Need for Children with Complex Epilepsy to be Admitted to Hospital: Christchurch now has the fewest Emergency Department admissions of children with diagnosed epilepsy in New Zealand. The achievement is due to enhanced community management in place using clinical nurse specialist/neurology team access. One aspect of Paediatric Neurology Clinical Nurse Specialist Dawn Anderson's role is to co-ordinate the neurology team specialist care for children whom have been diagnosed with a neurological disorder/epilepsy that involves intractable seizures (a seizure disorder in which a patient's seizures fail to come under control with treatment). Dawn provides education and support to enable parents/caregivers to safely manage their child's seizure frequencies which can regularly occur in the home or community setting. This approach has significantly reduced the frequency of ambulance call out and admissions to ED for many of these young patients, which lessens the strain on acute hospital service departments, but more importantly improves the quality of life for these patients and their parents/caregivers and whānau.

MĀORI AND PACIFIC HEALTH

Performance Highlights

Raraunga Whakauru – Positive Lift in Enrolment Rates: Patient enrolment data is instrumental in monitoring service access and engagement with our Māori population. Trends across the PHOs and

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

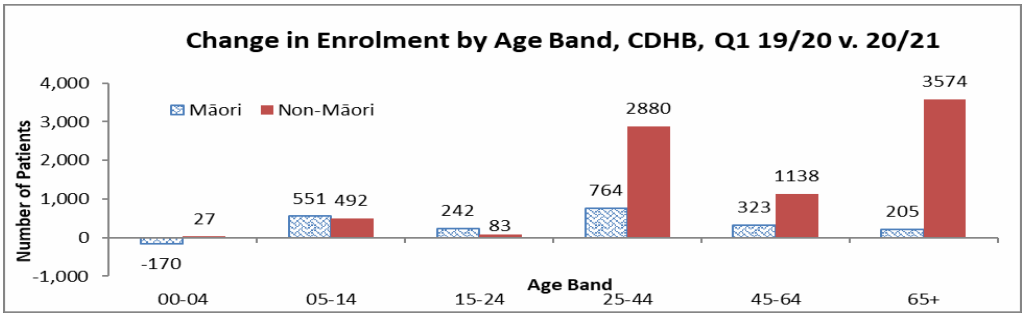
between Māori and non-Māori are charted each quarter and we have seen a positive increase in Māori enrolment rates this quarter (+0.8%), along with increases in enrolments of non-Māori (+0.4%). The graphs that follow compare the changes in enrolment by age band from Q1 2019/20 to Q1 2020/21.

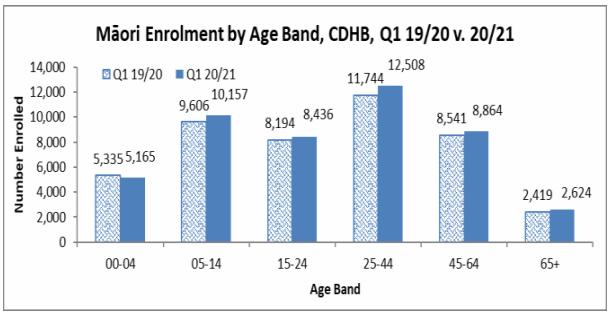
Graph 1: Māori enrolments have risen in all age bands, except 00-04, the non-Māori population has grown in all age bands.

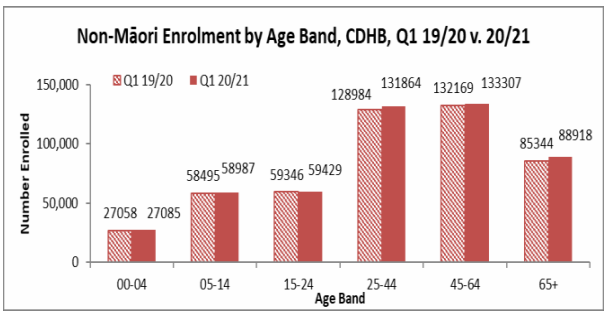
Graph 2: The highest increase in Māori enrolments in absolute numbers is the 25-44 age band (+764) with the biggest % change in the 65+ age band (+8.5%) and the lowest in the 00-04 age band (- 3.2%).

Graph 3: Non-Māori enrolments do not show losses in any age band. The highest % growth is in the 65yrs+ group (+4.2%) and this age group also shows the biggest increase in absolute numbers (+3,574).

Tamariki Ora e Waru - Before School Checks on Track: The Canterbury Before School Check (B4SC) programme comprises two parts; the nurse component carried out by B4SC trained nurses in general practice and public health, and the vision & hearing component delivered by the DHB testers. The first quarter of the 2020-2021 financial year shows a good start to the year with 90.5% of all eligible children and 93% of eligible Māori tamariki having had their full B4SC with both elements completed.



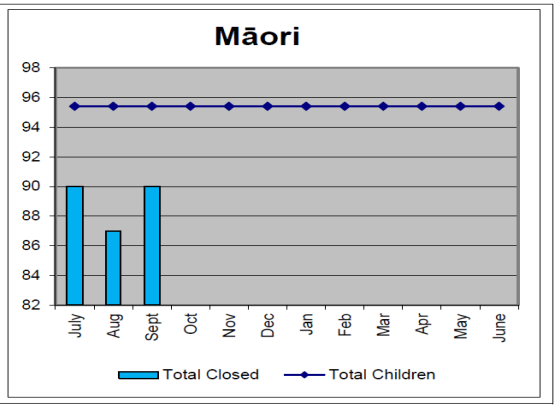




CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

Māori			
Month	Total Children	Target (90% of children)	Total Closed
July	95	86	90
Aug	95	86	87
Sept	95	86	90
Oct	95	86	
Nov	95	86	
Dec	95	86	
Jan	95	86	
Feb	95	86	
Mar	95	86	
Apr	95	86	
May	95	86	
June	95	86	
2020/2021	1145	1031	267



New Whānau Ora Community Clinic Operational: Our Kaupapa Māori provider, He Waka Tapu, are now fully operational with their Whānau Ora Clinic on Pages Road in Wainoni. The Whānau Ora Community Clinic model was established in 2014 from a policy developed by the government which focused on Whānau Ora. The organisation has established many clinics around the country in Kaeo, Kaikohe (in Northland), Auckland, Pukekohe, Waikato, Bay of Plenty, Naenae and now Ōtautahi. While based around general practice, the clinic offers a very different model of whānau engagement and He Waka Tapu have collaborated with the organisation to enable this clinic to be built and opened. Their cost structure offers much cheaper access to general practice than most other practice models in Canterbury and is specifically aimed at improving access and equity for our most vulnerable populations, particularly Māori and Pacific Peoples.

COVID-19 Testing Reaching Our Vulnerable Populations: To date we are fortunate to have no known community cases in our Māori and Pacific populations. We continue to be vigilant with our vulnerable Māori and Pacific populations and ensure pro-active approach to equity. The testing rates for Māori and Pacific Peoples are the two highest compared with other ethnicities, the data for our population over the entire pandemic period is presented below, as at 01/11/2020.

	Asian	European	Maori	MELAA	Pacific Peoples	Residual/Other	Not Stated	Total
Population	58427	409764	47066	7634	15824	4826	0	**543541**
% of Total Population	10.7%	75.4%	8.7%	1.4%	2.9%	0.9%	0.0%	**100%**
Ethnic Group Tested	7221	60592	8394	1213	2798	986	16840	**98044**
Testing rate of ethnic group (per 10,000)	1236	1479	1783	1589	1768	2043	N/A	**1804**
Positives	22	92	6	3	6	7	64	**200**
Positive rate of ethnic group tested (per 10,000 tested)	30	15	7	25	21	71	38	**20**
Positive rate of the ethnic population (per 10,000)	3.8	2.2	1.3	3.9	3.8	14.5	N/A	**3.7**

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

LIVING WITHIN OUR MEANS

Performance Highlights

Excluding the impacts of Covid-19 and Holidays Act compliance, the consolidated financial result for the month of September is a net expense of $11.460M, being $78k unfavourable to the Annual Plan agreed by the Board on 20 August 2020. YTD, Canterbury DHB is favourable to plan by $313k.

The following table provides the breakdown of the September result excluding the impacts of Covid-19 and Holidays Act compliance:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.012	0.000	0.012	0.148	0.000	0.148
Funder	(6.332)	(7.229)	0.897	(22.423)	(22.666)	0.243
DHB Provider	(5.140)	(4.153)	(0.987)	(12.478)	(12.401)	(0.077)
Canterbury DHB Group Result	**(11.460)**	**(11.382)**	**(0.078)**	**(34.754)**	**(35.067)**	**0.313**

COMMUNITY & PUBLIC HEALTH SERVICES

Performance Highlights

Active Transport Supporting our Vulnerable Communities: CPH's active transport health promoter explored the demand for cycling among migrant and former refugee women throughout 2019 and the start of 2020. Finding significant need for support, partners and funding were sought to establish a sustainable project and 'Bike Bridge' was launched in October 20202. Over the past three weeks, there has been excellent attendance at both the men's and women's courses. The course is a 'wraparound cycling skills and resources project', which teaches the basics of bike riding, on and off-road skills acquisition, managing in traffic, as well as bike maintenance and the provision of free cycles. The project has brought together many volunteers and has provided an excellent opportunity, not only for awhinatanga, but also whangaungatanga and manākitanga.

Equity Initiative

Canterbury Wellbeing Index Updated: CPH continues to work on the 2020 updates of the Canterbury Wellbeing Index. The Index is an online wellbeing monitoring tool that comprises three sections: Our Wellbeing describing the wellbeing of the greater Christchurch population across 57 indicators; He Tohu Ora focusing on Māori conceptualisations of wellbeing across 19 indicators; and Our Population describing the population of greater Christchurch across 10 indicators. The Index takes a strengths-based approach and presents a large number of equity-focused indicators. The He Tohu Ora component of the Canterbury Wellbeing Index was developed in liaison with Ngāi Tahu and Te Pūtahitanga o Te Waipounamu (the Whānau Ora commissioning agency for the South Island) and the name was gifted by Ngāi Tahu. Indicators were selected on the basis of a te ao Māori worldview and the availability of suitable quantitative data. He Tohu Ora uses Canterbury Wellbeing Survey data as well as data from the national Census and Te Kupenga surveys of Māori wellbeing across New Zealand conducted by Statistics New Zealand. The Index is available online at https://www.canterburywellbeing.org.nz/ and this work will help to support the development of the DHB's Māori Health Profile and Māori Health Improvement Plan over the coming year.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

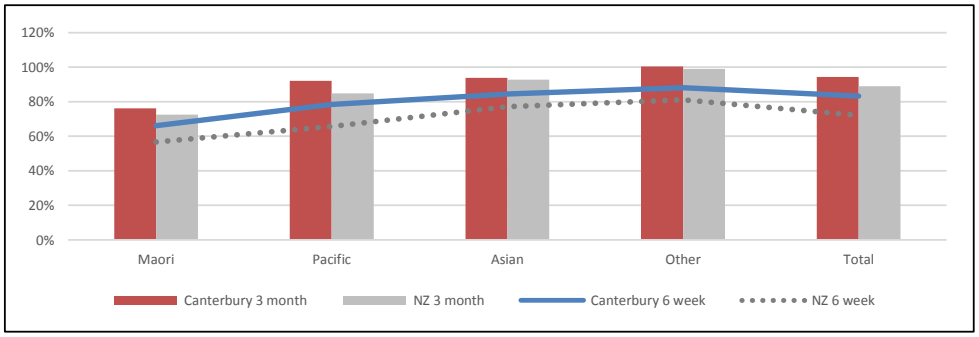
Risk Management Update

Expanded Contract Tracing Workforce Needed: The key strategy for managing these significant risks around COVID-19 is to ensure CPH's workforce is well equipped and as well supported as possible. The identification and training of additional staff (external to CPH) is a priority. CPH is required to be able to respond to a COVID-19 outbreak of up to 67 new cases per day. To achieve this, we require an available and suitably trained workforce of up to 150 additional staff to take on roles such as case investigators, contact management and administration support. Approximately 30 staff have already been identified across the wider Canterbury DHB workforce but a staffing shortfall remains. Additional strategies are being worked on to support the identification of suitable staff who could be seconded to CPH in the event of a community-wide outbreak.

PRIMARY AND COMMUNITY SERVICES

Performance Highlights

New Born Enrolment Rates High: Enrolling new-borns in general practice is a key performance target for DHBs and mechanism for supporting improved child health outcomes. This quarter, Canterbury's new-born enrolment coverage was among the highest in the country and above the national average across all population groups. Quarter one results (graphed below) show that 83.3% of all new-borns were enrolled with general practice at 6-weeks of age and 94% at 3-months of age. This work is supported by the Canterbury designed and developed LinkKIDS service that supports the enrolment of new-borns and young children moving into the Canterbury region across multiple child and youth services including general practice, immunization services, wellchild services and oral health services.



More Pharmacists Delivering Immunisations: The DHB is funding pharmacies for giving Influenza and Measles-Mumps-Rubella (MMR) immunisations to priority populations. This programme is going well with access to immunisations from community pharmacists continuing to grow, as more pharmacists complete their training to become vaccinators. Of the 137 pharmacies in Canterbury, 100 are now funded to give influenza immunisations and 66 to give MMR immunisations.

Improving Choice and Access to Mental Health Services: After being selected as one of the early implementers, the DHB is rolling Te Tumu Waiora out across Canterbury general practices in collaboration with the three Canterbury PHOs, local NGOs and the CCN. The goal is to provide up to 170,000 people with access to mental health and wellbeing support in general practice across Canterbury. While there have been some initial delays due to COVID, national training is underway, and 22 general practices are engaged in the programme with 14 of the 17 Health Improvement Practitioners and 17 of the 24 Health Coaches in place. We anticipate the remaining practices will have services in place by January 2021.

Improving Access to AOD Withdrawal Management Regionally: Canterbury is leading the development of a new service model to increase local access to withdrawal management /detox services across the

South Island. This involves the establishment of a specialist nurse coordinator in Canterbury who will support a regional network to work alongside general practice teams and provide detox services closer to home. All South Island DHBs are now funded for community withdrawal management nurses with workforce development provided via the regional coordinator. In Canterbury we have also added a Kaupapa Māori position to our existing community detox nursing workforce to increase responsiveness for Māori. This initiative is expected to reduce the need for people to travel out of district to access inpatient/residential withdrawal management services and will improve the patient experience of care.

Improving Access with Virtual Consultations: Access to services through virtual health and telemedicine has taken a significant leap forward over the last few months as clinicians adopt technologies such as Zoom, Microsoft Teams and doxy_me to offer virtual appointments in primary and secondary care settings. Following the COVID-19 lockdown, clinicians and patients have recognised the opportunities this technology brings in terms of convenience and accessibility across a wide range of specialties. We have successfully sought Planned Care Improvement Initiative Funding to implement and test the use of virtual consultations between GPs and Specialists to agree treatment plans for patients within primary care, without the need to refer patients into the hospital setting for a First Specialist Assessment. This approach is expected to significantly reduce the length of time people wait to commence an agreed treatment plan (currently up to 120 days for an ESPI compliant service) to between 1-10 days and in many cases will reduce the need for the patient to take time off to attend a hospital consultation. This will initially be limited to Cardiology and Child & Families Specialities.

Electronic Triage for Restorative Community Services: An improvement project to redesign the service delivery model for restorative community services in Canterbury has resulted in the development of an electronic system which will automatically triage referrals to community services. This new system will allow simple referrals to be sent directly to service providers, as opposed to every referral being considered and redirected by referral centre staff. Complex referrals will still be individually reviewed and directed but streamlining the referral process will be clearer for referrers and service providers and has enabled us to close one of the two community referral centres – providing a more cost efficient and sustainable service. The Canterbury Care Coordination Centre closed on 31 October, with all complex referrals transferring to the DHB's Adult Community Referral Centre from 1 November.

Equity Initiatives

Engagement with Pasifika Providers: Engagement and collaboration with Pasifika providers has been a highlight of the first quarter of this year. The DHB and Pasifika Futures (national Pacific Whānau Ora Commissioning Agency) are jointly funding Etu Pasifika to provide a range of health and social services for Pacific Peoples. Mental health and wellbeing is a significant component of this and the Ministry of Health has selected Etu Pasifika to implement additional services as part of the pool of "Choice and Access" initiatives being funded nationally. This will result in increased access to primary mental health and addiction services for our Pacific populations within a primary care setting, with a range of whānau ora services also available to provide wrap around care and support.

Diabetes Education Available in the Community: As part of the Diabetes Service Review completed in 2018 it was determined that the delivery of Type 2 Diabetes Education should move out of the DHB's Diabetes Service and into the community to better support a wellness focus and provide access to services closer to home. Community sessions started after the COVID lockdown, with good attendance and excellent feedback from those that attended. This shift has been enabled through an integrated delivery model with Canterbury Sports Canterbury Trust, Nurse Maude and Diabetes Christchurch. Work is now underway to ensure priority populations have access to culturally appropriate and targeted education. Tangata Atumoto Trust are developing Pacific diabetes education classes which will commence in February 2021. Classes focusing on Māori will be co-hosted by Te Pua Waitanga and the Diabetes Centre will also commence in early 2021.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

Māori Provider Referrals Electronic Enabled: Referrals to a group of kaupapa Māori providers within the Maui Collective, are now being enabled through our Electronic Request Management System (ERMS). Previously referrals to these providers required individual forms to be completed and sent to the providers manually. Referrals will now be able to be sent electronically from the GPs desktop, increasing the ease of referral and awareness of the services available. It is anticipated that this move will improve access for Māori to the services these providers offer.

Risk Management Update

Changes to COVID-19 Testing Expectations: With the opening of Australian Boarders there is likely to be increased pressure on the system to perform this COVID testing and guidance has been issued to General Practice on the procedure for testing people prior to leaving the country. If a person is enrolled in a general practice that is not available to perform the test within the required timeframe, the person may be able to arrange to be tested at one of the urgent care facilities: Moorhouse Medical, Riccarton Clinic, or 24-Hour Surgery. This testing is not eligible for funding, so patients will be required to pay.

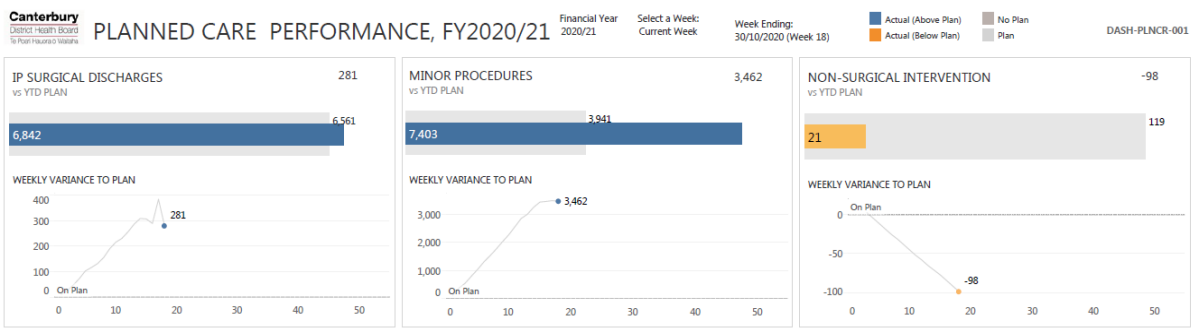
Slow Uptake of Measles Programme: The measles catch-up programme is off to a slow start with uptake lower than we would like. The vaccination workforce is limited and currently engaged in the flu season response or redirected to support the COVID response programme. Pharmacies are engaging in the programme with 66 pharmacies able to deliver MMR vaccinations, but our population is not, with little national campaign material circulating to raise the profile of the programme. 64% of our population are vaccinated for MMR, with around 35,000 people to reach. Rather than waiting for the national campaign, we are working locally with our Māori, Pacific and Asian communities to identify ways to engage these populations and increased visibility of the programme locally.

MEDICAL / SURGICAL SERVICES

Performance Highlights

Planned Care Plans Approved: The Canterbury DHB 3-year Planned Care plan and the 2020/21 Planned Care funding schedule have both been approved by the Ministry of Health this month. These plans support our plan for achieving planned care targets this year, but also the longer-term direction with increased support for the delivery of minor procedures and non-surgical interventions in community rather than hospital settings. Canterbury was also successful in securing funding for four planned care improvement projects totalling $1,162,546 in additional funding. These projects will begin in quarter two with benefits expected to be realised in this financial year.

Planned Care Performance: We are on track to deliver against planned care targets for 2020/21 with targets for the provision of 19,614 surgical inpatient discharges – 432 more than the 2019/20 plan. As at 30 October (following week 18) we have delivered 6,842 planned surgical discharges. This is 281 discharges ahead of target. While non-surgical interventions are behind scheduled we are well exceeding the target for minor procedures delivered in hospital and community settings at the end of week 18.



CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
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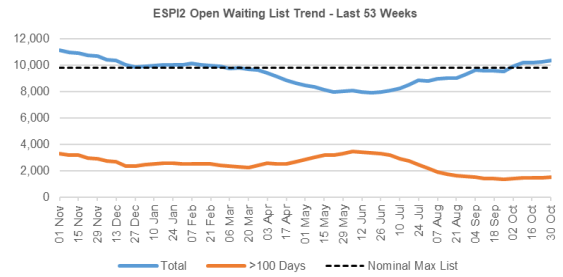
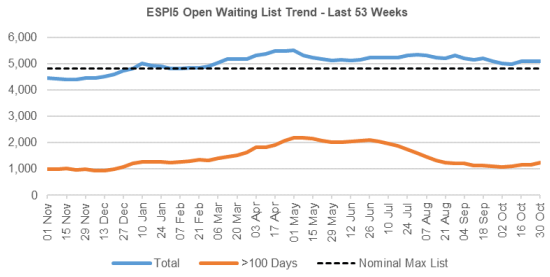
Reducing Waiting Times: Performance against the national Elective Services Patient Flow Indicators is improving and the DHB is on track to meet our ESPI 2 recovery targets - demonstrating a reduction in waiting times for our population. As at 30 October 15 of the 39 specialty areas with ESPI 2 targets have achieved compliance and have no patients waiting for longer than 120 days between referral and their first specialist assessment and a further 16 specialty areas are meeting their recovery plan target.





COVID Catch-Up Almost Complete: Of the 993 admitting events cancelled due to the COVID-19 lockdown all but 3 of these events have been closed and 2 of those have an admission rebooked. In total 4% of the 11,438 outpatient events cancelled during this period have been fulfilled, work is occurring to show which of the remaining commitments have been provided for and book those that are outstanding. A huge effort from the teams across the campus.

On Track with Faster Cancer Treatment: In the three months to the end of August the Canterbury DHB exceeded both the faster cancer treatment targets with 98% of cases meeting the 62 day measure, against a 90% target and 94% of cases meeting the 31 day measure, against an 85% target.

Equity Initiative

Reducing DNAs: Several initiatives are underway to reduce the 'did not attend' (or DNA) rates across our services as we examine how we can better engage and support our patients to attend appointments. It is acknowledged that our Māori and Pacific patients have a higher DNA rate and this will be a focus. The Retinal Screening Programme has a 12% rate of patients not attending appointments (did not attend, or DNA rate), this is double that experienced within the general eye service. The service is exploring opportunities to reduce rates by improving engagement with the service. As a starting point the Retinal Screening Co-ordinator and two SMOs attended Te Whare Roimata Health Day late in October to highlight the importance of retinal screenings and managing eye disease when you have Diabetes. The Gastroenterology and Respiratory Services are also starting work in this space.

Workforce Highlight

Leave Care Improving**:** Activity reports across the Christchurch Campus indicate that 838 of 1,260 people with a red category annual leave balance (i.e. >30 days) have had first level conversations with their managers towards putting a leave plan in place. 428 have had a follow up conversation. Based on leave bookings 154 of these 1260 people will move out of the red zone by the end of January. Annual leave taken by Christchurch Hospital Campus employees in the three months to the end of September has been consistently higher than that taken in the same months in 2019/20. Leave bookings for the summer months continue to increase.

Hours of annual leave taken	2019/20	2020/21	Proportion increase
July	82,689	95,867	16%
August	71,786	87,115	21%
September	79,193	112,526	42%

New Online Chemo Training Module supporting Nursing to Upskill: Existing courses on chemotherapy delivery required nursing staff to attend study days offered just twice a year and it was challenging for nursing staff to schedule these opportunities into their off-duty time. This was limiting the ability for nurses to be upskilled in this area and was requiring significant input by senior nursing staff to ensure the required competence was developed in our workforce. We have worked with Ara to re-create the training via an online Moodle portal which is now being rolled out South Island wide. This approach is enabling more nurses to participate in the training, providing equity of access for rural nurses and freeing up senior nursing capacity.

Accelerating Our Future

Improving the Capture of Revenue: The team is undertaking a review on all revenue lines to ensure the DHB is capturing all payments due for service delivery. The review has already resulted in an additional amount of $332k being billed to an outside provider which will be recognised in September 2020.

Better Ways of Working: A focus on overtime and better ways of working across the Campus is producing operational savings. An example is the proposal for change from an allied health 'on-call' system to a 24/7 'on-site' system which has reduced the overtime FTE by having a team on site to avoid call backs. In this way both overtime and penal time costs have been saved without reducing the service.

Risk Management

Readiness to Shift into Waipapa: The facility is now in transition to full occupation which commenced on 30 October with successful migration of sterile services to TSU in preparation of the Perioperative services moves. Perioperative services have run first cases in the theatres through the week of 9 November following simulation testing with the clinical teams in the weeks before. In parallel the Radiology service has been 'apps' testing their new equipment and a series of outpatient groups.

The testing and simulation process has assisted the project in identifying teething issues in the building readiness and resolution before the broader migration occurs. The perioperative service move on 23 November includes acute and non-deferrable cases.

The Chief of Surgery, theatre leadership and the DHB's facilities team are working together to examine the appropriate timing of return of outplaced surgery as part of this. Given the complexity of 'standing up' New Zealand's largest ever health facility we need to adopt a conservative approach to managing both the new building and new ways of working. Because of the lead times on scheduling operations and notifying patients of their surgery details, the current planning is looking to create some capacity contingency to provide a further level of comfort around the migration period.

Data Risks with Waipapa Migration: There is a possibility that the new Waipapa configuration (of wards and beds) will not match current DHB systems and lead in the short-term to incomplete or inaccurate data collection until activity can be mapped over and recaptured. Decision Support are monitoring this process closely to identify any potential issues and to address risks as soon as possible to ensure we are accurately tracking activity and patient flow across the campus.

Increasing Urgent Care Demand: Emergency Department presentations are sitting at 102% of forecast levels and are 5% higher than the same period last year with 8,105 presentations to the Emergency Department in the four weeks to 16 October 2020. A whole of system approach is taken with a voucher system for the 24hour surgery, increasing pull from our acute demand management services and CREST teams to support people in the community. We understand that demand is high across the country and a deep dive of presentation data is underway to identify any drivers that might be able to be addressed.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
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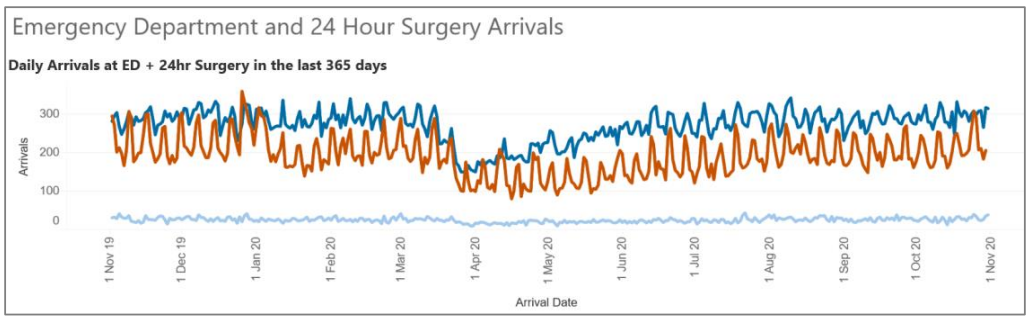


OLDER PERSONS HEALTH & REHABILITATION | COMMUNITY DENTAL

Performance Highlights

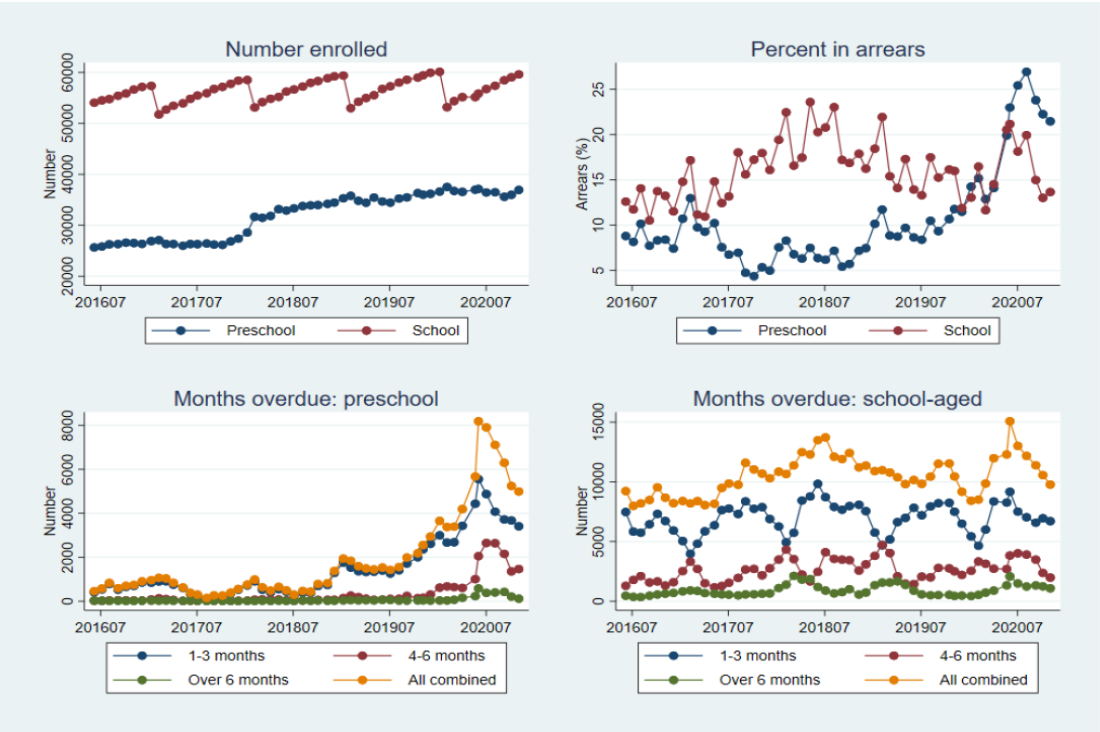
Greater Scope for the Podiatry Service: The Older Person's Health and Rehabilitation Division are enhancing the Podiatry service provided at Burwood Hospital and have recently created an Advanced Podiatrist role to provide top of scope Podiatry services to inpatients. In the past, Podiatry services have been utilised to provide basic foot care services and not able to provide specialist input for patients who would benefit from a higher level of clinical expertise. We were also unable to maximise opportunities to educate our staff, patients and whanau on the importance of good foot hygiene and explain the links with wellbeing and overall health. By utilising our resources differently, we have increased the number of Podiatry hours from 4 to 8 hours per week. The Advanced Podiatrist will provide necessary clinical leadership and input to design and implement a stepped approach which supports appropriate delegation to other workforces including unregulated staff where appropriate, whilst ensuring the appropriate training, competency and supervision is provided. The Podiatrist will also be able to provide specialist input to a range of wider organisational priority areas such as pressure injury prevention and treatment and safe mobility.

COVID Catch-Up on Track: The Community Dental Service continues to make good progress with its post COVID recovery Plan. The arrears for all children both pre-school and school aged has decreased from 22% (20,360 children) to 17% (16,074) at the end of May 2020. The numbers waiting greater than six months have decreased by 55% from 2,660 to 1,195. To achieve this the Community Dental Service have focused on prioritising appointments cancelled during the lock down period and prioritised visits of mobile dental units to schools with the most overdue children.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

Community Dental Service: Enrolments and arrears at end of October 2020



CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
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SPECIALIST MENTAL HEALTH SERVICES (SMHS)

Equity Initiative

Improving Support for Tangata Whaiora and Whānau: The Te Korowhai change process, approved in 2019 is well underway. The process for change was in response to increasing numbers of Tangata Whaiora and their Whānau accessing the Specialist Mental Health Service, resulting in greater demands on the role of the Pūkenga Atawhai (Māori Mental Health worker). FTE for Pūkenga Atawhai has been increased (within budget) and fully allocated and prioritised to clinical areas of greatest need. The outstanding element from the direction for change is the resourcing of a new cultural educator position (Pou Ako Matauranga) to support the development of cultural competency across the service.

Workforce Highlight

Staff Safety Improvements: At the recent ACC Accredited Employers Programme audit, the auditor commented on the large improvements in both lost time through injury and frequency of incidents within the Specialist Mental Health Service division. This has been driven mainly by a large drop in incidents of violence and aggression. The net result for the division is not only a 50% reduction in lost time through injury, but also the significant benefit of improvements to staff safety and wellbeing. There has been positive support from the unions to continuously reduce incidents. This support combined with ongoing commitment from frontline staff and managers has achieved these excellent results.

Risk Management Update

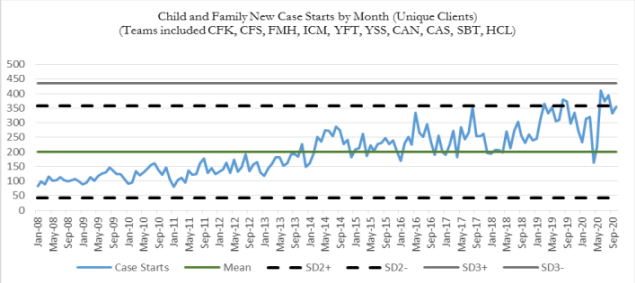
Adult Inpatient Occupancy: The adult acute inpatient unit (Te Awakura) continues to have a reduced capacity of 62 beds, due to a complex patient requiring lone use of the 3-bedded East High Care Area for an extended period. Admissions to Te Awakura are gradually increasing post-COVID. Optimum occupancy for adult acute inpatient units is 85% and Te Awakura is currently averaging 89%.

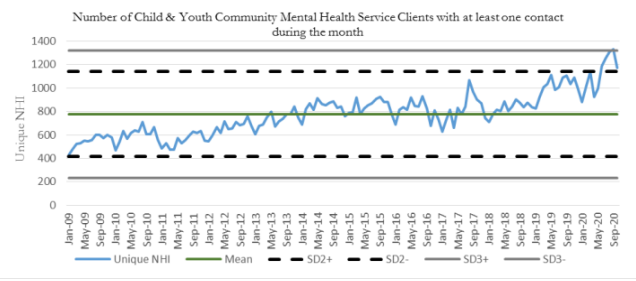
CAF Community Service Demand: There is an ongoing, significant increase in the number of referrals received by the Child, Adolescent & Family Service (CAF), particularly for the cohort 13yrs and over. The first graph indicates new starts (a case 'starts' as soon as any activity e.g. a face to face appointment or phone call is attached to new referral) and the second graph indicates unique contracts an indicator of demand from both new and existing patients. The ongoing and significant increase in referrals to CAF is of concern. There is pressure across the system which is impacting on the ability to signpost young people and their families to alternate providers and the increase in referrals is driving an increase in wait-times for people requiring routine assessment and treatment There is associated concern related to staff well-being given the high workloads associated with this demand. The team is focusing resource on effective triage to ensure that acute and urgent referrals are seen in a timely way and is working with community providers to respond to the demand. The DHB has supported a youth collaborative, the Community Youth Mental Health Service, to be another of the early implementers of the Choice and Access initiatives to increase capacity. Mana Ake will also continue in schools for younger children at current capacity until mid-2021 and the Te Tumu Waiora service is being rolled out at pace to provide increased resource across the sector.

Please note that data for October (in the graphs below) is incomplete as there is still some data yet to be entered to due timeframes for reporting.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha





AT&R delay: Practical completion of the Assessment Treatment and Rehabilitation high care area has been delayed and is now expected to be completed later in December 2020. This delay is due to contractor issues primarily related to COVID-19 restrictions and weather impacts. As part of this build a temporary reduction in beds (four) has been required to enable the high care and main unit to be linked. Alternative options for admission during this period depend on assessment of the individual's presentation, clinical needs and risk. Decisions regarding an admission will be made in collaboration with the wider service and involve negotiations with other DHBs during this period.

ASHBURTON RURAL HEALTH SERVICES

Performance Highlights

Improving Access to Services: NASC assessments ensure people's needs are identified and they are supported to continue to live in the community, supported by access to short or long-term support services. A NASC assessment can only be completed by an InterRAI credentialed provider and capacity issues within the Needs Assessment and Service Co-ordination (NASC) Services in Ashburton had meant long wait times for new assessments and 120 reviews outstanding at the end of September 2020. Lean thinking practices were utilised to identify the main issues delaying progress. Actions for improvement have been implemented including: recognising the small 'team' of three Registered Nurses were operating as individuals with separate caseloads and addressing the distribution of work flow; addressing gaps in referral information from inpatient ward areas and educating teams on essential information to improve turnaround; increased education across the wards on service referral and options of service provision increasing their confidence in referring directly, releasing up to 10 hours per week in capacity to redirect into InterRAI reviews. As a result there is now a two-week maximum wait time for new assessments, 100 reviews have been completed within the month, with just 20 remaining and the services has systems in place to maintain the new practice and performance measures under development to report as a Dashboard to increase visibility of service performance.

Future Performance Measurement in Development: The core function of Ashburton Hospital is to provide acute and episodic care via a specialist-generalist medical model of service delivery. Benchmarking performance that demonstrates the quality and efficiency of our service lens has been challenging with few hospitals operating an acute and inpatient model completely led by Rural Hospital Medical Specialists. We are partnering with the University of Otago, the DHB's Decision Support Team and other generalist hospitals to investigate the case-mix presentation to the Acute Assessment Unit (the core after hours care provider for the Ashburton community) and the comparative transfer rate to a tertiary hospital, admission and readmission rate by demographic cohort. These measures will give a base line for service improvement. Early research indicates Rural Hospital Medical Specialist-led facilities transfer less than the traditional physician/surgical led model in a satellite service. We can complete this research through our philanthropic partnership with Advance Ashburton and ongoing support of the Rural Health Academic Centre Ashburton and we thank them for their support.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

Equity Initiative

Improving Engagement with Primary Care: Community feedback has consistently raised the challenges faced in Ashburton with general practice enrolment. With the introduction of a PHO navigator approach in Ashburton in May of this year, non-enrolled patients presenting to the Acute Assessment Unit are able to be referred (with their consent) to the PHO navigator to support engagement and enrolment with general practice. Since May, a total of 57 people have been referred and we are socialising the opportunity and connection with multiple community services and providers.

Workforce Highlight

Developing a rural workforce: Ashburton Health Services has made a commitment to the development of the rural workforce, based on the generalist model of service delivery. We are currently embedding a significant change in the nursing leadership and operational structure, focused on the three core principles of operating in a generalist model, building on the Rural Hospital Medical Specialist model implemented in 2016.

Acute and Inpatient Service delivery	Creating a single flow and consolidated nursing team that provides care across the facility, resources distributed/redistributed to follow demand and manage within the planned resources.
Integration	A wide range of existing services that are based on maintaining patient care in the community, under the care of their general practice team. Moving away from a focus of a separate hospital-based community service team to an integrated partnership with primary care, building on the health care home models is the substantive for this cluster, alongside the development and efficiencies that can be gained in partnering with the visiting sub-specialist services to develop new models founded in generalist service delivery.
Quality, Safety and Workforce Development	This cluster provides the workforce development and quality lens across the division. In line with the medical council's definition of a broad range of generalist skill requirement, this team will lead the comprehensive development plan to build a cohesive generalist nursing workforce for all settings, inclusive of the current and future integrated inter-grated service models such as Kaikoura Health Services.

LABORATORY SERVICES

Performance Highlights

Successful Upgrade of the Laboratory Information System: This last month has seen the successful upgrade of the Laboratory Information System from Delphic V9 to Delphic V10 and migration to the cloud. The project has involved four DHB Laboratories with our Labnet partners from Taranaki DHB, Hawkes Bay DHB and West Coast DHB for whom Canterbury DHB is the hosts for the Laboratory Information System. This is the culmination of many months of collaborative efforts from a multitude of groups including the project team, dedicated laboratory testers, Canterbury Health Laboratories Laboratory Information System team, the DHB Information Service Group, the software vendor, Sysmex, and our Labnet partners Information Services teams and Laboratory teams. This upgrade provides a Laboratory Information System platform which is future proofed, with increased valuable functionality. Movement to the cloud is a first in NZ for a medical laboratory information system and for Sysmex.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

IANZ Audit: During October CHL hosted IANZ for our lab wide surveillance and peer review of Microbiology services including Virology and COVID testing. No major non-conformities were identified during the audits with a final written report pending.

Bowel Screening Programme: Canterbury DHB was given the go-ahead from the Ministry of Health for the Bowel Screening Programme to go live from 29 October 2020. The Anatomical Pathology Department is expecting the first delivery of colonoscopy/histology specimens towards the end of November and is looking forward to participating in this important programme of work for Canterbury patients and their families.

Increase in Volumes: Canterbury Health Laboratories experienced a significant drop in referral activity over the COVID-19 lockdown period. This has now recovered. The overall volume increase over the last 12 months is 1%, but this includes the lockdown period. Volumes for the last four months of the 2020/21 financial year are 4.6% higher than same period in 2019/20. COVID-19 testing contributes approximately 3.5% to this increase.

Equity Initiatives

Development of Laboratory Equity Dashboards: The Canterbury Health Laboratories Team have been working with the Māori and Pacific colleagues Hector Matthews, Finau Heuifanga Leveni and Kiki Maoate, as well as key primary and secondary care representatives to develop equity dashboards providing analysis of laboratory data to make visible equity gaps within our health system. This information shows lower uptake of testing for Māori and Pacific peoples and for the selected test groups we reviewed higher test abnormality rates for certain conditions. Through this work we hope to help identify specific initiatives/pilot projects that can address the access issues identified and in turn improve outcomes for these population groups.

Workforce Highlights

Clinical Microbiologist Recruitment: After an extended recruitment process further impacted by COVID-19 travel restrictions, the team was pleased to welcome Dr Erik Otte in October. Dr Otte has been appointed into the role of Clinical Microbiologist, Senior Medical Officer and is a welcome and long-awaited addition to the team adding much needed capacity to the small team.

EFFECTIVE INFORMATION SYSTEMS

Performance Highlights

Robotic Process Automation Underway: Following robotic process automation training, members of our Information Services Group (ISG) team developed the first use case which has been successfully been implemented in our production system. Further cases and other fully automated forms continue to be developed in ServiceNow. By upskilling our staff in Robotic Process Automation tools and methodology we can also provide guidance on further Automation developments within the organisation.

ServiceNow Upgrade Complete: A recent ServiceNow Upgrade was completed to mitigate the On Boarding application running into some development roadblocks. This upgrade also released functionality for the other ServiceNow workstreams. The upgrade required a move off Server 2008 so the DHB took the opportunity to move the ServiceNow Mid Servers onto our Azure Cloud platform. We also completed a full regression test of all applications on the ServiceNow platform including Max.; Oracle; ISG; Outpatients and Orderly to make sure these products continued to operate effectively in the new Cloud environment.

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora o Waitaha

Accelerating our Future

Electronic Delivery of Outpatient Clinic Letters to GPs: Technical pre-work has been completed and initial testing has commenced for this project. We are planning to pilot this with General Surgery in November to assess performance before planning further rollout to remaining services. The ISG team are also working on a solution for those patients who request that a letter is not sent to their GP as this has previously been a manual process. The automation project is expected to release significant capacity across our system and generate considerable operational savings.

Risk Management

Paging Replacement System: Our paging system is end of life and requires replacement. Capital expenditure has been approved in principle and we are working through a procurement process.

Cyber Security: Canterbury DHB continues to make inroads to increase our maturity to mitigate the risk of cybersecurity threats. This includes updating policies, delivering security awareness and phishing training, penetration testing and remediation and improving security solutions such as email, web and end point security.

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

Performance Highlights

National Bowel Screening Programme Underway: After a superb multi-disciplinary effort, Canterbury joined the National Bowel Screening Programme during the last week of October. Test kits will first hit mailboxes from mid-November, coinciding with the start of a modest media campaign to help promote the existence of the programme and what it hopes to achieve, and tell our target age band when they can expect to receive their kit and what to do when they do. There is a strong equity focus to the National Bowel Screening Programme to ensure Māori and Pacific Peoples as well as those in quintile 5 engage with and take advantage of the programme.

COVID Information: Online information about COVID-19 continues to be well utilised by the general public, particularly for up to date information about hospital restrictions, and the availability and locations of free community based COVID-19 testing centres. The Canterbury DHB website is the main point of reference for this information locally. In the past 3 months our COVID-19 information page has been viewed over 46,000 times, by over 35,000 visitors.

Accelerating our Future Update

Increasing Staff Engagement: A website has been developed and gone live to share information about the programme with everyone in our health system. Communication packs for managers were prepared and distributed and further engagement plans and materials are being developed to support this work.

Risk Management

Cyber Attacks: An attack on Canterbury DHB's website would disrupt a key communication and information sharing channel. Improvements have been made to the security of Canterbury DHB's public website which have seen it move from a C to an A rating. These improvements ensure that the DHB's website is more secure, and less able to be compromised.

FINANCE REPORT 30 SEPTEMBER 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Dr Andrew Brant, Acting Chief Executive**

DATE: **19 November 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the consolidated financial result for the month of September 2020 including the impacts of Covid-19 and Holidays Act compliance is a net expense of $17.162M, being $5.780M unfavourable to the annual plan agreed by the Board on 20 August 2020. The YTD result is now $4.683M favourable to the annual plan;
ii. notes the consolidated financial result for the month is unfavourable to plan by $0.078M (YTD $0.313M favourable) excluding the impact of Covid-19 and the Holidays Act compliance provision;
iii. notes that a provision of $4.311M has been made in September for 2020/21 Quarter 1 estimated Holidays Act Compliance. This was not included in the annual plan. The full year impact of this is estimated to be $17.244M; and
iv. notes liquidity (cashflow) risk has been alleviated by the recent receipt of $180M of equity support.

3. DISCUSSION

Overview of September 2020 Financial Result

Summary DHB Group Financial Result excluding the impact of Covid-19 and Holidays Act compliance

The following table provides the breakdown of the September result:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Governance	0.012	0.000	0.012	0.148	0.000	0.148
Funder	(6.332)	(7.229)	0.897	(22.423)	(22.666)	0.243
DHB Provider	(5.140)	(4.153)	(0.987)	(12.478)	(12.401)	(0.077)
Canterbury DHB Group Result	**(11.460)**	**(11.382)**	**(0.078)**	**(34.754)**	**(35.067)**	**0.313**

4. KEY FINANCIAL RISKS

Savings Plans – Although we are largely on target with our overall savings plans, there is a risk that we do not substantively achieve these savings. The savings plans are heavily phased in the later part of the financial year.

Liquidity – On 5 October we received $180M from the MoH for equity support in relation to our 2019/20 deficit. Our immediate liquidity issue has been resolved, and we are forecasting that we will not need to use our overdraft facility until June or July 2021. Our annual plan had forecasted to receive $135M in November and another $41M in January 2021. Receiving the full amount of equity support earlier than planned will increase the capital charge expense for the year by $1.350M.

Covid-19 – the forecasted impact of Covid-19 on CDHB's performance is dependent on a number of uncertain parameters, and the long term impact will take time to determine, and will include factors such as elective revenue, IDF revenue, and ACC revenue, and the costs associated with these (e.g. what level of outsourcing is required to catch up on lost throughput). CDHB is also managing six Managed Isolation Quarantine Facilities (MIQFs) for the Canterbury Region.

The ongoing impact of Covid-19 on CDHB is now centred around the running of the MIQFs, support for contract tracing, and testing. The Primary Care sector remains heavily involved in testing and our primary care costs exceed the funding made available at the end of September by $1.1M.

Holidays Act Compliance – the workstream to determine CDHB's liability under the Holidays Act is continuing. We have accrued a liability based on the draft report from EY; there is risk the final amount differs significantly from this accrued amount. We are likely to have a qualified opinion on this issue in our annual report (as was done last year).

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

The new **Waipapa facility** will be operational at the end of November. The annual plan had assumed 1 November, and this further delay will likely impact the operating result of CDHB.

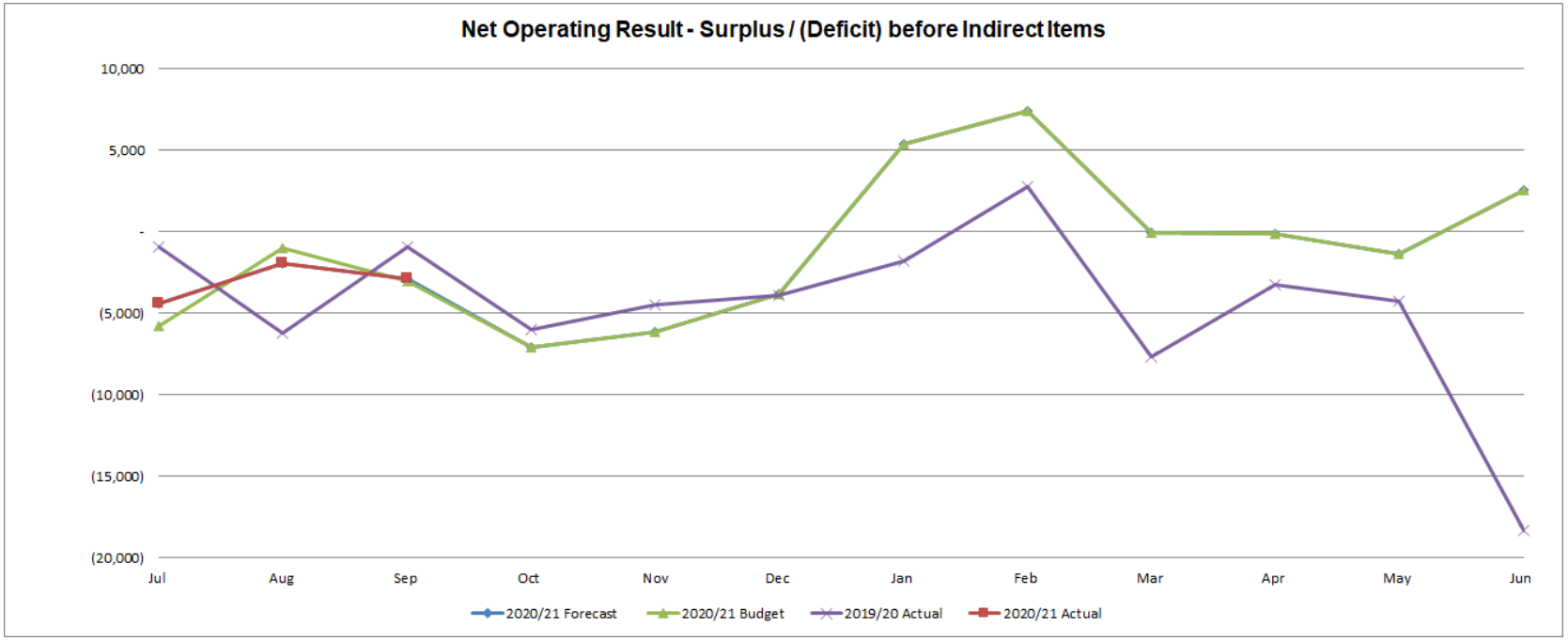
5. APPENDICES

Appendix 1: Financial Result excluding the impact of Covid-19 and Holidays Act compliance
Appendix 2: CDHB Group Income Statement
Appendix 3: Statement of Financial Position
Appendix 4: Cashflow

APPENDIX 1: FINANCIAL RESULT (BEFORE INDIRECT ITEMS)

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED 30 SEPTEMBER 2020

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2019/20 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
Surplus/(Deficit) before Indirect items	(2,895)	(3,056)	161	-5% ✔	(9,200)	(9,817)	617	-6% ✔	(54,827)	(23,257)	(23,257)	-	0% ✔



NB: The actual results in the above graph excluding the impact of Covid-19 and Holidays Act Compliance.

KEY RISKS AND ISSUES

This graph shows the operating result before indirect items such as depreciation, interest, donations, capital charge and the offsetting capital charge funding.

In September CDHB incurred a net expense of $1.391M of Covid-19 pandemic related expenditure. Additionally, we expensed $4.311M for July – September 2020 Holidays Act compliance. Excluding these expenditure items, our operating result would have been $0.161M favourable (YTD $0.617M favourable).

The following table shows the impact of Covid-19 and the Holidays Act compliance:

	Period to date							Year to date						
September 2020 Result	Month Actual $000	Month Budget $000	Month Variance F/(UF)	Covid-19 $000	Holidays Act $000	Excl Covid-19 & Hols Act $000	Underlying Variance	YTD Actual $000	YTD Budget $000	YTD Variance F/(UF)	Covid-19 $000	Holidays Act $000	Excl Covid-19 & Hols Act $000	Underlying Variance
MOH Revenue	(164,365)	(161,372)	2,993	(1,082)		(163,283)	1,911	(489,819)	(484,116)	5,703	(4,837)		(484,982)	866
Patient related revenue	(9,559)	(6,072)	3,486	(3,607)		(5,952)	(121)	(23,024)	(18,112)	4,912	(4,790)		(18,234)	122
Other Revenue	(4,171)	(3,591)	579	(1,182)		(2,988)	(603)	(13,188)	(10,373)	2,815	(3,609)		(9,579)	(794)
Total Operating Revenue	(178,095)	(171,035)	7,059	(5,871)	-	(172,223)	1,188	(526,031)	(512,601)	13,431	(13,236)	-	(512,795)	195
Employee expenses	84,935	78,573	(6,362)	3,533	4,311	77,091	1,482	242,645	235,335	(7,310)	4,955	4,311	233,379	1,956
Outsourced Personnel	1,625	1,664	39	209		1,416	248	5,501	4,974	(527)	209		5,292	(318)
Treatment Related costs	16,883	13,510	(3,373)	1,053		15,830	(2,320)	45,553	41,000	(4,553)	1,728		43,826	(2,826)
Other expenses	10,411	10,020	(390)	93		10,318	(297)	30,305	29,158	(1,147)	1,139		29,166	(8)
External Provider costs	72,837	70,324	(2,513)	2,373		70,464	(140)	216,224	211,951	(4,273)	5,890		210,333	1,618
Total Operating Expenditure	186,691	174,091	(12,599)	7,262	4,311	175,118	(1,027)	540,228	522,418	(17,810)	13,921	4,311	521,996	422
Operating result - (Surplus) - Deficit	8,596	3,056	(5,540)	1,391	4,311	2,895	161	14,196	9,817	(4,379)	685	4,311	9,200	617
Total Indirect revenue and expenditure	8,565	8,326	(239)	-		8,565	(239)	25,554	25,250	(304)	-		25,554	(304)
Total - (Surplus) / Deficit	17,162	11,382	(5,780)	1,391	4,311	11,460	(78)	39,750	35,067	(4,683)	685	4,311	34,754	313

MoH revenue covers most of the external provider costs incurred to date, which relate mainly to community surveillance and testing. In total, $8.096M of specific funding is available in 2020/21 for the Covid-19 response. This includes $5.292M of new funding, and $2.804M for the Public Health Unit (PHU) and the Primary Mental Health Response. YTD September, $4.837M of this funding has been recognised as revenue.

There is a risk of insufficient funding for Covid-19 surveillance and testing.

Patient related revenue includes revenue for MIQFs.

We received an update from MoH on 20 October regarding the funding of the MIQFs proposing a change in funding methodology effective from 1 July which could reduce our September YTD result by $1.2M.

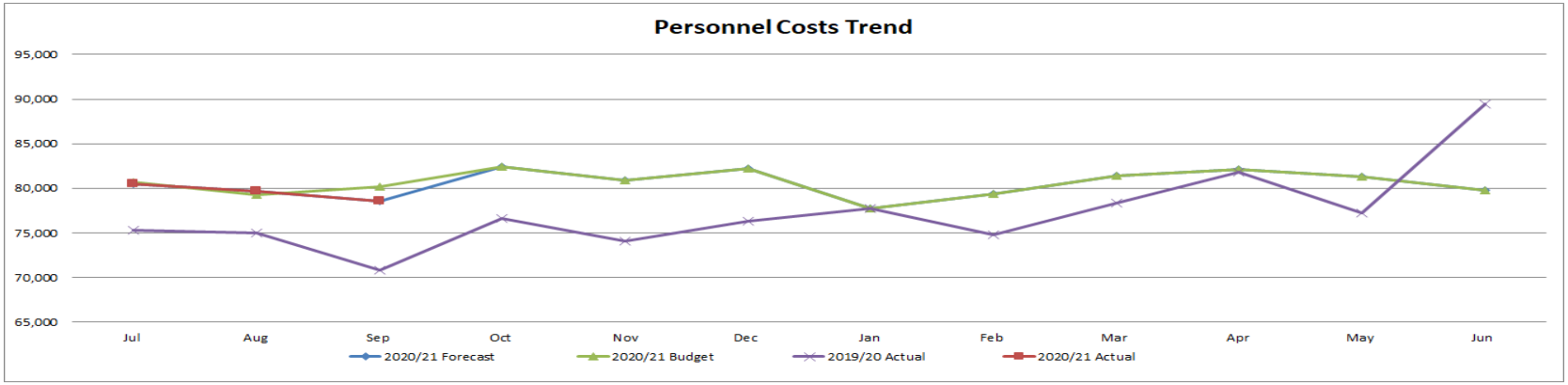
The annual cost for CDHB has been estimated at $24M based on the current scenario running 6 isolation hotels at full capacity and including all costs. As at 20 October we are currently running at close to full capacity.

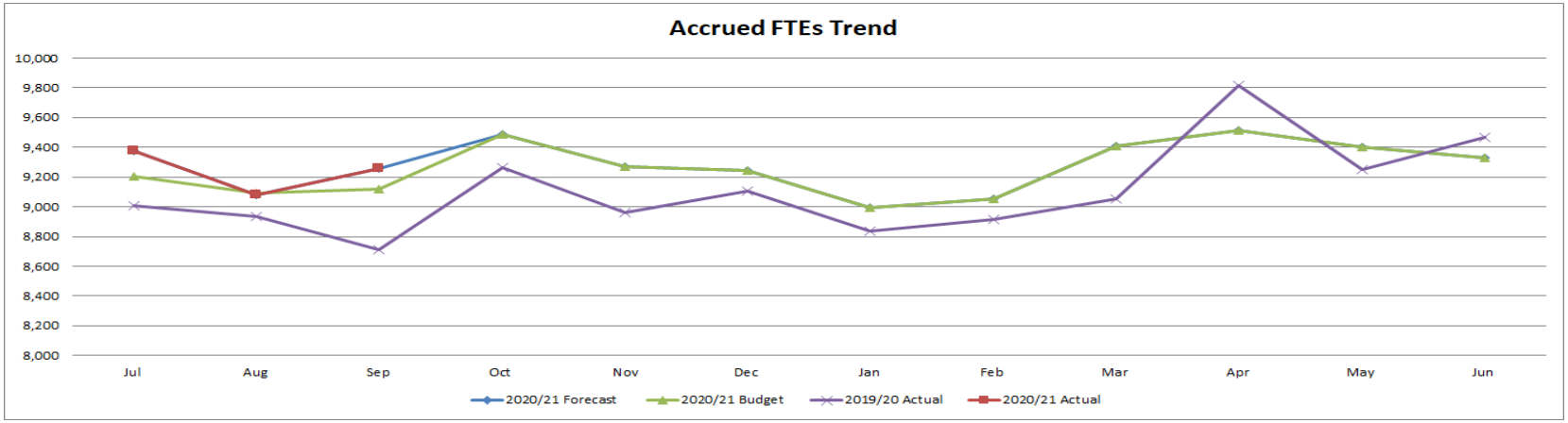
Other revenue is from Covid-19 pathology tests processed by Canterbury Health Laboratories (CHL) for Canterbury and other regions. In August 2020 there was a significant increase in demand due to the Auckland region lockdown and increased testing requirements.

Personnel cost for Covid-19 is mainly related to the running of the MIQFs. A provision of $4.311M has been made for the 3 months to 30 September for further Holidays Act Compliance costs.

Treatment Related Costs and Non Treatment Related costs are mainly related to the running of the MIQFs and lab testing.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE EXCLUDING COVID-19 & HOLIDAYS ACT COMPLIANCE



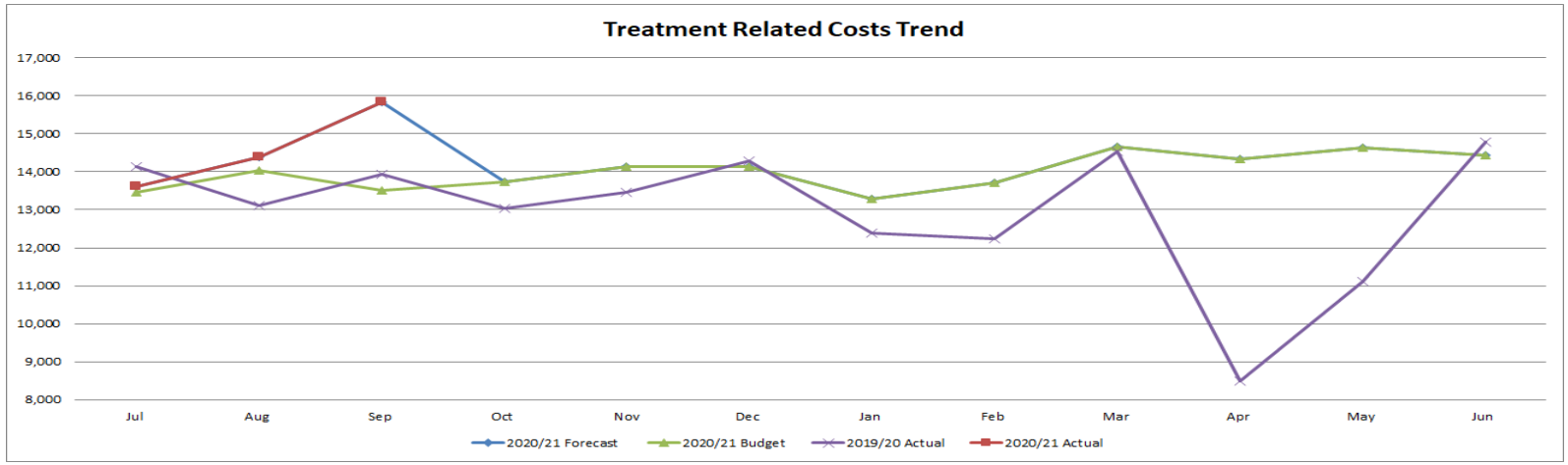


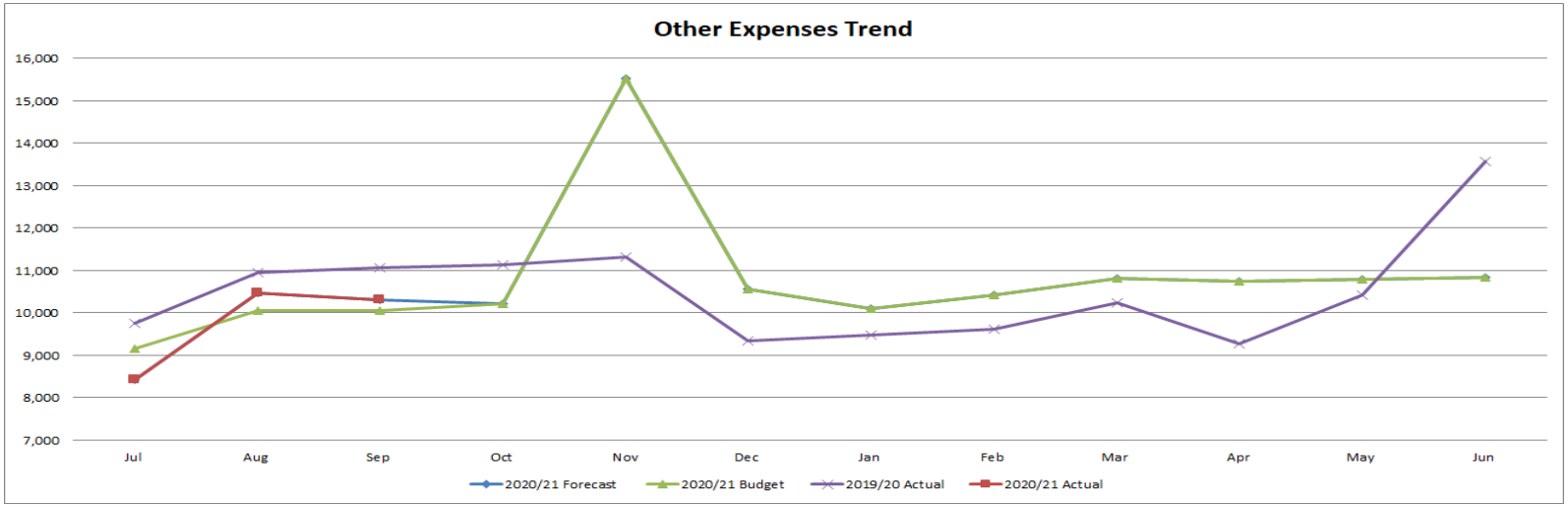
KEY RISKS AND ISSUES

YTD BAU personnel costs are $1.956M favourable to plan.

Note the FTE shown in this graph is an “accrued” FTE and differs from contracted FTE. The methodology to calculate accrued FTE causes fluctuations on a month to month basis dependant on a number of factors such as working days (the range is 21-23 across the year), the accrual proportions, annual leave impacts (particularly school holidays and Easter, Christmas and New Year periods), etc. The accrued FTE largely correlates with the trend in contracted FTE.

TREATMENT & OTHER EXPENSES RELATED COSTS EXCLUDING COVID-19





KEY RISKS AND ISSUES

YTD BAU treatment related costs is $2.826 unfavourable to plan. Some of the unfavourable BAU variance is related to setting up expense inventory locations in the new Waipapa facility, these costs will be offset by closing expense inventory locations in the existing facility over the next few months. Cardiac, orthopaedic, and spinal implants are higher than planned; there has been a higher than expected number of acute patients in the month.

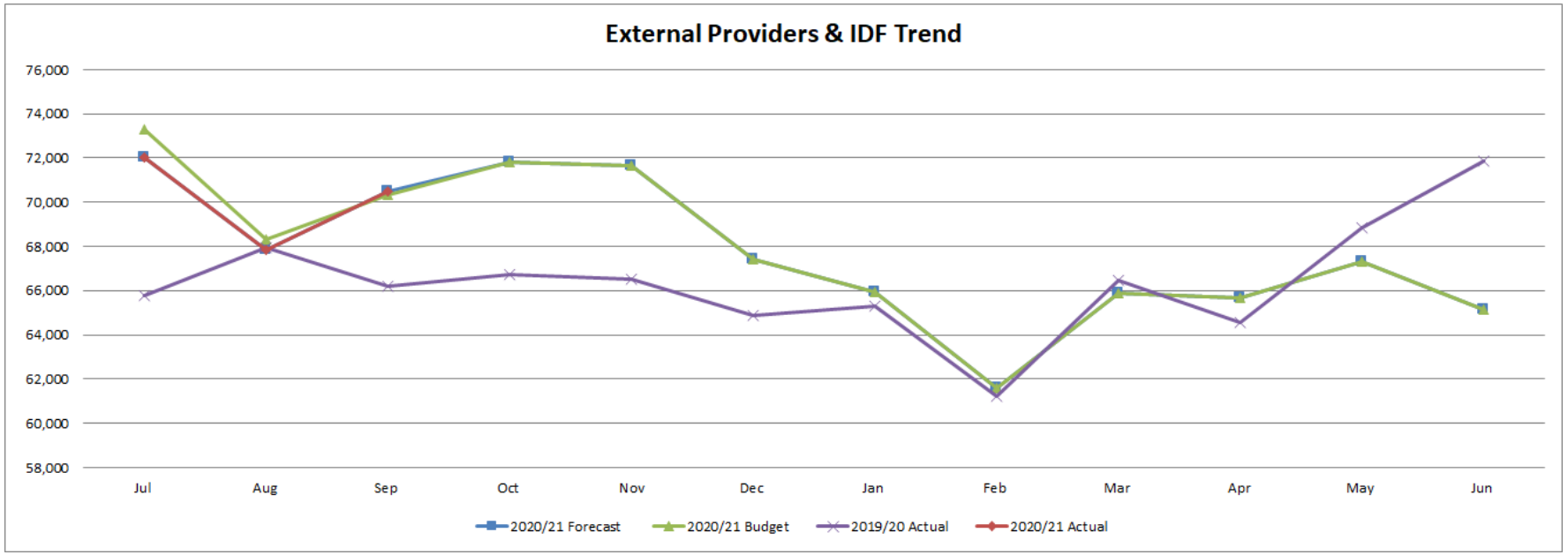
The BAU treatment related costs decrease in April 20 primarily related to lower patient activity during the Covid-19 pandemic lock-down period.

Additional facility costs continue to be incurred in relation to The Princess Margaret Hospital (TPMH) campus, including security, basic maintenance etc. Some of these additional costs are in relation to a number of mental health services that remain stranded at that site. Although we have Ministerial approval to progress a shift of services to Hillmorton, TPMH is still unlikely to be fully vacated until the 2022/23 financial year.

The budget increase in November 20 relates to the tunnel project and is equally offset by revenue; this was accrued in June 2020 and is therefore not in our year end forecast for the current year.

EXTERNAL PROVIDER COSTS EXCLUDING COVID-19

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2019/20 Actual $'000	Yr End Forecast $'000	Yr End Budget $'000	Yr End Forecast to Budget Variance $'000	
External Provider Costs	70,464	70,324	(140)	0% ✗	210,333	211,951	1,618	1% ✓	790,838	814,341	814,341	-	0% ✓



YTD BAU external provider costs is $1.618M favourable to plan, which is offset by lower MoH revenue. Some MoH contract spend has been delayed, which is a timing issue only.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000		YTD Actual $'000	YTD Budget $'000	Variance $'000	Year End 19/20 $'000
Equity	452,522	523,205	70,683	Cash	(56,176)	(43,932)	(12,244)	(6,966)

KEY RISKS AND ISSUES

Equity - The equity variance to budget is primarily due to the additional Holidays Act compliance provision made at 30 June 2020.

Cash - From the last week of September we commenced paying suppliers within 10 working days; this will have an impact on our cashflow although we do not expect to have a liquidity cashflow issue for the remainder of this financial year.

As we move into the Waipapa facility we will be incurring high capital spend on FF&E (reimbursed by the MoH, but there is a timing delay to this reimbursement).

Spend on the Mental Health facilities redevelopment continues and is expected to increase as construction activity increases (we have received an initial equity drawdown for the Mental Health project and have submitted a request for a further drawdown).

The pandemic stock purchased on behalf on the MoH continues to have short term cashflow implications.

APPENDIX 2: CANTERBURY DHB GROUP INCOME STATEMENT

The Group financial results include Canterbury DHB and its subsidiaries
For the 3 months ending 30 September 2020

Month					Year to Date				Annual (Year End)			
20/21 Actual 000's	20/21 Budget 000's	19/20 Actual 000's	Variance to Budget 000's		20/21 Actual 000's	20/21 Budget 000's	19/20 Actual 000's	Variance to Budget 000's	20/21 Forecast 000's	20/21 Budget 000's	19/20 Actual 000's	Variance to Budget 000's
165,656	162,733	153,480	2,923 ✓	MoH Revenue	493,653	488,199	463,135	5,454 ✓	1,960,878	1,952,782	1,864,766	8,096 ✓
8,268	4,711	4,366	3,557 ✓	Patient Related Revenue	19,190	14,029	12,877	5,161 ✓	55,498	55,498	53,364	- ✓
4,171	3,591	3,882	579 ✓	Other Revenue	13,188	10,373	11,800	2,815 ✓	77,102	47,534	48,770	29,568 ✓
178,095	**171,035**	**161,729**	**7,059**	**Total Operating Revenue**	**526,031**	**512,601**	**487,811**	**13,431**	**2,093,478**	**2,055,814**	**1,966,900**	**37,664**
86,560	80,237	70,786	(6,323) ✗	Personnel Costs	248,146	240,309	221,027	(7,837) ✗	1,003,692	967,342	1,000,806	(36,350) ✗
16,883	13,510	13,932	(3,373) ✗	Treatment Related Costs	45,553	41,000	41,173	(4,553) ✗	177,777	168,059	160,676	(9,718) ✗
72,837	70,324	66,198	(2,513) ✗	External Service Providers	216,224	211,951	199,858	(4,273) ✗	825,369	814,341	810,046	(11,028) ✗
10,411	10,020	11,068	(390) ✗	Other Expenses	30,305	29,158	31,836	(1,147) ✗	131,615	129,329	133,335	(2,286) ✗
186,691	**174,091**	**161,985**	**(12,599)** ✗	**Total Operating Expenditure**	**540,228**	**522,418**	**493,894**	**(17,810)** ✗	**2,138,453**	**2,079,071**	**2,104,863**	**(59,382)** ✗
(8,596)	**(3,056)**	**(256)**	**(5,540)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**(14,196)**	**(9,817)**	**(6,083)**	**(4,379)** ✗	**(44,975)**	**(23,257)**	**(137,963)**	**(21,718)** ✗
56	48	31	8 ✓	Interest Revenue	176	144	159	31 ✓	577	577	695	- ✓
-	-	-	- ✓	Capital Charge Relief / Debt Equity Swap Fund	-	-	-	- ✓	10,170	10,170	8,220	-
192	243	492	(51) ✗	Donations	226	489	1,020	(263) ✗	2,674	2,674	3,674	- ✓
22	-	6	22 ✓	Profit on Sale of Assets	32	-	13	32 ✓	-	-	17	- ✓
270	**291**	**529**	**(21)** ✗	**Total Indirect Revenue**	**434**	**633**	**1,192**	**(199)** ✗	**13,421**	**13,421**	**12,606**	- ✓
2,437	2,437	2,961	- ✓	Capital Charge	7,311	7,311	8,883	- ✓	50,112	48,762	38,136	(1,350) ✗
6,321	6,072	5,914	(249) ✗	Depreciation	18,472	18,248	17,896	(224) ✗	85,489	85,108	74,960	(381) ✗
77	108	75	31 ✓	Interest Expense & Forex Gains and Losses	202	324	90	122 ✓	1,300	1,300	315	- ✓
-	-	3	- ✓	Loss on Sale of Assets	2	-	8	(2) ✗	-	-	57	- ✓
8,836	**8,617**	**8,953**	**(219)** ✗	**Total Indirect Expenses**	**25,987**	**25,883**	**26,877**	**(104)** ✗	**136,901**	**135,170**	**113,468**	**(1,731)** ✗
(17,162)	**(11,382)**	**(8,680)**	**(5,780)** ✗	**Total Surplus / (Deficit)**	**(39,750)**	**(35,067)**	**(31,768)**	**(4,683)** ✗	**(168,455)**	**(145,006)**	**(238,826)**	**(23,449)** ✗
				Other Comprehensive Revenue & Expense								
-	-	-	-	Impairment	-	-	-	-	-	-		-
	-	-	- ✓	Gain on Revaluation of Land and Buildings	-	-	-	- ✓	-	-	-	- ✓
(17,162)	**(11,382)**	**(8,680)**	**(5,780)** ✗	**Total Comprehensive Revenue & Expense**	**(39,750)**	**(35,067)**	**(31,768)**	**(4,683)** ✗	**(168,455)**	**(145,006)**	**(238,826)**	**(23,449)** ✗

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 30 September 2020

Unaudited 30-Jun-20 $'000		Group Actual 30-Sep-20 $'000	Group Budget 30-Sep-20 $'000	Annual Group Budget 30-Jun-21 $'000
597,378	Opening Equity	492,272	558,272	558,272
136,588	Net Equity Injections / (Repayments) During Year	-	-	26,139
200	Other Movements	-	-	719,355
(3,068)	Reserve Movement for Year	-	-	(0)
(238,826)	Operating Results for the Period	(39,750)	(35,067)	(145,006)
492,272	**TOTAL EQUITY**	452,522	523,205	1,158,760
	Represented By:			
	Current Assets			
4,066	Cash & Cash Equivalents	5,608	1,033	31,443
750	Short Term Investments	750	750	750
105,853	Trade and Other Receivables	110,554	103,253	103,253
5,649	Prepayments	11,042	5,649	5,649
14,549	Inventories	15,233	14,549	14,549
14,666	Restricted Assets	14,558	14,425	14,425
145,533	**Total Current Assets**	157,745	139,659	170,069
	Less Current Liabilities			
11,032	Overdraft	61,784	44,965	-
165,172	Trade and Other Payables	136,677	135,325	128,015
21,974	Income in advance	23,077	22,224	22,224
14,691	Restricted Funds	14,849	14,256	14,256
343,643	Employee Benefits	343,842	277,644	277,644
534,538	**Total Current Liabilities**	580,230	494,414	442,139
(389,005)	**Working Capital**	(422,484)	(354,755)	(272,070)
	Non Current Assets			
16	Restricted Funds	16	16	16
3,225	Investment in NZHPL	3,225	3,225	3,225
884,340	Fixed Assets	878,249	881,023	1,433,893
887,581	**Term Assets**	881,490	884,264	**1,437,134**
	Non Current Liablilties			
6,304	Employee Benefits	6,483	6,304	6,304
6,304	**Term Liabilities**	6,483	**6,304**	**6,304**
492,272	**NET ASSETS**	452,522	523,205	1,158,760

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

APPENDIX 4: CASHFLOW

Unaudited 30-Jun-20 $'000		Actual 30-Sep-20 $'000	YTD Budget 30-Sep-20 $'000	Budget 30-Jun-21 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(48,394)	**Net Cash from Operating Activities**	(38,604)	(22,035)	(72,459)
	CASHFLOW FROM INVESTING ACTIVITIES			
(63,551)	**Net Cash from Investing Activities**	(10,606)	(14,931)	(109,917)
	CASHFLOW FROM FINANCING ACTIVITIES			
136,788	**Net Cash from Financing Activities**	-	-	220,785
24,843	Overall Increase/(Decrease) in Cash Held	(49,210)	(36,966)	38,409
(31,809)	Add Opening Cash Balance	(6,966)	(6,966)	(6,966)
(6,966)	**Closing Cash Balance**	(56,176)	(43,932)	31,443

COVID-19 TESTING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CPH&DSAC – 5 NOVEMBER 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Aaron Keown, Chair, Community & Public Health & Disability Support Advisory Committee**

DATE: **19 November 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Community & Public Health and Disability Support Advisory Committee's (*CPH&DSAC*) meeting held on 5 November 2020.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from CPH&DSAC's meeting on 5 November 2020 (Appendix 1).

3. APPENDICES

Appendix 1: CPH&DSAC Draft Minutes – 5 November 2020.

MINUTES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE COMMUNITY & PUBLIC HEALTH AND DISABILITY SUPPORT ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 5 November 2020 commencing at 1.00pm

PRESENT

Aaron Keown (Chair); Gordon Boxall; Tom Callanan; Catherine Chu; Rochelle Faimalo; Jo Kane; Naomi Marshall; and Michelle Turrall.

Attending via Zoom: Rawa Karetai; and Sir John Hansen (Ex-Officio).

APOLOGIES

Apologies for absence were received and accepted from Yvonne Palmer; and Olive Webb.
Apologies for lateness were received and accepted from Gordon Boxall (1.28pm); and Michelle Turrall (2.05pm).

EXECUTIVE SUPPORT

Dr Andrew Brant (Acting Chief Executive); Evon Currie (General Manager, Community & Public Health); Dr Jacqui Lunday Johnstone (Director of Allied Health, Scientific & Technical); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES

None

IN ATTENDANCE

Full Meeting

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

Items 1 to 7

Anne Hawker, Ministry of Social Development
Grant Cleland, Chair, Disability Steering Group

Item 8

Dr Martin Lee, Clinical Director, Community Dental Service
Bridget Lester, Child & Youth Team Leader, Planning & Funding

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF MINUTES

Resolution (02/20)
(Moved: Aaron Keown/Seconded: Naomi Marshall – carried)

"That the minutes of the meeting of the Community & Public Health and Disability Support Advisory Committee held on 3 September 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

The carried forward action list was noted.

4. ACCESSIBLE INFORMATION CHARTER

Dr Jacqui Lunday Johnstone presented the report, which was taken as read. It was noted that this is part of the journey in continuing to implement the Canterbury West Coast Disability Action Plan and further recognises that we are on a journey to improve how we do things in a way that supports all our community to have access to the support, information, guidance etc that they require in order to support their health journey.

Kathy O'Neill, Team Leader, Planning & Funding, introduced Anne Hawker from the Ministry of Social Development, who was in attendance. Ms Hawker is the founder of this document, along with her DPO colleagues nationally. A training session was held this morning across CDHB, with CCN also present. It was a very informative and useful session and we thank Ms Hawker for that.

Ms Hawker noted that disability is not about an impairment, it is about the barriers that are created to effective participation. This is about creating equity or equality of opportunity.

There was a query around the five years. Ms Hawker advised we are already two years into it and we are just starting to get some of the thinking to change. It is quite a behavioural and cultural change. It is the behavioural change that takes the time. This is saying you embed accessibility from the beginning.

Dr Lunday Johnstone advised there is a real opportunity to build on momentum. This is a particularly timely point for us in our journey in Canterbury because we are looking at how we automate communication with patients and GPs etc. To make this an integral part of how we do it from the get go, rather than doing something and then having to retrofit.

Dr Lunday Johnstone further advised there is a compelling narrative around doing better in this space – only data will help us show that what we have done has made a difference. It is marginal gains in a number of areas and it is the accumulation of people owning the need to do things differently.

Ms Hawker commented the disabled community is not an interest group, it is a population group, counting for about 24% of the population. There needs to be a focus on how you make information born accessible.

Resolution (03/20)
(Moved: Aaron Keown/Seconded: Jo Kane – carried)

The Committee recommends that the Board:

i. endorses the New Zealand Government Accessible Information Charter (the *Charter*);
ii. approves a signed copy of the Charter being forwarded to the Office of Disability Issues and the Charter's founder within the Ministry of Social Development to recognise CDHB's commitment;
iii. notes the Terms of Reference for the Accessible Information Working Group;
iv. notes that six monthly updates will be provided to CPH&DSAC on actions undertaken to meet the objectives of the New Zealand Government Accessible Information Charter; and
(v) looks at innovative ways and opportunities to source new monies to help support the budgets in this area.

Gordon Boxall joined the meeting at 1.28pm.

5. WORKING MATTERS – MINISTRY OF SOCIAL DEVELOPMENT (PRESENTATION)

Anne Hawker, Ministry of Social Development, spoke to the Committee about "Working Matters" – an Action Plan to ensure disabled people and people with health conditions have an equal opportunity to access employment.

Ms Hawker provided the history to this document, as well as outlining:

- Who the plan is for.
- Why the plan is important.
- What success looks like.
- How the plan will be implemented.
- The kaupapa guiding the plan.
- The objectives of the plan:
    - support people to steer their own employment futures;
    - back people who want to work and employers with the right support; and
    - partner with industry to improve work opportunities for disabled people and people with health conditions.

The Committee had the opportunity to ask questions and discuss various aspects of the plan with Ms Hawker.

The Chair thanked Ms Hawker for her attendance.

6. DISABILITY STEERING GROUP UPDATE (ORAL)

Grant Cleland, Chair, Disability Steering Group (*DSG*), provided an update on the work of the DSG. The following points were highlighted:

- Looking at the priorities within the Disability Action Plan.
- Getter the Accessibility Charter across the line has been a number one priority, in terms of changing the systemic and structural change that is required.
- Physical access. Getting systems in place that are looking at systemic change and ensuring that we are not having to retrofit.

- Disability responsiveness training for staff. Members of the DSG have been working with members of the People & Capability Team around reviewing training, particularly for non-clinical staff, but also clinical staff. This is an essential piece of work going forward.

Michelle Turrall joined the meeting at 2.05pm.

- Continuing to look at how we get more disabled people employed. Project Search has done wonderful things and continues to do so. Building on that is important.
- Had a workshop on 23 October 2020 around the UN Convention, the process of which was to help identify some of the gaps in terms of the UN Convention and Services.
- Working on the development of a template for monitoring the Disability Action Plan, so that we are very clear about the outcomes, priorities, how we measure that etc.
- Have met with the recruitment team for the new Chief Executive and other Executive positions, giving advice on what was thought to be required from a disability perspective.

There was a query about the New Brighton Chaired Plan Pilot. Kathy O'Neill, Team Leader, Primary Care, advised this is using the acute and personalised shared care plans initially looking at people who are in residential learning disability facilities. Went to NZ Care, a large residential provider in Christchurch, a lot of whose facilities go to the New Brighton medical centre. It is the GP and their team that populate the shared care plan with the carers from NZ Care and the individual that the plan is written about. Wanted to use it as a pilot, because the plans were not written for disabled people – they were written with more of a health focus in mind. We wanted to know if it worked for that population. It was found that while it does take quite a bit longer to get fully completed, we are now looking wider and getting it publicised in general practice that you need to be using these with disabled people. We have also started promoting it on the West Coast.

Dr Lunday Johnstone noted there are a number of future work pieces that will help us have a greater understanding of what we have achieved. The challenge is actually knowing who our employees are who identify as disabled, and we have done work to identify that through Max. Similarly, we need to understand if people identify as disabled when they are in our system, it allows us then to make those reasonable accommodations that people with communication difficulty, for example, may have – including interpreters – this is not just for people with disabilities, it relates to people whose first language is not English. There are lots of opportunities for that cross fertilisation, but we need to recognise what we know now and what do we not have data on that will help inform our improvement journey.

The Chair thanked Mr Cleland for his attendance.

7. CANTERBURY ACCESSIBILITY CHARTER – ACCESSIBILITY WORKING GROUP UPDATE (PRESENTATION)

Allison Nichols-Dunsmuir, Health In All Policies Advisor, presented an update on what has been happening with the Canterbury Accessibility Charter. The presentation highlighted the following:

- The big picture – progress to date.
- Accessibility Charter strategic issues.
- Accessibility Charter strategic challenges.
- The Accessibility Charter:
  - Terms of Reference for the Accessibility Charter Working Group (ACWG)
  - Implementation Plan (July 2019)
  - Meeting monthly aligned to the Disability Steering Group

  - Update Report to EMT
  - One–pager includes Three Pillars Model
  - Busy work programme
  - Influencing processes via specifications
  - Report to Ministry Disability Support DDG
  - Why this makes sense nationally
  - Specification framework
    - commitment to accessibility MoH and DHBs
    - tender documents
    - project management
    - specific areas eg toilets, car parking
- Hillmorton new buildings.
- Outpatients Audit of Toilet Rooms.
- Car parking building.

A member queried whether there was anything else needed from the Committee to help endorse the direction. Dr Lunday Johnstone advised that in the context of our current issues and challenges we are looking to explore a hybrid model where we are using existing expertise built onto someone's existing role. We will try that and see how that goes. Given the extent of additional construction that will be going on in this DHB for some considerable time, then if there is more than this individual person can do, we may need to come back to this Group with a proposal.

Mr Keown noted that at the Christchurch City Council there is a Disability Issues Working Group. Where CCC wants to end up at is: "what does best practice look like?". It is very hard to work out. Even consenting staff are struggling to find what best practice looks like.

There was a request for information to be provided on lessons learnt with regards to the Outpatients Audit of Toilet Rooms and how we stop this happening again.

With respect to car parking, it was stressed we will never get this right if we only put a few mobility carparks in. Attention also needs to be paid to the width of carparks, to ensure appropriate accessibility.

Dr Lunday Johnstone noted that the key thing that Ms Nichols-Dunsmuir is articulating here is that we are trying to learn as we go and systematise what we are doing to avoid these things from happening. It is not straight forward, especially when you are dealing with a building that is being looked after by a Ministry, and the points at which audits are required to be done. None of that is always at our door. What we are trying to do is make sure that right from the concept design commission, that our processes and systems and project management is being put in place.

There was a query about the upcoming retrofit of Parkside. A member requested that this Committee get to look at what a retro-fit will look like on tight dollars.

The Committee thanked Ms Nichols-Dunsmuir for the update.

8. ORAL HEALTH UPDATE (PRESENTATION)

Dr Martin Lee, Clinical Director, Community Dental Service; and Bridget Lester, Child & Youth Team Leader, Planning & Funding, provided an oral health update to the Committee. An apology for absence was noted from Dr Lester Settle, Clinical Director, Hospital Dental Service.

The presentation highlighted the following:

- Oral Health System in Canterbury
- Community Dental Services (*CDS*) outcomes
- CDS Challenges and Opportunities
- Patient demographics for adolescent oral health
- Adolescent dental – challenges and opportunities
- Key findings from talking to Year 10-11 students about dental health
- Hospital Dental Services
- Tertiary Level Services & Relief of Pain
- Relief of Pain services 2018/19
- Hospital Dental 2019/20 data
- Oral Health Service Development Group 2020-2022
- Oral Health Promotion

A member queried the slide that commented "access to oral health services, and poor oral health remains an issue for Maori and Pacific within the CDHB region", noting this was not an issue for Maori and Pacific, but rather an issue for CDHB with its Maori and Pacific population.

There was discussion around oral health for the disabled community and also for those receiving mental health services.

There was considerable discussion around fluoride, including Ashburton's experience with fluoridating / not fluoridating its water.

A member commended progress being made on accessibility for Child Oral Health. The extension to clinic hours, clinical availability during school holidays, as well as notes being sent home has proven very beneficial. Very positive to see things are progressing.

The Committee noted the Oral Health Update.

Catherine Chu retired from the meeting at 3.32pm.

9. FIRST 1,000 DAYS REPORT UPDATE

Evon Currie, General Manager, Community and Public Health presented the report. She noted this was a South Island report for the Hauora Alliance. Found that the report itself was circulated much more widely than anticipated and was picked up by areas we had not even anticipated would find it of value. It has had an influence in a variety of different settings, across a variety of groups.

There was no discussion.

The Committee noted the First 1,000 Days Report Update.

Naomi Marshall retired from the meeting at 3.40pm.

10. COMMUNITY & PUBLIC HEALTH UPDATE

Ms Currie presented the report which was taken as read, noting it provided an update on activity in Community and Public Health.

Surprise was expressed at the recent "rheumatic fever and housing" case. Ms Currie noted whilst it is not as significant an issue in this area as it is in the likes of Auckland, it is a little more common than perhaps we realise.

The Committee noted the Community & Public Health Update report.

INFORMATION ITEMS

- Disability Steering Group Minutes: 24 July & 28 August 2020
- Maori Population, Partnership, Health & Equity (ex Board – 15 Oct 20)
- CCN Q3 & Q4: Jan-Jun 2020
- 2021 Meeting Schedule
- 2020 Workplan

There being no further business the meeting concluded at 3.42pm.

Confirmed as a true and correct record:

_____	_____
Aaron Keown	Date of approval
Chair	

CPH&DSAC MEETING 5 NOVEMBER 2020
ACTION NOTES

Clause No		Action Points	Staff
	Apologies	Absence - Yvonne Palmer and Olive Webb Lateness – Gordon Boxall (1.28pm) and Michelle Turrall (2.05pm).	Anna Craw
1.	Interest Register	Nil	
2.	Confirmation of Minutes – 3 September 2020	Adopted: Aaron Keown / Naomi Marshall	Anna Craw
3.	Carried Forward Items	Nil	
4.	Accessible Information Charter	Recommended through to Board: Aaron Keown/Jo Kane	Anna Craw
5.	Working Matters – Ministry of Social Development	Nil	
6.	Disability Steering Group Update	Nil	
7.	Canterbury Accessibility Charter – Accessibility Working Group Update	Provide to committee information on lessons learnt with regards to the "Outpatients Audit of Toilet Rooms" and how we stop this happening again. One page paper to CPH&DSAC meeting on 5 March 2021. **Report due to Anna Craw: 20 February 2021.**	Allison Nichols-Dunsmuir
8.	Oral Health Update	Nil	
9.	First 1,000 Days Report Update	Nil	
10.	Community & Public Health Update	Nil	
	Info Items	Nil	

Distribution List:
Allison Nichols-Dunsmuir

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: **19 November 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATIONS

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, & 11 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 – 15 October 2020	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues	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.	Hillmorton Laundry Building Fitout – To Enable CAF Outpatient Service Consolidation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Parkside Block A Strengthening	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	Supply Chain Relocation	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Ministry of Health Q1 Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
10.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
11.	Advice to Board: • QFARC Draft Minutes *3 November 2020*	For the reasons set out in the previous Committee agendas.	

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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