AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

HOSPITAL ADVISORY COMMITTEE MEETING
to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
Thursday, 28 January 2021 commencing at 9:00am

Administration			
	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 3 December 2020		
3.	Carried Forward / Action List Items		
Reports for Noting			
4.	Hospital Service Monitoring Report: • Rural Health Services • Mental Health • Older Persons Health & Rehabilitation • Medical/Surgical; Women's & Children's Health; & Orthopaedics ESPIs	Win McDonald *Transition Programme Manager Rural Health Services* Dr Greg Hamilton *General Manager, Specialist Mental Health Services* Dr Helen Skinner *General Manager & Chief of Service, Older Persons Health & Rehabilitation* Pauline Clark *General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics*	9.05-9.50am
5.	Clinical Advisor Update (Oral) • Nursing	Becky Hickmott *Acting Executive Director of Nursing*	9.50-10.00am
6.	Services Supporting Older People Living in Rural Communities	Ralph La Salle *Acting Executive Director, Planning Funding & Decision Support*	10.00-10.10am
7.	2021 Workplan	Anna Craw *Board Secretariat*	10.10-10.15am
8.	Resolution to Exclude the Public		10.15am
Estimated Finish Time			**10.15am**

NEXT MEETING: Thursday, 1 April 2021 at 9:00am

ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

Andrew Dickerson (Chair)
Naomi Marshall (Deputy Chair)
Barry Bragg
Catherine Chu
James Gough
Jo Kane
Ingrid Taylor
Jan Edwards
Dr Rochelle Phipps
Michelle Turrall
Sir John Hansen (Ex-officio)
Gabrielle Huria (Ex-officio)

Executive Support

(as required as per agenda)

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

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

COMMITTEE ATTENDANCE SCHEDULE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	28/01/21	01/04/21	03/06/21	05/08/21	07/10/21	02/12/21
Andrew Dickerson (Chair)						
Naomi Marshall (Deputy Chair)						
Barry Bragg						
Catherine Chu						
James Gough						
Jo Kane						
Ingrid Taylor						
Jan Edwards						
Dr Rochelle Phipps						
Michelle Turrall						
Sir John Hansen (ex-officio)						
Gabrielle Huria (ex-officio)						

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

CONFLICTS OF INTEREST REGISTER HOSPITAL ADVISORY COMMITTEE (*HAC*)

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 – HAC** Board Member	**Canterbury Health Care of the Elderly Education Trust** - Chair Promotes and supports teaching and research in the care of older people. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Canterbury Medical Research Foundation** - Member Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB. **Heritage NZ -** Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance and Heritage NZ has already been involved with CDHB buildings. **Maia Health Foundation -** Trustee Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital. **NZ Association of Gerontology** - Member Professional association that promotes the interests of older people and an understanding of ageing.
Naomi Marshall **Deputy Chair - HAC** Board Member	**Riccarton Clinic & After Hours** – Employee Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB.
Barry Bragg Board Member	**Air Rescue Services Limited** - Director Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services. **Canterbury West Coast Air Rescue Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Farrell Construction Limited** - Shareholder Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Trustee The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.

	Ngai Tahu Farming – Chairman Farming interests in North Canterbury and Queenstown Lakes District and Forestry interests in Canterbury, West Coast and Otago regions. **Paenga Kupenga Limited** – Chair Commercial arm of Ngai Tuahuriri Runanga **Quarry Capital Limited** – Director Property syndication company based in Christchurch **Stevenson Group Limited** – Deputy Chairman Property interests in Auckland and mining interests on the West Coast. **Verum Group Limited** – Director Verum Group Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.
Catherine Chu Board Member	**Christchurch City Council** – Councillor Local Territorial Authority **Riccarton Rotary Club** – Member **The Canterbury Club** – Member
Jan Edwards	**Age Concern Canterbury** – Member **Anglican Care** – Volunteer **Neurological Foundation of NZ** - Member
James Gough Board Member	**Amyes Road Limited** – Shareholder Formally Gough Group/Gough Holdings Limited. Currently liquidating. **Christchurch City Council** – Councillor Local Territorial Authority. Includes appointment to Fendalton/Waimairi/ Harewood Community Board **Christchurch City Holdings Limited (*CCHL*)** – Director Holds and manages the Council's commercial interest in subsidiary companies. **Civic Building Limited** – Chairman Council Property Interests, JV with Ngai Tahu Property Limited. **Gough Corporation Holdings Limited** – Director/Shareholder Holdings company. **Gough Property Corporation Limited** – Director/Shareholder Manages property interests. **The Antony Gough Trust** – Trustee Trust for Antony Thomas Gough **The Russley Village Limited** – Shareholder Retirement Village. Via the Antony Gough Trust

	The Terrace Car Park Limited – (Alternate) Director Property company – manages The Terrace car park (under construction) **The Terrace On Avon Limited** – (Alternate) Director Property company – manages The Terrace.
Jo Kane Board Member	**Christchurch Resettlement Services** - Member Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes. **HurriKane Consulting** – Project Management Partner/Consultant A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised. **Latimer Community Housing Trust** – Project Manager Delivers social housing in Christchurch for the vulnerable and elderly in the community. **NZ Royal Humane Society** – Director Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.
Dr Rochelle Phipps	**Accident Compensation Corporation** – Medical Advisor ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers. **OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive) The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with: • the negative impacts of climate change on health; • the health gains possible through strong, health-centred climate action; • highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and • reducing the health sector's contribution to climate change. **Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member The RNZCGP is the professional body and postgraduate educational institute for general practitioners.
Ingrid Taylor Board Member	**Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB. **Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB. **Sir John and Ann Hansen's Family Trust** – Independent Trustee.

	Taylor Shaw – Partner Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time. • I / Taylor Shaw have acted as solicitor for Bill Tate and family. **The Youth Hub** – Trustee The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB.
Michelle Turrall Manawhenua	**Canterbury Clinical Network (CCN) Maori Caucus** - Member **Canterbury District Health Board** - Daughter employed as registered nurse. **Christchurch PHO Ltd** – Director **Christchurch PHO Trust** - Trustee **Manawhenua ki Waitaha** – Board Member and Chair **Oranga Tamariki – Iwi and Maori** – Senior Advisor **Papakainga Hauora Komiti – Te Ngai Tuahuriri** – Co-Chair
Sir John Hansen **Ex-Officio – HAC** Chair CDHB	**Bone Marrow Cancer Trust** – Trustee **Canterbury Cricket Trust** - Member **Christchurch Casino Charitable Trust** - Trustee **Court of Appeal, Solomon Islands, Samoa and Vanuatu** **Dot Kiwi** – Director and Shareholder **Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member The JCA is an independent statutory authority constituted under the Racing Act. The JCA ensures that judicial and appeal proceedings in thoroughbred and harness racing are heard and decided fairly, professionally, efficiently and in a consistent and cost effective manner. **Ministry Primary Industries, Costs Review Independent Panel** **Rulings Panel Gas Industry Co Ltd** **Sir John and Ann Hansen's Family Trust** – Ingrid Taylor sits as independent Trustee; and provides legal services to the Trust and to Sir John and Ann Hansen.
Gabrielle Huria **Ex-Officio – HAC** Deputy Chair, CDHB	**Nitrates in Drinking Water Working Group** – Member A discussion forum on nitrate contamination of drinking water. **Pegasus Health Limited** – Sister is a Director Primary Health Organisation (*PHO*).

	Rawa Hohepa Limited – Director Family property company **Sumner Health Centre** – Daughter is a General Practitioner (*GP*) Doctor's clinic. **Te Kura Taka Pini Limited** – General Manager **The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs. **Upoko Rawiri Te Maire Tau of Ngai Tuahuriri** - Husband

MINUTES – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

DRAFT
MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING
held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch
on Thursday, 3 December 2020, commencing at 9.00am

PRESENT

Naomi Marshall (Deputy Chair); Jan Edwards; James Gough; Jo Kane; Dr Rochelle Phipps; and Ingrid Taylor.

Via Zoom – Catherine Chu.

APOLOGIES

Apologies for absence were received and accepted from Barry Bragg; Andrew Dickerson; Michelle Turrall; and Sir John Hansen (Ex-officio).

EXECUTIVE SUPPORT

Dr Andrew Brant (Acting Chief Executive); Becky Hickmott (Acting Executive Director of Nursing); Ralph La Salle (Acting Executive Director, Planning Funding & Decision Support); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Dr Rob Ojala (Executive Director for Facilities); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

EXECUTIVE APOLOGIES

Dr Sue Nightingale (Chief Medical Officer); and Kirsten Beynon (General Manager, Laboratories) – absence.

IN ATTENDANCE

Full Meeting

Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Dr Helen Skinner, General Manager & Chief of Service, Older Persons Health & Rehabilitation
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Win McDonald, Transition Programme Manager Rural Health Services
Berni Marra, Manager, Ashburton Health Services

Item 4

Cherie Porter – Clinical Manager, Older Persons Health & Rehabilitation
Claire Pennington, Director of Allied Health/Interim Group Operations Manager, Older Persons Health & Rehabilitation

Naomi Marshall, Deputy Chair, HAC, opened the meeting welcoming those in attendance. Ms Marshall noted she would be Chairing today's meeting in the absence of Andrew Dickerson (Chair, HAC).

1. INTEREST REGISTER

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

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

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

The meeting moved to Item 3.

3. CARRIED FORWARD / ACTION ITEMS

Dr Rochelle Phipps joined the meeting at 9.04am.

The carried forward action items were noted.

4. PRESSURE INJURY PREVENTION PROJECT (PRESENTATION)

Ingrid Taylor joined the meeting at 9.06am.

The Committee received a presentation on the Pressure Injury Prevention Project from Dr Helen Skinner, General Manager & Chief of Service, Older Persons Health & Rehabilitation; Cherie Porter, Clinical Manager, Older Persons Health & Rehabilitation; and Claire Pennington, Director of Allied Health/Interim Group Operations Manager, Older Persons Health & Rehabilitation. The presentation included:

- Background
- Purpose-T Risk Assessment Tool
- Why change was needed
- What was done next
- Key early objectives
- Project progress so far
- Outcome to date
- Learning so far
- What next?

Ms Marshall thanked the presenters for the positive work being undertaken. She queried whether there were any thoughts of rolling this work out to Christchurch Campus. It was noted the project is due to be evaluated around March/April 2021. It will be important to evidence outcomes first prior to rolling out further.

A member noted it was good to see things starting to head in the right direction and it is good to see an intentional effort to address this problem.

Another member offered congratulations to the team, noting this was a very well structured initiative. The member noted the possibility of sharing the initiative with the Aged Residential Care sector.

There was discussion around over-reporting. The Committee was advised this is being addressed as part of the clinical governance structure, where all incidents are reviewed every week, regardless of harm level, and it is able to be picked up from the narrative that is provided with those incidents if things have been incorrectly coded. In addition, we also validate each month via deep dives what actually did happen and correct recordings in the system if appropriate to do so – authority to do this sits at a senior clinical level. It does not change the end month reporting, but obviously will change for the month after. There is a slight risk that we will over report at the time, but over time that will be adjusted and show a more accurate reflection of pressure injuries.

In response to a query, it was noted that most of the actual injuries are sustained from people being in bed with their head up past 30 degrees. It has been established that the positioning of the bed and how we change that is preventing harm. Also, there are people who sit for long periods of time, for hours on end in a seated position, so it is important to encourage them to

adhere to best practice, which is to move every 30 minutes for a minimum of 30 seconds. Extensive education is also important around what a neutral pelvis looks like and what a good sitting position looks like.

The meeting moved to Item 2.

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (15/20)
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 1 October 2020 be approved and adopted as a true and correct record."

The meeting moved to Item 5.

5. CDHB ALLIED HEALTH STRATEGIC DIRECTION (PRESENTATION)

The Committee received a presentation on CDHB's Allied Health strategic direction from Dr Jacqui Lunday Johnstone, Executive Director, Allied Health, Scientific & Technical. The presentation included:

- Allied Health. Who are we and where are we based?
- Allied Health Strategic Plan
- What do we need?
- Six strategic dimensions:
  - Workforce Development
  - Enhancing Leadership
  - Partnership, Participation and Empowerment
  - Digital Optimisation
  - Professional Practice & Skills Development
  - Research, Innovation & Improvement Science

There was no discussion.

Ms Marshall thanked Dr Lunday Johnstone for the presentation, noting the trajectory in terms of utilising Allied Health Professionals earlier and preventing admissions is key, particularly for the elderly population.

6. CARE CAPACITY DEMAND MANAGEMENT UPDATE

Becky Hickmott, Acting Executive Director of Nursing, presented the report which was taken as read. Ms Hickmott also provided the Committee with a presentation on CDHB Trendcare Staffing. The presentation highlighted the following:

- TrendCare is the CDHB's acuity tool which measures efficiency and productivity of the ward environment. It is internationally validated and used by all of NZ.
- It forms part of the Care Capacity Demand Management (*CCDM*) Programme. It is the only validated acuity tool available and is utilised in all DHBs across New Zealand.
- CDHB commenced late 2019 and is progressively implementing sequentially throughout all inpatient areas.
- Some wards have already completed their Inter-rater Reliability (*IRR*) testing (the extent that two or more nurses or midwives agree on the acuity), averaging a score of over 98% with external testing completed by the CCDM Coordinators for robustness.

- Safe Staffing Healthy Workplaces Unit recommends that wards should have a productivity index of approximately between 85-95% during the day and 75-85% in the afternoon shift and the night shift to ensure all care can be delivered during the shift. Most wards fell within this index or were above this index. This means that staff are working at maximum capacity because hours required for patient care are closely matched to staffing hours available. Critical event(s) or unplanned admission(s) could result in staff potentially being unable to meet demand.
- What the data shows:
    - Canterbury has the lowest actual cost per FTE nurse $5K below the national average.
    - The physical environment of hospital wards in both Riverside and Parkside are challenging to provide nursing care within. For example: frail elderly patients' access to appropriate ablutions further impacts on nursing time.
    - Transfer of patients from these above areas into Waipapa theatres or procedure areas also means approximately 20-30 minutes away from ward. These issues are not taken account when entering the TrendCare data, yet we are already fully utilising all patient time allocated.
    - The impact of high churn of full capacity wards becomes apparent in TrendCare.
    - CDHB has less beds, shorter length of stay.

Ms Hickmont noted the letter attached to the report from the Safe Staffing Health Workplaces Unit (*SSHWU*) was very positive. We are the only one in the nation who received a positive letter. Feedback was noted from both the NZNO Union and staff involved from SSHWU around the exceeding pace that CDHB is moving at and being impressed with the quality of data to date.

There was a query around how long it will be before CCDM is embedded across the organisation. Ms Hickmott advised the one group that there has been delays with is Allied Health, who have unique challenges. Ms Jacqui Lunday Johnstone noted it was useful that the MoH supported the implementation of CCDM with some resource, but did not do this for Allied Health. Whilst some preliminary work has been done, it is quite different in terms of the requirement of the MECA. For us within Canterbury it is the missing piece of the jigsaw to complement all of the other data we have, because we know Allied Health make a particular contribution to patient flow, but also that if you have been seen by Allied Health you are much less likely to be readmitted. These are key things in terms of the overall pattern of activity.

In response to a query, Ms Hickmott advised we have permanent pool staff that are utilised all of the time – a highly utilised group that are able to be mobilised very quickly. Where possible we try to use permanent staff to fill planned gaps and leave areas. Most nurses are comprehensive trained nurses, so we should be able to mobilise them anywhere with some support, but where possible we also use other resources at hand immediately because they are more familiar in that space. Ms Hickmott noted we have competent, exceedingly skilled senior nursing staff, who keep a very sharp focus on the issues. Ms Hickmott advised what worries her at the moment more than anything is that staff are very tired.. She thought initial leave loading and sickness was not built in accurately from the beginning, because we are not getting people away and this is probably why we are seeing sick leave increase and why we are not seeing annual leave being taken.

There was a query about what the Accord agreement actually means. Ms Hickmott advised that with the Accord agreement reached, every DHB must rollout Trendcare, which we did. The other component we have to do is that once Trendcare has been rolled out, within a 12 month period of having data that is verified, we would then undertake FTE calculations. The first DHB to settle on their calculations was Capital & Coast DHB. The rest of the areas are underway, but still have some time to go. Canterbury will not have the benefit of years of data, which will be a challenge for us. Our data will be just for 12 months, whereas other DHBs have had Trendcare for ten years. We will have to come to an agreement on the FTE calculations,

which will be monitored from the SSHWU's perspective – they take all the FTE calculation data we give them, they then provide the calculation and recommendations. We will then work with the Chief Executive and members of EMT to come to agreement at that stage, with our Unions, as to what that will look like.

Ms Hickmott emphasized that CDHB is the lowest, by $40M less, than other DHBs in the agency usage space. She also spoke of the cost of FTE, noting the plan that has been in place for a number of years around bringing new graduates through – we have a good skill mix of senior and junior nurses. By not taking as many graduates, that skill level will change and be reflected in FTE costs.

The Care Capacity Demand Management Update report was noted.

7. ACCELERATING OUR FUTURE (*AOF*) UPDATE

Dan Coward, General Manager, Programme Management Office, presented the report which was taken as read. It was noted the report covers off and highlights the six key focus areas for change and improvement.

Mr Coward noted the paper touches on a couple of examples that gives a sense of work that the campuses are doing that are around both ensuring the improvement of care, maintaining the quality of outcomes, but also where initiatives can derive a saving and changing the structure that sits around it.

Ms Marshall noted she had spoken to Mr Dickerson about it being helpful for this Committee to have more detail around AOF, without duplicating reporting that is provided to the Quality, Finance, Audit and Risk Committee (*QFARC*), in order for members to provide more helpful input.

There was discussion around every change made having an impact, and how ongoing impacts would be monitored over time. For example, SMO recruitment – is that being impacted, is CDHB still an attractive place to work, are we attracting people to come into these roles, has this changed over time?

The Accelerating Our Future Update report was noted.

The meeting adjourned for morning tea from 10.40am to 10.50am.

8. CHATHAM ISLANDS HEALTH CENTRE

Win McDonald, Transition Programme Manager, Rural Health Services, presented the report which was taken as read.

There was a query around the decrease in telehealth use. Ms McDonald advised this was more about what telehealth was being used for. In 2015/16, telehealth was about connecting specialists so you could go into the clinic and share that knowledge and understanding of what to do and who to contact. Now that those contacts are sorted and there are such good working relationships in place, there is less of that. Telehealth appointments still continue, but sit within the individual specialities – for example diabetes, paediatrics, dietitians. Also not recorded here is external telehealth that is done by a mental health contractor.

In response to a query, Ms Win advised the Department of Internal Affairs leads the Whole of Government approach that is underway, noting a stakeholder group has been up and running for three years – a combination of MSD, IRD, Oranga Tamariki, Health, Police and Corrections. They meet and look at what are the best things that can be done to improve the overall wellbeing of the community. For example, upgraded the airport and port, a lot of roading work. Ms Win

noted there is a Strategic Plan for the Chatham Islands, which focuses on five to six key areas – this will be forwarded to Committee members for their information.

Ms Win confirmed that at the stakeholders meeting, they are aware of the health infrastructure issues and limitations faced. She further noted that it is an environment that is working really well together, doing the best things that are possible on Island.

There was a query around connectivity and internet reliability on the Island. Ms Win advised satellite connection is used. She further noted that at the stakeholders meeting just gone there was a commitment to improve that. There is a bigger case being written for government consideration for a $65M fibre cable. This has been an ongoing request to the government since the stakeholder group was established. A member noted this was an expensive cable per person.

There was a query where Island electricity comes from. Ms Win advised electricity is diesel generated.

The Chatham Islands Health Centre report was noted.

9. H&SS MONITORING REPORT

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

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

Rural Health Services – Win McDonald, Transition Programme Manager

- Ongoing staffing issues, mainly due to the age of the workforce.

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

- Biggest focus for the past month has been standing up the new Ashburton Nursing Leadership and Operational Structure, which will bring a generalist model in.
- Another focus has been on nurse manager integration - a lot of the work that traditionally sat in campus with the hospital services, which are really primary care services.

There was a query whether there was good buy-in from staff for the generalist model. It was noted this is an evolving space. Where necessary, there is a wraparound package of education which will be worked through to develop staff and bring them up to required levels.

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

- Following significant growth since the earthquakes, this report highlights a slowdown in mental health presentations over the past couple of years, which is entirely what the literature said should happen.
- Noticeable during COVID-19 that community work did not change at all in terms of volumes, but inpatient work did.
- HoNOS measure shows we are the same as the rest of NZ for our acuity on admission, but quite a degree higher acuity for our community services. We have more advanced community services than most, so this points to the fact that there is a higher underlying mental health burden of disease in Canterbury, as we may have expected.

There was a query about the increasing impact of substance abuse. Dr Hamilton advised we are seeing a change in those people with addiction problems in terms of what they are using.

In response to query, Dr Hamilton advised that with regards to the wait time from referral to telephone triage, 73% of people were seen in one day.

A member asked whether ADHD referrals could be removed from this data. It was noted that this is not straightforward. With regards to ADHD, Dr Hamilton advised that there is a question whether ADHD is a mental health problem and where the recipient of it is at risk, the rest of the government sector is not dealing with that higher risk and we, by default, receive them as a provider of last resource. It also means our ability to have therapeutic interventions with that group is not as high. People are using that assessment to get other services from other agencies. We are caught in a system that is not really working well. The member asked whether there was a better pathway for the ADHD assessment to which Dr Hamilton responded that nobody else is providing it unless you have a lot of money. Ms Hickmott commented it was a cross agency issue, but was not something that would be solved locally - there needs to be a whole of government approach.

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

- Have moved into Waipapa.
- Focus is on production to meet MoH targets and ESPIs.
- Engaged around Accelerating Our Future opportunities.
- Medical Oncology team is coming together. New SMO appointment starts next week, with a second starting early in 2021. There is an opportunity for a third SMO to join mid 2021.
- LINAC replacement programme is going well, and is scheduled to complete the middle of 2021. Also have one or two Cathlabs down at the same time.
- Xmas midwifery service is well organized.
- Xmas/New Year plans are well developed. Using predictive tools, which suggest we will have the usual challenges. Plans this year include the possible resurgence of COVID-19.

There was discussion around the Medical Oncology team, noting it was very much a multidisciplinary team.

In response to a query about outsourcing surgery, Ms Clark advised outsourced is still out. With regards to outplaced, this is back, however, in coming back to Waipapa it has exposed some teething challenges while Sterile Services are settling in. With the support of the Chief of Surgery and Planning & Funding, we have outplaced a small amount of work for a short period of time to give everyone breathing space to get settled in. Ms Hickmott noted that no-one probably understood the full depth of requirements in maintaining a business as usual service, moving into a new facility and then adding the extra outplaced back in. Ralph La Salle, Acting Executive Director, Planning Funding & Decision Support, advised that we have agreed to outplace up to four half day sessions a day between now and Xmas if needed. Over the past two and a half weeks we have not used that much.

With regards to ESPIs, Ms Clark advised we are going well. Against the plan we put to the MoH we are on target.

There was a query around data provided in the table on page 11 of Appendix 1. It was noted that all MoH data for September was incorrect. Resubmission has been made and will be refreshed with the end of October data.

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

- Highlighted one project being worked on in terms of Accelerating Our Future – the implementation of a formal Transalpine Service for Complex Wheelchair and Seating Services.

The H&SS Monitoring report was noted.

10. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (16/20)
(Moved: James Gough/Seconded: Dr Rochelle Phipps – 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 1 October 2020	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

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

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.30am.

Approved and adopted as a true and correct record:

Andrew Dickerson
Chairperson

Date of approval

HAC MEETING 3 DECEMBER 2020 – MEETING ACTION NOTES

Item No	Item	Action Points	Staff
	Apologies	Absence – Barry Bragg, Andrew Dickerson, Michelle Turrall, and Sir John Hansen.	Anna Craw
1.	Interest Register	Nil	
2.	Minutes – 1 October 2020	Adopted: Naomi Marshall / Jan Edwards	Anna Craw
3.	Carried Forward Items	Nil	
4.	Pressure Injury Prevention Project	Nil	
5.	CDHB Allied Health Strategic Direction	Nil	
6.	Care Capacity Demand Management Update	Nil	
7.	Accelerating Our Future Update	Nil	
8.	Chatham Islands Health Centre	Chatham Islands Strategic Plan to be circulated to Committee members for information.	Anna Craw
9.	H&SS Monitoring Report	Nil	
10.	Resolution PX	Adopted: James Gough / Dr Rochelle Phipps	Anna Craw
	Info Items	Nil	

Distribution List:

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 28 JANUARY 2021

DATE RAISED		ACTION	REFERRED TO	STATUS
1.	06 Aug 2020	Initiatives to support rural older population to remain in own homes/communities into the future.	Ralph La Salle	Today's agenda – Item 6.
2.	01 Oct 2020	H&SS Monitoring Report – development of "Living With Our Means" section	David Green	Under action.

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair & Members, Hospital Advisory Committee**

PREPARED BY: **General Managers, Hospital Specialist Services**

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

DATE: **28 January 2021**

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

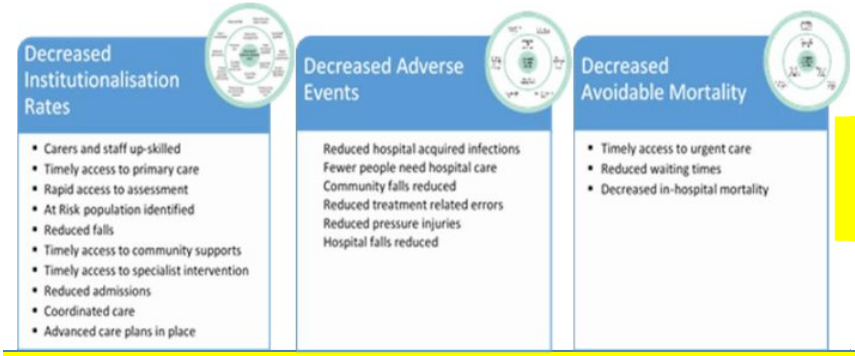
Appendix 1: Hospital Advisory Committee Activity Report –December 2020

Hospital Advisory Committee

Hospital Activity Report

December 2020

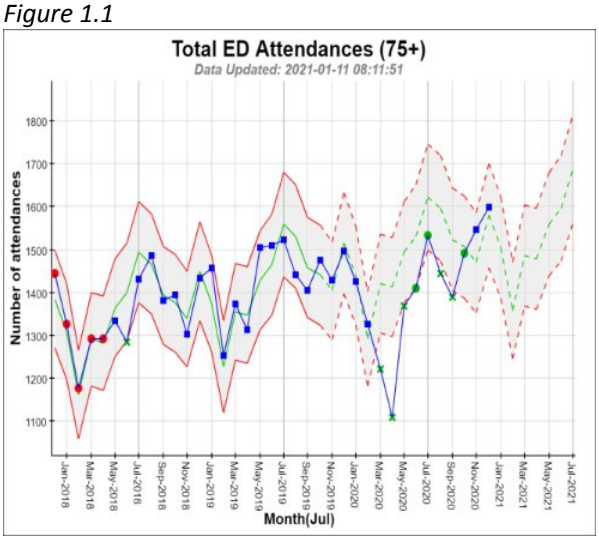
Index — Based on the CDHB Outcomes Framework and Five Focus areas plus Specialist Mental Health



Frail Older Persons' Pathway

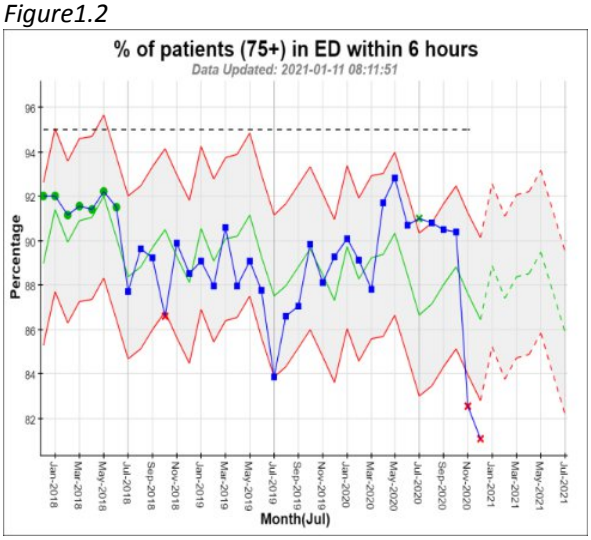
Outcome and Strategy Indicators

Figure 1.1



Covid 19 Alert Level restrictions led to a reduced number of ED attendances by people over 75 years in March and April with a subsequent return to forecast levels by that group.

Figure1.2



Since mid-October total ED visits have increased by around 30 people a day, predominantly by those under 30 years old.

This mostly involves triage levels 4 and 5, and thus places demand within the ED as these patients are not generally admitted.

This, along with the team working in a new and larger unit, is providing challenges that contribute to patients spending a longer time in ED.

Planning and Funding, ED, the Communication team, Healthline and Urgent Care providers are working together to put in place plans to improve the system's ability to provide the care required by the population. Key hospital services including General Medicine, Cardiology, Orthopaedics and General Surgery are also working with the Emergency Department to optimise timeliness of flow through the department for people requiring specialist service care.

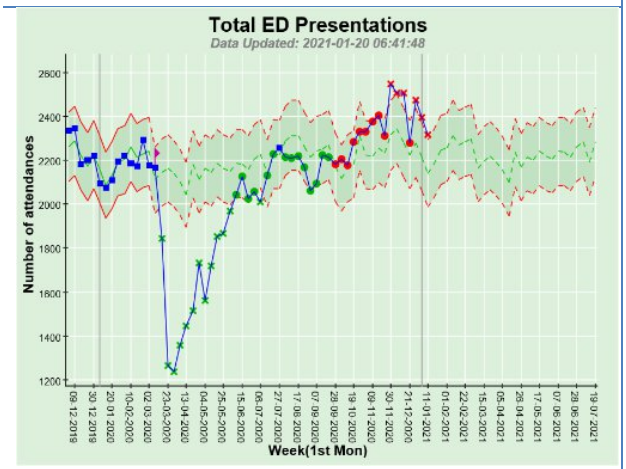
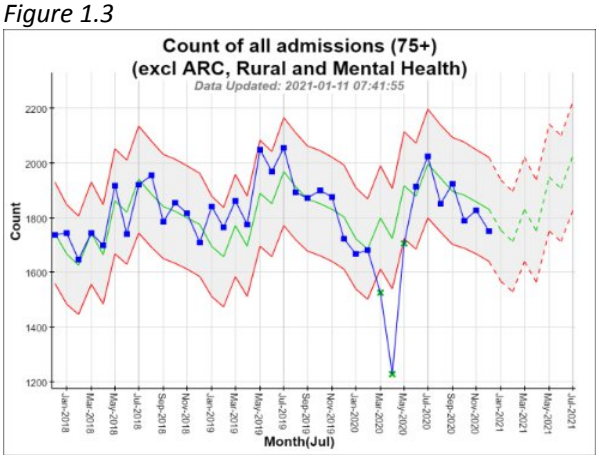
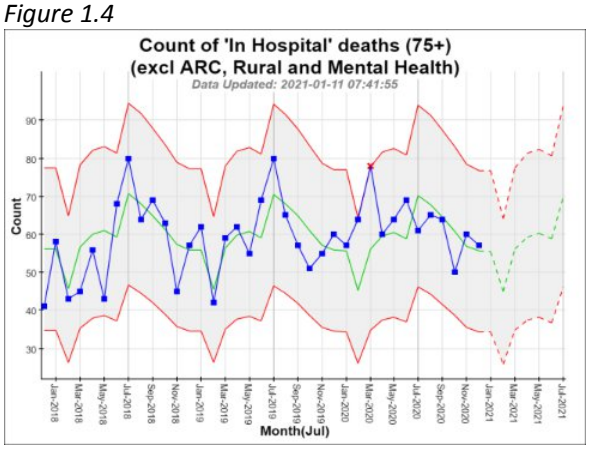


Figure 1.3



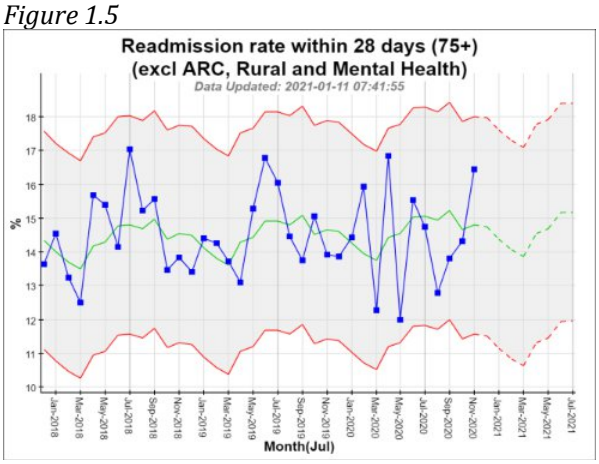
The number admitted has returned to the forecast range following the COVID lockdown period.

Figure 1.4



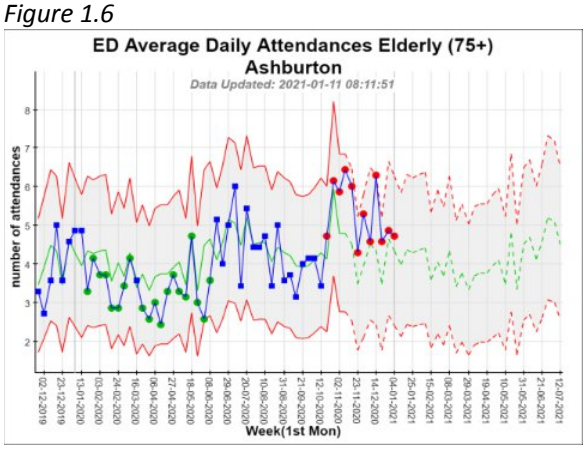
During the last nine months the number and rate of in hospital deaths against admissions has been within forecast range, which reflects an underlying reducing trend in the rate.

Figure 1.5



Readmissions remain within the expected range.

Figure 1.6



Ashburton rate of attendances,75+ age group, has been running in line with expected attendance, except for the latest records in November-January which is above the mean.

Achievements/Issues of Note

Older Persons Health & Rehabilitation (OPH&R)

Pressure Injury Prevention Project Update

At the presentation to HAC by OPH&R on the Pressure Injury Prevention project on 3rd December 2020 we discussed the need for the division to validate the Burwood acquired Pressure Injuries to ensure the accuracy of reported data. All reported Burwood acquired pressure injuries are clinically reviewed by senior interdisciplinary staff members, to ensure accurate staging and early learnings. However, we have identified that a process also needs to be developed to update the data recorded in our incident management software to reflect the post validation outcome. Review of monthly clinical indicator reports will continue as usual however the division will now create a quarterly post validation report.

Total BWD acquired Pressure Injuries				
	September	**October**	**November**	**December**
2019	16	20	23	14
2020	19	25	15	19
2020 validated	14	15	8	11

Vestibular screening tool pilot

Background

Dizziness in older adults is a complex diagnosis, with vestibular dysfunction frequently overlooked. Screening for vestibular dysfunction has been recommended as a routine component of assessment, particularly in those with balance disorders and falls.

Purpose

To describe the implementation of a physiotherapy-led vestibular screening pilot within an Older Persons Health inpatient setting.

Methods

Following a literature search to identify screening tools in clinical use, the Vestibular Screening Tool was selected for pilot. The tool was completed for all new admissions to four older persons rehabilitation wards. Two audits (A1 and A2), conducted between January 2019 and January 2020, assessed use of the screening tool for admissions over a two-week period and analysed compliance and outcomes.

Results

Of the 84 (A1=40, A2=44) admissions, utilisation of the screening tool was 53% (n= 21) and 61% (n=27) respectively. Completion varied depending on clinical area. Over the audit period, 30 patients (average age 82.2 years) met the criteria for further assessment. Sixty percent of those assessed had documented falls within the two years prior to admission. Twenty-four (80%) were identified as having vestibular dysfunction. Follow up actions included treatment for Benign Paroxysmal Positional Vertigo (n=9), vestibular rehabilitation exercises (n=8), referral to specialist vestibular consultant clinic (n=3) and referral to outpatient vestibular physiotherapy (n=6). The remaining six patients had normal assessments.

Conclusions

The implementation of a Vestibular Screening Tool was effective in identification of older inpatients with underlying vestibular disorders and prompting appropriate therapy or referral. Therapist utilisation of the screening tool was variable, with higher use on wards with permanent therapists rather than rotational staff.

Implications

The Vestibular Screening Tool in the older person's inpatient rehabilitation setting is a feasible way to further assess risk of falls in this population. For increased therapist utilisation, appropriate induction, education and ongoing support/education is recommended.

OPH&R will be looking to implement this screening as part of routine assessment, via skill sharing across other professional groups.

Ashburton Health Services

A distinct increase in presentation of over 75 population cohort has been monitored over the last quarter of 2020. The trend of increased presentations in November, has been experienced over the past three years and challenges the traditional concept of winter planning in isolation. The challenge this year has been continued growth and complexity of case mix. Investigating the information further, this is reflected in a distinct growth in presentations by Ambulance, as opposed to self-referrals. Figures 1, and 2 demonstrate this, the information noted in Figure 1.6 is a daily average, the detail below identifies total numbers.

The medical team have reflected that a number of these presentations and corresponding admissions are older persons from Aged Residential Care (ARC) facilities. A quality audit is underway, reviewing clinical presentation and exploring opportunity to review or refocus a more proactive approach to clinical care within the facility and the community. We are connecting with work designed under the Urgent Care Service Level Alliance and the 24-Hour Medical Centre, providing telehealth consults afterhours to ARC facilities who are unable to access local primary care responses.

During this quarter foundation work was also undertaken reviewing the community health pathways that enable primary care to refer directly to what has been traditionally described as community services, including Needs Assessment and Service Co-ordination, Gerontology Clinical Nurse Specialists, Home Support, Allied Health and Clinical Nurse Specialists working with long term conditions such as respiratory,

diabetes and cardiology. The approach is to move to a single standardised community nursing form, that supports primary care to easily complete a referral and become familiar with the information required. It has been through this we have uncovered the complexity and lack of clarity in the health pathway referrals process for local OPH services and opportunity to improve and redesign the pathway information and partner with primary care teams to access care. The value of this opportunity is to also increase the partnership with the nursing teams within practices, who remain relatively stable, whereas the medical workforce is heavily reliant on international locums whom change annually.

Whilst the Ashburton Service Level Alliance (ALSA) has a workplan for Frail Elderly, there has been no service redesign or change in practice to mitigate or plan a population /systems level approach to care for this cohort. Ashburton Health Services are currently standing up our new service model, operating in service clusters of Acute and Inpatient, Integration and Quality, Workforce and Safety as opposed to the traditional secondary hospital care structure. This provides the opportunity to bring a whole of system approach to redesigning care models for this community and focusing an approach that supports care alongside the general practice team. This is founded in the Integration Service Cluster, where the medical care and leadership remains with primary care but can be supported better with direct integration to virtual specialist service consults via telehealth and an on-ground team of nursing workforce that can partner with the practices both in workforce development and providing complex assessments where required. Built on a focus of integrated service design, moving away from localised service design by each provider arm, primary care, NGO and hospital services, this aligns well with the recommendations of the Health and Disability review and drive towards locality models. Changing the paradigm of hub and spoke that traditionally identifies Tertiary/Specialist Based Hospital Services as the hub and the multiple community-based services as spokes, to a model of Integrated Community Services as the hub, accessing episodic care from the various spokes of specialist service advise and treatment. This model lends itself to efficiencies in investment and expands the framework to be considered across localities outside of Ashburton as our balanced score care and KPIs will include target reductions in declined referrals, reduced admissions and length of stay.

Figure 1.

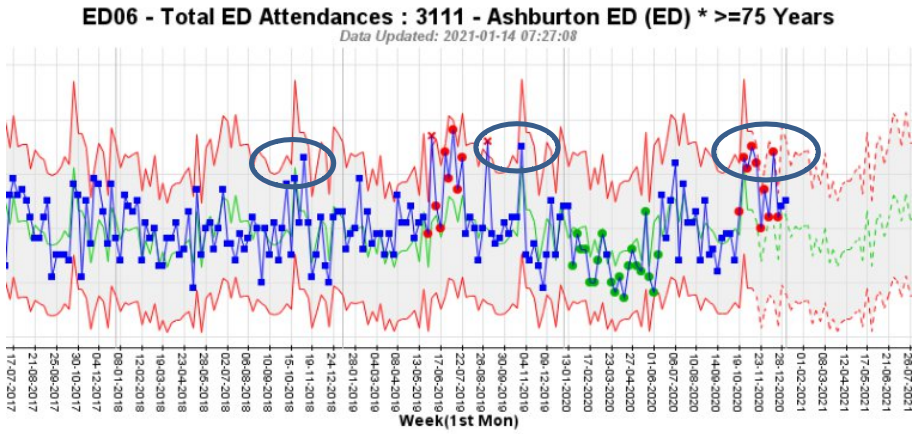
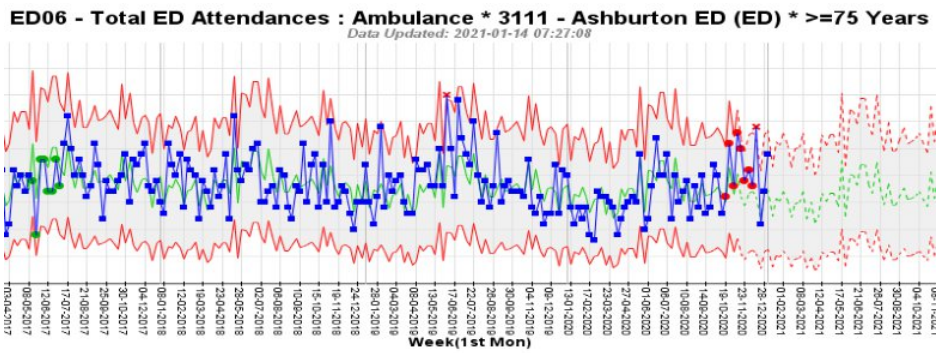
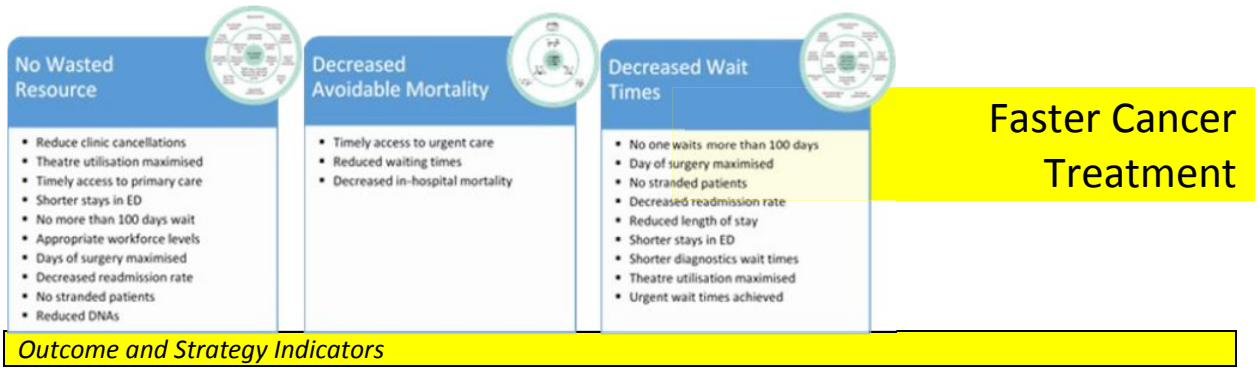


Figure 2





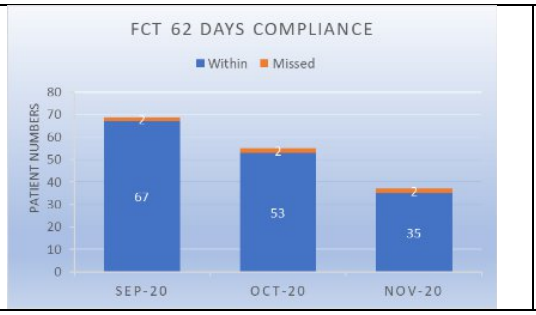
Key Outcomes - Faster Cancer Treatment Targets (FCT)

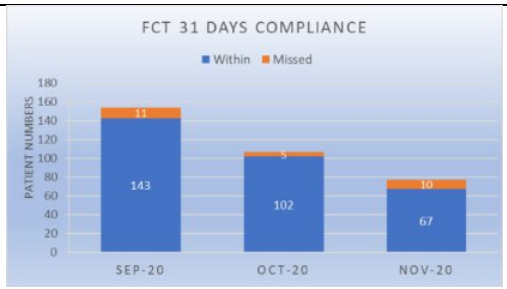
62 Day Target. In the three months to the end of November there were 180 records submitted by Canterbury District Health Board – down just one less from 181 for the three months to the end of October. 25 patients missed the 62 days target, 19 did so through patient choice or clinical reasons and are therefore excluded from consideration. With 6 of the 161 patients missing the 62 days target through capacity issues our compliance rate was 96.3%, once again meeting the 90% target.

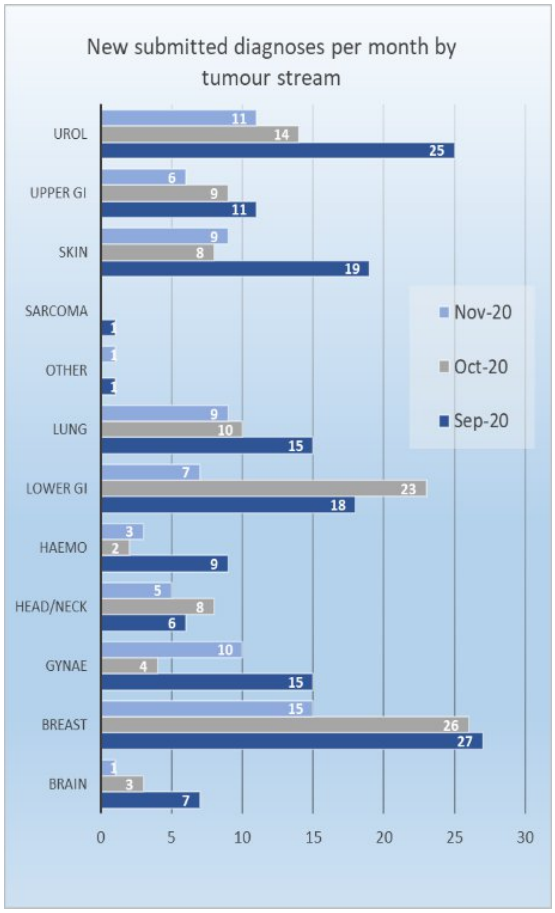
31 Day Performance Measure. Of 338 records submitted towards the 31-day measure 318 (92.3%) eligible patients received their first treatment within 31 days from a decision to treat, the CDHB continues to meet the 85% target. A total of 20 patients did not meet the 31 days target but it is worth noting that 10 missed it by 5 days or less and 2 through patient choice or clinical considerations.

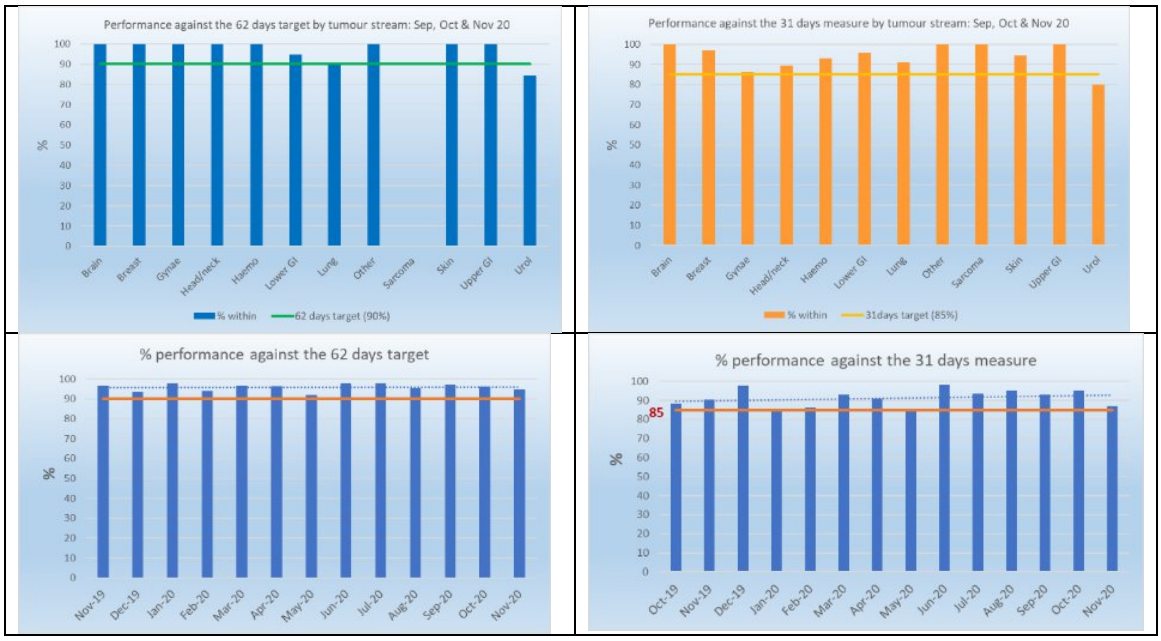
FCT performance in CDHB

The dip in numbers in the last month of every report (November in this case) reflects the timing of when the report is compiled in order to fulfil the deadline set by the Ministry. A significant number of the patients who have a 1st treatment date in the period this report covers will be awaiting coding and will be picked up in the following month's extract.






New submitted diagnoses per month by tumour stream
UROL
UPPER GI
SKIN
SARCOMA
OTHER
LUNG
LOWER GI
HAEMO
HEAD/NECK
GYNAE
BREAST
BRAIN
Nov-20
Oct-20
Sep-20
0
5
10
15
20
25
30

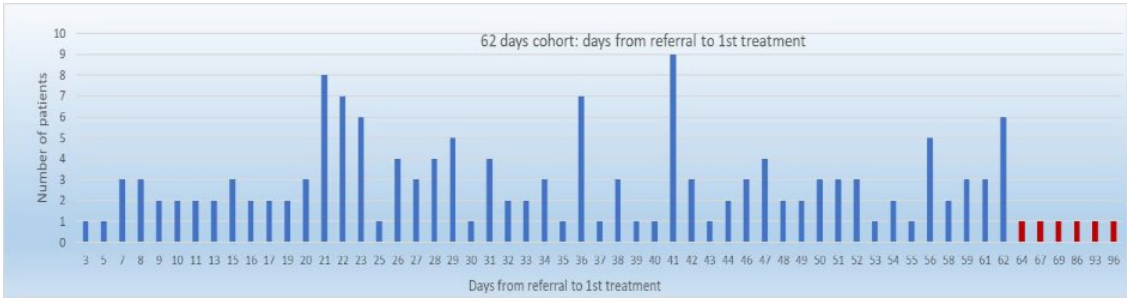

Performance against the 62 days target by tumour stream: Sep, Oct & Nov 20
% within
62 days target (90%)
Performance against the 31 days measure by tumour stream: Sep, Oct & Nov 20
% within
31days target (85%)
% performance against the 62 days target
% performance against the 31 days measure
85

Patients who miss the targets

The MoH requires DHBs to allocate a code (referred to as a delay code) to all patients who miss the 62 days target. There are three codes but only one can be submitted, even if the delay is due to a combination of circumstances, which is often the case. When this happens the reason that caused the greatest 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 delay the start of their treatment
3. Capacity: this covers all other delays such as lack of theatre space, unavailability of key staff or process issues.

Each patient that does not meet the target is reviewed to see why. This is necessary in order to determine and assign a delay code, but where the delay seems unduly long a more in-depth check is performed. These cases are usually discussed with the tumour stream Service Manager(s) to check whether any corrective action is required.The graph below shows the days waiting for each patient who met the 62 days criteria.



Achievements/Issues of Note

Efficiencies in Radiation Oncology

Within Radiation Oncology there is a constant focus on developing more efficient ways of working to ensure that timely treatment can be provided to the population, at the same time utilising the advanced technology to deliver high end care. This provides benefit to patients and creates staff satisfaction from involvement in technique development and quality improvements. The team is taking full advantage of the significant capital investments into the service.

- With the opening of Waipapa, theatre capacity available for prostate brachytherapy has doubled – meaning that four prostate brachytherapy procedures are conducted each month. This results in each of these patients needing to receive less external beam radiation treatments - down from 39 to 15. Each patient on this clinical pathway releases six hours of treatment capacity for someone else.

- Following the recent publication of an international trial, women older than 50 with early stage breast cancer are prescribed a course of 5 radiation treatments in place of the standard regimen of 15 treatments. This has the potential to increase the intervention rate for those women who live in the regions who would perhaps normally have opted for no treatment or a mastectomy. It releases 1.5hrs of machine capacity per patient. The clinical protocol established in October will be audited after a four-month trial to assess the impact on the service.
- Stereotactic Body Radiation Therapy (SBRT) for spinal metastases is a technique that delivers a high dose of radiation in two or three treatments with pin point accuracy. This requires a highly specialised multi-disciplinary team to plan and deliver the treatment. After several months of development and support from other services such as the MRI team and peers at Auckland Radiation Oncology the first two patients were successfully treated in December 2020. Having the skills and capability to deliver this expensive treatment here means it is no longer outsourced to private, releasing that funding to support the treatment of other patients.

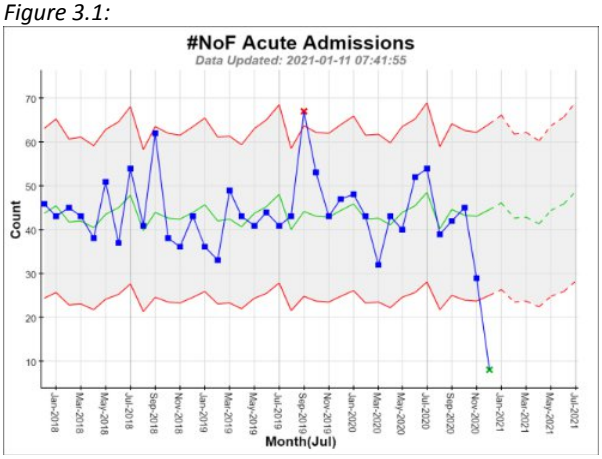
Medical Oncology Update

- The focus for improvement continues to be addressing demand and capacity issues, to deliver timely access to treatment and ongoing clinical management, in line with assessed priority.
- As of 18 January 2021, 78 patients are waiting for a First Specialist Assessment, compared with 94 in mid-December 2020. In line with usual patterns of demand referrals dropped in the weeks leading into the holiday break and have subsequently increased with referrers return following the festive season.
- Monitoring waiting times continues to be a priority specially to ensure timely management of an expected increase in referrals in the New year.
- A revised clinic configuration, incorporating nursing roles, to better support booking both new and follow-up patient appointments in line with assessed priority is in the process of finalisation, with a view to implementation commencing in February.
- Supporting this is the commencement of a further SMO in late January, in addition to the SMO that commenced in December. A written offer for a further position with the successful candidate, with a view to commencement in May 2021. Accommodating the additional clinical staff will require reallocation of space both within and beyond Medical Oncology - this is being scoped currently.
- The outsourcing arrangement with St George's has commenced, with referrals expected to increase following the holiday break.
- Nursing initiatives are having a positive impact on capacity with nurse-led clinics for specific tumour streams
- There are six workstreams either commenced or ready to start this month to support improved demand management, capacity utilisation, improved service organisation and team development.
- The development of a revised model of care for Medical Oncology is in its early stages, recognising that considerable work within the service needs to take place through 2021, and also engagement with referrers, external services and stakeholders to agree the basis for a sustainable Medical Oncology service into the future.

Enhanced Recovery After Surgery (ERAS)

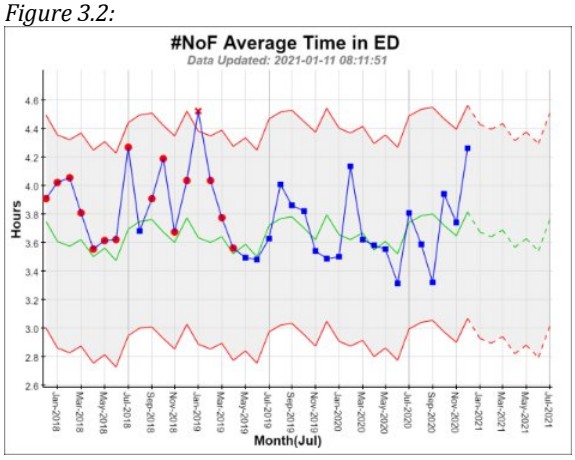
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



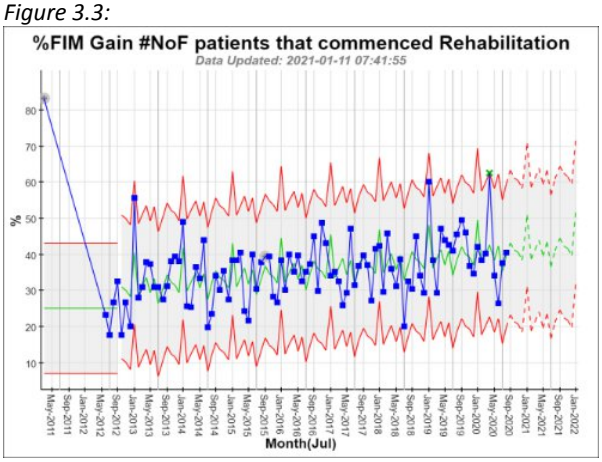
Admissions are generally following the expected mean count. Coding delay impacts the latest data point.

Figure 3.2:



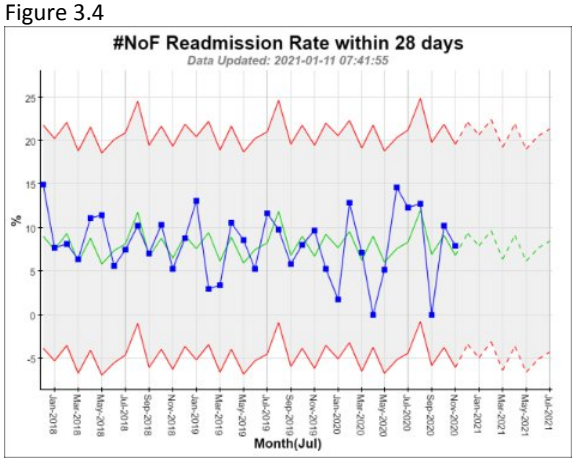
#NoF time in ED is generally following the expected mean times.

Figure 3.3:



The Functional Independence Measure (FIM) is a basic indicator of severity of disability.

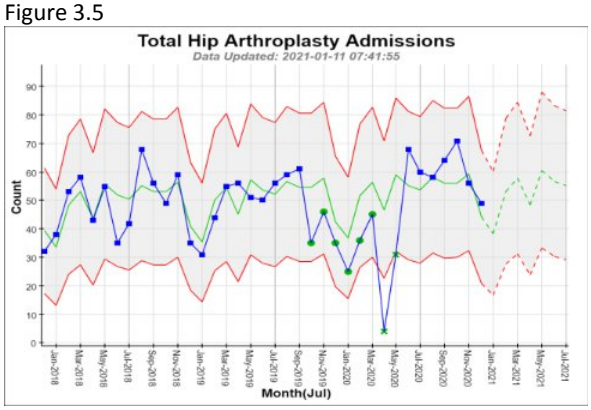
Figure 3.4



Readmissions continue to remain within expected mean values.

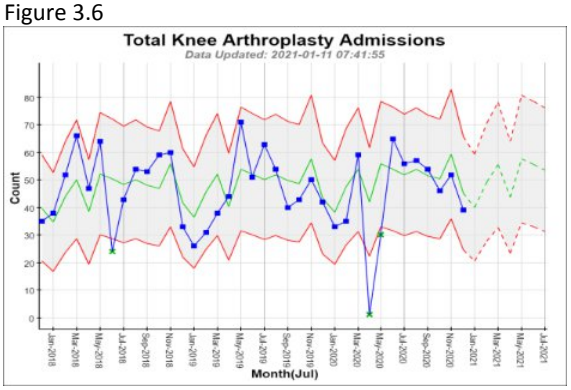
Outcome and Strategy Indicators – Elective Total Hip Replacement (THR) and Knee Replacement (TKR)

Figure 3.5



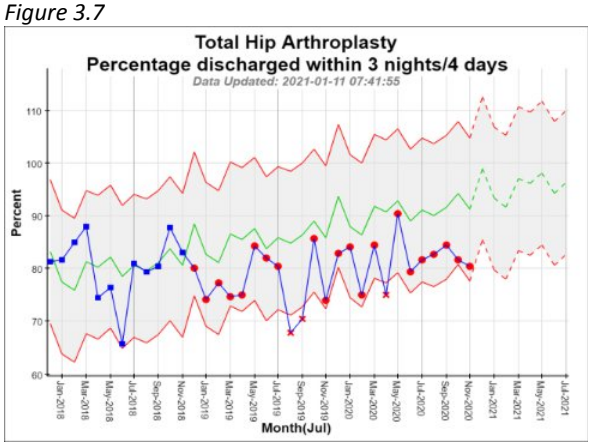
Admissions are trending within the expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.6



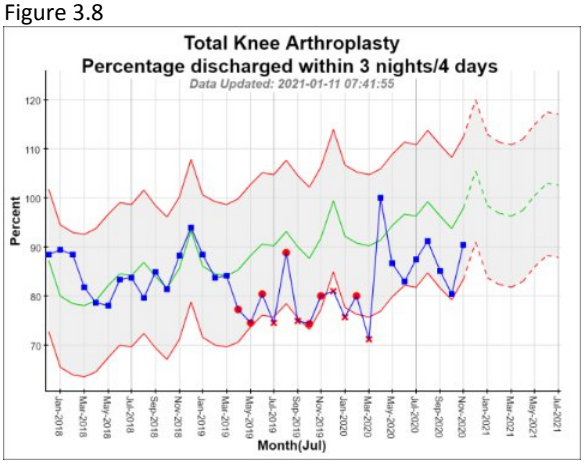
Admissions are trending within expected range. April shows no record of planned admissions in line with NZ Covid 19 Alert Level 4 restrictions

Figure 3.7



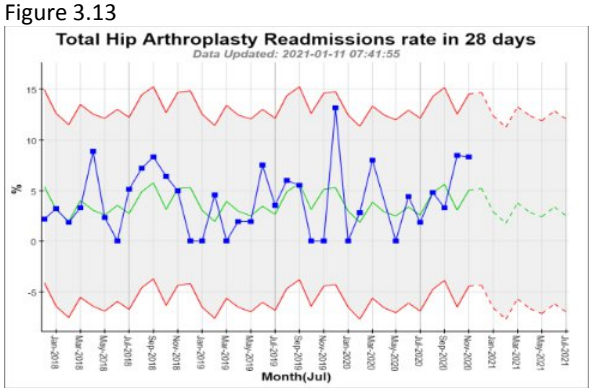
Joint surgeries provided during the three weeks of the Christmas closure were acute joint replacements and are more complex than planned procedures. The length of stay is predicted to be longer for these cases.
In the longer term, there has been an increase in proportion patients with high complexity factors being provided with hip replacements. This is associated with a longer hospital stay for these patients and has contributed to the reduced proportion leaving hospital within the target period.

Figure 3.8



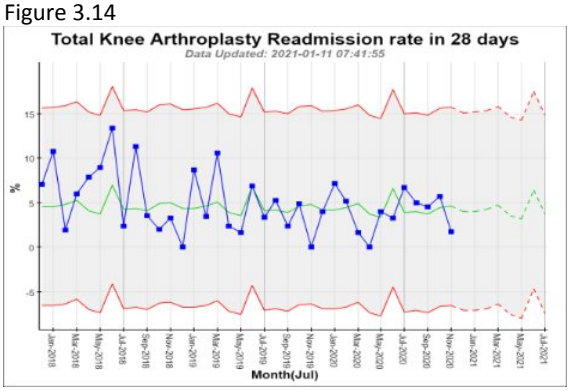
The proportion of people discharged within three nights/ four days following knee replacements has been improved over the past eight months compared with the prior year. It has returned to the levels achieved in 2018. When viewed on a quarterly basis this value is higher than it has ever been.

Figure 3.13



Readmission rates remain a low percentage.

Figure 3.14



Readmission rates are maintaining within tolerances.

Achievements/Issues of Note

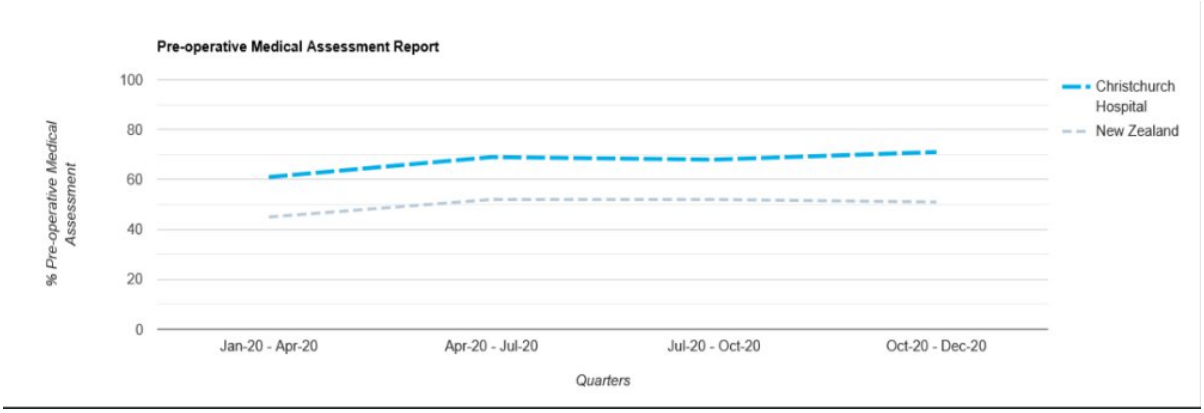
OPH&R 2020 Hip registry database results.

Active Patients	Last Modified
43	6 Jan 2021
2021 Records	**All Records**
8	1795

08/01/2020 07/01/2021

459 records	Time in ED (hrs) [393]	Time to Surgery (hrs) [451]	Acute Length of Stay (days) [412]	Hospital Length of Stay (days) [416]
Average	3.46	36.04	6.72	18.82
Median	3.27	26.92	5.94	17.30
Shortest	0.00	3.17	1.13	0.47
Longest	11.30	191.20	50.52	85.52

QS1 Care at Presentation	QS2 Pain Management	QS3 Orthogeriatric Model of Care	QS4 Timing of Surgery	QS5 Mobilisation & Weight Bearing	QS6 Minimising Risk of Another Fracture	QS7 Transition from Hospital Care
Cognitive Assessment prior to surgery (459) 49%	Pain Assessment within 30 minutes (448) 28%	Assessed by geriatric medicine (455) 92%	Surgery Within 48 hours (451) 78%	Day 1 Mobilisation Opportunity (447) 87%	Bone Medication on Discharge (415) 78%	Patients returning to Private Residence @ 120 Days (166) 79%
	Nerve Block before or at surgery (459)			Unrestricted Weight Bearing (450) 92%	Specialist Falls Assessment (416)	



The Ortho-medicine service consists of Geriatricians contributing to the care of patients post fractured neck of femur. QS3 shows the proportion of patients seen by a Geriatrician both pre and post operatively, and the graph shows those seen pre-operatively in comparison with the national average

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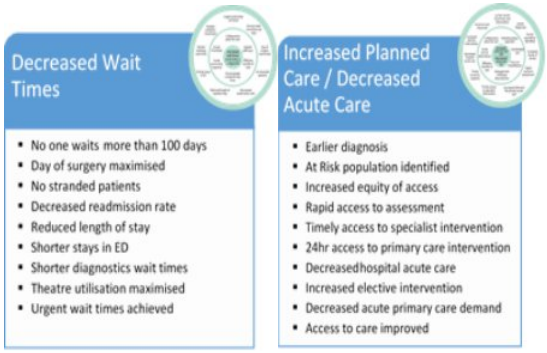


Elective Surgery Performance Indicators 100 Days

Elective Services Performance Indicators

Summary of Patient Flow Indicator (ESPI) results
DHB: Canterbury

	Dec		Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov	
	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %	Imp. Req	Status %
1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe.	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %	28 of 28	100.0 %
2. Patients waiting longer than four months for their first specialist assessment (FSA).	1501	15.4%	1627	16.4%	1546	15.8%	1537	16.5%	1964	23.6%	2244	28.7%	2273	28.9%	1815	21.5%	1200	13.3%	908	9.3%	995	9.6%	1076	9.8%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	72	0.4%	50	0.3%	2	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
5. Patients given a commitment to treatment but not treated within four months.	595	14.3%	722	17.1%	739	16.9%	883	18.4%	1393	26.7%	1330	28.2%	1169	25.2%	1280	26.5%	918	19.0%	709	15.1%	756	15.7%	822	16.5%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	0	100.0 %	0	100.0 %	0	100.0 %	3	99.8%	1	99.9%	0	100.0 %	1	99.9%	0	100.0 %	0	100.0 %	8	99.5%	1	99.9%	0	100.0 %

Summary of ESPI 2 Performance - From MoH Final Summary September 20 (published on 2 November)

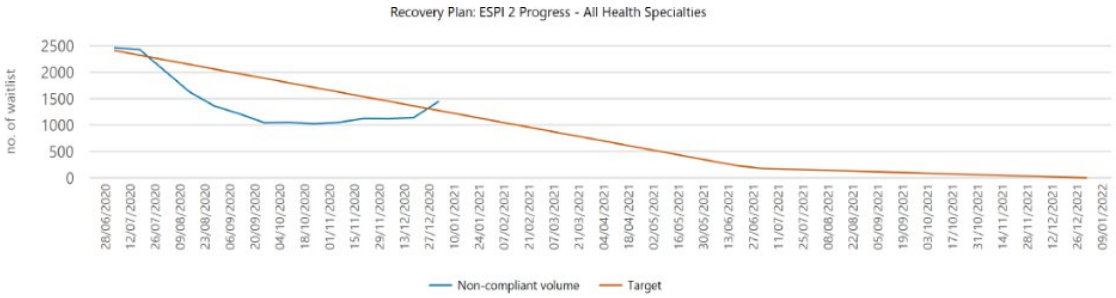
	Sep-20		Oct-20		Nov-20	
ESPI 2 (FSA)	Improvement required	Status %	Improvement required	Status %	Improvement required	Status %
Cardiothoracic Surgery	1	4.8%	0	0.0%	0	0.0%
Ear, Nose and Throat	21	2.4%	30	3.3%	65	6.4%
General Surgery	14	1.6%	26	2.4%	18	1.4%
Gynaecology	7	2.3%	5	1.5%	4	1.3%
Neurosurgery	0	0.0%	1	0.8%	1	0.8%
Ophthalmology	27	2.8%	56	5.0%	112	9.2%
Orthopaedics	36	5.1%	52	6.9%	83	8.7%
Paediatric Surgery	3	2.1%	3	2.4%	7	6.4%
Plastics	188	32.5%	178	34.9%	164	30.9%
Thoracic	0	0.0%	0	0.0%	0	0.0%
Urology	1	0.2%	0	0.0%	0	0.0%
Vascular	81	31.4%	63	32.3%	65	34.8%
Cardiology	7	1.9%	14	3.2%	17	4.2%
Dermatology	0	0.0%	1	1.3%	1	1.5%
Diabetes	3	2.1%	3	2.0%	13	7.6%
Endocrinology	6	2.2%	12	4.8%	9	3.4%

Endoscopy	311	22.5%	312	22.3%	292	21.0%
Gastroenterology	0	0.0%	5	1.8%	16	5.1%
General Medicine	1	0.7%	1	0.7%	4	2.9%
Haematology	1	1.8%	1	2.1%	0	0.0%
Infectious Diseases	1	5.9%	1	7.7%	1	10.0%
Neurology	9	2.7%	27	7.0%	13	3.7%
Oncology	7	3.1%	7	2.8%	8	2.9%
Paediatric Medicine	165	29.9%	170	32.6%	159	30.8%
Pain	1	20.0%	0	0.0%	0	0.0%
Renal Medicine	5	12.8%	6	12.5%	2	5.1%
Respiratory	12	4.9%	20	8.0%	22	7.3%
Rheumatology	0	0.0%	1	0.4%	0	0.0%
Total	908	9.3%	995	9.6%	1076	9.8%
ESPI 5 (Treatment)						
Cardiothoracic Surgery	0	0.0%	0	0.0%	0	0.0%
Dental	98	31.0%	74	25.7%	85	28.2%
Ear, Nose and Throat	107	17.4%	127	20.0%	148	22.1%
General Surgery	203	29.3%	219	32.7%	236	35.0%
Gynaecology	38	11.3%	58	17.8%	56	16.7%
Neurosurgery	0	0.0%	0	0.0%	0	0.0%
Ophthalmology	67	16.9%	52	13.0%	35	8.9%
Orthopaedics	63	9.3%	71	11.1%	63	10.0%
Paediatric Surgery	17	15.7%	17	13.4%	18	14.6%
Plastics	55	6.6%	68	7.2%	84	8.4%
Urology	6	1.8%	5	1.4%	10	2.8%
Vascular	6	6.8%	4	5.8%	5	6.3%
Cardiology	49	18.8%	61	19.7%	82	23.0%
Total	709	15.1%	756	15.7%	822	16.5%

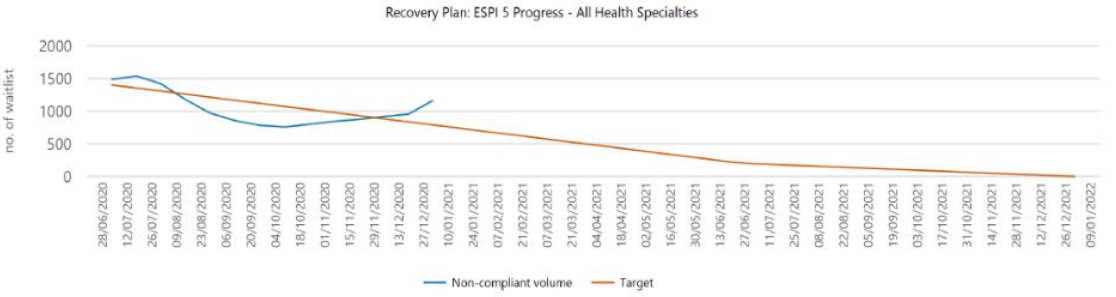
Note - ESPI 5 figures and ESPI2 figures are taken from the MoH ESPI Finals report for November 2020, published 11 January 2021.

The CDHB Improvement Action Plan 20/21 is in place and focusses on CDHB achieving ESPI/Planned Care compliance in the majority of services within six months. Prior to the Christmas holidays CDHB was meeting the plan's overall target for the number of patients waiting for First Specialist Assessment longer than 120 days however as at 8th January the overall target is no longer being met. Within this the overall target twelve specialty areas have no patients waiting for First Specialist Assessment for longer than 120 days, 21 are meeting their recovery plan target and 17 are not.

When considering patients waiting times for admission and treatment as at 8th January CDHB is not meeting the plan's targets. As at 14th September one specialty area has nobody waiting longer than 120 days, five are meeting their recovery plan target and eight are not.



	03/07/2020	17/07/2020	31/07/2020	14/08/2020	28/08/2020	11/09/2020	25/09/2020	09/10/2020	23/10/2020	06/11/2020	20/11/2020	04/12/2020	18/12/2020	01/01/2021	15/01/2021	29/01/2021	12/02/2021	26/02/2021	12/03/2021	26/03/2021	09/04/2021	23/04/2021	07/05/2021	21/05/2021	04/06/2021	18/06/2021	02/07/2021	16/07/2021	30/07/2021	13/08/2021	27/08/2021	10/09/2021	24/09/2021	08/10/2021	22/10/2021	05/11/2021	19/11/2021	03/12/2021	17/12/2021	31/12/2021
Actual vol	2,469	2,433	2,033	1,632	1,363	1,215	1,048	1,054	1,029	1,053	1,126	1,122	1,142	1,448																											
Drop required	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	87	14	14	14	14	14	14	14	14	14	14	14	14	14	14
Target vol	2,412	2,325	2,238	2,150	2,063	1,976	1,888	1,801	1,714	1,626	1,539	1,452	1,364	1,277	1,190	1,102	1,015	928	841	753	666	579	491	404	317	229	179	165	151	137	124	110	96	82	69	55	41	27	14	0
Balance	-57	-108	205	518	700	761	840	747	685	573	413	330	222	-171																											



	03/07/2020	17/07/2020	31/07/2020	14/08/2020	28/08/2020	11/09/2020	25/09/2020	09/10/2020	23/10/2020	06/11/2020	20/11/2020	04/12/2020	18/12/2020	01/01/2021	15/01/2021	29/01/2021	12/02/2021	26/02/2021	12/03/2021	26/03/2021	09/04/2021	23/04/2021	07/05/2021	21/05/2021	04/06/2021	18/06/2021	02/07/2021	16/07/2021	30/07/2021	13/08/2021	27/08/2021	10/09/2021	24/09/2021	08/10/2021	22/10/2021	05/11/2021	19/11/2021	03/12/2021	17/12/2021	31/12/2021
Actual vol	1,489	1,543	1,418	1,176	968	856	784	758	800	845	877	916	954	1,164																											
Drop required	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	47	15	15	15	15	15	15	15	15	15	15	15	15	15	15
Target vol	1,403	1,356	1,309	1,262	1,215	1,168	1,121	1,074	1,027	979	932	885	838	791	744	697	650	602	555	508	461	414	367	320	273	226	195	180	165	150	135	120	105	90	75	60	45	30	15	0
Balance	-86	-187	-109	86	247	312	337	316	227	134	55	-31	-116	-373																											

Specific actions are being focussed in services to address the factors at play rather than assuming a single set of actions will address the challenges in all services:

- Services are being encouraged to book patients in the order of clinical need and then age of referral. If age of referral was the only factor needed to be considered when determining which patient to book next the waiting time problem would be resolved very quickly.
- Ear, Nose and Throat. Changes have been made to HealthPathways and triage criteria are being more strictly applied that will reduce the number of lower priority referrals (specifically children with mild sleep apnoea) accepted by the specialist service. This is proving to have an effect on FSA waiting list size. ESPI 5: Parental leave has affected our capacity in the rhinology subspecialty. The full team is now back on board, this will contribute to more timely management of patients waiting for surgery in that subspecialty. Head and neck surgeon capacity is being consumed by the ongoing increase of cancer cases in this area. The service is seeking specific funding from the MoH to enable outsourcing of surgery in this subspecialty to improve waiting times for these procedures.
- General Surgery: A number of Senior Medical Officer (SMO) staff have recently returned from extended sick, and annual leave. Along with this a new fellow will start at the end of January and

will provide Outpatient's clinic capacity over and above that which is normally available. In addition to this, outsourced providers are being followed up with about referrals already sent to them and a new cohort is being prepared for outsourcing. The service is planning to be ESPI 2 compliant by the end of June.

- Orthopaedic Surgery. ESPI5: The ability of Orthopaedics to provide surgery in a timely way has been affected in the long term due to the requirement to utilise planned operating lists to provide acute surgery to patients. This was exacerbated during migration of services to Waipapa and contributed to some growth in ESPI 5 compliance as has the Christmas closure has also impacted compliance. The Orthopaedic Service has also taken 64 long waiting elective patients requiring hand surgery from the Plastic Service Waitlist, these are breaching CTR patients that ortho has picked up to operate on, this has impacted the ortho ESPI 5 compliance. The increase in acute theatre capacity provided by Waipapa clears the way for full utilisation of planned lists for elective patients. This, along with the Orthopaedic Service's practice of triaging to capacity and will enable the service to gain ESPI compliance.
- Ophthalmology: SMO capacity was reduced by the recent resignation and departure of two employees. The service is focussing on recruitment and clinical pathways that substitute technical and nursing activity for that previously provided by SMOs, releasing SMO capacity for other purposes. Alongside this the service is reviewing its triage guidelines and acceptance criteria. An update will be provided on HealthPathways over the coming weeks.
- Vascular Surgery ESPI2: The service is utilising MoH funding to run additional clinics and will be ESPI2 compliant by the end of June. ESPI5: The service has repatriated ambulatory treatment of varicose veins to the outpatient department and is working to match accepted referrals to capacity to ensure that ESPI compliance is reached..
- It is acknowledged that the Christmas/New Year period has seen a further increase due to closure of clinics during this period. Staff return from leave is associated with capacity increasing back to normal levels, and improvement in waiting times.
- The opening of Waipapa theatres will enable a cohort of patients that were unsuitable for outplaced operations and had be waiting longer than target

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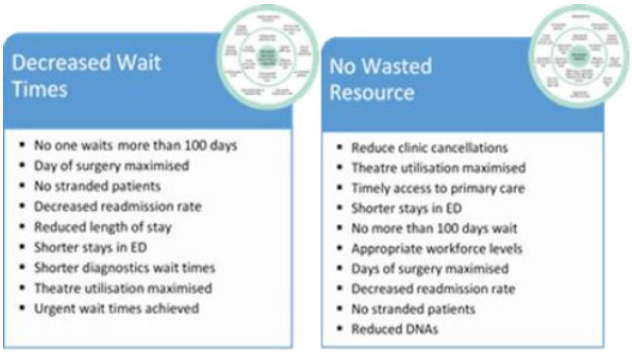
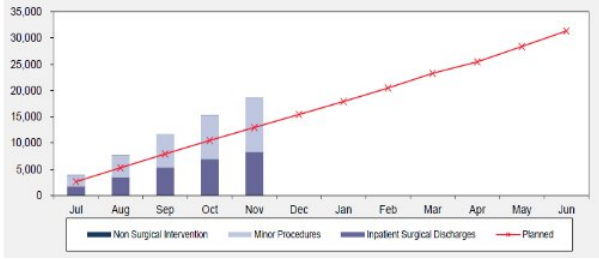


Theatre Capacity and Theatre Utilisation

- Planned care targets have been provided to the Ministry of Health. As per last year, they incorporate planned inpatient operations as well as range of procedures provided to hospital inpatients, outpatients and patients in community settings.
- As at year end our target is to deliver a total of 31,359 planned care interventions: made up of 19,614 surgical discharges, 11,409 minor procedures and 336 non-surgical interventions. This is 2% higher than the 2019/20 target of 30,675.
- Reporting from the Ministry of Health to the end of November shows that Canterbury District Health Board is exceeding its planned care targets by 44% with targets being met in the major categories.

	2020						2021					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	2,617	5,270	7,898	10,482	12,942	15,420	17,911	20,472	23,273	25,442	28,379	31,345
Actual	3,883	7,582	11,636	15,241	18,604							
Variance	1,266	2,312	3,738	4,759	5,662							
%Achievement	148%	144%	147%	145%	144%							



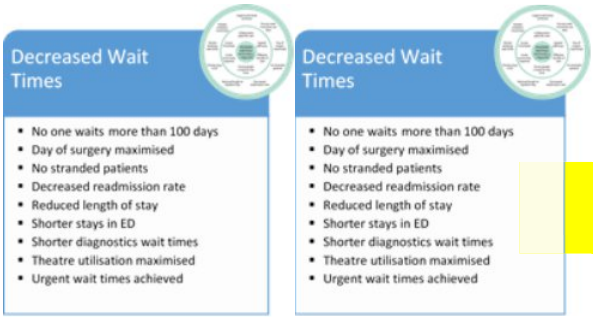
	Interventions		
	Plan	Actual	%
Non Surgical PUC with Surgical DRG	335	325	97.0%
Surgical PUC	7,731	7,963	103.0%
Inpatient Surgical Discharges	**8,066**	**8,288**	**102.8%**
Inpatient Minor Procedures	630	1,100	174.6%
Outpatient Minor Procedures Hospital	3,123	4,548	145.6%
Outpatient Minor Procedures Community	988	4,651	470.7%
Minor Procedures	**4,741**	**10,299**	**217.2%**
Non Surgical Interventions	135	17	**12.6%**
Total	**12,942**	**18,604**	**143.7%**

- Internal reporting to the week ending 8 January shows that 21,514 planned care events have been provided – this is 5,275 ahead of the target of 16,239.
- Within this, 9,758 planned inpatient surgical discharges were provided – 232 below the phased target of 9,990.
- 11,735 Minor procedures have been provided 5 654 ahead of the target of 6,081. Inpatient, outpatient and community provision are all ahead of target.
- 191 non-surgical interventions have been counted, 32 below target of 223.

Current theatre volumes

- Waipapa theatres opened in the week of November 23rd. During and immediately following the transition period planned surgical volumes were reduced to support a safe and effective transition.
- Challenges have emerged in provision of sufficient sterile equipment to enable the new theatre schedule to be fully utilised. Some increased capacity was put in place by increasing overtime and bringing in some outsourced staff to assist. Along with this elective theatre sessions left vacant due to leave have not been backfilled as they usually would be.

- Sterile equipment was provided on time for all surgery booked and no patients had their surgery cancelled due to lack of sterile equipment.
- Work continues to develop an improved understanding of the stock of equipment required to optimally support the new theatre schedule and the variation in demand created by the new schedule for sterile equipment so processes and capacity within Theatre and Sterile Services can be optimised.
- Overall, considering in house, outplaced and outsourced provision, fewer operations were provided in theatres in November 2020 than in November 2019 (2,439 compared with 2,645) and more in December 2020 than December 2019 (2,420 compared with 2,377) despite a significant reduction in the use of outplaced and outsourced surgery following transition to Waipapa. Further detail follows.
- Demand for acute or arranged during November and December was about 10% lower than in 2019 with 1,097 theatre events in November 2020 and 1,164 in December. Initial analysis indicates that patients spent less time waiting for acute General and Orthopaedic surgery following acute and arranged admission due to the improved availability of acute surgical capacity. Waiting times grew during the Christmas and New Year Period. As is our usual practice, further analysis will inform planning of theatre capacity required during future public holidays.
- The number of planned operations carried out at Burwood Hospital was 9% and 18% higher in November and December than the same months the previous year with 290 planned events in November 2020 and 241 in December.
- The number of outsourced and outplaced events has been reduced with increased in-house capacity enabling much of this work to be repatriated. Further reduction will occur when dental surgery is brought back to Christchurch Hospital later this quarter. During December 226 outplaced or outsourced theatre events were provided – 58% of December 2019.
- Despite reductions in productivity around the transition period more elective surgery was provided at Christchurch Hospital during both November and December 2020 than in 2019 with 679 elective theatre events in November 2020 and 805 in December 2020 compared with 621 and 565 in 2019.
- Surgical Service, Theatre and Sterile Services staff are working together to optimise processes within the new theatre footprint to maximise benefit provided to the people of Canterbury.



Mental Health Services

Focus on SMHS Intellectual Disability Services

The SMHS provides both inpatient and outpatient care to adults who have a primary diagnosis of intellectual disability as eligible for support from the Intellectual Disability Service teams. This comprises two inpatient, and two outpatient teams.

Across the teams there is a strong interdisciplinary focus with a mix of disciplines including psychiatrists, nurses, occupational therapists, social workers, behaviour support specialist and access to other services available through the wider service (dietician, physiotherapy etc).

PSAID (Psychiatric Services for Adults with an Intellectual Disability)

PSAID (Psychiatric Services for Adults with an Intellectual Disability) inpatient (IP) and outpatient (OP) teams work with consumers who present with a suspected or confirmed mental health issue. These teams offer specialist assessment, treatment recommendations, case management and inpatient support (15 beds). The teams have a close working relationship to ensure consumer-centred care. This service for part of DHB's population-based obligations.

Whaikaha (AT&R - Assessment Treatment and Rehabilitation)

The Whaikaha (AT&R/Assessment Treatment and Rehabilitation) inpatient unit works with a diverse section of this population. The two main criteria for admission are those people who present with challenging behaviour that cannot be safely managed in the community, and those directed by the courts under orders, these being the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act) and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act). This service is contracted by Disability Support Services at the Ministry of Health.

The latter cohort are people who have offended and entered the judicial system. They may be referred for assessment to determine whether they are fit to plead under CPMIP, or as part of their rehabilitation once they have been charged and placed under the IDCCR Act and are waiting to move to a community provider. People may be readmitted for a further period of assessment/review if there is a risk of their placements breaking down due to behavioural issues. Due to the nature of the consumers under care this is classed as a Medium Secure Forensic unit and is locked (six beds).

Outpatient follow up is not usually provided through SMHS for people admitted to Whaikaha with challenging behaviours. Ongoing support is available through Explore Specialist Advice under the umbrella of Health Care New Zealand's portfolio of services.

The IDL (Intellectual Disability Liaison)

The IDL (Intellectual Disability Liaison) community team works with people under the IDCCR Act, providing specialist advice and support to the NGO services who provide community services (secure and non-secure for this cohort). This team works in close conjunction with Whaikaha.

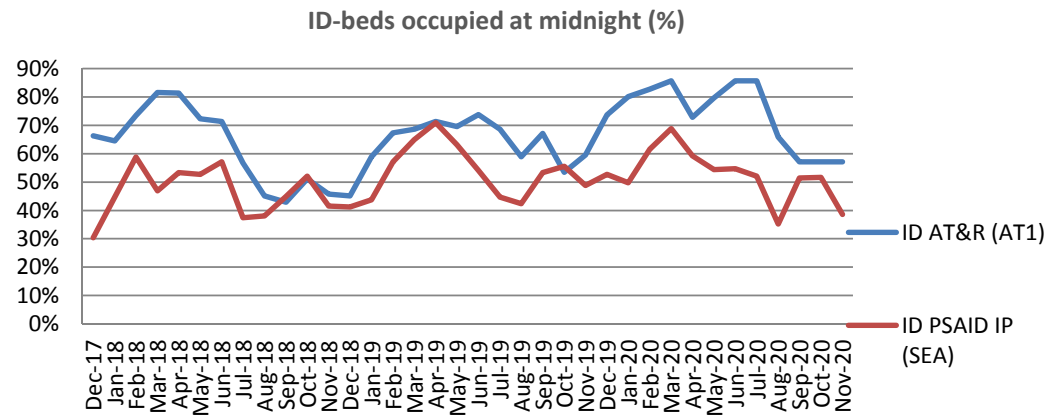
Issues and Challenges

While the number of people under care are low in contrast to mainstream mental health services, these consumers seen historically have a higher risk of mental and physical health issues, poorer health outcomes, poor health literacy and reduced access to mainstream community services. A higher percentage of the intellectually disabled population will require support through Specialist Mental Health Services than that of the general population, and their complexity makes it a highly challenging environment to work in.

Both inpatient units share similar challenges. The buildings are outdated and not fit for purpose. There is currently a new four bedded wing in Whaikaha that will be completed early in 2021 that will provide a therapeutic, purpose-built environment. Further developments are planned as part of the longer-term site master plan.

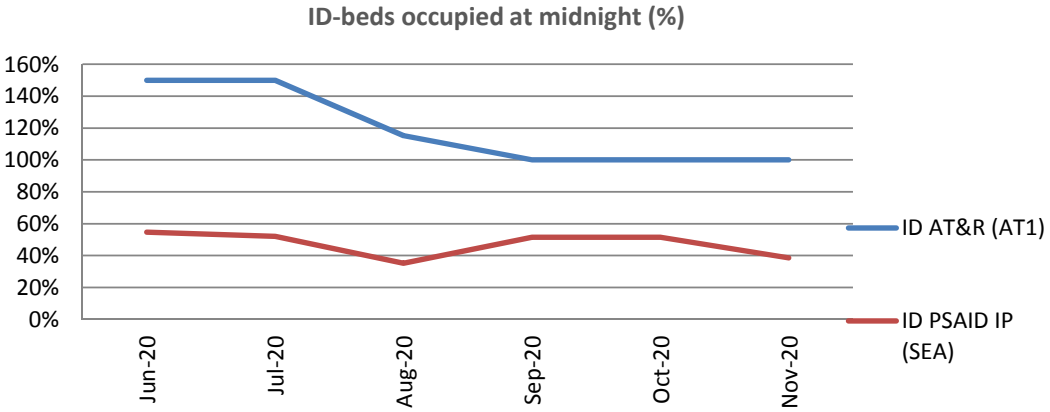
Recruitment to this area can be difficult given the specialist nature of the work and the limited exposure to this area in training programmes for nursing, medical and allied health staff. There are also perceptions related to assaults that have occurred in this working environment.

Whaikaha (AT&R) Occupancy[1]



[1] Reporting currently uses ATR (AT1) designation though this will be changed to Whaikaha once the building is operational.

Current occupancy for Whaikaha (AT&R) is based on full capacity of seven beds. However due to the recent decommissioning of beds as part of the Whaikaha build the actual number of available beds currently available is four. With consumers frequently needing to be transferred to from Whaikaha (AT&R) to PSAID IP the actual occupancy figure is 100% or above as shown below



Bed management

Supporting consumers in other areas often requires staff to be transferred from Whaikaha to work with them. When there are no staff available to transfer, consumers are supported by the staff in their destination who often do not have the level of experience and skills to manage the risks the consumers present with. Both scenarios impact on already limited resources.

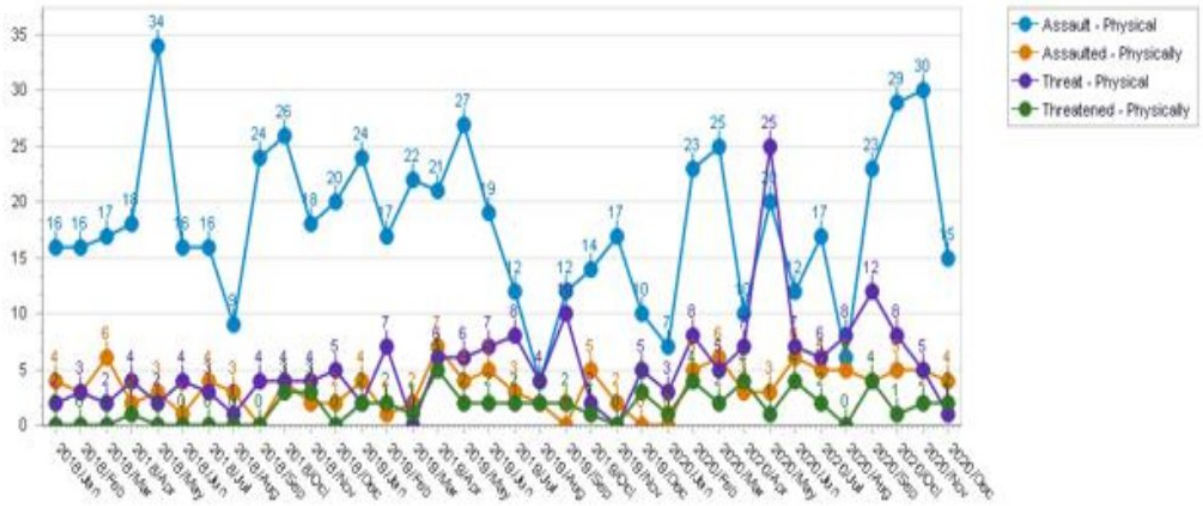
There are currently two consumers under the care of the Forensic Service (they are captured under Forensic occupancy stats, not Whaikaha) due to the high level of risk. These people are staffed by Forensic staff.

Gender safety is an ongoing concern due to the limited options to support people in separate areas, this is generally more of a risk in Whaikaha than in PSAID.

Incidents, environmental restraint and seclusion

Seclusion and environmental restraint are strategies to manage risk to both staff and consumers associated with behaviours. The risk of violence is present due to the unpredictable nature of some consumers. Treatment plans support management and de-escalation to reduce these risks. Fit for purpose facilities will support a safer environment.

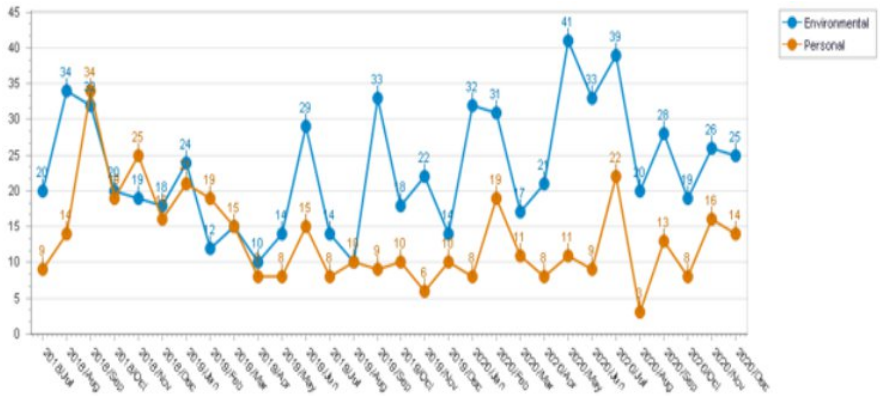
Intellectual Disability –Safety 1st forms for physical assaults/threats (includes staff and consumer)



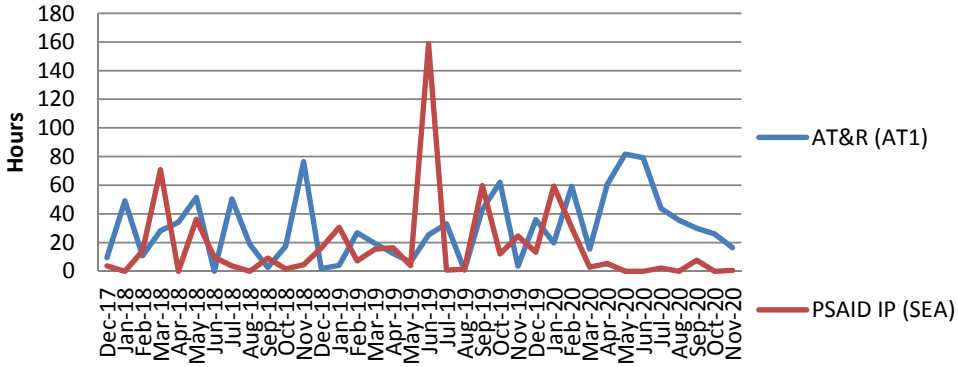
Whaikaha has been restructured to support the reduction of seclusion. Although seclusion may still be a required intervention to safely manage consumers with a high risk of violence. The service has developed protocols to support treatment plans that involve environmental restraint which isolates consumers to a living area while staff withdraw until it is safe to engage again. The current de-escalation and seclusion areas in both wards are often subjected to damage which results in them being unavailable for use while repairs are undertaken.

The poor physical environment can often contribute to incidents. Therefore the opening of the new wing will provide safer spaces for consumers and staff, which along with the use of positive behaviour support, should allow further reduction in the use of seclusion.

ID Service – restraint use



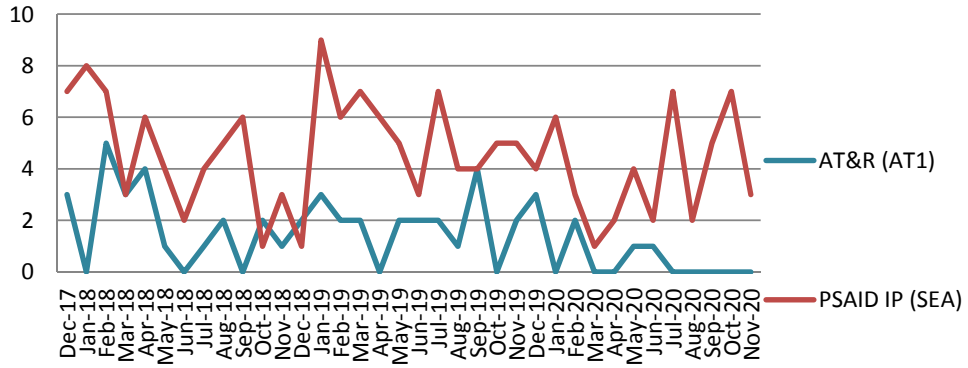
ID seclusion hours by team



Admissions and discharges

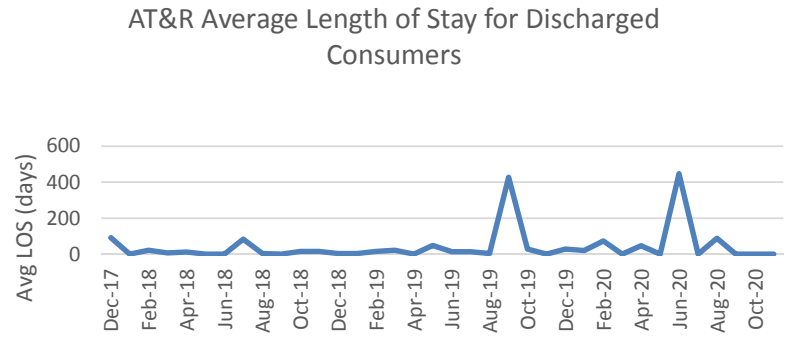
Both Whaikaha and PSAID have a relatively steady flow of admissions and discharges. There are some long stay consumers who have not been able to be discharged to the community. This is due to the limited resources in the NGO sector to safely support high risk consumers within their services. Both inpatient units are currently experiencing this barrier to discharge for several consumers.

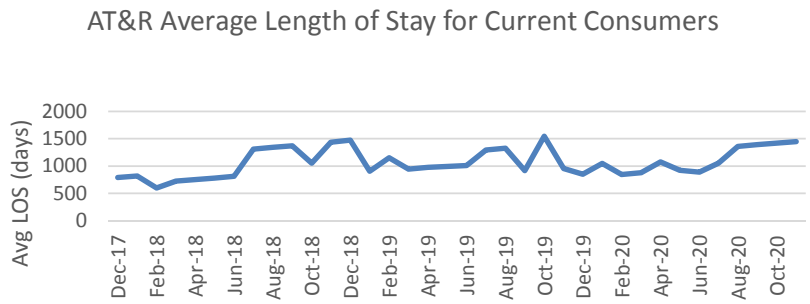
ID Admissions by ward

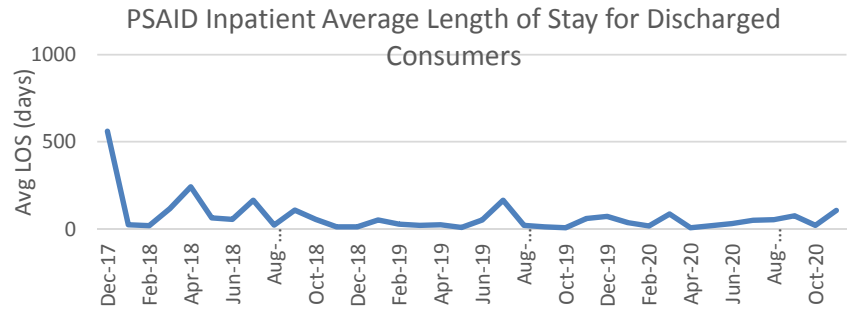


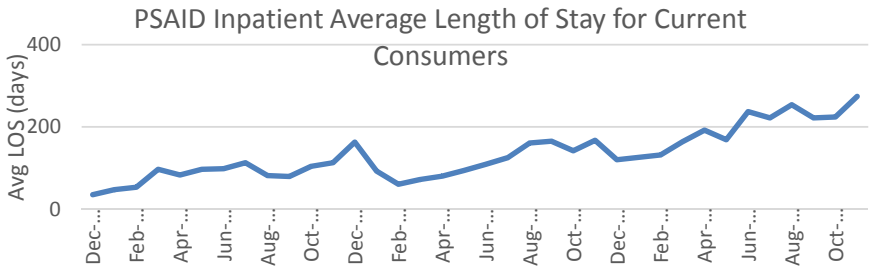
Length of stay

Availability of beds within the NGO sector can also impact on length of stay for consumers. This can be equally problematic in the mental health, disability and forensic sectors that provide community services for this group. The figure below shows the average length of stay, however this is an under-estimate due to some consumers having being inpatients for many years who have yet to be discharged (shown in the figures with Average Length of Stay for Current Consumers). Therefore the length of stay for discharged patients remains similar for both units but the length of stay increases for those who remain in the units.









Outpatient teams wait time

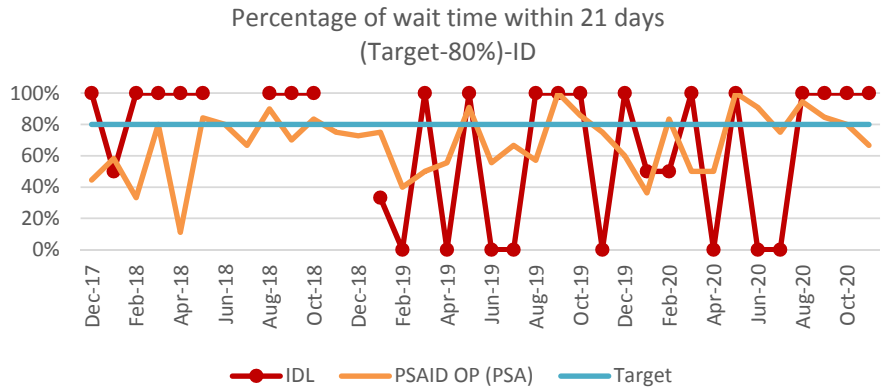
Both Intellectual Disability Liaison team and the PSAID Outpatients team are small in terms of FTE.

Intellectual Disability Liaison team

The Intellectual Disability Liaison team have a different referral process from other adult community teams. Referrals are sent externally through the Forensic Coordination Service and as such they do not have a wait list. Any delays in responding to referrals are due to logistical issues. Consumers referred to the Forensic Coordination Service may require specialist assessor reports before they are seen. Timeframes for completion of specialist assessor reports are impacted on by staff availability. The Team will attempt to arrange visits for local and out of district referrals with the specialist assessor when possible.

PSAID Outpatients

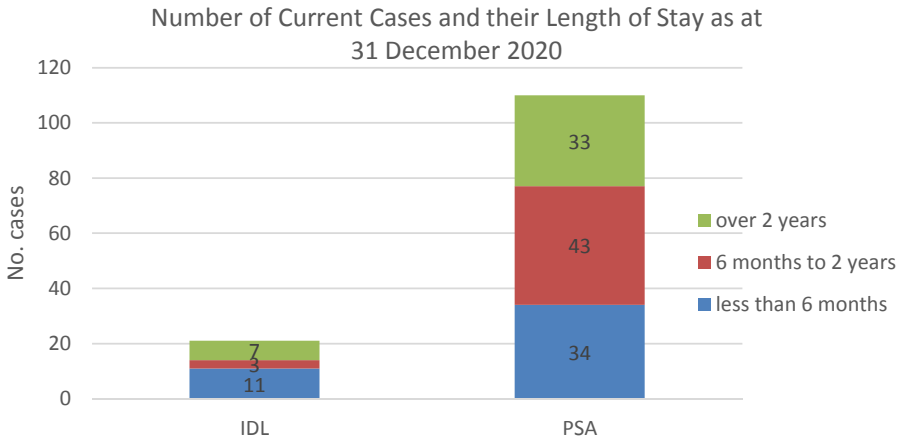
PSAID OP's often has an issue with staff availability to undertake the initial assessment, depending on who is the most appropriate person to see the consumer, i.e. consultant or one of the case managers. Wait time targets for the outpatient teams are shown below.



Case starts

A case 'starts' in the information system once any activity (e.g. assessment, phone call) is logged against a referral. Both teams have approximately 10 case starts per month. The PSAID team has approximately 200 face-to-face contacts per month and the IDL team conducts around 80.

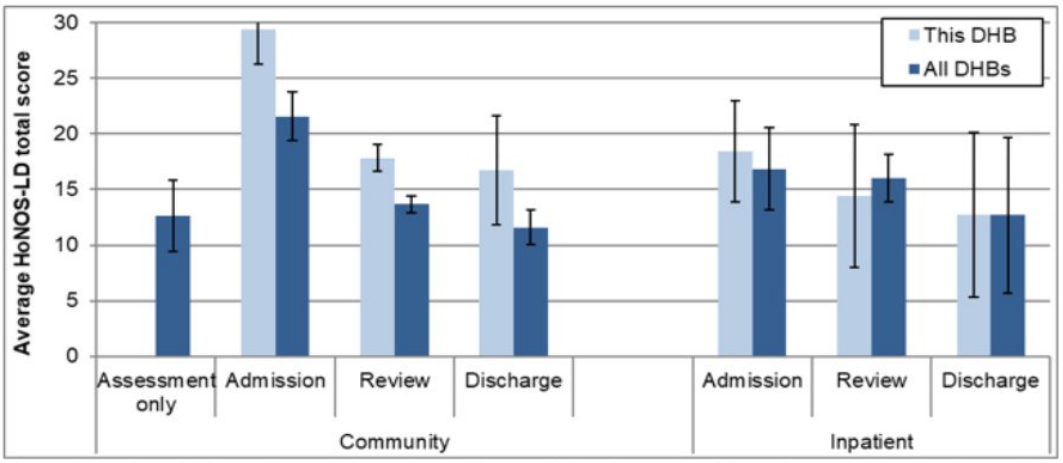
Number of current cases and length of stay



HoNOS-LD

HoNOS-LD measures the symptom severity and social functioning across time (in five domains: disability, behaviour, impairment, symptoms and social functioning). Compared with other DHBs Canterbury has similar severity for inpatients to other DHBs with some improvement over time and higher severity for outpatients than other DHBs with significant improvement by discharge.

Average HoNOS-LD total score (18 items) by collection type: Canterbury DHB, Jul 2019 – Jun 2020



Notes: Error bars indicate the confidence intervals around the data point. If error bars overlap, the data points are not significantly different. **Interpretation:** Decrease between admission and discharge is an indication of the outcomes achieved by the service user and service. The greater the decrease between admission and discharge, and the lower the average HoNOS-LD score at discharge, the more positive the outcome. **Target**: A greater decrease from admission to discharge and lower average rating at discharge.

Living within our means

Canterbury District Health Board

Statement of Financial Performance

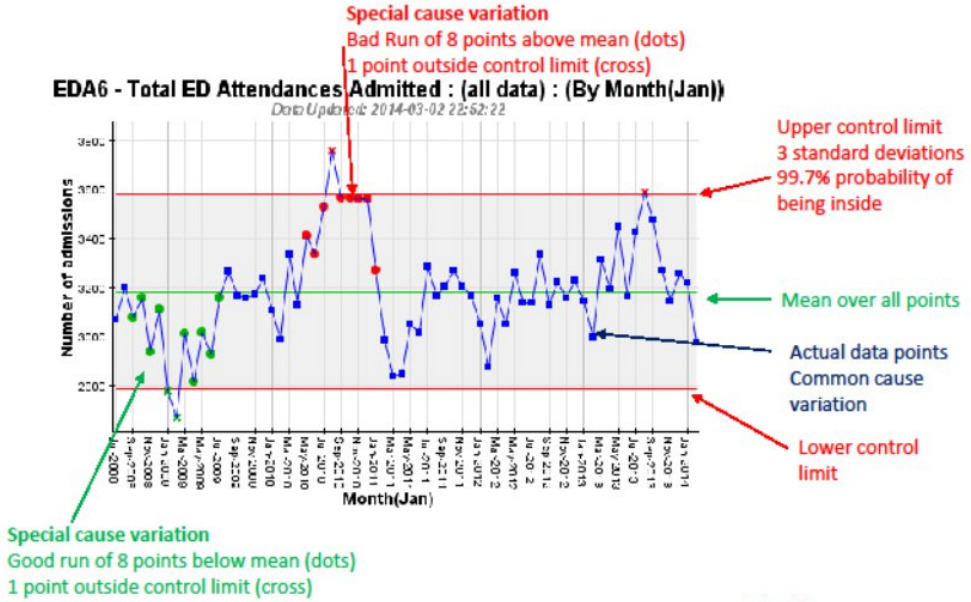
Hospital & Specialist Service Statement of Comprehensive Revenue and Expense For the 6 Months Ended 31 December 2020

MONTH $'000				YEAR TO DATE		
20/21 Actual $'000	20/21 Budget $'000	20/21 Variance $'000		20/21 Actual $'000	20/21 Budget $'000	20/21 Variance $'000
			Operating Revenue			
295	255	40	From Funder Arm	1,626	1,599	27
1,881	1,738	143	MOH Revenue	9,778	9,540	238
4,249	4,395	(146)	Patient Related Revenue	28,203	26,521	1,682
3,009	1,731	1,278	Other Revenue	17,632	10,262	7,370
9,434	8,119	1,315	**TOTAL OPERATING REVENUE**	57,239	47,922	9,317
			Operating Expenditure			
			Personnel Costs			
70,768	73,602	2,834	Personnel Costs - CDHB Staff	410,767	412,842	2,075
-	-	-	Personnel Costs - University of Otago	-	-	-
2,026	1,957	(69)	Personnel Costs - Bureau & Contractors	12,605	11,933	(672)
72,794	75,559	2,765	**Total Personnel Costs**	423,372	424,775	1,403
14,050	14,029	(21)	Treatment Related Costs	84,259	82,903	(1,356)
4,541	4,155	(386)	Non Treatment Related Costs	25,025	24,128	(897)
91,385	93,743	2,358	**TOTAL OPERATING EXPENDITURE**	532,656	531,806	(850)
(81,951)	**(85,624)**	**3,673**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(475,417)**	**(483,884)**	**8,467**
			Indirect Income			
48	1	47	Donations & Trust Funds	97	8	89
-	-	-	Gain on Disposal of Assets	-	-	-
48	**1**	**47**	**TOTAL INDIRECT INCOME**	**97**	**8**	**89**
			Indirect Expenses			
2,932	2,437	(495)	Depreciation	16,387	14,860	(1,527)
-	-	-	Loss on Disposal of Assets	330	-	(330)
2,932	**2,437**	**(495)**	**TOTAL INDIRECT EXPENSES**	**16,717**	**14,860**	**(1,857)**
(84,835)	**(88,060)**	**3,225**	**TOTAL SURPLUS / (DEFICIT)**	**(492,037)**	**(498,736)**	**6,699**

The CDHB Statement of Financial Performance covers the following Hospital Services:

Older Persons Health & Rehab
Women's & Children's Health
Mental Health
Medical & Surgical
Hospital Support & Labs
Facilities Management

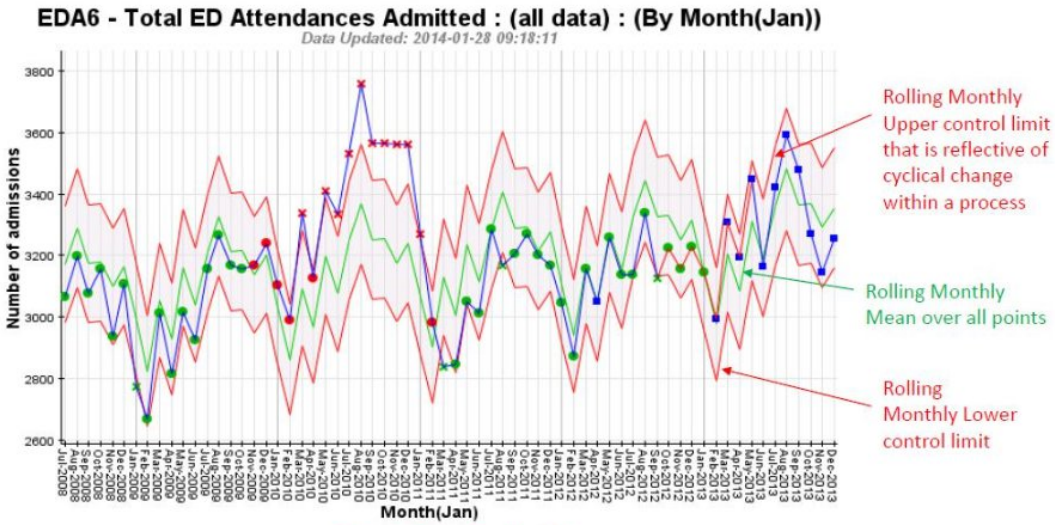
SPC: How to Interpret a Control Chart



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

CLINICAL ADVISOR UPDATE – NURSING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NOTES ONLY PAGE

SERVICES SUPPORTING OLDER PEOPLE LIVING IN RURAL COMMUNITIES

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

PREPARED BY: **Mardi Postill, Team Leader, Planning & Funding**

APPROVED BY: **Ralph La Salle, Acting Executive Director, Planning Funding & Decision Support**

DATE: **28 January 2021**

Report Status – For:	Decision	☐	Noting	☑	Information	☐

1. ORIGIN OF THE REPORT

This report was requested by the Committee late last year to better understand the initiatives/services in place currently and those that are planned to support our rural older population to remain in their own homes / communities and into the future.

2. RECOMMENDATION

That the Committee:

i. notes the report.

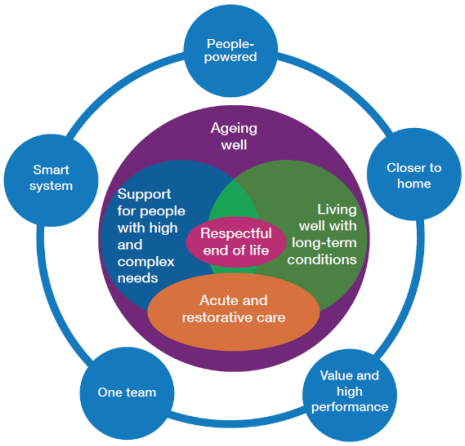
3. SUMMARY

A restorative approach to health care supports people to maximise their independence for as long as possible. It is a flexible approach to health care that respects the individual and supports them to obtain and maintain their highest level of function. This includes strengthening their ability to live independently and participate within their community, family and whānau for longer. It also includes strengthening their ability to recover quickly from injury or illness and contribute actively to decisions about their care. In Canterbury, we are using a restorative care framework to improve the patient journey in acute hospital care, rehabilitation and community-based care.

4. DISCUSSION

Background

The Canterbury health system follows the Ministry of Health (*MoH*) Healthy Ageing Strategy (2016). This strategy sets a framework whereby policies, funding, planning and service delivery enable older people to live well, age well and have a respectful end of life in age-friendly communities.



Rural Enablers of Health Ageing in Canterbury

a. General Practice

The general practice team is the centre of a person's health journey, particularly in our rural areas.

b. Home and Community Support (Access Home Health)

Home and Community Support Services are a key component of achieving the long-term vision of the Healthy Ageing Strategy[1] by supporting older people to live well, age well and have a respectful end of life in age-friendly communities.

The purpose of Home and Community Support Services is to provide restorative Client-centred, culturally appropriate support to older people that maintains or enhances the functional ability, health and social connectivity of older people living in the community. The activities of support provided by Providers include interRAI assessment and reassessment, service planning, resource allocation, service review, personal care and support, household management and case management to facilitate achievement of goal-based outcomes that are co-designed and owned by the Client.

c. Rural District Nursing

CDHB contracts with several local providers to ensure District Nursing can be provided in all rural areas of Canterbury. District Nurses provide nursing care to people in their own homes, allowing people with often quite complex conditions to remain living in their communities.

Rural District Nurses provide a range of supports including wound care, medication oversight, diabetes support and dialysis supervision, as well as supporting people with injuries or acute illness, and delivering palliative care at the end of life. They may source and provide equipment and may support individuals with case management to ensure other clinical and even social needs are met.

These services (which in an urban setting might be provided by a range of people) are delivered by local nurses with wide-ranging expertise (often employed through General Practice). Rural District Nursing is an essential element of equitable service delivery to those living rurally, ensuring even those who are located very remotely can receive nursing care.

d. Aged Residential Care (*ARC*) Facilities and Community Hospitals

There is a well-documented increase in people over the age of 85 requiring health care in rural communities. ARC facilities provide respite, transitional, hospital level and end of life care. A small number of ARC beds are provided within Rural hospitals.

Rural CDHB Community Hospitals

Campus	Transitional Beds	ARC Beds	Maternity *	TOTAL BEDS	Average Occupancy 70%
Darfield Hospital	5	4	2	11	8
Ellesmere Hospital	4	6		10	7
Oxford Hospital	7	8		15	11
Waikari Hospital	6	4		10	7
Totals	**22**	**22**	**2**	**46**	**32**

* changing to GP Flexi

[1] Ministry of Health. 2016. Healthy Ageing Strategy.

e. Community Activity Programmes

These programmes are provided in some rural areas (for example, Rangiora) for older people living at home, providing social integration and ensuring that carers can have some relief.

Additional community outreaches, such as Presbyterian Support's HomeShare programme, are also supported: this programme arranges for small groups of older people to spend the day at the home of an approved host.

Older people living rurally may also be allocated Carer Support, which supplements the cost of relief carers employed in the home to give main carers a break. CDHB Older Person's Health Team Clinical Assessors can work with families to ensure that appropriate services are allocated to support those looking after older people who are living at home in rural areas.

f. Service Accreditation

The aim of Service Accreditation is to enable a wider range of health professionals to identify and prescribe low cost, low risk and high-volume equipment for clients, thereby providing intervention sooner and allowing them to gain faster access to equipment which impacts on a person's daily functioning and safety. Service accreditation training has now been completed widely across our rural areas by our Falls Champions, Practice Nurses, District Nurses, and home and community support teams.

g. Falls Prevention

For those people with a falls risk, Sport Canterbury coordinates the availability of evidenced based strength and balance classes for those over 65 across the Canterbury region. This includes most rural areas. For those who cannot get to a community class, the CDHB funds in-home programmes (the Modified Otago Exercise Programme, usually provided by a local physiotherapist.)

h. Early Supported Discharge (in development)

In the urban areas of Canterbury our early supported discharge team is available to support people who have recently been in hospital or to prevent an admission to hospital. Throughout 2019 and 2020 we have worked to establish a similar response in the rural areas using the local general practice team and the district nursing service (as the coordinators of care) in collaboration with our home-based community service provider, and local allied health to deliver a 'wrap around' service, supporting the restoration of function and independence for people who have experienced a period of illness or a hospital stay.

This approach is about to be formally trialled in the Hurunui area, expanding into Oxford and other rural communities.

We will trial a process that will provide a care package that will be responsive to patient needs and goals, and that will enable patients to maintain independent living at home or be discharged to home after a hospital event to continue with their rehabilitation. When implemented, this service will reduce the patient's need for home support and increase their function and independence at home, over time. The use of Acute and Personalised Care Plans will be part of this integrated approach.

Service Summary Table

Region	ARC incl respite	Transitional care	EOL	HCSS	DN	Service Accreditation	Early Supported Discharge	Falls Prevention
Banks Peninsula	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Hurunui	Yes	Yes	Yes	Yes	Yes	Yes	Trial	Yes
Oxford	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Waimakariri	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kaikoura	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Ashburton	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Selwyn	Yes	Yes	Yes	Yes	Yes	Yes	On request	Yes

Risks / Challenges to Service Provision in Rural Canterbury

a. Workforce

Filling vacancies is a significant issue across all our services in rural areas.

The healthcare staff required to meet minimum staffing requirements across the four community hospital locations is 34 FTE for an average of 32 patients, with a further 4 FTE support staff. This workforce is also ageing with 14/30 (47%) of the permanent registered nurse workforce over the age of 60.

b. Ageing Population

There is a well-documented increase in people over the age of 85 requiring health care in rural communities. This presents a challenge in terms of the provision of Aged Residential Care, and in terms of supporting people to continue living in the community.

c. Dementia Care

The demand for dementia care across New Zealand is growing exponentially. Care for people with advanced dementia cannot be delivered safely in the community or in standard ARC facilities. Specialised ARC facilities with appropriate staffing models are required to care for this cohort of patients – currently many people requiring this kind of care are forced to move away from their rural area and familiar community.

d. Community Models of Care

A growing number of people with complex care needs are electing to stay in their homes until they die rather than enter an Aged Residential Care facility. How we respond to this need with the limited (and ageing) workforce and our ongoing recruitment issues remains a challenge.

5. CONCLUSION

While we have a number of core services in place to meet the needs of our ageing rural population, we need to continue to invest (and to refocus current investment) into further local community-based initiatives to enable our population to age in place with supports to meet their increasing complex needs. This is a question of equity for our ageing rural population, most of whom, as in more urban locations, wish to continue living in their own homes as long as possible.

WORKPLAN FOR HAC 2021 *(WORKING DOCUMENT)*

9am start	28 Jan 21	01 Apr 21	03 Jun 21	05 Aug 21	07 Oct 21	02 Dec 21
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 Services Supporting Older People Living in Rural Communities	Clinical Advisor Update – Allied Health 2021 Winter Planning Update	Clinical Advisor Update – Medical Care Capacity Demand Management Update	Clinical Advisor Update – Nursing H&SS 2020/21 Year Results	Clinical Advisor Update – Allied Health	Clinical Advisor Update – Medical Care Capacity Demand Management Update 2021 Winter Plan Outcomes
Presentations						
Governance & Secretariat Issues	2021 Workplan					
Information Items		2021 Workplan	Quality & Patient Safety Indicators - Level of Complaints 2021 Workplan	2021 Workplan	2022 Meeting Schedule 2021 Workplan	Quality & Patient Safety Indicators - Level of Complaints 2021 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)

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

TO: **Chair & Members, Hospital Advisory Committee**

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

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

DATE: **28 January 2021**

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 3 December 2020	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege.	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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"