AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 20 August 2020 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes • Ordinary Meeting - 16 July 2020 • Emergency Meeting – 04 August 2020 • Emergency Meeting – 12 August 2020		
3.	Carried Forward / Action List Items		
Reports for Decision			
4.	CDHB Pacific Health Strategy	Hector Matthews *Executive Director, Maori & Pacific Health* Carolyn Gullery *Executive Director, Planning Funding & Decision Support*	9.35-10.30am
5.	Schedule of Meetings - 2021	Justine White *Executive Director, Finance & Corporate Services*	10.30-10.35am
Reports for Noting			
6.	Chair's Update (Oral)	Sir John Hansen *Chair*	10.35-10.40am
7.	Chief Executive's Update	David Meates *Chief Executive*	10.40-11.10am
8.	Finance Report	Justine White	11.10-11.20am
MORNING TEA			**11.20-11.35am**
9.	Accelerating Our Future (Presentation)	Michael Frampton *Chief People Officer* Stella Ward *Chief Digital Officer*	11.35-12.15pm

10.	Advice to Board: • HAC – 6 August 2020 – Draft Minutes	Jo Kane *Deputy Chair, HAC*	12.15-12.20pm
11.	Resolution to Exclude the Public		12.20pm
ESTIMATED FINISH TIME – PUBLIC MEETING			**12.20pm**

NEXT MEETING
Thursday, 17 September 2020 at 9.30am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEMBERS

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

Executive Support

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

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

BOARD ATTENDANCE SCHEDULE – 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	25/02/20	19/03/20	16/04/20	01/05/20 SM	21/05/20	18/06/20	16/07/20	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	^	√	√	√	√	√	^	√	√					
Andrew Dickerson	√	√	√	√	√	√	√	√	√					
James Gough	√	√	√	√	√	√	√	√	√					
Jo Kane	√	√	√	√	√	√	√	√	√					
Aaron Keown	√	√	√	√	√	√	√	√	√					
Naomi Marshall	√	√	√	√	√	√	√	√	√					
Ingrid Taylor	√	√	√	√	√	√	√	√	√					

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

	and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
James Gough	**Amyes Road Limited** – Shareholder Formally Gough Group/Gough Holdings Limited. Currently liquidating. **Christchurch City Council** – Councillor Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board **Christchurch City Holdings Limited (*CCHL*)** – Director Holds and manages the Council's commercial interest in subsidiary companies. **Civic Building Limited** – Chairman Council Property Interests, JV with Ngai Tahu Property Limited. **Countrywide Residential (2018) Limited** – Director/Shareholder Residential Property Development **Gough Corporation Holdings Limited** – Director/Shareholder Holdings company. **Gough Property Corporation Limited** – Director/Shareholder Manages property interests. **The Antony Gough Trust** – Trustee Trust for Antony Thomas Gough **The 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, 16 July 2020 commencing at 9.30am

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

CROWN MONITOR
Dr Lester Levy.

APOLOGIES
An apology for absence was received and accepted from Dr Andrew Brant (Board Clinical Advisor).

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Michael Frampton (Chief People Officer); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Hector Matthews (Executive Director, Maori & Pacific Health); Dr Sue Nightingale (Chief Medical Officer); Stella Ward (Chief Digital Officer); Justine White (Executive Director, Finance & Corporate Services); Karalyn van Deursen (Executive Director Communications); Susan Fitzmaurice (Executive Assistant to Chief Executive); and Anna Craw (Board Secretariat).

Hector Matthews opened the meeting with a Karakia.

Sir John Hansen, Chair, advised of the formal resignation of Sally Buck from her position as Board member due to ill health. Sir John has written to Ms Buck. The Board accepted Ms Buck's resignation with regret and acknowledged the significant contribution she has made to this Board and the patients of Canterbury.

Jo Kane spoke of Ms Buck being a true community advocate who worked at grass roots level. Ms Buck had a range of interest areas in health that she brought to the table. She was a good elected member that worked for the community and certainly brought in issues from the Eastern suburbs.

Aaron Keown recalled the first time that Ms Buck ran for the Board, noting that whilst she did not run one advertisement or have one bill board, she polled first. Mr Keown believed this was because of what Ms Buck had written for the candidate booklet, noting it had clearly resonated with the public. To come from nowhere, then to run and come first means that whatever you are standing up for is what a lot of people believed in. Ms Buck has been an honest representative for the community for many years.

1. INTEREST REGISTER

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

Declarations of Interest for Items on Today's Agenda
Item 6 – Approval of Trust/Donated Funds - Andrew Dickerson advised he is a Trustee of the Maia Health Foundation.

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

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETING

Resolution (22/20)
(Moved: Aaron Keown/seconded: James Gough – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 18 June 2020 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

- Selwyn Health Hub

  Carolyn Gullery, Executive Director, Planning Funding & Decision Support, advised that conversations have been had with the Ministry of Health (*MoH*). There is no policy to say that we cannot use the capital on FF&E inside a property that we are leasing, but this is the approach the MoH have chosen to adopt. There is no written formal policy. The MoH does acknowledge, however, that as we have a 30 year lease, it is going to go onto the DHB's asset sheet and become one of our capital assets.

  Ms White, Executive Director, Finance & Corporate Services, advised that changes in accounting rules means that all leases are effectively recognised in the balance sheet. They are recognised as an asset and recognised as an obligation, but the net of those two will not necessarily match dollar for dollar timing wise, therefore the net result may create an asset for capital charge purposes.

  There was a query whether other DHBs were facing a similar problem. Ms Gullery undertook to check with colleagues and advise the Chair.

  Ms Gullery noted that the MoH has confirmed that $5M is still there for CDHB to allocate to some other project. The Board was reminded that there was a $300M pool of funding that became available for small projects across DHBs. The project CDHB put up was the Selwyn Health Hub as this seemed to fit the MoH's focus of child health, mental health and maternity. However, the MoH said they could not allocate the money to that project because it was an asset that we were leasing that we were fitting out.

  David Meates, Chief Executive, advised that the alternative we have gone back to the MoH with is tying it back into the new mental health CAF outpatient facility, which got valued out of the development at Hillmorton. The contribution from Maia Health Foundation ($5M), CDHB ($5M) and potentially $5M from the MoH, will enable a potential facility to be delivered. This comes back to the basis that the MoH cannot get its head around leased facilities compared to a facility owned and operated by the DHB.

The carried forward / action list items were noted.

4. COVID-19: POPULATION WELLBEING UPDATE

Evon Currie, General Manager, Community and Public Health (*CPH*), introduced Sue Turner, Public Health Manager; and Sara Epperson, Advisor Collaborative Partnerships, who were in attendance to present to the Board on Psychosocial Wellbeing. Ms Currie noted that Psychosocial Wellbeing is a very important component of the wellbeing for our populations. In Canterbury it has been an important focus for some time. CPH as the public health division of the DHB has focused a lot on developing and normalising some of the programs to address psychosocial and mental health wellbeing at a population level.

The presentation highlighted the following:

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

There was discussion on measures of success. Ms Turner advised that for the All Right? campaign there is a yearly reach of impact evaluation. Recent results have shown 90% coverage and in terms of impact approximately 41% of people have said they have done something differently as a result of seeing the messages. It was noted the size of the cohort measured was 600 people in Christchurch.

Mr Meates advised that All Right? is a highly successful campaign. Right from the start it had to be able to demonstrate that it was making a difference. The methodology of reporting and tracking from the beginning has been robust, as it needed to be able to provide evidence it was making a difference.

There was a query about funding for the programmes. Ms Turner advised that funding for "Getter Through Together" ends at the end of September 2020. The funding for All Right? Canterbury continues through to the end of June 2021. The MoH have made it clear that although the Psychosocial Recovery Plan has been designed for 12 to 18 months, it is thought that it will be more like two to three years. Mr Meates advised that Canterbury's recovery plan will be partially offset by the All Right? component, so will not become an additional cost impediment. However, Mr Meates, noted that if it is going to be rolled out nationally there will need to be additional funding. There is ongoing dialogue and conversation in terms of securing funding streams for that. If it goes national, it has to be contingent on a funding stream sitting with that.

5. SUBMISSION: INQUIRY INTO STUDENT ACCOMMODATION

Ms Currie presented the report which was taken as read. There was no discussion.

Resolution (23/20)
(Moved: James Gough/seconded: Gabrielle Huria – carried)

"That the Board:

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

6. APPROVAL OF TRUST / DONATED FUNDS

Justine White, Executive Director, Finance & Corporate Services, presented the report which was recommended to the Board for approval by the Quality, Finance, Audit and Risk Committee. There was no discussion.

Resolution (24/20)
(Moved: Barry Bragg/seconded: Jo Kane – carried)

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

DRAFT

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

7. CHAIR'S UPDATE

Sir John referred to the ongoing work being done by the whole organisation, but particularly management, public health and others in relation to COVID-19. That burden is still upon the organisation.

Sir John also noted the fantastic effort that has been made in catching up backlogs that were occasioned by the lockdown. It is an outstanding effort to bring it up to date as quickly as it has.

Sir John and the Board acknowledged the work that has gone into both of the items above.

The Chair's update was noted.

8. CHIEF EXECUTIVE'S UPDATE

Mr Meates presented his report which was taken as read. An update on COVID-19 was provided as follows:

- Six hotels have been stood up in Christchurch as quarantine / isolation facilities. We are working more closely with the MoH and a clinical governance group has been set up within the MoH to oversee the facilities, which has streamlined things a lot. Whilst going reasonably well in Christchurch, the challenge is the ongoing sustainability of that. Indications are that this could continue out over an 18 month to two year timeframe, and it is important that the timeframe is set on a stable and sustainable basis. Service specifications and funding elements are still to be worked through and will remain a work in progress – a national process to be finalised by the MoH.
- Catch-up: absolutely stunning the way the catch-up and recovery plans have been playing through, resulting in at 30 June 2020 having delivered all of the planned care volumes. Whilst the mix is a little bit different, volume targets have been hit.
- The approach taken by Radiology through the COVID-19 component was highlighted. Radiology used it as a means of catching all the backlog and this has left the service in a really robust position.
- Plans are in place to stand up surge capacity for contact tracing, with further plans to stand up additional contact tracing elements. This is a requirement and reflects the ongoing nervousness with what is playing out in Australia in terms of how quickly and rapidly community spread could occur and the ability for us to be in a position to respond to that. Plans are in place and we have the ability to step up very quickly. Labs play a really important component and will continue to be impacted for quite a prolonged period in terms of the level and type of testing required. With regards to ongoing surveillance testing across the community, the MoH are looking to encourage all GPs to be doing about five swabs a day in order to have a sense of what is going on in communities across NZ.

There was a query around Inter District Flow (*IDF*) funding that had not been picked up or invoiced. Mr Meates advised that in terms of normal IDFs these are picked up as a matter of course. There are a number of things we provide for other DHBs that do not fit under the IDF definitions, but we are moving to overtly cost recover and/or charge directly for those. It was noted that this is a consistent issue across most parts of the country. There have been attempts at various stages to address this. Requires a charging mechanism that is outside the normal bounds of what has sat with the district flow framework.

There was discussion around perioperative nursing levels. Mr Meates advised that we have been very deliberate with perioperative staff, building up the theatre compliment with new graduates who undergo a very comprehensive training programme. Mary Gordon, Executive Director of Nursing, advised that perioperative nursing is a specialty area of practice. A nurse cannot walk in there tomorrow and be competent to undertake the skills and care required. It takes training – a minimum of six months, but ideally 12 months in order to be able to provide full 24 hour acute cover. It was noted that with the opening of the new Hagley, we will be going up by 12 operating theatres, requiring a significant nursing resource. The average number of nurses in an operating theatre is four to five, depending on the complexity of the surgery. It is a highly intensive resourced area. Ms Gordon advised that we have been taking new graduate nurses (they are the cheapest) and have put a specialised training programme in place on site – on the job training. Ms Gordon advised that there are not the required number of nurses in the community that we can go out and recruit who hold the specialised training and skill set required. It takes a lead in time. Unfortunately, the facility delays that have occurred are beyond our control.

There was a query on appointments cancelled due to COVID-19, how rebooking is tracking and the prioritisation process. Mr Meates advised that through the COVID-19 process all specialty teams, both surgical waiting lists and outpatient waiting lists, went through a classification and clinical prioritisation based on type of surgery, type of condition, what was deferrable, what was non-deferrable, what was deferrable for 3-4 weeks without harm occurring, what was deferable for 8-12 weeks without harm occurring, and care that actually needed to be done. The process was based on clinical criteria and urgency, which was critical to ensure that we did not have cases or care falling through the cracks. The catch-up component has been driven by the clinical urgency and need.

There was discussion regarding cost saving work in Maternity services. A presentation to the Hospital Advisory Committee is to be scheduled.

There was discussion around Specialist Mental Health Services (*SMHS*) and occupancy within the Adult Acute Inpatient Unit (Te Awakura). It was noted that occupancy reduced in response to raised admission thresholds put in place as part of the COVID-19 response plan, however, we are seeing a return to a more typical occupancy pattern. Mr Meates advised that over time a new balance will be found. It will not go back to what it was, but will involve a new balance between face to face and virtual care.

There was a query around the Labs cost saving initiatives of $1M. Mr Meates advised this is incorporated in part of this year's plan.

There was discussion around the Cancer Centre. Mr Meates advised that this is currently with the MoH and we await feedback. The Board was reminded that it had approved the broad concept plan and initial elements, and had been clear that for the next stage of that work it needed the commitment from the MoH to do that. There was query around timing. Mr Meates advised that work needs to be underway now, otherwise the inevitable conclusion is that we will end up replacing the linacs into existing facilities and will have significant capacity issues. Mr Meates noted that once installed you do not want to be going through an uninstall and replacement process as this will involve machines being out of commission for a significant period.

There was a query about FTEs in relation to the COVID-19 uplift plan. Mr Meates advised that in terms of contact tracing we have existing capacity to deal with up to 21 community cases. The capacity for the initial 21 is within our existing establishment - people within CPH pulled from jobs they are currently doing into contact tracing. We have then identified a further range of about 60 staff that will, if needed, be trained and stood up into a service delivery component. We do not have FTEs sitting idle. If we get to full community spread, there are arrangements and agreements in place with Ara and others.

There was query around how happy we are with the system in relation to new hotels being stood up and what is happening within occupied facilities. Sue Nightingale, Chief Medical Officer, advised

that with our system, we are working very cooperatively with Defence. All the hotels have our Infection Prevention Control Team go through them before they are approved and commissioned. Things such as streaming guests to minimise risk of infection is worked out prior to guest arrival. There are strict rules about exercising and smoking. PPE guidelines are very clear, as are guidelines around who has contact with guests and who does not. We are as confident as we can be with the facilities. Ms Nightingale noted there is always a risk, although low, that there may be a transmission and this is why we have to have very good contact tracing to ensure that such a transmission is picked up quickly and contained. Mr Meates advised that contact tracing is a fundamental part of New Zealand's strategy and this is why the surge capacity is so important.

There was discussion around the challenge of influenza, particularly in the northern hemisphere at the moment, which is starting to become an additional burden at the same time as COVID-19. Another concern is the number of people or conditions that have been either deferred or are not presenting. Cancers are most concerning, because numbers have dropped off and it is hard to imagine that they have disappeared. It was noted that influenza is often a trigger for a number of other conditions, and we are not seeing these at the moment. Mr Meates advised that this is a big concern in many countries at the moment, in terms of what that burden is.

The Chief Executive's update was noted.

The meeting adjourned for morning tea from 11.08 to 11.25am.

9. FINANCE REPORT

Justine White, Executive Director, Finance & Corporate Services presented the Finance Report, which was taken as read.

Ms White noted the operating results in the paper are the May results, which show that the month, including COVID-19 costs, was favourable by $172k. If you exclude COVID-19, you essentially end up with a $7.74M favourable operating result (pre indirect items) for the month and $14M favourable year to date.

We have had confirmation of Whakaari funding of $1.1M. That has been accrued into the June results and will be paid in August. Largely covers the direct costs of those patients, but does not cover the costs of any deferred activity as a result of those patients.

The MoH has declined the request around policy recognition for insurance proceeds and capital draw down, so there is an additional $12M that has been put through in the June result.

In terms of the June result, the provisional results (pre Holidays Act, any impairments and year end audit) for the full year are sitting around $175.9M deficit, compared to the budgeted deficit of $180M. Ms White noted that that is essentially $4.6M favourable, including all the COVID-19 unfunded costs (which is a net of about $17M) and including the additional $11.8M capital charge. If you were to take out the unfunded COVID-19 component, that is $21.7M favourable to budget, and obviously if you take out the other $11.8M it becomes $33.7M favourable to budget.

In response to a query, Ms White advised that in the last month of the financial year there is the recognition of the additional capital charge ($11.8M) plus a standard month, some MECA provisions, and significant extra costs around clinical supplies because of some of the catch-up.

There was discussion around the Holidays Act accrual. Ms White advised that we have a provision that was put in at the end of last year which was $65M for the Holidays Act. We have been going through the process of looking through our records over the last seven years to determine what that liability looks like. There was high level analysis done at the end of last year to satisfy Audit New Zealand to enable that $65M provision. Ms White's expectation is that we will be asked to revisit that figure and is waiting to get some clarity on those numbers so as to work with Audit NZ to determine what the level of accrual put through for this year should be. The level is likely to be higher that $65M. It was noted that this is consistent with every other DHB's position. Ms White advised that there will be funding to offset those costs coming through, but we do not know whether they will be revenue or equity funded, which will have an impact on the final look of the result. Mr Meates advised that this is a national process and there are a range of conversation and dialogues happening with both Unions and Government. Mr Frampton, Chief People Officer, advised that this is the largest and most complex Holidays Act remediation in the entire economy. This is affecting 135,000 people nationally, including 23,000 CDHB employees (both current and previous employees over the last 10 years).

Resolution (25/20)
(Moved: Jo Kane/Seconded: Naomi Marshall - carried)

"That the Board:

i. notes the consolidated financial result (before comprehensive income) for the month of May 2020 is a net expense of $31.992M, being $8.591M favourable to plan, and year to date $13.235M favourable to plan;
ii. notes the operating result (pre indirect items) for the month is favourable to plan by $172k, year to date $2.096M unfavourable to plan;
iii. notes that costs associated with the Whakaari tragedy (excluding IDF) as included in the year to date operating result are in excess of $1M;
iv. notes that net costs associated with COVID-19 pandemic as included in the month of May results are $7.570M, and year to date $16.470M;
v. notes the operating result (pre indirect) excluding COVID-19 costs, is favourable to plan by $7.742M for the month, YTD $14.374M;
vi. notes liquidity (cashflow) risk continues to be a significant concern without any sustainable long term resolution; and
vii. notes that the Ministry has declined our request for the exclusion of EQ insurance capital in excess of capital impairment from the capital charge calculation, the impact of $11.8M has been included in our full year forecast."

10. MAORI & PACIFIC EQUITY REPORT JUNE 2020

Hector Matthews, Executive Director of Maori and Pacific Health presented the report, which was taken as read. He also provided a presentation to the Board which highlighted:

- What is health equity / inequity?
- Health is impacted by determinants - some are from outside the health system.
- CDHB Population Projections 2020-21.
- CDHB Maori Health Dashboard May 2020.
- CDHB Pacific Health Dashboard May 2020.
- CDHB Children Immunised at Age 8 Months.
- CDHB Children with Caries Free Teeth at Age 5 Years.
- CDHB Child Oral Health.

DRAFT

- Benefits of Fluoridation.

There was a query around the dashboard being centrally created. Mr Matthews advised that its genesis was centrally created but we have adjusted it to suit our own population. Mr Matthews advised that when doing snapshots, you need to find what is useful. Oral health is a very good one, as it is a red flag for a whole number of things and frequently leads to a range of other issues opening up. In the scenario we are in, we have got to find things that will demonstrate red flags. We are constantly looking at these sorts of things.

There was a request that the next report focus on solutions. It was recognised that some solutions will be outside of our control, but there is interest in getting cross-sectorial gains, and how to utilise the strength of the DHB in this space.

The Maori & Pacific Equity Report June 2020 was noted.

11. ADVICE TO BOARD

Community & Public Health & Disability Support Advisory Committee (*CPH&DSAC*)
Jo Kane, Chair, CPH&DSAC, provided the Board with an update on the Committee's meeting held on 2 July 2020.

Resolution (26/20)
(Moved: Jo Kane/Seconded: Naomi Marshall - carried)

"That the Board:

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

12. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (27/20)
(Moved: Sir John Hansen/Seconded: Gabrielle Huria - 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 and the information items contained in the report;

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of the public excluded meeting on 18 June 2020	For the reasons set out in the previous Board agenda.	
2.	Chair's Update (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
3.	Chief Executive - Emerging Issues (Oral)	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)

4.	Seismic Monitoring System, Christchurch Hospital Campus	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	2020/21 Planning Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	2020/21 Capital Intention	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Chief Digital Officer Report	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
9.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	S9(2)(a) s9(2)(j) s9(2)(h)
10.	Advice to Board: • QFARC Draft Minutes *30 June 2020*	For the reasons set out in the previous Committee agendas.	

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

The Public meeting concluded at 12.31pm.

Sir John Hansen, Chairman

Date of approval

DRAFT

BOARD MEETING 16 JULY 2020 – MEETING NOTES

Clause No	Item	Action Points	Staff
	Apologies	Dr Andrew Brant	Anna Craw
1.	Interest Register	Item 6 – Approval of Trust/Donated Funds - Andrew Dickerson advised he is a Trustee of the Maia Health Foundation.	Anna Craw
2.	Confirmation of Minutes – 18 June 2020	Adopted – *Aaron Keown / James Gough*	Anna Craw
3.	Carried Forward/Action Items	Selwyn Health Hub – follow up with DHB colleagues as to their experiences with similar situation. **Report back to Chair, Sir John Hansen, prior to 6 August 2020.**	Carolyn Gullery
4.	COVID-19: Population Wellbeing Update	Nil	
5.	Submission: Inquiry into Student Accommodation	Adopted – *James Gough / Gabrielle Huria*	Anna Craw
6.	Approval of Trust/Donated Funds	Adopted – *Barry Bragg / Jo Kane*	Anna Craw
7.	Chairs Update	Nil	
8.	CEO Update	Maternity Services cost saving work – update to be provided to HAC. **Update to be scheduled for HAC's 6 August 2020 meeting.**	Anna Craw
9.	Finance Report	Nil	
10.	Maori & Pacific Equity Report June 2020	Next report to focus on solutions and getting cross-sectorial gains. **Next report due for CPH&DSAC's 5 Nov 2020 meeting – report due to Anna Craw on 27 Oct 2020.**	Hector Matthews
11.	Advice to Board: • CPH&DSAC – 2 Jul 2020 - Draft Minutes	Nil	
12.	Resolution to Exclude the Public	Adopted – *Sir John Hansen / Gabrielle Huria*	Anna Craw
	Information	Nil Meeting concluded at 12.31pm.	

Distribution List:
Carolyn Gullery
Hector Matthews

CC: Regan Nolan, Jenna Manahi

MINUTES – EMERGENCY MEETING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD EMERGENCY MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Tuesday, 4 August 2020 commencing at 12.40pm

BOARD MEMBERS

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

EXECUTIVE SUPPORT

Kay Jenkins (Executive Assistant, Governance Support).

APOLOGIES

There were no apologies.

1. INTEREST REGISTER

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

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

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

2. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (28/20)
(Moved Sir John Hansen/seconded Ingrid Taylor - carried)

"That the Board:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Staffing Numbers	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)

iii notes that this resolution is made in reliance on the Act, Schedule 3, Clause 32 and that the public conduct of the whole or the relevant part of the meeting would be likely to result in the

disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982."

There being no further business the public meeting closed at 12.45pm.

_____ _____

Sir John Hansen, Chair Date of approval

MINUTES – EMERGENCY MEETING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE CANTERBURY DISTRICT HEALTH BOARD EMERGENCY MEETING
held via zoom on Wednesday 12 August 2020 commencing at 4.00pm

BOARD MEMBERS

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

EXECUTIVE SUPPORT

David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Tim Lester (Corporate Solicitor); and Kay Jenkins (Executive Assistant, Governance Support).

APOLOGIES

Barry Bragg and Gabrielle Huria were apologies for lateness due to conflict of interest for Item 1.

1. INTEREST REGISTER

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

Declarations of Interest for Items on Today's Agenda
Barry Bragg and Gabrielle Huria were apologies for lateness due to conflict of interest for Item 1.

Perceived Conflicts of Interest
Board member Jo Kane stated that she believed that the two Board members conflict of interest should have been raised earlier in the process around car parking and she believed this left the Board exposed.

Considerable discussion took place around this.

2. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (29/20)
(Moved Ingrid Taylor/seconded Catherine Chu - carried)

"That the Board:

i. adds the item "Appointment of Interim Chief Executive" to the Public Excluded Agenda". (Note this item was added when the Board reverted to a public meeting later in the Public Excluded section of the meeting).

Resolution (30/20)
(Moved Ingrid Taylor/seconded Catherine Chu - 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;
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.	Carparking Proposal	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
2.	Appointment of Interim Chief Executive	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)

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

There being no further business the public meeting closed at 4.20pm.

_____ _____

Sir John Hansen, Chair Date of approval

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CANTERBURY DISTRICT HEALTH BOARD
CARRIED FORWARD ITEMS AS AT 20 AUGUST 2020

DATE	ISSUE	REFERRED TO	STATUS

There are no carried forward items.

CDHB PACIFIC HEALTH STRATEGY

Canterbury District Health Board
Te Poari Hauora o Waitaha

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

PREPARED BY: **Finau Heuifanga Leveni, Pacific Portfolio Manager**

APPROVED BY: **Hector Matthews, Executive Director, Maori & Pacific Health**
Carolyn Gullery, Executive Director, Planning Funding & Decision Support

DATE: **20 August 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

This report originated from the aspiration of the Canterbury District Health Board and Pacific communities in Canterbury to improve the health outcomes of Pacific people in Canterbury. The purpose of this report is to present the Pacific Health Strategy for Canterbury, to update the Board on the achievements to date from the strategic partnership with Pasifika Futures Ltd and to recommit to working collaboratively in this manner.

2. RECOMMENDATION

That the Board:

i. endorse the Pacific Health Strategy - Canterbury District Health Board Pacific Plan 2020-2030; and
ii. endorses the ongoing strategic partnership with Pasifika Futures Ltd to improve health outcomes of Pacific people in Canterbury.

3. SUMMARY

The Canterbury District Health Board, together with strategic partner Pasifika Futures Ltd, have developed a Pacific health strategy and action plan to guide the actions of the wider Canterbury health system in Pacific health from 2020 – 2030. The strategy defines two outcomes:

(a) Pacific peoples live longer, healthier and better lives, able to manage their own health and wellbeing; and
(b) Pacific peoples have equitable health outcomes.

In order to realise these outcomes, the strategy identifies six focus areas:

- Service Priorities
- Workforce Development
- Pacific Leadership
- Partnerships
- Innovation
- Research, Data and Evidence

The strategy also includes an Outcomes Framework, Priority Actions, and Targets & Indicators to support the implementation of the strategy.

4. DISCUSSION

Background

Pacific people continue to experience poor health and social outcomes. In Canterbury progress has been made in children's immunisations, cervical screening, and general practice enrolment. Despite this there remains low rates of breast-feeding, poor rates of oral health enrolment and low rates of breast screening. Much more concerning are the high rates of avoidable admissions to hospital for both children and adults and the increasing rates of chronic disease.

The health challenges facing Pacific families are complex and multi-layered often going hand in hand with poor socioeconomic status. Pacific families aspire to live long and healthy lives and to contribute to New Zealand society as active members. In order to achieve this aspiration, families need to be supported by a responsive, innovative health system that recognises the diversity of Pacific families and the context within which they live. The challenges facing a rapidly growing population in Canterbury will require a collective effort to make an impact.

Accountability

The content of the strategy is a result of two co-design workshops held with organisations, leaders in the health sector and most importantly, representatives from Pacific communities in Canterbury, where families told us what they need from the health system and how it might be shaped. We remain accountable to our communities in the implementation of this strategy.

In addition, this Strategy also aligns with the Ministry of Health's Pacific Health and Disability Action Plan and its strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples.

5. CONCLUSION

The purpose of this document is to provide strategic guidance and direction for Pacific health across the CDHB and the broader Canterbury health system. It is intended to provide a clear direction on the areas we will be focussing on and the actions we intend to take. All parts of the health and disability system are responsible for improving Pacific health outcomes. The strategy can help guide not only CDHB but also Pacific NGOs, primary care, community health and social services. This strategy will also be used to monitor and evaluate our progress as we move forward.

6. APPENDICES

Appendix 1:	Pacific Health Strategy: 'Alunga Fo'ou: A New Path. Canterbury District Health Board Pacific Plan 2020-2030
Appendix 2:	List of Attendees at CDHB meeting: 20 August 2020.

‘Alunga Fo’ou: A New Path

Canterbury District Health Board Pacific Plan 2020-2030 DRAFT

Canterbury District Health Board PACIFIC HEALTH

Pasifika futures PROSPERITY FOR PACIFIC FAMILIES

'Alunga Fo'ou' is a Tongan phrase referring to a "new way" or "new pathway". *'Alunga* is a combination of the Tongan words *'alu* - 'to go' and *anga* - 'way' (in this context) and the word *fo'ou* which means 'new'. It speaks of forging new pathways or changing existing ways in order to reach the desired destination. It also inspires connotations of the courage, fortitude and resilience required before embarking on a new voyage or journey.

Acknowledgements

The development of this Strategy is the collective result of our strategic partnership with Pasifika Futures the Whānau Ora Commissioning Agency for Pacific families. Together, we led two co-design workshops held with organisations, leaders in the health sector and most importantly, representatives from Pacific communities in Canterbury, where families told us what they need from the health system and how it might be shaped. Canterbury District Health Board and Pasifika Futures would like to take this opportunity to thank all those who were involved in the co-design and contributed to this Strategy. This Strategy would not have been possible without your valued input, honest insights, and ongoing talanoa.

The Canterbury District Health Board would like to thank our strategic partner for Pacific health – Pasifika Futures Limited, for partnering with us on this journey to improve Pacific health outcomes in Canterbury and for always challenging us. We are grateful for your tireless support.

This Strategy acknowledges Te Tiriti o Waitangi as the foundation for the relationship with Tangata Whenua. Pacific peoples place great importance and respect for the Tangata whenua and their status as indigenous people of Aotearoa New Zealand. Pacific people are connected to Maori through genealogy, traditional kinship ties and cultural beliefs that strengthen their relationships in modern day Aotearoa New Zealand.[1]

[1] Ministry for Pacific Peoples, 2018. *Yavu Foundations of Pacific Engagement*. Wellington: Ministry of Health, p1.

Kia Ora Koutou from the Chief Executive, Canterbury District Health Board

David Meates
Chief Executive,
Canterbury District Health Board

Talofa lava, Kia orana, Malo e lelei, Ni sa bula vinaka, Fakaalofa lahi atu, Taloha ni, Halo olaketa, Ia orana, Namaste, Mauri.

It is our pleasure to present the first Pacific Health Strategy for Canterbury District Health Board. The strategy recognises our commitment as an organisation to work in partnership with Pacific communities and families to improve health outcomes and to ensure that our collective

Vision of "Prosperous and Healthy Pacific Families in the Canterbury region" is achieved.

This strategy is a milestone in our health journey with Pacific people in Canterbury. We have long-standing relationships with Pacific communities and see this strategy as building on the gains we have made. It sets a firm stake in the ground and signals our intentions to do better. We want to do better, we MUST do better. The strategy recognises that in order to impact and meet the diverse needs of Pacific communities, we may need to do things differently, structure things differently, fund things differently and think differently. We recognise that not only is this critical, it is the right thing to do if we are committed to achieving equitable health outcomes with and for Pacific communities.

The Canterbury population is changing and becoming more diverse, the Pacific population has increased by 31% in the last five years and Pacific under-15s have grown by 35%. It is appropriate that health services are fit for purpose and can meet the needs of all communities. The challenges in Pacific health are complex. Pacific people continue to face inequities which are complex and longstanding. In Canterbury too many Pacific adults and children are admitted to hospital with preventable conditions and complications that could be best managed in the community and at home. Pacific communities are often overrepresented in negative health statistics, but these challenges are not insurmountable. We can overcome these challenges if we are willing to do it the Pacific way – together, collectively. We are willing and prepared to face the challenge.

We would like to thank and acknowledge all those who contributed to the development of this plan and this new pathway forward. We are extremely grateful to Pasifika Futures the Whānau Ora Commissioning Agency for Pacific families, our strategic partners for Pacific Health, who have been a valuable source of guidance, support and insight on this journey.

We look forward to walking alongside you and invite you to join us in our efforts to ensure equitable outcomes for Pacific families and communities become a reality.

Haere ora, haere pai

Go with wellness, go with care.

Kia Orana from the Chair, Pasifika Futures

Dr Kiki Maoate ONZM, FRACS
Chair,
Pasifika Medical Association Group, Pasifika Futures Ltd, Whānau Ora Commissioning Agency for Pacific Families

The launch of this strategy marks an important point in time for both Canterbury District Health Board and the many Pacific communities in our region. This strategy recognises the many dedicated community members who have worked tirelessly for more than 20 years to ensure that the "voices" of the Pacific community are heard and that health services are accessible and available to meet our aspirations.

As we enter these challenging times, we have a new opportunity, a new pathway forward and a new way of working. This strengthens our collective approach to the most serious challenges our communities face. The challenge to ensure that Pacific people live longer, healthier and better lives. We all have an obligation to work together to see our aspirations realised and to co-create a better future.

We recognise this would not have been possible without the commitment from Canterbury District Health Board and the leadership from CEO David Meates. We acknowledge your desire for meaningful and real change and your commitment to innovation. This has enabled us to build on our strengths together, to challenge each other but most of all to make a significant difference and move forward.

As a clinician, a member of the Canterbury Cook Islands community and a resident of Christchurch I understand the complexity of Pacific communities, the inequalities communities experience and the work required to make an impact. I also recognise the diversity, the strength and the immeasurable talent and contribution that Pacific communities make and will continue to make in the future in Canterbury. It is our time to shine, it is our time to step forward. I am excited about the opportunities ahead and the future we are facing.

Thank you for inviting us to join you we treasure our partnership.

Kia manuia

Purpose

The purpose of this document is to provide strategic guidance and direction for Pacific health across the Canterbury District Health Board and the broader Canterbury health system. It is intended to provide a clear direction on the areas we will be focussing on and the actions we intend to take.

All parts of the health and disability system are responsible for improving Pacific health outcomes. The strategy can help guide not only Canterbury District Health Board but also Pacific non-governmental organisations, primary care, community health and social services. This strategy will also be used to monitor and evaluate our progress as we move forward. For the strategy to be successful we require unity, collaboration and partnership. Therefore, this document also serves as an invitation, to all government agencies, community organisations, businesses and individuals who share the same vision for equitable health outcomes for Pacific communities, to partner with us and walk alongside us as we navigate this journey together.

Achieving equitable health and wellbeing outcomes for Pacific peoples

The core of this strategy is achieving equitable health outcomes for Pacific peoples. The Ministry of Health defines equity as:

"Differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."[2]

The Health and Disability System Review says:

"Of all ethnic groups in New Zealand, Pacific peoples are amongst those most affected by inequities in the socioeconomic determinants of health, including living in areas of high socioeconomic deprivation, being unemployed and having low weekly earnings..."[3]

Equity in health outcomes is a priority for Canterbury District Health Board and will require us to continue to build our own capacity and capability to ensure equity is achieved for Pacific communities.

[2] Ministry of Health. 2019. *Achieving Equity in Health Outcomes: Summary of a discovery process*. Wellington: Ministry of Health.

[3] Health and Disability System Review. 2019. *Health and Disability System Review – Interim Report – Hauora Manaaki ki Aotearoa Whānui – Pūrongo mō Tēnei Wā*. Wellington: HDSR., p25

Our Vision

Prosperous and healthy Pacific families in Canterbury.

The vision is based on the aspirations and ideals shared by Pacific communities in Canterbury who spoke of Pacific families being supported to shape better outcomes for the future and achieve health and wellness.

Our Values

▸ Families:

Āiga, kāiga, magafaoa, kōpū tangata, vuvale, fāmili are the core of our communities and influence all we do. Family provides identity, status, shelter and comfort.

▸ Shared responsibility:

We are committed to working with partners and families to improve outcomes. This requires us to understand our own responsibility for achieving outcomes and to support others in our shared vision.

▸ Integrity:

Our actions will be intentionally consistent with our words and agreements. Decisions will be aligned with our shared vision and guiding principles. Our collective words will be for the greater good of the relationship.

▸ Relationships:

Are important in all aspects of our work and will be based on care, respect and reciprocity. We recognise the diversity in all Pacific communities and understand that relationships are multi layered and complex, anchored in evolving cultural frameworks.

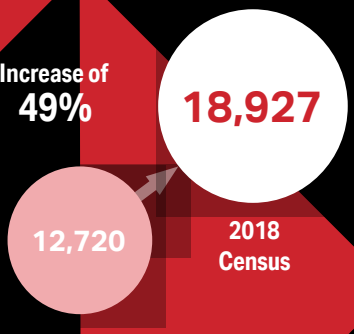
▸ Strengths based:

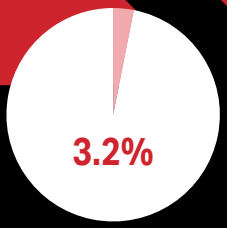
We celebrate the resilience and strength in our families and communities. We focus on what is possible and build on our collective strengths.


'Alu[illegible] Fo'ou Canterbury District Health Board Pacific Plan 2020-2030
9

18,927
Pacific peoples
in Canterbury, NZ

Increase of **49%**





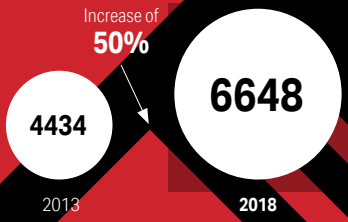
Pacific peoples make up **3.2%** of the total Canterbury population

Median age
22.9 years

Age Group

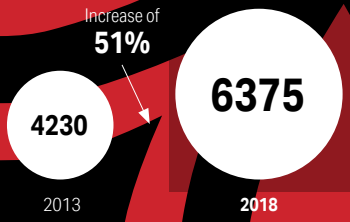
Under 15 years

Increase of **50%**



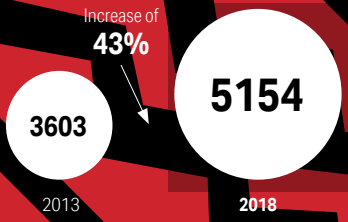
30-64 years

Increase of **51%**



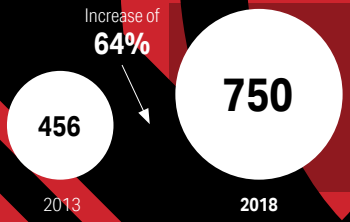
15-29 years

Increase of **43%**



65 years & over

Increase of **64%**



Total

12,723
2013

Increase Of **49%**

18,927
2018

"There is no generic 'Pacific community' but rather Pacific peoples who align themselves variously, and at different times, along ethnic, geographic, church, family, school, age/gender-based, youth/elders, island-born/ New Zealand-born, occupational lines, or a mix of these."[4]

Pacific Diversity Statement

The term "Pacific" is used in this document to describe the ethnically diverse group of people in New Zealand, who are derived from and connected to the indigenous cultures of the Pacific islands.

Canterbury District Health Board acknowledges the commonalities, but also recognises the important differences, between the Pacific ethnic groups. As highlighted in Yavu: Foundations of Pacific Engagement: "Each Pacific nation is different and within each nation there is further diversity. It is also important to recognise that status, authority, tradition, obligations and power structures are different for every group. "

The term "Pacific" is used in this document to describe the ethnically diverse group of people in New Zealand, who are derived from and connected to the indigenous cultures of the Pacific islands.

Canterbury District Health Board acknowledges the commonalities, but also recognises the important differences, between the Pacific ethnic groups. As highlighted in *Yavu: Foundations of Pacific Engagement*: "Each Pacific nation is different and within each nation there is further diversity. It is also important to recognise that status, authority, tradition, obligations and power structures are different for every group."[5]

It is therefore important in the varied contexts of 'Pacific communities' that Canterbury District Health Board, are clearly defined in the advice that we provide and the intelligence we impart.

This Strategy also refers to families as the unit of change rather than generic communities. It is our Pacific families that are directly impacted by inequity and therefore our Pacific families that should be the drivers of change and innovation.

Canterbury District Health Board is designated as one of 7 District Health Boards with specific Pacific responsibilities and the only District health with specific responsibilities in the South Island.

[4] Anae, M., Coxon, E., Mara, D., Wendt-Samu, T., Finau, C., 2001. *Pasifika Education Research Guidelines Final Report*., Auckland: Auckland Uniservices Limited., p7.

[5] Ministry for Pacific Peoples, 2018. *Yavu Foundations of Pacific Engagement*. Wellington: Ministry of Health, p1.

Pacific peoples in Canterbury

The number of Pacific peoples in Canterbury reached 18,927 in the 2018 census[6], an increase of 49% from 12,720 in the 2013 census[7]. Pacific peoples living in the Canterbury region make up 3.2% of the total Canterbury population (599,694) slightly increasing from 2.4% in 2013. This growth in Canterbury's Pacific population also represents an increasing proportion of the total Pacific population in New Zealand (381,642) increasing from 4.1% in 2013 to 5% in 2018.

There were 9,999 Pacific males in Canterbury, making up 52.8% of its Pacific population. This is slightly higher than the number of Pacific females at 8,928 (47.2%) as recorded in the 2018 census. Pacific population in Canterbury continues to be youthful with a median age of 22.9yrs compared to 38.7yrs for total Canterbury. A breakdown of Canterbury's Pacific population by age group and change is provided. The largest change was in the 65 years and over age group, followed by 30 – 64, under 15 then 15 – 29.

Christchurch City remains home to most Pacific peoples in Canterbury despite declining from 79% in 2013 to 75% in 2018. This is followed by Ashburton (9%) and Timaru (5%) Districts both increasing slightly from 8% and 4% respectively in 2013. The number of Pacific peoples residing in these Districts is provided including the percentage change from 2013. The largest change was recorded in Timaru (84%), followed by Ashburton (69%) then Christchurch city (40%). Eighty-nine percent of the Pacific population in the Canterbury region resides in these three Territorial areas[8].

A breakdown of Pacific ethnicities[9] in Canterbury from the 2018 Census is provided. The largest Pacific ethnicity continues to be Samoan (10,092), followed by Tongan (3,192) surpassing Cook Islands Maori in third place (3,132). Compared to the 2013 Census, Fijian experienced the largest increase (72.9%), followed by Tongan (63.4%) while Samoan had the lowest (44.5%).

The Pacific population in Canterbury is projected to continue its strong growth estimated to reach 30,600 in 2038[10], which is more than double the 2013 population[11] (base year) as shown in the table below.

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[6] 2018 Census, Statistics New Zealand. https://www.stats.govt.nz/2018-census/

[7] Statistics New Zealand, 2013 Census. http://archive.stats.govt.nz/Census/2013-census.aspx#gsc.tab=0

[8] Statistics New Zealand, *Age and sex by ethnic group (grouped total responses), for the census usually resident-population count, 2006, 2013, and 2018 Censuses* (RC, TA, SA2, DHB). http://nzdotstat.stats.govt.nz/WBOS/Index.aspx?DataSetCode=TABLECODE8277

[9] Statistics New Zealand, *Ethnic group (detailed total response - level 3) by age and sex, for the census usually resident population count, 2006, 2013, and 2018 Censuses* (RC, TA, SA2, DHB).http://nzdotstat.stats.govt.nz/WBOS/Index.aspx?DataSetCode=TABLECODE8277#

[10] Statistics New Zealand population projections (2013 base on medium growth.

[11] Statistics New Zealand, *Subnational population and dwelling projections: 2013 (base)-2043 update* http://nzdotstat.stats.govt.nz/wbos/Index.aspx?DataSetCode=TABLECODE746&ga=2.164356927.1807635901.1596595077-1088216397.1534214871#

Territorial Authority/District

Christchurch City

Increase of **40%**

10,101 (2013) → **14,178** (2018)

Timaru

Increase of **84%**

480 (2013) → **882** (2018)

Ashburton

Increase of **69%**

1017 (2013) → **1716** (2018)

Total

11,598 (2013) → Increase Of **45%** → **16,776** (2018)

Ethnic Groups

Samoan

Increase of **44.5%**

6984 (2013) → **10,092** (2018)

Cook Island Maori

Increase of **45.6%**

2151 (2013) → **3132** (2018)

Niuean

Increase of **49.5%**

612 (2013) → **915** (2018)

Tongan

Increase of **63.4%**

1953 (2013) → **3192** (2018)

Fijian

Increase of **72.9%**

984 (2013) → **1701** (2018)

Tokelauan

Increase of **54.3%**

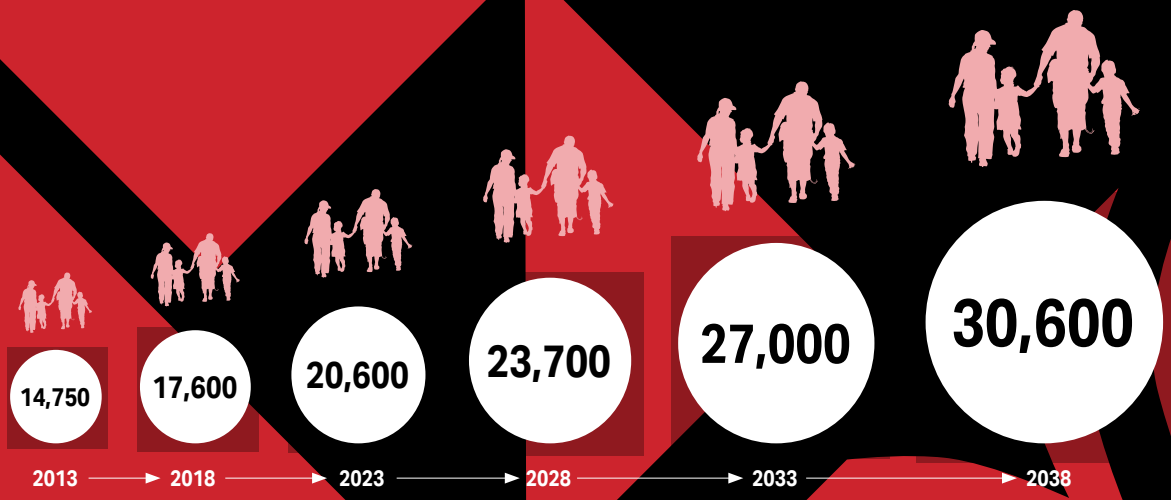
138 (2013) → **213** (2018)

Other Pacific Peoples

Increase of **48.1%**

468 (2013) → **693** (2018)

Projected Pacific Population in Canterbury



Pacific Health Outcomes

Pacific people continue to experience poor health and social outcomes. In Canterbury progress has been made in children's immunisations, cervical cancer screening, and general practice enrolment. Despite this there remains low rates of breast feeding, poor rates of oral health enrolment and low rates of breast screening. Much more concerning are the high rates of avoidable admissions to hospital for both children and adults and the increasing rates of chronic disease. The health challenges facing Pacific families are complex and multi-layered often going hand in hand with poor socioeconomic status. Pacific families aspire to live long and healthy lives and to contribute to New Zealand society as active members. In order to achieve this aspiration families, need to be supported by a responsive, innovative health system that recognises the diversity of Pacific families and the context within which they live. The challenges facing a rapidly growing population in Canterbury will require a collective effort to make an impact. Canterbury District Health Board and Pasifika Futures have the collective expertise, resources and commitment to make this a reality.


'Aiunga Fo'ou Canterbury District Health Board Pacific Plan 2020-2030
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Our Outcomes

In our talanoa with Pacific communities about their aspirations and the outcomes they want for themselves and their families, Pacific families told us they wanted to have greater autonomy and control over their health, they wanted to feel empowered when engaging with the health system. They also told us they wanted to see their children and grandchildren prosper with more opportunities, not just regarding physical health, but also mentally, spiritually and financially. And finally, they told us they wanted to be treated fairly and with respect and to have good access to services when they need it.

We are grateful for the gift of the many stories that have been shared with us and that have provided the direction for this strategy:

Priorities
— Pacific people described a desire to live active, healthy lives enabling them to contribute to their families, communities and country. They envisioned a world where they were the leaders in their own health and well being and services were arranged to respond to and support their needs.
— Pacific communities described driving the design and development of services and programmes that reflect family driven, family centred, culturally anchored principles. This will necessarily require a prioritisation of policies, resources and processes that explicitly intend to improve outcomes for Pacific peoples and reduce inequalities.

Our Strategic Priorities

In order to achieve these two outcomes, we have identified several strategic priorities and focus areas, highlighted from the co-design talanoa workshops, to help focus and direct efforts in a consolidated and coordinated manner.

Outcomes	Strategic Priorities
▸ **Outcome 1:** **Pacific peoples live longer, healthier and better lives, able to manage their own health and wellbeing**	— Strengthening health knowledge to support Pacific families to be leaders in their own health and well being — Co-designing and reimagining services that deliver services in a community-based setting that are family centred, family driven and support families setting their own pathway.
▸ **Outcome 2:** **Pacific people have equitable health outcomes**	— Partnering with Pacific communities to ensure that health and social sector creates environments that improve health equity for Pacific communities

Actions to achieve outcomes

The health system in Canterbury is complex and multi-layered. In order to achieve our aspiration of better health outcomes for Pacific peoples we will need to take a measured and systematic approach. Appendix A presents some actions that build on the work already underway.

Focus Areas

Focus Areas	Outcomes
1. **Service Priorities** At the heart of supporting Pacific families in Canterbury to be healthy and prosperous is the way in which that support is designed and delivered by the Canterbury District Health Board and how it is accessed by Pacific communities. This requires services to be co-created and codesigned by Pacific families to improve access, quality and equity. Priority areas for focus will be mental health, child and youth health integrated primary/ community-based care	▸ **Outcome 1:** – Ensure Pacific families have access to more knowledge and skills to manage their own health and well-being ▸ **Outcome 2:** – Creating a space where Pacific people can access quality primary integrated healthcare, can receive and access timely health information and feel culturally supported and safe. – Improve mental health, addictions and wellbeing outcomes for Pacific families through improving Pacific people's access to and choices of accessing mental health and addiction services.
2. **Workforce Development** We recognise that as a health system we need to value, understand and reflect the communities we serve. Developing a more diverse workforce is not just about representation, it is about equity and doing what is needed so our communities feel valued, supported, respected and welcomed. The workforce needs to be culturally safe and responsive to the health needs of all Pacific communities and the capacity and capability of the Pacific health and disability workforce will be strengthened. Partnerships with the University of Otago, University of Canterbury and other training institutions will be key to progress this priority.	▸ **Outcome 1:** – Ensure that Pacific communities are aware of pathways into health careers, including access to scholarships and training opportunities. Increase the recruitment of Pacific peoples into the health workforce. Increase the Pacific health and disability workforce. ▸ **Outcome 2:** – Support Canterbury Health System staff to become culturally safe and responsive to Pacific families through strengthening the skills of the non-Pacific workforce. Deliver Pacific cultural safety training that addresses the issues of bias and ensures that the workforce understand the context in which Pacific families live their lives, culture and how they can make a positive impact on Pacific health outcomes.
3. **Pacific Leadership** Pacific leadership needs to be grown and actively supported within Canterbury District Health Board Health system and community-based services	▸ **Outcome 1:** – Actively support Pacific community leadership capability and capacity ▸ **Outcome 2:** – Increase Pacific participation in clinical governance, leadership and management at all levels of Canterbury District Health Board. Develop a Pacific centre of focus within Canterbury Health system to support staff, organisational development and Pacific intelligence and monitoring and become the lead Pacific District Health Board for the South Island.

Focus Areas	Outcomes
4. **Partnerships** Partnerships and relationships are integral to the Pacific way of life. Canterbury District Health Board is committed to genuine relationships of mutual trust and respect. Long standing partnerships have been developed with the Pacific community including support to the region through humanitarian responses and training.	▸ **Outcome 1:** – Continue to strengthen and develop partnerships with Pacific communities and families and give 'voice' to the diversity within the region. ▸ **Outcome 2:** – Continue to partner with Pasifika Futures as Canterbury Health Systems Strategic Partner to advance Pacific health outcomes. – Continue to support humanitarian responses to the Pacific region & opportunities.
5. **Innovation** Canterbury District Health Board is recognised for its innovative approach to service delivery, design and integration. Services for Pacific people need to be culturally anchored and utilise technology to support better outcomes. Canterbury Health System is a center for Pacific Health innovation.	▸ **Outcome 1:** – Partner with Pacific communities to develop innovative approaches and solutions to Pacific health challenges. ▸ **Outcome 2:** – Support the strengthening of a family centred integrated Primary care, family, community and mental health service. Utilise technology to improve access for Pacific families to health services
6. **Research, data and evidence** Story telling is a way of life in the Pacific with histories being told and re-told through our talanoa and skilled orators. In order to tell the Pacific health story correctly, Pacific research, data collections and the use of Pacific data to drive evidence-based actions that improve Pacific health outcomes must be strengthened.	▸ **Outcome 1:** – Increase Pacific family's participation in research pathways and programmes. ▸ **Outcome 2:** – Improve the way that ethnicity data is collected and the quality of Pacific ethnicity data. – Strengthen accountability for Pacific health outcomes through establishing a Pacific evidence and data insight framework. Establish innovative research partnerships to enable research that will strengthen Pacific health outcomes.

Outcomes Framework

Focus Areas	Short term (1-2 years)	Mid-term (3-5 years)	Long-term (6-10 years)
1. Service Priorities	**Pacific families are:** — Increasing their knowledge and skills to manage their own health and wellbeing. **Health system:** — A Pacific centre of excellence and innovation where Pacific people can access integrated primary care, family, mental health and addiction services is developed.	**Pacific families:** — Manage their own healthcare and wellbeing. — Reduce presentations at the Emergency Department and avoidable admissions to hospital. **Health system is:** — Actively engaging with Pacific families through culturally safe and equitable models of care. — Access to priority services is achieved.	**Pacific families have:** — Improved health outcomes in mental health and addiction, child and youth health and long-term conditions. — Reached equity in health outcomes with non-Pacific Cantabrians. **Health system has:** — Demonstrated equitable Pacific health outcomes in Canterbury region.
2. Workforce Development	**Pacific families are:** — Aware of pathways into health careers and are undertaking training in health professions. **Health system:** — Pathways are strengthened in schools to increase the uptake of STEM and improve access into health career training. — The current health system is prepared for the reality of a diverse workforce through delivery of a cultural safety program.	**Pacific families:** — Are reflected in the Canterbury Health system workforce. **Health system:** — Staff demonstrate cultural capability and capacity to provide culturally safe and responsive services for Pacific families. — The number of Pacific graduates employed, increases and supports the Pacific health and disability services workforce in Canterbury.	**Pacific families:** — Are visible at all levels of the Canterbury Health system workforce. **Health system:** — Reflects the diversity of the Pacific population of Canterbury and is a culturally safe and responsive employer. — Non-Pacific workforce understands Pacific culture, context and inequities.
3. Pacific Leadership	**Pacific families:** — Pacific leaders are engaged in the design of services. — A "Pacific space" os co-designed within Canterbury District Health Board. **Health system:** — Training and professional development of Pacific Leaders is supported through a targeted approach.	**Pacific families:** — Pacific Leadersare present in the Canterbury Health system. — Actively utilise the "Pacific space" in Canterbury District Health Board as a community resource and feel welcomed and safe. **Health system is:** — A place where Pacific Leadership both clinical and non-clinical is visible and supported to excel and advance in their careers.	**Pacific families:** — Canterbury District Health Board has strong and established relationships with Pacific community leaders. **Health system has:** — Pacific leadership is an integrated part of governance, planning, funding, management and clinical leadership in the Canterbury Health system.

Focus Areas	Short term (1-2 years)	Mid-term (3-5 years)	Long-term (6-10 years)
4. Innovation	**Pacific families;** — Co-designing innovative solutions to challenges they face. **Health system** — Develops technology to improve access for Pacific families to services.	**Pacific families:** — Partner to implement innovative solutions. **Health system** — Integrated primary care, child and youth health and mental health and addiction services are well established.	**Pacific families** — Use technology to support their health journey and partnerships. **Health system** — Canterbury District Health Board leads Pacific health innovation in New Zealand.
5. Partnerships	**Pacific families are:** — In partnership with health professionals to support their management of their family health plan. **Health system:** — Pasifika Futures, the Whānau Ora Commissioning Agency, is the Pacific strategic partner, strengthening existing partnerships and exploring new ones.	**Pacific families are:** — Partner in the development of policy and services in the health sector. **Health system:** — Provides a platform for Pacific voices — Partners and influences government agencies to address Pacific health issues.	**Pacific families:** — Have a strong partnership of mutual trust and respect with the health system. **Health system:** — Recognises Pacific families as partners in healthcare.
6. Research, Data & Evidence	**Pacific families are:** — Aware of research partnerships and projects for Pacific health. — Access their own health data. **Health system:** — Accountability framework based on Pacific health data and evidence covering services, policies, plans and outcomes is implemented.	**Pacific families:** — Access new and innovative research on Pacific health. — Access good quality data on ethnic specific Pacific health statistics. **Health system:** — Produces quality Pacific health research, data and evidence to inform interventions.	**Pacific families:** — Benefit from Pacific specific health research. **Health system:** — Delivers analysis of Pacific ethnicity data. — New, innovative and equitable Pacific health actions are based on collected data and evidence.

Appendix A: Priority Actions

Priority	Actions
1. Service Provision	1.1 Develop a pacific public health communication campaign to enable families to improve their knowledge to support management of their own health and wellbeing. 1.2 Support the development of a Pacific Innovation Hub that includes an integrated Pacific primary, family support, mental health and addictions services. 1.3 Establish Pacific specific services in Ashburton. 1.4 Reorganise all Pacific contracts through a "One family – Outcome agreement" that reflects a new commissioning framework for Pacific health service sin Canterbury.
2. Workforce Development	2.1 Scope a business case for a Pacific STEM academy in Canterbury to improve Pacific entry into health sciences. 2.2 Complete a Pacific Health Workforce Plan for the Canterbury Health system, including a workforce census. 2.3 Implement a Cultural Capability program for Canterbury Health staff. 2.4 Develop a Pacific pathway for recruitment at all levels into the Canterbury health system.
3. Pacific leadership	3.1 Identify a cohort of Pacific health professionals across the Canterbury Health system to commence a Pacific health leadership program. 3.2 Implement a Pacific health leaders' pathway within the Canterbury Health system to support improve Pacific health capacity. 3.3 Establish a Pacific community leadership forum to develop a strong sustainable partnership with pacific community leaders in Canterbury.
4. Parnerships	4.1 Continue to strengthen the Co-commissioning partnership with Pasifika Futures to improve Pacific health and social outcomes. 4.2 Formalise partnerships to extend our impact with organisations with similar vision including University of Otago, University of Canterbury. 4.3 Strengthen our support and partnerships with regional partners including Pacific Ministries of Health.
5. Innovation	5.1 Develop technology innovations to improve access for Pacific families to services and information. 5.2 Implement innovative solutions to Pacific family needs.
6. Research, data and evidence	6.1 Develop research proposals that extend our understanding of effective interventions for pacific families. 6.2 Ensure all Canterbury health system partners collect ethnicity and family data. 6.3 Partner with research agencies to implement specific Pacific research.

Appendix B: Targets & Indicators

Priority	Target	Indicator
1. Service Priorities		– % Pacific people enrolled in primary care – % ASH Rates – % Pacific people with a mental health disorder who are utilising services – % Alcohol, drug use and smoking – % Pacific people up to date with cancer screening – % Pacific babies exclusively breastfed 0-6 months – Total alcohol consumption 15 years and over – Tobacco use and prevalence – Weight for height in Pacific children under 5 years – % Obese pacific adults – % Intimate partner violence
2. Workforce Development		– # Pacific health workers per population – Pacific health workforce and distribution – % Pacific health professionals per ethnicity of population – %Pacific people customer survey experience improved
3. Pacific leadership		– # Pacific health professionals in governance, management and clinical leadership roles – %Pacific Community survey satisfaction with services – # Pacific leaders supported with professional development
4. Parnerships		– % Satisfaction survey between Canterbury DHB and Pasifika Futures – # Outcomes achieved through Partnership Agreements – # Partnership Agreements completed
5. Innovation		– # Innovations implemented – % Innovations evaluated
6. Data, evidence & research		– % Ethnicity reporting – Investment in Pacific research – Published articles

Appendix C: Agreement

Introduction

A. Canterbury District Health Board (CDHB) was established under the New Zealand Public Health and Disability Act 2000 to improve, promote and protect the health of communities residing in the Canterbury region.

B. The Pasifika Medical Association (PMA) was established in 1996 as an incorporated society of Pacific health professionals working together to meet the health needs of Pacific people in the Pacific region. After 20 years of exponential growth, the Pasifika Medical Association Trust (PMA Trust) incorporated on 28 August 2017 as a limited liability charitable company (company number: 6407414) and a registered charitable organisation under the Charities Act 2005. The PMA Trust controls various entities, including: Pasifika Medical Association Membership Trust; Pasifika Futures Trust; Etu Pasifika Trust; and Fale Futures, which are collectively referred to as Pasifika Medical Association Group (PMA Group). The PMA Group commissions and invests in programmes that improve outcomes for Pacific families living in New Zealand and the Pacific Region, and also deliver Pacific, and health and social services.

C. Pasifika Futures Ltd is the Whānau Ora Commissioning Agency (PFL) for Pacific families in Aotearoa.

Collectively, referred to herein as the Parties to this Memorandum of Understanding

Background

A. Canterbury is home to approximately 19,000 Pacific peoples, who represent 5% of Aotearoa New Zealand's Pacific population. The pacific population in Canterbury makes up 3.2% od the total population in Canterbury. Although relatively small the Pacific population is responsible for an increasing number of ambulatory sensitive admissions to hospital and is over represented in poor health and social outcomes.

B. Pacific peoples are one of the fastest growing, diverse and youthful populations in Aotearoa New Zealand. They represent 16 distinct ethnic groups, languages and cultures, many identify with more than one ethnic group, more than one-third are younger than 15 years old and only 5% are older than 65 years. In Canterbury the growth rate over the 5 years between 2013-2018 is 49% indicating this population is one of the fastest growing populations in New Zealand.

C. Our diverse, youthful Pacific population continues to contribute significantly to cultural, social and economic life in Aotearoa New Zealand. Despite this, Pacific peoples continue to experience poor socio-economic well-being, which is related to their poor health outcomes. The impact of these disparities on the health of Pacific families is reflected across all ages and important summary measures of health. There is a 7-8-year gap in life expectancy between Pacific and non-Maori/non-Pacific ethnicities. At CDHB, Pacific people have the lowest life expectancy of all groups.

D. The diversity, youthfulness, and unique characteristics of Pacific peoples, coupled with the inequities they experience, poses both challenges and opportunities for those working to improve Pacific outcomes. We recognise that we can achieve more working together. We will partner and align our efforts to better support and empower Pacific patients, āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāmili to experience equitable healthcare and health outcomes, shape a better future and achieve their aspirations.

E. We recognise the strengths we bring to our partnership and joint work. CDHB works in the community and with other agencies to support the more than 600,000 people living in their region; commissions a range of health and disability services; owns and operates hospital and outpatient services.

F. As the only Whānau Ora Commissioning Agency for Pacific families in the country, Pasifika Futures and partners continue to engage and connect with Pacific families and communities in ways that are meaningful and relevant for them. Since 2014, more than 18,155 Pacific families comprising of 104,001 individuals have engaged with Pasifika Futures' Whānau Ora programme (35% of the Pacific population in New Zealand) and achieved 39,000 well-being outcomes. Pasifika Futures also provided substantial support to Pacific families during COVID-19 Alert Level 4 and supported the Canterbury Public Health Welfare Response by rapidly standing up a pathway for Pacific cases and contacts to receive the welfare supports required to enable them to safely complete their isolation and quarantine periods. In Canterbury the Pacific partner ETU Pasifika delivered 1140 packages of support to families, benefiting over 5,400 individuals and over 1,000 families. In addition, they supported 19 positive COVID-19 referrals and provided supported accommodation for 5 families.

G. Pasifika Medical Association Membership Trust is a network of over 3000 Pacific health professionals in New Zealand and across the Pacific region, who work collaboratively to strengthen Pacific health workforce capacity and capability. They are in a unique position to support Pasifika health workforce initiatives.

H. Etu Pasifika Trust is an integrated Primary Care, Whānau Ora and Behavioural Support service based in Christchurch delivering innovative, family-based services to over 5,000 Pacific people in the Canterbury catchment area. The integrated model design is led by the PMA/PFL Trust and provides unique opportunities to support health service re-design.

I. We recognise the value of having a strategic partnership, and collaborative approach to strengthen the capacity and capability of the Pacific health workforce, to develop a joint work programme to improve health care and outcomes for our Pacific āiga, kāiga, magafaoa, kōpū tangata, vuvale, fāmili and communities, and to share and develop insights and data about the needs of Pacific populations, their experiences of health care and health outcomes, and effective models of care.

We Agree:

1. Purpose

This Memorandum of Understanding (Memorandum) supports us to have a strategic, collaborative, respectful relationship. It sets out the vision, values and principles that will underpin the relationship between us, and clarifies the scope and effect of this Memorandum.

2. Vision

Prosperous and healthy Pacific families (āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāmili) in Canterbury.

3. Values

The values that guide our joint work to achieve our vision:

▸ Families:

Āiga, kāiga, magafaoa, kōpū tangata, vuvale, fāmili are the core of our communities and influence all we do. Family provides identity, status, shelter and comfort.

▸ Shared responsibility:

We are committed to working with partners and families working to improve outcomes. This requires us to understand our own responsibility for achieving outcomes and to support others in our shared vision.

▸ Integrity:

Our actions will be intentionally consistent with our words and agreements. Decisions will be aligned with our shared vision and guiding principles. Our collective words will be for the greater good of the relationship.

▸ Relationships:

Are important in all aspects of our work and will be based on care, respect and reciprocity. We recognise the diversity in all Pacific communities and understand that relationships are multi layered and complex, anchored in evolving cultural frameworks.

▸ Strengths based:

We celebrate the resilience and strength in our families and communities. We focus on what is possible and build on our collective strengths.

3.1 Relationship principles

The principles that will guide our relationship and how we work together:

3.1.1 Reciprocity - we conduct ourselves recognising the need for mutual benefit and understanding. We each bring unique strengths and resources that enable us to overcome our challenges together.

3.1.2 Autonomy – we each have the freedom to manage and make decisions. We commit to make decisions and take actions that respect and strengthen the collective interest to achieve our shared vision.

3.1.3 Honesty – we will be truthful and authentic even when that makes us uncomfortable. This includes honesty about facts, feelings and intentions;

3.1.4 Loyalty – we are each committed to our relationship. We will value each other's interests. Standing together through adversity will be key.

3.1.5 Equity – we are committed to fairness which does not always mean equality. We will make decisions based on a balanced assessment of needs, risks and resources.

3.1.6 Integrity – our actions will be intentionally consistent with our words and agreements. Decisions will be aligned with our shared vision and guiding principles. Our collective words and actions will be for the greater good of the relationship.

4. Scope

The Parties agree to collaborate on work that will contribute to achieving equity for Pacific peoples living in Canterbury, as described in the Canterbury Pacific Health Strategy: "'Alunga Fo'ou – A New Path"

Canterbury
District Health Board
PACIFIC HEALTH

Pasifika futures
PROSPERITY FOR PACIFIC FAMILIES

Appendix 2: List of Attendees

1. Dr. Kiki Maoate ONZM, FRACS Chairperson Pasifika Medical Association/Pasifika Futures Whanau Ora Commissioning Agency
2. La'auili Sir Michael Jones KNZM,MNZM Director Pasifika Futures Ltd
3. Dr. Francis Agnew, MNZM, FRANZCP, FAChAM Director Pasifika Futures Ltd
4. Dr. Siniva Sinclair, FAFPHM Director Pasifika Futures Ltd
5. Ms. Soanna Pamaka, Director Pasifika Futures Ltd
6. Mrs. Debbie Sorensen, CEO, CCT. Pasifika Medical Association/Pasifika Futures Ltd
7. Taulapapa Wilmason Jensen, LLB. Deputy CEO
8. Mr. Amanaki Misa, General Manager, MBA. ETU Pasifika Ltd
9. Dr. Greg Hamilton, General Manager, Mental Health, CDHB
10. Ms. Sandy McLean, Team Lead, Mental Health, Planning and Funding, CDHB
11. Mrs. Finau Heuifanga Leveni, Pacific Portfolio Manager, Planning and Funding, CDHB

SCHEDULE OF MEETINGS - 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **20 August 2020**

Report Status – For:	Decision ☑	Noting ☐	Information ☐

1. ORIGIN OF THE REPORT

The purpose of this report is to seek the Board's confirmation and support to a schedule of meetings for the Board and its Committees, both statutory and non-statutory, for the 2021 calendar year as required by the NZ Public Health and Disability Act 2000.

2. RECOMMENDATION

That the Board:

i. confirms support for the proposed schedule of meetings for 2021 (Appendix 1);
ii. reconfirms the delegation of authority to the Chief Executive, in consultation with the Chair of the Board and/or relevant Committee Chairperson, to alter the date, time or venue of a meeting, or cancel a meeting, should circumstances require this.

3. SUMMARY

The purpose of this report is to seek the Board's support for a proposed schedule of meetings for the 2021 calendar year.

The dates for Committee and Board meetings are to a large extent determined by the reporting cycle required to produce information for the Quality, Finance, Audit and Risk Committee and the Hospital Advisory Committee in particular. The proposed meeting cycle for 2021 is:

- Board – monthly meetings on a Thursday, starting at 9:30am
- QFARC – monthly meetings on a Tuesday, starting at 9.00am.
- HAC – bi-monthly meetings on a Thursday, starting at 9:00am.
- CPH&DSAC – bi-monthly meetings on a Thursday, starting at 1.00pm.

Background

If a DHB does not adopt an annual schedule of meetings then, in terms of the New Zealand Public Health and Disability Act 2000 (the *Act*) and in accordance with Standing Orders (Clause 1.14.1), members are instead required to be given written notice of the time and place of each individual meeting, not less than ten working days before each meeting.

The adoption of a meeting schedule allows for more orderly planning for the forthcoming year for the Board, Committees and staff. The proposed schedule also serves as advice to members that the meetings set out on the schedule are to be held.

The suggested meeting dates for 2021 are based on a similar cycle to 2020 meetings, with Committee meetings on Tuesdays and Thursdays, and Board meetings on the third Thursday of each month.

In situations where additional meetings of the Board and its Committees are required, these will, in terms of the Act, be treated as special meetings. Notice of these meetings will be given to members in each case prior to the meeting. In addition, where workshops are required, which are not part of the regular meeting cycle, notice of these meetings will also be given to members prior to the workshop.

On rare occasions it may be necessary to alter the date, time or venue of a meeting or to cancel a meeting. It is recommended that the authority to do this be delegated to the Chief Executive in consultation with the Chair of the Board or the Committee Chairperson.

Meetings of the Board and its Statutory Committees will be publicly notified in accordance with Section 16 of Schedule 3 of the Act.

4. APPENDICES

Appendix 1: 2021 Proposed Schedule of Meetings

	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed
January 2021						NEW YEARS DAY 1	2/3	BOXING DAY OBSERVED 4	5	6	7	8	9/10	11	12	13
February		1	2	3	4	5	6/7	WAITANGI DAY OBSERVED 8	9	10	11	12	13/14	15	16	17
March		1	QFARC 9AM 2	3	CPH&DSAC 1PM 4		6/7	8	9	10	11	12	13/14	15	16	17
April					HAC 9AM 1	GOOD FRIDAY 2	3/4	EASTER MONDAY 5	6	7	8	9	10/11	12	13	14
May		31					1/2	3	QFARC 9AM 4	5	CPH&DSAC 1PM 6	7	8/9	10	11	12
June			QFARC 9AM 1	2	HAC 9AM 3	4	5/6	QUEEN'S BIRTHDAY 7	8	9	10	11	12/13	14	15	16
July					CPH&DSAC 1PM 1	2	3/4	5	6	7	8	9	10/11	12	13	14
August	1	2	QFARC 9AM 3	4	HAC 9AM 5	6	7/8	9	10	11	12	13	14/15	16	17	18
September				1	CPH&DSAC 1PM 2	3	4/5	6	7	8	9	10	11/12	13	14	15
October						1	2/3	4	QFARC 9AM 5	6	HAC 9AM 7	8	9/10	11	12	13
November		1	QFARC 9AM 2	3	CPHAC/DSAC 1PM 4	5	6/7	8	9	10	11	CANTERBURY ANNIVERSARY DAY 12	13/14	15	16	17
December				1	HAC 9AM 2	3	4/5	6	7	8	9	10	11/12	13	14	15

Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	Mon	Tues	Wed	Thu	Fri	S/S	
14	15	16/17	18	19	20	21	22	23/24	25	QFARC 9AM 26	27	HAC 9AM 28	29	30/31	January 2021
CDHB BOARD 9.30AM 18	19	20/21	22	23	24	25	26	27/28							February
CDHB BOARD 9.30AM 18	19	20/21	22	23	24	25	26	27/28	29	QFARC 9AM 30	31				March
CDHB BOARD 9.30AM 15	16	17/18	19	20	21	22	23	24/25	ANZAC DAY OBSERVED 26	27	28	29	30		April
13	14	15/16	17	18	19	CDHB BOARD 9.30AM 20	21	22/23	24	25	26	27	28	29/30	May
CDHB BOARD 9.30AM 17	18	19/20	21	22	23	24	25	26/27	28	QFARC 9AM 29	30				June
CDHB BOARD 9.30AM 15	16	17/18	19	20	21	22	23	24/25	26	27	28	29	30	31	July
CDHB BOARD 9.30AM 19	20	21/22	23	24	25	26	27	28/29	30	QFARC 9AM 31					August
CDHB BOARD 9.30AM 16	17	18/19	20	21	22	23	24	25/26	27	28	29	30			September
14	15	16/17	18	19	20	CDHB BOARD 9.30AM 21	22	23/24	LABOUR DAY 25	26	27	28	29	30/31	October
CDHB BOARD 9.30AM 18	19	20/21	22	23	24	25	26	27/28	29	QFARC 9AM 30					November
CDHB BOARD 9.30AM 16	17	18/19	20	21	22	23	24	25/26	CHRISTMAS DAY OBSERVED 27	BOXING DAY OBSERVED 28	29	30	31		December

CHAIR'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

DATE: **20 August 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

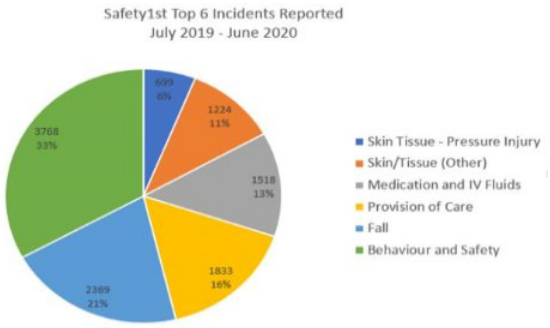
i. notes the Chief Executive's update.

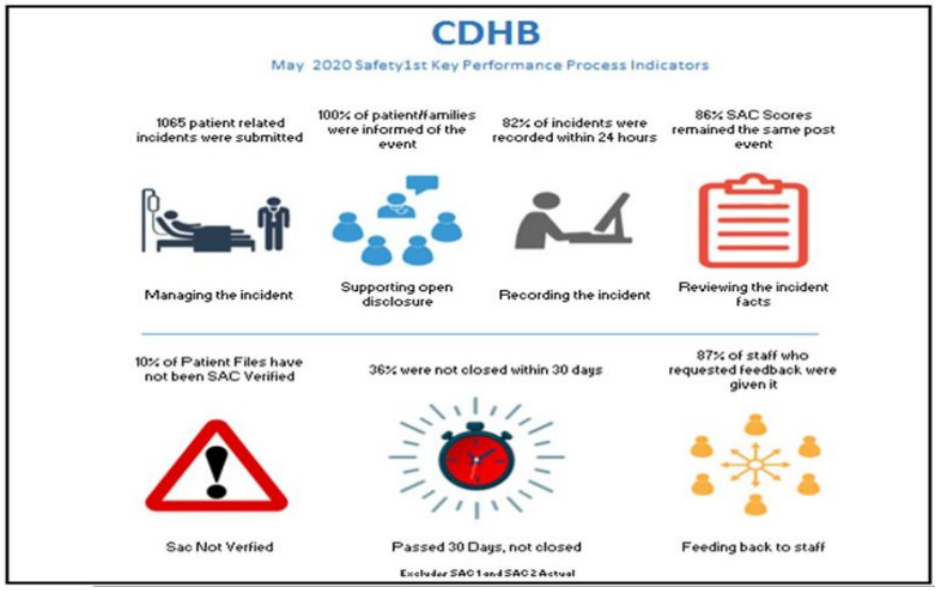
3. DISCUSSION

PUTTING THE PERSON FIRST – PATIENT SAFETY, QUALITY AND IMPROVEMENT

Quality & Patient Safety

- Canterbury has a strong quality & patient safety reporting culture, as evidenced by the 16,664 incidents reported in the last financial year, 13,680 of these were clinical. Excluding suspected suicides there were 73 serious adverse events reported out of the total of 13,680 incidents reported by the DHB in 2019/20.
- Of the 73 serious adverse events reported, 40 were inpatient falls and 27 were healthcare acquired pressure injuries. All serious adverse events are reviewed through a formal process to provide information to patients and families about the contributing factors and causes of the event and how we intend to make our systems safer.
- The top 6 categories reported are (1) behaviour and safety, (2) Falls, (3), Provision of Care, (4) Medication and IV fluids, (5) Skin and Tissue, (6) Pressure Injuries.
- The use of the weekly reports through the Safety1st reporting platform has seen an improvement and Quality Teams continue to work with managers to understand the workflows and timely support review.

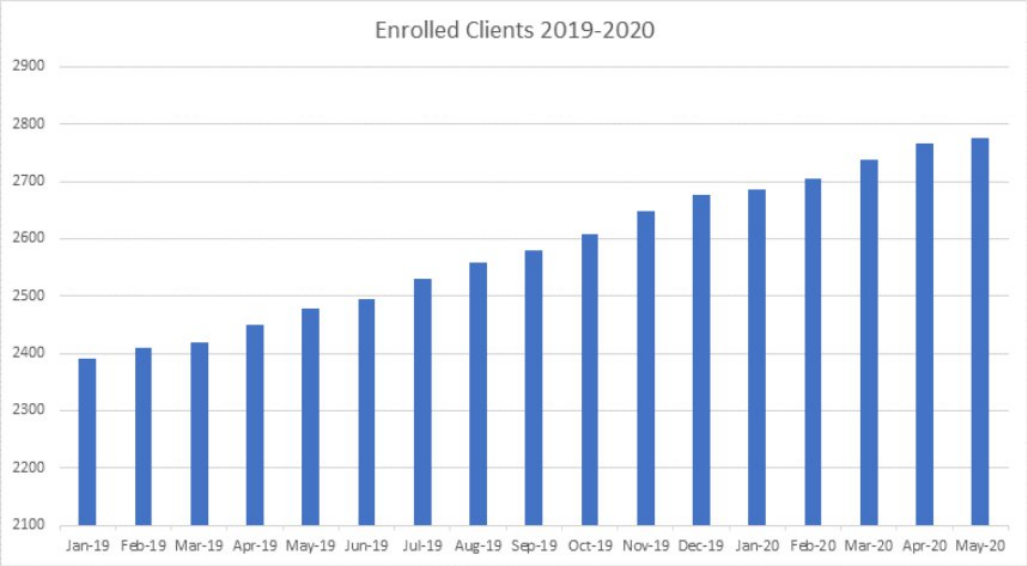




MĀORI AND PASIFIKA HEALTH

- **Whakamaua: Māori Health Action Plan 2020-2025:** Whakamaua: Māori Health Action Plan 2020-2025 was formally launched by the Ministry of Health in July. Whakamaua is the latest implementation plan for He Korowai Oranga, New Zealand's Māori Health Strategy. It is designed to help New Zealand achieve better health outcomes for Māori by setting the government's direction for Māori health advancement over the next five years.
- Whakamaua is underpinned by the Ministry's new Te Tiriti o Waitangi framework, which provides a tool to support the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown.
- Whakamaua outlines a suite of actions that will help to achieve four high-level outcomes. These are:
  - Iwi, hapū, whānau and Māori communities exercising their authority to improve their health and wellbeing.
  - Ensuring the health and disability system is fair and sustainable and delivers more equitable outcomes for Māori.
  - Addressing racism and discrimination in all its forms.
  - Protecting mātauranga Māori throughout the health and disability system.
- Whakamaua has been developed alongside an Expert Advisory Group, its membership including Māori academics and researchers, health professionals, and iwi, disability and rangatahi leaders. Whakamaua has been shaped by feedback provided through an extensive engagement process, A summary report outlining the engagement process has been published as a companion document to Whakamaua – giving visibility to the voices of Māori communities and the health and disability sector. This report provides a summary of key themes from the Ministry's engagement process with key stakeholders in 2019.
- Whakamaua has four main outcomes, and they respond to important cultural, social, economic and population health challenges present in Aotearoa New Zealand. They align closely with what Māori aspirations and what the evidence indicates is necessary to shift the health and disability system towards achieving pae ora.
    - Objective 1: Accelerate and spread the delivery of kaupapa Māori and whanau-centred services;
    - Objective 2: Shift cultural and social norms;
    - Objective 3: Reduce health inequities and health loss for Māori;
    - Objective 4: Strengthen system accountability settings.

- The Ministry has drawn guidance from the health and disability system, Māori individuals, whānau, hapū and iwi and other agencies to develop eight priority areas for Whakamaua: Māori Health Action Plan 2020–2025. These priority areas are highly interdependent. They are where Māori and the wider system said action is most needed in the next five years to enable change and set a strong foundation for the future.
- **Tamariki Ora:** The Well Child Tamariki Ora programme is a series of health visits and support that are free to all families for children from around 6 weeks up to 5 years of age. The free Well Child Tamariki Ora visits cover: Our Tamariki Ora provider in Canterbury is provided by our Kaupapa Māori provider, Te Puawaitanga Ki Ōtautahi. Visits are timed to watch the developmental milestones for each age and stage. All Tamariki Ora checks are free and provided in the home throughout a child's first years.



- **Tirohanga Whānui:** Pūrongorongo hauwhā is a quarterly update from data and information from the PHOs on three key operational areas which particularly monitor Māori equity performance of PHOs:
  - Raraunga whakauru – Enrolment data
  - Ārai mate – Immunisation
  - Tamariki ora e waru – B4 School Checks
- **Raraunga Whakauru** (PHO Enrolment): PHO Enrolment is a measure of access and is an indicator of inequity if there are (statistically) significant differences in enrolment numbers by ethnicity. Trends across the PHOs and between Māori and non-Māori can be charted each quarter.

  A positive increase in Māori enrolment (+2.3%) within the DHB this quarter, along with increases in enrolments of non-Māori (+0.9%). The graphs that follow over page compare the changes in enrolment by age band from quarter four 2018/19 to quarter four 2019/20 between Māori and non-Māori.

  Enrolment data is based on the new National Enrolment Service (NES) which produces monthly snapshots. This report will use the data from the first month of each quarter to produce the year on year comparisons.
- **Ārai mate (Immunisations)**: The immunisations for this report include the National Childhood Schedule, Human Papiloma Virus (HPV) and the influenza vaccine for over 65 years.
- It is pleasing to see that immunisation coverage has bounced back following the COVID lockdown, with childhood immunisation rates remaining consistent or improving overall.

  Influenza coverage continues to remain high, however there is concern around the MoH projected population data which sees the DHB coverage at 50% compared to the CDHB analysis of being in the 90% mark. At lot of this appears to be around ethnicity coding of those 65 years and old. This needs to be looked at by the PHOs to streamline and improve coding.

Measure	Previous Quarter Jan – Mar 2020	Quarter Apr – Jun 2020		Target Coverage (Māori)
	Coverage (Māori)	Coverage (Māori)	Coverage (Total)	
Fully immunised - 8 months	91%	91%	95%	95%
Fully immunised - 2 years	90%	94%	95%	95%
Fully immunised - 5 years	93%	93%	94%	95%
Fully immunised - 12 years	66%	68%	65%	95%
HPV (Final dose) Cohort 2006*	n/a	58%	62%	75%
Influenza > 65**	79%	94%	85%	75%

* Represents the 2019/20 year
** Results subject to confirmation from the Ministry of Health

- **Tamariki ora e waru (Before School Check):** 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 testing component by the CDHB.
- Our results show a good recovery in the second half of this quarter once we had moved into level 1 Covid restrictions. The result for this quarter was 55% of eligible Māori tamariki having their full Nurse and Vision and Hearing Testing (VHT) B4SC. An excellent result for the whole of the 2019/2020 year with 91% of all Māori tamariki having the full (Nurse and VHT) B4SC exceeding our 90% target.

MEDICAL SURGICAL AND WOMENS AND CHILDRENS HEALTH

- **Planned Care performance and recovery:** During the COVID lockdown, 1,158 admitting events were cancelled and deferred. Specialist services have been working to catch up these events which are being booked following clinical reprioritisation. As at 5 August all but 107 of these events have been closed with most having received treatment, however some returned to primary care or no longer require treatment.
- Planning and Funding has produced three planned care improvement plans which outline the actions and timelines for Canterbury returning to compliance in its planned care services. The 2020/21 Canterbury Planned Care Improvement Action Plan has been provided to the Ministry of Health. This plan focusses on how the DHB will achieve Elective Services Patient Flow Indicator (ESPI)/Planned Care compliance in the majority of services within six months.

  As at 3 August, 1,805 people are waiting for longer than 4-months for a First Specialist Assessment (FSA) (ESPI 2). Four service areas are ESPI 2 compliant, 19 service areas are meeting their recovery plan target and 16 are not.

  In relation to waiting times for treatment within 4 months (ESPI 5), significant work still needs to be done with 1,470 people waiting longer than 4-months. One specialty area is compliant, three are meeting their recovery plan target and nine are not.
- **Productivity and planned care:** Ministry of Health reporting shows Canterbury has met its overall Planned care delivery target for 2019/20 with 31,013 interventions against a target of 30,675 (101%). The

planned care target for 2020/21 is still awaiting Ministry approval however an yet to approved target of 31,339 has been submitted.

- **Christchurch Campus Leave Care Programme:** The Leave Tracker shows 157 of the 1,126 staff (13.9%) in the red category will have moved from red to yellow or green categories by 31 January. Work continues with those remaining. The General Manager and People and Capability are meeting with leaders across the campus to highlight leave levels, expectations and achievements so far.

  All senior nursing leaders are committed to utilising every available opportunity to provide leave to nursing team members. There is an emphasis on ensuring staff with high aged accrued leave balances have plans in place reflecting taking leave in both the short and medium term. Buying out leave is also being used to reduce annual leave balances, especially where the size of leave balance available and operational requirements are at tension. Staff that use high levels of sick leave due to injury and illness and who have high annual leave balances is another area of focus.

- **Preparation for the migration of services to Hagley:** The Hagley Operational Team working with the Supply Department, Pharmacy and Information Services on final planning for stocking and preparing the building for service provision. This work will commence mid-August and run through until occupation.

  Staff orientation will begin on October 5th. The 15 members of the Hagley Operational Team and 102 trainers will provide orientation to approximately 3,000 staff prior to first patients being transferred in the week of 16 November.

  In the two weeks prior to go live dry runs will be carried out to ensure systems and processes will work in the way envisaged, for example there will be a walk through from the operating theatre to the intensive care unit with a "patient", bed and the other equipment required to transfer patients following cardiac surgery to ensure that transit is smooth and our practice does not need to be modified. After dry runs there will be testing of each theatre, directly involving patients.

  Initial planned procedures will be at the lower end of complexity to ensure familiarity with the facility and systems.

  Anaesthesia and surgical services are working to confirm their readiness to implement the new theatre schedules that will enable improved flow of acute surgery and repatriation of work from outplaced settings.

  The Emergency Department is revising its models of care to ensure that it can continue to provide the current level of care in the new environment using current resource levels. The recently approved front of house model that ensures rapid provision of care to our less complex patients is key to this.

- **New Technology and Treatment's Programme:** Women being cared for in maternity following birth are provided with bottles for expressed milk. Bottles were previously treated as single use and as many as were required were provided. This practice consumed around 50,000 bottles a year and has been costing an average of $113 for each four day stay. A change in practice is being put in place with provision of four bottles to each woman, along with then cleaning and sanitising bottles between use. This will reduce the number of bottles required by around one third, supporting our sustainable practice, along with saving around $54,000 per year.

  Currently a system incorporating a single use syringe is used to deliver contrast material to patients receiving a CT scan. A new system that incorporates a multiuse system that can be used for 12 hours following opening has been trialled and, assuming probity and procurement arrangements are endorsed, is being adopted. This will significantly reduce the plastic syringes consumed and sent to waste – eliminating 1,700kg of plastic waste a year - saving around $240,000 on syringes, $60,000 on contrast and $20,000 for other consumables each year, while enabling a faster turnaround time for patients undergoing scans.

  Work is also beginning towards reducing the number of group and hold (blood transfusion) requests for patients in the emergency department. The current cost of this work is currently around $200,000 a year, with only 8% of those requests being associated with subsequent transfusion.

OLDER PERSONS HEALTH & REHABILITATION | COMMUNITY DENTAL

- **Aged Residential Care, COVID response:** In response to the resurgence of COVID, all Aged Care Facilities have been placed into level 4 lockdown. This applies to all visitors however facilities are accepting new residents utilising a process that includes a COVID Screening Form, developed alongside the Ministry of Health earlier this year for a person entering ARC. If a person is asymptomatic they will not require a COVID negative test before being admitted to ARC. We are expecting there may be some pushback from individual facilities around this.

  In line with Ministry of Health and government expectations, a large number of surgical masks have been distributed to aged care and residential care facilities both in Canterbury and West Coast. The response to this has so far been positive.

- **Pressure Injury Reduction Project:** The Pressure Injury reduction project which began in February and originally planned to finish in June has been extended to September in recognition of the disruption to the project from COVID. An education session at the Older Person's Health and Rehabilitation grand round provided several 10 minute tutorials for groups of staff around seating and positioning and how pressure is distributed across the body. A root causes analysis has been completed for all pressure injuries that have occurred in April and June regardless of severity score. An expert occupational therapist contact has been identified for each ward to be contacted for discussion of any seating and positioning strategies to minimise pressure injuries; labelled all pressure distribution equipment to ensure it can be used correctly. Six rapid audits have been undertaken to measure compliance with skin check screening upon admission and plan for managing risk of pressure injury using the Purpose-T screening tool. Work is ongoing to increase patient and whanau awareness of causes of pressure injuries to empower patients to keep themselves well.

- **Telehealth:** The Older Person's Health and Rehabilitation Telehealth survey which was undertaken post COVID has been completed with 274 responses from patients, whanau and staff across all clinical areas. Most patients and whanau reported high levels of satisfaction including wanting the option of further appointments in this way, 26% wouldn't want this as an option in future appointments. Staff also liked the use of telehealth with 51% reporting reduced travel and 42% reported time savings. There were several recommendations from the survey including strengthening cross site working to reduce travel for patients between hospitals and how to increase the use of telehealth as an option, facilitating increased choice for patients.

- **Pain Management Service:** During COVID the Pain Management Service was unable to provide its Burwood assessment, screening and education (BASE) education programme on-site. As an alternative the service developed a series of online videos via the Vimeo Platform that covers all the material. Completing this online course is a direct replacement of attending BASE in-person and offers some advantages including patients able to work at their own pace and take breaks/pause video as they move through the material. When participants have finished viewing the videos, they complete some revision questions and a form to inform decisions about best meeting their pain-management needs and provide feedback on the online material. Initial feedback has been positive, but an on-site course is still requested by some participants.

- **Driving Assessment Service:** During 2019/20 we received 635 referrals for the Driving Assessment service based at Burwood Hospital a 17% increase from the previous year. Prior to COVID the Waiting List for driving assessments was at 5 months and increasing due to this increase in referrals. During the lock down the service re-designed how it would deliver its service and now offers double appointments with both on and off road on the same day for appropriate groups of patients, for over 70's separate appointments are offered. Also, a virtual review of patient notes to determine those which requires only an on-road assessment. These changes have increased the number of patients seen per week by 50% which has reduced the wait time to 3-4 months.

- **Support to Ashburton Services:** To support physiotherapy services at Ashburton Hospital the outpatient Physiotherapy Waiting list has been transferred to Burwood Hospital and all future referrals re-directed. All referrals will be managed by the Burwood Physiotherapy team using a combination of telehealth Burwood based appointments and outreach clinics. The Older Persons Mental Health team have worked collaboratively with Ashburton services and Specialist Mental Health to ensure that there

is support for patients. Referrals will be directed to the Older Person's Health and Rehabilitation referral centre and a training programme developed to support staff based in Ashburton.

SPECIALIST MENTAL HEALTH SERVICES (SMHS)

- **SMHS Facilities**: Facility related activity remains a key focus for the division. The Programme Business Case (PBC) is under development to support the Masterplan for Hillmorton Campus. The focus is on outlining the Tranche 1 developments. Due for presentation to QFARC special meeting 14 August 2020.

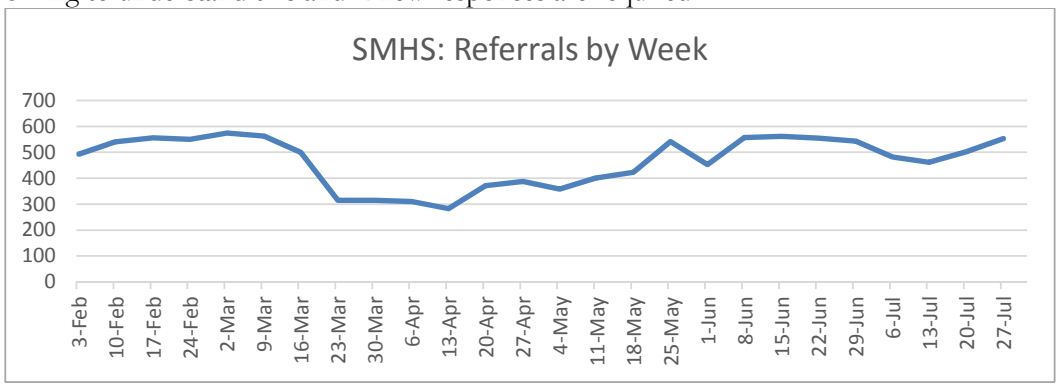
  The detailed design phase for the new builds, Integrated Family Services Centre and High and Complex Needs, is coming to a close. Furniture, fittings and equipment process work has commenced with user groups.

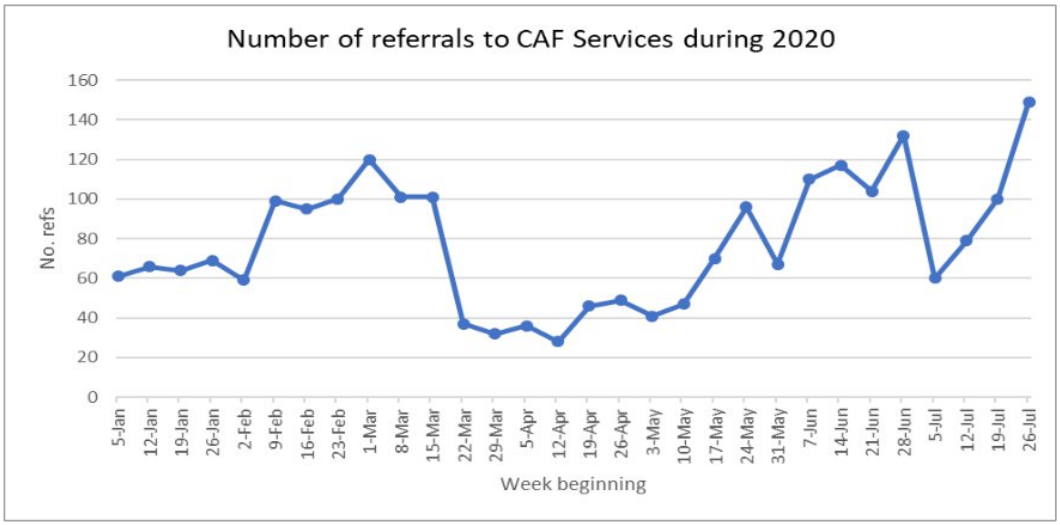
  The Assessment, Treatment and Rehabilitation (AT&R) high care (pod extension) is expected to be completed in October 2020. Operational planning with the service leadership is underway. This will mean the temporary loss of two rooms while the link to the new pods is built.

  The mobile duress solution has been approved in principle with scoping and business case submission being progressed. This will enable a single site wide solution which includes AT&R extension, new builds and existing services.

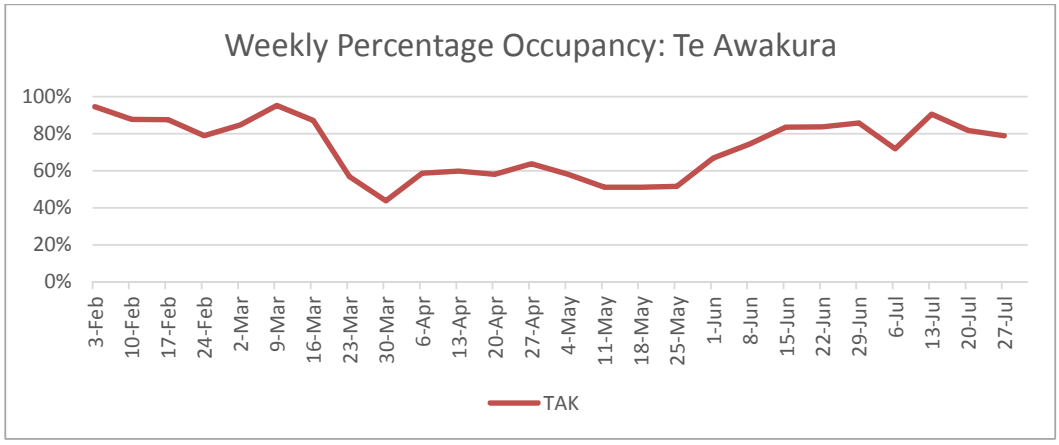
- **Monitoring Demand and Wait-times:** Monitoring demand remains key to service delivery within Specialist Metal Health Services. An updated set of data for referrals, occupancy and wait times has been provided in this report.

- **Referrals:** Referrals have returned to expected volumes, however of concern is the referral rate for Child Adolescent and Family (CAF) services which has seen a significant increase post-COVID. We are working to understand this and if new responses are required.

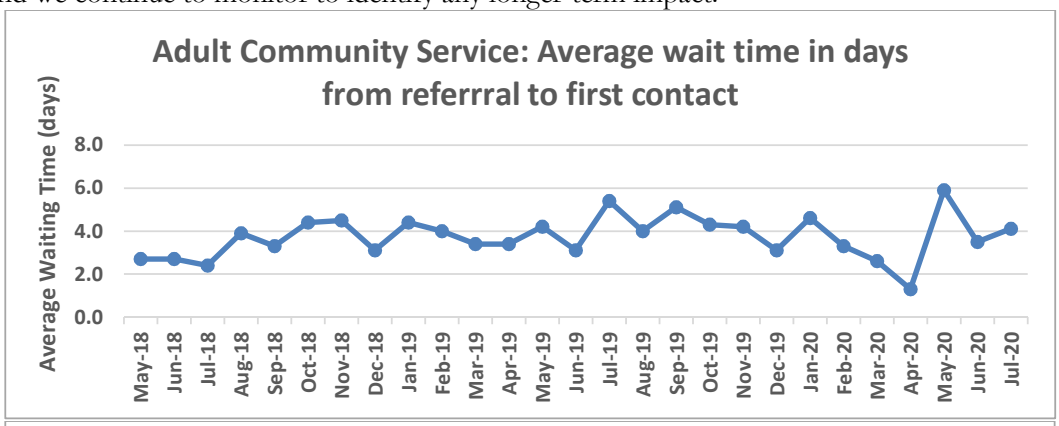


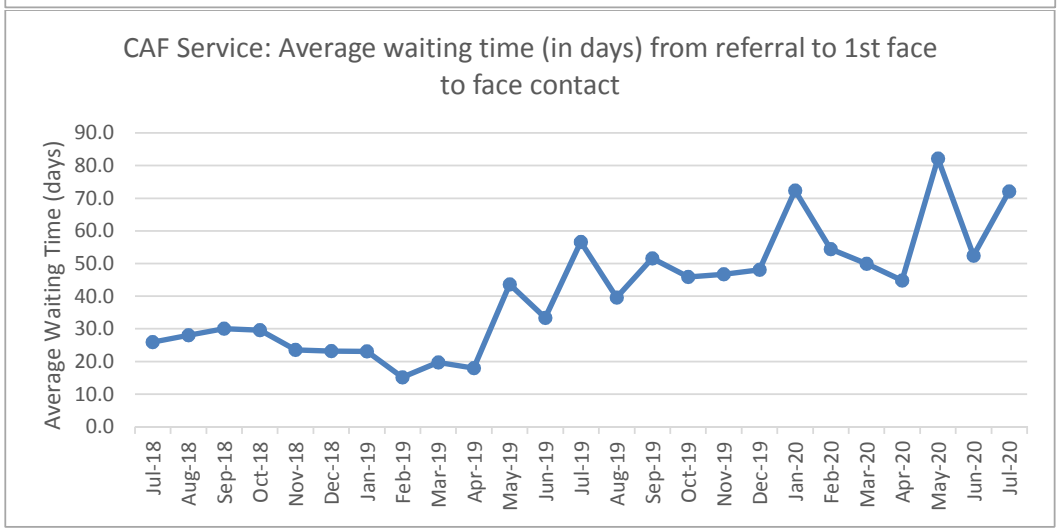


- **Occupancy** within the adult acute inpatient unit (Te Awakura) reduced in response to raised admission thresholds put in place as part of the COVID response plan, we are seeing a return to a more typical occupancy pattern however.



- **Wait times** within both Adult and CAF outpatient services saw an expected increase during COVID and we continue to monitor to identify any longer-term impact.



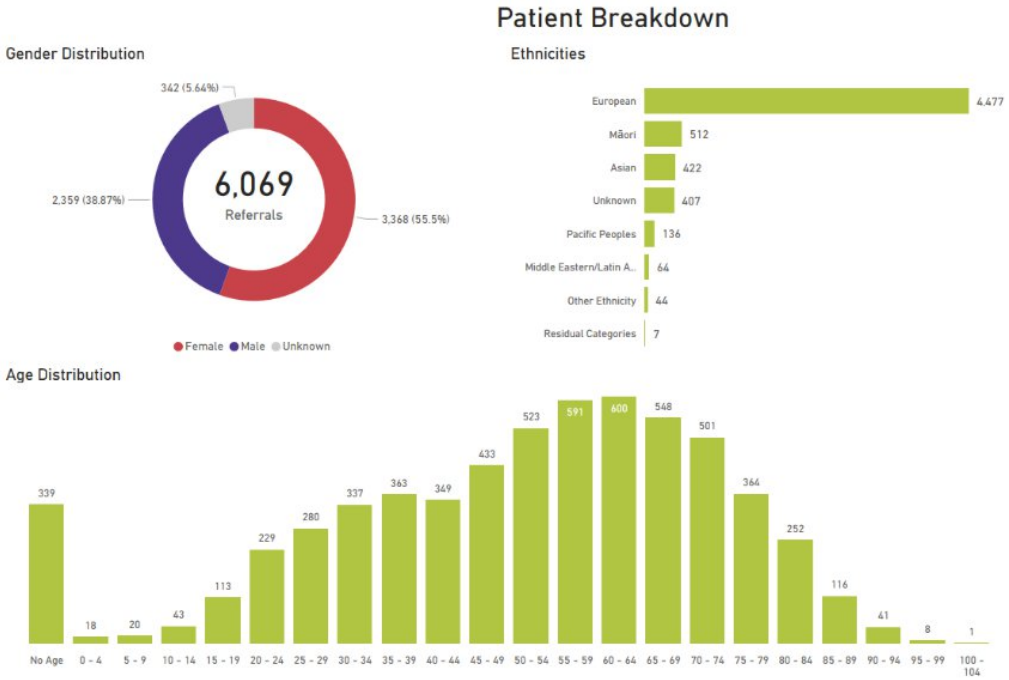


- Given the extended wait-time for first face-to-face contact in CAF services, a new comprehensive telephone triage process has been implemented to prioritise acute and urgent cases, and to ensure that people who do not need our services are signposted to the correct services in a timely way. There is active contact (and reprioritisation where indicated) with young people who are waiting.

LABORATORY SERVICES

- **Electronic Referral Management System (ERMS):** As a part of the changes required to support the COVID response across Canterbury, an ERMS for lab tests was rolled out to enable GP's and outpatients to provide patients with an electronic laboratory request form. This allows patients to present to their

most convenient blood collection centre for their required test without the patient needing a paper request form. The use of ERMS has also had a flow on benefit of being able to provide an overview of the time taken between GP referral and the patient presenting for their blood tests and how many requests remained unfilled across a variety of groups within the Canterbury Health System. The DHB is also exploring an éclair orders option for referrers. ERMS is providing early ethnicity information such as the below, this has enabled more informed decision making and visibility.



- **Equity of Access and Outcomes – Laboratory Data and Reporting:** we have had a small team making lab testing information visible from across the system with business intelligence software. We have targeted some key conditions (e.g. Diabetes) of which there are specific tests we can use as indicators of how well we are doing. We have been able to look at this information by ethnicity, including testing rates, abnormality rates and drug therapies. The prototype report was completed in August and we will now work with primary, and secondary care clinicians as well as our Executive Director of Māori and Pacific Health to review our prototype and assumptions.

- **COVID-19:** COVID pandemic testing remains the largest risk for pathology and laboratories. Business continuity plans have been prepared to ensure we maintain essential services to support the health and wellbeing of our population, including cancer diagnostics and acute non-COVID as well as COVID testing services. Canterbury DHB and Canterbury Health Laboratories received the first drop of samples from Auckland DHB on the 13th and expect an increase in numbers from other regions as demand grows, as well as helping some other DHB labs with supplies.

- Canterbury Health Laboratories continues to be intrinsically involved in the wider Canterbury Health System response to COVID. This is essential as the system works together on managing our pandemic response and phases. Far from the traditional role of providing diagnostics only, the DHB lab was invited to be involved in the planning and delivery of services from the initial phases. The close working relationships developed early on with Canterbury Primary Response Group (CPRG) has resulted in a nimble whole of system approach, allowing an integrated rapid response to national requests for additional activity, such as contact tracing and surveillance testing – all of which have been delivered within tight timeframes, successful due to the nature of the multidisciplinary approach. This now extends to support for the Managed Isolation Facilities, community testing and development of border and staff surveillance programmes. Provision of results in a timely manner and accurate reporting to the Ministry are critical aspects of the national response.

ASHBURTON RURAL HEALTH SERVICES

- Ashburton Hospital services delivers a model of acute and inpatient care provided by generalist-specialist services, with the medical model well embedded and discussions underway for nursing and allied health. Generalist-specialist models are not replicas of specialist services with less full-time equivalents. They are a service model with a breadth of scope that is challenging and complex as they assess and manage complex care, defining who requires the intervention of a tertiary level hospital and how we can maintain care closer to home. It is our clear responsibility to describe the quality, fiscal and population benefits of leading a model of generalist-specialist service delivery and we are developing appropriate dashboards to demonstrate this.

- Ashburton Health Service represents the integration opportunity of multiple services, that in an urban setting are often divided into individual NGO and community organisations only. Our intent is to provide a cohesive functional employer-agnostic ambulatory health system/service in partnership with our primary care and community providers, that meets the needs of our patients right across the system. This includes functional support systems, including employment arrangements that enable people to work across the private and public model, technology that captures patient management and digital service delivery, collectively reflecting the aspirations as best described by Don Berwick.

  "To improve health care, we require not better professions, but better systems of work. A "system" in this sense is a set of elements interacting to achieve a shared aim. Here is the trick: to improve the performance of the system you need to attend more to the inter-actions than to the elements. Great health professionals inter-acting well with all of the other elements of the healthcare system make great health care." Don Berwick, "Medical Associations: Guilds or Leaders? BMJ, Vol 314, 564-1565

- Our local contribution to health expands wider than the hospital base, contributing this month to community initiatives including participating in the Mid Canterbury Suicide Prevention Network Charter, the District Council led Caring for Communities Welfare Recovery Group, alongside a number of community and population health initiatives such as the establishment of a Citizen's Advice Bureau (CAB) and supporting the cohesion of parenting programmes across the spectrum. This cohesive approach is distinctive in rural health care, evidenced in many published research articles that evidence the interdependent relationship between health and community in a rural setting. This in turn highlights one of our many challenges, the agreed descriptive of rural.

- Ashburton Health Services, through our Rural Health Academic Centre (RHACA) has a strong partnership with the University of Otago, and the School of Medicine. It is through this relationship we recently participated in the opportunity to meet with Dr Gary Nixon, who is providing a much-anticipated definition of rural in the context of health care in New Zealand, the team from Dunstan Hospital, and Professor Rathan Subramaniam, Dean of the University of Otago Medical School and Dr Carol Atmore. We were warmly welcomed to this discussion, highlighting Ashburton is considered one of the pillars of rural health service delivery in New Zealand and will be a key partner in any future model of a Rural Health Division established through the University of Otago.

- The challenge has been laid down to consolidate and speak with one rural voice, both nationally and within the DHB models. Alongside this our practical challenge is to co-ordinate the defined rural placements both in primary and rural hospitals for the 55 x 4th year medical students ringfenced for rural placements in 2021. We consider this achievable, and like other models across nursing, we will take the lead and work with our colleagues to make this happen. This is a fundamental to deliver the future workforce we have been aspiring to.

- Closing our challenge is the descriptive of rural, Dr Nixon has highlighted that historically statistics NZ and Health have worked with different definitions. A recent update has reported that health and Statistics NZ have migrated to using SA units which describes population in 200 people units. This is the new methodology adopted by Statistics NZ. Currently DHBs are using census area units. The result is you cannot easily use the data sources to describe equity of access in rural. It is inferred that that inter DHB variations in access to services for rural populations will be much greater. It is this information that cannot easily be accessed as the numerator and denominators will be using different units. In summary reporting on equity of access in a rural community, either by digital platform or face to face, is not robust and our navigation of demand and the response to this in CDHB needs careful consideration.

Dr Nixon's research is due to be published in early 2021, but on questioning, his confirmation is Ashburton Health Services are most definitely rural.

PRIMARY CARE AND COMMUNITY SERVICES

Primary Care

- **Measles Catch Up Programme:** Planning is underway for the Measles Catch up Programme, targeting people aged 15 – 30. A soft roll out of the programme will start in general practice and community pharmacy on 1 September 2020. Practices will be asked to recall eligible people who are overdue for an MMR vaccine, and invite them into be vaccinated. Work is also underway to develop specific Māori and Pacific plans to target those population groups. The national advertising campaign will start in late September (after the election). Current data shows that around 64% of our population is vaccinated for MMR, which leaves around 35,000 people to reach.
- **Primary Care COVID Response in Level 2:** The response in Primary Care is being co-ordinated by the Canterbury Primary Care Response Group (CPRG) which has been operational since March. The Ministry has requested DHBs report testing numbers three times a day at 10am, 2pm and 6pm. The following areas are operational at the time of writing this report however this is a very fluid and changing situation.
- The Whanau ora Welfare Response Centre moved from Nga Hau e Wha marae to the Community Clinic at He Waka Tapu from 3 August 2020. Operating hours were for 4 hours per day, 5 days per week and available to people walking in without an appointment. At Level 2 this immediately ramped up to more than 8 hours per day, 7 days per week at the Nga Hau e Wha marae. This equity response has become core to our testing strategy.
- A pop up community test site at Orchard Road Christchurch Airport was stood up on Saturday 8 August 2020 in response to a South Korean visitor who tested positive once arrival back in Korea. On the 2nd day of Level 2 this site was secured indefinitely from Christchurch Airport and was operational within 24 hours. By 10am on 13 August, 85 people had been tested with 55 people in the queue. The Orchard Road CBAC is also being used in a separate stream to test workers at our aviation border as required by the Ministry of Health.
- The Maritime border at Lyttleton Port commenced testing of port workers from 7 August and is using a combination of the ports Occupational Health nurse and back up from the Mobile Testing Team co-ordinated by Pegasus PHO. This group have been slow to uptake the offer of testing and numbers are small however Community and Public Health are working with Lyttleton Port management to improve communication with workers and are encouraging their consent to swabbing.
- Managed Isolation facilities are being staffed by Canterbury DHB staff who are meeting the health needs of those in isolation and quarantine but are also swabbing these people at days 3 and 12 as well as the hotel staff on a rotational basis. The Primary Care needs are being met by the 24-Hour Surgery.
- General Practice report being very busy with the increase in demand for patients to be swabbed from the commencement of Level 2. From the Canterbury Labs data collated from 9am 12 August to 9am 13 August 1,297 tests were completed of which 783 were requested by General Practice. This compares to just over 1800 tests being completed in the whole week to 9 August. At midday on 13 August Labs reported they had 1800 tests being processed in their system.

COMMUNITY & PUBLIC HEALTH

- **COVID-19 Update:** Community and Public Health continues to focus on the management of cases identified at the border and to ensure staff are fully trained in the necessary platforms for managing cases and contacts. Community and Public Health has continued to devote significant resource to meeting the Ministry of Health's requirements that we be ready to support any surge in COVID cases locally and nationally.

- Extensive local follow up has been necessitated following the identification in South Korea of a COVID positive recent arrival from New Zealand (Christchurch, via Singapore). Locally this situation has involved following up a significant number of people from different settings who may have been in contact with the case to offer them testing and information (as at 03/08 no positive tests have been associated with this case).
- Community and Public Health has played a central role in the establishment of regional psychosocial responses. In addition, the All Right? team almost completely reoriented its work towards supporting psychosocial wellbeing locally and nationally through the 'Getting Through Together' (GTT) campaign. GTT is proving popular, with a significant increase in social media activity and orders of collateral.
- The most recent evaluation of the reach and impact of the All Right? campaign in Greater Christchurch shows a 90% awareness rate among those surveyed, with 40% of these respondents recalling that they had taken some form of action as a result of seeing the campaign.

While the COVID-19 response has dominated, work with HiAP partners continued as possible and was often driven by the pandemic response. Early on CCC approached .C&PH to support their COVID response. The outcome was a collaboratively developed Pandemic Supplement to the Integrated Planning Guide (IPG). Produced, peer reviewed and published in a short space of time, the supplement is designed to be used alongside the IPG with questions and thinking prompts that came to the fore during the pandemic response.

- **Risk Management**
  - Managing increasing demands at the border; ongoing work with partner agencies to manage arrivals/departures at the border (both air and maritime ports)
  - Ongoing work with partner agencies around managed quarantine/isolation for incoming international passengers and passengers arriving on air bridge flights from locations within NZ.
  - Responding to cases in local Managed Isolation and Quarantine (MIQ) facilities.
  - Ongoing work in relation to National Contact tracing Solution (NCTS), including training, data entry and reporting.
  - Readiness to rapidly upscale (including staff and equipment) should case numbers significantly increase.
  - Managing staff availability for COVID-19 work together with demands associated with increasing BAU (i.e. non-COVID priority work).

EFFECTIVE INFORMATION SYSTEMS

- The new ISG iSupport incident management and self-service portal on the ServiceNow platform was released on 11 June for Canterbury and West Coast DHBs. This aligns to our organisation direction to be on an enterprise application and the expiry of our current incident management software.

  iSupport looks and works the same as max, our HR portal which is also on the ServiceNow platform. iSupport allows our staff to log service desk requests directly and keep track of the progress, view knowledge articles and set-up new users.

  Since its launch 22,000 tickets have been logged in iSupport, ranging from 2,700 to 3,000 tickets per week.

  This platform also helps us better support our regional and national customers which is crucial for our role as host for a number of applications.

- **Risks/Issues**
  - **Paging Replacement System:** Our paging system is end of life and requires replacement. Clinical and non-clinical options have been identified including capability available under our Microsoft license, and capital expenditure has been approved in principle.

COMMUNICATION AND STAKEHOLDER ENGAGEMENT

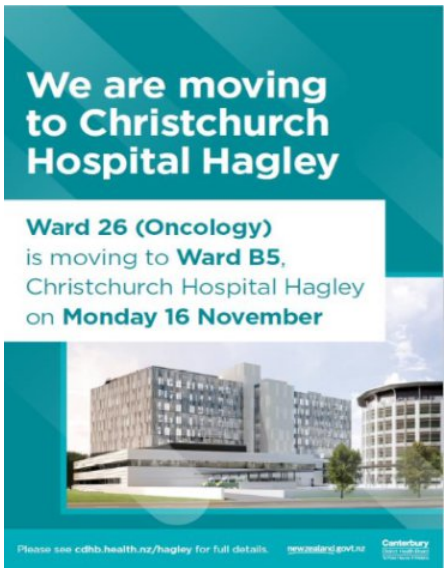
Communications and Engagement

- During July, the Communications Team provided communications support to promote research into the health of Kiwi kids' teeth and raise awareness of the role of community water fluoridation in equitably reducing the severity of cavities. The research, undertaken by a team of legal, public health, dental, water quality, and geospatial specialists, was published in the world-leading child health journal JAMA Paediatrics. Communication activities included coordinating with co-authors from the University of Canterbury on a proactive television media pitch, sending out a general media release, responding to media enquiries and publishing an opinion piece in the CEO Update. The research was covered by TV1 Breakfast and the evening news.
- We have worked with Medsalv on an entry to the Sustainable Business Awards. Medsalv has been working with Canterbury DHB since late 2017 to investigate reprocessing single-use medical devices to enable them to be re-used up to 12 times instead of being sent to landfill after only one use. The first single-use device to be reprocessed was for Deep Vein Thrombosis prevention and Canterbury DHB has realised savings of over $100,000 on that product alone, with the reprocessing of other devices underway or planned as part of an ever-lengthening list.

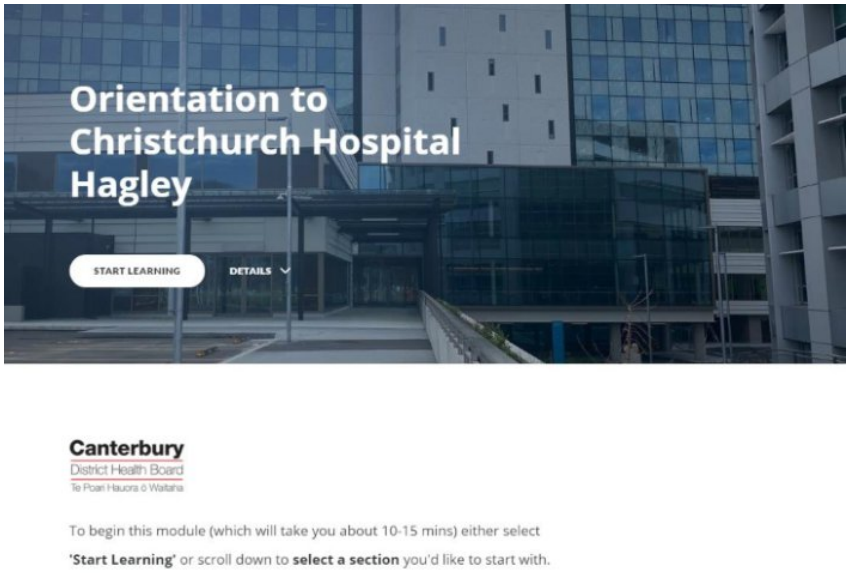
Media

- July was another busy month for media. Specific topics of media interest have included:
  - A media release about the NZ-first use of an electroclave for safely sanitising electronic devices returned for repair
  - Whether mental health consumers identified as 'high risk,' are put in residential care under the Mental Health Act, rather than in appropriately equipped facilities
  - Dr Peri Renison, Chief of Psychiatry, was interviewed by The Press on the impacts of COVID-19 on mental health in Canterbury
  - The number of joint surgeries being carried out in Canterbury, and our plans to resource catching up those missed while under COVID Alert Levels 3 and 4
  - Alcohol-related harm reduction in Canterbury
  - Early childhood dental decay and wait lists for children
  - Guests from hotels in Christchurch being hospitalised, and protocols for managing infection risk from COVID cases being hospitalised
  - Canterbury DHB cost saving initiatives
  - Questions on Rosewood Rest Home and COVID-19 prior to the airing of the Sunday programme and also after the programme went to air
  - Nursing graduate numbers for Canterbury DHB and employment opportunities
  - The number of premature babies during lock-down
  - Expected dates and plans for the National Bowel Screening Programme in Canterbury
  - Questions on our "Expanded Emergency Department" and when it will be up and running
  - Closure of Lauriston school due to tummy bug
  - Interview with Carolyn Gullery on a new 'pool' system for some general surgery and urology electives.
  - Interview of Stella Ward, Chief Digital Office by NZ Doctor on digital integration
  - Media release sent out to mark Cortex platform reaching the 1 million notes milestone, and an interview given by Dr Alistair Rumball-Smith, Co-Funder Sense Medical Ltd (our partner in creating Cortex) to NZ Doctor
- **Christchurch Hospital Hagley – facilities development communication:** The announcement of confirmed dates for handover and migration has kick-started activity for Hīkina to Hagley, including

weekly newsletters and the creation of promotional and informative collateral. Posters, banners, information sheets for patients and a large fence banner are in creation to energise staff and inform the public about the firm dates for the move into the new building. These will be rolled out over the next 12-16 weeks to assist with awareness of and involvement in the move.



- The refreshed healthLearn package is being fine-tuned to provide individual services access to the information most relevant to their specialty, ensuring the courses are tailored and timely for staff. It has been specially built by the L&D team and promises to be accessible and effective for staff learning ahead of migration.



- Most services moving to Hagley have expressed interest in sharing their new spaces with their colleagues through video and planning is underway to carry out profile and showcase videos for each, similar to the Te Nikau video created for West Coast DHB that was well received.
- Additional videos are being produced to assist with orientation and familiarisation of the building. These videos feature footage and photographs from inside Hagley along with 3D renders and floor plans to illustrate the location of wards and services within the building.
- **Maps and wayfinding:** The Communications Team is helping produce maps for transit routes for patient and staff migration and assisting with wayfinding strategies for patients, staff and visitors. This includes work with a 3D animated wayfinding application.

- **Mental Health facilities:** The team is assisting with communications around facilities development for the Hillmorton campus. Staff, public and patient communications are being planned for the impending AT&R facility, North Car Park works, Integrated Family Services Centre and High and Complex Needs units. Plans include static displays in and around campus, community discourse, and regular staff updates that incorporate the cultural narrative and provide useful and engaging information.
- **Canterbury DHB Website:** A helpful online application for changing contact details has been developed for the general public. The electronic form allows people to tell us of a change to their address, doctor, phone number or name. The form can also be used to change the details for several family members at once. Since its launch last month is has been used over 120 times, and has been very positively received with recent feedback saying "Everything was so simple to update all my details".

LIVING WITHIN OUR FINANCIAL MEANS

- The YTD result to June continues to be favourable after the COVID-19 impact, mainly due to a lower capital charge (relating to EQ insurance drawdowns excluded from CDHB's calculation of the payment due, as well as the June 2019 Holidays Act accrual), and depreciation (due to the delay with the Hagley transfer). Although the favourable depreciation variance is a non-operational expense, the delays in Hagley result in additional operational expense that partly offset this variance (eg: outsourced elective surgery). Note this result excludes further Holidays Act compliance costs.
- The following table provides the breakdown of the June result:

		MONTH			YEAR TO DATE		
		Actual	Budget	Variance	Actual	Budget	Variance
		$M	$M	$M	$M	$M	$M
Governance		(0.148)	(0.000)	(0.148)	(0.229)	(0.000)	(0.229)
Funder		(5.024)	(4.524)	(0.500)	(80.290)	(70.763)	(9.527)
DHB Provider		(22.692)	(14.683)	(8.009)	(95.376)	(109.707)	14.331
Canterbury DHB Group Result		**(27.864)**	**(19.207)**	**(8.657)**	**(175.895)**	**(180.470)**	**4.576**

4. APPENDICES

Appendix 1: Facilities Repair and Redevelopment

FACILITIES REPAIR AND REDEVELOPMENT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

General EQ Repairs within Christchurch Campus

- **Parkside Panels:** North-East corner Request for Proposal (RFP) closed at the end of April 2020. Tenders have been reviewed in July and a preferred contractor identified – awaiting approval. Parkside South-East corner RFP documentation being prepared for approval.
- **Lab Stair 4:** The restart of the project will need to be coordinated with longer-term Government COVID-19 response due to the disruption that the construction work will have on the laboratories. The repurposing of the old Eyes Portacoms directly affects access for works. We are currently looking at other options to allow us to undertake this work. All alternatives will have time and cost implications.
- **Riverside L7 Water Tank Relocation:** Maintenance and Engineering (M&E) is managing this project. Management has approved the design for tanks to be relocated to the basement of Parkside. Design has commenced.
- **Riverside Full Height Panel Strengthening:** Design is complete. The Business Case for construction is awaiting final information from the structural engineers prior to submission for approval. Expecting construction to commence 4th quarter of 2020.
- **Parkside Strengthening:** As part of the Parkside seismic strengthening works, the structural consultants have completed the revised Non-Linear Time History Analysis (NLTHA) on Parkside Block A. The submitted report includes concept designs for a strengthening scheme using Fluid Viscous Dampeners (FVD's). The structural consultants are also in the final stages of completing a similar analysis and concept design report for Block B. This is due to be completed in early August. Quantity Surveyors RLB are providing a high-level cost estimate for the options being developed.

Christchurch Women's Hospital

- **Passive Fire Programme Stair 2:** The team has identified several potential passive fire targets for improvement. ROI and Business Case have been placed on hold temporarily due to master planning issues and reassessment of available budget allocations. The balance of fire analysis work is awaiting master plan sign off and migration dates for Christchurch Hagley before works can be programmed to complete proposed works.
- **Level 4:** Crack injection around core to be undertaken. Parent room, kitchen and toilet areas complete. There are difficulties gaining access to the area due to patient levels. Continuing to work with staff to develop options to commence the remedial and passive fire protection works.
- **Level 5:** the small amount of work to the corridor area is unable to commence due to operational constraints - Neonatal Intensive Care Unit (NICU). Working with teams to identify a suitable time but expect to progress work during Women's Passive fire protection works that will occur post Christchurch Hagley occupation.
- **Level 3:** All areas complete except reception, which is to be done at the same time as stair strengthening to minimise disruption.
- Remaining work for levels 3, 4 and 5 are unlikely to occur until after Christchurch Hagley occupation.

Christchurch Hagley Building

- **Ensuite Door Replacement:** Project on hold as requested by the Ministry of Health (MoH). Installation works are tentatively planned to commence 3 August.
- **CT Installation:** Installation work underway.
- **Fluoroscopy:** Following delays with CPB room handover, installation work is tentatively planned to start on the 3rd of August 2020. Works will include drilling the floor slab, fire stopping, electrical works and beam installation.
- **Emergency Department X-Ray Room G228:** Siemens contractor has commenced installation of Ysio X-Ray equipment. The contractor is delayed with the associated fit-out work due to a lack of clarity of responsibilities with the Siemens scope of work. This work is now planned to be completed in August.

Other Christchurch Campus Works

- **Passive Fire/Main Campus Fire Engineering:** Site Redevelopment is making good progress with the initial investigations for all 85+ fire cells on the Christchurch campus. Previously, this work had been planned to progress over several years. Individual Business Cases will continue to be prepared to undertake works within specific areas of the Christchurch Campus buildings, and the scope of work for each fire cell will still require review by Fire and Emergency NZ (FENZ) and the Christchurch City Council (CCC).
    - Draft Business Case prepared for Christchurch Women's Risers, requires FENZ and CCC agreement to scope of work. Procurement, Registration of Interest and consent application documentation have been placed on hold due to master planning changes.
    - Business Case to be prepared for Parkside A passive fire remediation work.
- **Christchurch Hospital Campus Energy Centre (managed by MoH):** Developed design complete with detail design now underway. Some delays have occurred due to the coordination of design elements.
- **235 Antigua St and Boiler House (Demolition):** No work to be undertaken until the new energy centre is constructed and commissioned. This demolition project will be managed by the CDHB.
- **Parkside Renovation Project to Accommodate Clinical Services, Post Hagley:** Planning ongoing. Still waiting on formal advice from management as to the outcome of master planning process and funding.
- **Backup VIE Tank:** This project was included as a separable portion to the Health Labs Stair 4 Project but due to delays in that project this work is now going to be undertaken as a separate item as soon as is practicable.
- **Co-ordinated Campus Program:** Work is progressing on a co-ordinated programme to tie together:
    - demolition of Riverside West
    - relocation of clean and dirty loading docks
    - demolition of the Avon generator building
    - Parkside Panel replacement/repairs and
    - strengthening and passive fire remediation works.

- This will provide insight into timing, relocation requirements and potential sequencing options and issues. It is still subject to confirmation of who goes where and subsequent endorsement in relation to the MoH led campus master plan. It is also dependent on which components of work will be MoH or CDHB managed.
- **Avon Switch Gear and Transformer Relocation:** Design complete. This M&E led project is on hold as it is co-ordinated with Christchurch Hagley commissioning.
- **Avon Generator Building Demolition:** The building is redundant once new Christchurch Hagley generators are commissioned. Business Case for remaining design and demolition has been prepared and submitted for approval. The site will provide space for relocated loading docks. Work cannot commence until after go-live of Christchurch Hagley and 3-month bedding in period for new generators.
- **Riverside Loading Docks:** The loading docks need to be relocated to Riverside East. Concept designs have been completed. A business case to complete designs and undertake work has been prepared and submitted for approval.
- **Cancer Centre Radiology:** A design and budgeting project has been completed for the proposed Cancer Centre to initially house two LINAC machines while considering longer-term requirements. The investigation-stage project is now closed. No more work will be undertaken until guidance has been received from MoH.

Canterbury Health Labs (CHL)

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

Burwood Hospital Campus

- **Older Persons Health (OPH) Community Team Relocation:** Plans to relocate the Older Persons Health Team to the Burwood Administration area are not being progressed. Currently reviewing requirements for an alternative location.
- **Earthquake Repairs:** Six buildings have outstanding earthquake repair work to be completed. Consultants selected to assist with initial scoping work, which will be coordinated with other maintenance and engineering investigations and work.
- **Community Dental Administration Relocation:** The Community Dental Administration team needs to be relocated from the Fergusson building at the Hillmorton Campus. An investigation is underway to ascertain if the Burwood Administration area is a suitable option.

Hillmorton Hospital Campus

- **Hillmorton SMHS:** Detailed design is complete. Finishes have been presented to the Facilities Development Governance Group (FDGG) - Autex and vinyl options to be finalised. ROI for the main construction contractor has been evaluated and five companies have been taken through to RFP. The Northern Car Park RFP closes on 28 July. The project is continuing to programme and on budget.

- **Laundry Repurposing:** Initial concept design to relocate the Design Lab is progressing. The relocation of CAF Outpatients and O/T equipment to the laundry is also being investigated. The financial report is expected in early August.
- **Fergusson Upgrade:** A Business Case has been approved to progress initial designs for the relocation of the admin team from the earthquake-prone Avon building to the Fergusson building. Preliminary works have included reviewing the space in the Fergusson building to establish its suitability, developing some concept costings, and developing a preliminary schedule of accommodation.
- **Food Services Building:** The structural engineer has completed the strengthening design and a consent application will be lodged to CCC in the coming weeks. ROI evaluation is complete, and the contractors have been shortlisted to four. An RFP will be issued to the shortlisted contractors by 7 August 2020.
- **Cotter Trust:** On-going occupation being resolved as part of overall site plan requirements.
- **AT&R:** Project is progressing to the revised programme that takes into account delays caused by COVID-19. Roofing is complete and internal fit-out progressing.
- **Masterplan:** Cost and programme review has been completed and the report submitted. Programme Business Case being developed by Sapere with report delivery time planned for the August Board Meeting.

The Princess Margaret Hospital Campus

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

Ashburton Hospital & Rural Campus

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

Other Sites / Work

- **Central City Health (Endoscopy and Maternity):** Schedule of accommodation and RFP have been prepared. RFP was released on GETS 15 June 2020.
- **Chatham Island Accommodation:** The need for additional accommodation is more pressing following advice that one of the existing rented properties will not be available later this year. Two properties have just been listed for sale close to the health centre. A Business Case has been submitted for their purchase and approved in principle. Currently going through due diligence with the intent of making an offer on these properties.
- **Rangiora Demolition:** ROI submissions have been received and assessed to shortlist contractors to undertake the demolition works and building a new driveway. Five contractors have been shortlisted. The Business Case has been submitted for approval.
- **Selwyn Health Hub:** Developed Design is progressing. An ROI for the main contractor is being prepared. Mock-up sessions at Design Lab started 22 July.

Project/Programme Key Issues

- Sign off on the direction of the Master Planning process is required to plan the next stage of the Programme of Works (POW), Passive Fire and Parkside Panel rectification works.

- Delays to the POW continue to add risk outside the current agreed Board time frames. Key high-risk areas of panel replacement commenced, as instructed by CDHB Board.
- Access to NICU to undertake EQ repairs to floors continues to be pushed out due to access constraints. Work in these areas will not be possible until the Christchurch Hagley project is complete and space elsewhere on the campus becomes available.
- Confirmation on way forward for the Cancer Centre is urgently required to ensure replacement requirements for new linear accelerators are achieved.
- Some CDHB buildings have an NBS of less than 67% and/or unrepaired earthquake damage which creates risks of interruption to clinical services.

FINANCE REPORT 30 JUNE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **20 August 2020**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the consolidated financial result (before comprehensive income and further Holidays Act remediation provision) for the month of June 2020 is a net expense of $27.864M, being $8.657M unfavourable to plan, and year to date $4.576M favourable to plan;
ii. notes the operating result (before indirect items) for the month is unfavourable to plan by $11.444M, year to date $13.542M unfavourable to plan;
iii. notes that net costs associated with COVID-19 pandemic as included in the month of June results are $0.666M, and year to date $17.136M;
iv. notes the operating result (before indirect items) excluding COVID-19 costs, is unfavourable to plan by $10.778M for the month, and favourable to plan YTD $3.594M;
v. notes liquidity (cashflow) risk continues to be a significant concern without any sustainable long term resolution; and
vi. notes that a further $66M accrual will be made for the Holidays Act compliance provision at 30 June 2020 for the Crown consolidation (CFIS) submission, and that the agreement with the Ministry has been that any remediation and rectification will be funded by the centre, although this has not been accrued, as it is likely to be equity support.

3. DISCUSSION

Overview of June 2020 Financial Result

Summary DHB Group Financial Result

The following table provides the breakdown of the June result:

	Appendix	MONTH Actual	MONTH Budget	MONTH Variance	YEAR TO DATE Actual	YEAR TO DATE Budget	YEAR TO DATE Variance
		$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate		(22.922)	(14.628)	(8.294)	(98.419)	(109.569)	11.150
Community & Public Health		(0.049)	(0.037)	(0.012)	(0.414)	(0.186)	(0.228)
Total In-House Provider excl Subsidiaries	**8**	**(22.971)**	**(14.665)**	**(8.306)**	**(98.833)**	**(109.755)**	**10.922**
Add: Funder & Governance							
Funder Revenue	6	157.783	147.650	10.134	1,801.670	1,767.946	33.724
External Provider Expense	6	(73.972)	(63.419)	(10.553)	(815.426)	(773.439)	(41.988)
Internal Provider Expense	6	(88.836)	(88.755)	(0.081)	(1,066.534)	(1,065.270)	(1.264)
Total Funder		**(5.024)**	**(4.524)**	**(0.500)**	**(80.290)**	**(70.763)**	**(9.527)**
Governance & Funder Admin	7	(0.148)	0.000	(0.148)	(0.229)	0.000	(0.229)
Total Canterbury DHB (Parent)		**(28.144)**	**(19.189)**	**(8.954)**	**(179.352)**	**(180.518)**	**1.166**
Add: Subsidiaries							
NZ Health Innovation Hub	9	0.074	0.000	0.074	0.139	0.000	0.139
Brackenridge Services Ltd	9	0.098	(0.003)	0.101	0.362	0.062	0.300
Canterbury Linen Services Ltd	9	0.108	(0.014)	0.122	2.956	(0.014)	2.971
Canterbury DHB Group Surplus / (Deficit)	**2**	**(27.864)**	**(19.207)**	**(8.657)**	**(175.895)**	**(180.470)**	**4.576**

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

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

- Capital charge on the $65M Holidays Act accrual at 30 June 2019; and
- Capital charge on the Hagley facility transfer planned for November 2019; and
- Depreciation expense on the Hagley facility; less
- Additional operational expenses that partly offset this variance (eg, outsourced elective surgery); less
- Additional CME expense; less
- Specific personnel cost claims and Board approved staff and service reconfiguration.

4. KEY FINANCIAL RISKS

Liquidity risk continues to be a key issue.

Note that the capital charge outstanding due to CDHB's position on EQ insurance proceeds was fully paid in July; the impact of this was reflected in the June financial results.

Our liquidity risk has been brought forward by the request to move to 10 day payment terms. The impact of this move will not be fully known until we actually make the transition. The impact on our current cashflow forecast would move our current forecasted inability to clear our financial obligations as they fall due forward by approximately 4-5 weeks. Being a large organisation there are inevitably variations in the daily cashflow, so it is prudent to have a small buffer to allow for payments that cannot be

withheld without significant detrimental impacts on CDHB. We continue to actively manage and mitigate the issue, and continue to send weekly cashflow forecasts to the MoH. We have also continued to raise the liquidity issue with the MoH; at this stage no long term solutions have been clearly identified.

COVID-19 – the forecasted impact of COVID-19 on CDHB's performance is dependent on a number of uncertain parameters, and the long term impact will take some time to determine, and will include factors such as elective revenue, IDF revenue, and ACC revenue, and the costs associated with these (e.g. what level of outsourcing is required to catch up on lost throughput). Refer Appendix 1 for estimated costs to date and forecasted full year costs.

Holidays Act Compliance – the workstream to determine CDHB's liability under the Holidays Act is continuing. The draft report from EY indicates that the potential liability is significantly higher than our current provision, so we will increase our provision for the CFIS submission by $66M. We are likely to have a qualified opinion on this issue in our annual report (as was done last year).

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

Personnel Costs - The costs for the month include an alignment of CME expense and leave liability to the MECA. We had been accruing at less than 100% of the potential CME contractual liability and, with the extension to the time limit that CME can be utilised (due to COVID-19 disruptions), we have prudently increased our provision. Additionally, a job sizing review has resulted in an additional charge in June.

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

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

Land & Building Valuation – Every three years we revalue our land and buildings – these were last revalued 30 June 2019. Between these three yearly cycles we perform a "fair value" assessment – we engage our valuer to assist with this. This year there is uncertainty around market conditions, and it is unlikely that Audit NZ will be able to confirm that our fair value assessment meets their audit requirements. Our audit report is likely to note this uncertainty. This issue is likely to be present with other DHBs (and other commercial entities) as well.

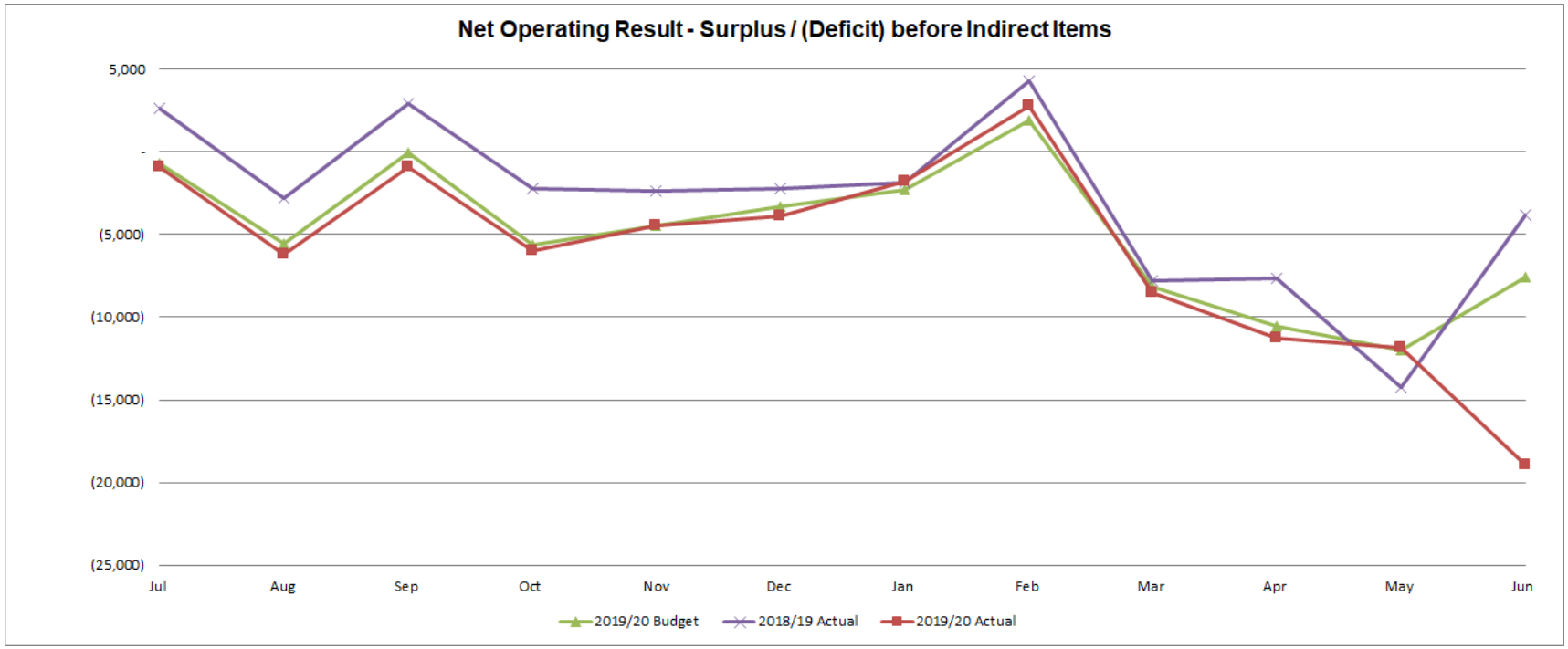
5. APPENDICES

Appendix 1: Financial Result
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 June 2020

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2018/19 Actual $'000
Surplus/(Deficit) before Indirect items	(18,953)	(7,509)	(11,444)	152% ✗	(71,879)	(58,337)	(13,542)	23% ✗	(100,335)



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

KEY RISKS AND ISSUES

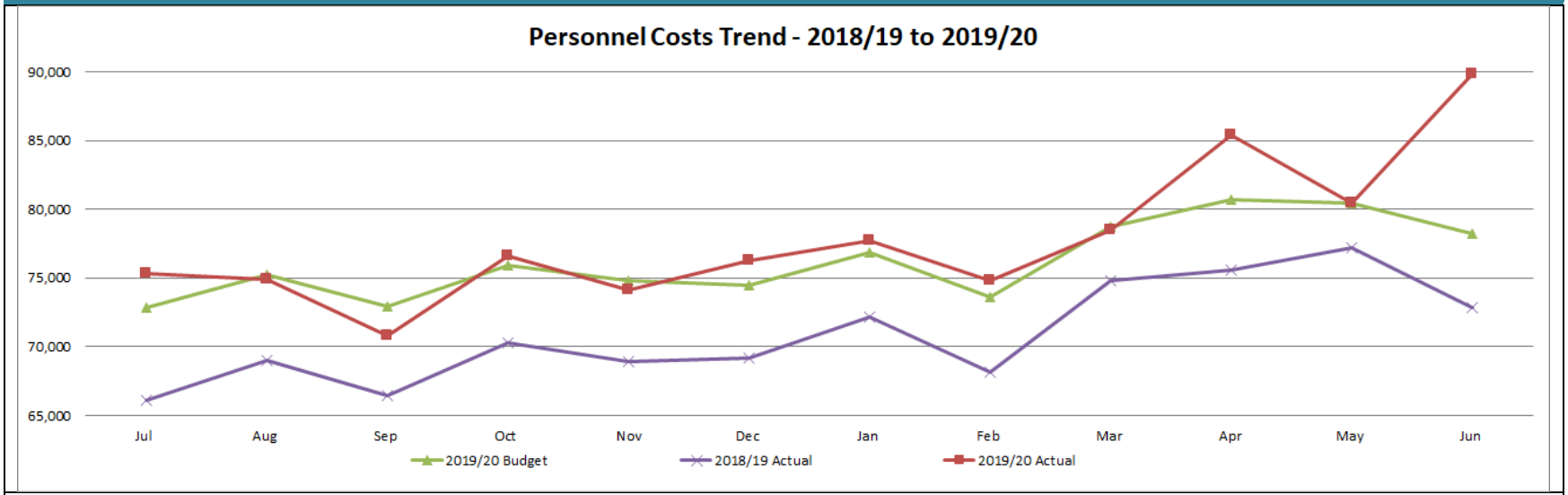
- This graph shows the operating result before indirect items such as depreciation, interest, donations, capital charge and the offsetting new capital charge funding.
- CDHB incurred a net $17.1M of COVID-19 pandemic related costs YTD. Adjusting for these costs, our YTD operating result would have been $3.594M favourable.

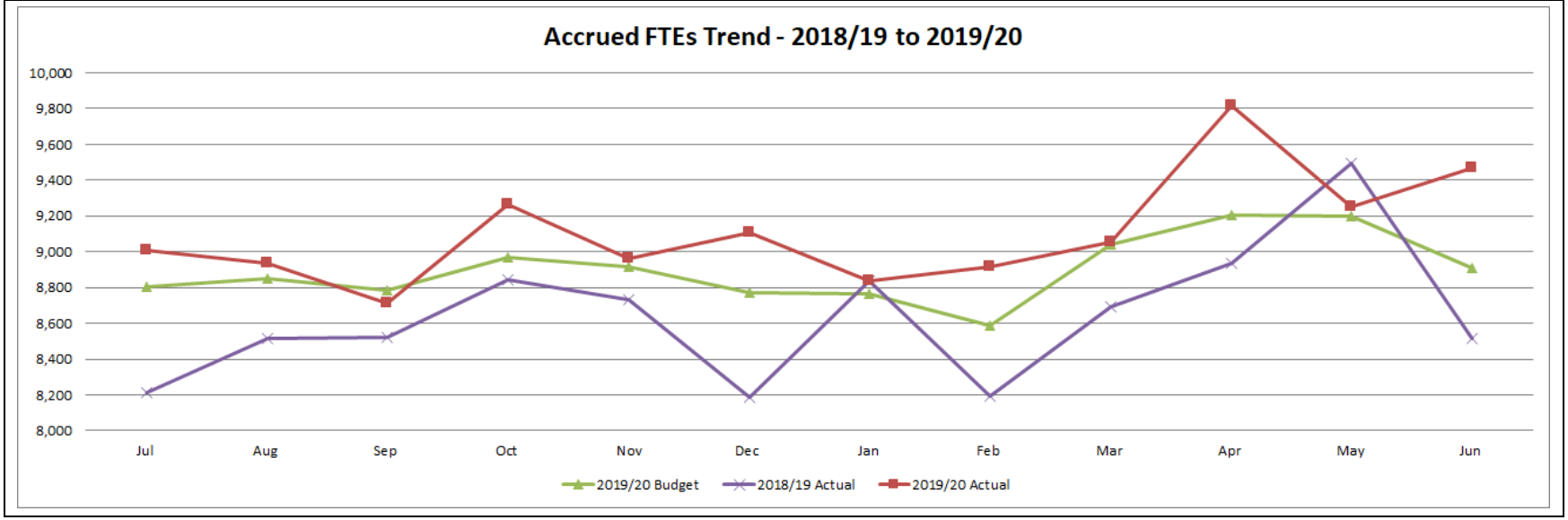
- The following table shows the impact of COVID-19 on the month and YTD:

	Period to date							Year to date						
June 2020 Result Snapshot	Month Actual $000	Month Budget $000	Month Variance F/(UF)	Covid-19 $000	Excl Covid-19 $000	Month Budget $000	Underlying Variance	YTD Actual $000	YTD Budget $000	YTD Variance F/(UF)	Covid-19 $000	Excl Covid-19 $000	YTD Budget $000	Underlying Variance
MOH Revenue	(165,133)	(152,328)	12,805	(1,694)	(163,439)	(152,328)	11,111	(1,870,139)	(1,829,389)	40,750	(16,257)	(1,853,882)	(1,829,389)	24,493
Patient related revenue	(5,129)	(4,097)	1,032	-	(5,129)	(4,097)	1,032	(53,364)	(49,121)	4,243	657	(54,021)	(49,121)	4,900
Other Revenue	(5,904)	(4,110)	1,794	(3,045)	(2,859)	(4,110)	(1,251)	(43,769)	(51,708)	(7,939)	(1,310)	(42,459)	(51,708)	(9,249)
Revenue	(176,166)	(160,535)	15,631	(4,739)	(171,427)	(160,535)	10,892	(1,967,272)	(1,930,218)	37,054	(16,910)	(1,950,362)	(1,930,218)	20,144
Employee expenses	89,878	78,208	(11,670)	395	89,483	78,208	(11,275)	934,806	915,003	(19,803)	7,426	927,380	915,003	(12,377)
Treatment Related costs	16,781	14,709	(2,072)	1,984	14,797	14,709	(88)	160,676	164,745	4,069	5,146	155,530	164,745	9,215
Other expenses	14,488	11,708	(2,780)	904	13,584	11,708	(1,876)	128,243	135,368	7,126	2,266	125,977	135,368	9,392
External Provider costs	73,972	63,419	(10,553)	2,122	71,850	63,419	(8,431)	815,426	773,439	(41,988)	19,208	796,218	773,439	(22,780)
Total expenditure	195,119	168,044	(27,075)	5,405	189,714	168,044	(21,670)	2,039,151	1,988,555	(50,596)	34,046	2,005,105	1,988,555	(16,550)
Operating result	18,953	7,509	(11,444)	666	18,287	7,509	(10,778)	71,879	58,337	(13,542)	17,136	54,743	58,337	3,594
Total Indirect revenue and expenditure	8,911	11,698	2,787	-	8,911	11,698	2,787	104,016	122,133	18,117	-	104,016	122,133	18,117
Total Surplus/Deficit	27,864	19,207	(8,657)	666	27,198	19,207	(7,991)	175,895	180,470	4,575	17,136	158,759	180,470	21,711

- We have received MoH funding to cover most of the expenditure to community providers, however there remain some costs that have not been funded. Other direct costs in our Provider arm are being tracked, and we are submitting weekly reports as requested by the MoH. These additional costs include Public Health costs associated with border screening and contact tracing. Our Laboratory also has additional workload and costs associated with testing, and we are more involved with the provision of isolation facilities. Outpatient volumes and all elective surgery volumes have been impacted from mid March. The pandemic situation has presented unique challenges for staffing and roster modelling to ensure both staff and patient safety, which has led to higher payroll costs. Payroll costs also include the impact on leave taken.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE

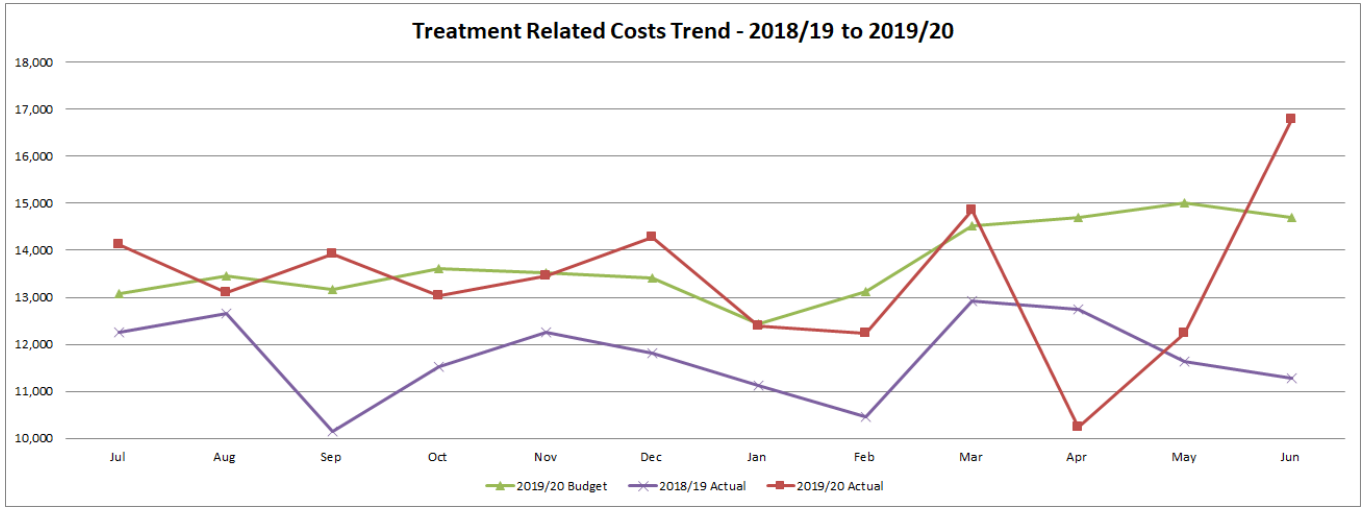


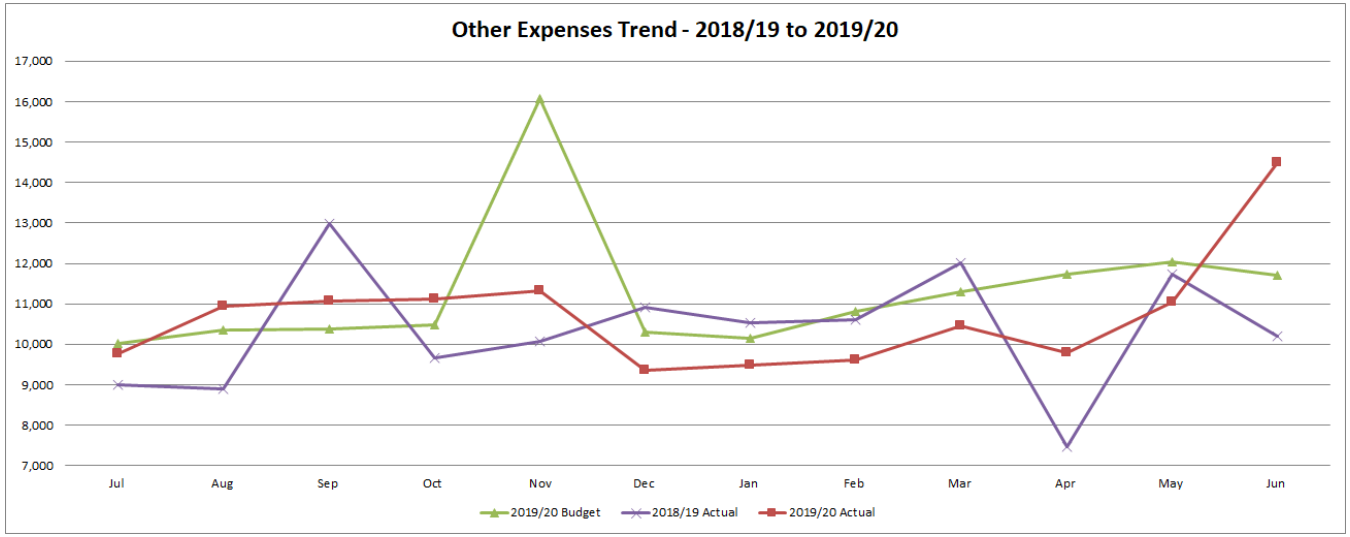


KEY RISKS AND ISSUES

- Although there continues to be a focus across the whole DHB on staff taking leave to ensure personnel costs remain on budget, leave management initiatives have been severely disrupted with the COVID-19 issue, eg Senior Doctor CME leave has seen significant cancellations. In addition there was FTE resource utilised for incident management of COVID-19. The Hagley delay has also impacted the results.
- Medical costs for the month include an alignment of CME expense and leave liability to the MECA. We had been accruing at less than 100% of the potential CME liability, and, with the extension to the time limit that CME can be utilised (due to COVID-19) we have prudently increased our provision. Additionally, a job sizing review has resulted in additional expense charge in June.
- We have transitioned cleaning services to an in-house model from 1 December; the payroll cost increase for June is $0.695M, and for the 7 months to June is $4.480M - this is offset by a reduction in cleaning costs reported in Other Expenses for June of $0.803M, and $5.4M YTD.
- Accrued FTE: The transition of cleaning from an outsourced provider to an in-house model has impacted of an additional 180 people from December 2019. FTE is higher than plan due to COVID-19. Note the FTE shown in this graph is an “accrued” FTE, and differs from contracted FTE. The methodology to calculate accrued FTE causes fluctuations on a month to month basis dependant on a number of factors such as working days (the range is 21-23 across the year), the accrual proportions, annual leave impacts (particularly school holidays, Easter, Christmas and New Year periods), etc. The accrued FTE largely correlates with the trend in contracted FTE.

TREATMENT & OTHER EXPENSES RELATED COSTS



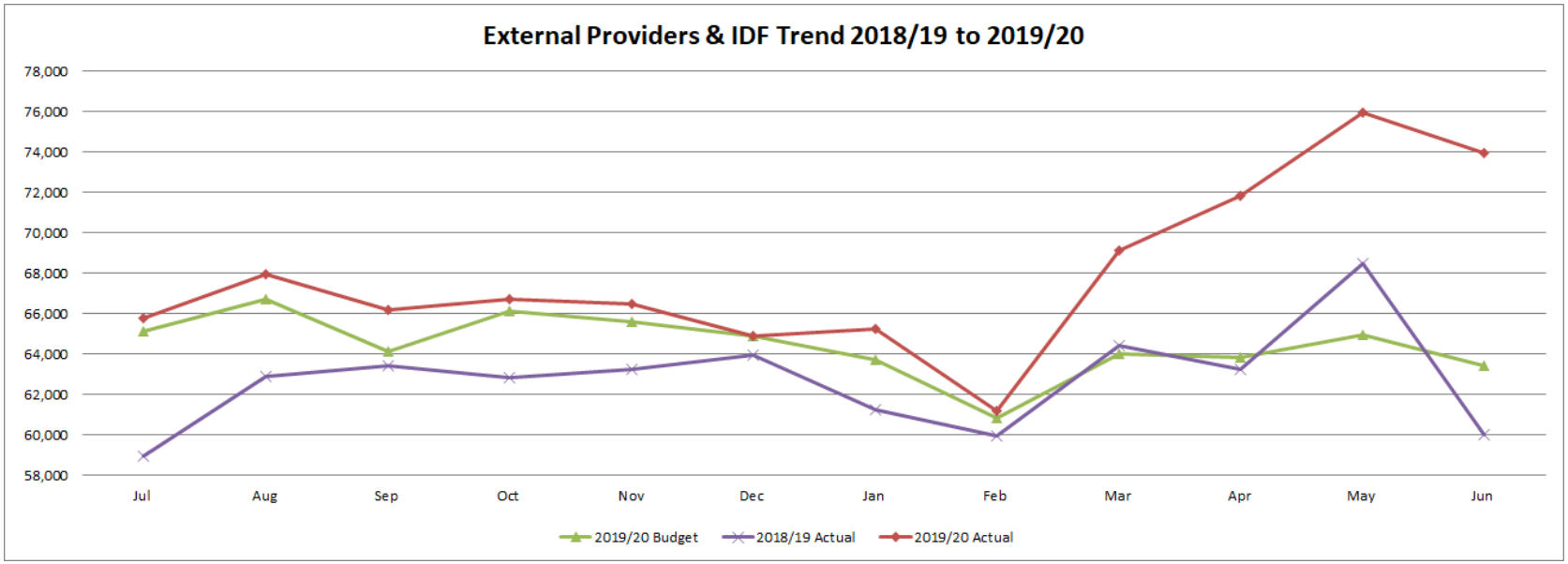


KEY RISKS AND ISSUES

- The increase in clinical costs for the month of June is due primarily to treatment disposables and diagnostic supplies. We also received additional MoH revenue in our Labs Division for COVID-19 tests performed. Clinical costs are coming back to the level expected pre COVID-19.
- June treatment related costs include a correction to a May transaction recording COVID PPE stock given to CDHB from MoH (May costs should have been higher, and June lower).
- Growth in pharmaceutical spend YTD is higher than planned but is being masked by an adjustment to PCT recovery costs where the budget sits in the Provider but the costs are being incurred in External Providers. Hospital pharmacy costs continue to increase, specifically immunosuppressants and cancer drugs.
- The November budget for Other Expenses included $5M for the opex portion of the Tunnel handover (which will be offset by an equal earthquake programme of works drawdown). The forecast has been amended to reflect the delay in the Hagley handover to the 2020/21 financial year. YTD expenditure is $8.9M favourable due to earthquake expenditure – this is matched with an unfavourable variance in Operating Revenue.
- We have transitioned cleaning services to an in-house model from 1 December. The reduction in Other Expenses is $6.9M YTD, partly offset by increased payroll costs, ie there is a savings component to this service delivery change.
- Security costs in our Specialised Mental Health division continue to be higher than planned. Additional facility costs continue to be incurred in relation to The Princess Margaret Hospital (TPMH) campus, including security, basic maintenance etc. Some of these additional costs are in relation to a number of mental health services that remain stranded at that site. Although we have Ministerial approval to progress a shift of services to Hillmorton, TPMH is still unlikely to be fully vacated until the 2022/23 financial year.

EXTERNAL PROVIDER COSTS

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000			2018/19 Actual $'000
External Provider Costs	73,972	63,419	(10,553)	-17%	✗	815,426	773,439	(41,988)	-5%	✗	756,973



KEY RISKS AND ISSUES

- External provider expenditure was $10.553M unfavourable - $2.1M of this relates to COVID-19 costs.
- We were recently advised that our contribution to the national haemophilia costs has been increased by $1.6M for this financial year.
- Community pharmaceutical costs have been increasing in recent months, in line with the increase in the CPB. PCT continues to be impacted by the addition of the high cost non-PCT medicines which relate to conditions with a high prevalence in South Island populations.
- Note that part of the month, YTD and year end forecast variance relates to PCT drugs where the budget is in the Provider arm, but expenditure is being recognised in External Providers. This will be corrected in the 2020/21 financial year.

FINANCIAL POSITION

	YTD Actual $'000	YTD Budget $'000	Variance $'000	
Equity	558,271	1,132,950	574,679	51% ✔

	YTD Actual $'000	YTD Budget $'000	Variance $'000		2018/19 Actual $'000
Cash	(6,966)	(62,397)	55,431	✔	(31,576)

KEY RISKS AND ISSUES

- The equity variance to budget is due to the Holidays Act compliance provision made in June 2019 that impacted retained earnings, as well as the large increase anticipated in November 2019 related to the new Hagley facility handover which will now occur post 30 June 2020. The increase in April as shown in the graph relates to the $130M of equity injection received in the month.
- The sweep account was in funds at the end of June with a balance of $11M. In April we received a $130M equity injection, noting that $80.5M of cash advances was repaid from our 4 June MoH funding. This has alleviated our liquidity issue in the short term. Depending upon when we transition to paying suppliers within 10 working days, the date we will no longer be able to pay our debts as and when they fall due is within the first half of the new financial year.
- COVID-19 expenses have also added to our cashflow situation.
- A longer term resolution to our liquidity issue from the MoH and Treasury is urgently required to avoid CDHB defaulting on payments when they fall due.

APPENDIX 2: CANTERBURY DHB GROUP INCOME STATEMENT

The Group financial results include Canterbury DHB and its subsidiaries
For the year ending 30 June 2020

Month					Year to Date				
19/20 Actual 000's	19/20 Budget 000's	18/19 Actual 000's	Variance to Budget 000's		19/20 Actual 000's	19/20 Budget 000's	18/19 Actual 000's	Variance to Budget 000's	
165,133	152,328	143,122	12,805 ✓	MoH Revenue	1,870,139	1,829,389	1,740,486	40,750 ✓	
5,129	4,097	4,290	1,032 ✓	Patient Related Revenue	53,364	49,121	49,201	4,243 ✓	
5,904	4,110	3,415	1,794 ✓	Other Revenue	43,769	51,708	39,747	(7,939) ✗	
176,166	**160,535**	**150,826**	**15,631**	**Total Operating Revenue**	**1,967,272**	**1,930,218**	**1,829,434**	**37,054**	
89,878	78,208	138,075	(11,670) ✗	Personnel Costs	934,806	915,003	915,946	(19,803) ✗	
16,781	14,709	11,281	(2,072) ✗	Treatment Related Costs	160,676	164,745	140,795	4,069 ✓	
73,972	63,419	63,721	(10,553) ✗	External Service Providers	815,426	773,439	756,973	(41,988) ✗	
14,488	11,708	6,783	(2,780) ✗	Other Expenses	128,243	135,368	116,055	7,126 ✓	
195,119	**168,044**	**219,860**	**(27,075)** ✗	**Total Operating Expenditure**	**2,039,151**	**1,988,555**	**1,929,769**	**(50,596)** ✗	
(18,953)	**(7,509)**	**(69,033)**	**(11,444)** ✗	**Total Surplus / (Deficit) Before Indirect Items**	**(71,879)**	**(58,337)**	**(100,335)**	**(13,542)** ✗	
32	85	- 195	(53) ✗	Interest Revenue	695	939	627	(244) ✗	
685	685	-	- ✓	MoH Revaluation Cap Charge funding	8,220	8,220	-	- ✓	
-	748	-	(748) ✗	MoH Debt Equity Swap funding	-	3,740	-	(3,740) ✗	
242	127	314	115 ✓	Donations	3,674	2,586	4,067	1,088 ✓	
-	1	0	(1) ✗	Profit on Sale of Assets	17	7	133	10 ✓	
959	**1,646**	**119**	**(687)** ✗	**Total Indirect Revenue**	**12,606**	**15,492**	**4,827**	**(2,886)** ✗	
2,656	5,693	1,195	3,037 ✓	Capital Charge	38,136	53,864	24,241	15,728 ✓	
7,208	7,601	7,765	393 ✓	Depreciation	78,028	83,161	57,515	5,133 ✓	
19	50	156	31 ✓	Interest Expense	401	600	552	199 ✓	
- 13	-	14	13 ✓	Loss on Sale of Assets	57	-	23	(57) ✗	
9,870	**13,344**	**9,131**	**3,474** ✓	**Total Indirect Expenses**	**116,622**	**137,625**	**82,331**	**21,003** ✓	
(27,864)	**(19,207)**	**(78,045)**	**(8,657)** ✗	**Total Surplus / (Deficit)**	**(175,895)**	**(180,470)**	**(177,839)**	**4,576** ✓	

APPENDIX 3: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 30 June2020

Audited 30-Jun-19 $'000		Group Actual 30-Jun-20 $'000	Annual Group Budget 30-Jun-20 $'000
496,272	Opening Equity	597,378	662,639
141,600	Net Equity Injections / (Repayments) During Year	136,588	650,781
	Other Movements (NZHIH)	200	-
137,345	Reserve Movement for Year	(3,068)	-
(177,839)	Operating Results for the Period	(172,827)	(180,470)
597,378	**TOTAL EQUITY**	558,271	1,132,950
	Represented By:		
	Current Assets		
4,999	Cash & Cash Equivalents	4,066	627
750	Short Term Investments	750	750
91,010	Trade and Other Receivables	100,853	91,010
5,838	Prepayments	5,649	5,838
13,209	Inventories	14,549	13,209
14,510	Restricted Assets	14,425	14,685
130,315	**Total Current Assets**	140,292	126,119
	Less Current Liabilities		
36,575	Overdraft	11,032	63,024
123,935	Trade and Other Payables	138,208	123,936
14,760	Restricted Funds	14,441	14,760
245,602	Employee Benefits	277,643	180,342
420,872	**Total Current Liabilities**	463,298	382,062
(290,557)	**Working Capital**	(323,006)	(255,943)
	Non Current Assets		
16	Restricted Funds	16	16
3,225	Investment in NZHPL	3,225	3,225
890,595	Fixed Assets	884,340	1,391,554
893,837	**Term Assets**	887,581	1,394,795
	Non Current Liablilties		
5,902	Employee Benefits	6,304	5,902
5,902	**Term Liabilities**	6,304	5,902
597,378	**NET ASSETS**	558,271	1,132,950

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

APPENDIX 4: CASHFLOW

Audited 30-Jun-19 $'000		Actual 30-Jun-20 $'000	Budget 30-Jun-20 $'000
	CASHFLOW FROM OPERATING ACTIVITIES		
	Cash was provided from:		
(52,680)	**Net Cash from Operating Activities**	(48,843)	(97,305)
	CASHFLOW FROM INVESTING ACTIVITIES		
	Cash was provided from:		
(43,992)	**Net Cash from Investing Activities**	(63,334)	(70,913)
	CASHFLOW FROM FINANCING ACTIVITIES		
	Cash was provided from:		
(29,715)	**Closing Cash Balance**	(6,966)	(62,397)

HAC – 6 AUGUST 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Jo Kane, Deputy Chair, Hospital Advisory Committee**

DATE: **20 August 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 Hospital Advisory Committee's (*HAC*) public meeting held on 6 August 2020.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from HAC's public meeting on 6 August 2020 (Appendix 1).

3. APPENDICES

Appendix 1: HAC Draft Minutes – 6 August 2020

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 6 August 2020, commencing at 9.00am

PRESENT
Jo Kane (Deputy Chair); Dr Rochelle Phipps; Ingrid Taylor; and Michelle Turrall.

Via Zoom – Andrew Dickerson (Chair); Catherine Chu; James Gough; and Naomi Marshall.

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg, Jan Edwards; and Sir John Hansen (Ex-officio).
An apology for lateness was received and accepted from Ingrid Taylor (9.10am).

EXECUTIVE SUPPORT
Mary Gordan (Executive Director of Nursing); Carolyn Gullery (Executive Director, Planning Funding & Decision Support); Jacqui Lunday-Johnston (Executive Director, Allied Health, Scientific & Technical); Sue Nightingale (Chief Medical Officer); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES
David Meates for absence.

IN ATTENDANCE
Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Helen Skinner, General Manager, Older Persons Health & Rehabilitation
Greg Hamilton, General Manager, Specialist Mental Health Services
Kirsten Beynon, General Manager, Laboratories
Win McDonald, Transition Programme Manager Rural Health Services
Berni Marra, Manager, Ashburton Health Services

Item 4
Norma Campbell, Director of Midwifery CDHB & WCDHB
Sonya Matthews, Charge Midwife Manger of Birthing Suite
Laura Aileone, Project Manager

Draft

The meeting was Chaired by Jo Kane, Deputy Chair of the Hospital Advisory Committee (*HAC*).

Hector Matthews opened the meeting with a Karakia and mihi to Michelle Turrall.

Andrew Dickerson, Chair of HAC, acknowledged the recent resignation of Sally Buck from the Board of the CDHB, thanking her for her valued contribution to HAC over several terms.

1. INTEREST REGISTER

Additions/Alterations to the Interest Register
Michelle Turrall is to provide her interests to the Board Secretariat.

There were no additions/alterations.

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (06/20)
(Moved: Dr Rochelle Phipps/Seconded: Andrew Dickerson – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 4 June 2020 be approved and adopted as a true and correct record."

Ingrid Taylor joined the meeting at 9.10am.

3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

4. MATERNITY ASSESSMENT UNIT – 9 MONTH UPDATE

Pauline Clark, General Manager, Medical & Surgical; Women's & Children's Health, & Orthopaedics, introduced Norma Campbell, Director of Midwifery CDHB & WCDHB; Sonya Matthews, Charge Midwife Manager of Birthing Suite; and Laura Aileone, Project Manager. Louise McKinney, Clinical Lead, and Emma Jackson, Clinical Director, were both apologies for today's meeting.

The paper provided a nine month overview of the newly established Maternity Assessment Unit (*MAU*), the first of a number of really positive changes to be reported. It was noted that it is positive for women and whanau, and it is positive for staff.

Ms Campbell noted the MAU was established in August 2019 with the purpose of being able to redirect as clinically appropriate antenatal activity to a dedicated assessment space. The initial goal being able to improve flow and redirect a quantum of antenatal attendances per month from the Birthing Suite environment, thus creating more capacity within Birthing Suite to deal with intrapartum care and acute presentations. This also brought Christchurch Women's Hospital (*CWH*) into a more nationally and internationally consistent model with a clearer pathway for presentation, assessment and treatment as required.

The MAU has seen positive results within the last nine months since establishment, including the following:

- Approximately 206 antenatal assessments per month have been taken off Birthing Suite.
- There are approximately 152 less women attending Birthing Suite for assessment per month – so antenatal assessment workload decreases for staff in this area.
- The average wait time for women having antenatal assessments has reduced by 47% (three hours 30 minutes to one hour 52 minutes). Previously, some women were waiting on Birthing Suite for up to seven hours for assessment.
- The MAU is costing less to run with fewer staff rostered than had previously been forecasted prior to implementation. Staffing numbers have been continually refined throughout the last nine months.
- There has been no additional cost to Birthing Suite for consumables (MAU consumables come from Birthing Suite).

- Overall, Lead Maternity Carers (*LMCs*) are more satisfied with the MAU than the previous Birthing Suite process.
- Consumer feedback has highlighted that women are happy with the care they receive through the MAU.
- The MAU is completely midwifery led.
- Medical staff feedback is highly supportive of this unit and the positive impact this has on the birthing suite workload.

Next steps for development include:

- Maintain the MAU as a unit.
- Expand the functionality to include Day Assessment Unit (*DAU*) activity and essentially have both planned and unplanned antenatal assessments in one space. This to be renamed Antenatal Assessment.
- Note the potential changes to greater primary assessments within the community (clinics now established at Lincoln and Rangiora, during COVID-19) with the Women's Outpatient Clinic realignment work, including greater use of telehealth from rural units (ie. Ashburton, Kaikoura and West Coast).
- Review what component of women could potentially have planned care (i.e. twice daily CTGs) through the MAU, rather than be admitted onto the Maternity Ward as an inpatient admission.
- Review what space may be required to be occupied to maintain MAU functionality, if the current Parkside location requires vacating.
- Note the current Misoprostol for Induction of Labour Project and the potential for a cohort of women to start their induction of labour (*IOL*) on MAU with the new regime. The MAU must be within the CWH footprint for this to occur.

The ethnicity of MAU attendees was noted as follows: 15% Asian, 62% European, 16% Maori, 2% Middle Eastern/Latin American/African; and 4% Pacific Peoples.

There was discussion on the Induction of Labour Project and the intention to shift away from the current drug used to a new drug, which will save around $120K a year, as well as meaning women will mostly go into labour within 24 hours resulting in better outcomes. It is a priority to do this piece of work for our population of women and their babies.

There was a query around the reduction in wait times for some significant presentations and whether there was data on reduction in harm. Ms Matthews advised there is anecdotal data. There have been no SAC 1s. This is a reflection of the more rapid assessments.

Ms Clark also noted the close working relationship with Dr Nicola Austin and the Neonatal Unit.

Ms Kane noted it was a very people centric initiative and encapsulates necessary partnerships and relationships – a very valuable piece of work. The Committee thanked those in attendance for the update and asked that the Committee's appreciation be passed to the rest of the team for the very positive start to this piece of work on the Maternity Strategy.

Draft

Resolution (07/20)
(Moved: Naomi Marshall/Seconded: Ingrid Taylor – carried)

"That the Committee:

i. notes the paper and outcome update of MAU; and
ii. notes the need to progress combining unplanned and planned antenatal activity in the same physical space."

5. H&SS MONITORING REPORT

Ms Kane congratulated Greg Hamilton on his recent appointment as General Manager of Specialist Mental Health Services.

The Committee considered the Hospital and Specialist Services Monitoring Report for July 2020. The report was taken as read.

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

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

- Had a very warm welcome from Mental Health and has found a division that is in very good heart, even better than hoped.
- Have continued growth particularly in Child, Adolescent and Family. That will remain an ongoing area where the increased volume has caused waiting times that are not acceptable. There is a lot of energy going on to make sure the right people are seen in a timely way. We are triaging and re-triaging that list of referrals coming onto the list, so that although the average wait time is not good, there has been quite a change in the active process to ensure that those who need early access are getting it. Have brought in a second tier of clinical support, some of whom have made it their life passion to get the wait lists down. A lot of effort and passion going into this, as the team recognises the risk factors.

There was a query around data for under 12s and over 12s being separated out, volumes continuing to rise and barriers associated with this. Mr Hamilton noted that the problem we have is a multi-sectorial problem, that is being referred to Mental Health to solve. There are a lot of children in the under 12s who have problem behaviours in a school environment that we are asking Mental Health teams to do an assessment of in order to access education support. A paper was requested providing further detail and analysis on CAF presentations, and in particular under 12s.

There was a query around an article relating to an increase in eating disorders in teenagers. Mr Hamilton advised this is a very specialised service. The increase in volume that has been reported is not what CDHB's clinical leader in that area is seeing.

Hospital Laboratories – Kirsten Beynon, General Manager, Laboratories

- Bowel Screen Readiness Audit: the DHB has had its audit from the MoH and peer review of Bowel Screening Readiness. Verbal feedback from the Clinical Director of Anatomical Pathology (*AP*) is that this has gone extremely well, with positive comments made on the preparedness of the overall project across the DHB and commitment to ensure its success.

  The assessors commented on our cramped facility and that in their opinion the only reason we cope with our workload in these circumstances is due to our high quality processes. They would like to see a timeline documented for facilities improvement.

- Equity of Access and Outcomes: A small team making visible lab testing information from across the system with business intelligence software. We have targeted some key conditions (eg. Diabetes) of which there are specific tests we can use as indicators of how well we are doing. We have been able to look at this information by ethnicity, including testing rates, abnormality rates and drug therapies. The prototype report was completed this week and we will now work with primary and secondary care clinicians, as well as our Executive Director of Maori and Pacific Health, to review our prototype and assumptions.
- COVID-19 remains front and centre for pathology and laboratories. CHL has taken an integrated approach to our COVID-19 diagnostic strategy and are playing a key role in supporting the system response in partnership with primary and secondary care. CHL is also focussed on ensuring we have robust business continuity plans for when we have another wave of COVID-19 to ensure we maintain essential services to support the health and wellbeing of our population, including cancer diagnostics and acute non-COVID-19 as well as COVID-19 testing services.

There was a query around supply and demand challenges with regard to COVID-19. Ms Beynon advised that everyone learnt a lot from the first wave. All laboratories around the country are working together, as well as closely with the MoH. Teams have done a lot of work around maximising the use of consumables and reagents. There is a Plan A,B,C & D.

There was discussion around the Bowel Screening Programme roll out. Carolyn Gullery, Executive Director, Planning Funding & Decision Support advised we are working towards a November 2020 rollout, but this is dependent on being able to demonstrate we can pull back the people who are long waits on the list (both diagnostic and surveillance). We need to provide a plan that shows that we are meeting our step down to reduce that.

There was a query whether COVID-19 had moved point of care testing initiatives forward. Ms Beynon advised there is point of care testing in Canterbury in support of our hospital and acute setting, and within specific criteria. This is an area where there is still a shortage in supply.

There was a query about the randomness of pop-up testing, as well as the testing of various staff working in quarantine facilities. Sue Nightingale, Chief Medical Officer, advised there is very good Infection Prevention and Control (*IP&C*) processes and rules about PPE. The IP&C team is circulating through the hotels regularly checking on people to make sure that things do not slip. There is surveillance testing being done at the hotels with staff. It was noted that mixed messages are being received from the MoH as to what they are requiring with regards to pop-ups. Most of the surveillance targets are directed by the MoH; we then work as a team (Labs, Primary Care, Emergency Management Team) to get these set up within 24 hours.

In response to a query about people who missed their cervical screening appointments during the lockdown period, Ms Gullery confirmed that these are all being picked up and are being managed through primary care.

Rural Health Services – Win McDonald, Transition Programme Manager

- Continuing to see an increase in end of life care across rural facilities.
- Working well with primary providers and tertiary facilities.
- Increased challenges with Chatham Islands, with a team (whole of stakeholders group) in place to provide assistance. It was noted a Chatham Islands update report is scheduled for the Committee's 1 October 2020 meeting.
- Services in rural facilities are being maintained at a high level and community need is being met.
- Working with Statistics NZ and the information coming from Decision Support on the equity of access across primary care in rural.

There was discussion around Ellesmere and Waikari hospitals, future capacity and sustainability of facilities to cope with the demand for end of life care given the aging population, as well as growing dementia rates. Ms Gullery noted it has always been the strategy to maintain access to end of life care in the rural communities. A paper was requested on initiatives to support the rural older population to remain in their own homes/communities into the future.

Rural Health Services – Berni Marra, Manager, Ashburton Health Services

- Presentations of persons over 75 years to Acute Assessment Unit (*AAU*). Information presented is a watching brief – not tracking or seeing an increase post COVID-19 of presentations or admissions of people over 75 years into the Ashburton Area.
- The community remains concerned about access to primary care.
- Primary care is not necessarily understanding the restorative model of care being talked about. An opportunity for Allied Health, District Nursing and Clinical Nurse Specialist workforce to go into the primary care practice environment in order to build and sustain the level of community service delivery.
- Working closely with Garry Nixon, a doctor from Dunstan who is also partnered with the Otago of University, on determining a rural generalist model. A collaborative piece of work to design what is sustainable generalist delivery and how to partner with other rural hospitals. The intent is to keep people away from the tertiary centre by maintaining strong, stable and cost effective care in the local community.

There was discussion around presentations coming through to AAU, with it noted that triage 3 is where the growth level is.

Medical/Surgical; & Women's & Children's Health; & Orthopaedics – Pauline Clark, General Manager

- Whilst do not have influenza presentations, a number of other presentations are being experienced across Medicine and General Surgery.
- Contributing staff to quarantine and isolation facilities, and also contributed to the successful move on the West Coast into their new facility.
- National Bowel Screening Programme Rollout Readiness Assessment. The team was down from Wellington on 5 August 2020.
- Migration planning is well underway, with confirmation that the move into Hagley will commence on Monday, 16 November 2020.
- Strong focus on planned care ESPIs, with most services scheduled to meet compliance by the end of this calendar year. Coupled with this, is picking up on those people who were not seen during COVID-19.
- Focused on the Leave Care Programme.
- Experiencing a number of random requests from the MoH. All valid questions, but no coordination.

There was a query around staff being made available for the quarantine facilities. Ms Nightingale advised that five were working in other places, but that has now stopped – 76 others were not. Ms Nightingale noted that CDHB did not think this was necessary, given the IP&C structures CDHB has in place. CDHB sees people with infectious diseases in hospital all the time and nurses are not stood down after care has been provided to them. So whilst we are complying, we do not agree that it is necessary.

Draft

Older Persons Health & Rehabilitation Service – Helen Skinner, General Manager

Ms Kane welcomed Helen Skinner as the new General Manger of Older Persons Health & Rehabilitation Service, as well as maintaining her role as Chief of Service.

- Ongoing demand for older persons health beds. During COVID-19, were at high levels of occupancy and also providing increased numbers of community contacts, both virtually and at home. That demand in terms of need in the community has continued.
- Inpatient demand, particularly for older persons health beds has been driven predominantly around surgical and orthopaedic flow.
- Highlighted the floor line beds trial, one part of a piece of work being done around clinical governance, which has been a high priority for the division. An ongoing programme of work to reduce falls, has reduced falls, but in particular has reduced significant harm. Year to date has seen a reduction of more than 40% in significant harm in terms of SAC 2 events compared to the year prior.
  The floor line beds trial looks at falls and the ongoing reduction in significant harm for patients who fall, but also how from a cost point of view we continue to work on that. One of the challenges has continued to be around how safety is maintained as well as looking at things fiscally. Close observation in terms of hospital aides has been high as we continue to keep patients safe.
  The fall line beds trial initiative, led by one of the Nursing Directors in conjunction with the Clinical Director for Older Persons Health, started last month. It has been running for 2½ weeks. There have been no falls in terms of patients who have been using the floor line beds. There has been an estimated saving on two wards in two weeks of $1,700 on reduction in close observation. The trial will run for three months, with a potential roll-out dependent on the outcome.

Discussion took place on the floor line beds trial. It was noted that the driver behind the initiative is reducing patient harm, keeping patients safe. It is only one part of a piece of work to reduce harm. There is also a big project on pressure injury prevention; a lot of work on falls prevention; and work on medication instances.

There was a query around voice activated alarms, as opposed to call bells, and whether CDHB has trialled these. Ms Skinner advised that this has been trialled in an Older Persons Health ward, as well as the Spinal Unit. Unfortunately, for a number of reasons it was not well used by the patients. It was noted that a further trial is to be conducted in maternity services.

Resolution (08/20)

(Moved: Dr Rochelle Phipps/Seconded: Naomi Marshall – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

6. CLINICAL ADVISOR UPDATE - NURSING

Mary Gordon, Executive Director of Nursing, provided updates on the following:

- CDHB would normally be taking 95 NETP graduates, but this intake has been reduced to 46, with only 34 on permanent contracts. This has sent shockwaves through the sector. A phone call had been received from the Chief Nursing Officer from the MoH saying that Minister Hipkins was wanting to know what was happening following media interest in Canterbury not taking new graduates. Ms Gordon advised that her response to the Chief Nursing Officer was that Canterbury was doing the same as Auckland – the Minister has sent very clear messages that the deficit was unacceptable. The Chief Nursing Officer noted the Minister has been very clear that there is to be no denigration in quality or

clinical outcomes, and that he is committed to the Care Capacity Demand Management (*CCDM*) programme and the nursing accord which was that all new nursing graduates got employment, to which Ms Gordon responded she could not do that at this particular point in time.

- 34 new NETP graduates have been hired within the DHB, 4 outside in community, ARC settings.
- 12 NETP graduates have been hired for the isolation / quarantine facilities with a wrap around process to support them on the programme being developed up.
- 11 NESP graduates for SMHS have been hired.
- All other graduates will be appointed into vacancy, or offered roles within the isolation / quarantine facilities if further staffing required.

- The Enrolled Nurse programme that the government is funding – our supporter programme has started. CDHB has not taken any graduates from the first round because our graduates have not graduated as yet.
- Postgraduate Nursing – we usually have a waitlist that cannot be met, however, this year have managed to fund all of the waitlist.
- Internationally, this is the year of the Nurse and Midwife. There is a nursing leadership development programme running across a number of countries. The programme is for nurses under 35 years and developing leadership capability for the future.

Ms Gordon provided a presentation on the Care Capacity Demand Management (*CCDM*) programme, which was mandated from the last MECA. The presentation highlighted the following:

- One aspect of the CCDM programme is the implementation of a nursing acuity system called Trendcare. It was noted that acuity is a measure of the severity of the hospitalised patient's illness and the level of nursing care they will require.
- CDHB has had its first phase, with the programme rolled out in medical and some surgical wards at Christchurch Hospital, as well as Burwood and Mental Health. A little behind implementation timeline, due to COVID-19, but expecting full rollout by the end of this calendar year. Have to do 12 months of collection of data, so full implementation is another 12 months away.
- Physical utilisation versus productivity index by ward.
- Ward daily hours graph detailing bed utilisation; and hours worked vs hours required.
- Nursing agency hours logged at Christchurch Hospital.
- Canterbury has the lowest actual cost per FTE nurse, $5K below the national average.
- Only one DHB has a lower overall cost per FTE (Hawkes Bay at $97K). CDHB is $98k versus a national average of $104k.
- CDHB has less beds, shorter length of stay and low readmission rates.
- The current inadequate hospital wards are very challenging to care within. For instance, frail elderly patients' access to appropriate ablutions, which further impacts on nursing time. This issue is not taken into account when entering the Trendcare data, yet we are still fully utilising all patient time allocated.
- The impact of high churn of full capacity wards is not being accounted for in the simple analysis. Becomes apparent in TrendCare.
- Nursing works at top of scope allowing for less medical workforce.
- Nursing does out-patient activity on wards, including own appointments.

There was discussion around CDHB's in-house nursing pool and its advantages. It allows CDHB to cover its own sick leave, which is not only good use of dollars, but ensures better care is being provided to the patient. CDHB staff know the system, whereas agency staff are not so familiar. This continuity of care reduces harm. If you get care right the first time, it is the cheapest you will ever get that care delivered for, because if you have to rework and have a lot of variation it costs you money.

Discussion took place around safari ward rounds and the impacts of these on staff, patients, and whanau. It was noted that today, as an example, General Medicine has 39 patients outside the General Medicine wards. This impacts the discharge process as well, significantly slowing it down. This highlights that when a hospital gets too tight it becomes inefficient. Ms Gordon noted that this is the reason why we need the next phase of the facility development on the Christchurch Campus site. Ms Gullery also reminded the Committee that CDHB has 30% lower acute admissions because of the way our primary care system works. If the primary care system stopped working in the way that it does and you had another 30% of patients in Christchurch Hospital, that would be another 15,000 to 20,000 patients per year. In addition, the Committee was reminded that CDHB is a tertiary centre, so needs to be in a state of readiness.

There was a query whether there is a point from a clinical basis that risk is too high and how that is assessed. Ms Gordon spoke of a "response variation", where if the number of nurses available is not sufficient to meet patient care needs on a ward, care given to each patient is prioritised. However, if this is happening on a day to day basis, this indicates that base staffing is wrong and needs to be readjusted. If advised that there are to be no more staff, then in this situation beds would have to be closed.

Ms Kane thanked Ms Gordon for the presentation, noting this was a critical piece of work. Ms Kane requested the presentation material be included as an appendix to the meeting minutes, as well as be provided to the Quality, Finance, Audit & Risk Committee for information. In addition, Ms Gullery, noted that its content would be addressed in Management's formal response to the EY report, which will be presented to the Board at its meeting on 20 August 2020.

A joint presentation from the Nursing Director of CCDM and Decision Support staff is to be scheduled for a future meeting.

The Nursing Clinical Advisor's Update was noted.

7. ED PRESENTATIONS – OVER 75 YEARS OLD – ANALYSIS PAPER

Carolyn Gullery presented the report which was taken as read, noting that an increase in over 75 years olds is being seen in presentations to the Emergency Department (*ED*) and inevitably the chance of being admitted is quite high – 65 to 75%.

Analysis has been undertaken. This is one of the initiatives that has been put up for the savings plan, because we do think that a number of the issues driving this can be mitigated.

Ms Gullery highlighted the ED presentation rates by practice, noting there are approximately 16 of the 117 general practices that have a rate above the average, but there are about 10 notable outliers – one being an extraordinary outlier which has one of the biggest populations of over 75 year olds enrolled and is managing to send 50% of that population to hospital in a year. Those practices will be invited to a meeting and asked how the DHB can help and what can be done differently to support them not having this number of people arriving in our hospitals.

We understand the issue, know we have a problem, and have a plan to start addressing the problem. This will have flow on benefits not only to our hospitals, but we also know from previous work that this triggers a cascade into aged residential care (*ARC*).

Mr Gullery noted that 73% of these patients arrive by ambulance, and 81% of these presentations are triage levels 1 to 3, so we are talking about people who are arriving unwell.

Resolution (09/20)
(Moved: Jo Kane/Seconded: Dr Rochelle Phipps – carried)

"That the Committee:

i. notes the ED Presentations – Over 75 Years Old – Analysis paper."

8. FASTER CANCER TREAMENT

Ms Gullery presented the report, noting it had been requested so people better understood how we measure Faster Cancer and how it flows through. The other question was whether Maori were being specifically disadvantaged in this process. Ms Gullery noted there is some risk around this, which is why some intentional interventions are being put in place. One of the risks we are seeing around particularly Maori in planned care generally, is that because quite often Maori have co-morbidities and that complicates their path, people end up navigating a winding path through the system instead of a straight path.

There are also less Maori going through the pathway than what might be expected. Ms Gullery noted that this is partly because cancer is directly related to age and the age profile for the Maori population is different to the age profile for the non-Maori population. When you look at the national registrations, Maori has a big cohort in the 40 to 55 age bracket. You do not see that same representation in non-Maori. Ms Kane requested that this data be appended to the meeting's minutes.

There was discussion around the Bowel Screening Programme and the issue that it starts at too late an age for the Maori population. Ms Gullery advised that what is planned for this cohort are some joined up plans to work with kaumatua to run an awareness programme to find people earlier and prompt symptom related referrals as opposed to screening related referrals. Working with Manawhenua on that to increase our chances of identifying people with symptoms earlier.

Resolution (10/20)
(Moved: James Gough/Seconded: Catherine Chu – carried)

"That the Committee:

i. notes the Faster Cancer Treatment report."

9. SOUTH ISLAND BARIATRIC SURGERY SERVICE – SUMMARY 2019/20

Ms Gullery presented this report, which was taken as read. For background purposes, Ms Gullery noted that there was some money put out by the MoH a few years back for Bariatric Surgery. It was allocated per DHB. The South Island in its alliance type process decided to do it differently, pulling all the money into one bucket and allocated access to bariatric surgery by clinical need of the patient irrespective from which DHB they came from.

Whilst acknowledging that we operate in a restrained environment, there was considerable discussion around the issue that there was not enough money being spent on this and it is currently falling behind. Ms Gullery noted that if you were making good decisions based on ability to benefit and outcomes you would be providing a lot more bariatric surgery through the public system.

Ms Gullery noted that although Maori and Pacifica are getting higher access than their population share, and it is being done on clinical priority and ability to benefit, she reiterated there are an awful lot more people who would benefit.

There was discussion around this being an investment, as an intervention at a point in time can avert health dollars spent later on. A very good investment strategy, but not enough focus being given to it from a national perspective. It is an equity of access issue, but also an investment return business case that stacks up. We continually talk about the aging population and implications on the health system, but we do not talk about the unmet need for bariatric surgery and the future impact of this on the system.

There was comment that the issue for the Board to consider in terms of a strategic plan for the future is how we shift a really constrained environment where there is a lot of pressure to reduce cost, to focus on preventative strategies which are an investment in the future.

Resolution (11/20)
(Moved: Michelle Turrall/Seconded: Ingrid Taylor – carried)

"That the Committee:

i. notes the South Island Bariatric Surgery Service – Summary 2019/20 paper."

Naomi Marshall retired from the meeting at 12.22pm.

Ms Kane noted this was Ms Gullery's last HAC meeting and offered the opportunity to members to speak. Members wished Ms Gullery all the best for the future, noting she would be a huge loss to the CDHB, as would the other members of the Executive team who were leaving. The opinion was voiced that this is "obviously shocking, concerning and a massive crisis for our community".

There was further comment that Ms Gullery's input has always been appreciated and she has done a lot to reform the health system. She will be missed.

As Chair of HAC, Mr Dickerson noted that Ms Gullery's input into CDHB and to HAC has been huge, and thanked her for her significant contributions.

10. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (12/20)
(Moved: Dr Rochelle Phipps/Seconded: Ingrid Taylor – carried)

"That the Committee:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2 and 3;
ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 4 June 2020	For the reasons set out in the previous Committee agenda.	

2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)
3.	CDHB Planned Care Plan 2020/21 and CDHB Improvement Action Plan 2020/21	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s 9(2)(j)

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

INFORMATION ITEMS

- Quality & Patient Safety Indictors – Level of Complaints
- 2020 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 12.27pm.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson Date of approval
Chairperson

Draft

HAC MEETING 6 AUGUST 2020 – MEETING ACTION NOTES

Item No	Item	Action Points	Staff
	Apologies	• Apologies for absence - Barry Bragg, Jan Edwards; and Sir John Hansen (Ex-officio). • Apology for lateness - Ingrid Taylor (9.10am).	Anna Craw
1.	Interest Register	Nil	
2.	Minutes – 4 June 2020	Adopted: *Dr Rochelle Phipps / Andrew Dickerson*	Anna Craw
3.	Carried Forward Items	Nil	
4.	Maternity Assessment Unit – 9 Month Update	Nil	
5.	H&SS Monitoring Report	• Paper on initiatives to support rural older population remaining in own homes/communities into the future. **Report to December HAC meeting – report due to Anna Craw 23 November 2020.** • Paper providing analysis on CAF presentations, and in particular under 12s. **Report to October HAC meeting – report due to Anna Craw 21 September 2020.**	Carolyn Gullery / Win McDonald Greg Hamilton
6.	Clinical Advisor Update - Nursing	• Presentation material be included as an appendix to the meeting minutes, as well as be provided to the Quality, Finance, Audit & Risk Committee for information. • Presentation content to be addressed in Management's formal response to the EY report, which will be presented to the Board at its meeting on 20 August 2020. • A joint presentation from the Nursing Director of CCDM and Decision Support staff is to be scheduled for 3 December 2020 meeting, in conjunction with six monthly CCDM update – **report/presentation material due to Anna Craw 23 November 2020**.	Anna Craw Carolyn Gullery / Justine White Mary Gordon / Carolyn Gullery

HAC MEETING 6 AUGUST 2020 – MEETING ACTION NOTES

7.	ED Presentations – Over 75 Years Old – Analysis Paper	Nil	
8.	Faster Cancer Treatment	National registration data – age cohorts for Maori and non-Maori population. Append to meeting minutes.	Carolyn Gullery / Anna Craw
9.	South Island Bariatric Surgery Service – Summary 2019/20	Nil	
10.	Resolution PX	Adopted: *Dr Rochelle Phipps / Ingrid Taylor*	Anna Craw
	Info Items	Nil	

Distribution List:
Justine White
Carolyn Gullery
Mary Gordon
Win McDonald
Greg Hamilton

CC: Mary Howell; Regan Nolan; Jenna Manahi; Ralph La Salle; and Sharryn Sunbeam

Nursing Update

CDHB Trendcare Staffing Report

prepared by Janette Dallas, Nursing Director CCDM

Trendcare is the CDHB acuity measurement tool and forms part of the Care Capacity Demand Management (CCDM) Programme. Trendcare is the only validated acuity tool available and is utilised in all DHBs across New Zealand. Acuity is a measure of the severity of the hospitalised patient's illness and level of care they will need.

We are progressively implementing the CCDM programme and Trendcare, sequentially throughout all inpatient areas. We began the implementation of trendcare with the Medical wards and three surgical wards since late 2019.

In addition, as part of the implementation, these wards have completed an interrater reliability (IRR) programme (inter reliability is the extent that two or more nurses, midwives agree on the acuity), with an average score of over 98%. External testing done by the CCDM Coordinators to ensure validity and robustness of testing process. The Trendcare programme reports on the data collected to allow the CDHB to measure efficiency and productivity amongst other things.

The graphs below display the efficiency for the wards that are live and have completed IRR. The top graph displays the bed utilisation (throughput) by percentage of physical beds occupied for each day of the selected month, which can be more than 100% if the bed has had two people in the bed over the 8- hour shift. The bottom graph displays the daily clinical nursing hours (HH.mm) required by acuity for inpatient care (Red) against the nursing hours worked (Green) over the 8-hour shift, in the selected ward for the month of July.

The productivity index is the ratio of actual nursing hours available to actual nursing hours required by acuity. The recommendation from the Safe Staffing Healthy Workplaces Unit is that wards should have a productivity index of approximately between 85-95% during the day and afternoon shift and 75-85% on the night shift to ensure all care can be delivered during the shift. The small amount of spare capacity ensures wards can receive patients at any time and increase the ability for them to support the broader hospital variance response management. For instance, it allows flexibility to move staff across the service. The average productivity for the month is represented at the right-hand side of the table. As per below, there is a small degree of flexibility.

Physical Utilisation versus Productivity Index by Ward – Christchurch Campus

Ward	Physical Utilisation %	Productivity Index %
Ward 24	101.31	101.07
Ward 11	94.54	72.61
Ward 12	102.32	83.12
Ward 14	97.6	81.5
Ward 20	95.59	87.39
Ward 23	101.83	95.17
Ward 25	92.35	89.62
Ward 27	104.7	101.93
Urology Unit	93.19	85.87
CCU	47.48	104.64

Safe Staffing Healthy Workplaces Unit is that wards should have a productivity index of approximately between 85-95% during the day and afternoon shift and 75-85% on the night shift to ensure all care can be delivered during the shift. Most wards fell within this index or were above this index. Those who fell below are having the data closely examined by the CCDM team external to their wards.

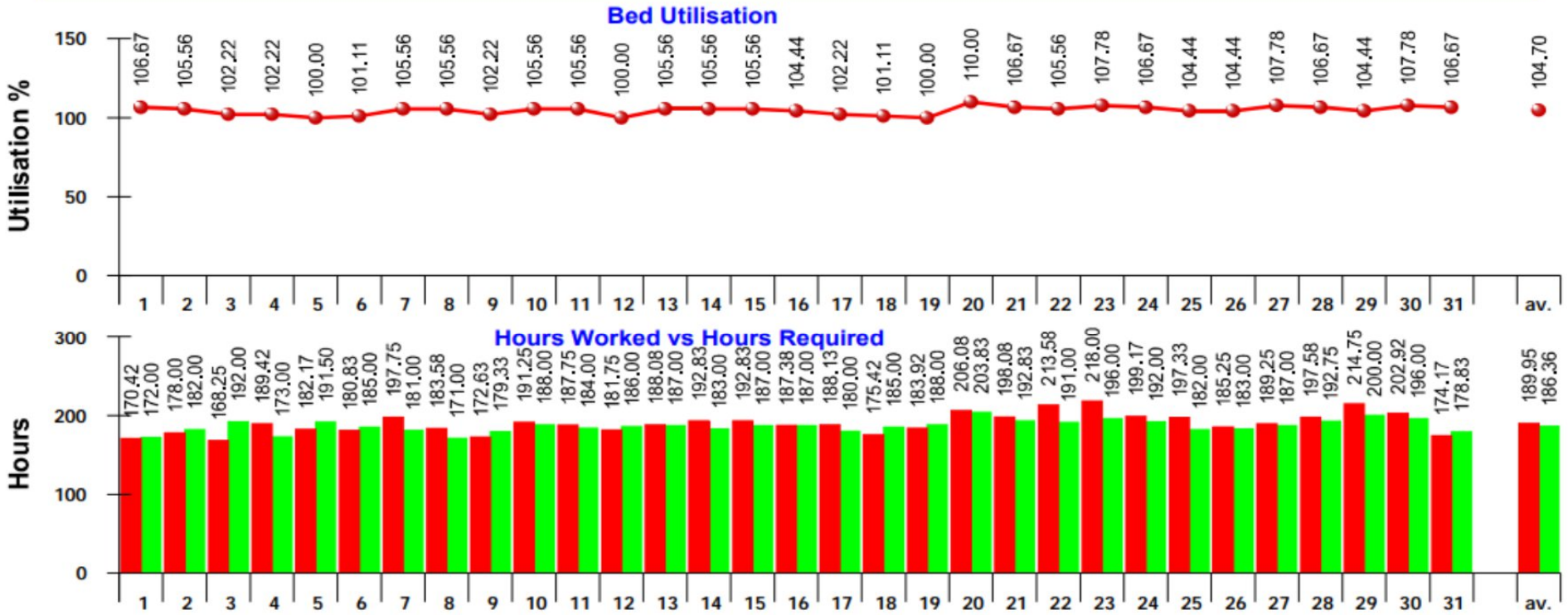
A productivity index near 100% would suggest that delivery of care may have be missed due to the lack of available nursing hours. This indicates that staffing is exceedingly tight in those wards above the 85-95% mark. Note: the productivity index (nursing hours available and required to deliver safe care) data is combined for the three shifts. There may be significant nursing hours deficits if shifts are viewed individually.

- The next pages show samples of different wards and their physical bed utilisation graphs as well as their actual nursing hours available to actual nursing hours required by acuity. In the red is the required inpatient clinical hours versus the green actual inpatient clinical hours worked.
- ***Bed utilisation means actual physical beds used throughout all graphs**

Ward Daily Hours Graph

Printed: 3/08/2020
8:36:15 AM

Ward: CHC-Ward 27 (* All Shifts *)
Month: July, 2020



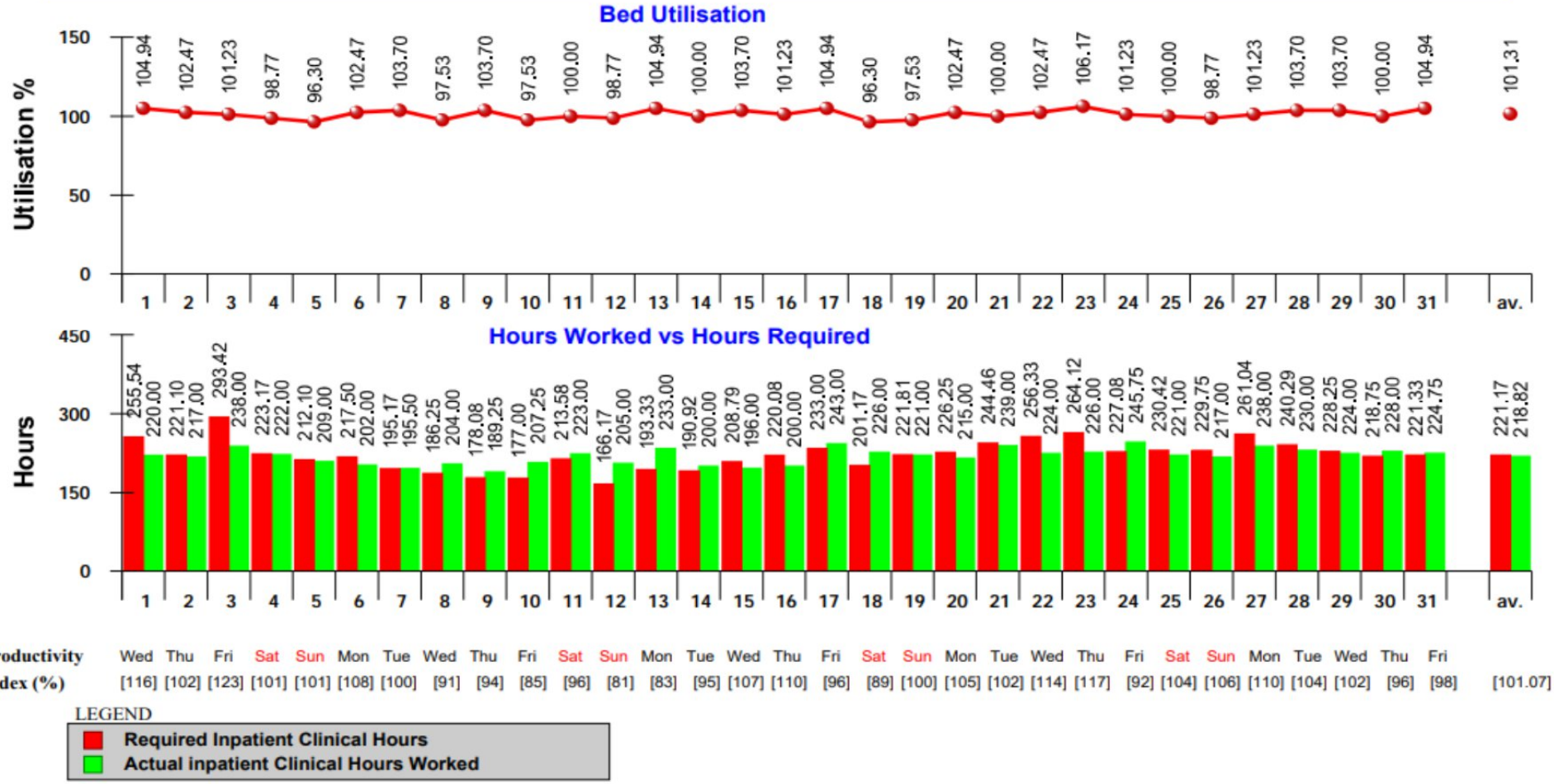
Productivity	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
Index (%)	[99]	[98]	[88]	[109]	[95]	[98]	[109]	[107]	[96]	[102]	[102]	[98]	[101]	[105]	[103]	[100]	[105]	[95]	[98]	[101]	[103]	[112]	[111]	[104]	[108]	[101]	[101]	[103]	[107]	[104]	[97]	[101.93]

LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

Ward Daily Hours Graph

Printed: 3/08/2020
8:36:15 AM

Ward: CHC-Ward 24 (* All Shifts *)
Month: July, 2020



Productivity	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
Index (%)	[116]	[102]	[123]	[101]	[101]	[108]	[100]	[91]	[94]	[85]	[96]	[81]	[83]	[95]	[107]	[110]	[96]	[89]	[100]	[105]	[102]	[114]	[117]	[92]	[104]	[106]	[110]	[104]	[102]	[96]	[98]	[101.07]

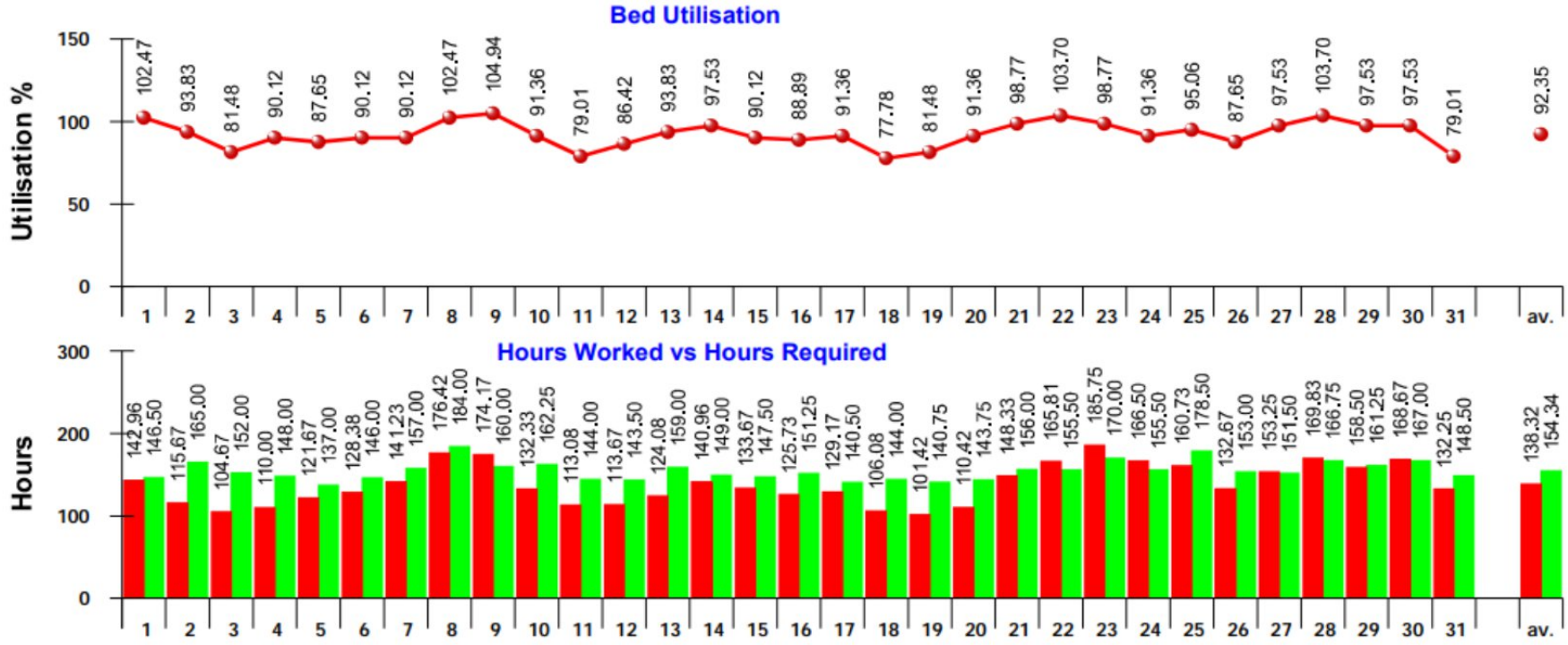
LEGEND

- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

Ward Daily Hours Graph

Printed: 3/08/2020
8:36:15 AM

Ward: CHC-Ward 25 (* All Shifts *)
Month: July, 2020



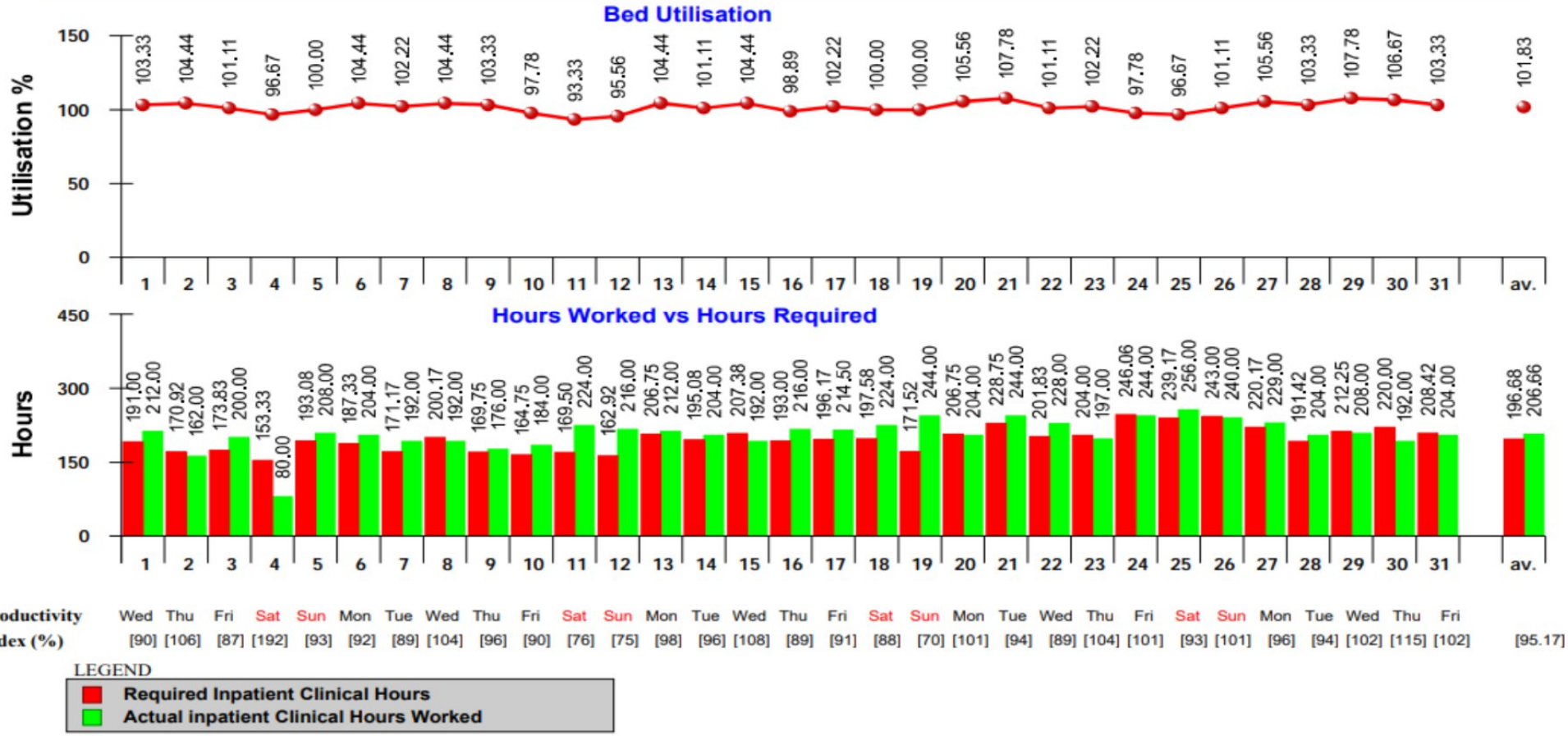
Productivity	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
Index (%)	[98]	[70]	[69]	[74]	[89]	[88]	[90]	[96]	[109]	[82]	[79]	[79]	[78]	[95]	[91]	[83]	[92]	[74]	[72]	[77]	[95]	[107]	[109]	[107]	[90]	[87]	[101]	[102]	[98]	[101]	[89]	[89.62]

LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

Ward Daily Hours Graph

Printed: 3/08/2020
8:36:15 AM

Ward: CHC-Ward 23 (* All Shifts *)
Month: July, 2020



Productivity Index (%)	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	
	[90]	[106]	[87]	[192]	[93]	[92]	[89]	[104]	[96]	[90]	[76]	[75]	[98]	[96]	[108]	[89]	[91]	[88]	[70]	[101]	[94]	[89]	[104]	[101]	[93]	[101]	[96]	[94]	[102]	[115]	[102]	[95.17]

LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

Ward Daily Hours Graph

Printed: 3/08/2020
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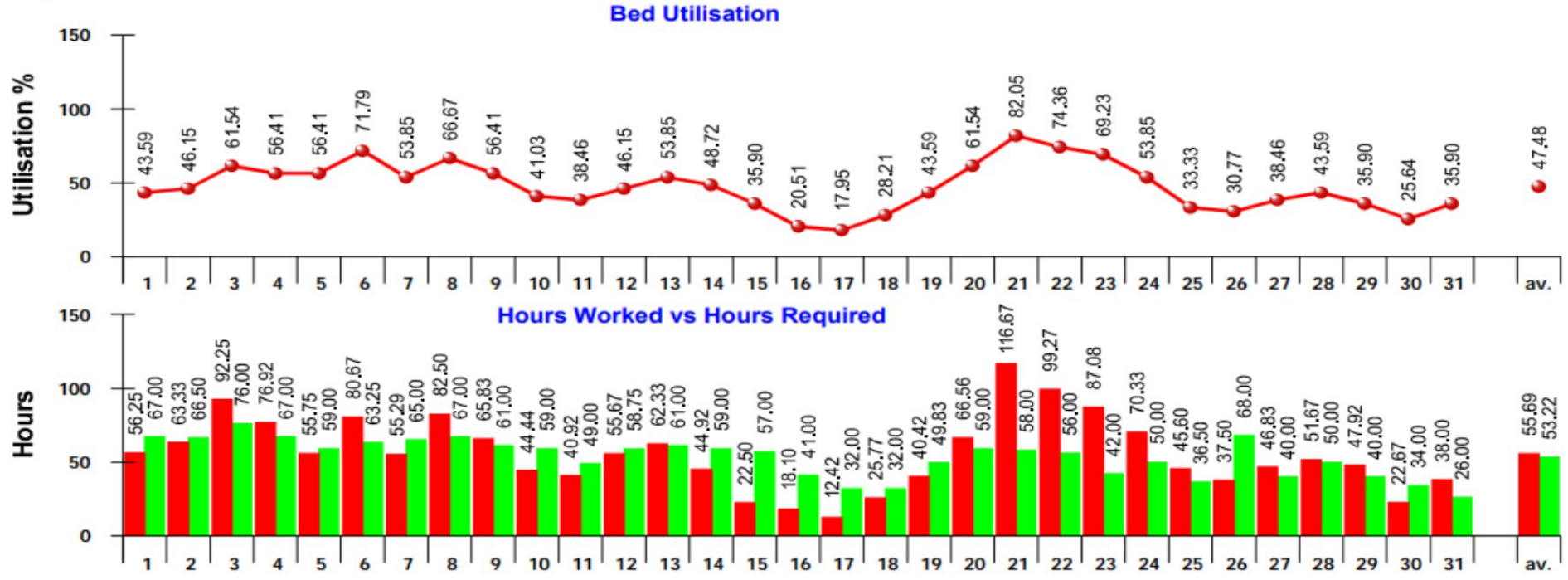
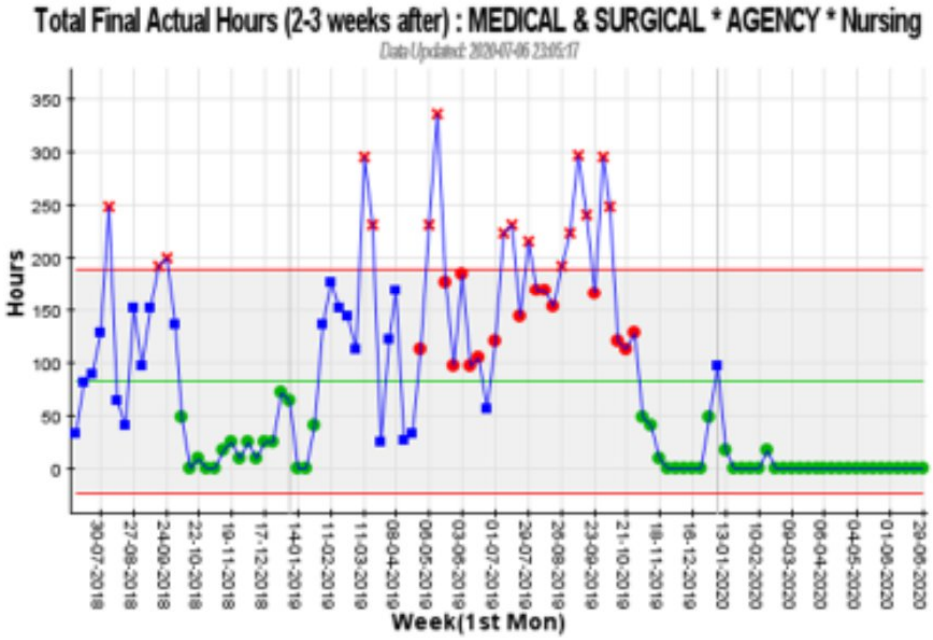
Ward: CHC-Coronary Care Unit (* All Shifts *)
Month: July, 2020



Productivity Index (%)	Wed [84]	Thu [95]	Fri [121]	Sat [115]	Sun [94]	Mon [128]	Tue [85]	Wed [123]	Thu [108]	Fri [75]	Sat [84]	Sun [95]	Mon [102]	Tue [76]	Wed [39]	Thu [44]	Fri [39]	Sat [81]	Sun [81]	Mon [113]	Tue [201]	Wed [177]	Thu [207]	Fri [141]	Sat [125]	Sun [55]	Mon [117]	Tue [103]	Wed [120]	Thu [67]	Fri [146]	[104.64]

LEGEND
- Required Inpatient Clinical Hours
- Actual inpatient Clinical Hours Worked

Nursing Agency Hours logged at Christchurch Hospital



March 2020 YTD- Provider Arm Out-sourced

CDHB - $24M (pop - 578,290) 20/21 funding populations
ADHB - $103M (pop – 493,990)
CMDHB-$80M (pop – 578,650)
Waikato-$67M (pop – 435,690)
WDHB-$62M (pop – 628,770)

Validation from Finance

Jul -19 - Dec 19			
RN Agency	Total Hours	Average Hours	Average P.H
Jul 19 to Dec -20	3,892.25	648.71	$40.51

Jan-20-Jun 20			
RN Agency	Total Hours	Average Hours	Average P.H
Jan 20 to Jun -20	125.00	25.00	$40.51

What the data shows

- Canterbury has the lowest actual cost per FTE nurse $5K below the national average.
- Only 1 DHB has a lower overall cost per FTE (Hawkes Bay at $97K) CDHB is $98k versus a national average of $104k
- CDHB has less beds, shorter length of stay and low readmission rates
- The current inadequate hospital wards are very challenging to care within. For instance, frail elderly patients' access to appropriate ablutions, which further impacts on nursing time. This issue is not taken account when entering the Trendcare data, yet we are still fully utilising all patient time allocated

- The impact of high churn of full capacity wards is not being accounted for in the simple analysis-becomes apparent in TrendCare
- Nursing works at top of scope allowing for less medical workforce
- Nursing does out-patient activity on wards, including own appointments
- NMDS data extract was still incomplete (missing more than 800 events) until July 21

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **20 August 2020**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATIONS

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, & 15 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: • 16 July 2020 – Ordinary • 04 August 2020 – Emergency • 12 August 2020 - Emergency	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.	Executive Management Team Response to EY Taskforce Review – Phase 1	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Programme Business Case - Hillmorton	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

6.	NZHP Statement of Performance Expectations 2020/21	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	NZHP Health System Catalogue Business Case	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Audit NZ Fraud Risk Assessment	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Insurance Premium Approval	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Community & Public Health and Disability Support Advisory Committee Membership	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	S9(2)(a) s9(2)(j)
11.	2020/21 Planning Update	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
12.	Going Concern Assessment	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
13.	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)
14.	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)
15.	Advice to Board: • HAC Draft Minutes *06 August 2020* • QFARC Draft Minutes *04 August 2020* *14 August 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.*