# AGENDA – PUBLIC

Canterbury District Health Board
Te Poari Hauora o Waitaha

**HOSPITAL ADVISORY COMMITTEE MEETING**
**to be held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch**
**Thursday, 5 August 2021 commencing at 9:00am**

| | | | |
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| **Administration** | | | |
| | Apologies | | 9.00am |
| 1. | Conflict of Interest Register | | |
| 2. | Confirmation of Minutes – 3 June 2021 | | |
| 3. | Carried Forward / Action List Items | | |
| **Presentation** | | | |
| 4. | RSV & Impacts | Clare Doocey<br>*Chief of Child Health* | 9.05-9.35am |
| **Reports for Noting** | | | |
| 5. | Hospital Service Monitoring Report:<br>• Medical/Surgical; Women's & Children's Health; & Orthopaedics<br>ESPIs<br>• Specialist Mental Health Service<br>• Older Persons Health & Rehabilitation<br>• Hospital Laboratories<br>• Rural Health Services | Pauline Clark<br>*General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics*<br>Dr Greg Hamilton<br>*General Manager, Specialist Mental Health Services*<br>Kate Lopez<br>*Acting General Manager, Older Persons Health & Rehabilitation*<br>Kirsten Beynon<br>*General Manager, Laboratories*<br>Win McDonald<br>*Transition Programme Manager Rural Health Services*<br>Berni Marra<br>*Manager, Ashburton Health Services* | 9.35-10.30am |
| 6. | Clinical Advisor Update (Oral)<br>• Nursing | Becky Hickmott<br>*Executive Director of Nursing* | 10.30-10.45am |

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| 7. | Resolution to Exclude the Public | | 10.45am |
| **ESTIMATED FINISH TIME** | | | **10.45am** |
| | Information Items:<br>• Making Our System Flow (ex Board 15 July 2021)<br>• 2021 Workplan | | |

**NEXT MEETING: Thursday, 7 October 2021 at 9:00am**

# ATTENDANCE

Canterbury District Health Board
Te Poari Hauora ō Waitaha

## HOSPITAL ADVISORY COMMITTEE MEMBERS

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

## Executive Support

(as required as per agenda)

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

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

# COMMITTEE ATTENDANCE SCHEDULE 2020

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

| | |
|---|---|
| **Andrew Dickerson**<br>**Chair – HAC**<br>Board Member | **Canterbury Health Care of the Elderly Education Trust** - Chair<br>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.<br><br>**Canterbury Medical Research Foundation** - Member<br>Provides financial assistance for medical research in Canterbury. Recipients of financial assistance for research, education or training could include employees of the CDHB.<br><br>**Heritage NZ -** Member<br>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.<br><br>**Maia Health Foundation -** Trustee<br>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.<br><br>**NZ Association of Gerontology** - Member<br>Professional association that promotes the interests of older people and an understanding of ageing. |
| **Naomi Marshall**<br>**Deputy Chair - HAC**<br>Board Member | **College of Nurses Aotearoa NZ** – Member<br><br>**Riccarton Clinic & After Hours** – Employee<br>Employed as a Nurse. Riccarton Clinic & After Hours provides general practice and after-hours care. It is part privately and PHO funded. The PHO receives funding from the CDHB. |
| **Barry Bragg**<br>Board Member | **Air Rescue Services Limited** - Director<br>Subsidiary of the Canterbury West Coast Air Rescue Trust. Has gaming licenses with specified purpose of fundraising for air rescue services.<br><br>**Canterbury West Coast Air Rescue Trust** – Trustee<br>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.<br><br>**CMUA Project Delivery Limited** - Director<br>100% owned by the Christchurch City Council and is responsible for the delivery of the Canterbury Multi-Use Arena project within agreed parameters.<br><br>**Farrell Construction Limited** - Shareholder<br>Farrell's Construction Limited is a commercial and light commercial construction company based in Christchurch. |

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

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| | **Medical Kiwi Limited** – Independent Director<br>Research and distribution company of medicinal cannabis and other health related products.<br><br>**The Antony Gough Trust** – Trustee<br>Trust for Antony Thomas Gough<br><br>**The Russley Village Limited** – Shareholder<br>Retirement Village. Via the Antony Gough Trust<br><br>**The Terrace Car Park Limited** – (Alternate) Director<br>Property company – manages The Terrace car park<br><br>**The Terrace On Avon Limited** – (Alternate) Director<br>Property company – manages The Terrace. |
| **Jo Kane**<br>Board Member | **Christchurch Resettlement Services** - Member<br>Christchurch Resettlement Services provides a range of services to people from refugee and migrant backgrounds. It works alongside refugee communities in delivering services that aim to achieve positive resettlement outcomes.<br><br>**HurriKane Consulting** – Project Management Partner/Consultant<br>A private consultancy in management, communication and project management. Any conflicts of interest that arise will be disclosed/advised.<br><br>**Latimer Community Housing Trust** – Project Manager<br>Delivers social housing in Christchurch for the vulnerable and elderly in the community.<br><br>**NZ Royal Humane Society** – Director<br>Provides an awards system for acts of bravery in New Zealand. It is not anticipated any conflicts of interest will arise. |
| **Dr Rochelle Phipps** | **Accident Compensation Corporation** – Medical Advisor<br>ACC is a Crown entity responsible for administering NZ's universal no-fault accidental injury scheme. As a Medical Advisor, I analyse and interpret medical information and make recommendations to improve rehabilitation outcomes for ACC customers.<br><br>**OraTaiao: New Zealand Climate & Health Council** – Founding Executive Board Member (no longer on executive)<br>The Council is a not-for-profit, politically non-partisan incorporated society and comprises health professionals in Aotearoa/New Zealand concerned with:<br>• the negative impacts of climate change on health;<br>• the health gains possible through strong, health-centred climate action;<br>• highlighting the impacts of climate change on those who already experience disadvantage or ill health (equity impacts); and<br>• reducing the health sector's contribution to climate change.<br><br>**Royal New Zealand College of General Practitioners** – Christchurch Fellow and Former Board Member<br>The RNZCGP is the professional body and postgraduate educational institute for general practitioners. |

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| **Ingrid Taylor**<br>Board Member | **Loyal Canterbury Lodge (*LCL*) – Manchester Unity** – Trustee<br>LCL is a friendly society, administering funds for the benefit of members and often makes charitable donations. One of the recipients of such a donation may have an association with the CDHB.<br><br>**Manchester Unity Welfare Homes Trust Board (*MUWHTB*)** – Trustee<br>MUWHTB is a charitable Trust providing financial assistance to organisations in Canterbury associated with the care and assistance of older persons. Recipients of financial assistance may have an association with the CDHB.<br><br>**Sir John and Ann Hansen's Family Trust** – Independent Trustee.<br><br>**Taylor Shaw** – Partner<br>Taylor Shaw has clients that are employed by the CDHB or may have contracts for services with the CDHB that may mean a conflict or potential conflict may arise from time to time. Such conflicts of interest will need to be addressed at the appropriate time.<br>• I / Taylor Shaw have acted as solicitor for Bill Tate and family.<br><br>**The Youth Hub** – Trustee<br>The Youth Hub is a charitable Trust established to provide residential and social services for the Youth of Canterbury, including services for mental health and medical care that may include involvement with the CDHB. |
| **Michelle Turrall**<br>Manawhenua | **Canterbury Clinical Network (CCN) Maori Caucus** - Member<br><br>**Canterbury District Health Board** - Daughter employed as registered nurse.<br><br>**Christchurch PHO Ltd** – Director<br><br>**Christchurch PHO Trust** - Trustee<br><br>**Manawhenua ki Waitaha** – Board Member and Chair<br><br>**Oranga Tamariki – Iwi and Maori** – Senior Advisor<br><br>**Papakainga Hauora Komiti – Te Ngai Tuahuriri** – Co-Chair |
| **Sir John Hansen**<br>**Ex-Officio – HAC**<br>Chair CDHB | **Bone Marrow Cancer Trust** – Trustee<br><br>**Canterbury Cricket Trust** - Member<br><br>**Christchurch Casino Charitable Trust** - Trustee<br><br>**Court of Appeal, Solomon Islands, Samoa and Vanuatu**<br><br>**Dot Kiwi** – Director and Shareholder<br><br>**Judicial Control Authority (*JCA*) for Racing** – Appeals Tribunal Member<br>The JCA is an independent statutory authority constituted under the Racing Act. The JCA ensures that judicial and appeal proceedings in thoroughbred and harness racing are heard and decided fairly, professionally, efficiently and in a consistent and cost effective manner.<br><br>**Rulings Panel Gas Industry Co Ltd** |

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| | **Sir John and Ann Hansen's Family Trust** – Ingrid Taylor sits as independent Trustee; and provides legal services to the Trust and to Sir John and Ann Hansen. |
| **Gabrielle Huria**<br>**Ex-Officio – HAC**<br>Deputy Chair, CDHB | **Pegasus Health Limited** – Sister is a Director<br>Primary Health Organisation (*PHO*).<br><br>**Rawa Hohepa Limited** – Director<br>Family property company<br><br>**Sumner Health Centre** – Daughter is a General Practitioner (*GP*)<br>Doctor's clinic.<br><br>**Te Kura Taka Pini Limited** – General Manager<br><br>**The Royal New Zealand College of GPs** – Sister is an "appointed independent Director" College of GPs.<br><br>**Upoko Rawiri Te Maire Tau of Ngai Tuahuriri** - Husband |

**MINUTES – PUBLIC**

Canterbury District Health Board
Te Poari Hauora ō Waitaha

**DRAFT**
**MINUTES OF THE HOSPITAL ADVISORY COMMITTEE MEETING**
**held in the Board Room, Level 1, 32 Oxford Terrace, Christchurch**
**on Thursday, 3 June 2021, commencing at 9.00am**

## PRESENT

Naomi Marshall (Deputy Chair), Barry Bragg; Jan Edwards; James Gough; Jo Kane; Dr Rochelle Phipps; Ingrid Taylor; and Sir John Hansen (ex-officio).

Attending via Zoom: Andrew Dickerson (Chair).

## APOLOGIES

An apology for absence was received and accepted from Catherine Chu.
An apology for early departure was received and accepted from James Gough (10.20am).

## EXECUTIVE SUPPORT

Becky Hickmott (Executive Director of Nursing); Dr Jacqui Lunday-Johnstone (Executive Director, Allied Health, Scientific & Technical); Dr Helen Skinner (Chief Medical Officer); Kay Jenkins (Executive Assistant, Governance Support); and Anna Craw (Board Secretariat).

## APOLOGIES

Dr Peter Bramley (Chief Executive); Kirsten Beynon (General Manager, Laboratories); Ralph La Salle (Acting Executive Director, Planning & Funding); and Berni Marra (Manager, Ashburton Health Services).

## IN ATTENDANCE

Pauline Clark, General Manager, Medical/Surgical; Women's & Children's Health; & Orthopaedics
Dr Greg Hamilton, General Manager, Specialist Mental Health Services
Kate Lopez, Acting General Manager, Older Persons Health & Rehabilitation
Win McDonald, Transition Programme Manager, Rural Health Services

**Item 5**
Jacqui Summers, Portfolio Lead, Secondary Care, Planning & Funding

Naomi Marshall, Deputy Chair HAC, opened the meeting, welcoming Dr Helen Skinner as newly appointed Chief Medical Officer, as well as Kate Lopez, Acting General Manager, Older Persons Health & Rehabilitation.

## 1. INTEREST REGISTER

**Additions/Alterations to the Interest Register**
James Gough – Amendment - Medical Kiwi Limited – remove "in process of listing on NZX".

There were no other additions/alterations.

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

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

## 2. CONFIRMATION OF PREVIOUS MEETING MINUTES

**Resolution (04/21)**
(Moved: Naomi Marshall/Seconded: Jan Edwards – carried)

"That the minutes of the Hospital Advisory Committee meeting held on 1 April 2021 be approved and adopted as a true and correct record."

## 3. CARRIED FORWARD / ACTION ITEMS

The carried forward action items were noted.

*The meeting moved to Item 8.*

## 8. CLINICAL ADVISOR UPDATE (ORAL)

Dr Helen Skinner, Chief Medical Officer, provided the following updates:

- There are some challenges in terms of workforce. Some of this is around SMO recruitment, although we have managed to recruit into haematology and radiation oncology which have been pressure points for a while. Currently, we are recruiting in anatomical pathology which is another pressure area.
- We continue to support other DHBs, particularly in terms of surgery.
- Look forward to getting results from the Staff Survey and to see what things will come from that.
- Patient flow is on the minds of the medical workforce, particularly with the challenges of inflow into ED, but also the outflow and flow into the hospital. Work is being done to look at that.
- Demand continues to be challenging in terms of radiology.
- Facilities issues, particularly for those who have been left in the older wards, continue to be challenging.
- COVID-19. A state of readiness in term of the Labs. Continued challenges (if or when) in terms of community transmission particularly in the older wards.
- COVID-19 continues to impact on overseas recruitment, particularly in radiology.
- Continuing to innovate and do things differently. To manage compliance in terms of paediatrics we have been doing Saturday clinics which is working well.
- Older Persons Mental Health have started to review Dementia Hospital Level Care residents to look at whether they are in the right place.

The Clinical Advisor Update was noted.

*The meeting moved to Item 4.*

## 4. MAKING OUR SYSTEM FLOW (PRESENTATION)

Dr Jacqui Lunday-Johnston provided a presentation on "Making Our System Flow". It was noted that this is a system challenge and is not a quick fix in one place. The presentation highlighted:

- The establishment of an Acute Flow Governance Group
- Key operational constraints to plan:
  - ED volumes – increase in self-referred with non-emergency needs (50-80 additional patients a day); and

- Christchurch Hospital bed capacity – it is not a volume problem but an increase in Length of Stay issue.

- Factors being focused on, including:
  - Better public understanding of accessing their GP 24x7 for all medical needs;
  - Enhanced access to multi-disciplinary support in the community for frail elderly (preventative actions before admission to hospital);
  - Flow within the CHCH campus to reduce delays of care;
  - Flow between our facilities to reduce delays in care;
  - Cohorting general medicine patients to improve doctor decision making time;
  - Delayed discharge drivers; and
  - Reasons for readmissions to hospital and reattendances to ED.

Members had the opportunity to discuss the presentation and ask questions.

Ms Marshall requested a further update on progress to the next meeting.

The Making Our System Flow update was noted.

## 5. ESPI PERFORMANCE (PRESENTATION)

Pauline Clark introduced Jacqui Summers, Portfolio Lead, Secondary Care, Planning & Funding. Ms Summers presented to the Committee providing an update on progress in terms of Elective Service Performance Indicators (*ESPI*) 2s & 5s. The presentation highlighted:

- When ESPI compliance is expected
- Current ESPI 2 performance - medical specialties
- Current ESPI 2 performance - surgical specialties
- Current ESPI 5 performance – surgical specialties
- Our current state
- What we are doing (business as usual)
- What we are looking to do differently

Members had the opportunity to discuss the presentation and ask questions.

*James Gough retired from the meeting at 10.20am.*

The ESPI Performance update was noted.

## 6. H&SS MONITORING REPORT

The Committee considered the Hospital and Specialist Services Monitoring Report for June 2021. The report was taken as read.

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

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

- This week is a challenging week. We have had to not go ahead with some planned surgery – surgery requiring overnight inpatient bed nights. Where possible, we have swapped to do day case surgery.
- Orthopaedics and General Surgery, who do large volumes of acute surgery, have perfect flow – which means people are not waiting unduly long before we are able to get to them.

- Industrial action by members of the NZNO is scheduled for Wednesday, 9 June 2021 from 11.00am to 7.00pm. Coming off the back of a long weekend, it is likely to be a big hospital on Tuesday. We currently have insufficient people to fulfil the Life Preserving Service (*LPS*) requirements in the hospital and we have insufficient numbers of volunteers. Staff are very tired.

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

- The report rounds up the last of the speciality areas that have been highlighted to the Committee over recent months – Forensic Mental Health Services.
- A complex area, which is an interface between prison, courts and other mental health services. The people in our service are over 18 years, have a major mental health disorder, as well as serious offending – almost always of a violent nature.
- There are only five of these services nationally. They each are relatively small, apart from the Mason Clinic, in Auckland.

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

- To provide patient choice, waitlist reduction and earlier intervention, outpatient clinics for OPH&R Speech Language Therapy are now being offered.
- Have recruited a Service Manager for Patient Flow on a 12 month fixed term contract. In line with the organisational priority of patient flow, this role will work with bed management teams at the Christchurch campus to support and enhance transfer of care to Burwood Hospital and discharge processes out of the hospital to ensure that barriers to discharge are identified early and escalated for resolution to avoid wasting patients' time and ensure good patient flow across the system.
- Continue to collaborate with surgical specialties to appropriately resource the increased surgical volumes occurring and planned for at Burwood Hospital.

There was a query with regards to the graph on page 2 of Appendix 1 with regards to the Frail Older Persons' Pathway and the significant drop in the "% of patients (75+) in ED within 6 hours". Management undertook to report back.

**Rural Health Services – Win McDonald, Transition Programme Manager**

- Ashburton Health Services:
  - Level of support which staff are needing in light of the recent weather event.
  - There is a level of GP stress that is starting to show through, with an increase in afterhour presentations and the impact this is having on Ashburton Hospital.
- Rural Health Services:
  - Biggest issue remains staffing.
  - Doing some great work in the Hurunui District, with community meetings coming up within the next two weeks to talk to the community around their models of care, particularly with their GPs.
  - Home services have been reinstated in both Cheviot and Waikari. Previously, they had been dependent on Amberley for this.
  - Chatham Islands. Had a stakeholders meeting two weeks ago. Key things that arose were: water, fuel, power, getting food onto the Island, and the effects of tourism on the Island. As a whole of stakeholders group, they are now working collectively to try to manage this better so that the basic necessities are available for the local community. There are currently three wellbeing surveys on the Chatham Islands and out of that will come a collective view of how best to respond to the needs of the community.

The H&SS Monitoring report was noted.

## 7. CARE CAPACITY DEMAND MANAGEMENT UPDATE

Ms Hickmott spoke to the report, which was taken as read.

Ms Hickmott stressed that when looking at a very high level aggregation of our workforce and making assumptions that potentially we may be looking like we are overstaffed, it is absolutely important to understand the narrative at the clinical interface. We need to continually be mindful that when making analysis of a situation, that we also understand at the ward and clinical interface what the risks are and why things are the way they are.

The Care Capacity Demand Management Update report was noted.

*The meeting moved to Item 9.*

## 9. RESOLUTION TO EXCLUDE THE PUBLIC

**Resolution (05/21)**
(Moved: Dr Rochelle Phipps/Seconded: Ingrid Taylor – 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 28 January 2021 | For the reasons set out in the previous Committee agenda. | |
| 2. | CEO Update *(if required)* | Protect information which is subject to an obligation of confidence.<br>To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).<br>Maintain legal professional privilege. | s 9(2)(ba)(i)<br>s 9(2)(j)<br>s 9(2)(h) |

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

## INFORMATION ITEMS

- Quality & Patient Safety Indicators – Level of Complaints
- 2021 Workplan

There being no further business, the public section of the Hospital Advisory Committee meeting was closed at 11.10am.

Approved and adopted as a true and correct record:

_____ _____

Andrew Dickerson Date of approval
Chairperson

# CARRIED FORWARD/ACTION ITEMS

Canterbury District Health Board
Te Poari Hauora ō Waitaha

## HOSPITAL ADVISORY COMMITTEE
## CARRIED FORWARD ITEMS AS AT 5 AUGUST 2021

| DATE RAISED | | ACTION | REFERRED TO | STATUS |
|---|---|---|---|---|
| 1. | 01 Oct 2020 | H&SS Monitoring Report | Dr Peter Bramley / Andrew Dickerson | Under action |
| 2. | 03 Jun 2021 | Making Our System Flow – Update | Becky Hickmott<br>Dr Jacqui Lunday-Johnstone<br>Dr Helen Skinner | Today's Agenda – Information Item |
| 3. | 03 Jun 2021 | Explanation for sudden drop in Frail Older Persons' Pathway graph for % of patients (75+) in ED within 6 hours. | Pauline Clark | Today's Agenda – Item 5 |

# H&SS MONITORING REPORT

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

**APPROVED BY:** **David Green, Acting Executive Director, Finance & Corporate Services**
**Tracey Maisey, Executive Director, Planning Funding & Decision Support**

**DATE:** **5 August 2021**

| Report Status – For: | Decision ☐ | Noting ☑ | Information ☐ |
|---|---|---|---|

## 1. ORIGIN OF THE REPORT

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

## 2. RECOMMENDATION

That the Committee:

i. notes the Hospital Advisory Committee Activity Report.

## 3. APPENDICES

Appendix 1: Hospital Advisory Committee Activity Report – August 2021.

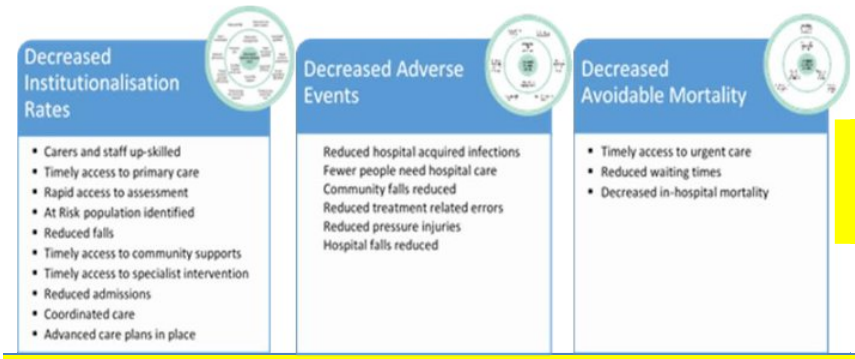
# Hospital Advisory Committee

# Hospital Activity Report

## August 2021

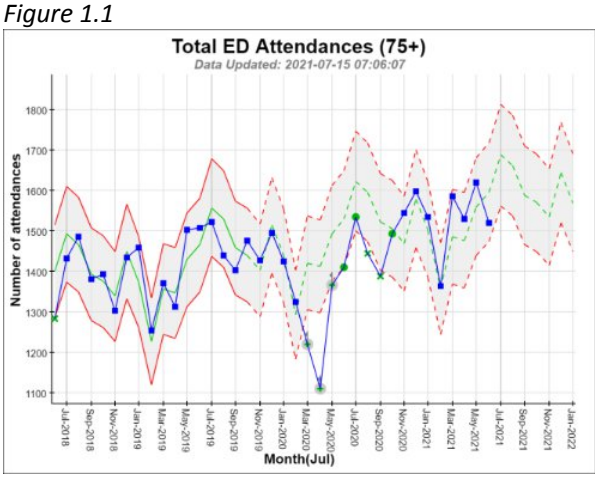
### Based on the CDHB Outcomes Framework and Five Focus areas plus Specialist Mental Health

INDEX




*Outcome and Strategy Indicators*

*Figure 1.1*




Covid 19 Alert Level restrictions led to a reduced number of ED attendances by people over 75 years in March and April 2020 with a subsequent return to forecast levels of attendances by that group.

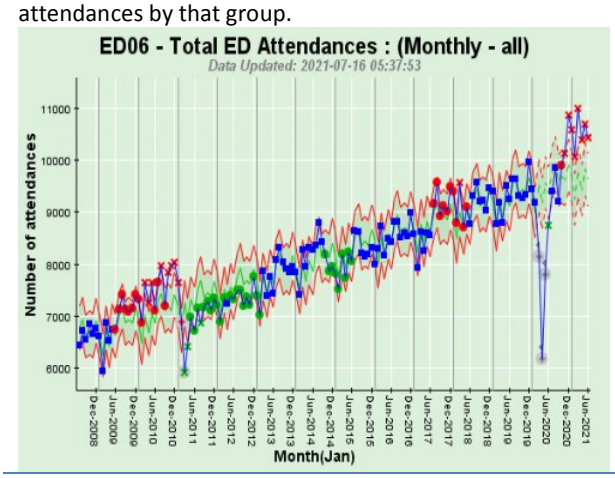
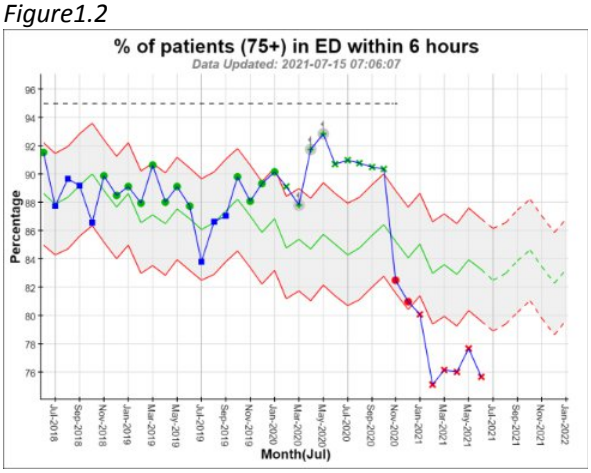
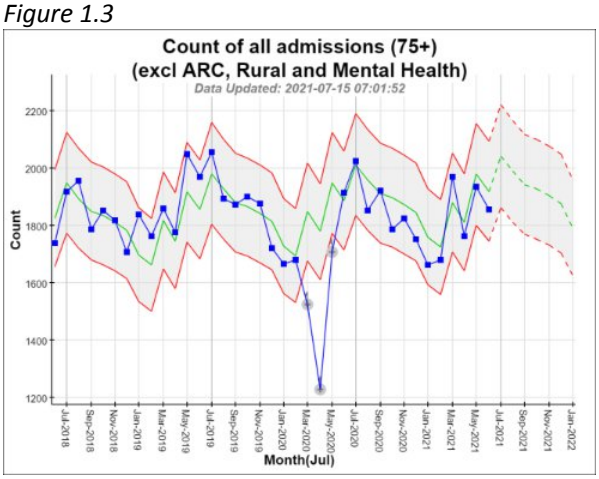



*Figure1.2*



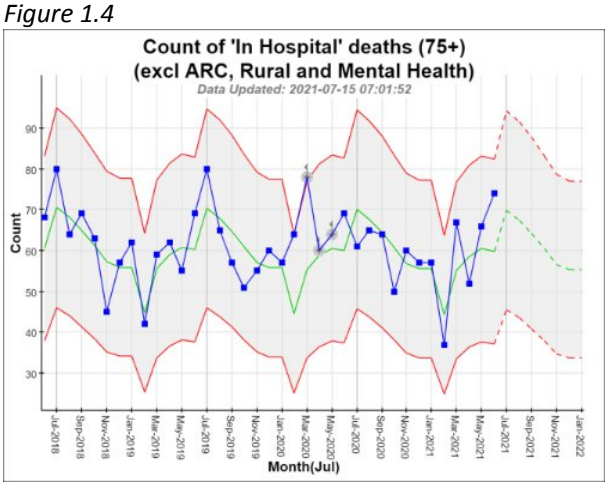

As requested, an explanation of this change in process is provided below.

*Figure 1.3*



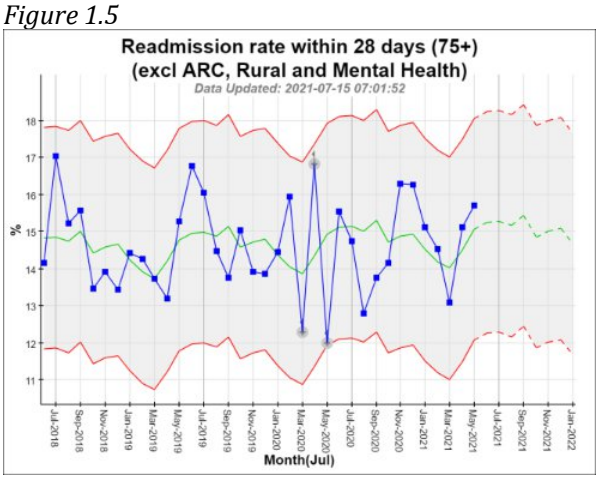

The number of older people admitted has returned to the forecast range following the COVID lockdown period.

*Figure 1.4*



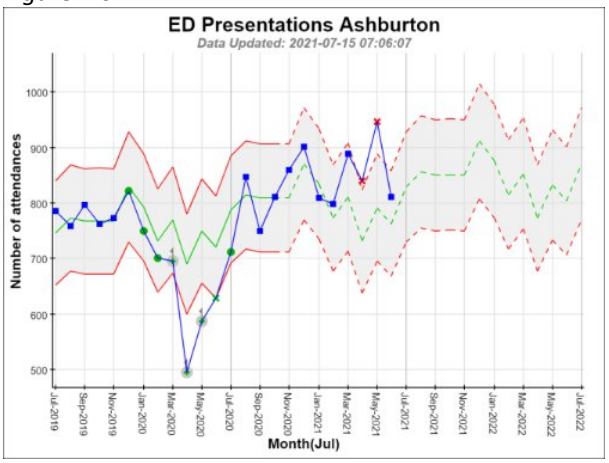

During the last 15 months the number and rate of in hospital deaths against admissions has been within forecast range, which reflects an underlying reducing trend in the rate.

*Figure 1.5*




Readmissions remain within the expected range.

*Figure 1.6*




Ashburton rate of attendances, 75+ age group, significantly exceeded the forecast range April and May 2021.

*Achievements/Issues of Note*

## Explanation of significant reduction in the 75plus six-hour Emergency Department measure

The Hospital Advisory Committee has asked for an explanation of the significant drop in the proportion of patients 75 years and older exiting the Emergency Department within six hours since November 2020.

- The graph provided in the standard HAC report includes both Christchurch and Ashburton data. The discussion that follows is limited to the dynamics in play at Christchurch Hospital where the change in waiting time is concentrated.
- People younger than 75 years are also spending longer in the Emergency Department than they did prior to November2020, however the effect is less marked.
- More people are staying longer than six hours in the Emergency Department irrespective of whether they are admitted or not. The effect is more marked for people that are admitted to hospital
- The increased proportion of people spending longer than six hours in the Emergency Department also exhibits as a longer average length of stay in the department:

- For all patients, the average time spent in the department in the first five months of 2021 was 233 minutes, 29 minutes longer than during the same months in 2019.
- For patients that are admitted the average is now 283 min – 58 minutes longer than in 2019.
- For patients that are not admitted the average is now 211 minutes, 23 minutes longer than in 2019.
- The increase in the time that people spend in the Emergency Department is associated with several changes:
    - An increase in the number of presentations to the emergency department that started in mid-October 2020, prior to the shift to Waipapa. This increase is not peculiar to Christchurch with other centres in New Zealand are reporting a similar experience.
    - The Emergency Observation area was closed when the department moved to Waipapa, as it could not be staffed given the geographical challenges of the new department. A proposal for more staff to open this area has not been supported. Older and other vulnerable patients who do not require a hospital admission but do require some care while arrangements are made for provision of services in their home now either spend longer in the Department or are admitted to hospital.
    - A shift into Waipapa included some changes in clinical models and has teams working spread across much larger departments and a larger hospital.
- General Medicine has a footprint of 132 beds and is regularly providing inpatient care to 170-200 patients. Patients spend time in other wards that are not focussed on the care required for this cohort of patients leading to delayed Allied Health input. This along with the distances travelled by medical teams delaying medical attention contributes to a prolonged length of stay and further overcrowding on the Campus. Alongside this flow through Christchurch and Burwood Hospitals and to the community is increasingly challenging leading to increased occupancy at Christchurch Hospital.
- Consequently, it has become more difficult to find a bed that best suits patients' care requirements.
- Increased distances and demand for care have been associated with delays in medical staff reviewing patients following referral by the Emergency Department and delays in orderlies being able to respond to requests to transport people and equipment around the hospital.
- So while the time from a patient being triaged to first seeing a doctor has shown a marginal decrease and the time from referring the patient to the department under which they are admitted to request of allocation of a bed has not changed , the time taken to allocate a bed and then to commence transport of the patient to the ward have extended by around 20 minutes in total. This explains around one third of the increase in time spent in the department by people that are admitted to hospital.

| **Actions being taken within the Emergency Department to speed up flow** | **Actions being taken within the broader hospital being taken to speed up flow of patients out of the Department** |
|---|---|
| • Seeking support to open the Emergency Observation area. Children's Emergency Care area was prioritised<br>• Refinements of all models of care as the department settles into the facility, including the "Front of House model"<br>• Working with other services to improve timely registrar review of patients likely to be admitted<br>• Working with community partners to reduce the presentation rate to the Emergency Department.<br>• Promoting the idea of a communications campaign to educate the public on the appropriate use of acute health care options and which facility is best suited to their needs<br>• Partnering with Cardiology, Orthopaedics, Midwives and others to improve clinical models, reducing presentations to and increase flow through the department. | • An improvement programme has been established, focussing on acute flow of patients pre, post and during hospital stays to address high occupancy and demand seen across the Canterbury system<br>• Key focus areas are ED flow, flow within surgical and medical teams, flow between facilities, and flow pre and post hospital stays<br>• A clinician led group has been established with a data diagnostic to be developed to understand bottlenecks and changes in flow. This along with further staff engagement will provide a consolidated programme of work / improvements to be progressed. |

## Older Persons Health & Rehabilitation (OPH&R)

**Making Our System Flow**

OPH&R clinical and operational leaders are engaged in workstreams for the Making Our System Flow project led by our clinical executives, with the General Manager OPH&R sitting on the Governance Group for this work. Key areas of focus for our team are the Flow Between Facilities Workstream, Surgical Workstream, and Transitions of Care Workstream. A priority activity of the Flow Between Facilities Workstream has been collaboration to establish a Signals from Noise dashboard, which will support monitoring of key metrics as focussed improvements are identified and implemented.

With the recent appointment of the Service Manager – Patient Flow, several key initiatives have already been implemented within OPH&R including trial of an audit tool that allows the leadership team to better understand why our patients remain in hospital beds at Burwood Hospital on any given day.

This tool, loosely based on the 'day of care audit' developed for the NHS, aims to provide an opportunity for the auditor to understand the exact reason a patient cannot be discharged that day. The tool provides a list of categories that each patient is placed in to which best represents the reason that they are in a hospital bed that day and cannot be discharged and will allow the division to see trends of reasons why our inpatient beds are occupied and easier identification of barriers to discharge.

These audits are undertaken at some point during the day after the board round to ensure that the ward team have discussed each patient's discharge plans and the information provided is up-to-date.

The tool has now completed its trial phase and is being rolled out across all wards at Burwood and many of the OPH&R leadership team and clinical leader team will be trained to undertake an audit. Initial feedback from ward leaders is positive, suggesting that there are multiple opportunities for improvement in the discharge planning process. Feedback has also suggested that the increase in awareness created via regular auditing around discharge planning has led to more proactive decision making, assisting the ward to minimise delays and support our patients to be discharged to their residence.

To enhance this work further, next steps will include the development of local escalation pathways that support discharge barriers to be overcome as soon as they are identified, avoiding unnecessary length of stay due to delays in decision making or responses.

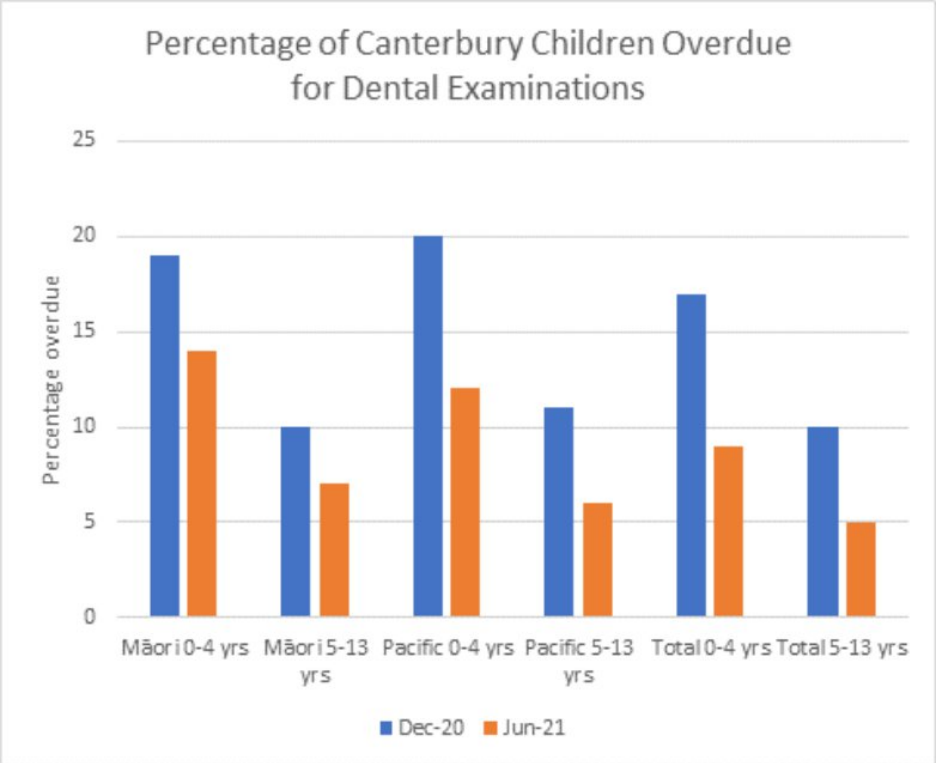
**Community Dental Service**

The Ministry of Health has increased its surveillance (from annual to quarterly) of the number of children overdue for scheduled examinations in DHB child oral health services. Most children are scheduled to have a dental examination every 12 months, with a smaller proportion on 6 or 18 months recall intervals. The Ministry of Health target is less than 10% overdue and is reported by ethnicity in two age bands – 0 to 4 years-old and 5 to 13 years old.

While the picture is different elsewhere in the country, Canterbury's Community Dental Service has seen sustained falls in the percentage of children overdue since the end of the Covid-19 lockdown in May last year. At the end of June, the Service reported -- for the first time since reporting started in 2016 -- that less than 10% of children in both age groups were overdue.

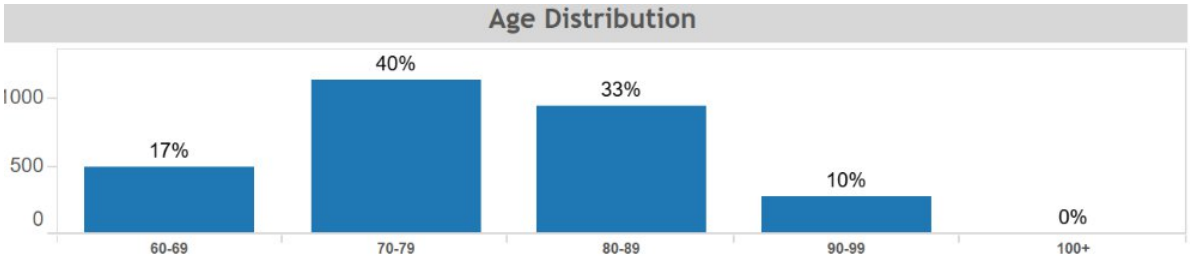
One area of continued opportunity for improvement is that arrears for Māori and Pacific 0-4-year-olds, while improving, are still above 10% -- and the Service has identified that new ways of working are needed for communicating with Māori and Pasifika whānau when contact needs to be made to arrange appointments.

Work on resolving this equity problem is underway with changes expected to be embedded by the end of 2021.

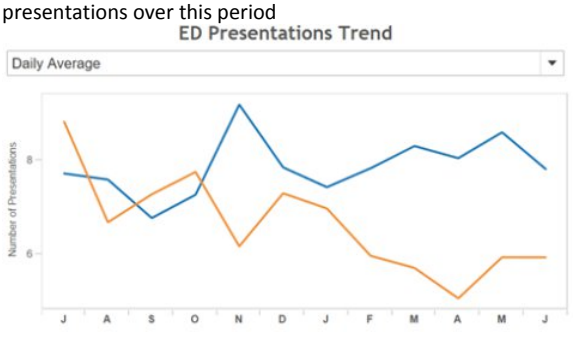


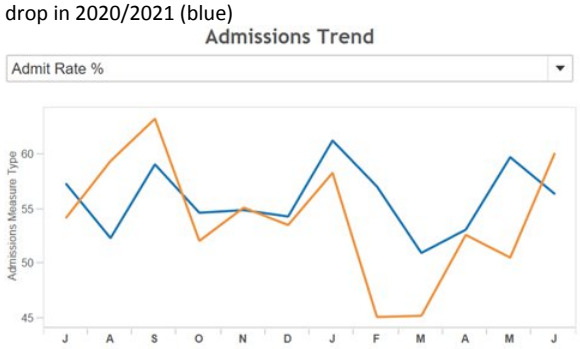

## Ashburton Health Services

Figure 1.6 reflects an increasing trend in the 75+ cohort presenting to the Ashburton Acute Assessment Unit, which reflects a similar trend in overall presentations to the unit in recent months. In reviewing all presentations to the unit for the cohort 65+ during the financial year 2020/2021 and comparing with the previous year, the following graphs provide some key markers for further work and partnership with our primary care providers. The age distribution in these presentations aligns with our population demographic.



| | |
|---|---|
| The graph below demonstrates the trend on presentations for all person's over 65, between 2019/2020(orange) and 2020/2021 (blue). Noting a significant increase in presentations over this period | However, we note a decrease in our admission rate of the same cohort, with 2019/2020 (orange) demonstrating a steady increase throughout the April to June period and slight slight drop in 2020/2021 (blue) |




Comparing the clinical presentation between both years confirms our focus on improving our coding practice has been rewarded, compared 24% of the presentations identified as null in the previous year. However, the information does not high-light any specific condition that would immediately support the development of alternate pathway.

**Table 1 2020/2021**

| Top 10 Diagnosis | | | |
|---|---|---|---|
| 1 | Non-cardiac chest pain (finding) | 176.0 | 6% |
| 2 | Abdominal pain - cause unknown (finding) | 135.0 | 5% |
| 3 | Collapse (finding) | 115.0 | 4% |
| 4 | Dyspnea (finding) | 106.0 | 4% |
| 5 | Urinary tract infectious disease (disorder) | 78.0 | 3% |
| 6 | Null | 76.0 | 3% |
| 7 | Generally unwell (finding) | 72.0 | 3% |
| 8 | Falls (finding) | 68.0 | 2% |
| 9 | Heart failure (disorder) | 66.0 | 2% |
| 10 | Pneumonia (disorder) | 61.0 | 2% |

**Table 2 2019/2020**

| Top 10 Diagnosis | | | |
|---|---|---|---|
| 1 | Null | 588.0 | 24% |
| 2 | Non-cardiac chest pain (finding) | 132.0 | 5% |
| 3 | Abdominal pain - cause unknown (findi.. | 91.0 | 4% |
| 4 | Dyspnea (finding) | 77.0 | 3% |
| 5 | Collapse (finding) | 68.0 | 3% |
| 6 | Falls (finding) | 52.0 | 2% |
| 7 | Acute exacerbation of chronic obstructi.. | 45.0 | 2% |
| 8 | Urinary tract infectious disease (disord.. | 41.0 | 2% |
| 9 | Pneumonia (disorder) | 40.0 | 2% |
| 10 | Atrial fibrillation (disorder) | 39.0 | 2% |
| | Heart failure (disorder) | 39.0 | 2% |

It is noted that 50% of the 24/7week Ashburton Acute Assessment Unit is the sole provider of acute primary care and the information presented is in context with presentations to any of the urgent care providers within urban Christchurch. The referral source below supports the information that we are an accessible point of a care for older persons presenting acute unwell. The comparison to the previous year does not indicate any significant change in trend pattern, the referral from primary care indicates we remain a core partner to the primary care team locally. The Acute and Inpatient leadership team are participating in the Urgent After Hours Care SLA, that is facilitating direct access for Aged Residential Care (ARC) facilities to connect with the 24-Hour Medical Centre (Bealey Avenue) via telehealth afterhours, supporting the principle

to enable residents to stay within their facility where possible. When comparing the ARC presentation rate with Christchurch Emergency Department, they also report 5% for 2020/2021.

**Table 3 2020/2021**

| Top 10 Referral Source | | | |
|---|---|---|---|
| 1 | Self or relative referral | 2,035 | 71% |
| 2 | General practitioner | 504 | 18% |
| 3 | Rest Home/Hospital | 155 | 5% |
| 4 | Other External Health Provider | 86 | 3% |
| 5 | Emergency (hospital ED) | 48 | 2% |
| 6 | Outpatients | 32 | 1% |
| 7 | Accident/Urgent Medical Centre (external) | 3 | 0% |
| 8 | Other Facility/DHB | 2 | 0% |
| 9 | Police | 2 | 0% |

| Top 10 Referral Source | | | |
|---|---|---|---|
| 1 | Self or relative referral | 1,508 | 62% |
| 2 | General practitioner | 539 | 22% |
| 3 | Rest Home/Hospital | 132 | 5% |
| 4 | Other External Health Provider | 109 | 4% |
| 5 | Emergency (hospital ED) | 107 | 4% |
| 6 | Outpatients | 25 | 1% |
| 7 | Accident/Urgent Medical Centre (extern.. | 4 | 0% |
| | Police | 4 | 0% |
| 9 | Specialist Medical Officer - Own DHB | 1 | 0% |

The datasets above provide an overview of the information relating to acute flow. The opportunity and detail is available for us to drill down into a more comprehensive set of information and opportunity if we compare presentations with other interventions and services we have available within our Integration team and in partnership with primary care.

Having completed several core activities on our road map for the past quarter, including:

- COVID vaccination for front line staff in partnership with primary care
- Shoring up professional leadership for our Allied Health service areas and developing opportunities to align Allied Health within Acute and Inpatient and Integration Cluster models
- Implementing a single community referral form for all community services provided through Ashburton Health Services and reviewing all Health Pathways associated with this, confirming areas for further improvement
- Process mapped all referral points and patient flow to Acute and Inpatient and Integration Services, including Clinical Nurse Specialists, District Nursing, NASC, Home Based support and community based Allied Health. We are in a strong position to turn our collective nursing and allied health focus on understanding the wider system flow with other NGO services and how we can best explore service redesign in the context of community-based localities.

Health NZ presentations on the framework to shape primary and community localities identifies the following key cohorts that could benefit most from locality provider networks as follows:

Whanau with complex health and social care needs

- Joining up social service providers (NGO/kaupapa Maori/Pasifika) with general practice

First 2,000 days

- *Joining up maternity, wellchild/tamariki ora, child development and general practice*

Last years of Life

- *Joining up NASC, home care, District Nursing, palliative care, ARC and general practice*

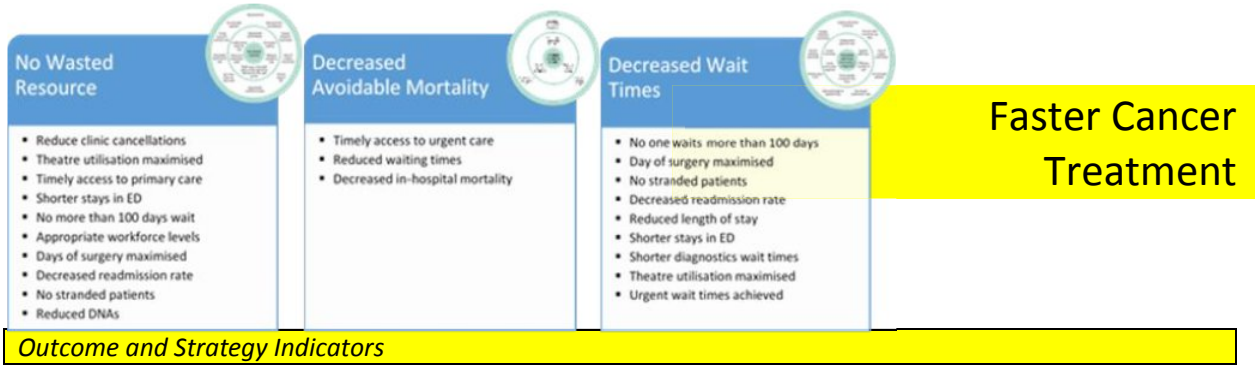
People with distress/mental illness

- Joining up primary, NGO, and specialist mental health services and general practice

People with complex long-term conditions

- *Joining up care across providers with general practice team and H&S services*

Ashburton Health Services is a core provider of many of these services and had previously identified the opportunity to integrate these with our primary care through our Ashburton Service Level Alliance workplan. Alongside this, many of the rural hospitals that are clinically led by Rural Hospital Medical Specialists (RHMS) are messaging their role as integral partners in primary and community localities, with a strong clinical partnership to the future state Hospital Networks. The Rural Hospital Summit in August will provide an opportunity to further discuss this with the Transition Unit as they workshop with the representation opportunities for future models.




*Outcome and Strategy Indicators*

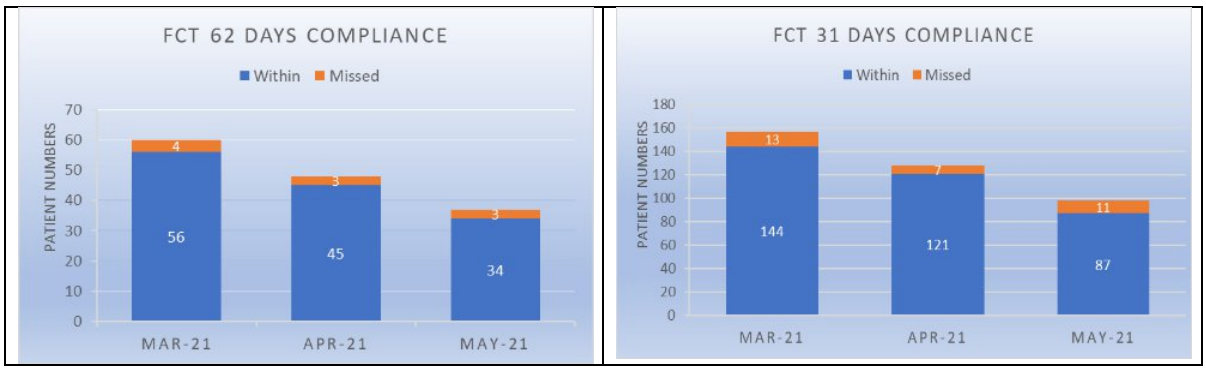
## Key Outcomes - Faster Cancer Treatment Targets (FCT)

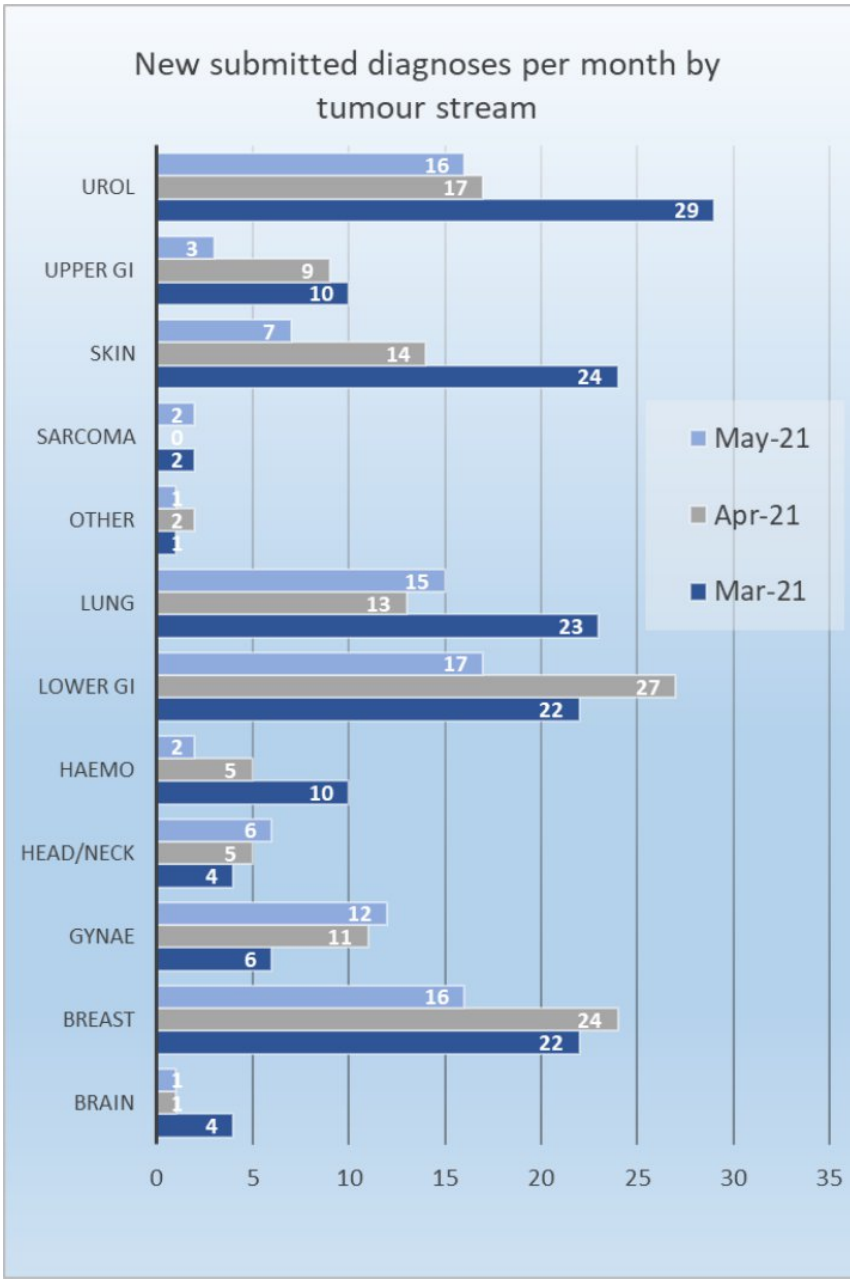
**62 Day Target.** In the three months to the end of May 2021 there were 195 records submitted by Canterbury District Health Board – slightly down on the 184 submitted for the three months to the end of April. Canterbury District Health Board missed the 62 days target for 60 patients, of those 50 were through patient choice or clinical reasons and are therefore excluded from consideration. Target was not met for 10 of the 135 remaining patients due to capacity issues thus Canterbury District Health Board's compliance rate was 93.1%, once again meeting the 90% target.

**31 Day Performance Measure.** Of 383 records submitted towards the 31-day measure Canterbury District Health Board met the target of providing first treatment within 31 days of a decision to treat for 352 (91.9%) eligible patients. Canterbury District Health Board continues to meet the 85% target. Of the 31 patients not provided with treatment within 31 days, 11 were missed by five days or less, 4 were due to clinical reasons and 2 through patient choice.

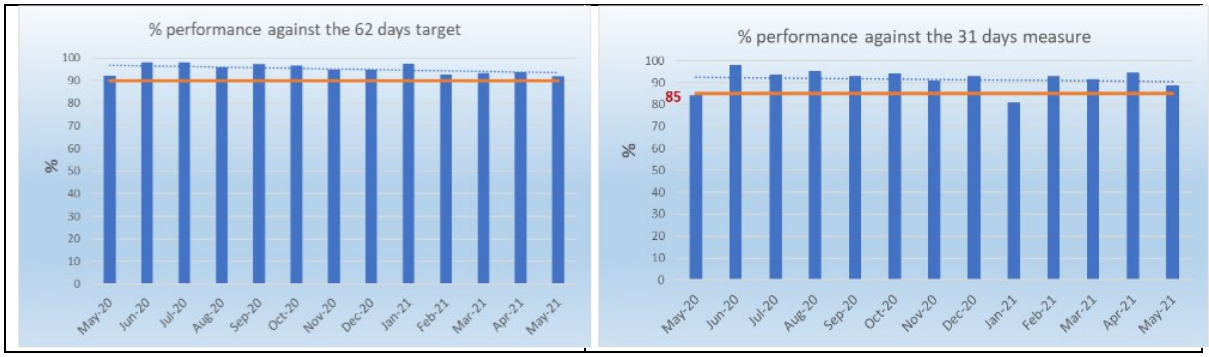
## FCT performance in CDHB

The dip in numbers in the last month of every report (May in this case) reflects the timing of report compilation which is governed by the reporting requirements of the Ministry. A significant number of the patients who have a first treatment date in the period this report covers will be awaiting coding and will be picked up in the following month's extract.




New submitted diagnoses per month by tumour stream
UROL
16
17
29
UPPER GI
3
9
10
SKIN
7
14
24
SARCOMA
2
0
2
OTHER
1
2
1
LUNG
15
13
23
LOWER GI
17
27
22
HAEMO
2
5
10
HEAD/NECK
6
5
4
GYNAE
12
11
6
BREAST
16
24
22
BRAIN
1
1
4
May-21
Apr-21
Mar-21
0
5
10
15
20
25
30
35


Performance against the 62 days target by tumour stream: Mar, Apr & May 21
%
Brain
Breast
Gynae
Head/neck
Haemo
Lower GI
Lung
Other
Sarcoma
Skin
Upper GI
Urol
% within
62 days target (90%)
Performance against the 31 days measure by tumour stream: Mar, Apr and May 21
% within
31days target (85%)



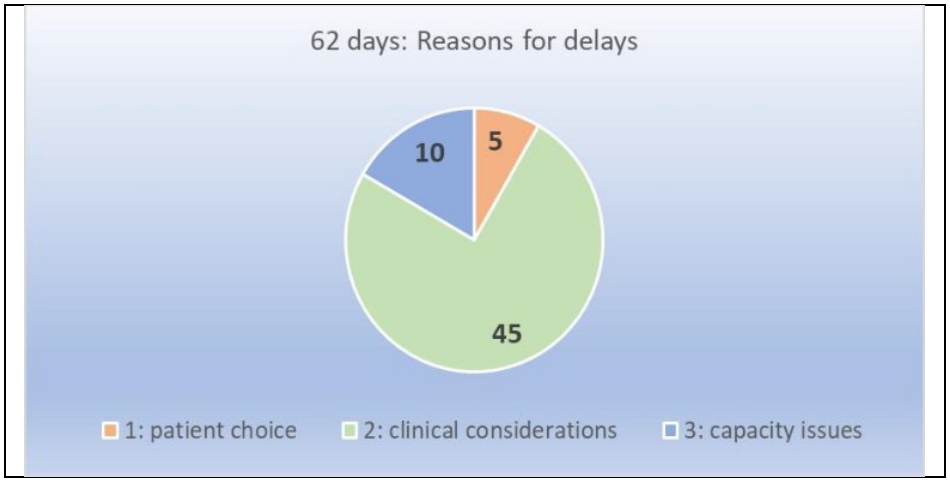

## Patients whose treatment does not meet target.

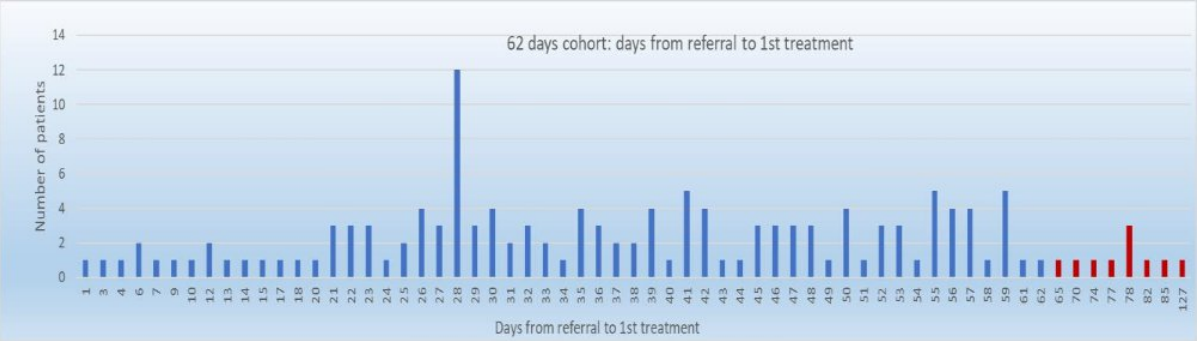
The MoH requires DHBs to allocate a delay code to all patients who are not treated in line with the 62 days target, Canterbury District Health Board does the same for those where treatment does not meet the 31 day target. Only one code can be submitted, even if the delay is due to a combination of circumstances, which is often the case. When this happens the reason that caused the greatest delay is the one chosen.

The codes are:

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

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






*Achievements/Issues of Note*

## Medical Oncology Service Development Project Update

Current activity focusses on:

- A workshop to better understand the Medical Oncology and Primary Care interface, led by the Canterbury Initiative, was held on 2 June 2021. Feedback from primary care was overwhelmingly positive about communication and the service provided by Medical Oncology. Improvement opportunities will be reviewed by the Medical Oncology team and acted on.
- Actions to assist with the development of the Medical Oncology team, covering all disciplines, are being developed with the People and Capability Team.
- To ensure that the service carries out work that only it has the expertise to provide, triage and prioritisation of patients now requires that patients have a histological diagnosis prior to acceptance into the service (with a small number of exceptions).
- Stand-up meetings of the administration team have been established - to ensue all clinic capacity is fully utilised.
- Decision Support will improve reporting of key measures of service delivery performance that have been established out of the Service Development Project, enabling a single source of information from multiple data sources, to improve the quality of production planning and provide meaningful information to clinicians to support their prioritisation and delivery of care.
- Outcomes from the range of work underway are promising. Overdue follow-up appointments have reduced from 960 (64% of patients waiting) on 15 February 2021 to four (effectively 0%) on 28 June 2021. All new patients are being seen within established timeframes for First Specialist Assessment.

## Nurse led Late Effects Assessment Programme Clinics

- Late effects assessment Programme (LEAP) clinics are provided to young people who have received treatment for cancer to assess and manage the long-term effects of cancer treatment. Typically, the team providing this clinic consists of a doctor, nurse and psychologist.
- The programme recognises that while the technical aspects of a patient care are well managed patients often have poor knowledge of their previous treatments. This is vital as each patient's future health relies on them being able to advocate for their own health needs.
- Lack of ability to travel during the COVID19 lockdown led to a backlog of patients requiring care. In addition, discharged patients were contacting the service seeking further input.
- During COVID pandemic in 2020 all late effects shared care clinics were run via Zoom as team members were unable to travel. A survey was run following lock-down to guide plans for future care delivery.
- Nearly three quarters of patients indicated a desire to be assessed in person. Some noted they had to make an extra clinic appointment at their nearest hospital to get a physical examination due to health concerns raised during their Zoom appointment. Nearly a half of patients experienced barriers to obtaining weight and height measures prior to online appointments.
- With an increase in survival more patients will require long term follow up.

- To address these challenges nurse led clinics have been introduced and have assisted in providing care to an increasing number of patients especially in the shared care centres (Dunedin, Invercargill and Nelson). They have enabled provision of care to more patients in person since lockdown.
- Introduction of nurse led clinics has been a positive change that will enable provision of the required care to patients with less complex requirements, releasing paediatrician capacity for those that require it, while reducing avoidable hospital admissions.

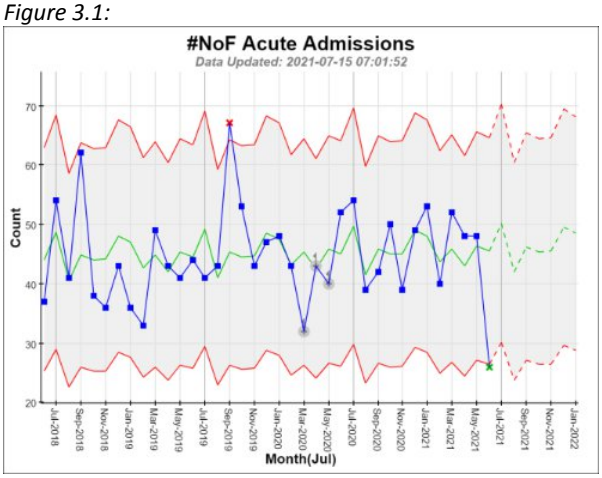
## Off-axis small field dosimetry for Brain Stereotactic Radiotherapy

- Hypo-fractionated stereotactic treatment has been offered at Canterbury District Health Board since January 2019 and allows treatment of brain metastases with very intense doses of radiation while minimising damage to the health tissues surrounding the lesions.
- The standard approach has been to treat each brain lesion separately at central axis (so-called “isocentre”) of the radiation beam, requiring re-positioning the patient for each lesion.
- A new method is being implemented for brain metastases which allows the patient to stay in one treatment position while multiple lesions are treated with off-axis radiation beams. As well as avoiding the need to accurately position the patient several times it significantly reduces the patient-on-couch times and improves overall treatment precision.
- Putting this in place has required that the Medical Physics team verifies that there is good agreement between calculated and measured doses at a range of different off-axis positions for the typically small treatment fields. The results of this verification show that the treatment machine output is well in line with international literature enabling this method to be adopted at Christchurch Hospital.
- Around five patients per year will benefit from this method and numbers will increase over time.


## Enhanced Recovery After Surgery (ERAS)

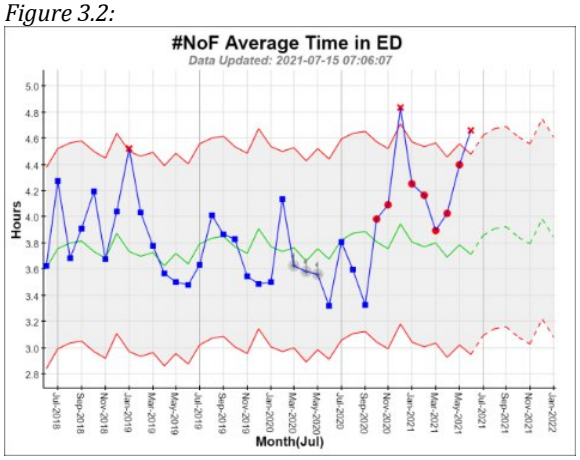
### *Outcome and Strategy Indicators – Fractured Neck of Femur (#NoF)*

*Figure 3.1:*



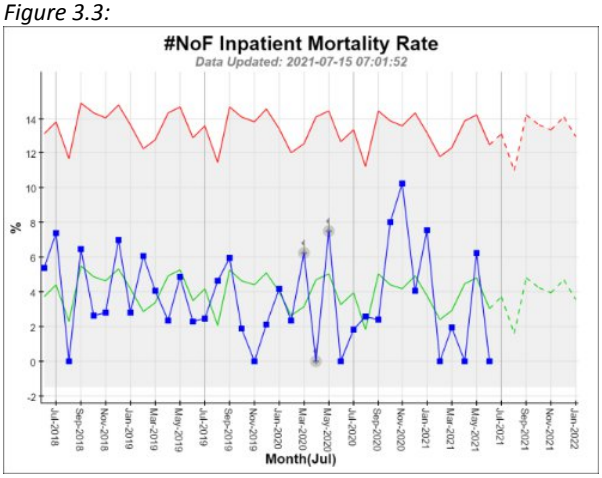

The number of admissions generally follows the projection. The time taken to code discharges impacts the latest data point.

*Figure 3.2:*



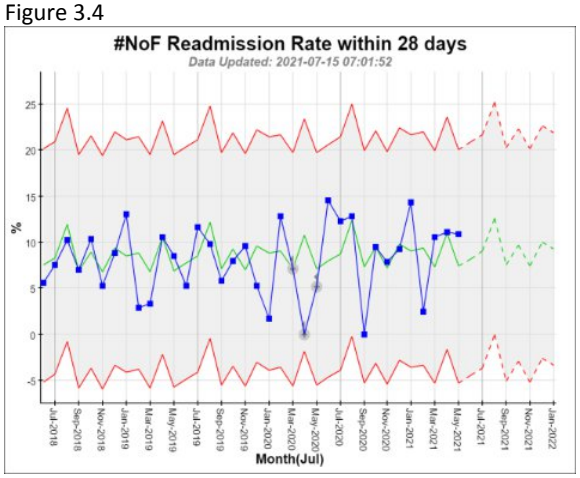

The time spent in the ED by people with a fractured neck of femur has increased. This is in line with the degradation in the proportion of people leaving ED within six hours of arrival that is commented on above. It is associated with a step change in the number of people attending ED that occurred in October 2020 and the shift to a new building. Review of work practices and resource levels against demand and the requirements of the environment is underway.

*Figure 3.3:*




The #NoF inpatient mortality rate while variable follow the projected values.

Figure 3.4

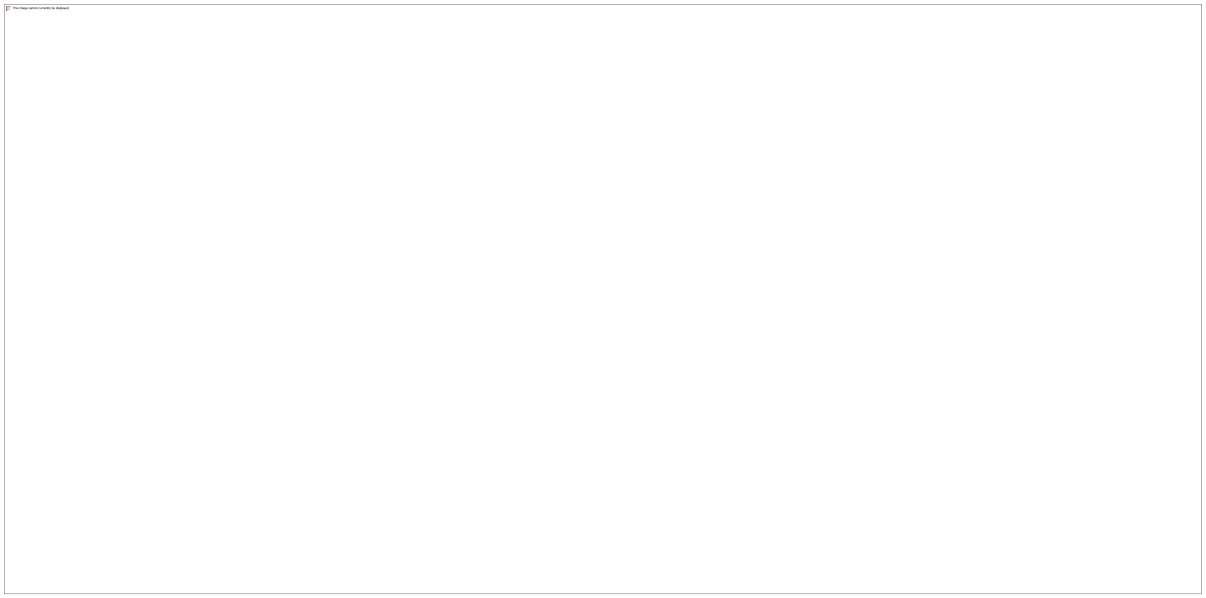


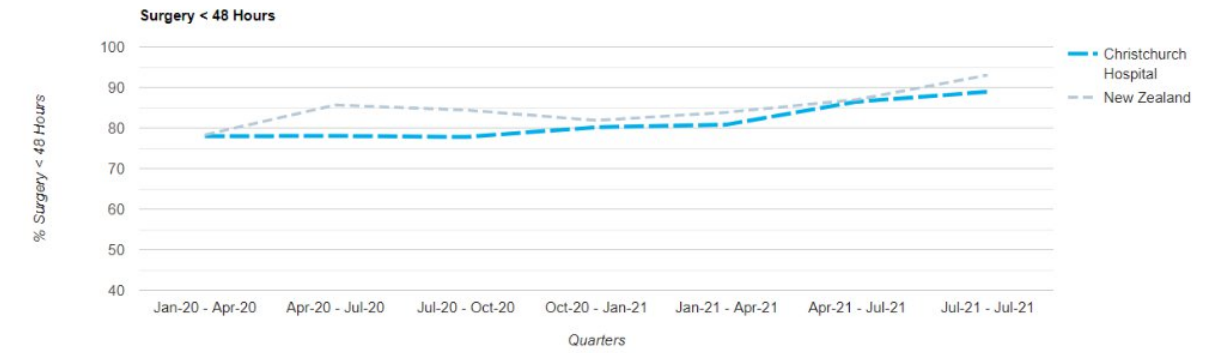

Readmissions continue to remain within the expected range.

*Achievements/Issues of Note*

## OPH&R Hip Fracture Registry database results

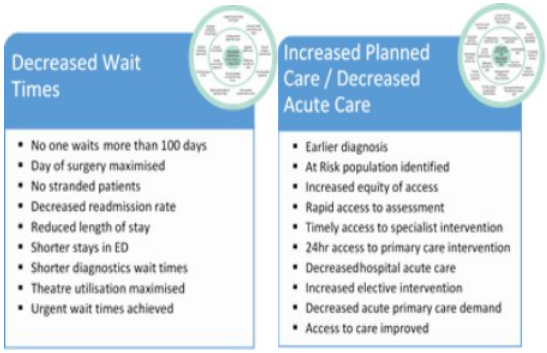
The NZ Hip Fracture Registry reports performance against quality standards for care of patients post fractured neck of femur. When compared with the calendar year Jan-Dec 2020, the period Jan – July 2021 shows an increase in time in ED from average of 3.44 to 4.02 hours. 83% of patients had surgery within the expected 48hrs for the period Jan – July 21; as seen in the graph below this has continued to improve since Jan 2020. This improvement is felt to be due to an ongoing focus on ensuring theatre space for patients with hip fracture, and continuing to prioritise these patients, as well as proactive medical care early on to avoid cancellation due to acute medical issues.






## Allied Health and transalpine care: Supporting enhanced recovery following surgery

- Allied health has had some great feedback about its service delivery and patient outcomes on the Christchurch campus and following the transalpine transfer of care.
- This includes a patient from the West Coast with Crohn's disease, referred by anaesthetist as high risk of major complications post operation.
- The expert Gastro Dietitian advised the West Coast District Health Board to start supplementation pre and post operation. This provides an example of the "expert" gastroenterology role, transalpine collaboration and remote management to optimise patient care impacting on improving the chance of timely recovery following surgery.




# Elective Surgery Performance Indicators 100 Days

## Elective Services Performance Indicators

**Summary of Patient Flow Indicator (ESPI) results**

**DHB: Canterbury**

| | Jun | | Jul | | Aug | | Sep | | Oct | | Nov | | Dec | | Jan | | Feb | | Mar | | Apr | | May | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % | Imp. Req | Status % |
| 1. DHB services that appropriately acknowledge and process patient referrals within the required timeframe. | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % | 27 of 27 | 100.0 % |
| 2. Patients waiting longer than four months for their first specialist assessment (FSA). | 2272 | 28.9% | 1815 | 21.5% | 1200 | 13.3% | 908 | 9.3% | 995 | 9.6% | 1076 | 9.8% | 1313 | 11.6% | 1877 | 15.7% | 1864 | 15.5% | 1815 | 15.2% | 1952 | 15.9% | 1694 | 14.1% |
| 3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT). | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| 5. Patients given a commitment to treatment but not treated within four months. | 1133 | 25.0% | 1241 | 26.3% | 885 | 18.8% | 661 | 14.7% | 702 | 15.3% | 737 | 15.8% | 942 | 19.3% | 1223 | 23.3% | 1233 | 23.0% | 1125 | 20.0% | 1149 | 19.7% | 1054 | 18.6% |
| 8. The proportion of patients treated who were prioritised using nationally recognised processes or tools. | 1 | 99.9% | 0 | 100.0 % | 0 | 100.0 % | 8 | 99.5% | 1 | 99.9% | 0 | 100.0 % | 0 | 100.0 % | 0 | 100.0 % | 0 | 100.0 % | 0 | 100.0 % | 0 | 100.0 % | 0 | 100.0 % |

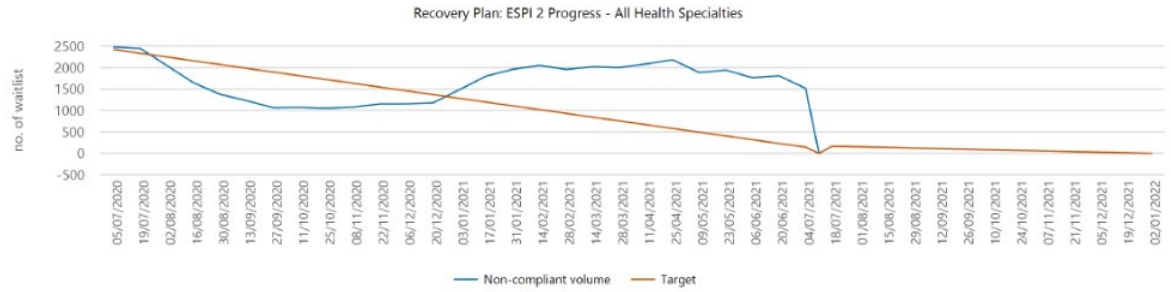
## Summary of ESPI 2 and 5 Performance by service

| | Mar-21 | | Apr-21 | | May-21 | |
|---|---|---|---|---|---|---|
| **ESPI 2 (FSA)** | Improvement required | Status% | Improvement required | Status% | Improvement required | Status% |
| Cardiothoracic Surgery | 7 | 21.2% | 10 | 34.5% | 1 | 4.8% |
| Ear, Nose and Throat | 135 | 12.5% | 151 | 14.6% | 137 | 12.1% |
| General Surgery | 147 | 15.6% | 91 | 9.3% | 70 | 8.0% |
| Gynaecology | 22 | 4.3% | 29 | 4.9% | 75 | 11.8% |
| Neurosurgery | 2 | 1.8% | 2 | 1.6% | 0 | 0.0% |
| Ophthalmology | 242 | 16.7% | 401 | 25.6% | 304 | 21.2% |
| Orthopaedics | 68 | 7.8% | 52 | 5.8% | 28 | 3.0% |
| Paediatric Surgery | 1 | 1.0% | 1 | 1.1% | 1 | 1.0% |
| Plastics | 214 | 44.9% | 184 | 43.3% | 139 | 36.8% |
| Thoracic | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Urology | 10 | 1.4% | 16 | 2.1% | 13 | 1.9% |
| Vascular | 60 | 26.7% | 46 | 25.6% | 27 | 16.6% |
| Cardiology | 28 | 5.7% | 47 | 8.5% | 60 | 10.8% |
| Dermatology | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Diabetes | 8 | 6.9% | 11 | 9.6% | 4 | 3.7% |
| Endocrinology | 47 | 15.2% | 45 | 14.3% | 12 | 4.9% |
| Endoscopy | 458 | 27.6% | 465 | 26.2% | 512 | 26.1% |

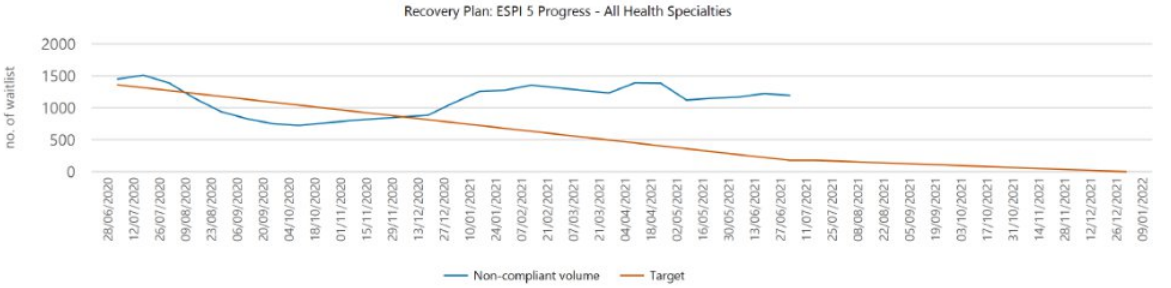
| | | | | | | |
|---|---|---|---|---|---|---|
| Gastroenterology | 33 | 10.4% | 29 | 9.0% | 17 | 5.8% |
| General Medicine | 8 | 4.1% | 9 | 4.9% | 8 | 4.9% |
| Haematology | 1 | 1.6% | 2 | 3.6% | 1 | 1.5% |
| Infectious Diseases | 1 | 7.1% | 4 | 30.8% | 0 | 0.0% |
| Neurology | 59 | 13.8% | 80 | 17.2% | 98 | 20.4% |
| Oncology | 37 | 11.3% | 24 | 8.2% | 9 | 2.7% |
| Paediatric Medicine | 182 | 33.1% | 199 | 34.3% | 140 | 27.2% |
| Pain | 11 | 42.3% | 17 | 65.4% | 16 | 48.5% |
| Renal Medicine | 2 | 3.9% | 1 | 2.2% | 0 | 0.0% |
| Respiratory | 31 | 6.6% | 26 | 6.5% | 13 | 3.5% |
| Rheumatology | 1 | 0.3% | 10 | 3.1% | 9 | 2.9% |
| **Total** | **1815** | **15.2%** | **1952** | **15.9%** | **1694** | **14.1%** |
| **ESPI 5 (Treatment)** | | | | | | |
| Cardiothoracic Surgery | 0 | 0.0% | 5 | 8.6% | 6 | 11.8% |
| Dental | 59 | 18.3% | 44 | 10.8% | 91 | 20.7% |
| Ear, Nose and Throat | 251 | 33.8% | 271 | 37.2% | 244 | 35.9% |
| General Surgery | 266 | 31.9% | 297 | 33.9% | 275 | 31.2% |
| Gynaecology | 31 | 9.7% | 34 | 9.2% | 33 | 11.5% |
| Neurosurgery | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| Ophthalmology | 37 | 7.0% | 60 | 10.3% | 46 | 7.4% |
| Orthopaedics | 82 | 14.6% | 73 | 11.1% | 62 | 9.8% |
| Paediatric Surgery | 24 | 18.9% | 17 | 14.2% | 13 | 11.9% |
| Plastics | 193 | 16.3% | 177 | 15.7% | 119 | 10.4% |
| Urology | 33 | 8.5% | 33 | 8.3% | 25 | 7.0% |
| Vascular | 22 | 17.5% | 28 | 23.5% | 19 | 17.0% |
| Cardiology | 115 | 35.5% | 110 | 32.9% | 121 | 37.1% |
| **Total** | **1125** | **20.0%** | **1149** | **19.7%** | **1054** | **18.6%** |

**Note - ESPI 5 figures and ESPI2 figures are taken from the MoH ESPI Finals report for May 2021, published 5 July 2021.**

- The CDHB Improvement Action Plan 20/21 is in place and focusses on CDHB achieving ESPI/Planned Care compliance. As at 9 July the overall target is not being met with 1,472 people waiting longer than 120 days for their appointment. This is a reduction of 488 since the last HAC report which showed 1,960 long waits as at 21st May. Ten specialty areas have no patients waiting for First Specialist Assessment for longer than 120 days and 30 are not meeting their recovery plan targets.
- When considering patients waiting times for admission and treatment as at 9th June CDHB is not meeting the plan's targets, 1,300 people have waited longer than 120 days. This has increased by 84 since the last HAC report when the result was 1,216 long waits as at 21st May. One specialty area has no long-waiting patients and thirteen are not meeting their recovery plan target.




(the last data point should be ignored)




- Services are working to ensure that waiting list entries are correctly assigned so that there is improved information about the true state, limiting the number of referrals being accepted to match accepted demand to capacity and working to maximise availability of capacity to see new patients to enable targets to be reached.
-

*Achievements/Issues of Note*

## Physiotherapy - Conservative Management of Prolapse and Incontinence Update

- Prolapse and incontinence can limit women's ability to take part in physical activity and work and have a significant effect on quality of life.
- People referred for First Specialist Assessment and Surgery due to incontinence and prolapse are not receiving care within the 100-day target.
- Approximately 50% of women on the surgical list have not received conservative management prior to entering the waiting list.
- To address this, the existing waiting list for First Specialist Assessment was reviewed with appropriate referrals sent onto a physiotherapist. This ensured provision of treatment in line with international guidelines while reducing the waitlist for First Specialist Assessment.
- This approach was shown to improve access for Maori and Pasifika wāhine to publicly funded physiotherapy for prolapse.
- Referrals to gynaecology for women with prolapse or incontinence are now referred to Physiotherapy and accepted regardless of severity of symptoms.
- This will ensure improved health outcomes through earlier intervention to prevent deterioration of symptoms to a level that may need surgery while reducing the number of people waiting for consultations with Senior Medical Officers.
- It will create increased patient satisfaction by reducing waiting times for first appointment and it will also provide an improved pathway to service with aim to reduce inequities.

## Māori Health worker within Nephrology

- The Nephrology service identified a requirement for a cultural advocate, with an equity lens, to support the increase in Maori consumers on the transplant list who are successfully receiving transplants.
- To address this, the Nephrology service has provided establishment to support a 0.25 FTE Kaimahi Hauora Māori Health worker, supporting Nephrology Outpatients and Christchurch Womens' Hospital.

- The position will also support Maori patients coming onto dialysis to stay healthy so they can be assessed for a transplant.
- Access to transplants has a huge impact on consumers and whānau quality of life by ensuring that patients no longer need to have dialysis for five hours three times a week and can re-engage in many aspects of life that would otherwise be challenging.
- Longer term, a transplant is less demanding on health and social system resources.

## Shared Goals of Care in Medicine and Cortex

- Shared goals of care documents have recently gone live on Cortex. These documents promote a conversation between staff and patients to ensure people receive the care they want, but also ensure that they are not over-treated. The new Cortex forms do not yet replace the paperwork directing staff not to commence cardiopulmonary resuscitation but will eventually.
- This promotion of shared goals of care in medicine, should ensure patients and their families are empowered to obtain the desired level of care and inform all staff in the circle of care, to know how much care to deliver depending on the patient's presentation and progress during their episode of care.

## Dermatology Virtual Clinics

- Publicly run dermatology services are scarce resources. To create the greatest benefit for patients Canterbury DHB's Dermatology service, via its Clinical Director Caroline Mahon, has placed a great focus on the use of virtual First Specialist Assessment to support general practitioners to provide high quality care to a far greater number of people than would otherwise be possible.
- During the year to the end of June 2021, a total of 1,540 virtual specialist appointments have been provided for new patients, close to 50% higher than during the previous 12 months.
- This has enabled provision 2,496 new patient contacts, compared with 1,913 during 2019/20
- Every virtual assessment involves provision of an extensive treatment plan to the patient's General Practitioner. General Practitioners have indicated their appreciation of this service.

## Nurse and Dietician Led Diabetes Clinics for Children

- The Paediatric Diabetes Team provides ongoing care to well over 200 children. Previously the model had the service's two Clinical Nurse Specialists supporting Senior Medical Officer clinics and working with children, whānau and other support services between appointments. Research has shown that use of nurse-led clinics, where nurses carry their own caseload, provides an improved patient experience while offering opportunities to further develop nursing roles.
- A nurse and dietitian led clinic has been developed within the paediatric diabetes service that allows children to benefit from these new opportunities.
- One or two clinics are being run each month and are easily filled by referrals from the service's doctors.
- A focus is being placed on providing care to those children with the greatest challenges in glucose control in between their usual three-monthly visits with a Senior Medical Officer.
- These clinics enable more engagement with both the child and family, assessing and addressing gaps in understanding and making interim insulin changes. Each session involves patients setting their own goals and enables provision of feedback.
- Improved engagement has been demonstrated via extremely high attendance rates and improved management of glucose levels reflected in HbA1c levels.

## Primary care-based sleep assessment service

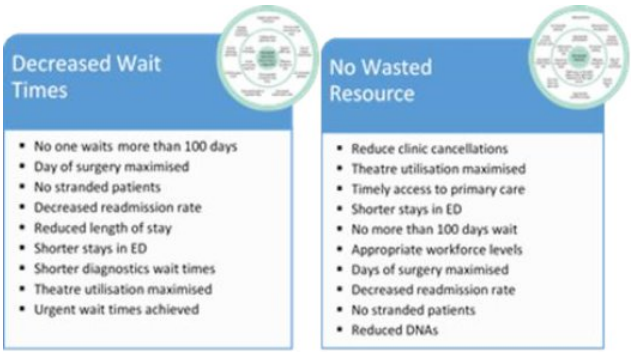
- Canterbury, West Coast and South Canterbury District Health Boards have a well-established community sleep assessment service with assessment carried out in general practice using a standardised tool and a screening sleep study. These assessments are reviewed by a specialist multi-disciplinary team with outcomes based on disease severity and medical complexity.
- An audit was carried out to ascertain whether there is population equity in access, timeliness and outcomes.

- During 2020 there were 2,499 total case discussions at multidisciplinary team meetings covering 2,094 individual cases.

Table 1: Summary of population data for the Community Sleep Pathway.

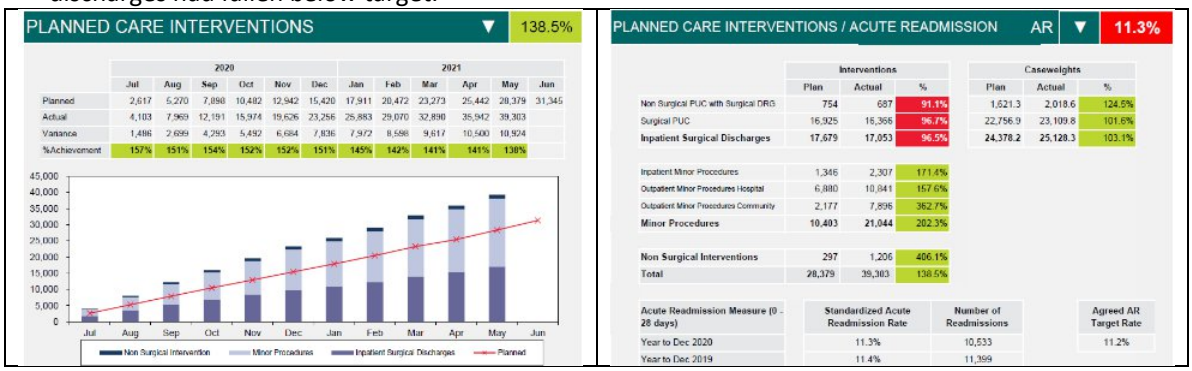
| Population Description | Other | Māori | Pacific | P |
|---|---|---|---|---|
| Total Population (%) | 589037 (87.6%) | 66278 (9.9%) | 17479 (2.6%) | - |
| Community sleep patients (%) | 1783 (85.1%) | 241 (11.5%) | 70 (3.3%) | - |
| Referral-Outcome (days, mean ± SD) | 92 ± 91 | 95 ± 95 | 93 ± 89 | NS |
| Discharged post MDT (%) | 51% | 48% | 34% | - |
| Trial of CPAP (%) | 26% | 30% | 51% | <0.0001 |
| To see specialist (%) | 11% | 16% | 7% | - |

- The audit found that Māori and Pacifica present within the primary care-based sleep assessment service at population prevalence.
- However, with the known increased prevalence of obstructive sleep apnoea in these groups it is possible that this is proportionally under-represented, indicating a need for more effective community partnerships to be built to improve access.




# Theatre Capacity and Theatre Utilisation

- Planned care targets agreed with the Ministry of Health include planned inpatient operations as well as procedures provided to hospital inpatients, outpatients and patients in community settings.
- Canterbury District Health Board's target was to deliver a total of 31,345 planned care interventions: made up of 19,614 surgical discharges, 11,409 minor procedures and 322 non-surgical interventions. This is 2% higher than the 2019/20 target of 30,675.
- In order to avoid penalties, it was necessary to exceed 95% of planned care discharges target (18,634 discharges).
- Reporting from the Ministry of Health to the end of May showed that that Canterbury District Health Board was exceeding its overall planned care targets by 38%, however within this, inpatient surgical discharges had fallen below target.




- Cancellation of surgery during the final months of the year, due to anaesthetic technician workforce constraints, bed constraints and industrial action led to concerns that Canterbury District Health Board would fail to meet 95% of its target for planned care discharges. The production planning framework, based on the typical production of each theatre session scheduled for the remainder of the year, was used to calculate expected provision at end of year.
- On this basis Improvement Action Plan funding provided by the Ministry of Health to reduce backlogs associated with COVID-19 and other constraints, e.g. acute capacity, was used to purchase additional outsourcing to ensure that financial penalty was avoided.
- Internal reporting to the end of the year shows that 42,567 planned care events have been provided – this is 11,208 ahead of the target of 31,359.
- Within this, 18,850 planned inpatient surgical discharges were provided – 764 (3.9%) below the target of 19,614. This is sufficient to avoid financial penalty.
- The cost of the additional volumes produced/purchased with the Improvement Action Plan funding was approximately $2.7million less than the revenue received.
- To ensure that these discharges count towards the target, clinical coding must be completed and then be accepted by the Ministry of Health. The clinical coding team has undertaken a mammoth effort to ensure that all discharges prior to 30th June are coded and accepted prior to the deadline at end of July. As at 20th July 95% threshold has been exceeded.

- 22,510 minor procedures have been provided 11,101 ahead of the target of 11,409. Inpatient, outpatient and community provision are all ahead of target.
-

*Achievements/Issues of Note*

## Current theatre volumes

- Overall, when all operating by or on behalf of Canterbury DHB is considered (in house, outplaced and outsourced) more operations were provided in both May and June 2021 (2,862 and 2,912) than in prior years. It was more 8% more than in (COVID affected) 2020 and 9% higher than in 2019. This increased number of operations has been provided despite a significant reduction in the use of outplaced and outsourced surgery following transition to Waipapa.
- There were 2,386 operations following arranged and acute admissions during May and June 2021 15% more than during those months in 2020 and 5% less than those months in 2019.
- The number of outsourced and outplaced events has been reduced with increased in-house capacity enabling much of this work to be repatriated. The final tranche of outplaced surgery being repatriated occurred in the last week of February when dental operating returned to Christchurch campus. Subsequently a reduced Anaesthetic Technician workforce and bed shortages are leading to outplacing being resumed. During May 2021, 289 outplaced or outsourced theatre events were provided – 43% of May 2020, there were 467 such events in June 2021 – 72% of June 2020.
- More elective surgery was provided at Christchurch Hospital during both May and June than in the two prior years. 1,040 elective theatre events were provided in May 2021 and 1,002 in June 2021 compared with 779 in May 2020 and 768 in June 2020.

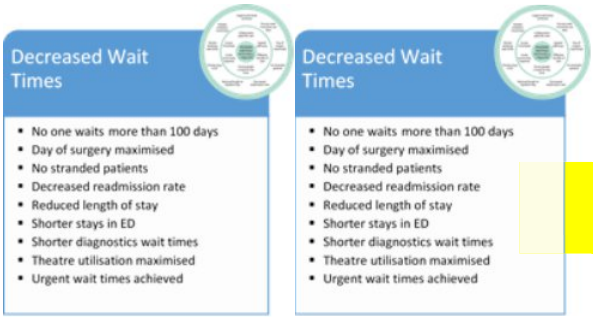
## Operating theatre assistant communication

- Operating theatre assistants provide delivery and basic care tasks in the operating theatre.
- Until now this team has only been contactable by pager, this has not been effective.
- Expansion in operating theatre capacity when Waipapa opened saw the team expand by 24 FTE, exacerbating the requirement for a new way of working.
- Use of mobile phones in conjunction with the Max system used by orderlies was chosen as the preferred method.
- This offers a range of benefits including:
  - Making many roles more versatile, with a range of members within the team being able to take next job raised. This decreases the travel and repetitive movements which previously made some roles physically demanding. Equity in job allocation will be improved.
  - Tasks have been split into predicable tasks which are preloaded in the system with times allocated and tasks that cannot be pre-allocated.
  - Improved data collection to enable analysis of tasks and planning.
- Audit against expected benefits will occur at 4, 12 and 24 weeks.

## General Surgery

- From the 14th June general surgical registrars have moved onto a new roster formalising the arrangements for afterhours care of Paediatric Surgery patients and rib fracture patients by General Surgery. This has been enabled by the addition of two non-training registrars enabling two registrars to work acute long days each weekday.
- The “Who Goes Where Group” has approved the relocation of the general surgical registrar quiet/study room from Parkside East to a location between General Surgery wards in Waipapa. This collocation will enable the registrars to remain closer to their inpatients.
- Discussions regarding provision of clinical governance and support for the West Coast have commenced with General Surgery’s Clinical Director agreeing to provide clinical oversight of the General Surgical service on the West Coast to ensure consistency with clinical standards in Canterbury.

- Digitising letters to general practice have been piloted in General Surgery and is now live with 'GP only' letters being sent electronically; this project will continue to improve as more letter options are introduced.
- The end of the financial year saw a concerted effort to clear the General Surgery ESPI 2 backlog via the provision of additional outpatients' clinics. This included seeing the large volume of patients accepted onto the waitlist for First Specialist Assessment when the 'Patient Pool' approach was extinguished.
- Outplacing has resumed with a regular outplaced breast surgery session being scheduled on a regular basis to overcome risks of constraint due to bed and Anaesthetic Technicians shortages. More sessions are likely to follow




# Mental Health Services

## Information Collection and Use in Specialist Mental Health Services

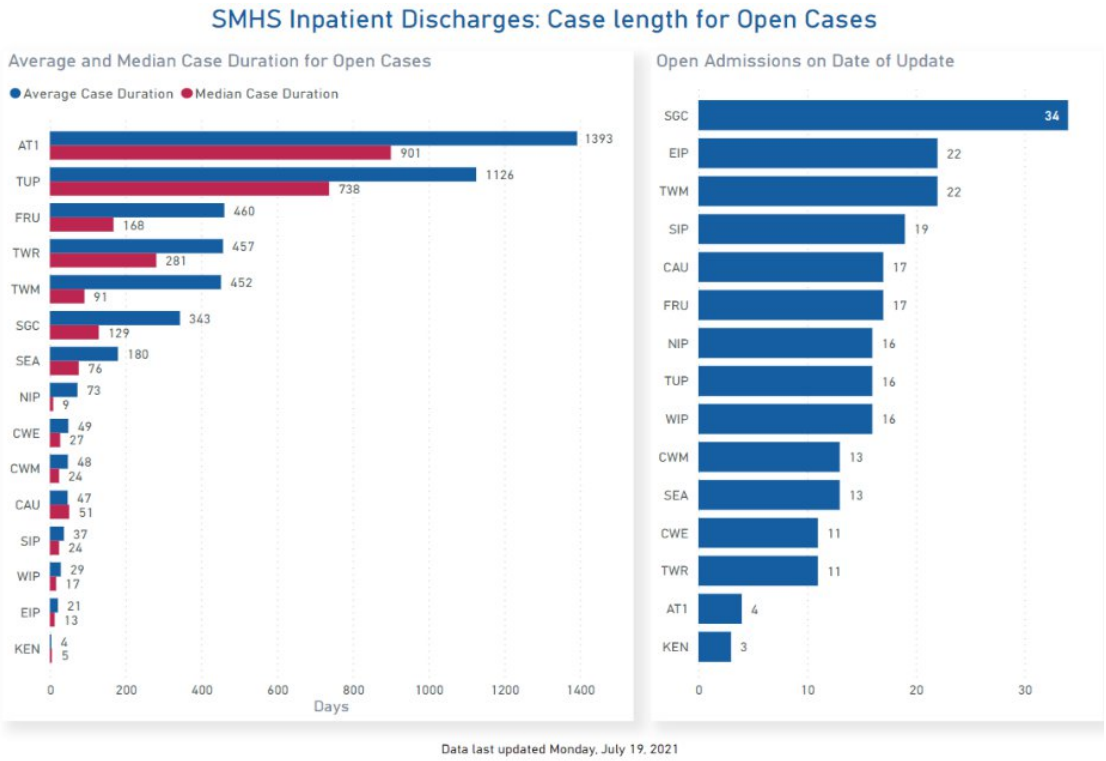
Understanding the mental health needs of our population relies on assessing the demand for services, complexity of need as well as how well our services are operating to address peoples' issues. Specialist Mental Health Services has established a number of information sources which are driving opportunities for improvement:

- Demand and service provision – for operational and flow data
- Patient behaviour (Safety 1st) – for incident data
- Consumer experience survey – for consumer experience information
- Clinical audit programme – for assessing how well clinical processes are followed.

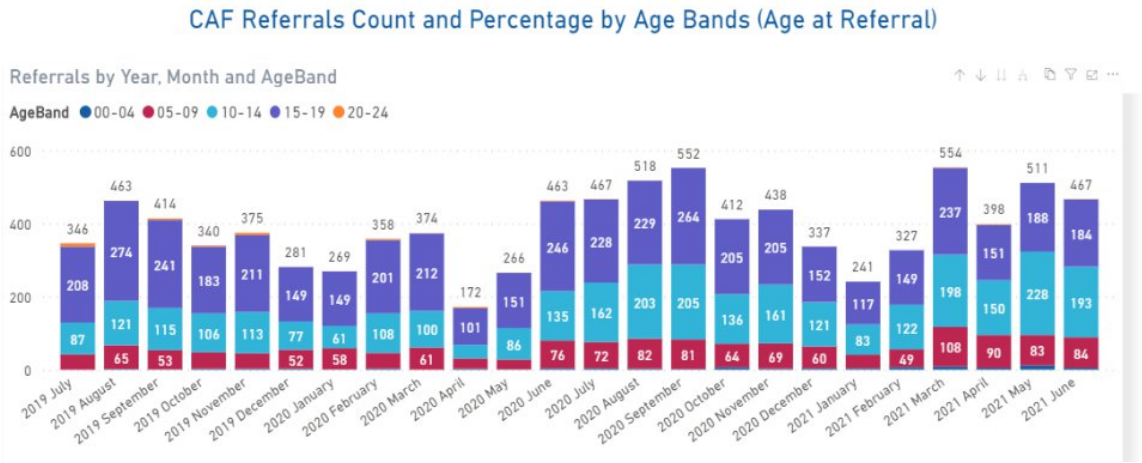
Each source of information is examined in greater detail and linking this to quality improvement initiatives.

## Demand and Service Provision

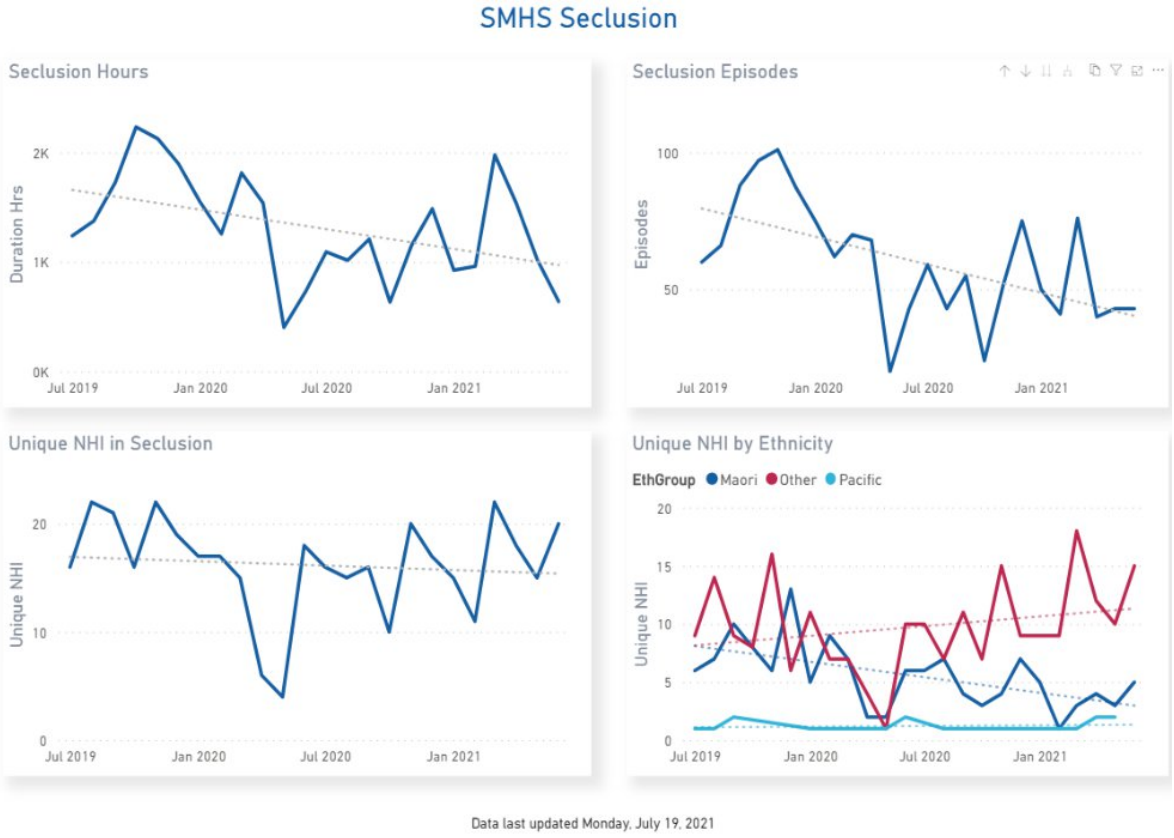
There are a number of measures that are monitored that reflect a wide range of demand and service provision metrics with the ability to explore these in each service and/or unit and by demographic and other factors such as age, ethnicity and gender. These cover inpatient services (e.g. admissions and discharges, length of stay, bed days, seclusion) and community outpatient services (e.g. referrals, case starts, waiting times, contacts, mode of contact). The figure below illustrates the length of stay for people still in services with AT&R and Tupuna having the longest average cases.



Referrals to child, adolescent and family services show growth over the last two years with a decrease during Covid lockdown. The majority of referrals are among 10-14 and 15-19 year olds.




The use of seclusion is monitored for a range of dimensions including hours, episodes and unique individuals for each inpatient service. There have been significant disparities in seclusion with high Māori rates historically, so this monitored closely.

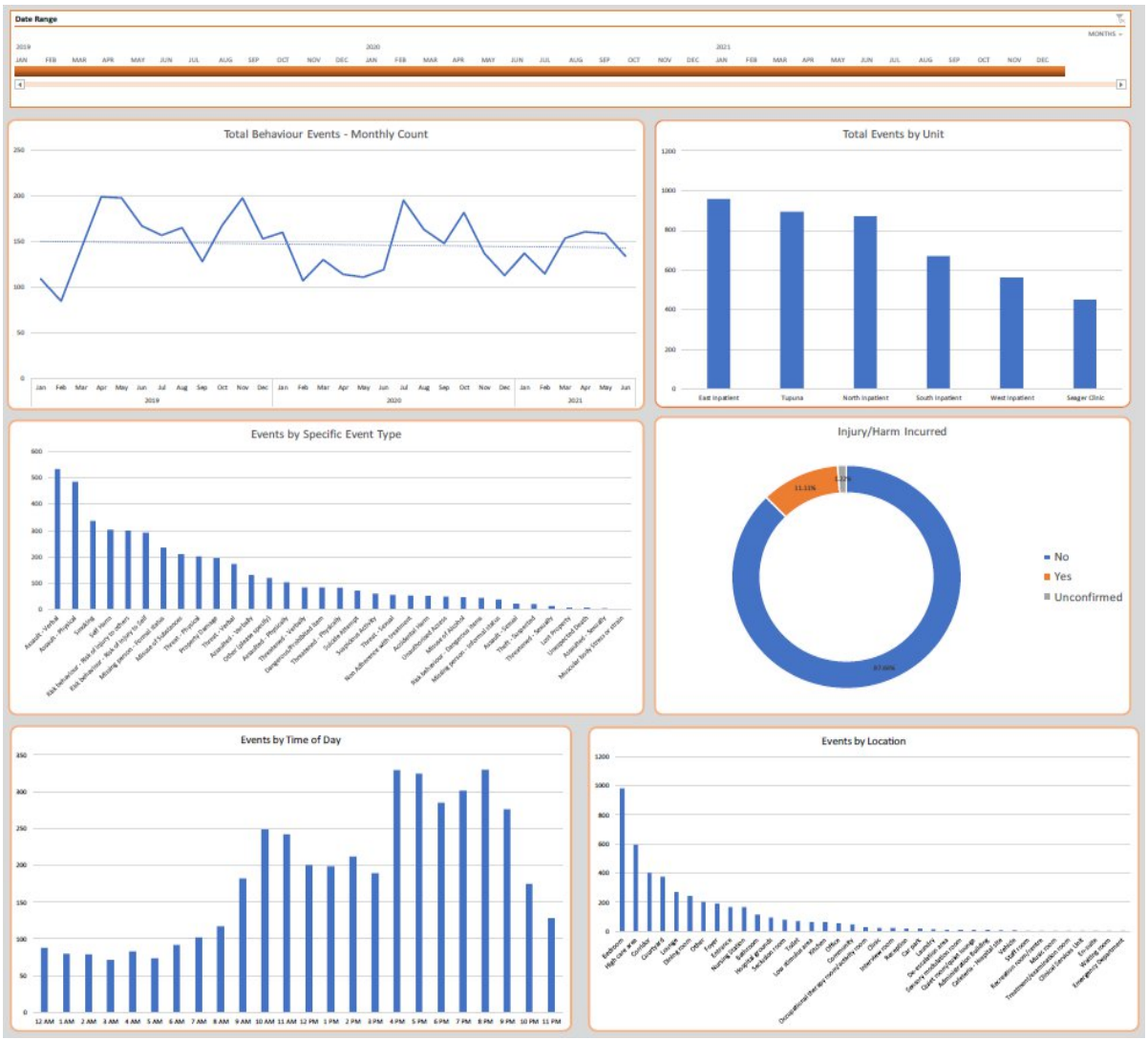


## Patient Behaviour (Safety 1st) – Interactive Dashboard

An interactive dashboard containing information on reported 'patient behaviour' events has been developed using data extracted from Safety 1st. The dashboard is displayed on screen at monthly clinical incident review meetings with Charge Nurse Managers and other key staff from the adult inpatient service.

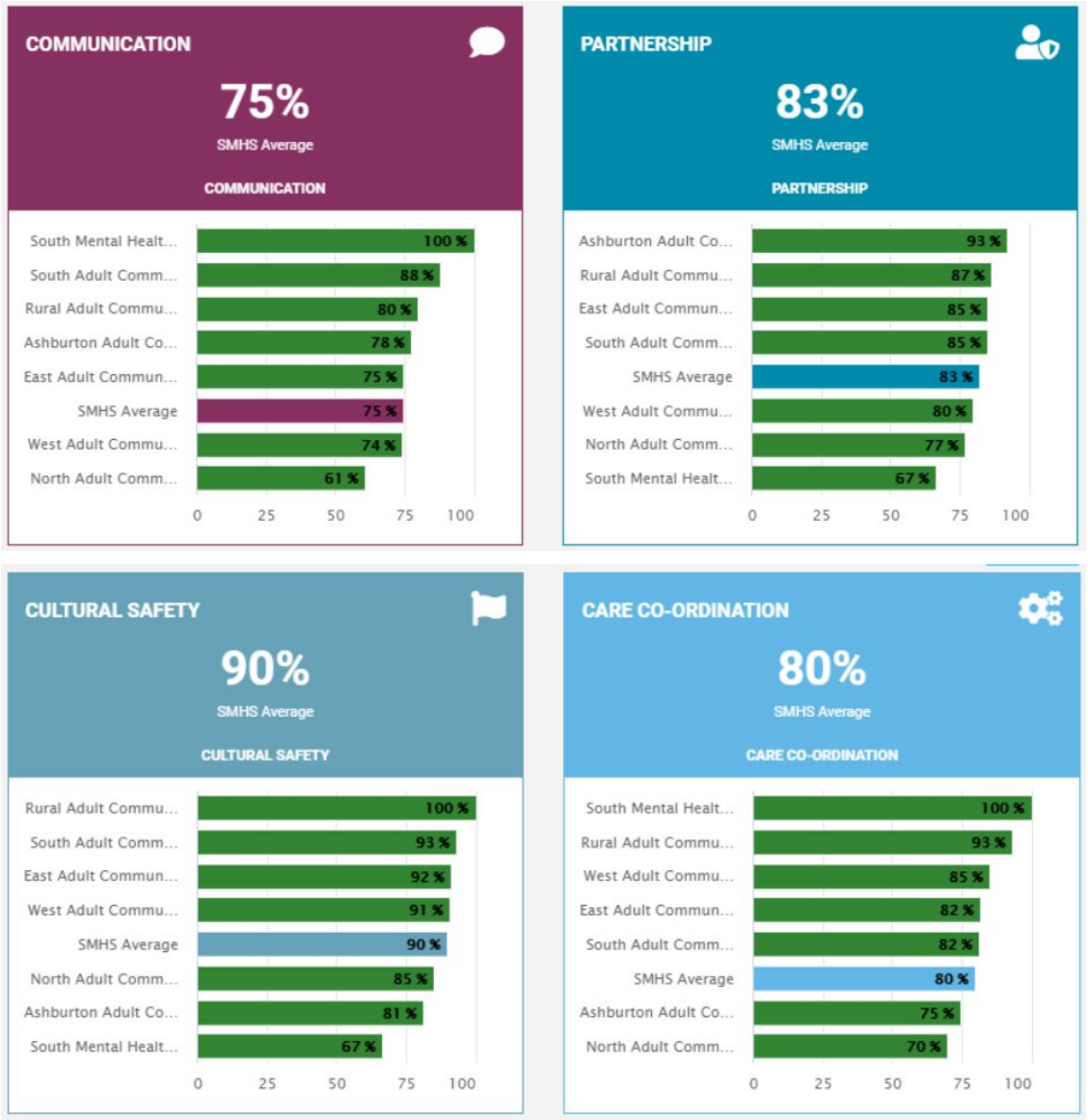
The overall aim of the dashboard is to inform discussions, provide context to the data, identify trends/patterns and inform the development of safety plans for high profile consumers. The dashboard provides useful insights that may not otherwise be visible by allowing the data to be filtered by ward, time periods, incident types, people affected and, where required, individual patients. The ultimate goal is to make clinical incident data as meaningful and clinically relevant as possible. Dashboards are also in development for SMHS' Intellectual Disability, Forensic and Child and Adolescent services.

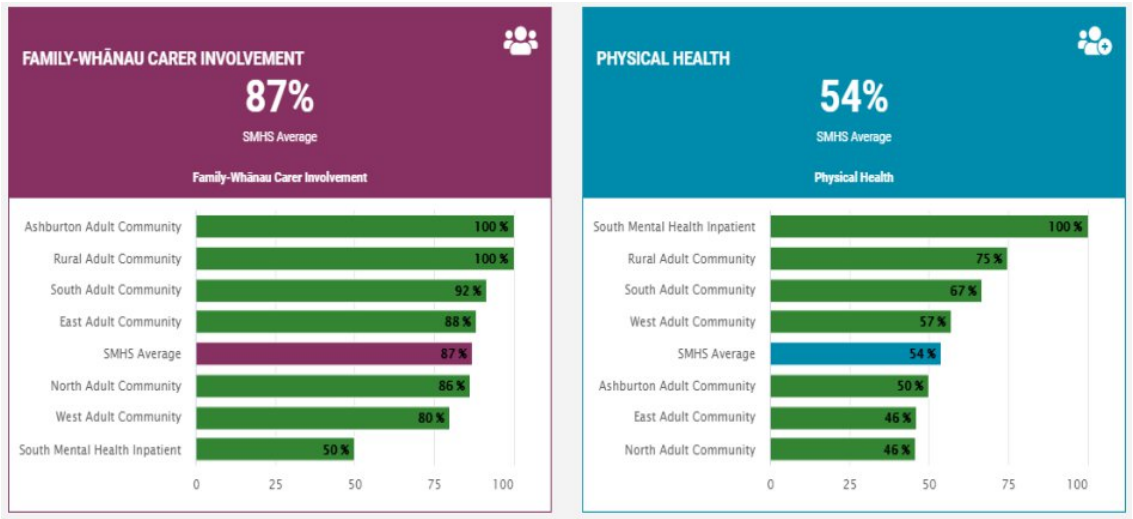
The dashboard below provides an overview of behaviour events across the Division.



## Consumer Experience Survey Adult General Mental Health Service (Launched May 2021)

This survey captures consumer experience in six domains (communication, partnership, cultural safety, care co-ordination, family/whanau involvement and physical health) for patients discharged from adult acute inpatients or who have an in-person appointment with a community team. Data is presented via an interactive dashboard which will be available to all staff. Until recently there has not been a mental health-based consumer experience survey.






Results can be viewed by service, gender, age and ethnicity. Single questions or questions grouped by domain allow for deeper analysis. Qualitative data is available through patient comments which can be collated by theme and sentiment. Some examples of comments from consumers to date have included:

- *I always felt listened to & by the end of each session had a plan to move forward with. I always found the appointments were valuable as I had previously worked with both Clare & Charlie so we had a good working relationship to begin with.*
- *Charmaine was fantastic. I felt listened to and we made decisions together. The woman I spoke to in the weekend virtually asked me what I wanted and I wasn't in the state to answer her.*
- *The excellent staff involved in my care. I can at times be very reluctant to receive help but by having consistent people involved is helping me through a lot of issues.*
- *Once I got into mental health services the doctor and nurse I saw were amazing. They listened carefully, were kind and lovely. It was the getting the help to start with that was hard.*

As the launch is in early stages, positive data is fed back to leadership groups, individual teams and through the General Manager's update to increase interest and engagement from staff. A quarterly report for staff, SMHS Clinical Governance Group and consumers is under development. Once leadership teams and staff have been engaged with the survey, the Quality and Patient Safety Team will begin quality improvement conversations with individual teams.

## Clinical Audit Program

The Quality and Patient Safety team continue to develop a clinical audit programme to ensure that services comply with national mental health standards, local health pathways and other relevant legislation. Data is collated and analysed by Quality Co-ordinators and reported back to individual teams. Three components of the patient journey are assessed: referral/assessment; treatment; and discharge/transition. Summary reports outlining divisional level data and a focus area of more in-depth analysis, improvement suggestions and improvement stories is being built.

The audit for community teams is underway (see report below). Early results show teams have used the data to implement team-based changes such as strengthening process to ensure better quality multidisciplinary team meetings and treatment plans. Reports providing summary data will be made available to clinicians, service leaders and the SMHS Clinical Governance Group. The clinical audit programme also allows for priority audits to be conducted following an adverse event, HDC review or Coroners report. The first of these audits is under development with results presented to the SMHS Serious Events Review Team and the SMHS Clinical Governance Group.

# SMHS Clinical Audit Report Community Teams June 2021

## INTRODUCTION

The community-based clinical audit started in September 2019. Overseen by the Q&PS team, the audit tools cover three areas of the consumer journey; assessment, treatment and discharge. Audit questions are designed to measure service compliance with national mental health standards, local health pathways, relevant legislation and best practice. Quantitative and qualitative data is provided to teams to identify areas of strength, as well as areas for improvement.

This report provides a brief overview of key findings for adult and child community-based services for the first half of 2021.

| Audit Tool | No. of Teams Responded | Total no. of files audited |
|---|---|---|
| Assessment | 13 | 69 |
| Treatment | 6 | 34 |
| Discharge | 14 | 79 |

***Care Coordination*** integration & communication between services/providers

***Care Processes*** adherence to HHP, policy/ protocols, documentation

***Communication*** information sharing & communication with consumers.

***Risk*** Documentation, formulation, management & communication

***Cultural*** Recognising, respecting, & supporting cultural identity

***Family/Whanau*** Involving family/whanau in decision making

***Partnership*** Encouraging & supporting collaboration in decision making

*Audit tip*

Checking when contacts were last updated

Open contact/disclosure window,& click on history. Date column indicates when last altered, ST column shows what kind of change occurred.

## IN FOCUS

Family & whanau are a source of valuable information when assessing and providing treatment for consumers. Involving key support people in a consumers treatment plan has numerous benefits including reduced hospital stays, better treatment compliance and relapse prevention. Several items in the clinical audit serve as a proxy measure for family/whanau involvement. The table below is a deeper dive into our compliance with family/whanau involvement items at different stages of the consumer journey.

| | Consumer Journey * | | |
|---|---|---|---|
| Audit Item | Assessment | Treatment | Discharge |
| Present at assessment/discharge meeting | 51% | | |
| Family contacted (if not in assessment) | 46% | | |
| Outcome of meeting discussed | 75% | | 60% |
| Family/whanau involved in treatment planning | | | |
| Involved in clinical review | | 56% | |
| Family/whanau updated during treatment | | 60% | |
| Family/whanau advised if significant risk | 57% | 87% | |
| Treatment plan given to family/whanau | | | |
| Copy of crisis plan given to family | | 23% | |

**** Average of all results from participating SMHS community teams***

*Relevant SMHS Policy*

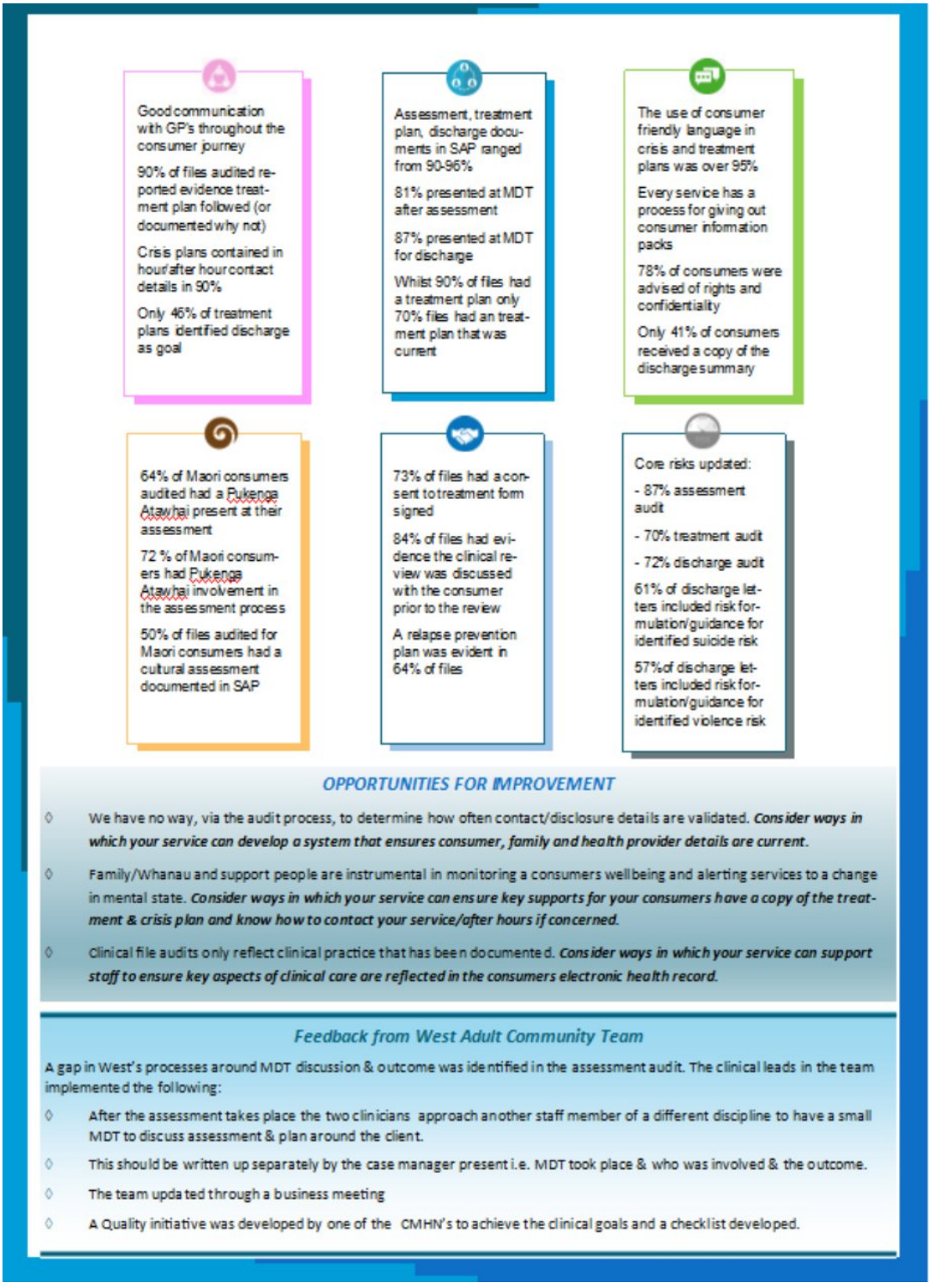
https://prism.cdhb.health.nz/site/policies/SitePages/Policy%2520View.aspx?ppid=2400054

### *What we do well*

- Up to 80% of files audited showed evidence of risk status being discussed with family/whanau, where consumer risk was identified as moderate or high ,during the *treatment* and *discharge* phase of the consumer journey
- 75% of files had evidence the *assessment outcome* was discussed with family/whanau
- 60% of files had evidence family/whanau were consulted during the consumers *treatment*
- Only 16 % of files audited gave no disclosure

### *What we could do better*

- Only 23% of files audited had evidence that family/whanau had a copy of the *crisis plan*
- 58% of consumers had a family member present at assessment or were offered a meeting with the team with 30% of assessments with no family/whanau member present documented as by consumer choice.
- Where no family member present in assessment only 48% had evidence *collateral information* was sought
- Family/whanau were advised of significant suicide/violence risk in only 56% of cases following assessment


Good communication with GP's throughout the consumer journey
90% of files audited reported evidence treatment plan followed (or documented why not)
Crisis plans contained in hour/after hour contact details in 90%
Only 46% of treatment plans identified discharge as goal
Assessment, treatment plan, discharge documents in SAP ranged from 90-96%
81% presented at MDT after assessment
87% presented at MDT for discharge
Whilst 90% of files had a treatment plan only 70% files had an treatment plan that was current
The use of consumer friendly language in crisis and treatment plans was over 95%
Every service has a process for giving out consumer information packs
78% of consumers were advised of rights and confidentiality
Only 41% of consumers received a copy of the discharge summary
64% of Maori consumers audited had a Pukenga Atawhai present at their assessment
72 % of Maori consumers had Pukenga Atawhai involvement in the assessment process
50% of files audited for Maori consumers had a cultural assessment documented in SAP
73% of files had a consent to treatment form signed
84% of files had evidence the clinical review was discussed with the consumer prior to the review
A relapse prevention plan was evident in 64% of files
Core risks updated:
- 87% assessment audit
- 70% treatment audit
- 72% discharge audit
61% of discharge letters included risk formulation/guidance for identified suicide risk
57%of discharge letters included risk formulation/guidance for identified violence risk
OPPORTUNITIES FOR IMPROVEMENT
◊ We have no way, via the audit process, to determine how often contact/disclosure details are validated. Consider ways in which your service can develop a system that ensures consumer, family and health provider details are current.
◊ Family/Whanau and support people are instrumental in monitoring a consumers wellbeing and alerting services to a change in mental state. Consider ways in which your service can ensure key supports for your consumers have a copy of the treatment & crisis plan and know how to contact your service/after hours if concerned.
◊ Clinical file audits only reflect clinical practice that has been documented. Consider ways in which your service can support staff to ensure key aspects of clinical care are reflected in the consumers electronic health record.
Feedback from West Adult Community Team
A gap in West's processes around MDT discussion & outcome was identified in the assessment audit. The clinical leads in the team implemented the following:
◊ After the assessment takes place the two clinicians approach another staff member of a different discipline to have a small MDT to discuss assessment & plan around the client.
◊ This should be written up separately by the case manager present i.e. MDT took place & who was involved & the outcome.
◊ The team updated through a business meeting
◊ A Quality initiative was developed by one of the CMHN's to achieve the clinical goals and a checklist developed.


Living within our means

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

Canterbury District Health Board

## Statement of Financial Performance

### Hospital & Specialist Service Statement of Comprehensive Revenue and Expense For the 12 Months Ended 30 June 2021

| MONTH $'000 | | | | YEAR TO DATE $'000 | | |
|---|---|---|---|---|---|---|
| 20/21 Actual $'000 | 20/21 Budget $'000 | 20/21 Variance $'000 | | 20/21 Actual $'000 | 20/21 Budget $'000 | 20/21 Variance $'000 |
| | | | **Operating Revenue** | | | |
| 254 | 268 | (14) | From Funder Arm | 3,113 | 3,195 | (82) |
| 1,760 | 1,758 | 2 | MOH Revenue | 19,904 | 19,070 | 834 |
| 5,295 | 4,431 | 864 | Patient Related Revenue | 59,742 | 53,088 | 6,654 |
| 2,016 | 1,203 | 813 | Other Revenue | 24,614 | 14,412 | 10,202 |
| 9,325 | 7,660 | 1,665 | **TOTAL OPERATING REVENUE** | 107,373 | 89,765 | 17,608 |
| | | | **Operating Expenditure** | | | |
| | | | **Personnel Costs** | | | |
| 72,580 | 70,943 | (1,637) | Personnel Costs - CDHB Staff | 832,020 | 830,184 | (1,836) |
| 2,182 | 1,914 | (268) | Personnel Costs - Bureau & Contractors | 24,401 | 23,114 | (1,287) |
| 74,762 | 72,857 | (1,905) | **Total Personnel Costs** | 856,421 | 853,298 | (3,123) |
| 15,048 | 14,023 | (1,025) | Treatment Related Costs | 166,125 | 166,695 | 570 |
| 6,174 | 4,745 | (1,429) | Non Treatment Related Costs | 56,183 | 54,288 | (1,895) |
| 95,984 | 91,625 | (4,359) | **TOTAL OPERATING EXPENDITURE** | 1,078,729 | 1,074,281 | (4,448) |
| **(86,659)** | **(83,965)** | **(2,694)** | **OPERATING RESULTS BEFORE INTEREST AND DEPRECIATION** | **(971,356)** | **(984,516)** | **13,160** |
| | | | **Indirect Income** | | | |
| (145) | 1 | (146) | Donations & Trust Funds | 2 | 15 | (13) |
| **(145)** | **1** | **(146)** | **TOTAL INDIRECT INCOME** | **2** | **15** | **(13)** |
| | | | **Indirect Expenses** | | | |
| 7,395 | 4,070 | (3,325) | Depreciation | 77,458 | 59,692 | (17,766) |
| (3) | - | 3 | Net (Gain) Loss on Disposal of Fixed assets | 2,685 | - | (2,685) |
| **7,392** | **4,070** | **(3,322)** | **TOTAL INDIRECT EXPENSES** | **80,143** | **59,692** | **(20,451)** |
| **(94,196)** | **(88,034)** | **(6,162)** | **TOTAL SURPLUS / (DEFICIT)** | **(1,051,497)** | **(1,044,193)** | **(7,304)** |

Older Persons Health & Rehab
Women's & Children's Health
Mental Health

Medical & Surgical
Hospital Support & Labs
Facilities Management

## Achievements/Issues of Note

### Allied Health

- Project planned to commence on cytotoxic wastage in the new aseptic and cytotoxic area (Sterile Production Unit). Will be reviewing why wastage occurs and if there any changes that can be made to practices to reduce wastage.
- The sterile production unit is over twenty-five years old and at risk of failure; parts are extremely expensive and are sourced from overseas. Reconfiguration means the ability to design a smaller, fit for purpose area for compounding which won't break down and free up some space in the Pharmacy footprint. The sterile and non-sterile areas will be combined so work can be more streamlined.
- Nutrition and Dietetics has made a saving of $4,600 in nutritional spend for this month.
- Short Term Loan Equipment hires from Enable NZ: 16% of equipment has been hired for greater than 8 weeks (71 items). This compares with 34% (124 items) in April 2021
- Weekend Services. Further work to be done on the weekend service. Looking at what the weekend hours are used for and if there is capacity, what other tasks can be initiated. Working with finance to develop budget for 24-hour weekend roster aiming to adjust rostering practice to minimise staff working over 80 hours within a fortnight, reducing the requirement for over-time.

### Anaesthesia

- Gelofusine – following a change in practice, this product is no longer being purchased. It is anticipated that this will result in a small savings of approx. $5,700 p.a.
- Optiflow circuits – following a change in practice, anaesthesia is no longer replacing circuits after daily use, shifting to a weekly replacement. This is expected to reduce the amount required by almost 50% with an anticipated savings of approx. $3,500 p.a.

### Cardiology

- Savings have been made due to a reduced cost of electrophysiology catheters as a part of national procurement. Over the 12month period ending 31 March, Canterbury District Health Board has saved approximately 100K (16.4%) by moving to national pricing.

### Gastroenterology

- The introduction of Spyglass technology into the Endoscopy Day Unit to improve visualisation of the common bile duct is expected to save over $100,000 per annum due to being able to treat patients in house rather than on the lithotripsy bus or in Auckland.

### Services provided to other districts

- A list of services that are provided to other District Health Boards that are not remunerated is being collated. This will enable examination of whether the services need to continue and if so whether income can be sought to cover the costs. The services include Infectious Diseases, Respiratory, and Sexual Health.

### Lipids

- Genetic test requests are being reviewed and will be limited to those with the most severe signs.

### Nursing

- Oncology - the plan to introduce the pre-spiking of chemo bags will potentially save up to $30K a year – the service is in the process of determining measures to show progress.
- Medical Nursing: Introduction of bar code scanning for stock supply has allowed a more responsive and financially robust management of stock.
- Cost saving initiatives continue to be explored related to the use of consumables, following changes with incontinence products, cleaning wipes and filter needles.
- Promoting the reduction of requests for urine tests through education.
- Gastro Day Service Nursing: Looking at environmental recycling and ways to reduce waste.

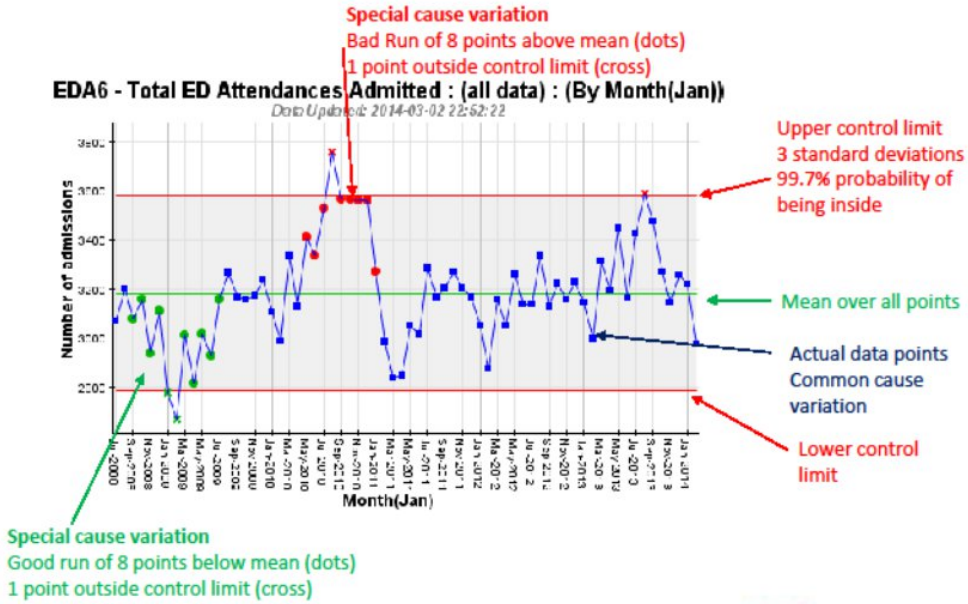
- Stocktake completed with less stock written off this year.

## Clinical Coding: audits

Results of recent coding audits include:

- Embolectomies: this audit saw an increase of 63.4 costweights, a total of $351,538 at the current rate. Of this 27.0781 costweights, $150,155, related to inter district flow events.
- Defibrillators/Pacemakers: this audit saw an increase 52.8 costweights, a total of $292,518. Information about the portion of this relating to inter district flow is not available.
- All of these events have been resubmitted to the Ministry so will be included in this year's wash-up totals.

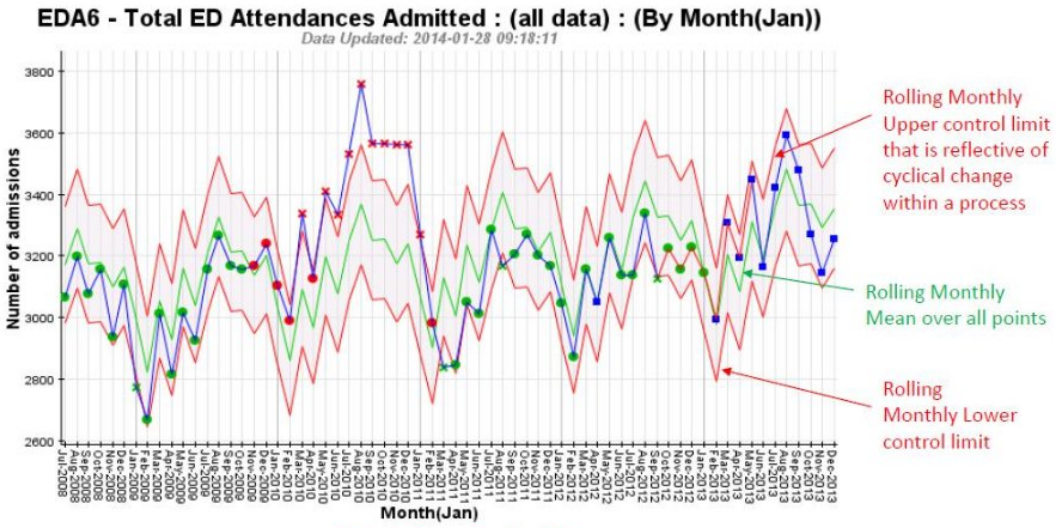
# SPC: How to Interpret a Control Chart




sfn signals from noise

make it better

# SPC: How to Interpret Cyclical and Trended Data




**Criteria for a Cyclical Process:**

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

sfn signals from noise

make it better

# CLINICAL ADVISOR UPDATE – NURSING

Canterbury District Health Board
Te Poari Hauora ō Waitaha

**NOTES ONLY PAGE**

# RESOLUTION TO EXCLUDE THE PUBLIC

Canterbury District Health Board
Te Poari Hauora ō Waitaha

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

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

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

**DATE:** **5 August 2021**

| Report Status – For: | Decision | ☑ | Noting | ☐ | Information | ☐ |
|---|---|---|---|---|---|---|

## 1. ORIGIN OF THE REPORT

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

## 2. RECOMMENDATION

That the Committee:

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

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

| | GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED | GROUND(S) FOR THE PASSING OF THIS RESOLUTION | REFERENCE – OFFICIAL INFORMATION ACT 1982 (Section 9) |
|---|---|---|---|
| 1. | Confirmation of the minutes of the public excluded meeting of 3 June 2021 | For the reasons set out in the previous Committee agenda. | |
| 2. | CEO Update *(if required)* | Protect information which is subject to an obligation of confidence.<br>To carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations).<br>Maintain legal professional privilege. | s 9(2)(ba)(i)<br>s 9(2)(j)<br>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*

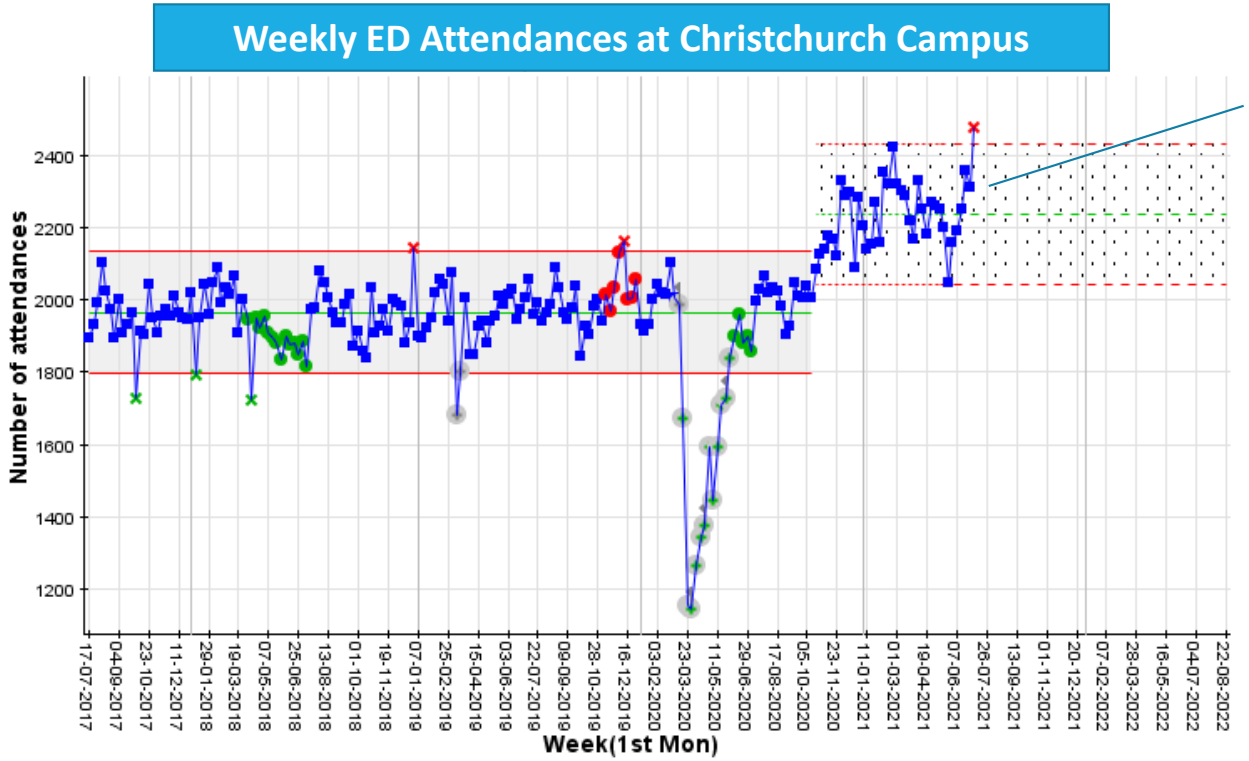
*(c) the grounds on which that resolution is based(being one or more of the grounds stated in Clause 32).*

*(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"*


# Board Update

# Context & Data Insights

# There has been a step change in ED attendances from October 2020




**Step change = 200 to 350** extra attendances per week from October 2020 which equates to 40-50 per day

**Increases in:**

- Triage 4s and 5s
- 16-80 olds with no change in +80 year olds
- Both accident and non-accident related
- Frequent attenders

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Making our system flow
Valuing the time of patients and staff

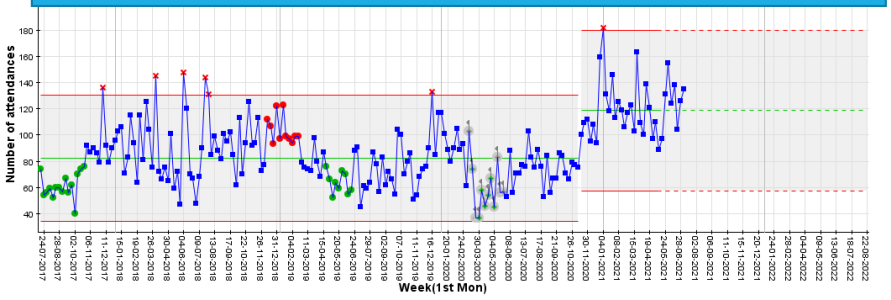
# This has *not* translated to increased acute admissions

**Attendance acuity decreased**

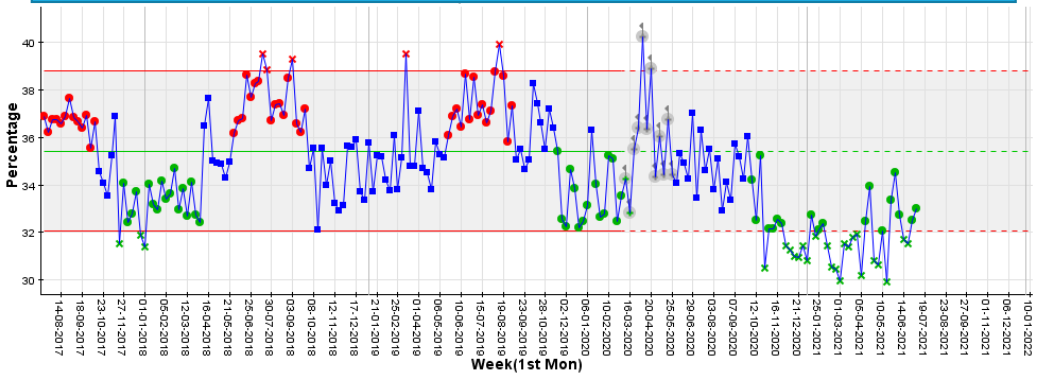
**ED Obs wasn't opened**

180/week

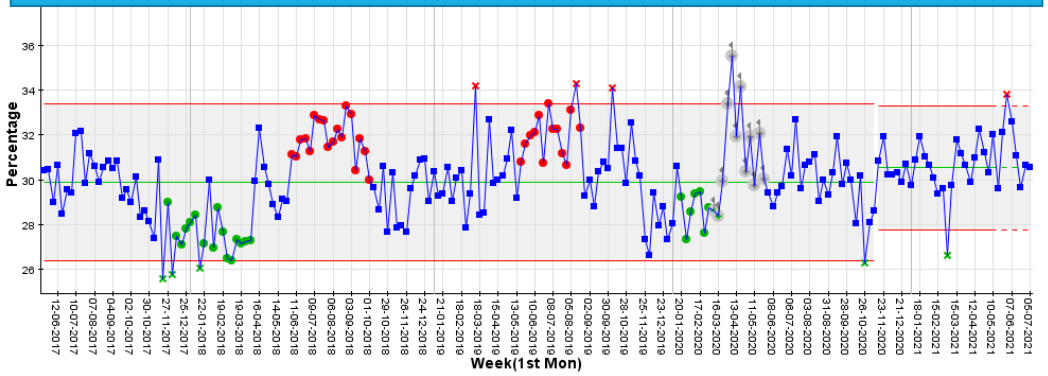
## Weekly Triage 5 Attendances at Christchurch




## Percentage of Patients Admitted (exc ED Obs)




## Percentage of Patients Admitted (all)

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Te Poari Hauora ō Waitaha

flow
Valuing the time of patients and staff

# This has *not* translated to increased acute admissions

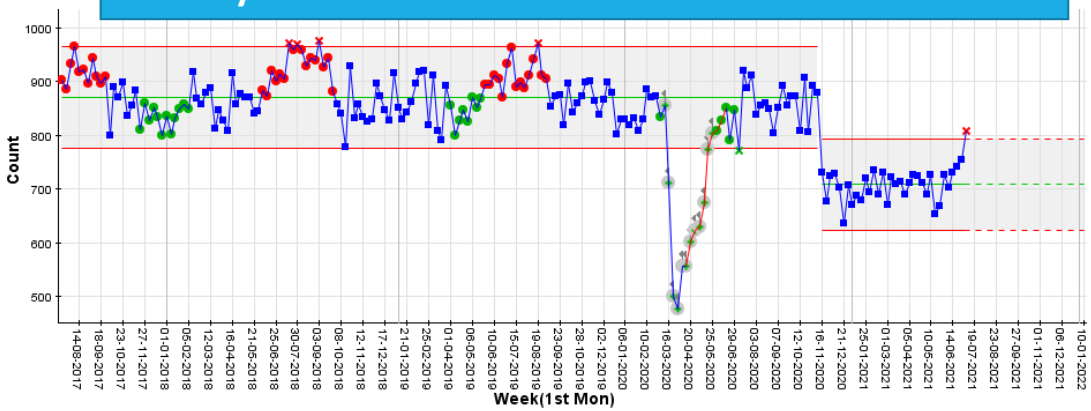
**Attendance acuity decreased**

**ED Obs wasn't opened**

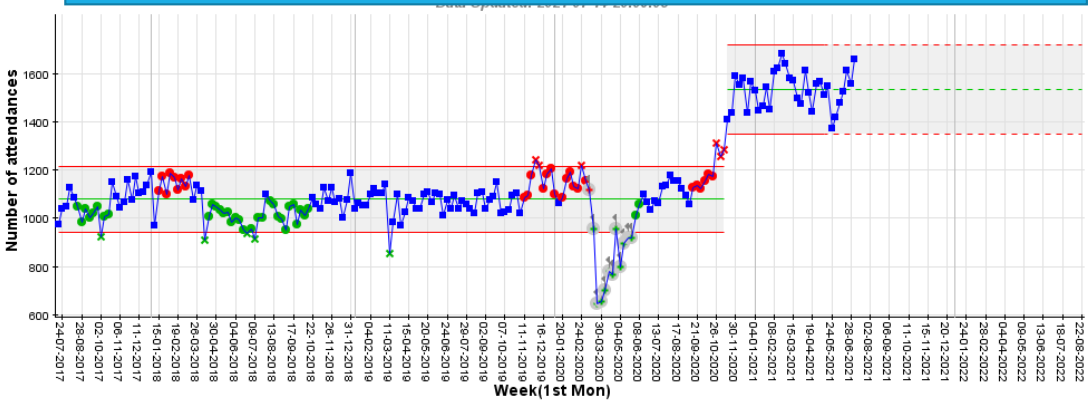
180/week

**But not-admitted ED attends has increased by 300 per week**

**Weekly Admitted Attendances to Christchurch from ED**

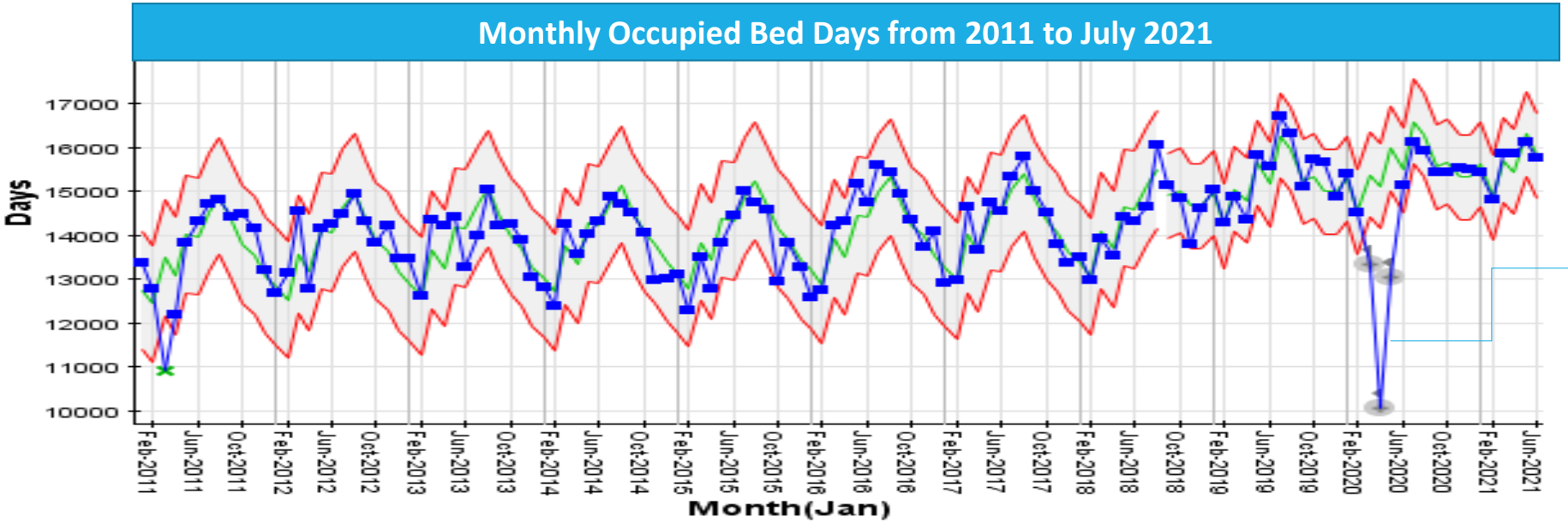



**Weekly Not-Admitted Attendances to Christchurch from ED**




Canterbury District Health Board
Te Poari Hauora ō Waitaha

# Hospital Occupancy has been higher than expected since October 2018




**With the expectation of COVID lockdown period, there have been no seasonality dips since October 2018**

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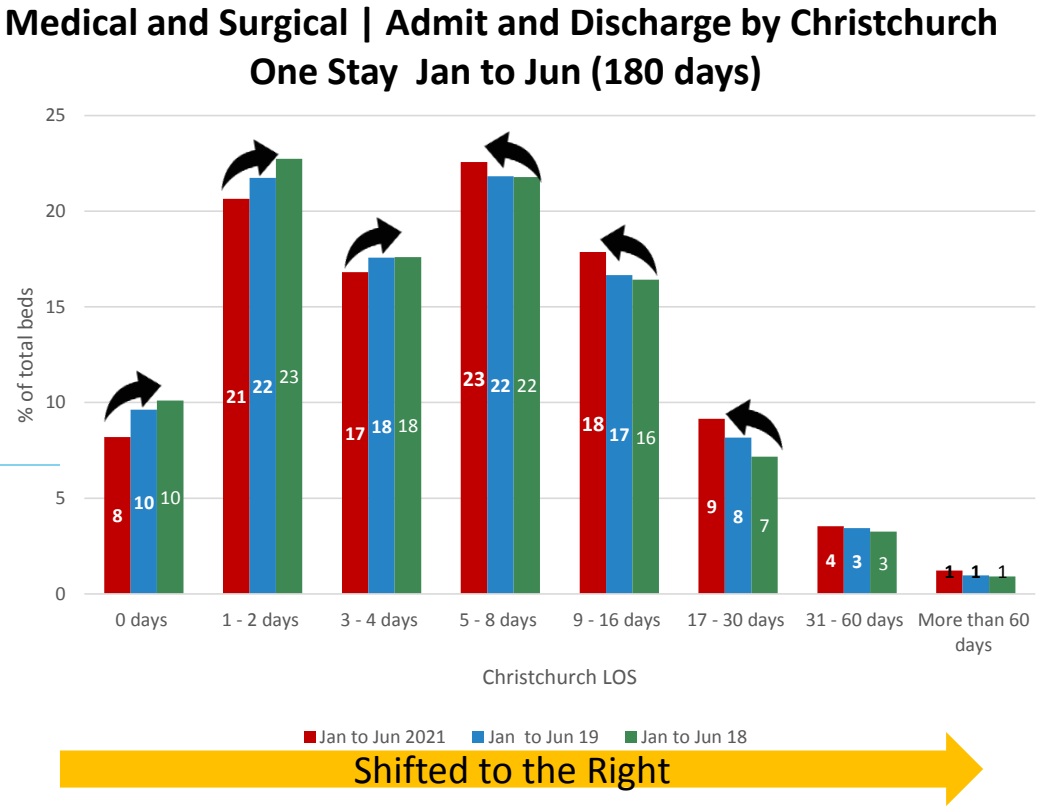
# Length of stay has right-shifted i.e. less 'short stays' with more people staying +5 days

**0-1 cohort does include ED Obs patients – provides an opportunity for enhanced ambulatory care**

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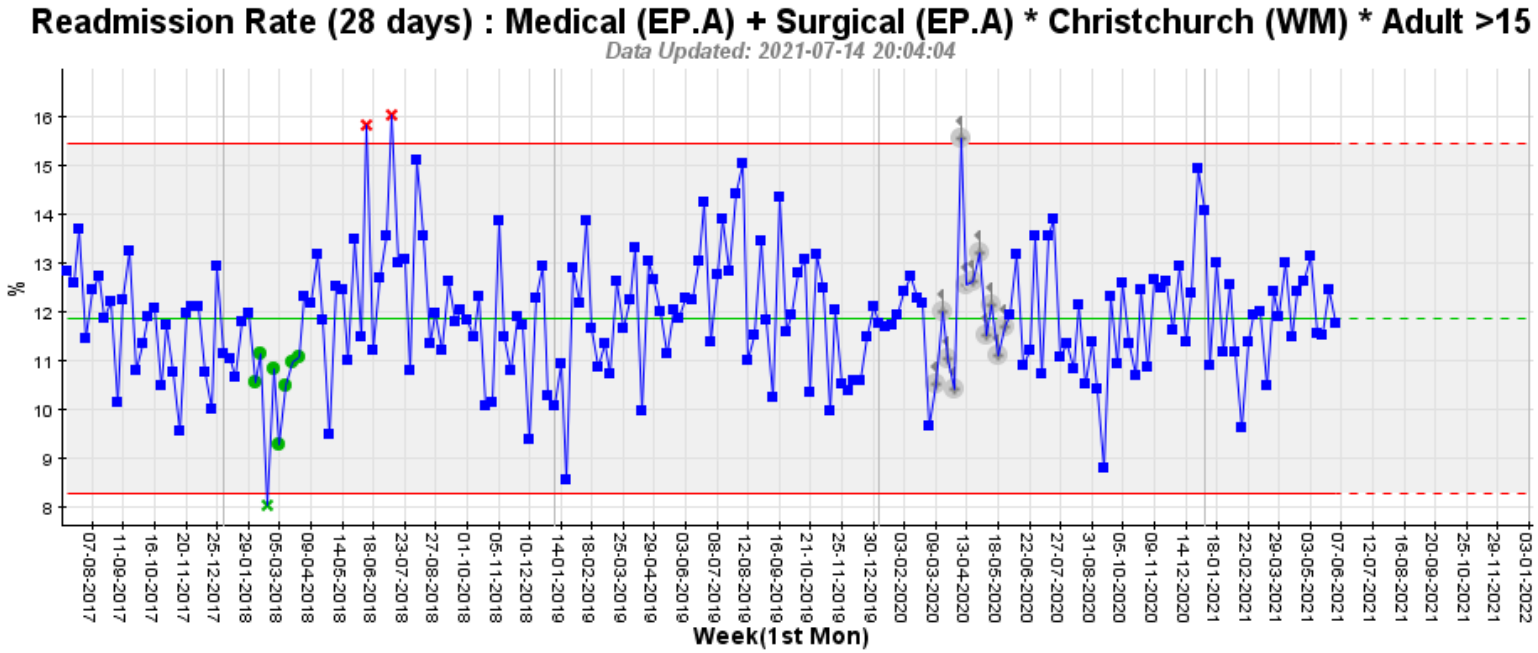
# The readmission rate has stayed consistent

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# Recap: Context and Data Insights

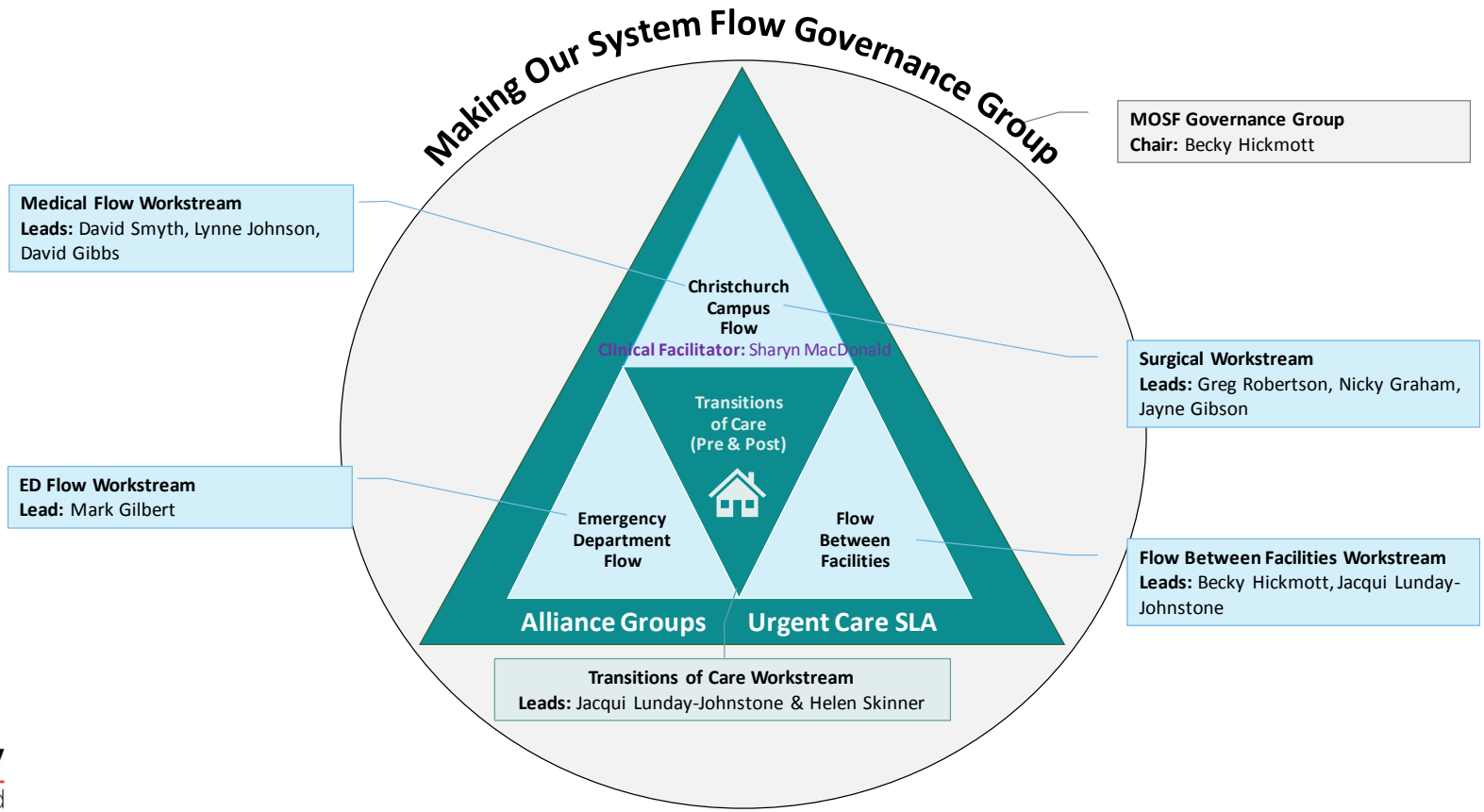
- There has been a step change in ED attendances from October 2020
- This has *not* translated to increased acute admissions
- Hospital Occupancy has been higher than expected since October 2018
- Length of stay has right-shifted i.e. less 'short stays' with more people staying +5 days
- The readmission rate has stayed consistent

**Given these insights, what are we doing to change and improve patient flow across the Canterbury Health System?**

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Making our system flow
Valuing the time of patients and staff

# We have established: Making Our System Flow

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Te Poari Hauora ō Waitaha

Making our system flow
Valuing the time of patients and staff

# Key Opportunities: ED Flow

- Quick win: Created a screen for patients to know their approx. wait time at the front of ED
- Quick win: Improved utilisation of patient information on discharge
- Establish a process for unenrolled patients who are better managed within primary care
- Clarify patient streaming at Front of ED
- Establish direct referral pathways from community into hospital
- Establish an ED-Orthopaedic working group to improve flow for orthopaedic patients
- Reinvigorate flow orientated pathways
- Review role of allied health in ED
- Work with inpatient teams / key specialties on response times to ED
- Contribute to escalation planning

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# Key Opportunities: Medical & Surgical Flow

- Agreeing standards within specialties and between specialties and professions for referring and responding including exploring a one-way flow from ED to specialties
- Reviewing the Clinical Model of Care including the geographical footprint of specialties and junior doctors, the sub-specialty review process and enhanced allied health input
- Developing a clinician-led tool to agree and capture delays to patient discharge at board rounds
- Initiating advanced care planning at discharge
- Initiating a nurse/allied facilitated see and treat model in Orthopaedics and other areas
- Exploring new models for the orderly/transit team to reduce delays

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# Key Opportunities: Flow Between Facilities

- The pathway for non-weight bearing patients is established
- Daily management of +25 day LOS review for Active Rehab wards at Burwood (currently 24% of this cohort stay +25 days)
- Established service manager for flow OPH&R to provide better reporting, monitoring and service improvement
- Review occupancy, readmissions and opportunities for nurse and allied health facilitated discharge across all campuses

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# Key Opportunities: Transitions of Care

- Working in partnership with PHOs around data sharing
- Working with Urgent Care SLA on priorities previously identified
- Explore Discharge to Assess model and Early Supported Discharge to help facilitate timely discharge of complex patients
- Gap analysis of community services we are currently contracting or providing and criteria for acceptance to address any barriers between secondary and community / primary care
- Increase visibility regarding delays on referrals / acceptance of community services
- Promote advanced care planning in the community following discharge

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# What Next

| Steps | Timeframe |
|---|---|
| Identify quick wins and start rapid cycle tests of change | Early Aug |
| Implement ‘wave one’ of focused improvements | Jul to Oct |
| Implement ‘wave two’ of focused improvements | Oct to Dec |
| Progress strategic change opportunities | Jul to Jul 22 |

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# WORKPLAN FOR HAC 2021 *(WORKING DOCUMENT)*

| 9am start | 28 Jan 21 | 01 Apr 21 | 03 Jun 21 | 05 Aug 21 | 07 Oct 21 | 02 Dec 21 |
|---|---|---|---|---|---|---|
| **Standing Items** | Interest Register<br>Confirmation of Minutes | Interest Register<br>Confirmation of Minutes | Interest Register<br>Confirmation of Minutes | Interest Register<br>Confirmation of Minutes | Interest Register<br>Confirmation of Minutes | Interest Register<br>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<br>Services Supporting Older People Living in Rural Communities | Clinical Advisor Update – Allied Health | Clinical Advisor Update – Medical<br>Care Capacity Demand Management Update | Clinical Advisor Update – Nursing | Clinical Advisor Update – Allied Health<br>H&SS 2020/21 Year Results | Clinical Advisor Update – Medical<br>Care Capacity Demand Management Update |
| **Presentations** | | Mental Health: The Acute Adult Pathway | Making Our System Flow<br>ESPI Performance | RSV & Impacts | | |
| **Governance & Secretariat Issues** | 2021 Workplan | | | | | |
| **Information Items** | | 2021 Workplan | Quality & Patient Safety Indicators - Level of Complaints<br>2021 Workplan | Making Our System Flow<br>2021 Workplan | 2022 Meeting Schedule<br>2021 Workplan | Quality & Patient Safety Indicators - Level of Complaints<br>2021 Workplan |
| | | | | | | |
| **Public Excluded Items** | Confirmation of Minutes<br>CEO Update (as required) | Confirmation of Minutes<br>CEO Update (as required) | Confirmation of Minutes<br>CEO Update (as required) | Confirmation of Minutes<br>CEO Update (as required) | Confirmation of Minutes<br>CEO Update (as required) | Confirmation of Minutes<br>CEO Update (as required) |