HOSPITAL ADVISORY COMMITTEE MEETING

Thursday, 29 March 2018
9.00am

Board Room
Level 1
32 Oxford Terrace
Christchurch

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

AGENDA - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
To be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
32 Oxford Terrace, Christchurch
Thursday, 29 March 2018 commencing at 9.00am

ADMINISTRATION			**9.00am**
	Apologies		
1.	**Interest Register** *Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Committee Meeting** ▪ *1 February 2018*		
3.	**Carried Forward/Action List Items**		
MONITORING			**9.05am**
4.	**General Medicine Presentation**		9.05–9.35am
5.	**Hospital Service Monitoring Report** • *Hospital Laboratories* – Kirsten Beynon • *Older Persons, Orthopaedics & Rehabilitation* – Dan Coward • *Mental Health* – Toni Gutschlag • *Rural Health Services* – Berni Marra & Win McDonald • *Medical/Surgical* & *Women's & Children's Health* – Heather Gray • *ESPIs* – Heather Gray		9.35-10.30am
6.	**Clinical Advisor Update (Oral)** • Medical	Dr Sue Nightingale *Chief Medical Officer*	10.30-10.45am
7.	**Resolution to Exclude the Public**		10.45am
ESTIMATED FINISH TIME			**10.45am**
INFORMATION ITEMS			
-	2018 Workplan		
NEXT MEETING: Thursday, 31 May 2018			

ATTENDANCE LIST - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

Andrew Dickerson (Chair)
Jo Kane (Deputy Chair)
Barry Bragg
Sally Buck
Dr Anna Crighton
David Morrell
Jan Edwards
Dr Rochelle Phipps
Trevor Read
Ana Rolleston
Dr John Wood (Ex-officio)
Ta Mark Solomon (Ex-officio)

Executive Support

David Meates – *Chief Executive*
Mary Gordon – *Executive Director of Nursing*
Stella Ward – *Executive Director of Allied Health Scientific & Technical*
Carolyn Gullery – *General Manager – Planning & Funding*
Justine White – *General Manager – Finance*
Sue Nightingale – *Chief Medical Officer*
Kay Jenkins – *Executive Assistant – Governance Support*
Anna Craw – *Board Secretary*

CONFLICTS OF INTEREST REGISTER
HOSPITAL ADVISORY COMMITTEE

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)

ANDREW DICKERSON (CHAIR)

Accuro (Health Service Welfare Society) - Director (from 9 December 2016)
Is a not-for-profit, member owned co-operative society providing health insurance services to employees in the health sector and (more recently) members of the public. Accuro has many members who are employees of the CDHB.

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.

Canterbury Health Care of the Elderly Education Trust - Chair
Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB.

Canterbury Medical Research Foundation - Member
Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB.

Heritage NZ - Member
Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings.

No Conflicts of Interest are envisaged for the following interest, but should a conflict arise this will be discussed at the time.

NZ Association of Gerontology - Member
Professional association that promotes the interests of older people and an understanding of ageing.

JO KANE (DEPUTY CHAIR)

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.

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.

BARRY BRAGG

Ngai Tahu Property Limited – Chairman
Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu.

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.

New Zealand Flying Doctor Service Trust – Chairman
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.

CRL Energy Limited – Managing Director
CRL Energy 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.

SALLY BUCK

Christchurch City Council (*CCC*) – Community Board Member
Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC.

Registered Resource Management Act Commissioner
From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time.

DR ANNA CRIGHTON

Christchurch Heritage Trust – Chair - Governance of Christchurch Heritage
Christchurch Heritage Limited - Chair - Governance of Christchurch Heritage
Heritage New Zealand – Honorary Life Member

DAVID MORRELL

British Honorary Consul
Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time.

Nurses Memorial Chapel Trust –Chair
(CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.

Heritage NZ – Subscribing 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.

Canon Emeritus - Christchurch Cathedral
The Cathedral congregation runs a food programme in association with CDHB staff.

Great Christchurch Buildings Trust – Trustee
The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing.

Hospital Lady Visitors Association - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time

Friends of the Chapel – Member.

JAN EDWARDS

Integrated Family Health Service Programme, Canterbury Clinical Network – Project Manager
The programme supports primary care teams to develop integrated models of care that better support at risk individuals in their own communities. The programme is hosted by Pegasus Health (Charitable) Ltd and funded by CDHB. Should a conflict arise, this will be discussed at the time.

DR ROCHELLE PHIPPS

Accident Compensation Corporation – Medical Advisor
Royal New Zealand College of General Practitioners – Christchurch Fellow and Former Board Member
OraTaiao: New Zealand Climate & Health Council – Founding Member
Institute of Directors in New Zealand – Chartered Member

TREVOR READ

Lightfoot Solutions Ltd – Global Director of Clinical Services
Lightfoot Solutions has contracts with CDHB, and other health providers who have contracts with CDHB, to provide business intelligence tools and related consulting services. Should a conflict arise, this will be discussed at the time.

ANA ROLLESTON

Manawhenua ki Waitaha – Trustee
Representative of Wairewa Rūnanga. Manawhenua ki Waitaha is a collective of health representatives of the seven Ngāi Tahu Papatipu Rūnanga that are in the CDHB area. There is a Memorandum of Understanding between Manawhenua ki Waitaha and CDHB.

Christchurch PHO – Board Member
The Christchurch PHO is mostly funded by either the Ministry of Health and/or the CDHB. The Christchurch PHO supports General Practitioners delivering primary health care in Christchurch.

Māori Women's Welfare League – Member
The Māori Women's Welfare League has contracts through the Ministry of Health for the delivery of health services for Māori.

Te Kàhui o Papaki Kà Tai – Member
A Canterbury-wide combined group of primary care organisations, clinicians, community organisations, Manawhenua, Maori community provider and District Health Board. The group is supported by Pegasus Health.

DR JOHN WOOD (EX-OFFICIO)

Advisory Board NZ/US Council – Member
Chief Crown Treaty Negotiator for Ngai Tuhoe
Chief Crown Treaty Negotiator for Ngati Rangi
Chief Crown Treaty Negotiator, Tongariro National Park
Chief Crown Treaty Negotiator for the Whanganui River
College of Arts – External Advisory Committee Member
Governing Board, Economic Research Institute for ASEAN and East Asia (ERIA) – Member
Kaikoura Business Recovery Grants Programme Independent Panel – Member
Member of the Governing Board of the Office of Treaty Settlements, Ministry of Justice – Ex-officio (as Chief Crown Treaty of Waitangi Negotiator) – Ex-officio member.
School of Social and Political Sciences – Adjunct Professor
Te Urewera Governance Board – Inaugural Member
University of Canterbury - Chancellor
University of Canterbury Foundation – Ex-officio Trustee
Universities New Zealand – Chair, Chancellors' Group

TA MARK SOLOMON (EX-OFFICIO)

Te Waka o Maui – Independent Representative
Oaro M Incorporation - Member
Ngāti Ruanui Holdings - Director
Pure Advantage - Trustee
He Toki ki te Rika / ki te Mahi - Patron
Te Ohu Kai Moana - Director
Deep South NSC Governance Board - Member
Sustainable Seas NSC Governance Board - Member
Canterbury Recovery Learning & Legacy Sponsors Group - Member
Liquid Media Operations Limited - Shareholder
Greater Christchurch Partnership Committee - Member
Police Commissioners Māori Focus Forum - Member
Post Settlement Advisory Group – Member
Royal NZ Police College - Patron of Wing 312
SEED NZ Charitable Trust – Chair and Trustee

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch,
on Thursday, 1 February 2018, commencing at 9.00am

PRESENT
Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Barry Bragg; Sally Buck; Dr Anna Crighton; Jan Edwards; Dr Rochelle Phipps; Trevor Read; and Dr John Wood.

APOLOGIES
Apologies for absence were received and accepted from David Morrell; Ana Rolleston; and Sir Mark Solomon.
Apologies for lateness were received and accepted from Sally Buck (9.54am); and Rochelle Phipps (9.05am).
An apology for early departure was received and accepted from Jo Kane (11.40am).

EXECUTIVE SUPPORT
David Meates (Chief Executive); Mary Gordon (Executive Director of Nursing); Dr Sue Nightingale (Chief Medical Officer); Stella Ward (Executive Director of Allied Health); Justine White (General Manager, Finance and Corporate Services); Jan van der Heyden (Business Manager); and Anna Craw (Board Secretary).

IN ATTENDANCE

Item 4
Hayley Beckman - Charge Nurse Manager
Dr David Gibbs - Clinical Director, Medical Oncology
Dr Avtar Rania - Clinical Director, Radiation Oncology
Jane Trolove - Oncology Service Manager

Item 5
Michael O'Dea - Team Leader, Older Persons Health, Planning & Funding
Dr Adrian Hopper - Geriatrician, Guy's and St Thomas NHS Foundation Trust, London
Professor Matthew Parsons - Gerontologist, Waikato DHB/The University of Auckland

Item 8
Dan Coward – General Manager, Older Persons, Orthopaedics & Rehabilitation
Toni Gutschlag – General Manager, Specialist Mental Health Services
Dr Peri Renison – Chief of Psychiatry, Specialist Mental Health Services
Kirsten Beynon – General Manager, Hospital Laboratories
Berni Marra – Manager, Ashburton Health Services
Win McDonald – Transition Programme Manager, Rural Health Services
Pauline Clark – General Manager, Medical/Surgical and Women's & Children's Health

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (01/18)
(Moved: Anna Crighton/Seconded: Jan Edwards – carried)

"That the minutes of the meeting of the Hospital Advisory Committee held on 30 November 2017 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

The Committee noted the carried forward items.

4. MEDICAL & RADIATION ONCOLOGY - PRESENTATION

Rochelle Phipps joined the meeting at 9.05am.

Pauline Clark – General Manager, Medical/Surgical and Women's & Children's Health, introduced Dr David Gibbs, Clinical Director Medical Oncology; Dr Avtar Rania, Clinical Director Radiation Oncology; Hayley Beckman, Charge Nurse Manager; and Jane Trolove, Oncology Service Manager; who presented to the Committee on Medical and Radiation Oncology.

The presentation provided an overview of the Oncology service in terms of:

- Who they are, who they work with and what they do.
- Challenges faced, including increased age and numbers, increased complexity and expectations, along with environmental issues in which to provide services.
- Local and regional challenges, as well as global challenges.
- What the service is doing to overcome these challenges, as well as what it needs now and longterm to ensure demand for the service is met.

There was a query around the booking of appointments for rural patients and consideration being given to travel times. The Committee noted that whilst not perfect, such matters are taken into account when appointments are made, as well as booking other appointments on the same day where appropriate. However, it was noted that in some instances too many appointments on one day can result in information overload, so a balance is required in this area. It was further noted that the increased use of telemedicine is assisting in this area.

There was discussion around the importance of using resources wisely and appropriately, with it noted that as treatment evidence builds up, this has resulted in a reduction in treatments used. These advancements have significantly contributed to the service being able to manage increased demand to date.

There was a query around scheduled linear accelerator replacements and whether these have been budgeted for. The Committee noted that the capital components have been budgeted for. Issues will sit around disruption to services during the replacement programme, with each accelerator requiring a six month decommissioning and commission process. Operationally, in order to keep services running, well coordinated scheduling of patients will be required. In addition, it was noted that projected demand growth and MoH targets require the commissioning of a 5th linear accelerator within the South Island over the same time frame.

Andrew Dickerson, Chair, thanked those in attendance for the presentation, noting that achievements in the Medical and Radiation Oncology service over the past decade are commendable and should be regarded as an exemplar within Christchurch Hospital.

5. UK VISITING GERIATRICIAN - PRESENTATION

Michael O'Dea, Team Leader, Older Persons Health, introduced Dr Adrian Hopper, a Geriatrician at Guy's and St Thomas NHS Foundation Trust in London and also the Medical Patient Safety Lead for Guy's and St Thomas' NHS Trust and the South London Academic Health Science Network. Also in attendance was Professor Matthew Parsons, Gerontologist, who is jointly appointed to Waikato District Health Board/The University of Auckland.

Dr Hopper spoke of his close involvement in a number of programmes to link Comprehensive Geriatric Assessment to clinical services in Medicine (OPAL), Surgery (POPS) and Oncology (GOLD); developed the AMBERcarebundle to improve patient-centred decision making in patients with uncertain recovery, which has spread widely in the UK; and is running a catheter safety programme to reduce catheter urinary infections and gram negative sepsis. He also spoke about starting as the Geriatric Medicine lead for the "Getting it Right First Time" quality programme in NHS England.

Sally Buck joined the meeting at 9.54am.

The Chair thanked Dr Hopper and Professor Parsons for their attendance and wished them well for their continued visit with Canterbury DHB.

6. REVIEW OF WINTER PLAN 2017

Dan Coward, General Manager, Older Persons, Orthopaedics & Rehabilitation, presented the report which was taken as read. An overview was provided of the 2017 winter plan, achievements, lessons learnt and work underway for 2018 planning.

New Zealand's 2018 vaccine programme was discussed. Along with the flu vaccination, the importance of washing hands, staying home when unwell, and wearing a mask when unwell, was stressed.

It was noted that a further update will be provided to the Committee's 31 May 2018 meeting on 2018 winter planning.

Resolution (02/18)
(Moved: Andrew Dickson/Seconded: Barry Bragg - carried)

"That the Committee:

i. notes the Winter Review 2017 paper; and
ii. notes the ongoing work for planning in 2018 for winter."

7. CLINICAL ADVISOR UPDATE

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

- Nurse Entry to Practice (*NETP*) programme has been in place for 15 years this year. CDHB has just taken in its largest intake of new graduates.

- Nurse Entry to Specialty Practice (*NESP*) programme has been in place 21 years this year. CDHB has recently taken 50 graduates, three of which have gone to the NGO sector. This is the largest cohort in New Zealand history.
- Work continues in preparation for the shift to the new Outpatients building and ASB, and work on the releasing time to care model.
- Nurse structure is being consulted on to support the new ward configurations.
- Mindfulness meditation programme for nurses – six month pilot programme for ED and Acute Inpatient Services at Hillmorton Hospital is complete and has been positively received. There are plans to train further facilitators with a view to expand the programme to include Forensic, AT&R, and Oncology Services. This is planned for February 2018.
- Patientrack – electronic observations. Progressing well, with roll out in process for Paediatrics and West Coast DHB.

There was a query around the number of male new graduates. The Committee advised that this sat at approximately 6% of the intake. There was discussion around profiling male graduates/nurses as a way of encouraging male students to consider a career in nursing.

Stella Ward, Executive Director of Allied Health, provided updates on the following:

- Wendy Fulton has announced her retirement as Director of Allied Health.
- Canterbury Initiative is looking at the adult rehabilitation model and ways for it to support greater movement to outpatient/community care.
- Health Workforce NZ Funding – permission has been received to look at how funding is utilised across the South Island and prioritised.
- Vulnerabilities in the physiotherapy workforce.
- Social Workers Registration Bill, which CDHB submitted on.
- PSA and APEC currently in negotiation of MECAs.
- Social workers in ED – a co-design process is underway to support the ED workload.

There was a query around the Social Workers Registration Bill and whether consideration has been given to contract provisions moving forward. It was confirmed that passing of the Bill will have a big impact on NGOs. Discussions have been held with Planning & Funding around changes that will need to be made to future contracts.

The Committee wished to acknowledge the retirement of Wendy Fulton and extend to her appreciation for the significant and high level of leadership she has provided in her role at CDHB.

The meeting adjourned for morning tea at 10.44am, reconvening at 11.00am.

8. HOSPITAL AND SPECIALIST SERVICES (*H&SS*) MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for January 2018. The report was taken as read.

General Managers spoke to their areas as follows:

Older Persons, Orthopaedics & Rehabilitation Service – Dan Coward, General Manager

- The months of May through to September saw the opening of an additional 20 beds across Burwood Hospital to assist with patient flow.

- There has been a focus on ensuring that patients who have longer stays are being clinically reviewed on day seven.
- Elder Abuse Policy – has been reviewed and work undertaken with stakeholders. This will cover both CDHB and West Coast DHB, and is due to go out for consultation shortly. The new policy is expected to be in place by approximately April 2018.

Specialist Mental Health Services – Toni Gutschlag, General Manager & Peri Renison, Chief of Psychiatry

- An additional resource from the People and Capability Team has been provided to SMHS, to assist with a programme of work to commence in February around recruitment to fill current vacancies.
- Te Awakura (the acute adult unit) continues to exceed capacity. With demand exceeding bed numbers, sleepovers are continuing to be utilised. This is not ideal for patients or staff.
- Along with increased occupancy rates, the level of acuity is very high. A high number of methamphetamine related presentations are being experienced. This increase is new, concerning and proving to be challenging.
- AT&R Unit – changes to space configuration have resulted in a dramatic reduction in staff assaults over the past two months. A very positive result.
- Services based at The Princess Margaret Hospital – work progressing on future facility options.
- School Based Mental Health Programme – workshop to take place tomorrow with the Ministry of Health to work through issues and progress planning. Attendees to include representatives from Health, Education, Police and the Council.

There was a query as to what is in place nationally to address growing methamphetamine issues. The Committee noted there is a National Addictions Board tasked with preventative measures/campaigns. It was noted that the Police spend an inordinate amount of time attempting to limit the supply of methamphetamine. In addition, Police hold education programmes in community probation centres.

Hospital Laboratories – Kirsten Beynon, General Manager

- Anatomical Pathologist Workforce – pinch point currently being experienced which could impact on surgical services, however, good monitoring systems are in place in order to assure prioritisation. Continue to look at options around future recruitment campaigns and how to speed up the process for overseas appointments entering New Zealand.
- Blood Centre Team – volume, testing and resource matching is continuously being assessed.

Ashburton Health Services – Berni Marra, Manager Ashburton Health Services

- Focus continues on the Frail Older Persons Pathway and the coordination of services.
- Primary care have agreed to meet in February to progress an agreement for the provision of consistent after hours care.

Rural Health Services - Win McDonald, Transition Programme Manager

- Akaroa Model of Care – is a living document, with ongoing development work to occur.
- Hurunui Model of Care – currently out for consultation, which has been extended through to 28 February 2018. A simplified version of the consultation document is to be distributed by mail drop.
- Oxford Model of Care – anticipated that the draft model of care will be ready to go out for consultation in April 2018.
- Workforce issues with regards to vacancies.
- South Island PICs rolling out to rural hospitals in February/March 2018.

There was discussion around fundraising by the Akaroa community, with it noted that $1M has been raised to date, with a number of fundraising activities planned for the forthcoming year. Very positive.

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

- Alan Pithie has stepped down as Chief of Medicine, with David Smyth having been appointed to the role.
- Xmas/New Year proved to be a busy period, with demand for acute surgery being high. A post Xmas/New Year review has been conducted which will assist with planning for the 2018/19 period.
- Link corridor work is two weeks behind which has resulted in rescheduling of surgeries.
- New Zealand Census in March – work underway with Census staff to ensure capture of information.
- Full certification is to take place in June 2018.
- South Island PICs roll out on Christchurch Campus scheduled for June 2018.
- MoH Faster Cancer Treatment Team is visiting on 26 February 2018. A full day's programme is scheduled.

In response to a query around access issues, the Committee was advised that this continues to prove challenging, but communication channels with relevant parties are open.

ESPIs

Pauline Clark advised that delays in the link corridor works have resulted in 20 half day theatre sessions having to be moved. In light of these delays, as well as preparatory work underway for the rollout of South Island PICs, CDHB has written to the MoH seeking dispensation for ESPI compliance for a period of time.

Discussion took place around ophthalmology and orthopaedic performance, issues faced, improvements made and ongoing work.

Resolution (03/18)
(Moved: Trevor Read/Seconded: Sally Buck - carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (04/18)
(Moved: Jan Edwards/Seconded: Trevor Read - 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 30 November 2017.	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."

INFORMATION ITEMS

- 2018 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.40am.

Confirmed as a true and correct record.

_____ _____

Andrew Dickerson
Chairperson

Date

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 29 MARCH 2018

DATE		ISSUE / ACTION	REFERRED TO	STATUS
1.	02 Aug 2016	AT&R Unit Update	Toni Gutschlag	Verbal Update.
2.	30 Nov 17	Progression of Maternal Health Strategic Direction	Carolyn Gullery	Verbal Update.
3.	30 Nov 17	Status of drink dispensing machines	GMs	Verbal Update.
4.	01 Feb 18	2018 Winter Planning Update	Dan Coward	Report to 31 May 2018 meeting.

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Hospital Advisory Committee

SOURCE: **General Managers, Hospital Specialist Services**

DATE: **29 March 2018**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report is a standing agenda item, highlighting the Hospital Specialist Services activity on the improvement themes and priorities.

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

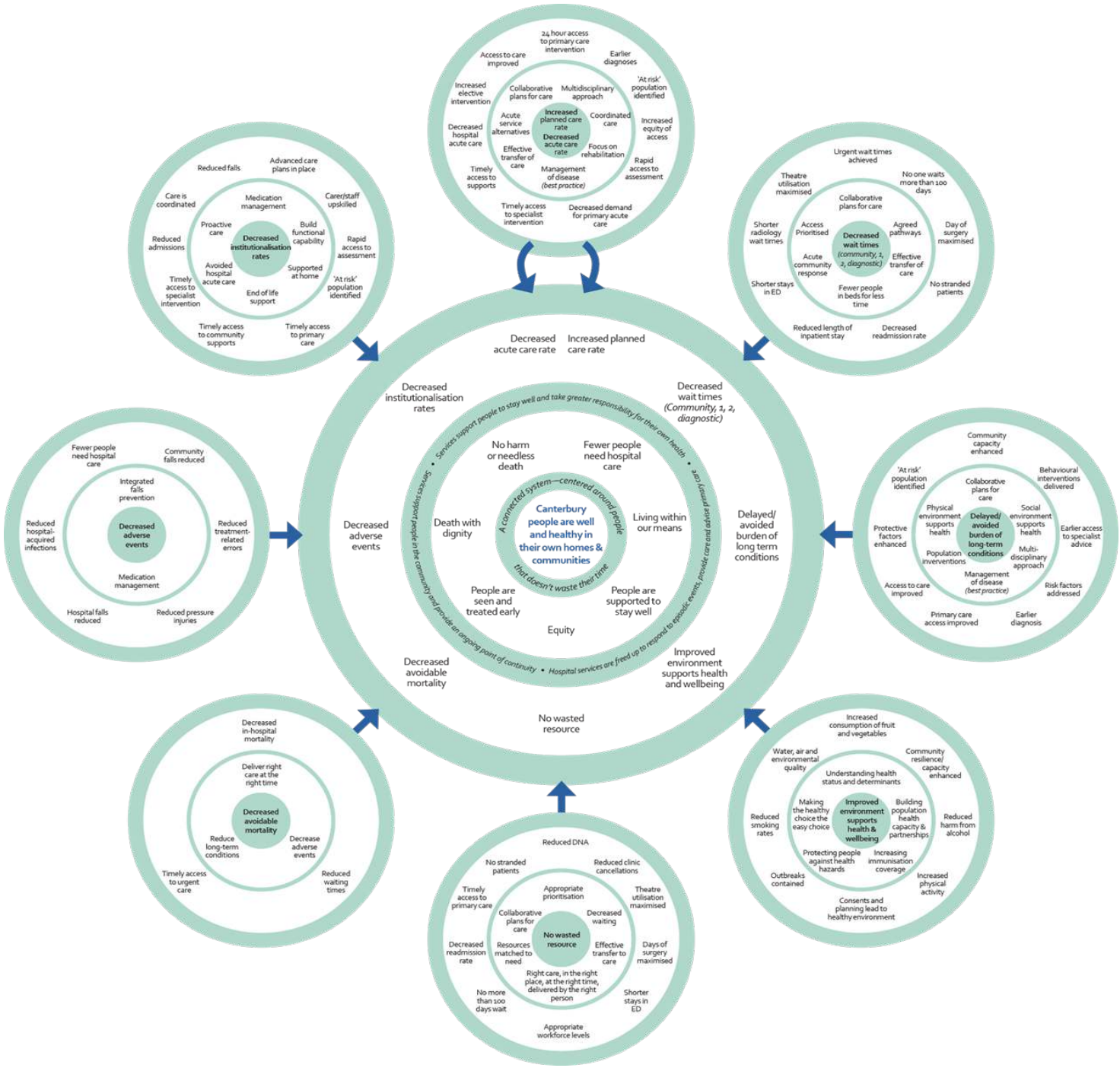
Appendix 1: Hospital Advisory Committee Activity Report – March 2018

Report prepared by: General Managers, Hospital and Specialist Services

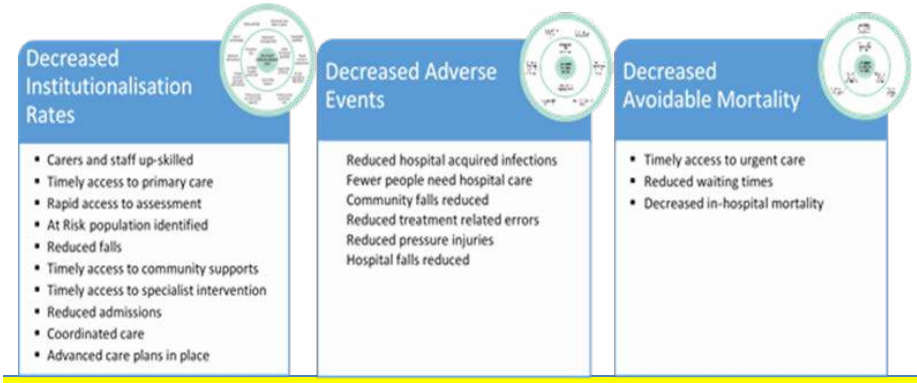
Report approved for release by: Justine White, GM, Finance and Corporate Services
Carolyn Gullery, GM, Planning & Funding

Hospital Advisory Committee

Activity Report



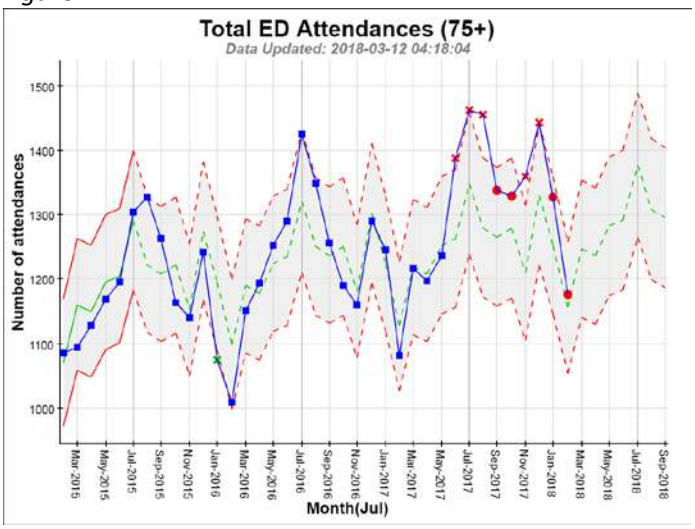
March 2018



Frail Older Persons' Pathway

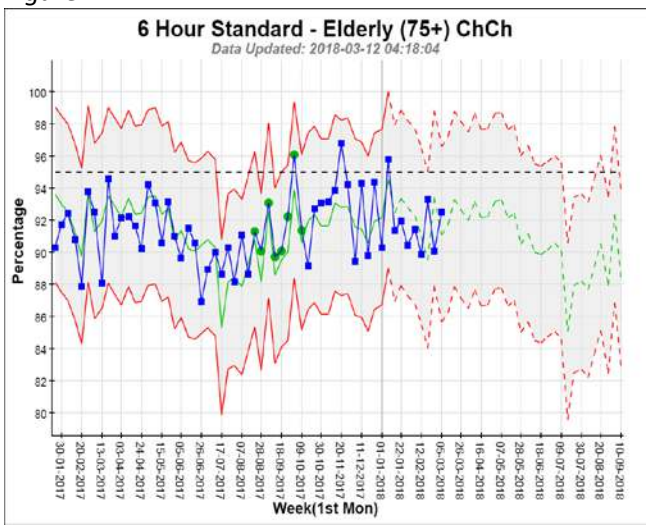
Outcome and Strategy Indicators

Figure 1.1



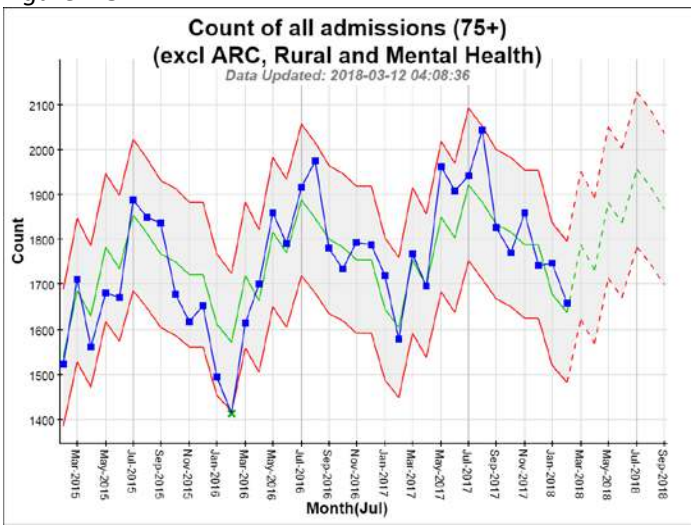
Total attendances of people over 75 has increased well above the projected trend. This increase is in line with that seen for the overall population

Figure1.2



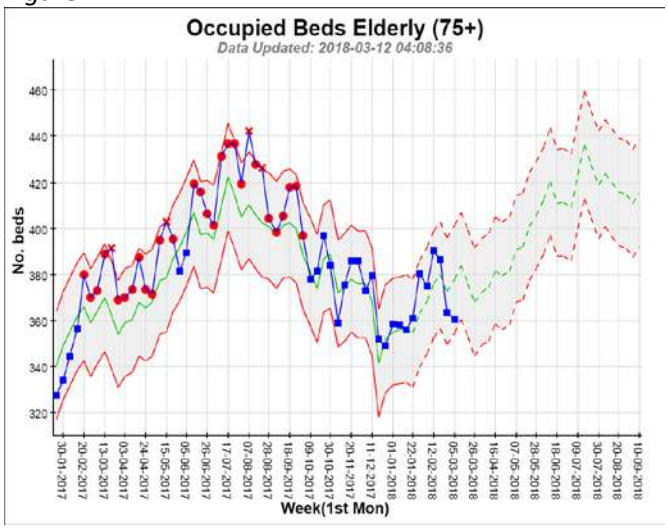
Patients 75+ seen within the 6 hour target is tracking within the expected range.

Figure 1.3



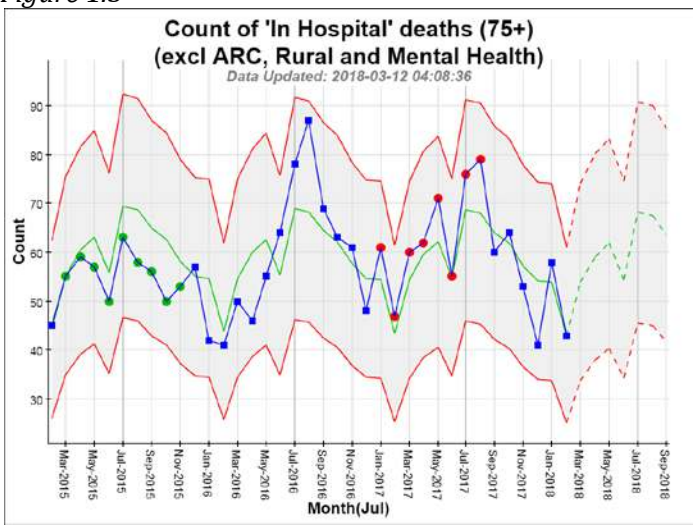
Admission volume of people 75 years and over is running higher than previous years but remains within the projected range.

Figure 1.4



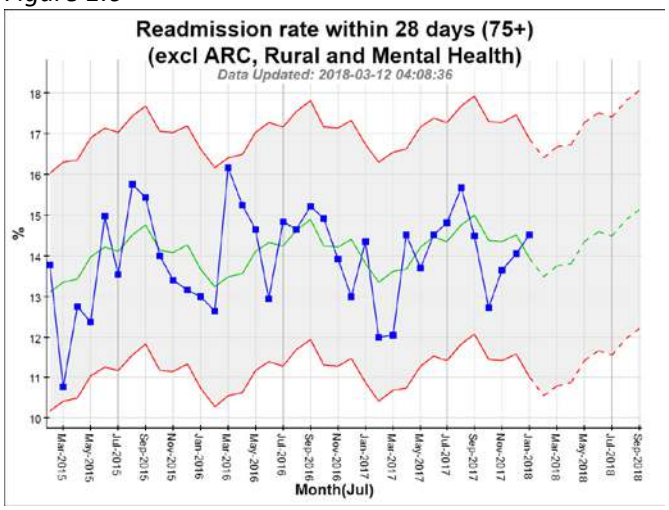
Winter periods OPH increased the number of beds across the inpatient environment to support flow. Levels returned to expected outside of this period. Resourcing for Winter 2018 is planning an increase of 20 OPH beds

Figure 1.5



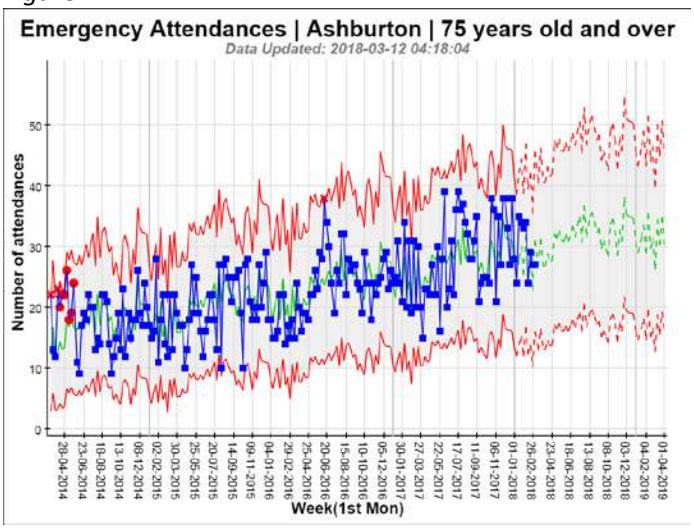
The number of in hospital deaths is within the expected range and continues along the established trend of reducing in hospital mortality.

Figure 1.6



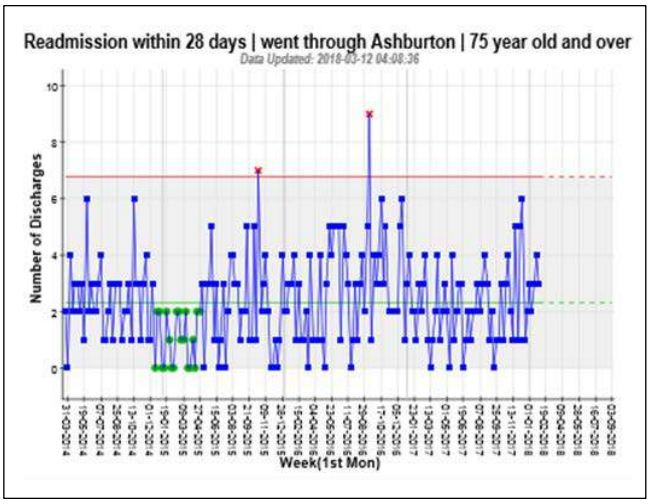
The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

Figure 1.7



Ashburton Emergency Department attendances for the age group 75 years, are higher than previous years.

Figure 1.8



The readmission measure (balancing measure) for people aged 75 years and over continues to be within the expected range with no extreme decrease or increase indicated.

Achievements/Issues of Note

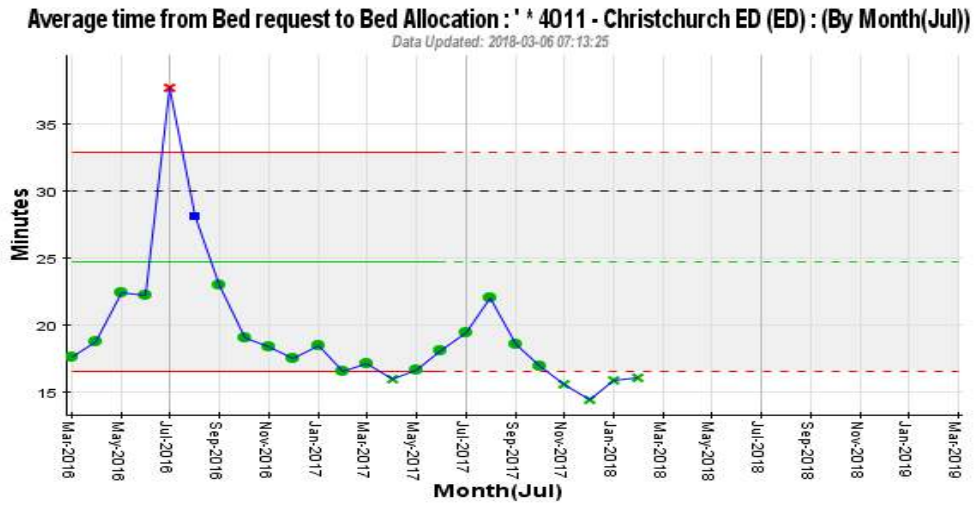
Ensuring Effective Flow from the Emergency Department to Inpatient Wards

In most cases it is important that patients who have presented to the Emergency Department and require inpatient care are transferred to the ward as soon as possible after a decision is made about which service will provide definitive care. Once a patient has been accepted by a service a bed is allocated in an appropriate ward and the patient is transferred to that ward. The time taken for these processes to occur is measured to help us understand how we are performing.

We've been working to reduce the time taken to complete the first of these two steps in recent years. This has included focussing on throughput so that inpatient beds are available for the patients that most require them, continually fine tuning where we target nursing resources, ensuring that the Acute Medical Assessment Unit (AMAU) and Surgical Assessment and Review Area begin each day with sufficient beds for incoming patients and that there are at least one or two beds available in all areas. Ensuring that Duty Nurse Managers have a standard way of

choosing the next most appropriate placement for each cohort of patients and make use of mobile technology have been important contributors.

This constant attention has led to a marked reduction in the time taken for this part of the journey over the long term. December 2017 saw us reach an all-time record for this measure with the average time from bed request to allocation sitting at just over 14 minutes. Performance has been maintained at very low levels since then.



Over the coming year we aim to maintain this performance while working to reduce the time it takes between bed allocation to the patient leaving the Emergency Department.

Winter Planning

Winter planning is underway. The focus for 2018 continues the activity from last year. The focus on communication through the 8:30am huddle continues to ensure service resources are aligned across the hospital setting. Further work is being undertaken to connect and engage with primary care through Planning and Funding and through the Urgent Care Service Level Alliance with a focus on ensuring connectivity around solutions to address forecast demand.

Additional resourcing is being prepared for Burwood Older Persons Health wards, increasing to 24 beds in each ward (total 20 additional beds).

The other focus across the Burwood campus is on maintining flow with additional SMO resource into Older Persons Health. Additional focus on the Clinical Nurse Specialist role continues .

Further work on the review of CREST is occurring with a focus on ensuring the ability to keep flow through to community providers.

Canterbury Health Laboratories (CHL) planning continues in the Microbiology service, with a focus on rapid diagnosis options for respiratory viruses, to support the triage of patients for hospitals.

The system's focus on reducing pressure injuries.

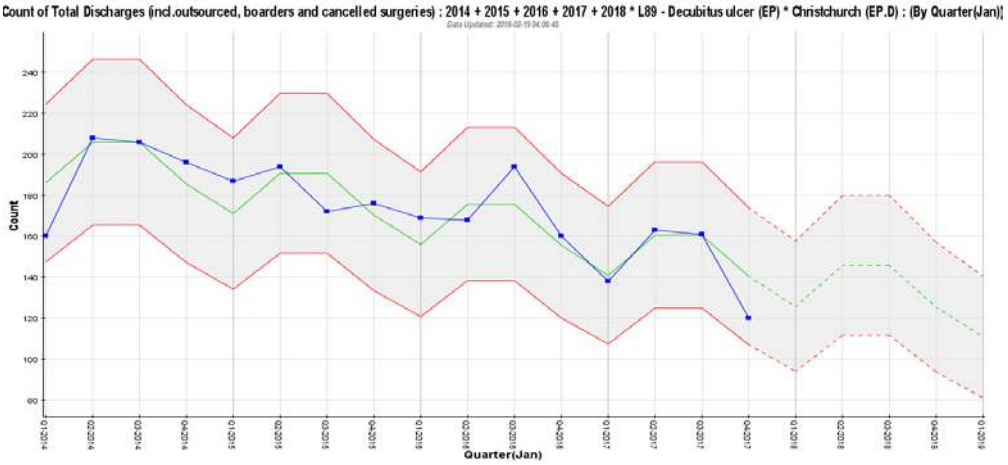
Pressure injuries cause pain, disability, extended hospitalisation and sometimes death for those that are affected by them. The best approach to minimising the harm caused is to prevent them before they occur.

Between 2011 and 2015 a series of prevalence studies was carried out in a selection of wards across Canterbury's hospitals. Initial studies found a prevalence of 39% of pressure injuries in those areas. This was significantly higher than international standards which sit between 4 and 21%. By the end of the four year period prevalence was reduced to 14.5%.

Early work included providing feedback to clinical teams about rates of pressure injury in their areas, replacing the worst of our mattresses with high density foam mattresses and implementation of a screening and process audit on prevention of pressure injury. The Intensive Care Unit, whose patients are at especially high risk of pressure injury,

now has full pressure relieving mattresses as its standard. These are used except when the patient condition means they are not appropriate.

The number of cases coded as having pressure injuries on discharge from Christchurch Hospital has continued to reduce since 2015. Based on this information there were around 100 less cases in 2017 than in 2016.



Over the past four years there has been a significant increase in awareness of the importance of preventing pressure injury. Senior clinical nurses continue to promote work in this area across Christchurch, Burwood and Ashburton Hospitals but note that while they might champion this area of practice, success requires the whole system to be working.

The Canterbury Pressure Injury Group leads work in this area and involves Nurses, Medical Staff, Corporate Quality, District Nursing Organisations and Occupational Therapists from the hospital and community

In 2015 a national focus on pressure injury prevention was promoted with the involvement of the Accident Compensation Corporation, Health Quality and Safety Commission and Ministry of Health. Data indicated that more people are admitted to hospitals in Canterbury already experiencing pressure injuries than those who develop them while in Hospital. Canterbury District Health Board will be working with the Accident Compensation Corporation on the Pressure Injury Prevention Community of Practice to work on primary care prevention and raise awareness of the risk factors and management strategies to prevent pressure injuries in the community and Aged Residential Care and hospital facilities.

New equipment to help maintain activity for bed-bound patients

People who are bed or chair bound due to acute illness decondition quickly, this slows down their rehabilitation and makes it more difficult to regain the function required to successfully return home.

CDHB trust funds have enabled the Physiotherapy Service to purchase two pieces of equipment that will support patients to engage in therapeutic exercise across the Christchurch Hospital Campus. The two MOTOmed devices are designed to increase physical activity and reduce sedentary time for people who are bed or chair bound, through passive or active, arm or leg cycle exercises. This activity has been shown to decrease intensive care unit and hospital length of stay, improve functional outcomes at hospital discharge, and is safe and effective even for patients who are critically ill.

A trial was carried out on the Christchurch Campus in the middle of 2017 where both machines were utilised for two and half months by physiotherapy staff across the campus. 129 individual sessions were completed with the majority of use in the Intensive Care Unit (59) and the Acute Stroke Unit on Ward 24 (45). 68 (53%) of these sessions were solely undertaken by Allied Health Assistants following prescribed delegation from Physiotherapists. In total, 2,381 mins of physical activity was provided through the use of MOTOmed machines and the majority of this activity was additional to what would normally have occurred for these patients. No negative incidents occurred and patient satisfaction was very high.

MOTOmed Letto

MOTOmed Viva

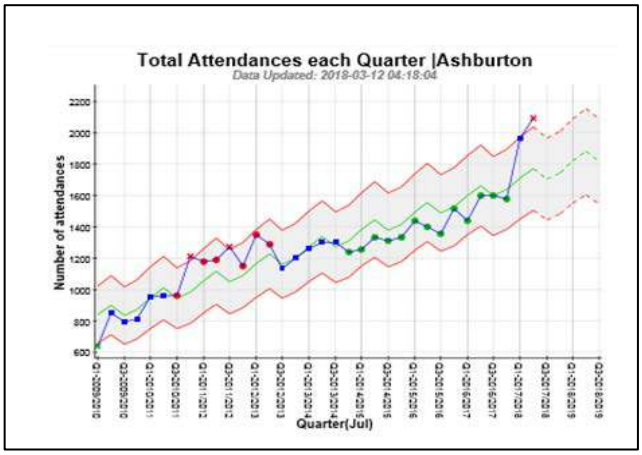
Ashburton Health Services

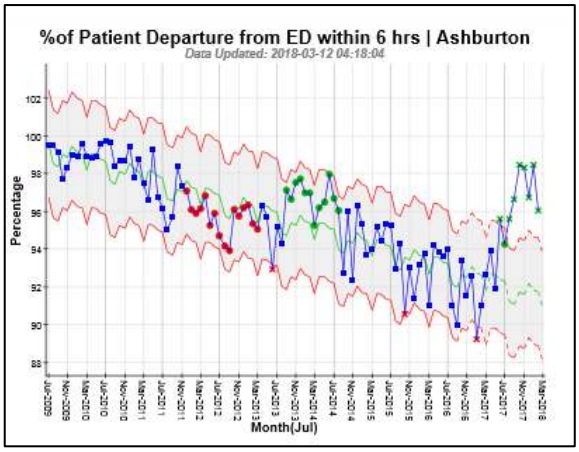
Ashburton Health Services continue to explore the development of localised Frail Elderly Pathway that will identify any barriers to accessing care in the community and explore opportunities to reconfigure our service delivery that will support people 75 years and over. As the volume of presentations to the Acute Assessment Unit increase, analysis of the presentations identify a significant portion of these presentations are represented by people over 75. These developments are in partnership with the Ashburton Service Level Alliance, in particular work we can progress via the Primary Health Organisations. A collective one off workshop is planned for April with all stakeholders.

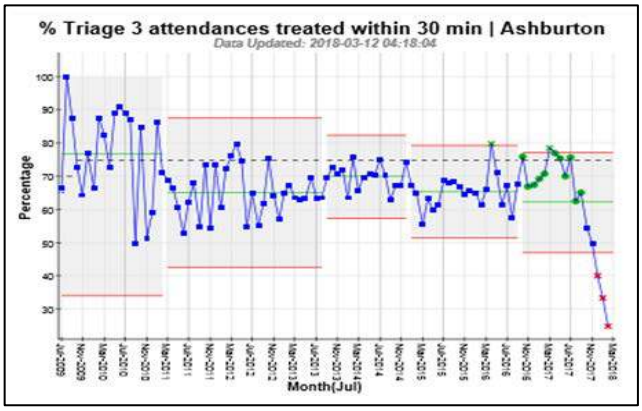
The clinical and quality team are aware that the increased volume in presentations (*refer Fig1.7*) has a corresponding delay in patients being seen in the unit and subsequent pressures this places on the nursing and medical team, particularly on the weekend. Whilst we have introduced a triage nurse 'role' within the AAU nursing shift who has a core task of checking back in with patients who are waiting, the increased delays are resulting in an increase in complaints from patients and self-discharge without waiting to be seen by a doctor. A common theme in all these complaints is praise for the nursing and medical workforce they are in contact with, the frustration is in the delay in being seen and waiting time in the unit. We are working closely with the AAU team to explore options to address this. Work includes a review of our nurse rostering looking to distribute our workforce across the hospital to manage peak periods, work with our administration teams to provide more support and move non clinical tasks away from nursing teams and feedback from our triage nurse role. Feedback from both the nursing and medical workforce recognises the key constraint on the weekends is the limited medical workforce available as the single registrar and supporting SMO over both the AAU and the inpatient wards. As weekend presentations are now averaging 30 patients or more per day, the resources in this area are stretched.

Within the hospital resources our response is focused on opportunity our Clinical Nurse Specialist (CNS) and District Nursing Workforce can contribute. With the retirement of our CNS gerontology we are taking the opportunity to focus the replacement role with more support for psycho-gerontology. This new role with work with the visiting Consultant providing nurse led clinics and support the wards with in-patient care. In addition to this as part of our winter planning our CNS workforce will ensure all our long term condition patients have a personalised care plan completed and an acute plan, addressing any key issues to ensure early access to primary care and community providers. In April our Nurse Practitioner gerontology returns and we will continue to progress the design of specialist gerontology community led clinics.

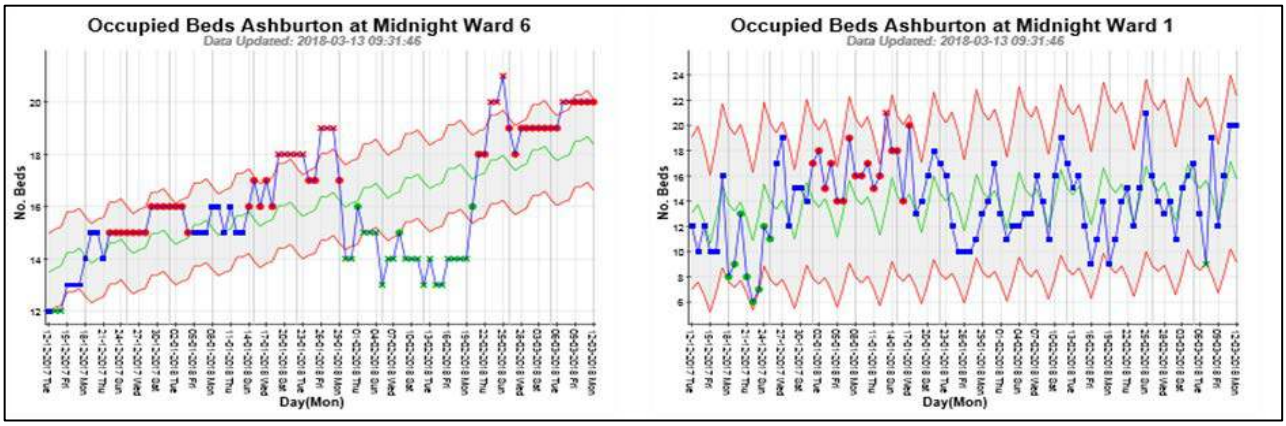
Ashburton ED







These data pieces show AAU is challenged to maintain performance within the expected target range with the increased presentations There is an increased percentage of patients who are scored Triage 3 on presentation. It is noted that the timeline of this change coincides with the implementation of the dedicated Triage Nurse Role. Further investigation of the measurement is underway to confirm the drivers and system response to this.



Over the last 91 days occupied ward beds are varying. Ward 6 occupancy includes a cohort of non-weight baring patients and Assessment Treatment and Rehabilitation (AT&R) patients and Ward 1 is our acute medical ward. We are actively working to manage our bed planning and occupancy as a collective ensuring we are able to plan our occupancy and transfers back from Christchurch through both wards. Ward 6 has had high numbers of inpatients over the last month, a times Ward 6 has had admission numbers outside control points. Ward 1 has had no particular trend over the last 91 days over the last month.

Clinical Pharmacology contributes to patient flow in Canterbury and around New Zealand

The Clinical Pharmacology Service provides a range of services that contribute directly to improving the treatment of patients in Canterbury's hospitals.

One of these is the production of **patient information leaflets** that help patients understand what a medicine does, how it should be taken, whether it can be taken with other medicines and what side effects might be experienced. This information is available to patients and clinicians in an online format or is able to be printed if required. Providing people with this information helps them to make proper use of their medicine, giving them the best chance of returning home from hospital sooner and remaining healthy in the community.

- Work is underway with Te Pou NZ to consider costs and timeframes of providing medicine sheets that are relevant to Mental Health requirements.
- Work is complete for Haematology drugs. The Haematology pharmacists fed back that in 2017 she was able to complete a patient counselling session with all the required sheets available.
- Work is completed on provision of sheets for HIV and hepatitis related drugs.

This work is resourced by funding from CDHB, New Zealand Formulary and MIMS, although it is understood that there is some risk of MIMS leaving the New Zealand market. While this work has been developed and sustained in Canterbury it benefits patients throughout New Zealand. http://www.mymedicines.nz/

Another arm of the service is the **drug information service** which provides drug information to health professionals to assist with the management of patients, focussing on responding to questions that relate to the care of specific patients rather than general questions. This service is clearly directed at hospital and community based clinicians in Canterbury. Most enquiries come from within this district but some enquiries (close to 300 out of a total of 2000) do come from outside of Canterbury. The majority (512) were from community doctors (general practitioners or private consultants); followed by community pharmacists (435); hospital pharmacists (390), hospital consultants (210) and other health professionals (360).

The **Therapeutic Drug Monitoring Service** provides clinical interpretation and oversight of drug concentration testing for CDHB, working closely with Canterbury Health Laboratories which provides the greatest range of therapeutic drug assays in New Zealand. This service provides clinical advice that assists with the fine tuning and use of specific drugs for patients. This advice enables patients' drug concentrations to reach optimal point as quickly as is safely possible.

A future focus for the service is on making use of prescribing data from e-medicines (electronic prescribing) to assist, among other things, in the development and maintenance of standard approaches to therapy within services. It will also allow analysis down to the level of specific clinician detail, which will enable peer review of practice. This will require an initial commitment of clinical resource so that an analytical system can be constructed in a way to enable fast responses to specific enquiries.

Benefits continue to be provided by having a pharmacist in the Emergency Department.

As reported previously a pharmacist is stationed in the Emergency Department to provide a range of services directly to patients. Foremost amongst these is ensuring that an accurate medication history is provided, especially for patients on complex or high risk medication regimes who are being admitted to hospital. Typically between 60 and 100 patients are admitted to hospital from the Emergency Department each month with a completed medication history.

Alongside this information is provided to nursing and medical handover about changes in medicine brand, guidelines for drug use and changes in process, patient yellow cards are updated, patient counselling carried out and specific enquiries about drug information are answered.

The following gems, cases that illustrate the type of benefits provided by the pharmacist, have been provided from the past three months.

- An elderly patient presented to ED following a seizure. His weekly blister pack indicated he was only taking the morning dose of his epilepsy drug and missing the larger evening dose. During conversation the patient expressed frustration that it was inconvenient for him to take his medicine labelled as "dinner time" in the middle of the day as he is always busy at that time. He considered that dinner time related to midday, and tea time to the evening meal. He and his whanau agreed that there should be no problem for him to take the medication with evening meal or at night. The community pharmacy was contacted and asked to change the "dinner time" dose to "bed time" when the patient would remember to take his medication. It was also suggested to the GP to change the larger dose to the morning when medication compliance was more reliable.
- Another gentleman was suffering pain from a fractured neck of humerus, and had been taking dangerously high doses of paracetamol and codeine. As increasing doses of codeine were not working he sought help from ED. When looking through his medication history it was discovered the patient had been taking fluoxetine – which inhibits the enzyme responsible for converting codeine to morphine. The pain improved

with a dose of morphine the patient was discharged home with a prescription for morphine with laxatives and advice on safe doses of paracetamol.

- A patient presented to ED following a second episode of anaphylaxis from sulphite food allergy. She had been prescribed an Epipen® however didn't use it as she was unfamiliar with how to operate it. This had led to her requiring high doses of injected and nebulised adrenaline in the ambulance on her way to hospital and had put her at high risk. While she was in the Emergency Department she was provided with further education and the opportunity to practice using an Epipen® placebo device. She was discharged with a further prescription for an Epipen® and the confidence to use it should the need arise.

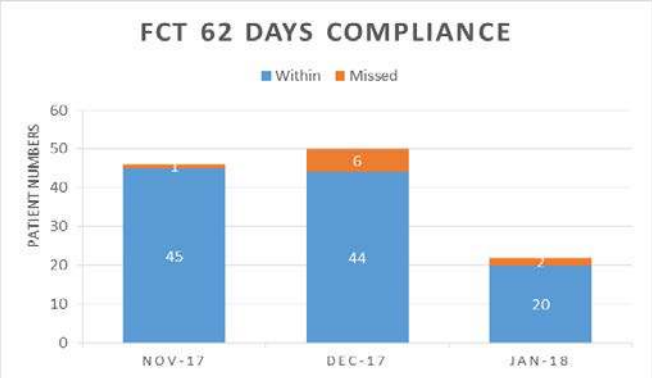
Faster Cancer Treatment

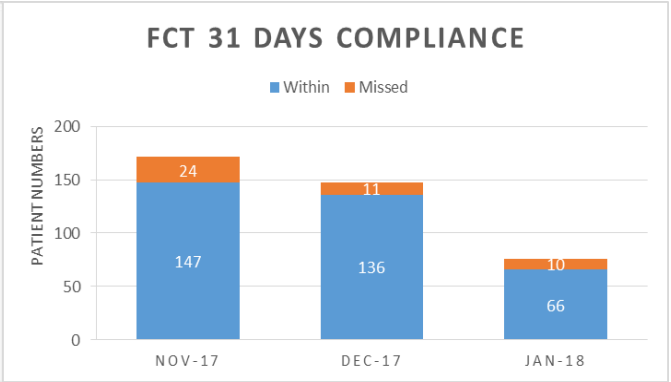
Outcome and Strategy Indicators

Key Outcomes - Faster Cancer Treatment Targets (FCT)

62 Day Target. For the months of November and December 2017 and January 2018 Canterbury District Health Board submitted 140 records to the Ministry of Health (MoH). Of the 31 who were not treated within 62 days of their referral, 22 were because of patient choice or clinical considerations and are subsequently excluded from the compliance calculation. Therefore our compliance against the 90% target was 92.4%

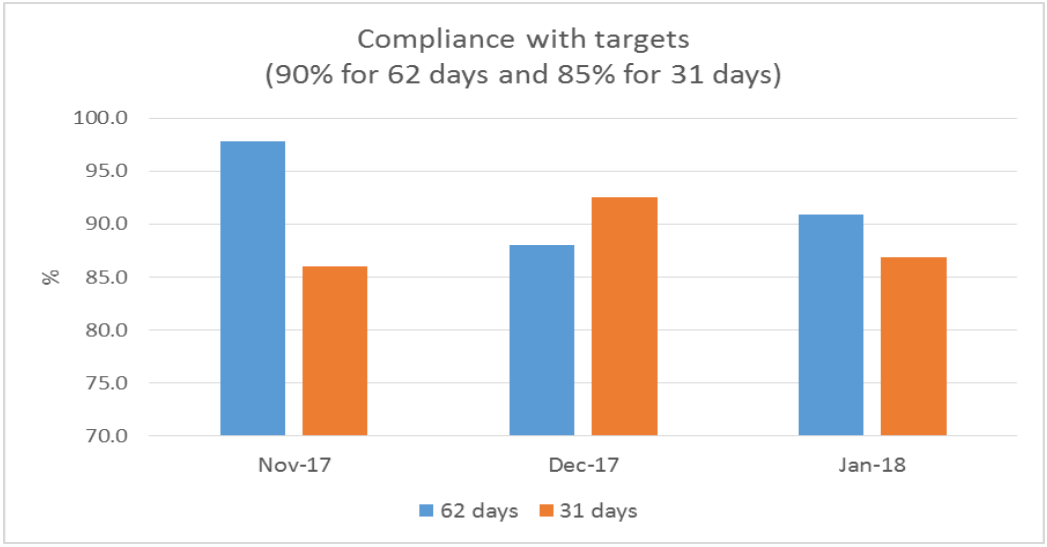
1 Day Performance Measure. Canterbury DHB submitted 394 records in November and December 2017 and January 2018. This figure includes patients also eligible for the 62 days target. In this period 89% of eligible patients met the 31 day measure against a threshold of 85%, Canterbury District Health Board continues to be compliant.

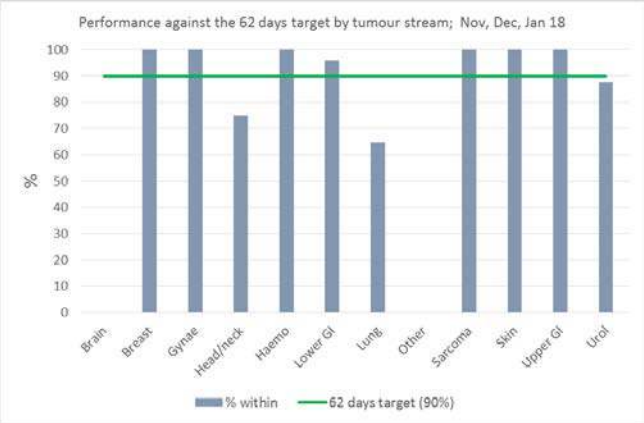


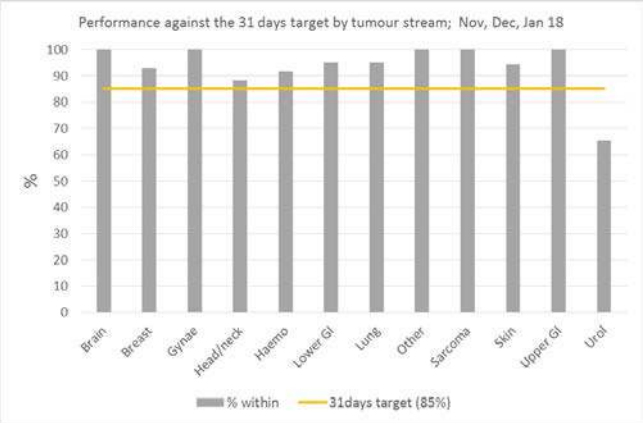


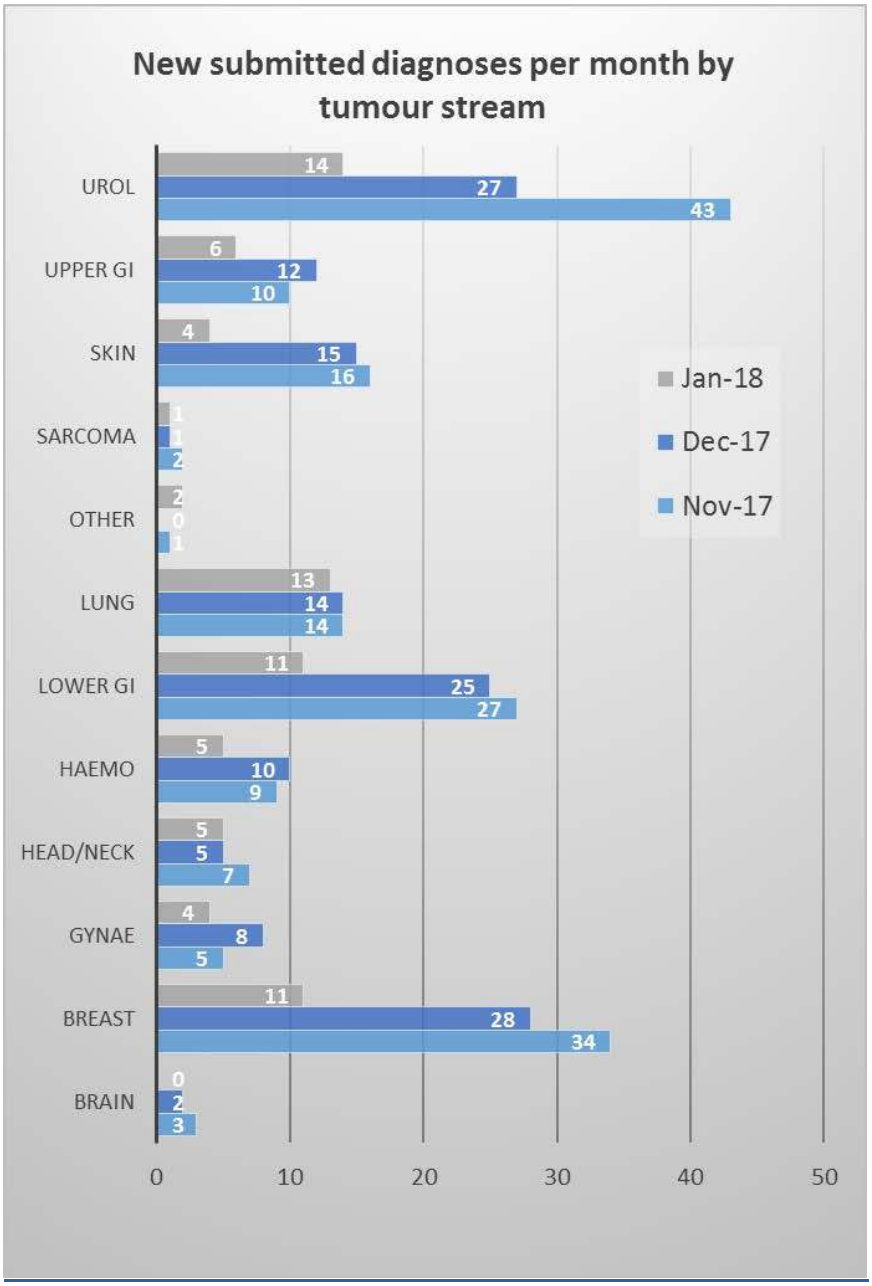
Faster Cancer Treatment performance in Canterbury

The relatively low volume of patients for January reflects that the analysis was completed soon after the end of the month, prior to coding being completed. January's complete volumes will be included in future reports




Performance against the 62 days target by tumour stream; Nov, Dec, Jan 18
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)


Performance against the 31 days target by tumour stream; Nov, Dec, Jan 18
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)

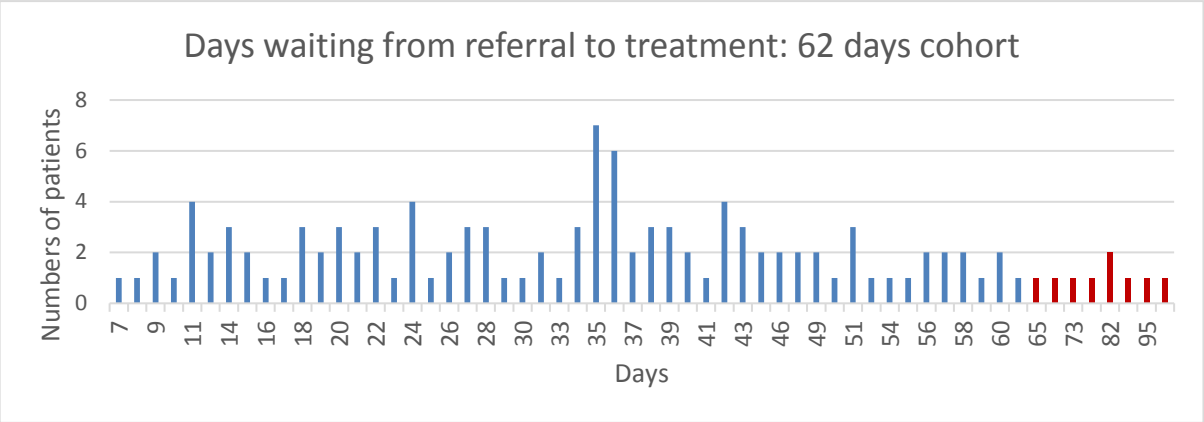

New submitted diagnoses per month by tumour stream
UROL
14
27
43
UPPER GI
6
12
10
SKIN
4
15
16
SARCOMA
1
1
2
OTHER
2
0
1
LUNG
13
14
14
LOWER GI
11
25
27
HAEMO
5
10
9
HEAD/NECK
5
5
7
GYNAE
4
8
5
BREAST
11
28
34
BRAIN
0
2
3
Jan-18
Dec-17
Nov-17
0
10
20
30
40
50

Patients who miss the targets

The Ministry of Health requires District Health Boards to allocate a "delay code" to all patients who miss the 62 days target. There are 3 codes and only one can be used even if the delay is due to a combination of circumstances which is often the case. When this happens the reason that caused the most delay is the one chosen.
The codes are:

1. Patient choice: e.g. the patient requested treatment to start after a vacation or wanted more time to consider options
2. Clinical considerations: includes delays due to extra tests being required for a definitive diagnosis, or a patient has significant co-morbidities that delays the start of their cancer treatment
3. Capacity: this covers all other delays such as lack of theatre space, availability of key staff and process issues.

Patients who missed the 62 days target and were non-compliant through choice or because of clinical considerations are not included so that the graph aligns with MoH reporting requirements.



Each patient that does not meet the target is reviewed to see why. This will have happened in order to assign a delay code, but where the delay seems unduly long then a more in-depth check is performed. These cases are usually discussed with the Service Manager to see if any corrective action is required.

Achievements/Issues of Note

FCT update

On the 26th February the CDHB hosted two colleagues from the Ministry to discuss a range of issues relating to FCT. It was attended by clinicians, service managers, cancer nurse co-ordinators (CNCs) and members of the Southern Cancer Network. Topics that were covered included the:

- Benefits of a South Island-wide prospective tracking tool;
- Positive difference that CNCs make to patients' journeys and how they have become so valued by services that have them;
- Challenges faced by the radiology dept. (in terms of capacity and reporting) with meeting increasing demand;
- Impact that fluctuations in acute work have on elective services;
- Difficulties, as demand increases, in identifying how to provide more radiotherapy capacity in a physically constrained site;
- Need to replace ageing linear accelerators;
- Wider impact that the introduction of new chemotherapy drugs has on services such as radiology, labs and day units, including for patients who need these services prior to privately funding drugs.

The meeting was very positive and we will be working on the issues identified to further improve the pathways for our patients.

Proof of concept for hospital sourced referrals; General Surgery to Oncology.

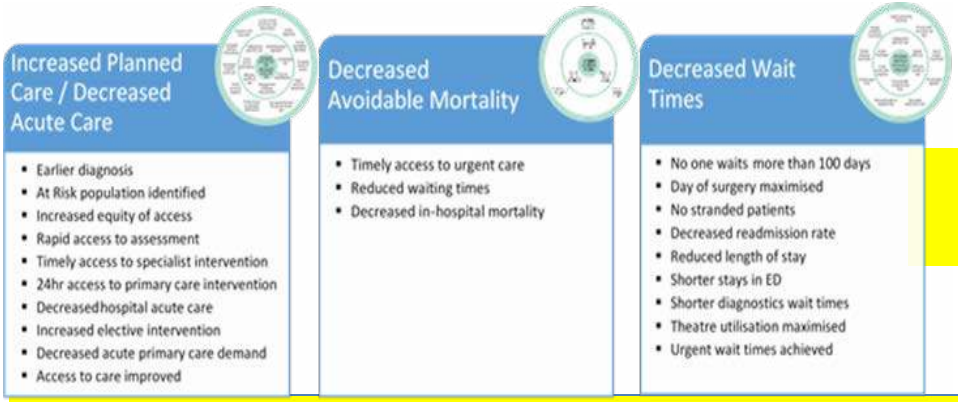
Many patients are referred to hospital based specialist services with a disease that requires they receive care from a series of specialist services. Internal, or hospital sourced, referrals between services are made in multiple different ways dependent on the context. We do not have a single, standardised method that provides a timely transmission of referrals or that provides a feedback loop showing that they have been received.

This was clearly illustrated during the initiation of the project to improve the pathway for patients with colorectal cancer. In this setting it was found that half of referrals were dictated and typed. The average time from dictation in clinic to receipt by oncology was 5.6 days with outliers up to 12 days. The other half of the referrals were handwritten and/or faxed with associated issues of completeness, legibility and traceability.

As a part of improving this pathway an interim electronic solution has been developed using SharePoint. This provides an easy way for general surgeons to provide patient details to Oncology, the service that will provide the next phase of care to the patient. This system immediately provides the details required to Oncology's administrators so that they can register the patient in a timely manner with the information being legible and complete. Because of this it supports timely treatment of patients and achievement of the faster cancer treatment targets. Patient safety is ensured because referrals are traceable and will not be lost. Clinician acceptance of the system is high with its use spreading like wildfire without the need for a plan to convince users to take it up.

This system has now been used to refer over 600 patients from General Surgery to Oncology likely saving 1,500 days of waiting by patients with various forms of cancer.

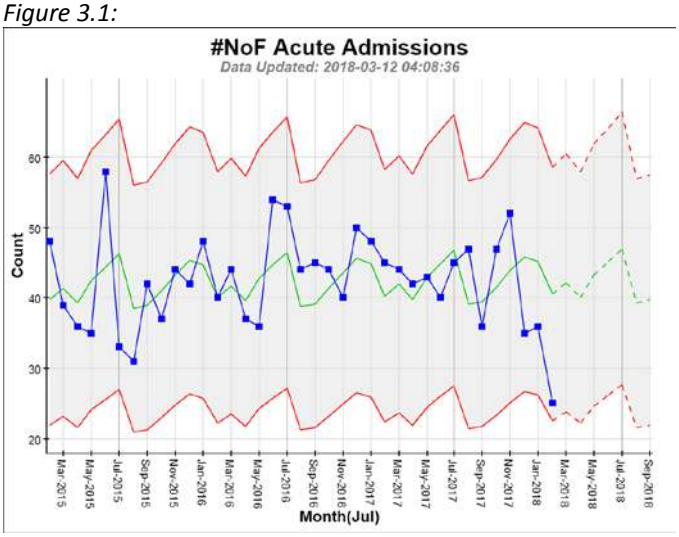
This interim approach is being expanded to other services that refer to Oncology. It has attracted a lot of attention with many other clinicians keen to adopt it in their area. This system is serving as a useful proof of concept that is informing design of a fully integrated e-referrals system that will be developed in the near future.



Enhanced Recovery After Surgery (ERAS)

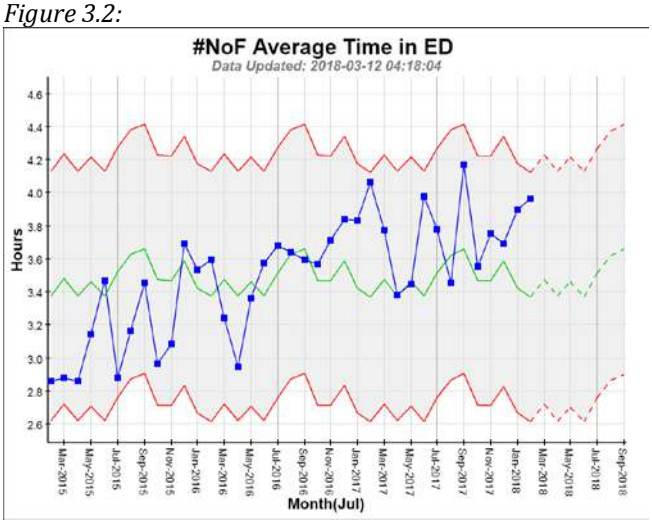
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



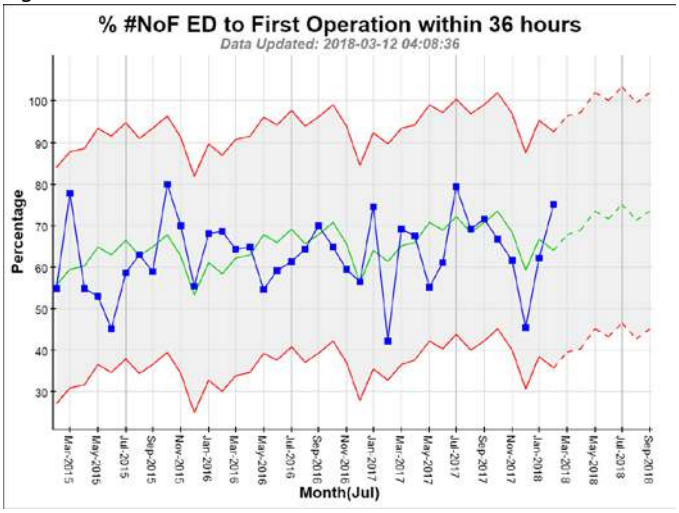
#Nof admissions per month over December, January and February have dropped below the expected mean

Figure 3.2:



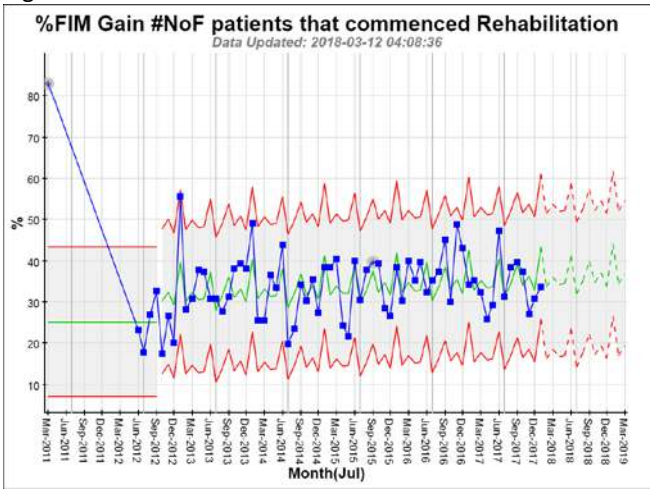
Patients with #NOF appear to be spending longer in ED than the expected mean.

Figure 3.3:



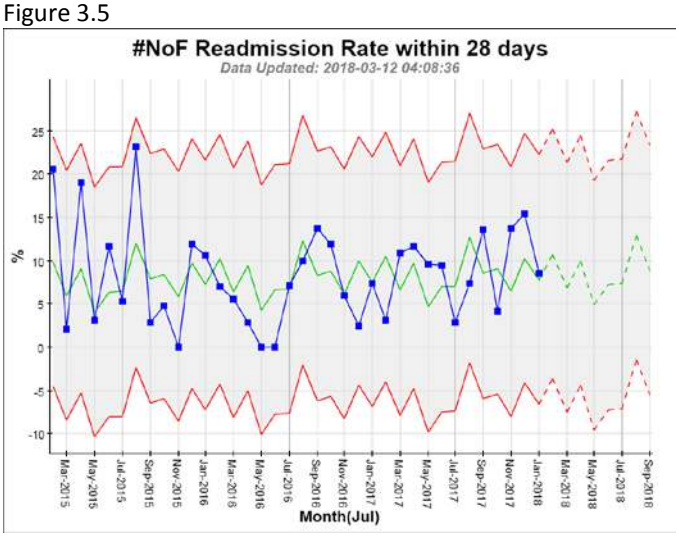
The target is set for patients to be operated on within 36 hours 'when clinically ready' is following the expected pattern which indicates an ongoing improvement.

Figure 3.4



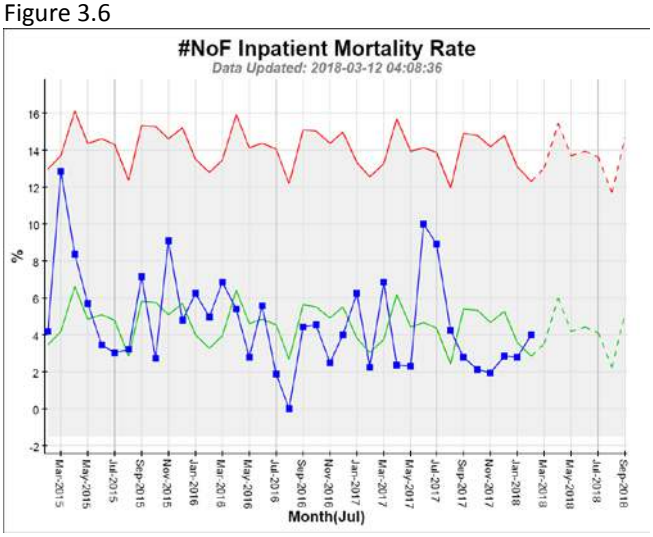
Functional change is a key outcome measure of rehabilitation in the #NoF pathway. The Functional Independence Measure (FIM) is a basic indicator of severity of disability. The above graph shows the percentage gain for #NOF patients.

Figure 3.5



The readmission balancing measure continues to remain within expected mean values.

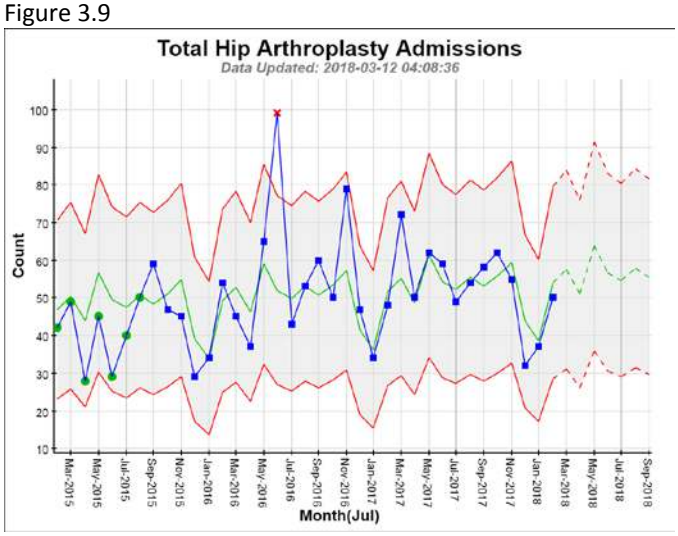
Figure 3.6



The mortality rate remains within the anticipated range.

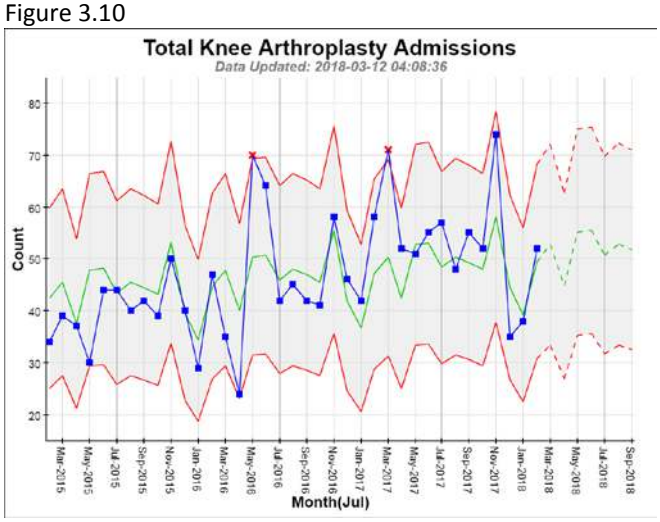
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.9



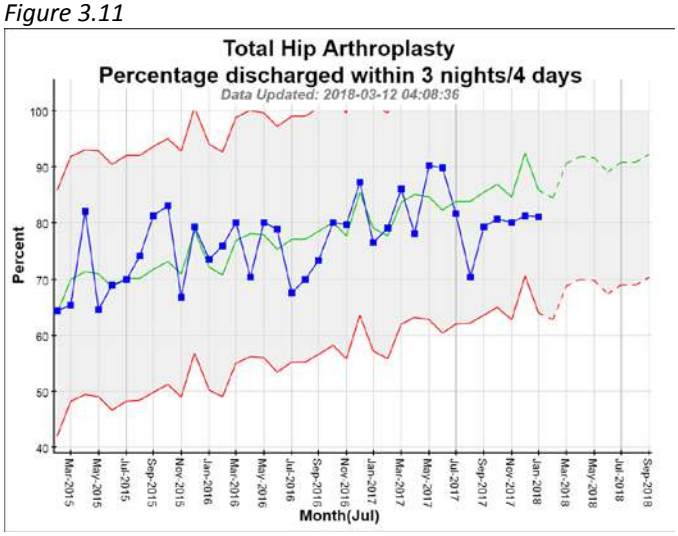
The health target and ESPI compliance for joint replacements remain a focus. In recent months hip replacements have been tracking within average levels.

Figure 3.10



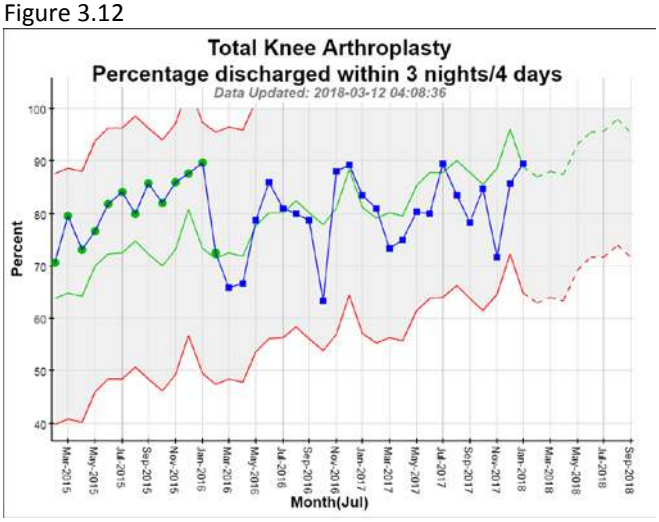
Knee replacement admissions over the previous twelve months have been at or above average levels. Orthopaedic surgery has been focussing on non-joints health target after reaching the joint target.

Figure 3.11



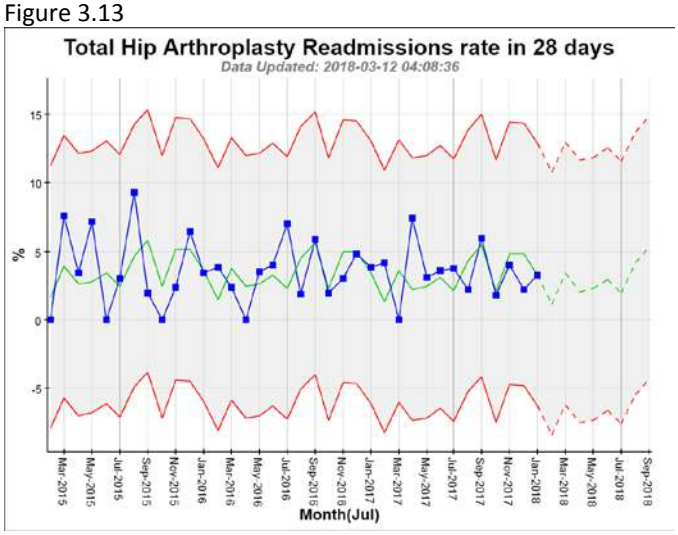
The proportion of patients clinically safe to be discharged within 3 nights/4 days has increased in the previous two years from approximately 65% to reaching 90% in May and June 2017.

Figure 3.12



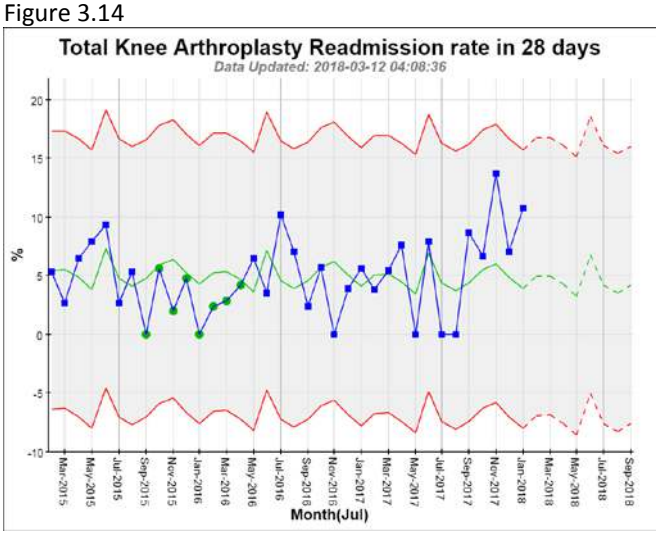
Discharges are following projected trends for anticipated levels.

Figure 3.13



Readmission rates remain close to the mean and well within expected limits.

Figure 3.14

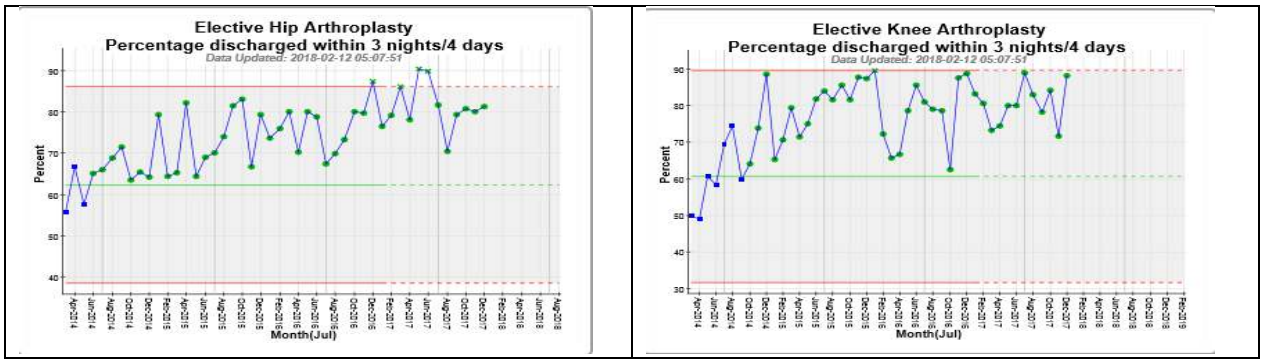


Readmission rates are maintaining within tolerances although a slight increase above the mean noted in the past 3 months.

Achievements/Issues of Note

ERAS

Enhanced Recovery After Surgery (ERAS) – Overall trend for both Elective Hips and Knees seeing improvement in the percentage of patients discharged within the target. Still some variation however variation on the positive line of improvement



Orthopaedic Flow

From 2009 to 2017, the overall number of patients admitted into Christchurch Public Hospital orthopaedics has increased by approximately 28% (growth rate per year of 2.8%) and in the over 65 year group by 36% (growth rate per year 3.5%) (Fig A & B)

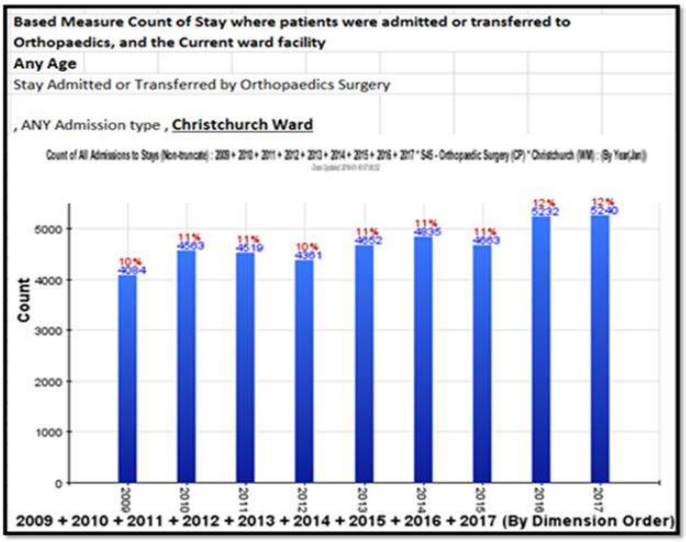


Fig A Count of all admissions to stays Orthoapedics

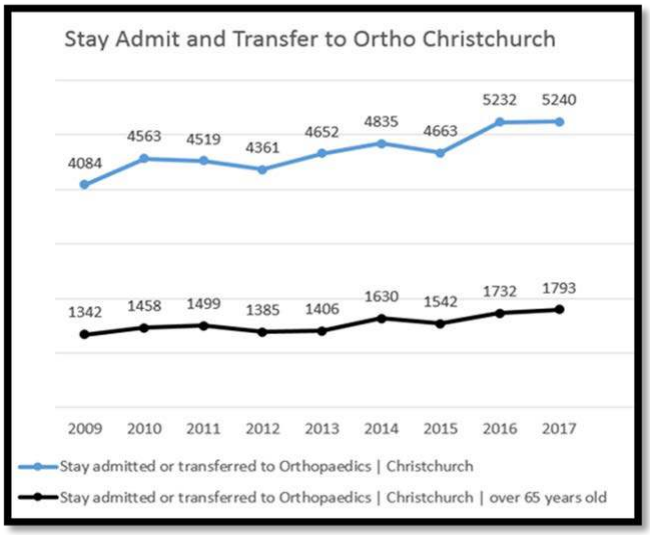


Fig B All stay admissions and transfers to orthopaedics

However, overall admissions to Orthopaedic Rehabilitation Unit Ward (D1) in Burwood have remained stable at a little under 500 patients per year (Fig C)

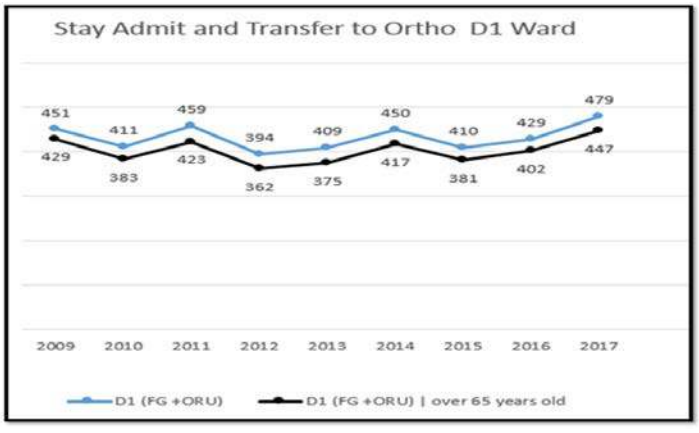
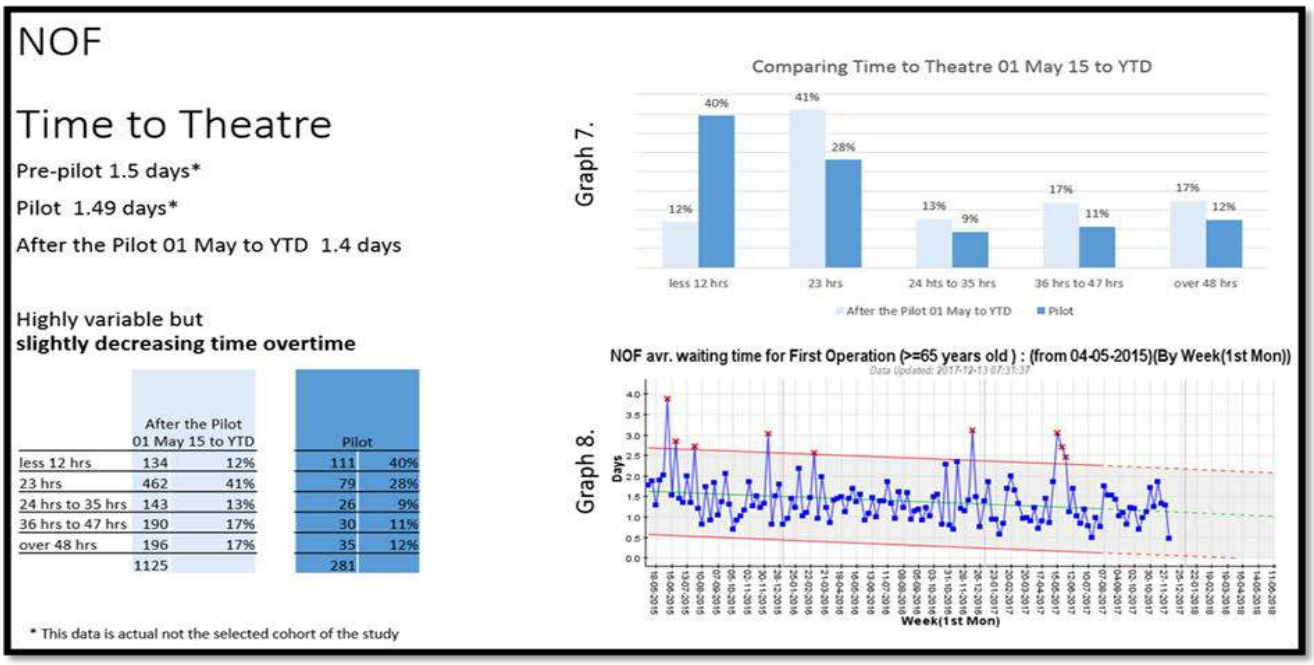


Fig C Admissions to ORU Burwood Ward D1



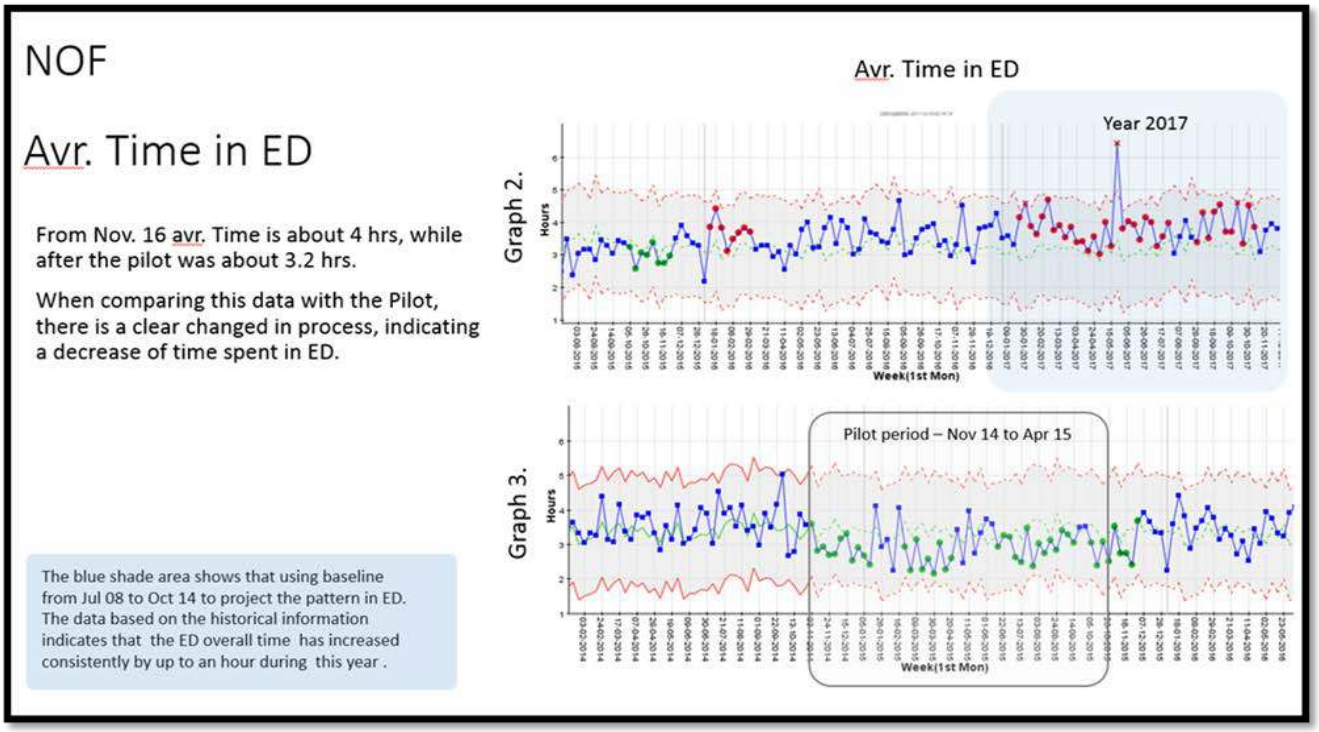
	After the Pilot 01 May 15 to YTD		Pilot	
less 12 hrs	134	12%	111	40%
23 hrs	462	41%	79	28%
24 hrs to 35 hrs	143	13%	26	9%
36 hrs to 47 hrs	190	17%	30	11%
over 48 hrs	196	17%	35	12%
	1125		281	

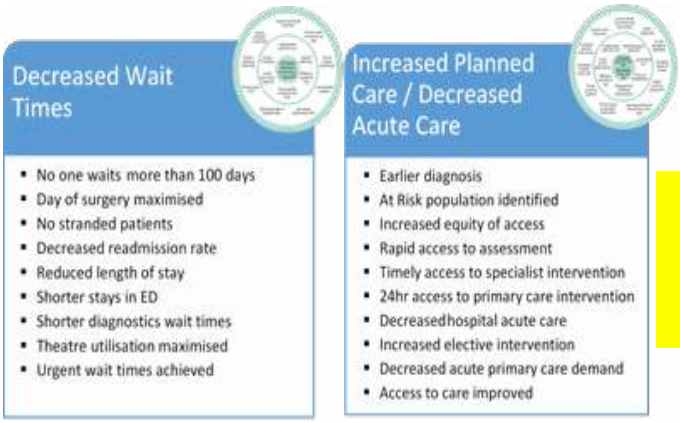
Fig D Summary of Time to theatre

While the wait for theatre, the context of increasing overall numbers of orthopaedic patients, has gone down from 1.47 hours to 1.42 hours (Fig 3.2). Our Enhanced Recovery After Surgery (ERAS) continues to be a focus and a revisiting of the markers used to identify patients is taking place to ensure timely access to theatre, and/or referral for Older Persons Health.

Fast track pathway times

The average time in ED (Fig 4) has increased from 2.66 hours in 2014 to 3.5 hours in 2017





Elective Surgery Performance Indicators 100 Days

Outcome and Strategy Indicators

Figure 4.1:

ESPI 5: Number of people waiting >120 days for treatment

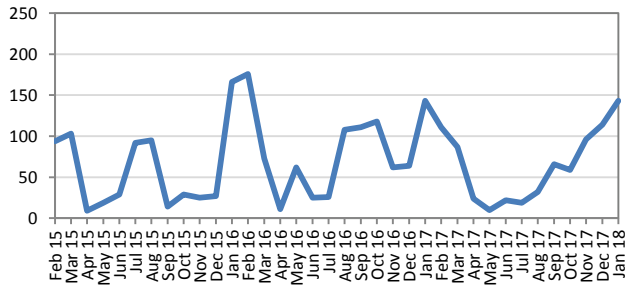


Figure 4.2:

ESPI 2: Number of people waiting >120 days for FSA

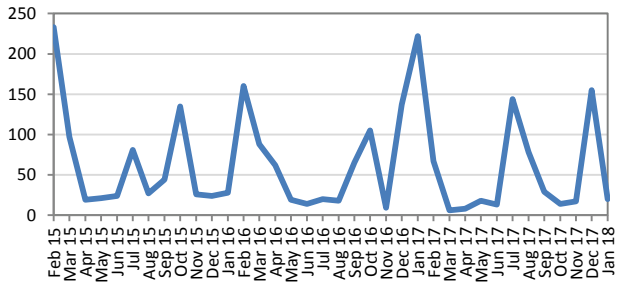


Figure 4.3:

ESPI 2 Result By Specialty – Surgical

Specialty	Number	%	Change
Cardiothoracic	0	0.0%	0
ENT	3	0.3%	-8
General Surgery	3	0.5%	13
Gynaecology	0	0.0%	-1
Neurosurgery	0	0.0%	0
Ophthalmology	1	0.1%	-35
Orthopaedics	1	1.0%	-3
Paediatric Surgery	0	0.0%	0
Plastics	3	0.9%	1
Urology	0	0.0%	-4
Vascular	7	3.1%	3

ESPI 2 Result By Specialty - Medical

Specialty	Number	%	Change
Cardiology	0	0.0%	0
Dermatology	0	0.0%	-3
Diabetes	0	0.0%	-1
Endocrinology	0	0.0%	-4
Endoscopy	0	0.0%	-34
Gastroenterology	1	0.2%	-2
General Medicine	1	1.2%	-2
Haematology	0	0.0%	0
Infectious Disease	0	0.0%	-2
Neurology	0	0.0%	-2
Oncology	0	0.0%	-12
Paediatric Medicin	0	0.0%	-1
Pain	0	0.0%	0
Renal	0	0.0%	0
Respiratory	0	0.0%	-8
Rheumatology	0	0.0%	0

Figure 4.4

ESPI 5 Treatment by Specialty

Specialty	Number	%	Change
Cardiothoracic	1	2.5%	1
Dental	1	2.1%	0
ENT	9	1.4%	6
General Surgery	11	2.5%	1
Gynaecology	0	0.0%	0
Neurosurgery	0	0.0%	0
Ophthalmology	21	5.9%	7
Orthopaedics	88	12.6%	20
Paediatric Surgery	2	2.6%	1
Plastics	3	0.5%	0
Urology	5	1.5%	5
Vascular	2	2.8%	1
Cardiology	0	0.0%	0

ESPI Results

Waiting > 120 Days

	Number	%	Status
ESPI 2 (FSA)	20	0.2%	
ESPI 5 (treatment)	143	3.7%	

Achievements/Issues of Note

Elective Services Performance Indicator (ESPI) Target Outcomes

Latest final reporting from the Ministry of Health shows that Canterbury District Health Board achieved a yellow result for elective services performance indicator two (covering first specialist assessment) at the end of January.

The same report shows that Canterbury District Health Board achieved a red result for elective services performance indicator five (covering waiting time for surgery) for the fifth month in a row. Data issues associated with the transition of data between patient management systems is one cause for this ongoing apparent failure to make target. The Ministry of Health has provided Canterbury District Health Board with dispensation for Elective Services Performance Indicator achievement related to data issues until the end of June, agreeing that we will use a notional buffer of 35 people failing to meet target time to define transition from yellow to red, and report against this manually. Reports distributed to District Health Boards will continue to be published using the usual methodology with manual reporting used to inform discussions about improvements required.

In addition to this the number of operations provided at Christchurch Hospital was reduced throughout January and February because work to form a link between the Parkside and Acute Services Buildings required that two theatres were closed down. This closure lasted much longer than originally estimated. Accordingly the Ministry of Health has provided a dispensation in relation to the delay caused by this work that covers January and February, requiring that we will once again exit red status before the end of June. This will allow four months for a recovery plan to eliminate the backlog.

The indicators above (figures 4.1 – 4.4) provide an up to date reflection of the status at the time this report went to print.

Glaucoma backlog improvement.

People with glaucoma require regular follow-up to check whether the treatment provided continues to be appropriate. If the condition changes and treatment is not altered there is a risk of irreversible vision loss.

Early in 2017 Canterbury and other District Health Boards were experiencing challenges in providing timely follow up of people with glaucoma. At the end of May 2017, of the 1,508 people being followed up for treatment of glaucoma 166 were overdue by more than 50% of the intended time. As an example, a patient who is due to come back six months after an initial appointment, and is still waiting at nine months is considered to be overdue by more than 50%.

A number of changes have been put in place including running additional clinics at nights and weekends along with more effectively backfilling clinics freed up when specialists are on leave. Files have been reviewed to ensure that patients are correctly categorised and appropriately included in specific follow up lists, this has included a clinical review of files to identify patients who should be discharged from specialist care.

Other improvements have been put in place that will have an ongoing impact on our ability to reliably provide high quality follow up to people with glaucoma. These include:

- Acceptance criteria and triage processes have been clarified;
- An updated model of care has been developed that includes follow-up by in-house optometrists or technical staff working within defined parameters. This will create increased follow up capacity, with specialist ophthalmologists being involved in the care of each patient on a regular but less frequent basis, unless clinically required;
- Pathways used by general practitioners are being clarified to ensure optometrists are used where appropriate. These also provided clearer information for community optometrists to ensure that only people requiring specialist investigation or care are referred to the department;
- Physical space has been made available for new specialist clinics by shifting diabetes retinal screening clinics to Burwood Hospital;
- Improved administrative processes ensure that we have clear information.

These changes will ensure that people are not waiting unnecessarily for the care they require, that care is provided in a community setting to those for whom this is appropriate and that specialist resources are used for tasks that only they can safely perform.

Alongside these changes a new specialist Ophthalmologist has been recruited and will begin work in August 2018. Until she arrives we will continue purchasing additional capacity from clinicians already in Christchurch.

These changes have been successful as while the total number of people receiving treatment for glaucoma in Canterbury District Health Board at the end of January 2018 has increased to 1,585 there is now only one person waiting for more than 50% longer than stipulated. This focus has created an improvement for the people we care for. It has required that we utilised extra resources (staff, equipment and space) and has required that we further tighten our triage criteria. Future capacity issues are looming and we are working towards ensuring these are covered with the staff, facilities and equipment required.

A structured approach to operational management is being put in place to ensure that we sustainably manage the eye care required by the people of Canterbury with a focus on the long term care required by many eye conditions. This includes embedding systems for reliable data collection, ensuring we continue to use models of care that utilise a range of professional groups appropriately and development of a production planning system that enables us to project the human resources, space and equipment required in the future as well as working effectively on a day to day basis.

Orthopaedic acute workload

We continue to see the impact of increased acute orthopaedic workload on elective capacity at Burwood. During the month of January 32 acute operations were provided at Burwood. Of note we did not have to actively cancel any acute lists, rather utilising backfilled or dedicated acute lists.The acute case mix included:

- Maxillo-Facial = 3
- Plastic acute = 1.
- Orthopaedic = 25.

Ongoing pressures on the spinal resource available for elective surgery continues to place orthopaedic ESPI 5 compliance at risk. Further work is planned on increasing elective capacity through staff movements to remove two spine surgeons from the general acute orthopaedic trauma rosters, replacing this capacity with two surgeons' elective capacity. This will give us the options for an additional four spine cases each four weeks. We will continue to work towards our plan for spine surgeon resource while maintaining out input into the spinal cord impairment strategy.

Linwood Medical Centre and the Diabetes Centre working together to improve care

Linwood Medical Centre and the Diabetes Centre have together become one of six successful teams who submitted innovation projects to the Health Quality and Safety Commission Whakakotahi 2018, Primary Care Quality Improvement challenge.

This grant is designed to support the release of staff from primary care practices to attend workshops, work closely with a specialist team, gain collaborative insight from the other involved national teams and learn valuable improvement techniques.

The aim of the Canterbury project will be to improve the way that the system supports a cohort of people who have especially poor glucose control and currently receive a lot of support from the specialist service that could be better provided through their general practice. Success will be shown by an improvement in glucose control along with an increase in retinal screening rates.

The first step in the project is formation of a practice consumer group to help direct our activity. The project is expected to take a range of approaches to improving the way that patient self-management is supported and extending the clinic's confidence and practice with people who have diabetes. These approaches are likely to include building confidence and trust through joint case conferences, introduction of new tools to support self-

management, patient co-design to improve the way that we work so that it suits patients better, the fostering of other partnerships across the health system.

Updates will be provided as results become available.

Work with Christchurch Men's Prison to simplify care for people with Hepatitis C

People with Hepatitis C require ongoing monitoring to ensure that changes to their liver are recognised early and that appropriate treatment is provided. Providing treatment that eradicates the virus has the significant benefit of halting any further progression of scarring in the liver which could ultimately result in liver failure or liver cancer, and also decreases the prevalence and subsequent transmission of the virus in the wider population. The care required includes provision of a specialised liver scan (fibroscan), and where people are incarcerated in prison, supporting corrections staff to treat and monitor this vulnerable group.

Clinical Nurse Specialists from Gastroenterology and Infectious Diseases departments have worked closely with the Department of Corrections health teams to provide regular clinics at Christchurch Men's Prison and Christchurch Women's and Rolleston Men's as required. Additional resources such as a portable fibroscan, have allowed us to provide an enhanced service on site. This enables care to be provided to up to ten prisoners per visit. Clinics are fully utilised and make effective use of the nurses' time. Running these clinics at the prison ensures that the required care is provided in a timely manner without the need for increased resource demands on the Department of Corrections.

This collaboration has already shown additional benefits for prisoners, The Department of Corrections, and Christchurch Hospital staff. It is our observation that the prisoners are more engaged, and we do not have prisoners electing not to attend, which decreases the non-attendance rates at Hagley Outpatient Clinics.

This model is a significant improvement on the way things were previously done, which involved prisoners being required to attend outpatient appointments at Christchurch Hospital to receive care. Each of these visits required the Corrections Department to provide transport and at least two corrections officers. This model aligns with the Ministry of Health (MOH) plan for an integrated approach to the delivery of Hepatitis C services for groups considered to be at increased risk of infection. This initiative saves both time and costly resources, while having a positive impact on all involved.

An 0800 number has been launched for Gynaecology Outpatients

Women who have been sent appointment letters for Gynaecology Outpatients' regularly need to contact the department to ask about details of the appointment, seek rescheduling or for other reasons.

There has previously been confusion about how best to contact the department, also reliance on mobile phones without sufficient credit to make calls has served as an obstacle to many women successfully contacting the department.

Provision of a 0800 number that is publicised in the appointment letter gives a single point of contact for these patients and removes cost as a barrier to communication. This is just one part of our efforts to ensure that we're working to make it easier for the people we care for to use our services, and to reduce "did not attend" events.

Newborn hearing screening programme – here's the numbers

Over the past six months two brief accounts have been provided about aspects of the work done by the Universal Newborn Hearing Screening and Early Intervention Programme at Canterbury District Health Board. Neither of these have discussed the number of children whose lives have been improved as a result. A review has recently been published covering the programme's first seven years of operation – from January 2010 to December 2016.

Each year, up to 180 infants are born in New Zealand with hearing loss. The first six months of a baby's life is a critical period for language development. Early detection and intervention significantly improves long-term outcomes for children with hearing loss and promotes normal development of communication.

New Zealand's National Screening unit has set three relevant high level objectives. These are that:

- Babies are to be screened by one month of age;
- Audiology assessment to be completed by three months of age for children who do not pass screening;

- Children identified as having hearing loss will have appropriate medical, audiological and early intervention education services initiated by six months of age.

In order to achieve this the service, made up of ten part time screeners and a coordinator, works seven days a week and in a range of contexts including Christchurch Women's Hospital, birthing centres and community clinics to make it easier for mothers to have their baby's hearing screened. If need be, home visits are arranged. There is regular interaction with hospital midwives, Lead Maternity Carers and General Practitioners. The National Screening Unit has commented positively on the presence of a combined Canterbury District Health Board and West Coast District Health Board clinical advisory group which has promoted close interdisciplinary relationships.

The members include:

- The coordinator of the newborn hearing screening programme from Christchurch and Greymouth;
- Audiology services and the surgeons who specialise in otology and cochlear implants;
- Neonatologists and developmental paediatricians;
- Advisors on Deaf Children, who provide advice and direct support to families of deaf children to the age of 18;
- The van Asch Deaf Education Centre;
- Triton Hearing Aid Service paediatric audiologists as the fitting of hearing aids for babies has been contracted to this private provider;
- The Southern Cochlear Implant Programme Audiologist;
- Consumer representation.

This committee ensures regular case reviews so that the service continues to refine its practices and services provided. Inter-disciplinary Information is shared through Health link south as Canterbury has developed an integrated data management system that uploads automatically to Health Connect South which supports clinicians working with babies with hearing loss throughout their journey. A national information system will soon be developed.

The recent report describes the service's engagement with 43,712 babies born between January 2010, when the service was introduced, and December 2016. Since introduction almost all parents have been offered screening with 99.7% or more receiving an offer over each of the last three years reported. One of the National Screening Unit's goals is that 95% of babies will receive screening by one month of age. This has been consistently achieved in Canterbury, with achievement improving further to 97% and 98% over 2015 and 2016.

It is expected that less than two percent of babies will require referral to audiology, with the exception of 2010 this has been the case in Canterbury. Of those that are referred to audiology 16.8% (128 babies) were diagnosed with permanent hearing loss. Less than half of this group had known risk factors for hearing loss. 75% of the babies with hearing loss had a completed diagnosis before three months of age – often within the six to eight week period so that interventions can begin.

Babies diagnosed with bilateral hearing loss are contacted within two days by a specialised advisor who becomes the family's key contact. They work with family members to help them understand the implications of their child's hearing loss and talk with parents about how deaf children learn to communicate and understand. Support provided includes accompanying families to appointments and visiting them at home, preschools and schools. Advisors follow an 'Informed Choice' approach ensuring that families and whanau are fully informed and have a good understanding of all communication pathways including New Zealand Sign Language. They help families identify their priorities and goals for their child and ways to achieve these.

23 infants have received at least one cochlear implant. Two babies that were not suitable have travelled to Germany to receive a brain stem implant.

This programme is a great success story, working as part of a wider system to identify and support children with hearing loss to achieve different outcomes throughout their lives than would otherwise be possible.

Dr Philip Bird and Dr Melanie Souter: CDHB Ear, Nose and Throat Specialists and Southern cochlear implant surgeons have said. "Prior to the introduction of Neonatal hearing screening, often severely deaf children weren't diagnosed until 18m-5yrs which is traumatic for the family let alone the developmental impacts for the child. The Newborn

Hearing Screening Program has been a major milestone for paediatric hearing loss. Early diagnosis and early intervention not only makes a huge difference for early speech and language development, but has a massive impact for the rest of their life. This is a clear example where screening makes an astronomical difference to individual outcomes and is highly cost effective to society.

With the ability to screen babies by one month, we can have babies implanted with bilateral cochlear implants by 6 months of age or in some cases sooner. With the continuing advances of technology and research the role of cochlear implantation for single sided deafness is emerging. The availability of other implantable and non-implantable hearing devices means that early stimulation of auditory pathways to achieve binaural hearing is our goal. This can only be achieved with a reliable Neonatal Hearing Screening Program".

Elective Services Guidelines Updated

The popular bible for anything to do with Elective Services, the "Orange Book", has received an update to better support staff.

The Orange Book, generated by the 100 days programme team, is structured around the health care journey of a patient with a requirement for elective treatment, covering the journey from referral through triage, first specialist appointment and treatment. It explains who does what, why things are done the way they are and is designed to support standardised and more consistent work practices ensuring that processes are clear, consistent and accessible to all, especially new starters. It also helps the DHB in extracting data for reporting to the Ministry of Health and in making sure we hit our 100-day targets for helping the patient progress through to treatment if required.

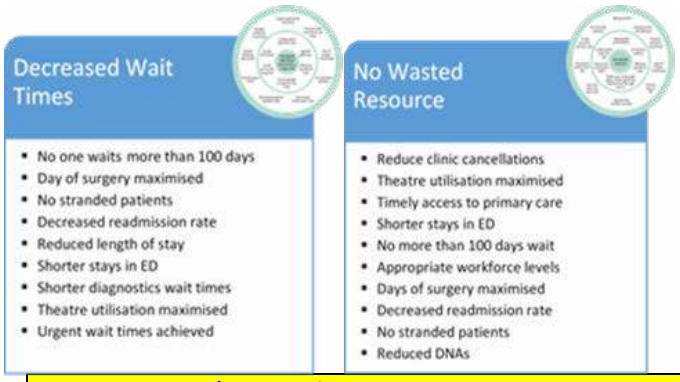
Version two features improvements in format and updates content based on staff feedback. Both the old and new editions outline the principles of the 100 days project, providing a foundation for the management of elective services from patient-centric and Elective Services Patient Flow Indicators perspectives. Version Two expands on the original comprehensive resource, now providing guidance on scheduling appointments, waitlist management and the use of booking horizons, making it especially useful for Service Managers, Team Leaders and Booking Administrators alike. New content also includes defining reasonable notice, managing 'Did Not Attend' and long diagnostic delays, and scheduling principles.

Canterbury leader contributing to international standards for spirometry.

Spirometry is a test used to assess how well your lungs work by measuring how much air you inhale and exhale and how quickly you exhale. Spirometry is used to monitor respiratory disease and assist the diagnosis of asthma, chronic obstructive pulmonary disease (COPD) and other conditions that affect breathing. Patients in Canterbury have been benefitting from access to community based spirometry testing for many years. In order to support this activity, spirometry testing standards and a training programme have been developed and put in place in order to ensure that we are providing results that are of sufficient quality to guide diagnosis and treatment.

The American Thoracic Society and European Respiratory Society have formed a taskforce that will update the international spirometry standards that are followed throughout the world by people carrying out this test. The increase in testing spirometry outside of respiratory laboratories has driven the requirement for many health professionals to be trained to provide high quality spirometry testing. This training relies on clear, useable standards.

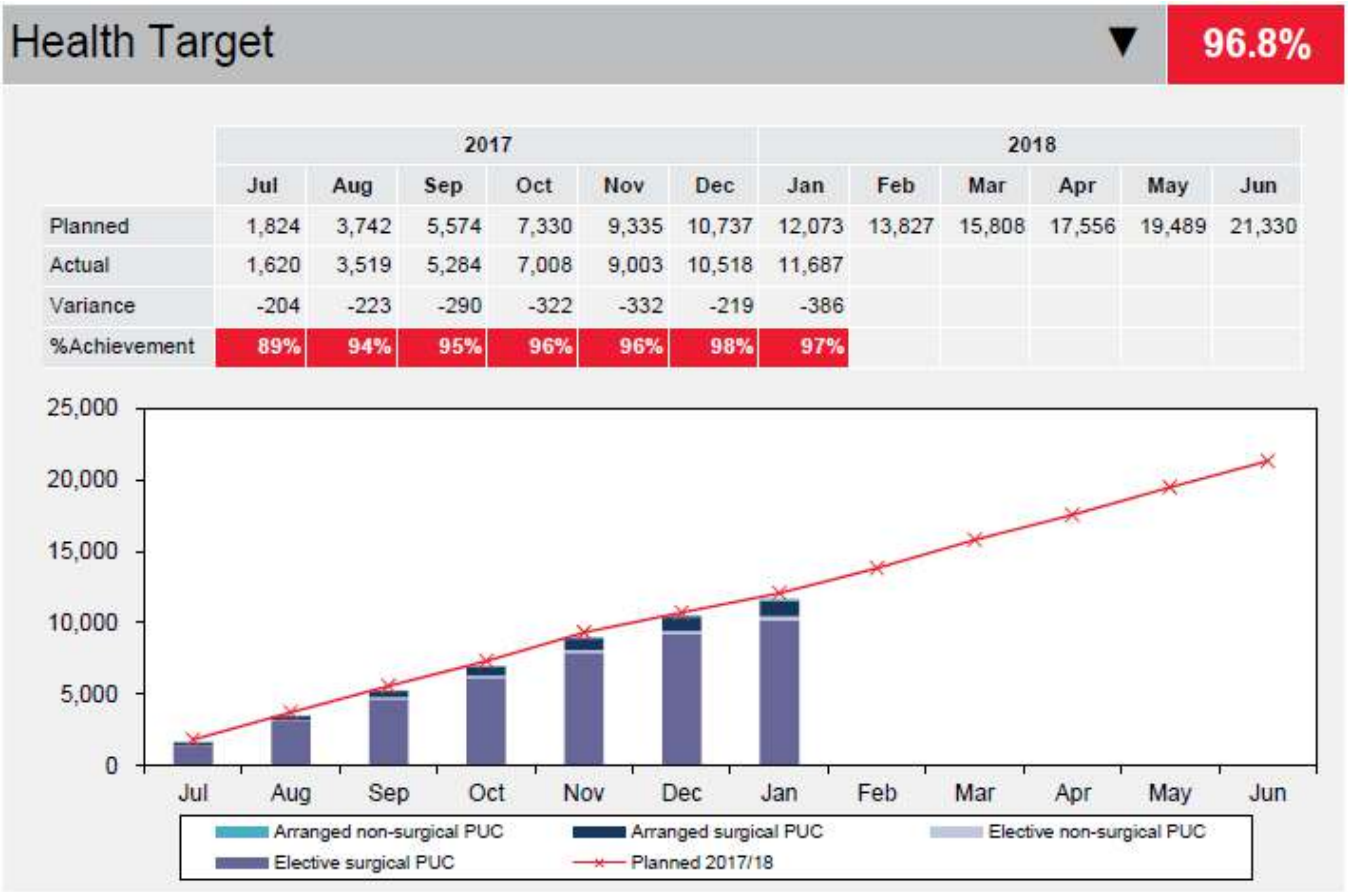
Dr. Maureen Swanney, the Scientific Director of the Christchurch Hospital Respiratory Physiology Laboratory, has been appointed to this taskforce which aims to complete the guideline by the end of 2018. Dr. Swanney is the first New Zealander to be appointed to such a taskforce, a move that recognises her expertise and provides a Canterbury system perspective on the panel.



Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Ministry of Health reporting for 2017/18 showed that following January 2018 CDHB was running behind target.



Internal reporting shows that in house delivery is sitting above planned levels with the overall deficit explained by a current under-run of outsourced operations. We are confident that this will be corrected prior to the end of June 2018 meaning that Canterbury District Health Board is on track to achieve the Elective Health Target volumes. Note however that there is a mismatch between target and delivery in the various sub-categories (i.e. arranged versus elective and between specialties). Canterbury District Health Board is working through this with the Ministry of Health.

Updated model in Christchurch operating theatres – freeing nurses for clinical work

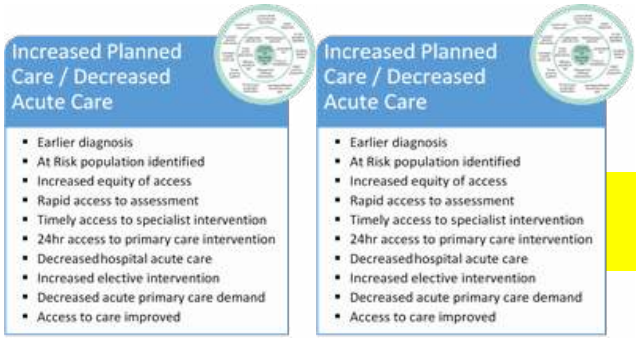
Until recently operating theatre assistants have been used within the perioperative environment at Christchurch hospital to carry out a range of support roles outside of operating theatres. Nursing staff have been responsible for the provisioning and setup of theatres as well as for a range of patient care tasks that occur in that setting.

We are working towards changing our model so that operating theatre assistants will carry out a range of delegated tasks within operating theatres, supporting nursing staff to focus more on clinical tasks. This will see operating

theatre assistant's roles expanded to include gathering the equipment, instruments and consumables required for operations and setting them up in theatres along with clean-up following operations. Implementation of this new model has begun in General Surgery. This initial phase has taught us that operating theatre assistants can provide the most value when individuals are focussed on working in a single specialty so that they can develop expertise in that area. When this is the case they truly add value as part of an integrated team by supporting clinical staff to focus on clinical tasks. This programme is currently being expanded to cover Neurosurgery.

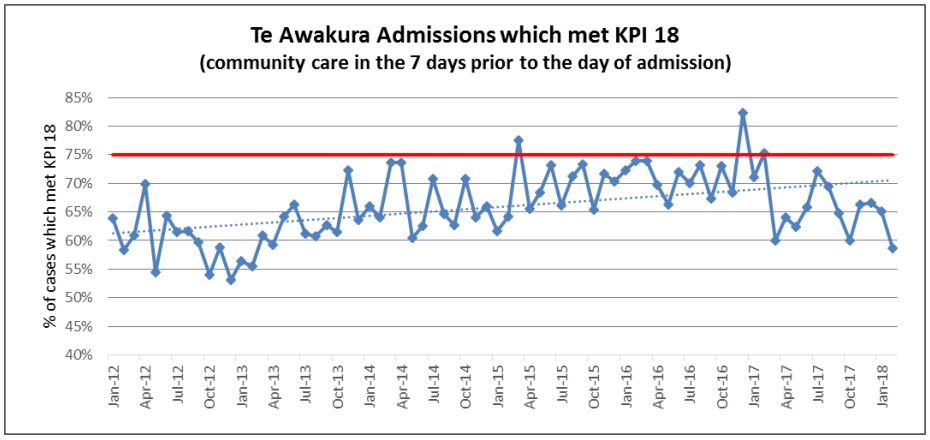
In February six operating theatre assistants will begin a Career Force course leading towards a New Zealand Certificate in Health and Wellbeing, Health Assistance Strand.

This evolution in our way of working was prompted by the requirement to think about a standard model of care we will use in operating theatres across the Christchurch campus following the opening of the Acute Services Building's new theatres. Beginning to work this way now reduces the change load we will face at that time, and enables us to begin delivering the expected benefits sooner.

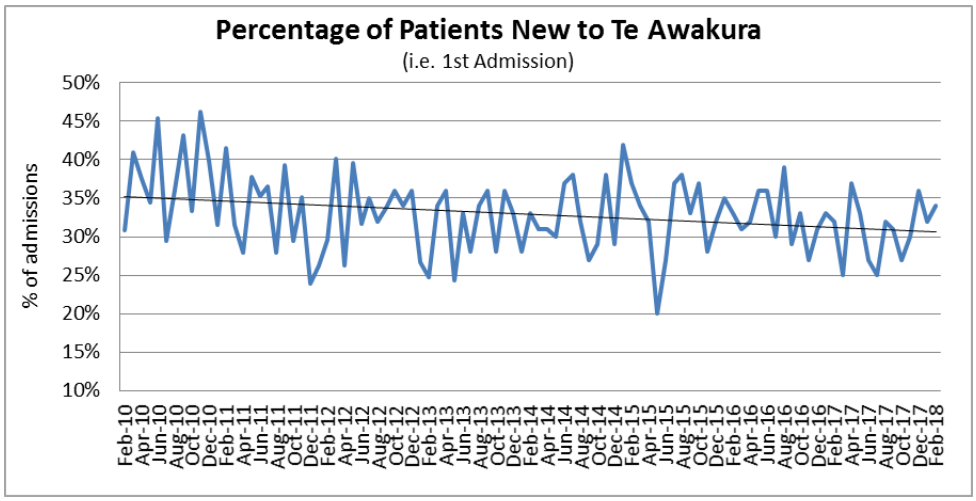


Mental Health Services

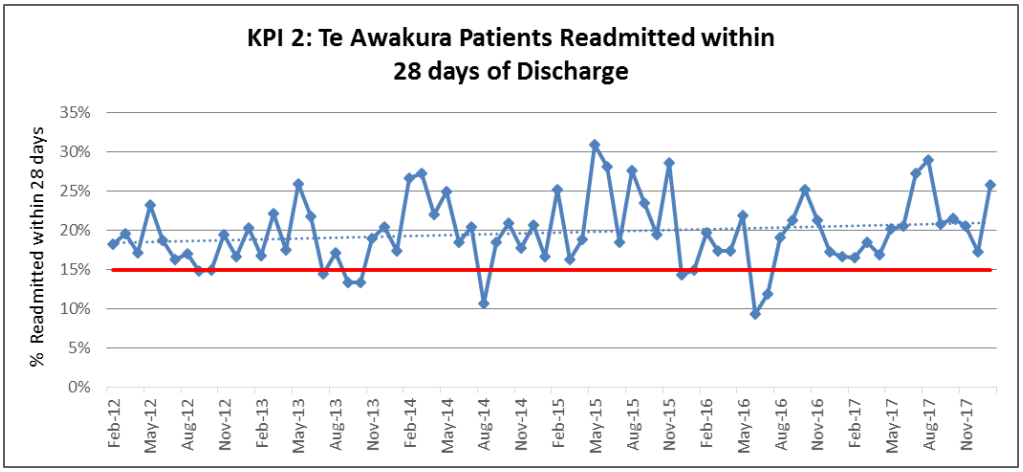
Adult Services



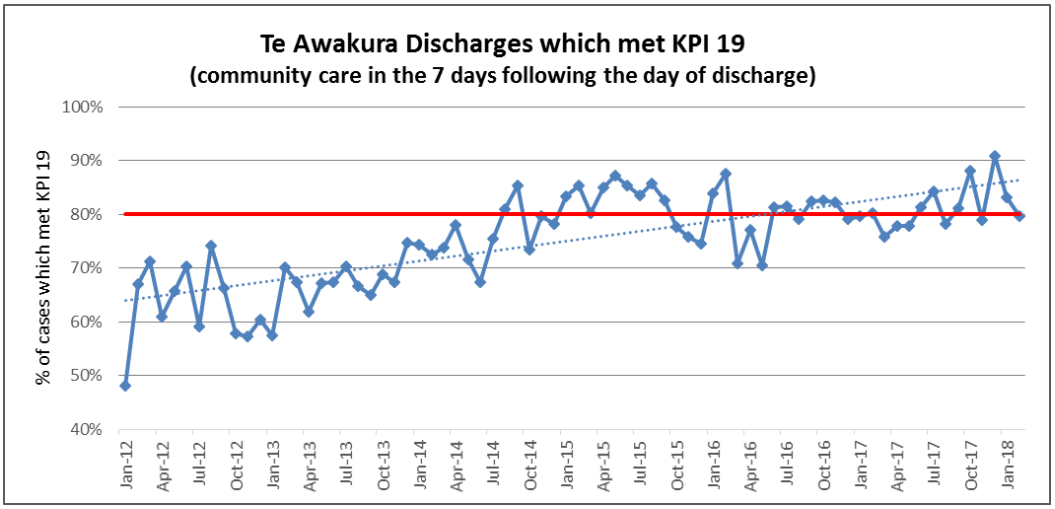
KPI 18 is an indicator of how well engaged we are with the consumers in our services. In January 2018, 65.1% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In February 2018 the figure was 58.7%.



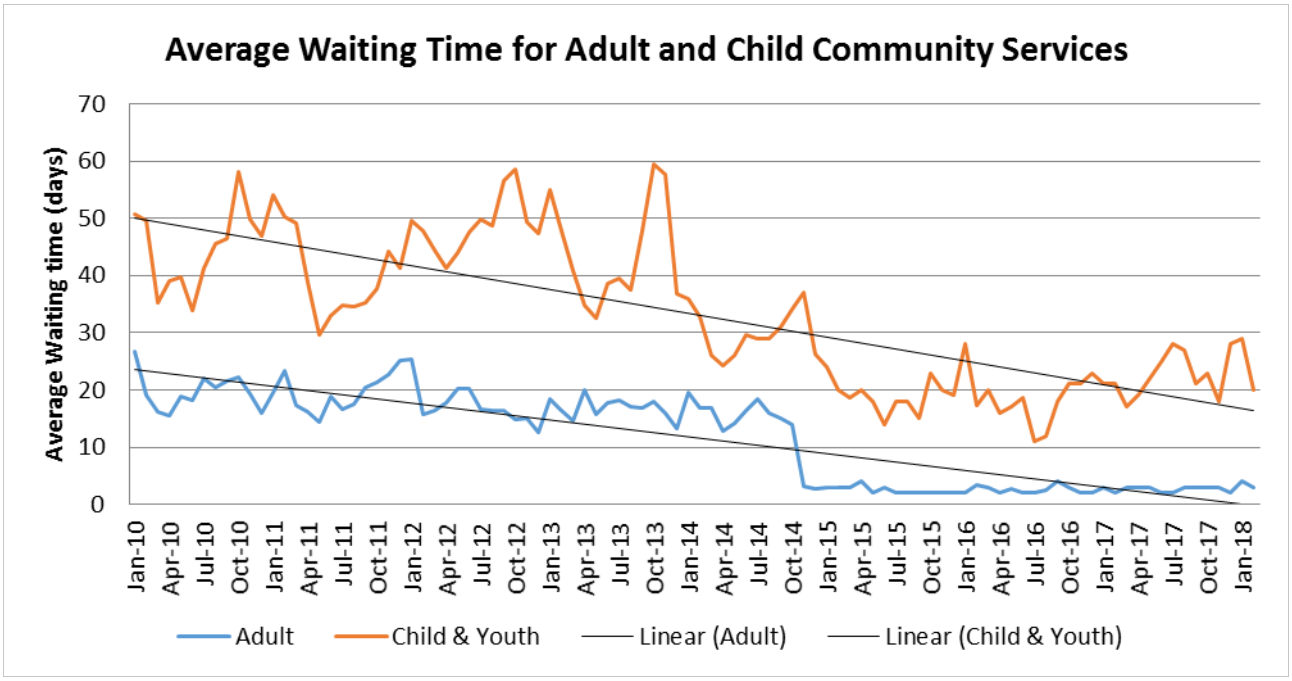
In February 2018, 34% of people admitted to Te Awakura were new (had not been admitted there previously). There is a strong correlation between the number of new patients to Te Awakura and the decline in KPI 18.



The graph above shows the readmission rate within 28 days of discharge. Of the 124 Te Awakura consumers discharged in January 2018, 25.8% were readmitted within 28 days. Whilst the increase in admission rates is within the natural variation, the increase is likely related to the ongoing increase in demand, high occupancy rates and a desire to minimise sleepovers where possible.

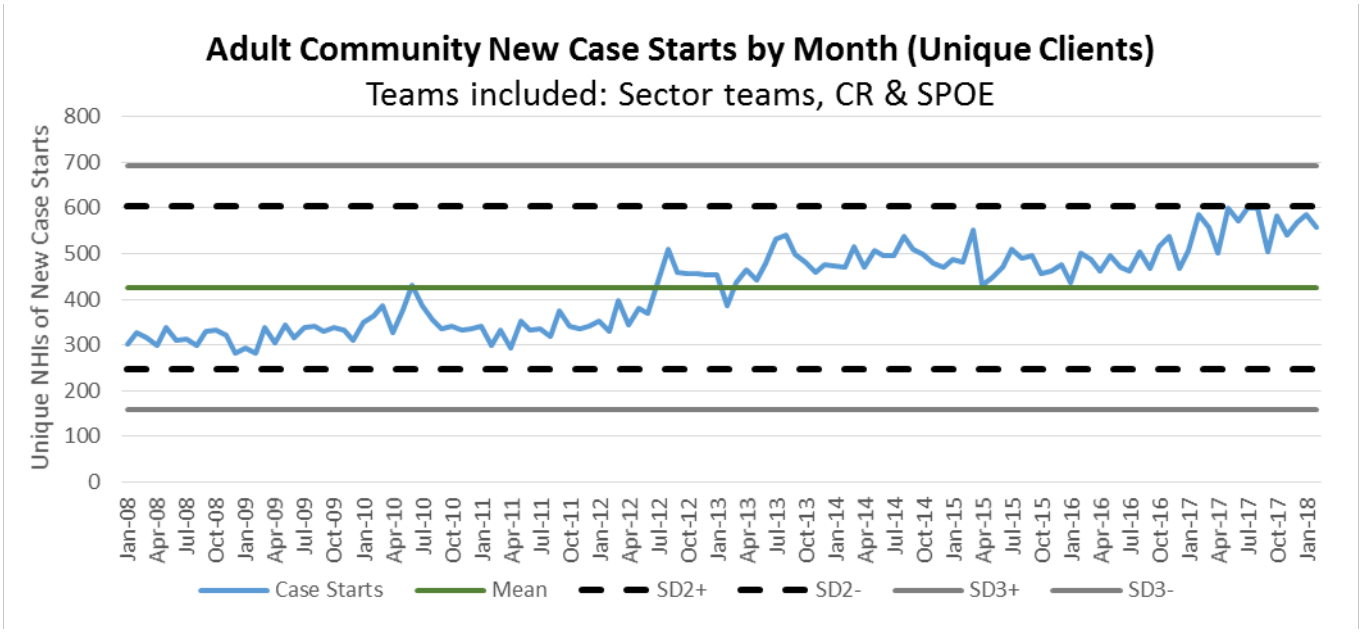


KPI 19 is a key suicide prevention activity and patient safety measure. In February 2018, 79.7% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. Whilst there has been a reduction in follow up, the rates remain within normal variation. Clinical teams proactively review all cases that did not receive follow up within 7 days. Reasons for lack of follow up are generally consumer related; follow up declined, non-attendance at follow up appointments, non-availability for local follow up.

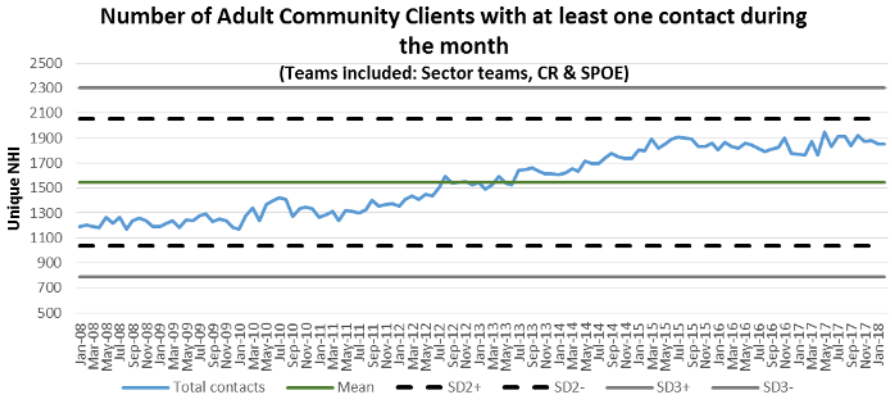


The graph above shows there has been an overall reduction in the time people spend waiting. Ministry of Health targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 3 days for February 2018. Our results for the Adult General Mental Health Service show 96.4% of people were seen within 21 days of referral in February 2018 and 99.3% were seen within 56 days of referral. This result is occurring in the context of significant increase in demand.

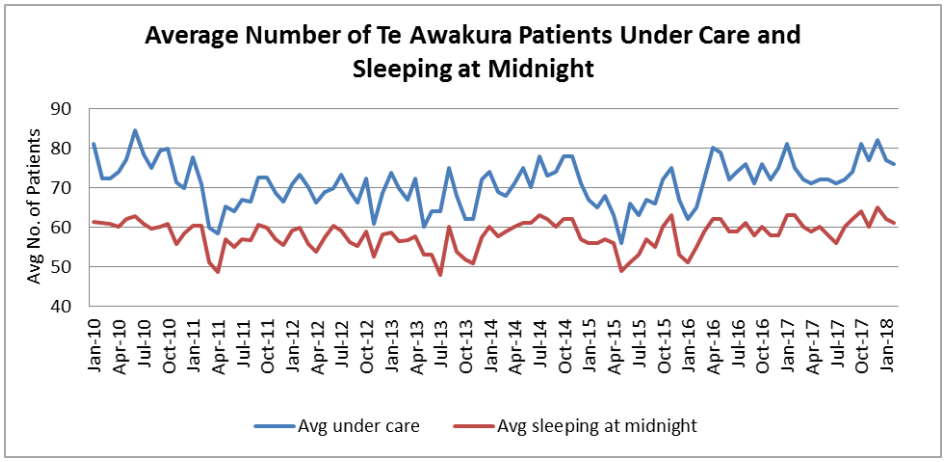
For child and family services the average waiting time was 20 days for February 2018. Reducing wait times has been a key focus for CAF services. Our results show 76.7% of people were seen within 21 days of referral in February 2018 and 89.5% were seen within 56 days of referral. CAF services are currently undertaking a job planning process to identify and maximise appointment time availability and they are reviewing the wait list management process.



New cases were created for 558 individual adults (unique NHIs) in February 2018.



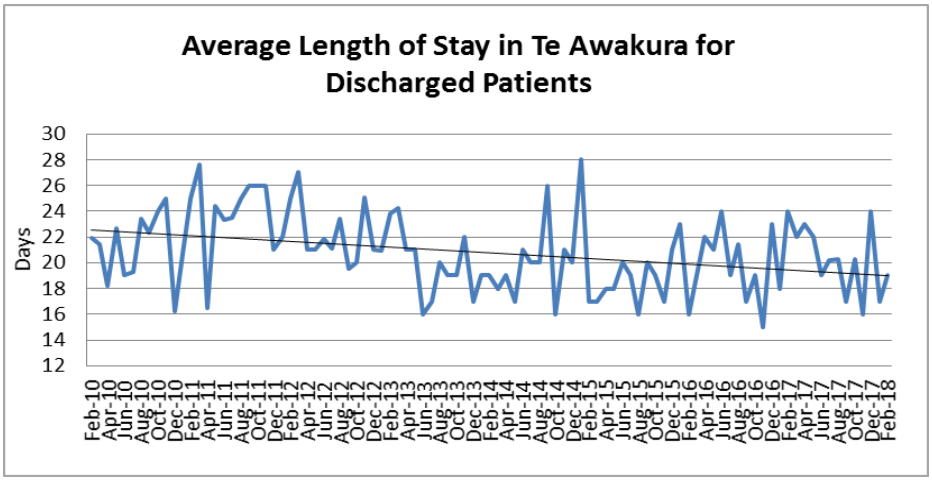
In February 2018 there was at least one contact recorded for 1854 unique adult community mental health consumers.



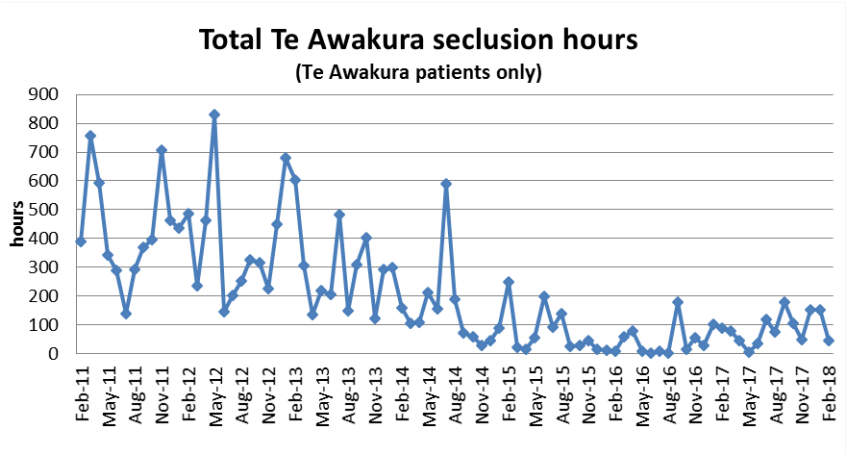
85% occupancy is optimal for mental health acute inpatient services.

Occupancy in Te Awakura (the acute inpatient service) remains above this figure. Occupancy was 97% in January and 96% in February 2018.

The average number of consumers under care in this 64 bed facility was 77 in January and 76 in February 2018. There were 18 sleepovers during January and 2 sleepovers during February 2018. Sleepovers are very undesirable from a patient and family, and workforce perspective.

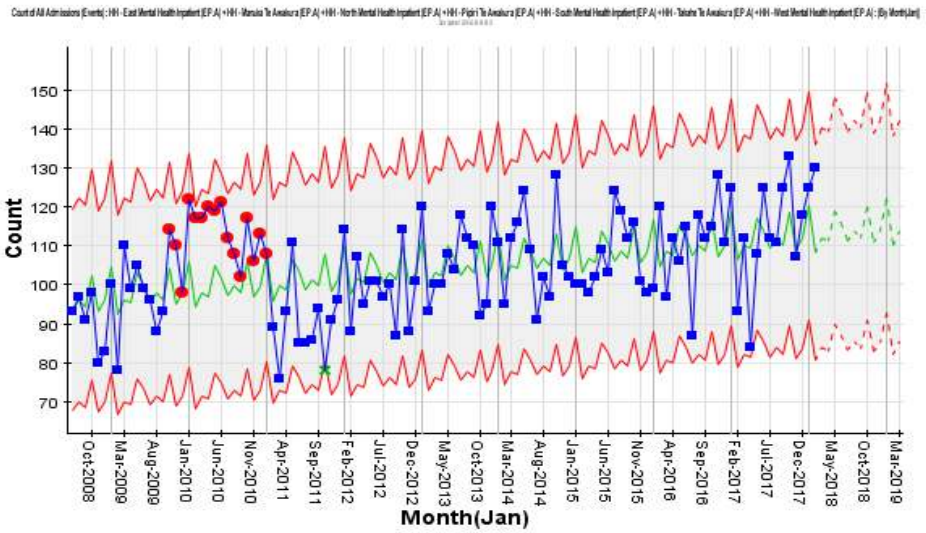


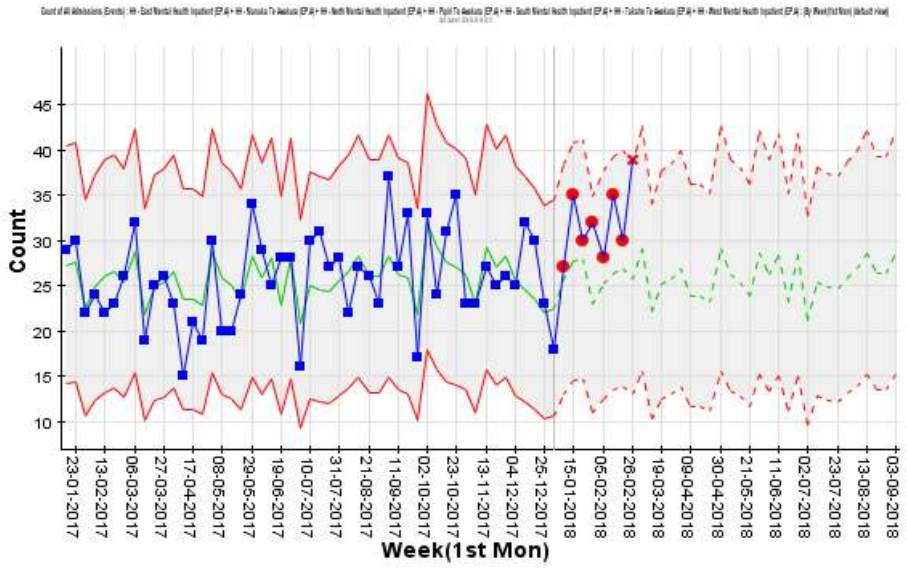
The average length of stay for consumers discharged from Te Awakura during January was 17 days and February 2018 was 19 days. We are closely monitoring length of stay in terms of difficulties with accommodation supply in Christchurch and working particularly closely with Comcare to source emergency and social housing options for people in inpatient services.



Our focus on reduction of seclusion in Te Awakura continues with a significant reduction overall. In February, seven consumers experienced seclusion for a total of 45.7 hours. There is strong ongoing commitment to maintain the focus of reduction.

The next two graphs show a count of admissions to Te Awakura (the acute adult unit) – the first is a monthly view, and the second a weekly view. The number of adult admissions (to Te Awakura) remains within the expected trend range.



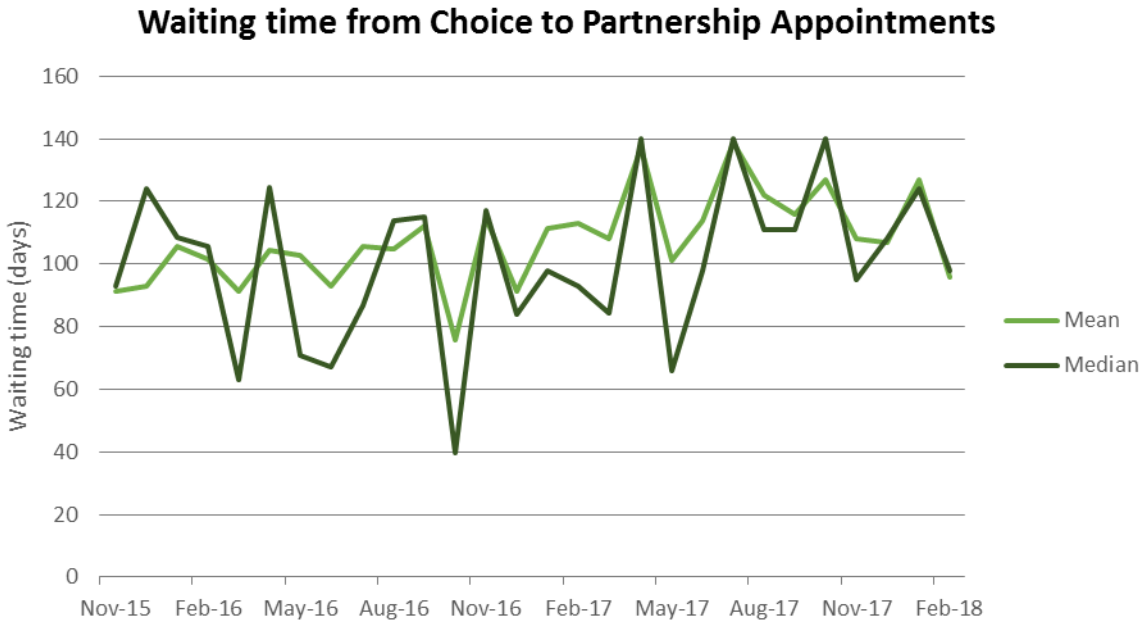


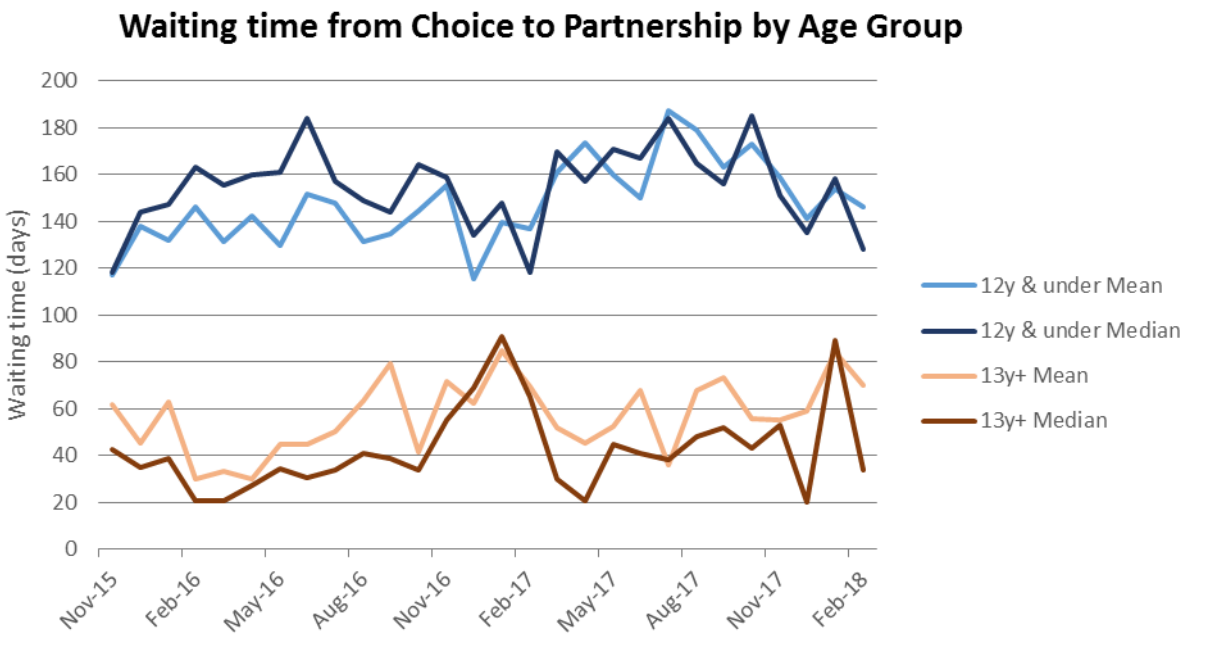
Child and Youth

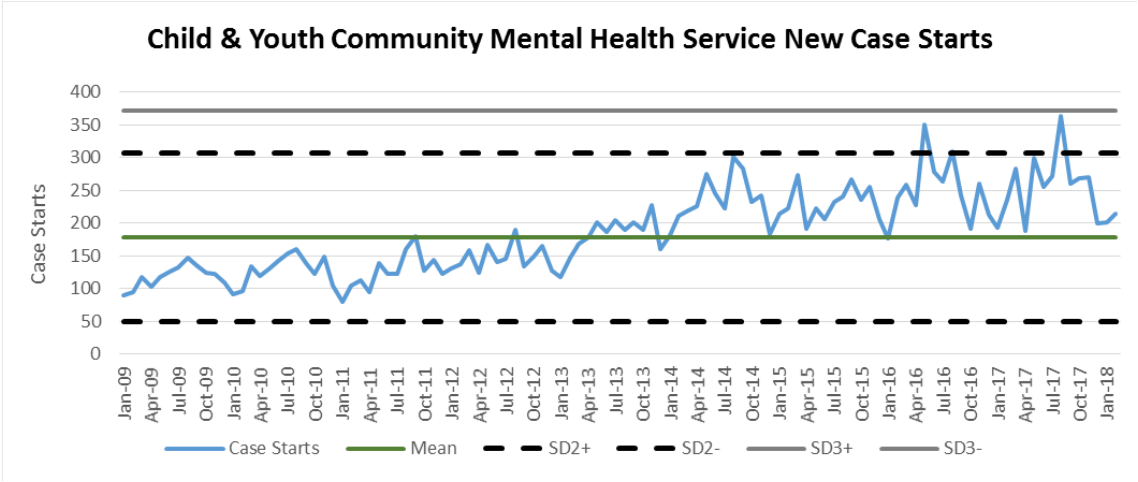
There has been a 98% increase in child and adolescent case starts in the past six financial years.

The focus on reducing wait times in the child and adolescent services is resulting in an internal wait of 20 weeks for some children and their families. Being seen early for the first contact is still important as it enables clinicians to make informed decisions about who is able to wait and who needs to be seen urgently. In the past we have had significant wait times for the first contact and the level of need/acuity was unknown. The level of demand for services is however concerning and challenging.

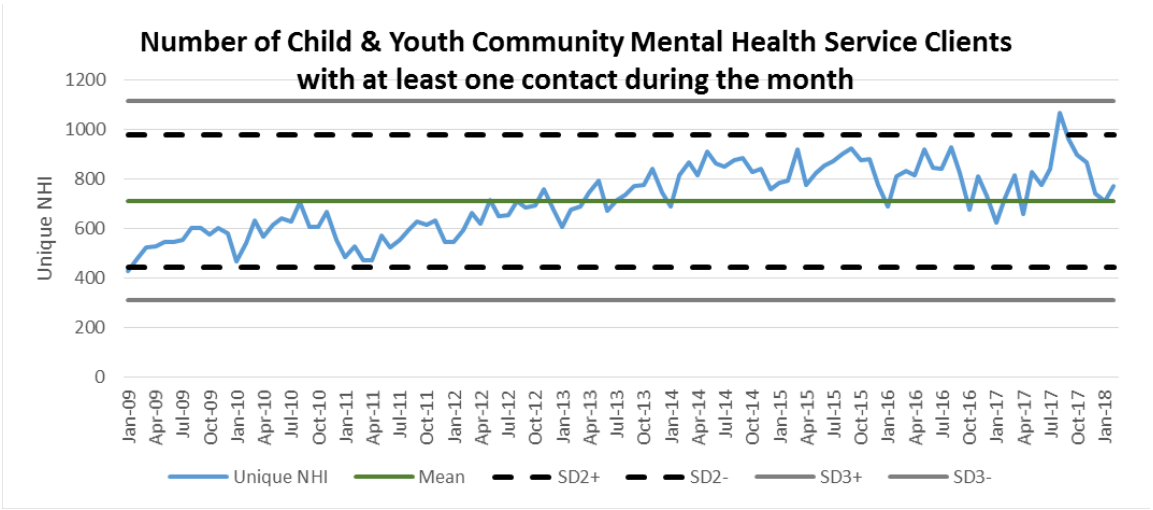
The graphs below show the waiting time between Choice (1st) and Partnership (2nd) appointments. Children and adolescents assessed as being of very high priority go straight to a Partnership appointment, bypassing the Choice appointment process.



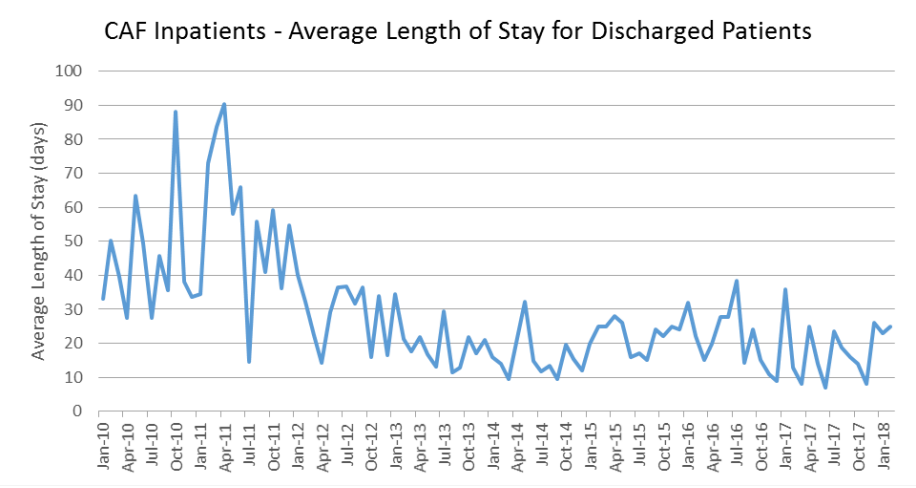




There were 201 new CAF case starts in January and 214 in February 2018. CAF services are making good progress with implementation of a Direction of Change that supports more integrated services across the age ranges.

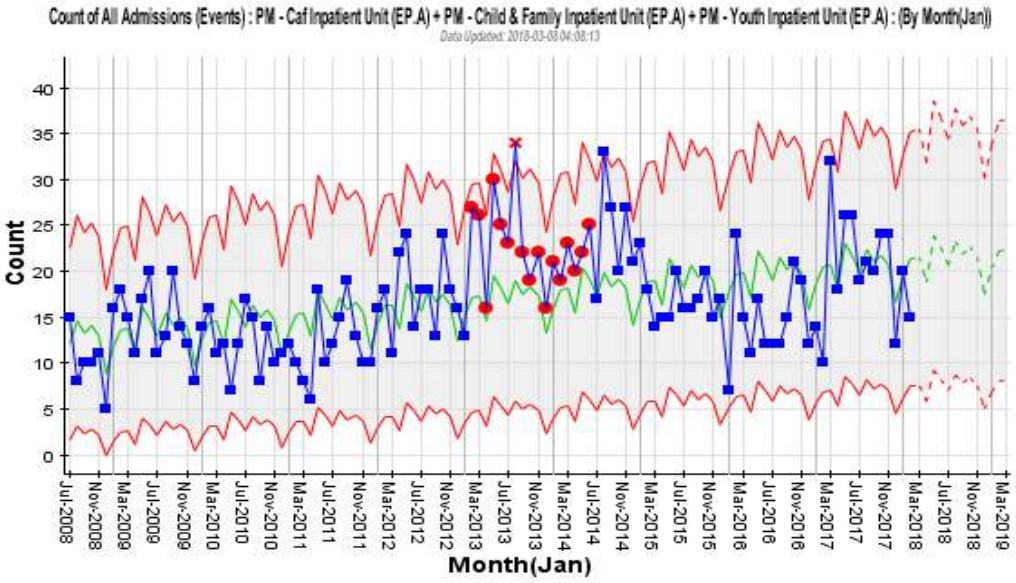


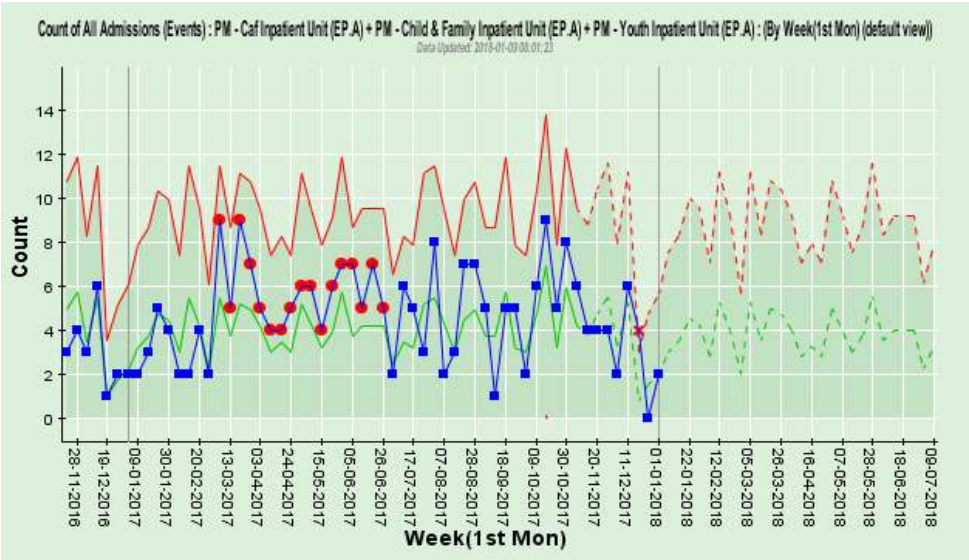
The number of unique clients with contacts above shows a similar pattern to new case starts graph, which demonstrates an increase in demand for Child and Youth community Mental Health Service. There were 712 unique patients with at least one contact during the month of January and in February 2018 there were 774. In August 2017 the CAF Service ran a drive on improving data accuracy and ensuring all contacts were being entered into the patient information system in a timely manner.

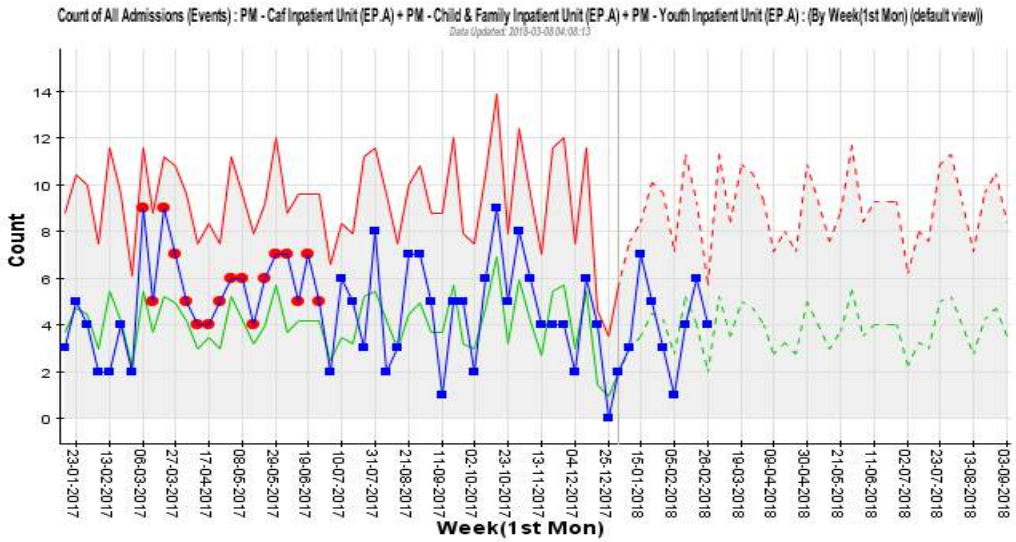


The average length of stay for discharged patients was 23 days for January and 25 days for February 2018.

The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.

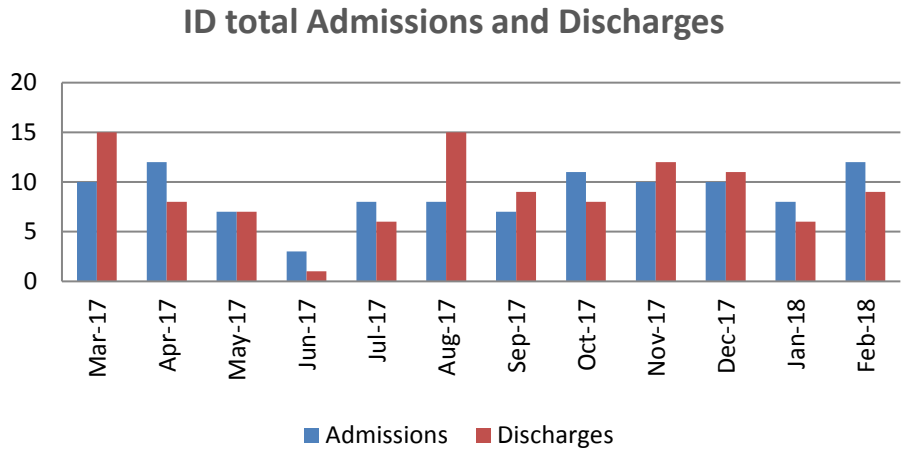


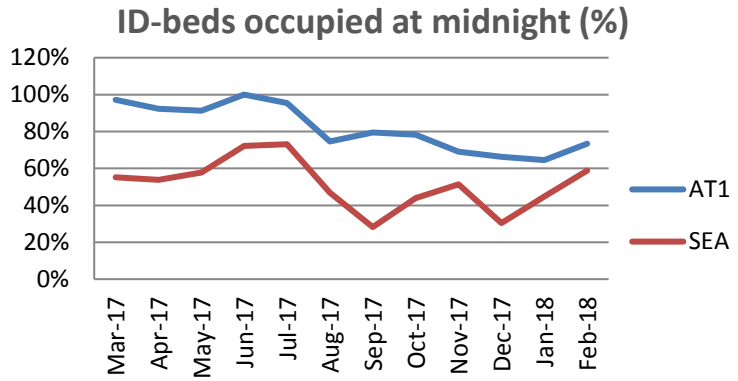




Intellectually Disabled Persons Health Service

The IDPH Service inpatient units comprise a 8-10 bed secure unit, Assessment, Treatment and Rehabilitation (AT&R), and a 15 bed dual disability unit, Psychiatric Service for Adults with Intellectual Disability (PSAID) within the Aroha Pai Unit, Hillmorton Hospital.



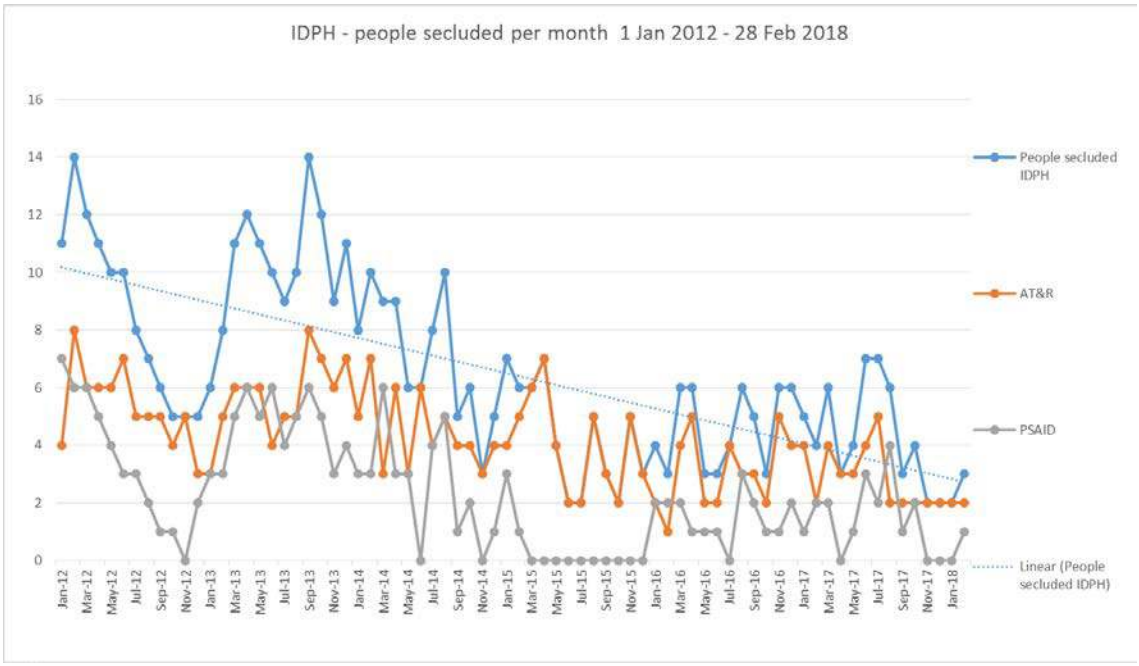


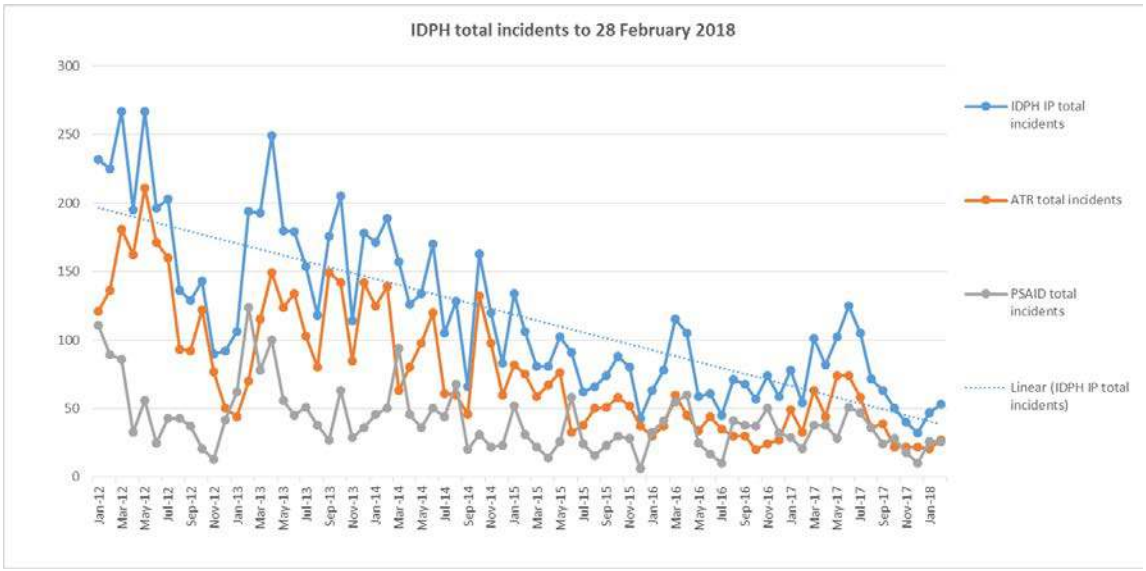
Occupancy in AT&R (AT1) was 65% for the month of January and 73% for February 2018. The figures for PSAID (SEA) were 45% and 59% respectively.

There have been longstanding delays in discharge for patients in the AT&R Unit. The delays continue to place pressure on the service and, for some of the patients, can lead to a deterioration in their presentation, affecting their readiness for discharge.

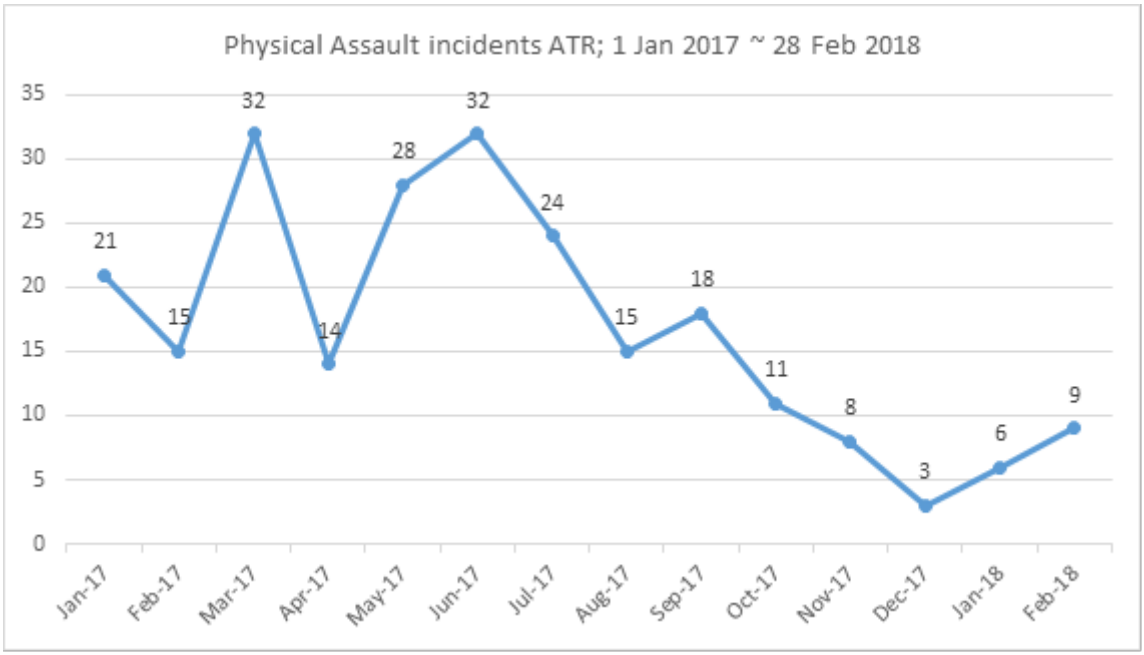
We work closely with the National intellectually Disabled Care Agency (NIDCA) and Lifelinks NASC (Needs Assessment Service Coordination) to seek solutions for placements. We provide both training for staff and carefully developed transition to discharge plans. A monthly teleconference with the Ministry of Health takes place to inform and discuss the delays in discharge.


IDPH seclusion hours per month 1 Jan 2012 - 28 Feb 2018
800
700
600
500
400
300
200
100
0
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Secl hours IDPH
AT&R
PSAID
Linear (Secl hours IDPH)


IDPH - people secluded per month 1 Jan 2012 - 28 Feb 2018
16
14
12
10
8
6
4
2
0
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
People secluded IDPH
AT&R
PSAID
Linear (People secluded IDPH)


IDPH total incidents to 28 February 2018
300
250
200
150
100
50
0
Jan-12
Mar-12
May-12
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
IDPH IP total incidents
ATR total incidents
PSAID total incidents
Linear (IDPH IP total incidents)

The Assessment, Treatment & Rehabilitation Unit has recently completed an interim environmental modification to address significant health and safety concerns. Whilst this has reduced the admitting capacity of the unit, there has been a significant improvement in seclusion reduction, a reduction in physical assaults and improved safety for patients and staff.



Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 8 Months Ended 28 February 2018

MONTH $'000						YEAR TO DATE				
17/18 Actual $'000	17/18 Budget $'000	16/17 Actual $'000	17/18 Variance $'000	17/18 vs 16/17 Variance $'000		17/18 Actual $'000	17/18 Budget $'000	16/17 Actual $'000	17/18 Variance $'000	17/18 vs 16/17 Variance $'000
					Operating Revenue					
592	271	225	321	367	From Funder Arm	4,696	2,199	1,301	2,497	3,395
1,459	2,174	1,861	(715)	(402)	MOH Revenue	12,158	16,445	9,325	(4,287)	2,833
4,041	4,523	3,412	(482)	629	Patient Related Revenue	32,664	35,845	17,709	(3,181)	14,955
1,364	1,138	1,122	226	242	Other Revenue	10,809	8,834	5,368	1,975	5,441
7,456	8,106	6,620	(650)	836	**TOTAL OPERATING REVENUE**	60,327	63,323	33,703	(2,996)	26,624
					Operating Expenditure					
					Personnel Costs					
54,733	52,608	52,727	(2,125)	(2,006)	Personnel Costs - CDHB Staff	435,639	432,068	260,755	(3,571)	(174,884)
1,649	1,532	566	(117)	(1,083)	Personnel Costs - Bureau & Contractors	14,608	13,043	7,572	(1,565)	(7,036)
56,382	54,140	53,293	(2,242)	(3,089)	**Total Personnel Costs**	450,247	445,111	268,327	(5,136)	(181,920)
11,557	11,264	12,370	(293)	813	Treatment Related Costs	93,326	93,299	57,841	(27)	(35,485)
3,508	3,906	3,522	398	14	Non Treatment Related Costs	29,008	31,252	17,892	2,244	(11,116)
71,447	69,310	69,185	(2,137)	(2,262)	**TOTAL OPERATING EXPENDITURE**	572,581	569,662	344,060	(2,919)	(228,521)
(63,991)	**(61,204)**	**(62,565)**	**(2,787)**	**(1,426)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(512,254)**	**(506,339)**	**(310,357)**	**(5,915)**	**(201,897)**
					Indirect Income					
10	3	9	7	1	Donations & Trust Funds	20	25	19	(5)	1
(1)	-	(1)	(1)	-	Gain on Disposal of Assets	(22)	-	4	(22)	(26)
9	**3**	**8**	**6**	**1**	**TOTAL INDIRECT INCOME**	**(2)**	**25**	**23**	**(27)**	**(25)**
					Indirect Expenses					
2,160	2,447	3,384	287	1,224	Depreciation	17,235	18,158	10,499	923	(6,736)
2,160	**2,447**	**3,384**	**287**	**1,224**	**TOTAL INDIRECT EXPENSES**	**17,235**	**18,158**	**10,499**	**923**	**(6,736)**
-	-	-	-	-	Intra Division/Organisation Wide	-	-	-	-	-
(66,142)	**(63,648)**	**(65,941)**	**(2,494)**	**(201)**	**TOTAL SURPLUS / (DEFICIT)**	**(529,491)**	**(524,472)**	**(320,833)**	**(5,019)**	**(208,658)**

Summary of initiatives

Indication of Latest Efficiencies (including costs avoided)

		Core Financial Benefit			Ancillary Benefit	
		Budgetary Benefits			Non Budgetary Benefits	
Service	Name of initiative/project	Investment for project	$ savings	Financial year of savings	Costs avoided to date	Non-Financial Efficiency

Achievements/Issues of Note

Use of telehealth reducing travelling time for rural patients

Patients living in rural areas often travel long distances to see health professionals at Christchurch Hospital. In many cases the service being provided can be effectively provided using TeleHealth. Recently the practice manager at Hanmer Springs Health Centre has been working with Canterbury District Health Board's Telehealth Service to ensure that people living in Hanmer take advantage of this technology when it is clinically appropriate.

In one recent example, arrangements were made for a child with two siblings to be seen by a dietitian via video conference. This significantly reduced the travel time for the mother and children as they only had to make their way to the Health Centre, avoiding more than 250 kilometres of driving. The mother reported being really happy with both the reduced travel and the way the session went. Following this the dietitian has identified three other patients that they plan to see using TeleHealth early in 2018.

Having a practice manager at Hanmer who is dedicated to encouraging appropriate use of this technology is proving to be effective at helping patients cared for by that centre, and is assisting specialist services to work through the changes in workflow that are required to deliver services to other rural patients in a safe, effective and efficient manner.

Supporting access to midwifery services

Each year a number of women are unable to secure the services of a Lead Maternity Carer (LMC) midwife for births expected to happen during December or January because this is a period when more midwives are keen to take some time off than at other times during the year. This effect has been exacerbated nationally this year while contract discussions between the Ministry and the College of Midwives relating to pay equity and changes to a longstanding contracting model occur.

The local Midwifery Resource Centre, based in Manchester Street, supports women to access midwives. Given the difficulties this year the Canterbury maternity system supported their efforts, including ensuring that the Midwifery Resource Centre had sufficient capacity and remained the first point of contact for women unable to find a midwife between November and February. The Centre was successful at allocating midwife capacity to over half of the group more than 140 women who needed assistance to book with a midwife.

Lead Maternity Carer Midwives responded by providing additional clinics antenatally and the maternity system facilitated clinics at Lincoln and St Georges primary units. North Canterbury has a group of midwives who are strongly attached to the community and there was no difficulty in ensuring all women in that area had a LMC.

One objective was to ensure women who are well and do not require the tertiary services at Christchurch Women's Hospital are provided with their care in an appropriate environment. In order to achieve this all midwives were invited to be part of an on call group messaging system for the women who have not been able to secure a LMC for

labour and birth along with a smaller number for postnatal care. A list was developed which enabled contact with midwives available to provide care for women that present at Christchurch Women's Hospital or the community units. As a result, while this group of 50 women did not have the continuity of care throughout their pregnancy the system was able to provide many with continuity either during labour, birth and postnatal periods or antenatal and postnatal periods with one of the on call midwives responding when they went into labour.

These, and a series of other actions, served to ensure that wherever possible care was provided at primary care units for women who were expected to experience a normal, low risk labour and maintained capacity at Christchurch Women's Hospital for women that had complex needs. The arrangement has worked well with almost all of the identified women having had their babies by mid-January. The maternity services are very thankful that the Lead Maternity Carers responded so well to the call for assistance. The team is already thinking about how we can further improve our response for Christmas 2018.

Canterbury health Laboratories

Testing:

- New quantitative BCR/ABL test went live in early February – this will bring about a reduced turnaround time and less labour required overall. This frees up a portion of scientists time to better utilise their skills and experience in high value activities.
- Next Generation Sequencing (NGS) validation of the Illumina Tumour TruSight 15 panel is complete, with a presentation to the Anatomical Pathology Department on 26/01, and go live scheduled for end of Feb 2018.
- Investigation is continuing into the circulating mumps genotype.
- Trialling a replacement analyser (QTOF) for the 3200 Liquid chromatography–mass spectrometry (LCMS) which was able to identify the presence of the Tutin toxin from the Tutu berry in samples from a patient in ICU, queried as having ingested them.
- Mass spectrometry (MS) strategy and planning underway, with ongoing discussions to develop CHL wide plan to maximise capacity, test development opportunities, increase standardisation and choosing the most appropriate new technology.

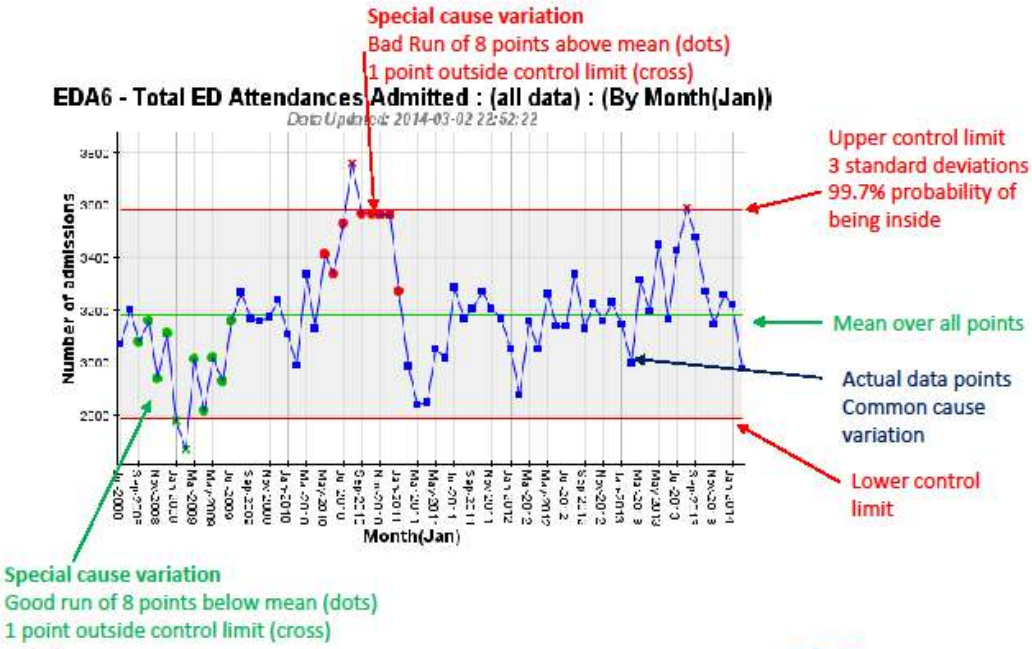
Phlebotomy workload project:

The Phlebotomy team at Canterbury Health Laboratories collect specimens for laboratory analysis from both inpatient and outpatients across various sites. A five week project has been undertaken by our process improvement team to make visible the service demand requirements for both patient populations, enabling the development of optimal staffing levels across the day. This visibility is now informing our current recruitment process to ensure the best utilisation of FTE to meet service requirements and engagement with staff and unions is being undertaken.

Quality:

A complete list of chemicals has been updated and uploaded into Chemwatch which facilitates compliance with aspects of new health and safety legislation.

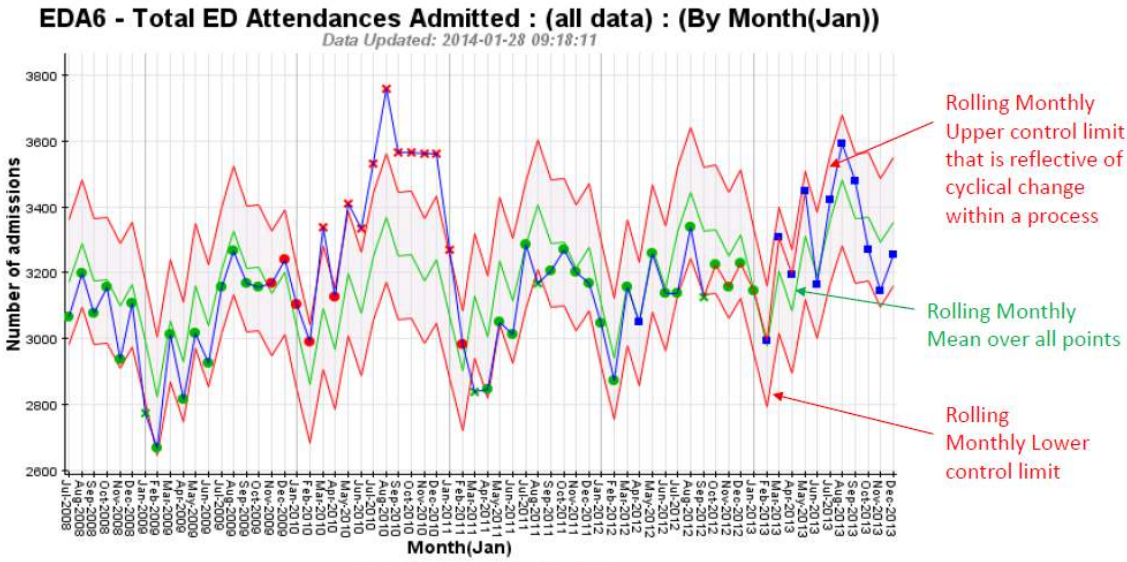
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

- There are two or more complete cycles
- There are peaks and troughs at the same points in each cycle
- You know why there is a cyclic pattern

sfn signals from noise

make it better

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair and Members**
Hospital Advisory Committee

SOURCE: **Corporate Services**

DATE: **29 March 2018**

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, Clause 32 and 33, and the Canterbury District Health Board (*CDHB*) Standing Orders (which replicate the Act) set out the requirements for excluding the public.

2. RECOMMENDATION

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 1 February 2018	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.

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"

Approved for release by: Justine White, General Manager, Finance & Corporate Services

WORKPLAN FOR HAC 2018 *(WORKING DOCUMENT)*

9am start	1 Feb 18	29 Mar 18	31 May 18	2 Aug 18	4 Oct 18	29 Nov 18
Standing Items	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes	Interest Register Confirmation of Minutes
Standing Monitoring Reports	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report	H&SS Monitoring Report
Planned Items	Clinical Advisor Update – Nursing (Mary Gordon) & Allied Health (Stella Ward) Review of Winter Plan 2017 Medical & Radiation Oncology Presentation UK Visiting Geriatrician - Presentation	Clinical Advisor Update - Medical (Dr Sue Nightingale CMO) General Medicine Presentation	Clinical Advisor Update – Nursing (Mary Gordon) & Allied Health (Stella Ward) Older Persons Health Presentation 2018 Winter Planning Update System Level Measures Update	Clinical Advisor Update - Medical (Dr Sue Nightingale CMO) H&SS 2016/17 Year Results TBC: Presentation	Clinical Advisor Update – Nursing (Mary Gordon) & Allied Health (Stella Ward) TBC: Presentation	Clinical Advisor Update - Medical (Dr Sue Nightingale CMO) TBC: Presentation
Governance and Secretariat Issues						2019 Workplan
Information Items	2018 Workplan	2018 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2018 Workplan	2018 Workplan	2019 Meeting Schedule 2018 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2018 Workplan
Public Excluded Items	CEO Update (as required)	CEO Update (as required)	CEO Update(as required)	CEO Update (as required)	CEO Update (as required)	CEO Update (as required)

2018

Fracture Liaison Service Update (ex 1 Jun 17 mtg)