HOSPITAL ADVISORY COMMITTEE MEETING

Thursday, 1 February 2018
9.00am

Board Room
Level 1
32 Oxford Terrace
Christchurch

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

AGENDA - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

ADMINISTRATION			**9.00am**
	Apologies		
1.	**Interest Register** *Update Committee Interest Register and Declaration of Interest on items to be covered during the meeting.*		
2.	**Confirmation of the Minutes of the Previous Committee Meeting** ▪ *30 November 2017*		
3.	**Carried Forward/Action List Items**		
MONITORING			**9.05am**
4.	Medical & Radiation Oncology - Presentation	Pauline Clark *GM, Medical/Surgical & Women's & Children's Health*	9.05-9.35am
5.	UK Visiting Geriatrician - Presentation	Michael O'Dea *Team Leader, Older Persons Health*	9.35-9.55am
6.	Review of Winter Plan 2017	Dan Coward *GM, Older Persons, Orthopaedics & Rehabilitation*	9.55-10.10am
7.	**Clinical Advisor Update – Verbal Report** • Nursing • Allied Health	Mary Gordon *Executive Director of Nursing* Stella Ward *Executive Director of Allied Health*	10.10-10.30am
MORNING TEA			**10.30-10.45am**
8.	**Hospital Service Monitoring Report** • *Older Persons, Orthopaedics & Rehabilitation* – Dan Coward • *Mental Health* – Toni Gutschlag • *Hospital Laboratories* – Kirsten Beynon • *Rural Health Services* – Berni Marra & Win McDonald • *Medical/Surgical* & *Women's & Children's Health* – Pauline Clark • *ESPIs* – Pauline Clark		10.45-12.00pm
9.	**Resolution to Exclude the Public**	Anna Craw	12.00pm
ESTIMATED FINISH TIME			**12.00pm**

Canterbury District Health Board
Te Poari Hauora ō Waitaha

INFORMATION ITEMS

- 2018 Workplan

NEXT MEETING

Date of Next Meeting : 29 March 2018

ATTENDANCE LIST - PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE MEMBERS

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

Executive Support

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

CONFLICTS OF INTEREST REGISTER
HOSPITAL ADVISORY COMMITTEE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

ANDREW DICKERSON (CHAIR)

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

Maia Health Foundation - Trustee
Is a charitable trust established to support health care in the CDHB area. Current projects include fundraising for a rooftop helipad and enhancements to the children's wards at Christchurch Hospital.

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

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

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

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

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

JO KANE (DEPUTY CHAIR)

Latimer Community Housing Trust – Project Manager
Delivers social housing in Christchurch for the vulnerable and elderly in the community.

Registered Resource Management Act (*RMA*) Commissioner
From time to time sits on RMA panels throughout Canterbury. If any conflicts of interest arise from this they will be advised.

NZ Royal Humane Society – Director
Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise.

HurriKane Consulting – Project Management Partner/Consultant
A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised.

Key to Life Charitable Trust – Undertakes consultancy work for this trust.

BARRY BRAGG

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

Canterbury West Coast Air Rescue Trust – Trustee
The Trust has a services agreement with Garden City Helicopters for the provision of air rescue and air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.

New Zealand Flying Doctor Service Trust – Chairman
The Trust has a services agreement with Garden City Helicopters for the provision of air ambulance services. Garden City Helicopters has a long-term air ambulance contract with the CDHB.

CRL Energy Limited – Managing Director
CRL Energy Limited provides air quality testing and asbestos sampling and analysis services; methamphetamine contamination testing; dust; gas and noise workplace monitoring services in New Zealand. There is the potential for future work with the CDHB.

SALLY BUCK

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

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

DR ANNA CRIGHTON

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

DAVID MORRELL

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

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

Heritage NZ – Subscribing Member
Heritage NZ's mission is to promote the identification, protection, preservation and conservation of the historical and cultural heritage of New Zealand. It identifies, records and acts in respect of

significant ancestral sites and buildings. CDHB owns buildings that may be considered to have historical significance.

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

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

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

Friends of the Chapel – Member.

JAN EDWARDS

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

DR ROCHELLE PHIPPS

No conflicts.

TREVOR READ

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

ANA ROLLESTON

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

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

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

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

DR JOHN WOOD (EX-OFFICIO)

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

SIR MARK SOLOMON (EX-OFFICIO)

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

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, 30 November 2017, commencing at 9.00am

PRESENT

Andrew Dickerson (Chair); Jo Kane (Deputy Chair); Sally Buck; Dr Anna Crighton; Jan Edwards; Dr Rochelle Phipps; Trevor Read; Ana Rolleston; and Sir Mark Solomon.

APOLOGIES

Apologies for absence were received and accepted from Barry Bragg; David Morrell; and Dr John Wood.
An apology for early departure was received and accepted from Sally Buck (11.46am).

EXECUTIVE SUPPORT

Mary Gordon (Executive Director of Nursing); Carolyn Gullery (General Manager, Planning & Funding and Decision Support); Justine White (General Manager, Finance and Corporate Services); Jan van der Heyden (Business Manager); and Anna Craw (Board Secretary).

Apologies

David Meates (Chief Executive); Dr Sue Nightingale (Chief Medical Officer); and Kirsten Beynon (General Manager, Laboratories).

IN ATTENDANCE

Item 4

Kathy Davenport - Service Manager, General Surgery
Grant Coulter - Clinical Director, General Surgery
Greg Robertson – Chief of Surgery

Item 5

Wayne Turp - Team Leader Child and Youth Health
Norma Campbell – Director of Midwifery
Janet Whineray - Clinical Director, O&G
Nicola Austin - Chair, Child and Youth Health Workstream

Item 8

Dan Coward – General Manager, Older Persons, Orthopaedics & Rehabilitation
Toni Gutschlag – General Manager, Specialist Mental Health Services
Berni Marra – Rural Health Services
Pauline Clark – General Manager, Medical/Surgical and Women's & Children's Health
Andy Macknelly – Senior Project Manager, Planning & Funding

Andrew Dickerson, Chair, opened the meeting welcoming those in attendance and in particular Dr Rochelle Phipps, a newly appointed member to the Committee.

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 (20/17)
(Moved: Trevor Read/Seconded: Sally Buck – carried)

"That the minutes of the meeting of the Hospital Advisory Committee held on 5 October 2017 be confirmed as a true and correct record."

3. CARRIED FORWARD/ACTION ITEMS

It was noted that there was nothing further to report with regards to funding for migrant workers. This will be incorporated into wider discussions planned with the Minister/Ministry of Health (*MoH*) to be held in the near future. It was agreed that this item could be removed from the carried forward items.

Dr Anna Crighton and Jo Kane joined the meeting at 9.05am.

The Committee noted the carried forward items.

4. GENERAL SURGERY - PRESENTATION

Pauline Clark – General Manager, Medical/Surgical and Women's & Children's Health, introduced Kathy Davenport, Service Manager, General Surgery; Grant Coulter, Clinical Director, General Surgery; and Greg Robertson, Chief of Surgery, who presented to the Committee on General Surgery.

The presentation included:

- An introduction to the department and the changing role of general surgery.
- Increase in both acute and elective (planned) surgery.
- The opening of the new Outpatients and Acute Services buildings and the positive impact this will have.
- The appointment of new General Surgery/Trauma surgeons and the development of a trauma service in the department.

There was a query around readmission rates, with the Committee noting that these are stable. Ms Davenport advised that readmission should not necessarily be viewed as a negative. It is recognised that patients do better in their own environments and where appropriate patients are discharged home with appropriate contact details to enable readmission if required. Finding the right balance for the patient is important.

The Committee thanked those in attendance for the comprehensive presentation.

5. STRATEGIC DIRECTION OF MATERNAL HEALTH

Carolyn Gullery, General Manager, Planning & Funding and Decision Support, presented the report which was taken as read. Also in attendance were Wayne Turp, Team Leader Child and Youth Health; Norma Campbell, Director of Midwifery; Janet Whineray, Clinical Director, O&G; and Nicola Austin, Chair, Child and Youth Health Workstream.

There was discussion around primary maternity services, including previous plans as well as Burwood options. The Committee was advised that at this stage there is no plan for a birthing unit at Burwood.

With Christchurch Women's Hospital coming under increasing pressure as the tertiary birthing centre for the South Island, there is increasing pressure to resolve the availability of primary birthing services in Christchurch.

A Project Manager from Planning and Funding is to be appointed, to assist with the development of a plan. This is seen as a priority project for 2018.

The Committee provided its endorsement to move forward with the development of a preferred option. Verbal updates are to be added to the carried forward list and provided at each meeting; along with a comprehensive report to the Committee in 2018.

Resolution (21/17)
(Moved: Sally Buck/Seconded: Jan Edwards – carried)

The Committee recommends that the Board:

i. notes the strategic direction for maternal health.

6. CLINICAL ADVISOR UPDATE

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

- Recruitment of new graduate nurses. CDHB has employed 200 across Canterbury, with 50 going into Mental Health.
- Competency Assessment Programme (*CAP*). There is an increasing number of overseas trained nurses based in Auckland who are participating in Canterbury's 12 week CAP, consisting of theory provided through Ara and clinical placement provided through CDHB. 50% of participants in the most recently completed CAP were from Auckland.
- South Island policy framework for registered nurse prescribing.
- Post graduate nursing study.
- Work underway looking at the nursing structure for new wards at Christchurch Hospital.
- Health Research Education Facility (*HREF*) – detail now being worked through around operational matters.
- Recent release of the Health Quality & Safety Commission's adverse events report for 2016/17. CDHB has appointed a senior nurse into the role of SAC 1 & 2 investigations in an attempt to improve CDHB's ability to meet reporting requirements.

There was discussion around the CAP update, including a query on the number of Auckland participants returning to Auckland at the completion of the programme. Ms Gordon advised that all returned to Auckland. Discussion took place as to why Auckland was not providing its own CAP and whether it was CDHB's role to fill this gap.

7. 2018 WORKPLAN

The Committee received the 2018 Workplan, noting that it was a working document.

The following presentations were confirmed:

- 1 Feb meeting: Medical and Radiation Oncology
- 29 Mar meeting: General Medicine

There was a request for the following:

- General Managers to report back on the status of drink dispensing machines within CDHB facilities; to include whether sugary and/or artificially sweetened beverages are available via any machines; and also the status of advertising on dispensing machines.
- A presentation/update highlighting the impact of sugary and/or artificially sweetened beverages on hospital services and theatre utilisation.

The Chair undertook to discuss with Management how best to address these items.

The meeting adjourned for morning tea from 10.45 to 11.00am.

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

The Committee considered the Hospital and Specialist Services Monitoring Report for November 2017. The report was taken as read.

General Managers spoke to their areas as follows:

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

- Winter flow - highlighted the success of the pilot scheme of a Clinical Nurse Specialist (*CNS*) based at the Christchurch campus working alongside all of the General Medical wards.
- Fall incident notifications – continue to see reduction in overall patient falls, however, there has been a slight rise (1.4%) in falls resulting in injury.

There was a query around falls resulting in injury, with it noted that this currently sits at 22%.

Specialist Mental Health Services – Toni Gutschlag, General Manager

- KPI19 – a key suicide prevention activity and patient safety measure. CDHB is the highest performer across all DHBs, which is very pleasing.
- AT&R – for safety reasons a separate area has been created for one patient, which to date is working well.
- Child and Youth – continued concerns around pressures and wait times. Discussions with MoH and other DHBs indicates that CDHB's experience with wait times and staff turnover issues is evident across other DHBs as well. Work continues with Planning & Funding to increase support options.
- TPMH based facilities – clinical review has been completed and accepted, with the project now moving to the Detailed Business Case phase.
- Workforce challenges are a national issue. Many options are now available to staff.

Discussion took place around a recent article in the NZ Herald concerning children being admitted to adult mental health wards. It was noted that this was not a practice that CDHB supported, with CDHB being very aware of its obligations in this area.

There was discussion around wait times for child and adolescent services, which led to discussion on the School Based Mental Health programme. Ms Gutschlag advised that the School Based Mental Health programme has been extremely successful to date and is well

regarded. The Committee noted that without the programme, child and adolescent services wait times would be even higher.

Hospital Laboratories – Mary Gordon, Executive Director of Nursing

- Labs project – medium and long term options around facility constraints are being worked through, with an options paper going to the Facilities Committee late January 2018.
- Some facility issues will need to be addressed immediately in order to meet IANZ accreditation requirements for 2018.

Ashburton Health Services – Bernie Marra, Manager Ashburton Health Services

- Ashburton Emergency Department attendances for the age group 75 years are higher than previous years.
- Count of re-admissions for patients over 75 is trending downward.
- Core focus is on the Frail Older Persons Pathway and the coordination of services.

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

- 2017 Canterbury Health System Quality Improvement and Innovation Awards. The Supreme Award Winner was: A "one stop shop" for students with type 1 diabetes at the University of Canterbury Health Centre.
- Provided example of collaborative care practice from Paediatric Daystay Unit and Paediatric Outreach Service.
- CDHB's Radiology Service's Charge Sonographer, Rex de Ryke, has been selected as Australasian Sonographer of the Year.
- Steady progress being made towards the aim of not taking paper clinical records into the outpatient facility. This is enabling medical records staff to redirect their work to the recall and/or destruction of files.
- Work to support people with haemophilia to maintain healthy lives in the community.
- The development of paediatric neurosurgical clinics that run each fortnight in the Paediatric Outpatient Department, ensuring that children are seen in a child appropriate environment and cared for by people who have child specific competencies.
- Improving access to training material for theatre nurses. Two SharePoint sites have been set up; one holding policy and procedures, and the other holding a wide range of information required by nurses working in the perioperative service.
- A drive on professional development for administrators.

There was a query around the identification of melanomas underneath the hairline and whether education was provided to hairdressers on the identification of such melanomas.

Sally Buck retired from the meeting at 11.46am.

Accessibility issues around the Christchurch Campus were discussed, with particular concern expressed for the increasing deterioration of road and pedestrian access. The Committee was advised that weekly meetings, instigated by CDHB, continue with a number of external parties in an attempt to remain informed and be able to plan ahead to minimise access issues where possible. This area continues to be an ongoing challenge.

ESPIs

Carolyn Gullery, General Manager, Planning & Funding and Decision Support, advised that a letter had been sent to the MoH yesterday seeking ESPI dispensation due to IT issues that have been identified. There is now an understanding of what has occurred and work is underway to remedy the issue.

With regards to Faster Cancer Treatment (*FCT*) reporting, there was further discussion around the tail and the request for data around the distribution of wait times for these patients. Andy

Macknelly, Project Manager, Planning & Funding, explained the importance of having an explanation behind the figures for those patients who miss the target, without which it is difficult to provide a complete picture.

There was a query around Do Not Attend (*DNA*) figures, with the Committee advised that DNAs can be excluded from ESPI figures.

There was a query whether the Christmas period will impact on ESPI production. A slight impact is anticipated.

Resolution (22/17)
(Moved: Sir Mark Solomon/Seconded: Anna Crighton - carried)

"That the Committee:

i. notes the Hospital Advisory Committee Activity Report."

9. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (23/17)
(Moved: Jan Edwards/Seconded: Sir Mark Solomon - 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 5 October 2017.	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

INFORMATION ITEMS

- 2017 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 12.10pm.

Confirmed as a true and correct record.

_____ _____

Andrew Dickerson
Chairperson

Date

CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

HOSPITAL ADVISORY COMMITTEE
CARRIED FORWARD ITEMS AS AT 1 FEBRUARY 2018

DATE		ISSUE / ACTION	REFERRED TO	STATUS
1.	02 Aug 2016	AT&R Unit Update	Toni Gutschlag	Verbal Update.
2.	16 Nov 17 (Board)	2017 winter numbers and flow, plus impact on 2018 winter planning	Dan Coward	Today's Agenda – Item 6.
3.	30 Nov 17	Progression of Maternal Health Strategic Direction	Carolyn Gullery	Verbal Update.
4.	30 Nov 17	Status of drink dispensing machines	GMs	Verbal Update.

REVIEW OF WINTER PLAN 2017

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Planning and Funding**

DATE: **1 February 2018**

Report Status – For:	Decision ☐	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

This report has been prepared at the request of the Board, to provide the Committee with an overview of the 2017 winter review, as well as planning underway for the 2018 winter.

2. RECOMMENDATION

That the Committee:

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

3. SUMMARY

A winter planning process commenced in late 2016 looking at what the data was predicting in terms of flow, beds and capacity impacts that we may face in 2017. Reviewing the data resulted in looking at what activity we could do as a health system that may mitigate the predication of capacity being reached within the hospital setting in July and August. A series of initiatives were identified, 24 in total, and a plan developed that drove a focus on what we needed to do - a dashboard that made visible the data that was available and a team that began to focus on our activity, our relationships and communication. All 24 of the initiatives were actioned, with several becoming the way in which we continue to operate throughout the year. The gains seen from this focus include:

a. an increase of same day discharge from 10% to 12%;
b. an increase of transfer and discharge prior to midday from Acute Medical Admitting Unit to 24% (up from 22%);
c. an improvement in the Emergency Department wait time for people over 75 years old by 3% (who were waiting more than six hours in ED), from 11.5% down to 8.5%; and
d. a reduction in the readmission rate at 28 days for over 60 years in age from 11.4% to 8.5%

4. DISCUSSION

We identified a number of work streams we felt would add value to the changes needed for the winter in 2017. Our proposed work streams were:

- Forecasting demand and capacity options within the CDHB provider arm.
- Workforce recruitment for the CDHB provider arm.
- Promoting wellness across the sector.
- Connecting our response with the wider health services of Canterbury.
- Doing things differently with different approaches.

In all of the 24 actions, an outcome was achieved contributing to continued flow across the health system. In preparation for 2018, the ongoing planning process has begun, ensuring the gains achieved in 2017 continue, with a revised focus in a number of areas. Further planning around resourcing for Burwood forms part of this process to ensure flow and reducing the demand on Christchurch campus beds during the winter period.

A further update on 2018 winter planning will be provided to the Committee's 31 May 2018 meeting.

5. CONCLUSION

A focus on winter planning has produced results that enabled the system to cope with the increasing population demands, while balancing the demand on service and beds. This forms the basis for the focus in 2018 for the winter planning process.

6. APPENDICES

Appendix 1: Winter 2017 In Review

Report prepared by: Dan Coward, GM Older Persons, Orthopaedics & Rehabilitation

Report approved for release by: Carolyn Gullery, GM Planning & Funding and Decision Support

Winter 2017 in review

"We need the whole system to be working for the whole system to work"

Dan Coward

CANTERBURY DHB | NOVEMBER 2017

The winter story

The earthquakes of 2010 and 2011 have had a major impact on the people of Canterbury as well as the Canterbury Health System. While the health system has been able to maintain and deliver innovative services to address the emerging needs of our population, there remain a number of significant challenges and successes; we still have broken buildings, and stretched capacity and we have a population that is more fragile and more likely to require support from our health system, particularly for mental health services. The ongoing delivery of care and services in buildings that don't comply with new building codes while we repair and redevelop our building stock requires balance with the immediate harm caused by denying our population access to services.

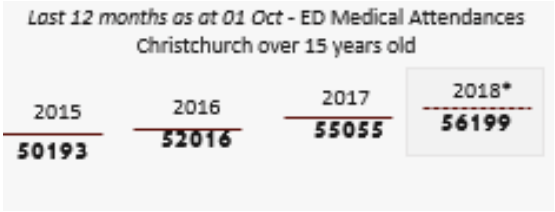


Figure 1.Overall Medical Attendances at ED Christchurch over the 12 months to 01 October 2017

- *40% admitted to Inpatient Wards*
- *11% admitted to ED Short Stay Unit*
- *49% discharged home*

We face further challenges to meet our population's needs with sub-standard housing, crowded, damp and cold conditions and winter periods where our capacity remains constrained. To achieve our vision, the three key directions in Canterbury's Health Services vision for future health services are:

- Further development of services that support people to take increased responsibility for their health and a change of approach within existing services to support this
- Development of primary health care and community services' capacity and capability to support people in a community based setting and provide a point of ongoing continuity
- Freeing up secondary care based specialist resources to be responsive to episodic events, more complex cases and the provision of advice and support to primary care.

Canterbury continues to have an increasing aged population and has the largest DHB populations of over 65 years and over 75 years in absolute numbers, however while remaining above average these proportions of national share have slightly reduced as the national population also ages.

During 2017 the Canterbury Health System responded to a known winter challenge where we would encounter flow challenges throughout winter. A winter planning process commenced in late 2016 looking at what the data was predicting in terms of flow, beds and capacity impacts that we may face in 2017. Reviewing the data consolidated our response and preparedness into looking at what activity we could do as a health system that may mitigate the predication of capacity being reached within the hospital setting in July and August. A series of initiatives were identified, 24 in total and a plan developed that drove a focus on what we needed to do. A dashboard that made visible the data that was available and a team that began to focus on our activity, our relationships and communication. Ultimately reaching this point in reviewing how we did against the environment of growing population and a constrained system.

The approach

Through our workshops, looking at the data and having the conversations, we identified a number of work streams we felt would add value to the changes needed for the winter. Our proposed work streams were:

- Forecasting demand and capacity options within the CDHB provider arm
- Workforce recruitment for the CDHB provider arm
- Promoting wellness across the sector
- Connecting our response with the wider health services of Canterbury – the Urgent Care SLA is leading an integrated winter response to ensure community services continue to reduce presentation and admission to hospital
- Doing things differently with different approaches, such as a pilot to have a geriatrician in AMAU, OPH&R changes in flow, assessments and bed plan, direct community admissions, increased occupancy at OPH and extended hours for acute theatres.

Conclusions

The use of data to shape our conversations and planning is well embedded and the 2017 winter planning process is a great reflection of this. This winter we achieved a number of new initiatives and maintained flow across the system. There were periods that were tight, and staff made an extraordinary effort in meeting these demands. The activities that are now undertaken as part of our practice is the 830 huddle at Christchurch Campus are testimony to how we prepare and respond to highly predictable peak periods. Key activities that now need to be undertaken for 2018 and beyond include:

1. Confirm the Clinical Nurse Specialist role from Older Persons Health and Rehabilitation Services to continue focus on early transfer of care from Christchurch
2. Establish the plan for resourcing Ward D2 Burwood Hospital for 2018
3. Plan for increased winter staffing for Older Persons Health and Rehabilitation Services Inpatient environment to resource 24 beds during winter peak period
4. Confirm training needs during winter periods
5. Recruitment process for vacancies pre winter periods to be focus on of People and Capability alongside the business
6. Maintain system level focus for winter flow

So how did we go?

			
Yes, we achieved this and now forms part of what we do now	No, we did not achieve this and we need to know why	Work in progress	Did not start and need to understand why

Theme 1: Forecasting demand and capacity			
1.	Daily 0830 Huddle on CHCH Campus involving key clinical and operational leads.		Embedded as a business as usual practice that is having benefits to awareness of flow, communication and relationships across the system.
2.	Monitor community services such as the 24 Hour Surgery and Acute Demand utilization and update 0830 Daily Huddle		Work needs to be undertaken to include a dashboard of this information, challenged as not all information is available.
3.	Booking system for beds in Intensive Care Unit (ICU) post elective surgery		This is working well, and forms part of the 0830 Huddle looking at bed capacity across the system.
4.	Extended hours MDU- increased flow		The practice has not yet changed however progress to moving some volumes to community is underway.
5.	Iron infusions to be done in primary care. (phase 1 provision from Burwood outpatients)		Following changes it was decided to not progress Phase I to Burwood but proceed straight to community and is underway.

Theme 2: Workforce Recruitment			
6.	Timely recruitment, ensuring vacancies are appointed prior to and during winter, pool and casual levels increased.		Reporting shows an average of 100 day turn around for recruitment, while focus ensured less vacancies pre Winter, still constraints on workforce and timeliness and vetting process was observed and reflected in budgets.
7.	Monitor staff numbers on ACC (work and non-work accident) and recruitment to cover the longer term absences over the winter period in 2017		Large gap in information for managers. Will form part of Occupational Health Service Improvement Project currently underway.
8.	Training halted during months of June-September for all staff except mandatory training.		Some training was deferred. Need to define what core competency training is, versus discretionary training and what impact this has during constrained periods on staff numbers.
9.	Clinical Nurse Specialist (CNS) and Clinical NE groups will be focused on supporting delivery in the ward environment where identified.		Successful involvement and integration of our CNS workforce with our inpatient environments.
Theme 3: Promoting Wellness			
10.	Flu shot promotion, supporting wellbeing, and visibility of safety and wellbeing advisors, supporting workload.		Good gains for flu shot, however need to explore role of safety and wellbeing advisors in supporting front line managers with wellbeing during this time.
11.	Support staff with chronic and long term illness, and ensuring return to work plans support and enable patient flow activities as a priority.		Forming part of occupational health review to ensure we have robust process going forward.
12..	Influenza monitoring through community and public health, Labs and communications		Reporting is now visible across system with regular reporting. As a DHB we were a top performer nationally in the delivery of flu vaccinations within the community ultimately contributing to our low influenza rates this winter

Theme 4: Connecting the response			
13.	ED Fellow presence extend to 0200 hours		This was achieved and has had a positive impact on flow and support during the late evenings.
14.	ED patient flow focus on improving flow, patient experience, less waiting and faster decision making for discharge to home and or observation in ED observation unit before inpatient transfer.		Positive outcome with more senior decision making occurring. Improved flow due to WorkUp with a second Assistant Charge Nurse Manager
15.	Community services working with patients with known chronic conditions.		This approach is well embedded within our health system. We continue our focus with the Community Service SLA redesign to ensure we continue to support people in their own home and develop for the future sustainable care in the home solutions.
16.	Identification of known patient cohorts (eg COPD and heart failure) for alternate ambulance response including access to general practice.		Current Clinical criteria is working for Heart Failure, however the steering group has noted no uptake of alternative ambulance response. COPD continues to be a success.
17.	Use of Acute Demand for supported discharge as well as hospital avoidance		The pathway for supporting - discharge using the Acute Demand Management Service continues to be an effective model for appropriate patients with ongoing work to understand impacts on readmissions
18.	Regular communication with general practice on winter pressures, including community escalation strategies seeking support for hospital avoidance activities in times of extreme pressure		The mechanisms to communicate with general practice include through the Urgent Care SLA and regular communications with 24HS, and general practice via PHOs, using a step up process in response to identified pressure. In 2017 specific messaging was communicated on one occasion, noting that the threshold for extreme pressure requiring community escalation strategies was not reached.

19.	Additional Medical Registrar working between General Medicine, AMAU and ED on nights at Christchurch Hospital from June to September to support review and flow of patients		This was successful with handover occurring, variance did occur with support going across both General Medicine and Specialty Medicine.
Theme 5: Doing things differently			
20.	Rapid assessment by geriatrician 0800 – for morning session with utilisation of community follow up clinics to promote rapid discharge.		Completed the pilot, stopped and made a different choice to focus on a CNS pilot.
21.	Appropriate patient transfer in the morning to older person's health for patients identified from morning assessment.		Achieved intention of activity. Ongoing focus for what flow and bed numbers needed for system
22.	Rapid assessment clinics for the community referrals, ensuring they do not need admission to Burwood further creating capacity for flow from Christchurch Hospital.		We identified our current resources and with some changes to clinic format, we identified had the right resource in the right place and did not need to change our admission pathway to meet demand.
23.	Trigger identified to review patients predicted (via SFN) for LOS that will be over 10 days		Our LOS did not increase over Winter and focus has been to move to reviewing those with increased LOS to see what if any different activity can be undertaken for the individual
24.	Change in discharge summary to transfer of patient from CHCH to Burwood		Not yet landed. Agreed a priority, and working to ensure our patient focused needs can meet Ministry reporting needs alongside project surrounding discharge documentation which encompasses transfer documentation through the Office of the Chief Medical Officer.
Theme 6: What we did that we hadn't planned			
25.	CNS Liaison to facilitate timely and appropriate transfer of patients to the Burwood site from CHCH Campus.		Working alongside the senior medical officers who provide a consult service to Christchurch Hospital this is a pilot

In a nutshell, the information below indicates some of the system challenges:

(For the purpose of the data winter was defined as between 01 May to 30 September).

Admissions

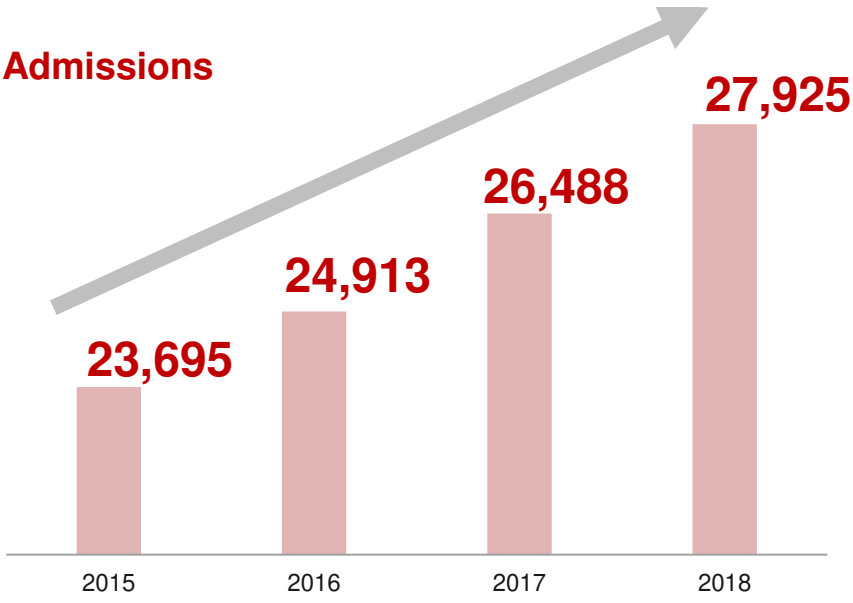


Figure 1: Acute Medical volume between 01 May and 30 September (hospital stay)

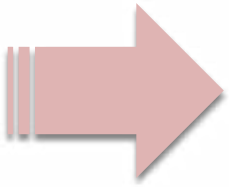
Population growth

The ability to prevent or slow unplanned demand growth is a strength of the Canterbury Health System and an outlier nationally. If Canterbury performed at the national average there would be approximately 14,000 more acute admissions. The reduced demand for acute medical beds has averted significant investment, and while acute medical volumes have grown, against our population growth we have demonstrated the investment in our models of care and approach as a Canterbury Health System to demand.

General Medicine: 2017

6,127

ED Admissions



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Direct Admissions

Admission Distribution

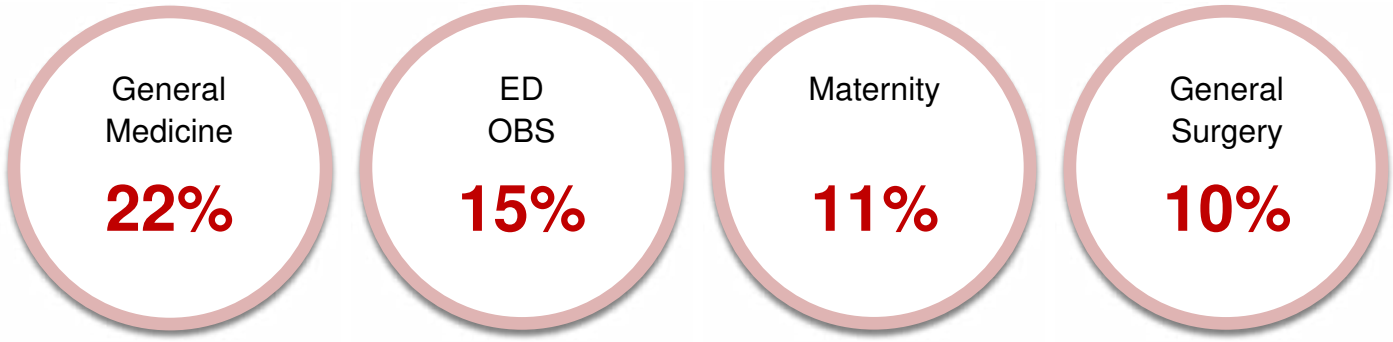


Figure 2: Comparison of General Medicine Admissions and the pattern of distribution across the Christchurch Hospital campus

FLOW

Occupancy | Monday before 8am

150 **occupied beds** in 2017 *(median)*

*up from a median of **135** across the previous 3 years*

IN

⇒ 17% Mon

⇒ 15% Tue- Fri

⇒ 12% Weekend

OUT

⇒ 18% Monday

⇒ 16% Tue-Fri

⇒ 10% Weekend

OUTCOME

28 Day Readmission Rate

3% **Decrease** for **<60** year olds *from 11.4% to 8.5%*

1% **Increase** for **>61** year olds *from 15% to 16%*

4.4% Mortality In-hospital

Occupied Bed Days

Same pattern of occupancy from 1 July in 2017 compared to:

90 **2016** *Median, range 64-120*

87 **2017** *Median, range 67-97*

CHANGE

Same Day Discharge

12% Compared to 10% for the previous three years

Transfer/discharge from AMAU

24% Before midday, a 2% increase

ED to admission

3% **improvement in ED wait time for** people over 75 years old (who were waiting more than 6 hours in ED) from 11.5% to 8.5%

Christchurch → Burwood

7% of all admissions are transferred to Burwood and stayed an average of **9** **days** at Christchurch Hospital, down from 2016

Figure 3: System outcomes *(Icons from TheNounProject.com: Delwar Hossain, Icon Track)*

Theme 1: Forecasting demand and capacity

Approach System Flow

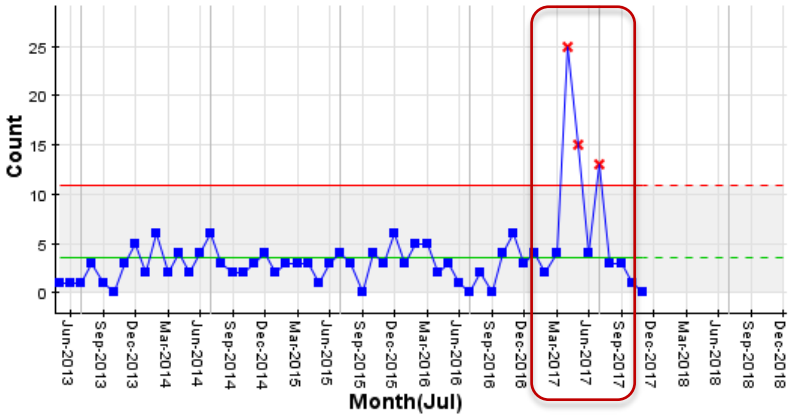
Dependent on the entire system working together. If we incorporate general practice, community urgent care, acute demand, ED, general medicine and surgery, and older person's health and rehabilitation as partners to managing the system flow, each enables the system to flex to its demands.

Aim: Flow into Burwood from Community Admissions

As part of the response to 2017 winter, we looked at how community admission could increase flow into Burwood, reducing impacts on ED or AMAU. This also reduces the disruption to patient care from multiple handovers of care.

Way of working1: Early transfers of General Medicine patients to Burwood

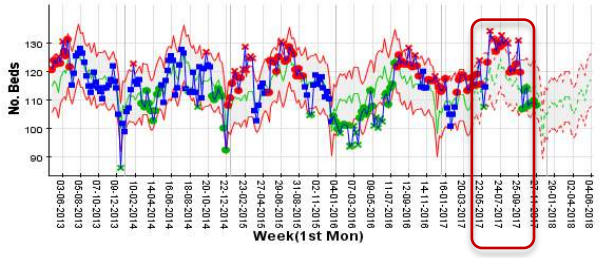
We can see that this winter we achieved a greater direct admission to Burwood (see **Graph 1**.), that **applied for patients that did not require acute treatment**, alongside the opening of more beds.



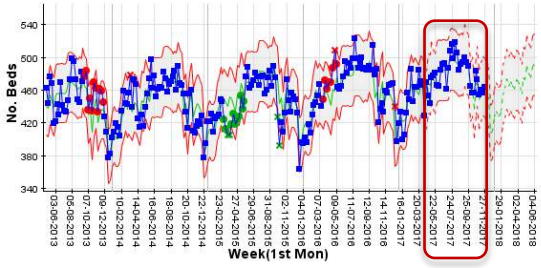
Graph 1. AMAU to Burwood transfers

Way of Working 2: Managing Occupancy across Christchurch Campus and Burwood

An additional 20 beds were resourced throughout the winter resulting in an increase of admissions to OPH (see **Graph 2**). This contributed to the bed numbers in Christchurch campus not breeching despite periods of high demand and admissions within Christchurch (see **Graph 3**). However the increased bed occupancy for Burwood is evident, with additional admissions and discharges. Occupied bed days across the system shows the increased high occupancy period during winter across both campus.



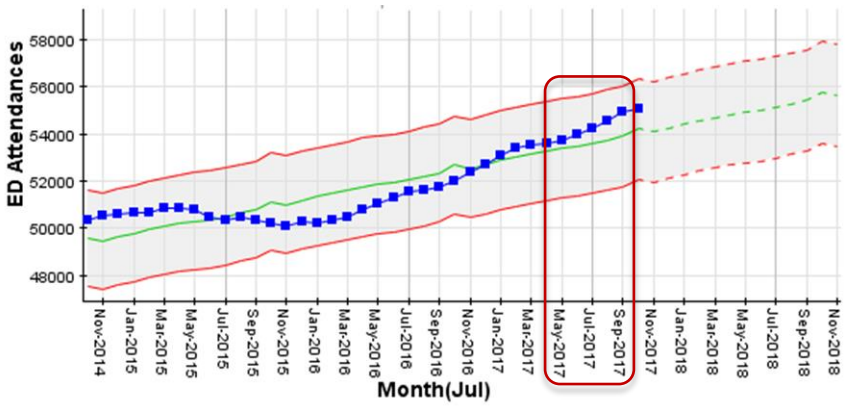
Graph 2. Average Bed Occupied end of the Day by week Burwood Hospital



Graph 3. Average Beds Occupied at end of the day Christchurch Medical and Surgical (excl. paeds.) by week

Way of working 3: Using historical projection to manage demand

Preparing the system for the response required greater visibility of the demand projection. The winter projection based on historical pattern of Emergency Attendances indicates that action had to be taken to manage internal flow, as volume would follow the normal pattern of growth and ageing.

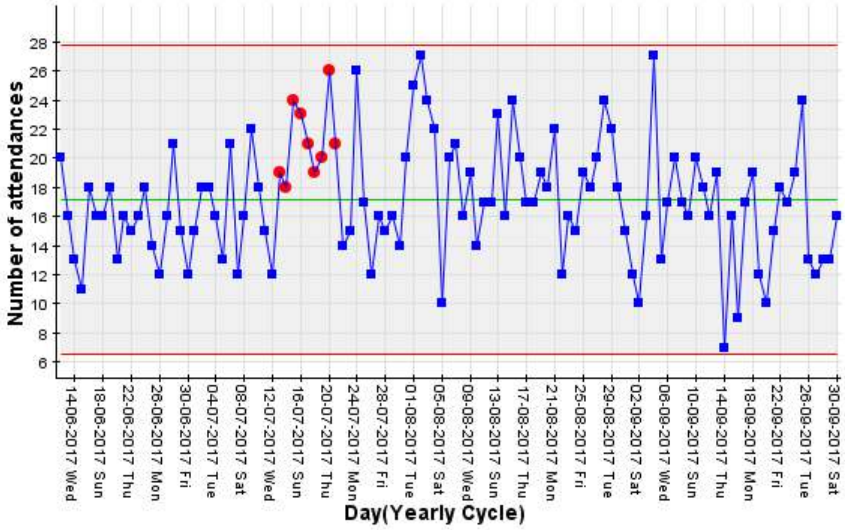


Graph 4. Accumulative view of ED Attendances at Christchurch - last 12 months as at 01 October - Adult Medical attendances

Way of working 4: Additional Medical registrar working between General Medicine, AMAU and ED on nights

The additional Medical register worked from June to September to support review and flow of patients at Christchurch Hospital.

The volume during this period ranged between 15 and 19 admissions per night, compared to summer with a range of 8 to 13 admissions per night to General Medicine. Admission is a significant work load for a single Registrar to manage, along with clinical emergencies during the night. Activity included both Registrars attending morning handover for General Medicine, and it was clear that they had both undertaken a clinical workload reflective of the forecast growth. There was variance, however this enabled some cover with the Specialties night Registrar.



Graph 5.Daily departure from Emergency Christchurch departure of patients admitted between 6pm to 7am to Gen. Medicine

Way of working 5: 830 Huddle

The 8:30 Huddle contributes to communication flow across the campus and sees the system data to inform decisions both on the day and forecast activity, enabling conversations about elective service flow and changes to prioritization of acute workload. The 830 Huddle is embedded as an activity that contributes to the system in all we do, whether winter or summer, peak periods or not. Contributing wider was aligning the daily staffing, reviewing capacity and demand for Burwood with the Clinical Team Coordinator and Duty Manager Handovers.

Conclusion:

- **Additional Medical registrar:** Going forward, this position should be a floater, who can help in any part of internal medicine, though Gen Med will probably be the main service of need.

Unintended consequences of this process:

- **Managing Occupancy:** Process focus on General Medicine, we need to ensure visibility of Surgical Cluster and how system links

Theme 2: Workforce Recruitment

Approach Timely recruitment

Our workforce is key to the success of the health system. How we respond to timely recruitment to ensure the right person in the right place at the right time is critical during peak periods. A rapid solution to the visibility of workforce vacancies linked to establishment numbers is important. People & Capability's role to support and lead initiatives that support internal transfer of staff, to further streamline the recruitment process supports this aspiration and forms part of the wider people strategy.

Aim: Sharing of recruitment expertise

A focus to include the sharing of recruitment expertise across portfolios to ensure no particular workforce is under resourced due to unforeseen issues including the NetP recruitment timing was a critical factor in this process this winter. Winter 2017 saw more pressure on West Coast recruitment than previously, with little or no change from previous patterns in Canterbury. There were three areas providing difficulty recruiting to. The people life cycle strategy has a focus on streamlining a number of activities to gain consistency of recruitment practices across services. The difference in approval process identified will be addressed through P&C reviews.

Way of Working 1: Visibility of Recruitment Timing

We maintained higher levels of nursing pool and casual staff, and this year increased allied health numbers. Our aim to enable a greater pool for recruitment, entering Winter without an early deficit in recruitment levels reduces impact on the system flow, cost to the organisation and supports improved wellbeing for all our workforce. This winter reporting on the timeliness for recruitment was made visible. Impact of maintaining involvement in projects such as life cycle review did have create impact for some staffing groups.

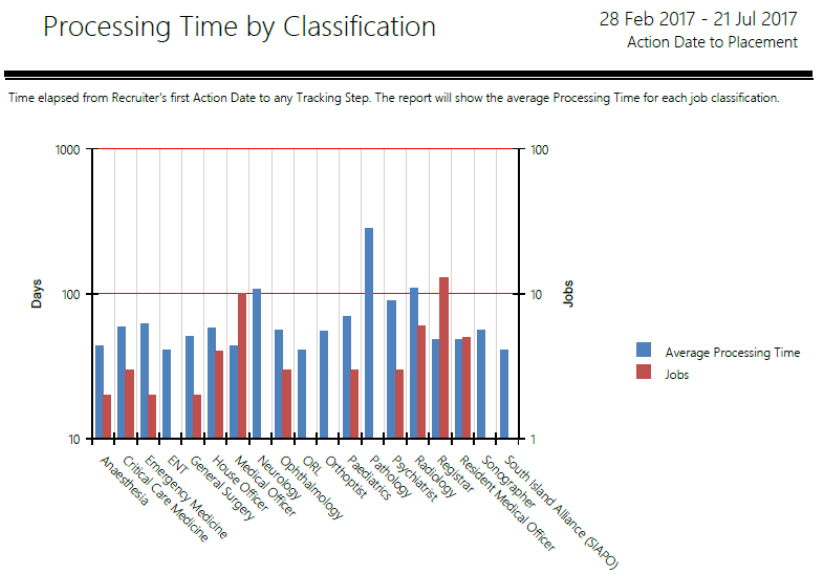


Figure 2.Recruitment processing time Jan-Jun 17

Figure 3Recruitment processing time Jul-Nov 17

Way of Working 2: Non-mandatory training postponed

Ensuring all training that is not mandatory is postponed during the months of June-September did not deliver the efficiencies expected.

Way of Working 3: Clinical Nursing focus on Patient direct care

All Clinical Nurse Specialists and Clinical Nurse Educators focused on supporting patient flow and activity on the ward environment when identified and this contributed at high periods of staff sickness.

Conclusion:

- Clinical nursing focus on direct patient care: A focus on working towards recruiting over base numbers before winter is necessary to enable work readiness and manage projected vacancies as a part of winter preparedness going forward
- Non-mandatory training postponed: Ensuring our training and development plan is adaptable for peak periods throughout the year is needed to reduce peak period demands on staffing.

Unintended consequences of this process:

- Non-mandatory training postponed: While some courses were deferred, the delay in training has all but off set training replacement needs to other pinch points of the calendar year and phasing across the calendar year is needed, with greater visibility of what the training programme needed.

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Theme 3: Promoting Wellness

Approach

Partnering with the Communications Team, Health and Safety, Public Health and Primary Health services to develop communications and initiatives that focus on sustaining health rather than focusing only on vaccination.

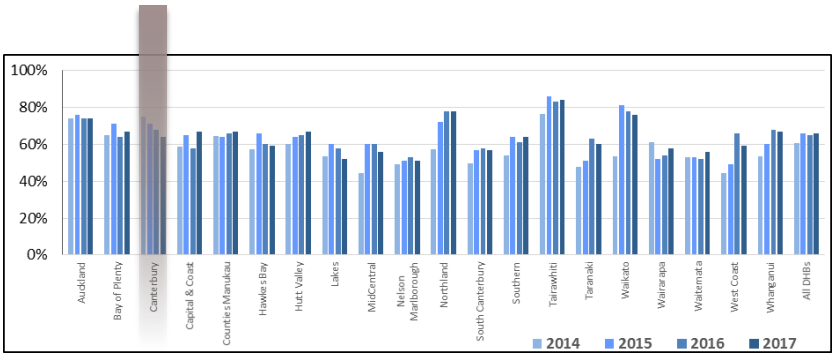


Figure 4. Comparison of DHB Health Care Worker Coverage by DHB 2014 - 2017

Aim: Increase Influenza Immunization

Vaccination is important all year and there are other factors in staff wellness. Health care workers, by virtue of their occupation, are at increased risk of contracting influenza and may transmit the infection to patients or whanau with the potential for serious outcomes, particularly for a baby, older person, or someone with a medical condition.

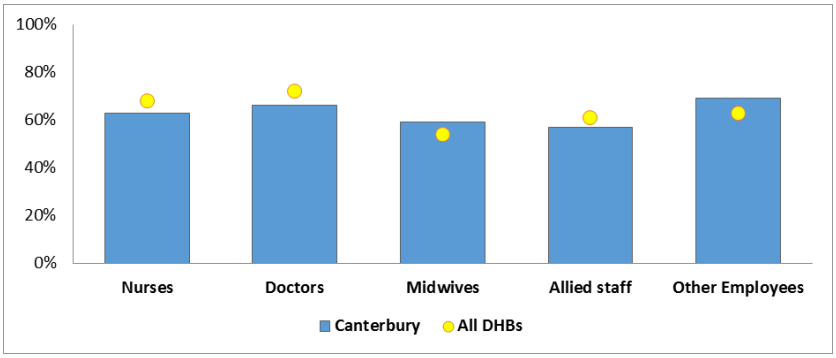


Figure 5.Canterbury DHB 2017 Health Care Worker Influenza Immunization Coverage Rates

The Canterbury DHB target for the 2017 workforce influenza programme was an 80% vaccination rate. Uptake for free influenza vaccine was lower this year by our people, and continues a downward trend. Contributing factors include the late arrival of influenza, and rates being below the seasonal average.

Way of Working 1: Staff Wellbeing programme

While the activities delivered through the staff wellbeing programme support the health and wellbeing of our people, they is still significant pressure both inside and outside work that is impacting on their wellbeing. We are seeing the effect of these pressures on our people through

the increased requirement for sick leave, in addition to normal seasonal variation, and their ability to utilise annual leave.

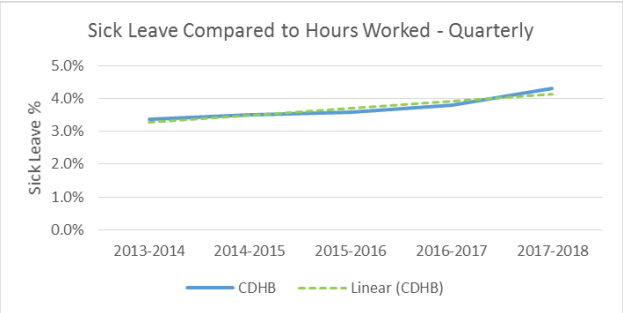


Figure 6. Sick Leave to hours worked

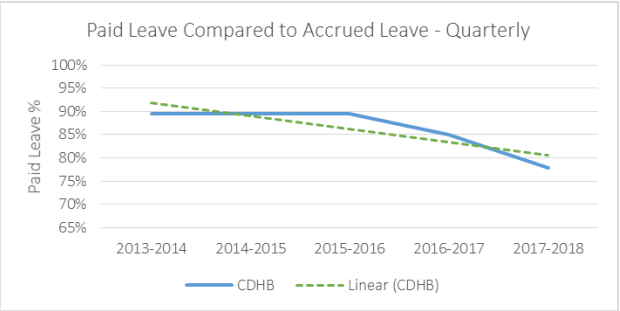


Figure 7. Paid Leave to Accrued Leave

Theme 4: Connecting the response

Approach Maintaining a cross sector planning coordinating group

Maintaining a cross sector planning coordinating group, that brings the key decision makers/leaders to support flow from community in through the hospital setting to the community again, maintaining patient flow is a learning from this winter process. The CCN Urgent Care SLA is key to maintain a system-wide view and connections. Included in this is the Community Service Service Level alliance (CSSLA) focused on ensuring the right place at the right time principles reflected in our pathways today.

Table 1. Admissions Discharged from Christchurch - IDF - May to September period

LOS	2017	%	2016	%
up to 3 days	1039	58%	1023	60%
4 to 7 days	497	28%	513	30%
8 to 11 days	**154**	**9%**	127	7%
Over 12 days	**105**	**6%**	51	3%
Total	1795		1714	

Aim System response due to extreme pressure to Emergency Department

A focus by Planning and Funding with the ambulance service to improve access to inter-hospital transport for mid-Canterbury before the winter and ongoing monitoring is key. Delays for seamless transfer of care through road transportation can impact on overall flow within the system. The mechanisms to communicate with general practice include through the Urgent Care SLA and regular communications with 24 Hours, and general practice via PHOs using a step up process in response to identified pressure. In 2017 specific messaging was communicated on one occasion, noting that the threshold for extreme pressure requiring community escalation strategies was not reached. General practice have good knowledge, strategies and appropriate expectations regarding winter illness peaks. Consideration could be made for increasing the number of steps at a lower threshold to support a more scaled response.

Way of working 1: Heart Failure patients post-discharge support

The pathway for supporting people with Heart Failure post-discharge using the Acute Demand Management Service continues to be an effective model for appropriate patients (those with multiple comorbidities requiring symptom management). The ongoing work to develop the ADMS dataset will enable improved understanding of the cohort of patients receiving this service and the impact on readmission rates.

Way of Working 2: No delays to initiate Rehabilitation, inter-district continuum of care

The role of the South Island Alliance is also something that has been highlighted through our review process. Questions of how we ensure our role as a tertiary hospital and our process for returning patients to the DHB of domicile, and the continuum of care, whether rehabilitation or post-acute care. Additionally what are thresholds for admission in DHBs across the South Island, and do these impact on timely repatriation. South Island DHBs could provide greater visibility of their winter plans utilising the South Island Alliance monthly meetings while responding to this occurring as a result of bringing to life a whole of south island system approach.

Conclusion:

- Work towards no delays to initiate Rehabilitation, inter-district continuum of care: Make information visible of impact of the flow and continuum of care through the South Island Alliance

Theme 5: Doing things differently

Approach No delay to care

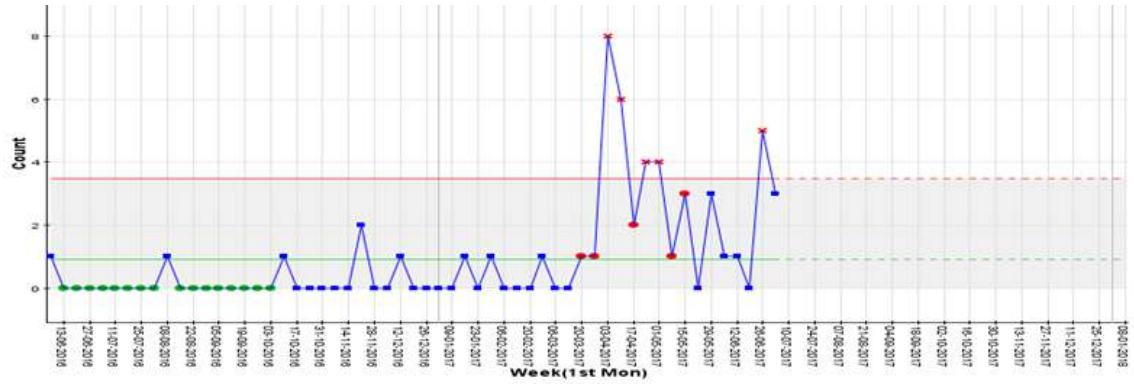
Geriatrician in AMAU- for a 3 month trial. A Geriatrician from Older Persons Health and Rehabilitation Services was placed in General Medicine with the. Aim of earlier identification and management of patients who were frail resulting in earlier discharge and transfer to Burwood when required.

AMAU - to distribute acute admissions among five General Medicine acute teams each day so that patients are assessed quickly by doctors, nurses and allied health in AMAU. The distribution process is designed to decrease the patient-consultant "time to contact" and protect patient-doctor continuity for the duration of the in-hospital journey.

Way of Working 1: Comprehensive Geriatric Assessment (CGA) and improving flow within the Christchurch campus

Aiming to provide these patients with Comprehensive Geriatric Assessment (CGA) and improving flow within the Christchurch campus. Patients were identified as frail by using frailty markers, including patients already known to the community services.

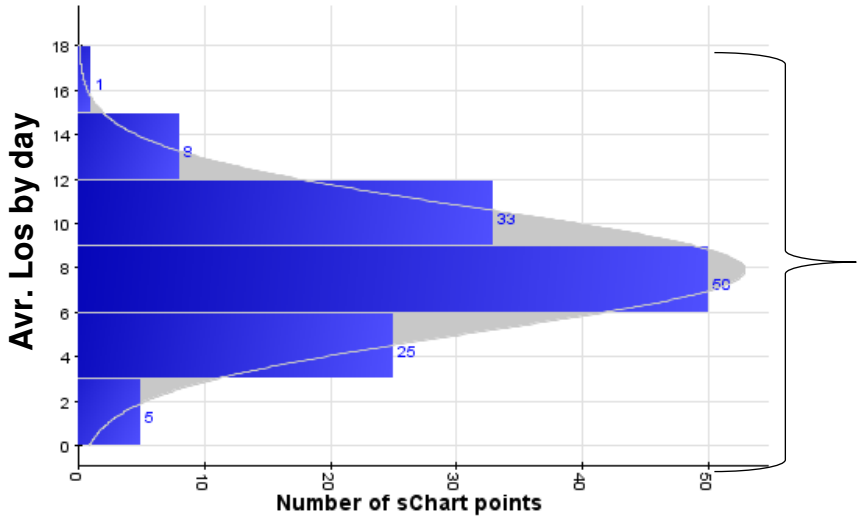
The referral process was from the post-acute and AMAU teams including what was identified by the on-site geriatrician to pull and transfer to either Burwood or for discharge back into community. If not appropriate, guidance for medical team on other options (later referral, home with CREST, and return to ARC). Patients will be identified as being fit for discharge utilizing community clinics for follow up, requiring ongoing OPH input and transferred to Burwood was utilized.



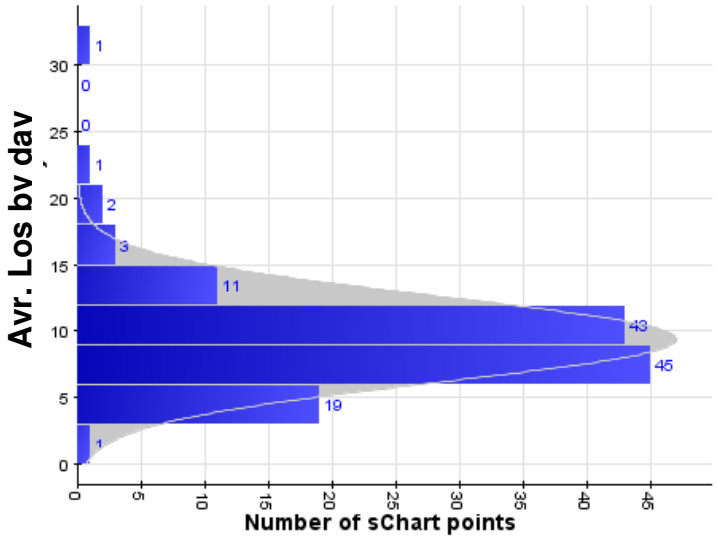
Graph 6. Count of people transferring directly from AMAU to Burwood during Pilot

Way of Working 2: Reduction of LOS to minimize deconditioning

The data shows that on average during 2016/2017 14 patients per week began their hospital journey in AMAU, being provided with care by General Medicine then the Older Person's Health Team. This patient cohort are then discharged from the Older Persons Health wards at Burwood Hospital. During the trial period this increased to an average of 18 per week. As a result of changes being put in place this group of patients is spending two days less in Christchurch hospital this year compared with last year as shown in the graph 7 and 8 below. The graphs shows the distribution of time against the frequency of number of days for patients under the care of General Medicine before transferred to Burwood.



Graph 7. Distribution of the Average Time at Christchurch under General Medicine before transfer to Burwood - May to Sep 17



Graph 8.Distribution of the Average Time at Christchurch under General Medicine before transfer to Burwood - May to Sep 16

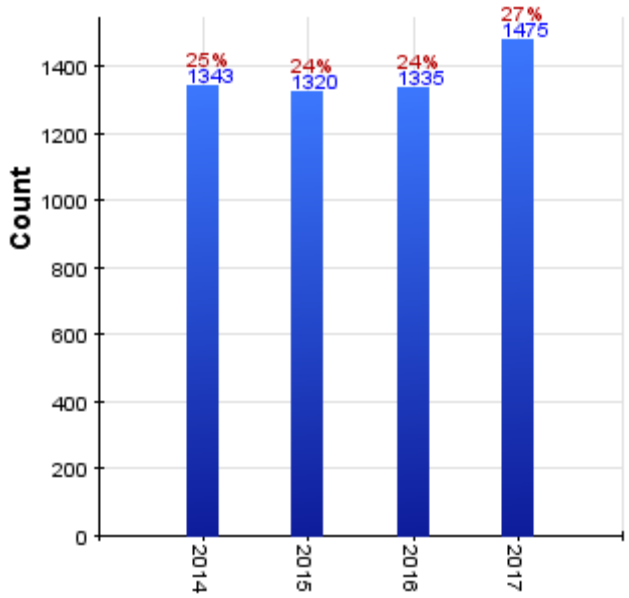
Way of working 3: Improving Clinical Oversight, Liaison and Coordination

Physician of the Day (POTD)

To think differently and focus on the activity, a Physician of the Day (POTD) concept introduced on every weekday 8am-4pm. One of the acute SMOs is the POTD on top of their normal work load.

Focus on clinical oversight to support the ambulatory clinic, provides advice, coordination and liaison with Senior Registrars, General Practice, Emergency Department SMO's.

This contributed to flow within AMAU and improved direct patient information flow within the department (see Graph 9).



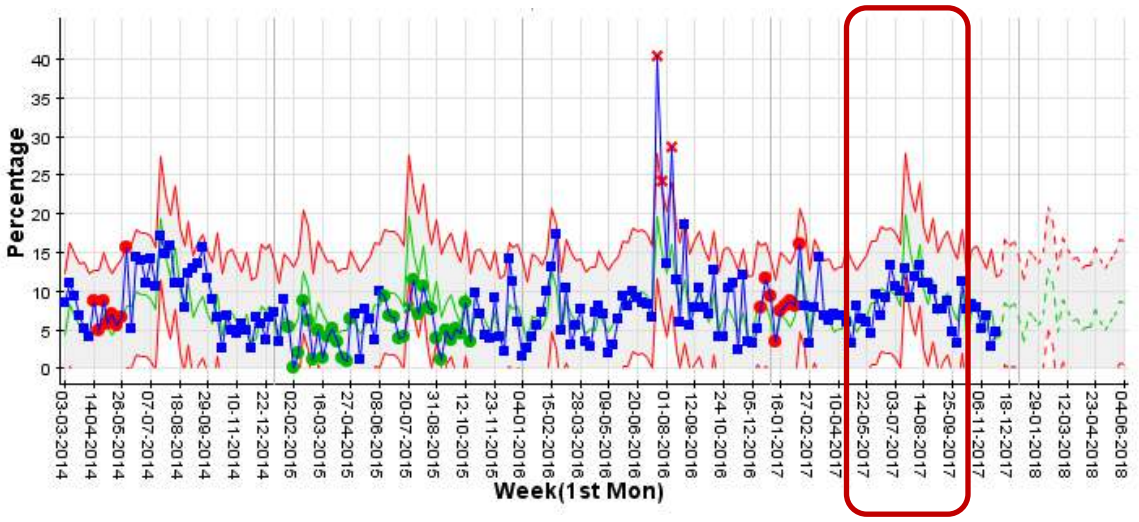
Graph 9. Hospital Discharges home from AMAU, period May to September

Clinical Nurse Specialist

The outcome of this new approach in the past 4 months has seen 83% of the 746 patients referred to Older Persons Health and Rehabilitation Services, have direct interaction with the Clinical Nurse Specialist. This has resulted in earlier intervention and assessment from referral and has freed up consultant time to continue to focus on increased beds and the associated ward rounds and care planning with the teams. This will expand further across Christchurch.

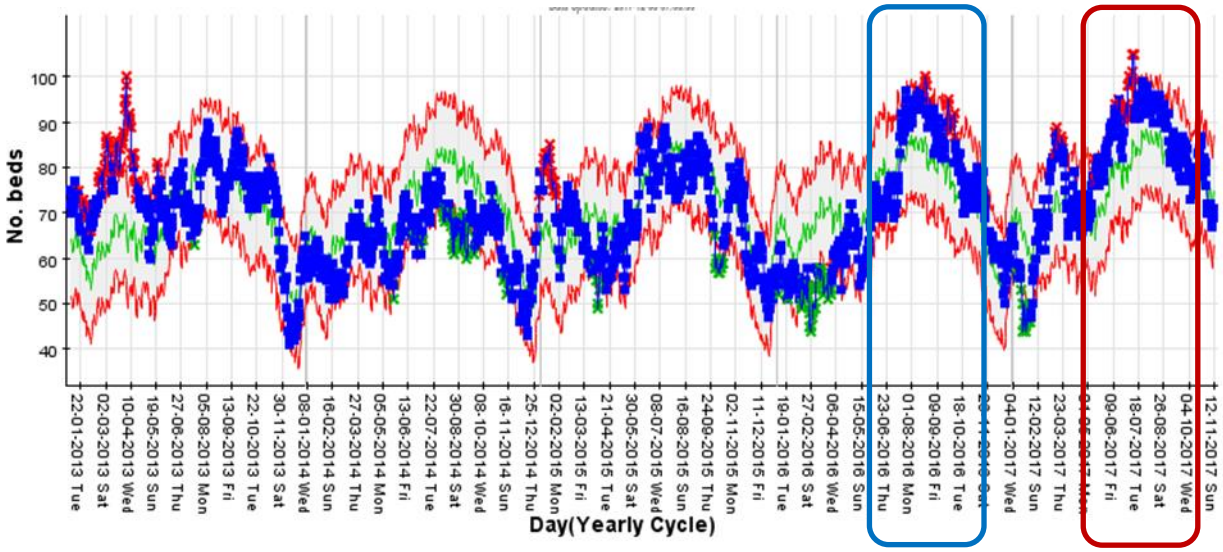
Way of working 4: Ambulatory Clinic diversion

Another activity undertaken was appropriate patients were diverted to the next working day Ambulatory Clinic by the acute Registrar (in discussion with Physician Of The Day) or Senior Registrar. Priority was given to investigations. This Ambulatory Clinic incorporated the current Rapid Response clinic. Expected to reduce 800 overnight stays per year.



Graph 100. Patients in ED Christchurch over 6 hours over 75 years old admitted to General Medicine

Canterbury continues to have an increasing aged population and has the largest DHB populations of over 65 years and over 75 years in absolute numbers. Despite this, and the growing population, our ability to manage and respond to demands across winter are demonstration of the Canterbury Health system looking at solutions as a whole. Despite these challenges, again the response to how we manage flow and those patients with longer stays has been within the norms for the past 2 winters with short periods where we exceeded forecast (highlighted below graph)



Graph 111. Patients with Stays 14 days and over, admitted through General Medicine

Conclusion:

- **Clinical Nurse Specialist**: Change in process of the discharge plan between both sites to a transfer of care. This transfer documentation would be useful to reduce delays and ensure we continue to embed the philosophy of transferring care. Additionally ensuring this role continues and expands into Emergency Department and resourced as part of Older Persons Health and Rehabilitation Services ongoing involvement of care at the front door of Christchurch campus for our frail older people.

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: **1 February 2018**

Report Status – For:	Decision	Noting ☑	Information ☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

3. APPENDICES

Appendix 1: Hospital Advisory Committee Activity Report – January 2018

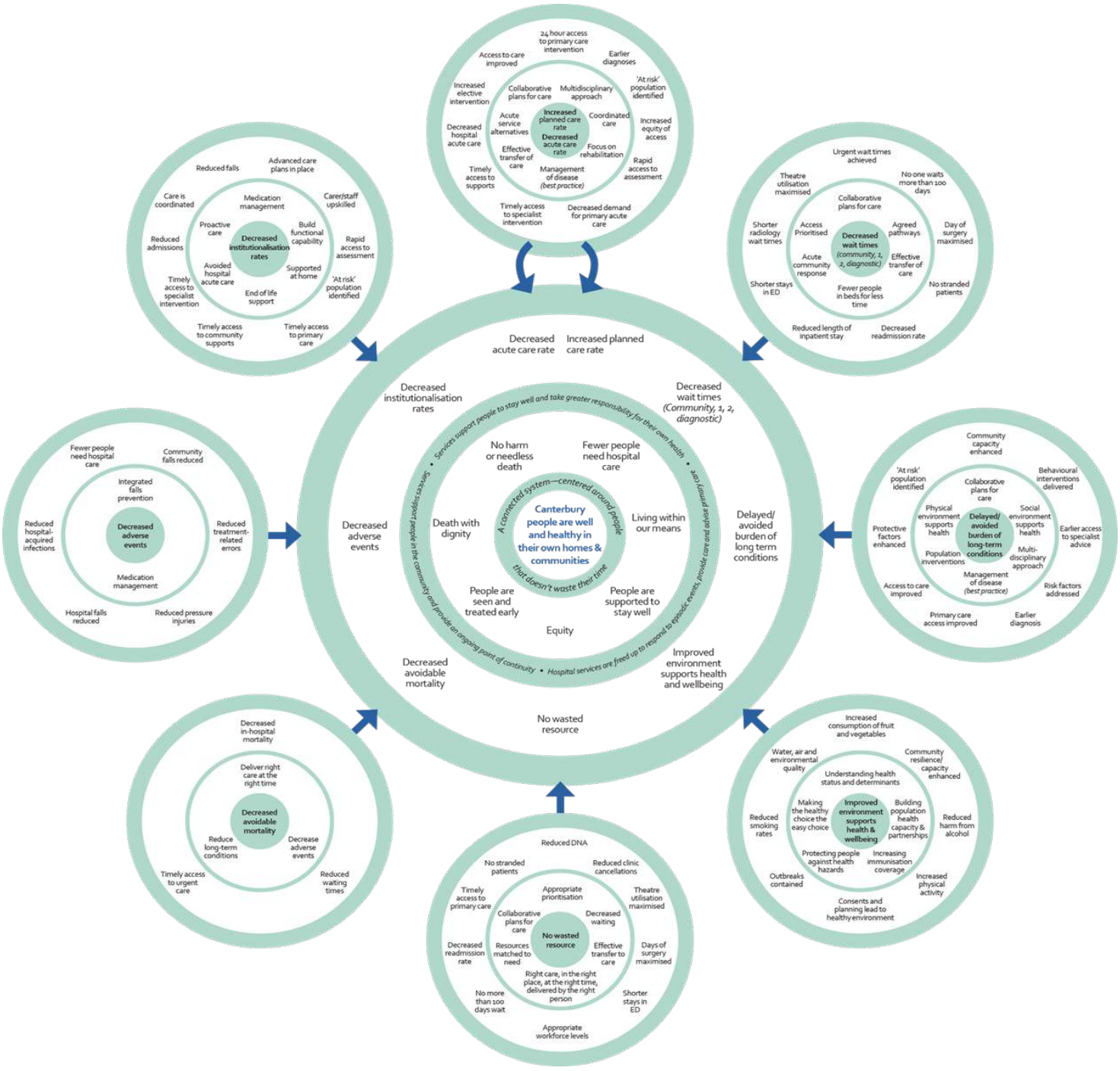
Report prepared by: General Managers, Hospital and Specialist Services

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

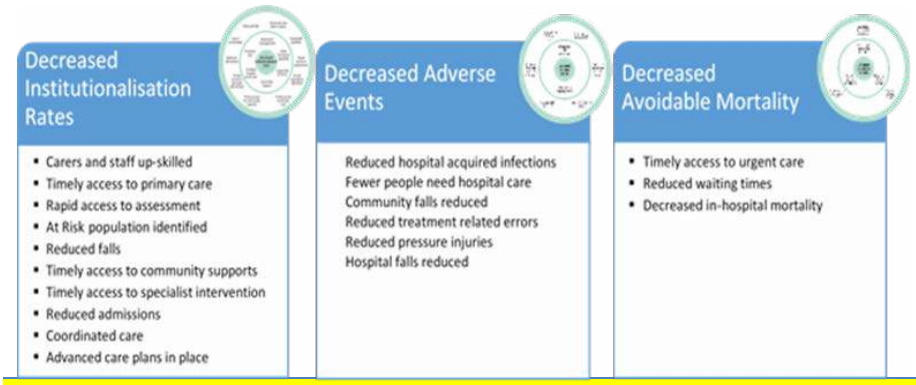
Appendix 1:

Hospital Advisory Committee

Activity Report



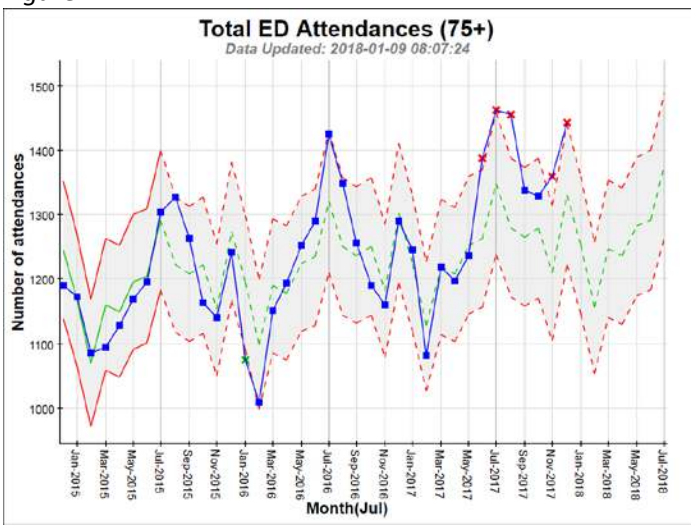
January 2018



Frail Older Persons' Pathway

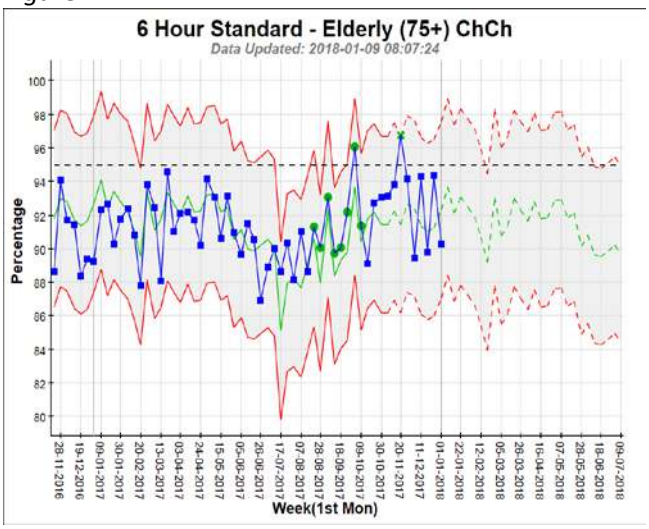
Outcome and Strategy Indicators

Figure 1.1



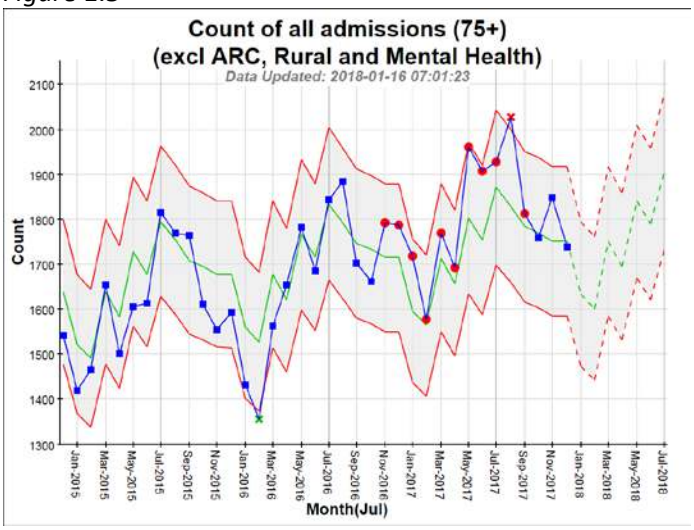
During five of the past seven months Emergency Department attendances for the age group 75 years are higher than projected. However when all age groups are considered the number of presentations fits well with the projected ongoing increase.

Figure1.2



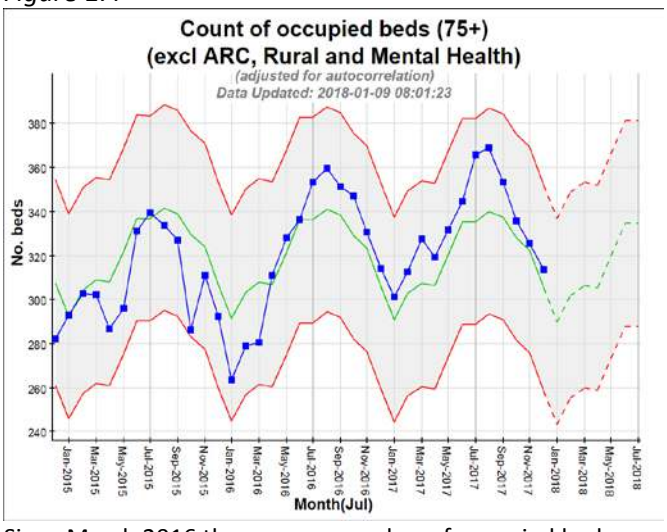
Patients 75+ seen within the 6 hour target is tracking within predicted mean levels but needs improvement.

Figure 1.3



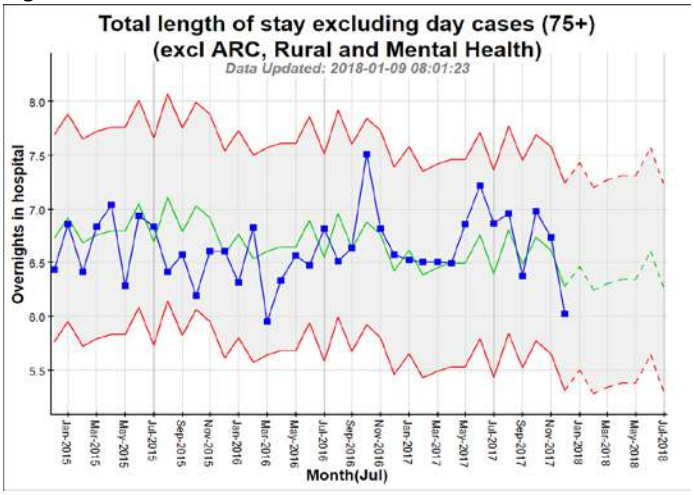
During 2016/17 the volume of people 75 and older admitted into hospital was consistently above the projected level. This has settled back to fit within the projected range in 2017/18

Figure 1.4



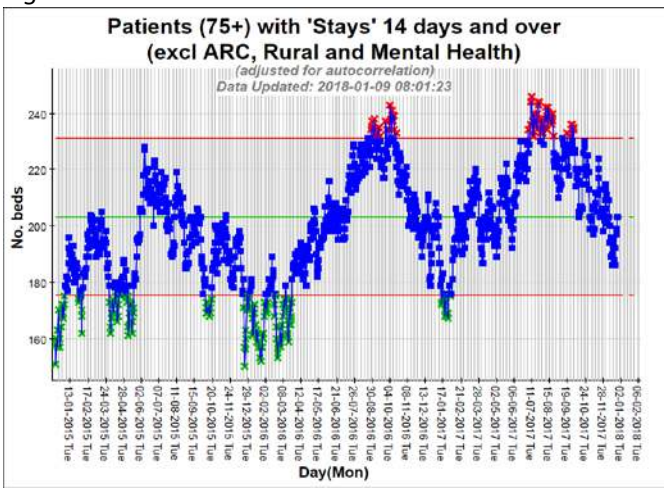
Since March 2016 the average number of occupied beds each month has been higher than projected, also for all but the last two months this value has been higher than the same month the previous year. Growth in occupancy has been constant and higher than projected.

Figure 1.5



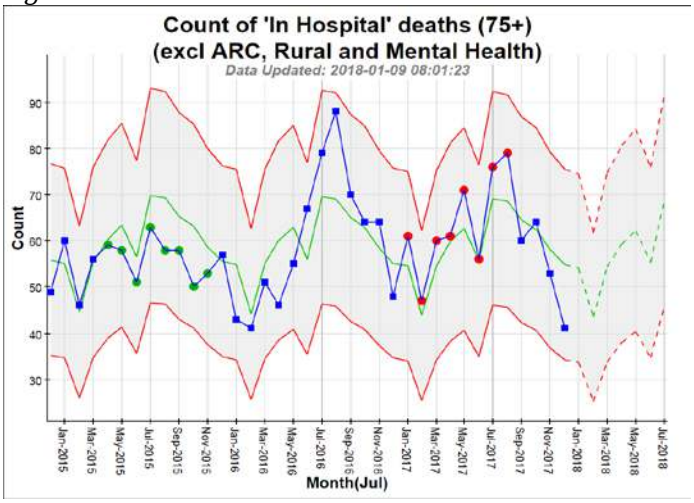
The total length of stay for patients aged 75 and over in 2017 has largely followed the expected mean of overnight stays.

Figure 1.6



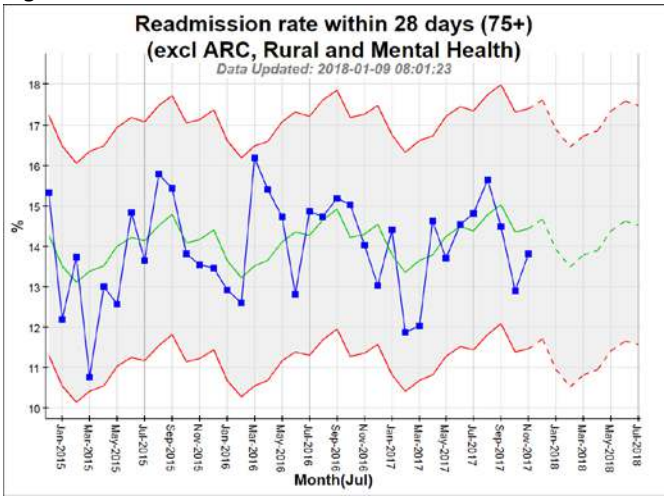
Over the past two years the number of people older than 75 years in hospital whose stay extends to 14 days or longer has increased.

Figure 1.7



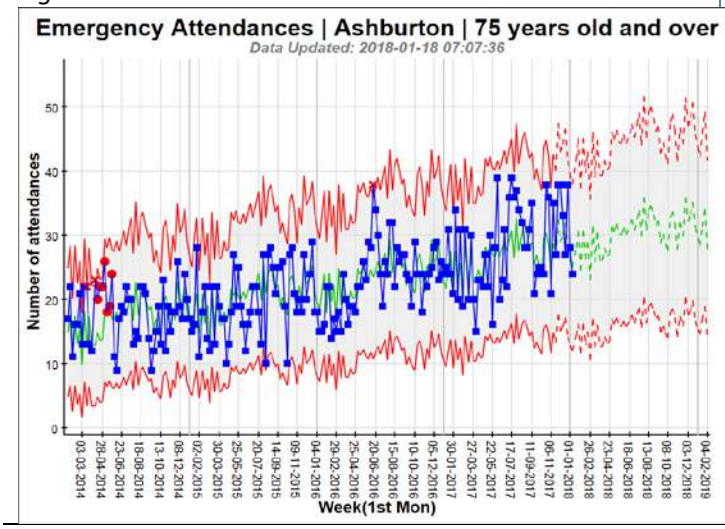
The increased number of in hospital deaths through the eight months of 2017 is explained by the increase in admissions. During 2016/2017 the proportion of people aged 75 years or more dying in hospital compared with the number of admissions has continued to follow the established downward trend.

Figure 1.8



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

Figure 1.9



Ashburton Emergency Department attendances for 75 years old and over age group, show attendances have increased compared with previous years.

Achievements/Issues of Note

Timely blood testing in the Surgical Progressive Care Unit

The team working in the Surgical Progressive Care unit continually makes small changes to the way it works to improve the safety and timeliness of care it provides. One of these has been to ensure that blood specimens are taken before six o'clock each morning.

The Surgical Progressive Care Unit is a small, busy ten bed unit that admits patients that are stepping down from the intensive care unit, or who do not require the services of the intensive care unit but are too unwell to be nursed in a standard ward. Patients can be admitted with acute post-operative complications and trauma and can be accepted directly from the emergency department. All patients require daily blood tests.

Nurses starting work in the progressive care unit are now encouraged to gain competency in venepuncture prior to working in the unit and are then asked to take their patients' blood tests prior to 6am. This reduces the time that patients spend waiting for their blood tests and subsequent changes to their treatment. Patients are no longer required to wait until doctor or phlebotomist is free to carry out the test. Blood test results are returned to the unit prior to the doctors' morning rounds. This enables changes to the treatment of patients to be agreed during the round. This timely decision making contributes significantly to faster recovery for patients and earlier discharges home.

Changes to the management of pancreatitis

People who present with pancreatitis as a result of having very high triglyceride levels are at risk of deteriorating very quickly and so timely diagnosis intervention is crucial to improve patient outcomes. The Clinical Nurse Specialist recently identified that a patient's management had been put at risk as they had been transferred to a ward where staff are not familiar with the treatment of this group of patients.

In response to this a number of actions have been. This patient's care was escalated and the acute pancreatitis pathway on Hospital HealthPathways has been updated including recommending care of this group is provided in a specialist unit, providing clearly defined parameters to enable escalation of care to specialist staff and appropriate therapeutic intervention and ongoing involvement of the multidisciplinary team.

These changes will support provision of appropriate treatment so that people have the best chance of returning home as healthy as possible while reducing lengthy periods during which intensive or specialist care is required.

Improving the care of readmitted inpatients

Late last year an update was provided about the work being done to identify people being re-admitted to hospital for care by General Medicine so that the multidisciplinary was able to put arrangements in place to ensure they have the best chance of remaining healthy without the need for further hospital admissions. One of the actions being taken to ensure this was the addition of an icon to FloView so that reasons for repeated admissions are considered at the daily Board Round. At the height of winter between 5 and 7 patients were being identified each day as requiring special attention.

This approach has now been expanded across all other services in Christchurch hospital with the objective of starting conversations that will see teams to explore different support mechanisms to enable people to stay as healthy as possible in the community without requiring repeated admission to hospital.

Medication Management

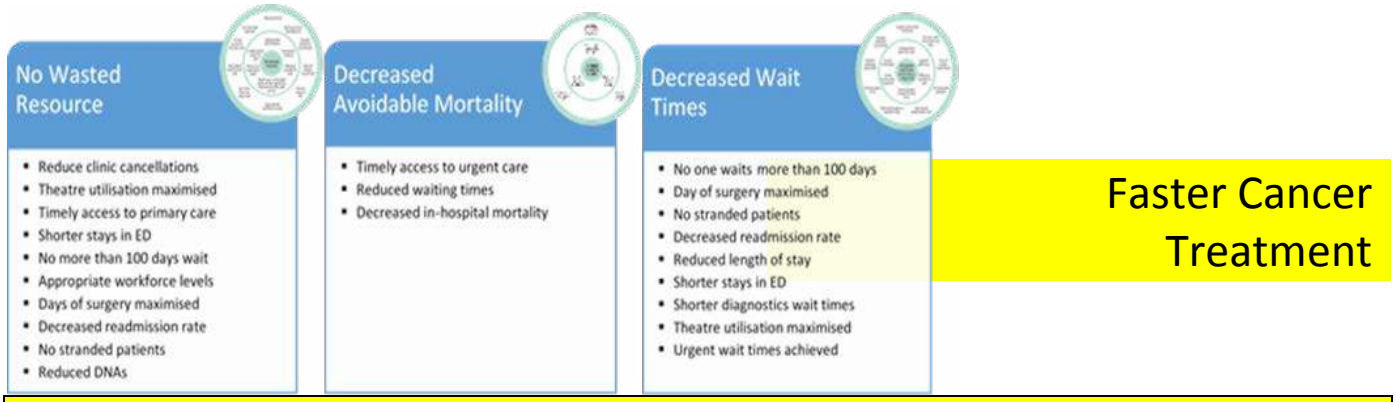
A Medication Management Module Planning Group under the releasing time to care (RT2C) project was established in December 2017, this group will deliver the first on site Medication Module Workshop to Burwood Hospital staff on the 28th of February. This fits with the Older Persons Health & Rehabilitation (OPH&R) Serious Event Group's focus of medication management across the Burwood Hospital site.

Elder Abuse Policy Review.

A working group was established in November 2017 to undertake a review of the Elder Abuse Policy for CDHB. OPH&R services have held responsibility for the Elder Abuse Policy that requires updating. The project covers the Canterbury and West Coast DHB health systems, and includes outlying representatives (Ashburton). The improvement includes standardising the elder abuse policy for our Health System, in line with the National policies and ensuring maximum clarity and consistency in the provision of service to vulnerable elderly. This opportunity also enables the separation of governance and practice documentation and to ensure accountability to The Treaty and bi-cultural practice. Completion date scheduled for April 2018.

Ashburton Frail Elderly Pathway

In partnership with Ashburton Service Level Alliance, work has commenced to develop a "local" Frail Elderly Pathway. This will build on the clinical governance established in October and build on the community redesign work led in Christchurch.



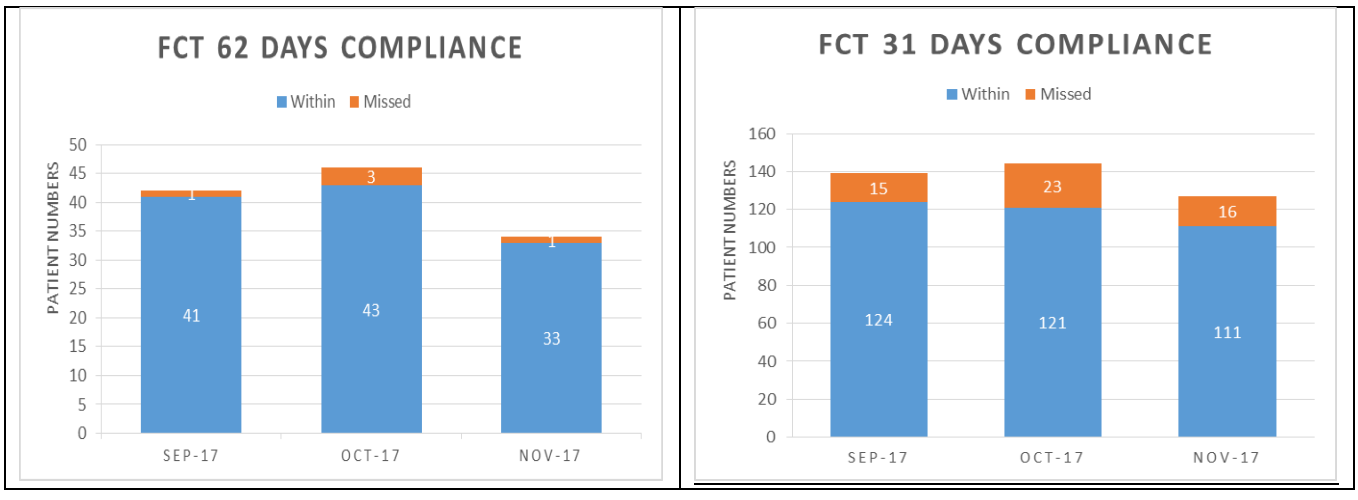
Outcome and Strategy Indicators

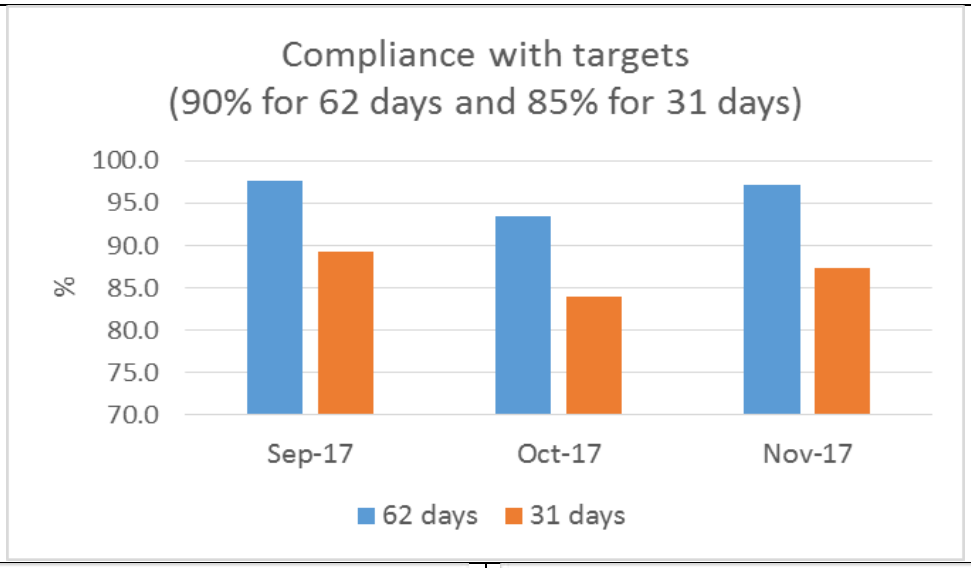
Key Outcomes - Faster Cancer Treatment Targets (FCT)

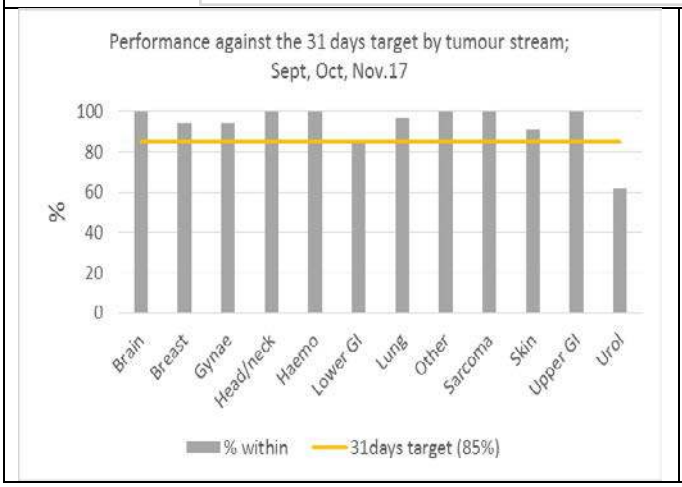
62 Day Target. For the months of Sept, Oct. and Nov. 2017 Canterbury District Health Board submitted 141 records to the Ministryof Health (MoH). 23 who were not treated within 62 days of their referral, 19 were because of patient choice or clinical considerations and are subsequently excluded from the compliance calculation. Compliance was 96% against a target of 90%. Although patients on the 62 days Faster Cancer Treatment pathway whose treatment is delayed because of patient choice or clinical reasons are now excluded from the Ministry of Health's Faster Cancer Treatment compliance calculations, Canterbury District Health Board continues to record and submit data on all Faster Cancer Treatment patients as before. The calculations to account for the new eligibility changes are performed by the Ministry when they receive the data.

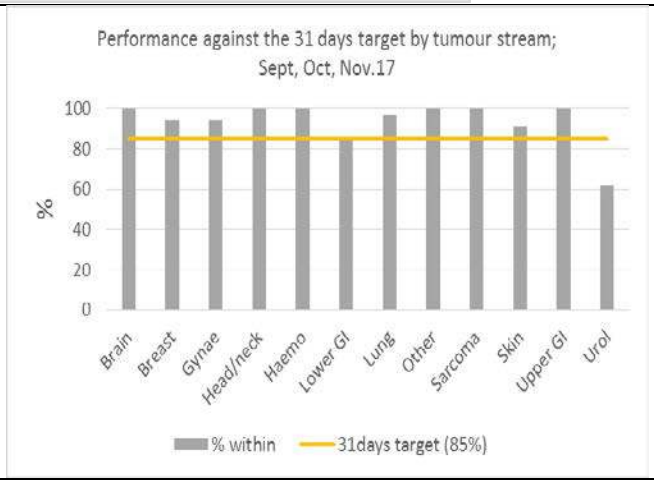
31 Day Performance Measure. Canterbury DHB submitted 410 records in Sept, Oct. and Nov. 17. This figure includes patients also eligible for the 62 days target. In this period 87% of eligible patients met the 31 day measure against a threshold of 85%. To date the MoH has not applied the same changes to the 31 days measure as have been introduced for the 62 days target. This means that all patients who are not treated within 31 days of agreeing a treatment plan are included in the compliance calculation irrespective of whether the delay was through patient choice, clinical considerations or capacity issues.

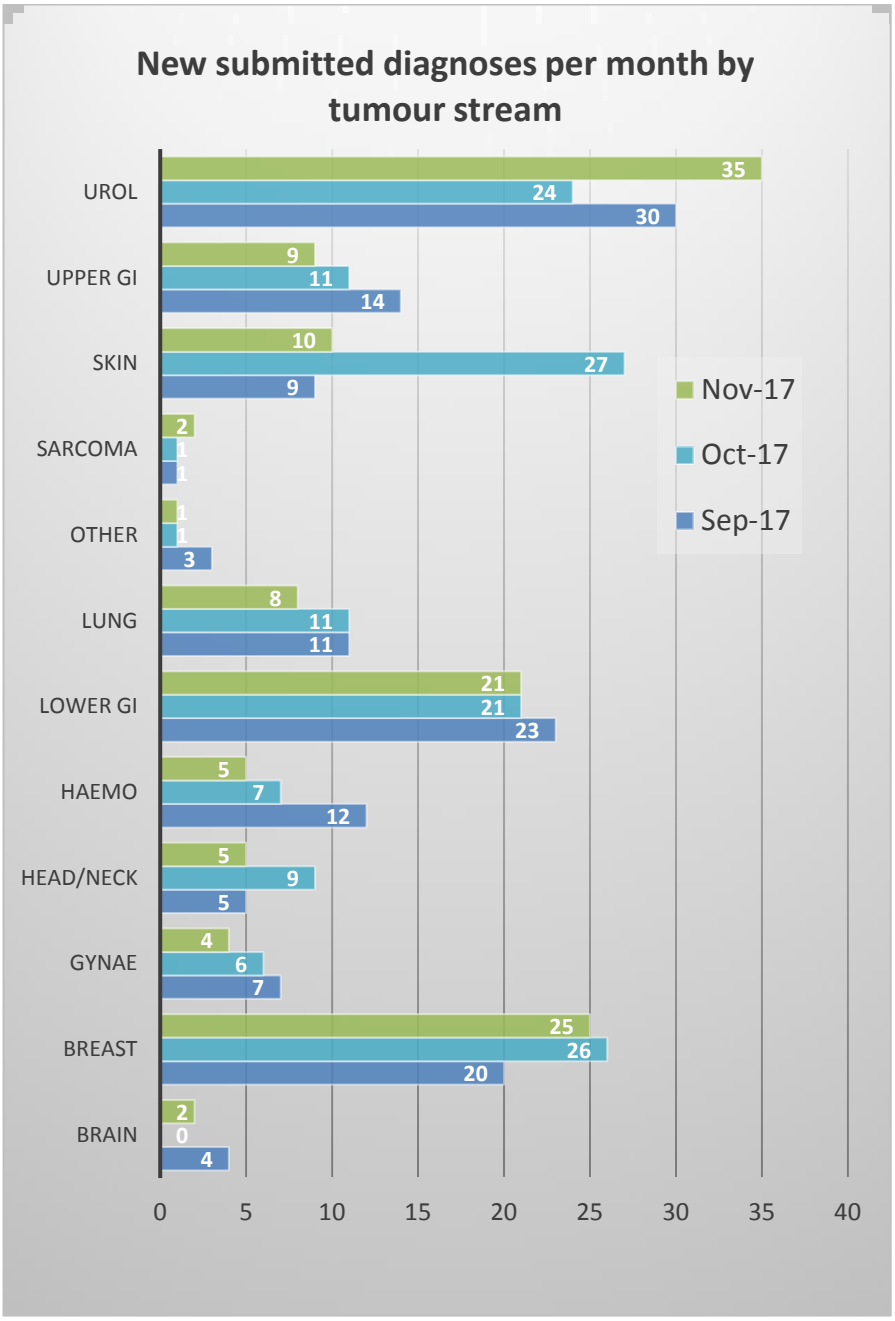
FCT performance data




Compliance with targets
(90% for 62 days and 85% for 31 days)
100.0
95.0
90.0
85.0
80.0
75.0
70.0
%
Sep-17
Oct-17
Nov-17
62 days
31 days


Performance against the 31 days target by tumour stream;
Sept, Oct, Nov.17
100
80
60
40
20
0
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)


Performance against the 31 days target by tumour stream;
Sept, Oct, Nov.17
100
80
60
40
20
0
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
31days target (85%)



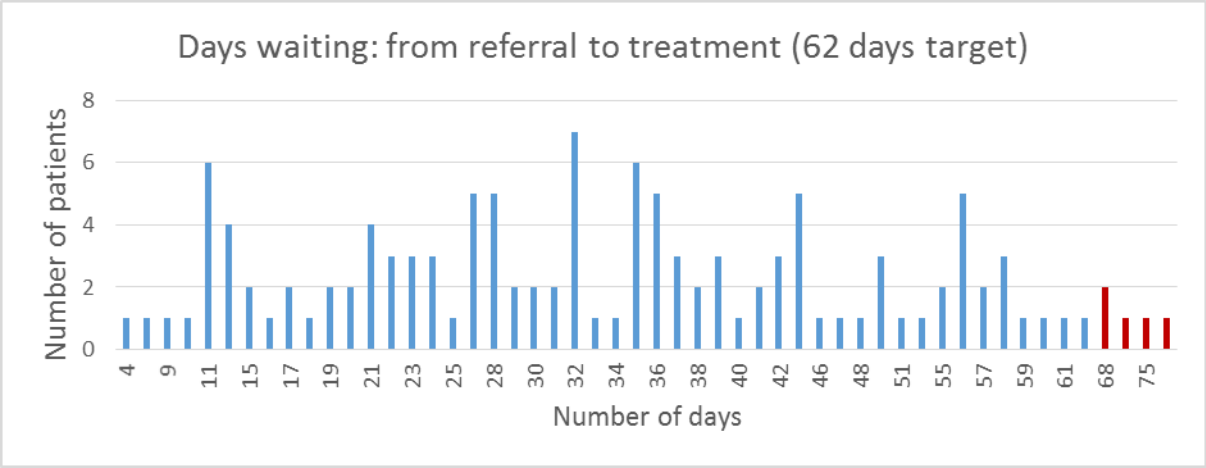
Understanding the reasons for patients not receiving treatment within target times

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

The codes are:

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

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



Who missed and by how much?

Tumour stream	Days waiting
Gynae	68
Lower GI	2 pts: 1 waited 75 days, the other 68 days
Respiratory (lung)	87
Haematology	72

The reason for delay is evaluated for each patient that does not meet the target. This will have happened in order to assign a delay code, but where the delay seems unduly long then a more in-depth check is performed. These cases are discussed with the Service Manager and Clinical Director to see if any corrective action is required.

Achievements/Issues of Note

Head and neck pathway

This is a project jointly undertaken by Nelson Marlborough and Canterbury District Health Boards.

A workshop held in Christchurch at the end of August identified some improvements to be made to the pathway experienced by patients with head and neck cancer, especially where their care is provided by each the two DHBs throughout the journey. Both District Health Boards have been using the outcomes to focus on ways to improve the patient pathway. Changes made so far include:

- Booking coordinators now phone all patients who have a first specialist appointment within two weeks in order to reduce non-attendance.
- Dentists now have access to MOSAIQ, the oncology appointment system, in order to better coordinate teeth extractions.
- Information provided to new patients of the head and neck clinic has been shared with Nelson Marlborough District Health Board.
- Radiation Oncologists are now notified when a patient living greater than 50km from Christchurch is booked into their clinic in order to coordinate appointments with other specialties.

These changes will be reviewed in six months to assess if they have achieved the desired outcome.

Data presented to the workshop confirmed that the vast majority of patients have their first specialist appointment within two weeks and any imaging within two weeks. Canterbury District Health Board also investigated whether any inequalities existed within the current patient pathway.

Ethnicity

Despite the small numbers a common theme identified was frequent missed appointments, possibly because the information provided to patients does not meet the needs of Māori patients. In order to improve this, the information that is sent to new patients attending the head and neck clinic has been sent to the Canterbury District Health Board Māori Health Services team seeking advice about required changes. Changes are currently being made to better meet the needs of the Māori population.

The project also identified that ethnicity data collection is very poor, with only 4% of Māori on the FCT database.

Deprivation

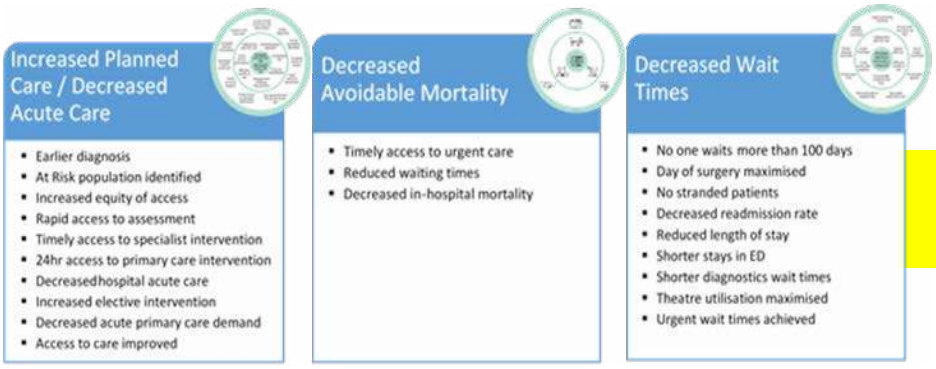
The patients from the audit were divided into two groups using the New Zealand Index of Deprivation. These groups were 1-5 and 6-10 (relatively less deprived and more deprived respectively).

The average time on the 62 day pathway for the 1-5 group was 42 days and for those in the 6-10 group it was 51. In the 31 day pathway the difference was reversed with those in the 6-10 group waiting an average of 17.3 days and those in the 1-5 group 27.7 days. The difference in the 62 day pathway might be explained by the low number of patients, as only 8 patients in the 6-10 group were on the 62 day pathway compared to 27 in the 1-5 group. Investigation will continue.

Place of Domicile

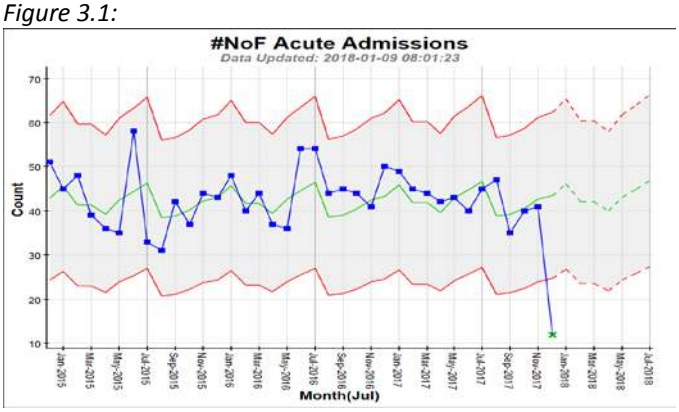
Rural patients had a lower average time in the 62 day pathway (36 days) than the urban patients (49 days). Again, however, it is difficult to draw any meaningful conclusions because the numbers of patients from the rural area is so small.

This audit has led to improvements in our communication with patients being developed and further analysis is being planned which will inform other improvements.



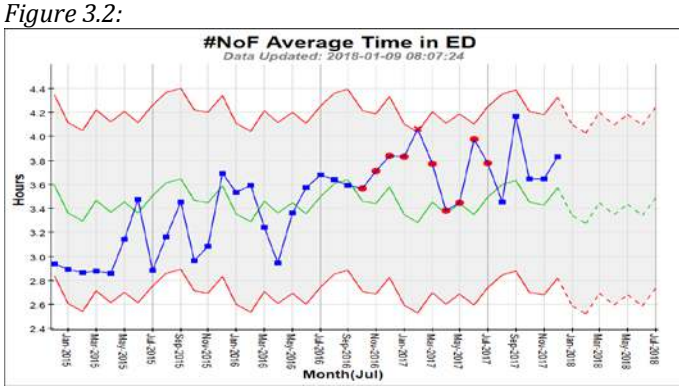
Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)

Figure 3.1:



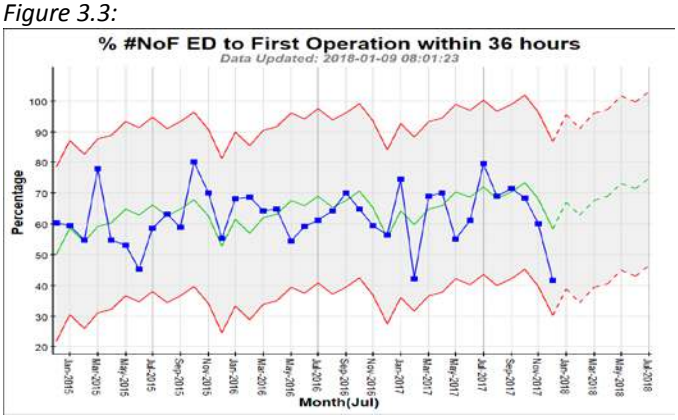
#Nof admissions per month have remained relatively constant.

Figure 3.2:



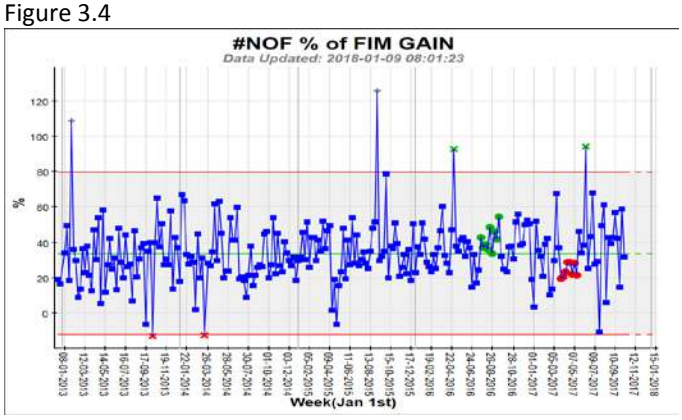
Patients with #NOF spent longer in ED during 2017, between 3.4 and 4.2 hours. In 2016 time spent in ED by this group sat between 3 and 3.8 hours.

Figure 3.3:



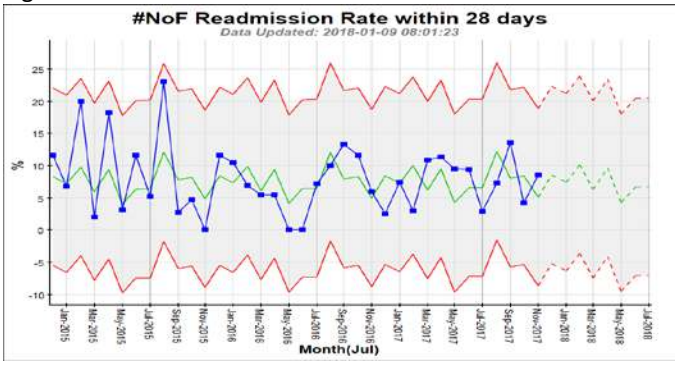
The target is set for patients to be operated on within 36 hours 'when clinically ready' is following the expected pattern which indicates an ongoing improvement.

Figure 3.4



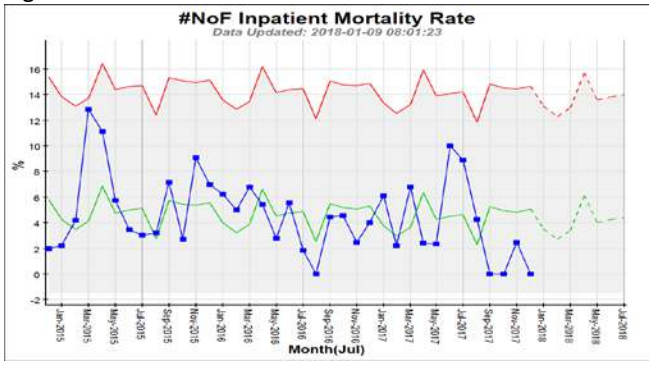
The Functional Independence Measure (FIM) is a basic indicator of severity of disability. The above graph shows the percentage gain for #NOF patients.

Figure 3.5



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

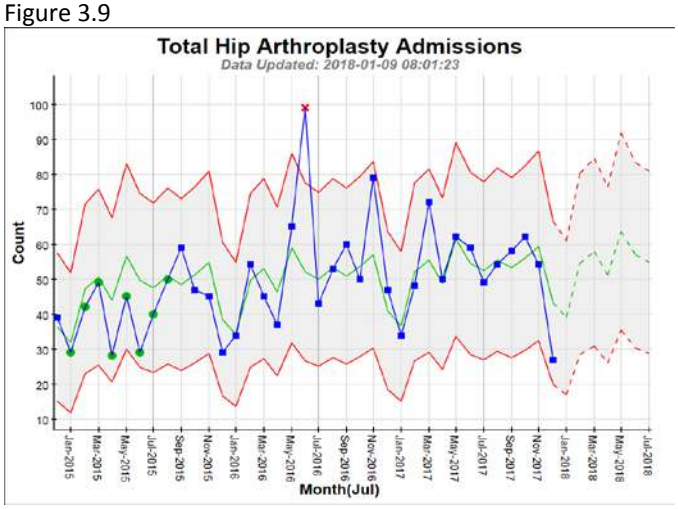
Figure 3.6



The mortality rate remains within the anticipated range.

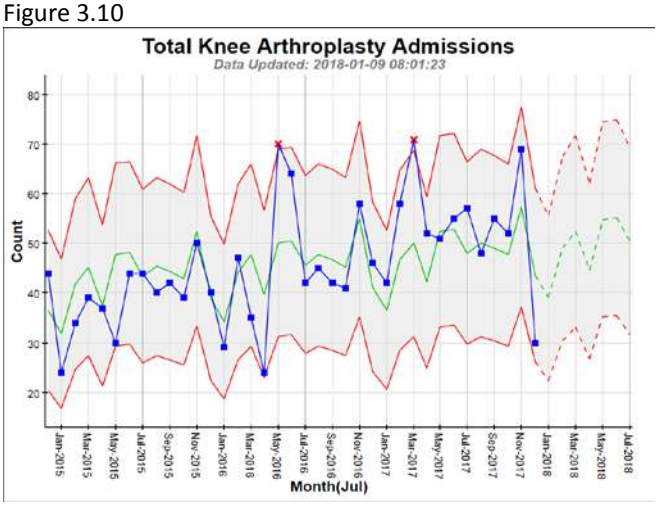
Outcome and Strategy Indicators – Elective Total Hip Replacement(THR) and Knee Replacement(TKR)

Figure 3.9



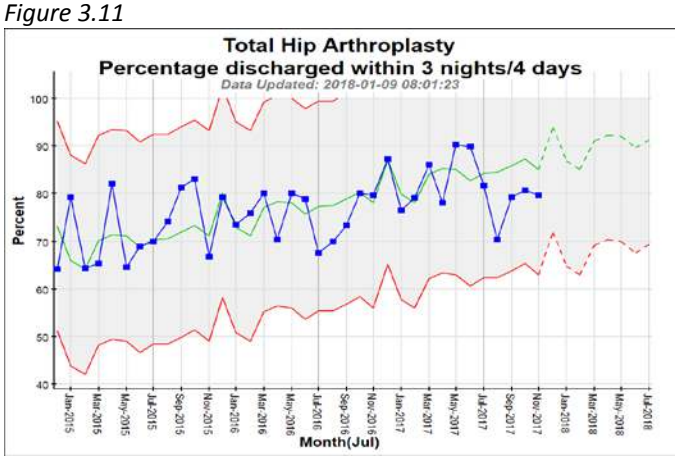
The health target and ESPI compliance for joint replacements remain a focus. In recent months hip replacements have been tracking within the projected range.

Figure 3.10



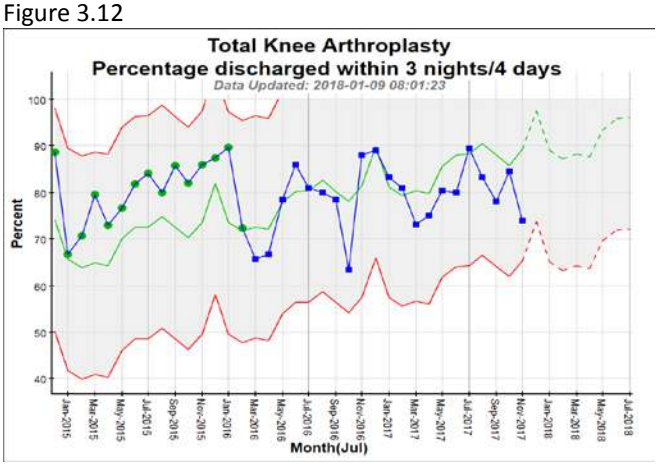
Knee replacement admissions over the previous twelve months have been at or above projected levels.

Figure 3.11



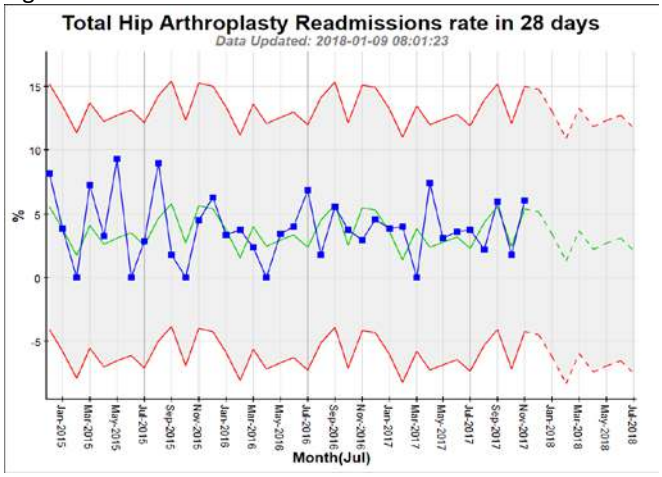
The percentage of patients clinically safe to be discharged within 3 nights/4 days has increased in the previous two years from approximately 65% to reaching a maximum of 90% in May and June 2017.

Figure 3.12



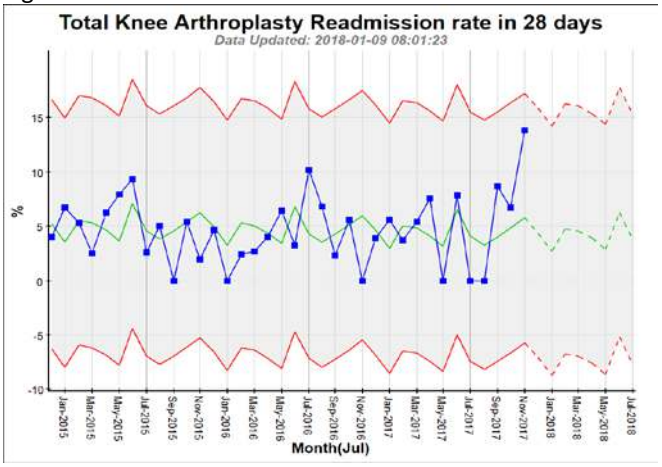
The proportion of people discharged within 3 days/4 nights following knee arthroplasty is following the projected trend.

Figure 3.13



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

Figure 3.14



Readmission rates have been mainly consistent with the mean. The increase recorded for November was investigated and found to be an increase in extended LOS due to a variety of unrelated complications.

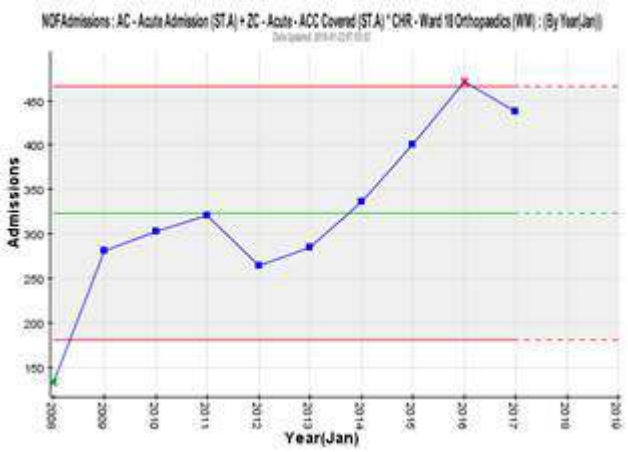
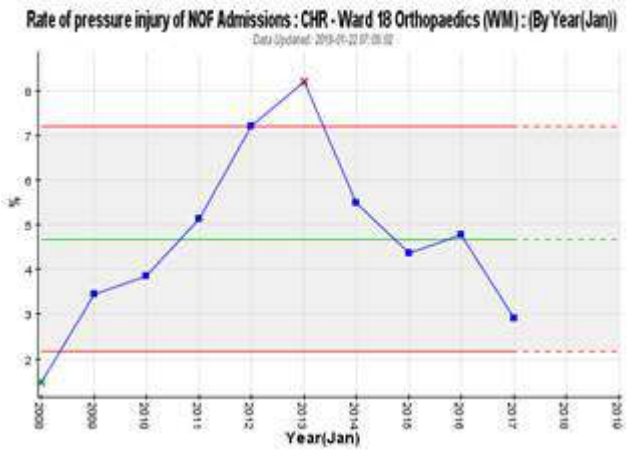
Achievements/Issues of Note

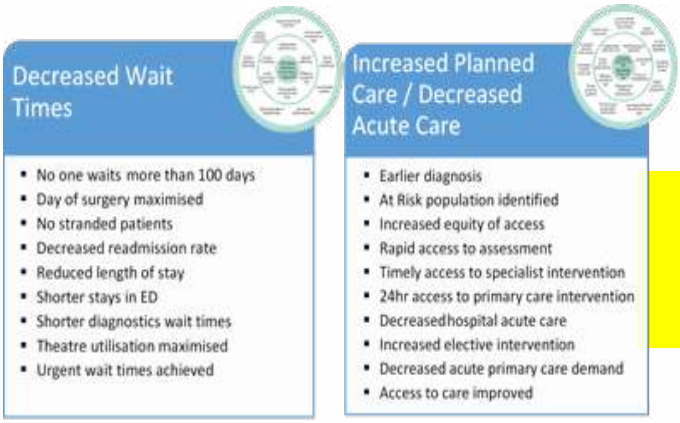
Provision of pressure care to people with a fractured neck of femur

Frail older people with a fractured neck of femur and decreased mobility always require use of special equipment after admission to prevent pressure injuries. In the past a special mattress was ordered following the person's admission, creating a risk that a pressure injury would be created before this equipment was available. A transfer from one mattress to the other was required and meant that the patient experienced multiple, often painful, transfers. There was also risk of manual handling associated injury for patients and staff.

Our aim is to "fast track" care of this group of people. Nursing staff have arranged for the rental organisation to have specialised mattresses available on the ward, awaiting the arrival of a patient. These are kept set up on a bed dedicated to this group of patients and the rental period is only activated at the point it is required by a patient.

Since this change, in 2015, the total number of people with a fractured neck of femur admitted into ward 18 has increased and the rate of pressure injuries has reduced. Patients are more comfortable as they are not experiencing multiple bed transfers prior to surgery. The decreased rate of pressure injuries improves the recovery of patients, ensuring they return home in a better state of health and avoids extended hospitalisation that results from pressure injuries.

Number of patients with fractured neck of femur ward 18.	Rate of pressure injuries – patients with fractured neck of femur, ward 18.
	



Elective Surgery Performance Indicators 100 Days

Outcome and Strategy Indicators

Figure 4.1:

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

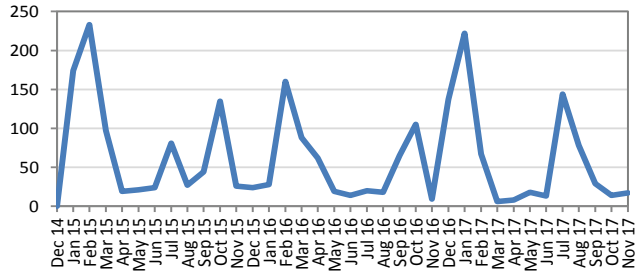


Figure 4.2:

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

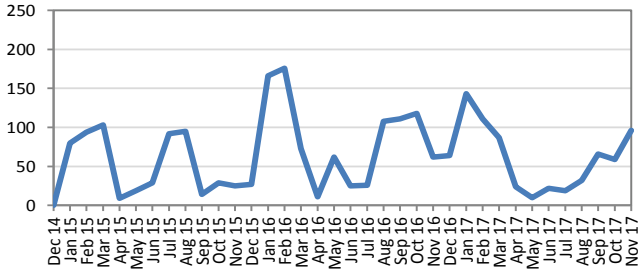


Figure 4.3:

ESPI 2 Result By Specialty – Surgical

Specialty	Number	%	Change
Cardiothoracic	0	0.0%	0
ENT	4	0.4%	4
General Surgery	0	0.0%	0
Gynaecology	0	0.0%	0
Neurosurgery	0	0.0%	0
Ophthalmology	0	0.0%	-4
Orthopaedics	4	3.7%	0
Paediatric Surgery	0	0.0%	0
Plastics	0	0.0%	0
Urology	1	0.2%	1
Vascular	8	4.5%	2

ESPI 2 Result By Specialty - Medical

Specialty	Number	%	Change
Cardiology	0	0.0%	0
Dermatology	0	0.0%	0
Diabetes	0	0.0%	0
Endocrinology	0	0.0%	0
Endoscopy	0	0.0%	0
Gastroenterology	0	0.0%	0
General Medicine	0	0.0%	0
Haematology	0	0.0%	0
Infectious Disease	0	0.0%	0
Neurology	0	0.0%	0
Oncology	0	0.0%	0
Paediatric Medicin	0	0.0%	0
Pain	0	0.0%	0
Renal	0	0.0%	0
Respiratory	0	0.0%	0
Rheumatology	0	0.0%	0

Figure 4.4

ESPI 5 Treatment by Specialty

Specialty	Number	%	Change
Cardiothoracic	0	0.0%	0
Dental	0	0.0%	-1
ENT	1	0.2%	1
General Surgery	5	1.5%	1
Gynaecology	1	0.3%	1
Neurosurgery	1	2.6%	0
Ophthalmology	21	5.9%	4
Orthopaedics	60	9.9%	27
Paediatric Surgery	2	3.5%	1
Plastics	1	0.2%	1
Urology	2	0.7%	2
Vascular	2	2.1%	1
Cardiology	0	0.0%	0

ESPI Results – 4 Month Target

Waiting > 120 Days

	Number	%	Status
ESPI 2 (FSA)	17	0.2%	
ESPI 5 (treatment)	96	2.7%	

Achievements/Issues of Note

Elective Services Performance Indicator (ESPI) Target Outcomes

Latest monthly final reporting from the Ministry of Health shows that Canterbury District Health Board achieved a yellow result for ESPI two (covering first specialist assessment) at the end of November.

The same report shows that Canterbury District Health Board achieved a red result for ESPI five (covering waiting time for surgery) at the end of November for the third month in a row. However internal reporting indicates that a yellow result is expected during this period and work is underway to correct the data provided to the Ministry of Health. Data issues have been associated with the transition of data between patient management systems.

An approach has been made to the Ministry of Health seeking a period where a notional buffer is used to calculate target achievement, in place of the usual method, and enable a realistic assessment of performance during transition between systems. Communication about this continues.

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

Many services have taken up the 100 days approach as their own and are working to ensure that no patient waits for longer than 100 days, rather than the nationally mandated 120 days. When achieved, this provides a buffer that should ensure that even when the system is under stress no patient will wait longer than 120 days. Within this many services have adopted the standard six week booking cycle and are supporting other services to apply this way of working.

Acute Urinary Retention Pathway

The Urology services receives referrals from the primary and hospital services for a trial of void, a procedure that tests the ability of a person's bladder to empty properly. The service has been receiving more referrals than it can manage. Evaluation of the referrals showed that some were for patients that could have been provided with their care in the primary sector. Others were for repeat procedures and information already available about the patients' conditions indicated it would be more appropriate for the patient to receive direct referral for surgery or specialist outpatient care. People in this second group were often receiving repeated catheterisation without moving onto having a full investigation, negatively affecting their quality of life.

All referrals for trial of void are now triaged by an experienced urology nurse, using a structured tool providing a uniform approach to determining the appropriate pathway for each patient.

Based on this many patients move directly on to receive care in a urology clinic or surgery without the need for a further trial of void. Patients requiring surgery are therefore receiving it sooner. Other patients are being provided with the care they require in the community.

Not only are these patients receiving the right care sooner, but the reduced load on trial of void clinics mean that people who need this service in an outpatient setting are able to receive it sooner with Urology Unit staff having to put fewer extra clinics in place.

Effective use of freed capacity

During the second half of 2017 Canterbury District Health Board experienced a short term challenge in providing sufficient registrar capacity in Cardiothoracic Surgery. This meant that some theatre sessions scheduled for cardiac operating were not able to be used for that purpose.

This freed up anaesthetic capacity that was directed towards enabling cardiology to carry out more transcatheter aortic valve implantation procedures (TAVI). This procedure enables aortic valve implantation to be carried out through a catheter, rather than via the conventional operation and is able to be provided to people that are not clinically eligible for the conventional approach.

This substitution enabled an additional six people to receive TAVI procedures during the second half of the year, eliminating the waitlist for this procedure. Patients are now receiving this procedure within 19 days of a decision to treat, this compares with a waiting time of 45 days earlier in the year. Because people receiving this operation

typically present acutely this is saving significant time spent waiting in a hospital bed, enabling a quicker return home.

Supporting children with mobility challenges to attend clinic

Parents of children with mobility challenges have been experiencing problems bringing their children to clinic. Our Park and Ride services do not serve this group well as the shuttles are not suitable for wheelchairs. While there are car parks for people with mobility parking permits, these parks are quite a distance from the paediatric outpatients and are heavily used.

In response to this, following input from the Child Health Advisory Council, four parks have been set up that are closer to the paediatric outpatient's area and are identified as only for use of child health mobility parking.

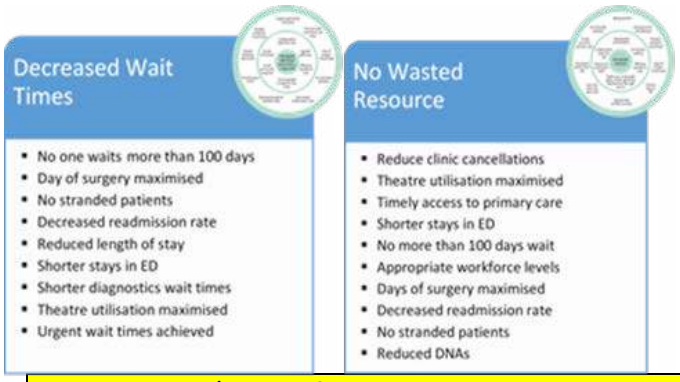
Parents have been provided with information about how to gain access to these areas and the security team is aware of the guidelines for the use of these parks and what information parents will display on their car dashboards. It is anticipated that use of these areas will increase steadily from the beginning of February, removing a barrier to parents bringing this vulnerable group of children to the specialist clinics they require and likely avoiding instances when children are not brought to appointments.

Continuity of service throughout multiple changes for the Hospital Dental Service

Since the February 2011 earthquake, the Hospital Dental Service has relocated three times. Leaders from the service have now been actively involved in the planning and design for three new builds for the service and are looking forward to their final shift to the new outpatients' building in mid-2018.

Through thorough planning and good co-ordination the service has rarely closed due to earthquakes or relocations, prioritising the consistent provision of emergency dental care over elective outpatients work. Communication is supported via the production of a fortnightly newsletter by the Practice Manager to ensure that all staff are informed of upcoming changes and an "Extra Mile" award is given on a monthly basis to staff that are recognised for contributing above and beyond the routine requirements. The service has committed to ensuring that patients are not disadvantaged during relocations and has made extra efforts to communicate well with patients so that they know where their appointment is to be held.

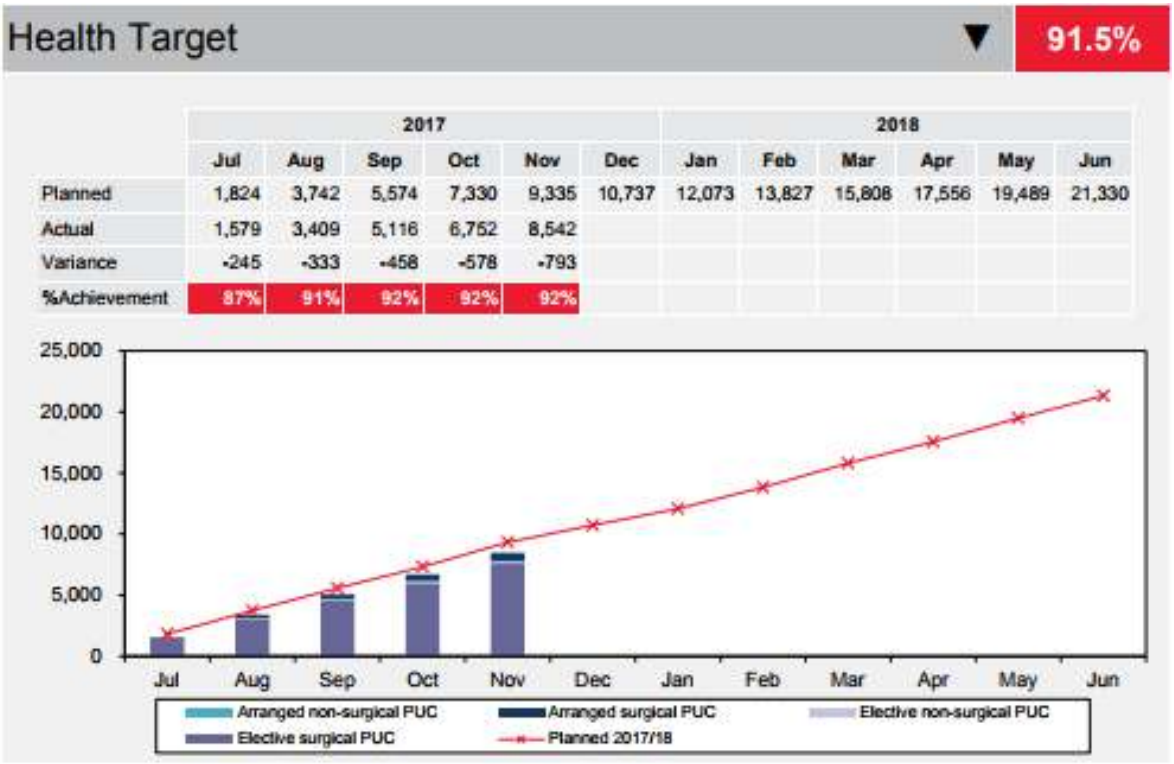
Staff have seen significant change since February 2011 and due to good communication and planning, have embraced the changes well. These changes include working from hot desks and focussing on working in paperlite ways.



Theatre Capacity and Theatre Utilisation

Achievements/Issues of Note

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



All outsourcing arrangements were finalised and put in place during October 2017. Approximately half of the deficit at the end of November was associated with the planned volume of outsourced work. This cohort of discharges will quickly catch up to the planned volume.

Internal reporting shows that at the end of December Canterbury DHB is on track to achieve the Elective Health Target with no deficit of in-house discharges. Once coding of discharges is completed this information will flow to the Ministry of Health and be reflected in its reports.

Perioperative Materials Management Project

Every week day around 85 people are provided with operations in the 18 theatres on Christchurch Campus. Each of these operations requires availability of specific consumables to enable safe anaesthesia, surgery and recovery. Ensuring that these products are available requires a systematic approach to ordering and storing the required materials in the department's many store areas, each of which holds hundreds of stock lines.

Over the past 12 – 18 months staff from the Perioperative Service, Supply Department and Finance Systems have been working together to improve these processes covering surgical, anaesthetic, kitchen and stationary supplies within the perioperative environment.

Prior to this stock management involved manual counting and a multitude of paper forms. Inconsistencies and work-arounds abounded as the system was unreliable and there was no consistent way of working. Too much stock was held of some lines, and regular use of other lines meant that surgeons occasionally had to use a different product than the preferred one.

The project replaced the multiple processes that were in place with three ordering systems:

- Previously ordering was carried out by a large number of people in the department. Ordering is now only carried out by a few Operating Theatre Assistants who have developed expertise in this area;
- New systems include barcoding of high cost items and use of scanning systems to order current and required stock;
- Use of maximum values prevents over-ordering due to duplicate orders; and
- Standard processes have been put in place and are progressively covering more stock lines.

Having predictable systems in place has reduced the need for urgent orders to be delivered by courier to the Theatres. All supplies that can be are delivered to the Supply Department and then to Operating Theatre using routine methods.

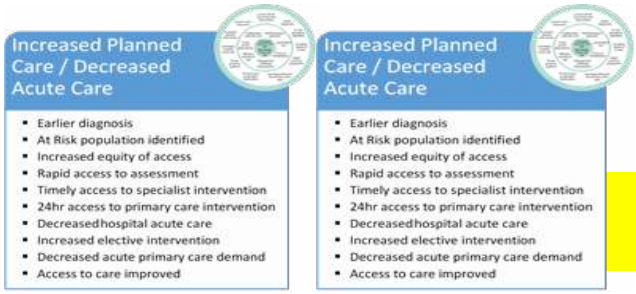
Following the 12 months' of implementation the new systems and they are delivering benefits:

- Processes are reliable and predictable, people can trust that they will have the goods they need when they need them;
- Unnecessary duplication of processes has been removed;
- Unnecessary duplication of stock has been reduced and for other lines stock holdings have been increased, surgeons are not relying as much on substitute products;
- The right people are now doing the ordering, nurses' time has been released to focus on tasks that only they can carry out;
- Far fewer couriers are visiting the Operating Theatres each day, reducing traffic in the department and on the campus in general;
- Stocktake previously took days of dedicated activity whereas it can now be fed from routine scanning.

Acute cases at Burwood

There was an increase in the number of acute cases undertaken at Burwood Hospital Operating Theatres during November and December 2017. 34 cases in November and 45 cases in December 2017. Most of these cases utilised existing Theatre capacity which had been held for acute cases. There was a minimal impact on planned Elective capacity for these months. Most of the cases were overnight stays which were accommodated within planned capacity for the Surgical Ward.

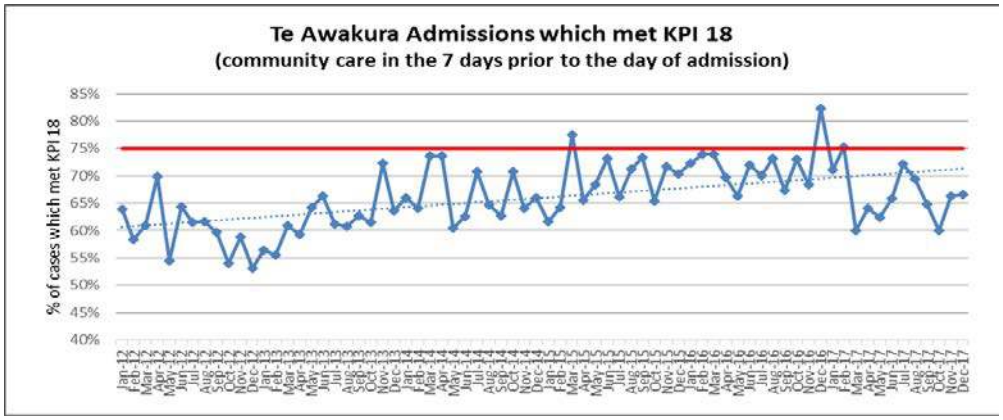
Burwood Theatres and the Surgical Ward closed as planned over the Christmas period. Planning in conjunction with Christchurch Hospital ensured that theatre utilisation was maximised up until closing.



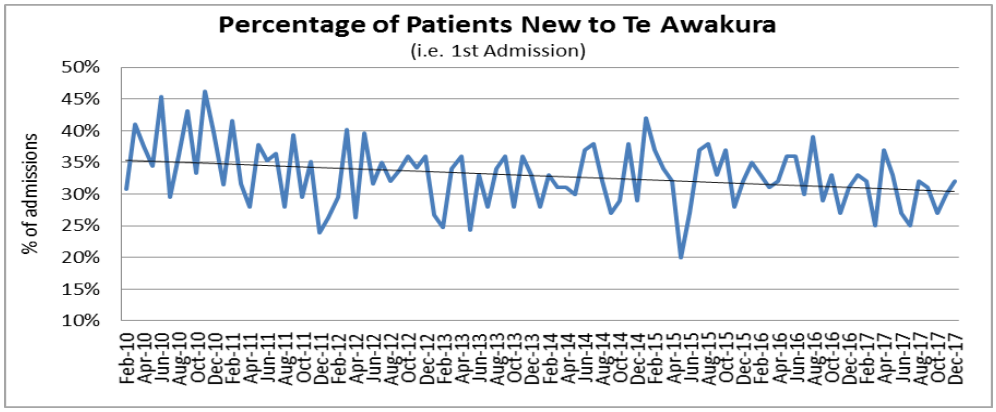
Mental Health Services

Outcome and Strategy Indicators

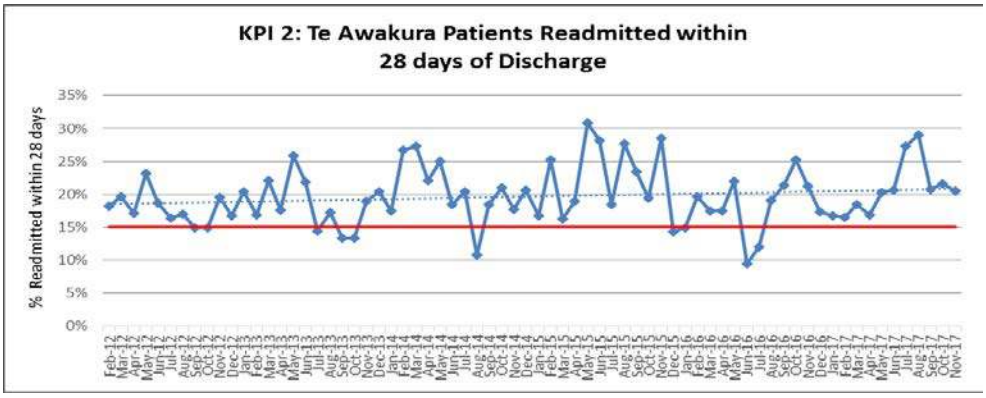
Adult Services



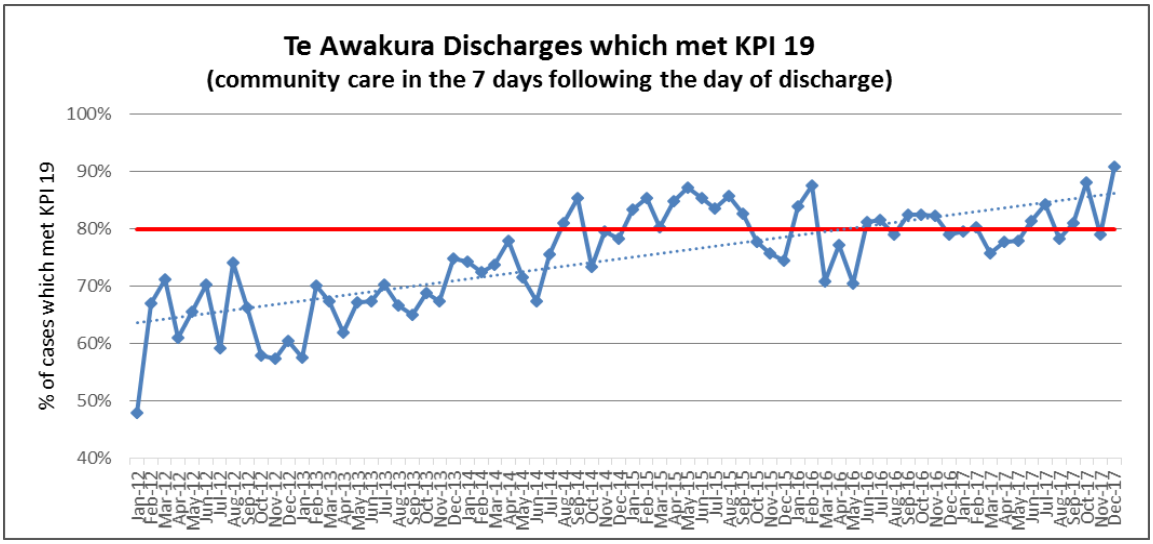
KPI 18 is an indicator of how well engaged we are with people using our services. In November 2017, 66.4% of acute admissions to Te Awakura had a community contact in the seven days prior to the date of their admission. In December 2017 this remained stable at 66.7%. The most common reason for people not have not been seen in the seven days prior to admission is that they are not known to us.



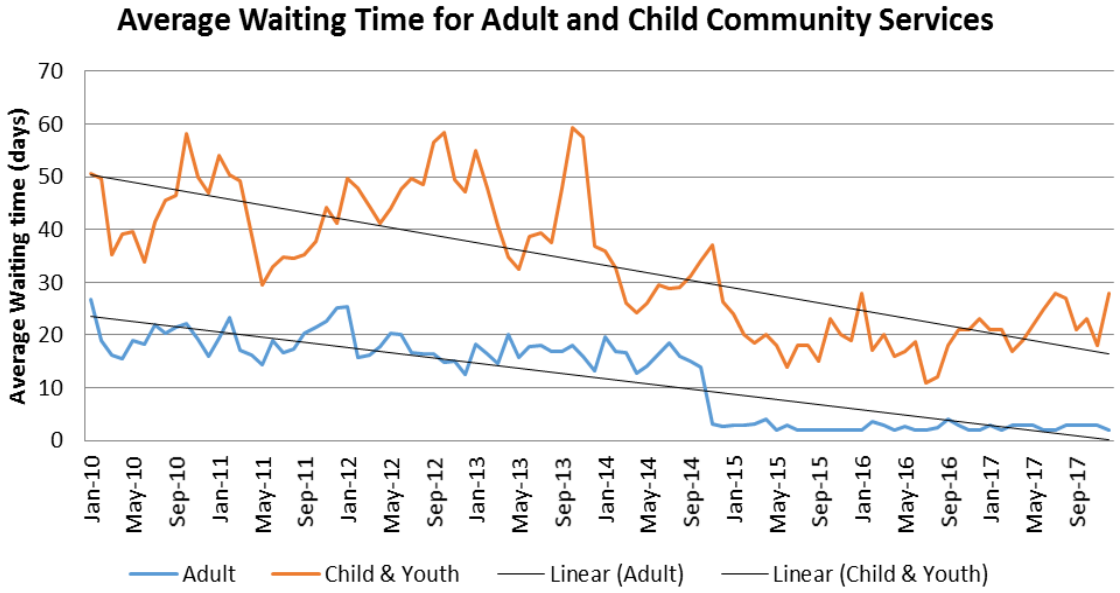
In December 2017, 32% of people admitted to Te Awakura were new (had not been admitted there previously).



The graph above shows the readmission rate within 28 days of discharge. Of the 112 Te Awakura consumers discharged in December 2017, 20.5% were readmitted within 28 days.

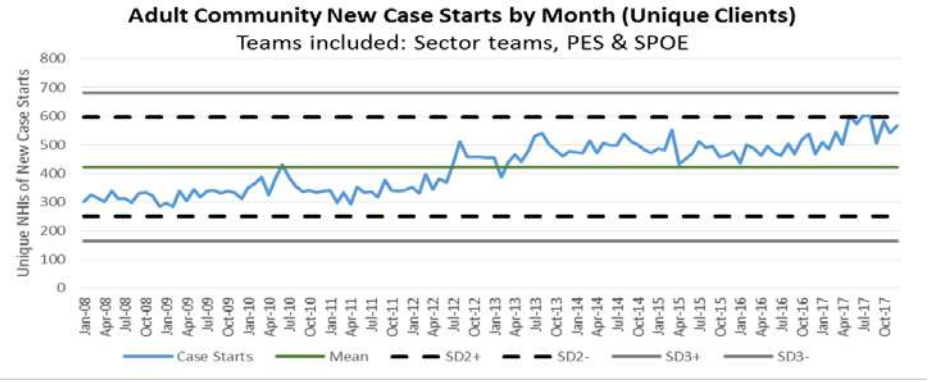


KPI 19 is a key suicide prevention activity and patient safety measure. In December 2017, 90.9% of consumers discharged from Te Awakura received a community care follow-up within seven days of discharge, and so met KPI 19.



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 2 days for December 2017. Our results for the Adult General Mental Health Service show 97.4% of people were seen within 21 days of referral in December 2017 and 99.4% were seen within 56 days of referral. This result is occurring in the context of significant increase in demand.

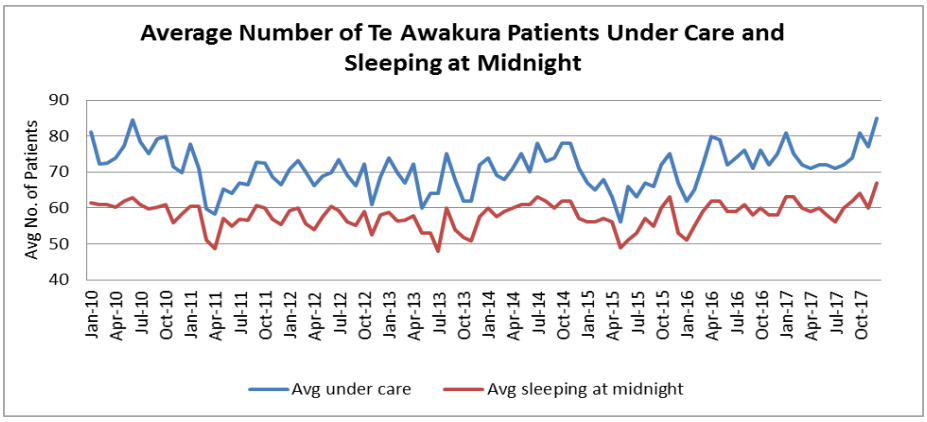
For child and family services the average waiting time was 28 days for December 2017. Our results show 65.0% of people were seen within 21 days of referral in December 2017 and 87.6% were seen within 56 days of referral.



New cases were created for 568 individual adults (unique NHIs) in December 2017.

Adult community services experienced a significant increase in demand following the Canterbury earthquakes. This increase has now levelled off, but demand still sits well above pre-earthquake levels.

In December 2017 there was at least one contact recorded for 1879 unique adult community mental health consumers.

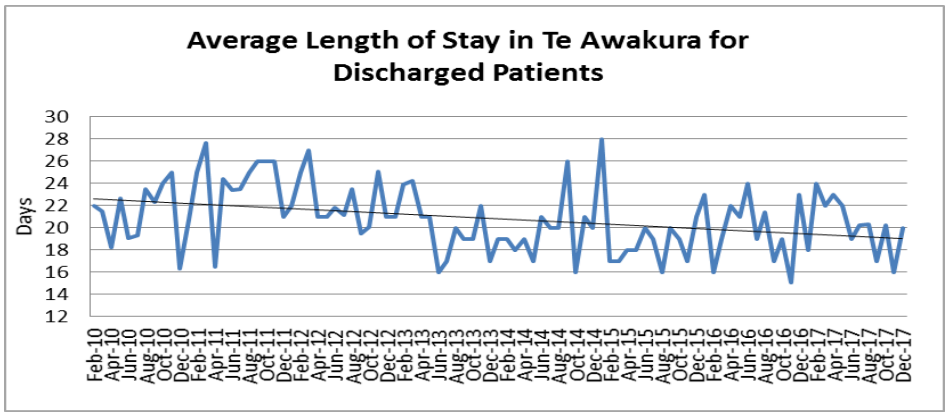


85% occupancy is optimal for mental health acute inpatient services.

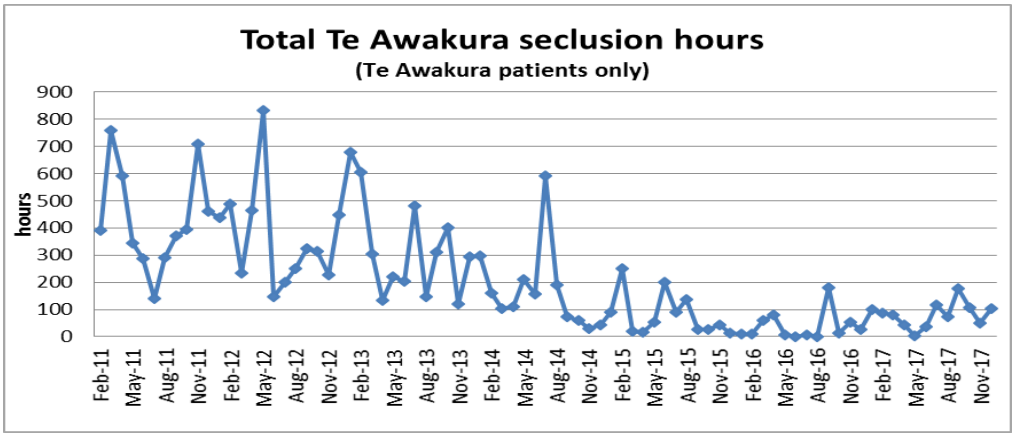
Occupancy in Te Awakura (the acute inpatient service) remains above this figure. Occupancy was 93% in November and 102% in December 2017.

The average number of consumers under care in this 64 bed facility was 77 in November and 85 in December 2017. There were 4 sleepovers during November and 41 sleepovers during December 2017.

SMHS and Planning and Funding are working on potential community options that could assist with acute demand for mental health inpatient services.

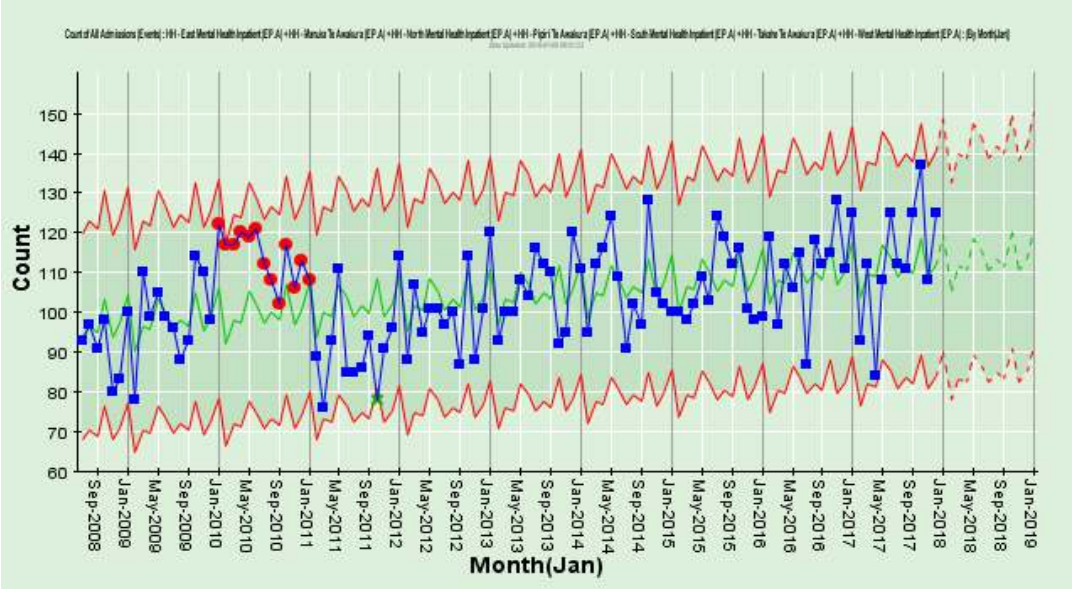


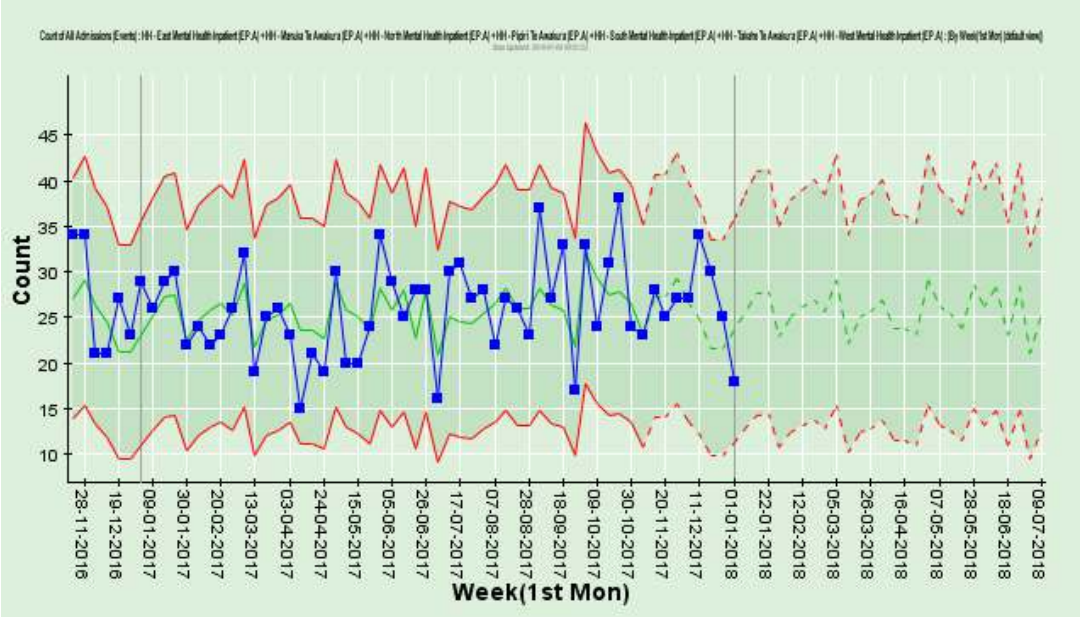
The average length of stay for consumers discharged from Te Awakura during November was 16 days and December 2017 was 20 days. We are closely monitoring length of stay in terms of any challenges accessing social and affordable accommodation and working closely with Comcare Trust.



Our focus on reduction of seclusion in Te Awakura continues with a significant reduction overall. In December 2017, nine consumers experienced seclusion for a total of 103.0 hours.

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.



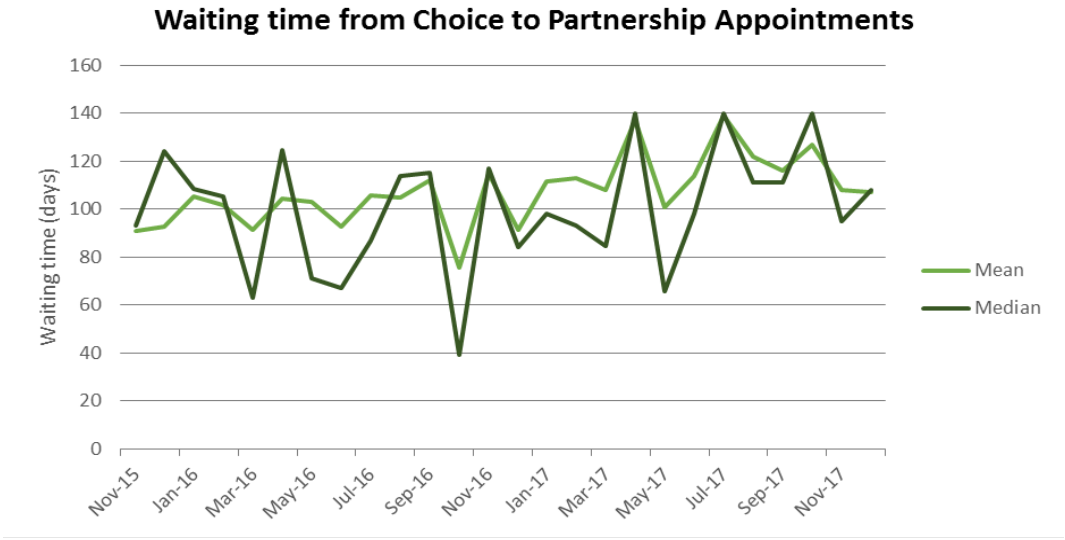


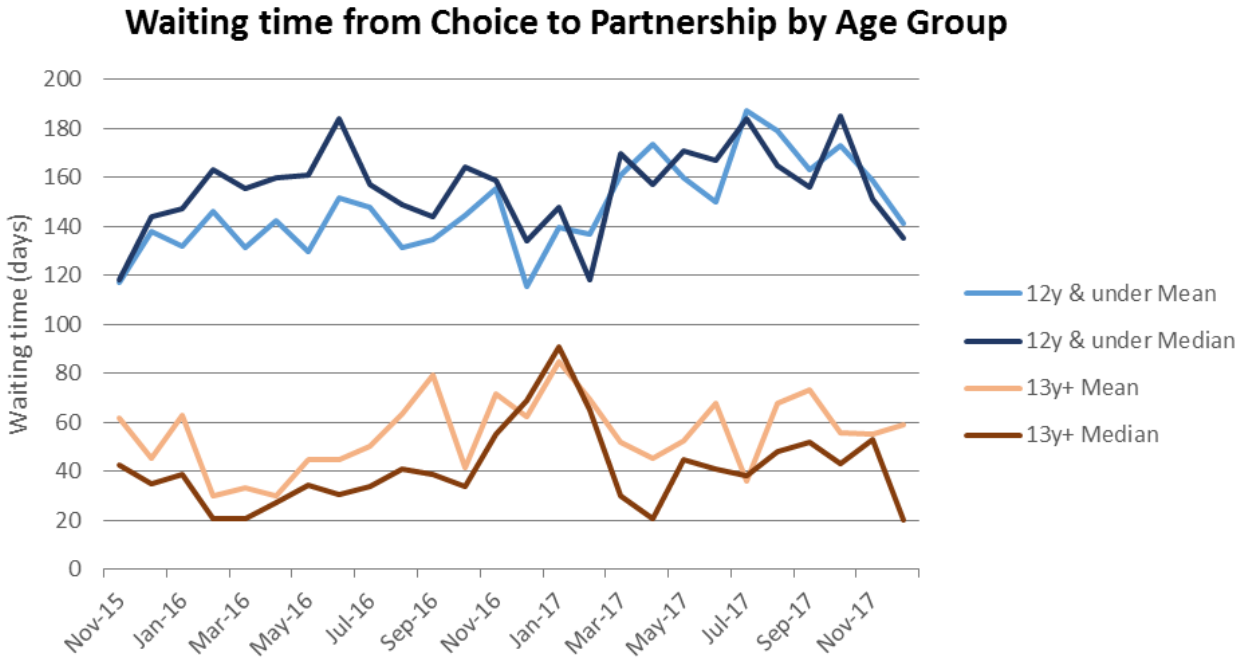
Child and Youth

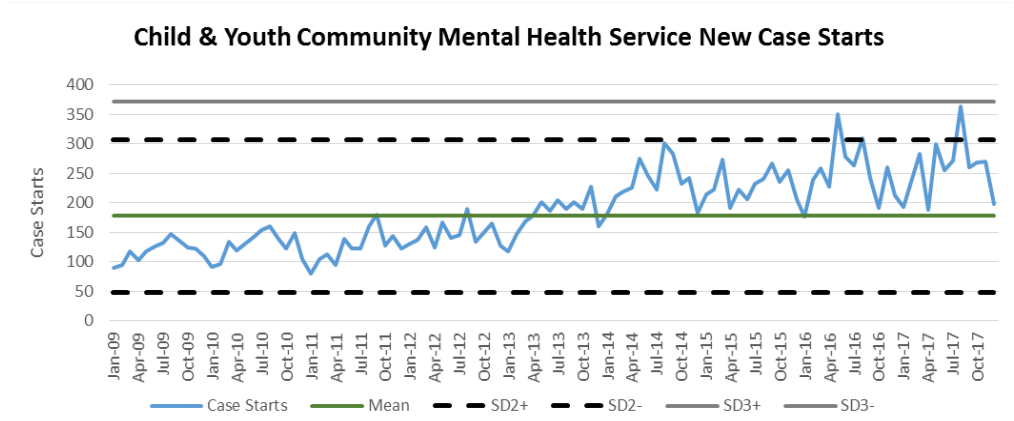
There has been a 98% increase in child and adolescent case starts in the past six financial years.

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

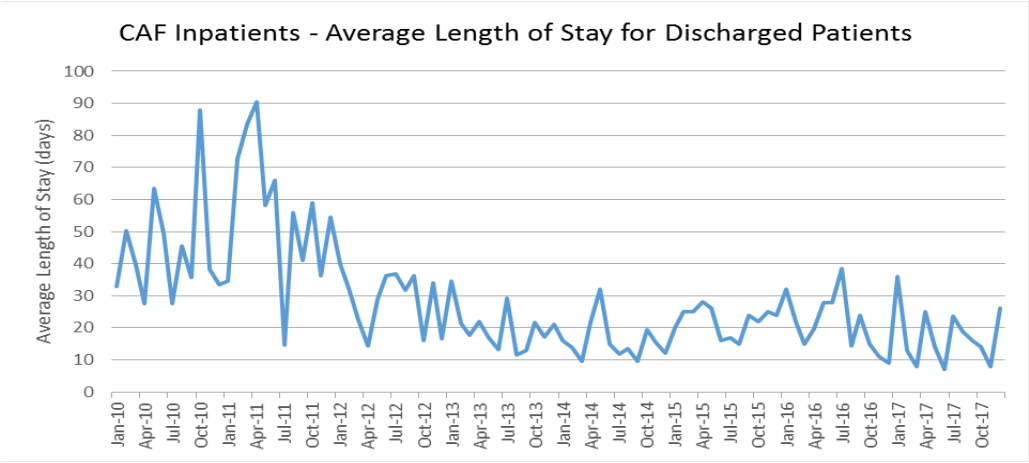
The graphs below show the waiting time between Choice (1st) and Partnership (2nd) appointments. Children and adolescents assessed as being of very high priority go straight to a Partnership appointment, bypassing the Choice appointment process.





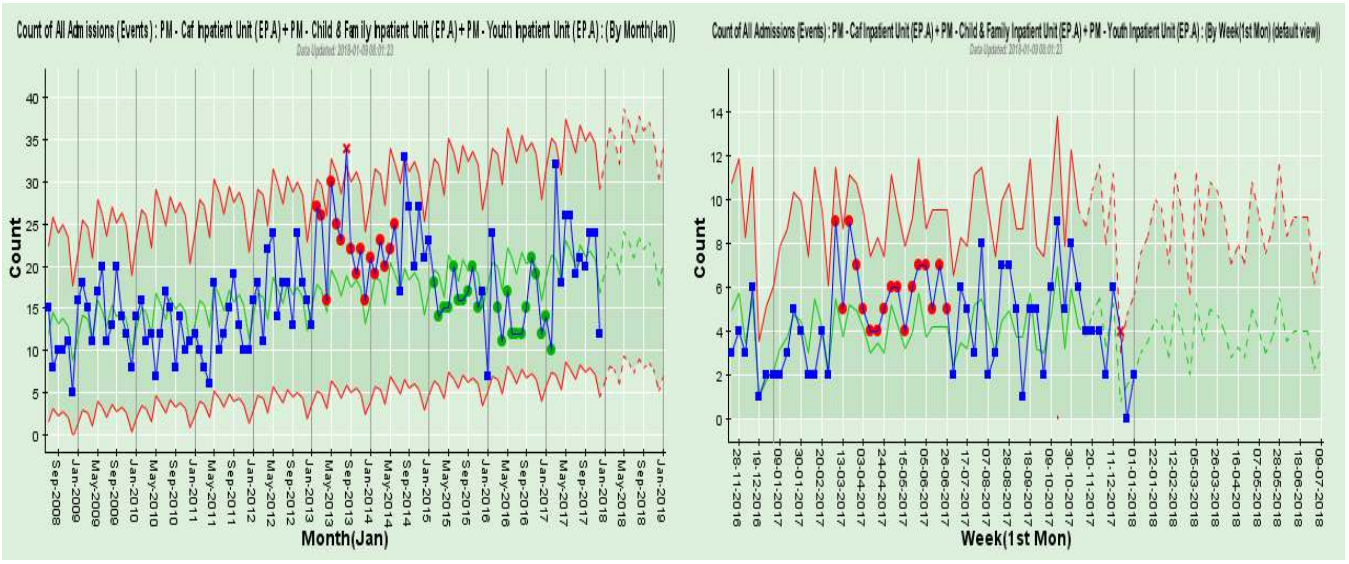


There were 270 new Child and Family (CAF) case starts in November and 198 in December 2017, new starts are always lower during school holidays. CAF services are making steady progress with implementation of a Direction of Change that supports more integrated services across the age ranges.



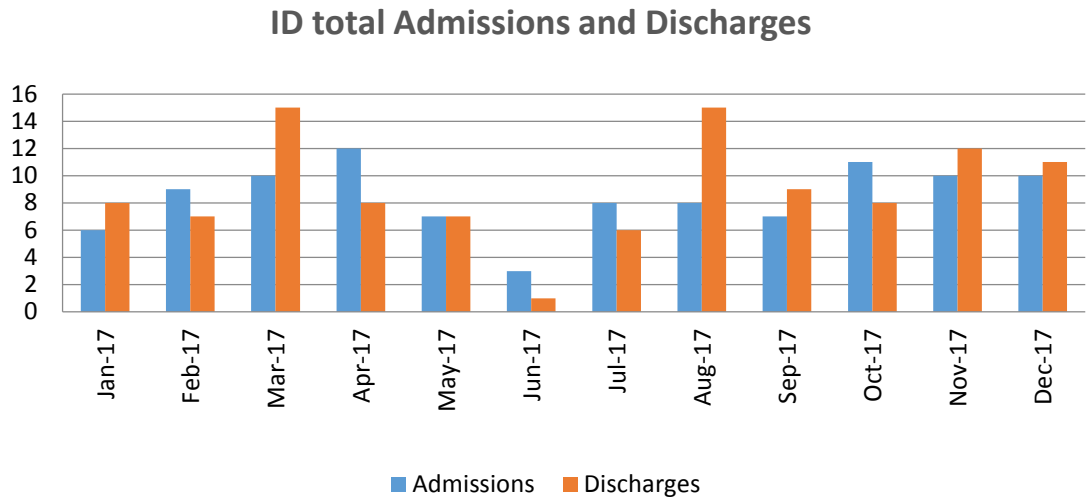
The average length of stay for discharged patients was 8 days for November and 26 days for December 2017.

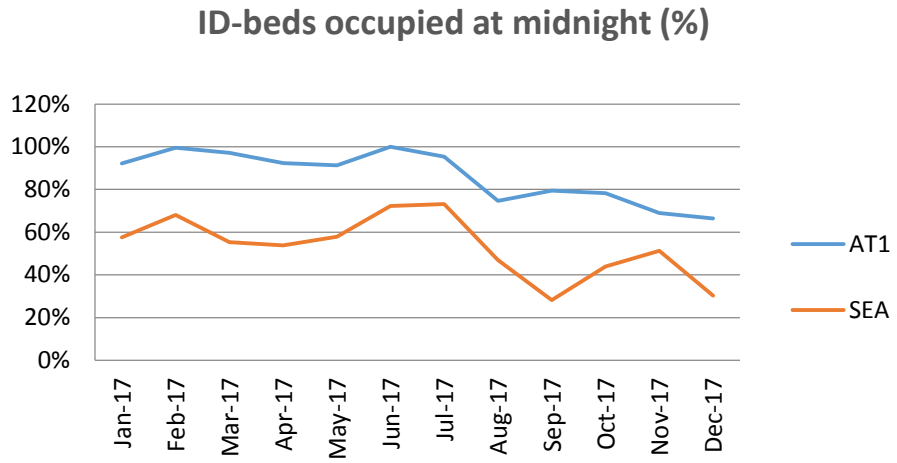
The graphs below show the number of admissions to the Child and Adolescent Unit and its predecessors. The first graph is a monthly view, and the second a weekly view.



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.





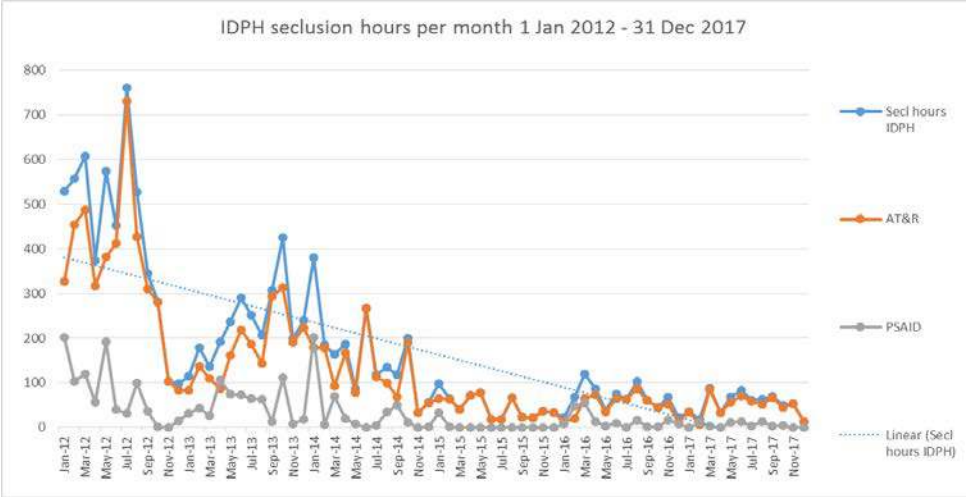
Occupancy in AT&R (AT1) was 69% for the month of November and 66% for December 2017. The figures for PSAID (SEA) were 51% and 30% respectively.

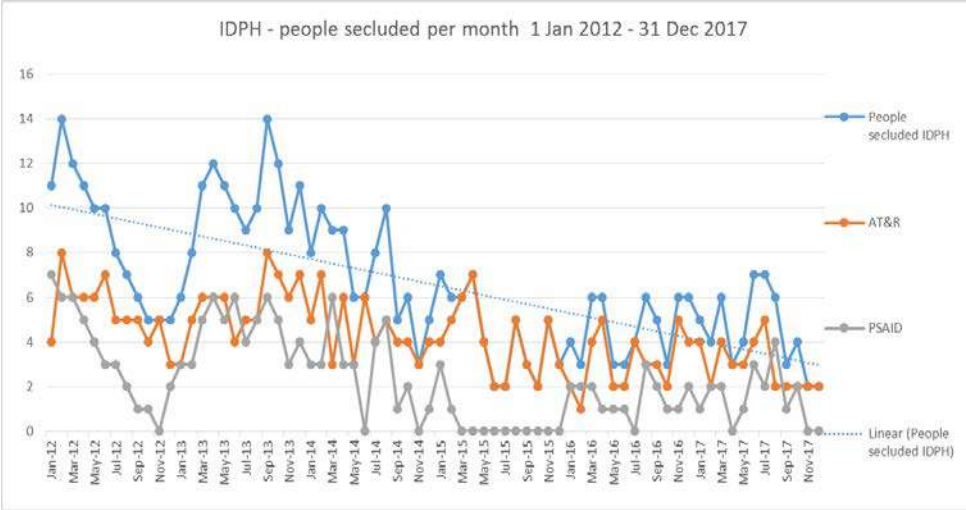
There have been longstanding delays in discharge for patients in the AT&R Unit. The delays continue to place pressure on the service and, for some of the patients, can lead to a deterioration in their presentation, affecting their readiness for discharge.

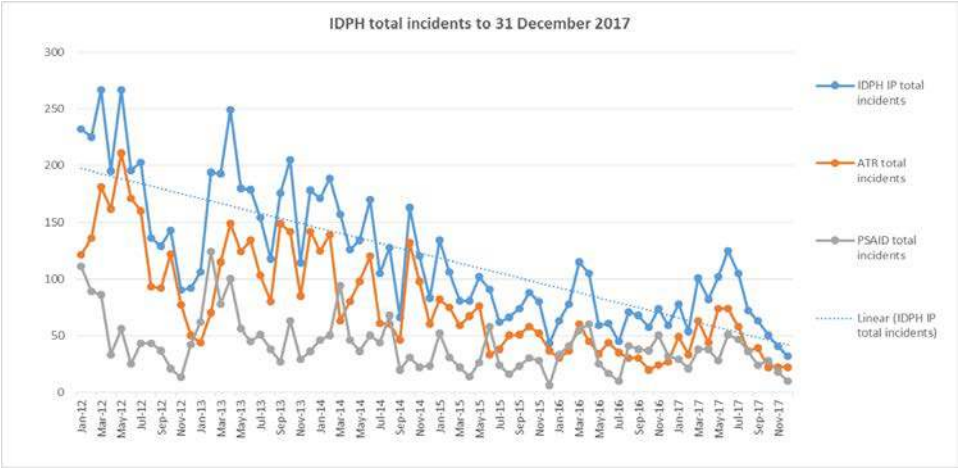
Half of our current inpatients have been assessed as clinically ready for discharge. The time delay for these discharges ranges from four months to twelve years.

Delays in discharge are predominantly due to the lack of suitable community placement options for patients with significant challenging behaviour.

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







Integrated Safety Response

The Integrated Safety Response (ISR) pilot was launched in Christchurch on 4 July 2016. A second pilot site in Waikato began on 25 October 2016. The ISR pilot is one element of a larger cross-agency work programme overseen by the Ministerial Group on Family Violence and Sexual Violence.

A recent evaluation[1] of the pilot found that since the pilot began:

- Multi-agency safety plans have been developed for nearly 10,000 families, involving just under 30,000 individuals.
- Close to 400 of these families have been identified as high risk (4% of all plans)
- Every week, an average of 183 episodes of family harm are being processed through ISR in Christchurch.

The evaluation also reported some key outcomes:

- A reduction in the prevalence of family harm behaviour after contact with ISR
- A reduction in the prevalence of family harm episodes for Maori after contact with ISR
- A significant reduction in the experience of physical abuse on exit from ISR (76% of high-risk clients had experienced physical abuse in the 3 months prior to ISR, reduced to 25% on exit from ISR).

Equally Well

Equally Well a New Zealand wide collaborative, supporting initiatives aimed at reducing physical health disparity for people who experience mental health and addiction problems. Adult community mental health services have been working to develop specific Equally Well plans for their respective consumer groups. This has involved developing new processes to inform, connect and record access to healthy lifestyle advice and health monitoring. A focus on connection with primary care alongside developing new ways of working with our NGO partners will facilitate improvement towards consumers' physical health outcomes. Staff education along with accompanying mentoring will enable physical health concerns to become more visible allowing for more assertive action to take place in this area.

Totara House Healthy Eating Study

Patients with serious mental illness are at significantly increased risk of long-term poor physical health outcomes as a result of poor nutrition and medication related weight gain. This is a particularly serious issue for young people with first episode psychosis, such as Totara House clients. Over the last 2 years Dr Jane Elmslie, Clinical Leader, Dietetics, SMHS has supervised two MDiet students to research stakeholder (clients, families and staff) support for a healthy eating and cooking programme at Totara House and to develop a ready to implement programme based on stakeholder feedback. The programme has now been finalised and intended to be rolled out in Totara House in the near future.

Totara House Integrated Support Project

Totara House is working collaboratively with Emerge Aotearoa and Comcare to explore the benefits of an integrated approach to the provision of employment support, Community Support Worker provision and a physical health and wellbeing initiative.

Specific NGO staff have been assigned to support the Totara House clinical programme, attending Totara House meetings as appropriate and being physically present within the team environment to promote positive staff relationships, develop trust and respect for the different skills sets offered

The aim is to integrate NGO activity into the development of a single support plan, created collaboratively by Totara House staff, client, family and NGO workers that maximises the efficiencies evident with everyone working closely together. The project is in the early stages but already showing great benefits to both clients and staff.

- More co-ordinated, targeted and timely response
- Shared understanding of consumer support needs and goals
- Increased integration and co-ordination between hospital and community based services.

[1] "Evaluation of the family violence Integrated Safety Response pilot. Final report." August 2017. Social Policy Evaluation and Research Unit. Data is drawn mainly from Christchurch but does include some Waikato data.

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 6 Months Ended 31 December 2017

MONTH $'000						YEAR TO DATE				
17/18 Actual $'000	17/18 Budget $'000	16/17 Actual $'000	17/18 Variance $'000	17/18 vs 16/17 Variance $'000		17/18 Actual $'000	17/18 Budget $'000	16/17 Actual $'000	17/18 Variance $'000	17/18 vs 16/17 Variance $'000
					Operating Revenue					
507	271	225	236	282	From Funder Arm	3,541	1,655	1,301	1,886	2,240
1,520	1,926	1,861	(406)	(341)	MOH Revenue	9,227	12,225	9,325	(2,998)	(98)
3,757	4,493	3,412	(736)	345	Patient Related Revenue	24,818	26,815	17,709	(1,997)	7,109
1,270	1,164	1,122	106	148	Other Revenue	8,410	6,533	5,368	1,877	3,042
7,054	7,854	6,620	(800)	434	**TOTAL OPERATING REVENUE**	45,996	47,228	33,703	(1,232)	12,293
					Operating Expenditure					
					Personnel Costs					
54,967	55,489	52,727	522	(2,240)	Personnel Costs - CDHB Staff	324,716	323,875	260,755	(841)	(63,961)
1,626	1,428	566	(198)	(1,060)	Personnel Costs - Bureau & Contractors	11,298	9,836	7,572	(1,462)	(3,726)
56,593	56,917	53,293	324	(3,300)	**Total Personnel Costs**	336,014	333,711	268,327	(2,303)	(67,687)
11,576	12,222	12,370	646	794	Treatment Related Costs	70,611	71,430	57,841	819	(12,770)
3,437	3,758	3,522	321	85	Non Treatment Related Costs	22,370	23,573	17,892	1,203	(4,478)
71,606	72,897	69,185	1,291	(2,421)	**TOTAL OPERATING EXPENDITURE**	428,995	428,714	344,060	(281)	(84,935)
(64,552)	**(65,043)**	**(62,565)**	**491**	**(1,987)**	**OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION**	**(382,999)**	**(381,486)**	**(310,357)**	**(1,513)**	**(72,642)**
					Indirect Income					
-	3	9	(3)	(9)	Donations & Trust Funds	10	18	19	(8)	(9)
(2)	-	(1)	(2)	(1)	Gain on Disposal of Assets	(21)	-	4	(21)	(25)
(2)	**3**	**8**	**(5)**	**(10)**	**TOTAL INDIRECT INCOME**	**(11)**	**18**	**23**	**(29)**	**(34)**
					Indirect Expenses					
2,145	2,342	3,384	197	1,239	Depreciation	12,903	13,319	10,499	416	(2,404)
2,145	**2,342**	**3,384**	**197**	**1,239**	**TOTAL INDIRECT EXPENSES**	**12,903**	**13,319**	**10,499**	**416**	**(2,404)**
-	-	-	-	-	Intra Division/Organisation Wide	-	-	-	-	-
(66,699)	**(67,382)**	**(65,941)**	**683**	**(758)**	**TOTAL SURPLUS / (DEFICIT)**	**(395,913)**	**(394,787)**	**(320,833)**	**(1,126)**	**(75,080)**

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
Emergency Dept	Reducing wasted intravenous cannula use		$62,000pa			Released staff time for other purposes
						reduction in: -complications -haemolysis -use of IV drugs -admissions
Orthopaedic Service	Orthopaedic data transferred to Health Connect South		$25,000			
Surgical	PICC line improvements				$12,000 of resources	
					$120,000 associated with additional care required	

Achievements/Issues of Note

Improved treatment of bronchiolitis

Historically, bronchodilators, steroids, chest x-rays, adrenalin and antibiotics have been used in the treatment of bronchiolitis, despite an overwhelming body of evidence showing that these treatments do not decrease length of stay, reduce the need for hospitalisation, or reduce the severity or duration of the illness.

The Paediatric Department and Emergency Department, working together, have introduced a guideline discouraging the use of chest x-ray, salbutamol, antibiotics, adrenalin and steroids in infants under 12 months with a clinical diagnosis of bronchiolitis. The importance of caregiver education, hydration and nutritional support were promoted.

Before this, adherence to the guideline occurred in 71.4%of infants with bronchiolitis, with use of salbutamol being the most common breach of the guideline. Several audits following its introduction showed an improvement to between 90 and 100 percent.

This change has ensured that effective interventions are reliably used and not substituted for by ineffective ways of working.

Reducing wasted intravenous cannula use

A large proportion of patients coming to the Emergency Department have a blood test as part of their workup, and many of these were receiving a “just-in-case” intravenous cannula. An audit showed that 43 percent of Emergency Department patients were having a cannula inserted and up to 55 percent of these lines were not used for anything other than drawing blood for blood tests.

A goal was set to bring the number of unused cannula down to 20 percent using audit and education. In addition to saving time and the cost of cannulae, it was expected to reduce complications associated with cannulation and the rates of haemolysis which interferes with many blood test results and is more common when blood is taken through a cannula.

Criteria were determined and implemented for when a cannula should be used. Since implementation the proportion of Emergency Department patients having an intravenous catheter inserted has fallen from 43 to 22 percent and the proportion of inserted cannulae not used has fallen from 55 to 27percent.

It is estimated that we have saved $62, 000 in consumable costs per year and released $42,000 of staff time for other purposes. Other benefits delivered include a reduction in complications, haemolysis, consequent unnecessary use of IV drugs and admission.

Orthopaedic data transferred to Health Connect South

In the past the Orthopaedic Service used a clinical information system called Plato to collect information about clinicians' engagement with patients. Since the development of Health Connect South these functions have been transferred to Health Connect South. During 2017 the historical information held within Plato has been transferred to Health Connect South in order to ensure ongoing access to these records. Not only does this mean that this clinical information is available within a single system, we have now been able to allow the Plato license to expire, eliminating the annual $25,000 cost of license and maintenance fees.

Zero duplicate National Health Index Numbers

The National Health Index number is a number that is assigned to each person using health and disability support services. This number which allows people to be positively and uniquely identified for the purposes of treatment and care, and for maintaining medical records. New National Health Index numbers are created when staff are unable to find an existing one for a patient.

However sometimes creation of a new number results in a duplication – with a person being having two of these unique identifiers. This causes a clinical risk because clinicians are unaware of all the information held under the other number. It is also time consuming to fix duplicates later, taking between 30 minutes and six hours per patient depending on the complexities of investigating and merging electronic and paper records into one.

During November there were 8,342 patient attendances in the Emergency Department and 185 new National Health Index Numbers registered. The Ministry of Health's regular report showed that no duplicate numbers were created in the Emergency Department during the month. This is a great result requiring good systems and the dedication of Clerical Officers who are the first point of contact when patients arrive at hospital no matter the time of day. Getting it right first time saves significant re-work and is a fundamental part of providing a safe health system for people requiring care.

PICC line improvements

In June 2017 an update was provided about improvements being put in place to prevent peripherally inserted central catheters (PICC) migrating in or out of the vein at Christchurch Hospital. At that point the rollout of SecurAcath® had been completed.

Successful securement protects the catheter from failure before the completion of therapy by stopping the catheter from moving within the patient's vein. It was expected that the use of SecurAcath® would reduce the number of reinsertions required, reduce the harm potentially caused by catheter migration (which can include death) and reduce the number of peripherally inserted central catheter related blood stream infection. An audit has been carried out to test whether these benefits were delivered.

In the year to the end of July 2017, in Ward 15 and Ward 16 which incorporate the Surgical Progressive Care Unit and Surgical Acute Assessment and Review Area, seven catheter reinsertions were required compared with 38 in the previous 12 months – a reduction of 31 reinsertions despite an overall slight increase in the use of these catheters. In addition there was a reduction in the number of peripherally inserted central catheter related hospital acquired blood stream infections from 11 to five.

This change has improved the care of patients by reducing the risk associated with migrating PICCs and hospital acquired infections, discomfort and anxiety associated with catheter reinsertions while saving (in these wards alone) over $12,000 of resources associated with line reinsertion and $120,000 per year associated with additional care required by patients with hospital acquired infections.

Use of this product had started earlier in Oncology Day Ward, Bone Marrow Transplant Unit and Ward 17 and results have been impressive in these areas too. There have been no catheter migrations in Ward 17 between 2015- 2017 and none in the oncology day ward during 2016 and 2017.

Specialist Mental Health Recruitment

Recruitment remains an ongoing focus, both to fill vacancies and reduce associated staffing costs related to ongoing use of agency staff to cover gaps

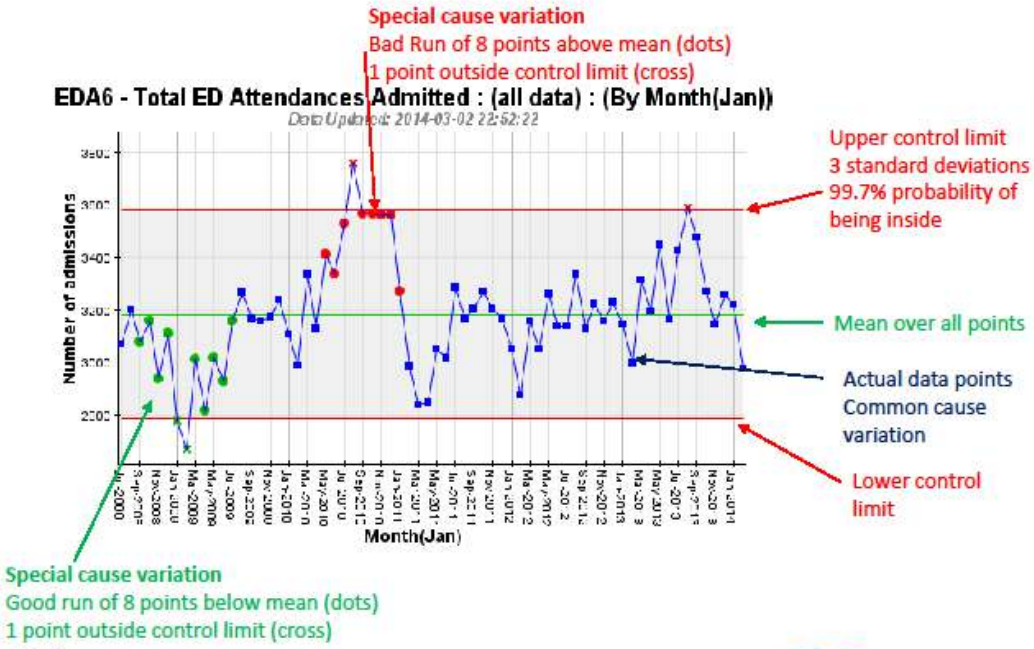
Some of the reasons for vacancies include retirements (linked to the demographics of our workforce), movement of staff within SMHS and out to non-DHB mental health services such as primary care and corrections.

We are expecting some appointments to result from the international recruitment campaign. Immigration and health professional registration requirements and the logistics of moving families between countries, mean that such recruitments may take up to a year.

Orthopaedic Outpatients Confirmation Line.

Confirmation line for Orthopaedic Outpatients fully operational with 1400 calls during November. This line is for patients to phone and leave a message to confirm their appointment attendance, after hours staff confirm the appointment in the patient management system or arrange for rescheduling. This ensures that we are more efficiently utilising appointments with increased certainty that patients will attend, reducing DNA's (did not attend) and rescheduling available appointments to improve overall utilisation.

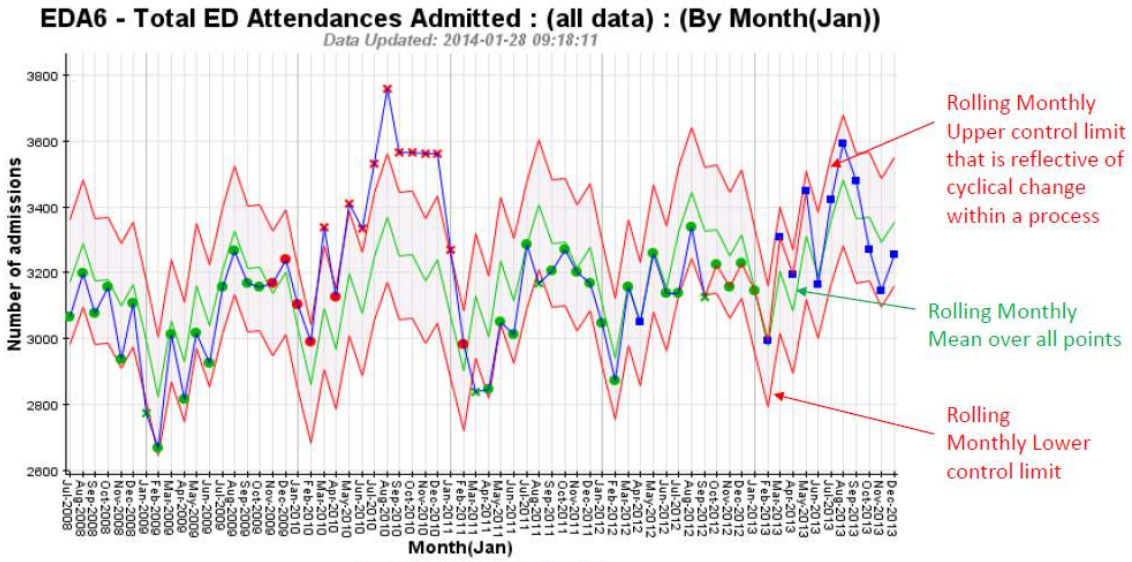
SPC: How to Interpret a Control Chart



sfn signals from noise

make it better

SPC: How to Interpret Cyclical and Trended Data



Criteria for a Cyclical Process:

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

sfn signals from noise

make it better

RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

SOURCE: **Corporate Services**

DATE: **1 February 2018**

Report Status – For:	Decision	☑	Noting	☐	Information	☐

1. ORIGIN OF THE REPORT

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

2. RECOMMENDATION

That the Committee:

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

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

	GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED	GROUND(S) FOR THE PASSING OF THIS RESOLUTION	REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9)
1.	Confirmation of the minutes of the public excluded meeting of 30 November 2017	For the reasons set out in the previous Committee agenda.	
2.	CEO Update *(If required)*	Protect information which is subject to an obligation of confidence. To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations). Maintain legal professional privilege	s 9(2)(ba)(i) s 9(2)(j) s 9(2)(h)

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

3. SUMMARY

The Act, Schedule 3, Clause 32 provides:

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

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

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

Clause 33 of the Act also further provides:

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

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

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

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

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

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

WORKPLAN FOR HAC 2018 *(WORKING DOCUMENT)*

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

2018

Fracture Liaison Service Update (ex 1 Jun 17 mtg)