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, 4 April 2019 commencing at 9:00am

	Apologies		9.00am
1.	Conflict of Interest Register		
2.	Confirmation of Minutes – 31 January 2019		
3.	Carried Forward / Action List Items		
4.	Older Persons Health & Rehabilitation - Presentation	Sally Nicholas	9.05-9.45am
5.	Avoidable Admissions in General Surgery - Presentation	Kathy Davenport	9.45-10.00am
6.	Hospital Service Monitoring Report: Older Persons, Orthopaedics & Rehabilitation Mental Health Hospital Laboratories Rural Health Services Medical/Surgical & Women's & Children's Health ESPIs	 Sally Nicholas Toni Gutschlag Kirsten Beynon Berni Marra Win McDonald Pauline Clark	10.00-10.40am
7.	Clinical Advisor Update (Oral) • Nursing	Mary Gordon	10.40-10.50am
8.	Resolution to Exclude the Public		10.50am
ESTIMATED FINISH TIME – PUBLIC MEETING			**10.50am**
	Information Items: 2019 Workplan		

NEXT MEETING: Thursday, 30 May 2019 at 9.00am

ATTENDANCE – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

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

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

COMMITTEE MEMBER ATTENDANCE SCHEDULE 2019 – PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

NAME	31/01/19	04/04/19	30/05/19	01/08/19	03/10/19	05/12/19
Andrew Dickerson (Chair)	√					
Jo Kane (Deputy Chair)	√					
Barry Bragg	#					
Sally Buck	√					
Dr Anna Crighton	√					
David Morrell	√					
Jan Edwards	√					
Dr Rochelle Phipps	√					
Trevor Read	√					
Dr John Wood (ex-officio)	√					
Ta Mark Solomon (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.
Jo Kane **Deputy Chair – HAC** Board Member	**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.
Barry Bragg Board Member	**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. **CRL Energy Limited** – Managing Director CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.

	Farrell Construction Limited - Chairman Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. **New Zealand Flying Doctor Service Trust** – Chairman The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB. **Ngai Tahu Property Limited** – Chairman Potential for future property development work with the CDHB. Also, Ngai Tahu Property Limited manage first right of refusal applications from the CDHB on behalf of Te Runanga o Ngai Tahu.
Sally Buck Board Member	**Christchurch City Council (*CCC*)** – Community Board Member Chair of the Central/Linwood/Heathcote Community Board which has delegated responsibilities from the CCC. **Registered Resource Management Act Commissioner** From time to time, sit on Resource Management Act panels for the CCC. Specific interests will be declared at the time. **Rose Historic Chapel Trust** – Member Charitable voluntary body managing the operation of the Rose Historic Chapel, a CCC owned facility.
Dr Anna Crighton Board Member	**Christchurch Heritage Limited** - Chair - Governance of Christchurch Heritage **Christchurch Heritage Trust** – Chair - Governance of Christchurch Heritage **Heritage New Zealand –** Honorary Life Member CDHB owns buildings that may be considered to have historical significance.
Jan Edwards	No conflicts at this time.
David Morrell Board Member	**British Honorary Consul** Interest relates to supporting British nationals and relatives who may be hospitalised arising from injury related accidents, or use other services of CDHB, including Mental Health Services. A conflict of interest may also arise from time to time in respect to Coroners' inquest hearings involving British nationals. In addition, the British Foreign and Commonwealth Office (*FCO*) may expect Honorary Consuls to become involved in trade initiatives from time to time. **Canon Emeritus - Christchurch Cathedral** The Cathedral congregation runs a food programme in association with CDHB staff. **Friends of the Chapel** - Member **Great Christchurch Buildings Trust** – Trustee The Trust seeks the restoration of key Christchurch heritage buildings, particularly Christchurch Cathedral, and is also involved in facilitating the building of social housing. **Heritage NZ –** Subscribing Member Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the 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 heritage significance. **Hospital Lady Visitors Association** - Wife is a member of this, but no potential conflict of interest is expected. Should one arise it will be declared at the time. **Nurses Memorial Chapel Trust** – Member (CDHB Appointee) Trust responsible for Memorial Chapel on the Christchurch Hospital site. Note the chapel is now owned by the Christchurch City Council.
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.
Trevor Read	**Lightfoot Solutions Ltd** – Global Director of Clinical Services Lightfoot Solutions has contracts with CDHB, and other health providers who have contracts with CDHB, to provide business intelligence tools and related consulting services. Should a conflict arise, this will be discussed at the time.
Ta Mark Solomon **Ex Officio – HAC** Deputy Chair CDHB	**Claims Resolution Consultation – Senior Maori Leaders Group** – Member This is an Advisory Board to MSD looking at the claims process of those held under State care. **Deep South NSC (National Science Challenge) Governance Board** – Member The objective of Deep South NSC is set by Cabinet, and is to understand the role of the Antarctic and Southern Ocean in determining our climate and our future environment. Building on this objective, the mission was developed to guide our vision, research priorities and activities. **Greater Christchurch Partnership Group** – Member This is a central partnership set up to coordinate our city's approach to key issues. It provides a strong, joined up way of working and ensures agencies are travelling in the same direction (so they do not duplicate or negate each other's work). **He Toki ki te Rika / ki te Mahi** – Patron He Toki ki te Rika is the next evolution of Māori Trade Training re-established after the earthquakes to ensure Maori people can play a distinguished role in the Canterbury rebuild. The scheme aims to grow the next generation of Māori

	leadership in trades by building Māori capability in the building and infrastructure industries in Canterbury. **Liquid Media Operations Limited** – Shareholder Liquid Media is a start-up company which has a water/sewage treatment technology. **Maori Carbon Foundation Limited** – Chairman The Maori Carbon Foundation has been established to deliver environmental, social and economic benefits through the planting of permanent carbon forestry, to Maori and New Zealand landowners throughout the country. **Ngāti Ruanui Holdings** – Director Ngati Ruanui Holdings is the Investment and Economic Development Arm of Ngati Ruanui established to maximise profits in accordance with Te Runanga directions in Taranaki. **NZCF Carbon Planting Advisory Limited** – Director NZCF Carbon Planting Advisory Limited is a company that carries out the obligations in respect of planting and upskilling relating to the Maori Carbon Foundation Limited. **Oaro M Incorporation** – Member 'Oaro M' Incorporation was established in 1968. Over the past 46 years successive Boards have managed and maintained the whenua, located at 'Oaro M', Kaikōura, on behalf of its shareholders. Over time shareholders have requested the Board consider establishing an education grant in order to assist whānau with their educational aspirations. **Police Commissioners Māori Focus Forum** – Member The Commissioner of Police has a group of senior kaumatua and kuia who meet with him regularly to discuss issues of mutual interest and concern. Known as the Commissioner's Māori Focus Forum, the group helps guide policing strategy in regard to Māori and provides advice on issues of the moment. The Māori Focus Forum developed The Turning of the Tide with help from Police. The forum plays a governance role and helps oversee the strategy's implementation. **Pure Advantage** – Trustee Pure Advantage is comprised of business leaders who believe the private sector has an important role to play in creating a greener, wealthier New Zealand. It is a not-for-profit organisation that investigates and promotes opportunities for green growth. **QuakeCoRE** – Board Member QuakeCoRE is transforming the earthquake resilience of communities and societies through innovative world-class research, human capability development, and deep national and international collaborations. They are a Centre of Research Excellence (CoRE) funded by the New Zealand Tertiary Education Commission. **Rangitane Holdings Limited & Rangitane Investments Limited** - Chair/Director The Rangitāne Group has these two commercial entities which serve to develop the commercial potential of Rangitāne's settlement assets. A Board of Directors oversee the governance of the commercial entities, and are responsible for managing Crown lease properties and exploring commercial development opportunities to support the delivery of benefits to Rangitāne members.

	SEED NZ Charitable Trust – Chair and Trustee SEED is a company that works with community groups developing strategic plans. **Sustainable Seas NSC (National Science Challenge) Governance Board** – Member This is an independent Board that reports to the NIWA Board and operates under the Terms and Conditions specified in the Challenge Collaborative Agreement. The Board is responsible for appointing the Director, Science Leadership Team, Kāhui Māori, and Stakeholder Panel for projects within the Sustainable Seas NSC. The Board is also responsible for approving projects within the Research and Business Plan and for allocating funding. **Te Ohu Kai Moana** – Director Te Ohu Kai Moana is an organisation that works to advance Maori interests in the marine environment, including customary commercial fisheries, aquaculture and providing policy and fisheries management advice and recommendations to iwi and the wider Maori community. **Te Waka o Maui** – Independent Representative Te Waka o Maui is a Post Settlement Governance Entity. **Interim Te Ropu** – Member An Interim Ropu has been established to work in partnership with the Crown, Ministers, and the joint venture to help develop and shape initial work on a national strategy to prevent and reduce family violence, sexual violence and violence within whānau. The interim Te Rōpū has been appointed by the Minister of Māori Development and the Lead Minister in consultation with the Minister of Māori/Crown Relations. It comprises up to ten members who bring appropriate skills and expertise and who can reflect communities, rangatahi and whānau, urban and regional Māori and wāhine Māori. The group will help inform the terms of reference of the permanent Te Rōpū, with advice due by April 2019.
Dr John Wood **Ex Officio – HAC** Chair CDHB	**Advisory Board NZ/US Council** – Member The New Zealand United States Council was established in 2001. It is a non-partisan organisation, funded by business and the Government, and committed to fostering and developing a strong and mutually beneficial relationship between New Zealand and the United States. The Advisory Board supports the day to day work of the Council by providing strategic and operational advice to both the Executive Board and the Executive Director. **Te Arawhiti, Office for Maori Crown Relations Governing Board, Ministry of Justice** – Ex-Officio Member Te Arawhiti, Ministry of Justice, are responsible for negotiating the settlement of historical Treaty of Waitangi claims, and the administration of the Marine and Coastal Area (Takutai Moana) Act 2011. They also advise and help claimant groups so they are ready to enter negotiations. **Chief Crown Treaty Negotiator for Ngai Tuhoe** Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Treaty Negotiator for Ngati Rangi** Settlement negotiated. Deed signed and ratified. Legislation awaiting enactment. **Chief Crown Treaty Negotiator, Tongariro National Park** Engagement with Iwi collective begins July 2018.

	Chief Crown Treaty Negotiator for the Whanganui River Settlement negotiated. Deed signed and ratified. Legislation enacted. **Chief Crown Negotiator & Advisor, Mt Egmont National Park Negotiations** High level agreement in principle reached. Aiming for deed of settlement end of 2018. **School of Social and Political Sciences, University of Canterbury** – Adjunct Professor Teach into graduate and post graduate programmes in political science, trade policy and diplomacy – pro bono appointment. **Te Urewera Governance Board** –Member The Te Urewera Act replaces the Te Urewera National Parks Act for the governance and management of Te Urewera. The purpose of the Act is to establish and preserve in perpetuity a legal identity and protected status for Te Urewera for its intrinsic worth, its distinctive natural and cultural values, the integrity of those values, and for its national importance. Inaugural term as a Crown appointment, re-appointed as a Ngai Tuhoe nominee. **University of Canterbury (*UC*) Council** – Council Member The University Council is responsible for the governance of UC and the appointment of the Vice-Chancellor. It sets UC's policies and approves degree, financial and capital matters, and monitors their implementation.

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, 31 January 2019, commencing at 9.00am

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

APOLOGIES
Apologies for absence were received and accepted from Barry Bragg and Ta Mark Solomon.

EXECUTIVE SUPPORT
Dr Greg Hamilton (Team Leader, Intelligence & Transformation, Planning & Funding); Becky Hickmott (Nurse Manager, Nursing Workforce Development); Jacqui Lunday-Johnstone (Executive Director of Allied Health, Scientific & Technical); Dr Sue Nightingale (Chief Medical Officer); Stella Ward (Chief Digital Officer); Anna Craw (Board Secretariat); Charlotte Evers (Assistant Board Secretariat); and Kay Jenkins (Executive Assistant, Governance Support).

IN ATTENDANCE

Item 4
Paul Tudor Kelly, Laboratory Manager, Sleep Services
Robin Rutter-Baumann, Service Manager
Michael Hlavac, Respiratory Physician
David Smyth, Chief of Medicine

Item 5
Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health
Dan Coward, General Manager, Older Persons, Orthopaedics & Rehabilitation Service, Burwood Hospital
Barbara Wilson, Quality Manager, Specialist Mental Health Services (*SMHS*)
Win McDonald, Transition Programme Manager, Rural Health Services

1. INTEREST REGISTER

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

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

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

2. CONFIRMATION OF PREVIOUS MEETING MINUTES

Resolution (01/19)
(Moved: Jo Kane/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 29 November 2018 be approved and adopted as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

The Committee noted the carried forward items.

4. SLEEP HEALTH SERVICES IN CANTERBURY (PRESENTATION)

Pauline Clark, General Manager, Medical/Surgical & Women's & Children's Health, introduced Paul Tudor Kelly, Laboratory Manager, Sleep Services; Robin Rutter-Baumann, Service Manager; Michael Hlavac, Respiratory Physician; and David Smyth, Chief of Medicine; who provided a presentation on Sleep Health Services in Canterbury. The presentation highlighted the following:

- the importance of good sleep;
- the prevalence of sleep disorders;
- the associated costs of poor sleep;
- what the sleep team does (diagnostic, treatment, long term care, and education); and
- current and future projects.

There was discussion around the correlation between alcohol / drug intake and sleep apnoea, as well as the association between sleep apnoea and depression.

There was discussion around an increasing group of non-complex patients, and the potential to reverse the condition as opposed to treat the symptoms. It was acknowledged that sleep apnoea is reversible in many cases when there is a reduction in body mass. The need for adjunct therapies was acknowledged.

Education was stressed, with it noted that this will be a focus for the Service over the next couple of years.

Jan Edwards congratulated the team for its passion and commitment, noting that successes were now being seen as a result of a number of initiatives implemented to improve the Service.

The Chair thanked those in attendance for the informative presentation.

5. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for January 2019. The report was taken as read.

General Managers spoke to their areas as follows:

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

- The Safe Recovery Program has been extended through to the end of November 2019. The goal of this evidence based intervention program is to reduce the rate of patient falls during rehabilitation and their subsequent injuries.
- An audit by the Ombudsman's Office of Older Persons Teams has led to changes in nurse practices and a reduction in restraint usage.
- Increased acute orthopaedic volumes over the December / January period, directly impacted on elective volumes.
- Spinal build is progressing well. Framing is up and work is underway on the roof.

There was discussion around the beneficial use of volunteers (eg, retired nursing volunteers), as evidenced in the Safe Recovery Program. It was acknowledged that such volunteers make a difference and were seen as an untapped resource.

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

- Christmas / New Year was a demanding period.
- Increased use of texting (eg. "text to remind" service for outpatient appointments). Educating the public on the importance and growing use of NHI numbers in communication.
- RDA industrial action. Second round of strikes now complete. Whilst the system has managed, this has been a demanding period requiring a lot of planning on the part of a lot of people. It was noted that a number of RMOs worked through the strikes.
- Notice of industrial action from the Midwifery Employee Representation and Advisory Service (*MERAS*) has been received. There will be period in February where both midwives and RMOs will be striking.

There was a query around the drivers behind the increased demand over the Christmas period. It was noted that this was not due to a lack of visibility or understanding of the hospital flow. Increases had been planned for, however, the actual increase in demand was bigger than expected. Not only was there a step change in what was being seen in presentation numbers, there was also increased complexity in the presentations.

ESPIs

The Committee agreed to defer an update on ESPIs until its next meeting.

Specialist Mental Health Services (*SMHS*) – Barbara Wilson, Quality Manager

- A workplan for Worksafe engagement in 2019 is in place.
- Two new policies are in place with regards to requesting assistance from, and reporting matters to, the Police.
- Increased security on the Hillmorton Campus has received positive feedback.
- Associate charge nurse managers have been introduced into afterhour leadership roles.

Rural Health Services – Win McDonald, Transition Programme Manager

- Akaroa – construction of the Health Hub is progressing. Staff transition process is currently being worked through.
- Kaikoura - Steering Group has been established for Kaikoura Health. A Clinical Governance Group has also been established.
- Oxford – work is progressing on the model of care, with a report anticipated to go to the Board's meeting on 21 February 2019.
- Waikari – work continues on strengthening telehealth capability.
- Chathams – GP contracts are in place through to January 2021. Registered nurse positions are being reviewed to reduce the risk of issues around overtime and / or no cover.
- Ellesmere / Darfield – experiencing increased levels of "end-of-life" patients. Palliative support levels have been increased accordingly.

There was discussion around the consultation process with regards to the Hurunui Model of Care.

There was a query around the relocation of the old Outpatients building to Rangiora Hospital, and when the facility would become operational. It was noted that the relocation has taken place. An update is to be provided to the next meeting on the building's operationalisation on the Rangiora site.

There was a query about the upward trend of acute presentations to the Acute Assessment Unit in Ashburton and whether this was seen as sustainable. The Committee was advised that the growing trend was concerning and a strategic piece of work is underway. It was noted that continuing close alliances between ED, Burwood and Ashburton will be critical, with telehealth to play an essential role.

Resolution (02/19)
(Moved: David Morrell/Seconded: Sally Buck – carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

6. CLINICAL ADVISOR UPDATES (ORAL) – NURSING AND ALLIED HEALTH

Nursing
Becky Hickmott, Nurse Manager, Nursing Workforce Development Team, presented a nursing update advising that work is underway to fill the agreed number of nursing, midwifery and hospital aide positions as per the MECA settlement.

There was discussion on Canterbury being a leader in hiring local nurse graduates, and that Ara is meeting the demand as well as working on future demand. It was noted that this strong relationship with the education providers is not the case in many other parts of the country. There was further discussion around an international shortage of nurses and the potential impact this may have on NZ's nursing workforce, especially where offshore positions are offering salaries which are unsustainable for NZ to match. This is concerning.

It was noted that the official opening of Manawa health research and education facility, as well as the Christchurch Outpatients building, will take place this afternoon.

Allied Health
Jacqui Lunday-Johnstone, Executive Director, Allied Health, Scientific & Technical, advised that she has been spending time familiarising herself with the substantial allied health professions across the DHB, getting an understanding of their totality and the fantastic pool of talent across the organisation. Ms Lunday-Johnstone highlighted the following:

- Ongoing work in the area of professional development.
- A visit from the Northern Health Team, Victoria. CDHB shared its learnings on integrative health.
- Focus on increasing connectivity between hospital and community pharmacists, in order to optimise pathways.
- Work continues with community colleagues to prevent hospital admissions, by challenging people to live well through a holistic approach.

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (03/19)
(Moved: David Morrell/Seconded: Trevor Read – carried)

"That the Committee:

i resolves that the public be excluded from the following part of the proceedings of this meeting, namely items 1 and 2;

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 4 October 2018.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

- 2019 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 10.35am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson
Chairperson

Date of approval

CARRIED FORWARD/ACTION ITEMS

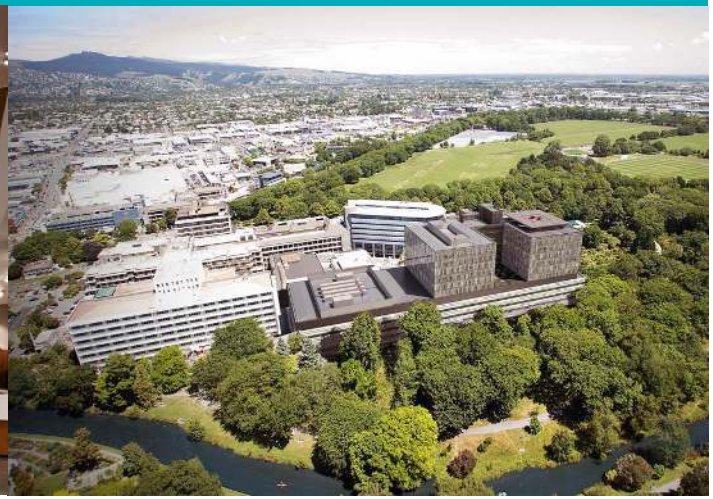
Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 4 APRIL 2019

DATE		ISSUE / ACTION	REFERRED TO	STATUS
1.	31 Jan 2019	Rangiora Hospital – update on relocation of Old Outpatients building	Mary Gordon	Verbal Update
2.	21 Feb 2019 (Board)	Detail around ambulatory model for people requiring acute general surgery care	Pauline Clark	Today's agenda – Item 5

Older Persons Health and Rehabilitation (OPH&R)

Supporting the Frail Older Persons Pathway across Christchurch, Burwood and Community

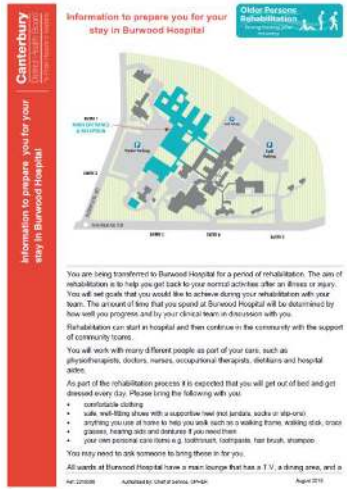


Introduction

- Names and roles
  - Helen Skinner, Chief of Service, OPH&R
  - Sarah Hurring, Clinical Director, Older Persons Health Inpatient
  - Sally Nicholas, Operations Manager, OPH&R
  - Diana Gunn, Director of Nursing, OPH&R
  - Claire Pennington, Director of Allied Health, OPH&R
  - Jo Lilley, Quality Manager, OPH&R
  - Pip Hyde, Clinical Nurse Specialist, Older Persons Health
- Team approach within OPH&R
- Work in and across Christchurch, Burwood, Community
  - 3 Senior Medical Officers and Clinical Nurse Specialist working in Christchurch Hospital
- Quality integrated with clinical areas

Clinical Nurse Specialist Liaison, Older Persons Health

- Role description: managing a virtual ward, coordinating transfers to Burwood, facilitating discharges, liaising with community teams, working closely with ward Interdisciplinary Team (IDT), supporting restorative care approach, residential care assessments, providing education for patients and their whanau and staff
- Pilot started in July 2017 and the role became permanent in April 2018
- Embedded across General Medicine and Medical Specialties


Canterbury

Information to prepare you for your stay in Burwood Hospital

Older Persons Rehabilitation

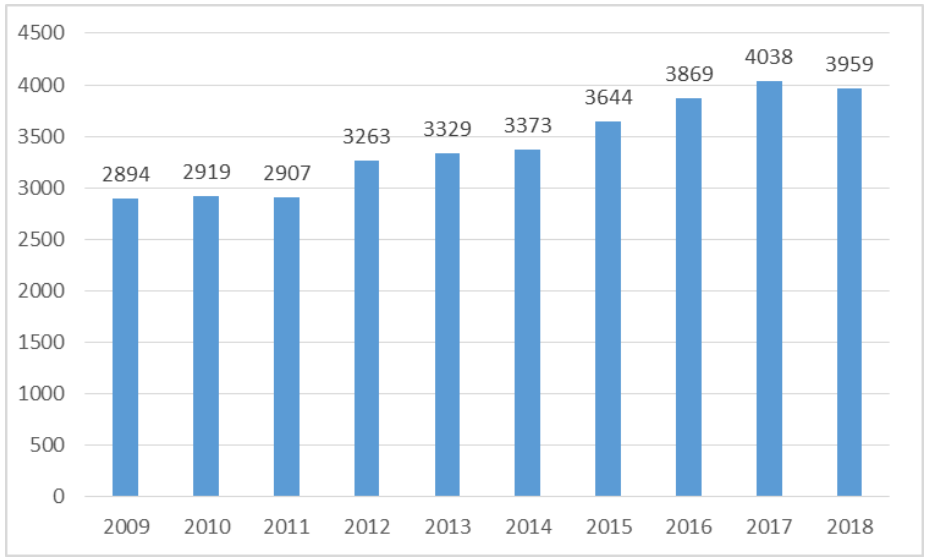
Information to prepare you for your stay in Burwood Hospital

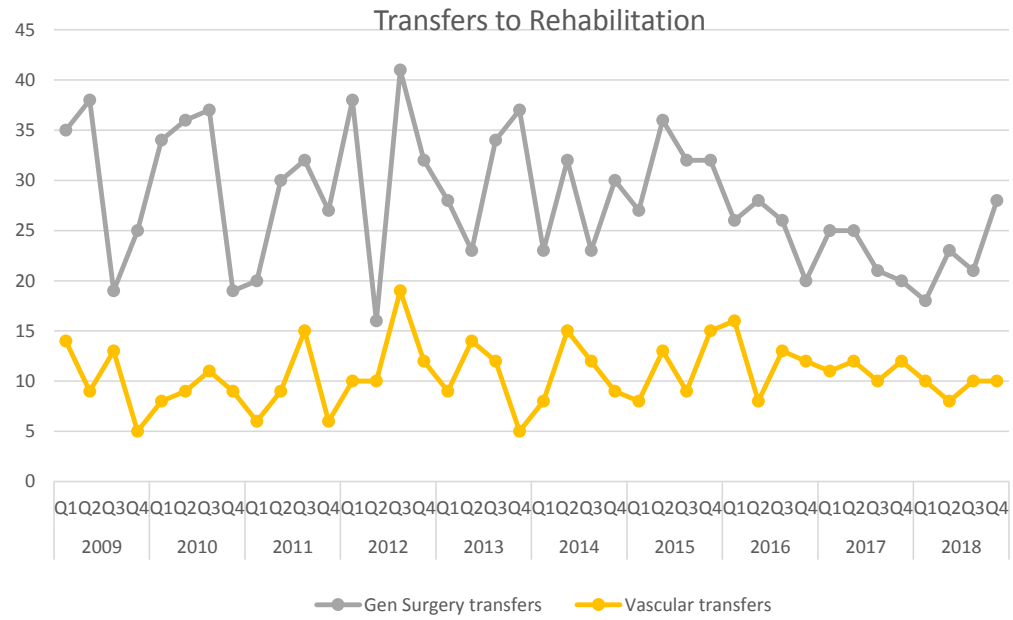
Clinical Nurse Specialist Liaison, Older Persons Health

- 1868 patients reviewed since the role began
- Summer: 20 -30 patients seen each week; Winter: 30 – 50 patients
- On average 10 – 15 patients under review at any one time
- Over 80% of General Medicine and associated speciality consults seen by Clinical Nurse Specialist Liaison
- Average length of time on waitlist: 2.00 days and length of time for General Medicine referrals to be seen is 0.76 days (August 2017 – October 2018)
- General Medicine and medical speciality referrals: 65% went to Burwood, 20% had an alternative plan made and 12% received a residential care assessment and sign off
- Only signing off 50% of the patients that the referral specifically asks for residential care sign off.

Surgical Medicine – Older People Under Surgery (OPUS)

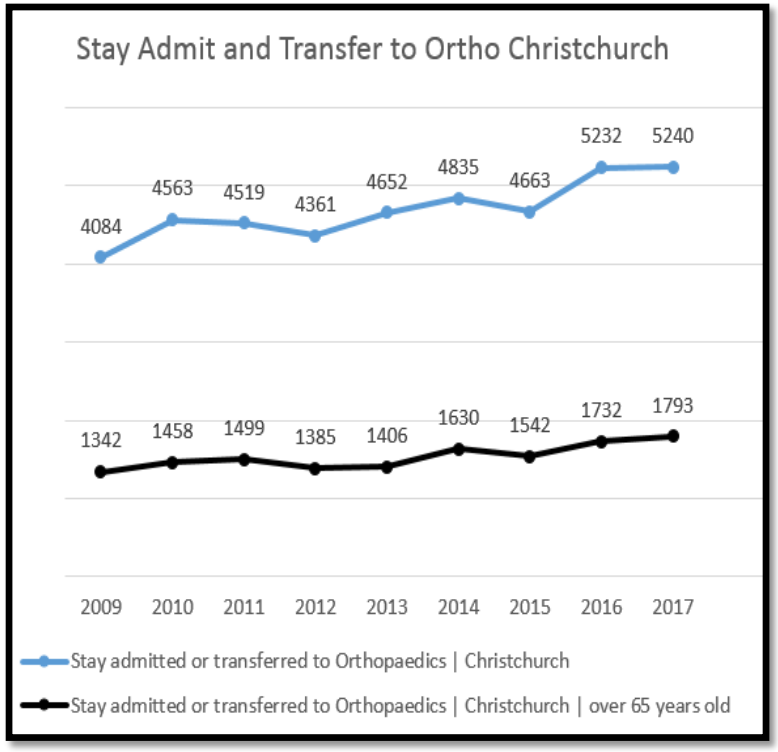
65 years old and over: General and Vascular Surgery

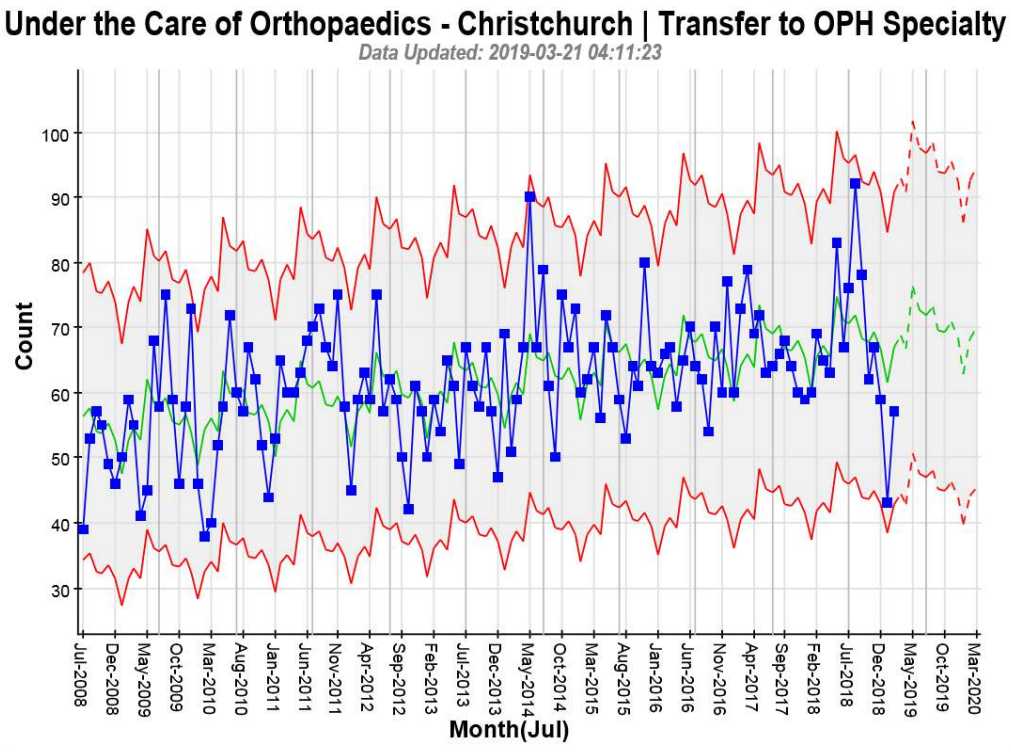




2018 - 37% of Surgical admissions >65 years
Older People Under Surgery (OPUS) reviewed 500 patients

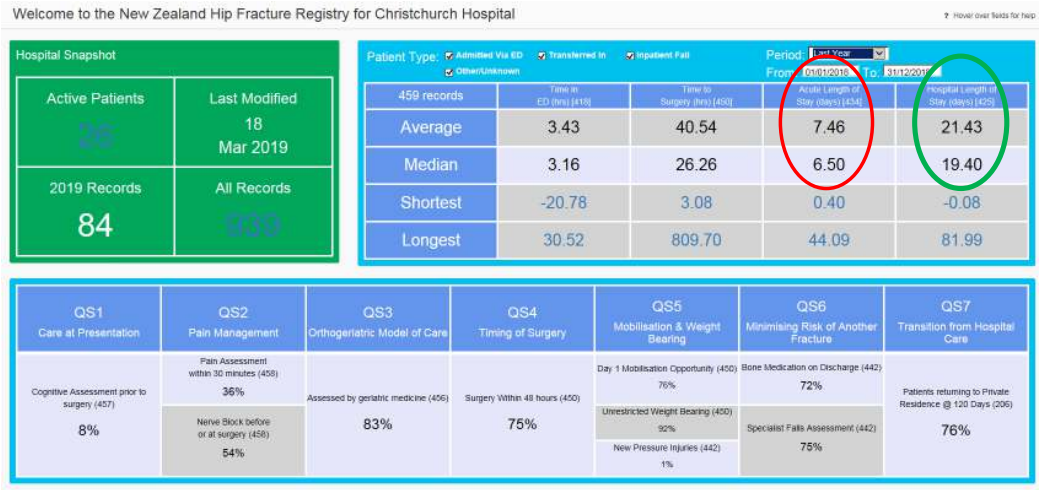
Orthopaedic Medicine



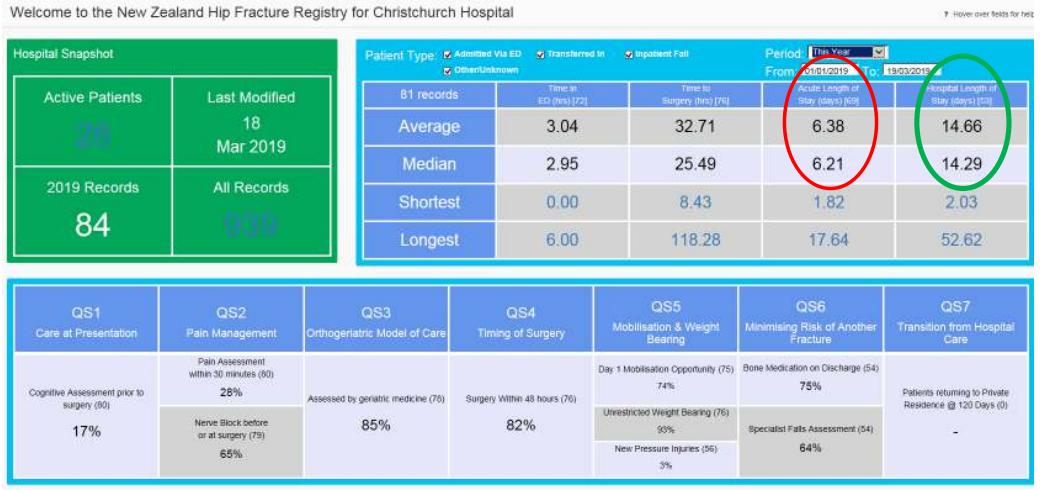


Fractured Neck of Femur (NOF) Pathway

- Fast track NOF pathway – reduced overall length of stay (LOS) by 4 days
- Australia & New Zealand Hip Fracture Registry (ANZHFR) – real time data



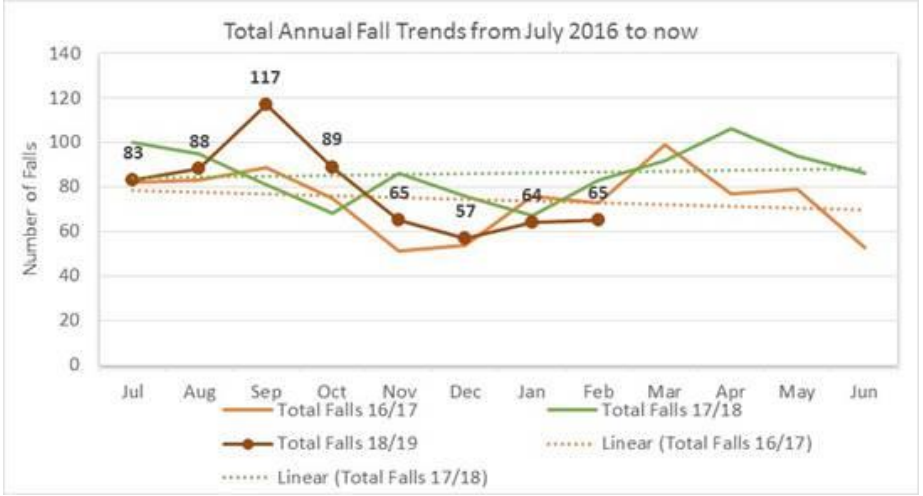
2018



2019

Quality Improvement

- “It takes a team to prevent a Fall” – April Falls theme
- Intentional Rounding
- Staggered meal breaks
- Patient Status at a Glance boards
- Knowing How We Do boards – safety crosses
- Safe Recovery



Quality Improvement

- Pressure injury prevention – introduced new tool, staff education, increased and more complete reporting, reporting at earlier stage, degree of injury not progressing
- Medication errors – workshop, ongoing work to do
- Plans and ongoing focus

Burwood Hospital ACQUIRED Pressure Injury SAC Rating

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD 18/19	YTD 17/18
SAC 2			1	2									**3**	**2**
SAC 3			2	1	4	1	2						**10**	**66**
SAC 4	14	11	11	9	10	11	9	11					**86**	**60**
Not Stated								1					**1**	**0**
2018-2019 Total	**14**	**11**	**14**	**12**	**14**	**12**	**11**	**12**					**100**	**128**

Quality Improvement

- Clinical Governance
  - Interdisciplinary team approach
  - ‘Champions’, engaging clinical staff
  - Clinical Record Rapid Audit – collaborative
  - More timely data, shared with clinical staff
- Serious Event Review (SER) Group
  - Transparency
  - Proactive: Severity Assessment Code (SAC) 3 & 4
- Blood Fridge
  - Continuous improvement cycle

Ongoing Plans

- Ways of Working
- ‘Rethinking Rehabilitation’ workshop May 2019.
- Personalised Care Plan roll out in Allied Health in March/April, medical and nursing to follow through 2019.
- DeloitteASSIST
- Vestibular impairment screening tool for patients admitted to Older Persons Health wards
- Upskilling staff in technology

Summary of Recent Presentations

- **Collaborating for Success**: Interacting with Surgical Services to improve the journey of frail older people
- **The value of screening for frailty in an orthopaedic preadmission clinic**
- **Management & Oversight of the Burwood Hospital Blood Fridge**
- **Rehabilitation in the Community**: Improving the competence & confidence of Key Support Workers
- **Safe Recovery**: Implementing the evidence-based 'Safe Recovery' falls prevention programme into Burwood wards
- **OPH&R Get Moving poster**

Hospital Advisory Committee

Avoidable Admissions in General Surgery

04 April 2019

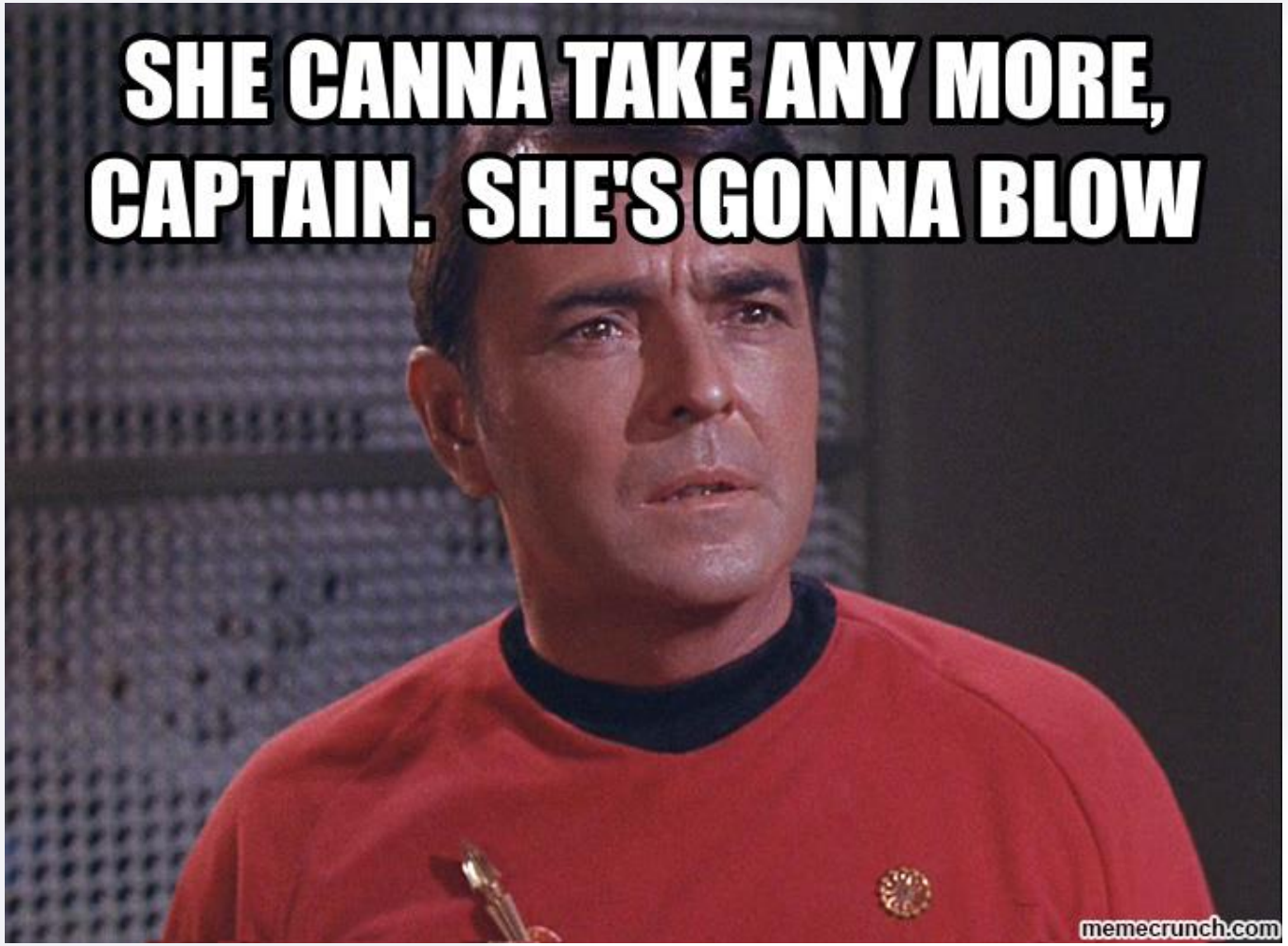
Outline

- Issue to be addressed – patient flow in General Surgical wards
- Introducing change
- Progress – where are we up to?

Issue to be solved - Patient flow

- Christchurch Hospital is near, or at capacity…
- Action…please expedite discharges
- Response from Surgical teams…

In the words of Montgomery Scott…



Problem

- Why - many patients were waiting on their definitive treatment & not ready for discharge
- Acute Theatre constraints…
- CDHB Financial constraints…

"We haven't got the money,
so we'll have to think."
Ernest Rutherford

Department Discussion…

- Question - Are there any admissions we could safely prevent/avoid?

Avoidable Admissions

- SMO/RMO discussion concluded the following conditions should be reviewed:
  - Painless Jaundice – Grant Coulter
  - 2 week old abdo pain – Grant Coulter
  - Uncomplicated diverticulitis
  - Biliary Colic
  - Abscesses
  - Proctology conditions

What the Data showed

- Top three conditions
  - Abscesses = 793 per annum
    (4-12 admissions p/w - 60% Gen Surg)
  - Painless Jaundice = 19 per annum
    (0-2 admissions p/w – 100% Gen Surg)
  - Proctology conditions = 344 per annum
    (0-2 admissions p/w – 100% Gen Surg)

Focus on Abscesses for maximum impact on patient flow

- At least 476 SARA admissions avoided
- What impact might this have on bed nights?
- What is the ALOS for an abscess patient from admission to theatre?

ANSWER = **40 hours**

Where to from here?

- Project Lead – James Haddow (Fellow)
- Project Team – MDT confirmed
- First Meeting – held
- Project Charter – agreed

Timeline…

By When	What
• Mar 2019	Arrange a project team, decide aims and objectives
• Apr 2019	Develop metrics and data reporting
• May 2016	Develop improvement ideas
• Jun 2019	Get staff and patient input
• Jul 2019	PDSA testing
• Aug 2019	Write and ratify new pathway and policies
• Sep 2019	Plan implementation
• Nov 2019	Launch new pathway
• Dec 2019	Interim analysis and improvements
• Jan 2020	Final evaluation

Questions

H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

DATE: **4 April 2019**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

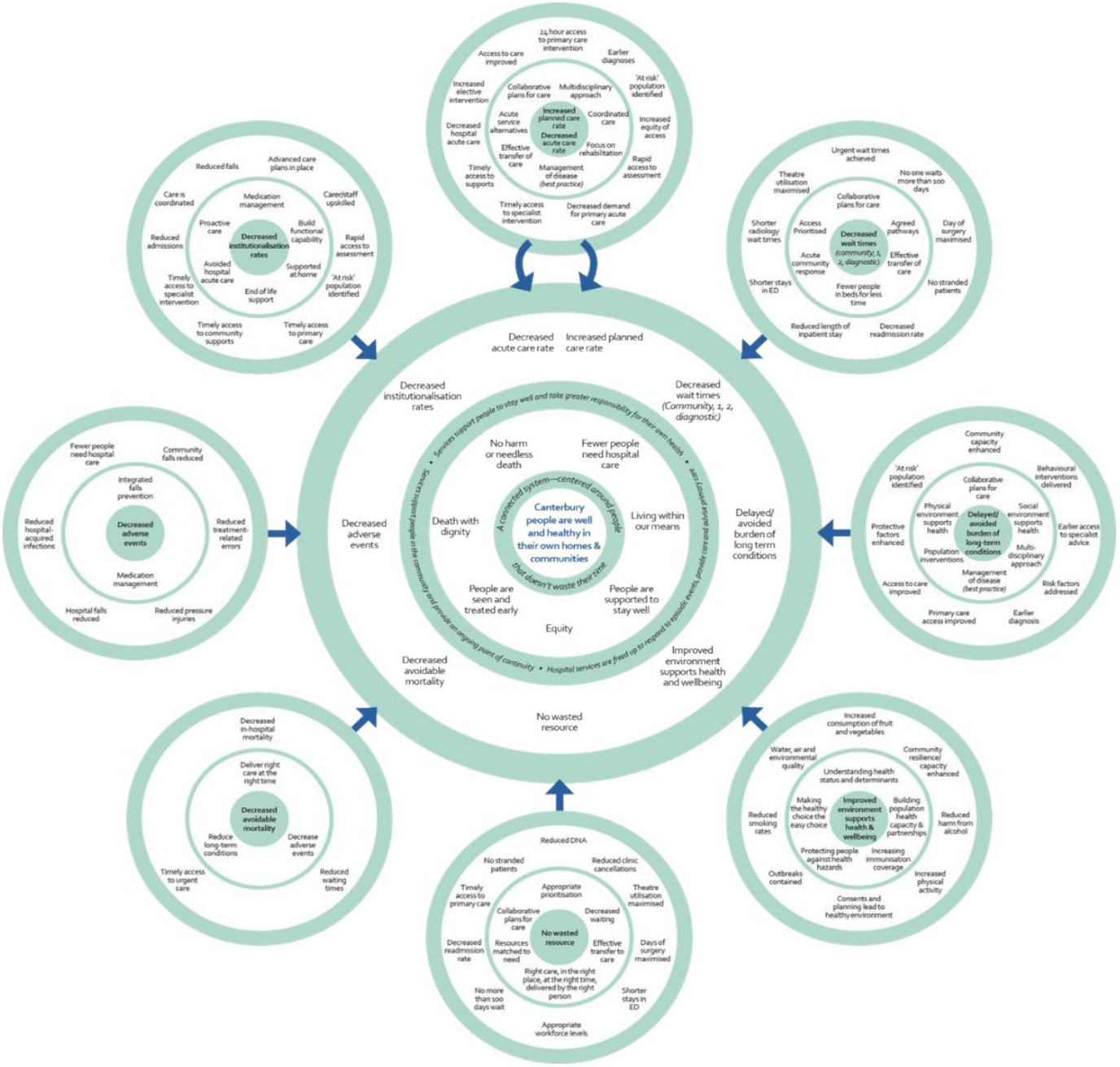
Appendix 1: Hospital Advisory Committee Activity Report – March 2019

Report prepared by: General Managers, Hospital and Specialist Services

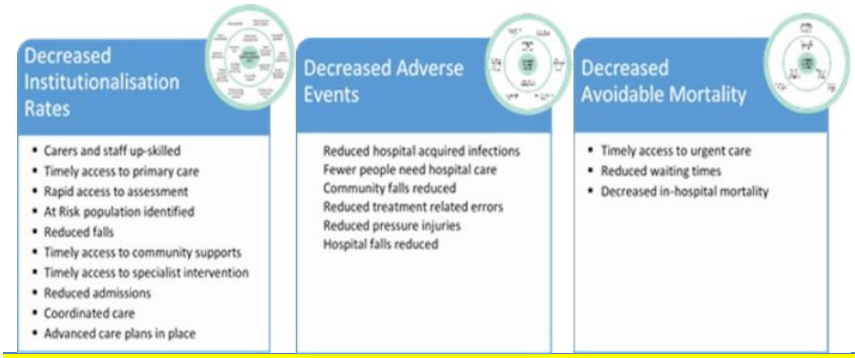
Report approved for release by: Justine White, Executive Director, Finance & Corporate Services

Hospital Advisory Committee

Activity Report



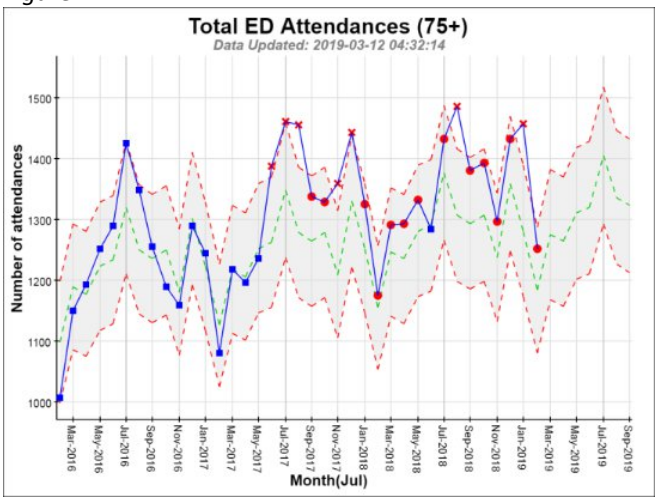
March 2019



Frail Older Persons' Pathway

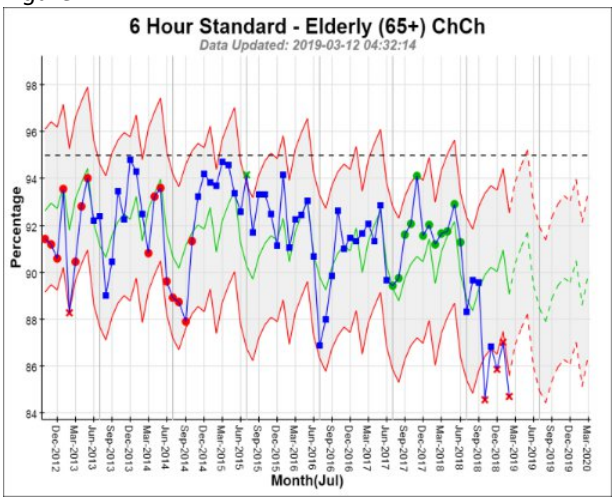
Outcome and Strategy Indicators

Figure 1.1



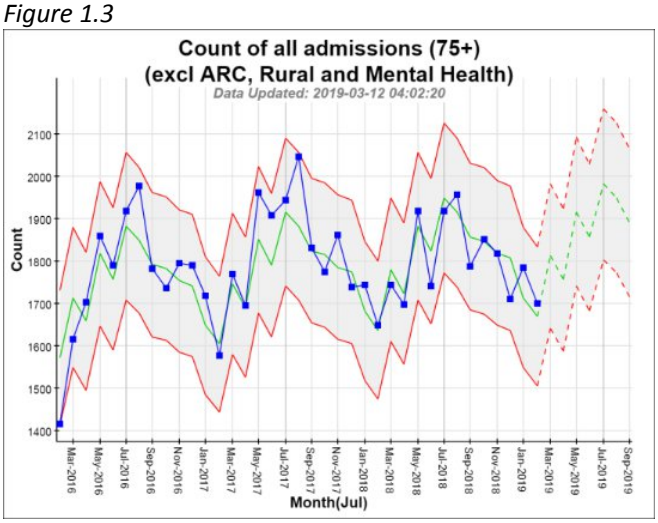
Total ED attendances of people over 75 has increased at a higher rate than the established trend. This increase is in line with that seen for the overall population.

Figure1.2



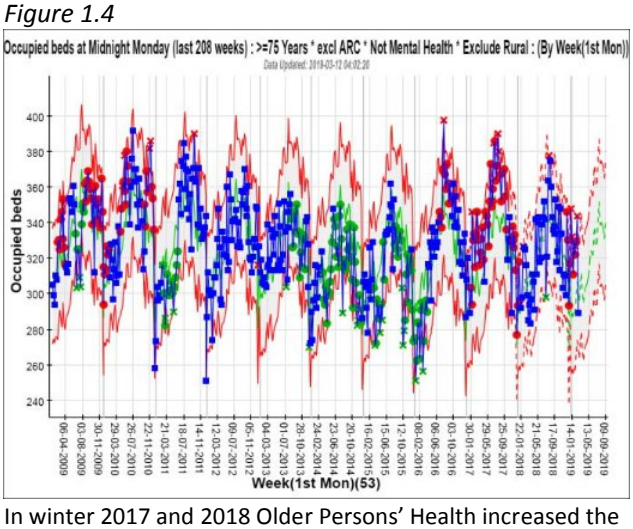
Patients 75+ leaving ED within the 6 hour target is tracking below the expected range since September 2018.

Figure 1.3



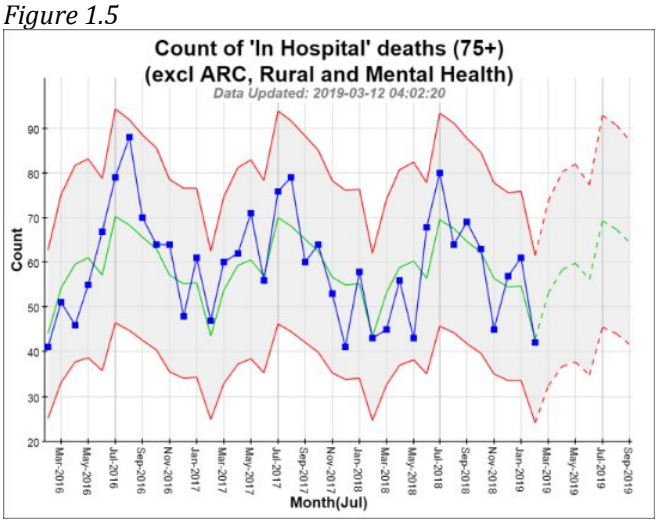
The count of all admissions for people 75 years and over continues to increase consistent with the established trend

Figure 1.4



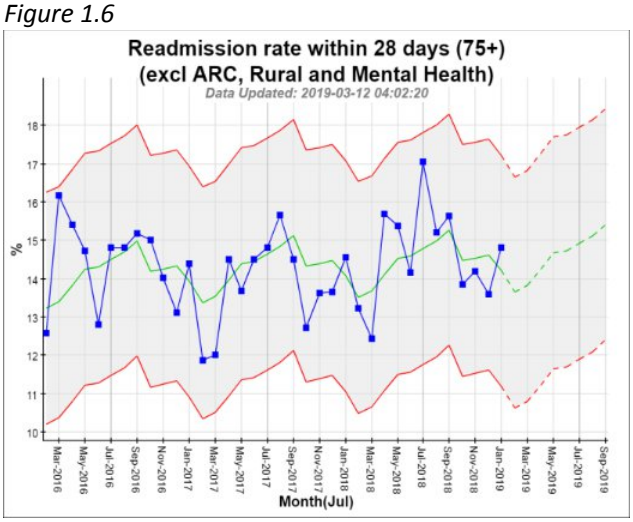
In winter 2017 and 2018 Older Persons' Health increased the number of beds across the inpatient environment to support flow. Levels return to lower levels outside of this period.

Figure 1.5



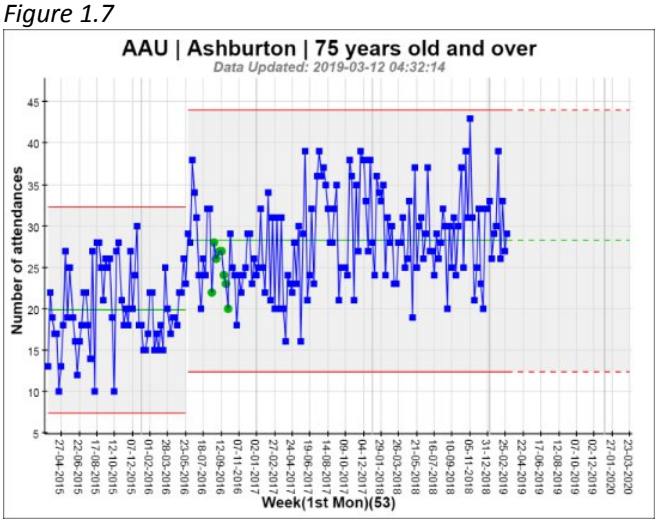
The number of in hospital deaths is within the expected range and continues the established trend of reducing rates of in hospital mortality.

Figure 1.6



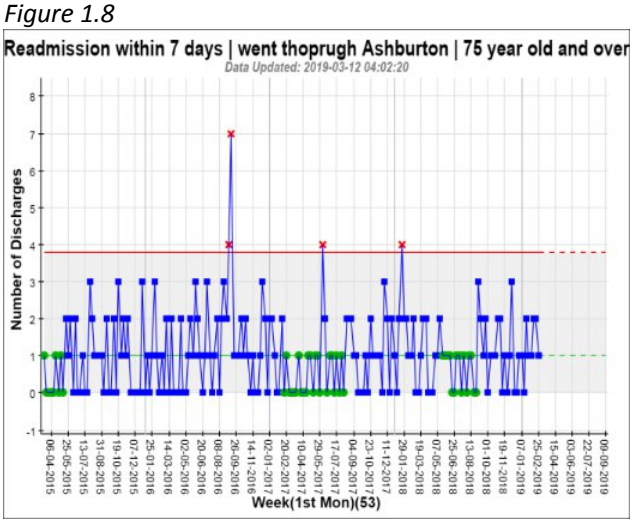
The readmission measure (balancing metric) for people aged 75 years and over continues to be within the expected range.

Figure 1.7



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

Figure 1.8



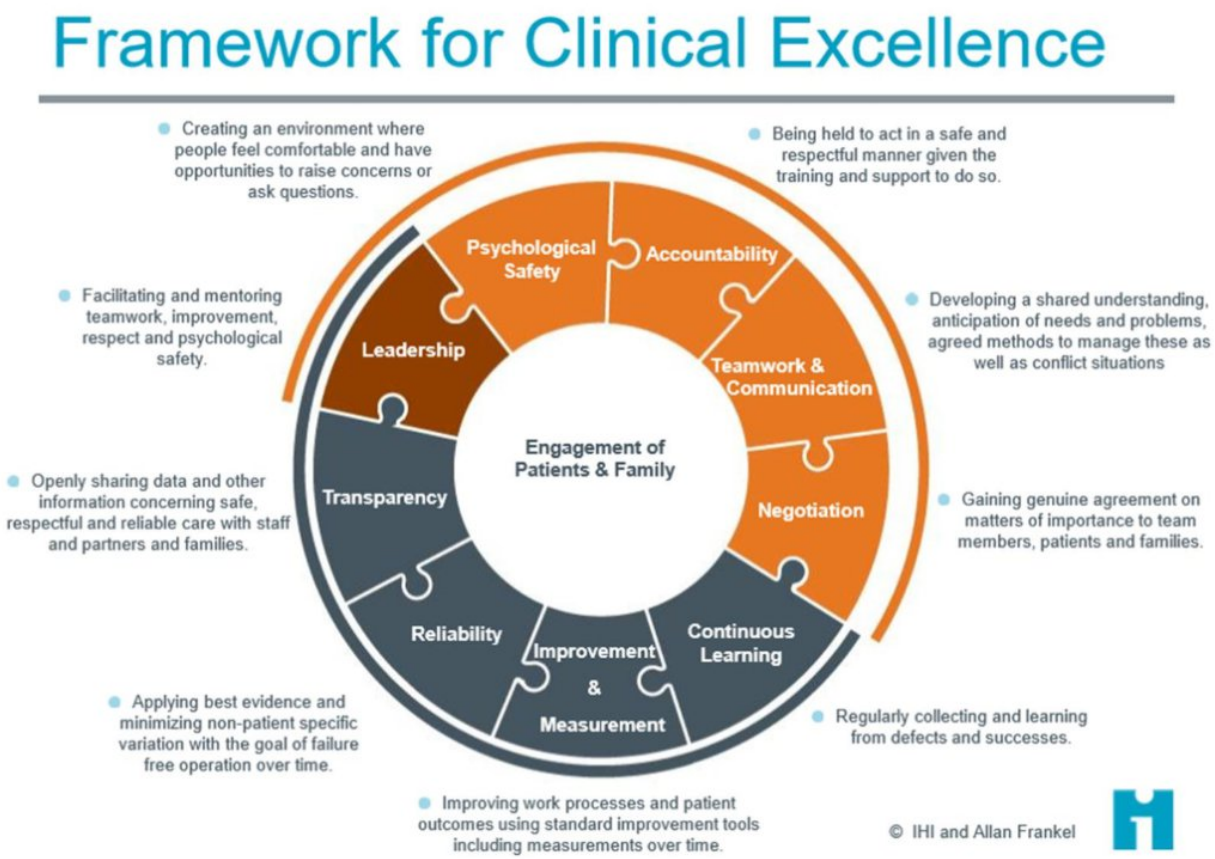
The readmission measure (balancing measure) for people aged 75 years and over continues to be within the expected range with no extreme decrease or increase indicated.

Achievements/Issues of Note

Older person Health (OPH&R)- Frail Older Persons pathway

- We are keeping a focus on our falls. The strategies as part of safe recovery programme have been focusing on what activity we can improve during night shift. This includes how we work as a team on admission. New Admissions are (where possible), cohort in close proximity to the pod where the nurses will be stationed at night. Focus closer attention for the first few days. We ensure new arrivals go into a room which has sensors in use.
- Intentional Rounding education has been completed in all wards. All wards are now embedding this into their practice on all shifts and a focus currently surrounds continence. This is one of the causes for falls to occur when mobilising for toileting. To reduce this we are highlighting that intentional rounding includes toileting and holds an importance in the reduction of falls.

- Medication errors is a current focus and in a partnership approach with members of the New Zealand Nursing Organisation (NZNO) to ensure we embed a culture change to increasing reporting of never events with medication. A focus on behaviour and culture supported by illustrating through process and system language changes. In addition is the recent joining of Senior Pharmacist and Quality Facilitator in conjunction with existing Nurse Educator to the CDHB Fluid and Medication Manual Committee. We are using the framework for clinical excellence to support our change.



Burwood Hospital Transfusion Focus Group.

This is a response from the Medical/Quality OPH&R partnership audit of appropriate prescribing and administration of blood over a 6 month period across the OPH wards.

- The first meeting defines the Terms of Reference with the aim to meet quarterly for information sharing and updates around the management of the blood fridge, transfusion safety updates and New Zealand Blood Service requirements.
- What this looks like in application, utilising a whole of system approach towards incident management where inter-organisational review will produce the greatest learnings with the greatest benefit to patients and safe practice, members of the group most appropriate will convene between times in needed to response to specific situations. The group will be a primary gateway to communication to the right people at the right time where required across the Burwood Campus. Within the group, the plan is to establish a professional network.
- Reporting into the OPH&R Clinical Governance Group, the Transfusion Focus Group can also escalate to the CDHB Hospital Transfusion Committee (HTC) any findings outside divisional control and will inform the CDHB HTC where themes may emerge that may have potential implications outside of the division.
- Membership includes:
    - Charge Nurse Managers (CNM)s from the OPH wards that transfuse the least and the most

- Nurse Educator (NE) across OPH&R, NEs from Spinal and Orthopaedics
- Operating Theatre CNS and Anaesthetic Technician
- Quality Facilitator
- Quality OPH&R Manager (Chair)
- Orderly Manager
- New Zealand Blood Service Christchurch Blood Bank Team Leader
- Quality Associate
- Transfusion Nurse Specialist

These activities are key to ensuring the right clinical outcome for those in our care, which adds with our flow through reducing the incidents and subsequent readmission, bed days and length of stay impacts these quality indicators have on our frail elderly.

Expediting acute admissions into General Surgery

In 2018 almost 8,000 acute admissions were accepted by the Department of General Surgery. More than 2,100 of these acute admissions were as a result of referrals directly from General Practitioners. People referred directly to General Surgery do not need to be seen in the Emergency Department to determine which service will provide the best care for them, as this assessment has already been provided by their General Practitioner. Their first stop in the hospital is the Surgical Assessment and Review Area.

While this provides a timely response for the patient, avoiding unnecessary time in the Emergency Department, it is time consuming for the General Practitioner who until recently has had to make a phone call and wait for a response from the General Surgery registrar. It also means that the General Surgery Registrar spends a significant amount of time each day on the phone receiving these calls (around ten on an average weekday). In order to expedite this process an Electronic Referral Form has been put in place enabling General Practitioners to send a self-populating form to the service. This alerts the ward and the registrar to expect an acute patient's arrival, releasing time for both the general practitioner and registrar to provide other patient care tasks. This process will be piloted for three months, following this it will be further improved.

Ambulatory model for people requiring acute general surgery care

A day surgery model is commonplace for a wide range of elective operations at Christchurch Hospital. This model sees people present at the Day of Surgery Admission unit on the morning of their operation and being discharged home during the evening following surgery. However people requiring acute surgery are not usually able to benefit from such a quick turnaround. In these circumstances people spend an average of 40 hours in hospital prior to receiving their operation.

A range of conditions have been identified that are amenable to a day surgery approach that will see patients receiving diagnosis and pre-operative evaluation on their presentation to hospital before being booked into a theatre list within the following days, and being provided with support to be cared for at home in the interim period.

Abscesses, painless jaundice and proctology result in over 1,100 people acutely spending time in hospital each year. If the right support is provided, there is no benefit, to many patients, of waiting in hospital, with most patients preferring the comforts of home. This approach will be an improvement for patients as well as potentially saving over 900 bed nights each year.

This approach will be piloted by General Surgery in the coming months and will be subject to fine tuning during that period.

Improved Central Line insertion continues to provide benefits for patients.

The June 2018 report included information about the implementation of a product called SecurAcath which is used to prevent both internal and external migration of peripherally inserted central catheters from patients' blood vessels. This product was shown to effectively reduce migration and had reduced the number of hospital acquired bloodstream infections associated with these catheters.

This improvement has been sustained with the number of peripherally inserted central catheters increasing to 1,711 in 2018, 80 more than the previous year. The associated bloodstream infection rate over the past two years has remained between 0.6-0.8%, well below the accepted threshold for healthcare acquired blood stream infections of 2%. Migration of these catheters has also been shown to be a thing of the past which no longer affects patients in Christchurch Hospital.

Also, a series of improvements is being put in place in relation to management of peripheral catheters:

- The first is that many patients on chemotherapy are susceptible to developing allergies to chlorhexidine and some adhesives, which results in dermatitis, so the team in Oncology has evaluated a new dressing to be used with peripherally inserted central catheters. This has proven to be very effective with minimal dermatitis reported. It has provided a significant benefit for patients.
- The introduction of the new peripheral IV cannula, that Canterbury District Health Board (CDHB) has had design input into, is entering stage two with implementation occurring throughout the remainder of Canterbury District Health Board hospitals this month.
- In order to accurately assess the stages of phlebitis and to make our policy congruent with international best practice standards, cannulae will no longer be routinely changed every 72hours and will only be changed 'when clinically indicated'.

There are financial benefits from the latter two of these changes.

Human Milk Bank

The Human Milk Bank was set up to support those mothers wishing to exclusively breastfeed, to bridge the gap between birth and development of the mothers own breastmilk supply. Statistics over the past four years show that for babies in the neonatal unit this support is required from the milk bank for six days on average. Since the introduction of the milk bank the proportion of babies admitted to the neonatal intensive care unit able to be supported in this way has continued to increase

Some Statistics	2014	2015	2016	2017
No receiving PDM	158	266	244	387
No of admissions	839	1002	853	902
%	18%	26%	28%	43%

Previous reports have highlighted the Human Milk Bank's success in providing pasteurised donor milk to babies being cared for in the neonatal intensive care unit. Since the end of 2017 this service has been expanded to high risk infants on the Maternity ward and community when supplies allow, with the objective of keeping mother and baby together and to support, value and encourage breastfeeding. . The lactation consultants and staff in maternity have worked very hard to design a dispensing system that balances and determines the genuine requirements of pasteurised donor milk with the minimum of wastage while supporting the mother's commitment to transition to full breastfeeding. So far babies in the Maternity Unit have been supplied with 91 litres of pasteurised donor milk.

Treatment now available to all people with Hepatitis C

There are an estimated 50,000 people in New Zealand living with Hepatitis C, and half of them don't know they have it. If left unchecked, up to a quarter of infected individuals will develop cirrhosis of the liver. Without successful treatment, 2–5% of those with cirrhosis will progress to life-threatening liver cancer or liver failure each year. Hepatitis C is the leading cause of liver transplantation in New Zealand.

February 1st heralded the arrival of a new fully-funded treatment, Maviret, for all patients with untreated hepatitis C. The potential consequences of untreated Hep C include cirrhosis and liver cancer.

Maviret has several distinct advantages over the previous regimen, the most significant being that it treats all genotypes (G1-6) with a 98 % cure rate. As a result of this initiative, patients will no longer need to source medication off-shore through 'buyers' clubs', or endure treatment with very unpleasant side effects, administration via tablets and injections and relatively low chance of cure (Interferon). Other advantages include;

- It is a once a day, tablet only regimen
- Significantly fewer interactions with other medications
- Patients without more advanced liver disease can be easily and safely managed by primary care, as this patient group requires no blood tests or additional visits to GP whilst on treatment. The patient has a single blood test at 3 months post treatment for test of cure.

The funding of Maviret is such a significant event that there is national backing and resources for this treatment. The Health Promotion Agency has launched a national, multimedia, awareness campaign, with a focus on undiagnosed New Zealanders.

Canterbury has a strong collaborative approach to Hepatitis C, as evidenced by our region having the highest number of patients treated with Maviret's predecessor (Viekira Pak) in the country. As an extension of previous work on Hepatitis C locally we are working hard to find the undiagnosed and/or untreated patients in the CDHB. Strategies include:

- Nurse specialists from Gastroenterology, Infectious Diseases and the Hepatitis C Community Clinic working collaboratively to support PHO's throughout Canterbury in identifying and treating Hepatitis C.
- Holding various clinics in the community to facilitate easy access to a fibroscan, a simple scanning tool which identifies whether a person has liver damage.
- Supporting corrections staff to identify and treat affected prisoners.
- Looking back to identify patients who can now be treated.
- Following up on lost or hard to find patients.
- Spreading awareness and encouraging testing.

Availability of this treatment means that people with Hepatitis C can be treated and avoid the risk of serious liver damage along with its implications for their quality of life and impact on health system resources.

Avoidance of unnecessary intravenous antimicrobial therapy at Canterbury District Health Board hospitals

The Infectious Diseases Department works alongside other services and groups, such as the Antimicrobial Stewardship Committee to help CDHB clinical staff use antimicrobial agents appropriately (right agent, right route, right dose and right duration). This helps improve treatment of infections and reduce adverse consequences of antimicrobial use including development of multidrug resistant organisms and *Clostridium difficile*-associated diarrhoea. A key antimicrobial stewardship theme has been to avoid unnecessary intravenous administration of antimicrobial therapy to:

- avoid preventable complications from IV access, e.g. phlebitis,
- improve patient mobility and comfort, and facilitate discharge,
- reduce nursing time for drug administration,
- decrease cost.

This report updates information about two successful initiatives that produced a sustained reduction in intravenous antimicrobial use, and a substantial decrease in cost. The initiatives are:

- Changing the mix of macrolides used to treat community acquired pneumonia, encouraging the use of oral azithromycin instead of intravenous clarithromycin
- Using two, rather than three, doses of metronidazole daily, with a preference for oral administration.

In order to facilitate changes the relevant services agreed to proposed guideline changes. The two initiatives were staggered, with macrolides commencing December 2013 and metronidazole in October 2015. Guideline changes were publicised online, verbal education was provided at multidisciplinary and multiservice teaching, written information was provided via bulletins and posters and ability to access the various agents was altered in clinical

areas. Ward and dispensary pharmacy staff provided support of the initiatives on an ongoing basis. Ongoing success of the changes was regularly assess using data extracted from the ePharmacy dispensing software.

Since initiation of these changes:

- **Macrolides.** Mean total annual macrolide use in CDHB hospitals decreased by 21% in the four years following the changes, compared with the prior four years
- Intravenous Clarithromycin use decreased by 72%, with ~2,600 intravenous doses avoided per year. Use of oral clarithromycin and roxithromycin (another macrolide antimicrobial) also decreased, by 91% and 71%, respectively. Azithromycin use increased by 833%.
- Direct cost savings were approximately $105,000 per year
- **Metronidazole.** Mean total annual metronidazole use (all routes) decreased by 14% in the two years following the change compared with the five prior years
- Intravenous metronidazole use decreased by 43%, with approximately 11,800 intravenous doses avoided per year. Administration via oral or rectal routes increased by 104%.
- Direct cost savings were approximately $111,000 per year.

Cortex implementation continues

Late in 2017 this report provided information about the launch and uptake of Cortex in General Surgery. Cortex has been designed by clinicians for clinicians, to improve the quality of patient care and the efficiency of hospital care teams. It is a care coordination platform that provides documentation of clinical notes, team and individual task management, electronic ordering of diagnostic tests, notification of results availability, and direct access to the results themselves – all at the patient's bedside. Expanding the use of the platform within Canterbury District Health Board has produced impressive results that confirm Cortex is already making a measurable difference. At the time of the last report, between June and November 2017, the District Health Board had saved patients more than a thousand nights in hospital, achieving an almost 20 percent reduction in the average length of stay. The new Acute Services Building, Christchurch Hospital Hagley, has been designed to be 'paperlite' from day one, ensuring that notes are legible, handovers are clearer and critical clinical information is always available to the right people at the right place and at the right time. Cortex is a key component of Canterbury District Health Board's emergent paperless and world class mobile environment in its hospitals.

As at November 2018, a further year on, this system has been embedded in General Surgery with a median of 160 unique users per day, a total of 1.5 million patient views, 86,000 notes made, 50,000 tasks sent and 35,000 orders raised. The Orthopaedic Spinal team is in the process of deploying the system and Paediatrics will follow in April 2019. Further rollout is dependent on the required devices being available and significant effort will be required to have full deployment before the opening of Christchurch Hospital Hagley.

Allied Health Digital Notes

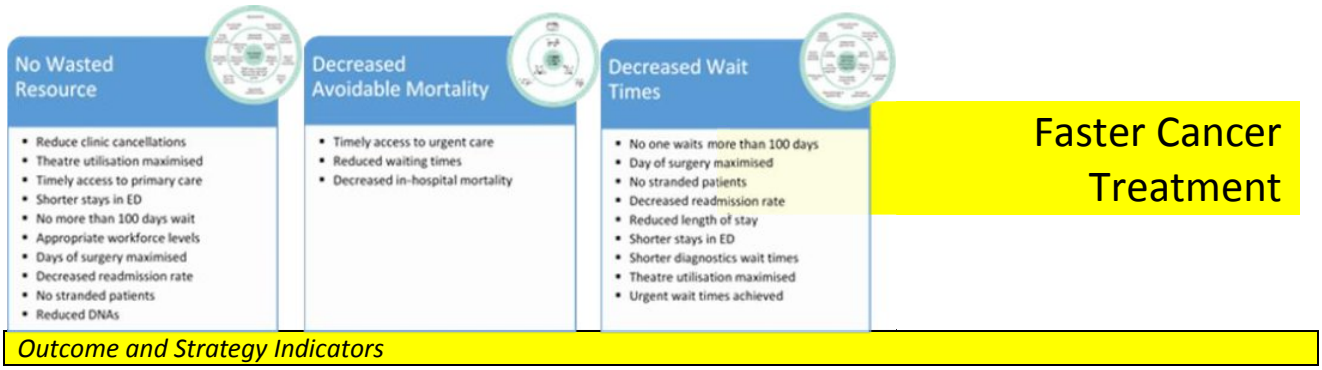
A strategic aim, passive data integration, had been set for the Acute Site Allied Health services in 2014, has recently been realised. The Clinical Lead for Allied Health Informatics and Director of Allied Health services for Christchurch Campus, have been keen to eliminate waste for patients and staff by releasing clinicians from the need to enter data describing their workload in addition to that created through documentation required to support clinical care.

Following national engagement and participation, the Allied Health Data Set Standard was published in March 2018. Subsequently, local development and co-design of the inpatient Allied Health digital notes, within Cortex, has aligned to this standard, enabling the first acute inpatient Allied Health eNotes with passive data integration.

This provides data supporting planning and allocation of capacity to areas and tasks without requiring separate entry of workload data as this is gleaned directly from clinical notes.

Major incident simulation in Radiology

The team in Radiology is using simulation to ensure that various aspects of its system will serve it well in the event of a major incident. This has led to a review of the equipment kept for and procedures used during major incidents, creation of text groups for different workforce cohorts and has also prompted the team to explore what changes will occur to the way orderlies work in these situations. Further simulations are planned



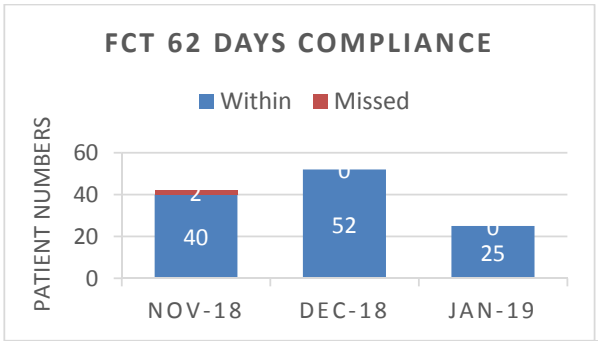
Outcome and Strategy Indicators

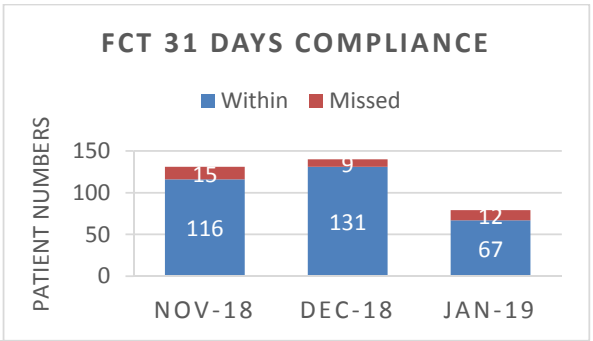
Key Outcomes - Faster Cancer Treatment Targets (FCT)

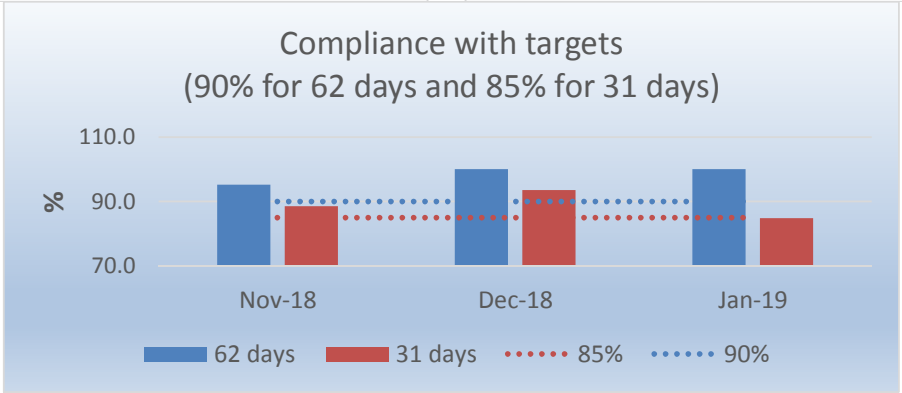
62 Day Target. For the three months of November, December 2018 and January 2019, Canterbury District Health Board submitted 138 records to the Ministry of Health. Of the 21 who missed the 62 days target, 19 did so through patient choice or clinical reasons and are therefore excluded by the Ministry in compliance calculations. This leaves 119 patients eligible for inclusion in the target calculations.

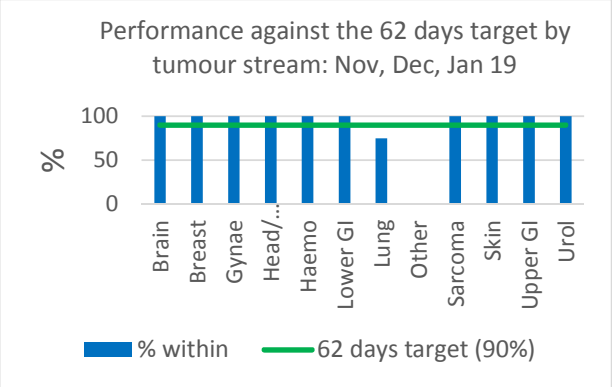
With two of the 131 patients missing the 62 days target through capacity issues, our compliance rate was 98%, once again meeting the 90% target.

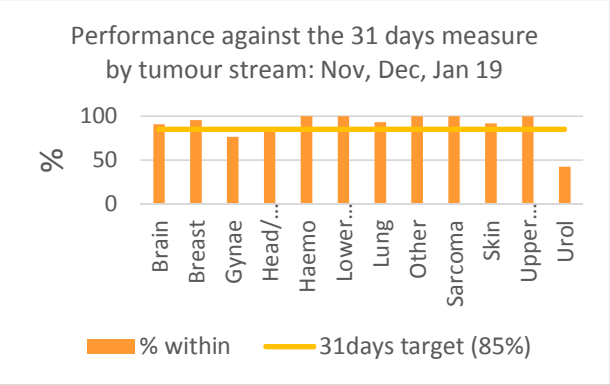
31 Day Performance Measure. Canterbury District Health Board submitted 350 records towards the 31 day measure in the same three month period. Unlike the 62 days target, all reasons for missing the target are included: there are no exceptions made for patient choice or clinical considerations, but the threshold is lower, at 85%. With 314 of the 350 (89.7%) eligible patients receiving their first treatment within 31 days from a decision to treat, Canterbury continues to meet the 85% target.

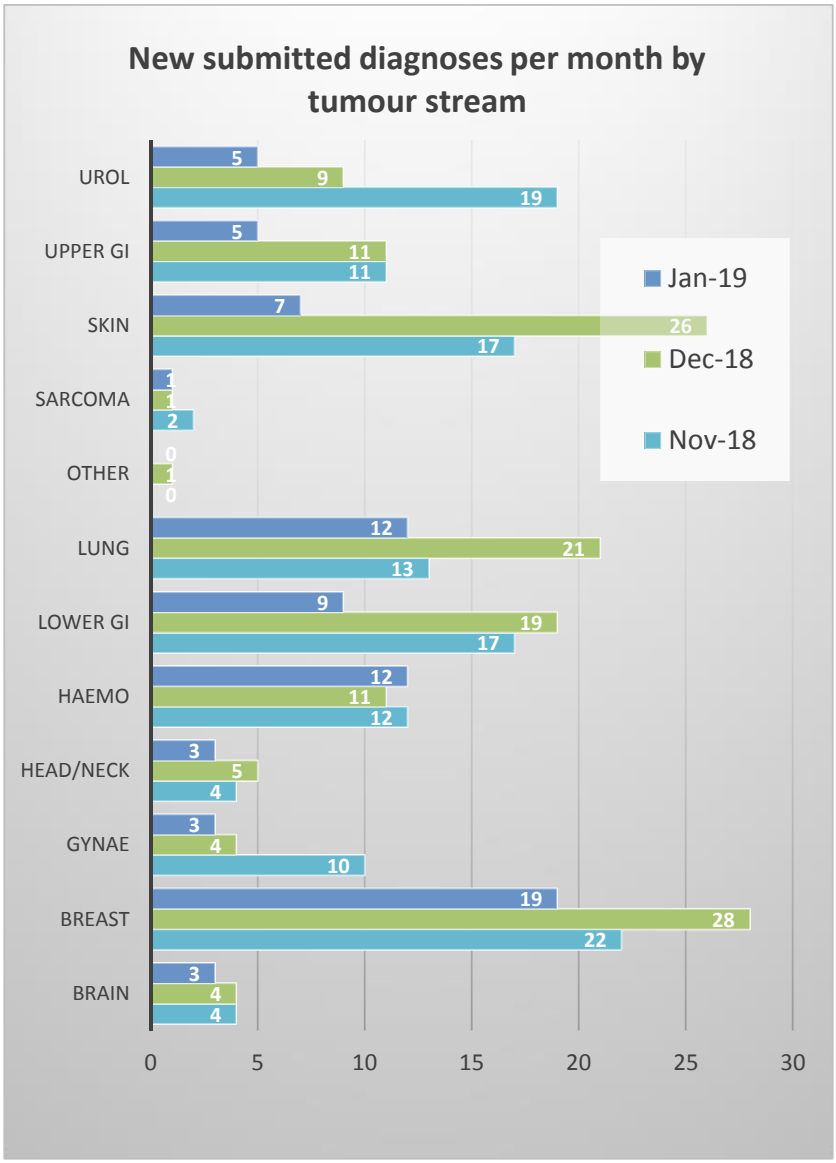










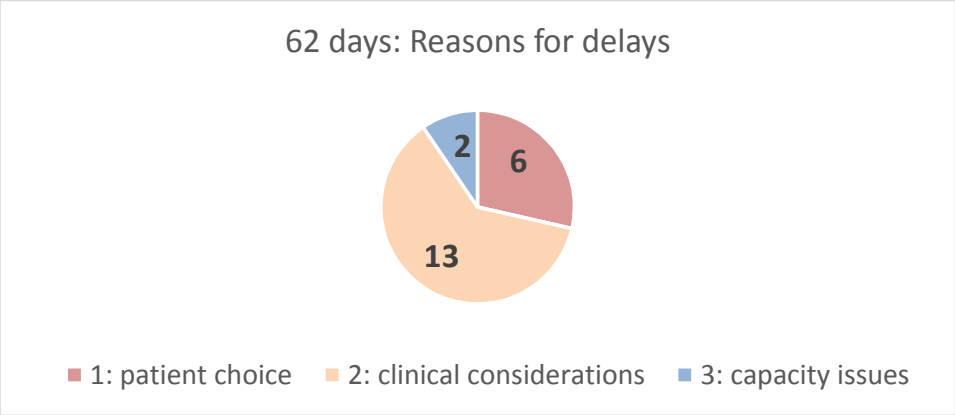


Patients whose treatment time misses the targets

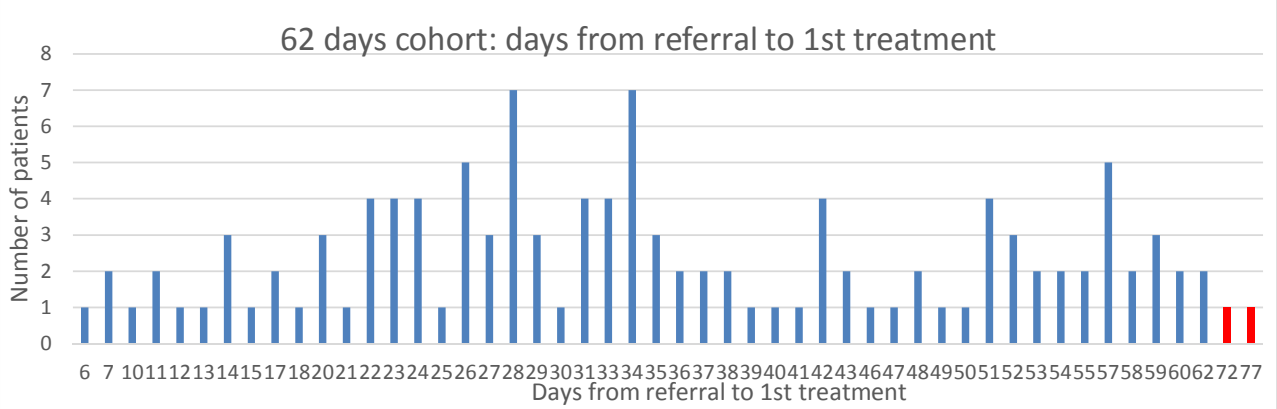
The Ministry of Health (*MoH*) requires District Health Boards to allocate a "delay code" to all patients who miss the 62 days target. There are three codes and only one can be used even when the delay is due to a combination of circumstances. In this circumstance the reason that caused the most delay is the one chosen.

The codes are:

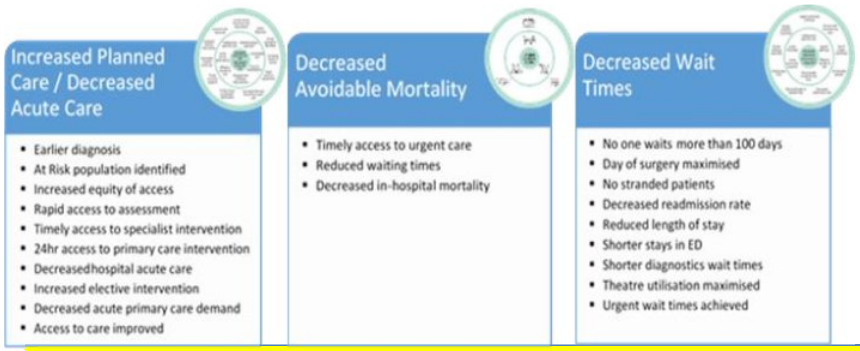
1. Patient choice: e.g. the patient requested treatment to start after a vacation or wanted more time to consider options.
2. Clinical considerations: includes delays due to extra tests being required for a definitive diagnosis, or a patient has significant co-morbidities that delays the start of their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



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



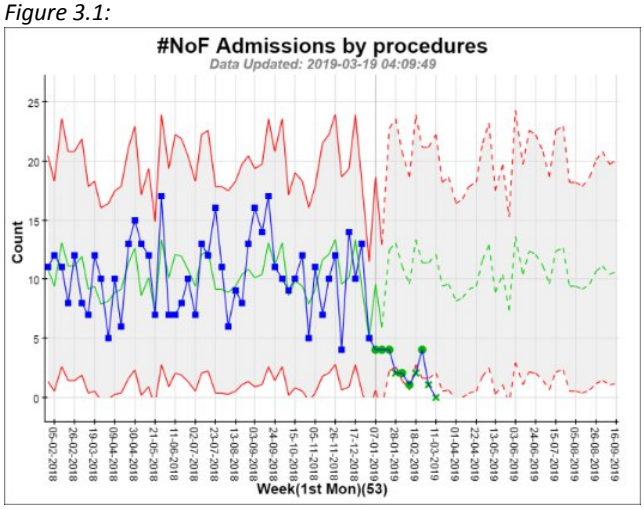
Each patient that does not meet the target is reviewed to see why. This is required in order to determine and assign a delay code, but where the delay seems unduly long then a more in-depth check is performed. These cases are usually discussed with the tumour stream Service Manager(s) to check whether any corrective action is required.



Enhanced Recovery After Surgery (ERAS)

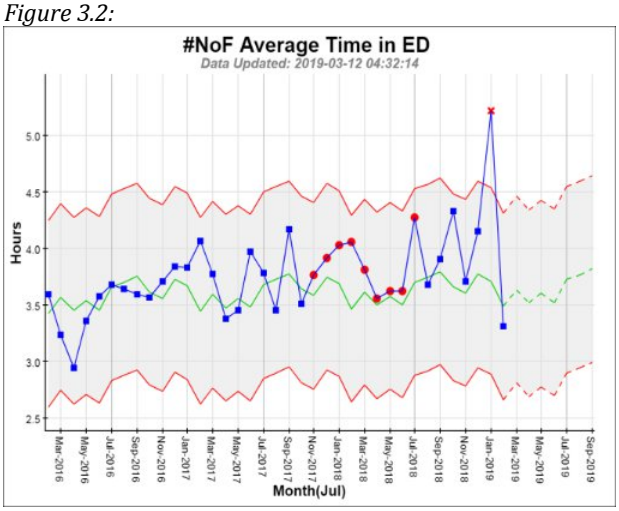
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



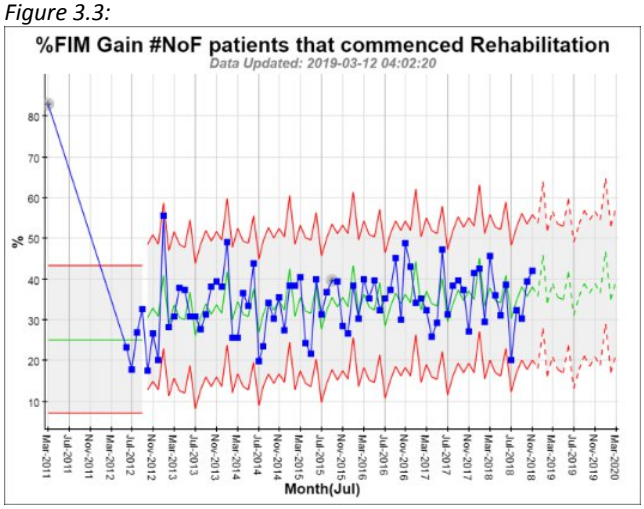
Coding delays have impacted on any information that relates to discharged patient with a specific conditios. This is being addressed.

Figure 3.2:



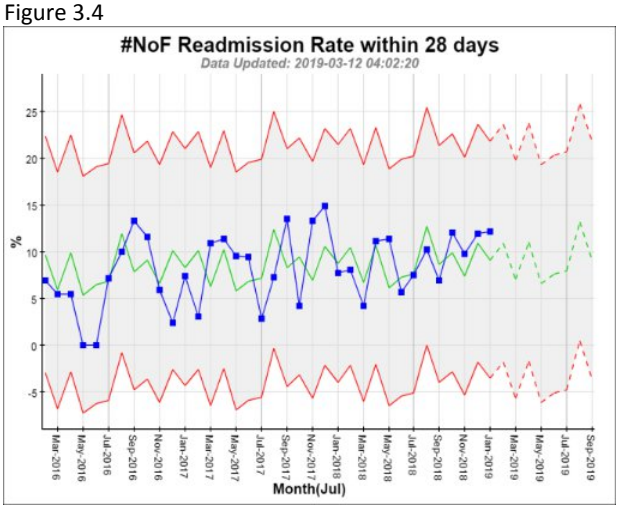
Patients with #NOF show a variable length of stay in ED. The red signals show that a statistically significant increase in the time spent in ED has occurred.

Figure 3.3:



The Functional Independence Measure (FIM) is a basic indicator of severity of disability. The above graph shows the percentage gain for #NOF patients.

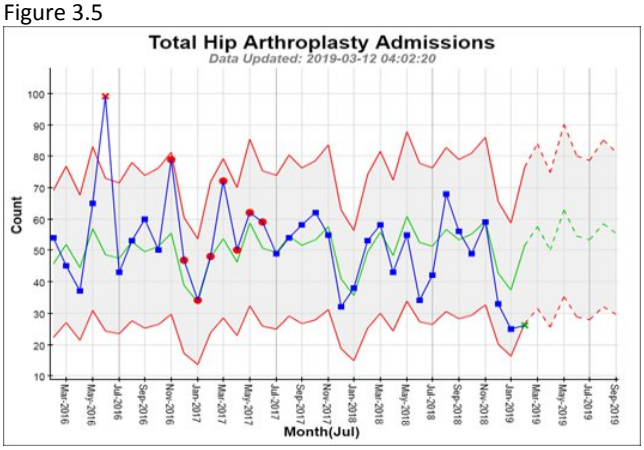
Figure 3.4



Readmissions continue to remain within expected mean values.

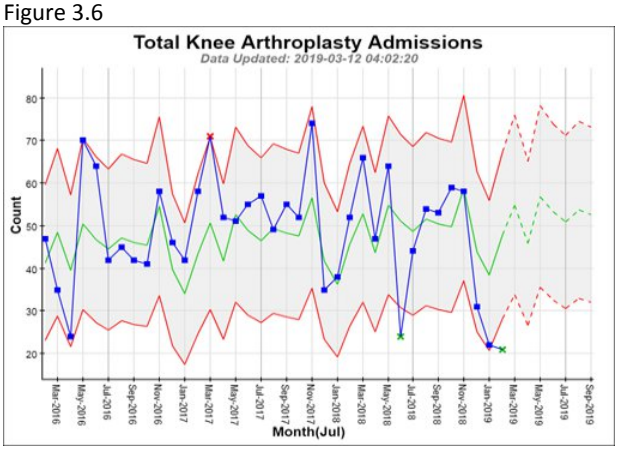
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.5



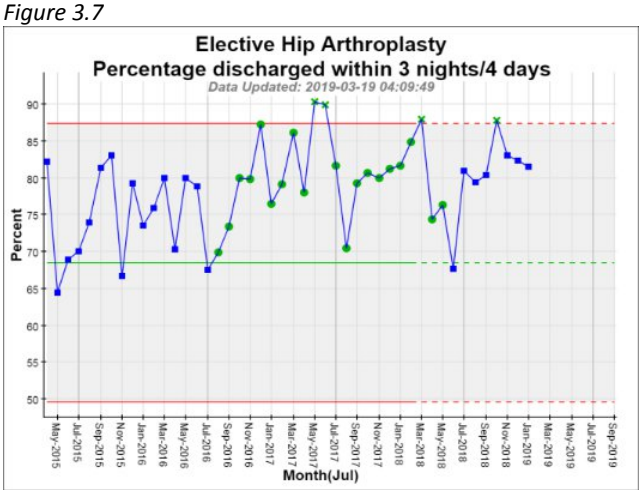
In recent months hip replacements have been tracking within or below projected levels.

Figure 3.6



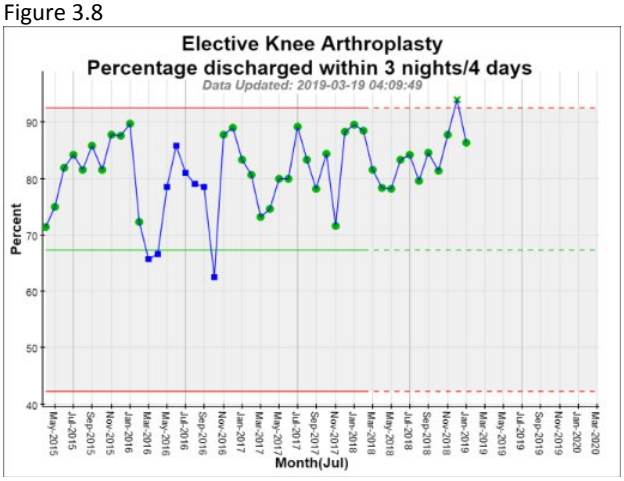
Knee replacement admissions over the previous twelve months have been tracking around the projected levels.

Figure 3.7



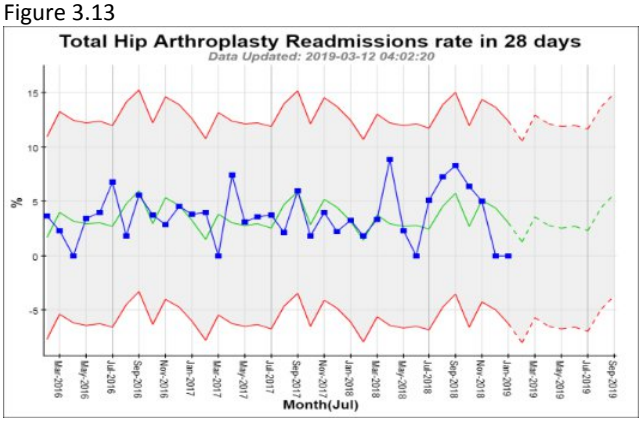
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.8



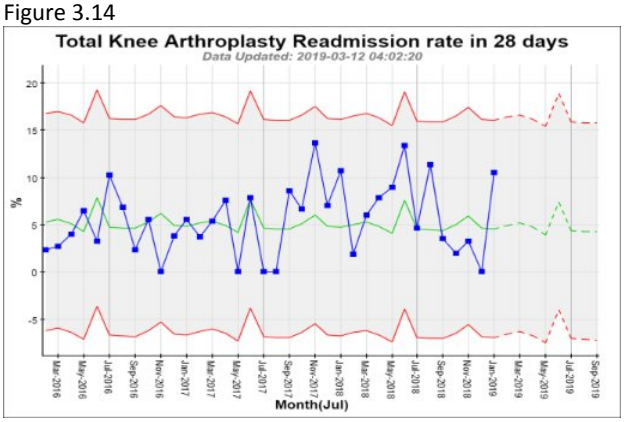
The proportion of patients clinically safe to be discharged within 3 nights/4 days is following established, increasing trend.

Figure 3.13



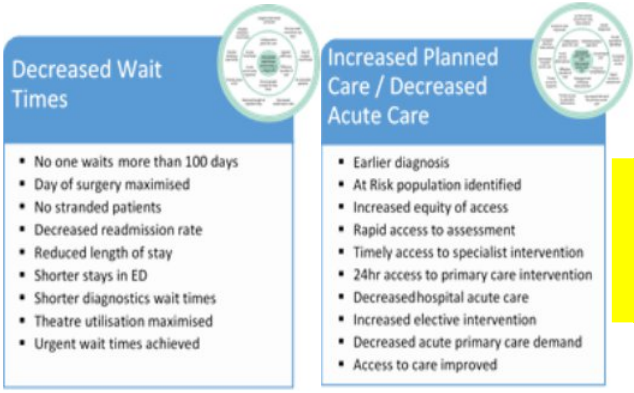
Readmission rates remain close to the midline of the expected range.

Figure 3.14



Readmission rates are maintaining within tolerances.

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



Elective Surgery Performance Indicators 100 Days

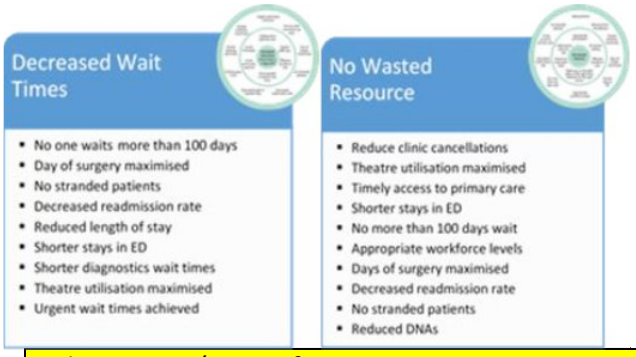
Achievements/Issues of Note

Children's Respiratory Outreach Nurse can now prescribe

The Respiratory Outreach Nurse provides oversight of patient care while in hospital to expedite early discharge and then provides home visits to monitor treatment and modify when needed. This service enables children to be assessed in their home setting and for advice to be provided to the child and their whānau. In the past engagement with a doctor was still required in order to make changes to the medication the child was prescribed. This meant that children had to wait before they could obtain the required medication, and the outreach nurse and doctors involved spent time liaising and making the required arrangements. In addition to this many pharmacies charge additional fees to families to cover the increased work required to process faxed prescriptions.

The Respiratory Outreach Nurse has completed a master's degree and post graduate diploma in order to be allowed to prescribe medication from a set list that is relevant to her field of practice. This prevents the need for patients to wait for their prescription as it can be written for them while the nurse is visiting in their home. In addition it avoids wasteful double handling of work and the need for whānau to pay faxed prescription fees.

Additionally, the nurse is a point of contact for the families who have a child with a chronic respiratory illness. This means that they have ongoing direct contact with her to enable assessment and treatment to be commenced more quickly, preventing complications.



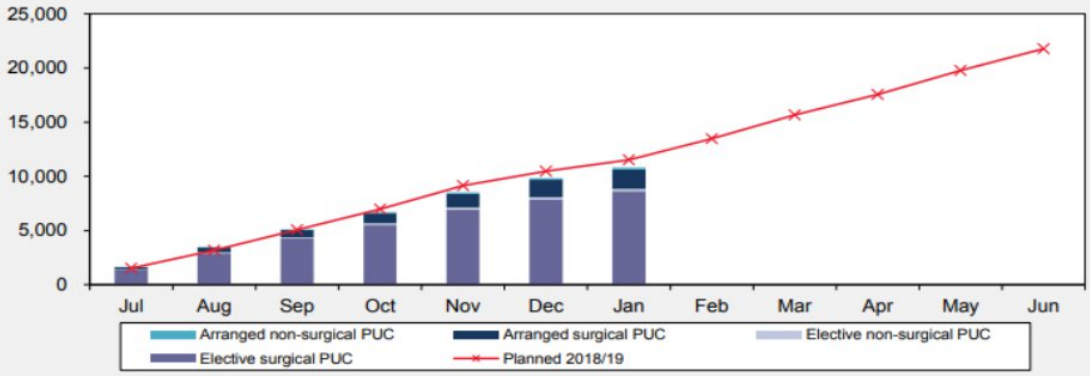
Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

Elective Services Discharges

Elective Surgical Discharges ▼ **93.8%**

	2018						2019					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Planned	1,520	3,182	5,065	6,985	9,132	10,470	11,532	13,474	15,676	17,548	19,773	21,782
Actual	1,617	3,474	5,119	6,703	8,533	9,835	10,812					
Variance	97	292	54	-282	-599	-635	-720					
%Achievement	106%	109%	101%	96%	93%	94%	94%					

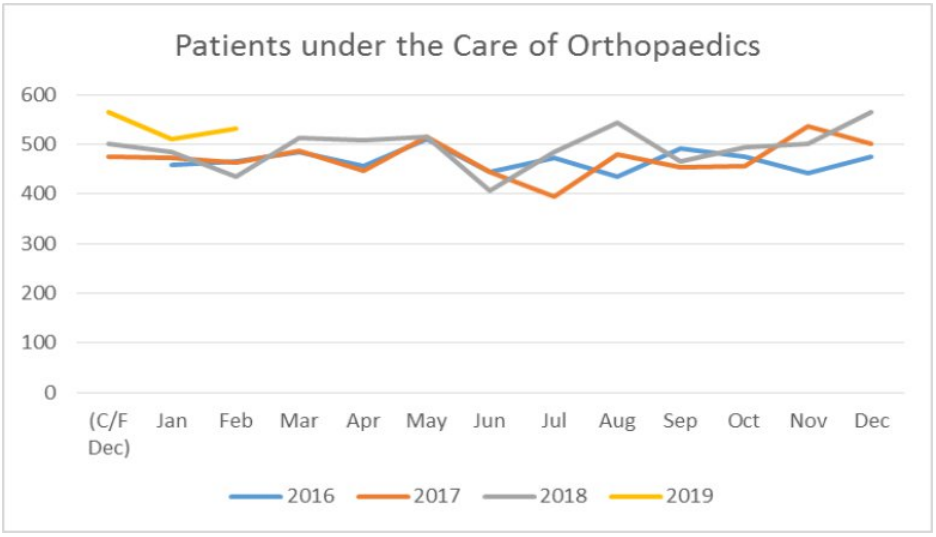


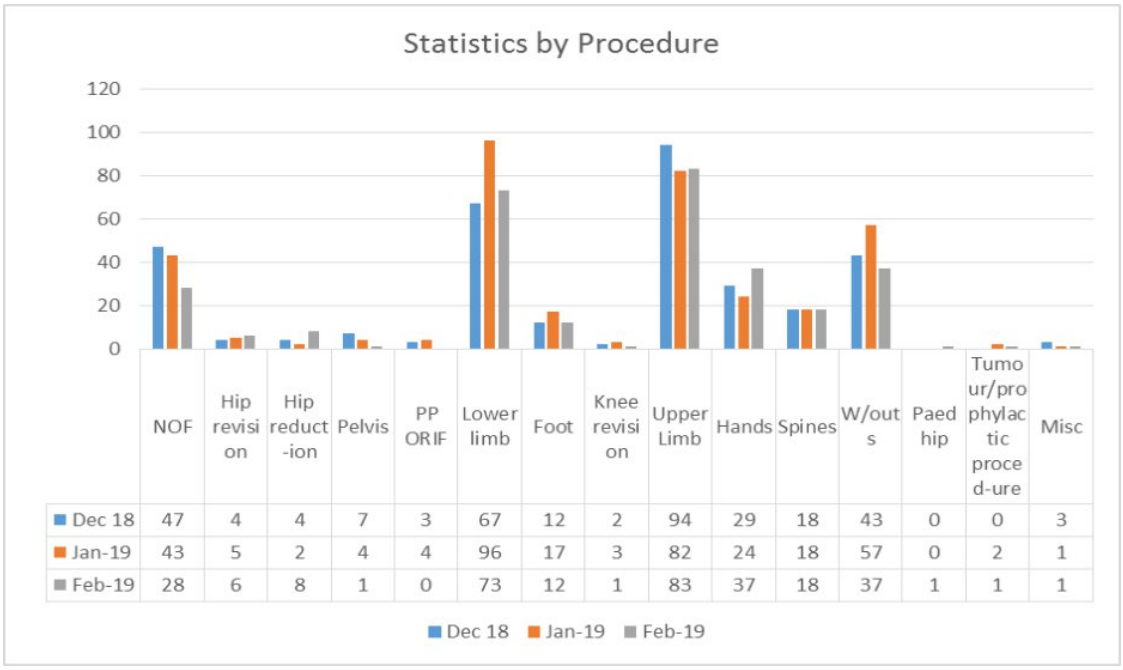
Reporting from the Ministry shows that Canterbury DHB met its elective discharges objectives at the end of the first quarter (until the end of September 2018), but indicates a significant under delivery by the end of January. However internal reporting shows that at the end of February over 13,150 elective and arranged discharges have been completed. While this is a shortfall of around 300 cases compared with our agreed target, it is expected that data corrections will reduce this shortfall significantly.

Burwood Theatre Utilisation

Orthopaedics: Activity for Orthopaedics continues to result with multiple additional theatres being made available to cope with volumes. There have been 533 patients admitted under Orthopaedic's care in February with 307 acute procedures undertaken. Of note:

- Increased volume of patients admitted in February 2019 compared with Feb 2018 (436) and Feb 2017 (464).
- Average length of stay has decreased from 3.46 days in January to 3.09 days in February.
- Average wait for theatre in February has reduced to 0.81 days, a reduction from January where average was 1.07 days.
- There were 45 acute procedures of the 307 procedures transferred to Burwood for surgery.



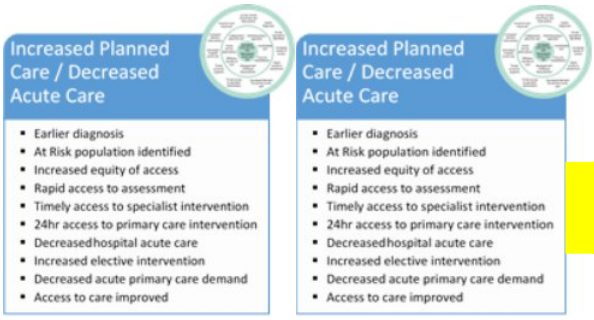


	NOF	Hip revision	Hip reduction	Pelvis	PP ORIF	Lower limb	Foot	Knee revision	Upper Limb	Hands	Spines	W/outs	Paed hip	Tumour/prophylactic proced-ure	Misc
Dec 18	47	4	4	7	3	67	12	2	94	29	18	43	0	0	3
Jan-19	43	5	2	4	4	96	17	3	82	24	18	57	0	2	1
Feb-19	28	6	8	1	0	73	12	1	83	37	18	37	1	1	1

- The impact that spine cases continue to have on overall flow of acute orthopaedic cases continues. However a noticed drop in the number of fractured neck of femur (#NOF) procedures during February.
- The number and type of surgery we are transferring to Burwood includes:

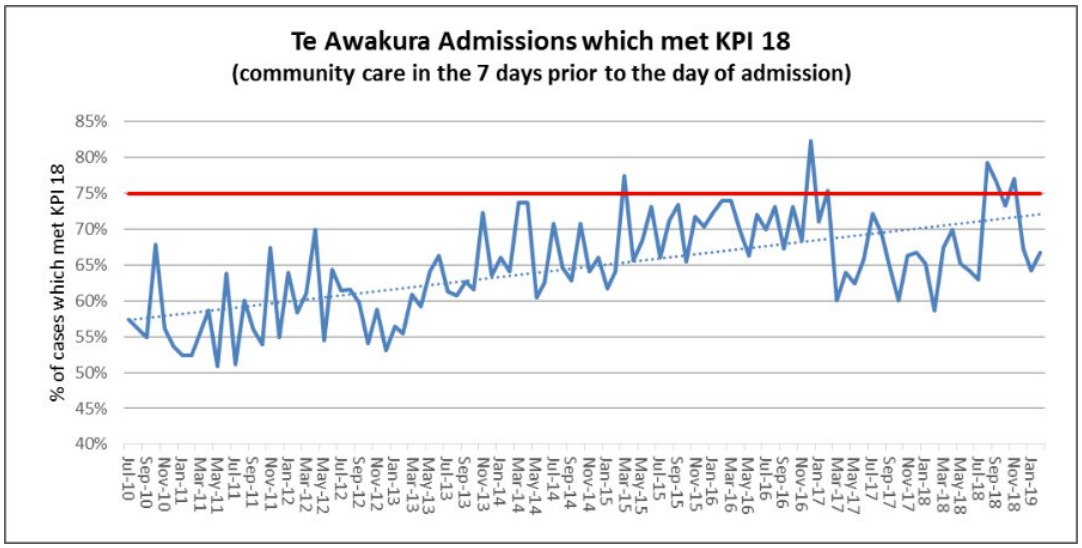
Lower limb	13
Upper Limb	17
Foot	3
Hands	1
Spines	-
Hip NOF	-
Hip revision	-
Knee revision	-

- The impact on electives has resulted in some cases being cancelled to enable the volume of acute cases to be undertaken. Cases are rebooked. A total of 6 elective cases were cancelled at Burwood to accommodate acute activity

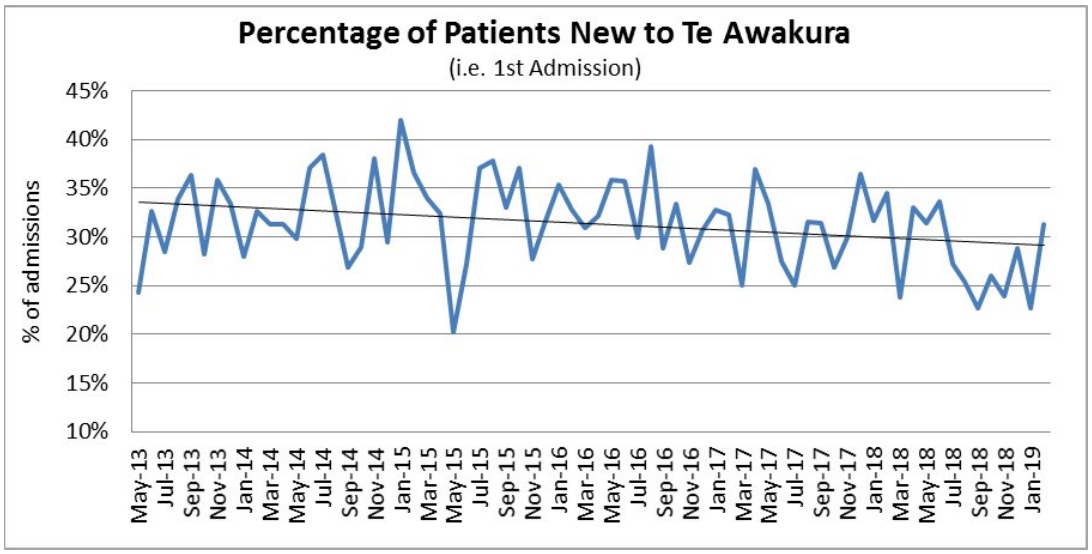


Mental Health Services

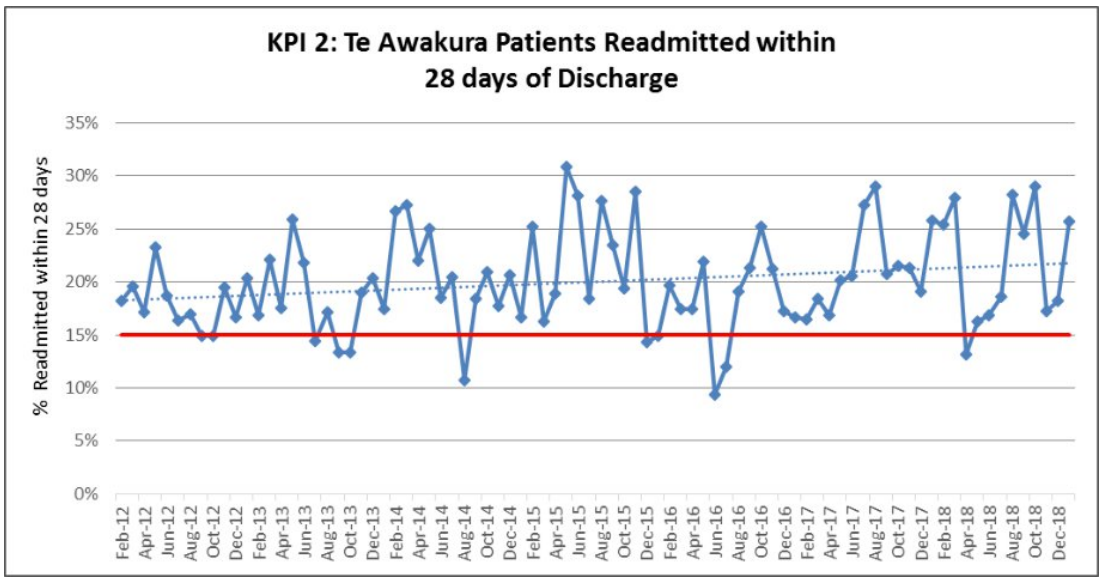
Adult Services



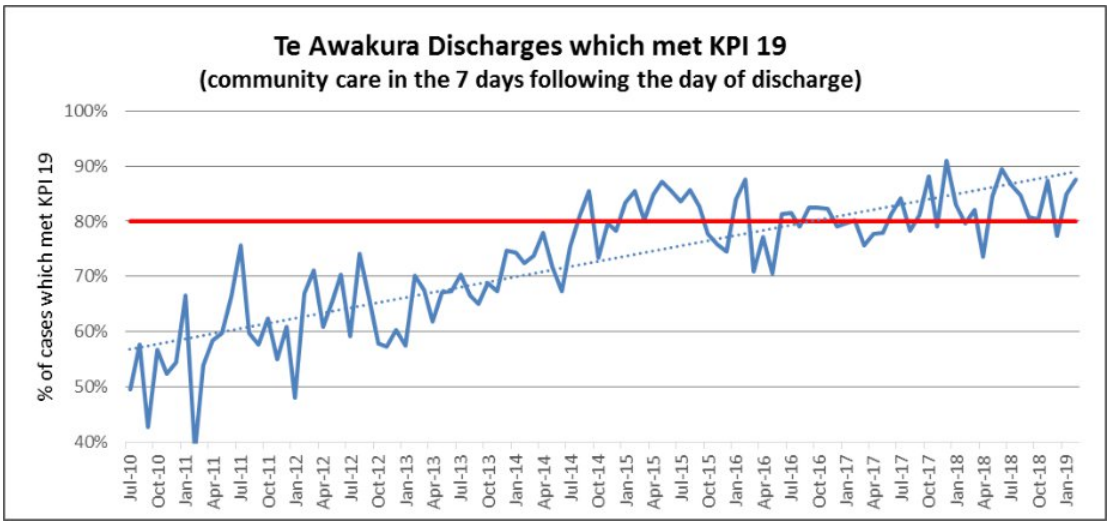
KPI 18 is an indicator of how well engaged we are with the consumers in our services. In January 2019, 64.2% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In February 2019, the figure was 66.5%.



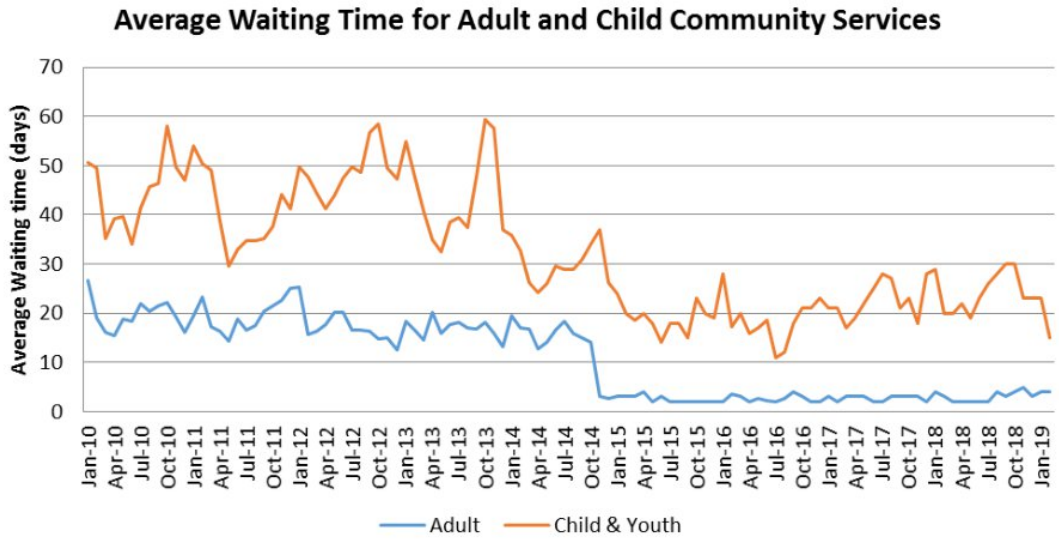
In February 2019, 31% of people admitted to Te Awakura were new (had not been admitted there previously), in January 2019, the figure was 23%.



The graph above shows the readmission rate within 28 days of discharge. Of the 113 Te Awakura consumers discharged in January 2019, 25.7% were readmitted within 28 days. Readmission rates are closely monitored.

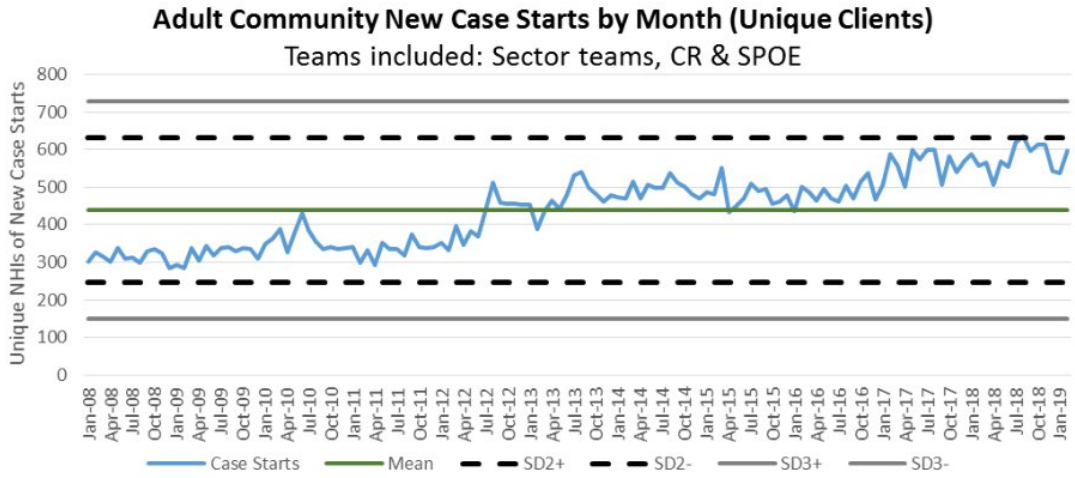


KPI 19 is a key suicide prevention activity and patient safety measure. In January 2019, 85.0% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19. In February 2019, the figure was 87.5%.

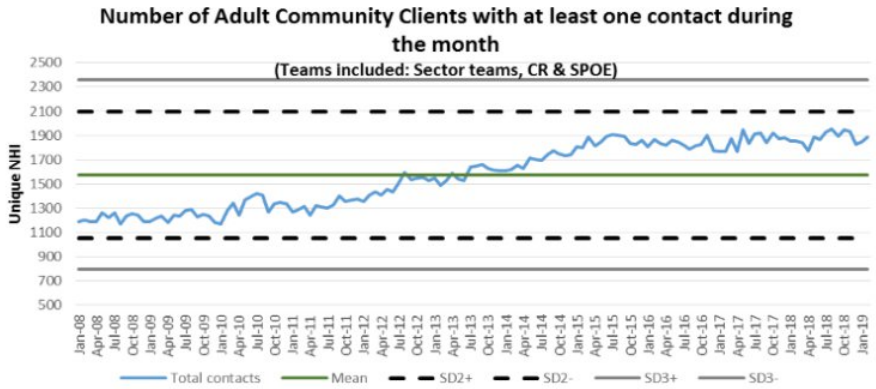


The graph above shows there has been an overall reduction in the time people spend waiting. Ministry of Health targets for these services require 80% of people to be seen within 21 days and 95% of people to be seen within 56 days. The average waiting time for adults was 4 days for both January 2019 and February 2019. Our results for the Adult General Mental Health Service show 92.8% of people were seen within 21 days of referral in January 2019 and 99.2% were seen within 56 days of referral. In February 2019, these figures were 94.4% and 99.2% respectively. These results is occurring in the context of significant increase in demand.

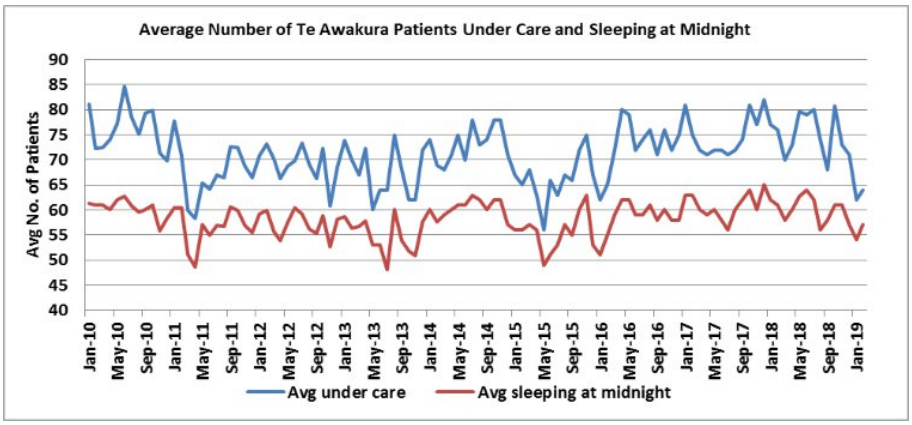
For child and family services, the average waiting time was 23 days in January 2019 and 15 days in February 2019. Reducing wait times has been a key focus for CAF services. Our results show 76.7% of people were seen within 21 days of referral in January 2019 and 86.1% were seen within 56 days of referral. In February 2019, these figures were 91.1% and 94.9% respectively.



New cases were created for 536 individual adults (unique NHIs) in January 2019 and 596 in February 2019.



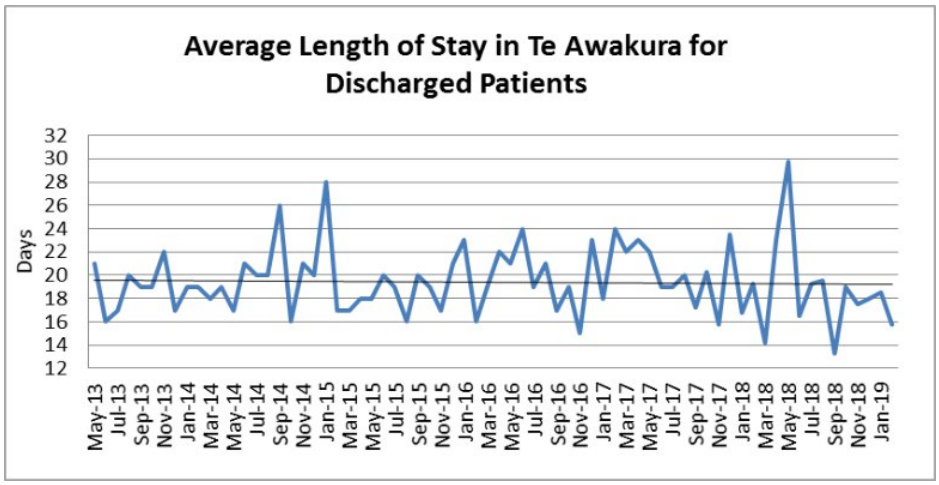
In January 2019 there was at least one contact recorded for 1847 unique adult community mental health consumers and 1887 in February 2019.



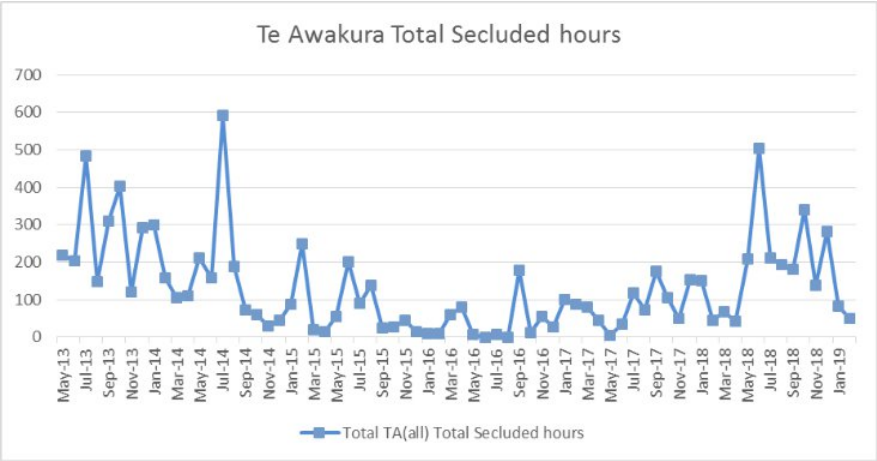
85% occupancy is optimal for mental health acute inpatient services.

Occupancy in Te Awakura (the acute inpatient service) has regularly been above this figure. Occupancy was 85% in January 2019 and 89% in February 2019.

The average number of consumers under care in this 64 bed facility was 62 in February 2019 and 64 in February 2019. There were 12 sleepovers during January 2019 and 1 sleepover during February 2019.

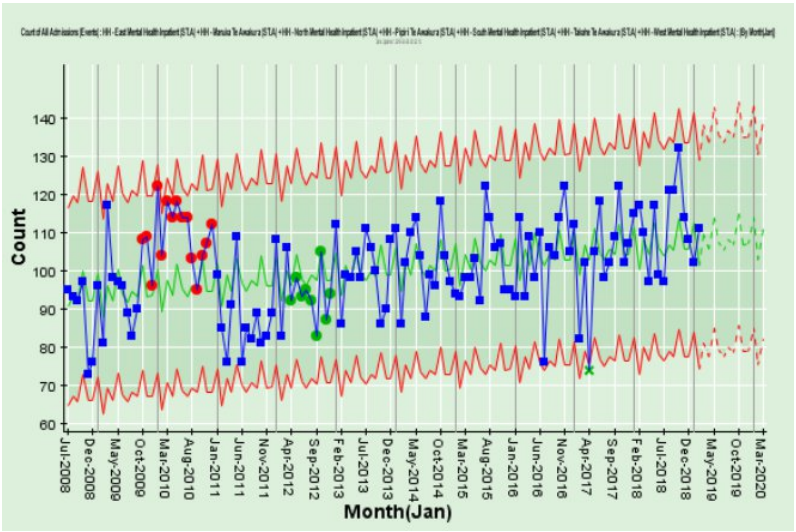


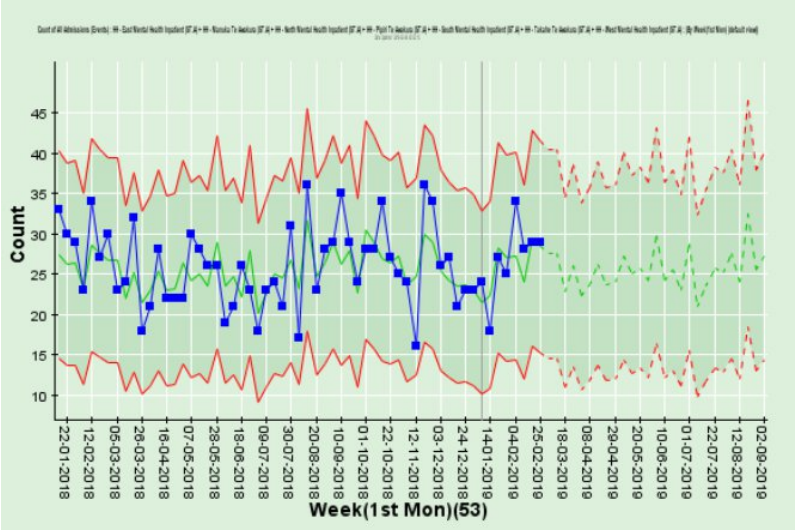
The average length of stay for consumers discharged from Te Awakura was 19 days for January 2019 and 16 days for February 2019. We are closely monitoring length of stay in terms of difficulties with accommodation supply in Christchurch.



Our focus on reduction of seclusion in Te Awakura continues. In January 2019, four consumers experienced seclusion for a total of 83.2 hours. In February 2019, three consumers experienced seclusion for a total of 49.9 hours. There is strong and effective nursing leadership and staff dedication and commitment to maintain the focus on reduction.

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



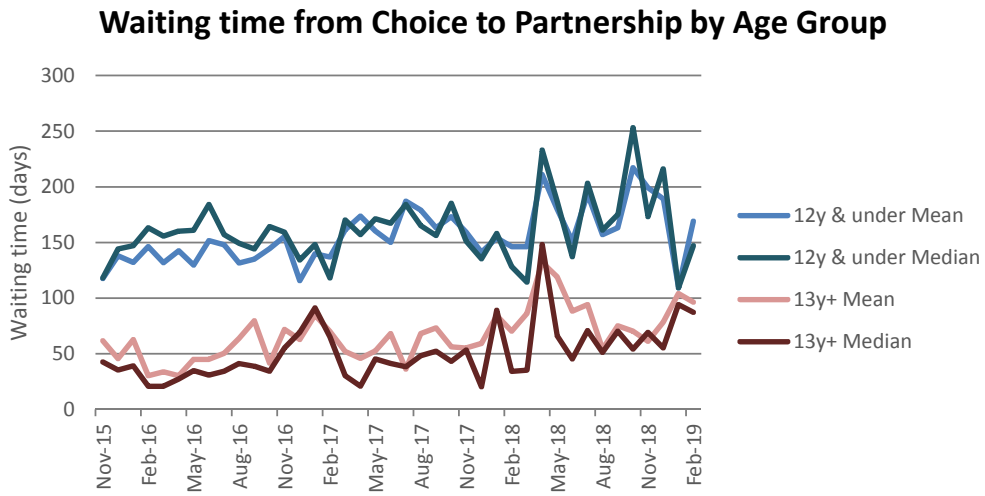


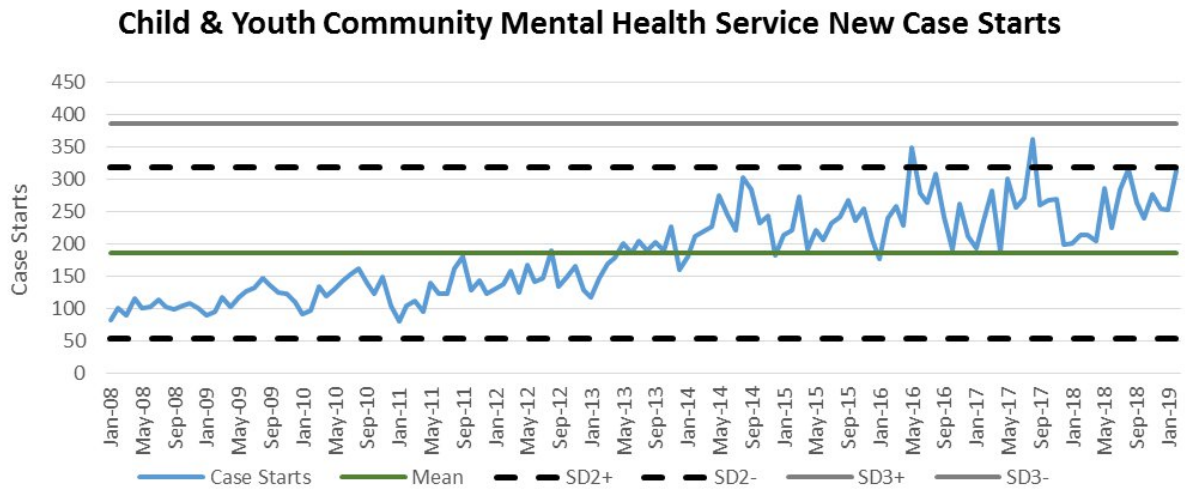
Child and Youth

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

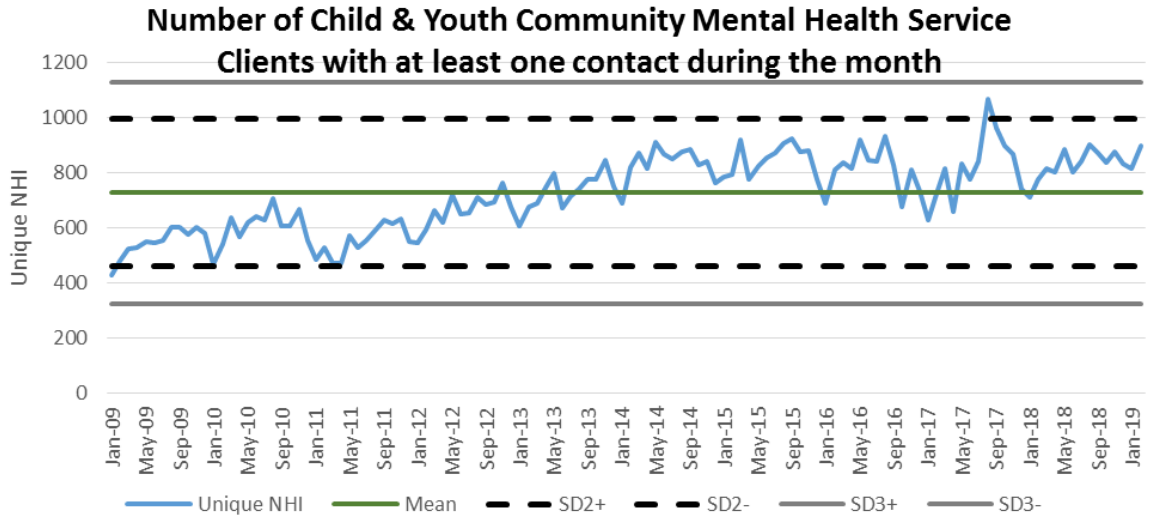
The focus on reducing wait times in the child and adolescent services is resulting in an internal wait of 20 weeks for some children and their families. Being seen early for the first contact is still important as it enables clinicians to make informed decisions about who is able to wait and who needs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

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

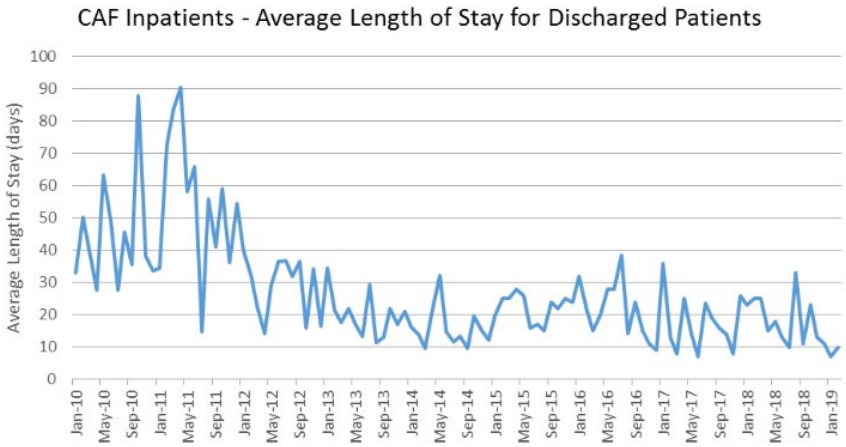




There were 253 new CAF case starts in January 2019 and 314 in February 2019. CAF services are making good progress with implementation of a Direction of Change that supports more integrated services across the age ranges.

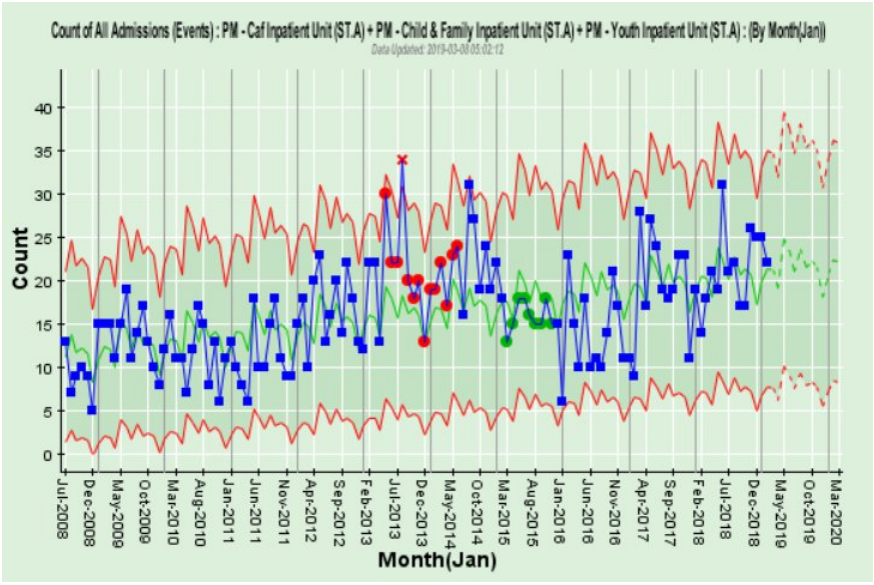


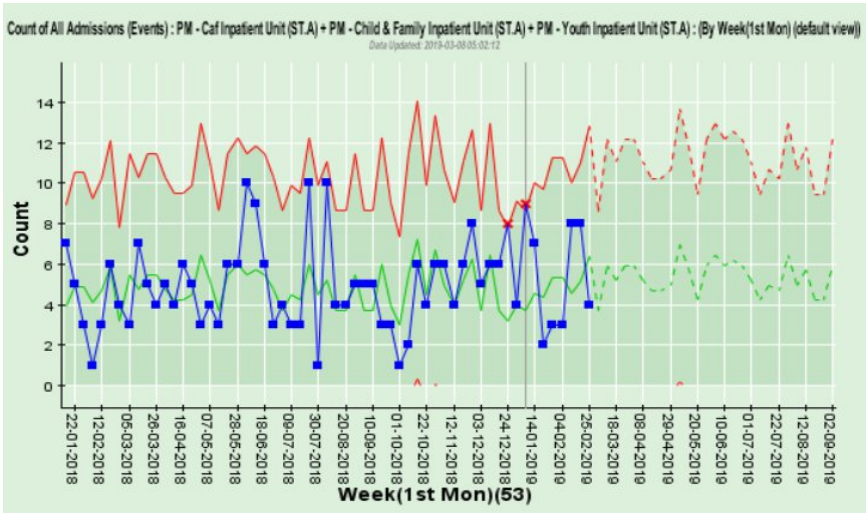
The number of unique clients with contacts above shows a similar pattern to new case starts graph, which demonstrates an increase in demand for Child and Youth community Mental Health Service. There were 814 unique patients with at least one contact during the month of January 2019 and in February 2019 there were 898. In August 2017 the CAF Service ran a drive on improving data accuracy and ensuring all contacts were being entered into the patient information system in a timely manner.



The average length of stay for discharged patients was 7 days for January 2019 and 10 days for February 2019.

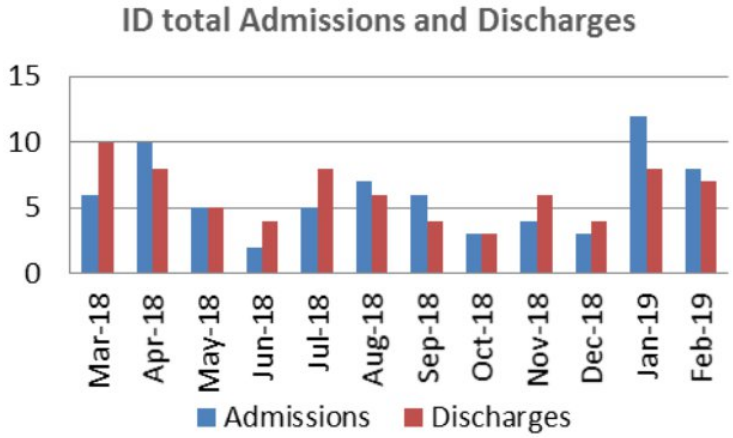
The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.

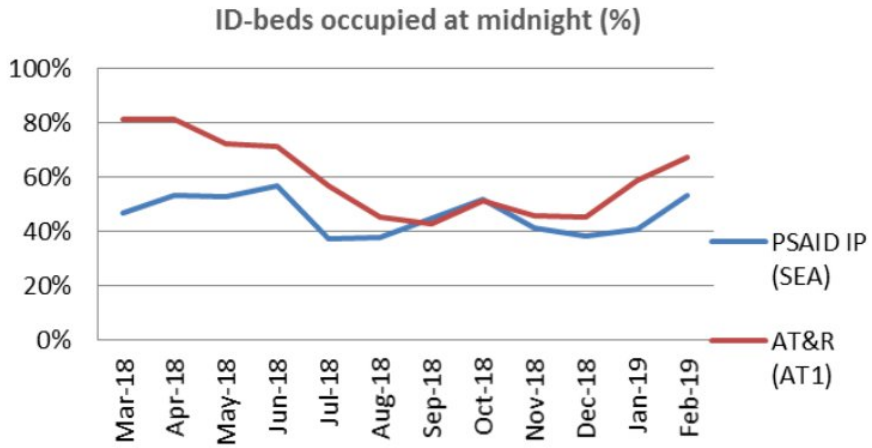




Intellectually Disabled Persons Health Service

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



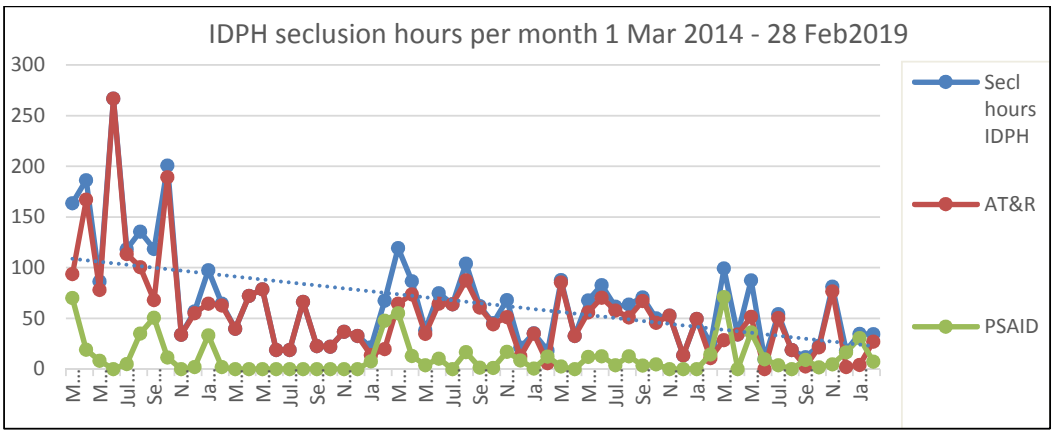


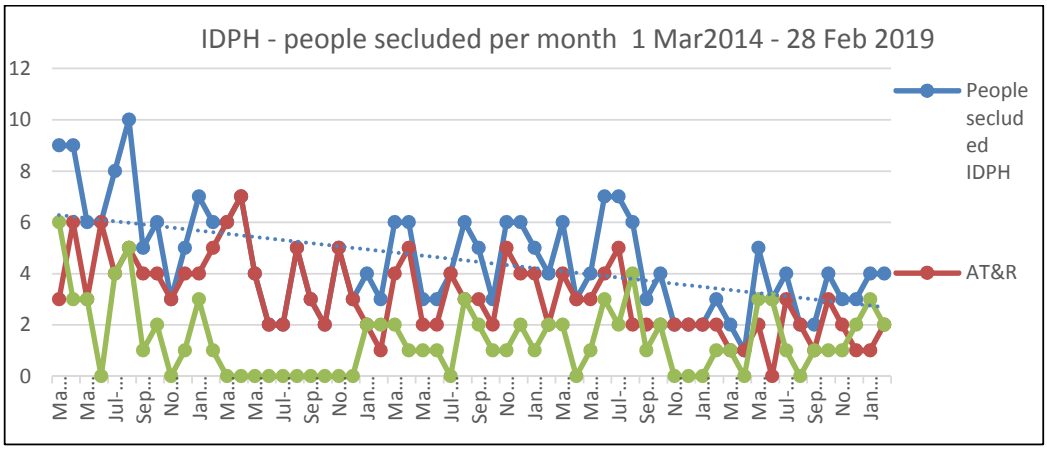
Occupancy in AT&R (AT1) was 59% for the month of January 2019 and 67% for February 2019. The figures for PSAID (SEA) were 41% and 53% respectively.

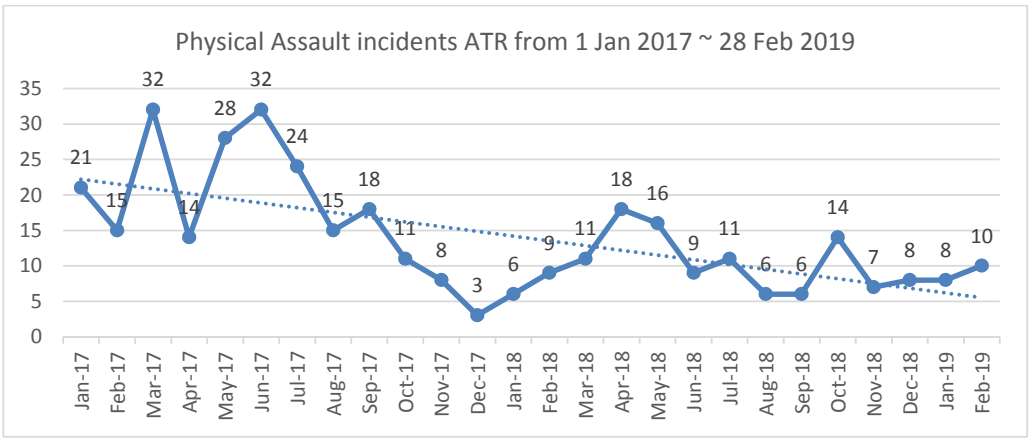
There have been longstanding delays in discharge for patients in the AT&R Unit. The delays continue to place pressure on the service and, for some of the patients, can lead to a deterioration in their presentation, affecting their readiness for discharge.

We work closely with the Forensic Coordination Service for Intellectual Disability (FCSID) and Lifelinks Needs Assessment Service Coordination to seek solutions for placements. We provide both training for staff and carefully developed transition to discharge plans. A monthly teleconference with the Ministry of Health takes place to inform and discuss the delays in discharge.

Due to health and safety concerns, the Health and Safety concern Assessment, Treatment & Rehabilitation Unit has had internal modifications as an interim measure, which has reduced the admitting capacity of the unit but resulted in a reduction in physical assaults and the requirement for seclusion. Further extensive modifications to the building have been approved which will further reduce the physical assaults and improve safety for patients and staff. The increase in assaults during the February 2019 period was directly related to conflict between two peers.


IDPH seclusion hours per month 1 Mar 2014 - 28 Feb2019
300
250
200
150
100
50
0
Secl hours IDPH
AT&R
PSAID


IDPH - people secluded per month 1 Mar2014 - 28 Feb 2019
12
10
8
6
4
2
0
People secluded IDPH
AT&R


Physical Assault incidents ATR from 1 Jan 2017 ~ 28 Feb 2019
35
30
25
20
15
10
5
0
21
15
32
14
28
32
24
15
18
11
8
3
6
9
11
18
16
9
11
6
6
14
7
8
8
10
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
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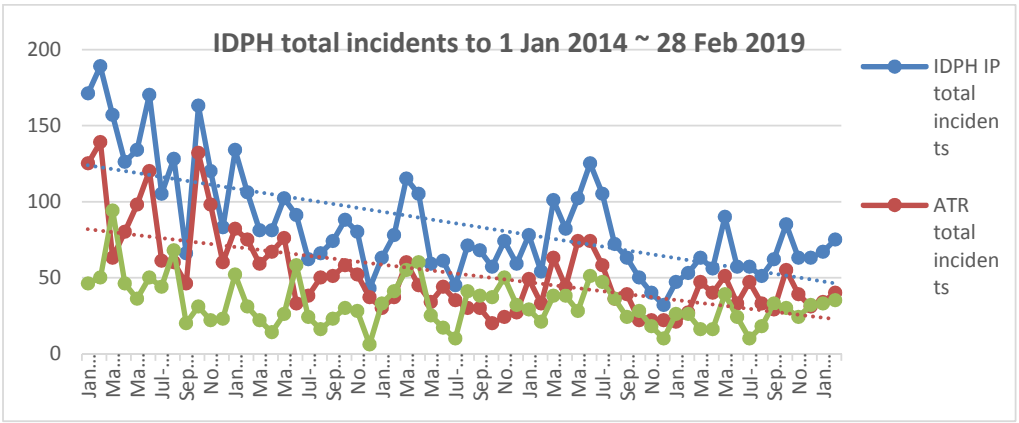
Dec-18
Jan-19
Feb-19


IDPH total incidents to 1 Jan 2014 ~ 28 Feb 2019
200
150
100
50
0
IDPH IP total incidents
ATR total incidents

Living within our means

Living within our Means, including No Wasted Resource

Financial Performance

Canterbury District Health Board

Statement of Financial Performance

Hospital & Specialist Service Statement of Comprehensive Revenue and Expense
For the 8 Months Ended 28 February 2019

MONTH $'000						YEAR TO DATE				
18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000		18/19 Actual $'000	18/19 Budget $'000	17/18 Actual $'000	18/19 Variance $'000	18/19 vs 17/18 Variance $'000
					Operating Revenue					
514	389	592	125	(78)	From Funder Arm	3,951	3,197	4,696	754	(745)
1,433	1,726	1,459	(293)	(26)	MOH Revenue	12,051	12,772	12,158	(721)	(107)
4,292	4,399	4,041	(107)	251	Patient Related Revenue	33,316	36,718	32,664	(3,402)	652
1,474	1,232	1,364	242	110	Other Revenue	12,294	10,056	10,809	2,238	1,485
7,713	7,746	7,456	(33)	257	**TOTAL OPERATING REVENUE**	61,612	62,743	60,327	(1,131)	1,285
					Operating Expenditure					
					Personnel Costs					
59,806	56,456	54,733	(3,350)	(5,073)	Personnel Costs - CDHB Staff	480,681	465,236	435,639	(15,445)	(45,042)
1,918	1,819	1,649	(99)	(269)	Personnel Costs - Bureau & Contractors	15,052	15,529	14,608	477	(444)
61,724	58,275	56,382	(3,449)	(5,342)	**Total Personnel Costs**	495,733	480,765	450,247	(14,968)	(45,486)
11,351	12,871	11,557	1,520	206	Treatment Related Costs	99,976	103,034	93,326	3,058	(6,650)
3,130	3,275	3,508	145	378	Non Treatment Related Costs	27,955	26,553	29,008	(1,402)	1,053
76,205	74,421	71,447	(1,784)	(4,758)	**TOTAL OPERATING EXPENDITURE**	623,664	610,352	572,581	(13,312)	(51,083)
(68,492)	**(66,675)**	**(63,991)**	**(1,817)**	**(4,501)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(562,052)**	**(547,609)**	**(512,254)**	**(14,443)**	**(49,798)**
					Indirect Income					
3	(46)	10	49	(7)	Donations & Trust Funds	7	(321)	20	328	(13)
-	-	-	-	-	Gain on Disposal of Assets	-	-	(21)	-	21
3	**(49)**	**10**	**52**	**(7)**	**TOTAL INDIRECT INCOME**	**7**	**(343)**	**(1)**	**350**	**8**
					Indirect Expenses					
2,114	2,317	2,160	203	46	Depreciation	13,775	16,775	17,235	3,000	3,460
-	-	1	-	1	Loss on Disposal of Assets	(8)	-	1	8	9
2,114	**2,301**	**2,161**	**187**	**47**	**TOTAL INDIRECT EXPENSES**	**13,767**	**16,763**	**17,236**	**2,996**	**3,469**
(70,603)	**(69,025)**	**(66,142)**	**(1,578)**	**(4,461)**	**TOTAL SURPLUS / (DEFICIT)**	**(575,812)**	**(564,715)**	**(529,491)**	**(11,097)**	**(46,321)**

Summary of initiatives

Indication of Latest Efficiencies (including costs avoided)

		Core Financial Benefit			Ancillary Benefit	
		Budgetary Benefits			Non Budgetary Benefits	
Service	Name of initiative/project	Investment for project	$ savings	Financial year of savings	Costs avoided to date	Non-Financial Efficiency
RMO office	Appropriate payment for first year house officers during orientation		20,000	2019		

Achievements/Issues of Note

Improved processes identifying nursing staff available for vacant shifts at Christchurch Hospital

A Roster Manager/ Administrator from Roster Support has worked in partnership with staff from the Department of Nursing to develop a system in Microster that improves the processes utilised to fill vacant shifts. Both casual pool and permanent staff now provide a text to the pool administrator showing their availability. This is entered into Microster, providing a repository of information that enables the Duty Nurse Manager and Administration staff to quickly identify available staff when roster gaps emerge. This new system has released Duty Nurse Manager time from ringing a long list of staff to ascertain staff member's availability at short notice when a rapid and often urgent response is required. It also reduces risk to the organisation by enabling timely replacement of staff and addressing staffing gaps to ensure safe patient management.

Overseas Chargeable Patients

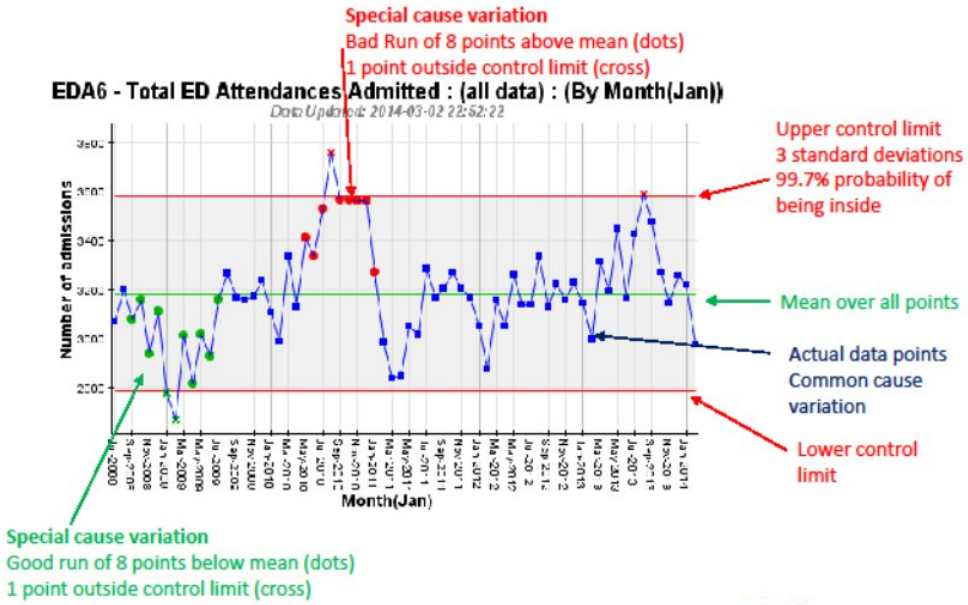
Diligent work on the Christchurch campus has resulted in an increase in revenue from overseas chargeable patients in January 2019. This requires the Campus Finance team and staff working closely with the clinical units throughout the campus.

During January 2017 overseas chargeable revenue was $252,958 and January 2018 was $327,493. During January 2019 the Christchurch Campus raised over 130 invoices for overseas chargeable patients. Net total revenue for the Campus was approx. $530k (including credits). Of these:

- 123 invoices were under $10k each. Totalling $176k
- 10 invoices were $10k and over totalling nearly $379k including $62k potentially delinquent accounts.
- 13 credits totalling $25k issued in January

The trend appears to be an increase in insured parents or adult family members travelling to New Zealand. While the increase in numbers is never a positive, the increase in the numbers of insured patients is.

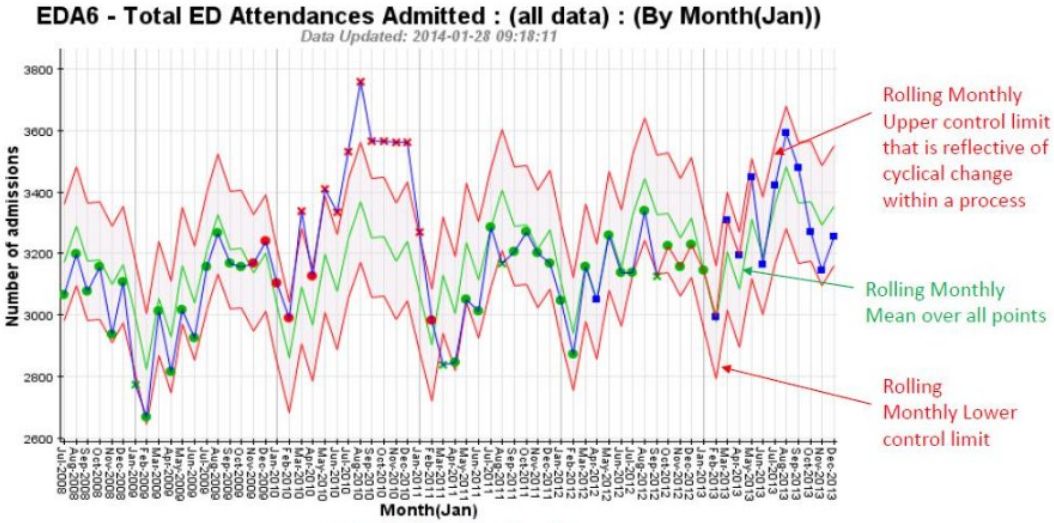
SPC: How to Interpret a Control Chart



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

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Corporate Services**

DATE: **4 April 2019**

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 31 January 2019	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(if required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

Approved for release by: Justine White, Executive Director, Finance & Corporate Services

WORKPLAN FOR HAC 2019 *(WORKING DOCUMENT)*

9am start	31 Jan 19	04 Apr 19	30 May 19	1 Aug 19	3 Oct 19	5 Dec 19
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 (Becky Hickmott) & Allied Health (Jacqui Lunday-Johnstone)	Clinical Advisor Update –Nursing (Mary Gordon)	Clinical Advisor Update – Medical (Dr Sue Nightingale) 2019 Winter Planning Update	Clinical Advisor Update –Allied Health (Jacqui Lunday-Johnstone) H&SS 2016/17 Year Results	Clinical Advisor Update - Nursing (Mary Gordon)	Clinical Advisor Update – Medical (Dr Sue Nightingale) 2019 Winter Planning Review
Presentations	Sleep Health Services in Canterbury	Burwood Campus Avoidable Admissions in General Surgery	Christchurch Campus - Child Health	SMHS	Christchurch Campus – ORL (ENT) TBC: Ashburton / Rural Health	TBC: Christchurch Campus – Dept. of Anaesthesia TBC: Labs
Governance and Secretariat Issues						2020 Workplan
Information Items	2019 Workplan	2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 Workplan	2019 Workplan	2020 Meeting Schedule 2019 Workplan	Quality & Patient Safety Indicators - Level of Complaints (6 mthly) 2019 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)