AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

CANTERBURY DISTRICT HEALTH BOARD MEETING
to be held via Zoom
Thursday, 17 February 2022 commencing at 9.30am

	Karakia		9.30am
Administration			
	Apologies		
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 16 December 2021		
3.	Carried Forward / Action List Items		
Overview			
4.	Chair's Update (Oral)	Gabrielle Huria *Deputy Chair*	9.35-9.40am
5.	Chief Executive's Update	Tracey Maisey *Executive Director, Planning Funding & Decision Support*	9.40-10.00am
Reports for Noting			
6.	Finance Report	David Green *Acting Executive Director, Finance & Corporate Services*	10.00-10.10am
7.	Localities Update	Tracey Maisey	10.10-10.20am
8.	Care Capacity Demand Management	Becky Hickmott *Executive Director of Nursing*	10.20-10.30am
9.	Advice to Board: • HAC – 3 February 2022 – Draft Minutes	Naomi Marshall *Deputy Chair, HAC*	10.30-10.35am
10.	Resolution to Exclude the Public		10.35am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.35am**

NEXT MEETING
Thursday, 17 March 2022 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
Fiona Pimm
Ingrid Taylor

Executive Support

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

BOARD ATTENDANCE SCHEDULE – 2022

NAME	17/02/22	17/03/22	21/04/22	19/05/22	16/06/22
Sir John Hansen (Chair)					
Gabrielle Huria (Deputy Chair)					
Barry Bragg					
Catherine Chu					
Andrew Dickerson					
James Gough					
Jo Kane					
Aaron Keown					
Naomi Marshall					
Fiona Pimm					
Ingrid Taylor					

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

	CMUA Project Delivery Limited - Chair 100% owned by the Christchurch City Council and is responsible for the delivery of the Canterbury Multi-Use Arena project within agreed parameters. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Farming** – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Paenga Kupenga Limited** – Chair Commercial arm of Ngai Tuahuriri Runanga **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Three Waters Governance Working Party** - Member A Crown appointed taskforce of Mayors and iwi representatives to recommend a governance framework for the four proposed new Water Services Entities. **Venues Ōtautahi** - Advisor A Christchurch City Council controlled organisation. Venues Ōtautahi is responsible for attracting, planning and delivering events for the Christchurch venues it owns, operates and manages. **Verum Group Limited** – Director Verum Group Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.
Catherine Chu	**Christchurch City Council** – Councillor Local Territorial Authority **Riccarton Rotary Club** – Member **The Canterbury Club** – Member
Andrew Dickerson	**Canterbury Education and Research Trust for the Health of Older Persons** - Trustee Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of

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

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

	Te Runanga o Ngāi Tahu – Director Governance entity of Ngāi Tahu iwi. **Whai Rawa Fund Limited** – Chair Ngāi Tahu investment and savings scheme for tribal members.
Ingrid Taylor	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee. **Taylor Shaw** – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • 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 December 2021 commencing at 9.30am

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

CROWN MONITOR
Dr Lester Levy (via zoom)

CLINICAL ADVISOR
Dr Andrew Brant (via zoom)

APOLOGIES
Apologies for absence were received from Gabrielle Huria, Jo Kane & Fiona Pimm
An apology for early departure was received from Dr Lester Levy (10.30am)

EXECUTIVE SUPPORT
Tracey Maisey (Acting Chief Executive); Norma Campbell (Executive Director,); David Green (Acting Executive Director, Finance & Corporate Services); Becky Hickmott (Executive Director of Nursing); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical)(via zoom); Tanya McCall (Interim Executive Director, Community & Public Health)(via zoom); Dr Rob Ojala (Executive Director, Infrastructure); Dr Helen Skinner (Chief Medical Officer); Karalyn van Deursen (Executive Director, Communications); Anna Craw (Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support – Minute Taker).

APOLOGIES
Apologies for absence were received from Dr Peter Bramley (Chief Executive); James Allison (Chief Digital Officer) and Hector Matthews (Executive Director Maori & Pacific Health).
An apology for absence during the meeting was received from Norma Campbell (Executive Director, Midwifery & Maternity Services (10am – 11.15am).

Barry Bragg opened the meeting with a Karakia.

1. INTEREST REGISTER

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

Declarations of Interest for Items on Today's Agenda
Sir John asked if there were any declarations of interest apart from Ngai Tahu and Car Parking in respect of Barry Bragg and Christchurch City Council in respect of Catherine Chu, James Gough and Aaron Keown.
Aaron Keown advised that he would not take part in Item 6 in Public Excluded due to a conflict around holding a Liquor License and Bar Manager's License. James Gough advised that he would not participate in this item either due to his property interests.

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

2. CONFIRMATION OF MINUTES OF PREVIOUS MEETINGS

Resolution (44/21)
(Moved: Sir John Hansen/seconded: Aaron Keown – carried)

"That the minutes of the meeting of the Canterbury District Health Board held on 18 November 2021 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION LIST ITEMS

It was noted that the carried forward/actions item was included on today's agenda.

4. CHAIR'S UPDATE

Sir John Hansen, Chair, commented that now we have a COVID case in hospital here in Christchurch and I know that this will raise concerns in our community around what is going to happen but I believe as an organisation we are as well as preparedness we can be because of the very impressive vaccination rates that have been achieved by a large enthusiastic and hard working team. To put in in raw figures this team has delivered over 900.000 individual vaccinations since they commenced which is quite an extraordinary achievement. He added that we were criticised for starting slowly but it seems that our vaccination team has very much been the tortoise that has overtaken the hare. He expressed his gratitude to the Pacific and Maori communities who have done so much and advised that last week we were getting first doses greater than the combined three Auckland DHBs which puts us in good shape to face what is to come. He also added that whilst there has been the odd incident that has attracted media attention which is understandably of concern it does need to be put in the context of over 900,000 jabs and in a perfect world these would not happen.

Sir John commented that a great deal of work has been undertaken by the facilities and clinical teams so that we can accommodate COVID patients and also do our best at planned care. Although COVID has significantly interfered with planned cared he wanted to pay tribute to and recognise the sterling effort right across the clinical community who have kept planned care moving on and again we stand at the top of the pile in that regard.

He acknowledged the additional $12m of government funding for the 12 ICU Pods and wished everyone a very Merry Christmas.

The Chair's update was noted.

5. CHIEF EXECUTIVE'S UPDATE

Tracey Maisey, Acting Chief Executive, thanked Sir John for the recognition of staff. She added that it has certainly been a mammoth effort by the vaccination teams and all of those working across our health system, particularly with such a large area to look after and providing service of a very high quality. She took the report as read.

Ms Maisey advised vaccination stats as follows: As at 12 December Canterbury population were 92.9% fully vaccinated with 97.2% first dose. As at 14 December Maori were 81% double vaccinated and 90.9% first dose and Pacifica 88.2% double vaccinated and 95.9% first dose. She commented that we are seeing slightly lower vaccination rates in the mental health and addictions population which is consistent with the rest of New Zealand and we are doing some particular work in this area. In regard to boosters half the people due for these have received them. It was noted that

we are continuing with our outreach programme and community drive through until 23 December and these will recommence from 5-28 January.

In relation to our workforce we have completed 5187 fit tests which is a core protection for our workforce so congratulations to the trainers and educators in this area.

Ms Maisey advised that there are currently 10 active cases – 8 close contacts and 1 in hospital. She advised that we are using "it takes a community to care for a community" and to facilitate that partnership approach we have established the Canterbury Hauora Coordination Hub in the old Pegasus building to allow colocation to easily occur.

She added that all of this is taking place while we continue to deliver high quality services to those members of the community requiring it.

Ms Maisey advised that the ECC will be stood up as necessary if required and rosters are in place for this.

A query was made in regard to the new Cancer Centre and Dr Rob Ojala, Executive Director, Infrastructure, advised that a process is taking place with the oncology service in advancing this proposal. We were initially focusing on a proposal centred around the Antigua campus where we would provide LINACs and a modular extension however it has become clear that to deliver to the current time lines we are currently running a 5th virtual LINAC. He advised that the focus is now on a satellite facility and a business case will come to the Board early in the new year.

In relation to the presentation the Board received from the Christchurch Cancer Foundation in October 2020 the Chair advised that he has suggested to them that they contact Health New Zealand. He added that we have continued to protect the proposed site where possible.

The Acting Chief Executive's update was noted.

6. SUBMISSION – PAE ORA (HEALTHY FUTURES) BILL

Tanya McCall, Interim Executive Director, Community & Public Health, presented this report which was taken as read.

A point was made that the submission focuses on the Public Health Stream and does not acknowledge other streams of work and also that the legislation does not give any indication of meaningful accountability. It was noted that the call for input went right across the DHB and only Public Health responded. It was also noted that the South Island Alliance will be submitting separately and that would cover other work streams.

Resolution (45/21)
(Moved: Sir John Hansen/seconded: Barry Bragg – carried)

That the Board:

i. approves the submission on the Pae Ora (Healthy Futures) Bill.

7. FINANCE REPORT

David Green, Acting Executive Director, Finance & Corporate Services, presented the Finance Report for the month of October 2021. Mr Green advised that these results were discussed in detail at the last QFARC meeting.

There was no discussion on the report.

Resolution (46/21)
(Moved: Barry Bragg/seconded: Ingrid Taylor – carried)

That the Board:

i. notes the consolidated financial result YTD is unfavourable to plan by $0.823M;
ii. notes that the YTD impact of Covid-19 is $0.206M favourable to budget;
iii. notes that the YTD impact of the Holidays Act Compliance is an additional $5.391M expense which is in line with budget; and
iv. notes that excluding HAP and Covid-19, the YTD result is $1.037M unfavourable to budget.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (47/21)
(Moved: Sir John Hansen/seconded: Ingrid Taylor - carried)

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 & 13 and the information items contained in the report;
ii. notes that the general subject of each matter to be considered while the public is excluded and the reason for passing this resolution in relation to each matter and the specific grounds under Schedule 3, Clause 32 of the Act in respect to these items are as follows:

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of minutes of public excluded meetings – 18 November 2021	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.	IEA Remunerations Strategy 2021/22	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	DHBs and the Smokefree Aotearoa 2025 Goal	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
6.	National DHB Position Statement on the Sale and Supply of Alcohol. Act	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

7.	Antigua Street Carpark Extension	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Hillmorton Laundry Building Strengthening and Fit Out Scope Changes	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	Old Rangiora Building Demolition Scope Change	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	Cardiac Catheter Laboratory 2 Replacement Scope Change	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(a) s9(2)(j)
12.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s9(2)(a) s9(2)(j) s9(2)(h)
13.	Advice to Board • QFARC Draft Minutes *30 November 2021*	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 9.55am

_____ _____

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 17 FEBRUARY 2022

DATE	ISSUE	REFERRED TO	STATUS
30 Nov 21 (QFARC)	Fee for Service Contracts – how many; what are they for; and assurance that good process has been followed.	Mary Johnston	Today's Agenda – Item 11 PX (Oral Update)
16 Dec 21	CDHB Contractors Update – how many; in what services; and effectiveness of this form of employment.	Mary Johnston	Today's Agenda – Item 11 PX (Oral Update)
16 Dec 21	Quarterly Personal Grievance reporting.	Mary Johnston	Today's Agenda – Item 11 PX
03 Feb 22 (HAC)	System/Pressure Points & Planned Care Management	Dr Peter Bramley	Update to 17 March 2022 meeting.

CHAIR'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

CHIEF EXECUTIVE'S UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

DATE: **17 February 2022**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

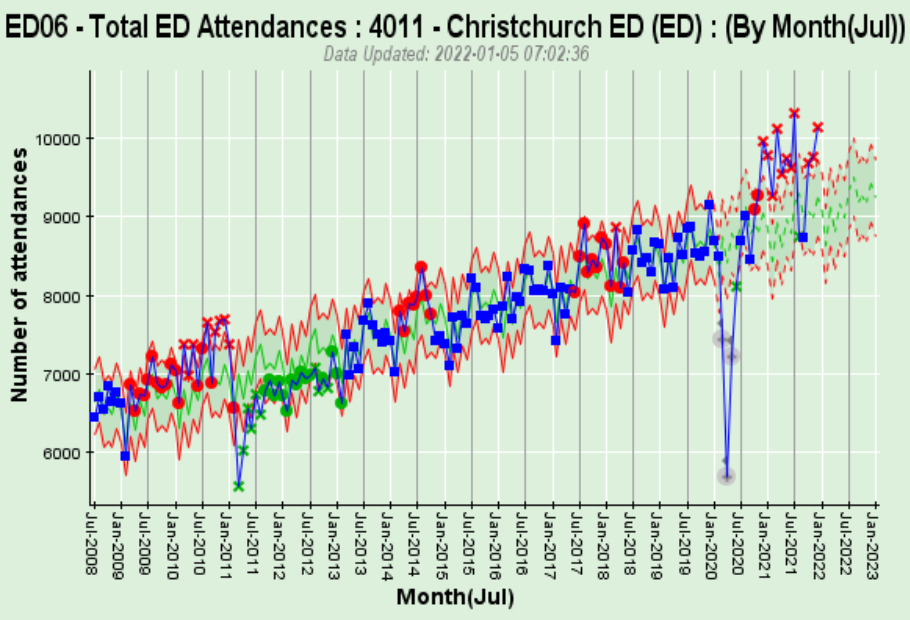
i. notes the Chief Executive's update.

3. DISCUSSION

MEDICAL / SURGICAL SERVICES

Emergency Department

- There were 10,148 attendances at the Christchurch Hospital Emergency Department during December 2021, around 200 more than in December 2020. This is the second highest number of attendances ever seen in a month at the Christchurch Emergency Department, exceeded only in July 2021.
- When compared with December 2020 triage 1 and 2 attendances have increased by 156 (12%), triage 3 attendances increased by 466 (9%) and triage 4 and 5 attendances reduced by 431 (11%).



- 3,061 people were admitted to hospital from the Emergency Department – 102 fewer than in December 2020.
- 84% of people attending the Emergency Department left the department within six hours. This is at the lower end of values reported since the shift to Waipapa and is well short of the 95% target.

Planned care

- Canterbury District Health Board has an agreed phased schedule with the Ministry of Health for planned care delivery that will provide the targeted volume of 19,614 discharges (the same target as for 2020/21).
- Total delivery versus phased target gives an indication of progress towards the phased target. At the end of December 8,764 planned care discharges have been provided – 1,069 less than the phased target.
- At the end of December 2021 CDHB is exceeding target for minor procedures in hospital settings having delivered 1,133 as inpatients (384 ahead of target) and 6,633as outpatients (2,745ahead of target).

Use of Theatre Capacity

- More acute and planned operations were provided at Christchurch Hospital in December 2021 than December 2020, with a total of 2,125 theatre events – this is 8% higher than in December 2020.
- A small volume of outplacing was carried out during November in mitigation of constraints across the campus, these constraints were Anaesthetic Technician shortages, nursing and bed constraints.
- When all operations provided by or for Canterbury District Health Board (including in house, outsourced and outplaced) 2,513 operations were provided during December 2021 – 2 % more than was provided during December 2020. Within this there were 94 more acute operations (9%) and 55 less elective operations (4%).
- **Anaesthetic Technician** vacancy continues to constrain theatre capacity and therefore delivery to below the scheduled level. This has been one of the factor's considered in planning towards achieving internal production capacity for 2021/22. The constraint is being managed in many ways including use of agencies to recruit national and international staff alongside work within the domestic market and outplacing operating sessions to the private hospital settings.

The CDHB Improvement Action Plan 20/21

- 2,685 people were waiting for longer than 120 days for first specialist assessment at the end of December. This is an increase of 32 from the end of November.
- The number of people waiting >120 days for surgery has also increased during December with 1,833 waiting at the end of month, an increase of 115 during the month.

Allied Health: Expert Occupational Therapy role in the Emergency department

- A new fixed term role has commenced, leading the introduction of a seven-day occupational therapy service in the Emergency Department. The appointee comes with experience of a working in emergency care at John Radcliffe Hospital Oxford, England and her experience will be critical in establishing these roles.
- This service will assist with improving the assessment of frail elderly patients and prevent unnecessary admissions. As assessment of hospitalised patients will commence earlier in their hospital journey, this will assist with streamlining the discharge planning process.

Radiology

- Radiology will be continuing its dual focus working well initiative this year (well-being at work and doing the work we do well i.e. continuous improvement).

- Increased numbers of Resident Medical Officers have begun to graduate from the local training scheme (three in December 2021) with the majority doing local fellowships and indicating a desire to work at Canterbury District Health Board as Senior Medical Officers in the future.
- **Staffing Constraints**: Computerised tomography has insufficient Medical Imaging Technicians to meet the significant increases in Emergency Department, inpatient and outpatient demand. A request to increase establishment was approved immediately prior to Christmas and will be recruited to as soon as possible.

SPECIALIST MENTAL HEALTH SERVICES

- Staffing and Recruitment remain the highest priority for Specialist Mental Health Services. We are filling 25 to 40 roster gaps daily which is resulting in large amounts of overtime to ensure our consumers receive appropriate care and therapy. This is not sustainable and sick leave has increased at the same time. Addressing our deficits in staffing to ensure we have an experienced and skilled workforce will remain a focus through this year.
- Demand on services remains high following lockdown. This is particularly evident in among young people and eating disorders which have higher referrals than pre-COVID-19.

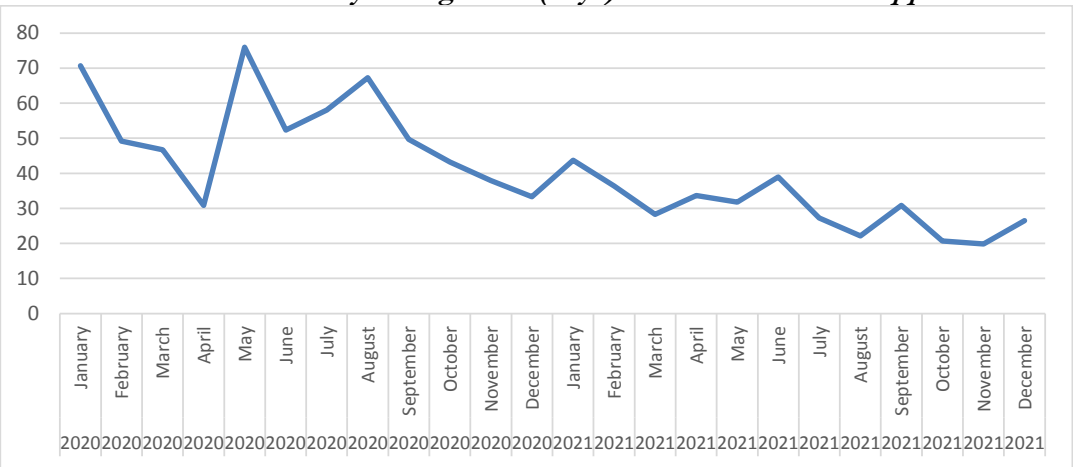
Service Delivery/Performance

- In December there were 178 admissions to Specialist Mental Health Services and 9,259 contacts with 2,484 individuals.
- **Adult Acute:** Recent work on discharge pathways from Te Awakura has resulted in slightly lower occupancy following a spike after last year's Level 4 lockdown. However, numbers under care remain high meaning the teams care risk associated with early discharge. The focus has moved onto considering transition for consumers in longer-term rehab and establishing community-based options for this group. This is driven by working with the consumers to create supports that can allow people to have the best possible lives and meet their aspirations for living functional lives in the least restrictive setting possible.
- The inpatient and community teams have focused on supporting mental health consumers to access COVID-19 vaccinations. Some cohorts of mental health consumers are reluctant to become vaccinated so teams have taken individualised approaches and devoted significant time to accompanying some consumers for vaccination. We are acutely aware that some mental health consumers are vulnerable and have the poorest health outcomes in our society, therefore vaccination is even more important. This effort has resulted in 82% of mental health consumers (both those under specialist and/or NGO care) being fully vaccinated and 87% have one vaccination.

Child Adolescent and Family

- The cohort in Child Adolescent and Family inpatient cohort continues to have very high acuity. In Canterbury COVID-19 has impacted on younger people to a greater degree than adults.
- Of note, despite the significant pressure on the Child Adolescent and Family service in recent years, the processes implemented by the team have reduced the average wait for first face-to-face appointment for community referrals (see figure below).

Child Adolescent and Family average wait (days) for first face-to-face appointment

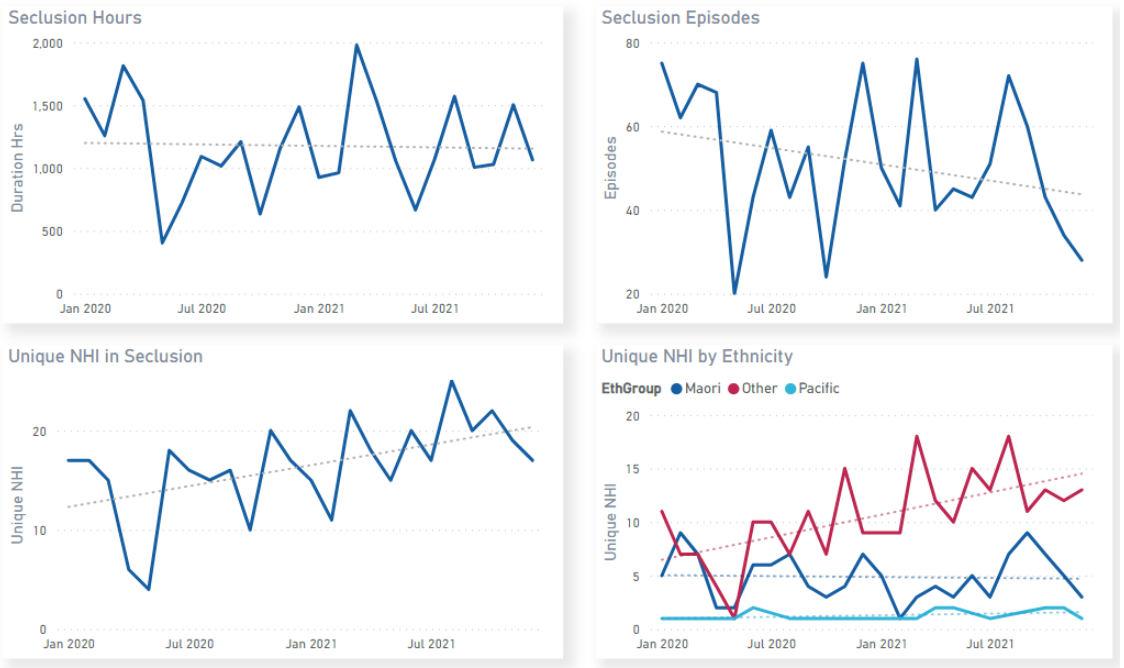


Forensic

- Our Forensic units remain under pressure with high volumes and we have temporarily capped the bed numbers due to staffing shortages (see staffing section). There are concerns that the reduced numbers of beds may not allow some people in prison to appropriately access care in our services. We are working closely with Corrections and Justice to mitigate any risks and prioritise those who require specialist care.

Quality and Safety

- The number of serious assaults has continued to decrease over the last three years, and we aim to further reduce these numbers.
- Reducing seclusion is a key focus for our restraint minimisation committee which aligns to the national Health Quality and Safety Commission campaign to reduce seclusion for inpatients. New systems that document the clinical rationale for seclusion which addresses the corrective action identified in last year's Certification audit. Our facilities remain a significant barrier to supporting best practice with lack of space and ability to provide physical separation and de-escalation.



- Recruitment remains problematic with difficulties in recruitment from overseas during the pandemic, perceived and real risk of working in mental health, other mental health and wellbeing opportunities (Mana Ake, Te Tumu Waiora, Manu Ka Rere funding streams resulting from He Ara Oranga), the vaccine manadate and COVID-19-related nursing opportunities. The number of new nurses has dramatically decreased with almost no overseas nursing having come into mental health since COVID-19 (New Zealand is the largest importer of overseas trained nurses in the OECD). Significant gaps exist in Forensic services, Adult Acute, Intellectual Disability and Community teams (especially Crisis Resolution).

OLDER PERSONS HEALTH & REHABILITATION (OPH&R)

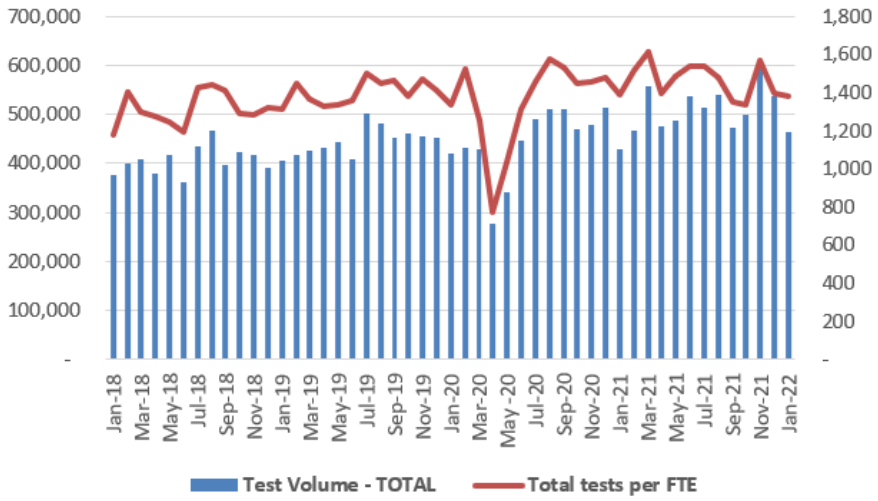
- Older Persons Mental Health has been working with aged residential care providers due to significant constraints around dementia hospital beds and the impact on flow. It has recently completed a review of existing residents with a view to reassess any appropriate residents who may no longer require that level of care. This process, over several visits, has resulted in reassessment of 12 residents who no longer required that level of care and will be transferred.
- The Kowhai programme continues in early stages of implementation with the first cohort of volunteers now active on the wards. We have received good feedback from staff and participants, with 100 hours contributed by volunteers in January.

LABORATORIES AND PATHOLOGY

- The COVID Readiness response within the teams in the laboratory is exceptional and the understanding of how to support each other and the DHB through what may be coming our way has shown their willingness to work together across the sector.

Total volume - tests processed by CHL (including COVID 19)

- Total workload increase over last 12 month (incl. COVID 19 testing) – 15.4%
- Total test per FTE increase over last 12 month – 8.5%



ALLIED HEALTH

- **Allied Health roles for Intensive Care Unit, tranche 1 approved and recruitment commenced**: 8.2FTE of new permanent positions have been approved for Allied Health for the 9-bed expansion in ICU, defined as tranche 1. These include roles in Physiotherapy, Dietetics, Pharmacy, Occupational Therapy, Speech-language Therapy, Maori Health, Social Work and an Allied Health Assistant. This will provide a much-needed staffing investment that in ICU and will improve patient outcomes by reducing hospital acquired deconditioning and decrease length of stay in ICU. Recruitment has commenced.
- **The physiotherapy pre-operative assessment clinic has been successful in reducing post op pulmonary complications:** A pre-operative assessment clinic for patients undergoing upper abdominal surgery commenced late 2020 has gone from seeing 2-3 patients through the clinic to seeing an average of 19 patients each month since May.
- **Pharmacy:** The Christchurch Hospital Pharmacy service hosted the annual New Zealand Hospital Pharmacists Association conference via a virtual platform and had 16 posters/oral presentations accepted. Three posters won awards as below:

Best poster by a technician	phebra	**Ashleigh Russell, Canterbury DHB** Reallocation Vs Wastage. Can We Do More?
Best poster in clinical research / audit	THE UNIVERSITY OF AUCKLAND NEW ZEALAND | MEDICAL AND HEALTH SCIENCES SCHOOL OF PHARMACY	**Ashleigh Kortegast Canterbury DHB** Attainment of Pharmacokinetic Targets with Once Daily Gentamicin Dosing for Synergy in Infective Endocarditis
Best poster in medication safety / innovation	douglas improving lives	**Lye Jinn Ng, Canterbury DHB** Creating a Visual Tool of Funded Emollients and Plain Steroid Creams in New Zealand to Support Dermatitis Management

- **Social Work:** Social Work are developing a Prioritisation Tool for consistency and visibility on how referrals are prioritised and triaged. Currently there is not a consistent clear and visible service delivery timeframe expectation from all aspects of AH to the organisation. Each AH service is working on operationalising a standardised timeframe tool for their prioritisation guideline.
- The expanded OT service in the Emergency Department commenced on 6 December 2021. This expanded service covers 7 days a week and is focusing on the frail elderly as well as concussion assessment.

INFORMATION SERVICES GROUP

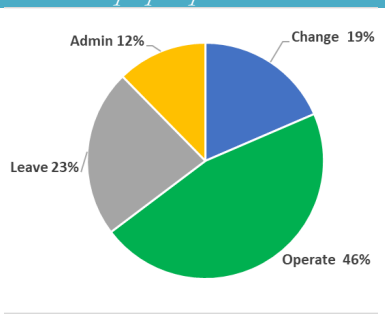
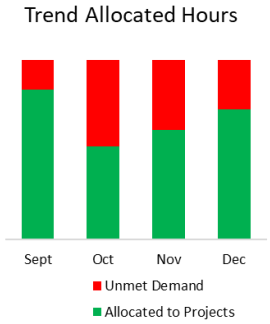
- ISG work on developing a complete view of project demand against ICT capabilities continues and is critical information for managing the forward demand and will be key information for the IS Governance forum. Developments here will see the expansion of our reporting to include regional work.

Service Delivery/Performance

Projects

Total		29
Green	On Plan	22
Amber	Needs Attention	6
Red	In Trouble	1

Project status stable over last month.
4 projects now in closure.

Overall Portfolio Status	*Where our people spent their time*	*Allocated Hours*
		
Overall portfolio remains GREEN, but some ongoing technical and resourcing risk.	As expected, much higher leave for December, but proportions for Operate and Change still fairly constant.	Project resourcing challenges remain. Focus on resource planning with delivery teams for better view of capacity.

Highlights

- OneCall (Telephone Office) software upgrade to 5.4, to enable ISG Call Centre software (also OneCall) implementation to proceed
- Cortex deployment to Christchurch campus complete to current plan
- Project Manager and Project Co-ordinator to start at ISG

Challenges

- Citrix platform instability has caused ongoing problems with access to TrendCare, and is slowing progress on VDI Replacement. TrendCare upgrade deferred.
- Further round of testing required for MedChart software (Round 4)

Next Steps

- IS Governance
- Further develop resource planning methodology.

Service Delivery

Activity	November	December	Trend
ISG opened tickets	13,510	10,151	↓
ISG resolved tickets	13,701	10,210	↓
ISG aged tickets (30+ days)	2,050	2,423	↑
ISG average incident resolution time	50 hours	79 hours	↑
ISG major incidents opened Last Month (P1)	9	1	↓

ISG average incident resolution time (P1)	16 hours 55 minutes	27 minutes	↓
Service Desk - Tickets resolved same day # (%)	3,588 (85.71%)	2,794 (82.42%)	↓
Service Desk call abandoned rate	22.19%	14.64%	↓
Top 3 departments tickets opened / resolved	1. Covid-19 Vaccination 2. Orthopaedic Outpatients 3. Oncology	1. Covid-19 Vaccination 2. Admin (MSRMAM) 3. WCSMG	
Training attendances recorded (incl. e-learning)	292	156	↓

- December started as a busy month for Service Desk, but the team brought the unassigned tickets in the queue from 340 to 57 by the last week of December.
- 98% of all training delivered in December was directly related to a clinical or a patient management system.

Highlights
- New starters are up to speed and demonstrating excellent skills
- The Self-Service Password tool went live, and 9096 users were registered in the first week of the tool being available. Many staff have used the service successfully.
- In December, call abandoned rate was 14.64% which was under our baseline of 15%

Challenges
- A shortage of office licences affected new accounts. The issue was resolved by freeing up some licences for short periods but created disruption of service for some customers.

Next Steps
- Proactive monitoring of calls to identify areas for improvement.

PEOPLE & CAPABILITY

- 16 Māori and Pasifika rangatahi were inducted into the organisation on 17 January as part of the mana enhancing recruitment campaign
- Recruitment commenced for two new part-time Welfare Advisor roles (SMHS and West Coast)
- A trial of the recruitment team managing the external offer letter process commenced end of January to accelerate the offer process and minimise the risk of candidates accepting offers elsewhere given competitive external market. This will continue for the next two months.
- Working in partnership with Mana Taurite (equity team) to support the Rangatahi Rōpu onboarding programme, with great feedback from attendees.
- Tāngata Ora Pulse Survey – we've released the Pulse Check and have been monitoring uptake.
- Orientation – we've released the pilot for the new experience and welcome, and our focus will be in refining and getting it right for when we return to an environment that allows for face-to-face events.
- Employee Anniversary Milestones – employee anniversary notifications have been updated and include a link to a knowledge article in max. This article contains suggestions for managers as to how they can acknowledge and celebrate these.
- Safe moving and handling team have started working with teams across the DHB on small Injury Prevention interventions.

FINANCE REPORT FOR THE PERIOD ENDED 31 DECEMBER 2021

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Keri Page Kreis, Acting Corporate Finance Manager**

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

DATE: **17 February 2022**

Report Status – For: Decision ☐ Noting ☑ Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Board:

i. notes the consolidated financial result YTD is favourable to plan by $1.978M;
ii. notes that the YTD impact of Covid-19 is $4.068M favourable to budget;
iii. notes that the YTD impact of the Holidays Act Provision (*HAP*) is an additional $8.085M expense which is in line with budget; and
iv. notes that excluding HAP and Covid-19, the YTD result is $2.106M unfavourable to budget.

3. FINANCIAL RESULTS EXECUTIVE SUMMARY

Summary DHB Group Financial Result – December 2021:

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
	$M	$M	$M	$M	$M	$M
Hospital & Specialist Service and Corporate	(3.969)	(7.187)	3.218	(32.488)	(37.978)	5.490
Community & Public Health	0.064	(0.038)	0.101	0.456	(0.037)	0.493
Total In-House Provider excl Subsidiaries	**(3.905)**	**(7.225)**	**3.319**	**(32.032)**	**(38.015)**	**5.983**
Add: Funder & Governance						
Funder Revenue	202.255	168.066	34.189	1,070.190	1,008.209	61.981
External Provider Expense	(75.717)	(73.053)	(2.664)	(462.855)	(430.230)	(32.625)
Internal Provider Expense	(137.017)	(103.883)	(33.135)	(657.670)	(623.293)	(34.376)
Total Funder	**(10.479)**	**(8.869)**	**(1.610)**	**(50.335)**	**(45.314)**	**(5.020)**
Governance & Funder Admin	0.227	0.000	0.227	1.095	0.000	1.095
Total Canterbury DHB (Parent)	**(14.157)**	**(16.094)**	**1.937**	**(81.272)**	**(83.330)**	**2.057**
Add: Subsidiaries						
NZ Health Innovation Hub	(0.010)	(0.029)	0.019	0.050	(0.075)	0.125
Brackenridge Services Ltd	0.045	(0.048)	0.093	0.245	0.156	0.089
Canterbury Linen Services Ltd	(0.089)	(0.020)	(0.069)	(0.394)	(0.102)	(0.292)
Canterbury DHB Group Surplus / (Deficit)	**(14.211)**	**(16.191)**	**1.980**	**(81.372)**	**(83.350)**	**1.978**

4. KEY FINANCIAL RISKS & EMERGING ISSUES

Covid-19 continues to have both a direct and indirect impact on our financial result. The Readiness and Resilience programme has been setup and we are awaiting MoH advice on the funding process.

Holidays Act Compliance - the workstream to determine CDHB's liability under the Holidays Act is continuing. We have accrued a liability based on an assessment from EY; there is risk that the final amount differs significantly from this accrued amount.

Staffing - The transition to Health NZ as well as ongoing Covid-19 restrictions on international travel are creating disruptions to recruitment. The pool of potential employees that we can recruit from is currently very limited, and some positions are hard to recruit to. This is adversely impacting on personnel costs as it increases overtime, additional duty payments, and locum costs. Additionally, the transition to Health NZ has created a level of uncertainty around the future of individuals and services, and there is risk we will lose staff until there is more certainty of the environment post 30 June 2022.

5. APPENDICES

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

APPENDIX 1: FINANCIAL RESULTS

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

	Period to date									Year to date								
December 2021 Results	Month Actual $000	Actual Covid-19 $000	Actual Holidays Act $000	BAU Actual $000	Month Budget $000	Budget Covid-19 $000	Budget Holidays Act $000	BAU Budget	BAU Variance	YTD Actual $000	Actual Covid-19 $000	Actual Holidays Act $000	YTD BAU Actual $000	YTD Budget $000	Budget Covid-19 $000	Budget Holidays Act $000	YTD BAU Budget	Underlying Variance
MOH Revenue	212,714	8,352		204,362	174,004	1,190		172,814	31,548	1,124,814	60,013		1,064,801	1,042,656	7,115		1,035,541	29,260
Patient related revenue	6,895	1,951		4,944	6,331	1,335		4,996	(52)	38,690	8,705		29,985	38,373	7,528		30,845	(860)
Other Revenue	6,620	3,912		2,708	4,215	1,025		3,190	(481)	32,875	12,913		19,962	25,477	6,149		19,328	634
Total Operating Revenue	226,230	14,215	-	212,015	184,550	3,550	-	181,000	31,015	1,196,379	81,631	-	1,114,748	1,106,506	20,792	-	1,085,714	29,034
Employee expenses	123,009	4,589	1,347	117,073	89,253	1,601	1,351	86,301	(30,772)	564,953	22,273	8,085	534,595	519,426	9,056	8,102	502,268	(32,327)
Treatment Related costs	17,928	721		17,207	16,720	699		16,021	(1,186)	110,847	6,188		104,659	107,263	4,191		103,072	(1,587)
External Provider costs	75,717	3,842		71,875	73,053	1,101		71,952	77	462,855	38,882		423,973	430,230	6,608		423,622	(351)
Other Expenses	11,932	2,375		9,557	9,939	151		9,788	231	68,881	8,793		60,088	62,955	911		62,044	1,956
Total Operating Expenditure	228,585	11,527	1,347	215,711	188,964	3,552	1,351	184,061	(31,650)	1,207,536	76,136	8,085	1,123,315	1,119,875	20,766	8,102	1,091,007	(32,309)
Operating result Surplus / (Deficit)	(2,355)	2,688	(1,347)	(3,696)	(4,414)	(2)	(1,351)	(3,061)	(635)	(11,157)	5,495	(8,085)	(8,567)	(13,368)	26	(8,102)	(5,292)	(3,275)
Total Indirect revenue and expenditure	(11,855)	(244)		(11,611)	(11,777)	(10)		(11,767)	155	(70,215)	(1,441)		(68,774)	(69,982)	(40)		(69,942)	1,168
Total - Surplus / (Deficit)	(14,211)	2,444	(1,347)	(15,308)	(16,191)	(12)	(1,351)	(14,828)	(480)	(81,372)	4,054	(8,085)	(77,341)	(83,350)	(14)	(8,102)	(75,234)	(2,106)

Covid-19 - Canterbury DHB's net result in relation to Covid-19 is a YTD surplus of $4.054M.

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

Patient related revenue includes revenue for MIQFs. We are invoicing MoH based on the actual costs of services provided.

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

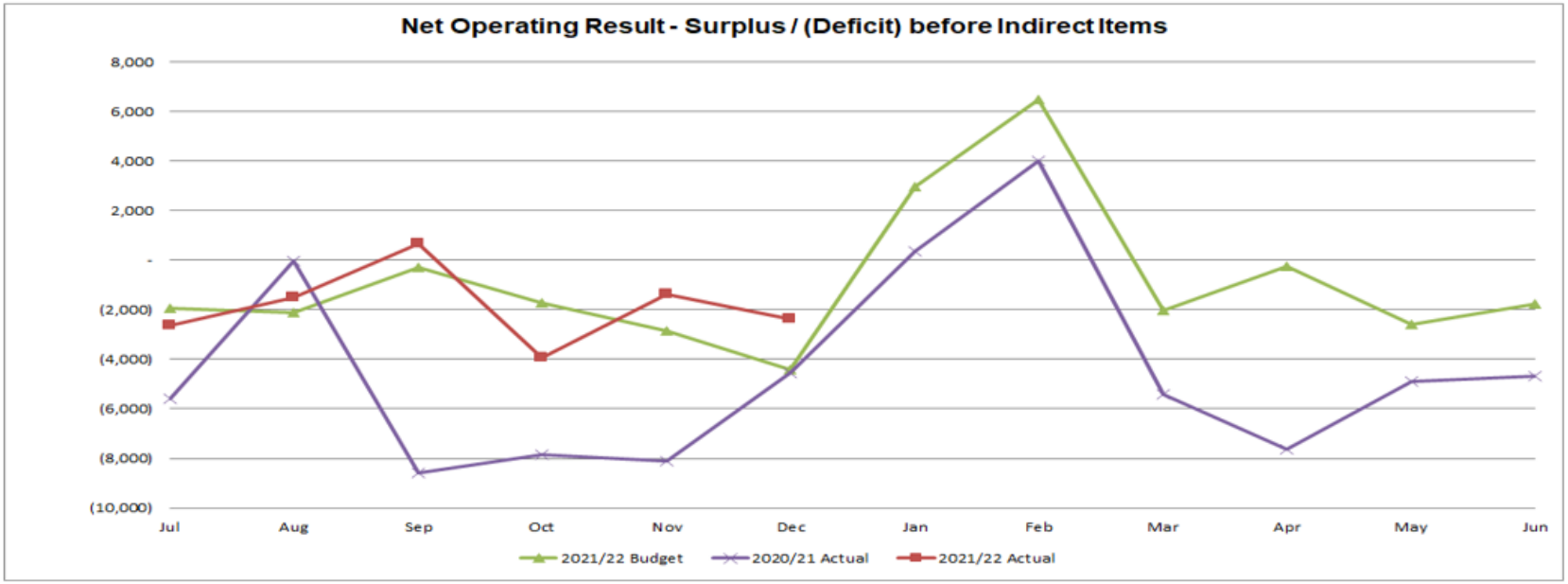
Variances to budget are generally related to vaccination activity as this programme is not included in the budget as per MoH instruction.

Our **Savings initiatives** for the full year total $42.2M, with $6M phased December YTD. Noting that our result excluding Covid-19 and HAP is a deficit of $2.107M, explainable by Chathams underfunding, RSV, and subsidiaries' results, our savings targets to date can be assumed to be achieved.

APPENDIX 2: FINANCIAL RESULT BEFORE INDIRECT REVENUE & EXPENSES

FINANCIAL PERFORMANCE OVERVIEW – PERIOD ENDED DECEMBER 2021

	Month Actual $'000	Month Budget $'000	Month Variance $'000		YTD Actual $'000	YTD Budget $'000	YTD Variance $'000		2020/21 Actual $'000	Yr End Budget $'000
Surplus/(Deficit) before Indirect items	(2,355)	(4,414)	2,059	-47% ✔	(11,157)	(13,368)	2,211	-17% ✔	(50,211)	(10,568)

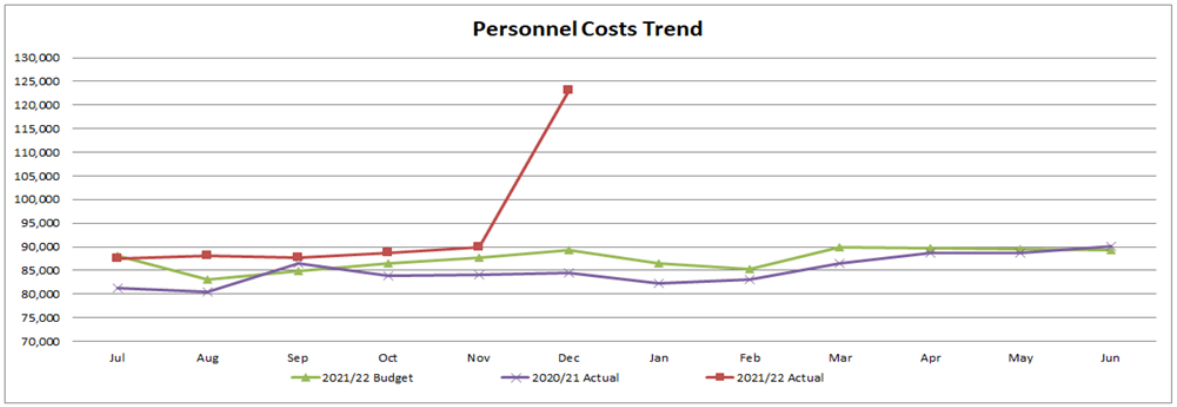


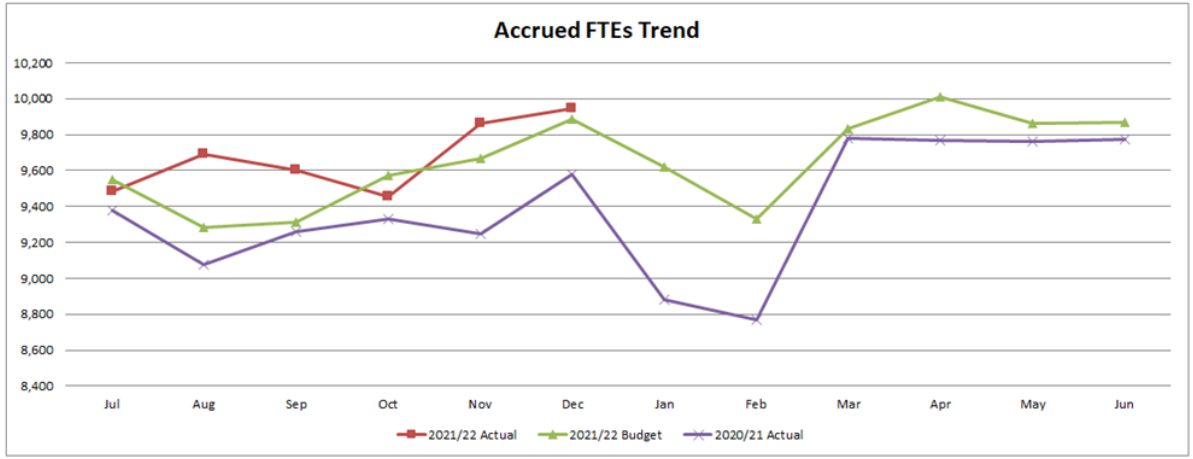
KEY POINTS

Our YTD result before indirect items is $2.211M favourable to budget. The main variances are:

- Additional costs for the Chatham Islands over and above the funding received ($1.109M YTD).
- RSV treatment costs estimated ($0.5M in July).
- Revenue from subsidiary below budget –Canterbury Linen ($0.396M YTD) due to reduced hotel and motel revenue impacted by Covid-19.
- Offset by YTD surplus of $4.054M for Covid-19.

PERSONNEL COSTS/PERSONNEL ACCRUED FTE



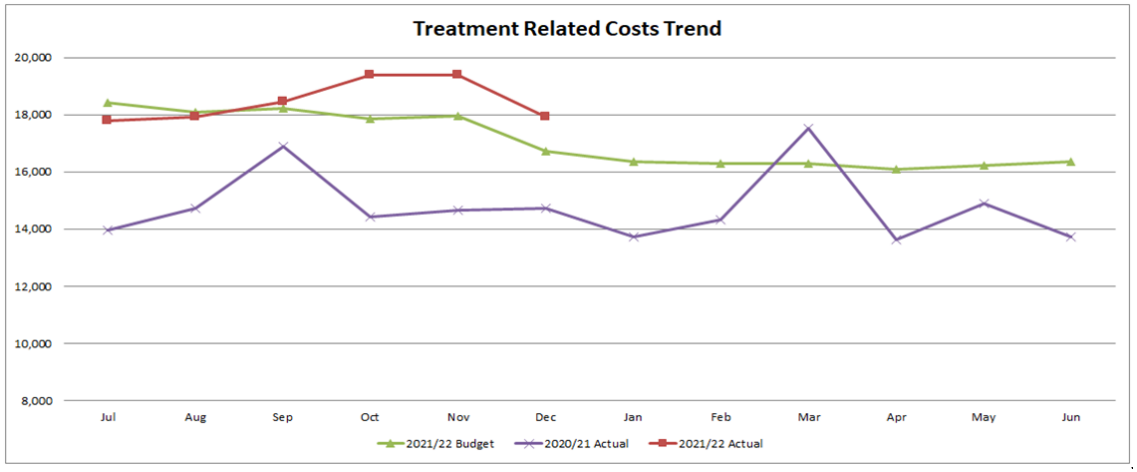


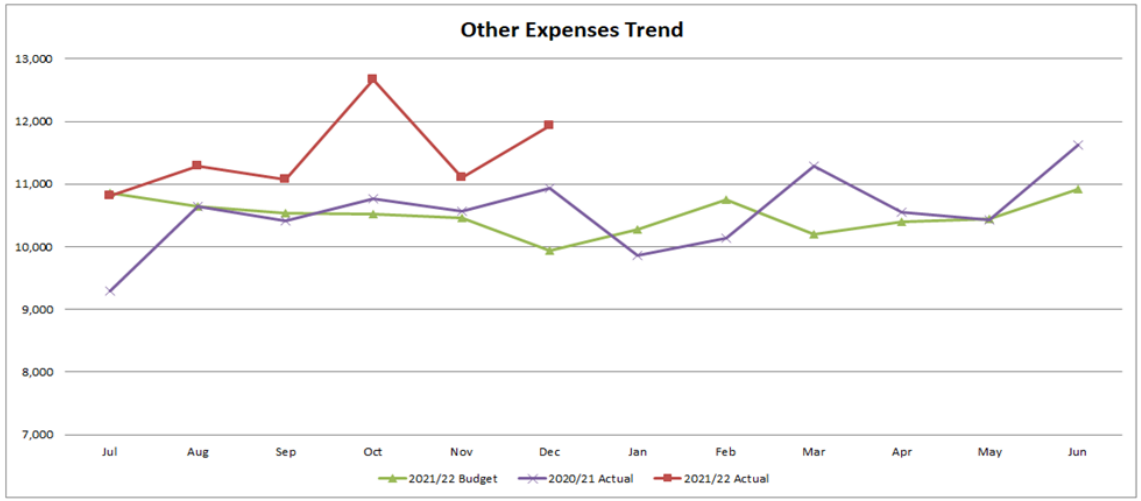
KEY POINTS

Personnel Costs are unfavourable to plan YTD. $13.271M is related to Covid-19 (vaccination costs were not included in the budget as instructed by the MoH); however, Covid costs are offset by additional revenue. The interim pay equity settlement for Nurses and Midwives was paid out in December, which is offset by additional revenue.

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

TREATMENT RELATED & OTHER COSTS (excluding Covid-19)





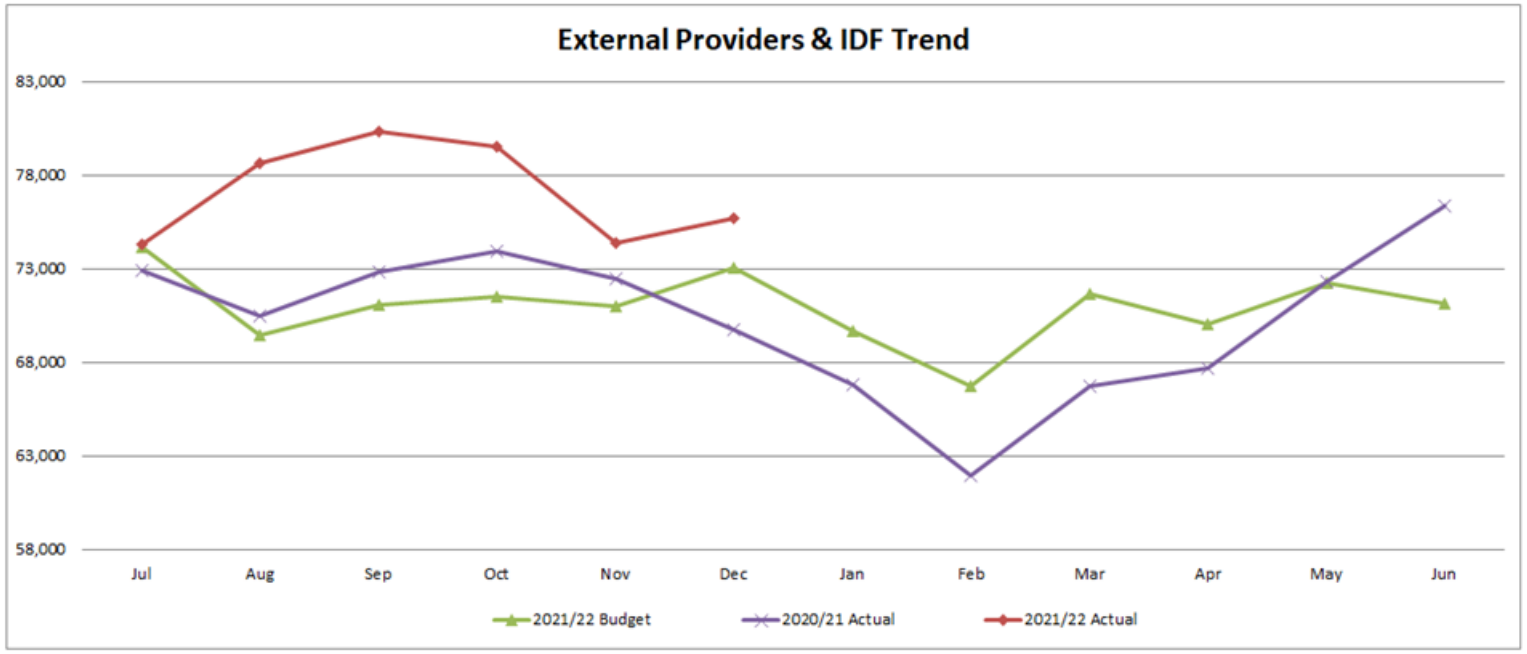
KEY POINTS

Treatment related costs include $1.997M of Covid-19 related costs offset by Covid revenue; the YTD BAU variance is $1.587M unfavourable.

Other Expenses are unfavourable to budget YTD. Maintenance and outsourced costs are tracking lower than expected. Covid-19 expenses are $7.891M unfavourable, which is offset by additional Covid revenue.

EXTERNAL PROVIDER COSTS (excluding Covid-19)

	Month Actual $'000	Month Budget $'000	Month Variance $'000			YTD Actual $'000	YTD Budget $'000	YTD Variance $'000			2020/21 Actual $'000	Yr End Budget $'000
External Provider Costs	75,717	73,053	(2,664)	-4%	✗	462,855	430,230	(32,625)	-8%	✗	844,188	851,785



KEY POINTS

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

FINANCIAL POSITION – EQUITY & CASH

	YTD Actual $'000	YTD Budget $'000	Variance $'000		YTD Actual $'000	YTD Budget $'000	Variance $'000	Year End 20/21 $'000
Equity	1,053,947	1,051,974	(1,973)	Cash	195,765	112,442	83,323	50,775

KEY POINTS

The December cash position is high due to the January PBFF payment being received early.

APPENDIX 3: CANTERBURY DHB GROUP INCOME STATEMENT

The Group financial results include Canterbury DHB and its subsidiaries
For the 6 months ending 31 December 2021

Month					Year to Date					
21/22 Actual $000's	21/22 Budget $000's	20/21 Actual $000's	Variance to Budget $000's		21/22 Actual $000's	21/22 Budget $000's	20/21 Actual $000's	Variance to Budget $000's	21/22 Budget $000's	20/21 Actual $000's
212,714	174,004	165,230.59	38,710 ✓	MoH Revenue	1,124,814	1,042,656	987,595	82,158 ✓	2,086,388	1,991,657
6,895	6,331	4,069	564 ✓	Patient Related Revenue	38,690	38,373	35,339	317 ✓	76,994	73,244
6,620	4,215	4,645	2,406 ✓	Other Revenue	32,875	25,477	26,063	7,398 ✓	58,295	48,140
226,230	**184,550**	**173,944**	**41,680**	**Total Operating Revenue**	**1,196,379**	**1,106,506**	**1,048,997**	**89,873**	**2,221,677**	**2,113,041**
123,009	89,253	84,435	(33,756) ✗	Personnel Costs	564,953	519,426	500,479	(45,527) ✗	1,049,643	1,019,771
17,928	16,720	14,720	(1,208) ✗	Treatment Related Costs	110,847	107,263	89,358	(3,584) ✗	204,873	177,141
75,717	73,053	69,733	(2,664) ✗	External Service Providers	462,855	430,230	432,330	(32,625) ✗	851,785	844,188
11,932	9,939	9,681	(1,993) ✗	Other Expenses	68,881	62,955	61,326	(5,926) ✗	125,943	122,152
228,585	**188,964**	**178,569**	**(39,621)** ✗	**Total Operating Expenditure**	**1,207,536**	**1,119,875**	**1,083,493**	**(87,662)** ✗	**2,232,245**	**2,163,252**
(2,355)	**(4,414)**	**(4,625)**	**2,059** ✓	**Total Surplus / (Deficit) Before Indirect Items**	**(11,157)**	**(13,368)**	**(34,495)**	**2,211** ✓	**(10,568)**	**(50,211)**
147	60	164	88 ✓	Interest Revenue	410	321	669	89 ✓	700	1,075
398	418	674	(20) ✗	Capital Charge Relief / Debt Equity Swap Funding	2,390	2,510	-	(120) ✗	5,020	8,940
351	430	477	(79) ✗	Donations	2,625	2,414	1,015	211 ✓	5,010	2,384
-	-	5	- ✓	Profit on Sale of Assets	1	-	413	1 ✓	-	1,653
-	-	-	-	Joint Venture Income	-	-	-	- ✓	-	25
897	**908**	**1,320**	**(11)** ✗	**Total Indirect Revenue**	**5,426**	**5,245**	**2,096**	**182** ✓	**10,730**	**14,078**
4,762	4,656	2,024	(106) ✗	Capital Charge	27,982	27,956	12,147	(26) ✗	53,949	39,871
7,740	7,788	9,052	48 ✓	Depreciation	46,160	45,689	41,865	(471) ✗	92,104	94,651
245	236	123	(9)	Financing Component of Operating Leases	1,479	1,515	736	36	3,015	2,079
(10)	5	64	15 ✓	Interest Expense & Forex Gains and Losses	(4)	67	306	71 ✓	100	60
15	-	1,253	(15) ✗	Loss on Sale of Assets	24	-	1,290	(24) ✗	-	4,336
12,752	**12,685**	**12,516**	**(67)** ✗	**Total Indirect Expenses**	**75,641**	**75,227**	**56,343**	**(414)** ✗	**149,168**	**140,998**
(14,211)	**(16,191)**	**(15,821)**	**1,980** ✓	**Total Surplus / (Deficit)**	**(81,372)**	**(83,350)**	**(88,742)**	**1,978** ✓	**(149,006)**	**(177,131)**

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

Overall the vaccination revenue and expenses net off.

APPENDIX 4: CANTERBURY DHB GROUP STATEMENT OF FINANCIAL POSITION

as at 31 December 2021

Audited 30-Jun-21 $'000		Group Actual 31-Dec-21 $'000	Group Budget 31-Dec-21 $'000	Annual Group Budget 30-Jun-22 $'000
490,730	Opening Equity	1,124,844	1,124,844	1,125,762
178,139	Net Equity Injections / (Repayments) During Year	9,557	9,557	151,139
537,624	Other Movements	-	-	97,357
95,482	Reserve Movement for Year	-	-	-
(177,131)	Operating Results for the Period	(81,372)	(83,345)	(149,006)
1,124,844	**TOTAL EQUITY**	1,053,030	1,051,056	1,225,252
	Represented By:			
	Current Assets			
50,775	Cash & Cash Equivalents	195,765	112,442	120,487
750	Short Term Investments	750	750	750
107,157	Trade and Other Receivables	131,225	107,157	107,157
6,278	Prepayments	16,639	6,278	6,278
13,811	Inventories	14,681	13,811	13,811
15,095	Restricted Assets	14,768	15,094	15,094
193,866	**Total Current Assets**	373,827	255,532	263,577
	Less Current Liabilities			
-	Overdraft	-	-	-
1,682	Borrowings (Finance Leases Current)	1,689	1,682	1,682
159,296	Trade and Other Payables	380,614	299,843	155,218
15,111	Restricted Funds	16,312	15,111	15,111
381,697	Employee Benefits	406,925	381,696	381,696
557,786	**Total Current Liabilities**	805,541	698,332	553,707
(363,920)	**Working Capital**	(431,714)	(442,800)	(290,130)
	Non Current Assets			
16	Restricted Funds	16	16	16
4,253	Investment	4,365	4,253	4,253
1,541,081	Fixed Assets	1,536,216	1,546,173	1,567,699
1,545,350	**Term Assets**	1,540,596	1,550,442	1,571,968
	Non Current Liablilties			
7,544	Employee Benefits	7,439	7,544	7,544
49,042	Borrowings (Finance Leases Non Current)	48,413	49,042	49,042
56,586	**Term Liabilities**	55,852	56,586	56,586
1,124,844	**NET ASSETS**	1,053,030	1,051,056	1,225,252

Restricted Assets and Restricted Funds include funds held by the Māia Foundation on behalf of CDHB.

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

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

APPENDIX 7: CANTERBURY DHB GROUP STATEMENT OF CASHFLOW

Audited 30-Jun-21 $'000		Actual 31-Dec-21 $'000	YTD Budget 31-Dec-21 $'000	Budget 30-Jun-22 $'000
	CASHFLOW FROM OPERATING ACTIVITIES			
(46,875)	**Net Cash from Operating Activities**	177,071	106,050	(56,903)
	CASHFLOW FROM INVESTING ACTIVITIES			
(78,847)	**Net Cash from Investing Activities**	(42,016)	(53,940)	(121,881)
	CASHFLOW FROM FINANCING ACTIVITIES			
183,463	**Net Cash from Financing Activities**	9,935	9,557	248,496
57,741	Overall Increase/(Decrease) in Cash Held	144,990	61,667	69,712
(6,966)	Add Opening Cash Balance	50,775	50,775	50,775
50,775	**Closing Cash Balance**	195,765	112,442	120,487

LOCALITIES UPDATE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Linda Wensley, CCN Executive Director (Acting)**

APPROVED BY: **Tracey Maisey, Executive Director, Planning Funding & Decision Support**
Michelle Turrall, Chair, Manawhenua ki Waitaha Charitable Trust
Hector Matthews Executive Director, Māori & Pacific Health.

DATE: **17 February 2022**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report comes from the Canterbury Clinical Network (CCN), on behalf of system partners on the request of the Canterbury DHB Executive Director Planning Funding and Decision Support, and the Chair of Manawhenua ki Waitaha Charitable Trust.

2. RECOMMENDATION

That the Board:

i. notes the Localities Update report.

3. SUMMARY

Canterbury was invited to submit a locality prototype proposal by the Interim Health New Zealand (*Health NZ*) and Māori Health Authority (*MHA*), due 18 February. This report summarises actions taken and the decision not to submit a proposal.

4. DISCUSSION

Background

A key feature of the Health and Disability System Reforms is the establishment of localities, described as 'a geographic area defined and bounded by what makes sense to people'[1]. From a practical perspective, localities are a unit for the planning and delivering of health services. Health NZ and the MHA describes localities as providing a platform for:

- Partnership with Māori;
- Community and whānau engagement;
- Addressing social determinants of health;
- Development of enhanced models of care;
- Improved data sharing and digital tools; and
- Integrated service delivery with provider networks established to strengthen collaboration.

A phased approach has been adopted to establish localities across New Zealand. Prototypes are being used to test and refine the approach and inform the future rollout. More information on localities is available here.

[1] It might follow iwi or rohe lines, or it might follow a similar boundary to current regional or local councils. https://www.futureofhealth.govt.nz/about-the-reforms/how-health-system-changing/localities/

Canterbury health system's approach in particular our Rural Models of Care development provide learnings relevant to the localities approach; see CCN Learnings document (pg 12) here.

Current Situation

On 30 November the Health NZ and MHA invited Canterbury to develop and submit a locality prototype proposal collectively with mana whenua partners, and primary and community providers, due 18 February 2022.

Canterbury was one of 13 DHB areas identified as having a prototype 'locality of interest' based on an assessment of population demographics, provider relationships and the view that Canterbury has an advanced model of integration with learnings relevant for future locality development.

Five to six locality prototype proposals from tranche one will be selected and funded to complete the next phases of locality plan development and implementation.

The CCN was supported by system partners to coordinate our response on behalf of the Canterbury health system.

At a meeting involving Canterbury's alliance partners[2], Manawhenau Ki Waitaha Charitable Trust (*MKWCT*) and Pasifika Futures, it was noted:

- All system partners were committed to working collaboratively on locality development and in partnership with Māori.
- Ngāi Tahu was yet to confirm its takiwā boundaries and determine a consistent approach to localities. All partners affirmed the importance of this mahi to enable mana whenua readiness to work on localities.
- Partners acknowledged that to achieve a different outcome (i.e., improved equity for Māori), partnering with mana whenua at the start was critical.

At a subsequent meeting with the Localities Co-Directors at Health NZ, Canterbury health system's position was discussed. MKWCT acknowledged the strengthening relationship with local system partners and signalled more time was required to properly engage papatipu rūnunga ahead of any locality development and submission of a prototype proposal.

The Localities Co-Directors complimented our commitment to partner with Māori and advised Canterbury against progressing a proposal for tranche one, recommending that we take time to advance our localities approach, ahead of tranche two (to be confirmed late in 2022). They also noted this came with retaining flexibility to balance work on localities with other system priorities.

What's Next?

MKWCT are engaging with papatipu rūnunga over February / March to discuss the development of localities. Regular communication between CCN and MKWCT will seek guidance on their readiness to engage with system partners in the localities development.

Opportunities for Canterbury to participate in national events for sharing tranche one prototype learnings is being explored.

Risks & Mitigations

No risks identified

[2] Canterbury DHB, Pegasus Health, Waitaha and Christchurch PHOs, Canterbury Community Pharmacy Group, Nurse Maude, Healthcare NZ, Access Healthcare, St John, The College of Midwives (CWC Branch).

Canterbury system partners support to partner with Māori at the start of the localities work positively signals our commitment to addressing inequities in health outcomes for Māori.

Communications

Communication to system partners that Canterbury will not be submitting a localities prototype proposal in tranche one is underway, including to the DHB and MKWCT Boards, the CCN Alliance Leadership Team, alongside a formal response to Health NZ and the MHA.

5. CONCLUSION

While Canterbury will not be submitting a localities prototype proposal for tranche one, local work to build on previous learnings and advance our localities approach will continue in partnership with mana whenua.

CARE CAPACITY DEMAND MANAGEMENT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Janette Dallas, Nursing Director, Care Capacity Demand Management**

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

DATE: **17 February 2022**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report has been generated for the Board as a quarterly update on the Care Capacity Demand Management (*CCDM*) programme. The CCDM programme was approved by the Board for implementation in August 2019 to better match nursing and midwifery supply to patient care demand.

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

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

- Shows examples of improvements to a patient care process/system.
- Changes to workforce management/environment.
- Efficiencies across wards/units resulting from CCDM.

2. RECOMMENDATION

That the Board

i. notes the Care Capacity Demand Management report.

3. SUMMARY

The CCDM programme is progressing well, however, as reported previously we did not meet our June 2021 deadline for the Ministry of Health. Full implementation is dependent on the completion of all the FTE calculations and these calculations commenced in 2021 within the CDHB and are continuing to be phased throughout this year as able. We are working on contingency plans with COVID disruptions to continue to progress with guidance by the Safe Staffing Healthy Workplace Unit (*SSHWU*).

4. DISCUSSION

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

Governance

The governance group meets monthly and contains membership of the Executive Management Team, senior nursing and midwifery leads and members of each union. Working groups as a subset as part of the CCDM requirements are also working well and we have moved to a business as usual (*BAU*) model.

TrendCare / Acuity Tool

TrendCare has been implemented in all inpatient areas apart from the Dialysis Unit and Oncology Day Unit. We have been delayed due to resourcing in installing the latest version of TrendCare. Trendcare data is now visible within the core data set display allowing us to monitor that we are meeting the vendor gold standards.

Core Data Set

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

Variance Response Management (*VRM*)

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

FTE Calculations

We have commenced the first round of FTE calculations (26 out of 72 wards) for the first tranche wards. Seventeen wards have had FTE approved by the CCDM Council and recruitment has commenced. We aim to have completed all wards by December 2022. The FTE calculations are annual for each clinical area, so we will be commencing our next year's round of FTE review in June 2022 for those first tranche wards.

The Safe Staffing Healthy Workplaces (*SSHW*) Governance Group will be evaluating the status of the implementation of the CDHB's CCDM approach in March this year as part of each DHB's rollout, however, this may be delayed.

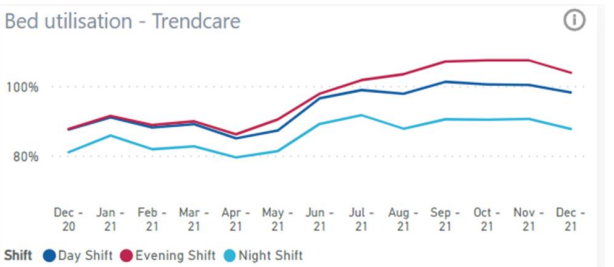
5. CONCLUSION

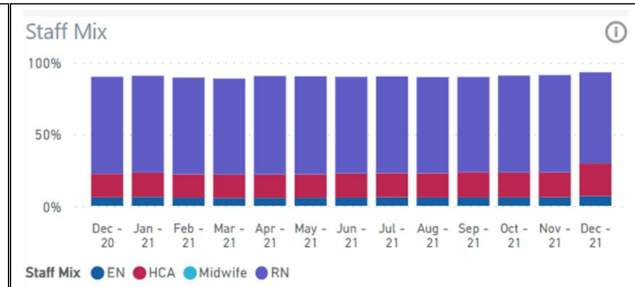
Our CCDM team are working at exceptional pace with the assistance of the team within the SSHW Unit during what can only be described as a challenging year. We are working very closely and in partnership with our unions and we are all deeply committed to ensuring safe patient care, a quality patient care environment and healthy workplaces are the outcome.

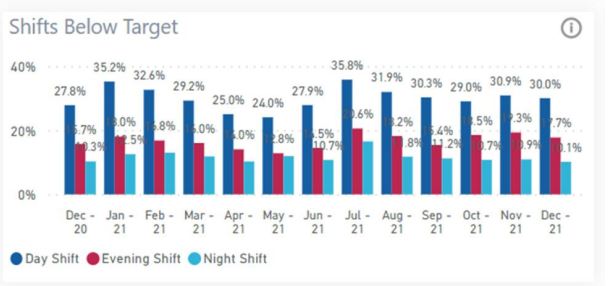
6. APPENDICES

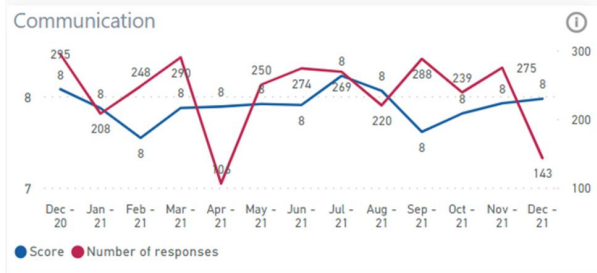
Appendix 1: CCDM Data – Christchurch Campus, Ashburton, Burwood & SMHS
Appendix 2: CCDM Data - Midwifery

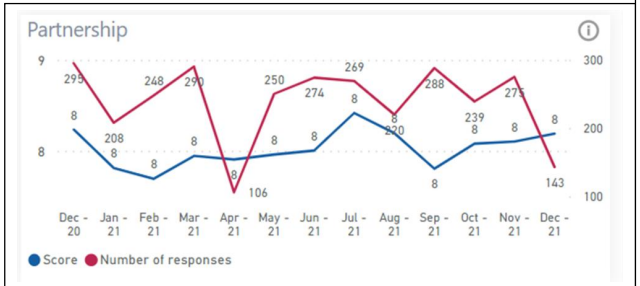
Christchurch campus, Ashburton Burwood and SMHS,

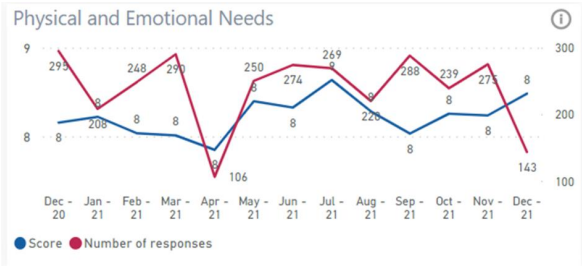


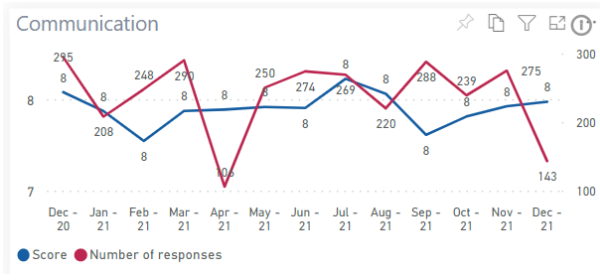












Christchurch campus, Ashburton Burwood and SMHS,

Bed Utilisation (Monthly)

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

Staff mix (Monthly)

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

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

Patient incidents (Monthly)

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

Shifts Below Target (Monthly)

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

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

Safe Staffing (reporting commenced October 21)

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

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

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

Coordination (quarterly)

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

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

Partnership (quarterly)

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

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

Physical and Emotional needs. (quarterly)

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

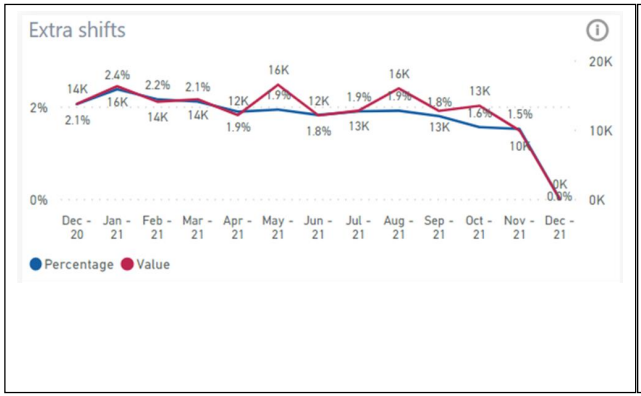
Example
Did the hospital treat you with kindness and understanding while you were in the hospital?
Did the hospital treat you with respect?
Did hospital staff help you to get to the bathroom or to use a bedpan as soon as you wanted?

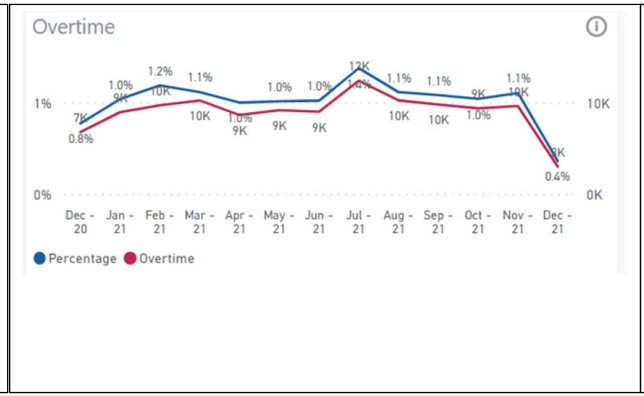
Communication (quarterly)

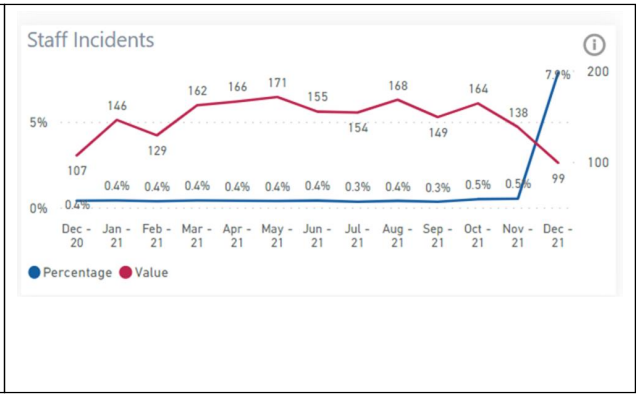
Results from the patient experience survey as defined by the Health Quality Safety Commission. Reported as a total score (/10) from each of the four domains. The line in red is the number of responses.

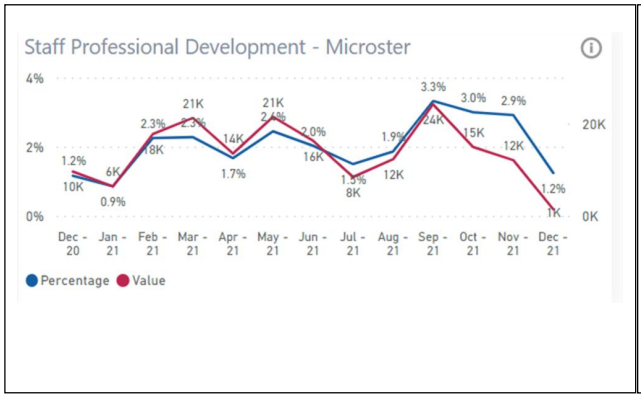
Note: This cannot be drilled down to a ward level - reported by DHB only.
Patient experience is an indicator of the quality of care provided to patients. There is evidence that quality work environments and higher levels of registered nurses are associated with higher patient satisfaction. There is a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

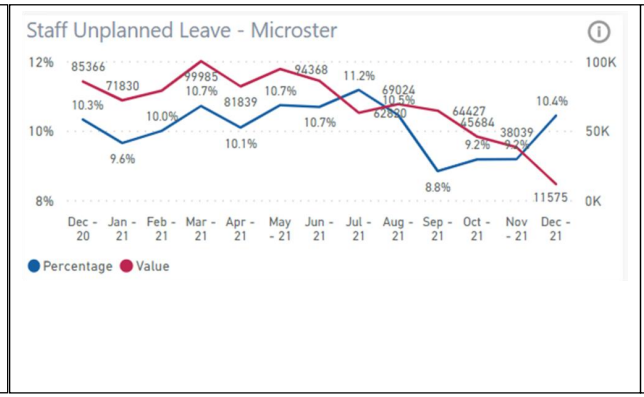
Christchurch campus, Ashburton Burwood and SMHS,



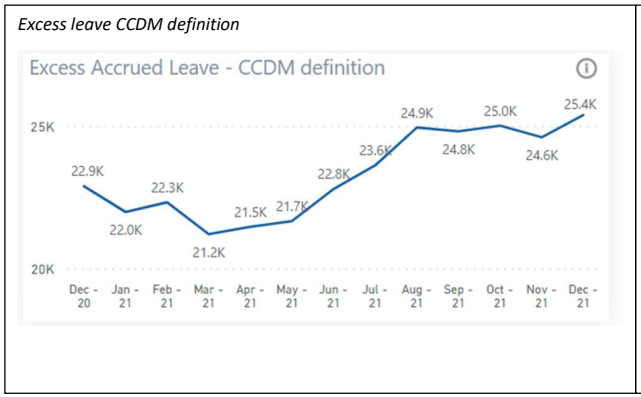


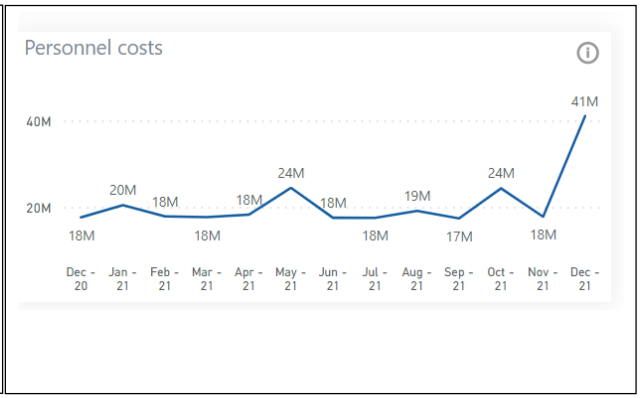






Excess leave CCDM definition





Christchurch campus, Ashburton Burwood and SMHS,

Extra Shifts (Monthly)

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

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

Overtime (Monthly)

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

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

Staff Incidents (Monthly)

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

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

Staff Professional Development (Monthly)

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

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

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

Unplanned Leave (Monthly)

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

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

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

Excess Accrued Leave/ CDHB

Actual number of annual leave hours remaining above 30 hours

Rationale

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

Excess Accrued Leave/ CCDM

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

Rationale

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

Total Leave Accrued.

Total hours of leave accrued.

Source: HRIS leave data

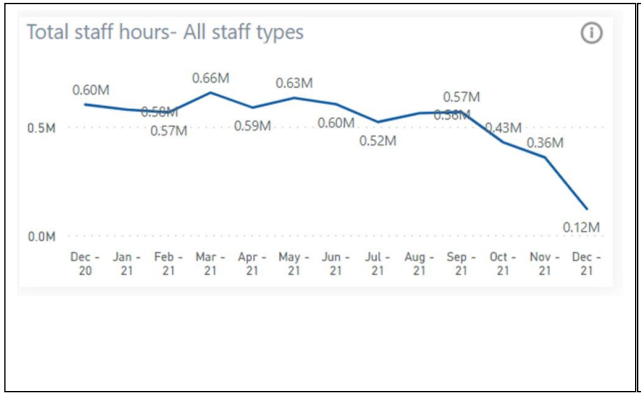
Personnel Costs (Monthly)

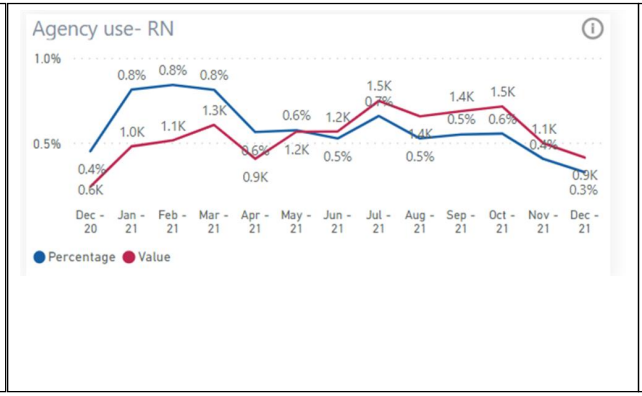
The dollar amount spent per month on personnel costs (e.g. nursing, HCA). Includes personnel costs for casual staff. The peaks are when there are more than two pay periods in one month.

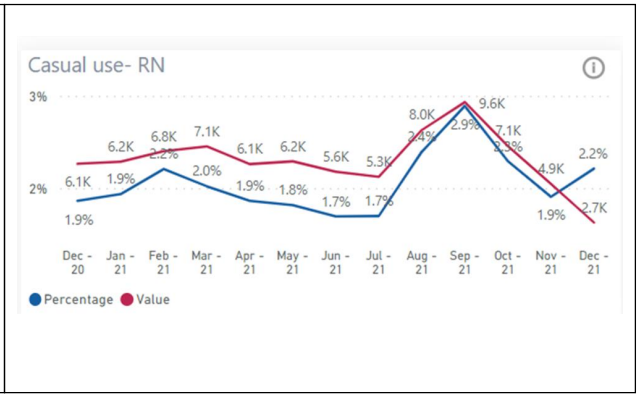
Rationale

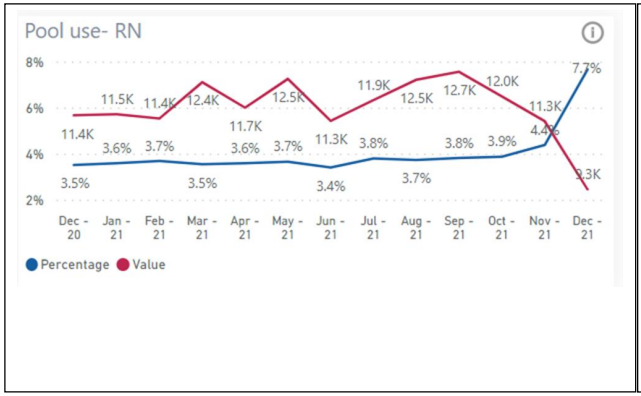
Nursing is the largest workforce and therefore one of the biggest investments in providing healthcare services. DHBs are responsible for best value for public health system resources. A logical step in achieving this is to monitor the spend on nursing personnel costs. Some studies suggest higher staff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

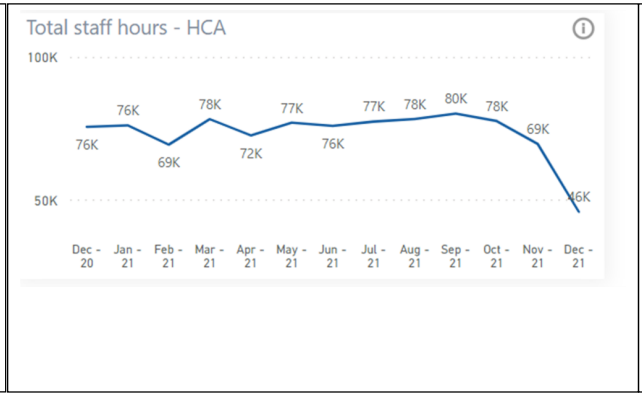
Christchurch campus, Ashburton Burwood and SMHS,

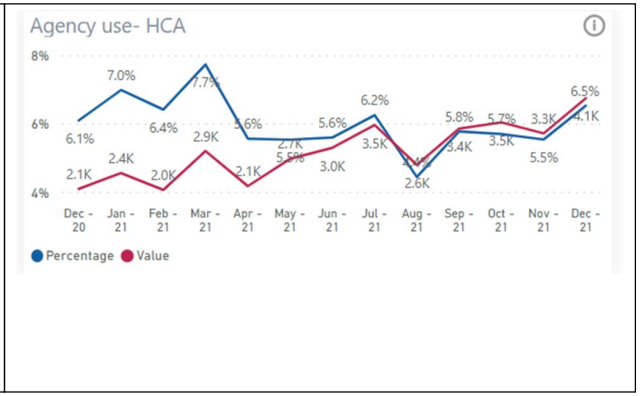


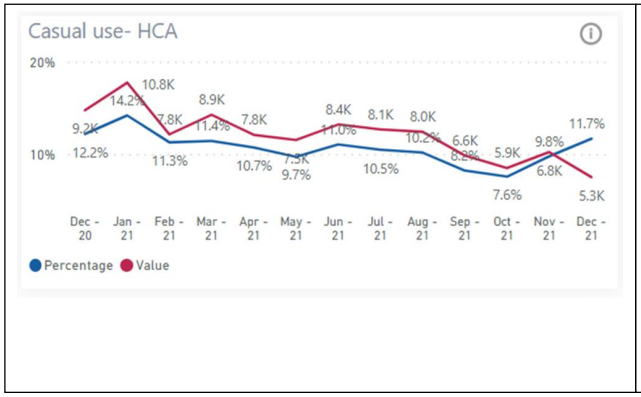


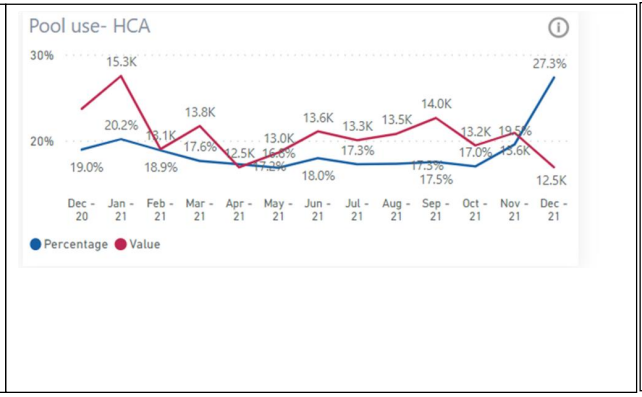


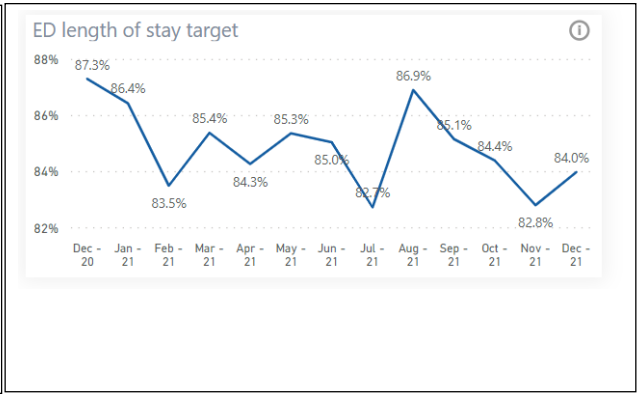












Christchurch campus, Ashburton Burwood and SMHS,

Total staff hours Registered Nurse

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

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

Rationale

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

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

Agency use Registered Nurse

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

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

Casual Registered nurse (casual pool)

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

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

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

Casual Registered nurse use (from permanent pool)

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

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

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

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

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Casual HCA (casual pool)

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Rationale
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ED length of stay target

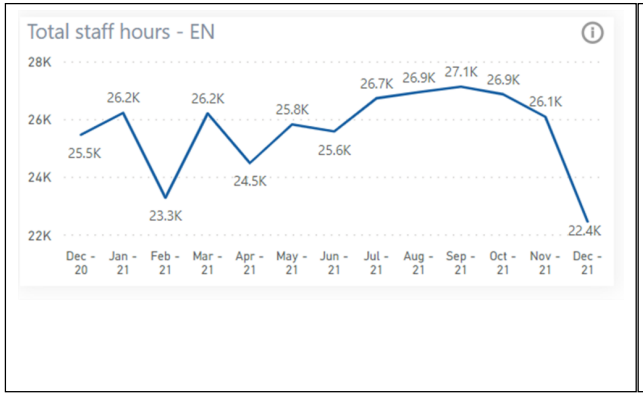
Sum of patients admitted, discharged, or transferred from ED within six hours / total number patients seen x 100.

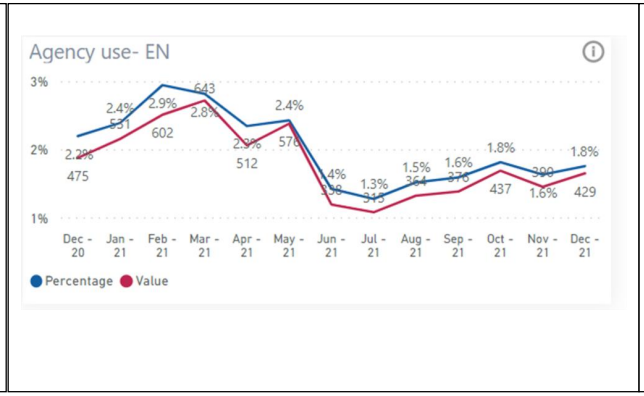
We moved into Waipapa on the 18th November and the ED observation unit was closed.

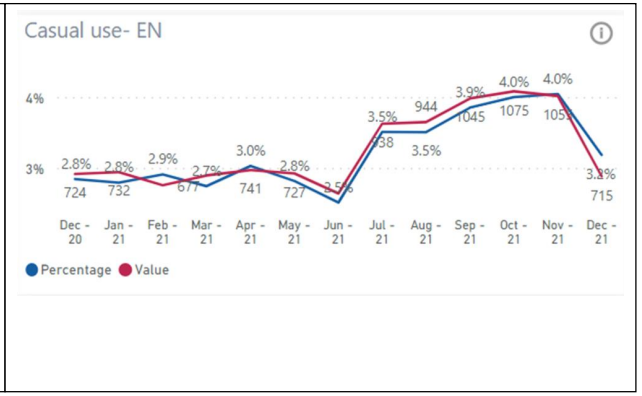
Rationale

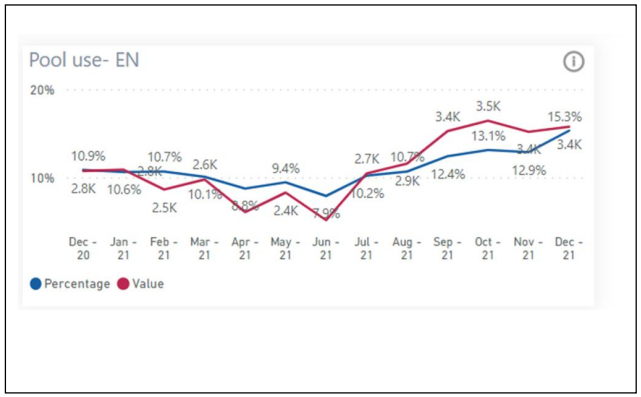
This is a national DHB performance measure. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals and home again.

Christchurch campus, Ashburton Burwood and SMHS,









Christchurch campus, Ashburton Burwood and SMHS,

Total staff hours enrolled nurse Displayed in red for percentage of worked hours and in blue as the actual hours The total hours includes all productive (clinical and other productive hours) and non-productive (annual, sick, bereavement) hours, includes casual staff. **Rationale** It is important to see the total hours so that the dollar spend can be accounted for in terms of productive and non-productive hours. Nursing hours have a significant impact on patient outcomes such as morbidity, mortality and incidents.	**Agency use enrolled nurse** Displayed in red for percentage of worked hours and in blue as the actual hours Hours paid to agency staff working in inpatient areas compared with total hours worked by staff CDHB.	**Casual enrolled nurse (casual pool)** Displayed in red for percentage of worked hours and in blue as the actual hours Hours paid to staff working in inpatient areas on casual contract compared with total hours worked by staff on permanent contracts. As percentage of total hours of care. **Rationale** Casual staff play an important role in the hospitals variance response management system. However, increasing or persistently high casual use is of concern for several reasons. Casual staff may not be familiar with the environment or have the same skill set as the staff they are replacing. Team function can be altered by high levels of casual staff. Casual labour may also directly and indirectly cost more.

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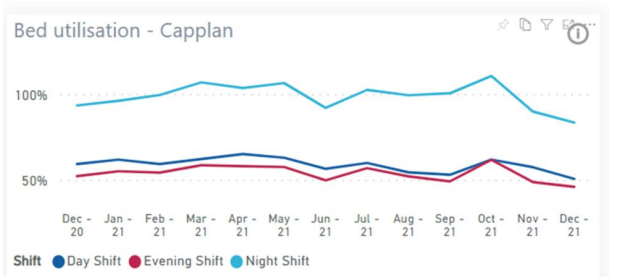
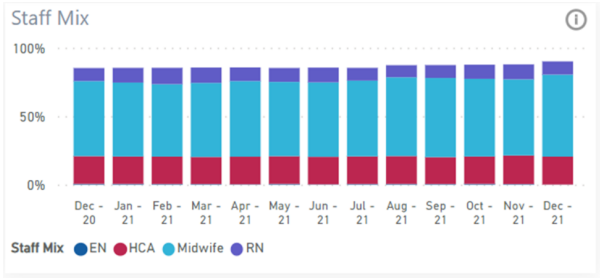
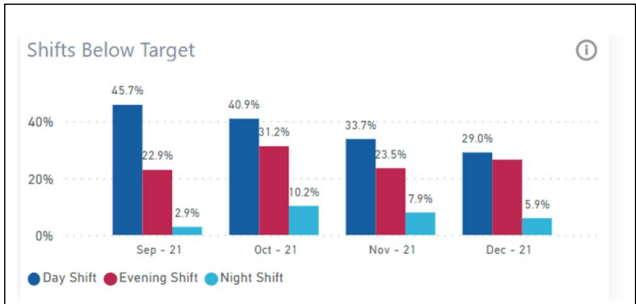
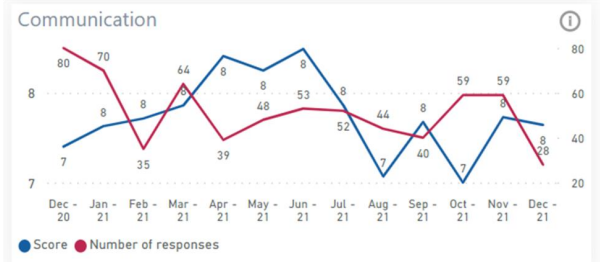
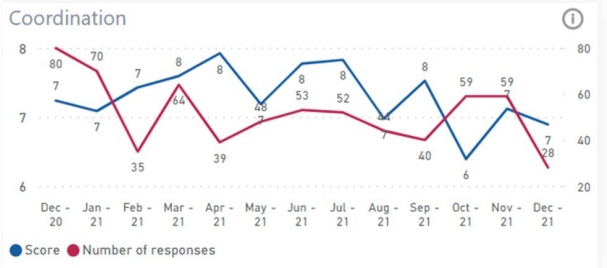
Midwifery

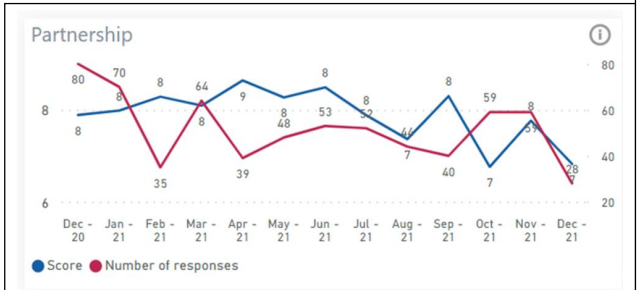


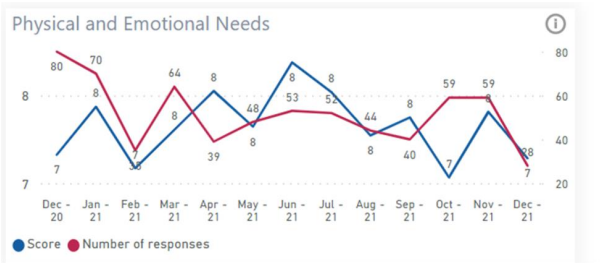




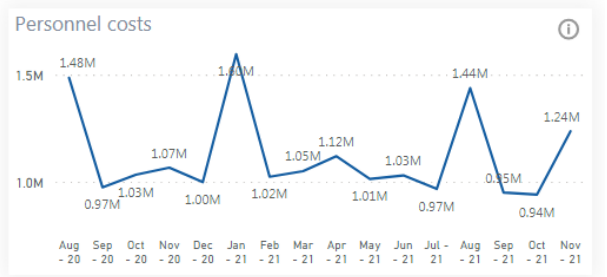








Personal cost monthly



Midwifery

Bed Utilisation (Monthly)

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

Staff mix (Monthly)

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

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

Patient incidents (Monthly)

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

Shifts Below Target (Monthly

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

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

Communication (quarterly)

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

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

Coordination (quarterly)

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

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

Partnership (quarterly)

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

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

Physical and emotional needs. (quarterly)

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

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

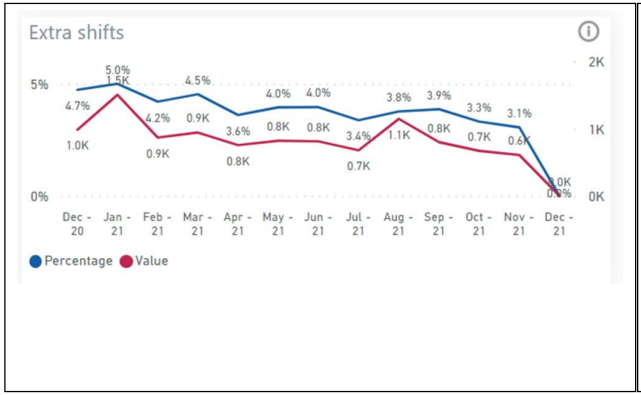
Personal Costs (Monthly)

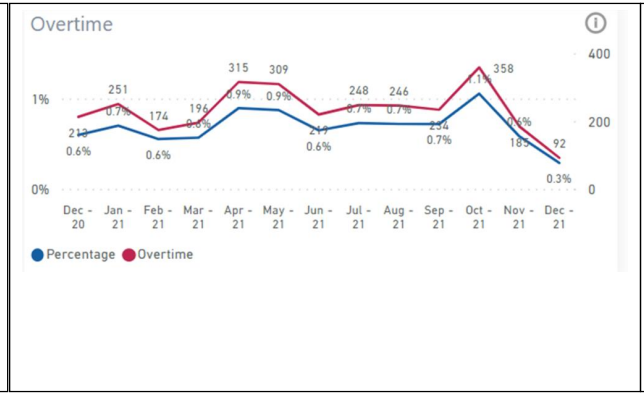
The dollar amount spent per month on personnel costs (e.g. nursing, HCA). Includes personnel costs for casual staff. The peaks are when there are more than two pay periods in one month.

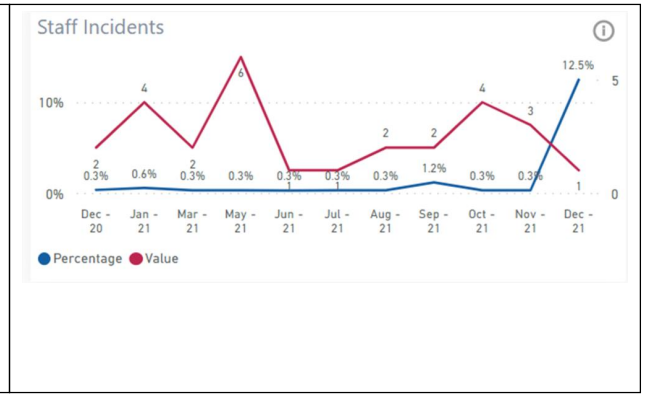
Rationale

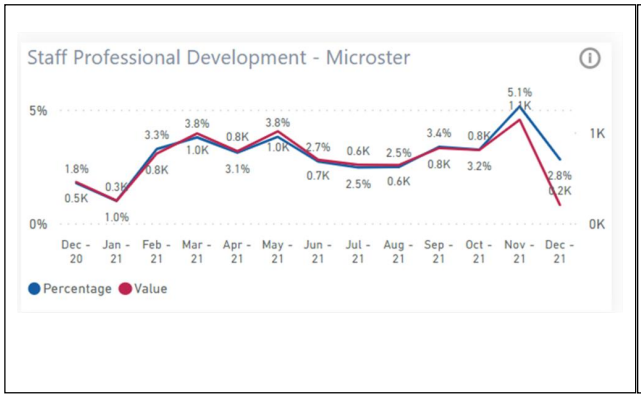
Nursing is the largest workforce and therefore one of the biggest investments in providing healthcare services. DHBs are responsible for best value for public health system resources. A logical step in achieving this is to monitor the spend on nursing personnel costs. Some studies suggest higher staff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

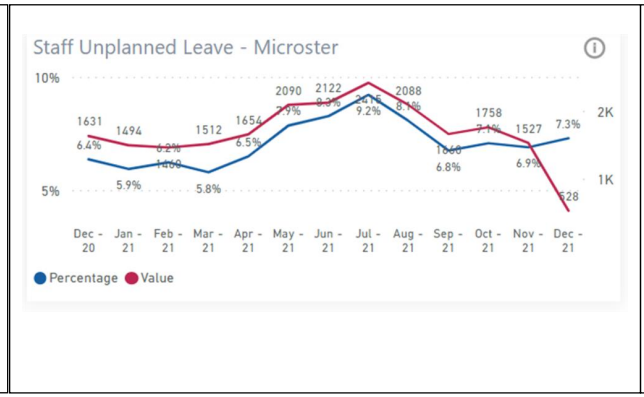
Midwifery

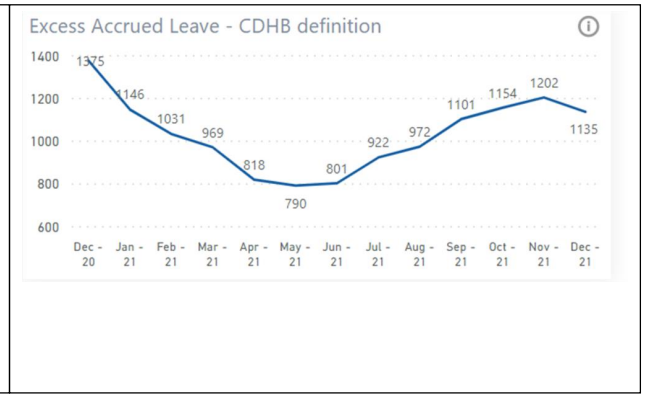

Extra shifts
Percentage
Value


Overtime
Percentage
Overtime


Staff Incidents
Percentage
Value

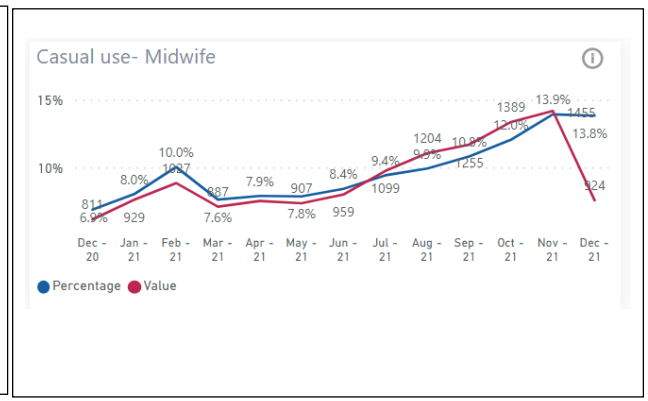

Staff Professional Development - Microster
Percentage
Value


Staff Unplanned Leave - Microster
Percentage
Value


Excess Accrued Leave - CDHB definition


Safe Staffing
Oct - 21
Nov - 21
Dec - 21


Total leave accrued


Casual use- Midwife
Percentage
Value

Midwifery

Extra Shifts (Monthly)

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

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

Overtime (Monthly)

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

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

Staff Incidents (Monthly)

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

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

Staff Professional Development (Monthly)

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

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

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

Unplanned Leave (Monthly)

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

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

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

Excess Accrued leave

Actual number of annual leave hours remaining above 30 hours

Rationale

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

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

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

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

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

Total Leave Accrued.

Total hours of leave accrued.

Source: HRIS leave data

Casual Use Midwife

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

HAC – 3 FEBRUARY 2022

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

APPROVED BY: **Naomi Marshall, Deputy Chair, Hospital Advisory Committee**

DATE: **17 February 2022**

Report Status – For:	Decision	☐	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

The purpose of this report is to provide the Board with an overview of the Hospital Advisory Committee's (*HAC*) public meeting held on 3 February 2022.

2. RECOMMENDATION

That the Board:

i. notes the draft minutes from HAC's public meeting on 3 February 2022 (Appendix 1).

3. APPENDICES

Appendix 1: HAC Draft Minutes – 3 February 2022.

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held via Zoom
on Thursday, 3 February 2022, commencing at 9.00am

PRESENT
Naomi Marshall (Deputy Chair); Catherine Chu; Jan Edwards; James Gough; Jo Kane; Dr Rochelle Phipps; Ingrid Taylor; and Sir John Hansen (Ex-Officio).

APOLOGIES
Apologies for absence were received and accepted from Andrew Dickerson; and Barry Bragg.
Apologies for early departure were received and accepted from James Gough (9.40am); and Catherine Chu (10.20am).
An apology for absence during the meeting was received and accepted from Sir John Hansen (9.30am to 9.45am).

EXECUTIVE SUPPORT
Norma Campbell (Executive Director, Midwifery & Maternity Services); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Dr Helen Skinner (Chief Medical Officer); and Anna Craw (Board Secretariat – Minute Taker).

APOLOGIES
Dr Peter Bramley, Chief Executive; Becky Hickmott, Executive Director of Nursing; and Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics.

IN ATTENDANCE
Gloria Crossley, Interim General Manager, Laboratories
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Ralph La Salle, Senior Manager, Specialist Services & Non-Clinical Support
Allan Katzef, Finance Manager, Christchurch Campus
Kate Lopez, Acting General Manager, Older Persons Health & Rehabilitation
Berni Marra, General Manager, Rural Health Services

Naomi Marshall opened the meeting, welcoming those in attendance. Ms Marshall acknowledged the work to date of management and staff in preparedness for Omicron in the community.

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (01/22)
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 7 October 2021 be approved and adopted as a true and correct record."

3. CARRIED FORWARD / ACTION ITEMS

There were no carried forward / action items.

4. H&SS MONITORING REPORT

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

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

Medical/Surgical; & Women's & Children's Health; & Orthopaedics – Allan Katzef, Finance Manager, Christchurch Campus

- Pressure on the system is huge with staff absences and vacancies in a lot of areas, particularly in nursing. High sick leave over the Xmas/New Year period, which was a struggle to backfill.
- High numbers of ED attendances and acute presentations.
- Have had to defer some elective surgery. Almost caught up with cancelled surgery and outpatient appointments from August to October 2021. The team has done an incredible job to pull this back.

A member queried the plan for delivery of health services (business as usual and planned care) outside of Omicron. Dr Helen Skinner, Chief Medical Officer, advised there are multiple plans around a number of services that are under pressure, however, she stressed that all plans will be challenged as we move into Omicron.

The Committee requested an update be provided to the February Board meeting, providing transparency around system pressure points, plans in place to address these, and management of planned care wait times during the Omicron outbreak.

In response to a query about CDHB supporting Southern DHB neurosurgery elective cases, Ralph La Salle, Senior Manager, Specialist Services & Non-Clinical Support, confirmed that Southern DHB is covering the cost of what it takes to provide neurosurgery in Southern and anything CDHB does for Southern domiciled patients, Southern DHB is covering the cost.

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

- Demand – seasonal variation, with quite a significant drop off over the Xmas period. Staff go on holiday, but also consumers get different levels of support from their own community and families over the Xmas period.
- Changes in demand with COVID. Have had significant increases in three areas in particular:
  - Alcohol and Drug
  - CAF
  - Eating Disorders

  Both CAF and Eating Disorders, services amongst young people, are where there has been significant COVID growth, part of a worldwide phenomenon.

- Have had less growth in adults compared to other parts of NZ. This may be due to the Canterbury population having a history of dealing with difficult issues and disasters for an extended period of time.
- CAF volumes – there has been a decrease in the wait time for first face to face appointments.
- Staffing is a challenge. Each day we try to fill around 25 gaps in the roster, invariably through a range of mechanisms such as pool and agency staff, both of which dry up in January as people take holidays. Rely on filling gaps with the use of Allied Health Staff and also through overtime.
- The short staffing situation has been a long time in the making. NZ is the number one importer of overseas trained nurses, but none have come into SMHS since COVID. In addition, there are also a number of things that staff have left the service to do – for example: vaccination, testing, and other COVID work, as well as some of the community elements that have started, such as Te Tumu Waiora in primary care.

There was discussion around the presentation format for CAF data.

Sir John Hansen left the meeting at 9.30am.

A member queried how much the short staffing in SMHS has cost, over what it would cost if it was fully staffed. Dr Hamilton advised that the overtime spend for SMHS staff for the previous six months of the financial year (July to December 2021) was just under $2M. The member commented that it would be useful to have this data included in the report, so as to better understand the extent of the issue.

In response to a query around temporary capping of bed numbers to ensure safe environments for staff, Dr Hamilton advised of the following temporary soft caps on bed numbers:

- Psychiatric Services for Adults with an Intellectual Disability (*PSAID*). Capped at six, due to a reduction in demand over a number of years. Was previously ten.
- Te Whare Manaaki – medium secure acute forensic mental health service. Fifteen (15) beds, but is capped at 12. Probably the highest risk area in terms of access to services. The team has changed how it operates with a greater focus on flow through the system. We are moving people through from that service into a rehabilitation service more quickly to create some of the space. The risk sits with people potentially being in Corrections, needing our services, but not having access to a bed. That has always been a tension point, but that tension has got higher.

In response to a query, Dr Hamilton advised that the piece of work being taken control of is the "staffing mix". We will not get a whole lot of new Registered Nurses (*RNs*). He noted that whilst RNs are needed, and they need to be experienced so that they can direct and delegate, the mix of staff with both allied health and health care assistants is where the opportunity is.

James Gough left the meeting at 9.40am.

Older Persons Health & Rehabilitation (*OPH&R*) Service – Kate Lopez, Acting General Manager

- Significant focus on planning and contingency for Omicron.
- Workforce challenges across services - across both Burwood campus and the community components of the services. This is most notably in nursing.
- Care Capacity Demand Management Programme. A recent development is the early implementation of an ability for the nursing leadership team to manage and monitor nursing capacity versus patient demand at a glance. A new dashboard is being implemented and will support the team's ability to read the hospital at a glance and

understand what clinical areas are needing the support from a nursing resource perspective. Up until now this has been quite a manual process, so this is a positive step forward.

- Currently carrying 16 FTE vacancies from a nursing perspective.
- Recently taken on a number of new graduates.
- Kowhai Programme is providing potential to support the clinical areas. To date, in the first month of the programme, 100 hours have been contributed. The programme is receiving fantastic feedback and will be a critical resource going forward over the next couple of months.

Sir John Hansen rejoined the meeting at 9.45am.

Discussion took place around access to Dementia Hospital Level Care Facilities.

In response to a query about length of stay barriers and work to prevent hospital admission in the first place, Ms Lopez advised that while focus is on physical hospital beds, a fundamental part is to support people to remain in their own homes and to avoid admission. There is a lot of work going on in this space and will continue to be an area of focus, particularly as we go into the next few months, noting the hospital pressures we will be under.

Discussion took place about Aged Residential Care (*ARC*) in the Omicron environment. Ms Lopez commented that there is a lot of dialogue happening in this space, both at a regional and national level. Conversations are underway to agree a screening tool and framework for decision making. Strict protocols will be in place with regards to clinical assessment criteria, epidemiological assessment criteria, as well as stringent criteria as to when a test may or may not be required.

Hospital Laboratories – Gloria Crossley, Interim General Manager, Laboratories

- Acknowledged the efforts of the workforce.
- Projects running around the Laboratory space include:
  - The tearoom being moved to create room for a high volume molecular space, to better utilise what we have in the way of equipment. It will also be more secure for staff.
  - Stairwell 4 replacement, which is starting today.
  - The Ngāi Tahu carpark, which will begin soon.
- High volume chemistry instruments are largely in place. Working through some teething problems.
- Have a number of staff vacancies.
- Acknowledged the specific nature of the workforce and the need to work collaboratively with alliance partners.

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

- Now covering two primary health centres (Kaikoura and Chatham Islands), rural ARC services, Ashburton acute and inpatient space, and work in the Ashburton community.
- Pressure on dementia level care.
- Workforce challenges. Working strongly as a team around doing things differently. The ability to flex and focus is a strength in rural. Focusing on opportunities.
- Acute and inpatient flow remains busy, but admission rates are consistently dropping or remaining steady.

Discussion took place around the generalist nursing model introduced at Ashburton.

In response to a query around the increase in sick leave in rural areas, Ms Marra advised that rural has a proportionally older workforce. It is important to look at every opportunity to restrengthen, to share resources, and to work in a different way.

Ms Marra commented that she is working with Planning & Funding on equity of access for primary health care in Ashburton. There needs to be strong, resilient, primary care, so that people have access to care consistently, and that the acute space is for acute and not just a type of care that you get because you cannot get into primary care.

There was a request for additional information on people accessing services in the fast growing areas of Ashburton, Selwyn and Waimakariri.

The H&SS Monitoring report was noted.

5. OFFICE OF THE CLINICAL EXECUTIVE UPDATE

Norma Campbell, Executive Director, Midwifery & Maternity Services; Dr Jacqui Lunday-Johnstone, Executive Director, Allied Health, Scientific & Technical; and Dr Helen Skinner, Chief Medical Officer; presented the report. The following points were highlighted:

- Themes around models of care, sustainability, and the multi-disciplinary workforce.
- Working with clinical executive around an Emergency Clinical Governance Framework, so that when we are in this state of emergency we do not take our eye off the ball; we keep an eye on who is accessing services; that our most vulnerable are accessing; that we have metrics that we can look at each week to see that all the changes we are making are not disadvantaging anybody; and that when there is capacity that we are making sure that services are continuing.
- The clinical executive are working within their respective areas and across the whole system, ensuring they have full oversight of what everybody is up to and using opportunities that present themselves to look at doing things differently.
- A lot of work is happening around flow, particularly on Christchurch campus. Whilst Omicron is taking a huge amount of planning, it has galvanised the team to look at different ways of working. There is a huge amount of work here, but also a real opportunity for those models of care that we have been making inroads in, to move faster.

The Clinical Advisor Update was noted.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (02/22)
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the Committee:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1 and 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.	Confirmation of the minutes of the public excluded meeting of 7 October 2021	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)

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."

Catherine Chu left the meeting at 10.20am.

INFORMATION ITEMS

- 2022 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.20am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

DATE: **17 February 2022**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATIONS

That the Board:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 & 13 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 December 2021	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.	Stealth Navigations System	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
5.	Liquid Chromatography Mass Spectrometer Replacement	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)

6.	Christchurch Hospital Campus COVID ICU 4th POD	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
7.	Waipapa Lower Ground Floor Fit-Out for Clinical Teams	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
8.	Energy Centre Project	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
9.	COVID-19 Response Hub Lease	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
10.	2022/23 Budget Update + Forecast	To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(j)
11.	People Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).	s9(2)(a) s9(2)(j)
12.	Legal Report	Protect the privacy of natural persons. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s9(2)(a) s9(2)(j) s9(2)(h)
13.	Advice to Board • HAC Draft Minutes *3 February 2022* • QFARC Draft Minutes *1 February 2022*	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.